CDCI HEALTHCARE CURRENTS
Addressing Pertinent Issues for Community Health Centers
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ASSIGNED PATIENTS BUT NOT SEEN – WHAT DO WE DO?

Is Your Health Center Set Up to Earn Pay for Performance for Good Quality of Care Scores?

Who are a community health center's patients? Seems like a simple enough question. We could use the UDS definition, of individuals seen in a calendar year. Or we could use paneling guidelines of patients seen in the last 18 months by a particular provider, or even the CPT definition of patients seen in the last three years. Perhaps we could subtract from the list patients who have moved, died, have been discharged from the CHC, or who have requested that their chart be sent to another primary care provider.

But what about patients that have been assigned to a health center by a managed care company, even though the health center has never seen the patient? Some Health Centers report they have not seen as many as 70% of assigned patients. But, are they patients of the health center? It depends on who you ask. A health center that has limited provider capacity and a long wait time for appointments could argue that operationally and missionally it doesn't make sense to consider those patients as health center patients. The managed care company would argue that they are the health center's patients, especially if they are paying capitation for the patients.

While there may be disagreement today, we can all see that the future of healthcare is moving towards the health center being responsible for all patients assigned to it. Health centers will be expected to practice population health, that is caring for a population, not just patients who request service. And it's clear that the measurement systems for any form of pay-for-performance, including HEDIS-based systems, will be based on the clinical quality and total cost results of that entire assigned population. Some FQHC Alternative Payment Methodologies also rely on total assigned patients.

"Even with these considerations, the goal is NOT necessarily to have a visit with each assigned patient," according to Eric Henley, MD, Chief Medical Officer of Lifelong Health Center in Berkeley, CA. "Generally a health center's visit capacity would not allow for this increase in volume, all the population doesn't need to be seen every year, and while we may want to see many of our members for an annual health maintenance visit, we know that doesn't happen in real life." Therefore, according to Dr. Henley, it is possible to stratify the assigned members ordered by urgency, as follows:

Assigned Patients by Urgency

Patient Category	Patient Type	Action Plan
TIER 1*	ER Patient – High Risk Condition or Hospitalization Required	Patients should have priority to be seen quickly, and there should be a follow-up program to keep them well and prevent re-admission. This group would NOT include patients presenting in the emergency department for low risk conditions, such as a sprained ankle.
TIER 2	Patients with chronic disease needing regular follow-up	Note that there are patients who are acutely ill who should be a priority, but they will probably seek care on their own
TIER 3	Patients who are well, but need a health maintenance service.	Patients are determined by age and gender. Care would include child examinations, pap smears, blood pressure checks, diabetic exams, cancer screenings, and immunizations.
TIER 4	Unwell, but do not need to be seen by a provider	

* Data comes from the managed care organization (including an IPA or MSO) or directly from the hospital itself, either as part of a discharge planning program, or some other notification process (generally this is easier for inpatients than ED patients).

Once the assigned not seen patients are stratified using the methodology listed above, staff would outreach to them to bring them in. Presumably this task would include verifying contact information; which, in a Medicaid managed care

environment, may be challenging. With limited resource, the health center should first concentrate on Tier 1, and move to Tiers 2 & 3 once all Tier 1 patients are addressed.

On a related issue, would it be a reasonable expectation of a patient centered medical home that every patient be "touched" at least once a year? This could include something as basic as a Medical Assistant calling them to ask them how they are. According to Dr. Henley, Lifelong's long-term goal is to provide some 'limited' contact to Tier 4 patients. Currently, all newly assigned managed care Medicaid members get a letter from Lifelong welcoming them and describing how to access health center systems, but no outreach beyond this. The care model might include that Tier 4 patients come to the clinic, for a nurse visit or lab test.

CHC Survey Question: Do you get real-time results from your partner health systems on emergency department utilization? Share your answers at curt@degenfelderhealth.com

Look for the next CDCI Healthcare Currents to address, "How to run your numbers - the ACA Impact."

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