



HEALTH CARE HOME

Second Year: Achievements and Reflections

Tū Ora Compass Health
Health Care Home Development Team

SEPTEMBER 2018





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1.

Foreword



This publication is an overview of our second year implementing the Health Care Home Model of Care in the Wellington region.

It offers some insights, stories and early data from our Health Care Homes locally. Collectively, they cover a population of just over 240,000 enrolled patients, across three Primary Health Care Organizations: Ora Toa Health Service, Cosine and Tū Ora Compass Health.

Among the critical success factors of the Health Care Home programme have been the sustained commitment of funding, people resource, and leadership by the three Primary Care Organizations and Capital & Coast District Health Board (CCDHB) 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 HCH practices and from CCDHB community health teams over the last two years to achieve some complex change.

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

As we further establish the model in our region, developing measures around patient contacts and 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.

“Health Care home is based on an assumption that high performing primary health care is essential to a high performing health system. The model of care is derived from just a few core principles, a better experience for patients, reducing waste, and great teamwork. It is exciting to share the growth and early success of our Health Care Home programme with a wider audience. Our early achievements are encouraging and our aim in the coming year will be to build on these, as we support more of our General Practices develop into Health Care Homes.”

Martin Hefford, CEO, Compass Health

Our future Health Care Home rollouts will continue to consider and incorporate the lessons learned from our second year, as well as continuing to respond to lessons from elsewhere in New Zealand where the model is being implemented.

News of our early success has spread amongst our primary care colleagues, and we now have more practices wanting to take up the programme locally than there are spaces available.

With the intention of increasing the pace to ensure this improved model reaches more of our population faster, we have decided to take on an additional 14 practices this year. This brings us up to a total of 34 practices and over 80% population coverage in the CCDHB region by April 2019.

“The Health Care Home initiative is one of the Capital & Coast DHB Board’s key investments in the health and wellbeing of our communities.

Integrating specialist skills into primary care teams, and giving people access to enhanced services and options at the GP or medical centre, are key components of the health system going forward.

Board members who have visited Health Care Home practices have been very impressed with what we have seen, and we have no doubt that the initiative will continue to go from strength to strength as it continues to be rolled out to people and families across the region.”

Andrew Blair, Board Chair, CCDHB and Hutt Valley DHB



Andrew Blair, Board Chair, CCDHB and Hutt Valley DHB

“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 whānau 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, Compass Health



Larry Jordan, Chair, Compass Health

Our approach



Adri Isbister, WrDHB
Chief Executive

“Health Care Home will be 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 whānau and community wellness, and introduces better ongoing management of conditions. It increases efficiencies, builds sustainability and provides better care where and when it is needed. Health Care Home is an opportunity to future-proof healthcare in New Zealand.”

Adri Isbister, WrDHB Chief Executive



Julie Patterson, CCDHB
Interim Chief Executive

“Health Care Home puts the needs of patients and their families at the heart of local healthcare delivery. It is an investment in helping to ensure people are able to access services close to home and stay well in the community.

It has represented a significant change in the delivery of primary care and was achieved through successful collaboration between the DHB and all three PHOs, Ora Toa, Cosine and Tū Ora Compass Health.

Since this initiative began, tens of thousands of people have benefitted from better preventative, proactive and urgent care. Health Care Home remains a priority investment and we are excited that it will reach 80 percent of the DHB population this year.”

Julie Patterson, CCDHB, Interim Chief Executive



Sir Paul Collins
WrDHB Board Chair

“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, WrDHB Board Chair

The CCDHB’s Alliance, the Integrated Care Collaborative, continues to be the vehicle for the joint approach to the local Health Care Home model. The progress has been achieved through an ongoing collaboration between the CCDHB, all three PHOs in CCDHB and local hospital services.

As a collective, there is an ongoing commitment to the model, with support for further expansion. The joint goal is to reach 80% of the CCDHB population by the third year of the programme.

Together as sector partners, we have worked with a common purpose to develop an enhanced primary care model, with integrated specialist services. We are planning to utilise the robust platform of the local Health Care Home model to further progress the networking of additional services closer to the community.

In addition to joint leadership, there has been a combined implementation approach. The Tū Ora Compass Health, HCH Development Team, has supported the developments within practices. This team has been partnered with project leads in the Strategy, Innovation and Performance and the hospital, who have led the integration of District Nurses, Community Allied Health and other new services with the practices.



The Health Care Home Project Team
(left to right): Melissa Simpson, Emma
Hickson, Astuti Balam, Susan Melvin,
Chantalle Corbett, and Matthew Callahan.

Together we set out on a clear programme of work to achieve our shared milestones and follow key design principles that are aligned to the Quadruple Aim:

- Patients and their whānau remain the focus for the model
- A whole-of system investment approach and shared purpose is required for success
- Ensuring there is a focus on improvements in equity and support for vulnerable populations
- Strengthened primary care is the foundation of any successful health care system
- Workforce satisfaction and development of new teams will enable sustainability
- Integration of hospital specialist skills, starting with District Nurses and Allied Health, is integral to the model
- Trialling new approaches to care (e.g. video conferencing for multidisciplinary teams, group care planning, trialling virtual outpatient services) and learning as we go, will be key to its success
- Working together, surmounting hurdles and getting across the line together



Patients and their
whānau remain the
focus for the model.

3.

Our practices

Supporting over 240,000 patients in the greater Wellington region.

Karori Medical Centre
Newtown Union Health Services
Courtenay Medical
Island Bay Medical Centre
Kelburn Northland Medical
Newtown Medical Centre
Brooklyn Medical Centre
Capital Care Health Centre
City GPs Ltd
City Medical Centre
Miramar Medical Centre
Peninsula Medical Centre
The Terrace Medical Centre
Victoria Student Health Centre Mauri Ora

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

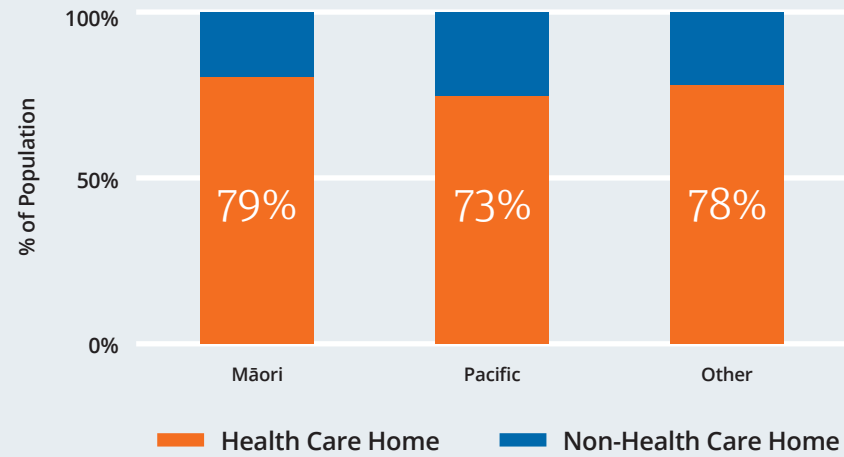
Ora Toa — Takapuwahia Medical Centre
Ora Toa — Mungavin Medical Centre
Ora Toa — Cannons Creek Medical Centre
Mana Medical Centre
Porirua Union & Community Health Services
Titahi Bay Doctors
Whitby Doctors

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

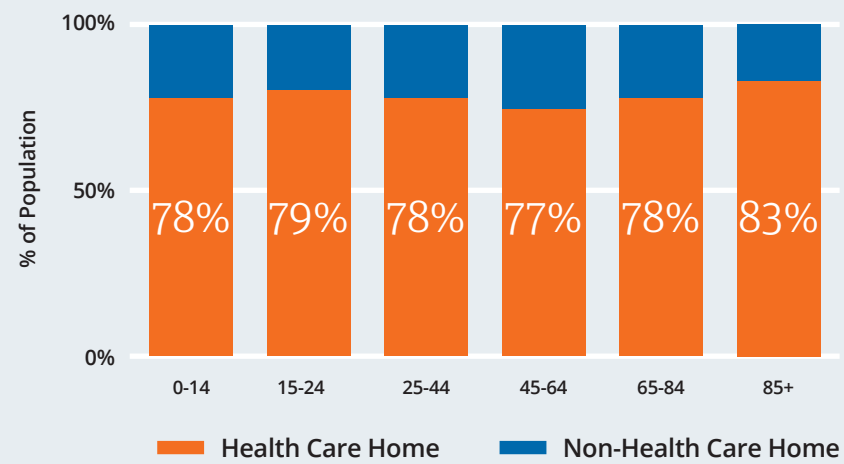
Carterton Medical Centre
Featherston Medical Centre
Greytown Medical Centre
Martinborough Health Service
Masterton Medical Centre
Whaiora

