



# Implementing the Health Care Home model

Experiences from three privately owned general practices in the Pinnacle Network

November 2019



# Background

“Health Care Home is designed to improve the quality and efficiency of services and the experience of both patients and staff.”

In common with most modern health systems, New Zealand has been confronted with the challenges of rising demand and an ageing and overstretched health workforce. Evidence-based approaches to increase efficiency and capacity have been adopted throughout the health system, alongside a strategic intent to shift the focus of services from hospitals to primary and community care.

Health Care Home (HCH) is a model of care that maximises the role of general practice and its integration with other services. Health Care Home is designed to improve the quality and efficiency of services and the experience of both patients and staff.

Pinnacle introduced New Zealand to Health Care Home in 2011, following a global search for new sustainable models of care to address the challenge of meeting increasing demand for care with a shrinking and changing workforce in regional New Zealand. It was adapted from the medical home model being rolled out by Group Health (now part of Kaiser Permanente) in the United States in 2010.

Pinnacle tailored Health Care Home to the New Zealand context. The model continues to be refined and adapted based on local experience and outcomes, though the core principles remain unchanged—placing people at the centre of the health system and making the best use of all resources to ensure great outcomes for all. Pinnacle currently has 17 very diverse practices that are Health Care Homes, with more set to adopt the model now that *indici*<sup>™</sup>, the network’s new patient health information system, has been developed to enable more effective and broader adoption of Health Care Home.

Pinnacle works closely with practices and communities to manage the changes involved in becoming a Health Care Home, from initial financial and workflow modelling, workshoping with practice teams to develop a bespoke implementation plan, through to community meetings and patient engagement, alongside ongoing support and review.

Pinnacle has self-funded the development and roll out of Health Care Home, using its own reserves, a small contribution from the Ministry of Health and some flexible funding from the national PHO agreement.

The Health Care Home model has now been rolled out across New Zealand, and by mid-2019 covered approximately a quarter of the enrolled general practice population, supported by individual PHOs and a national Health Care Home collaborative<sup>1</sup> which has developed standards and learning networks.

Independent evaluation by Ernst and Young in 2017<sup>2</sup> and 2018<sup>3</sup> has confirmed the benefits of the model.

If you are enrolled with a Pinnacle Health Care Home practice you are:

**20%**

less likely to be admitted to hospital for unplanned care



If you are enrolled with a Pinnacle Health Care Home practice you are:

**32%**

less likely to attend ED if you are over 65



If you are enrolled with a Pinnacle Health Care Home practice you are:

**24%**

less likely to attend ED if you are Māori



Pinnacle Health Care Home Care Plans affect populations with the greatest need:

**50%**

of those with care plans aged 45–64 are Māori



With online and phone-based help from a Pinnacle Health Care Home practice:

**62%**

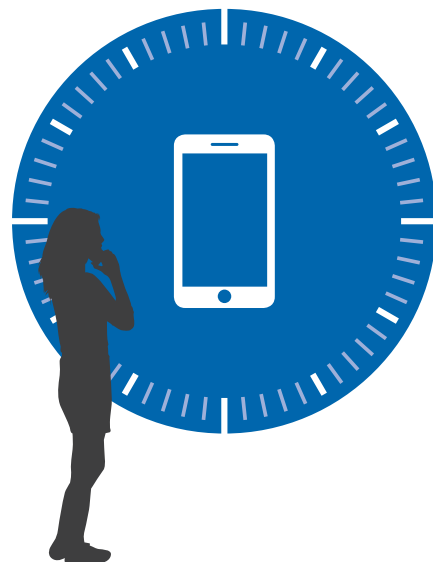
of same day appointment requests managed without need for visit that day



If you are enrolled with a Pinnacle Health Care Home practice you will:

Get your phone call answered

**quickly**



## Research methodology

This small qualitative research project aims to provide additional learning to supplement the findings of the Ernst & Young evaluations.

Semi-structured interviews were conducted with staff in three privately owned Pinnacle Health Care Home practices during July and August 2019:

- Health Te Aroha
- Hauraki Plains Health Centre
- Taupō Medical Centre.

The interviews focused on the experience of each practice in implementing the model and the impact each of the key elements of the model has had on the functioning of the practice and on the working lives of its staff.

Practice visits also included observations of general areas and attendance at team meetings in two of the practices.

A small number of patient interviews were conducted by phone for two of the practices and in person at Hauraki Plains Health Centre.

The conclusions here are based on the subjective personal opinions gathered from 13 in-depth interviews with staff and a similar number of shorter, informal conversations with a further group of staff, and eight patient interviews.

