Annual Report 2018

Cosine
Primary Care Network

Report for the period 1 July 2017– 30 June 2018

Vision

Our vision is to be recognised by the Ministry of Health, the local District Health Boards and the relevant communities as one of New Zealand's most innovative and effective primary care networks in terms of delivering better, sooner, more convenient Primary Health Care to its enrolled population.

Mission Statement

Cosine Primary Care Network's (Cosine) mission is to be an independent, high performing and innovative organisation providing high quality primary health care services to our enrolled population.

Population

Cosine serves an enrolled population of 33,884 patients. Of these 6% (1909) are Maori, 3% (936) are Pacific and 14% (4677) Asian.

13% (4522) are identified as High Needs.[1]

[1] High Need Groups are defined as groups of persons who are Maori, Pacific and/or person residing in New Zealand Deprivation Index deciles 9 &10 areas. (Capital & Coast DHB/ KPHO Contract Version 18.0)

EXECUTIVE SUMMARY

Cosine Primary Care Network (Cosine) has maintained the high performance achieved in the preceding years through the continued efforts of both Karori Medical Centre and Ropata Medical Centre.

A key focus for both the Cosine practices during 2017-18 has been the delivery of services under the Health Care Home model of care. Karori Medical Centre entered in to the programme on 1 July 2016. Ropata Medical centre were accepted in to the programme in November 2017 and signed a contract with Hutt Valley DHB with a start date of 1 July 2018.

High performance against the national health targets continues to be a contractual requirement

Cosine has maintained a high profile through extensive participation and representation at various forums within the health arena at local, regional and national levels. *(See appendix 1)*

Two major successes for Cosine during 2018-18 were success in meeting the Health Care Home targets and the highest rate of enrolments in the patient portal nationally.

Governance

Cosine delivers services under the PHO Services Agreement.

Cosine is a not-for-profit charitable trust governed by a Board of Trustees. The Trust Board consists of eight Trustees appointed to represent the community, providers and local iwi.

