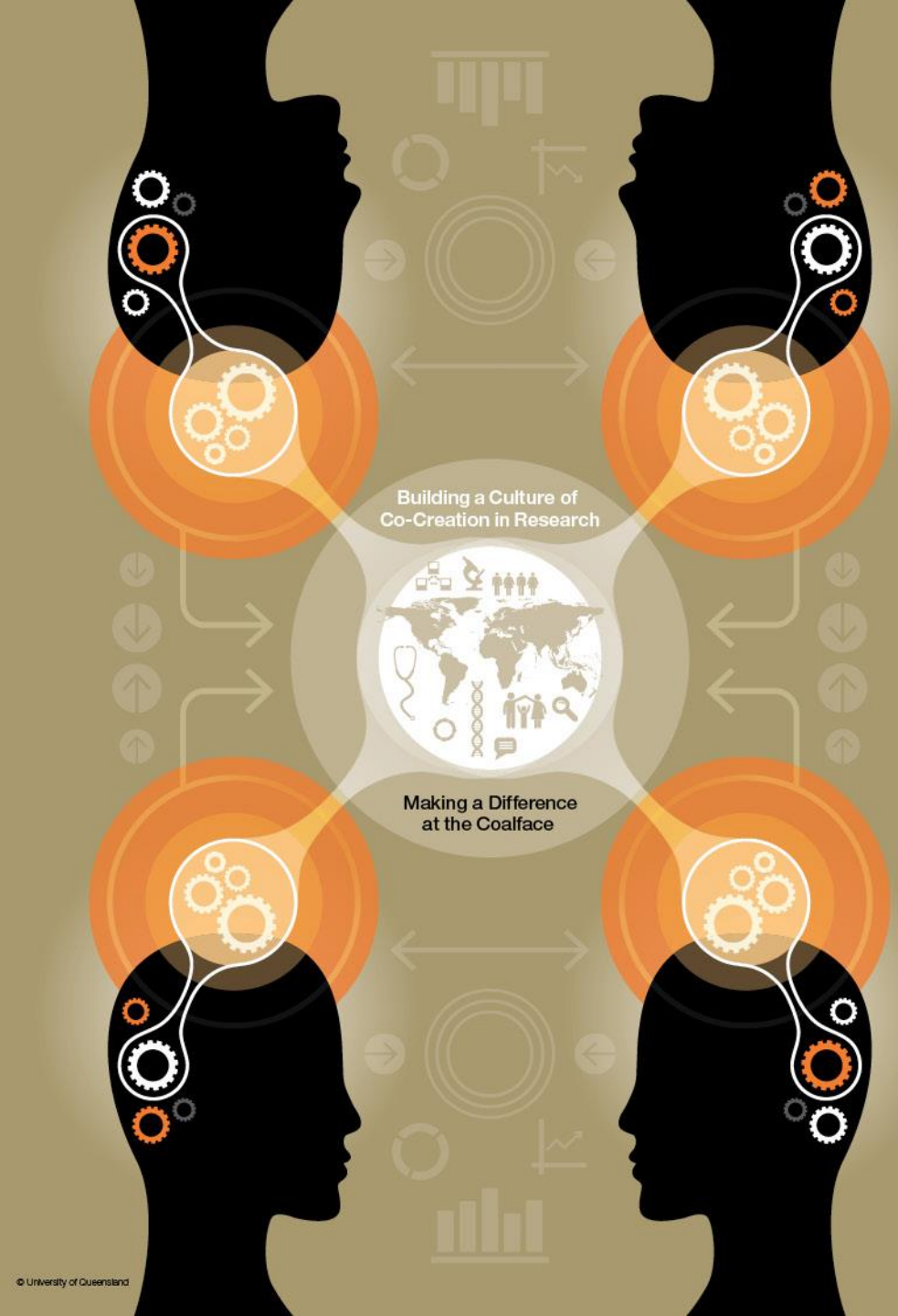

Integration of Chronic Care: the Health Care Home, Continuity of Care and the Medical Neighbourhood

