Panels: Where is the DATA

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Objectives

- Review the literature on panels
- Recognize the gap
- Describe UW Health panel journey
- Review UW Health Paper
- Discuss an example of a successful writing collaborative that bridges the gap between primary care clinical transformation and rigorous scientific study
**Your job as you hear this talk**

- Jot down one or two goals for panels at your institution.
- What are the barriers to progress in your institution? What are strengths?
- Think about connecting clinicians who transform clinical care with researchers.
- Are groups in ACLGIM interested in serving as a cohort for studying panels and addressing gaps in the literature.
- Is it you?

**Panel**

- Dictionary definition: “a small group of people brought together to discuss, investigate, or decide on a particular matter, especially in the context of business or government.”
<table>
<thead>
<tr>
<th>Health Care Panel</th>
<th>empanel</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The group of patients attributed to a PCP.</td>
<td>• im·pan·el</td>
</tr>
<tr>
<td>• The group of patients empaneled with a PCP.</td>
<td>• (im-păn′əl) also em·pan·el (ĕm-)tr. v. 1. To add or include (a person's name) on a list of persons selected for jury duty.</td>
</tr>
<tr>
<td>• The group or population of patients for whose primary care a specific provider is responsible.</td>
<td>• 2. To select (a jury) for trial from such a list.</td>
</tr>
<tr>
<td>• VA</td>
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im·pan·el

tr.v.
1. To add or include (a person's name) on a list of persons selected for jury duty.

2. To select (a jury) for trial from such a list.
Empanelment is the act of assigning individual patients to individual primary care providers (PCP) and care teams with sensitivity to patient and family preference.

- Safety Net Medical Home Initiative.
- “Empanelment is a foundational building block of high-performing primary care.”
  - Bodenheimer
Literature Review

• Writing about panels stated after the IOM report in 1996 entitled “Defining Primary Care: America Health in a New Era”
• Concept: primary care was to be accessible, integrated, physicians accountable large majority of person health needs, continuous partnership with patients and community

VA’s role as early adopter

• Primary Care Implementation paper:1998
• VHA directive in 2002-2003 to define and measure primary care panels.
  – one PCP
  – defined active panel
  – face to face and non face to face
  – staffing
  – space
  – disease complexity
Early to mid 2000’s

- Little written on panels
- Papers looking at ability of PCP to provide care required in IOM report, specifically access.
  - 7.4 hrs. a day for prevention only.

2007

  - Methodology for determine panels: supply and demand
  - Early weighing system
- Kaiser Permanente moved to PCP level panel management for Pop Health.
<table>
<thead>
<tr>
<th>2010-Now</th>
<th>What does the literature say? Size</th>
</tr>
</thead>
</table>
| • Descriptive  
  – Capacity  
  – Developing models  
  – how to papers  
• Policy papers  
• Outcomes  
  – Observational  
  – Retrospective  
  – Cross sectional | • Only 1/3 of PCP’s can estimate panel size  
  • [Peterson 2015](#)  
• Panel size can be modified by who is on the PCP team.  
• All over the board on size  
  – VA 1,200 MD 900 APP  
  – 1000-3000 with 1,800-2500 most standard  
  – Murray paper 1800-2000 |
Two methods to determine panel size

• Work load formula (Murray 2007)(VA)
  \# of visits per day × \# of days worked per year (supply)
  Average \# of visits per patient per year (demand)

• “Target” panel size
  – Size determined and then adjusted by a variety of contextual factors. (UW Health System)(VA)

What does the literature say? panel weighting

• Limited number of papers. Leaning toward answer of yes. Needs to be based on institutional context.
  – Work of the panel (UW Health)
  – Complexity of illness (VA, Palo Alto)
  – Operational issues such as staffing, rooms (VA)
What does the literature say:
Outcome measurements

• Access: mixed and limited.
  – Right sizing improves access (UW Health)(Mayo)
  – Right sizing did not change access (UW Health)
  – Over paneling decreased access
  – No correlation with large panels and access (Margolius 2018)

What does the literature say:
Outcome measurements

• Staffing: extremely limited data on optimal staffing models
  – Staffing model affects panel size (VA)
• Burnout: very limited
  – Helfrich, Finn 2107 over paneling … burnout
• Quality metrics: mixed tending toward minimal impact
  – VA minimal
  – Pt sat no change (mayo)
  – 8 measures minimal change (Carrier)
UW Health is the integrated health system of the University of Wisconsin-Madison serving more than 600,000 patients each year in the Upper Midwest and beyond with 1,400 physicians and 16,500 staff at six hospitals and 80 outpatient sites.

