Health Care Homes

Handbook for General Practices and Aboriginal Community Controlled Health Services

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Abbreviations

AAPM – Australian Association of Practice Management
ACCHS – Aboriginal Community Controlled Health Service
ATO – Australian Tax Office
DVA – Department of Veterans Affairs
EDP – Eating Disorder Treatment Plan
GP – general practitioner
GST – goods and services tax
HARP – Hospital Admission Risk Program
HCH-A – Health Care Homes assessment tool
HPOS – health professional online services
IRN – individual reference number
MBS – Medical Benefits Schedule
MMP – Medication Management Plan
PBS – Pharmaceutical Benefits System
PHN – Primary Health Network
PIP – Practice Incentives Program
RST – Risk Stratification Tool
SA – Services Australia
SIP – Service Inventive Program
the Department – Department of Health
WIP – Workforce Incentive Program

Please note: In this Handbook, the term 'practice' refers to both general practices and Aboriginal Community Controlled Health Services.

1 Health Care Homes Introduction

This handbook has been designed for general practices and Aboriginal Community Controlled Health Services (ACCHS) as a set of guidelines for the participation in the Health Care Homes Program.

The Health Care Homes model further builds on the integrated and patient-centred care that many high performing general practices and ACCHS around Australia are already providing. The transformation of a practice or ACCHS to a Health Care Home takes time and the involvement of the whole team. You will be supported by the Primary Health Network (PHN) and their practice facilitators, together with detailed information in the Health Care Homes training modules.

1.1 What is a Health Care Home?

A Health Care Home is an existing general practice or ACCHS that further commits to a systematic approach to chronic disease management in primary care. This approach supports accountability for ongoing high quality patient care. It uses an evidence-based, coordinated, multi-disciplinary model of care that aims to improve efficiencies and promote innovation in primary care services.

The team approach and the bundled payment model provide general practitioners, nurses and other health care professionals, greater flexibility to shape care around an individual patient's needs and goals, and encourages patients to participate in and direct their own care.

The Health Care Homes vision is for:

- better coordinated, more comprehensive and personalised care
- empowered, engaged, satisfied and more health-literate patients, families and carers
- improved, timely access to health care and services, including through appropriate use of non-face-to-face telephone and internet-based digital health options
- improved health outcomes, especially for patients with chronic conditions
- increased continuity and safety of care, including more consistent adherence to clinical guidelines
- increased productivity of health care service providers
- increased provider satisfaction, working to the full scope of their license
- enhanced sharing of up-to-date health summary information.

1.2 The Health Care Home approach

The implementation of the Health Care Homes Program is an opportunity to transform the way care is provided for people living with chronic and complex conditions.

Chronic conditions are the leading cause of illness, disability and death in Australia. According to the Australian Institute of Health and Welfare, 50 per cent of Australians – over 11 million people – have a chronic condition; and one-in-four people have at least two chronic conditions.

These patients may experience fragmented and uncoordinated access to health care from multiple providers and will benefit from the patient-centred, co-ordinated and targeted approach of the Health Care Homes model of care.

Patients who are most likely to benefit will be targeted, i.e. patients with multiple chronic and complex conditions.

1.3 Quadruple Aim

The Quadruple Aim is an approach to optimise health system performance. The dimensions of performance include:

- Improved patient experience of care
    - The long-term approach to patient-care is timely, recognises the needs of patients and their families and provides equitable access. Services are better coordinated including

links with hospitals and allied health providers. Access is enhanced through the use of technology, such as telephone and email. Better patient self-management will shift the focus from treatment to prevention.

- Improved health outcomes and population management
  - Benefits to the Australian population in terms of quality and population health that will include more proactive ways for patients to receive the right care at the right time, reducing demand on hospitals. This enhanced coordination will improve patient outcomes and reduce escalation of conditions.
- Improving cost efficiency and sustainability in health care
  - By being more proactive and using new roles within practices, some tasks can be managed by other staff freeing up GPs and nurses. This brings greater efficiencies and improves the capacity of the practice to meet the needs of all patients. This means more patients will be able to access health services at practices and ACCHS.
- Improved health care provider experience
  - The removal of a number of Medicare item restrictions will reduce pressure on GPs and allow nurses and other practice team members to work at the top of their professional capacity and individual capability. This provides greater work satisfaction for all team members. Monthly bundled payments will reward practices for value rather than volume. By encouraging a collaborative and systematic team-based approach to care, there will be reduced pressure on individual providers. This has been shown to improve job satisfaction, reduce burnout and support a better work/life balance.

1.4 Characteristics of a Health Care Home

The Health Care Home approach to primary health care puts consumers at the centre of the health care system. It provides a home base for the management of an eligible patient's chronic conditions; and delivers co-ordinated, team based care around the needs and goals of the patient.

Each Health Care Home will share these characteristics:

Voluntary patient enrolment — Health Care Homes will identify eligible patients and facilitate their enrolment with the Health Care Home, and registration in the program.

Patients nominate a clinician — the nominated clinician will lead the team providing the ongoing care. A nominated clinician would usually be their GP or in some cases a nurse practitioner.

Patients, families and their carers as partners in their care — this ensures cultural preferences and values are respected; and patients, families and their carers are genuine partners in a patient's care.

Enhanced access and flexibility through timely advice; and greater access options enabled by a bundled payment model.

Team-based care from a range of clinical providers through shared information and care planning.

A commitment to **high-quality care,** through the enhancement of systematic and quality approaches to support evidence-based decision making.

Data collection and sharing to continuously and transparently monitor and improve performance, quality and service.

The Health Care Home model will facilitate a partnership between the patient, their families and carers, their treating GP and the extended health care team, enabling better-targeted and effective coordination of clinical resources to meet patient needs.

This diagram provides an example of how care is transformed when delivered through the Health Care Home model.

Care currently	Care within a Health Care Home
My patients are those who make appointments to see me	Our patients are those who are registered in **our Health Care Home**
Patients' chief complaints or reasons for visit determines care	We **systematically assess** all our patients' health needs to plan care
Care is determined by today's problem and time available today	Care is determined by a **proactive plan to meet health needs, with or without visits**
Care varies dependent on memory and scheduled time of doctor	Health care providers have **access to evidence-based guidelines** to build the right care plan
Patients are responsible for coordinating their own care	A **prepared team** of professionals supports the coordination of a patient's care
Patients are passive recipients of care	Patients play an **active** role in making decisions about their care and are **empowered** to better manage their conditions
I know I deliver high quality care because I'm well trained	**We measure our quality and make changes to improve it**
It's up to the patient to tell us what happened to them	We **track tests and consultations, and follow-up** after visits to other services (e.g. ED visits or specialist appointments)
Clinic operations centre on meeting the doctor's need	An **interdisciplinary** team work at the **top of their professional capacity** to serve patients

Source: Adapted with permission from F. Daniel Duffy, MD, MACP, Senior Associate, Dean for Academics, University of Oklahoma School of Community Medicine.

2 Health Care Homes Program

The Health Care Homes Program commenced in a staged approach – 22 Health Care Homes commenced on 1 October 2017; and the remaining Health Care Homes commenced on 1 December 2017.

The Health Care Homes Program is undergoing a rigorous evaluation, and the findings will be used to assess the suitability of the Health Care Home model for national rollout for different practice types across a range of contexts. The program's extension or expansion beyond the trial period will be a decision for Government. Participating general practices and ACCHS will be informed of this decision.

Regardless of the outcome, the general practices and ACCHS involved in the Program will have undergone a whole of practice transformational process to support optimised performance in the dimensions of the Quadruple Aim.

As Health Care Home concepts become embedded and normalised, practices will notice the benefits not only in terms of improved patient experience and outcomes but also improved efficiency within the practice and improved provider satisfaction.

3 Practice eligibility and registration

3.1 Practice eligibility requirements

A general practice or ACCHS participating in the Health Care Homes Program must meet the following eligibility requirements for the duration of the Program:

- Be a recipient of a one-off incentive grant under the Health Care Homes' Grant Program Guidelines.
- Have already obtained, or will obtain by the first anniversary of the Commonwealth executing the separate Letter of Agreement, full accreditation as a general practice or ACCHS, against the current Royal Australian College of General Practitioners Standards for general practices.
- By 1 December 2017 be registered in the Practice Incentives Program (PIP) eHealth Incentive.
- By 1 December 2017 have access to Services Australia (SA) health professional online services (HPOS) portal.
- Participate in the Health Care Home training program, as required by section 5.2 of this handbook.
- Use the Risk Stratification Tool (RST) to identify the eligible patient cohort in their general practice or ACCHS; assess individual patient eligibility; and stratify their care needs to one of three complexity tiers according to their level of risk, as required by section 4.2 and 4.3.
- Develop, implement and regularly review each enrolled patient's shared care plan, as required by section 7.3.
- All patients that have, or wish to have, a My Health Record are registered and connected to the My Health Record system, and contribute up-to-date clinically relevant information to their My Health Record.
- Provide care coordination for enrolled patients.
- Provide care for enrolled patients using a team-based approach.
- Ensure that all team members have roles which utilise their qualifications and allow them to work to their scope of practice.
- Provide enhanced access for enrolled patients through in-hours telephone support, email or video-conferencing, as well as access to after-hours care where clinically appropriate, as required by sections 6.2 and 7.1.
- Ensure that all enrolled patients are aware of what to do if they require access to after-hours care, as required by section 6.2.
- Collect data for internal quality improvement processes.
- Complete the twice-yearly HPOS patient confirmation, as required by section 4.6.

