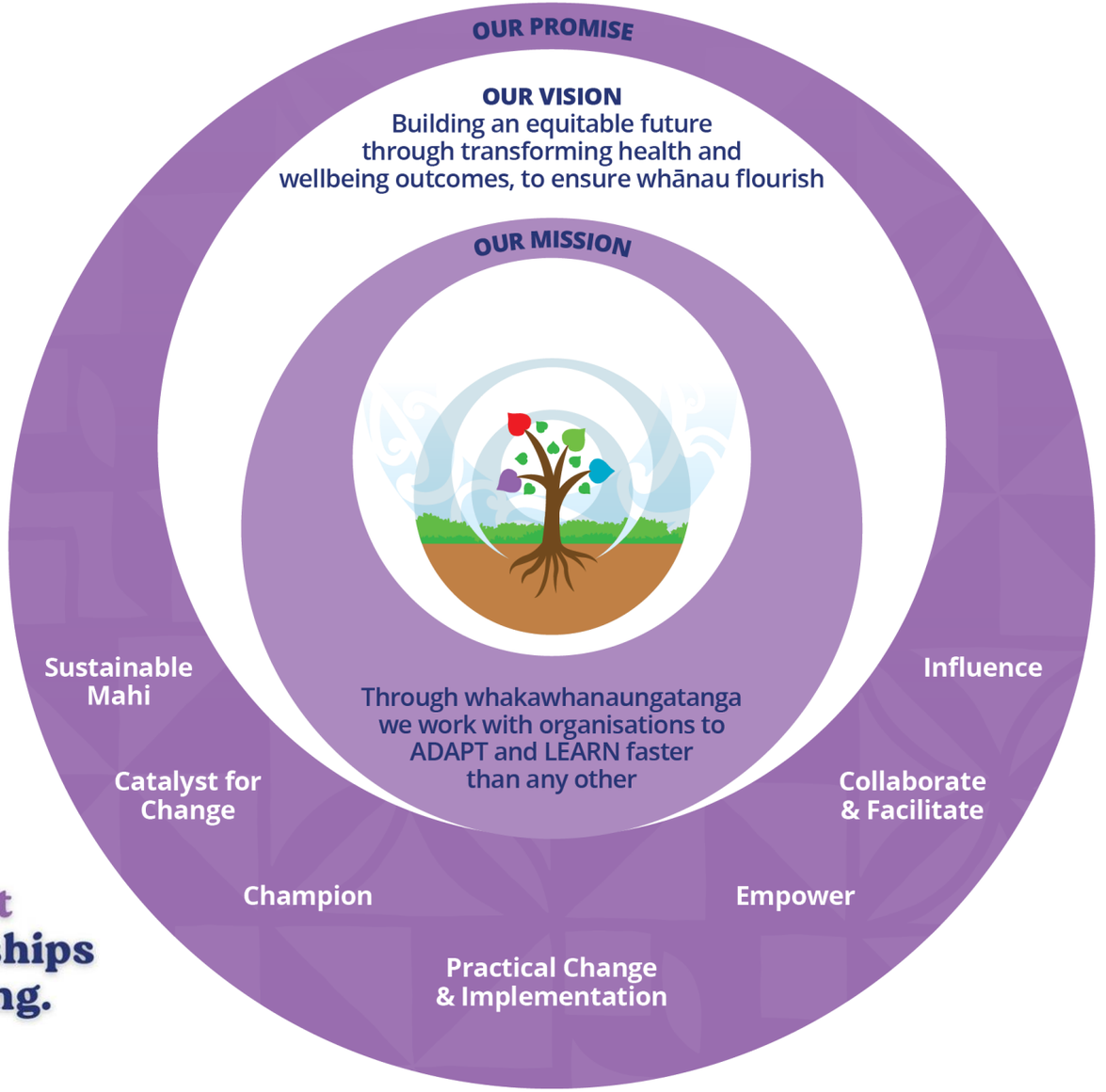
HEALTH CARE HOME

Collaborative Aotearoa

Health Care Home Model Of Care
What's in it for Whānau, Community and General Practice?

