Australian Government
Department of Health

HEALTH CARE HOMES

Patient-centred | Coordinated | Flexible

INFORMATION BOOKLET
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Patient-centred Coordinated Flexible

HELP SHAPE AUSTRALIA'S HEALTHCARE SYSTEM

The implementation of the Health Care Home model in Australia is a timely opportunity to transform the way care is provided for people living with chronic and complex conditions.

General practices and Aboriginal Community Controlled Health Services (ACCHS) participating in stage one will have a vital role in shaping the future roll-out of this important reform. The implementation of the Health Care Home model will revolutionise the provision of care for people with chronic and complex conditions in Australia's primary healthcare system.

BENEFITS FOR PRACTICES AND SERVICES

Better experience of care delivery for clinicians through:

- Removal of a number of Medicare item restrictions will **reduce pressure on practices** by allowing for delegation to nurses and other team members who can then function at the top of their scope of practice.
- More flexibility leads to **increased clinical and organisational efficiencies** and removes duplication of work.
- **Bundled payments** to align with the model of care and reward value over time rather than volume.
- **Team-based approach** to support communication, collaboration and comprehensive patient care.
- **Clinical development and leadership** opportunities.
- **Increased flexibility** around how care is provided, such as support for group health coaching.
- **Reduced red tape** for patient access to allied health, mental health services and home medicine reviews.

WHAT IS A HEALTH CARE HOME?

The Health Care Home is an existing general practice or ACCHS that commits to a systematic approach to chronic disease management in primary care, which supports accountability for ongoing high-quality patient care. It uses an evidence-based, coordinated, multi-disciplinary model of care that aims to improve efficiencies and promote innovation in primary care services. It is consistent with similar models adopted successfully around the world, including the United Kingdom and New Zealand, and reflects and formalises the attributes of many high performing primary care practices here in Australia.

The approach provides doctors, nurses and other healthcare professionals greater flexibility to shape care around an individual patient's needs and encourages patients to participate in and direct their own care. While this flexibility means no two practices may be alike, all Health Care Homes will share key characteristics.

Target Group

The target group for stage one are those Australians with multiple complex and chronic conditions comprising approximately 20 per cent of the population. Health Care Home services will be available to those within this group assessed as most likely to benefit from the new model.

BENEFITS FOR PATIENTS

Better experience of care for patients through:

- **Patient-centred care** based around an individual patient's needs and preferences.
- **Improved coordination** of services, including links with hospitals, allied health and other community care providers.
- **Improved personalised care** through a more formal link with the patient nominated clinician (usually a GP) leading the care team developing and delivering their tailored care.
- **Improved access to services**, including remote support such as phone, email or video conference where clinically appropriate.
- A **long-term approach** to disease management, support, prevention and health promotion to improve health outcomes.

WHAT ARE THE KEY CHARACTERISTICS OF PARTICIPATING HEALTH CARE HOMES?

Patients, families and their carers as partners in their care

People living with chronic and complex conditions, supported by their carers and families where appropriate, will be actively involved in planning and implementing their care. They will be engaged in shared decision-making and supported to stay healthy and to better self-manage their conditions.

Voluntary patient enrolment

Eligible patients will be provided with information about the Health Care Home model and, after discussion with their healthcare team, 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 healthcare team to identify their goals and needs to better manage their health.

Enrolled patients will also be provided with information detailing how the approach to their care may change, both in terms of changes within the service (such as MBS billing and accessing care in different ways and from different team members) and about their active role in the management of their conditions, including ongoing care planning and supportive management.

"Health Care Homes have the potential to transform the way people with chronic disease seek care."

Consumer Health Forum of Australia

Enhanced access and flexibility

Enhanced access, even to timely advice can support a patient's ability to self-manage their conditions. Enhanced access could include in-hours telephone support, email or video-conferencing (where available and accessible), as well as access to after-hours primary care where clinically appropriate.

The increased flexibility offered through the model allows practices to be innovative and deliver care more efficiently. This could include offering health and lifestyle coaching to small groups, shared health appointments and could support remote monitoring of patients' symptoms and signs. Health Care Homes will also need to ensure that all enrolled patients are aware of the arrangements the Health Care Home has in place for after-hours care and what to do if they require access to after-hours care. Depending on local arrangements, a Health Care Home may choose to provide increased access to after-hours care for enrolled patients.

