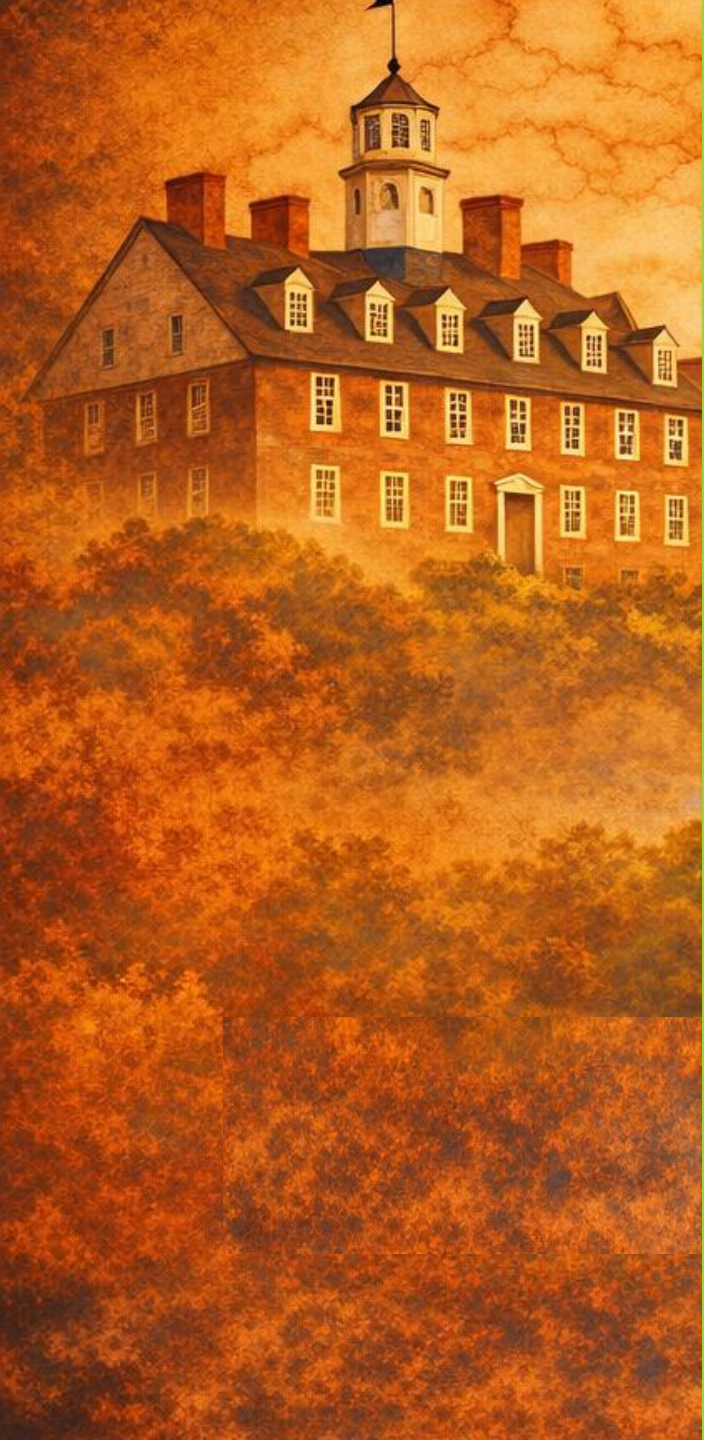




ADVOCATE[™]
EDUCATE
ELEVATE

Access Starts with Panel Size

How Many Patients Can You Actually Serve?

September 16–18, 2026

| Williamsburg, Virginia



Jason Harris

President, PanelWise

Jason.harris@panelwise.com

www.panelwise.com

EXPERIENCE

Trinity Health Michigan

15 years

Chief Operating Officer, Michigan Medical Groups

Vice President, Strategy

- 2,000 provider multispecialty group across the state
- Grew attributed lives from 150,000 to over 700,000, mostly organic

EDUCATION

BSE, Industrial and Operations Engineering, University of Michigan

MBA, Ross School of Business, University of Michigan

OUTSIDE OF WORK

Trying to visit all 50 states with my two kids, ultramarathons, golden retriever therapy dog



What PanelWise Does

Consulting and analytics for primary care capacity

EXPERTISE

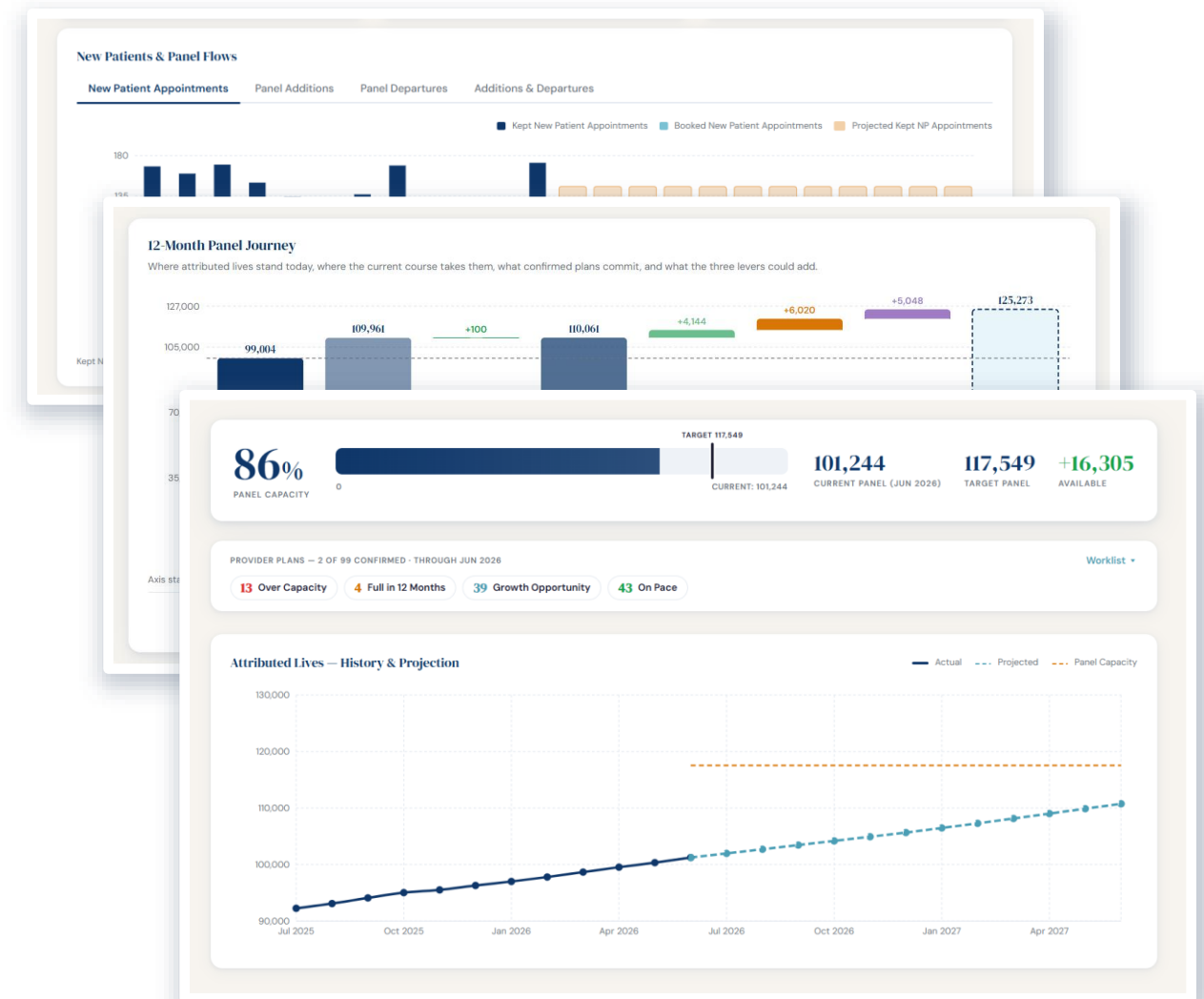
Evidence-based panel sizing models

- Built on the literature and on national UDS benchmarks
- Adjusted for your providers, not a standard number

ANALYTICS

Tools that do the heavy lifting for you

- Panel size, capacity, attrition and new patient targets
- Refreshed every month from your own data



Agenda & Objectives

WHERE WE ARE GOING

- 1 **Why panel size matters right now**
- 2 **A simple model for panel management**
- 3 **How to build your model, step by step**
- 4 **Putting panel size to work**

WHAT YOU WILL LEAVE ABLE TO DO

- Say what unused capacity costs your health center, in money and in mission
- Define an attributed life and choose the right lookback window for the job
- Calculate panel capacity from your own visit data, adjusted for your providers
- Set and track a new patient target for every provider

Everything today is built from data you already have.

EMPANELMENT

Why do we care about this now?

Why This Matters Now

Medicaid is the revenue base

Medicaid provides about 42 percent of community health center revenue. Virginia covers more than 595,000 adults through Medicaid expansion.

Work requirements begin January 1, 2027

Expansion adults 19 to 64 must earn \$580 a month or complete 80 hours of approved activity. Virginia will verify every six months at renewal.

What is at stake for health centers

Up to 5.6 million health center patients in expansion states could lose coverage, putting up to \$32 billion in health center revenue at risk over 5 years.

Geiger Gibson Program, George Washington University, and Commonwealth Fund analyses of H.R. 1 (2025). Virginia figures: Virginia Department of Medical Assistance Services, federal work requirement guidance, 2026.

Knowing who your patients are and how many you can serve is more important than ever.

The Perils of Over-Empanelment

Five outcomes the peer-reviewed literature shows degrade when panels go unmanaged



Preventive quality

+11%

avoidable admissions

Ambulatory-care-sensitive hospitalizations rise ~11%, and cancer screening falls by 5–8%, from the smallest to the largest panels studied (8.3M patients).

