HEALTH CARE HOME

THIRD YEAR: ACHIEVEMENTS AND REFLECTIONS

TŪ ORA COMPASS HEALTH - HEALTH CARE HOME DEVELOPMENT TEAM

SEPTEMBER 2019

CONTENTS

1. FOREWORD

"This year I, like many thousands of other Wellingtonians, gained access to my full clinical GP team notes. I had already been using secure messaging with my GP to save time and make services more personal and more convenient. Rolling out the patient portal is one of the most visible changes Health Care Home practices embrace - but it is one of the most revolutionary. Contrary to some initial fears, it deepens rather than weakens the GP - patient relationship."

Martin Hefford,
CEO, Tū Ora Compass Health

This publication is an overview of Tū Ora Compass Health's third year implementing the Health Care Home Model of Care in the Wellington region and our first in the Wairarapa.

It offers some insights, stories and data from our Health Care Homes locally. Collectively, they cover a population of just over 270,000 enrolled patients across two District Health Boards, covering the Capital and Coast and Wairarapa area.

One of the critical success factors of the Health Care Home programme has been the sustained commitment of funding, people resource, and leadership, by the organisations involved 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 practices and from DHB community health teams to achieve some complex change.

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

As we further establish the model in our region, developing measures around patient outcomes and long-term 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 Health Care Home programme will continue to consider and incorporate the lessons learned from our third year, as well as being receptive to emerging evidence published through the Health Care Home National Collaborative - now covering a population of 1.2 million people.

"It is exciting and invigorating to share the growth and early success of the Health Care Home transformative model of care. With community, equity and whanau at the centre, general practice teams increasingly embracing positive change for future demands, specialist and DHB services collaborating , and encouraging early evidence of improved outcomes - we know we are on a winner and we are committed to and enthusiastic about further progress in the Health Care Home programme."

Dr Larry Jordan, Chair, Tū Ora Compass Health

Dr Larry Jordan,
Chair, Tū Ora Compass Health

"We are proud to be a frontrunner in the implementation of the Health Care Home programme for New Zealand. Capital & Coast DHB and its associated PHOs have achieved a shared goal of reaching 80% of our population within three years with this new and improved model of care. Together, we have sustained this commitment for change and our teams have worked systematically to implement this transformation.

The Board is excited by the positive performance that has been demonstrated already. We have seen better access for health care, innovative service models and increased connections with specialist services. We will look to build on these achievements and continue to build a stronger integrated system for our population."

Andrew Blair, Chair, Capital and Coast DHB Board

Andrew Blair,
Chair, Capital and Coast DHB Board

1. FOREWORD

Fionnagh Doughan,
CEO, Capital and Coast DHB Board

"As we implement the Health System Plan and focus on working more closely with our community partners, the Health Care Home programme demonstrates how we can work together to deliver better care. We welcome the enhanced and improved primary health care services that Health Care Home is delivering for our communities, and we are proud of our hospital services partnering in the programme.

Our early findings have been positive across performance data, clinician feedback, and the new ways we are working. We have commissioned a Health Care Home evaluation to learn, reflect and continue to evolve how we deliver care in our communities.

I am looking forward to working together over the next year, to complete the Health Care Home transformation as we progress to our next phase of integrating care across the CCDHB region. Health Care Home will be at the centre of our plan to develop Community Health Networks to better respond to the individual needs of our communities across the region.

Congratulations to all those involved. Thank you for everything you do every day to improve the health and wellbeing of our people."

Fionnagh Doughan, CEO, Capital and Coast DHB Board

"The changing demographic landscape that we work in demands an innovative and proactive approach to healthcare. The Health Care Home model will meet our DHB's strategic commitment to improving outcomes for our community. It is care for the patient, with the patient; and will help to better support our families to manage their health and be well.

Health Care Home provides an opportunity to introduce more sustainable healthcare. It is an excellent example of providers working together and maximising the resources available to build a healthier future - we are excited to become part of the programme."

Sir Paul Collins, Chair, Wairarapa DHB

Sir Paul Collins,
Chair, Wairarapa DHB

"Health Care Home has been an innovative and exciting change for our community. It supports Primary Care to offer improved access to care and choice of services for patients, promotes whanau and community wellness, and introduces better ongoing management of conditions. The first year of the Wairarapa programme has seen good progress from the practices involved. As we move into year 2 there will be a focus on integrating community health services into the programme."

Dale Oliff, CEO, Wairarapa DHB

Dale Oliff,
CEO, Wairarapa DHB

2. OUR APPROACH

In the Capital and Coast and Wairarapa area, we have achieved our Health Care Home programme goal – to reach over 80% of population coverage in three years.

Through an alliance approach, together we have been committed to improving health care for our population through the development of a strong health system.

We identified that Health Care Home provides a model that will enhance primary care and create a platform for integrating specialist skills. We also recognised that to meet the health needs of our population, we needed to create change at scale and pace.

The progress in the local programme has been achieved through strong and dedicated collaboration between the CCDHB, WrDHB, all the PHOs and local hospital services.

The change support required for the programme has evolved. We have moved fast this year, with all 42 practices being active and requiring different levels of support.

In the CCDHB area for the community hospital teams this has also been a demanding time of change, as members of these teams are now connected across all the Health Care Homes. In the WrDHB area, this work is at the early stages of development.

While the change requirements are diverse, everyone involved in the programme continues to work towards the key principle of keeping people and their whanau at the core of all developments.

In the CCDHB area, where they are in the third year of programme delivery, there has been a focus on future planning. CCDHB have agreed an ongoing commitment to the three-year change process for practices, as well as ongoing support beyond year three. They have also agreed expectations of what this enhanced health system should deliver. To strengthen the CCDHB approach moving forward, they have commenced an independent evaluation process and look forward to sharing this in the future.

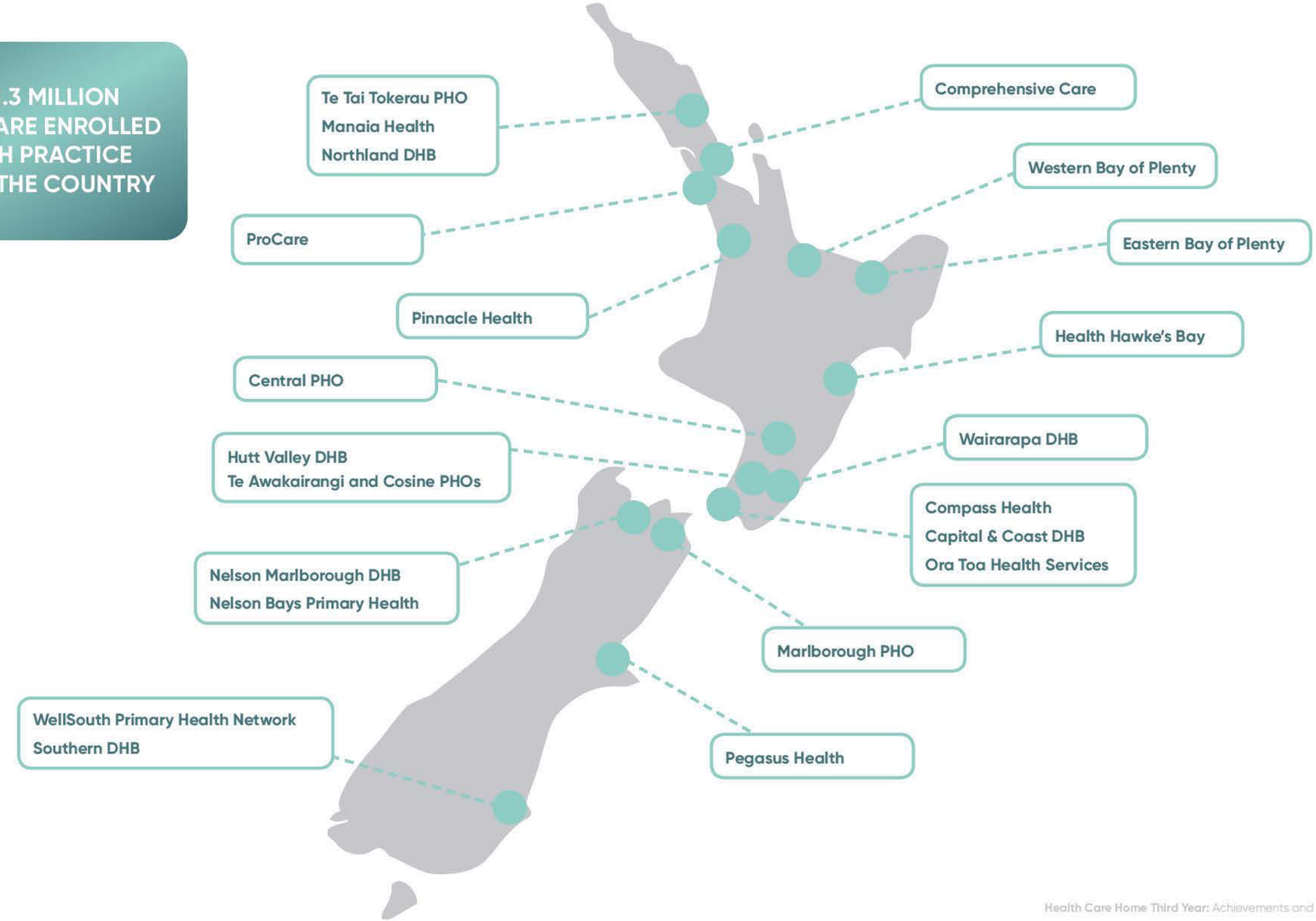
The approach to reach our goal has been a demonstration of our shared values of partnership. We have held our collective vision, invested in significant change and continue to learn as we go. The future is exciting, as collectively we are looking towards planning for Community Health Networks, our next stage of integrated care.

