HEALTH CARE HOME COLLABORATIVE

Health Care Home Model of Care Requirements

Contents

Introduction to the New Zealand Health Care Home Model of Care Requirements

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.

The Health Care Home Model of Care Requirements document sets out the Health Care Home service elements and characteristics of a Health Care Home practice **over and above** the traditional model. These are grouped into 4 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 Health Care Home model of care requirements;
- **Characteristics** that allow a practice to map their current model of care systems and processes on a developmental scale

The Health Care Home 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 Health Care Home practice. A maturity matrix approach has been used to recognise that Health Care Home practices are on a continuous improvement journey, hence a developmental approach is being taken, rather than a quality assurance approach.

The Health Care Home Model of Care Requirements have been developed by the National Health Care Home Collaborative and it has been endorsed by the Collaborative members (see back page).

This version is effective for the period from 1 July 2017 and will be reviewed in October 2018. In addition, the Health Care Home Collaborative is developing national benchmarking **measures** to support continuous improvement. The measures are a work in progress and will be updated with the Model of Care by October 2018. All credentialed health care home practices are expected to participate in ongoing benchmarking within this programme. A national evaluation of the Health Care Home model of care is being planned by the Ministry of Health and the Health Research Council.

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 GP triage 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 historical demand
	1.2 Appointment systems Can PMS support?	...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	...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 and email, and multiple provider visits
	1.3 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 email and phone interaction, utilising systems which are monitored for timeliness and ensuring no calls are missed and regular reporting is undertaken
	1.4 Patient wait times at the practice	...are not monitored	...are not reduced systematically	...are regularly measured, and are reduced through assessing likely appointment lengths at booking	...are minimised through active management of staff loads throughout the day evidenced by clinics running to time, clinicians have reserved time for their other work minimising double-booking
	1.5 Patient needs assessed via triage	...is not done systematically	...is limited to providing patients appointment times/modalities based on assessed need	...assesses patient needs in a systematic manner to appropriately decide the next step of care	...in a systematic manner, including the use of a senior, experienced clinician who is able to access, diagnose and treat, managing the call directly avoiding where possible the patient to visit the practice. GPs triaging their own patient where possible
	1.6 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

2. Domain: Proactive Care for those with more complex needs

Patients with more complex care needs deserve a well co-ordinated, proactive approach to their care.

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 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 plan care and scheduling, including for proactive patient outreach, and pre-visit planning
3. Proactive assessment, care planning, and care coordination processes are in place to support individuals/whanau with complex needs, facilitating integrated health and social care	3.1 Care plans tbd - regional?	...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 recorded or used to guide subsequent care for high risk	...are developed collaboratively with the patient, include self-management and clinical management goals, routinely recorded and guide care at every subsequent point of service. Care plans are shared with other healthcare providers
	3.2 Patient with complex needs	...are not specifically identified	..are sometimes identified and planned for	..are identified and planned for some of the time	...are kept in a live register and have a process for care planning/reviewing across the multidisciplinary team
	3.3 An interdisciplinary approach	...is not done systematically	...is used for some patients	..is done for some disease states for some patients	...is used routinely when planning patients care and scheduling appointments
	3.4 Processes in place to link patients to supportive community based resources such as NGOs and other Allied Health Care services	...are not done systematically	...are used for some patients	...are done for some disease states for some patients	...are used routinely when planning patient care across the multidisciplinary team
	3.5 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 ah-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

2. Domain: Proactive Care for those with more complex needs

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Health Care Home Maturity Matrix

Service elements	Characteristics	1	2	3	4
4. People identified as having high and complex needs have a named care coordinator	4.1 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 via one or two modalities	...have a care coordinator who is accessible to patients and other health care clinicians in a variety of ways that are convenient to patients—e.g. patient portal, mobile apps
	4.2 Practice workforce model	...has no capacity for care coordinator	...has limited capacity for care coordination provided by GPs/ nurses	...has capacity for providing named care coordinator most of the time	...has capacity for providing a named care coordinator for all complex patients at all times
	4.3 Care plan development	...has no systematic approach	...process is very basic	...has a partially developed system, covering some patients some of the time	...is systematic, with a planned process for their application
5. The practice proactively works to involve whanau support practitioners (where available) in care planning/coordination for Māori patients.	5.1 Each care plan is	...developed without a cultural consideration	...has limited cultural consideration determined by a health care professional	...has some cultural consideration with limited patient and whanau participation	...reflective of specific cultural needs of the patients and whanau

3. Domain: Routine and preventative Care

The Health Care Home model enables a practice to systemise its approach to delivering national and local health targets and preventative care.