Dahrouge 2016, Ann Fam Med



Patient access

11×

more likely: worst appointment access

Physicians whose capacity-adjusted panels ran above average were ~11× more likely to rank among the worst for time to third-next-available appointment — even in a mature team-based practice.

*Angstman 2016, J Am Board Fam Med
Murray & Berwick 2003, JAMA*



Continuity of care

–25%

mortality with sustained continuity

Once demand outstrips the schedule, patients take whoever is available and relational continuity erodes. What's forfeited: sustained continuity is associated with 25% lower mortality.

*Dahrouge 2016, Ann Fam Med
Sandvik 2022, Br J Gen Pract*



Total cost of care

\$1,134

extra cost per patient per year

Medicare patients of the lowest-continuity physicians cost \$1,134 more per year than patients of the highest (\$8,092 vs \$6,958), with 16% higher odds of hospitalization. Fragmented care is expensive care.

Bazemore 2018, Ann Fam Med



Clinician burnout

+19%

odds of burnout

Panel overcapacity raises burnout odds (OR 1.19); burnout in turn nearly doubles the odds of patient-safety incidents (OR 1.96).

*Helfrich 2017, J Gen Intern Med
Panagioti 2018, JAMA Intern Med*

Under-Empanelment Is Valuable Unused Capacity

And unused capacity costs a health center twice

THE MONEY

\$750,000

the all-in annual cost of one primary care provider FTE

Salary, care team, space and overhead. The majority is fixed cost, so under-empanelment has a direct impact on the bottom line.

THE MISSION

33.9 million

people served by health centers in 2024

Unused capacity are patients who are not seen, in a community where the alternative is often nobody at all.

FY24 UDS. Cost per provider is the median across 671 health centers reporting Table 8A; patients served across 1,512 centers.

Under-empanelment has real costs to the bottom line and to the mission of serving your community

DISCUSSION

We don't turn anyone away

Is panel management at odds with that?

Our Why is Our People, Our Patients and Our Communities



PANEL BASICS

What is the right panel size?

1,200

There Is No Optimal Panel Size

Everyone does this differently, and the national data says that is exactly what to expect

600 – 3,300

one standard deviation around a mean of 1,933, across 21,770 family physicians

WHAT THE PUBLISHED EVIDENCE SAYS

- A systematic review looked for an optimal panel size and did not find one.
- Federal clinics have about 43% smaller panel sizes
- Panels run about 21% smaller where more than half of patients are vulnerable.
- Self-reported panels fell from about 2,400 to 1,700 between 2013 and 2022.

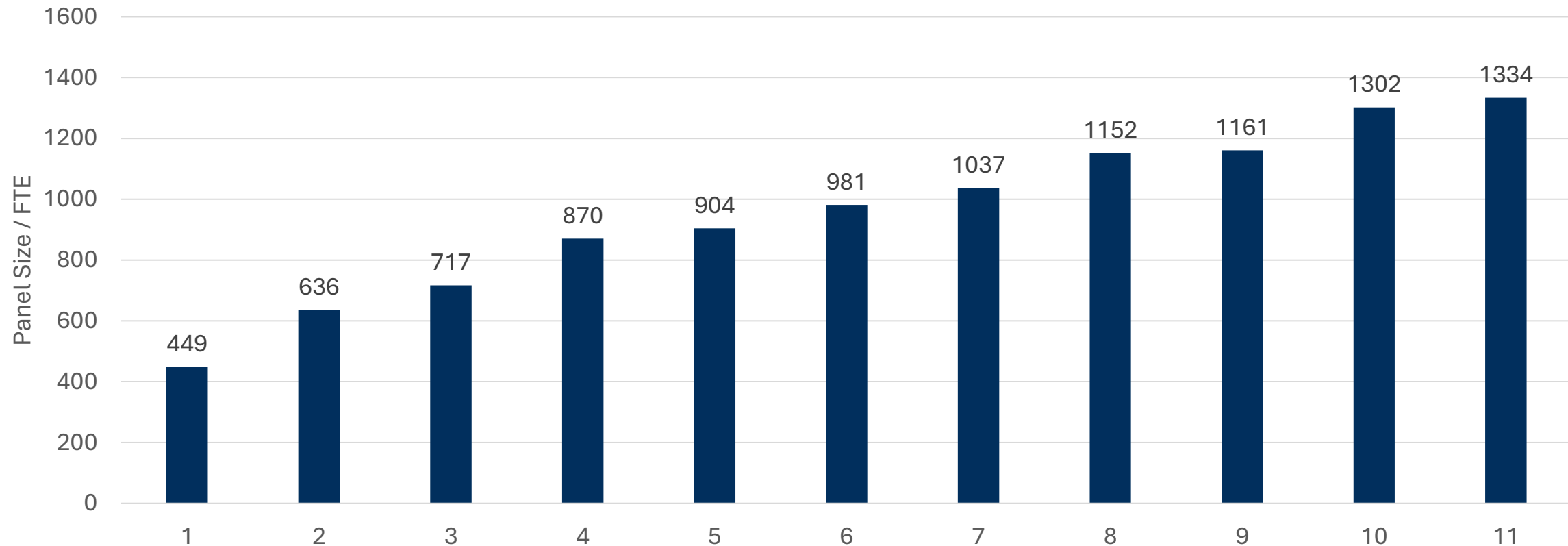
Paige NM et al., Ann Intern Med 2020. Bazemore A, Morgan ZJ, Grumbach K, J Am Board Fam Med 2026. Bazemore A et al., J Am Board Fam Med 2024.

Panel size is a fingerprint of your providers, patients, community and care model.

Virginia FQHC Panel Size / FTE

Source: FY24 UDS Data. Health Centers with > 5 PC FTE

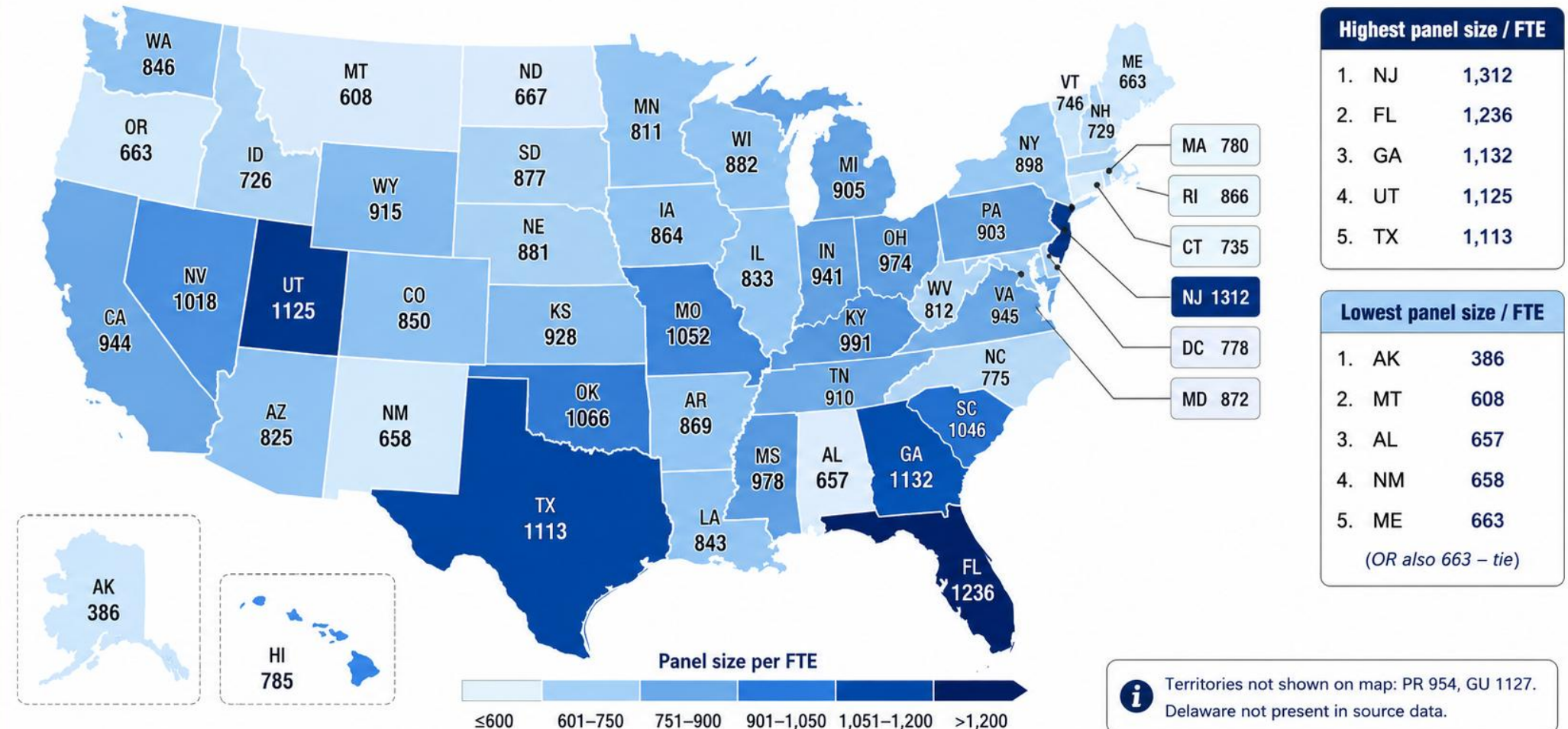
1 Year Active Patient Definition



Panel sizes differ significantly across FQHCs in Virginia

FY24 UDS Panel Size per FTE by State

Patients per primary care provider FTE



DISCUSSION

What does your panel look like today?

