NATIONAL ASSOCIATION OF Community Health Centers®

ELEVATE NATIONAL LEARNING FORUM

elevate

Empanelment

Supplemental Session

February 6, 2024

THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

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Agenda

Welcome and Logistics

Empanelment: *WHAT, WHY, HOW*

Q&A and Discussion

Closing

During today's session:

- **Questions:** Throughout the meeting, type your questions in the chat feature. There will be Q&A and discussion at the end.
- **Resources:** If you have a tool or resource to share, let us know in the chat!

Empanelment

WHAT, WHY, HOW

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WHAT is empanelment?

Empanelment is the process of matching every patient to a primary care provider and care team.

- Considers patient and family preference
- Identifies the population of patients a provider and care team are responsible for

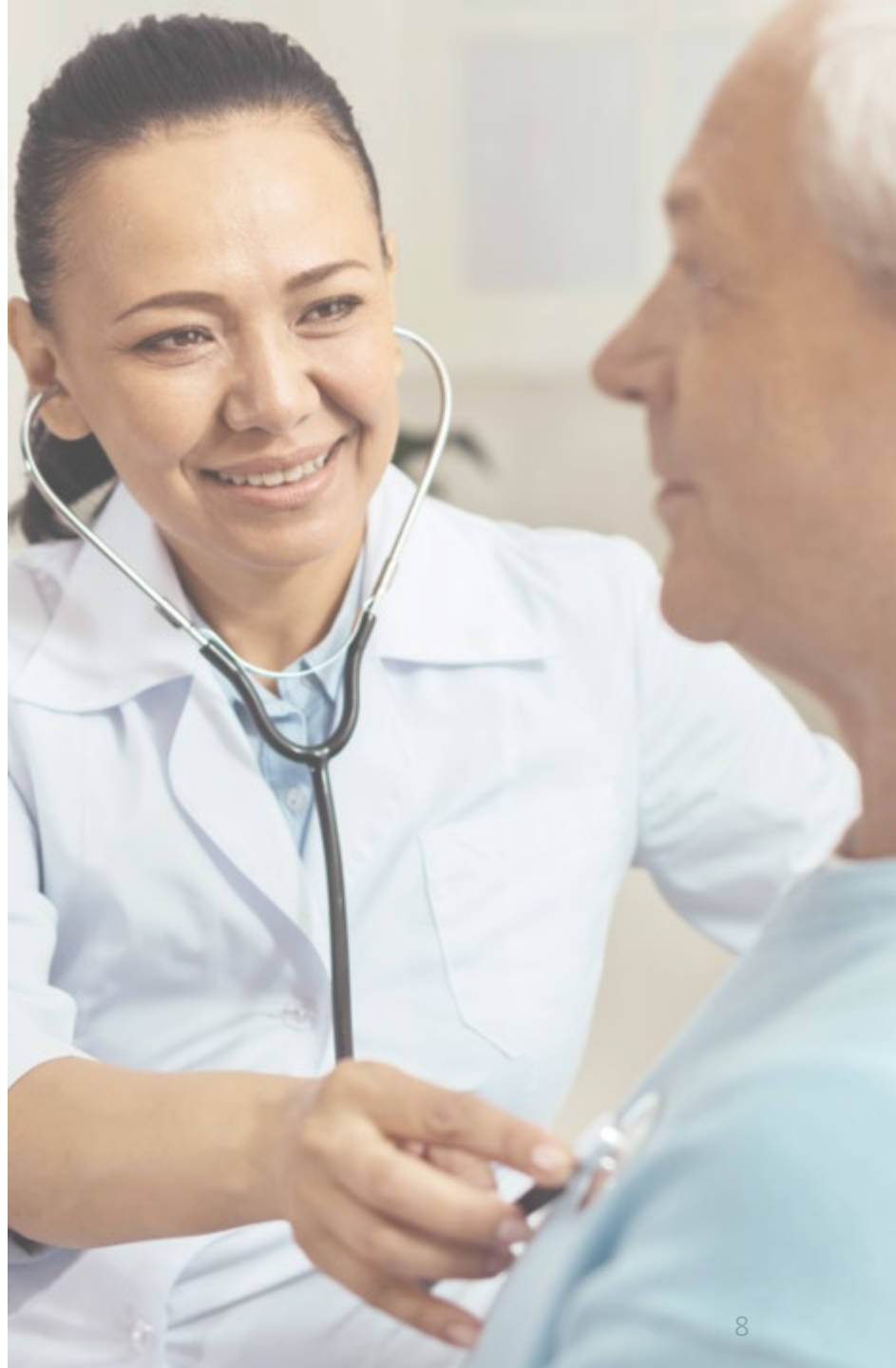
WHY empanelment?

Improved patient-provider partnership

- ✓ Improved patient-provider communication
- ✓ Better identification of medical problems
- ✓ Higher patient and staff satisfaction

Essential population health management tool; enables providers to customize care to subpopulations through risk stratification

Useful evaluation tool; evaluate provider workload and distribution, staffing models, and data-driven decisions supporting practice management and growth



HOW to empanel patients and utilize empanelment data?

