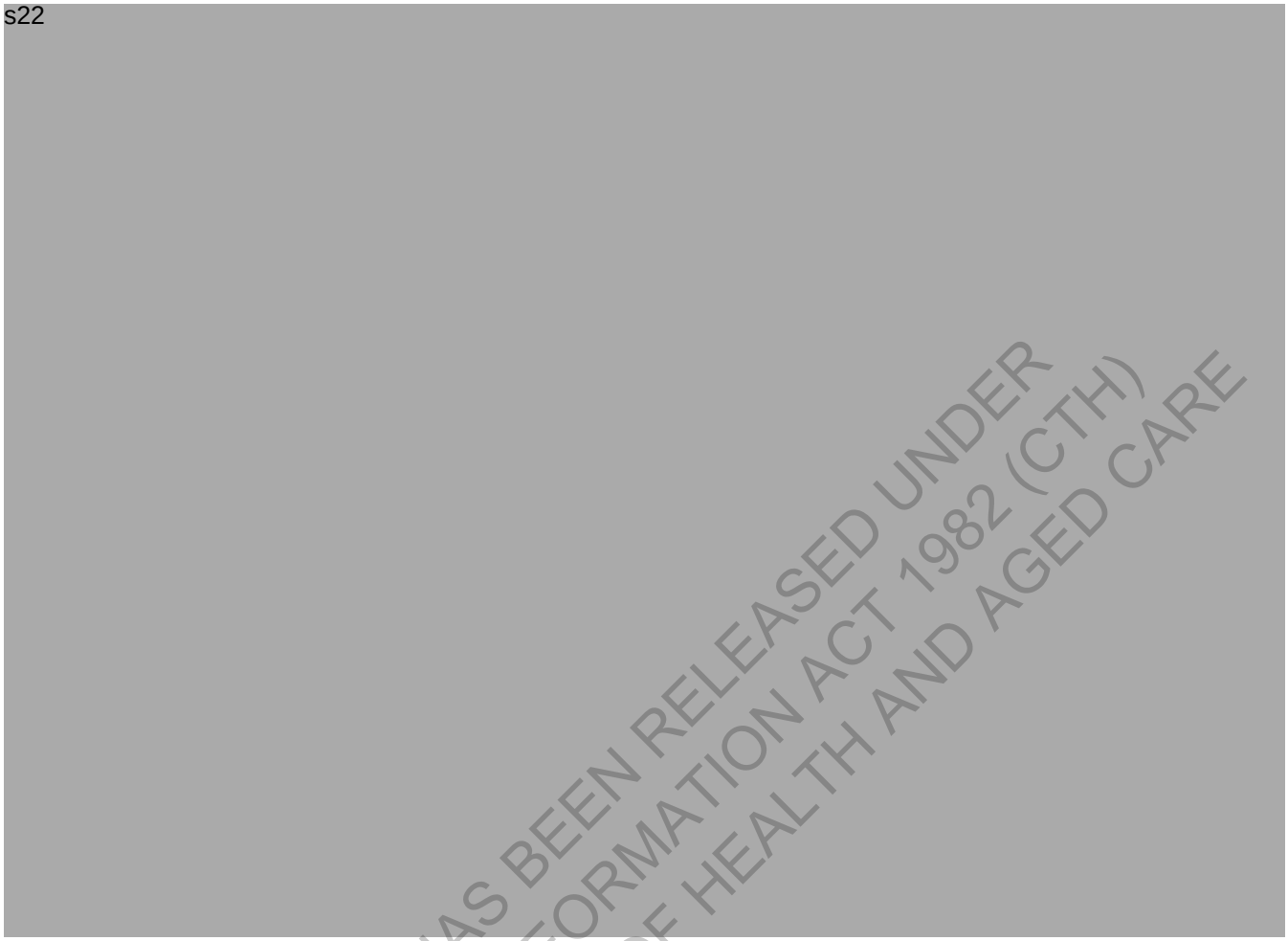
s22 [redacted]

s22 The claiming of MBS health assessment and management items (such as Chronic Disease Management Plans) and access to telehealth were proposed to be linked to registration status, and practices would be required to be accredited, with exemptions available for Aboriginal Community Controlled Health Services (ACCHS), Aboriginal Medical Services (AMS) and mobile or outreach practices.

s22 [redacted]

s22 [redacted]

s22



Evidence from Health Care Homes suggests there are benefits to be gained, but more needs to be done to engage hard to reach populations

The Health Care Homes (HCH) trial aimed to provide better support to people with chronic disease, through improved care planning, improved access to practice services (including allied health) and better access to prescription and referral services from their care team. The model included voluntary enrolment of targeted patients at risk of hospitalisation to a general practice – their health care home – nominating a GP as their preferred clinician, and a bundled payment for every enrolled patient based on the complexity/severity of their chronic condition, replacing Medicare chronic disease management fee-for-service arrangements.

