The Hon SUSSAN LEY MP
Minister for Health
Minister for Aged Care
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Media Release

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Health Care Homes to keep chronically-ill out-of-hospital

For the first time, Australians living with multiple complex and chronic illnesses will be able to officially enrol with their local GP to have all of their conditions and health care needs conveniently managed in one place, as part of the Turnbull Government’s revolutionary Healthier Medicare reform package, announced today.

One in five Australians now have multiple chronic conditions. This means they are living with any mix of heart disease, diabetes, cancer, mental health issues, eye disease, respiratory problems, arthritis and more.

Yet, Australians who are very high users of our health system saw an average of five different GPs in a year – triple those who are low users of our health system.

This fragmentation in the health system has led to a number of adverse and preventable issues for chronically-ill patients, as found by the Turnbull Government’s clinician-led Primary Health Care Advisory Group (PHCAG):

“Most patients with multiple chronic conditions receive treatment from many health providers: most of them working in different locations, and often working in different parts of the health system. This leads to concern regarding the quality and safety of patient care.”

“Every 2-3 hours in Australia there is an amputation that could have been prevented with better management of diabetes.”

To combat this, the Turnbull Government will support the establishment of ‘Health Care Homes’ in General Practices or primary health care services that will design tailored care plans (in consultation with these patients) that not only outline the health services they need, but coordinate them as well.

This means patients will be supported with access to coordinated medical, allied health and out-of-hospital services, regardless of whether they are provided by Medicare, state and local governments, the community sector or the multitude of other sources currently fragmenting the system.

This is supported by the recommendations of PHCAG, chaired by immediate past Australian Medical Association President and GP Dr Steve Hambleton:
“Personalised care is essential to addressing individuals' full range of needs.”

“Central to the reform is the establishment of Health Care Homes, which provide continuity of care, coordinated services and a team based approach according to the needs and wishes of the patient. Our new approach offers an opportunity to improve and modernise primary health care and maximise the role of patients as partners in their care. It represents innovative, evidence-based best practice that harnesses the opportunity of digital health care. Importantly, it has strong support from consumers and healthcare professionals.”
- PHCAG Report - Better Outcomes for People with Chronic and Complex Health Conditions

The new Health Care Homes model will also be supported by a more-flexible payment structure allowing health practitioners to focus on quality improvement without the rigid constraints of Medicare’s current fee-for-service model.

Primary Health Networks will have an important role in supporting Health Care Homes through the establishment and promotion of local clinical health pathways and through education and training support.

About 65,000 Australians will participate in initial two-year trials of Health Care Homes in up to 200 medical practices from 1 July 2017.

An extra $21 million will be committed to support the rollout of trials, starting 1 July 2016. The remaining balance of the package is expected to be cost neutral, in line with PHCAG recommendations, with further evaluation to continue ahead of a national rollout.

Our Healthier Medicare reforms will truly transform the way primary care is delivered and funded in this country by giving GPs the flexibility and tools they need to work with a patient’s full health care team to keep them happier, healthier and out-of-hospital.

“Reforms being considered to aged care, mental health and private health insurance, as well as review of key health care enablers such as digital health and the MBS, are designed to improve health system integration and highlight a shift in the service delivery paradigm towards better integrated, more regionally relevant, patient-centred care.”
- PHCAG Report - Better Outcomes for People with Chronic and Complex Health Conditions

Key features of Health Care Homes, as recommended by PHCAG and adopted by the Turnbull Government through its Healthier Medicare package of reforms, include:

- **Voluntary patient enrolment** with a practice or health care provider to provide a clinical ‘home-base’ for the coordination, management and ongoing support of patient care. This includes the development of an individualised care plan for patients tailored to their specific conditions and health care needs.

- **Patients, families and their carers as partners in their care** where patients are motivated to maximise their knowledge, skills and confidence to manage their health, aided by technology and with the support of a health care team.

- **Patients have enhanced access** to care provided by their Health Care Home in-hours, which may include support by telephone, email or videoconferencing, and effective access to after-hours advice or care.

- **Patients nominate a preferred clinician** who is aware of their problems, priorities and wishes, and is responsible for their care coordination.
• **Flexible service delivery and team based care** that supports integrated patient care across the continuum of the health system through shared information and care planning.

• **A commitment to care which is of high quality and is safe.** Care planning and clinical decisions are guided by evidence-based patient health care pathways, appropriate to the patient’s needs.

• **Data collection and sharing** by patients and their health care teams to measure patient health outcomes and improve performance.

*Case study – Option 1*

**The Health Care Home – Patient-Focused Care**

Michael is a 77 year old retired wood turner whose health is failing. He lives in the family home alone having lost his wife and his adult children have moved on. He has multiple medical problems including: depression; heart disease; osteoporosis; diabetes; cataracts; and chronic obstructive pulmonary disease. Michael is not looking after himself, he is eating poorly, has had multiple recent hospital admissions, and he is taking a number of medications that are causing serious side-affects.

The GP in Michael’s Health Care Home involves the local care team to help manage his issues with the focus being on making Michael’s life easier and safer. The GP develops a chronic disease management plan around Michael’s preference to continue to live independently. He is referred to the visiting dietician, diabetic educator and physiotherapist to enable him to better manage his medical care. A community pharmacist is asked to develop a medication management plan.

The Health Care Home also coordinates social services offered and funded by different Government and community programmes to improve Michael’s quality of life and provide the support he needs to continue to live independently. These include: organising the regional aged care assessment service to visit Michael in his home to assess his needs and to determine what type of home care package would suit him best; engaging a cleaner; finding a way to address home modifications recommended by a hospital based Occupational Therapist; and organising Meals on Wheels to deliver food.

As a result of this coordinated care Michael’s nutritional status improves and he feels stronger, more informed, better supported and more engaged with his care team. His GP and community pharmacist together rationalise the timing of use and the range of his medications. This improves his understanding of them and leads to increased compliance while minimising their side effects.

The future for Michael is looking much brighter as he regains autonomy.

*Case study – Option 2*

**The Health Care Home – Patient-Focused Care**

Derek is a 74-year-old retired coal miner who now lives on his own in the community after losing his partner. Derek has multiple health problems (including heart disease, osteoarthritis, poor hearing, and Type 2 Diabetes), and was recently hospitalised.

Derek saw his GP because he was having trouble breathing after a cold. Derek also told his GP he was not eating well and found it difficult to do the things he used to do because of increased pain in his left hip. The GP and health care team developed a care plan with Derek around his goals to remain independent and active. Derek was started on treatment for his breathing problems and was referred to a physiotherapist, dietician and psychologist.
Knowing that Derek had private health insurance, with Derek’s permission the practice contacted his private health insurer and arranged for Derek to register for an osteoarthritis management program being delivered by his insurer. Derek now feels more confident that he will be able to better manage his health into the future.

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