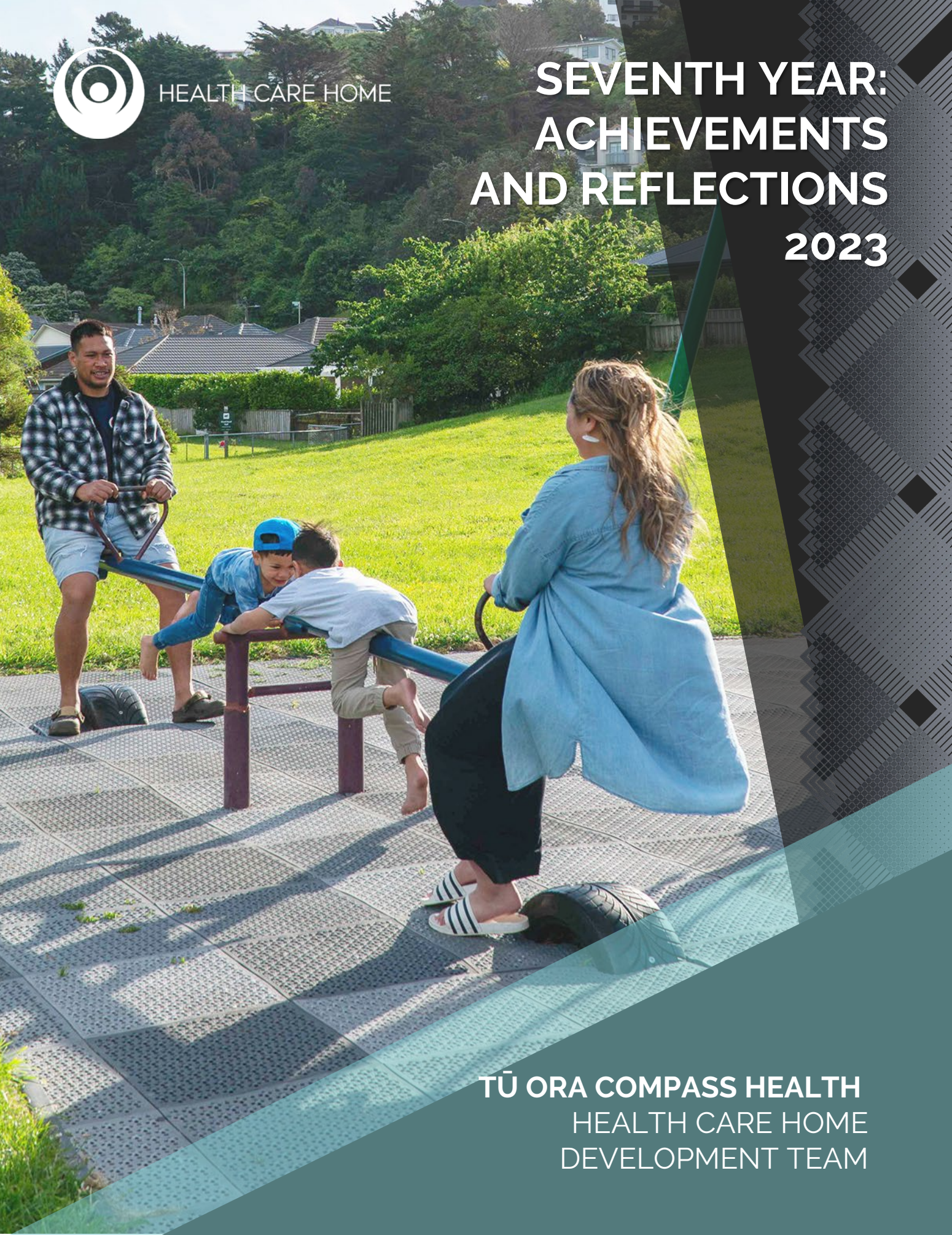
HEALTH CARE HOME

SEVENTH YEAR: ACHIEVEMENTS AND REFLECTIONS 2023



TŪ ORA COMPASS HEALTH
HEALTH CARE HOME
DEVELOPMENT TEAM

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FOREWORD

The Health Care Home programme is moving into its eighth year at Tū Ora Compass Health, implementing and embedding the model of care within primary health across the Wellington and Wairarapa regions. In this publication, reflections share further insight and depicts the positive impacts of the Health Care Home (HCH) model through practice stories and the patient voice.

First introduced to Aotearoa over a decade ago, the sustained collaboration between **Tū Ora Compass Health, Te Whatu Ora** and **Community Health Services** has supported continued implementation of the Health Care Home model where meaningful change has resulted in a positive impact on our practices, people, and whānau.

Over the last few years, the pandemic has had an immense impact on primary care as it highlighted the need to constantly pivot in an ever-changing environment. The core elements of the Health Care Home model became a necessity as we embraced these new ways of working. A journey from which primary care teams across the nation were forced to re-examine and adjust to alternative ways they deliver health services while continuing to address the health inequities at full front and centre.

Change has been integrated and well-embedded with our approach. We have witnessed Health Care Home practice's forward thinking and response in adapting and delivering **unplanned and urgent care** in a pandemic setting, take an equity lens and a targeted approach to **routine and preventive care**, continue to support a **sustainable** workforce and apply improvement techniques with current **proactive care** processes.

As we look to the future and further develop the model in our region, we observe the cultural shift in patient participation and practice service delivery. Embracing the ideology that the Health Care Home model delivers for Māori means that future models of care designed in this way will deliver for our priority communities and lead to better health outcomes for everyone.

HEALTH CARE HOME AROUND AOTEAROA

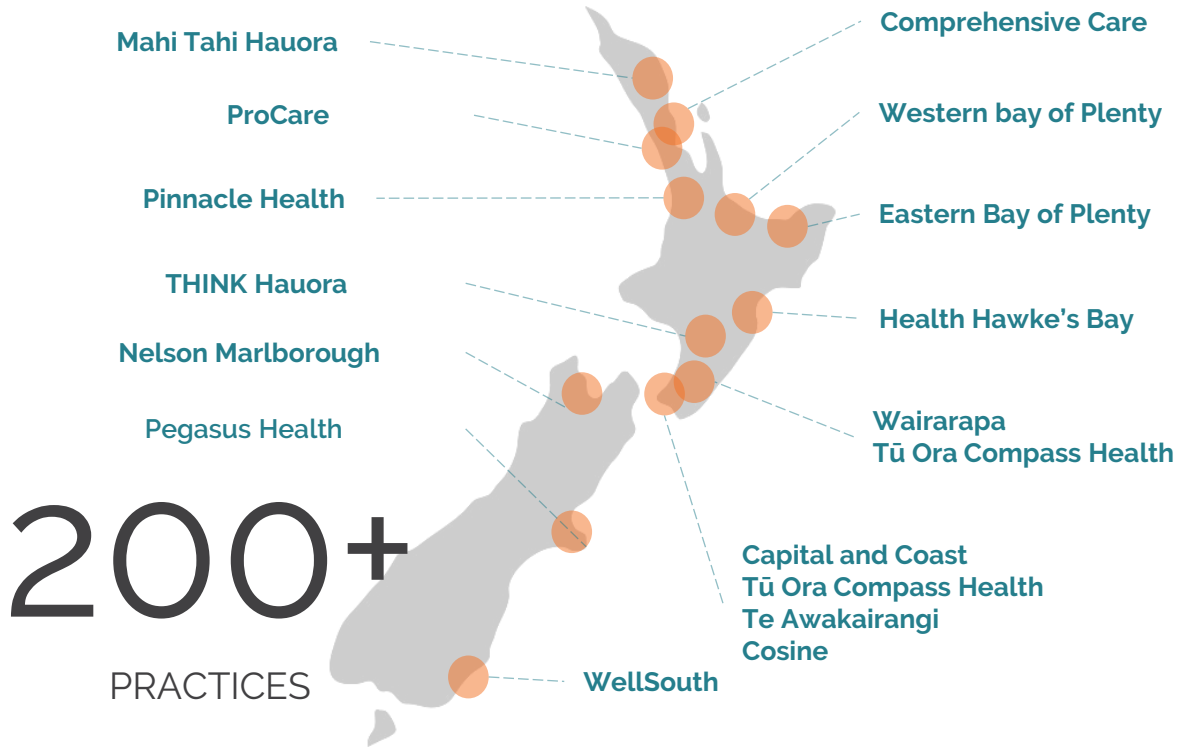
The Health Care Home programme has now been incorporated into more than 200 general practices across the country covering an enrolled population of over 1.5 million people.

1.5M

PATIENTS ENROLLED IN A HCH PRACTICE ACROSS AOTEAROA

The programme is being continually refined and developed for our current context, with the most recently updated version of the model of care enhanced for equity and lived experience leadership. The model shifts the traditional system of general practice from one that is mostly reactive, to a more proactive, and team-based approach that focuses on the individual needs of the patient and their whānau.

"The enhanced Model of Care was introduced to the sector in October 2020 and focused on embracing Māori models of health and its domains related to Māori world views and delivering tangible benefits for Māori and other priority populations. For that reason, it is framed in the context of Te Tiriti o Waitangi, Wai 2575, Pae Ora and Whānau Ora." (Collaborative Aotearoa)



200+

PRACTICES

Nāu te rourou, nāku te rourou,
ka ora ai to iwi.

With your food basket and my food basket, the people will prosper.

Justine Thorpe
CEO, Tū Ora Compass Health

As we have emerged from the COVID-19 pandemic, it has been impressive to see the continued progress of the Health Care Home programme across our region. Our first tranche of Health Care Home practices are now entering year 8. This is a significant achievement, making our region's Health Care Home program the most sustained and at scale in Aotearoa New Zealand.

Health Care Home practices are leading the way in innovation with new technology, expansion of roles within the primary care team and ways of working. It is positive to see the continued increase in patient engagement and focus on equity for Māori, Pacific and other priority populations, supporting people and whānau to be more engaged in their wellbeing journey and how they want services delivered to them.

Critical to the success of the program over the eight years has been the change management team. This is a key enabler to sustainable change, and I congratulate the team for their tenacity and flexibility during the pandemic in supporting the practices to stay on the journey, and of course, without the ongoing commitment of the practices to continuously develop their model of care so it is responsive to the needs of their community, the change would not have been possible. So, I congratulate all 39 practices on the program.

NGĀKAU PONO
INTEGRITY

KOTAHITANGA
TEAM WORK

Tū Ora
COMPASS HEALTH

MANAAKITANGA
CARING & RESPECT

WHAKAPAI
CONTINUOUS IMPROVEMENT

Debbie Chin
Chair, Tū Ora Compass

Debbie was appointed Chair of Tū Ora Compass Health in 2022. In her previous role as CEO of Capital and Coast DHB Debbie championed primary care, embraced the vision of the HCH programme, and laid the foundation to enable the transformation to make it the success it is today.

The HCH programme is widely recognised as the new normal and we are proud to have come this far to build a transformational and healthier future. The model of care is part of many advancements to primary care, a movement towards trust in developing new model of care to accommodate the changing needs of our ageing population, working closely with general practice, and family doctors to keep people safe and well in the community. The programme pathed a way for few people needing to be admitted to hospitals, and those who are discharged less likely to be readmitted.

I also want to acknowledge all the individuals, practices, and organisations involved with HCH from its inception. It is through the leadership and commitment of all involved that that we have witnessed the growth and transformation enabled by this model of care.

Dame Karen Poutasi
Chair, Te Whatu Ora

Dr Karen Poutasi was named in the 2020 Queens Honours as a Dame Companion of the New Zealand Order of Merit for services to Education and the State.

The Health Care Home programme has changed the way general practice operates these past seven years. It has done so by establishing strong foundations towards a real system-wide transformation of health care services where patients, whānau and the community are at the centre. We have witnessed a shift towards a more genuine partnership and valuing that, we want to strengthen it further.

