Performance Measurement in Comprehensive Primary Care:
Different Perspectives from Different Approaches

George Southey, MD, FCFP
Lead Physician and Medical Director
Dorval Medical

May 27, 2012

fresh care

Contents

Introduction

This paper is for people who sense that Ontario's health care system may be facing significant risk to its sustainability. This group will consist primarily of decision makers in government and health policy but may also include medical professionals and members of the public who share knowledge of and a passion for our health system. The author intends this document to assist them in exploring reform options if incremental adjustment fails to stabilize the current system. It looks specifically at the challenges facing comprehensive primary care.

Significant change requires a clear understanding of *objectives*, a *strategy* – the elements -- to achieve them, and the ability to *measure* performance towards them. The four sections of this paper describe in turn:

- choices available within primary care (i.e., measurable elements of performance)
- why it's worthwhile to measure performance vis-à-vis those elements
- an example of how one practice selected and implemented its choices
- how its experience can benefit both the system and individual practices

This paper is not a scientific description of a right answer. It seeks rather to describe and list the options one might consider when assessing performance in comprehensive primary care. The description of the components does not answer the problem of defining performance, but it suggests a framework for understanding and appreciating the choices that arise.

A Significant Risk?

Most doctors and members of the public do not see a significant risk to the health care system (sustainability, affordability). Others have expressed concern for many years, and yet the system has continued to evolve.

In 2010 (as chief economist of TD Economics)[1] and in 2012 (as a provincial commissioner)[2], Don Drummond advised the Ontario government that stabilizing its finances would require control of health costs. He also stated that managing these expenses required reform of the health system. Both of his reports gave suggestions for such reform. To date, these proposals have not led to change.

The government is currently discussing contracts with the Ontario Medical Association (OMA) and has recently reduced the fees on numerous services. It did so within the existing system and did not attempt the sort of reform that Drummond suggested. So far, neither side has articulated objectives, strategies, or implementation of reform.

[1] "Charting a Path to Sustainable Health Care in Ontario," *TD Economics Special Reports*, May 27, 2010.
[2] Commission on the Reform of Ontario's Public Services, February 15, 2012.

Given the seeming disconnect between Drummond's recommendations and the province's non-actions, risk is likely to arise from the financial sector, which funds government services. Such risk can manifest itself suddenly and dramatically (as in the housing bubble of 2008 and the current sovereign debt crisis in Europe).

The medical profession might consider another factor in its risk analysis. The general impression has been of a scarcity of primary care personnel. If this perception is true, then the profession is in a position of strength and can use the threat of further loss of personnel as a reason to limit financial cuts. Yet data from the OMA indicate 7,650 comprehensive primary care physicians in Ontario[3] working at least 30 hours/a week in direct and indirect patient care.[4] There are about 13 million people in the province. As a result, with the current number of physicians working in the way they do, the system would reach capacity with 57 patients per practitioner.[5]

Dorval Medical reports a practice capacity of 63, and informal discussion with other family health teams (FHTs) suggests similar capacity there. If similar capacity were to become the norm in the province, the current levels of personnel would suggest about 10 per cent surplus of primary care physicians.

Performance and Risk

Primary care services represent less than 10 per cent of the health system's costs, but 60 per cent of its encounters and an even greater proportion of ongoing relationships between health providers and the public. In other words, despite its small system cost, primary care -- the locus of ongoing important relationships -- shapes the public's experience of its health system.

Comprehensive primary care requires management of patient information, coordination of care, and management of expectations, in addition to medical services. [6] Better management in primary care could significantly increase the system's efficiency.[7]

Reform Objectives

Don Drummond has suggested clear objectives for reforming the health system. As an appointee of the Ministry of Finance, his primary objective was to limit increases in health care costs to 2 per cent per year – well below the expected growth of 6 per cent. Despite an ageing, growing population, this cost objective requires savings of about $1.8 billion per year.

