L20: Primary Care Transformation in Academic Medical Centers

IHI National Forum
December 8th, 2013
Asaf Bitton, MD, MPH; Jonathan Sugarman, MD, MPH; Ziva Mann, Patient Partner; Cory Sevin, RN, MSN; Erika Pabo, MD, MBA; Rebecca Steinfeld, MA

These presenters have nothing to disclose.

Objectives of Session

- Identify successful strategies for setting up primary care transformation in an academic setting.
- Describe practical strategies in the move to team-based care and empanelment in academic primary care practices.
- Describe how to include patient input in the work of primary care transformation.
Introductions
Double Helix of Academic Primary Care Delivery Reform

Practice Change

Educational Change

Building Blocks for Change
- Teams
- Leadership
- QI strategy
- Empanelment

Academic Innovations Collaborative (AIC)
The Academic Innovations Collaborative

- 19 AMC-affiliated primary care practices
  - 6 hospital-based
  - 13 community-based
    - Community health center and private practices
- 11 Residency Programs
  - 7 Internal Medicine, 1 Family Medicine, 1 Med-Peds, 2 Pediatrics

What We Aim to Accomplish Together

1. Establish team-based care
2. Manage populations prospectively
3. Find/manage “high-risk” populations
4. Improve physician/workforce satisfaction
5. Improve patient and trainee experience
The Power of Teams

Effects of QI Strategies for Type 2 Diabetes on Glycemic Control

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[Image 141x428 to 486x612]

Overall Goal/Aims of AIC

- **Create a learning community** across Harvard clinical affiliates focused on continuously improving systems for primary care delivery and education
- Create a platform for combined educational and delivery innovation
  - Trainees are integrated within **high-functioning primary care teams** that provide:
    - proactive, population-oriented care focused on wellness, prevention and highly effective chronic disease management
- Achieve sustainable improvements in the **experience of care** for patients & trainees in our affiliated clinics
- **Increase quality** and start to **reduce costs** for patients at our affiliated clinics

*JAMA. 2006;296:427-440.*
Key Components of the AIC

- **Funding sources:**
  - HMS Center for Primary Care - $8 million
  - Academic Health Centers - $6 million

- **How we spend our funds:**
  - Full-time program manager at each large AHC
  - Protected time for practice transformation
  - Learning sessions, academies, coaching
  - Design, operation, evaluation

- **Time frame:** 2 years, launched July 2012

The Structure of the AIC

- **At each clinic site:**
  - Transformation team – 6-12 staff members including residents
  - Aims statement
  - Develop and test changes during Action Periods

- **Learning sessions – 3x per year, in person**

- **Monthly conference calls**
The Structure of the AIC

- Practice coaching - from CPC/IHI/Qualis Health
- Leadership academy
- Educator and trainee academy –
  - Resident curriculum
  - Learner-led quality improvement and care coordination activities
- Patient engagement – patient/family advisory councils, regular patient surveys, patients on transformation teams

Confounding Factors
- Patients
  - Age, Sex
  - SES
  - Medical Complexity
- Providers
  - Size, Location
  - Case Mix
  - Payment Change
- Perceived Needs
  - Patient Mix

Aim 1
- Strategies/Tools for AMC Practices

Aim 2
- Provider Work Satisfaction
- Trainee Skills and Experience

Aim 3
- Care Quality and Health Plan Costs

Courtesy of Alyna T. Chien, MD, MS
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Engaging Leadership
The SNMHI Framework: The Change Concepts for Practice Transformation

Goal:
To have effective, involved leaders help staff see a better future, and give them the tools, resources and time to achieve it.

Goal:
To have in place a sustainable, broadly inclusive approach to continuous quality improvement that includes trusted performance measurement and a strategy for changing practice.

Laying the Foundation: Why is it Important?

