# Health Care Home National Collaborative Funding Proposal to Ministry of Health December 2019

https://www.healthcarehome.org.nz/

**He waka eke noa**

**We're all in this together**

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# 1 Overview

The principle object of the Health Care Home National Collaborative (the Collaborative) is to support the establishment and ongoing development of the Health Care Home (HCH) model of care (MoC) across New Zealand. It works to support the PHO members of the Collaborative to ensure their HCH practices are of a high quality and provide a consistent standard of care. The Collaborative currently supports 17 PHO members and several DHB partners. With 147 practices on the HCH journey there are over one million enrolled patients benefiting from this model of care. Please refer to Appendix 1 for population coverage by PHO – including Māori, Pacific and Quintile 5 populations – noting that PHOs implementing HCH are experiencing significant improvements in equity.

Membership of the Collaborative has grown quickly and surpassed initial expectations. As well its core member PHOs and DHBs, the supporting organisations include General Practice NZ, the Health Quality and Safety Commission, Health Navigator Charitable Trust and the Royal New Zealand College of General Practitioners. The Collaborative with its small level of investment is leveraging support from across its network to strengthen primary care and in particular, to create equitable health outcomes. The Collaborative is working towards providing access to all PHOs and Practices wishing to implement the HCH MoC.

The HCH Collaborative is continuing to work on strengthening equity, consumer co-design and Māori engagement as part of its HCH MoC Requirements enhancement project. There is a growing body of evidence that shows the positive outcomes from the HCH MoC which is discussed as part of this proposal. More recently, practices are demonstrating a strong linkage between HCH and indigenous models of care, such as the Whānau Ora model and Nuka (Alaskan) model. Health Care Home is complementary to these models and offers positive benefits for Māori and other population groups. The Collaborative is supporting practices in the implementation of indigenous models of care and will continue to share learnings to fast track change. The Collaborative will also take into consideration the recommendations of the Waitangi Tribunal from Stage One of the Wai 2575 Inquiry and will stay abreast of the Health and Disability System Review work. The commitments to te tiriti o Waitangi and equity must be met and this is a responsibility of us all.

For the Collaborative to continue its work in strengthening primary care as well as the wider health system, we are seeking core financial support from the Ministry of Health (MoH) to allow a focus on projects that will make the biggest positive impact across our sector. These projects will be discussed later in the report but include equity, performance benchmarking, population stratification and shared care planning – all of which requires additional clinical leadership that will also strengthen our core programme team. The Collaborative will also seek core funding to support PHOs and Practices that are not currently members of the Collaborative and wish to implement the HCH MoC – making the service more equitable across New Zealand.

## 2 Collaborative members and supporting organisations

## 3 History of investment into the HCH Collaborative

Since its inception in 2016 the investment across primary care into the roll out of the HCH MoC is close to one million dollars and is shown in the table below. The Collaborative has supported joint memberships to ensure it is cost effective to its members.

| | | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|---|
| | **Joined** | **Actual** | **Actual** | **Budget** | **Budget** |
| **Carry forwards** | | | 25,521 | 55,699 | 16,999 |
| **ProCare** | Inaugural | 20,000 | 20,000 | 20,000 | 23,000 |
| **Pinnacle** | Inaugural | 20,000 | 20,000 | 20,000 | 23,000 |
| **Pegasus** | Inaugural | 20,000 | 20,000 | 20,000 | 23,000 |
| **Tū Ora Compass** | Inaugural | 20,000 | 20,000 | 20,000 | 23,000 |
| **Mahitahi Hauora** | Inaugural | 20,000 | 20,000 | 20,000 | 23,000 |
| **THINKHauora** | Aug 2017 | | 20,000 | 20,000 | 23,000 |
| **Comprehensive** | Feb 2018 | | 20,000 | 20,000 | 23,000 |
| **Nelson Marlborough** | Nov 2017 | | 20,000 | 20,000 | 23,000 |
| **WellSouth** | Mar 2018 | | 20,000 | 20,000 | 23,000 |
| **TeAHN** | Aug 2017 | | 20,000 | 20,000 | 23,000 |
| **Hawkes Bay** | Aug 2018 | | | 20,000 | 23,000 |
| **WBOP/EBOP** | Aug 2018 | | | 20,000 | 23,000 |
| **Totals** | | **100,000** | **225,521** | **295,698** | **292,999** |
| | | | | | |

