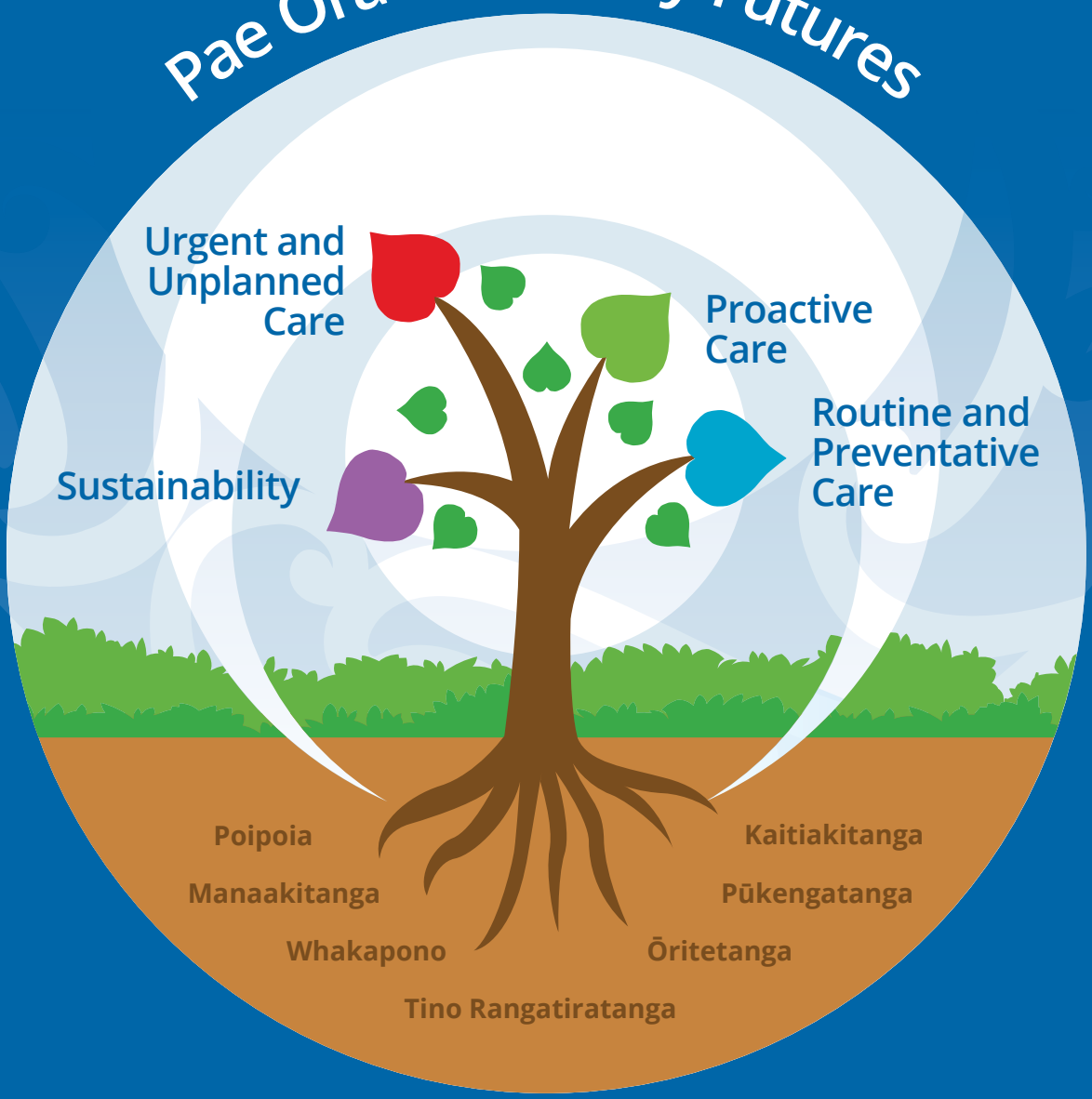
HEALTH CARE HOME COLLABORATIVE

JUNE 2021

Enhancing the Health Care Home Model of Care



He Kōrero Whakatau

Ka takina te kawa, ko te kawa tēnā
i takea mai i a Tāne.

Ko Tāne kukune, ko Tāne nukunuku,
ko Tāne te pupuke, ko Tāne tuturi, ko
Tāne pēpeke, ko Tāne te wehenga i ōna
matua, a ko Ranginui e tu ake nei.

Ka tū ko Tāne te tokotoko i te rangi.
Ka rewa ko Tāne nui a rangi.

Tēnei ko Tāne tikitiki i te rangi ka
whakapiki.

Tēnei ko Tāne te wānanga ka
whakakake

Tēnei ko Tāne Mahuta ka whakatau
i te mata o te whenua o Papatuanuku
e takoto nei!

Kei roto i te waonui o Tāne; he āhuru,
he ngahue, he ranea kia ora te ai te
tangata.

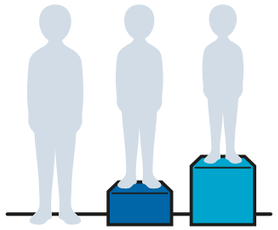
Waiho mā te ringa rehe hei rapu ai ngā
hua mo te iwi e.

Tūturu whakamaua kia tina, tina!

Haumi e, hui e, taiki e!

Contents

Our enhanced Health Care Home Model of Care



We continually review and refine the Health Care Home (HCH) Model of Care (MoC) to ensure that it improves patient/whānau care and health outcomes.

The need for change

Work to develop this version of the MoC requirements takes place as primary care embarks on a 'new normal' — preparing for major health reforms emerging from the Health and Disability System review, and taking on board the learning from our experiences of the COVID-19 pandemic.

Our response to the pandemic has already encouraged bold changes, including embedding access to virtual consultation as the norm. This mahi continues.

As a result of guidance from clinicians and extensive network engagement this updated version of the MoC Requirements has an explicit focus on improving equity and consumer involvement.

As the model grows and matures, we aim to constantly challenge its contribution to improvement in equity of access and outcomes for those communities in need of additional support, particularly Māori. If the HCH MoC delivers for Māori, it will deliver for most of our priority communities and, ultimately, lead to better outcomes for all New Zealanders.

The model needs to embrace Māori models of health, and its domains need to relate to Māori world views and deliver tangible benefits for Māori and other priority populations. For that reason, it is framed in the context of Te Tiriti o Waitangi, of Wai 2575, of Pae Ora and Whānau Ora.

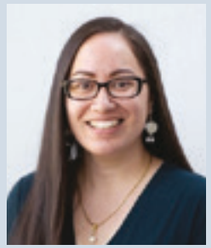
If the model delivers for Māori, it will deliver for most of our priority communities and, ultimately, for all New Zealanders.

For further detail of the revision process and our journey of enhancement please refer to our website www.healthcarehome.org.nz

Hei Whakamarama... Inspiration for design

We acknowledge and value Whaea Merle Samuels leadership in nurturing and shaping the HCH MoC.

