

Patient-centred health care homes in Australia: Towards successful implementation

Report of a Roundtable held on the
12th July, 2016

LOGOS TO BE INSERTED

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About this report

Background

In Australia and internationally the health care system is challenged by increasing demand on all care sectors, an aging population with a growing incidence of chronic and complex conditions, higher expectations by consumers, and an ageing health workforce. There is an increasing recognition that primary care has a key role to play in addressing these challenges, but in order to do so models of primary care must adapt and change.

In December 2015, the Department of Health's Primary Health Care Advisory Group (PHCAG) provided a report to the Australian Government – *Better Outcomes for People with Chronic and Complex Health Conditions*, with a key recommendation that Health Care Homes (HCH) be established as a model of care.

Health Care Homes are a model of practice that build comprehensive and co-ordinated care planning, delivery and treatment around the patient, using multidisciplinary care teams within General Practice, all working to the full scope of their practice and offering alternate models of care delivery to match patient needs and preferences.

The PHCAG recommendations provided a vision and direction for the HCH but the PHCAG was not tasked with developing an implementation strategy. As part of its recommendations for stage one of implementation the PHCAG stated “... *Health Care Homes are new in an Australian context, and would benefit from refinement best achieved through further implementation design, establishment, evaluation and adjustment, prior to rolling out nationally.*”

In the May 2016 Budget the Australian Government announced funding for a first stage of the Health Care Home. From July 2017 up to 65,000 patients should be able to voluntarily enrol in a trial of Health Care Homes in up to 200 practices across 7 Primary Health Network regions. The trial will be reviewed after two years. Few further details have been released, and nothing on the details of how the scheme will be implemented

Implementation Roundtable

On the 12th July 2016, the Consumers Health Forum of Australia, the Royal Australian College of General Practitioners(RACGP), the Menzies Centre for Health Policy and The George Institute for Global Health hosted a Roundtable in Melbourne. The Roundtable discussed the patient-centred health care home model (PCHCH) and developed consensus principles to guide implementation in the Australian context.

The outcomes of the Roundtable are intended to provide a seminal contribution to future debate on building patient centred care, by developing principles for implementation of the Australian PCHCH that have the backing of consumers, clinicians, peak bodies and researchers. Roundtable participants were acknowledged lead thinkers in primary health care reform and those with “skin in the game”.

The Roundtable included representation from Universities, General Practice, Primary Health Networks (PHN), and consumer and professional peak bodies. A full list of participants is included on page 20. This report summarises the outcomes of the Roundtable.

Acknowledgements

The Consumers Health Forum of Australia, the RACGP, The George Institute for Global Health and the Menzies Centre for Health Policy thank all those who participated in the Roundtable for their contribution to this report, and Andrew Hollo from Workwell Consulting for facilitating the Roundtable.

The Roundtable hosts would like to acknowledge the particular contributions of Leanne Wells and Jo Root (CHF), Roald Versteeg and Josephine Raw (RACGP), Stephen Jan, Cathie Sherrington and Maya Kay (The George Institute), Jim Gillespie and Andrew Wilson (The Menzies Centre) and Andrew Hollo to the Roundtable and their work on this report.

Recommendation

It is recommended that the following principles underpin the planning and implementation of the [Patient Centred Health Care Home](#), and are translated into action at commonwealth, regional and local level.

Implementation Readiness

1. Implement a PCHCH for all [applicable](#) patients, not just those with chronic conditions
2. Engage with frontline General Practice
3. Allow adequate time for planning and preparation prior to implementation
4. Measure success against realistic process and outcome goals
5. Define and maintain the core elements of the PCHCH.
6. Support adaptiveness for local conditions.
7. Utilise PHNs as key implementation partners
8. Build future capacity to sustain the PCHCH approach

Patient-centred Care

9. Develop marketing to establish clear mutual expectations and genuine shared accountability between patients and the PCHCH
10. Implement the necessary infrastructure and build staff capability to assess care needs and deliver care through a mix of face to face, video, phone and email consultations with all the health care team
11. Increase capacity to provide care for underserved populations
12. Enable and support patients to be active members of the health care team.

Collaborative, comprehensive and co-ordinated care

13. Build and fund multidisciplinary health care teams that work collaboratively at full scope of practice.
14. Include preventive health, and patient life and social issues in care planning and delivery
15. Adopt a right care, right time approach
16. Recognise and work collaboratively within the wider care system
17. Build IT infrastructure and tools to support shared care planning and delivery

Data driven improvement

18. Establish practice level processes for monitoring progress towards becoming a PCHCH
19. Assess and build on existing capacity to use data effectively for quality improvement
20. Focus on building take-up of evidence-based models of care

Engaged leadership

21. Recognise existing leadership and actively invest in building GP leadership
22. Invest in building the capacity of the entire practice team to deliver this new model of care
23. Establish and communicate a shared vision

Financing and payment paradigms

24. Ensure the payment system is designed to support achievement of the PCHCH
25. Invest in the information systems required to monitor and support new payment models

A new approach to primary care

The Australian Government's planned Health Care Home (HCH) implementations have the potential to drive a fundamental shift in Australia's health services toward patient-focused health care practices.

