BUSINESS PATHWAYS

Patient Panel Assessment

Q - What is a patient panel assessment?

A A patient panel assessment is completed in the first two phases of panel management offered through the Practice Support Program (PSP). Panel management is a process of proactively managing a defined population of patients, using EMR data to identify and respond to patients' chronic and preventative care needs. The first two phases of panel management included in this assessment are:

1. Empanelment: Defining your patient panel size, the number of active patients under your care.

2. Building Registries: Building patient registries that identify vulnerable populations.

Q - Why undertake a patient panel assessment?

A
- For recruiting physicians:
    - To frame recruiting efforts. Many incoming physicians would like to join or assume a practice with an appropriately sized, stable, and mixed patient panel.
    - A registry identifying vulnerable patients promotes proper handoff to a replacement physician for continuity of care

- For physicians closing a practice: It is your professional and legal duty to:
    - Notify active patients of your practice closure at least three months in advance
    - Make reasonable efforts to ensure that there is a process in place to support continuity of care for patients who require it

- A registry identifying vulnerable patients supports continuity of care in the case of an unplanned retirement due to departure/illness

- To identify potential areas for allied health professional support based on the types of patients in your register (e.g. if you have a disproportionate amount of CDM-diabetes patients, consider bringing in a chronic disease nurse).

This information was adapted from a resource developed by the Richmond Division of Family Practice.

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- As with paper charts, EMRs are only as good as the accuracy and comprehensiveness of the physician/staff who is entering the data. Following these instructions and starting early will ensure that you are coding correctly, optimizing billing incentives, and can readily and easily identify your CDM, complex care and/ or vulnerable patients when it comes time for your practice transition.

Q - Where do I start?

A   **Define your patient panel size.**

Method	Description
Mini profile	An accurate reflection of claims submissions and payments made for services provided in the calendar year based on Medical Services Plan payments. Statistics describe your panel size, demographics and the costs incurred for services against your province-wide peer group. Doctors of BC members can find a downloadable PDF of their Mini Profiles online in their My Account area.
EMR query	Identify your active patients* by using key indicators in your EMR, such as: • Clinic or Primary Care Provider • Active status • No. of visits: > X • Date of last contact: today's date X number of years in the past or appointment during last X number of years, etc. Generate a report based on the identified criteria. This report can be saved on your computer (i.e. Excel/Word) or in a binder/folder. *Defining an "active patient" is at the physician's discretion. For medical record management companies, an active patient is one that has physically visited the office anywhere in the past 2 to 7 years.
Patient Panel Size Worksheet	Calculate and identify discrepancies between your current and ideal patient panel sizes and assist an incoming physician in defining the ideal number of patients he/she can effectively care for (see Appendix G).

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A Build a patient registry that identifies vulnerable patients for continuity of care – *EMR-Based Offices*

Step 1:

Identify vulnerable patient populations by using key indicators, such as:

- Clinic or Primary Care Provider
- Active status
- ICD-9 Codes (see Table A)
- Service Codes (see Table A)
- Medication
- Lab Results
- Demographics (e.g. seniors (aged 65+), immigrants/newcomers)

TABLE A. SERVICE AND ICD-9 CODES FOR IDENTIFYING VULNERABLE PATIENT POPULATIONS

Vulnerable Patient Population	Service Code	ICD-9 Code
Complex care	14033, 14075	All
Mental Health	14043 - 14048	All
Chronic Disease - Diabetes	14050	250
Chronic Disease - Congestive heart failure	14051	428
Chronic Disease - Hypertension	14052	401
Chronic Disease - COPD	14053	496
Chronic Disease - Kidney	--	585
Frailty Complex Care (for pts with the single diagnosis of significant 'Frailty' (Can Study of Health & Aging Levels 6 & 7)	14075	V15
Mom & baby dyads (pregnancy to babies 18 mos old)	14094	08A

You can also identify patients during chart review and then add the condition to the patient's medical summary as a coded entry (problem list; disease registry; clinical details etc). Consider a polypharmacy review to ensure medications lists are accurate.

NOTE: Include 'date last seen' and/or 'date last billed' when running the report to see when the incentive was last billed.

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Step 2:

Generate a report based on the identified criteria.

Example: To pull all of Dr. Xanadu's diabetic patients, he could choose the following search criteria:

Clinic or Primary Care Provider - Dr. Xanadu
ICD-9 Codes - patients with a 250 in problem summary

This report can be saved on your computer (i.e. Excel/Word) or in a binder/folder.

Step 3:

To keep an updated registry, each newly identified patient should be coded accordingly.

A   Build a patient registry that identifies vulnerable patients for continuity of care – *Paper-Based Offices*

Build a **Patient Registry** using billed codes to identify your vulnerable patients and potential billings.

- Do a search for the appropriate billed codes to identify your vulnerable patients. For example, see Table A.

- Create a list of patients; this list can be saved on your computer (i.e. Excel/Word) or in a binder/folder.

- Review the list to see if the patients on it have that condition as part of their problem list.

- Check to see if you have a flow sheet in their chart
  Tip: flow sheets can be a different colour for easy access. You can place a sticker on the chart to remind your staff to have the flow sheet prepared with date and ht, wt, etc.

- Check to see if they have been seen at least two times in the past year.

- If they have been seen two times in the past year you can bill the incentive fee above for their care.

- Make sure to add to the list every time you get a patient with a new diagnosis.

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