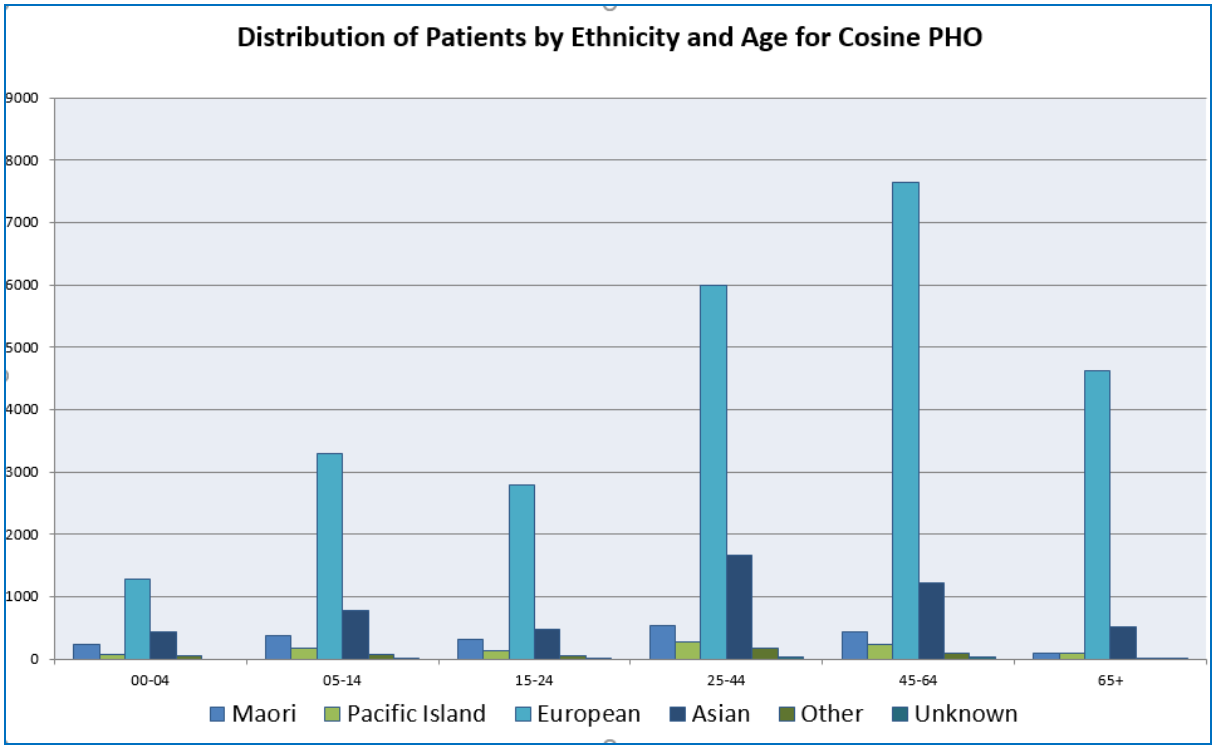
The Trustees are

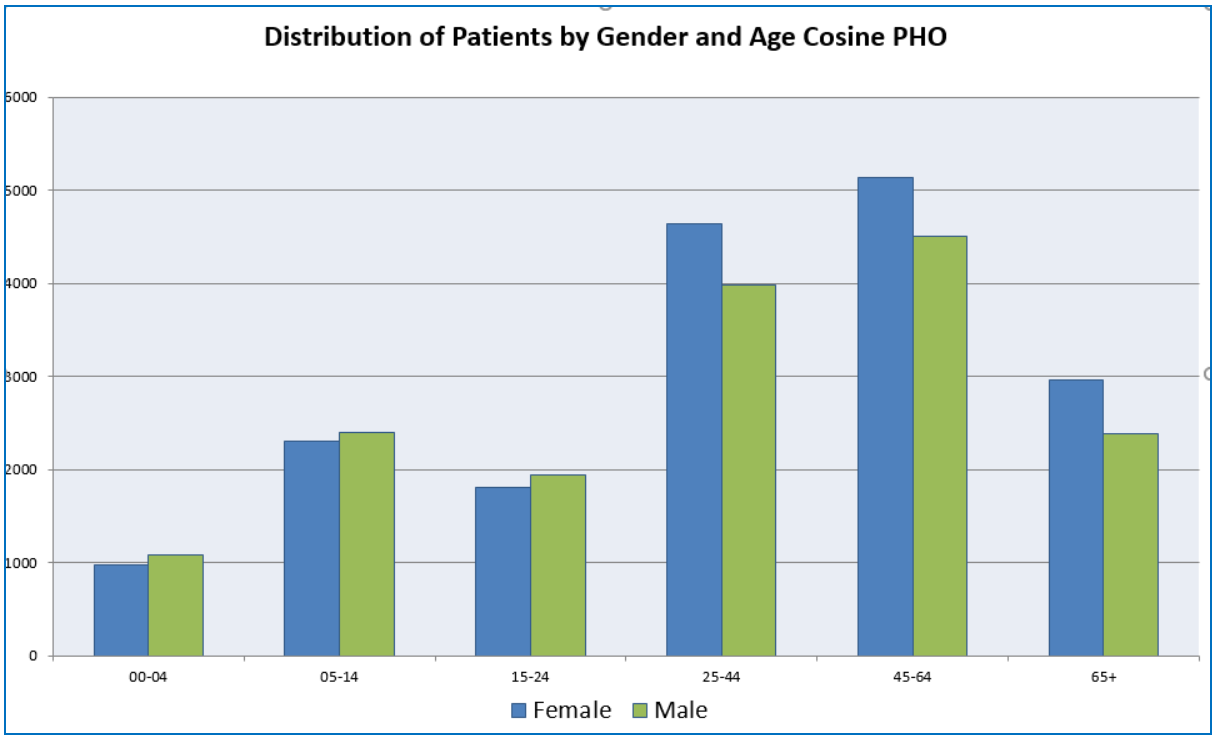
- An independent Chair - Murray Gough
- Two community/consumer representatives - Nolaine Coombes (Ropata Medical Centre), one position vacant
- An Iwi representative – position vacant
- Four provider representatives - Drs Chris Masters and Paul Rowan (Ropata Medical Centre) and Drs Jeff Lowe and Peter Moodie (Karori Medical Centre).

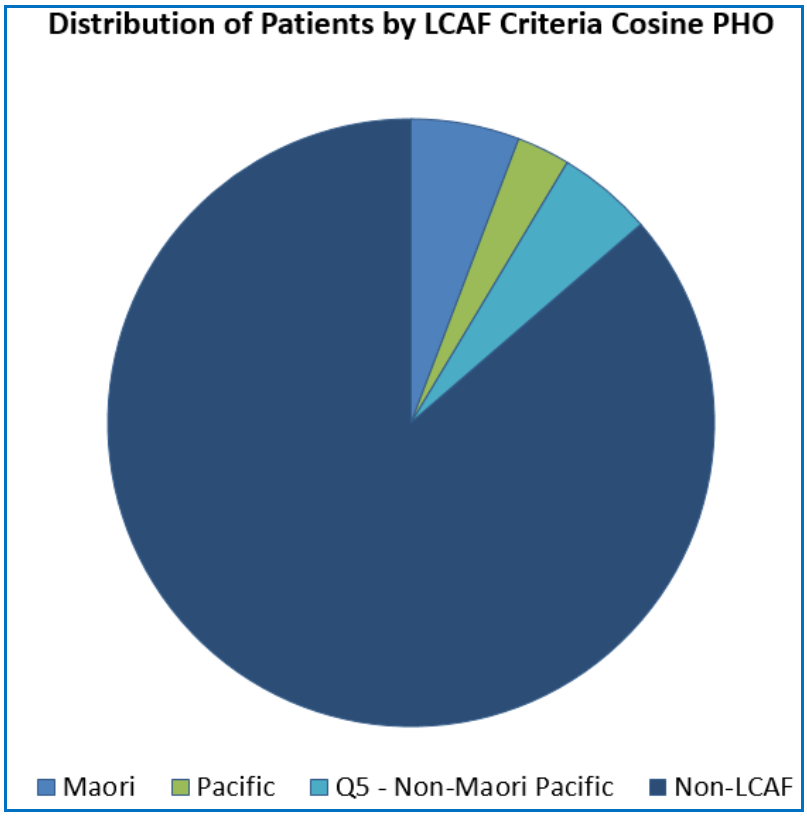
Cosine Primary Care Network

The practices provide primary health care services to people in the suburbs of Karori and Lower Hutt, and across the wider Wellington region. Capital and Coast District Health Board is the lead DHB for the for the PHO. Ropata Medical Centre also works in conjunction with the Hutt Valley DHB.

Cosine works closely with others in the provision of healthcare and has a strong working relationship with both of the local DHBs and the other local PHOs; Ora Toa and Tu Ora Compass Health. Increasing collaboration with allied health workers is also proving to be highly beneficial in the delivery of effective patient care.




Distribution of Patients by Gender and Age Cosine PHO
6000
5000
4000
3000
2000
1000
0
00-04
05-14
15-24
25-44
45-64
65+
Female
Male


Distribution of Patients by LCAF Criteria Cosine PHO
Maori
Pacific
Q5 - Non-Maori Pacific
Non-LCAF

Background

Cosine is contracted to CCDHB to provide services under the PHO Services Agreement. Cosine is bound by the following Strategies and plans when considering service delivery.

- New Zealand Health Strategy
- PHO Services Head Agreement
- CCDHB Annual Plan
- System Level Measures and health targets
- Health Care Home model of care requirements and targets.

