

# The Primary Partnership

Working with GPs to transform care

RESEARCH REPORT

## Look inside for:

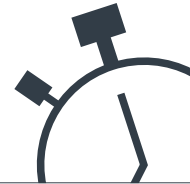
- An overview of the current state of primary care
- Strategies to form a cohesive and robust partnership with primary care
- Best practices to work alongside GPs to transform the primary care model
- An in-depth case study on one of the world's leading population health organisations

TOPIC

# Primary care

READING TIME

**1.5** hr.



BEST FOR

Chief executives  
and strategy  
directors

## RECOMMENDED PREP

Have your computer available to download related resources and tools available at [advisory.com/gfhi/primarycare](https://advisory.com/gfhi/primarycare)

## LEARN HOW TO

- Understand and approach the challenges surrounding primary care
- Build a foundation to partner with primary care organisations
- Work together with general practitioners to transform primary care's delivery model
- Implement advanced primary care model best practices

# The Primary Partnership

Working with GPs to transform care

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RESEARCH REPORT

# Global Forum for Health Care Innovators

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# The Primary Care Partnership Mandate

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## Primary Care No Longer Centre of Health System

Modern health care began with general practitioners (GPs) serving as the first line of care for patients. Over time, however, an explosion of medical knowledge and technological advances led to the aggressive growth of the modern hospital—one of the most complex organisations on the planet and, for many people, the physical embodiment of health care as they know it. Emergency departments became one-stop shops for care, and patients began seeking basic care in hospitals instead of in the community.

## Hospitals and GPs Struggling Alike

Now hospitals are struggling to meet a demand they were never designed to manage. To meet the mandates and budget pressures they face, providers and systems need primary care to manage the majority of patient care in the community and refer only the most appropriate specialty patients to the hospital.

But the current primary care model cannot handle this additional demand and meet the needs of today's patients. Primary care clinics are often too small and/or busy to deliver either the team-based care that complex patients require, or the immediate access that patients of all complexities increasingly demand.

In short, primary care is in need of reform. However, it often lacks the resources necessary to change on its own. Hospitals and health systems benefit from scale and scope that can support such change, and they can partner with primary care to drive true transformation.

## Two Steps to Partner with Primary Care

Though engaging in this work is complex and ambitious, this research provides a framework that organisations can follow to form resilient, long-lasting partnerships with GPs. This will result in a primary care model that is able to adequately care for patients in the community.

### Master Partnership Fundamentals

*Lay the foundation for a partnership with primary care*

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Hospital, health system, and commissioner executives must first assemble the building blocks of a successful partnership with primary care by understanding one another, defining shared goals, developing a partnership plan, and aligning incentives accordingly.

### Accelerate Primary Care Transformation

*Pursue a primary care delivery model that is fit for purpose*

---

Once a partnership is formed, organisations must work alongside GPs to transform the primary care delivery model. Initial efforts involve increasing primary care access points and expanding the primary care team, with more advanced steps that may follow.

## ▶ Introduction




“One thing we’ve heard time and time again from our GPs is: **Don’t ask us to fix the system until you help us first.**”

*Head of Primary Care Strategy,  
NHS<sup>1</sup> CCG,<sup>2</sup> United Kingdom*

# The State of the Primary Care Partnership

In recent years, primary care has shot to the top of health care executives' agendas around the world, and for good reason. With mandated performance targets for quality, cost, and access becoming standard as populations age and chronic disease worsens, hospitals are under more pressure than ever. Because of this, a hospital's relationship with primary care is now much more of a concern than it has been in previous decades. To run effectively, public hospitals need primary care to manage chronic patients, and private hospitals need general practitioners (GPs) to refer specialty patients to them. Not to mention, commissioners depend on primary care too: they need GPs to streamline longitudinal care and manage low-acuity cases in the community. However, primary care needs the hospital, too. To work efficiently, GPs need to know when their patients present at the emergency department (ED), they need discharge summaries once patients leave, and they need to know how to navigate the system to connect patients to the right specialists.

## Symbiotic Relationship Between Continuum Entities

Organisation Type	Organisation Goal	Acute Imperative	Primary Care Imperative
 <b>Public Hospital</b>	<ul style="list-style-type: none"> <li>Decrease utilisation and expenditure</li> </ul>	<ul style="list-style-type: none"> <li>Provide truly acute care</li> <li>Eliminate unnecessary ED volume</li> </ul>	<ul style="list-style-type: none"> <li>Prevent polychronic patient escalation</li> <li>Treat low-acuity patients outside of hospital</li> </ul>
 <b>Private Hospital</b>	<ul style="list-style-type: none"> <li>Increase referrals</li> </ul>	<ul style="list-style-type: none"> <li>Attract appropriate specialty patients</li> </ul>	<ul style="list-style-type: none"> <li>Identify and triage proper referrals</li> </ul>
 <b>Commissioner</b>	<ul style="list-style-type: none"> <li>Contain costs</li> </ul>	<ul style="list-style-type: none"> <li>Embrace new payment models</li> </ul>	<ul style="list-style-type: none"> <li>Streamline longitudinal care and activate patients</li> </ul>

## External Forces are Undermining GP Effectiveness

Despite primary care's role as the linchpin of continuum success, GPs are struggling. An industry that once thrived as a group of independent, fee-for-service businesses is now being undermined by several external factors that largely are outside any one GP's control.

We see three trends impacting primary care's ability to function well. First, multimorbidity is on the rise, and GPs often do not have the skills to treat such complex patients in the community. Second, evolving expectations are pushing patients to seek quick, convenient care, which the ED tends to offer. Lastly, GPs are increasingly not able to work top of license due to non-clinical tasks crowding their schedules.

### Heightened Case Complexity



**53%**

Projected growth of people with multiple conditions in England<sup>1</sup>

### Misaligned Patient Expectations



**60%**

Canadians with family doctor waiting at least two days for visit

### Inefficient Practice Capacity



**47%**

Young<sup>2</sup> Australian doctors reporting burnout<sup>3</sup>

1) Between 2008 and 2018.

2) Ages 18-30.

3) Burnout measured by the Maslach Burnout Inventory (MBI), which includes emotional exhaustion, cynicism, and low professional efficacy.

Source: Coulter A, et al., "Delivering Better Services for People with Long-Term Conditions," *The King's Fund*, 2013, [https://www.kingsfund.org.uk/sites/files/ktf/field/publication\\_file/delivering-better-services-for-people-with-long-term-conditions.pdf](https://www.kingsfund.org.uk/sites/files/ktf/field/publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf); Maple, <https://www.getmaple.ca>; "National Mental Health Survey of Doctors and Medical Students," *Beyond Blue*, October 2013, [https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report\\_web](https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web); Advisory Board interviews and analysis.



## Primary Care Transformation Is Happening...

Some primary care groups and governments are starting to trial new policies and test new care models to respond to these challenges. To address capacity issues, practices are forming networks and federations to achieve scale. Care teams are expanding in an effort to solve for both capacity and complexity challenges. And other practices are creating easily accessible, one-stop-shop offerings to satisfy patient expectations.

### Mosaic Life Care | US

#### Consumer-Centric Care Models

- Expanded to eight one-stop-shop, patient-centric clinics in 2013
- Offer same-day walk-in appointments, e-visits, and multiple specialties onsite

### A GP For Me | Canada

#### Provincial Access Innovation

- 2014 initiative to fund projects aimed at improving GP capacity and patient attachment
- 156 local projects throughout British Columbia

### Health Care Homes | Australia

#### Facilitated Chronic Access

- Launching stage one trial of Health Care Homes in 2017
- Developing coordination programmes to manage polychronic patients

### Whistable Medical Practice | UK

#### Advanced Primary Care

- Part of MCP<sup>1</sup> Vanguard site that is integrating social and medical care
- Care teams are expanding to enable top-of-license practice for all staff and to coordinate care across sectors

### Zorg | Netherlands

#### Collaboration for Scale

- GP network of 90 GPs covering 170,000 people
- Practices are joining into network-based organisational models to scale efforts

### Pinnacle Midlands | New Zealand

#### Shared Primary Care Records

- Launched cloud-based system that provides shared access to patients' records to three GP clinics and their 16,000 patients in 2017
- Goal is to integrate system with secondary care



## ... but Not Fast Enough

Despite advances in primary care delivery, transformation is not happening fast enough. Hospitals are feeling this strain in their emergency departments. When looking at ED volumes throughout the world, we repeatedly see that anywhere from 30% to 50% of ED visits are non-urgent and could instead be managed in primary care:

**39%**

Of Canadian ED visits are ranked as level 4 or 5, the two least acute CTAS<sup>2</sup> levels

**40%**

Of ED attendees in the UK could be managed in primary care according to hospital reports<sup>3</sup>

**53%**

Of Australian ED visits are ranked as level 4 or 5, the two least acute ATLS<sup>4</sup> levels

**56%**

Of Belgian ED visits are estimated to be inappropriate

This begs the question, if some primary care transformation is happening, but overall it is not occurring at the pace necessary to inflect serious change in emergency departments, why isn't it moving faster?

Source: Mosaic Life Care, <https://www.mymosaiclifecare.org/>; General Practice Service Committee, <http://www.gpscbc.ca/what-we-do/innovations/a-gp-for-me/>; "Patient-Centred Healthcare Homes in Australia: Towards Successful Implementation," *Consumers Health Forum of Australia*, July 2016, <https://chf.org.au/sites/default/files/patient-centred-healthcare-homes-in-australia-towards-successful-implementation.pdf>; Whistable Medical Practice, <http://www.whistablemedicalpractice.co.uk/files/2014/08/Capture.png>; "Primary Care in Europe: Can We Make It Fit for the Future?" *Nuffield Trust*, 13 December 2013, <https://www.nuffieldtrust.org.uk/media/primary-care-in-europe-can-we-make-it-fit-for-the-future>; Brown R, "Indici: New Player on PMS Front Goes Live in Pinnacle Practices," *New Zealand Doctor*, 1 March 201, <https://www.nzdoctor.co.nz/in-print/2017/march-2017/1-march-2017/indici-new-player-on-pms-front-goes-live-in-pinnacle-practices.aspx>; QuickStats National Ambulatory Care Reporting System, <https://www.cih.ca/en>; Cowling TE, et al., "Access to Primary Care and Visits to Emergency Departments in England: A Cross-Sectional, Population-Based Study," *PLoS ONE*, 2013, 8(6), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3680424/>; "Emergency Department Care 2014-2015: Australian Hospital Statistics," Australian Institute of Health and Welfare, 2015, <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129553618>; Berchet C, "Emergency Care Services: Trends, Drivers and Interventions to Manage the Demand," *OECD Health Working Papers*, 1 September 2015, 83, <http://dx.doi.org/10.1787/5jrt344cms-en>; Advisory Board interviews and analysis.

1) Multispecialty community provider.  
2) Canadian Triage and Acuity Scale; data for 2015-2016.  
3) Studies range from 30% to 50%.  
4) Australasian Triage Scale; 2014-2015 data (n=7,360,441).

## Transformation Is Often Siloed and Incomplete

Our research has yielded two key reasons why primary care transformation is not happening quickly enough:

### 1. Transformation is happening in isolation

Providers have spent decades building up silos and working independent of others in the continuum. The current reality is that, apart from some rural areas, hospital doctors and primary care doctors barely know each other, let alone fully understand what each other does or needs.

>90%

Of European members are funded separately from primary care

### 2. Current efforts augment a broken model

Efforts to transform care mostly attempt to work within a model that is no longer fit for purpose. Tweaking the model by expanding GP hours or lengthening visit times by a few minutes is insufficient. The primary care delivery system needs to be reengineered to meet the needs of today's patient.

92%

Of Swiss GPs lack clinic support<sup>1</sup> to manage polychronic patients

Within these two challenges, there is a commonality: primary care lacks the resources, scale, and scope to single-handedly propel its own development. For the first challenge, individual or groups of primary care clinics might want to transform, but they don't often have the size or cohesive voice necessary to engage the continuum in their efforts. For the second, it is unreasonable to assume that a solo practitioner—who is likely overworked as it is—can easily expand hours or add staff in a cost-effective manner. Unless someone offers assistance, large-scale transformation is not going to happen.

## Working with GPs to Transform Primary Care

The good news is that a number of organisations have achieved a strong partnership with primary care. Successful institutions that we have encountered take a two-part approach in doing so: first, they work to master the fundamentals of partnering with GPs; next, they work alongside GPs to accelerate primary care transformation. This publication highlights this two-part approach, and provides lessons and best practice examples within each step.

### 1 Master Partnership Fundamentals

1. Build Mutual Understanding
2. Define Shared Goals
3. Codify a Concrete Plan
4. Incentivise Engagement

### 2 Accelerate Primary Care Transformation

5. Increase Access Points
6. Expand the Care Team

Source: Osborn R, et al., "Primary Care Physicians in Ten Countries Report Challenges Caring for Patients with Complex Health Needs," *Health Affairs*, 2015, 34(12):2104-12, <http://content.healthaffairs.org/content/34/12/2104.full?keytype=ref&siteid=healthaff&ijkey=Wvt51Tp9QSLg>; Advisory Board interviews and analysis.

1) Nurses or case managers to monitor and manage care for patients with chronic conditions.

# How to Use This Resource

This resource provides tactical guidance on each of the lessons discussed, including:

- ▶ **Advisory Board analysis:** Key insights from case studies for those considering implementation or adaptation
- ▶ **Prerequisites for success:** Crucial investments, considerations, organisational capabilities, and cultural attributes that help to improve rate of success in implementation
- ▶ **Red flags:** Common pitfalls to avoid when deciding to pursue tactic
- ▶ **Questions to consider:** Topics and areas of inquiry to raise in strategy conversations and meetings with operational teams to assess whether tactic is right to pursue

Each element is also graded along three key dimensions:

## 1 *Regional Adaptability*

- ● ● **High:** Minimal adaptation needed to adopt in different countries or organisation types
- ● **Medium:** Moderate adaptation needed to adopt in different countries or organisation types
- **Low:** Adaptation dependent on nuances of tactic that may be difficult to replicate in other countries or organisation types

## 2 *Ease of Implementation*

- ● ● **High:** Minimal additional complexity and investment to execute successfully
- ● **Medium:** Moderate complexity and investment needed to execute successfully
- **Low:** Significantly complex; high investment required

## 3 *Urgency*

- ● ● **High:** Immediate action is required to prevent lagging behind market standard
- ● **Medium:** Near-term action is suggested to maintain market standard
- **Low:** Near-term action not necessary, but will likely result in differentiation



## ▶ Master Partnership Fundamentals

“**We can’t run hospitals without sufficient primary care collaboration.**  
The relationship is not developed, and hospitals are sometimes even  
viewed as opponents.”

