From good to great: the potential for the Health Care Home model to improve primary health care quality in New Zealand

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Are we there yet?

It's 8.15am on Monday morning and you have been feeling miserable since Sunday midday. You pick up the phone to get an urgent appointment with your GP. The phone rings and rings. You hold on and eventually the receptionist answers – you can hear her asking the patient in front of her to wait a moment. You ask for an urgent appointment, but your GP is booked up. You can book in to see a different GP, or wait two days. You really want to talk to your GP because it may be related to the problem you had last week. But it's not going to happen. Since you are going to have to tell the story again anyway, you decide to go to your local emergency department instead.

In 2008, the New Zealand (NZ) Treasury published a document titled, 'How can primary health care contribute better to health system sustainability?',[1] in which the authors conclude:

> 'The main effect of the investment to date has been to replace private, out of pocket payments with public subsidies. There is little evidence that the funding has changed the content and delivery of first contact primary health care services….' [P3]

In other words, the move to enrolment and partial capitation as part of the implementation of the NZ Primary Health Care Strategy reduced general practice co-payments, but has not resulted in any fundamental change in the way primary healthcare services are delivered at the micro level, or a wholesale move to a population health focus. The NZ Health Care Home initiative aims to help complete the transition from good general practice to great primary health care.

The NZ Health Care Home model of care draws from four international developments in health care. First, the worldwide renewal of interest in comprehensive primary care; second, the adoption of 'lean' quality improvement theory in health; third, the use of technology to make services more convenient for consumers; and fourth, coordinated care for patients with complex needs. The NZ Health Care Home model has been significantly influenced by the Group Health Cooperative in Seattle, which applied lean healthcare concepts to the emergent Patient-Centred Medical Home model in 2008, to develop a model of care that involved investing in access to well-organised primary care, to reduce use of hospital services.[2] An evaluation after 24 months found reduced ED visits, improved patient satisfaction, better diabetes care, and reduced clinician burnout.[3]

The NZ version was developed by Pinnacle primary care network, using lean methodology in a series of clinician-led value stream mapping workshops, to redesign the way general practice services work to be more patient-centred, more efficient, and to make better use of technology. The new model of care was first implemented in Northcare Grandview Road Medical Centre in Hamilton, NZ in April 2011.

How does the Health Care Home model of care differ from more traditional general practice?

The vignettes below illustrate three of the most noticeable changes associated with adoption of the Health Care Home model of care.

In most general practices, implementation of GP triage and call management is an early change that delivers quick benefits in managing demand and making the GP teams' day more enjoyable. Experience is that GPs can manage ~30–40% of

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Managing urgent 'on the day' requests

Traditional model of care	Health Care Home model of care
Reception juggles answering telephone calls and greeting patients. Heavy call demand first thing in the morning means some calls go unanswered – but this is not monitored and the number of dropped calls is unknown.	Telephony is physically separated from reception, so reception area is mostly call free. Call volumes are monitored and staff numbers adjusted to ensure that dropped calls are infrequent. Call volumes are reduced by a switch to online bookings and e-consults (see below).
Reserved 'on the day' appointments are booked until they are full, then urgent requests for appointments are forwarded to a nurse to triage.	GPs have time reserved in the morning to call back their patients – some of whom can be treated by phone; others may be booked in that day or later in the week – sometimes with diagnostics (eg laboratory test/X-ray) to be completed before the visit.
Triage nurse organises to double-book urgent appointments in GP template, and tells others to book another day.	On-the-day acute appointments are reserved by each GP, based on forecast volumes, but where clinically appropriate, patients do not need to attend the clinic, saving them time.

the patients over the phone who would otherwise have booked in for an appointment that day.

Getting a majority of adults using the patient portal for routine care is one of the next most important interventions. This is a slower change to implement.

Putting in place risk stratification and proactive care is also a medium-term endeavour, but one that is likely to provide significant longer-term benefits for patients and the health system. Integration with community health services is dependent on simultaneous redesign of district nursing and allied health by District Health Boards.

Supporting change – the NZ Health Care Home Collaborative

The NZ Health Care Home Collaborative is a cooperative endeavour between participating primary care organisations (PHOs) and supportive national organisations (DHBs, the Ministry of Health, and the Royal NZ College of General Practitioners). The Collaborative aims to support the establishment and ongoing development of the Health Care Home model across New Zealand by: setting minimum standards; encouraging continuous improvement and peer review; developing a national benchmarking programme; training in effective implementation; and sharing learning on best practice

Managing 'routine care'

Traditional model of care	Health Care Home model of care
Patient calls are taken during office hours by the receptionist who negotiates a mutually acceptable time, balancing the availability of the preferred GP(s) and patient convenience, while also greeting patients presenting at the medical centre.	Patients mainly use an online patient portal to book appointments at a time convenient for them, and provide the GP with information on what the consult is about, allowing pre-work to be done (eg laboratory tests) and chaperones, etc. to be organised in advance.
Face-to-face consults at the clinic are the only treatment option available. Repeat scripts require telephone calls, messages and transcription.	Some routine issues are dealt with purely by secure e-consult, avoiding the need for a visit. Patients can also book a telephone (or in the future, a video) consult. Long-term medicines are pre-authorised as repeat scripts and requested through the online patient portal, allowing one click prescribing and note entry.

