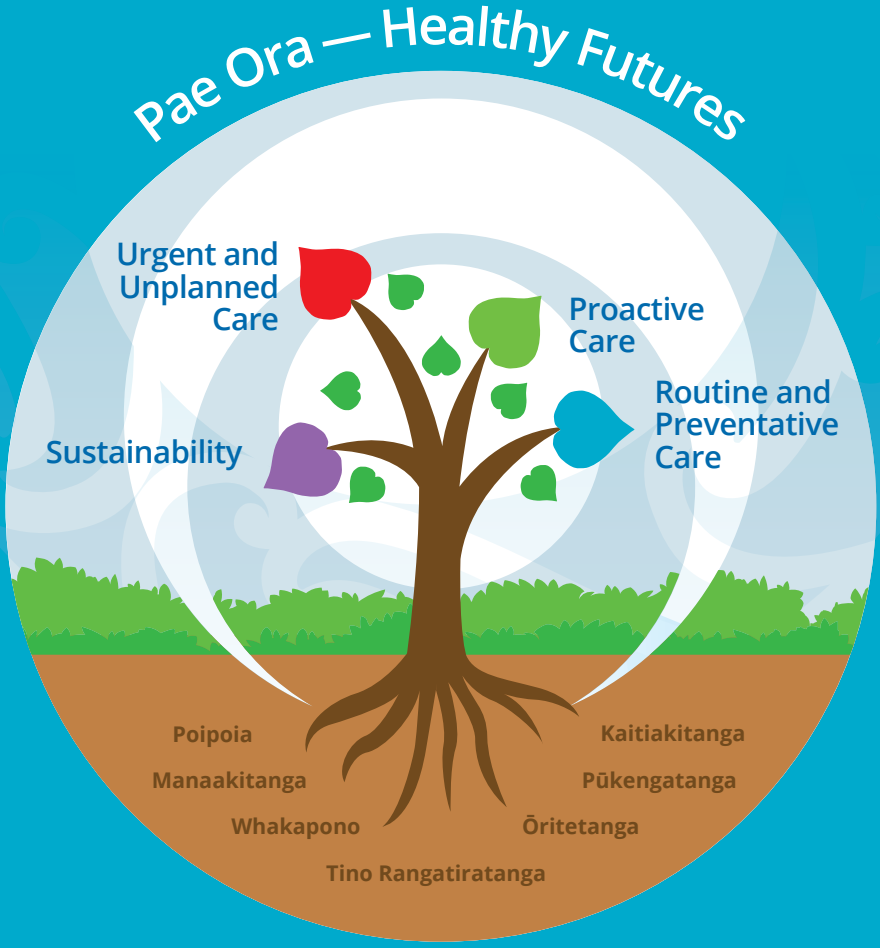
HEALTH CARE HOME COLLABORATIVE

Building Blocks of Health Care Home

Ko te oranga te tūrangawaewae mō te Hauora
Health is founded upon wellbeing



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!

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Introducing the Building Blocks of the Health Care Home

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 Health Care Home Model of Care is a practical whānau-centric approach to modernisation of primary care, leading to a better patient and staff experience, enhanced quality of care, and improved sustainability.

This short booklet gives a basic introduction to the model of care, which has now been adopted to underpin change and improvement in many general practices all over Aotearoa.

Implementation of the model may seem a bit daunting, but it's a process that is flexible and adaptable, regardless of practice size, location or individual circumstances. Practices typically incorporate the model over a period of time so it can support their service, workforce and business priorities in the best possible way to help achieve better outcomes for their patient population.

The model features a small number of core Building Blocks designed to improve access and outcomes, including making more use of telehealth and of a wider range of workforces, as well as focusing on planned and proactive care.

The Building Blocks continue to be refined, based on learnings and population health needs, with the most recent enhancements centred around achieving equity for Māori, Māori aspirations and tikanga. That includes alignment to Pae Ora (Healthy Futures) as a vision, a new set of values grounded in equity, and incorporation of whakawhanaungatanga (creating connection/relationship) in the delivery of care.

Practices may choose to implement some or all of the building blocks, choosing aspects that fit the needs of its community/whānau. This is not a one size fits all model of care but one that is flexible and adaptive.

The recent experience of Covid-19 has reinforced the importance of alternatives to in person consults, and we are continuing to develop our resources to help integrate telehealth options.

Our current focus also includes developing tools and resources to support the creation of a new networked approach to primary care and community services.

The full range of practical support and resources of the Health Care Home Collaborative is available to any practice embarking on the Health Care Home journey — see our website at www.healthcarehome.org.nz or e-mail us at collaborative@hch.org.nz

Continuous Quality Improvement (2.1)

Practices have a clear and structured pathway for introducing new innovations and ways of working, enabling them to plan, track and assess the impact of change and involve all members of the team.

Clinical and Cultural Leadership (6.3)

All members of the team have a role in developing and delivering the practice's values, vision and improvement plan; cultural competency and safety is evident in all practice staff.

Same day access (7.1)

Processes are in place to ensure same day appointments are available for those people who need them most, making use of clinical triage to prioritise and release capacity.

Telephone assessment & triage (7.4)

Suitably qualified clinicians triage and manage appropriate patients over the phone, including providing prescriptions, self-care advice, and referral for diagnostics without the need for a face to face appointment.

Practice population stratification (8.1)

Systematic processes are in place to identify and target patients who would benefit most from primary care support, combined with opportunities to identify what matters most to people to improve their wellbeing.

Hauora / Wellness Health Plan (9.1)

A holistic plan is developed in partnership between the practice and patients with complex or long-term conditions, setting out goals, care and support interventions and social and cultural needs.