## 4 HCH MoC value proposition for members

The Collaborate operates within an agreed budget supported by its members. All members are asked to provide resource to support the work programme of the Collaborative. Member benefits include:

- **Health Care Home Bootcamp** – an introduction into the Health Care Home Model of Care as well a focus on implementation of core HCH components / features
- **Health Care Home Mentor** – an individual from the current Collaborative network will be matched with your organisation and provide support for the first year
- **Access to Health Care Home Resources** – getting started on the Health Care Home journey is made easier through access to tools and templates via an online secure website – how to guides that are practical in supporting implementation
- **Access to the national HCH Data Central performance benchmarking** – including a standardised data set of HCH outcomes in a comparative national cloud based datalake. This includes combined national collections data alongside a range of practice and local DHB datasets
- **Health Care Home credentialing and certification** – support to achieve the Model of Care Requirements and maintain consistent quality care
- **Access to Health Care Home Leads Peer Groups** – support from across the network with bi monthly meetings to work share learnings and monthly peer learning sessions
- **Annual HCH Symposium** to share learnings and show case practice initiatives that benefit whānua and communities

## 5 HCH MoC Research and evidence of success

Research and evidence to date suggests that the outcomes from the roll out of the HCH MoC are very positive. The table included in Appendix 2 shows a summary of the key findings. Of particular interest from the research and evidence is the Ernst Young 2016/17 findings from the Pinnacle HCH network:

- Maori 25% less likely to attend ED
- People over 65 years have a 32% less likelihood of hospitalisation
- Via clinical triage, 25-45% of patients seeking same day care were managed without the need to visit the practice
- Both lower ASH and ED rates were particularly pronounced for people living in areas of the highest quintile of socioeconomic deprivation'
- Significant proportion of acute need being successfully dealt with out of hospital
- The associations for Maori, highly deprived and elderly populations suggest the model is pro-equity, and has its greatest effects on populations with the greatest needs
- Saved time for patients through alternatives to face-to-face consults
- Added capacity created
- Positive changes reported by patients and practices.

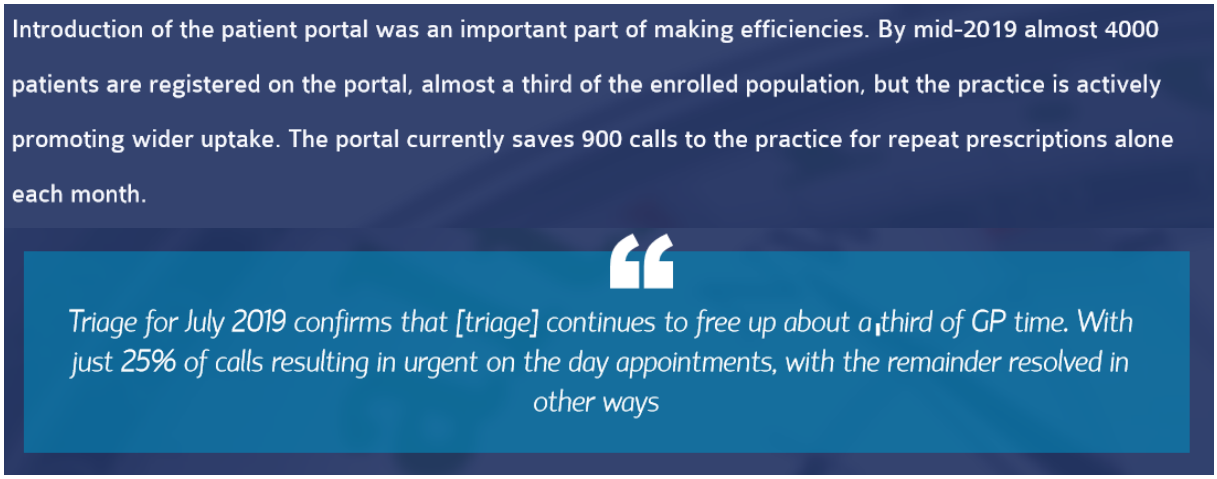
Tū Ora Compass commissioned qualitative research that confirmed the following findings in HCH practices during a 2018 study:

- Overall higher satisfaction
- Improved overall efficiency
- Better management under pressure
- Role expansion & development
- Enhanced workplace relationship
- Better care for patients.

