



# Empanelment and Risk Stratification

PCTM SHARED LEARNING WEBINAR

JANUARY 25, 2024

# Introductions

- ▶ Name
- ▶ Title
- ▶ Organization Name
- ▶ Type of Organization (FQHC, Privately Owned Clinic, etc.)
- ▶ EMR your organization uses?
  
- ▶ If you had one wish to be granted by the Primary Care Transformation "Fairy Godmother", what would it be?
  - Free Population Health/Care Management Software
  - a Community Health Worker
  - a Nurse Care Coordinator
  - A data analyst dedicated to making reports for me
  - Something else?

# Empanelment Defined

The act of  
assigning individual  
patients to  
individual primary  
care providers

Process for sorting  
patients into  
populations

Way to manage  
supply and  
demand

# Sorting Patients into Populations

- ▶ Allows for a group of patients to be easily identified *including those that do not come in for a visit*
- ▶ Allows a provider and team to customize their services to the needs of their specific clients
- ▶ Allows for determination of performance regarding specified quality metrics

# Managing Patients into Populations

- ▶ How do you define "Active Patient" for your organization?  
(patient seen within past 18 months, 2 years, or 3 years)

- Apply the Four-Cut methodology to assign patients not already assigned to a PCP

Table 3: The Four-Cut Methodology

| Cut     | Report Description  | PCP Assignment   |
|---------|---|--|
| 1st cut | Patients who have seen only one provider in the past year.  | Assigned to that sole provider.                                |
| 2nd cut | Patients who have seen multiple providers, but one provider the majority of the time in the past year.          | Assigned to majority provider.                                 |
| 3rd cut | Patients who have seen two or more providers equally in the past year (no majority provider can be determined). | Assigned to the provider who performed the last physical exam. |
| 4th cut | Patients who have seen multiple providers.  | Assigned to last provider seen.                                |

Source: Murray M, Davies M, Boushon B. Panel size: How many patients can one doctor manage? *Fam Practice Mgmt.* 2007;14(4):44-51.

# Managing Supply and Demand

Formula for determining the number of patients it's possible to take care of:

$$\begin{aligned} &(\text{provider visits per day})(\# \text{ days in clinic year}) \\ &= \\ &(\# \text{ patients})(\text{patient visits per year}) \end{aligned}$$

# Managing Supply and Demand

Solve for the # of patients:

$$\frac{(\text{provider visits/day})(\text{days in clinic/year})}{(\text{patient visits/year})} = \# \text{ patient}$$

Fill in values:

Provider visits/day = 18

Days in clinic/year = 210

Patient visits/per year = 3.6

# Managing Supply and Demand

- Solve for # patients for 1 FTE provider:

