
CONFERENCE ABSTRACT

Weaving many strands

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The healthcare home model drives major change in the way general practice is delivered, strengthens the basics of primary care, (access, coordination, comprehensive, continuity) and adds into the mix the opportunities that arise from technological advances and reorienting the system so it is patient and whanau focussed. That's the theory but what does it look like practically?

Northland DHB in collaboration with the two Northland PHOs, and supported by the broader national NZ Healthcare Home Care Collaborative have embarked on a major change process to establish Neighbourhood Healthcare Homes (NHH). We are working with six general practices in the first year, (small and large, rural and urban, traditional private business, corporate and iwi owned to make the NHH changes. New joint (NDHB and PHOs) change facilitation and financial analyst positions have been established to support practices with the NHH model changes. Northland DHB has funded release time for the establishment phase and contributed \$16 per ESU capitation funding for the re designed practices. The PHOs have redirected Care Plus and SIA funding.

The NHH model of care includes the standard healthcare home building blocks which are designed to release capacity within the general practice so that high needs /risk patients can be managed more proactively. These standard building blocks include practice teams driving portal uptake, using Doctor triage for patients requesting urgent appointments, expanding nurse roles and establishing new roles, reorganising appointment systems, including LEAN methodology into planning. In addition to these standard healthcare home offerings Northland is actively developing equity management tools and processes and social and health integration responses.

The preparation for the NHH development included two key pieces of work to establish baseline, but also to support practices to make change using their individualised evidence. Firstly the DHB and the PHO collaborated on the piece of work with the former Health Partners Consulting Group to develop a shared dataset to inform General Practices about their current delivery of care. This information is packaged up and delivered by a public health physician who helps the practices to interpret results. There is a particular focus on equity markers.

Secondly a multi-faceted piece of research looked at appointment availability, using the TNAA methodology and complemented by a manual acute appointment query. In communicating the outcomes, the team delivered the results to the practices with opportunities for discussion and with additional academic papers and a MOPs point's audit tool to support further development.

Concurrently work revising the way community and primary nurses link with general practices has been in development, with a new primary secondary navigator role to be implemented within the emerging NHHs, in Whangarei.

Keywords: collaboration; patient centred; health care home; model of care