As part of the mahi Whaea Merle Samuels provided the whakaaro to our designer and this has led to the new design including the vision and values to be incorporated in the HCH MoC.



Kia ora, my name is Piri-Hira Tukapua.

I whakapapa to Muaupoko, Ngati Raukawa ki te Tonga, Te Ati Awa ki Whakarongotai, Ngati Toa Rangatira, Ngai Tahu, Taranaki, Tuwharetoa and Tainui.

A source of inspiration for me is reflecting on the knowledge and gifts from my ancestors. On the topic of hauora or health, Rongoa or Māori medicine comes to mind first. My grandfather was well known for practising rongoa and passed this on to my father. As a result, we maintain very good health and rarely need a Doctor. We know the native plants in Aotearoa have many healing properties and attributes. I chose to focus on the Kawakawa for this tohu because of its wide-ranging benefits and heart shaped leaf.

There are 4 branches that make up this small Kawakawa tree which depict the 4 domains of the Health Care Home model. The 4 colours represent diversity of people and also link to the 4 domain icon sets. The 7 tree roots represent the 7 core values that are foundational and vital to the success of the Health Care Home model.

The Health Care Home logo glows in the background as an arch of community wide support and to reinforce the Health Care Home brand. The Māori design that descends from above is symbolic of Karakia which is essential in the practice of Rongoa and healing. Karakia connects the spiritual and physical realms together for effectiveness and completes the Kawakawa concept.

Enhancements to improve equity

A core part of this enhancement mahi is the alignment to Pae Ora (Healthy Futures) as a vision and a new set of values grounded in equity.

The HCH MoC aims to support and enhance Māori individual and whānau wellbeing.

Wai 2575 recommendations make it clear that equity for Māori is a key priority for primary health care services and all services should provide Māori options that include active protection of health, Māori aspirations and tikanga. Partnership and tino rangatiratanga for Māori enable the realisation of these aspirations.

A core part of this enhancement mahi is the alignment to Pae Ora (Healthy Futures) as a vision and a new set of values grounded in equity. The HCH MoC incorporates whakawhanaungatanga (creating connection/relationship) in the delivery of care. Relationship centred care creates better health outcomes for our whānau — this can be as simple as ensuring that practice information resonates with people in terms of language and visual presentation or enhancing the cultural skills and competencies of staff, including understanding the unconscious bias inherent in many services.

This HCH MoC has focused on:

- Equity for Māori and other priority populations as well as honouring Te Tiriti o Waitangi
- Meaningful consumer engagement being more explicit with a clear framework for ongoing involvement
- Sustainability domain (*When I visit the practice*) reflects improvements in provider and patient/whānau experience using change management techniques
- Urgent and unplanned care domain (*When I am unwell*) reflects experience of care and improving access for acute care through a variety of modalities, utilising technology, without compromising continuity of care
- Proactive care domain (*To help me stay well*) reflects population health and the care for complex and high priority patients/whānau, with a focus on equity and a culturally appropriate approach while encouraging patient/whānau autonomy
- Routine and preventative care domain (*To keep me healthy*) reflects all aspects of daily care in relation to the practice population and understanding their needs and experience.

NZ Health Care Home Model of Care Requirements

The HCH MoC is a whānau-centric approach which enables primary care to deliver a better patient and staff experience, improved quality of care, and greater sustainability.

The HCH Collaborative established the HCH MoC Requirements, first published in July 2017 to demystify the HCH MoC, and provide clear guidance for those who want to implement it. Consistent implementation of the HCH model in general practices nationally is important so that all patients/whānau enrolled in HCH practices can expect the same standard of care.

The HCH MoC Requirements document sets out the HCH service elements and characteristics of a HCH practice. These are grouped into four core domains:

1. Improved sustainability
2. Ready access to urgent and unplanned care
3. Proactive care for those with more complex needs
4. Better routine and preventative care

Within each domain a maturity matrix is provided with:

- Service elements that describe important HCH MoC Requirements; and
- Characteristics that allow a practice to map their current model of care systems and processes on a development scale.

The HCH maturity matrix for each domain provides a continuum of MoC descriptors, using scoring of 1 (low maturity) to 4 (high maturity) for each indicator, with 4 being the target on the continuum, i.e. what best looks like for a HCH Practice. A maturity matrix approach has been used to recognise that HCH practices are on a continuous improvement journey.

Our vision for the future

Pae ora encourages everyone in the health and disability sector to work collaboratively, to think beyond narrow definitions of health, and to provide high-quality and effective services.

Vision

Pae Ora — Healthy Futures

Pae Ora is a holistic concept and includes three interconnected elements:

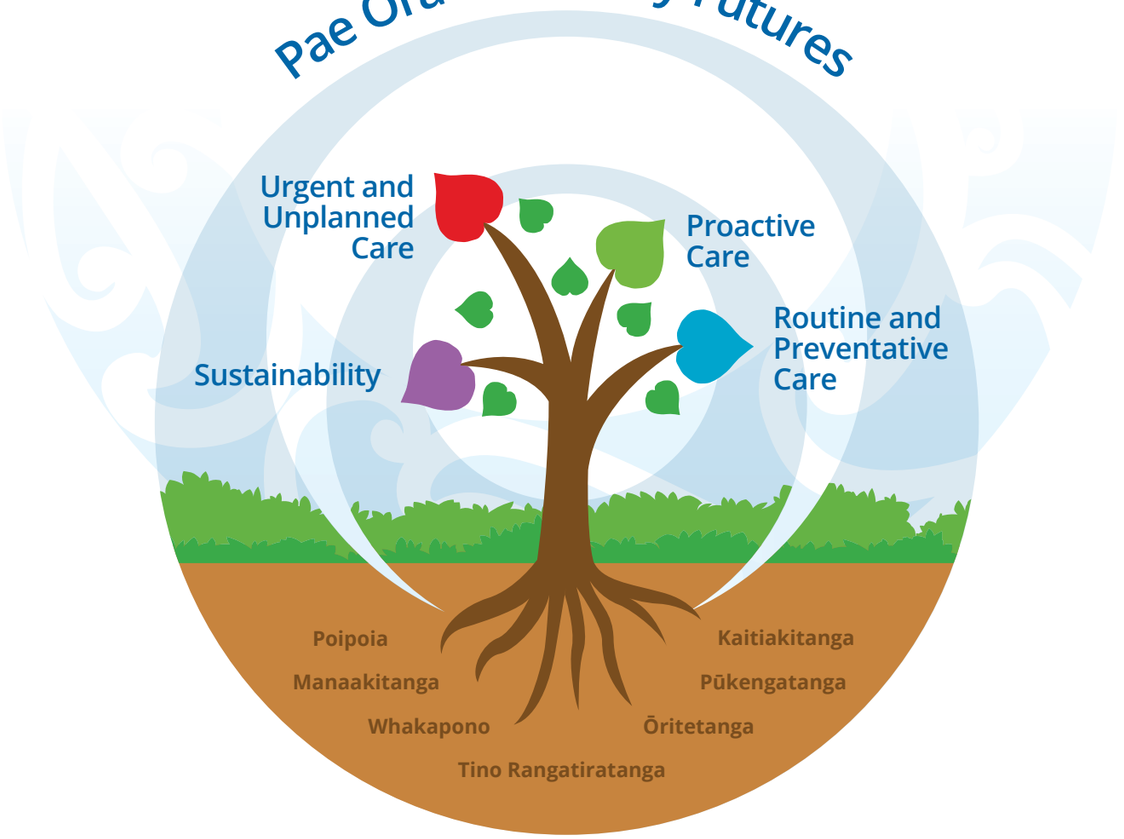
- mauri ora — healthy individuals
- whānau ora — healthy families
- wai ora — healthy environments.

