



Australian Government Department of Health Evaluation of the Health Care Homes program

Interim evaluation report 2020

Volume 2: Main report

Revision history

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0.1	12 October 2020	Initial draft.
0.2	25 November 2020	Comments from the Evaluation Working Group and the Department of Health incorporated.
0.3	8 December 2020	Minor edits by HPA.
0.4	15 March 2021	Minor amendments requested by NPS MedicineWise to correct references to MedicineInsight.

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Acronyms

ACCHS Aboriginal Community Controlled Health Service

AGPAL Australian General Practice Accreditation Limited

AIHW Australian Institute of Health and Welfare

AMS Aboriginal Medical Service

CBDRH Centre for Big Data Research in Health (University of New South Wales)

CHERE Centre for Health Economics Research and Evaluation (University of Technology

Sydney)

FTE Full time equivalent

GP General practitioner

HARP Hospital Admissions Risk Program (tool)

HCH Health Care Homes

HPA Health Policy Analysis

HPOS Health Professionals Online Services

IT Information technology

LHN Local Hospital Network

MBS Medical Benefits Schedule

MMM Modified Monash Model (remoteness categorisation)

PCMH Patient-centred medical home

PBS Pharmaceutical Benefits Schedule

PHCAG Primary Health Care Advisory Group

PHN Primary Health Network

PIP Practice Incentive Program

PIP QI Practice Incentive Program Quality Indicators

POLAR Population Level Analysis and Reporting

R1 Round 1 of the evaluation. R2, R3, R4, R5 refer rounds 2-5 respectively.

RST Risk stratification tool

1. Introduction

This document is the **Health Care Homes (HCH) trial: Interim evaluation report 2020, Volume 2: Main report.** This volume is one of three featuring the findings of the evaluation of the HCH trial. The volumes are described in Table 1.

Table 1 – Interim evaluation report 2020: Description of volumes

Volume	Description
Volume 1: Summary report	Summarises the findings of the interim evaluation.
Volume 2: Main report	Presents the findings from the interim evaluation.
Volume 3: Evaluation progress	Describes progress with the evaluation and provides further information about evaluation data and the practice and PHN
	benchmark reports.

The Interim evaluation report 2020 builds on the findings reported in the Interim evaluation report 2019 (Health Policy Analysis, 2019b). The 2019 report covered the period from the inception of the trial (including pre-implementation activities) to mid-2019. The 2020 report moves beyond the establishment phase of the trial, reflecting developments following the end of the patient enrolment period through to 30 June 2020. It reflects the **early to mid-point experiences** of practices and their staff, patients and PHNs, but not yet the overall findings of the evaluation. The report is principally based on analysis of qualitative data, except for descriptive data about practices and patients participating in the trial, and about the community pharmacy component.

The final evaluation report will cover the full evaluation period to the end of the trial (30 June 2021), and report on the outcome measures specified in the evaluation plan.

The Health Care Homes (HCH) trial

The HCH trial started on 1 October 2017 and will end on 30 June 2021. HCH incorporates elements of the patient-centred medical home (PCMH), focusing on coordinated and comprehensive primary care that is responsive to patients' needs and preferences. The features of the trial are:

- Voluntary enrolment of patients to a practice their health care home nominating a GP as their preferred clinician.
- Tools to identify patients at risk of hospitalisation and stratify them to a complexity tier.
- A bundled payment for every enrolled patient based on their tier (for services relating to the patient's chronic conditions), departing from the traditional Medicare fee-forservice model.
- Training resources to support transformation of practices towards an HCH model.
- Support for practices to undertake transformation, provided by Primary Health Network (PHN) practice facilitators.
- Shared care planning, giving authorised health professionals access to an up-to-date electronic medical record for each enrolled patient.
- Evaluation of the program.

These features are consistent with the 10 building blocks of high-performing primary care (Bodenheimer, Ghorob, Willard-Grace, & Grumbach, 2014) and the quadruple aims:

improving patient health, enhancing patient experience, reducing health care costs and improving the work life of providers and staff (Berwick et al., 2008; Bodenheimer & Sinsky, 2014), both of which underpin the PCMH.

Participating practices have implemented HCH in different ways. However, common to all of the models is the intention to:

- Involve patients, families and their carers as partners in their care. Patients are activated to maximise their knowledge, skills and confidence to manage their health, aided by technology and with the support of a health care team.
- Provide enhanced access to care in-hours (including to practice nurses and other staff), which may include support by telephone, email or videoconferencing, and effective access to after-hours advice or care.
- Provide 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.
- Deliver high-quality and safe care. Care planning and clinical decisions are guided by evidence-based patient health care pathways, appropriate to the patient's needs.

(Primary Health Care Advisory Group, 2015, p. 4).

A note on the effects of the COVID-19 pandemic on the findings reported

This report mostly uses data from practice, patient and carer, and PHN interviews and surveys. These were gathered prior to public health measures taken to manage the COVID-19 pandemic. Therefore, the experiences of these groups during the pandemic have not been captured in this report. The effects of the pandemic have come through in the data extracts from the practice clinical management systems and reflect reduced recording of lifestyle and clinical measures (although not reduced GP consultations). The effects of the pandemic on the trial will be analysed in the final evaluation report.

The Interim evaluation report 2019 described the background to HCH and the set-up of the trial and reported on developments to 31 August 2019. A summary of the key points from the report are:

- The HCH trial is being undertaken within practices from 10 PHNs across Australia.
- Participating practices were selected following an expression of interest (EOI) issued
 in late 2016. One of the considerations in selecting practices to participate was to
 ensure a mix of locations, practice size, ownership status and staffing. This was so the
 model could be tested in different contexts.
- Successful practices were announced in mid-2017. These practices received a \$10,000 grant to assist with participation in HCH and implementation of the model.
- The Department originally targeted enrolling 200 practices for the trial. However, not all practices originally selected proceeded to implementation. These were replaced by other practices. However, there continued to be withdrawals from the trial. By August 2019 there were 131 participating practices. As shown in this report, this fell to 120 by 30 June 2020.
- The trial was originally intended to run between late 2017 and June 2019, with enrolments occurring up to December 2018. An extension was announced in

- December 2018, with the patient enrolment period continuing through to June 2019 and the trial to June 2021.
- Patient enrolments commenced in late 2017 but were initially slow, accelerating towards the end of 2018.
- A risk stratification tool (RST) was commissioned by the Department of Health and has been used by most practices in identifying patients suitable for enrolment in HCH and to allocate patients to one of three tiers.
- Practices receive a bundled payment for each patient, with the amount determined by the patient's tier (tier 1 is the least complex and has the lowest payment). The bundled payment is intended to cover the costs of care delivered by the practice related to patients' chronic health conditions. Practices can still bill Medicare for other conditions the patient may present with.
- Practices are required to develop a comprehensive care plan with enrolled patients, and update this regularly. Practices are also required to install shared care planning software (if they didn't have this already), which they use to share care plans with other health providers and patients and their families.
- To support implementation, the Department of Health commissioned the
 development of online training modules and related materials. The Department also
 provided funding to the 10 participating PHNs to support practices and facilitate the
 implementation of HCH. PHN facilitators have received training and ongoing support
 (through regular webinars and coaching by a national facilitator) through the
 Australian General Practice Accreditation Limited (AGPAL).

HCH evaluation

The HCH trial is being evaluated by a consortium led by Health Policy Analysis and including the Centre for Big Data Research in Health (University of New South Wales), the Centre for Health Economics Research and Evaluation (University of Technology Sydney) and other Australian and international experts.

Methods have been described in the HCH evaluation plan (Health Policy Analysis, 2019a¹). Figure 1 shows the key evaluation questions for HCH and the community pharmacy trial. For each key question, more detailed questions and measures were also specified in the evaluation plan.

¹ This reference is to the version of the plan that was updated to accommodate the extension of the program. The updated plan maintains the evaluation approach and measures published in the original 2017 plan.

Health Care Homes Community pharmacy trial Is community pharmacy How was the HCH beneficial to the broader model implemented HCH coordinated care and what were the model and should it be included as part of any barriers and enablers? future roll out? Do patients who received How does the HCH model medication management change the way practices services as part of the approach chronic disease trial experience better management? health outcomes than patients who did not? What was the level of Do patients enrolled in engagement between HCH experience better HCH practices and quality care? community pharmacy (care coordination)? What are the financial Is the inclusion of a effects on governments, pharmacy component in providers and HCH financially viable? 8 individuals?

Figure 1 – Key evaluation questions, Health Care Homes and the Community pharmacy trial

Data collection for the evaluation has been organised into five 'rounds'. There are also three 'waves' of patient surveys. Table 2 shows the dates relating to these.

Table 2 – HCH evaluation: Data collection 'rounds' and patient survey 'waves'

Data	a collection round	Patient survey wave		
Round 1 (R1)	October 2017 to June 2018	Wave 1 (Baseline)	December 2017 to March 2019	
Round 2 (R2)	July to December 2018	wave i (basellile)		
Round 3 (R3)	January to June 2019			
Round 4 (R4)	July 2019 to June 2020	Wave 2	December 2019 to March 2020	
Round 5 (R5)	July 2020 to June 2021	Wave 3	January 2021 to March 2021	

The evaluation is using mixed methods. Data sources are described in Table 3. Qualitative data are being collected through interviews and focus groups with patients and their carers/families, GPs, other primary care staff, pharmacists and other external care providers. Interviews and focus groups are being undertaken in 20 case study practices from a variety of locations and circumstances across Australia. Four of the case study practices interviewed for the *Interim evaluation report 2019* subsequently withdrew from the HCH trial and these have been replaced by other practices with characteristics similar to the withdrawn practices. The case studies include clinics operated by two Aboriginal Community Controlled Health Services in two remote communities in the Northern Territory. Chapter 5 reports on the

results of the initial round of interviews for these case studies². Qualitative data have also been collected through several rounds of surveys of HCH practices and PHNs. Analyses of the surveys completed in round 4 have been included in this report. Patient surveys are also being conducted via computer-aided telephone interview. The baseline measures for these were included in the *Interim evaluation report 2019*. Changes from baseline will be included in the final evaluation report.

Quantitative data are being used to compare patients enrolled in HCH with similar patients receiving usual care and investigate changes that have occurred for patients enrolled in HCH (using before/after and interrupted time series analysis).

Table 3 – Evaluation data sources

Table 5 – Evaluation data 3001Ce3					
Data source	Key	Collection	Report in which data are used and d collection round/period		
Daia source	questions	type	Interim 2019	Interim 2020	Final report 2021
Patient surveys	3, 6	Primary	Wave 1 (baseline)	n.a.	Waves 1, 2 and 3
Practice surveys	1, 2, 4	Primary	R1 R2	R4	R1 R2 R4 R5
Practice staff surveys	1, 2, 4, 5, 7	Primary	R1	n.a.	R1, R5
PHN surveys	1, 2, 4	Primary	R1 R2	R4	R1 R2 R4 R5
PHN interviews	1, 2, 4, 5, 7	Primary	R1 R2	R4	R1 R2 R4 R5
Case studies ¹	2, 4, 5, 6, 7	Primary	R2	R4	R1 R2 R4 R5
HCH program data ²	1, 4	Secondary	Oct 2017- Aug 2019	Oct 2017- Jun 2020	Oct 2017-Jun 2021
Community pharmacy Health Outcomes Data	5, 6, 7, 8	Secondary	July 2018- June 2019	July 2018- June 2020	July 2018- June 2021
Risk stratification	2	Secondary	July 2018- June 2019	July 2018- June 2020	July 2018- June 2021
Practice extracts	2, 3	Secondary	Various- June 2019	Various - June 2020	Various -June 2021
Linked data ³	3, 4	Secondary	n.a.	n.a.	To be confirmed

¹ Case studies include patient interviews/focus groups, practice interviews, related provider interviews (e.g. pharmacists, allied health), PHN interviews, LHN/state & territory health authority interviews; ² Includes, among other issues, data from Services Australia on patients registered with the program; ³ Includes MBS, PBS, hospital, emergency department, aged care, and fact of death data.

The data featured in each evaluation report are described in the box below.

Data featured in evaluation reports

Interim evaluation report 2019 (previous report):

- Patient surveys at entry of HCH (from December 2017 to March 2019): Patient activation, experiences of primary care and coordination of care, health conditions, health status.
- Practice surveys Round 1 (March to June 2018) and Round 2 (November 2018 to March 2019): Characteristics of HCH practices and early experience of HCH implementation.
- Case studies (late 2018): Patient, family/carer, practice, PHN and related provider experiences in the establishment phase of HCH.
- Practice data extracts (up to 30 June 2019): Profile of enrolled patients from practice data, baseline for key measures.

 $^{^{\}rm 2}$ A second round is planned in the first half of 2021.

 Selected program data, including practice participation and patient enrolment (up to 31 August 2019).

Interim evaluation report 2020 (this report):

- Practice surveys Round 4 (early 2020): Experience of HCH after 1-2 years.
- Case studies (late 2019 to early 2020): Patient, family/carer, practice, PHN and related provider experiences of HCH after 1-2 years. Includes case studies undertaken in two NT Aboriginal Community Controlled Health Services for the first time in 2019.
- Practice data extracts (up to June 2020): Descriptive statistics and changes in key measures after 1-2 years.
- HCH program data (up to 30 June 2020): HPOS registrations and reasons for patients withdrawing.
- Community Pharmacy Health Outcomes data (up to 30 June 2020): Descriptive statistics about patients participating in the trial and services provided to them.

Final evaluation report (late 2021):

- Patient surveys Round 5 (first half of 2021): Changes in patient activation, experiences of primary care and coordination of care, health conditions, health status.
- Practice and practice staff surveys (first half of 2021): Experience of HCH implementation, nature of changes introduced and practice/staff assessment of their effect, changes in staff satisfaction.
- Case studies (first half of 2021): Patient, family/carer, practice, PHN and related provider experiences of HCH after 2-3 years of HCH.
- Practice data extracts (up to June 2021): Changes in evaluation measures, including clinical processes and selected clinical outcomes.
- HCH program data (up to 30 June 2021): HPOS registrations and reasons for patients withdrawing.
- Community Pharmacy Health Outcomes data (up to 30 June 2021): Descriptive statistics about patients participating in the trial and services provided to them.
- Linked MBS, PBS and hospital data (time frames to be confirmed): Comparison of trends for HCH patients and comparator patients for key evaluation measures. Effect of HCH on practice revenues. Early indicators of change in hospitalisation/emergency department attendance.

Overview of HCH practices and patients

Key points:

- There were **120 practices participating in HCH** at 30 June 2020.
- These practices had 8,959 patients enrolled in HCH, an average of 75 HCH patients per practice.
- 107 practices had withdrawn from HCH. Most of these (58%) had not enrolled any patients into HCH and a further 20% had enrolled less than 10.
- Some practices withdrew for reasons unrelated to HCH (practice closure and staff turnover). Others withdrew for a range of reasons such as the change required was too extensive, GPs in the practice weren't comfortable with the model, the value to patients or GPs was not clear, and the assessment that the level of the bundled payment was inadequate. Several practices withdrawing reported that they considered the HCH a good model, but they could not fully commit to it at the time.
- About 32% of patient enrolled in HCH are allocated to tier 3 the highest level of risk. A further 50% are allocated to tier 2 and 18% to tier 1. The distribution across tiers varies from the original expectation that tier 1 would have the largest proportion of patients.
- Of the patients that were re-stratified, 8% patients were reallocated to another tier: 6% to a
 higher risk tier and 2% to a lower risk tier.
- 2,373 patients have withdrawn from the program. 25% of withdrawals (5% of all enrolled patients) related to patients opting out of HCH. Other patient withdrawals related to practices withdrawing from HCH (39%), patients moving out of the area (27%), leaving the practice (13%) or dying (13%).

HCH practices

Table 4 shows the number of practices and patients, as of 30 June 2020 and over the course of the HCH trial. By 30 June 2020, there were 120 practices participating in HCH. A further 107 practices had participated at some stage but had withdrawn (48.5%). Most practices that withdrew had not enrolled any patients (n = 62) or had enrolled less than 10 (n = 21) (see Table 5). Practices withdrew from the trial at a steady rate, until July-August 2019 when those that had not enrolled any patients by the end of the enrolment period formally withdrew.

Table 4 and Table 5 refer to 'active' and 'withdrawn' practices. 'Active' means the practice was participating in the HCH trial as of 30 June 2020. 'Withdrawn' means that the practice was participating at some stage between October 2017 and June 2020 but had withdrawn prior to 30 June 2020.

Table 4 also shows the number of practices by three of the four dimensions used in the selection process for the trial: location, practice size (based on the number of FTE GPs) and practice type (corporately owned, independent or Aboriginal Medical Service³). The Table

³ Aboriginal Medical Service is used to refer to both Indigenous Health Services and ACCHS.

also includes information on the level of socio-economic disadvantage of the communities in which practices are located, using the Australian Bureau of Statistics (ABS) Index of Relative Socio-economic Disadvantage (IRSD). The index has been grouped into three categories using the deciles of the IRSD.

The analysis shows that:

- Medium size practices (5-8 FTE GPs) tended to have a lower rate of withdrawal and large practices a higher rate.
- Independent ownership category tended to have a lower rate of withdrawal and corporates a higher rate.
- Practices located in remote areas (Modified Monash Model MMM category 7)⁴ tended to have a lower rate of withdrawal and those located in regional centres (MMM category 2) had a higher rate.
- Practices located in areas in the mid-range of socio-economic disadvantage (deciles 4-7) tended to have the lowest rate of withdrawal and those of most and least disadvantage equally a higher rate.

Table 4 – Participation status of practices and number of patients enrolled by active practices, by sampling strata¹, as at 30 June 2020

Practice	Patients	Practices			
characteristic	in active practices	Active	Withdrawn	Total	Percent withdrawn
Total	8,959	120	107	227	48.5%
Practice size (based	on FTE GPs)				
Sole practitioner	527 (5.9%)	13 (10.8%)	15 (14.0%)	28 (12.3%)	53.6
Small practice	3,563 (39.8%)	62 (51.7%)	50 (46.7%)	112 (49.3%)	44.6
Medium practice	2,815 (31.4%)	25 (20.8%)	18 (16.8%)	43 (18.9%)	41.9
Large practice	2,054 (22.9%)	20 (16.7%)	24 (22.4%)	44 (19.4%)	54.5
Practice ownership					
AMS ²	1,495 (16.7%)	17 (14.2%)	15 (14.0%)	32 (14.1%)	46.9
Independent	6,509 (72.7%)	88 (73.3%)	49 (45.8%)	137 (60.4%)	35.8
Corporate	955 (10.7%)	15 (12.5%)	43 (40.2%)	58 (25.6%)	74.1
Remoteness (MMM c	ategory) ³				
MMM 1	6,258 (69.9%)	83 (69.2%)	63 (58.9%)	146 (64.3%)	43.2
MMM 2	464 (5.2%)	12 (10.0%)	22 (20.6%)	34 (15.0%)	64.7
ммм 3	414 (4.6%)	5 (4.2%)	7 (6.5%)	12 (5.3%)	58.3
MMM 4 & 5	854 (9.5%)	6 (5.0%)	5 (4.7%)	11 (4.8%)	45.5
MMM 6 & 7	969 (10.8%)	14 (11.7%)	10 (9.3%)	24 (10.6%)	41.7

⁴ MMM classifies metropolitan, regional, rural and remote areas according to both geographical remoteness and town size. It is intended to enhance the Australian Statistical Geographic Standard, Remoteness Areas (ASGS-RA) used by the Australian Bureau of Statistics (ABS). The classification has been adopted by several Government programs, including the General Practice Rural Incentives Program (GPRIP). MMM 1 aligns fully with the ASGS-RA category of 'Major cities'. MMM 7 relates to the most remote areas.

Practice	Patients	Practices				
characteristic	in active practices	Active	Withdrawn	Total	Percent withdrawn	
ABS Index of Relative	ABS Index of Relative Socio-economic Disadvantage (IRSD)					
Deciles 1-3 most disadvantaged	3,581 (40.0%)	46 (38.3%)	46 (43.0%)	92 (40.5%)	50.0	
Deciles 4-7	4,294 (47.9%)	51 (42.5%)	38 (35.5%)	89 (39.2%)	42.7	
Deciles 8-10 least disadvantaged	1,084 (12.1%)	23 (19.2%)	23 (21.5%)	46 (20.3%)	50.0	

Source: Practice survey R1 Mar-Jun 2018 for information about practice size and ownership, HPOS data for active and withdrawn patients and number of patients. Notes: 'Does not include strata in dimension relating to range of clinical staff available at the practice; 'See footnote 3, p. 8; 'MMM refers to the Modified Monash Model (see footnote 4, p. 9).

Table 5 – Practice withdrawal status by the number of patients they enrolled

Number of	Status of p	oractices
patients enrolled	Active	Withdrawn
0	0 (0.0%)	62 (100.0%)
1 to 4	5 (22.7%)	17 (77.3%)
5 to 9	7 (63.6%)	4 (36.4%)
10 to 49	47 (71.2%)	19 (28.8%)
50+	61 (92.4%)	5 (7.6%)
Total	120 (52.9%)	107 (47.1%)

Source: HPA analysis of Services Australia data as at 30 June 2020.

The evaluation aimed to achieve a minimum number of practices – 10 – for each sampling stratum (Measure 1.02.03). Table 4 shows that at 30 June 2020, the minimum number was achieved for all study strata except practices located in areas classified as MMM category 3 (five active practices) and areas classified as MMM categories 4 and 5 (six active practices). The evaluation also aimed to ensure that at least 100 patients were enrolled in practices across the sampling stratum (Measure 1.02.04). This target was achieved at the end of the enrolment period (30 June 2019), and was maintained at 30 June 2020.

Reasons for withdrawing – practices

Since the *Interim* evaluation report 2019, a further 11 practices withdrew from HCH by 30 June 2020. In July 2020, a further two practices withdrew. From the 13 withdrawn practices, the evaluation team received exit surveys or conducted interviews with 10.

Practices identified similar issues for withdrawing as those outlined in the *Interim* evaluation report 2019:

- **Practice closure.** Three of the 13 practices withdrew because the practice closed.
- Staff turnover. Four of the 13 practices withdrew when key staff left. Either these staff were
 championing the model, or the work required to train up new staff was perceived as too
 much.

- Extent of change required. A few practices never started implementing the model, and even with the time extension for enrolling patients, they did not enroll any patients or too few for the model to be viable. They did not progress as they perceived that the transformation required was too far from where they were or that the administrative requirements were too onerous.
- GP attitudes to HCH. Attitudes of GPs that did not engage with the model ranged from
 disinterest to dislike. In two instances, GPs who had previously worked in the United
 Kingdom under a capitated payment system actively lobbied other GPs in their practice
 to give up the model. In one instance where the model was implemented, GPs actively
 dissuaded patients from enrolling.
- Value proposition for GPs and patients. In some instances, practices perceived that a clear value proposition for HCH was missing for their GPs or their patients.
- Adequacy of the bundled payment. A small number of practices perceived that the bundled payment was inadequate for the amount of care required for patients with chronic illnesses.
- **Shared care with external providers.** Practices reported that shared care with external providers was not working. For example, they were not using the shared care platform and were requesting printed copies of shared care plans.

Despite withdrawing, practices that were interviewed identified some positive aspects of the model:

- Team care. A few practices noted that they intended to maintain elements of team care
 and increased patient care responsibilities for non-GP staff. Nurse-led clinics and care
 coordination were specific examples of initiatives practices developed under HCH and
 intended to maintain after withdrawal.
- Quality improvement. Practices reported an intention to maintain quality improvement
 measures put in place to facilitate HCH, including data quality measures and various
 reporting using practice management software and plugins.
- **Financial model.** While the direct financial benefit to GPs and/or the practice has been front of mind for many practices that withdrew, there are examples of practices that thought that the financial model was working well, but withdrew for other reasons:

"From a financial side the model was working brilliantly, by the end of June we had 4 nursing staff and 5 receptionists and the daily volume of consultations was normally over 100 and add to this we only had one GP at that time ... I was more managing from a financial side and all I can say is that the numbers worked and allowed us to bring on more staff that could support [the GP] and produce great patient-centred outcomes. The only point I need to raise in regard to that side is that the GP didn't take any % of the HCH funding initially, we were postponing that until we had been able to work out that side of the business model. I am sure that in some clinics that could be an issue if you potentially have GPs wanting % of these funds, we were able to allocate it all to the nursing and allied health side and build the team and services up firstly." [CFO, Exit survey]

HCH patients

Patients began to enrol in the HCH trial in October 2017 and enrolment continued until 30 June 2019. Figure 2 shows the trend in the number of active patients and the trend in the average number of patients per practice, with the shaded area highlighting the enrolment period. Enrolment increased slowly during the first half of 2018, then more rapidly through to the end of 2018. Enrolment rates then slowed again, with relatively steady increases through to the end of the enrolment period. Over the past 12 months (i.e. since the end of the enrolment period) there has been a gradual attrition of patients from the trial. Table 8 shows the reasons for withdrawal, and there is discussion about these reasons closer to the Table.

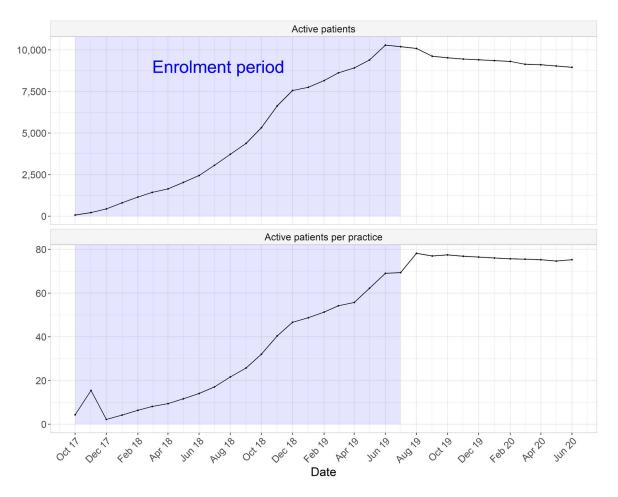


Figure 2 – Number of active patients in the HCH trial and number per practice

Table 7 shows the tier, sex and age group of patients at the time they enrolled in the HCH trial, by whether or not they were still active in the trial on 30 June 2020.

The assignment of patients to tiers was detailed in the *Interim evaluation report 2019*. Table 6 highlights the characteristics of patients in each tier, for reference.

Table 6 – Tier characteristics

Tier 3 Highly complex, multiple morbidity	Tier 2 Increasing complexity, multiple morbidity	Tier 1 Multiple morbidity, low complexity
 Many require ongoing clinical care within an acute setting (e.g. severe and treatment-resistant mental illness). Require a high level of clinical coordinated care. Some could be supported through better access to palliative care. 	 Most should be managed in the primary health care setting. Have an increased risk of potentially avoidable ED presentations and hospitalisations as their conditions worsen or if not well supported. Require clinical coordination and non-clinical coordination. Will benefit from selfmanagement support. 	Are largely high functioning but would gain significant long-term benefits from improved engagement and structured primary health care support.

Source: Australian Government Department of Health, 2016.

Of the 11,332 patients who enrolled, 8,959 (79%) were still participating in the trial on 30 June 2020.

At 30 June 2020, 2,373 patients had withdrawn from HCH. These patients tended to be slightly older (34.8% vs. 26.1% 75 years or older; p<0.001) and allocated to a higher tier at baseline (38.8% vs. 31.5% in tier 3; p<0.001) than patients who remained in the trial.

Patients were recruited over a 21-month period and by 30 June 2020, patients had been in the trial for periods between 12 and 33 months. Therefore, examining differences in withdrawal rates between groups of patients at a particular point in time may be misleading, as the groups may have been in the trial for different lengths of time. Figure 3 shows the probability of patients withdrawing from the trial as a function of the time from enrolment. In calculating the denominator for the curve, patients who withdrew because their practice withdrew were removed (at the time point the practice withdrew) and are not considered to have withdrawn from the trial themselves. Separate lines are fitted for risk tier at the time of enrolment. The Figure supports the data presented in Table 7, which shows that patients in tier 3 were more likely to withdraw from the trial than patients in the other two tiers. Further analysis of this and commentary is provided below.

Table 7 – Key characteristics of HCH patients

Characteristic		Patient status ¹	
Characteristic	Active	Withdrawn	Total
Total patients	8,959	2,373	11,332
	:	Sex ²	
Female	4,855 (54.2%)	1,243 (52.4%)	6,098 (53.8%)
Male	4,104 (45.8%)	1,130 (47.6%)	5,234 (46.2%)
	Age group	at enrolment³	
0 to 17	145 (1.6%)	26 (1.1%)	171 (1.5%)
8 to 24	185 (2.1%)	28 (1.2%)	213 (1.9%)
25 to 44	1,074 (12.0%)	173 (7.3%)	1,247 (11.0%)

Characteristic	Patient status ¹			
Characteristic	Active	Withdrawn	Total	
45 to 64	2,921 (32.6%)	748 (31.5%)	3,669 (32.4%)	
65 to 74	2,295 (25.6%)	573 (24.1%)	2,868 (25.3%)	
75 to 84	1,729 (19.3%)	537 (22.6%)	2,266 (20.0%)	
85+	610 (6.8%)	288 (12.1%)	898 (7.9%)	
Risk tier at enrolment ³				
Tier 1	1,645 (18.4%)	367 (15.5%)	2,012 (17.8%)	
Tier 2	4,488 (50.1%)	1,086 (45.8%)	5,574 (49.2%)	
Tier 3	2,826 (31.5%)	920 (38.8%)	3,746 (33.1%)	

Source: HPA analysis of HPOS data to 30 June 2020. 1 'Active' means patients participating in the trial as at 30 June 2020. Withdrawn means patients who were enrolled any time from 1 October 2017 to 30 June 2019, but withdrew any time prior to 30 June 2020. 2 Difference between active and withdrawn patients not significant (p=0.121).

3 Difference between active and withdrawn patients is significant (p<0.001).

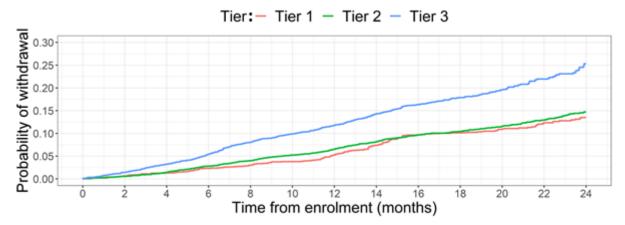


Figure 3 – Probability of patients withdrawing from the HCH trial by time and tier

Notes: Time cut-off at 24 months.

Among all patients who enrolled in the trial, 5.1% opted out of the trial. Almost 40% of the patients who withdrew did so because the practice withdrew (Table 8). Other reasons for withdrawing include: the patient opted out of the trial (24% of withdrawals), the patient was no longer with the practice (13%), the patient died (13%), the patient moved from the area (10%). In interviews with practices, staff commented that patients who opted out did not understand the HCH model or wanted more face-to-face time with their GP.

Table 8 – Number of patients withdrawing from HCH and reasons: 30 June 2020

Reason	Tier n (% of all patients within the tier)			Total n (% of all	
	1	2	3	patients)	
Patient died	19 (0.9%)	102 (1.8%)	185 (4.9%)	306 (2.7%)	
Patient moved from the area	26 (1.3%)	101 (1.8%)	102 (2.7%)	229 (2.0%)	
Patient opted out	117 (5.8%)	253 (4.5%)	211 (5.6%)	581 (5.1%)	
Patient no longer with the practice	42 (2.1%)	141 (2.5%)	135 (3.6%)	318 (2.8%)	
Patient not entitled to Medicare	1 (0.0%)	3 (0.1%)	0	4 (0.1%)	
Practice withdrawn from HCH	162 (8.1%)	482 (8.6%)	284 (7.6%)	928 (8.2%)	
Other	0	4 (0.1%)	3 (0.1%)	7 (0.1%)	
Total	367 (18.2%)	1,086 (19.5%)	920 (24.6%)	2,373 (20.9%)	

Source: HPOS to 30 June 2020.

The tier to which patients are assigned reflects the risk of being hospitalised within the following 12 months, as reflected in the patient's score on the HARP tool. The validity of the tool is partially supported by the data presented in Table 8, which shows that patients allocated to tier 3 at enrolment were more than five times more likely to die than patients in tier 1 (4.9% vs. 0.9% of patients enrolled), and more than twice as likely to die as patients in tier 2 (4.9% vs. 1.8%). Patients in tier 3 were also more likely to withdraw because they moved from the area or were no longer with the practice. Unadjusted and adjusted hazard ratios (for risk of dying) from a survival analysis technique that adjusts for both different lengths of follow-up time and clustering of patients within practices are presented in Table 9. The hazard ratios suggest that older patients, males and patients allocated to a higher tier at baseline were more likely to die during the follow-up period.

Table 9 – Risk of death by level of baseline characteristics

Table 7 - kisk of dealth by level of baseline characteristics						
Variable	Level	Unadjusted hazard ratios		Adjusted hazard ratios		
Vallable		HR (95% CI)	р	HR (95% CI)	р	
	1	Referent		Referent		
Tier	2	2.85 (1.41 to 5.76)	0.003	2.62 (1.30 to 5.31)	0.007	
	3	9.13 (4.59 to 18.16)	<0.001	7.43 (3.72 to 14.84)	<0.001	
	45 to <65	Referent		Referent		
Age group	65 to <75	0.95 (0.65 to 1.40)	0.815	1.12 (0.76 to 1.65)	0.560	
	85+	6.43 (4.53 to 9.12)	<0.001	5.83 (4.12 to 8.26)	<0.001	
Gender	Females	Referent		Referent		
	Males	1.32 (0.99 to 1.75)	0.055	1.42 (1.07 to 1.89)	0.015	

Source: HPA analysis of HPOS data as at 30 June 2020.

According to the Department of Health's Handbook for general practices and Aboriginal Community Controlled Health Services (Australian Government Department of Health, 2019):

"An enrolled patient's tier level is intended to account for fluctuations in their health care needs over the course of 12 months. A patient's risk stratification certificate is valid for 12 months, at which time their risk tier level will need to be reviewed by repeating the risk stratification process." (p. 9)

Among the patients who were still active at 30 June 2020, 717 (8.0%) were reallocated to a different tier at least once prior to 30 June 2020. About 6% were reallocated to a higher risk tier and 2% to a lower risk tier. Of the 1,645 patients allocated to tier 1, 271 (16.5%) moved to a higher tier. Of patients initially allocated to tier 2, 309 (6.9%) moved to tier 3 and 59(1.3%) to tier 1. Of patients initially allocated to tier 3, 75 (2.7%) moved to tier 2 and a further 3 (0.1%) to tier 1.

Table 10 – Tier changes among active patients

Tier at	Total	Tier at follow-up ¹		
enrolment	patients	Tier 1	Tier 2	Tier 3
Tier 1	1,645	1,374 (83.5%)	222 (13.5%)	49 (3.0%)
Tier 2	4,488	59 (1.3%)	4,120 (91.8%)	309 (6.9%)
Tier 3	2,826	3 (0.1%)	75 (2.7%)	2,748 (97.2%)

Source: HPA analysis of HPOS data as of 30 June 2020. ¹ Follow-up periods are variable; at minimum they should occur 12 months after a patient is enrolled and each 12 months thereafter.

3. Practice implementation of HCH

Key points:

- Once patient enrolment closed, practices turned their attention to enhancing their model of care. The changes most practices (50% or more) reported they did not have in place prior to HCH but were now working on, included:
 - proactive contact with patients to check how they were going
 - introducing new roles within the practice
 - reassigning components of care from the GP or nurse to a medical assistant
 - patients able to communicate by email or secure messaging with the GP or nurse.
- Initiatives that practices said they had now implemented or were making good progress implementing were:
 - HCH patients able to refill scripts without a GP consultation
 - HCH patients able to telephone the practice and talk to the nurse or GP about their health concerns⁵
 - improved systems for follow-up and recall of HCH patients.
- Practices reported making progress in **team-based care**. Practices that had all GPs participating in HCH found it easier to achieve this. Practices that had in-house allied health professionals and/or pharmacists also found team-based care easier to achieve.
- Working as a team with external providers was challenging for many practices. Barriers were knowledge and awareness of HCH among the external providers and ineffective use of shared care planning tools. A lesson from the Interim evaluation report 2019 was the need to consider how solutions will be taken up by health care providers across a region when promoting shared care planning (#23)6. An additional lesson that has emerged is the need to raise awareness of HCH among health care providers that general practices work closely with (allied health providers, hospitals, community pharmacists) (new lesson #33).
- Scale has emerged as a key contributor to success both in terms of the number of patients enrolled and the proportion of GPs participating in HCH. Having more enrolees allows implementation costs to be spread and absorbed, and the swings and roundabouts of a bundled payment to be better managed. It also means specific processes for HCH patients can be better absorbed into the everyday operations of the practice. Some practice staff suggested that a minimum of 100 patients is required for the model to be viable. However, scale economies may occur well beyond this number and in larger practices significantly more enrolees may be required.
- Practice staff and PHN facilitators commented that without all or most GPs within a practice
 participating in HCH, implementation is problematic. Lower levels of participation of GPs
 affects both costs (e.g. having multiple processes in place for different GPs), team-based
 care and the overall organisational culture and commitment to implementation. However,
 some warned it may not be feasible to have all GPs involved with a program such as HCH.

⁵ Note that this was prior to the telehealth items introduced as part of the COVID-19 response.

⁶ Numbering of lessons from the *Interim evaluation report* 2019 is used. Numbering for new lessons arising from this report continues from the 2019 list. See Volume 1 for the complete list of lessons.

- For the benefits to be realised, HCH practices need to achieve an adequate level of scale in the number of patients enrolled and the participation of GPs (new lesson #31). Therefore:
 - Participating practices should commit to a threshold level of enrolments. The threshold should vary according to the number of participating GPs.
 - Most GPs in a practice should participate and ideally all GPs. In further rollout of HCH, practices should commit to achieving a threshold proportion of GPs that are willing to participate in the initiative.

The Interim evaluation report 2019 described practices' experiences of implementing HCH, from the expression of interest stage through to the end of 2018. At that time, practices were still in the early stages of implementing the model, for example, implementing infrastructure such as shared care planning software, and enrolling patients. This Chapter builds on the reflections and findings presented in the Interim evaluation report 2019. The data for this Chapter are drawn from case study interviews, conducted between November 2019 and March 2020, surveys completed by the practices over the same period, and extracts from practices' clinical management systems that have been provided over the whole trial period. Two Aboriginal Community Controlled Health Services (ACCHS) were also part of the case studies. Their experiences are described separately in Chapter 6.

How practices have progressed

In December 2018, the Department announced the extension of the HCH trial, as the evaluation team was finishing the first round of practice interviews. The trial was extended to 30 June 2021 (from 30 November 2019) and the patient enrolment period to 30 June 2019 (from 31 December 2018). When the evaluation team began this round of practice interviews in November 2019, the enrolment period had ended five months prior and the practices had just attended the HCH forum conducted in early November 2019.