Proactive care for patients with complex needs

Traditional model of care	Health Care Home model of care
Patients with complex needs are not identified proactively, resulting in: • no differentiation in booked appointment length • high numbers of reactive visits per year dealing mainly with symptomatic issues.	The practice uses a risk stratification tool to identify complex patients and patients at high risk of admission. Complex patients have a care plan developed and are scheduled visits with appropriate appointment length to manage both current symptoms and to update plan of care.
• Relationships with community health services (district nursing, community allied health, etc.) are *ad hoc* and based on referrals. • There is little interdisciplinary care planning or delivery.	The practice regularly meets with local community health services to bolster effective working relationships and uses an interdisciplinary approach where appropriate.

and effective models of care. The Collaborative is club-funded by participating primary care networks including (as at April 2017): ProCare, Pinnacle, Compass Health, Manaia Health PHO, Te Tai Tokerau PHO, Central PHO, and Pegasus Health, covering between them approximately half the NZ population.

What are the key features of the Health Care Home model?

The way the model is being introduced reflects local priorities in each area. The Northland DHB implementation, for instance, labelled the 'Neighbourhood Health Care Home' has a major focus on equity and on service integration in local communities. Health Care Home Collaborative members have developed a working framework for describing and credentialing the Health Care Home model of care. The core service elements in the framework are summarised below.

Still under development is a set of national benchmarking measures to support practice level performance comparisons.

In Northland and Capital and Coast districts, the DHB and local PHOs are working in partnership to implement the Health Care Home programme through an Expression-of-Interest process, with additional capitation funding available for selected practices. Some model of care changes reduce costs once the change management is complete – such as use of a patient portal, and use of medical centre assistants. Other model of care elements have ongoing opportunity costs for the practice – such as attendance at an interdisciplinary meeting to review high-need individuals with district nurses, or GP triage to avoid patients coming in for a face-to-face appointment. Some DHBs are recognising the value of these service elements for the overall health system, and are willing to contribute to the cost of implementing them.

Health Care Home common model of care elements

• Advanced call management	• Consultations over the phone and via secure email
• GP phone triage and clinical management	• Web and smart phone-based patient portals
• Same day appointment capacity	• Enhanced layout and composition of General Practice facilities to support new ways of working with more effective use of physical space
• Extended acute treatment options	• Community Health Service Integration
• Increased hours of access	• New professional roles to expand the capacity and capability of General Practice
• Person-centric (varied) appointment lengths	• Application of lean quality improvement processes
• Care planning for patients with high needs or at risk	
• Clinical and administrative pre-work to improve the efficiency of time spent with patients	

Table 1. Current number of practices working towards the Health Care Home (HCH) model of care

Area	# HCH Practices in development	Funding arrangements
Compass / Capital & Coast DHB	16	DHB: NZ$16 per enrolled patient, with NZ$5 at risk based on performance, plus NZ$7,000 per practice for engagement and release. PHO: NZ$14 per enrolled patient available through flexible funding plus up to NZ$16,000 per practice for change management and workforce development.
Northland DHB/ PHOs	6	DHB: NZ$15k per practice contribution to establishment costs in the change planning phase plus $16 per enrolled patient capitation funding. PHO: $14 capitation made available through PHO flexible funding. 25% at risk based on performance.
Midland	15	PHO funding only.
Procare	10	PHO funding for 10 practices, with three of these practices also receiving funding under a DHB pilot (viz, NZ$10,000 per practice to support change, learning sessions, etc.).
Pegasus	42 (IFHS rather than HCH)	Service redesign workshops and help with transition co-funded by DHB and PHO through the Integrated Family Health Services programme, which shares features with the Health Care Home programme.

DHB (District Health Board); PHO (Primary Health Organisation); IFHS (Integrated Family Health Service).

Table 1 summarises the spread of the Health Care Home model of care, recognising that the specific service elements will continue to evolve, and that the model is still a work-in-progress.

What is the evidence base?

A work-in-progress evaluation by Ernst and Young found that the Health Care Home programme showed promising early results in better call management, patient and staff satisfaction and patient portal use.[4] The US-based Patient-Centred Primary Care Collaborative publishes an annual review of evidence, which indicates a positive effect on utilisation of secondary care services, and overall costs.[5] It is too early to gauge the medium-term effect on use of secondary care services in NZ, but in an era where the average age of a GP is 51 years, and the number of people aged over 65 years is increasing rapidly, this is a promising start to ensuring modern, patient-focused and sustainable primary health care. The Health Care Home Collaborative is working with the Ministry of Health to commission an independent, formative and summative evaluation, which will hopefully tell us about the effect of the Health Care Home programme on the patient experience, on the workforce, and on the overall health system.

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COMPETING INTERESTS
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