PANEL BASICS

A Simple Model for Panel Management

“Open or closed?” is the wrong question

It is how most panels are managed, and it is why panel sizes yo-yo

THE QUESTION WE ASK

Is your panel open or closed?

A switch with two settings. A panel opens, fills past capacity and slams shut. Access suffers, patients wait, the panel quietly shrinks. Then it opens again and the cycle repeats.

THE QUESTION TO ASK

How many new patients are you accepting this year?

A number each provider can manage against, set from their own capacity, panel and expected attrition. Reviewed together, adjusted as the year unfolds.

0 = closed

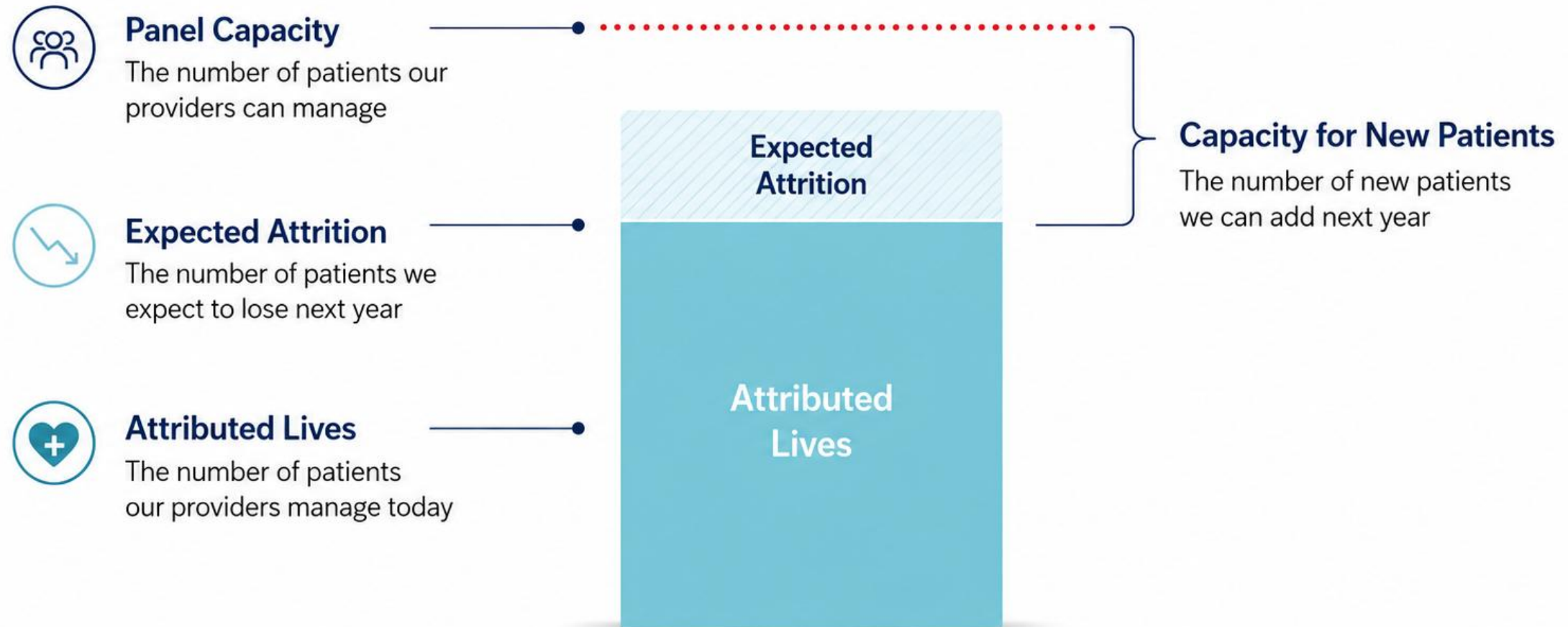
the old answer still fits

New patient targets simplify panel management

One answer connects strategy to operations



A Simple Model for Panel Management



New patient capacity = panel capacity - current attributed lives + expected attrition impact

What is an attributed life?

1

Decision 1: Timeframe

When did the patient need to be seen last to be considered active?



2

Decision 2: PCP

Who is the patient's primary care provider?



EMR PCP Field



Attribution



Payer Assignment

3

Decision 3: Qualifying Visits

How many and what type of visits are required?



1 or 2



Establishing visits



Physicals



Wellness

What is an attributed life?

Same underlying panel. Different active-patient definitions.

How long ago a patient had to be seen to be considered active

	1 year	2 year	3 year
 Panel Size	1,200	1,500	1,800
 Attrition Rate	10-15%	7.5-12.5%	5-10%
 Visits / Patient	3.0	2.5	2.0



Key takeaway: These are all the same panel — changing the lookback period changes panel size, attrition, and visits per patient.

Panels Need Bouncers

We want the bouncer's job to be easy



Simple version

One door in, one door out

-  One way in New patient appointments
-  One way out Patients leaving the panel
-  Simple control point Let new patients in as patients leave

The bouncer's job is easy.

DISCUSSION

How does your bouncer work today?

But There Might Be a Door Nobody Is Watching

If your active patient definition does not match your new patient definition, your panels grow without you knowing.



Make your new patient and active patient definition the same

But those are not my patients!

Your attribution model has a second job

DR. JONES, 2026 QUALITY SCORECARD

Patient 1	seen Mar 2026
Patient 2	seen Jan 2026
Patient 3	seen Nov 2025
Patient 4	last seen 2023
Patient 5	last seen 2023
Patient 6	last seen 2023

Use a shorter window if measuring quality, closing care gaps, or prioritizing outreach or follow up, especially if compensation is involved.

The Solution: Use Two Windows for the Two Different Jobs

Each job is different, the models should be too.

3 years

Panel size, open and close decisions, new patient targets and growth planning.

12-18 months

Quality, care management, population health, scorecards and anything tied to pay.

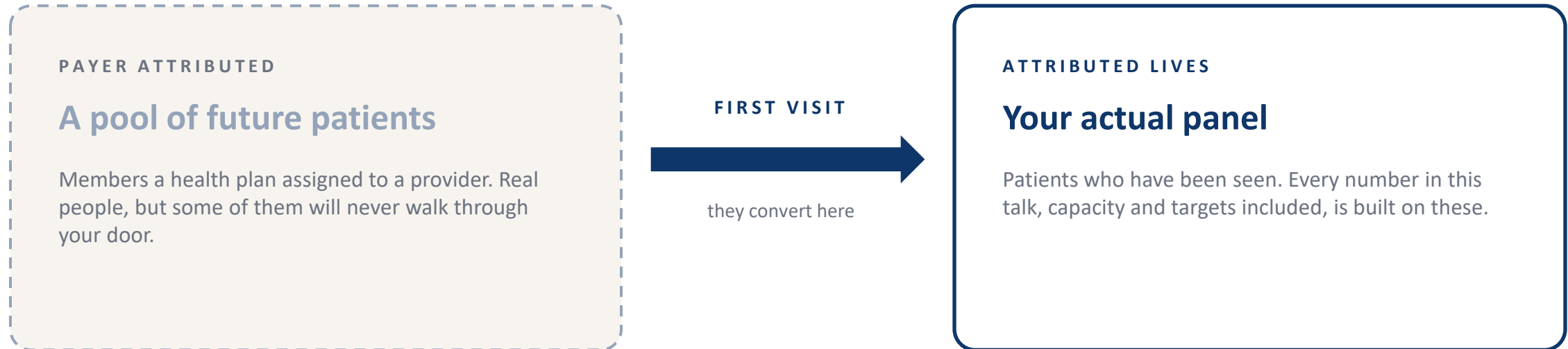
IF YOU CAN ONLY RUN ONE, KNOW THE PITFALLS AND ACCOUNT FOR IT

If your active patient definition is shorter than your new patient definition, you need to account for the other door.

You can close a panel and still gain patients. Watch panel growth via returning patients, not just new patient visits.

Payer Attribution Is Not on Your Panel

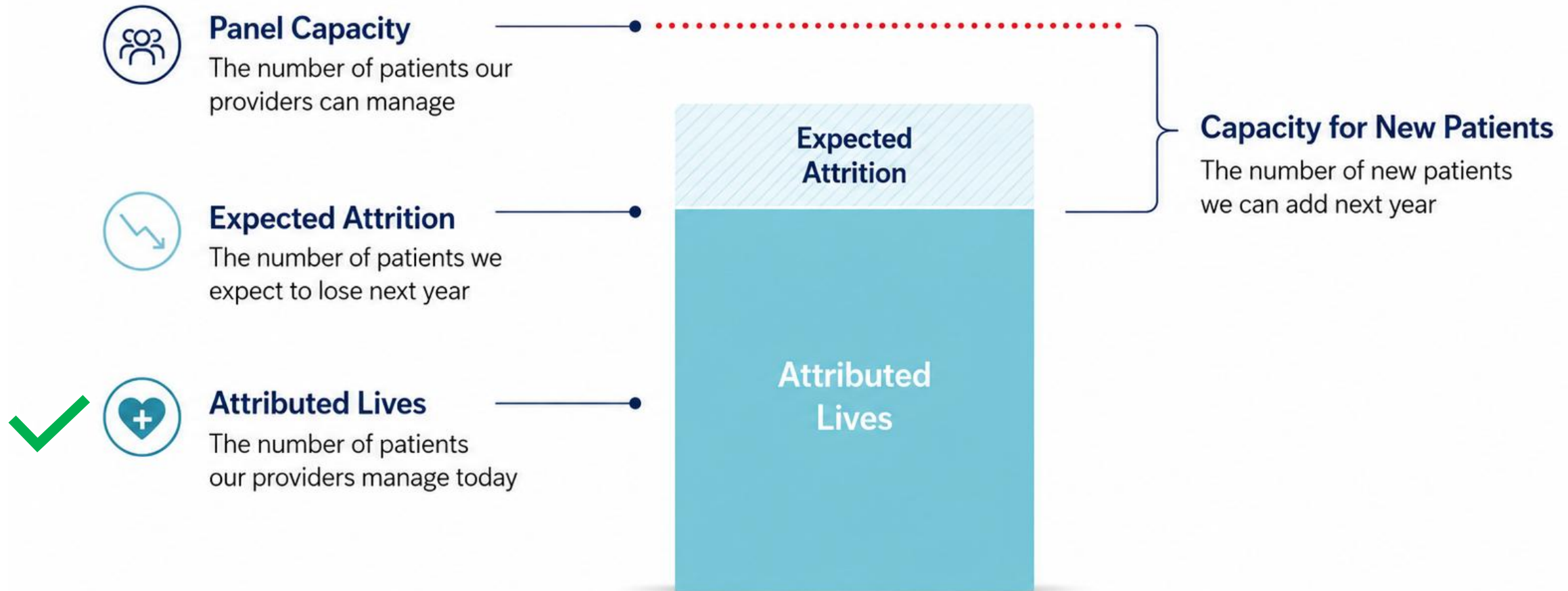
Two things with similar names. Only one of them belongs on your panels.