STEP 1 Define and document patient-provider assignment process

STEP 2 Measure patient-provider assignment process

STEP 3 Determine each PCP's 'right' panel size

STEP 4 Adjust 'actual' panel size toward 'right' panel size

STEP 5 Use the 4-cut methodology to suggest PCP assignments

STEP 6 Review panels using PCP and care team input

STEP 7 Use risk stratification to segment and manage patient panels

STEP 8 Optimize care team roles for effective panel management

STEP 9 Use empanelment data to improve patient access

STEP 10 Incorporate payer attribution data

[Action Guide]

[Microlearning]

STEP 1

DEFINE AND DOCUMENT PATIENT-PROVIDER ASSIGNMENT PROCESS

Define and document the process for recording the PCP that each health center patient is assigned to and keeping the PCP assignment up to date

Policy should clearly address:

- ✓ Patients new to the health center who have not yet established care
- ✓ Patients who transfer care to another PCP within the health center
- ✓ Patients who transfer care to another PCP outside of the health center
- ✓ Patients who are assigned to a PCP who leaves the health center
- ✓ The frequency that the PCP assignment is verified with the patient
- ✓ The patient's right to choose their PCP
- ✓ Criteria for when a provider's panel is 'closed'
- ✓ How often panel sizes are assessed

Educate staff on policies and procedures

Tools & Resources:
- NACHC Empanelment Action Guide
- Safety Net Medical Home Empanelment Implementation Guide

STEP 2

MEASURE PATIENT-PROVIDER ASSIGNMENT PROCESS

Work smarter! A few simple reports can be used to assess if PCP assignments are being kept up to date, without having to review patient by patient.

Run a report out of your EHR that lists patients with a primary care visit in the last 2 years and their assigned PCP.

Review the number of patients with:

1. **An 'unassigned' PCP:**
   If this filter displays a significant number of patients
2. **An assigned PCP who is no longer at the health center:**
   If this filter displays a significant number of patients
3. **An assigned PCP who is currently at the health center:**
   If there are obvious variances in the total # assigned to each PCP

this indicates your PCP assignment and updating process are not being followed.

STEP 3

DETERMINE EACH PCPs 'RIGHT' PANEL SIZE

A provider's right panel size is the number of patients a provider can reasonably support.

Unique to provider: A right panel size is based on a provider's schedule availability and complexity of patients. Determining a right panel size can be accomplished through a series of calculations measuring supply and demand using this Right Panel Size Worksheet

DEMAND	**Appointment needs of current population**	=	**# of unduplicated patients seen in the last year**	X	**average # of visits per patient per year**
SUPPLY	**Provider availability**	=	**# of appointment slots available in the schedule last year**		
RIGHT PANEL SIZE	**The # of patients the provider can support based on current availability**	=	**# of appointment slots available on the schedule last year**	÷	**average # of visits per patient per year**

STEP 3

DETERMINE EACH PCPs 'RIGHT' PANEL SIZE

RIGHT PANEL SIZE = **# of appointment slots available on the schedule last year** ÷ **average # of visits per patient per year**

This number is influenced by:

- Provider FTE
- Length of appointment slots
  - Provider experience
  - Care team support
  - Type of appointment/reason for visit
  - Patient complexity

This number is influenced by:

- Health/care needs of the panel
- Patient complexity
- Care team support

STEP 4

ADJUST 'ACTUAL' PANEL SIZE TO 'RIGHT' PANEL SIZE

> OVER-EMPANELED

If actual panel size is larger than right panel size, consider:

- 'Closing' the panel
- Expanding the provider's schedule
- Re-empaneling some of their assigned patients to other providers (use 4-cut methodology!)
- Forming a 'provider team' (e.g., partner an MD/DO with a PA/NP to care for a panel together)
- Increasing care team support

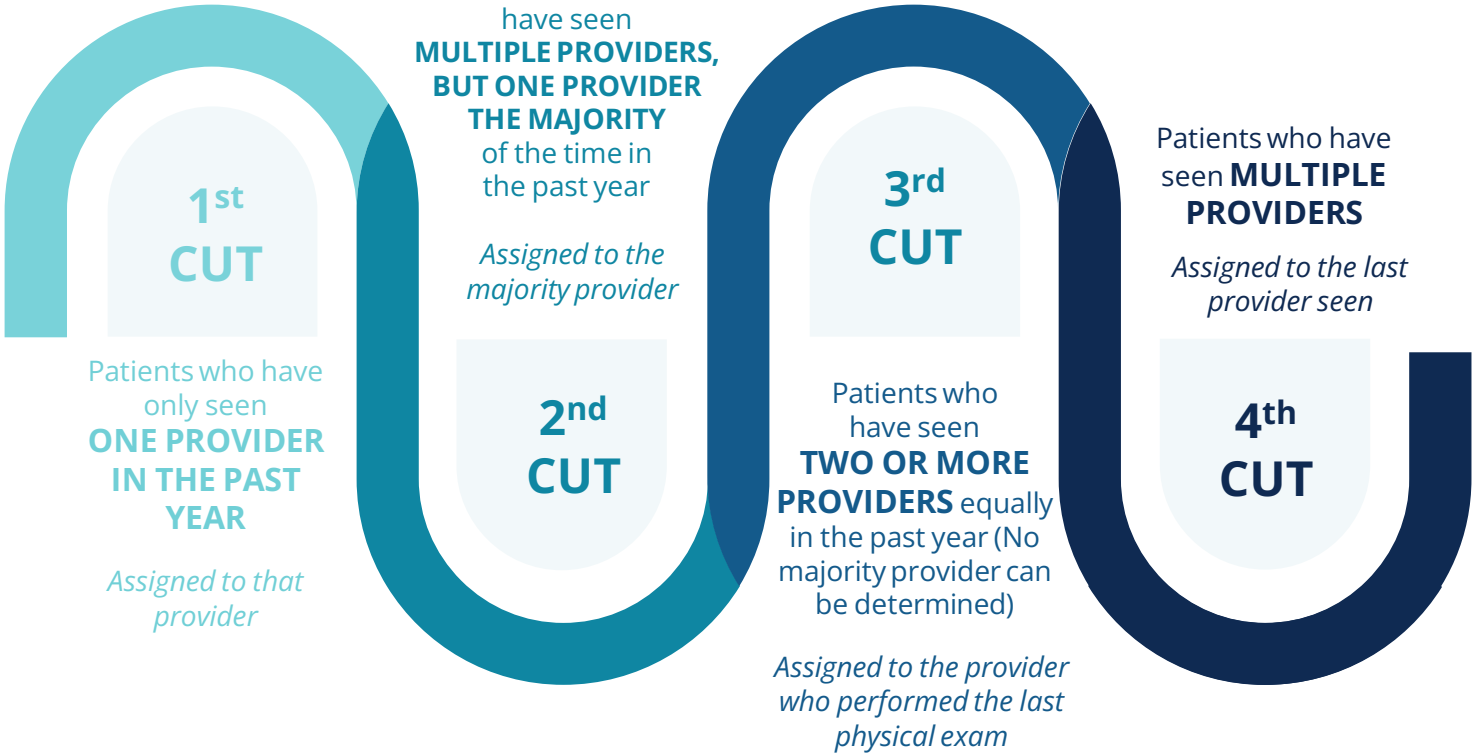
If actual panel size is less than right panel size, consider:

- Assigning new health center patients to this provider
- Re-empaneling patients from over-empaneled providers to this provider
- Forming a 'provider team' with an over-empaneled provider

UNDER-EMPANELED <

STEP 5

USE THE 4-CUT METHODOLOGY TO SUGGEST PCP ASSIGNMENTS



When determining which PCP to assign a current patient, it can be inefficient and time-consuming to manually review one patient at a time.

The 4-cut methodology can be used for large lists of patients to efficiently determine which PCP patients 'should' be assigned to.

4-cut method can be used for:

- Patients with an 'unassigned' PCP
- Patients assigned to a provider who is no longer at the health center
- Patients assigned to an over-empaneled provider

STEP 6

REVIEW PANELS USING PCP AND CARE TEAM INPUT

1

RUN REPORTS

of patient panels by PCP (after re-empaneling patients, as needed)

2

SHARE LIST

of assigned patients with each PCP and care team for their review

3

COLLECT FEEDBACK

from the PCP and care team on patient-provider assignments

4

RE-EMPANEL

as needed based on PCP and care team input

5

REVIEW PATIENT-PROVIDER ASSIGNMENT

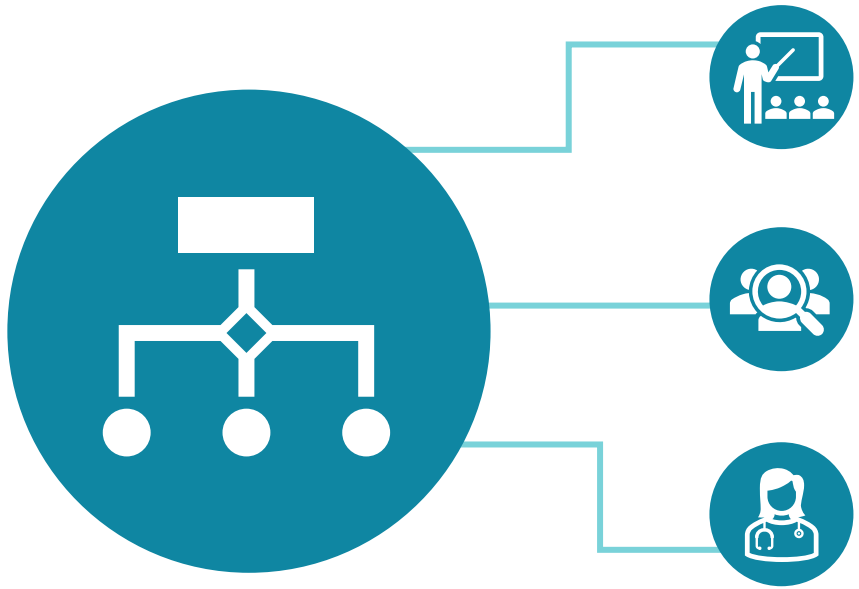
with the patient. They ultimately have the right to choose their PCP

STEP 7

USE RISK STRATIFICATION TO SEGMENT AND MANAGE PATIENT PANEL

Each provider and care team can segment their patient population into unique subgroups

(e.g., common conditions, social support needs, etc.)



Allows the provider and care team to target preventive and/or care management services

Informs staff training and resources needs

Drives care team model and allocation of staff roles and responsibilities

Tools & Resources: NACHC Risk Stratification Action Guide

STEP 8

OPTIMIZE CARE TEAM ROLES FOR EFFECTIVE PANEL MANAGEMENT

LEVERAGE RISK STRATIFICATION

to determine which care team roles are needed (care management, integrated behavioral health, etc.), and by which panels

DEFINE CARE ROLES

to enable each staff member to work at the top of their license

FOCUS PROVIDER ACTIVITIES

on those tasks and responsibilities that only a provider can carry out

OPTIMIZE CARE TEAM WORKFLOWS

to leverage technology and support enhanced care team roles

IMPLEMENT EFFECTIVE HUDDLES

to anticipate patient care needs and gaps in care

UTILIZE STANDING ORDERS

to empower care team members to carry out key preventive and chronic care screenings and services