- Tranche 1
- Tranche 2
- Tranche 3

Ethnicity of HCH Enrolled Population – Tranches 1,2 &3



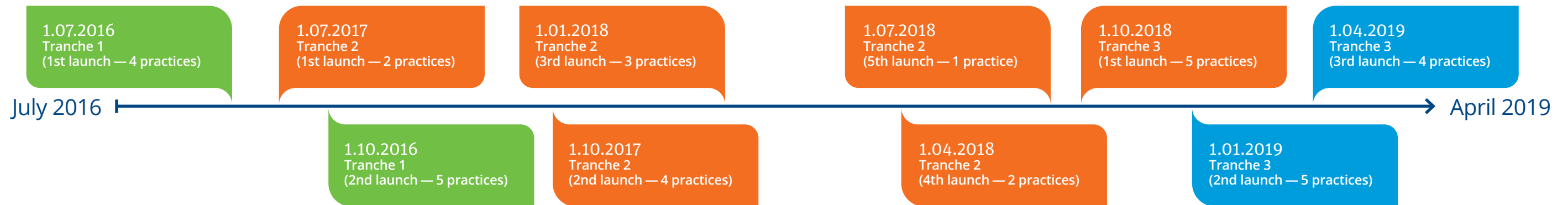
Age Band of HCH Enrolled Population – Tranches 1,2 &3



4.

Our progress

The Health Care Home model of care is being implemented through a gradually increasing phased enrolment of practices, joining in tranches. Practices are selected through submission of an agreed expression of interest.



- Seven practices were selected for Tranche 1, covering over 60,000 patients (19%) in CCDHB. This tranche included practices from each of the four CCDHB PHOs, and covers three key localities: Porirua, Wellington and Kapiti. These practices launched between July — October 2016.

- In addition, a weighting was given to practices that sat in geographical clusters where clinical networks and further integration of hospital and support services could be developed.
- The six selected practices covered a population of over 50,000 patients which, in addition to the first tranche, would cover about 36% of the CCDHB population.

- The CCDHB has approved a faster roll out of the Health Care Home and an additional seven practices have been selected, taking the total of HCH practices to 20 by April 2018. Including the second tranche, the CCDHB population coverage will be about 150,00 patients (51%). These HCH practices are due to launch during 2017/18.

- With Tranche 3 rolling out in 2018, our aim is to bring the Health Care Home model to approximately another 90,000 patients, which increases the total coverage to 80% of the region's population.

5.

Patient and team stories



“GP triage and the patient portal have been the best things ever for Raumati Road Surgery.”

Dr. Ruth Brown,
Raumati Road Surgery

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.

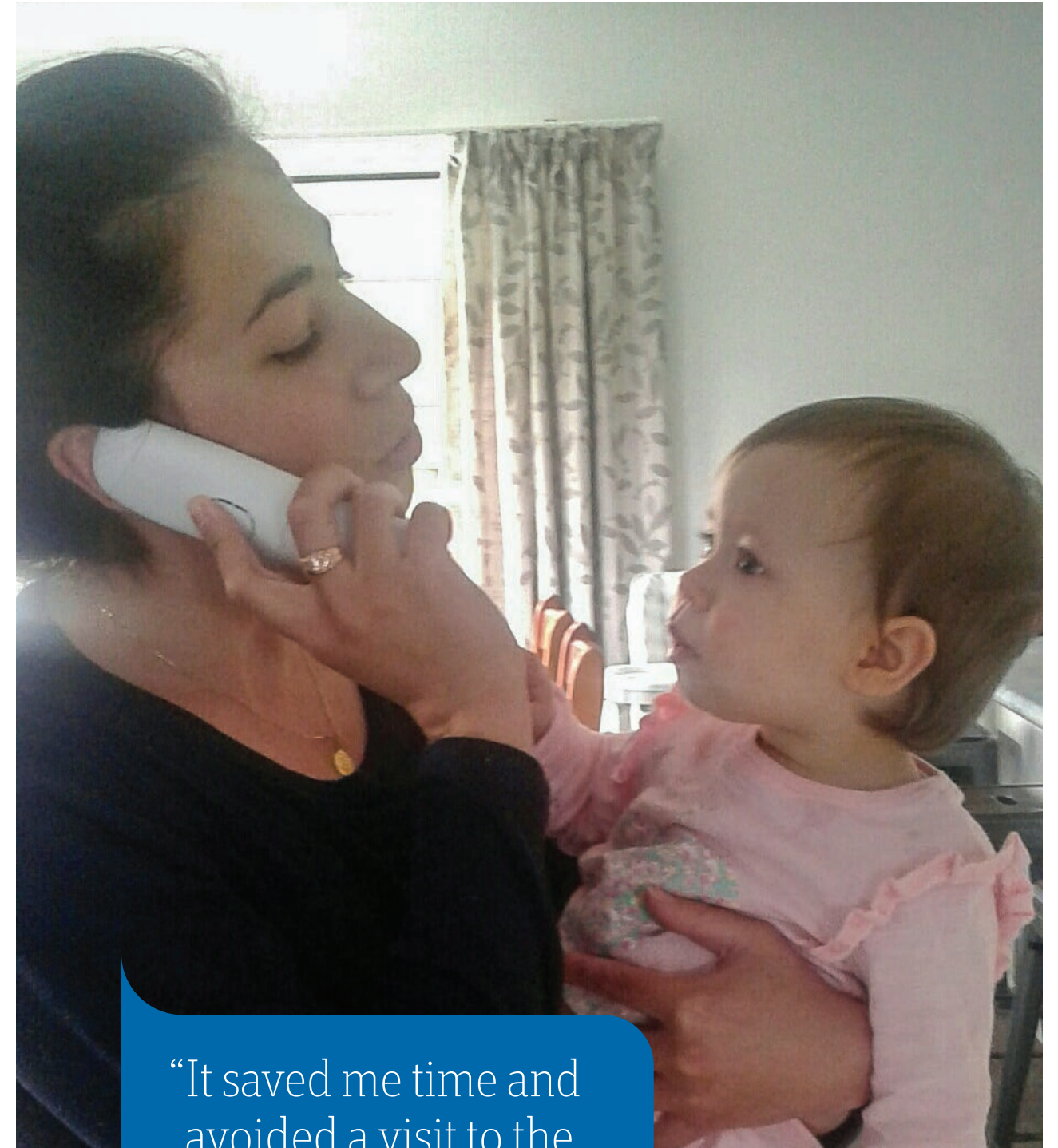
We will continue to gather and store them safely as our programme rolls out. They provide an essential record of our journey, and they highlight the human impact of the change.

1. Improving access for urgent and unplanned care

Telephone Assessment and Treatment (GP Triage)

With demand rising and resources stretched, it is essential to ensure that those patients that really need one can get a booking and be seen urgently, whilst others can be managed in other ways.

GP Triage or Telephone Assessment and Treatment, as it is increasingly becoming known, is one approach to this and has become popular with both patients and practitioners as confidence in it has grown. “For a long time, receptionists had been put in the unenviable position of being a wall between the patient and the doctor,” says Chris Fawcett, a GP at Hora Te Pai Health Services, “Now we're saying, ‘The doctor will talk to you,’ and patients are (pleasantly) surprised by that.”



“It saved me time and avoided a visit to the GP – this new service is awesome.”

35% of patients are being successfully managed over the phone.



Dr Chris Fawcett, Hora Te Pai Health Services.