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The International Reform Environment

'5 year forward view' (UK), PHO (NZ), ACOs, PCMH (USA and Canada), PHCAG, COAG (Australia)

- Primary-care led reform:
- Increasing relevance, funding and accountability of the sector
- Changing governance structures to achieve this
- Strong integration with acute, private sector and social care
- Whole of system planning, funding and service delivery
- Advanced care delivery access within the community
- Linking incentives with desired structure and function
- Innovative use of 'e'
- Quadruple Aim

International trends

USA:

- Blended funding model
- Accountable Care Organisations, and
- Patient Centred Medical Home;

UK:

- the NHS ‘5 year Forward View’ : STP, ACOs, PACS, MCPs, PCH
- Evaluation of 50 Vanguard sites

NZ:

- Blended funding model
- the expansion of PHO / DHB relationship eg Alliance contracting
- ‘One system, One budget’
- HCH MOC now disseminating widely

Australia's Commitment to Excellence: primary care quality and accountability

- 1990s: Accreditation / PIP / College QI&CPD
- 2008:National Health & Hospitals Reform Commission
- 2009: National PHC Strategy / ACQSHC /NHPA
- 2012:National ATSI Health Plan / National Strategic Framework for Rural and Remote Health / National PHC Strategic Framework
- 2015: PHC Advisory Group (15 recommendations)/ growing role for PHNs /integrated clinical pathways (Health Pathways)
- 2016: COAG health reforms, PIP review, Revalidation, ADHA,
- 2017: strengthening PHN / LHN contracting and data sharing / MBS Review / myHR / PIP and PHI Reform /Health Care Home (HCH) pilots

The Patient Centered Medical Home (PCMH) :the prototype

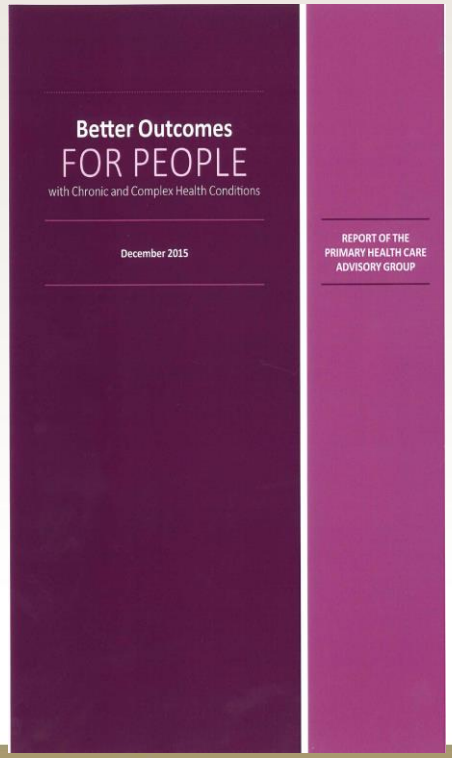
- Personal physician - each patient has an ongoing relationship with a personal physician who provides first contact, and continuous and comprehensive care. Physician directed medical practice – the personal physician leads a team of individuals who collectively provide care for the patient.
- Whole person orientation – the personal physician is responsible for meeting all the patient's health care needs or for arranging care with other qualified professionals.
- Care is coordinated and integrated across all elements of the complex healthcare community - coordination is enabled by patient registration, information technology, and health information exchanges.
- Quality and safety - hallmarks of the patient centred medical home.
- Evidence-based medicine and clinical decision-support tools guide decision making - physicians in the practice accept accountability voluntary engagement in performance measurement and improvement.
- Enhanced access to care is available - open scheduling, expanded hours, e-access.
- Payment reform - recognizes the added value provided to patients.

Why adopt a ‘medical home’ approach in Australia?

