HEALTH CARE HOMES

Patient-centred | Coordinated | Flexible

HEALTH CARE HOME ASSESSMENT (HCH-A)

To be used by Health Care Homes involved in stage one implementation
To asses practice readiness, monitor progress, and for evaluation purposes.

Practice name

Your name

Date completed

This document has been adapted for use in Australia by Western Sydney Primary Health Network (WentWest) in 2015. It was further adapted by Australian General Practice Accreditation Limited (AGPAL) in 2017 with permission from the following source:

Safety Net Medical Home Initiative

The Patient-Centred Medical Home Assessment Version 4.0.

The MacColl Center for Health Care Innovation at Kaiser Permanente and Qualis Health; Seattle, WA. September 2014.

QUALIS HEALTH

The Commonwealth Fund

improving chronic illness care

WentWest Progressing Health Now

AGPAL QUALITY IN PRACTICE

Introduction to the HCH-A

The Patient-Centred Medical Home Assessment (PCMH-A) tool was developed by the MacColl Center for Health Care Innovation at Kaiser Permanente and Qualis Health for the Safety Net Medical Home Initiative (SNMHI).

The PCMH-A was extensively tested by the 65 practices that participated in the SNMHI, including federally qualified health centres (FQHCs), residency practices, and other settings, and is in use in a number of regional and national initiatives.

With permission from the developers, WentWest adapted the tool in 2015 and AGPAL further adapted the PCMH-A in 2017 to better align with Australian Health Care Homes model and terminology. It was renamed as the Health Care Home Assessment (HCH-A) tool to be used by Health Care Homes in Australia.

The HCH-A tool is intended to help practices understand their current level of "Health Care Home Readiness" and identify opportunities for improvement. The HCH-A can also help practices track progress toward practice transformation when it is completed at regular intervals.

Where there is reference to a "practice" that means both a General Practice and an Aboriginal Community Controlled Health Service (ACCHS), whichever is applicable to your circumstances.

Before you begin the HCH-A

Identify a multidisciplinary group of practice staff

We strongly recommend that the HCH-A be completed by a multidisciplinary group (e.g. GPs, practice nurses, practice manager, allied health professionals, and operations and administrative staff) in order to capture the perspectives of individuals with different roles within the practice and to get the best understanding of 'the way things really work.'

We recommend that all practice staff complete the assessment individually, and that you then meet to discuss the results, produce a consensus version, and develop an action plan to prioritise improvements. The Primary Health Network Practice Facilitator will support general practices and ACCHS in completing the HCH-A, analysing the results, and using the results to develop action plans for transformation. We discourage practices from completing the HCH-A individually and then averaging the scores to get a consensus score without having first discussed the results as a group. The discussion is key to identifying opportunities and priorities for transformation.

Have each practice location in your organisation complete an assessment

If your organisation has multiple locations, each practice should complete a separate HCH-A. Practice transformation, even when directed and supported by practice leaders, happens differently at the practice level. Practice leaders can compare HCH-A scores and use this information to share knowledge and cross-pollinate improvement ideas.

Consider where your practice is on the transformational journey

Answer each question as honestly and accurately as possible. There is no advantage to over-estimating item scores, and doing so may make it harder for progress to be apparent when the HCH-A is repeated in the future. It is typical for teams to begin the transformational journey with average scores below "5" for some or all areas of the HCH-A. It is also common for teams to initially believe they are providing more patient-centred care than they actually are. Over time, as your understanding of patient-centred care increases and you continue to implement effective practice changes, you should see your HCH-A scores increase.

Directions for Completing the Assessment

You can download a pdf version of the HCH-A tool at any time from the Health Care Homes training website at: ***www.healthcarehomes.training***. You can print and complete the HCH-A using the following steps:

1. For each row, click the point value that best describes the level of care that currently exists in the practice. The rows in this form present key aspects of patient-centred care. Each aspect is divided into levels (A through D) showing various stages in development toward a patient-centred Health Care Home. The levels are represented by points that range from 1 to 12. The higher point values within a level indicate that the actions described in that box are more fully implemented.
2. Review your subscale and overall score on page 15. These subscale and overall scores are automatically calculated based on the responses entered. Average scores by Change Concept (subscale scores) and an overall average score are provided. Using the scores to guide you, discuss opportunities for improvement.
3. Save your results by clicking the "save" button at the end of the form. To clear your results, and retake the assessment, click on "clear" button at the end of the form.