All Health Care Home practices now provide a telephone assessment and treatment service — with an average of 35% of patients being successfully managed over the phone and therefore avoiding the need to come in for a face to face appointment.

Patients are reporting that they value the new service, with very positive feedback in terms of both time saved and concerns swiftly addressed.

At the same time, doctors and nurses are finding themselves better able to manage their day, knowing what to expect and ensuring that appropriate time is allocated to everyone.

Triage outcomes can be monitored in-house by reviewing the practice specific data using the new GP Triage Advanced Form. Among other data, they show them resolution rates — those patients who had an unnecessary face to face appointment — information that is of real value to all.

In addition, we are able to review the data through an equity lens with outcomes for Māori and Pacific Island patients recorded and fed back to practices.

Open notes

Open Notes — the process by which patients are granted online access to their medical records and notes — is one of the criteria for Year 2 of Health Care Home, made available to patients via Manage My Health and the patient portal. It's become more widely adopted by HCH practices in the last year.

Dr. Kirsty Lennon, a GP at Raumatī Road Surgery, looked into Open Notes for Compass Health. She says, "Some practices are already happily running an Open Notes set-up, but it was clear from a couple of workshops we ran that there was still a degree of anxiety about implementing it." Research, however, suggests that such anxiety is misplaced. "Doctors reported little change in workload," notes Lennon, "And patients overwhelmingly approved of note sharing. Reading notes helped them feel more in control of their health and health care, and patients using it were also better able to comply with medication and care plans."

Both doctors and patients at Island Bay Medical Centre, where it has been used for a couple of years now, agree. "I do like the immediacy," says Ross Jones, a patient with the practice, "And the fact that I can consult my notes and interact with the practice at any time via my phone."

"A big concern for medical staff was that the jargon might cause a degree of confusion, resulting in a lot of enquiries and requests for clarification and explanation," says Clinic Manager Fiona Kymbrekos, "This hasn't happened. As long as you've got a clear plan at the bottom of the notes — a plainly expressed conclusion, which is normal practice anyway — then the patients are usually happy. It's most useful, we've found, for people with long-term conditions, people who are being monitored and treated on a continuing basis, who often have self-management goals that can be stated in the notes and subsequently referred to by them."

Open Notes undoubtedly does require commitment from practices that adopt it, but it is a commitment towards transparency and clear dialogue with their patients.



"I do like the immediacy, and the fact that I can consult my notes and interact with the practice at any time via my phone."

Ross Jones, Patient, Island Bay Medical Centre



"It's most useful, we've found, for people with long-term conditions, people who are being monitored and treated on a continuing basis, who often have self-management goals that can be stated in the notes and subsequently referred to by them."

Fiona Kymbrekos
Clinical Nurse Manager
Island Bay Medical Centre



Shared Medical Appointment at Hora Te Pai Health Services.

2. A coordinated and proactive approach to care

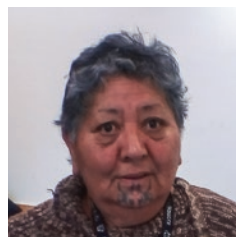
Shared Medical Appointments

In an age of people living longer, long-term conditions increasing, and with a GP workforce under pressure, Shared Medical Appointments (SMAs) look like being one of the smarter ways forward. They're one of Health Care Home's more recently introduced tools, and are proving popular with both clinicians and patients.

At Hora Te Pai Health Services in Paraparaumu, Practice Manager Cherie Seamark recalls, "Susan (Change Facilitator from the HCH team), contacted us and suggested we give it a go." The practice has some 60 or so patients with COPD, and forming the first group was surprisingly easy. "We had at least a 60% immediate take-up," says Seamark, "People were very keen to get aboard."

Says Snooks Forster, one of the attendees, "Cherie mentioned the group consult and I immediately liked the idea. Being Māori, it's easier to share your conditions with a group of other people. If you're hurting, sometimes the tendency is to shut up — 'she'll be right', you know? But when you're all in there with the same problem, it's easier to share."

Seven patients attended the 90-minute SMA, along with GP Chris Fawcett, Cherie Seamark, Robyn Elms (Community Health Worker) and observers from HCH. Says Forster, "I liked it because it was a small group, so there was time for everyone to make themselves heard and understood. I was able to help some of the group with quite basic stuff, but it wouldn't have come out if it weren't for the group sharing."



"Cherie mentioned the group consult and I immediately liked the idea. Being Māori, it's easier to share your conditions with a group of other people."

Snooks Forster, Patient, Hora Te Pai Health Services



Right Place, Right Time

Nestled in the Cannons Creek district of suburban Greater Wellington is the Porirua Union and Community Health Service (PUCHS). This modest practice has a "dynamic team" servicing an enrolled population of some 6,065 patients, of whom 90% are deprivation quintile 5: 49% are Pasifika and 24% Maori. In addition, 11% are refugee families.

PUCHS started their Health Care Home journey in October 2017, as part of the tranche 2 practices. "Ioana Viliamu Amusia, our Clinical Coordinator, and I had been shown around some practices that had implemented HCH," recalls Practice Manager, Hiueni Nuku, "And we were impressed with the service improvement and waste reduction they'd achieved. In addition to a general improvement through applying some of HCH's practices, we had some specific issues we wanted to address for our high needs population. For instance, our DNA (Do Not Attend) rate was somewhere around 40% before HCH, but the various changes we've made around our front desk and phone set ups have seen that drop closer to 10%."

Some of the DNA patients are also contacted by the doctors during their patient phone triage sessions. These occur daily over the first 15 minutes after a doctor starts their day. The aim of this triage is — where practicable — to enable the patient to avoid having to come in. They can do scripts, too. For some of PUCHS most high needs patients, even getting to the practice can be a real challenge, so this service has an added benefit.

Three team members from Porirua Union Community Health Service: Hiueni Nuku (Manager), Ioana Viliamu Amusia (Clinical Coordinator), Jacqueline Ward (Senior Administrator).

Health Care Home’s flexibility gave PUCHS the framework and support it needed to address not only a range of improvements they could make to their services, but also the specific issue of supporting their high needs patients to get the right help, at the right time, in the right place.

Continuity of care for our complex patients is particularly important to the PUCHS team, where possible, the doctors triage their own patients. If they are not available, the doctors will triage other clients in the queue.

Another significant initiative that has taken place at PUCHS following their commencement of HCH can be seen in their efforts to improve appropriate presentation at nearby Kenepuru Hospital’s Accident and Medical (KAMC). Kenepuru lies some 4 km to the west of PUCHS, and had become, over time, the presentational venue of choice for a significant number of PUCHS’ registered patients. This wasn’t doing anyone any favours, least of all the patients themselves, and had long been something that the PUCHS staff wanted to address.

A team, consisting of a number of KAMC staff, PUCHS GP, Dr Simon Saena and Hiueni Nuku, put their heads together and developed strategies aimed at gently but firmly helping re-direct patients, and educating them about where they could best be seen as quickly and effectively as possible.

Says Amusia “Simon (Saena) and I monitor the mobile phone that we carry, the Kenepuru nurses will ring us directly to see if PUCHS have capacity or not. We’ve managed to take from 6 to 15 patients a week in the last few successive months, which is high for our clinic. We’re very thankful for the relationship we’ve developed with the Kenepuru team, which has been invaluable for us both.”



Community Services Integration (CSI)

“We believe that the integration of community teams’ clinical specialist expertise will enable the development and expansion of the HCH model. CSI is a platform that has demonstrated the ability for teams from across the sector to come together around a patient to provide better care,” says Jennifer Chong-Bradley Project Manager for HCH CCDHB.

The CSI started off with District Nurses and Community Allied Health teams establishing working relationships with each of their allocated HCH teams. It has matured with the delivery of hundreds of cases that have been worked through at multidisciplinary team meetings for proactive care planning and troubleshooting, the use of e-tools to support virtual links and skill sharing across the teams.

Says Chong — Bradley, “New teams are being introduced to HCHs through the CSI approach. NASC Care-Coordinators and Palliative Care Co-ordinators are joining the regular multidisciplinary team meetings and other specialists are being linked in for particular patients.”

