Better Outcomes for People

with Chronic and Complex Health Conditions

through

PRIMARY HEALTH CARE

Primary Health Care Advisory Group

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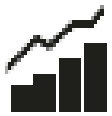
What is the problem?

Around 20% of Australians have at least one chronic condition, and this doubles to 40% for people over 45



Medicare spending is projected be the fastest growing area of Australian Government expenditure over the coming decades

Risk factors for chronic conditions such as obesity are already at high levels and are increasing

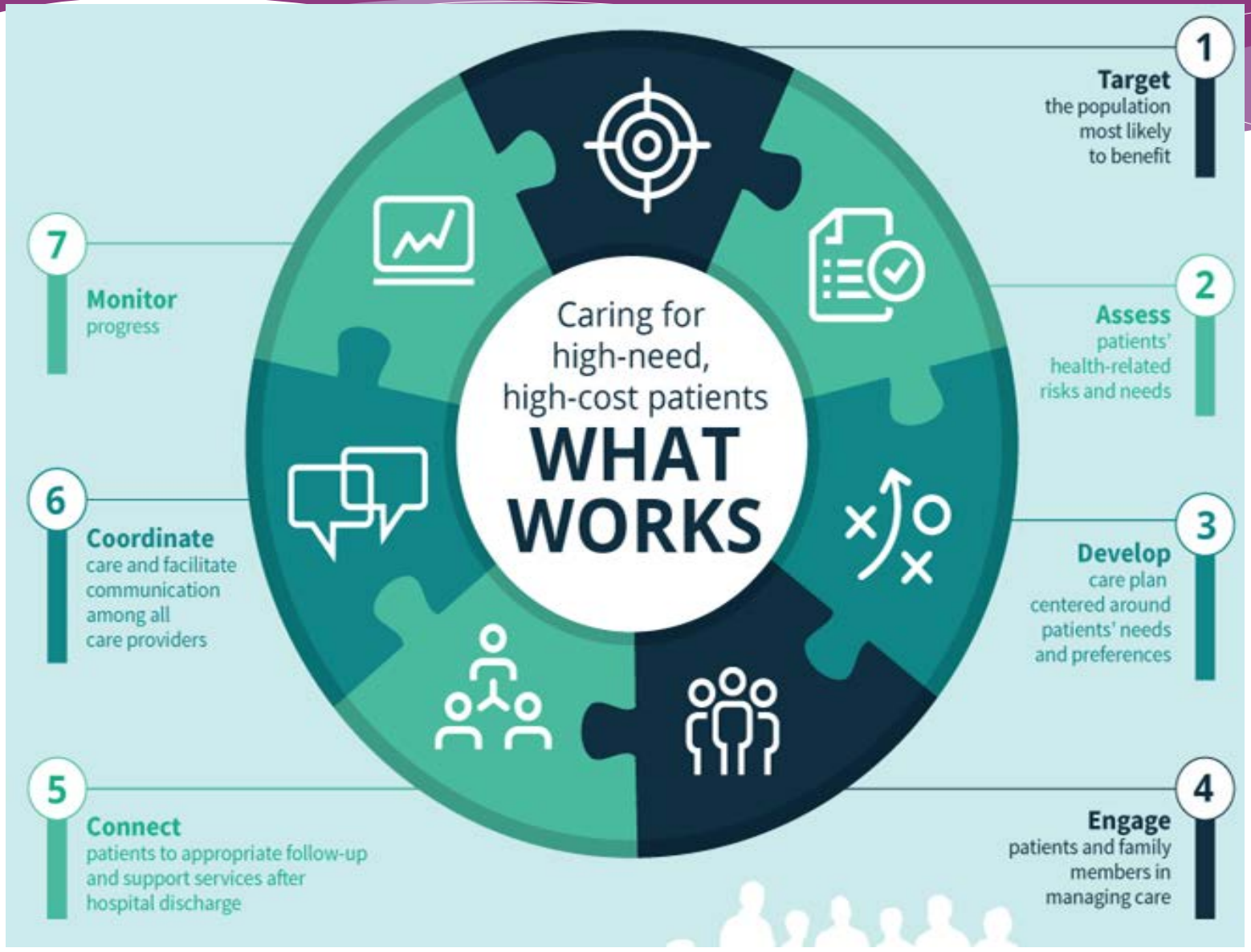
There is a potentially preventable hospitalisation for chronic disease in Australia every 2 minutes (285,000) – (a diabetes related amputation every 2-3 hrs)

