
HEALTH CARE HOME
COLLABORATIVE

What we will cover:

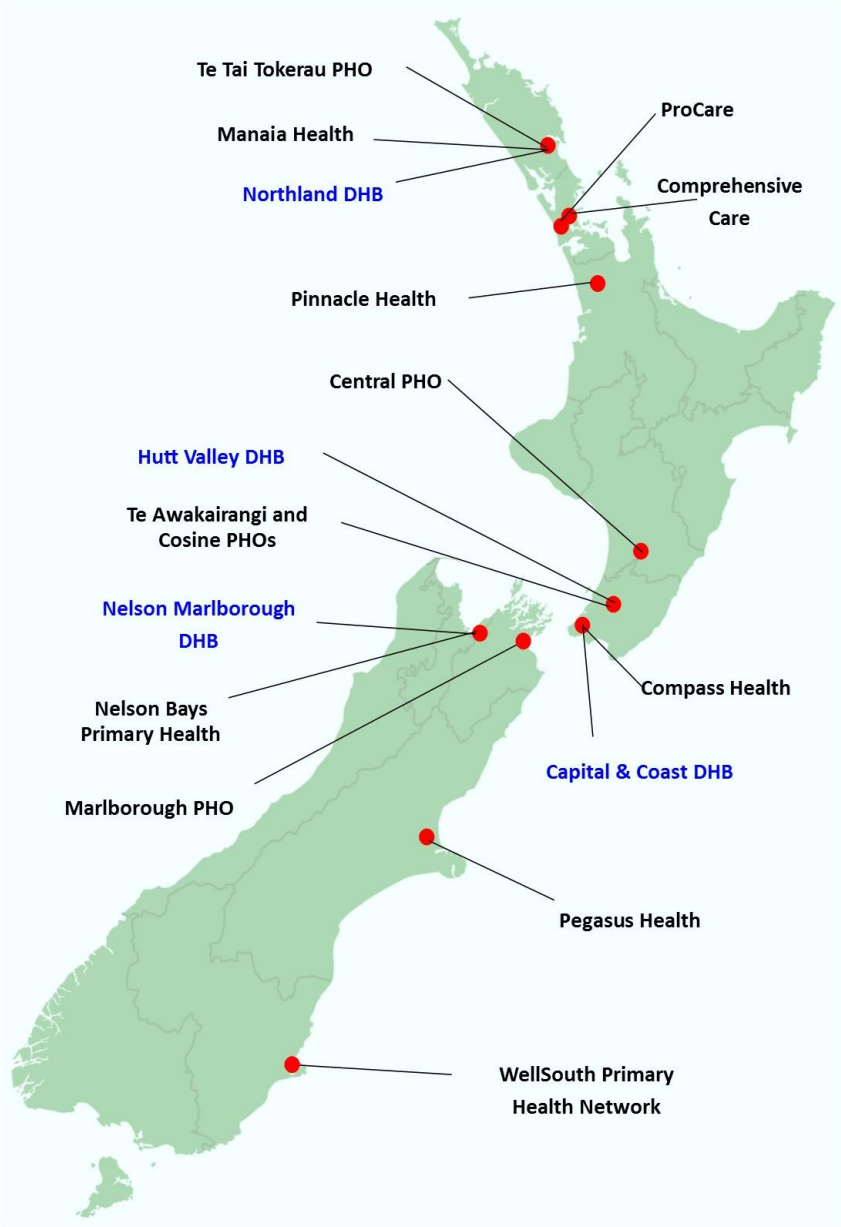
- HCH Collaborative – Members
- HCH Model of Care – What & Why
- HCH Collaborative - Focus areas
- HCH National Dataset – Update
- HCH early evidence / outcomes

