HEALTH CARE HOME

Health Care Home
Nelson & Marlborough
First Year in Review
October 2019

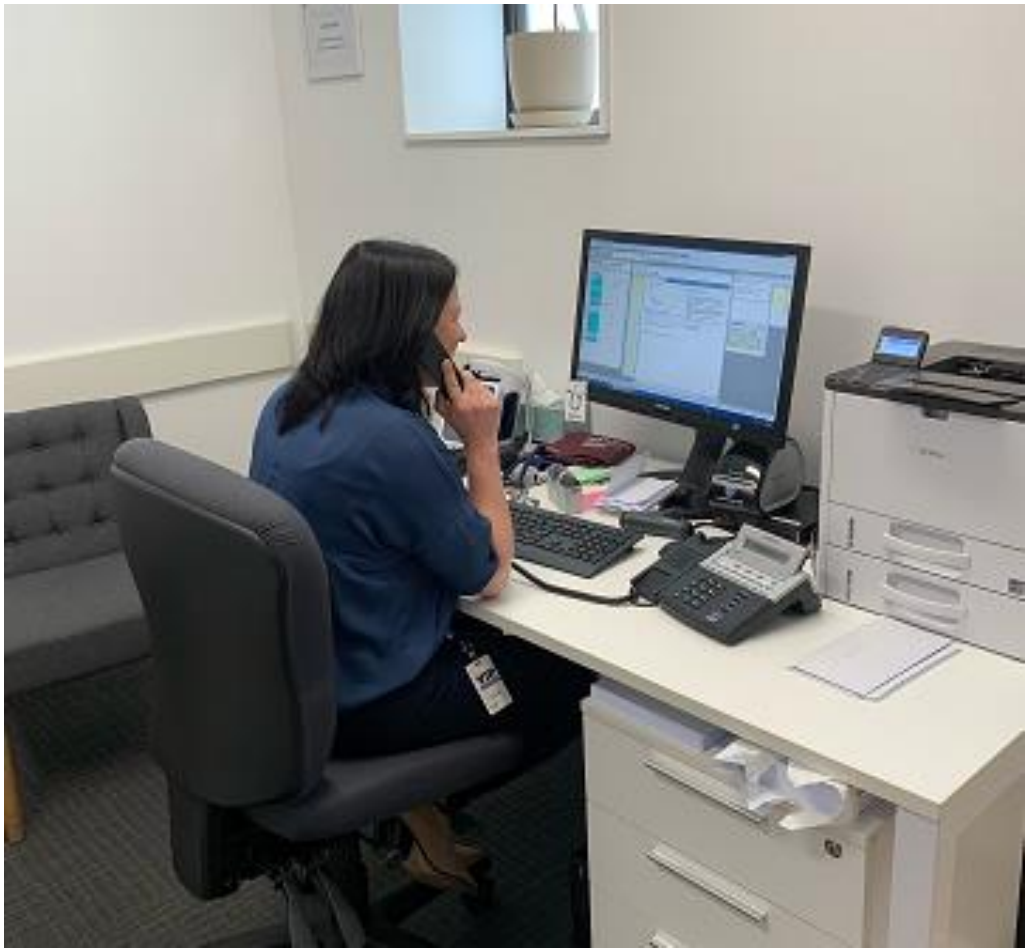


Photo: Civic Health GP Triage

Contents

Executive Summary

The purpose of this 'First Year in Reflection' report is to share progress and achievements that have occurred in the first year of Health Care Home (HCH) in Nelson Bays and Marlborough.

As a priority focus of the Top of the South Alliance (Nelson Marlborough Health (NMH); Nelson Bays Primary Health (NBPH) and contract holder Marlborough Primary Health (MPH) supported the establishment of the HCH in the region in April 2018.

Five practices commenced the Health Care Home establishment stage in October 2018 and started their implementation of their first-year plans in Dec 2018.

In July 2019, a further four practices commenced their HCH establishment stage.

This first year for the Tranche One practices has been focused on the business efficiency and urgent care domains. Through adjusting appointment templates, offering alternates to face to face consultations and with the introduction of GP triage, practices have reported a more manageable and calmer work environment, where patients urgent care is more proactively managed.

A focus on increasing the number of patients using the portal has seen growth in the number of patients making appointments, viewing their results and ordering repeat prescriptions. HCH practices have also opened the function on the portal that enables patients to email their doctor, which has improved access, saved time and enhanced the patient doctor relationship.

In three of the five HCH practices, patients now have access to their notes. In these HCH practices, patients can go straight back to view the clinical notes via the Portal, saving the patient and the practice time.

Practices have also introduced several other time saving technologies such as self-check-in kiosks to support improved patient flow and save reception time.

Another practice has introduced a patient feedback kiosk which provides a mechanism for patients to provide instant feedback before or after their appointment. This has provided the practice with information that supports quality improvement, in addition to regular affirmation for the team.

The implementation of Lean Methodologies to support improved processes and efficiencies has been another significant change for the Tranche One HCH practices.

Photo: Civic Health Self Check-in

The following report provides a snapshot of results and some reflections on the first year. Some further detailed data analysis is provided in apprendix one. It should be noted that the HCH initiative is not expected to show any significant contribution to hospital utilisation rates in the first year as the proactive service elements are the focus of the second year implementation plans and beyond.

First Year – A Snap Shot

- 3 Practices October 2018
- 3 Practices July 2019

- 2 Practices October 2018
- 1 Practice July 2019

4% (average) enrolment growth
8% in Marlborough
1% in Nelson

4399
Emails sent to GP's via portal compared to 550 prior to HCH

4 of the practices have implemented extended roles such as a Mental Health Wellbeing practitioner

42% of the population are enrolled in a Health Care Home practice

All practices have visual boards up and are 'huddling' or running 'Stand Up's' daily

All practices are systematically implementing their Lean Action Plans

All practices have Health Care Assistants and have increased their FTE

GP/NP Triage

5 All practices have started GP/NP triage

4563 received phone triage with GP or NP

28% 28% resolution rate with GP's

46% 46% resolution rate with NP

1261 patients didn't need to come into the practice.

4965
Open notes

21% more patients are using the portal

As of October 2019

9191 patients using portal now compared to 4330 prior to HCH

2417
Appointments were made via the patient portal compared to 277 prior to HCH

Our Approach

Background

The New Zealand based Health Care Home (HCH) model was originally developed and piloted through Pinnacle Midlands Health Network.

A National Health Care Home Collaborative has developed a HCH Model of Care framework in the form of a maturity matrix, a credentialing and certification process and a national dataset, to measure practice and System level outcomes for Health Care Home practices.

The membership of the National Collaborative is growing and now includes 15 Primary Health Organisations and 6 DHBs and supporting organisations include GPNZ; RNZCGP and the DHB National CEO group.

Photo: Omaka Medical Self check-in Kiosk

Project Statement

General Practice is facing increasing demands relating to the changing demographics in its enrolled population and the practice workforce. There is also the emergence of competitive internet-based health care providers and an increasing demand from consumers as to how they access primary health care. Growing evidence both in New Zealand and overseas support an approach that strengthens general practice to be adaptive and responsive by proactively managing acute demand and complexity and offering different ways for patients to access the general practice team.

