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Acknowledgements

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Introduction

Our paper *Australian Health Care Reform: Challenges, Opportunities and the Role of PHNs*¹ explored the challenges facing the Australian health care system, including the rising burden of chronic disease, increasing costs of providing care, health inequity and poor alignment of funding and incentives.

A range of opportunities and solutions are currently being explored across the sector, including innovative funding models that break down traditional barriers to improved care, risk stratification, integrated care and the patient-centred medical home model.

The patient-centred medical home model

The patient-centred medical home model promotes care that is patient-centred, physician-guided, cost-efficient and aimed at achieving agreed long-term health goals.² The model introduces the concept of accountable care, where a single provider or group of providers, usually a general practitioner (GP), becomes the central coordination point for a patient, and accepts a level of accountability for that patient's outcomes. In this model, best practice care is provided, usually by a multidisciplinary care team, and coordination is enhanced through the use of systems, tools and coordination workers. (See Figure 1.)

Health Care Homes

Better Outcomes for People with Chronic and Complex Health Conditions: Report to Government on the Findings of the Primary Health Care Advisory Group (the PHCAG report) was provided to government in December 2015. The Australian Government followed with the announcement of the *Healthier Medicare* package in March 2016.

The PHCAG report identified high rates of chronic disease and associated high use of medical services as being a key challenge for the system, along with fragmentation and poor coordination and communication between providers. The report recommends a set of reforms aimed at transforming the system to better meet the needs of people with chronic and complex conditions. Central to the proposed reform agenda is the concept of accountable care through the

introduction of Health Care Homes, based on the patient-centred medical home model (referred to hereafter in this document as the health care home model, or Health Care Homes).

As proposed by PHCAG, Health Care Homes would include:

- voluntary patient enrolment
- provision of high quality, flexible, enhanced models of care
- a patient- and carer-centric approach to planning and providing care
- a high level of data sharing.

This model would be supported by complementary work around:

- risk stratification
- system integration and improvement
- case management
- alternative payment mechanisms and incentives
- enhanced monitoring of outcomes.

The *Healthier Medicare* package includes a range of initiatives centred around the establishment of Health Care Homes, including:

- tailored patient care plans
- bundled payments
- a risk stratification tool to determine patient eligibility
- enhanced use of digital health tools and a range of supports relevant to data collection
- monitoring and evaluation
- coordination mechanisms
- workforce development.³

The Commonwealth has announced a health care home trial involving 65,000 patients, 200 medical practices and ten PHNs nationally.

Importantly, the *Healthier Medicare* package identifies the importance of improving coordination between PHNs and the acute sector in the planning and commissioning of local services.

1 North Western Melbourne PHN (2016). *Australian Health Care Reform: Challenges, Opportunities and the Role of PHNs*. Accessed June 2016 at <http://nwmpnh.org.au/uploads/ckpg/files/About/Challenges%20%20Opportunities%20Feb2016.pdf>

2 Ernst and Young (2015). *A model for Australian General Practice: The Australian Person-Centred Medical Home*.

3 The Department of Health (2016). Accessed June 2016 at <http://www.health.gov.au/internet/main/publishing.nsf/Content/healthiermedicare>

Figure 1: Key features of the patient-centred medical home model



Patient-centred: Care is planned and provided through a partnership between patients, families and clinicians, and decisions reflect patient wants, needs and preferences. Patients are educated, equipped and empowered to make decisions and participate in their care.

Comprehensive: A team of clinicians within the medical home is responsible and accountable for providing holistic care, including prevention, management of acute and chronic conditions, and mental health and wellbeing.

Continuous: Continuity of care is supported by the relationship between the patient and their medical home.

Coordinated: Where care is necessary outside of the medical home, the medical home ensures coordination between different parts of the system, and maintains overall accountability for the patient and their journey.

Accessible: Patients are able to access services with shorter wait times, and when they need them, and care is available through alternative means including telehealth.

Committed to quality and safety: The medical home provides best practice, quality care and engages in continuous quality improvement.⁴

The Royal Australian College of General Practitioners (RACGP) also supports an approach to reforming health care based on the health care home model, as described in 'Vision for general practice and a sustainable healthcare system' (the Vision).⁵ The Vision emphasises the importance of funding reform to support a sustainable primary health care system. It highlights the need to shift the way care is provided in order to achieve high quality and effective care that meets the needs of patients and general practice.