A general practice or ACCHS must also:

- participate in the evaluation of the Program
- meet additional requirements as indicated in this Handbook.

3.2 Practice registration

In order to register your practice or ACCHS, follow the instructions in your letter of offer, including:

- signing the attached grant schedule
- signing the attached declaration
- sending or emailing a scanned copy to the address outlined, so that it is received by the required date.

Once the signed copy of the grant schedule is countersigned by the Commonwealth, the letter of offer and the grant Schedule and the Commonwealth letter of offer conditions will form a legally enforceable agreement in relation to the grant.

4 Practice systems

4.1 Practice readiness and practice assessment tools

Specialist practice facilitators will be located in PHNs to support the transformation of practices and ACCHS into Health Care Homes. One of the key resources used by practice facilitators in this process will be practice self-assessment tools.

A number of self-assessment tools are available to practices, including the Health Care Home assessment (HCH-A) tool. The HCH-A tool is available free to all practices as part of the Health Care Home training. PHN practice facilitators will be able to assist you to use the tool to develop a customised training plan using the results.

The general practice or ACCHS may use the HCH-A tool at the start of services and may repeat it several times during the Program to assess their progress over time. General practices or ACCHS may re-do different parts of the HCH-A tool relevant to the modules in the training program. The HCH-A tool, together with other Health Care Home tools and the learnings from their experience, enable the general practice or ACCHS to effectively plan their ongoing development. Practice facilitators will assist with administering and analysing the HCH-A tool and supporting Health Care Homes to identify and plan for improvement.

Tips for getting the most from the assessment tool:

- identify a multidisciplinary group of Health Care Home staff
- have all the team (clinical and non-clinical) involved in the assessment
- complete the assessment individually, to capture different perspectives
- have the team meet to discuss their individual assessments and produce a consensus version (but avoid averaging the scores)
- use team discussions to identify opportunities and priorities for practice transformation
- if you have multiple locations, each general practice or ACCHS should complete separate assessments. Practice transformation, even when directed and supported by practice leaders, happens differently at the practice level
- share the assessments from multiple locations to encourage the cross-pollination of improvement ideas
- answer the questions honestly and accurately. Over-estimating item scores may make it harder for real progress to be apparent when the assessment is repeated in the future.

The HCH-A tool is outlined further in training Module 1.

4.2 Patient identification and eligibility – Risk Stratification Tool (RST)

The use of the RST is the critical first step to identifying patients and assessing their eligibility for the Health Care Homes Program. All participating general practices or ACCHS must use the same tool.

The RST has been developed using the cdmNet platform, from Precedence Health Care. CSIRO has validated and calibrated the RST using Australian primary care and hospital data. The platform is cloud-based and requires internet connectivity. The software has been developed to be compatible with Medical Director, Best Practice, ZedMed, Monet, Communicare and MedTech32. Health Care Homes should contact their PHN practice facilitator to download and install the software. User guides and technical support are available to participating general practices and ACCHS.

The RST identifies potential patients by determining the complexity of each patient's chronic conditions, represented by a tier, and their eligibility for Health Care Homes. Each patient is assigned to a complexity tier (see figure below). The RST collects patient information in order to provide eligibility assessments and assign risk tiers to patients, and this data is stored safely and securely without any identifying information.

It is important to note that the RST is intended to assist practitioners in their decision making. Information should not be provided to patients.

Patients with chronic health conditions have varying requirements for care and different abilities to self-manage. Depending on the number, combination and complexity of those conditions, combined with social risk factors, some patients are more likely to experience poor health outcomes. The RST identifies the relative risk of unplanned need for hospital-based care for people, by considering an individual's circumstances, health and medical history.

An enrolled patient's tier level is intended to account for fluctuations in their health care needs over the course of 12 months. A patient's risk stratification certificate is valid for 12 months, at which time their risk tier level will need to be reviewed by repeating the risk stratification process. Health Care Homes will then need to update the patient's risk stratification certificate number and if required their assigned tier level on HPOS. A review of a patient's risk tier level can also be triggered where there is a significant change in an enrolled patient's chronic conditions. Reviews should be conducted in accordance with clinical best practice guidelines. The HPOS bi-annual patient confirmation process (see section 4.7) requires Health Care Homes to confirm the accuracy of each patient's enrolment details every six months, including the risk tier assigned by the RST.

Figure 1 below shows the population estimates and characteristics of patients.

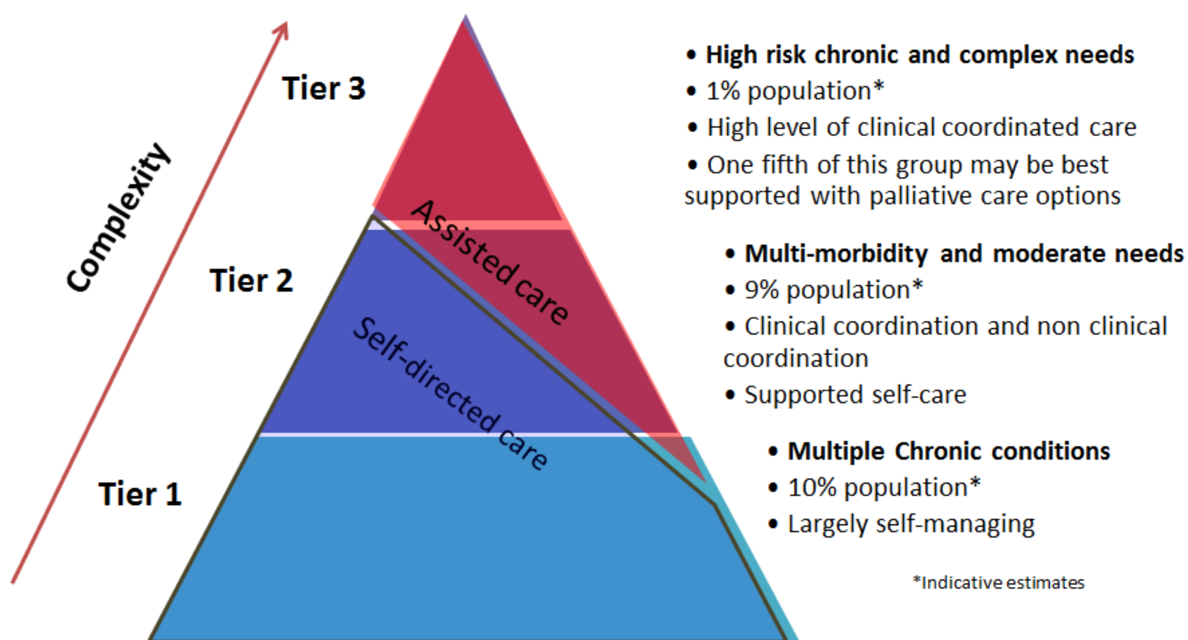

Figure 1: Estimates and characteristics of patients requiring targeted support.
Estimates based on analysis of available population, hospitalisation and Medicare data. Accurate estimates of population sub-groups are limited due to limited national data to support such analysis. Source: Department of Health (2015). Primary Health Care Advisory Group report Better Outcomes for People with Chronic and Complex Health Conditions.

The RST will produce its most accurate and reliable assessments with high quality and complete data records. General practices and ACCHS can prepare for using the RST by ensuring that they are consistent and skilled in their coding of clinical information (for example, minimising free-text when drop-menus are appropriate; recording diagnoses, medications and measurements; and filing of discharge summaries and letters).

Residents of aged care facilities and participants in the Department of Veterans' Affairs (DVA) Coordinated Veterans' Care Program are not eligible to enrol in the Health Care Homes Program. Recipients of other Commonwealth-funded aged care support, including the Home Care Packages Program and the Commonwealth Home Support Program, can enrol as Health Care Home patients.