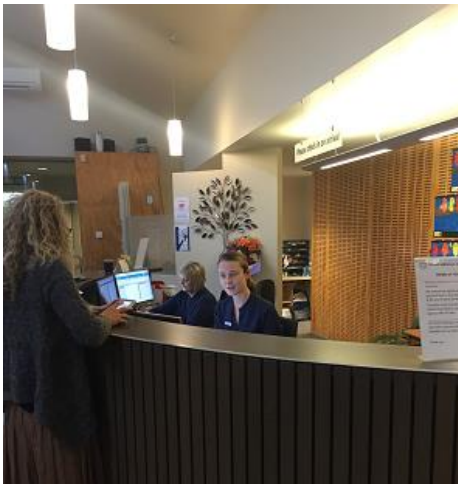


Photo: Stoke Medical Phone free reception

Photo: Stoke Medical – Daily Team huddle

The Health Care Home Model

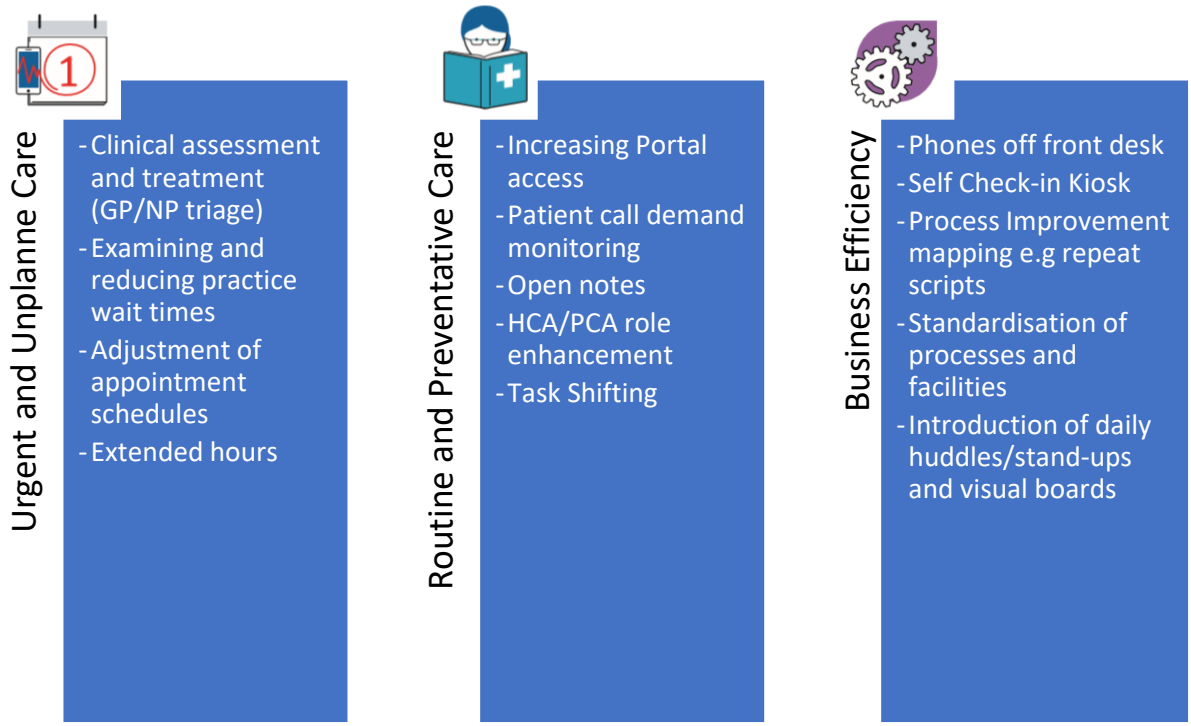
The aims of the HCH model are:

Patient Experience:

"It is great to be able to book on line and order my prescriptions. It means I can do it when it suits me and not wait for business ***hours****".*

Year One focus:

All practices have introduced and refined several new ways of working and are achieved business efficiencies through the implementation of their year one plans. Implemented service elements included but were not limited to:



Reflections and Insights…

Data Analytics and Reporting Capabilities

In order to efficiently capture HCH data, Marlborough Primary Health and Nelson Bays Primary Health have outsourced the HCH data analytics to Datacraft Analytics and a Health Care Home Data Dashboard has been created enabling practices to analyse their own patient and practice data.

> ***Staff member*** *"I just love the huddles, it brings us together and keeps us informed. I have even managed to get up and run three myself now, which I thought I would never do – I feel so very brave!"*

IT Connectivity

IT connectivity has proven to be a challenge for some practices. One practice implemented a new patient management system while undertaking the first year of Health Care Home. Due to this being a technically challenging process, it created significant pressures unforeseen prior to its introduction. As a result, there has been some change fatigue experienced when combining two such significant change management process.

Onboarding of whole team in to the Change Process

An observation is that where practice leaders and owners have an advanced understanding and engagement in the HCH change process, they are better able to disseminate this to the wider team. The role of the change team is vital in leading the HCH change process. In practices where there is strong and shared responsibility for the HCH implementation, they have experienced greater success and stronger results over this first year.

Staff changes effect on HCH implementation

Another observation is that where staff changes have occurred or where there have been other changes within the practice, this has resulted in the HCH implementation being compromised in varying degrees. In saying that, it should be acknowledged that where this has occurred, progress has continued through other members hard work and drive, which has been greatly appreciated.

> ***Re GP – Triage****: "I rang the patient off the Triage list and after assessment, I was able to provide a prescription for conjunctivitis and advice to contact us if not improving. That saved both her and my time. The patient recovered well and did not need to attend for a consult" …GP*

Task Shifting

Tranche One HCH practices have all actively grown their Health Care Assistant/Primary Care Practice Assistant roles which has enabled task shifting to occur to enable a more 'patient facing' role for nurses.

Care Planning and Care Coordination

In year one, there were delays in the provision of system tools such electronic shared care plans and a coordinated care framework. These tools are now being facilitated via the Models of Care programme and will be a major focus of the second year.

Looking forward

Second year focus

In completing year one, the Tranche One practices have worked to manage their acute demand differently and maximise their business efficiency in order to be more sustainable and improve the patient experience.

The Tranche One practices have all completed their second-year implementation plans with a focus on equity, patient engagement, care planning and locality-based care coordination. This will enable targeted and proactive care for patients with high needs, vulnerability and/or complexity.

It will also enable more systematic coordination of care through strengthened care coordination across services and with the patient firmly in the centre.

The second year service elements will include but are not limited to the following:

Photo: Omaka Primary Care Practice Assistant

Patient Engagement

- Consumer working groups
- Invite cohorts of patients into practices
- Technology feedback optionsWorking with community based groups
- Working with community based groups

Focus on Equity

- Working with community based groups
- Identifying cohorts of patients who aren't accessing care
- Ensuring a culturally appropriate and inclusive approach to how the practice is set up for example signage
- Upskilling staff on cultural competencies

Coordinated Care

- Introduction of care coordination models within Practices and in Locality Care Coordination teams
- Introduction of additional roles such as Wellbeing practitioner
- Upskill of workforces to support self-management approach
- Use of electronic Shared Care Plans
- Risk stratification of patients

The Patient and Provider Voice…

Nurse reflection on GP Triage: *"Fantastic how many patients the GPs are talking to and the transparency of the Clinical Triage Phone template – These calls used to stack up as phone messages".*

Patient Experience *who was supported to get access to the patient portal and told that she would have access to her notes – "that will be awesome because I get home and my husband asks me what the doctor said, and I can't remember – now I can show him… Patient Mrs NM*

Patient Experience

"The GP phoned me as I was needing a referral done. I could not come in as I am a truck driver and was out of town. My GP offered a phone consultation which was more convenient to me and much appreciated. My referral was completed really fast and I was happy to pay for the phone consultation".