Final six months of patient enrolment

The trial extension gave some practices more time to engage staff and firmly implement HCH, allowing them to enrol more patients:

"I think last year, January [2019], we were a bit ramped up a little bit, and [the GP] got quite a few more of these patients in, because he understood how things would work." [Business Manager, R4, Practice 15]

"Well, they basically wanted us to have more patients, and to try and enrol more patients. So, we focused on it and got to calling more patients and see who wanted to be part of the program and that's all patients who had chronic conditions ..." [Nurse, R4, Practice 3]

Other practices found it challenging to increase their enrolments even with the time extension. A frustration was the lack of time to simultaneously implement the model and enrol patients:

"It was a bit frustrating that you only had a specific timeline to register the patients in, because we were experiencing a lot of [IT] issues ... which then delayed it longer." [Practice Manager, R4, Practice 14]

"I think it was hard to incorporate the registration timing into the existing clinics, you sort of had to get these registrations done and care plans done whilst the clinic was going on. ... [Y]ou still had your other ... duties or patients to attend to ... [H]aving to do these as well was hard." [Nurse, R4, Practice 10]

- "... patient enrolment is quite complex. We need to enrol them in HPOS, Best Practice ... There were seven data entry points. And then explaining to a patient what the system involved took a lot of effort." [GP, R4, Practice 07]
- "... there's a lot of time required for the nurses up front to go through the risk stratification and put together their shared care plan and everything else, yes, that was also a limiting factor in how quickly we could sign up new patients." [GP, R4, Practice 13]

A variation of the above was time to engage GPs:

"Originally, we had one doctor on board to do the Health Care Home program, which meant there was one doctor trying to look after 50 or nearly 60 something-odd patients. And that was really quite difficult for that doctor. But since I've been here and since I've been able to explain to them the program a bit better and explain how everything works and what their requirements are, we actually have at least six doctors on board now, helping care for these patients ... I think we could benefit from enrolling a few more patients in the program ... being [a] six doctor clinic, we have the capacity and the ability to offer more." [Practice Manager, R4, Practice 14]

"We would definitely have liked more [patients], yes. We spent all our time convincing the doctors, and then we had to convince the patients." [Owner, R4, Practice 6]

Another reason practices did not ramp up their enrolments with the extension was that they wanted to test the model before committing to enrolling more patients:

"This ... is why we choose 100. Because we want to try this out on all aspects from financial, from the doctor's happiness, patient's happiness. All these things we take into consideration. That's why we do not want to increase [the] number." [GP, R4, Practice 03]

Some practices had concerns with investing significant resources in the trial when it was not clear it would continue beyond the trial period. This deterred them from enrolling more patients:

"... the other reason why we didn't end up [enrolling] too many patients in the program was uncertainty about where the program would be after two years. So, it's difficult to get ... a large cohort of patients used to it and then after two years say well, we're going to now can it and we'll have to do things differently." [GP, R4, Practice 11]

"You'll get the cynic out of me, but generally, what happens in these situations is the program is started with fanfare and with plenty of funding and then once the hook is set and everybody is using it, it tends to get wound back ... there'll be this expectation about what the care looks like in general practice and the funding will disappear for it." [GP, R4, Practice 2]

Post patient enrolment

"It's working, it's time consuming. The other work is still there, it never ends unfortunately. But it's working." [GP, R4, Practice 8] It wasn't until patient enrolment closed that practices could fully turn their attention to enhancing specific aspects of their model. They identified the following areas of focus:

- streamlining management of patients
- increasing nurse involvement
- improving teamwork and communication
- reserving time for HCH tasks and patients
- enhancing telehealth and teleconferencing capabilities.

Some practices identified the HCH forum as a catalyst for new ideas, further staff engagement, and implementing specific changes within their practice:

"I went to the [HCH forum] back in November, and from that, I took away a lot of things that we could implement here. And since then, we've changed a few of our processes around the billing and the types of care, and the conferencing we do now with our patients." [Practice Manager, R4, Practice 14]

Level of change

The level of change to care delivery has varied between practices. Some believed that changes made were evident to their patients:

"Our patients that are on the program have definitely seen the advantage in the sense that they were being monitored and regularly recorded and reviewed by [nurse] periodically. Which, the whole point is to reduce acute care to GP or any secondary, tertiary health services. So that's also elevated our doctors' working load as you can imagine to take care of other patients or new patients." [Receptionist, R4, Practice 3]

"... in terms of ... the accessibility of care of the patient from the GP has dramatically improved. Absolutely. Where it's not now only a face-to-face conversation. And most of our patients who are enrolled on the program are people with complex chronic conditions. Which not always involves having to have them physically sitting in front of you ... the ability to be able to do a phone conversation to check in on them, but, also, then to have a nurse be involved ..."
[GP, R4, Practice 5]

"I think that their management is quite thorough and is almost more similar to the sort of care that you would get as a hospital inpatient, in that it's very multidisciplinary. We work as a team and so, we have routine meetings in which patients are discussed and everyone's brought up to speed on it. It also helps, having multiple eyes on the same patient, over a period of time. Their care is

more thorough and so, every aspect is explored and picked up. It's easier to be on top of lots of different things because multiple people are seeing them, multiple times a week or even just having your mind aware of processing some of their complex issues." [GP Registrar 2, R4, Practice 12]

Others did not think that their HCH model was any different to usual practice:

"To be honest with you, not a lot has changed. The patients aren't treated any different, that I've noticed. So not a lot of change at all really." [Nurse, R4, Practice 10]

"Well, the only thing that I would say is they are happy they don't have to come in for scripts, and things. They can just leave a message at the front desk. That's the only difference, I'd say." [GP2, R4, Practice 1]

Many staff attributed the lack of change to already having strong chronic disease management prior to HCH:

"I don't think we've gained or seen as much change within the practice as we might have been hoping might have occurred. So we had already invested quite a bit of our time in developing a model of care for enhanced primary care, in particular, chronic disease management. And I suppose what I was ... hoping for out of it, was maybe further increasing the role of the practice nurses with the management of people with chronic disease. And, in particular, because at the time we embarked on this, we were having a fairly major issue with lack of medical staff, hoping to increase the role of practice nurses with less input from the medical staff. And that hasn't really happened and I think in part that occurred because we already had quite a large role for the practice nurses with what they were doing. And that really hasn't developed any further with Health Care Homes." [GP, R4, Practice 2]

Some identified staff turnover and high administrative burden as barriers to progressing implementation:

"It's hit a bit of a plateau probably due to a few things ... [W]hat I'd say is that 90% of our focus ended up being on the administration implementation. That has made it very hard to change the clinical context too much because the administration load was high ... And then our team administrator had a baby and has taken 12, 18 months off work. And our nurse who was running a program moved ... And so with key staff and personnel and such a complex administrative system, it really has stifled our ability to innovate in the Health Care Homes space much in the last 12 or 18 months. If it was a simpler system to administer, then rather than to bring people up to speed on the administration when you have key personnel changes, you could focus more on the clinical aspects. So, it's been a little bit disappointing in that regard." [GP, R4, Practice 7]

Type of change

The section below describes the changes that practices had made as part of HCH or were planning to make. Note that **these were prior to the COVID-19 pandemic**, which may have sped up some initiatives (e.g. non face-to-face communications with clinical staff), and

slowed down others. The effects of the pandemic will be explored in the next evaluation report.

Practices were asked whether specific initiatives were features of their practices in the past or would become so in the future. The questions were formulated as, 'Is the initiative a feature of the practice now?' (Figure 4), 'Will this be a change you are planning to make?' (Figure 5), and 'What is your assessment of the extent to which this change has been implemented for your HCH patients as at November 2019?' (Figure 6). Initiatives that were a feature in less than 50% of practices prior to HCH included (Figure 4):

- D: Reassigning components of care from the GP or nurse to a medical assistant.
- E: New roles within the practice.
- G: Proactive contact with patients to check how they were going.
- H: Dedicated clinics for patients with specific chronic conditions
- I: Group consultations.
- L: Patients able to communicate by email or secure messaging with the GP or nurse.
- M: Having a patient portal through which clinical information could be shared with patients.

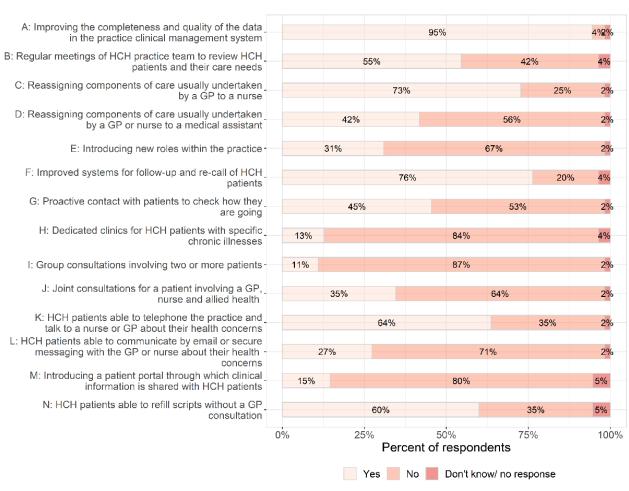


Figure 4 – Features of the practice prior to HCH

Source: Practice survey R4.

Of the initiatives that were a feature in less than 50% of practices prior to HCH (see list prior to figure above), practices had progressed/planned to progress as follows (Figure 5):

- D: Reassigning components of care from the GP or nurse to a medical assistant 44% were implementing at the time of the survey, 9% planned to implement by December 2020.
- E: New roles within the practice 45% were implementing at the time of the survey, 7% planned to implement by December 2020.
- G: Proactive contact with patients to check how they were going 73% were implementing at the time of the survey, 11% planned to implement by December 2020.
- H: Dedicated clinics for patients with specific chronic conditions 15% were implementing at the time of the survey, 24% planned to implement by December 2020.
- I: Group consultations 11% were implementing at the time of the survey, 18% planned to implement by December 2020.
- L: Patients able to communicate by email or secure messaging with the GP or nurse –
 42% were implementing at the time of the survey, 13% planned to implement by
 December 2020.
- M: Having a patient portal through which clinical information could be shared with patients – 16% were implementing at the time of the survey, 16% planned to implement by December 2020.

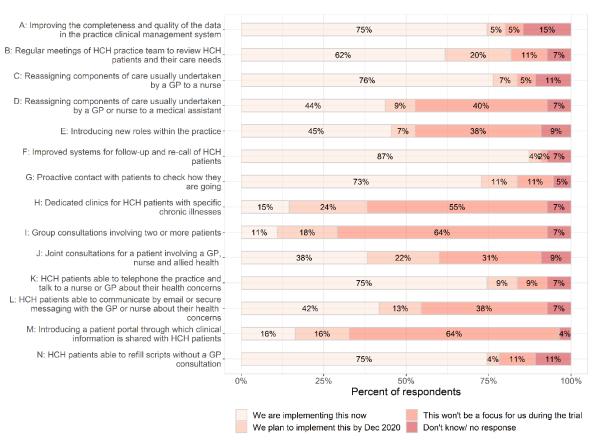


Figure 5 – Will this be a change you are planning to make?

Source: Practice survey R4.

In terms of changes they had completed at the time of the survey (Figure 6), practices had most success in:

- B: Regular meetings of HCH practice team to review HCH patients and their care needs – 13% had completed the change, and 36% reported making good progress.
- C: Reassigning components of care usually undertaken by a GP to a nurse 13% had completed the change, and 49% reported making good progress.
- F: Improved systems for follow-up and recall of HCH patients 16% had completed the change, and 56% reported making good progress.
- K: HCH patients able to telephone the practice and talk to the nurse or GP about their health concerns 16% had completed the change and 49% reported making good progress.
- N: HCH patients able to refill scripts without a GP consultation 25% had completed the change, and 44% reported making good progress.

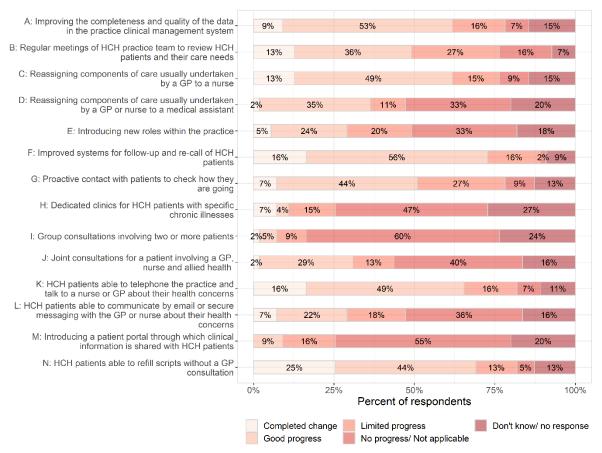


Figure 6 – What is your assessment of the extent to which this change has been implemented for your HCH patients as at March 2020?

Source: Practice survey R4.

Several practices described their future plans for HCH. In conjunction with implementing and managing HCH, staff members said they would like to continue to establish or enhance the following:

- increased nurse engagement
- group sessions for patients
- streamline systems for non-face-to-face contact with patients
- video call services for patients

- email contact for HCH patients
- staff uptake of shared care planning software, ensuring the practice is using the technology to its full potential
- streamlined referral processes
- improve management and recall of HCH patients
- enhance management and planning to prepare for voluntary enrolment of the over-70s patient cohort
- increased scope of team-based care
- introduce or further incorporate allied health into HCH patient care
- fund additional allied health visits through HCH
- establish additional structure around case conferencing meetings
- establish processes to better track and measure HCH patient outcomes
- maximise chronic disease management processes for HCH patients.

Team-based care

"You ... have to have a group of people that want to make it happen. It's not a half-hearted exercise." [Practice Manager, R4, Practice 4] Team-based care is a fundamental building block of HCH. During the trial, practices worked on instilling it or enhancing it:

"To make it work, you really need the clinic to form a small group of a team to run it. You just cannot throw this to one person to take responsibility." [GP, R4, Practice 3]

Some staff considered a barrier to team-based care was GPs' willingness to let nurses have greater responsibility for patient care:

"We've had to, probably, re-educate GPs to allow the nurses to take on the responsibility of care of some of the patients. So that was probably a really difficult thing to navigate around, but we got there eventually. But yes, probably having to put a lot more nurses on to be able to manage the demographics of our practice." [Practice Manager, R4, Practice 4]

"I guess many GPs particularly those ... that have been around for a while struggled to delegate a little bit and feel that [they] have to be in control." [Nurse, R4, Practice 4]

"We are trying quietly to get the nurse more involved in a kind of autonomous way. You heard from [GP] that she wants to see all her patients and all the doctors are saying that, but we are quietly trying to introduce it bit by bit."

[Business Owner, R4, Practice 6]

"Yes, we want it to be a group. We want it to be not just the doctor. And I think that's been hard for doctors to really to give up control. They think that this is my patient and I want to do this. It's actually getting used to sharing it. And I think they've all found that a bit difficult." [Practice Manager, R4, Practice 17]

"... there's still an expectation amongst patients that some things they still think they need to see the doctor about." [GP, R4, Practice 2] Another barrier reported was patients' expectations:

"... the way I imagined it, is that we get a block of funding which should free up me as a doctor to be able to focus more on high value care. And provide more opportunities to have non face-to-face contact with a patient and provide opportunities for the nurse to do more to support the patient. What I've seen in reality is there has been a bit of that but there's still a lot of time where the patient is contacting me when they should be contacting the nurse or taking up my time in ways that aren't always productive. And part of that has been because of the confusion, because it's hard to follow new systems. Because patients don't understand the process ... because patients are so used to seeing a doctor ... It's hard for them to adjust to a new way of doing things." [GP, R4, Practice 13]

"Communication's probably the biggest thing that's changed. It's hard to get the patients to learn going from Medicare, fee-for-service, got to come in and see the doctor, to there are different ways of doing it. That's probably been the biggest challenge." [Nurse, R4, Practice 5]

Nevertheless, practices reported getting over these barriers and movement towards a stronger team-based culture:

"... the doctors are more trusting with us now under the Health Care Homes because they know that either way they're going to see them but it just depends on when." [Nurse, R4, Practice 6]

"Okay, so, the way I look at it is from the GP's perspective and from the patients'. So, on the GP side of things, or from a general practice side of things, I think what I've noticed is a massive shift in the team culture and how we started working as a team in a fairly positive manner ... we've got our team of the GP, the nurses, the clinical pharmacist. We've got [medical practice assistant] now ... So, our team and the way we work as a team, there's been a big improvement. And that I can even tell you from 12 months ago to now, that we see everybody is given their own roles to do. But when it comes together, for the benefit of the patient, I think we work really well as a team." [GP, R4, Practice 5]

"... [the] doctors ... they have the option of giving to the nurse and the nurse could follow-up with that. A lot of those things have been pushed to the nurse and doctor will instruct them, 'This is what I want them to be done'. And then the nurse gets them done. Which is ... easier for us, in terms of managing the time for the doctors and the nurses ..." [Practice Manager, R4, Practice 9]

Practices reported that it was easier to establish strong teamwork once all of the doctors agreed to participate in the trial and all staff members were engaged:

"At every meeting, we have a part for Health Care Homes. Then we go through them. The good thing about our practice is all doctors here are involved in Health Care Homes. So, everyone is on the same page and knows what's happening. So, it was easy for us to do all that." [Practice Manager, R4, Practice 9]

"[HCH] had a big impact on the team, obviously because when it first started, we didn't have all our doctors on board, assisting. And the reception staff were not familiar with what Health Care Homes was, and how the program worked, and what the program meant, and what patients could do, who were enrolled in that program. So, since we've had a re-evaluation of it since I started here last year ...

And with all the doctors on board now, too, it means that they've got a better understanding of why these patients are on this program, and what benefits it is to the doctor and the patient as well." [Practice Manager, R4, Practice 14]

Strategies that practices have employed to enhance teamwork included:

- "... we do have regular Health Care Homes meetings as well between myself, the clinic director and ... [the] head nurse to see how everything's going, if we need any improvements, how we can improve and what we can do from there." [Practice Manager, R4, Practice 13]
- "... we've got a structure where we've all got Excel sheets with all [of] our patients on there. And then we do allocate things. Where there are certain things reception staff can do. And so, we would have rows and columns allocated for each person. So, there will be one for the reception to do and one for [medical practice assistant MPA name], our MPA, to do. And one for the nurse to do, and one for, say, myself, and that's something that I'll have to pick up the ball and talk to my patient when that's there. And then when we do our huddle, we put that in, and then we make sure that all of us are actually looking at our Excel sheet on a regular basis to see if that task has been completed and we mark it off as complete as we go. And because we do it on a regular basis, I think we seem to be on top of it now." [GP, R4, Practice 5]

"We still have our huddles. We have our meetings, mostly each week ... But we're still caring for our Health Care Homes patients in amongst that and still making sure that they're not getting lost. As far as them coming in, it might be diabetic education or touching base with some of our elderly ones that are in the Health Care Homes ... Making sure that, I guess, even loneliness isn't becoming an issue or that they're still safe at home. And especially coming into the winter seasons and things like that." [Nurse, R4, Practice 12]

Practices also commented on the effect of teamwork on their patients:

- "I think that they feel that the team of people that's involved in their healthcare is better equipped. They're in more communication, they're talking more, and they feel that they are, again, better cared for by that team." [Practice Manager, R4, Practice 13]
- "... it becomes more like a patient in the hospital, where they're under your care for that period of time and you're dynamically discussing them. It's not like a closed moment in time where you're dealing with this patient. It's just an ongoing process and that means that whatever needs, can be flexible in that." [GP Registrar 2, R4, Practice 12]

Team-based care extends beyond the GP and nurse; it includes other providers, both internal and external. Where practices had allied health professionals and pharmacists inhouse, team-based care was reported to be easier:

"Because we have our own certain allied health, so we can follow-up and see if they've seen the allied health or not." [Nurse, R4, Practice 3] "For some of the patients it's me looking through the database and often with the nurse. We have a look at patients, and she'll know a bit more about them. So, she can say these are good patients to talk to or patients who need to be spoken to. At other times doctor will see the patient and say, I'm putting you on this drug. Go and see [Pharmacist] now, and he'll talk to you all about it, tell you all about it. So I'll be involved in immediately. The drug has been prescribed or the treatment's been prescribed to educate the patient, and then I'll call them back for follow-up." [Clinical Pharmacist, R4, Practice 5]

"... we are engaging them with the allied health people also, doing the health care plan and engaging them with the Health Care Homes patients, with the allied health team. It's trying to give a combined care rather than an individualised care." [GP, R4, Practice 14]

Some practices found team-based care with external providers more challenging. Although they regularly communicated with external providers through letters and over the phone, they were not using tools to work effectively as a team (see Shared care planning software, p. 49). Some practices also suggested that limited knowledge and awareness of HCH among providers outside of the practice was a major barrier in team-based care:

"... we should educate the allied health providers, we should make Health Care Homes public knowledge, identification cards, the donor bracelets ..." [Business Owner, R4, Practice 6]

New staffing roles

As discussed in the Interim evaluation report 2019, some practices hired new staff and established additional roles within their practices to help manage HCH patients. Beyond expanding the roles and responsibilities of nurses and administrative staff, practices reported adding coordinators and medical practice assistants (MPAs) to their team to specifically help manage their HCH patients. In the most recent round of interviews, practices elaborated on the contribution of this role to care delivery:

"... [The MPA] helps us out with other things. Like a lot of excisions and things that we don't need to actually to be there to assist the doctor. So, she does those kinds of jobs. And then it makes more room for us too, so we are doing well but I think ... [MPA]'s only on that role, two days, three days a week, two days a week. So even if she was to come on more time as MPA, that would help us out more. But, she's still got to do reception. She's all over the place. She's at reception and here and she helps us. She's everywhere. She's a big, very important role." [Nurse, R4, Practice 5]

The MPA at this practice was equally enthusiastic about the role:

"I'm loving it. It's really good. I definitely feel more confident in it as well, since I've been doing it for longer. Because at the start, even myself, patients were hesitant seeing me, and I still was a bit worried about seeing them ... So, I've changed. I think I'm more confident in it now, which is a great thing, and [the] patients can tell that I am as well." [MPA, R4, Practice 5]

Staff turnover has affected all HCH staffing roles, including the new roles:

"... we've got our list of our Health Care Home patients and ... I did have a medical assistant who was responsible for making sure that the Health Care [Home] patients were up to date with those care plans. She did enrol in nursing and finished and left. And so now I've given that task to just one of the admin girls." [Practice Manager/Nurse, R4, Practice 18]

Data

Practices commented on the importance and value of data in general practice. In particular, they expressed the need for additional emphasis and work on data quality and benchmarking for enhancing quality of care, establishing targets and more effectively measuring program outcomes:

"... I think a key weakness of our system and I think it also relates to Health Care Home program is benchmarking ... it's very difficult as the practice principal here to have much data about how do we compare to other practices with almost any metric, you might want to pick ... if in theory being part of the Health Care Home program means that we're more proactive with helping people manage their chronic health issues and that maybe they end up with better targets for blood pressure or fewer relapses or whatever. There are no systems in place for us to be able to easily benchmark us against other Health Care Home clinics or even non-Health Care Home clinics. And I think without that level of data tracking, it's hard for us to understand at an individual level, is this even beneficial in making a difference to anyone." [GP, R4, Practice 13]

"I know the Primary Health Network, for example, collects data, but we don't get to actually do a comparison to see where we are sitting with our data compared to like practices, and that everybody's got a bit of a competitive nature about them. When you look at what your rates of HbA1c or your rates of, like, measuring hypertension, managing hypertension and you're just getting heart disease. And if you're not leading the pack, you get a little bit pissed off as a group. It sort of, like, improves performance, I think." [GP, R4, Practice 2]

In some instances, the PHN was doing work in this area, and practices found this beneficial:

"The PHN is doing a bit of that work with data and that's been really helpful for our quality improvement. That's not just helped us with Health Care Homes, it's helped us as a practice for our patient outcomes and those sort of things. So that's certainly, I think, beneficial to have that." [Practice Manager, R4, Practice 10]

Many practices reported prioritising enhanced data collection and data quality since becoming an HCH practice:

- "... we have seen some improvements both in our [business intelligence] tool use, particularly under the PIP QI and in our care planning processes spilling to other patients. So, we've achieved that aim that we wanted to, really, which is that we've had the chance to focus on with the Health Care Home patients we've been able to apply that to other people." [GP, R4, Practice 12]
- "... we've implemented a couple of new things. We've started [measuring patient activation] and the patient-reported outcomes measure which we didn't

do before. So, we think that's been a bonus. We actually went to the [November 2019 HCH] forum and got a better tool ... So, we're going to use that now instead." [Practice Manager, R4, Practice 17]

"The other thing which would have really focused that improvement journey more, apart from funding for that, is a much more explicit enunciation of measuring of outcomes at each practice. It doesn't mean a benchmark level has to be achieved but is actually very much along the lines of what the QI PIP for example, is doing, where you say, you have to be able to produce the data for this group of patients. It might mean that you'd say for all our cohort of patients with diabetes and Health Care Homes, you need to able to produce this data."

[GP, R4, Practice 11]

"Yes, the [patient-reported outcome tool]. So, I [would] like to follow-up with them once again. So, basically everyone's going to need another one. So, that's going to take a bit of my time, but that's what I do as well, send it out." [MPA, R4, Practice 5]

Chapter 4 presents some initial analysis of trends in the recording of key lifestyle and clinical measures for their HCH patients.

Evaluation benchmarking reports

As a means of feeding back data received for the evaluation, the evaluators disseminated benchmark reports for practices and for PHNs at six-monthly intervals. To date, four benchmark reports have been issued. The reports are largely based on practice data extracts, with selected demographic and enrolment data derived from the HPOS extracts. Volume 3 contains further information on the benchmarking reports and includes samples of the practice and PHN reports.

The practice reports compare data for HCH patients in the practice with HCH patients in similar practices (i.e. practices of similar size and geographic remoteness), and HCH patients in all other HCH practices. Information presented includes:

- recording of patient clinical assessments (e.g. smoking status, height, weight)
- patient measurements (e.g. blood pressure, cholesterol, HbA1c)
- recording on various patient health conditions.

Practices were asked about the benchmark reports in the recent practice survey. One-third rated the reports as moderately useful (Table 11). They commented qualitatively that they generally found the reports valuable, asking for them to be more frequent and automatically emailed to the practice for easier access (they are currently available to practices through the HCH evaluation online portal, which requires a secure login for each practice). They expressed an interest in seeing more comparisons of patient outcomes, or proxies for patient outcomes like average HbA1c, and were also interested in seeing deeper comparisons with like practices through more detailed patient demographics. One practice suggested self-comparison or tracking of the practice's progress over time as a useful addition.

Table 11 – Practice and PHN rating of the benchmark reports

Rating	Number of practices (%)	Number of PHNs
Very useful	0(0%)	2
Moderately useful	19 (34.5%)	4
Limited usefulness	9 (16.4%)	2
Not useful	3 (5.5%)	0
Did not receive ¹	9 (16.4%)	0
Can't say/don't know	15 (27.3%)	1
Total	55 (100%)2	9 3

Source: Practice survey R4. PHN Survey Round 4. Notes: ¹Some practices did not receive a report as there were issues with their practice extracts (e.g. not available or HCH patients not flagged). ²55 of the 120 practices participating responded to the survey. ³9 of the 10 PHNs participating in HCH responded to the survey.

PHNs also rated the benchmark reports in their survey. Six of the nine PHNs responding rated the reports as moderately useful to very useful (Table 11). Qualitatively they commented that they would like practice-level reports (PHNs are receiving aggregated reports across all of their HCH practices), as:

"The reports provide interesting information, good talking points with practices. If possible would be nice to have access to practice reports so we can support practices to analyse the data." [PHN survey R4, PHN10].

They also thought that the reports could be more frequent, for example:

"Practices are accustomed to quarterly reporting, benchmarking reports would assist practices on a quarterly basis in line with practice PIP payments and quality improvement activities." [PHN survey R4, PHN01].

One PHN suggested that standardised activity codes may have provided greater insight into changes in chronic disease management across practices. Another requested the template for the reports so they could maintain providing these reports to their practices beyond the trial.

Impact of change

Patient access

"Telehealth conferencing is fantastic. Yes, we use that." [Nurse, R4, Practice 2] Improved patient access was commonly cited as a benefit of HCH. Practices reported they had improved access through offering telephone and, to a much lesser extent, video consultations with the nurse or GP (including requests for repeat prescriptions) and email correspondence, a

direct telephone line for HCH patients to call, streamlined referral processes, and increased nurse involvement in patient care:

"One of our clinical changes is we now have a [video conferencing application] account. And in [region], it's really challenging for patients to see a doctor. There's a lot of high turnover ... And so [it has] attracted a couple of patients from [suburb] ... And so the ability ... [of] being able to communicate over email, text message and [videoconferencing application] has been really helpful for them and for me to be able to do that side because I've got some level of funding attached to it. So that's probably our biggest change." [GP, R4, Practice 7]

"But the thing we're seeing is they've got the ability to do a script over the phone, and ... you don't need the patient just to come in for that. And that ... [makes] our patients happy because that gives the doctor a bit more time for other patients. It also gives that patient time because they're not having to drive in just to get a script. Or, for some minor thing that they don't necessarily need to see the doctor for. So that definitely is working well, and it certainly is giving the doctors more time." [Practice Manager, R4, Practice 10]

The practices reported that these alternative access points and delivery modes had also reassured patients that their practice is there for them beyond their scheduled appointments, establishing more personalised care and helping both patients and practices more effectively manage their care:

"Yes, at least they are reassured somehow over the phone that somebody is listening to [them]. So, it's not about just the physical side of it. It's the mental side of things, that oh somebody is accepting my call, somebody is listening. That preliminary part is already a big theme for these patients." [GP, R4, Practice 6]

"No, I guess I feel like I know those patients better, because I guess there's only a small pool of them, and because I've got the direct line. We're their direct point of contact, and they refer to [Nurse] as their nurse ... Yes, I guess it's a little bit more personalised." [Administrative assistant, R4, Practice 7]

"They often more respond to an email than a phone call. Some of them ... And even accessibility to the doctor because now we've got ... We have [pharmacist] kept aside for us doctors to sit together and pre-plan and huddle and discuss the patients. And the ability to be able to do that without the patient needing to be there ... is a huge thing for patients. So, many of them are working and this just makes it so much easier, just to deliver that care but not have to drag them in each time." [GP, R4, Practice 5]

Practices also judged that they have enhanced patient monitoring, care management, and follow-up under the HCH model. Improvements often came in the form of more regular contact and monitoring, frequent care plan reviews, pastoral care, and an overall increase in communication between the practice and their patients:

"We've got our spreadsheet we regularly contact them for phones calls in between their visits here with the care plans, care plan reviews. We're thinking now with the coronavirus we might turn those care plan reviews into phone interviews except we won't be able to take their blood pressure and weight. But some of them have blood pressure machines at home and they usually all have scales so we can cover that like that. Yes, they've been really good picking up on their uptake with the scripts, emailing us for scripts and referrals, questions, leaving

phone messages for the same. So, communication has been improving and has improved a lot with a lot of them." [Coordinator, R4, Practice 4]

"Basically, I have the freedom to ... Because I know the patients very well, I will be giving them frequent calls, especially when I know certain things are coming up. I keep my own little diary for my Health Care Homes patients knowing where you'd love to be able to do it for all patients. But with the Health Care Homes patients, I've got that ability to go, I know such and such is having surgery, which means that they make it onto my list to make sure I give them that welfare call. And follow-up and make sure that they if they need anything or if they need to come in ... If they call into the practice and [GP] isn't here, then I'm their contact. They've got that continuity." [Nurse, R4, Practice 12]

In addition, some practices implemented new services to enhance their chronic disease management, including home visits, remote monitoring services, group sessions, point of care testing, and internal allied health services:

"So, we've had a lot of our Health Care Home patients that have also got obesity and diabetes issues. So, from that we've actually brought in a diabetes educator, who sees them free of charge. There's no cost to the patient, and we also order them in the free glucometers, so that they can have better understanding of how to manage their diabetes and the devices that they need to be using." [Practice Manager, R4, Practice 14]

"... I suppose ... [HCH] has the potential for people to, you know, so we can do things a little bit different. You can do some stuff on the phone if you need, you know, scripts and repeat referrals and things like that. Like that was another thing that's one of the benefits is to try and do some group stuff." [GP, R4, Practice 18]

"I think it's been nice to have care plans reviewed on a regular basis. It's been nice to have medication requests and other phone requests handled through the nursing staff, initially, that's also been useful, rather than via the receptionists. Yes, so I think there's that aspect of it. Those aspects, plural, have worked well. The review of care plans has also incorporated the use of point of care testing. And there's no doubt that that, also, has been of benefit clinically. It doesn't remove the need for formal blood testing at appropriate intervals completely, but it does make some aspects of regular clinical care more straightforward." [GP, R4, Practice 4]

Patient health outcomes

"I honestly feel it's probably too early to see outcomes." [Nurse, R4, Practice 9] Practices thought it was too early to tell whether patients' health had improved as a result of the changes they had made as an HCH:

"That is something I could not answer. But I would be interested in actually doing an evaluation for ourselves here after maybe six months, next year, to see whether anything has actually changed." [Business Manager, R4, Practice 15]

"Well, at the very least we have a much better idea of what's going on." [Clinical Pharmacist, R4, Practice 5]

Some were turning their mind to this as their next goal in their HCH journey:

"We're at this point, what's the next thing that we can focus on to try and improve. Get better outcomes. So it's that in general. But certainly the Health Care Homes clients are the ones that we tend to focus on a little bit more because we can identify those and we can track them a little better through the system." [Practice Manager, R4, Practice 10]

Staff experience

Receptionists and administrative staff

Administrative staff largely reported limited changes to their roles with the introduction of HCH in their practice:

"I don't have a lot to do with it, so it's not made any ... difference or changes to me." [Receptionist, R4, Practice 4]

"It doesn't affect reception at all, it has no affect at all. It's our basic duty most of the time we pass calls to the nurse or leave a message to the nurse." [Receptionist, R4, Practice 3]

Other administrative personnel said they are responsible for helping the nurses manage the HCH cohort of patients, assisting with certain administrative tasks and ensuring any patient issues are dealt with by the appropriate staff member:

"Yes. I do manage the nurses' books and talk to quite a lot of the patients and organise [Chronic Disease Management] referrals and all of that kind of stuff. With another lady, so we job-share." [Administrative assistant, R4, Practice 7]

"... my job is admin, reception, so I am nurse back-up. Primarily anything with Health Care Homes." [Administrator, R4, Practice 9]

Some practices did not actively involve administrative staff in HCH because they thought these staff were already too busy:

"I think our admin's sort of really stayed the same. Because we don't have a receptionist designated to us to help us out. Because they [have] still got to do all the other admin stuff. And it's hard. If they're not having such a busy day, I'm happy to offload it." [Nurse 1, R4, Practice 5]

At some practices key staff noted the importance of engaging the administrative staff in HCH and are hoping to increase their involvement or have already begun to focus on training:

"It has engaged our two administration staff into thinking a little bit more about the processes and so on as well. Although I don't think that we have engaged the admin people to the same degree as perhaps is ideal in the whole model." [GP, R4, Practice 12]

"... we want continuity right from reception, so if there's any concerns from the receptionist, and, say, you've got patients ringing up for appointments, it's

nothing to do with their chronic disease or their Health Care Homes, it's documented and signed off and dealt with." [Business Owner, R4, Practice 6]

"... [the] reception staff have all undergone more training. They've all received helpful cheat sheets that will help them to manage the patients when they call, or when they come in." [Practice Manager, R4, Practice 14]

Practice managers

Practice managers reported varying degrees of involvement in HCH. Though they were predominantly responsible for managing HCH billing, several noted limited engagement beyond managing these processes and, in turn, that the model has not greatly affected their roles:

"Honestly, [my involvement has been] minimum. I have to say all the credits go to the doctors and the nurses that are part of it ... it wasn't really my role to enrol, it was [GP]'s role, and he did a great job at that, but my contribution would be minimum." [Practice Manager, R4, Practice 3]

"From my point of view, it doesn't make a great deal of difference to my day-to-day." [Practice Manager, R4, Practice 11]

Others stated they were the initial drivers of signing up for the trial and were responsible for initiating important aspects of implementation, such as engaging GPs and staff and setting up internal processes:

"I was the one that pushed the whole thing ... you need someone to head it, you'd have to have the GPs on board, equally on board, to be able to do it." [Practice Manager, R4, Practice 4]

"[There was] ... a lot of impact, I think right at the start, because there was a lot of planning to be done, a lot of business modelling to be done, and a lot of getting people on board. So, from my point of view, there was a lot of stressors right at the start of the program, just getting everybody on board and a lot of talking and discussing in meetings." [Practice Manager, R4, Practice 17]

The degree to which practice managers were engaged in the model was largely dependent on a variety of factors, including how practices chose to engage their staff in HCH and practice leadership.

Nurses

"I think the main thing ... that I'm really excited with, is being able to give the nurses more autonomy with patients."

[Practice Manager R4 Practice 17]

Practices elaborated on the degree to which HCH has affected their nursing staff. Some individuals stated HCH has had the largest effect on their nurses by changing their overall scope of practice and increasing their involvement in patient care:

"It has changed a lot, in a big way. I'm dedicated to two days a week that I just do Health Care Homes and sometimes I even feel that two days is just not enough ..." [Nurse, R4, Practice 17]

"Our role has expanded a lot and ... There's much more practice nursing or treatment room nursing which is cool." [Nurse, R4, Practice 5]

"... it's definitely empowered our nurse ... to take more responsibility, and to become more involved in the clinical care of the patients rather than just the issues when they actually turn up at the practice." [GP, R4, Practice 12]

Other practices reported limited changes in their roles as they were already heavily involved in patient care and management:

"I think we're trying a lot harder to implement some of the changes around getting the nurses more involved. I think [this] has been the focus. Really trying to make sure that they're all trained up well ... And just trying to give them more time to manage some of those patient groups that are Health Care Homes patients. We've still got a long way to go, but I think we're getting there and we're starting to work out where the gaps are, where the holes might be, where we need to try and resource a little better to try and deliver that service."

