Australian Government
Department of Health

Information Brief
MB18-000628
Date sent to MO:13/02/18

To: Minister Hunt

Subject: HEALTH CARE HOMES IMPACT ON SMALL GP PRACTICES

Minister Hunt …… **Date:** /			
Comments:			
Contact Officer:	*Janet Quigley*	*Assistant Secretary, Primary Care, Dental and Palliative Care Branch*	Ph: (02) 6289 5323 s22(1)(a)(ii)
Clearance Officer:	*Natasha Cole*	*First Assistant Secretary, Primary Care and Mental Health Division*	Ph: (02) 6289 5372 s22(1)(a)(ii)

Key Issues:

1. Dr Deery has previously met with Senator Seselja to raise concerns about the corporatisation of general practice in Canberra.

2. Dr Deery has suggested that the stage one trial of Health Care Homes will have an impact on small private general practices due to the changed payment arrangements for enrolled patients from fee-for-service to bundled payments to the practice. He is concerned that this will change the relationship between GPs and practices from contractors to permanent employees, resulting in liabilities such as payroll tax and leave entitlements.

3. During the Health Care Home implementation and design phase, the Department of Health sought advice from KPMG and the Australian Taxation Office (ATO) on the matter of the employee/employer relationship.

4. Consistent advice was provided from both KPMG and the ATO that the Health Care Home model in and of itself does not create an employer/employee relationship under tax or superannuation guarantee legislation. Accordingly, adopting the Health Care Home model will not change the existing relationship that a health practitioner has with the medical practice. This advice is available on the department's website.

5. The ATO advice goes further to note that there are a range of factors under common law relevant to determining whether an employment relationship exists and that no particular factor is determinative, rather the totality of the arrangement between the parties must be considered.

6. Accordingly, participating practices in the stage one trial of Health Care Homes have been encouraged to seek their own advice specific to their individual circumstances.

Key Stakeholder Engagement:
Dr Deery is Chair of the the Australian GP Alliance, which was established to work alongside the Australian Medical Association and Royal Australian College of General Practitioners as an independent voice to represent GPs who believe ownership of practices by GPs best aligns business objectives with patient outcomes. The Alliance claims to differentiate from large corporates by 'not needing to achieve short term financial goals to sustain share prices and not seeking to dominate the industry with market share.'

Sensitivities:
As Chair of the Australian GP Alliance, Dr Deery has previously raised concerns through the media about the Medicare Rebate freeze and pathology rental.

In a Sydney Morning Hearald article of 6 November 2016, Dr Deery criticised the proposal to regulate pathology rental claiming, that it would allow large corporate entities such as Sonic Healthcare and Primary Health Care Limited to further influence general practice.

Attachments:

Attachment A	Key discussion points
Attachment B	Biographical details – Dr John Deery

Attachment A

Key discussion points and background

Discussion points:

- The Health Care Home trial will evaluate a possible model of health care for patients with chronic and complex conditions, supported by innovative technology and new payment approaches.

- The model is testing a possible payment arrangement to increase flexibility in the system to enable GPs and practices greater scope to treat patients with chronic and complex conditions.

- In response to concerns raised on the impact of the bundled payment, the department sought advice from KPMG consulting and the ATO.

- The advice received was clear in that the Health Care Home model by and of itself does not create an employer/employee relationship under tax or superannuation guarantee legislation. Accordingly, adopting the Health Care Home model will not change the existing relationship that a health practitioner has with the medical practice. This advice is available on the department's website.

- Individual circumstances will vary from practice to practice however; and these must be considered in totality when determining whether an employee/employer relationship exists between practitioner and practice. Accordingly Health Care Home participants have been encouraged to seek their own advice, specific to their circumstances.

- The vast majority of Health Care Home participants (134 of 180) are privately owned, Aboriginal Community Controlled or small business investors.

- The evaluation of the Health Care Home trial will examine the effect of the model on quality of care, patient and provider experience, practice behaviour, service usage and cost impacts. It will explore how the model works in various situations and settings and look at what works best for different patients, practice types and in different communities with varied demographics.

Background:
The Health Care Home model was developed following the consultations of the Primary Health Care Advisory Group with patients, carers, doctors, allied health professionals and health system organisations.

Up to 200 general practices and Aboriginal Community Controlled Health Services (ACCHS) will give up to 65,000 Australians with chronic and complex conditions better coordinated care.