THE PROGRESS IN THE LOCAL PROGRAMME HAS BEEN ACHIEVED THROUGH STRONG AND DEDICATED COLLABORATION BETWEEN THE CCDHB, WRDHB, ALL THE PHOS AND LOCAL HOSPITAL SERVICES.

3.

HEALTH CARE HOME AROUND NEW ZEALAND

OVER 1.3 MILLION PATIENTS ARE ENROLLED IN A HCH PRACTICE AROUND THE COUNTRY



4. OUR PRACTICES

Hora Te Pai Health Services
Raumati Road Surgery
Drs Cammack & Evans
Paraparaumu Medical Centre
Waikanae Health
Coastal Medical Room
Team Medical

Ora Toa Health Services
Mana Medical Centre
Porirua Union & Community Health Services
Titahi Bay Doctors
Whitby Doctors

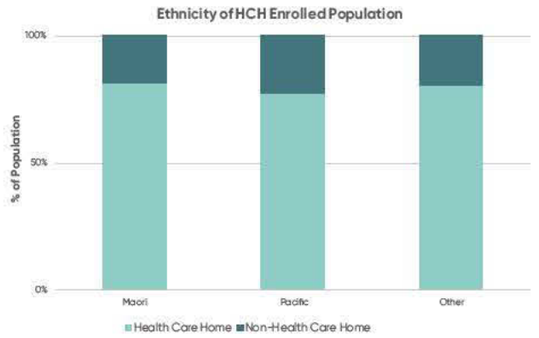
Johnsonville Medical Centre
Newlands Medical Centre
Ngaio Medical Centre
Khandallah Medical Centre
Onslow Medical Centre
Tawa Medical Centre
Linden Surgery

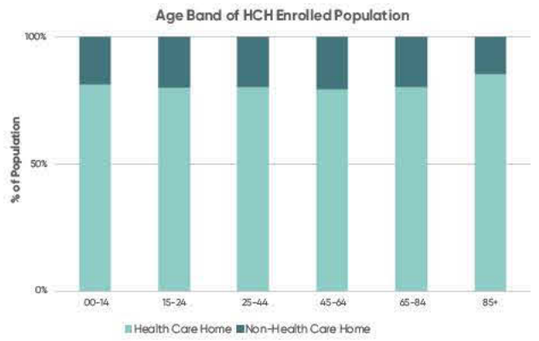
Karori Medical Centre
Newtown Union Health services
Island Bay Medical Centre
Newtown Medical Centre
Kelburn Northland Medical
Courtney Medical
Brooklyn Medical Centre
Capital Care Health Care
City GP's Ltd
City Medical Centre
Miramar Medical Centre
Peninsula Medical Centre
The Terrace Medical Centre
Mauri Ora Victoria Student Health Centre

Masterton Medical Centre
Greytown Medical Centre
Featherston Medical Centre
Carterton Medical Centre
Whaiora
Martinborough Health Service
Kuripuni Medical Centre

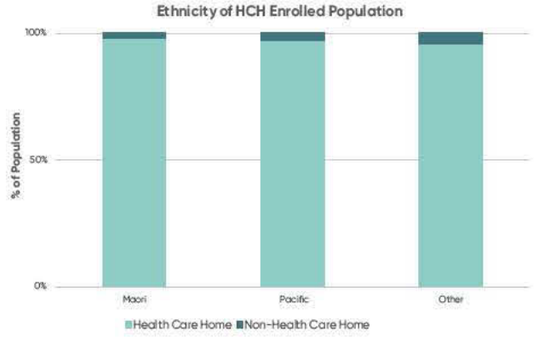
Tranche 1 Tranche 2 **Tranche 3**

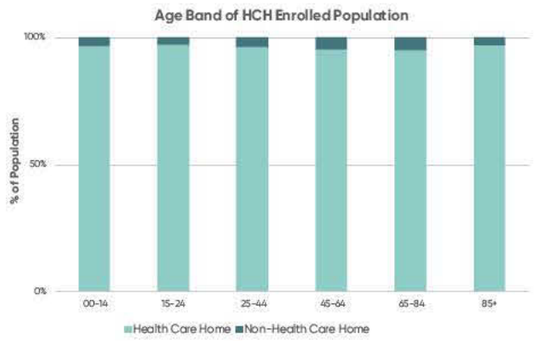
CCDHB





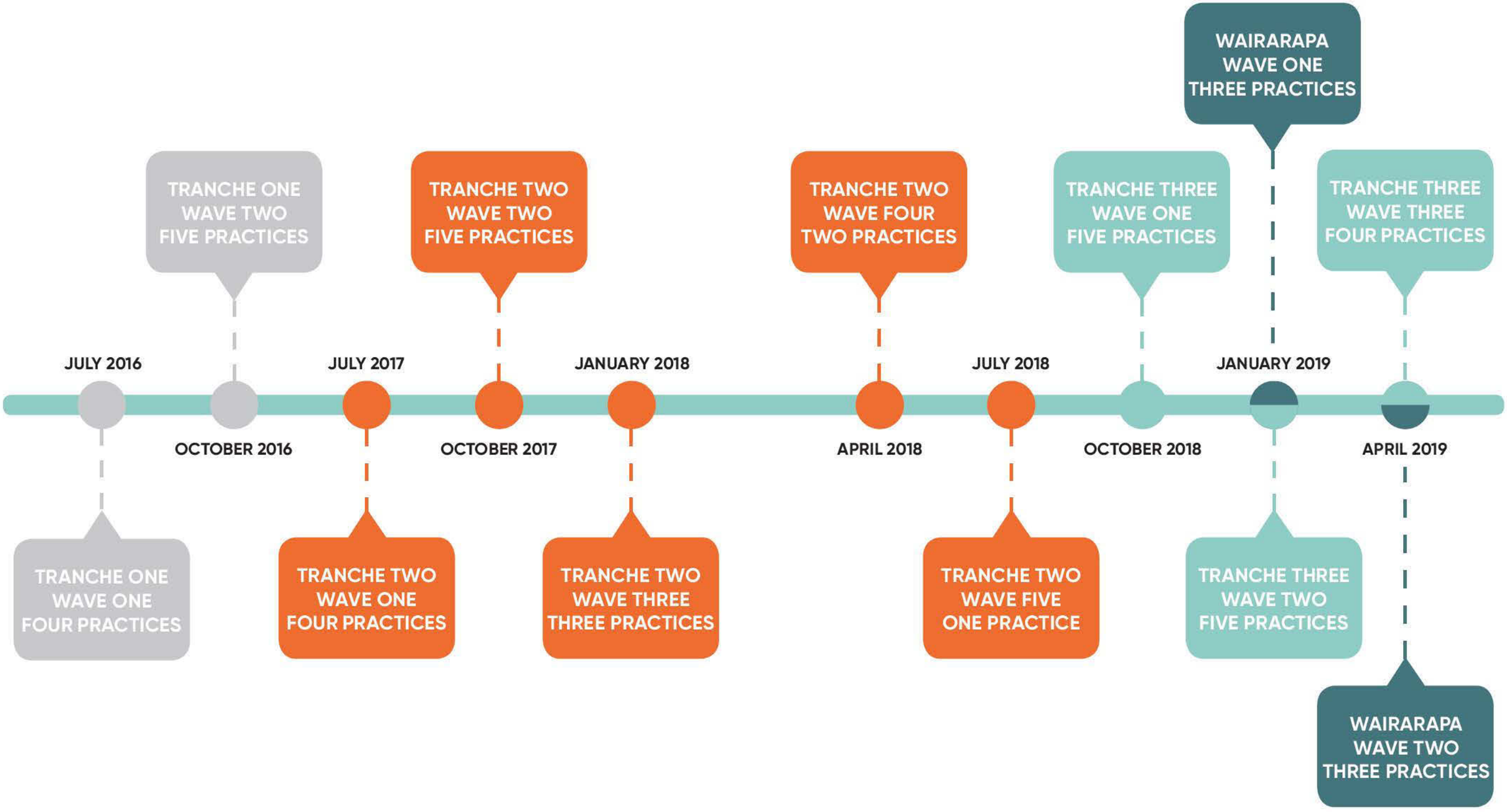
WrDHB





SUPPORTING OVER 270,000 PATIENT'S IN THE GREATER WELLINGTON REGION

5. OUR PROGRESS



6. PATIENT & TEAM STORIES

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.

