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Better Outcomes for people with Chronic and Complex Health Conditions

Report to Government on the Findings of the Primary Health Care Advisory Group

December 2015

REPORT OF THE PRIMARY HEALTH CARE ADVISORY GROUP 2015

Primary Health Care Advisory Group Final Report Better Outcomes for People with Chronic and Complex Health Conditions

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The Hon Sussan Ley MP
Minister for Health
Minister for Aged Care
Minister for Sport
Parliament House
Canberra ACT 2600

Dear Minister,

It is my pleasure to present this report of the Primary Health Care Advisory Group: "Better Outcomes for people with Chronic and Complex Health Conditions".

Our current primary health care system works well for the majority of Australians. However, for the growing number of people with chronic and complex conditions, care can be fragmented and the system can be difficult to navigate.

Through consultations with patients, carers, doctors, allied health professionals and health system organisations we have identified a model of care supported by a new way of funding that can transform the way we provide primary health care for Australians with chronic and complex conditions.

Central to the reform is the establishment of Health Care Homes, which provide continuity of care, coordinated services and a team based approach according to the needs and wishes of the patient. This new approach is supported by new payment mechanisms to better target available resources to improve patient outcomes.

Our new approach offers an opportunity to improve and modernise primary health care and maximise the role of patients as partners in their care. It represents innovative, evidence-based best practice that harnesses the opportunity of digital health care. Importantly, it has strong support from consumers and health care professionals alike.

On behalf of the Advisory Group, I commend this report to you and thank you for the opportunity to contribute to building a healthier Medicare.

Yours sincerely

Dr Steve Hambleton
Chair
Primary Health Care Advisory Group

EXECUTIVE SUMMARY

The current primary health care system is high performing and works well for most Australians. However, in common with a number of developed nations, Australia is experiencing increasing rates of chronic and complex conditions, which challenge our current primary health care system and its connection to secondary care.

35% of Australians, over 7 million people, have a chronic condition, and an increasing number have multiple conditions, making care more complex and requiring input from a number of health providers or agencies. The Australian Institute of Health and Welfare (AIHW) reported in mid-2015 that approximately 20% of the population have two or more chronic conditions (multiple morbidity)[1]. This population group has different service needs depending on the level of complexity of their conditions. A risk stratification approach can more effectively support identification of patients with specific needs and target services accordingly

Patients with chronic and complex conditions are high users of health services. Very high general practice (GP) attenders saw three times as many different general practitioners (GPs) compared to low attenders (4.8 compared to 1.5). Just one third (34%) of very high and frequent GP attenders combined saw three to four GPs in 2012-13, while a further 36% of very high and frequent GP attenders saw five or more[2].

Currently, primary health care services in Australia for this patient cohort can be fragmented, and often poorly linked with secondary care services, making it difficult for patients to be confidently engaged in their care as evidenced by the experience of patients that can be found in the Appendices. Most patients with multiple chronic conditions receive treatment from many health providers: most of them working in different locations, and often working in different parts of the health system. As a result, effective communication between the health 'team' can be challenging and may be inconsistent. This leads to concern regarding the quality and safety of patient care.

Submissions to this review also suggest that resources for some patients with chronic and complex conditions could be better targeted to improve quality of care and access, minimise waste and maximise appropriate use of available resources across the whole of the health system.

A NEW MODEL OF PRIMARY HEALTH CARE FOR PATIENTS WITH CHRONIC AND COMPLEX CONDITIONS

This report details the evidence for change and recommends broad adoption of a new model of care and supporting reforms to better meet the needs of Australians with chronic and complex conditions into the future. Given the time constraints it has not been possible to cost the model, however the implementation section of the report outlines a staged approach to progressing the model that will include an assessment of affordability.