Health Care Homes commenced on 2 October 2017 with a second phase commencing on 1 December 2017. Additional practices are expected to come on line and the current number of participants is 180.

Biographies

Dr John Deery graduated from UNSW in 2000. He is the business owner of YourGP@Crace and YourGP@Lyneham in Canberra and Chair of the Australian GP Alliance.

Dr Deery practices in all areas of general practice with special interests in sports medicine, paediatrics, men's health and minor surgery.

Australian Government
Department of Health

Information Brief
MB18-001520
Date sent to MO: 20/04/2018 via email

To: Minister Hunt

Subject: s47C **HEALTH CARE HOME RISK STRATIFICATION TOOL**

Minister Hunt …… **Date:** / /			
Comments:			
Contact Officer:	*Janet Quigley*	*Assistant Secretary, Primary Care, Dental and Palliative Care Branch, Primary Care and Mental Health Division*	Ph: (02) 6289 5372 s22(1)(a)(ii)
Clearance Officer:	*Natasha Cole*	*First Assistant Secretary, Primary Care and Mental Health Division*	Ph: (02) 6289 5323 s22(1)(a)(ii)

Key Issues:
s47C

Background:
The RST is used by Health Care Homes to determine patients' eligibility based on the PRM or clinicians' judgement if they override the PRM. The RST then prompts assessment of patient complexity using the Hospital Admission Risk Program (HARP) questionnaire developed in Victoria, and produces an electronic record of the assessment outcome.

The RST software was developed in 5 months by Precedence Health Care and the PRM developed by the CSIRO.

The PRM determines patients' risk of potentially preventable and unplanned hospitalisations using more than 50 variables recorded in patients' medical records, including: demographics; diagnoses; medical observations; medications and lifestyle factors.

s47C

Ministerial Submission – Standard
MS17-002927 Version (4)
Date sent to MO: 25/4/18

To: **Minister Hunt**

Subject: **HEALTH CARE HOMES - COMMUNITY PHARMACY COMPONENT**

Critical date:

s47C

Signature …..…….. **Date:** / /

Comments:

Contact Officer:	*Julianne Quaine*	*Assistant Secretary, Private Health insurance and Pharmacy Branch, Technology Assessment and Access Division*	Ph: (02) 6289 8372 s22(1)(a)(ii)
Clearance Officer:	*Mark Cormack*	*Deputy Secretary, Health Financing Group*	Ph: (02) 6289 3348 s22(1)(a)(ii)

s47C

s47 or s47G - & s47C

s47 or s47G - & s47C

9. Bundled services include:
   - an initial medication reconciliation and development of a collaborative Medication Management Plan (MMP) in consultation with the patient and HCH s47C
     s47C
   - regular follow-up reviews, in consultation with the patient and HCH, to monitor achievement of medication goals s47C
     All patient tiers will receive three follow up reviews over the 18 month trial period remaining;
   - a 'supporting services' flexible category for Tier 2 s47C and Tier 3 patients s47C where pharmacists may deliver from a range of medication adherence and management services as agreed in the patient's MMP. The flexible category offers the ability to individualise services based on individual patient need. Services may include:
     - Dose administration Aid service;
     - blood glucose monitoring;
     - blood pressure monitoring; and
     - developing asthma management plans.

s47 or s47G - & s47C

s47C

Background:

Pharmacists, allied health professionals and specialists will play a key role in the success of the HCH trial and will be important members of the care team.

The HCH trial aims to reach up to 65,000 Australians living with multiple chronic and complex conditions who will benefit from coordinated medication management services. The first 22 HCHs began enrolling patients and delivering services on 2 October 2017, with the remaining practices starting to offer HCH services on 1 December 2017. The stage one trial is due to conclude 30 November 2019.

The HCH model promotes a team based approach to care, with stage one focussing on GP services. The inclusion of allied health and specialist care was to be explored in future stages and there is significant interest from the allied health sector in defining their contribution to the HCH model.

Attachments:

s47 or s47G - & s47C

B: Comparison of the roles to be performed by the HCH and Community Pharmacy.

s47 or s47G - & s47C

D: Department's proposal for incorporating medication management within the HCH trial.