- Do track how many each provider has, and whether that provider has room for them.
- Do not add them to panel size, capacity or utilization.

They join the panel the day they are seen. Not before.

A Simple Model for Panel Management



New patient capacity = panel capacity - current attributed lives + expected attrition impact

Understanding Attrition



Attrition is the number of patients you lose from your primary care panels each year.



Key insights

- ✓ Often ranges from 5%–20%
- ✓ Some is preventable, some is not
- ✓ Important signal of disruption in the patient-physician relationship
- ✓ Must be accounted for in access planning



Expect meaningful variation by provider and by clinic.



How to measure attrition

12 Months Ago

Patient	PCP
Patient 1	Dr. Garcia
Patient 2	Dr. Jones
Patient 3	Dr. Nguyen
Patient 4	Dr. Smith

Today

Patient	PCP
Patient 1	Dr. Garcia
Patient 2	Dr. Smith
Patient 3	Dr. Nguyen
No longer a patient —	
Patient 5	Dr. Ahmed



Patient 1: Still a patient



Patient 2: Still a patient, but different PCP



Patient 3: Still a patient



Patient 4: No longer a patient



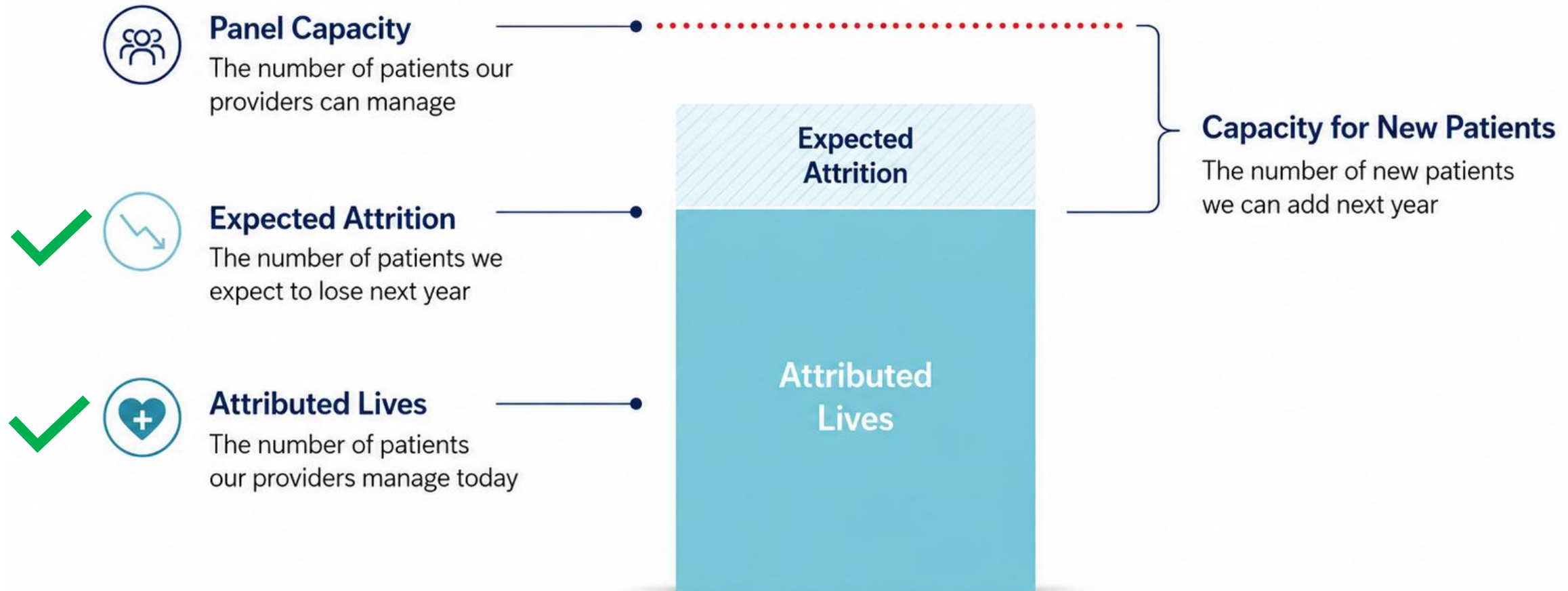
Patient 5: New patient



Example: 25% attrition

Of the 4 patients you started with, 3 are still patients today.

A Simple Model for Panel Management



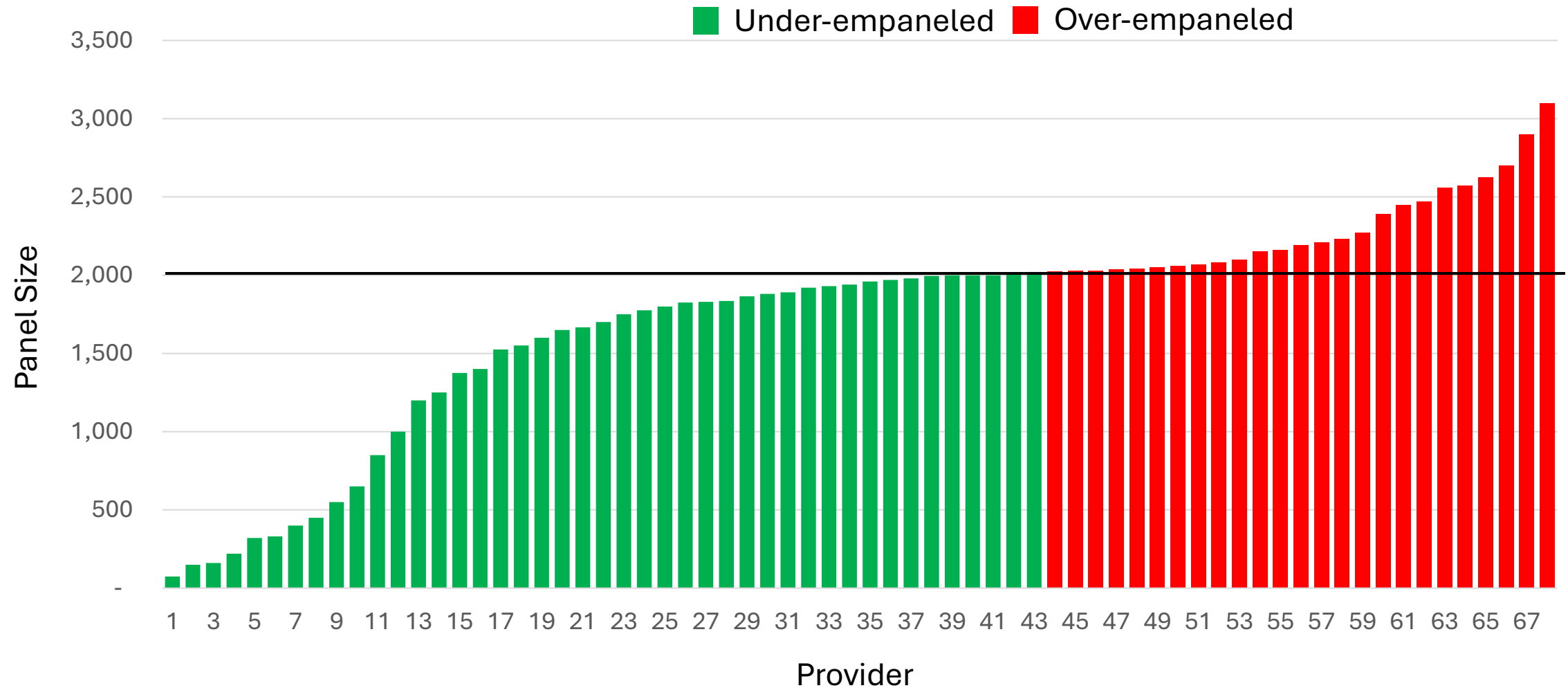
New patient capacity = panel capacity - current attributed lives + expected attrition impact

“How many patients can each doctor have on their panel?”

