# From PCMH to health care homes

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# Minister Ley

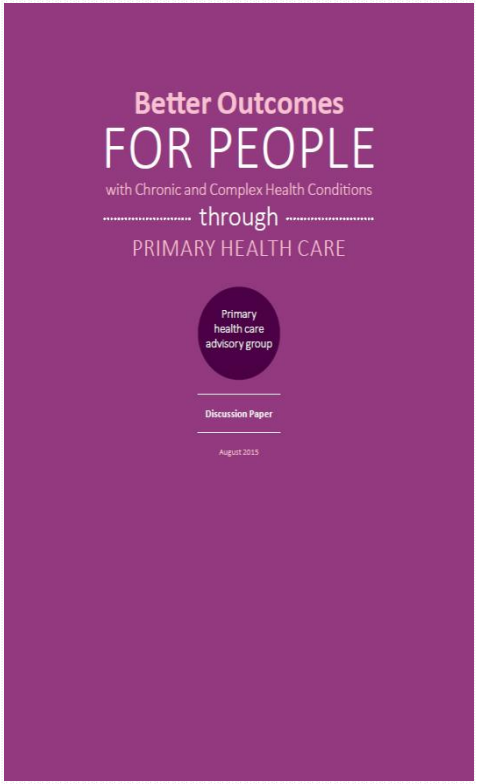
Announced 3 initiatives in April 2015

- 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?

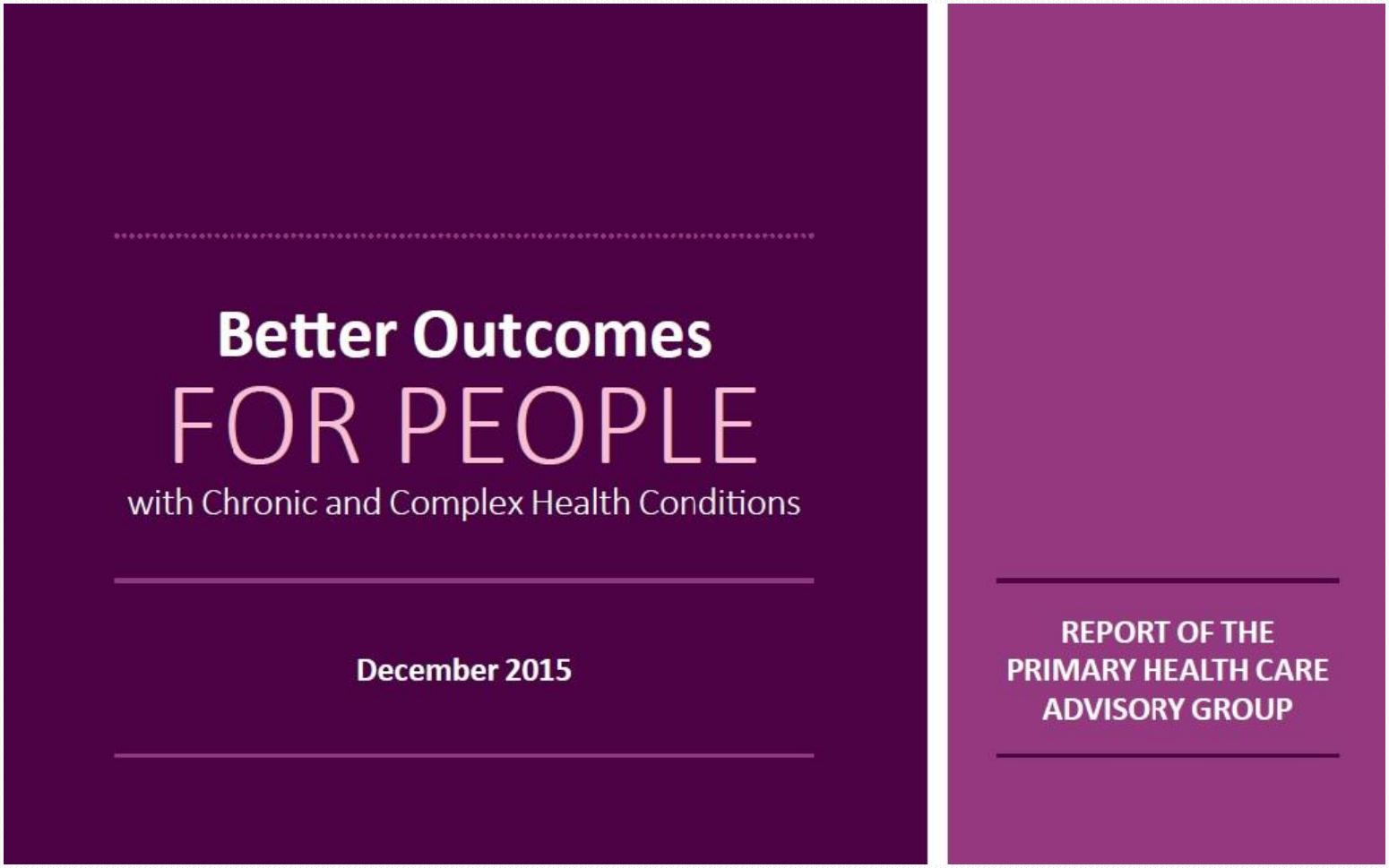
- Ageing population
- Growing burden of chronic disease
- Care is fragmented
  - Patients attending multiple GPs and practice
  - Poor communication between health services
- Care delivery is driven by funding model
- Care planning is increasingly complex
  - something for access to allied health services 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

