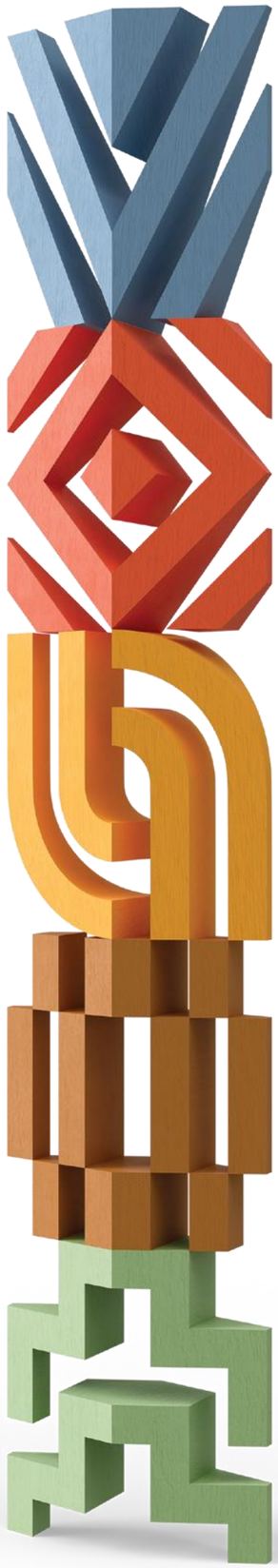


Pou Ora |Pillars of Health Model of Care

Provide your feedback here [Pou Ora - Pillars of Health Model of Care]

The way we deliver primary healthcare is evolving to meet the changing needs of our communities. Our new model of care, Pou Ora, is designed to strengthen the foundation of general practice by ensuring care is accessible, sustainable, and responsive to the needs of whānau.

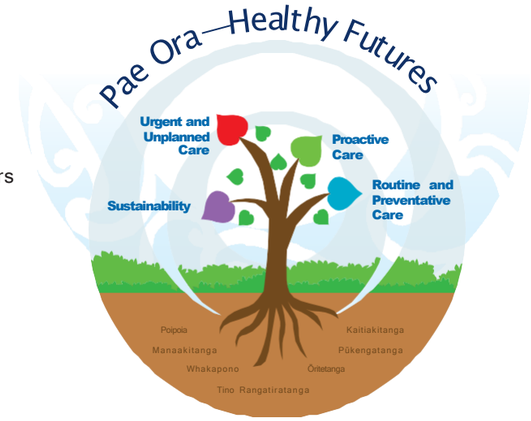
Grounded in five interconnected pou (pillars), this model provides a framework for delivering high-quality, equitable, and patient-centered healthcare.

A kawakawa tree stands at the heart of the Health Care Home model of care, its roots grown deeply through the values of Collaborative Aotearoa. This tree provided strength and support, its branches offering care to those in need. It was our foundation, strong, resilient, and rooted in the principles that guided our model of care.