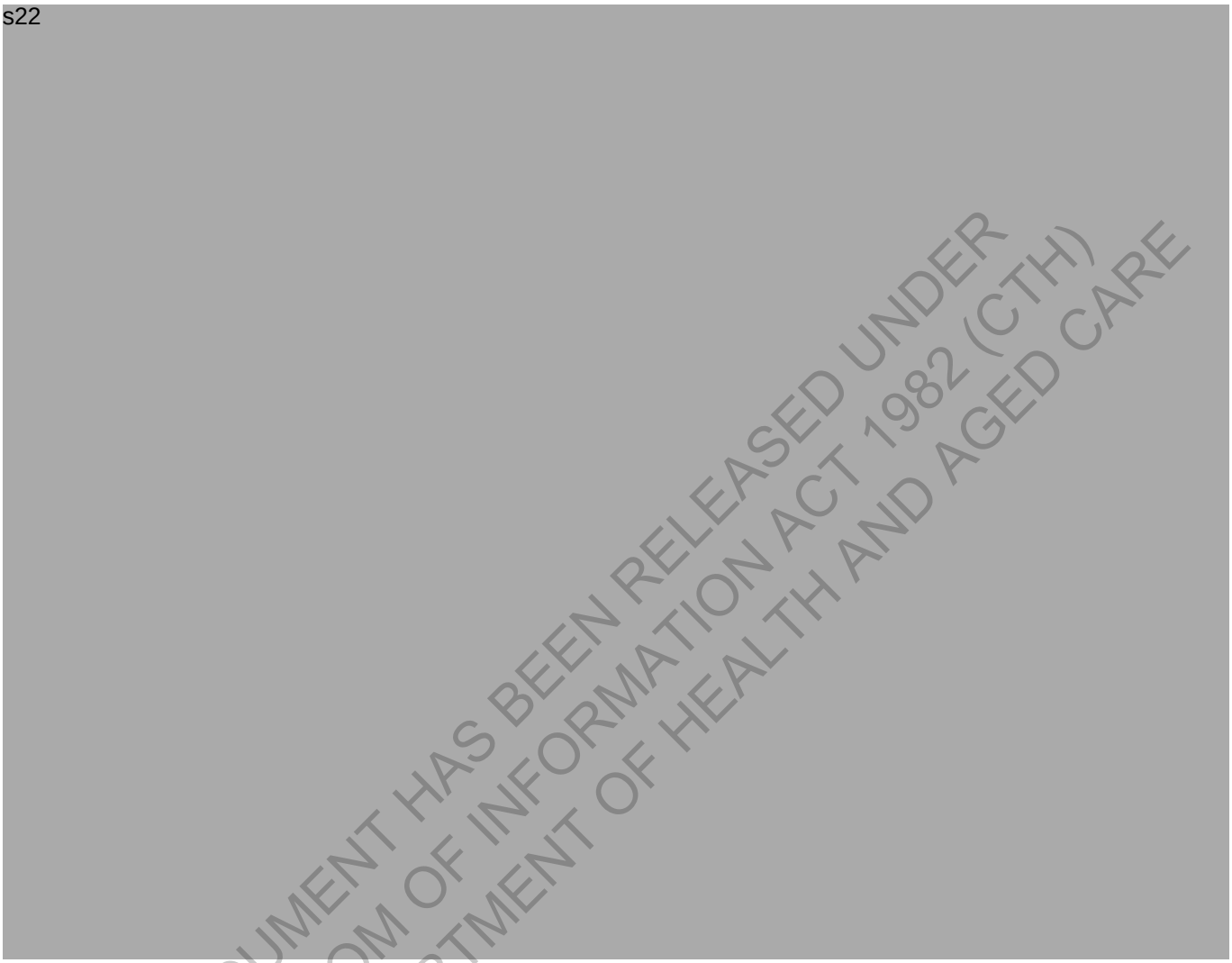
While the trial saw a number of improvements in patient care, coordination and access to services (i.e. GP, practice nurse and to allied health services outside the practice), there was no significant change in patient experience or impact on patient outcomes due to a number of limitations. In particular, this included that implementation of the HCH model amongst the participating practices was patchy, limited by scale, and not to the extent originally envisaged. The short length of the trial combined with practices being more likely to select patients that were more activated and engaged with their care for the trial also limited the ability to measure improvements in patient outcomes.

s22

s22

- the claiming of other MBS health assessment and management items (such as Chronic Disease Management Plans) would be linked to registration status (however for non-registered patients, access to these items would remain unchanged)

s22



s22

s22

2. How could MHR and clinical software be expanded to enable more effective multidisciplinary care, including where there is limited access to doctors, and how can this support integrated health assessments, care plans and health encounters with nurses, allied health professionals, pharmacists, and others?

