



Changing the patient experience

A CASE STUDY FOR INTEGRATING HEALTH SERVICES

NOVEMBER 2015



ACKNOWLEDGMENTS

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Disclaimer: The findings in this document were informed by a qualitative review, as well as quantitative information and data gathered from various sources across the Canterbury health system. The review process included focus groups and individual interviews with key participants in the Travis Medical Centre Integrated Family Health Services Programme. The publishers acknowledge that the changes achieved by Travis Medical Centre are a culmination of the Integrated Family Health Service (IFHS) Programme activity along with other integration activity occurring across the wider health and social services system in Canterbury. This document has been compiled in good faith with the information available at the time of publication.

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Acknowledging the entire Travis Medical Centre team who all contributed to significantly changing the patient experience:

Doctors

David Pilbrow
Sue French
Harsed Chima
Arthur Collins
Heather Peacock
Ellie McDougall

Practice Nurses

Nicky Scott
Sue Peers
Shelley Hall

Care Coordination

Jackie Cooper

Practice Manager

Linda Adams

Administration Team

Carolyn Tritt
Jessica Englefield
Karen Mitchell
Tracy Frunt
Di Forgie

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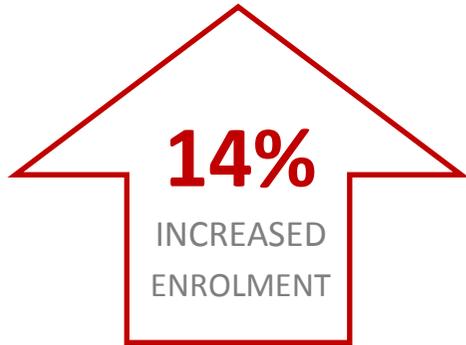
Outlines the key components for achieving an integrated and collaborative way of working that improves patient and staff satisfaction.

FIND OUT MORE

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Where to find more information on this free system-wide support available to all practices across the Canterbury health system.

Observations of Travis Medical Centre's consultation data, the enrolled population's use of secondary care and surveys indicate the following achievements since the start of the practice's journey through the IFHS Programme.



AVERAGE
25%
capacity
freed up
across all GPs

**Better
relationships**



with community providers &
associated health professionals
& patients



MORE *planned*
CARE FOR PATIENTS



Increased **satisfaction**
among staff & patients



**Emergency
Department
presentations**

by enrolled
patients
decreased

\$
**No negative impact
on the practice's
bottom line**
(all investments repaid
through benefits
achieved)



+ AVERAGE
ED VISIT RATE

180/1000 | Canterbury
90/1000 | Travis MC

Better care for patients
with *complex needs*

Zero frequent COPD
attenders in the past 12
months

Lifestyle changes and better work/life balance achieved for GPs

50%

Increase in PN consultation
with same FTE

What does “freed up” capacity mean?

Travis Medical Centre’s General Practitioners have allocated freed up capacity according to their own personal goals. For example:



GP1

freed up 30% of his capacity, enabling him to take on 14% more patients while also increasing the time he was able to spend supporting his patients with complex needs.



GP2

freed up 18% of his capacity, enabling him to reduce the number of hours he needs to work by 0.3FTE, while still maintaining the same number of patients he sees.

Changing the patient experience

A CASE STUDY FOR INTEGRATING HEALTH SERVICES

This case study outlines one Canterbury General Practice Team’s journey towards improving care for their patients and improving the sustainability of their model of care.

Travis Medical Centre was one of the first groups to be supported by the Integrated Family Health Services (IFHS) Programme. With the support of the IFHS Programme, the practice has been implementing changes to their model of care over the past four years.

The IFHS Programme team worked closely with Travis Medical Centre to evaluate whether the practice’s desired outcomes at the beginning of the IFHS process had been achieved. While it is early days, in all aspects, the indications are that they have, without any negative impact on the financial bottom line and without feeling these changes have added pressure.

During the four year process, an average of 25% (a range of 9% to 30%) capacity gain across General Practitioners has been realised. This has enabled a 14% increase in patient enrolment without additional resources, allowed for more time to be spent with complex patients (identifying unmet need), and has provided lifestyle options for General Practitioners wishing to reduce their workload. Practice Nurses are feeling more empowered and providing more care to patients, access to unplanned care has improved and patient satisfaction has increased. Improved relationships with community providers and associated health professionals across the system have enabled initiatives to progress that would previously not have been possible. A shift to more pre-planning of care has enabled patients to take greater responsibility for their outcomes and is reducing both patient and clinician time spent during patient visits.

This document outlines the practice’s journey through the IFHS Programme and demonstrates what can be achieved by better integrating health services.

The Travis Medical Centre team describes the experience of the past four years as one of continuing improvement, positive patient feedback and staff satisfaction as the team has worked to improve the practice's model of care.

The practice wanted to confirm this anecdotal feedback with more quantitative measures wherever possible.

The information presented throughout this document uses data from Travis Medical Centre's practice management system, along with data supplied by the Canterbury District Health Board and Pegasus Health's 24 Hour Surgery.

The data has been presented with an aim to help observe whether the changes that the Travis Medical Centre team members expected to see when they began this journey have actually occurred.

As well as its involvement in the IFHS Programme, the practice has been supported by other initiatives introduced in the Canterbury health system that enable General Practice to better care for their enrolled patients, including Care Coordination, Collaborative Care Programme, Acute Demand Management Service, subsidised procedures, Community Falls Prevention Programme, Medication Management Service, Community Rehabilitation Enablement and Support Team, HealthPathways and HealthInfo.

All of these initiatives have together enabled Travis Medical Centre to achieve these results.

WHAT IS THE IMPACT?

TRAVIS MEDICAL CENTRE SET THE FOLLOWING INDICATORS OF SUCCESS FROM THE BEGINNING:

①

We will create capacity across our team

②

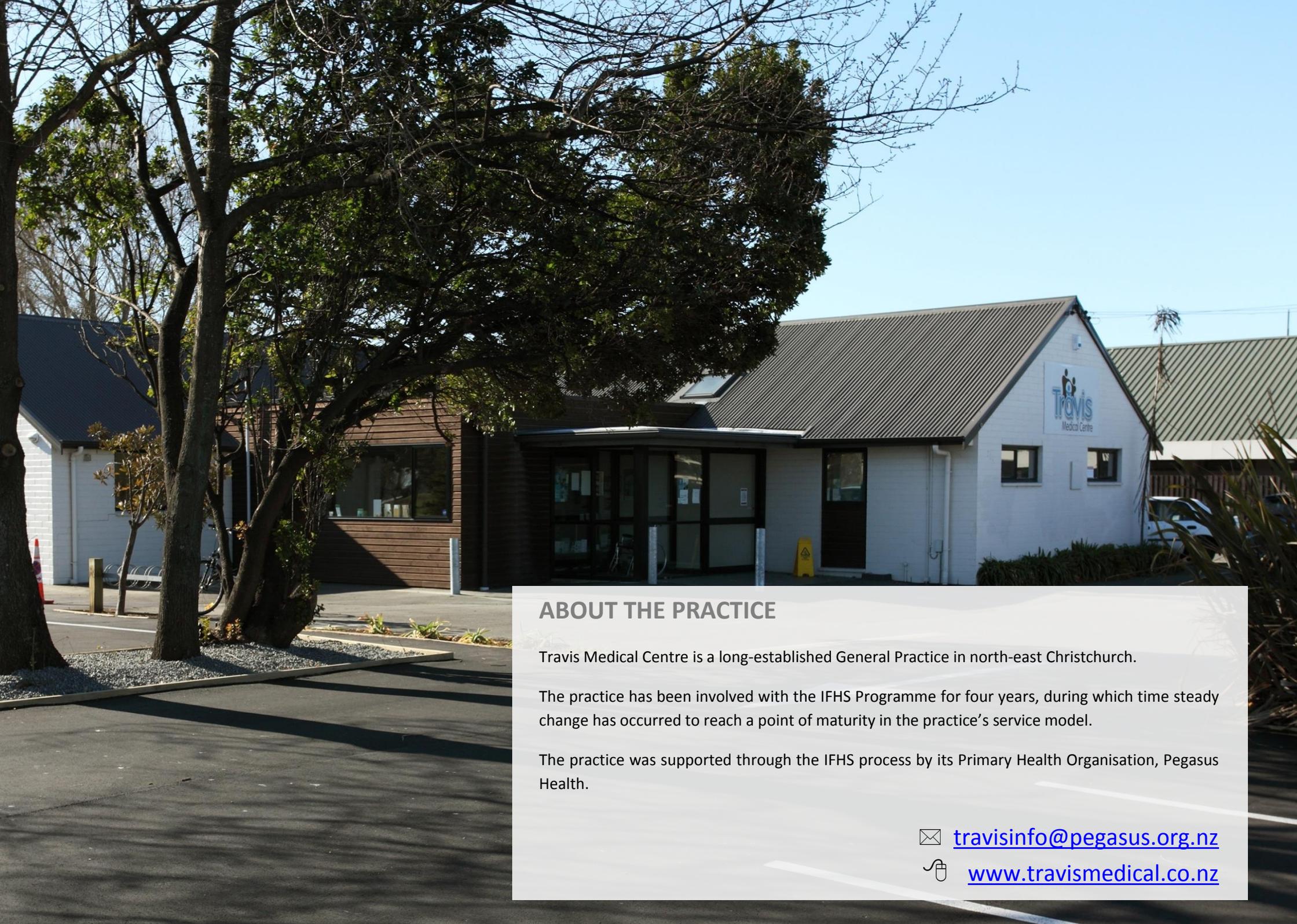
We will capture and use that freed up capacity to improve our service

③

We will improve access for our patients

④

Our patients will pay less on average for their primary care



ABOUT THE PRACTICE

Travis Medical Centre is a long-established General Practice in north-east Christchurch.

The practice has been involved with the IFHS Programme for four years, during which time steady change has occurred to reach a point of maturity in the practice's service model.

The practice was supported through the IFHS process by its Primary Health Organisation, Pegasus Health.

✉ travisinfo@pegasus.org.nz

🌐 www.travismedical.co.nz





What they did

In 2009 the Travis Medical Centre team began to realise that its model of care was becoming unsatisfying and increasingly unsustainable. They felt that their current way of working did not support the significant care improvements they knew were possible. There was a strong desire to do things better for patients, the business' sustainability and the practice team's professional satisfaction.

The practice owners wanted to ensure that the practice was positioned to cope with the ageing and increasingly complex population and that they were able to continue to attract and retain a great team. They wanted to play their part in the wider health system vision by meeting the needs of patients closer to home and putting the patient at the centre of care. Key to this was addressing unmet need that they sensed was being overlooked in their current episodic way of working.

While the Travis Medical Centre team had a desire to work differently, the current way of working was deeply entrenched and change appeared radical and daunting, requiring specialised skills that the practice did not have. Practice staff didn't know quite where to start the change process.

In 2011, in addition to their own practice innovation, Travis Medical Centre's General Practitioner owners began to explore the opportunity for greater partnership with other practices in the area, as well as strengthening links with the wider health and social services system. Discussion progressed with local practices and pharmacies which resulted in a collective desire for the local providers to work in a networked model to further enhance the way they provided care for their community.

Travis Medical Centre enrolled in the IFHS Programme in 2011.

The team's objectives at the start of this journey included releasing General Practitioner capacity to be focussed on more complex patients and enabling a better work life balance for the General Practitioners and practice teams. Staff wanted to work more closely as a team and enable all team members to work at the top of their scope of practice, enabling more flexible care options and therefore better access to care for patients.

Over four years the practice team has steadily gone about making a number of systematic changes to the way care is provided to achieve these objectives.