• Leadership and QI strategy provide the foundation for redesign.
• Practices that succeed in quality improvement initiatives have adaptive reserve – the ability to learn and change.
• Key feature is leadership that can: envision a future, facilitate staff involvement, and devote time and resources to make changes.
• Practices that don’t routinely measure and review performance are unlikely to improve.

What Does it Actually Look Like?

• The responsibility for conducting quality improvement activities is shared by all staff, and made explicit through protected time to meet and specific QI resources.
• Quality improvement activities are conducted by practice teams with meaningful involvement from patients and families.
• Leaders support continuous learning throughout the organization. They review and act on data.
• Transformation toward the patient centered medical home (PCMH) is built into hiring. Training and incentives focus on rewarding patient-centered care.
What Have We Learned?

- Turnover is one of the most disruptive events to successful transformation:
  - PCMH transformation must be embedded in the organization to protect against leadership turnover.
- Most sites have little capacity to collect, analyze, and report data from valid, reliable measures.
- QI is difficult unless information technology is stable.
- All staff must understand the value of measurement and have confidence in using data to drive change.

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**Goal:**
To assign all patients to a provider/care team to facilitate continuous care and population management.

**Goal:**
To develop skilled and well organized care teams, and ensure that patients are able to see their care team consistently over time.

Teams should be designed to meet the needs of patient panels (typically include provider, MA, RN, front desk staff)
Building Relationships: Why is it Important?

- **Empanelment** is the platform for population health:
  - Links patients to care teams
  - Profoundly changes culture and sense of accountability
- Team involvement in the care of chronically ill is the single most powerful intervention.
- Patients who have a continuity relationship with a personal provider have better health process measures and outcomes:
  - Continuity of care increases the likelihood that the provider is aware of psychosocial problems impacting health.

What Have We Learned?

- Empanelment is harder than it looks:
  - Assumes stability of providers and patients
  - Requires continuous attention
- Teamwork does not necessarily happen just because people are working on a team:
  - NEW relationships and NEW communication strategies have to be established.
  - Providers need to be trained and given protected time to lead the team.
- Creative practices are expanding the roles of less highly trained staff such as MAs or Community Health Workers.
Goal:
To encourage patients to expand their role in decision-making, health-related behaviour change and self-management and to communicate with them in a language and at a level they understand.

Goal:
To use planned interactions and follow-up with patients according to patient need, and to identify high-risk patients and ensure they are receiving appropriate care management services.

Changing Care Delivery: Why is it Important?

• Patient activation is tied to health improvement.
• Patient involvement in QI activities and health center boards helps maintain the focus on patient and family needs.
  – It also makes change process more efficient by incorporating end-user feedback in real time, and potentially avoiding useless or even harmful tests of changes
• Well-organized care is patient-centered care.
• Well-organized care is good care:
  – Practices that do pre-visit planning (huddle) have better measures of chronic disease control and preventive care.
What Does it Actually Look Like?

- Assessing patient/family needs and preferences, and involving patients in decision-making is systematic, not ad hoc.
- The principles of patient-centered care inform organizational level decisions and patient interactions.

What Have we Learned?

- Effective practices train all staff on patient communication and engagement techniques: “teach-back”
- Strategies to involve patients in the re-design process are still being identified. High-performing practices have adopted: “Nothing about me without me.”

**Goal:**

Care Coordination

To track and support patients when they obtain services outside the practice, and ensure safe and timely referrals or transitions.

Enhanced Access

**Goal:**

To ensure that established patients have 24/7 continuous access to their care teams via phone, email, or in-person visits.
Reducing Barriers to Care: Why is it Important?

- Evidence of cost savings comes, primarily, from improvements in care coordination and access.
- Even a few hours of off-hours appointment access is associated with reduced ED use.

What Have We Learned?

- Care coordination isn’t left to chance. Effective practices assign key activities and embed them in daily work.