As Health Care Home enrolment is intended to provide longitudinal care, patients with a yellow Medicare Card are not eligible for Health Care Home enrolment due to their visitor status. Holders of yellow Medicare Cards are covered by a Reciprocal Health Care Agreement. These patients are residents of countries with which the Australian Government has an agreement in place to provide medically necessary care for the duration of their approved visit to Australia.

4.3 Patient enrolment and consent

Patient enrolment is a vital component of the Health Care Home model. Your PHN practice facilitators can help with recruitment and enrolment.

All eligible patients must be enrolled not just with a general practice or ACCHS, but a team led by the patient's nominated clinician within that Health Care Home.

A patient is deemed to be enrolled when they sign the Health Care Home enrolment/consent form. A patient must then be registered through HPOS within seven days of signing this form.

The following steps in the enrolment process are also outlined in Module 3 of the training.

Step 1 — Identify eligible patients using practice scan tool

- Run the RST in practice scan mode to identify a potentially eligible patient cohort. General practices or ACCHS should have an existing relationship with the patient. The sole purpose of using the RST at this stage must be for providing a health service to your patients.
- General practice or ACCHS communicates with these patients over the phone or via letter or SMS and invite them to attend a consultation.

Step 2 — Discuss Health Care Homes with potentially eligible patients

- Confirm that the patient holds a green or blue Medicare Card – N.B. Patients with a yellow Medicare Card are not eligible for enrolment.
- Confirm that the patient is not a resident of a residential aged care facility or enrolled in the Department of Veterans' Affairs (DVA) Coordinated Veterans' Care Program.
- Provide potential patient with brochure. This brochure has been posted to practices/ACCHS. Consumer information is also available on the Health Care Homes consumer webpage.
- Provide patient with information on any fees charged by the practice for Health Care Home care, including that a small MBS rebate will be claimable for any out-of-pocket costs. This administrative mechanism will ensure that these expenses count towards the patient's Medicare Safety Net thresholds.
- Enrolled patients may continue to contribute to their healthcare costs. However this must be agreed with the patient when they enrol. Information on out-of-pocket expenses and the Medicare Safety Net is available on page 19.
- Verbal consent must be obtained to proceed with the eligibility assessment and to assign a patient with a risk tier. A script will need to be read to the patient to obtain the consent before proceeding to the next step.

Step 3 — Assign a risk tier during the consultation

- Use the questionnaire in the RST to determine the risk tier. The RST will prepopulate the questionnaire based on existing information in the patient's medical record. Additional information from the patient and their family members/carers will need to be used to complete the questionnaire.
- The RST will produce a risk tier certificate.
- The risk tier determines the level of care required by the patient and the value of bundled payment provided to the Health Care Home.

Step 4 — Patient consent process

- Answer any further questions from the patient, including any questions about the collection, use and disclosure of patient information.

- If patient agrees to enrol, patient completes and signs the enrolment/consent form.

Step 5 – Complete the consultation

- Provide the patient with a copy of their signed enrolment/consent form (including the Patient Information Statement that precedes the form).
- Upload the following to the patient's clinical record:
    - risk tier certificate
    - Health Care Home enrolment/consent form signed by the patient.
- Give the patient the Patient Handbook (hard copies have been sent to all participating Health Care Homes). The Patient Handbook is also available on the Department of Health's Health Care Homes website.
- Check if the patient has a My Health Record. If not, encourage the patient to set one up and if necessary assist them to do so (for example, by making an appointment for the patient to see the practice nurse).
- Make an appointment for the patient to come in and develop their shared care plan.

Step 6 – Register the Patient

This includes registering the patient on HPOS so the Health Care Home receives payment, flagging the patient in the practice system so they can be identified as a Health Care Home patient, flagging the patient in the data extraction tool for the evaluation and providing patient contact details to the evaluators through the evaluation portal.

Patient Registration in HPOS

- Within seven days of the patient completing and signing the enrolment/consent form, the general practice or ACCHS confirms the following through HPOS:
    - First, search for the patient. Where an exact match is found, patient details (i.e. Medicare card number, IRN, First Name, Last Name and DOB) will be returned in a table format. The user will then be required to complete the following fields:
        - Centrelink CRN (optional)
        - Nominated clinician provider number (correct entry of this number will return the provider name)
        - Starting tier (as per the RST tier result)
        - RST certificate number
        - Consent form signed date
        - Registration start date
        - Tick the declaration about patient consent.
- More information on the HPOS process is covered in the *Health Care Homes Practice User Guide* provided to Health Care Homes by Services Australia.
- Payments for an enrolled patient are calculated from the patient enrolment date. A patient's enrolment date can be no more than seven days prior to the actual date the Health Care Home registers them on HPOS.

Patient Flag in Practice System

- Health Care Home patients must be flagged in the practice system so that you can identify them as a Health Care Home patient for the provision of care.
    - Please refer to the Australian Association of Practice Management (AAPM) guide for suggestions on how to flag patients in different systems.

Patient Flag for Data Extraction

- Health Care Home patients must also be flagged in the clinical system so that the data extraction tool can pull out that information.

- Health Care Homes using PenCS with Topbar can flag Health Care Home patients using the HCH App
    - Health Care Homes using PenCS without Topbar can flag Health Care Home patients using 'CAT4' to flag a patient and their tier
    - Health Care Homes using Communicare should refer to instructions provided by Telstra Health
    - For Health Care Homes using POLAR methods for flagging Health Care Home patients are being developed
    - Health Care Homes using other methods for data extraction please refer to the AAPM guide for alternative options.
- More information on how to flag patients is available on the Health Care Homes Evaluation website.

Patient Details for the Evaluation (not required for ACCHSs in the Northern Territory)

- The Health Care Home will need to provide basic details about patients registering to the evaluators. These details will enable the evaluators to invite patients to participate in surveys, interviews, and focus groups. These details are not required for ACCHSs in the Northern Territory, as patients of these services will not be surveyed. Instead, for the Northern Territory ACCHSs, interviews and focus groups with patients will be organised through the ACCHS.
- The evaluation team will provide each Health Care Home (via the PHN) with a secure log-in to the evaluation website (www.hchevalaution.com).
- The Health Care Home will be required to provide the following information on the enrolled patient:
    - last name and given name(s)
    - age (in years)
    - residential address (street name, suburb, postcode)
    - home phone number
    - mobile telephone number
    - email address.

4.4 Patient review

Health Care Homes are required to formally reassess patients' tier level annually. The Risk Stratification Tool will provide Health Care Homes with a prompt to notify them that a patient's risk certificate has expired and that a new assessment is required.

The process for reviewing a patient's tier level is as follows:

- identify with the patient what has changed in their circumstances to change the complexity of their condition or their ability to manage
- re-run the RST with the patient present
- update the patient's risk tier in HPOS
- where available, upload new certificate to the patient's clinical record and update relevant details within the patient's My Health Record.

If a formal review takes place and a patient's health status has improved to the extent that his/her risk score drops below the Tier 1 threshold (a Hospital Admission Risk Program (HARP) score of 5) that patient does **NOT** have to be removed from the Program. In that instance, a patient should remain enrolled at the Tier 1 level. In this instance, Health Care Homes can use the patient's previous risk certificate number when entering details into HPOS. Health Care Homes may also wish to schedule an appointment with the patient one year in advance to ensure that the patient is formally reassessed.

While Health Care Homes are required to reassess each patient annually, Health Care Homes may undertake a reassessment at any time should there be a significant change that may either increase or decrease the complexity of the patient's health care.

4.5 Patient withdrawals

Participating in Health Care Homes is voluntary for patients and patients are able to withdraw from the program if they wish.

However, every effort should be made to support patients to stay in the program.

If a Health Care Home has been unable to make contact with an enrolled patient for a period of 6 months, the patient should be withdrawn from the Program. Prior to the withdrawal of the patient, all effort should be made to contact the patient through all known mechanisms.

Health Care Homes must also withdraw a patient from the program if they are no longer eligible to receive care under this model.

There are two stages for patient withdrawal.

N.B. This process is ***not*** to be used when a patient has ***died***. Please refer to section 4.6 below for information on how patient deaths are managed by Services Australia.

Stage 1 – Discussion with patient
Discuss with the patient:

- the reason for withdrawal
- any changes in the services they will receive after they withdraw.

Ensure the patient understands that they will not be able to re-enrol at any other Health Care Home.

Stage 2 – Completing patient withdrawal

- HPOS reconciliation for the patient: enter the last date of service received as an enrolled patient. Payment will cease after this date.
- Enter reason for withdrawal, e.g. patient has moved from the area, patient no longer with the Health Care Home, patient has opted out.
- Patient feedback: let the patient know that they may be contacted to complete an exit survey as part of the evaluation.