1. Improving access for urgent and unplanned care

Talking it through

Telephone Assessment and Treatment (TAT) aims to ensure that patients are referred to the appropriate clinician for appropriate levels of care within an appropriate period of time. The initiative is designed to deliver an improved experience for both patients and staff.

Last year we reported on TAT's successful implementation at Raumati Road Surgery situated on the Kapiti coast. A couple of hours eastwards from there is another practice that introduced it relatively recently. Since early January this year, Wairarapa's Masterton Medical Centre (at 22,000 patients, the largest practice in the Tu Ora Compass network) has been running a TAT system. Patients phoning to request an urgent or same day appointment will be called back shortly by one of the Practice's GPs to discuss their condition and assess the next steps to be taken.

Dr Tony Becker, one of the practice's GP owners, says, "We were keen to look at new ways of managing our patients' needs more efficiently. We'd had some experience with phone consults, and a focus group of patients really loved the idea, so I trialed it on behalf of the practice. It went well and my colleagues soon jumped on board."

So successful has GP Triage proved at Masterton, that the practice is looking at ways to expand the service. His colleague, Dr Matt Mills, explains, "We're thinking about flexing it up. That was always the plan – trial it over the summer and get confident with it. We're thinking of taking it up to 30 minutes this winter or maybe even longer (depending on how busy we get), to make sure that patients are getting to speak with a GP when they need to.

"We're looking at more effective work to get tests or any other pre-work done before patients come in," adds Dr Becker, "We're all confident with phone consults now, and are really keen to experiment with video consultations. I believe indici (the new Practice Medical System) is offering this as one of its features. That can be more convenient for the patients, too, for the elderly, or especially in rural areas where you have to travel some distance."

One of the first patients to use GP Triage at Masterton was 'Alice' (not her real name), who, coincidentally, called in on the very day it was first implemented. Having felt that her chronic conditions had worsened considerably and rapidly, Alice placed a call to the new service. She received a prompt call back and, subsequently, a visit from a doctor who examined her, spent time with her assessing her medication and, ultimately, referred her for further tests.

Dr John Gordon, Dr Matt Mills, and Dr Tony Becker - GP owners at Masterton Medical Centre

2. A coordinated and proactive approach to care

Helping people help themselves

How can a modern general practice offer more time, thought and care to patients who need it – sometimes desperately – but whose ongoing problems traditional clinical staff simply don't have the time to address? One possible solution may be found in the emerging role of Health Coach. This complementary role is intended to help doctors and nurses, by helping patients to locate the resources to help themselves. Health Care Home is investing in this idea, and in January 2019 we spoke with Cici Xu, then Health Coach at Newtown Medical Centre.

Q: How have the first couple of months been for you?

A: "Quite busy – I've had 32 referrals from the medical staff since I started, covering a wide range of needs. Every morning we have our team huddle, and I catch up with my manager about patients with appointments that day"

Q: Could you give an example of the sort of work you do?

A: "My role is to assist the doctors and nurses to help their patients achieve their goals. Many patients have multiple requirements, and doctors' time is limited. They want to be able to help their patients, but it's not practical, time-wise. That's where I can come in."

Q: It sounds like work – or occupation of some sort – can be helpful...

A: "In addition to the various clinical options, tying the help offered with useful employment is very good, I think. For people who have various

Cici Xu, Health Coach at Newtown Medical Centre

issues – depression, anxiety, addiction to drink or cigarettes - giving them a job to do can be extremely helpful. It gets them out of the house, and can give their lives shape and meaning, as well as helping them to meet and connect with others. I regard it as therapy, albeit not medicine based."

Leah Gordon, a Senior Practice Nurses at Newtown, speaks of the impact of Xu's joining the team in glowing terms. "Her complementary work on helping to prepare patients' Year of Care Plans, for example," she says, "Has quickly made her invaluable. She contacts people on our complex needs list, inviting them to become involved and sending the appropriate questionnaires. Senior nursing and medical staff supervise the clinical side, but CiCi brings a wealth of experience to bear on patients' needs."

Xu's ability to help people in an extra-clinical capacity is highly valued. "Illness of various sorts can isolate people terribly," says Gordon, "She understands where a very wide range of people are coming from, and she's empathetic and completely non-judgmental, which helps enormously."

The role of Health Coach is a new one, but the early signs of success it has shown are intriguing and promising.

Nurse Janine Emrys with Patient, Miramar Medical Centre

Facing the Future

One certainty we all face in our lives is its ending. Whether that of family, friends or oneself, death and the period immediately preceding it are universal experiences, and yet it's a subject that people can find very difficult to talk or even think about.

Advance Care Planning (ACP) is a concept that was introduced internationally in the late 1980s but has only gained momentum in New Zealand in recent years. Since July 2016, the Advance Care Planning (ACP) programme here has been coordinated by the Health Quality & Safety Commission. It is also built into the Health Care Home model.

ACP is designed to encourage patients to think about how they wish to handle all aspects of their live's later stages, and the period leading up to its ending. We spoke recently with Gill Freeman, Clinical Manager at Newlands Medical Centre, and her colleague Wendy Slight, the Centre's Practice Manager, about how they went about introducing their patients to ACP, and about a new initiative that has helped bring it to a wider audience.

Gill Freeman and Wendy Slight from Newlands Medical Centre

Tell us a little about your approach to ACP

Gill Freeman: "It all starts within our Year of Care planning. We use the risk stratification that comes out from the CCDHB, and those people are offered the Year of Care plan, and within that plan (which is nurse-led), we will talk with them about ACP.

We have a care plan and guide for them to read through. If they're not quite at that stage, there's information about how to access the ACP cooperative run website if they want to, or there's a brochure. If they are interested, they can take home a care plan and guide to help them fill out the questions. They will have a nurse 'champion', who will contact them in a couple of weeks to see how they're going, and what questions they might have. They're also offered a funded appointment to come in and go over the plan."

Wendy Slight: "Anyone can do this at any time, but one logical point is when you're sorting out your will. Dealing with the idea of your own mortality can be difficult. It's a conversation which is becoming more common, however, which is great. Also, some families are, as it were, less supportive of one another than others, and the ACP can help clarify what exactly Mum, Dad or whoever, wants."

Tell us about the group sessions

GF: We'd had quite a few people expressing interest in ACPs, and because I was the only champion at the time, I was finding it difficult to meet each and every individual. We decided, as part of the HCH, to have a focus group meeting – an afternoon session with refreshments aimed at patients, addressing many of the issues that arise with ACPs – medical situations, family matters, ACPs' legal standing. Then we had a Q&A session.

WS: "The group dynamic really worked in its favour, too. They were chatting amongst each other, giving each other ideas, as well as receiving them. It's a very good way of introducing the subject in a productive and efficient way, rather than having lots of initial conversations. We noticed that some of them brought their partners with them."

GF: "It was a really good foundation and introduction to the whole concept. We gave out a feedback sheet, and it was all very positive – so much so that we are planning to run another session with different people. It could well become a regular feature."

"I'm now in the process of following the group session up, and seeing where these people are at. Some people, for instance, are saying they'll discuss it over Christmas time, when families traditionally come together."

Power of Community Services Integration (CSI)

The integration of community teams' clinical specialist expertise is a vital element of the local model. The CSI approach has demonstrated the value of teams from across the sector to come together around a patient to provide better care.

The CSI approach has focused on District Nurses and Community Allied Health teams working with identified HCH's to deliver collaborative care. NASC Care-Coordinators and Palliative Care Co-ordinators are joining regularly with additional specialists being invited for particular cases. Through joint multidisciplinary team meetings, hundreds of proactive care plans have been completed for people at higher health risk.

With the final tranche of practices coming on board this year, CSI will also enter a new phase. Support for those starting to build relationships between the teams will remain, as well as a focus on developing processes for embedding this new way of working and expansion. CSI is proving to be an effective change platform on which to include further collaborative care services for complex patients.

Health Care Home Project Team (left to right):

Kate Marshall, Kevin Harris, Melissa Brazier, Astuti Balram, Sarah Henderson, Emma Hickson, Mabli Jones, Molly Chandler

Dr Matthew Shaw, GP at Titahi Bay Doctors, Te Huri Arthur, Clinical Quality Facilitator (Maori) at Tū Ora Compass Health and the Titahi Bay Doctors Men's Group

3. Responding to routine and preventative care

Getting through: Titahi Bay Doctors Mens Group

Dr Matthew Shaw identified eleven men who had long term health conditions and who would really benefit from some focused support in relation to changing their lifestyles: the problem was they didn't come to the practice often enough! He wanted to bring the men together, to see if they would be interested in forming a support group that would promote friendships, facilitate organising activities to benefit their health and engage them with the practice.