I couldn't imagine doing what I was doing for the rest of my life with no change because it certainly was a pretty average model before. A great model for fee for service when your actual driver was making money by just clipping the ticket and seeing people. Which is just, when you think about it, terrible because it hasn't got the patient's best interest at heart.

Dr David Pilbrow



STAGE 1

Engaging health professionals

Through the IFHS Programme, Travis Medical Centre along with the teams from two other local General Practices, local pharmacies and a number of consumers and community providers participated in a series of workshops to explore new ways of working.

STAGE 2

Prepare a common vision

The practice team was presented with information about their enrolled population and also sampled their consultations to establish patterns of acute and chronic presentations.

This provided a starting point and focussed thinking on how to better manage patients with complex and long term conditions to ensure they were receiving appropriate planned care, amid the daily demand for acute care. The information provided a perspective previously not visible and set the scene for the development of a new Model of Care.

Through a facilitated workshop, a shared vision for the future was developed. The workshop allowed debate on often difficult issues in a safe environment outside of the usual day to day practice setting. The outcome was a useful reference tool to underpin subsequent work.

STAGE 3

Develop a new model

Three workshops were attended by the whole team plus invited health providers and consumers.

The practice considered various types of patients, understanding that each required a different response and resource allocation. The patients' current experiences were mapped and ideas for improvement developed.

Though there was an initial focus on co-locating and sharing a building, it became clear that the requirement was much more about the ways the General Practice Teams organised themselves and their relationships with partner care providers.

The model that developed saw a shift towards better use of the practice team's diverse skills in a way that maximises the team's potential and continues to put the patient at the centre.

STAGE 4

Implement and measure the impact

The practice put in place project governance, an implementation plan and a project team with representation from each of the team's clinical professions, alongside the Practice Manager, the practice administration team, the Care Coordinator and a partner pharmacist.

The team began making immediate changes to the way they worked. They found that the best way to make large scale change was by making small changes regularly, usually once a month. Following these changes they would assess the change. If it worked they would continue the new way of doing things. If it didn't work, they would pull back.

The team reported that a lot of trial and error was required, but with the changes being small and gradual, it never became overwhelming and large scale change became achievable.

Their vision

Facilitated workshops at the beginning of the IFHS process, including engagement with provider partners, helped the Travis Medical Centre set a vision for the future and the key objectives they wanted to achieve from the process.

Overall objectives

- To work across the whole health system and enable a model of care that integrates primary, hospital and community services in a manner that is seamless for patients
- To create a more sustainable way of working that is attractive to patients, staff and future owners
- To work in a partnership model with other health and social service professionals to enable tailoring of care to the specific needs of patients
- To put in place a business model that supports the integrated service model
- To pursue happiness!

From a patient care perspective the team intended to improve the patient's experience and service at Travis Medical Centre. The team felt that:

- Access to urgent care for patients could improve
- The inflexible 15 minute appointment time was not allowing comprehensive care to be planned, nor all unmet need to be identified
- Patients were paying to visit General Practitioners unnecessarily for care that did not require a doctor
- Patients were having to navigate the system without support, which often resulted in gaps in care or in duplication of effort

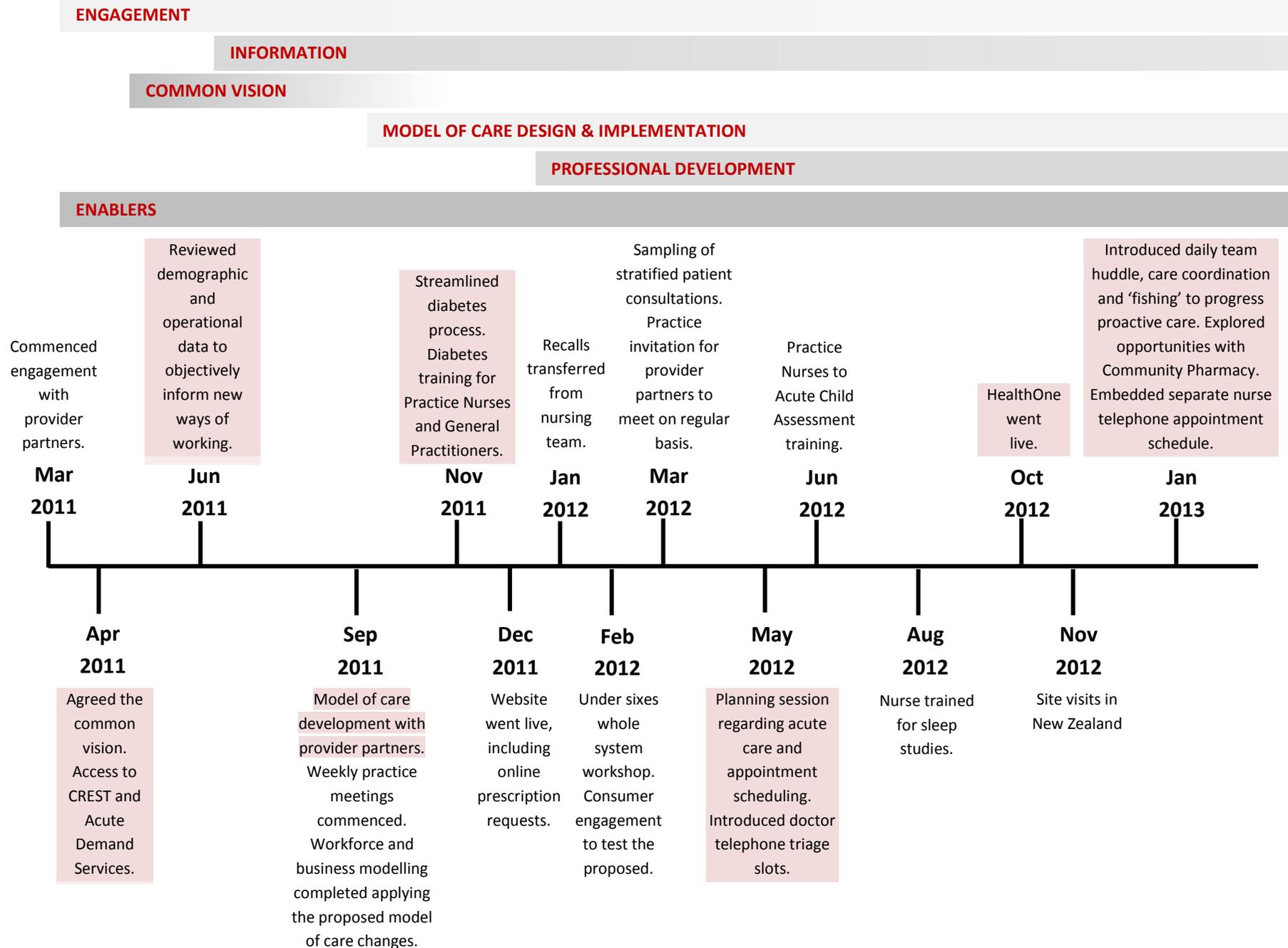
From a General Practitioner perspective the team intended to make General Practitioner working life more sustainable while continuing to improve service to their patients and colleagues. The team intended to:

- Continually improve the care offered to their patients
- Make working life satisfying and balanced with other lifestyle choices
- Make Travis Medical Centre attractive to young General Practitioners to work in and eventually invest in
- Enable collegial contact with secondary care and community colleagues
- Teach less experienced doctors as they made their way in the General Practice discipline
- Protect practice incomes

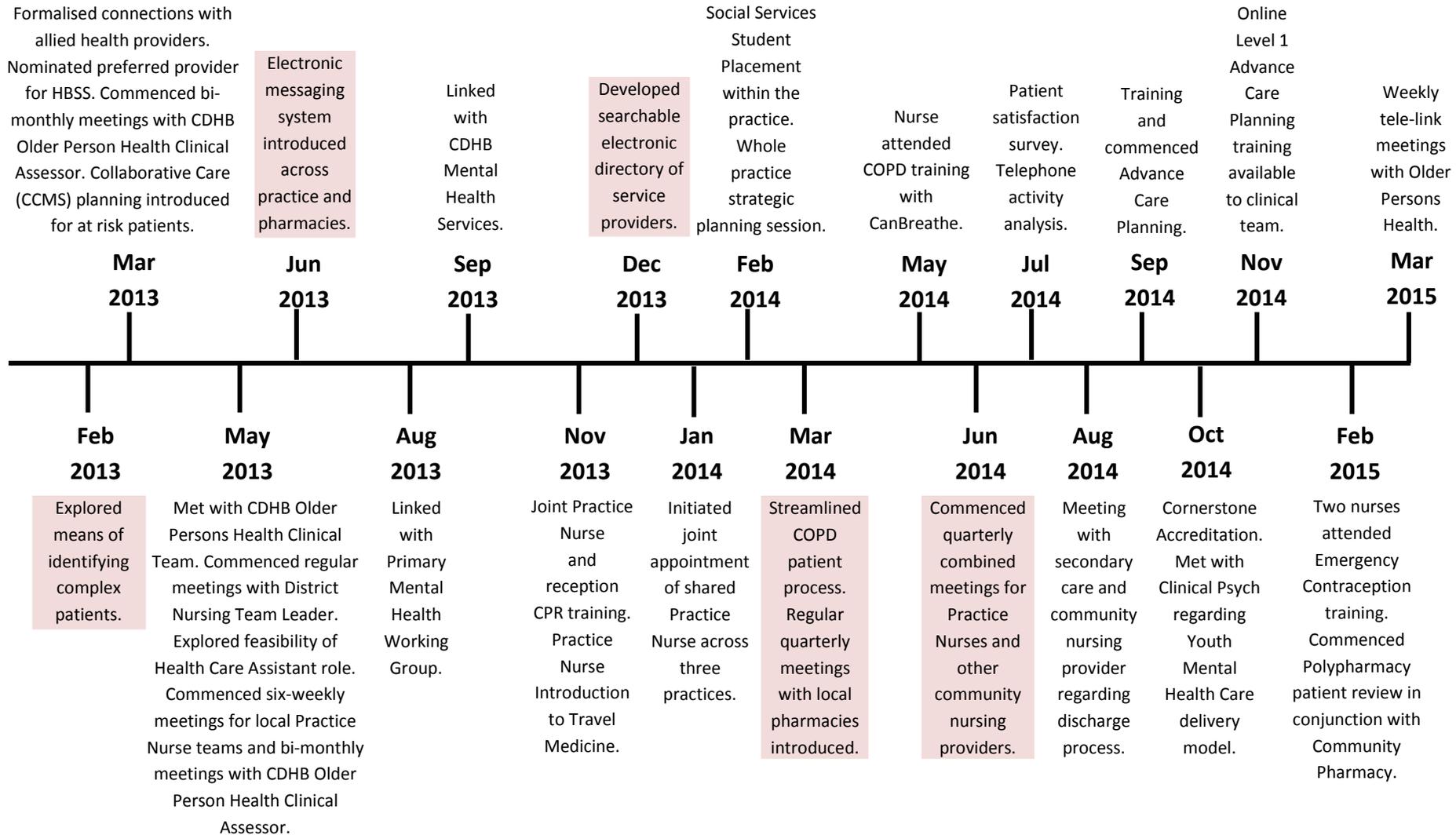
From a nursing perspective the team felt there was much more opportunity to utilise the skills and experience the nursing team carried. The team intended to:

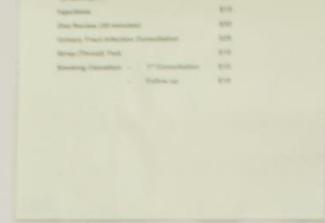
- Enable more nursing involvement in care of patients, as allowed by the nursing scope of practice
- Ensure training and support was available to guarantee this advancement to the nurses' skills took place safely
- Ensure as much nursing time as possible was available to direct patient care
- Teaching less experienced nurses and showcasing primary care nursing as a rewarding career option

The practice's journey through change along with their partners



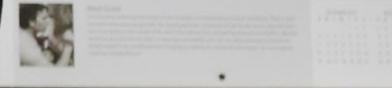
EVALUATION





August 2015

30	31					
2	3	4	5	6	7	
9	10	11	12	13	14	
16	17	18	19	20	21	
23	24	25	26	27	28	



How they did it

The Travis Medical Centre has achieved model of care improvements through a united desire across the team to improve access for patients, a steady and considered approach to change and a quality cycle attached to each initiative.

