



HEALTH CARE HOME

First Year: Achievements and Reflections

Compass Health — Health Care
Home Development Team

SEPTEMBER 2017



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Cherie Seamark (left), Practice Manager of Hora Te Pai Health Services, with a patient

1.

Foreword



Martin Hefford
CEO Compass Health



Debbie Chin
CEO Capital & Coast
District Health Board

This publication is an overview of our first year implementing the Health Care Home Model of Care in the Wellington region.

It offers some insights, stories and early data from our first seven Health Care Homes—Raumati Road Surgery, Newlands Medical Centre, Johnsonville Medical Centre, Karori Medical Centre, Hora te Pai Health Services, Ora Toa Health Services and Newtown Union Health Services—early adopters and pioneers of the model locally. Collectively, they cover a population of just over 60,000 enrolled patients.¹

One of the critical success factors for the first year of the Health Care Home programme has been the sustained commitment of funding, people resource, and leadership, by both Compass Health and Capital & Coast District Health Board (CCDHB) in pursuit of a joint vision: better services for our shared population.

The implementation of the Health Care Home (HCH) model was—and is—ambitious. It is based on the need to dramatically adapt the way our general practice and community health services are delivered, to better meet the growing demand for health care. It has involved a sustained effort from our pioneer practices and from CCDHB community health teams over the last year to achieve some complex change.²

Overall, we've found that the model has had positive impacts for both patients and practices, and this publication discusses some of the early successes, and highlights some local stories from both patients and staff.

As we further establish the model in our region, developing measures around patient contacts and sustainability will be important. Gathering the evidence to demonstrate the impact of the model—both on patient outcomes and on health service utilisation—is vital.

Our future Health Care Home rollouts will consider and incorporate the lessons learned from our first year, as well as continuing to respond to lessons from elsewhere in New Zealand where the model is being implemented.

News of our early success has spread amongst our primary care colleagues, and there are now more practices wanting to take up the programme locally than there are spaces available.

With the intention of increasing the pace to ensure this improved model reaches more of our population faster, we have decided to take on an additional seven practices this year. This brings us up to a total of twenty practices and over 50% population coverage in the programme by April 2018.

Our aim is for over 80% of the region's population to be receiving care through a Health Care Home practice by 2018. We are well on track to achieving this ambitious goal.

“CCDHB Board is optimising investment in its health system on behalf of its people, and one of the key investments is the CCDHB Health Care Home model. This investment recognises that primary care and the integration of specialist skills with these teams are key components of our future health system. Many of the Board members, including myself, have been able to visit a number of our flagship Health Care Home practices, and we have been impressed with the changes that we can see on the ground. The Board has been encouraged by the early results that are indicating positive outcomes for our population and health system.”

Andrew Blair, Board Chair, CCDHB and Hutt Valley DHB

“Compass Health is very excited about and committed to the Health Care Home model of care. We all know that change in health care in our communities is coming fast in many ways, and the challenges are multiple. Health Care Home development will equip providers and the community to meet these challenges. General Practice, wider primary care, and our District Health Board are all working together to future-proof our services and care. Early achievements are encouraging, and I eagerly look forward to increasing momentum and success.”

Larry Jordan, Chair, Compass Health



Andrew Blair, Board Chair,
CCDHB and Hutt Valley DHB



Larry Jordan, Chair,
Compass Health

¹ Appendix 1: Practice profiles

² Appendix 2: Health Care Home model of care

2.

Our Approach

This is a joint programme between the CCDHB, all the PHOs in CCDHB and local hospital services. The local model has benefited from the cohesive leadership, commitment and investment under the umbrella of the CCDHB's Alliance, the Integrated Care Collaborative. Together as sector partners we have worked to a common purpose to develop enhanced primary care model, with integrated specialist services.

The Compass HCH Development Team has supported the implementation of the HCH model of care within practices. The development team is lean, highly skilled and motivated. Learning from our Pinnacle colleagues, who began their Health Care Home journey a few years ago. These developments have been coupled with a change team that has led developments to integrate community services with the practices. Together we set out on a clear programme of work to achieve our shared milestones.

Crucially, we jointly agreed upon and employed with our partners the following key design principles to guide the implementation of the HCH programme:

- that a whole-of-system investment approach and shared purpose is required for success
- that supported integration of hospital specialist skills, starting with District Nurses and Allied Health, is integral to the model
- that primary care is the foundation of any successful health care system, and we need to build on good, traditional general practice to ensure it is sustained;
- that patients and staff need to be front and centre of any transformational change in health care;

Collaboration is the recipe for success as we work alongside our community service colleagues in multi-disciplinary teams



The Health Care Home Project Team (left to right): Melissa Simpson, Emma Hickson, Astuti Balram, Susan Melvin, Chantalle Corbett, and Matthew Callahan

- that we will operate in a high trust environment that engenders a spirit of innovation and learning as we go.

