



Health Care Home





What is the Health Care Home?

1.

Health Care Home is a primary health care model that’s been designed to support the everyday needs of general practices, while keeping the focus on the most important thing—the patient.

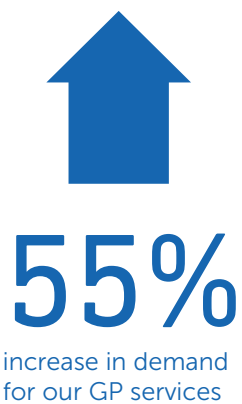
Between 2014 and 2020, we’re expecting a 55 percent increase in demand for our GP services. Unfortunately, along with that, we’re also expecting a 30 percent decrease in capacity. That leaves us with a shortfall of 1.4 million consults—or translated into doctors, that’s 289 Full-Time Equivalent GPs. We’re simply not training or attracting the number of doctors that we need to bridge this gap.

There are a number of reasons for these upcoming challenges. A steadily aging population is bringing an increasing pressure to our GPs; with longer lifespans come many more complex health issues alongside the increasing demand for chronic disease management. Meanwhile, as the previous generation of GPs retire, the next are increasingly choosing to work part-time, exacerbating the shortfall. In addition, we also have an ageing nursing workforce adding to the pressures. There is also a growing gap between funding received by practices and actual costs, which means fewer resources to go around.

As the emerging generation of GPs go part-time they are also opting out of practice ownership. In just seven years the number of owner-operator GPs has dropped by 20 percent. With this becoming particularly acute in rural areas, there are strong implications for who is driving change.

To meet these challenges, we need to stop, pause and have a rethink. We need to hold on to the things that make general practice work, but not be afraid to make changes. With new technology, there is a very real opportunity here to build a model of practice that will ensure our ability to provide top-quality primary care to our communities—but in new ways.

Between 2014 and 2020





"I wouldn't choose to go back to the old way of doing things. I think this is a better way of operating. The pressure of constant face-to-face visits has eased and I can now make a considered response to patient needs. My work-life balance is much better, my workday is more structured and predictable and I think I am offering a better service to our patients."

Dr Nick Binns, GP,
NorthCare Hamilton

Health Care Home is our response to this changing primary healthcare ecosystem. It's the approach we're taking to help general practice and the broader primary care environment move into the future.

As well as the work with general practice to proactively manage patients and increase access, Health Care Home also supports improved co-ordination of care across the health and social care system, wrapping an integrated extended care team around those people with more complex needs. Our vision, model and service plans are outlined in detail in our publication Health Care Home: Developing the Extended Care Team.

Under Health Care Home, the focus is on planning as much care as possible to ensure the right patient receives the right care in the right place by the right person. By making the best use of each clinical role and creating new ones to serve particular needs, practices can be more efficient and give our patients more customised and appropriate attention. Planning allows us to be more proactive in our care, which in turn allows for more preventative measures to be taken for many patients. The patient portal allows the patient to have more control of their care too.

With technology, we can start to move many aspects of primary care out of the consulting room. Not all patient medical care needs a face-to-face consultation, so if we can save those in-person appointments for those who really need them that's a win for everyone.

Health Care Home also has some excellent advantages for the business side of general practice. Using 'lean' methodologies allows us to strip out many unnecessary aspects of the day-to-day workflow and standardise our routines and procedures as much as possible. When we can reclaim time that would otherwise be wasted, it can go to where it's needed most—looking after our patients.

"The concept of the Health Care Home is really fantastic for patients with chronic diseases and long-term conditions. Proactive pre-planning saves a lot of repeated visits."

Penny Clark, Clinical Pharmacist, NorthCare Hamilton

"Patients can choose the most convenient way for them to interact with health care providers"

Dr Mike Tombleson, The Lake Surgery Taupo

"I'm very happy with the changes that have been made. Technology actually gives me greater control of managing my health."