Nearly a quarter of people who visited an emergency department felt their care could have been provided by a general practitioner (GP)

- Patients too often experience fragmented services
- Payment system is in conflict with the model of care

Primary Health Care Advisory Group Priorities

- Better care for people with chronic and complex health conditions;
- Innovative care and funding models; and
- Greater connection between primary health care and hospital care.

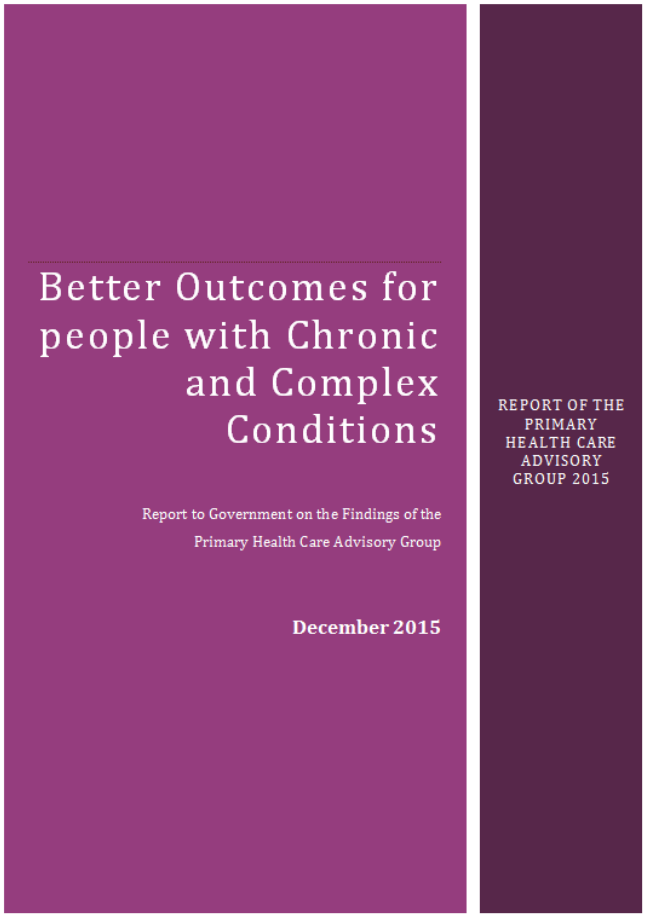


D. McCarthy, J.Ryan and S.Klein. "Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis, October 2015." Retrieved from: http://www.commonwealthfund.org/interactives-and-data/infographics/2015/oct/caring-for-high-need-high-cost-patients

Towards a more effective service model for chronic and complex conditions

Today's Care		Health Care Home
High-volume practices offer short term care; assumes patients are opportunistic	→	Home-base for the care coordination and management of enrolled patients
Only doctors direct care; treatment is end goal rather than means to an end	→	Patients, families and their carers as partners in their care
Often 9-5 only; face-to-face only	→	Patients have enhanced access
No formal partnership or accountability	→	Patients have a personal clinician
Doctors refer to allied and other medical specialists, but work in silos	→	Flexible service delivery and team-based care
Care planning evidence-base is variable	→	Commitment to high quality, safe care
Weak primary health care outcomes data	→	Data collection, sharing and reporting