# 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.

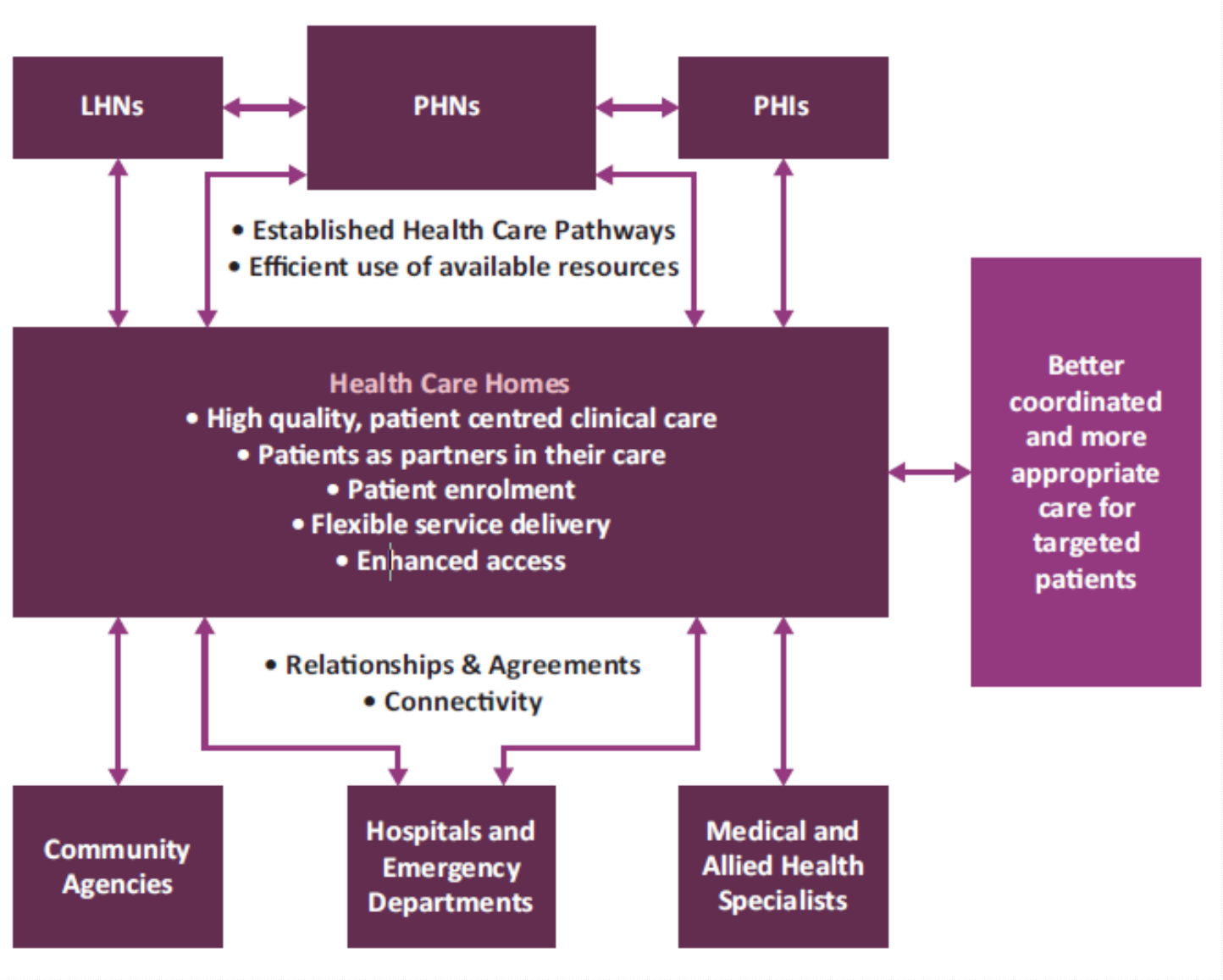
(Source PHCAG, 2015)

