FROM PCMH TO HEALTH CARE HOMES

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Announced 3 initiatives in April 2015

- Complete review of MBS
- Improve Medicare compliance
- Primary Health Care Advisory Group
  - Tasked to identify opportunities to better meet the health needs of people with chronic and complex conditions
  - Report and recommendations to Health Minister end of 2015
What are the problems?

- Ageing population
- Growing burden of chronic disease
- Care is fragmented
  - Patients attending multiple GPs and practice
  - Poor communication between health services
- Care delivery is driven by funding model
- Care planning is increasingly complex
  - something for access to allied health services and less about patients
  - Multiple conflicting care plans
- Costs are rising – patients (out of pocket), and overall for providers (effects of the Medicare Freeze)
- These issues are compounded with people with multiple medical conditions (inc. mental health)
Primary Health Care Advisory Group

- Only for patients with multiple chronic diseases
  - Recognition that this group have most to gain from better coordinated care
- Guide a necessary shift from a fragmented system based on individual transactions, to a more integrated system that considers the whole of a person’s health care needs
Better Outcomes
FOR PEOPLE
with Chronic and Complex Health Conditions

December 2015

REPORT OF THE
PRIMARY HEALTH CARE ADVISORY GROUP
PHCAG REPORT

- Develop a new model of primary health care needed for patients with chronic and complex conditions
- 15 key recommendations
- Formalisation of the relationship between patients and a “Health care Home”
- Setting to received enhanced access to holistic coordinated care, and wrap around support for multiple health needs.

(Source PHCAG, 2015)
PHCAG Report

- 15 key recommendations
  - Better target services to need
  - Establish Health Care Homes
  - Encourage patient and carer engagement
  - Encourage flexible team based care
  - Better coordinated care between GP, LHD, PHN, PHI
  - Restructure payment to support this new approach
  - Establish national minimum data set for patients with chronic and complex conditions
  - Evaluate any reforms

(Source PHCAG, 2015)
PHCAG Model

- Established Health Care Pathways
- Efficient use of available resources

Health Care Homes
- High quality, patient centred clinical care
- Patients as partners in their care
- Patient enrolment
- Flexible service delivery
- Enhanced access

Better coordinated and more appropriate care for targeted patients

- Relationships & Agreements
  - Connectivity

Community Agencies
Hospitals and Emergency Departments
Medical and Allied Health Specialists
HEALTH CARE HOMES

- Voluntary patient enrolment
- Patient centred care (and engaged patients families and carers)
- Enhanced access to care (telephone, email)
- Preferred clinician nominated
- Flexible service delivery supporting integrated care
- High quality and safe care
- Data collection and sharing

(Source PHCAG, 2015)
A Healthier Medicare for chronically-ill patients

The Turnbull Government will revolutionise the way we care for Australians with chronic diseases and complex conditions, aiming to keep them out-of-hospital and living happier and healthier lives at home.

The primary care 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.
**FEATURES**

- A Health Care Home (HCH) is a home base that will coordinate comprehensive care for patients with chronic and complex conditions.
- Health Care Homes will be delivered by General Practices or Aboriginal Medical Services.
- Only for patients with chronic and complex conditions.
- Patients will enrol with their chosen HCH.
- Voluntary for patients and practices.
- Flexibility of service delivery.
- New payment model.
HOW WILL IT WORK?

- Patients need to be assessed as eligible and likely to benefit before ‘enrolling’ with a participating HCH
- Introduction of risk stratification tools for identifying patients who may need coordination and team care
  - 10% of practice patients Tier 1 – low to medium care
  - 9% of patients Tier 2 – medium to high care
  - 1% of patients Tier 3 – highest care
3 tiers of care within HCH

- **Tier 1**: Largely self-managing

- **Tier 2**: Assisted care
  - Self-directed care

- **Tier 3**: High risk chronic and complex needs
  - 1% population*
  - High level of clinical coordinated care
  - One fifth of this group may be best supported with palliative care options

**Notes**:
- Multi-morbidity and moderate needs
  - 9% population*
  - Clinical coordination and non-clinical coordination
  - Supported self-care
- Multiple Chronic conditions
  - 10% population*
- Largely self-managing

*Indicative estimates

*estimates based on analysis of available population, hospitalisation and Medicare data. Accurate estimates of population sub groups are limited due to limited national data to support such analysis.
How will it work?

