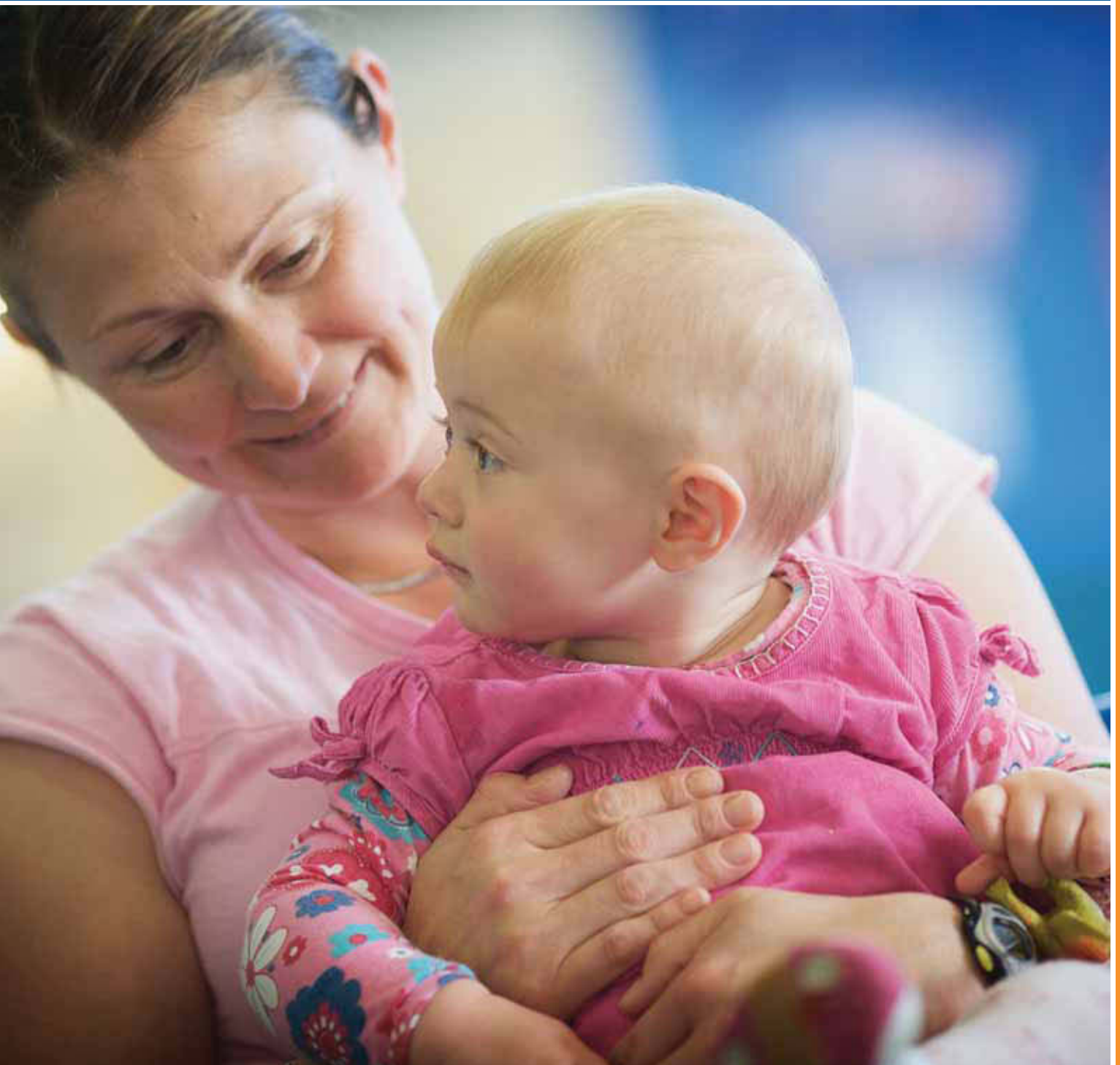


## INTEGRATED FAMILY HEALTH CENTRES

PUTTING THE PATIENT AT THE CENTRE OF PRIMARY CARE



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# Introduction

Imagine a health system where:

- Patients visits to practices don't involve long waits
- Necessary tests are completed before the consultation to avoid return visits to the practice
- The Practice is modern, clean and safe
- Patients develop and maintain a long term relationship with their GP which is supported by a range of health care professionals that focus on patient's health needs
- Patients receive advice and support from members of the health care team in different ways, including face-to-face, phone and even email
- Patients access their health care records like online banking; they can check test results, medication records and order prescriptions, and can share their records with other health professionals if they wish to
- The patient and their health care team use an online service where they can work together to manage the patient's health
- The GP can book the patient in to other services and electronically pass their health needs onto other providers
- The performance of the health care team is visible to everyone.

From April 2011 you will be able to expect this.....

The New Zealand health sector has many achievements to be proud of and sits well when compared to other developed economies. Its workforce is highly trained and committed, access and quality of services is high and the health status of New Zealanders remains well above that of other developed nations.

Yet things are changing, we are ageing as a nation and the next 10 years will see significant changes in the demographic profile, seeing for the first time in our history older people outnumbering younger people. For health services this is significant, as our utilisation of health services increases dramatically as we age. We are living longer but the majority of us will still die from chronic condition related illness, meaning the pressure on our health services will increase. In Midlands our current utilisation of GP services will increase by 20%.



As we age, so does our workforce and the same trends in the general population are also being faced by our workforce. The average age of our doctors and nurses is now in the mid-fifties, which means we face a significant loss of the bulk of the existing workforce in a condensed period. While we are training more doctors and nurses, we are not training enough and we are not attracting them into primary care fast enough. We are also seeing males not choosing general practice in the same numbers and a shift to a female dominated workforce. This is leading to the demand for a more flexible working environment, where full-time work and practice ownership do not feature as highly as they have in the past. In Midlands we will need more than 230 full-time equivalent GPs over the next 14 years just to meet current demand.

## Introduction *continued*

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Where our doctors and nurses work is also changing. Small cottage-based general practice, the cornerstone of the model since the 1940s, is becoming less attractive to the next generation of clinicians. Compliance costs and increased complexity in running a small business is also leaving few willing to take up the challenge of running a business as the returns shrink. The next generation does not want to work in isolated settings with ageing facilities, seeking the safety and comfort of modern multi-disciplinary based centres. A change in society's view of risk and blame are also seeing medico-legal issues creating greater levels of complexity around provision of safe standards. But the ownership of the majority of primary care still sits with male doctors in their late fifties, who despite the market need for investment and development lack an appetite for risk, especially in a market that is failing to offer opportunities to extract the investment equity let alone a fair market based return.

**So how do we and our children and their children experience the same levels of health status and access to quality health care?**

Over the past 10 years the public health system has invested heavily in buildings; modernising, upgrading and enlarging our hospitals. This investment was needed to see the continuation of specialist services and the increased capacity to meet the increased demands of an ageing population. However, hospitals alone will not meet or solve the health needs of New Zealand. Primary care needs investment in order to grow. Not simply increased access (much of the focus of policy for the last ten years) but an investment in and the development of a new approach – a primary care system that better bridges the gap between public service funding and private ownership of the facilities and the workforce.