## The Health Care Home model of care

The Health Care Home model shifts the traditional system of general practice from one that is mostly reactive and based around the provider, to a proactive, team-based approach focused on the needs of the patient.

The model covers four domains (see Appendix 1).

1. Timely provision of urgent and unplanned care.
2. Planned, proactive care for people with complex needs.
3. Systematic, routine and preventative care.
4. Maximising business efficiency.

Key elements include targeting face-to-face consultations to the patients who need them most, offering patients access to the practice online and to a wider range of services. It features some simple adjustments to how practices operate that have been shown to have a transformational impact, such as a quick daily team meeting or 'huddle', and having telephones answered away from the practice reception desk.

### Notes

1. <https://www.healthcarehome.org.nz>
2. **Evaluation of the New Zealand Health Care Home, 2010-2016.** Auckland: Ernst & Young, 2017. Retrieved from: <http://www.healthcarehome.co.nz/wp-content/uploads/2017/03/EY-Health-Care-Home-Evaluation-2017.pdf>
3. **Health Care Home evaluation – updated analysis, April-September 2017.** Auckland: Ernst & Young, 2018. Retrieved from: <http://www.healthcarehome.co.nz/wp-content/uploads/2018/05/EY-HCH-Evaluation-April-18.pdf>



# Executive summary

02

A number of clear themes can be drawn from the implementation experience of the three Pinnacle practices included in this review.

- The Health Care Home model succeeds in supporting future sustainability of practices and their workforces.
- The working lives of practice staff are significantly improved as a result of the model.
- Staff strongly believe the model enables them to offer improved quality of care.
- Strong and focused leadership is important to successful implementation, and buy-in to planned changes is needed from all members of the team.
- Practices need to have the capacity and the capability for change management and business development.
- Having the necessary underpinning infrastructure is a key ingredient.

“It appears, from the perspectives of both patients and providers, that the model has achieved positive changes. In addition, there is reported evidence of increased clinical capacity within existing operational funding in practices as a result of implementing the HCH model. Future HCH model rollouts should consider the lessons learned from these early implementations, but also recognise the need for substantial investment in time and effort to achieve sustainable change.”

(Ernst and Young, 2017, p. 4)

In-depth interviews conducted with practice staff and patients supported this conclusion.

Each of the practices had a compelling need for change; each was trying to some extent to secure the future viability of the practice. Each had also embarked on some degree of change before formally adopting the Health Care Home model. The model provided an evidence-based framework for sustainable change and was able to generate control from chaos.

Application of the model varies, and flexibility allows practices to incorporate elements in a way that suits individual circumstances.

# 02

Staff at these practices are in no doubt that the model has enabled them to offer better care to their patients and to provide services that are more sustainable, more varied and more tailored to individual needs

As Taupō Medical Centre GP Dr Giles Turner says, “The model of care was initially fairly prescriptive, but as it has evolved, more flexibility has been introduced that enables practices to apply the key elements in the way that works best for their circumstances.”

In each case there was also one key factor—sustainability of the practice was not about generating more revenue by seeing more patients, but about making quality paramount in order to attract and retain both staff and patients.

All three practices described and demonstrated having additional clinical capacity, and being able to schedule and prioritise clinical time much more effectively as a result of becoming a Health Care Home. All three also clearly identified the need for focused and protected time on an ongoing basis to plan, manage and embed change and to realise the potential of the model.

Staff at these practices are in no doubt that the model has enabled them to offer better care to their patients and to provide services that are more sustainable, more varied and more tailored to individual needs.

Without exception, practice staff who were interviewed said they would never return to how things functioned before the model was introduced. And though there were things that, in retrospect, people would do differently to implement change, there was no aspect of the model that practice staff would do without.

In particular, freeing up clinical capacity has created a new work-life balance, which has been dramatic in some cases, and enabled a focus on quality rather than relentless demand. For GPs that has stimulated positivity and motivation about their role and a reminder of why they chose the profession.

There is no doubt the working lives of staff have been transformed in these practices, and staff strongly believe they are able to offer better care and a better experience to their patients. The practices themselves have a solid future, thriving in a way they were not before the model was introduced. Staff are also confident the improvements to both access and capacity create a new and better relationship with patients.

Nevertheless, administrative staff, nurses, GPs, and, in particular, the practice owners who were driving Health Care Home implementation, all agreed that change was hard, no matter how strong their motivation was to move away from how things had been done before. Even the most passionate advocates of the model had periods where they felt overwhelmed and had doubts about the degree to which the model could transform the outlook for their practice.

However, there was also total consensus that perseverance and patience was worth it, and that staying focused on the prize ultimately leads to better care and more sustainable general practice, benefiting both patients and staff.



