**Australian Government Department of Health**

*Evaluation of the Health Care Homes program*

Interim evaluation report 2020

Volume 1: Summary report

Revision history

| **Version** | **Date** | **Modification** |
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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. |
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Acronyms

ACCHS Aboriginal Community Controlled Health Service

AIHW Australian Institute of Health and Welfare

GP General practitioner

HCH Health Care Homes

HPOS Health Professionals Online Services

IT Information technology

MBS Medical Benefits Schedule

NT Northern Territory

PHCAG Primary Health Care Advisory Group

PBS Pharmaceutical Benefits Schedule

PHN Primary Health Network

PCMH Patient-centred medical home

RST Risk stratification tool

Introduction

The Health Care Homes (HCH) trial was established by the Australian Government in response to the Primary Health Care Advisory Group’s (PHCAG’s) recommendations for better outcomes for people with chronic and complex health conditions (2015). 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. As per PHCAG’s principles and key recommendations, the features of the trial are:

* Voluntary enrolment of patients to a practice – their health care home – nominating a GP as their preferred clinician (HCH principles 1 and 4).
* Tools to identify patients at risk of hospitalisation and stratify them to a complexity tier (key recommendation 1).
* 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-for-service model (key recommendation 9).
* Training resources to support transformation of practices towards an HCH model (key recommendations 2 and 8).
* Support for practices to undertake transformation, provided by Primary Health Network (PHN) practice facilitators (a component of the change management required to implement key recommendation 2).
* A system of shared care planning that gives authorised health professionals access to an up-to-date electronic medical record for each enrolled patient (key recommendation 4).
* Data sharing arrangements (HCH principle 7 and key recommendation 13) and an evaluation of the program (key recommendation 15).

These features align with the 10 building blocks of high-performing primary care (Bodenheimer, Ghorob, Willard-Grace, & Grumbach, 2014), which underpin the PCMH model. HCH is also consistent with 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).

Practices implementing HCH aim 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 trial of HCH started among Australian primary care practices in late 2017 and is continuing through to mid-2021. In addition, in August 2018, under the Sixth Community Pharmacy Agreement, the Government dedicated funds for HCH patients to receive additional medication management services from community pharmacists, including:

* Medication reconciliation and assessing the patient’s medicines regimen.
* Identifying any potential medication-related issues and agreeing on medication management goals.
* Developing a medication management plan in collaboration with the patient and their HCH.
* Providing regular follow-up reviews with the patient (in consultation with the referring HCH practice).
* Providing support services for the more complex patients, such as dose administration aids, blood glucose monitoring, blood pressure monitoring and asthma management planning.

HCH practices can refer patients to receive the above services from a community pharmacy of the patient’s choice.

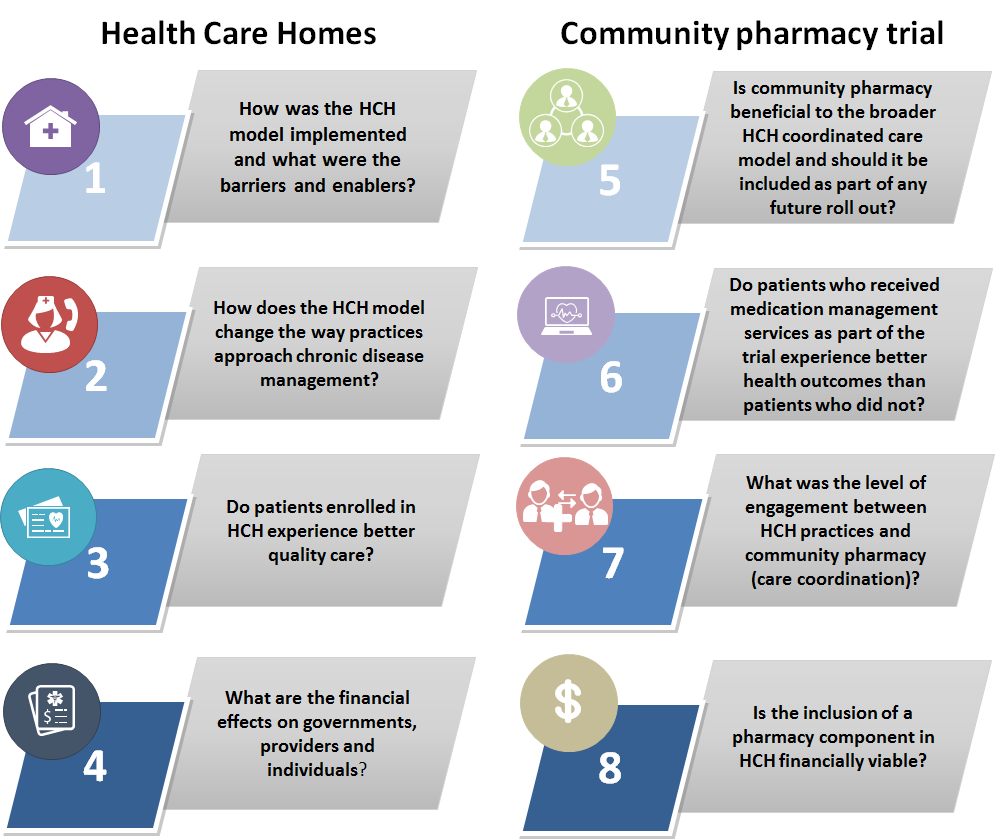
## The HCH evaluation

The Department engaged Health Policy Analysis as the lead for a consortium to evaluate the trial. The consortium includes 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.

An evaluation plan (Health Policy Analysis, 2019a[[1]](#footnote-2)) was developed as one of the first steps in the evaluation. 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.

These questions have many dimensions. More detailed questions have been developed for each key question and are documented in the evaluation plan (Health Policy Analysis, 2019a).

