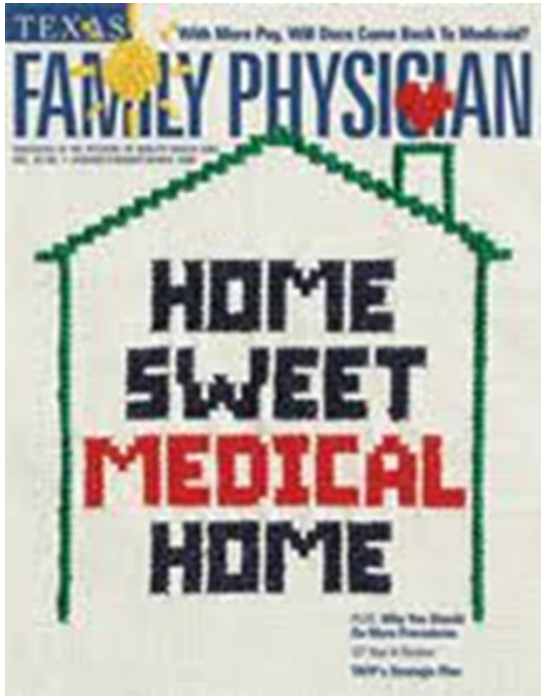
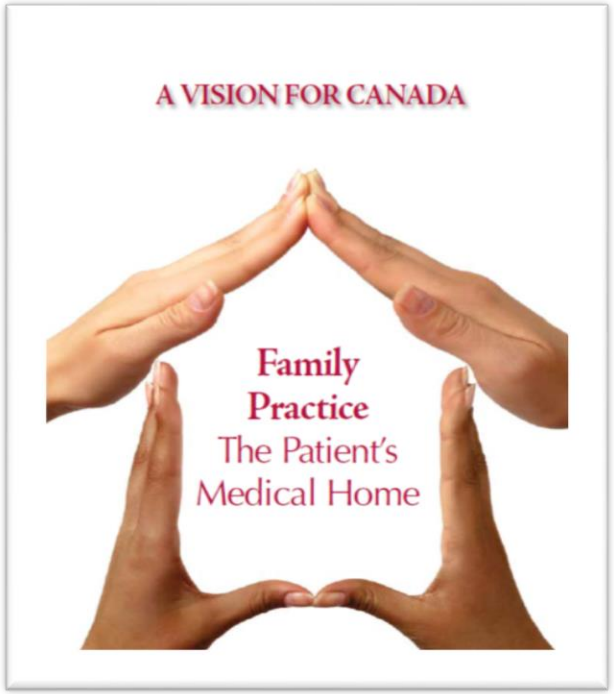
Health Care Home

CCDHB – Tu Ora Compass Health – Cosine – Ora Toa

Where we started?

2015/16 Annual Planning session





At joint Annual Planning session Primary Health Care leaders presented about the concept... First interest

Where we started – Collaborative from the beginning.

Small joint planning team

- CCDHB – 3DHB – 2DHB – CCDHB
- Initially wrapped with “rapid response” service

Our Approach

- In partnership with the local hospital
- Jointly funded, developed and governed
- GP practices applied and were selected against set criteria
- Gathering evidence and learning as we go - setting ourselves targets
- Part of a wider HCH national programme – early adopters like Pinnacle PHO have led the way
- Establishing a national data base to demonstrate impact
- Linking with the College of General Practice and GPNZ to ensure one message
- Establishing national HCH standards framework
- Supported by the MoH