The HCH, integrated with hospitals, specialists, allied health and community-based services would offer a one-stop shop, providing patients with more individualised attention including tailored care, alternative consultation modes, on-line access to their own health information, tests and appointment bookings.

In Australia we are faced with a complex health system with entrenched practices, multiple layers and stakeholders divided across Federal and State systems, which is also often hard to navigate for both patient and provider. The question we must address is how do we ensure the Health Care Home can reach its potential in Australia and deliver the best outcomes for patients?

This report outlines recommendations around the following guiding principles towards successful implementation:

- ▶ Implementation readiness
- ▶ Patient-centred care
- ▶ Collaborative, comprehensive and co-ordinated care
- ▶ Data driven improvement
- ▶ Engaged leadership
- ▶ Financing and payment paradigms....

What is the Patient Centred Health Care Home?

The PCHCH model is a transformative model of primary care that shifts the epicentre of health care delivery from the clinician to the patient. It is distinguishable from current good general practice by its absolute redesign of infrastructure, health care team roles and modes of delivering care around the preferences and needs of the patient.

While recognising the initial focus by the PHCAG on chronic conditions, the PCHCH is a model that encompasses care for all people and all conditions and is not limited to those with chronic and complex conditions.

The model has been introduced in other countries, for example in the USA (PCMH) and Canada (PMH)¹. Models are designed to fit the unique characteristics of national health systems and culture but they share key defining elements. Below are descriptions of the USA and Canada HCH models:

¹ PCMH – Patient centred Medical Home, PMH – Patient Medical Home

What Is a Patient-Centered Medical Home (PCMH)?

It's not a place... It's a partnership with your primary care provider.



PCMH puts **you** at the center of your care, working with your health care **team** to create a **personalized plan** for reaching your goals.



Your **primary care team** is focused on getting to know you and earning your trust. They care about you while caring for you.



Technology makes it easy to get health care when and how you need it. You can reach your doctor through **email**, **video chat**, or after-hour **phone calls**. **Mobile apps** and **electronic resources** help you stay on top of your health and medical history.

As you pursue your health care journey, you may make stops at different places:



Wherever your journey takes you, your **primary care team** will help guide the way and coordinate your care.

Studies show that PCMH:



Provides better **support** and **communication**



Creates **stronger relationships** with your providers



Saves you **time**



To learn more about the PCMH, visit www.pcpcc.org

A Patient-Centered Medical Home is the right care at the right time. It offers:



Personalized care plans you help design that address your health concerns.



Medication review to help you understand and monitor the prescriptions you're taking.



Coaching and advice to help you follow your care plan and meet your goals.



Connection to **support and encouragement** from peers in your community who share similar health issues and experiences.

² <https://www.pcpcc.org/about/medical-home>



The Patient's Medical Home

Patients say that patient-centred family practices are where they are most comfortable – most at home – discussing their personal and family health concerns.

As the providers most responsible for Canadians' health care, family physicians play a vital role in our health care system. We know that the relationships patients build with their personal physicians over time contribute to better health outcomes.

The Patient's Medical Home (PMH) is a vision for the future of family practice in Canada that builds upon these truths.

In this vision, every family practice across Canada readily offers the care that Canadians need - care that is centred on the patient's needs, encompasses patients at every stage of life, and provides reliable links to other health services. A Patient's Medical Home practice delivers this care and ensures the best possible outcomes through the patient's own family physician's collaboration with health care teams and using the latest technology.

Meeting the following 10 goals transforms a family practice into a Patient's Medical Home:



1. Patient-Centred Care

A PMH provides care that is focused on the individual patient and tailored to his or her specific needs.



6. Continuity of Care

A PMH provides continuity of care, continuity of relationships, and information for its patients.



2. Personal Family Physician

The patient's own family doctor, the most responsible care provider, is at the core of the PMH.



7. Electronic Medical Records

A PMH maintains and meaningfully uses electronic medical records (EMRs) for its patients.



3. Team-Based Care

A PMH offers a broad scope of services carried out by teams or networks of providers, including each patient's personal family physician.



8. Education, Training, and Research

A PMH serves as an ideal site for training medical students, family medicine residents, and those in other health professions. A PMH is also an ideal setting for carrying out medical research.



4. Timely Access

A PMH ensures timely access to appointments within the practice. The PMH also coordinates timely appointments with services outside the practice.



