

## **PANELS AND PANEL EQUITY**

Our patients are very clear about what they want:

- the opportunity to choose a primary care provider
- access to that PCP when they choose
- a quality healthcare experience
- a good value for their health care dollar

World class access is requires optimal continuity and sufficient flexible capacity to respond to our patients' desires. The best access systems make continuity a system property and reduce backlogs to open the capacity on the provider's schedule. In addition, appointment types and times often are reduced in order to reduce excessive triage, queues and delays for appointments. Appointment types are changed from sorting by clinical condition to sorting by the presence of absence of the chosen PCP or specialist.

Once backlogs are reduced, in order to keep demand and supply in equilibrium, contingency plans are introduced to maintain the daily equilibrium and unnecessary visits are reduced to maintain that equilibrium over extended time.

Just as these principles work for an organization or a practice, they need to work for the individual providers. If demand is truly greater than supply (a provider or practice has exhausted all methods to reduce demand and increase supply both appropriately and effectively), then this mismatch is ultimately dangerous for the practice. We have found that in most practices demand and supply are in equilibrium. Occasionally they are not. When this occurs in the organization as a whole, the organization cannot keep up with the demand and backlogs or deflections of patients occur. When this occurs in an individual practice, patients overflow to practice partners and this has potentially serious consequences.

Backlogs are not the best method to determine if demand is greater than supply since often the backlog is stabilized indicating equilibrium. Hence, we need better methods to determine demand and supply. We recommend the determination of daily true demand over time for each PCP and the department, with a comparison to the potential supply in the practice and an analysis of the deployment of that supply to meet the predicted demand by day of week.

### **DEMAND AND PANELS**

An important factor in the determination of demand is the size of the panel. The panel size does dictate the demand that is created external to the practice itself. Other factors include:

- Mood and attitude of a population (do our patients trust us to provide appropriate care when needed or desired?)
- Scope of the physicians practice. Is this a full service practice or are there restrictions?
- In addition to the external determinants of demand there are internal factors as well: primarily the internally generated visit return rates and the individual style of the PCP.

In order for a provider to see her patients when they choose, she must have a panel size that permits and facilitates that. Thus, panel size and a “right-sized panel” are crucial determinants of access success. An “over-full” panel with its consequent demand creates false expectations in the market for our patients and may make the task of the physician and her support team impossible. When panels are “over-full” and patients are systematically deflected to others in the practice or to other venues for care (Urgent Care or the Emergency Department), patient satisfaction cascades downward as does provider satisfaction while costs and rework increase. In both capitated and fee for service models, the effect is the same: more unnecessary visits due to mismatches, less satisfying visits for both providers and patients alike, more unnecessary tests, less valuable visits, and growth opportunities for the practice are constrained. The effect of deflections within a practice is also harmful as the other providers on the team observe the over-full provider’s patients filling their schedules with less than robust visits, generating lower RVU’s and making it difficult for them to see their own patients or growing their own panel.

Thus, some degree of panel equity is essential for successful and sustainable access improvement. An “over-full” panel harms the over-full provider as well as the practice partners and patients.

## **PRIMARY CARE PANELS**

In some cases the determination of panel is relatively easy; calculate the number of enrolled patients or members. In other environments, primarily fee for service or mixed payer models, the task is more complex. We have found that determining the number of unique patients who have accessed the group within the last 18 months is the best surrogate measure. Unique patients reflect the number of unique individuals who have accessed any one of the providers within that time frame. The number of actual visits is not important in this calculation since we are looking at volume of patients served not volume of visits.

With this determination, a baseline “target panel size” can be derived by dividing this number by the number of full time equivalent providers. Key discussions should include decisions about how to calculate for non-physician providers and the determination of what constitutes a full time PCP equivalent. If demand and supply are in equilibrium this target panel size calculation then helps a practice determine which providers are potentially over-full and which providers have room to grow their panels.

At the level of the individual provider practices, demand as determined from the panel size, can be calculated and compared to the expected supply. This allows us to identify potential mismatches in demand and supply. Keep in mind that demand arises externally from the population of patients (panel) that has chosen this provider and internally by the PCP’s practice style and the rate and frequency of return visits.

Thus, calculations of demand are directly related to panel size. In a system where providers are expected to do all today's work today for their panel and there is PCP accountability for quality standards, identification of panel is crucial.