Investment

Annual funding to practices

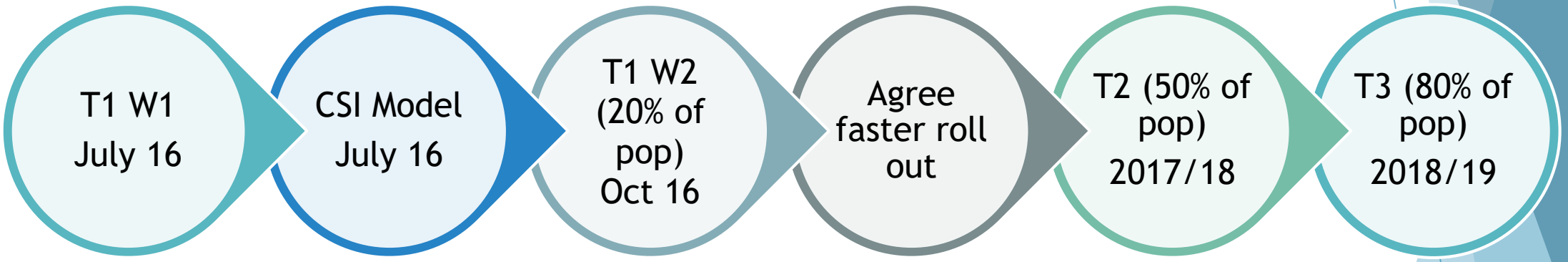
- $16 per enrolled pop from DHB
  - 70% in quarterly payments (prerequisites of Health targets & service elements)
  - 30% at end of year (performance)
- $14 per enrolled pop redirected from PHO

Change Team to support practices $350-$500k pa

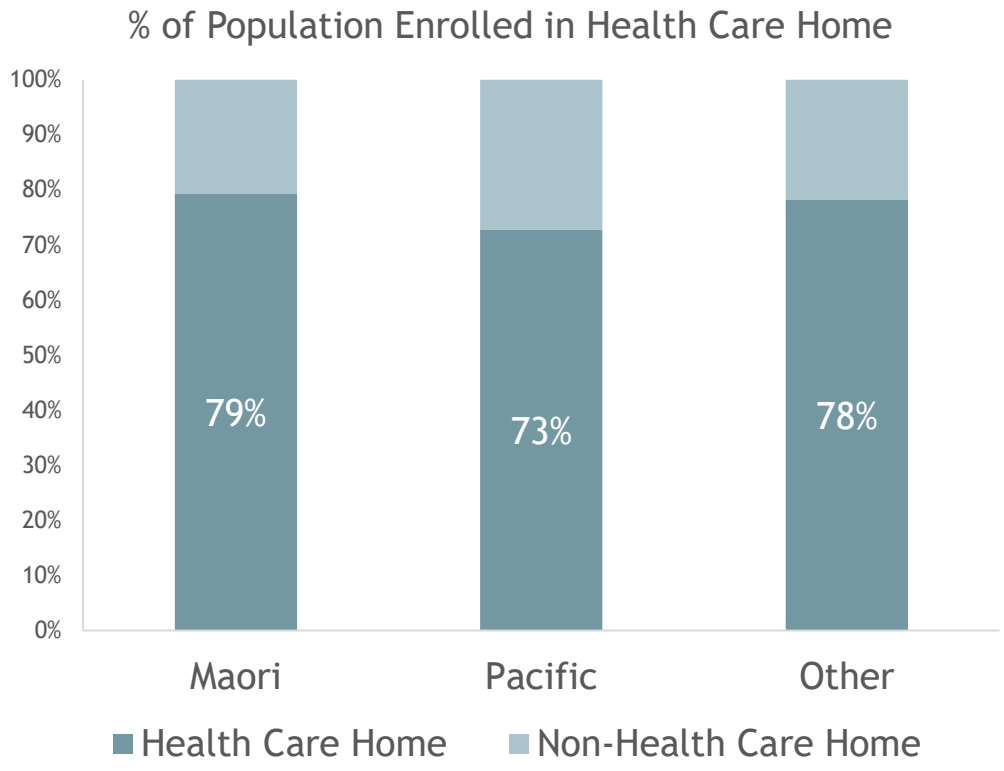
Community Team – District Nurses & Allied Health $150k pa

