

HEALTH CARE HOME

A MODEL FOR PRIMARY HEALTH CARE

This paper is intended to provide an introductory evidentiary and policy context to the implementation of the Health Care Home model of primary health care in Western Australia. In this paper, the model is applicable to the management of people with chronic and complex health conditions within general practice. The model itself is described, together with a discussion of the rationale for its role in primary health care and importance to the WA Primary Health Networks in the future planning and commissioning of services.

The paper details proposed funding models that underpin the Health Care Home model as outlined in the Better Outcomes for People With Chronic and Complex Health Conditions report. This report has prompted an Australian Government response and Healthier Medicare package announcement that has, at its core, the Health Care Home.

Further, the paper provides a summary of the strategic directions for the Health Care Home model within the Australian context and the optimal framework for PHNs to evaluate the outcomes of the Health Care Home.

This paper seeks to align the WAPHA Strategic Plan to the fundamental elements of the Health Care Home model. WAPHA and the WA PHNs have a clear role in the change management process associated with introducing the Health Care Home model in WA, and this paper seeks to provide a basis for the ongoing development of this role. There is also a brief overview of the integration of the Health Care Home model into the PHN Activity Plans and the links to the findings of the PHN Comprehensive Needs Assessments.

The Health Care Home model has important links to current reviews and policies of the Australian Government, and these are identified within this paper.

The paper is intended to provide some much-needed preliminary information to WAPHA and WA PHN staff, the WAPHA Board, PHN Committees and Councils and key stakeholders. Further detail relating specifically to the Health Care Home model and the WA trials and Naïve Inquiry process will be provided in separate papers and GP facilitated workshops.

Regular updates will be communicated to assist in providing clarity on the policy and activity direction of WAPHA and the PHNs in the context of the Health Care Home. This will include ongoing alignment with evidence-based modelling, discussion of the PHNs' future direction for design, planning and commissioning of the Health Care Home, and the environment within which WAPHA and the PHNs are working.

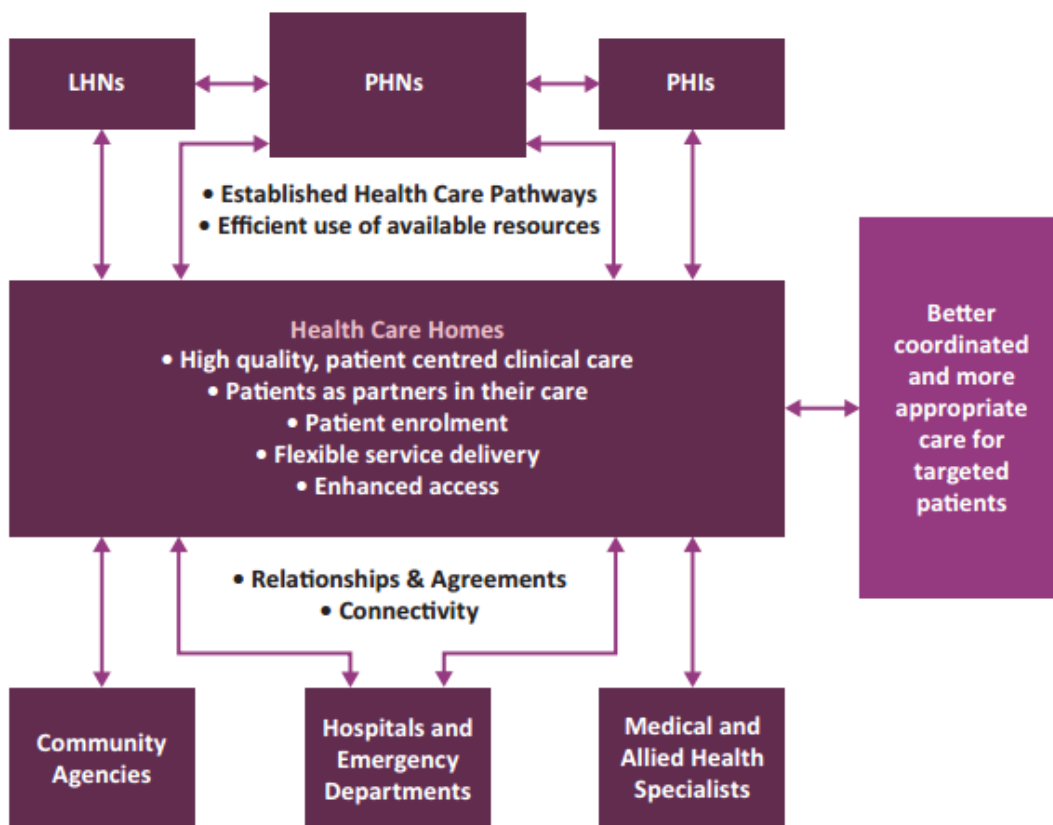
Introduction

The Health Care Home (also referred to as the Patient Centred Medical Home) is a key pillar in the Australian Government's transformation of the way primary health care is provided to Australians with chronic and complex conditions. The Health Care Home provides a 'home-base' for these people, co-ordinating the comprehensive care they need on an ongoing basis.

The Primary Health Care Advisory Group (PHCAG) was established by the Australian Government to investigate options into the reform of primary health care to support people living with chronic and complex ill health, and the treatment of mental health conditions. This work culminated in the release of the group's *Better Outcomes for People with Chronic and Complex Health Conditions* report on 31 March 2016.

Central to the PHCAG's recommended reform is the formal establishment of Health Care Homes that: provide holistic support and co-ordinated care for patients; support enhanced team based care; are underpinned by shared information, and are supported by new payment models.

Figure 5: The Health Care Home

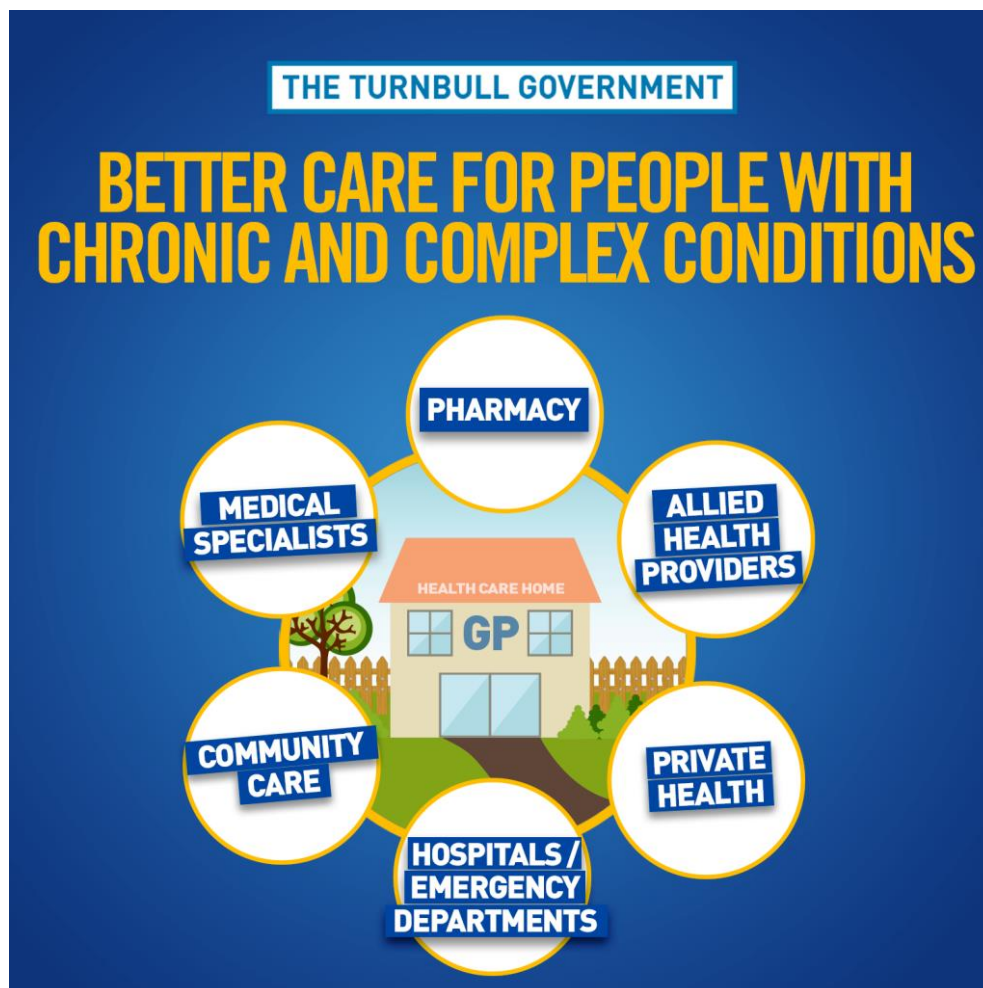


Reference: *Better Outcomes Report*

Internationally, similar innovation models centred within a Health Care Home framework have been at the forefront of improved preventative health and treatment services and improved patient satisfaction, whilst also reducing hospital admissions, particularly for people with chronic and complex conditions. Reported benefits include higher patient satisfaction, improved clinical quality and patient outcomes, and reduced 'burnout' of health services providers.