9. Evaluation and Quality Improvement

A PMH regularly evaluates the effectiveness of its services as part of its commitment to continuous quality improvement.



5. Comprehensive Care

A PMH provides each of its patients with comprehensive family practice services. A PMH also meets and supports the public health needs of the community.



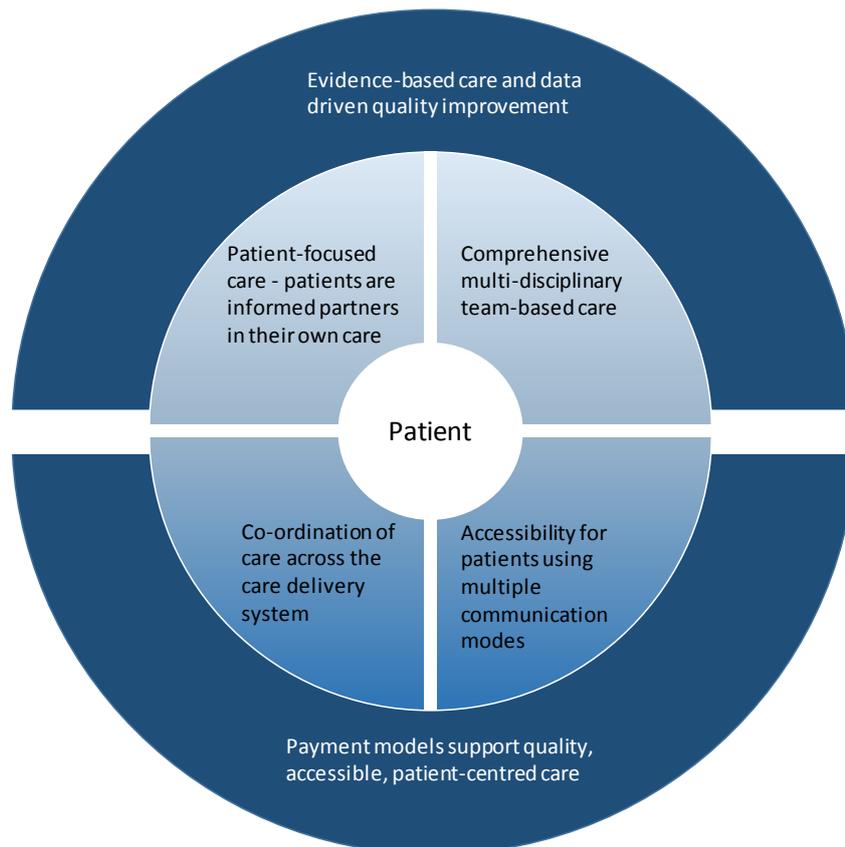
10. Internal and External Supports

A PMH has strong internal support, from practice-appropriate administration. A PMH also is supported by governments, the public, and other health professions.

³ <http://patientsmedicalhome.ca/files/uploads/CFPC-Patients-Medical-Home-EN.pdf>

In summary the key elements of the HCH are:

- Patient-focused care where patients are informed, active partners in their own care
- Comprehensive multi-disciplinary team-based care
- Co-ordination of care across the care delivery system
- Accessibility for patients using multiple communication modes
- Evidence-based care and data driven quality improvement
- Payment models that support all of the above



The PCHCH requires a fundamental change to how practices are funded, how they do business, how clinicians work and how patients engage with their primary care providers.

Implementation also requires appropriate recognition of the role of Primary Health Networks (PHN) and a consistency in the way PHNs give priority to their role in organisational development and support for practices and the stewardship of emergent models of care such as PCHC homes.

What might success for an Australian PCHCH look like?

The Roundtable considered the what success might look like for the PCHCH in the Australian context. Elements of success are described below, based on the Quadruple Aim

Patient experience

- Patients and consumers report a better experience, and levels of patient activation are increased.
- Consumers feel they are at the centre of care and at the centre of the decision making process.
- The ability of patients to choose their provider is protected
- Patient and consumer time is clearly valued and there is a reduction in time and effort to navigate the system, seek care, await or make appointments, get to care locations.
- Improved access, particularly for those who experience inequity and poorer access to care.
- Technology is used effectively to share patient care planning and information and to support alternative methods of patient consultations.

Population health

- There has been a shift from an illness model to a wellness model – keeping the person as well as possible through planned care rather than reactively treating their condition.
- There has been a change to the way we provide health care to close population health gaps, by including preventive care in routine patient contacts and focusing on those populations most at risk.
- The model works effectively within the local service system and with state and territory public health systems to reduce duplication and increase integration.
- Payments to providers reflect differences in risks across patients, and the greater costs associated with managing patients in lower socio-economic and rural and remote areas.