There are developments underway for additional specialist services to be linked to HCH through this vehicle and expand the network of services that provide care closer in the community.

“CSI is a platform that has demonstrated the ability for teams from across the sector to come together around a patient to provide better care.”

Jennifer Chong-Bradley
HCH Project Manager
Capital Coast DHB



PCPA Peer Group September 2018.

3. Responding to Routine and Preventative Care

PCPAs

The role of Primary Care Practice Assistant embodies Health Care Home’s approach to broadening out the primary care workforce in order to respond to the growing health care needs. This last year has seen these roles really starting to develop at pace, becoming invaluable features of the nursing and wider teams.

At Masterton Medical, Anissa Billington has been working as an PCPA for over a year. She’d been working in Reception there for nine years and was ready for a different challenge, and the expanded role she now plays has been a source of great satisfaction. “There’s more variety, more interaction with both the patients and staff — I love it,” she says.

Meanwhile, at Mana Medical Centre in Porirua, PCPA Hannah Reid came into the role from a different direction. “My background is in nursing. I worked for many years as a Registered Nurse, and I was looking for something new and challenging, so I was delighted when I saw the PCPA role at Mana advertised. My background meant that I was already up to speed in most of the clinical side of things, and the admin side was, initially, where many of the challenges came. The core competencies Health Care Home requires have offered further opportunities to broaden my scope, and brought me new elements to incorporate — co-ordinating the MD team meetings, for example. I love the job and would highly recommend it.”



“My background is in nursing. I worked for many years as a Registered Nurse, and I was looking for something new and challenging, so I was delighted when I saw the PCPA role at Mana advertised.”

Hannah Reid, PCPA,
Mana Medical Centre



“The HappyorNot terminal gives our patients another, more immediate, way to let us know how we are doing. The monthly results are posted on our team board in the staff-room, and we have just begun reviewing weekly results at our management team meeting.

We recently upgraded to the new SmileyTouch terminal, which allows patients to give up to three levels of feedback. This will provide us with more detailed information on their rating of us.”

Wendy Slight
Practice Manager
Newlands Medical Centre



Patient feedback kiosk at Victoria Student Health Centre Mauri Ora.

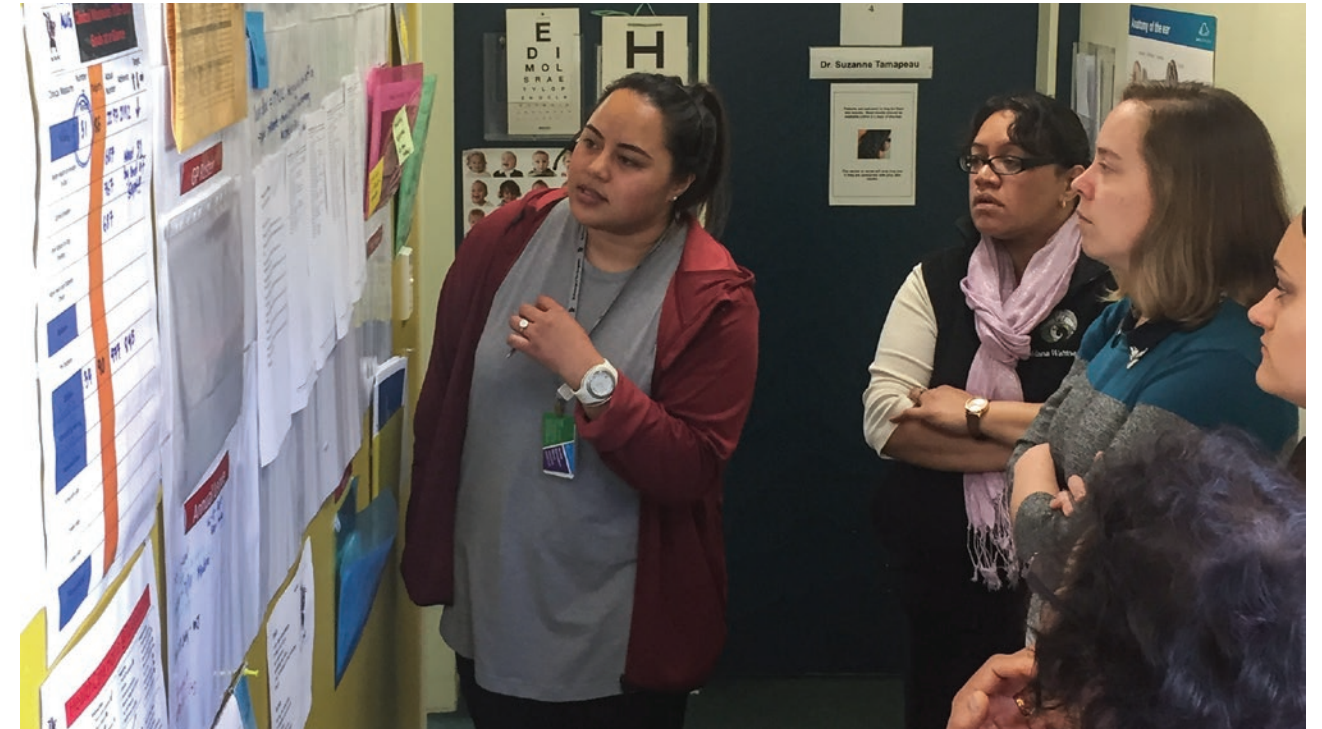
Patient engagement framework

Integral to the Health Care Home (HCH) model of care is that patients, their whānau and family are at the heart of health service delivery and design in General Practices.

A practical guide for practices was developed this year — The Patient Engagement Framework (PEF) — to support practices.

It outlines four levels of attainment for patient engagement, along with examples of activities at each level.

It’s a toolkit to inform practices of the options and processes associated with establishing a patient engagement strategy/ programme. “We’ve found it a useful toolkit” says Kevin Rowatt, General Manager for Student Health Service at Victoria University. “Our students are responding really well to some of our new initiatives, like the HappyorNot patient feedback terminal.”



Huddle at Ora Toa Health Services.

4. Maximising business efficiency

Huddles

Huddles — or Stand Ups, as they’re sometimes known — have enjoyed near universal acclaim from practices that adopted them over the last year. These short, focussed meetings, commonly held just before the working day starts, are conducted standing up, usually in front of a board. They last just a few minutes and are intended to include all staff working that day. The huddle is a hit, it seems, wherever it’s been introduced.

At Whitby Medical Centre, Practice Manager Miranda Wassenaar says that the benefits are real, if not necessarily obvious. “When you have a group of doctors, nurses and administrators together there’s certainly a theoretical cost implication, even if it’s just for a few minutes,” she says, “But the gains made in terms of staff happiness, team spirit and improved communications more than offset this.”

Newtown Medical Centre in Wellington only introduced the huddle last April. Dr. James Parsons, a GP at the Centre, says of their introduction, “It was very easy to set up — it took only about a day’s worth of preparation. We anticipated some degree of resistance, but that just didn’t happen because the benefits were so immediately apparent. It’s a great way to set ourselves up for the day. It’s very short — just 5 or 10 minutes at the most — and people arrive when they can and leave if they have to. But it really pulls the day ahead into focus.”



“It was very easy to set up — it took only about a day’s worth of preparation. We anticipated some degree of resistance, but that just didn’t happen because the benefits were so immediately apparent.”

Dr. James Parsons, GP,
Newton Medical Centre

LEAN in a New Zealand cultural context — it works!

Primary Health Care
Compass Health is a Primary Health Organisation that provides primary care services to over 300,000 patients across the greater Wellington region in New Zealand.

Health Care Home Kāinga Hauora
New Zealand's Health Care Home Model of Care enables primary care teams to deliver an improved, more personalised patient experience. Our commitment to work alongside practice staff is based on mutual respect — to eliminate waste for patients and staff.

Our Challenge
Interweaving LEAN principles and ensuring Māori cultural values are not compromised
Implementing LEAN initiatives within health care services and business systems to achieve better health outcomes for indigenous people

Our Approach
We work at the Gemba with practice staff developing LEAN programmes and applying LEAN to drive enhanced benefits — eliminating waste in healthcare utilisation by patients and saving staff time/resource.