- Promotes the essential role that general practice plays in providing evidence-based quality primary care from NPHCS.
- Builds on and formalizes the relationship most Australians have with their general practice, ACCHS or rural MPS.
- Fits neatly with the RACGP “Quality General Practice of the Future’.
- Accelerates benefits of :
    - Improved health outcomes for individual patients (effective management of chronic diseases, routine preventive screening, coordinated quality care).
    - Reduction of overall health expenditure with greater community care responsibility.
    - Current reform initiatives.
    - Builds on and links myHR roles and responsibilities.
    - Identifies A/H care and continuity of care responsibilities.

PHCAG's Health Care Home

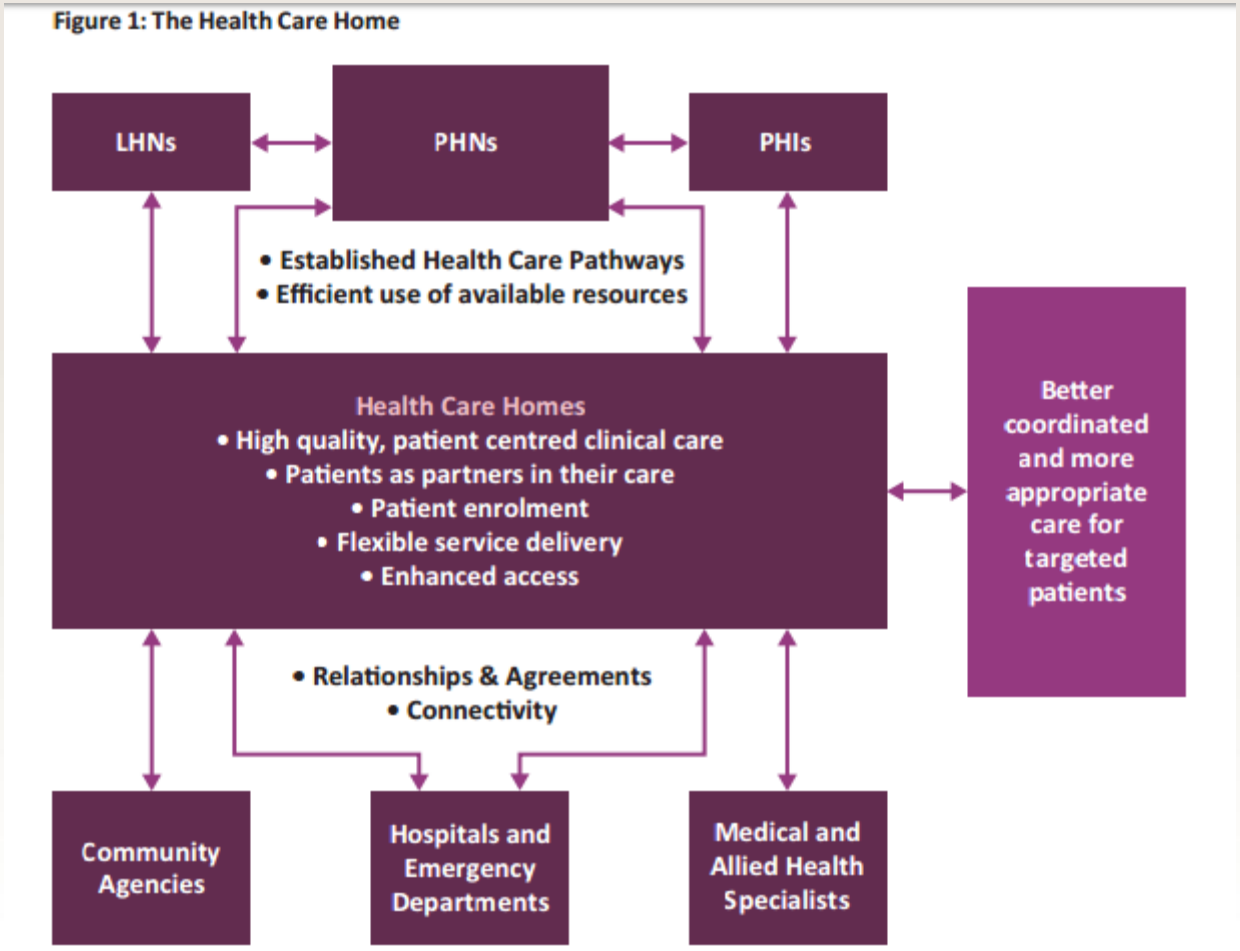
- Voluntary patient enrolment
- Patients, families partners in care
- Enhanced access to care – non F2F, a/hours
- Patients nominate a preferred clinician, responsible for their care
- Flexible, team-based care
- High quality, safe
- Use of data to improve outcomes and performance
- Bundled payment model



PHCAG's other recommendations..