Patient, NorthCare Hamilton



Planning the patient flow

2.

Traditionally, general practice has been largely a reactive and universal service, given in response to a patient seeking care in the form of a face-to-face appointment.

The decision about how the GP's time is used is made between patients and the receptionist. Most patients are generally given the usual 15-minute appointment with their GP or nurse, irrespective of the complexity of need. This can mean clinicians run out of time, causing lengthy waits for other patients, or patients feeling frustrated that they haven't had the time they need to discuss their needs and care.

For patients with complex health and social care needs, who typically need longer than the usual 15-minute appointments, the 'Year of Care' programme allows for comprehensive health planning over a full year. This is a proactive, multi-disciplinary team approach in which the team schedules in a patient's appointments, reviews, specialist care and social care over a full year, appointing a care co-ordinator to the patient to monitor delivery of the plan. The 'Year of Care' takes the form of a partnership with the patient and their whanau, with the patient encouraged to take a leading role in setting and meeting their own health goals. Managing patients in this way is widely recognised as producing better outcomes, and it reduces the likelihood of urgent, ad-hoc treatment causing problems for other patient scheduling.

"When the patient comes in, we can spend our time setting up a plan together, taking account of their beliefs, priorities, abilities and goals, so it is much more holistic. Medicine used to be about treatment, but now it is much more about prevention."

Penny Clark, Clinical Pharmacist,
NorthCare Hamilton

“The difference between the model of care and government initiatives over the past decade is that this is change from within, not imposed from the outside. At the heart of the change is the welfare of patients and staff in our practices.”

Dr Frank Cullen, Chairman, Pinnacle

Developing new roles

The primary care sector is beginning to deal with a serious shortfall in the number of GP consults. This puts a huge load on existing GP and nurses, which in turn makes it harder to attract new doctors and nurses to the sector.

By developing new roles, we are able to re-allocate tasks that might otherwise be done by GPs and nursing staff. In this way, we can ensure that patients are receiving care in a timely fashion while freeing up time for clinical staff to do what they’ve been trained for—as well as upskill. It also makes for an efficient business model, ensuring all clinicians are working at the top of their scope.

These new roles include:

Medical Centre Assistants

These are unregistered staff who undergo accredited training to support clinical staff by taking on lower-level nursing and administrative tasks to support clinical staff. These roles have no component of diagnosis or clinical judgement but have a large role to play in supporting clinical care allowing nurses especially to spend more time on direct patient care.

Thanks to the Patient Access Centre increasing their capacity, most practices employ medical centre assistants from their existing reception staff.

Medical centre assistants may perform roles such as:

- Greeting and rooming patients
- Taking core health measurements, such as blood pressure, height and weight and ECGs
- Providing smoking brief advice
- Urine testing and phlebotomy
- Planning and organising records and equipment for the following day’s procedures
- Preparing packs for, and cleaning up after, minor surgeries
- Preparing and stocking consulting rooms
- Changing linen
- Ordering stock and clinical supplies

“In my typical day, I will be on the phone triaging for the Patient Access Centre first thing, we will have a daily huddle at 8.45am, and then the rest of the day will be spent on face-to-face and virtual consults. These are great for follow-up if no physical exam is needed.

Dr John Morgan, GP, NorthCare Hamilton



Some of our MCAs together at the annual HCH symposium 2015



“Additional support in our team will ensure the nurses and GPs can spend better quality time with patients.”

Dr Giles Turner, Taupo Medical Centre

Clinical Pharmacists

These add a much-needed specialist skill set to the primary care team. A clinical pharmacist works with the clinical team to target patients with complex health and social care needs who are on multiple medications, ensuring that they maintain an optimal drug regime.

They work to support medicine reviews, compliance and education, and are integral to the Year of Care approach for patients with higher needs.

