HEALTH CARE HOME COLLABORATIVE

New Zealand Health Care Home Model of Care Requirements

DECEMBER 2018

Contents

Health Care Home Collaborative (the Collaborative)

The Collaborative was formed in 2016 with the principle objective to support the establishment and ongoing development of the Health Care Home across New Zealand and to ensure HCH practices are of a high quality and provide a consistent standard of care.

To achieve its principle objective, the Collaborative will support, promote, maintain and oversee the HCH Model of Care with a view to improving patient health care, health outcomes and the management of related services. Members of the Collaborative include various PHOs and DHBs in New Zealand.

NZ Health Care Home (HCH) Model of Care Requirements

The HCH Model of Care is a patient-centric approach which enables primary care to deliver a better patient and staff experience, improved quality of care, and greater efficiency. The Collaborative established the HCH Model of Care Requirements, first published in July 2017 to demystify the HCH Model of Care, and to 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 enrolled in HCH practices can expect the same standard of service.

The HCH Model of Care requirements document sets out the health care home service elements and characteristics of a health care home practice. These are grouped into four core domains:

1. Ready access to **urgent and unplanned care**.
2. **Proactive care** for those with more complex need.
3. Better **routine and preventative care**.
4. Improved **business efficiency** & sustainability.

Within each domain a maturity matrix is provided with:

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

More information about the Collaborative and a digital copy of this document can be found at: healthcarehome.org.nz

The HCH maturity matrix for each domain provides a continuum of model of care 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, hence a developmental approach is being taken, rather than a quality assurance approach. Further clarification and descriptions of several terms and processes mentioned in this document are provided in a supplementary online guide and is available on the HCH Collaborative website: **healthcarehome.org.nz**

What's changed in this version?

This is the second iteration of the national HCH Model of Care requirements. We aim to review the requirements annually to ensure they remain relevant and to ensure that patient and whanau needs are reflected in the model. The changes in this version include a number of minor alterations to more accurately reflect the model as it is being implemented, and to clarify the expectations and definitions as set out by the National Collaborative. This second version also incorporates a stronger, more explicit equity lens. The addition of a new equity-focused service element requires HCH practices to demonstrate an understanding of inequities within their enrolled population. HCH Certification will require evidence of the Practice's ability to monitor processes and outcomes by ethnicity and to develop a practice-based approach to achieving equitable health outcomes where possible (especially for Māori, Pacific and patients living in high deprivation). In addition, the national benchmarking measures (currently in development) will include reporting by ethnicity, to support continuous improvement for all enrollees.

The Collaborative is currently undertaking work to strengthen consumer co-design, and partnership, participation and protection of Māori within the HCH Model of Care. This work will be reflected in the next iteration of the requirements.

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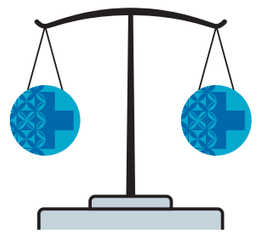


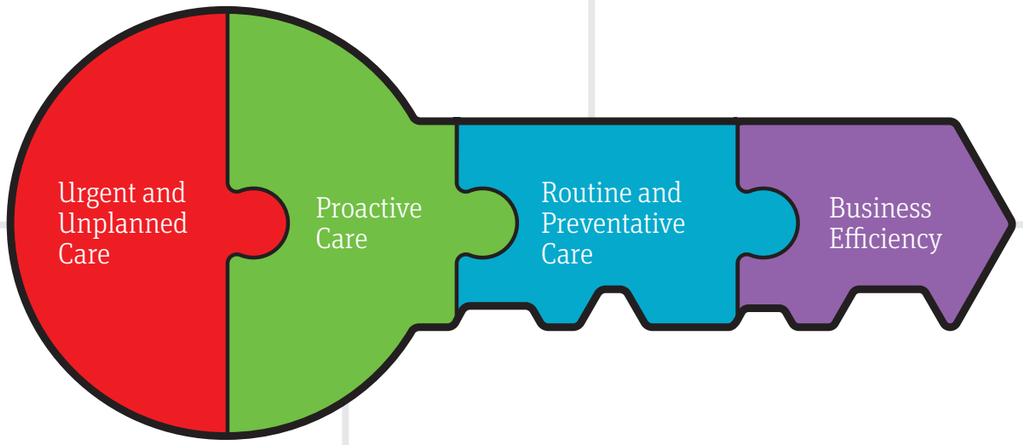
Health Care Home
Summary Characteristics


