Empanelment – for TBC and PHM
Connecting the Dots for Better Patient Engagement

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QUALIS HEALTH™

Advancing Healthcare
Improving Health

Learning Objectives

- Review key steps for creating and maintaining right-sized patient panels .

- Assess empanelment implementation and opportunities to strengthen it in your practice.

- Review connections and synergies among empanelment, team-based care (TBC) and population health management (PHM).

- Identify opportunities to leverage TBC and PHM to support and engage patients for improved outcomes in your practice

- Identify specific opportunities to improve use of TBC and PHM in your practice to engage and support patients for improved BP control.

The Challenge

- Provide structure + resources (human, tools, time) for right care at right time to each person in the population
- Structures
  - Empanelment: the population group for a provider-care team
  - PHM approach: to group patients by risk level; workflows for each set of interventions by risk level
- Team-based care – fundamental organizing principle
  - provide care and support to patients; build relationships
  - Flight control for direct and coordinated care
- Tools
  - HIT for data to assess risk, track progress
  - effective communication tools (IT and H)
  - Tools to coordinate

Empanelment

Vital enabler of many elements of high-performing primary care

Whose Patient Is It?

Our Team's Patients

New Goals, New Thinking, Improved Results

What it Takes – The Commitment

- Leadership enabled, supported

- Data to support the work – essential; support from IT, analytics

- Team to lead process for forming initial panels

- Commitment to empanel all patients
  - Those not empaneled very small number with specific reason

- Operational System to be developed – not once and done; ongoing

Supply - Demand Balance is Key to Success

- Maintain workload balance among providers
- Enable access and continuity to be reliable features of the system → relationship based care

Empanelment Key Steps

1. Assess practice supply and demand to determine "right-size" for each provider panel

2. Assign all patients to a provider panel and confirm panel assignments with providers and patients

3. Review and update panel assignments on a regular, on-going basis to ensure all panels remain right-sized and current

4. Establish a process for re-empaneling patients when their provider (or resident provider) leave the practice or reduce clinical time in the practice

5. Provide care teams with data to enable them to proactively plan care, close gaps, track patients

Empanelment Assessment

PART 3: EMPANELMENT

3a. Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis.

3b. Assess practice supply and demand, and balance patient load accordingly.

3c. Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.

Items	Level D	Level C	Level B	Level A
9. Patients	…are not assigned to specific practice panels.	…are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes.	…are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes.	…are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.
	1 2 3	4 5 6	7 8 9	10 11 12
10. Registry or panel-level data	…are not available to assess or manage care for practice populations.	…are available to assess and manage care for practice populations, but only on an ad hoc basis.	…are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states.	…are regularly available to assess and manage care for practice populations, across a comprehensive set of diseases and risk states.
	1 2 3	4 5 6	7 8 9	10 11 12
11. Registries on individual patients	…are not available to practice teams for pre-visit planning or patient outreach.	…are available to practice teams but are not routinely used for pre-visit planning or patient outreach.	…are available to practice teams and routinely used for pre-visit planning or patient outreach, but only for a limited number of diseases and risk states.	…are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states.
	1 2 3	4 5 6	7 8 9	10 11 12
12. Reports on care processes or outcomes of care	…are not routinely available to practice teams.	…are routinely provided as feedback to practice teams but not reported externally.	…are routinely provided as feedback to practice teams, and reported externally (e.g., to patients, other teams or external agencies) but with team identities masked.	…are routinely provided as feedback to practice teams, and transparently reported externally to patients, other teams and external agencies.
	1 2 3	4 5 6	7 8 9	10 11 12

Gnarly Issues for Empanelment – What are Yours?

- Should part-time providers have a panel?
- What are others....?

The Work Going Forward

"… systematically measuring, standardizing, and addressing panel size as a core element of practice management."

Think About It:
Translation to Action

- At what stage is the empanelment development process in your practice?

- What are steps that are needed to advance empanelment in your organization?

- Who in your organization do you need to engage in this work?

- What are two action steps to advance this work?