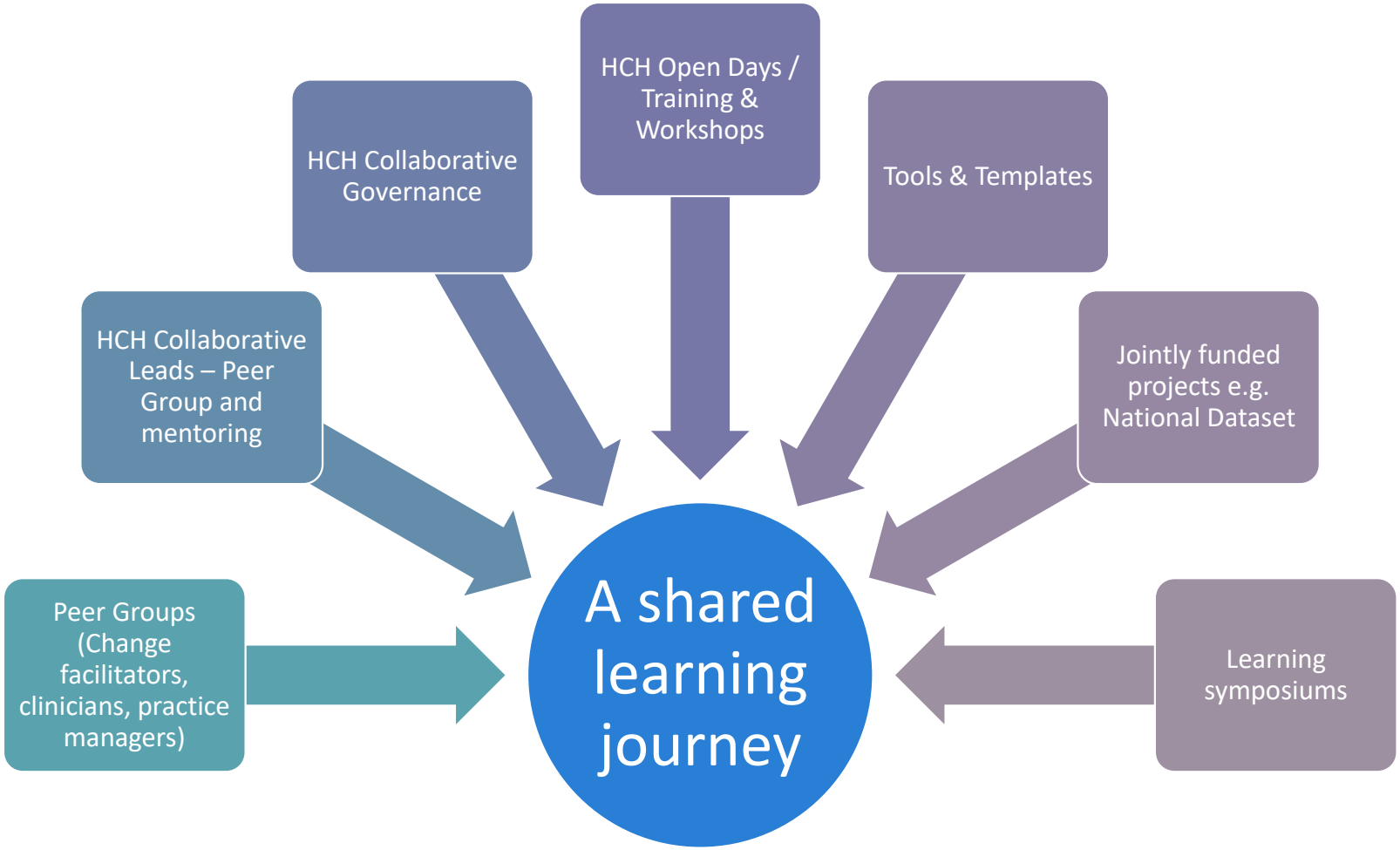
The HCH National Collaborative Group - Members

- ProCare
- Pinnacle Health
- Compass Health and Capital & Coast DHB
- Pegasus Health
- Northland DHB (including Manaia Health and Te Tai Tokerau PHO)
- Central PHO
- Hutt Valley DHB (Te Awakairangi & Cosine)
- Comprehensive Care
- Nelson Marlborough DHB (including Nelson Bays Primary Health and Marlborough PHO)
- WellSouth Primary Health Network

Supporting organisations:

- *GPNZ*
- *RNZCGP*
- *DHB National CEO Group*




HCH Open Days / Training & Workshops
HCH Collaborative Governance
Tools & Templates
HCH Collaborative Leads – Peer Group and mentoring
Jointly funded projects e.g. National Dataset
Peer Groups (Change facilitators, clinicians, practice managers)
A shared learning journey
Learning symposiums

Health Care Home Model of Care Requirements

4 key 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 and Sustainability

http://www.healthcarehome.org.nz/Model-of-Care-Requirements

Reasons for a new Model of Care

- Aging population → greater demand for complex health care services
- Aging health workforce → shortage of supply
- Hospitals are going to become unaffordable given the growing trends
- Increasing number of unstainable small and/or VLCA practices
- Changing expectations from patients regarding how they access care