Same day access and appointment systems


Access to care during business hours

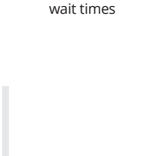

Patient wait times


Telephone assessment & treatment (clinical triage)



Risk stratification

Development of care plans


Cultural consideration in care plans


Interdisciplinary approach

Community based resources

Care coordination


Equity lens


Health plans


Prework


Continuity of care


Information Technology support


Affordability systems


Cultural needs


Patient engagement


Fully functional portal


Alternatives to F2F consults


Patient experience


Proactive planning


Health literacy


Call demand monitored


Appointment systems

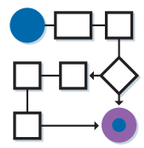

Extended hours


Health records

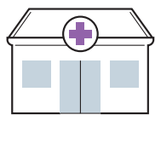

LEAN processes in place

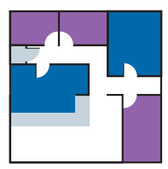

Continuous quality improvement


Staff training


Workflow

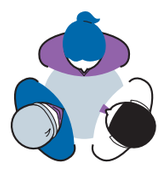

Standardisation


Facility infrastructure


Practice layout


Reception F2F and call free


Workforce planning & development


Clinical leadership


Extended practice team

1. Domain: Urgent and Unplanned Care

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

Health Care Home Maturity Matrix

Service elements	Characteristics	1	2	3	4
1. The Health Care Home provides alternatives to face to face consults and utilises telephone assessment and treatment to proactively manage demand	1.1 **The approach to providing same-day access relies on**	… booking urgent patients into a clinician's ordinary appointment schedule	… designating a "clinician of the day" who has slots open for urgent care	… reserving a few slots in each clinician's daily schedule for urgent appointments	… systematically implementing a schedule that reserves sufficient appointment slots each day to match documented demand
	1.2 **Access to care from the practice team during regular business hours**	… is difficult	… relies on the practice's ability to respond to telephone messages	… is accomplished by staff responding by telephone within the same day	… is accomplished by providing a patient a choice of multiple channels including secure messaging and phone interaction, utilising systems which are monitored for responsiveness
	1.3 **Patient wait times at the practice**	… are not monitored	… are monitored but not reduced systematically	… are regularly measured, and are reduced through assessing likely appointment lengths at booking	… are minimised through, triage, prework, and active management of staff workloads throughout the day
	1.4 **Patient needs assessed via triage**	… is not done systematically	… is limited to providing patients appointment times/modalities based on assessed need	… is done in a systematic manner to appropriately decide the next step of care	… is done in a systematic way, throughout the day, using a clinician who can diagnose, order investigations and prescribe at times of heaviest demand. Triage system supports continuity of care where possible

2. Domain: Proactive Care for those with complex needs

A well co-ordinated, proactive approach to care for patients with complex needs.

Health Care Home Maturity Matrix

Service elements	Characteristics	1	2	3	4
2. Population stratification is used to identify levels of clinical risk and those with complex health or social needs	2.1 **Practice population risk/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	… is regularly available to assess and manage care for practice populations	… is available to practice teams and routinely used to identify patients with complex needs, plan care and scheduling, including for proactive patient outreach, and pre-visit planning
3. Proactive assessment, care planning, and care coordination processes are developed with cultural consideration to facilitate integrated health and social care. This is to support individuals/whanau with complex needs.	3.1 **Care plans**	… are not routinely developed or recorded	… are developed and recorded but reflect providers' priorities only	… are developed collaboratively with patients and families and include self-management and clinical goals, but they are not routinely used to guide subsequent care	… are developed collaboratively, include self-management and clinical management goals, routinely updated and guide care at subsequent points of service. Care plans are shared with other healthcare providers
	3.2 **Each Care Plan**	… is developed without cultural consideration	… has limited cultural consideration determined by a health care professional	… has some cultural consideration with limited patient and whanau participation	… is reflective of specific cultural needs of the patient and their whanau
	3.3 **An interdisciplinary approach**	… is not used systematically	… is used for some patients but not systematically	… is used routinely for some disease states	… is used routinely for high risk patients when planning care and scheduling appointments
	3.4 **Processes in place to link patients to supportive community-based resources such as NGOs**	… are not used systematically	… are used for some patients	… are used for some disease states for some patients	… are used routinely when planning patient care
	3.5 **Patients with complex needs**	… have no named care coordinator	… have a care coordinator available but only to some patients with complex needs	… have a care coordinator, for most patients, available via one or two modalities	… have a care coordinator who is accessible to patients, other health care clinicians, and community teams, in a variety of ways that are preferential t to the patient

