Visits and Panels: Q & A

Question:

I know it is really important to have the executive and central leadership involved in efforts to reach our goals on Advanced Access.

I imagine that there will be certain "realities" that play into our efforts. One of these is the issue of panel "closure." Having been in recent discussions with our executive leadership team (ELT), I think the idea of closing clinic panels is not one that will be "on the table" for fear of the impact of this on visits. I think that panel management or the closure of individual providers' panels is fine as long as visit numbers remain at target. There are too many "rumors" or "real anecdotal" events that shape the views of our ELT. An example is a provider whose panel is closed and there are some ways to address this scenario (and I think this is often not discussed with all the facts), but coming to some common language within our organization will be important.

As you might imagine, we have a budget that relies heavily on the presumption of a certain number of visits and visits are something that our board and ELT will be very keen on maintaining. I wanted to bring this up because I hope you can help us proceed despite or in lieu of this reality. Perhaps (*one of our sites*) can be a site that helps us reach Advanced Access while meeting the "productivity" expectations of our board and ELT. Our ELT is currently in heart to heart discussions on how we can most effectively measure this productivity (e.g. visits/hour, visits/week, etc.) and how to convey this to our staff and providers most effectively.

Finally, I (as a member of our central leadership group) will be listening for ways to approach our ELT and which issues are purely dependent on the ELT vs. which issues can be addressed at the health center level.

Answer:

The visit issue clouds our perceptions and adversely affects our behaviors.

If we over-panel a provider intentionally we are giving him/her more work than he/she can do and the work will get deflected elsewhere. When that happens the satisfaction (intentionally) goes down, the costs go up and the clinical care and outcomes are adversely affected. If a provider sees another provider's patients, the visit will take longer due to the time necessary to establish credibility - the time it takes to establish rapport (tell me something about yourself) and the time it takes to do a history (when did these headaches start?). So the visit length is longer and the total number of visits is less.

On the other hand, if we drive all work to the patient's own provider, and ensure that the provider is not over-worked by right-sizing the panel, there will still always be up-variation days and down-variation days (some days will be fuller and some days less full). If we can absorb this variation, then we can optimize delivery, satisfaction and maximize panels. If we choose not to absorb this variation, and instead choose to either 1.) put a limit on visits, or 2.) choose to fill to

a limit, then we will create waits for patients, we will create over-flow to others and will experience the undesirable consequences noted above.

If providers realize that they live in an environment where there is 1.) a limit on visits, or 2.) that we will fill to that limit, and, in particular, if the providers are on salary, then the providers exhibit some predictable behaviors:

a. they will not report cancellations or expected no-shows since there is no advantage to them
b. they will continue to needlessly churn visits
c. they will create a mini-backlog of a few days as a protective buffer.

The choice is ours. If we choose to have visit limits or choose to have a “fill to the limit" philosophy with its inherent emphasis on visits, then we will get wait times, useless visits and high no-shows. If we choose to right-size the panel and drive the work to the individual, we will get some days of up variation and some days of down variation. If the down variation frequency is below an acceptable revenue production level, then right size/up size the panel with a conscious and intentional plan. This may ultimately require reviewing the compensation scheme.

For now, I would do an over/under:

1. Look at the last 6 months (or a part of 6 months). How many days was the provider activity below the supply and how many days above? I generally see that if the supply calls for 20 visits, for example, the likelihood of seeing 20 (activity) is about 33% and the likelihood of going over or under is 67%. Over is due to work ins. Under is due to no-shows.
2. Then move the providers, as a trial, to seeing only their own patients (and their fair share of absent providers’ work). Don't punish with over-books from any other provider. Put up with up or down variation, stay committed and then check the over/under after a time frame. The visits will stay the same or increase. If the visits are consistently below the supply line this is probably a panel issue and should be dealt with as such.

I think that there is far too much tendency to solve a defect with another defect and to look to the work not as it unfolds over time, but day by day. The focus on visits does that to us. Visits are an outcome, not a goal.

The following is a way to reconcile visits and panels.

The work in improving access and optimizing primary care delivery requires strategies to promote continuity and reduce wait times for and at services. As an inevitable consequence of the utilization of these strategies, the number of visits per patient per year will be decreased. This will make your executive director nervous. On the other hand, if you can replace those “lost“ visits per patient per year with new visits from new patients, external to the practice, or with new visits from patients with unmet needs from inside the practice (e.g. women that need PAP smears, etc.) you can either break even or actually increase the number of total visits into the system, increase your market share, create opportunity for more “mixed portfolio” of patients, pursue your mission of caring for the underserved, and improve clinical care. But to do this, doctors have to see more unique patients, and you’ll have to inspire them to this mission and support them in this regard