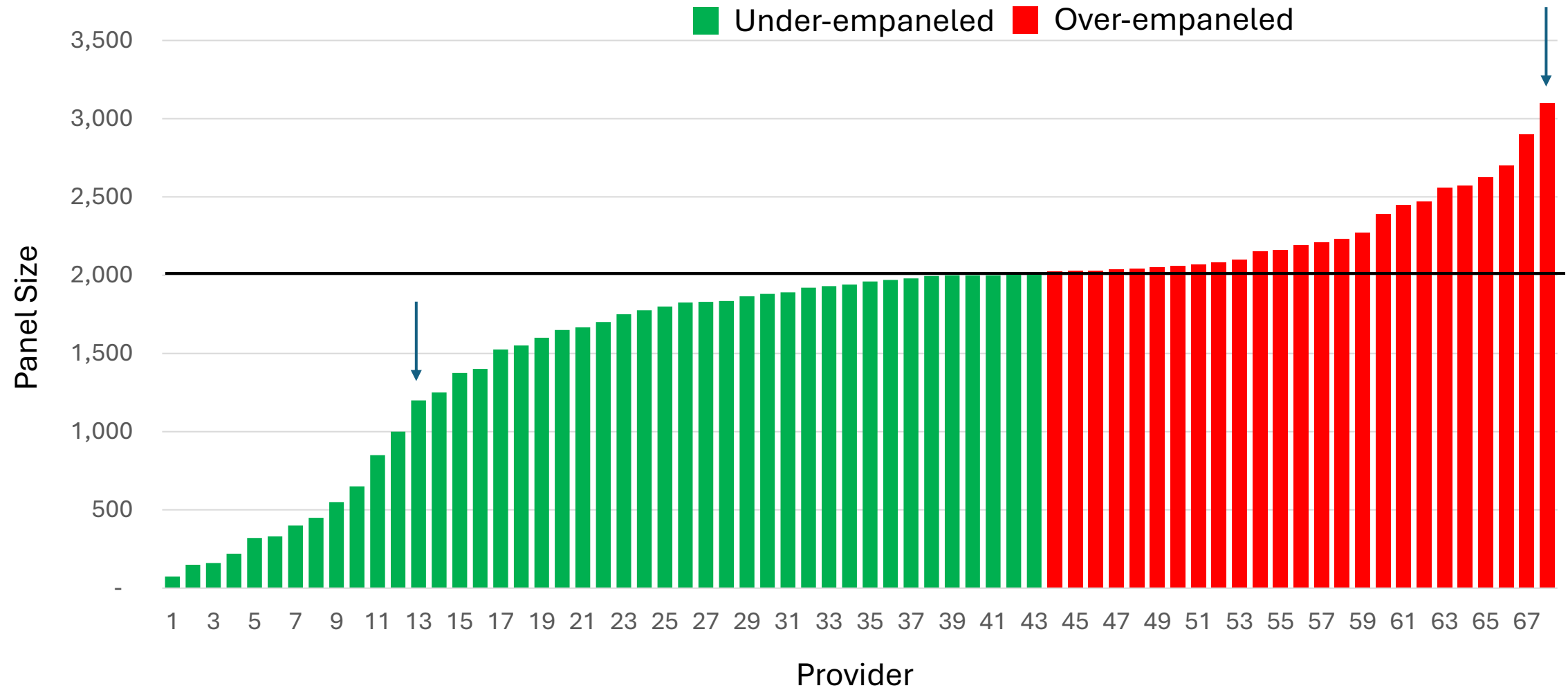
Our Answer

2,000

What we thought our panels looked like



What we thought our panels looked like



Standard Panel Sizes Don't Reflect True Capacity

One size fits all panel capacity ■■■■■■■■

Dr. Team Lead



- Sees 25 patients a day
- Works 4.5 days per week
- Younger patients
- High functioning care team
- “My nurse will call you in a week”
- Longstanding staff

Attributed Lives

Standard Panel Sizes Don't Reflect True Capacity

One size fits all panel capacity ■■■■■■■■

Dr. High Touch



- Sees 15 patients a day
- Works 4.5 days per week
- Older, complex patients
- No care team in place
- “Come back and see me in a week”
- Chronic staffing problems

Attributed
Lives

Standard Panel Sizes Don't Reflect True Capacity

One size fits all panel capacity ■■■■■■■■

Dr. Team Lead



- Sees 25 patients a day
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Attributed Lives

Dr. High Touch

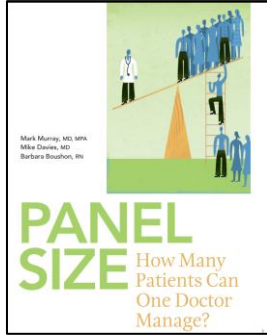


- Sees 15 patients a day
- Works 4.5 days per week
- Older, complex patients
- No care team in place
- “Come back and see me in a week”
- Chronic staffing problems

Attributed Lives

Same FTE.
Very different panel sizes

A Framework for Sizing Panels



Panel Size: How Many Patients Can One Doctor Manage?

 PDF  Print  Comments

There are limits to the number of patients you can effectively care for. Here's how to determine that number, improve patient access and better manage your workload.

MARK MURRAY, MD, MPA, MIKE DAVIES, MD, AND BARBARA BOUSHON, RN

 *Fam Pract Manag.* 2007;14(4):44-51

$$\text{Panel capacity} = \underbrace{\text{Visits next year}}_{\text{Accounts for Productivity, Clinical FTE}} \div \underbrace{\text{Visits per patient next year}}_{\text{Accounts for Patient complexity, Provider style}}$$

Accounts for

- Productivity
- Clinical FTE

Accounts for

- Patient complexity
- Provider style

Adjusting Panel Sizes Reflects True Capacity

One size fits all panel capacity ■■■■■■■■

True panel capacity ■■■■■■■■

Dr. Team Lead



- Sees 25 patients a day
- Works 4.5 days per week
- Younger patients
- High functioning care team
- “My nurse will call you in a week”
- Longstanding staff



4,500 visits
2.0 provider visits per patient
2,250 sustainable panel size

Dr. High Touch

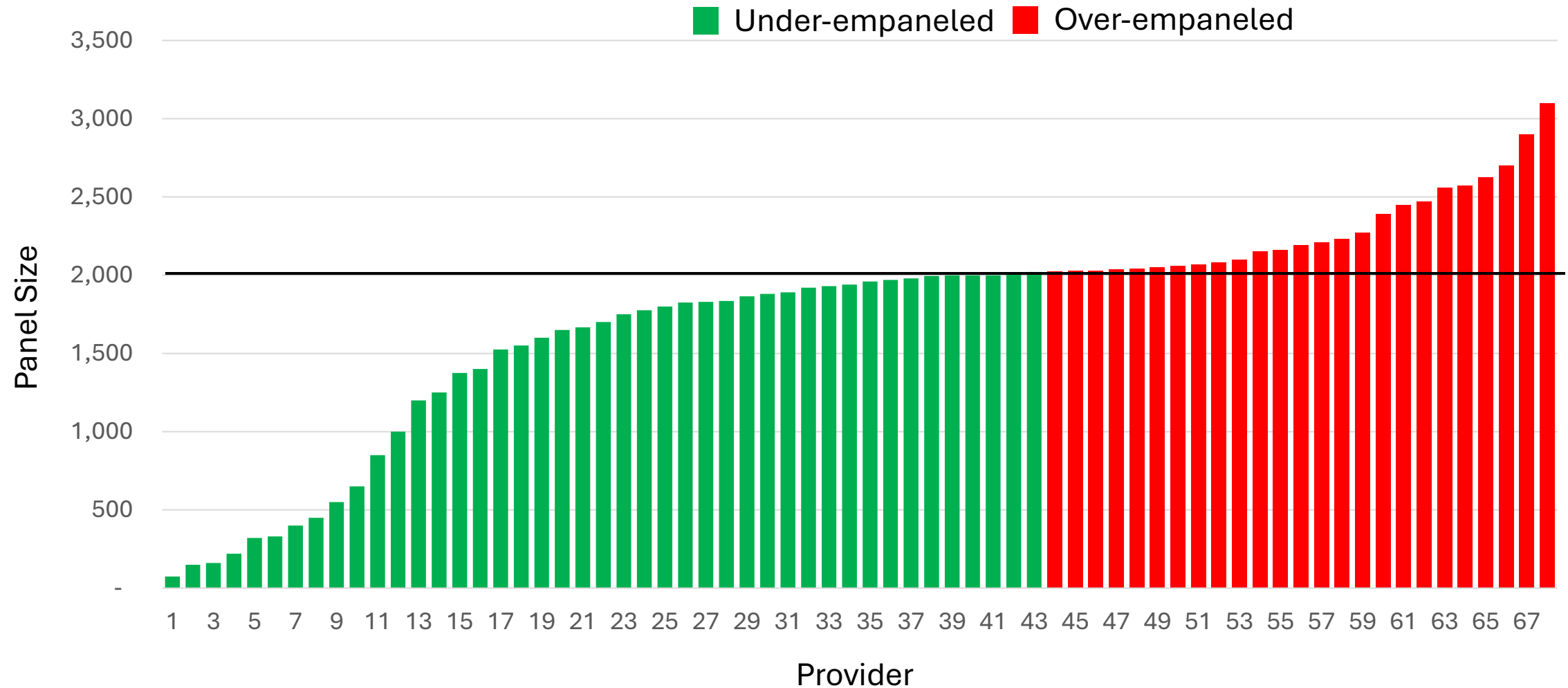


- Sees 15 patients a day
- Works 4.5 days per week
- Older, complex patients
- No care team in place
- “Come back and see me in a week”
- Chronic staffing problems