In response to the PHCAG Report's 15 recommendations, the Australian Government announced its Healthier Medicare package, promoting it as one of the biggest health system reforms since the introduction of Medicare 30 years ago. Essentially, Healthier Medicare will provide for patients with multiple chronic conditions to receive a health care package tailored to their needs. That care will then be co-ordinated to help them easily navigate the complex system. Consistent with the priorities of the WA PHNs, the overall aim is to keep patients well at home and out of hospital.

The Healthier Medicare package will be trialled through creating 'Health Care Homes' that will be responsible for the ongoing co-ordination, management and support of a patient's care. About 65,000 Australians will participate in initial two-year trials in up to 200 medical practices from 1 July 2017. An extra \$21 million will be committed to support the rollout of trials. The remaining balance of the package is expected to be cost neutral, in line with PHCAG recommendations, with further evaluation to continue ahead of a national rollout. Note that the Commonwealth trials are discrete from, but complementary to, the Health Care Home trials that will be undertaken by the WA PHNs.

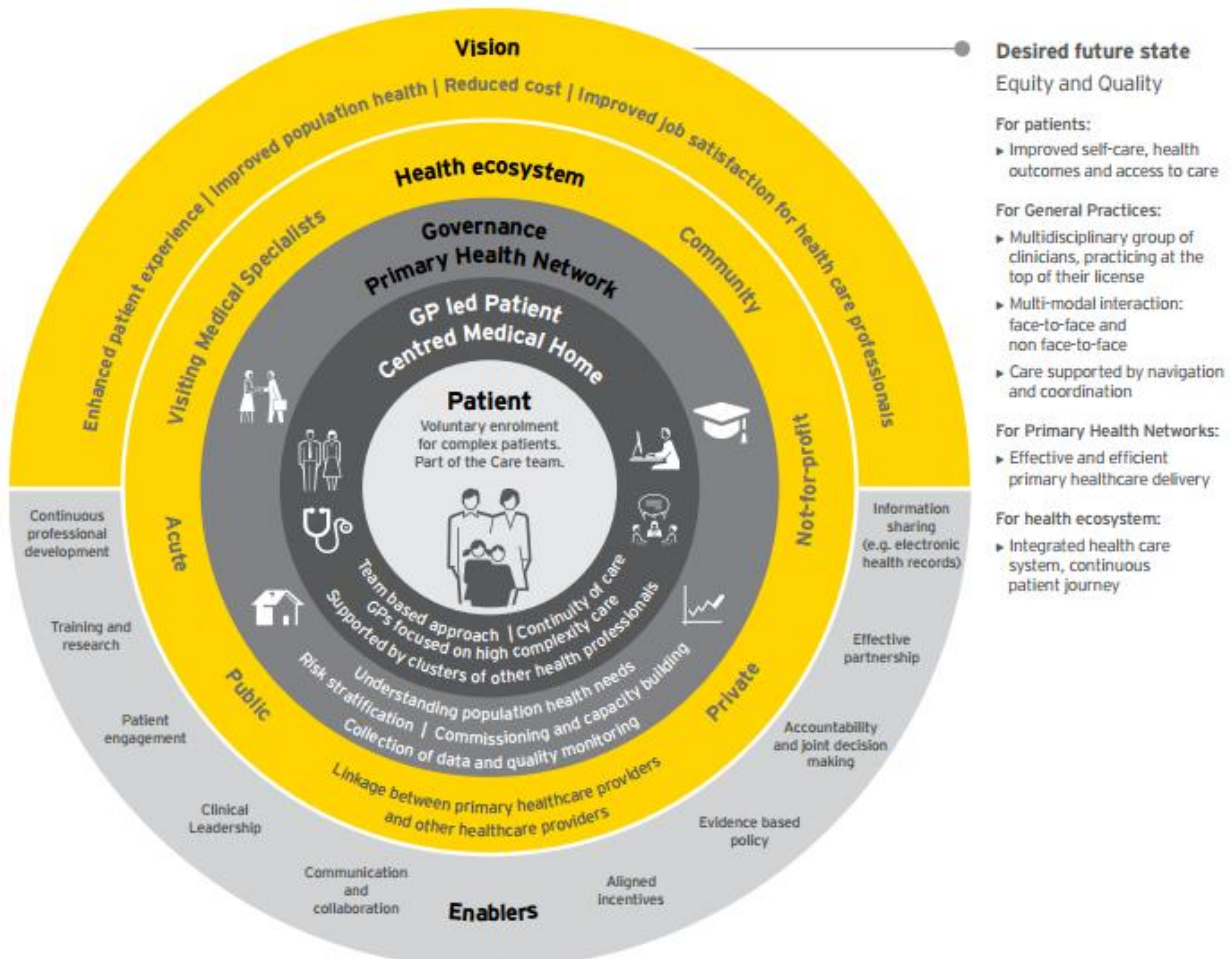


The Healthier Medicare package, will consist of:

- Tailored patient care plans developed in partnership with patients and their families;
- The establishment of 'Health Care Homes', which will co-ordinate all of the medical, allied health and out-of-hospital services required as part of a patient's tailored care plan. Health Care Homes will be delivered by GP practices or Aboriginal Medical Services. Patients will be able to enroll with the Home of their choice;
- Payments for Health Care Homes will be bundled together into regular quarterly payments. This will encourage providers to be flexible and innovative in how they communicate and deliver care, and will ensure that the patient's health care needs are regularly monitored and reviewed. This signals a move away from the current fee-for-service model for these eligible patients, except where a routine health issue does not relate to their chronic illness;
- Improved use of digital health measures to improve patient access and efficiency, including the new MyHealth Record, telehealth and teleweb services, remote health monitoring and medication management technologies etc;
- A risk stratification tool to determine an individual patient's eligibility for the new packages;
- Stronger data collection, measurement and evaluation tools to allow a patient's individual progress to be measured and their care plan to be better tailored to their needs;
- The creation of a National Minimum Data Set of de-identified information to help measure and benchmark primary health care performance at a local, regional and national level to inform policy and help identify regionally-specific issues and areas for improvement;
- Processes to empower patients and their families to be partners in their own care and take greater responsibility for the management of their conditions;
- Greater co-ordination between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) in the planning and procurement of health services for their local communities;
- Additional training to care co-ordinators and providers so they are aware of their responsibilities under the new model;
- A Health Care Home implementation advisory group to oversee the design, implementation and evaluation of the trials ahead of the national rollout.

What is the Health Care Home?

Figure 6: Features of the APCMH model of care (Source: EY)



Reference: A Model for Australian General Practice: The Person-Centred Medical Home

The RACGP *Vision for General Practice and a Sustainable Healthcare System* provides a useful definition of the Health Care Home as an approach to providing quality patient care whereby each patient has a stable and ongoing relationship with a general practice that provides continuous and comprehensive care throughout all life stages. The Health Care Home facilitates a partnership between individual patients, their usual treating GP and extended healthcare team, allowing for better targeted and effective co-ordination of clinical resources to meet patient needs.