*CEO, Swiss Hospital*



# Fundamentals of Productive Partnership Are Scarce

Simply put, fewer opportunities exist today than in the past for connection across sectors. The result is that providers seldom fully understand each other, develop actionable plans, or identify ways to incentivise even basic collaboration efforts. These may seem like simple tasks on the surface, but they are far from it in practice.

Underpinning the successes seen by some of the best population health managers in the world are the less-known stories of how they started and the foundations they laid with primary care to achieve such outcomes. In each of these examples, organisations devoted the time and resources to form a deep-rooted partnership with primary care before working alongside GPs to augment their delivery model. We have seen such organisations overcome four hurdles in forming this primary care partnership:

## ▶ Providers not seeing eye to eye

“If we can’t get past what each does, what their roles are, and then understand those in the context of today’s challenges, we waste our time.”

*Director of Primary Care Integration  
Regional Health Authority, Canada*



1



### Build Mutual Understanding

Educate your organisation on partner workflow, habits, and needs

## ▶ Partners not knowing where to start

“People would be surprised at how simple it is [to build relationships], but...people don’t know how, don’t do it, and don’t feel they have permission to do it, because we’re still in the world of competing interests. [That doesn’t] mean you can’t form relationships that work.”

*CEO  
NHS<sup>1</sup> CCG,<sup>2</sup> United Kingdom*



2



### Define Shared Goals

Work with partner(s) to develop shared vision and common goals

## ▶ Expectations remaining vague and unmet

“There’s no direct communication by the hospital staff. No one will ring the GP and say, ‘Mrs. Jones has been in hospital ...this is how we’d like you to follow up.’”

*Chronic Disease Management Lead  
Local Health District, Australia*



3



### Codify a Concrete Plan

Outline clear, discrete divisions of labour and expectations for each stakeholder involved

## ▶ Doctors not participating

“I think we could expect more of [primary care] if we paid them. Now, we might call a meeting at 7am or during the evening, but they still won’t come.”

*President and CEO  
Regional Health Centre, Canada*



4

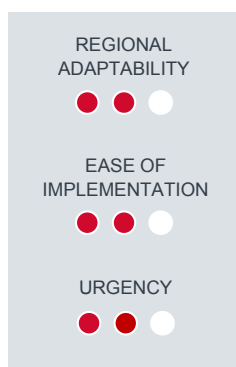


### Incentivise Engagement

Employ levers to engage doctors and stakeholders

1) National Health Service.  
2) Clinical Commissioning Group.

# Create Mutual Understanding Between GPs and Specialists



## Background

Under Spain's publicly-funded, single-payer health system, each autonomous region administers its own care scheme. In 1997, the regions were first allowed to hire private companies to manage care delivery, and the town of Alzira in Valencia contracted Ribera Salud to build a hospital there and manage the care of its residents under a capitated budget.

Ribera's model, also known as the Alzira Model, began in 1999. At first, Ribera struggled to stay afloat because they couldn't control what happened before or after patients visited the hospital, nor could they effectively move people into less expensive, more appropriate care. In 2003, Ribera made the case to include primary care in its contract to make the model viable.

Once under this contract, Ribera began investing in their primary care partnership.<sup>1</sup> One of the most impactful initiatives was a two-way immersion programme, meant to share knowledge and expertise across providers to facilitate collaboration.



## Case in Brief: Ribera Salud Group

- Private company located in Alzira, Spain
- Assumed responsibility for health of Valencia region's population of 250,000 based on capitated annual payment for each citizen
- Renegotiated contract to include primary care after first endeavour failed
- Facilitated cross-sector collaboration by immersing GPs in acute setting and specialists in primary care

## Ribera's Approach to Primary-Acute Care Collaboration

In the two-way provider immersion programme, GPs are encouraged to choose specialties they feel would be complementary to their professional development, or ones for which they have seen great demand in their primary care clinic. GPs can participate in the exchange every year and are encouraged to choose at least two specialties to shadow during their immersion week.<sup>2</sup> During this week, specialists switch spots with the GPs, taking their place in primary care clinics.

After the exchange, all GPs fill out an evaluation highlighting how they would change or improve the care that was provided. This allows them to regain their voice in the hospital. The shadowing department then evaluates the doctors, providing performance reviews and areas for individual improvement.

A key aspect of Ribera's model is the commitment to improvement taken by its doctors. Specialists dedicate time to GP consultations in primary care clinics and also support development of cross-continuum pathways on a weekly basis.

## Results from Ribera's Contract

Functions	Other Valencia Hospitals	Ribera Hospitals
Three-day readmissions (per 1,000 discharges)	6.1	<b>4.1</b>
External consultation delay	51 days	<b>25 days</b>
Patient satisfaction (out of 10)	7.2	<b>9.1</b>
Average hospital stay	5.8 days	<b>4.5 days</b>

1) Ribera had three main investments: setting a system-wide vision, independent of provider type; setting up a cross-continuum EMR system; and developing the two-way immersion programme.

2) When GPs are placed in the hospital, their ability to practice depends on the specialty in which they are placed. As hospitalists, GPs can see the same patients they see in the community and learn about the diagnostic process, but do not discharge patients. As ED doctors, they can see patients on their own and are able to discharge them. In surgery, they can learn about minor surgery (and perhaps participate) with support training from surgeons.

Source: Serrano CT, "Alzira Model: Hospital de la Ribera, Valencia, Spain," *EUREGIO III*, 2009, [http://wiki.euregio3.eu/download/attachments/7209069/EUREGIO+III\\_Berlin+WS\\_The+Alzira+model+++la+ribera+case+study.pdf](http://wiki.euregio3.eu/download/attachments/7209069/EUREGIO+III_Berlin+WS_The+Alzira+model+++la+ribera+case+study.pdf); "The Search for Low-Cost Integrated Healthcare," NHS European Office, 14 December 2011, <http://www.nhsconfed.org/resources/2011/12/the-search-for-low-cost-integrated-healthcare>; Advisory Board interviews and analysis.



## Advisory Board Analysis



*The programme builds understanding across providers in an ongoing manner*

Participating doctors are required to provide feedback from the immersion experience, which includes possible process improvements. This feedback is incorporated into Ribera's operating procedures. Thus, the benefits are two fold: doctors increase understanding of each other's specialties, and their key learnings are continually implemented in clinical processes after each cohort completes their training.



*What started as a volunteer service has become an integral part of Ribera's culture*

Though it was slow to get off the ground, the programme is now incredibly popular and has expanded to include nursing staff and midwifery. Ribera averages 250 doctors participating each year, including mental health professionals, specialists, and primary care doctors. Since the introduction of this initiative, staff have reported that care plans are much more specific, save time, and avoid waste.

### Prerequisites for Success



Agreement outlining each provider's role



Several options for cross-continuum shadowing



Means to engage GP participation



Ways to incorporate learnings back into system

### Be Wary of...



Decentralising role of primary care in partnership



Requiring doctors to engage in collaboration efforts immediately



### Questions to Consider

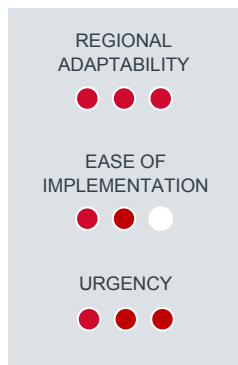
- ▶ Do your specialists currently have an understanding of what primary care doctors do daily?
- ▶ How would you incentivise GPs to engage with a cross-continuum training initiative?
- ▶ How would you work feedback into your operations?
- ▶ What outcomes would be necessary for you to deem a project like this a success? What metrics would you assign to track its progress?
- ▶ What departments do you have that could immediately benefit from primary care training?



### Learn More

Use our *GP-Specialist Immersion Programme Survey* to gauge your two-way immersion programme's effectiveness; available on [advisory.com/gfhi](https://advisory.com/gfhi)

# Build a Patient-Centric, System-Wide Vision



## Background

In 1997, an elderly Swedish patient known as ‘Esther’ arrived at her GP experiencing shortness of breath. The GP decided she needed emergency care and called an ambulance. During her five and a half hour journey through the system, Esther retold her story to 36 clinicians before she received treatment.

This journey highlighted a more pressing problem than just the glaring inefficiencies present across the continuum. Esther found herself lost in a system built around the provider, not the patient. With Esther’s experience in mind, Jönköping County Council sought to reengineer their care for elderly, complex patients by developing system-wide goals around caring for Esther.



### Case in Brief: Jönköping County Council, Sweden

- County Council in southern Sweden; responsible for health services for 330,000 citizens
- Difficult patient experience led to health and social care system redesign
- Systematic, multipronged approach to vision co-design and following system restructure associated with significant reduction in unnecessary acute utilisation among the elderly

### Lack of Communication Inspires System Redesign

With Esther’s experience in mind, the County Council initiated an extensive series of interviews and workshops to identify redundancies, gaps, and improvement areas in the medical and community care systems. They asked a GP to lead this initiative, as they believed that primary care should have a central role.

‘Esther’ came to represent all elderly persons who have complex care needs involving a variety of providers. Creating a persona helped caregivers to focus on the needs, preferences, hopes, and concerns of real people who need care. Providers could then have concrete planning conversations: What does Esther need? What is important to her when she is not well? How can we collaborate to meet Esther’s needs?

These questions served as the foundation of their four-pronged approach to creating a system-wide vision that gathers different employees from a variety of organisations, and includes Esthers in every meeting.

### Elements and Results of Vision Setting and System Co-Design



#### Yearly leadership steering group

Multisector executive leadership<sup>1</sup> team sets vision framework based on challenges



#### Quarterly Esther cafés

Cross-sector patient experience meetings held to ensure patient-centric approach



#### Ongoing shared training

Joint training sessions<sup>2</sup> run to facilitate collaboration and understanding



#### Annual strategic retreats

Staff and patients provide feedback, ensuring bottom-up approach to strategy

**30%**

Decrease in hospital admissions<sup>3</sup> (1998-2013)

**9%**

Lower readmissions within 30 days<sup>4</sup> (2012-2014)

1) Municipalities, hospitals, and GPs.  
 2) Topics relevant to target group (e.g., palliative care, and fall prevention).  
 3) Höglandet Hospital.  
 4) Among patients > 64 years old.

Source: Gray B, et al., “Sweden’s Esther Model: Improving Care for Elderly Patients with Complex Needs,” The Commonwealth Fund, September 2016, <http://www.commonwealthfund.org/publications/case-studies/2016/sep/sweden-esther-case-study>; Vackerberg N, “The Esther Approach to Healthcare in Sweden: A Business Case for Radical Improvement,” Governance International, January 2013, <http://www.govint.org/good-practice/case-studies/the-esther-approach-to-healthcare-in-sweden-a-business-case-for-radical-improvement/>; Advisory Board interviews and analysis.

## Advisory Board Analysis



### *Primary care is Esther Network's key stakeholder*

Jönköping takes a cross-system approach, and they credit primary care as the active ingredient in their success, essential to both building and implementing their ongoing vision. Placing a GP in a key leadership position publicly elevated primary care's significance.



### *Jönköping's model is truly collaborative*

The network offers a variety of opportunities across the year for different kinds of stakeholders to get involved—from CEOs to allied health workers. It effectively pairs up large and small groups, executives and patients, nurses and administrators, etc., while evading a finger-pointing culture that is common in cross-continuum collaboration.



### *The Esther Network is extremely replicable*

The four specific elements that Jönköping used to set its vision aren't set in stone for others to adopt. The Esther model has already been adapted and replicated around the world. In Singapore, SingHealth Regional Health System holds regional forums where people wanting to make changes come together and discuss ideas for collaboration. In the UK, the South Somerset Symphony Programme has the same 'Esthers' attend cafés every other quarter to report on progress they have seen, and the Kent Integrated Care and Support Pioneer Programme has expanded the model to include training care workers, social assistants, chefs, and maintenance employees on how to best care for 'Esthers.'

### Prerequisites for Success

- ✓ Including 'Esthers' in system vision meetings
- ✓ Meeting structure for ongoing collaboration
- ✓ Contextual adaption from original Esther model
- ✓ Methods of engaging stakeholders throughout the continuum
- ✓ Giving primary care a voice in vision design

### Be Wary of...

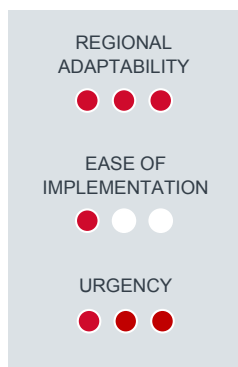
- ✗ Centring the initiative around one provider (i.e., the hospital)
- ✗ Not involving frontline staff in planning meetings



### Questions to Consider

- ▶ Would you say the different providers across your system have any common goals?
- ▶ Do you meet in a collaborative setting with primary care or other providers to discuss system issues?
- ▶ Who might you partner with in your community to offer shared trainings? What topics would be most valuable?
- ▶ How would your strategic planning sessions change if a patient were involved in every session?
- ▶ If you were to adopt a model like Esther, what parts of it would work in your setting? What parts would not work? How would you augment it to fit your context?

# Engage Primary Care Through Clinical Agreements



## Background

Gold Coast Hospital and Health Service (HHS) in Australia had a vision for an integrated health system that would address the needs of their complex, high-risk patient population through collaboration with primary care. To launch this initiative, Gold Coast spent 18 months solidifying buy-in from clinicians across the continuum, driving change management for GPs and specialists involved, and obtaining funding from a variety of local, state, and federal bodies.

After they laid the groundwork, Gold Coast sought to develop agreements with each clinician involved. Their care compacts, which outlined roles and responsibilities between GPs and the health service, were successful in solidifying the partnership between Gold Coast and primary care.

This pilot has helped make Gold Coast one of the pioneer health services in Australia, where they have recently received approval for a new risk-based funding model.