$$\frac{(18)(210)}{(3.6)} = \# \text{ patients}$$

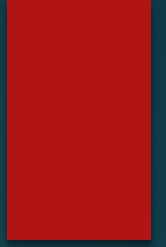
$$1,050 = \# \text{ patients}$$



## Steps of Empanelment

1. Assess Supply and Demand
2. Assign patients to PCP
3. Review
4. Risk-Adjust

# Resource for Empanelment

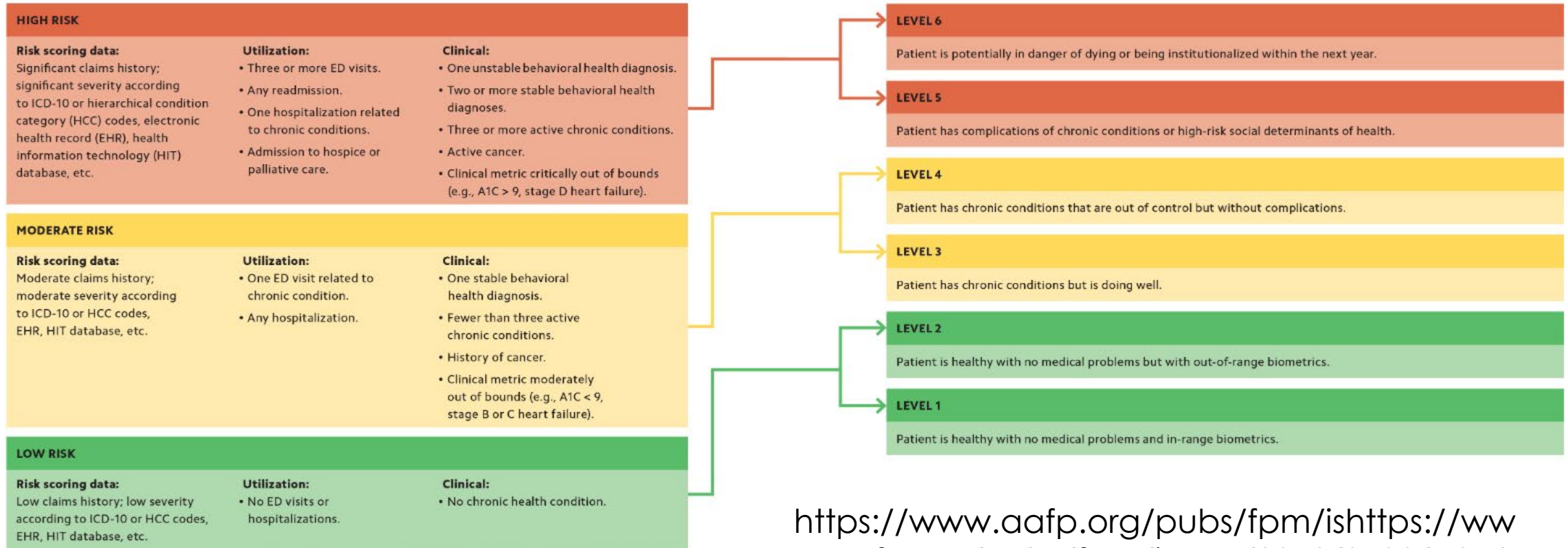


<https://www.safetynetmedicalhome.org/change-concepts/empanelment>

- Patient Acuity Rubric
- Determining the Right Panel Size
- Addressing Staff Pushback for Empanelment
- Sample PCP Assignment Policy
- Scripting for Appointment Scheduling
- Sample Provider Staffing and Scheduling Policy
- And so much more!

# Risk Stratification

- ▶ Presence or absence of chronic conditions
- ▶ Advanced Age
- ▶ Multiple Comorbidities
- ▶ Physical Limitations
- ▶ Substance Abuse
- ▶ Frequent Hospitalizations or Emergency Department Visits
- ▶ Polypharmacy



<https://www.aafp.org/pubs/fpm/issues/2019/0500/p21.html>

## COMPARISON OF RISK-STRATIFIED CARE MANAGEMENT AT DIFFERENT RISK LEVELS

|                         | Level 1   | Level 5   |
|-------------------------|---|---|
| <b>Care plan</b>        | <ul style="list-style-type: none"> <li>• Preventive care</li> <li>• Immunization</li> </ul>   | <ul style="list-style-type: none"> <li>• Preventive care</li> <li>• Immunization</li> <li>• Annual wellness visit</li> <li>• Chronic disease management</li> <li>• Monitor for second-degree complications</li> <li>• Medication reconciliation</li> <li>• Shared decision-making</li> <li>• Self-management support</li> <li>• Advanced directives</li> <li>• Transitions of care (as needed)</li> </ul> |
| <b>Goal</b>             | <ul style="list-style-type: none"> <li>• Prevent disease</li> </ul>   | <ul style="list-style-type: none"> <li>• Treat the later stages of disease and minimize disability</li> </ul>   |
| <b>Access</b>           | <ul style="list-style-type: none"> <li>• Annual face-to-face visit</li> <li>• Virtual health</li> <li>• Brief acute encounters</li> </ul> | <ul style="list-style-type: none"> <li>• Quarterly face-to-face visits (at least)</li> <li>• Prolonged acute encounters</li> <li>• Alternative visit types (e.g., video conference, telephone, group visit)</li> </ul>  |
| <b>Team</b>             | <ul style="list-style-type: none"> <li>• Physician</li> <li>• Medical assistant</li> </ul>  | <ul style="list-style-type: none"> <li>• Physician</li> <li>• Medical assistant</li> <li>• Care coordinator</li> <li>• Care manager</li> <li>• Behaviorist</li> <li>• Social worker</li> <li>• Pharmacist</li> </ul>  |
| <b>Resources needed</b> | <ul style="list-style-type: none"> <li>• Low</li> </ul>   | <ul style="list-style-type: none"> <li>• High</li> </ul>  |

<https://www.aafp.org/pubs/fpm/ishttps://www.aafp.org/pubs/fpm/issues/2019/0500/p21.html>

# Sharing from our PCTM Cohort

- ▶ Sarah Cashman, BSN, RN  
Nurse Care Navigator  
Lourdes Family Practice, Lourdes Internal Medicine
- ▶ Staci George  
Director of Quality, Population Health and Utilization Review  
Community Health of Central Washington

# Thank you for attending!

- ▶ Please complete the evaluation. Click on the link in the chat.
- ▶ What topics would you like to discuss in future Shared Learning Webinars?
  1. Incorporating Patient Care Plans into the Electronic Health Record
  2. How to Incorporate Self Management Support into Patient Care
  3. Patient Engagement Strategies
  4. Closing the Loop on Specialty Care Referrals
  5. Behavioral Health Integration Strategies
  6. Partnering with Community Based Organizations
  7. Methods for Measuring and Tracking Behavioral Health Outcomes