Attachment and Panel Identification in Primary Health Care

A Step-by-Step Workbook for Primary Health Care Providers, Teams and Leaders in Nova Scotia

Contents

Acknowledgements

This workbook is influenced by the *Panel Management Workbook* created by British Columbia's General Practice Services Committee Practice Support Program [PSP]; the *Guide to Panel Identification for Alberta Primary Health Care* and other panel and continuity resources developed Alberta's Accelerating Change Transformation Team; and empanelment resources developed by the Safety Net Medical Home Initiative, supported by The Commonwealth Fund, Qualis Health and the MacColl Center for Health Care Innovation at the Group Health Research Institute. Special thanks also to members of the NP Attachment and Panel Identification Using a QI Approach in Primary Health Care Task Team for supporting this work.

Visit PHCQuality.ca for resources to support you and your team to implement panel identification in your practice.

Introduction

A patient panel, or roster, lists the unique patients that have an established relationship with a primary provider (physician or nurse practitioner), also known as Most Responsible Provider [MRP]. Relational continuity (an ongoing relationship between a provider and a patient) is a key objective of establishing panel identification processes. Evidence shows that patients who consistently see the same provider use significantly fewer health care services,[1] have better outcomes and lower costs.[2-7] Higher levels of continuity between provider and patient the better leads to better clinical care,[8] improved efficiency,[2,9] and better patient[2,9] and provider satisfaction.

Panel identification is simply defining the list of patients whose care a physician or nurse practitioner is responsible for. Panel identification is a foundational element of high performing primary care, and is a building block for many elements of health homes including preventive care, timely access to care, continuity of care, team-based care, and performance measurement.[10,11]

Knowing your panel is fundamental to:

- Continuity of care, which improves clinical care outcomes and patient and physician/team satisfaction
- Establishing relationship and accountability, allowing for relational continuity and reliable follow-up;
- Understanding clinical needs for a given panel of patients, contributing to proactive population based service delivery planning (panel management);
- Achieving and maintaining access for patients, including measuring demand and supply within the practice to achieve balance;
- Planning distribution of work with the provider and team, as appropriate.

This workbook is for Nova Scotia Primary Health Care [PHC] teams, with support from PHC Leaders, to assist in establishing the processes of panel identification and attachment, as necessary, within the Nova Scotia context. It does not address the theory and evidence of attachment, panel management and continuity, nor does it address the many opportunities to improve efficiency and effectiveness that are available once a panel has been identified.

How to use the workbook:

- The workbook serves as a step-by-step guide to walk a practice or provider, with support from PHC Leadership, through the steps involved in identifying a provider's panel and maintaining panel processes.
- Fillable sections allow the team to establish office protocols for consistency, sustainability and training purposes.
- Use the workbook to record the details of your work. This workbook will become your team's reference and guide as you work on panel identification.

To support the workbook, there is an accompanying Administrative Checklist (Appendix A) that can help teams work through the administrative panel identification activities and track progress, as well as Med Access EMR and Accuro EMR supplements.

Primary Health Care Attachment and Panel Identification Approach

The *Primary Health Care Attachment and Panel identification Approach* (Figure 1) consists of three phases that flow into one another.

- Phase 1: *Identify*, includes steps to identify an accurate, up-to-date list of patients on a provider's panel (Figure 2).
- Phase 2: *Adjust*, provides guidance on determining whether supply and demand are in balance and informs conversations about panel size adjustments and supports.
- Phase 3: *Support and Sustain*, establishes mechanisms for ongoing maintenance of the panel to sustain improvements.

The three phases are depicted as a cycle to reflect the need to repeat this approach annually, though the first time will involve more work; if panel maintenance processes are maintained it is expected that subsequent cycles will be more straightforward.

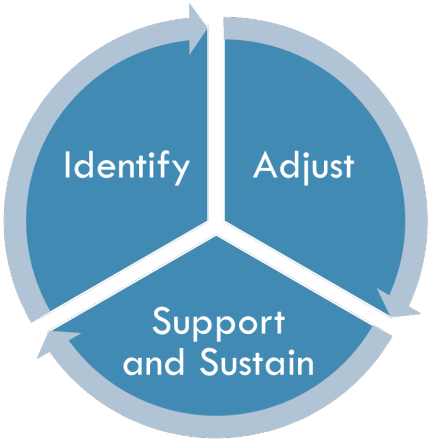


Figure 1. Phases of the Primary Health Care Attachment and Panel identification Approach

Identify

1. **Patient Validation Process:** To confirm patient information/MRP with patients.
2. **Define Patient Status Options**: Define patient status to ensure accuracy.
3. **EMR Clean-up: Run Reports to Assign MRP and Update Statuses**: Run appropriate patient lists to ensure all paneled patients have assigned provider and appropriate status.
4. **Active Patient Panel List:** Run your cleaned and updated active patient list.

Adjust

5. **Calculate**: Panel size and supply and demand data.
6. **Analyze**: Compare and reflect on panel data and operational factors that may impact panel size.
7. **Modify**: *As necessary*, provide supports to increase attachment or find panel balance based on analysis.

