Australian Government
Department of Health

HEALTH CARE HOMES
Patient-centred Coordinated Flexible

Health Care Homes

Handbook for General Practices and Aboriginal Community Controlled Health Services

2017

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Abbreviations

ACCHS	Aboriginal Community Controlled Health Service
DHS	Department of Human Services
DH	Department of Health
GP	General practitioner
GST	Goods and Services Tax
HPOS	Health Professional Online Services System
IRN	Individual Reference Number
MBS	Medical Benefits Schedule
PBS	Pharmaceutical Benefits System
HCH-A	Health Care Home Assessment tool
PHN	Primary Health Network
PIP	Practice Incentives Program
RST	Risk Stratification Tool

1 Health Care Home – Introduction

This handbook has been designed specifically for general practices and Aboriginal Community Controlled Health Services (ACCHS) as the guidelines for your journey to becoming a Health Care Home.

The Health Care Home model further builds on the sort of 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 involvement of the whole team. You will be supported by the Primary Health Network (PHN) and their Practice Facilitator, together with specific and detailed information which will be found in the Health Care Home 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 provides 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 Vision for Health Care Homes 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 who have 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 full scope of their license, and
- Enhanced sharing of up to date health summary information

1.2 Why adopt the Health Care Home approach?

The implementation of the Health Care Home model in Australia 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% 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 Home model of care.

In stage one, patients who are most likely to gain benefit will be targeted: those 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 experience is timely, recognises the needs of patients and their families and provides equitable access. Services are better coordinated including the links with hospitals and allied health providers, and access is enhanced through the use of technology, such as telephone and email consults. 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 improved 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 general practitioners (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.

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. 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 and reduce burnout as well as supporting a better work/life balance.

1.4 What is the Health Care Home approach?

The Health Care Home is an approach to health care that puts the consumers (patients) 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 key characteristics, including:

Voluntary patient enrolment. Practices will select eligible patients and facilitate their enrolment with the practice and registration in the program.

Patients nominate a clinician. The nominated clinician will lead the team providing the ongoing care.

Patients, families and their carers as partners in their care. This ensures cultural preferences and values are respected, and they are genuine partners in their health care.

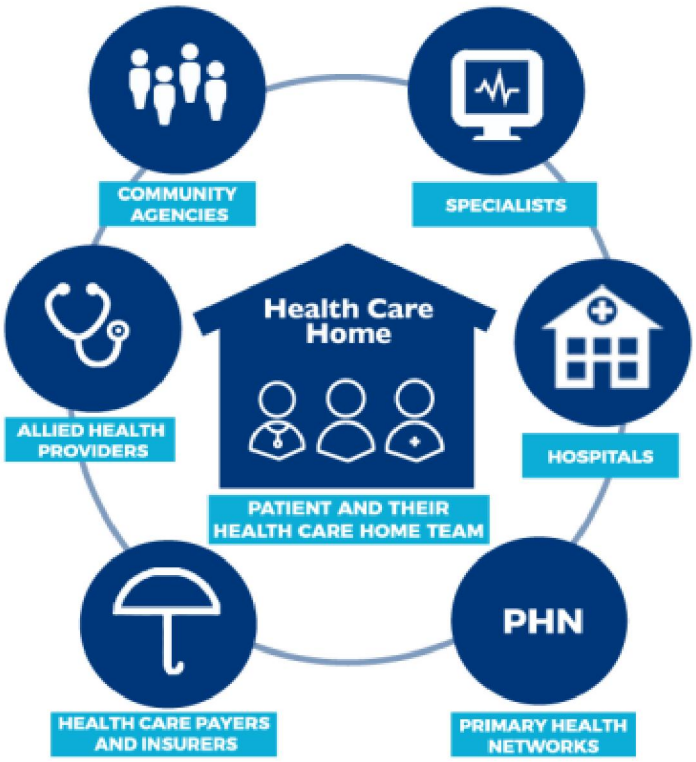
Enhanced access and flexibility through timely advice, and access options enabled by a bundled payment model.

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

A commitment to **care which is of high quality and is safe** through 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, allowing for 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 that 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 patients' 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 doctors need	An **interdisciplinary** team works at the **top of their professional capacity** to serve patients

Figure: Care transformation when delivered through the Health Care Home

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 Home – stage one trial

Implementation of the Health Care Home stage one trial will be phased, with up to 20 Health Care Homes that are ready to start delivering services, commencing on 1 October 2017 and the remainder commencing on 1 December 2017.

Stage one of Health Care Homes will undergo 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 provided with this information at that time.

Regardless of the outcome, the general practices and ACCHS involved in stage one will have undergone a whole of practice transformational process to support optimised performance in the dimensions of the quadruple aim. As the Health Care Home concepts become embedded and normalised, the 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 – stage one

3.1 Practice eligibility requirements

A general practice or ACCHS participating in stage one must meet, and continue to meet, the following eligibility requirements:

- Be a recipient of a one-off incentive grant under the Health Care Home 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 aboriginal Medical Service against the current Royal Australian College of General Practitioners Standards for general practices
- Already be, or will by 1 December 2017 be, a participant in the Practice Incentives Program (PIP) eHealth Incentive.
- Already have, or will by 1 December 2017 have, access to the Department of Human Services (DHS) Health Professional Online Services (HPOS) portal
- Participate in the stage one Health Care Homes training program, as required by section 5.2
- 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
- Ensure that all enrolled patients are registered and connected to the My Health Record system, and contribute up-to-date clinically relevant information to their My Health Records, as required by section 7.4
- Develop, implement and regularly review each enrolled patient's shared care plan, as required by section 7.3
- 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 stage one.