COLLABORATIVE AOTEAROA

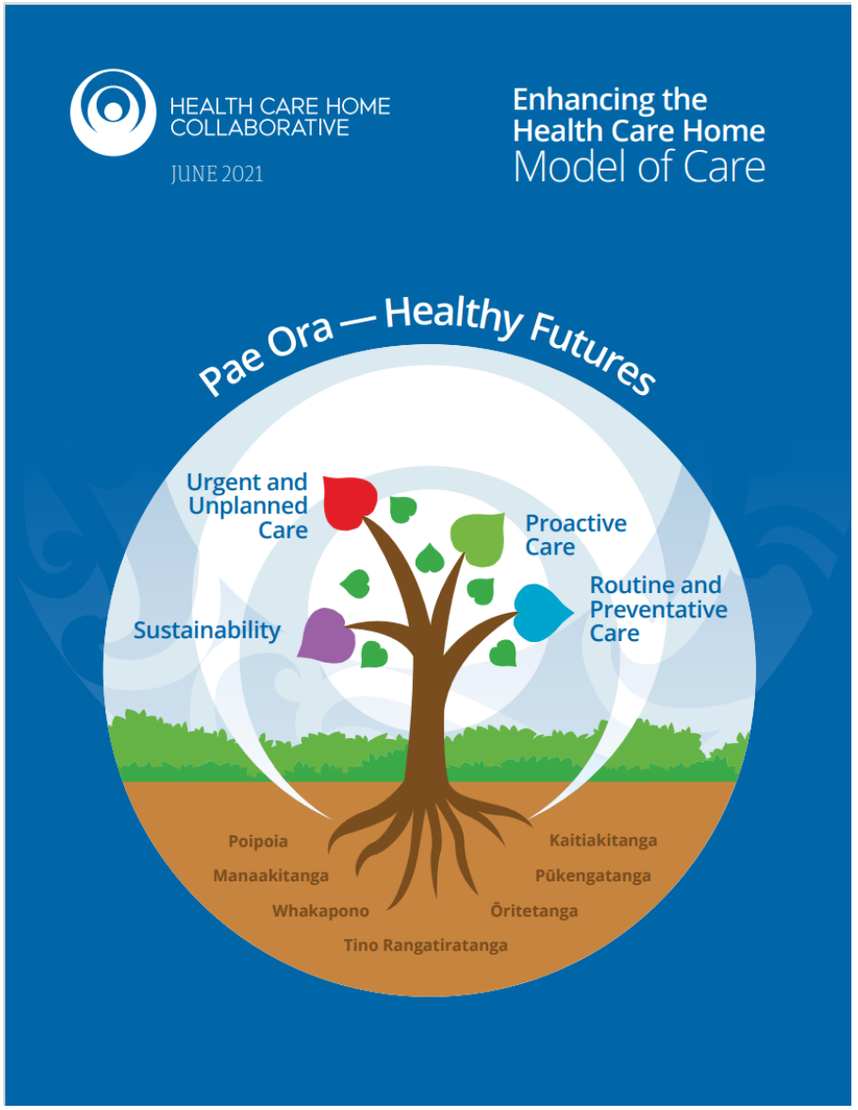
Our Vision and Mission

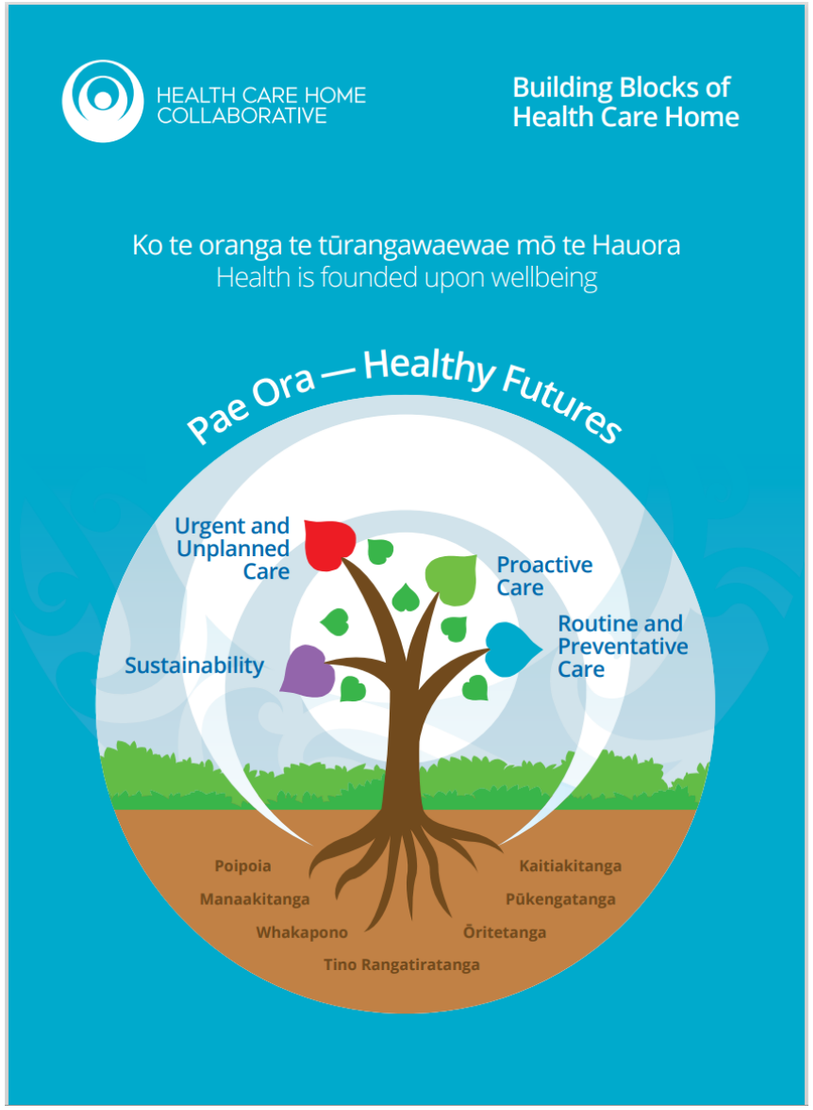


We believe that changing relationships changes wellbeing.

