RUTGERS François-Xavier Bagnoud Center

Today's Webinar will be starting soon

For the audio portion of this meeting:

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Enter participant code 733225

RUTGERS
François-Xavier
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SCHOOL OF NURSING

Best Practices in Empanelment from the California HIV/AIDS PCMH Demonstration Project

HIVMHRC

RUTGERS François-Xavier Bagnoud Center

Guidelines for Our Online Meeting Room

- **PLEASE TURN OFF YOUR COMPUTER SPEAKERS and Mute your phone line & computer speakers**
- **Questions**
  - Enter questions into the chat room
- **Interactive activities**
  - Polls
  - Chat room questions
- **Evaluation**

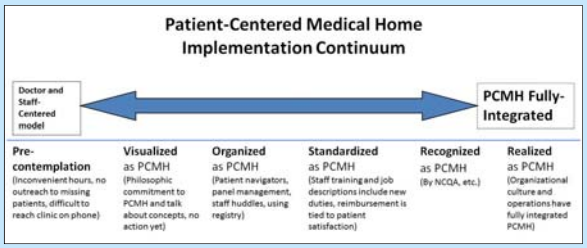
RUTGERS François-Xavier Bagnoud Center

Today's Presenters:

Steve Bromer, MD
Medical Director of Practice Facilitation
HIV Medical Homes Resource Center

Amy Sitapati, MD
Interim Medical Director, Owen Clinic
Associate Clinical Professor of Medicine
UC San Diego Health System

Kathleen Clanon, MD
Associate Chief Medical Officer
Alameda County Medical Center



A Tale from Two Presenters

Dr. Clanon

Dr. Sitapati

Agenda

1. Empanelment: What it Is
2. Participant Self-Assessment: PCMH-A
3. Examples of Robust Empanelment Implementation
4. Taking Steps Toward Empanelment
5. PCMH Recognition and Empanelment
6. Participant Q&A

Learning goals

Participants will:

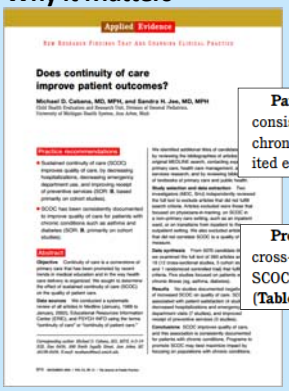
- Relate empanelment to continuity of care in the PCMH model
- Explain how empanelment can impact quality outcomes (including retention)
- Self-assess level of empanelment in their clinics
- Determine next steps toward empanelment in their clinics
- Identify empanelment deliverables are specific to PCMH recognition/certification
- Recognize specific challenges/solutions for empanelment from UCSD and HIV ACCESS (CHD) perspective

Empanelment: What It Is

Empanelment is a method of enhancing continuity and completeness of care across a clinic's patient population.

- Same provider/team for every routine visit
- Standardize the number and acuity of patients cared for by each team
- Encourage **proactive** care and accountability for coordination of care and outcomes

Sustained Continuity of Care (SCOC): Why it Matters


Applied Evidence

Does continuity of care improve patient outcomes?

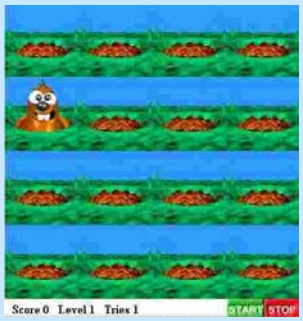
Patient outcomes. The effect of SCOC seems consistent across studies for patients with chronic conditions who were hospitalized or visited emergency departments (**Table 1**).

Process of care. For preventive services, 5 cross-sectional studies found that increased SCOC improved receipt of preventive services (**Table 1**).[24,28–30,32,33,35]

Cabana MD, Jee SH. Does continuity of care improve patient outcomes? J Fam Pract. 2004 Dec;53(12):974-80.