Dr Shaw and Practice Nurse, Joanna Taylor, along with Tū Ora Clinical Quality Facilitators, organised an initial meeting in May 2019, which in the end was attended by six of the men. As it turned out these men were keen to form a support group, and to engage with their practice around health issues and setting goals – they just needed more encouragement to get going! Together, they brainstormed ground rules for the group, set up a Facebook group to keep in contact, and agreed to undertake a six-week Stanford Self-Management Course. This would help them develop several self-management skills to support them with managing their chronic conditions. Green prescriptions and Kick Start Pool Programme referrals were organised, to enable subsidised entry to the Porirua pool.

The good news is that the six men have now completed the Stanford Self-Management Course, facilitated by a Tū Ora Clinical Quality Faciliator and Pacific Navigators and indeed two members of the group are interested in becoming Self-Management facilitators themselves. Subsequent to the course, the men are being followed by Nurse Taylor to engage in undertaking their Year of Care plans.

Furthermore, the men are currently attending weekly Fruit and Vegetable Co-op cooking sessions in Titahi Bay, Lite Pace exercise sessions at Te Rauparaha Arena, and are organizing weekly evening swimming sessions. Group members have used their own networks to organize these group activities.

The men have made strong friendships. They've developed a supportive environment for each other, and are more engaged with their practice – a success all round.

Greytown Medical Centre

Patient engagement framework

Health Care Home has never been a one-size-fits-all programme, and its adopters are, needless to say, an imaginative and resourceful bunch. A range of ways to address this issue have been developed, some of them already in place before HCH's arrival on the scene, others in response to it.

This variety of approaches is well demonstrated by several practices around the Wairarapa region. For Pam Shackleton, Practice Manager at Martinborough Health Centre, a walking group has added a useful arrow to their communications bow. "We're averaging 15 or 16 people every Friday morning," she says, "And the informal feedback from them is invaluable. Patients can ask us one to one about concerns and ideas they might have." Again, this complements existing strategies. "We've got a monthly newsletter which has been going for a couple of years now," she adds, "With physical copies in Reception and a digital issue that goes out to an email list. We don't have a supermarket here, so we set up a community larder based at the centre to help people eat healthier. Our Facebook page links up well with the gardeners. If we have a good crop of apples or plums, we can let people know and it's great having a centralised place where they can meet and feel comfortable."

Facebook is indeed a popular tool in many comms boxes. However, there's still plenty of room for simpler techniques. "We are a very traditional, family practice," says Aruni Dias joint owner of Featherston Medical Centre, "And we are determined to keep our 'traditional' feel, and all the connectivity with our patients that that implies – face to face conversations, phone chats and so forth. We use our local monthly paper, The Featherston Phoenix, to flag big changes like the new building we're currently constructing. We aren't aiming for a wider audience with such press releases. Being the only medical centre in a small town, you get to know everyone pretty intimately." But they aren't averse to innovation, of course. "We want there to be multiple ways for patients to contact us," Dias adds, "Choosing the one that feels right for them. The Patient Portal is the perfect way for many people to access their own information, if they wish to."

At Carterton Medical Centre, Practice Manager Sandy Moore has made excellent use of an old standby - the notice board. "I've long felt that there were enough leaflets, brochures and pamphlets in the world," she says with a smile,

"And the LEAN education we got as result of Health Care Home starting up, plus having a new staff member joining us who'd come from a paperless office, made an alternative much more attractive. We had been using the waiting room notice board just for general information," she continues, "But what we've changed a little since HCH appeared is that we now have a movable board which is away from that. It's much more visual, using pictographs, more user friendly for people to glance at. It's positioned at eyeline sight for when they're sitting down. When we're changing stuff on it, we ask the patients there and then what they think of the new information, getting instant feedback on our work, which they like."

Not dissimilar is Greytown's approach, where Debrah Johns complements the digital options with something much more 'low-tech'. "The Ideas Tree was first put up around 6 months ago," she says, "When we first started the whole discussion around patient engagement." The tree is a large card construction that dominates one wall of the practice waiting room. "We wanted something bright and attractive'" she continues, "The idea was to have a big visual touchpoint – anything patients want tell us, they can tell us by sticking it on the tree. It gets a lot of engagement from people passing through the waiting room, and it's been fantastic. There are always new stickies on there, and when changes are implemented as a result of 'tree feedback', that news gets put at the top of the tree."

So successful has the tree been, indeed, that Johns foresees further saplings down the line. "Trees that offer people a forum in which to feedback on particular topics are the next step," she says, "But these can wait to be established until after the changes have actually become bedded in to the practice."

Johnsonville Medical Centre

OVER 140 ADDITIONAL OPENING HOURS IN GENERAL PRACTICE

4. Maximising business efficiency

Leading from the Front

The edge that Health Care Home can bring in a wide range of areas is well established, and includes greater efficiency, effectiveness and, ultimately, happier staff and patients. These benefits, needless to say, entail a lot more than just signing on a dotted line and sitting back. They are hard won and require a high level of commitment and resourcefulness from the HCH team and all in the practice to implement successfully.

When a practice signs up to become part of the HCH programme, they are asked to nominate a HCH leadership team from within their numbers. A Lead GP, Nurse and Practice Manager tend to make up this group. This team is often the engine of the change management process that the practice undergoes, and strong engagement and leadership can make all the difference in terms of successful adoption and implementation of the HCH programme. Planning and updating on the HCH changes with the whole team as they happen can be crucial.

To learn more about how to lead the change process using HCH's straightforward yet often quite new and unfamiliar practices and habits, we spoke with two of the practice change teams at Wellington practices that seem to be getting it right – most of the time, at least.

At Kelburn Northland, the arrival of Health Care Home was certainly not a snap decision. "There was a very long lead in time for it," recalls Dr Emma Dunning, GP Partner, "There was an existing awareness and interest. The partners I'd previously worked with had been aware of the changes up in Waikato, and had considered bringing some of those changes in to our practice. Compass had a couple of workshops about HCH, and I went up to Hamilton to see how it all worked, and I'd been feeding back on all this, so there was already a good bit of awareness. We had quite a wide-ranging conversation among the partners around the time of the Expression of Interest, and once that was in place, we started working out how we would do it."

Dr Rose Dodd, GP Partner at Peninsula Medical Centre, agrees that a long lead in was helpful. "When Health Care Home first appeared on our horizon, we had a lot of other stuff on our plate, internally," she says, "And it all seemed a bit overwhelming. In fact, we decided not to get on board with the first tranche, joining instead the following October. This was a good idea, it turned out, as it meant we could pinch ideas from everybody else! Seriously, though, there were lessons learnt by other practices that we were able to bring to bear in our own implementation. For example, with Telephone Assessment and Triage, we found that some practices regretted not applying it practice-wide from the start, as it had made for more foot-dragging. So, though we did explain to staff what was happening and gave them some background to lead into it, ultimately it was 'all aboard' from the start. And I think that worked well."

Both Kelburn Northland and Peninsula put together a change management team aimed at addressing the anticipated changes in a timely and thorough fashion. GPs, nursing staff and the administrative staff were all represented on the teams. As Vicki Prebble, Practice Manager at Peninsula, puts it, "I strongly believe that

you need to get individuals connected to the change – invested in it - before you actually start implementing anything." To this end, HCH was on the agenda of staff and other meetings long before it actually kicked off.

Vicki Prebble, Dr Chitra Karunanidhi, Nurse Harriett Fitzpatrick and Dr Rosemary Dodd , Peninsula Medical Centre

Dr Emma Dunning and Nurse Helen Devine with the team at Kelburn Northland Medical Centre

Putting the joy back into General Practice

We asked four GPs about aspects of working with Health Care Home that have struck them – not just as a means of providing better care for their patients, but also as a means of bringing the joy back into their General Practice day.

Dr. Harsha Dias and Aruni Dias are the owners of Featherston Medical, a small (enrolled pop. 4221) rural practice in the Wairarapa. A husband and wife partnership, with Aruni working as the practice's Business Manager, they are the most recent of our interviewees to have joined HCH, having entered the programme in January 2019.

One aspect of the programme has already made a real difference to the practice and to their working life, they say. "GP Triage," says Harsha, "Telephone assessment and treatment, that is, is something I've been doing for the last couple of months, and so it's still at the 'fine tuning' stage, but the advantages it offers are already apparent. Less measurable – though no less tangible – are other benefits the new triage process can bring. Says Aruni, "I've noticed a huge difference in my husband's spirits – categorical and undeniable – he just looks like a different person. He's just got a much healthier work/lifestyle balance now."

Dr. Ruth Brown is one of two GP business owners at Raumati Road Surgery, a small practice near Paraparaumu on the Kapiti Coast. The enrolment is just over 4000, leaning towards older patients, but with a register that's growing as families move into the district. Her practice was one of the earliest adopters of Health Care Home, having entered the programme in July 2016.