- Support locally-relevant, evidence-based health care pathways and admission / discharge protocols
- Maximise the effectiveness of PHI investment in chronic disease management
- Improved care coordination and culture change across the health system relevant to new service delivery and funding models
- Broadened payment / funding mechanisms including poolled funding, non-MBS, local industries
- Support a quality and continually improving primary health care system
- New performance reporting and evaluation frameworks

Building a health care system



'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.'

Report of the Primary Health Care Advisory Group, Canberra, December 2015.

COAG April 2016

2. Bilateral agreements will be signed to provide flexibility for each jurisdiction to determine the best model of care for Australians with chronic disease.

4. The Commonwealth will establish any necessary enabling infrastructure, governance arrangements, or systems to support a pilot of a Health Care Homes model in primary health care, consistent with the advice provided by the Primary Health Care Advisory Group, initially to include:

   a. criteria for determining patient eligibility in Commonwealth funded services;

   b. funding levels and payment mechanisms in Commonwealth funded services;

   c. establish data collection associated quality improvement processes within participating general practices;

   d. a comprehensive evaluation to determine impact on patient outcomes, hospitalisations and overall cost effectiveness of the model; and

   e. establish early implementation of a pilot of Health Care Homes in Primary Health Network (PHN) regions, to be operational by 1 July 2017

5. The States will work with the Commonwealth in selected regions through bilateral agreements, which may include:

   a. establishing elements involving joint coordinated planning and, where appropriate, collaborative commissioning of services between PHNs and Local Hospital Networks (LHNs);

   b. identifying and implementing arrangements for the sharing of patient information, with patient consent, including relevant hospitalisation, MBS and PBS data;

   c. educating relevant state funded health service providers to work with Health Care Homes pilots in participating regions; and

   d. where feasible, implement collaborative, joint and/or pooled funding PHNs/LHN to support better coordination of care for specific patients at risk of avoidable admission.

The results of this first stage will be comprehensively evaluated and brought back to COAG in 2018 for further consideration of a joint national approach… which may include collaborative, joint or pooled funding arrangements

COAG policy 2016

- Trial of Health Care Home in 10 PHN Regions
- 65,000 patients with chronic conditions to be involved
- 200 general practices will transform to HCHs and trade in MBS chronic disease billings for a bundled payment model
- $21.3 million to support roll out till 30 June 2019, with $93 million in redirected MBS funding
- Practice EOI out Nov 4th, DoH practice selection announced May 17 with final contractual arrangements to be confirmed 31 July. DoH training consortium and independent evaluator chosen late 2016
- SIGNIFICANTLY DELAYED (as 200 HCHs to be operational and patients enrolled July 1 2017)

Commonwealth Practice EOI Nov 4th 2016

- 3 Tiers of chronic disease patients enrolled
  - Tier 3 – high risk, complex, includes palliative (1%) $ 1,795 / yr
  - Tier 2 – multi-morbid, requiring care co-ordination (9%) $ 1,267 /yr
  - Tier 1 – multiple chronic conditions, self-managing (10%) $ 591/ yr
- HCH Training Tender to support practice transformation using US '10 building blocks' approach but, unlike US, no accreditation criteria
- Risk stratification tools x 2 for patient identification and patient tier categorization
- Evaluation contract – HCH to participate in qualitative and quantitative data
- One-off $10,000 for HCH non clinical participation including training, RS tool, patient enrolment, MyHR usage, enhanced in-hours access, evaluation and data collection.

Where is the COAG policy now ?