Financial Implications: There are no new financial implications associated with this Ministerial Submission. Funding for the $30 million pharmacy component of the HCH trial is available under the 6CPA through the pharmacy programs allocations. s47C

s47C

Relevance to Election Commitments / Budget Measures: In May 2017, you signed a compact with the Guild (Strengthening PBS – Agreement with Pharmacy Guild to vary the Sixth Community Pharmacy Agreement). This included an investment of $600 million for new and expanded community pharmacy programs. The compact between the Guild and the Government specifies the intent to allocate $30 million of 6CPA funding to incorporate medication management programs within HCH.

s47C

Consultations: The Department is working closely with your office, the Guild and the PSA to develop the requirements to support inclusion of medication management services in the HCH trial. A portion of the $30 million (up to $1.1 million) is to be made available for the Guild and the PSA to jointly develop and lead education and training for the HCH multi-disciplinary team, including a workshop series at each of the Primary Health Networks. The PSA is also developing best practice guidance and online education modules to support pharmacists' delivery of these services. Education and training will leverage off existing materials developed for the HCH trial.

Primary Care and Mental Health Division was consulted in the preparation of this Submission.

Health Care Homes Community Pharmacy Component
Comparison of the role of the Community Pharmacy*and Health Care Home

s47C

Attachment B

Services to be performed by Community Pharmacist	Services to be performed by the Health Care Home
• Collaboratively develop a Medication Management Plan (MMP) and collect baseline data on patient health outcomes. The MMP, where clinically relevant, should form a part of the patient's shared care plan and My Health Record. • Participate in case conferencing (for relevant patients). • Deliver medication management services identified in the MMP (for example Home Medicines Review; and blood pressure and/or blood glucose monitoring).	HCH bundled services include: • Development of a shared care plan with the patient, to be implemented by a team of health care providers. This plan will: o identify the local providers best able to meet each patient's needs; o coordinate care with these providers; o include strategies to help each patient manage their conditions and improve their quality of life; and o where relevant, should include a plan to manage a patient's medication needs, working with the patient's pharmacy, enabling the provision for necessary medication support. • Conducting regular reviews. • Ensuring that the patient is registered and connected to the My Health Record systems and that up-to-date clinically relevant information is contributed to their My Health Record. • Conducting comprehensive health assessment. • Making referrals to allied health providers or specialists. • Case conferencing. • Tele-health services and monitoring. • Standard consultations related to an enrolled patient's chronic and complex conditions. • After-hours advice and care (where services are provided in practice rooms and relate to a patient's chronic conditions. After-hours services provided outside the service rooms are funded through the MBS).
• Conduct regular reviews in consultation with the patient/carer and HCH. Collaboratively report on achievement of medication goals against the MMP, as well as patient health outcomes. o Tier 3 patients must be reviewed three times annually o Tier 2 patients must be reviewed twice annually o Tier 1 patients must be reviewed annually • Participate in HCH team care meetings and case conferences (for relevant patients) to evaluate patient progress.	• The shared care plan (incorporating the MMP) should be reviewed as regularly as is clinically required. At a minimum shared care plans for: o Tier 3 patients must be reviewed three times annually o Tier 2 patients must be reviewed twice annually o Tier 1 patients must be reviewed annually • Lead and participate in HCH team care meetings and case conferences to evaluate patient progress.
• Participate in team care activities e.g. education and networking.	• Participate in team care activities e.g. education and networking.

s47C

alth

Health Care Homes Trial
Pharmacy Component

Role of Community Pharmacy

- Patient's usual Community Pharmacy and General Practice/Health Care Home (HCH) team, together with the patient and carer, collaboratively develop the patient's Medication Management Plan and collect baseline data on patient health outcomes. The Medication Management Plan, where clinically relevant, should form a part of the patient's Shared Care Plan and My Health Record (the Shared Care Plan is developed by the HCH with the patient).
- Community Pharmacy and General Practice/HCH team participate in the delivery of the Medication Management Plan to ensure that goals are delivered and support patients in change management/lifestyle approaches.
- Community Pharmacy delivers medication management services identified in the Medication Management Plan.
- Community Pharmacy conducts regular follow-up reviews in consultation with the patient/carer and General Practice/HCH. Collaboratively report on achievement of medication goals against the Medication Management Plan, as well as patient health outcomes (quality of life). The number of reviews will be dependent on the patient's level of complexity and need. Review observations must be reported to the patient, carer and the General Practice/HCH through the patient's Shared Care Plan and My Health Record.
- Community Pharmacy participates in HCH team care meetings and case conferences (for relevant patients).
- Community Pharmacy participates in other team care activities for example, education and networking.
- Community pharmacies should collaborate with Primary Health Networks. It is recognised that some practices may be already engaging with pharmacists and Community Pharmacy; and the pharmacy component of the HCH trial needs to support and align with existing activities.
- Community Pharmacy collects health outcome data on all eligible HCH patients with a Medication Management Plan at the initial (baseline) and follow-up review point(s) and through relevant Community Pharmacy medication management services and medication adherence services.