Improving health equity (10.1)

A clear understanding of equity is in place, allowing resources to be targeted to different levels of advantage in order to achieve equitable health outcomes, with a focus on Māori and other priority patients.

Cultural needs (12.2)

All health professionals are equipped to provide culturally competent care to people and their whānau, reflective of their practice population.

Alternatives to in person consults (13.1)

Systems are in place to offer a range of telehealth options, including e-mail, video, and phone consultations, determined by what is most suitable for the individual patient.

Fully functional patient portal (14.1)

An electronic portal offers patients convenient and secure electronic access to appointment booking, prescription requestions and personal health information.

Patient Engagement (15.1)

Patient co-design emphasises the importance of engaging with consumers and whānau in developing and delivering health care services. It can be described as a method for partnering with patients, consumers and service users right from the beginning of service planning.

Call demand monitored (18.1)

The right number of skilled people and supporting resources is in place at all times to manage incoming calls safely and efficiently, based on accurate modeling.

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:

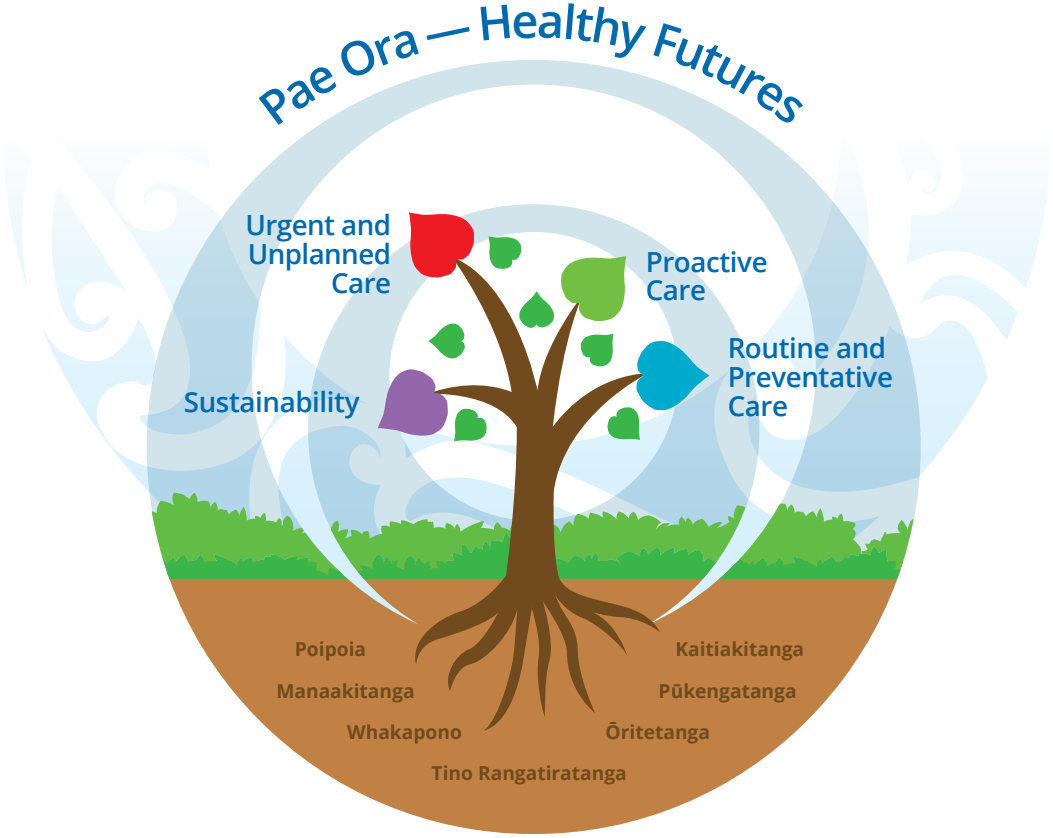
- mauri ora — healthy individuals
- whānau ora — healthy families
- wai ora — healthy environments.

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

Building Blocks Model of Care

Summary

2.1 Continuous quality improvement

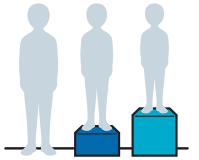
6.3 Clinical and cultural leadership

7.1 Same day access and appointment systems

7.4 Telephone assessment & treatment (clinical triage)

8.1 Opportunities stratification

9.1 Hauora/ Wellness plan



10.1 Improving health equity

12.2 Cultural needs

13.1 Alternatives to in person consults

14.1 Fully functional portal

15.1 Patient engagement

18.1 Call demand monitored

Building Blocks of Health Care Home

Poipoia	Manaakitanga	Whakapono	Tino Rangatiratanga	Ōritetanga	Pūkengatanga	Kaitiakitanga

Service elements	Characteristic	1	2	3	4
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
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	6.3 **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 under-taken with regular training and dedicated time to support staff to lead change, deliver new models of care, and to continuously improve services
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
	7.4 **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

Service elements	Characteristic	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 prioritisation 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
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
12. Socio-economic and cultural issues that are barriers to access to care are managed	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

Service elements	Characteristic	1	2	3	4
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
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
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

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

Health Care Home Patient Journey

Working to achieve equity

My practice works to ensure everybody receives the best care

When I visit the practice

- Greeting at reception
- Appointments that value my time
- My extended practice team
- Improvements in service delivery

When I am unwell

- Calling the practice
- Talking to my doctor on the phone
- Booking an urgent appointment
- Valuing my time

To help me stay well

- My practice team contacts me
- Developing a plan to stay well
- My care team knows the plan
- Getting help from others
- Coordination

To keep me healthy

- Accessing my health information and care online
- Appointments that meet my needs
- Ensuring access
- Continuity of care
- Understanding my health

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www.healthcarehome.org.nz