Doctor-led Health Care Homes to address continuity of care gaps

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In April 2015 Federal Minister for Health, the Honorable Sussan Ley announced the establishment of the Primary Health Care Advisory Group (PHCAG) as part of the Healthier Medicare initiative. The group was tasked with providing the Commonwealth Government options to reform the primary healthcare system.

It was chaired by Dr Steve Hambleton, a practising General Practitioner and the immediate past President of the AMA. Membership was comprised of clinicians including GPs, nurses and allied health practitioners, consumer and carer representatives, a state health administrator and a representative of the private health insurance industry. They were appointed for their individual expertise and also as representatives of their craft group or industry. The group met face-to-face on five occasions between June and November 2015.

The discussion began around the case for reform and quickly focused on the structural impediments to the care of people with chronic and complex conditions and co-morbidities, and the emerging international literature about better models of care, particularly the idea of the Health Care Home (HCH). It was made clear that the federal government was keen to explore different models of care of this group for patients in primary care with new funding and insurance models as a corollary.

The expressed underlying concern related to the structural patchiness of the Australian healthcare system and there was no implicit criticism of healthcare professionals.

The PHCAG established four key discussion themes:

- **effective and appropriate care for people with chronic and complex conditions;**
- **system integration and improvement;**
- **payment mechanisms to support a better primary healthcare system, and**
- **measuring the achievement of outcomes.**

The discussion around "effective and appropriate care for people with chronic and complex conditions" began with a careful dissection of the characteristics of the target group and evidence-based models of risk stratification according to complexity of needs and type of care that they required. The point was to clearly identify those patients for whom it was not only clinically possible to manage in a primary care setting but whose care was likely to be substantially improved. Clearly, avoidable hospital admissions were a major driver of that discussion but better outcomes for patients was the guiding principle.

The outcome was that the advisory group agreed that the 'Home' had real potential to improve the care of this patient group in General Practice as long as it was adequately supported by new funding models and other relevant structural reforms in the rest of the Australian healthcare system. Accordingly, in the final report, the advisory group recommended that Health Care Homes should be established in Australia.

'Homes' will be established in willing General Practices with new funding models to allow GPs, supported by an enhanced team to care for an identified subset of patients whose medical conditions would be better managed this way. It would run alongside the usual episodic care of the majority of patients in the fee-for-service model.

It was quite clear that the Commonwealth's vision is that the 'Home' is an enhanced service provided within the current structure of General Practice, to a small subset of carefully selected patients. That is, it will run in parallel to normal fee-for-service operations but funded through a distinct set of payments.

'Homes' will be doctor led – GPs will be funded to employ services to meet parameters in their context. It is likely that the majority of new employees will be nurses or nurse practitioners, and there will likely be a strong recommendation to also employ lay 'care co-ordinators' in the home as well. This latter role is new and permits an element of creative thinking – it could, for example, overlap with other concepts such as "concierge", "coach", welfare officer and social worker all in the same individual or a couple of individuals.

Other allied health services might be employed as part of the 'home' team but it is equally likely that their services will be purchased externally according to need.

CHARACTERISTICS OF THE HEALTH CARE HOME

So, a picture of the 'Home' in the Australian context is starting to emerge. Specifically, the features of the medical home include the following:

- **Patient enrolment**: patients identified by the clinicians as potential candidates would be offered voluntary enrolment in the 'Home'. Acceptance by the patient would commit both sides to an ongoing partnership predicated on enhanced access to, and continuity of, integrated and personalised care, based on an articulated but flexible and dynamic plan of management, shared electronic health records and ongoing evaluation of the service.
- **Patient-centredness** implies little more than established models of high-quality responsiveness to opinions and preferences of patients, their family and carers, around health decisions. Much of this revolves around more time being available to listen and 'hear'.
- **New funding models** will allow employment of additional staff and re-conceived roles, which might include, for example, dedicated nurse practitioners, non-clinician care coordinators, or social workers or welfare officers. Other allied health professionals may be employed in the practice or their services purchased according to need.
- **New or enhanced referral pathways** may be established with local health networks and hospitals to expedite integration of care often

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simply on the basis of better relationships and communication and certainly, shared goals.

There is a real prospect that this 'Home' model will lead to both more satisfaction and better outcomes for this group of patients, but also a genuine improvement in the whole healthcare teams' satisfaction. Team members will be able to work to their capacity and feel that their work is more meaningful as they will have more time and appropriate resources to do it well.

"System integration and improvement" refers to a basket of systems issues that PHCAG recognised, needs to be addressed as part of the establishment of Health Care Homes, and others that need to happen regardless. For example, so-called "health pathways", are essentially traditional referral pathways enhanced by formal collaborative agreements and commitments with local health networks, and are a necessary component of the 'Home'. Care co-ordinator roles will be explored and developed. Improved governance systems and co-operation between state and federal, and public and private components of the primary healthcare system are also desirable regardless of the 'Home' initiative. New roles and opportunities for the Private Health Insurance industry exist and will be important in relation to the care of patients with chronic and complex disease.

"Payment mechanisms to support a better primary healthcare system" particularly involve new funding models to enable the effective functioning of 'Homes'. The discussions were both wide-ranging and penetrating, but aimed to address the shortcomings of traditional fee-for-service payment mechanisms for this subset of patients. There is a good deal of international experience to draw from. So, blended or mixed payment methods and using combinations of payments were considered, potentially involving for example, 'per patient' block funding as well as 'incentivised', predominantly outcomes-based models, blended with fee-for-service, and opportunities for pooled funding.

Finally "measuring the achievement of outcomes" was a given, of course, but a great deal of thoughtful consideration was given to the detail of what should be measured, what data sources are already available, and the need to develop a National Minimum Data Set for patients with chronic and complex conditions.

IMPLEMENTATION OF THE HEALTH CARE HOMES

The Primary Health Networks (PHNs) will be responsible to roll out these initiatives, and Western Australia is in a particularly advantageous situation as the three PHNs (North Metro, South Metro and Country) are all managed by a single organisation called The Western Australian Primary Health Alliance (WAPHA). This provides for efficiencies, sharing and cross-fertilisation of ideas.

The organisational structure is available on the WAPHA website (www.wapha.org.au). WAPHA is getting on with the planning for the establishment of the trial 'Homes', while at the same time managing its other commitments to the Commonwealth. These largely revolve around reviews and commissioning Commonwealth funded primary healthcare services across the State.

After decades of underfunding of General Practice by governments of both political persuasions, and questionable spending on alternative primary care initiatives, it would be hardly surprising if GPs were not skeptical about the Health Care Home and the prospect of adequate funding to make it a reality.

However, it would be a mistake to dismiss the 'Home' idea out of hand – it does after all contain the essence of what we have always believed General Practice is about – continuity of high-quality personalised care which is accessible, comprehensive, coordinated and integrated. We can but hope that Australian governments will begin to recognise the emerging international consensus that a strong General Practice-led Primary Care System makes tertiary systems more efficient and cost-effective, saves the nation vast amounts, and results in substantially better patient outcomes.

GPs manage more than 90 per cent of all presentations locally. General Practice funding needs a revolutionary rethink and with that, proper funding of the research underpinnings of General Practice research in Australia such as PHCRIS and Beach.

And ongoing funding for Health Care Homes. ■