Connections and Synergies for PHM

Teams are forged by the work they do together

-Katzenbach & Smith

START HERE
Patient Panels

Engaged Care Teams

Team-based Care
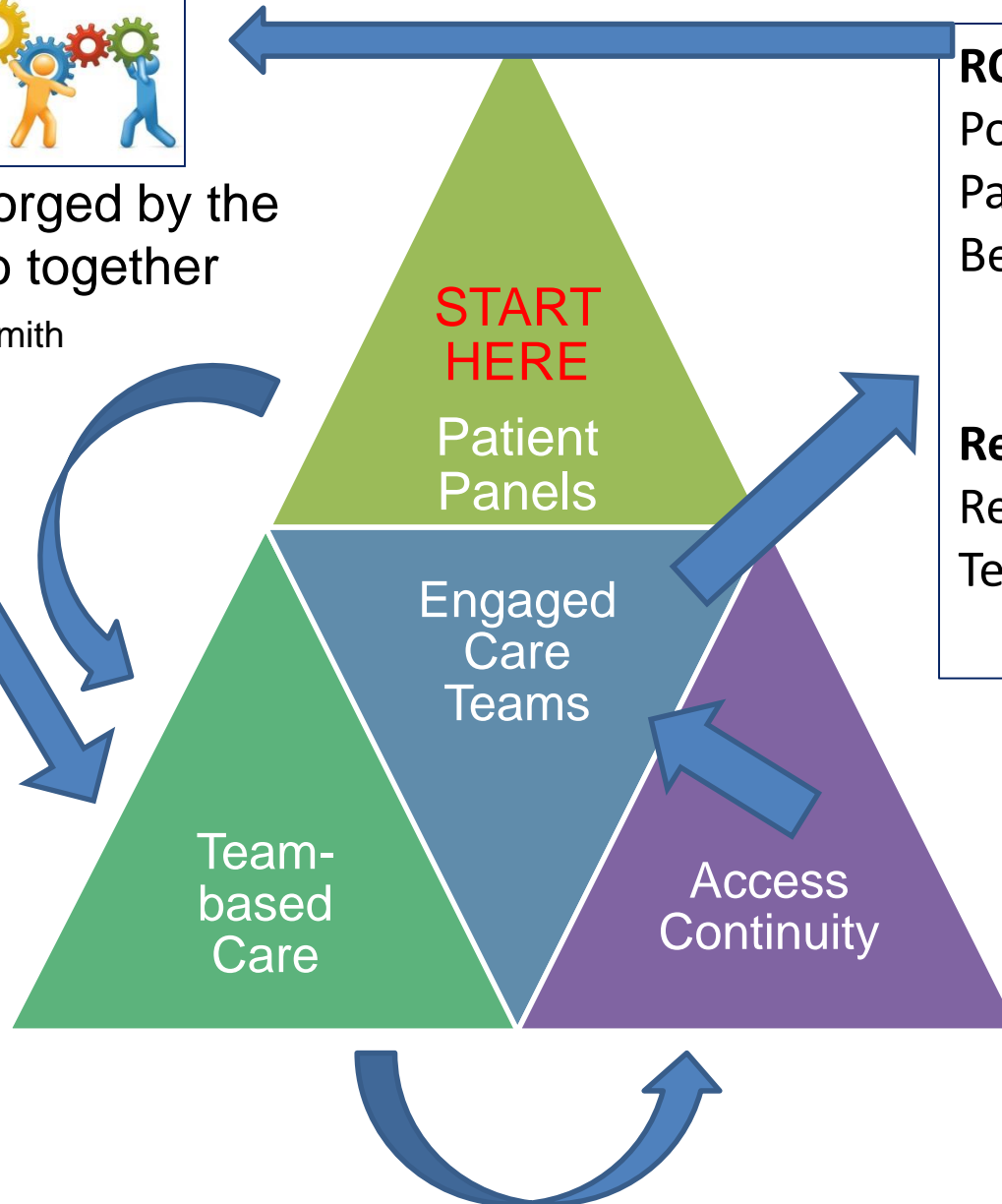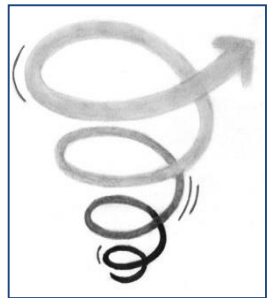
Access Continuity

ROL
Population Health Focus
Patient Support + F/U
Better Outcomes +
    Experience for Patient &
        Staff
Requires – Information
Registries
Team-based Performance
    Metrics

Redesign of System Processes for Continuity, Access
Best use of Team Capacity & Capability

Team-Based Care Essentials

- Provider – care team
  - work together all of the time
  - focus on optimizing the health outcomes and experience for their population/panel of patients

- Specific roles and responsibilities
  - plus training to ensure ability to carry out the responsibilities of the assigned roles

- Delegated care for shared care
  - all team members do all they can (top of capability) to share the care of patients

"Participants who adopted new forms of delegation and care processes using teamwork approaches, and who were supported with resources, system support, and data feedback, reported improved provider satisfaction and productivity."