The New Zealand Health Strategy Future Direction 2016 [2] is "the document that shares the common view of where we want to go in New Zealand health. The five themes- people powered, closer to home, value and high performance, one team and smart system- are cornerstones in establishing a health sector that understands people's needs and provides services that are integrated across sectors, investment early in life, maintaining wellness, preventing illness, and providing support for the final stages of life". The Minister of Health described the need to work on achieving equitable health outcomes for those groups who have poorer health and social outcomes than the population on average. In his Letter of Expectations to the DHBs and subsidiary entities December 2016, the Minister of Health stated that the DHBs plans for 2017-18 must demonstrate clear linkages to the five themes of the Health Strategy, "while maintaining a focus on Maori health outcomes and health equity".

Capital and Coast DHB

CCDHB's Annual Plan 2017-18 plan stated "For the 2017/18 year, as well as delivering against the national Health and Better Public Service targets, CCDHB will especially focus on performance in emergency department wait times, access to elective procedures, raising healthy kids, immunisation, and mental health transition plans for children and youth".[3]

[2] https://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-futuredirection-2016-apr16.pdf

[3] https://www.ccdhb.org.nz/news-publications/publications-and-consultation-documents/ccdhb-annual-plan-may-2018.pdf

Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector	Closer to home	**1. Health Care Home (HCH):** Progress roll-out of HCH model of care across primary care, targeting practices with high volumes of Māori and Pacific patients. Continue to integrate the District Nurses and Community Allied Health Teams. (EOA)	Q1-Q4; Launch two HCHs per quarter. Q4; Ensure ≥40% of enrolled Māori and Pacific populations are enrolled in the HCH model of care	PP22: Delivery of actions to improve system integration including SLMs
			2. Community Health Network: Establish a Community Health Network in Porirua, where 41% of the population is Māori or Pacific, using a locality approach to strengthen the HCH model. (EOA)	Q1-Q4; Implement processes to establish Community Health Network.	
			3. Health Pathway and Health Navigator: Increase the number and use of Health Pathway and Health Navigator tools to support clinicians and the community with best practice guidance/support.	Q4; >75 new Health Pathways localised and average number of users per month >1,000	
			4. ICT: Increase the utilisation of ICT enablers including the patient portal, shared electronic health record access, concerto access and shared care plan. (Refer to IT Planning Priority).	Q4; >20,000 people activated on the patient portal	
			5 Primary care packages: Increase the uptake and flexibility of existing primary care packages of care to deliver care closer to the patient.	Q4; >500 packages of care delivered in primary care	
	Refer to jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan attached as an Appendix.	Value and high performance	**1. Ambulatory sensitive hospitalisations:** Achieve within DHB equity for all population groups over 5 years (by 2021/22), and in 2017/18 achieve a 9% reduction in ASH rate for Pacific and maintain equity for Māori. (EOA)	Q1-Q4; Monitor and report against progress made each quarter to MOH	PP22: Delivery of actions to improve system integration including SLMs
			2. Patient Experience of Care: Ensure that 75% of primary care practices are participating in the patient experience survey and, in future years, achieve improvements in PES scores.	Q1-Q4; Monitor and report against progress made each quarter to MOH	

22

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
			3. Acute bed days: Achieve a 4% improvement in age-standardised acute bed day rates for Māori and Pacific, and over 5 years (by 2021/22) achieve equity for Māori and half the equity gap for Pacific.	Q1-Q4; Monitor and report against progress made each quarter to MOH	
			4. Amenable Mortality: Reduce amenable mortality rates for Māori and Pacific, and over 15 years (by 2026), half the equity gap.	Q1-Q4; Monitor and report against progress made each quarter to MOH	
			5. Proportion of babies who live in a smoke-free household at six weeks post natal: Achieve 50% of whānau who are asked about the smoking status of adults in the home and have this recorded at the 6 week WCTO check.	Q1-Q4; Monitor and report against progress made each quarter to MOH	
			6. Youth access to and utilisation of youth-appropriate health services: Achieve ≤15% of 10-24 year olds presenting to CCDHB hospitals whose answer to the alcohol screening question is Unknown.	Q1-Q4; Monitor and report against progress made each quarter to MOH	

CCDHB committed to work in partnership to jointly develop and agree the 2017/18 Improvement Plan with the Integrated Care Collaborative Alliance Leadership Team (ALT).

System Level measures [4] are high level aspirational goals for the health system that align with the five strategic themes of the Health Strategy and other national strategic priorities such as Better Public Service Targets. There is a focus on children, youth and vulnerable populations. System Level Measures are part of the DHB annual planning process and are developed in collaboration with

[4] https://www.health.govt.nz/system/files/documents/pages/system-level-measures-newsletter-apr18.pdf

primary, secondary and community care providers to improve health outcomes of the local population.

System Level Measures and Health Targets

The System level measures for 2017-18

- A reduction in Ambulatory Sensitive Hospitalisations 0-4yo
- An increase in the number of practices participating in the Patient Experience of Care (PES)
- A reduction in acute bed days
- A reduction in Amenable Mortality
- An increase in the number of babies living in smoke free homes
- Better access and utilisation of youth appropriate services

The SLM measures are carried through in to the four domains of the Health Care Home model of care; Urgent and Unplanned care, Proactive Care for those with more complex needs, Routine and preventative Care, and Business Efficiency.

Health Care Home

The CCDHB HCH initiative is a team-based health care delivery model, led by primary health clinicians, providing comprehensive and continuous health and social care with the goal of supporting individuals to obtain the best possible health outcomes. To deliver on this in CCDHB the HCH practices are required to deliver the following service elements: GP triage and on the day telephone consults; on the day appointment for triaged patients; call management arrangements; extended hours availability; patient portal uptake and increased use; delivery of packages of care (POAC); Person Centric Appointments; Year of Care planning for at risk; clinical and administrative pre-work; enhanced layout of facilities; workforce development; lean process and community Service Integration. CCDHB is working to achieve more than 40% coverage of its population by the end of 2017/18.

The Year 2 targets under the Health Care Home Contract are copied below.