# 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


LHNs
PHNs
PHIs
• 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)

**PRIME MINISTER**
**THE HON. MALCOLM TURNBULL MP**

**MINISTER FOR HEALTH**
**MINISTER FOR AGED CARE**
**MINISTER FOR SPORT**
**THE HON. SUSSAN LEY MP**

**JOINT MEDIA RELEASE**

31 March 2016

**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.

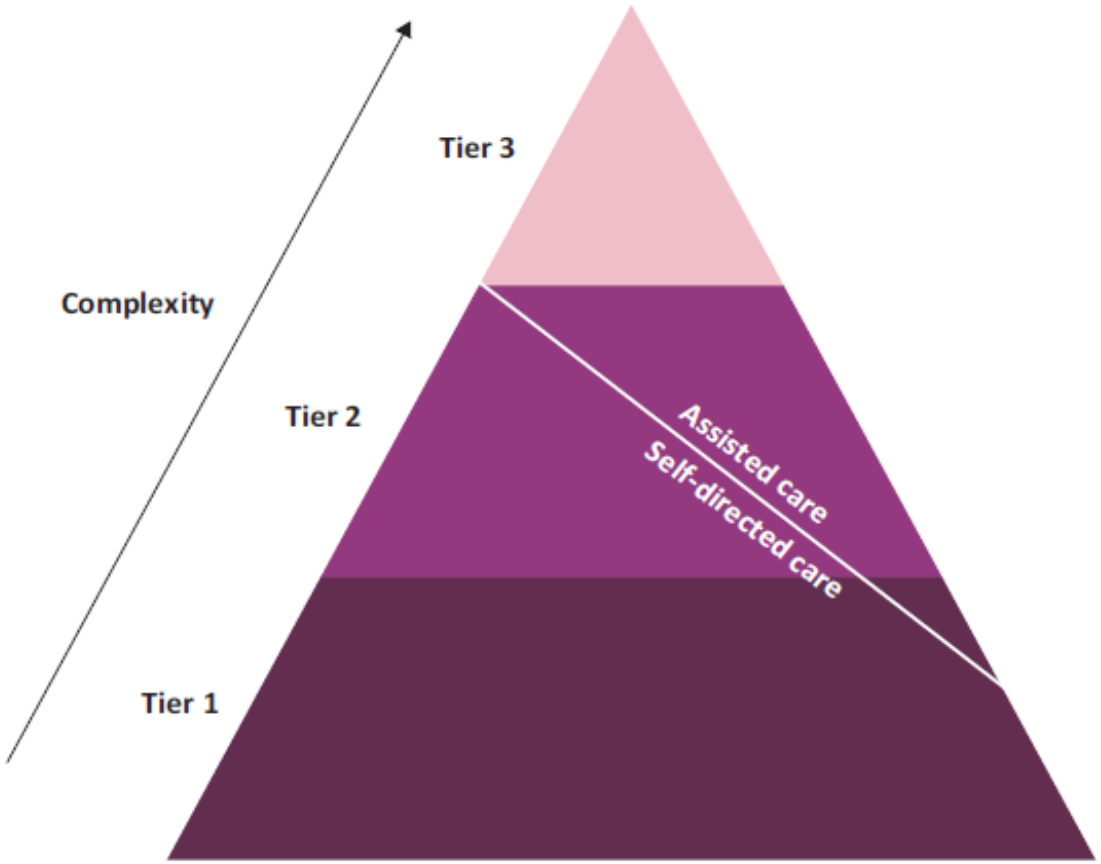

COMMUNITY AGENCIES
ALLIED HEALTH PROVIDERS