Over the past five years, conversations amongst GPs and nurses in Midlands Health Network have started to focus on many of these issues, both in rural and urban settings. The question of how to address these issues has started to drive a ground swell of change.

This document is about that conversation and reflects the efforts of many doctors, nurses, pharmacists, St John, DHB staff and primary care staff working together to address these issues and develop a New Zealand primary care system that puts the patient at the centre, cares for the patient and their family while also ensuring a sustainable provision of care.

**Welcome to a new view of the health system. Enjoy the new experience.**

John Macaskill-Smith

**CEO, Midlands Health Network**

# Moving to Integrated Family Health Centres

## What are Integrated Family Health Centres?

An integrated family health centre (IFHC) is about a new way of working to create a new patient centred model of care and the facilities required to support the developments.

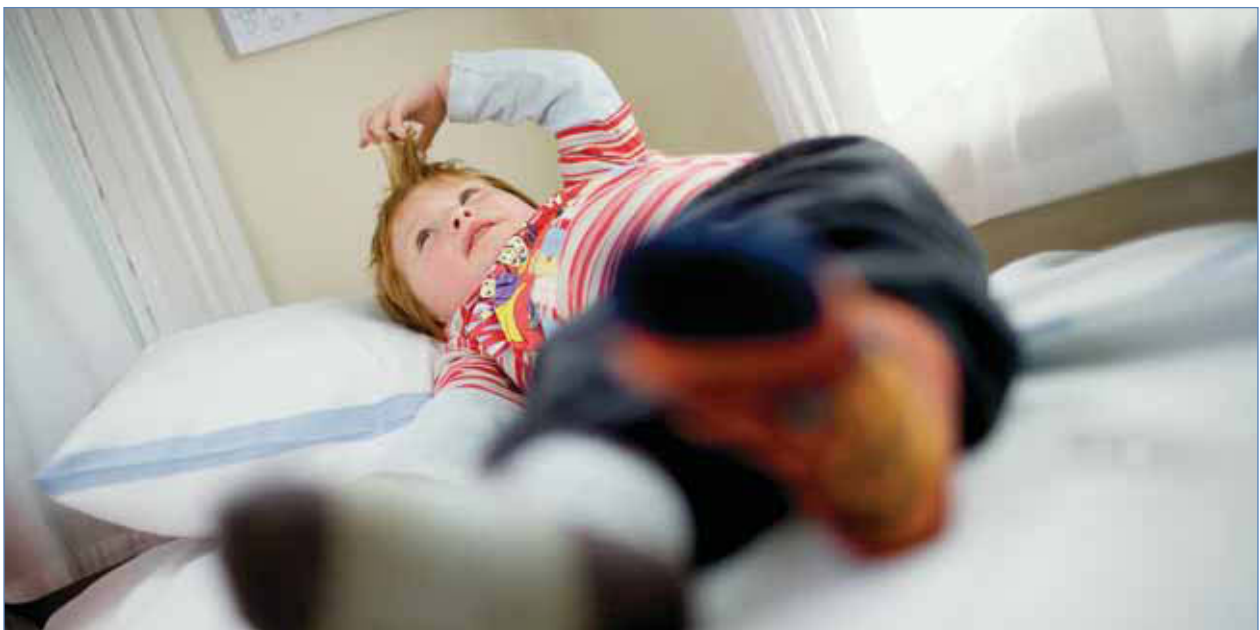
The model of care for an integrated family health centre is about creating a better patient experience and proactively putting the patient and their needs at the centre of the service. It is about maintaining a common focus on the duty of care to simplify and enhance the experience of the patient and their journey through the health system.

The current model of primary care is becoming unsustainable due to increasing demand on health resources and the health burden of the ageing population and health workforce.

The integrated family health centre model of care will see the level of proactive care management increase, which in the short term will increase workloads. However it will also redistribute workloads to ensure better and more sustainable use of resources. In the medium to long term we will be able to better manage demand and create a sustainable model of care by reducing incidents where at risk patients develop long term chronic illnesses. The health centre will manage their daily schedules and use virtual medicine as an agreed alternative to face-to-face consultations, thereby freeing up time for more focused management of the increasing number of patients with chronic illnesses, and reducing demand across the whole health system.

The coordination of health providers across the patient's pathway of care by the general practice team will reduce duplication of services and allow for funding to be targeted to services that will have the greatest impact on patient outcomes. Coordination and co-location of community based services from different sectors will make sure there is a whole health system response to patient care and utilisation of resources.

Supporting the integrated family health centre model of care is the development of IT platforms that allow health providers and patients access to patient information. The general practice team is responsible for a patient's health care throughout the lifespan and being fully aware of a patient's acute or planned episodes outside of general practice is essential for seamless care.



## Moving to Integrated Family Health Centres *continued*



The integrated family health centre model of care ensures members of the general practice team have the time and resources to concentrate on providing health care to their patients rather than some of the more administrative aspects of their current work. More time is made possible by the addition of the Clinical Pharmacist and Medical Centre Assistant roles, who will initially form the extended general practice team.

The general practice team will be supported by a patient access centre with new telephone technology and will link with the health centre for contacts and managing referrals. The general practice team will have the ability to email their patients securely through an online patient portal. The health centre will have standardised systems and processes supporting clinical practice and a working environment which enhances efficient and effective work practices based on Lean principles. Visual management of key performance

areas and targets will become part of the general practice team's daily activities providing instant feedback to staff and opportunities for celebration. Staff at the health centres will have increased job satisfaction and the culture created will retain and attract new staff into primary care.

A patient accessing care from an integrated family health centre will have the ability to self manage and monitor their care through the online patient portal as one of the many new ways to communicate with the general practice team. The practices will be better prepared when a patient visits the health centre by ensuring pre-visit tests and diagnostics are completed. Patients will understand their care plan and who is involved from their post consultation summary document.

A patient will only need to visit the health centre if they and their general practice team believe that the visit is necessary, however, the model of care doesn't discourage a patient choosing to visit the health centre for any reason. In essence, the patient will feel more involved in and responsible for their health and wellness because they have a trusting relationship with their general practitioner and more knowledge and understanding of their care plan.

For patients and populations who are not regular users of practice services, or struggle due to a range of reasons to manage complex health issues, the Integrated Family Health Centres will ensure they are not lost. Additional resources in the form of mobile and virtual services will be targeted towards meeting their unmet needs.

"Integrated family health centres are general practice teams with the patient at the centre, providing quality health care when, where and how patients need it."

## Why the Change was Needed

**Internationally, and here in New Zealand, there are mounting pressures facing the health sector. High among these is the growing, ageing and diversifying population, which brings with it a greater demand for services and more complex health needs.**

Demand for primary health services is set to grow. We know this and it is already happening. Integrated family health centres are how the Midland region will make sure that our population and communities continue to get the care they deserve, without placing more of a burden on the people and services providing the care. They will make primary health care and general practices feasible and sustainable now, and for the future.