In addition, they may also:

- Consult with patients, either face-to-face or over the phone, to review medications and answer any questions; these consultations are co-ordinated by the Patient Access Centre
- Review all hospital discharge notes to check that patients have been given the correct medication and dosage
- Follow up discharged patients to avoid any potential problems that could lead to re-admission to hospital
- Order blood tests and refer patients for a GP consultation if necessary

Physician Associates

An increasing number of practices are employing physician associates to supplement the clinical team members, especially when there are GP and nursing recruitment issues. Physician associates typically have spent two years in training at medical school following a health related profession or degree. They support GPs in patient diagnosis and management, taking on tasks such as test analyses, taking medical histories, performing examinations, and developing management plans. They work under the direct supervision of a doctor and are valuable when it comes to supporting timely unplanned care and chronic disease.

Nurse Practitioners

Nurse practitioners are registered nurses who have specialist training in certain skills. Not only does this add specialist expertise to the team, it means that GPs have more time to target at those who need it most. They are invaluable in leading the Year of Care programme for the higher needs patients.

Multi-disciplinary teams

Midlands Health Network has already done a lot of work to ensure that patients have access to a range of healthcare practitioners as part of the multi-disciplinary team approach. Health Care Home builds on this further, ensuring that all health and social care providers are ‘wrapped around’ those patients that need them in the most efficient way.



Patient Access Centre

3.

The Patient Access Centre is perhaps the biggest innovation in the Health Care Home, and the best example of how the model's focus on forward planning improves our patients' quality of care.

It's modelled on the concept of an extended practice receptionist and administrative team, who work from a centralised call and administration centre based in Hamilton. Each practice has dedicated staff who work as part of their team, taking all calls and looking after some administration functions.

The Patient Access Centre provides a vast range of services to support the practice, including:

- Managing all calls
- Triaging calls with emergent symptoms to forward onto practice team
- Booking, changing or cancelling an appointment
- Repeat prescriptions
- Managing recalls and reminders such as childhood immunisation, influenza vaccination, cervical screening, smoking cessation, cardiovascular risk assessment and management, and long-term conditions
- Sending out invoices, with follow-up letters and phone calls if necessary
- Informing and following up patients who are entitled to high-user health cards
- Checking up on incomplete ACC claims
- Contacting patients who have not had a consultation for two-and-a-half years

"The changes have been very positive. I think it's great that I can have more direct and personal contact with my doctor. It's good to be able to email him and/or ring at a certain time and be able to speak to him."

Patient, NorthCare Hamilton

On average calls to the Patient Access Centre are answered in



with only a

3.84%

abandonment rate by patients who can't get through

most practices have a call abandonment rate that exceeds

18%

in the peak morning hours meaning patients get frustrated or go elsewhere for care

70%

of calls are managed directly by the Patient Access Centre on the first call

30%

that require clinical input transferred back to the practice

The Patient Access Centre has roughly halved the number of phone calls coming in to nurses, freeing them up to work on direct patient care such as the Year of Care programme, diabetes and cardiovascular risk management consultations. This lets them be more proactive in monitoring and managing chronic conditions and running education programmes.

Telephone triaging

Practices tend to receive most of their acute patient phone calls in the first hour of the day. To ensure that the day's face-to-face consultations go to those with the greatest need, experienced clinicians and usually the patient's GP are rostered to take phone calls from the Patient Access Centre to assess and manage these patients.

A brief phone conversation allows the clinician to decide whether or not a patient should be seen that day, and they can quickly sort out other issues. For example, they can arrange a prescription, order further tests before an appointment is made, or just give advice on a recurrent or ongoing minor illness. On average, 30% of patients in our Health Care Home practices avoid what would have been a same-day appointment.

Planned phone consultations

These are phone consultations that are booked in at scheduled times of day. It's a way for a GP to follow up their patients' face-to-face visits or give advice on issues which don't require physical examination, such as changes in medications or ongoing symptoms of chronic illness. Phone consultations are usually charged at half the rate of a face-to-face consultation.

