Strategies for Partnering with Primary Care Providers

Deeply partnering with primary care providers is a *vital* activity for the success of any enhanced care model for individuals with complex needs and high costs. Primary care providers are caring for many of these individuals now and in the setting the individuals will most likely receive care in the long term. Primary care providers have knowledge about the individuals and, in all but ambulatory intensive care (AICU) models, will be the medical provider responsible for the clinical care. Primary care settings are often time and resource constrained.

For all these reasons, and more, deeply engaging primary care providers in the development and deployment of an enhanced care model for individuals with complex needs and high costs is seen as necessary for success.

The goals of these partnerships include:

- **A shared vision of the enhanced care model and the value proposition for stakeholders, including the primary care provider.**
- **A shared, operational understanding of the goals of the enhanced care model and how goals will be achieved. This includes:**
    - Developing a shared understanding of individuals who are a good fit for the program and individuals who, although have complex needs, are not a good fit.
    - Developing operational systems that make participation by the primary care provider and care team possible and add value to the practice.
- **Integrated, effective, and seamless care for individuals in the program.** Even in an AICU model, obtaining referrals and support for patients to leave their practice for the AICU is key, as well as, sharing key information.
- **Effective referrals of individuals who are a good fit for the program.**

The following guidance will support your efforts in developing effective partnerships with primary care providers and their care teams.

- **Develop a deep, shared understanding of the goals of the enhanced care program and the value to the primary care providers and to their patients.**
    - Meet in-person to talk about the enhanced care program.
    - Learn from and with them about the challenges patients with complex needs have, the challenges faced in providing effective care, and potential interventions needed in the enhanced care model.
    - Develop with them the value proposition for their participation and whole-hearted support.
    - Discuss referrals to the program and why some individuals with complex needs, but not high costs are not a good fit and those with complex needs and high costs are a good fit.
    - Conduct regular case conferences on individual patients for care planning and ongoing support of progress towards goals.
- **Co-design aspects of the enhanced care model to better meet the needs of potential patients and to meet the needs of the primary care practice.**
    - Engage primary care providers in understanding the root causes driving high utilization and in choosing your population to focus on.

  - Engage primary care providers in developing identification criteria and processes. Their knowledge of patients and their challenges not found in electronic records is necessary for good identification.
  - Hold shared case conferences on shared patients to develop integrated care plans and to further the shared understanding of the program.
  - Create an easy to use referral mechanism, such as a template in the electronic health record or template for faxing.
  - Discuss referrals of patients who are a good fit and those who are not to develop a shared understanding.
- **Assure good communication with primary care providers.**
  - Create coordinated, responsive, and easy communication methods between those who refer patients and care management staff. Strategies include co-location of staff, a dedicated phone the care manager uses to communicate with practice staff.
  - Communicate directly with primary care providers within 1 week of the referral to update them on your team's progress connecting with the patient.