ADAPTING WHAT WORKS IN PRIMARY CARE

A GETTING STARTED RESOURCE FOR PROGRAM MANAGERS
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All too often primary care is the weakest link in the health system—yet it serves as the crucial foundation for universal health coverage.

Primary care is the first point of contact and, in many communities, the sole source of care for most health needs. From managing diabetes to providing antenatal care, comprehensive primary care delivers a spectrum of preventative, promotive, and curative care. Health systems built on strong primary care delivery are more resilient, efficient, and equitable. Yet, it is all too often lacking—too many women still die in childbirth from preventable causes, too many people die from treatable chronic conditions, and too many people still lack access to quality basic care.

In many low- and middle-income countries, a significant proportion of primary care services are delivered by private providers. In these countries, the private sector can be a source for new approaches, innovation, and responsive care. But the private sector is also often unregulated, with quality and accessibility of care varying drastically. Poor patients often gamble with their health as they navigate these challenging and fragmented health markets. Additionally, catastrophic unexpected healthcare spending can push vulnerable households even deeper into poverty.
Many promising private sector models have emerged to provide primary care for the poor in low- and middle-income countries. However, as these private models continue to grow, program managers face challenges and look to learn from the experiences and solutions of others. But a copy-paste approach rarely works.

With this in mind, the Center for Health Market Innovations (CHMI) introduced a new framework to guide program managers through a process to identify and adapt solutions. Instead of replicating an entire model, managers can crack a promising model open to isolate, adapt, and transfer individual elements of "what works" to a new setting. The core program attributes necessary to achieving the desired outcome are what we call the active ingredients. Without these necessary components and practices, the model would not succeed. By focusing on one core component of a promising model, managers can more efficiently test actionable strategies, iterate quickly, and achieve practical results.

Adaptation provides innovators the ability to identify relevant solutions grounded in the experience and expertise of other innovators. It also provides the flexibility to test the new practices, obtain feedback, and make modifications. CHMI’s tools and guiding principles support program managers to adapt promising core components from models in other geographies. To learn more and access the tools directly, please download the Adaptation Framework at HealthMarketInnovations.org/ActiveIngredient.

Through these Learning and Adaptation initiatives, CHMI shares practical recommendations and knowledge as global public goods, through products like this one. For more information about the work of Results for Development at a broader institutional level on Learning and Adaptation, see our original research here.

Rather than focus on the program as a whole, this framework guides users to crack the program open and look at the core program attributes crucial to achieving the program’s outcomes—what we call the “active ingredients.”

---THE ADAPTATION FRAMEWORK

**GUIDING FRAMEWORK FOR ADAPTATION**

**SEARCH FOR PROGRAM MODELS**
Based on the problem you are trying to solve for and specified parameters, what models currently exist?

**OUTPUTS**
Short list of program models

**IDENTIFY THE ACTIVE INGREDIENTS**
What are the core components or attributes of the program that make it successful? What are the contextual factors for the active ingredient?

**OUTPUTS**
List of isolated active ingredients

**DETERMINE EFFECTIVENESS**
What evidence exists on the effectiveness of identified active ingredient(s)?

**OUTPUTS**
Narrowed list of active ingredients

**ASSESS ADAPTABLE**
What are the barriers and levers to adaptation of the active ingredient(s) to the U.S. health market?

**OUTPUTS**
List of barriers and levers to adaptation
## INTRODUCING THE PRIMARY CARE ADAPTATION PARTNERSHIP

Launched in 2015, the Primary Care Adaptation Partnership (PCAP) brought together programs from different regions to identify, test, and transfer “what works” in primary care. Over the six-month learning initiative, PCAP matched programs with learning partners, and helped program managers define their model’s adaptable components, unpack the promising practice, learn through site visits, and adapt the practice in their home setting (see Box 1).

## BOX 1: PCAP PARTNERSHIP

### STEPS

<table>
<thead>
<tr>
<th>PROCESS</th>
<th>IN PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MATCH</strong></td>
<td>PCAP programs selected a learning partner whose skills and expertise created a foundation from which to learn and a model from which to adapt new practices.</td>
</tr>
<tr>
<td><strong>DEFINE</strong></td>
<td>CHMI collaborated with programs to identify their own model’s care elements and practices.</td>
</tr>
<tr>
<td><strong>FOCUS</strong></td>
<td>Partnering programs narrowed their learning objectives to focus on three core active ingredients with the goal of applying the active ingredients to a current operational challenge.</td>
</tr>
<tr>
<td><strong>LEARN</strong></td>
<td>CHMI created in-country learning activities with partner organizations Africa Capacity Alliance and ACCESS Health International to respond to specific program challenges. The participating PCAP programs then conducted site visits at their partner’s facilities to observe the approaches and resources used to build these solutions. Through these site visits and immersive learning activities, they experienced the day-to-day reality of their partners.</td>
</tr>
<tr>
<td><strong>ADAPT</strong></td>
<td>Equipped with their observations and the new connections they formed, program managers returned home to adapt the active ingredients into their models.</td>
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</table>

Quinta Bonita’s mental health patients had a need for high-quality, affordable primary care services. Ross Clinics’ growing outpatient model in Delhi made it a promising candidate for adaptation through PCAP.

