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Caseloads, Time, and Quality of Care

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Introduction

The incentive under capitation is to carry a high caseload of patients because the accountable care organization ("ACO") is paid on a per person basis. Accordingly, at least one self-identified ACO in Massachusetts provides financial incentives to clinicians who see more patients and otherwise evaluates clinicians based upon the number of clients seen per week ("productivity"). As caseloads increase, the time that clinicians spend with their patients is reduced. This necessarily diminishes the quality of care.[1, 2]

Caseloads and Time

Research confirms the intuitive conclusion that the incentive to see more patients under capitation results in a reduction in individual medical attention. In a study that compared high-

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[1] One of the key factors in misdiagnosis and hence malpractice claims is a failure of communication; one article cited the time pressures that clinicians operate under in ambulatory settings. S. Hardeep & S. Weingart, *Diagnostic Errors in Ambulatory Care: Dimensions and Preventive Strategies*, 14 Adv. in Health Sci. Educ. 57–61 (2009).

[2] High caseloads can cause other problems as well. "Mental health advocates argue that…when patients cannot access care on a timely basis from mental health experts in a health plan's network of providers, they may have to go outside the network where typically they pay more out-of-pocket or they go without needed care." (K. Swartz, *Cost Sharing: effects on spending and outcomes,* Research Synthesis Report No. 20 (Dec. 2010) www.policysynthesis.org at 5. If high caseloads are the norm, there is a potential for delays in accessing care. If a person must go out-of-network, without sufficient protection of consumer choice, that will lead to higher consumer costs or the lack of needed care.

volume and low-volume physicians, "high-volume physicians had visits that were 30% shorter."[3] In another study, researchers who analyzed 46,320 doctor-patient visits found that shorter visits are associated with capitation, even after controlling for HMO enrollment status, race, and location.[4] There is little question that incentives inherent in prepaid plans result in a reduction of time spent with the patient.[5]

Time and Quality of Care

Not surprisingly, high caseloads and the concomitant lack of time to adequately provide services affects quality of care and outcomes.[6] The impact of these incentives is particularly severe for mental health patients. Under revisions imposed by MassHealth's capitated mental health manager, the time allotted for a standard medical management visit was reduced to 15 minutes (the former standard was 30). In this ¼ hour, Medicaid recipients must report their current mental health status, including reactions to current medications and personal factors that might be affecting their health. They also must receive information about new medication, how to administer it and potential side effects. This obviously leaves little time for questions or for the patient and provider to develop the sort of rapport that is so important for the successful treatment of persons with mental illness.[7]

Impact on patients' health resulting from shorter visits is hardly theoretical. Researchers linked the inappropriate prescription of anti-inflammatory drugs with shorter office visits.[8] Patients that

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[3] S. Zyzanski et al., *Trade-offs in High Volume Primary Care Practice*, 46 J Fam. Practice 397-402 (1998).

[4] H. Balkrishnan et al., *Capitation Payment, Length of Visit, and Preventive Services*, 8 Am. J. Managed Care 332-340 (2002). *See also,* E. Geraghty et al., *Primary Care Visit Length, Quality, and Satisfaction for Standardized Patients with Depression,* J. Gen. Intern Med. 22(12):1641–7 (practicing in an HMO was a key factor in shorter visits).

[5] K. Wells et al., *Detection of Depressive Disorder for Patients Receiving Prepaid or Fee-For-Service Care*, 262 JAMA 3298 (1989).(Prepaid plans also generally provide "incentives to clinicians to reduce services per patient.")

[6] F. Davidoff, *Time,* 127 Ann. Intern. Med. 483-485 (1997).

[7] M. Doherty et al., *Levels of physician involvement with psychosocial concerns of individual patients: a developmental model*, 25 Fam. Med. 337-42 (1993)(practitioners' involvement with patients' psychosocial concerns increased with length of visit).

[8] R. Tamblyn et al., *Unnecessary prescribing of NSAIDs and the management of NSAID-related gastropathy in medical practice*, 127 Ann. Intern. Med. 429-38 (1997).

had high-volume doctors had lower up-to-date rates of preventive services, and scheduled one third fewer patients for well care.[9] One study found that drug treatment programs with a lower ratio of counselors to clients are associated with better drug use and crime outcomes.[10] In another study, researchers linked shorter visits to lower rates of detection of depressive disorders.[11]

Both providers and clients are harmed by high caseloads. A review of child welfare worker studies demonstrated that high caseloads can cause burnout, which in turn leads to staff turnover and poorer case outcomes.[12] Staff turnover is particularly problematic with respect to behavioral health care where the success of treatment is dependent upon the therapeutic alliance between the clinician and the client.[13] Ironically, the same profit-driven systems that promote high caseloads will suffer from the effect of high caseloads. With higher staff turnover and consequent loss of continuity of care, pre-existing knowledge of the patient is lost and more time is required for the clinician to provide care.[14]

Higher caseloads also negatively affect patient and family satisfaction with the provider. Providers with high caseloads scored lower on measures of satisfaction and the doctor-patient relationship.[15] In a study of social workers working with families in intensive care unit palliative care, workers with larger caseloads were rated lower.[16] Although "physicians with high-volume practices are more efficient than those with low-volume practices in providing similar services in a shorter amount of time, this greater apparent efficiency may come at a cost of lower rates of

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[9] Zyzanski, *supra* note 3.

[10] M. L. Prendergast, D. Podus, and E. Chang. *Program Factors and Treatment Outcomes in Drug Dependence Treatment: An Examination Using Meta-Analysis*. Substance Use & Misuse, 35(12-14), 1958 (2000).

[11] Wells, *supra* note 5.

[12] *High Caseloads: How do they Impact Delivery of Health and Human Services*? Social Work Policy Institute: Research to Practice Brief, Jan. 2010.

[13] D. Martin et al., *Relation of the Therapeutic Alliance with Outcome and Other Variables: A Meta-Analytic Review*, 68 J. of Consulting and Clinical Psychology 438-450 (2000).

[14] Davidoff, *supra* note 6.

[15] Zyzanski, *supra* note 3.

[16] A. J. McCormick et al., *Improving Social Work in Intensive Care Unit Palliative Care: Results of Quality Improvement Intervention,* 13 J. Palliat. Med. 297-304 (March 2010).

preventive services delivery, lower patient satisfaction, and less positive doctor-patient relationship." [17]

Summary

Capitated systems of care encourage high caseloads and a reduction in the amount of time clinicians spend with clients. This reduction in time results in poorer quality care and reduced patient satisfaction, as well as stresses on the providers themselves. Reasonable caseload and normative patient visit standards will improve quality of care and might even, when all factors are considered, promote efficiency.

[17] *Id.*