When determining panel size there are important considerations:

- **Panel Adjustments.** Demand from a panel of 2000 eighteen year olds is quite different than demand from a panel of 2000 eighty year olds. We recognize that at the level of the individual practice, a panel determined by baseline number of patients alone may not be sufficient. Thus, for panel equity and accountability, adjustments may be made to the base panel number. For example, the application of adjustments based on age and gender have been used by many groups to more accurately reflect projected utilization and activity. An example is attached.

At the level of the organization or department adjusted panels need to be equal to the number of patients. If they are not, it is extremely difficult to compare one practice to another. In this situation where "credit" is given for specific characteristics of the population without having the adjusted panels equal the patient panels, the adjusted panels numbers quickly become inflated and useless. There are simple mathematical calculations that ensure a zero sum panel adjustment: age and gender cells are determined (males 0-11 months, for example), visit rates over a determined period of time are determined for each cell, these rates are divided by the overall average visit rate to give the relative risk of utilization number for each cell and then patients in these cells are credited to each provider according to the aggregate numbers from the accumulated cells. In this way total patients equal adjusted patients and a relative panel based on risk of utilization is derived. A target panel of adjusted patients can be determined as described above and the over full and under filled providers are identified.

We have found that the simplest adjustments are the best. Adjustments for age and gender capture most of the risk for outpatient utilization. Other adjustments in addition to age and gender can be made but must be made equitably for the entire practice or organization.

- **Scope of Practice.** When determining the "correct panel size" for a PCP, the scope of a provider's practice may be an important consideration. Providers with a broader scope of practice may require a smaller panel. For example a PCP practice that includes obstetrics.
- **Time in the Office.** Individual panels should be adjusted for time in the office. For example a 0.6 clinical FTE should have a 0.6 panel.
- **Help in the Office.** Those offices that provide additional assistance for the providers (extra exam rooms, an EMR, technology, more support staff, staff that directly help in the management of patients such as behaviorists, diabetic educators, case managers, etc) often find their PCP's can manage a larger patient panel.

## PANEL EQUITY AND COMPENSATION

Up to this point, we have assumed that we need to create panel equity within a practice. In practices where PCP's are paid a fixed salary (with consideration given for some minor oscillations for tenure within the Medical Group, some variable pay based on patient satisfaction, some "quality" considerations etc), generally, panel size and access expectations have been allowed to float. We have found both capitated and many fee for service organizations compensate their providers with a relatively fixed salary. In these environments, practice style often determines workload; the provider has a fixed salary and a fixed encounter expectation. The number of patient visits and patient return rates are provider driven, ("my patients are sicker and take more time, therefore, I can only see 18 patients in a day" or "my patients are sicker and need to come back more often than others"). When an access standard is introduced and fixed; *do all today's work today*, the equation changes. With a fixed salary and now a fixed access expectation, the panel needs to be fixed against it. Thus, panel size is not only crucial operationally but optimally is equitable. Practice style then is forced to float; a provider's patients may be sicker and come in more often but that provider will see all that call today. Thus, equitable and agreed upon panel adjustments must be introduced.

In environments where salary has been allowed to float, variable pay based on "productivity" of either encounters or other surrogates such as RVU's or revenue production-then the panel size can float as well, even if the access standard is fixed. Some providers either want to or have the skills to effectively manage a larger panel of patients. A word of caution; all systems of production incentive based purely on encounters, either in capitated environments or in fee for service salaried practices, tend to increase visits and increase low value RVU visits or unnecessary visits within the system. Increasing unnecessary visits and low value RVU visits have adverse effects on access improvement filling future capacity and stifling growth. One of the high leverage changes recommended for access improvement is the reduction of unnecessary visits. In managed capitated environments this makes sense. In fee for service environments where the production incentives are based directly or indirectly on RVU, the incentive to reduce demand for unnecessary visits still holds. When unnecessary visits are reduced and each visit is maximized in its efficiency (do more with each visit), then the RVU value of each visit increases. With the reduction of total visits, more capacity is opened for new patients who bring a higher value RVU. In incentive systems where the volume of encounters is rewarded there is no incentive to reduce unnecessary visits. Under these circumstances both access improvement and the management of individual panels becomes difficult. Incentives are not aligned.