In addition to the HCH-A tool being used as a self-monitoring tool for practices, the results will be used towards the evaluation of Stage one Australian Health Care Homes implementation. Instructions on when and how to upload your practice's results for evaluation are on the evaluation website ***www.hchevaluation.com***.

PART 1: ENGAGED LEADERSHIP

1A Provide visible and sustained leadership to lead overall culture change as well as specific strategies to improve quality, spread and sustain change.

1B Ensure that the Health Care Home transformation effort has the time and resources needed to be successful.

1C Ensure that GPs and other practice team members have protected time to conduct activities beyond direct patient care that are consistent with the Health Care Homes model.

1D Build the practice's values on creating a Health Care Home for patients into staff hiring and training processes.

Items	Level D			Level C			Level B			Level A		
1. Practice principals	…are focused on short-term business priorities.			…visibly support and create an infrastructure for quality improvement, but do not commit resources.			…allocate resources and actively reward quality improvement initiatives.			…support continuous learning throughout the practice, review and act upon quality data, and have a long-term strategy and funding commitment to explore, implement and spread quality improvement initiatives.		
	1	2	3	4	5	6	7	8	9	10	11	12
2. Clinical leaders	…intermittently focus on improving quality.			…have developed a vision for quality improvement, but no consistent process for getting there.			…are committed to a quality improvement process, and sometimes engage teams in implementation and problem solving.			… consistently champion and engage care teams in improving patient experience of care and clinical outcomes.		
	1	2	3	4	5	6	7	8	9	10	11	12
3. The practice's recruitment and training processes	…focus only on the narrowly defined functions and requirements of each position.			…reflect how potential new team members will affect the culture and participate in quality improvement activities.			…place a priority on the ability of new and existing staff to improve care and create a patient-centred culture.			…support and sustain improvements in care through training and incentives focused on rewarding patient-centred care.		
	1	2	3	4	5	6	7	8	9	10	11	12
4. The responsibility for conducting quality improvement activities	…is not assigned by leadership to any specific group.			…is assigned to a group without committed resources.			…is assigned to an organised quality improvement group who receive dedicated resources.			…is shared by all staff, from practice principals to team members, and is made explicit through protected time to meet and specific resources to engage in quality improvement.		
	1	2	3	4	5	6	7	8	9	10	11	12

Total Practice Score		Average Score (Total Practice Score/4)	

PART 2: PATIENT ENROLMENT

2A Assign each enrolled patient to a nominated GP and care team, confirm enrolments with the GP, care teams and patients; review and update enrolments on a regular basis.

2B Assess practice appointment supply and demand, and balance GP to patient ratio accordingly.

2C Use practice data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.

Items	Level D			Level C			Level B			Level A		
5. Patients	…are not linked to a primary GP and care team.			….are linked to a nominated GP and care team but assignment is not routinely used by the practice for administrative or other purposes.			….are linked to a nominated GP and care team and assignment is routinely used by the practice mainly for scheduling purposes.			…..are linked to a nominated GP and care team and assignment is routinely used for scheduling purposes and monitored for GP to patient ratio.		
	1	2	3	4	5	6	7	8	9	10	11	12
6. Practice data	…are not available to assess or manage care for practice populations.			…are available to assess and manage care for practice populations, but only on an ad hoc basis.			…are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states.			…are regularly available to assess and manage care for practice populations, across a comprehensive set of diseases and risk states.		
	1	2	3	4	5	6	7	8	9	10	11	12
7. Patient records	…are not available to care teams for pre-visit planning or patient outreach.			…are available to care teams but are not routinely used for pre-visit planning or patient outreach.			…are available to care teams and routinely used for pre-visit planning or patient outreach, but only for a limited number of diseases and risk states.			…are available to care teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states.		
	1	2	3	4	5	6	7	8	9	10	11	12
8. Reports on care processes or outcomes of care	…are not routinely available to care teams.			…are routinely provided as feedback to care teams but not reported externally.			…are routinely provided as feedback to care teams, and reported externally (e.g., to patients, other teams or external agencies) but with team identities masked.			…are routinely provided as feedback to care teams, and transparently reported externally to patients, other teams and external agencies.		
	1	2	3	4	5	6	7	8	9	10	11	12