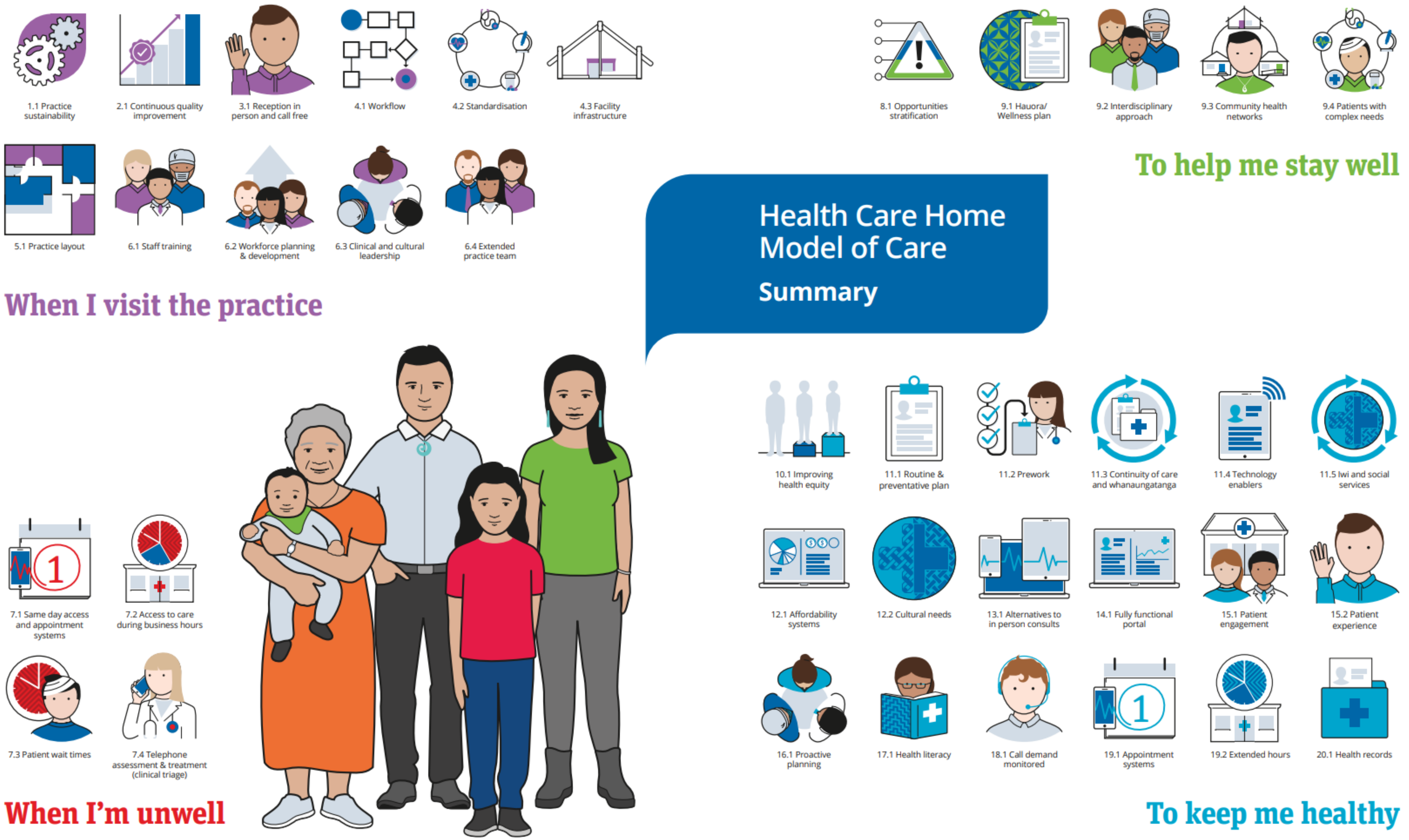
COLLABORATIVE AOTEAROA

The Health Care Home Program





The Enhanced Model of Care



The Building Blocks Model

Introducing the Building Blocks of the Health Care Home

A core part of this enhancement mahi is the alignment to Pae Ora (Healthy Futures) as a vision and a new set of values grounded in equity.

The Health Care Home Model of Care is a practical whānau-centric approach to modernisation of primary care, leading to a better patient and staff experience, enhanced quality of care, and improved sustainability.

This short booklet gives a basic introduction to the model of care, which has now been adopted to underpin change and improvement in many general practices all over Aotearoa.

Implementation of the model may seem a bit daunting, but it's a process that is flexible and adaptable, regardless of practice size, location or individual circumstances. Practices typically incorporate the model over a period of time so it can support their service, workforce and business priorities in the best possible way to help achieve better outcomes for their patient population.

The model features a small number of core Building Blocks designed to improve access and outcomes, including making more use of telehealth and of a wider range of workforces, as well as focusing on planned and proactive care.

The Building Blocks continue to be refined, based on learnings and population health needs, with the most recent enhancements centred around achieving equity for Māori, Māori aspirations and tikanga. That includes alignment to Pae Ora (Healthy Futures) as a vision, a new set of values grounded in equity, and incorporation of whakawhanaungatanga (creating connection/relationship) in the delivery of care.

Practices may choose to implement some or all of the building blocks, choosing aspects that fit the needs of its community/whānau. This is not a one size fits all model of care but one that is flexible and adaptive.

The recent experience of Covid-19 has reinforced the importance of alternatives to in person consults, and we are continuing to develop our resources to help integrate telehealth options.

Our current focus also includes developing tools and resources to support the creation of a new networked approach to primary care and community services.

The full range of practical support and resources of the Health Care Home Collaborative is available to any practice embarking on the Health Care Home journey — see our website at **www.healthcarehome.org.nz** or e-mail us at **collaborative@hch.org.nz**

Continuous Quality Improvement (2.1)

Practices have a clear and structured pathway for introducing new innovations and ways of working, enabling them to plan, track and assess the impact of change and involve all members of the team.

Clinical and Cultural Leadership (6.3)

All members of the team have a role in developing and delivering the practice's values, vision and improvement plan; cultural competency and safety is evident in all practice staff.

Same day access (7.1)

Processes are in place to ensure same day appointments are available for those people who need them most, making use of clinical triage to prioritise and release capacity.

Telephone assessment & triage (7.4)

Suitably qualified clinicians triage and manage appropriate patients over the phone, including providing prescriptions, self-care advice, and referral for diagnostics without the need for a face to face appointment.

Practice population stratification (8.1)

Systematic processes are in place to identify and target patients who would benefit most from primary care support, combined with opportunities to identify what matters most to people to improve their wellbeing.

Hauora / Wellness Health Plan (9.1)

A holistic plan is developed in partnership between the practice and patients with complex or long-term conditions, setting out goals, care and support interventions and social and cultural needs.

Improving health equity (10.1)

A clear understanding of equity is in place, allowing resources to be targeted to different levels of advantage in order to achieve equitable health outcomes, with a focus on Māori and other priority patients.

Cultural needs (12.2)

All health professionals are equipped to provide culturally competent care to people and their whānau, reflective of their practice population.

Alternatives to in person consults (13.1)

Systems are in place to offer a range of telehealth options, including e-mail, video, and phone consultations, determined by what is most suitable for the individual patient.

Fully functional patient portal (14.1)

An electronic portal offers patients convenient and secure electronic access to appointment booking, prescription requestions and personal health information.