## Case in Brief: Gold Coast Hospital and Health Service

- Australian public health system providing care in two hospitals and several community settings
- Created an integrated care model designed to manage high-risk patients through collaboration with GPs to reduce ED admits
- Spent 18 months engaging GPs and specialists, then hardwiring GP buy-in with care compacts
- Now have 100+ GPs enrolled over 14 practices, all using single care compact

## Process to Launch Gold Coast Integrated Care Model

Instead of trying to get all 100+ GP clinics in the area on board at once, Gold Coast piloted the model—and the compacts—with a smaller subset of 14 practices that expressed interest. Interestingly, there wasn't a 'typical' practice that signed on. Participating practices ranged in size from 1 to 24 doctors. Some had no nurses or allied health staff while others had full teams of each.

Since Australian primary care practices are independent businesses that each have different needs, Gold Coast had to work to get everyone on the same page. They met with each practice individually and reviewed the agreements line by line, working to understand the unique needs and requests of each GP. Gold Coast went through multiple iterations of the agreement with each practice to arrive at a single compact that laid out roles, responsibilities, and protocols for the integrated care model.

**Key Data Points**

**18 mo.**  
Length of pilot development

**6 mo.**  
Time spent in GP negotiations

**1**  
Final number of compacts

### Care Compacts in Brief

**Definition:** Formalised agreements between GPs and specialists that designate referral protocols, care transition expectations, and respective care management responsibilities. Also known as service agreements, transition of care records, and care coordination agreements, these documents are not legally binding contracts.

**Benefits:** *Patients*

- ✓ More coordinated care experience, with needs and preferences met regardless of site of care or treating provider
- ✓ Unnecessary or duplicative testing avoided

*Providers*

- ✓ Improved information sharing and clarity in management responsibilities, with an emphasis on closing the loop
- ✓ Improved efficiency (e.g., pre-visit tests and labs completed)
- ✓ Tighter network of trusted, high-quality partners with similar values

## Advisory Board Analysis



### *Gold Coast took time to plan the partnership before codifying it*

The 18 months Gold Coast spent planning the model and engaging primary care paid off. This time allowed Gold Coast and GPs to meet, understand one another, and create a vision of working together. Forming this initial partnership base allowed them to more effectively persevere through challenges that arose while creating the compacts.



### *Everyone's voice was heard when developing the compacts*

It seems tedious, but meeting with each of the 14 GP clinics over six months was an integral part of Gold Coast's success. This allowed each practice to express their individual needs, and gave Gold Coast the opportunity address and/or negotiate each point. Combined with individualised attention to each specialist involved, this approach led to a single compact that encompassed the needs of the entire system.



### *The compacts accommodated GPs while remaining true to Gold Coast's vision*

Gold Coast's CEO had the initial vision for an integrated system, and he tasked a partner at the local university's Innovation Centre with developing a care model that would work in Australia. Because the compact was extensively negotiated, the final agreement accommodated a wide breadth of practice sizes while not deviating from this initial vision.

### Prerequisites for Success

- ✓ Developing compact in iterations
- ✓ Honouring needs of each GP and specialist involved
- ✓ Specific targets, metrics, and goals for partnership
- ✓ Plan for driving change management

### Be Wary of...

- ✗ Codifying agreements before laying robust partnership foundation
- ✗ Rolling out compact to all stakeholders at once



### Questions to Consider

- ▶ Have you ever developed a compact with primary care? If not, how are you specifying what you need from GPs and specialists?
- ▶ How would you drive change management in primary care if your compact involved changes to how GPs operate?
- ▶ What specific initiative would you partner with primary care on? Which entity would manage each responsibility in the agreement?

# Bankroll GP Involvement



## Background

Vancouver Coastal Health (VCH), a Regional Health Authority in Canada, had difficulty getting GPs to attend collaboration meetings since they operate on fee-for-service payments; taking time away from their practice would mean less pay. And even when VCH could pay GPs to attend meetings, the funding was inconsistent. This slowed progress on shared initiatives, not only for VCH, but across the province.

In response, the Ministry of Health and the Doctors of British Columbia<sup>1</sup> set aside funds for collaboration work. The money flows through a Shared Care Committee,<sup>2</sup> which allocates the funds to British Columbia’s six Health Authorities each year.



### Case in Brief: Vancouver Coastal Health (VCH)

- 13-hospital Regional Health Authority (RHA) in Vancouver, Canada; provides acute and primary care, research, and training services
- Faced difficulty getting GPs to attend collaboration meetings for free
- Doctors of British Columbia developed Shared Care Committee, which allocates collaboration funds to RHA each year
- VCH uses funds to support its own projects and also partners with Divisions of Family Practice on innovative projects across RHA
- Allocating funds for collaboration efforts has facilitated increased doctor engagement

### Dedicated Funds Support Collaboration Projects

With this funding, VCH is able to pay GPs and specialists a sessional rate for collaboration activities. While VCH needs to request these funds each year from the Ministry, having dedicated funds guarantees they can consistently pay GPs for their time. In this case, VCH took their request directly to the Ministry and lobbied for collaboration funds—this may be something hospitals in other countries need to do. Otherwise, hospitals should try to earmark the funds themselves, setting aside a dedicated budget to support cross-continuum efforts.

#### Utilisation of Funds

- ✓ Pay GPs for session attendance
- ✓ Proposals to fund cross-sector initiatives
- ✓ Shared projects with the Divisions of Family Practice<sup>3</sup>

#### Benefits of Funds

- ✓ Allocates money in advance for shared ventures
- ✓ Promotes cross-continuum relationships
- ✓ Successfully engages GPs and specialists

### New Payment Models Unite Providers

Funding initial collaboration is useful, but the ultimate goal of the programme is to develop more holistic incentive structures for partnerships. Providers and commissioners around the world are exploring new payment models that do so, including the following:



1) The Doctors of British Columbia, formerly known as the British Columbia Medical Association, is the autonomous provincial arm of the Canadian Medical Association. It is a professional body of doctors that works to standardise care across British Columbia and advocate for its members.

2) The Shared Care Committee is a joint collaborative committee of the Doctors of British Columbia and the British Columbia Ministry of Health that provides funding and project support to family and specialist physicians to improve outcomes and the flow of care from primary to specialist services.

3) Divisions of Family Practice are community-based groups of family physicians who work together to enhance local patient care and improve professional satisfaction for doctors. There are currently 35 Divisions of Family Practice in British Columbia that encompass more than 230 communities.

## Advisory Board Analysis



### *Financial incentivisation is possible despite separate reimbursement streams*

Primary and acute care are funded separately in nearly every country. However, we have seen institutions circumvent this issue in almost every context. The tendency to dismiss funding partnerships with someone that is paid differently must be overcome in order to collaborate with providers across the continuum.



### *Multiple types of financial incentives exist*

Setting aside money to directly fund GP collaboration is just one example of a financial incentive. Elsewhere, we have seen population health managers employ innovative payment models to control risk and incentivise GPs. In the UK, South Somerset developed a shared contract where primary, acute, and community providers collectively own an accountable care organisation which has one collective budget. In Germany, Gesundes Kinzigtal reimburses GPs for specific preventive care tasks, such as developing individualised treatment plans or providing chronic case management, that are normally not covered by existing fee-for-service model.

### Prerequisites for Success

- ✓ Tailored incentives to market capability
- ✓ Strong partnership with providers demonstrating willingness to experiment
- ✓ Consistent pool of funds to incentivise collaboration
- ✓ Clear performance metrics to ensure accountability

### Be Wary of...

- ✗ Expecting cost savings instead of cost avoidance
- ✗ Complex negotiation processes
- ✗ One-size-fits-all solutions



### Questions to Consider

- ▶ How do you currently bring GPs to the table for collaboration meetings?
- ▶ Where could you find consistent funding for GP engagement? How much would be necessary?
- ▶ Have you considered lobbying policymakers for collaboration funds?

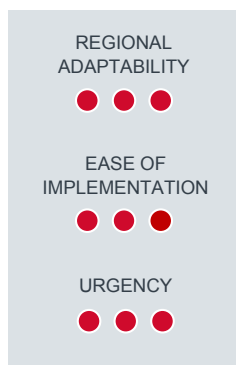


### Learn More

Review our executive research briefing on emerging payment models, *Shared Risk, Shared Rewards*, available on [advisory.com/gfhi](https://advisory.com/gfhi)



# Employ Stopgap Incentives if Money Is Not an Option



## Background

Australia started building Super Clinics in 2007, after being inspired by German and NHS polyclinics. The aim was to provide private GP services, dental care, chronic disease management, diabetes treatment, rehab, psychology, and allied health in one location. However, GPs didn't always want to participate. Northern Adelaide Local Health Network (NALHN) in Adelaide, South Australia, solved for this by using a unique incentive: free rent.

NALHN's Super Clinic was located within three kilometres of six existing primary care clinics, so GPs viewed it as competition and weren't using it. NALHN needed to entice GPs to fill the clinic's space but couldn't pay them, so NALHN offered GPs rent-free space in the clinic instead.



## Case in Brief: Northern Adelaide Local Health Network (NALHN)

- One of five LHNs in South Australia; provides acute and community services to northern metropolitan Adelaide and tertiary services to a catchment area of ≈370,000 people
- Government implemented a GP Plus Super Clinic to provide private GP services and preventive care in one location; Super Clinic owned and managed by NALHN
- GPs viewed Super Clinic as negative competition; NALHN offered free space in the building to incentivise GPs to co-locate with other providers
- After two years, the Super Clinic began charging rent and used alternative incentives instead

## Using Space to Spur Collaboration

Once the GPs started using the clinic, they soon saw the benefits of the relationship—most notably, there was an influx of outpatients from NALHN's nearby Modbury Hospital. Plus the internal pathways established within the clinic's GP groups facilitated more coordinated care. There were benefits to the hospital as well; inappropriate patients could be diverted from the ED to the Super Clinic instead. Truly a win-win.

After two years of providing free space, NALHN started charging the GPs rent but still provided them with administrative support. By that point, the GPs understood the benefits of the Super Clinic and were happy to contribute.

## Other Methods of Nontraditional GP Incentivisation

Free space is not the only type of non-payment incentive. We have seen other organisations offer pathology or waste management services, as well as novel offerings like grant-writing assistance. This is an area where you can truly be creative and think about what might be feasible in your market and attractive to GPs.



Free rent in your owned space



Pathology or lab services



Waste management services



Back-end office support



Grant-writing assistance



Laundry, grocery, or transportation services



## Advisory Board Analysis



### *Outside-the-box incentives are sometimes the only solution*

In countries where hospitals and primary care are paid differently, there are often perverse incentives for how care is delivered. This should not stop you from finding possible solutions. In many cases, non-financial support for GP clinics can be just as effective as a monthly check.



### *Incentives for GPs need not be permanent*

It is easy to see incentives as long-term commitments that funnel money away from your organisation. However, we have heard from several of our members that, while they had to provide incentives to GPs at the onset of an initiative, they eventually got on board and no longer needed the incentives. Payments for collaboration may be necessary, but they may not need to be long-lasting.



### *Acute providers almost certainly have something GPs want or need*

A hospital's scale and scope is usually massive. Thus, a hospital is likely to have assets that could engage GPs. Perhaps GPs in your area need access to a better EMR or they see an opportunity to set up a referral pathway from your hospital to their private practice. The incentive is there, you just have to find it.

### Prerequisites for Success

- ✓ Strong partnership with providers demonstrating willingness to experiment
- ✓ Plan for phasing out incentives and shifting toward sustainability

### Be Wary of...

- ✗ Limiting incentive options to just financial ones
- ✗ Local laws preventing any kind of 'gift' incentives



### Questions to Consider

- ▶ How do you currently bring GPs to the table for collaboration meetings?
- ▶ What does your organisation have that GPs may want or need that you can barter in exchange for their engagement?

# Key Takeaways and Relevant Resources

## KEY TAKEAWAYS

### Mastering Partnership Fundamentals

1. **Start with partnership basics:** Years or even decades of fragmentation between acute and primary care mean you can't simply dive into transformation efforts. Take the time to rebuild the relationship, understand each other, and develop a clear vision of working together.
2. **Develop actionable plans:** Lofty visions are easy to create but harder to make concrete. Develop a specific plan in collaboration with GPs that clearly defines the purpose, roles and responsibilities, communication standards, and protocols of your initiative.
3. **Incorporate creative incentives:** Don't let separate funding streams stop you from making progress. At a minimum, consider non-financial levers that could incentivise engagement, then move to dedicate funds to pay GPs for their involvement in collaboration efforts.

## Resources to Help Build Partnerships: Search for These Titles on [advisory.com](https://www.advisory.com)

### ▼ Plan the Primary Care Partnership



- **GP-Specialist Immersion Programme Survey:** Diagnostic survey used to audit how effective your primary care-hospital exchange programme is and garner participant feedback
- **The New Partnership Advantage:** Research briefing examining obstacles that hinder successful partnerships in health care, while highlighting key lessons to develop a comprehensive and proactive approach to partnership strategy
- **M.A.P. Partnership Toolkit:** Online tool library designed to help members identify major partnership objectives, assess their current partnership environment, and source and sell to potential partners

### ▼ Create Care Compacts



- **GP-Specialist Care Compact Development Toolkit:** Book of tools that includes action steps for implementing care compacts, as well as templates, worksheets, and other resources to get you started

### ▼ Incentivise Your Stakeholders



- **Shared Risk, Shared Rewards:** Research briefing providing an overview of four 'need-to-know' trends for health leaders interested in shifting to a risk-based finance model as well as examples of successful global risk-sharing experiments
- **The Essentials of Risk-Based Contracting:** Research briefing that identifies five financial pitfalls to avoid when pursuing sustainable, optimised risk-based contracts

## ▶ Accelerate Primary Care Transformation

“There has been a steady rise in patient expectations, a target-driven culture, and a growing requirement for GPs to accommodate work previously undertaken in hospitals... Small changes in general practice capacity have a big impact on demand for hospital care, so **the need to support general practice in underpinning the whole NHS has never been greater.**”

*Dr Arvind Madan, General Practice  
'Forward View,' NHS England*

# Primary Care Model Is in Need of Reconstruction

Today's primary care is often delivered by small practices where the type of access that patients want or need is not available, and where the GP is overburdened with non-clinical tasks.

One problem area is that access is consistently a challenge for patients. Practices are typically open only during weekday business hours, which leads some patients with busy days to visit the ED for basic preventive care. It is common to see patients wait almost a week before seeing their GP. Further, the pipeline of new providers is threatened by several workforce trends—doctors are frequently choosing more lucrative specialties over general practice, and even those who do choose general practice increasingly prefer salaried and/or part-time employment to starting their own practice.