The addendum to this document includes case studies collected by the Collaborative. Our member PHOs have contributed to these stories, sharing their learnings and insights. All of which acknowledge that the HCH MoC has created capacity within general practice to improve patient care and focus on delivery of equitable health outcomes. Some extracts from the HCH case studies are shown below.

**Whaiora Medical Centre - Masterton**

**Naenae Medical Centre**




**Porirua Union Community Health Services**

The portal had noticeably improved efficiency in the practice, Dr Betty says, and he is pleased at the uptake so with far in a community with so many challenges in terms of health literacy and language. The practice is aiming for uptake of around 40%.
All the GPs on duty each day triage first thing in the morning and an acute nurse is available for triage all day, which has significantly helped the work flow through the practice.

Prior to the introduction of triage, up to 60 people each day would turn up at the practice asking for an on the day appointment, which was unmanageable in terms of workload but also meant those people with long term conditions weren't getting the ongoing care and support they needed, because they were just walking in when they needed to be seen.

'We knew we had to address the acute demand, but we had to do it in different way. I would never go back to how it was.' he says. 'We have a lot fewer days now where we feel overwhelmed. We're still busy, but there's more of a sense of being in control and managing everything better. If we're suddenly down doctors or nurses, we can deal with it.
'It took a few months of explaining the new system to patients, but Dr Betty doesn't believe it's about advertising to patients that processes are changing; rather it's about demonstrating the improvement in the patient experience so that they can see that they're better off. The measure of success is that complaints have dropped significantly, and that ongoing patient feedback is more positive.

Other useful reference documentation includes published reflections document from Tū Ora Compass Health https://compasshealth.org.nz/Portals/0/HCH/Healthcare%20Home-Year%203-Reflections.pdf and digital versions of patient stories are available from Pinnacle Ventures.

## 6 HCH Collaborative Funding request

The Collaborative is seeking funding to undertake projects that will benefit the wider PHO network as well as supporting the continued focus on strengthening equity, consumer co-design and Māori engagement. The table below is a summary of the projects and increase in core funding to support new memberships.

| Project | 2020/21 $ | 2021/22 $ | 2022/23 $ | Outcomes |
|---|---|---|---|---|
| **Data Central (HCH Performance Benchmarking)**<br>The purpose of collecting the national dataset measures is to support practices to continuously improve their performance, and to demonstrate the impact of the HCH MoC and for individual practice and programme improvement.<br><br>Support is required to work with networks with less sophisticated data services to collate and contribute data for benchmarking. This requires both project management and expert analyst support for the Collaborative's members) | 80,000 | 62,500 | 62,500 | HCH Practices will be able to benefit from benchmarking using dashboards and reports created as part of Data Central. With direct data flows such as NMDS and NPAC, PHOs can seek support to directly upload agreed metrics into Data Central. As well as continuous improvement across practices, the HCH outcomes can be measured in more depth with metrics including those shown in Appendix 3. |
| **Shared Care Planning** – supporting an interoperable Shared Care Plan using HISO standards.<br>Versions of shared care plans are used in a number of New Zealand districts, and are a core requirement of the Health Care Home model of care. Project management support, workflow expertise and clinician time is required. | 135,000 | | | Shared care plan technology requires further workflow and clinical input to ensure ensure patients receive maximum benefit from shared care planning. There will be a focus on involving clinicians ensuring time to learn and train others. |
| **Patient Stratification development** – project management support and expert advice<br>The current risk prediction approach has now been used for some time in New Zealand, and it is increasingly clear that it has important limitations. It does not identify mental health need very well, nor is it clear that the blunt event of an acute hospital admission is the best basis on which to target a range of enhanced primary care services. The sheer prediction of the probability of a hospital admission doesn't necessarily mean that the enhanced services of primary care can prevent that admission, or that a patient can see benefit from those services. There is an emerging view that the time has come for a newer and better approach to stratifying populations and offering enhanced, targeted services. | 85,000 | | | To create a better approach to patient stratification that should have the characteristics of:<br>• Identifying patients that have capacity to benefit from a primary care intervention.<br>• Focussing on services that will reduce inequities in health outcome.<br>• Being more focussed upon supporting clinical decision making and providing a wider range of information to support clinicians. |