Health Care Home Maturity Matrix

Service elements	Characteristics	1	2	3	4
6. 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	6.1 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
	6.2 Prework	...is not complete	...is limited and adhoc	...is undertaken regularly	...is undertaken to make best use of patient and clinician time
	6.3 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 named clinician where possible to facilitate continuity of care
	6.4 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 bring-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
7. Socio-economic and cultural issues that are barriers to care are managed	7.1 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 all patients with affordability issues. The practice proactively identifies patients/whanau with affordability issues and puts in place a planned approach to facilitate access to the service
	7.2 The practice has an approach to provide care appropriate to cultural needs	...for no patients	...for some patients, with limited identification and planning around cultural needs	...for some patients, with identification and planning around cultural needs	...for all patients
8. The practice provides alternatives to face to face consults where appropriate	8.1 Patient contact with the health care team	...is limited to face-to-face or phone consults with GPs or nurses	...has some systems for phone/email consults and home visits are available for some staff (GPs/nurses)—provided on an ad-hoc basis	...has routine systems for phone/email consults, and home visits are available for some staff (GPs/nurses)	...can be via a variety of modalities. Provision of GP, nurse, pharmacist, (and other team member) consults over the phone and via email, video, IM and home visits for appropriate patients

3. Domain: Routine and preventative Care

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Health Care Home Maturity Matrix

Service elements	Characteristics	1	2	3	4
9. Provision of a patient portal to allow patients to view and manage their information	9.1 Access to a fully functional portal by patients	...is not possible	...is partially functional i.e. appointments, access to results and e-consults with the whole team are not always available	...is possible where appropriate, but excludes access to clinical notes	...is available to all, including access to clinical notes
	9.2 Patients	...do not have electronic access to practice data	... have email access to the practice	...are able to use email, and have access to basic care information through a patient portal	...have a choice of ways of accessing comprehensive care records through secure mobile phone or internet-based portals including Wi-Fi in the practice
10. The patient voice is heard and actioned	10.1 Measurement of patient interactions	...is not done	...is accomplished through using a survey administered sporadically at the organisational level	...is accomplished by getting input from patients and families using a variety of methods such as point of care surveys, focus groups, and ongoing patient advisory boards	...is accomplished by getting frequent and actionable input from patients and their families on all care delivery activities, and incorporating their feedback in quality improvement activities
11. The practice frequently measures patient experience and uses the information to improve services. The practice demonstrates that it values patient time, and facilitates patient self-care	11.1 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
12. Health literacy	12.1 Involving patients in decision-making and care	...is not a priority	...is accomplished by provision of patient education materials or referrals to classes	...is supported and documented by practice teams	...is systematically supported by practice teams trained in decision and self-management techniques and supported by mobile apps and/or patient electronic access to care plans
	12.2 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 by hiring multi-lingual staff if needed, and insuring that both materials and communications are at a level and language that patients understand	...is supported at an organisational level by translation services, hiring multi-lingual staff, and training staff in health literacy and communication techniques (such as closing the loop) for all patient groups, assuring that patients know what to do to manage conditions at home
13. Telephones are answered in a timely manner	13.1 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

4. Domain: Business Efficiency

The focus on creating maximum efficiency provides for an improved patient experience and better business effectiveness.

Health Care Home Maturity Matrix

Service elements	Characteristic	1	2	3	4
14. The practice uses a structured methodology to continue improve quality and reduce waste (e.g. Lean/ Kaizen). Practice leaders are trained in the structured methodology	14.1 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
15. The practice benchmarks quality indicators are shared with others locally and nationally	15.1 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 all aspects of the practice including health inequalities
16. The reception service is focused on face to face patient interactions	16.1 Receptionists	...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
17. The Health Care Home standardises consulting rooms and communal clinical spaces. Moved to measure: Clinicians are able to use any available room for consultation which improves the utilisation of space	17.1 Workflows for clinical 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
	17.2 Standardised rooms	...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
	17.3 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 purpose-redesigned to allow for planned HCH processes, including "off-stage" work and team space

4.

