Reinvention of Community Health Centers: The Movement from Visit to Panel

If we're going to build a healthcare practice or healthcare system that is successful, we have to build it around one fundamental issue: what is it that our patients want, and how can we deliver it? What our patients want is the opportunity to choose a primary care provider, get access to that provider when they want it (they don't want to wait for an appointment), and a quality healthcare experience (and they don't want to wait at the appointment). Clinical quality is assumed. But if we can't get our patients into the practice and to their chosen provider without a delay, then we have failed in the fundamental mission. Delays, both for and at an appointment, have significant adverse effects. The longer patients wait, the higher the patient dissatisfaction. The longer patients wait, the higher the staff dissatisfaction, due to frustration, rework and redundancy. The longer patients wait, the higher the provider dissatisfaction, due to frustrations in not being able to take care of their patients in a timely manner. The longer patients wait, the higher the cost of care, due to the increased rework and redundancy caused by the delay, the necessity to use precious resource to triage and sort the work because of the delay, and finally, the increased no-show rate, which is directly correlated with long waiting times. The longer patients wait, the lower the revenue in our fee-for-service components (although this is counterintuitive, there is a great deal of recent data that supports this). The longer patients wait, the worse the clinical outcomes, whether we're measuring compliance with preventive services, the care and management of patients with chronic illness, or the early detection of serious disease. Thus, the waiting time has tremendous adverse effects on system performance, and improvement in the waiting time will improve system performance in all of these areas. Waiting time improvement is the glue that holds all of this together.

Once the unnecessary waiting time, both for an appointment and at an appointment, is eliminated, then the practice needs to turn its attention to the further refinement of its operations: to care delivery models, to integration of care, etc. Once these operational issues are optimized, that is we have the right person doing the right work and in the right order, and once the basic infrastructure is built, the practice can turn its attention to explicitly improving clinical outcomes. Clinical outcome improvement can only be optimized when patients can see their own doctor without a delay, and the care team and care delivery model is focused on supporting the relationship between provider and patient. Previous efforts to improve Community Health Centers (CHCs) that focused on "redesign," which is a euphemism for operational improvement, and improvements in clinical care (the chronic care model) have been done in isolation, without access delay reduction improvements as a platform, and have therefore not achieved their full optimization or promise.

In the current CHC environment, there is a perceived contradiction and misalignment of incentive that grows out of the reimbursement methodology. The goal of our patients is simple: "I want the opportunity to choose a primary care provider. I want access to the provider when I choose, and I want a quality healthcare experience." The goal of the organization is, "I want to provide service as my customers desire, and at the same time I need to generate enough

revenue to be able to pay for it, in order to stay in business." Because the current reimbursement methodology is based on cost-based reimbursement, organizations and executive directors falsely believe that what they need to do is to increase the total number of visits into the practice. This is the best way, they feel, to guarantee the revenue in order to stay in business. They then pass this incentive on to the providers, and say to the providers, "Produce 4,200 visits per year, and produce three visits per hour." In light of this directive, and in light of the fact that the providers are reimbursed by salary, the providers' incentive then is mixed. On the one hand, there is, quite frankly, an incentive for avoidance of workload because of the salary. Secondly, there is a pressure and a directive to increase visits. The providers, feeling this tension, and after complaining about how their patients are more difficult, will often reluctantly comply by increasing visits. They increase visits by making a patient visit to a provider the final common pathway for all patient issues. For example, if a patient wants a question answered, a medication refilled, a lab test reviewed, etc., this is all done by a visit, rather than other alternative and potentially more satisfying methods of resolution. In this way, the providers can generate their visits and maintain a workload that they can feel comfortable with. The emphasis on the chronic disease model, which states that patients with chronic illness need monitoring and follow-up, then can and has become an excuse to generate more follow-up visits, because "the chronic care model" (CCM) says that I need to bring patients back very frequently. A closer review of the CCM reveals that monitoring does not equate with provider visits.

Here's the fundamental contradiction. The executive directors and the providers are, in a sense, in collusion to create visits. Visits do not equal value. Visits are a cost in the capitated environment and increased visits actually reduce potential revenue in a fee-for-service environment. On the other hand, visits generate cost-based reimbursement in a cost-based reimbursement environment. Most CHCs have varying levels of these three basic payment methodologies as part of their practices. For those with high capitated and fee-for-service components, increasing the visits has an adverse effect on the overall revenues. In addition, as the visits (visits are a manifestation of demand) go up, and many of these visits are clinically and socially unnecessary, then the waiting times rise due to the consequent mismatch of demand for appointment with supply (resource) for appointment, and delays are not addressed. In fact, the best way to guarantee that visits can be generated is by creating a waiting time - a warehouse - where patients are stored temporarily and then trucked over to the practice in order to guarantee a specified number of visits per day. This artificial creation of waiting times has, as I noted above, a tremendous adverse effect on system performance. Patient, provider and staff satisfaction is reduced; costs rise, revenues are sub-optimized, and clinical outcomes are adversely affected. Without addressing the delay as the fundamental improvement issue, CHCs will forever be sub-optimized and deliver less-than-satisfying, costly or clinically sub-optimal care.