A second set of challenges presents itself inside the GP clinic: the primary care team is no longer fit for purpose. Practices are often staffed by only a handful of practitioners, which does not offer the time or multidisciplinary care team knowledge necessary to provide preventive care for today's complex patient. GPs often are not working at the top of their license, performing tasks that could be delegated to a nurse or assistant.

The result is that significant numbers of patients present unnecessarily to the ED to receive care that should be delivered in the community. To alleviate this, the primary care model itself needs to transform. But it is difficult for individual primary care providers to facilitate this transformation on their own. Hospitals, planners, and payers almost certainly have scale and scope that individual primary care practices do not have. Institutions we have encountered that are successful in helping to transform the primary care model target two key issues plaguing general practice: access and staffing.

## ▶ GP Access Outpaced by Demand

11%

Of GP trainees in the UK intend to do full-time clinical work five years after qualification

6 days

Average time rural Australian patients wait to see preferred GP

52%

Of Canadian GPs lack arrangements for patients to see doctor or nurse after hours without going to ED



5

**Increase Access Points**

Enhance quantity and variety of primary care access options

## ▶ Primary Care Team No Longer Fit For Purpose

12 min.

Median Australian GP appointment length

54%

Of English GP clinics have 1-4 practitioners<sup>1</sup>

60%

Of Canadian GPs feel ill-prepared to care for patients needing long-term home care services

48 min.

Average time lost on patient care per day by US primary care doctors as a result of EMRs



6

**Expand the Care Team**

Enable top-of-license care delivery by diversifying team beyond the GP

Source: Baird B, et al., "Understanding Pressures in General Practice." *The Kings Fund*, 5 May 2016, <https://www.kingsfund.org.uk/publications/pressures-in-general-practice>; "Double Trouble with Rural Waiting Times." Australian National University, 20 November 2014, <http://www.anu.edu.au/news/all-news/double-trouble-with-rural-waiting-times>; Osborn R, et al., "Primary Care Physicians in Ten Countries Report Challenges Caring for Patients with Complex Health Needs." *Health Affairs*, December 2015, 34(12), <http://content.healthaffairs.org/content/34/12/2104.full>; Britt H, et al., "Debunking the Myth that General Practice is '6 Minute Medicine.'" Byte from BEACH, University of Sydney FMRC, 2014, <http://sydney.edu.au/medicine/fmrc/beach/bytes/BEACH-Byte-2014-002.pdf>; Workforce and Facilities Team, "General and Personal Medical Services: England 2004-14," *Health and Social Care Information Centre*, 2015, <https://digital.nhs.uk/media/26461/General-and-Personal-Medical-Services-England-2004-2014-As-at-30-September-General-Practice-Workforce-Census-Bulletin/Any/nhs-staf-2004-2014-gene-prac-rep>; McDonald C, et al., "Use of Internist's Free Time by Ambulatory Care Electronic Medical Record Systems," *Journal of the American Medical Association*, November 2014, 174(11), <http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1901114>; Advisory Board interviews and analysis.

1) 2014 Data.

# Provide More Convenient Care Options

While primary care ultimately needs to evolve, providers and commissioners can help GPs in the short term—the most feasible way to do so is by expanding primary care access options.

This research has identified three best practices to help enhance primary care access at critical points:

### 1. Enable Timely Access

Assist with primary care visit scheduling at the time of discharge to ensure continuity of care from the hospital into the community

### 2. Offer Patient Transportation

Deploy vehicles to transport non-emergent patients to their GP instead of the ED

### 3. Free Up GP Capacity

Host group medical appointments and care management educational sessions to free up GP capacity

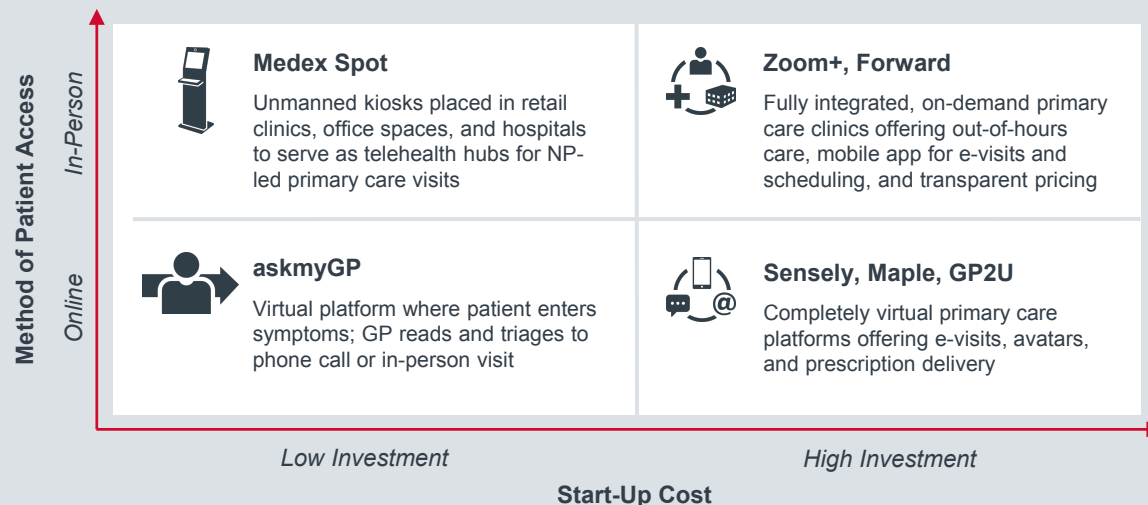
For public providers, these best practices serve as examples for how to think creatively about deflecting patients from unnecessarily using your emergency department. For private providers, these practices show ways to build bridges and become a trusted partner to primary care, with the aim of solidifying future referral pathways.

## SPOTLIGHT: Technological Alternatives to Traditional Primary Care

Some institutions are increasing access to primary care in a fourth, less ‘traditional’ way: consumer-friendly, technologically enhanced services. Examples include on-demand virtual primary care clinics and automated triage systems.

Your organisation may not be able to implement these solutions immediately, but you can innovate even if your resources don’t allow for full implementation. You may promote these options to patients who typically visit the ED due to poor access to primary care, pilot them in a partnership with primary care organisations, or lobby policymakers to push for virtual care incentives in your region. For additional resources on these options, reference the ‘Increase Primary Care Access Points’ resource section on page 46.

### Emerging Alternative Primary Care Options



Source: Medex Spot, <http://medexspot.com/>; Zoom, <https://www.zoomcare.com/urgent/>; Forward, <https://goforward.com/>; askmyGP, <http://askmygp.uk/>; Sensely, [sense.ly](https://sense.ly/); ClickWell Care, <https://stanfordhealthcare.org/medical-clinics/clickwell-care.html>; GP2U, <https://gp2u.com.au/>; Advisory Board interviews and analysis.

# Facilitate Access After Hospital Discharge



## Background

Expected and actual readmission rates at Silver Star Hospital<sup>1</sup> were more variable than expected. When they looked into the underlying causes, they saw that a significant portion were related to the handoff to primary care and realized the problems started within the hospital.

Silver Star was sending discharge summaries to the family doctor within 48 hours just 41% of the time, and was making a follow-up appointment for patients only 23% of the time. So the hospital revamped its discharge process, hardwiring discharge summaries and primary care appointment scheduling for each of their discharged patients.



### Case in Brief: Silver Star Hospital<sup>1</sup>

- Midsize general hospital located in Ontario, Canada
- Saw significant inappropriate readmissions, so enlisted a local GP to help reshape and troubleshoot discharge process
- Improved discharge process to include discharge summaries and scheduling GP follow-up appointments, which facilitated greater primary care access

### Silver Star's Approach to Improving Primary Care Discharge

To tackle this issue, Silver Star partnered with a local GP, who was instrumental in the initiative from start to finish. She helped develop project goals, map out processes, and troubleshoot issues throughout Silver Star's three implementation focus areas:

- 1 Dictation rates:** Silver Star noticed a high variability across doctors with respect to dictation rates<sup>2</sup> within 48 hours—ranging from 55% to 100%. So they created a competition among the clinicians. Silver Star posted a bar graph in the doctor's lounge showing each doctor's dictation rates. Even though the names were blinded, peer pressure caused rates to dramatically improve.
- 2 Automated sign-offs:** The doctors still had to review and sign off on summaries after they were dictated, despite 98% to 99% accuracy of the combined software transcription and transcriptionist review. To solve this, Silver Star implemented an auto-sign and send function in their electronic patient record to automatically dispatch summaries after transcriptionist review.
- 3 Follow-up appointments:** Silver Star saw that follow-up appointments were rarely scheduled on time. For this, they simply added a new task in the ward clerk's workflow to schedule follow-up appointments for patients. Over time they rolled it out to all of their units, and now the ward clerks schedule follow-up appointments for nearly all patients.<sup>3</sup>

1) Pseudonym.

2) The dictation system is outsourced, and doctors dictate through the phone. The voice component is housed on the outsource company's secure system; language processing software transcribes the voice recording into a written draft. Medical Transcriptionists are assigned draft documents with the corresponding voice files; they listen to the dictation and make modifications to the draft document as necessary. The dictation report is then transmitted from the outsource company interface into the Cerner EPR system. During the interface, all discharge summaries are auto-signed, which changes the report status from preliminary to final. The report is then viewable in the EPR as a completed document and is sent to the Attending Physician and Family Doctor, as well as any other reviewers who have requested to receive a copy. Employees of the outsourced company are all located in Canada, and nothing is stored on the Medical Transcriptionist's home computer. The Transcriptionist must complete confidentiality agreements before accessing hospital accounts.

3) If a patient is discharged over the weekend, the ward clerk follows up on Monday morning, calling the patient to let them know an appointment has already been scheduled. If a patient can't attend the prescheduled appointment, the patient has to call and reschedule it.

### Discharge Initiative Outcomes

93%

Of discharge summaries sent to primary care within 48 hours

98%

Of patients are scheduled for primary care follow-up appointments

## Advisory Board Analysis



### *Empowering a GP in the initiative gave primary care a voice*

Silver Star enlisted the help of a local GP to determine how to best address discharge summaries and follow-up appointments, since both issues were related to the handoff from secondary to primary care. They also treated the GP as an equal partner, and she was instrumental in the initiative from start to finish. By including primary care throughout the project, the final solutions reflected the interests of GPs.



### *Silver Star solved their internal problems first, then moved to follow-up visit scheduling*

The hospital recognised that they weren't getting information to GPs in a timely or consistent manner. But before they tried to implement a new process for follow-ups—which could easily have been met with skepticism and resistance—they made an effort to improve an existing, internal problem. With discharge summaries consistently in hand, GPs were more willing to accommodate a new process for follow-up appointments.



### *Internal competition nudged clinicians into changing their processes*

Instead of using incentives or executive mandates to improve dictation rates, Silver Star simply publicised data they already had. The peer pressure aspect of the competition was enough to motivate doctors to improve their rates, and those rates have remained high ever since.

#### Prerequisites for Success

- ✓ Understanding of how discharge processes affect primary care access
- ✓ Ability to engage doctors in improvement efforts
- ✓ Methods to track discharge and follow-up appointment data

#### Be Wary of...

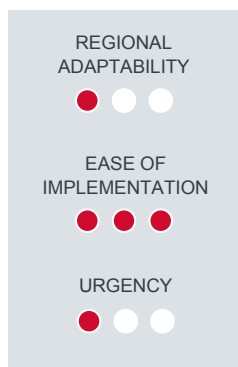
- ✗ Attempting to solve problems without the assistance of a GP
- ✗ Attempting to solve problems involving primary care before addressing internal issues



#### Questions to Consider

- ▶ How does your discharge process inflect primary care follow-up appointments?
- ▶ Are you getting discharge summaries to primary care in a timely manner, and is this process standardised in your organisation?
- ▶ How can you use data to identify gaps or challenges with access after discharge?
- ▶ How do you envision creating more primary care access for patients after they leave the hospital?

# Create Access Through After-Hours Triage



## Background

Many countries lack an after-hours option for primary care, which forces patients to use the ED unnecessarily during evenings and weekends. CHU de Liège, a university hospital in Belgium, faced this problem. In Liège, the local GP association ran an emergency phone line patients could call if an urgent need arose outside office hours. Instead of a practice remaining open all night long, GPs rotated on-call coverage for emergent house calls to respond to patients as necessary.

After the after-hours phone line launched, though, Liège continued to see a large number of unnecessary ED presentations, many of which were being referred from the GP phone line. When the hospital investigated the issue, they found that GPs did not feel safe doing house calls at night and continued to send patients to the ED. So Liège proposed a solution—the hospital would manage the GP emergency line instead.



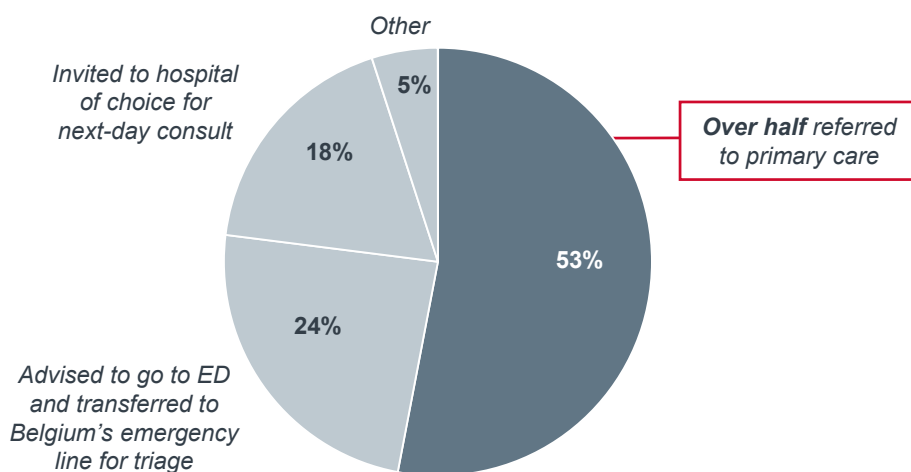
## Case in Brief: CHU de Liège

- 895-bed university hospital in Liège, Belgium, with an ED serving 95,000 patients annually
- Observed high evening emergency admissions due to GP capacity and safety concerns
- After-hours calls to GP emergency line diverted to ED, where nurses triage patients based on acuity
- GPs now view hospital as trusted partner, referring more patients during the day

## Patient Pathway Through Liège's Triage System

When a patient calls the after-hours phone line at night,<sup>1</sup> the call is diverted to a tenured nurse in Liège's ED who uses an acuity algorithm to triage the call. The nurse either addresses the patient's question, tells them to come to the ED, or schedules them to see a GP at another time. What started with just one participating GP group grew to include multiple GP clinics, and a nearby hospital even partnered with Liège to extend the service to their patients as well.