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# 03

## Key learnings about elements of the model from practice interviews: in search of the 'special sauce'

"What we have now is a manageable lifestyle, a practice where people want to work and that is growing, and where care is better"



**Dr Ant Smit**  
Co-practice owner  
Hauraki Plains Health Centre



**Bronny Robert**  
Co-practice owner  
Hauraki Plains Health Centre

### Practice sustainability

Each of the three practices had common goals to:

- secure future viability of their services
- enhance the quality of services offered to their patients.

Both Health Te Aroha and Hauraki Plains Health Centre, potentially vulnerable rural practices, are now thriving.

Hauraki Plains Health Centre has shifted from being a practice with a sole GP on the verge of burnout and a dwindling number of patients, to a practice with four part-time GPs and a growing enrolled population.

Hauraki Plains Health Centre GP owner Dr Ant Smit and co-practice owner Bronny Roberts made a conscious decision to put work-life balance before revenue. The GPs get a good salary, though practice profit is small, but there are clear benefits for staff and patients.

"What we have now is a manageable lifestyle, a practice where people want to work and that is growing, and where care is better," says Bronny. "This is the face of modern medicine because the old way of general practice can't continue. GPs are burning out and it's not attractive to future clinicians."

"We were on the verge of leaving but now we're evangelical about the model. We are organised so much better and we will leave the practice in a way where it's sustainable and providing better care for our community."

Health Te Aroha GP owner Dr Hayley Scott describes her working day as a world away from what it was before the Health Care Home changes were introduced.

"It was a definite decision to go for lifestyle over income," says Hayley. "You could see 29 people in a day and earn more money but that's not what it's about. I'd rather have less money and focus on the values of respect, excellence and teamwork."

Hayley says what they now have in Te Aroha is a sustainable rural general practice for a community where it was at risk.

Taupō Medical Centre GP Dr Giles Turner says before the introduction of the Health Care Home model, the large practice had been driven by volume. "The more people you saw, the more you earned." And he wanted that to change.

"At that stage we were convinced primary care was on the verge of falling over. GP retirements were a big factor and the sustainability of practices was being questioned. When I saw the potential of the model I was hooked. I saw it was going to be better for patients and better for my working life."

### **Improved working lives for staff**

No one who has experienced the 'before' and 'after' would go back to how things were, would want to change any of the core elements of the model, or choose to work in a practice that isn't a Health Care Home.

All three practices have shifted from double- and triple-booked GP and nurse appointments being the norm, to a situation where clinical time is scheduled to better meet the needs of the patients and to ensure staff have control over the day.

That means a better experience for clinicians and patients, as well as efficiency that supports the sustainability of the service.

"We want our doctors to be working at capacity," says Hauraki Plains Health Centre GP owner Dr Ant Smit. "We share the load and make best use of everybody's expertise."

Health Te Aroha practice manager Dwayne Stewart points out, "you can always fill appointments, but we knew we needed to do things differently".

Matching clinical time to patient need, both urgent and scheduled, and looking at how all the roles in the team can best contribute, means patients get the care they need, and staff can focus more on quality. "People choose to work here because they're not flogged," says Dwayne.

Health Te Aroha GP Dr Keegan Edwardson, coming to the end of his vocational training, has been able to personally experience the benefits of the Health Care Home model.

"I wouldn't go back to a practice that isn't a Health Care Home," says Keegan. "Anyone who's worked in an environment like this would really struggle in a traditional environment. It's just a better place to work. It's a better experience for patients. We're more effective and more responsive. We need to educate young GPs now—this is how it should be."

At the other end of the working life spectrum, Health Te Aroha GP Dr Tertius Coetzer has stayed on beyond his planned retirement because the model has reignited his professional motivation. "I wouldn't practice in any other way. It's the future," says Tertius.

### **Quality of care**

The impact of the Health Care Home model, according to all the staff, is the direct benefit for all patients. The acutely unwell get seen quickly, people with less urgent needs get directed to the appropriate care, and people with chronic or complex needs get the time and support they need.

"The biggest benefit is planned care," says Dr Ant Smit. "The workload is organised so much better, and we have a structure in place that allows patients to be seen when they need to be seen."

At Taupō Medical Centre, nurses and GPs believe that having a greater focus on planned, proactive care is one of the biggest advantages to being a Health Care Home.

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# 03

“We have a chance to unpick what the issues might be for an individual, link people in with the different services and professionals, as well as plan ahead.”

“It means we have a lot more control over what happens with our complex patients,” says nurse practitioner Tracey Liddell. “We have a chance to unpick what the issues might be for an individual, link people in with the different services and professionals, as well as plan ahead.”

Nurses at Hauraki Plains Health Centre agree, and say there is now much more time to work on care plans developed in partnership with the patient and the GPs.