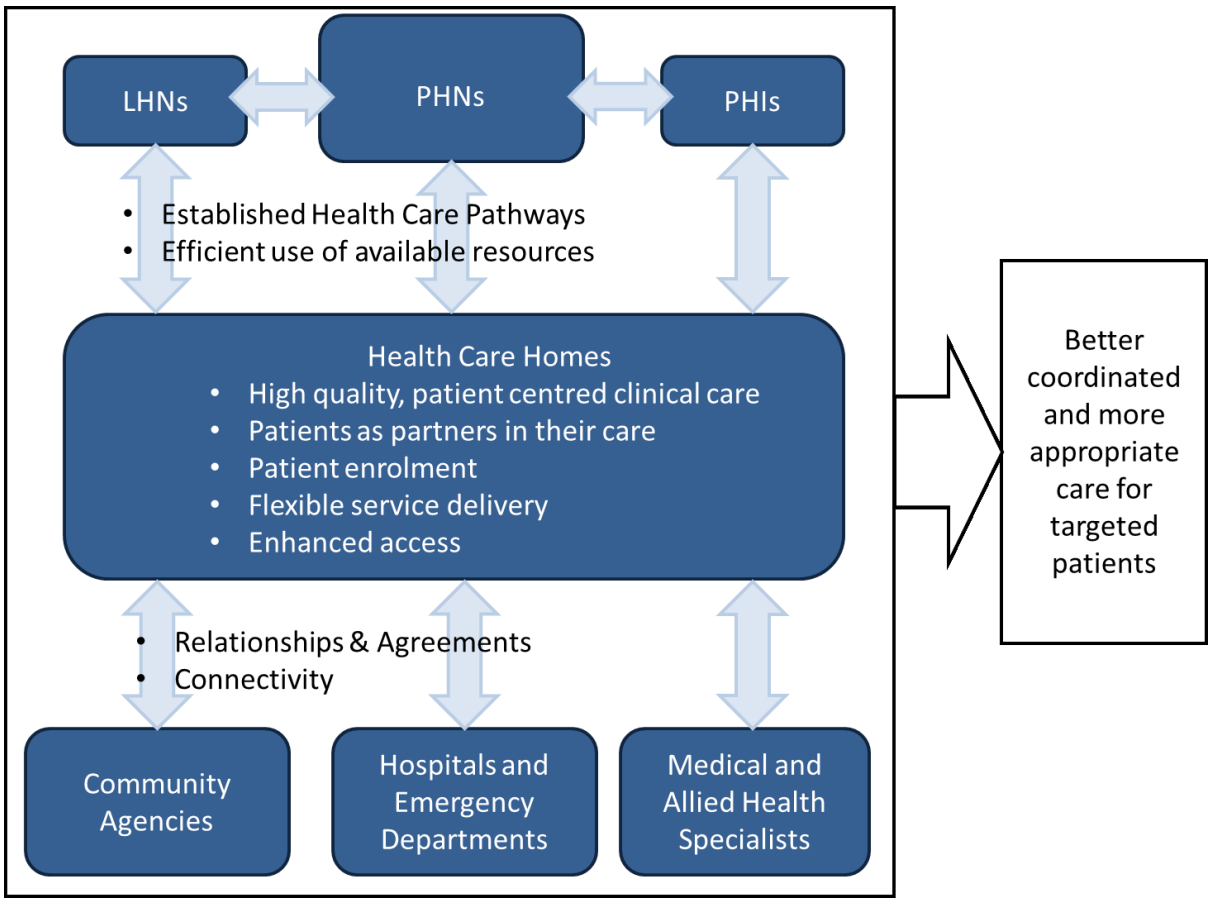
Central to the proposed reform is the formalisation of the relationship between the patient with chronic and complex conditions and their Health Care Home: a setting where they can receive enhanced access to holistic coordinated care, and wrap around support for multiple health needs.

Key features of the Health Care Home are:

- **Voluntary patient enrolment** with a practice or health care provider to provide a clinical 'home-base' for the coordination, management and ongoing support for their care.
- **Patients, families and their carers as partners in their care** where patients are activated to maximise their knowledge, skills and confidence to manage their health, aided by technology and with the support of a health care team.
- **Patients have enhanced access** to care provided by their Health Care Home in-hours, which may include support by telephone, email or videoconferencing and effective access to after-hours advice or care.
- **Patients nominate a preferred clinician** who is aware of their problems, priorities and wishes, and is responsible for their care coordination.
- **Flexible service delivery and team based care** that supports integrated patient care across the continuum of the health system through shared information and care planning.
- **A commitment to care which is of high quality and is safe.** Care planning and clinical decisions are guided by evidence-based patient health care pathways, appropriate to the patient's needs.
- **Data collection and sharing** by patients and their health care teams to measure patient health outcomes and improve performance.

Many patients will recognise features of the Health Care Home in their existing general practices.

FIGURE 1: THE HEALTH CARE HOME



Better targeting of services for patients with chronic and complex conditions in accordance with need

A risk stratification approach is needed to more effectively support the identification of patients with high coordination and team needs and target services accordingly. For the population who have multiple chronic conditions, the Advisory Group has identified three tiers of the population who may benefit from a Health Care Home, differing in their complexity and need for coordinated care and support in relation to patients' abilities to self-manage.

Many of the submissions to the Advisory Group recommended a much broader application of the Health Care Home model beyond the scope of this review. Some of the recommendations from those submissions may be considerations for the Medicare Benefits Schedule Review Task Force and others recommendations may be considered over time.