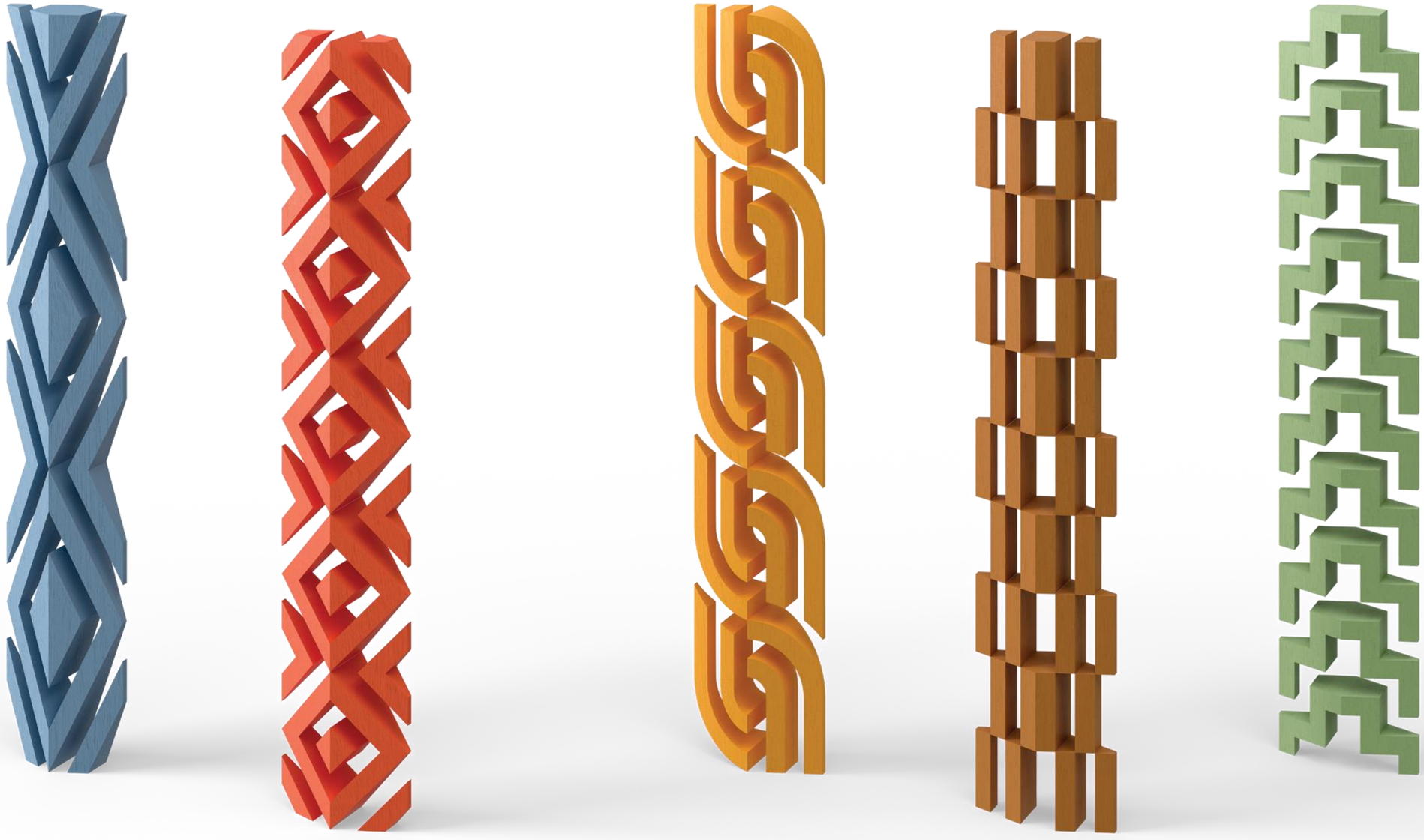
As the world changed, so too did our needs. New challenges arose, calling us to evolve. We did not discard the wisdom of the past, but instead transformed it, carving pou from the tree's wood. The five pou of Pou Ora (pillars of health) stand firm in the place of the tree, guiding us toward a sustainable future.

Each pou is a collective creation, shaped through kōrero (conversation), wānanga (discussions), and collaboration.
Te Pou Ohotata (urgent care), Te Pou Kaimahi (workforce),
Te Pou Auaha (innovation), Te Pou Hono (partnership), and Te Pou Karohia (prevention) are carved with care, their lessons etched by the experiences of those who have walked this journey.

Pou Ora are our guides, they protect, support, and mark the way forward. They ensure our model of care is equitable, modern, and accessible, deeply rooted in the past and crafted for a sustainable primary and community health care future.



The Five Pou of Pou Ora
Pillars of Health Model of Care



Collaboration
Te Pou Hono

Collaboration is key to delivering integrated healthcare. This pou strengthens partnerships between your general practice, and other healthcare providers to create a seamless, patient-centered system that enhances equity and access.

Access to Acute Care
Te Pou Ohotata

Timely access to urgent and unplanned care is essential for a well-functioning primary care system. This pillar ensures that patients receive the right care by the right healthcare professional at the right time by the most appropriate mode, reducing unnecessary hospital admissions and ensuring continuity of care within general practice.