Education

- The Pharmacy Guild of Australia (the Guild), the Pharmaceutical Society of Australia (PSA) and Department of Health will work together to coordinate orientation and information sessions for Community Pharmacists participating in the trial. This will be supplemented by factsheets and guidelines providing information about the HCH concept and how Community Pharmacy can work effectively with the HCH/General Practice to develop a team-based approach to primary health care.
- The Guild and PSA will work jointly (similar to the model used to roll out codeine training) to develop and lead education and training processes; and deliver education sessions to HCH doctors, health professionals and practice staff on site, including:
    - Quality use of medicines (including overprescribing and de-prescribing)

- Local themes (for example, opioid abuse) including new evidence, guidelines and therapies etc.

- Primary Health Networks will also play an important role in providing ongoing support to members of the HCH team, including Community Pharmacy.

Eligible patients

- Tier three enrolled HCH patients, who require a Medication Management Plan, as part of their Shared Care Plan. It is noted that some of these patients may need to be supported via palliative care services.
- Tier two enrolled HCH patients, who require a Medication Management Plan, as part of their Shared Care Plan.
- Tier one enrolled HCH patients, who require a Medication Management Plan, as part of their Shared Care Plan.
- Priority should be given to patients in tiers 3 and 2, as these patients have the greatest clinical need. It is acknowledged that the patient cohort within each HCH will be different.
- The pharmacy programs' patient eligibility criteria will be applied to the relevant services provided under a patient's Medication Management Plan.

Services for patient

- In partnership with the patient/carer and HCH care team, an initial reconciliation of the patient's medications and establishment of the Medication Management Plan.
- Activities and services to be provided, in accordance with the Medication Management Plan (for example, Dose Administration Aid; blood pressure and/or blood glucose monitoring).
- Medication Management Plan to be reviewed (and progress reported) at regular intervals. This may align with the delivery of medication management services that have been identified in the Medication Management Plan.
- Deliver medication management services identified in the Medication Management Plan, such as demonstrating use of asthma devices and developing asthma management plans, blood glucose and blood pressure monitoring (these services will be delivered in agreement with the patient and their GP/HCH and may coincide with the regular medication management plan reviews).
- Community Pharmacy may choose to offer additional services/support for patients, such as technology-assisted prescription reminders or home deliveries.

Health Care Homes Trial
Pharmacy Component

Funding

- Regular payments will be made to the Community Pharmacy of the patient's choice on a retrospective basis following the development of the collaborative Medication Management Plan (and submission of health outcomes data) and each follow-up review (and submission of health outcomes data).
- Payments will be allocated and capped on a per patient basis. There are three levels of payment. The amount paid is linked to each eligible patient's level of complexity and need, with the highest amount paid for the most complex and high-need patients.
- Funds to be allocated to the Community Pharmacy of the patient's choice, for duration of patient enrolment in HCH trial.
- A portion of the $30.0 million to be made available for the joint development and delivery of education sessions by the Guild and PSA (including new evidence, guidelines and therapies) to HCH doctors, health professionals and practice staff.
- Funding will be made available from under the Pharmacy Programs.

s47C

Background
Under the Sixth Community Pharmacy Agreement (6CPA), the Australian Government is supporting new and expanded pharmacy programs including through providing $30.0 million for incorporating medication management programs within HCH.

Medication Management Programs are provided under the 6CPA to support quality use of medicine services that are designed to reduce adverse medicine events and associated hospital admissions or medical presentations. These services are: MedsCheck/Diabetes MedsCheck; Home Medicines Review. (While the Residential Medication Management Review is a service available under the suite of Medication Management Programs, it is out of scope for the HCH trial).