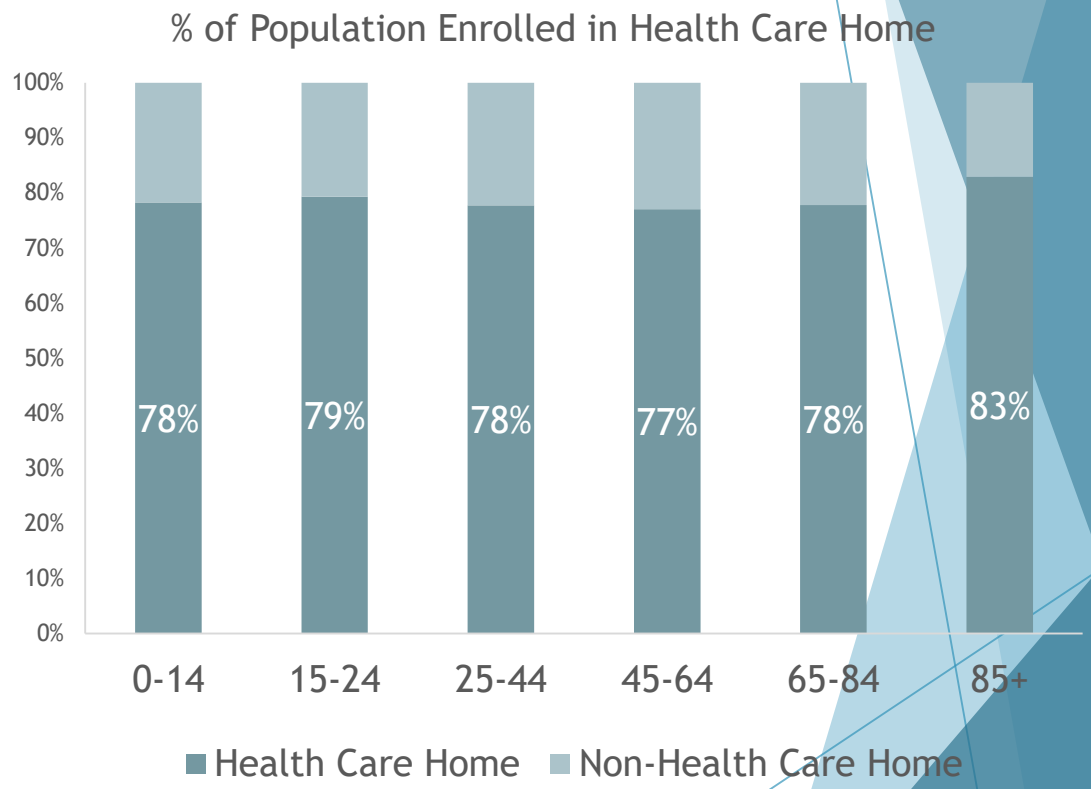
Evaluation

CCDHBs Health Care Home Journey



Population Coverage T1-T3





HCH Service Elements

- GP triage & on the day telephone consults
- On the day appointment for triaged patients
- Call management arrangements
- Extended hours availability
- Patient portal uptake and increased use
- Extended Acute Treatment Options
- Person Centric Appointments
- “Year of Care” planning for high needs
- Clinical and administrative pre-work
- Enhanced layout of GP facilities
- New professional roles
- Lean process