Dr Ruth Brown, Raumati Road Surgery

"We were well set up to be early adopters," recalls Ruth, "For us as a practice, and for me personally, Health Care Home has been great. I enjoy GP Triage for the way it sets up the day and allows doctors much more control over our workload. The patients like being called by their GP and sorting something out in consultation with them, instead of just being given an appointment time."

"As far as support is concerned Compass have always provided whatever we needed. Mel Simpson has been amazing to work with and she always comes back with considered advice and great support. Even with a way yet to go, I can honestly say that Health Care Home has revitalised the last few years of my time here at Raumati Road."

Dr. Jeff Lowe is an owner-operator at Karori Medical Centre in suburban Wellington. Karori is a large practice, with nearly 15,000 enrolled patients, largely middle-class but with a number of high needs patients, too. Jeff has key leadership roles nationally, and is proud of Karori's pioneering work.

"With our record of innovation and early adoption, HCH was an obvious thing for us to do, really. It pulled together a lot of the things

Dr Harsha Dias
GP Owner, Featherston Medical Centre

"I've noticed a huge difference in my husband's spirits – categorical and undeniable – he just looks like a different person. He's just got a much healthier work/lifestyle balance now."

Aruni Dias,
Practice Manager of Featherston Medical Centre and wife of Dr Harsha Dias

we were doing in terms of innovation, and we wanted to come at it strategically, rather than just trying to survive."

Dr Jeff Lowe, Karori Medical Centre

Karori's well documented success with take-up on their Patient Portal is a source of great satisfaction and, he further notes, "All the other components of HCH have helped ensure that workflow is much better. Ensuring that there's better on-day appointment availability, better triage, looking at roles, the LEAN business model and approaches to, for example, room standardisation – these are all fantastic and so firmly integrated that we take them for granted now. The sum of all those little parts is really what the magic of Health Care Home is."

Our last visit is to Wellington City itself, where Dr. Dave Pickett's Courtenay Place practice has operated for four years now. With a modest but growing enrolment of 5300 patients on the books, the majority of patients here are inner-city workers and students, but, with a number of patients in rest homes and some with mental health issues, the picture is a complex one. Dave has invested significantly in fitting out his new quarters with standardised equipment and in making it a pleasant place for staff and visitors.

"I've been the champion within the practice for change for some time," states Dave, "So when the funding became available, we stepped up. I should say that the key for Health Care Home's positive impact on us has been the LEAN model embedded within it, and the support and teaching around it given by Jo Henson. Her help enabled us to get started on a programme of change after we'd run out of drive to do it ourselves – we needed facilitators, and we needed more support."

"As far as LEAN itself is concerned, bringing some kind of rigour to what we do every day, some kind of standardisation, while still enabling people to be individuals and not automatons, made a lot of sense. People can be resistant to change and to opening their minds to it, and that's where Jo's help has been so invaluable. Having a third party come in and tell us what we needed to do helped sugar the pill of change, as it were. She is compassionate, firm and caring and she brings a degree of rigour that I don't necessarily have, and which helps people to understand that these new ways of doing things are there not at random or out of spite, but because they actually make sense."

Dr Dave Pickett, Courtenay Medical Centre

"Looking at Health Care Home in hindsight, it feels like the time was right. Speaking as an owner, I'd say that the key thing is to keep championing the value and benefits of change to employees and contractors."

"The Health care home model is a powerful innovation which sets practices on the path to more effective and efficient delivery of care, particularly to patients with the highest needs. It improves practice efficiency, patient responsiveness, professional satisfaction, and delivers benefits to the whole health system. It lays the foundation for the further development of high quality 21st century health care."

Dr Chris Fawcett, Health Care Home Clinical Lead and GP at Hora Te Pai Health Services

"Having now worked in several practices undergoing their Health care home journey I am always amazed each time I go back to see the changes and the positive differences it makes. It is such a pleasure to see."

Dr Kirsty Lennon, Health Care Home Clinical Lead and GP at Mahara Health Centre

Becky Wright, Hilary Krebs, Marilyn Tucker, Anna Kyle and Mara Coler. Clinical Pharmacists team

7.

A SNAPSHOT OF OUR FINDINGS IN THE THIRD YEAR

The purpose of collecting data is to demonstrate the impact the Health Care Home model of care is having on patients, practices and the wider health care system.

As part of our Health Care Home programme, we agreed a core data set of measures to track the impact of some of the changes the practices and community services teams were making.

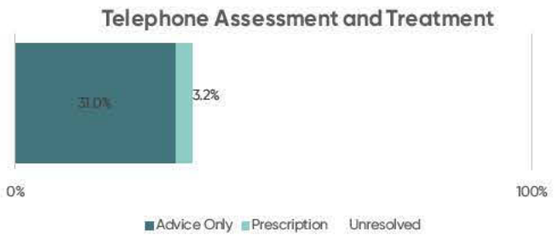
One of the key aims behind the Health Care Home is to support practices to create more capacity to better manage growing patient demand, and to more proactively manage those patients with complex needs alongside community services teams, who may also be high users of acute hospital services.

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), outcomes from practice triage data, 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 across a number of different areas.

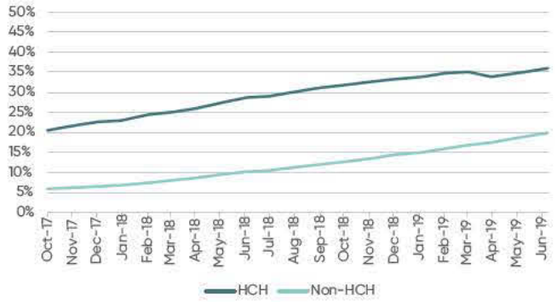
1. Clinical triage



34.2% of all calls resolved in triage

10.3% same day appointment requests changed to future face to face

2. Patient portal



Percentage of enrolled patients with activated patient portal access

12.5% increase of enrolled pop for non-HCH practices onto patient portal (Oct 17 - Jun 19)

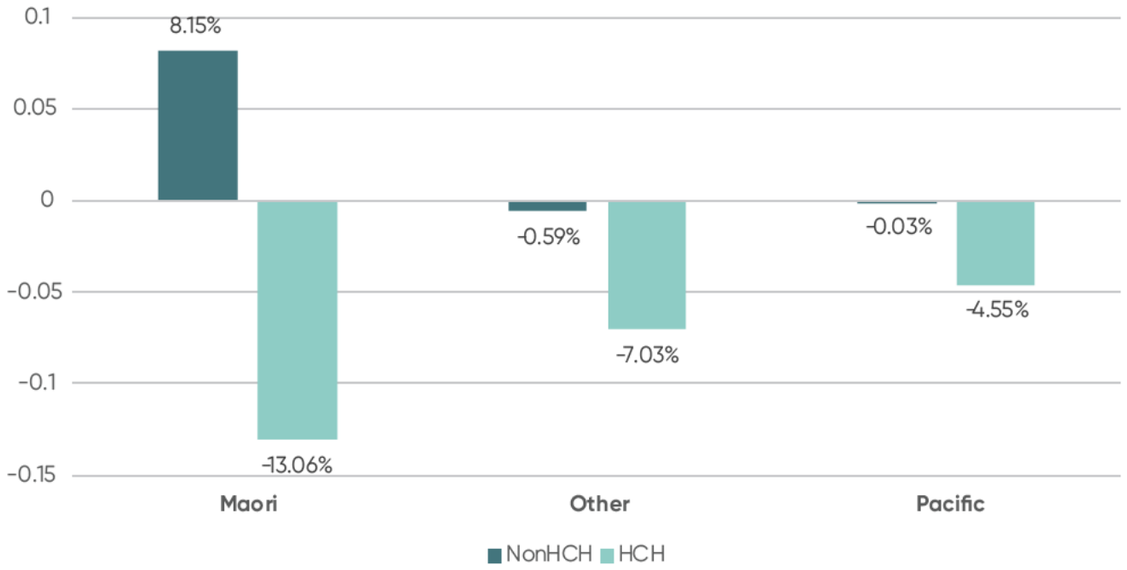
7.

A SNAPSHOT OF OUR FINDINGS IN THE THIRD YEAR

Emergency Department Attendances (Age std. 17/18 to 18/19)

Patients of all ethnicities enrolled with HCH practices should attend ED less over time.