Support and Sustain

8. **Monitor and Maintain**: Support for regular panel review, monitoring and maintenance.

Figure 2. Phases and steps of the Primary Health Care Attachment and Panel Identification Approach

Before you Start: Getting Ready

Team Engagement: Before you begin, it is important to engage the entire team in a discussion about the panel identification process about to begin. This will provide an opportunity to discuss who is involved, to make decisions such as how to assign any unassigned patients, and to address any questions.

Roles and Responsibilities: It is important to identify who is leading and supporting each step of this work. *Table 1. Roles and Responsibilities* provides an outline the activities of each step and suggested roles within a practice who *could* fulfill these functions. Roles that are expected to be involved in this work include, at a minimum, the primary provider (Nurse Practitioner or physician), Primary Health Care leadership staff (Health Services Manager and/or Health Services Lead), and often an administrative staff member with access to the clinic's electronic medical record (EMR). Take some time to review the activities involved in each step and identify who from the practice will be involved.

Table 1. Roles & Responsibilities

	Step	Activities	Suggested Roles	Who's Involved?
Identify	1. Patient validation process	Set up a process to confirm MRP and contact information with patients and validate in the demographics section of the EMR.	Admin Staff	
	2. Define patient statuses	Define patient statuses used in the EMR for clarity and accuracy.	Admin Staff or Provider	
	3. EMR Clean-up: Run reports and assign MRP & update statuses, *as necessary*	Run appropriate reports in EMR to ensure appropriate MRP assignments and patient statuses. Assign/re-assign as necessary.	Admin Staff or Provider	
		Discuss/agree on MRP approach with team.	HSL/M, Admin Staff	
		Validate any reassignments and status updates.	Provider	
	4. Run active panel list	Run cleaned list of active patients in EMR. Review for accuracy. Export into Excel file.	Admin Staff or Provider	
Adjust	6. Calculate	Gather panel data and calculate supply and demand.	HSM/L, Provider	
	7. Analyze	Compare and reflect on panel data and operational factors.	HSM/L, Provider	
	8. Modify	As necessary, provide supports to increase attachment or find panel balance.	HSM/L, Provider	

Support and Sustain	9. Monitor and Maintain	Identify supports and review processes necessary to monitor and maintain an accurate panel.	Adminis Staff, Provider, HSM/L	

EMR Configuration: It is also helpful to discuss who manages EMR settings and configurations in the team. Every EMR has the ability to be customized in a way that works the best for each clinic; this is referred to as configuring the EMR. As you work through this workbook, some activities will require configuration of the EMR. Some examples include configuring patient statuses; developing custom searches; and entering data in the chart.

We recommend that only one or two people are responsible for setting EMR configurations.

a. Do an inventory of the administrative privileges each user has within the clinic. Discuss as an improvement team if some privileges should be changed, and have a clear under-standing of what can and cannot be changed within the EMR.

b. Discuss any changes you make with the user's administrative privileges. If users continue to have administrative privileges that they should not use, ensure this is discussed with them.

At least one person generally has administrative privileges in the EMR; they can configure statuses and settings. Who is the person/are the people for the clinic? What happens if this person is on vacation or leave for an extended period of time? Is there a back-up?

Phase 1: Identify

The first phase of the process is identifying all active patients for which the provider is the Most Responsible Provider (MRP). This is identified in the Patient Demographics sections in EMRs, in the "Primary Provider" field in Med Access EMR and the "Office Provider" field in Accuro EMR. This process often requires review and cleaning of patient data in the EMR to ensure this is accurate. The output of this phase is an accurate, up-to-date list of every patient on the provider's panel.

Important Note: The steps within *Phase 1: Identify* do not have to follow the sequence as specified below, but all steps are recommended to be completed before moving onto Phase 2 to ensure the output (active patient panel list) is accurate.

Step 1: Establish Process for Patient Validation

Establish a process to regularly validate (confirm) MRP and contact information with patients.

Rationale: Validating patient information regularly is essential to maintaining accurate panel data, and ensuring both patient, provider and team agree on the attachment and commit to build and/or maintain the relationship. Only when information has been recorded consistently and updated regularly in the EMR can the information be searched and utilized reliably.

Patient Validation: Gradual Process or Big Lift?

In this step, you do not have to validate each and every patient on a provider's panel before moving on to the next step. At the very least, you should establish a process (if there is not one already) to make sure this is done on an ongoing basis. However, some clinics prefer to take this initial step on as a "big lift" by dedicating resources to validate each of their patients before moving on to the next step.

Each patient encounter (by phone, videoconference or in-person) is an opportunity to confirm patient information, including the name of their provider and contact information (mailing address, phone number, e-mail, secondary contact, and pharmacy). Best practice is to make this a routine part of the patient check-in process. This simple step builds a reliable panel list.

It is recommended that patient information is validated at appropriate intervals within the EMR. In Med Access, tick off the validation box and include the current date each time this is done. In Accuro, each time patient demographics are validated the chart is date stamped.