Final Report

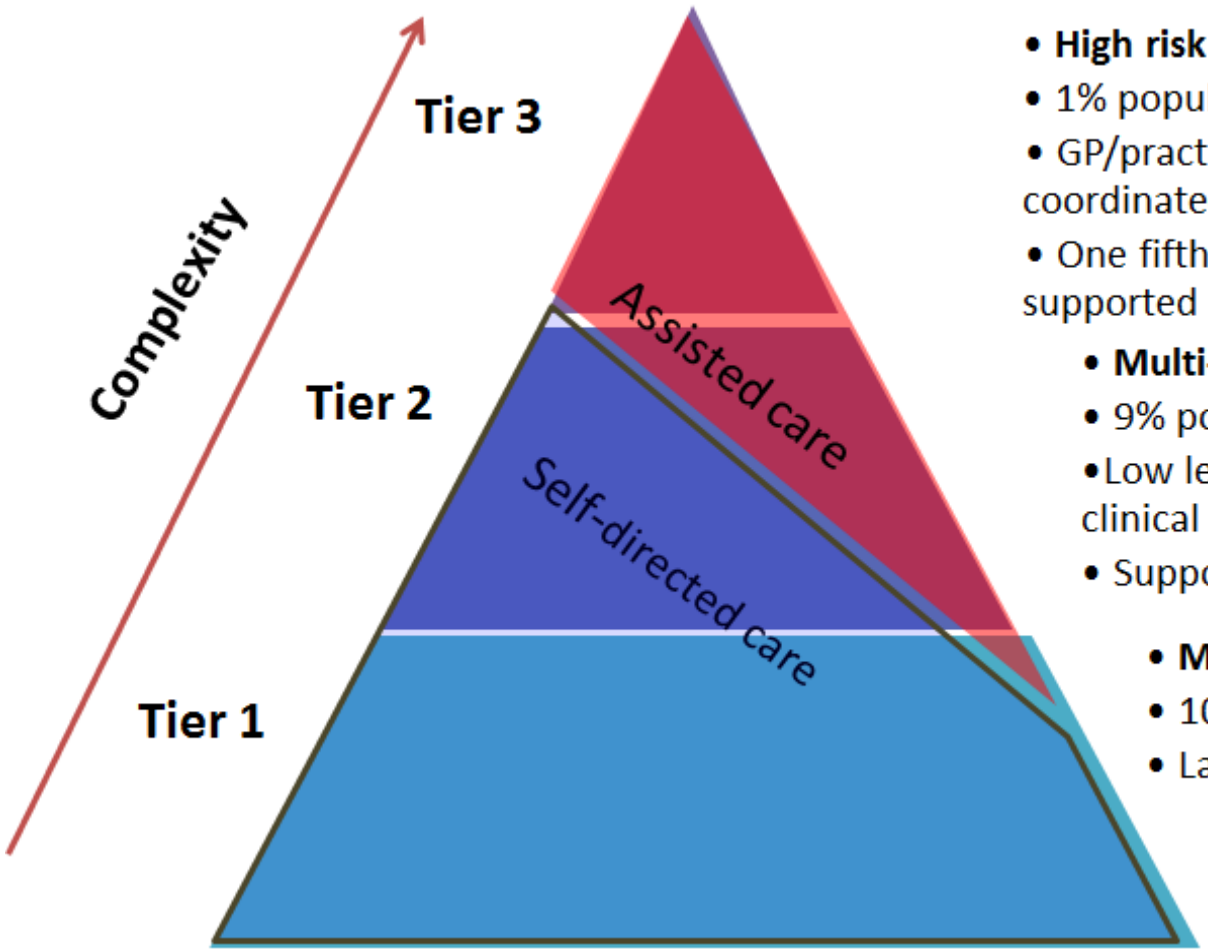


- 15 recommendations across 4 key themes:
  - Appropriate and effective care
  - System integration and improvement
  - Payment mechanisms to support a better primary care system
  - Measuring to ensure we achieve outcomes
- Staged rollout of new care model

Appropriate and Effective Care

- Recommendation 1: Better target patients through appropriate patient identification and risk stratification
- Recommendation 2: Establish health care homes
- Recommendation 3: Activate patients to be engaged in their care
- Recommendation 4: Establish effective mechanisms to support flexible team based care