Measure at Practice Level	Target for 30 June 2018
Acute Admissions per 1000 Patients (age standardised)	4.2% annual decrease from practice baseline at 1 July 2017
ED Attendances per 1000 Patients (age standardised)	4.2% annual decrease from practice baseline at 1 July 2017
Ambulatory Sensitive Hospitalisations per 1000 Patients (age standardised)	4.2% annual decrease from practice baseline at 1 July 2017
Time to third next available appointment	≤ 2 days by end of the year
Patient Portal – Minimum requirement & Inbound activity	Minimum requirement of all patient portal functionalities & 10% annual increase from practice baseline at 1 July 2017
NB: Targets will be established for all five measures, however evaluation of performance will be based on practices attaining three of the five targets.	

The practices have achieved the targets required.

Cosine is responsive to the direction outlined by the Ministry of Health, CCDHB, HVDHB, ICC, HUTT Inc. and programmes developed by these agencies to provider better health care for our enrolled patients.

Progress against the Business Plan to June 2018

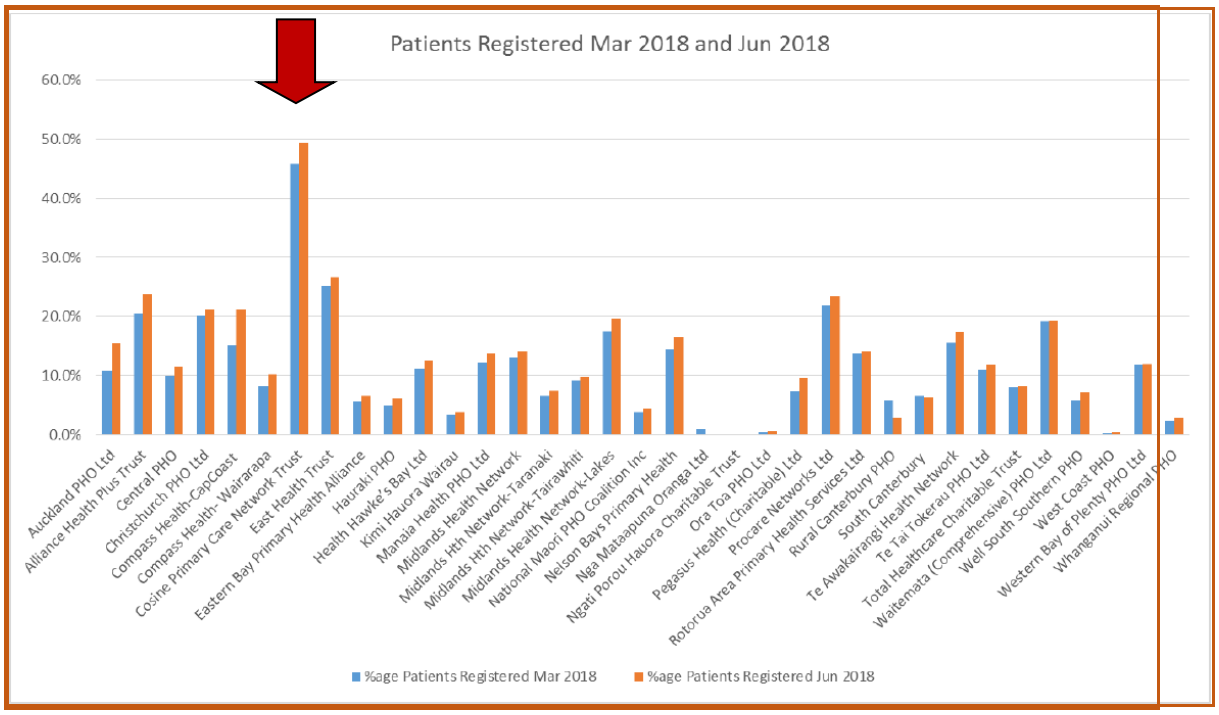
The following seven objectives were the focus areas for the Business Plan 2017-18

1. The provider practices of Cosine PCN will maintain their status as high achieving, innovative practices. This will be demonstrated by on-going success in relevant clinical performance measures.

   The practices continue to do well overall. The target for brief advice was achieved and part funding received for the immunisation and cardiovascular risk screening targets.

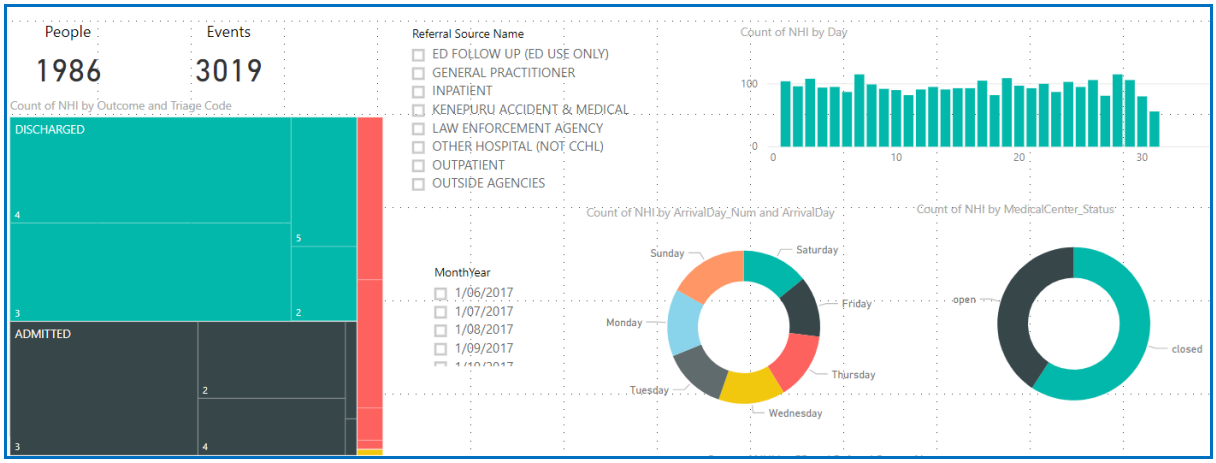
2. The provider practices of the PCN are held up as exemplars of Primary Health Care.