Mixed methods are being used for the evaluation. Figure 2 shows the data sources. Qualitative data are being gathered through interviews and focus groups with patients and patients’ carers/families, GPs, other primary care staff, pharmacists and other providers. The interviews and focus groups are being undertaken in 20 locations across Australia. Quantitative data are also being gathered or sourced from existing collections to analyse how things have changed for patients enrolled in the HCH trial and to compare their outcomes with similar patients receiving care from non-HCH practices.

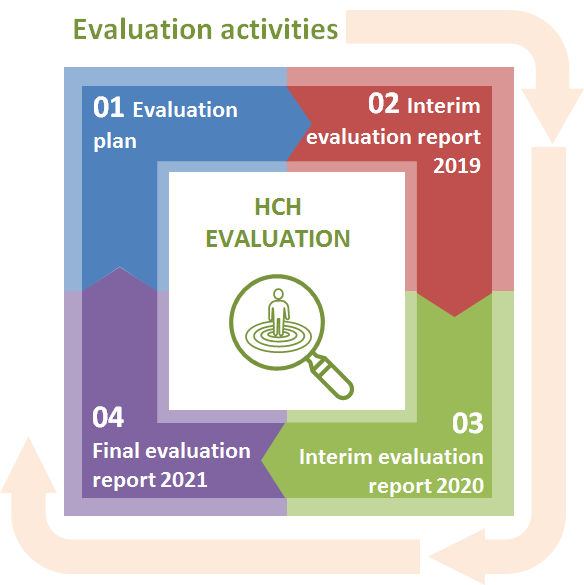


**Figure 1 – Key evaluation questions, Health Care Homes and the Community pharmacy trial**



**Figure 2 – Evaluation data sources**

Figure 3 shows the timing of the evaluation reports. The data featured in each report are described in the box.



**Figure 3 – Evaluation reports**

|  |  |  |
| --- | --- | --- |
| |  | | --- | | Data featured in evaluation reports  **Interim evaluation report 2019 (previous report – Health Policy Analysis, 2019b):**   * *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. * *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 andchanges 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. | |

## This report

This report is the **Interim evaluation report 2020, Volume 1: Summary report**. It is one of three volumes featuring the findings of the evaluation of the HCH trial up to 30 June 2020. 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. |

This report moves beyond the establishment phase of the HCH trial documented in the *Interim evaluation report 2019*. However, as the trial is ongoing, it reflects the **early to mid-point experiences** of practices and their staff, patients and PHNs, and not the overall findings. It is **largely based on qualitative data**, but also includes descriptive quantitative 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.

|  |  |
| --- | --- |
| |  | | --- | | 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. | |

Compared with the *Interim evaluation report 2019*, the *Interim evaluation report 2020* contains further information on the experiences of Aboriginal Community Controlled Health Services in the Northern Territory in implementing HCH, based on two case studies undertaken in the latter half of 2019. It also contains further information on the community pharmacy trial.

Key findings

The HCH trial started in late 2017, and practices could enrol patients immediately. Patient enrolment was initially due to end a year after the trial started – in late 2018 – but was extended to mid-2019. The decision to extend the enrolment period recognised the extensive effort required by practices to set-up as an HCH and enrol patients at the same time.

This report continues from the *Interim evaluation report 2019* (Health Policy Analysis, 2019b), which described the background to HCH and the set-up of the trial and reported on developments to 31 August 2019. This 2020 report focuses on the period after patient enrolment ended until 30 June 2020.

Many practices only just started to progress their HCH model after the enrolment period closed. They had started to reassign components of care from the GP to a nurse and/or a medical practice assistant, introduce new roles within the practice, and proactively follow-up their HCH patients. They also worked on getting patients more comfortable not seeing their GP at each encounter with the practice. The ACCHS in the NT had also just started to set up for HCH before the patient enrolment period ended. The community pharmacy component of the trial was only introduced in August 2018.

The data for this report was collected prior to the COVID-19 pandemic. Clearly, the pandemic will affect practices’ progress with HCH, either positively in leading them to implement innovative ways to effectively manage their patients’ health while reducing in-person contacts, or negatively, stalling their progress. This is yet to be seen.

The trial is currently scheduled to continue through to 30 June 2021. When last interviewed for the evaluation, participating practices were turning their attention to the future. Most are keen to continue to participate in HCH in some form but are looking for changes that will ensure the model is viable and sustainable. Practices highlighted that there needs to be sufficient time to manage their transition to the new approach. This includes sufficient time to communicate with patients and transition them to new arrangements if required. Practices require clarity about future arrangements well ahead of June 2021.

This report and the 2019 report have highlighted lessons that can help shape HCH in its next iteration. However, the evaluation is yet to address the questions that are crucial to decisions about the future of the program. Several of these relate to assessing the effect of HCH on patient outcomes, assessed through both the last round of the patient survey (comparing HCH patients’ assessments of their experiences and their health status over time) and comparison with like patients not enrolled in HCH. The main comparative analysis will be undertaken using linked MBS, PBS and hospital usage data. While a baseline set of linked data has been provided to the evaluators, data covering periods after HCH commenced will be provided in two tranches over the next 12 months. These data will be important for analysing the relative costs of HCH – for government, practices and patients – and the effect on measures such as hospitalisation, emergency department attendances and transitioning to residential care. The analysis will also be crucial for determining the adequacy of the bundled payment and modifications to the tiers and the risk stratification algorithm.

A key lesson from the *Interim evaluation report 2019* was to **allow sufficient time for implementing complex programs such as HCH (lesson #1)** [[2]](#footnote-3)**.** This remains important in transitioning to new arrangements or expanding HCH. Consideration could be given to **extending the trial a further 12 months**, so practices can continue with their transformation and provide continuity for their enrolled patients while the findings of the evaluation are considered by government and the components of the next iteration of HCH are put in place.