When used in conjunction with appropriate triaging, these consultations are an efficient and effective way of managing patient demand more efficiently and supporting a calmer and varied working day for the GP.

Email consultations

These work in the same way as phone consultations, for patients who are comfortable with this type of interaction. The patient portal enables patients to interact with their GP or nurse at a time that suits them. This makes it more convenient for them and reduces the need for face to face consultations or phone calls. Time to manage emails is built into daily templates to ensure it doesn't become an additional burden for staff.

"You cannot go to a model where you have 35 face-to-face consults a day without a drop in the quality of patient care and in your job satisfaction."

Dr John Morgan, GP, NorthCare Pukete Road

Morning huddles

The morning huddle is a surprisingly simple idea that nets some big gains in efficiency for a practice, whatever its size.

Every morning the whole practice team gathers for a 15-minute review of the workload for the day ahead. It provides staff with the opportunity to discuss particular patient needs, such as overdue smears or repeat bloodwork.

It's also a chance to proactively deal with unexpected issues, such as if a team member is away sick. The team can use the morning huddle to redistribute that team member's work, rather than dealing with tasks on an ad-hoc basis—or not at all.

It can even be used to discuss more lighthearted agenda items, such as wishing a team member a happy birthday or offering congratulations on an achievement.

Teams are generally very enthusiastic about the morning huddle, reporting that it is a great way to develop teamwork and communication, as well as build a positive team culture.

"We're communicating a lot better, both within and between teams, because of the huddles. In the mornings we know what's coming in and what we need to do."

Sharon Colville, Practice Nurse,
NorthCare Grandview



5.

Patient information— the 21st century way

“The online patient portal is a new way for patients to manage their health anytime and anywhere, similar to why internet banking has become so popular.”

Dr Rene Lenoir, Pihanga Health

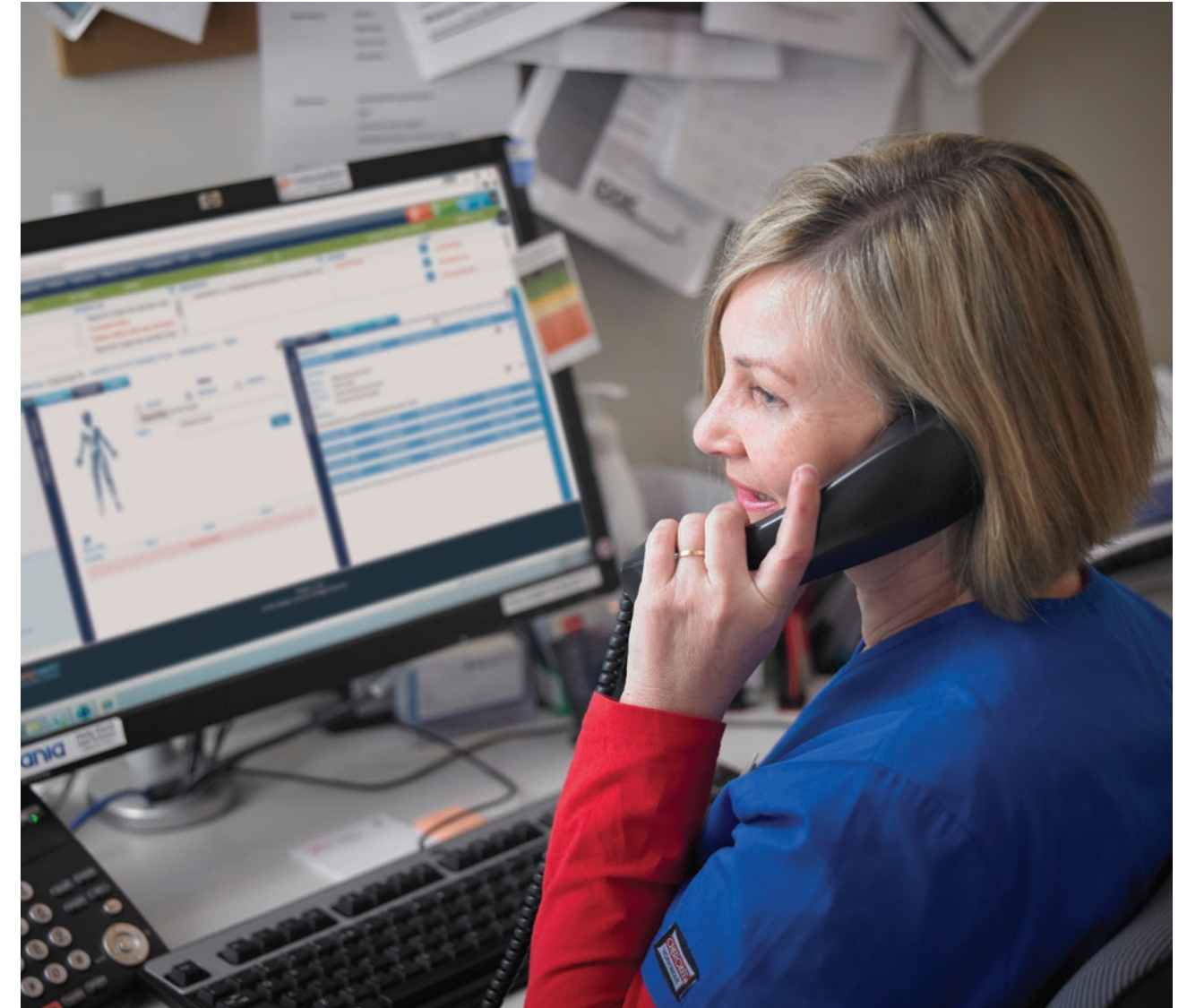
Patient information systems are being enhanced via patient portals, first introduced by the Midlands Health Network in 2011 as a way of improving patients’ access to their own health information and clinical teams.