[Practice Manager, R4, Practice 10]

"I think we always did a fair bit ... anyway to be quite honest. We've got a pretty good relationship with the doctors. So, yes, I don't think it's a huge change to be quite honest." [Practice Manager/Nurse, R4, Practice 18]

Some practices chose to involve only some of their nurses (and other staff) in HCH. This limited engagement with HCH by other practice staff and a high workload for those involved:

"They're all aware of the program but we have one nurse, [nurse's name], who comes in and specifically does Health Care Home. So, she deals with Health Care Home patients and she follows up with them. That's her main focus, whereas our other nurses are more so in the treatment room." [Practice Manager, R4, Practice 1]

"I largely do chronic disease entrants, so I provide admin support, and then falling into the Health Care Homes role just to assist [nurse]. But we had a meet just to talk with [GP] earlier and said that we probably need more of our team to be onboard to help [nurse] and I do it. It's just too much ..." [Administrative Assistant, R4, Practice 7]

Several nurses reflected on how increasing their clinical scope and responsibilities as part of HCH has affected their role. Benefits they identified included increased involvement in chronic disease management, stronger relationships with patients, the ability to better justify their time under the HCH funding model, more personalised patient care, and enhanced patient monitoring and recalls:

"... it does help empower the nurses too because we do feel a bit more useful now." [Nurse, R4, Practice 10]

"The thing I love about the Health Care Homes program is it has basically ... brought into practice what we, as a team, we're doing for a lot of our patients. But it's given me the authority to be able to do that more on a larger scale. With follow-ups, with really knowing them and their health and well-being and doing

follow-ups and being really involved in proactive, not just ... In proactive and preventative as opposed to reactive care. Being able to look ahead and see and plan and be able to help them to be the healthiest and best they can be with all of their different illnesses ... it's meant that their care is being able to be facilitated a bit more through the nurses, which has been beneficial for all of our patients." [Nurse, R4, Practice 12]

"I feel like I'm doing something extra for the patient. It gives me satisfaction in that I know that I am ... Not that I'm saving a life, but you picking up things, because lots of them with having the tests that they have done, some of them, with the faecal occult and mammograms and things, certain things have been picked up, and even with the pap smears and stuff." [Nurse, R4, Practice 3]

"You're not just there to assist, you know. You are there to actually to impact [a patient's] life." [Nurse 1, R4, Practice 5]

"... it gives you a different level of communication and a different level of relationship with the patients, a closer relationship with them, yes. And they end up confiding in you with all sorts of things ... It's bringing us closer to the patients." [Coordinator, R4, Practice 4]

The effect of the new model of care on nurses' workloads was recognised by many practices:

"It's a lot of work, because really, you have to dedicate your time. And it's not just that, but also you have to dedicate your thoughts about how you have to run things." [Nurse, R4, Practice 17]

"Well, I don't think [the nurse is] winning in terms of workload but she's aware of the aim and the benefit of the program and she's recognised, with the workload, we discussed with her, she agreed to take on the role. She's being financially reimbursed for her role as well. We're happy for her to dedicate her time to Health Care Home patients only so every week she will dedicate specific days, or day, just purely for her Health Care Homes. And as part of the management, I'm more than willing to assist in terms of other resources." [Practice Manager, R4, Practice 3]

GPs

In the initial stages of implementing HCH, practices actively worked on encouraging GPs in their practice to participate. Some individuals stated that, with time and some convincing, GP engagement increased, which has made it easier to roll out the model within their practices:

"... at the beginning, we had meeting after meeting after meeting, you know, the doctors and legal advice and just showing them how it would be better, and we believed it would be improved care ... so, yes, it took us quite a bit to convince all those doctors to actually say yes." [Business Owner, R4, Practice 6]

"So, every single doctor is involved. Even down to if they've only got one or two patients, but that's okay because at least they've got a little of buy-in from a financial point." [GP, R4, Practice 5]

Others cited ongoing difficulties engaging their GPs due to concerns about the model, such as workload, how it would work with their patients in practice, or the financial impact of the bundled payment:

"Out of the seven doctors here, I've got two doctors that actually wanted to do it. I did my best to try and sell it to them ... They had all the literature, but pretty much most of the doctors just said, no, it's going to be too hard. It's too much work and we don't want to do it. Or, we're going to lose money, we're going to lose money, we don't want to do it." [Business Manager, R4, Practice 15]

"I'm not that keen on it, to be honest, if I'm being blunt ... in a metro area, in a big city, the MBS serves us very well in my view." [GP1, R4, Practice 1]

"I think, like [GP], he just couldn't get his head around enrolling and how to approach the patients for it." [Business Manager, R4, Practice 15]

"At this stage ... we've only got four doctors participating out of 14 ... And saying that, I believe [GP1] only has one patient so ... He wouldn't have much idea at all. And [GP2] as well, he doesn't have too many enrolled himself." [Practice Manager, R4, Practice 1]

The HCH forum held in November 2019 was one of the catalysts for getting some GPs more interested in the model:

"... post the [HCH] forum, when [we] came back and did a debrief, [GP] said right, can we enrol some patients? Because I've got a few patients that I'd like to enrol. And I said, no, the enrolment is off now ... And he said, what a shame because if I had known what I know now, I could have got some more of my patients in and they would have really benefited from it. And I said, well [GP], I've been telling you this for 12 months, why haven't you done it? But I think getting that input from his peers was certainly more valuable than me giving him any figures or any information." [Business Manager, R4, Practice 15]

Participating GPs reflected on how HCH has affected their role and overall experience. Several GPs stated the effect of HCH on their day-to-day responsibilities has been relatively minimal:

"Yes, to be honest, it's relatively minimal, as far as the impact on myself. I think it's been nice to have care plans reviewed on a regular basis. It's been nice to have medication requests and other phone requests handled through the nursing staff, initially, that's also been useful, rather than via the receptionists. Yes, so I think there's that aspect of it. Those aspects, plural, have worked well." [GP, R4, Practice 4]

"It's generated slightly [more] work because there's non-contact patient work to sort out, but that's been fine because we're expecting that and we've managed to allocate time to that. And so that's fine. Yes, overall it's been largely similar. My role's not changed appreciably." [GP, R4, Practice 10]

Some stated HCH has negatively affected their roles due to confusion around billing and deciphering what is considered acute versus chronic care, increased workload during the enrolment period, and fewer face-to-face interactions with their patients:

"So when I see one of our patients and I've got to select the 408 Health Care Homes item number and figure out how they charge it back to the practice and work with a different system with a care plan that's not [in the] system ... it's all a bit too hard when you're treating a patient the same way. So a lot of [GPs] are glad they didn't get involved ..." [GP, R4, Practice 7]

"The recruitment process was, it felt like, a hindrance to the flow of my day. So getting the contents, getting all the relevant sort of administrative, behind-the-scenes work done, that, to me, felt like it was slowing my day down, so that recruitment process." [GP, R4, Practice 15]

"... I felt slightly disengaged with them in some ways, you know? Because I see them less often. Obviously they're talking to [nurse], the nurse here and I'm printing blood forms off. You know, I feel like they get less ... They come in for their care plans, they come in for their over-75 health assessments if they were over 75, and so I've had a bit more of an interface with them. I've examined them a bit more often than I would do with the Health Care Home program. But that was potentially a negative. But the positive is that obviously I've got a bit more flexibility than the non-Health Care Home patients." [GP1, R4, Practice 1]

Others reported that the model has given them and their patients more flexibility, that they were getting additional support working as a team and were better able to prioritise patients:

"From my point of view, clinically, to some extent it hasn't changed anything much from what I do with the patients, except that I know that I've got other people in my team who are aware of them and who can care for them when I'm not there in my part-time role. So, it's definitely opened up on the whole team care approach to this cohort of patients." [GP, R4, Practice 12]

"It gives me personally more joy in my work, if it means that I don't necessarily have to drag every patient in every single time. I can see little sparks of joy elsewhere, but, hopefully, there'll be a lot more of it in time to come." [GP, R4, Practice 9]

"I could easily ... delineate and prioritise, so patients probably from the least important to the most important. So, we as doctors, we would really want to zero in on the sicker patients, so those patients who somehow can be attended to by holding them at bay for the nurses to act upon, then that's a big help to us." [GP, R4, Practice 6]

Ongoing challenges

Impact of staff turnover and workforce shortages

Staff turnover and workforce shortages were ongoing issues for some practices. In certain instances, staff turnover stifled the practices' progression and transformation. A range of factors contributed to this:

 the staff member(s) who departed from the practice was the driver and/or champion of HCH

- general staff shortages in certain regions
- additional time and resources associated with recruiting new staff
- lack of personnel to effectively manage ongoing HCH operations
- the additional time required to onboard and train new staff members:

"... it was working really well with the admin team with the Health Care Home coordinator, but I've lost that one now, so I'm in the process of trying to train another Health Care Home coordinator." [Practice Manager, R4, Practice 16]

"... [Nurse] has gone, one of our lead doctors who had a lot of patients, he's retired as well." [Administrative assistant, R4, Practice 7]

"So, when we first embarked on the journey, I had a nurse manager ... and that's where I thought, this would be great because she's across the doctors. She knows the conditions, she's a little bit more experienced. She'd help with sitting in on their care plans, so that was great ... but then [nurse manager] ... resigned and moved onto a new role. With her moving, the two nurses that I have here are fairly new to general practice, so putting them into a program such as this, which is a lot more involvement with the amount of patients that we have was just not worth it for me ... So, that I think was a barrier for us." [Practice Manager, R4, Practice 15]

Patients' understanding and expectations of the HCH model

The Interim evaluation report 2019 discussed practices' challenges with explaining the HCH model to patients to enrol them. In the most recent round of interviews, practices reported many instances of patients misunderstanding the model:

"Do you mean I go to a home? I think it was because of the name. That's still an issue for us." [Nurse, R4, Practice 17]

"So, when I first started enrolling them in the program, things were a little bit more unknown at that time. And as a result of that, we were seeing that some patients, they just weren't coming in. And it was like, why aren't they coming in? ... as it turned out, they just thought that because they're on that program, that someone would come to their home every day, and that's what that meant. So, they got a bit confused. So, then we had to re-explain it ..." [Practice Manager, R4, Practice 14]

"I suspect and from what I hear some of the more elderly patients find it a bit onerous and that extra layer confuses them a little bit." [Nurse, R4, Practice 4]

"That's really variable. With some of them, yes, I mean, these few ones that you saw they all know what it is. I was thinking about it this morning and I thought I think some of the patients who are on it. But this lady that I spent 20 minutes on the phone this morning. I thought well if I asked her about it she probably would even forget what it meant that she's a Health Care Home patient." [Nurse and Practice Manager, R4, Practice 18]

Another area of misunderstanding was the extent to which patients would have access to their GP once enrolled in HCH. In some instances, patients withdrew from the trial when they found they would be interacting less with their GP and more with nurses and

other clinicians. Others persevered and found benefits with the team-based approach (see Chapter 5 Patient and carer experiences, section: Patients' experiences with practice staff, p. 71).

In other instances, practices thought some of their patients had become overdependent on the practice as HCH enrolees:

"You have to be a little bit careful. We do have a handful of people that they step into the realm of dependent personality and you don't want them to use the Health Care Homes thing as an excuse to call every ten minutes. We have had experience of that, and we've managed to sort that out." [GP, R4, Practice 10]

"... we have had one in particular patient, that just comes to my mind, she's on the Health Care Homes but she's in here every second day ... And the fact that they have someone to go to, yes, it can be taken a little bit too far. We've got the point with this particular person that I've ... If it gets much worse, I'll have to have a chat with her and say look, this isn't quite how the program works. We're almost becoming her social director. So, you've got people that just self-manage, they're great. But then, other people are very needy. And I'm not saying that in a bad way, they're isolated, they've got no support. So, they really take advantage of the fact that they have specialised contacts in the practice. So, that is just something we have to manage ourselves." [Practice Manager, R4, Practice 4]

Scale of implementation

"I think it's a numbers game. I don't think 75 patients is enough." [Practice Manager, R4, Practice 10] Many practices enrolled only a small number of patients and felt that the effect of HCH has been relatively minor:

"To give you an idea of scale, our practice when I ran a report a week ago has got 73,000 patients ...

Our patient population with Health Care Homes is 36 ... But it's really hard to deliver a scale of 36 people when you're operating a clinic of 70,000." [GP, R4, Practice 7]

They were not able to make any significant changes to their practice because of the very low enrolment numbers:

"... I think the problem is when we've got only a fraction of our patients engaged with this process, it's probably not as well managed as it would be if you had the whole practice. If you had the whole practice it would probably be ... In some ways, it would force us to have a better system if you like. But with the current system, I think the Health Care Home patients aren't doing any better than they would have done under the MBS." [GP1, R4, Practice 1]

A few suggested that enrolling 100 patients is the minimum number at which practices could start to make changes, mainly because they could fund additional staff and services with this number of patients:

"I think 100 probably would have been good to have got a good idea of really what it was going to do. And we would have had more numbers to try and do some more group stuff." [PM/Nurse, R4, Practice 18]

"We will have around 55 patients or 50 patients. If it goes double, then we can put a dedicated nurse and a dedicated team to look after these patients, 24 hours, constantly monitoring the patients." [Practice Manager, R4, Practice 14]

"So, because of all of those competing pressures, and because the Health Care Home portion, while it's important to us, it's a small part of our business. I have to focus a big chunk of my time on the other things. If we'd been able to recruit 100 patients or more, then it would have been a lot more cost effective from a dollars, time, effort perspective to be able to focus on Health Care Home." [GP, R4, Practice 13]

Some suggested that practices should be required to reach a minimum cohort size and have a certain number of GPs participating in HCH:

"So, you can only sign up practices where the whole practice is involved. Secondly, you have to have some kind of minimum target, minimum cohort size, reasonable cohort size. Very difficult implementing these potentially high-level, costly changes for such a small group of patients." [GP, R4, Practice 12]

"I feel like for it to work well it needs to be bigger. I think ... I haven't ... I don't really know anything about the numbers, but I suspect for the practice having 20% instead of 10% of your population on with a, I guess, guaranteed income makes it easy to manage the staffing. The idea of paying for something like me out of Health Care Homes funds would be a lot easier to do if you had a bigger, more reliable budget, I suppose, apart from just the benefits to the patients."

[Clinical Pharmacist, R4, Practice 5]

Staff members who worked at a practice that had a larger cohort of patients felt that this has been financially advantageous to their practice:

"Those practices that have bit piece number of patients, they can't change that model of care. They just don't have the volume to justify changing it ... I knew, once you get to the tipping point, or mass of patients, you don't have to worry about the funding." [Practice Owner, R4, Practice 9]

"So, if we had an opportunity to enrol more patients in the current program we'd probably enrol another 300, double. Because, financially, as I said, it's working. And the care ... Now we've got the care down pat, we can double this with higher numbers and that would become more ... And then you're hitting that ... So, people say that you only enrol 3% of your patient population. We're actually enrolling about 7% of the active population. But remember, these are chronic presenting patients and they're rarely active ... It wouldn't surprise if these people that are coming ... probably represent a significant proportion of these people. So, the ones that are frequent, they're sick. And the ones that are sick are not, right? And so, we'd probably hit that 10% to 12% activity rate. Take it up to 20%, and you've got a really good balance." [GP1, R4, Practice 5]

Concurrent initiatives impacting HCH

HCH is one of many initiatives operating in primary care in Australia, alongside other new and ongoing initiatives, for example:

- accreditation
- the PIP Quality Improvement (QI) Incentive (introduced in August 2019)
- My Health Record
- Headspace and other mental health initiatives
- screening and other national prevention campaigns.

In some instances, PHNs have been rolling out initiatives similar to HCH within their regions. These programs often emphasise aspects of the 10 fundamental building blocks of primary care or promote team-based models with the same end goal of providing higher quality, patient-centred care. Though these initiatives helped some of the current HCH practices in these regions better prepare for implementing HCH, some PHNs have not allowed practices to participate in initiatives concurrently. A key reason for this was being able to evaluate what methods and approaches work:

"So, we didn't allow Health Care Homes to apply for those grants, because it muddies the water too much, like how would you separate your success, then, how would you evaluate it? You just couldn't. So, we made a decision not to ... They all have commonalities, but they're all a different approach. So, yes, what we really want to know is ... what works and what shows the best outcomes, and what is the best model, what are the elements that work ..." [PHN09, Interview, R3]

Another reason was so that practices did not to become overwhelmed with multiple initiatives:

"... the feedback we always get is there's just so much. There's so much stuff that general practice are working on just on a day-to-day basis. And then we put something else in there and we want something else to go in as well. There's all the national campaigns. There's bowel screening and breast screening and cervical screening and smoking cessation. There's so much out there that the general practice can be overwhelmed." [PHN08, Interview, R3]

However, some facilitators were concerned that HCH practices were missing out on resources available to those participating other local initiatives:

"Because I see at a higher level, both of these programs, I would say that that's one of the frustrations, because I can see in our [other PHN-initiated and supported] programs, we had some initiatives which are really encouraging team-based care or really encouraging some other building blocks, and I can't put them into the Health Care Homes program. Those practices that might be down the road, they aren't getting that assistance. They do come to the training, but ... [for example] the PHNs do supply non-dispensing pharmacists. Or they do supply program money for exercise physiologists, we haven't been able to do that in our Health Care Homes program. Sometimes, it looks like the other program gets all the goodies, as it were ... we have continued to quarantine [the

programs] and to keep it pure, but I'm not sure that our national colleagues have done that." [PHN02, Interview, R3]

In contrast, one PHN explained they have pursued the opposite approach and encouraged practices to participate in concurrent local initiatives. In response to whether they have excluded HCH practices from any other local initiatives, they stated:

"No, not at all. If anything, we've probably been adding different services to support them for Health Care Homes." [PHN04, Interview, R3]

Bundled payment

The Interim evaluation report 2019 described the difficulties practices had in distributing the bundled payment among their providers. Some practices continued to have these difficulties:

"I think one of the key challenges we haven't yet really figured out, and I think one of the bigger challenges across the board, is how do you manage, when you've got multiple practitioners seeing one patient in the clinic. And if you've got a bundle of funding for the patient going directly to the clinic, how do you fairly portion that in a way that makes sense for each doctor and for the clinic? And how much flexibility can you allow depending on how often a patient sees Doctor A, B, or C? Or how do you manage that?" [GP, R4, Practice 13]

They also reported difficulties in keeping track of the services provided to patients without the claims to Medicare for individual services:

"We've also had to tweak our billing structure a little bit. How we manage and how we try and see the workflow ... We wrote up our own [items] and tried to mimic the MBS a little bit. Because that's where the doctors book in already, so we didn't reinvent the wheel. We were finding they just weren't using it, and wasn't getting used right ... So we found it working a lot better by creating that, and we're slowing getting nurses a little bit more onboard with them billing as well so that we can actually see the service that they're doing, and try and justify that a little better." [Practice Manager, R4, Practice 10]

Lastly, they continued to have problems with determining what was part of a patient's chronic condition and what could be billed separately:

"Yes, I think there is confusion as to what items we're supposed to be putting on the record so that if we are audited by Medicare, that they can see the patient was contacted for their Health Care Home condition. Or sometimes they come in for their Health Care Home condition and something that we could bill to Medicare. There's been a bit of confusion in that area." [Practice Manager, R4, Practice 1]

Some practices overcame the issues that they faced initially:

"In terms of funding, I think the way the payments are happening now is quite easy, it's quite good. We're not running an internal fee-for-service system, like new

practices are. We're just dividing up the money on a percentage basis to these patients, and that's it. So, we're doing it the easy way." [GP1, R4, Practice 5]

"Again, I'm actually pretty happy with how things are at the moment, and I think any tweaks would require a change in the funding model. So, there's nothing that I have planned to actually tweak at this state. I think it's actually working quite well of what it is currently." [GP, R4, Practice 4]

Perceptions of the financial impact of bundled payment

"The concept of having in-house clinical pharmacists, etc., somehow being funded through the program is a little bit pie in the sky as far as the current funding model is concerned." [GP, R4, Practice 4]

There were mixed views on the financial impact of the bundled payment on practices. Many practices estimated they had "broken even" or may be better off under the bundled payment compared with MBS feefor-service:

"So, for us, at the moment, that's exactly what we did around November, December last year. We

had a look at how although some were spending more, some were spending less, is that accurate? So, when you look at in terms of the cost of that patient is now spending through Health Care Homes and what we would be billing through Medicare, it actually ends up being almost exactly the same as what we would have got if we'd done it through Medicare." [Practice Manager, R4, Practice 14]

"My impression is that it's probably similar overall to if we weren't part of Health Care Homes. We might be slightly better off." [GP, R4, Practice 13]

"Overall, financially ... I really was very negative about the whole thing. But now that we have ... capped at [more than 200 patients] ... we're seeing a good amount of funding that's coming through to us now on a regular basis ... it has made no difference to us and the consulting pattern of the GPs that are involved. So, to me, the income is additional to what we're seeing. So, I have changed from very negative to quite positive." [Practice Manager, R4, Practice 4]

"... financially, for us, it's been a benefit too. We can say that. We've done the modelling on that. It's definitely beneficial. It's probably been 15%, 10% up." [GP1, R4, Practice 5]

To ensure that they did 'break even', and that patients were getting the services reflective of their needs as indicated by their tier, some practices carefully monitored patients' use of services:

"So, what happens is when the patient comes into the clinic and they see the doctor, the girls will process the account through the system, and give it a particular code that corresponds to that Health Care Home patient. And then, from there, that invoice is then transferred onto a spreadsheet, and the amount of money that they're utilising is recorded in that spreadsheet. And then, I will then get a bit of tally on what's left in that patient's funding area, to see what other things we can offer them if we can. Or, say, someone's running \$1,000 behind, that's okay because there might be something else we can do for them that will alleviate the costs." [Practice Manager, R4, Practice 14]

Some practices were not sure of the financial impact of the bundled payment at this stage. In some cases, although they were successful in redistributing work among their clinical team, they found that some staff members had a greater workload, which they were unsure would be compensated by the bundled payment:

"The calculation has been a bit of a task for [the] accounts team, and we haven't actually had time lately to calculate the exact differences." [Practice Manager, R4, Practice 3]

"... it has taken our nurse more time than expected to do the tracking and administration side of things ... If we're seeing a patient for something related to their chronic disease, we can't bill it to the MBS. But it's not been as easy from a tracking perspective to work out would that have been the case when they're not in Health Care Home. For example, if a patient has a few issues in the one visit and part of it is to do with their Health Care Home chronic disease, and part of it is completely acute which wouldn't be Health Care Home related, we should still be able to bill the MBS. And if it was say less than 20 minutes, either way we'd be getting the same money. So whether or not we'd be better off if the patient was Health Care Home or not, that's harder to judge at a more finite level." [GP, R4, Practice 13]

"Completely accepting the swings and roundabouts, but the answer to have we broken even is that because we have just given extra roles to the nurses and the front desk people, but they've still got their full-time other duties and so on. And instead of collecting fee-for-service, when I deal with these people I get block funding. It's probably hard to really judge, I have not and intentionally have not tried to do a comparison between what might've come into the practice in fee-for-service. Because you can really only look at the income the doctor would've received in the various ways, you can't really look at the cost of the nursing staff and so on, unless you've actually put someone else on into a new role. So, I find it difficult to really know whether we've broken even or not." [GP, R4, Practice 12]

Other practices felt they were losing money under the HCH model:

"I think it would be less. Because it's just the monthly payment each month comes through, which is a small amount, especially depending on the level. And they could have come twice during the amount. And the amount of work, we do actually put in a lot of work behind the scenes, and the patients don't actually come in. The nurse does a lot of monitoring on [Health App], and calls them if she needs to, and things like that. So, we're very proactive." [Practice Manager, R4, Practice 11]

"... my biggest concern, probably, with Health Care Homes is you could have patients who could have 30, 40 consultations, for example, who have such complex health needs that the funding just wouldn't cover their needs. And that's a big concern. Whereas, on a fee per item service, you know, well, okay, they can come in, see you, deal with the problem, and you claim an item service for that. And the other problem is other GPs wouldn't want to see those patients, because they wouldn't get remunerated for that consult. So, there's a risk that the workload, for the GPs involved in that, could spiral out of control." [GP, R4, Practice 1]

"I must admit, we didn't screen any of the patients ... It seems, talking to the nurses yesterday ... a lot of the tier two patients are quite demanding. They're needing a lot of phone calls and a lot of follow-up." [Practice Owner, R4, Practice 6]

While some practices initially thought that increasing the scale of HCH patients would potentially allow them to provide more services, allocate more time to program management and hire staff, this did not transpire:

- "... the funding is not enough for me to get a dietician here. We're not getting enough money from the government on Health Care Homes." [GP, R4, Practice 8]
- "... our nurse here, she's only doing this part-time. This is where we see 100 patients, right? Because we cannot afford to provide a nurse to do this full-time with 100 where we sit down and find that out of the 100 patients of this quality registrations, how many of them would call per week, how many our nurse can do this. The nurse also has other responsibilities as well." [GP, R4, Practice 3]
- "... you'll see since we last spoke, we've added a pathologist, cardiologists, urologist. There's a plastic surgeon, too, three new psychologists, a counsellor, another podiatrist, five physios, two exercise physiologists. So we've created a more integrated hub that's completely separate to Health Care Homes. The economics of Health Care Homes wouldn't support any of that sort of bundle of care." [GP, R4, Practice 7]
- "... I think the program is funded to the point to which we've taken it. I think remembering back to the initial video education sessions, the concept of having in-house clinical pharmacists, etc., somehow being funded through the program is a little bit pie in the sky as far as the current funding model is concerned. So, the true Health Care Homes in its pure academic sense, I think, it's not funded to do that. It's funded to do what we've done, which is to employ skilled practice nurses to coordinate the chronic health management of a section of our patient load. And I think that's important that is reflected. The funding model just does not support anything beyond that." [GP, R4, Practice 4]

Practice suggestions for HCH financial model

Practices offered a range of ways in which the bundled payment could be improved. Many recommended increasing the level of funding by tier or expanding the tiers to recognise more costly patient:

"... the next thought is that we've got some very complex patients at our tier 3 level. And there's no way that the process of payments as they're coming through in Health Care Home block funding model would match the Medicare money that we would earn from seeing those more complex patients on a feefor-service basis." [GP, R4, Practice 12]

"I think the other tiers are okay. I mean you're always going to get someone who's going to cost you more money than that anyway ... But I think the tier one probably needs looking at, because even know they're only coming in at tier 1,

they still do have a chronic disease. So, it's probably not quite enough ..." [Practice Manager, R4, Practice 17]

"In terms of the current program ... there needs to be a tier four ... there's some patients that will lose money badly if we enrolled them and we didn't ... But likewise, you probably need a tier zero, because there's the 40 to 50-year-old working, busy, middle that are just separate ... Their enrolment model would be perfect, insofar it would provide remote access. All their questions, their scripts, their referrals. And you don't need to pay much for that. But ... that would be tier zero." [GP1, R4, Practice 5]

Others suggested weighting the payment to account for specific regional, practice and patient factors:

"... the Health Care Homes funding model, I think it needed work, let's put it that way. And I think that if it was ever to become something which was broader-based, we would need a different way to work out the remuneration at a practice level. So, oddly enough, I'm totally not against the concept of having the block funding model, but I would have suggested it actually be done in a different way. It should actually be done at a practice level, saying that at this practice there are this percentage of diabetics, this percentage with this problem, this rating for social disadvantage. And so, the payment to the practice would be this much for the whole cohort of patients, rather than this individual cherry-picking of patients ... And then ... I'd say that the practice reporting should actually be on their outcome metrics. So, numbers of admissions, percentage of patients, whether outcomes, whether actual hard clinical outcomes have improved. I'd actually go even as far as saying, perhaps you go with the Patient Activation Measure, and say what percentage have actually had an improvement." [GP, R4, Practice 11]

In addition, some felt that running dual financial systems was too difficult; therefore, they suggested amending the MBS to increase flexibility or simply picking a single financial model:

"I think probably a decision needs to be made one way or the other whether chronic disease management's going to be funded through fee-for-service or is it going to be funded through Health Care Homes and running the two systems side by side seems a bit dumb. So a decision needs to be made about what the funding model is. And as far as, and which model is used, doesn't bother me either way." [GP, R4, Practice 2]

"... if I was in charge of Medicare, I would be saying look, I'm going to limit the number of care plans that can be done for X conditions. I'll be making sure people were locked in with their regular doctors for their chronic disease management so another doctor couldn't just do their [GP management plan] having seen them once or twice while that doctor was on holiday. So that would stop some of the abuse in the system. And just control it in that way, because obviously cost is an issue for the Department of Health and Medicare in terms of overbilling or too frequent attendances, you know? But I think in terms of the chronic disease management, I think it is pretty well run here ... I think the nurse's time is still undervalued, [so] I think again is an area which could be improved on. And ... have an item number which may come out with this coronavirus thing that

twice a year, or three or four times a year ... you could have a telephone consultation included in that person's chronic disease care, to make it less arduous than coming in for normal results or for routine follow-up." [GP1, R4, Practice 1]

"There's a different philosophy that you need to have patients say, but not like in the UK where ... you just see your one GP, I think you should have your chronic GP and you're only allowed x amounts of visits per year with another GP that Medicare will pay for. They need to look at other options on how to manage chronic care, but I do agree you should have one GP, one home ..." [GP2, R4, Practice 18]

Shared care planning software

In interviews, practices expressed ongoing issues with their shared care planning software. A key issue was that the software was separate from their practice clinical management software, and this created additional workload in learning new software and duplicating data across the two systems:

"... having two different systems hasn't been great either. I think as a GP, I'm working pretty flat out from 7:45 in the morning 'til six o'clock at night, and people are coming at me quickly. And I'm sorting out the problems as they're coming. And for me to go into a different software at the end of the day when I've already been at it for 10 hours is probably not the easiest thing to manage ... So, I think having one system would be very much easier." [GP, R4, Practice 1]

"The notion of electronic shared care plans no matter which one we've used ... But any of these are add-ons and, therefore, to some extent, duplications of what you're doing within your desktop software. They need to be very smart, and they need to be better integrated than even these newest ones are because otherwise trying to maintain something in an electronic environment simply means you're doing double extra work to really achieve it there. So, although philosophically and theoretically it's a fantastic idea, practically it's very difficult to implement those things." [GP, R4, Practice 12]

"The issue with, I think the software, has been a bit clunky at times. We found that having to use the [specific shared care planning] software, it didn't mesh very well with the software we were using, and the nursing staff when they were using it were finding, they felt like they were double handling data ... Whereas I think the care plans we'd previously been producing were of pretty high standard and we couldn't see that there was a lot of benefit in us using [it]." [GP, R4, Practice 2]

Another issue was the limited functionality of the systems to support key patient activities such as monitoring of physiological measures or symptoms, or setting and tracking goals:

"I think if there were better systems in place to help patients track things, and I don't think what we use with [shared care planning software] is effective in that way ... I think other businesses have great tools for you can see when things are due or get automated reminders in ways that are maybe more effective than

what our current tools, be it [system 1] or [system 2], offer. And I think it's the tools that constrain us." [GP, R4, Practice 13]

"Both my nurses and the allied health struggle in order to be able to set goals for patients, or in order to just put basic simple things in there that patients can stick to, or patients can manage. There's no option to put a goal in there and say, okay, we want to get six of these exercises within the next week. You can't do things like that that they find would be more beneficial to the patient ..."

[Practice Manager, R4, Practice 10]

Some practices reported that they were not using the shared care planning tool at all:

- "... the way I'm doing the care plans, because I tried to use the [shared care planning software] to do a care plan before, it's just so inconvenient. So, I'm still doing the same way of care plan as usual on our software, on the [practice clinical management system]." [Nurse, R4, Practice 10]
- "... in terms of using the [shared care planning] tool, we haven't done much with it, because we ... Like [the GP] found that quite clunky to actually do that much with and didn't find it valuable. He's like, well, we've already got this plan in place, why do we need to do all this?" [Business Manager, R4, Practice 15]
- "No, because we didn't go over to the independent care plan, like [shared care planning software] and stuff, we kept doing it through our software, because that's not worth going again to another software program while we've got it all in our current software." [GP1, R4, Practice 18]
- "... we have the shared electronic care plan. It's not really being used a lot ... it's clunky. It's useless ... we're using [software]. We're about to change." [GP, R4, Practice 5]

The PHNs commented that helping practices implement shared care planning software had consumed a lot of their efforts, and that the software was not "advanced enough for the implementation" [PHN survey R4, PHN 05].

To achieve key functions of shared care planning software that are not there, or to avoid using the tool altogether due to issues, some practices are using other tools outside of the software:

- "... [vendor] have just released an app for the medical software that we use. And so we're just in the process of setting that up which means that you can communicate with patients via the app as well and you can send them stuff." [Practice Manager and Nurse, R4, Practice 18]
- "Patient access. And for us, was putting the medical records onto [cloud software] so everybody had access to everything." [Business Owner, R4, Practice 6]

"We're literally trialling [app] ... [It] is a tool and it's easy to sign patients up ... And patients can track their own [measures] ... And then we can see their, whatever, blood pressure they put in, what sugar they've got in. And you can invite different people in. So, you've got a care team." [GP, R4, Practice 5]

Practices also reported ongoing problems with communicating with external providers about shared patients through the software:

"... with [shared care planning software] the only people that we've had put into that would be a couple of pharmacists, so we find that hard. None of the allied health are doing anything. They're like, we'll get information through [practice clinical management system] from them, appointment updates and things like that and team care arrangements, signatures coming back and everything for normal care plans." [Administrative Assistant, R4, Practice 7]

"Because when we first started, we've got allied health who come to the building here. So, they're the ones we refer to mostly. So, we actually met with them as well and got the guy from [shared care planning software vendor] on the computer and we did a demonstration. But I honestly don't think they're really using it." [Practice Manager, R4, Practice 17]

"Most people seem to have been fine. I know that [we] had a chiropractor that rang and spoke to our receptionist, and once the situation was explained to him, he was fine ... It's not really relevant for them, but the metro mental health service just didn't like the look of the software that we were using, which was [shared care planning software]. And got anxious about that, and said, no, we don't know about Health Care Homes, so we just don't want to be involved ... Because it was new and it was, well, we're a government agency ... So that was weird."

[GP, R4, Practice 10]

This was exacerbated by there being many potential providers that practices share care with:

"Other allied health it's really difficult in where we are because there's just so many tiny little practices that we haven't really engaged any differently with them for our Health Care Home patients. Because there's too many of them and there's not one group that we deal with any more than another ... so it's just not possible, which is also the other reason why we haven't taken up the shared, an electronic shared care plan because to me that would be impossible. How would we go about doing that? Would it be up to us to educate 50 Allied Health people scattered around and another 50 specialists as to how they were supposed to engage with them. It just doesn't seem feasible. If they can get the shared care plan integrated into the electronic health record, there's potential." [Practice Manager and Nurse, R4, Practice 18]

In some instances, practices were proactive with providers they share care with, explaining the HCH model and educating them about using the shared care planning software:

"We have all the allied health providers and the mental health clinicians and how to access these because you're not going to do any faxes or anything now, it's just all electronically. It involves a lot of myself and [admin]'s time and the nurse's time. So, you have to spend that time with the allied health people just to set it up and then this is how you are going to receive the electronic referrals on your PCs ... That initial communication is the key I think." [Practice Manager, R4, Practice 9]

"... when we started using [shared care planning software], we found that if we were using [the software] and it was going to be a main tool here within our clinic, that we would get our allied health on board. Which was basically me having a chat to them, saying, this is what the program involved. They were already seeing Health Care Home patients. They just weren't seeing Health Care Home patients under the Health Care Home [chronic disease management], or under certain different things ... we said, look, this is what your patient load looks like. You could benefit from utilising this tool. They then did a training session with [shared care planning software vendor] online. They went over the process and everything like that for them." [Practice Manager, R4, Practice 14]

Practice suggestions for HCH and future steps

"I'm a little bit disappointed with the whole rollout of it, because the concept's fantastic." [Nurse, R4, Practice 2] When asked if they would recommend HCH to other practices, participating practices had mixed views. Some were positive about it and recommended it:

"... I would really love it to be the norm because we sort of do it, do the same principles for all our

patients. As I said before, it's just, I think really, the communication is a lot more flexible. Patients need it regardless of Health Care Home. And our hospital system can't cope with chronic disease." [Nurse 1, R4, Practice 5]

"Yes, definitely. So, I definitely would recommend it. If anyone would say to me, have you heard of Heath Care Homes? What's your thoughts on it? I know my doctor would definitely recommend it and I know I would definitely recommend it to anybody. I would just tell them there's pros and cons with everything you do. You're never going to know whether or not it's beneficial until you participate, unfortunately. But in our experience, we've found it to be a more patient-centred care model ..." [Practice Manager, R4, Practice 14]

A few staff members felt that a practice's decision to participate in HCH is entirely dependent on its staff, patient demographics, values and goals:

"Yes. Probably. I don't know whether it will suit everyone ... So it's hard to know ... I think expanding the program is a great idea. I think the voluntary buy-in option is a good idea at this stage." [GP, R4, Practice 10]

"My advice would be that do it if you want to. The advantages of the block payment model is it does certainly cover for things such as non-face-to-face time. However, it does also come down to whether there's any extra administration time to do it" [GP, R4, Practice 11]

Others did not recommend HCH in its current form:

"If it was in its current form, I would say, stay away. If it's a current strategy with a different implementation, I would say go for it, a different funding model and implementation." [GP, R4, Practice 7]

"I'd say don't bother until it's really clear on what the incentive is going to be for you to do it. Because the thing about [the Primary Care] Collaboratives

compared to Health Care Homes is Collaboratives came in with the whole box of dice. Like they came in with the whole support mechanism, education, because it is a matter of managing change really, isn't it? And actually having enough education that people say, okay, yes, it is worth doing and I want to be involved and this is how we're going to do it." [GP, R4, Practice 2]

PHNs commented in their responses to the evaluation survey that they were detecting among practices an increasing anxiety regarding what would happen to the HCH program beyond June 2021. Practices did not comment on this, but enrolment had not long finished when they were surveyed and interviewed, so it was likely they were not thinking about it when responding to the evaluation at that stage.

Practices identified a range of potential improvements to HCH, listed below:

Guidance for practices

- Provide clearer definitions and guidelines around systems and processes, such as how to select patients, enrol them, and assist them with managing their chronic disease.
- Provide additional clarification and guidelines on what is considered chronic versus acute care.
- Produce guidelines or recommendations for practices around the effective distribution and management of the bundled payment.
- Develop legal guidelines around patient team-based care arrangements (e.g. GP responsibilities when care is delivered by a nurse).

Telehealth (note that the survey was conducted prior to the COVID-19 pandemic)

Promote the use of telehealth among practices, hospitals and specialists.

Community and patient awareness

- Provide additional education for patients on the HCH program and the importance of team-based care.
- Support practices with educating patients by providing them with additional resources.
- Promote HCH and provide additional education to allied health providers, community pharmacists, hospitals and specialists.

Systems

• Improve integration of HCH tools and shared care planning software (i.e. reduce number of passwords and logins required to stay compliant with HCH).

Peer-to-peer engagement

 Promote and improve peer-to-peer engagement, learning and sharing among practices and PHNs.

Evaluation

- Decrease practice reporting requirements.
- Share data and findings that have come out of the evaluation in relation to outcomes that have been achieved among HCH practices.
- Provide GPs with additional evidence and data on the positive effects and outcomes associated with HCH or similar programs.

Planning for post-HCH

- Establish requirements around the level of patient enrolment that practices should seek to achieve.
- Establish requirements around the proportion of GPs within a practice that should be willing to participate in HCH.
- Provide additional funding for practices for an HCH coordinator/administrator.
- Provide more transparency around the future of HCH funding.
- Inform practices of any upcoming changes to the program further in advance, so they can plan accordingly.
- Increase the bundled payment amount allocated for the three tiers (especially for tier 1 and tier 3).

4. Practice process measures

Key points:

- Participating practices are providing data extracts from their clinical management systems
 through third party software (Pen CS and POLAR) or through their corporate office (Sonic
 Clinical Services). For the latest reporting period (January–June 2020), practice extracts were
 received from 114 HCH practices (including 13 NT ACCHS), among the 120 practices
 participating in HCH at 30 June 2020. The evaluation is also receiving extracts from NPS
 MedicineWise for 417 non-HCH practices participating in the MedicineInsight program. These
 data will be used to compare patient outcomes with HCH practices in the final evaluation
 report.
- The top five health conditions flagged in practice extract data for HCH patients were high blood pressure (48.2%), high cholesterol (37.8%), type 2 diabetes (31.6%), osteoarthritis (25.4%) and depression (22.2%).
- In the 12 months to June 2020, HCH patients saw a GP in the practice 13.8 times on average (standard deviation 13.5, median 11 times), which is slightly higher than the mean reported in the Interim evaluation report 2019.
- The proportions of HCH patients who had data on lifestyle factors of clinical measures recorded in the clinical management system at least once in the previous 12 months were:

Lifestyle factors all HCH patients		Clinical measurements – All HCH patients		Clinical measurements – HCH patients with	
Smoking	41.4%	Blood pressure	81.0%	Diabetes Type 2	
Alcohol consumption	35.7%	Pulse	74.9%	HbA1c	86.0%
Weight	68.7%	Kidney function	75.1%	Kidney function	86.9%
Waist circumference	27.6%	Cholesterol	66.2%	Asthma/COPD	
Physical activity	6.8%			Spirometry	3.9%

- Recording of patient lifestyle and clinical measures trended upwards until the end of the patient enrolment period (until the end of June 2019), but then trended downwards. The downward trend was evident in data examined in December 2019 prior to the COVID-19 pandemic. The COVID-19 pandemic will have contributed to fewer measures being recorded in the June 2020 data, due to a reduction in in-person visits. The reasons for the earlier downward trends are not yet clear. They cannot be explained by decreasing services provided to patients (e.g. the mean number of GP consultations has remained steady over time see point above). Analysis of data at the patient level shows that recording of measures significantly increased at the point of enrolment but have trended down in periods after enrolment.
- The reasons for these patterns will be explored in the next round of data collection for the evaluation, particularly comparing the rates of measurement and trends for non-HCH patients and between HCH practices and comparator practices. Interviews with practices will also help us to interpret the trends.
- Trends in recording of measurements have been shared with HCH practices through the benchmark reports.

This Chapter provides a preliminary assessment of how regularly practices are recording key patient lifestyle factors and clinical measures, which are indicators of the quality of chronic disease management being provided by the practices. In addition, the Chapter provides the context for the clinical activity being undertaken by the practices (i.e. the conditions of patients and use of GP services).

