

Change Package: Implementing Panel Processes



Purpose:

Establish, optimize, and maintain panel identification processes

Aim Statement:

100% of panelling providers in the practice have the ability to produce an accurate panel list by ____ date.



Outcome Measure:

% of primary providers in the practice that can produce an accurate panel list

Balancing Measure:

Team impacts and benefits with panel identification and maintenance processes

Process Measures:

% of patients validated on the panel list

of patients with unassigned or invalid primary provider

Panel size by primary provider

% of patients on panel without a visit in previous 3 years

Why are panel processes important?

Having defined patient panels enables practices to address the needs of their patients in regards to relational continuity, timely access to care, and quality of care while optimizing team capacity.¹⁻¹⁶

This change package is part of New Brunswick Medical Society's (NBMS) broader strategy to support primary care physicians, nurse practitioners and teams to implement a Health Home model that aligns with College of Family Physicians of Canada's Patient's Medical Home vision.¹

With continuity and access as primary pillars of a Health Home, they first depend on a clearly defined, right-sized patient panel. In this way, panel identification is a foundational first step and driver for timely, team-based, longitudinal care for patients - all together which better patient outcomes, care delivery, provider/team experience, and health system cost.^{17-21, 30}


Using this change package:

This change package contains links to documents on the [NBMS Practice Support Program website](#) and is intended to be used by primary care practice teams with guidance and support by a practice facilitator. NBMS practice support can be reached at: practicesupport@nbms.nb.ca.


The change package is to be used with the [Sequence to Achieve Change \(STAC\)](#) quality improvement framework and supports clinics to implement panel processes through the high-impact changes of:

- Identify accurate patient panel lists
- Engage in ongoing panel maintenance processes to maintain accurate panel lists
- Improve relational continuity by fostering accessible, longitudinal relationships with patients
- Establish an ideal panel size for each provider within the practice
- Arrange the interprofessional team and primary provider to meet the needs of the patient panel in a shared way

Overarching Tools

 [Sequence to Achieve Change \(STAC\)](#)

 [What's In It For You? Panel Processes](#)

 [Example QI Plan and PDSA Cycles](#)

Implementing Panel Processes

By: Identifying accurate patient panel lists



Change Ideas





Develop and utilize standardized patient statuses within the EMR

Clean the patient panel by reviewing patient statuses, attachment, and visit history using a chosen approach:

- Ask patients at every interaction who their primary care provider is (long term, lowest effort)
- Review the entire patient panel at once (short intensive time, higher effort)
- Use the 4 cut method in group practices to review the patient panel in smaller sections based on visit history (moderate time, moderate effort)



Tools

-  [Guide to Panel Identification and Maintenance](#)
-  [EMR Panel Demo: Intrahealth Profile](#)
-  [Telus CHR Updating and Validating Demographics](#)
-  [Telus CHR How To Filter Analytics](#)

Implementing Panel Processes

By: Engaging in ongoing panel maintenance processes to maintain accurate panel lists



Change Ideas





Standardize panel processes for when patients are added, removed, or reassigned to the panel(s)

Improve the panel attachment verification rate by confirming and recording patient attachment at every interaction

Conduct regular EMR searches to routinely validate the panel list by confirming attachment and patient statuses



Tools

-  [Guide to Panel Identification and Maintenance](#)
-  [HIG Panel Maintenance Tool](#)
-  [Paneling in Paper Based Clinics](#)
-  [CFPC - Best Advice Rostering](#)

Implementing Panel Processes

By: Improving relational continuity by fostering accessible, longitudinal relationships with patients



Change Ideas

Prioritize continuity in scheduling practices

Communicate to patients the value of continuity through scripting and patient education

Enhance service delivery options that promote better access and continuity of care (e.g. hours of service, proportion of in-person and virtual appointments, email/secure messaging in delivering patient care)



Tools

HIG [Level Setting The Value of Continuity Within Your Clinic](#)

HIG [How to Measure Continuity](#)

HIG [Scheduling for Continuity Guide](#)

HIG [Out of Office Continuity Planning](#)

HIG [Planning Strategies to Support Continuity](#)

HIG [Alternate Visit Modes Planning](#)

HIG [Part-Time Provider Tipsheet](#)

Implementing Panel Processes

By: Establishing an ideal panel size for each provider within the practice



Change Ideas

Monitor panel size equation for each provider to inform adjustments in supply and demand

Compare equitability of panel sizes across clinic providers based on clinical FTE and panel complexity, and redistribute workload across the team

Understand the anticipated demand for care by considering unexpressed needs, evidence-based guidelines, and average return rate

Determine how new patients will be distributed across providers



Tools

HIG [Panel Size Equation Tool](#)

HIG [Ideal Panel Size and Panel Equity in Group Practices](#)