System integration and improvement

Care within the Health Care Home is supported by better integrated community and acute care within the broader health system. This allows the patient, family and health care team to more readily access important care within their own community. This might be a specialist opinion or visit, videoconference or additional home service to avoid a preventable hospitalisation.

This will require Primary Health Networks (PHNs) to work with Local Hospital Networks (LHNs) to strengthen and promote regional collaboration in commissioning services to support local and out of hospital health care. PHNs should collaborate with LHNs, Private Health Insurers (PHIs) and providers to develop or build upon locally relevant hospital admission and discharge approaches or protocols, including locally relevant patient health care pathways. Patients and providers are supported to develop more formal arrangements to involve PHIs in supporting policy holders' access to relevant chronic disease services.

Change management

Overseas experience has shown that such changes to care delivery models require significant change management support. Professional colleges and associations should be engaged early and in an ongoing way to: support the substantive cultural change required to establish Health Care Homes; assist the integration of primary and secondary care; and support uptake of the recommended reforms to policies, practice, training and professional development.

New payment mechanisms

Existing payment systems should be redesigned for eligible patients to more appropriately cover the wide range of services to be provided under the new approach. These should include the introduction of bundled payments, block payments and pooled funding to support the new approach, while preserving fee for service for episodic care. Payment approaches need to preserve regional flexibility, equity of access for patients, support evidence-based and non-face to face care, and encourage efficient use of resources. Nationally, there is significant capacity within the existing health system to redirect and re-profile existing expenditure to support the new approach.

Measuring the achievement of outcomes

Health Care Homes and the community reforms around them should support a continually improving primary health care system. The Advisory Group recommends that a nationally consistent, de-identified data set is developed and used at a regional and national level to

understand the impact of service change with a view to improving population health outcomes and informing ongoing health system improvements.

Elements of the Practice Incentives Programme should be refocused to support practices to use relevant data to undertake quality improvement activities in a structured way.

The process of data collection and analysis should be part of the establishment of Health Care Homes and related service-integration initiatives and is necessary to understand the impact of and progressively improve the quality of the new models of primary and integrated care.

Strong support by the sector and the public

Key elements of the recommended model are strongly supported by the feedback from the consultation processes:

- 77% of respondents indicated that they support patient enrolment with a Health Care Home for people with chronic and complex conditions.
- 92% of respondents supported team based care for people with chronic and complex conditions.
- 90% of respondents agreed that it is important to measure and report patient health outcomes.

IMPLEMENTATION CONSIDERATIONS

Australia is well placed to progress the recommended reforms. There are many elements of the existing health care system that already provide a solid foundation from which to establish the proposed new model of care.

A staged rollout of the model is recommended, to enable the individual elements of the model to be properly defined, established and evaluated before proceeding to a national rollout.

States, Territories and the Commonwealth, PHNs and PHIs are already conducting (or in the process of developing) trials that could be built upon or expanded as part of the first stage of implementation.

The Advisory Group recognises the need to work within existing resources as far as possible. International evidence demonstrates that a strong, well-resourced primary health care system leads to high quality care and is a more efficient use of available resources. However, the Advisory Group cannot rule out the requirement for additional resources to support the model. The proposed staged rollout provides the opportunity to assess the affordability of the model and should look to apply existing resources within the system.

An effective overarching governance mechanism is required to ensure that funders, providers and patients are engaged in the detailed design and implementation process. This should link with existing reforms underway, including the Reform of Federation, the Review of the Medicare Benefits Schedule (MBS) and other Commonwealth reviews.

Early and ongoing communication and engagement with governments, PHNs, LHNs, provider organisations, and PHIs and consumers is essential to ensure optimal support for the new model of care and the cultural changes and developments necessary to support the rollout of the new model of care.

SUMMARY OF RECOMMENDATIONS

APPROPRIATE AND EFFECTIVE CARE

Key Recommendation 1: Better targeting of services for patients with chronic and complex conditions in accordance with need

- Identify suitable case finding processes, drawing on existing validated Australian and international risk stratification tools to identify patients requiring high levels of coordination and team care.

Key Recommendation 2: Establish Health Care Homes

- Develop appropriate Health Care Home specifications, evidence-based education and training and other tools to enable providers, patients, practice managers and the broader health care sector to operate and engage with Health Care Homes.

Key Recommendation 3: Activate patients to be engaged in their care

- Develop an effective and standardised approach to support patients and providers to engage in shared goal setting and decision making.
- Develop advice on the application of digital health devices and any health system changes required.
- Enhance access to targeted online patient information and education and self-help resources.