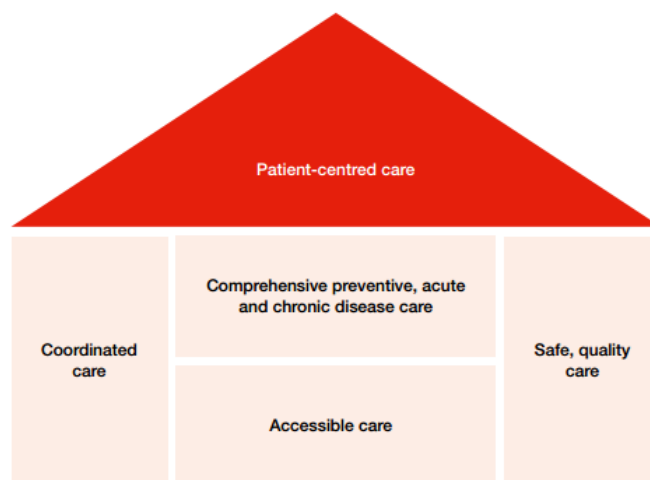


Figure 1. The key elements of the medical home (more detail on the medical home is provided in Section 1.3)

Reference: RACGP Vision for General Practice and a Sustainable Healthcare System

The full value of general practice patient services is achieved when GPs and practices are supported to deliver broad ranging preventive, chronic disease management and acute primary healthcare services in diverse practice settings. These activities, supported by workforce and infrastructure, will facilitate the provision of acute, preventive and chronic disease care, ultimately supporting quality healthcare services in diverse practice settings.

Key Features of the Health Care Home:

Key Features of the Health Care Home (as contained in the *Better Outcomes* report):

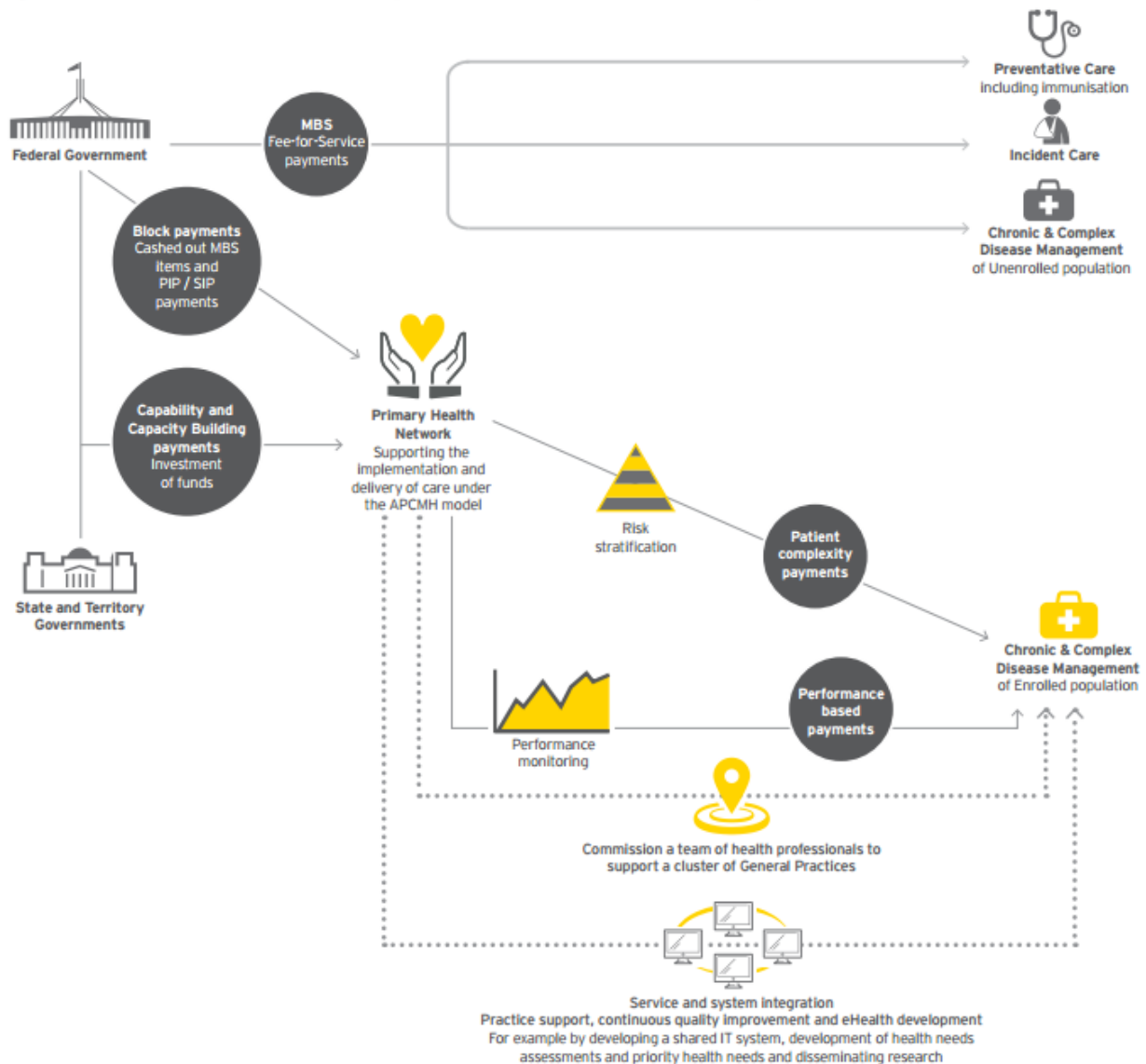
- **Voluntary patient enrolment** with a practice or health care provider to provide a clinical 'home base' for the co-ordination, management and ongoing support for their care;
- **Patients, families and their carers as partners in their care** where patients are activated to maximise their knowledge, skills and confidence to manage their health, aided by technology and with the support of a health care team;
- **Patients have enhanced access to care** provided by their Health Care Home in-hours, which may include support by telephone, email or videoconferencing and effective access to after-hours advice or care;
- **Patients nominate a preferred clinician** who is aware of their problems, priorities and wishes, and is responsible for their care co-ordination;
- **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;
- **A commitment to care which is of high quality and is safe.** Care planning and clinical decisions are guided by evidence-based patient health care pathways, appropriate to the patient's needs;
- **Data collection and sharing** by patients and their health care teams to measure patient health outcomes and improve performance.

Evidence shows that the Health Care Home model has positive outcomes across a range of measures, including lower use of EDs, increased provision of preventive services and improved experiences for patients and practice staff.

A recently published review of evidence in the US entitled *The Patient Centred Medical Home's Impact on Cost and Quality* (Annual Review of Evidence 2014-15) found that in 21 of 23 case studies that reported on cost, there were reductions in one or more cost measures, whilst 23 out of 25 case studies that reported on healthcare use showed reductions in one or more healthcare use measures.

Health Care Home Strategic Directions in the Australian Context:

Figure 5: How the APCMH model could operate in the Australian health care system (Source: EY)



Reference: A Model for Australian General Practice: *The Person-Centred Medical Home*

Key strategic elements of the Health Care Home:

- Identification of patients who can most benefit from more intensive care and support through application of an evidence-based approach;
- Health Care Home to support and co-ordinate care across the health care system;
- Development and refinement of Care Plans in partnership with patients, their families and carers. Implemented through a flexible team-based care approach;

- Patients (and carers where appropriate) are active members of the care team, involved as partners in setting shared goals and making shared decisions;
- Patients are supported to learn more about their conditions and how they can participate in managing them;
- Care Plans build upon a foundation of local patient health care pathways to ensure care is evidence-based and delivered in a local health care framework;
- More effective and efficient use of resources to deliver better patient outcomes.

Australia is well placed to progress the development of the Health Care Home and the associated primary health care reforms. In many ways, our current primary health care system already comprises many of the elements underpinning the Health Care Home model of care. As part of the initial stage of implementation of the Health Care Home model, the trials that are being undertaken by PHNs in States including WA are an important foundation upon which to build this new model of care.

The WA PHNs are committed to the meaningful and ongoing participation of providers and patients in the planning and design process of the Health Care Home model.

The Health Care Home concept has gained the support of key medical groups in Australia including the AMA and the RACGP which has included the Health Care Home as part of its *Vision Statement for a Sustainable Health Care System*.