Total Practice Score		Average Score (Total Practice Score/4)	

PART 3: QUALITY IMPROVEMENT (QI) STRATEGY

3A Choose and use a formal model for quality improvement.

3B Establish and monitor metrics to evaluate improvement efforts and outcomes; ensure all staff members understand the metrics for success.

3C Ensure that patients, their families and carers, GPs, and care team members are involved in quality improvement activities.

3D Optimise use of health information technology and clinical information systems such as data extraction and clinical audit tools, formal PDSA cycle, and division of populations by ethnicity/ culture, gender and age group.

Items	Level D			Level C			Level B			Level A		
9. Quality improvement activities	…are not organised or supported consistently.			…are conducted on an ad hoc basis in reaction to specific problems.			…are based on a proven improvement strategy in reaction to specific problems.			…are based on a proven improvement strategies and used continuously in meeting practice goals.		
	1	2	3	4	5	6	7	8	9	10	11	12
10. Performance measures	…are not available for the practice.			…are available for the practice, but are limited in scope.			…are comprehensive— including clinical, operational, staff and patient experience measures—and available for the practice, but not for individual GPs or care teams.			…are comprehensive— including clinical, operational, staff and patient experience measures—and fed back to the practice and care teams.		
	1	2	3	4	5	6	7	8	9	10	11	12
11. Quality improvement activities are conducted by	…a centralised committee or department.			…topic specific QI committees			…all care teams supported by a QI infrastructure.			…care teams supported by a QI infrastructure with meaningful involvement of patients, their families and carers.		
	1	2	3	4	5	6	7	8	9	10	11	12
12. Clinical information systems that optimise use of information	…are not present or are being implemented.			… are in place and are being used to capture clinical data.			…are used routinely during patient encounters to provide clinical decision support and to share data with patients.			… are also used routinely to support population management and quality improvement efforts.		
	1	2	3	4	5	6	7	8	9	10	11	12

Total Practice Score		Average Score (Total Practice Score/4)	

PART 4: CONTINUOUS & TEAM BASED HEALING RELATIONSHIPS

4A Establish and provide support for care teams accountable for the patient population.

4B Link patients to a nominated GP and care team so both patients and the nominated GP/care team recognise each other as partners in care.

4C Ensure that patients are able to see their nominated GP or care team whenever possible.

4D Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members

Items	Level D			Level C			Level B			Level A		
13. Patients are encouraged to see their nominated GP and care team	…only at the patient's request.			…by the care team, but is not a priority in appointment scheduling.			…by the care team and is a priority in appointment scheduling, but patients commonly see other GPs because of limited appointment availability or other issues.			…by the care team, as a priority in appointment scheduling, and patients usually see their own nominated GP or care team.		
	1	2	3	4	5	6	7	8	9	10	11	12
14. Non-GP care team members	…play a limited role in providing clinical care.			…are primarily tasked with managing patient flow and triage.			…provide some clinical services such as assessment or self-management support.			…perform key clinical service roles that match their abilities and credentials.		
	1	2	3	4	5	6	7	8	9	10	11	12
15. The practice	…does not have an organised approach to identify or meet the training needs for GPs and other staff.			…routinely assesses training needs and ensures that all staff are appropriately trained for their roles and responsibilities.			…routinely assesses training needs, ensures that staff are appropriately trained for their roles and responsibilities, and provides some cross training to permit staffing flexibility.			…routinely assesses training needs, ensures that staff are appropriately trained for their roles and responsibilities, and provides cross training to ensure that patient needs are consistently met.		
	1	2	3	4	5	6	7	8	9	10	11	12

Total Practice Score		Average Score (Total Practice Score/3)		

PART 5: ORGANISED, EVIDENCE-BASED CARE

5A Use planned care according to patient need.

