EMPANELMENT RESOURCE 4: SAMPLE EMPANELMENT POLICY AND PROCEDURE

Purpose and Definition

This section reiterates the language used in educational materials, defining key components (e.g., "empanelment", "PCP teams", "continuity") and why they are important (e.g., continuity has been shown to improve quality and save lives). It is the policy of [PRACTICE NAME] to continuously monitor and advance quality, outcomes and continuity of care for its community residents. [PRACTICE NAME] will implement empanelment to ensure improvement on delivery of care, population health management, and patient and provider satisfaction.

Processes:

This section defines the specifics of each needed process. Best practices have been defined where possible.

1. Empaneling New Patients

This subsection defines how empanelment choice is made. Are new patients empaneled with the primary care provider (PCP) with the soonest open appointment, or empaneled to the PCP who the patient sees at a walk-in/urgent appointment? Does the CHC have a process to understand patient preferences and match those with the most open panel?

Best practice: Establish a formal mechanism for capturing patient preferences and for balancing workload amongst PCPs.

2. Empaneling Assigned but Not Yet Seen Patients

Although the current data environment of most practices does not support the incorporation of "assigned but not yet seen" potential patients into the empanelment process, the empanelment design team recognizes that this should be part of the future state.

This section defines how outreach to these potential patients will be done. Are the "assigned but not yet seen" patients empaneled to individual PCPs and do they become the responsibility of the care teams, or are these potential patients empaneled only after being assessed?

Best Practice: Establish a mechanism to add the projected time (patient weight) of this set of potential patients to the panels because the practice bears the financial and quality responsibility for the patients, and a predictable number of patients will come in and need resources.

> **Example:** *GoodCare CHC has 10 PCPs with 10,000 empaneled patients. GoodCare enters into a contract with managed care and has 5,000 patients assigned. Of those, 2,000 are already on panels and 3,000 have not yet been seen. GoodCare sets up a centralized process to outreach to the 3,000 and does not yet empanel them individual PCPs or teams. Based on experience, GoodCare expects 40% of the assigned patients to engage in care in the following year. This equates to 1,200 patients, therefore panel sizes are adjusted up by 120 patients for each of the 10 PCPs (alternatively, expectations are reduced by 120). When assigned but not yet seen potential patients call with an urgent problem, these patients are seen promptly, and resistance to this is reduced because PCPs and care teams know they're already being counted in the panels.*

3. Adjusting for Patients Who Do Not Come in for Care

This section defines the circumstances under which patients that do not seek care are removed from a patient panel.

Best Practice: If a patient is assigned elsewhere by health plan per patient request, or has moved or died, remove them from the panel. Otherwise, even if a patient doesn't come in for care, keep patients empaneled for 3 years at which time they would be removed from the panel. If a patient has not been seen for an unexpectedly long time but less than three years, use weighting to reflect the likelihood of low future utilization (down to zero).

4. Changing PCP by Patient Request

Define who can make the change and how change requests will be tracked.

Best Practice: Create a PCP change template that is embedded in your EHR and tracks requests by site and provider. Document the reason why the patient is changing PCPs.

> **Example:** *GoodCare CHC is on NextGen. They implemented empanelment six months ago. They have an empanelment manager, and they consistently run monthly reports. The front desk staff notified the empanelment manager that patients have been calling in to change their PCP and sometimes request to change their assigned PCP after a visit. The empanelment manager was tasked with creating the PCP change process. They worked with IT to create a PCP change template with structured data fields to capture the following elements: patient name, patient medical record number, current assigned clinic, current assigned PCP, reason for PCP change and newly assigned PCP.*

5. Changing PCP for Other Reasons

Define the processes for changing PCP when panels are too full or for other reasons, such as provider suggestion/request, aging out of pediatric practice, provider changing location etc.

Best Practice: Patient notification should be part of the process.

6. Departing Providers

Establish a process for moving the panels of departing providers (either distributing or holding with current PCP assignment for interim time). Define "managed discontinuity" if necessary (who will see empaneled patients and how they should be scheduled). This will involve changing provider FTE time to zero in the empanelment technology solution.