- https://drive.google.com/file/d/0B5NmvuMDTwU0blFNeFFreDZpeGM/view

Aspects of the Health Care Home (Chris Fawcett GP)

HCH sign-off process

- Implementation plan to achieve HCH indicators at level 4
- Providing GP triage and alternatives to face-to-face consults
- Same-day appointment available
- Call management
- Extended hours
- Patient portal in place

- Credentialing criteria
- Population stratification and proactive care planning introduced
- Progress in all four domains

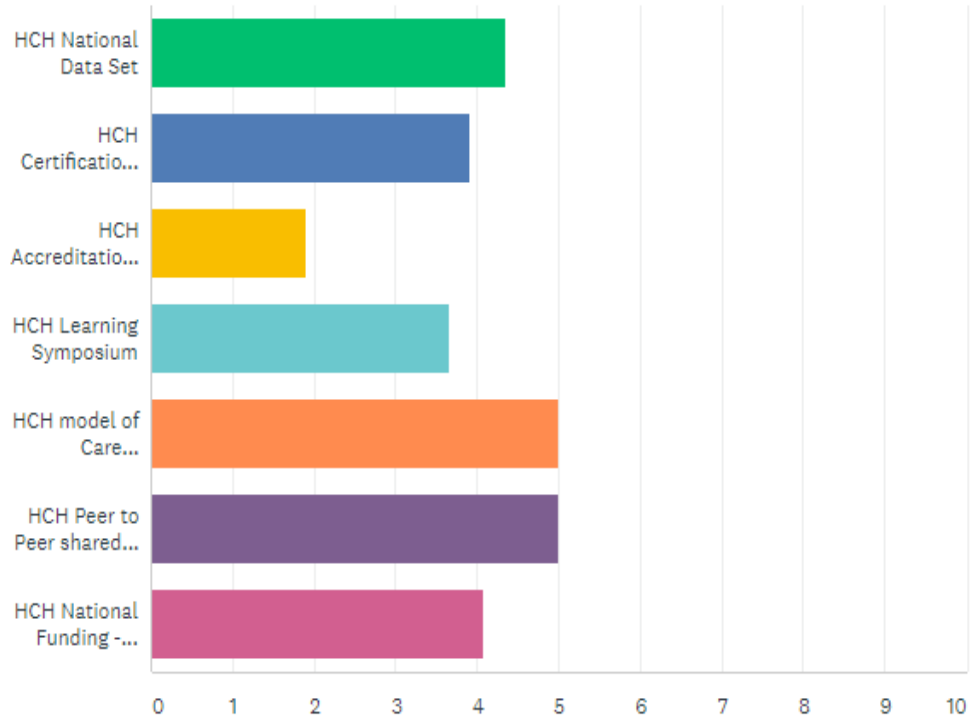
What is the HCH Collaborative focusing on?

Q4

Customize Export

What areas of focus should the HCH Collaborative prioritise (Please rank the following options)

