Australian Government
Department of Health

HEALTH CARE HOMES
Patient-centred Coordinated Flexible

Health Care Homes FAQ booklet

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These FAQs include minor revisions made in September 2017

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1 Staged start for Health Care Homes' services

Under a staged start to Health Care Homes' services announced as part of 2017 Budget measures, 20 practices will begin Health Care Home services on 1 October 2017. These will be announced soon. The remaining 180 practices will begin on 1 December 2017.

2 Payments

2.1 How do payments to Health Care Homes change from current Medicare Benefits Schedule (MBS) arrangements?

A new bundled payment approach will enable the Health Care Home model. The approach moves away from traditional fee-for-service, where services are provided on a transactional basis. The bundled payment will be paid according to complexity and should cover all of the clinical services provided by the Health Care Home associated with managing the patient's complex and chronic needs.

A bundled payment to the practice will enable flexibility in how services are delivered. This new approach will encourage practice level innovation — broadening the use of technology and the roles of the workforce in the services a Health Care Home offers.

2.2 How will Health Care Homes get paid?

Health Care Homes will register each enrolled patient through the Department of Human Services' (DHS) Health Professionals Online Services (HPOS) system. Monthly payments will be made to the practice on a retrospective basis.

2.3 How much will Health Care Homes receive for each enrolled patient?

Enrolled patients are eligible for one of three levels of payment. The amount paid is linked to each eligible patient's level of complexity and need, with the highest amount paid for the most complex and high-need patients.

The payment values represent 'best practice' annual packages of care for each tier level and recognise the individual variations in service delivery that patients will require at each tier level. Not all patients will require the maximum level of services possible within the payment. Payment values are:

Tier 3 – $1,795 per annum (highest complexity)
Tier 2– $1,267 per annum
Tier 1 – $591 per annum (lowest complexity)

2.4 How were the payment amounts calculated?

In developing the payment values, the characteristics of patients in each tier were identified, including through an analysis of similar patient identification models developed in Australia. Work was then undertaken with the department's medical

advisers to notionally allocate a clinical best practice annual package of care against each tier, utilising existing MBS items.

Although MBS items and current billing patterns were used to inform the clinical best practice package of care, the approach moves away from a fee-for-service model to support a flexible approach to the care of enrolled patients. The list of MBS items that determined the package does not directly determine what care is provided.

Health Care Homes will be required to provide particular services for each enrolled patient — for example the development of a shared care plan and regular reviews, and the model of care should move to one which is patient-centred, coordinated, team-based and flexible. However, how the payment is utilised is determined by the Health Care Home and the patient, working together to identify the patient's needs and goals.

2.5 What happens if the enrolled patient gets very sick and needs more care beyond what their bundled payment covers?

The bundled payment recognises that a patient's care may vary in intensity across an annual cycle of care, and that across the practice some patients will require fewer services than the payment level; others may require more in a given period. However, if the patient gets very sick and the Health Care Home model does not meet their needs then the patient can be withdrawn and treated under normal MBS arrangements.
See also 2.4 How were the payment amounts calculated?

2.6 If the care a patient needs is less than the bundled payment – do practices keep the unspent funds or are they returned to the government?

The bundled payment recognises that a patient's care may vary in intensity across an annual cycle of care. If the patient has been allocated to the correct tier, and clinical best practice care has been provided and they do not require the full annual amount, then the practice retains the funds.

2.7 Will any of the Practice Incentives Program (PIP) payments change for participating general practices and ACCHS?

General practices and ACCHS that participate in stage one will also be able to participate in PIP where they meet current eligibility requirements. Any PIP payments to a general practice or ACCHS will be in addition to the bundled payments. Recognising that PIP incentive payments are often dependent upon MBS billing, solutions to enable these payments to include interactions with enrolled Health Care Home patients, and the timing of the payments are being worked through.

A number of PIP incentives may be consolidated into a new quality improvement PIP focusing on data collection and improvement. A consultation process was recently undertaken by the department, with submissions closing on 30 November 2016, in which stakeholder views on how the PIP might best foster quality improvement and drive innovation were sought. Health Care Homes will be able to participate in the new PIP quality improvement incentive providing they meet any eligibility criteria that may be developed following the consultation process.

2.8 What should a practice that is not a Health Care Home do if a Health Care Home enrolled patient visits their practice and receives care related to their chronic conditions, and their enrolled status is not determined until after the consultation? Will the practice still be able to bill Medicare?