Several new lessons arising from this report are relevant for any further rollout of HCH beyond the trial, including:

* 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 (#31)**. Therefore:
* Participating practices should achieve 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 a further rollout of HCH, practices should commit to achieving a threshold proportion of GPs that are willing to participate in the initiative.
* **Protect from instability** by setting up mechanisms to enable quick response and adaptation to change and reduce key person dependency/risk (#32).
* **Implement strategies to help raise awareness about HCH among health care providers that general practice works closely with** (e.g. allied health providers, hospitals, community pharmacists) (#33).
* Develop strategies to **recruit patients into HCH who may be less motivated, activated and/or willing to try new things**, and for whom HCH may be most beneficial (#34).
* **Practice facilitation should include a mix of staff with advanced facilitation skills – located in meso or national level organisations** – and staff should be embedded within PHN-based teams responsible for supporting practices in quality improvement (#35).
* **Use a national event at the commencement of implementation** to efficiently build knowledge about the model and its implementation, motivation within practices, and relationships between participating practices and practice facilitators (#36).

Practices and patients

At 30 June 2020, there were 120 practices participating in HCH, and these joined the trial between late 2017 and mid-2018. The Department of Health aimed to maximise variation in the practices participating in the trial to test the model in different contexts, and thus selected practices of different sizes (sole practitioners, small, medium and large), ownership types (Aboriginal medical services, independent and corporate practices), locations (major cities through to remote regions) and those servicing populations at all levels of socio-economic disadvantage. Although practices withdrew along the way, representation across these sampling strata has largely remained.

From the inception of the trial until 30 June 2020, 107 practices withdrew (48.5%). Practices withdrew at a steady rate, until July-August 2019, when those that had not enrolled any patients by the end of the enrolment period (which was 30 June 2019) withdrew. Throughout the trial, most practices that withdrew had not enrolled any patients or had enrolled fewer than 10 patients[[3]](#footnote-4).

In interviews and surveys of practices that withdrew since the *Interim evaluation report 2019*, practices identified similar reasons for withdrawing from the trial as those documented in the previous report. These included:

* the practice closing/changing ownership
* key staff leaving (i.e. staff in key roles championing HCH or trained in HCH)
* having too few patients enrolled to invest in making changes and/or for the program to be financially viable for the practice
* perceived lack of a clear value proposition for GPs and/or patients
* GPs’ disinterest or dislike of the model
* inadequacy of the bundled payment
* inability of the practice to share care with external providers in the way that the program intended.

Some of the practices that withdrew stated that they intended to maintain elements of the model, such as team care and quality improvement activities.

Of the 11,332 patients who enrolled in the trial between 1 October 2017 and 30 June 2019, 8,959 (79%) were still participating on 30 June 2020. Almost 40% of the patients who withdrew from the trial did so because the practice withdrew. Other reasons that patients withdrew were:

* opted out (24% of withdrawals)
* no longer with the practice (13% of withdrawals)
* died (13% of withdrawals)
* moved from the area (10% of withdrawals)
* other reason (<1% of withdrawals).

Among all patients who enrolled in the trial, only 5% chose to opt out of the trial.

Practice implementation of HCH

The extension of HCH announced at the end of 2018 gave practices an additional six months to enrol patients. This gave practices more time to engage staff and implement the model. However, some still found it challenging to enrol more patients. Obstacles were time (including to engage their GPs), uncertainty about the impact of the model, and uncertainty about whether the program would continue beyond the trial period.

Having too few patients meant practices could not make any significant changes due to not having the financial flexibility to hire additional staff or appoint staff to HCH-specific roles. Also, the bundled payment was not financially viable for them as there were not enough patients for losses on any patients to be compensated by gains on others. This raises an additional lesson about scale, which is that 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** (#31). A few practices suggested that at least 100 patients should be enrolled for HCH to work in any practice. However, the number of patients to achieve viability may vary across practice size. One approach would be to seek a commitment from participating practices to achieve a threshold level of enrolments. The threshold could vary according to the number of participating GPs.

Without all or most GPs within a practice participating in HCH, implementation is problematic. Lower levels of GP participation 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 cautioned that it may not be feasible to have all GPs involved in a program such as HCH.

In a further rollout of HCH, practices should commit to achieving a threshold proportion of GPs that are willing to participate in the initiative.

Once patient enrolment closed, practices turned their attention to enhancing specific aspects of their models. The HCH initiatives that most practices (50% or more) said they did not have in place prior to HCH but were now working on were[[4]](#footnote-5):

* 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 on were[[5]](#footnote-6):

* 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 concerns[[6]](#footnote-7)
* improved systems for follow-up and recall of HCH patients.

Team-based care is a fundamental building block of HCH, and practices reported working on this during the trial. Barriers to team-based care were GPs’ willingness to let nurses take greater responsibility for their patients, and patients expecting that they would see their doctor each time they go to the practice. Nevertheless, practices reported progressing towards team-based care. Practices that had all GPs participating in HCH found this easier to achieve. 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). 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)** (lesson #33).

Medical practice assistants and coordinators were new roles practices added to their team specifically for managing HCH patients. Staff turnover affected all HCH staffing roles, including the new roles. As with the PHNs, staff turnover was not caused by HCH, but is a ‘fact of life’ and practices need to be resilient to its effects (see lesson #32).

Practices reported varying degrees of impact of the HCH model on their staff. Nurses’ roles were the most changed because of HCH. Nurses felt they now had greater involvement in chronic disease management, stronger relationships with patients, could justify their time (due to the bundled payment), were providing more personalised patient care, and enhancing patient monitoring and recalls. Nevertheless, some practices reported there had not been any change to nurses’ roles, either because they were still working on involving nurses more, or that their nurses already had a wide scope of practice prior to HCH.