Answered: 12 Skipped: 0



National Dataset update

HCH National Dataset

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

HCH National Dataset Progress

Working Group define and prioritise the 37 HCH measures

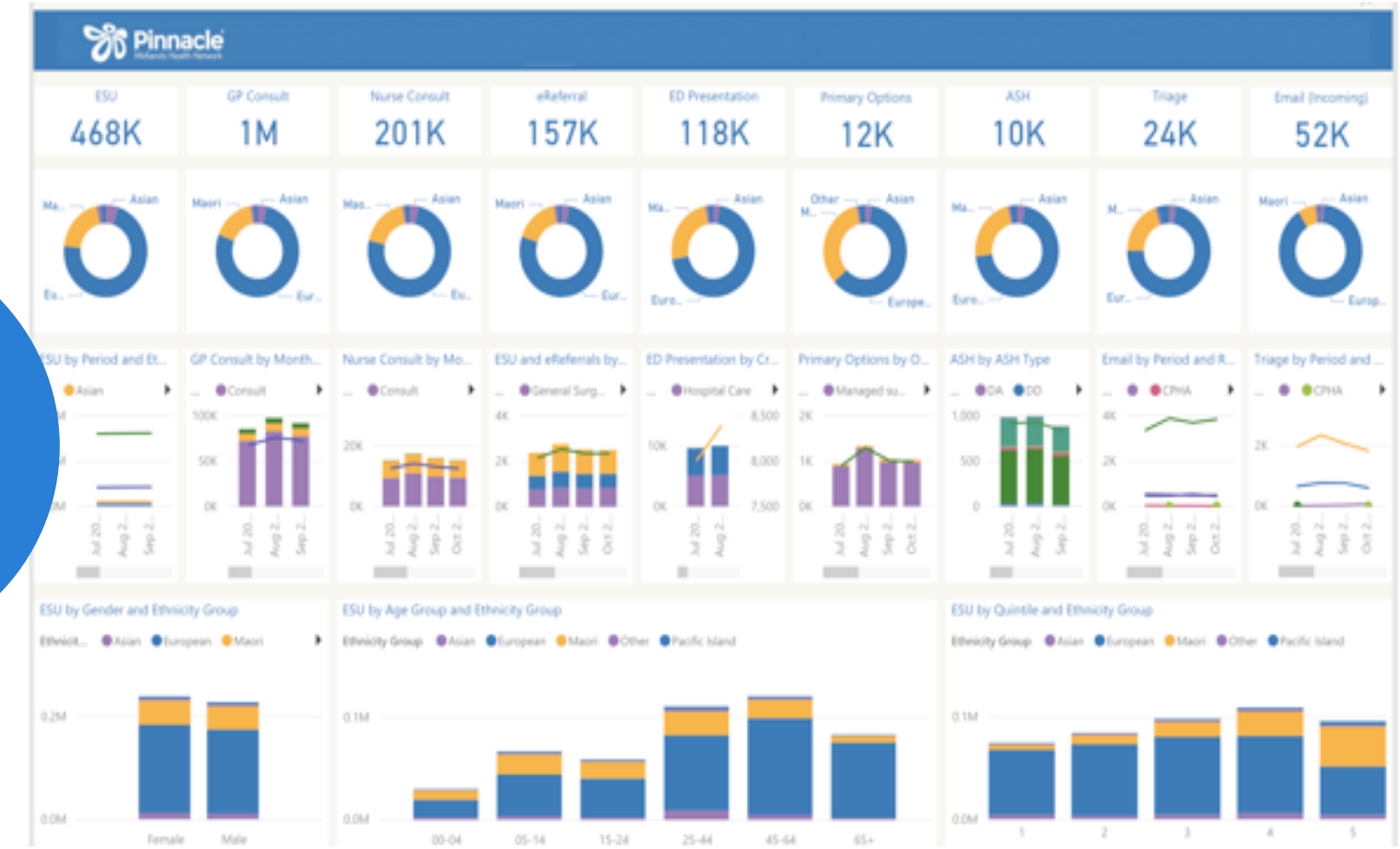
Representatives from member PHOs – Technical Leads ProCare and Pegasus

Proof of concept for priority measures – aggregated data from Compass and Pegasus

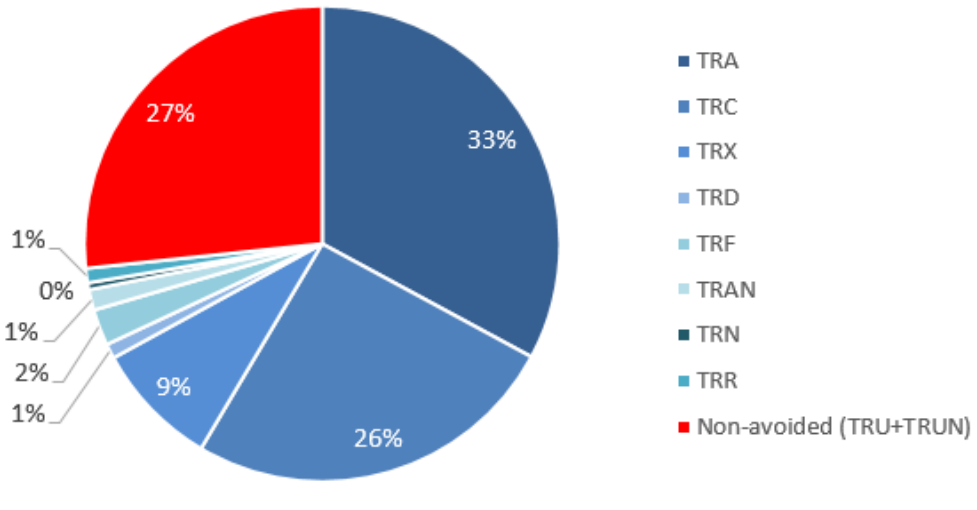
Request for consistent data feeds from MoH has been agreed

Set up of a Data Central Unit (Ventures) propose to stand up and operate a data store, to be used for Health Care Home Collaborative (HCHC) member benchmarking and analysis