Efficiency

- There is a clear connection between payment and quality/better practice.
- There have been reductions in unnecessary duplication of diagnostic tests and screening and measures in place to discourage the shifting of costs onto the hospital system.
- There has been a measurable increase in value to the system as a whole and to the patient – addressing patient value for money, out of pocket expenses, time and other costs of care.
- There has been an increase in overall primary care capacity, due to use of the health care team and a shift from a visit-based model to care delivery tailored to need, including remote access and use of technology.

Provider experience

- GP and health care team staff experience greater degrees of satisfaction and report increased professional fulfilment.
- The new generation of clinicians are being taught in this framework to manage chronic disease.
- There is a re-invigoration of general practice due to increased satisfaction and ability to work at their full scope of practice.
- There is no net loss of income for primary care providers as a result of implementing the PCHCH, with the funding model reflecting the input of all providers within the health care team.

Success is measured by a combination of implementation measures (process) and outcomes measures. It is possible that not all these elements can be measured for the impending implementations. However, clear definitions of success should be fundamental the first step in Government's HCH implementation as well as to a wider plan for primary health care reform, spearheaded by PCHCH introduction for all Australians.

Principles

It is recommended that the following principles underpin the planning and implementation of the PCHCH, and are translated into action by the various stakeholders at commonwealth, regional and local level. We have structured the recommended underpinning principles in two sections – firstly considering the national and regional foundations required for a sound implementation and then with regards to regional and practice level implementation.

Implementation readiness

1. Implement a PCHCH for all patients, not just those with chronic conditions

While recognising the initial focus by the PHCAG on chronic conditions, it is the strong view of Roundtable participants that the PCHCH is a model that encompasses care for all people and all conditions and is not limited to those with chronic and complex conditions.

Implementing for one sector of a patient population and not others increases the risk to practice and patient take-up, and potentially disadvantages those patients who are not in the eligible target group for the HCH approach.

2. Engage with front line General Practice

General Practice will be the heart of the patient-centred health care home. The majority of change will be in General Practices and will impact on General Practices, including those provided through the Aboriginal Community Controlled Sector. GPs and their teams know their local areas, and they know their business. General Practice must be engaged in the planning for implementation and in monitoring impact right from the very beginning.

3. Allow adequate time for planning and preparation prior to implementation

This is a large scale transformational change which will take time and requires significant upfront investment in change management. It is more than a cultural change, although that is significant. It is also a fundamental system change, and pragmatic progress goals as well as outcome goals need to be in place. The implementation should allow enough time for co-design, development, deployment and evaluation. Significant early investment needs to be made to support the change management process, both through PHNs and for individual practices, as well as specific strategies designed to ensure consumer and community confidence. Investment should recognise that many Aboriginal and Torres Strait Islander Australians currently attend their local AMS and this will continue to be their health care home.

4. Measure success against realistic process and outcome goals

Success should be measured using implementation measures as well as quality and outcome measures. Development of national outcome measures should be in tandem with outcomes at practice level that recognise the diversity of General Practice and their communities in Australia. Key stakeholders, as well as the primary care and health care sector, include states and territories, and central funders such as the Department of Finance and the Treasury. Demonstrating both health and economic benefits is paramount: the PCHCH model needs to achieve results that generate confidence and encourage further government investment. A research-based evaluation should be initiated before the implementation begins

5. Define and maintain the core elements of the PCHCH.

We know what the PCHCH looks like in other countries, but what elements of the Australian PCHCH are needed to align with our unique context? In December 2015, the Primary Health Care Advisory Group (PHCAG) recommended that Health Care Homes (HCH) be established with the following elements:

- **Voluntary patient enrolment** with a practice or health care provider to provide a clinical 'home-base' for the coordination, management and ongoing support for 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 patient needs
- **Data collection and sharing** by patients and their health care teams to measure patient health outcomes and improve performance.⁴

Additional elements of the PCHCH that Roundtable participants identified for consideration include:

- ▶ **A focus on whole of practice population rather than a clinical sub-group**
- ▶ **Inclusion of preventive care as well as treatment in the care model**
- ▶ **The PCHCH is embedded in the local health care system**
- ▶ **Inclusion of patient social and life issues in care models**

Core elements should be defined and standards developed to maintain the overall purpose and vision of the PCHCH. These sets of elements need to be tested within the context of federation, review of payment mechanisms and other key policies. Standards and minimum capacity requirements should be developed for the PCHCH, building on work already undertaken by the RACGP, that are measurable through implementation evaluation, outcomes indicators and accreditation.