Overall, it has required a whole team approach where each team member is enabled and encouraged to work towards the top of their scope of practice.

The team has commented that the changes to their model of care have not been as difficult to make as they initially thought.

Capacity has been found through a combination of process improvement, professional development for staff, technology investments, linking with other providers in the delivery of care and involving patients more in their care.

Patient access to services has improved through a combination of improving access for urgent care, involving practice nurses more in the delivery of care, aligning with Community Pharmacy and freeing up General Practitioner capacity to spend more time with patients who require more proactive approaches to care.

The changes that the practice implemented can be grouped into the following key areas:

- ① A different approach to acute presentations
- ② A more planned approach to consultations
- ③ Changes to the roles of team members
- ④ Widening the team
- ⑤ More proactive management of complex patients
- ⑥ Improving access to care for patients

“ We hold 'meetings without agenda' every week. These 20 minute meetings are held on different days each week so that every staff member gets to attend one meeting a fortnight. We all sit down in the staff room with a cuppa. Linda keeps the minutes. There is no agenda; anyone can raise items for discussion as they wish. It can be the latest episode of Downton Abbey, the flat tyres on the wheelchair or how best to arrange our flu vax clinics. With doctors, nurses and admin staff all present, some very useful discussions are had. The meetings allow us to iron out problems as they occur and are very good for staff relationships too. These meetings were instigated by David before I arrived and while it is hard to quantify the contribution they make to the overall success, I believe it is considerable.

”
Dr Sue French

A different approach to acute presentations

One of the earliest and most profound revelations for Travis Medical Centre was about the numbers and timing of patients presenting acutely. Using sampling-based patient consultation data, the IFHS Facilitators were able to analyse daily acute presentations compared to other booked consultations and how they were all distributed throughout the day.

The results of the acute and chronic presentations throughout the day surprised the team. They found that more than 55% of their consultations were in fact acute, which was much higher than they had expected.

These observations led to one of the first changes, which was how acute patients were managed throughout the day. They realised that acute presentations could be seen as highly predictable occurrences that could have a planned approach rather than being unpredictable events that had to be fitted in. For instance, they found that the great majority of acute patients arrived early in the day.

‘Acute slots’ were introduced before 8.30am for telephone consultations between the patient and a General Practitioner or Practice Nurse. In doing so, the team introduced a form of triage and planning for acute presentations. They found that by phoning patients with acute needs back rather than immediately booking them in, they were able in some instances (approximately 40%) to give advice that meant the patient did not need to visit that day and were often able to arrange investigations for the patient to occur prior to their visit. The team reported that the approach was received well by the patients who said it saved them time and sometimes the cost and inconvenience of a visit.

The team also changed the way calls are logged during the day. By setting up a new screen for recording the details of all incoming phone calls, staff can quickly see the details of a call and decide whether to take the call or return the call. This reduces interruptions to work flow and increases efficiency for receptionists as well as Practice Nurses.



“ We’d look at what’s happening with our acute patients and our flow in our systems in place and we thought ‘we can improve on that’. We found we had lots of acutes and perhaps we weren’t managing them as well as we should. So we changed the way we worked...It’s made us more efficient. ”

Linda Adams, Practice Manager

A more planned approach to consultations

The practice has implemented a more planned approach to their daily consultations. This has been as simple as introducing a daily process for previewing the records of patients with appointments booked.

Travis Medical Centre's General Practitioners and Practice Nurses meet for a daily 'huddle' every morning. Wherever possible, local pharmacists also attend. The team reports that the daily meeting gives them the opportunity to work better and be more proactive. They can activate other strategies before the consultation, such as investigations or calls to other providers involved in the person's care.

"In the morning we huddle...We'll look at my patients for the day and we'll look at the whole...[and ask] what else can I do while they're here to meet their needs?," the Practice Nurse explained.

The team members identified several flow on effects this has had for the patients, the practice and the pharmacy, including improved outcomes for their patients and improvements to the team's workflow. They found that a wider range of issues could be addressed when the patient attended the General Practice in one coordinated and planned appointment rather than having to come back again.

"...the doctors and the nurses [meet] at nine o'clock...It's a time where they can sit down and look, see who's coming in and coordinate appointments. So if somebody is coming in to see a doctor that really needs to have something done with the nurse as well, that will all be organised. They all talk to each other and sort out getting all the things done for the patient when they come in so that we're not trying to call them back later," the Practice Manager explained.

The planning meeting has also meant that decisions are made about who will be the best team member to see a given patient on that day. The team reported that this created a greater sense that the patient is being looked after by the whole team and that everyone is working "at the top of their game" (Dr David Pilbrow).



“ In the morning we huddle...We'll look at my patients for the day and we'll look at the whole...[and ask] what else can I do while they're here to meet their needs? ”

Nicky Scott, Practice Nurse ”

Changes to the roles of team members

Travis Medical Centre has deliberately sought to extend the roles of the practice's team members as part of the new model of care. This has included investment in professional development across the whole team, but especially for nurses, to enable team members to work towards the top of their scope of practice.

The Travis Medical Centre Practice Nurse team has undertaken a total of 900 hours of professional development to support the required increase in their scope of practice. Many members of the team comment that this enables them to make a better contribution while achieving greater professional work satisfaction.

Medical and nursing team members

Travis Medical Centre wanted to empower its nursing team to be more involved in patient care, in turn freeing up General Practitioner capacity. Practice Nurses are encouraged to undertake professional development that enables them to develop rewarding new areas of practice, including conducting cervical smears and starting patients on insulin. The practice identified that this extension of roles resulted in marked changes in consultation patterns. They found that General Practitioners are seeing fewer people overall and those they see are generally of higher complexity, while Practice Nurses are seeing 50% more consultations than before. Note: The nursing FTE has not been increased but is now supported by a care coordination function.

This suggests that patients are valuing their relationship with the whole care team. A patient satisfaction survey supports the team's sentiment that high quality care continues with this change.



“ For me continuous improvement is essential and having the opportunity to work together has been the critical factor for change. The opportunity to develop in your areas of interest has been very rewarding.

Nicky Scott, Practice Nurse ”

Reception team members

The practice involved the reception team in the IFHS process right from the very beginning. As a result, members of the reception team are more empowered to make decisions around a patient's care and assist the patient in taking greater responsibility for their own care.

As a result of training and changes to Practice Nurse roles, reception team members are now empowered to refer patients more appropriately rather than automatically booking appointments with a General Practitioner. By implementing a dedicated nurse screen on the communication system, reception staff are also able to refer calls straight through to the nurses when necessary.

The introduction of "Lofty" – a piece of medical equipment which measures heights, weights and blood pressures – has also supported the expansion of the reception staff members' role in the service provided to patients. Reception assists patients to use the machine and then record the results directly on the patient's record, assisting people in their own care and negating the need for medical colleagues to spend time collecting this information and freeing up time to focus on care.

“ We've changed things so the patients provide a lot of their own care and we give them the tools to do that.

So there are examples where [a patient] with high blood pressure will get their own blood pressure cuff. They monitor their own blood pressure and report back to us rather than coming in every three months to get their blood pressure checked...and we've got a machine here so people who can't afford their own blood pressure cuff can come in and do it.

There's been a shift that the patient is their biggest health provider and we are there to guide them with that.

Dr David Pilbrow ”



Widening the Team

For the Travis Medical Centre team there has not only been better teamwork within the General Practice, but the team they are working with is much broader.

The practice is actively coordinating and integrating with other members of the patient's health care team, particularly through integration with a local pharmacist and implementing a Care Coordination function.

Introducing the Care Coordination function

Travis Medical Centre identified the implementation of a Care Coordination function as one of the most important initiatives in supporting the changes.

The Care Coordinator provides a conduit between General Practices and other health and social services. Establishing regular meetings between doctors, nurses, community health providers and reception staff from across different practices, the practice has better relationships, learnings and can call on one another when necessary. Developing and maintaining a web-based contact directory of local providers and organisations has also facilitated medical staff in referring patients for services.

Also importantly, the Care Coordinator has assisted the practice to provide more planned and coordinated care for vulnerable patients and patients with complex health needs. The Care Coordinator supports the General Practice Team to identify patients with complex health needs and coordinate care with other appropriate services. By assisting in the development of care plans and linking patients with external services that will support their care, the Care Coordinator supports the proactive management of patients.



“ Integration is about getting in contact and creating contact with other providers who have been doing jobs which we’ve been trying to do, but they actually do it a hell of a lot better.

Dr David Pilbrow ”

Integrating with the Pharmacy Team

Pharmacists have been included actively in discussions with the General Practice about how they could all do things better and is seen by the practice as integral to their operation.

One Pharmacist comments that the new way of working has taken his relationship with the General Practice Team, which had always been good, to a whole new level. The increased ease of interaction means that he is working better and more closely with the practice, ultimately benefiting patients.

The Pharmacist reported that being more actively involved as a team member has led to him now doing International Normalised Ratio (INR) testing and an increased number of Medicines Management Service (MMS) reviews.

One tool that both the General Practice and the Pharmacist reported as improving the efficiency and quality of communication was the use of an instant messaging system called Jitsi. Instant messaging enables easy, instant communication within the practice, between the three General Practices in the area and with the Pharmacist. Positive effects on patient care reported by the practice include reducing calls through reception, reducing writing of notes by reception staff and allowing messages to go directly to the intended recipient.



“ You may as well be in the same room if you’ve got Jitsi...Small fires can get put out very quickly and that’s the biggest thing from the pharmacy side...the fires that smoulder, just go on and on, can get put out straight away...Previously I may not have asked the question depending on where I was with my day.

Steve Hanmer, Pharmacist ”

More proactive management of patients living with complex conditions

Travis Medical Centre has adjusted management of patients with chronic conditions to be more proactive. With the change, the practice expected complex patients to see the Practice Nurse more and their visits arranged around a plan and coordinated amongst a wider care team. The team expected that patients who are living with chronic conditions would present more regularly and become acutely unwell less frequently as a result. It was anticipated that proactively managed patients would have less acute visits.

Results show the frequency of patient visits to General Practitioners reduced between 2011 and 2014, except for those who are seeing the General Practitioner two and three times a year. Visits to Practice Nurses have increased overall.



Improving access to care for patients

A major focus for the practice has been improving accessibility of services. While change in access to care is challenging to measure quantitatively, improvements in access can be observed through the following.

Patients report satisfaction with the service they receive

The practice ran a patient satisfaction survey in July 2014 which reported patient satisfaction is rated highly. This is the first patient satisfaction survey conducted by the practice and will provide a benchmark for subsequent surveys.

The average cost of care per patient has declined overall

The practice team felt that the cost of consultation was a barrier to accessing services for some patients. They expected that with the model of care changes, patients would see General Practitioners less frequently and other clinicians more often as the patient relationship shifts to include their Practice Nurse and Pharmacist. Travis Medical Centre has found a reduction in the average number of times patients see their General Practitioner and an increase in the number of times patients see their Practice Nurse. Considering the practice's pricing policy, it is feasible to suggest that patients are paying less on average for their visits.