## Effects of Triage Line on Sites of Care



The programme has been a success. Over half of the calls result in a recommendation to see a GP at another time—most are not even urgent enough for a next-day appointment. In fact, only a quarter are truly emergent and need to be triaged for urgent care.

The after-hours phone line is now available to roughly 500,000 potential callers, and it receives more than 4,000 calls per year.

1) 8 pm to 8 am.



## Advisory Board Analysis



*Placing the after-hours line in Liège's ED equipped it with expertise that most triage lines lack*

Liège's senior nurses, who manage the triage line, already had experience managing ED throughput. Additionally, they had access to the hospital's robust triage algorithm to assist them. In our research, we've found that most triage lines are operated by newly trained students or support workers, who tend to over-refer to the ED to be safe. Consider using tenured nurses or clinicians as triage line operators to increase efficacy.



*The after-hours phone line created a scenario in which every stakeholder benefits*

The after-hours triage line has successfully reduced inappropriate presentations to the ED at night, thus alleviating some of the pressure on Liège's bustling ED. GPs appreciate the line because it has greatly reduced the need for evening house calls. And patients like it because they can speak to someone immediately and receive help for their symptoms.



*The after-hours phone line increased referrals from new GP partners*

The line has an unintended—but positive—result. In offering this service to GPs, the hospital became a trusted and valued partner among participating practices. Now, GPs more frequently think of Liège as a specialty referral site during the day. This is exactly what fee-for-service, acute providers are looking for—an increase in appropriate specialty referrals and a decrease in costly, unnecessary ED presentations.

### Prerequisites for Success

- ✓ Specific goals for triage line based on your context
- ✓ Partnering GPs able to accept diverted patients

### Be Wary of...

- ✗ Staffing line with workers who have insufficient phone triage training



### Questions to Consider

- ▶ What would you like to achieve from an after-hours triage line? A reduction in inappropriate admissions? An increase in specialty referrals from primary care? Something else?
- ▶ What staff would you have operating the after-hours triage line?
- ▶ How would you track the line's data to prove that it is a worthwhile effort in the long term?
- ▶ Does your country/region already have an after-hours triage line? If so, are there things about it that are ineffective and could be augmented in your setting?

# Transport Patients to Primary Care



## Background

In 2014, Sunshine Coast Hospital and Health Service (SCHHS) noticed that nearly half of their annual ED admissions were low-acuity cases. Not only did this drive up unnecessary costs, but patients were spending time waiting in EDs when they could have been treated elsewhere.

To address this, in 2016 SCHHS implemented a supplementary low-acuity response unit (or ‘GP ambulance’). These silver vehicles are marked ‘ambulance’ but do not have the sirens and lights normally associated with an emergency vehicle. They transport low-acuity patients directly to a GP, reducing non-urgent ED presentations and improving primary care access.



### Case in Brief: Sunshine Coast Hospital and Health Service (SCHHS)

- Four-hospital system providing care to 390,000 patients in Queensland, Australia
- Observed that 49% of 113,000 ED admissions in 2013-2014 were low-acuity cases
- Through a partnership with the Clinical Excellence Division, Silver Chain Hospital, Queensland Ambulance Service, Central Queensland, Wide Bay, and Sunshine Coast PHN,<sup>1</sup> SCHHS implemented Low-Acuity Response Unit to divert low-acuity patients from the ED

### Low-Acuity Ambulance Pathways at SCHHS

Often, patients call an emergency line because they lack transportation to and from their provider, and they know that a call to the emergency number will likely result in an ambulance ride to the ED.

With the SCHHS low-acuity response unit, when a patient calls the emergency line, the dispatcher triages and sends the right transport—GP ambulance or traditional—based on the patient’s acuity.

When the ambulance (either type) gets to the patient, paramedics reassess patients and use clinical pathways to identify the appropriate site of care for low-acuity patients.

If a patient’s primary GP is at capacity, the GP ambulance will call upon a pool of participating GPs in the area to find a practice with capacity for the patient.<sup>2</sup>

### Key Components and Outcomes



Dedicated vehicle for non-urgent patient support



Double triage embedded in pathway



Secondary GP pool for patient overflow

**22%**

Six-month reduction in ED admission rate for lowest-acuity<sup>3</sup> patients<sup>4</sup>

1) Primary Health Network.  
 2) GPs in the area are automatically enrolled as Tier 1 GPs. If they are at capacity, the patient will be taken to one of six GPs in the Tier 2 bracket—these are practices that have a service-level agreement saying they will provide care for 80% of the low-acuity patients that the ambulance refers to them.  
 3) Category 5 patients in Australia.  
 4) Across two hospitals in Queensland.

## Advisory Board Analysis



### *The service offers dual assessment to ensure appropriate triage*

One concern we often hear from members regarding triage initiatives is: Who will manage the risk? SCHHS guarded against this by embedding two rounds of triage—the patient is first reviewed over the phone and then again in-person. If the initial triage level is wrong, the second assessment can correct it, and they can escalate or deescalate the patient accordingly.



### *The service capitalises on existing primary care capacity across a pool of GPs*

About half of the time when the GP ambulance picks up a patient, the patient's primary GP is at capacity and the patient has to be taken to a 'secondary' GP. This is a pool of practices that has agreed to provide care for 80% of the low-acuity patients that the ambulance refers to them. There is also one overnight GP who is part of the programme for after-hours patients. By spreading out the demand, GPs are able to manage patients in a more timely manner.



### *If underutilised, the GP ambulances can be used in other ways to alleviate ED pressure*

While having a vehicle to transport low-acuity patients to a GP is effective, it may not be needed all the time. To justify the cost of the vehicle, it can have other uses. Perhaps you have two hospitals nearby and can use the ambulance to transport patients between sites. Or, you can partner with volunteer organisations that already transport certain patients, such as frail elderly, to primary care appointments.

### Prerequisites for Success

- ✓ Vehicles that can serve as low-acuity ambulances, or a partnership with ambulance service
- ✓ Care compacts with GP stakeholders and transportation partners
- ✓ Having a pool of 'secondary' GPs to serve as a contingency if primary practices fill up

### Be Wary of...

- ✗ Assessing patients only once
- ✗ High start-up costs
- ✗ Trying to use the same vehicle for emergent and non-urgent cases



### Questions to Consider

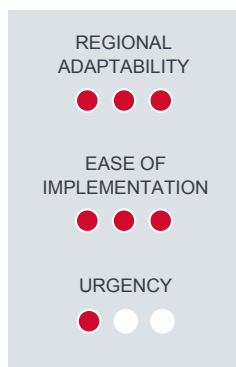
- ▶ How many low-acuity patients are coming to your ED that could be safely diverted to primary care?
- ▶ How would you get GPs on board? Would you approach one-off practices or a federation of them?
- ▶ Could you own your own low-acuity ambulance? If not, who could you partner with to develop a patient transportation programme?
- ▶ How would you protect against the risk of inappropriate triaging?



### Learn More

Read our blog post on patient transportation, *4 Ways Hospitals Can Provide Transportation Assistance to Drive Access Improvements*, available at [advisory.com/gfhi](https://advisory.com/gfhi)

# Streamline Patient Education



## Background

In primary care settings, doctors, nurses, and health coaches spend a significant amount of time educating individual patients on things like diabetes management basics, healthy lifestyle habits, and preventive care tips. What if, instead, there was an option of group visits or education sessions to review this material with multiple people at once and free up clinician capacity?

That's just what Group Health Cooperative in Washington, US, does. They offer a number of different initiatives for patients, but their weekly asthma classes and diabetes group visits are some of the most effective.

## Key Fact

Only **8%** of GPs offer group visits, while **40%** of patients say they would participate in them if offered the chance<sup>1</sup>



### Case in Brief: Group Health Cooperative

- Health plan and care delivery system based in Washington, US that provides coverage and care to over 600,000 members
- Offers group visits on a decentralised basis; doctors at individual practices decide what courses to offer based on demand and availability
- Visits cover a range of topics and typically include 8-12 patients with similar conditions or focuses for that day

### Group Health Cooperative's Group Visit Programme

For public providers, it is relatively inexpensive to provide patient education classes for your local GP clinics. For patients, these classes offer a range of shared resources that help with support and care management:



Weekly asthma classes



Online diabetes community



Monthly preventive health classes

For staff, classes like these free up time that they can then use to work on top-of-license tasks. For public hospitals, patient education is proven to decrease ED and specialist visits. And conversely, for private providers, these classes can serve as a way to build trust and rapport with GPs, and then use that relationship as a lever to form referral pathways.

### Diabetes Group Visit Pilot Results

**50%**

Fewer ED visits compared to non-participants

**24%**

Fewer specialist visits per year

### Other possible group visit topics:



Physicals



Retinal screenings



Anticoagulation



Parenting



Depression and anxiety



Cold and flu



Pain management



Pre- and neonatal health



Healthy living

Source: McCarthy D, et al., "Group Health Cooperative: Reinventing Primary Care by Connecting Patients with a Medical Home," *The Commonwealth Fund*, June 2009, <http://www.commonwealthfund.org/publications/case-studies/2009/jul/group-health-cooperative-reinventing-primary-care-by-connecting-patients-with-a-medical-home>; Group Visits, *Clinica Family Health*, <https://clinica.org/innovations/group-visits/>; Hudec W, "Are Group Visits the Key to Preventive Care?" *Advisory Board*, 19 February 2014, <https://www.advisory.com/research/medical-group-strategy-council/practice-notes/2014/february/are-group-visits-the-key-to-preventative-care/>; Advisory Board interviews and analysis.

1) US data.

## Advisory Board Analysis



### *A variety of care workers can oversee group visits*

Many group visits involve a GP seeing a group of 8-12 patients, thus freeing up time by not visiting with each patient one-by-one. However, GPs aren't always required for these visits. Nurses, case managers, medical assistants, or even former patients can effectively conduct them, which enables the entire practice to work more efficiently.



### *Peer support keeps patients engaged in the long term*

Providing patients with a peer network creates a safe space for them to ask for advice and learn about their conditions. At Clinica Family Health Services, a health centre in Colorado, US, 95% of patients participating in an anti-coagulation group visit cohort attended visits on a monthly basis. Further, through the sharing of experiences, lessons, and strategies, the peer group promotes mastery of self-care behaviours and improves disease outcomes.



### *Group visits increase the patient-to-provider ratio at little to no cost*

Group visits can be an effective way to provide preventive care services to high-risk patients without exposing the provider financially. Group visits offer a scalable method to increase primary care access without raising a large amount of funding or expanding your workforce.

### Prerequisites for Success

- ✓ Offer group visits as a voluntary option, not mandatory
- ✓ Enough GP or non-clinical time to conduct ongoing visits
- ✓ Target topics that apply to your patient population
- ✓ Community offerings or online database for peer support

### Be Wary of...

- ✗ Doctors who do not feel equipped to facilitate groups
- ✗ Drop-off in patient attendance
- ✗ Limiting educator role to just doctors



### Questions to Consider

- ▶ What segments of your patient base would be better served through group visits?
- ▶ What legal caveats would you have to navigate to implement group visits?
- ▶ Who could you partner with to host classes?
- ▶ How would you engage providers and staff in this change? Can you envision any additional provider training or coaching that would be needed?

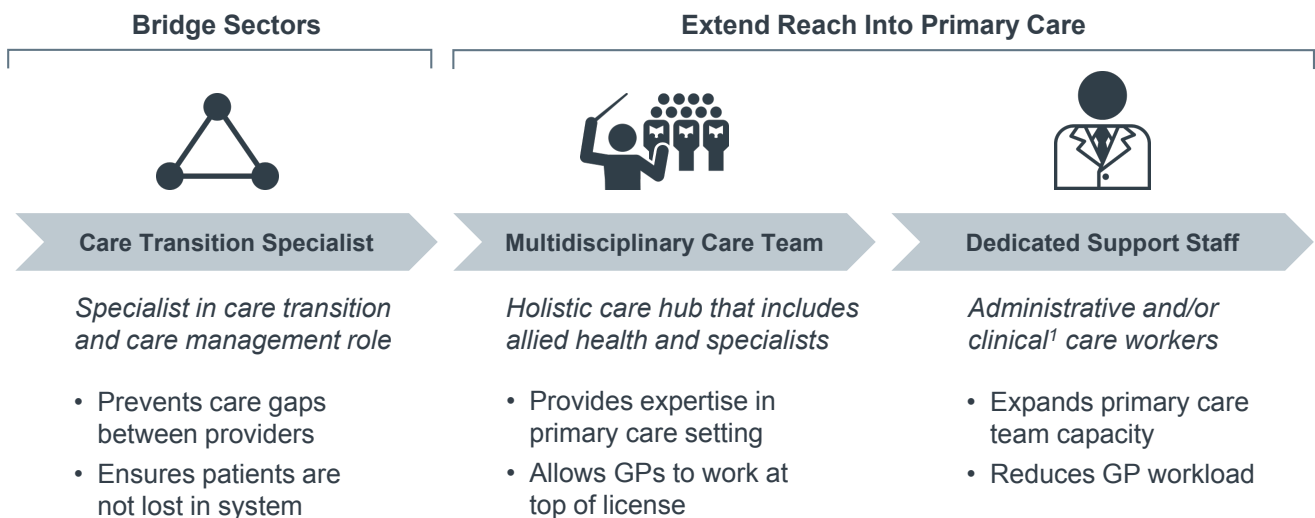


# Care Team Expansion Crucial to Transformation

In today's average primary care practice, a GP works independently and often has limited staff members for support, so GPs end up taking on work that could be delegated to others. By expanding the care team, you can free up GPs to work at the top of their license, providing better care to patients in need of care management in the community.