Being a part of this programme has meant primary care staff are competent, confident, and support one another in leading quality patient-centred delivery. It means we are operationally smarter and are meeting the demands of the ever-changing primary care environment.

OUR APPROACH

The Health Care Home Programme has now reached over 80% of Tū Ora's enrolled population within Capital, Coast, Hutt Valley, and 100% coverage in the Wairarapa.

The team is committed to honouring Te Tiriti o Waitangi while responding to Pae Ora – a healthy future for all New Zealanders. We support general practices with change and implementation of improvements to services. This is done through building trusting relationships, championing the Health Care Home programme, and creating an environment where the voices of whānau and communities are heard.

We have continued to support Health Care Home practices with:

- **Facilitating Health Care Home locality peer groups**
- **Facilitation of extended workforce peer groups**
- **Developing a Health Care Home dashboard, accessible to all practices displaying key measurables**
- **Robust practice resources**
- **Supporting communication between practices and community services for multi-disciplinary team meetings**
- **Winter initiatives to reduce patient hospitalisation and ED attendance**

100%

COVERAGE
WAIRARAPA

82%

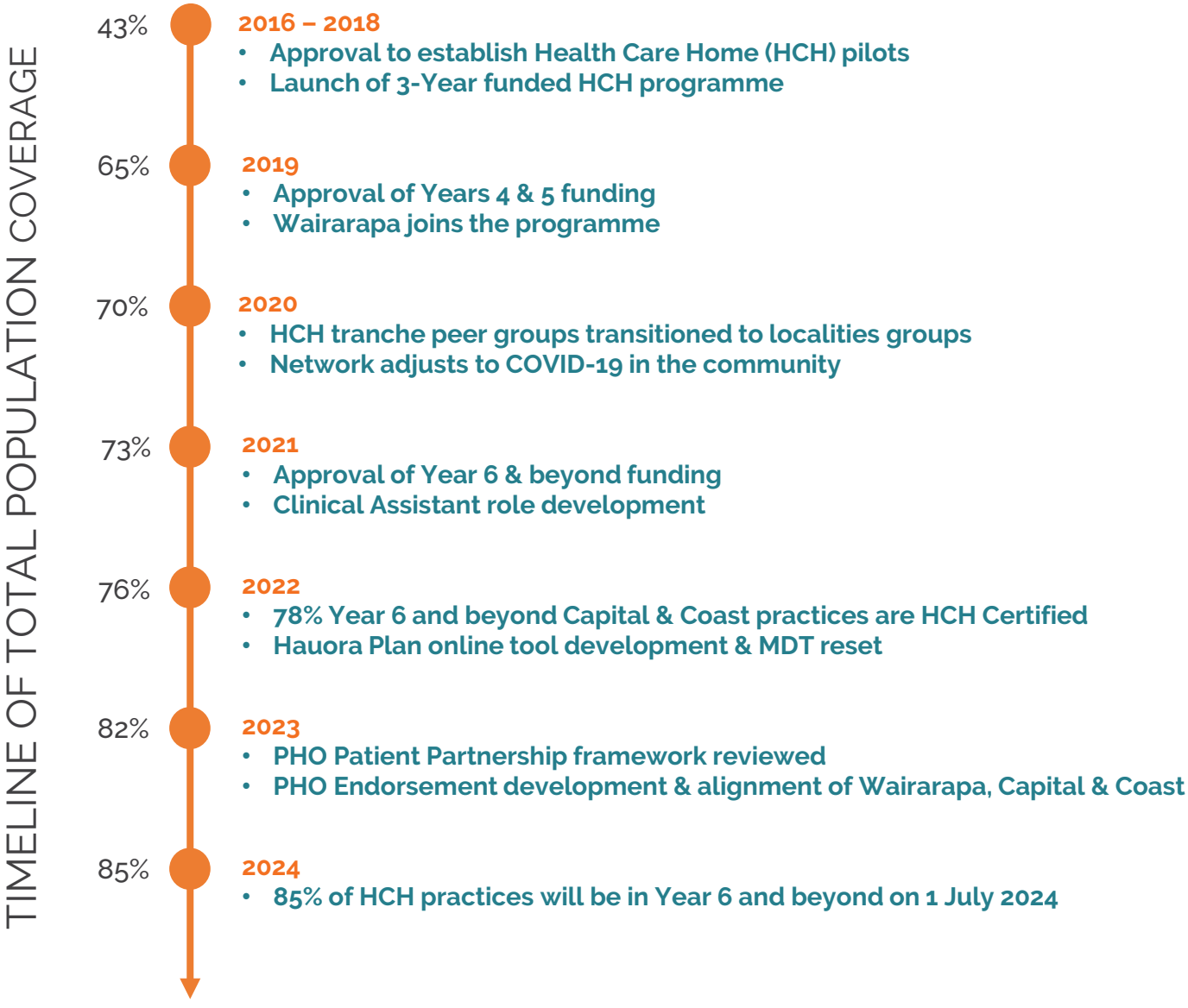
COVERAGE
TOTAL POPULATION

Tū Ora HCH Team (left to right) Ny Brunenberg (HCH Change Facilitator), Cara Keohane (Programme Coordinator), Amelia Walsh (HCH Programme Lead and Change Facilitator) and Lucie Ashford (HCH Change Facilitator).

OUR PROGRESS

The HCH journey so far has succeeded in establishing strong foundations for a real system-wide transformation of health and care services towards one where people and the community are at the centre and General Practice takes on more of a support role. In effect, the HCH programme has improved the awareness for integration beyond health care and more into the community.

Progress in our local programme has been achieved through strong collaboration between other Primary Health Organisations, Collaborative Aotearoa, Te Whatu Ora Capital, Coast, Hutt Valley and Wairarapa, and other community integrated services. We have witnessed it introduce more flexibility in delivery through improved relationships and technology making it more resilient.



OUR PRACTICES

Year 2 - 4, Year 5, Year 6+

39

PRACTICES INVOLVED IN THE GREATER WELLINGTON, HUTT VALLEY & WAIRARAPA

- Mahara Health
- Coastal Medical Rooms
- Team Medical
- Hora Te Pai Health Services
- Paraparaumu Medical Centre
- Raumati Road Surgery
- Waikanae Health Centre

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

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

- Hutt City Health Centres
- Onslow Medical Centre
- Tawa Medical Centre & Linden Surgery
- Mana Medical Centre
- Newlands Medical Centre
- Porirua Union & Community Health Services
- Titahi Bay Doctors
- Wellington Medical Group

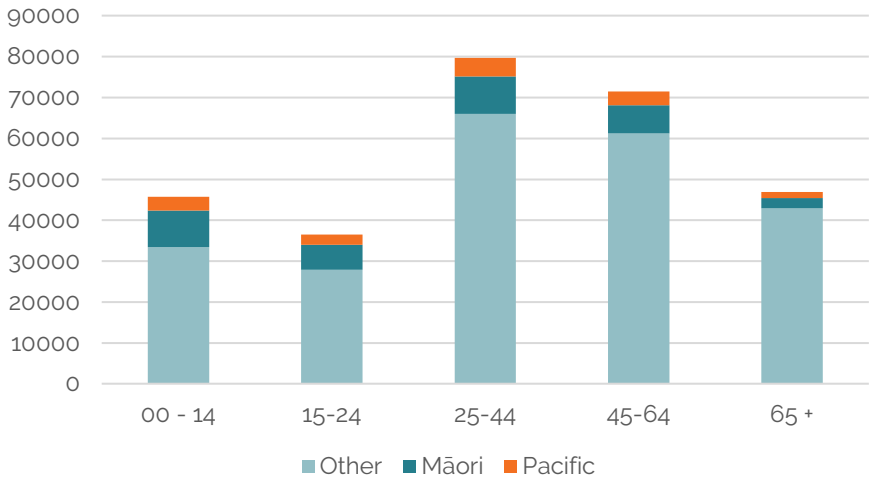
280K+

ENROLLED PATIENTS

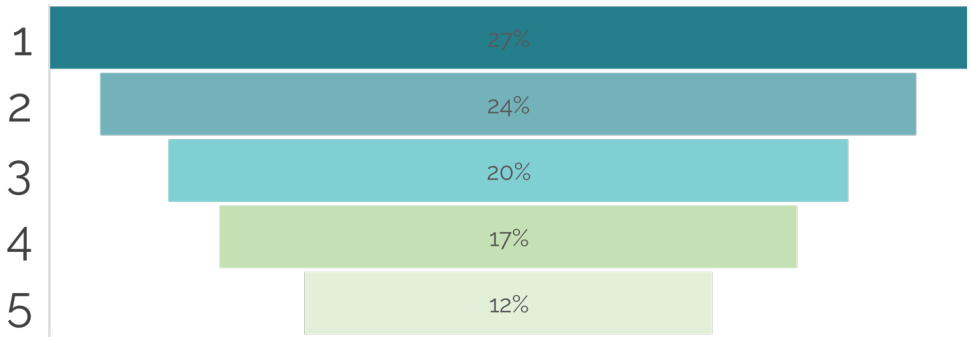
25%

HIGH NEEDS

% HCH Patients by Age Band



% HCH PATIENT BY QUINTILE



PATIENT & TEAM STORIES

These stories bring to life the impact the Health Care Home model of care is having on both patients and staff.

Sharing these stories and experiences highlight one of the key design principles guiding our programme, that patients and staff need to be front and centre of any transformational change in health care

It's important to celebrate what is working well and learn and reflect on what can be improved. We will continue to gather stories from the people doing the mahi and that have been kind enough to share with us. They provide an essential record of our journey, and they highlight the impact of the change.

SUSTAINABILITY

Sustainability values a patient's experience and looks to improve care using Lean methodologies and change management tools. Improving practice workflow, extending practice teams to provide better access for patients and developing staff to work at the top of their scope result in better outcomes for patients and their whānau.

Newtown Medical Centre Practice Team

Extended Workforce at Newtown Medical Centre

Newtown Medical Centre is a long running integrated family practice in the heart of Newtown, Wellington. Now in year 7 of the Health Care Home programme, Newtown Medical Centre has embraced the extended care team and is championing sustainability and innovation in primary care.

We spoke with the Business Manager Michelle Curel, Operations Manager Sharon Eggers, and Nurse Manager Karen Shonakan to find out more about the team and how they support their community.

What made you consider adding a paramedic to your team?

Initially, we had a doctor dedicated to doing one session each morning for triage. However, we realised that this was taking up a significant number of routine appointments and we had a wait time of up to three and a half weeks to see a clinician. We were approached about having an Extended Care Paramedic (ECP) join the team and saw this as an opportunity to use his skills in acute triage effectively.

How has having a Paramedic improved equity and access for your patients?

It is evident that Tony has had a significant positive impact on patient care and the overall functioning of the practice. We have reduced wait times, improved access to care, reduced reliance on ED, and more time for patient education which is improving our patient's health outcomes.

"If it's an urgent matter, I am happy to see whoever is available as I trust the practice. My health records are good, and I use the Manage my Health app."

(NMC Patient)

How long have you had a Clinical Assistant working at Newtown Medical?

The role was introduced around four years ago with a focus on sustainability for clinicians. Over time, this role has evolved, and we now have two Clinical Assistants, Anne-Marie, and Jean. These roles have not only improved the efficiency of administration tasks but have also played a role in helping with sustaining the wellbeing and work/life balance of the clinicians. One of our GPs tells his young family that the reason he can be home to have dinner together is because our Clinical Assistant helps with his inbox management.

Newtown Medical Centre Patient notice board

How has the role improved your team dynamics?