3. Domain: Routine and Preventative Care

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

Health Care Home Maturity Matrix

Service elements	Characteristics	1	2	3	4
4. The practice proactively works to achieve equitable health outcomes for all, especially for Māori, Pacific and patients living in high deprivation	4.1 **Reducing health disparities**	... is not a priority	... is considered, with some measurement of processes and outcomes but with limited focus on improving equity in health	... is considered, with measurement of processes and outcomes, and having a plan in place to improve equity in health, especially for Māori, Pacific and patients living in high deprivation	... is a priority, with measurement of processes and outcomes and having a plan in place that is developed collaboratively with Māori, Pacific and patients living in high deprivation to achieve equitable health care
5. 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	5.1 **Patient Health Plans**	... are not in place	... are limited to some patients only	... includes their routine and preventative care	... include routine and preventative care. Those patients that are not engaged in their care are proactively followed up
	5.2 **Prework**	... is not complete	... 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 and work processes, across the practice, making best use of patient and clinician time
	5.3 **Patients are encouraged and supported to see their preferred GP and practice team**	... only at the patient's request	... by the practice team, but is not a priority in appointment scheduling	... by the practice team and is a priority in appointment scheduling, but patients commonly see other GPs (because of limited availability or other issues.)	... systematically, and 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
	5.4 **Information technology**	... is available to support some clinicians	... is available to support clinicians in all rooms, and includes an electronic health record	... supports clinicians with a shared electronic health record, and automatic pop-ups and prompts individualised to the patient	... supports all clinicians with a shared electronic health record and profession-specific templates, with automatic alerts and prompts individualised to the patient across key aspects of care

3. 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
6. Socio-economic and cultural issues that are barriers to access to care are managed	6.1 **The practice has an approach to affordability issues and a plan to facilitate access**	… for no patients	… for some patients, with limited identification and planning around affordability	… for most patients with affordability issues. Such patients are identified, and some planning is done around an approach to facilitate access to the service	… for most patients with affordability issues. Such patients/whanau are proactively identified, and a systematic planned approach is in place to facilitate access to the service
	6.2 **The practice has an approach to manage cultural needs that affect access to care**	… for no patients	… for some patients, with limited planning to resolve barriers to access to care that are related to identified cultural needs	… for most patients, with some planning to resolve barriers to access to care that are related to identified cultural needs	… for most patients. Cultural needs of patients are proactively identified with a systematic plan in place to resolve related barriers to access to care
7. The practice provides alternatives to face to face consults where appropriate	7.1 **Patient contact with the health care team**	… is limited to face-to-face or phone consults with GPs or nurses	… can be via phone/secure messaging consults and home visits are available — but are provided on an ad-hoc basis	… has systems for phone/secure messaging consults, and home visits are available and planned	… can be via a variety of modalities. Provision of GP, nurse, pharmacist, (and other team member) consults over the phone and via secure messaging, text, video, and home visits for appropriate patients
8. Provision of a patient portal to allow patients to view and manage their information	8.1 **Access to a fully functional portal by patients**	… is not possible	… is partially available with appointments, access to results and e-consults but not with the whole team	… is possible with the whole team, where appropriate, but excludes access to clinical notes	… is available to all, including access to clinical notes
9. The practice frequently measures patient experience and uses the information to improve services as well as encourage patient engagement in service design	9.1 **Patient co-design in the practice's service development**	… is not done	… is accomplished through using a survey administered sporadically at the organisational level	… is accomplished by getting ad-hoc input from patients and families using a variety of methods such as point of care surveys, focus groups, and ongoing	… is accomplished by getting frequent and actionable input from patients and their families on all care delivery activities, and incorporating their feedback in quality
	9.2 **Patient experience at the practice**	… is not measured	… is measured occasionally	… is measured regularly in a systematic manner	… is measured regularly in a systematic manner and improved through active change management of the practice

3.

Domain: Routine and Preventative Care

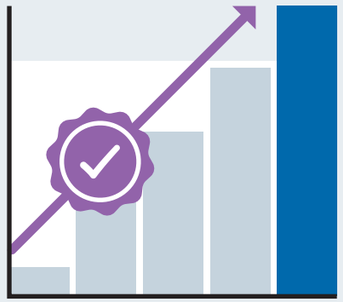
→ CONTINUED

Better healthcare is achieved with support from information technology.