Patients nominate a preferred clinician

Many Australians prefer to see their regular GP. Enrolled patients will nominate a preferred clinician (usually their GP), who is aware of their health problems, priorities and goals, and who will lead the team providing care. This ongoing relationship will help define accountabilities, support improved health outcomes and increase the satisfaction of both patients and providers.

"The concept of continuous care supports the critical and core role of the GP as the coordinator of patient care."

Royal Australian College of General Practitioners

A commitment to care which is of high quality and is safe

Australians already have access to a high quality and safe healthcare system. This will be enhanced through the use of evidence-based interactive care-planning tools tailored for local requirements. Such tools facilitate the integration of care using existing resources, and overcome barriers to quality and patient safety caused by fragmentation and communication breakdown.

Team-based care

The clinician leads a team which collectively provides care for the patient. This team may also include nurses, nurse practitioners, Aboriginal health workers, care coordinators, pharmacists, allied health professionals and specialists. The flexibility of the model supports targeted and effective coordination of clinical resources to meet patient needs, and is based upon the expectation that members work to their full scope of practice.

The Health Care Home is also responsible for meeting as many of the patient's healthcare needs as possible and for collaborating with other health and community services to minimise duplication and maximise support.

Data collection and sharing

Health Care Homes will use data collected through their activities, benchmark performance and improve the quality of care they deliver patients.

Health Care Homes will also facilitate the secure sharing of health data and other relevant information with patients and their health team including pharmacy, allied health, diagnostics, hospitals and specialists. Underpinning this will be My Health Record.

THE APPROACH FOR STAGE ONE: LOCAL FLEXIBILITY AND NATIONAL CONSISTENCY

To ensure the benefits of the flexible approach can be tailored to local services and patients' needs, how the key characteristics are implemented will generally be a decision for each Health Care Home. To ensure national consistency and support the effective evaluation of stage one, some elements, for example the patient identification process, will be the same in all Health Care Homes.

In addition, some elements, such as the patient identification tool, training and support arrangements, and the evaluation methodology, are still under development, with advice being provided by the established Implementation Advisory Group and associated working groups. These groups include individuals with a diverse range of experiences from across the healthcare system; ensuring on-the-ground experience is used to inform the design, development and implementation of Health Care Homes. As soon as these development processes are finalised, further information will be made available for participating services and interested stakeholders.

ENABLERS: A NEW PAYMENT APPROACH, PATIENT IDENTIFICATION TOOL, SHARED CARE PLAN, MY HEALTH RECORD, PHNs, TRAINING AND ONGOING SUPPORT

A new payment approach

The Health Care Home approach moves away from traditional fee-for-service billing which may be in conflict with this model of care, to a bundled payment to the practice. The removal of the constraints associated with traditional fee-for-service billing will better support flexible and innovative team-based approaches to deliver care around the needs of patients.

Each enrolled patient will be registered by the Health Care Home through the Department of Human Services' Health Professionals Online Services (HPOS) system. Regular payments will be made to the practice on a retrospective monthly basis which allows for regular patient review and, if appropriate, adjustment of the patient's tier level (information about payment levels and tiers is below). There are 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.

All general practice healthcare associated with the patient's chronic conditions, previously funded through the MBS, will be funded through the bundled payment.

Enrolled patients can still access fee-for-service billing for episodic care that is not associated with their chronic conditions, but it is assumed this need will be minimal. Consistent with current approaches in many practices, enrolled patients will be able to contribute towards their healthcare 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.

Funding for services provided by allied health professionals and specialists, as well as for diagnostic and imaging services are not included in the bundled payment and will continue to be funded through the MBS. Eligibility for allied health services currently triggered by a GP Management Plan, or where relevant 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.