| Project | 2020/21 $ | 2021/22 $ | 2022/23 $ | Outcomes |
|---|---|---|---|---|
| **Clinical Leadership programme development** | 37,500 | 37,500 | 37,500 | Clinical advice and support for the Collaborative will ensure a more patient focused approach. |
| **Improving Equity** – improving access within HCH MoC including consumer co-design and Māori involvement – | 23,040 | 23,040 | 23,040 | Working with consumers to co-design as part of enhancing the HCH MoC – focusing on how equity can be achieved as well as Māori engagement – building this into the core budget as part of all our projects. |
| **Extending HCH membership / coverage** to additional PHOs and Practices, with an equity focus | | 120,000 | 120,000 | Extending coverage to more of the NZ population by supporting remaining non-Member PHOs and Practices to join and receive access and support given their interest in rolling out the HCH MoC. There are many PHOs experiencing barriers to joining and we estimate 6 new memberships |
| **Total** | **360,540** | **243,040** | **243,040** | |

## 7 Conclusion

The Collaborative has already shown strong leadership in the roll out of the HCH MoC which is improving outcomes for our whānau. With the support of the MoH, the Collaborative will focus its attention on additional projects that will bring about even greater transformation in primary care – as well as supporting equitable health outcomes for all PHOs and Practices. As the body of research and evidence grows around HCH, it is confirming the positive outcomes and impact of the HCH MoC for our whānau / families and the wider health system.