Pae ora encourages everyone in the health and disability sector to work collaboratively, to think beyond narrow definitions of health, and to provide high-quality and effective services. All three elements are interconnected and mutually reinforcing, and further strengthen the strategic direction for Māori health for the future (MoH, 2015).

Whānau Ora

Whānau Ora is a culturally grounded, holistic approach to improving the wellbeing of whānau as a group and addressing individual needs within the context of whānau. Characteristics include:

- building whānau capability to support whānau self-management, independence and autonomy
- putting whānau needs and aspirations at the centre with services that are integrated and accessible
- building trusting relationships between service providers and whānau, and between government agencies and iwi
- developing a culturally competent and technically skilled workforce able to adopt a holistic, whānau centred approach to supporting whānau aspirations
- supporting funding, contracting and policy arrangements, as well as effective leadership from government and iwi, to support whānau aspirations (TPK, 2016).



Values

Poipoia

Having empathy and nurturing the provision of quality care for whānau

Manaakitanga

Acknowledging the mana of each party in order to create an environment of respect for different perspectives and behaviours

Whakapono

Acknowledges the need for trust in doing the right things to ensure high quality systems and quality care

Tino Rangatiratanga

Respecting the self-governance of each party and their control over their own destiny

Ōritetanga

All whānau experience the same excellent health and wellbeing outcomes regardless of situation and challenges

Pūkengatanga

There is an expected level of expertise by those delivering care and an obligation to do the best for patients and whānau

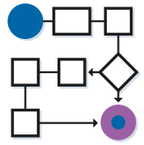
Kaitiakitanga

Acknowledges a duty of care as a custodian that has the best interests of the patient/whānau and staff at heart

1.1 Practice sustainability

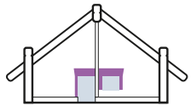
2.1 Continuous quality improvement

3.1 Reception in person and call free

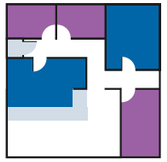


4.1 Workflow

4.2 Standardisation



4.3 Facility infrastructure



5.1 Practice layout

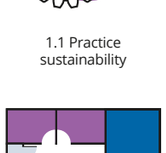
6.1 Staff training

6.2 Workforce planning & development

6.3 Clinical and cultural leadership

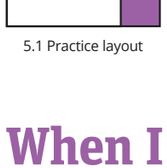
6.4 Extended practice team

When I visit the practice



7.1 Same day access and appointment systems

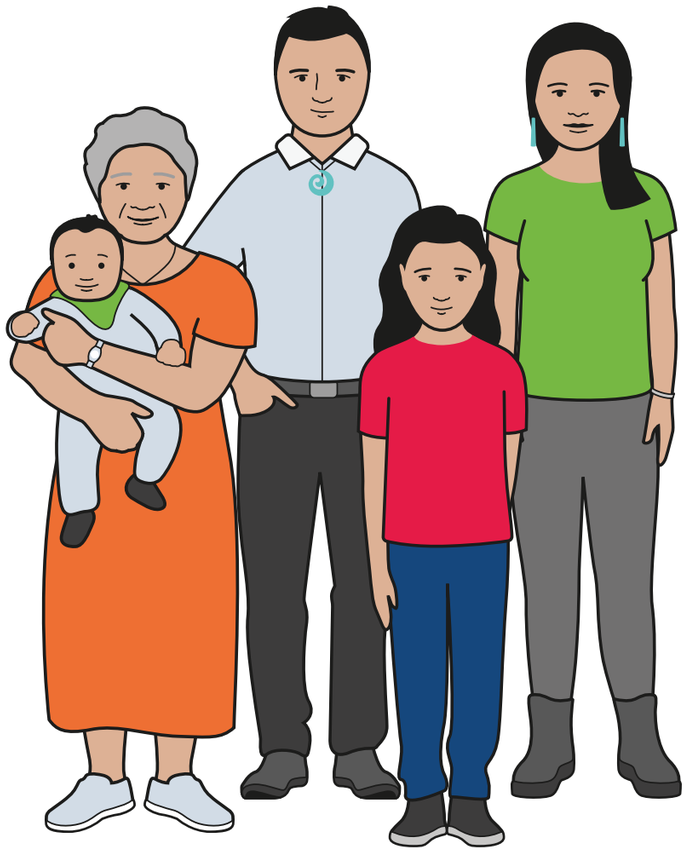
7.2 Access to care during business hours



7.3 Patient wait times

7.4 Telephone assessment & treatment (clinical triage)

When I'm unwell



8.1 Opportunities stratification

9.1 Hauora/ Wellness plan

9.2 Interdisciplinary approach

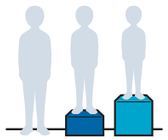
9.3 Community health networks

9.4 Patients with complex needs

To help me stay well

Health Care Home Model of Care

Summary



10.1 Improving health equity

11.1 Routine & preventative plan

11.2 Prework

11.3 Continuity of care and whanaungatanga

11.4 Technology enablers

11.5 Iwi and social services

12.1 Affordability systems

12.2 Cultural needs

13.1 Alternatives to in person consults

14.1 Fully functional portal

15.1 Patient engagement

15.2 Patient experience

16.1 Proactive planning

17.1 Health literacy

18.1 Call demand monitored

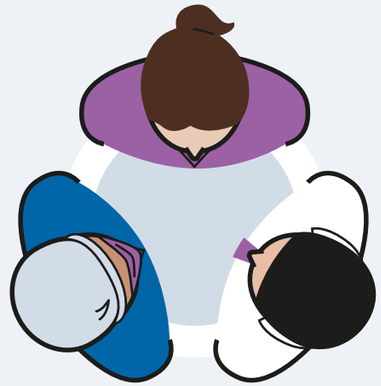
19.1 Appointment systems

19.2 Extended hours

20.1 Health records

To keep me healthy

1. Domain: Sustainability



The focus on ensuring practice sustainability provides an improved patient/whānau experience and better health outcomes.