   Cosine's patient enrolment rate in the patient portal is the best nationally- see graph below). Both practices are engaged in providing services under the Health Care Home model of care. Karori Medical Centre has achieved HCH Certification. This means that in addition to the credentialing criteria the practice has introduced population stratification and proactive care planning, and that the practice has demonstrated progress against their development plan in all four HCH domains.



3. Sharing of innovative ideas occurs across the Primary Care Network and the health sector.

   At a local level the practices openly share systems and process that aid workflow. During the past year the Health Care Home processes in particular. have been discussed between the practices. Karori Medical Centre has developed data tools to look at capacity management at the practice and ED attendances in line with the HCH requirements.



PJS

	Mon	Tue	Wed	Thu	Fri	Sat	Total
Morning	10	16	16	8	8		
Afternoon	0						
Evening	0						
Duty	2				2		
Extras							
Total	12	16	16	8	10	0	62

RH

	Mon	Tue	Wed	Thu	Fri	Sat	Total
Morning		9	13	15	13		
Afternoon	13						
Evening	2						
Duty							
Extras							
Total	15	9	13	15	13	0	65

MTK

	Mon	Tue	Wed	Thu	Fri	Sat	Total

Totals for the week

	Mon	Tue	Wed	Thu	Fri	Sat	Total
Morning	59	88	96	92	91	0	
Afternoon	80	50	71	48	38	0	
Evening	6	7	13	8	0	0	
Duty	4	3	0	0	7	0	
Extras	0	0	0	0	0	0	
Total	149	148	180	148	136	0	761

Ideal totals for the week

	Mon	Tue	Wed	Thu	Fri	Sat	Total
Day	172	150	182	141	153		798

Difference = #of appointments to be added or blanked out

	Mon	Tue	Wed	Thu	Fri	Sat	Total
Day	23	2	2	-7	17	0	37

4. To work within sustainable funding

5. To achieve the system level measures in order to receive 100% of the available funding

   Achieved for 2017/18

6. To attract funding for innovative pilot projects

   No progress on this aim.

7. To increasingly look across both primary and secondary care when considering the delivery of services, with the aim of relieving the increasing demand on hospital services.

8. Engaging with DHBs in the delivery of new programmes

   The practices have worked in collaboration with their local DHBS in implementing the HCH model. The clinical leads continue in their established roles within Hutt INC and the ICC and there is increasing participation from other representatives from both practices. (see appendix 1)

ACHIEVEMENTS IN 2017-18

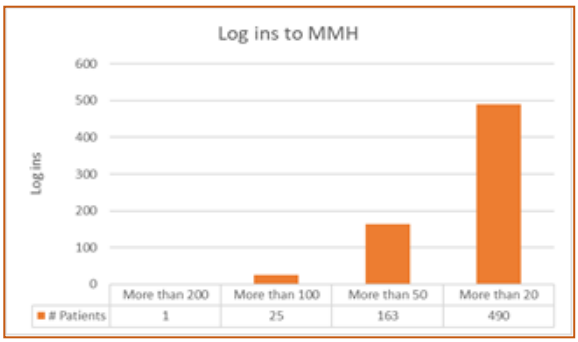
The story of the Patient Portal at Karori Medical Centre.

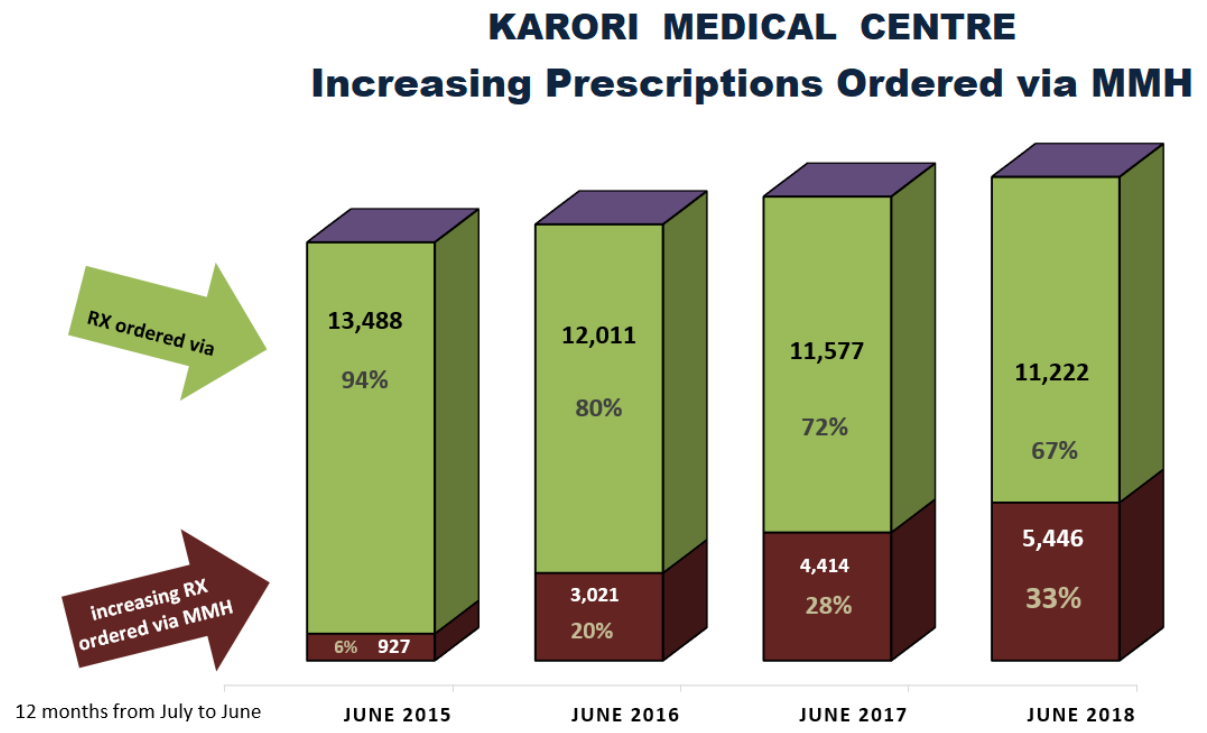
The first patient, now an 89-year-old man, has been a patient at Karori Medical centre since the practice was established, and was a patient of Dr Peter Moodie prior to that. He enrolled on the 30th of April 2009 and remains an active user of the portal.