“It’s a lovely way to get to know your patients better, as well as being better for their health,” says practice nurse Pauline. “We can now have much better engagement with our patients.”

With an increasing shift to virtual care and support in the health system overall, the challenge is to combine the convenience of online or telephone access with face-to-face contact. In all three practices, there is an indication that patients are still learning about and adapting to changes in access.

Even patients who could fully appreciate the telephone triage concept still prefer to maintain a trusted relationship with ‘their GP’, who knows their story and can be accessed without lengthy waits.

As Health Te Aroha patient Eileen King says, “I don’t mind who I see if it’s urgent, but it’s good to have the relationship with one person, so you don’t have to tell your story again and again”.

David King, another Health Te Aroha patient, recognises the advantages of the triage system in ensuring the practice runs efficiently and the sickest patients can get seen when they need to.

“I realise it might need a bit of getting used to. The preference is still to have a primary doctor who you relate most closely to, but when you need to see someone urgently it can be any one of the others in the team, you know they’re all competent and your details are all there. It means the practice can cope with those people who really need to be seen.”

However, online access, including the ability to email GPs, is already transforming patient relationships with their practices and the convenience is strongly valued.

As Taima Te Heuheu, a patient at Taupō Medical Centre says, “I love the portal. It’s fantastic to be able to just jump online and get an appointment or get scripts. It’s so much easier than having to wait on the phone and then trying to go through what’s available.”

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## Leadership

There is clear consensus across the practice teams—clinical and non-clinical, long serving and newer staff—that leadership is critical, through the change process and on an ongoing basis.

The practice leaders set the strategic direction and steered implementation of changes, managed risk and 'bumps in the road', but also actively facilitated teamwork and staff engagement and development.

Practice leaders needed the training, support and dedicated time to ensure practical changes were implemented and, equally importantly, to guide and encourage the whole team on the journey.

The leadership training provided to GPs and managers by Pinnacle was important to all three practices. Without that programme, Taupō Medical Centre GP Dr Giles Turner doubts whether they would have been able to manage the change process.

"It's been hard. I'm a doctor. I didn't have the principle of change management or of motivating different personalities, and the training was really important. You also need a lot of energy to get things moving and it's hard to sustain that energy, but once you get going there's a bit of snowball effect."

Health Te Aroha, one of the first Health Care Home practices, demonstrated how leadership combined with clear values that are owned and lived by all members of the team, and a culture of participation, are critical elements.

Dr Hayley Scott, who steered the practice through the change process, points out, "I want to trust and empower people. The values will reinforce everyone's approach to every patient and everything they do—thinking about excellence and respect."

Leadership, combined with the greater maturity of the model in Health Te Aroha, flowed through to staff buy-in to the model and the energy that goes into problem-solving and ongoing improvements.

## Buy-in from the team

From deciding to embark on adopting the Health Care Home model, through the initial planning, modelling and all stages of implementation, the three practices were clear that everyone in the team—and GPs in particular—needed to be on board with the necessary changes.

But, as Health Te Aroha GP owner Dr Hayley Scott says, "In any practice if you have four GPs you will have four different opinions, particularly about the business side when it's your own business. You need to have sufficient buy-in, but at the same time you can't wait for everyone to be in exactly the same place."

All the practices experienced some staff turnover, and the impact on people, preparation for losing some people and associated succession planning needed to be factored into the change process.

# 03

In addition to needing strong and resilient leaders, clinicians and administrative staff in the practices needed both expertise and time to manage change.

Older staff, in particular, sometimes struggled to adapt to new ways of doing things, no matter the promise of potential long-term benefits.

"Any practice can expect to lose people," says Hayley. "Even if people are reassured their jobs are safe, some won't deal so well with change or instability."

"It can actually feel worse for a while and at times we felt overwhelmed," says Hauraki Plains Health Centre practice owner Bronny Roberts. "You've been in a very tough situation, you're making these changes to help, but people find change really hard, particularly if it has an impact on jobs."

The practices drew on the support of Pinnacle and kept the faith during periods that were challenging.

Hauraki Plains Health Centre practice nurse Lydia Farley sums it up, "Embrace the change, it's worth it in the long run", while Health Te Aroha medical care assistant Raelean Tye says, "Health Care Home was exciting and a bit scary, but we rolled with it".

Notably, after more than 40 years in general practice, Health Te Aroha GP Dr Tertius Coetzer says, "Yes, it's hard to adapt to new ways of doing things, but if it was still the old way I wouldn't be practicing".

## Change management

"Any future planning for wider rollout of the HCH in New Zealand should recognise the inter-linked multiple changes needed, and factor into model planning the necessary time and effort required to build a sustainable model and effectively embed changes."