Figure 4. The benefits to patients, healthcare providers and governments

Reference: *RACGP Vision for General Practice and a Sustainable Healthcare System*

Importantly, the Australian Consumers Health Forum (CHF) has endorsed the model for its placement of the patient at the centre of care. The CHF recognises that the Health Care Home model will promote the idea of patients, families and their carers as partners with clinicians in their care, encouraging them to manage their health, aided by technology and with the support of a health care team.

Rationale for the Health Care Home:

Australia is experiencing increasing rates of chronic and complex conditions and this presents significant challenges for our healthcare system. The changing needs of patients requires a comprehensive response from primary health care to address the associated challenges and ensure a sustainable system into the future.

Australian Institute of Health and Welfare data reported in mid-2015 that approximately 20% of the Australian population have two or more chronic conditions (multi-morbidity). The service needs of this population are diverse (depending on the level of complexity of their conditions) and require input from a number of health providers or agencies. We also know that approximately 6.2% of Australian hospital separations (62,000 in WA) in 2013-14 were classified as preventable in the event that non-hospital care had been provided.

The population is also ageing with one in seven people aged older than 65, projected to increase to one in four people by 2060. The cost of healthcare is increasing exponentially, and all levels of Government are concerned at the impact of this on their current and future budgets. These factors will lead to increased and sustained health service demand, requiring a more co-ordinated approach to preventing and managing chronic and complex health issues.

The Australian healthcare system is challenged by the issue of how to better integrate care for patients with chronic and complex disease. Hence, the establishment of the Primary Health Care Advisory Group, the Parliamentary Inquiry into Prevention and Management of Chronic and Complex Disease and the Healthier Medicare package announcement.

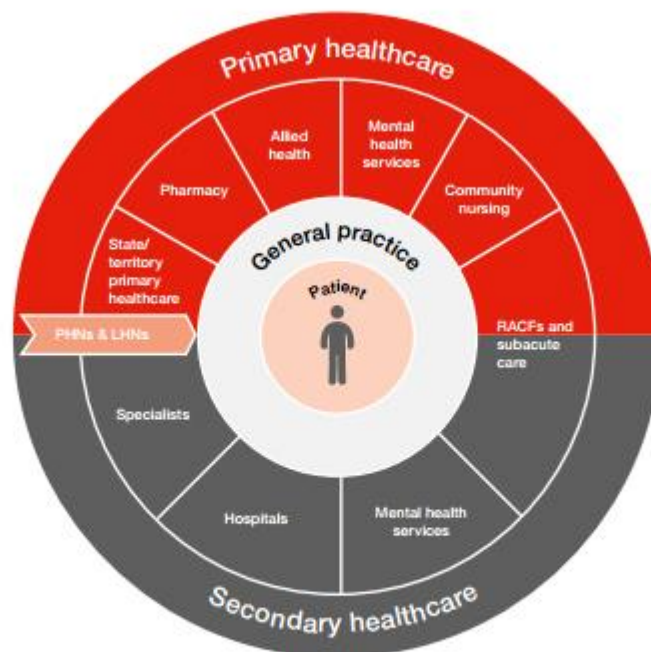


Figure 3. The current Australian healthcare system

LHNs, Local Hospital Networks; PHNs, Primary Health Networks; RACFs, residential aged care facilities

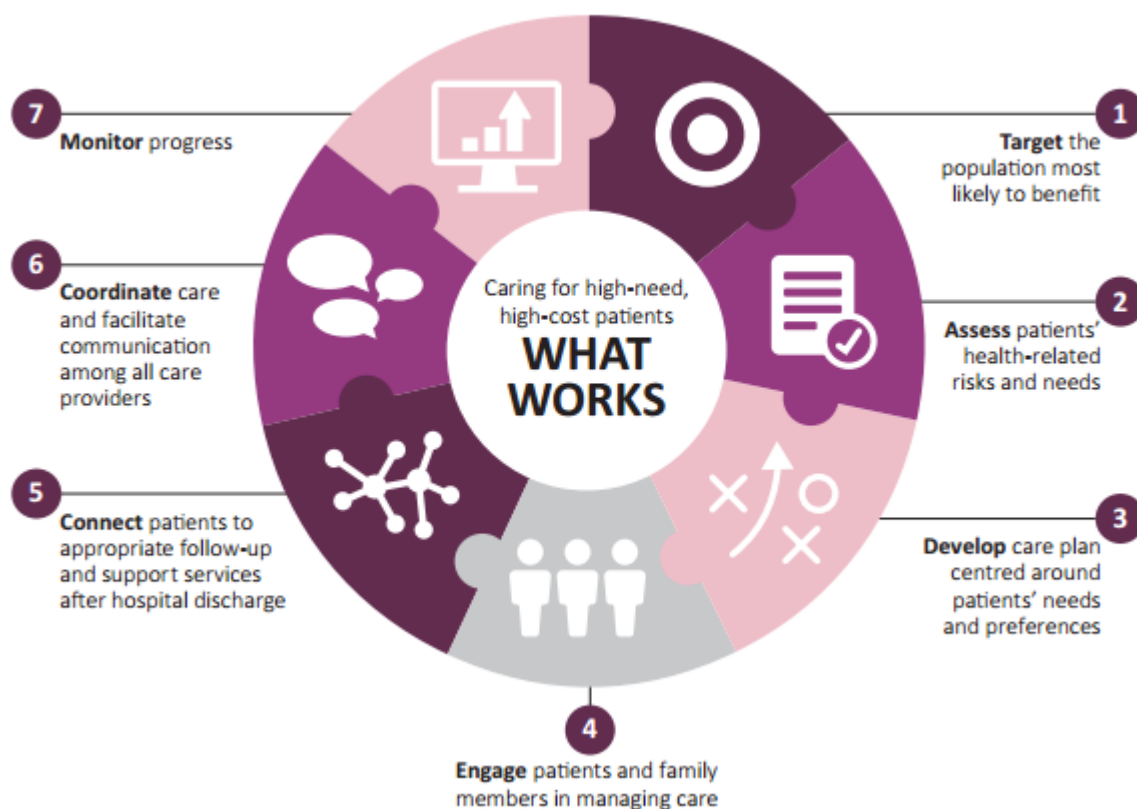
Reference: RACGP Vision for General Practice and a Sustainable Healthcare System

The *Better Outcomes* report highlighted that primary health care services for people living with chronic and complex conditions can be fragmented, and lack co-ordination with secondary care services. This will likely result in ineffective communication between the patient's health care 'team' and concerns in respect to the quality and safety of patient care. Our current system is not optimally set-up to effectively manage long term conditions. In 2013-14, 48% (285,000) of Australia's potentially avoidable hospitalisations were for chronic conditions (AIHW Admitted Patient Care 2013-14). Nearly a quarter (23%) of people who visited an ED felt their care could have been provided by a GP (NHPA Healthier Communities 2012-13).

Acknowledging that the cumulative effects of these factors significantly challenges the current system of health care, the Health Care Home model has been increasingly prominent in primary health care discussions and policy direction in Australia. This recognises the importance of implementing an approach that is evidenced to have efficacy in the management of people with chronic and complex conditions.

There is significant evidence to support what works for these high-need, high-cost patients, and this supports the intrinsic value of the core elements of the Health Care Home.

Figure 3: Caring for high-need, high cost patients: what works[20]



Reference: *Better Outcomes Report*

Chronic Conditions:

Chronic conditions are non-infectious health conditions of long duration and slow progression that usually have a number of contributing factors. In Australia, chronic diseases are the leading cause of disease burden and are associated with significant personal, community and economic costs.

Many health conditions fall under the category of chronic conditions, including cardiovascular disease (such as heart disease and stroke), diabetes, some types of cancers, and respiratory diseases (such as chronic obstructive pulmonary disease (COPD) and asthma). A broad range of risk factors exists for chronic conditions, some of which can be modified to reduce the risk of chronic conditions. In Australia, three quarters of all chronic disease deaths are attributed to either tobacco smoking, physical inactivity, poor nutrition and or harmful use of alcohol. Chronic conditions occur more often among some population groups, for example, Aboriginal and Torres Strait Islanders and those groups which are socioeconomically disadvantaged.