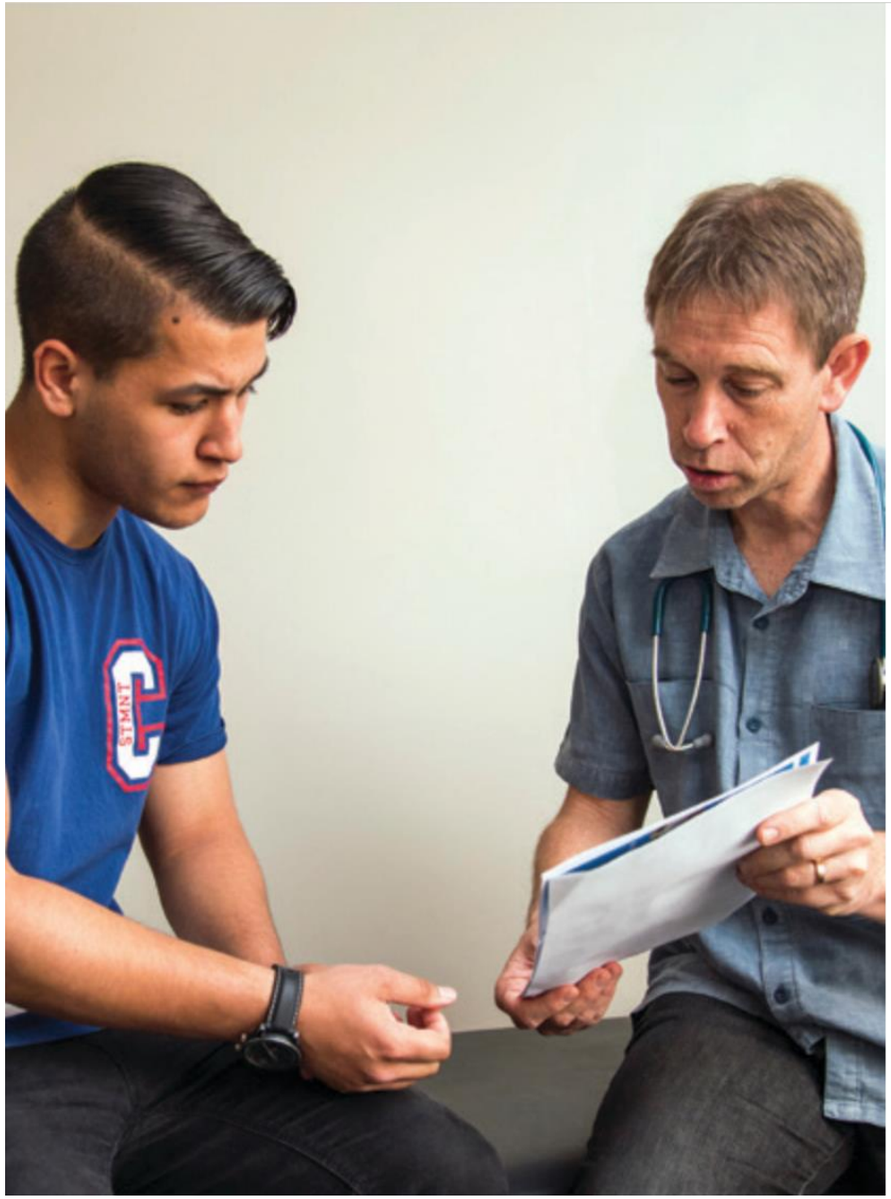
Patient Engagement (15.1)

Patient co-design emphasises the importance of engaging with consumers and whānau in developing and delivering health care services. It can be described as a method for partnering with patients, consumers and service users right from the beginning of service planning.

Call demand monitored (18.1)

The right number of skilled people and supporting resources is in place at all times to manage incoming calls safely and efficiently, based on accurate modeling.

The Patient Journey



Health Care Home Patient Journey

Working to achieve equity
My practice works to ensure everybody receives the best care

When I visit the practice

- Greeting at reception
- Appointments that value my time
- My extended practice team
- Improvements in service delivery

When I am unwell

- Calling the practice
- Talking to my doctor on the phone
- Booking an urgent appointment
- Valuing my time

To help me stay well

- My practice team contacts me
- Developing a plan to stay well
- My care team knows the plan
- Getting help from others
- Coordination

To keep me healthy

- Accessing my health information and care online
- Appointments that meet my needs
- Ensuring access
- Continuity of care
- Understanding my health

Domain Overview

Sustainability/LEAN

Working Lean.
Continuous Quality Improvement.
Working top of their scope.

Every where, every day, everyone

Routine and Preventative Care

Fully functional patient portal.
Continuity of care.
Pre-work is routinely utilized
Huddles and Visual boards

Urgent and Unplanned Care

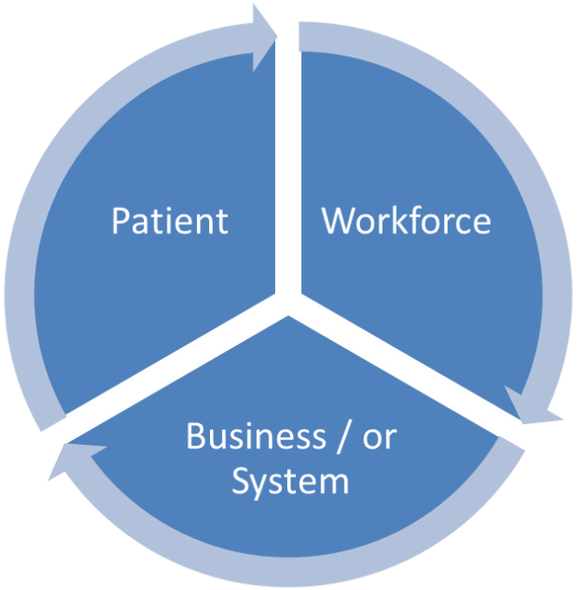
Clinical/Phone Triage
Same Day Access
Patient Wait Time

Proactive Care

Pre-work is routinely utilized.
Practice identifies patients with complex needs in a systematic way.
Collaborative Care plans.

What does good look like?

- I feel valued and cared for.
- I feel like I am treated like a whole person. My family and community needs are taken into account.
- I can chose when and where to consult with my GP practice.
- I can access primary care easily.
- I can use technology e.g. the portal to make appointments, look at my records, order repeat prescriptions.
- There are different appointment lengths that suit my needs.
- I can see the same health professional and team regularly.
- I am able to contribute to business improvements. I feel heard.