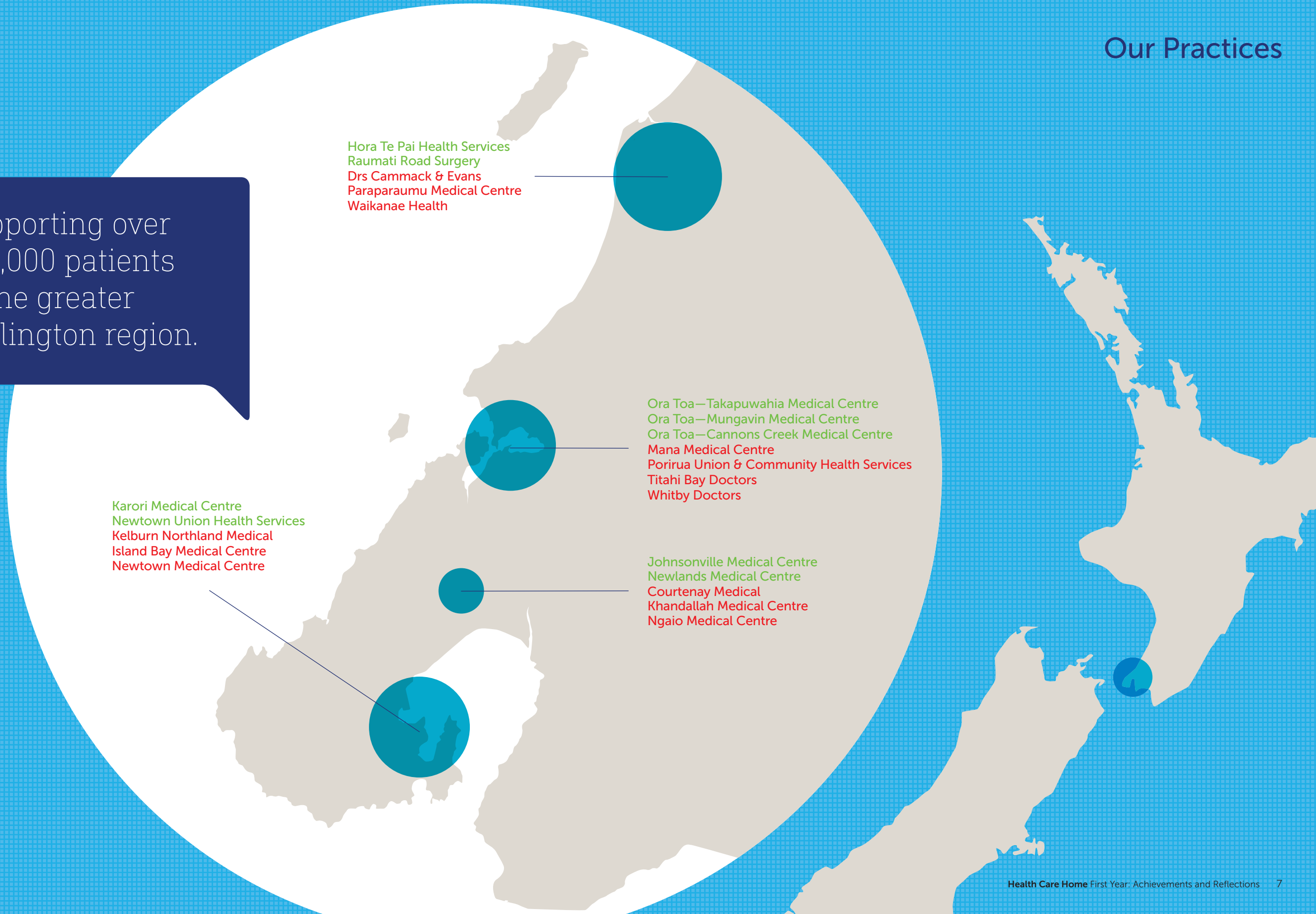
Community Service Integration (CSI) in Health Care Home

The Health Care Home model aims to provide comprehensive health care with the goal of supporting individuals for best possible health outcomes in the community. We believe that the sharing of community teams' clinical specialist expertise will enable the development and expansion of the HCH General Practice expertise in areas of complex wound management, IV therapy, continence and stoma care. Similarly, the general practices teams' in-depth knowledge of: patients' well-being and up to date primary clinical intervention will be shared with community services. CSI is a solution to the need for responsive services for acute circumstances and improved support at the transition of care. The delivery of a coordinated and integrated mobile community services will continue to be beneficial to the Health Care Home population.

3.

Our Practices

Supporting over 150,000 patients in the greater Wellington region.