A range of options exists to expand the primary care team. First, you may work to bridge the gap between a complex patient's acute stay and return to primary care with a care transition specialist. Next, you may extend your reach and enable multidisciplinary care provision in primary care in one of two ways: building out care hubs or providing individual team members for clinical and administrative support. These strategies enable GPs to serve as the care team captain alongside a full crew of support.

## Hospital-Owned Staff Used to Expand Primary Care Team



1) E.g., Pharmacist, advanced nurse, medical assistant, etc.

Source: Advisory Board interviews and analysis.

# Bridge Primary-Acute Gap with an Extensivist

**REGIONAL ADAPTABILITY**  
● ● ●

**EASE OF IMPLEMENTATION**  
● ● ●

**URGENCY**  
● ● ●

## Background

CareMore, a private insurance plan headquartered in California, US, developed the medical extensivist model in the early 1990s to ensure that frail, elderly patients were closely monitored after hospitalisation.

An extensivist is a doctor—often a GP<sup>1</sup>—who works primarily in the hospital but extends into the community as well. Extensivists are experienced in managing both acute and chronic conditions in patients with three or more long-term conditions. They provide individual care planning, coordination, and support for such patients.



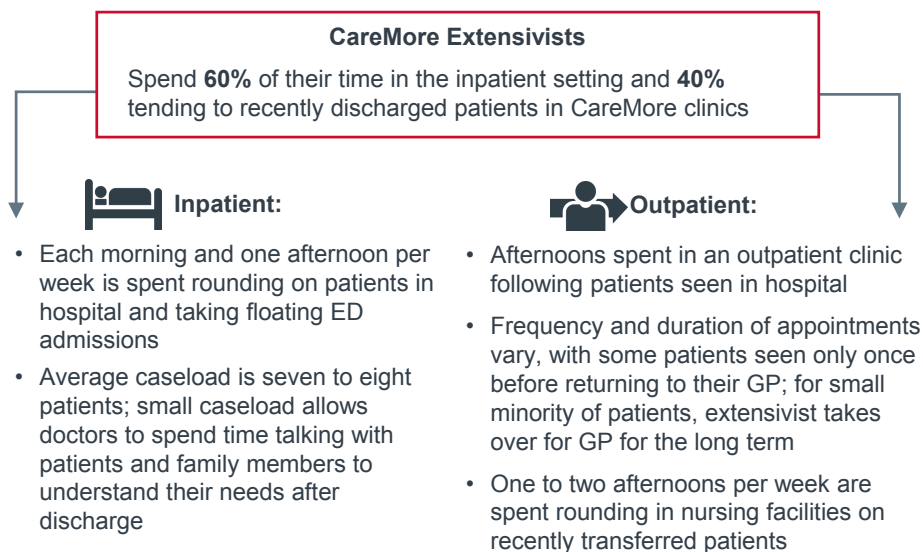
## Case in Brief: CareMore

- Health plan with 44,000 elderly patients located in California, Arizona, and Nevada, US
- To participate in CareMore plans, network doctors must agree to collaborate with CareMore on programmes designed to serve frail, elderly patients, including outpatient centres, house calls, and rounding in nursing homes
- Extensivist programme began in the mid-1990s; the impetus was that the traditional hospitalist programme was inadequate to ensure that discharged patients received needed support and coordinated care after leaving a hospital or nursing home

## Allocation of Time and Responsibilities for CareMore Extensivists

High-risk elderly patients are identified through risk assessments, predictive algorithms, and doctor referrals. When these patients are admitted to a hospital, extensivists provide care throughout the hospital stay and lead a care team that includes nurse practitioners, case managers, medical assistants, a social worker, and a nutritionist.

Extensivists also oversee discharge planning and continue to provide direct care when patients are discharged to post-acute sites. Patients who go home can follow up with their extensivist at an outpatient clinic.



**Extensivist Model Outcomes<sup>1</sup>**

**29%**

Shorter length of stay<sup>2</sup>

**20%**

Reduced 30-day readmission rate<sup>3</sup>

1) Though this is generally a GP, extensivists can have other medical backgrounds, such as internist or hospitalist.

2) Outcomes from 2012 study involving 67,424 patients at CareMore; cohort compared with patients enrolled in US insurance for the elderly.

3) From 5.2 days to 3.7 days.

4) From 18.4% to 14.7%.

Source: "Extensivist/Hospitalist," <https://www.smartrecruiters.com/Concerto/83920765-extensivist>; Powers B, et al., "Delivery Models for High-Risk Older Patients," *Journal of the American Medical Association*, 5 January 2016, <http://jamanetwork.com/journals/jama/fullarticle/2480493>; Advisory Board interviews and analysis.



## Advisory Board Analysis



### *Extensivists improve continuity of care*

Hospital staff are often focused on their own internal discharge processes and may not deliver patient knowledge to the next site of care. Similarly, staff in post-acute and primary care facilities may not have the time to contact hospital staff with questions or concerns when accepting a new patient. Extensivists remedy this by bridging the gap and sharing knowledge between providers.



### *Extensivists support frail and elderly patients when they are most vulnerable*

Elderly, chronic patients are often so vulnerable immediately following hospitalisation that they do not fare well in a regular primary care office, even with the best communication channels in place. Many traditional GP offices lack the resources needed by high-risk patients, such as ongoing patient education and connections to community resources. This need is met when the extensivist's specialisation is added to the primary care setting.



### *Extensivists are ideal for risk-based models but can benefit volume-driven providers as well*

Although CareMore developed the extensivist model in the 1990s, it has grown in popularity only recently because its financial feasibility is justified under emerging accountable payment models, such as shared savings or capitation. However, volume-driven acute centres can benefit too. Reduced LOS and readmissions free up bed capacity and enable more patient turnover. Also, extending into primary care can help bolster GP relationships and thus solidify referral streams.

### Prerequisites for Success

- ✓ Methodology for identifying high-risk patients
- ✓ Extensivist job requirements matched to fit your current risk model
- ✓ Care compacts with participating GP clinics

### Be Wary of...

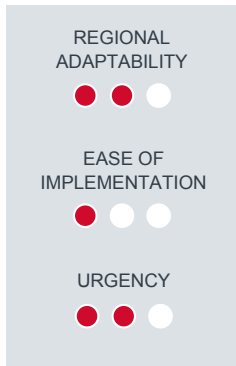
- ✗ Neglecting due diligence on legal and indemnity aspects
- ✗ Solely relying on communication with primary care to close care gaps
- ✗ Using extensivists as your only effort to bridge the primary-acute care divide



### Questions to Consider

- ▶ Are you currently under a risk-based payment model that involves utilisation management? Will you be undertaking greater risk in the near future?
- ▶ Do you have hospitalists, or similar clinicians, who have the training in chronic care management to handle frail, elderly patients, and can they easily step in to the extensivist role?
- ▶ What is the geographic span of your organisation? How many post-acute and primary care providers do you currently discharge patients to?
- ▶ Would it be possible to streamline your post-acute partners and steer patients to only a select number of facilities, which are bridged by extensivists?

# Enable Top-of-License Practice with Care Hub



## Background

In 2011, the commissioning group in Somerset, England, authorised an extensive analysis to determine what patient groups were most costly to the system and would most benefit from better coordinated care. After analysing a year's worth of anonymised health and social care data from 115,000 patients, the commissioning group found that higher costs were primarily explained by the number of chronic comorbidities, which went against their initial hypothesis that higher costs would be tied to age.

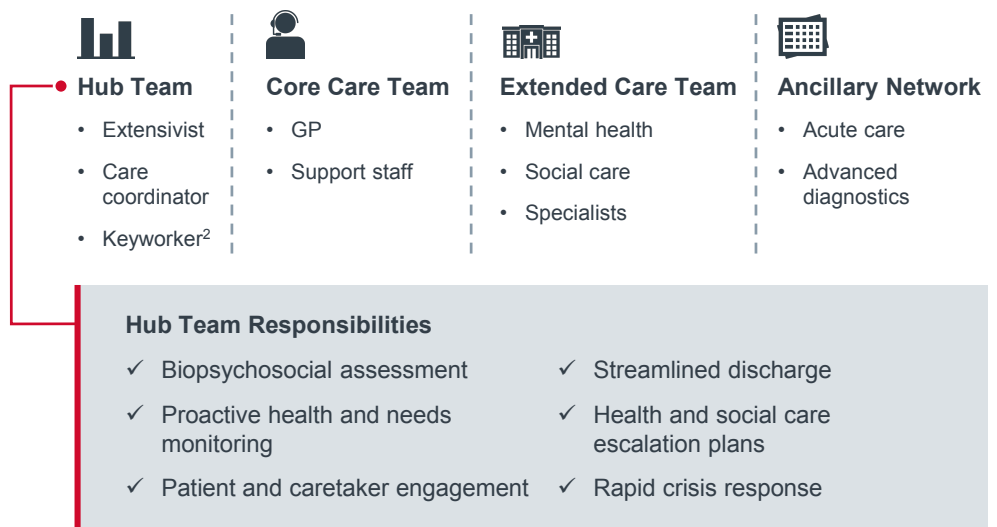
The leadership team at Yeovil Hospital latched onto this analysis to help focus their efforts in improving primary-acute integration and reducing inappropriate acute utilisation. In 2014, with Vanguard<sup>1</sup> funding, Yeovil launched the South Somerset Symphony Project, an integrated care pilot to provide multidisciplinary primary care for 1,500 high risk, multimorbid residents. A key part of this project was its integrated care hub that supports complex multimorbid patients.

## Case in Brief: South Somerset Symphony Project

- One of nine UK integrated primary and acute care system (PACS) Vanguard programmes; it's a partnership between Yeovil District Hospital, Somerset Clinical Commissioning Group, Somerset's GP federation, and the county council
- Analysis showed that polychronic patients overutilised care and could benefit from care integration
- Symphony launched a complex care hub, initially based in Yeovil District Hospital, to provide advanced multidisciplinary primary care services and care transition support to polychronic patients; hub teams are now integrated into GP clinics
- Advanced primary care services for complex patients linked to reduced emergency utilisation

## GP Patient Management Support with South Somerset Symphony Project

The hubs, each led by an extensivist, provide multidisciplinary care teams, care transition support, care coordination, specialist access, senior medical input, and personalised care plans that are codeveloped with each patient.



The multidisciplinary nature of the team enables each clinician to work at top-of-license. And, between visits, patient conditions are remotely monitored through a web platform where the hub team and patients can connect and view care plans.

## Complex Care Hub Outcomes<sup>3</sup>

**33%**  
Decrease in emergency admissions<sup>4</sup>

**29%**  
Decrease in ED attendances

**46%**  
Decrease in acute length of stay

1) The Vanguards are a collection of various care model experiments the NHS are testing in an effort to better manage patients, providers, and cost across the continuum. This funding was awarded to Yeovil's application to the programme in 2014, and it runs out in 2017.  
 2) First point of contact for patients who have concerns about their health; provides administrative support to extensivist and care coordinator.  
 3) Comparisons made between April to August 2014 and April to August 2015.  
 4) Includes ED attendances as well as elective and unscheduled care.

Source: "Symphony Integrated Care," <http://www.symphonyintegratedhealthcare.com/>; Street A, "Laying the Foundations for Integrated Care in South Somerset," *Health Service Journal*, 2 April 2014, <https://www.youtube.com/watch?v=Cr7aevRGBqM>; "Integrated Primary and Acute Care Systems Vanguard Sites: South Somerset Symphony Programme," *NHS England*, <https://www.england.nhs.uk/ourwork/futurehns/new-care-models/primary-acute-sites/#three>; Weyer I & Cummings J, "The Extensivist: A New Role for GPs and Physicians," *The Kings Fund*, <https://www.kingsfund.org.uk/sites/files/kf/media/lan-Wyer-GP-extensivist-role.pdf>; Advisory Board interviews and analysis.

## Advisory Board Analysis



### *Primary care buy-in is integral to a hub's success*

Initially, many GPs did not support this model. When a GP referred a patient, the hub team would assume care of the patient instead of working in partnership with the GP. So, GPs simply stopped referring patients to the care hub. Since the end of 2016, Yeovil has adjusted the model so that hub teams are integrated into primary care, with each hub partnering with three to four practices. GPs remain in charge of their patients, and hubs act as wraparound support.



### *Primary care alone is insufficient for complex patients*

While providing traditional primary care services to highly complex individuals helps meet patient demand, it doesn't provide nearly enough care management to deescalate these patients down the risk pyramid. Supplementing the hub's core team with allied health, mental health workers, specialists, and other support staff creates a holistic care environment. Together with the GP, this group can meet the care needs of patients with complex, long-term health conditions.



### *Care hub should be sized to fit your specific context*

The South Somerset Symphony Project's care hub houses a full gamut of care management professionals, including employees like the extensivist. However, not all care hubs need to be this robust. You should assess your patient population's size, habits, and needs, and scale your care hub to your needs.

### Prerequisites for Success

- ✓ Analysis identifying most costly patients in your system
- ✓ Ability to track care hub data
- ✓ Involvement of specialists and wraparound support
- ✓ Targeted care plans for each patient

### Be Wary of...

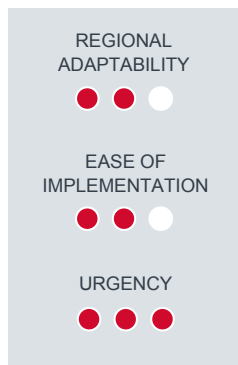
- ✗ Centring the hub around hospital instead of primary care
- ✗ Overlooking the importance of patient activation outside the hub



## Questions to Consider

- ▶ Who are the most costly patients in your local system? Which group could most benefit from the launch of an integrated care hub?
- ▶ What extended services do you have access to that could supplement a GP in a care hub?
- ▶ Where would a care hub be located in your context: in primary care, the hospital, or a neutral location?
- ▶ How would you remotely monitor hub patients outside of the hospital?
- ▶ What supplementary services, such as preventive and educational ones, would you include?

# Unlock GP Capacity with Acute Pharmacist



## Background

There is a growing trend to incorporate pharmacy expertise into the primary care setting. Unfortunately, not every GP is able to hire a pharmacist, even if it would be beneficial. In addition to salary costs, GPs sometimes have to pay incredibly high indemnity insurance for pharmacists to join their practice.

The Northumberland ACO<sup>1</sup> in England has spent the past two years evaluating strategies to reduce unnecessary hospitalisation. One of their most successful initiatives has been placing hospital-employed senior clinical pharmacists directly in primary care. Northumberland’s goal was twofold: increase primary care practice capacity by adding an FTE to local teams, and decrease medication-related hospital admissions.



