POSTER ABSTRACT

Implementation of the Health Care Homes model in Australian primary care

19th International Conference on Integrated Care, San Sebastian, 01-03 April 2019

Tina Janamian

Australian General Practice Accreditation Limited, Australia

**Introduction**: Worldwide health systems face the challenge of providing innovative models for delivering care that ensures high quality, accessibility, continuity and coordination of care. One in four Australians have at least two chronic health conditions and they require services from different health professionals. Often there is a lack of coordination and communication between care providers across different parts of the health system which can be frustrating for patients, their families and carers. It can also put patient safety at risk and cost the health system more.

**Aim and theory of change**: In Australia, the Health Care Homes model was introduced in 2016 to provide:
- Better coordinated, more comprehensive and personalised care
- Increased continuity of care
- Empowered, engaged, satisfied and more health literate patients and carers
- Improved access to services
- Enhanced sharing of up to date health summary information
- Increased productivity of health care service providers

**Targeted population and stakeholders**: The Health Comes model is implemented in 170 general practices and Aboriginal Community Controlled Health Services ('practices') across ten chosen Primary Health Network regions in Australia.

**Timeline**: In late 2016, the Department of Health released expression of interest for practices to self-nominate to be involved in the stage 1 implementation. In mid-2017, practices were selected using an eligibility and assessment criteria. The first tranche of practices commenced in October 2017 and stage 1 implementation ends December 2019.

**Highlights**: Participating practices are provided training to support their implementation efforts. Practices use a risk stratification tool to determine patient’s eligibility for enrolment and stratify patients based on their disease complexity and other factors. Identified patients are invited to enrol with a nominated clinician within their practice who will coordinate all their chronic disease management, face-to-face or virtual, within and outside the practice. Rather than the usual Medicare chronic care and planning items currently available for doctors and nurses, practices will receive a single bundled payment per patient per annum, based on assessment of the patient’s complexity using a risk stratification tool. Health Care Homes are free to work with the patient to tailor the care to the patient’s circumstances, clinical need and preference. Opportunities for more innovative use of e-health, both in-hours and after-hours, is encouraged.
Conclusion: Currently there are 170 practices involved in the Stage 1 Health Care Homes and they have collectively enrolled over 3,500 patients. An evaluation is being carried out over the next two years to determine the impact of the new model of care on patient outcomes, hospitalisations and costs.

Lessons learned: Transformation efforts have been slow due to a number of factors: The lack of time and resources devoted to assess practice readiness for change and ineffective practice change management processes; lack of leadership in many practices; inadequate protected time for practice staff training; and lack of accountability frameworks for practices and Primary Health Networks to report on their transformation journey. Large scale transformation such as this requires a robust implementation strategy and adequate funding and resources to support change that is measurable and sustainable.

Keywords: health care homes; implementation; practices; transformation