If a patient enrolled in a Health Care Home seeks services for their chronic condition from another practice, whether that practice is a Health Care Home or not, the practice providing that service will be able to bill the MBS for the service provided.
To realise the benefits of the Health Care Home model, patients do need to be receiving services from the Health Care Home care team. Patient information and practice education resources will highlight the benefits of the Health Care Home model to support all parties to understand their responsibilities as enrolled patients. Health Care Homes may wish to check in on their patients' understanding of the model intermittently.

2.9 Is the payment going to have indexation applied annually?

Indexation will not be applied to the payments during stage one.

2.10 Is there any acknowledgement of urban versus rural practice differences?

The General Practice Rural Incentive Program (GPRIP) will continue and the patient identification tool takes into account the range of social determinants of health that are known to contribute to poorer health outcomes for people living in rural and remote areas.

The bundled payment approach increases the flexibility at the general practice level, allowing accommodation for individual needs and regional difference, including through increased use of telehealth services in rural and remote areas and non-face to face patient consultation where appropriate.

3 Services included / not included and patient access to other services

3.1 What services will Health Care Homes provide for the payment and what MBS item numbers do the payments replace?

All general practice health care associated with the patient's chronic conditions, including that provided by a practice nurse or nurse practitioner working in the Health Care Home, previously funded through the MBS, will be funded through the payment. MBS items should only be claimed for routine care not related to the patient's chronic conditions. Examples of services could include care planning, comprehensive health

assessments, making referrals to allied health providers or specialists, telehealth services and monitoring, case conferencing, and standard consultations.

For enrolled patients, MBS items should only be claimed for routine care not related to the management of the patient's chronic conditions.

Health Care Homes will be required to provide particular services for each enrolled patient, for example the development of a shared care plan and regular reviews; and the model of care should move to one which is patient-centred, coordinated, team-based and flexible. However, how the payment is utilised is determined by the Health Care Home and the patient, working together to identify the patient's needs and goals.

Allied health, specialist services, diagnostic imaging and pathology are excluded from the payment and can be billed as per usual via the MBS along with episodic care unrelated to a patient's chronic condition. See also **3.5 How are allied health, specialist, diagnostic and imaging services included in the model and are these services included in the bundled payment?**

All general practice health care associated with the patient's chronic conditions, including that provided by a practice nurse or nurse practitioner working in the Health Care Home, previously funded through the MBS, will be funded through the payment. MBS items should only be claimed for routine care not related to the patient's chronic conditions. Examples of services could include care planning, comprehensive health assessments, making referrals to allied health providers or specialists, telehealth services and monitoring, case conferencing, and standard consultations. **See also 2.4 How were the payment amounts calculated?**

3.2 Can enrolled patients still access fee-for-service billing and can they still access other primary care and general practice services if necessary?

Enrolled patients can still access fee-for-service billing for episodes of care not related to a patient's chronic conditions. This will also enable patients to visit different practices, for example when travelling. The number of fee-for-service episodes of care, in addition to the bundled payment, will not be capped or restricted, and will be monitored during stage one.

Patients will, however, be strongly encouraged, both through patient information resources and discussions with their Health Care Home, to make every effort to receive all care — including routine and chronic disease related care — from the Health Care Home with which they are enrolled.

3.3 Does the payment include after-hours services?

A key feature of the Health Care Home model is that patients have enhanced access to care provided by their Health Care Home in-hours (which may include non-face-to-face support) and effective access to after-hours advice and care. This will be outlined in the guidelines that Health Care Homes will adhere to, as well as supported through training. While the department does not intend to prescribe how this is to occur

(recognising that after-hours arrangements vary between practices), the evaluation of stage one will provide an ability to assess how this is being achieved. Further to this, an expected outcome of the Health Care Home model is reduced need for unplanned after-hours care related to enrolled patients' chronic conditions.

In this context, Health Care Home bundled payments are intended to cover after-hours advice and care provided by the Health Care Home practice. After-hours services provided by other providers can continue to be billed to the MBS.

The PIP After-Hours Incentive will continue to support practices to provide their patients with appropriate access to after-hours care, with the highest payment going to those practices that provide after-hours care for all of their patients during the complete after hours period (i.e. 24 hours a day) when required.