PAYMENT LEVELS

Tier 3 — Payments totalling $1,795 per patient per annum

- High risk chronic and complex needs
- Approximately 1% of population*

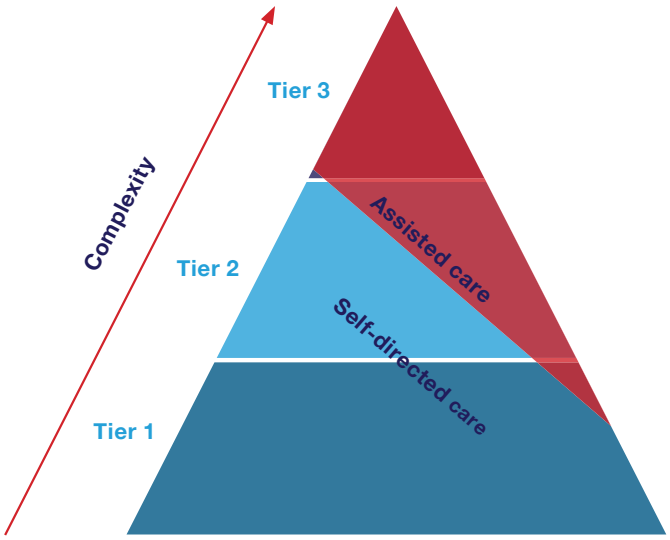
Tier 2 — Payments totalling $1,267 per patient per annum

- Multi-morbidity and moderate needs
- Approximately 9% of population*

Tier 1 — Payments totalling $591 per patient per annum

- Multiple chronic conditions, largely self-managing
- Approximately 10% of population*

Payments will be made monthly on a pro rata basis.



- **High risk chronic and complex needs**
- 1% population*
- High level of clinical coordinated care
- One fifth of this group may be best supported with palliative care options

- **Multi-morbidity and moderate needs**
- 9% population*
- Clinical coordination and non clinical coordination
- Supported self-care

- **Multiple chronic conditions**
- 10% population*
- Largely self-managing

* Indicative estimates

Patient identification tool

Work is currently underway to develop a universal patient identification tool that will be used by Health Care Homes. As the amount paid to Health Care Homes is linked to the patient's level of complexity, all participating services will use the same tool, which consists of a two-step process:

1. Practice level: identify eligible patient cohort
2. Patient level: in consultation with the patient, and relevant family members and carers where appropriate, assess the patient's individual needs and risk factors, stratifying their care needs to one of three complexity tiers according to their level of risk.

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, which will be considered in conversations amongst providers, patients and family members/carers.

Following identification, patients must agree to participate and provide consent for de-identified data (reflecting their care provision) being used for evaluation purposes. These consent forms will be universal to all participating Health Care Homes.

Shared care plan

A central element of the model is the development and use of a tailored and dynamic shared care plan by the team and the patient for the management of a patient's healthcare needs. Many shared care plans and tools are already being used by services across Australia. Recognising this, a set of minimum standards will be defined and Health Care Homes will then use a plan complying with these standards.

For example, the standards will include capabilities, with appropriate patient consent, to upload information into the patient's My Health Record. It will be accessible to all members of the care team, including providers outside the Health Care Home.

"Nurses are highly trained, cost-effective and trusted professionals, able to make a significant contribution within Health Care Homes by pursuing truly team-based, interdisciplinary care which puts patients at its heart."

Australian Primary Health Care Nurses Association

My Health Record

All participating services will be required to register and connect to the My Health Record system, and contribute up to date clinically relevant information to their patients' My Health Records. All enrolled patients will have a My Health Record. If they do not have one, the Health Care Home must assist the patient with enrolment.

Primary Health Networks, training and ongoing support

Primary Health Networks (PHNs) will play a vital role in supporting the effective implementation of Health Care Homes. The core business of PHNs in working directly with general practitioners, other primary healthcare providers, secondary care providers and hospitals to facilitate improved outcomes for patients is central to the Health Care Home model. In addition, many PHNs are driving local reforms consistent with this model, and the implementation of Health Care Homes is a valuable opportunity to build upon and extend these activities.

The training approach, which is currently being developed, will consist of a train-the-trainer approach with the ten PHNs in the announced regions. The PHN trainers will then work with general practices in each region to provide training and ongoing support based on need. Existing training programs will be leveraged.

The train-the-trainer approach for participating ACCHS will be similar, with the delivery method finalised once the number and geographical spread of participating services is known. Like general practices, the train-the-trainer approach will be developed in consultation with this sector.

The training process will take place over a twelve month period — up to three months prior to commencement of services and approximately nine months after commencement — to support practices through capacity and capability building. It is anticipated it will consist of a mix of intensive face-to-face training, seminars/webinars and self-paced online training modules.