Any additional requirements are indicated by a 'must' throughout the handbook.

3.2 Practice registration

What you need to do:

Follow the instructions in your letter of offer:

- sign the attached *Grant Schedule*;
- sign the attached *Declaration;* and
- send or email a scanned copy to the address outlined in a timely manner so that it is received by the Commonwealth by the required date

Note that 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.

You will be part of a group of 200 Health Care Homes across 10 PHN regions on a journey of learning and transformation to enhance provision of quality primary care for people living with chronic and complex conditions.

4 Practice – Systems

4.1 Practice readiness – Practice Assessment Tools

Specialist trainers, known as Practice Facilitators, will be located in PHNs to support the transformation of practices and ACCHS to become 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 to assist them when developing their transformation plan. The *Health Care Home Assessment (HCH-A) tool* is one of those tools that are available. The HCH-A tool is available free to all practices as part of the Health Care Home training, and 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 beginning and may repeat it several times during the transformation to assess their progress over time. General practices or ACCHS may redo different parts of the HCH-A relevant to the Modules in the training program. The HCH-A information together with Health Care Home tools and the learnings from their experience enable the general practice or ACCHS to effectively plan their ongoing development. The Practice Facilitator will assist with the administering and analysing the HCH-A tool and supporting practices to identify and plan for improvement.

Tips for getting the most from the assessment tool:

- Identify a multidisciplinary group of practice staff
- Have all the team involved in the assessment – clinical and non-clinical
- Complete the assessment individually. This will capture many perspectives and avoid group think
- Have the team meet to discuss their individual assessments and produce a consensus version
- Avoid averaging the scores to produce a consensus
- Utilise the team discussion to identify opportunities and priorities for the 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

The use of the Risk Stratification Tool is the critical first step to identifying patients and assessing their eligibility for the Health Care Home program. All participating general practices or ACCHS must use the same tool.

The Risk Stratification Tool will be developed using the cdmNet platform, from Precedence Health Care. The CSIRO will validate and calibrate the Risk Stratification Tool using Australian primary care and hospital data. The platform is cloud-based and requires internet connectivity. The software is currently compatible with Medical Director, Best Practice, ZedMed and Monet and compatibility with Communicare and MedTech32 will be achieved by 1 December 2017. The Risk Stratification Tool software will be made available for download and installation. User guides and technical support will be provided to participating general practices and ACCHS.

The Risk Stratification Tool assists identification of potential patients by determining the level of complexity of each patient's chronic conditions (represented by a tier) and hence eligibility to be in the Health Care Home program. Each patient is assigned to a complexity tier (see figure below). The Risk Stratification Tool will collect patient information in order to provide eligibility assessments and assign risk tiers to patients, but this data will be stored safely and securely without any patients' identifying information.

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 Risk Stratification Tool identifies the relative risk of unplanned need for hospital-based care for people in a population by considering an individual's circumstances, health and medical history.

The diagram below shows the population estimates and characteristics of patients.