Best Practice: Patient notification should be part of the process.

Leaves of Absence

This subsection is like the departing providers subsection, except there is a planned return. Consideration should be given to notifications of staff and patients, and the routing of messages and inbox.

7. New Provider

This subsection defines the steps to create an accurate reporting environment when a new provider is onboarded, including defining and entering clinical FTEs (the time seeing empaneled patients). Establish a plan for slowly increasing the panels of providers that are new to practicing in ambulatory setting. Having providers with different productivity standards can complicate empanelment. Complications are avoided if one standard of care is expected for all providers (physicians, advanced practice nurses, and physician assistants) and the primary care time projection (the weight of a patient in a

panel) is dependent only on patient factors. Even if there is the recommended single standard, individual providers may need to adjust productivity expectations, including ramping up slowly for a new graduate.

In these cases, it is recommended to adjust the FTE by a percentage of expected productivity. A new graduate with limited ambulatory experience may start at 50% productivity expectation and work up gradually to 100% over a year's time. At the six month mark, their panel size would be calculated as if they were 75% of an FTE, even assuming they are 100% clinical.

8. Balancing Patient Needs Against PCP Availability

This subsection may simply refer to the practice's scheduling guidelines. In other words, the CHC might want this subsection to refer to a living document that all staff are using to schedule. This subsection (or separate living document) tells schedulers how to respond to patients who want to be seen soon rather than wait for an appointment that would allow continuity with their PCP or PCP team. Best practices are very situation-dependent but result in high continuity and satisfied patients.

9. Defining the Number of New Patients and Opening and Closing Panels

This subsection defines how new patients will be assigned to panels and at what size panels are closed to new patients.

10. Monitoring

This subsection defines how continuity, attrition, and panel loads are monitored. Empanelment metrics should be added to the quality improvement plan at the organization. Core reports should be tracked monthly and reviewed the QI committee, including:

- Continuity: Percent of providers' appointments that are with patients who are on their panel.
- Continuity: Percent of patients' appointments (all or specific type) that are with the PCP they are empaneled with.
- Percent of population seen in last 18 months who are empaneled with a PCP.

Responsibilities and Accountabilities

For clarity, use this section to reiterate the preceding processes as roles.

Medical Director or Chief Medical Officer (CMO):

- Oversees and manages empanelment at the organization.
- Collaborates with the empanelment manager to achieve empanelment objectives.
- Addresses provider questions.

Panel Manager:

- Reviews PCP assignments and panel report monthly. The panel report consists of core reports listed in Empanelment Resource 11.
- Provides panel capacity report to the front desk and scheduling staff monthly.
- Runs all the required reports and shares the status of targets. Develops a performance improvement plan to address concerns if targets are not met.
- Addresses discrepancies in PCP assignments.
- Resolves unassigned patients by reviewing appointment history (and possibly the clinical record) to determine appropriate assignments.
- Reviews transfer of care requests, including patient-initiated PCP change requests. Tracks and processes PCP change request forsm and makes the change in the practice management system.

Scheduling, Front Desk or Call Center Staff:

- Confirms and schedules all patients with their assigned PCP.
- Schedules the patient with a member of the assigned PCP's care team if the patient's assigned PCP does not meet the access needs of the patient (e.g., the provider is booked too far out).
- Supports the patient with the process of changing their PCP, if requested.
- Assesses the preferences of newly assigned non-paneled patients before assigning them to a PCP (gender, location).
- Panels all newly assigned members to a provider panel.
- Reviews the panel capacity spreadsheet before assigning a patient to a provider panel, and assigns patients to a provider who has availability.
- Sends out welcome letter to all new patients.
- Implements a PCP change at the request of the patient.

Primary Care Provider (PCP):

- Reinforces continuity with assigned PCP to the patient.
- Alerts the empanelment manager when non-paneled patients repeatedly schedule appointments with them.

Care Team Member Scripts[1]

Here are examples of scripts for schedulers and care teams to reinforce the processes.

