Lessons from the implementation of the Health Care Homes program

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Summary

- Australia's primary health care system works well for most Australians, but 20% of people live with multimorbidity, often receiving fragmented care in a complex system.
- Australia's 10-year plan for primary health care recognises that person-centred care is essential to securing universal health coverage, improving health outcomes and achieving an integrated sustainable health system.
- The Health Care Homes trial tested a new model of person-centred care for people with chronic and complex health conditions.
- This model demonstrated that change can be achieved with dedicated transformational support and highlighted the importance of enablers and reform streams that are now established in the 10-year plan.

The centrepiece of the Australian Government's Healthier Medicare package in 2016 was to introduce the Health Care Homes model.[1] The model adopted the evidence-informed person-centred medical home approach,[2] which encompasses the ten building blocks of higher performing primary health care described by Bodenheimer and colleagues:[3] engaged leadership, data-driven improvement, empanelment, team-based care, the patient–team partnership, population management, continuity of care, prompt access to care, comprehensiveness and care coordination, and a template of the future.

Health Care Homes are practices that provide better coordinated and flexible care for Australians with chronic and complex health conditions — person-centred care. They achieve this ideal by promoting innovation in service delivery and efficiencies in the health system.[4] Key features include voluntary patient enrolment, risk stratification, a bundled payment per enrolled patient based on complexity, shared-care planning, and team-based care. Health Care Home practices were supported by education and training in the model and related change activities, and regional and national facilitation to strengthen transformation and data sharing.

The Australian Government trialled Health Care Homes from June 2016 to June 2021. Predisposing activity and recruitment of participating practices occurred until December 2017, recruitment of patients took place through to June 2019, and implementation concluded in June 2021. By 31 August 2019, 10 161 patients had been successfully enrolled across 131 Health Care Homes (mainstream general practices and Aboriginal Community Controlled Health Services) within ten selected Primary Health Network regions. Stakeholders included patients, their families and carers, general practice business owners and teams, allied health providers, specialists, hospital services, community agencies, Primary Health Networks, education and training providers, national facilitation leadership and support agencies, health care payers, software vendors, and evaluation partners.

Three key lessons from the trial

Australian General Practice Accreditation Limited was commissioned to provide education and training for all Health Care Homes, provide national facilitation support to Primary Health Networks, and document outcomes from the national forum held in November 2019. Results of the forum, input from subject matter experts and the program evaluation results[5-7] identified three key lessons.

Health Care Homes is a preferred model of care

While implementation was variable, Health Care Homes that recruited a larger number of patients and adopted a whole-of-practice approach optimised the model of care more successfully than others.[5-7] Practices that recruited small numbers of patients, had high staff turnover, or had less staff buy-in or leadership were less successful in implementing the model.[5-7]

Recognised as the most underutilised resources in the health care system,[8] patients and carers are considered core members of the care delivery team in a Health Care Home. While approaches to patient enablement have traditionally adopted a one-size-fits-all approach, the Health Care Homes model adopts a person-centred and team-based care approach in pursuit of value-based health care: better health outcomes, better consumer and provider experience, improved efficiency, and increased value per dollar spent.[9]

Patients, carers, practice staff and other delivery partners have been surveyed in multiple rounds across the program duration.[10,11] Where implementation was successful, feedback from enrolled patients and practice staff alike suggested that the model is preferred by and for patients with chronic and complex conditions.[5-7]

Patients reported: greater and more timely access to practice staff, clinical advice and services; greater involvement in shared-care planning, planned care and reviews; greater access to practice nurses, medical assistants or care coordinators; enhanced access to allied health services, health education and coaching; and increased confidence in self-management capability. Carer feedback highlighted similar benefits of the model. Challenges included limited awareness of the trial itself and a lack of trust or ability to use shared-care planning tools.

Many practices were able to strengthen team-based care through enhancing the contribution of nursing staff and introducing new roles such as medical assistants or care coordinators, who provided personalised care to patients through enhanced monitoring, care management, review and recall, health education and coaching, and pastoral care. Practices that had in-house allied health before the trial began found it easier to enhance shared-care planning and team-based care.[5-7]

Practice challenges included managing patient expectations to always see a general practitioner. Case studies on patient-reported

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health outcomes and experiences of care were collected by the evaluation team, participating practices and Primary Health Networks; while many of these reported positive outcomes for physical and mental health, it was difficult to demonstrate clinical health benefits due to the short implementation phase.