Thus, if an access standard is fixed within an organization and salary is allowed to float, then the panel size does not have to be equitable but, in fact, can be chosen by the provider based on her determinations of personal supply, desire and skill. In addition, to ensure balance, we have seen successful groups set an access standard and combine it with a patient satisfaction standard, and clinical quality standards (compliance with prevention guidelines, measures of other clinical quality indicators). In these kinds of settings a PCP is "paid" for an adjusted panel size while maintaining access, patient satisfaction and clinical quality standards set by the organization. Quality, access and patient satisfaction are a given expectation, within the context of a panel.

One of the choices for someone not meeting these standards might be a reduced panel size and consequent reduced compensation.

Groups are advised to identify an acceptable panel range for a PCP. This range would include a lower limit of panel size to assure the group that every PCP is managing a panel large enough to support their presence within the group.

## **RIGHT SIZE THE PANEL**

If a PCP has an over-full panel this can place a serious drag on the practice. Here is some strategies to right size the panel:

### ***Soft Strategies:***

- Close the panel and let the natural attrition take its course. This can be difficult for payers and others. On the other hand, an over-full panel helps no one. Many groups have found creative methods to overcome this barrier.
- Preclude the over-full provider from seeing any patients from either the absent providers ( T appointments) and any patients from outside the practice ( N appointments )
- Provide more assistance to the provider. Effective assistance strategies include; more exam rooms, more clinical/medical assistant help, more RN support, dictation, and help with tasks that could be done by a non-physician.
- A script for patients of the over-full provider who see a new under-filled provider in the practice. This would occur when the over-full provider is gone. This script might softly encourage those patients to switch PCP's and can be used at the time the appointment is booked and when the patient comes in for their appointment.
- A letter to patients of the over-full provider informing them of new providers in the practice. This letter simply announces the new PCP. Some patients will opt to be re-assigned for a variety of reasons.

### ***Hard Strategies:***

- Formulation of a plan to move patients from the over full panel to others in the practice. A direct conversation with patients of the over-full provider during the transition to ease the switch.
- A letter from the over-full provider to her patients stating that "I have taken on new responsibilities and have made the difficult choice to reduce my practice". Giving patients some choice about who they might empanel with or advising them of a colleague in the practice you have chosen, can be accomplished in this letter. Keep in mind that PCP's and their patients have a very tough time with this option. It should be used as the last option if the preceding strategies have not been sufficient.

**SUMMARY**

Understanding and analyzing individual panels is a critical issue. Right sizing panels is often necessary when balancing the workload for a busy practice and to ensure we are able to meet our commitments to patients for access, quality care and a satisfying healthcare experience. Below is a simple Age and Gender Panel Adjustment methodology referred to in this paper.

**WEIGHTED PANEL ADJUSTMENTS**  
**Age and Gender**  
**Methodology**

Historical visit activity was used to develop a formula to apply age and gender weighted adjustments to Primary Care panels. The formula works in such a way that the total of individual patients equals the number of "adjusted" patients. This method is called a zero-sum gain. .

Keep in mind these are weighted adjustments. They do not indicate actual visit frequency or utilization.

Age and Gender Specific Panel Adjustments				
Age Range	Age (Mos)	Rel. Wt.	Male	Female
0	0	11	5.02	4.66
1	12	23	3.28	2.99
2	24	35	2.05	1.97
3	36	47	1.72	1.62
4	48	59	1.47	1.46
5-9	60	119	0.98	1.00
10-14	120	179	0.74	0.79
15-19	180	239	0.54	0.72
20-24	240	299	0.47	0.70
25-29	300	359	0.60	0.82
30-34	360	419	0.63	0.84
35-39	420	479	0.66	0.86
40-44	480	539	0.69	0.89
45-49	540	599	0.76	0.98
50-54	600	659	0.87	1.10
55-59	660	719	1.00	1.20
60-64	720	779	1.17	1.31
65-69	780	839	1.36	1.46
70-74	840	899	1.55	1.60
75-79	900	959	1.68	1.70
80-84	960	1019	1.70	1.66
85+	1020	9999	1.57	1.39
			1.57	1.39

Advanced Access Information Series  
Tantau & Associates  
ctantau@gv.net