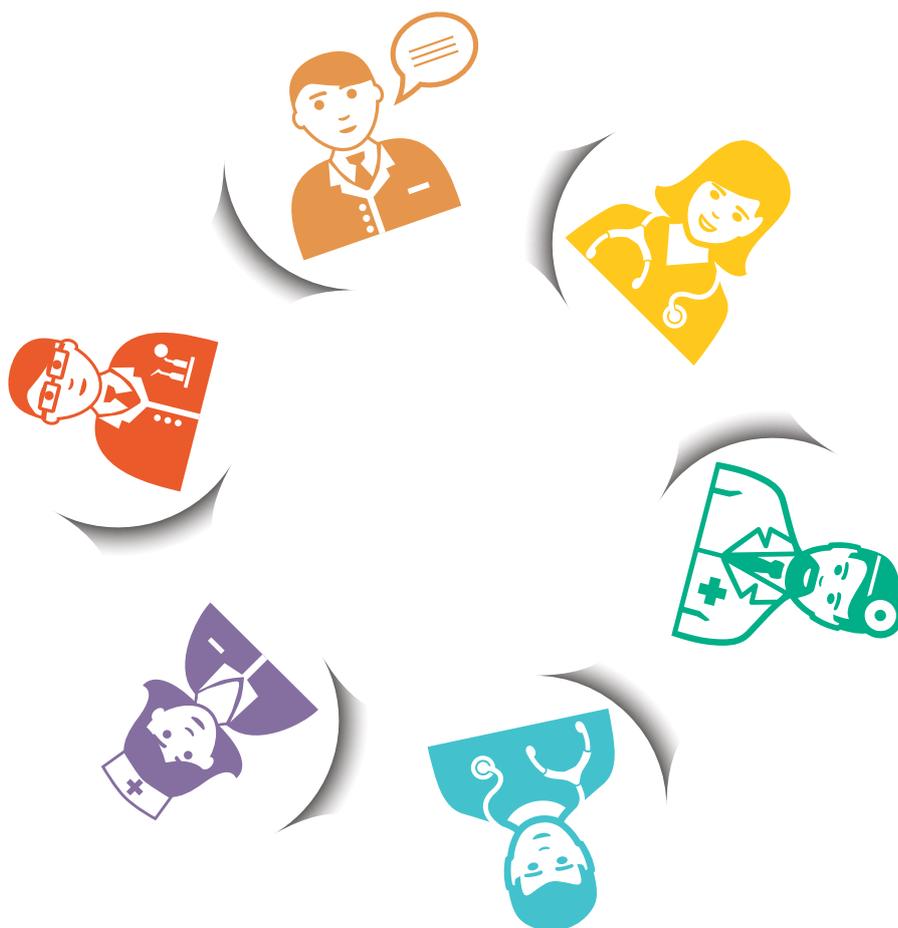
In July 2016 the RACGP, Consumers Health Forum of Australia, the Menzies Centre for Health Policy and The George Institute for Global Health hosted a roundtable to develop principles to guide implementation of the health care home model in the Australian context.⁶

Potential benefits and impacts

Benefits associated with the health care home model include increased access to appropriate care, decreased use of inappropriate services, improved access to preventative medicine, improved patient experience and reduced costs of care.⁷

The Patient-Centered Primary Care Collaborative⁸ has developed a framework outlining some of the key features and potential impacts of the health care home model. (See Figure 2.)

While there is a strong argument that the health care home model has much to offer in Australia, many aspects of the approach will only be fully understood once implementation is further progressed and local data and insights become available.