Quality Improvement Tip:

Validation rates can be produced and shared with the team to enable tracking over time. This will inform the team of how many patients have confirmed their MRP and can be considered as empaneled, and can be used as a process measure for panel improvement.

Patient Validation Process

Ideally, MRP and patient information will be validated at each patient encounter. Clerical / administrative staff may do this when patients check-in for in-person appointments, or call to schedule a virtual appointment. The ***Patient Validation Algorithm for Front Desk Staff*** *(Appendix B)* can assist administrative staff to establish processes. In cases where it is not possible or feasible for clerical / administrative staff to take on this task, the provider may need to embed this task into their encounter workflows.

Patient Validation Table. Use this space to answer the following questions and outline the Patient Validation Process for your team:

Considerations:
• Whose job is it to ask the patient to validate their information?
• Are there times when the admin is unable to verify contact information? If so, who will complete this task and when?
• Where is MRP entered in the EMR?
• Who is able to verify status and MRP in the EMR?
• How frequently do you want to confirm patient's contact information, status and MRP?
• Outline appropriate demographic fields required for new patients to ensure standardized data input.
  ○ MRP
  ○ Status
  ○ Phone, email, mailing address, pharmacy
  ○ Other
• How are patients with no primary provider identified assigned an MRP?	

Refer to the Med Access EMR Supplement (pages 4-5) or the Accuro EMR Supplement (pages 8-9) for instructions on how to ***validate patient information*** in your EMR.

Step 2: Define Patient Statuses

Define patient status options to assist with panel clean-up and improve consistency within the team.

Rationale: Being clear on patient status definitions will assist the clean-up of active patients, will improve consistency within the team and help ensure all staff and health care providers are informed.

The following are the most common patient statuses used in panel clean-up and established definitions. Ultimately the definitions need to make sense to the clinic and the community, so if there are differences or additions this is the place to capture this. Once each of these definitions are defined by the clinic team, share them with all EMR users so that everyone entering this information is doing so in a consistent way.

Table 3. Primary Health Care Patient Status Definitions

Patient Status	Definition
Active	1. The patient receives longitudinal primary care services from the clinic/provider (often, they would refer to someone at the clinic/office as their Most Responsible Provider (MRP) – the provider may refer to the patient as "attached"), 2. The patient is *19 years of age or older* and had a visit/encounter in the past 3 years[1] and meets the bottom 3 requirements, OR 3. The patient is *under 19 years of age* and meets the following 3 requirements regardless if they had a visit/encounter in the past 3 years, 4. The patient has not permanently moved away (out of town/province/country)[2], 5. The patient has not changed providers or requested their chart to be sent to another clinic for the purposes of the new clinic providing the patient with longitudinal primary care services, and 6. The patient is not deceased. [1] "Visits within the previous 3 years" has been shown to be statistically relevant and accurate for determining whether or not a patient considers a clinic/provider to be their Patient Medical Home (PMH) or MRP, as discussed in The College of Family Physicians of Canada's 2012 Best Advice Guide: Panel Size. If a person has not had a visit in this time frame, it is much more likely that they have moved away or are deceased. Looking at patient age, address of self or family members, and previous visit frequency may provide a useful second check when considering those outside of the 3 years' timeframe. [2] Patients who have moved away for a period of time, such as to college or university in another town or retirees who travel to warmer climates (i.e.: "snowbirds"), may still be considered "Active" patients. They may sporadically return home for care or simply consider the primary care services in their hometown as their MRP while receiving periodic care through a school or walk-in clinic.
Inactive	Includes formerly active patients with no clinic visits within the last 3 years AND does not meet any of the requirements to be considered an "Active Patient".
Temporary	Applied to a patient seeking walk-in or specialty service care (such as vasectomy, maternity care, IUD, aviation medical, etc). These patients are not considered to be part of the provider's panel.
If there are other patient statuses your clinic uses, name and define them below:	

Step 3: EMR Clean-up - Run Reports to Assign MRP and Update Statuses, *as necessary*

Run appropriate reports of clinic patients to ensure appropriate MRP assignments* and patient statuses (e.g. active, inactive). Review the list(s) to confirm patients on the list(s) are assigned appropriately, identifying those for further review and updating statuses as necessary. Coordinate with team members to ensure all patients are assigned to appropriate provider.

***** ***Important:*** *MRP reassignments only apply to patients who are/should be rostered to a responsible provider for ongoing primary care. Unattached patients who are being seen in a primary care clinic, for example, would not be assigned/reassigned to an MRP.*

Rationale: It is important to make sure all patients who *should* be assigned to a provider are, and this assignment is appropriate and indicated in the patient record. An accurate active list is important to inform the provider and team about the demand of services for these patients. Some patients on a provider's active patient list may not actually be active for a variety of reasons, and therefore should not be included on their final panel list. Alternatively, some patients may have been erroneously labeled inactive. To avoid inadvertently missing these patients from the provider's final panel list, do a quick scan of any patients labeled inactive to ensure accuracy.