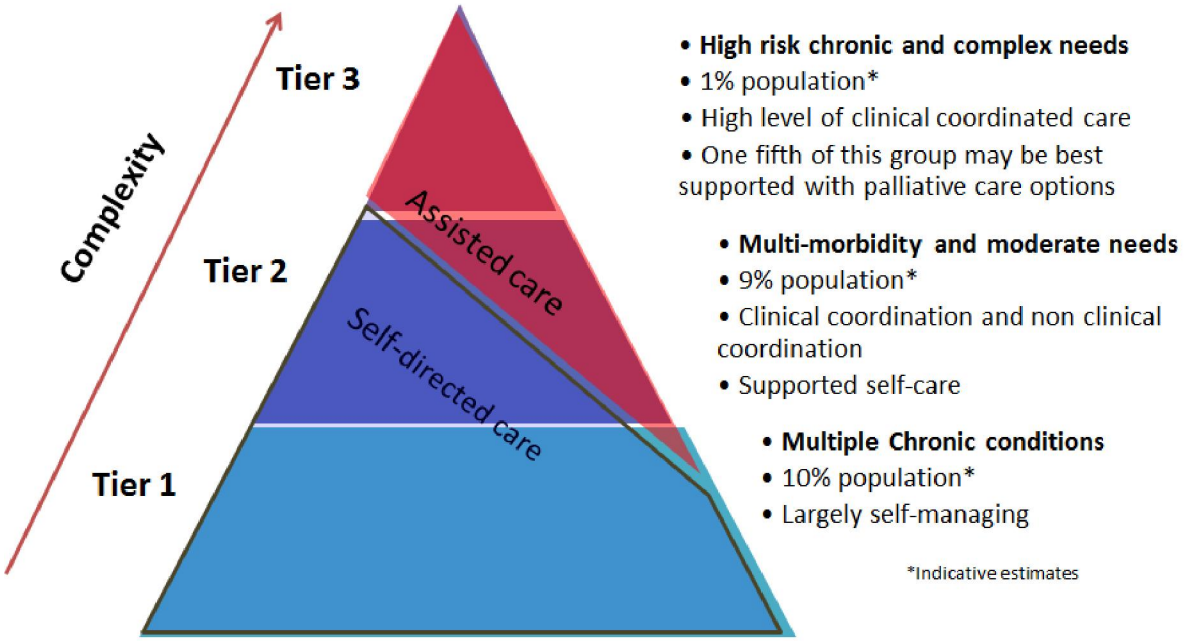


Figure 1: Estimates and characteristics of patients requiring targeted support.
* Estimates based on analysis of available population, hospitalisation and Medicare data. Accurate estimates of population sub-groups are limited due to limited national data to support such analysis
Source: Australian Department of Health (2015). Primary Health Care Advisory Group (PHCAG) provided a report to the Australian Government – Better Outcomes for People with Chronic and Complex Health Conditions.
http://www.health.gov.au/internet/main/publishing.nsf/Content/76B2BDC12AE54540CA257F72001102B9/$File/Primary-Health-Care-Advisory-Group_Final-Report.pdf

The Risk Stratification Tool will produce its most accurate and reliable assessments with high quality and complete data records. General practices and ACCHS can prepare for using the Risk Stratification Tool 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 as stage one Health Care Home patients. However recipients of other Commonwealth funded aged care support, including the Home Care Packages Program and the Commonwealth Home Support Program, are eligible to enrol as Health Care Home patients.

4.3 Patient enrolment and consent

Patient enrolment is an important component of the Health Care Home model. 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 practice. The patient enrolment process must include:

- Utilisation of the Risk Stratification Tool (RST) to identify and assess eligible patients
- Communication with the patient about the Health Care Home program
- Patient consent to and registration with the Health Care Home program
- Patient consent to the collection, use and disclosure of their personal information for specified purposes

A *brochure for Consumers/Carers* is available

A patient is deemed to be enrolled when they sign the consent form.

Patient registration through HPOS must be ***within 7 days*** of signing the consent form.

Your PHN's Practice Facilitator can help with recruitment and enrolment

The following steps are detailed in Module 3 of the training program.

Step 1 – Identify eligible patients using practice scan tool
Run the RST in *Practice scan mode* to identify a potential 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 confirms 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.

Step 2 – Invite potentially eligible patients to participate
Communication with patients will be customised by the general practice or ACCHS – telephone, email, post or during consultation. Provide potential Health Care Home patients with *Patient Information Brochure* to support understanding of model and service offering.

Enrolled patients may continue to contribute to their healthcare costs; however this **MUST be agreed with the patient at the time of enrolment.** Patients should also be informed that any gap fees will not be counted for the Medicare Safety Net.

Step 3 – Patient consent process
General practice or ACCHS provide eligible patient with information and answers to patient questions, including any questions in relation to the collection, use and disclosure of their personal information.

General practice or ACCHS confirms again 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.

If patient agrees to enrol, patient completes and signs the Health Care Home patient enrolment/consent form, using the template provided by the Department of Health and available through the RST).

If a patient indicates that they do not wish for their personal information to be included in the evaluation, the patient completes and signs the evaluation opt out form.

Steps 3 & 4 can be undertaken during the same consultation

Step 4 – Assign a risk tier using the questionnaire
Once the patient has completed and signed the Health Care Home patient enrolment/consent form:

- 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 and information from conversations with providers, patients and family members/carers can be used to complete the questionnaire). A Risk Tier Certificate will be generated by the RST
- Provide patient with Patient Handbook
- The risk tier determines the level of care required by the patient and the value of bundled payment provided to the practice

Step 5 – Patient registration using HPOS.

The registration will involve the general practice or ACCHS confirming the following through HPOS, **within seven days** of the patient completing and signing the Health Care Homes enrolment and consent form. The registration will require:

- Date of enrolment (date stamped by general practice or ACCHS)
- Provider number of nominated clinician
- Patient risk tier and Risk Tier Certificate number
- Signed informed consent (the Health Care Home patient enrolment/consent form)
- Centrelink Customer Reference Number (CRN), if relevant

Patient registration after the required seven days will impact practice payments.

Payments commence on patient registration date.

Documents that must be retained and uploaded to patient's clinical record by Health Care Home (i.e. general practice or ACCHS) for each registered patient, include the:

- Risk Tier Certificate
- Health Care Home enrolment and consent form
- As relevant, a copy of the Evaluation Opt Out form

Requirement*:* Evaluation opt out form MUST be provided to the evaluator as per instructions on the form.

4.4 Patient registration amendments

Health Care Home payments already account for variations in a patient's health throughout a twelve month period. If however there has been a significant change that either increases or decreases the complexity of the patient's health care needs, their tier level may need to be reviewed.