Ventures example Dashboard



HCH early evidence and outcomes by domain



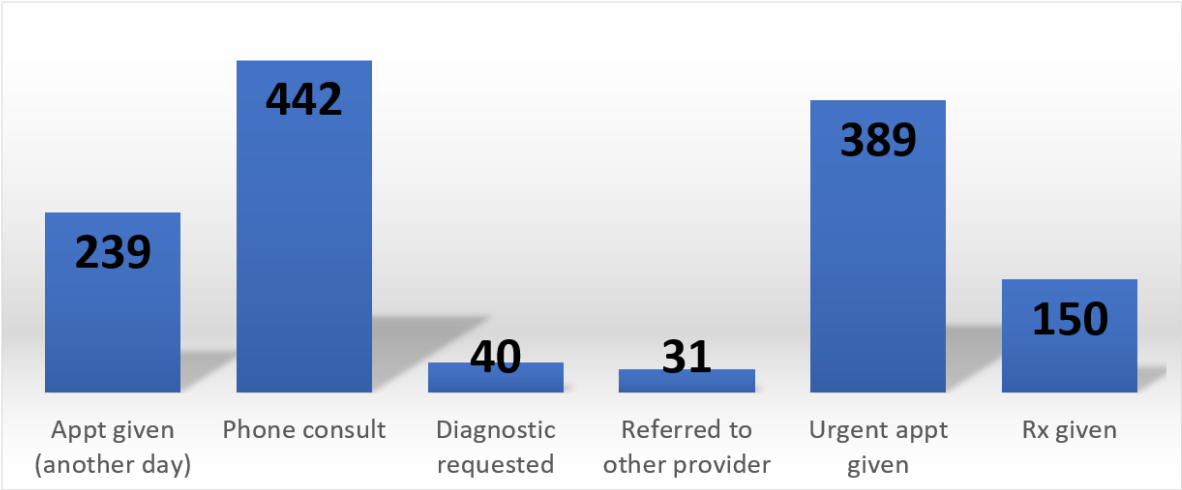
Service Code	Service	Count of Services	Percentage
TRA	Triage Appointment	6462	33%
TRC	Triage Call	5035	26%
TRX	Triage Call - Script	1676	9%
TRD	Triage Diagnostic	197	1%
TRF	Triage Future Appointment	484	2%
TRAN	Triage Nurse Appointment	275	1%
TRN	Triage Nurse Referral	92	0%
TRR	Triage Referral	193	1%
Non-avoided (TRU+TRUN)	TRU+TRUN	5237	27%
Total		19651	100%

Urgent & Unplanned Care

(triage outcomes from Capital & Coast region)