Poipoia	Manaakitanga	Whakapono	Tino Rangatiratanga	Ōritetanga	Pūkengatanga	Kaitiakitanga
Health Care Home Maturity Matrix						
Service elements	**Characteristic**	**1**	**2**	**3**	**4**	
1. The practice uses a structured methodology to continuously improve quality and reduce waste (e.g. Lean/Kaizen). Practice leaders are trained in the structured methodology	1.1 **Review of practice sustainability**	… is undertaken in response to an event	… is undertaken annually as part of accreditation and review processes	… is undertaken regularly during the year using recognised tools such as LEAN and Consumer codesign	… is built into practice operations and daily business, with LEAN and consumer codesign used by practice staff. Practice staff have evidence of training in one of the structured methodologies. Key worker is identified to drive this process	
2. The practice benchmarks quality indicators with others locally and nationally	2.1 **Continuous quality improvement (CQI) (incorporating equity)**	… is not specifically managed	… occurs in some areas of the practice but with no emphasis on reducing health inequities, e.g. through individual audit	… is undertaken with some equity for Māori and other priority populations. Health outcomes are considered but not prioritised but is supported at the practice team level with regular measurement and audit	… is undertaken with equity for Māori and other priority populations. Health outcomes are prioritised at the team level with regular measurement and audit, with allocated time to organise and undertake specific projects proactively	
3. The reception service is focused on kanohi ki te kanohi (face to face) patient interactions	3.1 **Front desk staff**	… perform administrative tasks, answer phone calls and interact with patients at the front desk. There is no focus or training given on developing manaakitanga	… perform some administrative tasks, answer some phone calls at the front desk but give some focus on developing manaakitanga	… have some administrative tasks, but phone calls are largely away from the front desk. Development of manaakitanga is considered a priority	… ensure kanohi ki te kanohi (face-to-face) interaction with patients. Reception space is call-free to enable staff to concentrate on manaakitanga. The majority of administrative tasks are undertaken away from the front desk	

1.

Domain: Sustainability

→ CONTINUED

Workforce development and extended team enable general practices to do more for patients/whānau.

Poipoia	Manaakitanga	Whakapono	Tino Rangatiratanga	Ōritetanga	Pūkengatanga	Kaitiakitanga

Health Care Home Maturity Matrix

Service elements	Characteristic	1	2	3	4
4. The Health Care Home standardises consulting rooms and communal clinical spaces	4.1 **Workflows for practice teams**	… have not been documented and/or are different for each person of the team	… have been documented to some extent, but are not used to standardise workflows across the practice	… have been documented and are utilised to standardise common practices	… have been documented, using LEAN techniques such as one-point lessons and visual aids to standardise workflows, and are evaluated and modified on a regular basis
	4.2 **Standardised room**	… do not exist	… all have the same basic equipment	… all have an agreed minimum set of equipment, everything is stored in the same place in each room	… have an agreed minimum set of equipment, everything is stored in the same place in each room and a systemised process ensures consumables are replaced routinely
	4.3 **Facility infrastructure**	… does not include spaces for “off-stage” work	… has allocated some multi-use space that can include “off-stage” work	… includes dedicated space for “off-stage” work	… has been designed to allow for planned HCH processes, including “off-stage” work and team space and maximise utilisation of clinical space
5. Clinicians and other staff have access to separate private spaces to take phone calls, work on their computers, process paperwork and consult with each other and other staff in the practice — helping make the Health Care Home a team effort	5.1 **The practice layout**	… requires staff to work in isolation	… provides limited capacity for staff to interact	… allows some staff to interact and consult with each other most of the time	… enhances teamwork by allowing all staff to take phone calls, work on their computers, process paperwork and easily consult with each other and other staff in the practice easily

Poipoia	Manaakitanga	Whakapono	Tino Rangatiratanga	Ōritetanga	Pūkengatanga	Kaitiakitanga

Health Care Home Maturity Matrix

Service elements	Characteristic	1	2	3	4
6. The practice develops broader team roles through training with a focus on Te Tiriti o Waitangi and cultural competency to enable GPs, Nurses and other clinicians to consistently work at the top of their scope, and expand their services to patients	6.1 **The practice's training and workforce scope**	… does not have an organised approach	… includes routine assessment of staff roles and responsibilities	… includes routine assessment of staff roles and responsibilities, and supports staff working at the top of their scope	… supports all staff having the capacity to work at the top of their scope, assesses training needs (including Te Tiriti o Waitangi and cultural competency) to take on wider roles that would add to the team's efficiency and whānau wellbeing
	6.2 **Practice workforce plan**	… is not considered	… is developed without consideration to cultural diversity and is ad hoc	… is developed with some consideration to cultural diversity and is undertaken through limited analysis of population and workforce skill mix	… is developed with consideration to cultural diversity, reflective of the practice population and carried out through a regularly reviewed practice development and workforce plan that meets the needs and welfare of the practice team and population
	6.3 **Clinical and cultural leadership with a focus on Māori and priority patients**	… is not actively encouraged and no time given to develop leadership roles	… has minimal focus on cultural and clinical leadership development, is encouraged but with limited training and dedicated time to support change	… has some focus on cultural and clinical leadership development and is undertaken with some training and dedicated time to support staff to lead change, deliver new models of care, and to continuously improve services	… has strong focus on cultural and clinical leadership development and is undertaken with regular training and dedicated time to support staff to lead change, deliver new models of care, and to continuously improve services
	6.4 **Extended Practice team**	… is not considered	… considers the value of additional roles (e.g. PCPAs, clinical pharmacists, health coaches, etc) but does not include these roles in the practice team	… is actively investigated and the value of additional roles are considered, but the extended practice team is limited and not yet fully integrated	… includes various additional roles, fully integrated and co-located where possible

2. Domain: Urgent and Unplanned Care

What's most important to our patients/whānau is that when they are ill or concerned about a health issue they receive clinical advice and treatment when needed.