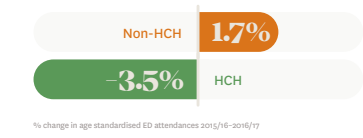
Key Learnings
Partnership is crucial and relationship is key
Leading with LEAN principles is paramount to success
Practices own their programme and are supported by LEAN practitioners to implement and embed the change
LEAN Leadership within the practice is an important component of the change process



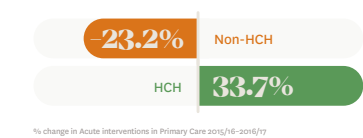
Māori
Māori are the indigenous peoples of New Zealand. They comprise of many tribes arriving in New Zealand by canoe, between 1250 and 1300 AD.

The Treaty of Waitangi
The Treaty is the founding document of New Zealand. It was signed in 1840 by the British and Māori chiefs. The Treaty principles underpinning the work we do in health are Partnership, Participation and Protection.

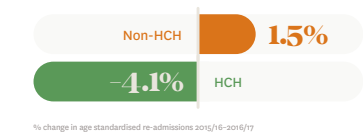
Our results
Emergency Department attendances
3.5% decrease for HCH practices, patients are increasingly less likely to attend ED.



Acute interventions in Primary Care
Increasing over time for HCH practices. More patients are receiving acute interventions, reducing acute hospital attendances.

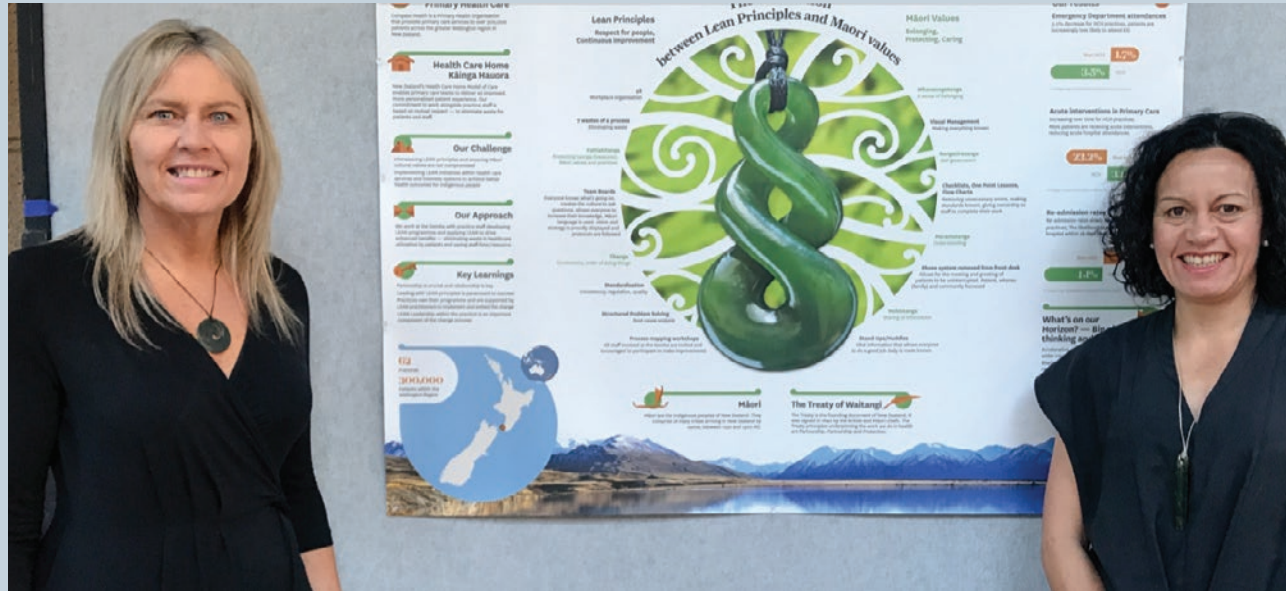


Re-admission rates
Re-admission rates slowly declining for HCH practices. The likelihood of patients returning to the hospital within 28 days post discharge is reduced.



What's on our Horizon? — Big picture thinking and sharing
Acceleration of our delivery within NZ, ensuring a wider coverage and reach
Sharing our approach and learnings with healthcare organisations globally





Melissa Simpson (left) and Jo Henson (right) presenting their poster at Lean Healthcare Academic Conference 2017.

Lean

Lean methods have been baked into HCH from the outset, and Lean has continued to inform our work over the last year. Its methodology has been applied to healthcare around the world, and in September last year a small group from Compass Health and its HCH team headed out to Stamford University in Palo Alto, California, to the Lean Healthcare Academic Conference. Here, healthcare practitioners from around the world presented, shared and discussed the ways in which Lean has informed and benefitted their work.

Melissa Simpson (Programme Lead, HCH) and Jo Henson (Change Facilitator) presented their Kiwi take on Lean, and its potential congruence with Māori beliefs and practices, as a poster — a standard means by which a story can be succinctly presented in a readily digestible form. This poster, and the original and intriguing ideas it showcased, proved the surprise hit of the conference, ultimately winning the team the People's Choice Award for Best Poster, beating out 59 other international entries, and maintaining NZ's reputation for world-beating work.

Says Henson, "Melissa and I have been implementing Lean for some time now. We found ourselves working with it increasingly in kaupapa Māori practices — those practices that have a deliberate, specific focus on incorporating Māori values into their work. We began to notice a high degree of alignment between Lean principals and kaupapa Māori values, a synergy that helped us to better partner up. We felt that our experiences in Aotearoa would make for an interesting topic at the conference, but they asked if we could present it as a poster.

Translating our brief abstract into a visually arresting poster proved to be quite the challenge, not least because the elements we were trying to convey were so culturally different from anything in America, or anywhere in the world."

"To be able to find Lean examples that match, without diminishing or taking away from the Māori concepts, was crucial," continues Henson, "And in addition, we also had to convey a little of Health Care Home in NZ, a bit of history — we even managed to include some of the early data we getting back from HCH practices. There was a lot to fit in."

"We began to notice a high degree of alignment between Lean principals and kaupapa Māori values, a synergy that helped us to better partner up."

Jo Henson, Change Facilitator, Health Care Home



Dr Dave Pickett, Courtenay Medical

Value stream mapping

More and more of our practices are seeing the benefits of holding process mapping workshops. In this exercise practices begin to understand and see wastes (rework, duplication, double-handling, lack of standards or standards are flawed). The biggest value that practice staff are gaining from the process mapping exercise is understanding the impact of the work that they do and how this contributes to their teammates who are also participating in the process. An add-on and essential part to the work is then understanding the root cause of the waste they are experiencing.

"A liberating facilitated workshop where participants in the same workplace learn to reveal the truth, the frustrations and successes, and eventually the waste detail within our system. We focused the Lean lens without distortion and can see where to look next in a disciplined respectful manner. The "Hubble telescope" of Lean."

Dr Dave Pickett
Courtenay Medical

6.

A snapshot of our findings in the second year

The purpose of collecting data is to demonstrate system impact of the Health Care Home model of care and — particularly in the early days — to support and steer individual practice and programme improvement to ensure our efforts were focussed on the right activities.

As part of our Health Care Home roll out, we agreed a core data set of measures to track the impact of some of the changes the practices were making, full details of which can be found in the appendices.

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, 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) and uptake of the patient portal.

These early findings are encouraging, indicating that the Health Care Home model appears to have a positive impact on both primary and acute health care systems.

