Patient Centered Access: Empanelment

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Patient Centered Access and Continuity

- Competency B
  - Practices support continuity through empanelment and systematic access to patients medical record
CORE

- **AC10**: Personal Clinician Selection
  - Documented process
- **AC11**: Patient Visits with Clinician/Team:
  - Sets goals and monitors the % of patient visits with the selected clinician or team
  - Report

CREDITS

- **AC13** Panel Size Review and Management:
  - Reviews and actively manages panel sizes
  - Documented process & report
- **AC14** External Panel Review and Reconciliation:
  - Reviews and reconciles panels based on health plan or other outside patient assignments.
  - Documented Process & Evidence of implementation
Why are Patient Panels Important?

1. It makes patients happy!
2. It defines the workload for the practice
3. Can help predict patient demand
4. Reveals provide performance issues
5. Helps improve outcomes
What is the panel size?

**PROVIDER PANELS**
- Panel size is the number of individual patients under the care of a specific provider.

**PRACTICE PANEL**
- The unique patients who have been seen by any provider (physician, NP, PA) within the last 18-24 months
- The practice determines the timeline
- Gather data from 12, 18 or 24 months.
  - 12 months may be an underestimate
Determining Individual Provider Panel

- Each patient on the practice’s panel- **should** be placed on the **panel of only 1 provider**

- Utilize a “Four-Cut” Method
  - This is not an 100% accurate method, but it is a **GOOD START!**
1. Patients who have seen only one provider for all visits are assigned to that provider.

2. Patients who have seen more than one provider are assigned to the provider they have seen most often.

3. Remaining patients who have seen multiple providers the same number of times are assigned to the provider who performed their most recent well visit, or physical.

4. Remaining patients who have seen multiple providers the same number of times but did not have an exam they are assigned to the provider they saw last.
1. Target panel is the practice panel divided by the number of full-time-equivalent (FTE) clinical providers.

2. To determine the number of FTE providers:
   - Subtract the portion of the provider’s time that is spent on non-appointment or nonclinical duties such as:
     - Hospital rounds
     - Operating room duties
     - Procedures
     - Management duties
     - Meeting time
LARGE PANELS

- Excess demand
- Delay in services
- Deflections to other providers
- Lack of continuity
- Provider dissatisfaction
- Patient dissatisfaction

SMALL PANELS

- Demand isn’t enough to support the practice
Demand for appointments must equal the supply of appointments if timely service is desired.

Panel size x visits per patient per year (demand) = provider visits per day x provider days per year (supply)

Right Panel Size- variables

PROVIDER VISITS PER DAY
- Look at historical data regarding the # of visits provider per day
- It is NOT the number of appointment slots available per day

PROVIDER DAYS PER YEAR
- Look at the # of days in a provider’s schedule was booked for patients visits per year

Isolating each of these variables helps providers understand how their practice patterns influence their panel size.
Adjusting for Age and Gender

- Patients have varying levels of needs and complexities
- Providers may express their patients are older and sicker
- Adjusting for age & gender can help determine accurately
- Timely process and one that should be done with entire team
There is a limit to practice and individual panel sizes

- If a practice/provider keeps saying “yes” to new patients, and exceeds its limit = increased wait times
- Increased wait times =
  - Chaos
  - Difficulty managing patient phone calls
  - Patient complaints
  - Increase of no-shows
  - Increase of cancellations
  - Decreased continuity
  - Lower productivity
Estimates on Panel Sizes

**TEAMS OF 2000**
- Good patient experience
- Well-coordinated care
- Adequate access
- Low staff and provider burn out
- Or there should be improvement plans in the place to make these things true

**TEAMS OF 2100 OR MORE**
- Experience stress
- Care could be less coordinated
- Barriers to access could arise
- Could lead to burn out
1. Let it take it’s course. Patients move away, die, and change insurances.

2. Close the over-paneled provider to new patients temporarily. Excuse them from seeing the patients of absent providers.

3. Shift more resources to support the provider (care managers, care coordinators, MA, etc.)

4. Move patients away from that panel and into another panel.
Resources to Ensure Continuity

- Appointment confirmation scripts
- Provider-staff scheduling polices
- Provider “team” cards
Panel Size References

Get Started By:

Contacting Kim Huff, Healthy Connections Health Resource Coordinator at Medicaid for practice empanelment reports.