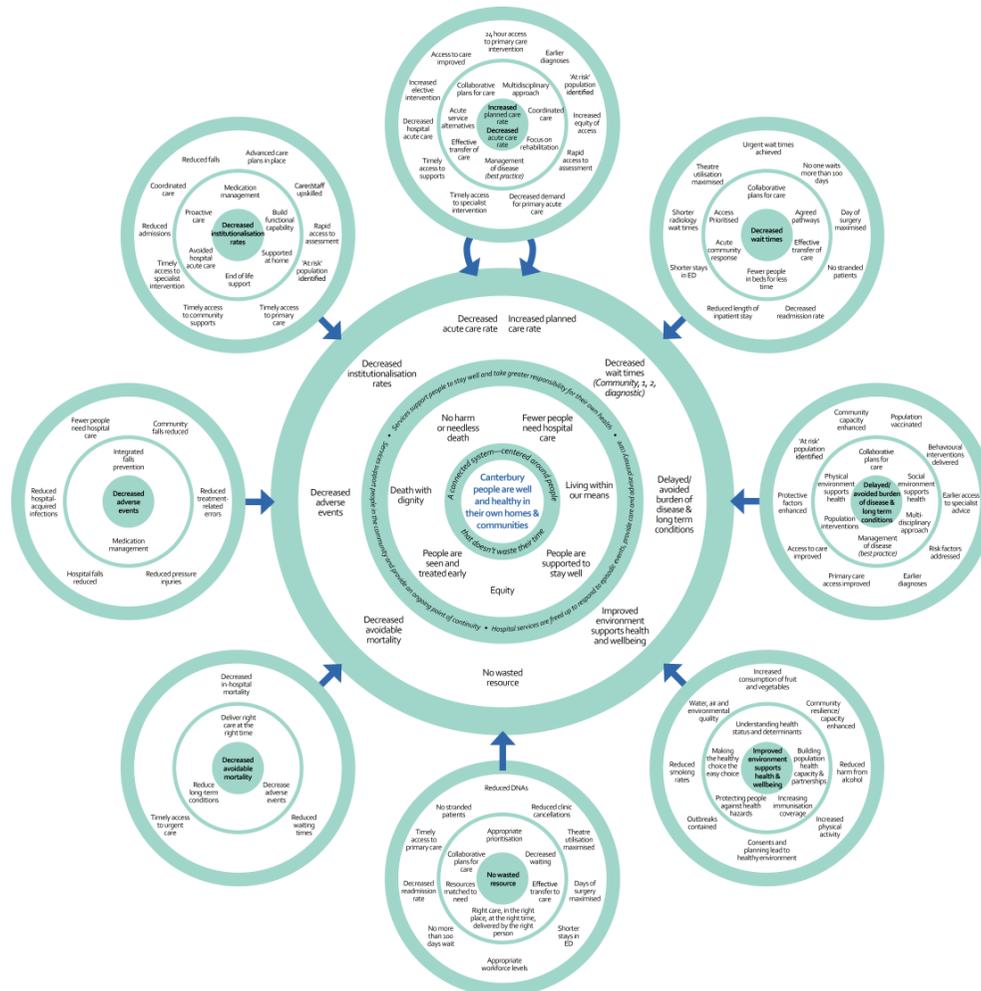
Patients can see appropriate members of the care team when needed

With the change to the model of care, Travis Medical Centre expects more patients to be able to access care on an "immediate" basis, as well as more ease in booking same day appointments. They would also expect these appointments to be shared amongst the patient's care team, as appropriate. As demonstrated previously, same day and other day General Practitioner consultations are declining at a rate consistent with the overall consult rate decline. However, there is an increase in walk in consultations being managed by the nursing staff, suggesting Travis Medical Centre patients are taking advantage of readily accessible care opportunities that are now available.



What they achieved

The development and measurement of outcomes for Travis Medical Centre has been aligned with the Canterbury Health System Outcomes Framework below. The Framework demonstrates the shared outcomes of our integrated and connected health system. The Canterbury health system recognises that our desired outcomes are achieved through a range of integrated activity which collectively contributes to progress. The Systems Outcomes Framework helps align this system-wide activity around a set of shared outcomes. The IFHS activity potentially impacts on every outcome.



BASED ON THE FRAMEWORK, TRAVIS MEDICAL CENTRE SET THE FOLLOWING INDICATORS OF SUCCESS AT THE BEGINNING OF THEIR JOURNEY:

①

Have we created capacity across our team?

②

What have we done with that capacity?

③

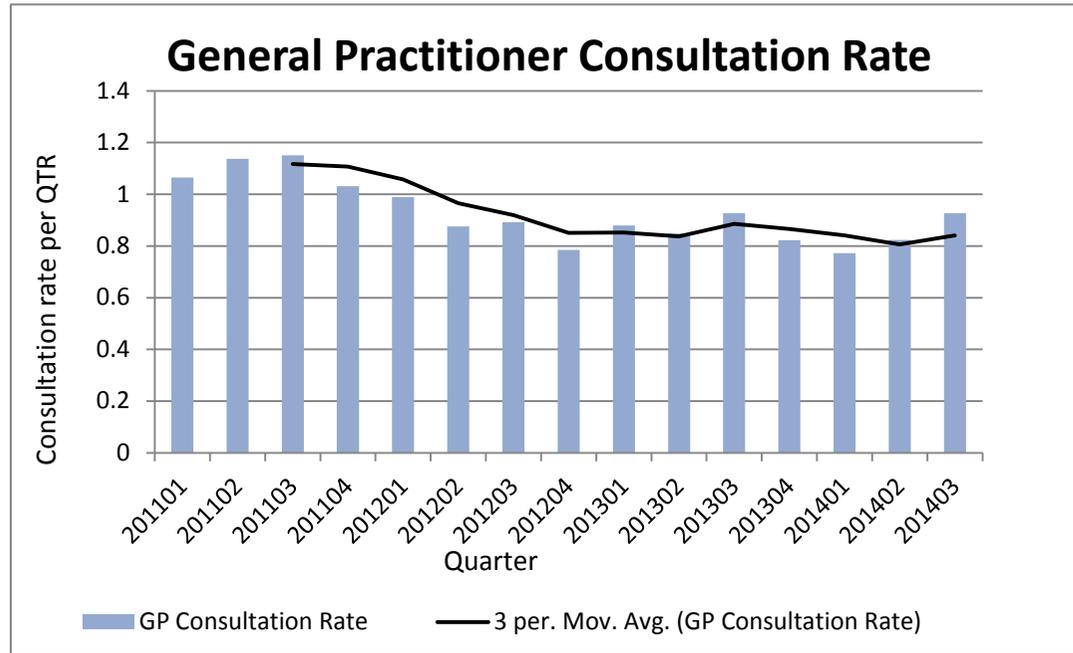
Have we improved access for our patients?

④

Are our patients paying less on average for their primary care?

PLEASE NOTE: Attributing the results demonstrated here with the changes the practice has made is difficult to prove. Instead, practice staff members have stated what they expected to achieve as a result of the IFHS process and the following analyses evaluate whether their expectations are being met.

Measuring impact at practice and patient level

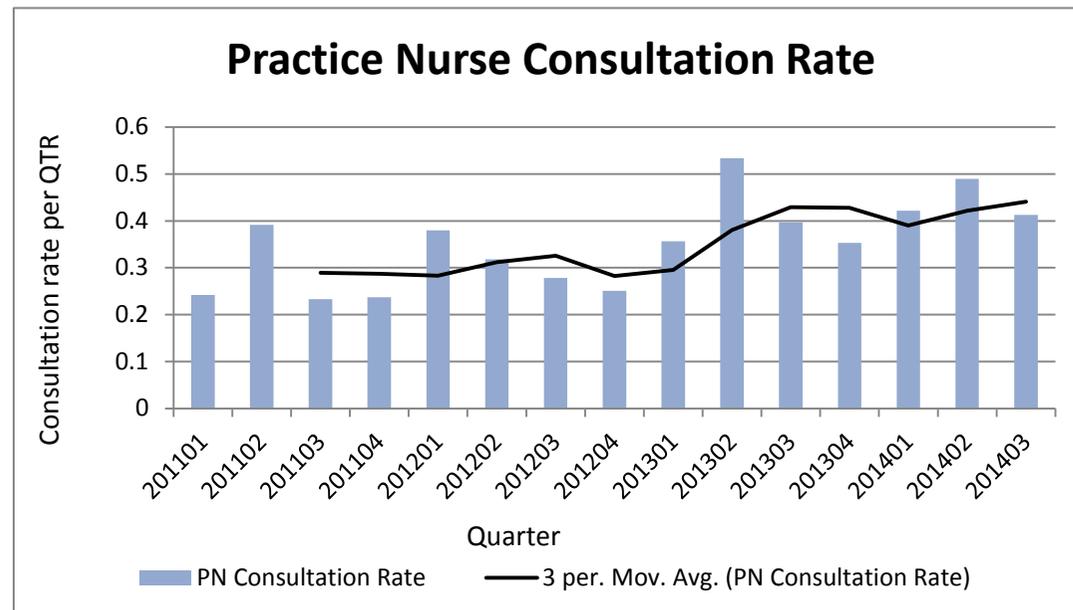


Consultation Rate Observations

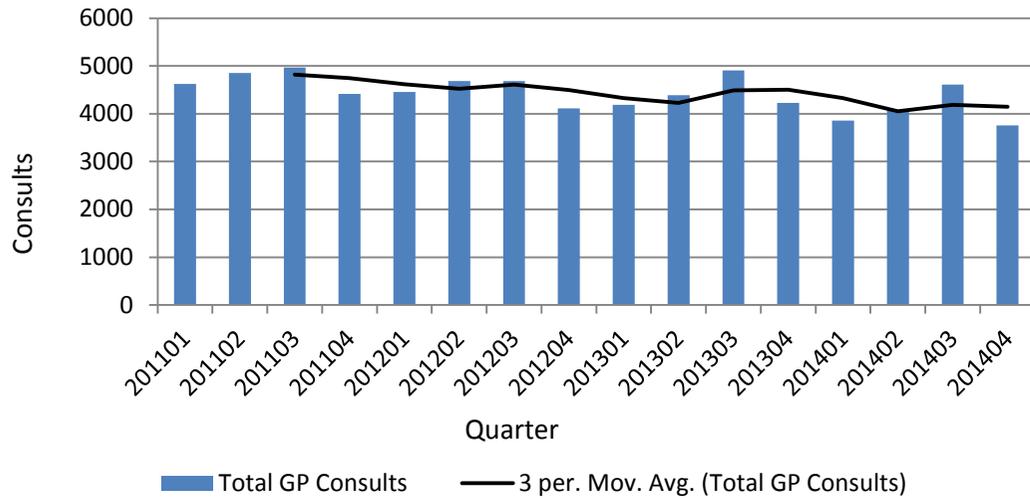
Consultation rate is defined as the number of times a patient visits a General Practitioner or Practice Nurse over a quarter. It is used as an expression of capacity. If Travis Medical Centre has lowered the General Practitioner consultation rate as a result of the changes they have made, they have generated more General Practitioner capacity.

The tables pictured here demonstrate a reduction in the average number of times a patient sees a General Practitioner and an increase in the average number of times a patient sees a Practice Nurse. The average capacity gain across all General Practitioners is measured at 25%. This can be further broken down to a range between 9%-30% for individual General Practitioners. Practice Nurse consultation rates have increased as they have extended their activity with their patients in line with their new model of care.