Where to begin? The reports that are appropriate to run and the information to verify depends on each practice. It may be helpful to start with the types of patients in the EMR who are not part of the practice (e.g. ED patients, LTC patients, well women's clinics) and determining how those patients are currently added into the EMR. Standardize and verify the fields to use or appointment types to keep them separate from paneled patients.

Optional: List any team-specific practices or clinics where patients are accessing care temporarily or for defined purposes (e.g. primary care clinic, walk-in clinic, well women's clinic, etc). Then, determine standardized status and MRP for each patient type.

Patient Description	Status	MRP Field (e.g. Office Provider)
e.g. Well Women	*Temporary*	*Patient's MRP*

MRP Assignment: As you review your lists of patients, ensure MRP assignments are correct. It is recommended to run a report of patients with '***no assigned***' or "***unassigned***" provider. If this report has no results, it means all patients have been assigned. If you have results, review this list and decide if any should be assigned to a provider in the clinic. If the list is too large, try adding components to the search to breakdown the list into smaller, more manageable, lists. For example, filter by appointment date and appointment provider.

How a clinic chooses to assign patients to an MRP may vary, depending on the coverage arrangement. The Fourth Cut Method (Appendix C) is ***one option*** for deciding which provider to assign a patient to in a larger clinic; *this would require discussion and decision making with the team*.

Refer to the Med Access EMR Supplement (page 13) or the Accuro EMR Supplement (pages 4-8) for instructions on how ***assign MRP*** in your EMR.

Active/Inactive Patient Statuses: The active and inactive patient definitions in Table 3 provides guidance on the patients who may be determined active and inactive. If a patient meets these definitions and is labeled incorrectly, do not update their active or inactive status unless there is a clear reason to do so. If a patient does *not* meet the appropriate definition, do not automatically reassign them as active or inactive without confirming with the provider. ***The provider's judgement and knowledge of their patient is crucial in appropriately assigning or reassigning a patient status***. For example, a young, healthy adult male who has not accessed services in over 3 years may remain active as it is expected he will resume services if a primary care need arises.

To generate a provider panel report showing all active or inactive patients attached to a provider, you will need to identify the primary provider and indicate search parameters to only select active (and then inactive) patients.

Refer to the Med Access EMR Supplement (pages 8-12 and 14-16) or the Accuro EMR Supplement (pages 11-14) for instructions on how to **review active patient lists and update patient statuses** in your EMR.

Review the active and inactive patient lists, and update any patient statuses as needed. If the status is changed to 'inactive', the patient can always be re-activated if they return to the practice. Inactivating patients from the EMR does not delete their record or mean the patient has been discharged.

EMR Tip: Most EMRs have the ability to make 'bulk' changes to lists. At times, it may be best to go in to the patient chart to verify information before you change their status. **Although several EMRs can make 'bulk' changes. You generally cannot undo a 'bulk' change, so be cautious!*

Step 4: Cleaned Active Patient Panel List

Run a "cleaned" and updated list of active patients again.

Rationale: Since reviewing and cleaning the MRP assignments and active and inactive patient lists, you can now be confident that the active patient panel list is accurate and these are the patients the provider is responsible for.

Congratulations! You now have an accurate list of all active patients on the provider's panel. This list is foundational for further panel management activities.

Phase 2: Adjust

Now that an accurate panel size has been determined, the next phase is for the provider and Health Services Manager/Lead to assess this panel size in relation to other operational factors to determine whether, and how, this panel size should be adjusted. Integral to this phase is supply/demand balance theory (Figure 3), which outlines the factors that impact supply of and demand for appointments.

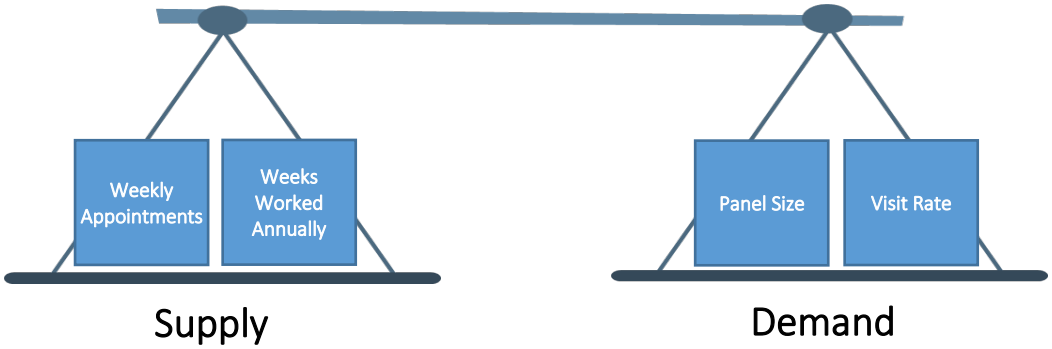


Figure 3. Supply / Demand Balance Theory

Supply: The total amount of appointment time available to provide services for panel of patients. (Note: this does not include clinical time for non-paneled patients, e.g. LTC coverage, primary care clinics, etc).

Supply is calculated by multiplying the following factors:

- The **number appointments available per week.** A simple count of the number of appointment slots in the schedule. Depending upon the work of the provider and their FTE, the number of appointments available per day may differ so it should be calcaulted over a month and then arrive at the average number of appointments available per week.