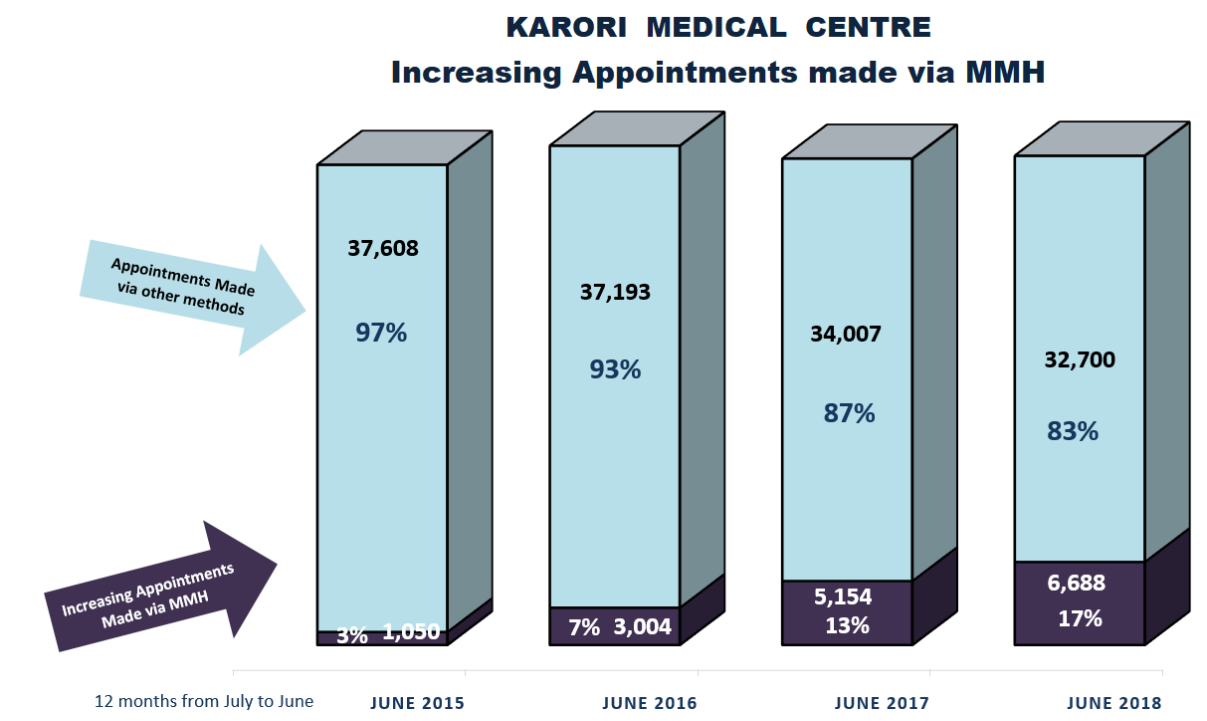
Enrolments increased very slowly and by May 2014 there were 400 people registered. The portal functionality had improved significantly by then, including a mobile app for cell phones, and a project was begun to actively increase enrolments. Led by Dr Peter Moodie, an 'all practice' approach resulted in a rapid increase to 4,215 by July 2015. At that level of enrolment, the changes in workflow and processes became increasingly apparent. For example, in May 2014 eight appointments were made and 12 prescriptions ordered online. A year later 237 appointments were made and 203 prescriptions ordered online. Secure messaging- emailing the GP- however increased 10 fold over the same period. Patients clearly valued communicating directly with their doctors and nurses. People in the Karori community became aware that the service was available and asked to be enrolled. All of those elements helped to increase the level of use.

Current enrolment levels in the patient portal at KMC are amongst the best nationally. The accumulated data tells the story of the increasing partnership between the patients and their health care providers. As at 30 June 2018,

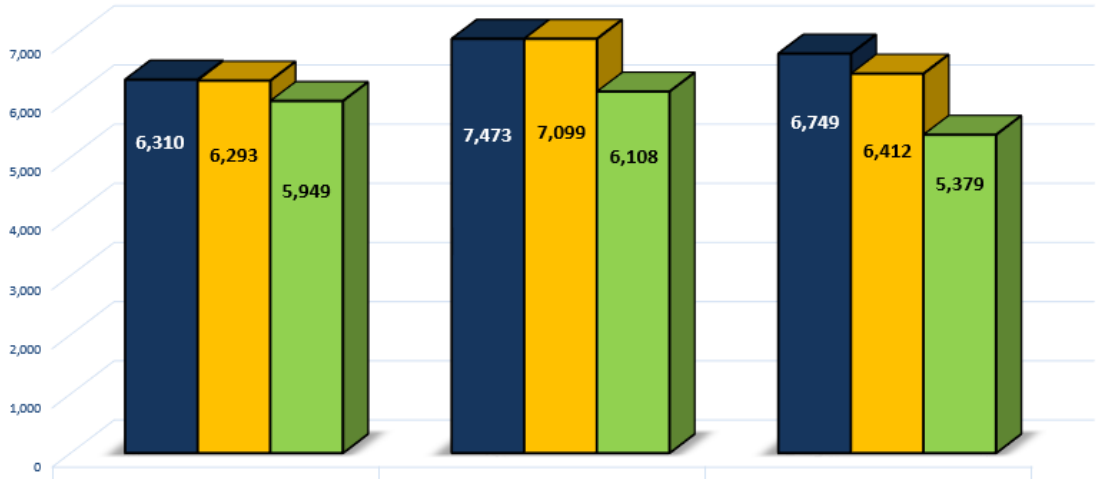
- **91 %** (10,366) of the eligible population aged **over 16 years were registered** to the portal.
- This number is **71%** of the total enrolled population.
- The percentage that are registered but **not activated** (use) the patient portal, has remained steady over time at approximately **15%.**
- Ethnicity is a factor in uptake with lower rates for Maori and Pacific people
- **73,193 patient log ins** for the period- **6,372 individuals**
- Users included **one patient** who logged in **more than 200** times, **25 more than 100** times, 163 more than 50 times, **490 more than 20 times**.
- Increasingly the portal is the **preferred channel**
    - more than **1,200 secure messages** a month in the past year
    - **615 online appointments** a month in the past year
    - **474 repeat prescription** requests a month in the past year