The Government agreed in the Compact (Strengthening PBS – Agreement with Pharmacy Guild to vary the Sixth Community Pharmacy Agreement) that it would advise participating HCHs that the shared care plans for HCH patients should include a plan to manage their medication needs, where clinically relevant, working with the patient's pharmacy, enabling the provision of necessary medication support. This has

been incorporated into the HCH Handbook for General Practices and Aboriginal Community Controlled Health Services.

The Guild agreed that it would work with its member pharmacies in HCH trial areas to build awareness of the trials and facilitate their engagement and collaboration with HCH participating in the trials.

Health Care Homes

The HCH will develop a shared care plan with the patient, which will be implemented by a team of health care providers. This plan will:

- identify the local providers best able to meet each patient's needs (for example, the patient's regular Community Pharmacy)
- coordinate care with these providers
- include strategies to help each patient manage their conditions and improve their quality of life.

Based on current population data, it is anticipated that, of patients participating in the stage one trial, approximately 9 per cent will be tier three (approx. 5,850 patients); 45 per cent will be tier two (approx. 29,250 patients); and 46 per cent will be tier one (approx. 29,900 patients).

Tier three: patients with chronic and complex needs, requiring a high-level of clinical coordinated care. It is anticipated that 20 per cent of these patients will require palliative care. Tier two: patients with multi-morbidity and moderate needs, requiring clinical and non-clinical coordination, as well as supported self-care. Tier one: patients with multiple chronic conditions, largely self-managing.

Australian Government
Department of Health

Meeting Brief
MB18-002317 Version (1)
Date sent to MO: 29/05/18

To: Minister Hunt

Subject: MEETING WITH DR WALID JAMMAL

Minister Hunt …..…… **Date:** / /

Comments:

Contact Officer:	*Janet Quigley*	*Assistant Secretary, Primary Care, Dental and Palliative Care Branch*	Ph: (02) 62895323 Mobile: s22(1)(a)(ii)
Clearance Officer:	*Natasha Cole*	*First Assistant Secretary, Primary Care and Mental Health Division*	Ph: (02) 62895372 Mobile: s22(1)(a)(ii)

Date / Time: Wednesday 30 May 2018, 17.30 – 18.00.

Location: Parliament House, Canberra.

Purpose: To discuss primary care and general practice.

Key Attendees: Dr Walid Jammal, GP and owner of Hills Family General Practice in Bella Vista, Sydney.

Key Issues:

1. Dr Jammal has over 20 years of experience as a general practitioner and was named RACGP NSW/ACT GP of the year in 2017. He is a current board member of the Western Sydney Primary Health Network and lectures at the University of Sydney's Western Clinical School and Western Sydney University.
2. Dr Jammal has a strong interest in health policy and serves as a member of the evaluation subcommittee of the Medicare Services Advisory Committee.
3. Dr Jammal is a strong supporter of coordinated, patient centred and team based care. His practice is involved in the New South Wales Integrated Care Demonstrator project and the stage one trial of Health Care Homes.
4. Hills Family General Practice commenced in the October phase of the Health Care Home trial s47

Key Stakeholder Engagement: The Western Sydney Primary Health Network nominated Dr Jammal as clinical champion for the Health Care Home trial. In this role Dr Jammal will discuss his approach and experience in Health Care Homes at conferences and participate in outreach and communication activity.

Dr Jammal is a member of the Guidelines, Education and Training (GET) Working Group established to support the deliberations of the Health Care Home Implementation Advisory Group. The GET Working Group assisted the department with the review and refinement of the Health Care Home online training and education modules, which were developed under contract by Australian General Practice Accreditation Limited. Dr Jammal played a key role in reviewing and providing advice on these resources.

Dr Jammal has also attended a number of Health Care Home Community of Practice events hosted by other Primary Health Networks in which the trial is operating. Dr Jammal attends as a speaker to discuss his experience and approach to implementation and operation of the model.

Attachments:

Attachment A	Key discussion points
Attachment B	Biography

Key discussion points and background

- Acknowledge Dr Jammal's involvement in the work of the Medicare Services Advisory Committee Evaluation Subcommittee.

- Ask Dr Jammal about his experience in coordinated, patient centred team based care, particularly as part of the NSW Integrated Care Demonstrator project and Health Care Home trial.