Practice Selection Process

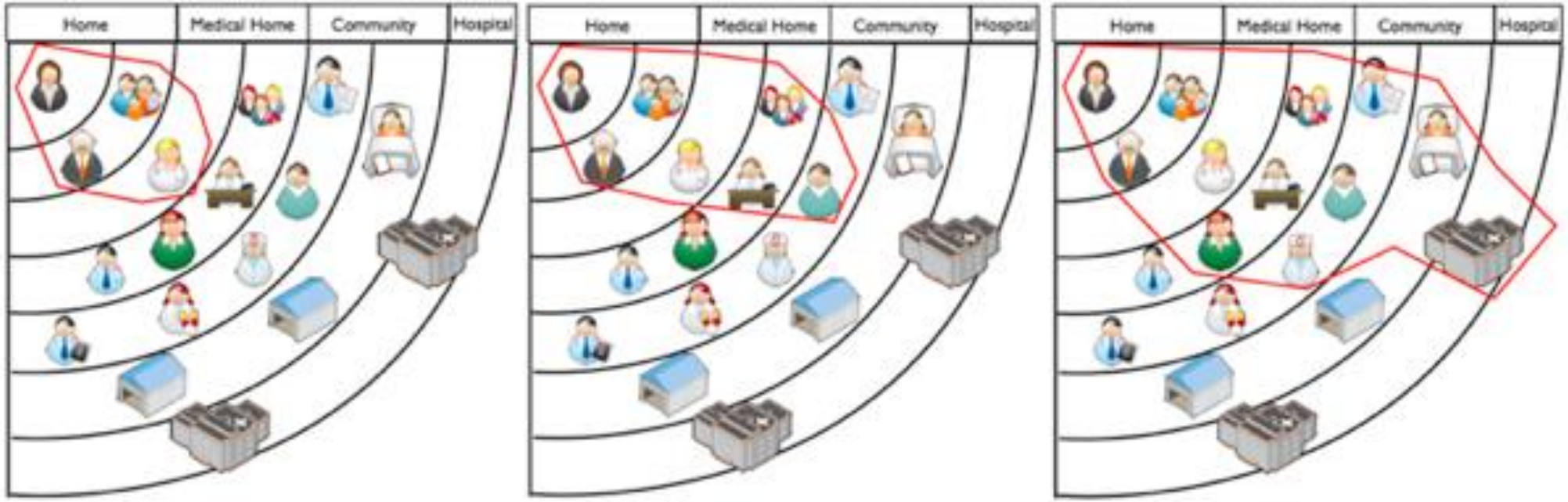
Tranche 1

- Minimum requirements
- Early adopters – evidence of ability to succeed

Tranche 2 & 3

- Minimum requirements
- High volumes of ED, ASH & numbers of Māori & Pacific

2016 – Community Service Integration



As care needs change, the Care Team gains additional members. It is not a different team.

6months


Development


Meetings
EXIT


Planning


Multidisciplinary Team

Community Service Integration

3

Alignment with HCH Practices

- Named & known DN/ORA aligned to HCH
- Part of integrated team bring specialist skill & contact
- To embed - Team building/development & enablers

Integrating existing community services

- Responsive (DN within 4hrs & ORA within 24hrs) & mobile
- Streamlined access, communication & collaboration
- Support transition of care
- Share skill sets

Proactive management of complex care

- Risk stratification/other for targeting
- Shared Care Plan & multiple levels of MDT collaboration

Target Setting

Measure at Practice Level	Target for Year 2	Target for Year 3
Acute Admissions per 1000 Patients (age standardised)	4.2% annual decrease from practice baseline at 1 July 2017	4.2% annual decrease from practice baseline at 1 July 2018
ED Attendances per 1000 Patients (age standardised)	4.2% annual decrease from practice baseline at 1 July 2017	4.2% annual decrease from practice baseline at 1 July 2018
Ambulatory Sensitive Hospitalisations per 1000 Patients (age standardised)	4.2% annual decrease from practice baseline at 1 July 2017	4.2% annual decrease from practice baseline at 1 July 2018
Time to third next available appointment	≤ 2 days by end of the year	≤ 2 days by end of the year
Patient Portal - Minimum requirement & Inbound activity	Minimum requirement of all patient portal functionalities & 10% annual increase from practice baseline at 1 July 2017	**Updated - Year of care planning**

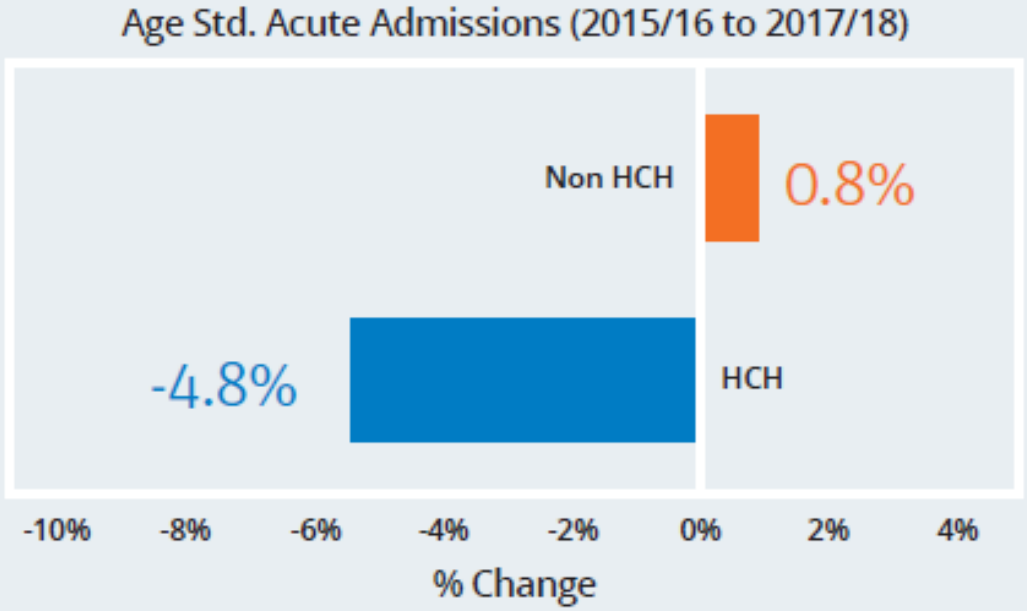
Monitoring

- Process eg. GP Triage
- Quality eg. Imms
- Impact eg. ED

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.