### Case in Brief: Northumberland ACO<sup>1</sup>

- One of nine integrated primary and acute care system (PACS) Vanguard programmes; it’s a partnership between two hospitals, commissioning group, city council, primary care practices, ambulance service, and mental health service in Northumberland County, England
- PACS site set up multidisciplinary home visitation triage to divert home visits from GP to acute pharmacists
- Acute pharmacist was key to increased GP capacity and provision of multidisciplinary care

### Polypharmacy Management at Northumberland ACO

The pharmacist is employed by the hospital participant, Northumbria NHS Foundation Trust. This ensures that GP clinics avoid costly indemnity insurance and small practices are still able to have support. Meanwhile, the pharmacist is able to offer same-day medication management in the clinic or on home visits. This helps guard against care delays and unnecessary escalation.

Pharmacist input has helped improve patient understanding of medication, involve care home residents in decisions about medication and, ultimately, reconcile unnecessary medication use and cost.

The ACO has also improved cross-continuum collaboration. According to their operations manager, the pharmacist has become the ‘glue’ of the multidisciplinary care team. The pharmacist is not perceived as a threat to nurses or GPs, but rather as a new team member with additive expertise.

### Benefits of Acute Pharmacist in Primary Care



Serves as liaison between hospital, patients, and GP groups



Complementary, rather than competitive, peer to nurses and GP



Coaches patients and works with stakeholders across continuum

30%

Of GP home visit workload shifted to pharmacist within one month

Source: "The Importance of Early Medication Management to Reducing Readmissions," Hospital-to-Home, 2016, <https://cvquality.acc.org/docs/default-source/h2h/3-med-management-evidence-slides.pdf?sfvrsn=2>; Isetts BJ, et al., "Clinical and Economic Outcomes of Medication Therapy Management Services: The Minnesota Experience," *Journal of American Pharmacy Association*, 2008, 48(2):203–11, <https://www.ncbi.nlm.nih.gov/pubmed/18359733>; "Joining Up Care in Northumberland, Stakeholder Update August 2016," 2016, <http://www.northumberland.nhs.uk/wp-content/uploads/2016/08/Vanguard-stakeholder-update-August-2016-FINAL.pdf>; "Integrated Primary And Acute Care Systems Vanguard," *NHS England*, <https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/primary-acute-sites/#/four>; Advisory Board interviews and analysis.

1) Accountable Care Organisation.

## Advisory Board Analysis



### *Primary care pharmacists can help curb ED and GP medication reconciliation visits*

For complex patients, medication reconciliation (med rec) is all but inevitable—but where these visits take place varies. Having a pharmacist available for med rec and patient education in the primary care setting can decrease the volume of patients coming into the ED for prescription issues, and can free up GP time in primary care. Further, in some contexts a practice could order a home medication management review from the pharmacist, shifting med rec visits entirely to a more patient-centric location.



### *Acute pharmacists are just one type of clinician that be placed in primary care*

Roles like physiotherapists or mental health practitioners are other examples of clinicians whose specific skills or knowledge gaps might be needed in primary care. Hospitals and commissioners could use their scale and scope to place these workers in primary care, which would translate to fewer inappropriate admissions. Further, in some cases hiring these types of clinicians would allow GPs to avoid the indemnity insurance they would otherwise have to pay to employ them.



### *Expanding the pharmacist role is gaining traction globally*

We have seen this model pop up in the UK, New Zealand, and the public and private systems in Australia. In 2016, Ramsay Health in Australia launched a retail pharmacy strategy with a cohort of community pharmacies to extend their footprint pre- and post-hospitalisation. And in 2017, the state of Victoria, Australia, launched an 18-month pilot that expands the role of community pharmacists to help manage chronic disease in partnership with GPs.

### Prerequisites for Success

- ✓ One acute pharmacist supporting a designated amount of GP clinics
- ✓ Pharmacist acting in concert with primary care workers

### Be Wary of...

- ✗ Due diligence on legal and indemnity aspects
- ✗ Implementing dedicated support pharmacist without overcoming GP resistance to change



### Questions to Consider

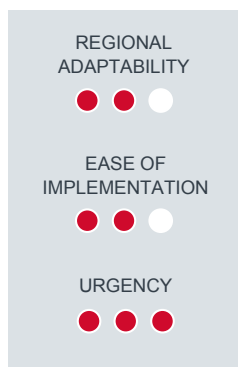
- ▶ Of possible GP clinics to partner with, which ones have doctors who actively embrace population health management?
- ▶ In your context, how will you and primary care benefit from this?
- ▶ How will you track results, data, and high-impact stories from the initiative to reinforce the added value that a dedicated pharmacist can bring?
- ▶ Do you have funds to invest in educating primary care teams about the value of adding a dedicated pharmacist to their practice?



### Learn More

Take our online quiz *Primary Care Pharmacist Readiness Assessment*, to decide if you are ready to add a pharmacist to your primary care team, available on [advisory.com/gfhi](https://advisory.com/gfhi)

# Introduce and Maximise the Medical Assistant



## Background

Most primary care pioneers arm care teams with registered nurses (RNs) or nurse practitioners to free up GP capacity. However, nurses are still an expensive resource. And, they still end up doing several tasks in GP clinics that keep them from operating at top-of-license themselves, such as back-office work.

This is where medical assistants (MAs) are most effective. In the US, MAs are typically defined as non-licensed care team members. Elsewhere, they roughly equate to support personnel such as a health care assistant or patient support worker. Often, their job is limited to basic transactions and administrative tasks. But with a little additional training, MAs can help a practice achieve larger goals around care management. Plus, they are far less costly than a nurse or GP.

## Key Fact

The cost of a GP + RN care team is **\$231,000**, while the cost of a GP + MA + shared-RN care team is only **\$217,000<sup>1</sup>**



## Case in Brief: Stanford Hospital & Clinics

- 613-bed academic medical centre located in California, US
- Launched Stanford Coordinated Care programme in 2013 for employees and dependents who struggle to manage their chronic conditions
- Streamlined task allocation across primary care team allows for scaling of primary care across larger chronically ill population

## Allocating Tasks to Support Top-of-Role Care

At Stanford, GPs serve as ‘captains’ of the care team, making leadership decisions and taking on the most complex patients. They also consult with specialists to provide cross-continuum care. Caring for these complex patients maximises the scope of the GP’s role, making the job more challenging and engaging.

With the doctor functioning this way, critical roles are available for nurses and MAs. RNs are responsible for the majority of patient diagnoses and treatment plans, as well as patient transitions. As RNs shift upward in their capabilities, other practitioners then shift up as well to backfill roles formerly assumed by doctors and nurses. This is where the MA comes in.

The MA orders routine care, highlights needed services, and checks the patient’s registry for care gaps. Stanford’s ideal staffing ratio is one doctor paired with one MA, plus one RN working across three of these GPs to create ‘MA pods.’

## Stanford’s Team Member Task Allocation

Functions	GP	RN	MA	Other providers <sup>2</sup>	Patient
Pre-visit planning		✓	✓		✓
Care plan development	✓	✓	✓	✓	✓
Registry management		✓	✓		
Ongoing care support		✓	✓	✓	✓

<sup>1</sup> Both costs are US averages, given in USD.

<sup>2</sup> Includes licensed clinical social workers, physical therapists, and clinical pharmacists.

Source: “How Four Organizations Trained MAs for the Advanced Medical Home,” *Advisory Board*, 2016; Advisory Board interviews and analysis.

## Advisory Board Analysis



### *Adding an MA forces GPs to reenvision task allocation*

Expanding the MA role provides an opportunity for the GP to reorganise who delivers which parts of care in a practice, and do so in a way that maximally utilises each team member's time and training. Perhaps the GP is responsible only for care planning, while RNs and MAs handle pre-visit planning and registry management, leaving patients and their families to manage day-to-day care.



### *Sharing RNs across multiple GPs achieves economies of scale*

This type of advanced GP support allows for MAs to be upskilled, thereby becoming critical primary care team members. This enables a restructuring of the care team: one MA is paired with each GP, and more costly RNs support several pairs of GPs and MAs. This results in cost savings of roughly \$14,000 per year<sup>1</sup> per team.



### *MAs can manage a spectrum of responsibilities when given the right training*

At other organisations implementing this model, we have seen groups train MAs to do chart prep, rooming, patient screening, pre-visit support, and even participate in care planning, and take on ownership of the operational efficiency of the practice.

### Prerequisites for Success

- ✓ Clear divisions of labour within care team
- ✓ MA job description that matches GP needs
- ✓ Ongoing MA training protocol

### Be Wary of...

- ✗ Limiting MA role to back-office, administrative work
- ✗ Expanding the role of every MA instead of only those who are most qualified



### Questions to Consider

- ▶ In your context, what are the obstacles for implementing an MA with an expanded role in primary care?
- ▶ What tasks in local GP clinics can you envision being performed by MAs?
- ▶ Would GPs support this, even though it may mean their responsibilities are reallocated? How would you navigate pushback?



### Learn More

Read our executive research briefing on medical assistants, *How Four Organisations Trained MAs for the Advanced Medical Home*, available on [advisory.com/gfhi](https://www.advisory.com/gfhi)

1) Both costs are US averages, given in USD.

Source: Advisory Board interviews and analysis.



# Key Takeaways and Relevant Resources

## KEY TAKEAWAYS

### Accelerate Primary Care Transformation

- 1. Identify key points where you can expand access:** In the long term, primary care needs to evolve in ways that expand access. But in the short term, you can support GPs and become a trusted partner by creating and facilitating increased primary care access.
- 2. Use hospital scale to boost primary care team:** Small primary care practices may not have the resources or scale to expand their care team, even if they believe it's the right thing to do. Identify and provide individual team members to expand GP capacity and bridge the transition between sectors.

Resources to Transform Primary Care:  
Search for These Titles on [advisory.com](http://advisory.com)

#### ▼ Increase Primary Care Access Points



- **What Do Consumers Want from Primary Care?:** Results from US survey of 4,000 patients that identify 10 insights surrounding patient preference for GP clinic attributes
- **Primary Care Access Opportunity Audit:** Diagnostic designed to measure member readiness and potential to increase access to primary care services and deploy practice productivity enhancements
- **How Virtual Primary Care Can Help Alleviate ED Pressure:** Blog post providing insight into three emerging virtual GP services in Australia, Canada, and the UK
- **4 Ways Hospitals Can Provide Transportation Assistance to Drive Access Improvements:** Blog post describing methods to reduce transportation barriers for low-income or rural patients

#### ▼ Expand the Primary Care Team



- **Population Health Job Description Library:** Compendium of descriptions of innovative population health-related roles to use when expanding your care management teams
- **Population Health Staffing Tool:** Forecasting tool enabling you to project primary care staffing needs based on population size, risk breakdown, and care management initiatives
- **Primary Care Pharmacist Readiness Assessment:** Online quiz assessing how prepared you are to add a pharmacist to your primary care team
- **How Four Organisations Trained MAs for the Advanced Medical Home:** Research briefing that details training efforts taken by four US organisations to extend the MA role and provides insights and action steps to help you initiate your own training protocol



## ▶ Partnering for Patient-Centred Care

“Health care’s purpose is not maintaining the perfect version of the wrong, or limited, model. **It is to improve the health of populations, longitudinally, over time, period.** Instead of being stuck in one model, as we have been, maybe the current model is just one piece of what we need to get a whole population to better health over time.”

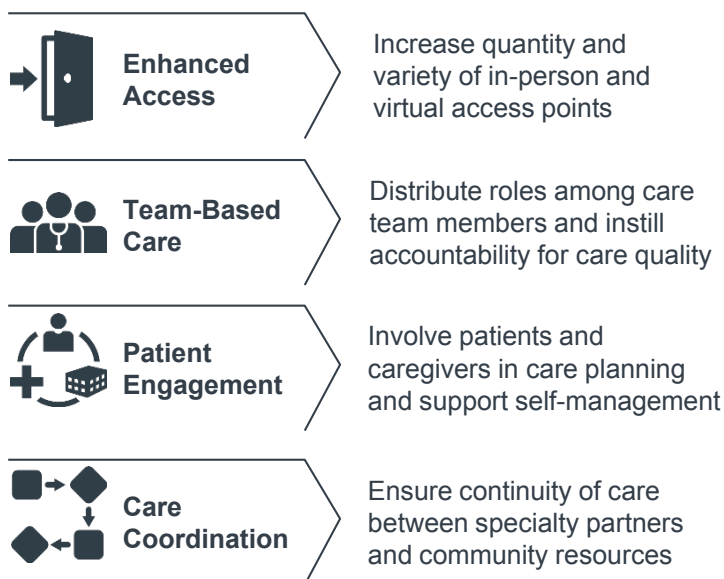
*Dr Doug Eby, VP Medical Services  
Southcentral Foundation, US*

# The Patient-Centred Medical Home

The most progressive organisations continue to innovate beyond increasing access and expanding the care team. In the US, this model of advanced primary care is called the Patient-Centred Medical Home (PCMH). It began in the early 2000s and gained significant traction under the Affordable Care Act<sup>1</sup> in 2010. Though PCMHs come in a variety of shapes and sizes, there are four criteria for a practice to be called a patient-centred medical home: enhanced access, team-based care, increased patient engagement, and improved care coordination.

In 2016, a published analysis found that over two years, patient-centred medical home pilots in Colorado, US, demonstrated sustained cost avoidance and reduced risk escalation through comprehensive and augmented primary care services. These pilots are reducing avoidable admissions through greater patient stability. They are also saving money for providers that are in capitated contracts—the very goal most providers and commissioners aim to achieve. We are already seeing variations of the PCMH pop up around the world.

## Building Blocks of the Patient-Centred Medical Home



## Where (Else) in the World?

- **Australia:** Stage one trial of Health Care Homes launching in 2017 in 200 GP clinics
- **Canada:** 2016 British Columbia mandate for all practices to move to Patient's Medical Home model
- **England:** 14 multispecialty community provider Vanguards adopted similar model starting in 2016
- **New Zealand:** Health Care Homes initially launched in 2010 by Pinnacle Midlands Health Network, now spreading across country

In this section, we offer an in-depth case study on one of the most successful Patient-Centred Medical Home experiments in the world: the Southcentral Foundation, located in Alaska, US.