Other challenges are:

- rising number of chronic conditions (such as diabetes, asthma and heart conditions)
- ongoing health inequalities between different areas and population groups
- workforce shortages
- rapid advancements in technologies
- a huge growth in health care spending at a time when there is less funding to go around
- managing acute demand at emergency departments and secondary inpatient and community services.

Taken together, it becomes obvious that something has to be done.

On the ground, these pressures mean that many people are not getting the health care they need. It can be difficult for people to see their doctor when they need to, and when they do get an appointment, visits can be rushed and inconclusive. People may be receiving primary care from many different places and this care is not always coordinated. Similar issues exist in the continuity of care between secondary and primary care services. For health professionals, there is often not enough time to give patients their optimum attention. Waiting rooms become full, days long and the practice hurried. Burn-out is common and staff retention rates low. In some rural areas, it can be difficult to attract staff at all.



The New Zealand Government has recognised that this situation cannot continue. It is seeking more timely and quality health care for everyone in New Zealand, in a sustainable way in both primary and secondary sectors, and it recognises this is going to require changes in how things are done. One of four trends in health service redesign focused on by the government for development, was a move to integrated family health centres.

The Midlands Health Network model of care for integrated family health centres is a primary care driven response, designed and led by frontline clinicians, to the government's call for change. It creates a new way of providing primary health care that addresses many of the issues our health system faces. At its core is better management of demand of scarce resources and a focus on ensuring those with the greatest health needs have those needs met.

*“The Midlands Health Network model of care for integrated family health centres is a primary care driven response, designed and led by frontline clinicians, to the government's call for change.”*

# Moving to Integrated Family Health Centres *continued*

## How We Did It

We planned, we consulted, we designed and developed a model of care.

In 2010, Midlands Health Network presented a business case to the Ministry of Health. The business case identified a number of strategies to provide better, sooner, more convenient health care, including a strategy to develop integrated family health centres.

The business case was accepted and a project established to explore what it would mean to be an integrated family health centre.

We knew that being an integrated family health centre would involve bringing together a greater range of services and professionals to provide more seamless, coordinated care. However, an interesting factor that emerged early on was that it was less about making changes to a facility (and the groups of health care providers within it), and more about focusing on the patient's journey within the whole health system.

This was a crucial shift. It involved reconfiguring how we provide services, so it was easier and more convenient for patients to access the care they needed in the way they wanted. From this, the doctors, practice nurses, mobile and district nurses, pharmacists, emergency staff, and other allied staff, designed and developed a model of care that not only addresses the key issues facing the health sector and achieving sustainable health care, but also places the patient at the centre of how that care is delivered.

After reviewing models from around the globe and within New Zealand, Midlands Health Network hosted a group of staff and clinicians to visit Group Health in Seattle, a company that has adopted a health care model placing the patient firmly at the centre. We were inspired by what we saw there, and in late 2010 to early 2011, we ran a series of workshops to develop our own model of care.

The workshops were facilitated by Gemba, an organisation involved with developing the Group Health medical home model. This meant we could incorporate those elements of Group Health's model we valued, tailor other elements to suit our community's particular needs, but use a proven process to design a New Zealand based model.





The workshops were long, with many difficult concepts to tackle and much vigorous debate. By the end of each one we had clear maps of where we are now in terms of care provision and where we wanted to be by 2015. We also had documented steps for how we were going to get there and project streams to make sure every aspect of the model's development was covered. We had our model of care and a process to implement it.

Design and development was followed by the implementation phase, and ran through until April 2011. Eight project streams took the various aspects of the project forward:

- systems and processes
- people and roles
- clinical practice
- facility requirements
- human resources and change management
- business modelling
- IT and information systems
- communication and project management.



Throughout both phases of the project, the core clinical components of the model had been documented and refined by practicing clinicians. These documents have evolved to become the standards of practice for an integrated family health centre, setting out at a day-to-day and individual consultation level what is involved.

Three proof of concept sites were chosen for the initial launch, and implementation involved putting the processes, systems, facilities and staff in place, so that from April 2011 they could start to operate as integrated family health centres. Clearly, as we progress, the model will continue to evolve. In particular, we want to further integrate other community and allied services with the health centres, to make the patient experience even better.

Other practices in Midlands Health Network have already expressed an interest in shifting to the integrated family health centre model, and there has also been considerable interest from outside the region. Our vision is that over time other practices in the Midland region (including those where services are not co-located) will adopt the philosophical and management practices that underpin the integrated family health centre model of care.

The outcomes will not be the same in every practice or town. This has never been the intention. Health care provision must always be tailored to the needs of the communities and individuals that practices serve. But it will mean a greater level of consistency between centres, and clear expectations from patients, so that the patient journey through the health system is understandable, accessible and guided by their general practice team.

**“Integrated family health centres are about focusing on the patient’s journey within the whole health system.”**

# Moving to Integrated Family Health Centres *continued*

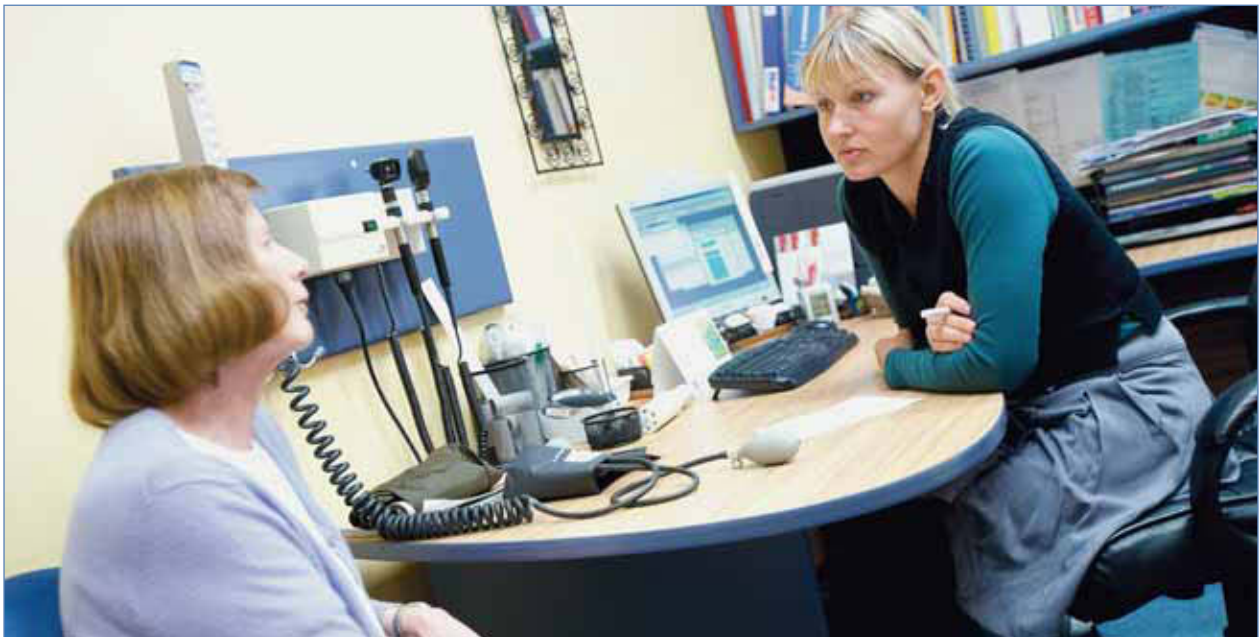
## Who We Worked With

Midlands Health Network has supported the process of developing and implementing the integrated family health centre model of care, but the journey was a wholly collaborative one. Many individuals and organisations gave their time and expertise to conceive and fine tune the model. Over one hundred clinicians and other health professionals attended the development workshops. As such, the model represents the best of thinking from the Midland region (and beyond) on how to best provide primary health care.