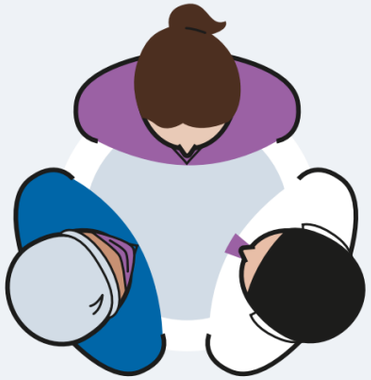
- I have enough time in my day to do all my tasks.
- I can go home on time.
- I am working to top of scope.
- I feel supported and part of a team.
- I feel respected and valued.
- I am using my time effectively.
- I feel like I am doing the best for our patients and community.

- The practice model is sustainable and profitable.
- The business can invest in its workforce.
- The practice works closely with the community to improve.
- Quality improvement is embedded in our workforce culture. Everybody can make things better every day.
- We love where we work.

Challenges

- System capacity and overload
- Workforce
  - Lack of GPs, and Nurses
  - Growing demand and complexity
  - Fatigue, exhaustion from capacity issues and increased demand
  - Pay Parity, Locum recruitment and costs
- The continually changing landscape of Healthcare – Government, Health Reforms, Localities
- Unenrolled population, closed books, wait times
- Perceived workload of the HCH model of care and Team Buy in

Domain: Sustainability and LEAN



The focus on ensuring practice sustainability provides an improved patient/whānau experience and better health outcomes.

Workforce development and extended team enable general practices to do more for patients/whānau.

The what and why of Kaizen (Lean)?

- A business culture characterised by the endless pursuit of the elimination of waste
- Comes from the Toyota Production system
- Continuous improvement
- Respect for people

‘Everything can be improved’

Clarence W Barron

The LEAN Aims and Why

- Eliminate waste – releases time
- Reduce Unevenness (Variability) - releases time, support change, provides consistent customer experience (and meets expectations), reduces stress and crisis...
- Solve Problems / Improve and standardize processes

Deep and thoughtful planning, quick execution!

KAI
Change

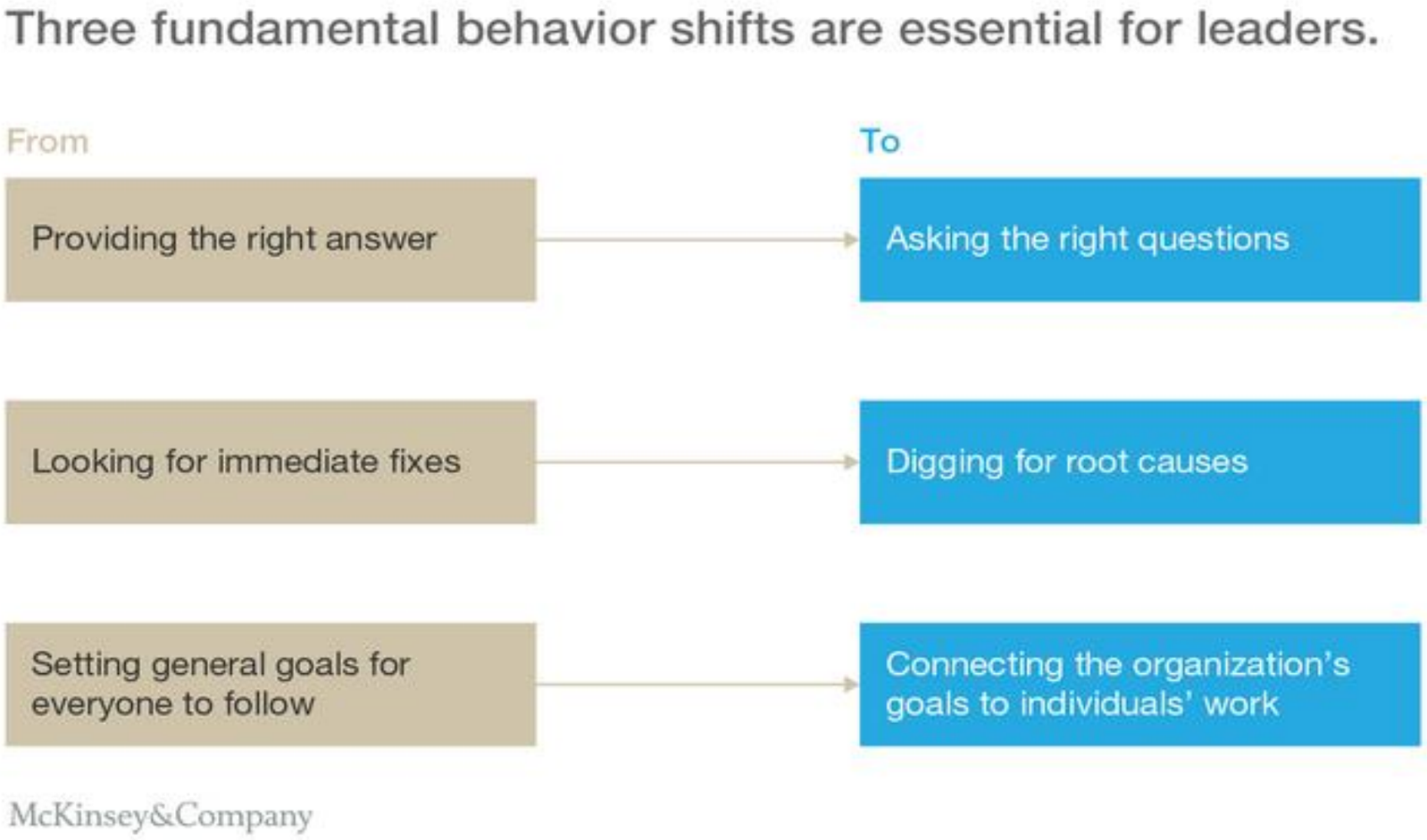
ZEN
Good
(for the better)