The Department will also provide practices with a detailed set of guidelines to complement the training program which will provide:

- information about the Health Care Home concept
- practical information to meet basic administrative requirements of the program
- information and advice on change management practices and how to develop the culture needed to support practice changes
- advice on how practices might restructure their activities, both on a professional and practice level, in order to deliver the full gamut of Health Care Home services that maximise the benefits and flexibility of the new model.

As detailed below, a $10,000 one-off grant will be paid to participating practices to support the practice changes required to operate as a Health Care Home. Technical support will also be provided for the use of the patient identification tool and payment mechanism.

Mechanisms for ongoing support are also being developed, with options under consideration including a web-based leadership series and a virtual knowledge hub where Health Care Homes and the Department can share valuable information, ideas on innovations and lessons learnt.

Primary Health Networks will also play a vital role in providing ongoing support to practices during the transformation process.

"The Health Care Home model will have the opportunity to ensure the most appropriate person provides the required care in the most cost effective and timely way."

Australian Association of Practice Managers

EVALUATION

All Health Care Homes will provide information for the evaluation of stage one, which will be vital in informing the future roll-out of the model.

An independent evaluator will be contracted by the Department to undertake the evaluation. The methodology, which will be finalised in the coming months in consultation with the Department, Implementation Advisory Group and the Evaluation Working Group, will require participating services to provide data on both qualitative and quantitative measures. In finalising the methodology, an important consideration will be ensuring the reporting burden on participating Health Care Homes is minimal. Wherever possible data that is routinely collected will be de-identified and automatically extracted.

WHAT IS REQUIRED OF A STAGE ONE HEALTH CARE HOME?

A general practice or ACCHS participating in stage one will:

- Be accredited and maintain accreditation, or be registered for accreditation, against the Royal Australian College of General Practitioners *Standards for general practices*.
- Participate in, or be prepared to participate in, the Practice Incentives Program (PIP) eHealth Incentive.
- Participate in the stage one Health Care Homes training program.
- Use the patient identification tool to identify the eligible patient cohort in their practice or service, assess individual patient eligibility and stratify their care needs to one of three complexity tiers according to their level of risk.
- Register and connect to the My Health Record system, and contribute up-to-date clinically relevant information to their patients' My Health Records.
- Ensure that all enrolled patients have a My Health Record.
- Develop, implement and regularly review each enrolled patient's shared care plan.
- Provide care coordination for enrolled patients.
- Provide care for enrolled patients using a team-based approach.
- Ensure that all team members have roles which utilise their qualifications and allow them to work to their scope of practice.
- Provide enhanced access for enrolled patients through in-hours telephone support, email or video-conferencing, as well as access to after-hours care where clinically appropriate.
- Ensure that all enrolled patients are aware of what to do if they require access to after-hours care.
- Collect data for the evaluation of stage one and for internal quality improvement processes.

BENEFITS FOR THE HEALTH SYSTEM

- Improved access arrangements to the right care at the right time will **reduce demand on hospitals**.
- Improved care coordination will **improve patient outcomes and reduce escalation of conditions**.
- **Better patient self-management** and a shift of focus from episodic treatment to long-term support, management and prevention strategies.
- A more responsive system that **meets the needs of patients in a proactive way**.
- **Better use of data** will build a culture of continuous quality improvement and will assist with needs analysis and resource allocation.
- **Health system savings** through greater efficiencies.

HOW TO APPLY

For stage one, participation will be limited to 65,000 patients within 200 practices across ten geographical regions. Participating general practices and ACCHS will receive a one-off grant of $10,000 (GST exclusive) to support their participation.

The selected regions represent a geographic and demographic cross section of Australia and include large metropolitan, outer metropolitan, regional and remote communities.

The selected regions are:

- 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

Stage one Health Care Homes will deliver services from 1 July 2017 to 30 June 2019.

More information on the grant, including eligibility requirements and instructions on how to apply are set out in the Health Care Home program guidelines which, along with the application form, are available on the Tenders and Grants page at **www.health.gov.au**.

ADDITIONAL INFORMATION

www.health.gov.au/healthcarehomes

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▶ Patient-centred ▶ Coordinated ▶ Flexible

www.health.gov.au

All information in this publication is correct as at November 2016

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