- The **number of weeks worked annually**. This could be the actual counted number, or you can use a standard of 220 days (44 weeks) for a 1.0 FTE NP which takes into account vacations, holidays, sick time, and education days.

Demand: The total demand for appointment time that is *estimated* to stem from a panel of patients based on past activity. (Note: as above, this does not include clinical demands for non-paneled patients, e.g. LTC coverage, primary care clinics, etc).

Demand is estimated by multiplying the following factors:

- The **total panel size,** which is calculated by running the active patient panel list in Step 4.

- **Visit rate** is the rate at which paneled patients are returning for care over a period of time. It is calculated as the number of visits to the practice (completed appointments) over a typical 12-18 month period divided by the number of unique patients seen in the same time period. Visit rate is

a complex factor, impacted by patient panel characteristics such as average age and rate of chronic conditions as well as provider preferences on frequency of follow-up appointments.

$$\text{Visit Rate (Visits per patient per year)} = \frac{\text{\# of completed appointments}}{\text{\# of unique patients seen}}$$

As you can see in Figure 3 above, when the supply and demand are balanced a provider has just the right amount of appointment capacity (supply) to meet the needs of their panel of patients (demand). The examples below show how this works in a perfect scenario using standard values for each factor (Figure 4: NP Jane), and also how balance is maintained if a supply factor and a demand factor are changed (Figure 5: NP Matt):

NP Jane is perfectly in balance:

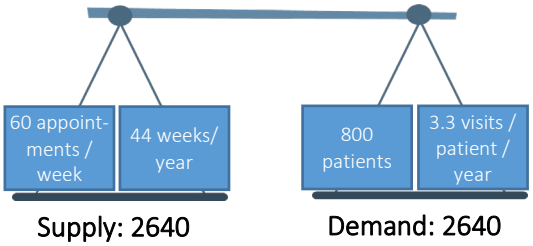


Figure 4. Balanced Supply / Demand

NP Matt is also considered in balance:

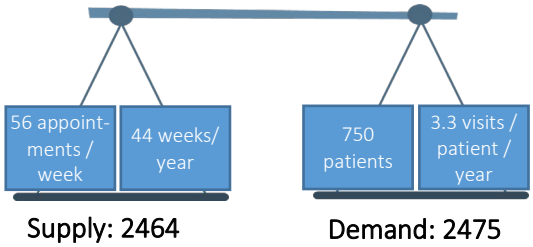


Figure 5. Balanced Supply / Demand

In real life, achieving NP Jane's perfect example of supply/demand balance is rare. However, running these calculations can provide important information on whether a provider is in balance, how to support them to achieve balance if not, and/or how to maintain balance if factors such as panel size are being adjusted.

Step 5: Calculate Panel Data

Gather panel data and calculate supply and demand.

Rationale: Having a good understanding of a provider's panel data is foundational to making informed decisions regarding panel balance and panel size adjustments.

Add the provider's panel data into Table 4 to assess for supply/demand balance. Each of these factors will be taken into consideration in Step 6. Insert data for each provider in a separate row.

Refer to Med Access EMR Supplement (pages 18-21) or Accuro EMR Supplement (pages 14-15) for instructions on how to ***obtain panel data*** from your EMR.

Table 4. Provider Supply and Demand Data

		Demand Data					Supply Data		
Provider Name	**Data Date Range**	**(A) Input Actual Panel Size** # of patients on Active Patient List obtained in Step 4	**(B) Input Completed Appoint-ments** # of appts with "done" appt status over defined time period	**(C) Input Unique Patients** # of unique patients seen over defined time period	**(D) Auto-Calculate Visit Rate (B ÷ C)** # of visits per patient per year	**Auto-Calculate DEMAND (A x D):**	**(E) Input Expected Weekly Supply** # of appoint-ments available per week to see panel of patients	**(F) Input Weeks Worked Annually** # of weeks worked per year (may use 44 weeks as a standard)	**Auto-Calculate SUPPLY (E x F):**
EXAMPLE: *NP Jane*	*Sept 1 2020 – Sept 1 2021*	*800*	*2145*	*650*	*3.3*	***2640***	*60*	*44*	***2640***

Step 6: Analyze

Compare and reflect on the panel data calculated in Step 6 and any operational factors that may impact a panel target.

Rationale: A fulsome analysis of a provider's panel data includes consideration of operational factors that impact a provider's capacity (supply) to care for their panel of patients. These factors may impact the provider's panel target, while also considering whether the provider's supply and demand are in balance and provider perceptions of panel demand and workload.

Operational factors include:

- *Full Time Equivalent (FTE)*: A provider working a 0.6 FTE can be expected to have a panel size that is 60% of a provider working a 1.0 FTE.
    - *Non-Panel Clinics*: Regular, scheduled time spent outside of the clinic providing clinical services to a community of patients that are not a part of the provider's panel essentially reduced the provider's FTE available for their panel. Examples include, but are not limited to, long-term care coverage and unattached patient clinics.