Age is also an important determinant for chronic conditions. The likelihood of developing a chronic condition increases with age, as do the proportions of people reporting to have more than one chronic condition. Being affected by more than one chronic condition is linked to more complex disease management and increased costs.

Twelve chronic conditions have been identified to pose a significant burden in terms of morbidity, mortality and health care costs in Australia. These include: coronary heart disease; stroke; asthma; lung and colorectal cancer; depression; type 2 diabetes; arthritis; osteoporosis; COPD; chronic kidney disease; and oral disease. Importantly, these chronic conditions are amenable to preventive measures.

Effective prevention and management of chronic health conditions relies on the delivery of integrated and coordinated services for people across the continuum of care. The *WA Chronic Health Conditions Framework* highlights a lack of integration and linkage of services for chronic disease, which is intensified in rural and remote WA. The Health Care Home model has been considered a means for improving chronic disease health outcomes providing more comprehensive, integrated and co-ordinated care. The model achieves this by building the Australian primary care system around a 'single healthcare home', where people 'enrol' with a single provider who becomes their first point of care and co-ordinates other services around the consumer.

Chronic conditions are the leading cause of illness, disability and death in Australia, accounting for 90% of all deaths in 2011. It is estimated that one in five Australians are affected by more than one chronic condition. In Western Australia, chronic conditions are the leading cause of potentially avoidable deaths. Further, just over half (54.1%) of all potentially preventable hospitalisations in WA result from chronic conditions. Australia's ageing population raises the potential that the prevalence of chronic conditions will increase further.

The table and figures below outline the prevalence of a range of chronic conditions in Australia, WA and the WA PHNs.

Table 1. Age-standardised rate of population with chronic condition, 2011 – 2013

	Perth North	Perth South	Country WA	WA	Australia
Diabetes	5.5	5.6	5.2	5.5	5.4
Mental and behavioural issues	13.6	14.4	14.3	14	13.6
Respiratory system diseases	30.4	29.4	31.6	30.2	28.7
- Asthma	9.3	9.4	11.5	9.7	10.2
- Chronic Obstructive Pulmonary Disease (COPD)	2.1	2.3	2.5	2.3	2.4
Circulatory system diseases	15.1	15.8	16.5	15.7	17.3
- Hypertension	9.2	9.3	9.3	9.3	10.2
Musculoskeletal system diseases	28.4	29	29.8	28.9	27.7
- Arthritis	14.6	15.4	15.8	15.1	14.8

Framework to Evaluate Against

10 Building Blocks of High Performing Primary Care:

In international studies of exemplar primary care practices, and work in assisting practices to become more patient centred, there has been a formulation of the essential elements of primary care, which are well-accepted and recognised in Health Care Home literature as the 10 building blocks of high-performing primary care.

The building blocks include four foundational elements - engaged leadership, data-driven improvement, empanelment, and team-based care-that assist the implementation of the other six building blocks - patient-team partnership, population management, continuity of care, prompt access to care, comprehensiveness and care co-ordination, and a template of the future. The building blocks, which represent a synthesis of the innovative thinking that is transforming primary care in the United States, are both a description of existing high-performing practices and a model for improvement.

The 10 Building Blocks of High-Performing Primary Care

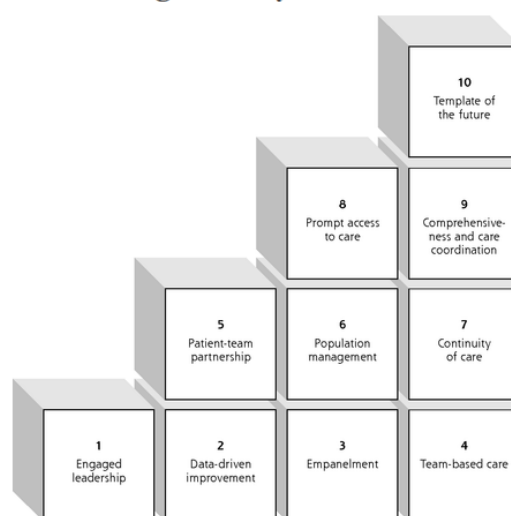


Figure 1

Ten Building blocks of high-performing primary care.

The Health Care Home model of care reinforces the central role of primary health care within the health system, with the following aims:

- Better co-ordinated, more comprehensive and personalised care;
- Empowered, engaged, satisfied and more health literate patients, families and carers;
- Improved access to medical care and services, including through appropriate use of non face-to-face phone and internet based digital health options;
- Improved health outcomes, especially for patients who have chronic conditions;
- Increased continuity and safety of care, including more consistent adherence to clinical guidelines; increased productivity of health care service providers;
- Increased provider satisfaction, working to full scope of their licence; and
- Enhanced sharing of up-to-date health summary information.

Alignment to WAPHA's Strategic Plan:

The emerging model for the Health Care Home in Australia clearly aligns to the strategic direction of WAPHA and the PHNs.

WAPHA and the PHNs exist to facilitate a better health system, with improved patient outcomes and better 'value' to the community.

Our Solution:

Curate: Build sustainable partnerships across the health and social care systems that most effectively address the barriers impacting on the health care outcomes of people in metropolitan, regional, rural and remote WA.

Plan and Commission for quality cost effective services that are sustainable to lead to better health outcomes for people with complex chronic conditions. Engage clinicians and community in commissioning services that meet priority needs and reduce potentially preventable hospitalisations.

WAPHA's strength is its ability to take a State-wide co-ordinated approach through the three WA PHNs with collaborative governance and shared decision making.

System Capacity: Addressing barriers that prevent access to quality co-ordinated primary health care in the community.

Role of PHNs:

The WA PHNs have already commenced the process of commissioning Health Care Home trials across the State to develop models that will support the sustainability of the Health Care Home model of care.

The WA PHNs have a central role in supporting health care providers and consumers in the development and staged rollout of the new service delivery and funding models, to ensure all stakeholders are engaged and ready for the new model of care as it is rolled out in WA. This change management role includes a key role in facilitating the development and implementation of the Health Care Home model that is relevant and sustainable within the WA context, for metropolitan, regional, rural and remote primary healthcare systems.

PHNs are expected to assist Health Care Homes to collect and report data and utilise it to improve local care quality.

PHNs are well placed to undertake these roles for the following reasons:

- PHNs' role in working with local health care providers on the development of patient health care pathways provides them with a strong base on which to support general practices in care planning and coordination;
- PHNs were established with capacity to better target resources in line with regional requirements through the use of commissioning approaches; and
- PHNs can support a managed competition model among service providers to achieve value for money and ensure the delivery of high quality, integrated health care services in their region.

PHNs play a key role in developing the potential of the Health Care Home model by:

- Commissioning services to meet identified service gaps;
- Facilitating development of teams of multi-disciplinary health professionals to support general practice;
- Developing capacity;
- Monitoring patient outcomes and quality of care;
- Enabling collaboration between primary health care and Area Health Services to better plan and deliver care in the region;
- Liaising with stakeholders

PHNs have been tasked with supporting general practices in attaining the highest standards in quality and safety. This includes providing support to general practices and collecting and reporting data to support continuous improvement. Many PHNs, and their predecessors, have been undertaking work in this area for some time. This work is important in the development of Health Care Homes.

Supporting the Health Care Home in Regional Communities:

In many areas, particularly rural and remote locations, a Health Care Home may already be the default model of service, although it is not formalised as such.

People living in regional and remote communities generally have poorer access to health services and higher incidence of chronic conditions than people in metropolitan areas. Co-ordination of care remains a challenge in many rural practices. Increasing care continuity for high needs patients through enrolment in the Health Care Home and increasing communication between health care providers through more effective use of digital health records holds considerable promise for the delivery of care in rural communities.

New Payment Mechanisms for the Health Care Home:

Current Medicare rebates recognise episodic, acute and sub-acute care, supporting the delivery of healthcare when the patient is physically present with the GP. The RACGP has acknowledged that, while this works well for many presentations, patient rebates do not adequately support healthcare delivery for patients with chronic and complex conditions.

The Medicare payment rules for planning, co-ordination and review items stifle innovation in the way general practices manage chronic disease. They pay for individual consultations rather than for the quality of care and patient outcomes achieved.