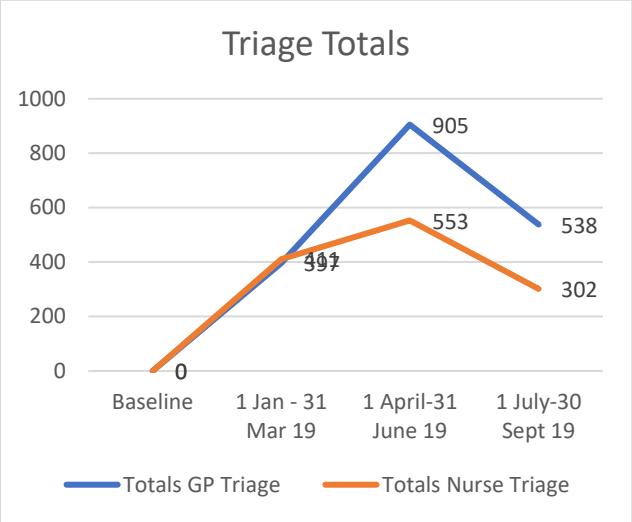
Admin Process Improvement: *"The new flow at the front desk makes it easy for me to drop off paperwork. I find it helpful that scanning is now done immediately, and letters are available reliably at consultations" …GP*

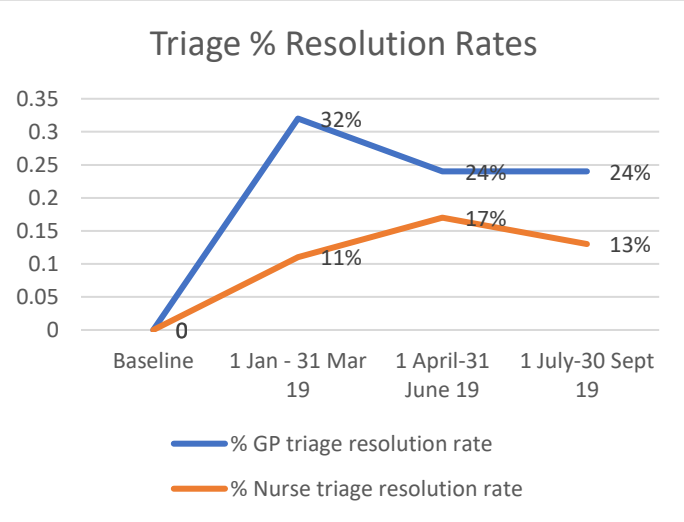
Patient Experience: *Re the Self Check in Kiosk – "I love the self-check-in Kiosk. It feels like I don't have to interrupt other people when I arrive and it's so easy"*

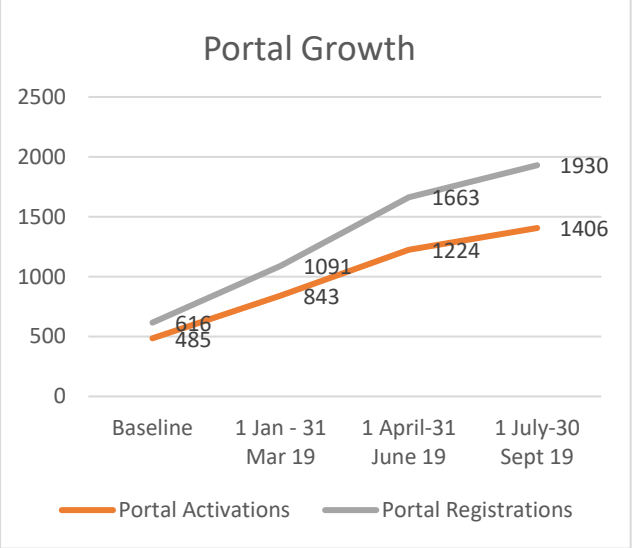
Provider voice: *Re GP-Triage – "I triaged Patient X and after assessment I asked the patient to get bloods. I initiated an E lab form and told the him to drop by the lab without having to collect a form from us. The patient later visited me when bloods were in. VERY APPRECIATIVE patient" ….GP*

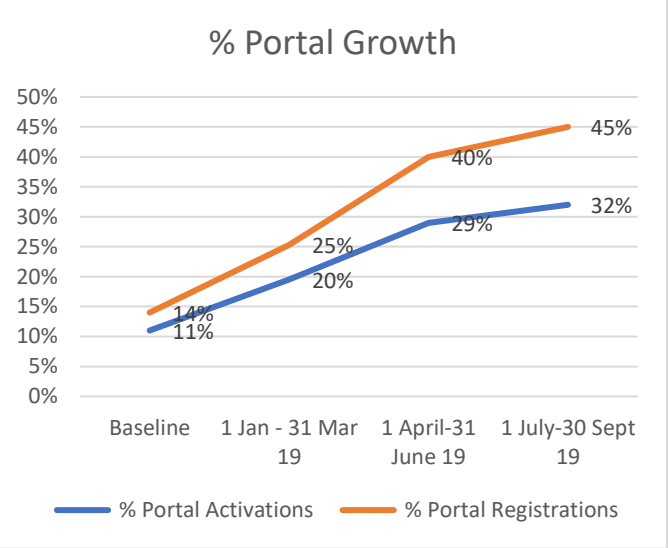
Appendix One: HCH Data Results in Detail

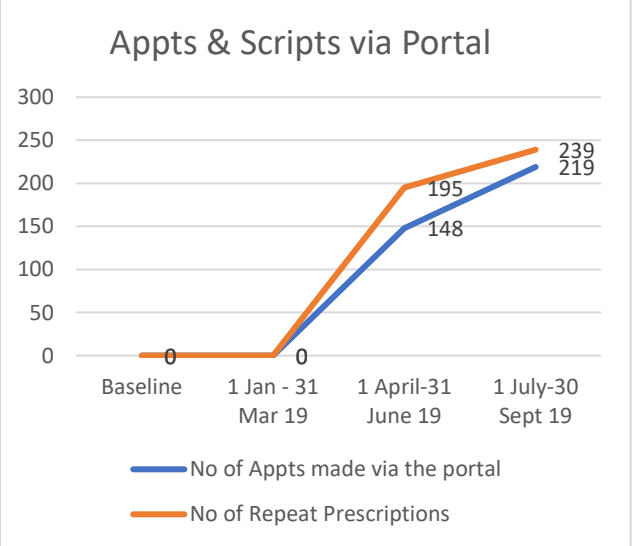
Table 1: Practice A: First Year HCH Data Results