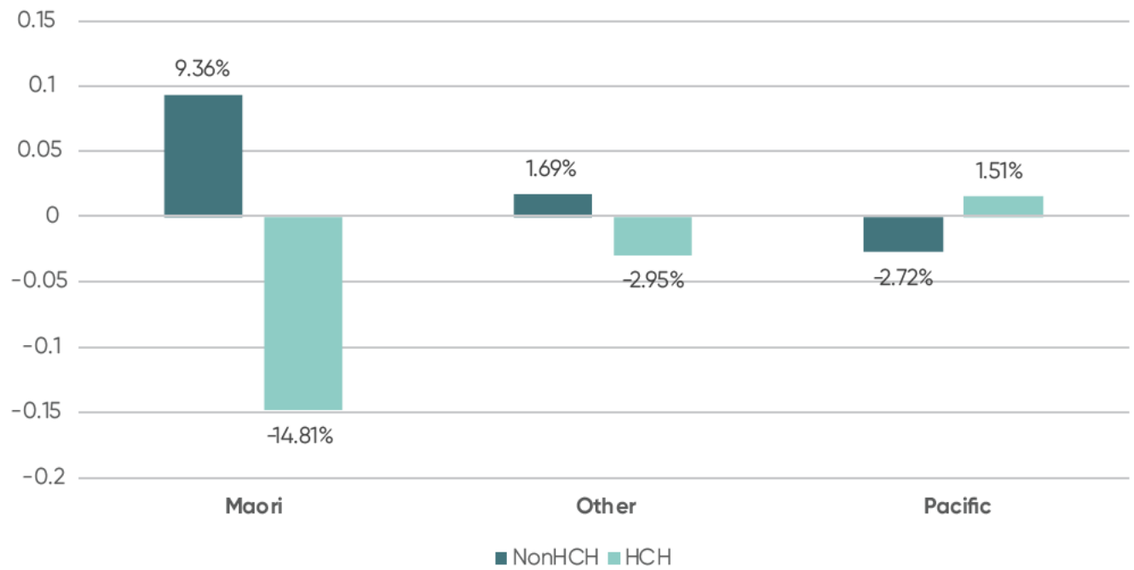
Māori: 13.1% rate decrease for HCH practices vs. 8.1% rate increase for non-HCH practices
Pacific: 4.6% rate decrease for HCH practices vs. no change for non-HCH practices
Other: 7.0% rate decrease for HCH practices vs. 0.6% rate decrease for non-HCH practices



Acute Admissions (Age std. 17/18 to 18/19)

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

Māori: 14.8% rate decrease for HCH practices vs. 9.4% rate increase for non-HCH practices
Pacific: 1.5% rate increase for HCH practices vs. 2.7% rate decrease for non-HCH practices
Other: 2.9% rate decrease for HCH practices vs. 1.7% rate increase for non-HCH practices



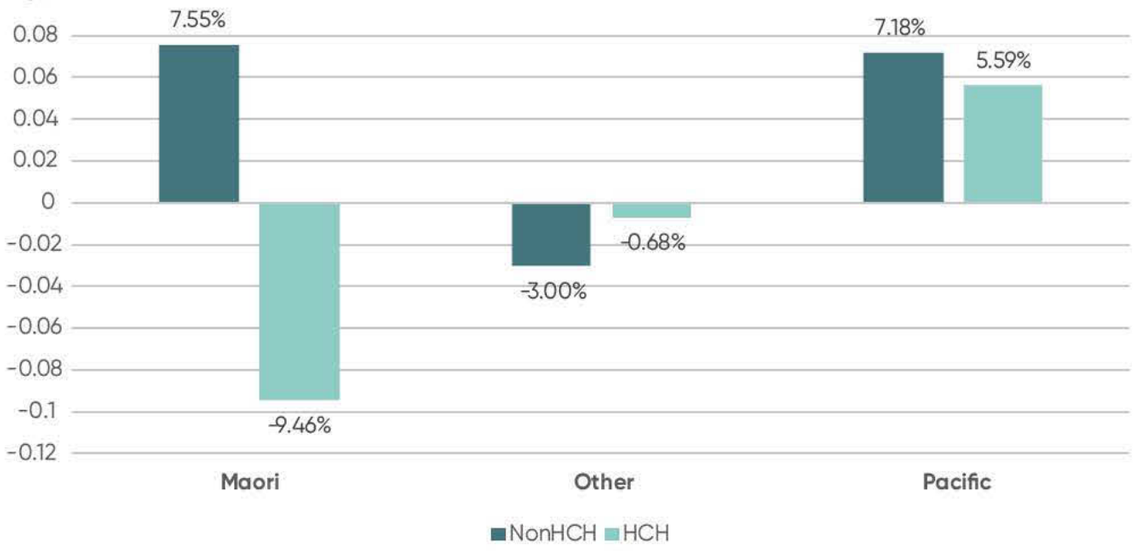
7.

A SNAPSHOT OF OUR FINDINGS IN THE THIRD YEAR

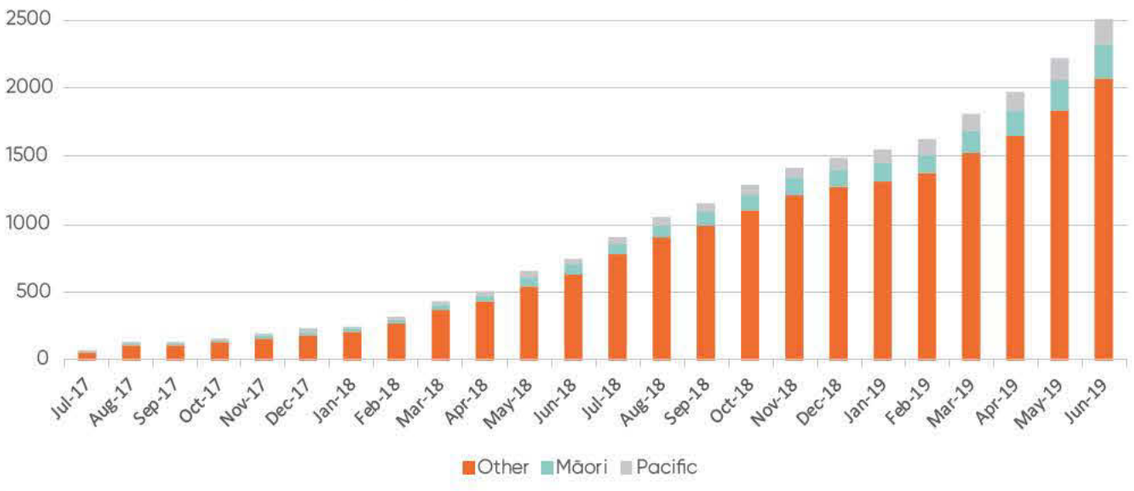
Ambulatory Sensitive Hospitalisation (ASH)

Likelihood of patients having an ASH admission is lower for patients in HCH practices

Māori: 9.5% rate decrease for HCH practices vs. 7.6% rate increase for non-HCH practices
Pacific: 5.6% rate increase for HCH practices vs. 7.2% rate increase for non-HCH practices
Other: 0.7% rate decrease for HCH practices vs. 3.0% rate decrease for non-HCH practices

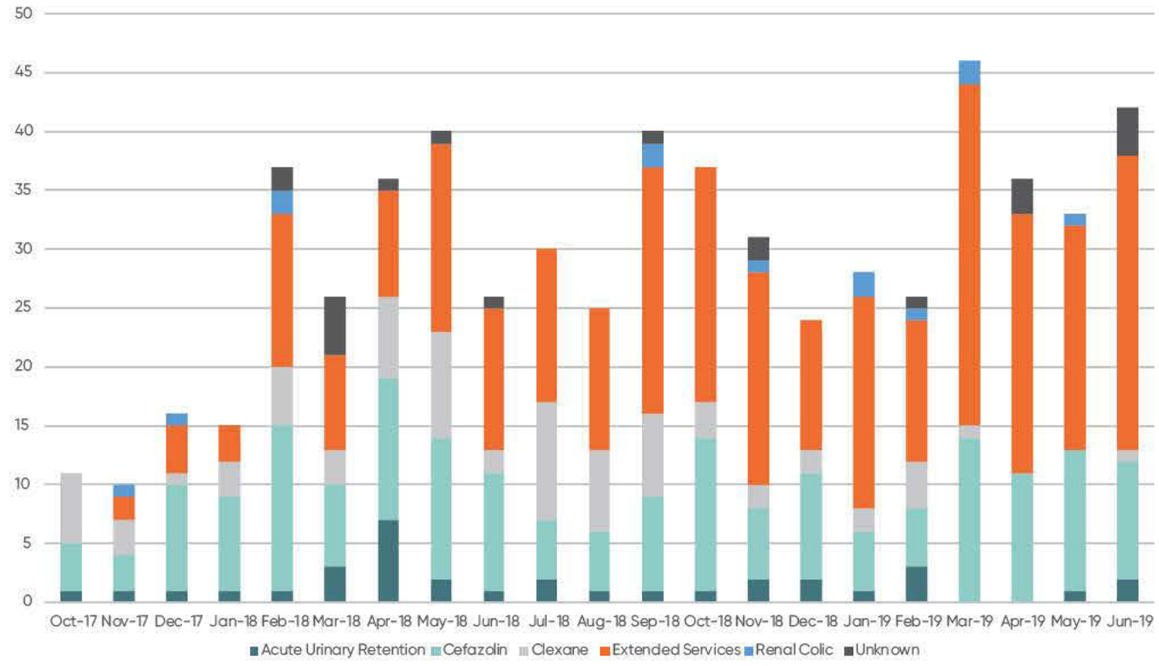


Number of YoC (Year of Care) Plans



POACs HCH practices

Increasing use of POAC over time (across all projects) by HCH practices to help reduce acute demand in hospitals



8. REFLECTIONS AND INSIGHTS

2019 has been another remarkable year for the Health Care Home Team at Tu Ora Compass Health. The last twelve months have seen the number of practices enrolled in the programme doubling - from 21 to 42 (including the Wairarapa practices) - as well as continued maintenance and development of the model within practices already on board (some of whom are entering their fourth year in the programme), and further planning for innovative service improvements and ideas that look to the future.