Practice facilitation supports practice transformation

Changing the model of care in general practice and Aboriginal Community Controlled Health Services is complex. For example, it takes new workforce models and behaviours, coordinated team-based care, and streamlined care processes to create the authorising environment in which staff can operate at their full scope of practice and as part of an effective team.[12,13]

The practice facilitation model is an evidence-based approach to supporting clinicians and health service providers to transform models of care and drive practice improvement.[14,15] Practice facilitators were employed by participating Primary Health Networks to support practice staff in implementing and retaining fidelity to the Health Care Home model. This included: fostering close working relationships with key stakeholders; establishing regional communities of practice; building capacity and capability through information, education, advice and guidance; linking and leveraging both program-wide and system-wide assets and resources; facilitating and supporting practice change activity and transformation; and monitoring and reporting on progress, challenges and successes.[4] Four core competencies of practice facilitation are: robust quality improvement and change management methods; data-driven improvement; health technology optimisation; and facilitative interpersonal skills.[12,13] In addition, a national practice facilitation role was fulfilled by Australian General Practice Accreditation Limited, which provided educational materials and resources to Health Care Home practices, and educated, coached and supported practice facilitators across the program duration.[4]

A key challenge of the Health Care Homes trial was recruiting and retaining appropriately experienced practice facilitation staff, which required multiple education and capability-building rounds.[4-6] Some practices reported frustration with practice facilitation staff turnover, yet practices were largely positive and recognised that external facilitators were critical to transformation and welcomed the support of this upskilled workforce.

The trial demonstrated that, when applied with concerted effort, practice facilitation can help general practices make and sustain change, and enhance their leadership and adaptive reserve, which can improve their ability to respond to changing requirements such as those resulting from the COVID-19 pandemic. Moving forward, enhancing system capability requires careful consideration of how practice facilitation is implemented, particularly in terms of: an appropriate remuneration, recruitment, training and retention strategy; a robust accountability framework to demonstrate impact; and a long-term, well supported national development plan that builds and sustains practice transformation capability.

Health Care Homes system enablers are prerequisites to value-based health care

System enablers such as workforce development, digital technologies, integrated information systems, quality data and alternative payment mechanisms are prerequisites to value-based health care.[16] Enhanced digital technologies and asynchronous communication modes stimulate consumer activation, engagement, self-care and care monitoring. Integrated clinical information systems encompassing risk stratification, shared-care planning and communication mechanisms, patient monitoring and outcome tracking are necessary for realising team-based care that is safe, person centred and effective.

Many challenges in introducing these system enablers were experienced, but they were not insurmountable.[5-7] For example, teething problems with the risk stratification tool were addressed before patient enrolment. Also, limitations of shared-care planning tools (such as the lack of interoperability with general practice software) were noted, yet many practices and allied health providers recognised the value in trialling these innovations. In addition, feedback from trialling such innovations provided software vendors with valuable insights for progressing development of these tools.

While there were mixed views on the implementation and financial effect of the bundled payment, there were two notable positives. First, there was an enhanced focus on the quality of data collected in general practice as a by-product and driver of higher performing primary health care. Second, some practices reported that they broke even or were better off under the payment model than under the Medicare Benefits Schedule, demonstrating that a bundled payment may be a feasible alternative.[5-7] While final evaluation results are pending, feedback suggested that this alternative payment model could be enhanced by expanding tiers to accommodate patients for whom costs are higher, increasing the level of funding by tier, or weighting the payment to account for patient, practice or regional factors.[6]

Health Care Homes as pioneers of change

The Health Care Homes trial incorporated insights and lessons from implementation of the person-centred medical home model that has been used overseas.[1-3] Health Care Homes have, to some extent, proven that this model of care can be successfully implemented over time with general practice commitment to person-centred and team-based care, effective practice facilitation, and investment in appropriate system enablers and supports.

While Australia's Primary Health Care 10 Year Plan contains key components of the Health Care Homes model and system enablers,[17] successful implementation will be challenging. However, the Health Care Homes model and its education and facilitation resources continue to provide a framework for practice transformation for Primary Health Networks, and system enablers provide mechanisms for reform.

However, large scale system reform requires more than a short term program approach: it demands sustained commitment and investment (emotional, practical and financial) that cascades through all levels of the system. Fundamentally, general practice transformation and system reform requires a longer term commitment. To achieve this, investment in person-centred and team-based care, as well as practice facilitation and system enablers, is essential.

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