      The simplest way to quantify the impact of these additional activities on a panel target is by determining the % of clinical time spent in these activities. For example, a provider working a 1.0 FTE spends one ½ day every week providing long term care coverage (10% of weekly supply). They also cover the primary care clinic one day a month, which averages out to 5% of total weekly supply. In total, this provider spends 15% of their clinical time providing care for patients outside of their panel. Therefore, they can be expected to care for a panel size 15% smaller than a 1.0 FTE, or equivalent to a 0.85 FTE.

      It is not always possible to quantify clinical activities in this way. For example, some providers may provide long term care coverage "on call", and do not have a defined, quantifiable schedule. If this is causing the provider to see more demand than their expected supply a conversation with HSM/HSL to determine best way to address this situation is recommended.
- *Team Composition*: Providers working in a collaborative team with the support of FPNs and allied health staff may be able to care for more patients than those working on their own. This may become apparent when looking at demand in comparison to panel size; a team with additional resources would be able to meet some of the needs of the panel. A conversation with HSM/HSL to determine best way to address this situation is recommended.

In Table 5 below, record details of any operational considerations and the impacts on panel size, if applicable, for each provider:

Table 5. Operational Considerations

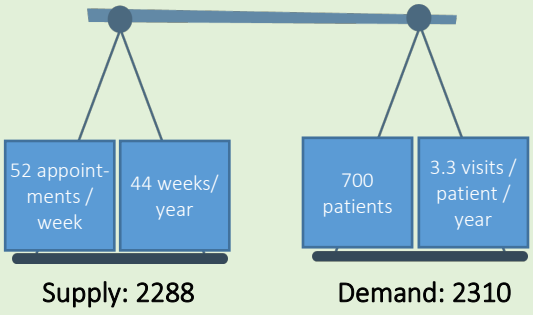
Considerations	Details and Panel Size Impacts (if applicable)

Based on the above considerations, if applicable, identify the target panel size for each provider:

Target Panel Size:	Currently at target?	
	Yes	Great! No panel size adjustments necessary. Is the provider's supply and demand in balance? Does provider need support to find balance?
	No	What adjustments can be made to achieve panel target *and* achieve or stay in balance? As panel size is increased through attachment, consider how this will impact the other panel factors and what supports are needed.

Example 1: **Operational Factors Impacting Panel Target**

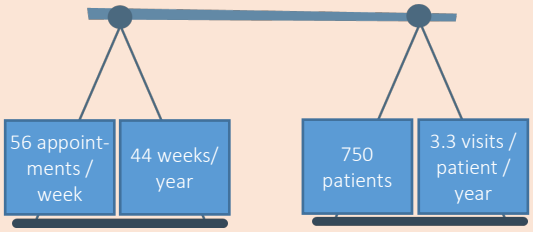
NP Beth works full-time (1.0 FTE), currently has a panel of 700 patients, and is in balance. Because NP Beth provides LTC (0.1 FTE) and primary care clinic coverage (0.1 FTE), her panel target of 800 patients may be reduced 20% down to 640 patients. In discussion with NP Beth, it is determined that because she is working in a collaborative team environment, she is in balance, and is not feeling overwhelmed, it is appropriate to maintain her current panel of 700. No panel adjustments are necessary, and her balance should be monitored over time to ensure this balance is maintained.



Example 2: Panel Not at Target

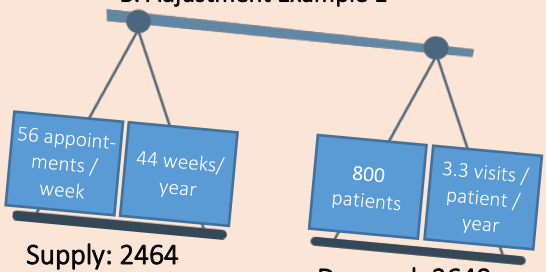
NP Joe is currently in balance (A. Before Adjusting), but he does not have any operational factors that would impact his panel target, thus his current panel size of 750 patients is below target. If he added 50 patients to his panel to achieve his target of 800 without adjusting any other panel factors, he would be at target but out of balance (B. Adjustment Example 1). Instead, while increasing attachment NP Joe could also be supported, if possible, to increase his weekly supply of appointments from 56 to 60 (C. Adjustment Example 2). Now, he is able to achieve his panel target and maintain balance.

A. Before Adjusting



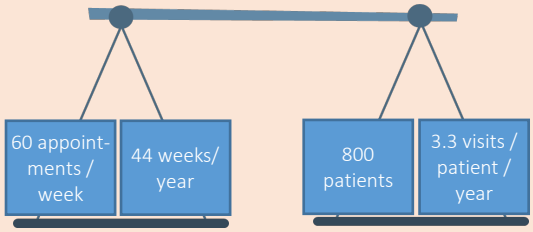
Supply: 2464 Demand: 2475

B. Adjustment Example 1



Supply: 2464 Demand: 2640

C. Adjustment Example 2



Supply: 2640 Demand: 2640

Step 7: Modify

As necessary, provide supports to increase attachment or find panel balance based on analysis of panel data and operational considerations.