Transformation

There is a way to resolve this perceived contradiction. If the CHCs commit to building a practice based around what their patients (customers) want: "I want the opportunity to choose a primary care provider, I want access to him/her when I choose, and I want a quality healthcare experience," then the delay issue (the access issue), will have to be addressed, since the fundamental patient issue is waiting times. In order to address the delay issue, we need to recognize that the delay represents a mismatch between demand for appointment service and

supply of appointment service. So we have to understand that, in order to build a system without a delay, we need to achieve a balance between the demand for appointments and the supply of appointments, at the organizational level, the practice level and the individual level. Thus, we need to recognize that in order to optimize performance, providers need to be positioned so that the demand for their service does not outstrip their personal supply for that service. The best way to operationalize this is to have providers of care responsible for an equitable panel of patients (the panel is that part of the practice that each provider is responsible for). The demand for appointments from that panel of patients needs to be balanced with the supply of appointments that provider can deliver. In this way, by making a commitment to a panel of patients and a commitment to continuity, that is, seeing those patients, and a commitment to no waiting times, system performance can be optimized. Providers need to have a panel that generates just enough demand and not too much demand. Patients can get what they want, staff can be satisfied, providers can get what they want, costs will go down, revenues will go up, and clinical outcomes can be optimized.

At the same time, this requires a transformation in the CHC perspective. This transformation is the change of incentive for visits (output equity - all providers deliver 4200 visits per year) to the incentive to manage a panel of patients (input equity - all providers are responsible for an equitable - not necessarily equal – panel of patients). When a practice or individual providers move from the incentive to manage or deliver a prescribed set of visits to the incentive to manage a panel of patients, the inevitable consequence is reduction of visits. This occurs because the incentive for the providers changes dramatically. When the provider is responsible for a set of patients and the patients can't wait, the incentive or the advantage for the provider becomes, "How can I comb the future schedule to look for unnecessary visits? How can I do more with each visit? How can I develop telephone treatment protocols? How can I extend visit intervals? and How can I optimize my care team?" Without the incentive to manage a panel, these activities will not occur. The inverse is also true - with high levels of discontinuity, unnecessary visits rise.

When the visits are reduced in this way there are financial consequences. In the capitated component of the practice, since visits are a cost, reduction of visits actually saves money over and above operational cost. In the fee-for-service component of the practice, the visits that are reduced are the low-level RVU visits (patients from one provider who see another provider, and vice versa). The result is that the RVU per visit that remains is much higher than the previous RVU per visit. In addition, when providers are put in a position where they have to see their own patients, and their patients can't wait, what we find is that they do more with every visit - they maximize the efficiency of that visit, and the RVU per visit rises to a greater degree than the loss of revenue from the loss of the lower RVU visits. So consequently, providers see fewer patients and generate more revenue. This increased revenue is over and above the net revenue increase that occurs due to reduction I cost. On the cost-based reimbursement side of the practice, it is clear that less visits equals less revenue. So the revenue in that component falls with less visits. On the other hand, if those visits can be replaced by other needy patients in the community, then this is a break-even proposition. So there will be some visits that are "lost," but when these are replaced by other new, unique, unduplicated patients needing service from the community, this then becomes a break-even. The challenge, of course, for the executive directors is to manage and inspire the providers to see more unique, unduplicated, new patients, so that instead of seeing the same patients over and over again, or seeing other

providers' patients and just sending them back to their own provider, the providers need to be managed, or inspired, to see more unique, unduplicated patients. In order to accomplish this, the executive directors will have to not only provide that inspiration, leadership and understanding of the overall mission, but they will also have to provide support for those doctors to be able to manage in this new way.

Thus, the reduction in visits that almost inevitably occurs, due to recognition of demand/supply dynamics at the practice and at the individual provider level and due to improved continuity which resonates strongly with our patients desires, when we address the access issue by reducing waits for service and as we move from focus on visits to focus on panel, will result in a stronger financial position. That position can be fully realized with the consequent reduction In cost, the increased revenue per visits and by replacing "lost" cost based reimbursed visits with new patients.

There are distinct advantages in a transformation to this kind of approach toward management of a panel, not visits:

1. In order to eliminate the delays (improve access) a practice will have to move toward managing a panel, not visits (if we keep doing what we're doing, we're going to keep getting what we've got). And consequently, as the transformation from visits to panel occurs and access improves, then patient, provider and staff satisfaction will improve, costs will go down, revenues will go up and clinical outcomes can be optimized.
2. There are currently approximately 16 million underserved patients in the United States. Only about 12.4 million of these are now currently served by CHCs. With the current staffing, moving from 12.4 million to 16 million is impossible. There are far too many unnecessary visits; there is far too much redundancy. The only way to be able to move in this direction is to streamline the operations and improve the overall aggregate practice panel size. The transformation to this methodology can accomplish that. When the waiting times go down, and the platform for further improvements is built, then projects like "redesign," which focus on improving the care delivery model, can finally be optimized, and clinical care can be optimized. Redesigning operations and attempting to improve clinical care without setting a platform that operationalizes patients being able to see their own providers without delay, is futile.
3. As the visits go down, the CHCs have an opportunity to grow. Not only can they grow into the underserved market, but they can also grow into the other capitated and fee-for-service components, in order to develop a more stable and diversified business structure. With growth, then the visits will rebound. The "goal" of 4200 then becomes a reality, but not as a goal but as an outcome of the correct panel size. The panel will generate 4200 visits and, at the same time, this panel will be larger.
4. As the visits go down and the continuity and responsibility for a panel increases, the movement toward self-care, self-management, and other alternatives to face-to-face visit methods and structures can be implemented (i.e. group visits, e-mail care, telephone care, care with the nurse, protocols, guidelines, and self-management).

5. As these other alternative forms of care become more predominant, the dependency and paternalism exhibited by visit-based care (all pathways lead to a visit with a provider) will start to melt away. Patients then can become more independent, self-confident, and empowered.

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