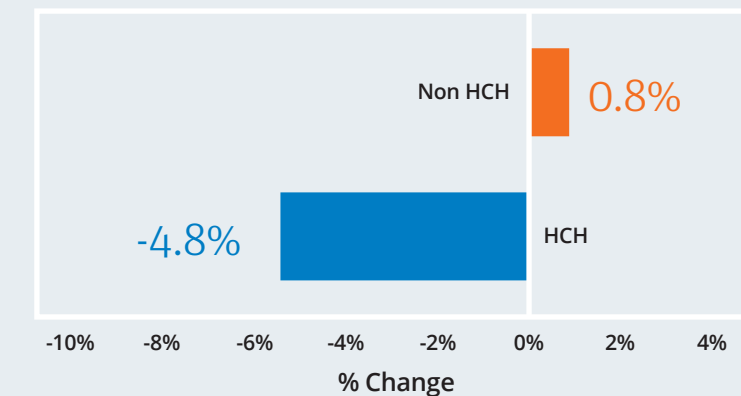
We've tracked the same group of practices from last year who cover a population of 42,000 patients. Following is the data set that demonstrate their achievements to date.

Acute admission

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

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

Age Std. Acute Admissions (2015/16 to 2017/18)

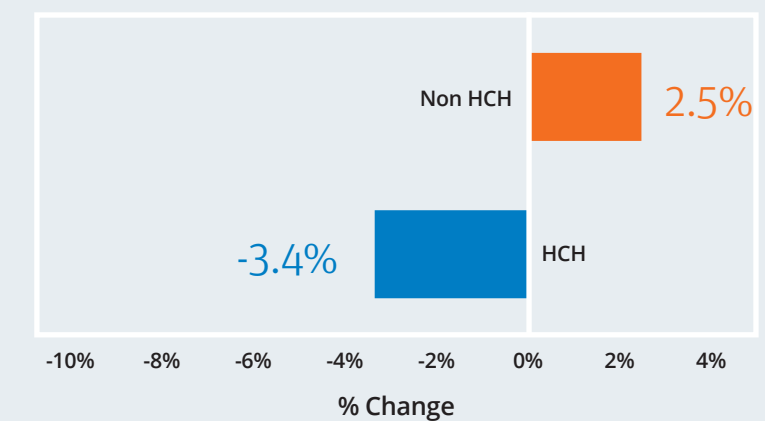


Emergency Department (ED) attendances

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

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

Age Std. ED Attendances (2015/16 to 2017/18)



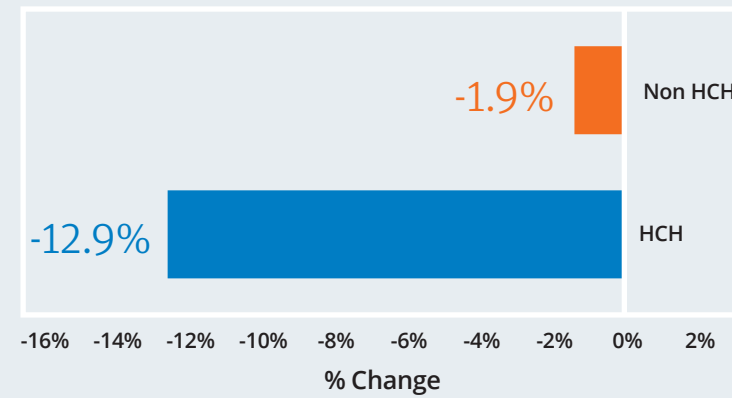
Hospital re-admissions

Likelihood of a patient returning to the hospital after a medical/surgical discharge is reduced for patients in HCH practices.

Re-admission rates declining for both HCH practices and non-HCH practices

12.9% rate decrease for HCH practices vs.
1.9% rate decrease for non-HCH practices

Age Std. Re-Admissions (2015/16 to 2017/18)

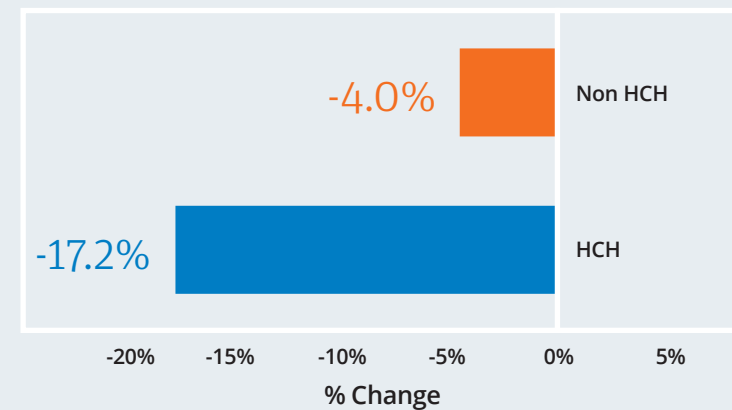


Ambulatory Sensitive Hospitalisation (ASH)

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

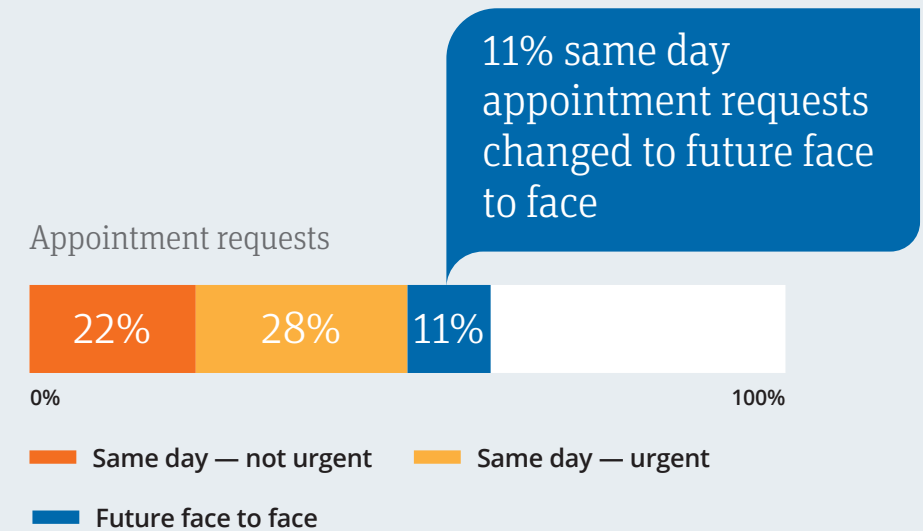
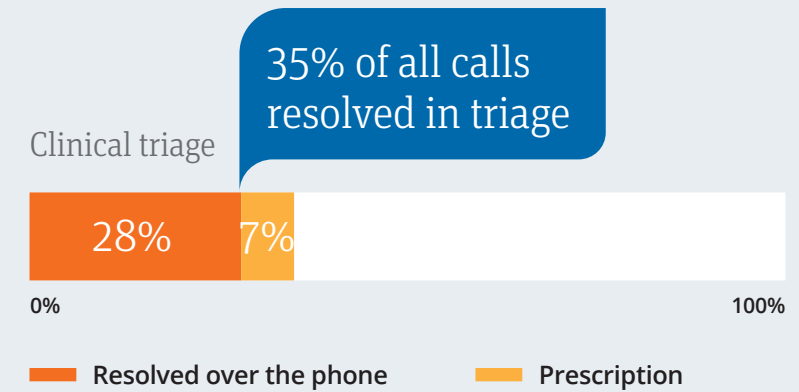
17.2% rate decrease for HCH practices vs.
4% rate decrease for non-HCH practices

Age Std. ASH Rates (Monthly Rolling) (2015/16 to 2017/18)