Team-Based Care Assessment

PART 4: CONTINUOUS & TEAM-BASED HEALING RELATIONSHIPS

4a. Establish and provide organizational support for care delivery teams accountable for the patient population/panel.
4b. Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.
4c. Ensure that patients are able to see their provider or care team whenever possible.
4d. Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.

Items	Level D	Level C	Level B	Level A
13. Patients are encouraged to see their paneled provider and practice team	...only at the patient's request.	...by the practice team, but is not a priority in appointment scheduling.	...by the practice team and is a priority in appointment scheduling, but patients commonly see other providers because of limited availability or other issues.	...by the practice team, is a priority in appointment scheduling, and patients usually see their own provider or practice team.
	1 2 3	4 5 6	7 8 9	10 11 12
14. Non-physician practice team members	...play a limited role in providing clinical care.	...are primarily tasked with managing patient flow and triage.	...provide some clinical services such as assessment or self-management support.	...perform key clinical service roles that match their abilities and credentials.
	1 2 3	4 5 6	7 8 9	10 11 12
15. The practice	...does not have an organized approach to identify or meet the training needs for providers and other staff.	...routinely assesses training needs and ensures that staff are appropriately trained for their roles and responsibilities.	...routinely assesses training needs, ensures that staff are appropriately trained for their roles and responsibilities, and provides some cross training to permit staffing flexibility.	...routinely assesses training needs, ensures that staff are appropriately trained for their roles and responsibilities, and provides cross training to ensure that patient needs are consistently met.
	1 2 3	4 5 6	7 8 9	10 11 12

Think About It: Translation to Action

- What are the missing elements in your team-based care model?

- Does each provider-care team have an identifiable panel of patients on which they focus their attention?

- Can you identify at least one opportunity to advance your team model?

- Whose support would be needed?

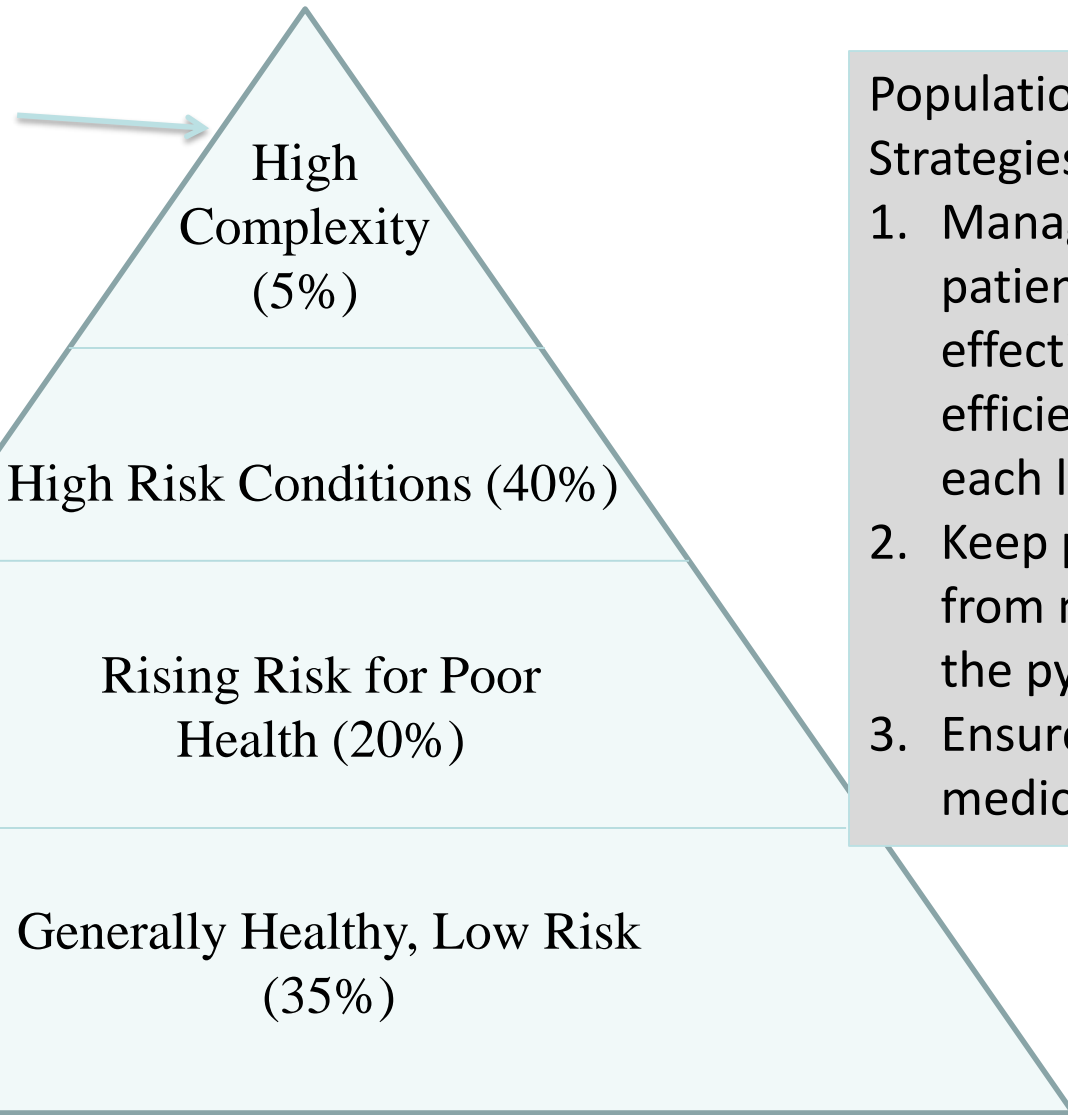# Population Health Management
Right Care, Right Patient