UW Health is governed by the UW Hospitals and Clinics Authority and partners with UW School of Medicine and Public Health to fulfill their patient care, research, education and community service missions.

What is UW Health?

Joint Ventures and Affiliations
- Cancer centers, surgery centers, dialysis programs, home health, infusion and many other programs and services

UW Health Clinics
- Throughout Wisconsin and Northern Illinois
- UWHealthClinics
- UWCarbone Cancer Center
- Comprehensive Cancer Center designated by the National Cancer Institute (NCI)
- UWMedical Foundation
- UW faculty physician practice
- Unity Health Insurance
- and Gundersen Health Plan
- Highly rated health plans
- University Health Care
- Regional relationships and contracting

UWHealth Madison Hospitals
- University Hospital
- American Family Children’s Hospital
- UWHealth at The American Center
- UW-Health Rehabilitation Hospital

UWHealth Regional Hospitals
- SwedishAmerican Hospital, Rockford, IL
- Belvidere Medical Center, Belvidere, IL
- Joint Ventures and Affiliations
- Cancer centers, surgery centers, dialysis programs, home health, infusion and many other programs and services
UW Health Primary Care

- 43 Primary Care Clinics in 27 locations
- 306 primary care physicians of which 103 are residents
- 288,149 active patients medically home at UW Health

UW Health Primary Care Redesign Journey

- GIM, Family Medicine, Peds Unified
- Panel weighting system
- Panel Based Compensation Plan
- Care model redesign
- Standard primary care job description
- Next Gen ACO
- Disseminate our work
AND IT ALL BEGAN WITH PANELS

**UW Health Panel Weighting**

**GOALS**

- Recognize true work of a panel of pts at the clinic level
- Standard for opening and closing panels
- One weighting system for all primary care
- Use for workforce planning
- Improve access
<table>
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<tr>
<th>UW Health panels refinement of panel weighting</th>
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<tbody>
<tr>
<td>• Stage one. GIM, primitive, weighting wrong</td>
</tr>
<tr>
<td>• Stage two: Utilization (work)- based panel weighting system using sociodemographic factors to account for patient complexity. Current paper.</td>
</tr>
<tr>
<td>• Stage three: Refine definition of work from touches to RUV’s including defining RVU’s for non-face to face work of phone calls and patient portal (My Chart)</td>
</tr>
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<tr>
<td>• Weighted panel of 1,800 with an APP 2,100.</td>
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<tr>
<td>• APP are not PCP’s in our system. They add 900 patients to a clinic.</td>
</tr>
<tr>
<td>• Ratio of 1 full time APP for 3 full time MD’s so an APP adds 300 pts to a panel.</td>
</tr>
<tr>
<td>• May close at 105%</td>
</tr>
<tr>
<td>• Limit at 120%</td>
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Panel Weighting System

• Derived from 3 years of historical UW Health utilization data at PCP sites
  – Attributed to a PCP
  – Active
  – Age
  – Insurance Type
  – Gender
  – Number of measured touches in our EMR
• Panels reflect work done per patient
  – Weightings range from .53-2.22