Some practices were still trying to get their GPs engaged with HCH. Where GPs were participating, they reported mixed views about how the model affected them. Some reported that the model had given them and their patients more flexibility, that they were getting additional support working as a team and were better able to prioritise patients. Others said it had negatively affected their roles due to confusion around billing and determining what is considered acute versus chronic care, increased workload during the enrolment period, and fewer face-to-face interactions with their patients.

Involvement of practice managers and administrative staff in HCH was variable among practices. It ranged from no involvement, peripheral involvement (e.g. billing), to full involvement (e.g. part of the leadership team).

Practices cited improved access for patients as a key benefit of the HCH model. They made their services more accessible to HCH patients by offering telephone (and in very few instances video) consultations with nurses or GPs, email correspondence, a priority telephone line, streamlined referrals, and increased nurse involvement in patient care.

Practices also judged that they have enhanced patient monitoring, care management and follow-up under the HCH model. Improvements have come in the form of more regular contact and monitoring, frequent care plan reviews, pastoral care calls, and an overall increase in communication with their patients. In addition, some practices have implemented new services to enhance their chronic disease management, including home visits by nurses, remote monitoring services, group sessions, point of care testing, and internal allied health services.

Practices thought that it was too early to tell whether patients’ health had improved because of the changes that they had made as an HCH. Some were turning their mind to measuring this as their next goal in their HCH journey.

Practices identified staff turnover, having too few patients enrolled and patients’ lack of understanding of the HCH model and expectation that they would continue to see their GP each time that they came to the practice as ongoing challenges of implementing HCH and/or achieving the desired outcomes for the practice and patients.

Patients’ expectations that they would see their GP each time they come to the practice reiterates a lesson from the *Interim evaluation report 2019*, which is that **patients, families and carers need time to build confidence in a wider primary care team** (lesson #13). We found instances where patients who were initially resistant to seeing practice clinicians other than their GP came to welcome this change, mainly because they had more time to ask questions about their conditions and work on strategies to self-manage (see section ‘Patient and carer experiences’ below for a summary of these experiences).

A set of evaluation measures relate to how regularly practices are recording key patient lifestyle factors and clinical measures, which are indicators of the quality of chronic disease management provided by the practices. We were able to do a preliminary analysis of this and found that the measures trended upwards until the end of the patient enrolment period (until the end of June 2019), but then downwards, and this downward trend started before the COVID-19 pandemic. The reasons for this are not yet clear and cannot be explained by decreasing services provided to patients (in other analyses we showed that mean number of GP consultations has remained steady over time). This issue 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 help us to interpret these trends.

Patient and carer experiences

Some patients appeared unaware of the nature of HCH and reported that little had changed with their care. However, most patients were very positive about how they were looked after by the practice. Practices attributed patients’ observations of no difference to the fact that they were already operating like an HCH before the trial. Increased patient 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. The lesson, which already surfaced in the *Interim evaluation report 2019*, is the **need to exploit multiple avenues to build patient awareness of HCH** (lesson #3).

Patients who noticed a difference in their care frequently cited increased access to a practice via telephone or email as one of the major benefits. Some patients stated this was the only change they noticed since 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 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. A few patients mentioned that being an HCH patient meant they were prioritised for appointments.

Many patients reported that they were involved in creating a care plan with their GP or a practice nurse. Though some had had a care plan for many years, others suggested that they first had one created when 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 every six months or annually. Patients reported that a few of the services they received (such as allied health) started after they enrolled in HCH, mostly prompted by the care planning process.

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 (i.e. inputting physiological measures to monitor their chronic conditions). In other instances, they were aware of ‘teething’ issues with other providers accessing their plan through the shared care software, and/or they did not wish to engage with the software themselves.

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 HCH was removed. Privacy was raised again by a few patients in the second round of interviews, although these views were not widespread. Many patients were not sure how to access their My Health Record.

Most patients reported they had strong long-standing relationships with their GPs and were satisfied with the care they received at their practices. Some patients observed the practice nurse has had 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.

A few patients had access to an HCH coordinator in the practice. Some practices hired a coordinator or designated a practice nurse as the HCH coordinator to help proactively manage HCH patients and be their main contact. Some patients felt they were not getting the benefit of the HCH nurse or coordinator because of staff turnover. One patient shared that an HCH coordinator had regularly contacted them, but since the coordinator left the practice, the patient no longer received ‘check-in’ calls from the practice. Another patient observed nurse turnover in their HCH had made it difficult to establish or maintain a strong relationship with a practice nurse. This goes back to the **lesson about organisational resilience** (#32); practices need to implement measures so the quality and consistency of care does not change when staff change.

Only a few practices set up groups for their enrolled patients, but others planned to set up groups in the future. Others did not think this was feasible due to low availability of allied health professionals, lack of space, potential cost and limited patient interest.

One practice established patient groups and initially had psychology, walking and dietician groups. Due to patient feedback, limited attendance in certain instances, and staff turnover, the practice continued only the dietician group. Patients were very positive about being in the groups and enjoyed the educational and social benefits. Some reported positive outcomes with both their physical and mental health.

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 have been very beneficial. **In a broader rollout of HCH and in communications about the program, the benefits for carers should be emphasised.** In the *Interim evaluation report 2019*, there was a lesson about communicating the benefits of the program to carers alongside patients (#11), and this has been emphasised in the current findings.

Practices reported that patients who enrolled in HCH were more motivated about managing their health. GPs also tended to approach patients to enrol that they thought were activated or were willing to try new things. Other 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** (#34). **These patients are more likely to have poorly controlled chronic conditions and may benefit significantly from HCH.**

HCH in NT Aboriginal communities

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 case studies found that although the HCH model is similar to the way they deliver care, implementing HCH meant more frequent reviews of patients’ care plans and 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 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 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 had limited awareness of what HCH is 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 to raise program awareness among patients and their communities so they know what to expect.