AIC Set-Up For Quality Improvement

- Using data to drive improvement
- At practice level
- Building capacity-writing aims, connecting measures and testing/implementation
The Work of the AIC

Aim Statement #1:
• Assign Panels
• Team-based Care Teams
• Outreach to Patients
by July 2013

Aim Statement #2:
• Balance Panels
• Team Huddles
• Self-Management Goals
by January 2014

Aim Statement #3:
• Balance Panels
• Pre- and Post-visit
• Planned Care Visits
by July 2014

Measurement for Improvement

• Measurement – monthly transformation updates, PCMH-A tool
• Tiered, flexible measurement strategy
• PCMH-A tool
Data: Site-Specific Measures

Data: PCMH-A Score
**Empanelment and Continuous, Healing Team-based Relationships**

**What did the AIC teams do?**

**What was unique as a result of having residents and academic faculty?**
Goal:
To assign all patients to a provider/care team to facilitate continuous care and population management.

Goal:
To develop skilled and well organized care teams, and ensure that patients are able to see their care team consistently over time.

Teams should be designed to meet the needs of patient panels (typically include provider, MA, RN, front desk staff).

Break-return at 3:30
Goal:

To encourage patients to expand their role in decision-making, health-related behaviour change and self-management and to communicate with them in a language and at a level they understand.

Including the patient voice: partnering with patients for improvement

Ziva Mann, MA
Patient Lead, Patient Partner
Cambridge Health Alliance
December 8, 2013
Overview

• Introduction: CHA’s approach to improvement

• Practice Improvement Teams (PIT) = front line staff and patients

• The lifecycle of partnership: how we find, integrate and support patients working with the PIT teams

• Who are the CHA partners?

• Staff and patient partner perspective on patient involvement in improvement work

• Examples of projects influenced/guided by patient involvement

• other ways to include the patient voice

Cambridge Health Alliance

100,000 underserved patients, served by integrated care delivery system
(10 clinics, 2 hospitals, specialty sites)
Models for partnership

The goal:

Redesign the system with the patients we intend to serve. Our patients have resources, ideas and guidance that we need to improve.

- Dr. Somava Stout
VP of Patient Centered Medical Home Development
Cambridge Health Alliance
Core Faculty for Leadership, Management and Innovation
Harvard Center for Primary Care
Steps Along the Journey

- System-wide Patient and Family Advisory Council formed.
- Had health center patient and family advisory councils, but not sustained
- Walking in the Patient’s Footsteps
- Patient and family partners as part of clinic-based practice improvement teams (PITs).
- Coordinating work of the PITs with the X-PIT.

Practice Improvement Teams
Who are the CHA patient partners?

Experience with medical system:
- adult patients
- parents of medically normal children
- parents of medically complex children
- primary caregivers for their adult parents
- ....or a combination

Occupation:
- retired
- stay at home moms
- on disability
- work part time
- work full time

Our partners also speak multiple languages, have a variety of educational and cultural backgrounds.
Why I am a partner:

“Because my doctor asked me to. We have a strong relationship, built on trust and teamwork. She has done so much for us - I could do this for her.”

-Dierdre, CHA patient partner

Lifecycle of Patient Partnership
Foundation of readiness

• Leadership engagement

• Shared vision of patient partner role

• Trust, relationships, and effective structures and processes
  • streamlined HR on-boarding

• Funding, if needed

• Ongoing support and resources

Finding effective partners

• “experience from existing programs suggests that important considerations are the patients' abilities to:
  – work with the health care team
  – their breadth of experience with the health care setting
  – their ability and willingness to communicate concerns
  – [their] ability to represent patients and families broadly rather than focus narrowly on a particular issue.”

• CHA also looks for leadership, listening skills and availability.

Recruitment: Slow down to go fast

1. Identify 4-5 potential patient partners
2. Call potential patient partners, explain the PIT team, team goals, team projects to date, patient partner role in these.
3. Interview several patient partners and see if the partner is interested and able
4. Show value: What would make it easier for you to participate?
5. Clarify mutual expectations
6. Select patient partners; consider other roles such as Advisory Council membership or focus group participation for remaining candidates.
7. Sign agreement.