In particular, we acknowledge the input and ongoing support of:

- General practitioners, nurses, managers and administration staff from across the Network
- Midland Pharmacy Group
- Midlands Health Network staff
- Midland District Health Boards and in particular Waikato District Health Board senior executives and project leaders
- Emergency services and allied health representatives.

“The Midlands Health Network model of care represents some of the best of thinking from the Midland region (and beyond) on how to best provide primary care.”



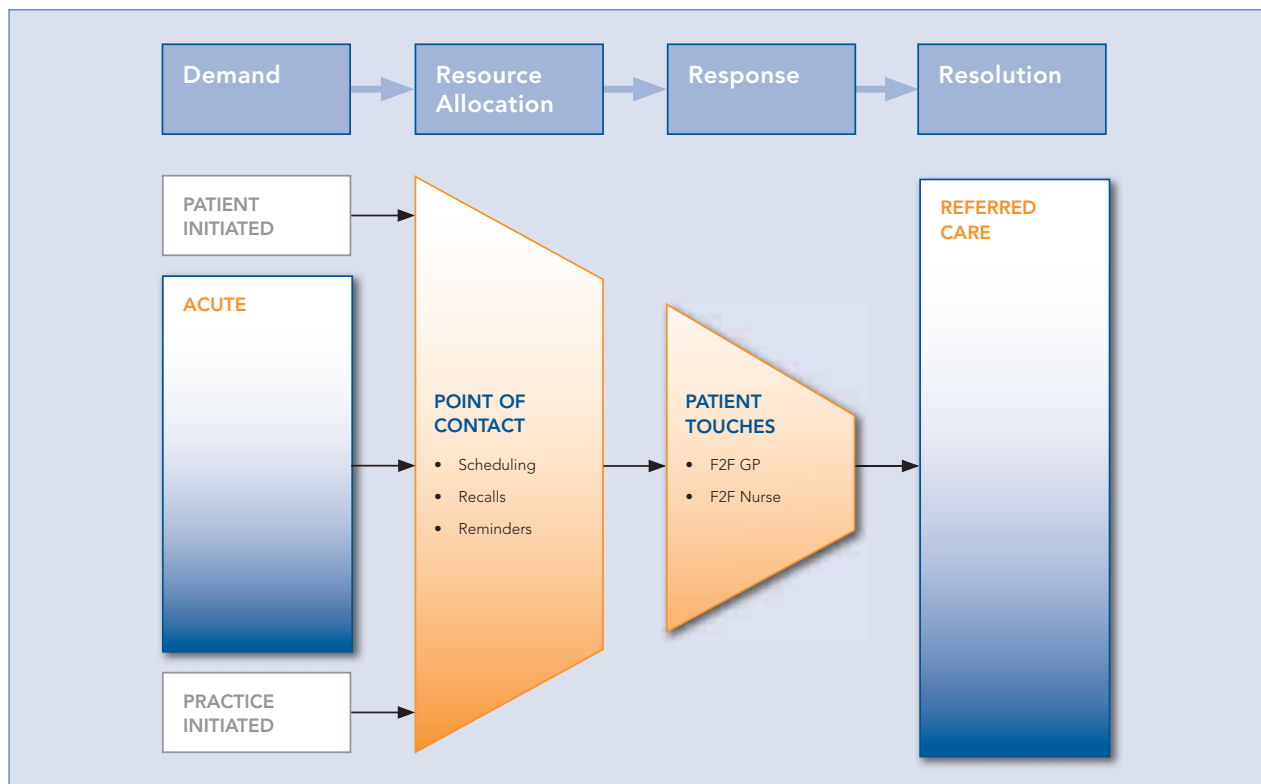
# Old to New: Mapping a New Model of Care

To get where we wanted to go, we needed to first understand where we are. To this end we used a value-stream mapping process to develop a current view of the existing model of care.

The current state model represents primary care in the Midland region at October 2010. It demonstrates that:

- most contacts with the health sector are acute and unplanned
- the point of contact does not usually include any form of triage or proactive management
- the major forms of contact with primary health are through face-to-face (F2F) contacts with GPs or nurses
- follow-up care of the patient is usually referred out of the health centre to other providers, in an unsupported and uncoordinated manner.

## The Current State Model of Care at October 2010



## Old to New: Mapping a New Model of Care *continued*

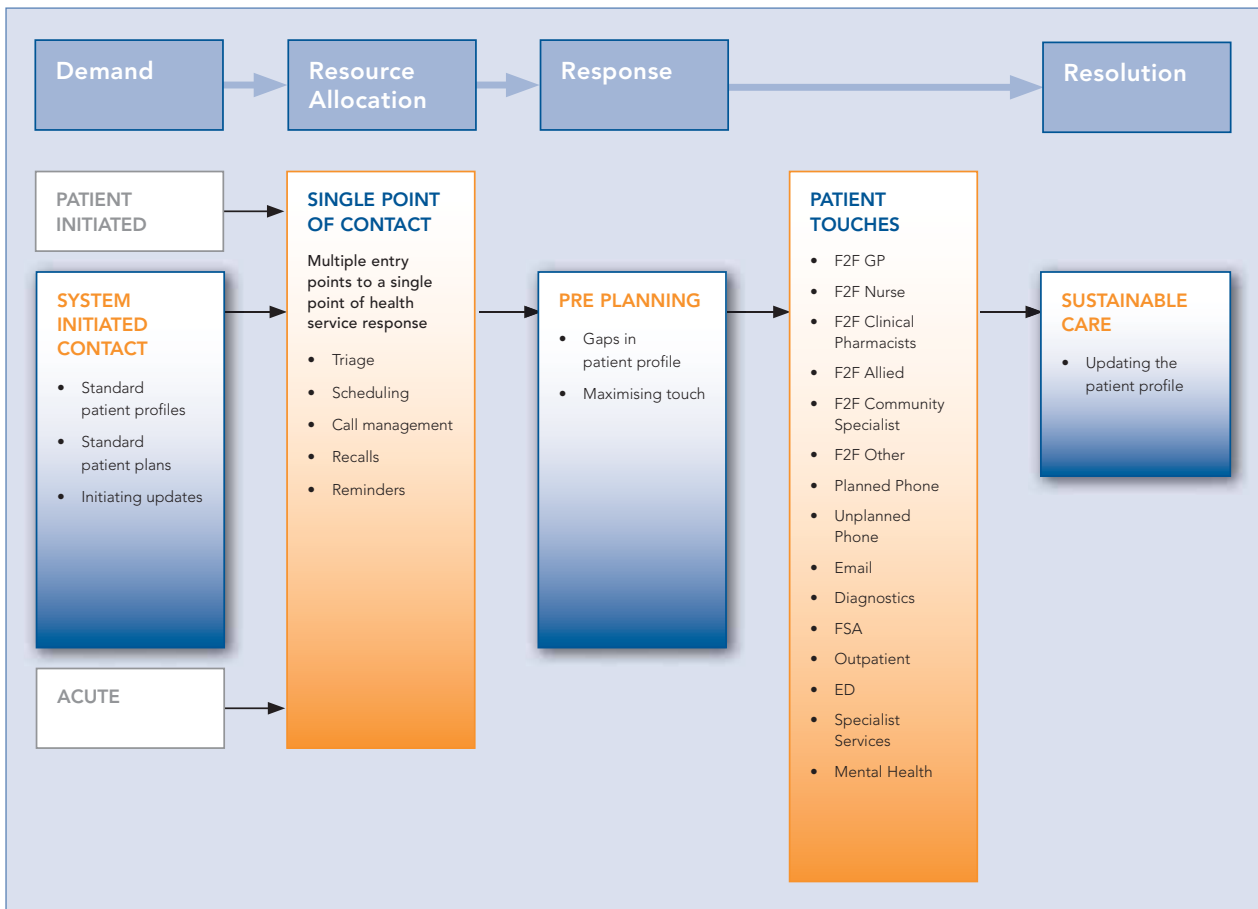
To develop the new integrated family health centre model of care, we identified those areas that were fundamental to making a difference for patients. Three distinct areas emerged: the patient access centre, system-initiated contacts and the consultation. These areas received further thought and design in separate workshops to clarify what was needed to do to take us from our current state to our desired future state.