4.6 Patient deaths

Registered Health Care Homes patients who have died will be automatically withdrawn from participating in the Health Care Homes Program when Services Australia receives official notification from Births, Deaths and Marriages. Health Care Homes payments will be automatically adjusted in the next monthly payment.

However, if a Health Care Home wishes to advise Services Australia that a Health Care Homes patient is now deceased, the following methods are available:

- In the Health Care Homes system on HPOS, the date of death can be entered in the 'Deceased Patient' section of the *Patient Amendment* screen. Once the information is submitted and confirmed, the patient will be withdrawn from the Program and the patient can no longer be selected on the system. In addition, the Medicare/Centrelink benefits for the patient may cease from the date provided.
- Call Services Australia's Medicare Program on telephone number: 132 011. Note: the caller from the Health Care Home will need to verify his/her identity.
- Complete Services Australia's *Advice of death* (SA116) form which is available on the Services Australia website. The completed form should be forwarded to Services Australia as per the instructions provided on the form.

4.7 HPOS bi-annual patient confirmation

Each Health Care Home general practice or ACCHS must provide a twice yearly patient confirmation, including:

- reconciliation of the patients enrolled with the general practice or ACCHS, confirming that the current list is correct and accurate for each patient, including the nominated clinician and risk tier
- declaration that the patients are being provided with Health Care Home services in accordance with the Health Care Homes' handbook.

Module 3 of the training program explains this process:

- Services Australia will send a letter to the practice mailbox in HPOS at the start of each confirmation period
- the confirmation period will be open for 30 days. During this time the reconciliation and declaration must be made
- failure to return the declaration to SA may affect payments or result in removal of the Health Care Home from the program.

4.8 Managing enrolment numbers in the Program

During the Program, up to 12,000 patients will be enrolled across approximately 170 Health Care Homes. This equates to about 55 patients per full-time GP equivalent (based on full-time GP equivalent data collected as part of the Health Care Home approach to market process). The enrolment of 55 patients per full-time equivalent GP should be used as a guide for patient enrolment, noting that there is a wide variation in the size of general practices and ACCHS across Australia. Based on current population data, it was anticipated that approximately 9 per cent of enrolled patients will be tier three; 45 per cent will be tier two; and 46 per cent will be tier one. However, this distribution should be used as a guide.

Health Care Homes will be able to monitor and manage their patient enrolment numbers through the HPOS system. The HPOS system will display the number of registered patients, the Health Care Home maximum patient load (i.e. number of FTE GP x 55), and the percentage of patient allocation (i.e. number of registered patients as a percentage of the Health Care Home maximum enrolment number). Once a Health Care Home hits its maximum enrolment number, the Health Care Home will not be able to enrol more patients on the HPOS system. However, Health Care Homes that wish to increase the total number of patients they can enrol into the program can submit requests through the PHN Facilitators to the Department. If supported, the Department will liaise with Services Australia to enable system adjustments to increase the number of patients that can be enrolled through HPOS by the Health Care Home.

Establishing routine monitoring will help Health Care Homes manage patient enrolment numbers as Health Care Homes approach their maximum patient load. The Department will monitor aggregate patient enrolment numbers and distribution of patients across the three tiers throughout the trial.

4.9 Managing patient personal information

All health care providers in Australia have professional and legal obligations to protect their patients' health information (as defined under the *Privacy Act 1988* (the Act)). Becoming a Health Care Home does not change privacy obligations for participating health care providers.

The important Australian Privacy Principles (APPs) under the Act for health care providers are:

- Health Care Homes, procedures and systems to ensure compliance with the APPs (APP1).
- Collecting Personal Information (APPs 3-5).
- Using and disclosing personal information (APPs 6-9).
- Protection of personal information from misuse, interference and loss, and from unauthorised access, modification or disclosure (APPs 10-12).

- APP13 covers the right of an individual to access information about themselves.

The Office of the Australian Information Commissioner has prepared specific guidance and training information on privacy for general practitioners and other health service providers, available online.

4.10 Withdrawal of Health Care Homes with no patients

Patient enrolment under the Health Care Homes Program closed on 30 June 2019. Registered Health Care Homes that had not enrolled any patients as at that date were withdrawn from the Program.

5 Support for practices/ACCHS and consumers

5.1 Information and resources

Handbooks and a series of information resources have been developed to support general practices or ACCHS, enrolled patients and care team members outside the Health Care Home.

- **Handbook for practices/ACCHS:** Information on procedures and ongoing eligibility requirements
- **Patient handbook:** For patients, their friends, families and carers
- **Care team handbook:** For members of the care team who are external to the Health Care Home

Copies of the handbooks are available from the Resources for general practices.

Additional resources are available on:

- Health Care Homes for health professionals. Resources for ACCHS are also available on this page
- Health Care Homes for consumers has resources for all consumers; and a fact sheet in five languages (Arabic, Greek, Italian and traditional and simplified Chinese).

5.2 Training program

For many Health Care Homes, most of the core elements of the Health Care Homes Program build on the way they already operate. But some elements, such as how patients are enrolled or how payments are made, are new and will require changes. Beyond the administrative requirements, the Health Care Homes model presents an opportunity for practices to re-examine how they provide services and consider how they can take advantage of the flexibility of the new model.

Practices participating in the Health Care Homes Program will undertake training during the first year of the Program that will provide a foundation for their ongoing transformation process.

The training program modules are based on the ten building blocks of high performing primary care.

The building block structure recognises that the transformation process is non-linear and that Health Care Homes will need to build capacity over time. The modules also include practical change tactics and tools to complement the ten building blocks of high performing primary care. The Co-creating Health philosophy and approaches have been incorporated in the training material to support care team behaviour change at the practice level and provide team members with a range of skills to work in partnership with patients to achieve better health outcomes and experience.

The eleven training modules are as follows:

- Module 1: Introduction to the Health Care Home
- Module 2: Engaged leadership
- Module 3: Patient enrolment and payment processes
- Module 4: Data-driven improvement
- Module 5: Team-based care
- Module 6: Developing and implementing the shared care plan
- Module 7: Patient-team partnership
- Module 8: Comprehensive and coordinated care

- Module 9: Prompt access to care
- Module 10: Population management
- Module 11: Quality primary care into the future

The training material is designed around the plan, do, study, act (PDSA) approach to learning. While practices will be required to set aside some time to do the online learning, the core of the training is practical and includes activities designed to assist practices to implement the Health Care Home model in a way that is tailored to the needs and structure of their practice. Health Care Homes can also use the results of their practice self-assessment (see section 4.1) to customise their training plan. The training material is designed to implement change in small manageable cycles.

Individuals completing training modules are able to claim continuing professional development points from the following organisations:

- Australian Association of Practice Management (AAPM)
- Australian College of Rural and Remote Medicine (ACRRM)
- Australian Practice Nurse Association (APNA)
- Royal Australian College of General Practitioners (RACGP)

Becoming a Health Care Home requires a whole-of-practice transformation. The training program and the practice facilitators will support general practices and ACCHS in their transformation. Each general practice or ACCHS will have their own starting point for their whole-of-practice transformation. Some useful activities to begin this transformation include:

- talking with your practice team about Health Care Homes and the benefits of the Quadruple Aim
- connecting with the practice facilitators at your PHN
- working with your practice facilitator using self-assessment tools (such as the HCH-A) to assess your practice needs and readiness
- creating a plan with your practice facilitators
- reviewing the modules of the training program for how-to details regarding the Health Care Home program
- prioritising and scheduling training to meet each staff member's specific needs.

Practice facilitators will be a valuable resource for information, discussion and decision-making in your general practice or ACCHS development and transformation.

5.3 Primary Health Networks (PHNs)

PHNs will have dedicated resources in each of the participating regions to assist practices with transformation and recruitment of patients.

Practice facilitators have a strong understanding of Health Care Homes concepts, and will work with practices to implement the lessons learned in the training modules and provide them with advice and support tailored to the needs and services available in their region.

The practice facilitators will support general practices and ACCHS in the manner which best suits each practice. The support may include a mix of face-to-face training sessions, telephone, email, webinar support and opportunities for shared learning among practices.

Practice facilitation activities include:

- assisting with administering and analysing the HCH-A tool and providing support to identify priorities and plan for improvement
- assisting to embed quality improvement frameworks
- coaching on change concepts
- establishing measurement strategies and reviewing data
- identifying additional resources and tools for transformation
- conducting workflow analysis and suggesting improvements

- assessing and monitoring progress
- assisting the general practice or ACCHS to provide data for the evaluation
- providing support for overall transformation as required
- facilitating learning
- assisting with the identification and enrolment of Health Care Home patients
- assisting the development of communities of practice where Health Care Homes link together to share tips, insights and learnings during the transformation process.