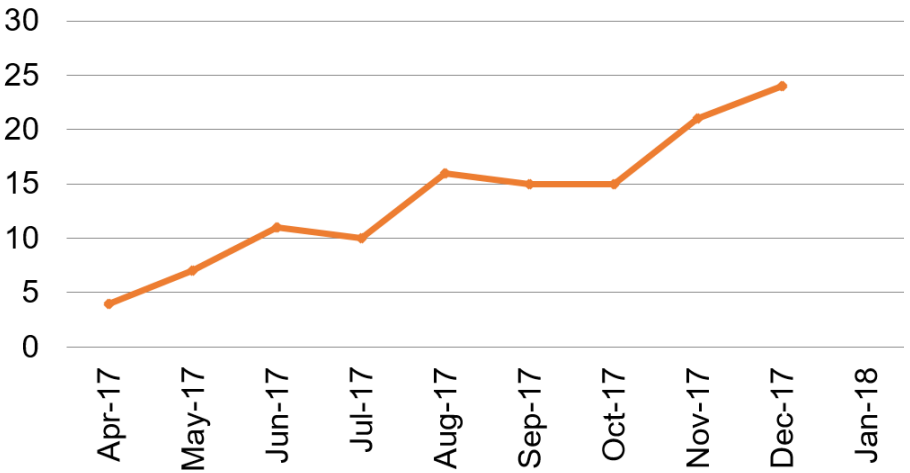
Urgent & Unplanned Care

GP Triage – 1,291 triaged since September 2017

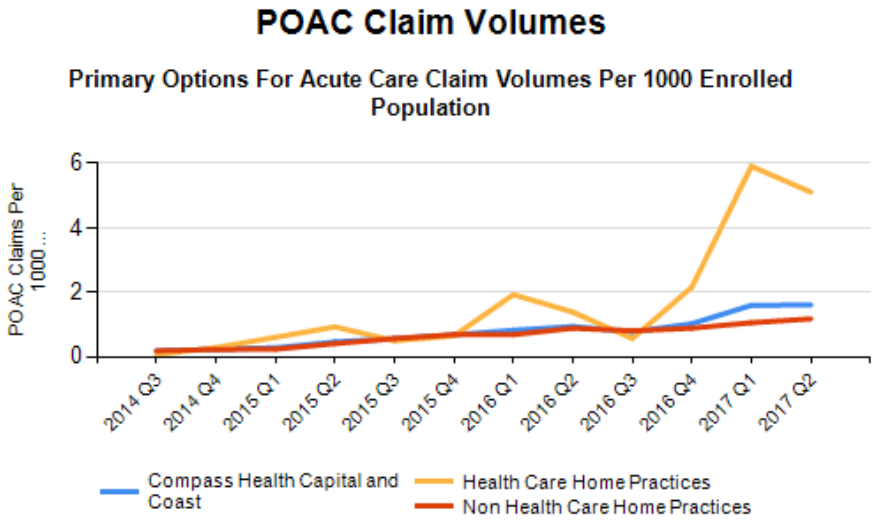


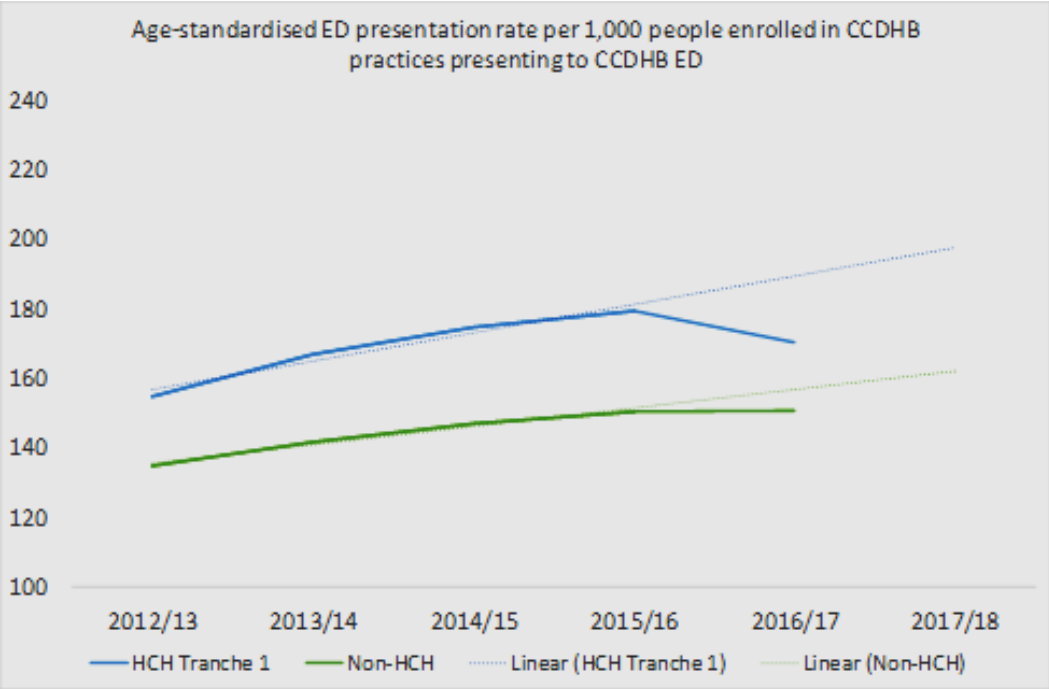
(Data from a practice at Central PHO Health Care Home since 2017)