Data source: Travis Medical Centre Patient Management System



Total General Practitioner Consults

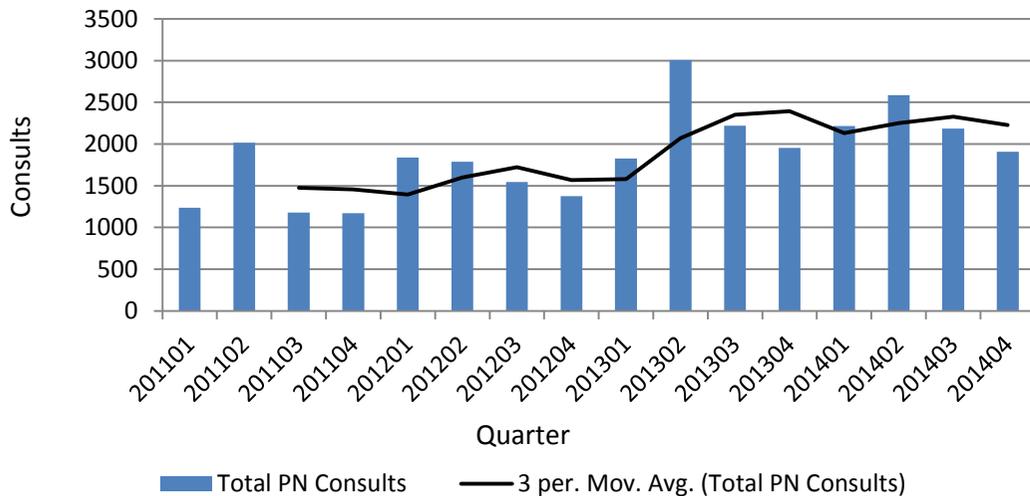


Consultations Observations

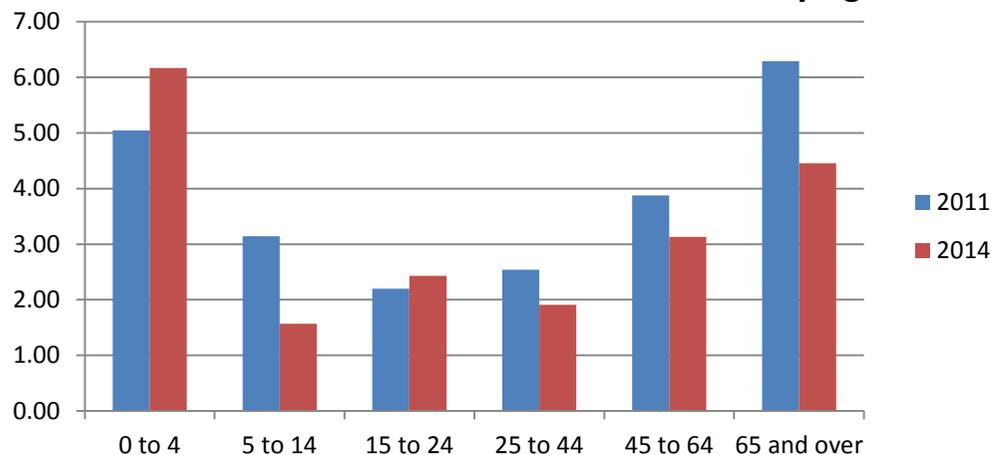
The tables pictured illustrate the actual amount of work the Travis Medical Centre team is doing. Total General Practitioner consultations have declined as the nursing team members take on more activity for selected patients that was previously carried out by the General Practitioners. This indicates the increase in team-based care for those patients rather than General Practitioner care alone. It should be noted that over this time the practice enrolments have increased by 14%.

Data source: Travis Medical Centre Patient Management System

Total Practice Nurse Consults



Annual General Practitioner Consultation Rate by Age

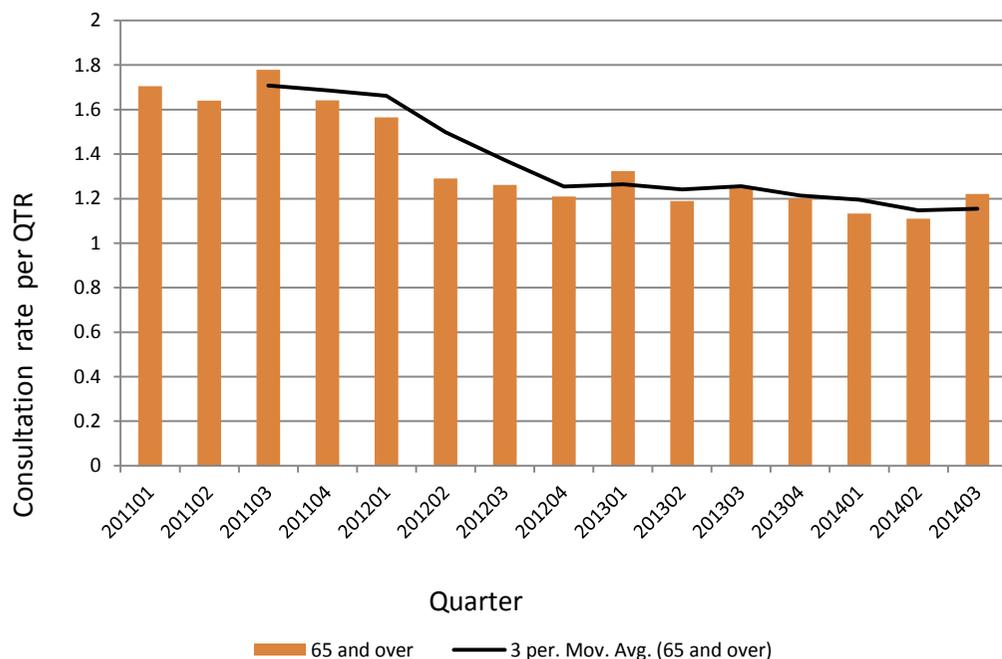


Over 65 Observations

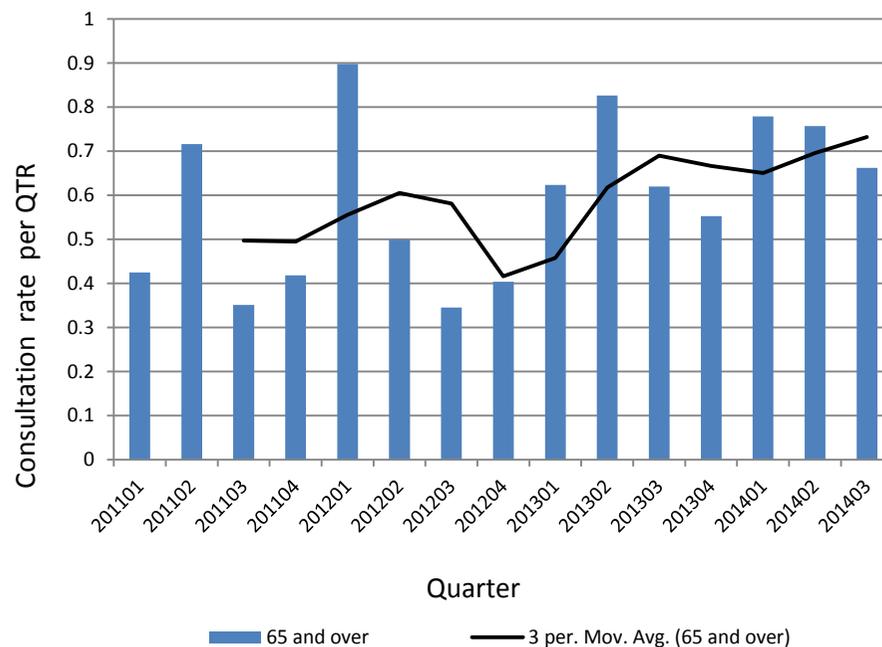
Travis Medical Centre General Practitioners are seeing their patients less. This is particularly apparent in the over 65 age group where their consultation rate has reduced by 29%. The practice has achieved this by improving organisation of some complex patients' care and transferred care tasks amongst the primary care team as is appropriate. An example of this is the increase in Practice Nurse consultation rates for the same age group.

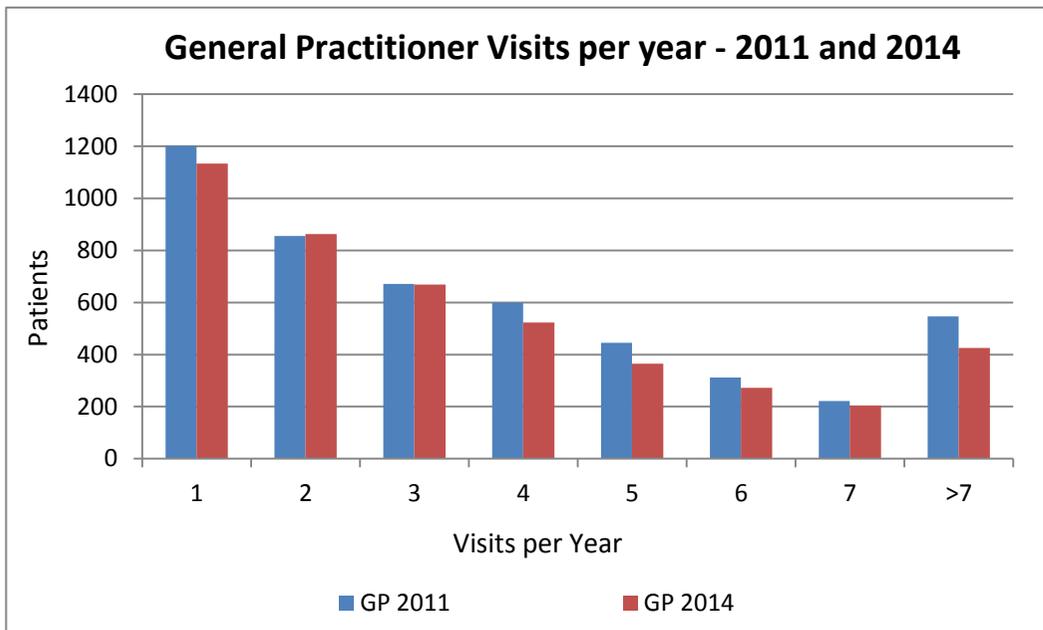
Data source: Travis Medical Centre Patient Management System

General Practitioner Consultation Rate 65 and over



Practice Nurse Consultation Rate 65 and over

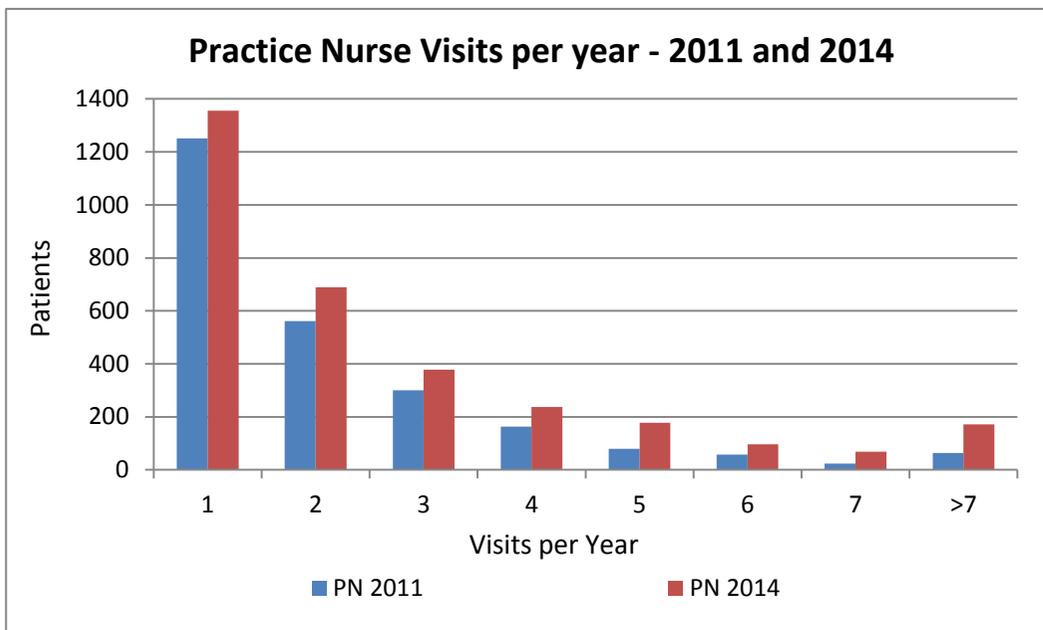




Visit Frequency Observations

The frequency of patient visits to General Practitioners has reduced between 2011 and 2014 except for those who are seeing the General Practitioner two and three times a year. Travis Medical Centre believe this is a result of complex patients seeing the Practice Nurse more, their visits arranged around a plan and care coordinated amongst a wider care team.