3.4 Can Health Care Homes still access chronic disease management items (CDMI) for patients who are not enrolled?

Health Care Homes will still be able to access all existing MBS items, including CDMI — for example, GP Management Plans and Team Care Arrangements — for patients who are not eligible or enrolled.

3.5 How are allied health, specialist, diagnostic and imaging services included in the model and are these services included in the bundled payment?

The Health Care Home will coordinate with other care providers, including allied health professionals, pharmacists and specialists, to assist enrolled patients to navigate the health system. The aim is that eligible patients, through assisted care coordination, will be further encouraged to access existing entitlements and services to support the management of their health conditions.

Funding for services provided by allied health professionals and specialists as well as for diagnostic and imaging services is not included in the bundled payment will continue to be funded through the MBS.

Diagnostic services provided by a Health Care Home that are not related to an enrolled patient's chronic conditions are also not included in the bundled payment and will continue to be funded through the MBS. Where diagnostic services are provided by a Health Care Home as part of the monitoring and management of an enrolled patient's chronic conditions, they should be funded through the bundled payment.

Eligibility for allied health services that are currently triggered by a GP Management Plan, a Health Assessment for Aboriginal and Torres Strait Islander People, or a GP Mental Health Treatment Plan, will be triggered by Health Care Home enrolment.

3.6 How are pharmacists involved in the model?

For many of the patients enrolled with a Health Care Home, it is likely that medication management and advice will be a critical part of their care plan. The current funding provided to pharmacists for Home Medication Reviews is not part of the bundled payment and will continue to be funded through the MBS.

Many general practices and ACCHS already have effective mechanisms in place for involving pharmacists in providing care for patients with chronic and complex conditions. The flexibility provided by the Health Care Home model will further support local Health Care Homes to establish and build on existing arrangements.

3.7 How is it envisaged that Health Care Homes will interact with community health programs?

The aim is that eligible patients, through assisted care coordination, will be further encouraged to access existing entitlements and services, including community health and state government services, to support the management of their health conditions. Primary Health Networks (PHN) will have a vital role in continuing to support linkages between general practices and community health providers and Local Health Networks/Local Health Districts (LHNs/LHDs).

In addition, the department is currently working with state and territory governments to develop new bilateral agreements to enhance coordinated care and reduce avoidable hospital admissions. These agreements will include activities to better align the parts of the health system, such as community health programs and general practice, which are funded by different levels of government to support and benefit Health Care Homes.

3.8 What is the role of private health insurers (PHI)?

The introduction of Health Care Homes will not change the range of primary health care services that insurers can cover (e.g. insurers will not be able to fund GP services).

In line with current arrangements, under general treatment policies, insurers will be able to assist members who enrol in a Health Care Home with the costs of approved services received outside of the hospital setting which are not covered by Medicare (i.e. additional services). For example, an enrolled patient may access PHI-funded dental, optical, dietetics and physiotherapy services.

Insurers will continue to fund an expanded range of primary health care services for their members, and continue to be able to fund hospital substitute and palliative care services for members who enrol in Health Care Homes. In doing so, they can provide members with choice to receive care outside the hospital environment.

Privately insured patients will be encouraged to inform their Health Care Home of their PHI provider as many insurers provide access to a range of services that can support the patient better manage their chronic and complex conditions. They will also be encouraged to share their enrolled health status and care plan if appropriate with their PHI provider. Many private health insurers develop care plans and rather than multiple plans, care will be better informed through a single shared care plan.

4 Bulk billing and patient contributions

4.1 Will enrolled patients who are currently bulk billed still be bulk billed and will there be changes for patients who already pay a patient contribution?

Many patients with chronic and complex conditions are bulk billed for primary health care services. Health Care Homes are strongly encouraged to continue to bulk bill for enrolled patients. However consistent with current approaches in many practices, enrolled patients will be able to contribute towards their health care costs. The determination and management of patient contributions will be up to each Health Care Home and must be agreed with the patient at the time of enrolment.

4.2 Before enrolment, there will need to be conversations with eligible patients about the model of care. How will these consultations be funded?

Up until the point where a patient is enrolled and registered, consultations will still be billed to the MBS.

4.3 Is a Health Care Home patient able to be charged for consumables e.g. dressings?

Bundled payments are flexible and do not attract the same restraints as Medicare bulk billing. However, Health Care Homes are not intended to increase the out of pocket expenses for patients. Any charges introduced by a participating practice, such as a fee for dressings, must be explicitly discussed with the patient, and as appropriate their carer, prior to enrolment in the program.