(Ernst and Young, 2017, p. 3)

The practice management teams all stress that good people and change management is key to success. In addition to needing strong and resilient leaders, clinicians and administrative staff in the practices needed both expertise and time to manage change.

According to Health Te Aroha GP owner Dr Hayley Scott, "We haven't cut corners in any of that. Historically general practice is not about taking time out to think about things, and there's even still some resistance to doing that. I have a half day off the floor, then it's important not just to get sucked into the business as usual; that time needs to be used for strategy and development."

GPs, who wanted to focus on 'being doctors', had to incorporate learning about change and create the space to make it happen. The practices also needed extensive practical support and advice and lots of 'hand-holding' from Pinnacle, both face-to-face and virtually.



“It was a leap of faith,” says Hauraki Plains Health Centre GP owner Dr Ant Smit. “I was a bit negative to start with. I was thinking we’re just a little rural practice, I just want to do doctoring. There’s a heap of stuff I need to do and you’re asking me to take on more.”

Change took time, often more than expected. Learnings from Taupō, in particular, showed that it wasn’t possible to achieve too much at once, no matter how strong the motivation for change. In retrospect, Taupō Medical Centre GP Dr Giles Turner says the practice would have opted not to attempt too many changes at once.

### **Infrastructure**

An appropriate and effective electronic system to communicate within the practice and between the practice and its patients underpins the Health Care Home model.

The Pinnacle practice software system, *indici*<sup>TM</sup>, is still in its infancy, with two of the practices still in the early stages of incorporating it. Inevitably implementation of the model has been closely intertwined with implementation of the new software.

The portal has been instrumental in releasing clinical and administrative capacity in the practices and promoting portal use is a continued focus. For a growing number of patients and clinicians, seeking and providing advice by email is becoming the norm. However, the wider potential of IT to support access, such as offering more email consults and introducing video consults, is yet to be exploited.

The physical environment also needs to support the model sufficiently. Regardless of the size of the practice, standardisation of rooms to ensure clinical efficiency is a core component.

Without adequate space, the option of having an off-stage area or offering rooming is limited, as has been the experience at Taupō Medical Centre. At Health Te Aroha, where space allows for rooming and a shared off-stage area, it is highly valued.

“Going back to the off-stage area gives you the opportunity to bounce ideas off people in those few minutes between appointments or in your paperwork slots,” says Health Te Aroha GP Dr Keegan Edwardson. “People don’t really appreciate the benefits of something like that until they experience it. It creates real teamwork through the whole day.”

### **Workforce development**

Based on the experience of the three practices, the Health Care Home model is a definite attraction for staff, and there are indications that GP registrars and newly qualified GPs will choose a Health Care Home practice and be less keen to work in a traditional practice if they have been exposed to the Health Care Home model. The two training practices—Health Te Aroha and Hauraki Plains Health Centre now have GP registrars seek placements with them because of the model.

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# 03

“Three years in we have had the ability to recruit doctors. Before, the GP registrars picked other practices, now they choose us.”

Hauraki Plains Health Centre GP owner Dr Ant Smit says, “Three years in we have had the ability to recruit doctors. Before, the GP registrars picked other practices, now they choose us.”

The role of the nursing team is variable between the practices, in part due to practice size and staff turnover. At Taupō Medical Centre, the large patient population and the partnership with the Pinnacle-Lakes extended care team has created significant opportunities for nurses to develop their roles.

Taupō Medical Centre practice nurse Ollie says, “I love the variety of it and all the things I’m able to do—the autonomy alongside the support I get. I thought I wanted to work in ED, but I get to do far more than any nurse in ED and I definitely wouldn’t change.”

Practice nurse Michelle Morley says the nursing team has been significantly upskilled. “Previously we were just waiting to be directed by the doctor. Now we work alongside each other.”

Where the skills of medical care assistants (MCAs) and nurses are being used to full effect, it is clear that capacity is being freed up across the entire team, offering people more rewarding careers.

Hauraki Plains Health Centre nurse Lydia Farley says, “In the beginning there was a sense from all of the nurses that it meant losing control when they were handing over certain tasks to the MCAs, but really a lot of it is about using nurses more effectively”.

The role of the MCAs and the interface with the rest of the practice team is crucial. Unsurprisingly, given the roles are relatively new to the New Zealand health system, they are still evolving in all three practices with more potential to maximise their impact. The MCAs themselves are learning on the job, growing their roles and adding increasing value to the team and to patient care.

The incorporation of the MCA role has been an asset to the practice that Hauraki Plains Health Centre practice owner Bronny Roberts describes as “massive”.