6. Support adaptiveness for local conditions.

Notwithstanding the need for clearly defined core elements and standards, the Australian model also needs to be flexible and adaptive to local conditions, while retaining the core elements that make a PCHCH. There should be a non-prescriptive, outcome-focused approach to developing models that reflect local population needs, take into account

⁴ PHCAG, Better Outcomes for People with Chronic and Complex Health Conditions, (2015), Australian Government

diversity, and specific community characteristics and build on (existing) good practice to get results. The PCHC should be seen as a key player in an integrated health care system, that includes public and private hospitals, medical specialists, the Aboriginal Community Controlled sector, allied health and specialist community-based services.

7. Utilise PHNs as key implementation partners

PHNs have a key role to play in implementation of the PCHCH and are uniquely placed to:

- ▶ take a local and regional approach to supporting practice change and system development,
- ▶ ensure that new approaches align and integrate with other characteristics of the local health economy, and
- ▶ promote the consumer benefits of the approach.

For example, PHNs may support practices to work in clusters or practice networks to achieve change and maximise opportunities to share associated costs, pooling resources to employ a dedicated practice change manager, across a network of practices. PHNs should take a leadership and change role, but practices themselves should also be funded to take time out from their clinical loads to undertake practice planning and redesign necessary to effectively establish sustainable practice models for PCHCH.

8. Build future capacity to sustain the PCHCH approach

Tertiary education of the next generation of primary health care professionals should include the patient-centred framework and should help students develop the skills required to work within this model of care. PHNs also play a key role in enabling and supporting the practice changes required to establish and maintain the PCHCH model through supporting capacity development in clinical and non-clinical members of health care teams.

The HCH Model at practice level

Principles to support the HCH at practice level are based on the growing body of evidence on the essential characteristics that define a PCHCH (see right).

Essentially, the elements needed relate to:

1. Patient focused care
2. Collaborative, comprehensive, coordinated care
3. Data driven improvement
4. Engaged leadership

It is also important to recognise that underpinning any of the above changes is:

5. A shift in the finance and payments paradigm to achieve change outcomes



Patient-focused care

Patient focused care relates to both the practice population and individual patients. Principles 9 to 12 address building capacity and movement towards patient-centred care in the PCHCH.

9. Develop marketing to support establishment of clear mutual expectations (including a common language) and genuine shared accountability between patients and the PCHCH

Accountability means taking responsibility for patients in all respects - addressing their health care and considering their social needs. Accountability applies to patients as well – “giving up” the flexibility and convenience of moving from doctor to doctor in order to reap the benefits of seeing one primary health care team who support patients to proactively manage their care. Patient registration is new to the Australian context, and it is not currently known whether Australians will embrace the concept of registration. Regardless, the concept is fundamental to the patient-centred and team based approach to healthcare delivery.

10. Implement the necessary infrastructure and build staff capability to assess care needs and deliver care through a mix of face to face, video, phone and email consultations with all clinical members of the health care team.

A key element of improving patient access and increasing practice efficiency is managing the demand driven flow of patients. Having in place processes to support alternate methods of delivering care, tailored appropriately to patient needs, will require investment in change management and in infrastructure. Sound infrastructure, systems and processes are required to enable patient access to care through a variety of modes, including virtual consultations on-line, video, phone and email consults and telehealth. The use of Practice Nurses and other clinician members of the health care team can support all providers working to their full scope of practice.

11. Increase capacity to provide care for underserved populations

The PCHCH is a model that applies to all patients not just those with chronic disease. The PCHCH should be actively seeking out the underserved people in our health system who need health services and are costly to treat because they have not previously had access to care. Being culturally inclusive in how services are designed and delivered is a key attribute.

The design of the PCHCH should include establishment of payment mechanisms that minimise out of pocket costs and financial barriers to appropriate care for consumers. The model should address the needs and preferred delivery models for and with patients who don't or cannot access a primary care provider currently. Consider developing and testing “virtual” PCHCH models to support patients in rural and remote communities.

12. Enable and support patients to be active members of the health care team.

Rather than the doctor taking sole responsibility for the care of a patient, the patient and the PCHCH health care team work in partnership. This begins at the co-design of the local PCHCH model, with patients and consumers working with PHN and practices to develop models that meet patient demand and maintain local relevance. For patients to be active members of the health care team, they need to:

- be informed, to have adequate levels of health literacy
- understand the benefits of the model and how it will work for them, and
- be familiar with the language of the PCHCH.

It will be important to establish systems for monitoring patient experience and patient activation and to build health literacy strategies into PCHCH activities. There is an opportunity for the PCHCH to go beyond purely clinical goal setting and consider the social and life goals that are important to patients in the context of managing their health. PCHCH will need support to establish electronic and IT capacity to provide patients' access to their own health information, health care plan, reminders and information on their condition (for example using an open notes approach). This moves to a level of detail beyond My Health Record.

Collaborative, comprehensive, and co-ordinated care

Collaborative, comprehensive and co-ordinated care is critical for all patients, including those living with complex and chronic conditions, and therefore a key element of the PCHCH. Principles 13 to 17 relate to the changes required to implement this element.