Ross Clinics and CHMI identified core elements and essential practices of Ross Clinics’ model. These active ingredients included approaches to: human resources, clinical quality assurance, pricing, labs/auxiliary services, and patient experience.

Quinta Bonita internally weighed and prioritized the active ingredients that were most relevant for their operations as they planned their expansion into primary care.

PCAP immersive learning exchanges highlighted the day-to-day operations needed for each active ingredient.

Back in Mexico, Quinta Bonita was equipped with an operational plan to develop primary care services. Ross Clinics provided continued guidance as Quinta Bonita assessed the adaptability of the model to Mexico.
From maternal health and childhood immunizations, to prevention and management of chronic diseases, primary care is the root of a strong health system. Strong primary care delivery models help ensure all people stay healthy and can access care when they need it. Health programs in the CHMI database are diverse both in geography and in the ways that they provide primary care for the poor. Despite their different models, the programs participating in the partnership came together around their shared commitment to delivering equitable and sustainable health care for the poor.

Over the course of the six-month PCAP initiative, the participating organizations identified, observed, and adapted promising approaches to address service delivery challenges. Many of these practices are applicable to similar challenges in other geographies and contexts. The approaches, knowledge, and experiences presented here address challenges to providing quality and accessible primary care. They should not be considered exhaustive, but rather are an illustrative snapshot of promising practices and opportunities.

This resource was developed in collaboration with the participating PCAP programs, building on the tacit knowledge they’ve accumulated while providing healthcare for the poor in the communities they serve. As we collected their insights, we asked the members of the Adaptation Partnerships what did they wish they had known when beginning these approaches, and what advice they would give others in the CHMI network looking to adopt and test similar ones. We also asked which key strategies and practices helped build their care functions, and what assumptions and questions others should consider before getting started.

CHMI recognizes the importance of intellectual property and that programs within our network have worked hard to reach where they are today. We would like to commend the PCAP programs’ commitment to transparency while sharing practical knowledge and collaborating with their partners. The participating program managers were generous with their time, sharing their experiences of what did and did not work” to save their partners time and money. CHMI would also like to thank the programs for sharing their experience globally through this publication and other written resources they developed. Through this publication, we are eager to celebrate and promote these organizations willing to “open their playbook.”

**WHO’S WHO IN THE PRIMARY CARE ADAPTATION PARTNERSHIP**

**JACARANDA HEALTH | KENYA**

Jacaranda Health is a maternal health social enterprise with a chain of hospitals designing and delivering high-quality, affordable care. Jacaranda also partners with government hospitals to scale their approach and improve the quality of care within the public sector.

**ROSS CLINICS | INDIA**

Ross Clinics is a chain of 14 outpatient health clinics delivering patient-centered primary care for the entire family.

**QUINTA BONITA | MEXICO**

Quinta Bonita delivers affordable high-quality mental health services through telemedicine. Its model connects poor and underserved populations with providers in high-resource urban centers.

**HINDUSTAN LATEX FAMILY PLANNING PROMOTION TRUST (HLFPPT) | INDIA**

As the franchisor, HLFPPT operationalizes the Merrygold Health Network, a social franchise model of over 730 MNCH hospitals in underserved regions of India. The Merrygold Health Network also includes over 10,000 community-based outreach workers to create awareness of maternal health and family planning services. To date, the Merrygold Health Network has served over 460,000 clients.

**HEALTHY ENTREPRENEURS | DRC, RWANDA, BURUNDI, UGANDA, GHANA, TANZANIA AND HAITI**

Healthy Entrepreneurs is a full supply and distribution chain solution to bring high-quality and affordable health products to rural regions. Healthy Entrepreneurs directly streamlines the supply chain, reducing inefficiencies caused by “middlemen” and sub-contractors. Their team equips, trains, and provides technical support to a network of franchisees who in turn provide health education and sell essential medicines and products to their remote communities.

**SAFE MOTHERS SAFE BABIES (SAFE) | UGANDA**

SAFE’s model provides a comprehensive approach to improving maternal and newborn health care delivery through community- and facility-based interventions. SAFE systematically partners with communities to address maternal mortality by increasing access to high-quality care.
IMPROVING PRIMARY CARE QUALITY

POOR QUALITY OF CARE IN HEALTH MARKETS FOR THE POOR

There is often a mismatch between the standards of how healthcare should be provided and what the patient actually receives. More simply put, patients often do not receive the right care, at the right time, at the right place, every time. This is particularly true in health systems with limited regulation. Despite the promise of private sector models, the reality is that not all provide care safely and responsibly. Poor quality care can be unresponsive, ineffective, highly fragmented, and even unsafe, with deaths attributable to system errors and failures.