General practices and ACCHS participating in the Program must work with PHNs to achieve practice transformation and develop communities of practice with other Health Care Homes in their region.

6 Payments

General Practices and ACCHS will be remunerated for providing services under the Program through a blended payment approach. This will involve a mix of bundled payments provided under the Health Care Homes program, plus fee-for-service payments for non-chronic disease related care and Practice Incentives Program payments.

Bundled payments

Health Care Homes will receive a monthly payment for each enrolled patient, paid according to the enrolled patient’s allocated risk tier. All general practice health care provided by the Health Care Home that is associated with the enrolled patient’s chronic and complex conditions, and that was previously funded through MBS fee-for-service items, should be funded through the bundled payment.

This bundled payment will be made directly to the general practice or ACCHS monthly on a pro-rata, retrospective basis. The Health Care Home will be responsible for appropriately distributing the bundled payment within the general practice or ACCHS.

Patient out-of-pocket costs and Medicare Safety Net

Many patients with chronic and complex conditions are bulk billed for primary health care services. Health Care Homes are strongly encouraged to continue to bulk bill enrolled patients. However, if it is the practice’s intention to ask Health Care Home patients to financially contribute to their healthcare costs, the nominated clinician must ensure that the patient is made aware of these potential costs at the outset. This is reflected in the Health Care Homes patient consent form and is considered good practise in terms of financial transparency. MBS billing should continue to be used for services not related to the patient’s chronic and complex conditions.

A new MBS item has been established (Item 6087) that, when claimed, will record an attendance for which a patient incurs an out-of-pocket expense for the treatment associated with their chronic or complex condition. This item, with a rebate of $1.15, was created to ensure that any out-of-pocket expenses contribute to the patient’s Medicare Safety Net threshold(s). The purpose of this rebate should also be discussed with the patient up front.

In the event that a Health Care Homes practice charges a patient an out-of-pocket amount, MBS Item 6087 can be claimed. Use of this MBS item will be monitored throughout the Health Care Homes Program.

More information about MBS Item 6087 is available at MBS Online.

Employment taxation obligations

KPMG has provided information to the Department about implications of the Health Care Home payment model in relation to practice/ACCHS exposure to employment tax obligations (i.e. PAYG, withholding, payroll tax, superannuation or worker’s compensation).

Based on four broad general practice business scenarios (sole trader; partnership; associateship; and large corporate practice) the Australian Taxation Office has also provided the Department with

general advice that implementation of the Health Care Home model would not necessarily change the existing relationship the doctor has with the medical practice, and the Health Care Home model will not, of itself, create an employer/employee relationship. For example, if a GP's engagement with a practice is as an independent contractor, then their participation in the Health Care Home program could also be on that basis.

The business scenarios on which this advice is based are broad and do not reflect all business structures and arrangements operating in Australia. Participating general practices and ACCHS should seek advice in relation to their individual circumstances.

Fee-for-service MBS benefits

Enrolled patients can still access fee-for-service MBS benefits for episodes of care that are not related to their chronic and complex conditions. This will also enable patients to visit different practices when essential, for example when travelling.

The number of fee-for-service MBS benefits that an enrolled patient can access for care that is not related to their chronic conditions will not be capped or restricted, and will be monitored during the Health Care Homes Program. It is expected that for the majority of enrolled patients, the number of fee-for-service MBS benefits accessed, in addition to the bundled payment, will be small.

6.1 Payment levels

Pro-rata, retrospective payments will be made to the Health Care Home monthly through the HPOS system for the Health Care Homes Program.

The value of these payments is linked to each enrolled patient's level of complexity and risk of hospitalisation. Each enrolled patient will be allocated to one of three payment tiers based on the patient's complexity, as determined by the RST. Patients on the highest tier will be allocated the maximum payment value. The allocated payment level, or payment tier, will be used to calculate the monthly payment that will be made to the Health Care Home for each enrolled patient.

The value of each payment tier (see table below) represents an average payment for each payment tier level. Within each payment tier level, some patients may require fewer services from their Health Care Home than others. The tiered payment values therefore recognise the individual variations in service delivery that patients will require. The payment values for the payment tiers were developed from best practice clinical models.

Payment Tier	Payment Value[1]
Tier 3 — the highest level of patient complexity	$1,851 per annum
Tier 2 — increasing level of patient complexity	$1,306 per annum
Tier 1 — the lowest level of patient complexity	$609 per annum

The calculation of each enrolled patient's monthly payment is determined by the number of days the patient was registered at a tier within the payment month.

The formula to calculate the Monthly payment per enrolled patient is:

> Number of days at complexity/risk tier, multiplied by
> Payment tier value per annum, divided by
> Number of days in the year

[1] Note: From 1 July 2019 annual indexation was introduced to the bundled payments to ensure consistency with the Medicare Benefits Schedule.

For example, if a patient was in Tier 3 for all of January 2020, the monthly payment for January would be calculated as follows:

31 (days in January) x $1,824 (Tier 3 annual payment) = $56,544

$56,544/366 (days in 2020) = $154.49

If the Health Care Home complies with the ongoing eligibility requirements of Health Care Homes, then the Health Care Home retains any unspent funds.

Health Care Home services may be provided by a range of health care providers, for example general practitioners, practice nurses, nurse practitioners, enrolled nurses or medical practice assistants. Participating Health Care Homes are encouraged to consider the clinical team members that are best placed to provide each type of service.

Where there has been a sustained change in an enrolled patient's chronic conditions, the RST can be used to determine whether the patient's complexity tier level has also changed. Health Care Homes will be able to update an enrolled patient's tier on HPOS to recognise the deterioration or improvement of the patient.

6.2 Service – bundled or not?

The Health Care Home payment approach differs from the traditional fee-for-service payment approach.

Traditional	Health Care Home
The traditional primary care model is fee for service. Payment for each individual service for which a MBS item number is identified.	The Health Care Home model uses a bundled payment model. The bundled payment supports delivery of all general practice services provided to the enrolled patient and related to their chronic and complex conditions.

Up until and including the date that a patient is enrolled, consultations can still be billed against MBS items. Following the date of enrolment, MBS items must only be billed for services provided by the Health Care Home that are either not related to the management or treatment of an enrolled patient's chronic conditions or when an enrolled patient is charged a co-contribution.

Services covered by the bundled payment include:

- shared care plan development
- regular reviews
- comprehensive health assessment
- making referral to allied health providers or specialists
- case conferencing
- tele-health services and monitoring
- standard consultations related to an enrolled patient's chronic and complex conditions
- after-hours advice and care.

Services provided by the following providers will continue to be funded through fee-for-service based MBS items and are **not** included in the bundled payment:

- allied health (including physiotherapist and psychologist)
- specialists
- radiology
- pathology
- Indigenous Health Assessment (MBS item 715).

Where diagnostic services are provided by a Health Care Home as part of the monitoring and management of an enrolled patient's chronic and complex conditions, they should be funded through the bundled payment.

After-hours services

A key feature of the Health Care Home model is that patients have enhanced access to care in-hours (which may include non-face-to-face support) and effective access to after-hours advice and care. At a minimum, all enrolled patients must be made aware of what to do if they require access to after-hours care.

Bundled payments must cover after-hours services for enrolled patients, where they are provided in the practice rooms and relate to the patient's chronic condition. After-hours services provided outside of the practice rooms are funded through the MBS.

A Health Care Home that also provides after-hours services for a broad region can continue to bill against MBS items for services provided after-hours to patients enrolled in other Health Care Homes.

The PIP after-hours incentive will continue to support practices to provide their patients with appropriate access to after-hours care, with the highest payment going to those practices that provide after-hours care for all of their patients during the complete after-hours period (i.e. 24 hours-a-day) when required.

Very unwell patients

If an enrolled patient becomes very unwell and the Health Care Home model does not continue to meet their needs, then the patient can be withdrawn and treated under the MBS arrangements.

The process for withdrawing a patient or Health Care Home from the Program is outlined in detail in Module 3 of the Health Care Home training modules.

Medicare Benefits Schedule (MBS) -funded access to allied health services

Health Care Home-enrolled patients may have multiple chronic conditions and, as such, would have previously been eligible to access MBS-funded allied health services that are currently triggered by the completion of a GP Management Plan and Team Care Arrangement. They may also have been eligible to access MBS-funded allied health services that are currently triggered by the completion of a Health Assessment for Aboriginal and Torres Strait Islander People or a GP Mental Health Treatment Plan.