---

[3] www.ophrdc.org/public/download.aspx?fileType=pdf&fileName=2010%20PIO%20Print%20Copy%20for%20Website.pdf

[4] www.nationalphysiciansurvey.ca/nps/2010_Survey/pdf/en/downloads/NPS2010-ON-Binder.pdf

[5] Physician capacity = the number of satisfied relationships/physician care hours in a week; see The Dorval Model: www.dorvalmedical.ca, Appendix D). A doctor with 1,500 patients who works 40 hours per week and satisfies their needs would have a capacity of 1,500/40 = 37.5.

[6] Subcommittee on Primary Care of the Provincial Co-ordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) (1996), *New Directions in Primary Health Care*. PCCCAR report to the Minister of Health Ontario, 21–31. These services are a part of every FHO [?] and FHN [?]contract

[7] The Dorval Model: www.dorvalmedical.ca, Appendix D.

The government also has articulated its objectives vis-à-vis quality and capacity. It wants an accountable assurance of quality and capacity that would allow everyone access to all primary care services.

Thus we can summarize the province's objectives in reform:

- *quality* that meets the province's expectations
- *capacity* that ensures primary care for every Ontarian
- *costs* as low as possible

The medical profession has not described its objectives in the event of system reform. In the absence of consensus, one might assume it wants general economic objectives: economic stability, to allow it to plan and implement professional practice, and resources to provide the expected services. These resources include income and access to capital.

Elements of Performance

Most people experience exposure to comprehensive primary care when they visit their family doctor. They may come away with a sense of the level of satisfaction they receive from the service. Despite the shared experience, there is little consensus on defining performance in primary care. There is even less understanding about the relationship between primary care services and achieving reform.

There is an old adage: "What cannot be measured cannot be managed." This applies to comprehensive primary care. The lack of consensus on defining performance means that measurement methods differ, and assuring and improving quality are difficult. Primary care is not simply the provision of clinical services, but also includes management services and effective interpersonal relations. The elements (clinical, management, and relationships) are inseparable and influence each other.

Differences in performance definition may reflect different perspectives. This discussion describes eight elements of performance and their definition, which can shape measurement of them.

1 authority
2 change
3 focus
4 perspective
5 scope
6 parameters
7 level
8 scalability

There are options available in each element. This discussion attempts to describe the implications for the choices in each of the eight elements. A practice's selections in elements 1--4 will tend to shape its character, and those in elements 5--8 will tend to flow from those choices.

1. Authority

Deciding where the ultimate authority lies to determine 'quality' depends on one's philosophy. Quality in primary care can be accountable to external authority (the population served) or internally (the profession of primary care). Internal and external perspectives of quality are not mutually exclusive -- components of each form part of a complete sampling of quality characteristics. The authority lies in determining the relative value of components. This authority is apparent at the global orientation of quality (see element 4, below).

The two perspectives (internal and external) measure performance differently. Internal perspectives may respond strongly to indicators relating to diseases or clinical practice. The Ontario Diabetes Registry can serve as an example.

External perspectives stress patient experience and access. We can see this in the comments on patient rating services such as <ratemds.com>.

Internal determination of quality would require professional consensus on the characteristics of quality – an elusive ideal!

External determination involves asking the population about its expectations of primary care and requires a method – not yet available – to allow popular opinion to express itself. Some observers might see such a method as inherent in the market system, but this is not relevant in Ontario's public system.

Both internal and external assessments of quality are naturally going to change over time, and both reference each other.

2. Change

Everything changes. Even the best framework for measuring performance must adjust to changing knowledge, shifting priorities, and new opportunities. The manner in which it does so decides its future viability, even its survival.

A framework that changes too slowly may precipitate conflict when comparisons cease to be useful or meaningful.

3. Focus

There are two competing ways of assessing performance and productivity in comprehensive primary care: measuring either **activities/transactions** or **outcomes/processes**. The choice a practice makes will shape its organization and activities decisively.