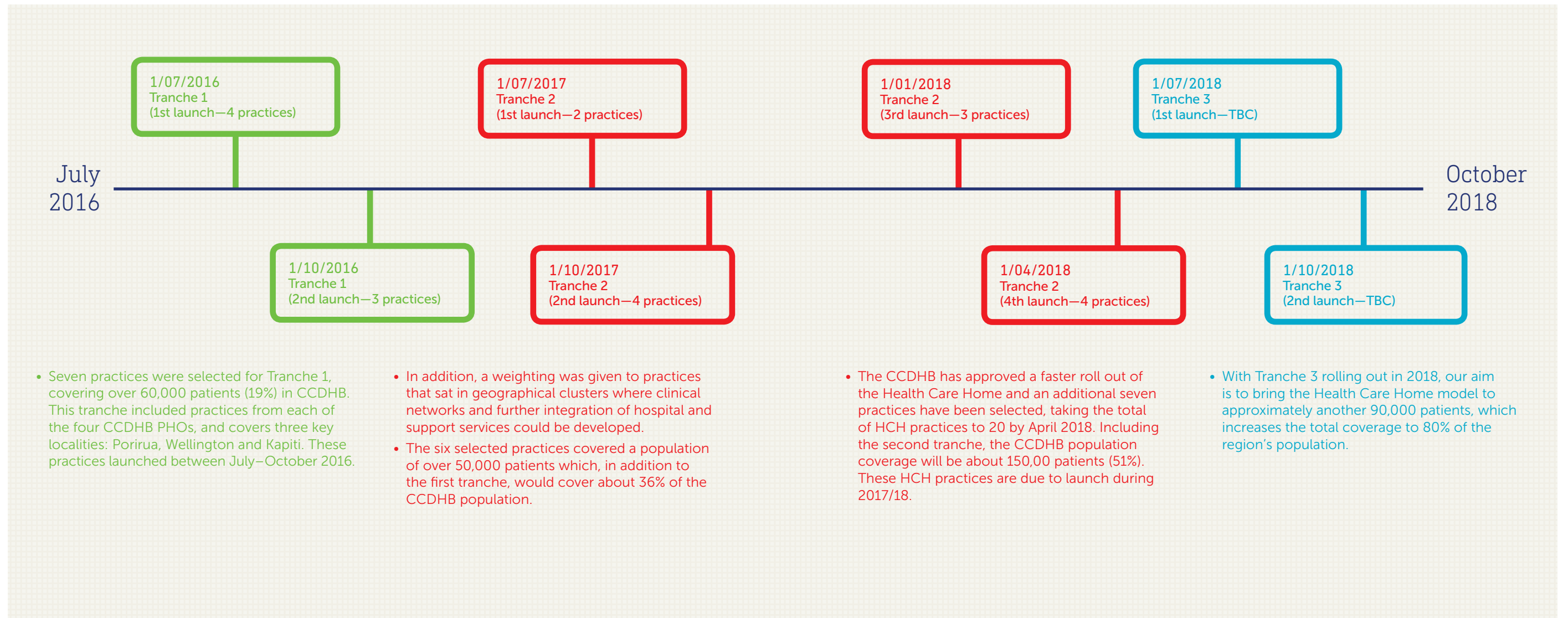


- Tranche 1
- Tranche 2

4.

Our Progress

The Health Care Home model of care is being implemented through a gradually increasing phased enrolment of practices, joining in tranches. Practices are selected through submitting an agreed expression of interest.



5.

A snapshot of our findings in the first year

The purpose of collecting data is to demonstrate system impact of the Health Care Home model of care and –particularly in the early days–to support and steer individual practice and programme improvement to ensure our efforts were focussed on the right activities.

As part of our Health Care Home roll out, we agreed a core data set of measures to track the impact of some of the changes the practices were making, full details of which can be found in the appendices.

One of the key aims behind the Health Care Home is to support practices to create more capacity to better manage growing patient demand, and to more proactively manage those patients with complex needs, who may also be high users of acute hospital services.

Following are snapshots of some of our key findings. These include: acute utilisation as represented by Emergency Department (ED), Ambulatory Sensitive Hospitalisation (ASH), admission rates, increased services in primary care as represented by primary options for acute care (POAC), and uptake of the patient portal.³

These early findings are encouraging, indicating that the Health Care Home model appears to have a positive impact on both primary and acute health care systems.⁴

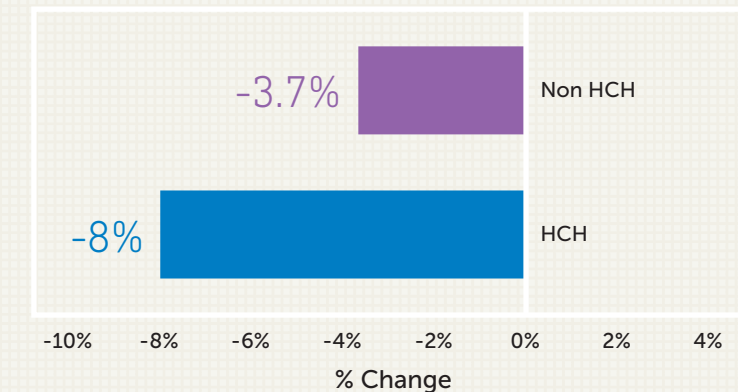
³ See appendix 3 for detail on Health Care Home National Dataset

⁴ Data obtained from the first four Health Care Home practices

Acute admission

HCH practices have a greater impact when it comes to reducing the likelihood of patients going to the hospital for medical or surgical admissions.

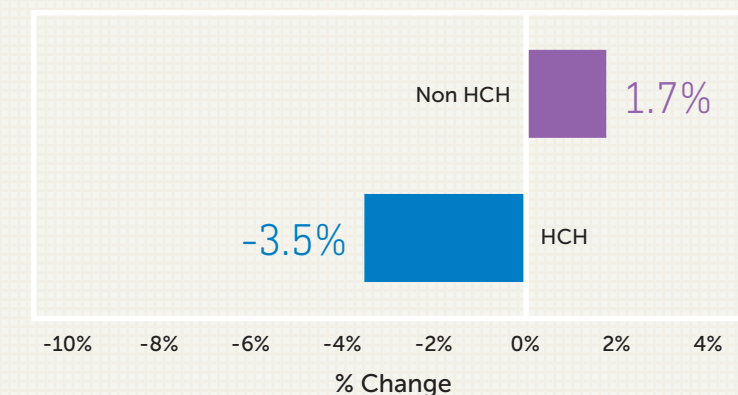
8% decrease for HCH practices vs. 3.7% decrease for non-HCH practices.



Emergency Department (ED) attendances

Patients enrolled with HCH practices are increasingly less likely to attend ED.

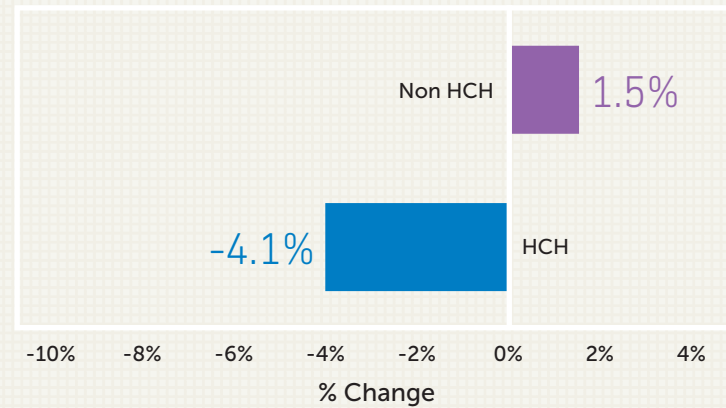
3.5% decrease for HCH practices vs. 1.7% increase for non-HCH practices.