Volume 3 describes the mechanisms via which the extracts from practices' clinical management systems are being received by the evaluators and the overall volume and quality of the data. Briefly, the evaluators are receiving data from the variety of clinical management systems used by practices. Some practices are providing data through third party software systems, namely Pen CS (95 HCH practices, including 13 NT ACCHS) and POLAR (10 HCH practices). Sonic Clinical Services is providing data for its practices directly (9 HCH practices). The evaluation is also receiving extracts from MedicineInsight for non-HCH practices (417 non-HCH practices). These data will be used to compare patient outcomes with the HCH practices in the final evaluation report. Four HCH practices are providing data both through Pen CS and MedicineInsight. For consistency, these practices' Pen CS data were used for this report.

Patient health conditions

The proportion of HCH patients who had a health condition flagged in practice data extracts is presented in Table 12. The most common conditions were high blood pressure (48.2%), high cholesterol (37.8%) and type 2 diabetes (31.6%) followed by osteoarthritis (25.4%) and depression (22.2%). About 2% of patients had bipolar disorder, schizophrenia or dementia.

Table 12 – Health conditions flagged for HCH patients, as at 30 June 2020

Patient with conditions recorded ¹	No. patients (%) ²
High blood pressure	4,394 (48.2%)
High cholesterol	3,451 (37.8%)
Diabetes type 2	2,878 (31.6%)
Osteoarthritis	2,315 (25.4%)3
Depression	2,027 (22.2%)
Asthma	1,745 (19.1%)
Coronary heart disease	1,529 (16.8%)
Osteoporosis	1,429 (15.7%) ³
Chronic kidney disease	1,351 (14.8%)
Cancer (any)	1,350 (16.7%)3
Anxiety	1,215 (13.3%)
COPD	1,141 (12.5%)
Atrial fibrillation	752 (9.3%) ³
Stroke	502 (5.5%) ³
Congestive heart failure	502 (5.5%)
Diabetes type 1	222 (2.4%)
Dementia	185 (2.1%) ³
Schizophrenia	163 (1.8%)³
Bipolar disorder	160 (1.8%)³

Patients by number of above conditions recorded ⁴	No. patients (%) ²
Nil	893 (9.8%)
One condition	1,314 (14.4%)
2–4 conditions	4,976 (54.6%)
5+ conditions	1,936 (21.2%)

Source: CBDRH analysis of extracts from their clinical management systems provided for the evaluation. ¹Patient conditions were ascertained based on derived variables in Pen CS extracts, and textual descriptions in POLAR and Sonic extracts. ²Percentages were calculated for 9,119 HCH patients identified in practice extracts, unless indicated otherwise. ³When Pen CS-derived variables relating to the condition were absent from entire extracts of a practice,

Use of GP services by HCH patients

Table 13 presents the number of GP consultations in Pen CS and POLAR practices in the last three, six and 12 months. It compares these with the figures in the *Interim evaluation report* 2019, which were to 31 August 2019. Despite the COVID-19 pandemic, the mean number of GP consultations per patient was slightly higher in the three months to 30 June 2020 compared with the three months to 31 August 2019 (4.1 vs. 3.7). The means for the last six and 12 months were also slightly higher in the later period.

Table 13 – HCH patients number of GP consultations, 31 August 2019 and 30 June 2020

GP consultations	All HCH		HCH risk tier ²		
Gr Consolidiions	patients	1	2	3	
Number of HCH patients (31 August 2019) ¹	8,323	1,477	3,963	2,697	
Mean (standard deviation) number of GP consultations					
In the last 3 months ³	3.7 (2.9)	3.0 (2.3)	3.6 (2.8)	4.1 (3.3)	
In the last 6 months ³	6.9 (5.3)	5.5 (4.1)	6.6 (4.9)	8.1 (6.2)	
In the last 12 months ³	13.4 (9.7)	10.7 (7.3)	12.8 (8.8)	15.7 (11.4)	
Number of HCH patients (30 June 2020) ²	8,559	1,419	4,098	3,042	
Mean (standard deviation) number of GP consultations					
In the last 3 months ^{3, 4}	4.1 (3.6)	3.6 (3.0)	3.9 (3.4)	4.5 (4.0)	
In the last 6 months ^{3, 4}	7.1 (5.9)	6.1 (4.8)	6.7 (5.5)	8.1 (6.8)	
In the last 12 months ^{3, 4}	13.7 (10.7)	11.3 (8.3)	12.9 (9.7)	15.9 (12.4)	

Source: CBDRH analysis of extracts from their clinical management systems provided for the evaluation. ¹GP consultations for all HCH patients were calculated for 81 Pen CS practices whose extract data contain the GP utilisation derived variables and patient risk tier and 4 POLAR practices whose extract data contain patient encounters. ²The number of GP consultations for 8,559 patients in Pen CS and POLAR practices. ³For Pen CS data, GP consultation was based on derived variables that indicate the number of times any GP in the practice used the practice's clinical management system within the defined period. For POLAR data, GP consultation was estimated as the number of patient encounters with a GP provider for any encounter type (e.g. visit, surgery, telephone, nonvisit) within the defined period. In instances where multiple GP provider encounter records with the same encounter type were recorded in one day, one encounter record was selected. The analysis of GP provider encounters in POLAR data shows that the majority of GP provider encounters (94%) related to patient consultations (i.e. type of encounter as visit or surgery). In Sonic data, type of provider is not included, thus it was not possible to analyse patients' usage of GP services. 4Calculated removing one patient with an implausible number of consultations in the last 3 months.

Quality of care received by HCH patients

To examine the quality of chronic illness care provided for HCH patients, key patient lifestyle factors and physiological and pathological measurements recorded in the practice data extracts were assessed. Table 14 presents the recording of lifestyle factors and whether an assessment was recorded in the previous year (July 2019 to June 2020).

Table 14 – Recording of assessment of lifestyle factors for all HCH patients and whether an assessment was recorded in the previous year (July 2019–June 2020)

	No. HCH patients (%) ¹		
Measure	Ever recorded	Recorded in previous 12 months	
Smoking status ²	8,567 (93.9%)	3,426 (41.4%) ³	
Alcohol consumption	7,357 (80.7%)	2,950 (35.7%) ³	
Physical activity ⁴	1,517 (22.0%) ³	468 (6.8%) ³	
Body weight	8,713 (95.5%)	6,264 (68.7%)	
Body height	8,477 (93.0%)	NA	
Waist	5,673 (70.0%)	2,237 (27.6%)	

Source: CBDRH analysis of extracts from their clinical management systems provided for the evaluation.

¹Percentages were calculated for 9,119 HCH patients, unless indicated otherwise. ²Smoking status was categorised in Pen CS as smoker (daily, weekly, irregular), ex-smoker and never smoked, and in POLAR and Sonic as smoker, ex-smoker and non-smoker. ³When Pen CS-derived variables relating to the condition were absent from entire extracts of a practice, all HCH patients in the practice were excluded from the calculation, i.e. the denominator is less than 9,119. ⁴Physical activity was available in Pen CS extracts only and categorised as sufficient, insufficient and sedentary.

Table 15 presents whether various clinical measurements had ever been recorded, were recorded in the previous 12 months, and were recorded in the last six months.

Figure 7 to Figure 12 present trends in practices' recording of the various measures between December 2018 and June 2020. The number of patients at each time point reflects enrolled HCH patients identified in the practice data extracts at each measurement time point: December 2018 included 59 practices and 3,903 patients; June 2019 included 76 practices and 7,461 patients; December 2019 included 92 practices and 8,381 patients; June 2020 included 101 practices and 9,119 patients.

Table 15 – Recording of key measures for all HCH patients and whether a measurement was recorded in the previous year (Jul 2019–Jun 2020) and previous six months (Jan–Jun 2020)

	No. HCH patients (%) ¹			
Measure	Ever record	Recorded in previous 12 months	Recorded in previous 6 months	
All HCH patients:				
Blood pressure ²	8,863 (97.2%)	7,387 (81.0%)	5,900 (64.7%)	
Pulse	7,753 (95.6%)	6,070 (74.9%)	4,577 (56.5%)	
Cholesterol ³	8,597 (94.3%)	6,040 (66.2%)	4,092 (44.9%)	
Kidney function ⁴	8,736 (95.8%)	6,844 (75.1%)	5,090 (55.8%)	
Patients with diabetes:				
Kidney function ⁴	2,862 (99.4%)	2,502 (86.9%)	1,998 (69.4%)	
HbA1c ⁵	2,981 (99.4%)	2,578 (86.0%)	2,071 (69.1%)	
Patients with asthma/COPD:				
Spirometry ⁶	504 (22.3%)	88 (3.9%)	28 (1.2%)	

Source: CBDRH analysis of extracts from their clinical management systems provided for the evaluation.

1Percentages were calculated for 9,119 HCH patients; 2Systolic or diastolic blood pressure; 3Total cholesterol, HDL, LDL or triglycerides; 4eGFR, serum creatinine, urinary creatinine or albumin-creatinine ratio; 5HCH patients with diabetes were identified in practice data extracts provided by 101 practices. The recording of HbA1c test was calculated among HCH patients with diabetes; 6Data relating to spirometry (FEV or FVC) were available in practice extracts provided by 81 practices. The recording of spirometry was examined among HCH patients with asthma or COPD within these practices.

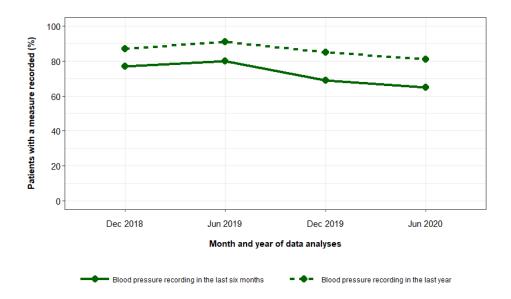


Figure 7 – Recording of blood pressure in all HCH patients, December 2018 to June 2020

Source: CBDRH analysis of extracts from their clinical management systems provided for the evaluation. Recording of systolic or diastolic blood pressure in enrolled HCH patients, irrespective of health conditions and whether patients visited the practice. The number of patients at each time point reflects current enrolled HCH patients identified in the practice data extracts at each measurement: December 2018 included 59 practices and 3,903 patients; June 2019 included 76 practices and 7,461 patients; December 2019 included 92 practices and 8,381 patients; June 2020 included 101 practices and 9,119 patients.

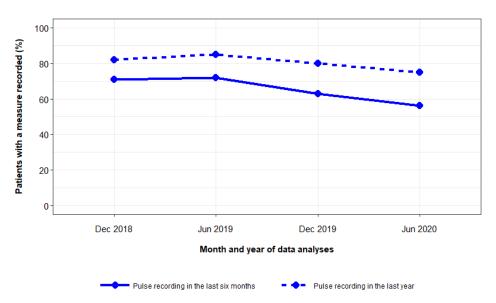


Figure 8 – Recording of pulse in all HCH patients, December 2018 to June 2020

Source: CBDRH analysis of extracts from their clinical management systems provided for the evaluation. Recording of pulse in enrolled HCH patients, irrespective of health conditions and whether patients visited the practice. The number of patients at each time point reflects current enrolled HCH patients identified in the practice data extracts at each measurement: December 2018 included 59 practices and 3,903 patients; June 2019 included 76 practices and 7,461 patients; December 2019 included 92 practices and 8,381 patients; June 2020 included 101 practices and 9,119 patients.

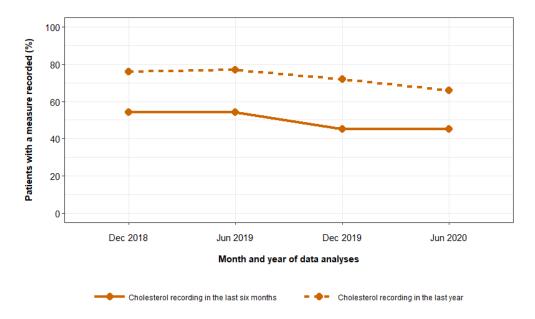


Figure 9 – Recording of cholesterol in all HCH patients, December 2018 to June 2020

Source: CBDRH analysis of extracts from their clinical management systems provided for the evaluation. Recording of total cholesterol, HDL, LDL or triglycerides in enrolled HCH patients, irrespective of health conditions and whether patients visited the practice. The number of patients at each time point reflects current enrolled HCH patients identified in the practice data extracts at each measurement: December 2018 included 59 practices and 3,903 patients; June 2019 included 76 practices and 7,461 patients; December 2019 included 92 practices and 8,381 patients; June 2020 included 101 practices and 9,119 patients.

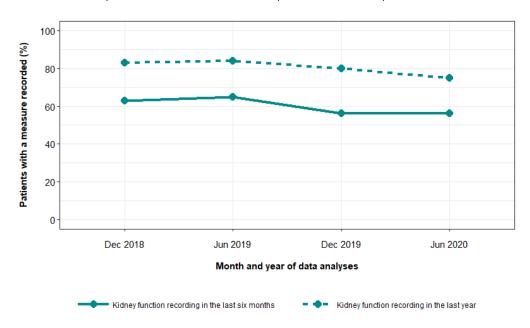


Figure 10 – Recording of kidney function in all HCH patients, December 2018 to June 2020

Source: CBDRH analysis of extracts from their clinical management systems provided for the evaluation. Recording of eGFR, serum creatinine, urinary creatinine or albumin-creatinine ratio in enrolled HCH patients, irrespective of health conditions and whether patients visited the practice. The number of patients at each time point reflects current enrolled HCH patients identified in the practice data extracts at each measurement: December 2018 included 59 practices and 3,903 patients; June 2019 included 76 practices and 7,461 patients; December 2019 included 92 practices and 8,381 patients; June 2020 included 101 practices and 9,119 patients.

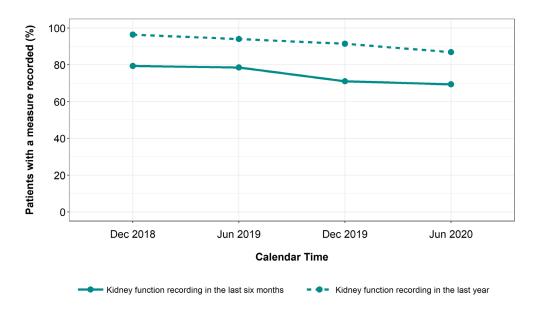


Figure 11 – Recording of kidney function in HCH patients with Type 2 diabetes, December 2018 to June 2020

Source: CBDRH analysis of extracts from clinical management systems provided for the evaluation. Recording of eGFR, serum creatinine, urinary creatinine or albumin-creatinine ratio in enrolled HCH patients who had Type 2 diabetes irrespective of whether patients visited the practice. The number of patients at each time point reflects current enrolled HCH patients identified in the practice data extracts at each measurement: December 2018 included 59 practices and 1,122 patients; June 2019 included 76 practices and 1,967 patients; December 2019 included 92 practices and 2,311 patients; June 2020 included 101 practices and 2,878 patients.

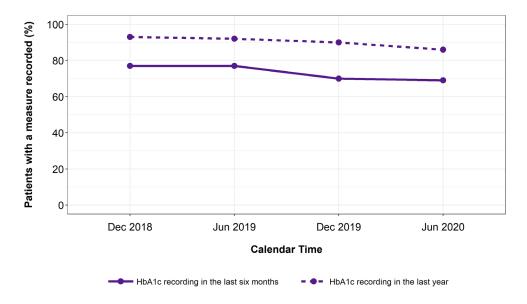


Figure 12 – Recording of HbA1c in HCH patients with diabetes, December 2018 to June 2020

Source: CBDRH analysis of extracts from clinical management systems provided for the evaluation. Recording of HbA1c in enrolled HCH patients with diabetes, irrespective of whether patients visited the practice. The number of patients at each time point reflects current enrolled HCH patients identified in the practice data extracts at each measurement: December 2018 included 59 practices and 1,192 patients; June 2019 included 76 practices and 2,630 patients; December 2019 included 92 practices and 2,434 patients; June 2020 included 101 practices and 2,999 patients.

Across all analyses above, except Figure 11 (kidney function for all patients), the trends are similar. Recording of the measures shows a small upward trend to the end of June 2019 (the end of the patient enrolment period) and then begin to decline. The decline continues or stabilises through to the final six months of the series. A superficial explanation is that practices ramped up recording of the measures as they enrolled patients, but subsequent follow-up of patients has been less vigilant. However, this is a simplistic hypothesis and further analysis and investigation is needed. Several possible explanations will be considered, including the following lines on enquiry.

Firstly, as shown in Table 13, the mean number of GP consultations has remained similar in the three, six and 12 months prior to 30 June 2020 compared with the same periods reported in the *Interim evaluation report 2019*. Therefore, reduced measurements cannot be explained by fewer consultants with GPs. However, it is not known whether these contacts were teleconsultations even in the pre COVID-19 period, and the growing use of telemedicine may have contributed to lower rates of measurement.

Secondly, in the figures, the number of patients at each time point reflects the enrolled HCH patients identified in the practice data extracts at each of these points. Therefore, the charts do not reflect a longitudinal picture of the same patients – new patients have been enrolled and patients who left the trial are not shown in latter time points. Furthermore, data for some practices were not available when they commenced with HCH and thus their data were added later as well.

Appendix 1 explores similar analyses restricted to practices that have provided practice data extracts from the time they joined the trial (between late 2017 and mid-2018) and were still participating in June 2020 (54 practices: 46 Pen CS and eight Sonic). Although the charts show similar downward trends in recording of the measures after June 2019, they show that at December 2019, the rates of recording are higher than they were before the trial started. It is only in the six months before June 2020 that they have dropped to pre-enrolment rates of recording, and this is likely due to the COVID-19 pandemic, specifically, that more of the consults are have taken place via telehealth, and thus measures may not have been taken.

Additional analysis included only patients enrolled at June 2018 and treated the point of enrolment of each individual patient as time 'zero'. This analysis showed patients with blood pressure measures recorded increased from about 50% before enrolment to 90% at enrolment. Measurement then decreased in the next six months (but by less than 10 percentage points), and in the next six months after that either stayed the same or increased slightly. After 12 months there was a slight dip in measurement (again by about 10 percentage points) and then a further dip at 18 months. The last period is associated with the COVID-19 pandemic. The measures for pulse and cholesterol followed similar patterns.

Another possible explanation is that the measures are being taken regularly, but not always recorded in the practice clinical management systems, and that greater efforts to do this were made at the time that patients were enrolled.

Processes for regularly taking and recording patient lifestyle and clinical measures will be explored in the next round of data collection for the evaluation, particularly comparing the rates of measurement and trends for non-HCH patients in HCH practices and comparator practices. Interviews with practices will also be used explore and interpret the trends.

Patient and carer experiences

Key points:

- Some patients appeared unaware of what HCH entails and reported that little had changed
 with their care. Practices attributed patients' observations of no difference to the fact that they
 were already operating like an HCH before the trial. Patients generally reported getting good
 care, but increased awareness may allow them to take full advantage of what HCH can offer.
 This is especially important for HCH with its emphasis on involving patients in their care and
 patient self-management.
- Most patients reported that they had strong, long-standing relationships with their GPs and were
 satisfied with the care received at their practices. Some patients observed the practice nurse
 has had a much more active involvement in their care since joining HCH. Many patients
 welcomed this change and felt they were not wasting the doctors' time and were able to ask
 more questions about their health and managing their conditions.
- Changes in care most noticed by patients included increased access to a practice via telephone or email. This included requesting routine prescriptions or referrals over the phone without an appointment with their GP, and a capacity to telephone with a practice nurse, HCH coordinator or doctor to discuss questions or concerns, which put them at ease and helped them manage their condition more effectively.
- Most patients were aware of the care plan that had been developed at enrolment. However, patients had limited awareness of electronic sharing of information from their shared care plan among their providers.
- Some patients found that turnover in staff at the practice mainly in practice nurses or HCH
 coordinators affected the level of contact they had with the practice.
- Some patients reported positive experiences from involvement in patient groups established by the practice, which have contributed improvements in knowledge and sometime their physical and psychological health. However, most HCHs have not established patient groups.
- Carers interviewed reflected that the trial has been a great support to them and the person
 they care for. Carers mentioned that the ability to request prescriptions and referrals over the
 phone and having the nurse or coordinator as a clinical resource has been very beneficial.
- Practices reported that patients who enrolled in HCH were already motivated about managing
 their health. GPs also tended to approach patients to enrol whom they thought were activated
 or were willing to try new things. Some practices observed that through HCH, patients have
 become more aware of their role in managing their health, and this has engendered
 enthusiasm about what patients can achieve for themselves.
- In the broader rollout of HCH, strategies to engage patients who are less motivated, activated and/or willing to try new things will be important. These patients are more likely have poorly controlled chronic conditions and may benefit significantly from HCH (new lesson #34)⁷.

⁷ Numbering of lessons from the *Interim evaluation report* 2019 is used. Numbering for new lessons arising from this report continues from the 2019 list. See Volume 1 for the complete list of lessons.

This Chapter builds on patient, family and carer experiences of being enrolled in HCH described in the *Interim evaluation report 2019*. The experiences are drawn from interviews with patients (including their carers and family members) conducted between November 2019 and March 2020. This Chapter also draws on interviews with practice staff, conducted in the same period. Experiences of patients in remote Aboriginal communities in the NT are discussed in Chapter 6.

Interviews were mostly conducted prior to COVID-19, and most were face-to-face. Only a few of the interviews with patients, those in early March, were conducted by telephone. Table 16 shows the number of interviews conducted during the round 1 of the evaluation (the results of which were reported in the *Interim evaluation report 2019*), and during round 4. There was a similar number of patients and carers during both interview rounds. Several of the patients interviewed during the round 4 evaluation had also been interviewed in round 1.

Table 16 – Number of patient and carer interviews conducted, by evaluation round

Interview round	Number of patients interviewed	Number of carers interviewed
Round 1 evaluation interviews	41	4
Round 4 evaluation interviews	40*	2

^{*}Note: Figure does not include patients from HCH ACCHS sites in NT Aboriginal communities (see Chapter 6).

Overall experiences with HCH

"I'm really happy with it, it's working well for me." [Patient 6, R4, Practice 6]

Overall, patients reported positive experiences with HCH:

"[HCH coordinator] enrolled myself and my wife in Health Care [Homes], and she's more or less

taken us under her wing. She more or less tells us if we're in any sort of trouble, here's her phone number, we ring her. And so it gets that way now, whenever we come down to the doctor's rooms there, we always look up [coordinator]. [Coordinator] sort of takes care of us. She checks our blood pressure and makes us really feel very, very at home, and she's a very good ambassador for Health Care [Homes]." [Patient 3, R4, Practice 4]

Practices also reported that patients seemed happy with HCH:

"Well, these patients they all seem to feel quite special ... That's the feedback that we get that they feel like they are getting special attention, extra attention to what most people get having their nurse there for them, more access to the nurse. They seem to be really liking it. So, that seems to be the biggest thing I think, they really appreciate that extra nurse that they can contact when they need to." [Coordinator, R4, Practice 4]

"We've not had any complaints. We've not had a single complaint about it. So, the patients seem to really like it." [Business Owner, R4, Practice 6]

"A couple of the patients that were initially registered, them being long-term patients here anyway ... The effect that it had on them ... being able to register, is quite a confidence boost for them. They've seen it in a positive way ..." [Nurse, R4, Practice 10]

"We have a handful of patients that since they have been on the program, they have seen a big difference in their healthcare and how it's being managed."

[Practice Manager, R4, Practice 14]

Some patients felt that little has changed with their care:

"It's good, it hasn't changed, because as I said, I've always been well looked after ..." [Patient 1, R4, Practice 7]

Practices commented:

"I don't think it's probably had major impact because I think we probably already were ... in the space of the patient-centred care model anyway. So, I think for us probably not been a drastic change for them. I'm speaking of my view. They may say something different to that. But I think it probably hasn't changed that drastically for them." [Practice Manager, R4, Practice 10]

"So, well, it hasn't made a huge difference really to people, I don't think. I don't think it has because they're just seeing them for what they need to be seen for. Initially in the set-up phase people were a bit more aware I suppose of what was going on. Now I think it's more, the patients have walked in, they've walked in with a special icon so that it's clear that they're a Health Care Home patient and they're not billed." [Practice Manager/Nurse, R4, Practice 18]

A few practices reported that there was initial resistance and concerns from their patients about enrolling in HCH, particularly around not being able to see their GP regularly. To manage this, they introduced changes gradually. Practice staff believed patients have adapted to these changes and are satisfied with the care they are receiving:

"... so when we began and where we are now. But even that has changed and shifted. When I started enrolling patients, more than half of my patients were very reluctant to get onto the program because they thought they'd lose me ... there was one woman, after I enrolled her and explained, she held my hand and she said, no one can separate you from me, [GP2]. Yes, so that's how we started. She's still enrolled ... The big shift that I've seen is in her now, where in the beginning, she would still keep booking in to see me. And was unable to trust her care could be given to her by the whole team. And it took a while, but now she's more than happy when my nurse rings her to just check in on her ... And she's finding it massively beneficial now. Where there are days when I'm not here and I've heard she's rung in and spoken to one of my nurses for something like I need a referral or can you please ask [GP2] to ring me back. Which she would never have done before. That's one success." [GP, R4, Practice 5]

"[There was] initial concern that they wouldn't be able to see the doctor but now they know that they still can." [Practice Manager, R4, Practice 4]

Case study

Patient F has lymphedema and diabetes. He also has had ongoing issues with his foot and thought that he would have to have it amputated two years ago but avoided this. He and his wife, who is his primary carer, have a long-standing relationship with the practice. Due to his conditions, his GP suggested HCH, and he was the first patient to enrol at the practice. Since joining HCH, the nurse rings him every three to four weeks to check on him, see if he needs any prescriptions or if she or the

GP need to see him. He and his wife have been able to change their lifestyle and his blood sugar levels are more stable. He has also had a home medication review by his community pharmacist and feels that his GP and pharmacist actively communicate about his medications. He highly recommends HCH and feels that it has taken a load off him and his wife knowing that they have a strong network behind them that is actively helping him manage his conditions.

Many patients would recommend HCH to others:

"I would [recommend HCH] because it personalises everything from the doctor, to the chemist, to your specialist in a way, to the hospital I suppose, in that sort of sense. It keeps it all together ... I think it's a better way of looking at it, it's a database there ready to go, all they've got to do is just access it from there, in a way." [Patient 9, R4, Practice 7]

"Yes, I think it's good ... I would be telling them that you don't have to make an appointment and go and see your doctor to get a script, you can just ring up and say I'm out of these scripts, can I get these scripts." [Patient 1, R4, Practice 6]

"I'd say [they] should be a part of it, my brother, he wasn't in it ... he's had a lot of issues in his life, he's five years older than I [am], and he said, no, I don't think I'll do that, but he joined up and said to the doctor, I think I should join up ... anyway he's in it and his wife passed and his daughter looks after him and I think they're very happy with it too." [Patient 1, R4, Practice 17]

Access

Patients frequently cited increased access to the practice via telephone or email as one of the major benefits of HCH. Some patients stated this was the only change they noticed with being enrolled in HCH. Increased access often included the ability to request routine prescriptions or referrals over the phone without having to make an appointment with their GP. Some patients also reported being able to ring the practice nurse, HCH coordinator or doctor if they had any questions or concerns, which put them at ease and helped them manage their condition more effectively:

"If I can ring up [nurse] and say, look, I think we need to check, because things change ... So if we didn't have this option there, my option would be to ring up the doctor and say, we can't get to see the thing, and they'd say, you can't get in for da-da-da, but now they will say to me, we'll put you in, [Nurse]'s free or if she's not free, we'll get you there, But the other thing, if I need something in the way of tablets, I don't always have to, the staff there can organise those for me, which is, they can talk to the doctor but you know what I'm saying, they squeeze you in to get those sort of things." [Patient 1, R4, Practice 17]

"... if I need a prescription I can just ring up and order it and then pick it up on my way out and go and get it filled. And that's done I don't have to sit and wait in the waiting room. Because with all my autoimmune problems I worry sitting in a waiting room if someone's got a cold or something contagious. They only have to walk past my front gate and I'll catch it." [Patient 5, R4, Practice 9]

Some patients reported they were also enjoying additional features such as booking appointments online or receiving reminders via the phone or text about upcoming

appointments. Though these features were welcomed by many patients, some of these access changes appeared to be independent of HCH:

"I go online and do what I need to. And I'm registered with ... it's an app ... And I can go pick a doctor, time, make an appointment for [name] or ... I can ask to see the nurse ... If we want to see a nurse, we go down there." [Patient 2, R4, Practice 9]

Case study

Patients C and D are a couple who have several chronic diseases between them: renal failure, heart issues, high blood pressure, deafness, Type 2 diabetes and anxiety. They joined HCH because they felt that they were getting older and wanted to see a regular doctor and establish a good relationship and continuity of care. Patients C and D feel HCH is working well and that the GP is taking very good care of them. Patient C has regularly been able to visit a podiatrist and Patient C can ring up the practice and request their regular prescriptions. Patient D does not talk on the phone, so staff members send him texts to check up on him, ask if he needs to come in for anything or remind him about upcoming appointments. The couple is also happy that they can see the nurse for any questions or concerns regarding their care that might not warrant a visit to the GP. They also feel that HCH keeps them on top of their care as the practice reminds them if they forget a blood test or that they are due for a prescription refill. The couple also registered with the practice's software to make online appointments. They recommend HCH and appreciate that they have someone available to support them with their care and feel that they do not have to jump through many hoops to see a nurse or GP at the practice.

"... I don't have a problem making appointments. In fact, I've been using [software platform] and doing it online a lot as well ... which is a big help. So, it saves me having to ring the practice." [Patient 1, R4, Practice 6]

A few patients reported that being an HCH patient meant they were prioritised for appointments:

"I get in quicker, I get in pretty much straight away ... Not saying that they would've turned me away before, but I've noticed ... everything's more responsive, a lot quicker, just sorted out." [Patient 9, R4, Practice 7]

"... the beauty of what this Homes Health, however you say it, is that I can just ring up, it's very hard to get in to our doctors, you might wait two or three weeks to get in to a doctor, because it's pretty full on out there, and I ring up [nurse] who coordinates all that and she just says, yes, you need to see the doctor or they will come and see you. It's been really helpful to me and my wife." [Patient 1, R4, Practice 17]

Care planning

Many patients reported that they were involved in creating a care plan with their GP or a practice nurse. Though some patients stated they have had a care plan for many years ["I've been on care plans for years, like I'm talking 10, 15 years." (Patient 6, R4, Practice 6)], others said they received a care plan upon enrolling in HCH. They reported that the plan included their goals and referrals to see specialists or allied health professionals. Many patients stated they have continued to review their care plans with their doctor or practice nurse annually or every six months:

"I initially had a care plan that was with the physio visits and all that. Now, I've stopped the physio visits, but I have my own home program that I do still from that. And I still go every six months and go through everything that was discussed ... they checked whether I need to get back to the physio, whether I need to have any more assistance." [Patient 4, R4, Practice 4]

"We have a care plan, you know the paperwork you fill out ... Yes. We're on the healthcare plan that we did here with the doctor about a year ago." [Patient 2, R4, Practice 10]

"I have a nurse who does a health care plan for me as well ... I have podiatry treatment, chiropractic remedial massage. And they are covered on the health plan ... Well, the nurse first put me onto it. And she's just worked out a plan for me asking me questions, what sorts of things I do, what care I have for my body to keep it in the best shape I can." [Patient 5, R4, Practice 9]

Others were not familiar with a care plan and could not recall creating one:

"... I told [the doctor] my problem and he talked me through it ... and we worked a solution. I've not sat down ... to design a plan." [Patient 1, R4, Practice 1]

Patients reported that a few of the services they were receiving started when they enrolled in HCH, mostly prompted by having a care plan developed. They reported positive experiences with these additional services:

"The physio has definitely made a difference to me as far as mobility is concerned and strength. It's helped reduce the arthritis pain because of the strengthening of the muscles around certain joints, and things like that ... I was going to the chiropractor and they hadn't picked up on certain things that were happening muscular wise. And when I went to the physio they picked things up straight away that had been an issue for a long time. So, I stopped going to the chiropractor, and just went to the physio instead." [Patient 2, R4, Practice 6]

"I got to see a dietician ... I had several visits with that, and that actually was quite helpful ... So, that's all worked out." [Patient 5, R4, Practice 4]

Case study

Patient G has asthma, arthritis, knee problems, gastroesophageal reflux disease (GERD) and a heart condition. She joined HCH as she felt it would allow the practice to take a more preventive approach to monitoring and managing her conditions. Since joining HCH, Patient G stated that her GP referred her to a specialist to help her manage her hip problems and a dietician. She felt the dietician was very helpful in alleviating her stomach pains and other issues associated with GERD.

Shared care

Most patients were confident that specialists, allied health professionals and hospital staff were sending their practice formal reports or letters about their visits and communicating with their GPs:

"Yes, [the communication is good] ... I always ask. When I've seen the specialist and I go to my GP I say have you got my last visit report from whoever. Yes, they have." [Patient 1, R4, Practice 6]

"... before I go to the hospital I think [my practice and the hospital] communicate. On their data they have the details of my health." [Patient 1, R4, Practice 3]

"[My psychologist] sends a letter when I tell him to. I just say, look, you know, we're having a bit of a problem with this. Let them know that I've come to see you. And then, when my referrals run out they will write a referral back to him and just say, well, we've seen her today, just keep an eye on her, more or less." [Patient 5, R4, Practice 6]

A few, however, felt that the communication between their GP and external providers was left up to them or was minimal.

Patients had limited awareness of electronic sharing of information from their shared care plan among their providers. Where they were aware, sometimes they engaged with it themselves:

In other instances there were still 'teething' issues with other providers accessing their plan through the shared care software, or they did not wish to engage with the software themselves:

"They've got [the care plan] on the computer ... We haven't accessed it for a little while because they've had trouble with their computer, but we know it's there if we, we can log in on somebody else's computer." [Carer, R4, Practice 17]

"The girls tried to put the app on my phone for me. Don't worry about that, I'll ring up. I actually like to ring up or I actually like to go in and talk to them face-to-face." [Patient 1, R4, Practice 7]

Furthermore, despite sharing of the information, it did not necessarily result in the intended sharing of care between the providers:

"I got the sense that this is just a good clinical, general practice that the reports that are coming from the specialist are landing in the software. The GP that I'm seeing would be aware, and he has commented on at some stage ... But I wouldn't call it shared care." [Patient 7, R4, Practice 7]

My Health Record

The Interim evaluation report 2019 documented patients' privacy concerns about My Health Record, and that these had deterred some patients from participating in HCH. Subsequently

the requirement to register for a My Health Record when enrolling in HCH was removed. Privacy was raised again by a few patients in the second round of interviews. One patient explained why he decided to opt out of My Health Record when enrolling in HCH:

"I just feel that my health conditions aren't that complex, it's pretty easy to say I've got asthma and arthritis ... And I just thought it was another level of privacy that I didn't have to have be involved in. I know it's crazy these days, everything is online, everything is accessible one way or another, but I just felt like I didn't want to make it." [Patient 3, R4, Practice 6]

Another patient had the opposite opinion of My Health Record and felt that it is an extremely valuable tool. The patient described an experience where the system proved to be very helpful when he had a medical issue away from home:

"I really think that [My Health Record is] just a tremendous thing ... Like you go and see a strange doctor somewhere and you can tell them you're part of My Health [Record] ... And this happened at the [Hospital] when I was up there. And you know, they found it very helpful ... I had this blooming turn up there where I woke up at three o'clock in the morning, thought I was dying, and ... we got an ambulance and then I was in intensive care for three days because I got this confounded cellulitis ... at the time, I couldn't recall what sort of trouble I was in in regard to what sort of medication I took or anything. But they could soon find all that out just by getting onto My Health [Record]." [Patient 3, R4, Practice 4]

Sometimes patients weren't sure about how to access their My Health Record, but were interested in learning about this:

"Well, I'd like to go in and have a ... If everything's on My Health Record, I want to be able to go and have a look at everything's that's there." [Patient 1, R4, Practice 6]

Patients' experiences with practice staff

Patients predominantly reported that they had strong, long-standing relationships with their GPs and that they were satisfied with the care they were receiving at their practices:

"I deal with [GP] for most of the time. We have seen other doctors here. If he's unavailable or if he's at rural or somewhere else that he has to do. But generally in the last three years we've dealt with him. He's fantastic." [Patient 1, R4, Practice 10]

"So far that's worked very well and [GP] takes care of both of us and she is very efficient." [Patient 2, R4, Practice 9]

"Our doctor has been a friend of ours for ... Our GP for over 11 years and we're pretty happy with her. We actually followed her from one practice to another, even though it's a bit more inconvenient because she's a bit further away ..."

[Patient 2, R4, Practice 6]

Some patients said the practice nurse has had a much more active involvement in their care since they joined HCH. Many patients welcomed this change and felt they were not wasting

the doctors' time and were able to ask various questions in relation to their health and managing their condition(s):

"I mean, sometimes, you go to the doctor and they're running an hour late or something, and you go in and you just don't have the time to talk to them. You feel ... I'll do that later. But the time that I spend with the nurses has been most helpful." [Patient 2, R4, Practice 4]

"Yes, [nurse] calls and said, we haven't caught up for three or four weeks, are you okay? ... thinking I should need something checking or this or that, so she'll come down tomorrow and have a look, and if the doctor needs to look, we'll do whatever, and been very reassuring. She's a lovely person, and very good."

[Patient 7, R4, Practice 17]

"Sometimes I ring [the nurse] and she's busy so she will call me back. Or if it's quite urgent I go to the clinic and I say can I see [Nurse]. If she's busy she will see me or she will say wait a few minutes and I will see you then. Most of the time I will call her and let her know what's going on and what I want and she will give me advice." [Patient 1, R4, Practice 3]

"I have run up and said, look, I'm having a difficulty with something. Can I speak to the nurse practitioner? And then, I've left it up to her whether she's deciding me to come in and see the doctor or something that we can handle at home." [Patient 5, R4, Practice 6]

A few patients stated they have also had access to an HCH coordinator. Some practices hired a coordinator or designated a practice nurse as the HCH coordinator to help actively manage HCH patients and act as their main point of contact. In some instances, patients were not getting the benefit of the HCH nurse or coordinator because of turnover of staff. For example, one patient stated their practice used to have an HCH coordinator who contacted them regularly, but the coordinator has since left the practice, and they no longer receive 'check-in' calls. Another patient said the practice has had quite a lot of nurse turnover, which has made it more difficult to establish or maintain a strong relationship with a practice nurse:

"Well, in the beginning we had a coordinator ... And she was quite good. She'd ring every couple of months ... she would always get me in ... [HCH Coordinator1] and [Coordinator2] mysteriously disappeared ... in the beginning it was regular. But then the calls just ... dried up." [Patient 1, R4, Practice 16]

"The nurses change quite frequently, I don't know whether there would be some way of encouraging them to stay ... it's a bit hard to build on a relationship with a nurse because each time you have to basically start afresh." [Patient 3, R4, Practice 6]

Experience of group sessions

"I feel heaps better ... through all this group stuff and with the doctors. It really helped me a lot." [Patient 1, R4, Practice 18] As discussed in the practice section, only a few practices set up groups for their HCH patients. Some practices planned to set up groups in the future, while others did not think this was feasible due to availability of allied health professionals, lack of space, potential cost and limited patient interest.