5B Identify high risk patients and ensure they are receiving appropriate comprehensive and coordinated care services.

5C Use point-of-care reminders based on clinical guidelines.

5D Enable planned interactions with patients by making up-to-date information available to GPs and the care team at the time of the visit.

Items	Level D			Level C			Level B			Level A		
16. Comprehensive, guideline-based information on prevention or chronic illness treatment	…is not readily available in practice.			…is available but does not influence care.			…is available to the Care Team and is integrated into care protocols and/or reminders.			…guides the creation of tailored, individual-level data that is available at the time of the visit.		
	1	2	3	4	5	6	7	8	9	10	11	12
17. Visits	…largely focus on acute problems of patients.			…are organised around acute problems but with attention to ongoing illness and prevention needs if time permits.			…are organised around acute problems but with attention to ongoing illness and prevention needs if time permits. The practice also uses clinical audit tool reports to proactively identify and recall patients for planned care visits.			…are organised to address both acute and planned care needs. Tailored guideline-based information is used in team meetings to ensure all outstanding patient needs are met at each encounter.		
	1	2	3	4	5	6	7	8	9	10	11	12
18. Care plans	…are not routinely developed or recorded.			…are developed and recorded but reflect GPs' priorities only.			…are developed collaboratively with patients (and their families and carers where applicable), and include self-management and clinical goals, but they are not routinely recorded or used to guide subsequent care.			…are developed collaboratively, by the patient (and their families and carers where applicable) and care team to include self-management and clinical management goals are routinely recorded, and guide patient care in the practice and across the health care neighbourhood.		
	1	2	3	4	5	6	7	8	9	10	11	12
19. Coordinated care management services for high-risk patients	…are not available.			…are provided by external care coordinators with limited connection to practice.			…are provided by external care coordinators who regularly communicate with the care team.			…are systematically provided by the care coordinators functioning as a member of the care team, regardless of location.		
	1	2	3	4	5	6	7	8	9	10	11	12
20. Mental health, alcohol abuse and behaviour change outcomes, such as improvement in depression	…are not measured.			…are measured but not tracked.			…are measured and tracked on an individual patient level.			…are measured and tracked on a population-level for the entire practice with regular review and quality improvement efforts employed to optimise outcomes.		
	1	2	3	4	5	6	7	8	9	10	11	12

Total Practice Score		Average Score (Total Practice Score/5)		

PART 6: PATIENT-CENTRED INTERACTIONS*

6A Respect patient and family values and expressed needs.

6B Encourage patients to expand their role in decision-making, health-related behaviours, and self-management.

6C Communicate with their patients in a culturally appropriate manner, in a language and at a level that the patient understands.

6D Provide self-management support at every visit through goal setting and action planning.

6E Obtain feedback from patients/family about their healthcare experience and use this information for quality improvement.

* Includes patient's families and carers where applicable.

