Primary Care Stepping Up: 
What does the learning from adoption of the Health Care Home tell us about the future of primary care?

HSRAANZ WEBINAR

Helen Parker
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This Session

Overview of the Health Care Home Model of Care
Outcomes
Patient Stories
Learning and Policy Questions
  - Patient Experience
  - Leadership and Change Management
  - Funding and Organisation of Primary Care
  - Workforce Development
  - Opportunity of Technology
General Overview

• Pinnacle is a GP owned network of 86 practices – incorporates PHO functions
• Model developed from global experience and evidence base
• 16 practices, 100k patients, with a growing pipeline (over 130 nationally)
• First pilot practices established in 2012
• Mix of urban and rural sites
• Most privately owned
• Dedicated change management team to support implementation
• Power BI data dashboard to monitor and evaluate change
• National HCH Collaborative established

National HCH Standards agreed (currently being updated)
Redesigning primary care

Transforming care models

Transforming care delivery

Transforming care connections
<table>
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<th>Model Aims</th>
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<td>Improving the patient experience - valuing time and self expertise</td>
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<td>Actively promoting and supporting ‘activated’ consumers</td>
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<td>Shifting from the reactive to proactive population health management</td>
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<td>Creating sustainable integrator within local health system</td>
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<td>Embedding culture of systematic quality improvement</td>
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<td>Increasing workforce capability, capacity and flexibility</td>
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<td>Improving workforce recruitment and retention – a better working day</td>
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<td>Ensuring best value for health $</td>
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<td>Ensuring sustainable general practice</td>
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What’s different about a Health Care Home practice?

Choice of consult mode
What’s different about a Health Care Home practice?

Comprehensive health plans and interdisciplinary team for those with complex needs
What’s different about a Health Care Home practice?

Enhanced primary care team with role reconfiguration to gain best clinical value from each clinician
Patient Partner Framework

Practice Patient Groups
Consumer Panel
Push my Button Feedback devices in practice
Patient experience app feedback
Patient experience surveys
Co-design focus groups
Patient portal app that enables more control
Making Health Care Home Work

Patient Information system with shared electronic health record
Making Health Care Home Work

iPads
enabling doctors to consult from anywhere
Making Health Care Home Work

Patient portal
Access via smartphone
Making Health Care Home Work

Enhanced Call management through a call centre approach
Making Health Care Home Work

Flexibility
Re-engineered working day to value patient and clinician time
Mobilising primary care

- St John’s Hospital
- Community Pharmacy
- Aged Residential Care
- Home Care
- School
- Workplace
- Marae
- Accident & Medical
- Retail
- NGOs
Outcomes overview

1. Improved patient experience
2. Improved clinical outcomes
3. Reduction in secondary utilisation
4. Highest impact on Maori, the elderly and those with highest need
5. Improved GP recruitment and workforce satisfaction
Patient Stories: George and Milton

Taking services out of general practice to where the people are

Addressing inequity

Interdisciplinary team and group consultation approach

Building on the evidence base of community health workers attached to clinical teams.

Shane Rakei, a peer support worker in the team runs group consultations, who meet every fortnight. Shane invites GPs, Dietician, Nurse Practitioner and Clinical Pharmacist into the group consultation as required for ‘light touch’ health education and individual assessment.
Group Consultation – Patient Story
(George / 70 years old / Taupo)

Severely disengaged with health services for a lot of his life, experiencing increased shortness of breath and high blood sugars, he was referred to the Health Care Home extended care team in Taupo. The package of care included dietician, exercise consultant and the nurse practitioner. This had a profound impact on his life...

Through attending the group it was discovered that George was in heart failure and had cellulitis of both lower legs, he is now being helped to manage his medications, checking in each fortnight to ensure he is self-managing his medications and health.

George’s legs improved so much he joined the early morning water walking exercise class, which the group also does fortnightly. His blood sugar levels have dropped and are now in single figures. He is now so engaged with his health that he has further appointments booked for an Echocardiograph and Spirometry.
Group Consultation – Patient Story
(Milton / 56 years old / Taupo)

Having had very little contact with health services for most of his life, ignoring his health and wellbeing, with no desire to seek medical help. Milton was referred to the Health Care Home extended care team in Taupo for support with diabetes, mobility and obesity issues.

Milton joined the group fortnightly meetings, where the health professionals were able to assess, treat and provide advice to him outside of the traditional practice setting and 1:1 environment.

Over the last two months Milton has lost 4kgs and has lowered his blood sugar levels from double to single figures. Through Shane’s coaching and learning from others in the group, Milton now has a better understanding of his diabetes and has made a lot of changes to his diet and lifestyle.

Thanks to the group, Milton’s health is now being managed successfully and it is improving steadily to afford him a better quality of life.
“Health Care Home is about shifting general practice from a reactive service, to one where all doctors’ or nurses’ consults are planned with the patient. Six years in, our patients and our staff are both better off for it. The way we work means more ‘urgent’ patients on our roll of 5,500 are seen on the day of their appointment, with less urgent needs treated in alternative ways such as over the phone, via virtual consults using a patient portal so they don’t have to come in, or at an appropriate time later in the week.

“Now in our practice each GP has just 20 appointment slots daily, with two reserved for paperwork, one for phone consults, and one for phone triage. We have more time to deal with necessary paperwork without overloading ourselves.