Another Benefit: Avoiding Quality Whack-a-Mole

address multiple quality indicators at once…



Empanelment and PCMH

- Essential early step toward PCMH transformation
- Forming care teams and empaneling patients sets the foundation for organized, proactive, patient-centered care

Empanelment and NCQA

From the NCQA 2011 PCMH Standards:

- Element 1D: Continuity
  - Factor 1: Expecting patients/families to select a personal clinician
  - Factor 2: Documenting the patient's/family's choice of clinician
  - Factor 3: Monitoring the percentage of patient visits with a selected clinician or team
- Standard 3: Plan and Manage Care
  - Empanelment will help ensure consistent implementation of care management

Joint Commission PCMH

Achieve the Gold Seal

- Focus Area B: Designated Primary Care Clinician
- Each patient has a designated primary care clinician
- The organization allows the patient to select his or her primary care clinician

What Are the Challenges?

- Academic Centers
- Expanded hours
- Very part time HIV providers with restricted hours at the clinic
- Determining panel sizes– how many HIV patients should one team care for?

Clinic – All Teams	Clinic Dyad
• All patients assigned to a team • Includes multiple providers and other clinical staff • On a given visit, the patient may see any provider on the team • E.g., prenatal care is done like this • Poor continuity	• Patients assigned to a single provider • Includes one provider • The patient will see the same provider each time • E.g., academic centers • Better continuity, but access may be poor

Continuity vs. Enhanced Access

Goal: Same-day appointments for routine and urgent visits (NCQA PCMH Factor 1.A.1)

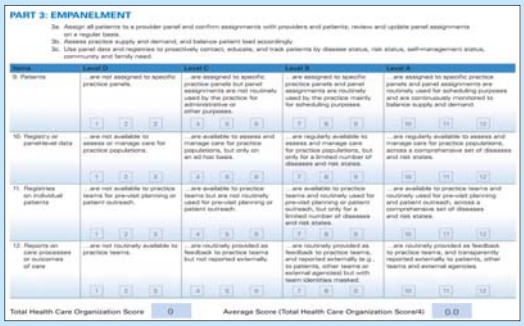
Challenge: Prioritizing same-day access may reduce continuity

Highlights the importance of communication within and between teams

Clinic Assessment: Where are you now with empanelment?

- Self-assessment important early step in transforming to PCMH
- Variety of tools available
- Following questions adapted from Safety Net Medical Home Initiative PCMH assessment tool
- www.safetynetmedicalhome.org

Self-Assessment: PCMH-A



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

Total Health Care Organization Score: 0 — Average Score (Total Health Care Organization Score/4): 0.0

http://www.safetynetmedicalhome.org/sites/default/files/PCMH-A.pdf

Patients…….

1. …..are not identified with a specific practice panels
2. ….are identified with a panel but the practice is not operationalized around panels
3. ….are identified with panels but panels are only used for scheduling purposes
4. …are assigned and used for scheduling and to balance supply/demand

Registry or Panel-level data….

1. ….are not available to assess or manage care for practice populations
2. ….are available on an ad-hoc basis but not used routinely
3. ….are available to assess and manage care but only for a limited number of conditions
4. ….are available to assess and manage care across a wide range of conditions and risk states including at point-of-care

Reports on care processes or outcomes of care….

1. ….are not available to practice teams.
2. ….are routinely provided as feedback to practice teams but not reported externally.
3. ….are provided to teams and reported externally but with team identities masked.
4. ….are provided to teams and reported externally with practice team identified.

Self-Assessment: What's your score?

Level D 1	Level C 2	Level B 3	Level A 4
Absent or minimal implementation of empanelment	First stage of implementing empanelment may be in place, but fundamental changes have not yet been made	Basic elements of empanelment have been implemented, although the practice still has significant opportunities to make progress with one or more aspect	Most or all of the critical aspects of empanelment are addressed by the item are well established in the practice

Taking Steps Toward Empanelment

<u>Goal</u>: Achieve balance between provider/team time and patient needs

A mature real life example from the Owen Clinic in San Diego

UC San Diego Health System:

Our HIV/AIDS medical home: The Owen Clinic

Providing care for 3,100 HIV/AIDS lives

"I feel like I am working alone and swamped by all the needs of my patients!" - Clinician

Do you have a team for care delivery?