- Note the importance of primary care in a strong and efficient health system and seek Dr Jammal's views on primary care integration.

Background:

Medical Services Advisory Committee
The Medical Services Advisory Committee (MSAC) is a non-statutory committee established by the Australian Government Minister for Health in 1998. MSAC appraises new medical services proposed for public funding, and provides advice to Government on whether a new medical service should be publicly funded based on an assessment of its comparative safety, effectiveness, cost-effectiveness and total cost, using the best available evidence.

The Evaluation Sub-committee is a standing sub-committee of MSAC that considers the clinical evidence and economic assessment presented in an assessment report in detail, provides advice on the quality, validity and relevance of the assessment, and identifies issues for MSAC to consider, for example where evidence may be weak.

Health Care Homes
The Health Care Home model was developed following the consultations of the Primary Health Care Advisory Group with patients, carers, doctors, allied health professionals and health system organisations.

The stage one trial of Health Care Homes commenced on 2 October 2017 and will cease on 30 November 2019. The suitability of the model for patients and practitioners will be tested and validated though the stage one trial. The outcomes will form the basis of an interim evaluation report that will be provided to Government in early 2019 and a final report expected in June 2020.

NSW Integrated Care Demonstrator Projects
Three NSW Local Health District Demonstrators are testing models of integrated care. The sites are working in partnership with Primary Health Networks and other health agencies in the primary care, not-for-profit and private sectors to develop and progress approaches to integrated care to address the coordination and provision of services for patients in full understanding of local factors. Each site has taken a different approach to integrating care which will be considered as part of the evaluation and inform potential future state-wide implementation.

Biography[1]

Dr Walid Jammal, M.B.B.S (Syd) F.R.A.C.G.P; Dip of Child Health; Mast Health Law

Dr Jammal started Hills Family General Practice in 2001, and has 20 years experience in general practice. His special interests include paediatrics, men's health, and health law. He has a passionate commitment to quality, continuous improvement, evidence based general practice, and health care policy.

He has been appointed as Clinical Lecturer at the University of Sydney's Western Clinical School, and Conjoint Senior Lecturer at the Western Sydney University. He is also a member of the evaluation subcommittee of Medicare Services Advisory Committee in Canberra, which assesses the effectiveness, safety and cost effectiveness of Medicare funded services and technology.

He has also been involved in various therapeutic guideline reviews. He has completed his Masters of Health Law at the University of Sydney

Dr Jammal was award 2017 NSW/ACT RACGP GP of the year.

[1] Hills Family General Practice Website

QB18-050

Date QTB Fact Brief created: 23 January 2018
Last Updated by Department: 26 June 2018
Last Updated by Adviser: 7 May 2018

HEALTH CARE HOMES - IMPLEMENTATION

BUDGET

Over $110 million has been provided for the implementation of Health Care Homes from 2016-17 to 2019-20. This includes $21.3[1] million announced in the 2016-17 Budget and $93[2] million that is being redirected from the MBS.

	2016-17 ($m)	2017-18 ($m)	2018-19 ($m)	2019-20 ($m)	TOTAL ($m)
Funding	7.8	21.6	60.8	25.5	115.7
Source	Internal Budget Documentation figures as at 2017-2018 MYEFO				

KEY POINTS

- The stage one trial of Health Care Homes (HCH) commenced on 2 October 2017 and will cease on 30 November 2019. The trial has capacity for up to 200 sites to provide services to up to 65,000[3] patients across ten geographical regions including regional and remote communities and Aboriginal Community Controlled Services.
- Eligible patients are now voluntarily enrolling. As a HCH, their medical practice has become a 'home base' for the ongoing coordination, management and support of their conditions. As at 20 June 2018, 175[4] practices are participating and 2,255 patients are enrolled across 102 practices[5].
- A significant amount of work has been done by practices to transition work processes and systems; complete staff education and training; and identify eligible patients that are likely to benefit from the Health Care Home model.
- While patient enrolment numbers are lower than anticipated, the independent evaluators (Health Policy Analysis) have indicated that between 4,000-6,000 patients will be sufficient to adequately evaluate the trial, which is expected to be achieved.
- The department is working closely with PHNs and Health Care Home practices to provide supporting information and resources to help increase patient enrolment.