Key Recommendation 4: Establish effective mechanisms to support flexible team based care

- Reduce barriers for allied health professionals and community-based specialists accessing and contributing to the patient record, complementing recommendations of the 2013 *Review of the Personally Controlled Electronic Health Record*.
- Ensure Health Care Homes use clinical software that is compatible with the Australian digital health infrastructure to support the integration of information technology (IT) systems.
- Formalise the roles and responsibilities for clinical and non-clinical care coordinators within the Health Care Home.

SYSTEM INTEGRATION AND IMPROVEMENT

Key Recommendation 5: Enhance regional planning

- Assess and share the benefits of evidence-based patient health care pathway tools that are currently available and being applied in Australia.
- Require PHNs to collaborate with LHNs, PHIs, providers and patients to support regional planning, including the establishment of locally relevant patient health care pathways and admission and discharge protocols.

Key Recommendation 6: Maximise the effectiveness of private health insurance investment in the management of chronic conditions

- Support a single care plan developed by the Health Care Home that better coordinates the provision of all relevant services, whether funded publicly, by PHIs or by patients.
- Source or develop protocols, including patient consent, to share relevant information between providers and PHIs.
- Further encourage PHIs to fund the prevention and management of chronic conditions, including through consideration of the use of the risk equalisation pool in relation to chronic disease management programmes to support patients in the Health Care Home.
- The private health insurance consultations should further consider ways to address disincentives for PHIs to support care service delivery in non-hospital settings, such as hospital in the home.

- Review the outcomes of current PHI chronic disease trials to further define the future role of PHIs in supporting management of chronic and complex conditions.

Key Recommendation 7: Coordinate care across the health system to improve patient experience

- Assess the applicability of existing care coordination capability in aged care and mental health for inclusion in the Health Care Home planning and patient and family service support.
- Ensure that all Health Care Home care coordinators identify the existence of, and engage with, care coordinators from other sectors in planning and delivering patient care.

Key Recommendation 8: Support cultural change across the health system

- Support PHNs, professional colleges, associations and consumer groups to develop and implement education and training for health care providers and consumers on the development and staged rollout of the new service delivery and funding models, to ensure all stakeholders are engaged and ready for the new model of care as it is rolled out nationally.

PAYMENT MECHANISMS TO SUPPORT A BETTER PRIMARY HEALTH CARE SYSTEM

Key Recommendation 9: Restructure the payment system to support the new approach

- Restructure the payment system to include alternative payment approaches that appropriately cover the wide range of proactive, coordinated and ongoing services to be provided under the new approach.
- Test upfront and quarterly bundled payments to Health Care Homes to support the new approach prior to wider rollout.
- Consider the range of Medicare Benefits Schedule (MBS) items and other Commonwealth funding programmes that could be brought together to support a more targeted and flexible approach to funding.
- Test new payment models to PHNs to enable them to commission appropriate non-general practice clinical care and coordination services for enrolled patients in their region based on the patient's allocated risk stratification level, prior to wider rollout.

Key Recommendation 10: Pursue opportunities for joint and pooled funding

- Explore opportunities for State and Territory governments, PHIs and local industries to contribute to the funding base for enrolled populations (through funding or in-kind contribution).

Key Recommendation 11: Patients contribute to their health care costs to the extent that they are able

- There should be no change to the expectation of Australians to continue to contribute to some of their health care costs to the extent that they are able to pay, consistent with current approaches.

MEASURING THE ACHIEVEMENT OF OUTCOMES

Key Recommendation 12: Support a quality and continually improving primary health care system

- Require Health Care Home practices to be appropriately accredited or have registered for accreditation (and achieve full accreditation within 12 months). Accreditation should reflect practice type and setting.
- Strengthen the focus of the Practice Incentives Programme towards quality improvement activities by providing payments to support general practices identifying as Health Care Homes to undertake quality improvement activities in a structured way, informed by data.

Key Recommendation 13: Establish a national minimum data set (NMDS) for patients with chronic and complex conditions

- Establish a suitable data governance mechanism to develop and implement a NMDS for patients with chronic and complex conditions, in consultation with health care providers, relevant organisations, patients and carers.
- Health Care Home practices and care providers to provide de-identified data to support a NMDS.
- Explore IT infrastructure requirements to support the automated extraction of de-identified data from clinical software, data analysis and reporting.
- Ensure PHNs are sufficiently supported to assist Health Care Homes to collect and report data and utilise it to improve local care quality.

Key Recommendation 14: Establish new performance reporting arrangements

- Provide NMDS summary data to practices, regional level data to PHNs and LHNs and build on the existing national reports on chronic disease management to support system improvements and resource allocation.

Key Recommendation 15: Integrate evaluation throughout implementation of the reforms

- Develop and implement an evaluation framework to ensure early and ongoing learning, and application of this learning, through the staged implementation of the reforms.