Tony's role as our ECP goes beyond just providing triage and patient care. He actively contributes to the overall efficiency and cohesion of our team. His collaborative approach, support for the nursing team, and ability to work under standing orders enhance the quality of care for our patients. Tony has also provided a lot of in-house training with the nurses and supports them with his assessment and triage skills which has been amazing.

"I was treated with respect and dignity during my consultation with the health professionals".

(NMC Patient)

Visual representation of a practice common room operating key HCH functions such as MDT meetings, Team huddles and using Lean methodology value stream mapping

"Right from the time I entered the reception area I was treated with respect and had everything explained to me." (NMC Patient)

Your practice has a great record with staff retention, how do you achieve this?

We foster a positive work environment and a culture for the adoption of new ideas and change management. We are innovative, encourage collaboration, and support our staff to upskill in their areas of interest, which helps with job satisfaction. We are a happy team who support each other, which makes it a great place to work.

The nurse practitioner was very friendly and experienced. She was able to answer my health questions quickly and in plain English, so I was able to understand." (NMC Patient)

How do you ensure your recruitment processes promote a diverse workforce that serves your community?

We place a strong emphasis on staff diversity, with members of our team collectively speaking multiple languages, including NZ sign language. We incorporate an equity-focused approach into all aspects of our work.

You've got 2 Nurse Practitioners; did you train them here and how do they fit into the team?

Our initial Nurse Practitioner, Leah, was an integral part of our nursing team for several years prior to training as a Nurse Practitioner. She was mentored by one of our GPs, Dr Jill Shepherd. Lynne, our second Nurse Practitioner, became part of our team just over one year ago. The combination of their training and expertise is a valuable addition to the clinical team, with patients registered under their care. Their versatile role contributes significantly to their patients' care. Leah has a special interest in women's health and is an essential member of the Menopause Clinic team, and Lynne has many years of experience in acute care from working in the Emergency Department.

"She really investigated my history and made a follow-up chest Xray to investigate further. I really felt heard and professionally triaged." (NMC Patient)

Lean approach to integrated care at Whitby Doctors

In May 2022, Whitby Doctors became part of Wellington Medical Group (WMG) and adopted Lean and integrated approach alongside their WMG partner practices (Johnsonville Medical and Thorndon Medical).

Lean is an approach that seeks to improve flow and eliminate waste (Lean6Sigma)

As one of the early Health Care Home adopters, the team at Whitby Doctors have displayed admirable teamwork as they adapt to workforce and internal system changes. Staff have benefited from Lean methodologies such as value stream mapping and the 5 S pillars. Application of these Lean tools made positive impacts on the team in learning and adjusting to new or different ways of working. The transition behind the scenes and the IT changes needed to undertake the shift appear seamless for patients.

From this integration, additional support and increased access is now being offered to patients, this includes acute care support, extended hours and weekend services. The team can now for the first time in a long time, welcome new enrolment to patients in their wider Porirua community.


Whitby Doctors Practice Team

"It was the first time a GP had called me for a phone consultation, and I really appreciated the provision. Especially because I rarely take sick days off work, and I couldn't physically come in to see the doctor. My usual GP was on leave, but I felt she had been my GP for years." (WD Patient)

"Access to lab results etc. via the web portal are particularly useful for me to prepare for the meeting and go a long way to ensuring that these virtual appointments work well."(WD Patient)

Here is what the team at Whitby Doctors have achieved:

- Daily digital team huddles across all three sites
- Seamless handover for patients who are welcomed at any WMG operating site
- Standardised processes, warm-handover, and clinical correspondence of patient's clinical notes between all sites
- Sustainable intranet platform to keep staff at all practices updated with key PHO messages and other relevant resources
- Overhaul of Whitby Doctors logo and online presences
- Improved access to appointment and Portal Communication for patients

The Clinical Assistant Role

Mabli Jones and Dr Louise Poynton

During the 2021 GP Forum a consistent theme around the extensive time needed for the clinical inbox, administration and paperwork burden was noted.

As a result of this, Tū Ora Compass Health developed the Clinical Assistant (CA) role with the intention to support clinicians to work to the top of their scope and reduce burnout, making it more sustainable. Further developed by Dr Louise Poynton (Tū Ora Medical Director) and Mabli Jones (Tū Ora Deputy CEO), the CA role was introduced to the network by the Health Care Home team in early 2022.

A delegation framework for an unregulated role

The extent of the CA role was reviewed by several clinicians and a wide number of possible tasks were identified, which was narrowed down to an inbox support role in its initial phase of development.

Introducing an unregistered workforce for this role into general practice meant that there was a requirement for a delegation policy and framework, and position descriptions and clear training guidelines, so that the role could be implemented safely.

The framework identifies inbox results by type and gives a set of actions that can be undertaken by the CA, depending on the result. The CA can file select normal results, where clear documentation is present in the practice's Patient Management System, update classifications, set reminders for follow-up tests, book follow-up appointments, and annotate letters and results so that the clinician can rapidly work through the final sign off for more complex or abnormal results.

Key Learnings from a GP involved in the Clinical Assistant Pilot

Wellington Medical Group (WMG) was one of 8 pilot practices. Overall, the team found the Clinical Assistant delegation framework to be flexible and adaptable, fitting the needs of the practice team. We spoke with Dr Sian Williams about the CA role and shared some insights and key takebacks from rolling out the CA role.

"We do what we're comfortable with and the team have worked out a way of doing things that suit them. From the original framework, we developed a more workable structure which now enables the CA role to move into different areas." Dr Sian Williams

The team at WMG advocates the importance of GP supervision for at least one hour per week. This provides an opportunity for a CA to troubleshoot, and time for further learning and systems development. Under an adapted delegation framework, WMG's CA is assigned to review portal messages. They have the approval to book a follow-up appointment if a patient's message requires a consultation. Anything they are unsure of is left for clinicians to pick up.

The WMG team undertook a time and motion study to see if there was time saved during the pilot period. They found that over half of their nurses felt they had saved over an hour a week by having the CA involved. It was positive to learn nurses are able to work to the top of their scope and reduce their computer time spent doing administrative tasks.

"In our study, we recorded a nurse spends 26 minutes inputting screening items over a period of one week, 26 minutes alone may not be a huge amount of time, but when you extrapolate that to our whole team and a patient load of 25 ,000 patients, that's 10 hours of nursing."

"As for our doctors, we looked to do a survey type study and over half of the doctors felt that they saved two plus hours per week and has some positive impacts for them."

After almost 2 years of on-boarding the CA role, WMG is now beginning to see the long-term benefits of having a CA conducting these administrator tasks.


WMG CA Shelly Marriot and Dr Sian Williams

Their Patient Management System is more accurate and there are clear systems in place for reconciliation process. There are efficient patient transfer processes in place which ensures new patients start their journey at the practice with everything in order and more.

"It's quicker for ACC details to be added and we don't have to do the extra work to try and get that sorted."

"It's useful for when we have a day off and if anything, abnormal comes through there are systems and protections in place. So, we can have a day off, relax and not worry, which is a nice thing."

"Even the most unsure, and sceptical of our GPs, have found benefits in the systems that we've put in place and by having someone take out that noise from their inbox, and just focus on the important stuff."

URGENT & UNPLANNED CARE

Urgent and Unplanned Care is about the right people, doing the right work at the right time, resulting in how to better manage acute demand and improving access using a variety of tools.

Establishing GP Telephone Triage at Eastern Bays Health Centre

In Year 2 of the Health Care Home programme, Eastern Bays Health Centre was in the last cohort of practices to join. They have been working to integrate the core elements of Health Care Home. We recently spoke to Tanya Prince, Practice Manager about initiating GP triage in the practice.

When did you start GP triage, and were there any reservations amongst the team?

We started doing GP triage in March this year (2023). It took some planning and training with the team before we initiated it.

As with any change, some staff were hesitant. For the GP triage to be successful we needed to ensure that there were urgent appointments available in the GP appointment book on the day. This meant a change in the way that appointments were used.

How have GPs found the process?

The GPs have really got on board with triaging. We are now seeing around a 50% resolution rate which is great for our patients. It is useful in ensuring that GPs are seeing the right people and smaller issues can be dealt with immediately, freeing up appointments for people needing them on the day.

Eastern Bay Medical Team

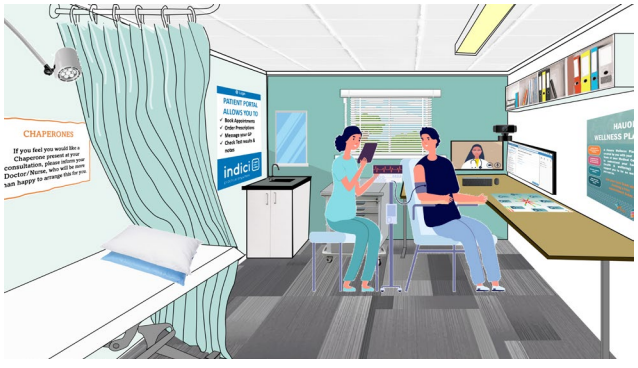
"I was very lucky to get same day a triage phone call with the Nurse then a phone appointment with another GP, mine wasn't available. I needed that to get the ACC claim in so I could then go to my physiotherapist and osteopath." (EBHC Patient)

Have there been any major challenges with GP triage?

The GPs do find it can be difficult to stick to the 5 minutes allocated, but they are learning to manage this with experience. They have found getting hold of patients can also be difficult at times.

How have your patients and other team members found GP triage?

Reception staff have found it incredibly useful in being able to book patients onto GP triage when no other appointments are available. Nursing staff have noticed a reduction in nurse triage work which has been great for them.



Case Study on PCPA assisting In-clinic GP Virtual care

"I feel my visit went well due to being able to talk to the doctor and nurse as people instead of them talking clinically like a robot to you. And also, how everything was explained thoroughly and in terms that I understood what was wrong what needed to happen, and the next course of my treatment and action towards me getting better". (EBHC Patient)

How do you ensure Māori and Pasifika patients are prioritised when they call for a same day appointment?

As a Pasifika health provider, we are acutely aware of the inequitable health issues within our diverse communities.

All patients are triaged according to clinical needs, and as such, inequalities based on ethnicity are taken into consideration during the triaging process.

You added an acute clinic over winter this year – how did you set this up?

We have four doctors working at our clinic. Each doctor has one morning session per week dedicated to the acute clinic.

How has your hospital utilisation been affected by the acute clinic?

We have seen a reduction in our hospital admissions and ED attendance rates since March. We believe that this is a result of a combination of factors – GP and Nurse triage and the availability of acute appointments with our acute clinic.

We have also been monitoring patients who are attending ED, and contacting them for review, along with promoting other services to patients when they need support such as Practice Plus, Healthline, and Wellington Accident and Medical Clinic.

The whole clinic has a friendly and kind vibration they genuinely care about each individual that comes through the door. I feel the rapport the staff have with each other reflects well towards creating that vibration it creates a nice feeling about the place." (EBHC Patient)

Extended Care Paramedic at Greytown Medical

Clinical Telephone Triage is a core component of the Health Care Home Programme at Greytown Medical Centre (GMC). It has enabled the practice to manage acute demand and ensure appointment availability for those patients who need to be seen on the same day. Matt Hitchiner is a highly skilled Extended Care Paramedic (ECP) who performs telephone assessment triage and assists the practice team with urgent care.

"The term 'Para' comes from the Latin 'to work alongside' doctors, and that's very much what I do here – though I'll extend that to working with all people in the health profession as an Extended Care Paramedic." (Matt - ECP)

Matt works under Paramedic Guidelines and standing orders. He works closely with GMC prescribing clinicians to ensure patients receive a positive outcome whether that be a prescription, dressing, referral, or stitches. We spoke with Matt who joined the team as an ECP in April 2023 after working at Wellington Free Ambulance for 8 years.