STEP 9

USE EMPANELMENT DATA TO IMPROVE PATIENT ACCESS

Measure patients' ability to access care through:

- **Actual panel size** compared to **right panel size**
- **Third Next Available Appointment:** The average length of time, in days, between the day a patient makes a request for an appointment with a provider and the third available appointment for a new patient physical, routine exam, return visit exam, or other visit categories

CONTINUITY OF CARE:

The percentage of visits patients have with their own PCP = **# of patients assigned to Provider X that were seen by Provider X** ÷ **# of patients assigned to Provider X that have been seen in primary care**

The percentage of visits that a provider has with patients who are assigned to them = **# of patients seen by Provider X that were assigned to Provider X** ÷ **# of patients Provider X has seen**

STEP 10

INCORPORATE PAYER ATTRIBUTION DATA

Attribution is the process that commercial and government payers use to assign patients to providers who are held accountable for their care

Payer attribution may be different from your internal empanelment data

Include payer attribution data into your internal empanelment data

- May receive attribution data through paper mail, pdf files, spreadsheets, portals, or interfaced rosters
- Sometimes payers will accept PCP “updates” to correct their attribution files

Payer data ultimately determines value-based care payments, so be sure to develop a process to empanel attributed patients and include these patients in outreach and closing of care gaps

HOW to empanel patients and utilize empanelment data?

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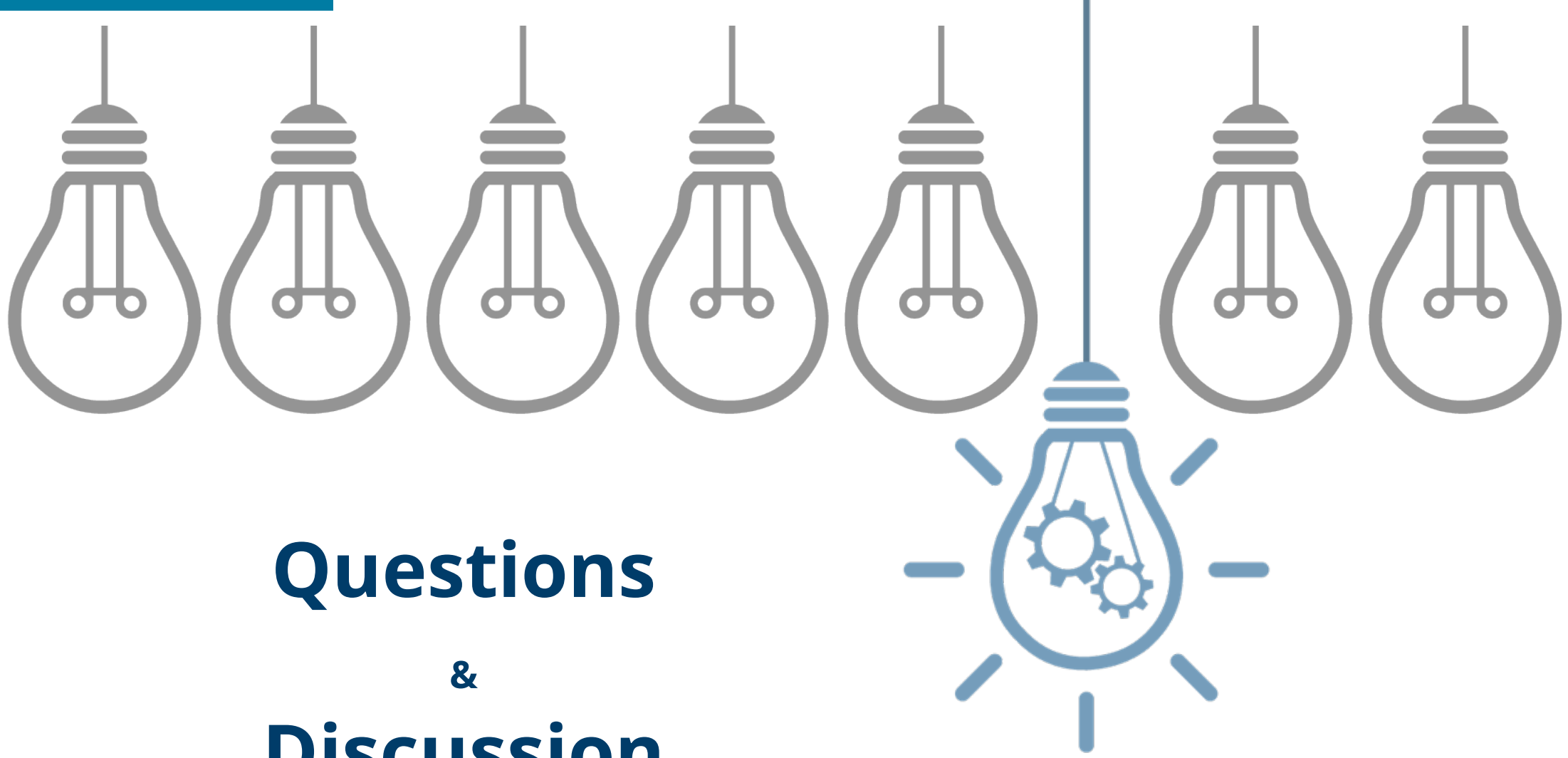
[Action Guide]

[Microlearning]



Questions

&

Discussion

Elevate Pulse

Be on the lookout for the **Elevate Pulse:**

- ✓ Slides & recordings
- ✓ Tools & resources
- ✓ Upcoming opportunities

Next Learning Forum:

Tuesday, February 13th, 1-2pm ET

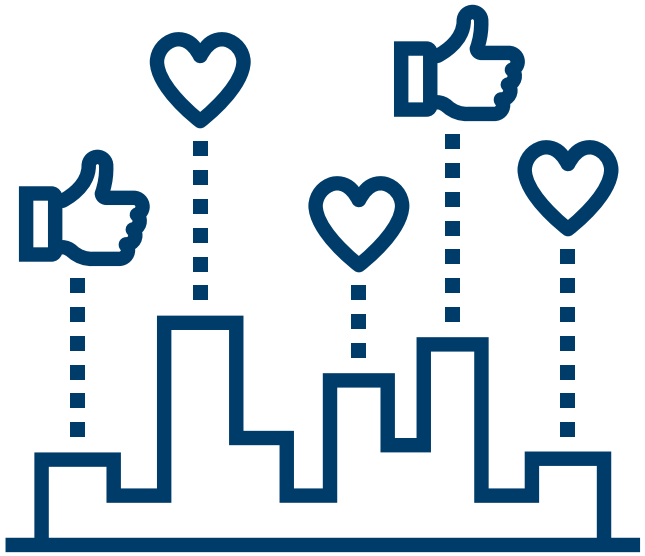
SDOH & Risk Stratification

Elevate on the NACHC Learning Hub

Access dozens of

FREE resources!

Elevate on the NACHC Learning Hub



Provide Us Feedback

FOR MORE INFORMATION CONTACT

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Next Monthly Learning Forum:

Risk Stratification & Social Drivers of Health

February 13, 2024
1:00 – 2:00 pm ET

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Together, our voices elevate° all.

The Quality Center Team

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Population Health

Empanelment & Attribution

NATIONAL ASSOCIATION OF Community Health Centers®

WHAT is population health management?

Using data on patient populations to target interventions that result in improved health outcomes, improved patient experiences, improved staff experiences, reduced costs, and equity.

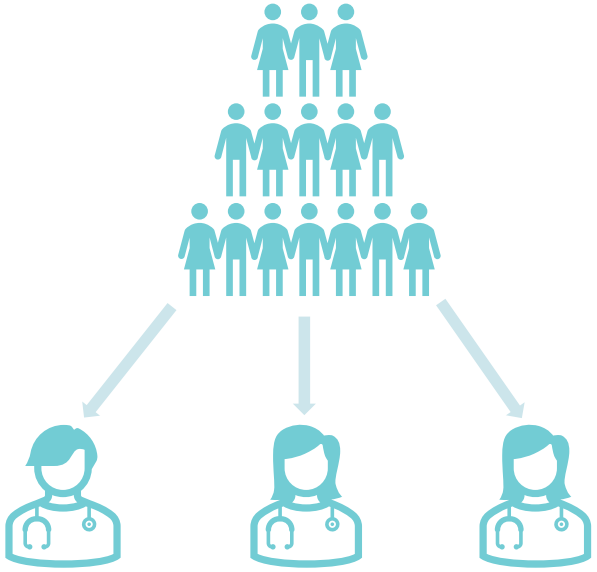
Population health management strategies include:

- ✓ Empanelment & Attribution
- ✓ Risk Stratification
- ✓ Models of Care

WHAT is population health management?

Empanelment → Risk Stratification → Models of Care

The process of matching every patient to a primary care provider and care team.



Segmenting patients into distinct groups of similar complexity and care needs to better target care and services.

- Low Risk → *Focus is keeping patients engaged in the health care system without use of unnecessary services.*
- Rising Risk → *Focus is on managing risk factors more than disease conditions.*
- High Risk → *Requires structured care management and one-on-one support.*
- Highly Complex → *Requires intensive, pro-active care management.*

Designing care models based on risk allows patients to be paired with more appropriate care team members and services.

WHAT is population health management?

Health Center Processes:

Include all health center patients.

Empanelment → **Risk Stratification** → **Models of Care**

Attribution lists may be shared with health centers; used to inform empanelment.

Member risk scores may be shared with health centers; used to inform models of care.

Payor Processes:

Include members of that payor.

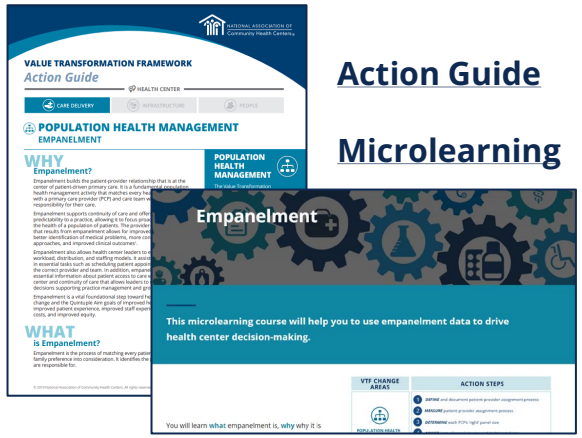
Attribution → **Risk Stratification**

A payor's process of assigning members to a provider.

A payor may have their own algorithm for risk stratifying members, for example, based on diagnosis codes or total cost of care.