As the programme jogs towards the end of its third year, pacing and bracing itself for another sprint around the track in 2019/20, we took the opportunity for the (by now traditional) review and preview chat with two of the programme's principal figures, Mabli Jones (GM Service Development) and Melissa Simpson (HCH Programme Lead) from Tu Ora Compass Health, who were joined for this conversation, as they were last year, by Astuti Balram (GM Commissioning, Integrated Care, Strategy, Innovation and Performance, CCDHB).

Mabli Jones, General Manager Service Development, Tū Ora Compass Health

Astuti Balram, General Manager commissioning, Integrated Care, Strategy Innovation and Performance, CCDHB

Melissa Simpson, Health Care Home Programme Lead, Tū Ora Compass Health

Q: After all the groundwork that you'd done over the first couple of years of Health Care Home introduction and implementation, give us an overview of how the third year went.

Mel: The third year saw the last group of practices coming on, which gave us a total of over 80% population coverage across both DHBs. We now have practices moving into their fourth year, as well as some that have only been in for six months or less. So, there's the challenge of trying to support practices at very different stages of the programme. It's managing that range then, this year, and as we move into Yr. 4, we must also look forward.

Astuti: It's been quite an interesting year, with a peak of work, and lots of different stages of the programme to consider, as well as forward planning. And then we've also done the planning for the evaluation - looking back, it's really been quite complex!

Mabli: Thinking beyond Yr. 4, we need to ask ourselves, then what? We've spent a couple of years strengthening primary care, but HCH isn't just the practice, it's the community services teams, it's the specialist teams coming out to the community, it's the integration of social services and the voluntary sector into that framework as well. In our heads, we're not even half way through the journey, and in terms of where this could all lead – it's exciting.

Changing tack a bit, I think a new thing we've done in Yr. 3 is migrate the Yr. 3 practices into small peer groups, in a way that we hadn't in Yrs. 1 and 2. Practices learn as much from each other at this stage – I mean, they do all the way through – but they really are very interested in the kind of improvements that other HCH practices at a similar point in the programme have made over time.

Q: So, what do you do to encourage that exchange of information between practices?

Mel: Trust has built up between the practices over time, and it's pretty open and transparent by a certain point in the HCH programme. They're all happy to see each other's data, and talk through the similarities and differences and discuss what might be causing those.

Mabli: Also, from a Community Services perspective this year, it feels like the relationship between the community teams and the practices just gets stronger and stronger, as the value of the MDTs is realised by everyone who participates.

Astuti: Yes, from the Community Services Integration (CSI) point of view, it's really matured in Yr. 3. Practices are expanding their own practice teams with new types of roles, and also looking to expand the types of people who are integrating with their practices. So, some we're facilitating, like the Gerontology team, and some we don't have to facilitate – practices just go off and find specialists to join their MDTs when they have a relevant group of patients for discussion - which is great.

Mel: On another subject, something else we've done this year is the Clinician Burnout Survey. Using a validated tool, we asked Tranche 1 and 2 practice teams a series of questions about clinical burnout. It threw up some interesting findings. Clinicians who have been in the programme longer reported lower levels of stress and dissatisfaction, compared to those who'd joined more recently. We need

to look into this more, but it's given us the impetus to do more work in this area in the coming year.

Q: **Mel, you talked before about focussing on working smarter – virtual MDT meetings and so on - have you been continuing to progress that?**

Mel: Certainly, with the MDT meetings we're using Zoom technology to have virtual meetings with the community services teams. That does allow additional members to come into the MDTs that weren't so core, like palliative care, geriatricians and hopefully, soon, some mental health team members.

Mabli: We're also beginning to test an electronic shared care plan.

Mel: Yes, we've made some progress towards getting a shared care plan. We've currently got a paper version, and we're aiming to move into an electronic shared care plan where in real time, the patient can update their goals etc. But also the community services teams, the neighbour, a friend, the pharmacist – anyone the patient wants to be part of their shared care plan can, through electronic means and via a phone app. We think it's got real potential.

Mabli: We're always thinking, 'How can we do this smarter?'. We talk a lot to practices about that – and practices really get this, because their working day is so busy. We have a real focus on patients being registered on the patient portal, as it has the potential to smooth the workflow significantly for a practice. Patients booking their own appointments, patients organising their own repeat scripts, patients secure-messaging their GP or nurse, patients being able to read their own records – all via the portal.

Working with practices the whole time and thinking 'how might you get that enabled through technology?', 'how can you move the traditional workflow away from the way we've always done things?', that's a big feature of the programme. It's essentially the application of LEAN thinking.

Mel: Another feature you'll see in a lot of HCH practices now is the self-check-in kiosk. I went to City Medical just this week and asked them what percentage of the patients are using this, and 40% of the patients that come in can check themselves in, as opposed to stacking up at the reception desk. That's a significant proportion, especially as they've only had it in place for six months. And while checking you in, the system will also update its records on you. Practices can also tailor it to use different languages, too, based on their demographics.

Mabli: The use of technology, using a LEAN lens, has real potential to improve both the patient and staff experience, so we push it quite hard.

Q: **Data was mentioned previously as something that was crucial, that there was a need for there to be a means of collecting data about the work you're doing, to support it. How's that's been progressing?**

Astuti: We're pretty strong in terms of data collection and sharing. Where we do find gaps, we try to wrap an improvement process around it.. At the moment, we can see rolling performance or we can do point in time differences, and that's really powerful - our team just did something yesterday, for example, using an ethnicity lens. In terms of understanding impact and further learnings, that's where the commissioned evaluation will come into play .We're looking at one that will look at the programme overall, as well as from a Maori/Pacific worldview.

As we get more sophisticated and Tranche 3 comes along and all the CCDHB HCH reach maturity, we will need to consider how we embed change. Using data for overarching monitoring will be key.. It will be a tool for feedback as well so practices will know, 'you're fine, keep going,' or 'change that'...

Mabli: Democratising data. I think we're strong in that area at Tu Ora Compass Health, because we have a great data sharing agreement with our practices, and we have a portal, which means they can see all their own data – it's self-service – so they're not waiting for us to give them data.

The thing we do get asked about is any data we have on the impact of the HCH programme on health outcomes, and it's an area we need to look at - but it's just too early. We can say that HCH is helping people's ability to manage their conditions, which therefore must be improving their longer-term health outcomes, because they are – for instance – living better with diabetes, but it's quite difficult to prove at this point.

Q: **Another key quality you have listed as being essential to your relationship with the practices, was trust. Is this still the case?**

Mabli: I think – and hope – that the trust just gets deeper as the years go on, and now with the Community Services teams as well. Chris, one of the GPs, talked recently about the 'iron curtain' that used to exist in the Kapiti Health Centre. The practice he works in, Hora Te Pai, and the Community Services team, all share a big building, but there's a door between them. Chris said that what the HCH has meant is that what had been an 'iron curtain' is now just an open door. We've built the relationship over the last three years, and now teams come in and out of each other's domains.

Astuti: It's interesting that when we were planning the HCH programme, at the beginning it was hard to describe the benefit of the CSI component, and it still is in some ways, if you really went into impact data. But it was like this soft fuzzy thing on the side – just people meeting each other and once a month chatting.

Mabli: It's that phrase – it's corny, I know – but the soft stuff is the hard stuff. Trust and relationships are the 'soft stuff', but so much of health care is based on relationships. Good technical competence is essential, of course, and the rest is relationships. Without the relationship, the communication isn't there, and so it goes on...

Q: **Last time we spoke, you had 21 practices on board, and said that by the end of Year 3 you were going to have – combined with Wairarapa - 42 practices in the programme. Is that how it happened? Anything further to report in that direction?**

Mel: Well, we've got 13 HCH implementation plans to view on the 13th of this month!

Astuti: There's no denying that Tranche 3 is the peak of work, all practices at different stages, different needs, also the time to plan forward and reflect back, so it's been a busy year.

Mel: I think we've also managed to support the practices to introduce new ways of working, such as moving into trying shared medical appointments. We've done significant facilitator training for staff within the practices, so looking at more group consultations and moving away from your traditional 15-minute face to face. We've got quite a few Shared Medical Appointments under our belt now...

Q: So, what's next? What else is changing? How do you see the next twelve months?