Health Care Home Maturity Matrix

Service elements	Characteristics	1	2	3	4
10. The practice demonstrates that it values patient time, and facilitates patient self-care	10.1 **Practice teams value patients' time by proactive planning**	… none of the time	… occasionally to plan some aspects of the work of the day	… through regular (but not every day) meetings to plan many aspects of the work of the day	… through daily meetings to plan the work for the day
11. Health literacy	11.1 **Patient comprehension of verbal and written materials**	… is not assessed	… is assessed and accomplished for some patients by assuring that materials are at a level and language that patients understand	… is assessed and accomplished for many patient groups ensuring both materials and communications are at a level and language that patients understand	… is supported at an organisational level assuring that patients know what to do to manage conditions at home by the use of translation services, hiring multi-lingual staff if possible and appropriate, and training staff in health literacy and communication techniques for all patient groups
12. Telephones are answered in a timely manner	12.1 **Patient call demand**	… is not measured	… is measured through audit, there is limited response to patient call 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
13. The Health Care Home offers flexibility in their appointment system to accommodate different needs of patients	13.1 **Appointment systems**	… are limited to a single office visit type	… provide some flexibility in scheduling different visit lengths	… provide flexibility and include sufficient capacity for same day visits and customised visit lengths	… are flexible and can accommodate acute, semi acute and routine visits in multiple formats including customised visit lengths, same day visits, scheduled follow-up, phone, secure messaging and shared medical appointments with the ability to offer multiple provider visits
	13.2 **Practice operating hours**	… are a normal business day, 4.5 days a week	… are a normal business day, 5 days a week	… are extended based on perceived practice population need	… are dictated by a careful analysis of practice population needs and are extended beyond normal business hours where this will suit population requirements
14. Health records are available to clinicians involved in a patient's care in a variety of settings	14.1 **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/ after-hours providers, and a care record is shared systematically with other health and community agencies involved in care of the patient

4. Domain: Business Efficiency



The focus on maximising efficiency provides an improved patient experience and better business effectiveness.

Health Care Home Maturity Matrix

Service elements	Characteristic	1	2	3	4
15. 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	15.1 **Review of process efficiency**	... is undertaken in response to an event	... is undertaken annually as part of accreditation and review processes	... is undertaken occasionally during the year using recognised tools such as LEAN	... is built into practice operations and daily business, with LEAN / other tools known and used by practice staff
16. The practice benchmarks quality indicators with others locally and nationally	16.1 **Continuous quality improvement**	... is not specifically managed	... occurs in some areas of the practice, e.g. through individual audit	... is supported at the team level with regular measurement and audit	... is supported at the team level with regular measurement and audit, with allocated time to organise and undertake specific projects proactively, covering specific aspects of the practice including health inequalities
17. The reception service is focused on face to face patient interactions	17.1 **Front desk staff**	... perform administrative tasks, answer phone calls and interact with patients at the front desk	... perform some administrative tasks, answer some phone calls at the front desk	... have some administrative tasks, but phone calls are largely away from the front desk	... concentrate on face-to-face interaction with patients. Reception space is predominately call-free
18. The Health Care Home standardises consulting rooms and communal clinical spaces	18.1 **Workflows for practice teams**	... have not been documented and/or are different for each person or 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, are used to standardise workflows, and are evaluated and modified on a regular basis
	18.2 **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
	18.3 **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

4.