Hospital re-admissions

Likelihood of a patient returning to the hospital after a medical/surgical discharge is reduced for patients in HCH practices.

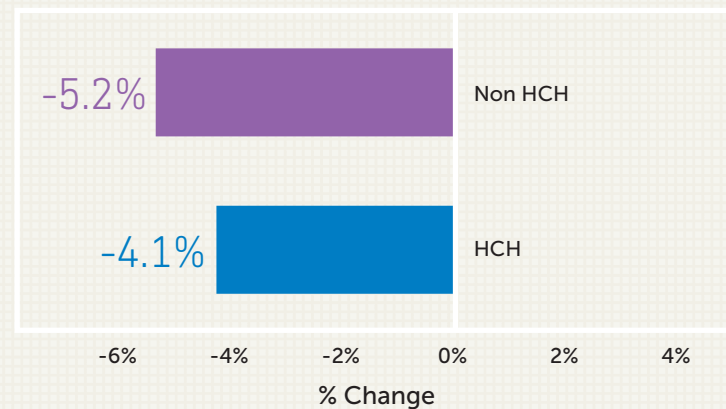
Re-admission rates slowly declining for HCH practices, while increasing for non-HCH practices.



Ambulatory Sensitive Hospitalisation (ASH)

Higher ASH starting rates for HCH practices, so a similar reduction in rates will have a greater overall effect on reducing people admitted to hospital.

From July 2015 to June 2017, decrease of 2~ per 1000 enrolled patients admitted to hospital for ASH conditions if enrolled at HCH practices.

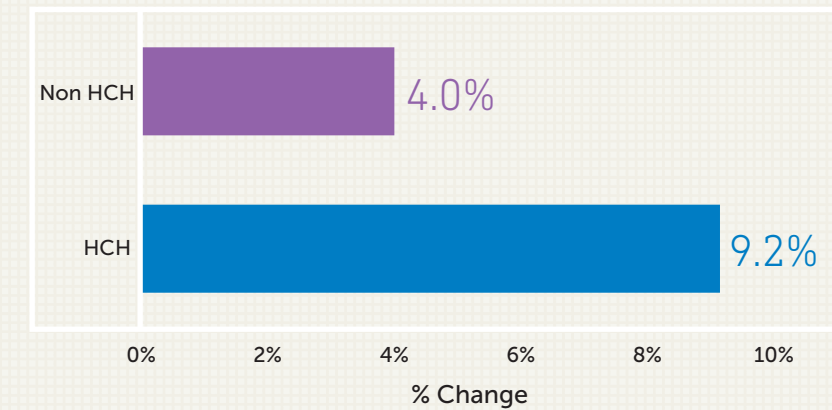


HCH practices have a higher proportion of enrolled high needs patients

Patient Portal Activation

Larger increase for patients in HCH practices that now have access to their health information online.

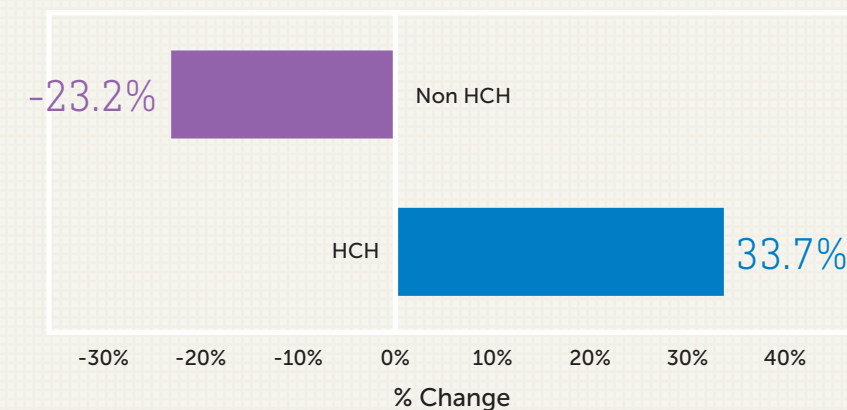
9.2% overall increase in HCH practice populations activated on the Patient Portal.



Primary Options for Acute Care (POAC)

POAC claims increasing over time for HCH practices, and declining for non-HCH practices.

More patients in HCH practices using POAC over time, reducing the acute hospital attendances and shortening the length of hospital stay for patients who attend ED/are admitted.





"It saved me time and avoided a visit to the GP— this new service is awesome."

Patient and team stories

6.

These stories bring to life the impact the Health Care Home model of care is having on both patients and staff. They are just a sampling of some of the experiences people have been kind enough to share with us.

One of the key design principles guiding our programme has been that patients and staff need to be front and centre of any transformational change in health care.

It's important to learn and reflect on what's working well and what can be improved through the sharing and review of these stories.

We will continue to gather and store them safely as our programme rolls out. They provide an essential record of our journey, and they highlight the human impact of the change.

GP triage

GP triage is about prioritising patients' treatments based on the severity of their condition. The purpose is to ensure that patients are referred to the appropriate clinician for appropriate level of care within an appropriate period of time.

"I called Hora Te Pai Health Services to book an appointment for my 7-year-old daughter, as she was complaining of a sore tummy," says one relieved mother, "My GP returned my call quickly, and after answering more questions, we established that there was no sore throat or fever, so we agreed that we would monitor over a day or two to see if the symptoms worsened. It saved me time and avoided a visit to the GP—this new service is awesome."



“MDTs are worth their weight in gold.”