## 8 Appendix 1 Total enrolled population by PHO (HCH population coverage)

**Total enrolled population by PHO, Jan to Mar 2019**

| Lead DHB | PHO Name | Total | % Q5 | % Q5 (nM nP) | Practices on the HCH journey | HCH Population coverage | DHB investment | HCH Collab member |
|---|---|---|---|---|---|---|---|---|
| Northland DHB | Manaia Health PHO (Mahitahi Hauora) | 101,780 | 31% | 22% | | | | |
| | Te Tai Tokerau PHO (Mahitahi Hauora) | 66,075 | 49% | 29% | 13 | 95,707 | Yes | Yes |
| Waitemata DHB | Comprehensive Care PHO | 250,364 | 6% | 4% | In progress | | No | Yes |
| Auckland DHB | Auckland PHO | 65,218 | 15% | 11% | | | | |
| | Procare Networks | 879,317 | 19% | 10% | 15 | 130,000 | No | No |
| Counties Manukau DHB | Alliance Health Plus | 106,500 | 41% | 21% | | | | |
| | East Health Trust | 97,796 | 3% | 3% | | | | |
| | National Hauora Coalition | 80,218 | 34% | 19% | | | | |
| | Total Healthcare | 111,824 | 58% | 24% | | | | No |
| Waikato DHB | Hauraki PHO | 152,280 | 31% | 22% | | | | |
| | Midlands Health Network - Waikato | 239,460 | 19% | 14% | 17 | 95,000 | No | Yes |
| Bay of Plenty DHB | Eastern Bay Primary Health Alliance | 27,940 | 58% | 37% | In progress | | | Yes |
| | Nga Mataapuna Oranga | 11,955 | 39% | 26% | | | | |
| | Western Bay of Plenty PHO | 187,569 | 16% | 12% | In progress | | | Yes |
| Lakes DHB | Midlands Health Network - Lakes | 36,428 | 27% | 15% | Included in Pinnacle network | | No | Yes |
| | Rotorua Area Primary Health Services | 72,665 | 39% | 25% | | | No | No |
| Tairawhiti DHB | Midlands Health Network - Tairawhiti | 39,165 | 38% | 22% | Included in Pinnacle network | | No | Yes |
| | Ngati Porou Hauora | 8,831 | 84% | 64% | | | | No |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Hawkes Bay DHB | Health Hawke's Bay | 161,074 | 28% | 16% | 3 | 31,787 | | Yes |
| Taranaki DHB | Midlands Health Network - Taranaki | 111,808 | 15% | 11% | Inc in Pinnacle network | | | Yes |
| Whanganui DHB | Whanganui Regional PHO | 58,886 | 35% | 28% | | | | No |
| Mid Central DHB | THINK Hauora | 161,408 | 25% | 21% | 5 | 75,841 | No | Yes |
| Wairarapa DHB | Tu Ora Compass Health Wairarapa | 44,916 | 20% | 16% | 6 | 43,007 | Yes | Yes |
| Hutt DHB | Te Awakairangi Health Network | 120,592 | 21% | 15% | 9 | 89,758 | Yes | Yes |
| Capital and Coast DHB | Cosine Primary Care Network | 34,427 | 7% | 6% | incl in Te Awakairangi Health Network | | | |
| | Ora Toa PHO | 18,358 | 58% | 32% | | | | |
| | Tu Ora Compass Health Capital and Coast | 275,551 | 10% | 7% | 35 | 252,288 | Yes | Yes |
| Nelson Marlborough DHB | Kimi Hauora Wairau | 43,858 | 8% | 7% | 9 | 63,489 | Yes | Yes |
| | Nelson Bays Primary Health | 102,670 | 9% | 8% | | | | |
| West Coast DHB | West Coast PHO | 29,878 | 10% | 10% | | | | No |
| Canterbury DHB | Christchurch PHO | 35,866 | 12% | 11% | | | | |
| | Pegasus Health | 445,063 | 9% | 7% | 20 | 109,938 | No | Yes |
| | Rural Canterbury PHO | 46,561 | 4% | 4% | | | | |
| South Canterbury DHB | South Canterbury Primary and Community | 57,916 | 9% | 8% | | | | |
| Southern DHB | WellSouth Primary Health Network | 305,272 | 10% | 8% | 15 | 121,722 | Yes | Yes |
| **Grand Total** | | **4,589,489** | **19%** | **12%** | **147** | **1,108,537** | | |

## 9 Appendix 2 Summary Research and Evidence related to HCH MoC

| Year completed | DHB/PHO (Target Population) | Evaluator (External/Internal) | Focus area (e.g. particular aspect of HCH/full model) | Key findings |
|---|---|---|---|---|
| 2012 | Pinnacle | University of Waikato Dr Antony Raymont Professor Natalie Jackson | Evaluation of the Midlands Health Network Integrated Family Health Centre (IFHC) Model of Care | 80% to 85% of patients gave good scores to all aspects of the service. Doctor and nurse consultations were scored good or great in 95% and 94% of cases.<br><br>A high score included the PAC and many people appreciated the alternatives to face-to-face consultations with the doctor. Some said that the process was quicker than it had been in the past.<br><br>Patients were also asked whether they had experienced specific activities; the percentage giving a positive response were:<br><br>o Face-to-face visit with a doctor - 92%<br>o Face-to-face visit with a nurse (without seeing a doctor) - 39%<br>o Telephone consultation with a doctor or nurse – 32%<br>o Email contact with a doctor or nurse – 15%<br>o System generated call from the health service – 32%.<br><br>In summary, patient satisfaction was high but some provision might be needed for those who find the new processes difficult. |