They allow patients to access their core medical information and lab results, send queries, request repeat prescriptions and track their healthcare goals—all online. For patients, this enables them to take a more active role in their own care as they feel more involved and connected. With their information readily accessible, it also enables continuity of care wherever they are—even on holiday.

The goal is to move health IT systems away from being simply a tool to deliver health services and more towards a collaborative model that places the patient, their whanau, and their broader life at the centre of their health journey.

The system also allows nurses to spend less time on the phone following up patients’ blood results and booking appointments, as this can all be done online at a time that is convenient to the patient.

A new patient information system is under development, one that supports a single information system that can be shared by all providers. As well as being a modern web-based service that is available on any device, it will support a range of methods of communication and enable the effective implementation of the Health Care Home model of care.



Technology continues to be a key aspect of health care services under Health Care Home. We are well aware of the power of devices such as smartphones, which can give far greater access to practice services. Apps in particular can do a great deal to support self-care and empower patients, providing online resources and advice, links to support communities, and ways for patients to monitor their conditions.

In addition, professionals are now using tablets to access patient information and clinical notes from anywhere, such as at a patient’s house or a rest home. These are all linked back to practice records, allowing for accurate information on the go, and easy updating.

Ensuring workflow efficiency



"The practice team getting together to map and strip out the steps in their everyday processes that add no value to the patient or their working day has saved practices significant clinical time. It's also a fun, team building exercise."

Helen Parker, General Manager,
Health Care Home

The Health Care Home model has drawn from experts in LEAN methodology to shape our continuous improvement programme for practices.

Practices adopting the model are supported to review their patient flow, systems and processes and facility design to ensure optimum efficiency, saving them time and money.

For example, practice teams have found that standardising the equipment layout in each consultation room saves time in searching for equipment. In addition, visual displays and developing a culture of continually asking 'is there a better way to do this?' have made a real positive difference to their working day and the patient experience.