5 Patient identification, eligibility, enrolment and attrition

5.1 Is there an age restriction for patient enrolment?

No, there is no age restriction. It is anticipated that the majority of enrolled patients will be 45 years old and over as the incidence of multiple chronic and complex conditions generally increases with age.

5.2 What about children with chronic and complex conditions?

There is no age restriction. GPs and other primary health care professionals involved in the care of a child living with chronic and complex conditions will have to decide, in consultation with the patient and their families and/or carers, if this is the best model of care for these patients, as is the case for all eligible patients.

5.3 What conditions does a person have to have to be eligible to enrol?

Eligibility and payment will be based on the complexity of the patient's chronic conditions, not on specific disease diagnoses.

Work is currently underway to develop a universal patient identification and risk stratification tool to determine patient eligibility. Once a patient is assessed as eligible, the tool will assign them to one of three tiers based on complexity and need. Assigning a complexity tier to a patient will draw upon information already captured in their medical record, such as diagnoses, medications, clinical risks and prior service use. Non-clinical information is also important, such as demographic and psycho-social factors, and this will be assessed through a conversation with the patient and, where appropriate, their family members/carer.

5.4 What if a patient's health improves or deteriorates? Will they move to a different tier?

An enrolled patient's tier level will need to be reviewed using the risk stratification tool. Health Care Homes will be able to update the patient's classification on the DHS HPOS payment system to adjust the tier to recognise the deterioration or improvement of the patient.

5.5 How many patients does a Health Care Home need to enrol and will there be a minimum number of patients that a general practice will have to enrol?

For stage one, participation will be limited to 65,000 patients within 200 practices across ten PHN geographical regions

While recognising that there is wide variation in the size of general practices and Aboriginal Community Controlled Health Services across Australia, the modelling for stage one was based on the assumptions that the average general practice in Australia has 5 full time equivalent (FTE) GPs and that approximately 70 patients per GP would be eligible for enrolment.

Health Care Homes will be expected to begin enrolling eligible patients prior to:

- 1 October 2017 for the 20 practices commencing services in October 2017
- or prior to 1 December 2017 for the other 180 practices

Enrolment is expected to be staggered across the course of the first 12 months of service delivery.

Health Care Homes should enrol as many eligible patients as possible. It is recognised that patient demographics in the local area and the FTE status of GPs within the Health Care Home will impact on actual recruitment numbers.

However, the rate of patient enrolment will be monitored during stage one. If necessary, participating Health Care Homes will be notified when the maximum level of patient enrolment is met.

5.6 How long will it take to enrol and register a patient to be part of the program?

This will vary, and will in part be dependent upon the data already available within participating Health Care Homes.

Work is currently underway to develop a universal patient identification and risk stratification tool that will be used by Health Care Homes. The tool will consist of a two-step process where it will firstly identify the potentially eligible patient cohort in the practice and then secondly assess each individual patient to confirm eligibility and assign a risk tier.

Assigning a complexity tier to a patient will draw upon information already captured in their medical record, such as diagnoses, medications, clinical risks and prior service use. This process will be automated, where possible, through the risk stratification software. Non-clinical information is also important, such as demographic and psycho-social factors, and this will be assessed through a conversation with the patient and, where appropriate, their family members/carers.

Once a patient has been confirmed as eligible and has agreed to enrol in the Health Care Home they will be required to sign consent forms and the practice can then register the patient on the DHS HPOS system.

The training program being developed for participating Health Care Homes will include a section on patient enrolment and the department will continue to work with PHNs to identify where they may be able to assist with patient enrolment.

5.7 Can eligible patients be identified now?

The patient identification and risk stratification tool is currently being developed and is not yet available. Some general practices and ACCHS may already have data systems in places where they can identify the likely patient cohort, based on the tier characteristics and risk stratification tools detailed in the patient eligibility factsheet. Go to More information on the Health Care Homes for health professionals' page at: health.gov.au/healthcarehomes

The tool being developed is based on the QAdmissions tool and the Hospital Admission Risk Programme (HARP). **See also 4.11, 4.12 and 4.13.**

5.8 Can a Health Care Home reject a patient's request to enrol?

Only eligible patients can be enrolled. If the lead clinician undertaking the assessment believes that the model of care would not be appropriate for the patient then this should be explained to the patient. Patients can only be enrolled by the Health Care Home.