Can you tell us about how your role fits into the medical centre?

My main role is to assess and treat acute presentations on the day, either via phone triage or people walking in. This role also allows me to support and focus on Primary Care cases such as home visits, ECG interpretations, and difficult cannulations and bloods. Another aspect of my role is utilising POAC funding through the delegated scopes. This includes the Extended Care Pathways which reduce the number of patients going to the hospital. As an ECP I can draw on the knowledge of doctors, nurses, and nurse practitioners in the practice, rather than just taking patients to ED as an Intensive Care Paramedic.

"I was referred to the paramedic who was excellent". (GMC Patient)

What made you interested in working in primary care?

I've got a particular passion for a holistic way of dealing with patients. I completed further study at a master's level in this area. I first worked as a Paramedic in London where there was significant trauma and medical emergency cases. What I progressively found was the patients seen in the ambulance sector were primary care cases. Looking after an ongoing cohort of patients at Greytown Medical really interests me.

"It's been a good progression into something I am passionate about".

(Matt - ECP)

Jane Taylor & Matt Hitchiner

The HCH team asked Greytown Medical Centre's Practice Manager Jane Taylor her thoughts since on-boarding Matt.

How has the practices' acute management improved now that there is a Paramedic on the team?

This has been a great initiative to have for our team. Matt has taken a huge stress off of our clinicians, who are not having to double book acute appointments or work through lunch times anymore. It is highly noticeable within the wider team. We discuss which clinician Matt is assigned to each day in our daily huddles. There is always someone who is his go to if he has a question or needs support with something beyond his scope of work.

How have patients responded to this way of working?

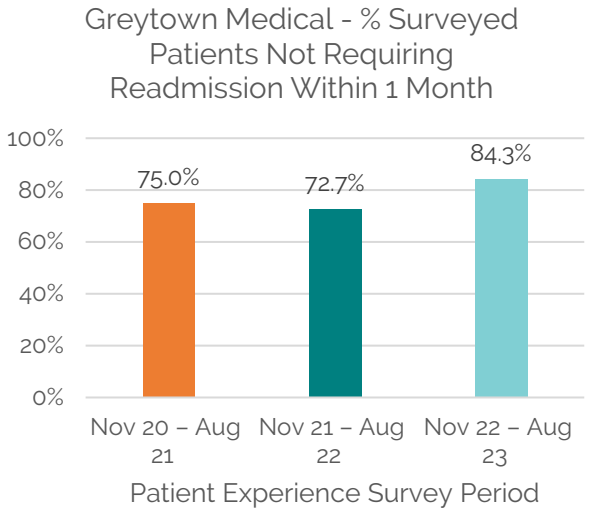
If a patient rings up and need to be seen on the day, they can be seen. Our patient's perception has improved already.

What background work did you have to put in place for this role - in terms of their scope of practice, job description and standing orders?

Finding the right person is important, particularly as there are different types of paramedics. It is a journey to incorporate a new clinical role like this into a practice, so you need to find someone who you can work with to set up their scope of practice. Matt was involved from the beginning in developing standing orders and processes.

He has worked alongside the rest of the wider team to ensure that it suited everyone.

"I am grateful to the Paramedic, Dr and NPs at Greytown Medical Centre for the care provided. As professionals they all listened and made an effort to help me and to get things in motion for me quickly." (GMC Patient)



In the 2023 patient experience survey, it showed 84.3% of Greytown Medical Centre's patients who had an overnight stay in hospital did not get re-admitted within 1 month after discharge, improving from previous surveys.

"I am grateful for access to the Paramedic who has just been taken on. He was most helpful to me recently." (GMC Patient)

PROACTIVE CARE

The Proactive Care approach is about stepping away from the reactive space, and making a fundamental shift in ways of working, prioritising our most complex patients for planned care with a holistic view to a person's life, and supporting them to stay well.

A Proactive Approach at Coastal Medical Rooms

Located in Kāpiti, Coastal Medical Rooms has been providing care to the community for over 20 years. Now in their 5th year of the Health Care Home programme, the team at Coastal stands out when it comes to providing proactive healthcare to their complex patients. We spoke with Nurse Becky Negus who has been leading the proactive care work at Coastal.

Coastal Medical Rooms was one of the first practices to test the new online Hauora (Wellness) Plan tool. How did you find the transition from Year of Care to a more holistic approach with your patients?

The transition to a holistic approach of proactive care planning has been a stepped process within the practice. It has been very well received by both our staff and patients. Patients like the wellbeing wheel because it is visual and interactive. As a nurse, I have the benefit of gaining insight and getting to know my patients in a different way. Together we look at a patient's whole self and support them to identify where they may want to make some personal goals. The transition to the online tool has taken some time to get used to, but ultimately it has been a positive change and has enabled us to refer to local community services.

Coastal Medical Rooms Nurse Becky and PCPA Nicola

Who at Coastal is involved in the process? Is it mostly driven by nurses or is it a team effort?

The work is driven mostly by myself and another nurse, Gayle. We hold the Hauora Plan consults during our nurse clinics, so this is protected time. We'd like more of the team to do the consults and use the tool. As time goes on, we plan to have more of the team trained up. The wider team supports us in different ways, such as by referring a patient in-house for a Hauora Plan consult. We will often be able to refer a Hauora Plan patient to our in-house HIP (Health Improvement Practitioner) or Health Coach. It's great we can offer all those services within the practice.

In general, we have found proactive care to be the more challenging HCH domain to embed. Have you got any tips for embedding proactive care planning within your practice? What has worked well?

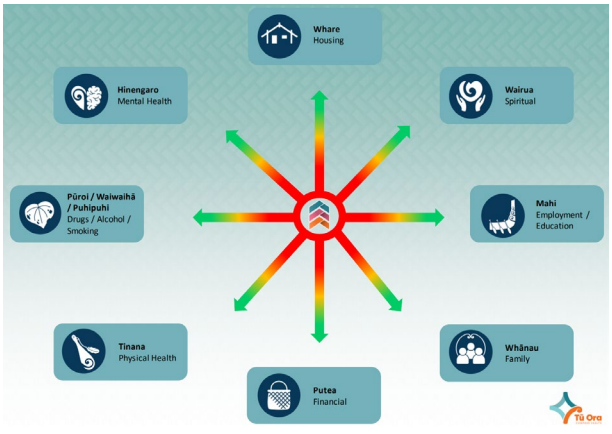
We know that proactive care planning is patient-led, so that's how I sell it to them. It's about empowering patients to sit in the driver's seat and have a bit more control. They can see the whole picture, what's going on behind the scenes, and if there is any more support that we can offer. If you don't know the patient well, it's good to say, "your doctor supports it". We have had a very good uptake, so it's about getting patient buy in.

In the appointment I let the patient guide the discussion and what they want to focus on because it is about what matters to them. If they are struggling to identify something to talk about, I might prompt them with some questions, which can assist them in starting the conversation. These might include, "is housing an issue?", or "is it about your physical health?". I always have a laminated copy of the wellbeing wheel for patients who have trouble with their eyesight or can't see the screen in the room. Patients also appreciate the follow-ups and the phone contact. Continuing to build a trusting relationship with your patients is a really important part of the process.

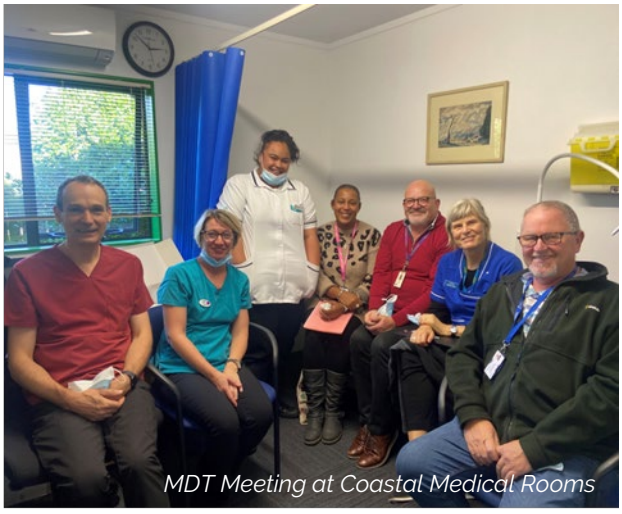
What benefits or outcomes have you witnessed with the patients who have had a Hauora Plan?

I have supported a patient to complete a proactive care plan every year for three years now. She has dementia, and her husband does all her in-home care and brings her in for her appointments. I've built a rapport with them over the years, and I feel I know them quite well. It's been really nice from that point of view. They have both appreciated the change to the holistic approach and using the wellbeing wheel.

Another patient was worried about being alone, as her husband had moved into a residential care facility after living together for 60 years since they moved here from South Africa. She wasn't coping and was worried about how she would manage the money side of things. After completing the Hauora Wellness Plan, we were able to refer her to the Health Coach and HIP, as well as connect her with a Social Worker. This is an example of how a care plan can work for people with good outcomes.



Wellbeing Wheel



MDT Meeting at Coastal Medical Rooms

In May 2023, the HCH team attended the Multi-Disciplinary Team (MDT) meeting at Coastal Medical Rooms, welcoming the much-anticipated integration of the Mental Health team (MHAIDS) to the wider MDT servicing the Kāpiti HCH practices.

During the hour-long meeting, nine patients had been discussed by the group. Three GPs attended the meeting at different times to discuss their own patients. Some previously discussed patients were followed up with, patients who had been discharged from the hospital had plans put in place, and some complex patients had further referrals. The group also discussed how the Mental Health team will fit into the MDT meeting. A patient was also recommended to be added to the list for the next meeting.

Following this meeting, we asked Becky a few questions about the challenges and successes of the MDT meetings, and what positive outcomes for patients and benefits for providers had resulted.

We also asked if she had any tips for coordinating successful MDT meetings (pre-work, during meeting, post meeting).

"As MDT coordinator of the meetings, I feel it's my job to make sure introductions are done at the beginning of the meeting to ensure everyone knows each other and what their role is. During the meeting keep track of time to ensure we don't run over time, check also at the end of the discussion of each patient that the plan made is correct, and relevant referrals if required, are needed. Then I will write up in their notes and set tasks to myself or the GP."

An important part of Becky's role is to liaise with clinical staff about which patients can be brought forward and discussed at an MDT meeting. The sharing of skills between the community teams and GP practice has supported the management of more focused care in the practice, follow-ups, and understanding of the services involved. Becky says ideas and suggestions from the MDT approach are a useful way to understand patients better and she enjoys being a part of delivering patient care from a different perspective.

"The positives from the meetings I feel are being able to hear what's been happening 'behind the scenes' at patients' home and different perspectives of what their needs are, also family dynamics that sometimes we are not aware of. It's an all-round holistic approach to their care, and the more services that are involved the better. Next steps will be to incorporate patients who have had a Hauora Plan discussed at our MDT meetings. This approach would be useful, having the other services assisting with managing these patients' health."

Proactive Care Planning at Island Bay Medical

Island Bay Medical Centre has been serving the community for over 50 years. They have been championing proactive care planning for patients and whānau to maximise their health, independence, and wellbeing. We spoke to Amelia Radford, Nurse Coordinator and Health and Wellness Champion, about how they have sustained proactive care planning through challenging times.

Island Bay Medical Nursing Team

Why have you prioritised proactive care planning at Island Bay Medical Centre?

Proactive care planning is first and foremost of significant benefit to the patient. Prevention of exacerbation and deterioration clearly enables the patient to live a more fulfilling life but also prepares them to manage these better should they occur.

Along with direct benefits for patients, the long-term support and planning means that clinicians are required less for acute care which could be avoided by proactive care planning. This in turn means that our clinicians can see other patients acutely and are able to quickly manage scenarios for those with long term conditions as per their care plan.