A new funding model

A new care model requires an aligned funding model to make it work for patients and the practice business.

The Health Care Home is funded in three ways:

1

Establishment Funding

One-off 'Establishment Funding' is made available to support practices through the change. This is used in a variety of ways: to support time out for staff to think and manage the change, and as a contribution towards infrastructure changes and patient communications.

2

Flexible Funding

Practices receive an increase in flexible funding to support new roles and virtual care.

3

Increased Range of Touches

The Health Care Home allows practices to make changes to the business side, which provides opportunity for increasing patient co-payments thanks to better use of clinical staff time. It allows the practice to create more income streams, rather than 'selling' only face-to-face consultations.



"We're just starting to see a freeing up of capacity as about 30 percent of our previous demand is dealt with in different ways. Hopefully we will see more of this in the future. So the 70 percent who do need to come get value from the visit, and have more resources wrapped about them."

Dr John Morgan, GP, NorthCare Hamilton

The Benefits of Health Care Home

8.

There are identified benefits to patients, the workforce and the system overall by adopting the core principles of the Health Care Home.

We continue to monitor the progress and outcomes from all our sites through the HCH performance dashboard.

Key benefits are summarised as:

Patient	Staff	System
<ul style="list-style-type: none"> • Care, treatment and processes are based around the patient's needs • Reduced waiting times and faster answering of calls • More personalised attention from reception and medical staff • More same-day appointments when they're really needed • Ease of access to a GP for a quick query or ongoing monitoring • Clinical triage saves face to-face appointments for those who really need it • Greater support for ongoing condition management and better planning for prevention • The ability to take a greater role in their own care and management 	<ul style="list-style-type: none"> • Professional expertise can be targeted at patient care and those who need it most • New roles such as Medical Centre Assistants reduce pressure on GPs and practice nurses, allowing them to do the work they've trained for • Patient Access Centre allows for less time on the phone and more time with patients • Planning allows for less pressure and fewer ad-hoc decisions • A less stressed team is a happier and more cohesive one 	<ul style="list-style-type: none"> • The practice can ensure the right staffing capacity every day for urgent and planned care reducing pressure on hospital services • More efficient systems and standard processes can reduce wasted time and wasted resources • Greater long-term sustainability of primary care • Shift of focus from treatment to prevention and greater level of patient self management