Dr. Ruth Brown,
Raumati Road Surgery.



“We have achieved quite a lot in a year,” she says, “And Wellington is now, I think, one of the leaders in CSI in New Zealand.”

Jennifer Chong-Bradley, Project Manager, Strategy Innovation and Performance, Capital Coast DHB



“I was always keen to do more, and when the PHCA was expanded to full-time and job-shared I really decided to go for it.”

Carol Slade, PHCA,
Newlands Medical Centre

Community Services Integration (CSI)

Community Services Integration (CSI) brings together healthcare workers from across the board, with the aim of improving communications, cooperation and coordination between different service branches. It is particularly useful for patients with complex and/or long-term needs.

Under the aegis of Project Manager for HCH CCDHB, Jennifer Chong-Bradley, a number of approaches are already in place in Wellington HCH practices. Of particular note are the monthly Multi-Disciplinary Team (MDT) meetings, which involve a broad range of care practitioners—GPs, Nurses, District Nurses, Social Workers and others—to offer a more rounded and detailed picture of patients’ needs and progress.

Says Chong-Bradley, “My goals are both to change-manage the new approaches through design models and workshops, and also to build relationships with primary care. Breaking down long-standing barriers between the huge number of healthcare providers and agents is crucial. No matter how robust you make the processes, if the relationships are not built it doesn’t go anywhere.”

Further targets in Chong-Bradley’s sights include Advanced CSI and MDT, bringing an even wider range of practitioners into the picture, and electronic shared care plans (currently in development), through which everyone involved in a patient’s care can continuously be apprised and updated on their current condition and needs.

Expanding the workforce

A crucial element in Health Care Home’s long range goal of future proofing New Zealand’s General Practices is the creation of new roles designed to improve efficiency ‘behind the scenes’, strengthen practices and enable doctors and nurses to do what they do best—see and help their patients. Primary Health Care Assistant is a prime example. The PHCA is someone who can become integral within the practice, bringing both primary care clinical and administrative skills to bear.

“I joined Newlands as a receptionist two and a half years ago. I was always keen to do more, and when the PHCA was expanded to full-time and job-shared I really decided to go for it. I started the course in February 2016, finishing at the beginning of last December”, says Carol Slade, PHCA at Newlands Medical Centre.

The opportunity to broaden her range and work at the top of her scope was, Carol admits, a challenge at times, but extremely rewarding.



(Left to right) nurse Carmel Rodrigo, Dr Kirsty Lennon and nurse Aileen Dunnett from Raumati Road Surgery

Lean

LEAN—the management methodology designed to eliminate waste in all its forms—is baked into the Health Care Home model. LEAN practices have been applied to both the practices’ drugs cupboard and the doctors’ room’s drawers.

“The standardisation makes the clinics run smoothly. For example, I have to leave the room to find something far more rarely, but if I do, I know exactly where I’m going to find what I need. This helps reduce time patients are waiting,” says a staff member at Raumati Road Surgery.

“It’s too soon to say, but I expect that this process will impact positively on the financial side—you’re not allowing stock to get out of date, and you’re ordering only what you need,” notes Carmel Rodrigo, a nurse at Raumati Road Surgery.

“It’s too soon to say, but I expect that this process will impact positively on the financial side—you’re not allowing stock to get out of date, and you’re ordering only what you need.”

Carmel Rodrigo, nurse,
Raumati Road Surgery

“Implementing something as large scale as Health Care Home was always going to require some initial disruption. When you can't see why you're changing, your reluctance to cooperate increases. Standardisation was a real sticking point for some of the doctors to begin with. But seeing the ways it can help them work has brought them round.”

Lyn Allen, Practice Manager, Karori Medical Centre



Nurse Manager Robyn Taylor (left) and Practice Manager Lyn Allen (right) from Karori Medical Centre

Change Management

Some of the tools in Health Care Home's kit seem no more than common sense, whilst others can appear quite radical. What they all have in common is that using them requires change. These changes—whether Big Bang or Evolutionary—require the enlistment of every member of staff, which in turn requires patient and sustained application and explanation.

Patient Portal

One of Health Care Home's key aims is the improvement of access to care, and its practices actively promote the use of the patient portal. A concern originally raised about the patient portals was that accessing care in this way would be something that only younger patients would be interested in doing.

However, early reports suggest that it's equally popular with older patients, and that it doesn't do to generalise too much when it comes to older people and the digital age.

Sheila Mottram, a patient registered at Johnsonville Medical Centre, would certainly agree with this. A resident of a Kilbirnie retirement village for the last eight years, she is a huge fan of ManageMyHealth.



“It's a godsend. Now I don't have to try to pronounce the names of my medications down the phone. I can just go online and go tick, tick, tick... Older people are not that intimidated by computers, as a rule, especially when it's as straightforward as ManageMyHealth.”

Sheila Mottram, patient, Johnsonville Medical Centre



Dianne Theobald, Nurse Team Leader, from Newtown Union Health Service

Clinical triage

Increasing the scope of what can be accomplished by triage makes a lot of sense, and Health Care Home is looking to both nurses and doctors to broaden their involvement in this crucial area. Nurse Practitioners are already broadening the range of what nurses can undertake in general practice, while for doctors, this means a proactive involvement in the triage process, speaking with patients during peak call times and actively helping to shape the working day.

“GP phone triage means I'm so much more in control of my day and allows me to better manage acute on-the-day demand as many patient needs can be met without the need for a GP consultation, i.e. repeat prescriptions, nurse consults, pre-testing or referral to other health services. Patient satisfaction has also increased as people value the more personal experience of being called and spoken to by their GP,” says Dr Kirsty Lennon, GP at Raumati Road Surgery.