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

1. Identify with the patient what has changed in their circumstances that has changed the complexity of their condition or their ability to manage
2. Re-run the *risk stratification tool* with the patient present
3. Update the patient's risk tier on the DHS HPOS System
4. Upload new certificate to the patient's clinical record and update relevant details within the patients My Health Record

4.5 Patient registration withdrawals

As participation in the Health Care Home program is voluntary for the patient, a patient must be able to withdraw from the program if desired. As stage one of Health Care Homes is being measured and assessed, every effort should be made to support the patient to stay in the program. Health Care Homes must withdraw a patient from the program if they are no longer eligible.

There are two stages of activities that must be completed for patient registration withdrawal:

Stage 1 – Discussion with patient

Formally discuss with the patient, if possible:

- 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 practice, during the period of stage one evaluation to November 2019.

Stage 2 – Completing patient withdrawal activity

HPOS reconciliation

For this patient:

- Enter the last date of service received as an enrolled patient. *Note: Payment will cease from this last date of service*
- Enter reason for withdrawal, e.g. *patient has moved from the area, patient no longer with the practice, patient has opted out*

Patient feedback – Program

- Request the patient complete an exit survey as part of the Health Care Home program evaluation process

4.6 HPOS Bi-annual Patient Confirmation

Each Health Care Home general practice or ACCHS must provide a twice a year patient confirmation. The confirmation consists of:

1. RECONCILIATION of the patients enrolled with the general practice or ACCHS to confirm that the current list is correct and the accuracy of each patient's enrolment details, including the nominated clinician and risk tier
2. 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 details the process.

- The Department of Human Services 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 DHS may impact on payments or result in removal of the practice from the program

4.7 Managing enrolment numbers in stage one

During the stage one trial, up to 65,000 patients will be enrolled across 200 Health Care Homes. This equates to approximately 55 patients per full-time GP equivalent (based on full-time GP equivalent data collected as part of the Health Care Homes Approach to Market process). The enrolment of 55 patients per full-time equivalent GP should be used by participating general practices and ACCHS as a guide for patient enrolment.

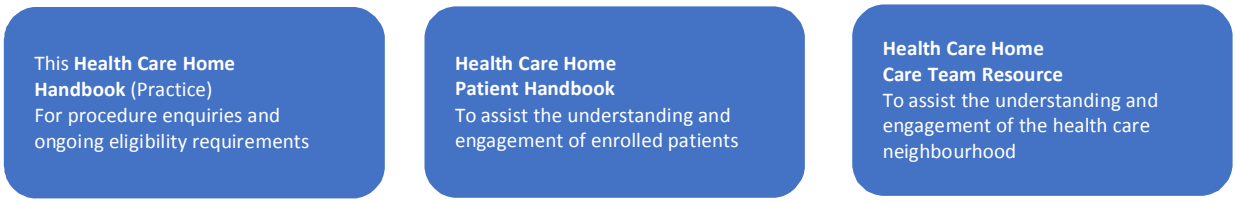
The Department of Health recognises that there is a wide variation in the size of general practices and ACCHS across Australia.

The rate and distribution of patient enrolment will be monitored during the stage one trial by the Department of Health and where enrolments are considered higher than expected, the Department of Health will work with general practices and ACCHS to ensure enrolment levels match GP and practice capacity.

5 Practice – Support

5.1 Technical and Promotional Supports

The Commonwealth Department of Health is the lead agency implementing Health Care Homes, alongside PHNs which provide guidance on local issues and work closely with practices one-on-one. Handbooks and a series of information resources have been developed to support the general practice or ACCHS, enrolled patients, and those potential care team members practicing outside the Health Care Home.



Promotional resources, templates and scripts will also be supplied to Health Care Homes and made available online at www.health.gov.au/healthcarehomes once finalised. Links to each of these tools will also be provided in future editions of this Handbook. These resources will assist Health Care Homes in the recruitment of patients, to identify as a Health Care Home and to supplement training. Targeted visual identity and resources are being prepared for Aboriginal and Torres Strait Islander audiences.

Culturally and Linguistically Diverse resources

All resources are provided in plain English.

Due to the trial nature of the Health Care Home program in stage one, only the promotional brochure for patients and carers has been translated. Translated material will be available online for download in five* languages based Australian Bureau of Statistics (ABS) Census data:

- Chinese –Mandarin and Cantonese
- Italian
- Greek
- Arabic
- Vietnamese

*http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2071.0main+features902012-2013

Risk Stratification Tool (Patient eligibility)

Technical enquiries and support for the Risk Stratification Tool (RST) will be provided by Precedence Health Care.

HPOS System (Patient Registration)

As is the case for existing MBS and PIP payments, DHS provides support services for general practices or ACCHS on patient registration technical issues and payment issues.

5.2 Training program

For many practices, most of the core elements of the Health Care Home 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 Home 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.

The Health Care Home training will be undertaken during the first year of the stage one trial.

The modules of the training program 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 practices will need to 'build' their 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 will be 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.

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. The training will be undertaken during the first year of stage one trial.