One practice that established patient groups initially had psychology, walking and dietician groups. Due to patient feedback, limited attendance in certain instances and staff turnover, the practice decided to continue with only the dietician group and no longer offers the psychology or walking groups. Patients were very positive about being in a group, enjoying the educational and social benefits. Some even reported positive outcomes with their physical and mental health:

"I think the group sessions are good, because when you're first diagnosed, you think, diabetes, what am I going to do? How have I got to change my life and stuff like that? And it's good because you do come down and interact. Everyone has their story. Someone's doing this and someone's doing that. You get to pick up some good hints." [Patient 2, R4, Practice 18]

"... when I was first diagnosed over at the hospital, they virtually said well, this is how you've got to do it. The diet, the diabetes plate. That, to me, the way I was growing up, was putting petrol on fire. With this dietician now, we can ask her anything. She individualises, I suppose, our needs and she says well, try it this way. If it doesn't work, try something else." [Patient 3, R4, Practice 18]

Case study

Patient E has diabetes. He has been a patient at the practice since it opened and travels 30 minutes by taxi or public transport to get to the practice. He joined HCH as it was suggested by one of the GPs. The practice initially had a walking group, and he would schedule his appointments on the days that the group was walking to reduce his travel time and ensure that he could still participate in the group. Though the walking group has since been disbanded, Patient E has seen great benefit from the dietician group. He stated that he has lost 5 kilograms since joining the group and no longer needs to test his blood sugar daily as his levels are much lower than before. He also noted that the dietician group offers some social benefits and has had a positive impact on his mental health.

Patient activation

Practices reported that it was generally patients who were already more motivated about managing their health that enrolled in HCH:

"... the ones that actually signed up were more likely to, I don't know, undertake required lifestyle changes and be proactive about their health. So the ones that actually signed up cared enough about their own health to take on board lifestyle and any other health recommendations that we presented to them."

[GP, R4, Practice 15]

They also tended to target patients to enrol that they thought were activated or were willing to try new things:

"The experience that I've had so far, I would say, doesn't encourage me to recruit those that I feel are less likely to proceed, because I sort of have to predict in my head: are they likely to be agreeable to anything I suggest? If they're a patient that's not likely to be agreeable, I might not even offer them the option, just because I know the effort that was required and the fruitless effort that I've experienced in the past." [GP, R4, Practice 15]

"I think we were quite selective ... Our director actually went through the list that he got out and decided ... But I think we just have to be a little selective. We have to look at ... that particular patient on a one-to-one type scenario, just actually do they fit. Are they going to be too much of a financial burden, or ... is it a program that we think is suitable for them?" [Practice Manager, R4, Practice 10]

However, some reported that patients have become more aware of their role in managing their health through initiatives that the practice introduced as part of HCH:

"... I'll give them a monitor on the first diagnosis. And it'll have the date and time and everything. So, I can actually go through and they know that I can see the dates and the times and all these have been monitored ... Those patients that are Health Care Home patients that are diabetic are much better than just the week beforehand now because I'm looking for a 30-day record, a 14-day record, a seven-day record and sometimes a 90-day record ... I think they are more compliant because they are coming more regularly, someone cares. They have more time and that they know that I'll sit and talk to them. They don't want to worry the doctor all the time about simple things that we can fix." [Nurse, R4, Practice 6]

"The change is in those patients who are at home and they were not taking care of their chronic conditions. Now somebody is talking to them and saying that, look, you need such and such thing. You are due for that one. Your GP had asked that you need to go for this blood test. This script is due for that one. We call the pharmacist, tell us that they are going to make the restore pack and they need that script. And the medicine review is done on annual basis, and that review gives us the idea if we need to make any changes." [GP, R4, Practice 17]

And when they did so, they became more enthusiastic about what they could achieve for themselves:

"Yes, it does make a difference ... The patients that get onboard with it and really get involved are a bit more engaged ... It has helped in that respect, rather than just storing up their problems and coming in to see me ad hoc. You do get a lot more phone calls, and messages saying such-and-such did this. So, they're seeking out earlier. So that is one noticeable difference." [GP, R4, Practice 10]

"It depends on the person. Some, like I said, have come a long way. Particularly the gentleman the other day who was so excited to actually see his results on his phone. [It was] ... the first time I thought, wow, because you could see he saw himself then as I'm in control here ..." [Nurse, R4, Practice 9]

Patients could identify that they could now better support themselves:

- "... it means that I've got a little bit of control of what's going on with me, rather than me saying, someone else has got control and I don't know what's going on." [Patient 1, R4, Practice 9]
- "... I feel more confident. I feel less pressure. As if someone over there is looking after me and helping me. I can find a solution to my problem." [Patient 1, R4, Practice 3]

In one instance, the patient knew about 'activation' and identified it as a key goal of the HCH model:

"I think there's a part of the equation as well, and the notion of patient activation. There's only so much a practice can do. They're only seeing you for a very limited time over the course of a month or a year. So, ultimately I think the benefit of the Health Care Home is really about support of the patient to support themselves better." [Patient 7, R4, Practice 7]

Additional things patients would like

Most patients reported that they were satisfied with their care and did not want anything further from the model or their practice:

"Yes, just stick with what they're doing. I can't see any actual improvements that they could make. They're doing pretty well." [Patient 6, R4, Practice 6]

"I think I'm very happy with the way I've been treated ... I'm very happy with [GP], it's been really good." [Patient 4, R4, Practice 18]

"If it ain't broke, don't fix it. But no, I wouldn't want anything to change." [Patient 1, R4, Practice 7]

Where patients did suggest improvements to the model or additional things that they would like to incorporate, they suggested that practices:

- listen to their patients
- provide additional allied health appointments
- limit staff turnover
- extend appointment times
- allow patients to communicate with the practice via text or email
- show patients how to access their care plan online
- provide additional support from the nurse or other staff members to help manage their conditions
- provide additional patient monitoring and care coordination
- encourage patients to achieve their goals (e.g. weight loss)
- promote HCH as a mindset, not a trial with a start and end date
- train all staff members to recognise HCH patients and provide interdisciplinary care
- provide free transport.

Carers and family members

The carers interviewed reflected that HCH has been a great support to them and the person they are caring for. Carers mentioned the ability to request prescriptions and referrals over the phone and having the nurse or coordinator as a clinical resource has been very beneficial:

"[Patient 4] hates coming to the doctors. She plays up like anything, screams and yells and then she goes through a good period ... So, it's good for us in that she doesn't have to come back here all the time ... It's good in that I don't necessarily have to bring [Patient 4] out here unless she really needs to see a doctor. If we're concerned about giving her, say, Nurofen, I can ring someone up and ask them ... And ... In time [they'll] ask the doctor and get back to me ..."
[Carer, R4, Practice 18]

Case study

A mother is the carer for her middle-aged daughter who has cerebral palsy and quadriplegia. Patient H is in a wheelchair and has limited verbal language. She currently lives in a group home with several other individuals and carers who help manage her care. The mother described difficulties ensuring that her daughter gets the appropriate care that she needs in the long term, such as financial support for weight management services and physiotherapy. Her daughter has been a patient at the practice for 12 years, and the mother reported that the practice has been incredibly helpful in supporting her care and meeting her needs. Though she feels her daughter's care has not changed since enrolling in HCH, she is very happy that she or the staff at the group home do not have to bring Patient H to the practice as often as it can be a difficult experience. HCH has allowed the mother and carers at the group home to contact the practice staff via phone if they have any questions about her care or if they need to request prescription refills. This has reassured the mother and made her feel that she always has a point of contact if there is ever a problem or question about her daughter's health.

6. HCH in NT Aboriginal communities

Key points:

- Fourteen Aboriginal Community Controlled Health Services (ACCHS) in the NT are
 participating in HCH. Among them they have enrolled 1,025 patients, with a median of 53
 patients per ACCHS (10 minimum and 268 maximum). Two ACCHS that operate within two
 different remote Aboriginal communities were selected as case study sites for the HCH
 evaluation. Staff members and patients within these communities were interviewed about
 their experience with the trial.
- The two NT ACCHS that implemented HCH found that although the HCH model is similar to the way they were already delivering care, implementing HCH meant more frequent reviews of patients' care plans and, overall, more comprehensive plans. They also found that team meetings were more effective and efficient, mostly due to improved care planning which allowed all members of the team to be across what was happening with individual patients.
- ACCHS staff felt that the risk stratification tool was not suitable for their context as it does
 not consider the cultural, social and geographic issues of their clients. They also faced many
 issues implementing the software.
- The key challenges for the ACCHS in implementing HCH were the transient nature of their populations, making it difficult for a single clinic to operate as their medical home, and suboptimal and inconsistent communications with external health care providers (specialists and hospitals) about the patients that they share.
- Patients of the ACCHS were largely not aware of what the HCH model entailed and did not
 notice any changes to their care. This might be due to the similarity of the HCH model to the
 ACCHS model, but, as with mainstream practices, it signals the need for raising the
 awareness of patients and communities about the model so that they know what to expect.

Of the total 227 practices that were participating in HCH at any time between the trial inception and 30 June 2020, 32 were Aboriginal Medical Services (AMSs). AMSs have withdrawn from the trial at a similar rate as all other practice types (15 out of 32 (47%) vs. 92 out of 195 (47%)). Of the 15 AMSs that have withdrawn, nine had enrolled no patients and another five had enrolled fewer than five patients. There are three AMSs active in the trial outside of the NT, and between them they have 570 patients.

The AMSs in the NT are all ACCHS. They have been more likely to remain in the trial, with 14 of the 18 that initially enrolled still active. The four that withdrew had enrolled only one patient between them. The total number of patients enrolled in the 14 ACCHS that are still active as at 30 June 2020 is 1,025, with a median of 53 patients per ACCHS (10 minimum and 268 maximum).

Two ACCHS that operate within two different remote Aboriginal communities in the NT participated as case study sites for the HCH evaluation. Staff members and patients within these communities were interviewed about their experience with the trial. This Chapter reports on these experiences. A total of 15 staff members and nine patients were interviewed

across the two case study sites. The staff members interviewed represented all of the key roles engaged with the HCH trial at both of the sites.

Context

ACCHS are governed by members and leadership involves both ACCHS management and the community. Clinics that are part of ACCHS tend to be centrally administered, and, depending on location and resourcing, staff either travel to the clinic or live in the community. Lack of staff and high staff turnover commonly affect service delivery.

In remote communities, services such as pharmacy, community nursing, and allied health are rarely consistently available and residents rely on clinics. Due to high staffing costs and small population sizes within these communities, albeit with complex health needs, there are often relatively few staff members available to support a clinic, and they tend to work across a spectrum of health needs.

Participants reported that residents of both of the communities that were part of the case studies had a high degree of complex health needs and conditions, exacerbated by poor social determinants of health, low health literacy and a limited number of health service options available within their communities.

Motivations to join HCH

Both case study sites felt that their model of care closely aligns with the HCH model, and this was a key motivation to join the trial. Several additional factors also influenced the decision to join. One was the opportunity to fund clinical work that isn't supported by MBS. Another was that the tiered nature of the bundled payment meant that they would be better able to support the needs of their patients compared with the MBS.

The medical director at one case study site also felt that the model would allow them more time for care planning. They were of the view that patient care plans were not working as effectively as they could be. It was their experience that when they saw a patient with complex health problems, they were spending too much time identifying the diseases and management issues and not enough time resolving them:

"I spend the first 10 minutes of a consultation coming to grips with the fact that she's got diabetes and bronchiectasis, I spend the next 15 minutes coming to grips with the fact that she does or doesn't take her medication. And although we certainly had care plans, and were paid by Medicare when we completed a 721 and a 723, because it was tied to a patient consult and because we knew there were other patients waiting in the waiting room, we never really, I believe, developed what I would consider a good care plan." [Medical Director, R3, Practice 20]

Initiation and implementation

The two case study sites approached the initiation and implementation of the trial differently. One site set up a project team comprised of clinicians, admin, the senior business manager and an IT representative. A part of their initial process was observing the implementation

experience of the other ACCHS, and this helped to inform decisions, particularly in relation to IT.

The decision to enrol in HCH at the second site was made centrally by the ACCHS, by senior medical staff. The ACCHS then arranged a meeting with clinic staff to explain what HCH would mean to them and the clinic.

Training and support

The sites had different experiences in relation to training and support. One ACCHS stated that they initially worked closely with the PHN to gather knowledge about the program and their sector body. Their sector body also employed a person to support the ACCHS with piloting HCH and their role was to work closely with the ACCHS as well as liaise with the PHN and HCH staff to provide support and information. The organisation also built a strong team that included IT, administrative staff and clinicians and they worked effectively as a team through challenges that emerged.

At the other site, it was unclear whether staff received training and support for implementing HCH. One allied health professional said they did not participate in training related to HCH. The clinic nurse also did not recognise terms associated with the online training modules, and the regular GP at the clinic had not used the modules. The clinical staff from the various clinics that are part of the ACCHS participate in weekly team meetings to discuss complex patients and for teaching sessions. During these meetings they discussed HCH.

The medical director at one of the sites expressed some frustration with the initial HCH process and the lack of answers to questions in relation to implementation. They understood it was a trial and that some of the answers may not have been known, but nonetheless, they felt frustrated.

Enrolment

Staff at the first case study site described significant learning involved with patient enrolment. To enrol patients, initially, a community barbeque was held (food events in remote communities are important for bringing people together to share information) and information about HCH was combined with health checks. While the barbeque formed the introduction to HCH, the GPs followed up with enrolling patients when the patients attended the clinic. It was decided that GPs and the clinic manager would be involved in enrolling patients because they were thought to have the strongest relationships with community members. Although it was useful to introduce HCH at a community event, in retrospect several people involved in the event felt that the process could have been undertaken solely within the clinic setting.

There was an attempt to use community liaison officers in the enrolment process, but there was little interest on their part. This lack of motivation was attributed to the perceived lack of difference HCH would make on the ground.

Clinic staff commented that the similarity of the ACCHS model to HCH model meant patients were unlikely to notice any difference in their care. Even though the PHN had produced videos in the local language, clinic staff found it challenging to explain HCH to clients, as they did not think the clients' care would change. HCH was explained as being about the

way the clinic was funded to deliver health care to clients. A shared care record already existed, so that component of the model was easier to discuss. However, some patients were still concerned that their care might change.

The transient nature of people living in the community was a challenge to enrolling clients. Initially GPs had to consider which clients to recruit, as for most community members, their care is shared among several clinics. There was a strong reliance on longer-term clinic staff to identify which patients *truly call* the community home.

No patient declined to enrol. This is largely due to the strong relationship that GPs have with their clients. A GP pointed out that she knows her clients and their families very well and attends their funerals and celebrations, and that this positively affected enrolment.

Identification of patients eligible for HCH at the second case study site was done centrally. The medical director went through the records of all potentially eligible patients and selected those to be approached. They provided the list of patients to be approached to staff at the clinic. The clinic coordinator (a nurse) then went into the community and approached each of the patients about participating in HCH. The main point used to encourage patients to participate was that it would provide more income to the clinic to care for them, and that the patient's care would not be adversely affected in any way. Most patients agreed to participate when they were approached by the nurse.

Risk stratification tool

The RST caused significant challenges at both case study sites. Staff members were particularly critical of the usefulness of the tool. They felt that it did it not consider the cultural, social or geographic issues of their clients.

At the first case study site, the team initially compared patients to other patients within the community and, after extensive team discussions, it became apparent that they needed to compare their client experience to people living in regional areas. In a remote setting, questions of access to transport, housing, allied health services and specialists are crucial. For example, while the clinic provides transport for clients to attend health services, it is not always available at times that enable clients to access the clinic when they need.

Due to issues with the software, the second case study site did not use the tool and identified patients across the organisation's clinics themselves:

"I actually manually got a list of all of our chronic disease clients with more than two chronic diseases, and actually went through the 700 of them, working out who engaged with the service enough, and who fulfilled the criteria in order to create a list that was a meaningful list for people to go out and seek their consent." [Medical Director, R4, Practice 20]

The GPs divided up the 700 patients and went through their medical records and developed a care plan for each patient. This was all done in the absence of the patient. The nurse was still not clear on how patients were identified for HCH.

The following additional issues with the RST were also raised:

• The tool does not consider certain chronic conditions:

"Some of our most complex patients who have extremely high care requirement needs but they don't actually come under any of those other chronic conditions that are included in the HARP. For example, people with malignancies just don't quite fit into that algorithm somehow and they are incredibly complex." [Staff member, R4, Practice 20]

- Social determinants of health should carry more weight in the tiering process, as they play a significant role in health in remote communities.
- Tier 3 does not provide enough support or cater to the needs of patients who are some of the sickest in the country. Many of these clients are in the clinic on a regular basis for support with their conditions.
- The tool is subjective and the questions are broad and binary:

"The HARP is very open to interpretation I would say, the way the questions are phrased ..." [GP, R4, Practice 20].

Shared care planning

Though shared care plans were already in place at both of the study sites prior to HCH, the process differed at the two sites. The first site stated that their plans were stored in their practice clinical management system. Involving patients in care planning aligned with the site's usual practice and was viewed as a fundamental component of the patient-clinician relationship. However, the level of engagement often depended upon the capacity of the patient to engage with staff.

In contrast, GPs at the second site prepared care plans for all patients registered for HCH, in the absence of the patient. Additional funding was provided by the site to free-up doctors to develop the care plan. Although the method used to develop the care plans would suggest the care plans are not patient-centred, this is not the way the GPs saw it. There is a section of the care plan that allows the GP to engage the patient during a consultation. For example, the GP is prompted to ask the patient, "Do you want to give up smoking?", "Do you want to improve your diet?", etc. The patient has the opportunity to input at these points.

Sections of the care plan allow other staff members, and those who provide care to the patient (i.e. allied health), to also have input to the care plan. This may lead to GPs being more aware of what other care providers suggest:

"... maybe before I might not have read the podiatrist's entry, I might not have read the optometrist's entry, I'd sort of notice that they'd seen them, whereas this way I actually read the optometrist's entry, I read the podiatrist's entry, I read the Tackling Indigenous Smoking entry ..." [GP, R4, Practice 20]

Staff members at both sites discussed the main differences with their own shared care planning process and that as part of HCH. Interviewees at one site stated that care plans were used in referral letters to the hospital and specialists. A marked difference with the shared care plans under HCH is that revision of the plans was prompted more frequently than

previously undertaken. Staff at the second site thought that the care plans developed as part of HCH were more comprehensive:

"There were care plans in place. They were a different sort of care plan. Probably Health Care Homes are more up to date and more cohesive. I think the care plans we had before actually weren't that wonderful, really. They were a bit scattered. I find these ones quite good." [Nurse, R4, Practice 20]

"I've come to see, and I think this is what's so great about the Health Care Homes, seeing as a model where all the different health people who are involved with a patient care communicate with each other in an effective manner." [GP, R4, Practice 20]

One site commented that it was now easier for the nurse to access the care plan and that the nurse had greater ability to influence the doctors to change the care plans. This allowed the nurse to advocate for the patient and discuss their concerns further with the GP. The GP said they had overhauled the way they were doing care plans. They had consulted other organisations and created a template they thought would be good for them. The GP thought this was a real positive from HCH:

"You get a better perspective on it, especially if you're new or somebody doesn't know the client, you've got a perspective on them that it doesn't take a lot of time to figure out. Yes, it's much more effective and much more efficient." [GP, R4, Practice 20]

There are monthly meetings attended by medical staff (one GP and many nurses) and a pharmacist, where they discuss the care of patients. Both GPs thought the meetings were substantially better and more efficient than previously. The care plans have been simplified and updated, which allows locums and other GPs not familiar with the patient to more easily identify who the patient was seeing, when and for what. However, although one of the GPs could see the benefit of the improved care plans, they commented on the additional burden this puts on them to keep the plans up-to-date.

Staff members at the first case study site stated that because of the transient nature of the population in remote communities, care of patients is spread across the clinics in the communities the patients visit. Currently, for security purposes, each clinic has its own practice clinical management database, which results in multiple entries for the same client across the clinics that are part of the ACCHS. Notes are made on the client's file to indicate their 'home' clinic, which is the clinic that is allocated responsibility for their shared care plan. The ACCHS is moving towards a centralised client database, and will eventually centralise shared care plans.

Communication with the regional hospital also remains a challenge that can affect shared care plans and the maintenance of client records. For example, hospital discharge summaries and letters from specialist appointments are inconsistent, which can lead to inconsistencies in patient data kept by the service. The GPs reported spending significant time and effort following up information from the hospital, although they acknowledged that this is not unique to them – it is experienced by GPs across the country. The allied health professional interviewed also reported similar challenges.

HCH model

At both case study sites, staff commented that the similarities between the current model of care and HCH meant that it has been difficult to see changes in care delivery. Many staff members across the sites indicated that they had not noticed any difference in the way patients were treated since the introduction of HCH, or that it was still too early to identify any significant changes.

The first case study site identifies HCH patients with a sticker in their notes indicating which tier they are in. The practice nurse could not think of any specific changes at the clinic, but felt that HCH would bring the components of health care for the patient together in a more cohesive way. The nurse indicated that she believes in patient-centred care and is practising it at the clinic. She outlined the approach she uses to ensure patients understand what she is asking them to do (i.e. she gets the patient to repeat back to her what she was asking them to do when they leave the clinic – the 'teach-back' method). They described one example where they were able to get a patient to be more confident and self-sufficient through goal setting:

"You need to goal set with them. Achievable goals. SMART goals." [Nurse, R4, Practice 20]

The GP at the clinic felt that patient activation has not changed as a result of HCH, but observed that care plans had improved and allied health staff were now more available, and this has led to more conversations with patients about their need for allied health services. There are now also flags in the ACCHS shared care planning system to recall patients for these types of services.

Though the staff at the second case study site stated it was too early to see any major changes as a result of implementing HCH, the clinic was working on introducing some group activities to increase patient exercise. For example, Zumba classes for ladies recently started.

While calculations were still underway to ascertain what additional funding would result from HCH, it was estimated by the first case study site that the additional funds would not be able to purchase a full-time staff member at each clinic. Possibly a full-time role could be shared among a few clinics. It was seen as an advantage that HCH funds are not tied to individual clients, and therefore they can be used flexibly across the clinic.

At one of the sites the GP observed that patients have had more access to a dietician and that the clinic was making better use of an exercise physiologist but was unsure if that was a result of HCH.

Impact on practice staff

Staff members across the two case study sites reflected that the impact of HCH on their workload was relatively minimal. At the first clinic, the staff workload was predominantly affected during the learning phase of the HCH trial when the clinic was identifying how to introduce the model to patients, gather their consent and work out aspects of billing (chronic versus acute care). However, the shared care planning process and other aspects of the model were considered to be very similar to what was done with the old care plan

system. No one cited any significant effect on workload. If anything, in relation to billing it was considered to definitely be more straightforward.

All of the staff involved in HCH at the second clinic also stated that there was little effect on their role or workload. The allied health staff member interviewed said they had been given the role of chronic conditions coordinator, but there had been no change to the work they were doing. The nurse said that her role, and the role of the other nurse, did not change during the time of the HCH trial.

Pharmacy services

Neither site had referred patients to a community pharmacy to receive services under the community pharmacy trial. One of the sites has a medicine room that is overseen by the clinic manager. Patients receive medicines at the clinic and the GPs have access to a pharmacist should they have any questions. Pharmacists employed by the ACCHS travel to the clinic about every eight weeks to review the medicine room and oversee processes. A contracted pharmacy provider also undertakes six-monthly reviews.

The other case study site orders medications for patients through a pharmacy in Darwin. The medications are delivered each week. The ACCHS employs a pharmacist, and they participate in the monthly meetings where patient care is discussed. On other occasions, the pharmacist contacts the GP to discuss the medications a patient is taking. Some patients look after their own medicines, but for others the clinic dispenses their medicines each day.

Remote clinics operate under the Highly Specialised Drugs program that provides access to specialised PBS medicines for the treatment of chronic conditions. Dispensing staff are required to undertake specific training.

The community pharmacy trial was not viewed as relevant in the remote context by staff at one of the case study sites. Senior management expressed frustration that community pharmacies would be paid almost as much as clinics for HCH patients. For clinics in remote communities, teaming up with a pharmacy would not lighten their workload as it is clinic staff that dispense medications.

In addition, staff members at the first case study site felt that it wasn't desirable to have visiting community pharmacists consult with their patients, as it is clinic staff that have the ongoing relationships with patients. Also, patients should get advice and other services related to their medicines when its suits them rather than when a community pharmacist is visiting. A special example of this is patients visiting from other communities, who often require an unscheduled visit to the clinic for their medicines.

The GP at the second case study site had heard of the community pharmacy trial, but had not referred patients.

Implementation enablers and barriers

The first case study site identified their ACCHS structure as a key enabler. Senior staff in the ACCHS in the first instance championed the model and facilitated its trial in the clinic, supporting the implementation when the challenges arose requiring an extensive investment of labour (such as IT implementation). The ACCHS also provided a lot of practical support along the way, for example, understanding of billing and help with this.

The site also identified the community and the strong relationships the clinic staff have with patients as an enabler, which meant it was relatively easy to enrol patients for the trial.

The same organisational structure that supported implementation was also identified as a potential barrier to introducing new approaches. That is, individual clinics and their boards have the final say as to whether they would participate in the trial. In some instances, it was difficult to convince them to participate in the HCH trial.

As with other sites around Australia, staff of ACCHS clinics found it difficult to explain the model to patients and how it would benefit them. This was especially a problem with ACCHS clinics and other practices that were already using a chronic disease management approach similar to the HCH model. Some patients were concerned that things might change.

The first case study site reported that software issues were also a large barrier in the early stages of the trial. These issues often took an extensive amount of effort, funding and commitment to address. Other practical issues clinics had difficulty with were understanding billing, for example, what services would form part of the bundled payment for a patient, and what could be billed separately.

Certain innovations that may be appropriate in other settings do not work in a remote context. For example, clinical group work is rarely appropriate. This is due to issues of confidentiality and privacy, which are critical to manage in a small community, coupled with long-standing issues between different family groups. Therefore, services need to find alternative methods of educating people living in this environmental context.

The two case study sites found it difficult to share care with care providers not employed by the ACCHS. For example, they found it hard to get feedback from specialists, and discharge summaries from specialists and other providers are often inconsistent.

Access to staff and other services to follow through with care plans was also more complicated for the ACCHS clinics. For example, it is often difficult to access particular sorts of specialists in remote communities, as well as aged care and disability services (plus distinguishing between the two).

The researcher and staff members at the first case study site reported difficulties getting patients to participate in evaluation interviews. Despite the significant time and effort by the researcher and GPs, only one patient interview was formally completed. These issues could be attributed to when the researcher visited the community and conducted interviews or the significant amount of research and survey requests that this population receives.

Patient experiences

The medical staff at both sites thought the patients would not be aware of any changes in the way they received medical care and, therefore, the patients would not be able to attribute any change to the introduction of HCH. Patient interviews at both sites mirrored staff views. All patients interviewed had limited to no awareness of how HCH is the same or different to their usual care.

Many of the patients that were interviewed had a good awareness of the association between lifestyle factors and their medical conditions, and they expressed their understanding that they needed to modify their lifestyle to improve their health. They mentioned the need to reduce or quit smoking (among the smokers), improve their diet, and to increase their physical activity. No patient indicated they did exercise to increase their physical activity, instead they mentioned doing work around the house and getting involved in recreational outdoor activity (such as camping) as a way of improving their physical activity.

The patients at both sites appeared to be satisfied with their care and felt that they had good access to the medical staff at the clinic.

ACCHS staff suggestions for HCH

Staff members at the first case study site had several recommendations for HCH. These included:

- Clarification of explanations of what constitutes acute care versus chronic care in the context of chronic disease.
- Consider an additional 'tier' or even 'tiers' for remote chronic disease stratification.
- In future iterations of HCH that involve additional pharmacy services, consider how pharmacy is delivered in remote settings.
- Review the HARP tool for plain language wording and the degree to which it reflects the remote context, particularly Part B.
- Consider developing a consent form that is relevant to ACCHS and is in plain language.

7. Support and training for HCH practices

Key points:

- Department of Health resourcing for PHN practice facilitators was scaled back following
 the end of the enrolment period to reflect the number of active HCH practices. Most PHNs
 have integrated the HCH facilitator role into units providing ongoing practice support more
 generally.
- Up until June 2019, the end of the enrolment period, the practices and the support from the practice facilitator role was primarily directed to the practical aspects of implementing HCH, particularly managing enrolment, risk stratification and care planning.
- Subsequently, PHN practice facilitators saw their role evolve towards helping practices to:
 - o re-focus and refine their model of care
 - o prioritise and implement quality improvement initiatives
 - o develop strategies to increase patient acceptance of team-based care,
 - use data more effectively to understand their HCH patients and develop strategies to support them.
- Practices were also assisted in re-stratifying HCH patients and implementing shared care
 planning. Practices remained largely very positive about the support they received from
 their PHN practice facilitators to implement HCH. Where critical, it was that they did not get
 enough support, or they were frustrated with the turnover of practice facilitators.
- The experience of facilitators in the post-enrolment period reiterates three lessons from the Interim evaluation report 2019:
 - External practice facilitation is valuable for practices to achieve the level of transformation needed to operate as an HCH (#14)8.
 - Rapport and trust between the practice facilitator and practice staff are foundations for practice facilitation (#15).
 - A key to facilitation is assessing each practice's readiness, culture and environment, and tailoring changes to the unique needs of the practice (#16).
- Challenges to delivering consistent practice facilitation included:
 - o Practice staff turnover. Facilitators were sometimes educating new staff about the fundamentals of HCH.
 - Turnover within the practice facilitation workforce: of 45 PHN practice facilitators trained for the role in late 2017, five have remained in the role. This is partly influenced by the scaling back of funding for practice facilitation, but also turnover within PHN staff.
- These challenges suggest that more resilient approaches for practice facilitation may be required in the further rollout of HCH. Considerations should include:
- Practice facilitators require a specific set of knowledge and skills, which go beyond having experience as a primary care clinician or working in primary care settings.

⁸ Numbering of lessons from the *Interim evaluation report 2019* is used. Numbering for new lesson arising from this report continues from the 2019 list. See Volume 1 for the complete list of lessons.

- There are advantages in placing practice facilitation roles with PHN-based teams
 responsible for supporting practices in quality improvement. For example, this can ensure
 that related PHN initiatives can be leveraged.
- However, there is also a need for facilitators with more advanced capabilities who can be
 consistently available over time to support practice transformation. Advanced level
 facilitators should be available to work directly with practices in transformative change
 such as HCH but should also work collaboratively with PHN-based facilitators. This will help
 integrate facilitators with PHN initiatives and build the skill set with the local PHN workforce.
 In the next five to 10 years, facilitators with advanced capabilities are most likely to be
 available within meso-level or national organisations.
- In further rollout of HCH, practice facilitation provided directly to practices should be undertaken by a mix of staff with advanced facilitation skills – located in meso or national level organisations – and staff embedded within PHN-based teams responsible for supporting practices in quality improvement (new lesson #35).
- A national two-day HCH forum occurred in November 2019. Financial support was provided to practices to attend. Representatives from 73% of HCH practices attended, along with PHN facilitators and other stakeholders. The forum involved presentations from HCH practices, presentations from experts, sessions for discussing the features of HCH model and approaches to implementation, and many opportunities for networking. Attendees found the forum:
 - o kindled or reignited enthusiasm for HCH
 - o increased knowledge and awareness of opportunities within HCH
 - o allowed sharing of approaches to implementation
 - o created networks between practices
 - o strengthened relationships between GPs, other practice staff and PHN facilitators.
- Attendees believed a similar forum held soon after the commencement of HCH would have mobilised enthusiasm, created stronger relationships between practices and facilitators and affected enrolment levels.
- PHNs have continued supporting local communities of practice and networking events to
 encourage collaboration between practices. Practices have mostly reported that these
 have been valuable. However, in some PHNs the frequency of these events has dropped
 away.
- A lesson from the Interim evaluation report 2019 was: Create more opportunities for peer-to-peer engagement of clinicians involved in implementation (#9). The success of the HCH forum reinforces this lesson, to which can be added: in further rollout of HCH, use national or state-level events in the early stages of implementation, involving practices, PHNs and other stakeholders, to efficiently build knowledge about the model and its implementation, strengthen motivations within practices and GPs, foster peer-to-peer learning, and create relationships between participating practices and practice facilitators (new lesson #36).

This Chapter updates analysis on support and training provided to the HCH practices. It reflects the perspectives of the PHN facilitators and practices receiving support.

PHN practice facilitation and support

Changes in the PHN HCH team structures

As described in the *Interim* evaluation report 2019, the Department of Health provided funding to PHNs to support practices during the initial set-up and enrolment phases of HCH. This funding was extended when the enrolment period was extended to June 2019, but then scaled back, to reflect that support for enrolment was no longer required. From July 2019, the funding each PHN received reflected the number of active HCH practices within its region. Around this time many PHNs changed their staffing structure, reducing the number of HCH practice facilitators and/or incorporating the HCH facilitation role into general primary care and chronic disease practice improvement roles:

- "... we made the decision reasonably recently because we had the Health Care Homes support officers ... they'd share Health Care Homes across all seven practice support officers. Then the Health Care Homes people now become generalists as well and they pick up other bits of work, which there are some synergies there, I'm hoping." [PHN09, Interview, R3]
- "... the role has been incorporated into more of a usual-business role in conjunction with the existing primary care improvement, so I guess that's our practice support role that we have at the PHN ... So, yes, it's been more just to facilitate the Health Care Homes practices that are still on board, but also doing that as a usual-business part of the primary care improvement role." [PHN06, Interview, R3]

Other PHNs were still developing new post-enrolment HCH team structures and determining how to continue providing ongoing support to their HCH practices now that patient recruitment had ended:

"Health Care Homes has moved into a different business unit and the new manager is ... currently finalising exactly what's going to happen ... we haven't exactly really got an exact plan at this stage." [PHN04, Interview, R3]

Support provided to practices post-enrolment

"The whole flavour of it has really changed ... now that they're acknowledging the hard yard is behind them." [PHN03, Interview, R3]

At the beginning of the trial, PHN practice facilitators focused on assisting practices with the administrative tasks of participating in the trial (e.g. working out what needs to be done, registering patients in HPOS and in the evaluation app), implementing software (the RST in the first

instance and then shared care planning software), assessing practice readiness, building relationships with practices, and identifying and implementing strategies to recruit patients. With the extension to patient enrolment announced in late 2018, PHNs continued to support and encourage practices to enrol patients through to the end of June 2019. This involved conducting patient forums and information sessions, assisting practice staff in explaining or 'selling' HCH to patients, and assisting practices with registering patients.

The practice facilitators observed that enrolling patients left practices with little time and energy for achieving the goals of HCH. Their role changed towards helping practices to focus on these goals once enrolment was over:

"... given that patient enrolment has been the focus, the practices might have lost sight in terms of what it is that they need to be doing in terms of patient care ... So the fundamental understanding of how they need to be improving, how they need to be patient-focused, how they need to be looking at quadruple aims, the building blocks to get there. [The practice facilitator] is now identifying that she needs to go back and regroup and refocus on those things." [PHN02, interview, R3]

"With the introduction of the quality improvements here, relating [to] the Health Care Home model of care and quality improvement plans that we can introduce at these practices has been really beneficial. It would have been lovely if the [quality improvement] had started two years ago ..." [PHN06, Interview, R3]

Practice facilitators also commented that some practices found the end of the enrolment difficult, as they were not sure what was supposed to happen beyond enrolling patients:

"Since enrolment finished, and there was such a big push on that, it's almost like, well, what's next?" [PHN07, Interview, R3]

"And we found that that's probably where the practices were struggling. Through that enrolment phase and registration phase, it was like, let's focus on that and then we'll think about that once the patients are in. I think it's those expectations that it is around the, what's next?" [PHN04, Interview, R3]

The facilitators stated that post-enrolment practice support still depended on individual practice needs, team engagement and the specific stage that practice staff teams were at in terms of change management and incorporating the HCH model into their practices. Staff turnover in practices meant that sometimes the facilitators were returning to the fundamentals of HCH, including training practice staff on the foundational elements of the model and the RST.

Beyond general practice support, post-enrolment training and support activities listed by the practice facilitators included:

- assisting practices in conducting plan-do-study-act cycles
- data cleaning and focus on data quality improvement activities
- re-stratifying HCH patients
- refining and individualising models of care
- care planning
- emphasising and reinforcing topics featured in the online training modules
- engaging the HCH neighbourhood
- fostering team care
- developing strategies to shift patients' thinking to accept a team-based care
- helping practices with compliance or billing issues
- engaging shared care vendors
- fostering peer-to-peer learning between GPs
- integrating practices and community pharmacists.

Some PHNs facilitators focused on data as a means of helping practices understand their HCH patients and develop strategies to support them:

"The priority for me is the profiling of the patient cohorts. For me, that's where we should start in supporting the practices to understand who their patients are and who the cohorts are. And then I think once we've got that, then we can move towards how can you manage those cohorts? ... if you have a cohort of respiratory patients could you do focus groups? Could you do walking groups or swimming groups ..." [PHN08, Interview, R3]

"That's something that we strongly focus on now with the [quality improvement] kit is, obviously we want them to be working on quality improvement activities but that are data-driven based on their own patient population." [PHN06, Interview, R3]

- "... the data piece, that's the data-driven care building block, or data-driven improvements. The work that [the practice facilitator] and our data team have been doing in terms of looking at the patient population and really starting to work with the practices on improving how they record information and seeing those improvements ..." [PHN02, Interview, R3]
- "... now we can share, we can go back to practices. I'll give you an example: a five-GP practice that was referring to different allied health, and from the information that we've received from [shared care software] around how many referrals have been made to certain allied health, there was four or five different areas of referrals throughout the city area, but yet they had their own allied health within their practice, so they weren't using ... that allied health. So, it's further conversations to the GP going, let's look at who we're referring to, why we're referring to them, etc. That dashboard that we can now showcase to the practices, starts that conversation with GPs to say, if we're referring to five different dieticians, would it be worth having a dietician here for half a day a week because we've got a room empty. They're starting to have conversations around increasing their team, utilising their space and their room and looking at possibly doing group sessions with allied health. The conversations, because of the dashboard, are really quite valuable." [PHN02, Interview, R3]

Emerging areas that facilitators worked on with practices included working out how the practice could sustain HCH beyond the trial period, using quality improvement tools such as patient-reported outcome and experience measures (PREMs and PROMs), and using telemonitoring systems to support the HCH model.

Variation in support

Practice facilitators divided practices within their region according to the level of support they needed, indicated by the level of staff engagement and buy-in, leadership and shared vision. As described in the *Interim evaluation report 2019*, facilitators described more fundamental and 'transactional' activities with less engaged practices and quality improvement initiatives using a coaching style with more engaged, higher-performing practices:

- "... we're still helping a lot with compliance, especially for some practices who are on the lower-engaged spectrum. With the higher-engaged practices, a shift, especially post-enrolment, has been switching to more of the coaching slash quality improvement focus." [PHN01, Interview, R3]
- "... we've got other members in our practice [team] ... focusing on those more transactional, for want of a better word, lower-engaged practices. And the other two practice facilitators working alongside [practice facilitator], they've both been working with practices that are really on the continuum of working towards transformation. They've got a real business in clinical, you know, optimisation type focus." [PHN04, Interview, R3]

Additional facilitation and practice challenges in rural areas

Facilitators based in PHNs that cover more rural and remote populations discussed additional challenges in these regions. Though staff turnover was cited by multiple PHNs and practices as an issue, turnover of PHN staff was often amplified among rural and remote PHNs. Facilitators described the effect of practice staff turnover, workforce shortages and the older GP workforce within these regions:

"... turnover in the PHN is just as challenging as it is out in practices. Sometimes when I'm talking to practices and they air their frustrations that ... you're another new manager or another new person, sometimes by saying to them we have the same workforce challenges that you have can actually help smooth that conversation over." [PHN08, Interview, R3]

"We've got major workforce shortages in all our regions ... And then ... our GPs have an age between 56 and 65, basically. So, not only have we got an aging population here we have an aging population when it comes to GPs also." [PHN10, Interview, R3]

Facilitators within rural regions also suggested geographic dispersion made it difficult for them to engage practices in face-to-face training and facilitation. They often relied heavily on remote sessions and designed team structures based on their PHN geography and the placement of HCH practices within their regions:

"We do a lot more remote sessions with our practices. So, we do see [the practices] face-to-face. I have a six-month visiting schedule but with our Health Care Homes we're actually out there more face-to-face and then we back up with a remote session because we need to travel quite heavily and that's a cost factor there." [PHN10, Interview, R3]

"We have three very distinct regions. So, we have a [Region 1] team, we have a [Region 2] team, and we have a [Region 3] team. Obviously, they all do the same role, but because of our geographical spread, and the number of practices that we have under our footprint, yes, we've split it into regions." [PHN06, Interview, R3]

Other challenges in rural and remote PHNs raised, which were also documented in the *Interim evaluation report 2019*, included poor internet connectivity and financial strains (e.g. in regions affected by drought).