[1] Budget 2016-17, Budget Paper No. 2, Part 2: Expense Measures, p.105
[2] Budget 2016-17, Budget Replated Paper No. 1.10, Outcome 4: Individual Health Benefits, p. 25
[3] Department of Health – Health Care Homes for Health Professionals
[4] Internal Departmental Statistics held by program area
[5] Department of Human Services Report submitted to program area on 30 May 2018

- The suitability of the model for patients and practitioners will be tested and validated though the stage one trial. The outcomes will form the basis of an interim evaluation report that will be provided to Government in early 2019 and a final report expected in June 2020.
- Health Care Homes is the first stage in the Government's focus on improving the quality of care and health outcomes for patients.
- Minister Hunt has been working closely with the AMA, the RACGP and the MBS review taskforce, to examine how we can improve the care that GP's provide and keep people healthier and out of hospital.
- The Minister raised this as a key issue when he addressed the AMA conference last week (25 May 2018) and reiterated the importance of Health Care Homes as the first phase of this work.
- The Government is working closely with the medical profession which also sees this as a priority, particularly with an ageing population and the increasing incidence of chronic disease.
- Health Care Homes is one model and lessons are being learnt.

FACTS & FIGURES

HEALTH CARE HOME PAYMENTS

- Health Care Home practices receive a $10,000 incentive grant to support their participation.[6]
- There will be three levels of payment via a bundled monthly payment linked to each eligible patient's level of complexity and need, with the highest amount paid for the most complex and high-need patients. Payments values are:
  - Tier 3 – $1,795 per annum (highest complexity)
  - Tier 2 – $1,267 per annum
  - Tier 1 – $591 per annum (lowest complexity)[7]
- Based on current modelling, the funding represents an approximately 10 per cent increase[8] for practices. These values were reviewed by a payments working group and have also been tested against individual clinician data outside of HCH selected regions.

[6] Department of Health, Health Care Homes, Factsheet: Payment Information
[7] Department of Health, Health Care Homes, Factsheet: Payment Information
[8] Internal Modelling not publicly available

- Enrolled patients can still access fee-for-service billing for care not related to a patient's chronic conditions. The number of items will not be restricted (but expected to be small) and will be monitored as part of the trial.
- For each enrolled patient, a shared care plan is created and regular reviews undertaken. The remaining care arrangements are a matter for each practice.
- Funding for services provided by allied health professionals, other specialists, pathology and diagnostic imaging services outside the HCH are not included in the bundled payment and will continue to be funded through the MBS.
- Following consultations with the Aboriginal and Torres Strait Islander health sector, MBS Item 715 has been removed from the bundled payment and can continue to be claimed separately.

OUR COMMITMENTS

LABOR'S RECORD (remove if not required, to be filled in MO)

IF ASKED

PRACTICE ENROLMENT

- Participating medical practices include a range of sizes and ownership models, including GP owned, community controlled and corporates.
- A small number of practices have recently expressed interest in joining the trial and the final number and makeup will be confirmed once completed.
- A number of practices have not proceeded to join the program following an initial expression of interest in the program.
- Reasons for this have been varied and include, for example, changes in staffing, business direction and ownership at the practice level.
- An Australian Doctor article published on 18 August 2017 questioned the negotiation of a "special" contract for IPN. This is incorrect. The agreement with IPN reflects their business models and all other requirements remain.

Date QTB Fact Brief created: 23 January 2018
Last Updated by Department: 26 June 2018
Last Updated by Adviser: 7 May 2018

PRACTICE INCENTIVES PROGRAMS

- The Department of Human Services' (DHS) calculation arrangements for a number of entitlement programs rely, in part, on service volume not calculated through the bundled payment arrangement.
- These programs include: Practice Incentives Program (PIP) payments; General Practice Rural Incentive Program (GPRIP) payments; Practice Nurse Incentive Program (PNIP) payments; and Service Incentive Payments (SIPs).
- The department is working with DHS to implement an agreed mechanism to ensure practices participating in the stage one trial are not materially disadvantaged, with regards to incentive payments.

RISK STRATIFICATION AND PATIENT IDENTIFICATION

- An Australian Doctor article (18 August 2017) questioned the use of risk stratification approaches linked to payment models and incorrectly claimed that clinicians are excluded from the process prior to patient enrolment.
- This risk stratification tool is a software product that integrates with GP's clinical record systems.
- It comprises two-steps; a predictive risk model to determine patients' risk of unplanned hospitalisation over 12-months, followed by assessment with a clinician using a Hospital Admission Risk Program (HARP) questionnaire.
- Patients will provide consent for this process.
- Precedence Health Care, developers of cdmNet software for chronic disease management have developed the risk stratification tool in consortia with the CSIRO.