Each general practice or ACCHS will have their own starting point for their whole-of-practice transformation. Some useful activities to commence this transformation include:

- Talking with your practice team about the Health Care Home and the benefits of the Quadruple Aim
- Connect with the Practice Facilitator at your Primary Health Network
- Work with your Practice Facilitator using self-assessment tools (such as the HCH-A) to assess your practice needs and readiness
- Create a plan with your Practice Facilitator
- Review the modules of the training program for the 'how to' details of the Health Care Home program
- Prioritise and schedule training to meet each staff member's specific needs

Your Practice Facilitator 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

Primary Health Networks (PHNs) will have dedicated resources in each of the stage one regions to assist practices with transformation and recruitment of patients. Funding will be provided for two dedicated Practice Facilitators in each of the stage one PHN regions, to assist practices throughout the process.

Practice Facilitators will be trained to have a strong understanding of the HCH 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 or ACCHS in the manner which best suits the 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 stage one evaluation
- Providing support for overall transformation as required
- Facilitating learning
- Assisting with the identification and enrolment of Health Care Home patients, and
- Assisting the development of *Communities of practice* where Health Care Homes link together to share tips, insights and learnings during the transformation process.

A general practice or ACCHS participating in the stage one trial must work with its PHN to achieve practice transformation and develop *Communities of practice* with Health Care Homes in their region.

6 Practice – Payments

How general practices and ACCHS are reimbursed for providing Health Care Home services will be different from the current fee-for-service, provider based approach under the Medicare Benefits Schedule (MBS). A more blended payment approach will be used to remunerate practices for providing Health Care Home services to their enrolled patients. This will involve a mix of bundled and fee-for-service payments under the Health Care Home program, and Practice Incentive Program (PIP) payments made under the PIP program.

Bundled payments

A new bundled payment approach will be tested in the stage one trial. Health Care Homes will receive a bundled payment for each enrolled patient that will be 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, must 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 practice will be responsible for appropriately distributing the bundled payment within the general practice or ACCHS.

Based on four broad general practice business scenarios, including a sole trader, partnership, associateship and large corporate practice, the Australian Taxation Office has 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 of the business structures and arrangements operating in Australia. Participating general practices and ACCHS should seek advice in relation to their situation and 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 stage one trial of Health Care Homes. Based on clinical advice, it is expected that for the majority of 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 practice monthly through the HPOS system.

The amount 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 levels based on the patient's complexity/risk tier, as determined by the Risk Stratification Tool. Patients on the highest complexity/risk 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 practice 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 at each Payment Tier level and at different times throughout the year. The payment values for the Payment Tiers were developed from best practice clinical models.

Payment Tier	Payment Value
Tier 3 — the highest level of patient complexity	$1,795 per annum
Tier 2 — increasing level of patient complexity	$1,267 per annum
Tier 1 — the lowest level of patient complexity	$591 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 patient's complexity/risk tier, which provides the Payment Tier and ergo the Payment Tier Value.

$$\text{Number of Days at complexity/risk tier} \times \frac{\text{Payment Tier Value Per Annum}}{\text{Number of Days in the Year}} = \text{Monthly payment per enrolled patient}$$

If the practice complies with the ongoing eligibility requirements of the Health Care Home program, then the practice 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.

Where there has been a sustained change in an enrolled patient's chronic conditions, the Risk Stratification Tool 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 classification on HPOS by adjusting the tier 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
Fee paid per service
Payment for each individual service for which a MBS item number is identified.

Health Care Home
Bundled payment for all services
Payment for 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 not related to the management or treatment of an enrolled patient's chronic conditions.

Bundled services 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 (see specific information below)

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

- Allied health
- Specialists
- Radiology
- Pathology

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 must 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 provided by their Health Care Home 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 meet their needs, then the patient can be withdrawn and treated under the MBS arrangements.

Allied health provider services

Eligibility for allied health services previously triggered by the completion of the following MBS items will now be triggered by the patient's enrolment with the Health Care Home:

- GP Management Plan (MBS items 721/723 and 732)
- Mental Health Treatment Plan (MBS items 2700, 2701, 2715 or 2717)
- Indigenous Health Assessment (MBS item 715*)

These item numbers will no longer be required for a Medicare benefit for allied health services to be paid. However, other prerequisites as defined under the MBS will continue to apply for enrolled patients to access allied health Medicare benefits, such as the need for a valid referral form or, where appropriate, Aboriginal or Torres Strait Islander descent status. The number of Medicare benefits for allied health services that an enrolled patient may access each calendar year remains the same as is currently available under the MBS.

Eligibility for allied health group sessions will also be triggered by enrolment for eligible enrolled patients with Type 2 diabetes.

*Note, Medicare item 715 – Indigenous Health Assessment is **excluded** from the Health Care Homes bundled payment in the stage one trial to provide an opportunity to tailor appropriate ways for Aboriginal and Torres Strait Islander peoples to access programs and services that are linked to this item. This exclusion will also enable time to ensure that data collections can continue to reflect the delivery of health assessment to this group of patients which is a national key performance indicator for Indigenous primary health.

6.3 Payment processes

The payment processes for Health Care Home practices 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 Risk Stratification Tool 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. Bundled payments made to Health Care Home practices are not subject to GST where:
     - the supply of the services from the Health Care Home practice to the enrolled patient is made by or on behalf of a medical practitioner; and
     - the services provided by the Health Care Home practice to the enrolled patient are generally accepted in the medical profession as being necessary for the appropriate treatment of the recipient.
   - Notice of payment will be via HPOS mail notification. The payment statement will include a payment amount for each enrolled patient.