Eligibility to access MBS-funded allied health services previously triggered by the completion of these MBS items will now be triggered by the patient's enrolment with the Health Care Home and preparation of a shared care plan. Health Care Home-enrolled patients no longer need to have a GP Management Plan and Team Care Arrangement or a Health Assessment for Aboriginal and Torres Strait Islander People or a GP Mental Health Treatment Plan to access MBS-funded allied health services. Eligibility for allied health group sessions will also be triggered by enrolment in the Health Care Homes Program for eligible patients with Type 2 diabetes.

It should be noted that other prerequisites as defined under the Health Insurance (Allied Health Services) Determination 2014 will continue to apply for enrolled patients to access allied health MBS benefits. These prerequisites include the need for a valid referral form, or, where appropriate, Aboriginal or Torres Strait Islander descent status. The Department has developed a Health Care Home referral form to assist practices when referring Health Care Home patients to allied health providers. The form provides details about the Health Care Home program, shared care planning arrangements and key patient information which practices can adapt to meet their specific needs and arrangements. This form is available from the Department's website.

The number of MBS funded allied health services that an enrolled patient may access each calendar year remains the same as is currently available under the MBS. If an existing patient enrols as a Health Care Home patient, this does not restart the number of Medicare-funded allied health services available to that patient in a calendar year, i.e. if rebates are available for up to five allied

health services in a calendar year and the patient has already received two services prior to enrolling as a Health Care Homes patient, the patient will have three services available for the remainder of the calendar year.

Allied health services provided to a Health Care Home-enrolled patient should be billed to the MBS in line with current arrangements.

New MBS items for eating disorders

On 1 November 2019, 64 new MBS items were introduced to provide psychological and dietetic support services to eligible patients with eating disorders. The new MBS items were introduced to enable access, through a stepped approach, to up to 40 psychological and 20 dietetic treatment services for people with eating disorders over a 12 month period. These services are triggered by the development of an Eating Disorder Treatment Plan (EDP) by a qualified health professional.

Further information on the new eating disorder MBS items can be found here.

Health Care Home patients with eating disorders

Due to the complexity of eating disorder treatment and management, and consistent with clinical advice, complex eating disorders should be managed separately to the Health Care Home bundled payment and through the development of an EDP for eligible patients. GPs are eligible to bill Medicare for the development of an EDP for Health Care Home patients with complex eating disorders, as well as the subsequent reviews of the patient. MBS items were introduced to enable access, through a stepped approach, to up to 40 psychological and 20 dietetic treatment services for people with eating disorders over a 12 month period. These services are triggered by the development of an EDP by a qualified health professional.

The Department’s position recognises that the management of eating disorders requires highly intensive and specialised care, which is considered to be outside the level of complexity intended to be supported through the Health Care Home bundled payment.

6.3 Payment processes

The payment processes for Health Care Homes include:

1. Establishment: One-off grant $11,000 GST inclusive.

2. Monthly bundled payments
    - Payment linked to eligible patient’s risk tier as identified by the RST and on the risk tier certificate.
    - Payments are made monthly in arrears on a pro-rata basis.
    - Payments are released by the 15th working day of the following month.
    - All payments are made by electronic funds transfer.
    - Notice of payment will be via HPOS mail notification. The payment statement will include a payment amount for each enrolled patient.
    - Health Care Homes should check their HPOS settings to enable alerts for notifications.

3. Bank accounts
    - The initial Health Care Home registration will use the bank details recorded for the Practice Incentive Program.
    - Health Care Homes can change bank details by sending an email to SA though the HPOS mailbox. The request must be made by an authorised contact with management access. A confirmation email will be sent from SA to all authorised contacts (and the practice owner where there is only one authorised contact).

4. Patient data
    - The Health Care Home must ensure the patient's details in the practice clinical information and management database are up to date.
    - Patients are responsible for ensuring their details are up to date with Medicare.

5. Incentive payments – PIP, SIP, Workforce Incentive Program (WIP) Practice Stream and Doctor Stream
    - Any incentive payments to a general practice or ACCHS will be in addition to the bundled payment the Health Care Home receives for participation in the Health Care Home program.
    - As Practice Incentives Program (PIP) payments, Service Incentive Program (SIP) payments, WIP Practice and Doctor Stream payments are dependent on MBS billing, incentive payment amounts may be affected for some participating practices and/or practitioners. The Department of Health and SA will monitor incentive payment levels and will provide top-up payments as required to ensure that no Health Care Home is disadvantaged as a result of their participation in the program.
    - If a practice/practitioner considers that they have been materially disadvantaged with regards to these incentive payments, they can request a review of the amount paid.
    - General practices and ACCHS participating in the Health Care Homes Program must be registered for the PIP eHealth Incentive by 1 December 2017.

6. Goods and Services Taxation (GST)

Bundled payments made to Health Care Home practices are not subject to GST where:

- the service provided to the enrolled patient is:
    i. made by or on behalf of a medical practitioner; and
    ii. generally accepted in the medical profession as being necessary for the appropriate treatment of the patient.
- it is another service provided by the Health Care Home practice to the enrolled patient that is:
    i. one of the specific services listed below;
    ii. provided by a recognised professional in that listed service; and
    iii. generally accepted in that listed profession as being necessary for the appropriate treatment of the patient:
        1. Aboriginal or Torres Strait Islander health
        2. acupuncture
        3. audiology, audiometry
        4. chiropody
        5. chiropractic
        6. dental
        7. dietary
        8. herbal medicine (including traditional Chinese herbal medicine)
        9. naturopathy
        10. nursing
        11. occupational therapy
        12. optometry
        13. osteopathy
        14. paramedical
        15. pharmacy
        16. psychology
        17. physiotherapy
        18. podiatry
        19. speech pathology
        20. speech therapy
        21. social work

In the following circumstances, the supply of services from the Health Care Home to the patient may be taxable:

- if the supply of the services is not made by or on behalf of a medical practitioner;
- if other health services supplied are not performed by a recognised professional in the health profession listed above; or
- if the medical services or other health services supplied are not generally accepted in the medical profession or the health profession listed above as being necessary for the appropriate treatment of the patient.

An example of services provided in a Health Care Home that may not be a GST-free medical service are health and lifestyle coaching to small groups. Group sessions aimed at providing general information or targeted at general health and wellbeing only and which are not directly targeted at a specific treatment need of the patient as assessed by a medical practitioner or nurse, will not be for the appropriate treatment of the patient and will not be GST-free.

In the event that a Health Care Home supplies a service that is taxable, the Health Care Home is liable for the GST amount and must remit the GST amount to the Australian Taxation Office (ATO) through normal ATO Business Activity Statement processes. GST paid may be claimed from the Department of Health by invoicing the Department for the GST amount only.

6.4 Service model

The move from fee-for-service MBS billing to bundled payments will impact on how a Health Care Home manages its finances and also how health professionals are remunerated.

Each practice will need to determine its Health Care Homes service delivery model before deciding on their approach for managing the bundled payments internally. The service delivery model should drive the approach to managing payments rather than the payment management approach driving the service delivery model.

Step 1: Determine Health Care Homes service delivery model

Step 2: Determine payment management approach

The difference between the bundled payment and fee-for-service billing is that the bundled payments are paid to the Health Care Home and then the Health Care Home determines how to manage these funds internally rather than being allocated to the provider directly.

1. Services Australia makes bundled payment to Health Care Home.
2. Health Care Home determines how these payments are managed.
3. Enrolled patients may contribute to their healthcare costs. This must be explained to patients and agreed with the patient at the time of enrolment.

7 Changes to service delivery

Changes to how services are delivered will be the key to improved outcomes for patients with chronic and complex conditions who enrol with a Health Care Home. Some of these key changes are outlined below.

7.1 Enhanced access

Enhanced access is aimed at supporting a patient’s confidence in their ability to self-manage their condition.

Each general practice and ACCHS will determine the enhanced access activities which suit their general practice or ACCHS and their enrolled patients.

General practices and ACCHS can be innovative in activities to provide enhanced access for patients as access is not linked to an MBS item number.

Examples of enhanced access are:

- In-hours telephone support
- Email support
- Video conferencing
- Open scheduling
- After-hours' access
- Small group health and lifestyle coaching
- Shared medical appointments
- Monitoring symptoms remotely through new technologies

7.2 Data driven improvement

Data driven improvement is the ability to use data collected through patient care and practice management activities to measure, analyse and improve the quality, efficiency and effectiveness of the care provided to patients. Data driven improvement strategies provide practices and ACCHS the tools to achieve the goals outlined in the Quadruple Aim.

The training modules provide further detail on data driven improvement.