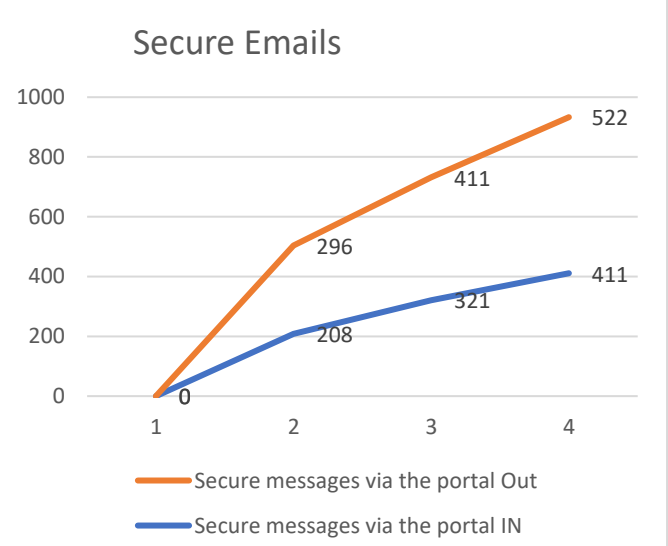
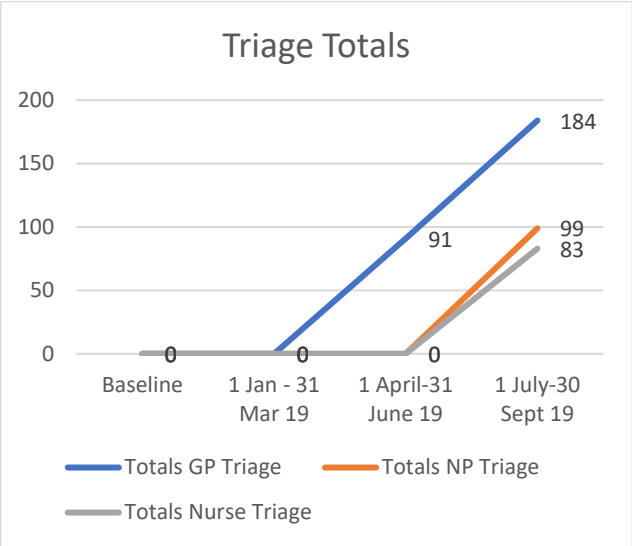
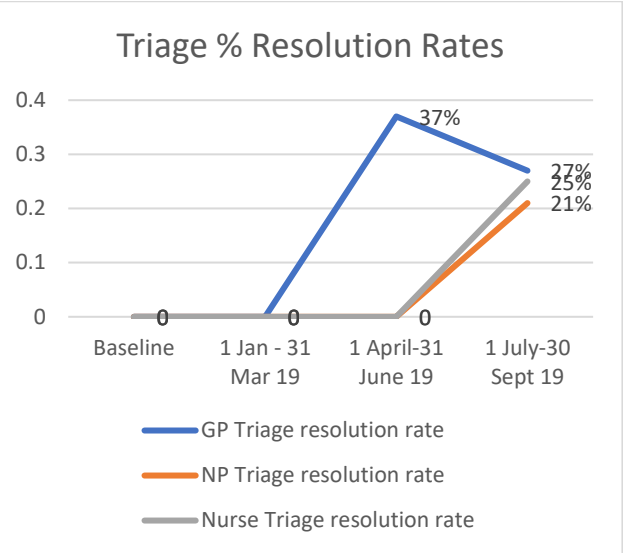
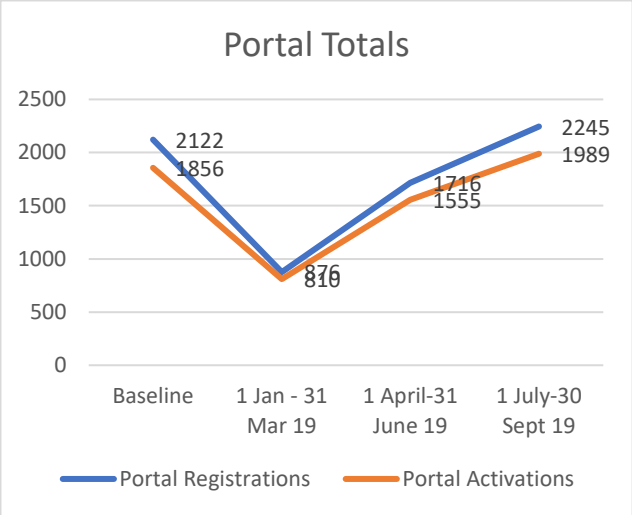


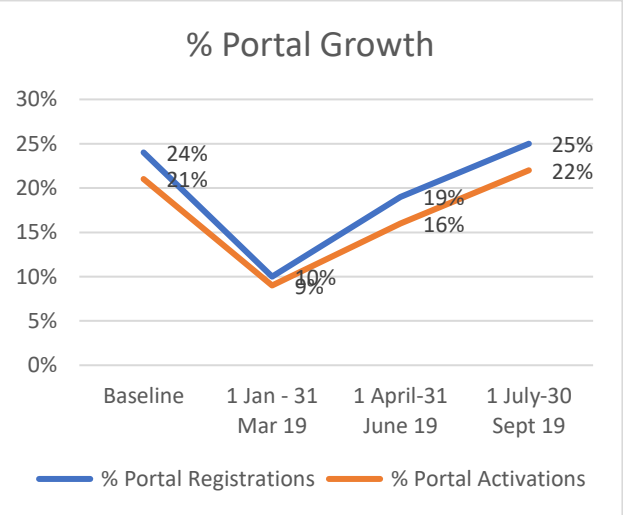
Table 2: Practice B: First Year HCH Data Results