Check your HPOS settings to enable alerts for notifications.

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

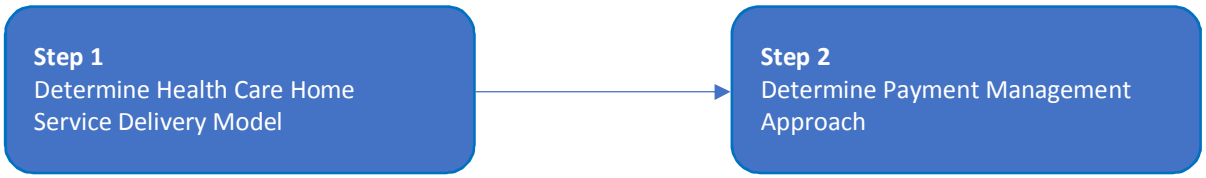
4. PATIENT DATA
   - The practice must ensure the patient's details in the practice clinical information and management database are up to date.
   - Patients are responsible for ensuring their details are up to date with Medicare.
   - Mismatch of data may impact on practice payments.

The process for withdrawing a patient or Health Care Home from the stage one trial is outlined in detail under the Training Module 3.

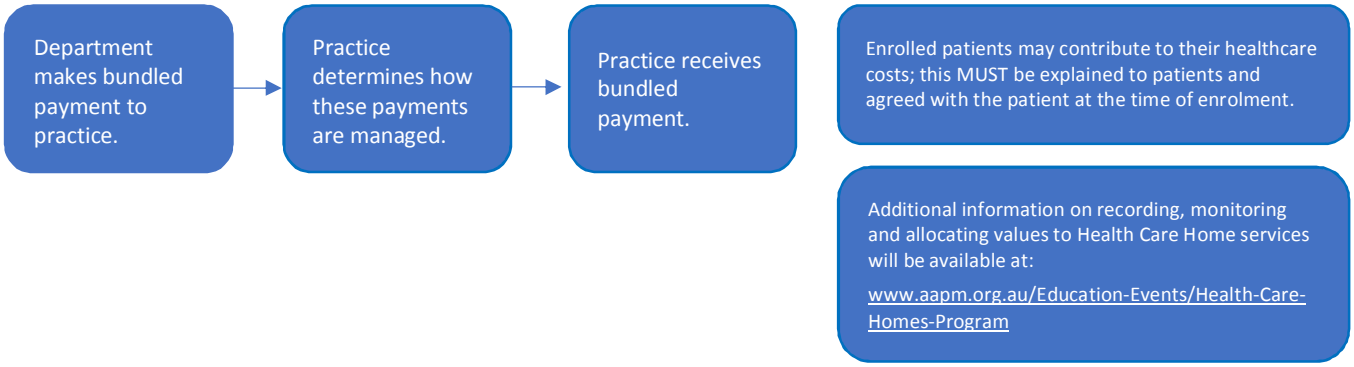
6.4 Service model

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

Each practice will need to determine their Health Care Home 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.



The difference between the bundled payments and fee-for-service billing is that the bundled payments are paid to the practice and then the practice determines how to manage these funds internally.



6.5 Practice Incentives Program (PIP) payments

General practices and ACCHS participating in the stage one trial will also be able to participate in PIP where they meet current eligibility requirements. Any PIP payments to a general practice or ACCHS will be in addition to the bundled payments.

Recognising that PIP incentive payments are often dependent upon MBS billing, the Department of Health is working through solutions to enable these payments to include interactions with enrolled Health Care Home patients and the timing of the payments.

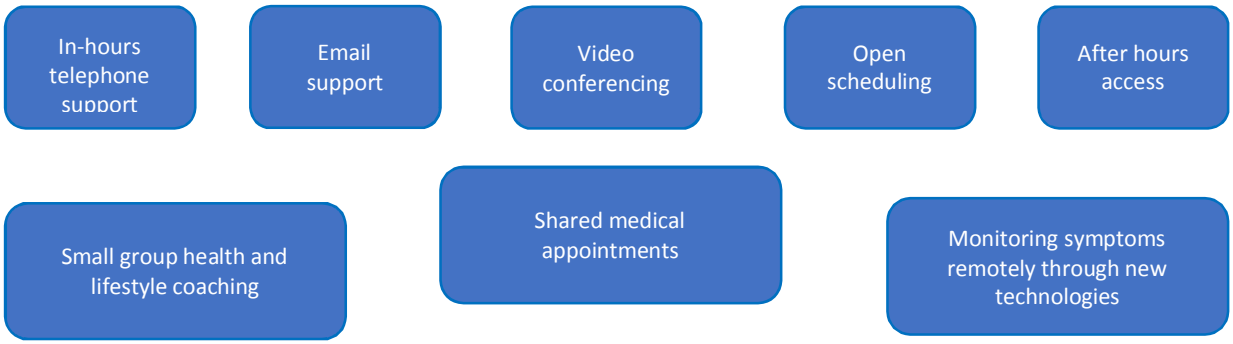
7 Changes to service delivery

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 or 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:



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. The training modules provide further detail on data driven improvement. All health care providers in Australia have professional and legal obligations to protect their patients' health information (as defined under the *Privacy Act 1988*). Becoming a Health Care Home does not change privacy obligations for participating health care providers.

