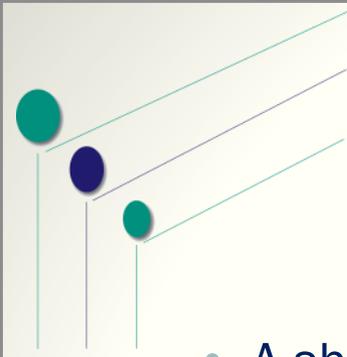




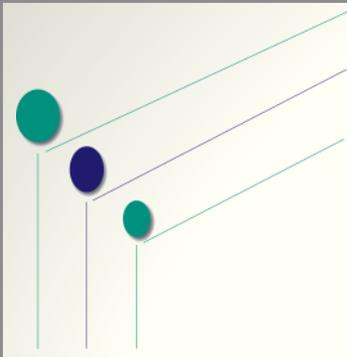
Developing Appropriate Size Community Health Center Primary Care Provider Panels

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Introduction

- A shift from **quantity** to **quality**
 - Currently patients receive **only 55%** of chronic & preventative services
- Transition from pay per service to pay for performance
 - Quality will be the focus instead of procedures and encounters
- Affordable Care Act will likely increase demand on PCPs
- Providers with complex patients will not have the same capacity as providers with less complex patients
- Movement to Primary Care Medical Homes (PCMH)



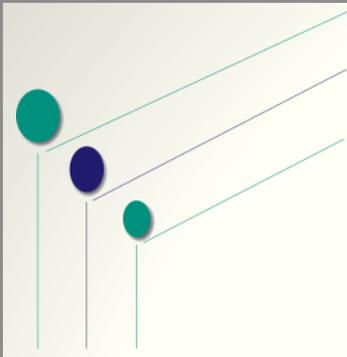
Background

- According to a recent Duke study, approximately 20 hours/day would be required for one physician to provide acute, chronic and preventative care for the average provider panel in the US
- Primary Care Workforce in the US is limited despite great need with increasing needs in the affordable care act
- Need a more efficient system: better quality and increased cost effectiveness
- Altamed's goal: To provide quality care without exception
 - Increase physician capacity without creating more burnout
 - Determine the best use of mid-levels
 - Design an leading model in primary care for optimal patient satisfaction and outcomes



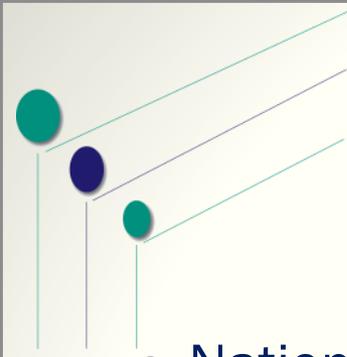
Methodology

- Literature search for Case Mix Adjustment & Primary Care Provider Panel Size
 - Cochrane Review
 - Geisinger
 - AHRQ
 - Institute for Health Improvement (IHI)
 - National Committee for Quality Assurance (NCQA)
 - Kaiser
 - California Academy of Family Practice
 - Health Care Partners
 - Community Clinic associates of California
 - Center for Primary Care Prevention
 - Pub med
 - ETC
- Contacted experts from many of the organizations above for direction
- After conducting this wide search the best sources were **AHRQ**, **IHI** & some primary literature via **pubmed search**



Why not just fill a providers schedule with as many patients as possible?

- Limiting panels allows clinics to offer good care in a timely manner to your patients
- Must have a goal number for good panel management
 - Good panel management= clinicians and their teams feeling responsible for their population
- If **demand** of the panel **exceeds** provider capacity than **access is compromised**
- Equitable division of labor insures good care in a timely way to a reasonable number of patients



What is the appropriate PCP panel size?

- National average is around **2300**
- **PCMH:**
 - Veterans Administration decreased panel size from about 1200 to **1000**
 - Group Health Cooperative piloted PCMH and found that decreasing panel from 2327 to **1800**, increasing average visit time from 20 to 30 minutes while increasing alternative communication methods with patients via email and telephone
 - Patients cost went down (ED, in patient, specialists and clinic)
 - Satisfaction went up
 - Care coordination agreements can decrease the cost of specialty appointments

Recent Duke Study

Nondelegated Model (Panel=983)

Delegated Model 1 (Panel=1,947)

Delegated Model 2 (Panel=1,523)

Delegated Model 3 (Panel=1,387)

Type of Care	Time Delegated %	Hours per Patient/Year						
Preventive	0	0.71	77	0.16	60	0.28	50	0.35
Chronic	0	0.99	47	0.53	30	0.70	25	0.75
Acute	0	0.36	0	0.36	0	0.36	0	0.36
Total	–	2.06	–	1.04	–	1.33	–	1.46



Duke study continued

- Panel size estimates with delegation were 1947, 1523, or 1387 depending on the aggressiveness of delegation
- The study used panels representative of the general population without accounting for different mixes.
- The model did not take into account using midlevels who could assist in more preventative care such as papsmears etc.
- Without delegating 1 physician can care for approximately 1000 patients



Design of the PCMH is key

- Mid-level providers should be part of the team, not leaders of the team
- According to the American Academy of Family Practice, Nurse Practitioners are
 - Cost effective for treating common common problems
 - Health maintenance
- The evidence suggests that nonphysician clinicians working as substitutes or supplements for physicians in defined areas of care can maintain and often improve the quality of care and outcomes for patients. The effect on health care costs is mixed, with savings dependent on the context of care and specific nature of role revision.