Support and training for practices

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 along with the extension of the enrolment period 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 their region. Many of the PHNs changed their staffing structure and roles in line with this. This predominantly included reducing the number of HCH practice facilitators and/or incorporating HCH facilitation into general primary care and chronic disease practice improvement roles.

At the beginning of the trial, PHN practice facilitators focused on assisting practices with the administrative tasks of participating in the trial (e.g. registering patients in HPOS and in the evaluation app), implementing software (the risk stratification tool – 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. When the extension to patient enrolment was announced in late 2018, PHNs continued to support and encourage practices to enrol patients through to the end of June 2019. This involved organising 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 practices found the end of the enrolment period the most difficult, as they were not sure what was supposed to happen beyond enrolling patients. Enrolling patients (and associated tasks such as implementing new software, and risk stratifying and registering patients) took up all their time, and they found they had not progressed with changes to their model of care. This reiterates a lesson raised in the *Interim evaluation report 2019*, which is to **allow time for practices to prepare for practice change prior to enrolling patients** (lesson #2).

Once enrolment was over, PHN practice facilitators saw their role as helping practices to re-focus on their model of care. They reported helping practices with:

* refining and individualising models of care
* re-stratifying HCH patients
* identifying and implementing quality improvement initiatives
* identifying ways to shift patients’ thinking to accept a team-based model of care
* care planning
* using data to understand their HCH patients and develop strategies to support them.

Many also focused on the healthcare neighbourhood, specifically raising awareness about HCH among providers practices referred patients to (such as allied health and local hospitals) and helping these providers with practical aspects of accepting referrals and communicating information back to practices about their shared patients. Examples of activities they undertook were:

* 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
* increasing participation of allied health in community of practice meetings.

Some also specifically reached out to community pharmacies in the area, raising awareness or educating them about the community pharmacy trial and about how to use shared care planning software.

The facilitators stated that much of the post-enrolment practice support still depended on individual practice needs, the level of 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. This lesson was also highlighted in the *Interim evaluation report 2019***: a key to facilitation is assessing each practice’s readiness, culture and environment, and tailoring changes to the unique needs of the practice** (#16). Staff turnover in practices also meant the facilitators were sometimes returning to the fundamentals of HCH, including training practice staff in the foundational elements of the model and using the RST.

In addition to practice staff turnover, turnover of practice facilitators was also a challenge for the PHNs. It mostly was not caused by HCH except towards the end of the enrolment period when the number of funded positions decreased. Of the original cohort of 45 PHN practice facilitators trained for the role prior to the start of HCH (August to November 2017), five individuals remained in the role in June 2020. Therefore, continuity has been a problem – each new facilitator has had to take time to learn about HCH and develop relationships with practices and other providers within the healthcare neighbourhood.

Relationship-building with practices continued to be fundamental to the PHN practice facilitator role, to enable access to key practice staff and to work with them effectively to implement the model. In some instances, the PHNs had pre-existing relationships, and in others HCH strengthened relationships with practices. 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. **Rapport and trust between the practice facilitator and practice staff are foundations for practice facilitation** (lesson #15)**.** This is challenging when there is a high turnover of staff. Therefore, an additional lesson arising is for **PHNs and practices to become resilient in the face of change** through, for example, having team-based leadership rather than depending on a key person and diversifying skills among team members, so others can take on aspects of a role if someone leaves (new lesson #32). Ongoing training is also important.

Practices were largely positive about the support they received from their PHN practice facilitators to implement HCH. Where they were critical, it was that they did not get enough support, or they were frustrated with the turnover of practice facilitators. Overall, **external practice facilitation is valuable for practices to achieve the level of transformation needed to operate as an HCH** (lesson #14).

The high turnover in PHN practice facilitators suggests more resilient approaches for delivering practice facilitation are required in the further rollout of HCH. Practice facilitators require specific knowledge and skills, which go beyond having experience as a primary care clinician or having worked in primary care. Building these skills within a local workforce is possible but challenging. 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 skill sets 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 facilitation with PHN initiatives and build the skill set among the local PHN workforce. **In further rollout of HCH, practice facilitation provided directly to practices should be undertaken by a mix of staff within 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).

PHNs used communities of practice and networking events to encourage collaboration between practices. PHNs also thought that networking events with other PHNs enriched their understanding of HCH and were a way to share resources. Practices identified that networking with each other was important, and they mainly did this through local community of practice meetings/events.

The Department of Health hosted a national two-day HCH forum 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 and experts on specific topics, sessions for discussing the features of the HCH model and approaches to implementation, and opportunities for networking. Attendees found the forum:

* kindled or reignited enthusiasm for HCH
* increased knowledge and awareness of opportunities within HCH
* allowed sharing of approaches to implementation
* created networks between practices
* strengthened relationships between GPs, other practice staff and PHN practice facilitators.

Strong relationships and sharing of experiences and resources between people involved in change has been emphasised throughout the HCH implementation. In the *Interim evaluation report 2019* this was articulated as: **create more opportunities for peer-to-peer engagement of clinicians involved in implementation** (#9). The HCH forum illustrated how these opportunities can have a material effect on motivation and implementation. 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).

Bundled payment

The *Interim evaluation report 2019* described the difficulties practices had distributing the bundled payment among their providers. Some practices continued to have these difficulties. They also reported issues with keeping track of the services provided to patients without the discipline of claiming each individual service item through Medicare, and continued to have problems with determining what was part of a patient’s chronic condition(s) and what could be billed separately.