“As a result of increasing capacity with the same FTE and managing urgent care demand more effectively we have not had to use locums for the past two years, even when a GP was off for 3 months unexpectedly. This, together with ‘seeing’ more patients through the use of virtual care, has resulted in a small year-on-year increase in financial turnover.

“With our increased turnover, the Directors decided to take a bit more time off having run faster to stand still for a number of years and having appointed more GPs. We had no difficulty finding GPs, even in our rural area, as they were previous registrars who enjoyed the new model of care.”

Dr Hayley Scott, Health Te Aroha
‘Both the lower ASH and ED rates were also particularly pronounced for people living in areas of the highest quintile of socioeconomic deprivation’

‘Significant proportion of acute need being successfully dealt with out of hospital’

‘The associations for Maori, highly deprived and elderly populations suggest the model is pro-equity, and has its greatest effects on populations with the greatest needs’
With online and phone-based help from a Pinnacle Health Care Home practice:

62% of same day appointment requests managed without need for visit that day
If you are enrolled with a Pinnacle Health Care Home practice you are:

24% less likely to attend ED if you are Māori
If you are enrolled with a Pinnacle Health Care Home practice you are:

20% less likely to be admitted to hospital for unplanned care.
If you are enrolled with a Pinnacle Health Care Home practice you are:

32% less likely to attend ED if you are over 65
But....

Comparatively more ED presentations for 0-14s
Key learning and policy implications
Patient Experience

- Over-communication and consistency of message of change essential
- Patients willing to trade known reception staff for efficient call management system
- Where offered and supported, majority of patients want choice of tel, online care rather than F2F
- Patients change behaviour when rationale for the change clearly explained but takes time
- Practice participation groups adding value to patient experience
- Enabling the consumer voice takes commitment, expertise, time and investment
- Lack of formal training available for staff

Questions
- Does NZ need a national health consumer strategy and forum such as the Australian CHF?
Leadership and Change Management

**Essential enablers**
- Coherent, consistent PHO vision, narrative and strategy alignment
- Skilled change management and leadership
- HCH Peer groups for sharing and learning
- Funded practice headspace to plan and review
- HCH Collaborative is plugging some of the gap in system debate
- The journey of change itself stimulates innovative thinking and model development
- Takes time to embed – understanding impact on health outcomes takes time

**Questions**
- *Early adopters have signed up – how do we incentivise others to achieve scale?*
- *Does the private GP business model inhibit state/federal investment in change management?*
- *Is there enough national professional leadership supporting new models of care?*
- *How are we growing the experienced change leaders required to support at scale transformation?*
- *Will our declining GP ownership reduce leadership capacity and engagement? Have we got enough engaged leaders?*
- *Can we shift focus of evaluation of value away from impact on hospital care to impact on prevention, patient experience, social capital and quality of care?*
Funding and Organisation of Primary Care

- The patient co-payment can inhibit shift to online care by incentivising F2F practice care
- Interdisciplinary team working effectively with practice clusters and populations of 30-50k delivering best outcomes
- Focus on highest need patients provides effective focus for integrated care
- Larger practices are able to separate delivery of acute and planned care more easily
- Increased focus on proactive care planning for highest needs is exposing a level of unmet need that primary care is neither funded or equipped to manage
- Centralised call management saving patient time, increasing capacity and improving patient experience
- Cloud based and shared records enables mobilising primary care from traditional practice setting

Questions

- If new market entrants offering online care pick up low acuity care, could we see changes to practice enrolment that disrupts capitation?
- Should commissioning drive and incentivise greater sector convergence through a health hub type models? Should it incentivise locality collaboration?
- Will a shift to online care, GP mobile care and group consults in community settings lead to general practice building largely for clinical procedures only?
- Are solo GP /small practices able to fully support new models of care?
- Do we need to think about a new funding model for primary care?
Workforce

- Focus on getting best clinical value from each clinician driver for extended practice teams. A solution for the reducing GP workforce and rural sustainability
- Workforce not equipped for proactive high needs complex care co-ordination
- GP Recruitment improving in most HCH practices
- Reaching the non-engaged showing early signs of success with practice-attached community health workers non-practice settings
- Access to real time data is driving change and engaging practitioners in change
- Engaging community service managers in working more collaboratively has been challenging in some regions
- Lack of formal training for virtual health and proactive high needs care

Questions
- Is a clinician focused primary care workforce the most appropriate for tackling health inequity and increased morbidity?
- Are we training clinicians to understand and act on various streams of data?
- Are we training a workforce trained in behavioural lifestyle support and coaching?
- How do we generate system level workforce development plans?
• Needed a completely new approach to managing patient information that enabled live, single and shared records – Indici developed

• Patients are keen to engage in using technology in partnership with team but clinicians generally slow to respond

• Use of portals significantly higher in HCH practices

• Over 45s highest users of the portal but Maori under-represented

• Online care increasing capacity with existing workforce

• Access to real time data is driving change and engaging staff in benefit of change

• Clinicians seeing opportunities for mobile working

Questions

• Will we have a coherent national strategy for health system technology to support the grass roots desire for new models of care

• Are we training a workforce that can deliver tech-enabled care?

• Will the NZ health sector review be radical enough to support mainstream tech enabled care?
Thank you

healthcarehome.co.nz

helen.parker@pinnacle.health.nz

@helenpparker

@HCH_NZ  @HCHcollab