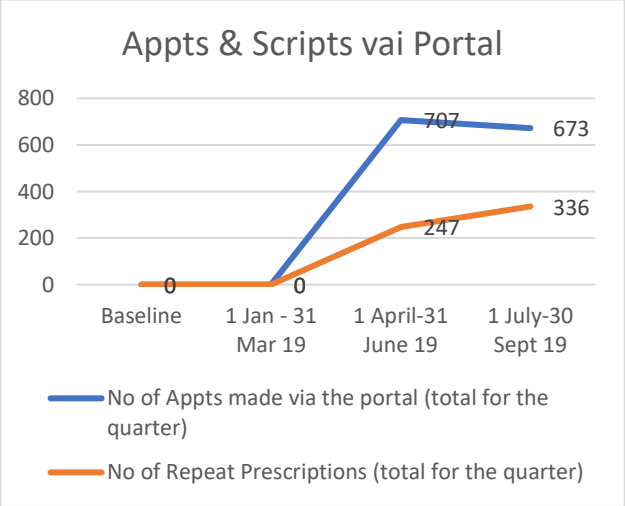




Note: Change of Portal provider in Feb 2019



Note: Change of Portal provider in Feb 2019



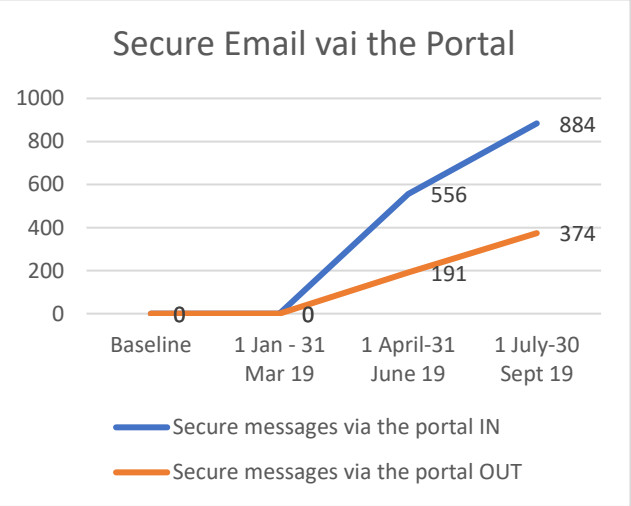
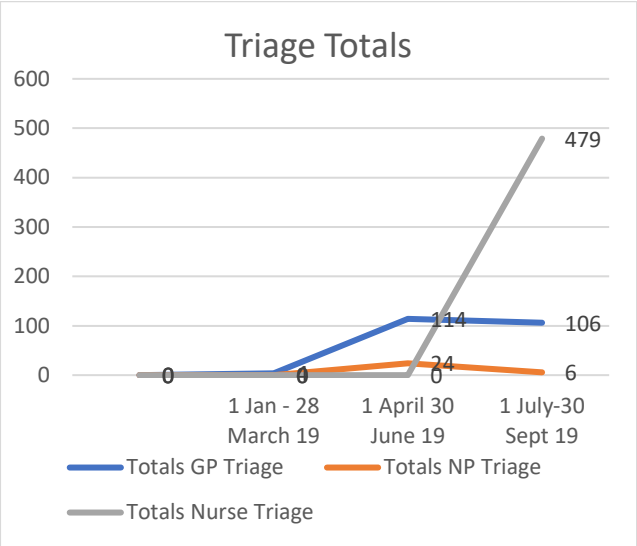
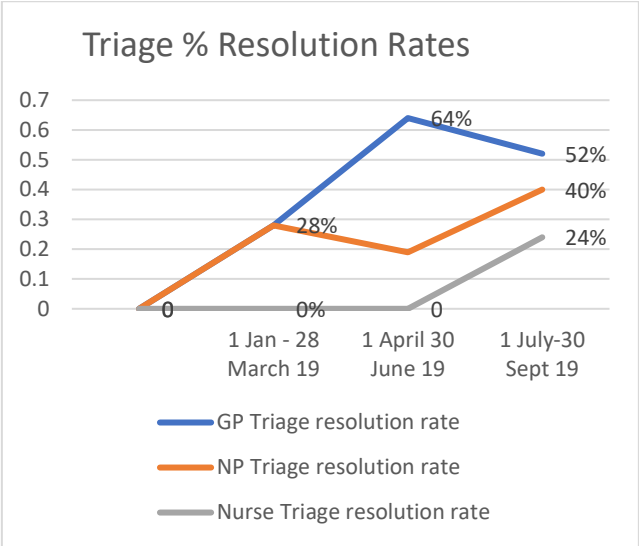
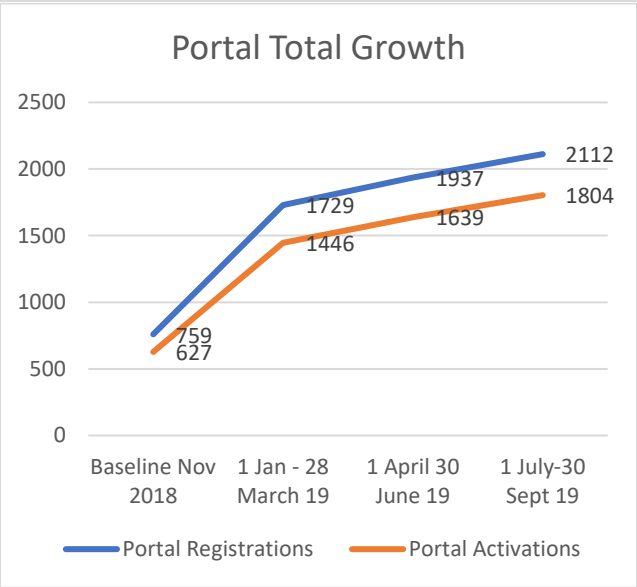
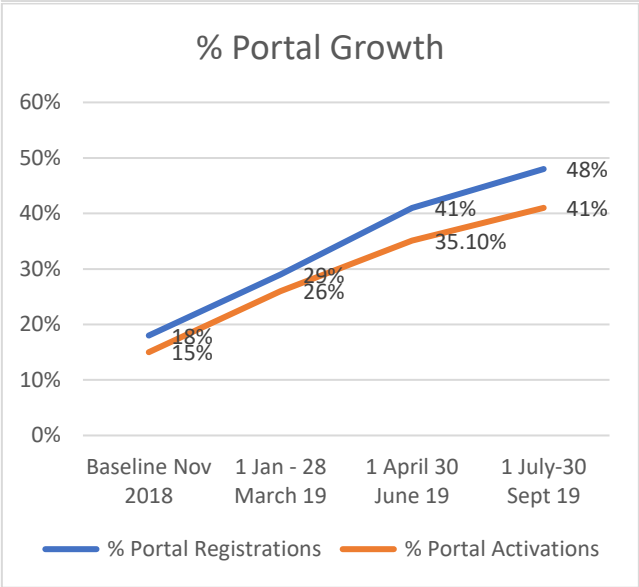


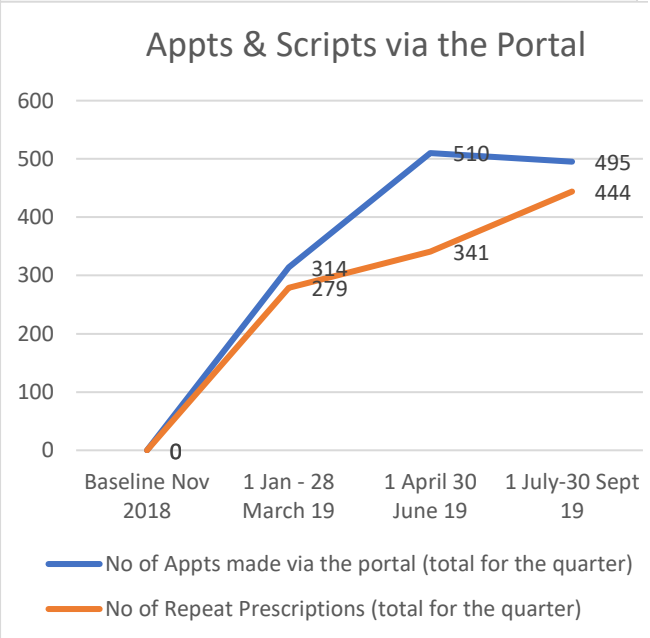
Table 3: Practice C: First Year HCH Data Results