“My first meeting, I listened. By my second meeting, I was ready to talk.”

—Ruth, CHA patient partner
Integration: where am I and who am I?

• Orient the patient partner to the clinic structure, systems in place, goals for improvement.
• Orient the patient partner to their role
• Review the shared purpose of the team, team resources, and team work to date
• Jargon is a dialect! Be aware of shared concepts and language the patient partner may not yet understand.
• Provide a mentor (ombudsperson) and a team buddy
• Remember: it takes time to settle in.

Ongoing Support
(for as much of the team as possible)

• **Building skills:** active listening, managing conflict, telling your story, looking beyond your backyard, understanding improvement and change management
• **Connecting partners:** networks of shared effort to catalyze change; peer mentorship
Departure

• Debrief with the customer partner and the team
  – Conduct an exit interview
  – Identify possible alternate opportunities for participation
  – Departure feedback questionnaire
• Assure no change in the relationship as it relates to their care and to the practice
• Express appreciation
• Identify opportunities for future engagement

Building trust and partnership: staff perspective

• What about our dirty laundry? Will they still come to the clinic if they see how the sausage is made?
  • Trust is key.
  • Learned that we often needed to fix the basic improvement process itself for all team members.
  • Power/hierarchy is the elephant in the room. Have to equalize as much as possible.
  • We found potential mistakes earlier and got much deeper and richer feedback.

-Dr. Rob Chamberlin, Dr. Soma Stout, Elaine Arsenault
Building trust and partnership: patient partner perspective

- What value can I add?
- What kind of change can I make?
- Will I offend my healthcare team if I criticize the clinic?
- Will I be a partner, or a mascot?

*Remember:* culture eats strategy for lunch!

How patient partners have helped change our system

- Help set the agenda for improvement
  - Lead the team (co-chair)
  - Refill process, access, new patient orientation, better care transitions, patient-centered care coordination process
- Give depth to the patient experience and improvement processes
  - Redesign of Walking In the Patient’s Footsteps to formally assess effectiveness of patient-centered interactions
- Break impasses and catalyze a move forward
  - Shared care plans for mental health
  - Adoption of patient portals, social media
- Be an active partner/leader in creating the change
  - Revised pediatric patient instructions to be readable to patients
  - Redesigned waiting rooms, mental health referrals
- Educational events for patients, online resources for parents
Examples:

**Somerville Primary Care**

**project:** check-in/check-out form: given to patient at check-in, patient told it's not for them, asked to hand to MA. Patients leave form in waiting room. PIT wanted to improve workflow.

**question:** why is this given to the patient?

**challenge:** make the sheet relevant to the patient, or find a workflow that doesn’t involve patients.

**outcome:** “Our Process Improvement Team revised the patient visit sheet. It now provides the opportunity to set a shared agenda, and to create patient priorities for the visit.”
Cambridge Pediatrics

**project:** offer complex care coordination to our patients and families

**Q:** what do our patients need? what can we offer them?

- Step One: identify patients, gather resources.
- Step Two: 52 patients identified and contacted. 8 patients come in for initial visit with coordinator
- Step Three: rethink.

**Q:** can we teach our patients and families about care coordination? Yes! More families turned up for care coordination visits.

But feedback: the initial appointment is “exhausting,” “too long,” and “emotionally difficult.”

**Q:** how can we make the first visit patient and family-centered?

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**Q:** What are our goals for this visit? How do our goals fit the patient/family’s needs?

**Goals:**

- Build a relationship, develop trust.
- Focus on strengths.
- Demonstrate value

**Methods:**

- Listen! Let them teach you about their life and needs.
- Look at the person, not the computer.
- Assess the whole picture, not just the challenges.
- Have a takeaway.
Every patient is a person. Every person has a map.