7.3 Electronic shared care plan

A central element of the Health Care Home model is a tailored and dynamic electronic shared care plan. A Health Care Home must ensure that all enrolled patients have a shared care plan and can access it. This plan must be developed and managed under the clinical direction of the nominated clinician and is used by the team and the patient for the management of a patient's healthcare needs. The aim of a shared care plan is to increase a patient's participation in their own care and improve the coordination of the services that they receive, both inside and outside the Health Care Home.

Shared care plan elements include:

- effective transfer of information between health care practitioners supporting patient care
- real-time information to enable evidence based decision making
- an outline of the patient's agreed current and long-term needs and goals
- identification of coordination requirements
- approaches to achieve the goals
- who is responsible for each activity, including the patient's activities
- electronic format for access and tracking ease
- electronic format for sharing with and providing feedback from the health care neighbourhood, which may include pharmacists, allied health professionals, specialists and other community support service providers.

Many general practices and ACCHS around Australia are already using shared care planning tools. The Department has developed a set of minimum requirements for shared care planning software. Health Care Homes can choose any software program that complies with these minimum requirements. Health Care Homes can see and amend the shared care plans. Other providers identified in the patient's care plan can view the whole shared care plan but can only alter elements of the plan assigned to them by the Health Care Home.

Software minimum requirements

The Medical Software Industry Association has a list of shared care planning products that software vendors have self-declared are compliant with these minimum requirements.

Shared care plan reviews

The shared care plan should be reviewed as regularly as is clinically required. At a minimum shared care plans for:

- Tier 3 patients must be reviewed three times annually
- Tier 2 patients must be reviewed twice annually
- Tier 1 patients must be reviewed annually

Where relevant, shared care plans should also include a plan to manage a patient's medication needs, working with the patient's pharmacy, enabling the provision for necessary medication support.

7.4 My Health Record

A My Health Record is an electronic health record with information that can be accessed by health care providers anywhere, and at any time. For example, the patient's latest shared health summary can be accessed in an emergency or accident situation.

While not a requirement, Health Care Home patients should be encouraged to register for the My Health Record noting the benefits, and the Health Care Home should assist the patient to sign-up for the system where necessary.

Health Care Homes should develop a shared health summary and contribute up-to-date, clinical information to a patient's My Health Record where available.

7.5 Team-based care

Practising team-based care is fundamental to a general practice or ACCHS achieving successful implementation and complete transformation into a high-performing Health Care Home. With the increasing emphasis on health care teams delivering high-quality primary care, opportunities exist for Health Care Homes and patients to work together – ensuring the care is patient-centred. New roles could be introduced into general practices or ACCHS to create multi-disciplinary team to improve patient satisfaction and health outcomes.

These new roles may include:

- nurse practitioners
- specialist or advanced practice registered nurses
- Aboriginal and Torres Strait Islander health practitioners/workers
- care co-ordinators
- medical practice assistants
- allied health professionals
- pharmacists.

Training modules provide more detail on how practices and ACCHS can take advantage of these new roles through the Health Care Home model.

7.6 Community Pharmacy in Health Care Homes' program

People with complex and chronic conditions often require a number of different medications to manage their conditions. Community pharmacy plays a critical role in ensuring that these medicines work together safely and effectively and that patients understand their use. The *Community Pharmacy in Health Care Homes' program* helps support patients participating in the Health Care Homes Program by offering them a range of patient-centred, coordinated medication management services tailored to their needs, delivered by the community pharmacy of choice.

The *Community Pharmacy in Health Care Homes' Program* requires Health Care Home patients to enrol with a community pharmacy of their choice in order to participate in the initiative. Once

enrolled, the pharmacist and patient can work together to achieve the health care goals set out in the patient's Shared Care Plan.

In addition, the *Community Pharmacy in Health Care Homes' program* supports community pharmacy to deliver a range of medication management services to their patients:

- a medicines reconciliation with a focus on education and helping patients to better manage their medicines;
- the development of a Medication Management Plan (MMP), forming part of the patient's Shared Care Plan, undertaken in collaboration with the patient and carer, Health Care Home and community pharmacist;
- regular follow-up reviews with the patient (in consultation with the Health Care Home), to maximise continuity of care, ensure that the patient's medication goals are achieved and to improve chronic disease management. All patient tiers will receive up to four follow-up reviews over the 18 month trial period remaining (Note: Fourth follow up review is only available to patients enrolled for Trial Program services before 1 July 2019); and
- a 'supporting services' flexible category for Tier 2 and Tier 3 patients, allowing pharmacists to deliver a range of additional medication adherence and medication management services based on the unique needs of the patient. Services may include:
    - Dose Administration Aid service (weekly);
    - blood glucose monitoring;
    - blood pressure monitoring; and
    - developing an asthma management plan.

Services provided by community pharmacies through the *Community Pharmacy in Health Care Homes' Program* are funded through the Sixth Community Pharmacy Agreement – Health Care Homes bundled payments are unaffected by participation in the program.

Participation in the *Community Pharmacy in Health Care Homes' Program* is voluntary, and Health Care Homes and patients should decide together if participation in the program will benefit that patient. To participate in the program, a Health Care Home needs to send a referral along with a copy of the patient's shared care plan, to the participating pharmacy chosen by the patient.

The program is jointly administered by the Pharmacy Programs Administrator and the Pharmacy Guild of Australia. For more information of the *Community Pharmacy in Health Care Homes program* please speak to your PHN Practice Facilitator, visit the Sixth Community Pharmacy Agreement website, the Pharmacy Programs Administrator website or the Health Care Homes website.

8 Health Care Home withdrawals

8.1 Health Care Home withdrawal process

If your general practice or ACCHS makes the decision to withdraw from the Health Care Home program, there are two stages which must be completed:

Stage 1 – Health Care Home contractual requirements

Health Care Home: notifies the Department to withdraw (email healthcarehomes@health.gov.au and cc to PHN).

Department: approves the Health Care Home's application to withdraw.

Once the general practice or ACCHS withdrawal has been approved by the Department, the general practice or ACCHS must clearly communicate with enrolled patients about the withdrawal, and what this means for their care.

Once a Health Care Home has withdrawn from the Program, its enrolled patients are automatically withdrawn. Health Care Homes are not required to manually withdraw their enrolled patients.

The Health Care Home will be required to complete a Statutory Declaration to acquit the grant funds received from the Department. It is a departmental requirement that unspent funds are repaid. Health Care Homes will also be required to sign the appropriate documentation to end its agreement with the Commonwealth under the Program.

Stage 2 – Patient information activity

HPOS reconciliation by the Department

- The Department will notify SA of approved Health Care Home withdrawal and the date of withdrawal.
- SA will close the practice registration in HPOS effective for all Health Care Home patients of the practice; and ceasing payments from the date of effect of withdrawal.

General practice or ACCHS notifies patients

- Notify all enrolled patients of the general practice or ACCHS's decision to withdraw and the consequences for the patient. Advise patients that they may be contacted to complete an exit survey as part of the evaluation.

Practice feedback

- The evaluators will contact the practice to complete an exit survey.

8.2 Practitioner turnover

If a general practitioner leaves the Health Care Home, all enrolled patients assigned to this provider must be notified in writing; and provided with options to identify a new nominated clinician within the Health Care Home.

Ideally, those patients should continue to see their other established Health Care Home team members to minimise disruption.

The nominated clinician should be updated in the HPOS system.

9 Health Care Home – Evaluation

9.1 Evaluation Framework and processes

The Department has engaged Health Policy Analysis (HPA) to undertake a comprehensive evaluation of the Health Care Homes Program, to establish what works best for different patients, general practices and ACCHS and in different communities with varied demographics.

The evaluation focuses on identifying the changes in the way primary care practices organise and deliver health care to their patients as a result of the model, and on estimating early impacts of the model on patient outcomes. The objectives of the evaluation are to:

- describe the process of implementing the Health Care Homes model
- evaluate the effect of the Health Care Homes program:
  - measurable quality improvement in the care of patients with chronic and complex conditions
  - patient experience of care (including engagement, activation and the patient journey)
  - Health Care Home experience and behaviour (including changes to scope of practice, quality improvement, system development, models of care, service delivery and business models)
  - service use (including potentially preventable hospitalisations)
  - the cost of care for Government, providers and patients
- assess the suitability of the Health Care Home model for national rollout for different practice types across a range of contexts.