13. Build and fund multidisciplinary health care teams that work collaboratively at full scope of practice.

All consumers, including those with chronic conditions, must be able to access general practice, nursing, and allied health as well as other key providers in an integrated health care team, and be involved in decisions as to how these providers are brought in. Many preventive, educative, and assessment activities can and should be delivered within the broader team. This requires work to recognise and build a patient care team comprising GPs, practice nurses, allied health professionals, medical specialists and administrative staff and, potentially, create new roles to support care co-ordination. It will be necessary to build into the model adequate administrative support to enable best use of clinical time and support all members of the multidisciplinary health care team working to the full scope of their practice

14. Include preventive health, and patient life and social issues in care planning and delivery

Preventive health should be a funded component of care, utilising appointments to ensure patients are up to date for screenings and delivering preventive health messages in routine appointments. This is already a component of good general practice and should not be lost in the PCHCH.

15. Adopt a right care, right time approach

Recognise that the greatest initial gains for patient-centred team care may lie in targeting patients before they reach advanced stages of illness progression, and better managing those patients with advanced stages of illness.

16. Recognise and work collaboratively within the wider care system

The PCHCH should be characterised by shared communication and use of an eHealth record between team members within the PCHCH, patients and other providers. The care

model should recognise that some of the greatest impacts on patient health are related to non-medical measures that require a comprehensive approach with other non-clinical services.

Implementation should consider the impact of the PCHCH on the rest of health system, particularly how the rest of the system communicates about the PCHCH and understands it. Health is a complex adaptive system and changes to primary care will impact on acute care and the rest of the health care sector.

Workforce development and reform should feature as part of the model. This should include new ways of teaching, embedding genuine multidisciplinary practice and making the most of existing workforce and the way it is configured and organised, including the extent to which hospital and community based specialists can be utilised as consultants and advisers to the wider primary health care team.

17. Build IT infrastructure and tools to support shared care planning and delivery

The PCHCH needs to have in place the necessary IT infrastructure to enable shared care planning and co-ordinated care, including patient access to their own information and health care team access to pharmacy, pathology, and diagnostic imaging. It will be necessary to support the development of a suite of tools (for patients and practitioners) to enable collaborative, comprehensive and co-ordinated care

Data driven improvement

There are some specific challenges associated with achieving data-driven improvement in the Australian context. Principles 18 to 23 relate to the implementation of data driven improvement.

18. Establish practice level processes for monitoring progress towards becoming a PCHCH

Routine use (benchmark and tracking) of a practice readiness tool (such as the Australian developed PC-PIT⁵, Bodenheimer's 10 Building Blocks of High Quality General Practice⁶ or the PCMH-A, which was developed by the MacColl Center for Health Care Innovation at the Group Health Research Institute and Qualis Health for the Safety Net Medical Home Initiative⁷) should be built in from the start to guide how practices improve and evolve as PCHC homes.

Systematic use of patient reported measures (experience and outcomes) and/or patient activation measures should also be built into the PCHCH from commencement

19. Assess and build capacity to use data effectively for quality improvement

Early on there needs to be a capacity assessment of existing patient management systems to assess common data elements that can support real time data reporting and measurement of identified PCHCH clinical outcomes.

⁵ Crossland, L., Janamian, T., Sheehan, M., Siskind, V., Hepworth, J. & Jackson, C., *Development and pilot study of the Primary Care Practice Improvement Tool (PC-PIT): an innovative approach.* (2014), MJA, Vol. 201, pp. 552-555

⁶ Bodenheimer T, Ghorob A, Willard-Grace R, Grumbach K. The 10 building blocks of high-performing primary care. *Ann Fam Med.*2014;12(2):166-171

⁷ Adapted for use in Australia by WentWest, ©2014 MacColl Center for Health Care Innovation, Group Health Cooperative. Sept 2014

20. Focus on building take-up of evidence-based models of care

This is an opportunity to build into the PCHCH model the application of care that is evidence-based and supported by research, evaluation, outcomes review and clinical audits. Assess current research gaps and build research strategies into the implementation of the PCHCH. Establish evaluation frameworks prior to implementation.

Engaged leadership

To achieve the change to the PCHCH, leadership is needed at all levels - meso level, within practices and at clinician level. Leaders exist across all staff within the PCHCH and within the patient population. Achieving the PCHCH is dependent on leadership across the system. Principles 20 to 22 address building and maintaining capacity for engaged leadership of the PCHCH movement:

21. Recognise existing leadership capacity in the primary care system and actively invest in building GP leadership

Clinical and consumer leadership is required to drive service development and improvement. Existing leadership capacity within the primary care system should be identified and become the base for further leadership capacity building. The leadership role of GPs as champions of the model needs to be embedded in the model to enable active engagement.