Domain: Business Efficiency
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Health Care Home Maturity Matrix

Service elements	Characteristic	1	2	3	4
18. 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	18.1 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 consult with each other and other staff in the practice easily
19. The practice allocates tasks to broader team roles to enable GPs, Nurses and other clinicians to consistently work at the top of their scopes throughout the day. All team members work at the top of their scope	19.1 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 taking on wider roles ("top of scope")	...supports staff taking on wider roles, and actively investigates the value of additional roles. (e.g. primary health care assistants) that would add to the team's efficiency and patient well-being. Training needs are assessed regularly
	19.2 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 need of the practice team and population
	19.3 Change management	...is not done	...is ad-hoc	...is undertaken through limited training to support clinical staff to lead change, deliver new models of care, and to continuously improve services	...is undertaken through regular training and support for administrative and clinical staff to lead change, support and deliver new models of care, and to continuously improve services
	19.4 Clinical pharmacists	...are not part of the practice team	...play a limited role in providing clinical care	...provide some services such as medication review and reconciliation	...provide services such as medication review and reconciliation, as well as patient consultations and are part of the practice team
20. The practice provides training to support administrative and clinical staff to lead change, deliver new models of care, and to continuously improve services	20.1 Managers, clinical leaders and practice owners	...are focused on short-term business priorities	...visibly support and create an infrastructure for process and quality improvement, but do not commit resources	...allocate resources and actively reward improvement initiatives	...support continuous learning throughout the organisation, review and act upon data in a transparent way, and have a long-term strategy and business plan that addresses continuous improvement and sustainability

Principles of the Health Care Home National Dataset

5.

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

The measures set out are the initial set for review in October 2018. Some of these are 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.

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 & readmissions per 1000 enrolled patients
5. Triage outcomes—% of patients managed appropriately without a same day face to face appointment
6. Age standardised After Hours primary care Consultations per 1000 enrolled patients
7. Primary options for acute care claim volumes per 1000 enrolled population
8. Same day access for those where clinically appropriate
9. A&M/other Practice visits during business hours
10. Hospital bed days in the last 6 months of life
11. Average patient wait time to consult
12. Annual audit of triage patients and re presentations