Poipoia	Manaakitanga	Whakapono	Tino Rangatiratanga	Ōritetanga	Pūkengatanga	Kaitiakitanga

Health Care Home Maturity Matrix

Service elements	Characteristics	1	2	3	4
7. **The Health Care Home provides telehealth, in person consults and utilises telehealth assessment and treatment in proactively managing acute response. The HCH has an equity focus on access for Māori and other priority patients**	7.1 **The approach to providing same-day access and prioritisation of Māori and other priority patients relies on**	… booking urgent patients into a clinician's ordinary appointment schedule with no prioritisation for Māori and other priority patients	… designating a "clinician of the day" who has slots open for urgent care with some prioritisation for Māori and other priority patients	… reserving a few slots in each clinician's daily schedule for urgent care to match documented demand with some prioritisation for Māori and other priority patients	… systematically implementing a schedule that reserves sufficient appointment slots each day to match documented demand with a focus on access for Māori and other priority patients
	7.2 **Access to urgent advice and care from the practice team during regular business hours**	… is difficult and uses only telephone and in person requests, with no systematic approach to managing response time	… relies on some aspects of telehealth and in person requests with no systematic approach to managing response time	… relies on several different modalities with increasing use of telehealth and monitored for same day response but with no targets to improve response time	… is accomplished by providing a choice of options including full range of telehealth which are accessible in accordance with acute clinical need and monitored for same day responsiveness with targets to improve response time
	7.3 **Patient wait times at the practice for scheduled consultations**	… are not monitored	… are monitored but not systematically managed	… are regularly measured, and are managed through assessing likely appointment lengths at booking	… are measured and managed in a culturally appropriate manner, that allows for high quality outcomes using telehealth and in person assessment, prework and active management of workloads
	7.4 **Patient needs assessed via triage**	… is not done systematically with no prioritisation for Māori and other priority patients	… is limited to providing patient appointment times/modalities based on assessed need with some prioritisation for Māori and other priority patients	… is done in a systematic manner throughout the day to appropriately decide the next step of care, does not utilise clinicians who are able to diagnose and prescribe, with basic prioritisation for Māori and other priority patients	… prioritises care according to patient needs and is done in a systematic way, throughout the day, using a clinician who can diagnose, order investigations and prescribe at times of heaviest demand. Telehealth assessment and treatment system supports continuity of care where possible with documented prioritisation for Māori and other priority patients

3. Domain: Proactive Care for those with complex needs

Health Care Home Maturity Matrix

Service elements	Characteristics	1	2	3	4
8. Population stratification is used to identify levels of clinical risk and those with complex health or social needs	8.1 Practice population opportunities/needs stratification	… is not available to assess or manage care for practice populations	… is available to assess and manage care for practice populations, but only on an ad hoc basis and does not prioritise Māori or other priority patients	… is regularly available to assess and manage care for practice populations, and includes some prioritision of Māori and other priority patients	… is routinely used to prioritise care for Māori, other priority patients and whānau to proactively plan care, including patient outreach, and pre-visit planning. Equity is measured and used at all levels
9. Proactive assessment, care planning, and use of community networks are developed with cultural consideration to facilitate integrated health (primary, secondary and social care). This is to support Māori, other priority patients and individuals/whānau with complex needs	9.1 Hauora/Wellness Health Plan	… are not routinely developed or recorded with no evidence of Te Whare Tapa Whā (holistic model) or other Māori or whānau led approach	… are developed and recorded but reflect providers' priorities only, and there is limited evidence of Te Whare Tapa Whā or other Māori or whānau-led approaches	… are developed collaboratively with patients using Te Whare Tapa Whā, or other Māori or whanau led approach, and begins to establish whanaungatanga (relationship) and includes self-management and clinical goals, but they are not routinely used to guide subsequent care	… are developed collaboratively with patients using Te Whare Tapa Whā, or other Māori or whanau led approach, and establish whanaungatanga with the patient and their whānau. The Hauora plan is routinely updated and guides care at subsequent points of service. Hauora (wellness) plans are shared with other well-being providers at the agreement of whānau
	9.2 An interdisciplinary and team approach	… is not used systematically with no focus for Māori or other priority patients	… is used for some patients but not systematically with no or limited focus for Māori and other priority patients	… is routinely used for some disease states. Starting to focus on Māori and other priority patients with use of practice population opportunities/ needs stratification to identify patients for team and interdisciplinary approach including secondary care and other agencies	… is culturally appropriate and is used routinely for Māori, other priority patients and those with complex needs as identified by population opportunites stratification, including secondary care and other agencies
	9.3 Community Health Networks with culturally appropriate resources	… are not used systematically	… are used for some patients, there is some connection starting to happen for Māori and whānau	… are utilised for some disease states for some patients and alignment of Māori whānau with kaupapa Māori NGOs has begun	… are fully integrated within general practice to support whānau wellbeing through open collaborative relationships with culturally appropriate resources and services
	9.4 Māori, other priority patients and patients with complex needs	… have no named Hauora coordinator/ navigator	… have a Hauora coordinator/navigator available but only to some patients with complex needs and no whanaungatanga (relationship) is established	… have a Hauora coordinator/ navigator, for most patients, available via one or two modalities. Particular considerations for Māori and other priority patients with establishment of whanaungatanga	… have a Hauora coordinator/navigator with whom the patient and whānau have established whanaungatanga. The Hauora coordinator/ navigator is accessible to patients, and whānau, other health care clinicians, and community teams, in a variety of modalities

4. Domain: Routine and Preventative Care

Poipoia	Manaakitanga	Whakapono	Tino Rangatiratanga	Ōritetanga	Pūkengatanga	Kaitiakitanga

Health Care Home Maturity Matrix

Service elements	Characteristics	1	2	3	4
10. The practice proactively works to achieve equitable health outcomes for Māori and other priority patients	10.1 **Improving health equity**	... is not a priority	... is considered, with some measurement of processes and outcomes, with no strategic plan or resources in place	... is considered, with measurement of processes and outcomes, and having a plan in place with some focus but little evidence of resources in place to ensure evidence based outcomes	... is a priority, with measurement of processes and outcomes and having a plan in place that is developed collaboratively with Māori and other priority patients. Resources are prioritised to ensure evidence based outcomes
11. The team identifies the purpose of a consultation and: • Utilises clinical pre-work so that required preliminary tests have been done • The appropriate appointment length is booked based on patient needs • Continuity of care is respected and enabled	11.1 **Routine and Preventative Plan for patient screening and proactive care**	... is not considered with no focus for Māori and other priority patients	... is limited to some patients only with mimimal focus for Māori and other priority patients	... includes a whānau led approach with some routine processes in place, but used at some points of care, and limited focus for Māori and other priority patients	... includes a whānau led approach that is routinely used at all points of care and includes focus for Māori and other priority patients. Patients that are not engaged are proactively followed up including outreach services
	11.2 **Valuing patient and clinician time through Prework**	... is not considered	... is limited and ad hoc	... is undertaken regularly through a variety of formats, such as use of an appointment scanner or clinician review of appointments	... is well documented and supported by technology, using recalls, task and work processes, across the practice. Patients are proactively involved in identifying need for prework
	11.3 **Patients are encouraged and supported to see their preferred GP and practice team with whom they have established whanaungatanga (relationship)**	... only at the patient's request	... by the practice team, but is not a priority in appointment scheduling. No consideration of whanaungatanga is given	... by the practice team and is a priority in appointment scheduling, but patients commonly see other GPs (because of limited availability or other issues). Some development of whanaungatanga and a clinical team approach for the patient is considered	... systematically, with special consideration to whanaungtanga and a team approach. This is measured, and systems altered accordingly. The practice directs patients to their clinical team (including their preferred GP) where possible, to facilitate continuity of care
	11.4 **Technology enablers**	... are available to support providers and includes an electronic health record	... is available to support all providers and includes an electronic health record and is fully utilised for preventative care including use of prompts, alerts and templates	... supports all providers with a shared electronic health record and is fully utilised for preventative care including use of prompts, alerts and templates. Enablers allow for telehealth to be integrated into day to day work	... supports all providers with a shared electronic health record and is integrated in all aspects of patient care allowing comprehensive recording of information, preventative care, prompts, alerts and templates. Enables telehealth and patient engagement in care including integration with secondary care
	11.5 **Relationships with Māori Health and Social Service Providers**	... are not yet established	... are beginning to be established and utilised	... are somewhat embedded in practice with some two-way referrals occurring between the practice and the provider to extend the care and supports available to whānau	... are fully embedded in practice with two-way referrals occurring between the practice and the provider to extend the care and supports available to whānau

4.