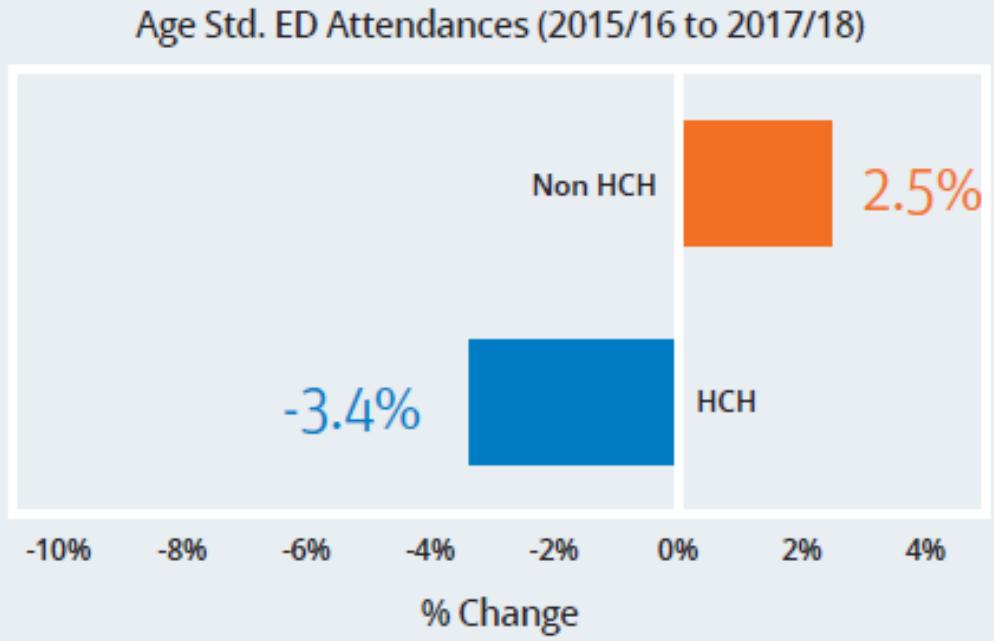
4.8% rate decrease for HCH practices vs.
0.8% rate increase for non-HCH practices



Emergency Department (ED) attendances

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

3.4% rate decrease for HCH practices vs.
2.5% rate increase for non-HCH practices