Global efforts to improve quality have mostly been clustered in high-income countries. However, there are opportunities, especially within the private sectors of low- and middle-income countries, for innovations and new approaches to move the needle on quality improvement. These promising approaches from the private sector can also bolster the growing accreditation and quality assurance mechanisms in the public sector.

WHY FOCUS ON QUALITY?

Private sector providers and managers in low- and middle-income countries face countless operational challenges daily. They regularly experience strained infrastructure, irregular revenue, supply chain challenges, and difficulty retaining human resources. Quality improvement is one way to begin addressing a multitude of challenges. Improvements in quality can support operational efficiencies and lead to increased capacity to serve more patients. Higher quality care can also boost demand; even poor customers will seek health services and spend their limited resources on them when they see value. A cycle of improved quality and patient volumes can generate more revenue and establish a sustainable business model. Improved quality further strengthens the entire delivery model with benefits to frontline providers, including improved working conditions, productivity, and retention of human resources.

Often in these markets, there is a public misconception that cost of care reflects the quality of care. Dr. Devashish Saini of Ross Clinics, notes “For the most part in the Indian market, the perception of quality changes with how much you pay for it; [people think] if I pay 10 times as much, the quality will be 10 times better.” This also factors into the complex decision-making process of poor customers as they try to navigate health markets for primary care services.

QUALITY CHALLENGES IN HEALTH MARKETS

The programs in the Primary Care Adaptation Partnership report consistent challenges to providing high-quality primary care. These challenges occurred while refining internal service delivery models or emerged due to difficult market conditions. Each participating program faces different quality challenges and has designed their delivery models to counteract them.

Some PCAP programs designed approaches to provide consistent quality of internal service delivery. For example, with rising patient volumes and increasingly strained providers, gaps arise in routine care delivery. These gaps result in patients receiving incomplete clinical care which reduce efficacy of the visit, treatment adherence, and or follow-up after the visit/interaction with providers. Similarly, variation in care delivery results in potentially unsafe deviations from evidence-based standards.

Other PCAP programs designed approaches within their service delivery models to address the difficulties of the market which translate into poor quality primary care. For example, some programs designed models to address fragmented care, delivered from multiple incomplete channels and providers, which typically causes delays that exacerbate health conditions.

WHERE WAS THIS CHALLENGE SEEN AMONG PCAP MEMBERS?

JACARANDA HEALTH, KENYA
Gaps in routine care delivery diluting treatment adherence or follow-up after the visit/interaction with providers.
Variations in service delivery that could result in ineffective and potentially unsafe deviations from evidence-based standards.

ROSS CLINICS, INDIA
Fragmented primary care that often results in care delays in care-seeking that exacerbate health conditions.
Task-shifting is a strategy to optimize health worker roles and combines a health worker’s skills, licensure and current clinical evidence. Task-shifting can be used to increase efficiency in primary care delivery and reduce bottlenecks caused by high utilization. Particularly in primary care facilities where high patient volumes often strain operational processes, it can ensure patients get the highest standard of care. Task-shifting is often noted as a strategy to reduce costs, but it can also be a strategy to improve quality.

Since task-shifting is a change from normal practice, there can be tension around which pieces of a clinical service can and should be shifted. Every month, Jacaranda Health revisits internal processes and examines how each clinical role delivers their specific part of a service like antenatal care or a routine immunization visit. During one of these process audits, they discovered that as outpatient volume increased, counseling was causing delays and ran the risk of potentially becoming overlooked. This was a red flag. Hasty, unclear counseling combined with low health literacy among the poor can lead to ineffective treatment. Missing this part of routine primary care can undermine the original care or make it worse, in cases like antibiotic resistance developing when patients mistreat simple infections.¹ To quickly address the issue, Jacaranda Health decided that they could shift family planning counseling to ensure that this essential part of outpatient visits would not slip through the cracks.

Task-shifting is a strategy to optimize health worker roles and combines a health worker’s skills, licensure and current clinical evidence. Task-shifting can be used to increase efficiency in primary care delivery and reduce bottlenecks caused by high utilization. Particularly in primary care facilities where high patient volumes often strain operational processes, it can ensure patients get the highest standard of care. Task-shifting is often noted as a strategy to reduce costs, but it can also be a strategy to improve quality.

1 Not all parts of primary care have clear guidelines and recommendations, but some like maternal health have global recommendations like the World Health Organization’s OptimizeMNH (2012).