KARORI MEDICAL CENTRE
Increasing Prescriptions Ordered via MMH
RX ordered via
increasing RX ordered via MMH
13,488
94%
6% 927
12,011
80%
3,021
20%
11,577
72%
4,414
28%
11,222
67%
5,446
33%
12 months from July to June
JUNE 2015
JUNE 2016
JUNE 2017
JUNE 2018

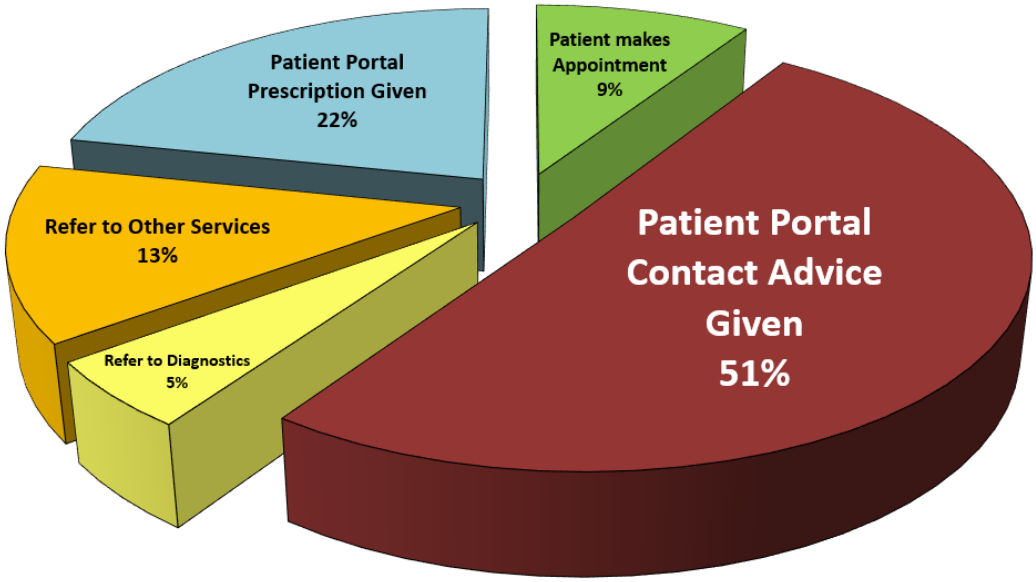

KARORI MEDICAL CENTRE
Increasing Appointments made via MMH
Appointments Made via other methods
Increasing Appointments Made via MMH
37,608
97%
3% 1,050
37,193
93%
7% 3,004
34,007
87%
5,154
13%
32,700
83%
6,688
17%
12 months from July to June
JUNE 2015
JUNE 2016
JUNE 2017
JUNE 2018

Calls Offered



	Jul	Aug	Sep
2016	6,310	7,473	6,749
2017	6,293	7,099	6,412
2018	5,949	6,108	5,379

Patient Portal Doctors Services via Manage My Health



The Physician Associate, a new role at Ropata Medical Centre

RMC commenced a 12-month trial of a Physicians Associate starting in March, 2018. A Physicians Associate (called Physician's Assistant in the USA) have been common place in the USA since 1967 and their health service would struggle to operate without them. Health Work Force New Zealand have done extensive trials and studies in New Zealand which have been very successful but there are still only a few practitioners in the country. A Physicians Associate works under the direct supervision of one or multiple doctors and consults with patients much the same way as a doctor does. It is our intention to conduct our trial with the PA working in the acute and LTC management arenas. The hope is that having a Physicians Associate, combined with Health Care Home, GP triage and new electronic applications, RMC will be better prepared to cope with any future health initiatives as they will be able to utilise the more experienced GP's to work in the most appropriate arena.

Alexandra Kayat, who has a Master's degree in Physician Assistant Studies, is seeing patients in the acute setting five sessions per week.

Ropata Practice Manager, Adrian tucker, describes the path to employing the person in this role.

"While advertising for a registered nurse about 12 months ago I received a CV from a Physician's Assistant and because we did not know what a Physician's Assistant was we dismissed the CV. A few months later I was pondering some staffing issues and remembered the CV, I got in touch with Alex (Physician's Assistant) and asked her to come in for a chat and explain what she did and how she thought she could fit into primary care within New Zealand.

I developed a business case for a 12-month trial which I presented to our partnership team. The idea was that Alex would work in our acute service alongside our doctors, she would conduct her own consultations under the supervision of the doctor and treat patients accordingly. We started off slowly. We had put in place a very detailed orientation which included working with another Physician's Associate (Assistant is an American term not used in NZ) in another part of the country, extensive work with our own pharmacist along with policy and procedure familiarisation, and eventually built Alex up until she was working full time. Alex now consults between 7 -8 sessions per week and has taken the pressure of our acute consultations, she has been accepted and is valued by our patients who often ask if they can register with her. She has formed a great collegial relationship with our team of doctors who respect and appreciate her clinical skills. The only pitfall currently is that Physicians Associates are not allowed to prescribe in New Zealand as they are not part of a regulated body. However, progress is being made on this front and Medical Council are considering their current application for registration. We believe there is a role for Physician's Associates within Primary Care in New Zealand and we would like to see Alex head a team of three at Ropata who would eventually be able to take care of all of our acute demand patients."