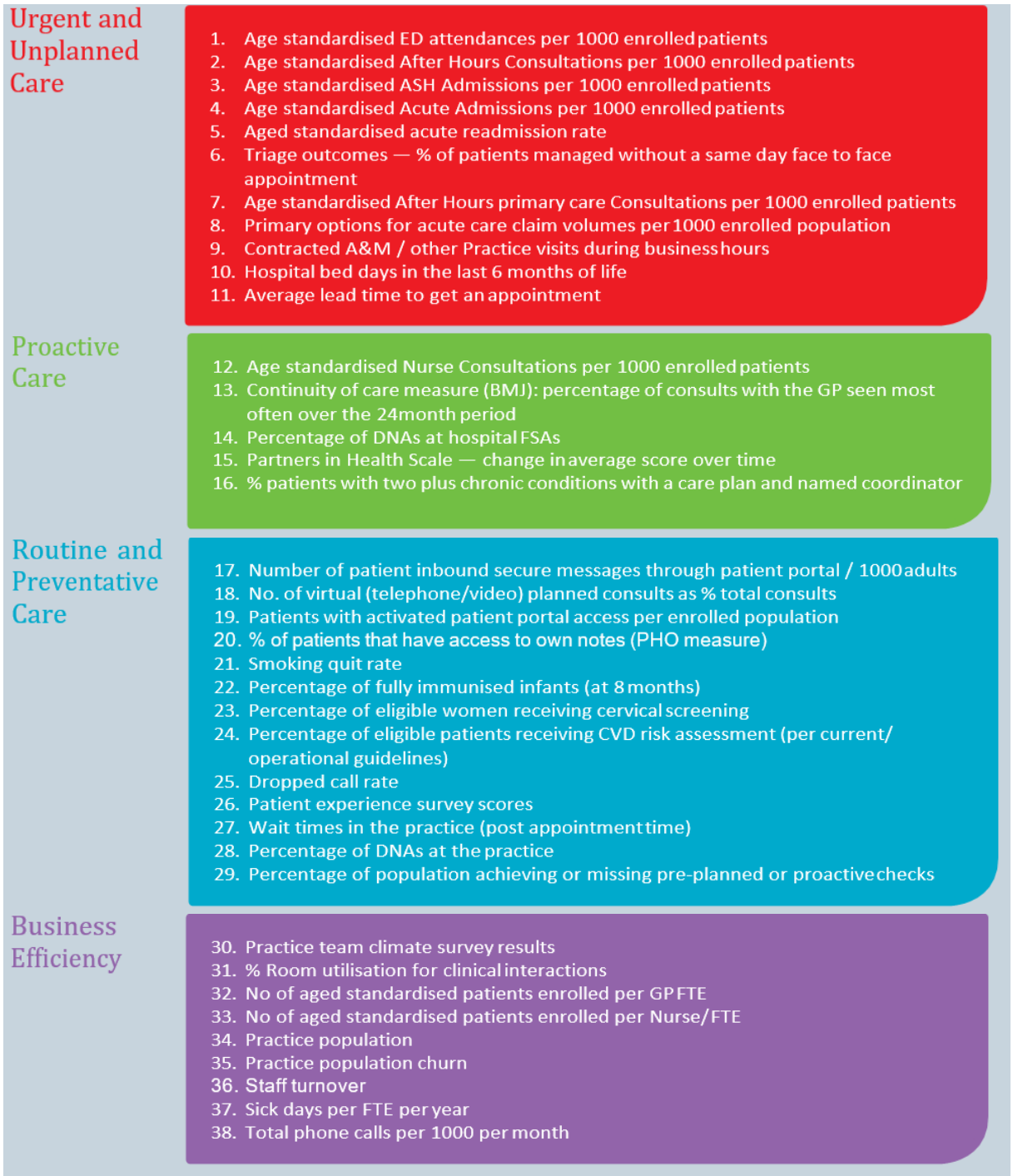
| | | | | |
|---|---|---|---|---|
| 2011 | Pinnacle | MHN | Review of Group Health Medical Home | Summarised the core components of the Group Health model of care and examined the possible implementation within New Zealand |
| 2104 | Pinnacle | Waikato Pharmacy Group | Role of the Clinical Pharmacist | • Improved medication management and increased capacity in the core team |
| 2013 | Pinnacle | Midland Pharmacy Group | Clinical Pharmacy | • Improved performance of the clinical team and improved health outcomes for patients with polypharmy and long-term conditions |
| 2013 | Pinnacle | Dr Antony Raymont | Evaluation of the Midlands Health Network Model of Care Phase II Report | Over the study period there is evidence that the face-to-face consultations were replaced with new forms of contact.<br><br>The rate of low urgency presentations (classified as Triage 4&5) declined slightly and the low urgency presentations with diagnoses seen as “ambulatory sensitive” declined markedly.<br><br>Suggests an increasingly more appropriate use of the ED department.<br><br>For Maori there is a decrease at in the model of care practices while an increase for the control practices for ED rates. |