Ontario defines productivity and performance in terms of activities or transactions (the number of assessments or procedures for a given time). In contrast, in the United Kingdom, the Quality Outcomes Framework (QOF) measures population-based outcomes and practice processes. The two systems conceive of effectiveness and efficiency very differently.

The choice between the two relates mainly to the philosophy of quality and who defines quality. A system valuing volume of services will measure services (activities/transactions) to reflect performance. A system focusing on population-based results will look at outcomes/processes. One might choose different parameters for assessing comprehensive primary care as opposed to specialty practice.

Both systems can measure the services of comprehensive primary care vis-à-vis the 15 PCCCAR services (see 5 below).

Although the Ontario Ministry of Health measures activities, Health Quality Ontario (HQO) looks at outcomes and processes, creating confusion for providers and stewards.

As an illustration, I apply here the two systems of measurement to a practice addressing hypertension -- the most prevalent treatable risk for the principal cause of premature death and disability in Ontario.

Measuring Activities or Transactions

A practice might decide to measure activities or transactions over time, such as the numbers of

- blood pressure measurements
- office visits where hypertension is a billing diagnosis
- low-sodium dietary counselling sessions

During the time of measurement, the practice tries to be productive by providing as many of these services as possible so as to appear productive. The practice is busy with a focus on hypertension.

The cost of this approach steadily increases with the volume of services. There is no feedback in this measurement system to lessen the pressure to provide more service. Thus measuring performance by activities may generate inappropriate activities, insensitive as it is to the distribution of transactions within the practice. For example, counting will not distinguish between 10 transactions to one patient and one transaction to 10 patients. Both scenarios appear the same.

This method does not address the control of blood pressure in patients with the condition.

Measuring Outcomes or Processes

A practice might decide instead to measure outcomes or processes, such as the proportion of

- patients it has screened for hypertension in the past five years
- all hypertensive patients with a blood pressure of 150/90 (or less) in the past year

In this system, the outcomes apply to the entire practice for screening and the entire registry of hypertensive patients for effective treatment. Outcome measurements miss no patient from either screening or treatment. Once the practice has measured all patients, there is no value to further effort to provide service.

Productivity in Both Methods

Productivity is a ratio of what a practice produces to what it requires to produce it. As we saw above, productivity in both measurement systems (activity/transaction or outcome/process) reflects the choice of measurements. With activities, more activities at the same price means

greater productivity. With outcomes, achieving the target outcome at lower cost means greater productivity.

One might assume that measuring activities is a potentially useful indirect measurement of outcomes. Yet the relationship of activities in the achievement of outcomes is not linear. While some activity is necessary to achieve an outcome, at some point further activities simply add cost without achievement. In other words, activities become an inverse indicator of productivity where measurement values outcomes.

Implications

It appears that the people of Ontario expect value for money in the provision of comprehensive primary care. They want service for the entire population and disapprove of volumes of service that fail to assure results. This philosophy is explicit in the work of Health Quality Ontario. For these reasons, measurement focusing on outcome and process best reflects Ontarians' values.

Measurement of activities in comprehensive primary care is inconsistent with the values of Ontario (and the Association of Family Health Teams of Ontario -- AFHTO). Persistent insistence on counting activities and transactions and failure to assess outcomes and processes distort the understanding of outcome achievement. Measuring activity can encourage non- or counterproductive behaviour.

If we want to exercise stewardship[8] and encourage performance in health care, we should encourage measurements of outcomes and processes.

4. Perspective

A granular (or detailed) perception of primary care observes at the level of specific attributes, conditions, indicators, or services. This view allows analysis of individual service characteristics in isolation. For example, the current Ontario initiative in diabetic care analyses performance of diabetes care in isolation. In a similar manner, Ontario's interest in reducing unnecessary visits to the emergency room focuses on the isolated service of access for acute episodic care.

There is no limit to the detail or level of achievement that such a perspective might generate. A passion for a particular issue can lead to neglect of other services or attributes.