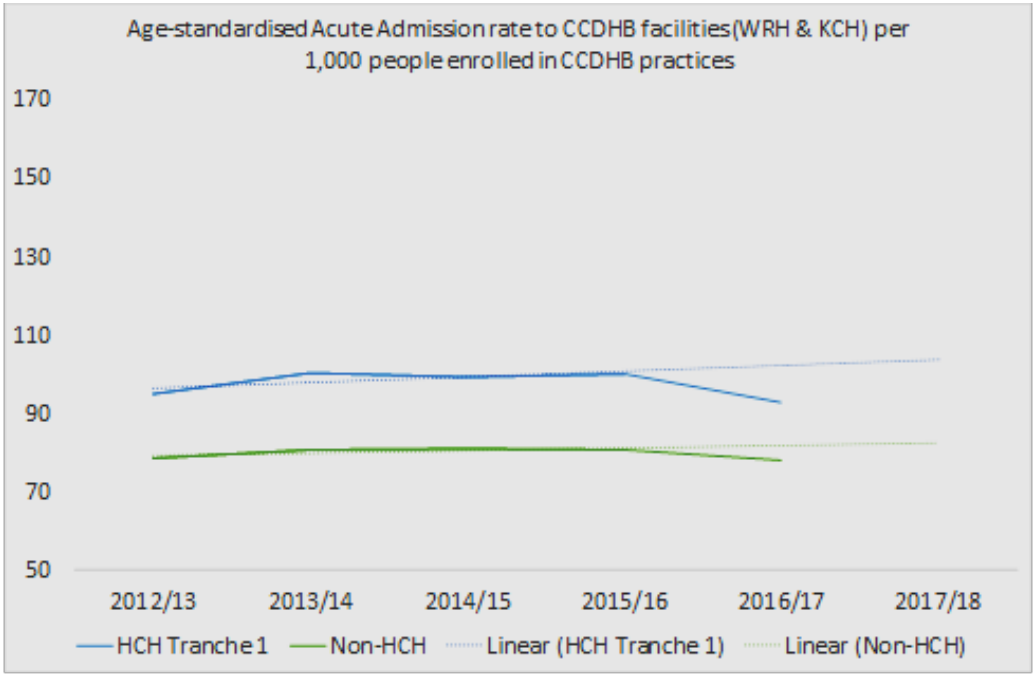
Primary Options to Acute Care



Feilding Health Care, Hauora Tangata





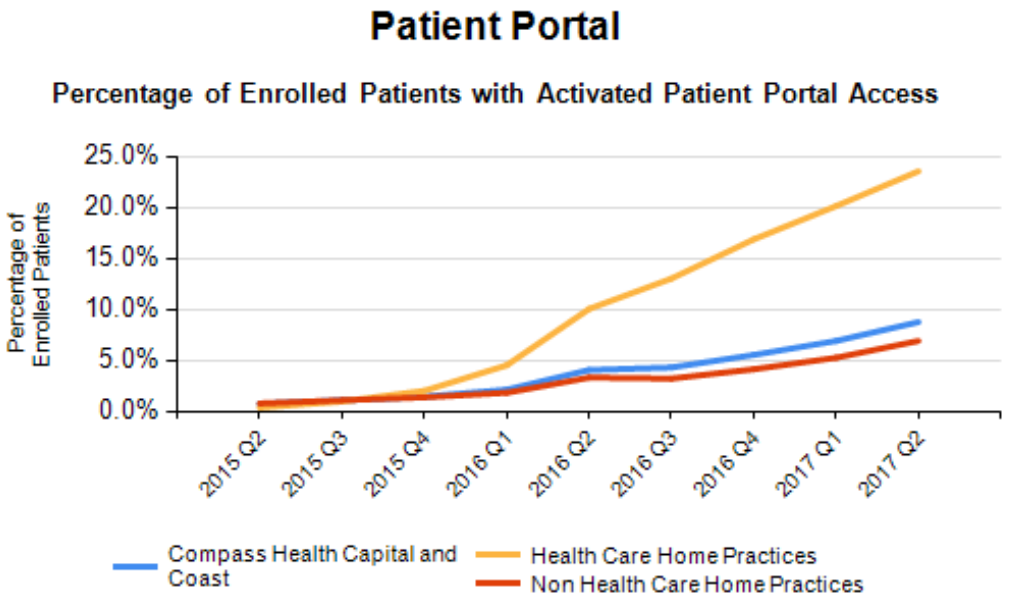


Positive effect on the hospital

Proactive Care

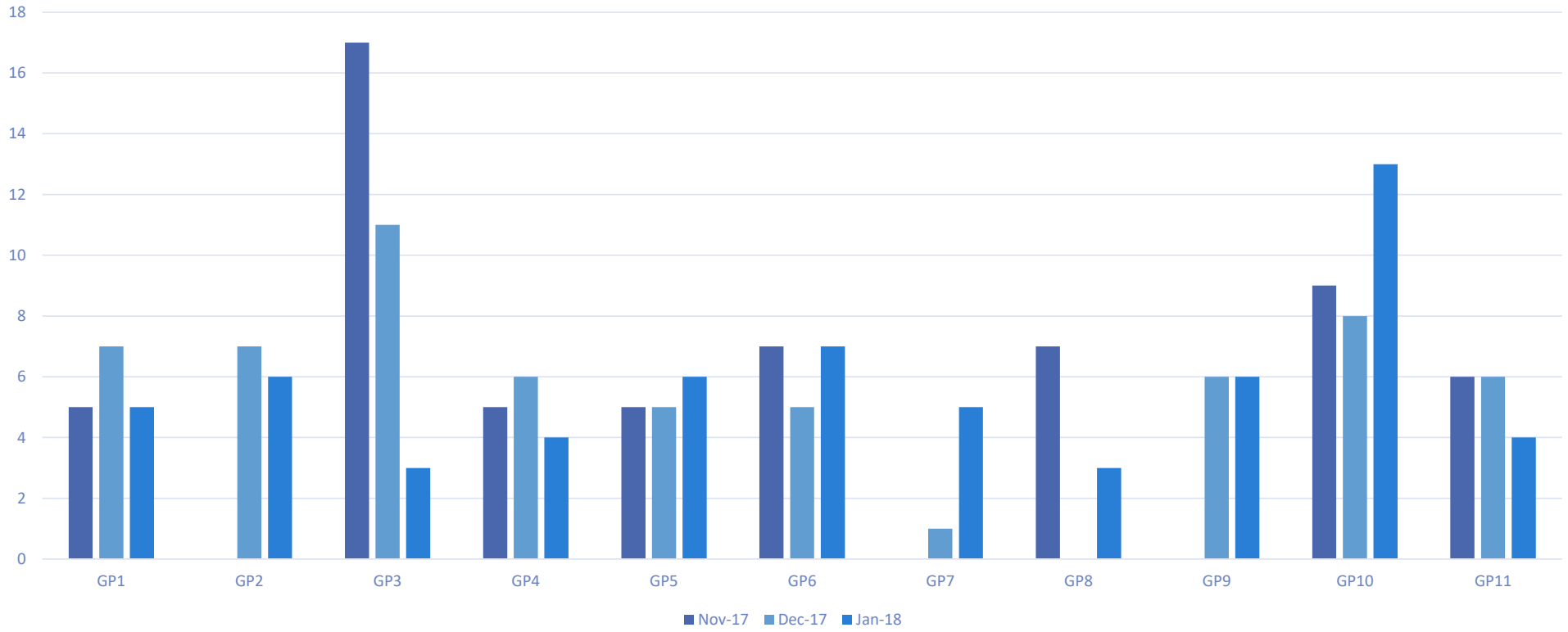
- The establishment of Multiple disciplinary teams
- Regular meetings to discuss care plans for patients with complex needs
- **“MDT is worth their weight in GOLD” – GP, Kapiti**

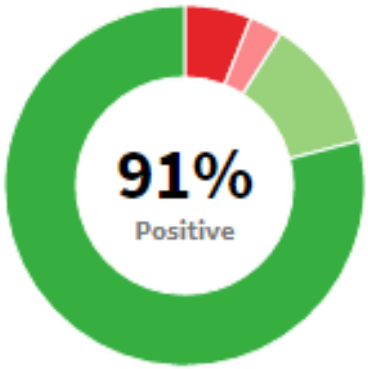
Routine and Preventative Care



Days till third next available appt

Note – methodology is a work in progress – Feilding Health





2,704
Responses

79%	**12%**	**3%**	**6%**
2,119	323	88	174

How satisfied were you with our service today?
January 2018 - Feilding Health

Business efficiency - Standardisation

5S event

Value-stream mapping

Quick billing – successes

Feilding Health

- Saving 16 hours per month at reception (192 hours per year)
- Queue moves faster – less congestion
- Less paper – 3 – 4 reams per week less. $54 per month saving ($648 p/a).
- Closer checking of invoicing – more awareness of errors
- No second guessing of consult type
- Smooth implementation – everyone took it on board

Positive Practice staff experience

- Overall improved efficiency
- To cope in times of great demand
- Role expansion & development
- Better workplace relationship
- Perceived better care for patients

➔ Higher satisfaction

"I'm learning about things that I would not have had the opportunity to learn before…I suppose the biggest change is always learning"

"We are in a good place to handle times when we have decreased capacity with less impact on patients as we can provide other options of accessing care"

In a nut shell

- GP triage is creating capacity
- Number of POAC claims is increasing
- Positive impact on secondary care
- Better coordinated care for patients through Community Service Integration
- Patient portal uptake continues to grow
- Cost-benefits through implementation of Lean principles
- Higher staff satisfaction

More information?

Healthcarehome.org.nz