Innovation and Sustainability
Te Pou Auaha

As healthcare demands grow, we must embrace new ways of working. This pillar drives the adoption of digital tools, innovative service models, and sustainable practices that enhance efficiency, reduce pressure on frontline staff, and future-proof primary care services.

Proactive and Preventive Care
Te Pou Karohia

A shift towards proactive and preventive care helps keep communities healthier for longer. This pillar focuses on early intervention, long-term condition management, and health promotion strategies that reduce the burden of disease and improve overall wellbeing.

Workforce
Te Pou Kaimahi

A sustainable and skilled workforce is at the heart of high-quality care. This pou focuses on growing, supporting, and empowering the health workforce, ensuring staff have the training, resources, and professional development opportunities they need to provide safe and effective care.

Workforce
Te Pou Kaimahi

A sustainable and skilled workforce is at the heart of high-quality care.

Workforce
Te Pou Kaimahi

Workforce refers to an integrated multi-disciplinary team (MDT) where clinicians fulfil consultation roles, engage in team huddles for coordination, and uphold cultural safety to deliver effective, patient-centered care.

Integrated Multi Disciplinary Teams	The care team includes a wide range of health professional skills. Roles should meet the need of the practice population. The practice integrates with other community health professionals to better manage the population's health needs and avoids duplication of work.
Clinician Consultation Role	The practice has a clinical consultant who is responsible for supporting, educating and supervising the multi- disciplinary team. This role is a senior clinician who also contributes to the practice's clinical governance responsibilities.
Advanced Workforce Pathways	New and existing roles have pathways for professional advancement.
Connected Teams	Regular brief standing huddles help keep the practice team connected and aligned, fostering teamwork and efficiency. These huddles should be quick, engaging, and provide an opportunity to discuss important messages within the practice.
Cultural Safety	The practice prioritises cultural education and supervision for all kaimahi/staff, supporting their ongoing development in delivering culturally safe care. A cultural safety roadmap provides clear steps for continuous improvement, ensuring kaimahi can effectively meet the cultural needs of their community.

Value Proposition

Patient	Whānau centred care Integrated care teams ensure whānau receive comprehensive and well-coordinated care
	Access to clinical expertise Clinical consultants provide guidance and mentoring, improving health outcomes
	Culturally safe care Prioritising cultural safety ensures the mana and dignity of patients is respected, and improves trust of the system
Practice	Fully utilised workforce A diverse care team ensures the right person manages the patients, reducing GP workload
	Kaimahi development Clinical consultants provide mentorship and ongoing professional development and up-skilling of practice staff
	Improved team synergy Daily huddles enhance communication, efficiency, and team collaboration
	Improved management of complex cases
	Improved retention of workforce due to increased support
System	Improved patient outcomes Access to MDTs ensures patients with complex health journeys are managed effectively
	Reduced ED admissions Coordinated care prevents unnecessary hospital admissions
	Culturally responsive care delivered A culturally responsive workforce leads to better engagement and improved equity

We know we are successful when...

Number and type of MDT members meets the needs of the practice demand

Patient survey results on culturally safe practice are positive

Staff satisfaction surveys on communication and team coordination are positive and improving

Access to Acute Care
Te Pou Ohotata

Timely access to primary health care enables patients to book appointments and receive problem resolution on the same day they seek care.

Access to Acute Care Te Pou Ohotata

This approach enhances responsiveness, minimises treatment delays, and ensures patients receive appropriate care when they need it.

Acute care clinic	Timely access to primary health care requires a dedicated allocation of practice resources to manage same-day demand, ensuring acute care remains separate from routine appointments. In medium-to-large practices, this is typically achieved through a designated acute care clinic, staffed by a multi-disciplinary team.
Clinical Triage Assessment	A structured clinical triage process enables clinicians to assess patients' needs and navigate whānau to the right professional at the right time.
Digital Booking System	Patients can book both same day triage assessments and routine care digitally.
Triage Technology	The practice utilises an electronic triage chatbot to help patients navigate their care, determining where, how, and by whom they could be seen.
Home Self-help	The practice links patients with information for self- management and help.