This implies some patients are seeing their General Practitioner less often and their Practice Nurse more frequently and in a more planned way. This will reduce the cost to some patients on average.



Patient Access Observations

Some patients are being seen in the practice less often, seeing the General Practitioner less and the Practice Nurse more. Combined with the Travis Medical Centre pricing policy, this means some patients are benefiting from both improved access and a reduced average cost of their care.

Data source: Travis Medical Centre Patient Management System

Measuring the impact on the wider health system

Travis Medical Centre's intention in changing their model of care was that patients' needs were met more effectively within the practice and that there would not be a shifting of demand to other parts of the health system. The following data demonstrates that the practice's enrolled patients are continuing to receive the care they need from the practice and not needing to access other acute services instead.

Observations are made with consideration that the reliability of that analysis is reduced as a result of the practice's small secondary care volumes. The data presented provides associations from which inferences can be made, but causality should not be concluded. The observations also apply to one practice which has small volumes of hospital services.



Travis Medical Centre set the following indicators in order to measure the impact the changes were having on the wider health system:

①

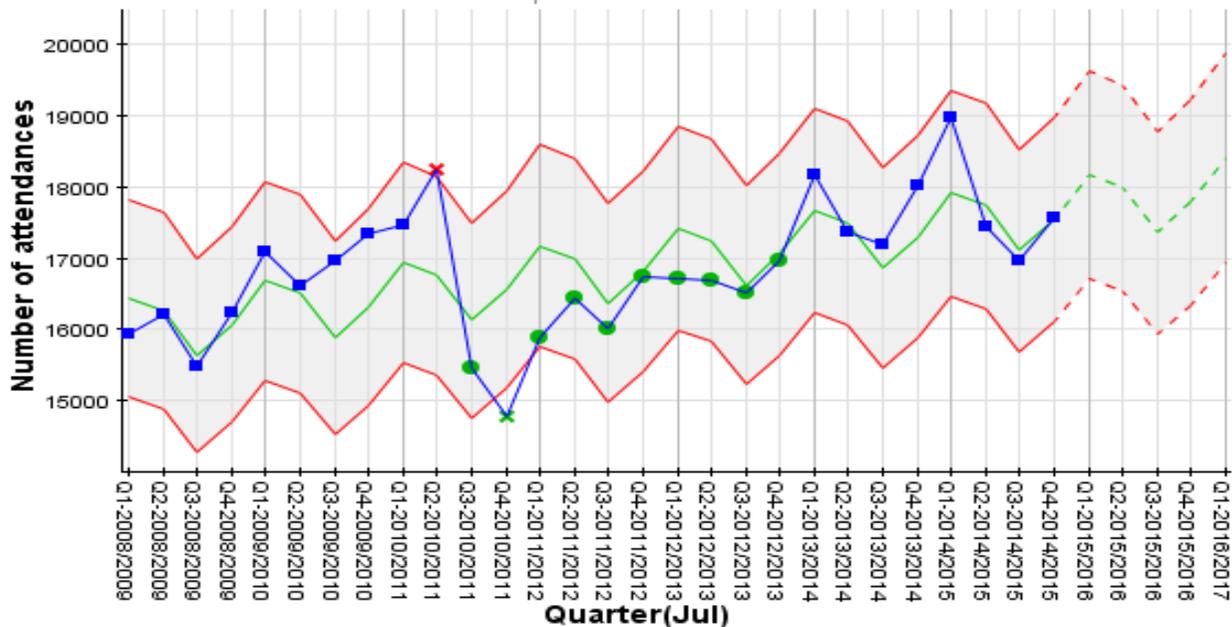
Have we inadvertently shifted work onto the rest of the health system?

②

How have our changes impacted on our patients' use of hospital resources?

All Emergency Department Attendances – Not Travis

Data Updated: 2015-08-02 22:25:32



Canterbury District Health Board Emergency Department

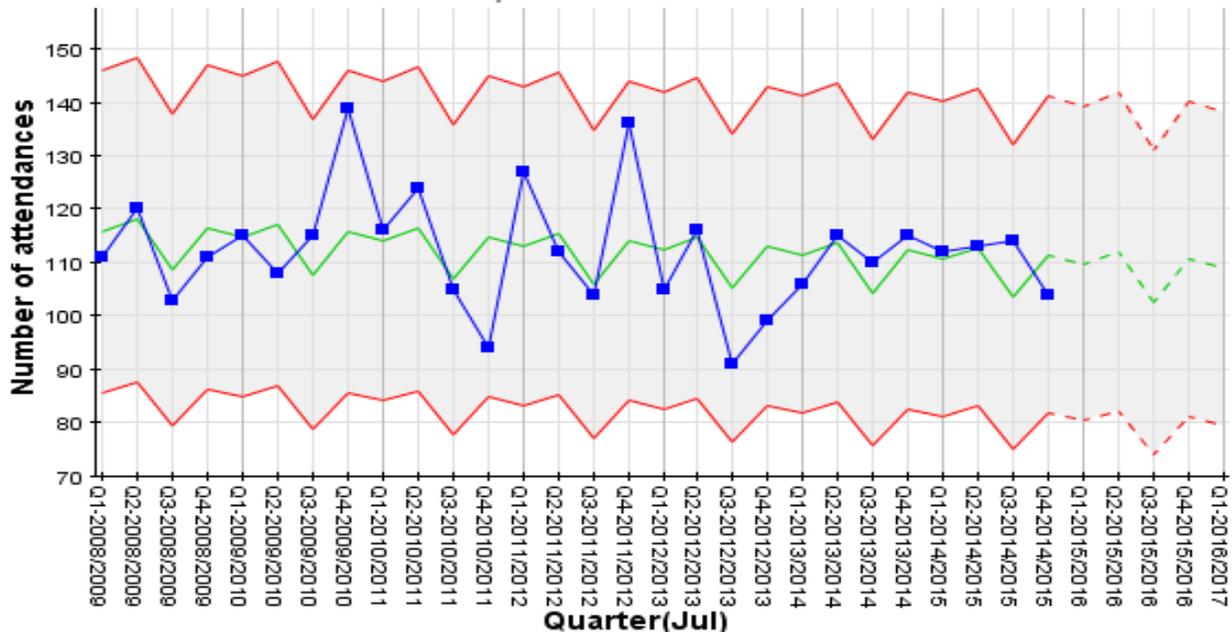
Canterbury has a low Emergency Department attendance rate compared with the rest of New Zealand.

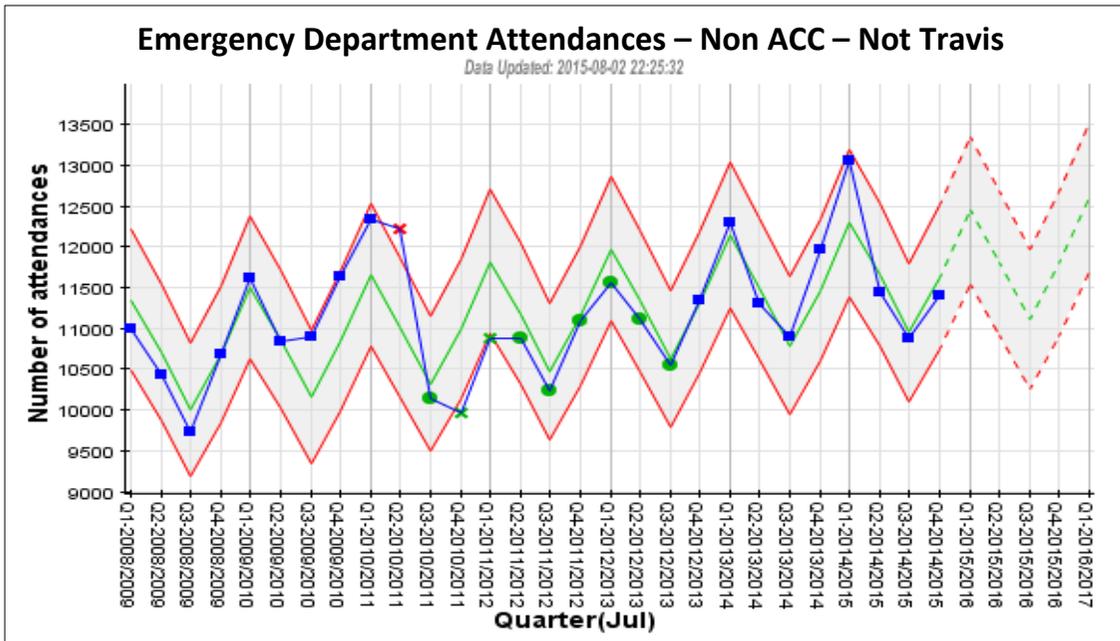
Between 2010/11 and 2014/15, there has been a Canterbury wide growth in Emergency Department attendances of approximately 7.6%. For the equivalent period, Emergency Department attendances for Travis patients also grew, but at a much slower rate of just 0.9%, even though their enrolment grew over this time.

Data source: Canterbury District Health Board

All ED Attendances –Travis

Data Updated: 2015-08-02 22:25:32

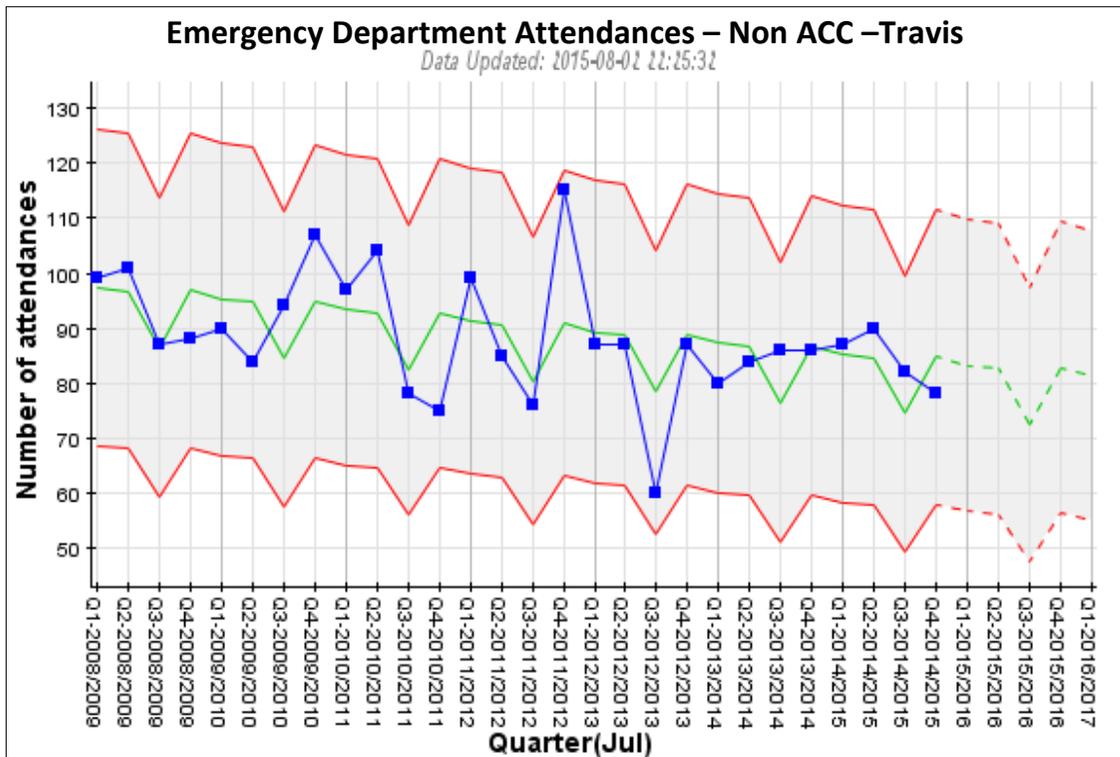




Non Accident Compensation Commission (ACC) Emergency Department Attendances

Between 2010/11 and 2014/15, there has been a Canterbury-wide growth in non ACC Emergency Department attendances of approximately 4.7%. For the equivalent period, non ACC Emergency Department attendances for Travis patients declined at the rate of -4.8%, even though their enrolment grew over this time.