The Health Care Home 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
• coordinate care with these providers
• include strategies to help each patient better manage their conditions and improve their quality of life

Care will be integrated across primary and acute care as required

Practices will receive regular payments based on Tier (but not based on activity)
HCH STAGE ONE ROLLOUT

- ~65,000 patients, ~200 general practices and Aboriginal Medical Services,

- Estimated that 70 patients per full-time GP eligible for enrolment. (Ave practice has 5 FTE)

- 9 Primary Health Networks (PHNs)  
  Perth North; Adelaide & Country South Australia; Brisbane North; Western Sydney; Nepean Blue Mountains; Hunter New England & Central Coast; South Eastern Melbourne; Northern Territory; Tasmania.

- Expression of interest closed 15 December 2016
HCH Stage One regions
HOW MIGHT PATIENTS BENEFIT?

- More personalised care and care planning
- Better coordinated care
- Formalised relationship with a regular practice
- More flexible care (not just F2F care)
- Access to more preventative care and self-management
- Improved health outcomes
- Decreased OOP costs
- Increased satisfaction
HOW MIGHT PRACTICES BENEFIT?

- More flexible care delivery
- Better usage of staff
- Formalised relationship with patients and clearer obligations
- GPs can delegate care/focus on more acute care
- More predictable funding stream away from Medicare fee for service
HOW MIGHT GPs Benefit?

- Providing more holistic better targeted care
- More flexible working
- Delegate CDM if appropriate
- Payment for non face to face care (care coordination, telephone con, email, scripts) and for prevention
- Clearer understanding of who regular patients are
- Increased satisfaction
What about funding?
FUNDING FOR HCH PROGRAM

- Over $100 million dollars committed
  - $21.3 million additional funding to 30 June 2019 for rollout
  - $93 million in redirected MBS funding—predominantly from current chronic disease items
- Upfront payment of $10000 per practice
- HCH will receive monthly payment to provide care ‘related to a patient’s chronic and complex conditions’
- 3 tiers of payment
  - Tier 3 – $1,795 per annum (highest complexity)
  - Tier 2 – $1,267 per annum
  - Tier 1 – $591 per annum (lowest complexity)
- HCH retains any underspend
What is the payment for?

“All general practice health care associated with the patient’s chronic conditions, including that provided by a practice nurse or nurse practitioner working in the Health Care Home, previously funded through the MBS, will be funded through the payment.”

Include care planning, comprehensive health assessments, making referrals to allied health providers or specialists, telehealth services and monitoring, case conferencing, and standard consultations.

Includes effective access to after-hours advice and care.
What is excluded?

- Allied health services,
- Specialist services,
- Diagnostic imaging and pathology
- Diagnostic services (such as ECGs)
- Episodic care unrelated to a patient’s chronic condition.

All using existing MBS numbers
OTHER DETAILS

- Care plan uploaded to My Health Record
- HCH can decline to enrol patient
- Nominated lead needs to be a GP- but nurse practitioner, practice nurse, or assistant may be key contact
- RACF and DVA patients ineligible
Both about multidisciplinary patients centred care
PCMH model more about transforming whole of practice
HCH focusing on chronic disease – particular clinical & funding model for this group
POTENTIAL ISSUES & UNKNOWNS

- Shift from GP funding to practice funding
  - How do people get paid?
    - Salary
    - Practice vs provider payment
    - Other staff
  - How to resource other activity (patient education, MyHealth Record)
- Final detail of assessment criteria
  - HARP and QAdmissions
- Exact details of clinical obligations
What next?

- 450 practices applied
- Chosen practices to be notified in April
- AGPAL developing training and education program
- RACGP has called for delay to roll-out until additional information available
- Evaluation framework been established –
  - Stage One- potential for program improvement before wider rollout
CONCLUSION

- Health Care Homes are a new clinical and funding model for patients with chronic and complex conditions—many similarities to PCMH
- Formalises relationship between practice and patients
- Provides access to more flexible care and more flexible payments
- Opportunity for GPs to lead multidisciplinary teams and provide holistic care
- Some important details to be delivered
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QUESTIONS?

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