Value Proposition

Patient	**Better Navigation** Clinical Triage ensures patients sees the right person at the right time. **Faster Access to Care** Same-day acute appointments reduce wait times and ensure timely access. **Empowerment** Self-help tools and telehealth options support patients in managing their own health.
Practice	**Improves Efficiency** Digital booking and triage streamline operations, reducing admin burden. **Workload** Reducing unnecessary appointments frees up resources for those who need them most. **ACC** Increase ACC revenue.
System	**Fewer ED and afterhours presentations** Whānau have access to quality and timely care thorugh their practice, reducing unnecessary hosptial, A&E and afterhous visits. **Cost Savings** Preventing avoidable hospital admissions and late-stage interventions reduces overall healthcare costs. **Increased Equity** Digital access opportunities support whānau, primary populations and those who live in rural or underserved areas to receive timely care.

We know we are successful when...

Patients Reported Outcome Measures (PROM) are measured and improve patients requesting a same-day appointment, receive one.

Clinical triage resolution rates meets the practice's demand for same day acute requests.

Practices has an increased number of digital bookings.

Patients are engaged in self-help tools and resources.

Proactive and Preventive Care
Te Pou Karohia

Focusing on early intervention, long-term condition management, and health promotion to prevent illness, reduce health inequities, and empower whānau to maintain lifelong wellbeing.

Proactive and Preventive Care
Te Pou Karohia

This pillar ensures that patients receive the right care by the right healthcare professional at the right time by the most appropriate mode, reducing unnecessary hospital admissions and ensuring continuity of care within general practice.

Extended Hours	Additional hours are offered to patients to engage with their care team for routine appointments beyond the PSAAP agreed 8 AM - 5 PM timeframe.
Population Stratification	Digital data tools are used to analyse the practice's population and identify patients with the greatest care needs.
Digital screening tools (recall processes)	Preventive screening recalls are centrally managed through digital tools, helping patients understand the purpose of the recall, its importance, and how to book their appointment.
Clinics (planned care)	Proactive and planned care clinics are available to provide targeted health services for patients with long- term conditions or those needing planned interventions. These clinics should be clearly communicated and advertised to patients.
Hauora Plans	Patients with complex conditions and health journeys collaboratively design an appropriate care plan with their healthcare team.

Value Proposition

Patient	Improved Access to Care Extended hours allow more flexibility for appointments, reducing barriers for those with work or whānau commitments. Better Preventive Health Digital recall systems and planned care clinics ensure patients have access to necessary screenings and interventions. Whānau-Centered Care Hauora Plans support patients with complex health journeys, providing personalised, long-term management.
Practice	Reduced Acute Demand Preventive measures lower the risk of emergency care and hospital admissions. Improved resource allocation Population stratification helps prioritise care for high-risk patients. Increased preventative screening participation Reducing the occurrence of late-stage diagnosis, and improving community health targets
System	Higher Preventive Screening Rates Early detection of conditions leads to better long-term health outcomes. Reduced Hospital & ED Pressure Proactive care reduces emergency admissions for patients with higher health needs. Better Health Equity Whānau-centered and group consults improve access for communities with lower healthcare engagement. Prioritise SLM Prioritise System Level Measures (SLMs) set by the government, such as ASH rates, access, immunisations, and renal/ diabetes outcomes. Proactive and preventative care at a general practice level will actively contribute to achieving the government's goals and performance targets.

We know we are successful when...

