Health Care Homes

Patient-centred 'medical home' (PCMH) models in primary care have been demonstrated to:

- Improve health outcomes and patient satisfaction, at a lower cost
- Improve continuity of care, preventive measures and reduce hospital admissions
- Improve access to required services, including preventive screening and chronic disease management
- Reduce or eliminate racial and ethnic disparities in healthcare access and quality.

The introduction of a Health Care Home model in Australia provides an opportunity to deliver better coordinated primary healthcare and adopt a more holistic view of meeting individuals' healthcare needs.

The Australian Government commenced trialing a Health Care Home program for people with chronic and complex health conditions in October 2017. Over 10,000 patients are now participating through >120 practices across 10 Primary Health Network (PHN) regions, with the trial extended to 30 June 2021. The program is characterised by:

- Voluntary patient enrolment with a general practice or Aboriginal Medical Service (AMS), with nomination of a preferred clinician (usually their GP)
- The preferred clinician leading a team, involving nurses, care coordinators, specialists and allied health
- A tailored and dynamic electronic shared care plan
- Flexible service delivery supported, including in -hours support via telephone, email or video conferencing.

A key feature of the model is the payment approach:

- Bundled payments are provided to the general practice or AMS, with 3 payment tiers reflecting the patient's level of complexity and need.
- All general practice or AMS health care costs associated with the patient's chronic condition previously funded through the MBS are funded through the bundled payment.
- Fee-for-service MBS payments are provided to the general practice or AMS for care not related to the patient's chronic condition.
- Specialist, allied health, diagnostic and imaging services are excluded from the bundled payment, with access to fee-for-service MBS payments for these services according to existing arrangements (including access limits per calendar year).
- Patients can also be charged out-of-pocket costs beyond the bundled and fee-for service payments.
- A one-off upfront grant of $10,000 provided to support the practice changes to implement the model.

In the Australian context much can be learned from the approach to primary health adopted by Aboriginal Community-Controlled Health Organisations, the Department of Veterans' Affairs Coordinated Veterans Care program and PCMH models led by a number of PHNs separate to the Health Care Home program.

AHHA POSITION:

- Achieving improved patient outcomes and system efficiencies will take both time and investment and will challenge existing models of care. This should not compromise commitment to integrated care.
- Findings and outcomes from the evaluation of the trial must be published swiftly, with action on recommendations to guide further reform and investment with continued support for the change in focus from volume to value.
- The Health Care Home model must be flexible and delivered according to local needs and local system capacity, including the flexible use of local healthcare professionals. PHNs have a key role in leading this work in partnership with Clinical Councils and general practice.
- Comprehensiveness and flexibility are needed with scope extended beyond primary clinical care and preventive and health promotion activity, to also provide assistance to access care (e.g. through transport, childcare, medication subsidies).
- Data-driven improvements need to be supported through monitoring clinical performance, and benchmarking through national and jurisdictional key performance indicators. The development of a national primary health minimum dataset that links to broader, more extensive national health data registries is necessary.
- Appropriate funding is required that reflects the risk being transferred to general practice. This risk relates to unexpected patient demand and the costs of providing new approaches to patient care. Rolling in some related items from the MBS is unlikely to be sufficient to drive meaningful change in the system. Funding needs to explicitly incorporate non-GP primary healthcare services when needed (beyond the limits of the MBS disease program) and be weighted for remoteness.
- A population health approach is needed, with all patients having access to the Health Care Home model, not just those with chronic conditions.
- Purposeful collaboration with state and territory governments is necessary, and should include opportunities to pool funding, particularly to address preventable hospitalisations and to promote innovative models of care.

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