2 Huddles are frequent 5 to 15-minute non-issue specific planning meetings which support teams to stay informed, quickly review work, make plans and move ahead with decisions. See more resources about how to build huddles into your team from Institute for Healthcare Improvement.
Map all tasks and functions of clinical services to identify where lower-level roles can contribute. Mapping all the steps or touchpoints of a typical patient visit identifies parts of care that are consistent to deliver from patient to patient, such as counseling. As patient volumes increase repetitive and routine tasks are often the first to fall through the cracks. Revisiting this map and each staff member’s contribution can be a helpful step. To begin, Faith Muigai also suggests, “Start with simple things like patient flow—how do patients come in and out of your doors? Then build on that. Once the first process is defined then you can go through what should happen next. Then when they go to the cashier or reception, what happens? And what is needed from all levels of staff.” Managers can examine where there are opportunities within regulatory structures to share or transition those tasks to other levels of staff.

WHAT ARE KEY QUESTIONS IN TESTING THIS ACTIVE INGREDIENT?

Central to testing task-shifting are the questions, (1) can lower-level providers take on new roles; and (2) can managers ensure consistent delivery of the new task? Ensuring that tasks are not overlooked does not automatically address quality. Systems to link the lower-level staff to nurse midwives were key for Jacaranda Health: “The sense of responsibility can’t change. If something doesn’t occur on the frontline, the person at the highest level is the one who takes accountability. We encourage our nurses to check-in, validate that [the counseling] happened, then reinforce [the counseling delivered by the PCA] and fill in any gaps if necessary. Even as simple as a conversation with the patient, ‘and did you receive your family planning counseling? Did you understand everything?’ It builds on what has happened.”

HLFPPT tested this active ingredient with paramedic staff in their Merrygold Health Network in India and found there was a fine line between accountability and duplication of effort. Despite conducting a joint doctor-paramedic training and using/distributing/ teaching evidence-based tools like the Balanced Counseling Strategy Plus tool for family planning, HLFPPT reflected that during the pilot, “Some of the doctors were not as confident about the family planning counseling given by the paramedics. We would like to try this again with a bit more time for the doctor to say ‘yes my staff can do this counseling.’” HLFPPT noted that the doctors could become bottlenecks by feeling the need to repeat the shifted task. Jacaranda noted this risk as well, adding that “the goal is not to repeat it, but build on it.” Also suggesting to encourage lower-level staff to ask for support when a task diverges from the protocol or when they reach the limits of their training.

THE SENSE OF RESPONSIBILITY CAN’T CHANGE.

IF SOMETHING DOESN’T OCCUR ON THE FRONTLINE, THE PERSON AT THE HIGHEST LEVEL IS THE ONE WHO TAKES ACCOUNTABILITY.

—FAITH MUIGAI, JACARANDA HEALTH

TIPS TO GET STARTED

1. Look for opportunities for lower-level staff to contribute to primary care delivery by mapping the steps of a routine primary care visit.
2. Help encourage doctors or senior staff to develop accountability mechanisms without repeating the task, which can create operational bottlenecks.
3. Learn more about finding the right role for the right task with resources from the Institute for Healthcare Improvement’s Optimize the Care Team tools and modules.

WHAT PRACTICES ARE NECESSARY IN THIS ACTIVE INGREDIENT?

Balance fixed costs with a mix of clinical services that address patient needs. At primary care clinics that function as one-stop-shops, providers often add new clinical services in response to the diversity and needs of patients. This can lead to operational costs that rise faster than revenue. To maintain this balance, Ross Clinics gathers client and caregiver feedback to determine which services add the most value for the patient. As they increase their clinical capacity, Ross Clinics recognizes the potential strain on their primary care doctors and clinic managers. Managers should consider investing time in both professional development and recruiting processes to ensure providers can work across broad spectrum of patient types and disease cases. As specialized provider salaries can dramatically increase costs, Ross Clinics has found that part-time or on-call clinical staff can be a low-cost way to test, then stage a new health service expansion. Managers can consider strategic investments in the most basic or “minimally viable” equipment, for services with high capital start-up costs like dentistry.
Create systems that link necessary patient information to coordinate, standardize, and centralize primary care. Ross Clinics synthesizes and centralizes all the typically disjointed pieces of a patient’s clinical care with strong health information management systems and an electronic medical record (EMR). Their EMR encourages a continuity of care that increases quality for patients. The system has features to aggregate referrals, labs, and other records, allowing doctors to digest the complex pieces and give the patient an action plan. Ross Clinics’ EMR also includes features to visualize lab results over time—this is then used as a tool in patient education for chronic disease prevention and management. Standardizing patient health information and enabling identification of frequent diagnostic patterns also led to more clinical efficiencies and reduced mistakes by doctors. Ross Clinics’ Dr. Devashish Saini notes, “I have prescription templates. I don’t have to write azithromycin once per day after meals for 3 days. As soon as I click on ‘azithromycin’ it remembers what my usual prescription is and I can make changes I can look at what worked for them last time even if they didn’t bring their prescription or old records.”

WHAT ARE THE KEY ASSUMPTIONS TO TEST THIS ACTIVE INGREDIENT?