Do you have a proactive care planning lead, or do you use a team-based approach?

We have a Health and Wellness Champion; however proactive care is prioritised by the whole team with support and priorities given to us by the partners of the practice. Progress of the care planning process is reviewed every two months.

What feedback have you had from patients about their proactive care plan appointment?

We have had feedback from patients who have expressed that having a care plan they can review themselves is helpful and aids them to feel in control of their own health. It has also enabled some patients to include their family in proactively caring for them, which has in turn supported a more positive management of long-term conditions and health.

"Amazing. Can't speak highly enough about IBMC. They have really helped me to take charge of my own health including preventative steps." (IBMC Patient)

"Great level of care with individually tailored approach - very helpful." (IBMC Patient)

"My GP is a very friendly and polite person who I genuinely believe has my best interests at heart and will fight for me when needed." (IBMC Patient

"Prompt investigations arranged, and medications initiated. Good follow up of my care after attending Cardiology Department." (IBMC Patient)

Island Bay Medical Nursing Team

How do you ensure you use an equity lens when you are selecting patients for proactive care plan appointments?

We raise equity at most weekly huddles and the equity champion attends our other champion meetings (Health and Wellness, Respiratory, Diabetes etc.) so that for each of these there is an equity lens included in these projects.

Do you think proactive care plans have prevented hospital admissions/ED attendance?

Yes - creating these care plans has meant that therapeutic relationships are formed which alongside clear plans for managing health conditions, patients are comfortable identifying when to contact us and have multiple ways to do so. So that they can be seen or treated before their condition deteriorates enough to need admission/ ED attendance.

What proactive care plan tool do you use?

Typically, we use the Year of Care, and we have added additional questions to the outline, including social supports, loneliness screening, and the use of Partners in Health screening.

"Always easy to book an appointment and the Dr's are always quick to reply to you and send test results to me". (IBMC patient)

The Multi-Disciplinary Team Reset

Wellington practices and Capital Coast Community Service Integration team - MDT meet and greet.

Health Care Home Practices have moved back to a proactive healthcare approach following the Covid-19 pandemic. The Proactive Care domain of Health Care Home is a framework to move away from a reactive approach and shift the focus to preventative and patient-centred care. This has involved practices re-prioritising Multi-Disciplinary Team meetings with the Practices and the Community Service Integration (CSI) Teams.

MDT meetings were the topic of the first Locality Peer Groups of 2023. These peer groups provided an opportunity for the general practice team and the regional CSI teams (District Nurses, Care Coordination, Health of Older Person, Rehabilitation and Allied Health Services) to connect and re-establish relationships.

Participants found this beneficial to identify gaps and solutions to issues in the current process. The teams were able to work collaboratively to map out a more streamlined approach to MDT meetings.

One of the issues identified was the lack of contact between the practices and CSI teams. The HCH team were able to implement changes to improve direct communication between each practice and their CSI liaison.

These improvements were positively received by both teams as it has resulted in an uptake of MDT meetings going ahead. The relationships that were built during the peer groups allowed for a smooth transition to this updated process.

ROUTINE & PREVENTATIVE CARE

Routine and Preventative Care reflects all aspects of daily care in relation to the practice population, understanding their needs and experience. It looks at how to better engage with patients, focusing on equity and taking a whānau led approach.

Pae Tu Mokai Featherston Medical Whānau Centred Model of Care

Located at Pirinoa Primary School, Featherston Medical developed a Whānau Centred clinic delivering healthcare services for hard to reach, at-risk whānau in the community who otherwise would not engage in healthcare services.

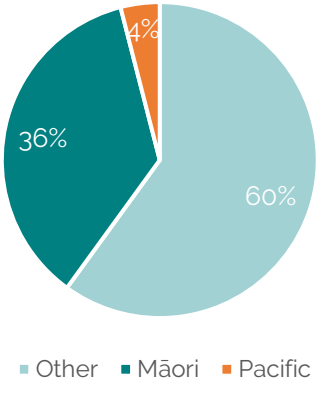
Pirinoa Community Medical Centre provides GP, and Nurse Practitioner services in the community and brings together other medical and social aspects of health & wellbeing (Hauora) through a multi-disciplinary approach to disenfranchised whānau.

"The way the nurse interacted with me was great. The vibe of the environment was warm and welcoming, and this put me in a relaxed mood." (FMC Patient)

Pirinoa is a rural community 20 minutes south of the township of Featherston. Clinicians from Featherston Medical are positioned at the clinic to support and facilitate health care services in the community side by side with other connectors (support agencies e.g., schools, ECE, foodbanks, community groups). This is to build community trust, identify the hard-to-reach population and deliver high-quality health services to whānau in one of these trusted settings in the community.

"I felt the nurse practitioner was proactive in her approach giving me confidence in her understanding of my health. I felt heard and always respected by her." (FMC Patient)

Between opening its doors from July 2022 to January 2023, Pirinoa Community Medical Centre has been received well within this rural community delivering consults with 36% for Māori, and 64% for other and Pacific ethnicities. From recent patient feedback, the team at the clinic has now increased their GP services to meet the demand.



Peninsula Medical Centre Patient Portal and Telehealth

Peninsula Medical Centre serves a community of over 9,000 patients in the Eastern Suburbs of Wellington. They have been early adopters of the core elements of Health Care Home - now in year 6 of the programme, they are constantly looking at ways to improve their service to meet the needs of their diverse population. We spoke to Nurse Manager Kate Lamport about the use of the patient portal and telehealth at Peninsula Medical Centre.

How do you track your portal activation rate?

We track the rate on Te Puna in the Health Care Home dashboard. It's been really helpful to see the rate increase over time. At the beginning of 2022 we were sitting at around 70%, with the work the whole team has done to increase the use of the portal we are now at 90% which is a great uptake.

What do you think has contributed to your high activation rate?

We have ensured that activating the portal is part of the enrolment process with new patients. We have a great admin team that provides support for patients using it as well. We promote using Manage My Health on our website, in the newsletter, in the waiting room, in the clinic rooms and on the phone message when patients call us. We have found patients from all backgrounds are happy to use it from younger to our older population, of which we have quite a large proportion in our community.

Do you use Manage My Health to communicate with patients?

We have found bulk messaging via the portal to be great for getting information out to our patients. We will do a bulk message about our flu vaccine clinics and how to book for example. We have also used it for communicating about changes and new offerings of services.

"I appreciate access to my own medical records on the Manage-My-Health website" (PMC Patient)

How have appointment bookings via the portal impacted the team?

It has really reduced the phone traffic for our admin team which is great, and patients really enjoy being able to see appointments available and book themselves. We do scan the templates to ensure people aren't coming in with respiratory illnesses, but we have found our screening questions sufficient in managing these patients appropriately.

What other functions do you have open in Manage My Health?

We have all the functions open - appointment bookings, prescription requests, messaging, and open notes. Prescription requests via Manage My Health are great for the team, they go directly to the GP which makes for a much more efficient process than other methods of requests which often involve the admin or nursing staff. We have had open notes for many years now and it has been well embraced by our clinicians.

I believe it gives patients a better understanding of their health and their care plan. Portal messaging has a lot of benefits, but I think it is important to have clear boundaries with patients. We are probably still working on getting the balance right for our GPs, we need to ensure they aren't getting bogged down in administrative tasks via the portal.

"My GP is always caring and open and honest about my health having Manage-My-Health helps me understand and makes me feel in control of my long-term health issues" (PMC Patient)

Visual representation of a practice hub operating key HCH functions such as Clinical Triage, Call metrics displays and phones off front desk

How long have you been offering telehealth consultations?

We have been offering telephone consultations for many years, it would have started when we integrated GP telephone triage into the practice. The big push was when all practices had to embrace telehealth during the COVID-19 pandemic, that is when we started doing video consultations as well. We have continued to offer both options but most of the time patients are happy with a phone consultation.

What has the patient feedback been about phone or video consultations?

Patients have given feedback that they really like being able to have a virtual consultation. It provides flexibility for patients who are busy or find it difficult to get into the practice. Our GPs have found that they can do a lot virtually, and only occasionally do they have to bring someone in for something. Most of the time they can assess, diagnose, and treat virtually.

"Being able to have phone consultation whilst in another city at Uni was invaluable." (PMC Patient)

"My daughter was contacted the same day we requested a consultation. A prescription was able to be sent remotely to another city." (PMC Patient)

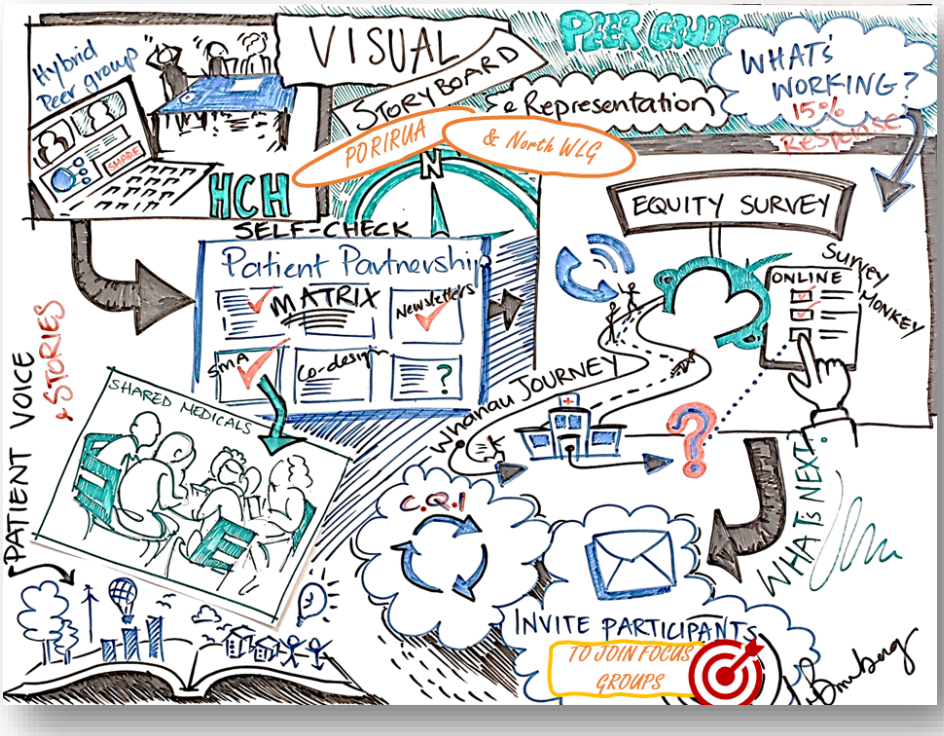
PATIENT PARTNERSHIP

The HCH programme has enabled general practice to identify as a team where they currently sit within the Patient Partnership Framework. A framework that encourages teams to expand on the multiple ways to engage with patients and ultimately improve their access to health care. Here are some examples of how some teams apply meaningful engagement.