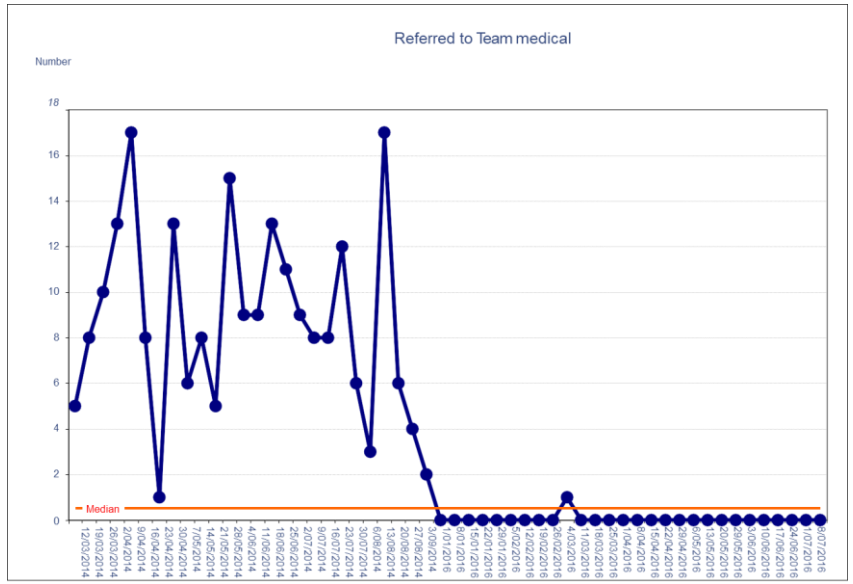
Early findings

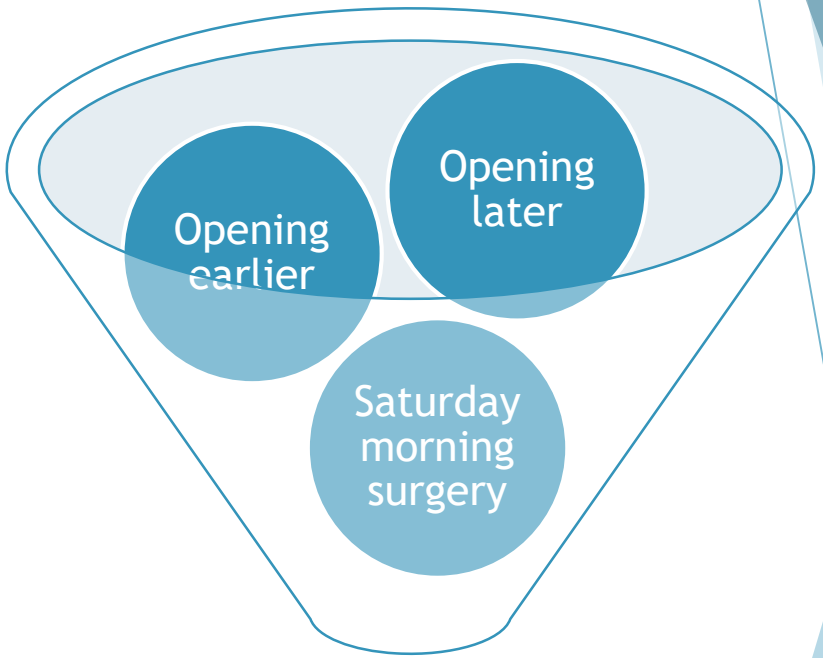
CCDHB HCH - Case study on the impact of Primary Care Developments by the State Sector Productivity Commission (Oct 2018). The report identified a statistically significant drop in emergency department (ED)

Thee Health Service Research Centre report on Primary Health Care Innovation (June 2018) identified that the collaborative network between the PHOs and partner DHBs in setting standards and sharing learnings around the implementation of the HCH is a key enabler for primary care innovation. The report identified the CCDHB approach with PHOs in the delivery of HCH model as example of this collaboration.

Examples of change

A reduction in patients attending their local A&M as a result of GPs introducing triage