- Goal: intentional focus on needs of patients in risk groups using a set of clinical, engagement strategies appropriate to the patient's needs

- Identify the population of focus

  - ❏ patients at risk of hypertension or with hypertension and/or with other conditions that raises risk

- Use a population health pyramid to group patients by risk level

- What services and/or support would benefit the patient in each risk level?

- Who can provide that service and/or support?

Adult Population Health Management Pyramid

40-50% costs

High Complexity (5%)

High Risk Conditions (40%)

Rising Risk for Poor Health (20%)

Generally Healthy, Low Risk (35%)

Population Health Strategies:
1. Manage patients effectively and efficiently at each level
2. Keep patients from moving up the pyramid
3. Ensure a good medical home

Source: Kevin Grumbach, M.D., UCSF. Webinar, "Patient Empanelment", July 18, 2016

Population Health Management

"Primary care physicians will increasingly be paid for their ability to achieve goals across the body of patients most closely associated with them: their 'panel'."

J Am Board Fam Med 2015;28:173–174

Think About It: Translation to Action

- Are you using a PHM risk grouping approach (stratification) for your HPT patients?

- How are the groups identified?

- Have you developed strategies for each group that utilize a set of guidelines for BP control for medication management and adherence?

- Have do you provide support for behavior change for lifestyle elements for BP control and risk reduction?
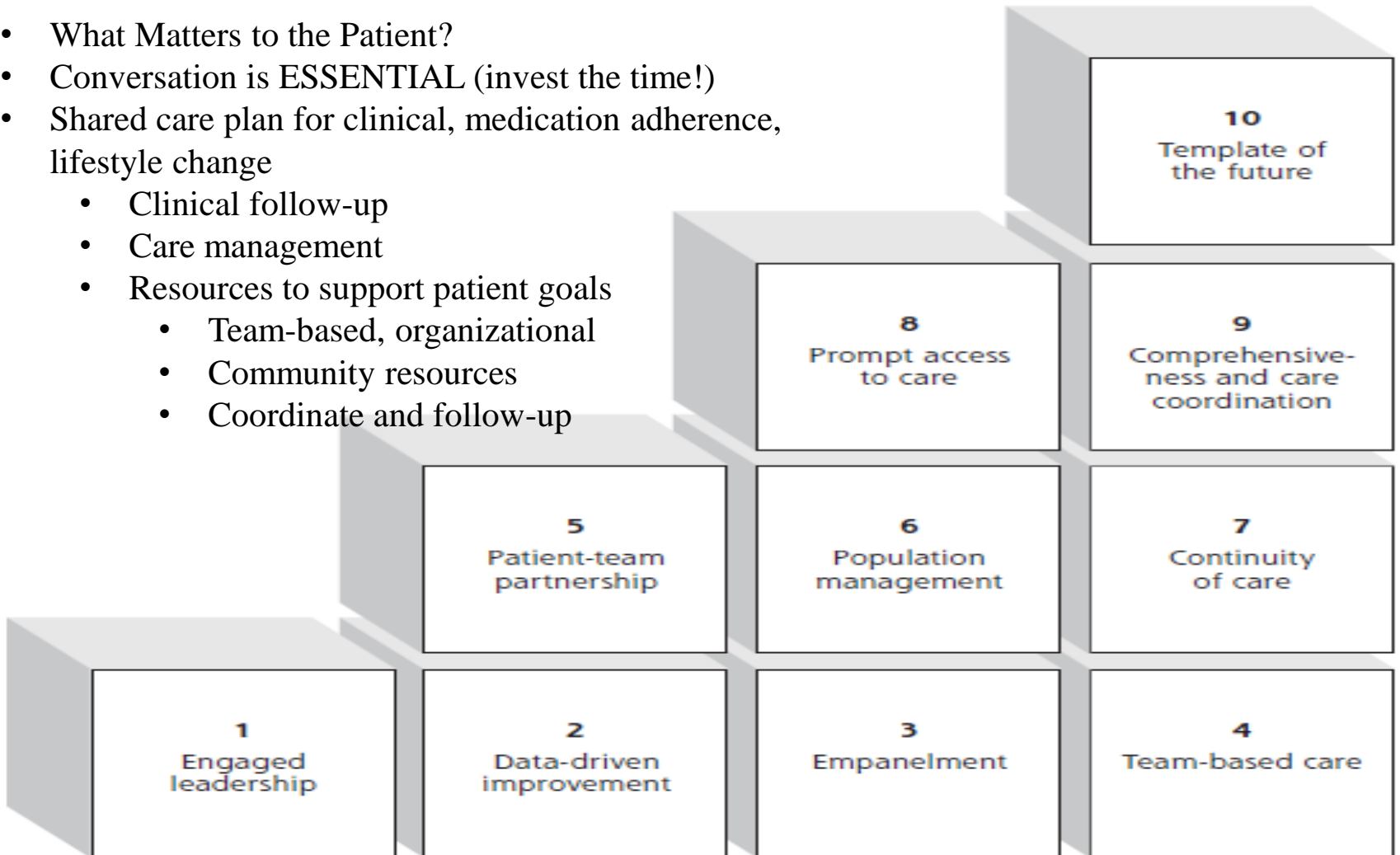
EMPANELMENT, TBC AND PHM PERFECT TOGETHER!