Combining assessment and takeaway:

- care map
- travel letter

Other ways to engage patients in QI

Training tools: videos of patients discussing experience of care:

- New employee orientation
- Ongoing trainings

Patients on committees:

- Advisory Councils
- In 2013, CHA’s advisory council placed patients on 3 committees focused on patient experience of care
- Cross-PIT includes two patient partners
Surveys: strategies and challenges

- Just in Time/6th Vital sign surveys: three sites collected data on patient experience of care, to complement Press Ganey surveys.
- All four AIC sites collected data on barriers to care (for AIC learning session)
- Cross-PIT taking on project to spread strategies for real-time feedback from patients and families

**Somerville Hospital PIT:**

- “We need to solicit more patients and staff on perceived burdens/barriers to care.”
- “The staff demonstrated a real spirit of inquiry for this process and looked forward to having the time to discuss these issues with patients and to learning what their concerns were.”
- “Most patients enjoyed the process of being asked”

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**Challenge: getting patients to respond to your survey**

- Malden: a patient partner simply went out and “found patients.”
  
  “I found them in the waiting room, at the bus stop and the lobby. I explained why I was there, and they were happy to talk to me. It was easy!”

- Windsor: taking it one step farther, with a cycle of communication, or closing the loop.
Windsor

**Goal:** obtain more patient feedback to improve patients’ experience of care and quality of care. It will also give us the opportunity to inform patients about our improvement work.

**Method:** 1 week of paper surveys that were handed to all patients.

**Communication:** created a flyer for our bulletin boards, listing the feedback we received, and how we addressed it.

"A change in culture of clinic where staff offer suggestions and solutions not only complaints and problems; generally more smiles – tangibly in things such as staff taking it upon themselves to make their own team displays."

- excerpt from “Our Accomplishments,” AIC Learning Session 4
Resources

- Society for Participatory Medicine and the Journal of Participatory Medicine [www.participatorymedicine.org](http://www.participatorymedicine.org)
- Institute for Patient- and Family-Centered Care. [www.IPFCC.org](http://www.IPFCC.org)
- NICHQ (PFAC toolkit and “Powerful Partnerships”) [www.nichq.org](http://www.nichq.org)
- IHI - including The Patient is IN booth, Forum 2013.
- AF4Q: [http://forces4quality.org/engaging-patients-improving-ambulatory-care](http://forces4quality.org/engaging-patients-improving-ambulatory-care)
- Coming soon! Our toolkit on partnering with patients on QI teams.
- Safety Net Medical Home Initiative [www.safetynetmedicalhome.org](http://www.safetynetmedicalhome.org)
- And your biggest resource--YOU!

Why I am a partner:

“I joined because I needed to understand my healthcare system and how it works - and maybe even make it better. If not for my sake, then for my parents' sake."

-CHA patient partner
Questions / Comments

zmann@challiance.org

Resources

- Center for Primary Care, Harvard Medical School
  https://primarycare.hms.harvard.edu/who-we-are
- Safety Net Medical Home Initiative
  http://www.safetynetmedicalhome.org/
- Institute for Healthcare Improvement
  http://www.ihi.org/Pages/default.aspx
The following slides are for your reference. They are slide sets used in AIC learning sessions.

P4: Establishing a Foundation for Team-based Care: Empanelment
Finding the Patient at the Heart of the PCMH

Regina Neal MS, MPH
Senior Consultant
Qualis Health

October 2, 2012
Empanelment: Topics To Cover

- Where are we starting?
- What is empanelment?
- Steps to create and use panels
- Processes for maintaining panels in the practice
- Special challenges

PCMH Transformation Framework

1. Laying the Foundation
   - Engaged Leadership
   - Quality Improvement Strategy

2. Building Relationships
   - Empanelment
   - Continuous, Team-Based Relationships

3. Changing Care Delivery
   - Patient-Centered Interactions
   - Organized, Evidence-Based Care

4. Reducing Barriers to Care
   - Enhanced Access
   - Care Coordination
## Empanelment Key Changes

**PCMH practices:**

- Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis.
- Assess practice supply and demand, and balance patient load accordingly.
- Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status, community and family needs.