The new (or future) model of care uses:

- a patient access centre to manage patient enquiries and coordinate patient care (the single point of contact)
- a system for proactive patient management (system-initiated contacts)
- pre-visit and pre-consultation processes to better prepare the patient (pre-planning)
- managed patient follow-up to continually support the patient (sustainable care)
- technology to enhance the patient consultation by introducing standardised virtual medicine and an online patient portal: [www.itsmyhealth.co.nz](http://www.itsmyhealth.co.nz)
- using patient information to turn even acute presentations into planned events.



## The Future State Model of Care



- Demand is shifted to standardised pre-planning of services, resulting in better care
- Resource allocation involves allocating the best resources available to meet the patient need
- All contacts are prepared for and attempt to make the best use of patient time
- Direct access to more services is available
- Demand on secondary services is better managed.

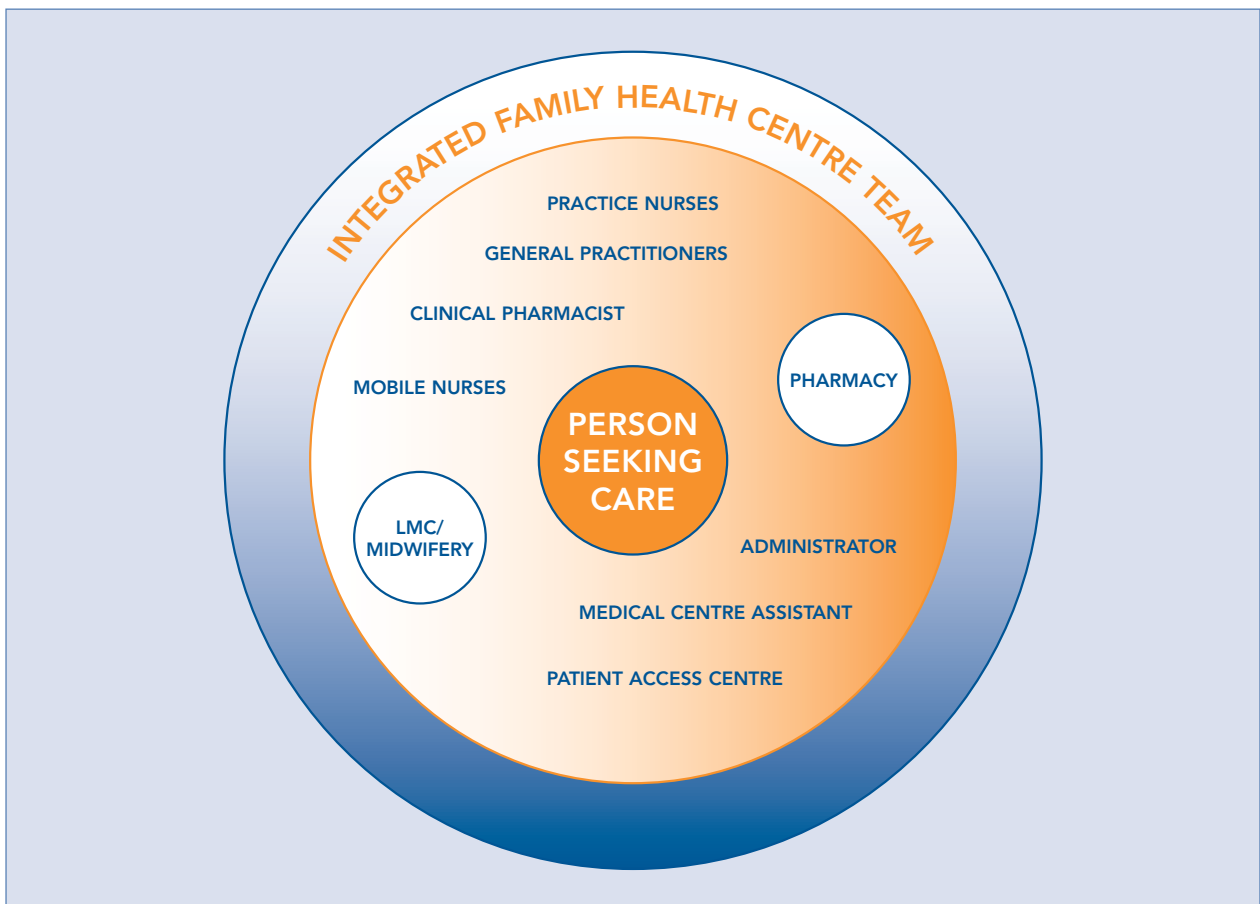
# The Midlands Health Network Model of Care

The integrated family health centre model of care is a new way of doing things. It describes the minimum standards general practices must attain and maintain if they are to be an integrated family health centre.

Becoming an integrated family health centre involves more than a change of name. It represents a fundamental shift in how we think about primary health care and how we deliver it. In particular, it involves putting the patient (not the services) at the centre of the health care journey, so that the journey is as easy, coordinated, tailored and effective as possible.

## Putting the Patient at the Centre

Putting the patient at the centre means simplifying and enhancing the patient's journey through the health system. It means seeing things from the patient's perspective, and ensuring that not only is it easy for them to contact us (in the way they prefer), but when they do contact us they get the answers and the care they need. To do this we need to proactively place our patients in the centre of our services. We need to ask ourselves what they need from us and how they want it delivered.