HOSPITALS
GP
PATIENTS
HEALTH CARE HOME
PRIVATE HEALTH INSURERS
PRIMARY HEALTH NETWORKS

# 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




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

- **Multi-morbidity and moderate needs**
- 9% population*
- Clinical coordination and non-clinical coordination
- Suported 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.

# 3 tiers of care within HCH

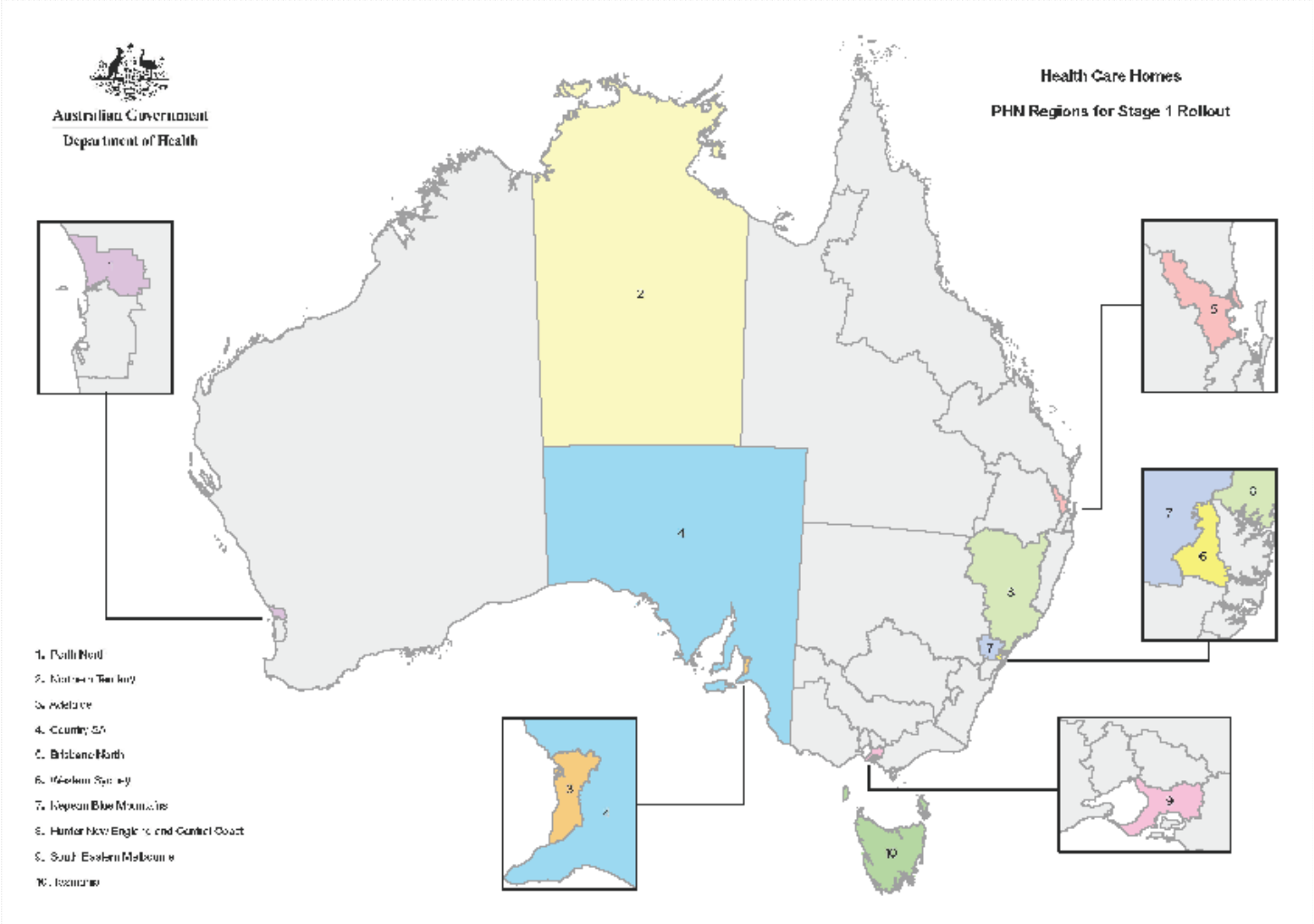
# How will it work ?