Sande McCheyne, who has pioneered the MCA role in the practice, relishes the opportunities and variety she has been offered, emphasizing the success of the role lies in it being fully supported by others in the team. “As my confidence grew, I could extend my skills. One thing you definitely need, whatever tasks you take on, is confidence in your people skills.”

Taupō Medical Centre MCA Sue Green describes taking on the role as a life changing experience, but agrees there needs to be clarity about how it fits within the wider team to make the most of its potential.

AVERAGE  
WAITING  
TIME = 7:16mins.

TUES	WEDS	THURS	FRI
661	668	671	548
30	30	30	18

(122 per week)

in 5 months

1101 = 33.17%

229 = 6.9%

1289

Wairakei  
MIDWINTER XMAS PARTY  
23/06/2018

Primary Options

Tues  
Education Updates  
Dr's/Nurses

Wed  
Ideas Update  
HCH Team

Thur  
Quality Updates  
HCH/Immunisation Group  
Smoking etc.

Gem Of Info

HINE

Gem Of Info

PETE



# Key elements of the model

## The huddle

A daily team meeting (huddle) in practices underpins quality and improvement and is critical to reinforcing a shared sense of direction.

Combining information-sharing, education, team building, quality improvement and social support, the 15-minute huddle at the start of the day can be transformational when fully supported by everyone in the team.

Health Te Aroha GP Dr Tertius Coetzer says, “The huddle is a little thing, but the impact is huge,” while Health Te Aroha practice manager Dwayne Stewart says, “We fix everything in the huddle”.

As well as planning the day ahead, reviewing anything that has arisen the day before and covering key topics, the huddle is where any problems are tackled. Informality and shared participation is key, as is capturing issues on the board so that they can be systematically addressed.

“The huddle has been amazing,” says Hauraki Plains Health Centre practice owner Bronny Roberts. “It did take some people time to see it as good use of time. Now everybody can see it’s where you get your answers and your support.”

With a much larger team, and being a more recent adopter of the model, the huddle at Taupō Medical Centre doesn’t have the full staff attendance every day that the two smaller practices rely on. Nevertheless, the quick meeting is an integral part of the day, which Dr Giles Turner says is essential to information-sharing and avoiding any issues surfacing later in the day.

## The patient portal

The ability of patients to make appointments and order repeat prescriptions online through the patient portal is a major administrative time-saver in the practices.

Promoting the portal is a priority for all the practices and uptake is continually monitored. With 40 per cent of patients using the portal, Taupō Medical Centre has one of the highest rates of any practice in the Pinnacle network and the team is actively encouraging more patients to sign up.

Health Te Aroha GP Dr Melissa Titterton says she loves communicating with patients through triage and the portal. “You develop a much closer relationship. You can tell people if they need to come in, you can help them to self-manage. It’s more virtual but it’s a partnership.”

“You need to allow time for learning for everybody. You also need to keep prompting people to let them know they can get their results or check their notes.”

The ability to email through the portal is another clear benefit. Health Te Aroha GP Dr Keegan Edwardson highlighted how a patient recently diagnosed with cancer and working full time could message him with a question or a concern, and he could message straight back. “It’s quick and convenient and he doesn’t have to come in every time.”

Patients are enthusiastic about the convenience. Eileen Joyce, a patient at Health Te Aroha says, "Instead of having to go in I can just email. That's one of the excellent aspects of the changes—it's not taking up too much of the doctor's valuable time."

### **Telephone triage**

Even between three practices with a broadly similar demographic, two of which are rural and relatively close to one another, there is no 'one size fits all' approach to telephone triage, how members of the team are deployed or how services are developed.

While the triage approach varies between practices, all three practices agreed that successful telephone triage needs trial and error, patient education and time to bed in well.

Hauraki Plains Health Centre practice owner Bronny Roberts says they struggled with triaging until they found a system that worked for them. "To begin with everybody did it, the nurses and the GPs. But it wasn't being effective. What we have now, where Dr Ant Smit does all the triage until mid-morning, is what suits our practice."

Ant explains, "It used to be a day of deep complexity, now there's balance. Triage has given me control of the day and my time."

Health Te Aroha GP owner Dr Hayley Scott points out, "Phone triage is not a wall. It's not about keeping people out. It's about getting the right people in at the right time to see the right person."

She says the initial view of GP triage at Health Te Aroha questioned why they would take 15 minutes out of their day to talk to people on the phone. "Two days into doing GP triage we realised it worked."

Health Te Aroha GP Dr Keegan Edwardson explains, "You have control over your schedule. If you do book somebody in, you know what it's about. Complex patients also know they'll get a call back and if they just need reassurance they can get it in two minutes. It's a good use of everybody's time."

