Visits are Fixed; Waits are Variable

The panel size issue is tricky:

1. The size of the panel changes each month - some patients leave, some join.
2. The acuity changes - some get sicker, some get well.
3. Some providers do more with each visit, some less.
4. Some providers bring patients back more frequently, some less frequently.

What we used to do at Kaiser - and this is common - is to try to take the patient and provider variability out of this by requiring a productivity standard. In our case, this was 25 visits per doctor per day. We got close to meeting this - most providers saw about 23 to 24 visits per day. And we could pre-rate bonuses based on visits. We finally came to our senses when we realized that first off, Kaiser is capitated so visits are cost. Each visit cost us money, so we were incenting absolutely the wrong thing.

Besides that, though, and deeper than that, we realized we were creating a culture and behaviors that were counter productive and dangerous to patients. Because we had a fixed point for visits – 25 - we shifted the variability clearly to providers and patients:

1. Panels were extremely variable: some providers had large panels and 25 visits while others had small panels and 25 visits.
2. Visit rates were extremely variable: some providers' patients returned nine times a year, others 2.1 times. Incidentally the patient satisfaction was no higher with the nine times a year providers.
3. Continuity was variable - some providers saw their own patients, some did not.
4. Satisfaction was highly variable and not correlated to panel size or visits. But satisfaction was correlated to continuity.
5. Cost per provider was extremely variable - some providers cost 10 times more than other providers. But the visits were the same!
6. Clinical care was highly variable - preventive screening rates and management of patients with chronic illness was not correlated to number of visits, to panel size, to satisfaction, or to visit rates. It was correlated to continuity (patients seeing their own provider).
7. Waiting times - which correlated to satisfaction, cost and clinical care (short waits improved all these measures) - were highly variable as well

So we said: **see your own** (which improved clinical care, satisfaction and cost) and **don't make them wait (**which improved clinical care, cost, satisfaction). But to do that we had to give up a focus on visits. Then in order to make sure that the providers had enough work to do (and enough visits to pay for the enterprise) we had to monitor panel size.

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We told the providers we would not monitor number of visits any longer, but that they had to see their own patients and not make them wait. Visits then were a tool to get the work done and, counter intuitively, the visits either stayed the same or went down. In that environment, fewer visits became the reward for doing a good job with the panel. How can we reconcile this with a pay by the visit-based system?

1. First, not all patients are pay by the visit. There is a mixed portfolio of customer types. The reduction of visits makes sense in capitation and in the low value visits in RVU based systems
2. We can raise panel and visits will rise. One correlates clearly with the other
3. To achieve a balance of just enough visits to pay the rent, but not so much as to burn out the doctors or destroy incentive, we need to
    a. inspire the providers to the mission of the practice and
    b. give the providers the support needed to accomplish this.

Ultimately we need a clear partnership between enterprise and providers in order to walk that fine line.

I think it is tough to open and close panels. Panel size does change monthly, so I think we need to either re-calculate each month or have an automatic report from the provider field that gives us a monthly running panel. Then we know who is rising, who is falling and who is the same.

I think it is valuable as well to see provider variability: not just in panel but in visits, in visit rate etc. This helps to normalize and standardize behaviors and helps us to discover the best way to practice. Does it help diabetic care to have ten visits per year? Does it hurt outcomes to have one visit per year?

I also see a problem if we can see that two providers are clearly over-paneled and one is not and all the new patients go to the one with lowest panel. But this creates an expanding wait time for these new patients. Actually what I would do is to get "non-provider" type work away from the over-paneled providers, get them some small space to see new patients and at the same time, eliminate the new patient appointment limit for the under-paneled provider (the new patient wait time is in part due to a restriction on the number of new patients permitted on the schedule template). And I would get rid of the wait time for all patients. There is a backlog here. All these issues are moving at once so it takes some time, some patience, some persistence and a committed plan.

The no-shows are an issue:

1. No-shows are directly related to wait time for an appointment
2. No-shows are related to loyalty
3. No-shows are related to the trade off of patient need and expected experience (“if I have to wait 4 hours, I can't do it.”)

- With regard to "budgetary restrictions," are you required to pay a set base salary? If you don't, will you be adversely affected in recruitment?
- Do you have a required budget per provider or is this discretionary? Could you have a set salary at 80% of current and then "allow" increases above the current 100%? Anything over 100% has to be paid for by reduced cost or increased revenue.

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