Patients will trust that the centralized point of care has sufficient expertise in each health area. Rather than seek out specialists, patients must determine that the same doctor that treated their child’s pneumonia is also able to manage their own high blood pressure. Patients also must value the convenience that a centralized point of care can provide. Ross Clinics tested several different strategies to build trust with patients who were previously used to navigating a fragmented system. For example, one strategy was to waive their fee for follow-up visits if the original condition has not improved within seven days of the initial consultation. Ross Clinics also does not charge a second fee if an accompanying family member has their own questions or needs quick physical examination. Dr. Saini advises that to build trust across patient types, managers should encourage doctors to “be open and ready to treat the family as a whole and look for opportunities to do that within the consultation with the original patient. But [we don’t charge] if it is just a quick thing, like let me listen to the child’s breathing make sure they are not wheezing. Just a thing to relieve the patient’s mind and make sure that the child is fine.” Another strategy was to conduct primary care home visits, found to be a high-value patient-centered service. Home visits provided a new value to patients and allowed Ross Clinics to gather in-depth patient feedback, which they then used to market their clinic-based services to broader market segments. The home visit service was very popular with middle-income market segments who might have traditionally “skipped” primary care to obtain specialty consultations directly. After gaining traction and building trust, Ross Clinics raised the price of home visits and they became a premium service. By doing so, Ross Clinics could cross-subsidize the more price sensitive clinic-based consultations.

WHAT PRACTICES ARE NECESSARY FOR THIS ACTIVE INGREDIENT?

Define each clinical process to be sure providers have a common understanding of the standard of care. Jacaranda Health recommends that managers start documenting processes with tools, like protocols, as soon as possible. Defined processes help normalize expectations of how each part of the visit, procedure, or test is conducted. Faith Muigai notes “the tools can be simple, even an algorithm or diagram [of an antenatal visit], all the way to a well-written protocol”, the important thing is that “they all keep people on the same page.” Revisiting and updating protocols also ensures that the standards reflect the day-to-day realities of providing care, like reflecting changes in drug availability.

**TIPS TO GET STARTED**

1. Record and review patients’ requests for services you are not currently offering as potential services to expand into.
2. Implement technology solutions that can centralize and detect patterns in patient data and help in patient education.
3. Explore the features of diagnostic and prescribing templates in electronic systems like Easy Clinic, Ross Clinics’ EMR software.
IMPROVING QUALITY

WHAT ARE THE KEY QUESTIONS TO TEST THIS ACTIVE INGREDIENT?

How can programs continuously reinforce standards and use tools like protocols?

Auditing or reviewing how care was actually provided through case-reviews or chart-reviews can solidify standards and support protocol adherence. Activities like case-reviews retroactively allow providers to discuss a deviation from a protocol in a learning environment. During these case-reviews, protocols can be revisited, discussed, and updated to reflect new realities. Regular and on-the-spot chart-reviews are crucial, as Muigai from Jacaranda notes, “If our hospital sees 60 patients per day, is there documentation in place to show that we cared for the clients or that medication was administered correctly? ... We actually assess if care was delivered to the expectation or protocol.”

Jacaranda Health

Specifically, they adopted how Jacaranda frames adherence within their overall commitment to continuous quality improvement and repositioning audits as opportunities for staff to identify areas for professional growth and skill development. HEFPTT found that encouraging Merrygold doctors to increase the frequency of audits and shift the style of their communication to jointly generate solutions was a promising start. Adding opportunities to appreciate staff’s adherence to protocols and overall quality of their practice also helped to solidify a new mentality surrounding audits and measurement. This new approach to performance management and appreciation of high-performing staff for their good habits at Merrygold hospitals was “wildly popular,” says Dr. Sumita Palival. She further notes, “there was a change from a punishment culture to an improvement culture...[and] we would like to continue building more tools to support our network in this.” They are also looking forward to measuring how encouraging a continuous improvement culture extends into retention and job satisfaction.

BUILDING TOOLS TO AUDIT CLINICAL PROCESSES

How Jacaranda Health Developed their Dashboard

DEVELOP

1. Identify clinical quality performance indicators. Benchmark against international standards and establish internal targets.

2. Develop data collection tool such as a checklist to capture quality indicators.

IMPLEMENT

3. Charge Nurses use the data collection tool to document patient level quality data. Inpatient data is tracked by nurses daily.

4. Data team inserts data from checklists into centralized electronic data collection system and extracts indicators for clinical dashboard.

5. Hospital Manager reviews dashboard and resolves any discrepancies with Nurse in Charge.

6. The dashboard is reviewed monthly by the Clinical Leadership team.

7. Dashboard is updated monthly and available for employees to view.

TIPS TO GET STARTED

1. Increase the frequency of reviews and measure positive change to shift the perception that audits only catch mistakes. Share positive change and impact with frontline staff to keep the quality improvement cycle moving forward.

