Better Outcomes for People with Chronic and Complex Health Conditions through Primary Health Care

Submission to the Primary Health Care Advisory Group

by

the Australian Centre for the Medical Home

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The Australian Centre for the Medical Home would be welcome the opportunity to meet with the Primary Care Advisory Group.

RECOGNISING AND SUPPORTING QUALITY PRACTICE

Objective

The Australian government needs a solution to the challenge of managing the healthcare for people with chronic and complex conditions and the increasing cost of hospitalisation.

The Australian community is crying out for a health system that is designed and resourced to provide the highest standards of care in a way which meets their needs

Australian General Practitioners also want to work in a system that is designed and resourced to allow them to provide the highest standards of care.

Australian General Practice has delivered excellent care to Australians for many decades. However, if we are to meet the changing needs of the Australian community in an equitable and sustainable way, we need a new approach to funding that recognises and supports **high quality, team based, high value general practice**.

Making best practice become normal practice

Many general practices in Australia currently provide care that is person-centred, comprehensive, coordinated and accessible, with a focus on quality and safety. These are the key features of a 'Medical Home' - a term used here to indicate an Australian general practice that aims to deliver the highest standards of patient centred care. **All Australian Medical Homes are General Practices or Aboriginal Medical Services - but not all general practices act as medical homes. The strong international evidence shows that the Medical Home model of care is preferred by patients and providers, and reduces the need for more costly acute care hospitalisations, especially for those patients with complex and chronic conditions.**

Yet our health financing system works against making it 'normal' to provide this level of care. **The current funding structure disadvantages those practices that care for the most disadvantaged communities and those with more complex conditions.** The more time a practice spends on quality improvement, the more it employs a practice team, and the more disadvantaged, indigenous and sick people it cares for, the less net income it makes.

We need to align **Professional Incentives** (what GPs want to be able to do for their patients) and **Commercial Incentives** (what they are paid to do) and the **Value to the Community** (through improved population health outcomes)

A Disruptive Change - From High Volume to High Value

Any redesign of primary care funding should aim to recognise, support and incentivise those practices who choose to provide high quality and accountable care for their patients. It should aim to make what is current best practice become normal practice across the country.

General practice will have to demonstrate that it is adding increased value to warrant increased funding. To achieve significant change, there should not be more funding for doing the same thing.

The health industry is not immune to the forces which apply in other industries where major change is taking place. Changing the funding model will be very disruptive.

There will be winners and losers. **The current model disadvantages those practices that care for the most disadvantaged communities, and those GPs that manage patients with more complex conditions. De-emphasising fee for service will change the business model for many, perhaps most, practices.** Some practices will choose to 'step up' to demonstrate their value, others will elect to keep doing what they are doing.

How do we recognise quality in such a way that we do not erode patient-GP relationship or interfere with clinical independence. How do we ensure that we do not enable distortion of practice through hoop jumping that increases remuneration but not value? We require professional leadership, with patients and communities as partners.

To be recognised for delivering the highest standards, all practices will need to improve their systems for delivering care. **New funding streams should reimburse the costs of providing quality care.** Practices they already have good systems for data-driven quality improvement will be well placed to take advantage of changes to funding formulae. They will be able to demonstrate improved processes and outcomes for their defined practice population.

General Practice Funding Streams

This paper argues that 'ideal' general practice funding is a blended system which incorporates the eight funding streams as listed below.

This paper suggests that practices that choose to be accountable for high-value high-quality care may register for the new funding streams that are additional to current Fee for Service, and that replace the current PIP program. To receive this supplementary funding, practices would need to demonstrate that they are participating in all aspects of the program and are accountable for improving their patients' care and outcomes.This paper would suggest that this program is referred to as The Australian Medical Home Program and those practices who choose to register are known as Australian Medical Homes.(see Appendix 1)

Funding Streams for General Practice

1) fee-for-service for acute, routine and chronic care consultations provided by GPs
2) fee-for-service for specific activities preformed by practice nurses or other clinical members of the general practice team
3) more flexible funding for people with complex and chronic conditions that enables systematic and proactive team based care.
4) per capita funding for enrolled patients, enabling practices to be accountable for the health outcomes of a defined population and to support a focus on prevention and maintaining health
5) funding to support participation in a data-driven Quality improvement program
6) direct funding to support nominated quality activity, such as After Hours Care and Teaching.
7) specific funding for nominated high care need patients for services such as home monitoring and more intense care coordination
8) funding that supports general practice 'in-reach' into hospital care

1) FEE FOR SERVICE BY GPS

All practices will continue to receive Fee for Service for acute, routine and chronic care consultations provided by GPs. Practices should be be able to continue to operate only under the Fee for Service Stream if they choose to do so.

2) FEE FOR SERVICE FOR OTHER MEMBERS OF THE GENERAL PRACTICE TEAM

The Practice Nurse Incentive Program has been successful in increasing the use of practice nurses. However, the removal of specific item numbers for immunisation and wound care performed by practice nurses has decreased their autonomy.
A practice team could be utilised more effectively by increasing the number of specific items numbers for health professionals working as part of a general practice team. This should include the reinstatement of item

numbers for practice nurses, as well as new items numbers for clinical pharmacists and other allied health providers.

3) MORE FLEXIBLE FUNDING FOR PEOPLE WITH COMPLEX AND CHRONIC CONDITIONS

The EPC program has been very successful in enabling general practices to adopt a more proactive and systematic approach to chronic disease management.

This program could be improved by allowing more flexibility for practices to manage nominated patents with complex and chronic conditions. This would include more efficient use of practice nurses in the role of care managers. Access to this funding stream would require more accountability by practices for outcomes.