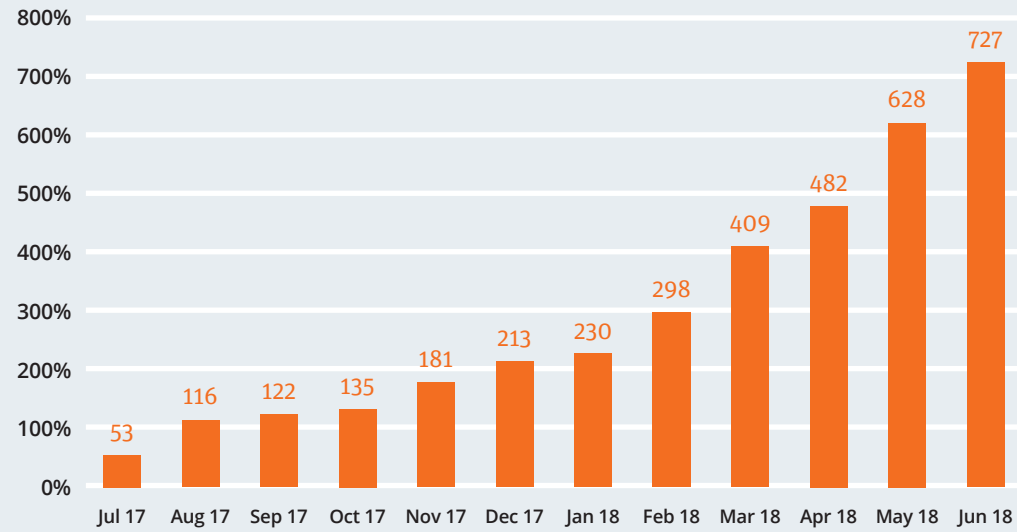


Lower overall ASH rates for patients enrolled in HCH practices

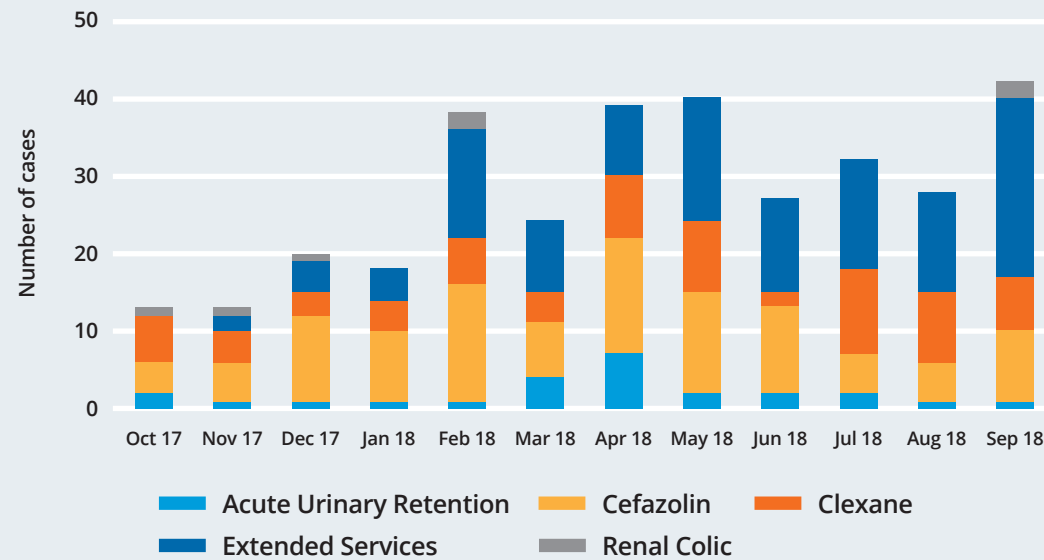
KPI data for clinical triage



Number of YoC plans

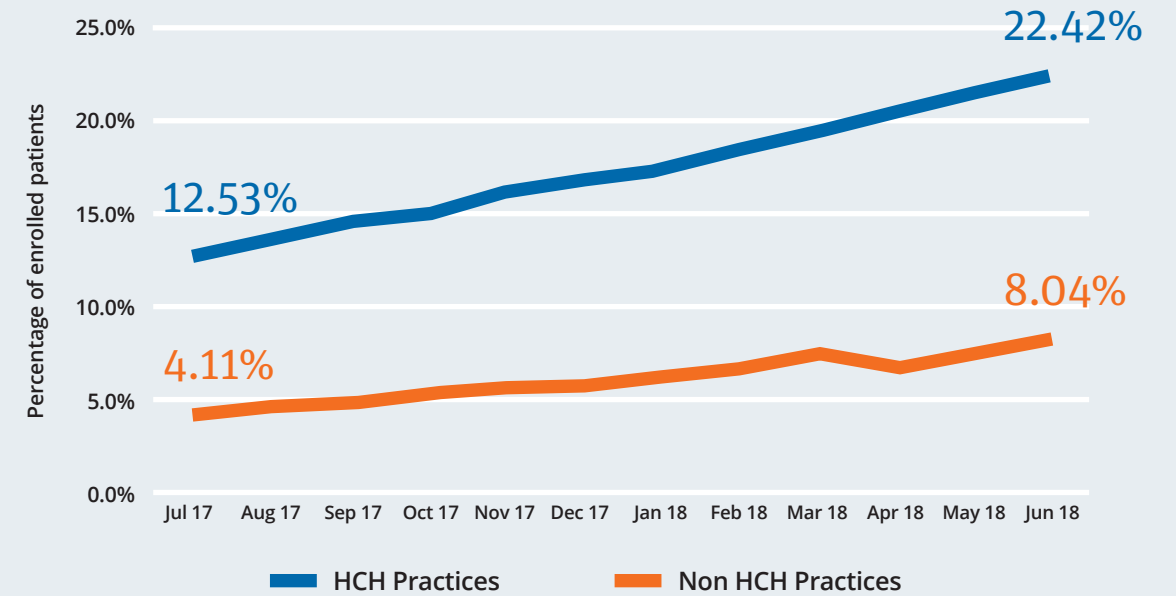


POAC cases by month



Patient Portal

Percentage of enrolled patients with activated patient portal access



The Patient Portal has completely changed the way I interact with my Practice – it's fantastic.

7.

Reflections and insights



Mabli Jones, GM Service Development, Tu Ora Compass Health



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



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

It's been another remarkable year for the Healthcare Home Team, twelve months that have seen growth in the number of practices enrolled, continued development of the model within practices already on board, and the planning and introduction of innovative service improvements and ideas that look to the future.

With the support and funding of the CCDHB, Tū Ora Compass Health Care Home development team have continued to work closely with practices to move from the traditional general practice to the Health Care Home model.

As we did a year ago, we spoke with Melissa Simpson and Mabli Jones from the team at their offices in Tū Ora Compass's Wellington headquarters — joined this time by Astuti Balram from the CCDHB — to find out what new experiences and lessons the second year or so of HCH implementation have given the team.

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

Mabli Jones (MJ): This year has been busier for us because we're holding more practices in the programme.

We ran the gamut, from practices who are just onboarding and are very new to the programme, all the way through to practices that are just entering Year 3 and have been working with the model for over two years.



Rob Stewart, Business Manager
Johnsonville Medical Centre.

We're thinking through how to flex our approach with practices at various stages, and of course it will get slightly more complex this year with the extra 14 practices coming on board — the 3rd tranche.

Supporting practices at all these very different stages has been one of the biggest challenges for us as a change team, and we've done a lot of thinking around that.

Astuti Balram (AB): I agree that it has felt quite busy. With the whole approach, one thing that has been very different is being able to utilise what we've learnt and apply it to improve our processes.

Also, building confidence and growing the model have been important, and how we continue to maintain interest has been a big focus, too.

There's been a real mind-shift from Tranche 1 and Tranche 2. Tranche 1 was introducing a largely new concept, Tranche 2 was embedding it and saying, 'what else can we do in terms of development within the community?' Before, we were concentrating on change, but now we're having to show impact. We have to show that HCH is actually making a difference.

Melissa Simpson (MS): Another change from last year to this year has been the use of technology, particularly Zoom, which has facilitated a switch to virtual MDT meetings rather than face to face. This is helping the community services teams logistically, for as we grow our HCH practices in numbers, they physically can't get around to every practice's MDT. So, focussing on working smarter — that has been a change.



Dr Jeff Lowe, Dr Peter Moodie and Practice Manager Lyn Allen — Karori medical centre receiving Health Care Home certification.

Q: Have you been doing that a lot?

MS: Yes. The first six practices are now having monthly virtual MDT meetings, which means they can invite different teams into the meeting, without the physical need for them to be in the building.

Q: Data was mentioned last year 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. Can you talk a bit more about how that's been progressing?

AB: I guess what we've been working on together now is to review what the data is beginning to demonstrate, and to make sure that, as a system, we are all looking at some shared data sets.

What we do want to show with the changes we're implementing is that we're having an impact, not just for our overall population, but particularly for our high needs population.