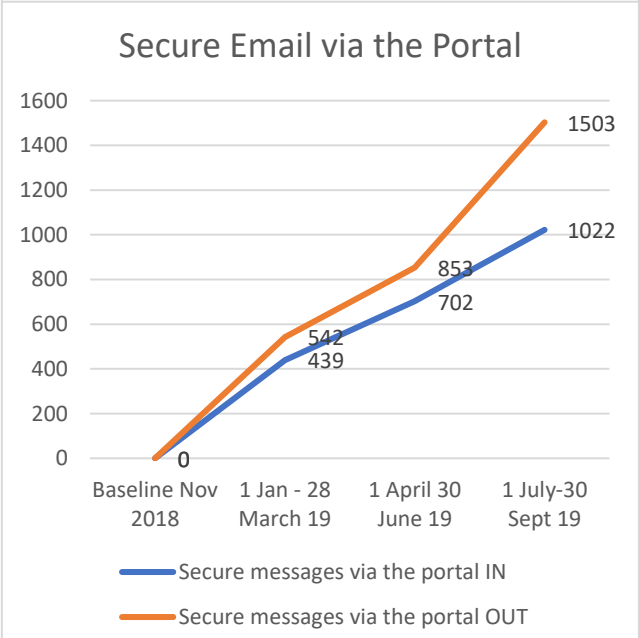
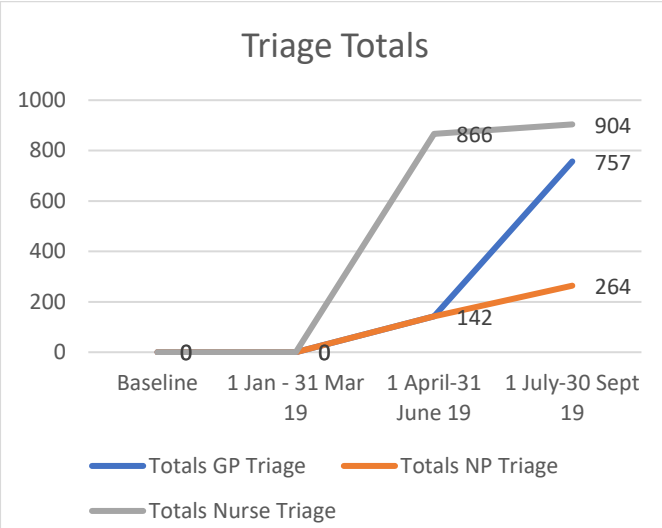
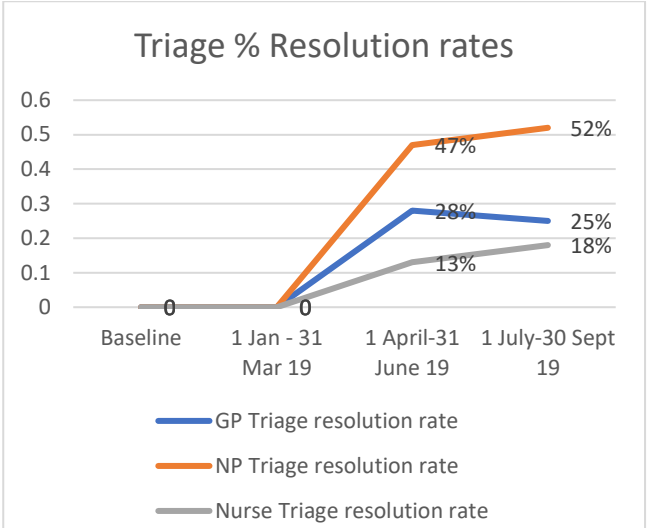
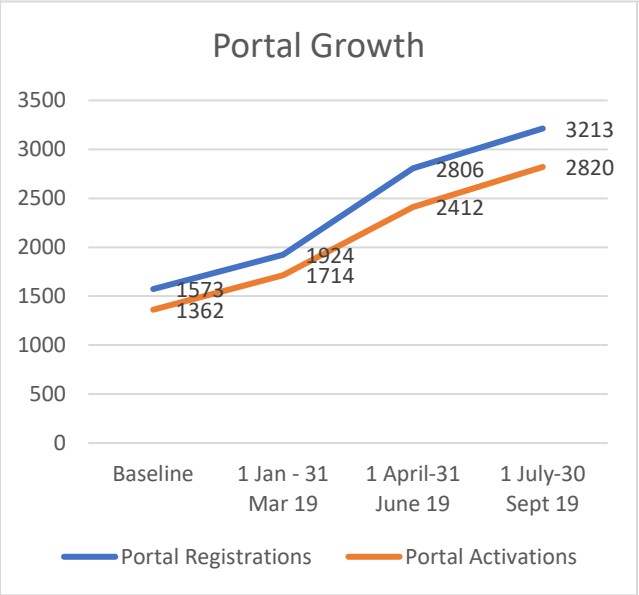
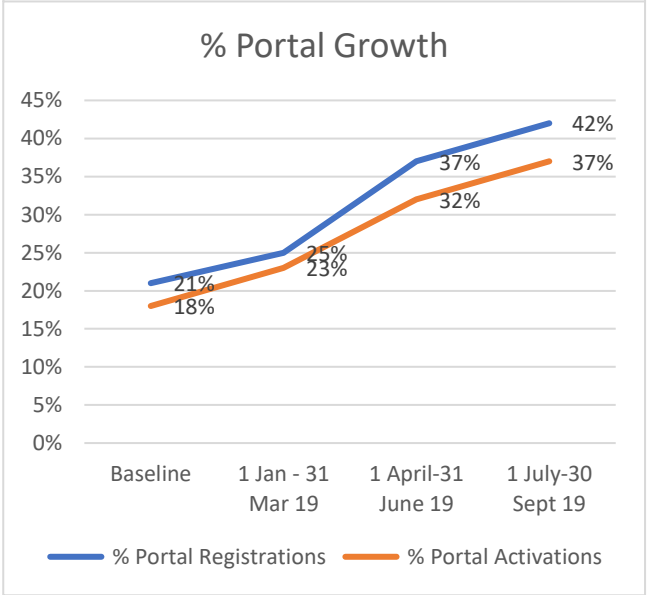


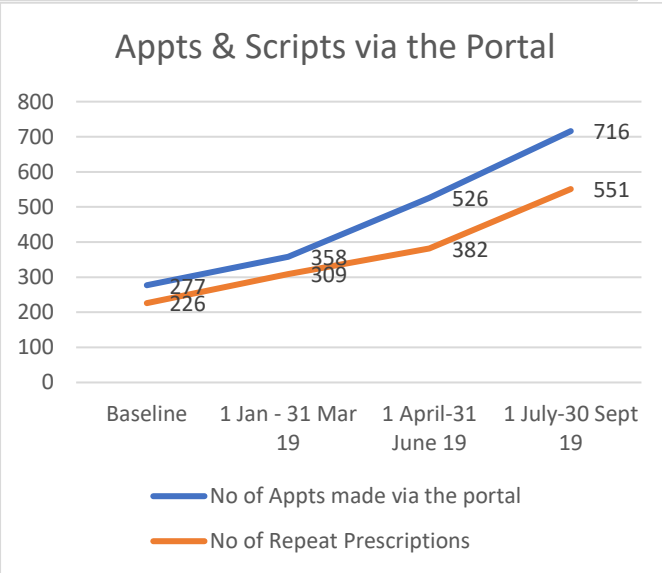
Table 4: Practice D: First Year HCH Data Results











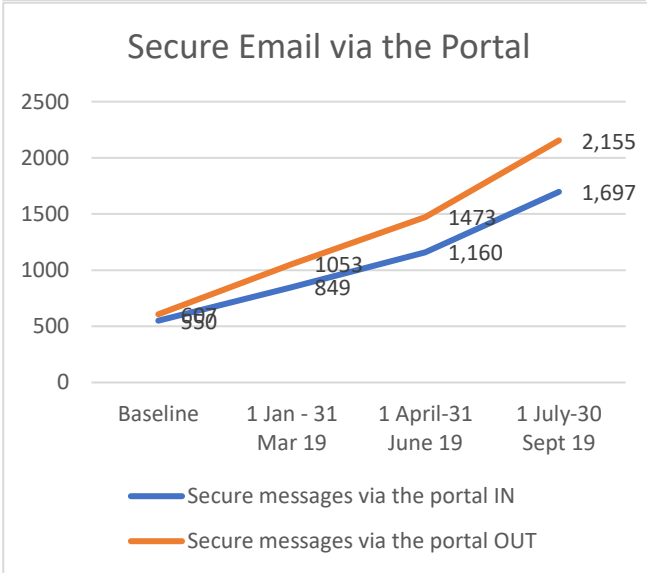
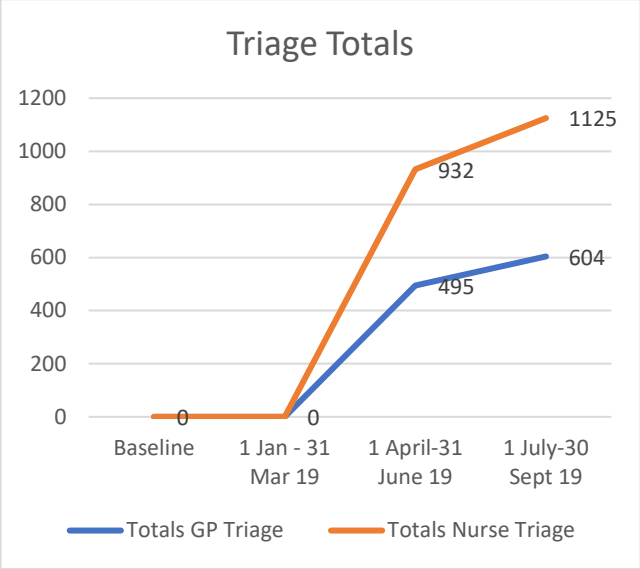
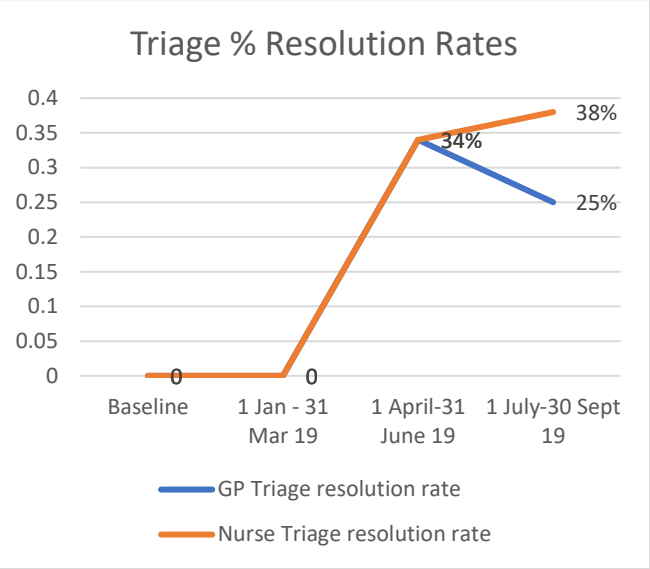
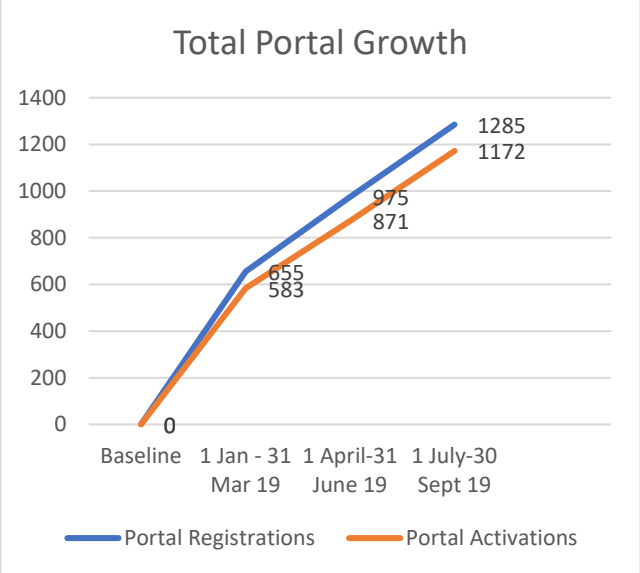