Better Targeting Resources According to Patient Risk Factors



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

- **Multi-morbidity and moderate needs**
- 9% population*
- Low level clinical coordination and non clinical coordination
- Supported self-care

- **Multiple Chronic conditions**
- 10% population*
- Largely self-managing

*Indicative estimates

Health Care Home model

- Eligible patients will voluntarily enrol with a participating medical practice known as their Health Care Home.
- This practice will provide a patient with a 'home base' for ongoing coordination, management and support.
- Care coordination and team-based care
- Regional clinical 'patient pathways'
- Patient participation

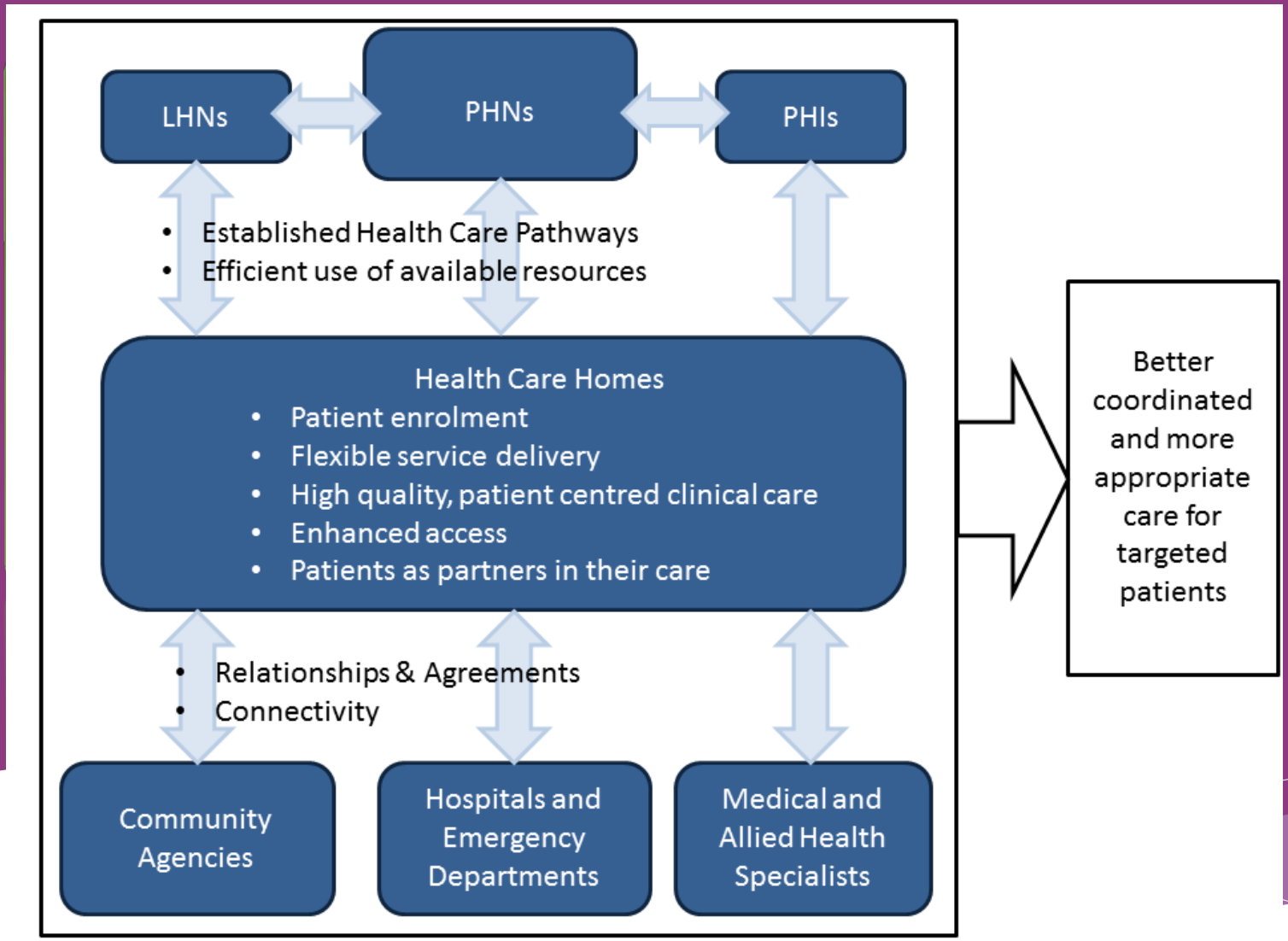
Partners in care

- Patients will be active partners in their care.
- The aim is to put patients in control of their own care with the knowledge, skills and confidence to manage their health, supported by their health care team, families and carers where appropriate.
- A tailored care plan will be developed in partnership with the patient.
- The care provided by Health Care Homes will be flexible to meet the needs of the patient.

System Integration and Improvement

- Recommendation 5: Enhance regional planning and commissioning
- Recommendation 6: Maximise the effectiveness of private health insurance investment in chronic disease management
- Recommendation 7: Coordinate care across the system to improve patient experience
- Recommendation 8: Support cultural change across the health system

The Health Care Home



Care Coordination

- Care coordination is critical to ensure that patients with high care needs can navigate the health care system.
- Patients enrolled in the Health Care home may also be eligible to receive support services through other programs that can improve their ability to manage their care.
- Approximately 59% of practices employ an additional staff member to coordinate their patients' care.
- These resources need to be effectively targeted to those patients who have the greatest need.

Payment Mechanisms to Support a Better Primary Care System

- Recommendation 9: Restructure the payment system to support the new service delivery model
- Recommendation 10: Explore opportunities for pooled funding
- Recommendation 11: Patients contribute to their health care costs to the extent that they are able

A New Payment Mechanism

- A new blended payment mechanism will provide flexibility in the delivery of care and incentivise delivery of high quality care.
  - Health Care Homes will be paid a quarterly bundled payment to provide care related to a patient's chronic and complex condition.