Step-by-Step Resources for Each Process

***Health Center* Processes:**



[Action Guide]

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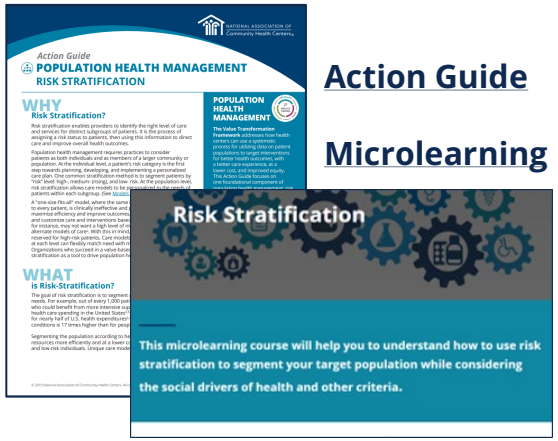
Empanelment →



[Action Guide]

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Risk Stratification →

[Action Guide]

Models of Care

***Payor* Processes:**

[Action Brief]

Leverage attribution lists to inform empanelment

Attribution → **Risk Stratification**

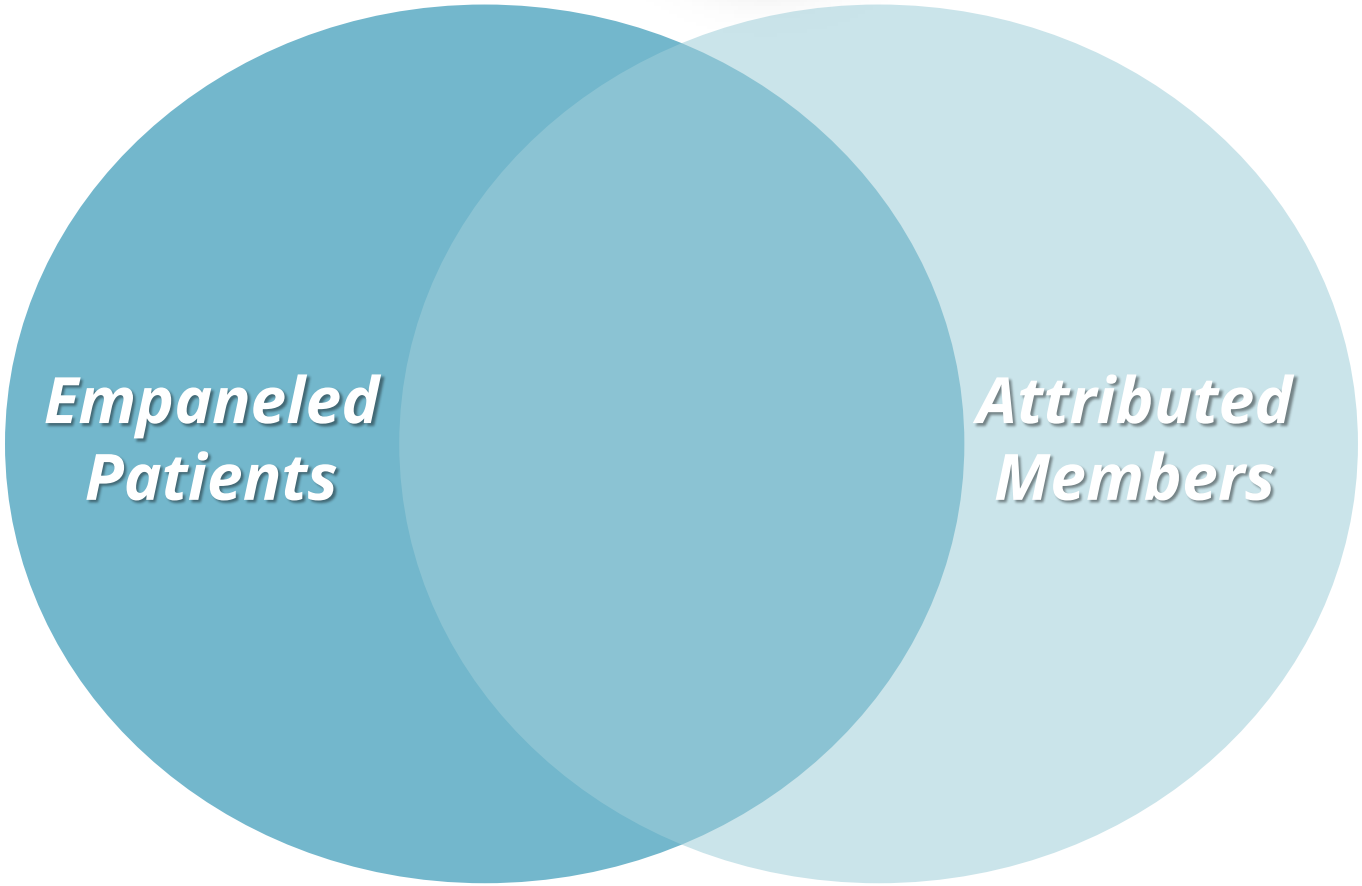
WHAT is the difference between empanelment and attribution?

Empanelment: The **health center's process** of assigning every patient to a primary care provider (PCP) and care team, with consideration to patient/family preference.

Attribution: A **payor's process** of assigning members to a provider for the purpose of tracking accountability for quality, patient experience, and total cost of care in value-based payment contracts.

A 'payor' refers to a Medicaid, Medicare, or commercial insurance plan.