Why Effective Team-Based Care Matters
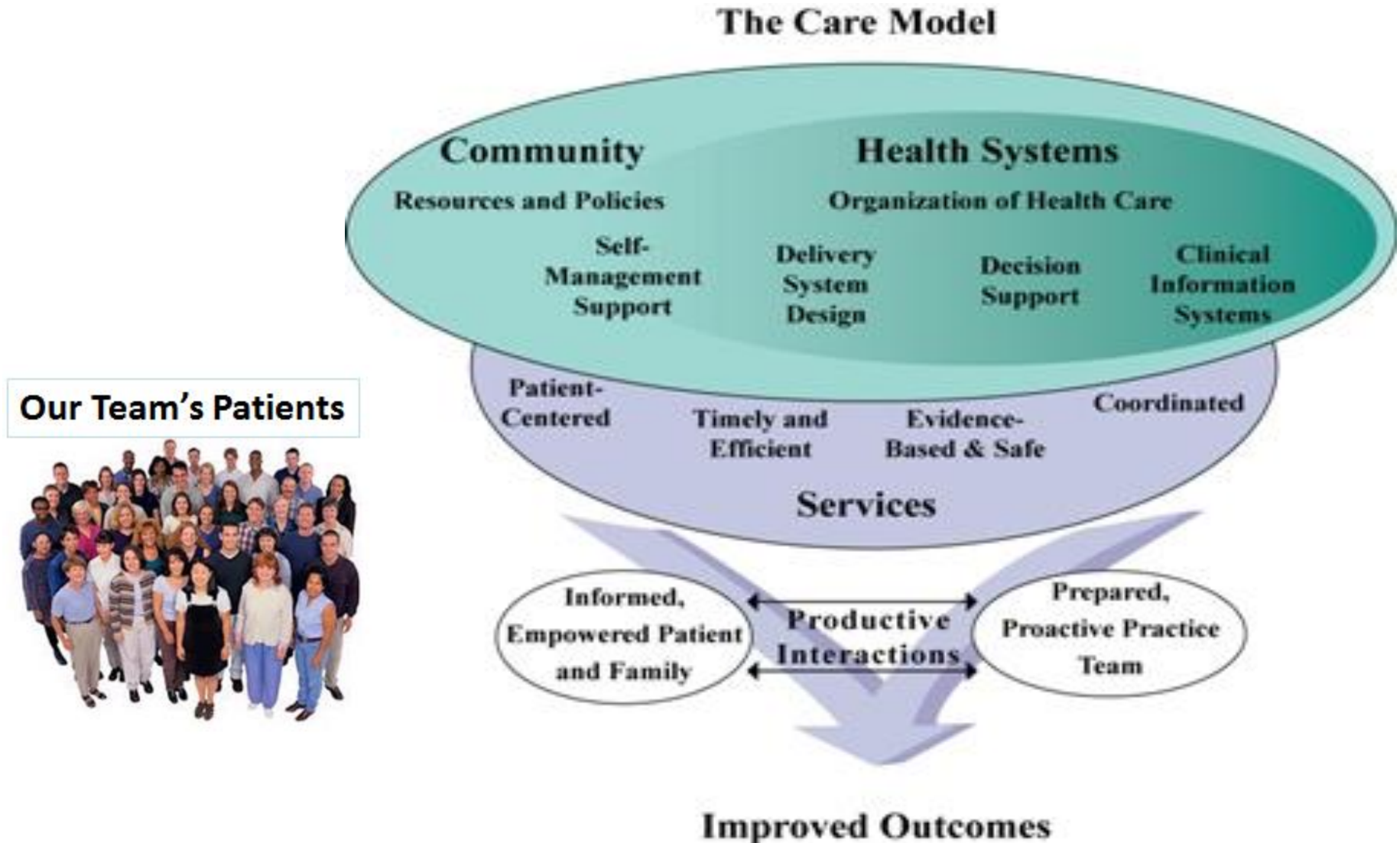
Key Opportunity – Engaging Patients as Partners

Figure 1. Ten Building blocks of high-performing primary care.

- What Matters to the Patient?
- Conversation is ESSENTIAL (invest the time!)
- Shared care plan for clinical, medication adherence, lifestyle change
  - Clinical follow-up
  - Care management
  - Resources to support patient goals
    - Team-based, organizational
    - Community resources
    - Coordinate and follow-up

			10 Template of the future
	8 Prompt access to care	**9** Comprehensive-ness and care coordination	
5 Patient-team partnership	**6** Population management	**7** Continuity of care	
1 Engaged leadership	**2** Data-driven improvement	**3** Empanelment	**4** Team-based care

HOW CAN WE USE THESE IDEAS?