## PCMH-A Results by Item

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Panel Assignment
Use in Population Management
Use in Pre-Visit Planning
Reports on Process/Outcomes

Total N = 18
Expectations in a PCMH

- The care, organization and design of the practice is patient-centered
- Continuity between patients and a specific provider and care team is a reliable property of the practice
- Practice has an organized, proactive approach for managing and improving the care of population of patients
- Every patient receives optimal care including preventive, chronic and acute through their life cycle
- Supply and demand are managed to assure access and continuity

*Empanelment is a key to meeting these expectations*

Whose Patient Is It?
My Patients

New Goals, New Thinking

What Empanelment Makes Possible

- Patient-centeredness; brings patients into focus
- Population health management
  - Transforms reactive, sick care to proactive health care
- Development of high performing care teams.
  - Needs of our patients as focus of joint effort
- Access with continuity
  - Empanelment elevates our ability to provide the best care by making continuity a key objective in providing access
  - Contributes to reduction in unnecessary demand and our knowledge of patients which both contribute to our capacity and access
- Results
  - Improved experience, improved care
Empanelment is Leadership-Driven

- A deliberate shift in thinking about the goals of care and design of systems to support this
- Early needs include
  - Dedicated time and information resources to create panels
  - Someone to lead the effort, coordinate the work of data review, conversations with clinicians around emerging panels to finalization of panels
- Resources for establishing the measures to use to monitor key data for empanelment, e.g., rate of continuity; percentage empaneled, etc.

Steps in the Process

1. Use actual provider-specific data of supply and demand for visits to determine ideal panel size
2. Determine the current de facto panel size and composition; compare to the ideal panel size
3. Review de facto panel and ideal panel size with providers to engage them in process and develop ownership of their final panel
4. Confirm panel assignments with patients
5. Make adjustments to panel size and composition as needed
6. Develop panel- and patient-specific data to be regularly available to the clinician and team to use for proactive care
1. Using provider-specific supply and demand data to determine *ideal* panel size
   - How many visits does each provider have available per year? (Supply)
   - How many visits do patients make per year on average? (Demand)
   - Calculate how many patients can be on each provider’s panel based on these supply and demand factors

### The Ideal Panel Size

**Calculate:**

\[
\frac{\text{(provider appointment slots/year)}}{\text{average number of visits / patient / year)} = 3.19
\]

Solve: \( 4520 = 1417 \approx 3.19 \)
Why Supply and Demand Matter

- Supply and demand need to be in balance for access and continuity to be reliable features of the practice
- When not in balance, panels end up being too large or too small
- Too large: delays for appointments, deflections, discontinuity, rework, overwork
- Too small: demand may not be adequate to support the practice
  - Financial
  - Work load equity among providers

Who’s on the Provider’s Current Panel?

2. Determine the current *de facto* panel and compare to the ideal panel size
   - Who did each patient actually see for each visit?
   - Often patients see providers other than assigned provider
   - Patients often see more than one and sometimes more than two providers in the practice
   - These data will be used to assign patients to the panel of one provider
Determine Current Provider Panel

- Patients are likely to have seen multiple providers
- Which provider’s panel should the patient be placed on?
- Use “four-cut” method to determine where to place patients
- Will not be 100% accurate but it is a starting point

Design data report to identify the provider for each unique patient’s visit(s) during the 24-month period

The visit history report is a look back at all of the visits for active patients in the last year, denoting which clinician saw the patient at each visit. This report will be very large.