HIG [Part-time Providers Tipsheet](#)

HIG [Planning Strategies to Support Continuity Tipsheet](#)

HIG [Know Your Panel Maintenance Tool](#)

Implementing Panel Processes

By: Arranging the interprofessional team and primary provider to meet the needs of the patient panel in a shared way



Change Ideas

Create a shared understanding of the needs of the patient panel by defining overall panel characteristics (e.g. age, gender, problems, diagnosis, screening status, social determinants of health)

Tailor established roles and responsibilities and optimize scope across the care team to meet the needs of the patient panel



Tools

-  [HIG Guide to Developing Team Roles and Responsibilities](#)
-  [New Brunswick Health Council - Data Tables](#)
-  [New Brunswick Health Council - My Community at a Glance](#)
-  [Poverty: A Clinical Tool For Primary Care Providers \(NB\)](#)

Summary: Implementing Panel Processes



Aim

100% of panelling providers in the practice have the ability to produce an accurate panel list by ____ date.

High-Impact Changes



Change Ideas

Identify accurate patient panel lists

Develop and utilize standardized patient statuses within the EMR

Clean the patient panel by reviewing patient statuses, attachment, and visit history using a chosen approach

Engage in ongoing panel maintenance processes to maintain accurate panel lists

Standardize panel processes for when patients are added, removed or reassigned to the panel(s)

Improve the panel attachment verification rate by confirming and recording patient attachment at every interaction

Conduct regular EMR searches to routinely validate the panel list by confirming attachment and patient statuses

Improve relational continuity by fostering accessible, longitudinal relationships with patients

Prioritize continuity in scheduling practices

Communicate to patients the value of continuity through scripting and patient education

Enhance service delivery options that promote better access and continuity of care (e.g. hours of service, proportion of in-person and virtual appointments, email/secure messaging in delivering patient care)

Summary: Implementing Panel Processes



Aim

100% of panelling providers in the practice have the ability to produce an accurate panel list by ____ date.

High-Impact Changes



Change Ideas

Establish an ideal panel size for each provider within the practice

Monitor panel size equation for each provider to inform adjustments in supply and demand

Understand the anticipated demand for care by considering unexpressed needs, evidence-based guidelines, and average return rate

Compare equitability of panel sizes across clinic providers based on clinical FTE and panel complexity, and redistribute workload across the team

Determine how new patients will be distributed across providers

Arranging the interprofessional team and primary provider to meet the needs of the patient panel in a shared way

Create a shared understanding of the needs of the patient panel by defining overall panel characteristics (e.g. age, gender, problems, diagnosis, screening status, social determinants of health)

Tailor established roles and responsibilities and optimize scope across the care team to meet the needs of the patient panel

Thirty Days to Better Panelling Processes

Day 29	Assess Balancing Measure - Share Learnings - Celebrate	Clinic Team	Practice Facilitator
Day 28	Review Panel Measures and Scheduling for Continuity, Produce Panel Lists, Confirm Panel Identification and Maintenance Roles/Responsibilities	Improvement Team	Practice Facilitator
Day 22-27	Test Scheduling for Continuity and Panel Maintenance	Clinic Team Member	Practice Facilitator
Day 21	Review Panel Identification Testing and Panel Measures; Introduce Scheduling for Continuity, Panel Maintenance Planning	Improvement Team	Practice Facilitator
Day 15-20	Continue Testing Patient Communications and Panel Identification; Bulk Assign Patients / Statuses	Clinic Team Member	Practice Facilitator
Day 14	Review Testing and Plan Panel Clean Up; Plan for Unassigned / Inactive Patients	Improvement Team	Practice Facilitator
Day 8-13	Test Patient Communications and Panel Identification; Create Panel Clean Up Reports	Clinic Team Member	Practice Facilitator
Day 7	Review Measures, Statuses, and Patient Communications	Improvement Team	Practice Facilitator
Day 1-6	Collect Panel Measures, Provider Information and Patient Statuses	Clinic Team Member	Practice Facilitator
Day 0	Meet as a Team and Agree to Work on Panelling	Improvement Team	Practice Facilitator

Acknowledgements & Evidence

The Practice Support Program extends its sincere gratitude to the Advisory Group members who contributed their time and expertise in designing this change package.