Applying PHM to HPT Population

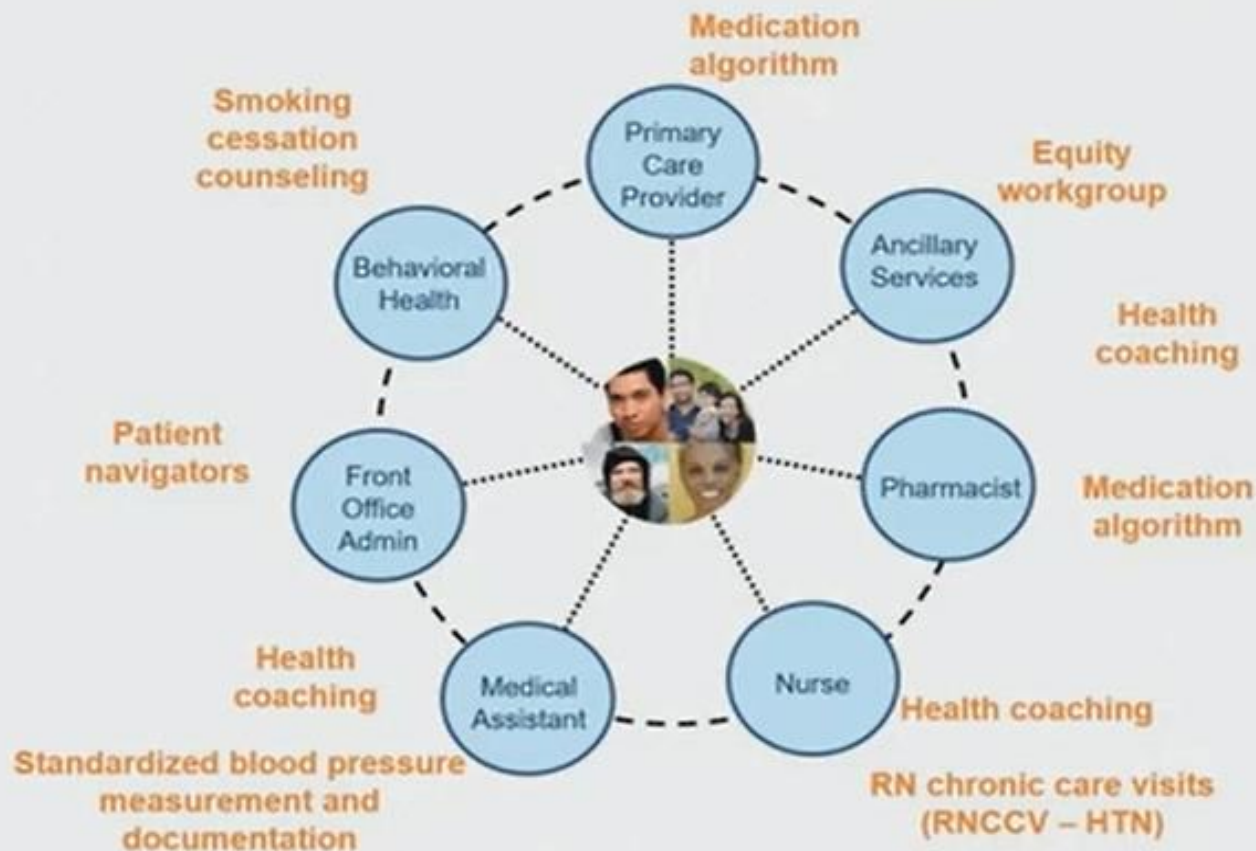