- Trial of Health Care Home in 10 PHN Regions
- Only 2,000 patients (3% target) with chronic conditions recruited
- 175 general practices participating with 79 still to recruit any patients
- Significant ongoing external criticism of the trial, with general consensus that the trial has been about re-jigging existing funding rather than the change PHCAG proposed
- Ongoing support for the model itself and principles and activity in many other PHNs
- MBS Review supportive and moving quickly
- 2 new Presidents (AMA / RACGP) and an election year ….

Challenges of implementing health care home

- **A systematic review of the challenges to implementation of the patient centred medical home: lessons for Australia** *MJA (2014); 201(3): S69-73*

  – Requires electronic health records and exchange
  – Requires change in funding and payment models (volume to value)
  – Requires internal practice resources and infrastructure; and support with transformation and change management
  – Requires measures of performance and consistent accreditation and standards

… What is a ‘Health Care Home’ ???

HCHs – the 'secret sauce' ?

- relationship / continuity of care?
- patient / family engagement?
- wrap-around support?
- 'medical neighbourhood?
- clinical connectivity
- innovative use of 'e'
- funding and new incentives
- culture change

- What are we testing?

Continuity of Care

- consistently associated with improved health outcomes
- growing observation in most CDM reform documentation
- highly valued by health consumers
- challenging to measure at scale
- secondary care a key player esp for chronic disease

Continuity of care

Vital, but how do we measure and promote it?

CONTINUITY OF CARE has been part of general practice philosophy since inception. It is a central tenet of The Royal Australian College of General Practitioners' *Quality general practice of the future*,[1] Royal College of General Practitioners' *Promoting continuity of care in general practice*,[2] and the The Royal New Zealand College of General Practitioners' *Aiming for excellence: The RNZCGP standard for New Zealand general practice*.[3] The concept underpinned Barbara Starfield's ground-breaking international work on the impact of high-quality primary care on health system outcome[4] and Julian Tudor Hart's legacy,[5] and it has been jealously guarded by generations of general practitioners (GPs) and family physicians.

Despite such protestation there has been a steady erosion of general practice continuity of care over the past 30 years. In Australia, 34% of very high and frequent general practice attenders see three to four GPs annually, while a further 36% see five or more.[6] New models of care, such as drop-in clinics (UK, ACT) and urgent care centres in Walmart and the drugstore chain CVS (US), offer easy access, non-medical, episodic care to increasing sectors of the population. In Australia, online services, such as GP2U[7] and Qoctor,[8] promote quick and inexpensive access to a one-off remote primary care encounter.