As in the previous report, there were mixed views on the financial effect of the bundled payment on practices, possibly due to the number of patients that practices enrolled, either as an absolute number or as a proportion of their patient population. Many practices estimated that they had ‘broken even’ or were better off under the bundled payment compared with MBS fee-for-service. Some were not sure of the financial effect at this stage. In some cases, although they were successful in redistributing work among their clinical team, practices found some staff members had a greater workload, which they were unsure would be compensated by the bundled payment. Other practices felt they were losing money under the HCH model compared with fee-for-service.

Practices thought the bundled payment could be improved by increasing the level of funding by tier or expanding the tiers to recognise more costly patients, or weighting the payment to account for specific regional, practice and patient factors. Some felt running dual financial systems (fee-for-service and bundled payment) was too difficult, therefore they suggested amending the MBS to increase flexibility or simply picking a single financial model.

Shared care planning software

Practices expressed ongoing issues with implementing and using shared care planning software. A key issue was that the software was separate from their practice clinical management software, and this created additional work learning how to use new software and duplicating data in the new system. Another issue was the limited functions of the systems to support key patient activities, such as monitoring physiological measures or symptoms, or setting and tracking goals.

To achieve functionality that was not available in the shared care planning software, or to avoid using the tool altogether due to integration and duplication issues, some practices reported using other tools to achieve the goal of sharing information (e.g. cloud-based shared directory). Practices also reported ongoing problems communicating with external providers about shared patients through the software. This problem was exacerbated by the fact that many providers use different software (see lesson #23 – **when promoting shared care planning, consider how solutions will be taken up by health care providers across a region**).

The PHNs commented that helping practices implement shared care planning software had consumed a lot of their efforts, and they felt the software was not sufficiently mature for what practices and patients need.

Community pharmacy trial

Community pharmacists have not been widely used under the community pharmacy trial. Although 652 pharmacies registered to participate in the trial up to 30 June 2020, only 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). Patients were being referred from 34 HCH practices out of the 120 participating (28%). Community pharmacists thought 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 instances, 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.

Conclusions

This report reflects the **early to mid-point experiences** of practices participating in HCH and their staff, patients, carers and PHNs. The findings in this report build on those documented in the *Interim evaluation report 2019*. This report expands on the implementation of HCH in ACCHS in the NT, and on the implementation of the community pharmacy component of the trial.

### Lessons from the Interim evaluation report 2019 strengthened from the findings in this report

The findings documented in this report strengthen some of the lessons arising from the *Interim evaluation report 2019* and draw out new lessons. The full list of lessons is in the attachment. Below we summarise the findings from the current round of evaluation activities that strengthen specific lessons identified in the *Interim evaluation report 2019* (note that we have retained the numbering of the lessons from the 2019 report), and following this we describe the new lessons.

*1. For complex programs such as HCH, allow sufficient time for implementation.*

In late 2018, the Australian Government extended both the period for enrolling patients (from the end of 2018 until 30 June 2019), and the length of the HCH trial (from mid-2019 to mid-2021). This allowed practices further time to enrol patients and a longer implementation time. However, a finding in this report is that patient enrolment was all-absorbing and left practices with little time to work on their model of care. Many started to focus on their model only after enrolment had finished. This means practices had not made as much progress as they had intended by the end of 2019, and with the end date of the trial coming up, they may instead focus on wrapping up the program with their patients and staff (which will inevitably take time) rather than working further on team care and other initiatives they started. The COVID-19 pandemic may have further stalled progress or may have stimulated innovation. Either way, time is needed to assess how practices responded to the pandemic and what effects this has had on HCH. Overall, **further time is needed for practices to continue with changes they have started to make, and for outcome data to be available before a decision about the future of the program is made**.

The community pharmacy trial started in August 2018, and as of 30 June 2020 had limited uptake (only 71 community pharmacies had undertaken a consultation with at least one patient, although 652 pharmacies had registered to participate). Additional time will allow for further uptake, and a sufficient follow-up period for patient outcomes to be properly assessed.

**It is recommended that the HCH trial is extended for another 12 months**.

*2. For programs such as HCH, allow time for practices to prepare for practice change prior to enrolling patients.*

As mentioned above, we found many practices turned their efforts to practice transformation once the enrolment period was over. Some were so absorbed in enrolling patients that they were lost as to what to do once enrolment finished. This reiterates the need to make time for practices to build a shared understanding and commitment to the goals of HCH, identify key components and how they interact, as well as implement their model, prior to enrolling patients. This lesson is reiterated for any further rollout of HCH beyond the trial sites.

*9. Create more opportunities for peer-to-peer engagement of clinicians involved in implementation.*

The HCH forum of November 2019 hosted by the Department of Health inspired those that attended. Many practices commented that they would have enrolled more patients if the event were held prior to enrolment closing. The event allowed participants to hear from peers about what they were doing, and to formally and informally discuss their concerns and barriers to implementation. In addition, GPs commented on the importance of learning from their peers, and the need to be a part of something outside of their own practice. In some instances, PHNs were successful in creating the ‘collegiate feel’ that GPs were after through their communities of practice. Others did not either due to being less prepared/skilled as a team or not having enough practices participating for these types of initiatives to be effective.

*3. Exploit multiple avenues to build patient awareness of programs such as HCH, including the benefits*

AND

*11. Use multiple avenues to communicate messages [about HCH] to patients, their families and carers, and the broader community.*

Many patients interviewed were not aware of how HCH was different to usual care at their practice. Practices did not always have the time and sometimes the skills or knowledge to explain the model to patients. Patients, their families, carers and the broader community, could benefit from receiving information about the program from different sources, and this would also help boost messages conveyed by practices.

The benefits of HCH for carers were highlighted in the previous report and continued as a theme in the current analysis of data. Therefore, initiatives to build awareness and communicate benefits about the program should be targeted at both patients and carers.