The Quadruple Aim is the optimisation of health system performance by striving to enhance patient experience, improve population health, improve cost efficiency and sustainability, and improve the experience of the health care providers and practice staff. Health Care Homes will systematically collect and use data to continuously monitor and improve care delivery in order to achive the Quadruple Aim.

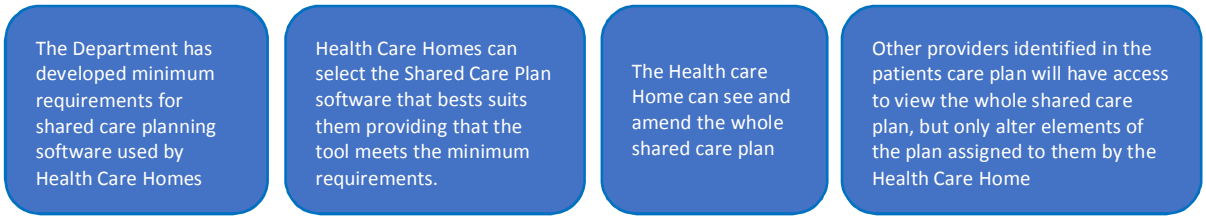
7.3 Electronic shared care plan

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 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 who contribute to addressing the health needs and goals of the patient).

Many general practices and ACCHS around Australia are already using shared care planning tools. The Department of Health has developed a set of minimum requirements for shared care planning software to be used in stage one. Health Care Homes can choose any software program that complies with these minimum requirements. The minimum requirements are available from the Health Care Homes website at www.health.gov.au/healthcarehomes



Software minimum requirements

The Medical Software Industry Association is hosting a list of shared care planning products that software vendors have self-declared are compliant with these minimum requirements. That list is available at www.msia.com.au/healthcare-homes/

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 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 they need, such as to review the patient's latest Shared Health Summary in an emergency or accident situation.

Information at www.digitalhealth.gov.au

Requirements for Health Care Homes:

- Must be registered with the My Health Record system
- Enrolled patients must have a My Health Record within one month of enrolment
  - Assist patients as required to have a My Health Record
- Must contribute up to date clinical relevant information to the patients' My Health Record

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 using health care teams to deliver high-quality primary care, opportunities exist for practices 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:

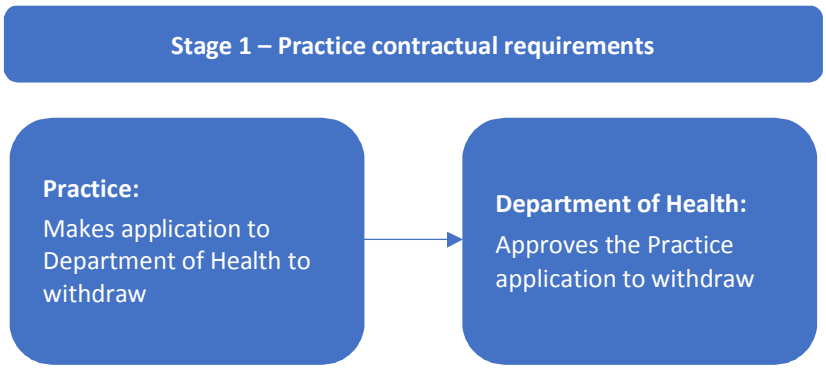
- Nurse practitioners
- Specialist or advanced practice Registered Nurses
- Aboriginal and Torres Strait Islander Health Practitioners/ Workers
- Care co-ordinators
- Medical Practice Assistants
- Allied Health professionals
- Pharmacists

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

8 Health Care Home withdrawals

8.1 Practice withdrawal process

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



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

Stage 2 – Patient information activity

Department activity

HPOS reconciliation

- The Department of Health will notify the Department of Human Services of approved practice withdrawal and the date of effect of withdrawal.
- The Department of Human Services will close the practice registration in HPOS, closing all patients of the practice and ceasing payments from the date of effect of withdrawal.

General practice or ACCHS activity

Formal notification

- Notify all enrolled patients of the general practice or ACCHS's decision to withdraw and the consequences for the patient.

Practice feedback

- **Complete all requirements, including requirements as outlined as part of the evaluation process.**

Patient feedback

- Request each enrolled patient to complete requirements as outlined as part of the evaluation process.

8.2 Practitioner turnover

There may be occasion that a general practitioner leaves the Health Care Home. If this is the case, all enrolled patients must be notified in writing that their nominated clinician will be leaving the Health Care Home 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 for the impacted patients.

9 Practice – Evaluation

Health Care Homes have committed to aspiring to the highest quality care for their patients by implementing patient-centred, accessible, comprehensive, and coordinated team-based care.

9.1 Evaluation Framework and processes

Stage one of Health Care Homes will be evaluated to establish what works best for different patients, general practices and ACCHS and in different communities with varied demographics. The Department of Health has contracted Health Policy Analysis to undertake a comprehensive evaluation.