Evidence: Commit to creating longitudinal relationships with patients

1. Van Walraven C, Oake N, Jennings A, Forster AJ. The association between continuity of care and outcomes: a systematic and critical review. *J Eval Clin Pract.* 2010 Oct;16(5):947-56.
2. Wolinsky FD, Bentler SE, Liu L, Geweke JF, Cook EA, Obrizan M, et al. Continuity of care with a primary care physician and mortality in older adults. *J Gerontol A Biol Sci Med Sci.* 2010 Apr;65(4):421-8.
3. Adler R, Vasiliadis A, Bickell N. The relationship between continuity and patient satisfaction: a systematic review. *Fam Pract.* 2010 Apr;27(2):171-8.
4. Waibel S, Henao D, Aller M-B, Vargas I, Vázquez M-L. What do we know about patients' perceptions of continuity of care? A meta-synthesis of qualitative studies. *Int J Qual Health Care.* 2012 Feb;24(1):39-48. <http://intqhc.oxfordjournals.org/cgi/lookup?view=long&pmid=22146566>
5. Kearley KE, Freeman GK, Heath A. An exploration of the value of the personal doctor-patient relationship in general practice. *Br J Gen Pract.* 2001 Sep;51(470):712-8. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1314098/>
6. Nutting PA, Goodwin MA, Flocke SA, Zyzanski SJ, Stange KC. Continuity of primary care: to whom does it matter and when? *Ann Fam Med.* 2003 Oct;1(3):149-55. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1466596/>
7. Guthrie B, Wyke S. Personal continuity and access in UK general practice: a qualitative study of general practitioners' and patients' perceptions of when and how they matter. *BMC Family Practice.* 2006 Feb 24;7:11. <https://bmcfampract.biomedcentral.com/articles/10.1186/1471-2296-7-11>
8. Crooks VA, Agarwal G, Harrison A. Chronically ill Canadians' experiences of being unattached to a family doctor: a qualitative study of marginalized patients in British Columbia. *BMC Family Practice.* 2012 Jul 16;13(1):69. <http://www.biomedcentral.com/1471-2296/13/69>
9. Al-Azri M, Al-Ramadhani R, Al-Rawahi N, Al-Shafee K, Al-Hinai M, Al-Maniri A. Patients' attitudes and experiences of relational continuity in semi-urban general practices in Oman. *Fam Pract.* 2014 Jun;31(3):303-10. <https://academic.oup.com/fampra/article-lookup/doi/10.1093/fampra/cmu004>
10. Health Quality Council of Alberta. Understanding patient and provider experiences with relationship, information, and management continuity. Calgary, AB: Health Quality Council of Alberta; 2016 Aug. Available from: <http://hqca.ca/studies-and-reviews/relationship-information-and-management-continuity/relationship-information-and-management-continuity/>
11. Reid J, Cormack D, Crowe M. The significance of relational continuity of care for Māori patient engagement with predominantly non-Māori doctors: findings from a qualitative study. *Aust N Z J Public Health.* 2016 Apr;40(2):120-5. <http://onlinelibrary.wiley.com/doi/10.1111/1753-6405.12447/full>
12. Ehman KM, Deyo-Svendsen M, Merten Z, Kramlinger AM, Garrison GM. How Preferences for Continuity and Access Differ Between Multimorbidity and Healthy Patients in a Team Care Setting. *J Prim Care Community Health.* 2017 Apr 1;2150131917704556.
13. Gerard K, Salisbury C, Street D, Pope C, Baxter H. Is fast access to general practice all that should matter? A discrete choice experiment of patients' preferences. *J Health Serv Res Policy.* 2008 Apr;13 Suppl 2:3-10.
14. Ehman KM, Deyo-Svendsen M, Merten Z, Kramlinger AM, Garrison GM. How Preferences for Continuity and Access Differ Between Multimorbidity and Healthy Patients in a Team Care Setting. *J Prim Care Community Health.* 2017 Oct;8(4):319-23. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1466596/>
15. Waibel S, Henao D, Aller M-B, Vargas I, Vázquez M-L. What do we know about patients' perceptions of continuity of care? A meta-synthesis of qualitative studies. *Int J Qual Health Care.* 2012 Feb;24(1):39-48.
16. Rubin G, Bate A, George A, Shackley P, Hall N. Preferences for access to the GP: a discrete choice experiment. *Br J Gen Pract.* 2006 Oct;56(531):743-8. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC17007703/>
17. Alberta Medical Association. (2016.). Evidence summary: The benefits of relational continuity. Alberta Doctors. Retrieved January 20, 2026, from <https://www.albertadoctors.org/resource-centre/relational-continuity-resources/evidence-summary-the-benefits-of-relational-continuity/>
18. Lewanczuk R. Complex, high needs patients: an Alberta perspective. IHE Innovation Forum XV - High Needs & High Cost Patients in Healthcare; 2016 Jun; Edmonton, AB [Video - Uploaded by Alberta Accelerating Change Transformation Team 2019: YouTube. <https://www.youtube.com/watch?v=9iFFHkEKf48>