5.9 Do all Health Care Homes have to use the same patient identification tool and who ultimately decides the tier level of a patient?

Each Health Care Home will use the same patient identification tool, which is currently being developed by the department. The tool will be provided free to all participating Health Care Homes.

This is to ensure that patient identification and the process of assigning a complexity tier (and the corresponding payment) is consistent across all Health Care Homes.

In assigning a complexity tier to a patient, the tool will draw upon information already captured in their medical record, such as diagnoses, medications, clinical risks and prior service use.

Non-clinical information will also be important, such as demographic and psycho-social factors, which will be assessed in a conversation with the patient and, where appropriate, family members/carers. This approach allows the clinician to ensure that any information that they are aware of which impacts on the patient's health and ability to manage their health, can be incorporated. **See also 5.6. How long will it take to enrol and register a patient to be part of the program?**

5.10 Will the patient identification tool be integrated with clinical information systems or will it use third party software?

The patient identification tool will use third party software which will include the capability to draw information from the majority of clinical information systems in use in general practices and ACCHS in Australia.

5.11 What is QAdmissions?

QAdmissions is a validated clinical risk prediction tool which can be used to assess a person's risk of emergency hospital admission over 1-2 years. The tool was developed in the United Kingdom and requires some modification for the Australian population.

Go to QAdmissions for more information on this tool.

5.12 Will QAdmissions capture Indigenous Australians and does it capture the impact of location on access to health care?

Yes. It currently includes an ethnicity variable which would require modification to the Australian population to incorporate Indigenous status. It currently uses a postcode to estimate a patient's deprivation using the Townsend Deprivation Index. In Australia, QAdmissions could be modified using the Australian Bureau of Statistics Socio-Economic Indexes for Areas. This would help capture impact of location on access to healthcare.

5.13 What is HARP?

The Hospital Admission Risk Program (HARP) is used to determine the overall risk of a person presenting to hospital in the next 12 months. The tool assesses presenting clinical symptoms, service access profile, self-management and psycho-social issues and classifies people into one of four categories (low, medium, high and urgent). Go to the HARP calculator for more information on this tool.

5.14 How will Indigenous status impact risk stratification and patient identification?

Indigenous status is one of many factors that can be taken into account to determine a patient's likelihood of unplanned hospitalisation and their risk tier. It is important to note that:

- Indigenous status alone is not sufficient to determine a patient's level of complexity.
- Individuals who currently, or in the future choose not to identify as Indigenous on their health records, will have their level of complexity assessed based on other relevant factors.

5.15 Are Department of Veterans Affairs patients currently on the Coordinated Veterans Care (CVC) program eligible to be enrolled?

Patients participating in CVC are not eligible as they already have access to a comparable service and would not receive additional benefit from enrolling in a similar service.

5.16 Are residents of residential aged care facilities eligible?

Patients who are residents of residential aged care facilities will not be eligible for enrolment in stage one. This will be considered in future implementation to ensure consistency with the significant reforms currently underway in the aged care sector.

5.17 How will natural attrition of patients be handled?

The modelling for stage one undertaken by the department incorporates natural levels of attrition resulting from patients moving and dying. For participating Health Care Homes, there will be a simple process of regularly acquitting the list of patients still enrolled with those identified as currently enrolled by DHS. Health Care Homes will receive payments including part payments up until the date of withdrawal by the patient.

5.18 What happens if an enrolled patient fails to engage with a Health Care Home after enrolment?

As part of the patient enrolment process, eligible patients will be provided with information about the Health Care Home model. After discussion with their health care team, patients will be asked to enrol. Enrolled patients agree to attend the general practice or ACCHS of their choice on an ongoing basis and commit to working

together in partnership with their health care team to identify their goals and needs to better manage their health.

If, despite attempts by the Health Care Home, the patient continues to not engage, the patient should be withdrawn by the Health Care Home. This can occur through the process where participating Health Care Homes will regularly acquit the list of patients still enrolled with those identified as currently enrolled by DHS. In such situations the patient will need to be notified by the Health Care Home of their withdrawal.

5.19 Is the eligibility definition that the practice or patient needs to be in the PHN region?

Eligible general practices and ACCHS need to be in one of the ten geographical PHN regions of:

- Perth North
- Northern Territory
- Brisbane North
- Nepean Blue Mountains
- Western Sydney
- Hunter, New England and Central Coast
- South Eastern Melbourne
- Tasmania
- Country South Australia
- Adelaide

Patients will need to enrol with a Health Care Home in one of these regions. Whilst it is likely most patients will also reside in the region of their nominated Health Care Home, this is not a requirement, recognising that some Health Care Homes may be located on the boundary of regions.