4 Adapted from the Patient-Centered Primary Care Collaborative (2015). Accessed June 2016 at <https://www.pcpcc.org/about/medical-home>

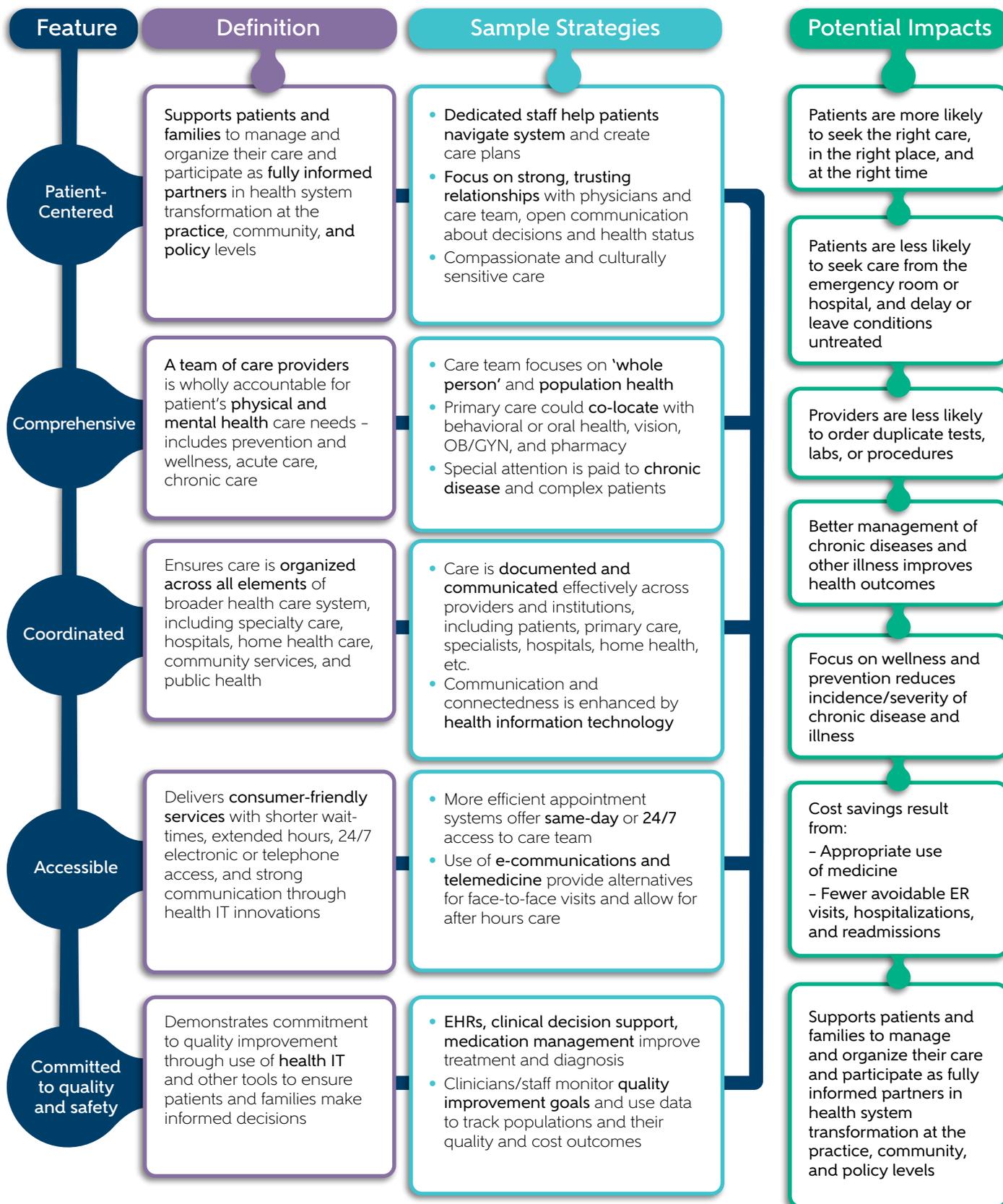
5 The Royal Australian College of General Practitioners (2015). Vision for general practice and a sustainable healthcare system.

6 Consumers Health Forum of Australia, the Royal Australian College of General Practitioners (RACGP), the Menzies Centre for Health Policy and The George Institute for Global Health (2016). Patient-centred healthcare homes in Australia: Towards successful implementation. Accessed July 2016 at <https://chf.org.au/sites/default/files/patient-centred-healthcare-homes-in-australia-towards-successful-implementation.pdf>

7 The Royal Australian College of General Practitioners (2015). Vision for general practice and a sustainable healthcare system.