| | | | | |
|---|---|---|---|---|
| 2016/2017 | Pinnacle Ventures | EY (Pinnacle Ventures) | Full model | • Maori 25% less likely to attend ED<br>• Over 65 years have a 32% less likelihood of hospitalisation<br>• Via clinical triage 25-45% of patients seeking same day care managed without the need to visit the practice<br>• Both lower ASH and ED rates were particularly pronounced for people living in areas of the highest quintile of socioeconomic deprivation'<br>• Significant proportion of acute need being successfully dealt with out of hospital<br>• The associations for Maori, highly deprived and elderly populations suggest the model is pro-equity, and has its greatest effects on populations with the greatest needs<br>• Saved time for patients through alternatives to face-to-face consults<br>• Added capacity created<br>• Positive changes reported by patients and practices |
| 2017 | Tū Ora Compass Health | Annual self-review | All four domains of the HCH model of care | • Progress in telephone assessment & treatment, care planning, MDT meetings, patient portal usage, and continuous improvement through LEAN<br>• Reduction in ED, ASH and acute admissions from the first 4 practices |
| | Pinnacle | EY | Full model | • Significant increase in phone access<br>• Increased patient portal utilisation<br>• Better management of same-day appointments<br>• Decreases n ED and ASH admissions<br>• Fewer referrals to specialists<br>• More care plans developed |

| | | | | |
|---|---|---|---|---|
| 2017/2018 | Tū Ora Compass Health | Summer Research Student from | Staff experience | Overall higher satisfaction<br>• Improved overall efficiency<br>• Better management under pressure<br>• Role expansion & development<br>• Enhanced workplace relationship<br>• Better care for patients |
| 2018 | Tū Ora Compass Health | Annual self-review | All four domains of the HCH model of care | • Continuous progress in telephone assessment & treatment, care planning, MDT meetings, patient portal usage, and continuous improvement through LEAN<br>• Reduction in ED, ASH and acute admissions from Tranche 1 practices ( |
| | Tū Ora Compass Health | Productivity Commission | Impacts on secondary care | Reduction in ED admission |
| | HCH Collaborative | Self-review with consultation from Ipsos | Full model Review | • Recognised positive impacts on primary care, for both patients and practice staff<br>• The need for a stronger focus on equity and Maori engagement |
| | Pinnacle | EY | Full model | • In the overall analysis model, the HCH model was associated with significantly lower rates of ambulatory sensitive hospitalisations (ASH), with an overall odds ratio (OR) of 0.83 favouring HCH.<br>• Each version of the analysis showed significantly reduced ASH rates<br>• Māori patients had similar proportionate reductions in ASH as European patients, despite those living in more deprived areas having a lesser reduction.<br>• By age children had a greater reduction than adults, with a significant reduction in those aged 65+. |

| | | | | |
|---|---|---|---|---|
| | Northland | University of Auckland, School of Population Health | Full model | • Overall positive experience with participating HCH practices<br>• Practices showed resilience, progress and capacity to work through initial implementation difficulties<br>• A staged approach to HCH implementation works |
| | Tū Ora Compass Health (ongoing research since 2018) | University of Otago | Care planning | Commonwealth Fund Project on Promising Delivery Models for Patients with Complex Health and Social Care Needs:<br><br>https://www.commonwealthfund.org/publications/international-innovation/2018/nov/health-care-home-programme-hch |
| | Tū Ora Compass Health (ongoing research since 2018) | Victoria University of Wellington | Full model | Primary health care research programme: Health Care Home model of care case study |

## 10 Appendix 3 Health Care Home Data Central proposed metrics



## 11 Addendum – Patient and Provider stories HCH Collaborative

Refer to Health Care Home Collaborative website for the patient and providers stories.
https://www.healthcarehome.org.nz/patient-stories