Proactive Care

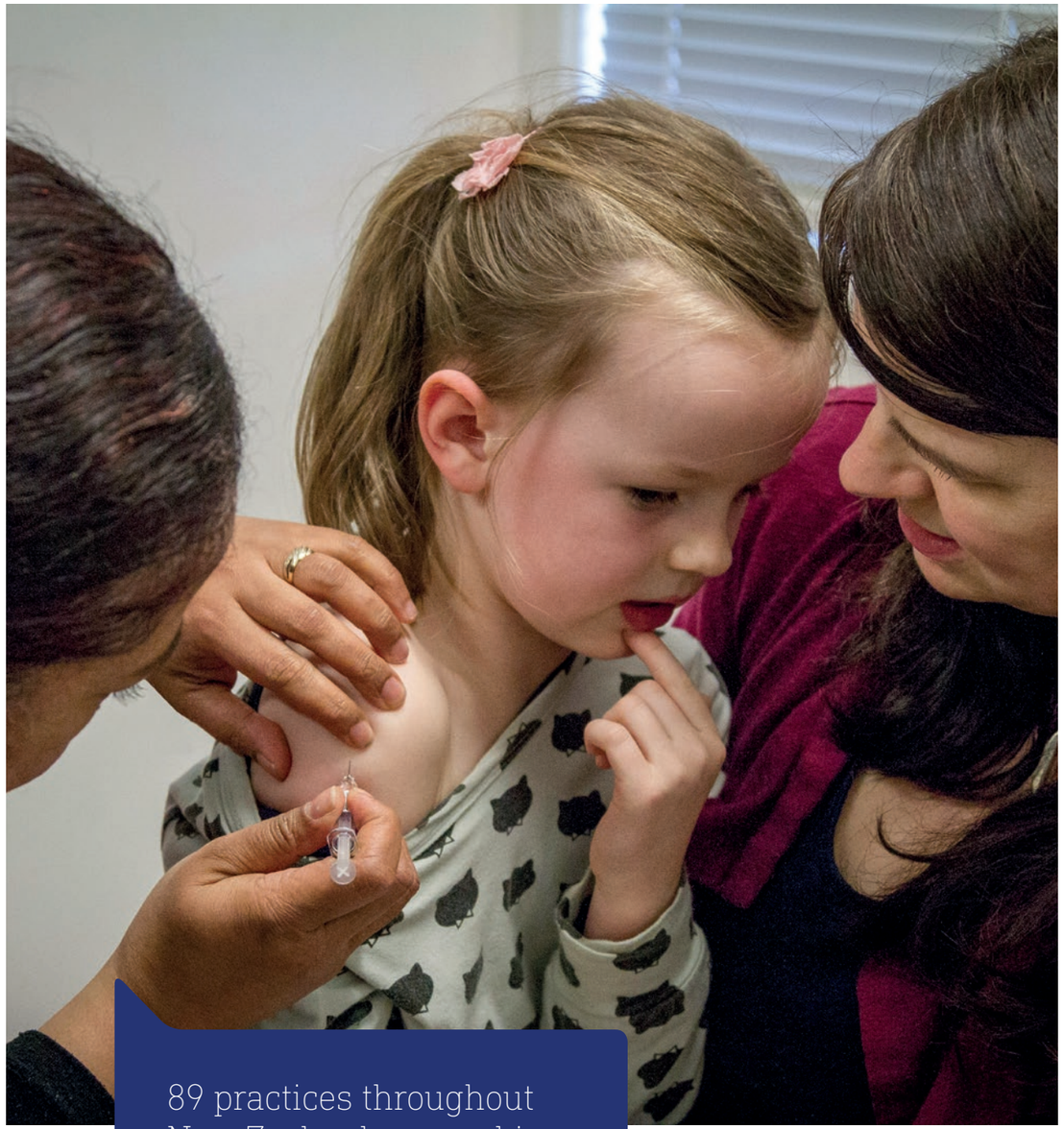
13. Age standardised Nurse Consultations per 1000 enrolled patients
14. Percentage of patients seeing their own GP
15. Average number of different clinicians seen over the last 10 visits
16. BMJ measure: percentage of consults with the GP seen most often over the 24month period
17. Percentage of DNAs at hospital FSAs
18. Partners in Health Scale—change in average score over time
19. % of high needs patients with a care plan and named coordinator

Routine and Preventative Care

20. Number of patient inbound secure messages through patient portal/1000 adults
21. No. of virtual (telephone/video) planned consults as % total consults
22. Patients with activated patient portal access per enrolled population
23. % of patients that have access to own notes (PHO measure)
24. Smoking quit rate
25. Dropped call rate
26. Patient experience survey scores
27. Wait times in the practice (post appointment time)
28. Time to 3rd available appointment
29. Percentage of DNAs at the practice

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. % of enrolled population who leave during the year
35. Staff turnover
36. Sick days per FTE per year
37. Total phone calls per 1000 per month



89 practices throughout New Zealand are working towards the Health Care Home model.

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 to achieve all Health Care Home Indicators at level 4 2. Providing GP triage and offering alternatives to face to face care (eg 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 assessor 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	RNZCGP Assessor familiar with HCH model	Not yet available. To be developed in conjunction with the RNZCGP.

New Zealand Health Care Home Collaborative participating organisations

7.

Practices or PHOs wishing to join or learn more about the Collaborative should contact:

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Compass Health

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or one of the participating organisations

CompassHealth
Working together, towards healthy and flourishing communities

Manaia Health

CentralPHO
Working together, towards healthy and flourishing communities

GENERAL PRACTICE NZ
The Heart of Integrated Care

Te Tai Tokerau Primary Health Organisation
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