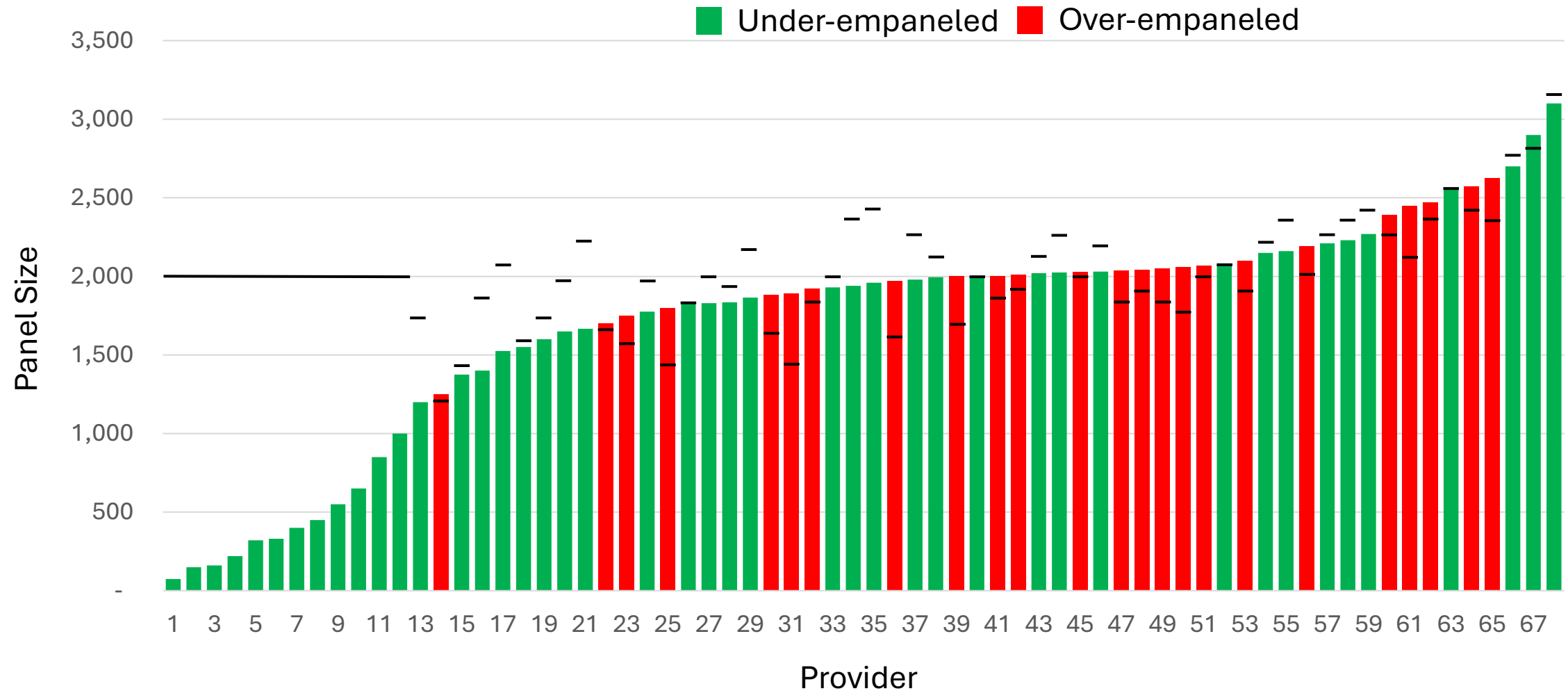


2,500 visits available for panel
3.0 provider visits per patient
833 sustainable panel size

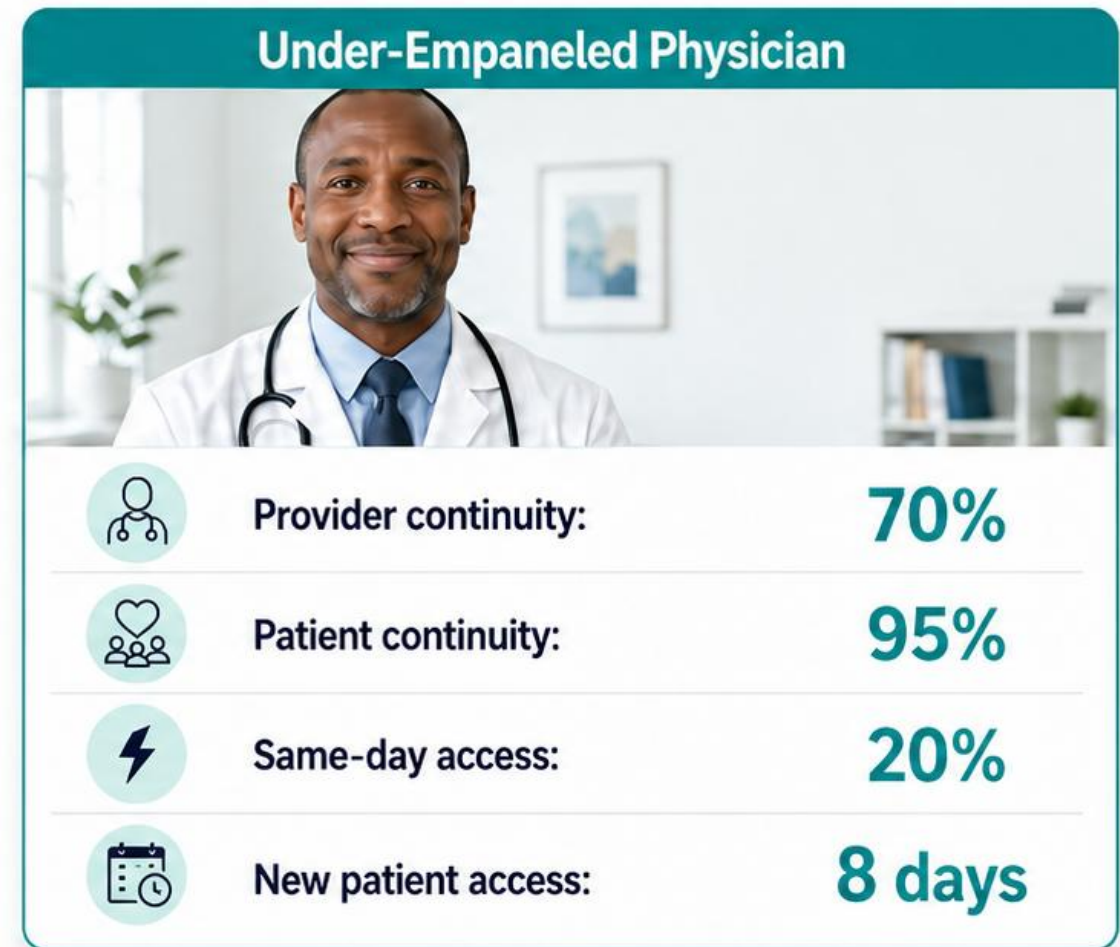
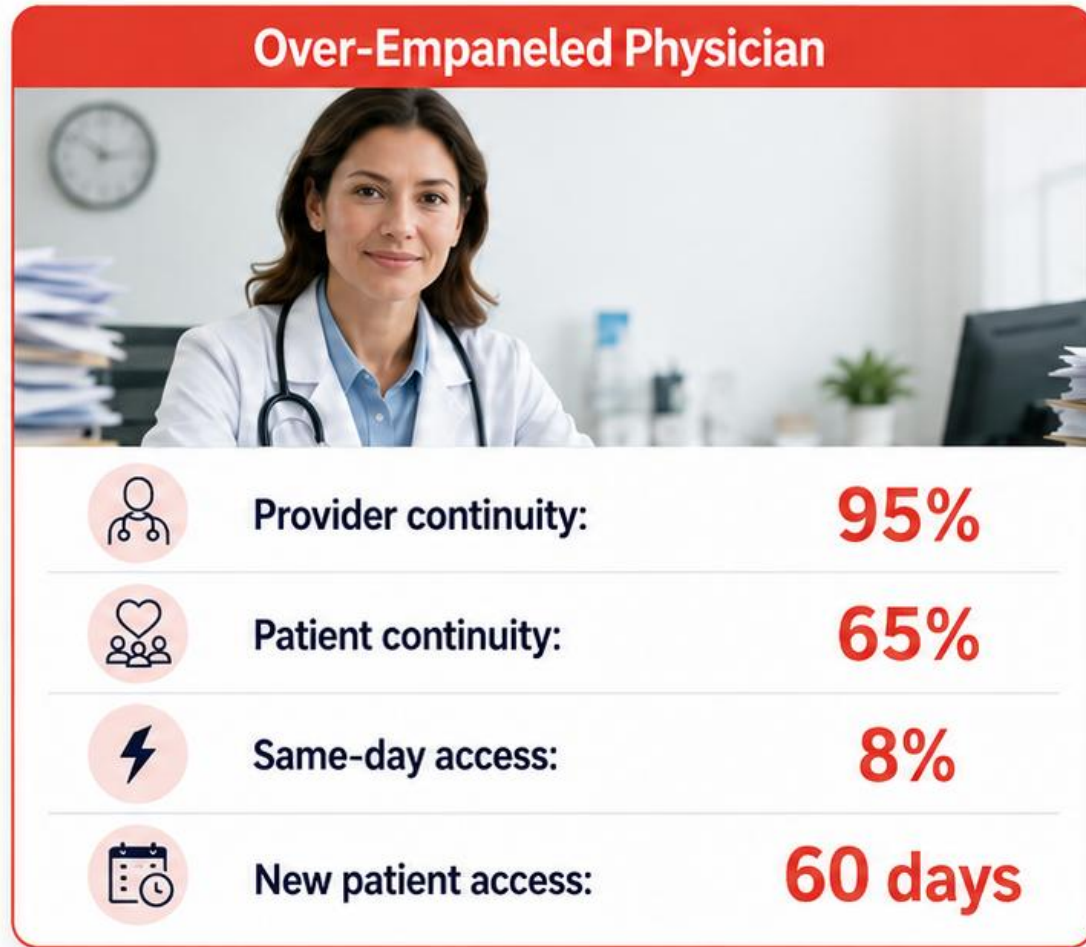
What we thought our panels looked like



What they actually looked like



It aligned with what Access & Continuity told us



what we said

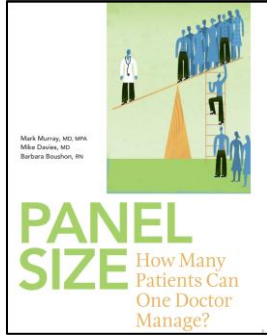
“Let’s accurately model your panel sizes”

what our doctors heard



“Your individuality is valued and respected.”