A granular orientation fails too vis-à-vis comprehensive primary care. Complex services require multiple indicators at a granular level. In this level of detail, it is very difficult to compare performance between service providers and even with the same service provider over time. Differences in various elements of the granular observations can carry different meanings.

A granular *and* global orientation of primary care starts with granular observations but then takes an additional, global perspective. The latter viewpoint requires a method that holds the values of the granular components in a relationship to each other. This perspective harnesses a variety of

[8] Stewardship: caring for someone else or for something that one doesn't own.

methods. The global orientation can be as simple as the 'overall assessment' in a rating system such as <ratemds.com>. Some people feel that global orientation can occur through market forces in open markets (e.g., segments of the U.S. health system). It is possible to estimate the global perspective in terms of a mathematical relationship between indicators, as occurs in Britain's Quality Outcomes Framework (QOF).

A global orientation must not be static. It should measure performance in such a way that it evaluates the relationship over time. In other words, it needs to adapt to changing reality over time.

Adding the global orientation to performance measurement can be problematic. Global performance may seem too subjective or too arbitrary or biased.

Despite these challenges, the global perspective can compare performances of a service provider over time and between service providers.

The global perspective also helps providers to ensure quality. It allows rational selection of initiatives. Consider a practice that can improve two indicators by 10 per cent. In the granular perspective, both initiatives appear to be equally beneficial. In the granular *and* global perspective, one indicator might appear much more important, suggesting focus on the most beneficial initiatives.

Figure 1 illustrates the philosophical choices available in elements 1 (authority) and 4 (perspective) and offers examples of models or research proposals.

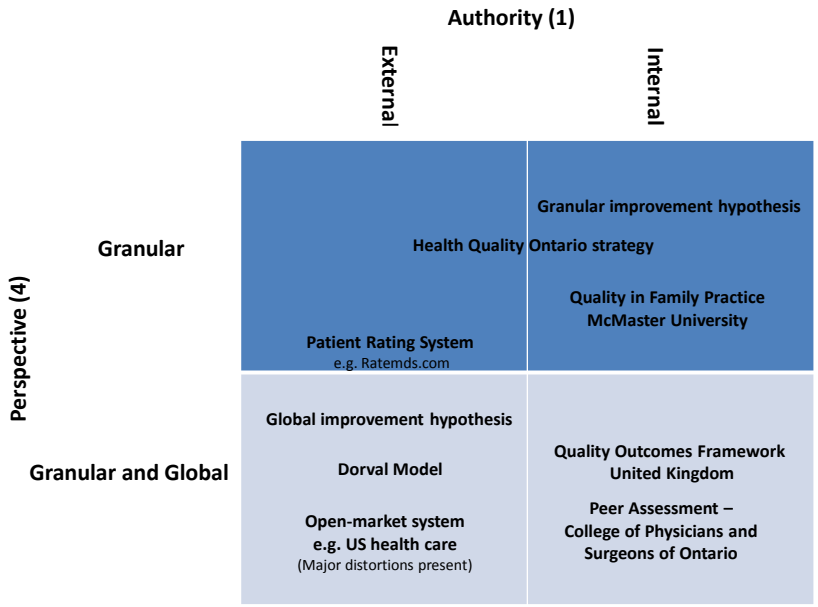

Figure 1
Choices available in elements 1 and 4

5. Scope

Many determinants of health – perhaps as many as 70 per cent -- do not fall within the responsibility of the health system. And the public system itself does not cover 30 per cent of health services (e.g., dental services, drugs, and aspects of institutional care).

Fortunately, in Ontario, the majority of comprehensive primary care physicians have signed contracts in patient enrolment models (PEMs). These contracts define the scope of services as the list of the PCCCAR basket of services (see Appendix). This consensus provides a convenient solution to this philosophical issue.