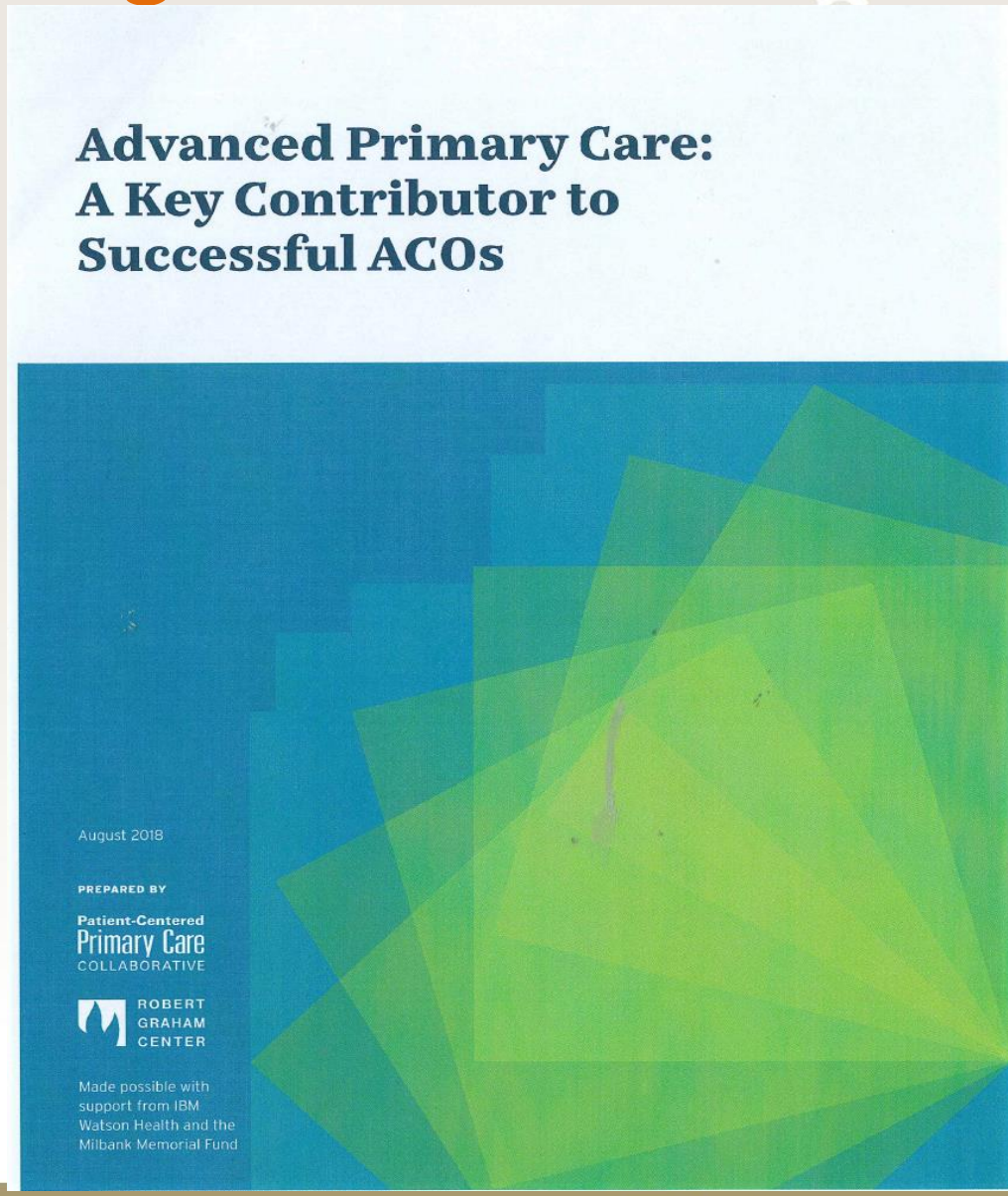
Benefits of continuity of care

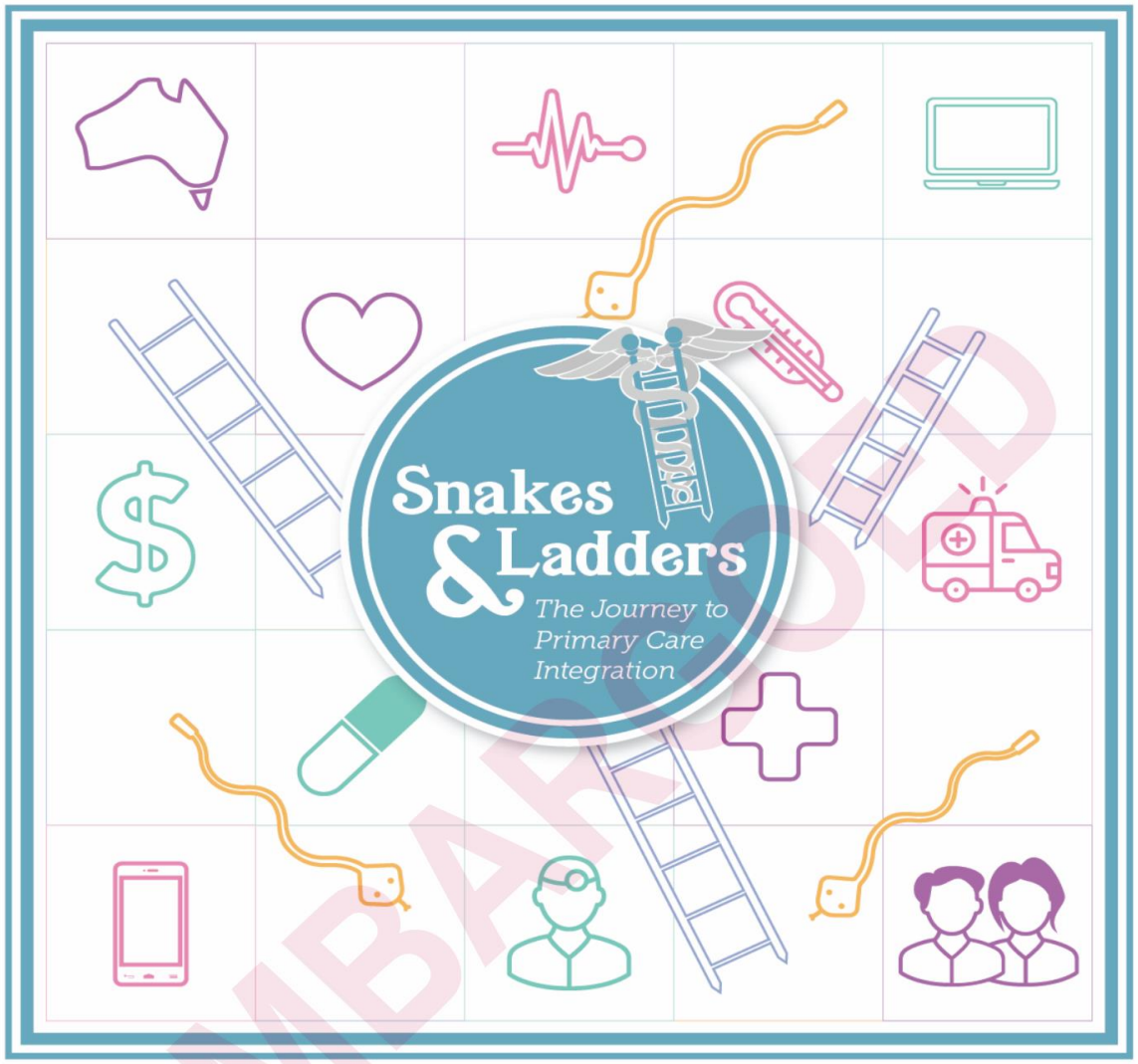
Continuity of care has consistently been associated with improved outcomes, despite some variation in how the concept is defined, interpreted and assessed. Terms such as therapeutic alliance,[9] working alliance,[10] continuity of care,[11] relational continuity[12] and relationship-based care[13] are fundamentally synonymous and refer to the positive outcomes that occur when a patient has an ongoing sense of affiliation, collaboration and trust with a single provider.[14] High levels of continuity of care (and other similar terms) have been shown to result in positive patient experiences, greater patient satisfaction, increased treatment adherence and improved patient outcomes.[9,10,15] A recent data linkage project identified continuity of care as a predictor for improved health outcomes, especially – and not surprisingly – for ambulatory-care sensitive conditions for older patients.[16] Furthermore, van Loenen's recent systematic review on organisational aspects of primary care related to avoidable hospitalisation identified adequate physician supply and better longitudinal continuity of care as key influences on avoidable hospitalisation.[17] Periera Gray's 2018 systematic review links increased continuity of care with lower mortality.[18]

Recently, two key health services studies have explored the benefits of continuity of care to patients and health systems. Last year, the Health Foundation

The Medical Neighbourhood

- growing prominence in the international policy environment
- Accountable Care Organisations (ACOs),
- Multispecialty Community Providers (MCPs),
- Integrated Primary and Acute Care Systems (PACS)