New premises for Ropata Medical Centre

Ropata Medical Centre's current building was conceived for its role over 30 years ago by the founding partners and although it was a rocky road to get the premises complete their persistence won out in the end. Originally consultations were only carried out on the ground floor where there were 8 consult rooms but over the years as patient numbers increased and services became more varied we have spread to all corners of the buildings three floors. There have been additions and changes with to the building with a minor surgery unit and meeting room added and a total reconfiguration of the reception area and due to rapid expansion we have also completed the renovation of a neighbouring property to add a further 5 consulting rooms. This building has served Ropata Medical Centre well over the past 30 years but due to the increasing demands on primary care we struggle to maintain to the high standard of service to our patients that we have been proud of for so many years and so the decision to look for alternative accommodation began.

In early 2017 Adrian was tasked with looking at the market to see if there were any suitable buildings available for conversion or sites available for development. After many dead ends the site we eventually chose was discovered and we decided to partner with Medispace who specialise in design and build projects in the health sector.

After close to 18 months of discussion construction is underway of a building that will be as iconic in the local area as the one we currently occupy but due to advancement in technology it will be for other reasons. This will be a truly integrated health centre with Ropata occupying most of the first floor, nearly 50% more space than we currently have. We will share the remaining space with pharmacy, child care, gymnasium, physiotherapy, dentists, hearing specialist, skin specialist, ophthalmology, cafe and there will be opportunity for visiting specialist and consultants to use the space. Long term we hope to see co location of some DHB services which will allow the true development of the Health Care Home model.

This building will be state of the art, it will be adopting the most advanced timber construction methods available and will be completed to IL4 Earthquake standards which will enable us to continue operations even in the event of an 8.5 earthquake. There will be 27 consulting areas, two minor surgery suites and multiple shared and offstage areas for those group discussions all located on one floor that has been designed through consultation with patients and staff to ensure the patient journey and staff experience is the best we can offer.

This building is truly a brave move from the current partnership group who wish to secure the future of Ropata Medical Centre for the next 30 years as their predecessors did before them. We wait in anticipation of the November 2019 completion date and if you would like to see the progress of the construction please follow this link to see a photograph of the progress that is updated every 15 minutes http://www.snowgrass.co.nz/cust/medispace/index.html

Appendix 1: Leadership and Representation

Ropata Medical Centre

Dr Chris Masters

- Chair of Hutt INC
- Clinical Director, Primary and Integrated Care, Hutt Valley DHB
- Clinical Lead, 3 DHB Health Pathways
- Clinical Director, Melon Health Ltd

Dr Paul Rowan

- Member of Hutt INC

Dr Sarah Painter

- Member of Hutt INC, Acute Care Clinical Network

Dr Gillian Yardley

- Member of Hutt INC, Child Health Clinical Network

Karori Medical Centre

Dr Jeff Lowe

- Clinical Champion for the CCDHB ICC Long Term Conditions Group
- Member of the DHBs Leaders Group
- Member of the Patients First steering group
- Chair of GPNZ
- Member of the ICC Alliance Leadership Team

Dr Peter Moodie

- Chair of the ICC Medicines Management Group

Dr Ros Wall

- Chair of the CCDHB Diabetes Clinical Network

Dr Richard Hornabrook

- GP representative Neurology Subcommittee.

Dr Myrto Kenny

- Member of the Community Radiology Advisory Group

Dr Chan Dassanayake

- ACC High Tech Imaging lead

Dr Chris Kalderimis

- Advanced Care Planning National Clinical Advisor

Letter of Notification of HCH Certification

HEALTH CARE HOME
COLLABORATIVE

22nd June 2018

Karori Medical Centre
11 Parkvale Rd
Karori, Wellington 6012

Dear Peter,

Thank you for applying for Health Care Home Certification. The Health Care Home Collaborative (the Collaborative) is pleased to see the progress made by your Practice in implementing the Health Care Home Model of Care.

The Health Care Home Model of Care enables primary care to deliver a better patient and staff experience, improved quality of care and greater efficiency[1]. As indicated in the Health Care Home Model of Care Requirements, there are currently three levels of sign off: Credentialing; Certification and Accreditation[2]. This recognises that Practices are on a continuous improvement journey, hence a developmental approach is being taken.

The Moderation Group met in June 2018 and was made up of Health Care Home Leads from different PHO members, including a GP Clinical Lead. The approach to moderation was taken in two stages.

Firstly, the Moderation Group endorsed the following credentialing aspects already reviewed by your PHO:

1. Practice implementation plan to achieve all Health Care Home Indicators at level 4
2. Providing GP triage and offering alternatives to face to face care (e.g. telephone / video consults)
3. On the day appointment availability for triaged patients
4. Call management arrangements in place including monitoring call metrics
5. Extended hours (in accordance with practice plan)
6. Patient portal in place and activated users increasing according to implementation plan

Secondly, to achieve Certification the Moderation Group assessed the following in relation to your Practice:

1. Practice's Population stratification and proactive care planning; and
2. Progress against the development plan in all 4 Health Care Home Domains.

[1] http://healthcarehome.org.nz/portals/sharedcarerecord/docs/Health-Care-Home-Model-of-Care.pdf
[2] The Collaborative is working alongside the RNZCGPs to develop a HCH Standard

After careful review and consideration, the Collaborative Moderation Group is pleased to inform you that Karori Medical Centre has achieved Health Care Home Certification.

Congratulations! Certification recognises that your Practice has made progress in implementation of the Health Care Home Model of Care. Please find attached a Certificate of Achievement[3].

We hope to see continued progress by your Practice on the Health Care Home Model of Care and look forward to working together towards a sustainable primary care.

Kind regards,

Martin Hefford
Chair
Health Care Home Collaborative

[3] Note that progress will be reviewed in 12 months should you wish to retain Certification status