PROBLEM: Providers historically have worked with interdisciplinary services but may not have clear roles and responsibilities targeting the care delivery needs

	O	W	E	N
Patients	775	775	775	775
MDs	Tyler Lonergan, MD Lalo Cachay MD	Winston Tilghman, MD Ankita Kadakia, MD Oliver Biederman, MD Rosa Andrade, MD	Gigi Blanchard, MD Jeanette Aldous, MD Theo Katsivas, MD	Dan Lee, MD Amy Sitapati, MD
Allied HP	Karla Torres, NP	Eva Stettner, NP	Kellie Freeborn, NP	Aaron Willcott, PA
ID Fellows	Gabriel Wagner, MD		Jill Blumenthal, MD	
Owen ID Urgent Attendings		Francesca Torriani, MD Richard Haubrich, MD John Allen McCutchan, MD Sarah Browne, MD Scott Letendre, MD		
On-site Specialties		Betty Maly, MD (Rehab Med)		

LEVEL ONE EMPANELMENT: RESTRUCTURING PEOPLE

RNs	Ludy Egasani, RN		Nelda Farnal, RN	Lisa Cosby, RN
LVNs	Jessica Davis, LVN		Gina Vu, LVN	
MAs	Xotchil Paez, MA	Dulce Del Rios, MA	Ben Cross, MA	
Front Desk	Gaby Guzman	Sarai Velarde	Daphne Patman	New

Wrap Around Services

Psychiatrists	Ildiko Kovacs, MD	New	New	Louisa Steiger, MD
Social Workers	Patricia Moriarty, LCSW		Adrian Curranza, MSW	
Inpatient Transition	Tari Gilbert, NP			
Pharmacists	Craig Ballard, Pharm D Brad Colwell, Pharm D Kari Abhulson, Pharm D			
Nutrition	Stuart Katsh, MS RD			

"My panel is too big and I see all the hard patients!" - Clinician

Are patients fairly distributed?

PROBLEM: Provider time is fixed (available minutes to work) – so is the work including number and type of patients fair in distribution?

What Time is Available For the Provider? Supply of Time

- Calculate provider time in clinic for Primary Care duties
- Urgent Care, hospital rounding, education time, meetings, vacation time, etc were all subtracted
- Every provider has a different and unique number of hours available annually for clinic work

Balancing Panels

- Balancing the Supply and Demand identifies the need for some providers to remove some patients from their panel and others to absorb more
- The Panel Manager's role is to ensure the continuous and fluid shifting of patients ensuring provider and patient awareness, as well as balanced panels

Making it simple to see "who is full" using the Stoplight Report

Owen Stoplight Report for Provider Panels

Provider 1	Team E	Green	Load %	92.5%
Provider 2	Team W	Green	Load %	53.1%
Provider 3	Team E	Red	Load %	186.6%
Provider 4	Team O	Green	Load %	67.5%
Provider 5	Team O	Green	Load %	80.5%
Provider 6	Team E	Yellow	Load %	148.8%
Provider 7	Team E	Red	Load %	153.2%
Provider 8	Team N	Red	Load %	192.0%

"How do I identify which patients need help!" - Clinician

Are patients at risk for outcomes readily identifiable?

PROBLEM: Standard EMR do not easily allow a registry of patients to be tracked and followed for outcomes and intervention?