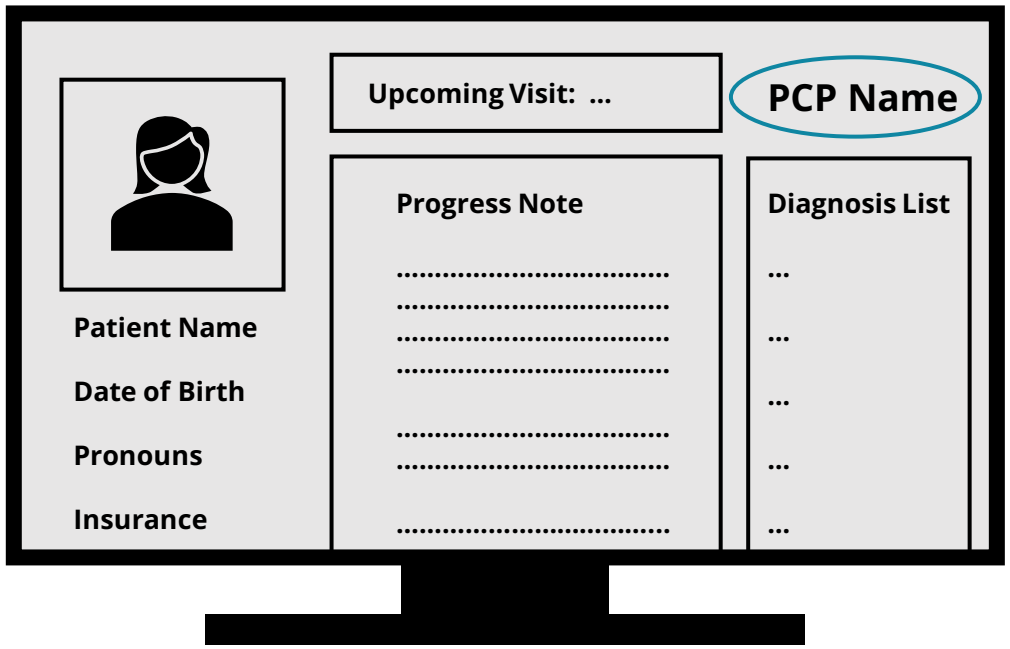
A 'member' refers to a person who has healthcare coverage through that payor.



WHAT are the data sources for empanelment and attribution?

Empaneled Provider

- ✓ Captured in the EHR within each patient's individual chart.
- ✓ EHR reports listing PCPs for multiple patients.
  (may use a population health management system if applicable)



Attributed Provider

It depends on the payor. Attribution lists may be shared with the health center through:

- Provider portals
- Secure fax/email
- Clinically Integrated Network (CIN) distribution
- Other methods

WHAT if the empaneled and attributed provider are different?

- **There are varying methodologies payors may use to attribute patients.**
- **The empaneled provider may not match the attributed provider!**
- What is most important is that a health center PCP and care team assumes responsibility for the patient. Always take patient/family preference of PCP into account.
- Attribution may inform empanelment if the patient has not yet been seen at the health center or if the empaneled provider is incorrect/outdated *(e.g., empaneled provider no longer works there)*.
- Some payors may work with you to update attribution assignments, some may not.

WHY are empanelment & attribution important?

Empanelment

Patients benefit from continuity of care

Improved communication, better identification of medical problems, more consistent treatment approaches, and improved clinical outcomes

Ease scheduling & access to care challenges

Scheduling stability and predictability allows leaders to make data-driven decisions supporting practice management and growth

Evaluate provider and care team workload

Leverage data to evaluate workload and staffing models needed to best support the patient panel (combine with strategies for risk stratification and models of care)

Attribution

Improve performance under value-based payment contracts

Provide care to members assigned to the health center

Contributes to financial expectations under value-based payment contracts

Understand financial risks and incentives

HOW can we act on empanelment & attribution data?

Engage patients in care!

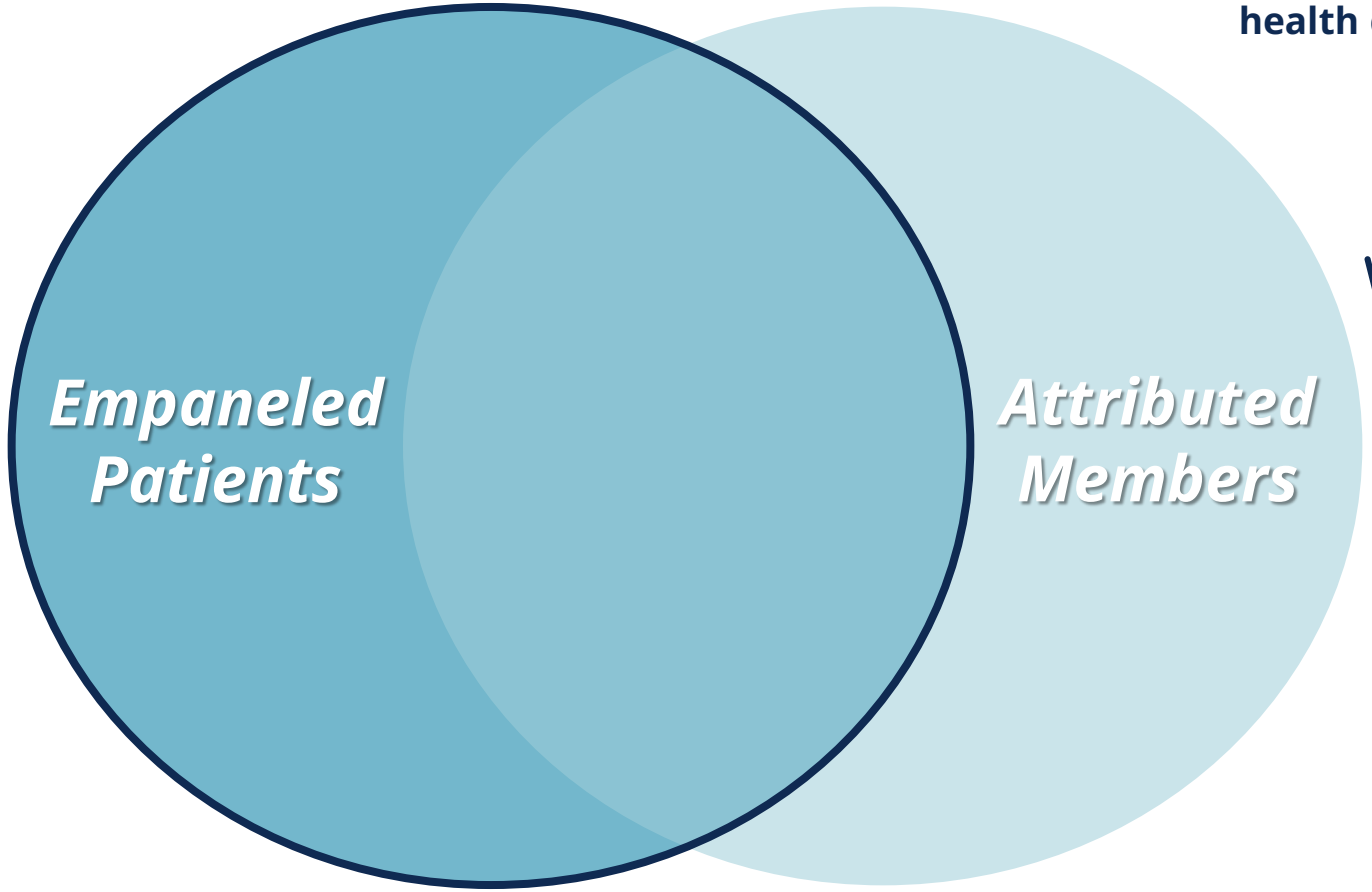
Outreach strategies may include:

- Calling patients on the phone
- Text message campaigns
- Email campaigns
- Letter campaigns

Are all these patients engaged in care?

(Scheduling annual visits, managing chronic conditions, etc.)

If not, re-engage!



Engage members in care at the health center

HOW can we leverage attribution data to inform empanelment and improve VBC performance?

STEP 1 Develop an accurate up-to-date list of all providers eligible for attribution

STEP 2 Understand the attribution methodology of payors

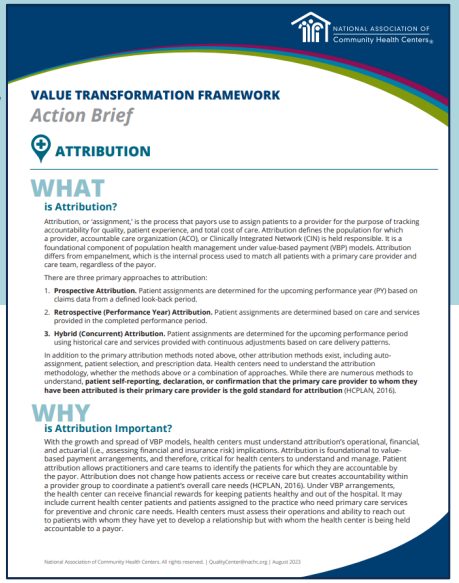
STEP 3 Develop processes for the intake of attribution lists

STEP 4 Leverage attribution lists to inform empanelment

STEP 5 Identify a process for patients who are not attributed but receive care from your health center

STEP 4 Use attribution information to drive patient engagement and care needs

Action Brief



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VALUE TRANSFORMATION FRAMEWORK

Action Brief

ATTRIBUTION

WHAT

is Attribution?

Attribution, or "assignment," is the process that payors use to assign patients to a provider for the purpose of tracking accountability for quality, patient experience, and total cost of care. Attribution defines the population for which a provider, accountable care organization (ACO), or Clinically Integrated Network (CIN) is held responsible. It is a foundational component of population health management under value-based payment (VBP) models. Attribution differs from empanelment, which is the internal process used to match all patients with a primary care provider and care team, regardless of the payor.

There are three primary approaches to attribution:

1. **Prospective Attribution.** Patient assignments are determined for the upcoming performance year (PY) based on claims data from a defined look-back period.
2. **Retrospective (Performance Year) Attribution.** Patient assignments are determined based on care and services provided in the completed performance period.
3. **Hybrid (Concurrent) Attribution.** Patient assignments are determined for the upcoming performance period using historical care and services provided with continuous adjustments based on care delivery patterns.

In addition to the primary attribution methods noted above, other attribution methods exist, including auto-assignment, patient selection, and prescription data. Health centers need to understand the attribution methodology, whether the methods above or a combination of approaches. While there are numerous methods to understand, **patient self-reporting, declaration, or confirmation that the primary care provider to whom they have been attributed is their primary care provider is the gold standard for attribution** (HCPLAN, 2016).

WHY

is Attribution Important?

With the growth and spread of VBP models, health centers must understand attribution's operational, financial, and actuarial (i.e., assessing financial and insurance risk) implications. Attribution is foundational to value-based payment arrangements, and therefore, critical for health centers to understand and manage. Patient attribution allows practitioners and care teams to identify the patients for which they are accountable by the payor. Attribution does not change how patients access or receive care but creates accountability within a provider group to coordinate a patient's overall care needs (HCPLAN, 2016). Under VBP arrangements, the health center can receive financial rewards for keeping patients healthy and out of the hospital. It may include current health center patients and patients assigned to the practice who need primary care services for preventive and chronic care needs. Health centers must assess their operations and ability to reach out to patients with whom they have yet to develop a relationship but with whom the health center is being held accountable to a payor.