The *Better Outcomes* report identified that the Health Care Home model will need to be underpinned by a payment system that appropriately supports the range of primary health care services and supports required by people with chronic and complex conditions. The PHCAG recommended that existing payment mechanisms be reviewed to ensure that they are structured in ways that best support the management of chronic and complex conditions delivered through the Health Care Home.

Key elements of the recommended restructure to the existing payment systems for chronic and complex condition management delivered through Health Care Homes include:

- The establishment of new bundled payments, including an upfront and quarterly payments to general practice (See Table A);
- Assessment of patient eligibility for enrolment in a Health Care Home through an existing fee-for-service benefit, such as a MBS level B standard consultation benefit;
- Block funding to PHNs to commission appropriate non-general practice clinical care and non-clinical care and non-clinical care co-ordination services for the enrolled population in their region;
- No change to patients' existing ability to contribute to their health care costs, and
- No change to fee-for-service for episodic care not attributed to the care plan.

The key principles underpinning these elements are:

- The level of primary health care funding for chronic and complex condition management will be maintained and will be better targeted and made more flexible through Health Care Homes;
- Payments to providers need to be appropriate for the range of services that will be delivered under the new service delivery model;
- Opportunities for State and Territory Governments, private health insurers and local industries to contribute to the primary health care funding base for chronic and complex condition management will be explored; and
- The new payment mechanisms proposed will be tested and refined before wider rollout so that they best support patients and providers to participate in Health Care Homes.

There is potential for the Health Care Home model to better target the current funding arrangements used to support patients with chronic and complex conditions through the Health Care Home and make it less confusing, involve less red tape, and make it more flexible for both providers and patients.

Blended Payment Models involve using combinations of payments and/or funding systems. In this way, the right mix of incentives can be utilised to improve care access, quality, integration and effectiveness while also trying to efficiently allocate resources and minimise any weakness of the different payment systems. In Australia, there is potential to implement a new blended payment model aimed at improving the care provided to Australians with chronic and complex conditions through Health Care Homes. In this situation, blended payments could include a mix of bundled, fee-for-service and block payments, as well as opportunities for other pooled funding.

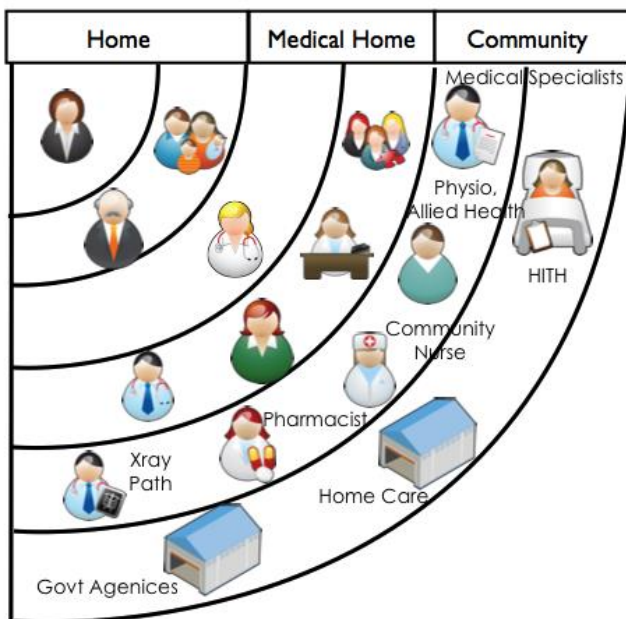
Bundled Payment Approaches are typically a single funding amount that links:

- The multiple services that a particular provider might deliver over a fixed period of time to manage a whole episode of care; or
- Various providers to deliver defined services for an episode of care over a fixed period of time that span the continuum of care, including primary, acute and post-acute health care.

By bundling payments together, to fund a whole episode of care, providers would be incentivised to better organise the whole episode of care by implementing new and innovative approaches that reduce fragmented and siloed care and that increase the co-ordination and integration of care across settings.

Block Funding for Care Co-ordination and Non General Practice Clinical Care (Allied Health)

may be appropriate under a Health Care Home model of service delivery. Block funding could be made available to PHNs to commission appropriate non-general practice clinical care and non-clinical care co-ordination services for the enrolled population in their region. This would enable services to be purchased from local private providers (general practices, pharmacists and allied health care providers), State and Territory Governments, private health insurers and and/or NGOs. Under this model, PHNs would be able to flexibly adapt funding to fit regional and local needs, and commission a range of services to meet the needs of specific populations. This approach is likely to be of most benefit in rural and remote regions and/or areas of workforce shortage. Providing block funding in this way recognises that non-clinical care co-ordinators do not necessarily need to reside in a general practice setting and can potentially be supported through PHNs to provide in-reach services to a range of practices within a region while still being considered part of the Health Care Home team. Payments to PHNs could be based on the allocated risk stratification level (i.e. Tier 1, 2 or 3) of patients within their jurisdiction, and/or could be proportional to the complexity of care required.



Reference: Australian Centre for the Medical Home

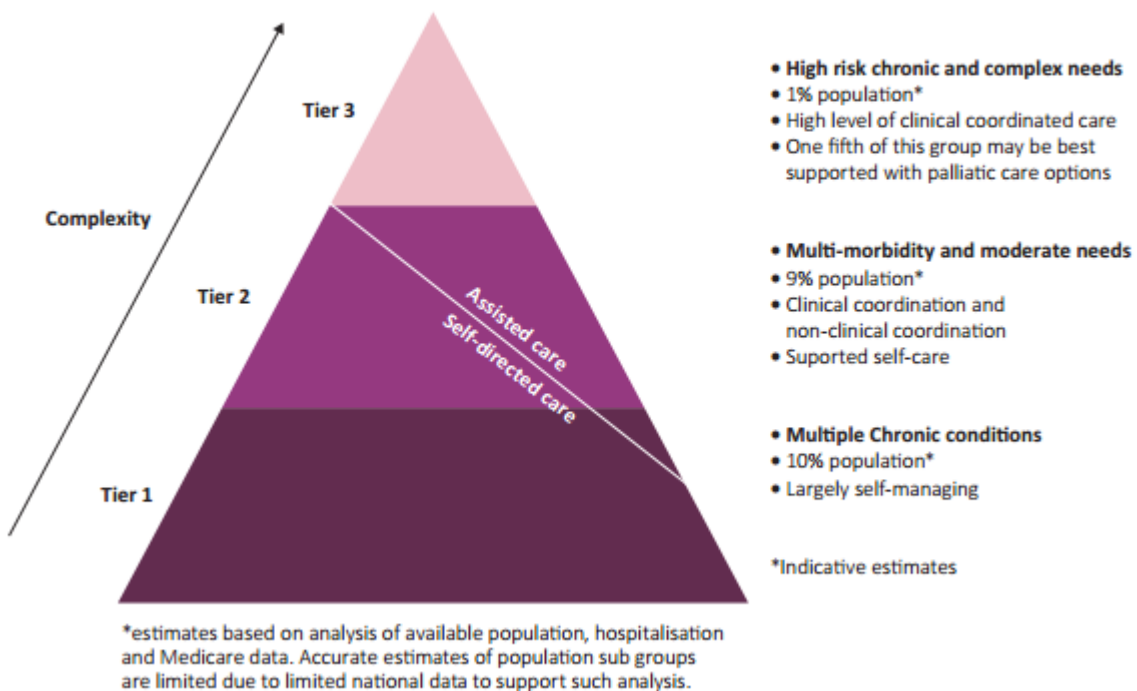
Table A – Proposed Payment Structure (as recommended in *Better Outcomes* report)

Payment Type	Services
Standard Level B	<ul style="list-style-type: none"> Assess patient eligibility for enrolment with a Health Care Home
Upfront Payment	<ul style="list-style-type: none"> Patient assessment and needs stratification of eligible patients (based on patient complexity as stratified under Tier 1, 2 or 3) Health Care Home enrolment, including establishing a patient provider commitment Initiation of a patient care plan development with input from the health care team, including providing necessary referrals
Quarterly Payments (services may be delivered by preferred clinician or delegated to other members of the practice team)	<ul style="list-style-type: none"> Preferred clinician role – first point of contact, continuous and comprehensive care as identified in patient's individual care plan, including the planned management of the patient with the chronic and complex conditions Patient education and self-management support Review and renewal of patient care plan, including input from the health care team Clinical care co-ordination Administrative elements of enrolment Maintenance of patient's My Health Record and shared health summary Non-face to face communications Patient monitoring, including through use of recall and reminder systems Ensuring access, including after hours and urgent care Commitment to quality improvement and outcomes measurement, including: implementation of integrated software systems that support secure data collection and transfer; and transition to include outcomes based measures in the medium to long term

Patient Identification and Eligibility:

Multiple options for patient identification include self-identification, nomination by the GP delivering patient care and identification through review of clinical patient outcomes or hospital records. The issues of piloting Health Care Home models depends on identifying patients most likely to benefit from the model. A key element in determining patient eligibility for enrolment in the Health Care Home involves stratifying patients according to risk.