Astuti: In the next 12 months, we'll see embedding of the progress of HCH within whatever Tranche the practices are in. There'll be some reflection time, when we get our evaluation back, what we can learn, what we could do differently. Particularly exciting will be when we start planning for a community health network, because, as we've said, HCH will strengthen primary health care base, and we've already started clicking in services. But how do we strengthen that community infrastructure? I think a network will require infrastructure, as well as strengthening the number of services that are connected together. So, creating connections between practices and across other specialist services, NGO services, and others – that will be pretty exciting.

Martinborough Health Centre with their Ministry of Health, Health Care Provider Service Team Volunteers Award for their Community Health Project

Porirua Union and Community Health with their CCDHB excellence in clinical care award

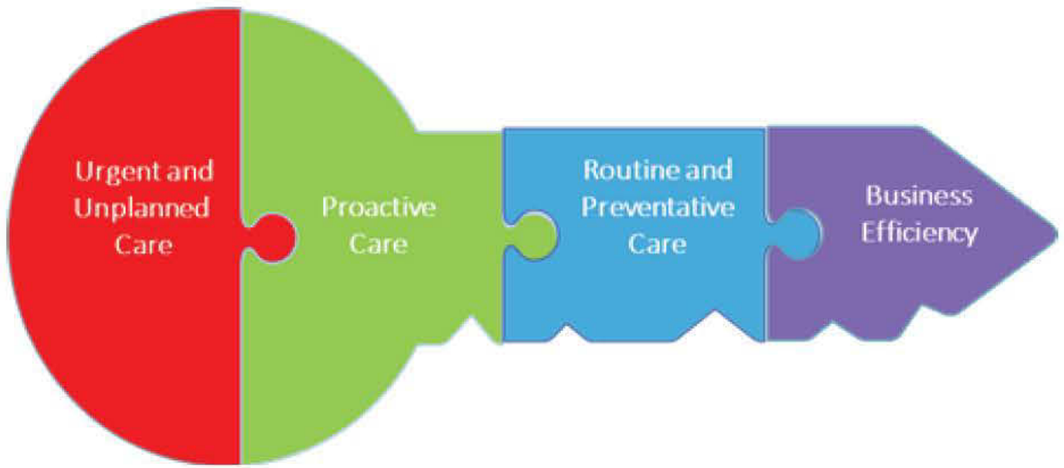
10. APPENDICES 1- HCH MODEL OF CARE

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 HCH 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 need.
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 below:

Health Care Home model of care service elements[1]

- Advanced call management
- Telephone assessment & treatment and clinical management
- Same day appointment capacity
- Extended acute treatment options
- Increased hours of access
- Person centric (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
- 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.

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.

[1]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

11.

APPENDIX 2 - HEALTH CARE HOME CERTIFIED PRACTICES

Certification and re-certification

The following practices have under gone certification process by the National Collaborative:

Health Care Home Certification

- Newlands Medical Centre
- Newtown Union Health Services
- Porirua Union & Community Health Services
- Newtown Medical Centre
- Whitby Doctors
- Paraparaumu Medical Centre
- Waikanae Health Centre
- Titahi Bay Doctors
- Mana Medical Centre
- Kelburn Northland Medical Centre
- Courtenay Medical Centre

Health Care Home Re-certification

- Johnsonville Medical Centre
- Raumati Road Surgery
- Karori Medical Centre
- Hora Te Pai Health Services
- Island Bay Medical Centre

Raumati Road Surgery

Kelburn Northland Medical Centre

Karori Medical Centre

Johnsonville Medical Centre

12. APPENDIX 3 - HEALTH CARE HOME NATIONAL DATASET: INAUGURAL MEASURES

Domain	Health Care Home National Dataset
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	1. Age standardised Nurse Consultations per 1000 enrolled patients 2. Percentage of patients seeing their own GP 3. Average number of different clinicians seen over the last 10 visits 4. BMJ measure: percentage of consults with the GP seen most often over the 24month period 5. Percentage of DNAs at hospital FSAs 6. Partners in Health Scale – change in average score over time 7. % of high needs patients with a care plan and named coordinator
Routine and Preventative Care	1. Number of patient inbound secure messages through patient portal / 1000 adults 2. No. of virtual (telephone/video) planned consults as % total consults 3. Patients with activated patient portal access per enrolled population 4. % of patients that have access to own notes (PHO measure) 5. Smoking quit rate 6. Dropped call rate 7. Patient experience survey scores 8. Wait times in the practice (post appointment time) 9. Time to 3rd available appointment 10. Percentage of DNAs at the practice
Business Efficiency	1. Practice team climate survey results 2. % Room utilisation for clinical interactions 3. No of aged standardised patients enrolled per GP FTE 4. No of aged standardised patients enrolled per Nurse/ FTE 5. % of enrolled population who leave during the year 6. Staff turnover 7. Sick days per FTE per year 8. Total phone calls per 1000 per month

HEALTH CARE HOME PARTNERS IN THE GREATER WELLINGTON REGION

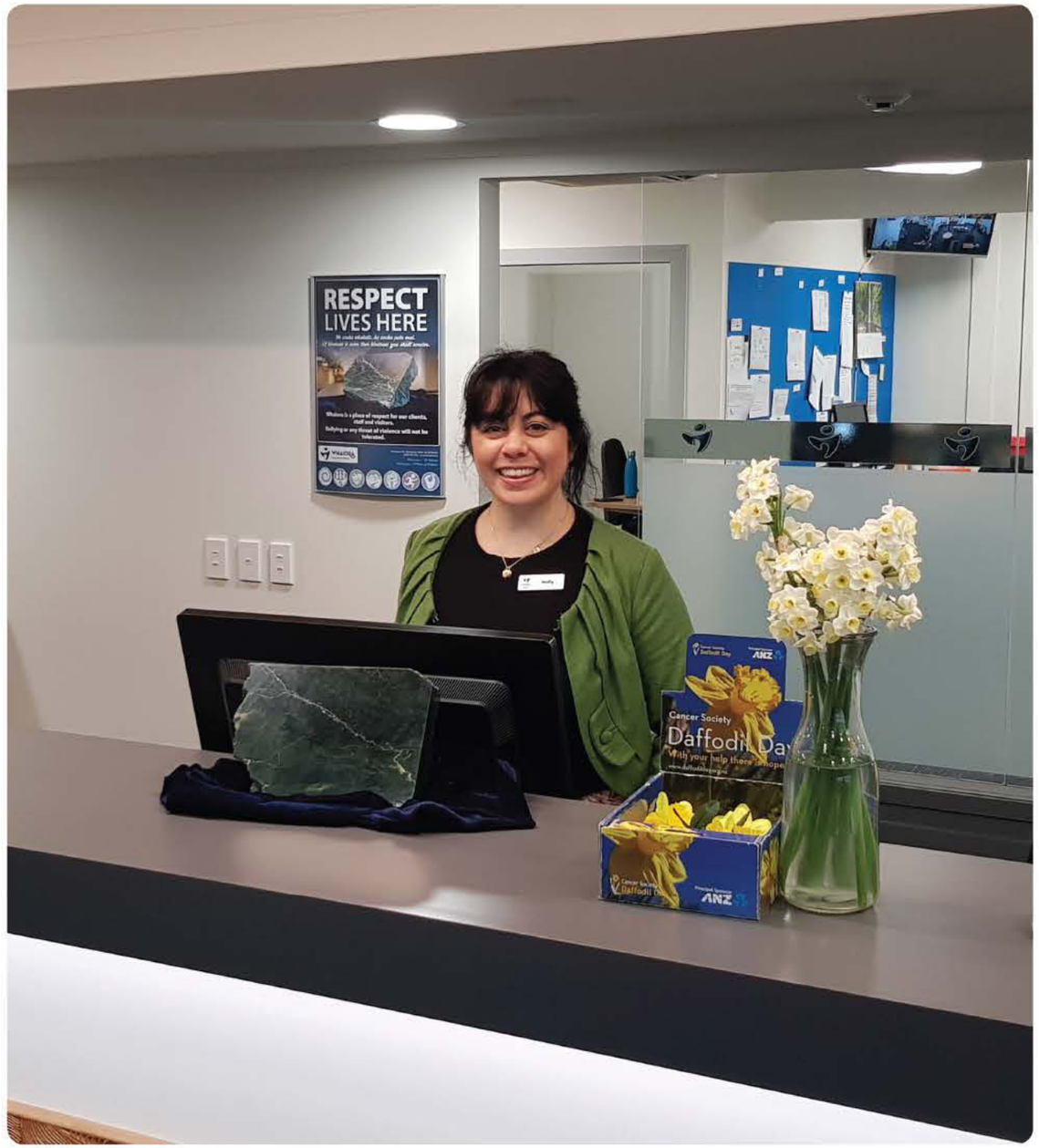
Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Cosine
Primary Care Network

Tū Ora
COMPASS HEALTH

Ora Toa PHO

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa



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