COMMENTARY

One Leader's Journey Toward Empanelment

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ABSTRACT

Empanelment is an important step toward managing population health. Achieving empanelment in a fee-for-service world necessitates organizational support for panel size measurement and creativity regarding use of panel size to inform access decisions. Empanelment efforts and access must be balanced to create sustainable, high-quality care models and to improve practitioner and patient experiences.

THE RIGHT CARE FOR THE RIGHT PATIENT

The US spends more on health care but has worse health outcomes than other wealthy countries.[1] This disparity between health care spending and health outcomes is a major concern for US citizens. Not only do we want to ensure health and longevity for our citizens, but as taxpayers we want to make sure our money is spent wisely to best protect and educate our country. One proposed solution to this problem is for health care systems to shift their focus to population health instead of increasing volumes of services. Improving population health entails providing the right care for the right patient by using the right care team. Identifying the "right patients" is more challenging than it would seem, particularly in a predominantly fee-for-service environment. In primary care, the act of figuring out who our patients are is known as *empanelment*. One study of family physicians found that only one-third of respondents could estimate their panel size.[2] The barriers to empanelment are numerous but must be surmounted in any quest for population health.

Bodenheimer and colleagues[3] described ten building blocks of high-performing primary care that guided their practice improvement. Building block one is engaged leadership: Leaders must be engaged in organizational transformation. Building block two is data-driven improvement: High-performance requires use of data to drive change. And building block three is empanelment: Each patient must be linked to a primary care practice and practitioner. Primary care practitioners (PCPs), and in turn, health care systems, must know which patients they are caring for to improve delivery of care between traditional office visits. Primary care leaders must help guide this change by using data as a tool.

JOURNEY TOWARD EMPANELMENT

I am a primary care leader of a large academic health care system that had to tackle major hurdles on its journey toward empanelment, including measuring panel size and using panel size to inform access decisions. The first hurdle, panel size measurement, necessitated active and diligent maintenance of accurate attribution of patients to PCPs. Even with a robust electronic health record (EHR) system, we struggled with managing the "PCP field"—the field in the EHR that designates which PCP is responsible for a given patient. In our organization, everyone with EHR access can change the PCP field. Our front desk staff who check-in patients can change the PCP field at a patient's request. Our PCPs also may change the PCP field because of patient request. However, PCP fields would sometimes change when PCPs left the system. The departing PCP's patients would automatically be assigned to other PCPs even though the process to request and implement such changes was unclear. As a result, many patients were automatically attributed to a PCP but never ended up seeing that PCP.

To assess how well our PCP field matched with actual PCP attribution, we developed an algorithm. Step one: We started with all patients who had seen a PCP in our system during the previous 24 months. Step two: We broke out the patients who had seen the listed PCP most frequently during the last 24 months and those who had seen the listed PCP at least once during the previous 24 months, which accounted for 80% of our starting group. Step three: The remaining 20% of patients had most of their visits with a different PCP during the last 24 months and were inaccurately attributed, so we reached out to PCPs to reconcile this group and encouraged them to actively manage their PCP fields. We also are in organizational-level discussions about who should be able to change the PCP field and the situations in which a PCP should be changed, with an understanding that there must be a balance between ensuring adequate access with empanelment and ensuring patient safety at times when PCPs leave the system.

The second major hurdle in the journey toward empanelment has been finding a way to straddle access and growth while at the same time limiting panel sizes for optimal population health and doing so in (at least) a cost-neutral model. Fewer than 10% of our organization's contracts are value-based; as a result, we continue to be highly dependent on volume and new patient access. The concept of right-sizing PCP panels to deliver the best-quality care can be viewed as contradicting the need to grow market share. Those in health care management are straddling two worlds, and the big question is how much to invest in population health and value-based care when we rely heavily on volume-based contracts. There is no clear answer on how to accomplish this, but the farther along the continuum an organization is in value-based payment models, the easier the argument becomes. What we do know is that we feel our current path of asking PCPs to do more with less is not a sustainable model. Our patients are dissatisfied with available access to their own PCPs (some of whom have panel

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sizes close to 3000); the PCP burnout rate has been as high as 50% during the last 5 years; and PCP turnover is about 6% per year, with an anticipation that 10% of our PCPs will retire during the next 5 years. We are not alone; similar trends are noted at other organizations.[4] All of this is particularly concerning given that the primary care workforce has been shrinking, and we do not have enough PCPs to manage the needs of the entire US population.[5]

It has been one year since our organization calculated its first panel sizes. Because our hospital often serves as the safety-net hospital for our city, we needed to implement empanelment while concurrently ensuring adequate new patient access across the system. There is no well-accepted national standard for what an ideal or "right-size" panel should be. Average panel sizes vary widely across health care organizations because of differences in populations served, care models, care team support, historical productivity, patient and clinician expectations, and other contextual factors.[6] Rather than set a panel size target for our empanelment efforts, we divided our PCPs into high, medium, and low panel groups and assigned new patient access according to these categories and other data points including third-next-available appointment availability, template utilization, and no-show rate. We also used this information to redistribute PCPs and access from site to site, ensuring new patient access at each location. This is an effort that we hope to continue at least yearly. Although our process continues to evolve and is far from perfect, the act of attempting to empanel PCPs has improved morale among PCPs, helped with recruitment efforts, and improved continuity access for patients. Empanelment efforts also help us target growth and new patient access to locations and PCPs who actually have access.

TEAM-BASED CARE

We are currently embarking on a team-based care initiative to support our PCPs in managing their patient panels with the "right teams." We know that if portions of preventive and chronic care services are delegated to nonphysician team members, PCPs can provide high-quality primary care with panel sizes that are achievable with the available primary care workforce.[7] We are early in our journey toward population health. As our efforts unfold, we will collect data on PCP recruitment and retention; burnout and turnover; patient satisfaction; and financial data, including the cost of PCP turnover and loss of patients from the system attributable to lack of continuity access. We have seen initial improvement in patient access across our system partly attributed to our empanelment efforts, with a volume increase of 8% between 2016 and 2017 and improvement in PCP burnout. These positive trends have buoyed further efforts toward empanelment and population health.

The journey to population health is a marathon, not a sprint. It requires constant vigilance and care, particularly around culture change and communication, accurate data collection, and empanelment. I am hopeful that with continued efforts toward maximizing efficiency in panel management, we can build sustainable financial models for health care and achieve our vision for population health as the right care for the right patients by the right care teams. ❖

Disclosure Statement

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Art of Medicine

The art of medicine cannot be inherited nor can it be copied from books.

— Paracelsus (Theophrastus Philippus Aureolus Bombastus von Hohenheim), 1493-1541,
Swiss physician, alchemist, and astrologer of the German Renaissance