Engagement with the healthcare neighbourhood

Engagement with the healthcare neighbourhood has been a goal from the outset of HCH, and many of the PHNs focused on this:

"But since involving the whole team, my role certainly has started engaging allied health services and that whole team-based care and patient-centred approach is starting to develop all of a sudden in the last few months." [PHN02, Interview, R3]

"And that is a very heavy focus at the moment. So, they've registered [for the shared care planning product] now let's use the mechanism for the allied health and the patient and the patient app that comes with it. So, it's that whole team environment going on." [PHN10, Interview, R3]

PHN facilitators recognised that despite team care working well within practices, for the approach to be truly effective it was necessary for providers outside of the practice to be aware and be part of the team:

"... probably the biggest problem is that even if a practice really is loving [the shared care planning software] and using it, trying to get other team members outside the Health Care Homes, the bigger scene, allied health and specialists, they don't like it and most of them won't use it, although they say they don't know anything about it even though we've tried to do information sessions. So, there really needs to be some recognition of looking at the broader health system. It's no use having a tool like this if no one else wants to use it because they're getting paper-based information because of it." [PHN07, Interview, R3]

"I think once we get it singing, it will be great, but because there's so many moving parts and so many people to rely on to have everything accurate ... So, once you've got a physio, a dietician, a pharmacist, a GP, a nurse all engaging with it, if people aren't picking it up and using it, it's not useful at all." [PHN03, Interview, R3]

The facilitators employed multiple approaches for improving engagement of the wider network of health care providers in HCH. These included organising education events, hosting community allied health events at HCH practices, conducting training sessions on how to use the shared care planning tools, fostering partnerships with local hospitals, incorporating allied health professionals into the PHN practice facilitator team, and increasing participation of allied health in community of practice meetings:

"What we've done is we've held two and we're actually starting on planning more of those is where we will hold an event in the individual practice. They invite all of ... their healthcare neighbourhood. And ... we have had conversations about Health Care Homes, what it is, what the changes are, and then the way that they would like to start communicating with their practices through the shared care planning tool. And that has had a very good uptake." [PHN04, Interview, R3]

The PHN practice facilitators identified several obstacles in attempting to increase external provider involvement in HCH. One key issue was that for practices with a small number of

HCH patients learning to use the software, for example, is often not a priority for them ("... the reality is, for a lot of people, it's not a priority. That's what it's come down to" [PHN01, Interview, R3]). Another issue was the overall lack of financial incentives for the extended network of providers to participate in HCH:

- "... it's a slow process. It would be lovely if they really embraced it. But where [allied health providers are] coming from is ... okay, what's in it for us, is there any additional money?" [PHN10, Interview, R3]
- "... [The adoption of shared care planning is not a priority for] the neighbourhood more because they're not paid for it, either. That's been a conversation from the beginning." [PHN01, Interview, R3]

Financial incentives were also an issue for allied health operating from within HCH practices:

"... some of the internal allied health, because they're using this practice's clinical software, are finding ... why am I doing this extra work, I'm not getting paid for it, it's giving me more admin. There's a few barriers around the internal allied health, because there's really nothing in it for them apart from more administration."

[PHN02, Interview, R3]

Some PHNs also commented on their ability to spend time training the wider neighbourhood of providers in using the shared care software:

"And [allied health have] got their own clinical systems or they don't even have clinical systems ... So, it's actually re-training them ... I think it's not just at a practice level. For us to get this right we need to be able to go out and train the allied health and there's no funding for that." [PHN10, Interview, R3]

Relationship-building with practices

PHN practice facilitators continued to stress the importance of relationship-building with practices to enable access to key practice staff and work with them effectively to implement the model. The facilitators explained that in some instances these relationships have been built over time, and in others HCH has strengthened these relationships:

"Yes, that's just about the relationships that have been built over time and maintained with different people. So, if somebody's started that for you, that's great. That's a huge step ahead. It's just about keeping that going." [PHN08, Interview, R3]

"I think, certainly first and foremost, we've had some pretty good long-standing relationships in [the PHN region]. From an engagement perspective, there have been a number of the practices that are Health Care Home[s] that have actually been partnering with us on that kind of patient-centred medical home journey ahead of Health Care Home coming into play. I think that certainly has been advantageous to do that." [PHN04, Interview, R3]

"We had a good relationship [with the practices] but [HCH] has actually tightened it actually to tell you the truth." [PHN10, Interview, R3]

Some facilitators reflected that their relationships with practices changed from focusing on tasks to focusing on the goals of change, and that that was due to having built trust:

"There are some practices that require significant handholding. And there are others who will take learnings that we provide them and go about it their own way. It has changed, though, overall, from more transactional to a bit more overt. We've built that trust, and from that it's now more of a relationship that focuses on transformational change." [PHN01, Interview, R3]

To strengthening their relationships with practices, PHNs added to and drew on individuals with specialist skills. This helped provide higher quality support in certain areas:

"In my team for instance I have an ex-practice manager, I have a doctor in my team. I'm the QI person, we've got an ... accredited surveyor who works three days a week for me. So, I'm trying to actually make sure that we've got the skill sets to go out. And anything that they ask from clinical to admin, to quality improvement, we're covering all those areas. So, I think it's like a doctor said the other day, you need to make sure that you've got the right people delivering the right messages. And we're all doing it nationally on the same level." [PHN10, Interview, R3]

"And we also have [practice facilitator] who is our chronic disease support nurse working predominantly around our integrated care program ... And [practice facilitator] is coming in with her clinical expertise around that whole clinical redesign." [PHN04, Interview, R3]

Fostering collaboration between practices

PHNs used communities of practice and networking events to encourage further collaboration with and between practices:

- "... sharing ideas, sharing resources, lessons learnt from other practices. The ones where there are engaged leaders, they have those clinical meetings with all the GPs. They involve all the GPs. That's worked well." [PHN04, Interview, R3]
- "... certainly having the networking, we were doing community of practice, we have been really doing very well within WA with our community of practice. We have had 11, since the program started. So that was definitely something, the practices began the journey and the relationship together with other practices." [PHN02, Interview, R3]
- "So, we've had [community of practice events] religiously. They're super important." [PHN03, Interview, R3]

Facilitators also remarked on the long-term benefits of collaborative practice events for peer-to-peer learning and networking among practice and clinical leaders:

"What's been valuable recently is to have one of the leading GPs in Health Care Homes form a relationship and do a number of things with some other leading GPs ... The learning between all of them has been very powerful, and I think has most favoured the fairly progressive GP with Health Care Homes to become even more progressive and more committed and to really understand the potential, I

suppose, of the building blocks, the quadruple aims and really having the patient at the centre of thought, rather than being focused on a financial model." [PHN02, Interview, R3]

"A couple of [practices] ... knew each other outside of Health Care Homes, and they're always interested, but we do see the communication between practices talking about Health Care Homes amongst themselves. Before, we used to facilitate that. We can sit back a little bit and that's still continuing. They're making regular contact with each other." [PHN04, Interview, R3]

One PHN stated that the success of their community of practice events has been largely dependent on the level of HCH practice engagement:

"They've worked out pretty good. The community of practice, I think, it's valued by those people that are engaged, because it's an opportunity for them to network with their peers who are involved in the program. Again, it comes down to those practices that are engaged and those that aren't. The practices that aren't engaged, they don't take the time and effort and they don't really value it. Whereas, the practices that are engaged, they see the value in doing things like that." [PHN01, Interview, R3]

Though some PHNs have had a high to moderate degree of success facilitating networking and community of practice events, other PHNs have not routinely hosted these due to various issues, including lack of practice engagement and wide geographic distribution of practices:

"I'm sure that in a metro area it could be different, but when you're in [PHN region] we've got ... practices, all dispersed across the [PHN region], and they just don't have an opportunity to meet with each other. And sometimes they don't feel confident enough to because they don't want to necessarily share with practices that they might feel are so close." [PHN07, Interview, R3]

"Yes, we had a community of practice ... but the participation rate decreased to zero, but yes, we had webinars and that to start with. We had no GPs involved in the webinars, it was practice nurses that took the lead in the webinars." [PHN06, Interview, R3]

Practice perspectives on support and training

PHN support

Practices reflected on PHN facilitation and support that they have received throughout their participation in HCH and in the post-enrolment phase of the trial. The experience of this was variable among them. While some practices felt they have not received enough support and training from their PHN, others stated they could not have implemented the model without the assistance and support of their practice facilitators:

"Fantastic team that have been very helpful, especially for the nursing staff." [Practice Manager, R4, Practice 16]

"I think they've been very supportive, both with the Heath Care Home in general and of our clinic specifically. What we found is that the staff from the PHN who have been assigned the Health Care Home portfolio were very eager to reach out to us, answer any questions we had, trying to be proactive in any support they could offer us." [GP, R4, Practice 13]

"[Practice facilitator] has been great, [practice facilitator] has been fantastic. It seems she's one of the only ones that's actually stayed throughout. Through the changes of people leaving and coming and what not, but she has been really, really good ... she's been very good with information." [Practice Manager, R4, Practice 14]

"I feel [the] PHN are a little bit catch-up ... That was probably the biggest issue to start off with, they weren't prepared. So, they were trying to introduce things into our practice that they weren't really prepared for themselves. And I don't know at what level that is. But we just found ... We were almost training those people. They had a lot of changes in staff as well." [Practice Manager, R4, Practice 4]

"I think they've been [less than optimal] because there's no collegiate feel about this ... I sometimes feel that when they show up, they're trying to sell us something." [GP, R4, Practice 2]

Some practices noticed the reduction in PHN support following the end of the enrolment period. Practices reported that the PHNs were assisting them with the following activities:

- coordinating and running community of practice events
- working to further engage the HCH neighbourhood
- providing training to new practice staff members
- hosting community training events
- focusing on data and quality improvement activities
- answering ongoing practice queries and troubleshooting when necessary.

Practice peer-to-peer learning and sharing of information

Practices have continually stressed the importance of learning from other practices and the ongoing exchange of information and ideas. PHNs have fostered this type of peer-to-peer engagement and learning by organising community of practice meetings and events. These have been vital for practices to discuss any issues they are experiencing with HCH, seek feedback and advice, and share ideas:

"Yes, [there] was [a meeting] actually just before the [HCH forum], so I think we were just talking about what we had done up to that point, and similar to what we're talking about now really. Mentioning the highlights from memory, yes." [Nurse, R4, Practice 9]

While some PHNs regularly scheduled meetings or hosted events, others have not done so, or the number of meetings has gradually decreased over time. Practices hoped that their PHN would increase these meetings and events in the future and expressed that they would like to have more engagement with other practices both within their PHN and nationally:

"... we used to do [the community of practice meetings] and we haven't had any in a while, the community sort of meetings where you just go every week. We

haven't had one for a long time ... And they were really good and ... I guess, speaking to other people, finding out what their issues were and getting a better idea of how to do things. Because when you're by yourself, you don't know if you're doing something right or not." [Nurse, R4, Practice 1]

Beyond community of practice meetings and events, one GP commented that HCH has lacked a collegiate feel compared to other initiatives the practice had been involved in previously. This has potentially stifled motivation and hindered their ability to progress with the HCH model:

"So, back when [the Primary Care] Collaborative was run, there was a very strong division of general practice and there was a collegiate feel between the practices as it was. And then when the Collaboratives ran, there were half a dozen practices in this region ... And so we would meet regularly through video conference, and then every now and then, we'd all end up at a conference together, whether that'd be in [State] or whatever, and there was a real collegiate feel. People knew who was in it and then there was also that competition that developed where you knew who you were being compared with within your block, in your region ... But that collegiate feel's all been lost when the division went under and the Primary Health Network hasn't done that." [GP, R4, Practice 2]

While several staff members expressed their interest in having more peer-to-peer learning meetings, individuals did consider the difficulty associated with coordinating these events around everyone's busy schedules:

"I think that this is a very difficult thing to do, because all the doctors are very busy. For them to coordinate all other groups to do something together, that is very, very difficult." [GP, R4, Practice 3]

"... it's hard for me to gauge what would be reasonable or not. But I agree that there'll potentially be a benefit of more of those activities. I think part of the constraint is finding time when staff from practices can all attend because obviously it needs to be out of hours, so some kind of sacrifice." [GP, R4, Practice 13]

The practice facilitator role

A challenge for the PHN practice facilitators has been staff turnover. An indicator of the extent of the turnover is that of the original cohort of 45 PHN practice facilitators trained for the role prior to the start of HCH (August to November 2017), only five individuals have remained in the role. One PHN commented on the effect that turnover of practice facilitators has had on their knowledge of HCH and thus their preparedness to support practices:

"Another challenge is we're really reactive to things that happen out in practice. So, often that means we don't get a chance to prepare or educate ourselves. So [practice facilitator], for example, when I came on board had not been trained in Health Care Homes other than being given access to the online modules and saying here you go, do the modules. That was it. So, there was no handover or

training ... I know that that was a source of frustration ... you learn stuff when things go wrong, we've found." [PHN08, Interview, R3]

In a paper on education and training for practice facilitators submitted to the evaluators (AGPAL, 2020b), AGPAL, who under contract to the Department of Health developed education and training resources for HCH and continues to support practice facilitators through webinars and other initiatives (see below), identified the following key requirements for the role going forward:

- Build practice facilitation capability. Practice facilitators are a new workforce and require specialist skills and training to be effective. Ongoing training and development is necessary due to the high turnover of staff.
- Facilitate knowledge transfer from practice facilitators to practices. This is important to maintain the fidelity of implementation of interventions at the practice level.
- Strengthen the learning collaborative for practice facilitators to share knowledge, insights, learnings, resources.

Training and support for PHN practice facilitators

The Department of Health contracted AGPAL to develop a suite of education and training resources for PHN practice facilitators and practices (including ACCHS) participating in HCH. The resources included the online training modules discussed in the *Interim evaluation report* 2019. In addition to the modules, AGPAL provided, and continues to provide:

- Training webinars, including train the trainer webinars for new practice facilitators (and those requiring a refresher) and ongoing webinars emphasising different aspects of HCH.
- Online learning collaborative, an online interactive forum aimed at fostering a
 community of practice through the proactive sharing of knowledge and experience
 including issues or challenges, strategies and solutions, quality Improvement
 approaches, tools and resources, articles, case studies and best practice.
- Pioneers of change, a platform for practice facilitators to showcase experiences, highlight areas of challenge, different approaches to implementation, solutions, and resources.
- Practice facilitator buddy scheme, linking recently appointed practice facilitators with more experienced facilitators to support learning, development and growth.
- Review of bi-monthly reports provided by the practice facilitators, capturing HCHrelated events and how these can be improved, identify and encourage collaboration on common issues, and suggest solutions to moving practices through transformation.
- Quarterly webinars, aimed at sharing highlights, learnings, strategies, and resources collected from the practice facilitators.

Appendix 4 gives an overview of the training and support activities provided by AGPAL between 2016 and 2020. AGPAL also assisted the Department of Health with the HCH forum described below. At the forum AGPAL delivered a workshop for the PHN practice facilitators aiming to build coaching capability and fostering the collegiate approach across the community of practice.

Collaboration between PHNs

Facilitators stated that collaborating with other PHN facilitators has helped develop their roles and has made them more effective in supporting their HCH practices. Facilitators described how networking events with other PHNs have enriched their understanding of HCH:

"Something really, really beneficial to us as practice facilitators has been the opportunity to have face-to-face training and networking with other practice facilitators around the country. Especially just so that we can learn from each other and including those areas in Australia that have been adopting a model like this for a lot longer than us." [PHN01, Interview, R3]

"The [other PHN has] been awesome. They've allowed us to adopt some stuff that they do down there. So we now provide our practices with monthly benchmarking reports. All practices." [PHN08, Interview, R3]

"I think even all the practice facilitators, throughout the PHNs, we've developed and built up that relationship. So, it's always there, there's always somebody to call. The information and support that we're getting has been quite significant to our role." [PHN02, Interview, R3]

Several PHNs stressed that these partnerships and sharing resources, ideas and knowledge are integral to the success of the practice facilitator role and the HCH trial. One facilitator commented that they would like to continue to increase the level of PHN collaboration:

"Sharing resources maybe might be something that would assist because [the PHNs are] all preparing the same documentation, the sharing of that would be ideal." [PHN10, Interview, R3]

HCH forum – November 2019

In November 2019, the Department of Health hosted a forum for practices participating in HCH and their PHNs. Two hundred and forty one people attended, including representatives from 91 HCH practices participating at the time. It was the first time that the HCH community was brought together.

The forum was designed for participants to learn from the HCH Clinical Champions, each other, and invited speakers. The program included:

- In-depth examination of key HCH topics such as: the development of a shared
 understanding of what it means to be an HCH; ideas and processes for personcentred shared care planning; successes from across Australia; data, evidence and
 funding; team-based care and group interventions; leadership and change
 management; data-driven improvement; emerging roles and empowering staff;
 utilising nurses to the top of scope.
- Overview of evaluation findings so far and further input into the evaluation.
- Keynote addresses covering topics including: the importance of shared purpose; person-centred care; lessons learned; training, education, tools and resources; Indigenous and rural health; the future of primary health care in Australia and the work of the Primary Health Care Reform Group, and; the Department of Health's commitment to the HCH program.

 A motivational guest speaker on the benefits of authentic and distributed leadership and the need to harness personality and commitment.

AGPAL developed a report of the outcomes of the HCH forum (AGPAL, 2020a). Appendix 2 reproduces the themes from the forum.

The evaluation team ran a breakfast session at the forum on the evaluation, in which about 150 people participated. The session focused on three questions: practices' priorities for the remaining period of the trial, measures of success, and sustainability of the model beyond the trial. A summary of participants' contributions to these three questions is in Appendix 3.

The practices interviewed after the event reported feeling more enthusiastic about HCH and its potential to transform care delivery within their practices:

"Our nurse and administrator went to [the forum] and were far more enthused, empowered [and] excited." [GP, R4, Practice 7]

"I thought [the forum] was great ... Well, probably that you could network with other people that are doing the same thing at different levels. So, it was great for people to get up and talk and everything else. But being able to talk to people that were experiencing the same issues was good. And just where everybody else is because you think you're going along okay, and then when you talk to someone, you think oh, well, actually, we're not doing that. Yes. And everything is about quality improvement in general practice. So, I think it's really important to know what everybody else is [doing] ..." [Practice manager, R4, Practice 4]

PHNs were equally positive about the forum, reporting in the PHN survey that the content was insightful and valuable, and that the forum provided networking and information sharing opportunities across the HCH community. In an interview, one of the practice facilitators commented:

"... it was very powerful for [practice facilitator] to be attending the national conferences and doing face-to-face work with her colleagues in other states ... people that we meet with, and then we come back with concrete, practical ideas of how to achieve." [PHN02, Interview, R3]

PHNs observed practices becoming more enthusiastic about the model following the forum, many investing in changes to their practice following the event.

Both PHNs and practices also felt the forum should have been held earlier, at the start of the trial or at least while practices were still able to enrol patients:

"I think as we said before that with the forum being when it was. It was interesting to hear what other people said in terms of timing, yes. For us it probably would have been good for it to have been earlier, before the registrations closed. I think because one of the doctors and myself went, I think we probably would have got more patients enrolled then." [Practice Manager & Nurse, R4, Practice 18]

"We did feel though and I've said this to [practice facilitator], and pretty much everyone that I talked to ... if that forum would have happened six months prior to the cut-off date of admissions, you would have seen a lot more people being enrolled. So, because the practices that are a little bit ahead of us gave us a lot

of valuable information to take back. Now, whether we implement that fully or not, we would have been armed with a lot more information to actually go back and go, right, this is what we want to do. And these are the kinds of patients we want to target." [Practice Manager, R4, Practice 15]

8. Community pharmacy trial

Key points:

- 652 pharmacies registered to participate in the trial up to 30 June 2020.
- 71 had undertaken a consultation with at least one patient, with an average of 17 patients being consulted per pharmacy (although more than half of the pharmacies had consulted with less than 10 patients to 30 June 2020).
- Patients were being referred from 34 HCH practices out of the 120 participating practices (28%).
- According to pharmacists, the key barriers to them seeing more HCH patients were practices' lack of awareness and engagement with the trial (which was sometimes exacerbated by turnover of key practice staff) and patients' lack of awareness and/or their receptiveness to consulting a pharmacist. Practices also identified the latter as a barrier to referring patients to pharmacies, as well as a lack of awareness of local pharmacies about the trial, issues with shared care planning software, and the small number of HCH patients in their practice. Another factor was that 23 HCH practices already had access to a pharmacist within the practice, either employed by the practice or through an arrangement with their PHN or Local Hospital Network, and therefore did not refer patients to community pharmacists.
- Community pharmacists reported mixed experiences with GPs when recommending
 changes to a patient's medicines. Some had strong relationships with the practice and
 received feedback about their recommendations. In other instances, the practice did not
 acknowledge their recommendations for a patient. In a few cases, practices were
 concerned about community pharmacists working beyond their scope or providing
 unnecessary services.
- Community pharmacists recommended additional training of practice staff and other mechanisms to raise their awareness about the benefits of pharmacist involvement in patient care.

In May 2017, the Government provided \$600 million through the Sixth Community Pharmacy Agreement (6CPA) to continue existing community pharmacy programs and enable pharmacists to deliver new and expanded medication management services for Australians needing additional assistance to manage their medications. The community pharmacy trial was a part of this agreement and commenced in August 2018. It included the following components (and funding):

- dose administration aids (\$340 million)
- staged supply (\$80 million)
- expansion of the MedsCheck and Diabetes MedsCheck programs (\$90 million)
- inclusion of follow-up services for Home Medicines Review (\$60 million)
- incorporating medication management programs within HCH (\$30 million).

Following the agreement, the Pharmacy Guild (the Guild) worked with the Department to design the core services that would be delivered under the community pharmacy trial. The

Pharmaceutical Society of Australia (PSA) was contracted to develop professional guidelines for pharmacists. They also worked collaboratively with the Guild to develop training modules and delivered national training sessions for community pharmacies across the 10 PHN regions.

The community pharmacy trial is jointly administered by the Guild and the Pharmacy Programs Administrator. The latter is a division of Australian Healthcare Associates (AHA), which took over administration of the 6CPA following success in a competitive tender in February 2019. The Pharmacy Programs Administrator is responsible for administering, processing and paying claims for the 23 community pharmacy programs funded under the 6CPA. The Guild manages pharmacy registrations, onboarding, training and support, data collection and verification, and general enquiries, while the Pharmacy Programs Administrator is responsible for managing payments to participating pharmacies.

The community pharmacy trial was added to HCH in August 2018. Under the arrangement, an HCH patient may be referred to a community pharmacy of their choice. In December 2018, the Government announced the extension of HCH for an additional 18 months to 30 June 2021. This extension also applied to the community pharmacy trial.

Trial uptake

The Guild is managing registrations of community pharmacies to participate in the trial and data collection from the pharmacies as they consult with patients referred to them as part of the trial. Data to the end of June 2019 were provided to the evaluation team, and analysis of this was included in the *Interim evaluation report 2019*. At that time, the initiative was still developing. Educational sessions had been provided in the 10 PHNs in which HCH is operating, but awareness of the initiative among GPs and pharmacies was still growing. This report contains cumulative data from the start of the community pharmacy trial to 30 June 2020.

Up to 30 June 2020, 652 pharmacies had registered with the Guild to participate in the trial, and 71 had consulted with at least one patient. More than half of these had consulted with less than 10 patients. There were a total of 1,212 patients consulted to 30 June 2020, referred from 34 HCH practices out of the 120 participating (28%). Just over 1,000 (83%) were referred from 23 practices located in three PHNs (Adelaide – 13 practices, 589 patients; Northern Territory – 2 practices, 216 patients; and Tasmania – 6 practices, 203 patients). In the initial survey of practices as part of the evaluation (R2, undertaken between November 2018 and March 2019), 23 practices that are still participating in HCH said they had access to a clinical pharmacist. Of these, six employed a pharmacist, eight had access to one from the local hospital, another six had access to one via a grant or other support from the PHN, and a further three through other means. Therefore, it is very likely that many of the practices did not refer patients to community pharmacists as part of the trial because they had access to pharmacists.

The 71 pharmacies consulted with 17 patients on average. Less than half of the 1,212 patients had had a second review by 30 June 2020 (45%), and close to one-quarter (24%) had a third review. Table 17 shows the characteristics of patients receiving a consultation from a community pharmacist as part of the trial. Half of the patients consulted were assigned to tier 2, 11% to tier 1 and 39% to tier 3. Other characteristics of patients were: 59.1% were female, 84.2% spoke English at home, and patients scored relatively high on the MedsIndex score – a

measure of medication adherence (72% scored above 80). Patients in tier 3 were slightly younger, with 50% of patients being less than 65 years old compared with 33% in tier 1 and 32.2% in tier 2. Patients in tier 3 were more likely to have attended hospital in the past 6 months (17.8% compared with 5.5% in tier 1 and 6.7% in tier 2).

Table 17 - Community pharmacy trial patient characteristics

Characteristic	Total	Tier 1	Tier 2	ristics Tier 3				
Characteristic	(n = 1,212)	(n = 128)	(n = 610)	(n = 474)				
Sex								
Female	696 (59.1%)	72 (59.0%)	331 (56.3%)	293 (62.7%)				
Male	481 (40.9%)	50 (41.0%)	257 (43.7%)	174 (37.3%)				
Age group		-	-					
0–24	25 (2.1%)	2 (1.6%)	13 (2.2%)	10 (2.1%)				
25–44	93 (7.8%)	5 (4.0%)	35 (5.8%)	53 (11.3%)				
45–64	350 (29.4%)	34 (27.4%)	145 (24.2%)	171 (36.6%)				
65–74	300 (25.2%)	43 (34.7%)	163 (27.2%)	94 (20.1%)				
75–84	290 (24.4%)	30 (24.2%)	179 (29.9%)	81 (17.3%)				
85+	132 (11.1%)	10 (8.1%)	64 (10.7%)	58 (12.4%)				
English speaking								
Yes	1,019 (84.2%)	122 (95.3%)	537 (88.0%)	360 (76.3%)				
Hospitalised in the	last 6 months	-	-					
Yes	132 (10.9%)	7 (5.5%)	41 (6.7%)	84 (17.8%)				
Medication adher	ence (MedsIndex s	score)		·				
0 to <50	70 (5.8%)	8 (6.2%)	38 (6.2%)	24 (5.1%)				
50 to <80	265 (21.9%)	16 (12.5%)	134 (22.0%)	115 (24.4%)				
80 to <85	139 (11.5%)	16 (12.5%)	79 (13.0%)	44 (9.3%)				
85 to <90	140 (11.6%)	18 (14.1%)	73 (12.0%)	49 (10.4%)				
90 to <95	253 (20.9%)	36 (28.1%)	114 (18.7%)	103 (21.8%)				
95 to 100	343 (28.3%)	34 (26.6%)	172 (28.2%)	137 (29.0%)				
Patient's MedsInde	ex score							
Mean (median)	82.7 (89.0)	84.2 (90.0)	82.4 (88.0)	82.7 (90.0)				
		-		-				

Source: HPA analysis of the Health Outcomes data set provided by the Pharmacy Guild, to 30 June 2020.

Patients were taking medicines for a wide range of conditions (Table 18). Medicines were commonly prescribed for: high blood pressure (67%); high blood cholesterol (50%); diabetes (39); heart disease (39%); arthritis (30%); respiratory conditions (30%); depression or anxiety (26%); pain (21%); and digestive disorders (21%). Prescriptions for medicines for depression and anxiety increased with tier, as did prescriptions for diabetes, heart disease, respiratory illnesses and cancer, although very few patients were taking medicines for cancer.

Table 18 – Health conditions for which patients are taking medicines

Condition	Total (n = 1,212)	Tier 1 (n = 128)	Tier 2 (n = 610)	Tier 3 (n = 474)
F04 Heart disease	473 (39.0%)	38 (29.7%)	231 (37.9%)	204 (43.0%)
F05 Stroke	77 (6.4%)	7 (5.5%)	44 (7.2%)	26 (5.5%)
F06 Cancer	44 (3.6%)	2 (1.6%)	21 (3.4%)	21 (4.4%)
F07 Osteoporosis	167 (13.8%)	18 (14.1%)	86 (14.1%)	63 (13.3%)
F08 Depression or anxiety	310 (25.6%)	23 (18.0%)	150 (24.6%)	137 (28.9%)
F09 Arthritis	364 (30.0%)	36 (28.1%)	206 (33.8%)	122 (25.7%)
F10 Diabetes	476 (39.3%)	34 (26.6%)	220 (36.1%)	222 (46.8%)
F11 High blood pressure	810 (66.8%)	92 (71.9%)	407 (66.7%)	311 (65.6%)
F12 Asthma	8 (0.7%)	0	2 (0.3%)	6 (1.3%)
F13 High blood cholesterol	600 (49.5%)	57 (44.5%)	309 (50.7%)	234 (49.4%)
F14 Pain	258 (21.3%)	29 (22.7%)	126 (20.7%)	103 (21.7%)
F15 Digestive	254 (21.0%)	34 (26.6%)	145 (23.8%)	75 (15.8%)
F16 Kidney disease	135 (11.1%)	4 (3.1%)	53 (8.7%)	78 (16.5%)
F17 Respiratory	366 (30.2%)	23 (18.0%)	193 (31.6%)	150 (31.6%)
F18 Other conditions	1,113 (91.8%)	91 (71.1%)	461 (75.6%)	561 (118.4%)

Source: HPA analysis of the Health Outcomes data set provided by the Pharmacy Guild, to 30 June 2020.

The most common goals agreed to in the patients' medication management plan (MMP) were 'improved medication adherence' (44%) and 'improved patient knowledge about their medicines leading to improved medication use and disease self-management' (48%), but these varied substantially between tiers. Patients in tiers 1 and 2 were much more likely to have the goal of 'improved patient knowledge' than patients in Tier 3 (66% in tier 1, 56% in Tier 2 and 33% in tier 3), but patients in tier 3 were far more likely to have the goal of 'improved medication adherence' (15% in tier 1, 36% in Tier 2 and 61% in tier 3). The goals of 'improved technique/usage of medication devices' (16%), 'optimise the medication dose' (18%), and 'reduced medication side effects' (10%) were less common.

For most conditions, at least two people were responsible for the patient achieving their goals and in general it was most likely to be the carer/patient and pharmacist. For the five pre-defined patient goals, both carer/patient and pharmacist were reported as being responsible in over 60% of cases. Pharmacists were considered responsible for improved medication adherence for 70% of patients who set this goal and responsible for improved knowledge for 86% of patients. Carer/patients were considered responsible in 82% of cases where the goal was to improve technique of medication devices. Although GPs were less likely to be considered responsible for a goal, GPs were considered responsible for goals relating to optimising dose (64%) and reducing side effects (63%).

Table 19 – Goals identified in medications review

Goal	Total (n = 1,212)	Tier 1 (n = 128)	Tier 2 (n = 610)	Tier3 (n = 474)
Improved medication adherence	530 (43.7%)	19 (14.8%)	222 (36.4%)	289 (61.0%)
Improved patient knowledge about their medicines leading to improved medication use and disease selfmanagement	581 (47.9%)	84 (65.6%)	342 (56.1%)	155 (32.7%)
Improved technique/usage of medication devices	192 (15.8%)	20 (15.6%)	97 (15.9%)	75 (15.8%)
Optimise the medication dose and/or number or type of medicines	220 (18.2%)	21 (16.4%)	96 (15.7%)	103 (21.7%)
Reduced medication side effects	125 (10.3%)	13 (10.2%)	54 (8.9%)	58 (12.2%)
Other	243 (20.0%)	33 (25.8%)	123 (20.2%)	87 (18.4%)

Source: HPA analysis of the Health Outcomes data set provided by the Pharmacy Guild, to 30 June 2020.

Patients were offered services to help them achieve the goals they agreed to in their MMP. Table 20 shows the support services offered to patients in relation to their identified goals. Ultimately, the most common service offered was blood pressure monitoring (30% of patients), followed by dose administration aid (29%).

Table 20 – Support services provided by community pharmacist

	Number receiving service (per cent of patients with goal)					
Goal	Asthma management plan	Blood glucose monitoring		Dose administration aid (DAA)	Medical device usage training/education	Other
Improved medication adherence	6 (1.1%)	34 (6.4%)	48 (9.1%)	287 (54.2%)	27 (5.1%)	70 (13.2%)
Improved patient knowledge about their medicines leading to improved medication use and disease self-management	11 (1.9%)	68 (11.7%)	202 (34.8%)	22 (3.8%)	38 (6.5%)	67 (11.5%)
Improved technique/usage of medication devices	22 (11.5%)	11 (5.7%)	8 (4.2%)	1 (0.5%)	85 (44.3%)	2 (1.0%)
Optimise the medication dose and/or number or type of medicines	3 (1.4%)	5 (2.3%)	28 (12.7%)	22 (10.0%)	5 (2.3%)	79 (35.9%)
Reduced medication side effects		6 (4.8%)	22 (17.6%)	7 (5.6%)	5 (4.0%)	55 (44.0%)
Other	4 (1.6%)	17 (7.0%)	52 (21.4%)	13 (5.3%)	5 (2.1%)	50 (20.6%)

	Number receiving service (per cent of patients with goal)					
Goal	Asthma	Blood	Blood	Dose	Medical device	
	management	glucose	pressure	administration	usage	Other
	plan	monitoring	monitoring	aid (DAA)	training/education	
Total number of patients receiving the service	46	141	360	352	165	323

Source: HPA analysis of the Health Outcomes data set provided by the Pharmacy Guild, to 30 June 2020.

Outcomes of the MMP (i.e. what the pharmacist did) are shown in Table 21. The most common outcomes for the first review included: the pharmacist updating reconciled medication list (96%), the pharmacist providing the patient with medicine education (83%), and the pharmacist providing the patient with disease state information (67%). The same goals were also commonly reported at the second and third reviews.

Table 21 – Outcomes of medication management plan

	Session				
Outcomes	Initial	2nd	3rd		
	(n = 1,212)	(n = 549)	(n = 292)		
M01 Pharmacist updated reconciled medication list	1167 (96.3%)	539 (98.2%)	287 (98.3%)		
M02 Pharmacist provided patient with medicine education	1007 (83.1%)	463 (84.3%)	258 (88.4%)		
M03 Pharmacist provided patient with disease-state information	814 (67.2%)	389 (70.9%)	217 (74.3%)		
M04 HCH/GP advised of issues identified through other communication	330 (27.2%)	123 (22.4%)	50 (17.1%)		
M05 Pharmacist used technology-assisted follow-up reminders (e.g. text messages, email messages)	188 (15.5%)	107 (19.5%)	69 (23.6%)		
M06 Health Care Home/GP verbally consulted about patient	274 (22.6%)	73 (13.3%)	31 (10.6%)		
M07 Pharmacist suggested patient referred to other health provider (e.g. allied health)	136 (11.2%)	55 (10.0%)	31 (10.6%)		
M08 Pharmacist participated in HCH team care meetings	38 (3.1%)	9 (1.6%)	1 (0.3%)		
M09 Pharmacist referred patient for an additional medication management service	77 (6.4%)	62 (11.3%)	46 (15.8%)		
M10 Other	49 (4.0%)	22 (4.0%)	11 (3.8%)		

Source: HPA analysis of the Health Outcomes data set provided by the Pharmacy Guild, to 30 June 2020.

From November 2019 to August 2020, the evaluation team interviewed 10 community pharmacists participating in the community pharmacy trial. The following section details their experiences with the trial.

Design of the trial

Working with the Department and within 6CPA program rules, the Guild developed the core components of the community pharmacy trial covering pharmacy registration, design and delivery of the medication management services, the medication management plan, supporting services, data collection (via GuildLink software), pharmacy training and support, and payment arrangements. As similar professional services have been provided to patients for many years, for example, Home Medicines Reviews, there was an existing framework that was used for the design of the program, which was flexible and patient-centred.

As the trial is administered under the 6CPA, pharmacies wishing to participate are required to conform to 6CPA program rules (The Pharmacy Guild of Australia, 2020). Among other things, this means that services must be delivered by a registered pharmacist in an area of the premises that is physically separated from the retail trading floor so that the privacy and confidentiality of the patient is protected. The area needs to be of sufficient size and layout to accommodate efficient workflow, including adequate room for the patient, their carer and the pharmacist, as well as all the consumables, equipment and documentation required for the service. The area needs to be clearly signposted as a private consultation area. When participating community pharmacies are providing services to patients in remote locations, they may be provided via community pharmacy outreach into an alternative private space or via videoconference.

Community pharmacies' motivations to join the trial

Community pharmacists listed a variety of reasons as to why their pharmacy wanted to participate in the trial. The main ones were that the pharmacy already provides services that align with HCH and additional services and benefits that the pharmacists can offer HCH patients.

Many interviewees stated that their pharmacies were already offering customers medicine reviews (including Home Medicines Reviews and MedsChecks), home medication delivery, dose administration aids and a range of other services prior to participating in the trial.

"It's just basically giving the patients a space. They can't always get appointments with their GPs. The pharmacists are always available." [CP, R4, Pharmacy 03] In addition to providing services, pharmacists felt that they had more time to devote to patients than did GPs, and that they have more frequent interaction with patients (who are regular customers of their pharmacies). Therefore, they felt that they could fill gaps in care that may have been overlooked by GPs and reduce the burden on GPs as well as "... giving

the patient a pharmacy home linked to their GP ..." [CP, R4, Pharmacy 03].

Other motivations for joining the trial that interviewees highlighted were:

- They saw the HCH model as the future for pharmacy.
- The pharmacy is in close proximity to participating medical centres.
- The pharmacy had strong relationships and/or existing arrangements with GPs and participating practices and/or also offered an opportunity to strengthen these.
- Many of the pharmacy's customers are patients at participating practices.

- They were encouraged by certain organisations to participate in the initiative (i.e. the Guild, the PHN, etc.).
- They attended an information session on HCH.
- The trial presented an opportunity to enhance communication between the pharmacy and general practices via a shared care planning platform.
- The trial allowed the pharmacy additional access to patient information, which
 would allow them to provide better quality care (including more wholistic care) and
 medication management.

Services community pharmacies are providing as part of the trial

Medication management

"We basically do it anyway ... Our dosage administration and packing program, we're already very well set up ..." [CP, R4, Pharmacy 03] Pharmacists mainly provided medication management services to patients. They described these as similar to services they were already providing prior to the trial (such as Home Medicines Reviews or MedsChecks), but that the main difference

with HCH was the ongoing management of patients and communication with the patient's GP:

"Certainly, more than a MedsCheck. A home medication review ... I think if they were using the same electronic system in an [Home Medicines Review] it would be similar, in a lot of ways. But an [Home Medicines Review's] just a point in time. So, the initial would probably be the same as an [Home Medicines Review], but then you wouldn't have the ongoing management of the person in terms of managing their medications and reordering prescriptions and that sort of thing. So, it's a bit of an amalgamation of both, in that sense. The ongoing monitoring. So, my answer is more overall." [CP, R4, Pharmacy 04]

"I feel like the Health Care Homes patients get a lot more follow-up. Because we are reporting straight to the doctors and then I've seen action from that. Like medications which we saw duplicated. Like same class is duplicated. And then you know, some of those medications were ceased. And then that patient might have put the same script in for that ceased medication but because I was there, I made sure that she didn't make that same mistake. So, I think there's a lot more follow-up with Health Care Home patients." [CP, R4, Pharmacy 02]

"To be totally honest, I would say probably 60% of them were just very similar to me doing a MedsCheck, other than I then had to do something to the doctor. So, you don't always do that with a MedsCheck. You just talk to the patient about it, and they'd walk away with that information. Whereas these patients, due to Indigenous status, or mental health status, or the tier that we're in, there was the benefit of having that ability to notify the doctor of anything that you had seen as being a potential problem or something that could be improved." [CP, R4, Pharmacy 10]

Support services

Some pharmacists reviewed what additional services they could add to benefit HCH patients:

"... we tried to see if there was anything more that we add to that for these HCH patients ... So we got in contact with a few reps, so [product 1] with one of them for the diabetes. You know [product 2] was another one for blood pressure checks and things like that. And just saw how they could add value to the pharmacy service. And then, you know, we got a few things. We got free spaces, we got, just information about how we could calibrate blood pressure machines. So, all those little things we could add on to, you know, these chronic health disease services." [CP, R4, Pharmacy 02]

Others continued to provide the additional services that they offered prior to participating in the trial.