Figure 4: CHronic disease by complexity in Australia



Reference: *Better Outcomes Report*

Risk Stratification:

Currently, the use of risk stratification in primary health care in Australia has largely been limited to research and innovative trials. A risk stratification approach is a key element of the Health Care Home to more effectively support the identification of patients with high co-ordination and multidisciplinary team needs and to target services accordingly. The Primary Health Care Advisory Group identified three tiers of the population who may benefit from a Health Care Home, differing in their complexity and need for co-ordinated care and support in relation to patients' abilities to self-manage.

Tools to help patients and clinicians 'match' the right treatment suite to the level of need use information including patient diagnoses, previous medical history and health service use and socioeconomic and demographic factors to correlate patients' needs for services.

Table 1: Patient Characteristics by Complexity

Tier 3: Highly Complex Multiple Morbidity

- Many Tier 3 patients will require frequent ongoing clinical care within an acute setting, including those with cancer requiring complex care, or patients with severe, persistent and treatment resistant mental illness.
- Up to 20% of patients in Tier 3 will have a high likelihood of mortality in the next 12 months, based on the progression of their health conditions. Many of these patients could be better supported through enhanced access to palliative care.
- Some Tier 3 patients could be better managed in primary health care settings, but all would benefit from better linkage.

Tier 2: Increasingly Complex Multiple Morbidity

- Most patients in Tier 2 are, or should be, managed in primary health care settings. They will have complex conditions requiring increased access to services, and are likely to be on multiple pharmacotherapies, but are able to function in the community with appropriate support.
- Some patients in Tier 2 may be in residential aged care settings.
- Tier 2 patients will have an increased risk of potentially avoidable ED presentations and hospitalisations as their conditions worsen or if not properly supported.

Tier 1: Multiple Morbidity – Low Complexity

- Patients have multiple diagnosed chronic conditions but are largely high functioning and experiencing limited reductions in quality of life associated with their diagnoses and stand to gain significant long term benefit from improved engagement and structured support.

My Health Record:

Use of My Health Record in Health Care Home general practices is a key element to the success of the model. PHNs have an important role in supporting general practice in using MyHR and uploading patient summaries in accordance with the current ePIP incentive payment.

National digital health infrastructure has been established to support secure health information sharing. My Health Record (MyHR) is already interoperable with general practice, pharmacy and aged care patient records systems and will be further developed by the Australian Digital Health Agency.

The Better Outcomes report recognises the importance of maximising digital health in team based care. The report recommends that technology should be used as far as possible to support care plans as living documents and, for example, for them to be linked to a My Health Record. This would enable real time opportunities for providers involved in the care of a patient to develop and update care plans, assess progress against goals, monitor the activities of the rest of the team and to share other documentation including event summaries, current medications, referrals, discharge and diagnostic information.

It is therefore imperative that the barriers to accessibility of the My Health Record by allied providers and specialists are also addressed and some additional capabilities must be developed. This could include the production of 'at a glance' summaries of useful health information on My Health Record and enhanced capacity for patients to provide feedback on their record or care plan to facilitate collaboration across the health care team.

Change Management:

There are some anecdotal reports within general practice of “change fatigue”, but this has been countered by a strong desire to be part of positive system reform. The early adopters of a Health Care Home model will be advantaged by engaging in the ongoing primary healthcare reform process during a time of significant innovation.

The introduction of the Health Care Home in the primary health care context in WA will require a substantive and nuanced process of change management from WAPHA and the three WA PHNs. WAPHA and the PHNs will engage early, and on an ongoing basis, with the WA Branch of the RACGP, the AMA (WA), the AAPM WA Branch, the WA Branch of the Pharmacy Guild and the leading Private Health Insurers operating in WA. The cultural change that is required to facilitate the optimal establishment of Health Care Homes in WA requires focus on the integration of primary and secondary care, understanding of primary health care policy reform and supporting general practice staff by way of training and professional development.

Transformation to a Health Care Home model calls for significant changes in the routine operations of practices. These are difficult to achieve and require more than a series of incremental changes. Key requirements are long term commitment, local variation, focus on patient-centredness and support through reform of the larger delivery system to integrate primary care within it.

Implementing the Health Care Home in Australia requires incentivisation for general practices and patients to participate in a new system of voluntary patient enrolment. Consideration needs to be given to ways in which improvements to system delivery design, clinical information systems and patient self-management support can be facilitated.

Challenges will arise in respect to the paradigm shift from a physician centred approach to a team-based approach involving a range of clinical, allied health and social care staff.

WAPHA will develop an effective change management process, will provide leadership and facilitate trust and readiness for change through an ongoing process of communication. Misinformation and lack of understanding about the Health Care Home model and how it will be applied in the WA context has the potential to lead to confusion and unwillingness to participate in pioneering the model in WA.

Significant challenge will occur in respect to the implementation and use of the My Health Record within the context of the Health Care Home, the availability, selection and applicability of risk stratification tools, data collection and the adaptation of new payment and funding models.

The WA PHNs have a critical role in educating and enabling practices to adapt and respond positively to the change process.

Compliance:

Compliance mechanisms supporting the Health Care Home should be effective in ensuring that:

- There is accurate use of risk stratification models;
- All eligible patients are encouraged to enrol with the provider of their choice;
- Patients are provided with a copy of all components of the agreement to participate in the Health Care Home;
- Patients are engaged and understand the benefits and commitments inherent in enrolment;
- All members of the health care team contribute to the development of evidence-based care plans;
- Care plans are based on locally developed, best practice patient health care pathways;
- GP services provided to enrolled patients are high quality, comprehensive and proactive;

- All members of the health care team and referred non-GP clinical care providers actively participate in review processes;
- Block payments are used appropriately and that the non-GP clinical services provided are consistent with individualised patient care plans; non-clinical care coordination support is effective and centred around the individual needs of enrolled patients; and
- All providers, practices and PHNs have appropriate data collection and analysis processes in place to support outcome based payment approaches.

Health Literacy:

Improving health literacy is a key to driving improvement in our health care system. Long-term PHN investment in health literacy is a key to effectively addressing population health outcomes.

As system-level health literacy improvement strategies take the stage among national priorities for health care, the Health Care Home model of care will be a logical vehicle for their widespread implementation. With a shared focus on effective communication and team-based care organised around patient needs, health literacy principles and the Health Care Home are well aligned.

Many health literacy interventions are limited by their focus on a single point along the continuum of care. Creating a central focus on health literacy within the Health Care Home has potential to deliver a multi-dimensional, system-level approach to tackling the full range of health literacy challenges. Potential for increasing uptake must be underpinned by Government support and financial incentives to further boost the model's potential for advancing health literacy. On the journey toward a reformed primary health care system, integrating health literacy into the Health Care Home presents a promising opportunity that requires concerted focus.

Relevant Findings of WA PHN Comprehensive Needs Analysis:

The Comprehensive Needs Analyses for the WA PHNs have identified poor health outcomes in specific regional areas. This includes the prevalence of chronic conditions, co-morbidities and poor lifestyle behaviours contributing to the burden of disease. The emergence of the WA PHNs provides a platform for change and opportunities to meet the needs, by way of local responses, of people with chronic and complex conditions.