A Framework for Sizing Panels



Panel Size: How Many Patients Can One Doctor Manage?

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There are limits to the number of patients you can effectively care for. Here's how to determine that number, improve patient access and better manage your workload.

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Accounts for

- Productivity
- Clinical FTE

Accounts for

- Patient complexity
- Provider style

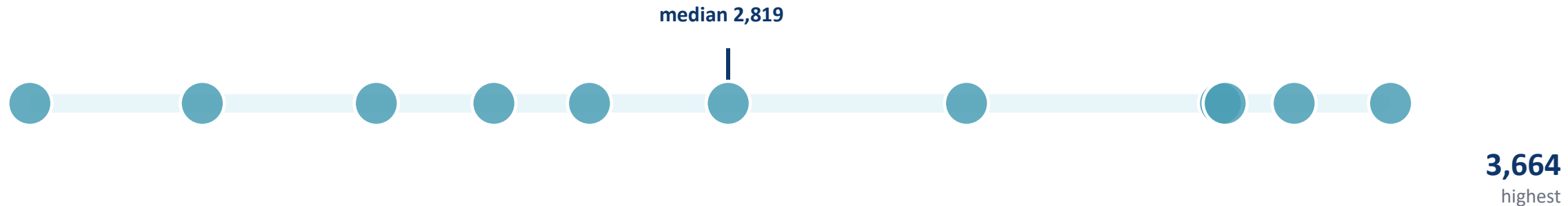
Virginia FQHC Visits per Provider FTE

Source: FY24 UDS Data. Health Centers with > 5 PC FTE

1 Year Active Patient Definition

1.9x

between the lowest and highest health center in Virginia. Each dot is one health center.



11 Virginia health centers with more than 5 primary care FTE, FY24 UDS

Visits per provider FTE differ significantly across FQHCs in Virginia

DISCUSSION

Why would two providers have different visits per FTE?

Virginia FQHC Visits / Patient

Source: FY24 UDS Data. Health Centers with > 5 PC FTE

1 Year Active Patient Definition

2.0x

between the lowest and highest health center in Virginia. Each dot is one health center.

median 3.24



4.29
highest

2.17
lowest

11 Virginia health centers with more than 5 primary care FTE, FY24 UDS

Visits per patient differ significantly across FQHCs in Virginia

DISCUSSION

Why would two providers have different visits per patient?

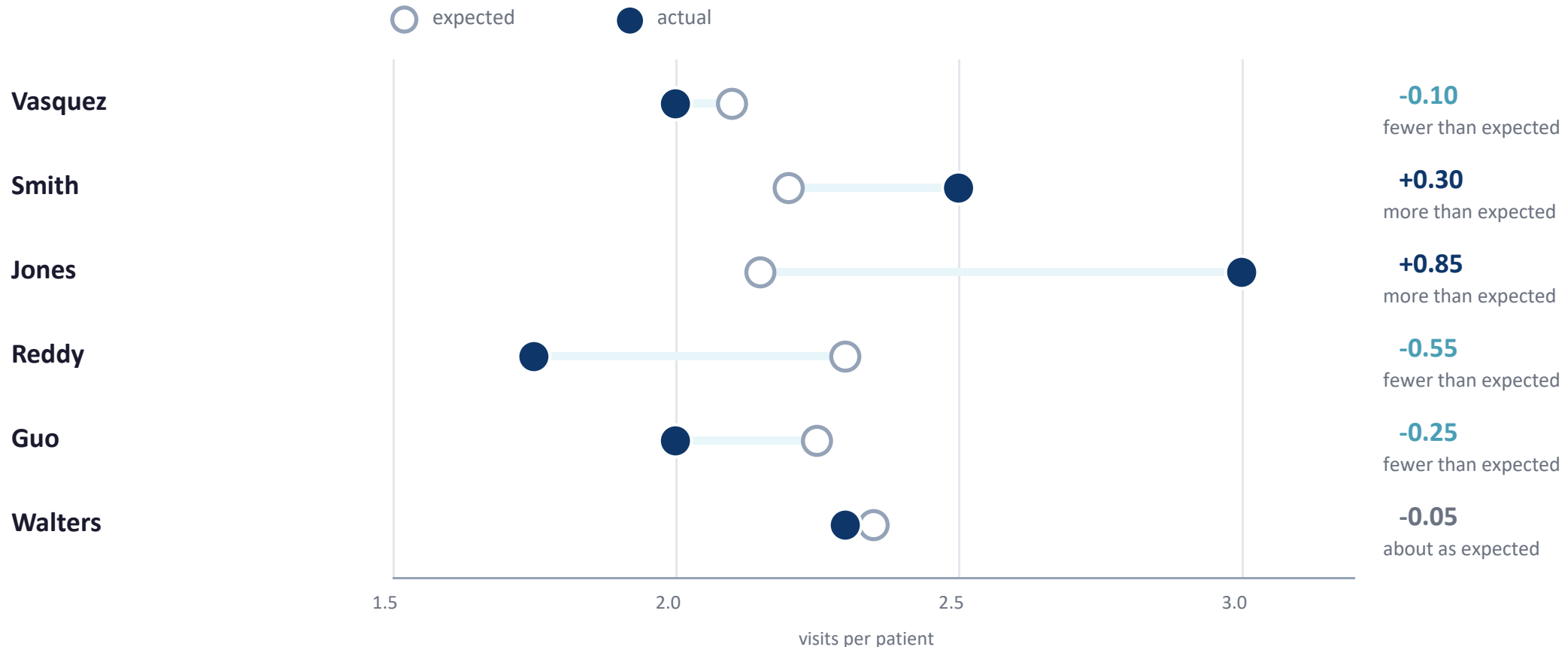
Patient Risk Adjustment



Use patient complexity to **estimate expected visits per patient** — not to directly adjust panel size with risk scores alone.

Expected vs Actual Visits per Patient

Expected is what patient complexity predicts. Actual is what the provider actually does.



Expected vs. actual shows the impact of patient complexity but many other factors impact visits/patient

THE METHOD

How to build your panel size model

How to Build Your Panel Size Model

Four steps, followed end to end with one worked example



Step by step from data to plan

Pull Data



Visits

Calculation

- ✓ Last year's visit volume

Adjustments

- ✓ Provider FTE changes
- ✓ New provider ramping up
- ✓ Provider departures
- ✓ Expected productivity changes



Visits per patient

Calculation

For the provider's panel, count total visits with **ANY PRIMARY CARE PROVIDER** over the last 12 months and divide by the provider's attributed lives.

Adjustments

- ✓ Set new providers visits per patient to group average

The data you pulled

STEP 1

Provider	Attributed Lives	Visits	Visits per Patient
Vasquez	1,200	3,000	2.00
Smith	1,350	2,500	2.50
Jones	1,300	3,500	3.00
Reddy	1,900	4,000	1.75
Guo	1,000	2,000	2.00
Walters	1,400	3,000	2.30
Group	8,150	18,000	2.21
<i>Average</i>		<i>3,000</i>	<i>2.00</i>

THE AVERAGE

3,000 visits, 2.0 visits per patient = 1,500 panel size

Use for planning purposes and as starting assumption for a new provider.

Calculate capacity and utilization

STEP 1

Provider	Attributed Lives	Visits	Visits per Patient	Panel Capacity	Panel Utilization
Vasquez	1,200	3,000	2.00	1,500	80%
Smith	1,350	2,500	2.50	1,000	135%
Jones	1,300	3,500	3.00	1,167	111%
Reddy	1,900	4,000	1.75	2,286	83%
Guo	1,000	2,000	2.00	1,000	100%
Walters	1,400	3,000	2.30	1,304	107%
Group	8,150	18,000	2.21	8,257	99%

THE CHANGE

Two columns added, both calculated from what you already pulled.

Panel capacity = visits / visits per patient. Panel utilization = attributed lives / panel capacity.

Make Adjustments

Four things that move a provider's numbers before you calculate a target

APPs

Add the visits an APP contributes to the panel they support.

FTE changes

Known clinical FTE moves, ramp-ups and departures for next year.

Productivity

Planned changes to how many patients a provider sees in a day.

Risk

Panel complexity, handled through visits per patient rather than a risk score.

Each adjustment changes one input. Panel capacity and utilization recalculate from it.

How to account for different APP models

SUPPORTS STEP 2

1

Empaneled APP



Visits from APP
go to own panel

2

Physician APP Shared Panel



Visits from APP
go to physician panel

3

Overflow APP



Visits from APP split
between each physician

4

Hybrid: Overflow + Empaneled



Visits from APP split
between own panel +
each physician



APP visits follow the panel they are supporting

Adjust for an APP

STEP 2

Provider	Attributed Lives	Visits	Visits per Patient	Panel Capacity	Panel Utilization
Vasquez	1,200	3,000	2.00	1,500	80%
Smith	1,350	2,500 → 3,500	2.50	1,000 → 1,400	135% → 96%
Jones	1,300	3,500	3.00	1,167	111%
Reddy	1,900	4,000	1.75	2,286	83%
Guo	1,000	2,000	2.00	1,000	100%
Walters	1,400	3,000	2.30	1,304	107%
Group	8,150	19,000	2.33	8,657	94%

THE CHANGE

Dr. Smith has an APP who shares her panel and contributes 1,000 visits a year.