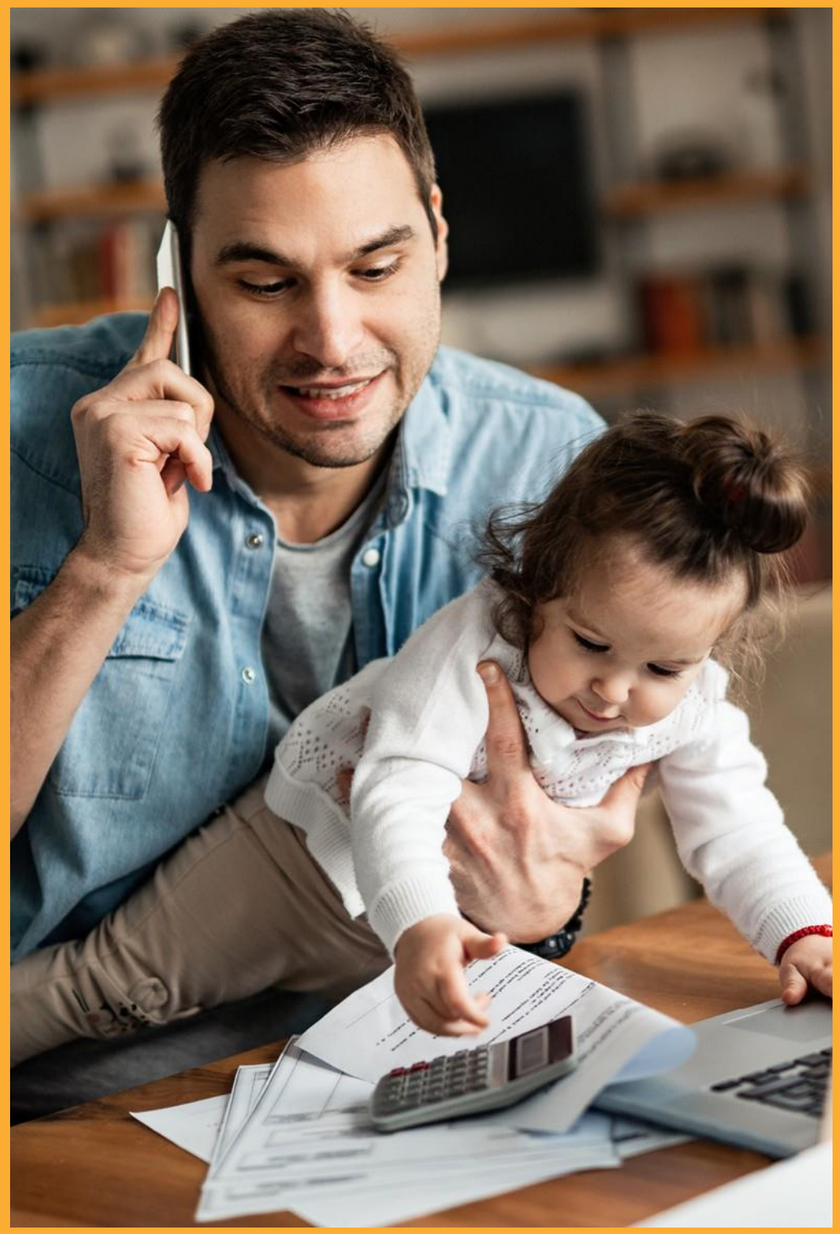
Preventive screening health targets are met or improving

Reduction in hospital admissions and ED presentations for identified high-risk patients.

Health indicators for clinic attendees improves (e.g., HbA1c for diabetes clinics).

The percentage of eligible patients with an active Hauora Plan increases and reflects the practices population needs

Innovation and Sustainability
Te Pou Auaha



The Innovation and Sustainability pou drives the adoption of digital tools, innovative service models, and sustainable practices that enhance efficiency, reduce pressure on frontline staff, and future-proof primary care services.

Innovation and Sustainability Te Pou Auaha

Te Pou Auaha supports practices in addressing the growing complexity of care through innovative models while enabling clinician succession planning.

