Panel and Caseload Equity

Questions commonly arise around panel and caseload equity. “Panel” is the term used to describe the formalized linkage between a primary care physician or provider and his/her patients. Caseload is the parallel term used to describe the number of cases each clinician is responsible for in specialty care. Panel implies a long-term ongoing relationship. Caseload implies a “temporary” (although temporary may, in some cases, be lifelong) relationship in specialty care.

Within a practice of a set of interchangeable providers, should panel or caseload size be “equitable, that is, divided proportionately according to amount of time worked in the office (supply)?

In an environment where providers are reimbursed by an equitable salary, equitable panels or caseloads are important. If the providers get the same reimbursement, then the workload has to be allocated equitably against the reimbursement. This is quite simply a matter of visible fairness.

Distribution of workload in these environments is done by pooling, that is, receiving the new work centrally and distributing it according to a plan informed by measurement. Work does not have to be pooled in a round robin fashion but workload has to be monitored in an organized, planned and periodic way. So work can arrive in a bolus but at some point, it must be periodically reconciled for equity. In this way there can be some “patient choice” or preference but there is a limit to choice due to the need to load level the work load, and due to provider capacity limits determined by the panel/caseload equation.

In “fee for service” environments where reimbursement “floats” and is not the same from one provider to another, the workload can float as well. So work – that is panel or caseload - does not have to be equitable. If a provider can manage a larger panel or caseload, that is, see his/her own patients and not make them wait, he/she can have a larger panel or caseload. On the other hand, if the provider cannot manage an increased number of patients and those patients get sent to others, get sent away, or there is more overtime work for the staff, attempting to manage the panel/caseload will not be successful. The limit to panel is determined by the three “overs,” that is, we can tell a provider has reached the limit if he/she sends work “over there” (outside the practice), creates the need for over time, or the work flows over to others within the practice. At the same time, if the provider can manage his/her panel or caseload well by creating a more effective care team, by optimizing and reducing red zone time, by increasing the number of visits, and by delegating “non-provider work” to other staff, then he/she can manage more work and have a larger panel or caseload. While in my experience, these strategies are more easily accomplished in primary care, providers in specialty care still have this opportunity. In addition, specialty care providers can open more capacity by addressing return visit rates and “graduating” patients back to primary care. Since caseload can be a more temporary relationship, this strategy is quite effective in opening up more capacity for new patients (increased caseload) in specialty care.

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There is another critical variable here - has the practice capacity limit been reached? The practice and individual capacity limit is determined by the panel/caseload equation: panel/caseload X expected patient visits per year must equal the provider days per year in the office X the expected visits per day. If the practice capacity limit has not been reached and there is still practice capacity, panels and caseloads have to be equitable in salaried environments for fairness but do not have to be equitable in fee-for-service environments. However, once the practice and individual capacity limits have been reached, the panels/caseloads, even in fee-for-service environments, have to be equitable. At the upper range of caseload – when the caseload reaches the limit - they have to be equitable proportionate to days worked. If each provider has reached his/her capacity limit and each has used the same strategies to achieve that limit, the visits per day remain the same for all. As a consequence, since the strategies are exhausted to the same extent for all, the work load can only reach the provider capacity limit and as such by default the panel is “distributed” equitably. Distribution can be managed by pooling all new referrals.

So below the caseload limit they can be inequitable but at the caseload limit, if all providers exhaust the strategies to the same degree, then they have to be equitable. The exception of course is the physician who can “change the equation” - add more days (which changes the office equivalent status and really does not change the equity argument) or add more visits per day. Adding visits per day (by creating a more effective care team, by changing the return ratio, by reducing the red zone, by removing unnecessary work) can provide capacity for the individual specialty care physician to build a bigger caseload.

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