One fundamental way that we can do this is through making better use of technology. Many people today are technologically savvy. They can, and expect to be able to, organise many of their day-to-day needs online. Banking, shopping, education and travel can all be accessed over the internet. But health has not kept up with this trend.

The integrated family health centre model of care addresses this by introducing an online patient portal where patients can access and update their health information and care plans. It makes use of virtual medicine, giving patients more flexible options for contacting their general practice team and receiving health care.

Another example where the patient will take centre stage is with respect to fragmented service delivery (about to become a thing of the past). Under the new model of care patients can be confident that a unified team approach is being taken to their health. Their general practice team is their one point of contact and will help them navigate their lifelong journey through the health system. Patients will feel supported and confident that when they contact their health centre they will get the services they need.

## Aiming for the Best Possible Outcomes

Integrated family health centres need to perform better than the current model of primary care delivery and the aim is to support them to achieve superior health outcomes.

The Midlands Health Network 10 clinical indicators represent an agreement with the government to sharpen performance in key areas in return for greater flexibility around funding. They are designed to drive clinical outcomes and performance and will form the foundation measures for monitoring and evaluation.

## Clinical Performance Indicators (2011 – 2012)

WORKSTREAM/ CATEGORY	#	OUTPUT/INDICATOR
Immunisations	1	% of 2 year olds who are fully immunised
	2	Flu vaccination coverage
Diabetes	3	% of the expected prevalence that have had a diabetes annual review (DAR)
	4	% of people who have had a DAR with HbA1c < B
Cardiovascular Disease	5	% of patients eligible for a cardiovascular risk assessment who have had a CVRA completed within the last 5 years
	6	% of patients with a CVRZ > 15% and are on a statin (cholesterol lowering drug)
Smoking Cessation	7	% of patients with smoking status recorded
	8	% of current smokers offered brief advice to stop smoking
	9	% of current smokers who have been offered smoking cessation support services in the last 12 months
Cervical Cancer	10	% of eligible population who have had a cervical smear in the last 3 years

# The Midlands Health Network Model of Care *continued*

The Midlands Health Network model of care for integrated family health centres is underpinned by a set of principle and baselines. These are what we draw on as we implement and refine the model. It is also supported by five key strategies, which together set out the main steps we will take to make the model a reality.

## Principles

These principles underpin what it means to be an integrated family health centre.

1. **Care based on rewarding patient-centred relationships** – the patient is placed at the centre of all that we do.
2. **Customisation based on patient needs and values** – every patient should have access to all relevant health services whenever they are required and in an appropriate form, regardless of culture, health beliefs or background. The health system will encourage high-needs populations to actively participate in their health care.
3. **Transparency** – patients should be given all the information and choice they need to develop shared care plans with health professionals. This should include information describing performance on safety and patient satisfaction.
4. **Shared knowledge and the free flow of information** – patients should have ready access to their own medical information and clinical knowledge.
5. **Evidenced-based decision-making** – patients should receive care based on the best available scientific evidence. Health professionals will be supported to continuously enhance their skills and knowledge.
6. **Safety underpins everything we do** – safe systems and practices underlie the entire patient journey.
7. **Anticipation of needs** – the health system should be proactive in anticipating patients' needs in advance.
8. **Continuous decrease in waste** – the health system should not waste resources or patient time. It will have a clear focus on standardisation to assist this.
9. **Collaboration and communication** – patients and health professionals will work together in partnership enhancing the patient journey and ensuring the best possible health outcomes.
10. **Plan, do, check, act** – we will continuously monitor, evaluate and improve the quality of our service delivery.
11. **Core relationship** – promotes and sustains the ongoing relationship between the GP and their patient.
12. **Resource allocation** – the system of care will have resources available to deliver the services required by any given population. These resources will be determined by the needs of our patients and their communities.
13. **Sustainability is the key** – the integrated family health centre design ensures that it can operate as a sustainable and viable business model for continuity of patient care.





# Key Strategies

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## Five key strategies will make the model of care a reality.

1. Expanding the current general practice team.
2. Improving access to services through a patient access centre.
3. Developing system-initiated contacts to provide proactive health care.
4. Increasing the number and nature of virtual consultations.
5. Implementing strategies to streamline the patient experience.

Each strategy is backed up by documented systems and processes (for how to do it), and visible targets and measures (so we can see how well we are doing).

## Strategy 1: Expanding the Current General Practice Team

Expanding the current general practice team to:

- increase capacity to address the increase in demand for services
- increase chronic care management available through active management of care plans.

The core general practice team will be expanded to include other health professionals.

The patient access centre, community workers, Maori and Pacific health providers, and mental health services, are just a few of the providers who will be working closely with the general practice team to provide better and more integrated care.

In larger practices, these services may all be located at the integrated family health centre. In smaller practices and rural areas, services may be linked to it through the centre's patient management system, shared patient care plans, the online patient portal or other virtual medium. In either scenario, the patient's care will be coordinated by the extended general practice team.

Two new key roles will be added to the core general practice team to help coordinate the patient journey and provide the best health outcomes for the patient. A Clinical Pharmacist will have scheduled appointments with patients, managing and monitoring their medications, and providing specialist input into their care plans. They will also support the general practice team, liaise with local and hospital pharmacies to make sure that medication-related information is transferred seamlessly.

The Medical Centre Assistant will perform various administrative and clinical tasks in the health centre. They will:

- make patients comfortable when they arrive
- make sure that any pre-work that has been ordered has been completed
- take baseline clinical recordings (such as blood pressure and weight)
- ensure that clinical team members have everything they need for the patient's consultation
- schedule work flows and coordinate visits so that everyone gets the maximum benefit from a visit to the centre.

District nurses will also be working closer with their general practice teams to provide mobile nursing services for patients with long-term and chronic conditions in the community.

**The result? A more seamless experience for the patient, with the general practice team always heading up and coordinating their care, leading to less cross-over and confusion of care.**

## Key Strategies *continued*

### Strategy 2: Improving Access to Services Through a Patient Access Centre

Improving access to services through a patient access centre by providing:

- a level of first-line triage to ensure patients who need a face-to-face consultation are scheduled for one
- first call resolution for phone calls made to the health centre
- following up on patients who do not attend, and escalating a response to issues and concerns.



A patient access centre will provide a single point of access for patients contacting their general practice team. The centre will establish what the call is about and either direct the patient to the most appropriate staff member to deal with it, or book the patient in for a face-to-face or virtual medicine or consultation.

The patient access centre will take the frantic activity out of integrated family health centre reception areas and clinical staff members' days. Overall responsibility for a patient's care still rests with the general practice team, but only those calls requiring a team member's immediate input will be put through. Other calls will be scheduled in for a virtual consultation or visit, with more routine calls (for example, about appointments, billing and business queries) dealt with by the access centre on the spot.