5.20 Are there strategies in place to minimise the risk of practices enrolling patients that are regular patients of another practice or ACCHS?

Enrolling a patient is a long term commitment by the Health Care Home. The risk stratification tool is designed to identify eligible patients within the existing practice population in the first instance, and a reasonable medical history will be essential to this process.

The patient enrolment process also requires an informed and signed commitment from the patient to work in partnership with the Health Care Home in an ongoing arrangement.

Patient enrolment will be monitored throughout stage one and Health Care Homes will be required to reconcile active patients against registration records on a bi-annual basis.

5.21 Will a practice be able to look up if a patient is enrolled with a Health Care Home?

No, not in stage one. The patient enrolment process, however, is comprehensive enough that patients or their carers will know if they are enrolled with a Health Care Home and as such, practices are encouraged to ask potentially eligible patients of their enrolment status.

The HPOS system will not accept the enrolment of a patient at more than one practice. Patients are only able to enrol with one practice during stage one.

5.22 What happens if an enrolled patient relocates interstate from another PHN area, and registers with us. How will sharing of the annual fee be determined?

In stage one, patients who withdraw from one Health Care Home will not be able to enrol with another Health Care Home. As such, patients who move to a new practice that is also participating in stage one, either locally or interstate, will not be able to transfer their enrolment status to the new practice. During stage one, the evaluation aims to capture the reasons patients withdraw, including due to relocation. See also 5.17. How will natural attrition of patients be handled?

5.23 Are there resources for consumers?

Consumer information is available on the Health Care Homes' consumer page at: health.gov.au/healthcarehomes-consumer

Additional resources are being developed and will be sent to each participating Health Care Home for distribution to potentially eligible patients. These brochures and fact sheets will also be uploaded onto the Health Care Homes' consumer page.

6 Aboriginal Community Controlled Health Services (ACCHS)

6.1 Will ACCHS be able to continue to access the other Commonwealth funding sources if they participate in stage one? If an ACCHS becomes a Health Care Home could they still also receive block funding for primary health care services?

Yes. Participating ACCHS can continue to access grant payments made under the Indigenous Australians' Health Programme (IAHP), including funding for primary health care activity.

Funding for PHNs to commission integrated team care (ITC) services will also continue at current levels in stage one. An ACCHS which participates in Health Care Homes' stage one will still be able to tender to provide ITC services.

6.2 If participation in the PIP eHealth Incentive (ePIP) is a requirement for practices to apply for Health Care Homes, will this exclude ACCHS if they are not ePIP registered?

All participating practices or ACCHS must register for ePIP before 1 December 2017.

6.3 If patients voluntarily enrol with a participating medical clinic, how will this work for transient patients?

Enrolled patients will still be able to access MBS benefits if they need to see a different health care provider outside their Health Care Home. Transient patients may be able to be treated by a number of Health Care Homes, where a lead Health Care Home would be nominated and manage the distribution of funds accordingly. Such arrangements would need to be negotiated between participating Health Care Homes. For patients who move between communities and who are not able to nominate and agree to a preferred Health Care Home provider, MBS billing may be more suitable than Health Care Home enrolment.

6.4 Are patients who are being care coordinated under the Integrated Team Care (ITC) activity funded by the Department of Health/PHN eligible for Health Care Home services?

Patients receiving care coordination support under an ITC activity who also meet Health Care Home eligibility requirements can be considered for Health Care Home enrolment in stage one. The Health Care Home care planning process will include an assessment of the range of services that an enrolled patient is currently receiving or eligible to access. The resulting care plan and services received should complement and not duplicate the services provided to enrolled patients.

7 Evaluation

7.1 What sort of information will practices need to provide for the evaluation? What KPIs are proposed and will providers be measured on health outcomes, outputs or activities?

Stage one of Health Care Homes will be evaluated to establish what works best for different patients and practices and in different communities with different demographics. The evaluation will need to examine the implementation process as well as the impact of the model. Findings will be used to make refinements to the model before government consideration of any further national roll out.

Health Care Homes **will be required** to participate in the evaluation by providing data in a number of ways.