6. Parameters

Performance measurement in primary care can involve the use of a wide variety of parameters: activities, capacity, costs, income, overhead, processes, qualitative attributes, service descriptions, and subjective impressions. Despite the wide variety of options, the purpose of this choice is to allow comparison, either of an individual's performance over time or of different individuals.

Selecting too few parameters may lead to an incomplete description of performance, while using too many may obscure performance. For example, considering only income from the practice will ignore crucial characteristics of primary care that the payment system ignores. Likewise, the many parameters in the Ontario Hospitals Balanced Scorecard make it almost impossible to compare performances. The Institute for Health Improvement strikes a balance in its Triple Aim using three parameters: clinical indicators (just a few), cost, and patient experience. Dorval Medical's choices of cost, capacity, and quality are somewhat different, as we see below.

7. Level

The system is not infinitely flexible and requires a balance between competing forces, which probably reflects political and policy judgment. Over several generations of physicians, OHIP's payment mechanism has embedded a sense that performance in primary care is a function of individual providers. Nothing in it encourages orientation towards group performance. This situation is arbitrary and a function of the economic distortion that flows from the historic funding system. A more realistic perception of the reality of practice might offer refreshing new perspectives.

There are at least two compelling arguments for including group performance.

First, in most services of any sort, groups outperform individuals. There are very few circumstances where individuals provide the greatest performance and productivity. If there is a group dynamic in primary care, then it should be possible to observe it and support it.

Second, measuring group performance may well improve performance. An individual provider is less likely to react to external feedback. But when a group works together towards common

objectives, individuals are more likely to respond. Group safety and support can be a great catalyst for change.

8. Scalability

The framework should consider incorporating scalability -- the option of having the framework scalable to different-sized populations. Reference population sizes include a single provider who might have a practice of about 1,300 patients; in contrast, Ontario's population is 13 million, or 10,000 times more than a provider's population.

A framework that is scalable by a factor of 10,000 provides a valuable advantage in Ontario: a successful innovation in the practice could suggest steps to improve the entire system. In other words, each scalable practice can innovate in ways that could apply readily to the system and the province as a whole.

When a framework opts for scalability, it restricts its own choices of indicators. Some indicators work only with small populations (e.g., the College of Physicians and Surgeons of Ontario (CPSO) chart audit method). Others work only with large numbers (rate of serious complications). With large numbers, such indicators can accurately observe shifts in performance of crucial factors such as premature death due to specific conditions. In small populations, indicators can measure only indicators that occur frequently in a population of 1,300. For example, the diabetic indicator of tracking amputation rates would not apply at a practice level, but control of blood pressure works in all scales of population.

Why Measure Performance?

This paper might seem an academic exercise without much relation to 'real world' experience, were it not for the work of Barbara Starfield[9][10][11][12][13][14][15]. This renowned researcher in primary care and health systems saw repeatedly and in many jurisdictions that investment in primary care correlated with a more effective and cheaper overall health system. She observed higher quality, adequate capacity, and lower cost.

The way in which this correlation works is not clear. Some experts believe that it flows from higher quality; others, from solid relationships in primary care, which encourage public stewardship of the health system.

Because the underlying causation for Starfield's findings is unclear, a framework for measuring performance should work both ends of the relationship – i.e., encourage better quality *and* foster solid relationships and stewardship. With a framework that allows both hypotheses to work, reform is more likely to succeed.

The empirical test of measuring performance will be to observe change in providers' behaviour vis-à-vis the system's three objectives, which appeared above:

- *quality* that meets the province's expectations
- *capacity* that ensures primary care for every Ontarian
- *costs* as low as possible

[9] Shi L, Starfield B, Kennedy BP, Kawachi I. Income inequality, primary care, and health indicators. J Fam Pract. 1999; 48:275-84

[10] Starfield B. Is US health really the best in the world?. JAMA. 2000; 284(4):483-4.