<table>
<thead>
<tr>
<th>Female</th>
<th>Weighting</th>
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<tbody>
<tr>
<td>Medicaid 0-3</td>
<td>1.44</td>
</tr>
<tr>
<td>Medicaid 4-14</td>
<td>0.78</td>
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<tr>
<td>Medicaid 15-39</td>
<td>1.20</td>
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<tr>
<td>Medicaid 40-59</td>
<td>1.45</td>
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<tr>
<td>Medicaid 60-74</td>
<td>1.57</td>
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<tr>
<td>Medicaid ≥ 75</td>
<td>1.71</td>
</tr>
<tr>
<td>Medicare 0-3</td>
<td>0.00</td>
</tr>
<tr>
<td>Medicare 4-14</td>
<td>2.62</td>
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<td>Medicare 15-39</td>
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<td>Medicare 60-74</td>
<td>1.17</td>
</tr>
<tr>
<td>Medicare ≥ 75</td>
<td>1.98</td>
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<tr>
<td>Other 0-3</td>
<td>1.55</td>
</tr>
<tr>
<td>Other 4-14</td>
<td>0.82</td>
</tr>
<tr>
<td>Other 15-39</td>
<td>0.81</td>
</tr>
<tr>
<td>Other 40-59</td>
<td>1.00</td>
</tr>
<tr>
<td>Other 60-74</td>
<td>1.21</td>
</tr>
<tr>
<td>Other ≥ 75</td>
<td>1.09</td>
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<table>
<thead>
<tr>
<th>Male</th>
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<tr>
<td>Medicaid 0-3</td>
<td>1.51</td>
</tr>
<tr>
<td>Medicaid 4-14</td>
<td>0.85</td>
</tr>
<tr>
<td>Medicaid 15-39</td>
<td>0.69</td>
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<td>Medicaid 40-59</td>
<td>1.13</td>
</tr>
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<td>Medicaid 60-74</td>
<td>1.42</td>
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<tr>
<td>Medicaid ≥ 75</td>
<td>1.04</td>
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<tr>
<td>Medicare 0-3</td>
<td>0.00</td>
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<td>Medicare 60-74</td>
<td>1.52</td>
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<tr>
<td>Medicare ≥ 75</td>
<td>1.89</td>
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<tr>
<td>Other 0-3</td>
<td>1.65</td>
</tr>
<tr>
<td>Other 4-14</td>
<td>0.84</td>
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<tr>
<td>Other 15-39</td>
<td>0.53</td>
</tr>
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<td>Other 40-59</td>
<td>0.80</td>
</tr>
<tr>
<td>Other 60-74</td>
<td>1.12</td>
</tr>
<tr>
<td>Other ≥ 75</td>
<td>1.33</td>
</tr>
<tr>
<td>Other uses for our panels</td>
<td>Critical for Success</td>
</tr>
<tr>
<td>--------------------------</td>
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</tr>
<tr>
<td>• Compensation</td>
<td>• Attribution. Must be able to do PCP level.</td>
</tr>
<tr>
<td>• Design Staffing model</td>
<td>• EMR</td>
</tr>
<tr>
<td>• Reporting quality metrics including public reporting</td>
<td>• No touching the PCP field. Hard stop.</td>
</tr>
<tr>
<td>• Create our chronic disease registries</td>
<td>• Define who is the PCP</td>
</tr>
<tr>
<td>• Assign chronic care nurses</td>
<td>• Define your panel number</td>
</tr>
<tr>
<td></td>
<td>• Define active</td>
</tr>
<tr>
<td></td>
<td>• Clean the PCP field</td>
</tr>
<tr>
<td></td>
<td>• Transparency</td>
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</tbody>
</table>
### Reports Given to PCP's

- Individual physician panel data
- Department/clinic site data
- Individual Physician Patient Add/drop list
- Percent My Chart active

### Issues

- Need to limit panels
- What to do with over paneling.
- Are APPs PCP’s or not
Outcomes

GOALS

- Recognize true work of a panel of pts at the clinic level
  - Yes/no
- Standard for opening and closing panels
  - yes
- One weighting system for all primary care
  - yes
- Use for workforce planning
  - yes
- Improve access
  - Yes/no

UW Health paper

- Observational, time series, retrospective
Outcomes

• Increased number of total patients by 2%
• Improved access as measured by the patient satisfaction question, Was an appointment available with needed?
• Increased open panels in GIM, decreased open panels in DFM and peds

Panels: Where is the DATA
Why is there a gap in the literature?

- It's not because national clinical systems are stagnant. They are transforming including innovative panel work.
- It's not because there are no Health service researchers interested in clinical transformation.
- There is a gap between clinicians transforming at the front line and health service researchers.

Our gap between clinicians and researchers

- Our transformation work started in 2008 with clinicians, operations, and quality improvement leaders at the front line.
- Five years into our redesign efforts our CEO asked us to disseminate our work. We didn't have the skills.
- A group on campus HIP did.
- [www.hip.wisc.edu](http://www.hip.wisc.edu)
Primary care redesign and scholarship before HIP alignment

We partnered with a tenure assistant professor in the Health Innovations Program (HIP) to form a writing collaborative. She had the skills. We had the programs. We had a common goal. PATH (Primary Care Academics Transforming Health care) was born. This article is a result.
Accomplishments since 2013

- 12 Published and Accepted Papers
- 1 Invited national talks
- 27 Manuscripts in process or under journal review
- 1 Editorial letter

Resources for free sharing

- HIP shares resources through tool kits
- Wisconsin Primary Care Compensation Toolkit. WIPCOT. Early 2019
- UW Heath Panel weighting formula and comp formulas will be in the tool kit.

www.hipxchange.org  www.hip.wisc.edu/PATH
Call to action

• Is there a group in ACLGIM interested in collaborating to study panels and address the gaps in the literature.
• Could we make an ACLGIM tool kit?

In summary

• There is literature on panels.
• It is limited.
• There is a need for more study.
• UW Health has been all in with panels since before 2008. We continue to refine.
• There may be a gap between researchers and clinicians in clinical transformation that contributes to literature gaps. There was at UW Health.
Thank You!

Contact Information:
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Questions