*13. Patients, families and carers need time to build confidence in a wider primary care team.*

Some practices still struggled to provide team care, and one of the reasons for this was patients’ expectations that they would see their GP each time they attended the practice. Where practices overcame this resistance, it was through working on this with patients. Sometimes PHNs helped with this as well. Once patients started to see team members other than their GP, they reported positive experiences about what that meant for them – greater access to care and time to discuss their health issues.

*14. External practice facilitation is valuable for practices to achieve the level of transformation needed to operate as an HCH.*

Practices were largely very positive about the support they received from their PHN practice facilitators to implement HCH, and in many instances they said they could not have done it without this support. Communities of practice and other initiatives organised by the PHNs were also very valuable to practices in their transformational journey. Where practices were critical about support, it was that they did not get enough of it, which also strengthens the case for external support.

*15. Rapport and trust between the practice facilitator and practice staff are foundations for practice facilitation.*

Rapport and trust have been recurring themes throughout the evaluation of HCH. They are important for all of the parties that interact with the model (such as between GPs and other practice clinicians, between patients and clinicians, between practices and the wider network of health care providers), including PHN practice facilitators and practice staff. For PHN practice facilitators, rapport and trust helped them get into the practices and work effectively with staff to implement the model. For practices, having trust helped them move from asking questions and seeking help with specific aspects of implementation to working jointly with the facilitator(s) to achieve the practice’s goals for transformation.

*16. A key to facilitation is assessing each practice’s readiness, culture and environment, and tailoring changes to the unique needs of the practice.*

As with the initial stages of implementing HCH, support in the post-enrolment period 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 also meant the facilitators were sometimes returning to the fundamentals of HCH, including training practice staff in the foundational elements of the model and using the risk stratification tool.

*23. In promoting shared care planning, consider how solutions will be taken up by health care providers across a region.*

Shared care planning was problematic for all involved, and a large part of this was due to the different software providers were using, requiring some providers to be across multiple software tools.

### Additional lessons

The additional findings and lessons from the analysis presented in this report are in relation to the scale of implementation of HCH, organisational resilience to maintain continuity and stability of services, program awareness, patient selection, and facilitation and support.

The *Interim evaluation report 2019* discussed the effect of practices having a small number of patients enrolled. The main issue was having separate protocols/systems for relatively few patients within the practice. When the enrolment period finished in mid-2019, practices with a small number of patients enrolled struggled to justify making or maintaining changes for a few enrolees, and they did not have the financial flexibility to hire additional staff or to appoint staff to HCH-specific roles. Overall, the bundled payment was not financially viable for them as there were not enough patients for losses on any to be compensated by gains on others. Some practices observed anecdotally that a threshold of at least 100 patients is required for the model to work in any practice. However, since HCH is not a specific model and involves initiatives suited to the practice and its patients, there might be a different threshold for different initiatives. That is, some initiatives only become viable once you reach a certain scale; others may be viable at a lower scale.

Having only a fraction of the practices’ GPs involved also creates a problem similar to having a relatively small number of patients enrolled. That is, the practice cannot effectively implement team care, and/or introduce different ways of working with patients. Practices talked about the majority of the practices’ GPs being involved for the model to work.

Scale was also an issue for PHNs. When PHNs had a larger number of practices within their region participating in HCH, they could organise community of practice and other events for practices to learn from each other and justify bringing in external speakers/experts to help their practices with transformation.

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| **Lessons –** **Scale**   1. 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. 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. |

Staff turnover affected both practices and PHNs. It affected practices’ ability to maintain the model, and patients’ ability to build relationships with team members other than their GP. In the *Interim evaluation report 2019*, GPs were concerned about delegating responsibilities to nurses who tended to turnover more often than they did.

For PHNs, turnover of staff within practices and their own organisations meant re-training/re-learning about HCH and re-establishing relationships with practices.

All programs and initiatives are affected by staff turnover that in most instances, including HCH, is not related to the program/initiative. Therefore, the lesson is about ensuring PHNs’ and practices’ preparedness to quickly respond and adapt to change and reduce ‘key person’ risks.

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| **Lessons – Organisational resilience**   1. Identify and implement strategies to prepare organisations to quickly respond and adapt to change and reduce dependency/risk associated with a key person. Strategies may include:    1. Team-based leadership.    2. Documenting desired practices/systems for new employees to take up.    3. Making available regular training for new staff that join the organisation (practice/PHN). Make the training part of induction.    4. Diversifying skills among team members so others can take on aspects of a role if someone leaves. |

In the *Interim evaluation report 2019,* we identified lessons around raising awareness of HCH among patients and communities (lesson #3) and GPs (#7). In this report, we reported on the challenges HCH practices had in working as a team with the wider network of providers within their region. Some of the issues were around the use of the shared care planning software, but they were also about the knowledge and awareness of HCH among these other providers. Therefore, an additional lesson is the need to raise awareness of HCH among the wider network of providers that work closely with primary care.

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| **Lessons – Awareness of HCH**   1. Raise awareness about HCH among health care providers that general practices work closely with (e.g. allied health providers, hospitals, community pharmacists). |

Although further analysis of patients participating in HCH is needed (compared with other similar patients in HCH practices and similar patients in non-HCH practices), there is an early indication that there are opportunities to recruit patients who are less motivated, activated and/or willing to try new things into HCH, since these patients are the most likely to have poorly controlled conditions and will derive the most benefit from HCH.

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| **Lessons – Patient selection**   1. Develop strategies to recruit patients into HCH who are less motivated, activated and/or willing to try new things, and for whom HCH may be most beneficial. |

More resilient approaches for delivering practice facilitation are also required in the further rollout of HCH. Practice facilitators require a specific set of knowledge and skills, which go beyond having experience as a primary care clinician or having worked in primary care settings. Building these skills within a local workforce is possible but challenging. 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 skill sets 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.