Table 20 earlier in this Chapter shows the support services that community pharmacists have provided in relation to patient goals. The most common service offered was blood pressure monitoring (30% of patients), followed by dose administration aids (29%). Community pharmacists commented on the support services that they are providing:

"A lot more blood pressure monitoring and a lot more glucose monitoring. We're probably doing more HbA1c testing strangely than we have done ... Yes. A bit of weight management, that sort of thing. So, I would say, yes." [CP, R4, Pharmacy 01]

"Most of them, I'd say the majority of them, the service the client wants is the dose administration aid. So that immediately puts us in close contact with the surgery to manage their prescriptions. And also then changes to the pack and that sort of thing, we stay in touch with the surgery as a result of that." [CP, R4, Pharmacy 04]

"Yes, [blister packs for medicines]. Because they are part of this trial, it makes them more receptive to the idea of receiving that kind of help. But because also we choose not to charge those patients for the packing, which can be a barrier to start. So, yes, we've actually gained a lot of patients through the Health Care Homes trial. And even just little things like leaving prescriptions on file. Using the SMS reminder services or downloading the app so they can streamline their scripts and things, like, must remember scripts. But get their scripts ready before they come in. Then we just make sure that we're monitoring their blood pressure when they come in." [CP, R4, Pharmacy 02]

"I think I mentioned earlier that one of our pharmacists, who's very active in the program, is a diabetes educator. So, she's been taking appointments. Saturdays are quieter in the pharmacy, so she's been fantastic at getting the patients back into the pharmacy on a Saturday, setting up blood glucose monitoring for them, doing follow-up appointments. So, she's been extremely active in doing that." [CP, R4, Pharmacy 03]

Some pharmacists felt that the trial could allow for larger scope of practice so pharmacists could use the funding to provide services that would provide the most benefit to their customers:

"... we have the resources to continue to monitor patients' compliance with their medication through regular follow-ups. And then we have the chance of monitoring their blood sugar, blood pressure, cholesterol and then we'll be more receptive to doing home deliveries. For example, if there's funding for Health Care Homes and then we'll be able to provide a lot more services. But what I'm

saying is the scope of practice needs to be more expanded and more well-defined, rather than just those few things that they mention on there. I feel it would be better ... I feel it would be good to continue on the service, but with more expanded practice." [CP, R4, Pharmacy 07]

Impact of patient tier and level of service delivery

Pharmacists stated that the amount of time they spent with a patient directly corresponded to the patient's tier. Tier 1 patient reviews often took the least amount of time to conduct while tier 3 patients were usually the most time-consuming:

"So, I would still say at least 30 minutes [for a tier 1 patient], if that's possible ... T2? I would say they'd probably be a good hour ... And then T3, I would say they're an hour and a half. Just needing more of those services and, yes, more of the write-up as well." [CP, R4, Pharmacy 02]

"A tier 1 is probably only about 10 minutes ... tier 2s were probably a tad longer than what you'd expect a normal MedsCheck to be. So, our normal MedsChecks would be 10 minutes, maybe 15 or so, if they were complicated ... And then, a tier 3 patient, if there were lots of complications, I could be there for a half an hour or a bit longer." [Pharmacy 10, R4, Pharmacy 10]

In addition to tier, the patient's condition and the medicines they were on determined the amount of time the pharmacist spent with the patient:

"For us, this is a guideline that we try to adhere to, but in practice, it just doesn't work that way. As I said, sometimes I have to talk to a patient, say, usually about 20 minutes, 30 minutes, just to re-consult on medication. And if you have inhaler techniques and things like that, you need to check to make sure they work. It may add up to another 10–15 minutes." [CP, R4, Pharmacy 08]

"More medications that are high-risk. They may be on high-risk medications, but they're not as many, and they don't have as many medical conditions. It, honestly, really varies. It varies between the three different tiers." [CP, R4, Pharmacy 05]

Despite variation relating to a patient's tier or individual patients, pharmacists agreed that the initial HCH patient consultation was the longest, and subsequent patient follow-ups were much shorter.

Patient follow-up

The level of patient follow-up among interviewees varied. Some pharmacists have followed up patients frequently and others are yet to review patients that they initially consulted. Sometimes it was hard to get patients to come in for a review, and a few pharmacists stated that they attempted to ring patients to come in for a follow-up or catch them during their regular visits to the pharmacy when they were picking up their medication or getting their blood pressure checked:

"Some of them, we have had the opportunity to do reviews with, which has been good as well. So, it's like some patients, we'll get patients that have had a change in between that time period. So, you can check to see how they're going. But we've done more of the initial ones and less of the reviews in the

meantime. But I think, at this point, we're starting to do a lot more of the follow-ups." [CP, R4, Pharmacy 05]

"I would like to review them, but I'm waiting to see what that clinic wants me to do." [CP, R4, Pharmacy 10]

"So, I attempt to catch them when they are in the pharmacy. Like every two or three months they have to come in anyway, so when I see them here I just catch them for, you know, to do the subsequent interviews. So, I find it hard to get people to come in especially just for this subsequent." [CP, R4, Pharmacy 07]

Pharmacists that had completed follow-ups reported they would check in with the patient, reinforce what was discussed in the initial consultation and discuss various subjects, such as medication changes, treatment goals, patient compliance and patient outcomes related to receiving certain health education (i.e. improved diet, smoking cessation or increased use of asthma inhaler):

"We initially had to make some goals, treatment goals, that sort of thing. So, I would say, okay, last time I saw you, we talked about this ... How are you going with that? Have you made an improvement? ... Or are you using your puffer more often? That sort of thing, because we talked about that last time, and yes, that sort of thing. That was more like the second ... The subsequent interviews were about reinforcing what was talked about in the first one." [CP, R4, Pharmacy 06]

One interviewee suggested that patient reviews should directly correspond to a patient's tier instead of allotting four pharmacy reviews annually to all patients:

"I thought that maybe, instead of having four interviews during the year, maybe three would be enough. I thought that maybe four was too many ... Yes, so maybe they could do it like say tier 1 has less interviews than say a tier 3, because a tier 3 needs more interviews than a tier 1. The tier 1 are coming in and okay, we're just talking about the same things again. Because there's nothing else to talk about." [CP, R4, Pharmacy 06]

Patient referrals

Since practices were responsible for referring patients, the number of referrals was determined by the numbers of patients the HCH practices had to refer (some had very few enrolments, and therefore, did not engage with the community pharmacy trial), HCH practices' relationships with community pharmacies, and patients' receptiveness to receiving these types of services.

Community pharmacists reported that they saw patients with various characteristics, for example, some pharmacies reporting that their HCH patients were older ("... so mostly 60-plus, and mostly into their 70s." [CP, R4, Pharmacy 06]) and others stating that they had provided pharmacy services to HCH patients across all age groups, including children:

"I actually had a couple of children, which I did ... One was an asthmatic issue. That one actually benefited from it ... And another little fellow just with severe anxiety ... So, there were a couple of things that I recommended there, that look like they've been implemented as well. But I think there was only two. The oldest was probably 80s, but the majority of them would have been probably late 30s to mid-50s." [CP, R4, Pharmacy 10]

Some interviewees stated that patients who followed through with referrals were more likely to be existing customers of the pharmacy:

"Because this pharmacy is the main one that provides medications to the clinic, most of the patients that we get here are regular patients. Well, actually, all the ones that are signed up are, pretty much, the regular patients that come in here. And they're due to pick up their medications on a monthly basis." [CP, R4, Pharmacy 05]

"So, because they're familiar with us I was able to get them involved, so I've got my regular customers involved. So, I've got a few that's nominated at our pharmacy but doesn't come to us, I don't really know them. So, I managed to actually get a small number to come in ... But the other ones, I don't know ..."
[CP, R4, Pharmacy 07]

Pharmacy relationships with general practices

Some pharmacies reported strong relationships with HCH practices, which enabled them to communicate easily:

"... the main interaction is via the platform, you know [shared care planning software] platform. So, every now and then when I log onto the [shared care] program, there will be a thing on there, for example, to say medication review requested for this patient ... There'll be a message on there ... So, I think that's how we communicate. So, each time I do interviews, I'll obviously upload their medication management plan into the platform. So, I think most communication is via the platform, for the [shared care] platform. And then but if there's anything urgent, I guess, I normally just ring up the doctor." [CP, R4, Pharmacy 07]

In some instances, they said HCH has enhanced their communication with the practice:

"It feels like we do have more of an involvement and more communication, so, since I've been here with that program." [CP, R4, Pharmacy 05]

Others have struggled with communicating with GPs and sharing care:

"This is the problem we feel about the Health Care Homes ... The management of the patients ... The reason for that is we find it difficult to get doctors to share those patients ... They seem to keep everything ... Not, I think, intentionally they want to exclude the process, even though we feel this way. But everything [is] done within the clinic, kept in the clinic, and you have to go and ask for it. And after a couple of times, you just give up, because you feel there's no encouragement there ... they're busy, they've got a lot going on, and the last thing they want on their table is a pharmacist coming and asking about what's your number for this patient, can we do this for this patient. The communication there we felt is just not as we hoped it to be." [CP, R4, Pharmacy 08]

Sometimes pharmacists reported that they predominantly communicated with the practice nurses:

"I had a little bit more interaction with the nurses to be honest. But that was more about if she was having problems writing up the care plans and stuff, the medication management plans. So, yes, I didn't really get a lot of interaction between the doctors." [CP, R4, Pharmacy 06]

"Also the registered nurse next door at the medical centre, she came after I was no longer managing it, she was recruited, and she's done a very good job of staying in touch with me and letting me know if referrals are coming through." [CP, R4, Pharmacy 04]

Pharmacists reported issues with practice staff awareness of or engagement with the trial. This was sometimes exacerbated by turnover of practice staff. Since pharmacists need HCH practices to refer patients to their pharmacy, practice staffs' awareness of the initiative and engagement with them is crucial:

"Well, we had a really good experience, but it got cut short because our doctor left the surgery, and then ... They basically ended our trial ... So, we were in full swing in about May and June. And then, at the end of June, all of a sudden, the doctor actually left. So, it was sort of cut short." [CP, R4, Pharmacy 09]

"We've trained our staff. We've set up the pharmacy in a workflow ... And then, it's gone quiet, which is really disappointing. But of those 112 active patients, and these are active patients, and many of them ... high-risk patients, we have only seen 11 of those 112. And we've been working really closely with the medical centre to encourage the practising nurse to really get her team care plans in place. We've been going and educating the doctors, and it's not happening. I feel it's a very confusing process for them ... It's an extra platform they need to be working on, to then refer to the pharmacy, and they just can't be bothered. How do I see it? I think they're busy, and they can't be bothered doing it." [CP, R4, Pharmacy 03]

"The other clinic was doing quite a lot of people, but they've just moved locations, and at this stage they're not progressing with it. I don't know whether they'll go ahead and start doing them again once they've settled, but at the moment they're not sending any ... They've verbally told me they're not doing it for a while ... none of the other local doctors' clinics have sent anybody to us. So, I don't even know if they're sending them to anyone." [CP, R4, Pharmacy 10]

"... I have made contact with other surgeries in the area that are participating in the Health Care Home trial and offered to go and visit them and detail the pharmacy services that are available to their clients. And that hasn't really met with much uptake, or any uptake. Even the PHN has offered to attend those meetings as well because I think some of the surgeries that side aren't doing as much with the pharmacy side of Health Care Homes. But they haven't really pursued that, so without the face-to-face or without the close proximity I don't think the electronic shared healthcare planning would have worked as well." [CP, R4, Pharmacy 04]

One interviewee felt that it is not viable to participate in the initiative and devote time to implementation if a participating practice refers only one or two patients to a pharmacy:

"So, particularly from a pharmacy point of view. You'd have to spend hours doing the online training, and potentially purchasing the software ... And then you'd have to allow hours of time for the pharmacist to provide the service. And if you only got one client out of that it would be a massive loser ... there is definitely a threshold that you need to meet in order to make it worthwhile participating in the service ... it's great, if all the stars align and the doctor's surgery next door to you participates and refers, and ... the clients are typically interested, I think once

the doctor's able to refer to you ... But if you were reliant on doctors that weren't interested then, hard work. Hard work." [CP, R5, Pharmacy 04]

Pharmacist medication recommendations to GPs

Some pharmacists had strong working relationships with GPs and HCH practices and actively received feedback or acknowledgment that GPs and practice staff took their recommendations into account:

"Yes, certainly, [GPs] would always act on them if you send them a fax or you ring them. As far as what we put out there in the medication management plan that we upload, it's hard to assess whether they're reading those and taking all that onboard. But I think generally, yes, would be my gut feeling." [CP, R4, Pharmacy 01]

"... a couple of the doctors there are very receptive to our recommendations. For example, if you find a doubt on a drug, which for example, causes some side effects like, for example, a dry cough and things like that, we would write a note to the doctor and say Mrs. Jones is complaining about dry cough so just change from this particular medicine to another one that does the same but doesn't quite have the side effects ... some of those are quite receptive to that." [CP, R4, Pharmacy 07]

"Yes, in most cases. At least the discussion about it if it's not ... There's sometimes a reason why [GPs] don't [take up a recommendation], but at least an interaction about it." [CP, R4, Pharmacy 04]

Others stated that they have received limited to no engagement from GPs about their patient medication recommendations:

"... we put any [Home Medicines Reviews] that we've been completing, any medication profiles, any monitoring, blood sugar, blood pressure. Anything that we do for the patient is being communicated back through [shared care planning software]. But another part of that is that the GP then needs to review those, and the GPs aren't reviewing those. So, I think valuable work is being done from our end, and then there's no clinical application of the monitoring that we're actually doing from the pharmacy setting. So, that's a bit disappointing as well. It's just not a priority for them in their practice, I don't think, at the moment. That's probably where it's falling over." CP, R4, Pharmacy 03]

"Even if I'm checking the scripts, I know if someone's medication has gone up or down. I know my patients really well. So, from that regard, yes, I know if something changes or anything. But otherwise, we wouldn't know anything. We don't hear anything from the doctor about it, no." [CP, R4, Pharmacy 08]

Pharmacists acknowledged that GPs are extremely busy and may not have time to regularly communicate with them or respond in relation to their recommendations for patients. However, it could also be that the GPs/practices are yet to learn to work as a team with external health care providers. In a few instances, practices' resistance to community pharmacists' involvement in patient care surfaced. One pharmacist reported that they received negative comments from a GP about their clinical recommendations:

"I had a couple of patients where I'd sent through recommendations ... he had rung me up and had a fair long go at me for doing something he thought was outside my scope of practice ... I think he's rung me twice, and one of them was

really unpleasant. And I was just, hang on a minute. And at the end of it I thought, I haven't done anything that was overstepping the lines, clinically, at all ... It's just that he feels that absolutely everything a pharmacist does is trying to tread on the toes of the GP." [CP, R4, Pharmacy 10]

Practice perspectives on the community pharmacy trial

"The pharmacies love it. The pharmacies are on board." [Practice Manager, R4, Practice 17] In the most recent round of interviews, practices were asked to reflect on their involvement and/or experience with the trial. Some practices stated they were participating in the trial and are beginning to or are actively referring patients to community

pharmacies through the shared care planning software:

"Yes. We've had one pharmacist actually ... So he came and spoke to us and said, you know, what's the deal here, what do you want me to do? How are we going to sort out referrals and do that? And that was good. And then we had another couple of pharmacies contact us and start doing the reviews through the Health Care Homes model ... Yes, we're making referrals, absolutely." [GP, R4, Practice 10]

"It is fairly new with our practice. We're all still trying to work out how this is supposed to work and to actually see it working in a novel way or to extra benefit than what currently exists ... There's been a few [referrals] ..." [GP, R4, Practice 9]

"Our allied health, yes. And also, we've got the pharmacy involved now, as well." [Practice Manager, R4, Practice 16]

"I don't know about [the Community Pharmacy Program ... I've got no idea." [PM/Nurse, R4, Practice 18] However, many were either unaware of the community pharmacy trial or were not participating at this time:

"We haven't done yet but I'm going to do that one also, yes." [GP, R4, Practice 14]

"[Practice Manager]'s made me aware of it. I haven't actually explored that at all." [GP, R4, Practice 15]

"We looked at whether we would be eligible to have community pharmacy locally and that wasn't an option. And we haven't been contacted by anybody to say that I'm providing a service ... we currently have somebody who lives in the community who does our home medication and residential medication reviews for us, and we asked Primary Health Network whether they would consider that person would be appropriate to run community pharmacy locally, and they said no. And so that's as far as we got with it." [GP, R4, Practice 2]

Practices identified barriers with referring patients to pharmacists as part of the trial, related to educating and engaging community pharmacists, the shared care planning software, increasing patient understanding of the model and the scale of HCH patients in their practice:

"The patients, I think, need more education on why it's important they see the pharmacist and have that small review ... So, we're trying to encourage them." [Practice Manager, R4, Practice 16]

"[Referrals have] been pretty difficult with our clientele, but everyone uses different pharmacies, to try and get them to stick to the one pharmacy is quite a challenge, because they'll do whatever's easiest for them, we're still trying to work on that." [Nurse, R4, Practice 10]

"The first reason [we have not referred patients to pharmacies] is that the electronic shared care plan stuff that was part of the deal isn't implemented to anything like an acceptable level or a useful level to actually engage with them. The second is that with a cohort of 39 patients ... I've probably got people that live between one and 30 kilometres from the practice. So, the number of individual Health Care Home patients that would go to any one particular pharmacy would be probably at maximum two. So, the pharmacies would then have an even greater problem than we do with 39 out of our 6000. Trying to get them to actually run a process for two people out of all the work that do, I just think that's insane. So, I certainly haven't tried to engage with them." [GP, R4, Practice 12]

Some were concerned about community pharmacists working beyond their scope or providing unnecessary services:

"... I have got serious concerns about the pharmacy ... And they're immunising children now. And the one across the road has got a resuscitation box outside ... But we've got oxygen, we've got adrenalin. They can't even give adrenalin. It scares me." [Business Owner, R4, Practice 6]

"There has been a bit of a push by ... some pharmacies will send requests to do home medication reviews particularly on patients in aged care facilities. And you'll get the request to do a home medication review ... for a patient who's on two medications. And the doctor will say, no, that's not necessary because that's ridiculous, they're on two medications, they want them on those two medications, I don't need a medication review by a pharmacist. So, that, a big push on that and I think that actually makes us all a bit suspicious, the medications reviews. That they're just a money-making exercise rather than something that's really going to benefit the patient." [Practice Manager/Nurse, R4, Practice 18]

Generally, practices felt pharmacists play a vital role in patient care and chronic disease management:

"Pharmacists are coming at things from a different angle, different knowledge ... And there's always new information. But I don't think I've ever done one pharmacy review where I haven't [learned] something I didn't know." [GP, R4, Practice 10]

Funding

When asked about the level of funding and whether it was appropriate giving the services that they provide to HCH patients, pharmacists were largely satisfied with the level of remuneration and felt that it was appropriate. Many pharmacists commented that HCH management reviews were more time consuming then regular MedsChecks, therefore, it

was reasonable for them to receive additional funding when completing these types of reviews:

"Yes, I think it's good remuneration, so, yes, I'm happy with that." [CP, R4, Pharmacy 06]

"Because obviously we get paid quite a lot for just a T1 one consultation which includes the medication review ... So the normal one, I think you get paid about \$60 and you're meant to spend half an hour to do that. So, Health Care Homes consultations will take me half an hour to sit in with the customer. But then it can take me about an hour to write it up. So, an hour and a half versus, let's just say, an hour for a normal one. You're probably only making about, you know, two or three times more what a normal would make ... coming out at about the same ... So I think it's a lot more time-consuming to do that ... And so they just breaking even in terms of dollars per minute or dollars per hour ..." [CP, R4, Pharmacy 02]

Others felt that, due to the current level of funding, pharmacists should provide additional services to HCH patients beyond the four reviews and glucose monitoring:

"I would think so, because the payment is there, right? And then all that we've got to do is like medication review like four times. Is it four times? Like, four interviews. And then the only supporting service that we're giving is just that glucose monitoring and blood pressure monitoring, which is what we've been doing anyway. So, I feel that you're really getting tight, with that payment, I feel we could do a little bit better." [CP, R4, Pharmacy 07]

One pharmacist commented that, since the level of remuneration is close to what practices are receiving, this may cause frustration among some general practices due to the amount of work that is required for participating GP practices:

"... from a GP's perspective ... he was a little bit peeved at the fact that his perception of the amount of work that the doctors needed to do to do a referral to a pharmacist for a patient to join the Health Care Homes Program. The remuneration they got was miniscule compared with the potential that the pharmacy could earn if they delivered this right through the whole program. That's just a comment." [CP, R4, Pharmacy 01]

Pharmacists' experience with the trial

Pharmacists commented that they have largely had positive experiences with their involvement in the community pharmacy trial. Benefits have included practising what they are professionally trained to do and making a positive difference to patients' health:

"... many pharmacists say to me that they did all this high level of training in pharmacy skills and then they work just basically dispensing it. And this kind of work brings more satisfaction to them and greater use of the skills that they've spent years acquiring. Is that fair to say? Yes, definitely. I think that's the type of pharmacist I am. I would prefer to do this kind of work ... I was happy to sort of be nominated as this kind of pharmacist for the trial." [CP, R4, Pharmacy 02]

"Yes, because it's the nitty gritty of it, really, you can make a difference, I think. And doing these reviews, there's been numerous things where we've found a problem or being able to make an improvement." [CP, R4, Pharmacy 01]

Patient experiences and outcomes

Overall experiences

Most patients interviewed had limited to no awareness of the community pharmacy trial and had not had their medications reviewed by a pharmacist:

"No, do they do that? ... I was thinking the other day, with what I'm on. I thought it'd be nice just to see what a pharmacist ... Because I was going to actually talk to the doctor when I saw her next. And I thought just what interacts with the different drugs and that?" [Patient 2, R4, Practice 18]

"No [we haven't had any medication reviews with the pharmacist]. We've only been with our pharmacist for about three years. And not to my knowledge, no. She always talks and discusses things with me, and whatever medication we're getting or whatever, and asks questions." [Patient 1, R4 Practice 10]

While a few patients stated that they had participated in a medication review with a pharmacist, this was often prior to the beginning of HCH, so not related to the trial.

Several patients mentioned that their GP often reviews their medications during their regular visits:

"They [haven't done any kind of medication reviews] but the doctor goes through it every so often. He checks what I'm having and whether it's still needed or ... yes." [Patient 8, R4, Practice 7]

A few patients stated that they have had medication reviews at home or at their local pharmacy. However, these may have been independent of the community pharmacy trial. Nevertheless, patients reported that having their medication reviewed by their pharmacist was largely a positive experience and that their pharmacist was able to adjust their medications or educate them:

"We had a pharmacist to our house. And, when we go in to have surgery or whatever we have the hospital pharmacist who will review our medications. And, they've been pretty good with me." [Patient 5, R4, Practice 6]

"[Practice] organised twice to have a pharmacist come and check [Patient 1]'s medication ... it was good ... the first time we got it was before this [Health Care Homes] came in." [Patient 2, R4, Practice 16]

"... [Patient 2] didn't want to go, remember you didn't want to go. You didn't see why chemists needed to interview us. So, we went down in the doctor surgery, there was a room provided for [Patient 2] ... And it was, do you understand your medication? Do you know the side effects of anything? And then, things that could make things better like I suffer from dry skin. So, he recommended a heavier moisturiser. And there were little things like that, that he gave me little clues to. That are not really medical-related as you need to see a doctor. I was just little bits of advice, and I thought, oh he understands us now. So, now we always go to the same chemist. And the prescriptions from the same pharmacy, because we had 12 within walking distance." [Patient 3, R4, Practice 9]

"Yes, I've been, I go and see the pharmacist, he came round once to our house, maybe he's been twice, but he does regular updates, and what's happening and all that, and he's switched on too, because if he thinks the doctor needs to change something he'll say, I'll give a ring and do it." [Patient 1, R4, Practice 17]

HCH patient reception to receiving pharmacy services

Pharmacists involved in the trial indicated that most patients were receptive to services from them as part of the trial:

"I think they all thought that they were a bit special, so, that was nice, to get this free service from the pharmacy. But also ... We said to them, you'll have to come in next week and get your blood pressure checked. They thought that was important, you know what I mean? They felt good that we were taking some responsibility for their care." [CP, R4, Pharmacy 09]

"Yes, most patients are [receptive]. It's in their benefit, why not? And they like us to be involved. All of them said the same thing, we'd like to have you on board. I'd like you to see my medication, to review it, to see what's going on. What should I be taking? Can I go without this medication? They ask us a few questions about their medication. So, in a way, we feel like this is a needed conversation with the patient on a one-to-one basis." [CP, R4, Pharmacy 08]

In some instances, there were HCH patients who were less receptive and felt that the service wasn't necessary. Pharmacists also described scenarios where they would receive a patient referral from a practice and would contact the patient, but they would not respond to their call or would not show up to their appointment. This may have been due to the practice referring patients that may not have needed medication reviews or lack of patient engagement and interest in receiving these services:

"I think the problem is with the Health Care Homes, what I find is the patient has no idea about Health Care Homes. They have no knowledge of what's going on. So, I had a few patients, and they all said exactly the same. They said, what's all this about? And I said, you signed up for the Health Care Homes, didn't the doctor explain it to you? No. Do you know what Health Care Homes is about? No." [CP, R4, Pharmacy 08]

"... other ones basically were like, you know, I don't need your help. So, you know, you can't really do much there. And you just let the doctors or coordinators know. And they know that you know, we're doing pharmacy services in on our end." [CP, R4, Pharmacy 02]

"When I say I want to do this review or interview, I mean, they'll do it, but I feel that they are lukewarm to the ideas, maybe they're not sure why we need to be involved." [CP, R4, Pharmacy 07]

"I did 30-something, yes. But I've got 106 that were referred to me ... We've rung them three or four times, and they've never responded. They've booked appointments and not shown up for them, and we've followed up and they still haven't shown up. The phone number's not the correct phone number, so I ring the clinic and they don't have a different one. There were quite a few people who said, look, I don't want to do that, I'm running on one medication, or I don't take any medications." [CP, R4, Pharmacy 10]

Patient outcomes

The community pharmacists interviewed generally considered that the trial was well received by patients, and in their view, patients' compliance with their medications was improved. These views are below, noting that data have not been analysed to verify changes in compliance related to the trial:

"[Patients are] probably like a little bit more happy to ask questions. [I] had like one particular patient who, she wasn't coming in herself very often. And then after our first consultation, she started coming in getting her own scripts dispensed ... when she was coming in herself, she was asking a lot more questions about her medication. So, maybe just building their own confidence and building our relationship as well." [CP, R4, Pharmacy 02]

"The patients have found it most beneficial. I think of the 11, we have started doing dosage administration for eight of those, which is really good. Their compliance has increased, their MedsCheck scores, their average have all increased. I had a quick look at that last night. So, the health care outcomes for the patients have been really remarkable, I would say." [CP,R4, Pharmacy 03]

"Say, for instance, one of the ladies had asthma, and she was still smoking, and so I talked to her about quitting smoking, and I actually got her to quit smoking ... Also, there were quite a few people who needed to be reminded to use their puffers the right way, the technique of using them. So, it was quite good that way. And to be using them regularly rather than just when they're sick and that sort of thing. So, there were quite a few incidences where that seemed to be of quite a good benefit." [CP, R4, Pharmacy 06]

A few pharmacists reported that it was difficult for some patients to visit the pharmacy for routine care, such as blood pressure checks, due to lack of transport or mobility:

"But it's really difficult to get them to follow through. So like with blood pressure checks. You know, can you come into the pharmacy every week? But sometimes it's a transport issue like the elderly. They need someone to come with them. Yes, so you know you put a plan out there. But it may not always be followed through. And then medication list is quite easy to have them involved. You know it's just making sure that you've got the right information and confirming it with them and the doctor. So, yes. I think it's just those extra services I think which are difficult to follow through with." [CP, R4, Pharmacy 02]

Barriers and enablers

As described in earlier parts of this Chapter, the Guild and pharmacists identified that where pharmacists had strong relationships with HCH practices and GPs and where there was a high level of practice engagement and knowledge of the trial among practice staff, patients were being referred to community pharmacies.

They reported that where patients weren't being referred or did not follow through with referrals, it was mainly due to awareness and engagement of practices (an issue that was sometimes exacerbated by turnover of key practice staff) and patients' awareness of the trial and/or their receptiveness.

However, practices also reported that a barrier in referring patients to receive services as part of the trial was community pharmacies' lack of awareness of the trial. Other issues for practices were the small number of HCH patients, which did not make it worthwhile to learn about the community pharmacy trial and refer patients. A few GPs were also concerned about the scope of practice of community pharmacists, and/or were not particularly receptive to community pharmacists' recommendations for changes to their patients' medications.

Another reason for the low referrals was, as mentioned earlier, that 23 out of the 120 active HCH practices already had access to a pharmacist through other arrangements than the community pharmacy trial (e.g. pharmacists employed by the practice, or supported under another arrangement (e.g. hospital clinical pharmacist integrated with/visiting the practice, PHN-supported pharmacist).

Finally, issues with shared care planning software, such as the many different software systems used by practices, meant that sometimes referrals were missed by pharmacists.

Community pharmacists' recommendations

The community pharmacists interviewed were positive about the trial. They hoped that in the future it would be expanded and that more GPs and practices would begin to participate:

"I personally think it's a great system. It's probably the best ever created. I love it. It's what we need." [CP, R4, Pharmacy 08]

"Certainly. It's well received by patients, yes. I think there is a lot of uncertainty at the beginning of it all, and not really understanding what's going on and paperwork and all those sorts of things ... The only people I can think of who've stopped participating in it are people that have died ... Every other patient has found it useful, at least from the pharmacy side of things ... I think it would be a good thing if it continued." [CP, R4, Pharmacy 04]

"Without a doubt, yes ... it works well in a little setting like we've got here, it's a good fit, I think." [CP, R4, Pharmacy 01]

To expand the initiative, community pharmacists recommended additional training of practice staff or other mechanisms to raise their awareness about the benefits of pharmacist involvement in patient care:

"Maybe a bit of a rollout where ... I think the practice managers were supposed to get training, but I don't know if that's right or not. But just a little bit more training. I was lucky that someone at the Pharmacy Guild sent me a whole heap of information. And then, I had to do one before I could work out how it worked. So, just having a little bit more training, I think." [CP, R4, Pharmacy 09]

"I actually would, but with a more targeted audience of people ... Definitely there needs to be more ... Education's not the right word. More communication to the clinics as to how much it can benefit the patient, so that they're less narrow-minded." [CP, R4, Pharmacy 10]

"The most important thing is we need meetings with the doctors to talk about the patients, of what we think that can be improved. And, also, hear the doctors' opinion. We may say to this, you probably should stop this medication. But the

doctor may have things that we're not aware of or know things. And then, sharing this conversation, and having the chat about the patient would be a great way to get things." [CP, R4, Pharmacy 08]

9. Conclusion

HCH key evaluation questions and progress

The HCH evaluation aims to answer the key questions described on page 2. The Interim evaluation report 2019 answered question 1: How was the HCH model implemented and what were the barriers and enablers? This report provides additional information on the implementation of HCH among two NT ACCHS.

The second key evaluation question is How does the HCH model change the way practices approach chronic disease management? We also documented this in the Interim evaluation report 2019, and add to it in this report in chapters 3 and 4. In Chapter 3 we documented the changes practices have been making to achieve team care within the practice and share care with external providers, involve patients in their care, help patients to self-manage, and other initiatives that they have implemented that are consistent with the patient-centred medical home. Also, in relation to this evaluation question, Chapter 4 of this report contains a preliminary assessment of how regularly practices are recording key patient lifestyle factors and clinical measures, which are indicators of the quality of chronic disease management being provided by the practices. In the final report we will document the full extent of changes practices have made and compare trends of practices' recording of key lifestyle and clinical measures with non-HCH practices.

The third key evaluation question concerns whether patients enrolled in HCH experience better quality care? Chapter 5 of this report documents patient and carer experiences. At this stage we found that although patients were positive about how they were looked after by their practice, they were not always aware of how HCH was different to usual care and felt that little had changed with their care. Practices attributed patients' observations of no difference to the fact that they were already operating in an HCH-like way before the trial. Where patients were aware of HCH, they frequently cited increased access to the practice via telephone or email as one of the major benefits. Many reported having a care plan for many years, and some remembered having one created upon enrolling in HCH. Patients had limited awareness of electronic sharing of their care plan among their providers.

Patients predominantly reported that they had strong, long-standing relationships with their GPs and that they were satisfied with the care that they were receiving at their practices. Some patients said that the practice nurse had much more of an active involvement in their care since they joined HCH. Many patients welcomed this and felt that they were not wasting the doctors' time and were able to ask questions in relation to their health and managing their conditions. A few patients stated that they have also had access to an HCH coordinator. In some instances, they were not getting the benefit of the HCH nurse or coordinator because of turnover of staff.

Some practices reported that patients have become more aware of their role in managing their health through initiatives that the practice introduced as part of HCH. And when they did so, they became more enthusiastic about what they could achieve for themselves.

The carers interviewed reflected that the program has been a great support to them and the person they are caring for. Carers mentioned the ability to request prescriptions and referrals over the phone and having the nurse or coordinator as a clinical resource has been very beneficial.

The fourth key evaluation question relates to the financial effects of HCH for governments, providers and individuals? Answering this question will require analysis of linked data related to medical benefits, pharmaceutical benefits, hospital and emergency department care, and residential care. This will occur in the final evaluation report.

Community pharmacy trial key questions and progress

The remaining key evaluation questions relate to the community pharmacy trial. Question 5 asks: Is the community pharmacy component beneficial to the broader HCH coordinated care model and should it be included as part of any future roll out? and question 6: Do patients who received medication management services as part of the HCH trial experience better health outcomes than patients who did not? There is inadequate information to answer these questions at this stage. They will be addressed in the final report.

Question 7 is: What was the level of engagement between HCH practices and community pharmacy (care coordination)? The experiences around this to date are documented in Chapter 8 of this report. Overall, there were relatively few referrals by practices to community pharmacies and/or low patient uptake of the service. Both the pharmacists and the practices identified patients' lack of awareness and/or their receptiveness to consulting a pharmacist as a barrier to this component of the trial. In addition, community pharmacists identified practices' lack of awareness and engagement with the community pharmacy trial (which was sometimes exacerbated by turnover of key practice staff) as a factor, and practices identified lack of awareness of local pharmacies about the trial and difficulties with shared care planning software. Also, about 20 of the 120 practices had access to clinical pharmacists within the practice, either employed by the practice or through an arrangement with their PHN or Local Hospital Network.

Community pharmacists reported mixed experiences with GPs when recommending changes to a patient's medicines. Some had strong relationships with the practice and received feedback about their recommendations. In other instances, the practice did not acknowledge their recommendations for a patient. In a few instances, practices were concerned about community pharmacists working beyond their scope or providing unnecessary services.

Question 8 is: Is the inclusion of a pharmacy component in HCH financially viable? At this stage there is inadequate information to answer this question. This will be addressed in the final report.

Summary

Table 22 summarises the reports in which the key questions are being answered partially vs. fully.

Table 22 – Key questions for the HCH evaluation and the evaluation reports in which these will be addressed

		Evaluation reports			
	Key question	Interim report 2019	Interim report 2020 (this report)	Final report (late 2021)	
1.	How was the HCH model implemented and what were the barriers and enablers?	•	•	•	
2.	How does the HCH model change the way practices approach chronic disease management?	•	•	•	
3.	Do patients enrolled in HCH experience better quality care?		•	•	
4.	What are the financial effects of the HCH model on governments, providers and individuals?			•	
5.	Is the community pharmacy component a beneficial component of the broader HCH coordinated care model and should it be included as part of any future roll out?			•	
6.	Do patients who received medication management services as part of the HCH trial experience better health outcomes than patients who did not?			•	
7.	What was the level of engagement between HCH practices and community pharmacy (care coordination)?		•	•	
8.	Is the inclusion of a pharmacy component in HCH financially viable?			•	

¶ = Partially addressed; ■ = Fully addressed.

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Appendix 1 Supplementary data on practices' recording of clinical measures

The following figures present the rates of recording of blood pressure, pulse, cholesterol, kidney function and HbA1c by 54 practices (46 Pen CS and eight Sonic) that are currently participating in HCH, that joined the trial between December 2017 and June 2018, and provided data from the time that they joined. Data from practice clinical management systems relating to 5,881 currently enrolled HCH patients are included.

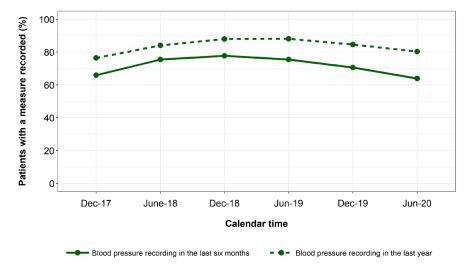


Figure 13 – Recording of blood pressure in HCH patients, December 2017 to June 2020 in practices that participated in the HCH by end of June 2018

Source: CBDRH analysis of extracts from clinical management systems provided for the evaluation. Recording of systolic or diastolic blood pressure in enrolled HCH patients, irrespective of health conditions and whether patients visited the practice. The analysis included data from 54 practices (46 Pen CS and 8 Sonic) that participated in the HCH by end of June 2018 and their 5,881 current enrolled HCH patients.

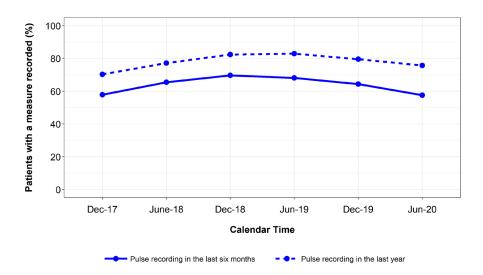


Figure 14– Recording of pulse in HCH patients, December 2017 to June 2020 in practices that participated in the HCH by end of June 2018

Source: CBDRH analysis of extracts from their clinical management systems provided for the evaluation. Recording of pulse in enrolled HCH patients, irrespective of health conditions and whether patients visited the practice. The analysis included data from 54 practices (46 Pen CS and 8 Sonic) that participated in the HCH by end of June 2018 and their 5,881 current enrolled HCH patients.

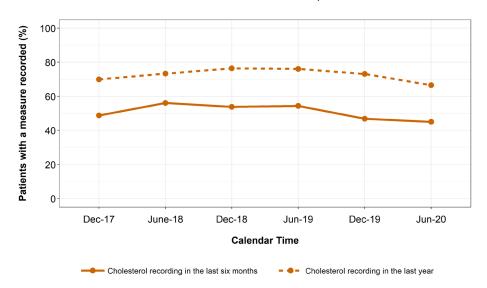


Figure 15 – Recording of cholesterol in HCH patients, December 2017 to June 2020 in practices that participated in the HCH by end of June 2018

Source: CBDRH analysis of extracts from clinical management systems provided for the evaluation. Recording of total cholesterol, HDL, LDL or triglycerides in enrolled HCH patients, irrespective of health conditions and whether patients visited the practice. The analysis included data from 54 practices (46 Pen CS and 8 Sonic) that participated in the HCH by end of June 2018 and their 5,881 current enrolled HCH patients.