“GP phone triage means I'm so much more in control of my day and allows me to better manage acute on-the-day demand as many patient needs can be met without the need for a GP consultation.”

Dr Kirsty Lennon, GP at Raumati Road Surgery

7.

Reflections and insights



Mabli Jones, GM Service Development, Compass Health



Melissa Simpson, Health Care Home Programme Lead, Compass Health

It's been an extraordinary year, and we are proud of our local HCH practices for achieving such a transformational change in the way they deliver their service, and for our hospital teams engaging in this new way of working in the community.

With the support and funding of the CCDHB, the Compass Health Care Home development team have been able to work closely with practices to move from the traditional general practice to the Health Care Home model of care.

We spoke with Melissa Simpson and Mabli Jones from the Health Care Home team at their offices in Compass's Wellington headquarters, to find out what experiences and lessons the first year or so of HCH implementation has given the team.

Q: Can you tell us a little about the preparatory work you did, what was in place before the whole project kicked off?

Melissa Simpson (MS): Well, upfront planning and readiness at Governance level was obviously essential. A great deal of preparation was in place well before the launch. My job is to hold the programme together, with dedicated project management support. Detailed planning has always been key to the success of the programme, and we ensured that all members of the team understood the task and timelines.

Q: Presumably clarity around expectations was important?

Mabli Jones (MJ): Oh yes—crucial. As part of the funding arrangements, business rules were clear to all parties. This allowed reporting processes to be consistent across Health Care Homes. Contractual and funding arrangements were also made very clear. Since, as they say, 'Data is King'—and that's especially true with clinicians—we needed sturdy mechanisms in place that would allow us to build an evidential database about what has (or hasn't) worked elsewhere.

Q: How do you approach your relationships with the new HCH practices?

MJ: Any new, radical approach such as HCH requires a great deal of trust from all parties, I think. The solid systems I've described helped facilitate the rapid pace of change, and sound relationship management—regular practice meetings and peer review groups—meant that strong trust and confidence in most relationships was built. We trusted the practices and—the feedback suggests—they trusted us.

MS: This approach of building strong, trusting relationships and testing the model of care helps embed the change. The Health Care Home model of care, once implemented, speaks for itself. Clinicians—sometimes initially sceptical—often become its biggest fans as they see the results of the changes kick in.

Q: Could you describe how HCH has been implemented at practice level? What worked best?

MS: It's worth saying that a stake in the change can make a real difference. A strong partnership between clinical leadership and managerial drive makes adoption of the model faster and broader. That said, we've also found that the Health Care Home model of care works in a wide range of settings, as it is focused on the patient, so what the ownership model is at a practice is not a deal-breaker.

MJ: We've also learned that best use of the clinical leads times is to offer coaching and mentoring within the practices rather than attend every Health Care Home meeting. In addition, we are having a lot of success with service integration, working alongside our community service colleagues in multi-disciplinary teams.

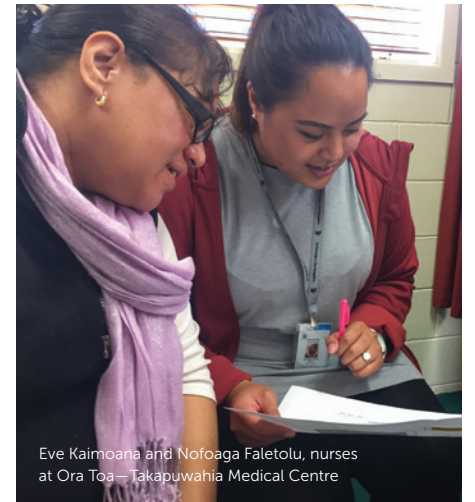
Q: What were the keynotes of your approach to support?

MS: Firstly, Relationship Managers were always available to provide advice as required. Our change team have focused always on what has been best for practice and patients. To that end, innovation and flexibility have been encouraged across our Health Care Homes.

MJ: We acknowledge completely that there are different ways that practices can achieve the model of care. For example, there is a link between Kaupapa Maori principles and LEAN methodology, and we've found that the uptake is good even where the fit doesn't immediately seem obvious. Creating new opportunities and sharing these at our peer groups has been a core focus of the programme.

Q: Can you tell us a little more about the peer groups?

MS: Regular peer review meetings have been invaluable. They capture and crystallise practice level insights. Peer review, shared lessons, and a mentoring approach—this reflective style allows for continuous improvement. It's also proved very popular with the practices. The sense of a joint venture—that you have friends and colleagues who are sharing the process, the changes—that can be a huge morale booster.



Eve Kaimoana and Nofoga Faletolu, nurses at Ora Toa—Takapuwhia Medical Centre

"We are having a lot of success with service integration, working alongside our community service colleagues in multi-disciplinary teams."



Word about HCH is getting around, and we have more practices wanting to join than we currently have room for—a problem, perhaps, but the best sort of problem to have.

Q: How's the future looking?

MJ: The future's looking great, thanks! A project on this scale is going to take time to show results, but the evidence we have, as the practices mature into their HCH implementations, is looking very good. Exciting initiatives like consumer groups, self-management, self-check in kiosks are kicking off. Word about HCH is getting around, and we have more practices wanting to join than we currently have room for—a problem, perhaps, but the best sort of problem to have. We're taking on seven more practices this year, and we're continuing to refine and improve the programme as it becomes more widespread.

Q: Final thoughts?

MS: More a few 'thank you's, really. Firstly, the biggest thanks should go to the seven practices who took that leap of faith and became our early adopters. Without them we'd be stuck at the starting gate, and HCH's advantages would be theoretical rather than proven. Thanks, too, to the HCH team here, who have worked so hard to help make it happen. We have enjoyed working collaboratively with our community service teams to create an integrated approach that provides better coordinated care for our patients. Finally, a huge thanks to the foresight of the CCDHB, as the development has enabled this proactive change in primary care and the establishment of new links with the services in the community. Together we are enabling our region's enrolled patients to reap the benefits from the Health Care Home mode of care.