Veteran Aging Cohort Study (VACS)

- Accurately **predicts five-year, all cause mortality** at combination antiretroviral therapy initiation and on treatment.
- Made up of **ten data points**
  - **Demographic: Age, Gender.**
  - **Lab: CD4, HIV-1 RNA, Hb, AST, ALT, PLT, Hepatitis C.**

Point values used to generate scores [4]

Component		Restricted Index	VACS Index
Age	<50	0	0
years	50 to 64	23	12
	≥65	44	27
CD4	≥500	0	0
cells/mm3	350 to 499	10	6
	200 to 349	10	6
	100 to 199	19	10
	50 to 99	40	28
	<50	46	29
HIV-1 RNA	<500	0	0
copies/ml	500 to $1x10^5$	11	7
	>$1x10^5$	25	14
Hemoglobin	≥14		0
g/dL	12 to 13.9		10
	10 to 11.9		22
	<10		38
FIB-4	<1.45		0
	1.45 to 3.25		6
	>3.25		25
eGFR	≥60		0
ml/min	45 to 59.9		6
	30 to 44.9		8
	<30		26
Hepatitis C			5

FIB 4: (years of age x AST)/(platelets in 109/L x square root of ALT)
eGFR: 186.3 x (serum creatinine$^{-1.154}$) x (age$^{-0.203}$) x (0.742 for women) x (1.21 if black)
ALT: alanine transaminase ; AST: aspartate transaminase
FIB: Fibrosis Index[2]; eGFR: estimated Glomerular Filtration Rate[3]

Source: http://www.vacohort.org/welcome/75_158724_VACS_Index_Handout_19Nov10.pdf

Daily Huddle -

Trigger Case Management service evaluation based on risk acuity score led by MA/LVN

MRN	Patient	Age	VACS	PCP Tx	CD4	CD4 Date	ART	VL	VL Date	BMI	Last Vst	Last IP Admit Dt	Lst IP Disch Dt
000	Cleveland, Grover	55	30	No	750	12/5/12	Yes	Not Detected	12/5/12	35	12/4/12		
111	Roosevelt, Eleanor	35		No	250	4/9/13	Yes	320	4/9/13	33	2/2/13	2/2/12	2/5/12
222	Washington, Martha		66	Yes	150	3/12/13	No	10,500	3/12/13	20	4/15/13	5/10/13	5/26/13
333	Madison, Dolley	43	20	No	682	4/13/13	Yes	Not Detected	4/13/13	28	4/13/13		
444	Washington, George	66	41	No	100	12/1/12	Yes	200,652	12/1/12	30	12/2/12		
555	Lincoln, Abraham	72		No	Not Tested		No	Not Tested		29			
666	Adams, John	37	32	No	550	2/2/12	Yes	Not Detected	2/2/12	16	3/12/12		
777	Ross, Betsy	45	30	No	800	5/15/13	Yes	Not Detected	5/15/13	45	5/16/13		
888	Lincoln, Mary Todd	73	41	No	80	11/11/12	Yes	120,333	11/11/12	40	11/1/12		
999	Fillmore, Millard		45	No	330	2/2/13	No	200	2/2/13	27	2/2/13	9/13/10	11/18/10

Getting ready for the day before the day begins!

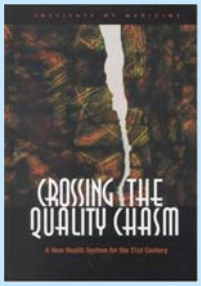
"My patients relocate and you have not updated the panel!" – NP

Do you participate in quality improvement related to empanelment and retention?

PROBLEM: 15-20% of our patients come and go each year. The Registry empanelled is dynamic and requires continuous activity.

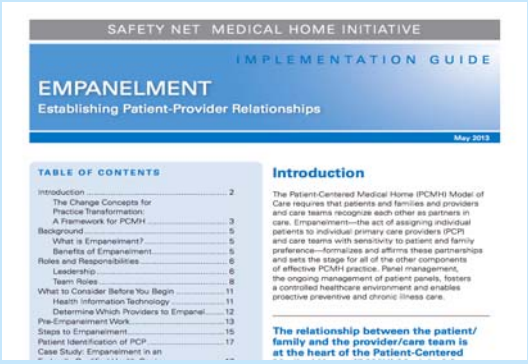
Weekly Retention/Empanelment Team Meetings

- **Quality improvement team: Retention Specialist, RN Panel Manager, Director, Nurse Manager, Case Manager**



- Running empanelment report
- Ensuring new patients were empanelled
- Strategy about outreach and communication
- Ensuring patients with new medical homes are disempanelled

What are Your First Steps?