Improving Access & Provider Capacity

- Well-designed care teams
 - Mid-levels in appropriate roles
- Payments for coordination of care
- Computer based care
- Other tools to facilitate non-visit care and self directed care
- Alternative models of care
 - Group models
 - Centering
 - Pregnancy
 - Parenting
 - Geriatrics

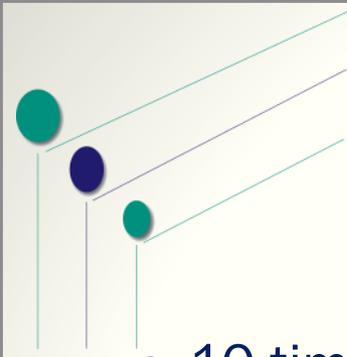
LARGER PANEL SIZE IS NOT MENTIONED!!

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- Researchers calculated that in 2008, an estimated 206,369 primary care physicians provided office-based primary care. That's one practicing primary care physician for every 1,475 persons. Primary care physicians averaged 2,237 patient visits each that year.



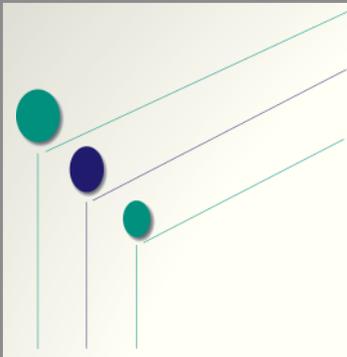
Factors to Consider with Risk Adjustment of Provider Panels

- Women make more visits than men
- Older adults= complex
- Insured individuals visit more than uninsured
 - Men or more likely to be uninsured



Strengths and weaknesses of different models

- 10 times Better than just age-sex adjusted
 - 3 models
- Hochman/Covas
 - Blue cross blue shield
- Kaiser model with prescriptions
- HCC scores



How can Altamed adjust for providers with more complex patients?

- Gender
- Language
- Substance use
- Prescription as proxy of complexity
 - Will this work for pediatrics as well?



Advantages of Case Mix Assessment Tools

- Fairer measurement of differences in expected resources
- Support internal plan management
- Provides a common language for clinicians, actuaries and managers to discuss utilization issues
- Enables a credible response to providers with more complex patient panels

Common ways to adjust panels:

- Age-sex
- Power of these models to explain variations in resource utilization is about 10 times greater than age-sex alone:
- Adjusted clinical groups (ACGs)
- Diagnostic Cost Groups (DCGs)
- Episode Risk Groups (ERGs)



Things not adjusted for as of yet

- Social determinants of health
- Provider variability



How can panels be altered in the least disruptive way to improve access?

- No need to reallocate abruptly
- Incremental changes as people leave could easily be accomplished
- Have front desk freeze providers who are over capacity
- Patient surveys could be used to determine preferences
- Change to another physician who the patient has seen almost as much as their own PCP or possibly to one in the same care team



Discussion

- There are many different ways to define panel sizes for providers
- Analyze findings, questions raised, further research possibilities, and possible tangible results of findings



Altamed Mission

- **Mission**

- To eliminate disparities in health care **access** and **outcomes** by providing superior quality health and human services through an integrated world-class delivery system for Latino, multi-ethnic and **underserved communities** in Southern California.

- **Vision**

- To be the **leading** community-based provider of quality health care and human services.

- **Core Values**

- **Patients** always come first.
- **Employees** are our most valuable asset.
- Encourage process excellence and **innovation** for quality outcomes.
- **Promote wellness** and advocate for strong and healthy communities.
- **Integrity, honesty and respect** in all of our endeavors.
- Commitment to **teamwork**.



Recommendations

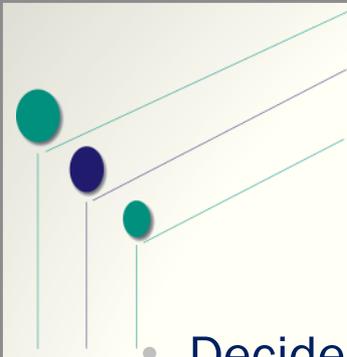
- What do I think would be best... Recommendations for site, patient population, etc based on findings
 - Smaller panel size, 1500-2000, depending on how much can be delegated based on the Duke study , after adjusting for gender-age, complexity....etc.
 - Cost effective to reduce size...
 - Recommend how to adjust...

- Smaller panel size increases patient and provider satisfaction and Altamed will actually compete with other private docs with ACA



Conclusion

- Panel sizes should be designed for optimal population health at decrease cost
- Provider panels should be manageable
- Factors to consider are
 - Delegating tasks to nonmedical providers
 - How to use midlevels
 - Alternative innovations to increase panel size



Next Steps

- Decide on goal provider panel size
- Decide on factors to use for adjusting panels
- Calculate provider panels
- Distribute the following to providers:
 - Current panel size
 - Goal panel size
 - HEDIS stratification of provider panel size
- Innovations
 - Hire more physicians and midlevels to address the needs gap
 - Use innovative models and create more (centoring & group visits) to increase capacity
 - Lead the research behind panel size adjustments for social determinants of health in hopes to push for increased reimbursement for dealing with the more challenging populations
 - Community health improvements



Acknowledgements

- Dr. Hochman & Dr. Rodriguez for their advise and support
- IHI ...
- Resources available upon request..?