Addressing Staff Pushback for Empanelment

Provider / Manager Push Back	Response	Management Opportunity

This sounds like thinly disguised productivity jargon.	This is not about productivity demands. It is about understanding providers' workload and applying balance measures to move from chaos to control. It allows for variation in provider practices.	• Educate providers that empanelment is:
		  • Critical to obtaining continuity of care.
		  • A means of understanding the provider's workload and the variables in practice styles and preferences.
		  • A tool for applying balance measures to move from a chaos-driven environment to one of provider control, improved efficiency and patient outcomes, and greater job satisfaction.

I have too many part-time providers for empanelment.	Consider why the practice relies on so many part-time providers and think about the impact of this staffing pattern on patients and families. Although part-time providers may have proven to be an efficient staffing method in the past, a long-term commitment to empanelment and the medical home means that management and senior leadership must rethink current provider contracts with consideration toward what is most beneficial for the patient and the practice. The PCMH Model of Care requires continuity of care that is compromised by lack of availability.	• Set minimum availability requirements for providers. Improve access by ensuring there are enough providers on schedule to meet patient demands. • Set goals to reduce the number of part-time providers. This can be accomplished through attrition and negotiation. • Review availability issues to negotiate higher availability. • Consider teaming part-time providers with other part-time providers or full-time providers to create stable provider teams. • Consider using part-time providers as internal *locum tenens* to maintain internal continuity and reduce training and contract expenses.
We don't have enough staff to tackle this special project.	Empanelment is not a special project, it is a core component of PCMH care. The initial effort will require a dedicated person for about four months to work with IT/report writing staff to pull data, help us understand it and move forward.	• Use this as a quality improvement (QI) project, supported by the medical director. • This is a great opportunity to groom someone to be the panel manager in the future.

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Can I assign this work to a summer intern or volunteer?	No. It is important that the person managing the datasets have a thorough understanding of your practice, the schedules, the patient population. While the initial effort will be about four months intensive, it should be considered an ongoing management activity into the future.	See previous.
I would like to assign the empanelment process to an administrator in our central office and not explain the entire process to the providers.	Caution: Provider understanding and buy-in is critical. Once providers understand the empanelment concept, and the structure you are using to define panels, they can be engaged in the development of policies that will support empanelment and continuity of care. They can become champions for the practice.	• Conduct an "intro to empanelment" session with providers to help them understand the approach, rationale, and how they and their patients will benefit. • Run the initial panel reports and work out the kinks in reporting. Calculate the right panel size for each provider, and compare the numbers. • Share the initial panel rosters with providers, either individually or as a group. The group format lends itself to rich discussion and helps the providers learn together about the process. Encourage discussion about panel size, inequities and how to resolve them through weighting or other means. • Once providers understand the empanelment concept, engage them in the development of policies that will set the structure for the empanelment work, part-time provider pairings, coverage expectations, etc.
Our health plans assign patients to the clinic, not to individual providers.	That process allows the health plan to efficiently reimburse you for all providers under one corporate umbrella. It also allows you the flexibility of assigning to the provider of your choice. Health plan assignment is not the same as empanelment. Our practice is responsible for empanelling patients.	• Ask the health plan if primary care provider (PCP) assignments can be designated on the member's ID card after you make the individual assignments. • Print clinic ID cards that display the name of the PCP or "Team ID" and phone number.

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What about mid-level providers? Are they capable of managing their own panels?	It depends on the comfort level of the medical director on how mid-levels are used in the practice. Some clinics assign mid-levels to one service area (pediatrics, women's health) and have them do wellness exams only. Other clinics "privilege" mid-levels to care for patients of all ages and all complexities.	• If the practice has no guidelines for the use of mid-levels, have an open dialog with the clinician staff to determine what makes the most sense. • Run the visit history report to see how they are used; look at disease management data to see that mid-levels are adhering to clinical practice guidelines; look at emergency department (ED) visit history to see if mid-levels have a higher incidence of ED visits.
What about providers who work in more than one clinic location?	You could establish panels for each location if the provider's time is split equally between the two sites (50:50). If the split is very lopsided (80:20), it won't work very well. Best to consider the 20% availability as an urgent care or fill-in slot rather than an "anchor" provider.	• The goal is continuity of care. Splitting the provider's time between locations may prevent you from achieving continuity.
We don't have sophisticated IT support to run calculations and weighting and all that seems to be required here. What can we do?	A simplified approach can be taken that does not include weighting. Practices report minimal benefit to weighting by morbidity. Understanding utilization by actual average visits per year (AVPY) data can help you predict appointment demand.	• Use the perfect panels calculations and understand the AVPY for each provider. The AVPY can be sliced by age group, allowing you to project patient appointment demand. • Once panels are assigned, determine provider tolerances for exceeding the right panel size number.

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What will I need to ensure proper panel management into the future?	Policies and procedures to delineate assignment of patients to providers ensure the proper scheduling of patients with assigned providers, and allow transition of patients from one provider to another. You will also need to assign a panel manager to coordinate the process and routinely run reports to ensure that patients are being assigned properly.	• Assign a panel management work group.
		• Develop policies:
		  • PCP assignment.
		  • Change in PCP assignment (patient choice).
		  • Change in PCP assignment (provider choice).
		  • Transition of 18–20 year-olds from pediatrics into adult care.
		• Create a job description for the panel manager.
		• Train staff on empanelment, continuity of care, and their respective and collaborative roles.

Here at XYZ Practice, our patients bounce between one clinic and another. We can't control that, so how will empanelment work?	Bouncing back and forth is chaos care, not continuity of care. There is wide opportunity for error, duplication of tests and prescriptions, and increased cost to the patient and/or insurer. Empanelment will help us build relationships. It will also help us improve access. Together, these improvements should reduce the likelihood that our patients will use other sources of primary care.	• Assigning each patient to a PCP will allow the clinic staff to make appointments at the "home" clinic more easily and stop the ping-pong effect.
Should we teach the patients that they now have a single provider?	Yes. This is key to forming the continuous healing relationship between patient, provider, and care team.	• Assign the PCP during the initial registration visit or new patient orientation, at the time their medical record number is assigned. • Issue a patient ID card with provider name, clinic address, phone number of care team, advice line, appointment line, etc. • Make a poster for the waiting room. • Add a blurb on the website. • Insert a patient education message into the "hold" void in the phone system.

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So, the goal of empanelment is continuity of care. We offer same-day sick appointments through our urgent care service. Isn't that good enough?	Many practices have developed an urgent care service, or "fast track" where sick patients are seen the day they call in. If this is the only same-day option you offer, you will not meet your continuity of care goals. Many practices report that some patients are seen only in urgent care and do not follow-up with their assigned PCPs as recommended. The urgent care services take the PCP out of the picture for illness events. It is important that the PCP understand the illness of a patient and participate in the care planning, just as in times of wellness. If the PCP did not see the patient for the illness event, the PCP will have to "recover" from another provider's interventions at the next visit, adding 7-12 minutes to the visit cycle time.	• In the empanelment work, you are forecasting the demand of your current population, based on utilization trends. Carry this concept into the appointment template by estimating the number of scheduled appointments needed for patients on a periodicity schedule (e.g., patients with chronic illness, well child exams). Reserve these slots as appointments, which can be set in advance, and leave the rest of the appointment slots open for same-day access. • The resultant schedule template might look different for each provider, based on the profiles of the empanelled patients. It is important to allow these differences in order to offer appointment availability that meets the needs of each panel.

Safety Net Medical Home Initiative

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The objective of the Safety Net Medical Home Initiative was to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org.

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