A Qualitative Approach

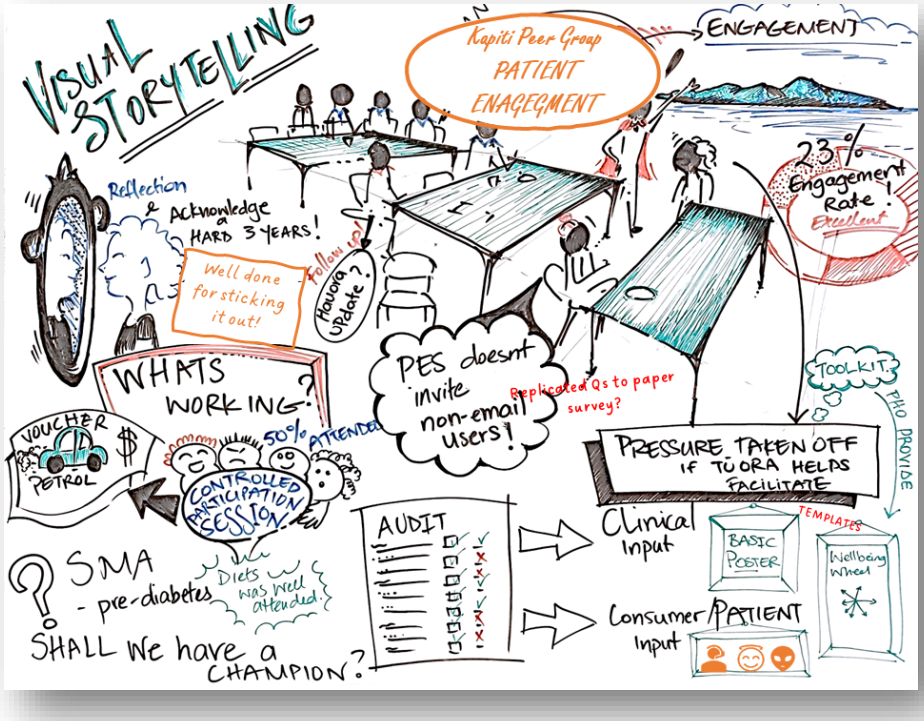
As the Tū Ora HCH team, we collect quantitative or numerical data to help us understand trends, rates, and patterns within our network. However, more often now we acknowledge that qualitative data is equally important. We take the approach that both qualitative and quantitative data are complementary and together they provide better information about situations, context, and opportunity.

To capture in-person discussions at the localities peer groups, we explored a unique method of storytelling. The following illustrations are visual storyboards of the recent patient engagement peer group held across the Wellington region.



At the Porirua and North Wellington Locality peer group, staff expanded on their successful methods of patient surveying and shared medical appointments. Participants took part in assessing and identifying where whey sit on the Patient Partnership Framework and Matrix. (Artist: Ny Brunenberg)

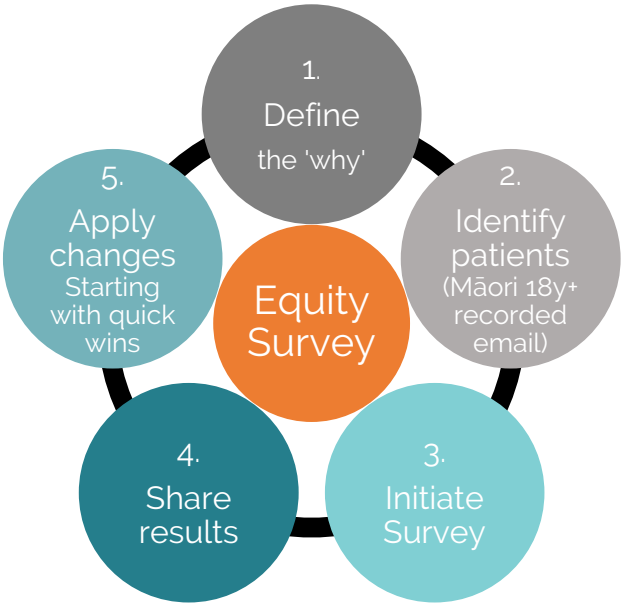
It was highlighted in the Wairarapa peer group that people are at different stages of patient engagement. This is depicted and represented as 'Mt Engagement' with different characters placed at different locations. (Artist: Ny Brunenberg)



Practices at the Kāpiti peer group shared ideas of incentivised activities such as patient focus groups to draw in community engagement, including to offering Petrol or Supermarket vouchers for all attendees. (Artist: Ny Brunenberg)

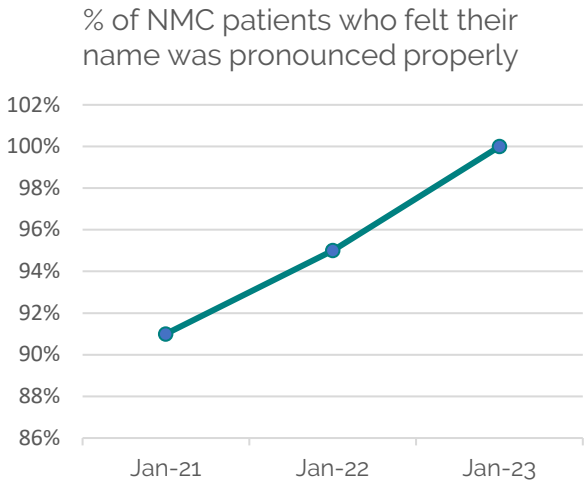
A Targeted Approach at Newlands Medical Centre

Newlands Medical Centre (NMC) has continued to work hard in engaging with their patients – from sending out quarterly newsletters to running an Equity Survey for a targeted audience. The practice Equity Champion Dr Tony Jackson allocates time to review risk stratification and clinical lists to advise ways of improving equity health outcomes for their population.



Responses and feedback from this target survey were overall positive and included some suggestions for improvement that the team was able to work through. This prompted staff to take part in Te Tiriti o Waitangi refresh and Pronunciation workshop to support staff in Te Reo Māori.

"Everything was excellent right from the reception staff to the nursing staff very welcoming and helpful staff." (NMC Patient)



"We are doing the Cornerstone Equity module at present. Part of this is patient engagement. We wanted to do this early in our module so we could focus on areas that our patients thought we should improve on. We decided to use Survey Monkey due to the low admin and quick result and accessible to a lot of our patients.
(Dr Tony Jackson, NMC)"

"Everyone at Newlands is respectful and lovely to work with. I arrived and was greeted before having a short wait that the nurse explained why, and the doctor was really good culturally, and at explaining what medically I needed and why." (NMC Patient)

Greytown Medical is partnering up with their community.

Greytown Medical is getting frequent, actionable input from their patients and their community. The team this year are focused on incorporating patient feedback in their quality improvements with equity as a focus.

"My NP always give me enough time to discuss any concerns or questions I have, and is genuinely interested in a holistic approach to improving my health" (GMC Patient)

Greytown Medical partners up with Kuranui College, a local school, to provide future doctors, nurses, paramedics, and everything else and in between, some 'real-life' experience and learning through their Wananga programme with the medical cohort.

Greytown Medical Centre was able to host two large community meetings with the intention to discover thoughts and feedback, and hear stories from patients about their experience of care at the practice and the new facility Five Rivers.

The first meeting was held at Five Rivers where the team received a huge level of engagement from the community about their thoughts, access to services and healthcare experiences. The second meeting was held at Kuranui College two months later as a follow-up so the team could share with patients and whānau key messages and other positive changes with improved access and introducing their extended workforce.

"The Nurse was absolutely amazing friendly professional made you feel at ease, and I felt that she genuinely understood how I was feeling and addressed this accordingly. I wish I had written in as she was the best I've seen." (GMC Patient)

On the road to accomplishing true and meaningful patient partnership, the team is seeing improvements in patient expectations of seeing either a Nurse Practitioner or Extended Care Paramedic for their acute needs instead of a GP.

The team is also seeing an improved patient experience in the HQSNZ National Adult Patient Experience Survey. In May of 2023, 92.5% of the patients who took part in the Survey felt they were able to have family and whānau involved in discussing their treatment and care. That's up 3% from the prior survey period.

"The Dr was excellent followed up with me text and phone calls and a subsequent appointment and I am most grateful he was available. I see a Nurse Practitioner for regular vaccinations tests and repeat prescriptions and I have no criticism in that regard either." (GMC Patient)

PRO-EQUITY IN ACTION

A strong equity lens has been applied at all levels of the model of care, acknowledging each practice and patient population is different, while actively prioritising Māori, Pacific, and unrepresented populations.

The Wall Walk Experience at Mauri Ora Student Health, and Counselling Victoria University of Wellington

In 2021 and 2022, Mauri Ora – Student Health and Counselling, at Victoria University of Wellington engaged with Dr Simone Bull to take the team on an interactive journey looking into the history of colonisation and bicultural relations in Aotearoa New Zealand.

Dr Simone Bull has developed a programme called the *Wall Walk*, which she describes as 'Part Theatre, Part Study and Part Kōrero'.

This is a different approach than passive learning modules that are often offered for cultural competency and Te Tiriti o Waitangi training.

The *Wall Walk* programme involved small groups researching and presenting on various topics. The groups were given time ahead of the presentation to prepare. The teams made posters, waiata, and plays to present their findings.

Examples of topics included:

The New Zealand Company & Edward Gibbon Wakefield's European settlement of Whanganui-a-Tara,

The Dog Tax War of 1898,

Māori objection to conscription in the First World War,

other social and economic changes faced by Māori over the past 35 years (including the treaty settlement process and the rise of Te Pati Māori).

Image Source: TheWallWalk

Along the way, we discovered that Victoria University, like many other universities in Aotearoa, was founded using the proceeds from land confiscated from Māori during the New Zealand wars. The land the University sits on was also confiscated from local Iwi. We also discovered Victoria University was the first to have its own campus-based marae – Te Tumu Herenga Waka. When the Living Pā is completed in 2024, it will be one of a few Living Buildings in the world and the only one drawing together Mātauranga Māori and sustainability practices.

The *Wall Walk* encouraged us to explore the colonial history of Aotearoa in a collaborative and interactive way, which really engaged us with our history in a way an online module never could.

"My GP was very friendly encouraging and easy to talk to. I felt that she also engaged in conversations about things outside of medical i.e., family situation etc. which helped." (Student Health Patient)

"Wall Walk was extremely creative and fun" (Staff)

TheWallWalk Practice staff attendance

"GP is informative, respectful and takes their time to explain whakawhanaungatanga always." (Student Health Patient)

"Dr Simone helped us develop our own programme. As 2022 was the 125th year of the founding of the University we decided to do a decade-by-decade examination of the relationship between the University (a colonial institution) and Māori." (Staff)

The Terrace Medical Centre: Creating a Trans Inclusive Medical Centre

The Terrace Medical Centre (TTMC) have been working to improve trans inclusivity and to provide gender-affirming services to patients.

This work has included:

- Ensuring resources and posters displayed in the practice are trans-inclusive,
- Removing gendered language from letters to patients (e.g., cervical screening reminders),
- Developing internal trans-inclusive informational resources to provide to trans patients where non-gendered pamphlets are unavailable,
- Providing space on enrolment forms for gender assigned at birth as well as current gender identity and pronouns,
- Training for all staff on gender diversity, and
- Offering a funded appointment to each trans and non-binary patient each year.

"My Dr was caring listened and offered suggestions for treatment without pushing his own view on to me." (TTMC Patient)

"I feel my perspective and feelings are understood and considered." (TTMC Patient)

"We are encouraging and supporting some of our GPs to employ the Primary Care Gender Affirming Hormone Therapy Initiation Guidelines published earlier this year. As we continue our work on improving trans inclusivity, we of course welcome any feedback on our services from the trans and non-binary whānau." (The Terrace Medical Centre).

Capital Care Health Centre B.L.E.N.D Programme

B.L.E.N.D is an initiative by Capital Care Health Centre to encourage Better Living, Exercise, and Nutrition Daily for their patients.

The programme uses Te Whare Tapa Whā model of promoting physical, spiritual, psychological, and family health. Creating an environment that empowers people in their personal journeys. The pilot group of participants have just graduated and there was amazing feedback.

BLEND
BETTER LIVING | EXERCISE | NUTRITION
DAILY

Kate Dominikovich Practice Manager.