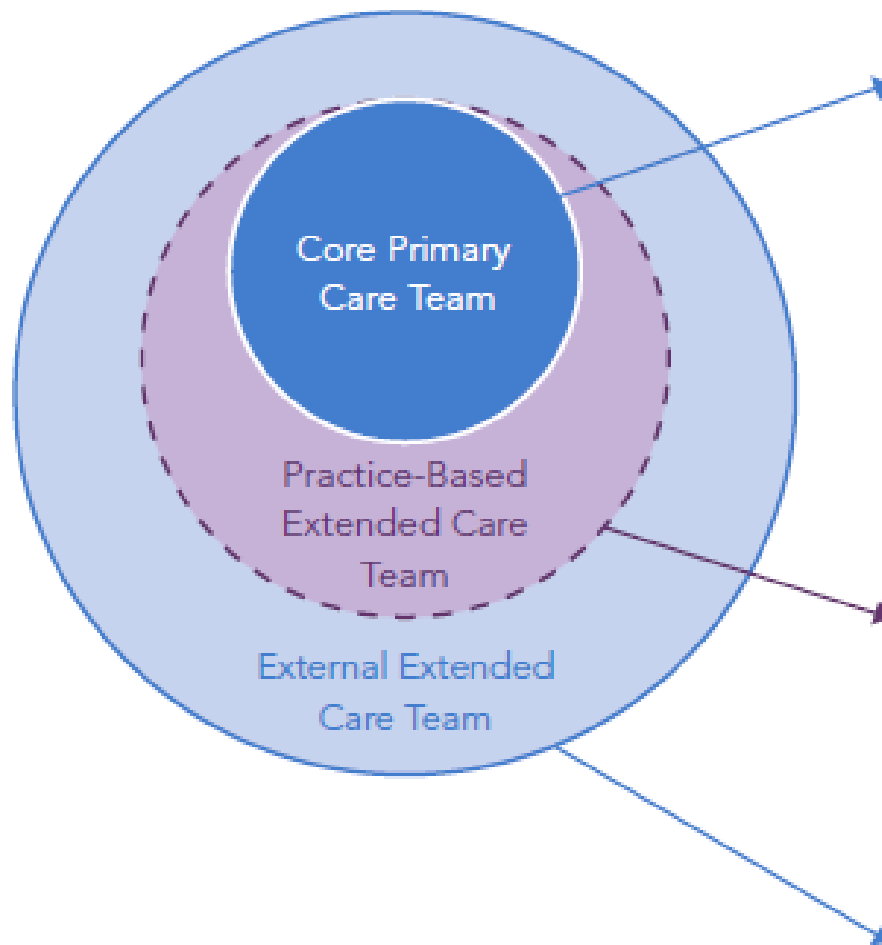**Level/Description**