Practice Profiles

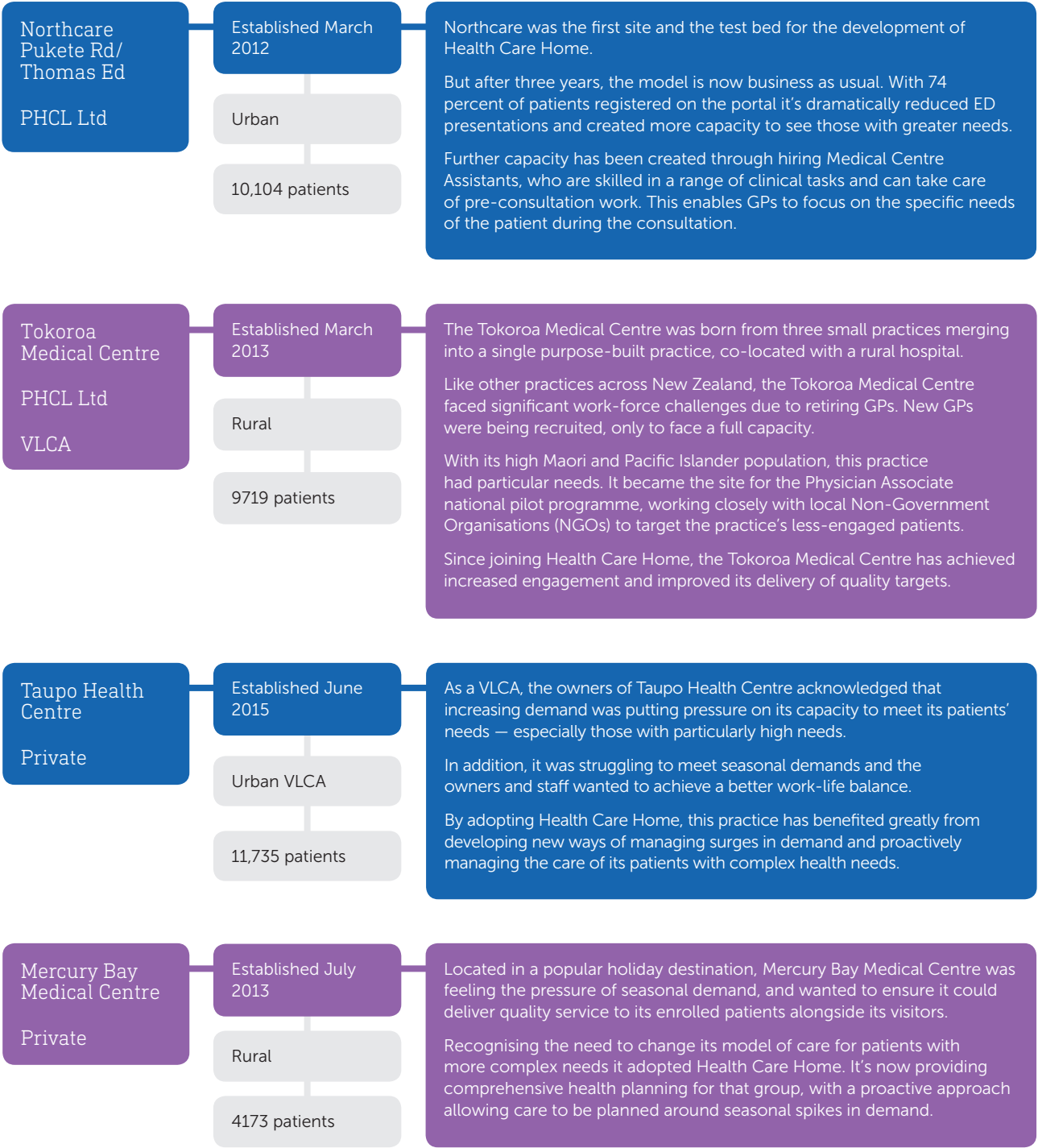
9.

As of March 2016, thirteen practices throughout our region have adopted the Health Care Home model, with another four in the pipeline.

When these practices adopt the model, it will cover a population of 123,000. The practices are a mixture of urban and rural practices and include very low-cost access (VLCA) practices, which shows how readily Health Care Home can be adapted to fit an individual practice’s needs.

Practice	Ownership	Commenced Model	ESUs
Northcare Pukete Rd / Thomas Rd	PHCL	2010	10104
Northcare Grandview	PHCL	2010	4631
Mercury Bay Medical Centre	Private	2011	4173
Health Te Aroha	Private	2012	5289
Waihi Beach Medical Centre	PHCL	2013	3099
Tokoroa Medical Centre	Private	2013	9719
Coromandel Family Health Centre	Private	2014	1845
Taupo Health Centre	Private	2015	11735
Avon Medical Centre	PHCL	2015	4731
The Lake Surgery	Pinnacle Incorporated/Private	2015	3214
Pihanga Health	Pinnacle Incorporated/Trust	2015	4026
Taupo Medical Centre	Private	2015	15399
Victoria Clinic	Private	2015	4649
Hauraki Plains Medical Centre	Private	2016	3615

Deeper profiles



Moving a locality of practices to the Health Care Home model like we are doing in Taupo/Turangi provides a strong platform and great opportunities for developing a fully integrated primary care and community health services. The focus on those with a higher level of need through proactive health planning enables all providers in the locality to work together within the same service model framework, sharing a single patient record and increasing efficiency. More importantly, for patients and carers, it delivers a less confusing care pathway with much improved co-ordination. We are working with Lakes DHB to fully integrate their community services with our practices.