"Since I started and built my confidence, I've connected with a local primary school and now help with their reading programme twice a week. I love it!" (BLEND Participant)

"I found purpose in this group and now feel worthy. Something I haven't felt for a long time. I'm working on a couple of areas of my life and seeing results." (BLEND Participant)

"I'm working two days a week now and slowly getting off the job seekers benefit. It's so good to be able to be useful to someone else and find my place in the world." (BLEND Participant)

"It's been the highlight of the month coming to the group, I hadn't wanted to leave my house let alone be in a group pf people to start with, but I've looked forward to coming each month." (BLEND Participant)

Group BLEND session with staff at Capital Care Health Centre.

"I'd neglected my physical health over the years but having made some small changes I feel more in control of my life. I'm eating healthy food, walking 10,000 steps a day and have started attending church again.

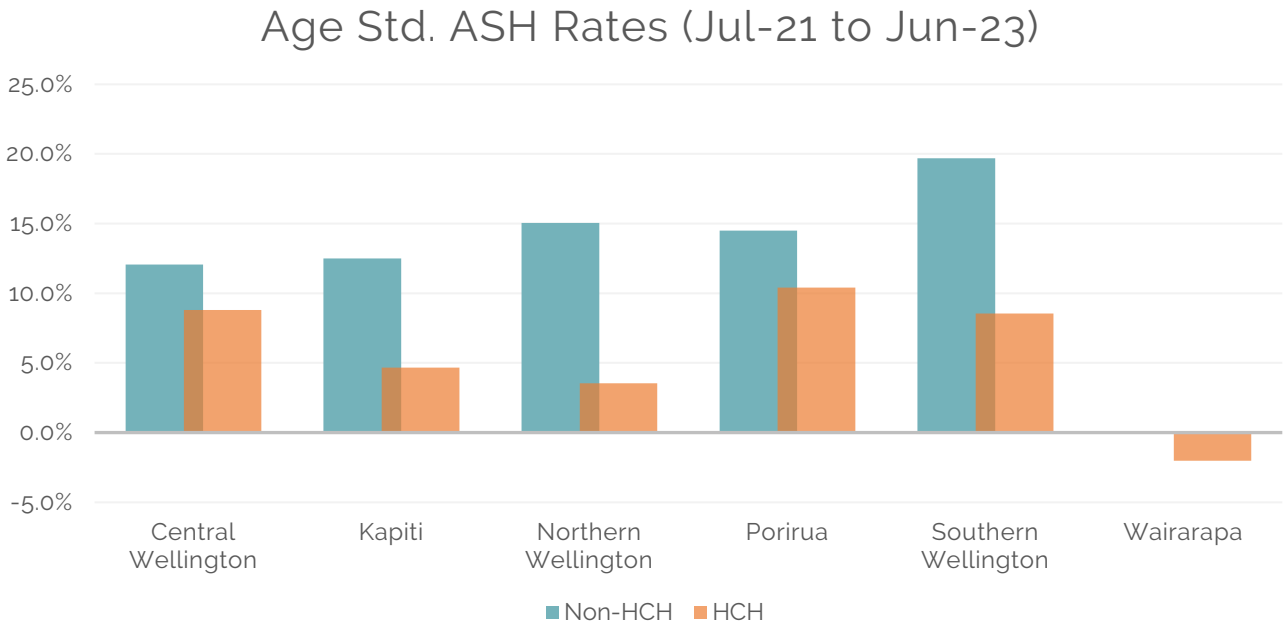
I'm also looking at making plans for the future, which is something I've avoided in the past." (BLEND Participant)

A SNAPSHOT OF OUR FINDINGS IN THE SEVENTH YEAR

Health Care Home practices have targets to reduce hospital admissions against 3 indicators. The following is a snapshot of the last 2 years of those indicators in the Capital, Coast and Wairarapa regions.

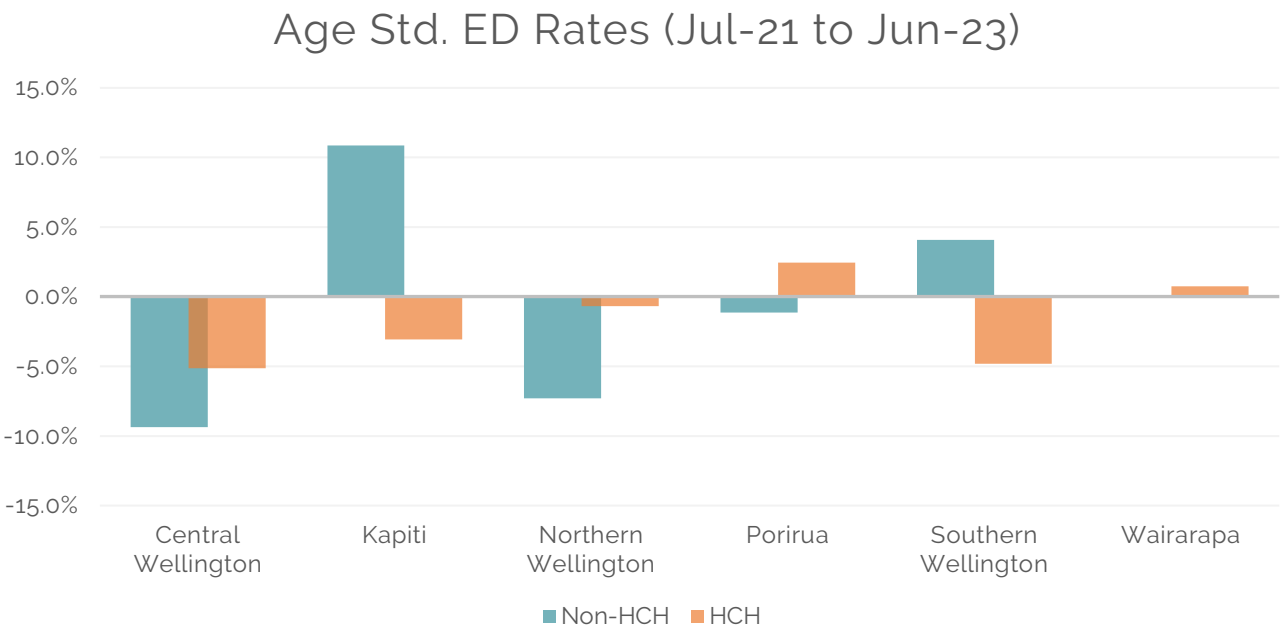
What has been the impact?

Health Care Home (HCH) Practices have done very well to maintain a decrease in hospital utilisation over the period of the programme. With COVID-19 and workforce constraints putting pressure on the primary care system, some of those gains have fluctuated over the last few years.

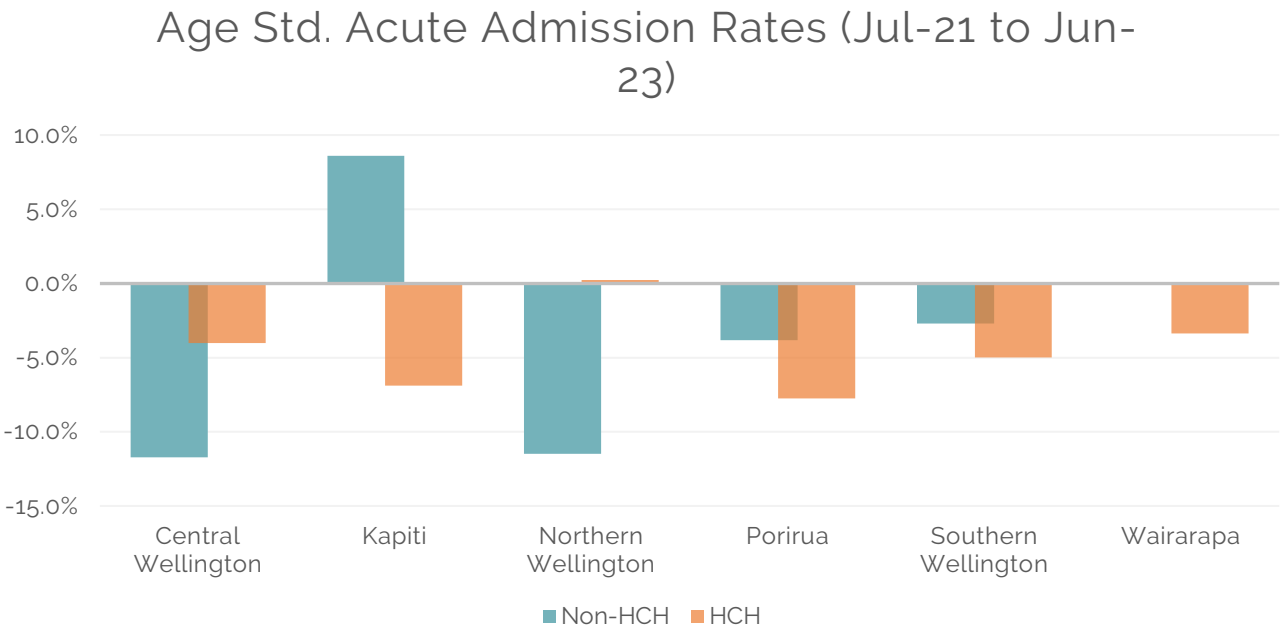


ASH stands for Ambulatory Sensitive Hospitalisations, and it indicates a person visiting the hospital for treatment that could have been dealt with in primary care.

The data shows hospital visits for HCH practice patients had less ASH rates in the 5 localities compared to non-HCH practice patients. The Wairarapa had a decrease of 2.5% in ASH rates.



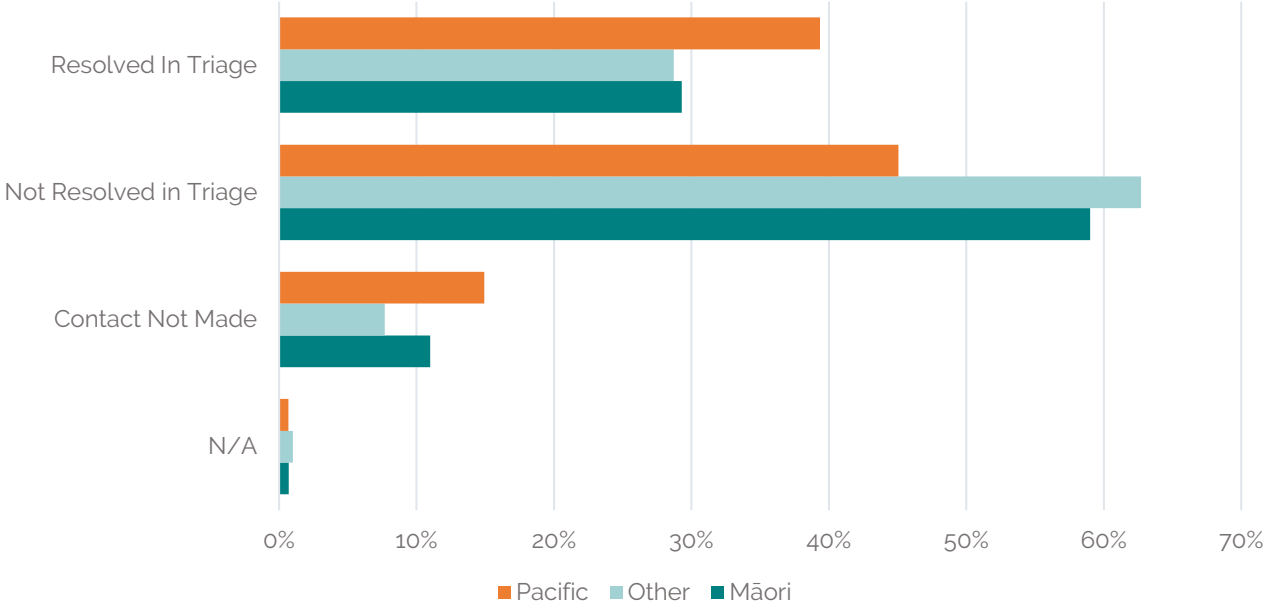
ED rates indicate when a person visits the emergency department. Hospital visits for HCH practice patients had a decrease in ED visits in 4 out of 6 localities.