Virtual patient coaching, navigation, assessment and monitoring	Virtual healthcare provision is provided to patients enabling the care team to engage and monitor patients' health virtually without being physically in practice.
Succession Planning	The practice business model has considered workforce succession planning and future ownership.
AI Enablers	Artificial Intelligence (AI) tools are maximised throughout the practice to support and compliment the practice team with clinical and non-clinical administration.
Digital Front Door	A digital front door is fully enabled, allowing patients to engage with their practice electronically.
Improvement Methodologies	The practice adopts improvement methodologies to support with efficient business operations.
Patient Engagement	A practice engages with patients and the community through surveys, patient groups, and local connections to gather feedback, enhance services, and strengthen relationships.

Value Proposition

Patient	Improved access	Whānau can access quality care from home
	Digital front door	Patients can connect with their practice and access their health information digitally improving access to care
	Increased engagement	Continuous virtual engagement helps with early intervention and long-term conditions management
	Sustainable care	Succession planning ensures whānau have access to quality care, even if their GP retires
Practice	Increased efficiency	Virtual care reduces unnecessary in-person visits, freeing up time for clinicians to support whānau with complex health journeys
	Improved quality	AI tools, such as AI transcribing, can be used improve accuracy and minimise errors
	Business Continuity	Succession planning ensures smooth leadership transitions and long-term sustainability.
System	Reduced ED admissions	Virtual care and AI reduce pressure on frontline healthcare services.
	Mitigate workforce shortages	Succession planning ensures ongoing availability of and access to healthcare professionals.

We know we are successful when...

- Staff satisfaction surveys reflect improved practice culture
- Number of enrolled patients accessing virtual coaching/ navigation services increases
- Percentage of eligible enrolled patients actively using the portal increases
- Improvement methodologies are used throughout the practice

Collaboration
Te Pou Hono

Collaboration is key to delivering integrated healthcare.

Provide your feedback here [Pou Ora - Pillars of Health Model of Care]

Collaboration
Te Pou Hono

This pou strengthens partnerships between your general practice, and other healthcare providers to create a seamless, patient-centered system that enhances equity and access.

Primary care networks	The practice engages with their primary health network to address population health priorities, access funding opportunities, and implement targeted initiatives that improve equitable community health outcomes.
Community and social service providers	The practice understands local community organisations and their service offerings. Collaboration with appropriate partner organisations are developed to support equitable health outcomes for the practices enrolled population. The opportunity for the practice to collaborate with community organisations to act as an extention to their general practice team is realised and activated.
Whānau engagement	The practice engages with patient and lived experience groups to gather feedback, ensuring that care is patient-centered, responsive, and aligned with the needs of the community. New practice services should be co-designed with lived-experience.
Iwi Māori Partnership Boards	The practice engages with Iwi Māori Partnership Board (IMPB) strategic objectives through the guidance of local iwi, hapū, rūnanga, and Māori health providers. The collaboration is to ensure: • culturally appropriate care • improve engagement with Māori communities • address health inequities
Wider Determinants of Health	The practice understands the broader social determinants of health affecting its population, utilising tools such as the Wellbeing Wheel. Collaboration with community partners is established when appropriate to support these patients effectively.

Value Proposition

Patient	**Access to options** Whānau have a direct and streamlined access to a variety of social and non-clinical supports within their community
	Holistic, Wraparound Support Connecting patients to social services ensures their broader health needs (e.g., housing, financial support, mental health) are met.
	Reduced Barriers to Care Co-locating services and integrating referrals streamline access to essential support.
Practice	**Improved Patient Outcomes** By integrating social services and NGOs, practices can address complex needs, leading to better overall health outcomes and targets
	Tools are available to enable providers to discuss wellbeing concerns with whānau
	Collaboration Support in addressing non- medical needs allowing clinicians to focus on medical care.
	Stronger Community Engagement Working with NGOs and volunteers strengthens trust and connection with the local population.
System	**Population health improvements** Addressing social determinants leads to healthier communities and reduced long-term healthcare costs.
	Efficient use of Health care professionals Integrating social and health services ensures patients receive the right care in the right place by the right people
	Stronger Collaboration Between Sectors Strategic partnerships foster a more integrated, patient-centered healthcare system.

We know we are successful when...

Population health targets are met or improving

Community health indicators are portraying positive change

Patient reported outcome measures are captured and improving