Everybody
Every day
Everywhere

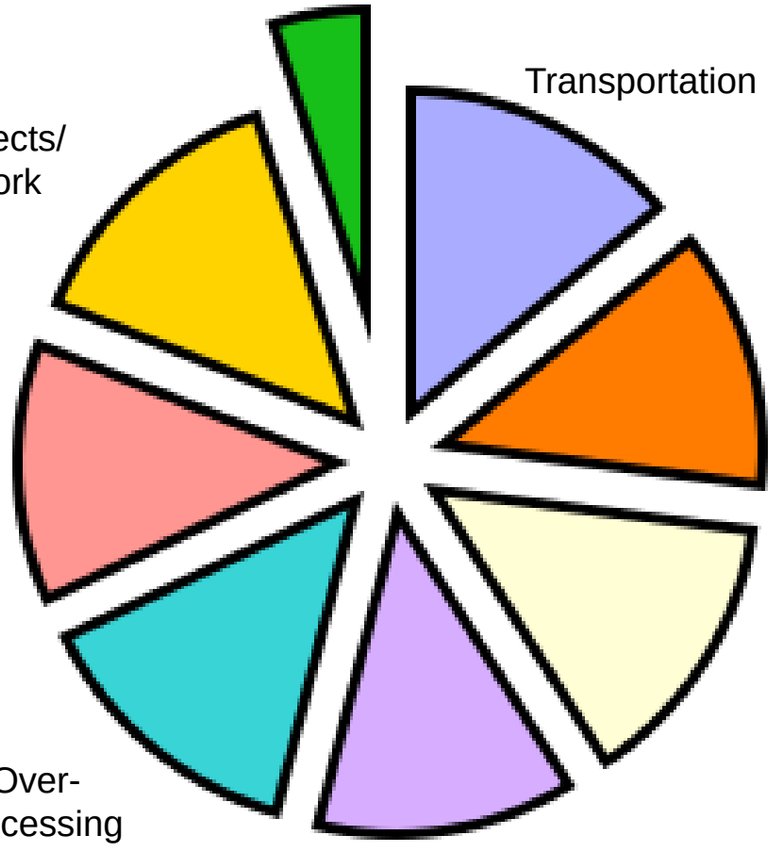
Using LEAN to Implement Sustainable Change

- LEAN/Kaizen – small, incremental Improvements, reduction of waste
- Culture Shift – empowered, growth mindset, improvement culture
- Change for the better (and know why)
- What problem are you trying to solve? (Root Cause Analysis)
- Multitasking is a myth

LEAN Leadership



Examples of Waste



Structured Problem Solving

BE VERY SPECIFIC

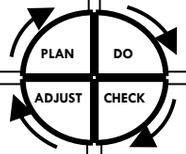
What happened? Speak with data.
Why did it happen & why is it an issue?
When did it happen? Has it happened before & how often?

Define the problem

Who was involved / affected?
Where did it happen?
How did it happen – sequence of events?

Root cause

GET TO THE BOTTOM



HOW WILL WE KNOW IT'S FIXED?

Verify

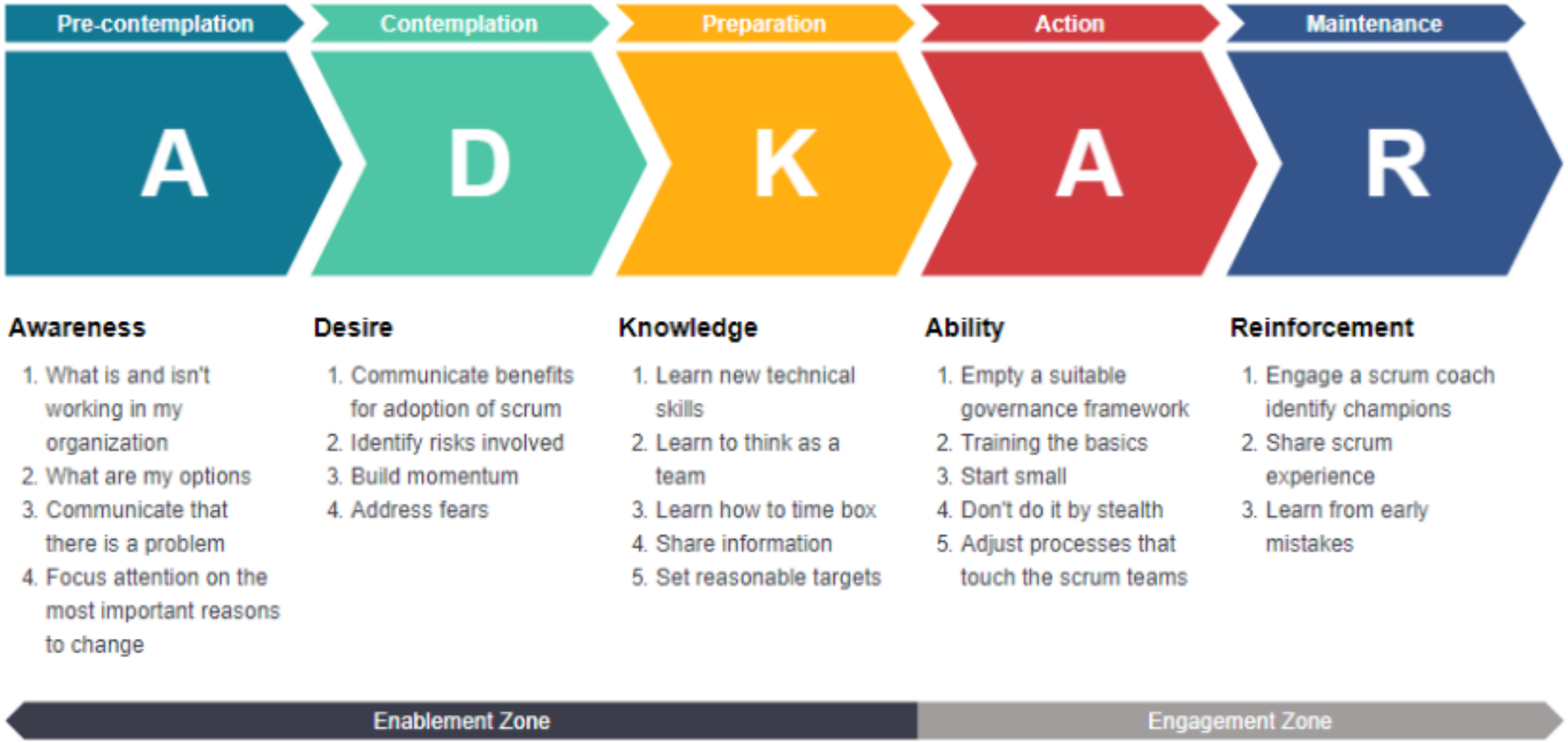
What will it look like when it has been fixed?