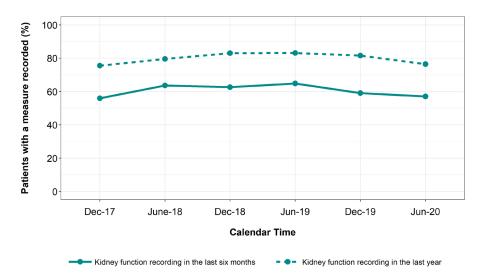


Figure 16– Recording of kidney function in HCH patients, December 2017 to June 2020 in practices that participated in the HCH by end of June 2018

Source: CBDRH analysis of extracts from clinical management systems provided for the evaluation. Recording of eGFR, serum creatinine, urinary creatinine or albumin-creatinine ratio in enrolled HCH patients, irrespective of health conditions and whether patients visited the practice. The analysis included data from 54 practices (46 Pen CS and 8 Sonic) that participated in the HCH by end of June 2018 and their 5,881 current enrolled HCH patients.

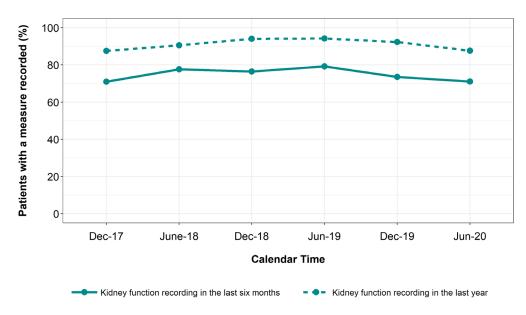


Figure 17– Recording of kidney function in HCH patients with diabetes type 2, December 2017 to June 2020 in practices that participated in the HCH by end of June 2018

Source: CBDRH analysis of extracts from clinical management systems provided for the evaluation. Recording of eGFR, serum creatinine, urinary creatinine or albumin-creatinine ratio in enrolled HCH patients who had diabetes type 2, irrespective of whether patients visited the practice. The analysis included data from 54 practices (46 Pen CS and 8 Sonic) that participated in the HCH by end of June 2018 and their 1,744 current enrolled HCH patients with diabetes type 2.

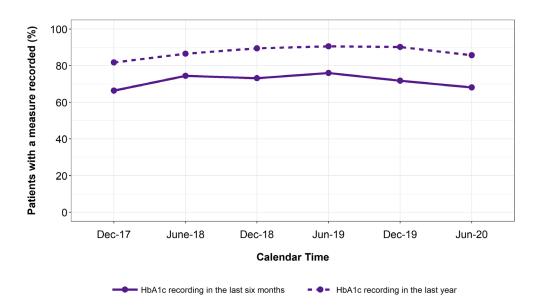


Figure 18– Recording of HbA1c in HCH patients with diabetes, December 2017 to June 2020 in practices that participated in the HCH by end of June 2018

Source: CBDRH analysis of extracts from clinical management systems provided for the evaluation. Recording of eGFR, serum creatinine, urinary creatinine or albumin-creatinine ratio in enrolled HCH patients who had diabetes, irrespective of whether patients visited the practice. The analysis included data from 54 practices (46 Pen CS and 8 Sonic) that participated in the HCH by end of June 2018 and their 1,831 current enrolled HCH patients with diabetes.

Appendix 2 Themes from the HCH forum November 2019

- **Person-centred care** This theme was embedded throughout every session with an emphasis on personalised care, coordinated care, patient enablement and care delivery founded on dignity, mutual respect and compassion.
- **Primary benefit of the HCH program** Whilst many of the themes below highlight the benefits of the HCH model, the primary benefit of the HCH Program from the perspective of participants was that the bundled payment model allows HCH practices more flexibility in their staffing profiles (e.g. they can employ clinical nurses, care coordinators, registrars, data collection officers and medical practice assistants). The bundled payment model therefore enables practices to refocus on the importance of team-based care, scope of practice and the redistribution of roles, responsibilities and tasks, employing staff to do what they were trained to do.
- Team-based care The importance of a shared purpose and understanding guided by adaptive and distributed leadership, effective teamwork and communication was emphasised. Furthermore, the need for well-trained clinical and non-clinical staff with access to appropriate education and training opportunities was stressed. The opportunity to share the workload and work at the top of scope was welcomed and the emergence of new roles such as medical practice assistant and practice pharmacist actively considered and the opportunity to extend the role of the medical receptionist explored.
- Patient activation and enablement The ability to spend an extended amount of quality time with patients who have chronic and complex illness was considered invaluable with the intent of keeping people well and out of hospital. The patient and health care team partnerships were considered central to the HCH model and the importance of shared decision making, patient advocacy, health literacy, self-management capability and confidence in self-care stressed. HCH practices felt that better use could be made of the Patient Activation Measure to better understand patients as individuals and their level of support needs.
- Indigenous and rural health perspective It was noted that Aboriginal Community Controlled Health Services (ACCHS) and Aboriginal Medical Services (AMS) already deliver team-based holistic and coordinated care for patients. The Australian primary care system can benefit from learnings from this model of care. Regarding the adoption of the HCH model, there had been significant variation in experiences ranging from those services that considered themselves "better off" and those who considered themselves "worse off".
- Innovation and leadership Innovative and successful experiences of the HCH Program were shared through keynote addresses and breakout sessions, Vox Pops video vignettes

and peer to peer conversations. Following the completion of patient enrolment, including the introduction of the bundled payment model and new technology, an opportunity now exists to enhance HCH learning and service transformation. HCH practices are well on the way to transforming the practice: carving out time to work "on the business" to enhance person-centred and team-based care.

- The continuous learning journey and the future of primary care Learnings gleaned from participation in the HCH Forum, keynote addresses from industry leaders, clinical champions and likeminded system innovators were considered invaluable. The ability to network with peers to share and reflect on different perspectives, successes and failures to strengthen HCH transformation at a practice level was commended along with the opportunity to learn about primary health care of the future.
- Learning and supports Although there are comprehensive training materials, including eleven online modules (with over 1,000 tools, resources and activities), developed and hosted by AGPAL through Australian Government funding, HCH practices perceived that they had limited capacity to undertake the training. Given the time and capacity devoted to the start-up and implementation of the HCH (e.g. HPOS, risk stratification, patient enrolment etc.), many practices have not optimised their use of the extensive resources that are readily available to them. Some participants from practices referred to their key barriers as being a 'lack of available time', 'being too busy setting up and enrolling patients' and the 'overwhelming amount of training.' Participants were reminded that the online learning was designed to be self-paced and progressively completed with the support of the practice facilitators, in line with the action plans of HCH practices. The role of the PF for coaching and supporting HCH in their transformation journey through the effective use of the training material was considered critical to success. The high turnover of previous practice facilitators had in part weakened relationships between HCH practices and PHNs. With a large number of new practice facilitators it is now opportune to strengthen the role through learning, coaching and peer supports to better support HCH practices in their transformational journey.
- Data and evidence The collection of data to monitor for improvement is a key
 component of the HCH transformational journey, providing the opportunity to manage
 change and identify and document success. Fear of change can be reduced amongst
 health professionals by demonstrating the benefits of the HCH model through data and
 evidence that supports claims of better value health services and reflects the quadruple
 aim.

Key concerns identified during the HCH Forum include:

- Making changes in a busy general practice environment is challenging and takes time. Making transformational change, is even more challenging and requires sustained efforts, shared purpose and commitment, adaptive and distributed leadership.
- General practices are not fully aware of or engaged with quality improvement
 approaches or how to undertake systematic quality improvement in practice. (Note:
 Module 4 Data driven improvement). There is a need to enhance the role of the PHN PF
 to educate, guide, coach and support HCH practices during their change.

Source: HCH Forum Outcomes Report Final (AGPAL, 2020a, p. 8, pp. 8–10)

Appendix 3 HCH forum evaluation session outcomes

Participants responded to three questions:

- 1. Over the next 20 months until June 2021 what does your practice want to prioritise as a HCH?
- 2. How will you know you've achieved the priorities that you identified in Question 1? That is, what will be your measures of success?
- 3. What would need to happen to make the HCH model embedded and sustainable across primary health?

Question 1: Priorities

Participants identified priorities relating to patients, patient outcomes, patient access, teams, the HCH model of care and shared care planning. These are shown in Figure 20.

Question 2: Measures of success

Participants listed measures relating to patients, staff and for practices as a whole. These are shown in Figure 19.

Figure 19 - Measures of success

Patients Practice Staff · Improved health Improved · Whole of practice experience/ involvement outcomes satisfaction (less Working as a team Improved · Team diversity experience/ stress/frustration) satisfaction (less Less turnover Increased frustration) Joint ownership communication/ · Able to identify their Empowered collaboration Confident health needs between staff and Work with practice Motivated patients to achieve their Engaged Shared care planning Clear roles tool used for all care goals More involved in · Working at the 'top plans their own care of licence' · Focus on good care · All staff show (rather than billing) Empowered More contact with leadership Financial viability · Improved clinical the practice Reduced hospital indicators admissions · Ongoing measurement/ evaluation

Question 3: Sustainability/embeddedness of the model

The following points were raised to help with embedding and sustaining the model:

- Convincing argument for those individuals that are not engaging with the model about its benefits. This may be helped by clearer/more convincing evidence.
- Spreading stories of success, making evidence of better outcomes/experience more available to GPs, practice nurses, practice staff and patients.
- Make the model simpler, including patient enrolment.
- Greater critical mass of patients and GPs in each practice.
- Embed the model in wider framework of health and social policy.
- Ensure that the model is adequately funded.
- Training on the principles of the model to start earlier during GP/nurse/practice management training. Credentialing organisations need to get on board with this.
- Single, easy to navigate platform for all HCH IT (same tools, same standard of care).
- Encourage continuity of care on behalf of patients (i.e. commit to a practice).
- Provide the right information to patients.
- Financial modelling to show it works financially for practices and for participating GPs.
- Public awareness campaign of the model to engage the public and patients.
- Improve awareness of the model with allied health and specialists.
- Continue sharing between practices implementing the model.
- Support move from individual GPs participating in HCH to the practice as a whole participating.
- Making shared care planning easier and interactive, especially with allied health providers.



Figure 20 – Practice priorities for HCH

Appendix 4 AGPAL training and support activities 2016 to 2020

2016

- March 2016: HCH model moved from FFS model to coordinated and comprehensive care model that is responsive to patients' needs and preferences
- November 2016: Department contracted AGPAL to develop suite of education and training resources for HCHs and PHN PFs

2017

- April 2017: AGPAL launches HCH Online Training website (https://healthcarehomes.training/)
- July 2017: Health Care Homes Program start
- August 2017: Practice Facilitator train-the-trainer workshop (3 days)
- September 2017 December 2017: Multiple coaching web in ars delivered to Practice Facilitators
- October 2017 December 2017: General Practice Recruitment
- October 2017: Department of Health/AGPAL contract variation specify the range of services provided by AGPAL across the HCHs program duration
- October 2017: AGPAL completes suite of Handbooks: Handbook for GP and ACCHS; Patient Handbook; and Care Team Handbook
- November 2017: Second Practice Facilitator train-the-trainer workshop (2 days)
- December 2017: AGPAL completed eleven online learning modules including all modules additional resources and activities.

2018

- January 2018 December 2018: Multiplecoaching webinars delivered to Practice Facilitators
- March 2018 November 2018: 4 x AGPAL newsletters developed and distributed
- . May 2018: AGPAL Interim Report 1 submitted to DoH
- May 2018: AGPAL conference held for a lIAGPAL Group of Companies clients and stakeholders sessions on Health Care Home included. Report provided to DoH with summary of sessions and outcomes
- November 2018: AGPAL Interim Report 2 submitted to DoH
- November 2018: On request by DoH, changes made to online modules for changes to My Health Record
- December 2018: HCH program extended

2019

- April 2019: Coaching webinar
- May 2019: AGPAL Interim Report 3 submitted to DoH
- June 2019: Patient enrolment closed
- September 2019 October 2019: 2 Pioneers for Change session delivered
- October 2019: Primary Health Reform Steering Group established
- November 2019: HCH Forum in Melbourne (2 days) & PF Workshop
- November 2019: New AGPAL National Practice Facilitator team allocated Angelene True and Shani Mughelli
- November 2019: AGPAL Interim Report 4 submitted to DoH
- December 2019: AGPAL Work Plan 2020 developed

2020

- January 2020 December 2020: Multiple coaching and Pioneers for Change webinars delivered
- February 2020: Department of Health Grant Opportunity Guidelines released reduction of number of PF's allocated for HCH from July 2020 – June 2021: 1 FTE PF per 16 practices supported
- February 2020: HCH on line modules unlocked
- March 2020 June 2020: 4 x Train-the-Trainer webinars delivered
- May 2020: DoH approved access to HCH online modules to PHNs not included intrial (5 users per PHN)
- May 2020: AGPAL Interim Report 5 submitted to DoH
- June 2020: Quarterly webinar delivered to all HCH participants
- August 2020: Quarterly webinar delivered to all HCH participants
- December 2020: AGAPL Work Plan 2021 to be agreed

2021

- January 2021 onwards: Implementation of annual work plan
- June 2021: Scheduled program end
- July 2021: TBC

Implementation

Start Up and Roll Out

mplementation

Appendix 5 Set up of the community pharmacy trial

Launch of the community pharmacy trial

Pharmacy engagement via electronic direct mail marketing

A key objective for the Guild was to engage as many pharmacies as possible in the 10 PHN regions. To achieve this the Guild undertook an extensive electronic direct mail marketing (EDM) campaign to community pharmacy as well as promoting the trial in Guild publications. The Guild did some geospatial mapping of pharmacies and HCHs to ascertain which pharmacies were within a close radius of the HCH trial sites. In the Northern Territory, where distances between medical practices/ACCHS and pharmacies are greater, it involved expanding the radius to 50 kms.

Pharmacies were segmented into different streams for marketing purposes. For example, those pharmacies that were within the trial regions that hadn't registered for the trial received an email encouraging them to participate, while pharmacies that had already signed up received a different email with information about the trial, available resources and training opportunities.

This campaign appeared successful, with 652 pharmacies registered to participate in the trial as of June 2020. But as discussed earlier, only 71 of these pharmacies actually provided a service to a HCH patient as part of the trial, and more than half of these provided services to less than 10 patients up until 30 June 2020.

Pharmacy registration

The Guild developed processes for registering pharmacies and resources to assist them to prepare for participation in the trial. The initial process for pharmacy registration included:

- Formal registration to participate in the trial.
- Registering the pharmacy for My Health Record (if not already registered).
- Set-up and training on the GuildLink and shared care plan software.

This initial onboarding process also included checking that the pharmacy can meet the eligibility requirements of the trial, for example, ensuring the pharmacy had a private consultation area available.

On approval, the details of the pharmacy and pharmacist details are forwarded to GuildLink for uploading to the software platform. After the pharmacy is approved to participate, the Guild project team contacts the pharmacy and provides them with some initial information to assist with implementation. This includes providing access to training and promotional

materials, guidelines and webinars. The Guild also provides information on which practices are participating in the trial in the local area, and tips for engaging with practices.

Preparing for implementation

After agreeing to participate in HCH, some pharmacies were proactive and initiated contact with HCHs in their area. This often involved a preliminary meeting or an initial phone call to express the pharmacy's interest in receiving referrals, specific services that the pharmacy could provide and/or identify HCH patients that would benefit from these services:

"We did have a meeting with [medical centre] ... and they were willing to work with us and say if we can make it like a streamline script service for these patients if we have like an arrangement with blood pressure medications then they were happy to do that. So yes, it was a lot easier when we had that meeting with the doctors and could come up with agreed services." [CP, R4, Pharmacy 2]

"I went over there and introduced myself and said we would like to participate in this trial and find out where they were up to. They had been having help from one of the [PHN coordinators] of the trial as well, so they had already enrolled quite a few patients in the trial on their end. Then, it was just a question of trying to get them to refer them to us. We went through their list with them and said, oh, these are the guys that come to us, the ones that they had ... they were our pharmacy's customers." [CP, R4, Pharmacy 6]

"... we jumped on and said, yes, we'd like to be a part of it. And so, then ... And we found out that [GP practice] had signed up to it. And so, it was a doctor surgery in our town. So, I actually rang them and said, we're happy to be involved." [CP, R4, Pharmacy 09]

Some pharmacies went as far as training practice staff members on the community pharmacy trial to increase enrolment numbers and pharmacy referrals:

"So, we actually went into the medical centre ourselves, to train the staff, and actually have pharmacists working in the medical centre to enrol the patients." [CP, R4, Pharmacy 3]

Other interviewees did not mention hosting an initiation meeting or contacting a participating practice, but commented that they got involved in the trial because they were encouraged by the Guild or their local PHN, contacted by an HCH practice, were in close proximity to an HCH practice or had some form of existing relationship with an HCH practice.

Changes that pharmacies made

Pharmacists described preparation and changes that they had to make for their pharmacies to participate in the trial. These were largely related to training, staffing and the physical layout of the pharmacy. In certain instances, pharmacies needed to hire additional staff members or change their roles to help them manage HCH patient consultations:

"... once we saw how busy and time-consuming that was, we sort of found out we needed to add you know the pharmacist to kind of allow for me to be off the floor for that time.." [CP, R4, Pharmacy 02]

"I was fortunate I had an intern, and ... so, we normally employ two pharmacists during the week ... we just had to ensure that we were able to have ... So, we've got a couple of consult rooms, and that allow [us] the time to spend with that patient one-on-one. And that wasn't difficult because our practice has enough pharmacists to do that." [CP, R4, Pharmacy 09]

"... we've got our regular pharmacist working as a pharmacist in there, and we've got our pharmacy assistant. So, the shop was running as normal. But ... with the Health Care Homes program because obviously it's extra activities, so I myself do the Health Care Homes because I can't expect the pharmacist on there to be doing the everyday things as well as taking on Health Care Homes ... so I'm just the additional extra pharmacist that's there a few days a week, just to do all these extra things." [CP, R4, Pharmacy 07]

Some pharmacies had to alter their physical space or allocate a specific room for patient consultations:

"Our pharmacy doesn't have a treatment room or anything like that, so we've used the room at the back so that there was privacy. We could shut the door and staff members weren't walking in and out. So, it was good enough." [CP, R4, Pharmacy 06]

Other pharmacies did not have to make any changes prior to participating in HCH as they already had the space and staff members required to handle HCH patient referrals. In addition, some pharmacies were already providing services that aligned with HCH, which made preparation and implementation easier:

"... I was running with a pharmacy that had consultation rooms and had a dosage administration service and a delivery service and those sorts of things before, so it hasn't really changed those aspects." [CP, R4, Pharmacy 04]

"we've got a couple of consult rooms, and that allowed us the time to spend with that patient one-on-one. And that wasn't difficult because our practice has enough pharmacists to do that." [CP, R4, Pharmacy 09]

Training and support

Online training modules

Ten eLearning training modules were developed collaboratively by the Guild and the Pharmaceutical Society of Australia (PSA). The modules provide information to assist pharmacies to set-up the trial. For example, Module 1 recommends that participating pharmacies should designate a 'Trial Program Team Leader'. This person (a pharmacist) is responsible for overseeing trial activities, communicating with other pharmacy staff and ensuring the trial is operating according to 6CPA rules. The other modules have a strong focus on communication and collaboration between the community pharmacy and the HCH team. The modules also include downloadable resources to help promote the pharmacy's services to HCHs and patients.

The modules became available in October 2018. They are hosted both on the Guild's GuildEd learning platform and the Pharmaceutical Society of Australia's (PSA) 6CPA Resource Hub and provided at no charge to pharmacies.

Data provided by the Guild showed that on 18 June 2020, 847 pharmacists had completed the training through the GuildEd learning platform (Table 23) out of the 6,511 pharmacists that had enrolled to undertake the training (13%). These figures does not include pharmacists completing the training through the PSA website, for which the evaluation team could not obtain numbers. As with the HCH trial training, the rate of completion declined with each subsequent module, starting at 23% for module 1, to 6–7% for the last two modules. The standalone module relating to pharmacy assistants was completed by 41% of those that enrolled.

Table 23 – Community pharmacy trial training modules and completion

Module	Enrolment	Completion	%
	number	number	Completed
Module 1: Preparing your pharmacy for the Health Care	808	184	23%
Homes Trial Program			
Module 2: Delivering the community pharmacy in	630	112	18%
Health Care Homes Trial Program			
Module 3: Health Care Homes in practice	629	95	15%
Module 4: Developing a Medication Management Plan	884	110	12%
Module 5: Implementing and reviewing a Medication Management Plan	777	80	10%
Module 6: Team-based health care	707	73	10%
Module 7: Enhanced communication for a new model of care	664	59	9%
Module 8: Embracing a new approach to community pharmacy practice	711	44	6%
Module 9: Patient journeys	584	42	7%
Health Care Homes: what pharmacy assistants need to know	117	48	41%
Total	6,511	847	13%

The Guild points out that while the HCH concept and the trial were new, the medication management services being provided by community pharmacies were not. Specifically, Home Medicines Reviews for patients residing the community setting have been in place since 2001 and medication reviews (MedsChecks) were introduced in 2012. For this reason, completion of the online learning modules was not compulsory.

The community pharmacists interviewed stated that they completed all 10 of the training modules, and were of the few that had done so (see Table 23). Feedback on the modules was largely positive, with many interviewees stating that the training was informative and helpful:

"I suppose I look back now that I did it, but I found them really good. Like they did kind of let me learn what was the ideal way of doing the trial." [CP, R4, Pharmacy 02]

"It gave us some understanding at the time about what is expected from us, like every other training GuildCare, you learn more as you go, work with doctors or work with the job itself, and see patients and understand the whole process." (CP, R4, Pharmacy 08]

"They were great. Easy to follow. If you missed something, you could go back. It wasn't difficult to do, and I think it was quite informative ... I think for people who

aren't [Home Medicines Review] trained, it was good in the way that it explained the best way to do a report ... and to be mindful of what you're actually recommending. That you're not a diagnostician, you're not there to prescribe, you're there to make recommendations that will improve outcomes. So, I think it was well set out for that." [CP, R4, Pharmacy 10]

Some described the modules as "a bit tedious" and that they created "a lot of busy work". But they also said that they included "some nuggets of wisdom."

A few felt that their pharmacies were already providing most of the services being offered to HCH patients or used similar software; therefore, the training acted as a review of things that staff members already knew:

"Yes, [it was] useful, just the software component of [the training] ... the training was probably stuff that we were doing already. The software platform is very similar to their MedsCheck platform ... so if you're familiar with that it wasn't a big change ... We've been going more and more towards meds checks, medication reviews, [Home Medicines Reviews], etc. So, they would have had a certain level of knowledge already over and above a lot of pharmacists who have just been the traditional stand in the dispensary and dispense medications and nod to the patient." [Business Owner, R4, Pharmacy 01]

As an alternative to the online training modules, a few interviewees felt that virtual or inperson webinars would be a more informative and useful method of learning:

"... it doesn't make sense until you're actually doing it ... Even if it was a virtual or a webinar, and just say ... with doctors and pharmacists and practice managers in the same webinar and saying, oh, this is your role. And then, you can see what they're supposed to do, and see how it flows through ... and then, what they see when we send back the review ... just so that they could see what we did, but also, we could see what they could see." [CP, R4, Pharmacy 09]

Pharmacy guidelines

The PSA was contracted by the Department to develop guidelines for pharmacists participating in trial (Pharmaceutical Society of Australia, 2018). The Guidelines contain:

- Information about the trial what it is, participating practices and ACCHSs, aims and objectives, types of patients/patient eligibility.
- The process pharmacy registration, patient referrals and consent, initial consultation, medication management plan, follow-up review and supporting services included as part of the trial.
- The shared care plan what it is, pharmacists' role in the shared care plan, communicating with HCHs and PHNs.
- Health outcome data collection requirements supporting documentation and recording platform software.
- How to participate in the trial: community pharmacy eligibility requirements and registration.
- Requirements for participation education and training, consultation area, shared care planning software, GuildCare software, My Health Record, patient privacy
- Support for pharmacies: information and resources, PHN support.
- Payment remuneration based on patient tier, payment schedule.

Guild support

In some instances, pharmacists stated that they received support from the Guild in relation to program implementation and training. Beyond contacting pharmacies to encourage them to participate in the initiative, interviewees reported that the Guild helped them install software, hosted training events and provided support via telephone:

"... the Pharmacy Guild installed the GuildCare program for us to be able to conduct the interviews and that sort of thing for the ... And prepare the medication management plan." [CP, R4, Pharmacy 06]

"I attended, like, a seminar. I don't know if they call it seminar, but there was a night that which I attend, and then basically we're doing case studies and things like that. And then we're discussing with our peers about the services we could provide." [CP, R4, Pharmacy 07]

"The first couple of times I had issues, I just contacted their number and somebody wrote me back ... but we do have somebody that works at the Guild that we know well, so if I was really stuck I could call her." [CP, R4, Pharmacy 10]

The Guild also established a helpline for the trial, with the project team available to respond to specific queries and support pharmacies requiring additional assistance. Support was also offered through the Guild's state branches. The Guild provided the same supports to member and non-member pharmacies.

Resource repository

The Guild created an online repository for stakeholders, including the Guild state branches and PHNs. These folders contain all the available resources and collateral to assist pharmacies to implement the trial, including guides on how to engage with their local HCH, how to identify eligible patients in the pharmacy and patient consent forms and other materials.

The folders also provide reports for the state branches detailing which pharmacies are participating within each jurisdiction, and those that have elected not to participate. This is to ensure there is a coordinated approach to implementation across the national and state offices.

"... We host online shared folders with our stakeholders, so PHNs and the branches primarily. So, these online folders contain reports on which pharmacies we've been contacting in their regions for the PHNs and for the branches, so they know what the status of the pharmacies are. So, they might have 90% of the pharmacies in South Australia have registered for the program and the other 10% haven't. And, I've got notes in there telling the branch why they haven't registered. So, please don't pester those pharmacies, but please help the other ones in terms of onboarding them. So, those are shared folders for our stakeholders ..." [R4, Pharmacy Guild]

To assist PHNs and ACCHS, the Guild packaged up the resources in a user-friendly way so that staff could download and use the materials to promote the service to HCHs.

Workshops

To further promote the trial, the Guild and PSA ran a series of joint workshops over October and November 2018 in the PHN regions participating in the trial. PHNs, HCHs (mainstream and ACCHS) were invited to attend the workshops. The workshops were also recorded and available as a webinar for those unable to attend.

The Guild reported the workshops were well attended by PHNs and pharmacies, but there was less interest among HCHs:

"....We encouraged the PHNs to attend ... We encouraged them to invite GP practices and ACCHOs in their regions to attend this face-to-face training so that they could engage with pharmacies as well and actually learn about what this pharmacy trial was all about, so what the benefit can be for their patients ...

"And, we did have a bit of mixed success with that I recall in terms of some of the practices. They would invite everyone they could and other PHNs would attend but it would just be the PHN representatives and the pharmacies. So, yes, mixed success with getting those extra stakeholders, but the whole idea was to just initiate the awareness of the pharmacy trial in each specific region ..." [R4, Pharmacy Guild]

The Guild extended invitations to all pharmacies in the 10 PHNs areas (not only Guild members) because they believed it was important that customers have a choice of the pharmacy that they wanted to undertake the service.

PHN support

PHN support across the pharmacies appeared variable, with some of the community pharmacists interviewed stating that their PHN encouraged them to join and provided support. The support came in the form of PHN practice facilitator visits to the pharmacy, phone support and in-person training sessions:

"The PHN [facilitator] came out ... she was actually helpful in showing me [the shared care software platform] ... and showing me some new things that I hadn't discovered myself. And then just offering more like additional services that we could offer to patients. So I think she suggested the whole blood pressure monitoring or calibration thing, all those sorts of services." [CP, R4, Practice 02]

"So it's been positive, I don't feel negative about my interaction with the PHN. I know who to contact there. I know if I have any questions where to go and ask them." [CP, R4, Pharmacy 04]

"I think the primary health care [network] did a few sessions in [city] and I attended those, and we learned more and more of what needed to be done." [CP, R4, Pharmacy 08]

Other community pharmacists interviewed had little to no interaction with their PHN about the trial:

"I think sometimes pharmacies are a bit forgotten in the PHNs." [CP, R4, Pharmacy 09]

"No, I didn't hear from them at all." [CP, R4, Pharmacy 10]

"I spoke to one of the facilitators at [PHN], and she sent me a set of instructions on how to do things." [CP, R4, Pharmacy 06]

Turnover of PHN practice facilitators was identified as an issue for both pharmacies and the Guild. The Guild reported having to re-engage with new PHN practice facilitators each time to provide them with information about the trial.

IT set-up

To participate in the trial, pharmacies had to learn about and implement software programs such as the GuildLink software through the GuildCare platform, and shared care planning software to communicate with and receive referrals from HCH practices.

Guildlink software

The Guild worked with its partner GuildLink to design the software to be used by pharmacies to record details of the pharmacy services provided. The software module is part of an existing software platform called GuildCare NG, which is used by many pharmacies to record other professional services, such as Home Medicines Reviews and MedsChecks.

The main objective in designing the software for the trial was to ensure that it was seamless and easy for pharmacists to use. The software is used to:

- Produce the initial medication reconciliation and medication management plan for a patient.
- Record ongoing medication management reviews.
- Upload the medication management plan to the electronic shared care plan, which is accessible by all members of the patient's HCH team.
- Perform pharmacy reimbursement for each enrolled patient.
- Capture Health Outcomes Data for all patients participating in the trial.

The software also includes a calendar for scheduling consultations and a screen to record other support services that the pharmacist wishes to recommend, as well as other features:

"So, most of them are familiar with it, but they log in there to record the service and to schedule the Health Care Homes service with the patient. And, when the patient's there in the room they can move through the service workload. They can record it all. They can print out a medication management template. And, that's how we know what to pay them. What services they've done as well ..." [R4, Pharmacy Guild]

Pharmacists detailed their experience with the GuildLink software and generally described their experience with the software as 'easy' and 'straightforward':

"No, I think if you just follow the prompts, I think it's pretty straightforward. So, if the template's already there I can just follow the template." [CP, R4, Pharmacy 07]

"No, I didn't have issues with that, with the GuildCare software, I found that quite easy ... Once I had asked them the questions and they were happy to sit there while I type a couple of things in, and then I can print out their plan and they can take it with them." [CP, R4, Pharmacy 06]

Some pharmacists experienced glitches or had some teething issues with Guildlink but were largely satisfied with the platform or have been able to resolve these issues as they have continued to use platform:

"Overall I've found them useful ... There are little glitches with all software programs. So, I won't be too narky about it. And often the information is only the person inputting the data, so yes, certainly not perfect ... Overall I've found it good." [CP, R4, Pharmacy 04]

"... we understand how the system works. I did have to call [the Guild] a couple of times, because it was hard to navigate that GuildCare. It's all difficult, even with other things we worked for, for pharmacy. At the end, we got the hang of it, and I started to do some work." [CP, R4, Pharmacy 08]

Other pharmacists were not satisfied with the platform and suggested making some improvements to the software. Many interviewees hoped that the Guild could integrate the platform with the shared care planning software to create a more seamless and efficient process. Pharmacists' recommendations included:

- Integrating the GuildLink platform with the shared care planning software so that
 relevant patient information is pre-loaded onto the system with their medication
 management plans. While some pharmacists have been able to pre-populate the
 GuildLink template using information from their dispensing software, others have not
 been able to do this.
- Allowing pharmacists to input recommendations beyond what is listed in the predefined check boxes.
- Listing patients' tiers on the platform or the medication management plan so that pharmacists do not have to contact the practice to obtain this information.
- Making the software more 'user friendly' and reducing repetitive questions:
 - "... it would have all of these ridiculous boxes, like what's the dose, and then how many times a day is it taken? How many tablets do they then take in a week? It was the same thing, three or four times, so it was time intensive in areas where it didn't need to be." [CP. R4, Pharmacy 10]

Shared care planning software

Guild engagement with shared care plan software vendors

The Guild worked to establish close working relationships with the shared care plan software vendors. This became important during the implementation phase when the Guild was contacted by vendors and pharmacies about the shared care software and its use in the trial.

During the implementation phase the Guild found that there were pharmacies that were receiving referrals from HCHs via the shared care software, however the emails were being missed for various reasons. The software vendor would then contact the Guild to inform them of the situation and the Guild would follow-up to explain to the pharmacist that they had received a referral from a HCH practice.

In some cases, the pharmacy was registered for the trial, but had simply overlooked the email from the shared care planning software referring a patient. In these cases the

pharmacy was able to contact the patient and make an appointment for a consultation. In other cases, the email from the practice's shared care software went to a pharmacy that had not registered for the trial. In this case, the Guild would contact the pharmacy to encourage them to participate; however, this invitation was often met with mixed responses:

"... So, they get the invitation. We call them and if they weren't already aware of the invitation they might actually in some cases tell us I can't take up this invitation. I can't do it. I just don't have the capacity. We only have X-number of pharmacists on the floor at any time and we just don't have the capacity ..." [R4, Pharmacy Guild]

In other cases, the pharmacy was not aware of trial and the Guild would be required to explain the benefits, the reasons why the pharmacy should consider participating and discuss next steps to register.

Another hurdle was the fact that the shared care software did not integrate with the GuildLink software and each PHN had a different software platform. This meant that the Guild had to work with individual software vendors to sort out these issues and ensure that referrals for patient consultations were actioned:

"....Yes, we don't know who the practice is. We don't know where they are, but we know that you've got a patient invitation so please check your emails. And, if they'd say, oh, I don't have it then the Guild would go back to the shared care plan vendor and say look, all these pharmacies have told us that they need it to be resent to them. So, there was a process that we developed around resending those invitations, making sure that they were actioned. I suppose we were mostly concerned about the patients not being seen" [R4, Pharmacy Guild]

Overall, the Guild reported that there were several issues with the shared care software which were a barrier that needed to be overcome:

"... Because that was quite evident a problem right from the start where pharmacies didn't have access, were not familiar with them and then each trial site had a different platform that they had to move with and then we couldn't actually get it to integrate with our trial software either. So then, we had to create workarounds of where they'd go into our trial software, download a PDF and then log onto the shared care plan and go backwards and forwards, which made it a bit more clunky ..." [R4, Pharmacy Guild]

What was helpful was that there were only three main vendors of shared care software that the Guild worked with. In some instances, this involved setting up a joint teleconference with the vendor, the Guild state office and the pharmacy(ies) involved to resolve issues.

In one PHN, the shared care software vendor required pharmacies to sign a deed of participation to access the shared care planning software. As the Guild was concerned with some aspects of the contract, they sought legal advice and tried to work with the software vendor as well as consulting with the relevant PHN to resolve the issues to allow pharmacies to participate. However, this was unsuccessful and community pharmacies in this PHN have not been able to participate in the trial:

"... so it didn't get resolved and our concern there is probably still that there's heaps of Health Care Homes patients that have been enrolled to that broader Health Care Homes trial that then weren't able to get referred through to community pharmacies because those community pharmacies didn't know what

to do with this deed of participation. Look, some of them might have signed it and then started receiving these patient invitations, but if they'd asked us for advice on whether to sign it we, according to our lawyers, couldn't endorse it because there was just so many problems within the deed ..." [R4, Pharmacy Guild]

The Guild also reported that another barrier to pharmacy participation was that some GPs didn't know how to use the shared care software, and thus did not refer patients to pharmacy.

The Guild reported that it was approached by a peak Aboriginal group asking how the ACCHS could refer patients to pharmacies. The Guild advised that referrals could only be generated via the ACCHS themselves, through the shared care planning software. The lack of awareness of this and the lack of integration of the shared care planning software with practice clinical management software is another barrier to community pharmacy involvement:

"....They're basically approaching us asking us how they can refer patients to pharmacies and we're saying, well, it's not our job to set-up the shared care planning tool. All we can do is make sure the pharmacies are ready to receive those invitations. So, it's different. It's unique in the Northern Territory, but it all seems to revolve around the shared care planning software and I suppose the lack of integration" [R4, Pharmacy Guild]

Pharmacists' experiences with the shared care planning software

Similar to the Guild, pharmacists discussed difficulties with the shared care planning due to the lack of integration of the various software platforms:

"This is one of the issues we've come across with ... all of these different records. So, in [practice clinical management software] there, probably in Guild software here, [shared care planning software] is trying to connect the two, and then you've got My Health Record looming over the top. So, there's a few different areas where you've got push things and click things and have things set-up. Here you're using [shared care planning software x], but in other jurisdictions they might be using a different [system], there's about three or four even maybe more providers of shared care plans. So, some places, one doctors surgery might be using [shared care planning software y] and another doctor's surgery might be using something else and another doctor's surgery's using something else. So, all of a sudden the allied health, including pharmacies are having to try and connect to three or four different [platforms], it can make it difficult." [CP, R4, Pharmacy 01]

"... [the shared care planning software] I would say I struggled a bit with. It was a little bit paint by numbers until you've figured it out, and there wasn't really anywhere to easily access how to do it. Once you were up and running and you'd done a few it was okay, but the first couple it was very hard to download the documents, because it's not integrated with the Guild. So, you had to save your reports in a file, and then go into [shared care planning software], and upload that report to the doctor." [CP, R4, Pharmacy 10]

Other interviewees stated that the software was "weirdly worded" and more difficult to follow in uploading the medication management plans and attaching associated patient information. Similar to issues described with the GuildLink system, another pharmacist also

stated that they could not identify patient tiers in the shared care planning software which made it impossible to claim for HCH pharmacy services without contacting the practice:

"But the thing that was really bad was they couldn't flag in their platform what tier they were, which is the most vital thing out of everything, because when you're doing a claim or when you're putting through the Guild and then back into the platform, you've got to say what tier they are. So, I had to ring the clinics all the time." [CP, R4, Pharmacy 10]

"The [shared care planning software] part of it was okay to use as well ... It was more a question of being able to attach my documents from the Guild ... I'd make a PDF document from GuildLink, and then to try and attach it to the care plan in [shared care planning software] ... It wouldn't send between me and the doctors. It was more technical problems rather than ease of use of the program. It was just [doing what] they said they were having teething problems or something, and they were trying to work it out, but I found that I had a lot of problems just between my end and their end, that's all." [CP, R4, Pharmacy 06]

Some pharmacists felt that there was limited training on the shared care software and stated that they devoted a lot of time trying to understand how to use the software:

"There's various platforms, and pharmacy has the added I would say step, and I would also call it a disadvantage, that we needed to also train ourselves on the [shared care planning software], which we have never used." [CP, R4, Pharmacy 03]

"I guess maybe there wasn't much [in the modules] about the [shared care planning software] itself. So, I had to spend a lot of time really kind of just learning about it myself and just playing around with it. That's probably one thing and then second thing, maybe just offering a way to kind of really set-up in the pharmacy. I guess they tell you how to do the medication, the management plans and all this, but maybe just how to set it up so you can call patients." [CP, R4, Pharmacy 02]

In other instances pharmacists felt that the shared care planning software was easy to use, and they did not experience any issues:

"So, with the shared care platform, I assume you mean the [shared care planning software]? I think that everything you need to know is pretty much on there. I mean, there's a wealth of information in there. So, you've got the patient history, you've got which medications they're on. It's pretty easy to use." [CP, R4, Pharmacy 07]

"Yes, easy. [Shared care planning software is] a good tool for us to have access to that, because you can see what their kidney function is or you can see what their cholesterol levels are like or their HbA1cs and all that sort of stuff. Whereas before we weren't privy to any of that." [CP, R4, Pharmacy 01]

Ultimately, community pharmacists' feedback predominantly focussed on further integrating the shared care planning software with the GuildLink platform.