  - Fee for service payments will be maintained for care not relating to the enrolled patient's chronic conditions.
  - Existing MBS items for allied health services will remain in place for patients enrolled in a Health Care Home.
- Pursue collaborative approaches to planning and allocation of health system resources, including joint and pooled funding with State and Territory governments and private health insurers.

Measuring to Ensure we Achieve Outcomes

- Recommendation 12: Support a continually improving primary health care system
- Recommendation 13: Establish a national minimum data set (NMDS) for patients with chronic and complex conditions
- Recommendation 14: Establish new performance reporting arrangements
- Recommendation 15: Develop and implement an evaluation framework for the model

Evaluation of the Health Care Home model (cont)

- As a first step Health Care Homes will be rolled out in up to seven Primary Health Network regions across the country.
- Up to 200 Health Care Homes will offer services to up to 65,000 people with chronic and complex conditions.
- Health Care Home services will be delivered in these regions from 1 July 2017.
- Any national roll out of Health Care Homes will be informed by the results of a rigorous evaluation of the first stage of implementation and consideration by Government.

Staged Rollout

- Elements of the model to be defined, established and evaluated in large demonstration sites
- Opportunities to partner with PHNs, PHIs and jurisdictions already trialling innovative care or developing new trials
- Refinement and national transition, informed by learnings from demonstrations sites

Evaluation of the Health Care Home model

- We need to test and evaluate the Health Care Home model to work out the best way of delivering the services that patients need and the best way of funding these services.
- It also ensures that the approach is flexible and effective in supporting communities with different demographics.

Feedback from consultations and written submissions

* There is strong support for **voluntary patient enrolment** for people with chronic and complex health conditions.
* There is **general support for myHealth records and an opt-out** approach.
* This is an untapped opportunity to **engage patients** in their own care, particularly with technology that people already want to use (e.g. smart phones).
* There is general support for the **reporting of outcomes** and changes in health status at an aggregate level.
* There is support for a **blended payment mechanism** which recognises and caters for different complexities and levels of care needed.