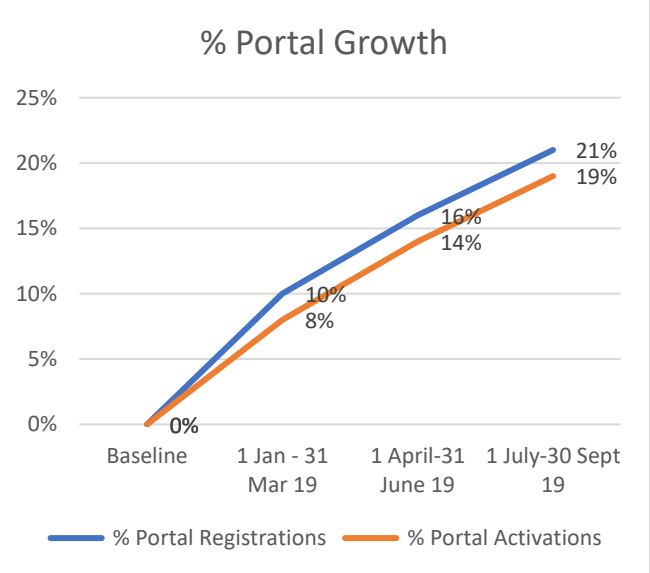
Table 5: Practice E: First Year HCH Data Results

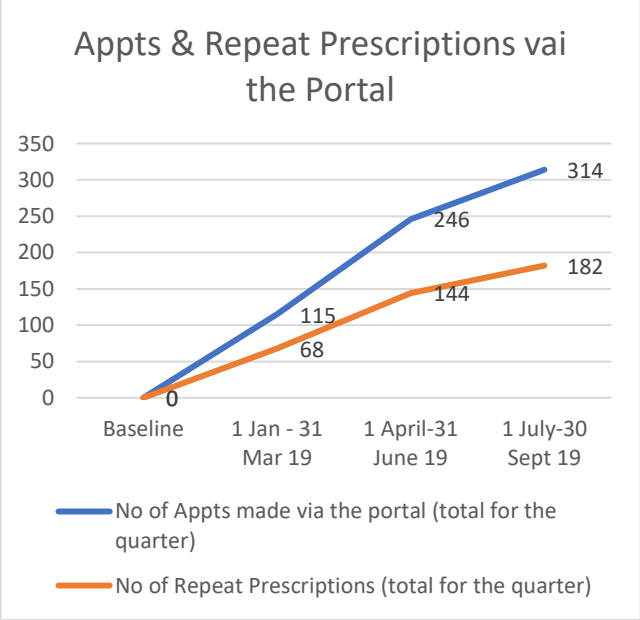




Note: High nurse % resolution rates relate to data entry error







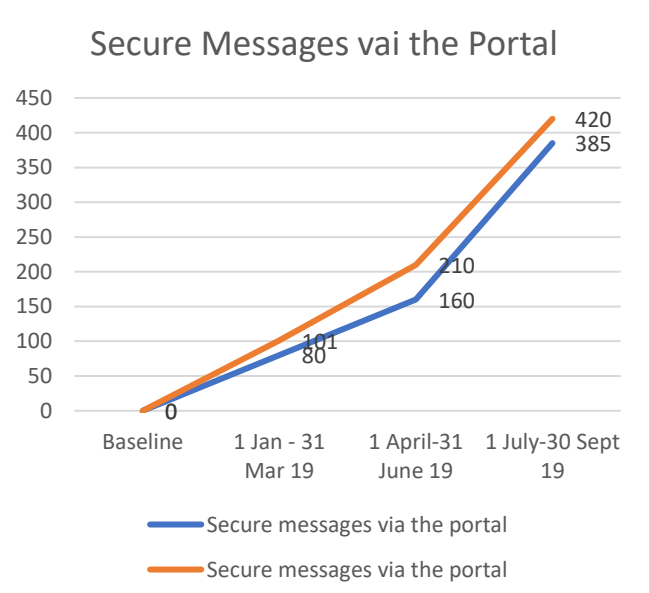
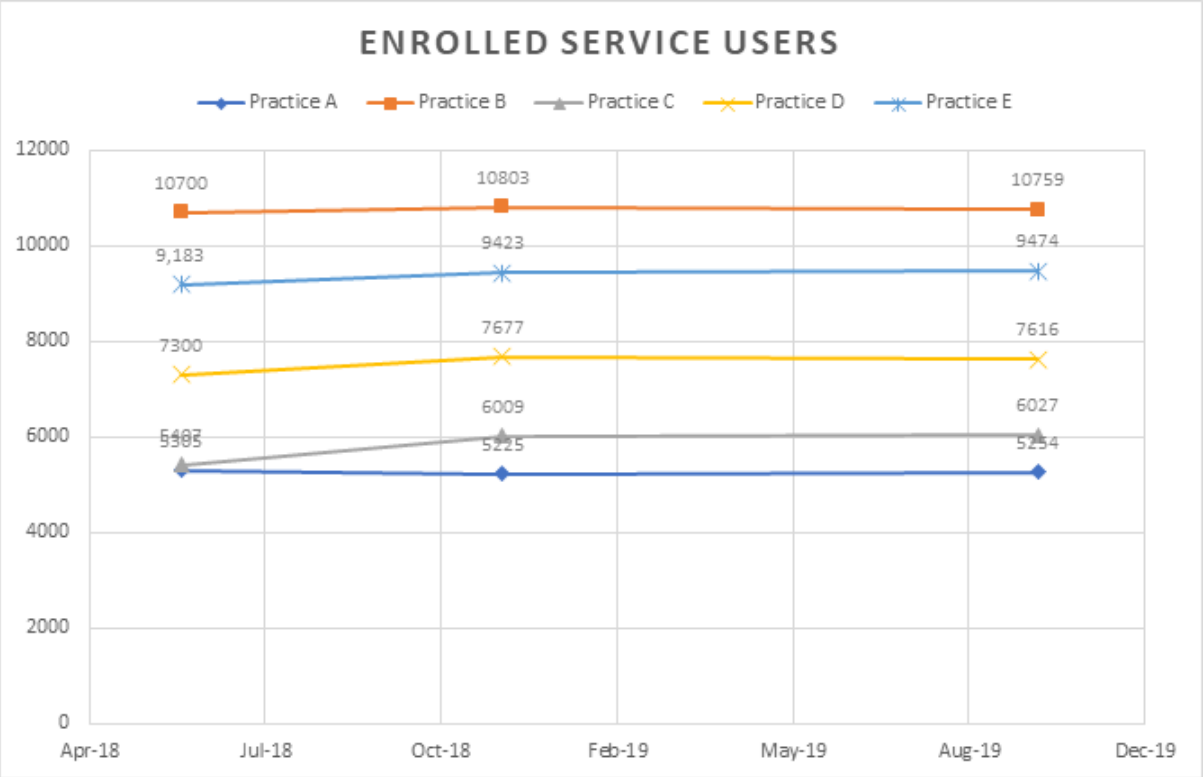