Items	Level D			Level C			Level B			Level A		
21. Assessing and respecting patient and family values and preferences	…is not done.			…is done, but not used in planning and organising care.			…is done and GPs and care team members incorporate it in planning and organising care on an ad hoc basis.			…is systematically done and incorporated in planning and organising care.		
	1	2	3	4	5	6	7	8	9	10	11	12
22. Involving patients in decision-making and care	… is not a priority.			…is accomplished by provision of patient education materials or referrals to self-management sessions.			…is supported and documented by care teams.			…is systematically supported by care teams trained in decision-making techniques.		
	1	2	3	4	5	6	7	8	9	10	11	12
23. Patient comprehension of verbal and written materials	...is not assessed.			…is assessed and accomplished by ensuring that materials are at a level and in a language that patients understand.			…is assessed and accomplished by hiring multi-lingual staff, and ensuring that materials and communications are at a level and language that patients understand.			…is supported at a practice level by translation and interpreting services, hiring multi-lingual staff, and training staff in health literacy and communication techniques (such as closing the loop and teach-back) ensuring that patients know and understand what to do to manage conditions at home and when they need to access care.		
	1	2	3	4	5	6	7	8	9	10	11	12
24. Self-management support	…is limited to the distribution of information (pamphlets, booklets).			…is accomplished by referral to self-management sessions or educators.			…is provided by goal setting and action planning with members of the care team.			…is provided by members of the care team trained in patient empowerment, health coaching and problem-solving methodologies.		
	1	2	3	4	5	6	7	8	9	10	11	12
25. The principles of patient-centred care	…are included in the practice's vision and mission statement.			…are a key practice priority and included in training and orientation.			…are explicit in job descriptions and performance metrics for all staff.			…are consistently used to guide practice changes and measure system performance as well as care interactions at the practice level.		
	1	2	3	4	5	6	7	8	9	10	11	12
26. Measurement of patient-centred interactions	…is not done or is accomplished using a survey administered sporadically at the practice level			…is accomplished through patient representation on boards and regularly soliciting patient input through surveys.			…is accomplished by getting frequent input from patients and families using a variety of methods such as point of care surveys, focus groups, and ongoing patient advisory groups.			…is accomplished by getting regular and actionable input from patients and families on all care delivery issues, and incorporating their feedback in quality improvement activities.		
	1	2	3	4	5	6	7	8	9	10	11	12

Total Practice Score		Average Score (Total Practice Score/6)		

PART 7: CARE COORDINATION

7A Link patients with community resources to facilitate referrals and respond to social service needs.

7B Integrate behavioural health and specialty care into care delivery through co-location or referral protocols.

7C Track and support patients when they obtain services outside the practice.

7D Follow-up with patients within a few days of an emergency room visit or hospital discharge.

7E Communicate test results and care plans to patients, their families and carers.

Items	Level D			Level C			Level B			Level A		
27. Medical and surgical specialty services	…are difficult to obtain reliably.			…are available from community specialists but are neither timely nor convenient.			…. are available from community specialists and are generally timely and convenient.			…are readily available from specialists who are members of the care team or who work in a practice with which the practice has a referral protocol or agreement.		
	1	2	3	4	5	6	7	8	9	10	11	12
28. Mental health services	…are difficult to obtain reliably.			…are available from mental health specialists but are neither timely nor convenient.			…are available from community specialists and are generally timely and convenient.			…are readily available from mental health specialists who are members of the care team or who work in a community with which the practice has a referral protocol or agreement.		
	1	2	3	4	5	6	7	8	9	10	11	12
29. Patients in need of specialty care, hospital care, or supportive community- based resources	…cannot reliably obtain needed referrals to health care providers with whom the practice has a relationship.			…obtain needed referrals to health care providers with whom the practice has a relationship.			…obtain needed referrals to health care providers with whom the practice has a relationship and relevant information is communicated in advance.			…obtain needed referrals to health care providers with whom the practice has a relationship, relevant information is communicated in advance, and timely follow-up after the visit occurs.		
	1	2	3	4	5	6	7	8	9	10	11	12
30. Follow-up by the practice and care team with patients seen in the Emergency Department (ED) or hospital	...generally does not occur because the information is not available to the care team.			…occurs only if the ED or hospital alerts the practice.			…occurs because the practice makes proactive efforts to identify and track patients.			…is done routinely because the practice has arrangements in place with the ED and hospital to track these patients and ensure that follow-up is completed within a few days.		
	1	2	3	4	5	6	7	8	9	10	11	12
31. Linking patients to supportive community-based resources	…is not done systematically.			…is limited to providing patients a list of identified community resources in an accessible format.			…is accomplished through a designated care coordinator or resource responsible for connecting patients with community resources.			…is accomplished through active care coordination between the practice, health care neighbourhood (providers and community service agencies) and patients and accomplished by a designated care coordinator.		
	1	2	3	4	5	6	7	8	9	10	11	12
32. Test results and care plans	…are not communicated to patients.			…are communicated to patients on an ad hoc approach.			…are systematically communicated to patients in a way that is convenient to the practice.			…are systematically communicated to patients in a variety of ways that are convenient to patients.		
	1	2	3	4	5	6	7	8	9	10	11	12