[11] Starfield B, Shi L. Policy Relevant Determinants of Health: An International Perspective. Health Policy. 2002; 60:201–18

[12] Starfield B. Research in general practice: co-morbidity, referrals, and the roles of general practitioners and specialists. SEMERGEN. 2003; 29(Supl 1):7-16

[13] Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. Milbank Quarterly. 2005; 83(3):457–502

[14] Starfield B. Global health, equity, and primary care. J Am Board Fam Med. 2007; 20(6):511-3

[15] Starfield B. Family Medicine Should Shape Reform, Not Vice Versa. Family Practice Management. 28/05/2009.

An Example

There is little or no system-level guidance, support, or feedback for many of the choices that this discussion presents. Some of the system's feedback is contradictory, presenting mixed messages to primary care physicians. Its expressions of support for group cohesion conflict with its individual payment and measurement. It praises measurement of outcomes but pays instead for activities. It leaves scope of service to the discretion of each physician.

In the face of conflicting feedback, Dorval Medical (a small family health team in Oakville[16]) addressed performance measurement and made choices vis-à-vis the eight elements I outlined above:

1 authority
2 change
3 focus
4 perspective
5 scope
6 parameters
7 level
8 scalability

1. Authority

Dorval Medical has always believed that it is accountable to the population it serves. As a result, it uses its patient population as the external reference for defining quality.

2. Change

The Dorval Model uses ongoing feedback from its patients to adjust its selection of indicators and their relative weighting. In this manner, its performance measurements respond to patients' shifting priorities.

3. Focus

For the reasons I outlined above and to be accountable to the population it serves, Dorval Medical chose to measure outcomes rather than activities.

4. Perspective

[16] 6,000 patients, six MDs (3.1 full-time equivalents, or FTEs), two nurse practitioners, four registered nurses, with average patient acuity slightly higher than the Ontario average.

The clarity of performance measurement diminishes with large numbers of indicators that lack a global perspective. Dorval Medical needed a way to establish the relationship of the various indicators, which I describe in "The Dorval Model."[17] Using this method, the practice has chosen the granular *and* global perspective in measurement.

5. Scope

All the physicians of Dorval Medical are committed to comprehensive primary care, and all have signed the Family Health Organization (FHO) contract. The document defines the scope of practice as the PCCCAR basket of services, which Dorval embraces.

6. Parameters

Dorval Medical chose three parameters to describe performance: quality, capacity, and cost. It defined quality as all characteristics of all services and included all these characteristics in a structure of weighted measurements. It then used the three parameters that reflect Don Drummond's reform objectives to cover all aspects of performance.

Dorval decided to measure capacity separately because it is independent of quality and cost in Ontario's health care system. It defined capacity as the number of satisfied relationships that the practice can maintain in relationship to doctors' time (booked hours in the week). This standard requires meeting patients' expectations as they emerge in the quality measurements.

Dorval measures cost so as to include both primary care (all the practice's costs divided by the total number of patients) and total health costs (the costs of all of the patients' health services divided by the total number of patients). In this way, it can work towards efficiency both in its provision of primary care and in how that provision affects its portion of total system costs.

7. Level

Dorval Medical has always held itself accountable to the population it serves at the level of the practice. It measures individual performance but uses the results only internally to ensure and improve quality.

8. Scalability

The Dorval Model is intentionally scalable for populations as small as an individual practice and as large as the entire province, as is clear from the model's choices of indicators.

Table 1 summarizes Dorval Medical's choices of elements.

[17] www.dorvalmedical.ca/about-us/the-dorval-model/

Element no.	Element	Dorval Medical's choice
1	authority	external
2	change	feedback from patients
3	focus	outcomes
4	perspective	granular *and* global
5	scope	PCCCAR's 15 services
6	parameters	quality, capacity, cost
7	level	organization
8	scalability	factor of 10,000

Table 1
Dorval Medical's choices of elements

Having Its Cake and Sharing It Too

The example of Dorval Medical might offer a solution to performance management should the environment require reform of primary care.