A specific item number (claimed quarterly) could be available to practices that will provide the resources needed to support these patients in a more flexible and appropriate way. This will replace the current EPC item numbers for preparing a GP Management Plan or Team Care Arrangement and reviews for these patients. General practice consultations will still be eligible for 'normal' consultation item numbers.

Patients managed under the new flexible funding stream will receive from their medical home:

- proactive and regular review by their general practitioner, face to face or by more appropriate technology
- proactive monitoring and care coordination by a practice nurse
- access to more allied health appointments instead of the current five
- access to urgent care on day of need by phone, telehealth or face to face

The practice will provide collated clinical outcome measures on these patients as part of their participation in a national Quality Improvement program, as discussed below.

The practice will also upload and maintain accurate Shared Health Summaries for enrolled patients

A similar package of care should be available to residents of Aged Care Facilities.

4) PER CAPITA FUNDING FOR PATIENT ENROLMENT

Each Australian should be able to nominate a particular general practice that they think is best placed to be accountable for their ongoing health care - their 'medical home'.

Enrolling with a practice should be voluntary. Enrolling in one practice should not restrict a person from receiving care in other practices. A strict auditing and dispute process will be established to maintain the integrity of the patient enrolment system.

There will be baseline funding available per enrolled person to each practice to resource higher quality care and to fund participation in quality improvement activities. The funding for each patient will be weighting for age, rurality, and disadvantage.

By having a clearly defined population for which to be accountable, a medical home will be able to adopt a population approach to preventative care and maintaining wellness.

Voluntary patient registration will allow the Medical Home to define its patient population so that accurate outcome measures can be quantified and followed over time.

Participating practices will be accountable for improving clinical outcomes for their enrolled patients as measured by the National Quality Improvement Program. (Stream 6)

5) NATIONAL QUALITY IMPROVEMENT PROGRAM

This funding stream will provide the resources for practices to undertake ongoing data-driven clinical improvement for their enrolled patients.

Participation will require regular submission of collated clinical data on a range of measures, which will be used to support improvement activities within the practice and by the local Primary Health Network.

These measures will include indicators of improvement in access, chronic disease management and preventative health for enrolled patients.

Practices will be expected to show improvements on a subset of measures that reflect national or local priorities.

The program acknowledges that clinical outcomes are determined by factors such as the demographics of the populations and local resources, and therefore will focus on improvement rather than absolute outcomes. This is a ‘Pay for Participation in Data-Driven Improvement Program’, rather than a ‘pay For Performance’ program.

Practices will also participate in national or local improvement networks that allow them to share best practice stories

Practices will be able to demonstrate how they use QI techniques to improve patient outcomes.

6) SPECIFIC QUALITY ACTIVITY FUNDING

The current PIP program has successfully funded General practices for specific nominated activities that have value to their community. Examples of such programs areThe After Hours Incentive, eHeath, Teaching, and Rural Infrastructure Grants.
These have been valuable contributors to quality practice and should be continued.

The current PIP program also funds some programs that are more quality improvement in nature, such as Cervical Screening and Diabetes, and some that aren't but should be more QI based, such as Closing the Gap. These programs would be better delivered under a separate Quality Improvement program

7) FUNDING FOR NOMINATED HIGH CARE NEEDS PATIENTS

Some very high care needs patients who are at risk of frequent hospitalisation benefit from additional services that are not currently funded by the MBS - such as home monitoring, visiting by a practice nurse, and increased levels of care coordination. This is recognised by the DVA in its successful Coordinated Veterans Care program.

Funding for nominated patients could come to practices from Private Health Insurers, State Health, or a patient's family.

8) FUNDING TO SUPPORT 'GP INREACH' INTO HOSPITAL

Quality and safety is increased and cost is reduced when a pesrons's medical home remains part of their care team when admitted to hospital. As experts in that patient, the general practice team can contribute at admission, during key points though the admission, during discharge planning, and in the post discharge period. Funding should support a virtual 'dual' admission to hospital, where the general practice teams is resourced to support the patient and have input to the care.

Conclusion

General Practice is well positioned to deliver the high value care that is required to address the challenge of the increasing incidence of chronic disease.

We need new funding streams that reimburse high quality, team based, data-driven care. This redesigned funding can bring alignment between the financial incentives, the professional incentives of GPs, and the needs of our patients and community. These funding changes will be disruptive in that many practices will have to change their business model to a more patient centred approach. They will have to focus on outcomes and value as well as activity. This will require significant clinical leadership, with patients and communities as partners.

It is worth fighting for.

Appendix 1 - Features of an Australian Medical Home

Participating practices have a commitment to clinical leadership.

PERSON CENTRED CARE

- support continuity of care provider
- have patient advisory groups that support system redesign
- have structures to improve patient self management

COMPREHENSIVE CARE

- provide whole of life family practice
- have systems that support acute, routine, and chronic disease care patient streams
- support continuity of care provider
- have a multi-disciplinary Medical Home team

COORDINATED CARE

- have systems in place for proactive, systematic chronic disease management
- utilise practice nurses as chronic disease managers
- proved electronic health summaries on the national system for appropriate patients
- have systems to maintain accountability for a patient's care though all contacts with the health system

ACCESSIBLE CARE

- are committed to same day appointments for all patients that require urgent care
- are committed to minimising the delay for routine appointments
- provide 24 hour accessibility for patients to clinical advice and extended hours for face-to-face after hours contact when needed

FOCUS ON QUALITY AND SAFETY

- are accredited to the RACGP standards and the Australian Centre for the Medical Home standards
- participate in the AMHG Improvement program, which includes monthly submission of collated clinical data on a range of measures related to health outcomes, chronic disease management, preventative care and access to services
- participate in the AMHG practice exchange program, in which members physically and virtually freqqunetly visit each other's practice so they can 'shamelessly steal' best practice ideas
- have systems to improve patient safety including Incident Registers and Committees