The evaluation is not designed to measure the performance of individual practices or providers. Data will be aggregated and then analysed to examine how the model worked in various situations and settings. Practices will provide de-identified patient data from clinical software using an automated extraction process.

An evaluation plan will be developed in 2017. It will include details on the indicators, measures and methods of data collection. It is expected that this will include a range of information on patient and provider experience, practice processes, such as referrals and recording of risk factors, and care provision methods, quality of care and service use. In addition, it is expected to include general clinical indicators, such as blood pressure, BMI or smoking status.

Health Care Home practices will also **provide information** through surveys and a sample of practices will also **participate in interviews or focus groups.** These methods will inform the evaluation of the implementation process, types of care provided to patients and changes to practice service delivery model.

As part of the data collection process, information may be fed back to practices to assist them to benchmark their progress against national and regional averages. This information may help practices in their quality improvement activities and may assist PHNs to better target practice support activities. In this case, practice level data would only be seen by the practice itself. Data provided to PHNs would be aggregated across all practices.

7.2 What sort of information will patients need to provide for the evaluation?

Patient experience of the Health Care Home model will be a key issue for the evaluation. Patients will likely provide data for the evaluation through participation in surveys, interviews and focus groups.

Patients will also be asked to consent to their de-identified clinical data being extracted from within practice information systems as well as to the linking of their MBS, Pharmaceutical Benefits Scheme and hospital data for the purposes of the evaluation.

Patient participation in data collection for the evaluation will be voluntary.

7.3 Will there be a duplicate reporting requirement for ACCHS? For instance, ACCHS who report on National Aboriginal Health Key Performance Indicators (KPIs) using Pencat or Canning Tool?

The department will endeavour to minimise duplication wherever possible. One issue that will require consideration is that reporting on National Aboriginal Health KPIs is done at an aggregate level. In order to measure the effect of the Health Care Home model on patients across time, the evaluator will need to be able to link the data from individual patients across time points, and this is not likely to be possible using data that is aggregated at the practice level. The department will work with the Indigenous sector to determine the best use of available data.

7.4 How will reports be required? Electronically? Monthly?

Practices will provide de-identified patient data from clinical software using an automated extraction process. The timing and processes for data extraction, and other methods of evaluation data collection, is currently being considered. Outside of the

evaluation data collection methods, there will be reporting requirements for Health Care Homes regarding enrolment and assurance activities.

8 Business considerations and impacts

8.1 If a general practice or ACCHS withdraws from stage one do they have to pay back the grant funds of $10,000?

The intention is for a Health Care Home not to have to refund if it withdraws. However, the department reserves the right to do so depending on the circumstances and the timing of the withdrawal.

Any Health Care Home which withdraws will have to meet certain requirements, including ensuring that patients are well-informed about the withdrawal and then unenrolled; and evaluation input and data is provided, including the reasons for withdrawal.

8.2 Do all practitioners in a Health Care Home have to participate? If not, what happens to the patients of a participating practitioner when they go on leave?

All practitioners in a Health Care Home do not need to participate. However, the model represents a significant reform opportunity for practices and providers, and as many GPs as possible within the practice are encouraged to participate.

Because the payments will be made to the practice, not individual practitioners, Health Care Homes will be expected to have arrangements in place to ensure that continuity of care is provided to all enrolled patients in instances where their nominated lead clinician is unavailable, for example due to leave or part-time arrangements.

8.3 Do the payments go to the lead clinician (usually a GP) or to the practice? If they go to the practice how will practices know who provided which service to the patient, and how will the practice allocate these funds?

Monthly payments will be made to the practice on a retrospective basis. It will be up to each Health Care Home to determine how the payments are allocated across the practice and to monitor services provided within the Health Care Home.

The impact of the bundled payment and allocation of these funds is a significant change to how the majority of general practices currently operate.

To assist general practices and ACCHS to identify how they will manage this transition, the department funded the Australian Association of Practice Management (AAPM) to run a payment management webinar which is now available on the AAPM website

8.4 What if there is no FTE and a remote practice operates using locums only?

Key characteristics of the Health Care Home model include a patient's nomination of a lead clinician to support continuity and safety of care. Practices participating as Health Care Homes need to provide services that align with the key characteristics of the model.

8.5 Will a process be established to monitor the use of MBS billed services by Health Care Home patients?

The Health Care Home billing activity, through HPOS and the MBS systems will be monitored in line with current monitoring processes.