Significant regional challenges for the WA PHNs, as identified in the Needs Assessments, include:

- Populations that are overweight and obese;
- High rates of potentially preventable hospitalisations;
- Difficulties navigating the health system;
- Inequitable access – location and appropriateness of service supply;
- Lack of multidisciplinary primary health care services;
- Lack of co-ordination and integration between primary, secondary and tertiary care;
- Lack of service co-ordination and management for people with multiple chronic conditions;
- Lack of services targeting high risk groups for people with multiple risk factors and one or more chronic conditions.

Implementation of Health Care Home in WA PHN Annual Plans:

The Primary Health Network Annual Plans have the Health Care Home firmly embedded into their priorities for design and commissioning of services in response to management of chronic and complex conditions.

WA's PHNs are conducting a 'Naïve Inquiry' process and Health Care Home trials to inform the ongoing development of Health Care Home models in this State.

The Naïve Inquiry (conducted in collaboration with WAGPET and RACGP) will seek information directly from selected metropolitan and country general practices as to what is currently happening in respect to the management of patients with chronic and complex conditions (specifically the tri-morbid patient cohort), what are the barriers to providing optimal care, what "work arounds" are currently being employed to address these barriers and what system changes are needed in primary health care to better manage the care of this patient cohort.

The trial process will seek Expressions of Interest from WA general practices to participate in trialling the various elements of a Health Care Home to inform future models of integrated health care for this patient cohort. Similar trials are being undertaken in other PHNs around Australia. The WA trial process is discrete from, but complementary to, the proposed Federal Government trials which are due to commence in mid 2017 as a key element of the Healthier Medicare reforms.

Data:

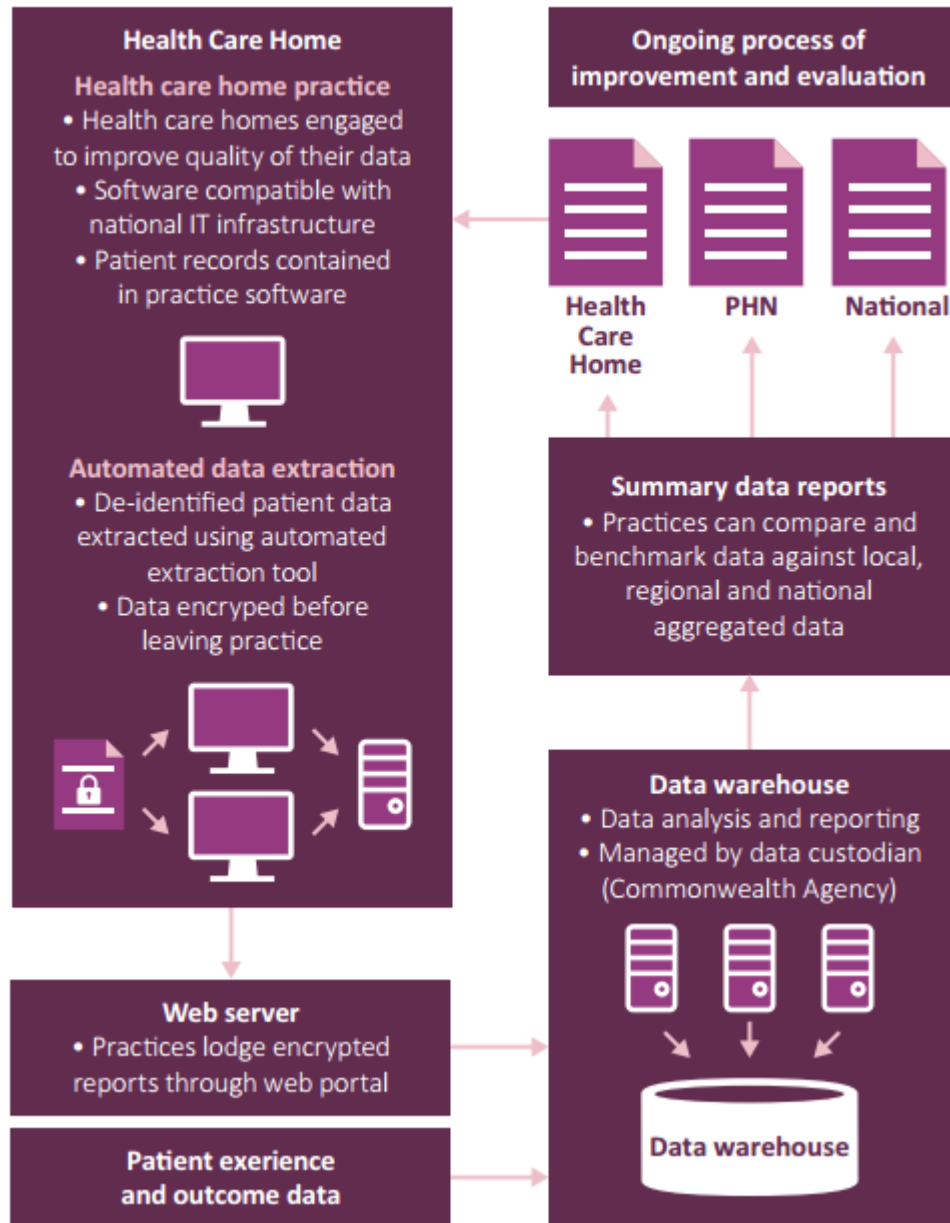
The AMA Position Statement on the Patient Centred Medical Home identifies that the Health Care Home offers an opportunity to collect data, which will help drive improvements to patient care. Data collection systems need to be well-designed, focusing on the collection and analysis of relevant de-identified clinical information. This data can provide practices with the opportunity to identify areas for improvement and monitor progress in these identified areas.

The Better Outcomes Report recommends that a nationally consistent, de-identified data set is developed and used at a regional and national level to understand the impact of service change with a view to improving population health outcomes and informing ongoing health system improvements.

The PHCAG further recommends that elements of the Practice Incentives Programme (PIP) should be refocused to support practices to use relevant data to undertake quality improvement activities in a structured way. The process of data collection and analysis should be part of the establishment of Health Care Homes and related service-integration initiatives and is necessary to understand the impact of and progressively improve the quality of the new models of primary and integrated care.

The implementation of a National Minimum Data Set (NMDS) is recommended with ensuing supply to practices, regional level data to PHNs and LHNs. This is intended to build on the existing national reports on chronic disease management to support system improvements and resource allocation.

Figure 9: Data collection model



Reference: Better Outcomes Report

Evaluation:

The process of data collection and analysis is key to the establishment of Health Care Homes and is necessary to understand the impact of, and progressively improve the quality of, the model.

Without measurable chronic disease targets for health systems, better outcomes of care are unlikely to be achieved. Quality and outcomes must be measured. Comprehensive schemes of indicators and targets for a range of chronic diseases have been developed in the UK and US.

Evaluation will be used to refine and continuously improve the Health Care Home model. Feedback loops will need to be established to ensure learnings can be identified and incorporated.

It will be important that the evaluation framework:

- Includes formative and real-time practical evaluation and summative elements;
- Includes both qualitative and quantitative methods;
- Enables consistent evaluation of the elements of reform cognisant that variations of the elements will be tested, as well as implementation in different contexts, and
- Provides regular reporting to support learning and refinement of the reforms along the way.

Evaluation to understand the impact of Health Care Home models is essential to ensure the maintenance and improvement of quality of care provided to patients. Use of PROMS, PREMS, measurement of clinical outcomes and other identified targets is required. Monitoring and reporting outcomes allows for identification of areas that are making good progress and those needing further development. Sharing of information is important to promote continuous learning and improvement in healthcare delivery.

Current Relevant Reviews and Papers:

- MBS Review
- PBS Review
- Reform of the Federation White Paper (Health)
- Chronic Disease Prevention & Management Parliamentary Inquiry
- Grattan Report
- RACGP Vision for General Practice and a Sustainable Health Care System
- WA Chronic Diseases Framework
- WAPHA Chronic Conditions, Co-morbidities and Multi-morbidities (Understanding Health Needs and Service Demands 2016-2018)
- Inquiry into Private Health Insurance
- 6th Pharmacy Agreement
- National Health Literacy Framework
- National Review of Mental Health Services and Programmes and Government Response
- Ice Taskforce Report and Government Response

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