Table 6: Comparative Enrolment Growth

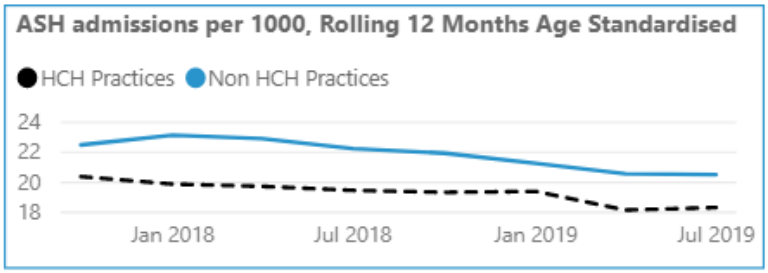
There has been an average enrolment growth of 4% across all HCH practices (8% in the Marlborough HCH practices and 1% in Nelson Bays HCH Practices)



Hospital Utilisation Rates

The first year HCH practice hospital utilisation rates are provided below but as expected there has not been any significant shift that can be attributed to the HCH implementation. It is expected that we will see either stable or improved rates over the next 2 years, as the proactive domain service elements are implemented.

Table 7: ASH Admissions per 1000, Rolling 12 Months Age Standardised



ASH Admission Rates

HCH practices had lower ASH admission rates than non HCH practices and there was a slight reduction in rates

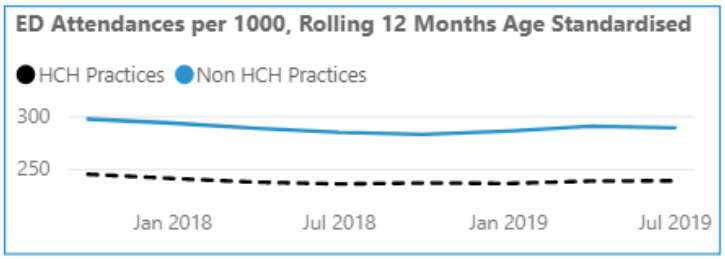
Results: HCH practices had less Ambulatory Sensitive Hospital ASH admissions during the first year of implementation but that was a trend already in place. There was a difference of 3.18 per 1000 in the period 1 Oct 2017-30 Sept 2018 and 2.19 per 1000 in the period 1 July 2018 – 30 Sept 2019.

There was also a small decline in ASH admission rates across both HCH and Non HCH practices:

HCH practices (19.73 per 1000 in the period 1 Oct 2017-30 Sept 2018) to (18.31 per 1000 in the period 1 July 2018 – 30 Sept 2019)

Non HCH home practices (22.91 per 1000 in the period 1 Oct 2017-30 Sept 2018) to (20.50 per 1000 in the period 1 July 2018 – 30 Sept 2019)

Table 8: ED presentations per 1000, Rolling 12 Months Age Standardised



ED Presentations

HCH practices had lower ED attendance rates than non HCH practices across both HCH and non HCH practices.

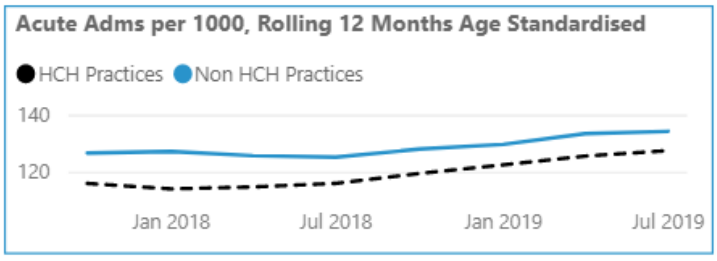
Results: Overall HCH practices had lower ED attendance rates than non HCH practices during the first year of implementation but that was a trend already in place. There is a difference of 48.80 per 1000 in the period 1 Oct 2017-30 Sept 2018 and 50.19 per 1000 in the period 1 July 2018 – 30 Sept 2019.

Although largely stable, there was a small increase in ED attendance rates across both HCH and Non HCH practices:

HCH practices (236.40 per 1000 in the period 1 Oct 2017-30 Sept 2018) to (239.35 per 1000 in the period 1 July 2018 – 30 Sept 2019). An increase of 2.91 per 1000

Non HCH home practices (285.20 per 1000 in the period 1 Oct 2017-30 Sept 2018) to (289.54 per 1000 in the period 1 July 2018 – 30 Sept 2019). An increase of 4.30 per 1000

Table 9: Acute admissions per 1000, Rolling 12 Months Age Standardised



Acute Admissions

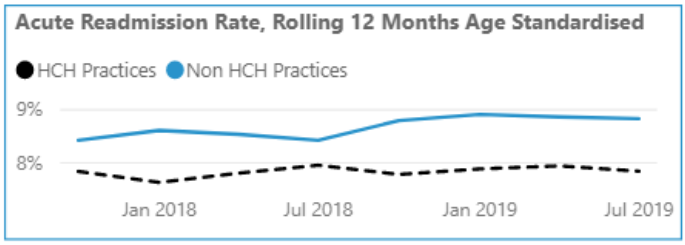
HCH practices had lower Acute admission rates than non HCH practices however admission rates have increased

Results: Overall HCH practices had lower Acute admission rates than non HCH practices during the first year of implementation but that was a trend already in place. Admission rates have increased slightly across both HCH and Non HCH practices:

HCH practices (116.19 per 1000 in the period 1 Oct 2017-30 Sept 2018) to (127.69 per 1000 in the period 1 July 2018 – 30 Sept 2019). An increase of 11.50 per 1000

Non HCH home practices (125.39 per 1000 in the period 1 Oct 2017-30 Sept 2018) to (134.47 per 1000 in the period 1 July 2018 – 30 Sept 2019). An increase of 9.06 per 1000

Table 10: Readmissions per 1000, Rolling 12 Months Age Standardised



Readmissions

HCH practices had lower readmission rates than non HCH practices and here has also been a slight decline in readmission rates.

Results: Overall HCH practices had lower readmission rates than non HCH practices during the first year of implementation but that was a trend already in place.

For HCH practices, there has been a slight decline in readmission rates and a slight increase in non HCH practices.

HCH practices (8.0% per 1000 in the period 1 Oct 2017-30 Sept 2018) to (7.8% per 1000 in the period 1 July 2018 – 30 Sept 2019).

Non HCH home practices (8.4% per 1000 in the period 1 Oct 2017-30 Sept 2018) to (8.8% per 1000 in the period 1 July 2018 – 30 Sept 2019).

Appendix Two - Year one Practice Road Map