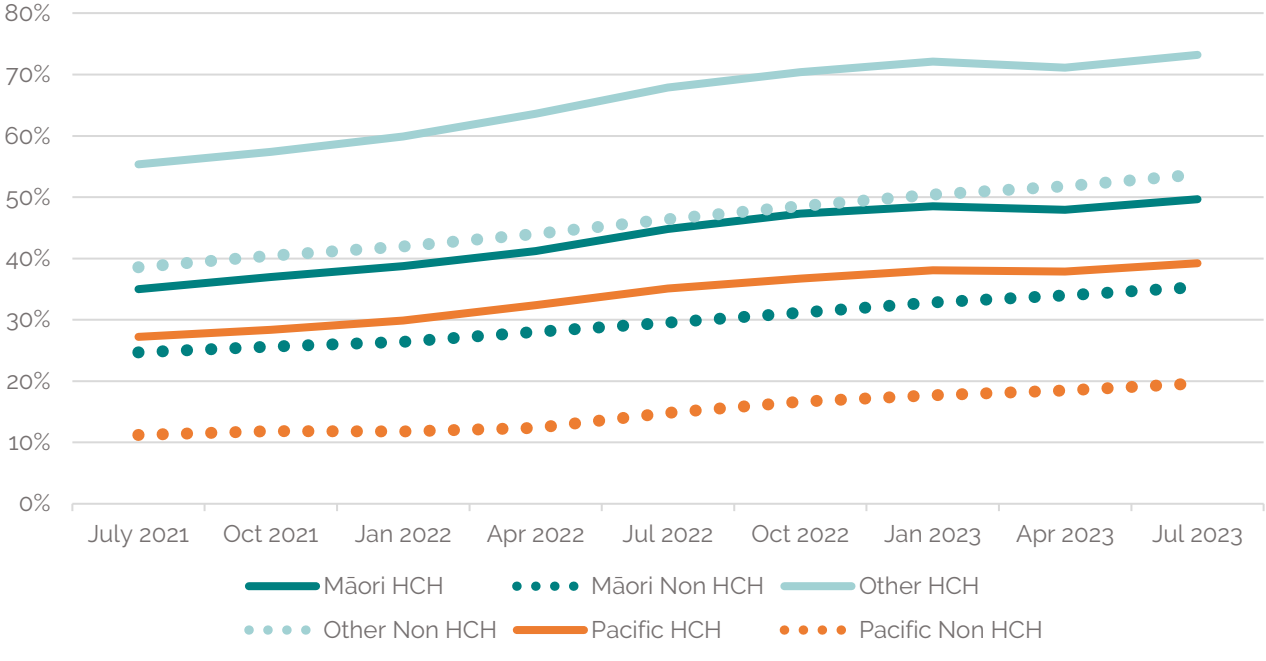
Acute Admissions indicate patients who were admitted for inpatient care without prior recommendation or planning. Acute admission rates for HCH practice patients had decreased in all 6 localities.

**Practices in their first three years of the programme have been removed from the HCH data set.*

Telephone Assessment and Triage Resolution by Ethnicity
June 2023 - September 2023



Portal Activitation over time
Comparison of HCH practices Vs Non HCH Practices by Ethicity



REFLECTIONS AND INSIGHTS

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Tū Ora Compass Health

Amelia Walsh,
Health Care Home Programme Lead
Tū Ora Compass Health

The focus for 2023 has been on refreshing and re-setting the Health Care Home programme. The team at Tū Ora has supported practice and re-established relationships - working with them to re-embed the model of care.

During 2020 and 2021, the world's focus changed to handling the global pandemic which saw a shift in engagement with the Health Care Home programme.

As we began to adjust to life with Covid-19, it allowed us to reflect, and ask what do practices and patients need to support them best.

To reflect on the achievements of the last three years, we took the opportunity to talk to two of the programme's principal leaders, **Mabli Jones** (Deputy CEO & General Manager Primary Care Development) and **Amelia Walsh** (Health Care Home Programme Lead) from Tū Ora, who were joined by **Dr Kirsty Lennon**, General Practitioner Raumati Road Surgery & Health Care Home Clinical Lead.

Reflecting on the past 3 years, can you perhaps start by giving us an overview of Health Care Home's journey to date?

Mabli: Our last Reflections document was written three years ago whilst I sat in an MIQ facility. The learnings we have acquired as a programme since then are evident. The last three years have forced us to rethink how we deliver the programme.

I am proud that the Health Care Home programme has continued to be funded and our decision to do this is fully supported by the results. Our region has become a standout example of the Health Care Home programme, and it has helped our practices become more sustainable.

Amelia: We have learnt many lessons about how we can deliver healthcare in the last few years, and practices have continued to embrace and use these changes as we transition back to a more 'business as usual' approach. Joining the team as the Covid-19 pandemic hit, I saw the programme adapt as we were forced to think about new ways of working. A key change is the use of telehealth and virtual care to support whānau at home, something not explored too deeply before. Now this approach is well embedded and is supporting improved access during challenging times.

We've had to rebuild relationships, have a diverse range of conversations, use data to increase understanding of our communities, and use a flexible approach with Health Care Home to continue to support our practices.

Kirsty: Tū Ora has been a leader in implementing the Health Care Home programme and it is one of, if not the most established in Aotearoa. From a practice perspective, I acknowledge that it is very unlikely that we would be here if it wasn't for the implementation of the model of care and skills from the PHO given the challenges we have faced in recent years. The pandemic made us think about how we do things, and Health Care Home allowed us to swivel on what's happening for our clinic and play to our strengths to problem solve.

What are some of the challenges general practices are facing now, and how has the Health Care Home model continued to support teams?

Kirsty: Primary Care continues to handle increasing challenges through workforce shortages and patient complexity to levels not experienced before. Health Care Home has enabled practices to diversify their workforce, increasing the services they offer to meet the needs of their communities to ensure they remain operational and increase the longevity of primary health.

Mabli: We are proud to have introduced the Clinical Assistant and Extended Care Paramedic roles in our network. We have received a lot of interest and great feedback about the Clinical Assistant role from other PHOs and practices around the country.

Amelia: An area that we have worked hard in over the past 18 months has been our relationships with our practices and community service providers. The conversations changed and dropped off as the world halted in response to Covid-19, so it's been important for us to restart those conversations and respond to the different voices and needs that have come through. There has been a lot of change in staff and service providers over this time, so we have had to work to build

those trusted relationships with our new and existing teams, which takes time but is an important aspect of this programme.

The practices working with the Health Care Home model shone through during this time, meaning we can now focus on areas of improvements to the model and how we can ensure it remains fit for purpose for our practices and communities.

Can you go further and touch on the first tranche of practices, where are they now?

Mabli: The first four Health Care Home practices from eight years ago are still doing really well. This is evidenced by the diverse services offered, the workplace culture, the focus on continuous improvement, and the feedback we receive from patients and staff alike.

Amelia: Implementing the model of care, along with Lean methodology, ensured there was consistency across the different practices. This included looking at the layout of a practice, what the workflow was, setting up visual management such as team boards and ensuring processes were in place for all staff. We have seen those first practices really embrace Lean and maintain it through their Health Care Home journey, which has been brilliant.

The first tranche have been real champions of the programme and have supported other practices by sharing their learnings and experiences.

When the Enhanced Model of Care was introduced equity became a focus, what has the impact been?

Amelia: A key driver to practices being able to improve equitable health outcomes was introducing reporting and data breakdowns in a way practices hadn't accessed them before. This had various benefits including understanding their population better such as the percentage of Māori and Pacific patients they had enrolled. Accessing this data meant they could use this to drive initiatives and target patients appropriately.

Mabli: Health Care Home has made many practices think more about equity. The introduction of the Enhanced Model of Care with equity as a focus, encouraged patient engagement. It gave patients a voice to feedback and engage with their practices.

Kirsty: I've continued to see great change in equity over the past six years and that has changed how we view healthcare. Conversations are now happening, difficult conversations for some but they are happening and it's important to continue this momentum and support people on their journey. The peer groups for Kaiāwhina Mana Taurite (Equity Champions) also saw many different members of practices find their voice and shine, guiding their practices to think differently about equity. It highlighted the different roles in practices, especially in administration and empowered those who may not have been in a leadership or decision-making position to have a voice and empower the change. In response to this Raumati Road Surgery also created an internal peer review group, to support the equity champion at the practice.

programme, how has that been received by practices?

Kirsty: Increasing to a team approach and flexibility embedding the program, practices have been able to adapt and implement the areas most relevant to them. We received a lot of inside and outside support for Health Care Home, especially from the PHO. The access to regular data, along with regular feedback helped practices understand their patient's needs to ensure areas implemented would benefit them the most.

Amelia: We have really focused on listening to the needs of the practices, and they have been able to identify what worked best for them and implement those parts of the model that would best support their sustainability while providing the best care for their patients. This then improved the longevity of the Health Care Home programme as it adapted to community needs more. This flexible approach was one of the key learnings since the pandemic. Rolling the programme out more slowly the last few years has actually been positive. It has meant that practices could be more methodical in what elements they implemented and when.

How has Lean methodology supported the programme and practices?

Amelia: Lean methodology has helped redesign our program and processes to ensure they are fit for purpose and respond to the changing environment our practices face. The process has made a drastic difference to patient flow and workflow which has improved responsiveness and trust between practices and the community. An example of this is

Wellington Medical Group Johnsonville, who has been using data to drive its initiatives and ensure people are held accountable for their part in the patient's journey. A new dashboard displays patient wait times when they call the clinic, making it much easier to monitor performance and respond to changes that staff may face. This has driven improvements to their business efficiency and workplace culture.

Kirsty: Many practices have used the Lean continuous improvement methodology to consistently improve and adapt how they work. The first practices to be part of the program used this process to develop non-clinical areas and encouraged thinking around why, what, and how it should be done. Practices continue to face a range of challenges which continue to grow post-pandemic. Those mentioned earlier,

coupled with a lack of reviews for funding are leaving practices in a relatively vulnerable position to maintain sustainability going into the future.

There is still a vast amount of work to do in this space and it's important to continue to adapt the model using the Lean view to ensure practices remain sustainable, as well as adapting them to community networks.

What does the future look like for Health Care Home?

Mabli: Tū Ora has supported the evolution and development of Health Care Home. I'm proud of just how much further ahead our practices are on this journey. The refresh of the model for a more whānau-led approach is anticipated and as always, welcomed.

LOOKING FORWARD

Our funder's continued investment in primary care at a time when resources are significantly limited, shows both foresight and leadership. They understand that strong primary care is the essential foundational stone of a health care system.

We need to continue to build on the strengths of general practice to ensure it is sustained — this change for practices has been transformational in our region.

The HCH programme has achieved coverage of over 80% of our enrolled population. Māori and Pacific Island patients make up 15% of this overall number. The importance of accessible and equitable health care, working in genuine partnership, is even more vital for these communities.

In recent years, we have had 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, complex and minority patients.

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

HEALTH CARE HOME ENDORSEMENT

Health Care Home PHO Endorsement assesses the core elements of the HCH programme that are now embedded in General Practice.


Peninsula Medical Centre

Porirua Union & Community Health Service

Paraparaumu Medical Centre

The Terrace Medical Centre


Hora Te Pai Health Services

Cannons Creek Village "Legacy of Champion" Bedford St mural. Artist: Gus Hunter, Ernest Sami, Ruby Sej, Zac Mateo, Jack Kirifi, Moses Viliamu

"We have found the PHO Endorsement task a smooth process"


Newtown Union Health Service


Newlands Medical Centre


Whitby Doctors

Capital Care Health Centre

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