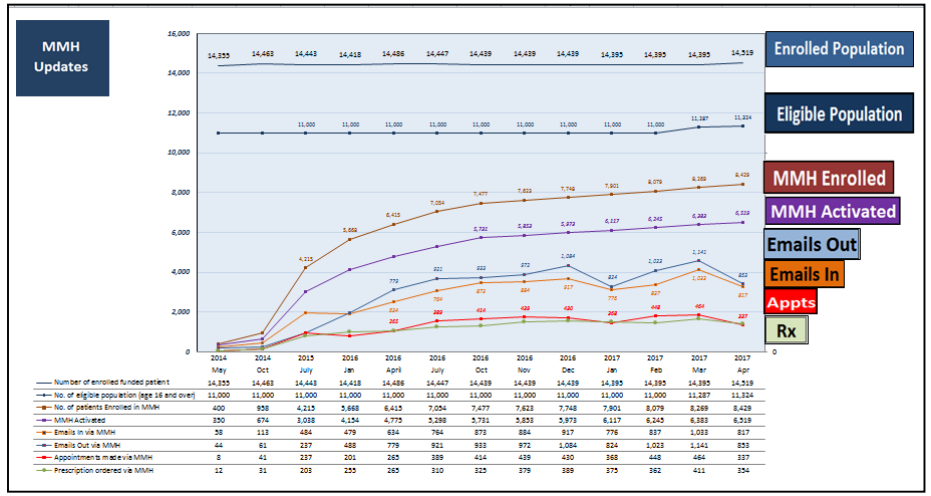


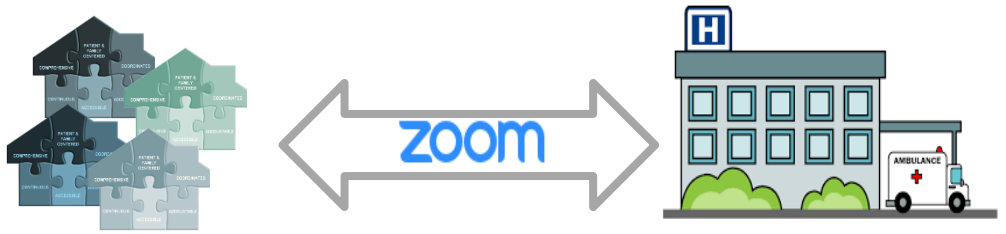


Over 60 hours more of General Practice time each week across 16 practices

Examples of change

>75,000 on the portal
Bookings, emails, appointments, repeat prescriptions
Open Notes



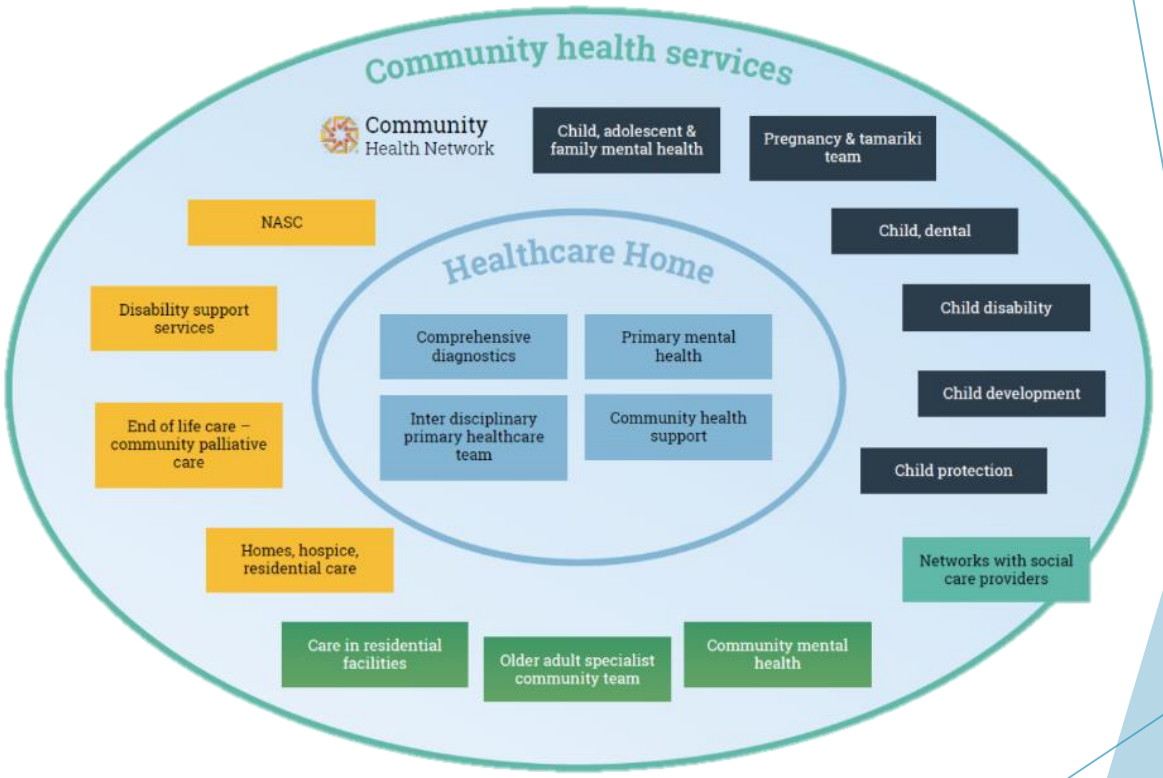


DN & AH link into HCH MDT
Pilot started 2018 b/w Paediatric and 4 Health Care Homes

Where to next

"Community Healthcare Networks are the central organising point for the delivery of effective and efficient healthcare."

CCDHB Health System Plan 2018



Community Health Networks

Networks are CCDHBs mechanism to organise the delivery of health services

Build a strong system, rather than focus on individual service

20,000 – 50,000 people supported by enhanced primary health care services and specialist services

8 Networks in specific geographies based on demographics, health need and physical proximity.