- 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?

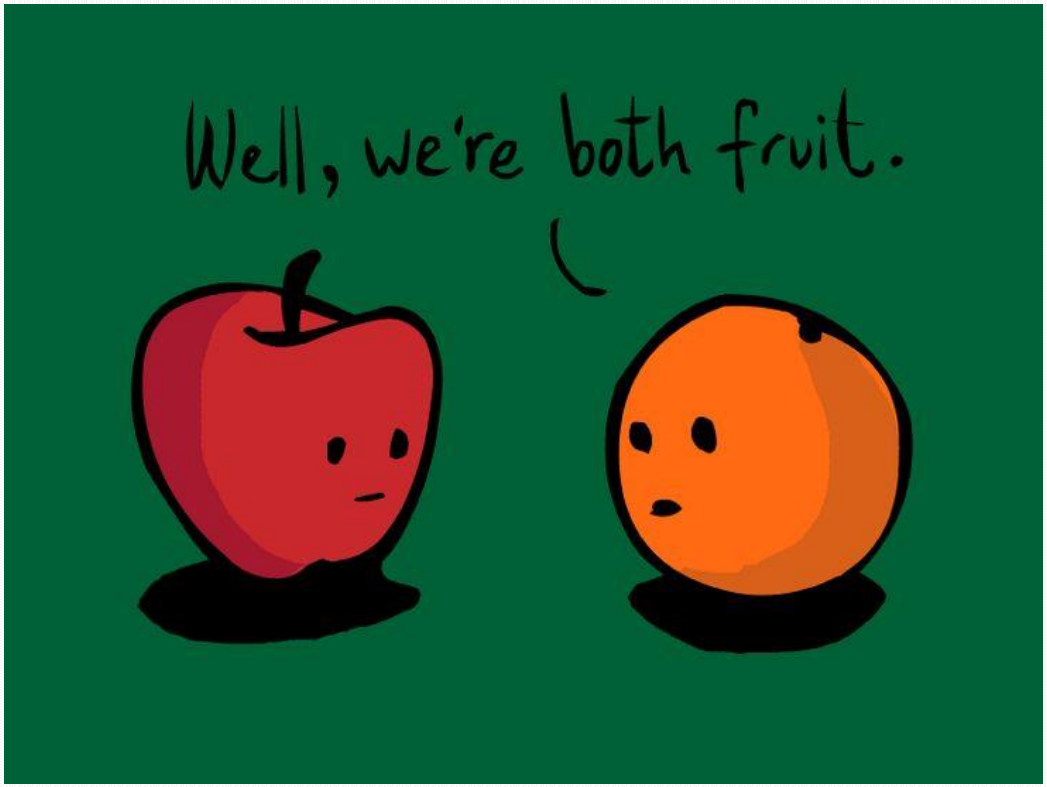
- Allied health services,
- Specialist services,
- Diagnostic imaging and pathology
- Diagnostic services (such as ECGs)
- Episodic care unrelated to a patient's chronic condition.