2. Explore dashboard tools to visualize data collected in audits in Jacaranda’s step-by-step approach: “Implementing a clinical quality dashboard in a low resource maternal and child health hospital”. See how dashboards can help management and frontline staff identify progress and areas for improvement.
INCREASING ACCESS

BUILDING SYSTEMS FOR ACCESSIBLE PRIMARY CARE

Increasing access to primary care helps ensure a more equitable distribution of health outcomes. But many gaps remain as the poor struggle to access care delivered through both the public and private sectors. Geographical barriers isolate last-mile populations; financial barriers, such as high user-fees, opportunity costs of lost income, or costly transport systems slow health-seeking behavior; and social barriers and limited consumer data on health markets for the poor further distort primary care markets.3

The lack of infrastructure and a sufficient supply of health workers heavily influences how and whether the poor can access primary care. There is still a massive global shortage of health workers in low- and middle-income countries, where current estimates indicate the gap may be as high as 13 million workers.4 Further, health workers are also often unevenly distributed; opportunities and financial incentives for providers frequently do not align with areas of highest need, such as remote rural populations or particularly vulnerable urban ones. It is difficult to determine and quantify willingness to pay for healthcare for these consumers—thus, private sector providers typically develop their businesses around customers who don’t pose as great a risk. Additionally, the distribution and competencies of the health workforce is rarely well-matched with the health needs of the poor, in both rural and urban areas.

ACCESS CHALLENGES IN HEALTH MARKETS

Market-based health programs are regularly confronted with challenges to providing accessible primary care. Within the Primary Care Adaptation Partnership, different programs built core components of their business models to improve access to primary care. Each model developed approaches to address different barriers to access specific to their contexts. Barriers include:

- Potential consumers in last-mile regions are too widely dispersed to be served by existing dispensers of medications and health products.
- High operational costs of existing distribution networks raise the prices of essential medicines and commodities too high for rural customers.
- A lack of appropriately trained providers to manage health needs of patients, especially for high need health burdens such as mental health and primary care.

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3 Read more about the broad issues of access to primary care markets through R4D’s Primary Care Performance Initiative http://phcperformanceinitiative.org/
INCREASING ACCESS

INCREASING ACCESS

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ADAPTING WHAT WORKS IN PRIMARY CARE

WHO MAKES THIS ACTIVE INGREDIENT HAPPEN?
The extent of training and support for informal providers and community-based workforces varies greatly. Some have strong engagement and financial incentives, while others are loosely supported and lack any compensation. A crucial foundation of the Healthy Entrepreneurs’ model is the motivated workforce of entrepreneurs, often youth with small business aspirations. Business skill trainings help entrepreneurs generate further income to support their growing pharmacy.

ACTIVE INGREDIENT TO EXPLORE
Train and incentivize community-based private sales agents to dispense essential medicines and health products through a franchise model.

CHALLENGE TO ADDRESS
Potential consumers in last-mile regions are too widely dispersed to be served by existing dispensers of essential medications and health products.

WHAT PRACTICES ARE NECESSARY IN THIS ACTIVE INGREDIENT?
Employ a community-based sales force to gather market data to shape the product mix for the rural customer. Healthy Entrepreneurs’ community-based workforce is equipped with essential medicines and products to serve last-mile customers. Through a point-of-sale monitoring system, Healthy Entrepreneurs captures data and determines the demand for different health products. These insights into their customers’ purchasing habits enable Healthy Entrepreneurs to equip their last-mile sales force with the targeted products that rural customers want and are willing to purchase. By ensuring that data drives their product offerings, Healthy Entrepreneurs can respond to demand in rural communities. They are also able to maintain reliable stock of the products with the highest health value, which may not be the most commercially viable.

Create incentive structures for a rural sales force that reduce risk and encourage buy-in. When a new rural sales agent joins Healthy Entrepreneurs, the organization loans the new agent 25% of the start-up costs through a co-investment loan, allowing the new agent to start selling products quickly. Through a structured repayment plan, the individual repays the co-investment loan over time as their business generates revenue. Each member of Healthy Entrepreneurs’ workforce earns 48 USD/month on average and is often able to pay off the loan within one year of starting. This loan increases a sense of ownership among members of the sales force, and has also helped recover costs for Healthy Entrepreneurs. Healthy Entrepreneurs has seen consistently low sales agent dropout rates of less than 5% since they launched their operations three years ago.

WHAT ARE THE KEY QUESTIONS TO TEST THIS ACTIVE INGREDIENT?
Can informal community-based providers develop a small business and the skills needed to sell essential medicines? Healthy Entrepreneurs draws new candidates from last-mile regions with limited resources or formal education. They’ve found that investing in business skill development is highly valuable, and provide training and technical job aids through their point-of-sale tablet computers. To keep drop-out rates low, Healthy Entrepreneurs shares successful sales strategies and offers regular mentorship opportunities to help entrepreneurs grow their businesses. Healthy Entrepreneurs integrates these opportunities into normal operations, including when regional managers bring entrepreneurs together monthly to deliver products and collect data. The networks and support help to retain the entrepreneurs, yet are logistically challenging to maintain.