CONSUMER RESEARCH

- An article in The Australian (22/11/17) by Sean Parnell, citing HCH consumer research commissioned by the Department and obtained under an FOI request, states that "Health Care Homes, has suffered from a lack of awareness and support among consumers."
- It goes on to say that the report "found "not one person offered an accurate definition" of Health Care Homes and many had questions even after it was explained to them. "The name 'Health Care Home' does not work," the research concluded."

- The Department engaged ORC International in May 2017 to conduct exploratory research with patients and carers who were likely to be eligible for enrolment in the HCH initiative through their GPs.
- The purpose of this exploratory research was to test consumer reactions before finalising information and training material to ensure their effectiveness at responding to the target market.
- The results of the research were generally positive and suggestions have been largely included in the information materials.
- GPs and other primary care clinicians taking part in the trial are best placed to explain the Health Care Home model and how their practice will support and engage the patient in the management of their health, to deliver better health outcomes.
- Participation in Health Care Homes will be driven by GPs who can explain the benefits for the individual patient and their carers and family in much more detail than a general focus group process allows.

PAYROLL TAX

- Some concerns have been raised in relation to the implications of the Health Care Home bundled payment model for participating practices in relation to their exposure to employment tax obligations (i.e. PAYG Withholding, payroll tax, superannuation or worker's compensation).
- Advice has been received from the ATO and KPMG that participation in the HCH program by a medical practice, and/or distribution of HCH funds by a medical practice to healthcare workers and contractors, will not in and of itself, alter existing employer / employee or contractor arrangements for employment tax purposes.
- Practices must consider potential arrangements that are appropriate for their business circumstances and should seek their own independent advice.
- The Department will continue to work with practices to support an effective trial.

MEDICARE SAFETY NET

- Under the Health Care Homes stage one trial, while bulk billing rates are expected to remain high, practices may choose to charge patients an out-of-pocket amount for some services.

- A new MBS item, with a rebate of $1, has been established that, when claimed, will record an attendance for which a patient incurs an out-of-pocket expense.
- This new item will ensure that these out-of-pocket expenses will contribute to the patient's Medicare Safety Net threshold(s)[9].

RACGP TRIAL

- The Government's compact with the Royal Australian College of General Practitioners includes $5million to support its' Quality in General Practice Trial.[10] The trial, which will run over 18 months, will investigate strategies to support practices to provide continuity of care for patients across the health system.

BACKGROUND

- The Primary Health Care Advisory Group was established in 2015 to develop options to improve care and health outcomes for people with complex and chronic conditions. These groups include a range of experts from across the primary health care sector, including experts from AMA and RACGP.
- The Advisory Group provided its report, "*Better Outcomes for People with Chronic and Complex Health Conditions*", to Government in December 2015.
- On 31 March 2016, the Government announced a Healthier Medicare for chronically-ill patients and the establishment of Health Care Homes. The measure responds to the report of the Primary Health Care Advisory Group.
- On 24 August 2016, the Prime Minister and the then Minister for Health and Sport announced the ten PHN regions in which stage one will be implemented. The selected regions are: Perth North, Northern Territory, Brisbane North, Nepean Blue Mountains, Western Sydney, Hunter, New England and Central Coast, South Eastern Melbourne, Tasmania, Country South Australia and Adelaide.
- Stage one service delivery commenced on 2 October 2017 and will end on 30 November 2019 with a report back to Government in early 2019.

[9] MBS Online
[10] Strengthening Medicare: Agreement with the Royal Australian College of General Practitioners (RACGP) on behalf of general practitioners

QB18-050

Date QTB Fact Brief created: 23 January 2018
Last Updated by Department: 26 June 2018
Last Updated by Adviser: 7 May 2018

Contact Officer: Assistant Secretary	Janet Quigley	Work Phone: (02) 6289 5372	s22(1)(a)(ii)
Cleared by: Assistant Secretary	Janet Quigley	Work Phone: (02) 6289 5372	s22(1)(a)(ii)