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

# Health Care Homes vs PCMH




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

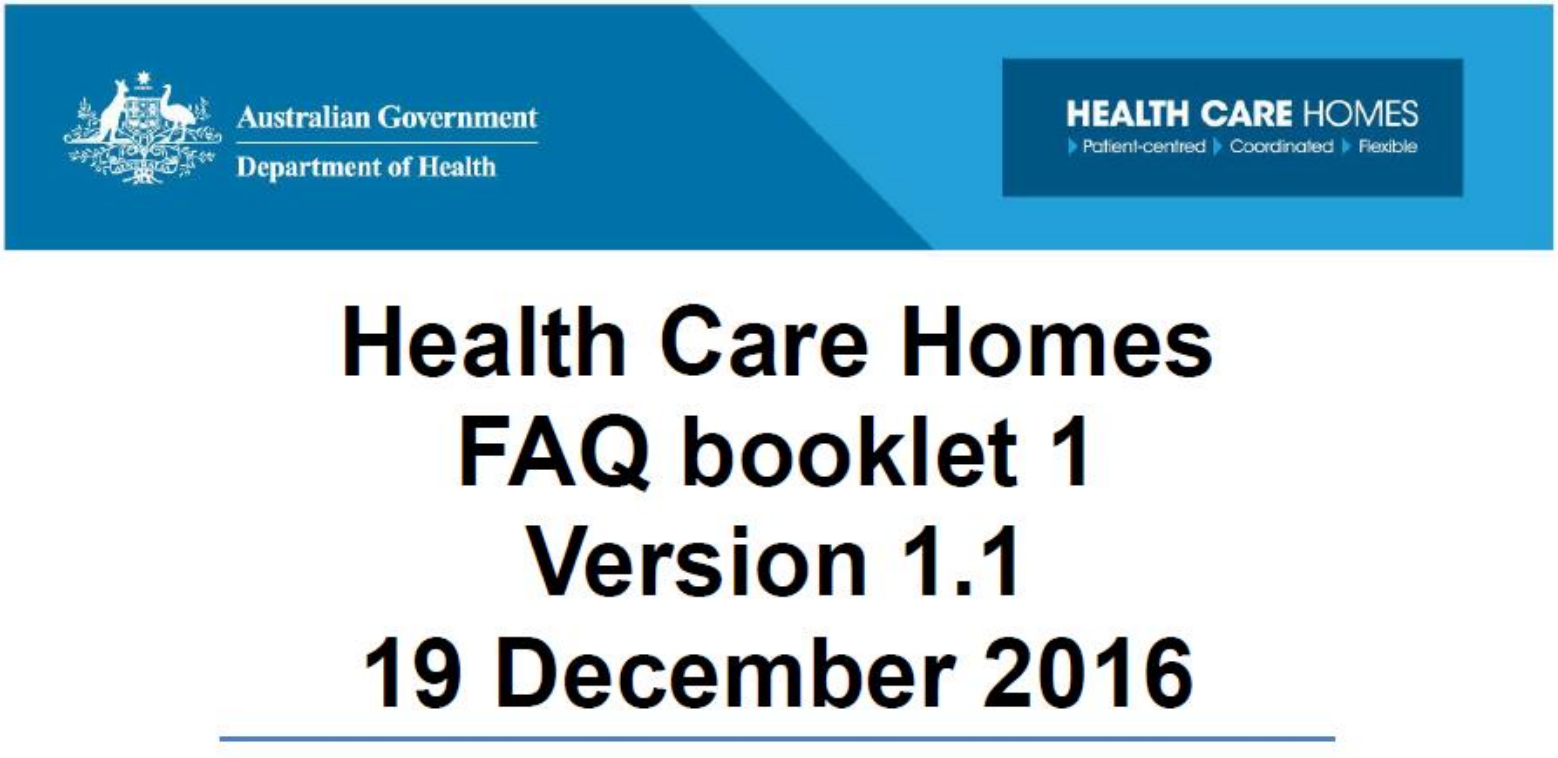
# Potential issues & unknowns

- 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

# More information




http://www.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes-information

# 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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