TIPS TO GET STARTED
1. Co-invest with new community-based workforce agents to motivate and retain sales agents. This can also help rule out candidates who might have competing income-generating activities that would limit their engagement.
**EXPLORE TECHNOLOGIES FOR LOGISTICS**

**ACTIVE INGREDIENT TO EXPLORE**
Explore technologies like procurement systems to support and simplify complex logistics and operational processes and to ensure that products get to last-mile sales agents and hard-to-reach customers.

**CHALLENGE TO ADDRESS**
High operational costs of existing distribution networks raise the prices of essential medicines and commodities too high for rural customers to afford.

**WHAT ARE THE NECESSARY PRACTICES IN THIS ACTIVE INGREDIENT?**
Guide process improvements with periodic data collection to increase reliability, while also balancing costs. Technology can be used to collect data to monitor processes, highlight areas for intervention, reduce costly inefficiencies, and simplify the complexities of a last-mile supply chain. For Healthy Entrepreneurs, additional data provides improved visibility to support accurate stock maintenance and forecasting and to ensure providers have the right products to meet the health needs of their customers.

However, managers need to balance these benefits with the potentially high costs of frequent data collection. In Healthy Entrepreneurs’ case, each sales agent enters data into a tablet-based business manager application to record sales and procure new products. Healthy Entrepreneurs’ system synchronizes these records with a country-level procurement system every two weeks. After carefully weighing trade-offs of real-time data collection (through data bundles on each tablet), Healthy Entrepreneurs ultimately determined that the marginal gain in more frequent data collection would not be cost-effective. Healthy Entrepreneurs noted that budgets often allow for continuous data collection, but do not factor in replacements of physical data collection tools. These could cause operational costs to steadily increase. Program Manager Timo Beentjes of Healthy Entrepreneurs noted, “While we put it in the entrepreneur’s contract that if the tablet is broken or stolen the replacement cost might come out of the co-invested deposit, we do sometimes replace the devices for entrepreneurs if there was no direct negligence. I would say always budget at least 5% extra for broken or stolen devices.”

**WHAT ARE THE KEY QUESTIONS TO TEST THIS ACTIVE INGREDIENT?**
Two key questions arise as managers develop or test a technology solution: (1) is it worth the time and resources to develop and maintain; and (2) is the system flexible enough to gather data to guide future decisions? Technology has been a crucial tool to improve operational efficiency for supply chain solutions. Reductions in the cost of connected devices, like smartphones and tablets, make technology solutions even more attractive. Yet, there are several upfront costs and trade-offs that may make some programs not worth the investment. Healthy Entrepreneurs built a custom tablet-based application, but found that it required considerable time and financial resources. Beentjes noted “developing (technology) in-house is great to shape the solution to your needs, but the cost is so high and I don’t mean just resources, but time too. You get a lot of grey hairs. Be sure there is nothing else on the market that you can use to start testing.” Healthy Entrepreneurs recommends that program managers consider long-term maintenance, and allocate resources to fix bugs that will undoubtedly arise. Technology solutions adapted off-the-shelf also require different trade-offs. Investments might still be necessary to develop technical expertise to customize, deploy, manage, and update such solutions.

**TIPS TO GET STARTED**
1. Consider the costs to launch, maintain, and update technology solutions. If a desired technology solution is identified, CHMI might be able to suggest programs that have launched a product with similar features.
2. Explore CHMI research and connect with other programs using ICT in their delivery models.
3. Learn more about designing mobile-enabled data collection systems using Open Data Kit from Safe Mothers Safe Babies.
Increasing access to primary care is essential to gather information for the doctor. However, for Quinta Bonita, the clinic manager is based in the same location as the patient and interacts with the doctor remotely. Quinta Bonita quickly learned that communication between the in-person clinic manager and the remote doctor required adjustments to the normal primary care visit protocol.

Quinta Bonita found that both doctors and clinic managers adjusted after just a few weeks to this new style of care delivery. Guerrero observed that they even created quicker ways to communicate with each other. “Sometimes instead of the actual word or instruction they used a code to avoid making the patient uncomfortable or potentially misinterpreting the doctor’s instructions.”

**WHO MAKES THIS ACTIVE INGREDIENT HAPPEN?**

Like their counterparts at Ross Clinics, Quinta Bonita’s clinic managers are nimble, non-clinician staff essential to the lean staffing model. Clinic managers own all administrative responsibilities and support clinical operations. They can quickly switch from administrative tasks (e.g., billing) to clinical tasks (e.g., taking vital signs and labs before patients see the doctor). They also help the doctor monitor the patient flow in the clinic. At Ross Clinics, clinic managers often join with prior expertise as lab technicians, but they are mentored and entrusted to keep each facility running smoothly. For more information on this role, download the Primary Care Innovators Handbook at HealthMarketsInnovations.org/Handbook.