The evaluation of stage one will focus 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 Home model
- Evaluate the effect of stage one:
  - Measurable quality improvement in care for patients with chronic and complex conditions
  - Patient experience of care (including engagement, activation and the patient journey)
  - Practice experience and behaviour (including changes to scope of practice, quality improvement, system development, models of care, service delivery, and business models)
  - Service use (particularly 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 practices and patients enrolled in Health Care Homes 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:
  - Data on the practice and provider (GP/nurse)
  - Information on patient demographics (age/indigenous status/health card holder)
  - Clinical encounters
  - Medical history
  - Prescriptions
  - Pathology and imaging test
  - Observations (BP/BMI)
  - Risk factors (smoking/alcohol)
  - Management activities (referrals/ immunisations/ plans)

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

While practices must participate in the evaluation, patients may opt-out from providing their data to evaluators. Consent to use patient data from practice extracts, national datasets and data linkage projects will be obtained via an opt-out approach.

Fully informed consent will also be obtained from participants, such as patients, staff and care team members, that are invited to complete surveys or participate in interviews and focus groups for the evaluation.

The impact on Health Care Homes and requirements in relation to the evaluation are as follows:

Data collection approach	Impact on and requirement from practice
Health Care Home surveys Practice staff surveys	• Affects all Health Care Homes. • Three survey rounds are planned at baseline, midpoint and end.
Health Care Home face-to-face interviews	• Affects a sample of Health Care Homes, and participating staff. • Three interview rounds are planned at baseline, midpoint and end.
Health Care Home extracts and national datasets and data linkage projects	• Provide participant information sheet and opt-out form to patients enrolling in Health Care Homes (at the time of enrolment). • Display posters/brochures in waiting areas re use of patients' data for evaluation purposes. • Provide extracts of practice data, according to the specifications and approach selected for the evaluation.
Patient surveys, interviews and focus groups	• Provide participant information sheet and opt-out form to patients enrolling in Health Care Homes (at the time of enrolment).

Evaluation results and lessons learned from the evaluation will be used to make refinements to the Health Care Home model and will inform decisions on any future roll out. Information on the findings of the evaluation will be available to key stakeholders, including HCH participants (health care providers and patients and their families/ carers), governments, professional and peak organisations, academics and researchers, and the general community.

10 Assuring the integrity of the HCH Program

A systems-based approach incorporating a strong focus on education is being used to manage compliance with the Health Care Home program in the stage one trial. 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 is being developed to support general practices and ACCHS to understand and comply with the new bundled payment approach for funding the delivery of Health Care Home services. This Toolkit will be made available online 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 Home program in understanding the ongoing requirements of participating in the program and ensuring that Government money is appropriately spent.

10.1 Practice 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 stage one trial 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 unable to provide evidence to verify that it meets the eligibility requirements or substantiate payments, the Commonwealth may seek to recover past payments.

Delegation of day to day operations

Day to day operations for Health Care Home assurance and compliance activities can be delegated to a practice manager or other person by the person authorised to sign the Health Care Home Declaration, who can also be authorised as a contact person for the Department of Health.

10.2 The Assurance Approach

The Department of Health will operate in line with best practice principles when monitoring and managing compliance with the ongoing requirements of the Health Care Home program outlined in this Handbook. Stakeholder engagement will occur early and often.

The Department of Health will also ensure that a risk based approach is used to monitor and manage compliance, with a light touch applied to low-risk participants and through ensuring that appropriate education and information is available.

Assessing Risk

To deter and detect error, misuse and fraud, assurance activities will be conducted to mitigate the risks of:

- Incorrect stratification of patients
- Non-provision of services
- Systematic double billing under HCH and Medicare

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 of Health to treat identified risks:

- Participating general practices and ACCHS must complete the annual assurance self-assessment tool provided by the Department of Health, which will assist Health Care Homes and the Department of Health to identify areas for improving compliance culture and adherence to the Handbook
- 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 letters 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 within the Department of Health 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.

Ongoing stakeholder engagement with both internal and external stakeholders is being used to gather intelligence and inform compliance risk. Intelligence sharing will help build an integrated strategic approach to managing compliance.

10.3 Compliance monitoring and management tools

Self- Assessment

An annual assurance self-assessment tool will be provided to Health Care Homes to ensure that minimum program requirements are checked and reported on by the Health Care Home, and to support the Health Care Home in building a culture of compliance. The self-assessment tool will identify areas that the Health Care Home can address or use to build a compliance culture.

Data and Analytics

Data and analytics will be used to monitor enrolment and other patient claiming data to establish norms during the stage one trial, 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 first phase of the trial, 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 annual assurance self-assessment tool 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 based on the level of risk. These tools could include practice or provider check-up, follow up audit, debt recovery, remedial action notice, conditions on participation, and if necessary, suspension of payments.

Where a Health Care Home does not transition back into compliance, actions such as removal from the stage one trial, referral to state or other authorities, or referral for criminal prosecution will be considered. Any referral to other agencies and state authorities will be considered on a case by case basis.

Note: The Department does not audit or review the quality of the clinical service provided, as 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.**