SAFETY NET MEDICAL HOME INITIATIVE

IMPLEMENTATION GUIDE

EMPANELMENT

Establishing Patient-Provider Relationships

May 2013

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Introduction

The Patient-Centered Medical Home (PCMH) Model of Care requires that patients and families and providers and care teams recognize each other as partners in care. Empanelment—the act of assigning individual patients to individual primary care providers (PCP) and care teams with sensitivity to patient and family preference—formalizes and affirms these partnerships and sets the stage for all of the other components of effective PCMH practice. Panel management, the ongoing management of patient panels, fosters a controlled healthcare environment and enables proactive preventive and chronic illness care.

The relationship between the patient/family and the provider/care team is at the heart of the Patient-Centered

Empanelment: Where to Start

- Dedicated staff time (Panel Manager role)
- Remember patient preferences
- Obtain relevant data
  - Provider supply (appointment slots)
  - Average visits per patient per year
  - Demand for services
  - Current provider assignments
  - Patient acuity (weight for risk adjustment)
- Use data to make adjustments to panels

HIT Considerations in Empanelment

- Is system capable of running reports on visit history?
- What kinds of reports can you run?
- Clearly defined PCP field in the system?
- Who will be able to run the reports needed to operationalize empanelment?

First Steps to Defining Your Practice Panels: Murray 4 Pass Method

1. Patients who have seen only one clinician are assigned to that clinician
2. Patients who have seen more than one clinician are assigned to one seem most frequently
3. Patients with multiple clinicians the same number of times, assigned to one who did last comprehensive visit
4. Remaining patients assigned to last clinician seen

Calculating Ideal Panel Size

- Many practices start with calculating supply and demand of visits.
- Capacity = visits/day x clinician days/year
- Determine average number of visits per year per patient
- Ideal panel size = Capacity/Average # of visits

Clinician visits per day
× Number of clinician days per year
÷ Average number of visits per patient per year
Ideal panel size

Visit Supply and Demand for HIV?
An example from HIV ACCESS – Not a standard, just an example

Visits PPPY	4.5	(6.0)
Provider visits per day*	16	
Provider days per year**	240	
Ideal panel size per FTE MD provider	853	(640)

*This assumes FT clinical work, 10 holiday days and 4 weeks off for vacation/CME.

What's your clinic's panel size?

(Write in chat box)

Other Panel Size Considerations

- Best Practice to adjust panel sizes based on acuity and other patient characteristics
- Patients meeting certain criteria will be weighted based on their expected healthcare needs
  - Weight by age/gender
  - Weight by acuity and/or morbidity
- Open and close panels to new patients based on data
- Use panel data to allocate resources to keep supply and demand balanced

KU HEALTHPARTNERS

Silver City Health Center

PATIENT ACUITY RUBRIC

CATEGORY	CRITERIA 0	1	2
Ability to Self Manage	• Minimal provider intervention to carry out plan of care • Demonstrates self management (example: blood sugar log presented each visit with appropriate home testing regimen)	• Somewhat able to carry out plan of care • Requires some provider intervention and reinforcement	• Repeated provider reinforcement and intervention required
Please select which criteria your patient falls under next to the category name "ability to self manage"			
Mental Health	• No mental health issues or • Long term stability demonstrated	• Has mental health issues but is under the routine care of a mental health care provider • Requires some provider intervention	• Has mental health issues not adequately controlled • Multiple and repeated provider intervention and support
Please select which criteria your patient falls under next to the category name "mental health"			
Chronic Illnesses	• No chronic illnesses or • Long term stability demonstrated	• Has chronic illness(es), which • Requires some provider intervention (i.e. specialist referrals, frequent monitoring, etc.)	• Has chronic illness(es) not adequately controlled • Multiple and repeated provider intervention and support
Please select which criteria your patient falls under next to the category name "chronic illnesses"			