**The result? More ways for patients to get in contact with their general practice team (email, phone, text, secure online messaging, letter) and quicker resolution of their queries when they do. And for staff, more time to get on with the job of providing quality care, including longer, less hurried face-to-face consultations.**

**The patient access centre model has been developed using the expertise of our partner, St John. Access will be totally secure, with patients retaining control of how they choose to contact and consult with their general practice team.**

## Strategy 3: Developing System-Initiated Contacts to Provide Proactive Health Care

Developing system-initiated contacts to provide proactive health care to:

- move away from reactive health care and make sure as many of the consultations as possible are planned
- initiate and follow up on screening opportunities for immunisations, smears, cardiovascular risk assessments, diabetes annual reviews, and other age, gender and ethnicity-related screening opportunities.

System-initiated contacts are one way that integrated family health centres will provide better, more patient-centred and proactive care. They are standardised approaches to make sure patients are contacted about their ongoing health needs in a timely and efficient manner.

Many health centres are already doing this work and doing it well. A standardised approach will help centres make smarter use of their resources (including time) and provide more sustainable care.

Standard information will be held (and regularly updated) in centres' patient management systems. From this, scheduled periodic contacts will be made with patients. These contacts will be initiated by the general practice team in response to various condition (immunisation, diabetes, cardiovascular risk, etc) and age-related criteria. In the future, they will also be scheduled based on patients' care plans.

**The result? Patients' health needs will be seen to in a timely manner and in the way they prefer. Health care will be more sustainable, targeted and based on the specific needs of each integrated family health centre's enrolled population. And in the longer-term, improved health outcomes for the community as a whole.**



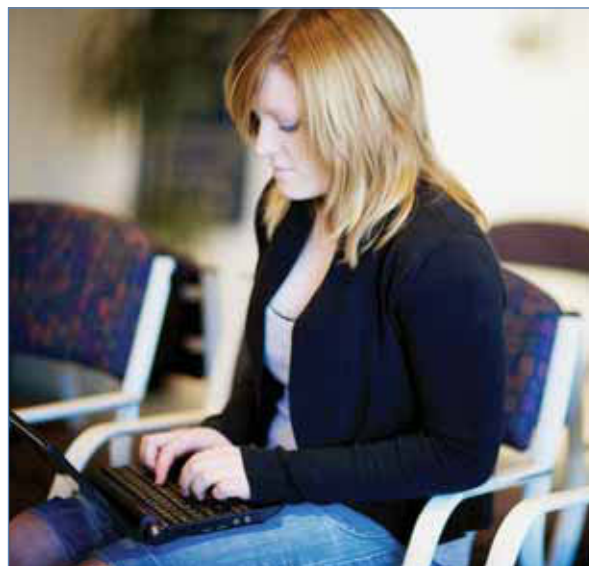
### Strategy 4: Increasing the Number and Nature of Virtual Consultations

Increasing the number and nature of virtual consultations by:

- making use of the current scarce resources in the primary care sector
- ensuring health centres can cope with the increasing need for consultations through clinically robust virtual consultations (phone) and virtual contacts (email and text)
- meeting patient needs for streamlined health services that minimise the need for irregular waiting times, and time off work or away from the family.

Virtual medicine involves replacing some face-to-face GP visits with virtual ones (phone or email) based on patient need and preference. It is a clinically sound and safe way of making better use of patients' and GPs time, while still providing the best possible care.

When patients contact their integrated family health centre (through the patient access centre) they will receive on-the-spot triage based on their stated needs. From this it will be assessed whether a face-to-face visit with a GP is necessary (for example for those patients requiring a physical examination), or whether a virtual consultation would be better. The option will then be given to the patient – the choice is theirs. Virtual visits and contacts will be given an allocated time on general practice team members' schedules, with scheduled visits checked beforehand by a clinical team member to ensure they are appropriate.



The online patient portal backs up virtual medicine by giving patients 24-hour online access to their health information and care plans through a secure log on. Patients can access the portal through their health centre's website or the Midlands Health Network website, using their own computer or, if they don't have one, kiosks are provided in all integrated family health centre reception areas and over time available through mobile phones.

The online patient portal gives patients direct involvement in their care. They can update their information, view a version of their records, and contact their general practice team through the secure messaging service. The portal answers patients' need for the type of online wrap-around services that has now become common in other sectors, and will increase patient buy-in and compliance with their care plans.

Other health professionals only have access to the patient's information through the online patient portal as determined by the patient and members of their general practice team. It cannot be shared through the portal with anyone else unless the patient logs on. The information in the portal is as secure as online banking.

**The result? Less wasted trips for patients to health centres, more time available for those patients who do need a face-to-face visit (longer standard consultation times), and less pressure, stress and burnout for health centre staff. Care will be available when and how patients need it, with more consultations possible in every working day, without the need to increase general practice team members' workloads.**

## Strategy 5: Implementing Strategies to Streamline the Patient Experience

Implementing strategies to streamline the patient experience by:

- providing processes to complete pre-visit diagnostics prior to face-to-face or virtual medicine consultations
- ensuring the patient feels supported throughout the patient pathway, and that their care is coordinated through a single care plan that is accessible through the online patient portal.

Streamlining the patient experience creates extra capacity for, and maximises the potential of, face-to-face consultations. It recognises the value of those consultations and makes sure that each one is as tailored and effective as it can be.

Having determined that a face-to-face visit is needed, pre-visit and pre-consultation preparation work will ensure that everything that can be done beforehand (for example, laboratory tests and results, visits to allied health professionals, updated health information and observations) is done, and that when the patient enters the clinical consultation room all the necessary information is at hand.

Pre-visit work is organised when the appointment is made, and pre-consultation work is carried out when the patient arrives at the practice. The patient access centre and the medical centre assistant have crucial roles to play with respect to both, although the process is controlled by a clinical team member. The first step is fishing: an ongoing process, whereby a nurse reviews general practice team members' schedules for the coming days, identifying those consultations that could be potentially be dealt with through virtual medicine, and specifying what work needs to happen beforehand.

Another key change is huddles. Huddles are a related activity that support pre-work. All integrated family health centres will use formalised regular team and practice huddles to plan their days, and manage the unforeseen events, and occasional crisis situations, that form part of a general practice teams' day.

By getting together (daily and weekly, same time, same place) to share information, discuss situations and allocate tasks, everyone's day runs smoother and the pressure can be taken out of many situations. For patients, integrated family health centres will become calmer, more organised places, where changes to schedules can be accommodated, and patients feel confident that their presence is welcomed and their health needs will be met.