The report is structured as follows:

<table>
<thead>
<tr>
<th>Patient</th>
<th>Visit Date</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Aaa</td>
<td>1-15-10</td>
<td>Dr. Goode</td>
</tr>
<tr>
<td>Patient Aaa</td>
<td>3-1-10</td>
<td>Dr. Goode</td>
</tr>
<tr>
<td>Patient Aaa</td>
<td>3-20-10</td>
<td>Dr. Monroe</td>
</tr>
<tr>
<td>Patient Aaa</td>
<td>8-2-10</td>
<td>Dr. Monroe</td>
</tr>
<tr>
<td>Patient Aaa</td>
<td>10-29-10</td>
<td>Dr. Schafer</td>
</tr>
<tr>
<td>Patient Bbb</td>
<td>2-2-10</td>
<td>Dr. Schafer</td>
</tr>
<tr>
<td>Patient Bbb</td>
<td>5-14-10</td>
<td>Dr. Goode</td>
</tr>
<tr>
<td>Patient Bbb</td>
<td>9-30-10</td>
<td>Dr. Schafer</td>
</tr>
</tbody>
</table>

- Assign each patient to a provider
- Analyze each provider’s panel for accurate assignments; adjust as necessary using 4-cut method
The 4-Cut Method for Panel Assignment

<table>
<thead>
<tr>
<th>CUT</th>
<th>PATIENT DESCRIPTION</th>
<th>ASSIGNMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Patients who have seen only one provider</td>
<td>To that sole provider</td>
</tr>
<tr>
<td>2</td>
<td>Patients who have seen multiple providers, but one provider the majority of the time</td>
<td>To the majority provider</td>
</tr>
<tr>
<td>3</td>
<td>Patients who have seen two or more providers equally (no majority can be determined)</td>
<td>To the provider who performed the last physical</td>
</tr>
<tr>
<td>4</td>
<td>Patients who have seen multiple providers</td>
<td>The last provider seen</td>
</tr>
</tbody>
</table>

Source: Mark Murray

Confirm Panel with Providers

3. Review *de facto* panel and *ideal* panel size with providers to engage them in process and develop ownership of their panel
   - This is an ongoing process from beginning
   - Medical leadership is essential
   - Start with goals, benefits
   - Review process, methods, data
   - Have a dialogue (on-going) about goals, benefits, concerns, process for assessment, making adjustments
   - What data will you use to assess outcome goals and panel size over time?
Engage Patients in the Process, Too

4. Engage patients in the process too; use an ongoing process
   - Want to minimize disruption of existing patient-provider relationships
   - Involve patients by checking with them when they come into the clinic to confirm that they agree that Dr. Smith or the NP, Ms. Jones, is their provider
   - When patients call the clinic always ask “who is your assigned provider?” and ensure that the call is routed to the right care team and appointment made with the right provider and care team
   - Communicate and reinforce provider – patient link in as many ways as possible

Possible Adjustments for Panel Size

- Patient age and gender can predict demand and reflect acuity
  - Need adjustment factors to apply
  - Need information system to do calculations to apply adjustments
- Variance for scope of practice (FP, IM, Peds)
- Weight by complexity, acuity, morbidity
  - Age, gender adjust captures much of acuity impact
  - Complex process: what are the right factors to use?
Adjustments for Final Panel?

- Consider this: One panel adjusted down requires another to be adjusted up
  - Can lead to a complicated process within the practice
  - Can stall or delay the process without material improvement in panel composition or sizes

“Practices should consider whether many of the age and acuity factors could be managed more effectively by providing focused team support than by adjusting panels.”
--- Mark Murray

How Big Can a Panel Be?

- Panel size has some elasticity
- Practice patterns and system design can influence maximum panel size possible
- Using teams who “share the care” is a key contributor to being able to manage larger panel sizes
  - Recent study suggests delegation of preventive and chronic care tasks to non-physician team members can allow team to care for a larger panel than would be otherwise possible
Practice Patterns Influence Panel Size

- Visits per patient per year (lower demand)
  - Decrease with continuity; lower visit return rate, provide more service at each visit, increase role of team members so all care not delivered by provider; use alternatives to traditional visits, e.g., telephone, email, group

- Provider visits per day (increase supply)
  - Increase by improving visit show rates, share the care among team members, improve workflow efficiency, increase number of exam, remove all unnecessary work from providers to optimize productive use of appointment supply