The practice's experience suggests that the choices for a performance framework provide a means to reform the system with:

- *quality* that addresses public expectations
- *capacity* that guarantees everyone primary care
- *costs* as low as possible through stewardship/conservation

Dorval Medical's experience also suggests that, even while fulfilling the system's reform objectives, the practice can enjoy reasonable income and access to capital. If the system provides the economic foundation for measuring performance, then it can eventually achieve stability.

With the right choices for performance measurement, the province can meet the reform objectives of both the system and the profession. It can have its cake and eat it too.

Appendix: PCCCAR Functions

All primary health-care agencies (PHCAs) should provide the following 15 PCCCAR[18] functions:

1. **health assessment:**
   - determination of patient's current health status and potential for health problems by collecting information on physical and psycho-social condition and lifestyle
2. **clinical, evidenced-based illness prevention and health promotion:**
   - clinical prevention services for patients and families, based on evidence-based guidelines, such as periodic health exams and immunization
   - approach (rather than specific set of services) that focuses on broad determinants of health, underlying causes of illness, and factors that affect ability to cope, and that looks at entire population
   - education and support and possibly community development, advocacy, and education
3. **appropriate interventions for episodic illness and injury:**
   - in case of illness or injury, timely access to primary care services through simple telephone advice, direct patient contact, and/or referrals to secondary and tertiary care
   - appropriate follow-up
4. **primary reproductive care:**
   - counselling for birth control and family planning, education, screening and treatment for STDs, ante- and post-natal care, and labour and delivery
   - in absence of full in-house maternal care, relationship with agency that provides service
5. **early detection and initial and ongoing treatment of chronic illnesses:**
   - range of services, including anticipatory care, monitoring to prevent/treat flare-ups, ongoing education for patient and family, and follow-up at appropriate intervals
   - knowledge about community-based services
6. **care for majority of illnesses (in conjunction with specialists, as necessary):**
   - comprehensive care to meet all primary medical-care needs -- i.e., for all health problems and illnesses
7. **education and support for self-care:**
   - encouragement of greater self-reliance, self-care, and mutual aid, through health education, counselling, links to resources in community, access to phone health information, advice, and triage services
8. **support for hospital care and care at home and in long-term facilities:**
   - in some communities, GP/FPs to deliver or coordinate and monitor hospital care

[18] Subcommittee on Primary Care of the Provincial Co-ordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) (1996), *New Directions in Primary Health Care.* PCCCAR report to the Minister of Health Ontario, 21–31.

- as minimum, involvement in planning pre- and post-hospital care, including linking patients at discharge with home care and other community services
- support for care and treatment at home and in long-term care
- links with home-care programs, appropriate referrals, and liaison and consultation with home-care coordinators and providers

9. response 24/7:

- ability to respond to patients' health problems 24 hours a day, 7 days a week
- direct response, not through answering machine or instruction to go to emergency

10. service coordination and referral:

- coordination of community, secondary, and tertiary care

11. maintenance of comprehensive health record for each patient:

- management of client information in order to facilitate coordination and referral

12. advocacy:

- support, referral, and liaison for patients aware of need but unable to organize help
- supportive listening, accompaniment if necessary, writing of letters, making of telephone calls, and/or speaking on patients' behalf and organizing of case conferences

13. primary mental-health care, including psycho-social counselling:

- recognition of emotional and psychiatric problems, comprehensive management planning, awareness of resources in community, knowledge of when to refer patients to and/or work with other mental-health providers

14. coordination of and access to rehabilitation:

- arrangements for appropriate rehabilitative care
- referral of patients to rehabilitation therapists, participation in treatment planning and follow-up, education and advocacy, 'care map' leading to return to function/school/work

15. support for people with terminal illness:

- home visits and capability for 24-hour response when necessary for care and advice
- coordination of medical care with home care and other community agencies
- arranging of timely access to hospital care and proper discharge