## ▼ Advisory Board Resources on the Patient-Centred Medical Home



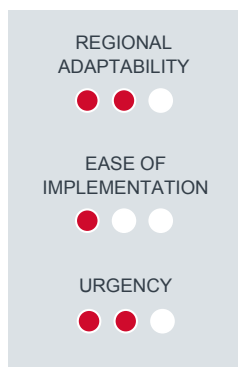
*Access these resources on [advisory.com](http://advisory.com)*

- **Medical Neighbourhood Primer:** Research briefing describing the advanced medical home model and providing five tactics to enhance coordination within it
- **Patient Education Toolkit:** Three best-in-class examples of successful patient education initiatives with tools accompanying each, as well as a chronic disease management action plan template
- **Improving PCP<sup>2</sup> Referrals to Care Management Toolkit:** Several templates, calculators, and surveys used to foster strong relationships between GPs and care managers

1) The Affordable Care Act was a piece of US legislation passed during the Obama administration in 2010 that aimed to expand coverage to millions of uninsured citizens. Included in the bill were provisions incentivising the implementation of new models of care, including Accountable Care Organisations and Patient-Centred Medical Homes.  
2) Primary care physician; this is the US term for general practitioner.

Source: Koh TW, et al., "Piloting the Patient-Centered Medical Home Concept: Singapore's Initial Experience," *International Journal of Integrated Care*, 2013, 13(8), <http://www.ijic.org/articles/abstract/10.5334/ijic.1492/>; "The Multispecialty Community Provider (MCP) Emerging Care Model and Contract Framework," *NHS England*, July 2016, <https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmrk.pdf>; Advisory Board interviews and analysis.

# Partnering for Patient-Centred Care



## Background

Until the mid-1990s, Alaska Natives were beneficiaries of the Indian Health Service (IHS), which was controlled by the US federal government from 5,000 miles away. IHS facilities around Anchorage, Alaska, were rundown, and patients entered the health care system through the ED. At the time, 65% of Alaska Natives were without an assigned GP, and it took an average of four weeks to get a GP visit.

But in the mid-1990s, legislation opened the door for tribes to take ownership over local care delivery services. With this, the Alaska Native-led Southcentral Foundation assumed responsibility for the region's health. The nonprofit health care organisation serves Alaska Natives and American Indians living in Anchorage, the neighbouring valley, and 55 rural villages.

Due to its successful primary care transformation, Southcentral Foundation is now considered one of the best population health enterprises in the world and has been asked to present its best practices over 1,750 times<sup>1</sup> internationally.



## Case in Brief: Southcentral Foundation

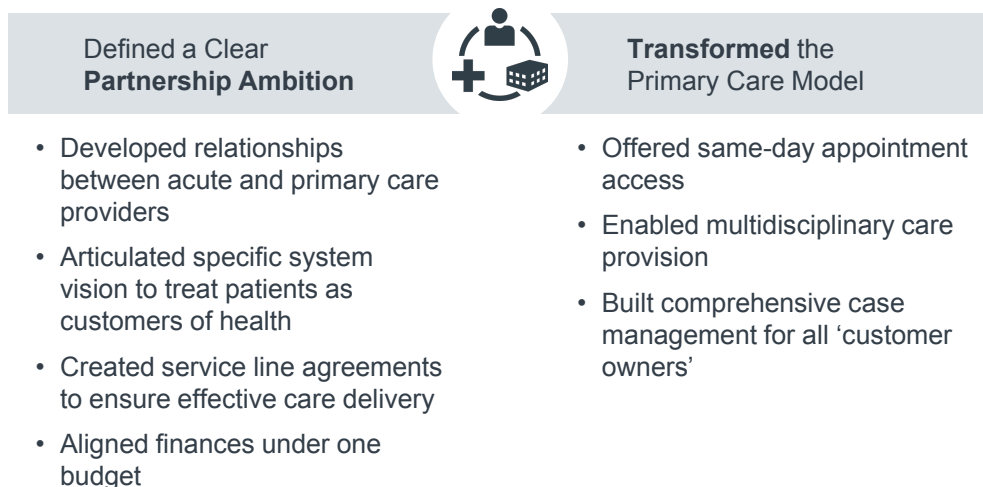
- Provides health and social services for >65,000 Native individuals in Alaska, US
- Region suffered from ineffectively utilised and poor quality care
- System 'centre' shifted from hospital to patient through primary care partnership and transformation
- Southcentral Foundation uses a care team, case management, co-located specialists, and expanded access in their advanced primary care delivery model

## The Nuka System of Care

Southcentral chose to build their system on the foundation of effective partnerships between providers and patients, grounded in the belief that the relationship with primary care is key. They actively sought out patient feedback once they assumed responsibility for care in the area, and learned that connected and individualised care was important to their patients.

Southcentral built what they call the Nuka<sup>2</sup> System of Care, which transformed the ineffective care delivery system by defining a clear partnership ambition and reenvisioning primary care. They focused on integrated budgets, IT, service line agreements, and most importantly, an accessible and multidisciplinary primary care delivery system.

## Elements of Southcentral Foundation's System Redesign



1) As of October 2016.

2) Nuka is an Alaska Native word meaning strong, giant structures, and living things.

Source: Gottlieb K, "The Nuka System of Care: Improving Health Through Ownership and Relationships," *International Journal of Circumpolar Health*, 2013, 72; "Learn About Nuka," *Southcentral Foundation*, October 13, 2016, "https://www.southcentralfoundation.com/nuka/learn-about-nuka; Advisory Board interviews and analysis.

Each patient, or ‘customer owner,’<sup>1</sup> is supported by a core Integrated Care Team that consists of a GP, an RN case manager, a case management administrative support worker, and a medical assistant. Each core care team partners with about 1,350 customer owners and sits in pods together. GPs and their teams review consumer utilisation patterns regularly and then connect with patients who utilise too many services to learn how to support them more efficiently.

### Components of Nuka’s Primary Care Model

- 1 GP-Led Core Primary Care Team** • GP, supported by case manager, admin support, and certified medical assistants; each team cares for ≈1,350 people
- 2 Case Management for All** Care of **all** customer owners coordinated across primary, acute, and social care providers on a continuous basis, scaled according to patient complexity
- 3 Accessible Care Team Extension** Specialists<sup>2</sup> co-located with core care team to enable accessible multidisciplinary care
- 4 Convenient and Timely Access** Same-day in-person or virtual appointments, as well as group visits available

#### Core Team (1 per GP)

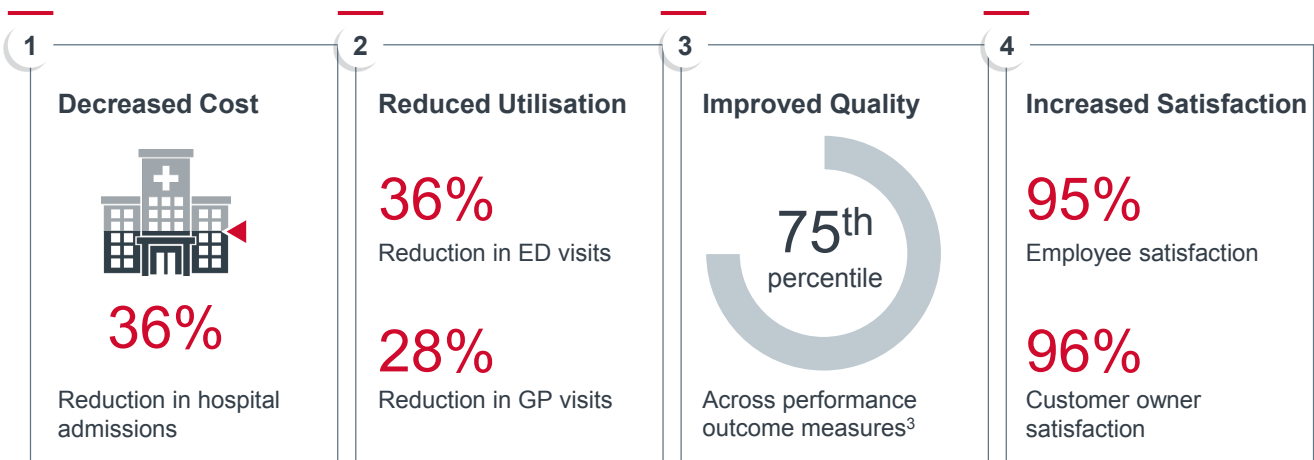
- Registered nurse case manager
- Case manager administrative support worker
- Certified medical assistant

#### Extended Team (1 per 6 GPs)

- Behavioural health consultant
- Registered dietitian
- Pharmacist
- Nurse midwife
- Non-clinical practice manager
- Co-located psychiatrists
- Coders and data entry staff

### Results

This customer-driven, systematic approach has paid off. The Nuka System of Care has achieved the elusive triple aim we strive for: improved access, decreased cost, and higher quality care. Most importantly, the system decreased utilisation not only in the hospital setting, but also in primary care.



1) Southcentral refers to Alaska Natives as ‘customer owners’ rather than patients, acknowledging the fact that they own their health.  
 2) Dietitian, midwife, pharmacist, behavioural health consultant.  
 3) Rated as *Healthcare Effectiveness Data and Information Set*, a tool used by more than 90% of US health plans to measure performance on important dimensions of care and service.

Source: Gottlieb K, “The Nuka System of Care: Improving Health Through Ownership and Relationships,” *International Journal of Circumpolar Health*, 2013, 72; “Learn About Nuka,” *Southcentral Foundation*, October 13, 2016, <https://www.southcentralfoundation.com/nuka/learn-about-nuka>; Advisory Board interviews and analysis.

## Advisory Board Analysis



### *Focusing care around the patient decreased both GP and ED visits*

The Nuka System of Care has decreased cost and usage, while at the same time improving quality and stakeholder satisfaction. Interestingly, utilisation decreased in the primary care setting as well as the hospital setting. The Southcentral Foundation leadership team attributes this success in great part to their patient-centric approach. Customer owners feel heard and known, and have strong relationships with all of their providers.



### *The onus of care management sits with the patient*

The Southcentral team realised that the hospital was not truly in control of a patient's health since most longitudinal care occurred in primary care, in the community, or at home. So they sought to develop their system around the principle that patients are in control of their own health in order to empower patients to control their outcomes.



### *Nuka provides a case manager to all of its patients*

Unique to Nuka is that every customer owner has a case manager, regardless of their acuity. On the surface, this may seem impractical and expensive, but according to Southcentral Foundation, case managers have different strategies for different types of patients. And, the strong relationship between the primary care team and the customer owners ensures that individuals are using the system intentionally. Since few resources are wasted, providing a case manager to each patient is in fact scalable.

### Prerequisites for Success

- ✓ Methods to garner patient feedback and incorporate it back into system
- ✓ Sufficient staff to provide each patient with a case manager

### Be Wary of...

- ✗ Tasking the hospital with managing day-to-day care
- ✗ Attempting to transform care before primary care partnership is established



### Questions to Consider

- ▶ How would the idea of 'customer ownership' be received in your context?
- ▶ Of the Nuka system's four primary care model components, which, if any, does your primary care system currently employ?
- ▶ If you are a hospital, what groundwork would you have to lay with primary care before embarking on a transformational journey like this?



### Learn More

Listen to our webconference about the Nuka System of Care, given by Southcentral Foundation executive leaders: [advisory.com/gfhi/nuka](https://advisory.com/gfhi/nuka)



# Case Study Grade Overview

Tactic Organisation	Regional Adaptability			Ease of Implementation			Urgency		
	High	Medium	Low	High	Medium	Low	High	Medium	Low
Grade	● ● ●	● ● ●	● ● ●	● ● ●	● ● ●	● ● ●	● ● ●	● ● ●	● ● ●
Ribera Salud		✓			✓			✓	
Jönköping County Council	✓				✓		✓		
Gold Coast HHS <sup>1</sup>	✓					✓	✓		
Vancouver Coastal Health			✓	✓				✓	
Northern Adelaide LHN <sup>2</sup>	✓			✓			✓		
Silver Star Hospital <sup>3</sup>	✓			✓				✓	
CHU de Liège			✓	✓					✓
Sunshine Coast HHS <sup>1</sup>			✓		✓				✓
Group Health Cooperative	✓			✓					✓
CareMore			✓		✓			✓	
South Somerset Symphony Project		✓				✓		✓	
Northumberland ACO <sup>4</sup>		✓			✓		✓		
Stanford Hospital & Clinics		✓			✓		✓		
Southcentral Foundation		✓				✓		✓	

1) Hospital and Health Service.  
 2) Local Health Network.  
 3) Pseudonym.  
 4) Accountable Care Organisation.





# Advisors to Our Work

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The Global Forum for Health Care Innovators is grateful to the individuals and organisations that shared their insights, analysis, and time with us. We would especially like to recognise the following individuals for being particularly generous with their time and expertise.

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CareMore

Group Health Cooperative

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Stanford Hospital & Clinics

# The Advisory Board Difference

The Advisory Board Company has over 35+ years of experience helping health care get better. Our ambition is to be the smart, efficient approach by leveraging our global knowledge base to find right answers that work in the real world.

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Upon joining, Advisory Board members receive full access to our entire archive of research and tools—available to everyone within the organisation at no additional cost. This enables teams to have the tools they need, when they need them, to elevate performance. Your dedicated service team will work with you to go deep on your key strategic priorities each year, enabling the organisation at large to leverage membership to advance the most critical priorities across the organisation.

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CEO, Public health system in Canada

”

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This report is a publication of the Global Forum for Health Care Innovators, a division of Advisory Board. As a member of the Global Forum, you have access to a wide variety of material, including webconferences, research reports, implementation resources, our blog, and more. Check out some of our other work on primary care.



### **Implementation Resource: The Primary Care Partnership Toolkit**

Use this suite of templates, calculators, and tools to assess your current relationship with primary care, master partnership fundamentals, and identify ways to increase primary care access and transform primary care's delivery model.



### **Executive Research Briefing: The New Partnership Advantage**

Examine the obstacles that hinder successful partnerships in health care and learn key lessons to develop a comprehensive and proactive approach to partnership strategy.



### **Executive Research Briefing: Medical Neighbourhood Primer**

Learn how to strengthen primary care-specialist coordination through an overview of the medical neighbourhood model, five tactics to build the neighbourhood, and case studies that illustrate each tactic in action.

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