Domain: Routine and Preventative Care

→ CONTINUED

Health Care Home model supports a practice-based approach to achieving equitable health outcomes.

Health Care Home Maturity Matrix

Service elements	Characteristics	1	2	3	4
12. Socio-economic and cultural issues that are barriers to access to care are managed	12.1 **The practice has an approach and plan to affordability issues with focus on facilitating access**	… for some patients on an ad hoc basis with no prioritisation for Māori and other priority patients	… for some patients, with limited identification and prioritisation for Māori and other priority patients	… for most patients with some focus for Māori and priority patients. Such patients are identified, and some planning is done around an approach to facilitate access to services	… for most patients, with focus for Māori and other priority patients. Such patients are proactively identified, and a systematic planned approach is in place including engaging with social agencies, to facilitate access to services
	12.2 **The practice has an approach to manage cultural needs reflective of the practice population that affects access to care, specifically for Māori and other priority patients**	… for some patients on an ad hoc basis with no prioritisation for Māori and other priority patients	… for some patients but with no prioritisation for kaupapa Māori and cultural diversity of the practice population with limited planning to resolve barriers to access to care	… for most patients, with some planning involving consultation with Māori, other priority populations and representation of cultural diversity relevant to the practice population to resolve barriers to access to care	… for the majority patients with planning involving consultation with Māori, other priority patients and representation of cultural diversity relevant to the practice population. Health navigation (whakatere) is used to aid access to services and include outreach services with involvement from other Māori service providers
13. The practice provides alternatives to in person consultations for routine care where appropriate	13.1 **Patient contact with the health care team**	… is limited to in person or phone consults with GPs or nurses	… can be via in person phone, secure messaging consults and home visits are available, but are not incorporated in the daily schedule and limited to GPs or nurses	… includes systems for offering all telehealth modalities. Home visits continue to be available and planned, but are limited to GPs and nurses only and incorporated within the daily schedule	… includes systems for offering all telehealth modalities and is determined by what is most suitable to the patient. Home visits continue to be available and planned with inclusion within the daily schedule. There is also access to the full team (including for example clinical pharmacist, Health Improvement Practitioner) via a full range of modalities
14. Provision of a patient portal to allow patients to view and manage their information	14.1 **Access to a fully functional portal by patients with prioritisation for Māori and other priority patients including whānau**	… is not possible	… is partially available with appointments and access to results. There is no prioritisation for Māori and other priority patients, with no assessment of appropriateness and use	… is fully available with appointments, access to results and e-consults with the whole team but excludes access to clinical notes. Māori and other priority patients are beginning to be prioritised, with an approach to facilitate access and an assessment is made of the appropriateness and use	… is fully available with all functions enabled with the whole team including access to clinical notes. Māori and other priority patients are prioritised with an approach to facilitate access and assessment is made of the appropriateness and use

4.

Domain: Routine and Preventative Care

→ CONTINUED

Better healthcare is achieved with support from information technology.

Poipoia	Manaakitanga	Whakapono	Tino Rangatiratanga	Ōritetanga	Pūkengatanga	Kaitiakitanga

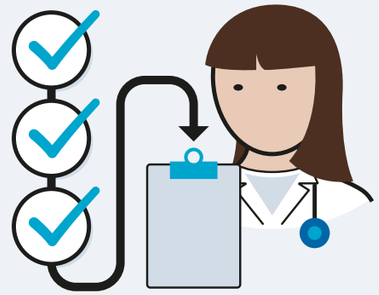
Health Care Home Maturity Matrix

Service elements	Characteristics	1	2	3	4
15. The practice frequently measures patient experience and uses the information to improve services, encourage patient engagement in service design	15.1 Patient co-design in the practice's service development	… is not considered	… is accomplished through using a survey administered sporadically at the organisational level. Representation is not reflective of Māori, other priority patients or practice population	… is accomplished by getting ad hoc input from patients and families using a variety of methods such as point of care surveys, focus groups. Representation is reflective of Māori, other priority patients and practice population	… is accomplished by getting frequent and actionable input from patients and their whānau on all care delivery activities, and incorporating their feedback in quality improvements. Māori and other priority populations are represented, and equity is a focus at each development meeting
	15.2 Patient experience at the practice	… is not measured	… is measured occasionally and does not represent Māori, other prioity patients or reflective of the practice population	… is measured regularly in a systematic manner and is representative of Māori, other priority patients and reflective of the practice population but no prioritisation of the outcomes	… is measured regularly in a systematic manner with Māori and other priority patients input and is representative of the practice population and diversity. The practice implements the feedback by active change management and focuses on implementing equity suggestions as the highest priority
16. The practice demonstrates that it values patient time, and facilitates patient self-care	16.1 Practice teams value patients' time by proactive planning	… infrequently	… occasionally to plan some aspects of the work of the day. Does not include identification of opportunities for proactive care for Māori and other priority patients	… through regular (but not daily) meetings to plan many aspects of the work of the day. Begins to include missed opportunities for proactive care especially for Māori and other priority patients	…through daily meetings to plan the work for the day including identification of improvement opportunities for proactive care for Māori and other priority patients
17. Health literacy	17.1 Practice Teams assess and provide health and wellbeing information that are fit for purpose and appropriate	… infrequently with limited resources	… for some patients and supporting materials available	… for most patients and with minimal training for staff and both materials and information are available	… for all patient groups with support at an organisational level and training for staff, includes translation services, hiring multi-lingual staff if possible and with a wide range of supporting materials available

4.

Domain: Routine and Preventative Care

→ CONTINUED



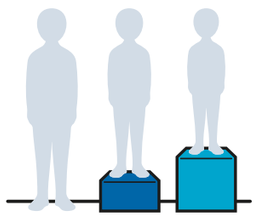
The Health Care Home model enables general practices to systemise their approach to deliver better health services to all patients/whānau.