FIGURE 4.1: CARE TEAM MEMBER SCRIPTS

1. Outbound call to an assigned new patient.

Scheduler: "Hello, this is [name and title] and I'm calling from [name of practice] to schedule an appointment with your new primary care provider. Can I help you do that?"

Patient: "Yes! I've needed to see a doctor."

Scheduler: "Great. We look forward to working with you. It looks like you were assigned to [Dr. X]; were you informed of that?"

Patient: "No, but if he's a good doctor, that's fine with me."

Scheduler: "Ok. [Dr. X] is a [type of care specialty and anything else that might be of interest]. I think you'll be pleased, but you always have the option to change doctors. I want to tell you a little bit about how we organize care here at [health center]. [Dr. X] typically works with the same nurse, the same medical assistant, and the same clerk (me!) most of the time. We call this team your medical home team. Seeing the same medical home team at each visit will allow you and the team to get to know each other better. Healthcare teams who really know their patients can take better care of them. Does that sound good to you?"

Patient: "Yes. I have a diabetes and COPD, and I hate having to tell my story over and over again to different people, so this will be a relief!"

Scheduler: "That's exactly the point. I'd like to schedule a time for you to come in for a history and physical, and for you to meet your medical home team."

2. Inbound call from an established patient whose PCP is not available.

Patient: "I would like to make an appointment with Dr. Green for tomorrow."

Scheduler: "I'm sorry, Dr. Green is not in tomorrow. He can see you today at 4 p.m. or Friday at 10 a.m."

Patient: "I can't come in this afternoon, and Friday is too late. I really need to be seen tomorrow morning."

Scheduler: "That's fine. I can schedule you with Dr. Green's partner, Dr. Purple. The next time we will try to get you in with Dr. Green."

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3. Inbound call from an established patient who wants to change providers.

Patient: "Hi. This is Christie Kosten. I need to come in for a repeat pap smear."

Scheduler: "I have an appointment available for tomorrow with your doctor, Dr. Male."

Patient: "Hmm. You know, I'd much prefer a woman doctor, especially with some of my new health problems. I think I'd just feel more comfortable talking about them with a woman doctor. Can I switch doctors?"

Scheduler: "Of course. Let me pull up the PCP change form and give you some details about one of our female providers. Dr. Female is an internal medicine doctor who has been practicing here for about five years, and patients really like her."

Patient: "Oh yes, I've heard of her. Can I be switched to her?"

Scheduler: "Yes. I just submitted the PCP change form. She will now be your assigned doctor. I can schedule you now with her. She has an available appointment for Friday at 11 a.m.; does that work for you?"

Patient: "Yes, thank you."

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4. Inbound call from an established patient who wants a follow-up appointment in three months.

Patient: "This is Mrs. Brown. I just had a visit with my doctor over there yesterday and I realized I left without a follow-up appointment. I need to come back in for my diabetes in three months like I always do."

Scheduler: "Actually, we have a new approach to patient scheduling. We purposely did not give you a follow-up appointment. We try not to schedule out so far because plans change. It can be hard to keep an appointment that is scheduled so far in advance. We will plan to call you around the time you should be seen. We keep several appointments open each day for follow-up visits. Is that okay with you?"

Patient: "I don't really like that. What if you forget to call me and my diabetes gets bad?"

Scheduler: "We have a reliable reminder system to make sure we call you when you are due for your next visit. You can also write it down on your calendar and plan to call us, if you prefer. Also, you should feel free to call us any time you're not feeling well so a nurse can talk with you and have you come in earlier, if needed."

Patient: "I just want to make sure I see my regular doctor, and I'm afraid if I wait so long to make the appointment, his schedule will be all filled up. I just don't like this!"

Scheduler: "It sounds like this new way of scheduling follow-up visits is causing you some stress. I can go ahead and schedule you now. We will call you the day before to make sure you are still able to come for that appointment."

ENDNOTES

1 Vachon G, Weiselberg L. Empanelment in an Accountable Care Environment. Chicago: Health Management Associates; 2013 [cited 2023 July 13]. Available from: https://www.healthmanagement.com/wp-content/uploads/Empanelment-Implementation-Guide-January-2013-FINAL.pdf.