Rationale: The information in step 6 will provide direction regarding panel adjustments and/or need to find balance. *How* a panel is modified or a provider is supported is unique, and requires consideration of additional contextual factors and discussion.

As a provider works toward their panel target of 800 (or adjusted based in FTE), there are contextual factors that may impact the rate at which a provider reaches their panel target, as well as the strategies / supports put in place to support them. Contextual factors that could be considered include:

- Population characteristics: age, gender, complexity of patient panel (*see Age-Gender Panel Tool below*)
- Practice / Community characteristics: geographical location, availability of community resources, socioeconomic status of patients

- Provider factors: time in practice, i.e. established panel or building a panel; scheduling preferences such as appointment times and revisit rates; and additional responsibilities such as teaching or preceptoring students

Age-Gender Panel Tool:

A useful tool to better understand the potential complexity of a provider's panel, based solely on age and gender, is the *Age-Gender Panel Tool*. This tool has been developed to provide an approximation of the expected "weight" (demand for care) of a provider's panel based on patient age and gender. ***This data is not specific enough to influence decisions around panel size adjustments***; the providers supply in relation to the panel's demand would be the primary comparison at this stage. However, it does give some basic insight into the potential level of complexity of the provider's panel in a way that is standard across the province, without having to do a full analysis of diagnostic codes, etc. Ideally this information can support discussions around case mix, how future attachment could be impacted (e.g. considering balancing panels based on composition), and health service planning. It is recommended to run the *Age-Gender Panel Tool* during annual panel reviews, as the demographics of panels will change over time.

Example: The following two scenarios show how the ***Age-Gender Panel Tool*** may be used to validate a visit rate that is higher or lower than the "standard" visit rate of 3.3 for NPs:

	Visit Rate	Actual Panel Size	Weighted Panel Size	Observations:
1	3.9	800	918	In this example, the higher visit rate and higher weighted panel size indicate an older, more complex population than average. If visit rate was high but weighted panel was lower than actual panel, this may indicate the internal demand/follow up visit rate is higher than necessary and adding unnecessary demand.
2	2.8	650	605	In this example, the lower visit rate and lower weighted panel size indicate a younger, less complex population than average. If visit rate was low but weighted panel was higher than actual, this may indicate inadequate follow up.

The strategies that are put in place to support providers are varied and unique to every practice and provider. Some examples may include but are not limited to:

- Establish mentoring relationship with a peer mentor who is available for advice and support
- Find supply/demand balance via scheduling and efficiency strategies via Enhancing Access supports
- Explore options for high revisits rates such as Group Medical Visits, or extending chronic disease visit intervals and pre-booking
- Have an informed conversation about team composition and applying for resources / staff support, e.g. bringing in an FPN to support some of the panel demand

Phase 3: Support and Sustain

Establishing mechanisms for ongoing maintenance of the panel data is essential to sustain improvements.

Step 8: Monitor and Maintain

Identify supports and review processes necessary to monitor and maintain an accurate panel.

Rationale: Maintaining an accurate panel is a team process that requires ongoing monitoring to maintain.

Panel Monitoring: Review and Reporting Frequency

Panel reviews are recommended every six to twelve months at a minimum; some practices maintain their list monthly, which can be especially helpful for providers who are building their panel. The more frequently panel reports are run and reviewed for accuracy, the smaller the task each time. Panel data is reported by PHC Leadership at regular intervals to monitor attachment rates and panel sizes across the province.

The following steps are typical for review:

- Identify the most efficient reports to run in the EMR, and automate this as much as possible. Review the panel list for active and inactive patient accuracy. Flag inactive patients and review their status.
- Identify the patients who are being kept on the list because they are part of the panel – i.e. patients who may be well and visit infrequently. You do not want to miss these patients when it becomes time for screening, recalls or follow-ups.
- Re-label inactive patients who are deceased, have moved away or are receiving their primary care elsewhere.

In the following tables, outline the processes that are planned as a team to maintain the panel list accuracy. While the tasks may seem simple, it is helpful if front office staff are oriented to perform them as part of their role at patient check-in or contact and that it is done the same way by all. Managing the patient panel is an everyday task and not a one-time activity. Work with the team to design processes that work in your clinic and fill them out in the following pages.

Table 6. Regular Review of Active Patients

Outline in detail the workflow process for ***maintaining an accurate list of active patients*** (e.g. are there patients listed as active who should not be?) Whose job is it to regularly update these? When will it be done? (How frequently?) How will you know it is due? (How will you be reminded that this task is due?)	

Table 7. Regular Review of Patient Statuses

Outline in detail the workflow process for ***updating a patient status*** to deceased, moved, or casual/temp etc.? Whose job is it to regularly update these? When will it be done? (How frequently?) How will you know it is due? (How will you be reminded that this task is due?)	

Maintaining Your Panel

Table 8 outlines some processes that will help you maintain your panel. Some of these processes may not be relevant to your practice. Try to address all applicable processes, and put N/A (in the 'How is this confirmed?' column) for those that are not.