Visits 2,500 to 3,500. Capacity 1,000 to 1,400. Utilization 135% to 96%, so she is no longer over her panel.

amber = what you changed blue = what recalculated

Adjust for planned productivity

STEP 2

Provider	Attributed Lives	Visits	Visits per Patient	Panel Capacity	Panel Utilization
Vasquez	1,200	3,000	2.00	1,500	80%
Smith	1,350	3,500	2.50	1,400	96%
Jones	1,300	3,500	3.00	1,167	111%
Reddy	1,900	4,000	1.75	2,286	83%
Guo	1,000	2,000 → 2,200	2.00	1,000 → 1,100	100% → 91%
Walters	1,400	3,000	2.30	1,304	107%
Group	8,150	19,200	2.36	8,757	93%

THE CHANGE

Leadership is asking Dr. Guo to see one more patient each day in clinic.

Visits 2,000 to 2,200. Capacity 1,000 to 1,100. Utilization 100% to 91%, which opens room to grow.

amber = what you changed blue = what recalculated

Adjust visits per patient

STEP 2

Provider	Attributed Lives	Visits	Visits per Patient	Panel Capacity	Panel Utilization
Vasquez	1,200	3,000	2.00	1,500	80%
Smith	1,350	3,500	2.50	1,400	96%
Jones	1,300	3,500	3.00 → 2.70	1,167 → 1,296	111% → 100%
Reddy	1,900	4,000	1.75	2,286	83%
Guo	1,000	2,200	2.00	1,100	91%
Walters	1,400	3,000	2.30	1,304	107%
Group	8,150	19,200	2.36	8,886	92%

THE CHANGE

Dr. Jones plans to use the care team more fully, so each patient needs fewer physician visits.

Visits per patient 3.00 to 2.70. Capacity 1,167 to 1,296. Utilization 111% to 100%.

amber = what you changed blue = what recalculated

Draft New Patient Targets

One formula, run for every provider

$$\text{New patient target} = \text{panel capacity} - \text{attributed lives} + \text{projected attrition}$$

Room on the panel

Capacity minus the patients already attributed.

Plus what you will lose

Projected attrition, added back because those seats reopen.

A number, not a switch

Zero is a valid target. It means closed, for a reason you can name.

This example uses a flat 10% attrition for every provider.

Draft the targets

STEP 3

Provider	Attributed Lives	Visits	Visits per Patient	Panel Capacity	Panel Utilization	Projected Attrition	New Patient Target
Vasquez	1,200	3,000	2.00	1,500	80%	120	420
Smith	1,350	3,500	2.50	1,400	96%	135	185
Jones	1,300	3,500	2.70	1,296	100%	130	126
Reddy	1,900	4,000	1.75	2,286	83%	190	576
Guo	1,000	2,200	2.00	1,100	91%	100	200
Walters	1,400	3,000	2.30	1,304	107%	140	44
Group	8,150	19,200	2.36	8,886	92%	815	1,551

THE CHANGE

Two columns added: what each provider expects to lose, and the target that falls out of it.

New patient target = panel capacity - attributed lives + projected attrition. Attrition is a flat 10% here.

Finalize with Providers

The draft is an input to a conversation. The number that survives it is the one that gets honored.

Show the inputs

Bring the panel size, capacity and attrition behind the number, not just the number itself.

Test it against the schedule

Template, planned leave, and how many new patient slots actually exist in a year. Expect numbers to move.

Agree to it, then roll it up

Every physician, NP and PA leaves with a number they have seen. Sum them and check the group total against your growth plan.

The yo-yo stops when the conversation is about a number instead of a yes or no.

Panels move. Revisit the targets on a regular cadence and adjust.

A constraint from the review

STEP 4

Provider	Attributed Lives	Visits	Visits per Patient	Panel Capacity	Panel Utilization	Projected Attrition	New Patient Target
Vasquez	1,200	3,000	2.00	1,500	80%	120	420
Smith	1,350	3,500	2.50	1,400	96%	135	185
Jones	1,300	3,500	2.70	1,296	100%	130	126
Reddy	1,900	4,000	1.75	2,286	83%	190	576 → 500
Guo	1,000	2,200	2.00	1,100	91%	100	200
Walters	1,400	3,000	2.30	1,304	107%	140	44
Group	8,150	19,200	2.36	8,886	92%	815	1,551 → 1,475

THE CHANGE

Dr. Reddy can only fit 500 new patient appointments into a year.

Target 576 to 500. The group target falls to 1,475. The model said 576; the schedule said 500.

amber = what you changed blue = what recalculated

MANAGING PANELS

Putting Panel Size to Work

Track It Monthly

A spreadsheet you can build this afternoon. Newly attributed lives, by provider, by month.

Provider	Target	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD	+/-
Vasquez	420	30 35	32 35	28 35	35 35	31 35	29 35	33 35	30 35	248 280	-32
Smith	185	16 15	14 15	15 15	17 15	15 15	16 15	14 15	15 15	122 123	-1
Jones	126	12 11	14 11	11 11	13 11	15 11	12 11	14 11	13 11	104 84	+20
Reddy	500	38 42	35 42	40 42	42 42	36 42	33 42	39 42	37 42	300 333	-33
Guo	200	17 17	18 17	16 17	15 17	19 17	17 17	16 17	18 17	136 133	+3
Walters	44	5 4	4 4	3 4	6 4	4 4	5 4	3 4	4 4	34 29	+5
Group	1,475	118 123	117 123	113 123	128 123	120 123	112 123	119 123	117 123	944 983	-39

Grey number underneath is that provider's monthly target: annual target divided by twelve, rounded. Under YTD it is where they should be after eight months.

Count newly attributed lives, not new patient visits. That is the only way to see every door.

Set the Cadence

Three loops, running at different speeds. Each one does a different job.

J F M A M J J A S O N D

Monthly

LOOK



Review new patients against plan

Quarterly

ADJUST



Adjust the new patient targets where a provider has drifted.

Twice a year

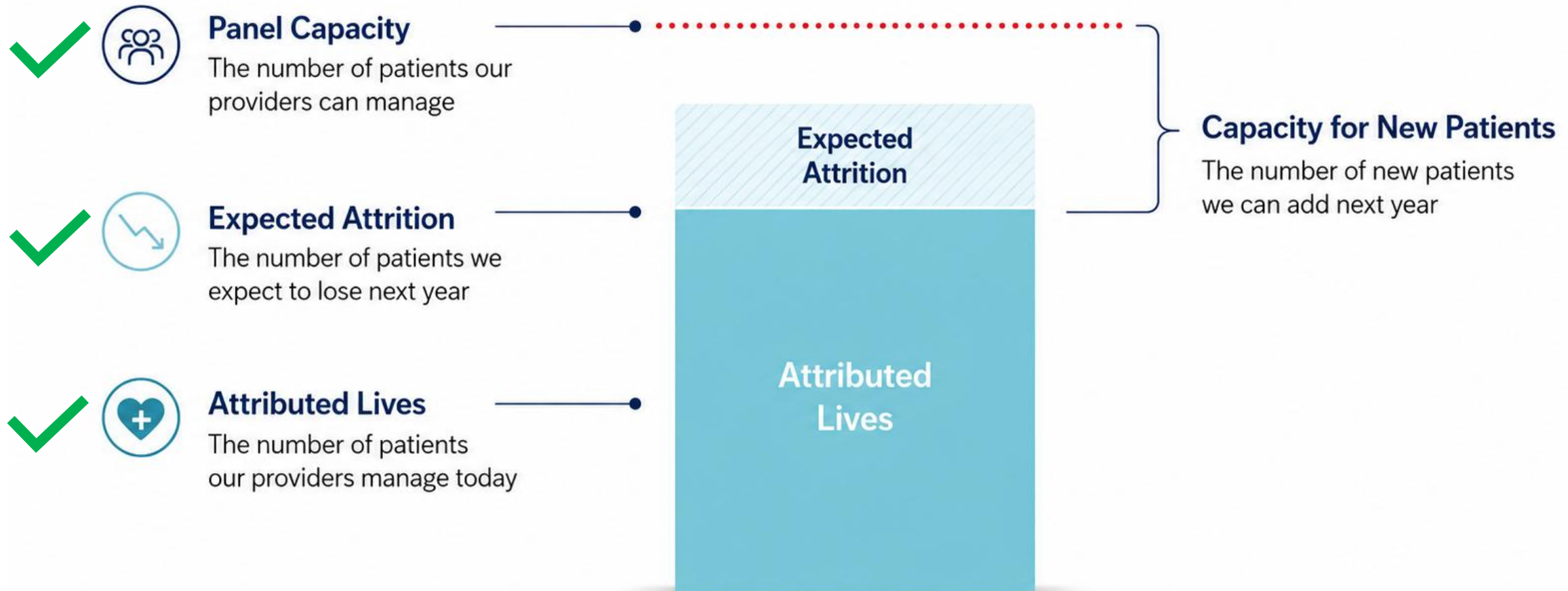
REBUILD



Recalculate ideal panel size, then reset the targets from it.

Simple, timely adjustments eliminate urgent open/close conversations

A Simple Model for Panel Management



New patient capacity = panel capacity - current attributed lives + expected attrition impact

Recap

The four things you came for

- **What unused capacity costs your health center**

About \$750,000 a year to field one provider, and it does not fall when the schedule has gaps. Health centers served 34 million people.

- **What an attributed life is, and which window to use**

Three years for panel management, twelve months for quality. Same visit history, counted twice, for two different jobs.

- **How to calculate panel capacity from your own data**

Panel capacity = visits divided by visits per patient. Then adjust for APPs, planned productivity and panel complexity. Trust the historical number.

- **How to set and track a new patient target**

New patient target = panel capacity minus attributed lives plus attrition. Review monthly, adjust quarterly, recalculate twice a year.

Start simple. Do not let perfect be the enemy of better.

**Jason Harris**

President, PanelWise
Former Medical Group COO

FREE, FOR EVERYONE IN THIS ROOM

Take the spreadsheet with you

The model we just built, as a template you fill in with your own data.

- One row per provider, with panel capacity and utilization calculated
- New patient target from your capacity, panel and attrition
- A monthly tab to track newly attributed lives against plan

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