8 The Patient-Centered Primary Care Collaborative, About Us (2016). Accessed June 2016 at <https://www.pcpcc.org/about>

Figure 2: Why the Medical Home Works: A Framework⁹



9 Patient-Centered Primary Care Collaborative (2013). Accessed June 2016 at <https://www.pcpc.org/content/why-it-works>

All rights reserved. PCPC 2013.

What we know – key enablers

While the health care home model can be implemented in many ways, some common features are key enablers and must be carefully considered and explored before the model can be successfully implemented in the Australian context. These include patient enrolment, integrated multidisciplinary care, payment mechanisms and data-driven care.

Patient enrolment

Patient enrolment (compulsory or voluntary) is a critical component of this model. Patient enrolment describes a formal relationship between patient and GP or general practice.¹⁰ Voluntary enrolment allows a patient to select their own GP and to change GPs at their discretion. In a compulsory model, the patient must enrol, possibly with a designated provider, in order to receive health care services or subsidies.

Patient enrolment is a feature of primary health care systems in many countries, including Denmark, New Zealand and Canada. The concept has only been trialled in Australia in very limited scope initiatives. Both the Diabetes Care Project (DCP) and the Coordinated Veterans Care (CVC) Program are based on a patient enrolment approach. The Practice Incentives Program (PIP) Indigenous Health Incentive includes enrolment of Aboriginal and Torres Strait Islander patients to receive enhanced monitoring and care.

Enrolment promotes a more stable and continuous relationship between a patient and their GP, which supports best practice primary health care.^{11, 12} Patient enrolment also enhances continuity and coordination of care for patients, improves management of patient information, facilitates population health planning, and can potentially reduce the overall cost of care for more complex patients.¹³

A potential downfall of the approach may be reduced patient choice, either genuine or perceived. The approach could also entrench health inequity by creating disincentives for providers to engage with complex patients, or create bottlenecks, particularly in areas of GP shortage.¹⁴ It could also introduce additional layers of complexity and bureaucracy that add no value for patients, and actually undermine the quality of care and drive up system costs.

While patient enrolment has not been widely trialled in Australia, and there are valid concerns about the approach, there is evidence that most patients already choose to be affiliated with a single practice. A 2011 study¹⁵ found that 89 per cent of respondents were informally affiliated with a single practice or practitioner. The same study found that patients with poor or fair self-assessed health were less likely to be affiliated with a GP,¹⁶ which highlights the potential to use patient enrolment to support vulnerable community members and promote health equity.

Integrated and multidisciplinary care

Highly integrated, multidisciplinary or team-based care is a common feature of the health care home model, and there is evidence that this approach can improve outcomes and reduce hospitalisations.¹⁷

Team-based care has been described as “the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers – to the extent preferred by each patient – to accomplish shared goals within and across settings to achieve coordinated, high-quality care”.¹⁸

10 McRae I, Yen L, Gillespie J, Douglas K (2011). Patient affiliation with GPs in Australia – who is and who is not and does it matter? *Health Policy*. 2011 Nov;103(1):16-23. doi: 10.1016/j.healthpol.2010.09.002

11 The Royal Australian College of General Practitioners (2015). Vision for general practice and a sustainable healthcare system.

12 Primary Health Care Research and Information Services (2014). Access June 2016 at http://www.phcris.org.au/phplib/filedownload.php?file=/elib/lib/downloaded_files/publications/pdfs/phcris_pub_8429.pdf

13 Adapted from Kalucy et al. (2009) and published by Primary Health Care Research and Information Services (2014). Accessed June 2016 at http://www.phcris.org.au/phplib/filedownload.php?file=/elib/lib/downloaded_files/publications/pdfs/phcris_pub_8429.pdf

14 Ibid

15 McRae I, Yen L, Gillespie J, Douglas K (2011). Patient affiliation with GPs in Australia – who is and who is not and does it matter? *Health Policy*. 2011 Nov;103(1):16-23. doi: 10.1016/j.healthpol.2010.09.002

16 Ibid

17 McKinsey & Company (2015). The evidence for integrated care.

18 Naylor MD, Coburn KD, Kurtzman ET, et al. (2010). Inter-professional team-based primary care for chronically ill adults: State of the science. Unpublished white paper presented at the ABIM Foundation meeting to Advance Team-Based Care for the Chronically Ill in Ambulatory Settings. Philadelphia, PA; March 24-25, 2010.