Table 8. Maintaining Your Panel

Patient Scenario	How is this Confirmed?	How is this Documented?	Who is Responsible?
New Patients Added to Panel			
New patient phones and requests a provider.			
New patient from the Need a Family Practice Registry is contacted and offered a provider.			
Patient requests/receives a "Meet and Greet" appointment, but is not yet assigned.			
Unassigned patient does not belong to any panel, but has been accepted into the practice.			
Non-panel child or relative attends appointment or separate visit is generated.			
Newborn patient.			

Patient Scenario	How is this Confirmed?	How is this Documented?	Who is Responsible?
Patients Removed from Panel			
Patient deceased.			
Patient moved away, has stated ended relationship with clinic.			
Patient moved away for extended period, but intends to return to community (e.g., university /college, mission).			
Lapsed patient: has not attended clinic in 36 months (or other specified time period).			
Orphaned patient: provider leaves the clinic, resulting in unassigned panel.			
Patient belongs to a provider panel, but is seen by other provider more frequently.			
Diagnostic Imaging visit: non-clinic patients.			
Emergency Department /"O/P" visits: Non-panel patients.			
Patients Seen, Not Added to Panel			
Walk-in patient: has a primary physician in another clinic in region.			
Transient patient: has a primary physician in a clinic outside of region.			
Specialty care (seen for specialized services, not accepted to panel).			
Other			

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Appendices

Appendix A: Checklist for Administrative Staff

This checklist is intended as a guide for the administrative activities of panel identification. It can be used to monitor and document progress. The Attachment and Panel Identification in Primary Health Care Workbook provides more detail on each activity.

✓	Activity	Output
	Phase 1: Identify	
☐	Establish a process to confirm MRP with patients along with updating their contact information at every encounter.	Documented clinic process for patient validation.
☐	Patient statuses are defined with the team to ensure clarity and consistency.	List of status definitions shared with the team.
☐	EMR Clean-up: Run appropriate reports of clinic patients to ensure appropriate MRP assignments and patient statuses. Review the list(s) and coordinate with team members to ensure all patients are assigned to appropriate provider.	Accurate active patient panel list.
☐	Run a cleaned, accurate list of all *active* patients for provider.	
	Phase 3: Support and Sustain	
☐	Establish processes to maintain panel accuracy. *Table 8. Maintaining Your Panel* may help.	Documented clinic processes for panel maintenance.
☐	Establish a process for regular panel reviews at a frequency determined by practice (minimum: 12 months).	Documented clinic process for panel reviews.

Appendix B: Patient Validation Process

Purpose: To accompany the Attachment & Panel Identification Workbook for administrative staff portion of this work. This is intended to provide the administrative staff with step-by-step process and scripts for the **Step 1: Establish Process for Patient Validation**. In this step, the administrative staff will confirm the MRP (most responsible provider) and confirm that the patient information in the EMR is accurate. Patient validation is intended to become a regular check-in process that ensures that the panel/roster lists are reliable and that accurate information is available for the providers.

Refer to the Med Access EMR Supplement (page 4-5) or the Accuro EMR Supplement (page 8) for step-by-step instructions on how to ***confirm and validate patient information*** in your EMR.

Scripts & Work Flow for Administrative Staff

Patient arrives for **In-person visit.**	Patient **phones** clinic asking to book for a **virtual care visit (Phone or Video).**
Admin Staff can say… "Thanks for checking in. I need to ensure that your information is correct in the electronic chart. So I need to confirm with you now the following,"	*Admin Staff can say… "Thanks for calling, I need to ensure that your information is correct in the electronic chart. So I need to confirm with you now the following,"*

Med Access EMR:

1. Open clinic schedule daysheet and check patient in.
2. Open demographic tab and review with patient;

    - HCN, patient status (ensure active showing in the dropdown box),
    - address, phone numbers,
    - ensure email is added by click on the green plus sign beside "phone type group" drop down box,
    - ensure rostered button is checked as "yes",
    - ensure primary provider is filled in and correct,
    - ensure demographic validated date is filled in at bottom right hand corner, If not click on calendar and click on "today".

Accuro EMR:

1. Open Scheduler tab and check patient in by checking off arrived.
2. Open Patients section and review with patient;

- HCN, patient status (ensure active showing in the dropdown box),
- address, phone numbers,
- ensure email is added in the “Other” tab,
- ensure “Office Provider” is filled in and correct

3. Click “update” to ensure changes are saved

When patient demographics are updated in the Patients section of Accuro the last updated field reflects the date of the update and the user who selected the Update Patient button.

Appendix C: Four Cut Method

How a clinic chooses to assign patients to an MRP may vary, depending on the coverage arrangement. The fourth cut method is ***one option*** for deciding which provider to assign a patient to in a larger clinic; *this would require discussion and decision making with the team*. Note this does not apply to patients seen on a temporary basis such as a primary care clinic for unattached patients.

Cut	Report Description	MRP 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 the 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 the 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. (As referenced by Safety Net Medical Home Initiative: Empanelment Implementation Guide [May 2013]).