“Medical centres across New Zealand are getting busier and these exciting changes will ensure patients receive high quality health care for future generations.”

Dr David Nixon, Taupo Health Centre

“This model offers hope for better enjoyment of general practice, where GPs will be less squeezed and will have more time to spend with their patients.”

Dr Frank Cullen, Chairman, Pinnacle



Midlands Health Network has a dedicated change management team who are experienced in all aspects of the Health Care Home and in supporting a practice team to make the change.

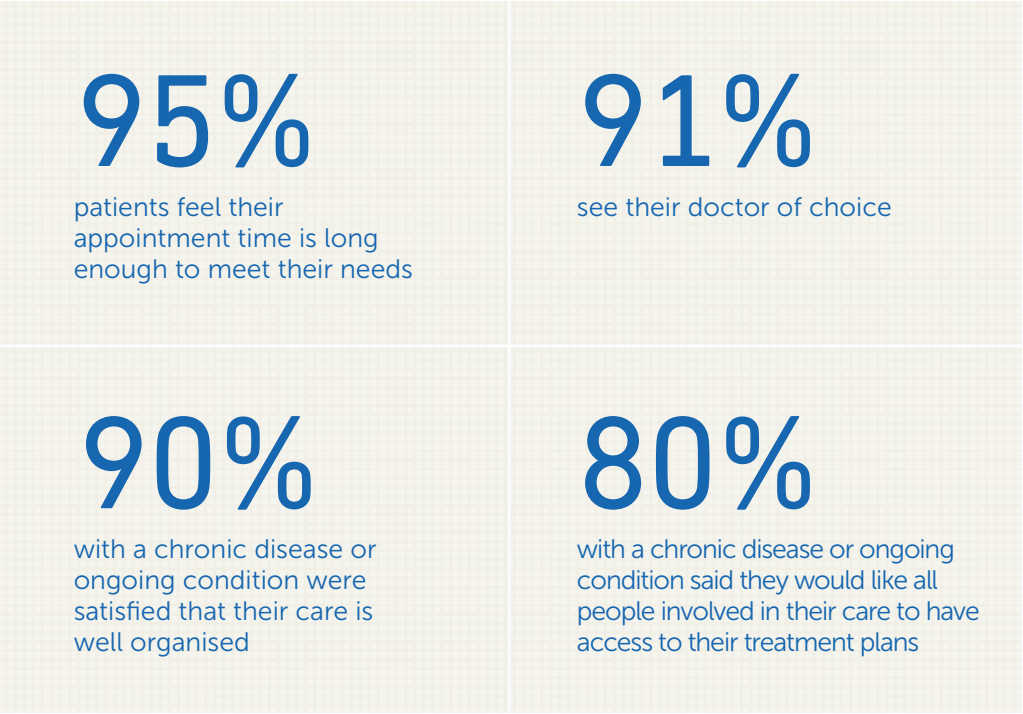
The team, which includes GPs who work in Health Care Home practices, nurses, facilitators and ‘lean’ experts, works alongside a practice team from the time the practice decides to adopt the model until it’s ‘business as usual’. The practice team make all the decisions about the nature and pace of the change as they know their practice and community best.

Through a series of workshops and planning meetings, the team agree an implementation plan that covers, for example, changes required to the care model, template design, facility and IT requirements and patient communications. In our experience, the transition journey takes approximately 18 months but the learning never ends.

We monitor the Health Care Home’s progress and impact through practice performance dashboards and patient surveys.



Patient Outcomes*



*University of Waikato Survey Sept 2015

We are a not-for-profit network of like-minded general practitioners and health professionals and we exist for one — and only one reason — to make it easier for people to stay healthy.





pinnacle.health.nz