Potential Activities

Highly Complex:

High Risk:

Rising Risk:

Low Risk:

What Ideas Could You Use or Adapt?

TEAM-BASED CARE MODEL FOR HYPERTENSION MANAGEMENT

San Francisco Health Network

Core Primary Care Team

Practice-Based Extended Care Team

External Extended Care Team

Are We Moving the Needle? Don't Guess. Measure.

- Use metrics to assess – periodic reports
  - Actual panel size compared to right-size
  - Operational and clinical measures
    - % of all patients empanelled
    - Continuity rate for patients by panel
    - 3rd next available for patients by panel
    - Clinical outcomes by risk groups

- Ask patients how it is working for them (experience)
  - Can they get an appointment easily when they want it?
  - Are they seeing their provider and care team regularly?
  - Are they getting the support they need to help them manage their hypertension?

- Ask staff how it is working from their point of view
  - Are they able to manage the demand?
  - Are they able to use registry data for planned care, outreach
  - How is the coordination and tracking of care going? Are tools working?
  - Is everyone "all-in"? What support, training, tools other resources are needed?
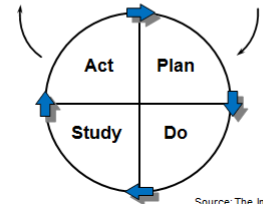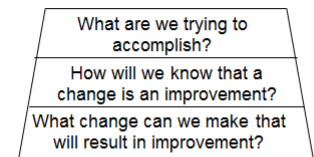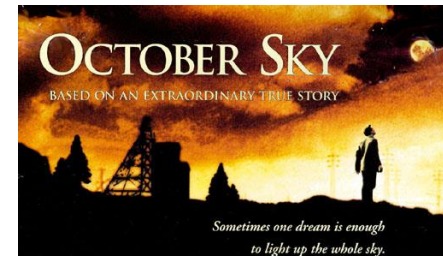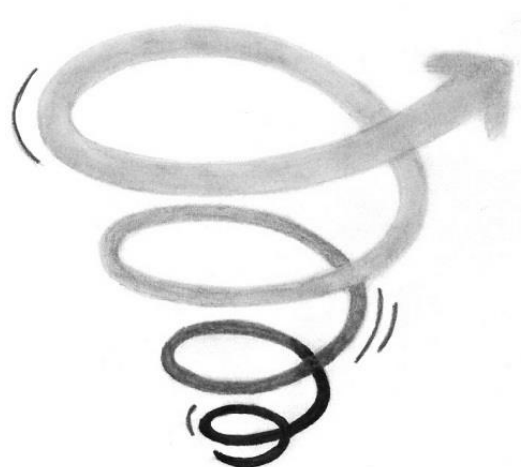
Improvement Approach

- Discover and learn how your system works now
  - Deep dive; No fear; Curiosity without judgment (on-going process)
- To start - apply best of what works (BPs, Bright Spots)
- Start with one (site, provider, patient, care team)
- Learn all you can as you apply changes; use PI methods to test and learn
- Adapt and refine
- Repeat until it works and you get the results
- Implement and Anchor
- Spread to next site or teams
- Use all you have learned
- Learn more
- Repeat the process

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act | Plan

Study | Do

Source: The Improvement Guide

OCTOBER SKY
BASED ON AN EXTRAORDINARY TRUE STORY

Sometimes one dream is enough to light up the whole sky.

Think About It:
Translation to Action

- Identify two action steps that you will take as soon as tomorrow for empanelment, TBC or PHM or a combination of the three.

- What goals for HPT control will these support?

- How confident are you that you can
  - complete these actions, and
  - take the next set of steps to create momentum?

- Whose support do you need?

- How will you secure it?

SHARE YOUR ACTION STEPS

Have Questions? Reach Out!

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Thank You