**The result? There will be less repeat, inconclusive and unnecessary visits. As far as possible, all of a patient's health needs will be addressed at the one visit, saving both the patient's and the general practice team's time. Visits will be structured and organised, with less surprises. General practice team members have everything they need to provide quality care, without having to waste valuable consultation time seeking out or clarifying information.**



# The Proof of Concept Sites

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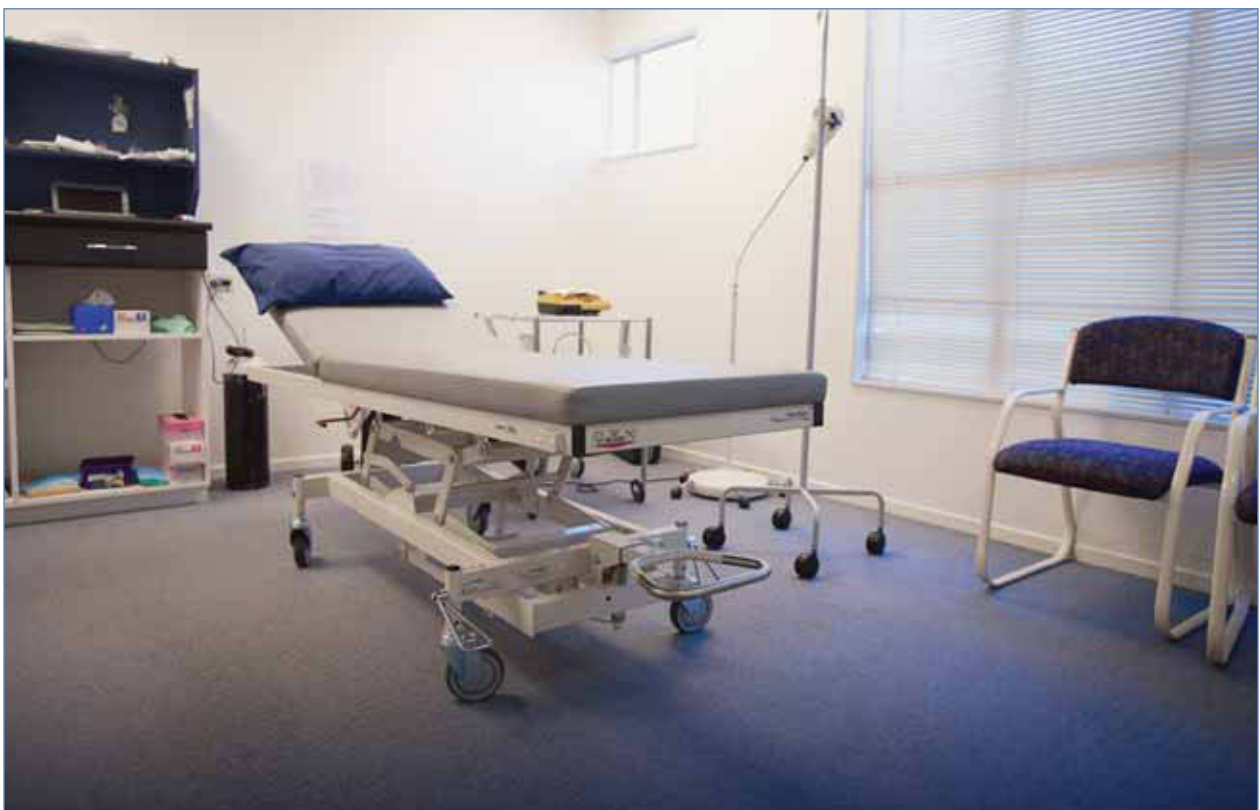
The journey to become an integrated family health centre has already been taken by a number of Midlands Health Network general practices.

These are the practices that, with us, helped to build and make a reality the vision of how primary health care could and should be. Together, we examined where we wanted to be, crafted the model of care, and worked out the steps we would need to take to achieve our goals. Then we implemented it.

Some elements of the model were the same at each site. Huddles, standard ways of working, pre-visit and pre-consultation processes all had to be introduced and mastered. The online patient portal, patient access centre, and patient management systems are uniform for all the sites, as is the commitment to working with other professionals and the community to provide seamless integrated care.

Remaining true to the model of care, and the minimum standards it (and its associated processes) contains, is a vital part of what it means to be a Midlands Health Network integrated family health centre.

Other aspects of implementation varied from site to site. Existing facilities and staff roles had to be reconsidered and, where necessary, restructured to accommodate the new ways of doing things.



# The Business Model

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**Core to the Midlands Health Network business case was making better use of the resources we have.**

Integrated family health centres are about best utilising existing funding streams.

It's about better use of capitated funding across all primary care funding streams, doing things collectively, sharing resources across many sites and reducing individual centre costs.

The funding used for the proof of concept sites is funding that can be freed up and applied to other sites as part of the agreement with the government.

Sharper performance, integrated teams and changed patient outcomes and experiences are the key enablers. As part of the multi-dimensional review process, understanding the economic model is a key outcome.

## Proposed Benefits to Patients

The model of care will increase the number and nature of virtual consultations. It is anticipated this will see reduced co-payments for patients with a variety of payment options, such as online payments. Faxing and emailing repeat prescription requests to the patient's pharmacy of choice will reduce visits to the practice, and again it is likely that prescription charges to the patients would reduce.



# Looking to the Long-Term

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Midlands Health Network is implementing phase one of the integrated family health centre model of care by April 2011 and will be using the Lean tool of 'plan, do, check, act' to further refine phase one and build phases two and three which will see a fully integrated model of care across health sectors.

## The Long Term

There is a lot of interest in the integrated family health centre model of care from a patient, clinical and business model perspective.

This model of care will be moving through planned phases to become a totally integrated primary health model of care. Opportunities for other practices to visit, work in and discuss key aspects of the model will be made available, as will support and assistance to practices who wish to move to this model of care.

Documentation of our journey to date is being written, guides and education modules have been developed, and a 'how to' package is available. These resources are also supported by a team of people who have developed the skills and knowledge to assist other staff and practices through the change management process.

Sharing of our journey will also occur through a range of publications, electronic releases and media channels.

## Evaluation

Midlands Health Network has developed a comprehensive set of targets and measures that we, and individual integrated family health centres, can use to see how well we are doing. Some measures cover changes in business efficiency and practice, while others focus on changes in workflows, service demand and health outcomes. All are based on national and regional targets.

In the future, implementation of the integrated family health centres will be independently evaluated. Evaluation objectives are likely to include:

- to understand the patient's experience of and satisfaction with belonging to an integrated family health centre
- to understand the impact of working within an integrated family health centre model for GPs, practice nurses and practice management staff, in terms of professional and personal career progression and satisfaction
- to determine if application of the integrated family health centre model has changed the pattern of acute demand for secondary care services from the centre's enrolled population
- to determine whether application of the integrated family health centre model has changed the pattern of service use in primary care and the pattern of referrals to secondary care services
- to determine the commercial viability and sustainability of the integrated family health centre model, as implemented by the Midlands Health Network, to manage future health service demand in primary and secondary care.



# For More Information

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## Integrated Family Health Centre Project Participants

### MIDLANDS HEALTH NETWORK PROJECT TEAM

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### CLINICAL REVIEW TEAM AND PROJECT MEMBERS

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#### With support from:

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Gemba	Workshop Facilitation and Lean Training
Simpl	Information System Support and Advice
Bettle Advertising	Marketing
Everest Group Ltd	HR and Change Management

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## For More Information *continued*

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The design and development of the model of care could not have happened without the additional support of clinicians and staff at the proposed sites, and other workshop participants, who, with their enthusiasm, knowledge and willingness to be brave, have assisted in making the integrated family health centre model of care come to life on 4 April 2011.

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