Evidence: Understand patient panel size

19. Mayo-Smith, M. (2021). Primary Care Panel Size: How You Measure Makes a Difference. *Annals of Internal Medicine*. Vol. 17(4) No. 2, 277.
20. Murray M, Davies M, Boushon B. Panel Size. How many patients can one doctor manage? *Family practice management*. 2007, April; 44-51.
21. Weber, R., & Murray, M. (2019). The Right-Sized Patient Panel: A Practical Way to Make Adjustments for Acuity and Complexity. *Family Practice Management*, 26(6), 23-29.
22. College of Family Physicians of Canada. Best Advice – Panel Size. Mississauga, ON: College of Family Physicians of Canada; 2012. Available from: <https://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-panel-size/>
23. College of Family Physicians of Canada. CFPC Brief: Family physician panel sizes in Canada Available from: <https://www.cfpc.ca/CFPC/media/Resources/Health-Policy/HPGR-Panel-Size-Policy-EN-Nov25-final-rev.pdf>
24. College of Family Physicians of Canada. Check your practice: Panel size Best Advice Guide: Quick Reference Available from: https://patientsmedica.wpengine.com/files/uploads/BAG_PanelSize_1pager_ENG-2.pdf
25. Altschuler, J., Margolius, D., Bodenheimer, T., & Grumbach, K., (2012), Estimating a Reasonable Patient Panel Size for Primary Care Physicians With Team-Based Task Delegation, *Annals of Family Medicine*, Vol. 10(5).

Evidence: Identifying / maintaining patient panel lists

26. College of Family Physicians of Canada. Best Advice: Patient rostering in family practice; November 2012.
27. Weber, R., & Murray, M. (2019). The Right-Sized Patient Panel: A Practical Way to Make Adjustments for Acuity and Complexity. *Family Practice Management*, 26(6), 23-29.
28. Guide to Panel Identification for Alberta Primary Care, 2014. Developed in Collaboration by Access Improvement Measures (AIM), the Alberta College of Family Physicians (ACFP), Alberta Health Services (AHS), Alberta Medical Association (AMA), Health Quality Council of Alberta (HQCA), Physician Learning Program (PLP), Practice Management Program (PMP), Primary Care Network Program Management Office (PCN PMO), Toward Optimized Practice (TOP), and University of Alberta, Department of Family Medicine. https://hqca.ca/wp-content/uploads/2018/05/Guide_to_Panel_Identification.pdf

Other Resources

29. College of Family Physicians of Canada. A new vision for Canada: family practice, the patient's medical home. Mississauga, ON: College of Family Physicians of Canada, 2019. Available from: <https://www.cfpc.ca/en/policy-innovation/health-policy-government-relations/cfpc-policy-papers-position-statements/a-new-vision-for-canada-family-practice-the-patient>
30. Haggerty J, Reid RJ, Freeman GK, Starfield B, Adair CE, McKendry R. Continuity of care – a multidisciplinary review. *British Medical Journal* 2003;327:1219-21.
31. Coordinating Committee. Coordinated approach to continuity attachment and panel. Draft report. Edmonton, AB: Published by Toward Optimized Practice; 2014 Feb.
32. Cooke, T. System Level Opportunities for Panel Management in Alberta Symposium: Using Panel Management to Improve Primary Healthcare Practice and Patient Outcomes Wednesday, December 4, 2013; <http://www.hqca.ca/assets/files/January%202014/Symposium%20Presentation%20Summaries.pdf>
33. Ionescu-Iltu R, McCusker J, Ciampi A, Vadeboncoeur A-M, Roberge D, Larouche D, et al. Continuity of primary care and emergency department utilization among elderly people. *CMAJ Can Med Assoc J J Assoc Médicale Can*. 2007 Nov 20;177(11):1362-8.
34. Raddish M, Horn SD, Sharkey PD. Continuity of care: is it cost effective? *Am J Manag Care*. 1999 Jun;5(6):727-34.
35. De Maeseneer JM, De Prins L, Gosset C, Heyerick J. Provider continuity in family medicine: does it make a difference for total health care costs? *Ann Fam Med*. 2003 Oct;1(3):144-8.
36. Hollander MJ, Kadlec H, Hamdi R, Tessaro A. Increasing value for money in the Canadian healthcare system: new findings on the contribution of primary care services. *Healthc Q*. 2009;12(4):32-44.
37. Kringos DS, Boerma WG, Hutchinson A, Zee J van der, Groenewegen PP. The breadth of primary care: a systematic literature review of its core dimensions. *BMC Health Serv Res*. 2010 Mar 13;10(1):65.
38. College of Family Physicians of Canada. Patient's Medical Neighbourhood: Implementation Kit New Brunswick College of Family Physicians Available from: <https://patientsmedicalhome.ca/files/uploads/PMN-2021-ImplementKit-NB.pdf>