- Provider sessions or days per year (increase supply)
  - Protect provider time during patient care hours from non-patient care activities; e.g., incorporate administrative time duties into the work of the team; use non-patient care hours for meetings
There Are Limits To Panel Size

• Saying “yes” can mean “no” if we can’t provide what the patient needs and wants, can’t maintain access with continuity
• Leads to escalating chaos within the practice, increase in rework, decrease in outcomes and experience; burnout, decreased patient experience and poorer outcomes
• To maintain panels at right size, you may find you need to add more providers. But this is a last step
• First
  – Build teams; redesign workflows; exploit power of technology; eliminate needless work and re-work; add staff to do the right work e.g., care coordinators, care managers, pharmacists, behavioral health, etc.

Adjusting a Panel That Is Too Large

• Bolster the care team: shift more resources to support the provider and care team, e.g., additional nursing and/or clerical support; additional exam rooms
• Excuse the provider from seeing patients of absent providers
• Let attrition take its course
• Close the panel temporarily
• Move patients to another panel. Develop a patient-centered and thoughtful process
  – Providers need to inform their patients directly
  – Patients need to agree to any transfer
What if the Panel is Too Small?

- Develop a plan to grow a small panel
  - Consider whether the provider is new to practice or is an experienced provider
- Consider moving patients from panels that may be too large
  - Always consider the patient’s desires in any plan to redistribute patients to a different panel
  - Providers need to be part of direct communications with patients about moving to another panel

Empanelment Process Takes Time

- Started with pilot clinic to ensure the process worked
- Process took 6 months for all clinics
- Had empanelled 99% of patients within 8 months; had started with 6,000 unassigned patients, many more assigned to an incorrect provider
- Implementation of new processes were maintained post-empanelment

Slide Source: Amit Shah, MD, Multnomah County, OR
Sustaining Empanelment in the Practice

Creating Patient Panels is Only One Step in the Process

- Patient panels need to be maintained over time
- System design must specifically support access and continuity for patients, especially scheduling system
- Processes for updating panels over time and monitoring supply and demand
Build an Empanelment Protocol

• Define Roles and Responsibilities for Panel Management
  – Assign a Panel Manager
  – Provide training for all levels of staff
  – Use scripts at clinic reception during check-in, when making appointments, to validate patient’s provider and patient preference
  – Routinely review panel reports, adjustment, and assignments

Link Empanelment to Appointment Scheduling for Continuity

• Ensure that scheduling is done to prioritize continuity for patient with provider and care team

• It is easy for scheduling process to revert to the old way, i.e., next available provider vs. the assigned provider

• Use scripting for appointment scheduling

• Monitor data to ensure access and continuity
Develop Standard Process for PCP Assignments

• Initial assignment of new patients
• Transitioning from one provider to another, one clinic to another
• Assignment of “outliers” identified on monthly panel reports
• Building panels for new providers; reassigning panels for exiting providers
• Determining when the panels are “open” and “closed”

Regular Access to Panel Data to Promote Proactive Care

• Panel-level data are available to assess and manage care for patient populations across a comprehensive set of diseases and risk states (registries)
• Individual patient data are available to practice teams and are routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states
Be Results Driven: Use Data to Measure

- % of total practice patients who are empanelled
- % of patient visits to assigned PCP (continuity)
- % of provider visits that are with panel patients
- Number of overbooks per week
- 3rd next available appointment
- Patient experience with access and continuity
- Provider/team experience with panel sustainability
- Clinical process and outcome metrics by panel: are you reaching goals?

Special Challenges

- Empanelment for part-time clinicians and for trainees
- Panel sizes for NP and PA clinicians
- Establish coverage standards to support continuity and enhanced access for our patients
Resources

Safety Net Medical Home Initiative Web-site:
http://www.safetynetmedicalhome.org/change-concepts/empanelment