Poipoia	Manaakitanga	Whakapono	Tino Rangatiratanga	Ōritetanga	Pūkengatanga	Kaitiakitanga
Health Care Home Maturity Matrix						
Service elements	**Characteristics**	**1**	**2**	**3**	**4**	
18. Telephones are answered in a timely manner	18.1 **Patient call demand**	… is not measured	… is measured through audit but there is limited response to patient demand	… is monitored, but limited responsiveness is in place	… is monitored routinely, with an enhanced call management approach to respond to patient demand, with 'time to answer' standards in place	
19. The Health Care Home offers flexibility in their appointment system to accommodate different needs of patients	19.1 **Appointment systems**	… are limited to a single office type with little availability for proactive care or prioritisation for Māori and other priority patients	… provide some flexibility in scheduling different visit types and lengths but does not include space for proactive care or multiple provider visits with no prioritisation for Māori and other priority patients	… provide flexibility and include sufficient capacity for same day visits and customised visit lengths with some prioritisation for Māori and other priority patients and considers a wide range of modalities including video/phone and has flexibility for proactive care	… are flexible and can accommodate acute, semi acute, routine visits and offer proactive care at time of contact with a focus for Māori and priority patients. Multiple formats are offered including customised visit lengths, same day visits, scheduled follow-up, secure messaging, telehealth and shared medical appointments, with the ability to offer multiple provider visits including secondary care	
	19.2 **Practice operating hours**	… are a normal business day, 5 days a week	… are minimally extended but insufficient to meet demand	… are extended based on perceived practice population need with some consideration given to providing telehealth consultations and proactive care	… are guided by a careful analysis of practice population needs and are extended where this will suit population requirements and reponsiveness to providing telehealth consultations and proactive care	
20. Health records are available to clinicians involved in a patient's care in a variety of settings	20.1 **Health records/care summaries and health information including clinical test results e.g. lab, radiology**	… are not shared	… are shared within the practice	… are shared within the practice and with after-hours providers, can be provided ad hoc to other agencies	… are shared within the practice and patient's practice and care team/after-hours providers, and a care record is shared systematically with other health and community agencies involved in care of the patient	

5.

Principles of the Health Care Home Performance Improvement Framework

Some of these measures continue to be developmental and will require further work to define numerators and denominators. Not all Health Care Home practices will wish to benchmark on all the indicators – practices and PHOs will choose those most relevant to their context locally.



All measures will be reported through an appropriate equity lens

The purpose of collecting the performance metrics is to demonstrate system impact of the HCH MoC and for individual practice and programme improvement.

The custodian of the Performance Improvement Framework will be the HCH Collaborative Governance Group. The national collection is solely for benchmarking within the Collaborative community, and will not be used for judgement, or distributed externally without explicit permission of the members.

The principles relevant to the measures include:

1. All measures will be reported through an appropriate equity lens
2. The measures will be meaningful and valid to practice teams and consumers
3. Only used for intended purpose
4. The measures will relate to the expected impact of the HCH model of care
5. The data will be able to be collected via easy/standardised processes within PHO and Practices
6. Incorporating easy interpretation/reporting at an individual provider level and in further detail where appropriate
7. The measures will be used for peer review to support mutual learning
8. No member shall criticise the performance of other member organisations, or use any of the information to the detriment of a fellow member
9. No external distribution of data or conclusions based on Health Care Home data is made without the unanimous consent of all contributors.

Health Care Home Performance Improvement Framework

The measures in the table are proposed and work is underway to create a Performance Improvement Framework to support benchmarking across Health Care Home general practices.

An equity approach to data and reporting will be prioritised.

Sustainability

1. Average patient/whānau wait time
2. Percentage of abandoned calls by hour of the day
3. Call service level by hour of the day — % of calls answered within 30 seconds
4. Patient/whānau experience survey scores
5. Percentage of DNAs at the practice
6. Patients/whānau enrolled per GP FTE

Urgent and Unplanned Care

7. Clinical triage — number of calls made
8. Clinical triage — percentage of calls resolved in triage
9. Number/age-standardised rate of ED attendances
10. Number/age-standardised rate of contracted A&M consults during business hours
11. Number of primary options for acute care claims
12. Days to third next available appointment (TNAA)

Proactive Care

13. Number of people with a care plan and named coordinator
14. Number of people in the top 5% of the risk stratified population with a care plan and named coordinator
15. BMJ measure: percentage of consults with the GP seen most often over the last 24 month period

Routine and Preventative Care

16. Number/age-standardised rate of ASH Admissions
17. Number of after-hours primary care consultations
18. Percentage of fully immunised infants (8 months)
19. Percentage of eligible women that received cervical screening
20. Percentage of eligible patients/whānau that received CVD risk assessment (per current/operational guidelines)
21. Number of virtual (telephone/video) consults
22. Number of face-to-face consultations
23. Number of patients/whānau with activated patient portal access
24. Number of inbound portal messages from patients/whānau
25. Number of repeat prescriptions via the patient portal

6.

The Credentialling & Certification Process

The credentialling and certification process are moderated against the HCH MoC Requirements.

Equity will be front and centre during the moderation process.

Level	Who undertakes	Criteria
Credentialling	PHO member of NZ Health Care Home Collaborative will credential local practices as Health Care Home practices in development	1. Practice implementation plan working towards achieving all Health Care Home characteristics at level 4 — including an explicit practice-based approach to achieving equitable health outcomes for all (especially for Māori and other priority populations) 2. Providing telephone assessment and treatment (clinical triage) and offering alternatives to in person care (e.g. telephone/video consults) 3. On the day appointment availability for triaged patients/whānau 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
Certification	NZ Health Care Home Collaborative peer assessors (Moderation Group) will certify practices outside their local network	As for credentialling, plus: 1. The practice has introduced population stratification and proactive care planning 2. The practice has demonstrated progress against their development plan in all 4 domains

7. Aligning the enhanced HCH MoC to the vision, values and the building blocks of primary care

Characteristic	Vision			Values							10 Building Blocks of Primary Care (amended)									
	Mauri ora	Whānau ora	Wai ora	Pūkengatana	Manaakitanga	Poipoia	Tino Rangatiratanga	Whakapono	Ōritetanga	Kaitiakitanga	Engaged leadership	Data-driven improvement	Patient/whānau Centred	Team-based care	Patient-team partnership	Population management	Continuity of care	Appropriate access to care	Comprehensive-ness and care coordination	Alternatives to in person care
1.1 Practice sustainability	♥		♥					♥			♥	♥								♥
2.1 Continuous quality improvement	♥		♥					♥			♥	♥				♥				♥
3.1 Reception in person and call free	♥		♥					♥			♥									
4.1 Workflow	♥		♥					♥			♥	♥								
4.2 Standardisation	♥		♥					♥			♥									
4.3 Facility infrastructure	♥		♥					♥				♥		♥						♥
5.1 Practice layout	♥		♥					♥				♥	♥	♥						♥
6.1 Staff training	♥		♥					♥			♥		♥	♥		♥				♥
6.2 Workforce planning & development	♥		♥					♥			♥	♥								
6.3 Clinical and cultural leadership	♥		♥					♥			♥									♥
6.4 Extended practice team	♥		♥					♥			♥		♥	♥		♥				