Attendees of the HCH forum held in November 2019 reported that 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.

A similar event held early in the implementation of the next phase of HCH would provide an efficient means to address a range of challenges that participants in HCH have consistently highlighted, not the least offering a powerful mechanisms for achieving peer-to-peer learning.

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| **Lessons – Facilitation and support**   1. In further rollout of HCH, practice facilitation provided directly to practices should be undertaken with 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. 2. 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. |

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Attachment – List of lessons from *Interim evaluation report 2019* and new lessons

**Overall implementation**

1. For complex programs such as HCH, allow sufficient time for implementation.

**Practice set-up**

1. For programs such as HCH, allow time for practices to prepare for practice change prior to enrolling patients

**Patient enrolment**

1. Exploit multiple avenues to build patient awareness of programs such as HCH, including the benefits.
2. Provide additional practical guidance to practices on how to communicate the benefits of programs such as HCH succinctly to patients and their carers/families.
3. In future, for programs such as HCH, allow sufficient time to implement processes for enrolling patients.
4. Streamline enrolment processes, whereby relevant information is recorded once and used for multiple purposes. In the HCH program this included registration with Services Australia, flagging enrolled patients within the clinical management software, risk stratification, shared care planning and evaluation.

**Changes within practices**

1. Use peer-to-peer approaches to raise awareness of initiatives such as HCH among GPs.
2. Practices to identify key people to facilitate the change process. A team comprising a GP, a nurse and a practice manager is potentially most effective. Members of this team should be trained and have protected time to plan as a team.
3. Create more opportunities for peer-to-peer engagement of clinicians involved in implementation.

**Patient experience**

1. Develop succinct messages that communicate the benefits of the initiative to the patient and address their concerns.
2. Use multiple avenues to communicate these messages to patients, their families and carers, and the broader community.
3. Develop the capacity of practices to engage with patients, families and carers in designing and implementing change.
4. Patients, families and carers need time to build confidence in a wider primary care team.

**Practice facilitation**

1. External practice facilitation is valuable for practices to achieve the level of transformation needed to operate as an HCH.
2. Rapport and trust between the practice facilitator and practice staff are foundations for practice facilitation.
3. A key to facilitation is assessing each practice’s readiness, culture and environment, and tailoring changes to the unique needs of the practice.

*New lessons from 2020 report*

35. In further rollout of HCH, practice facilitation should be provided by a mix of staff with advanced facilitation skills – located in meso or national level organisations – and staff embedded within PHNs-based teams responsible for supporting practices in quality improvement.

36. In further rollout of HCH, use a national event at the commencement of implementation to efficiently build knowledge about the model and its implementation, motivation within practices, and relationships between participating practices and practice facilitators.

**Training**

1. Shorten and sharpen training materials: identify opportunities to reduce their length, reduce repetition, make them more practical, and subset them further so that staff can focus on segments based on their level of knowledge and their role.

**Risk stratification and shared cared planning**

1. Allow time for developing and implementing new information technology.
2. Explore opportunities for better integration of functionality (e.g. risk stratification and shared care planning) within practice management software.
3. Invest in understanding how new technology will integrate into clinical processes and use these lessons to enhance tools.
4. Develop further training for clinicians in risk stratification tools, including improving their understanding of how the tools work and how they should be interpreted for consistent application.
5. Use quantitative and qualitative findings from the HCH evaluation to improve the current RST.
6. In promoting shared care planning, consider how solutions will be taken up by health care providers across a region.

**The bundled payment**

1. Guidance and tools to help with practical implementation of payment reform among practices with different revenue sharing schemes for their GPs are necessary.
2. The information required to manage a bundled payment within a practice should be captured in the practice management software.

**Practice recruitment**

1. For programs such as HCH, allow time and invest in developing and communicating information about the program during the EOI process or equivalent. This should include providing information sessions about the program for interested practices.
2. Make greater use of PHNs in any assessment process involving primary care practices.
3. In assessing applications, ensure there is evidence that GPs within the practice have been adequately informed about the program and a sufficient number support its implementation.
4. In funding agreements, set out clear expectations for practices and their staff in working with external facilitators.
5. Ensure funding contributions meet the costs of participation.

**Scale**

1. 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. 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 commitment to achieve a threshold proportion of GPs that are willing to participate in the initiative.

**Organisational resilience**

1. Identify and implement strategies to prepare organisations to quickly respond and adapt to change and reduce dependency/risks associated with a key person. Strategies may include:
   1. Team-based leadership.
   2. Documenting desired practices/systems for new employees to take up.
   3. Making available regular training for new staff that join the organisation (practice/PHN). Make the training part of induction.
   4. Diversifying skills among team members so others can take on aspects of a role if someone leaves.

**Awareness of HCH**

1. Raise awareness about HCH among health care providers that general practice works closely with (e.g. allied health providers, hospitals, community pharmacists).

**Patient selection**

1. Develop strategies to recruit patients into HCH who are less motivated, activated and/or willing to try new things, and for whom HCH may be most beneficial.

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. [↑](#footnote-ref-2)
2. 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 Attachment for the cumulative list of lessons from both evaluation reports. [↑](#footnote-ref-3)
3. n=62 (58%) and n=21 (20%) respectively, totalling n=83 (78%) of total withdrawn practices. [↑](#footnote-ref-4)
4. This list is ordered by the initiative that practices were most commonly working on. [↑](#footnote-ref-5)
5. This list is ordered by the most common initiative implemented/making progress on [↑](#footnote-ref-6)
6. Note that this was prior to the telehealth items introduced as part of the COVID-19 response. [↑](#footnote-ref-7)