Investment should be made in supporting GPs, PHNs and primary care providers to co-design models and to achieve the culture change needed to establish and maintain the PCHCH. This investment needs to recognise and acknowledge the current un-ease among some Australian GPs around key motivational drivers – leadership, autonomy and purpose.

Investment also needs to be made in systematic ways to integrate consumers' needs and experience in service planning and decision making particularly at the PHN level through consumer leadership and development strategies that allow the systematic and routine capture and analysis of the consumer perspective. Tools such as *Real People, Real Data* should be further developed and applied for this purpose and the adaptation of existing high-efficacy programs such as some of the UK's experience-based co-design initiatives (EBCD) should be explored.

22. Invest in building the capacity of the entire practice team to deliver in the PCHCH

Assess capacity levels and establish an ongoing professional development programme for all PCHCH staff in patient-centred care, patient engagement and the new models of care being tested, to support the cultural shift from a transactional to ongoing relationship-based model between patients and the health care team.

23. Establish and communicate a shared vision

There should be a defined and common view of the PCHCH and a shared vision with PHNs, hospitals, all medical specialists, allied health providers, specialist community health services and – importantly - consumers. A well-crafted communications campaign should be developed (with General Practitioners as a prime focus and other PC practitioners as key audiences), which would also reinforce positive community perceptions by providing clear and compelling positive messages about PCHCH benefits.

Financing and payment paradigms

The PCHCH depends on changes to funding and payments, especially how they impact on general practice business models. This change is significant and needs to be in place to the extent that local demonstrations are able to effectively test new payment models for sustainability. Principles 24 and 25 relate to financing and payment paradigms.

“The next generation of Medicare starts now”

Roundtable participant

24. Business models should be enabled by a payment system that is designed to support achievement of the PCHCH

Business models should be enabled by a payment system that is:

- Quality-focused
- Flexible (multiple delivery methods) and with appropriate measurement (evidence-based)
- Set up with win-win incentive / rewards (as behavioural change levers) at multiple levels: providers (organisations and individuals), funders & consumers
- Able to account for rurality and socio-economic disadvantage
- Supportive of provision for multi-practice investment in core, shared capability
- Supportive of ‘costs of changed business models’ / transition
- Embedded in a multi-lateral framework / bilateral implementation & co-funding / co-investment

The payments system must reward quality, comprehensiveness of care, and continuity, respond to context, and be safeguarded against cost shifting and other perverse incentives such as under-treatment and cream skimming. The system should be enabled to recognise and reward the quality care provided by clinicians.

Payments should reward effort at the point at which it occurs, which may differ from the point at which a change is demonstrable. For example, effort in the primary care sector may reduce costs in the hospital sector. Active consideration should be given to entering into funds pooling arrangements with states and territories where there is current duplication of services or where additional value can be leveraged. Practices must be supported with funding and tools to enable the re-design required to put in place new business models.

Invest in the information systems required to monitor and support new payment models and in practice capacity to deliver on the PCHCH model

It may be necessary to assess capacity and make investments into the IT systems required to monitor and support new payments models. This should be done early on and should recognise the relatively higher cost for small practices in implementing a new model. The payment models for the PCHCH must not disadvantage primary care practitioners and must reward appropriate provision of care by nurses and other allied health practitioners. Blended payment systems need consideration and appraisal. It will be necessary to make the investment in IT before expecting the outcome. Invest firstly in change management and building capacity, or there is a risk the system will not have the capacity to deliver.

Challenges to implementation

Roundtable participants identified a number of challenges that could impact on the implementation of the PCHCH. These include the following.

- ▶ Possible low levels of change readiness, transformative capability, and infrastructure within the sector
- ▶ Active engagement of general practice at a grassroots level
- ▶ GP practices in remote communities can experience additional challenges related to their size, remoteness and access to additional services. There is a multiplier effect for other challenges for rural and remote practitioners
- ▶ Funding models are needed to improve access to allied health practitioners and other key health care team members
- ▶ Under new funding models, incentives to cost shift, undertreat or discourage high-cost high-risk patients may still exist. Unintended consequences need to be identified as conscious risks and managed
- ▶ Primary care data and patient management systems (PMS) are not consistent across practices. There is no uniform view of practices in the region and how they are producing outcomes for interventions. Identification of relevant data is critical
- ▶ The PCHCH represents a major cultural shift and needs a staged approach. Otherwise the HCH programme, as a first foray, runs the risk of becoming a compliance/ tick the box process
- ▶ There is great variety in the models of general practice in Australia. It will be important to make sure all kinds of general practice are supported to fit the PCHCH model – that there are not additional benefits to be gained by one particular kind of practice
- ▶ Consumers will also need to make attitudinal shifts in order to value seeing the whole practice team and not want to always “see the GP”. If not brought along, health consumers may feel they are getting a “second-best” service.