Total Practice Score		Average Score (Total Practice Score/6)		

PART 8: ENHANCED ACCESS

8A Promote and expand access by ensuring that enrolled patients have timely access to care during business hours through a choice of interactions, and there is appropriate after hours coverage.

8B Provide appointment options that are patient- and family-centred and accessible to all patients.

8C Help patients understand any out of pocket expenses that may be incurred.

Items	Level D			Level C			Level B			Level A		
33. Appointment systems	…are limited to a single practice visit type.			…provide some flexibility in scheduling different visit lengths.			… provide flexibility and include capacity for same day visits.			…are flexible and can accommodate customised visit lengths, same day visits or scheduled follow-up, primary GP visits.		
	1	2	3	4	5	6	7	8	9	10	11	12
34. Contacting the care team during regular practice 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 the patient a choice of interactions (e.g. in-person, email, text message), utilising systems which are monitored for timeliness.		
	1	2	3	4	5	6	7	8	9	10	11	12
35. After-hours access	...is not available or limited to an answering machine.			…is available from a contracted after hours service or other arrangement (e.g. the practice provides after hours service) without a standardised communication protocol back to the practice for urgent problems.			…is provided by a contracted after hours service or other arrangement that shares necessary patient data (e.g. can access the patient's My Health Record and Event Summary or provides another written summary to the practice).			…is available via the patient's choice of telephone or in-person directly from the care team or a contracted after hours service or other arrangement closely in contact with the care team and patient information.		
	1	2	3	4	5	6	7	8	9	10	11	12
36. A patient's out of pocket expenses	…are the responsibility of the patient to resolve.			…are addressed by the practice's administration team.			…are discussed with the patient prior to the visit.			…are viewed as a shared responsibility for the patient and an assigned member of the practice to resolve together.		
	1	2	3	4	5	6	7	8	9	10	11	12

Total Practice Score		Average Score (Total Practice Score/4)		

Scoring Summary

Change Concept	Average Subscale Score
Engaged Leadership	_____
Patient Enrolment	_____
Quality Improvement (QI) Strategy	_____
Continuous and Team-Based Healing Relationships	_____
Organised, Evidence-Based Care	_____
Patient-Centred Interactions	_____
Care Coordination	_____
Enhanced Access	_____
Average Program Score *(Sum of Average Scores for all 8 Change Concepts/8)*	_____

What Does It Mean?

The HCH-A includes 36 items and eight sections each scored on a 1 to 12-point scale. Scores are divided into four levels, A through D. The overall score is the average of the eight subscale or Change Concept scores.

For each of the items, Level D scores reflect absent or minimal implementation of the key change addressed by the item. Scores in Level C suggest that the first stage of implementing a key change may be in place, but that important fundamental changes have yet to be made. Level B scores are typically seen when the basic elements of the key change have been implemented, although the practice still has significant opportunities to make progress with regard to one or more important aspects of the key change.

Item scores in the Level A range are present when most or all of the critical aspects of the key change addressed by the item are well established in the practice. Average scores for each Change Concept, and for all 36 items on the HCH-A, can also be categorised as Level D through A, with similar interpretations. That is, even if a few item scores are particularly low or particularly high, on balance practices with average scores in the Level D range have yet to implement many of the fundamental key changes needed to be a HCH-A, while those with average scores in the Level A range have achieved considerable success in implementing the key design features of the HCH-A as described by the Change Concepts for Practice Transformation.

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