So, in terms of data maturity, I think we have made some positive improvements. We've completed a piece of work with the Productivity Commission which is interesting and shows that

there has been a statistically significant impact on reduced ED attendances for our HCH practices, as compared to non-HCH. This gives us another level of data robustness, and we need to build on this.

MS: We've also increased the suite of data sets available to the practices. Through the Practice Portal, we're getting closer and closer to as much real time data as possible. One of the additions we introduced recently was patient wait times in the practice, which the teams find interesting.

MJ: I agree: the more data you give practices, the more they want data. There is this 'no story without data, no data without story' mantra. We are lucky, in that we have great data available for our practices, and they can self-service and access it through the Practice Portal. What we have experienced is this absolute hunger for data. Once practices start to see it, they want to share it on their team boards, and they want more of it — the data starts to drive the conversation.

Q: This data you're referring to — does it stay within HCH, or is it shared further afield?

AS: We have shared widely, because there's a real interest at every level, both in the overall change for practices and on its impact on the wider system.

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

MS: We touched on this at our recent HCH Open Day. I think building strong relationships with the practices is still one of the fundamental successes of the programme. Even though we've got 21 practices in the programme currently, we still manage to spend a lot of time undertaking bespoke work with individual practices who require some additional support. Having regular contact with the practices and building up that trust over time is one of the key successes of the programme.

MJ: For me, trust is a central feature of our programme, because we have a strong relationship with CCDHB and the other two PHOs, Ora Toa and Cosine, there's a high-trust environment, therefore we can innovate and take the occasional risk.

The practices hopefully trust us, and they trust that the change process that they're going through, while it won't be without its pain points, will be okay in the end. The DHB support us and take an evolutionary and developmental approach within the parameters of an agreed framework.

AB: Yeah, we're all on the same journey so we must work together, and I think the best way to do that is being open and honest. Without that trust, you wouldn't be able to drive change at the pace we are going. In terms of partnership, I think that's the first thing you need.

Q: Peer reviews for practices were also mentioned last time. Would you say that communication between the practices has improved?

MS: Yes, and that refers both to communications within the peer review groups, and also informal conversations that practices have between themselves, outside of anything that we have organised here. They seem to be getting more confident about reaching out to each other and helping to pro-actively share their HCH learnings and inviting in other services to be part of HCH activity.

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

MS: It's going to be a fast and furious next twelve months! There are lots of exciting things on the horizon.

I'll think we'll see the use of technology continue to grow and develop — a lot of our practices are investing in patient self-check-in kiosks, patient feedback tools and self-monitoring kiosks, so patients can take their own BP, weight etc, when they come to the practice.

The continued growth of the patient portal gives patients the ability to communicate with their practice in new ways, to view their clinical records, book their appointments, secure message their clinical team. Tū Ora Compass Health Care Home practices have the biggest uptake in the patient portal in New Zealand right now!

MJ: We're looking at new ways of consulting with patients with long term conditions. Having longer, shared medical appointments or group consultations with 8-10 people at a time rather than individual 15-minute consults, particularly for those with long-term conditions, will be a feature in the coming year.

AB: We'll be looking at increasing the range of services that can be plugged into general practices in the coming year through the community service integration programme and testing new ways of delivering specialist outpatients appointments to patients — building on the trial we had with paediatrics this year, when we tested the use of virtual appointments.

Q: By the end of Year 3 you're going to have 42 practices in the programme?

MJ: Well, 35 here and 7 in the Wairarapa. It's worth mentioning that, due to the success of the CCDHB roll out, Wairarapa are now moving forward with their own programme.





Raumati Road Surgery team members receiving Health Care Home certification.

Thanks first to all the practices for all their work and the good faith with which they've gone into the HCH programme.

Q: Any thanks or last words?

MJ: Of course. Thanks first to all the practices for all their work and the good faith with which they've gone into the HCH programme. Thanks, too, for all the open sharing of both their successes and challenges — and for allowing us to pinch their best ideas and spread them rapidly at scale!

We also really need to thank the Community Services teams, because for them it's been a huge change as well. It's not just a lot of work for the practices, but the community services folk are having to reorganise themselves, having to think differently, having to get used to new technology, and having to respond in different ways.

MS: We should also mention the extended practice teams — how Primary Care Practice Assistants and Clinical Pharmacists are now pretty much embedded in most of our 21 practices. To begin with, we were testing the role of Primary Care Practice Assistants. We've seen them becoming embedded in practices as fundamental and indispensable members of the team. In addition to that are the Clinical Pharmacists, who are now attending MDT meetings and doing more medicine concordance and prescribing with the patients — having more and more patient contact.

AB: It's also worth talking about the wider workforce, and how the HCH model is changing the look and feel of general practice. I know that in some people's views it's a very General Practice-centric model, so it would be good to acknowledge how this has really evolved over the last year to embrace the community services teams — it's been a real step forward.

Looking forward

8.

CCDHB's continued investment in primary care, at a time when resources are significantly limited, shows both foresight and leadership.

It supports one of the key design principles of the programme — that primary care is the foundation of any successful health care system. We need to build on good, traditional general practice to ensure it is sustained — this change is transformational.

The faster roll out of the programme will achieve coverage of 80% of the enrolled CCDHB population by the end of 2019. Māori and Pacific Island patients make up in the region of 75% of this overall number. The importance of accessible, strengthened General Practice is even more vital for these communities.

In the coming year, we will have an increased focus on equity as part of our data collection, in order that we can truly understand the impact of the Health Care Home programme, particularly for high needs patients.

We will, of course, continue to gather stories from our patients and staff. Capturing the human impact of the changes that are being made is imperative.

We look forward to learning from other areas in New Zealand where the Health Care Home model of care is being rolled out and, in turn, to sharing our story as it evolves and grows.

Appendix 2 – Health Care Home model of care

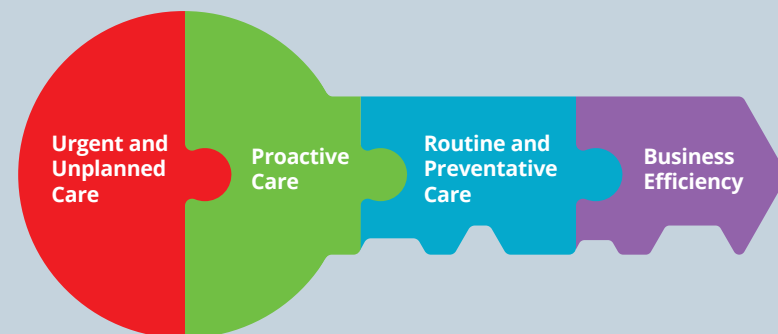
The Health Care Home Model of Care (HCH) was created to enable primary care to deliver a better patient and staff experience, improved quality of care, and to function with greater efficiency.

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 needs.
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 opposite.



Health Care Home model of care service elements ¹

- | | |
|---|---|
| <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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

Appendix 3 – Health Care Home National Dataset: Inaugural Measures

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

13. Age standardised Nurse Consultations per 1000 enrolled patients
14. Percentage of patients seeing their own GP
15. Average number of different clinicians seen over the last 10 visits
16. BMJ measure: percentage of consults with the GP seen most often over the 24month period
17. Percentage of DNAs at hospital FSAs
18. Partners in Health Scale — change in average score over time
19. % of high needs patients with a care plan and named coordinator

Routine and Preventative Care

20. Number of patient inbound secure messages through patient portal/1000 adults
21. No. of virtual (telephone/video) planned consults as % total consults
22. Patients with activated patient portal access per enrolled population
23. % of patients that have access to own notes (PHO measure)
24. Smoking quit rate
25. Dropped call rate
26. Patient experience survey scores
27. Wait times in the practice (post appointment time)
28. Time to 3rd available appointment
29. Percentage of DNAs at the practice

Business Efficiency

30. Practice team climate survey results
31. % Room utilisation for clinical interactions
32. No of aged standardised patients enrolled per GP FTE
33. No of aged standardised patients enrolled per Nurse/ FTE
34. % of enrolled population who leave during the year
35. Staff turnover
36. Sick days per FTE per year
37. Total phone calls per 1000 per month

Health Care Home Partners in the Greater Wellington Region