Conclusion

The work of this Roundtable builds on recommendations made by the PHCAG to design and implement the HCH in Australia. The Roundtable included key practitioners, peak bodies, PHNs, consumer leaders and researchers, all of whom will be required to play a major role in any reform to the delivery of primary care in the Australian context. The recommendation from the Roundtable is that the 25 principles for implementation are used across commonwealth, regional and local contexts to help guide the next stage of the development of the PCHCH, particularly in designing models and developing the infrastructure and supports needed to enable their implementation. These recommended principles are grounded in the real experience of people working in the primary health care sector and address the unique character of Australian Primary Care and the Australian health system.

Based on the 25 principles it is recommended that in planning and implementing the PCHCH

policy, the following questions are addressed.

Before Implementation

1. Is there a clear and shared vision for the PCHCH?
2. Have the core elements of the PCHCH been defined in a way that is operationally relevant?
3. Have the core elements been defined in a way that allows for adaptiveness to local conditions?
4. Are there defined realistic process and outcome measures against which to measure progress and success?
5. Is there a funding model that will allow business sustainability for PCHCHs in the real world?
6. Do the funding models recognise the higher needs of underserved populations?
7. Do the existing information systems allow monitoring of the process and outcome measures, facilitate shared care arrangements and support the new payment models?
8. Is there a communication strategy to convey the vision and benefits to patients, clinicians, and community?

During and After Implementation

9. Is there a communication strategy for clinicians, patient and community to convey the vision, benefits and the processes for participation?
10. Is there a flexible and widely accessible program to build capacity among clinicians in the skills necessary to support patients in PCHCH and in the operation of PCHCH?
11. Is there a process for clarification of role responsibilities with other non-primary care health care providers at a local level?
12. Is there a process for local level continuous quality improvement to monitor and respond to the measures of process and outcome?
13. Is there a communication strategy to enable practice level on-going messages and marketing to support establishment of clear mutual expectations (including a common language) and genuine shared accountability between patients and the PCHCH?

The 25 principles consolidate the expertise of the Roundtable to provide advice on how we can adapt our health system to improve patient outcomes and shape the future of healthcare – improving access for all Australians patient-centred, high quality, appropriate care as needed.

Appendix A – Roundtable attendee list

Name	Organisation
Dr Evan Ackermann	RACGP
Rosemary Calder	Australian Health Policy Collaboration
Dr Anthony Carpenter	Royal Australian College of Physicians
Anthony Cichello	Australian Psychological Society
Tracy Clark	Australian Association of Practice Managers
Rowan Cockerell	Consumers Health Forum
Helen Craig	Royal Australasian College of Physicians
Dr Paresh Dawda	Ochre Health Medical Centre
Dr Elizabeth Deveny	South Eastern Melbourne PHN
Jan Donovan	Consumers Health Forum
Karen Edwards	Professional Writer
Rebecca Edwards	Monash Health (CHF)
Melissa Fox	Consumers Health Forum
Jim Gillespie	The Menzies Centre for Health Policy
Andrew Hollo	Facilitator
Prof. Claire Jackson	Brisbane North PHN
Prof. Stephen Jan	The George Institute
Assoc. Prof Greg Johnson	Diabetes Australia
Dr Walid Jammal	Hills Family General Practice
Dr Frank Jones	RACGP
Chris Kane	WA Primary Health Alliance
Maya Kay	The George Institute
Walter Kmet	WentWest
Dr Andrew Knight	Upper Mountains Medical Centre
Shaun Larkin	HCF
Tony Lawson	Consumers Health Forum
Dr Kean Seng Lim	Mt Druitt Medical Centre
David Malone	Australian Primary Health Care Nurses Association
Dr Vicki McCartney	Moss Street Medical Practice
Sharon McGowan	Stroke Foundation
Lin Oke	Allied Health Professions Australia
Krister Partel	Australian Healthcare & Hospitals Association
Dr Nathan Pinski	RACGP

Name	Organisation
Josephine Raw	RACGP
Jo Root	Consumers Health Forum
Peta Rutherford	Rural Doctors Association of Australia
Madeleine Senior	RACGP
Dr Rashmi Sharma	Isabella Plains Medical Centre
Prof. Cathie Sherrington	The George Institute
Roald Versteeg	RACGP
Dr Christine Walker	Chronic Illness Alliance (CHF)
Leanne Wells	Consumers Health Forum
Dr Beres Wenck	RACGP
Kate Whittaker	Cancer Council Australia
Andrew Wilson	The Menzies Centre for Health Policy
Emma Wilson	Pharmaceutical Society of Aust.