Category	Score
Social	0
Language	0
Health Literacy	0
Self Management	0
Mental Health	0
Chronic Illnesses	0
Chronic Meds	0
TOTAL	0

Interpretation of Total Score		
Point Range	Acuity	Category
0 - 4	LOW	A
5 - 9	MEDIUM	B
> or = 9	HIGH	C
Patient's Acuity Category		0

http://www.safetynetmedicalhome.org/change-concepts/empanelment

Ongoing Maintenance of Patient Panels

- Decide how you define active patients
- Keep panel reports accurate by including only active patients (eliminate deceased, transferred, duplicate patients)
- Identify duplicate patients or patients assigned to multiple providers
- Ongoing monitoring of panels to make sure supply and demand are balanced
- Quality check to make sure reports based on panels are accurate

Summary

- Understand importance of Empanelment in PCMH model
- Highlight a robust example of empanelment and see the quality implications
- Help you do a self-assessment of empanelment in your practice setting
- Identify empanelment deliverables specific to PCMH recognition/certification
- Identify your next steps in empanelment

Q&A

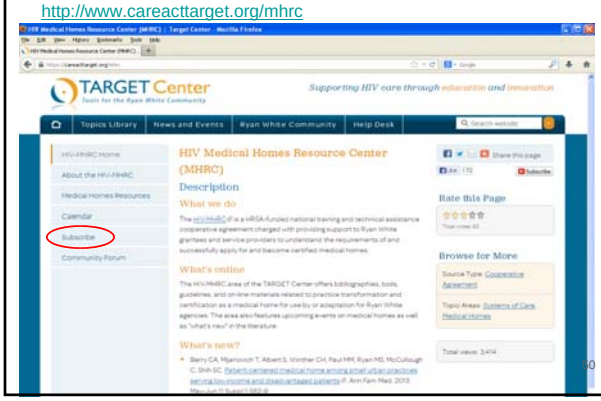
To ask the presenters a question:

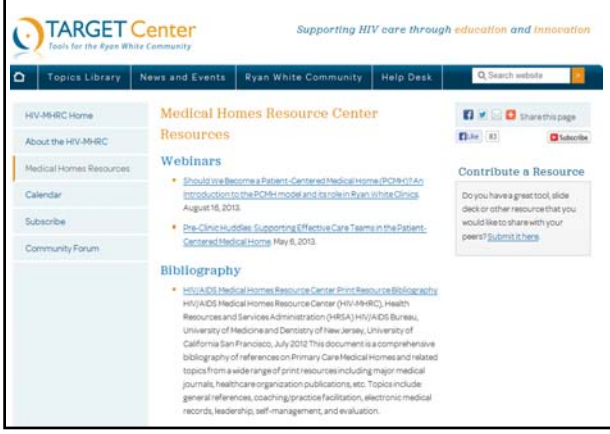
1. Enter question into Chat Box
2. Press *6 to mute/unmute phone

Empanelment Resources

- Safety Net Medical Home Initiative
  www.safetynetmedicalhome.org
- Institute for Healthcare Improvement
  www.ihi.org
- Building Blocks of High-Performing Primary Care
  www.chcf.org/publications/2012/04/building-blocks-primary-care

Resource Repository
http://www.careacttarget.org/mhrc





Please complete online
Webinar Evaluation
by Friday, October 11, 2013

https://www.surveymonkey.com/s/Empanelment

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Save the Date!

Join us for the next HIV-MHRC webinar:

Supporting Engagement and Retention in Care Using the PCMH Model:
Best Practices from the California HIV/AIDS PCMH Demonstration Project

Friday, December 13th, 2013
1pm - 2:30pm ET
10am - 11:30pm PT
12pm - 1:30pm CT

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Thank you!!!