

# EMPANELMENT: MANAGING PROVIDER PANELS

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Empanelment is the process of managing provider patient panels for changes and updates. This process begins with the attribution or assignment of the practice's active patients to the eligible providers in the practice. This process takes place within the practice based ideally on patient preference. *See Empanelment: Patient Attribution for more on this process.* Payers also attribute patients to providers based on a specific methodology utilizing claim data. Reconciling with these patient lists is a part of managing and updating provider panels within the practice.

Once all active patients have been attributed, processes will need to be implemented to monitor and update those panels. Patients and providers come and go and such changes often require adjustments to remaining provider panels.

Identify a Provider Panel Manager to be responsible for these changes and for working with providers and care teams to maintain panels. This individual will be the gatekeeper to facilitate the process of updating patient attribution as changes occur. For this reason, processes must be developed, documented, and communicated regarding how to manage changes.

Processes the Provider Panel Manager will be responsible for:

- Resolving unattributed patients based on agreed upon methodology,
- Tracking and noting patient active/inactive status changes such as moves, deaths, transfer to other care, etc.
- Reviewing and processing patient requests to change providers with the input and agreement of the providers impacted,
- Re-assigning patients due to provider status changes such as transfers, terminations, sabbaticals, or medical leaves,
- Overseeing the patient notification of changes to their assigned PCP, and
- Monitoring patient access to care and experience, with the help of the team and patient experience/satisfaction feedback, to ensure the practice continues to meet patient care needs.

As with the initial attribution process, all changes not requested by the patient should be confirmed with the patient before his or her next scheduled appointment.

## Adding New Patients

As new patients join the practice, allow them the opportunity to select their preferred provider through the new patient information packet. It may be helpful to include profiles of each provider to choose from in case the patient does not know the providers. If your practice uses a patient portal to communicate, include a "Meet the Team" section to introduce the providers and the members of the care teams.

If the patient doesn't have a preference, how do you determine which provider to assign the patient to?

- Who has the smallest panel?
- Who has the healthiest panel?
- Who has a panel with similar conditions, lifestyle, demographic as the patient?
- Who has the most experience with the patient's needs?

## Provider Leaves the Practice

Just as patients leave a practice, so do providers. If the provider is simply moving to another practice in the area, some patients may follow. However, there will be patients remaining who need to be re-attributed to another provider within the practice.

- Who would the patient like to see?
- Who would best serve the patients' needs?

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Consider the provider's style of care, the amount of time patient requires during a visit, known health issues, external resources needed, etc.

### Monitor for Patient Updates

A panel review should be conducted each month immediately following completion of the initial patient attribution. Each month, the Provider Panel Manager should pull a report of active patients using the same parameters when the practice initially completed the patient attribution process. This report will most likely reveal updates needed to maintain 100% attribution of your active patients. The frequency of this review process can be altered once you have consistently maintained a desired percentage of attributed patients, e.g. 95% for a specific period of time, e.g. six months. This will indicate the processes put in place to maintain provider panels have been adopted by the members of the practice.

1. Generate a new report of active patients for the time frame selected to initially attribute patients e.g. past 18 months, 24 months, 36 months, etc.
2. Review the list to identify patients without a preferred provider documented.
  - o Make a note to validate the patient's preferred provider if they have a visit scheduled within the next two weeks.
  - o For those patient's without a scheduled visit in the next two weeks, review the file for care gaps or past due age and gender specific preventive care. Contact these patients to close the care gaps and validate their preferred provider.
  - o Based on the number of patients without an assigned provider, determine the cost vs. benefit of taking the time to contact the patient to validate his or her preferred provider.
  - o Use this information to confirm the patient's preferred provider is validated and documented at scheduling and check-in.
3. Review the list to identify patients attributed to a provider no longer with the practice. To reconcile these patients, follow the outreach process listed above.
4. Verify all discrepancies with the provider and/or the care team.
5. Initiate the process to update the assigned provider.
6. Review the list to identify patients who are no longer "active" based on the definition of an active determined by the practice e.g. one visit in the last 24 months, not including nurse visits.
7. Verify all discrepancies with the provider and/or the care team.
8. Update the patient status in the medical record.

Each payer has its own attribution methodology and reconciliation process. If this methodology or process is unknown, contact the payer for clarification.

Since the payer attribution will be based on claim activity, there will likely be some discrepancies between your internal assignments and the payer attribution list.

Reasons for discrepancies could include:

- Time lag between and office visit and claim processing.
- The patient is seeing another provider for the plurality of their care.
- The patient is seeing a specialist and receiving the plurality of their primary care services from the specialist.

Consider the following process:

1. Generate an active patient report for the time-period listed on the payer attribution list filtered by the payer information.
2. Compare this list to the payer provided list.\*
3. Identify discrepancies between payer attribution and practice attribution.
4. Work with the providers and care teams to research the discrepancy to determine the reason for and how to resolve the discrepancy.

\*This may be done manually or if the information is available in Excel, you can utilize the look-up feature or pivot tables to match patient information across the two lists.

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*Determine the return on investment (ROI) for a proactive outreach program and attempts to re-engage with this patient group.*

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