Taupō Medical Centre GP Dr Giles Turner says, "It's so easy to triage someone you know. Our same day demand works amazingly well. It was incredible how quickly it worked and how well it was accepted by patients from the start."

From the patient perspective, it is summed up by David King at Health Te Aroha. "It's so much better to be able to give some key information when you first phone up so you can get slotted into the right place. You get a call back from the GP so quickly, and you get the help you need—like the appointment with the nurse before the appointment with the doctor. It's amazing."

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# Taking the next steps

05

The Health Care Home is a primary health care model that gives patients more control, the practice team an environment where quality of care and innovation can flourish. It enables truly proactive, coordinated care for those that need it most breaking down the professional and system barriers that we know prevent patients from getting the best care.

Each of the practices are at different stages in the Health Care Home journey, but all the practices see themselves as being on an improvement path that's ongoing.

Capitalising on and incorporating new roles in the wider general practice team, building partnerships with patients to focus more on proactive and preventative care, extended hours and outreach are among the areas where there has been progress, but all three practices acknowledge there is the promise of much more if resources allowed. In the words of Health Te Aroha practice manager Dwayne Stewart, "We need to be saying this is the sort of primary care we want and it should be funded".

Shared medical appointments (SMAs) have also had patchy success. Practices know they are very well received by patients, but it has proved difficult to get them going and to sustain them. All three want to focus on incorporating SMAs as a core practice offering in the future.

"We want to make it business as usual to help people get control of their conditions alongside other people in the same situation," says Health Te Aroha GP owner Dr Hayley Scott. As Taupō Medical Centre nurse practitioner Tracey Liddell says, "The concept is really good but we need to think outside the box to make sure they work well."

There is much more potential to grow the number of virtual consultations, subject to IT capability and the appetite for virtual access from patients.

## Future learnings

Themes have been identified which could merit more in-depth exploration to add to learning about the Health Care Home model for both existing and prospective Health Care Home practices.

- Better understanding of the importance of leadership, staff engagement and values to buy-in and successful implementation of the model could offer more insight into the 'people' elements associated with a major change process.
- A larger number of in-depth patient experience interviews would greatly enhance understanding of the impact of the model, in parallel with detailed analysis of practice surveys.
- The potential for extended workforces and workforce development, including targeted training programmes and career pathways for both regulated and unregulated roles in primary care could be explored further.

The model is still evolving and improving in each practice and the focus is on that constantly.

# Appendix 1: The Health Care Home model of care

## **Timely provision of urgent and unplanned care**

### *How does it work?*

Key to this domain is triaging those patients calling the practice to request an urgent appointment. A patient asking for a same day appointment will get a call back from one of the practice's clinical team, often within an hour, to determine how best to manage their situation.

National evidence indicates that roughly a third of calls are managed without the need for a visit to the practice, and less than half of people need a same day GP appointment, while some are provided with a prescription or a referral to another professional.

The experience varies between practices and can also vary substantially within practices, depending on the time of year or day of the week, but the overall pattern is that at least one third of general practitioner capacity is freed up by having a telephone triage system.

## **Planned proactive care for people with complex needs**

### *How does it work?*

Planned proactive care involves development of a single comprehensive health plan between the patient and everyone involved in their care. Health Care Home practices maintain a register of patients with long term conditions or other complex health needs who require this ongoing and co-ordinated care and support.

Care planning involves scheduling appointments and reviews in advance and typically encourages a high level of self-management, with the support of a named care co-ordinator to monitor progress and maintain ongoing support.

The care planning process is generally led by practice nurses, who are able to focus more of their time on proactive interventions by passing certain tasks on to the new medical care assistant (MCA) role or to practice administration staff.



## **Systematic routine and preventative care**

### *How does it work?*

Improving routine and preventative care means a strong focus on population health outcomes and consistent targeting of the practice's performance against national and local health targets.

This entails a systematic approach to recalls for immunisation, cervical screening, cardiovascular risk assessment and diabetes reviews and identifying opportunities for offering advice on smoking cessation. Recalls and reviews are flagged through the patient information system, and all members of the practice team share responsibility for acting on them.

Practices may also offer shared medical appointments (SMAs) where a small number of patients receive consultations in a group setting, with peer support shown to contribute to improved self-management and outcomes.

## **Maximising business efficiency**

### *How does it work?*

The Health Care Home model was designed with input from experts in Lean methodology, ensuring it is founded on robust processes to drive efficiency and continuous improvement.

Practices adopting the model generally start by attempting to streamline tasks and reduce waste by reviewing the physical environment, patient flow and systems and processes. Simply standardising the layout of consultation rooms reduces clinical time in searching for equipment, while the morning huddle, where the whole team gathers to share key information, is a simple idea that has been shown to make all types of practices more efficient.