Solutions

WHAT WILL FIX THE PROBLEM?

How can we fix the ROOT CAUSE?
Who needs to do what when?

Change Management - ADKAR



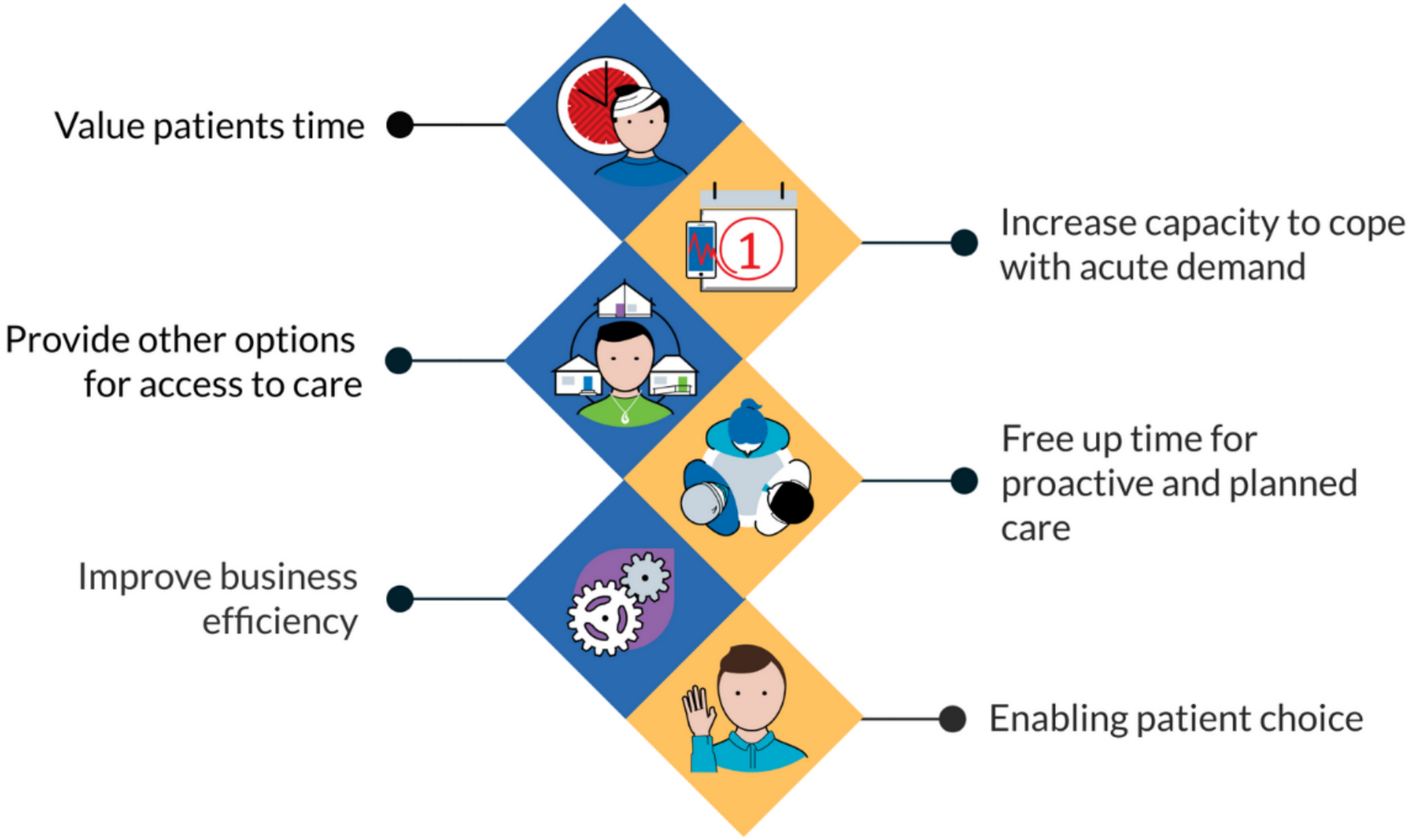
Domain: Urgent and Unplanned Care

7.4

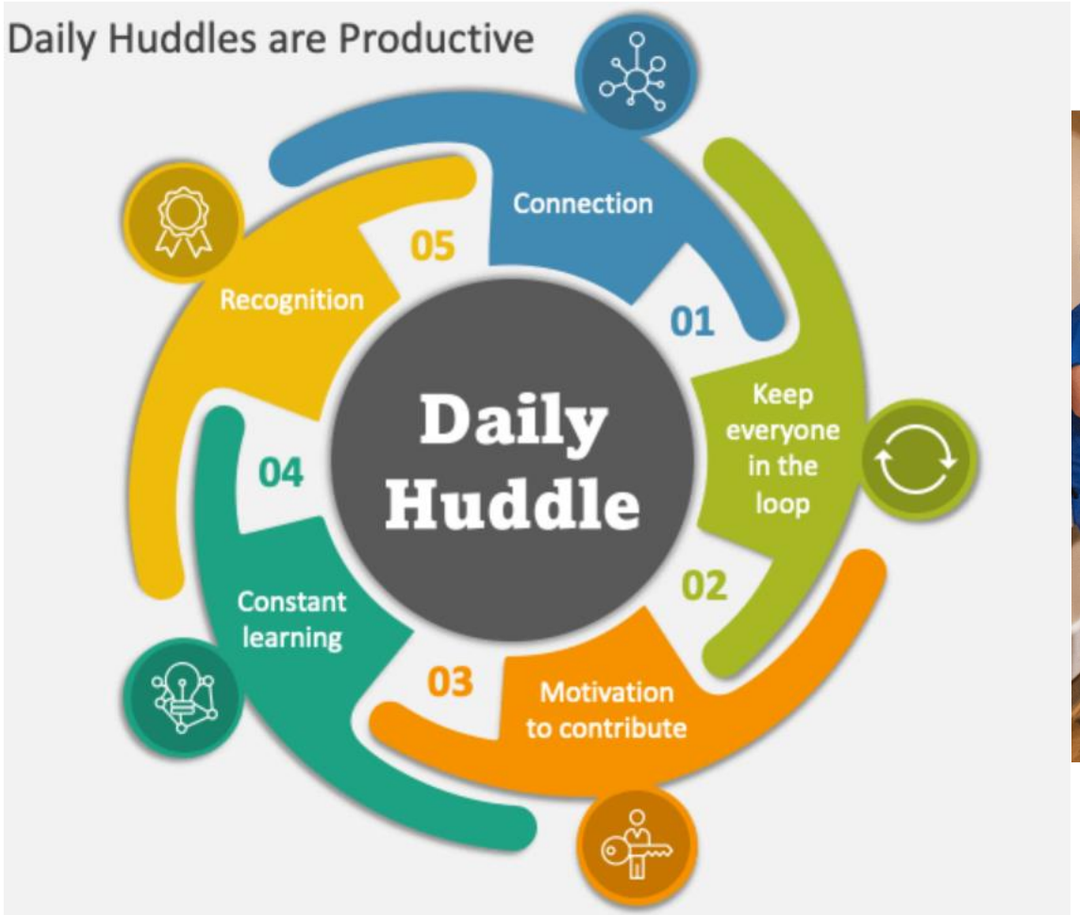
Clinical Phone Triage
Overview

What's most important to our patients/whānau is that when they are ill or concerned about a health issue they receive clinical advice and treatment when needed.

Why implement Clinical Triage?

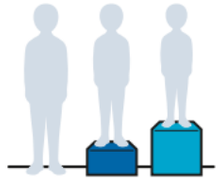


Domain: Routine and Preventative Care



Huddles and Visual boards

Domain: Proactive Care



10.1 Improving health equity

11.1 Routine & preventative plan