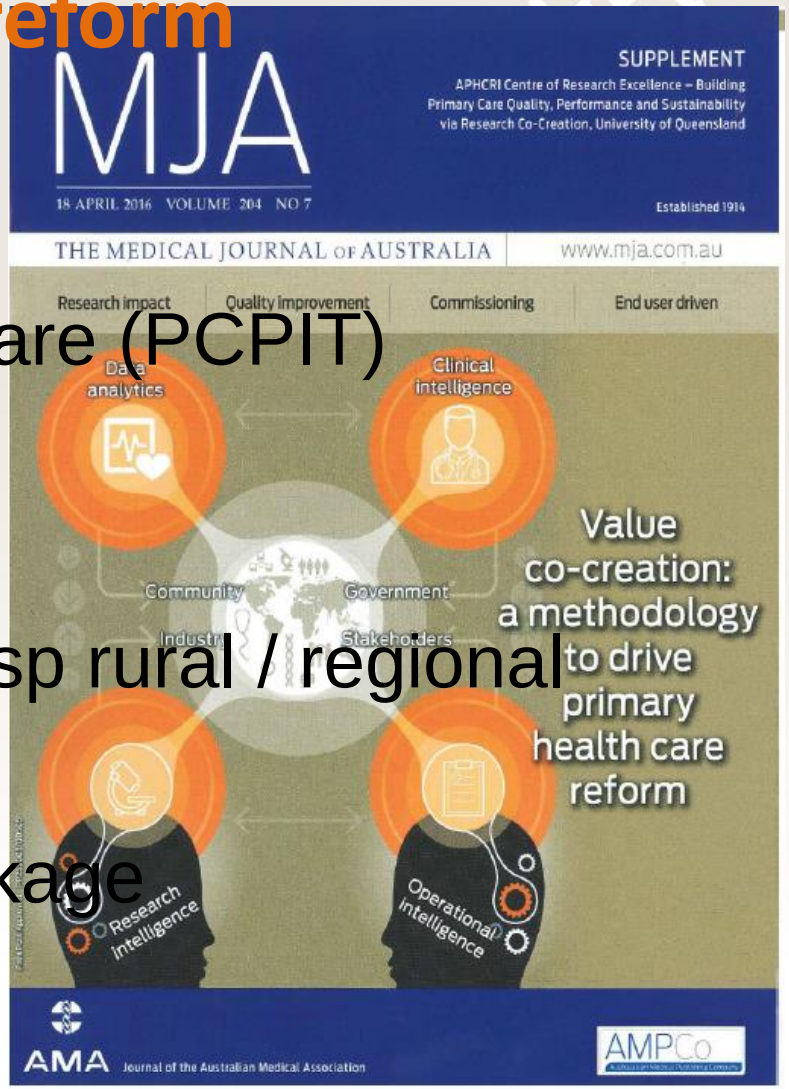




EMBARGOED

PHNs and their communities will play a key role in integration reform

- Advocacy
- Practice support in quality care (PCPIT)
- Data support and collection
- Co-commissioning
- Population-based funding esp rural / regional
- Dissemination of evidence
- Effective networking and linkage



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EXCLUSIVE

SEAN PARNELL
HEALTH EDITOR

GPs would be paid to prevent chronically ill patients being hospitalised and hospitals fined for readmissions that could have been avoided, under a reform proposal considered so important that Health Minister Greg Hunt is willing to offer the states a 10-year funding deal for their support.

Under the extraordinary pro-

INSIDE

Attempting to hold together the centre of politics, Scott Morrison warns that the politics of envy is the road to ruin.
PAUL KELLY P15

other foreign matter were left inside a patient after surgery, and 20 medication errors leading to the death of a patient.

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The speed bumps and challenges ahead

- 2 years on from COAG 2016, Australian primary and acute care still has a diversity of systems, culture, integration and performance based on local leadership, vision and partnership
- Service delivery integration requires a patient-centred rather than organisation-centric approach, energy, commitment, and a shared vision across settings
- Appropriate incentivization, change management, and clinician and consumer engagement and involvement in service re-design is fundamental
- Secondary care flexibility and a focus on improved community capacity to avoid hospital contact will be of increasing importance
- Such a complex service delivery change must be evidence-based and build new health partnerships between clinicians, academics, patients, organisations and funders