**WHAT ARE THE KEY ASSUMPTIONS TO TEST THIS ACTIVE INGREDIENT?**

One assumption is that patients will prefer to travel the shorter distance to the technology access points than to providers in high-income urban areas. Even with growing use of internet-enabled devices in Mexico, Quinta Bonita set up centralized telemedicine hubs in underserved regions early on. These access points added services like labs and a pharmacy to make primary care telemedicine more appealing. Guerrero noted that in their market, “patients want or value the opportunity to solve a health problem, to have all their health needs fixed at the same moment. Other [telemedicine] solutions add value where you can provide virtual consultations to your home, but we feel there is more value in getting all the other services—the medicines, the lab tests and the doctor—in the same place.”

**WHAT ARE THE NECESSARY PRACTICES IN THIS ACTIVE INGREDIENT?**

Employ on-site staff to support primary care telemedicine functions by conducting labs, physical examinations, and dispensing medications. Quinta Bonita adopted active ingredients from Ross Clinics’ model by transitioning their existing expertise in telemedicine for mental health to primary care. One component of that transition was to adapt the highly versatile “clinic manager” role they observed at Ross Clinics to support their new primary care telemedicine service. As at Ross Clinics, this role is essential to gather information for the doctor. However, for Quinta Bonita, the clinic manager is based in the same location as the patient and interacts with the doctor remotely. Quinta Bonita quickly learned that communication between the in-person clinic manager and the remote doctor required adjustments to the normal primary care visit protocol.

Sergio Guerrero, Quinta Bonita’s Chief Financial Officer, noted:

“It’s important for doctors to be good at delivering instructions. They need to give instructions to the patient and the clinic manager. For example, we had some cases where the doctors had to do a physical examination, like press a body part if there was some change in color or swelling, specific things. The questions were very simple, but the doctors were not used to articulating them or giving those instructions because they are used to doing the task themselves.”

**WHAT ARE THE KEY QUESTIONS TO TEST THIS ACTIVE INGREDIENT?**

How will patients trust telemedicine to deliver effective primary care? Quinta Bonita has found that providing added value for the patient is key to establishing trust in telemedicine services. When patients gain access to essential medicines and laboratory services at the same convenient location as telemedicine hubs, they are more apt to trust the efficacy of telemedicine. Guerrero noted, “[Patients] don’t trust telemedicine as much as having a consultation in person with the doctor but if they get these other benefits, like having the medicines there and being able to get all the results from their laboratory there, they sort of say that ‘it’s good enough or even better than going to the regular doctor.’”

**TIPS TO GET STARTED**

1. Design services to add additional value besides proximity to improve the patient experience.

2. Explore a different way to focus on patient experience with CHMI Innovator Penda Health in the Primary Care Innovator’s Handbook.

3. Consider recent evidence on the effectiveness of franchising telemedicine models in rural India, see CHMI’s blog for more details.
LOOKING FORWARD

THERE IS NO ONE-SIZE-FITS-ALL SOLUTION TO THE CHALLENGES CHMI-PROFILED INNOVATORS FACE IN PROVIDING PRIMARY CARE FOR THE POOR.

Identifying, testing, and refining an “active ingredient” provides an approach to grow and refine a business model. Adapting a promising practice or diffusing high-impact strategies provides pathway to scale. CHMI’s hope is that these active ingredients and the experience of the Adaptation Partners will contribute to practical conversations within our network, and help support a more equitable private sector committed to access and quality. We recognize the day-to-day operational challenges to growth, and that learning partnerships and activities are one of many competing strategic priorities.

Through the CHMI network, we strive to promote the broader transfer of innovative active ingredients, from these Adaptation Partnerships and elsewhere, to support strong private sector primary care models. At CHMI we carry the Adaptation Framework through our broader portfolio of Learning and Adaptation Initiatives, and are consistently learning ourselves. We invite feedback and conversations from the CHMI network on how this material can strengthen your model and enable you to provide more affordable high-quality care for the poor. If you are interested in learning from any of the Primary Care Adaptation Partners mentioned in this publication, or considering your own partnership, we encourage you to contact CHMI.

CHAI and Results for Development (R4D) seek to bring new tools and approaches to learning, collaboration, and adaptation to a variety of development professionals in the health sector and beyond. We support program managers who leverage the collective experience of the CHAI network in order to grow the quality, efficiency, sustainability and scale of their own health programs. To best meet the needs of program managers and help innovators scale, we:

- Promote process improvements by focusing on practitioner needs and tacit knowledge;
- Support practitioners to set the agenda and ask important research questions;
- Encourage shared responsibility for data collection, learning, and collaboration;
- Strive to understand what does and does not work; and
- Create learning networks and communities of practice to share lessons learned.
THROUGH THE CHMI NETWORK, WE STRIVE TO PROMOTE THE TRANSFER OF INNOVATIVE ACTIVE INGREDIENTS THAT SUPPORT STRONG PRIMARY CARE MODELS.