11.2 Prework

11.3 Continuity of care and whanaungatanga

11.4 Technology enablers

11.5 Iwi and social services

12.1 Affordability systems

12.2 Cultural needs

13.1 Alternatives to in person consults

14.1 Fully functional portal

15.1 Patient engagement

15.2 Patient experience

16.1 Proactive planning

17.1 Health literacy

18.1 Call demand monitored

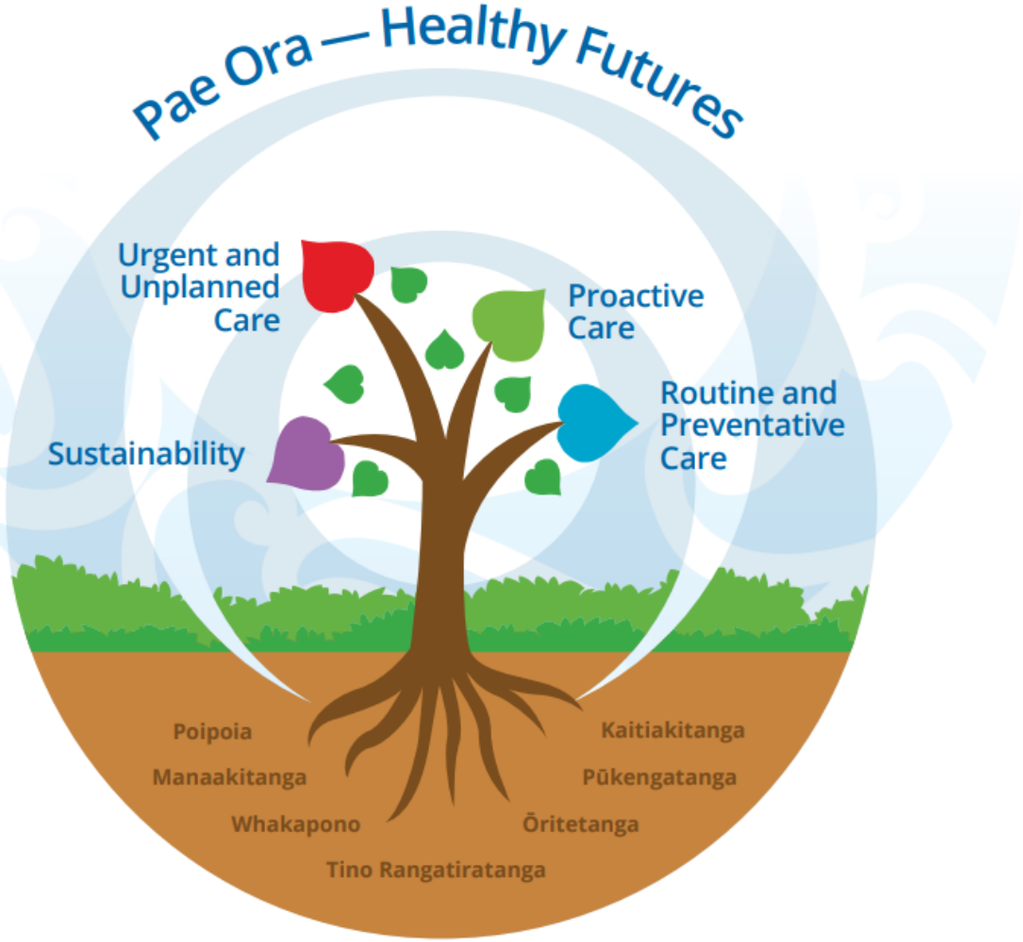
19.1 Appointment systems

19.2 Extended hours

20.1 Health records

To keep me healthy

Final Messages



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Building an equitable future, through transforming health and wellbeing outcomes every day, to ensure whānau flourish.