# Appendix 2: Underpinned by technology

User-friendly technology that serves the clinical and financial needs of the practice and enables convenient patient access to the information and services they need, is key to the success of the Health Care Home model.

## **Patient portals**

The patient portal is a secure online system provided by practices that allows patients to book appointments, request repeat prescriptions and access lab results electronically. Some practices also enable an 'open notes' function, allowing patients to access all the clinical information the practice holds about them.

All general practices are actively encouraged by the Ministry of Health to provide a patient portal and more than two thirds of patients in New Zealand were able to access to their practice through a portal by mid-2019.

The portal also allows patients to email the practice, with time to manage emails increasingly built into GP schedules. Email consultations allow the clinical team to manage their day more efficiently and ensure that patients get a prompt response that doesn't have to mean a visit to the practice or a fee.

## **Patient information system – indici™**

Practice management systems or patient information systems are software that combines the information practices needed for scheduling appointments, recording clinical information, generating data and managing finances.

Pinnacle Group, in partnership with Valentia Technologies, has pioneered indici™, the first cloud-based practice management system in New Zealand. Indici™ is designed to support the Health Care Home model and enable patients to take more control of their health through the my indici™ app.

Like the Health Care Home model of care, the indici™ system is based around the patient, from scheduling appointments, prompts and alerts, to creating care plans and allowing access to the practice team. All staff in the practice team can view schedules, information is accessible anywhere at any time and practice dashboards can provide detailed information about patterns of demand and performance reports.

Following beta testing in 2017 and 2018, the *indici*<sup>TM</sup> system continues to be refined and is being introduced into practices across Pinnacle, as well as being adopted by other networks, practices, PHOs and service providers in New Zealand.

### **The Patient Access Centre (PAC)**

Telephone access in traditional general practices is often challenging, and even in practices with advanced telephone systems, a considerable proportion of patients phoning practices first thing in the morning fail to get through.

One of the simple system changes in the Health Care Home model is to remove phones from the front desk in the reception area, so that reception staff are focused on the people in the room and staff answering phones are focused on the caller.

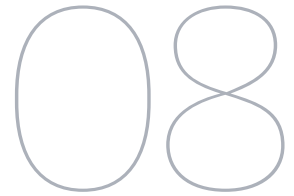
Pinnacle decided to centralise the telephone-answering service for its practices and more than 50,000 patients are served by their Patient Access Centre (PAC) based in Hamilton. This service has significantly reduced call waiting time for patients.

Each Health Care Home practice has dedicated staff within the PAC who work as part of a virtual extended team. The PAC team manages all phone calls, creates lists for triage call backs, books appointments, and co-ordinates requests for repeat prescriptions, recalls and reminders. Any patient requiring clinical advice is transferred to the practice team.

The PAC ensures more people are available to take calls at times of peak demand. In addition to freeing up practice administration time, it has roughly halved the phone calls coming in to nurses, allowing them to devote more time to direct patient care.



# Appendix 3: Glossary



## **Patient Access Centre (PAC)**

The PAC, based in Hamilton, handles phone calls for Pinnacle Health Care Home practices. Abandonment rates average 2 per cent—a significant drop from the rate experienced by practices without an advanced telephony system. Average call duration in PAC is just over two minutes, with an average wait of 22 seconds for calls to be answered.

## **Medical care assistants (MCAs)**

MCAs, also known as health care assistants or practice assistants carry out a wide range of clinical support tasks. This is a new role in New Zealand general practice and is still evolving. Typically MCAs have training to NZQA level 4, such as Wintec practice assistance. Every Health Care Home has a MCA as standard. This releases GP and nurse time and reduces patient waiting time for appointments.

## **Off-stage**

The off-stage area is a dedicated shared space where GPs and other members of the clinical team work and meet between face-to-face consultations.

## **Portal**

Patient portals are online systems that allow patients to see test results, make appointments and order repeat prescriptions among other functions.

## **Rooming**

Rather than a GP always remaining in his or her own consultation room, rooming means GPs move between different rooms, each set up identically, and then return to the off-stage area between appointments. The patient is first brought to the consultation room, usually by the MCA who can carry out any observations and ask initial questions before the GP comes to the room and begins the consultation.

## **Triage**

Telephone triage is an underpinning element of the Health Care Home model. Patients phoning to request a same-day appointment get a call back from one of the practice's clinical team, to determine whether they need to be seen on the day or at a later time, whether they need to see a GP or a nurse, or whether their problem can be managed with telephone advice rather than needing a face-to-face consultation.