Characteristic	Vision			Values						
	Mauri ora	Whānau ora	Wai ora	Pūkengatana	Manaakitanga	Poipoia	Tino Rangatiratanga	Whakapono	Ōritetanga	Kaitiakitanga
7.1 Same day access and appointment systems	♥				♥	♥		♥	♥	♥
7.2 Access to care during business hours	♥							♥		
7.3 Patient wait times	♥								♥	
7.4 Telephone assessment & treatment (clinical triage)	♥					♥		♥	♥	♥
8.1 Opportunities stratification	♥	♥	♥	♥	♥	♥		♥	♥	♥
9.1 Hauora Coordinator/ Navigator	♥	♥	♥	♥	♥	♥	♥	♥	♥	♥
9.2 Interdisciplinary approach	♥	♥	♥	♥	♥	♥	♥	♥	♥	♥
9.3 Community Health Networks	♥	♥	♥	♥	♥	♥	♥	♥	♥	♥
9.4 Patients with complex needs	♥	♥	♥	♥	♥	♥	♥	♥	♥	♥
10.1 Improving Health Equity	♥	♥		♥	♥	♥	♥	♥	♥	♥
11.1 Routine & Preventative Plan	♥	♥	♥	♥	♥	♥	♥	♥	♥	♥
11.2 Prework	♥	♥						♥	♥	
11.3 Continuity of care and whanaungatanga	♥	♥	♥	♥	♥	♥	♥	♥	♥	

Characteristic	10 Building Blocks of Primary Care (amended)									
	Engaged leadership	Data-driven improvement	Patient/whānau Centred	Team-based care	Patient-team partnership	Population management	Continuity of care	Appropriate access to care	Comprehensive-ness and care coordination	Alternatives to in person care
7.1 Same day access and appointment systems	♥					♥		♥		♥
7.2 Access to care during business hours	♥	♥	♥	♥				♥		♥
7.3 Patient wait times	♥	♥				♥		♥		♥
7.4 Telephone assessment & treatment (clinical triage)	♥	♥		♥	♥	♥	♥			
8.1 Opportunities stratification		♥				♥	♥	♥	♥	♥
9.1 Hauora Coordinator/ Navigator			♥	♥	♥	♥	♥	♥	♥	♥
9.2 Interdisciplinary approach	♥			♥		♥	♥			♥
9.3 Community Health Networks	♥									
9.4 Patients with complex needs				♥	♥		♥		♥	
10.1 Improving Health Equity				♥	♥	♥	♥		♥	
11.1 Routine & Preventative Plan			♥	♥	♥	♥	♥		♥	♥
11.2 Prework		♥	♥	♥		♥				
11.3 Continuity of care and whanaungatanga		♥	♥		♥		♥	♥		

Characteristic	Vision			Values						
	Mauri ora	Whānau ora	Wai ora	Pūkengatana	Manaakitanga	Poipoia	Tino Rangatiratanga	Whakapono	Ōritetanga	Kaitiakitanga
11.4 Technology enablers										
11.5 Iwi and Social Services	♥	♥	♥	♥	♥	♥	♥	♥	♥	♥
12.1 Affordability systems	♥	♥	♥		♥	♥	♥	♥	♥	♥
12.2 Cultural needs	♥	♥	♥	♥	♥	♥	♥	♥	♥	♥
13.1 Alternatives to in person consults	♥	♥		♥	♥	♥	♥	♥	♥	♥
14.1 Fully functional portal	♥	♥	♥	♥	♥	♥	♥	♥	♥	♥
15.1 Patient engagement	♥	♥		♥	♥	♥	♥	♥	♥	♥
15.2 Patient experience	♥	♥		♥	♥	♥	♥	♥	♥	♥
16.1 Proactive planning	♥			♥	♥	♥	♥	♥	♥	♥
17.1 Health literacy	♥	♥	♥	♥	♥	♥	♥	♥	♥	♥
18.1 Call demand monitored	♥							♥	♥	♥
19.1 Appointment systems	♥	♥					♥	♥	♥	♥
19.2 Extended hours	♥	♥					♥	♥	♥	♥
20.1 Health records	♥							♥	♥	

10 Building Blocks of Primary Care (amended)									
Engaged leadership	Data-driven improvement	Patient/whānau Centred	Team-based care	Patient-team partnership	Population management	Continuity of care	Appropriate access to care	Comprehensive-ness and care coordination	Alternatives to in person care
	♥								♥
				♥	♥			♥	
	♥			♥	♥		♥	♥	♥
	♥	♥	♥	♥		♥	♥		♥
		♥	♥	♥			♥		♥
			♥	♥			♥		♥
♥	♥		♥	♥					
♥	♥								
	♥	♥	♥	♥		♥			♥
		♥	♥	♥		♥			
	♥								♥
		♥	♥	♥			♥		♥
	♥	♥	♥		♥			♥	
				♥				♥	

New Zealand Health Care Home Collaborative Participating and Supporting Organisations

8.

Practices or PHOs wishing to become full members or wish to know more about the HCH Collaborative should contact **collaborative@hch.org.nz**

The HCH Collaborative will be offering support to all PHOs.

9.

Our expert advisors provided leadership for this mahi

Lance Norman, Head of Equity and Māori Health Outcomes, ProCare

Mark Liddle, Chair HCH Collaborative and COO Pegasus Health

Whaea Merle Samuels, Consumer Representative

Dr Kirsty Lennon, GP Clinical Lead, HCH MoC

Dr Dougal Thorburn, GP Hutt Union Health Services and Clinical Director. Population Health Te Awakairangi Health Network

Ants Toumoua, Nurse Manager & Nurse Lead, Health Care Home MoC Enhancement

Steering Group — Leadership and support

- **Dr Bryan Betty**, GP Lead, Porirua Union Health Centre
- **Lance Norman**, Head of Equity and Māori Health Outcomes, ProCare
- **Mark Liddle**, Chair HCH Collaborative and COO Pegasus Health
- **Hemaima Reihana**, Nursing Director, Mahitahi Hauora
- **Whaea Merle Samuels**, Consumer representative
- **Stuart Barson**, HCH Lead, WellSouth

Working Group Lead and Māori GP

- **Dr Dougal Thorburn**, GP Hutt Union Health Services and Clinical Director, Population Health; Te Awakairangi Health Network

Operational/Clinical expertise to support change to the MoC

- **Dr Kirsty Lennon**, GP Clinical Lead, HCH MoC
- **Ants Toumoua**, Nurse Manager & Nurse Lead, HCH MoC Enhancement

The HCH Collaborative wishes to acknowledge the support and valuable input from our member Primary Health Organisations, District Health Boards, General Practices, General Practice New Zealand, Health Quality Safety Commission, and Health Navigator Charitable Trust.

www.healthcarehome.org.nz