Domain: Business Efficiency

→ CONTINUED

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

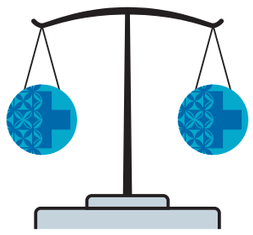
Health Care Home Maturity Matrix

Service elements	Characteristic	1	2	3	4
19. 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	19.1 **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
20. The practice develops broader team roles to enable GPs, Nurses and other clinicians to consistently work at the top of their scopes throughout the day, and expand their services to patients	20.1 **The practice**	… does not have an organised approach to workforce planning	… routinely assesses staff roles and responsibilities	… routinely assesses 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 to take on wider roles that would add to the team's efficiency and patient well-being
	20.2 **Practice workforce plan**	… is not in place	… is ad-hoc	… is undertaken through limited analysis of population and workforce skill mix	… is carried out through a regularly reviewed practice development and workforce plan that meets the needs and welfare of the practice team and population
	20.3 **Clinical leadership**	… is not actively encouraged	… is encouraged and not supported with training	… is undertaken with limited training to support clinical staff to lead change, deliver new models of care, and to continuously improve services	… is undertaken with regular training and support for administrative and clinical staff to lead change, support and deliver new models of care, and to continuously improve services
	20.4 **The practice**	… does not consider having an extended team	… investigates the value of additional roles (e.g. PCPAs, clinical pharmacists, health coaches, etc) but does not include these roles in the practice team	… actively investigates the value of additional roles but the extended practice team is limited, and not yet fully integrated	… has an extended team with various additional roles, fully integrated and co-located where possible

5.

Principles of the Health Care Home National Dataset

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 national data set measures is to demonstrate system impact of the Health Care Home model of care and for individual practice and programme improvement.

The custodian of the national data set will be the New Zealand Health Care Home National 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 National Dataset: Inaugural Measures

Urgent and Unplanned Care

1. Age standardised ED attendances per 1000 enrolled patients
2. Age standardised After Hours Consultations per 1000 enrolled patients
3. Age standardised ASH Admissions per 1000 enrolled patients
4. Age standardised Acute Admissions per 1000 enrolled patients
5. Aged standardised acute readmission rate
6. Triage outcomes — % of patients managed without a same day face to face appointment
7. Age standardised After Hours primary care Consultations per 1000 enrolled patients
8. Primary options for acute care claim volumes per 1000 enrolled population
9. Contracted A&M / other Practice visits during business hours
10. Hospital bed days in the last 6 months of life
11. Average lead time to get an appointment

Proactive Care

12. Age standardised Nurse Consultations per 1000 enrolled patients
13. Continuity of care measure (BMJ): percentage of consults with the GP seen most often over the 24month period
14. Percentage of DNAs at hospital FSAs
15. Partners in Health Scale — change in average score over time
16. % patients with two plus chronic conditions with a care plan and named coordinator

Routine and Preventative Care

17. Number of patient inbound secure messages through patient portal / 1000 adults
18. No. of virtual (telephone/video) planned consults as % total consults
19. Patients with activated patient portal access per enrolled population
20. % of patients that have access to own notes (PHO measure)
21. Smoking quit rate
22. Percentage of fully immunised infants (at 8 months)
23. Percentage of eligible women receiving cervical screening
24. Percentage of eligible patients receiving CVD risk assessment (per current/ operational guidelines)
25. Dropped call rate
26. Patient experience survey scores
27. Wait times in the practice (post appointment time)
28. Percentage of DNAs at the practice
29. Percentage of population achieving or missing pre-planned or proactive checks