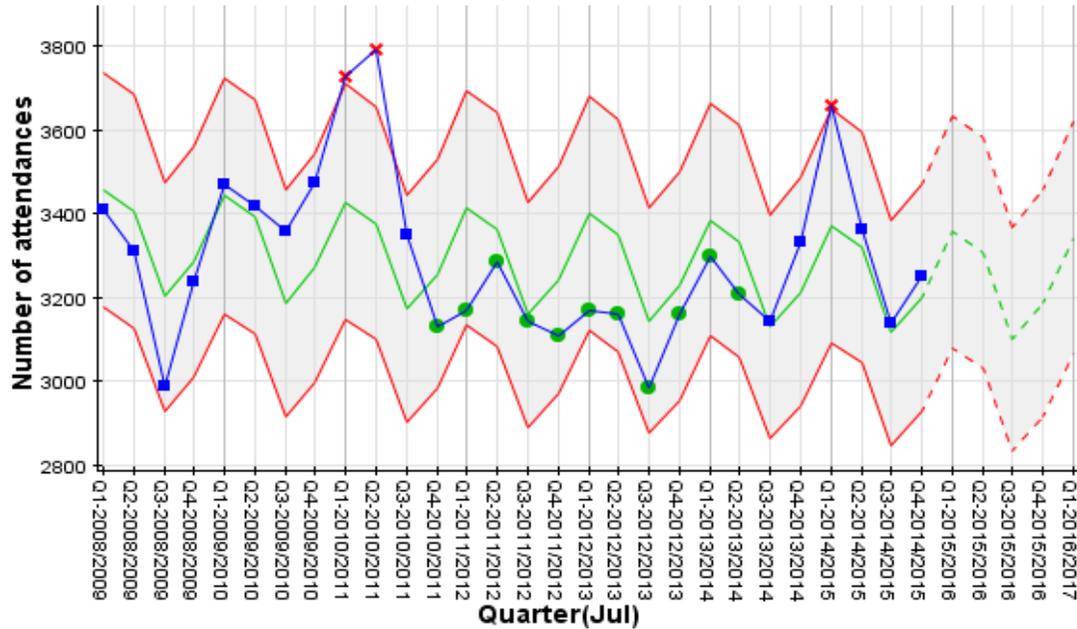
As shown in the timeline on pages 10-11, when Travis Medical Centre changed the way it managed its acute patients, this had immediate impact on non ACC Emergency Department attendances, as shown in the table. In 2013, there was also a decrease in the variation of attendances which coincides with the introduction of a Care Coordination function at practice level.



Data source: Canterbury District Health Board

Emergency Department Attendances – Non ACC – Not Travis – Over 65 years

Data Updated: 2015-08-02 22:25:32



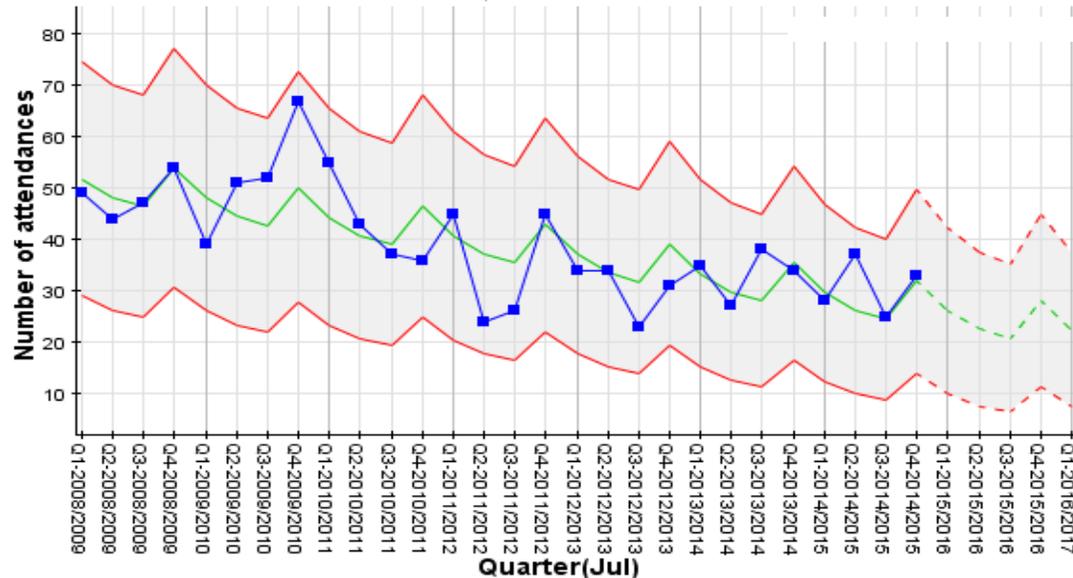
Non Accident Compensation Commission (ACC) Emergency Department attendances for over 65-year-olds

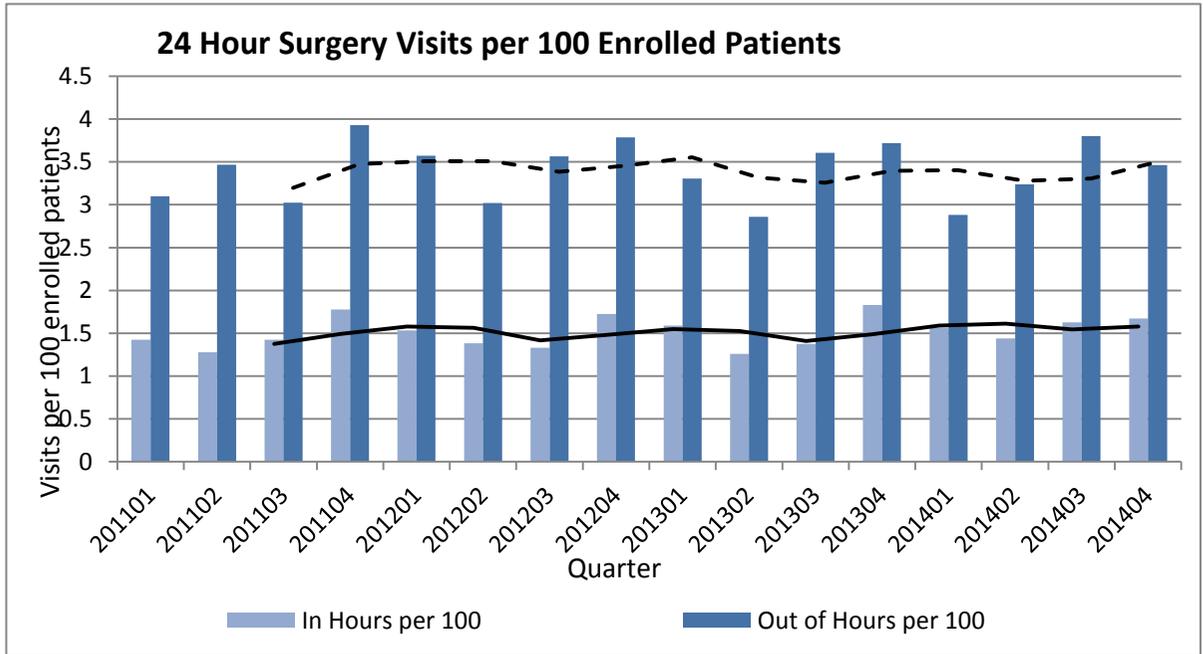
Between 2010/11 and 2014/15, there has been a Canterbury-wide reduction in non ACC Emergency Department attendances for people aged over 65 of approximately -4.2%. For the equivalent period, non ACC Emergency Department attendances for people aged over 65 for Travis patients declined at the rate of -28.1%. The practice enrolled patients over 65 years grew by 25% over this same period. In addition to this Emergency Department attendance data, in the past 12 months there have been zero frequent attender COPD admissions for Travis Medical Centre patients.

Data source: Canterbury District Health Board

Emergency Department Attendances – Non ACC –Travis – Over 65 years

Data Updated: 2015-08-02 22:25:32

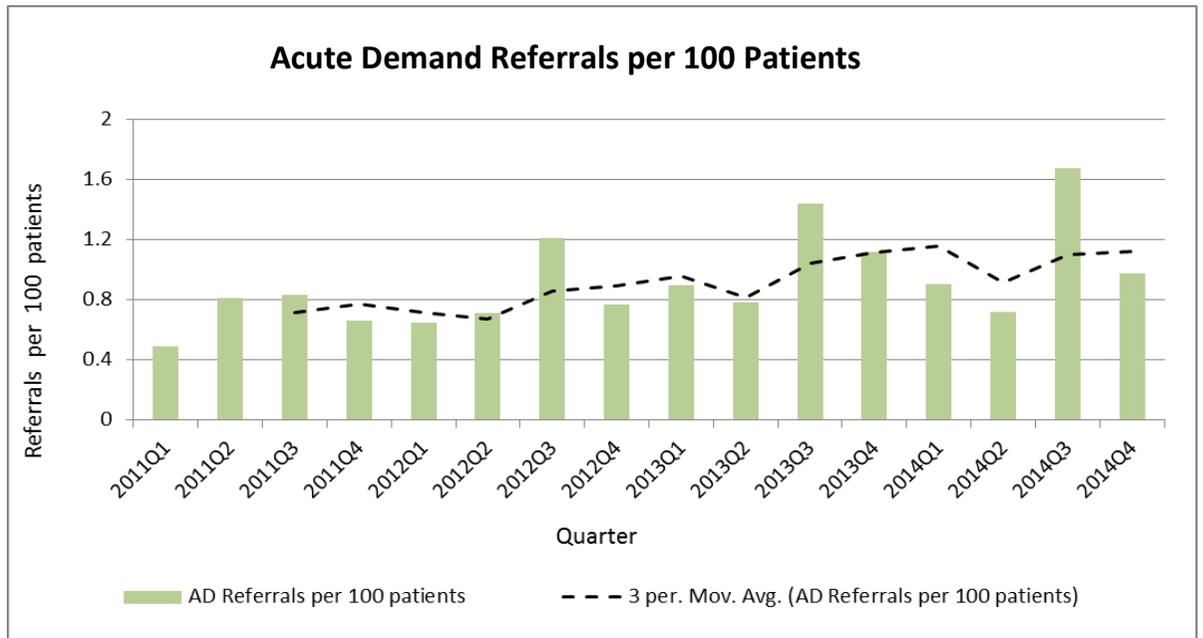




Pegasus Health 24 Hour Surgery

Travis Medical Centre’s patient visits to the Pegasus Health 24 Hour Surgery per 100 patients enrolled remains at the same level, demonstrating the practice’s patients use of the 24 Hour Surgery has not changed as a result of the practice’s model of care changes.