Looking forward

8.

CCDHB's continued investment in primary care, at a time when resources are significantly limited, shows both foresight and leadership.

The faster roll out of the programme will achieve coverage of

80%

of the enrolled CCDHB population by the end of 2018

It supports one of the key design principles of the programme—that primary care is the foundation of any successful health care system. We need to build on good, traditional general practice to ensure it is sustained—this change is transformational.

With our Tranche 1 practices now into the second year of their Health Care Home journey, the HCH development team at Compass have stepped back a little.

Much of this second year will be about bedding in the changes that have been made, whilst at the same time continuing to evolve and develop the model further to best meet the needs of their patients.

The focus now is bringing aboard thirteen Tranche 2 practices, as well as preparing for Tranche 3 roll out—a substantial challenge.

The faster roll out of the programme will achieve coverage of 80% of the enrolled CCDHB population by the end of 2018.

We will continue to learn as we go, collecting data to demonstrate the impact of the model, both on patient outcomes and on health service utilisation. We'll continue, too, to gather stories from patients and staff, capturing the human impact of the changes that are being made.

We look forward to learning from other areas in New Zealand where the Health Care Home model of care is being rolled out and, in turn, to sharing our story as it evolves and grows.

Appendices

Appendix 1 — Summary profiles of our Tranche 1 Practices

The map on pages 6-7 provides an overview of location and practice enrolment size. Below is further detail relating to the profile of each our Tranche 1 Practices.

Practice	Launch date	Practice profile
Johnsonville Medical Centre	July 2016	<p>Johnsonville Medical Centre is a modern and innovative practice in the northern suburbs, which serves a population of approximately 13,000 patients as well as delivering a variety of services to non-enrolled patients.</p> <p>It is Cornerstone accredited, and has recently completed its second year modules within its four year cycle. As a practice they are committed to the philosophy behind the Health Care Home model.</p> <p>The Practice believes that the redesign of its model of care to deliver enhanced patient care will benefit patients, its team, and the community as a whole. Health Care Home will create a practice which:</p> <ul style="list-style-type: none"> • Has capacity for future growth in its population; • Can deliver more services locally; and, • Is attractive for current and future staff (including succession).
Karori Medical Centre	July 2016	<p>Karori Medical Centre is a progressive community health service operating in their local community for 40 years. The great team of doctors, nurses and administration staff have a wealth of experience and expertise.</p> <p>The Practice uses high tech equipment combined with continuing education and fully integrated computer management systems to ensure that high quality, appropriate and accessible health care is available to all patients.</p> <p>The practice serves a population of over 14,500 patients.</p>
Newlands Medical Centre	July 2016	<p>Newlands Medical Centre is an innovative Practice with a long history of being dedicated to providing patients with quality family health services. Based in the Wellington northern suburb of Newlands, the experienced team of doctors, nurses, and administrative staff have a wealth of knowledge and pride themselves on providing comprehensive primary health care. Newlands Medical Centre is constantly seeking to improve its services, especially for high needs patients. This is evidenced by the early adoption of many service improvement initiatives such as Patient Portal, GP Clinical triage, and Cornerstone Accreditation. The practice is currently looking after nearly 10,000 patients</p>

Raumati Road Surgery	July 2016	<p>Raumati Road Surgery is a well-established General Practice which aims to provide a friendly, personal service to their patient population. As a practice they are committed to promoting sustainable General Practice and supporting workforce development.</p> <p>The practice has a team of highly skilled and qualified medical, nursing and administrative staff who provide high quality care to meet the needs of their practice population. The number of enrolled patients at Raumati Road Surgery is around 3,500.</p>
Ora Toa Health Services	October 2016	<p>Ora Toa Health Service is a Maori Health provider located in the Porirua area, owned and operated by Te Runanga o Toa Rangatira Incorporated. Ora Toa is also a Primary Health Organisation and has four Very Low Cost Access General Practice providers. All services are free or low cost, and include General Practice, Community outreach services and a Primary Mental Health and Addictions service.</p> <p>Three of the Practices (and integrated community teams) have adopted the Health Care Home model of care, including:</p> <ul style="list-style-type: none"> • Takapuwahia • Cannons Creek, and • Mungavin <p>They are all located in the Porirua area, with a combined population of over 10,000 people.</p> <p>The fourth Practice, Poneke, is located in Wellington and may adopt the Health Care Home model in the future.</p>
Newtown Union Health Services	October 2016	<p>Newtown Union Health Service provides comprehensive Primary Health Care Services for over 6,500 people from the Eastern and Southern Suburbs of Wellington.</p> <p>The practice has a large proportion of high need patients and refugees. Services are delivered from the main clinic site in Newtown, at the Broadway Clinic, Strathmore, and in communities through outreach.</p> <p>The Newtown Union Health Service direction is through a patient-centred lens using innovative models and available technology to make improvements.</p>
Hora Te Pai Health Services	October 2016	<p>Hora Te Pai Health Services is an iwi linked Kaupapa Maori Health provider focused on caring for Maori, Pacific Island and Community Service Card holders, within Te Atiawa ki Whakarongotai Iwi boundary. Although the Practice is small, it is able to provide clients with coordinated, comprehensive care. Working together, the service is able to coordinate care across many components of the broader health care system, secondary, primary and community services.</p> <p>Hora Te Pai is able to provide clients with support to social and health providers, increase health literacy and advocacy. The Practice currently serves approximately 2,800 patients</p>