The evaluation team will collect qualitative and quantitative data from participating PHNs, practices and Health Care Home patients via the following mechanisms:

- practice surveys and practice staff surveys
- practice staff face-to-face interviews
- patient surveys, interviews and focus groups
- automated extracts of data from practice clinical software, including
    - information on patient demographics (age/Indigenous status/health card holder)
    - clinical encounters
    - chronic illnesses
    - prescriptions
    - pathology and imaging test
    - risk factors (smoking/alcohol)

The evaluation team will also use national data sets (e.g. MBS, PBS, emergency department attendances and hospitalisation) to compare the use of health services by Health Care Home patients with a matched comparison group receiving usual care.

Informed consent will be obtained from patients, staff and care team members who are invited to complete surveys or participate in interviews and focus groups for the evaluation. This will be done at the time of participation.

Health Care Homes are required to participate in and support the evaluation in the following ways:

Data collection	Support requirement from Health Care Homes
Health Care Home surveys and Practice staff surveys	• Required from all Health Care Homes. • Three survey rounds are planned at baseline, midpoint and end.
Health Care Home face-to-face interviews with HPA	• Only from a sample of Health Care Homes and their participating staff. • Two interview rounds are planned at midpoint and end.
Health Care Home data extracts for data linkage projects with national datasets	• At the time of enrolment, provide patients with the *participant information sheet* and *enrolment and consent form*. • Provide electronic extracts of practice data, according to the specifications and approach selected for the evaluation.
Patient surveys, interviews and focus groups	• At the time of enrolment, provide patients with the *participant information sheet* and *enrolment and consent form*. • Record patient contact details on the evaluation website, and check currency of patient list prior to each round of surveys, interviews or focus groups (not required for ACCHSs in the Northern Territory). • Assist in recruiting patients for interviews and focus groups (in a sample of practices only) by displaying posters or providing flyers to patients.

Evaluation results will be used to make refinements to the Health Care Home model and inform decisions on any future roll out. The evaluation findings will be available to key stakeholders, including health care providers, patients, their families and carers, government, professional and peak organisations, academics and researchers and the general community.

For more information on the evaluation see the separate “Guide to Evaluation for Practices” document available at www.hchevaluation.com.

10 Assuring the integrity of the Health Care Homes program

A systems-based approach incorporating a strong focus on education is being used to manage compliance with the Health Care Homes program. In this way, participating general practices and ACCHS will have the information and support they need to put in place processes and procedures that will promote compliance and assist with delivering on the intent of the Health Care Home program.

A Health Care Home Funding Assurance Toolkit (the Toolkit) has been developed to support general practices and ACCHS to understand and comply with the new bundled payment approach for funding Health Care Home services. The Toolkit is available from the Health Care Homes Resources for general practices page and is modelled on the Medicare Billing Assurance Toolkit, which was the result of extensive collaboration with health peak bodies.

The Toolkit will further assist general practices and ACCHS participating in the Health Care Homes program in understanding the ongoing requirements of participating in the program and ensuring that Government money is appropriately spent.

10.1 Health Care Home responsibilities

Health Care Homes must meet the eligibility requirements outlined in this handbook.

Administration and record keeping

Good administration and record keeping standards will ensure that Health Care Homes are adequately prepared for compliance checks, such as reviews or audits. General practices and ACCHS participating in the Program may be required to provide relevant documentation to demonstrate compliance with the ongoing requirements of the Health Care Home program up to six (6) years after the relevant period. If a general practice or ACCHS is continually unable to provide evidence to verify that it meets the eligibility requirements or substantiate payments, the Department has the ability to request that a Health Care Home repays funds.

Delegation of day to day operations

The person authorised to sign the Health Care Home Program Declaration can delegate to a practice manager (or other person) to be an authorised contact person for the Department, and to carry out the day-to-day operation for Health Care Homes assurance and compliance activities. Instructions on how to do this can be found in Section 7.2 of the Health Care Homes User Guide.

10.2 The assurance approach

The Department will operate in line with best practice principles when monitoring and managing compliance with the requirements of the Health Care Home program outlined in this handbook. The Department will ensure that a risk based approach is used to monitor and manage compliance, with a focus on ensuring that appropriate education and information is available.

Assessing risk

The Department's compliance activities for the Program will be focused on:

1. appropriate use of the risk stratification tool provided by the Department
2. appropriate delivery of Health Care Homes services
3. appropriate billing of MBS services for enrolled patients by Health Care Homes.

- A range of techniques are used to identify, prioritise and respond to identified risks. The following activities, tools and treatments will be employed by the Department:
  - provision of education, compliance support and tools based on risk at the appropriate time

- use of established norms and baselines (determined through data analysis and random audits) to identify outliers and provide those outliers with targeted communications and/or education
- environmental scanning, previous audit information, published tip-off line and data analysis resulting in targeted audits and investigations.

Feedback mechanisms are in place in the Department to ensure the continuous improvement of monitoring and managing compliance is balanced with imposing minimal burden on Health Care Homes.

Stakeholder education and engagement

Education material to support compliance has been developed in consultation with the Health Care Home governance groups. These materials will help participants to understand and manage their compliance requirements and fulfil their obligations in the program.

Further information on compliance can be found on the Health Care Homes Assurance and Compliance webpage.

10.3 Compliance monitoring and management tools

Self- assessment

A practice self-assessment checklist has been provided to Health Care Homes to ensure that minimum program requirements are completed by the Health Care Home; and to support the Health Care Home in building a culture of compliance. The self-assessment checklist will identify areas that Health Care Homes can address or use to build a compliance culture.

Data and analytics

Data and analytics will be used to monitor patient enrolment and other MBS billing data to establish norms during the Program, and identify deviations from the norms.

Audits and reviews

Audits and reviews may be used to verify that program requirements, compliance with this Handbook, guidelines and standards have been met and, where applicable, that Health Care Home services were delivered.

During the Program, random audits will be conducted to establish norms and baselines and ensure that data analysis results are consistent with the rates of compliance expected.

Completion of the practice self-assessment checklist is expected to support Health Care Homes in assessing areas to improve their adherence to legislative and program requirements.

Non-Compliance Management

If a Health Care Home is found to be non-compliant, a series of tools will be used by the Department to determine the extent of the non-compliance. These tools could include practice or provider check-up, follow up audit and if necessary, repayment of funds.

Where a Health Care Home continues to be non-compliant, actions such as removal from the Program may be considered.

The Department will not audit or review the quality of the clinical service provided. There are already mechanisms in place for ensuring quality of care and protection of the public such as professional associations, regulatory frameworks and clinical standards.

11 Health Care Home outcomes

The Health Care Home model will produce benefits not only for the patients and practices involved, but for the health system overall.

Patient	Practices & providers	Health system & community
• **Patient-centred care** with care, treatment and processes based around the patient's needs. • **Improved coordination** of services, including links with hospitals and allied health providers. • **Improved personalised care** through a patient nominated GP leading the care team. • **Improved access to services**, including the use of telephone and email consults. • A **long-term approach** to improving health outcomes.	• **Increased flexibility** around how care is provided, such as support for group health coaching. • Removal of a number of Medicare item restrictions will **reduce pressure on GPs** and allow nurses and other team members to do the work they are trained for. • **Bundled payments reward practices** for the value rather than volume of care. • Workforce restructure allows practices to provide **more patients** with care. • **Team based approach** to care can reduce pressure on providers and potential burnout. • Clinical leadership opportunities. • Better **work/life balance** and more predictability to the day.	• Improved access arrangements to the right care at the right time will **reduce demand on hospitals**. • Improved care coordination will improve patient outcomes and reduce escalation of conditions. • **Better patient self-management** and a shift of focus from treatment to prevention. • A more responsive system that meets the needs of patients in a proactive way.

12. Quick Reference Guide for Health Care Home Practices and Patients

For program / policy related matters

Please call your PHN Practice Facilitator in the first instance. If following this you wish to speak to the Department directly, call the **Health Care Home hotline** on 1800 290 637.

Alternatively you can email the Department at healthcarehomes@health.gov.au

While patients are encouraged to raise any queries or concerns with their Health Care Home practice, if they wish to speak to the Department they are also welcome to call the Health Care Home hotline or email the Health Care Home inbox as per the contact information above.

For technical matters relating to payments and/or patient updates in the Health Care Homes application in HPOS

Contact the **Services Australia** Health Care Homes team:

Phone: 1800 222 032 Option 3 Monday to Friday (8:30 am to 5:00 pm Australian Central Standard Time)

Email: Via the HPOS Mail Centre

For technical matters relating to the Risk Stratification Tool

Precedence Support:

Phone: 1300 236 638 between 8.30am and 7pm (AEST) Monday to Friday

Email: support@precedencehealthcare.com

For technical matters relating to the Health Care Home Online Training modules

Please contact **AGPAL** if you are having any or username/password or technical issues relating to the platform or online programme delivery.

Email: hchstraining@agpal.com.au