Business Efficiency

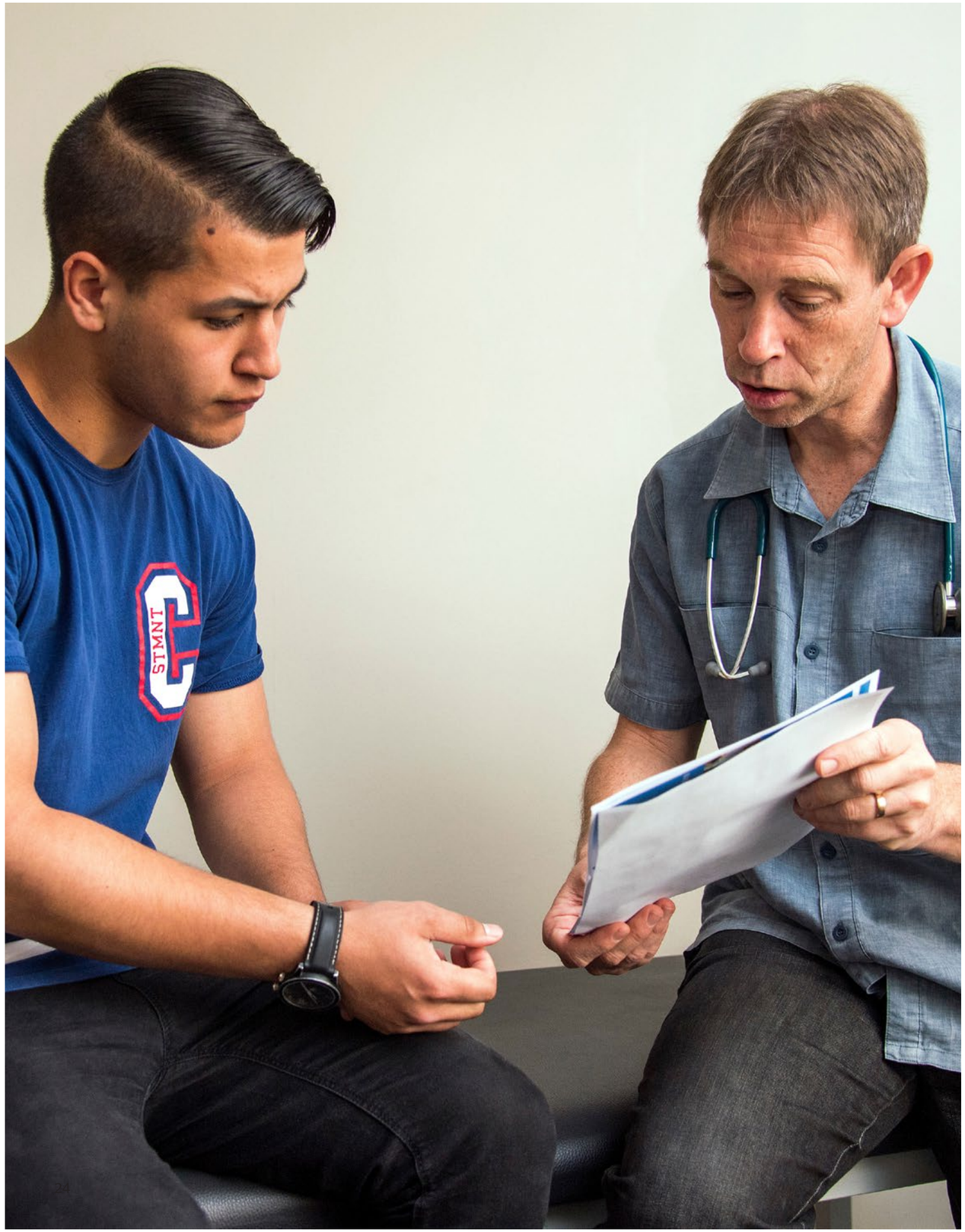
30. Practice team climate survey results
31. % Room utilisation for clinical interactions
32. No of aged standardised patients enrolled per GP FTE
33. No of aged standardised patients enrolled per Nurse/ FTE
34. Practice population
35. Practice population churn
36. Staff turnover
37. Sick days per FTE per year
38. Total phone calls per 1000 per month

Health Care Home Credentialing & Certification Process

6.

There are three levels to be considered for 'signing off' a practice against the Health Care Home Model of Care Requirements

Level	Who undertakes	Criteria
Credentialing	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, Pacific and patients living in high deprivation). 2. Providing telephone assessment and treatment (clinical 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
Certification	NZ Health Care Home Collaborative peer assessors (Moderation Group) will certify practices outside their local network	As for credentialing, 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.
Accreditation	NZ Health Care Home Collaborative	To be developed.



New Zealand Health Care Home Collaborative Participating Organisations

7.

Practices or PHOs wishing to join or learn more about the Collaborative should contact **collaborative@healthcarehome.org.nz**

or one of the participating organisations below

comprehensive care

Te Waiora Nelson Marlborough Health

Nelson Bays Primary Health
Hauora Matua ki Te Tai Aorere

Ora Toa PHO

Tū Ora Compass Health

Hutt Valley DHB

CentralPHO
Working together, towards healthy and flourishing communities

Southern District Health Board
Piki Te Ora

Marlborough Primary Health
Kimi Hauora Wairau | Seeking Wellbeing in Marlborough

Manaia Health

Cosine Primary Care Network

Te Awakairangi Health Network

General Practice NZ
The Heart of Integrated Care

Te Tai Tokerau Primary Health Organisation
Hei Oranga Ra

The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

WBOP PHO
Western Bay of Plenty Primary Health Organisation

Health Hawke's Bay
Te Oranga Hawke's Bay

Pinnacle Midlands Health Network | Health Care Home

Pegasus

Northland District Health Board
Te Poari Hauora A Rohe O Te Tai Tokerau

ProCARE

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

Capital & Coast District Health Board
Ūpoko ki te uru hauora

WellSouth Primary Health Network
Hauora Matua Ki Te Tonga

Eastern Bay Primary Health Alliance
Healthy Whānau, Healthy Lives


Forever
Cute