Considerable progress has been made in developing team-based approaches in primary care in Australia in response to workforce shortages, patient need and community expectations. Many primary care practices incorporate practice nurses, nurse practitioners and allied health practitioners in a GP led team.

In order to realise the potential benefits of integrated, multidisciplinary care, teams must function effectively. A 2012 discussion paper identified five key principles for high-functioning health care teams.¹⁹ (See Figure 3.)

A key barrier to multidisciplinary care is the current fee-for-service funding model. This model reinforces professional autonomy and independence. It does not support appropriate care for patients with chronic and complex conditions, who often require continuous care from multiple primary care professionals working together.

Patients with chronic and complex health conditions often need some care beyond the medical home, which speaks to the expanded concept of medical communities or neighbourhoods.^{20, 21} This model requires greater and more explicit collaborative relationships between primary care, acute care and community-based services, and structural changes to embed and support service integration across the patient journey. Examples include service co-commissioning, alternative funding models that incentivise team-based care, shared training, information and communication technologies, and collaborative practice spaces.

Payment mechanisms

Payment for health care in Australia is largely based on a fee-for-service model that involves paying a provider for an episode of care. In both primary health care and the acute sector, a fee-for-service model supports and incentivises individual episodes of care or procedures, rather than necessarily providing care that improves patient outcomes. Fee-for-service and activity-based funding can drive efficiency at a unit cost level, but are less suited to driving efficiency at a system level.

A health care home model may include alternative funding and incentive mechanisms such as:

- **Block or capitation payments**, where practices are allocated a set amount of funds for each of their enrolled patients on a regular basis (for example, quarterly). The practice can then use the funds to meet the patient's ongoing needs and proactively manage their chronic conditions to reduce their care needs over time. Because the practice has accepted responsibility for the care of the patient, they have a strong incentive to improve outcomes in order to minimise the cost of care over time.
- **Performance-based payments** based on clearly demonstrated improvements to patient outcomes monitored by clinical information systems and validated reporting. This approach provides a strong incentive for practices to deliver care that improves patient outcomes. However, using performance-based payments on their own can lead to perverse outcomes such as patient selection.
- **Equity or complexity payments**, which acknowledge that different patients need different interventions and levels of care to improve outcomes and reduce their cost of care. This might include additional payments for patients with highly complex co-morbidities or severe mental health issues, or those experiencing extreme disadvantage.
- **Blended payment models** that include a mix of fee-for-service and incentive (pay-for-performance) payments. For example, performance-based payments to GPs in the United Kingdom comprise approximately 25 per cent of GP payments.

19 Mitchell P, Wynia M, Golden R, McNellis B, Okun S, Webb E, Rohrbach V and Von Kohorn I (2012). Core principles and values of effective team-based health care. Discussion Paper, Institute of Medicine, Washington, DC.

20 Gullery C and Hamilton G (2015). Towards integrated person-centred healthcare – the Canterbury journey. *Future Hospital Journal* 2015 Vol 2, No 2: 111-6.

21 Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D. (2011). Coordinating care in the medical neighborhood: critical components and available mechanisms. White Paper. AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare Research and Quality.

It may also be necessary to support pilot site practices with some initial capability and capacity payments to enable them to put in place the systems, supports and workforce development activities they need to effectively implement a health care home model.

The only current Australian example of incentivised care is the Practice Incentives Program (PIP), which is designed to support general practices and boost continual improvement, quality care, enhanced capacity, and improved access and health outcomes for patients.²² Accreditation against the Royal Australian College of General Practitioners (RACGP) Standards for General Practice is an eligibility requirement for PIP participation, and it is generally acknowledged that PIP has helped increase the rate of accreditation.

Research indicates that performance-based payments have the potential to affect the behaviour of providers, and that these payments have helped improve immunisation rates and diabetes care for example.^{23, 24, 25} While there is evidence that performance-based payments can help improve quality of care and patient outcomes, this evidence is not universally considered to be compelling and there is an ongoing need to examine the most appropriate combination of incentives and funding mechanisms in the Australian context.^{26, 27, 28}

Data-driven care

The information required to improve support for patients with chronic and complex health conditions, and overall community health, is multilayered:

1. Patient-level data: help both clinicians and patients to manage their care (e.g. electronic health records, patient portals, recall and reminder systems).