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s22

s22

Patients want to know that their health information is available to those who have a role in their healthcare planning, and that it also follows them as they transition from one care setting to another, so they are receiving the right care, in the right care setting, at the right time.

s22

s22 [redacted]

s22 [redacted] Through greater capture of health encounter summaries, including health assessments and treatment/care plans, MHR will provide all members of a patient's primary care team with better visibility on the status of their health and care needs. s22 [redacted]

s22 [redacted]

s22

s22 As the central coordination point for their patients, primary care professionals need more rapid access to hospital discharge and event summaries, critical follow-up treatments, care plans and any diagnostic or pathology investigation results to support the on-going care of their patient. s22

s22

s22

s22 For example, coordinated programs of care for type 2 diabetes have been shown to correlate with improved clinical outcomes (HbA1c, diastolic and systolic blood pressure) in a systematic review of the evidence.[8] s22

s22

[8] Lee, J. et. al (2021), *Assessment of interprofessional collaborative practices and outcomes in adults with diabetes and hypertension in primary care*

s22

s22

Chronic Disease Management arrangements

CDM arrangements are available to patients with a medical condition that has been, or is likely to be, present for at least 6 months, or is terminal. The CDM GP MBS items include GP Management Plan (GPMP) planning and reviewing items, along with items for Team Care Arrangements (TCAs) for patients requiring multidisciplinary care. There are also nurse and Aboriginal and Torres Strait Islander health practitioner items for GPMP follow up services and up to five MBS allied health services per year for patients with a GPMP and TCA, or a Multidisciplinary Care Plan. There are also case conferencing items for a range of practitioner types to support the development and review of multidisciplinary team care arrangements (note: case conferencing items are not specific to the CDM arrangements).

For patients in the community these items are designed to ensure that the GP is coordinating and overseeing the multidisciplinary care of the patient, including ensuring the recommended care is clinically appropriate – meaning appropriate professionals are included and participate, not necessarily determining the specific treatment provided by those professionals. s47C

s22

s22

There is also evidence that the CDM arrangements are complex for practitioners to use. Historically, the CDM arrangements have represented a substantial proportion of queries to askMBS and Services Australia. Since March 2019, over 5% of all queries to askMBS have related to the CDM arrangements. They have also been a common focus of compliance activities.

s47C

s22

s22

s22 [redacted]

s22 While digital patient records are generated in many instances to support healthcare professionals to track their interactions with, and the treatment and care plans of their patients, this information is currently siloed in standalone clinical information systems with no ability for it to be shared easily and seamlessly with other members of a patient's care team, particularly across care settings.

s22 [redacted]

s22 [redacted] s47C [redacted]

s47C [redacted]

s22 [redacted]

s22 [redacted]

Appendix D

History of primary care funding reform in Australia

s22 [redacted]

s22 [redacted] Previous modified fee-for-service initiatives include Enhanced Primary Care (EPC) care planning items, which the Commonwealth Government began to introduce in 1999. The EPC offered additional payments for GPs to engage in care planning to improve health outcomes for older Australians, adult Aboriginal and Torres Strait Islander people and people of any age with a chronic or terminal condition. Subsequent modifications to the EPC included comprehensive medical assessments for vulnerable populations and multidisciplinary care plans. In 2005, the EPC care planning items were replaced by the current Chronic Disease Management (CDM) items[1]. Over time, the Government has also introduced other current modified fee-for-service measures to increase care integration and coordination, including GP Management Plans, Team Care Arrangements and medication management review.

s22 [redacted]

[1] Department of Health and Aged Care | Enhanced Primary Care Program overview

s22 [redacted]

s22 [redacted]

For example, in 1997, the Government introduced the Coordinated Care Trials to improve multi-disciplinary care planning and service coordination for people with chronic health conditions or complex care needs. The trials were financed by pooled funding between Commonwealth and State/Territory programs and the amount of money placed in each pool was based on an estimate of what would otherwise have been spent on services used by clients who were participating in the trials. The results of the trial showed increases in access to primary care services and improved knowledge of the health care system and available services among trial participants. However, an evaluation of the trial found that results indicating improved health outcomes were limited given the short time frames of the trial[3]. More recently, the Government conducted the Diabetes Care Project[4] in 2009 that improved the quality of diabetes care among the participating cohort and the Health Care Home Trial[5] in 2017, which indicated some improvements in patient care but faced similar resource and timing constraints to the Coordinated Care Trials.

s22 [redacted]

[3] Senate Standing Committee on Community Affairs (2000), Healing our hospitals: A report on public hospital funding, Chapter 4: Coordinated Care Trials, available at: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/1999-02/pubhosp/report/c04

[4] Department of Health and Aged Care (2015), Evaluation of the diabetes care project, available at: https://www.health.gov.au/resources/publications/evaluation-of-the-diabetes-care-project

[5] Department of Health and Aged Care (2022), Evaluation of the Health Care Homes trial – final evaluation report 2022, available at: https://www.health.gov.au/resources/publications/evaluation-of-the-health-care-homes-trial-final-evaluation-report-2022