Appendix 2 — Health Care Home model of care

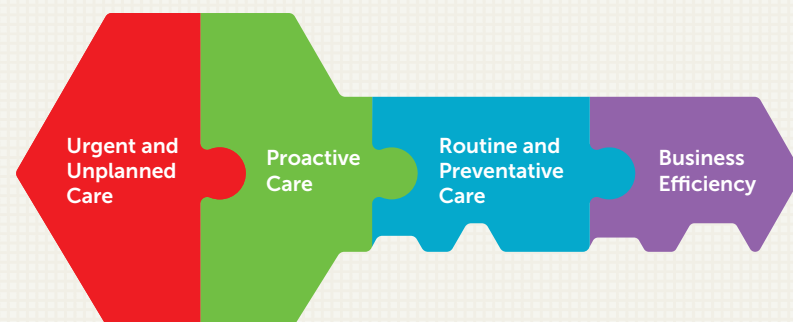
The Health Care Home Model of Care (HCH) was created to enable primary care to deliver a better patient and staff experience, improved quality of care, and to function with greater efficiency.

The Health Care Home differs from traditional general practice (even 'good general practice') in that it fundamentally shifts the focus of the practice from the GP to the patient. This is not a small thing and requires a significant degree of reengineering. It means the activities of the practice become aimed at improving access, experience and outcomes for patients and their families, rather than the professional demands of the clinical staff. It recognises that general practice is part of a wider system of primary health care that interacts with patients and shapes their overall health and wellbeing.

The newly launched Model of Care Requirements sets out the Health Care Home service elements, and the characteristics of a Health Care Home practice over and above the traditional model. These provide greater clarity for Practices, and are grouped into 4 core domains:

1. Ready access to urgent and unplanned care.
2. Proactive care for those with more complex needs.
3. Better Routine and preventative care.
4. Improved Business efficiency & sustainability.

These four domains can be broken down to the core service elements summarised in the table opposite.



Health Care Home model of care service elements ⁵

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| <ul style="list-style-type: none"> • Advanced call management • GP phone triage and clinical management • Same day appointment capacity • Extended acute treatment options • Increased hours of access • Patient-oriented (varied) appointment lengths • Care planning for those with high needs or at risk • Clinical and administrative pre-work to improve the efficiency of time spent with patients | <ul style="list-style-type: none"> • Consultations over the phone and via secure email • Web and smart phone based patient portals • Enhanced layout and composition of GP facilities to support new ways of working, with more effective use of physical space • Community Health Service Integration • New professional roles to expand the capacity and capability of General Practice • Application of LEAN quality improvement processes |
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Fundamentally, the model aims to achieve a shift from:

- A system/provider-driven care model, to a patient-driven care model
- Face-to-face, to virtual care where appropriate
- Reactive care, to as much planned care as possible
- A universal model, to care that is personalised to patient need and context, using a team approach across sectors
- A siloed, fragmented provider environment, to one that is a well co-ordinated, shared care environment
- Providers surviving the working day, to providers enjoying the day
- Vulnerable practices, to practices that are viable in the longer term

In general, the Health Care Home model of care is centred around the patient's needs and aspirations. It uses the skills and capacity of the entire practice team (clinical and non-clinical), rather than viewing the extended health team as accessories to GP care. In addition, the model builds business efficiency and standardisation around facilities and processes at general practices, rather than relying on the preferences of individual clinicians.

⁵ Source: Hefford, M. (2017). From good to great: The potential for the Health Care Home model to improve primary health care quality in New Zealand. *Journal of Primary Health Care*. Doi: 10.1071/HC17045

Appendix 3—Health Care Home National Dataset: Inaugural Measures

Urgent and Unplanned Care

1. Age standardised ED attendances per 1000 enrolled patients
2. Age standardised After Hours Consultations per 1000 enrolled patients
3. Age standardised ASH Admissions per 1000 enrolled patients
4. Age standardised Acute Admissions & readmissions per 1000 enrolled patients
5. Triage outcomes—% of patients managed appropriately without a same day face to face appointment
6. Age standardised After Hours primary care Consultations per 1000 enrolled patients
7. Primary options for acute care claim volumes per 1000 enrolled population
8. Same day access for those where clinically appropriate
9. A&M/other Practice visits during business hours
10. Hospital bed days in the last 6 months of life
11. Average patient wait time to consult
12. Annual audit of triage patients and re presentations

Proactive Care

13. Age standardised Nurse Consultations per 1000 enrolled patients
14. Percentage of patients seeing their own GP
15. Average number of different clinicians seen over the last 10 visits
16. BMJ measure: percentage of consultations with the GP seen most often over the 24month period
17. Percentage of DNAs at hospital FSAs
18. Partners in Health Scale—change in average score over time
19. % of high needs patients with a care plan and named coordinator

Routine and Preventative Care

20. Number of patient inbound secure messages through patient portal/1000 adults
21. No. of virtual (telephone/video) planned consults as % total consults
22. Patients with activated patient portal access per enrolled population
23. % of patients that have access to own notes (PHO measure)
24. Smoking quit rate
25. Dropped call rate
26. Patient experience survey scores
27. Wait times in the practice (post appointment time)
28. Time to 3rd available appointment
29. Percentage of DNAs at the practice

Business Efficiency

30. Practice team climate survey results
31. % Room utilisation for clinical interactions
32. No of aged standardised patients enrolled per GP FTE
33. No of aged standardised patients enrolled per Nurse/ FTE
34. % of enrolled population who leave during the year
35. Staff turnover
36. Sick days per FTE per year
37. Total phone calls per 1000 per month

Health Care Home Partners in the Greater Wellington Region