2. Practice-level data: assist practices to better understand their patient cohort, and to monitor the care they provide and the outcomes they achieve (e.g. safety and quality data, cost and resource utilisation and key performance indicators).
3. Population-level data: assist practices, PHNs, funders and policy makers to identify vulnerable patient cohorts and areas of need, and to monitor health outcomes and resource utilisation over time (e.g. ABS, hospital data sets, PenCAT, MBS, PBS).

Although improving, the systems for collecting data across health care in Australia are still somewhat siloed and fragmented. In Victoria particularly, sharing data between health providers around a single patient is difficult. For example, most hospitals in the state are unable to send general practitioners electronic admission advice or discharge summaries, and electronic referral systems are not well established. As many as 19 per cent of general practices in the north western Melbourne region are still not computerised, limiting their capacity to easily exchange information with other providers.

Data linkage at a population level is improving but still difficult, with linked data sets the exception rather than the rule. This limits research and the production of quality information about what works and the cost of care. Progression and uptake of My Health Record will be fundamental for implementation of the health care home model. Continued development of HealthPathways Melbourne and progression of the Victorian Government's electronic referral program²⁹ will also be key enablers.

22 Department of Human Services (2016). Access June 2016 at

<https://www.humanservices.gov.au/health-professionals/services/medicare/practice-incentives-program>

23 Wright M (2012). Pay-for-performance programs: Do they improve the quality of primary care? Accessed June 2016 at

<http://www.racgp.org.au/afp/2012/december/pay-for-performance-programs/>

24 Flodgren G, Eccles MP, Shepperd S, Scott A, Parmelli E, Beyer FR. (2011). An overview of reviews evaluating the effectiveness of financial incentives in changing healthcare professional behaviours and patient outcomes. Cochrane Database Systematic Review.

25 Hull BP, Deeks SL, McIntyre PB. (2009). The Australian Childhood Immunisation Register - A model for universal immunisation registers? Vaccine. 2009 Aug 13;27(37):5054-60.

26 Scott A, Schurer S, Jensen PH, Sivey P. (2008). The Effects of Financial Incentives on Quality of Care: The Case of Diabetes. Working paper No. 12/08. Melbourne Institute of Allied Economic and Social Research, The University of Melbourne.

27 Scott A, Sivey P, Ait Ouakrim D, Willenberg L, Naccarella L, Furler J, Young D. (2011). The effect of financial incentives on the quality of health care provided by primary care physicians. Cochrane Database Systematic Review.

28 Flodgren G, Eccles MP, Shepperd S, Scott A, Parmelli E, Beyer FR. (2011). An overview of reviews evaluating the effectiveness of financial incentives in changing healthcare professional behaviours and patient outcomes. Cochrane Database Systematic Review.

29 Victorian State Government, Victorian eReferral Program (2016). Accessed June 2016 at

<https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/victorian-ereferral-program>

What can we do?

The concept of health care homes has broad support from policy makers (through the *Healthier Medicare* package) and growing support from providers (led by the RACGP). While the evidence base around the potential impact of health care homes is unclear and untested in Australia, it is imperative that PHNs engage in the discussion and development of evidence.

North Western Melbourne PHN (NWMPHN) has a longstanding commitment to the patient-centred medical home model and welcomes Commonwealth and RACGP support to progress this model in Australia.

NWMPHN is already working towards implementing the principles that underpin the health care home model through:

- our approach to general practice engagement and support
- building the capacity of the primary healthcare sector
- promoting patient-centred models and a health literacy-based approach to care
- promoting technology-based solutions, including My Health Record and secure shared messaging
- the collection, collation and reporting of clinical data.

NWMPHN is well positioned to continue to support general practice to establish the foundations upon which a health care home model can be implemented in Australia.

NWMPHN will closely monitor the progress of the Commonwealth trial. We believe there are opportunities for PHNs to conduct complementary work to contribute to the evidence base around how the health care home model could transform the Australian primary health care system.

We invite stakeholders to register their interest in working with us to further develop our thinking about the health care home model, and to consider how NWMPHN can continue to progress the concept and contribute to the evidence base around how this model can add value in Australia and in our region.

Register your interest:

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For more information visit:

nwmpnh.org.au/services/The_Health_Care_Home