Data source: Pegasus Health



Acute Demand Services

The Travis Medical Centre team expected that it would increasingly access Acute Demand rather than have their patients attend the Emergency Department or 24 Hour Surgery. The growth in the practice’s patient referrals to Acute Demand per 100 patients enrolled indicates the practice is responsibly accessing the Acute Demand service more in order to ensure their patients are served in the community and as close to their homes as possible.

Data source: Canterbury District Health Board





About the Integrated Family Health Services Programme

The Integrated Family Health Services (IFHS) Programme is designed to support and mentor Canterbury General Practice Teams to take time out of their busy schedules and plan for the future. To plan how to spend more time with the ever increasing number of complex patients and feel greater satisfaction with the day-to-day General Practice environment; how to achieve a more inclusive team approach and interaction with a wider range of clinicians across the health system, but still preserve the critical doctor-patient relationship that is at the heart of family General Practice. The focus of the programme is putting the patient at the centre of care.

The programme's goal is to facilitate integration and collaboration between health and social services so that they are better coordinated to conveniently, efficiently and sustainably meet the needs of individuals and families. To achieve this, the programme supports groups of consumers, practices, pharmacies, community providers and hospital services to establish relationships and implement enhanced ways of working that reduce unnecessary work and free up time for clinicians to do what they are trained to do. The focus for the IFHS Programme is on building relationships that enable collaboration, not necessarily erecting buildings to assemble various services (although sometimes this is considered appropriate).

Participation in the IFHS Programme is voluntary. Trained facilitators guide groups through a process that is tailored specifically to their desired outcomes and participant groups lead their own course through the process at their own pace.

Benefits that can be achieved

Some of the benefits that have been achieved by practices involved in the IFHS Programme include:

- ✓ Improve patient care by enabling more time to be spent with patients who need it
- ✓ Increase patient satisfaction by providing more flexible and time-efficient care and services
- ✓ Improve clinical service by linking with secondary and community colleagues around the care of patients
- ✓ Free up time and staff to provide more services and grow the business
- ✓ Enable General Practitioners to achieve a better lifestyle with more work/life balance
- ✓ Free up time for professional development and to support less experienced staff
- ✓ Be able to exit the practice when the time is right with assurance that the same quality of services will continue
- ✓ Enable increased investment in the business and the premises
- ✓ Increase staff satisfaction by supporting each team member to work towards the top of their scope

The IFHS Programme aligns with the strategic objectives of the Canterbury health system, supporting people to stay well in their own homes and communities. By building the sustainable capacity and capability of primary and community teams to enable coordinated support for people in a community setting, the programme in turn facilitates hospital resources to be freed up to respond to more complex episodic events. The programme supports General Practices to access and gain maximum benefit from system-wide tools and programmes.

IFHS groups covering 330,000 enrolled people (68%) of the total Canterbury enrolment have expressed interest in the IFHS Programme.

While Travis Medical Centre is leading the way with its implementation, there are 41 urban and rural groups covering 42% of enrolled people actively involved at various stages of introducing new ways of working.

The IFHS Programme has now turned its focus to supporting these groups in their implementation journey in addition to supporting new groups.



DEVELOPING A NEW MODEL OF CARE

Steps commonly involved in developing a new model:

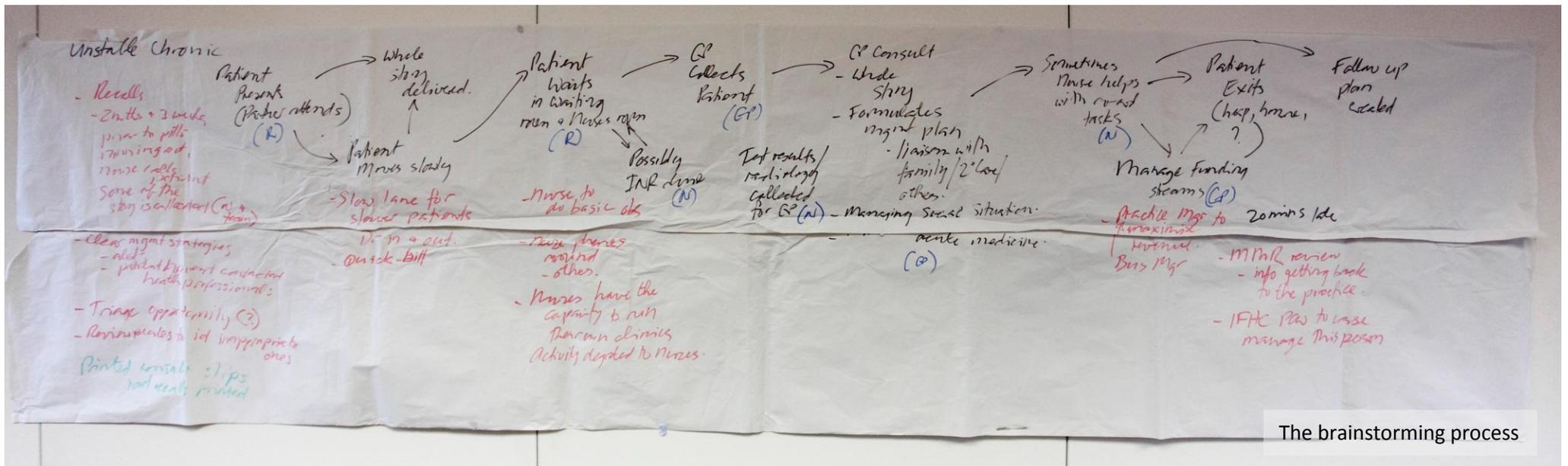
- ① Stratify your enrolled population
- ② Map the current processes
- ③ Identify opportunities, constraints and enablers
- ④ Generate proposed new work processes
- ⑤ Analyse
- ⑥ Implement
- ⑦ Evaluate and improve

Common changes implemented

Often it's not the biggest and most complicated changes to a model of care that have the most impact.

Highly effective changes implemented through the IFHS process have included:

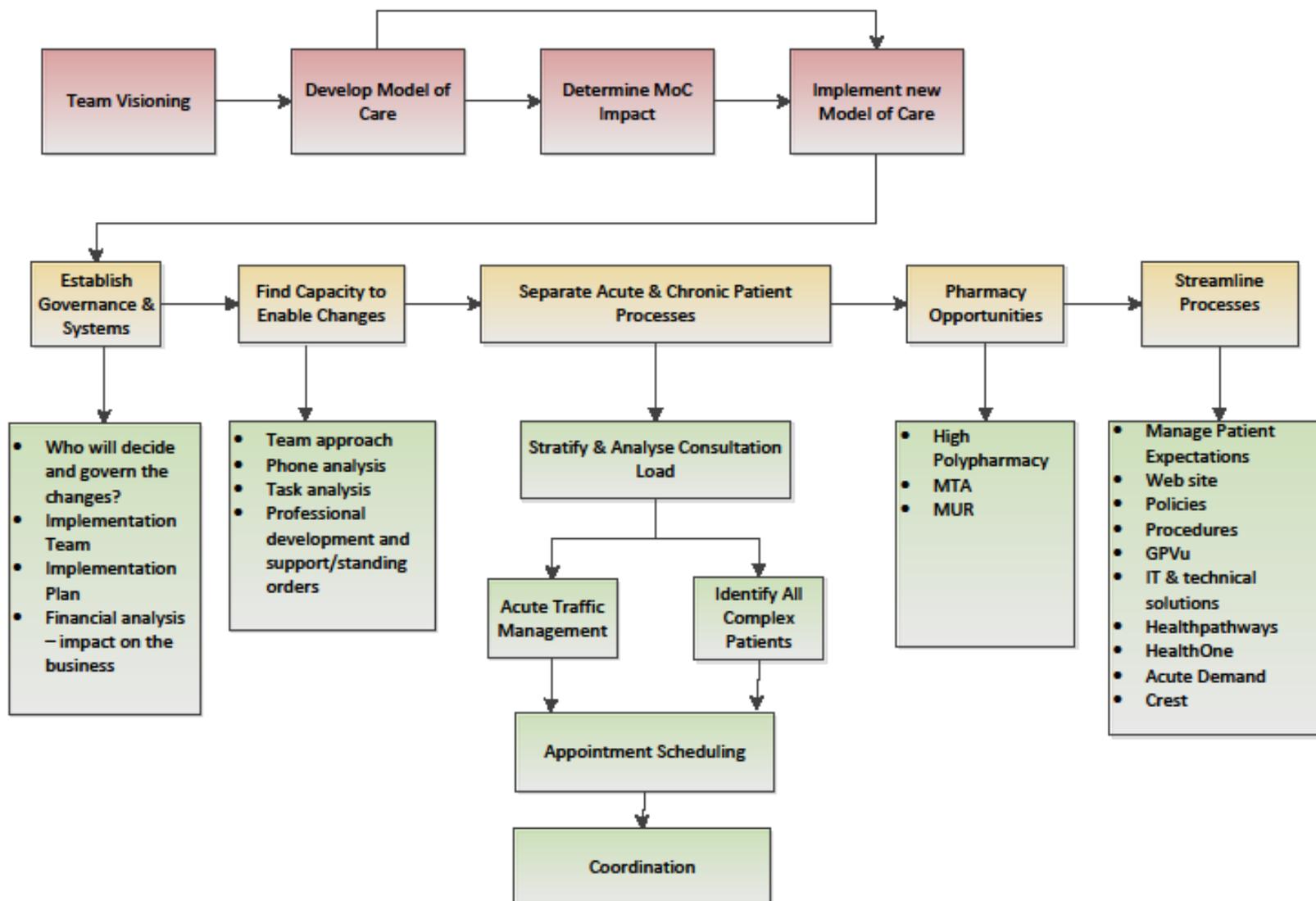
- ✓ Distributing tasks across the primary care team to those roles most suited to deliver them
- ✓ Setting aside time for acute or unplanned patients that is managed separately from booked patients
- ✓ Setting up processes to support patients better through patient management plans
- ✓ Setting up processes to better identify preventative care opportunities using the Patient Management System databases



The brainstorming process

This diagram depicts the sequence of changes that have taken place during the Travis Medical Centre patient journey. This should be read in conjunction with the timeline on pages 10-11.

Integrated Family Health Services – Implementation Process



Lessons Learned

The IFHS Programme has been running for a number of years with many groups at varying stages of the process.

It is possible within this journey to preserve the critical relationship between patient and doctor.

It is also possible to achieve the gains outlined in this report without impacting the General Practice's bottom line.

Through this experience, the IFHS Programme has established a number of key learnings when considering integrated and collaborative models of care.

Following are some of the lessons learned through facilitating Travis Medical Centre and other groups through the programme.

Key learnings from the IFHS Programme:

- ✓ Integration is about relationships.
- ✓ Focussing on the patient removes boundaries and equalises partners.
- ✓ Intelligent people in the same room working on the same problem will arrive at a great answer with buy-in and ownership.
- ✓ The role of the IFHS team is to facilitate – not impose solutions.
- ✓ The process needs to provide:
 - a structure
 - a safe environment for discussion
 - a way for everyone to win
- ✓ Use the energy created by the process immediately.
- ✓ The groups will need ongoing support to:
 - maintain their vision
 - implement their model of care

FIND OUT MORE

The IFHS Programme is a free system-wide support available to all practices across the Canterbury health system. It is designed to be sufficiently flexible to meet the needs of individual practices regardless of size, location or specific challenges faced. The programme support is tailored and confidential, with information only shared by agreement with the practice.

To find out more or enrol in the programme:



ifhsinfo@pegasus.org.nz



www.ccn.health.nz/IntegratedFamilyHealthService

www.travismedical.co.nz



Jan Edwards 027 2242 980

Mark Henare 021 820 651