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Health Care Home Activity Monitoring Guide

Guidance for Health Care Homes on building an internal system to record and monitor Health Care Home activities

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1. Purpose

The primary purpose of this guide is to assist general practices and Aboriginal Community Controlled Health Services (ACCHS) – hereafter referred to as 'practices' - to build internal systems to support the recording and monitoring of Health Care Home activities. This guide is intended to be read and used in conjunction with other Health Care Home supporting documentation and information.

It is acknowledged that Health Care Home implementation will vary between practices. The suggestions provided within this guide aim to support practices in transitioning from the current fee-for-service based payments approach to the more flexible and innovative service delivery that is possible under the Health Care Home bundled payments approach.

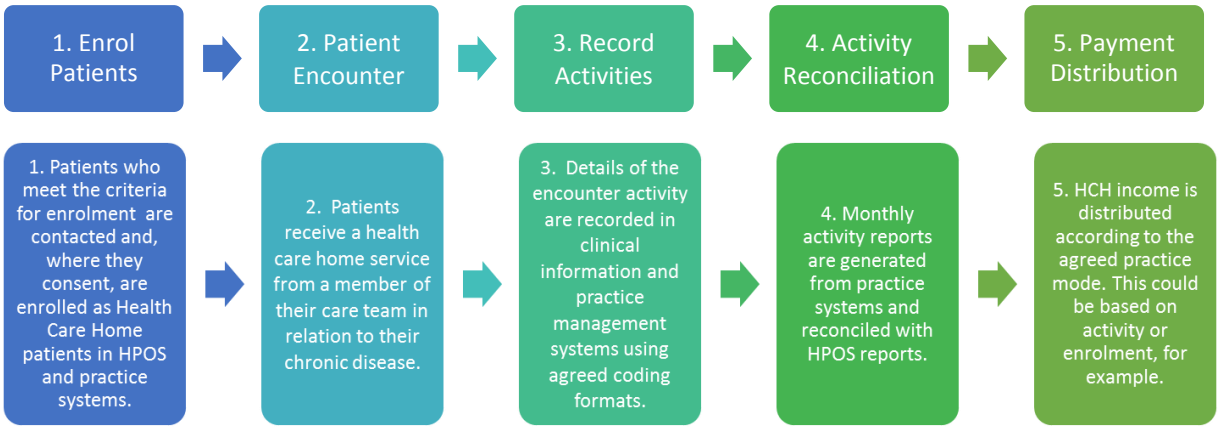
This guide does not attempt to provide advice regarding the overall business processes and income streams of a practice. Instead, it focuses on the Health Care Home component, which, beyond the stage one trial, may include up to 20% of a practice's patient cohort.

By encouraging a consistent approach to the recording of Health Care Home data, this guide may also be of benefit to the evaluation of the stage one trial, which is a key consideration for the Commonwealth Government

To fully evaluate the Health Care Home roll-out, the Commonwealth Department of Health also requires data on the levels and types of activities to understand different models of care and also validate the payment tiers. This guide addresses how the more prevalent practice business management and clinical information systems can be used to automate the collection of Health Care Home activity data if required for the evaluation.

High Level Process Flow *(See **Appendix B** for further detail)*

The flow diagram below identifies high-level information on Health Care Home activities that can be used to understand key Health Care Home business processes



This resource provides guidance for Health Care Homes on:

- the potential impact of, and opportunities offered by, the Health Care Home bundled payment approach;
- how to record and monitor Health Care Home activities using existing practice management software systems;
- core components of the Health Care Home program;
- recording and accounting for patient enrolment status;
- recording and reporting on Health Care Home activity;
- distributing and managing Health Care Home bundled payments;
- generating reports for the Health Care Home Stage One Trial Evaluation process; and
- using different practice management software programs to implement Health Care Home activity monitoring.

2. Background

This is a time of national health reform that will build on the core pillars and operations of our existing health system, which is amongst the most advanced in the world. Reform is aimed at helping Australia meet long-term challenges such as:

- improving access to services;
- increasing demand on those services;
- rising patient and carer expectations;
- the growing burden of chronic disease;
- population ageing;
- making better use of available resources;
- reducing fragmentation in health and social care;
- delivering on safety and quality;
- overcoming health workforce constraints; and
- the cost and opportunities presented by new health technologies.

The Primary Health Care Advisory Group report to the Commonwealth Minister for Health, the Hon. Sussan Ley MP, (December 2015) detailed the evidence for change. It recommended to Government the adoption of a new model of care and supporting reforms to better meet the health care needs of Australians with chronic and complex conditions. This was a future oriented report, acknowledging that the system must prepare now for the challenges to come as an increasing number of people exit the workforce and age. It noted that poor outcomes are more likely for Aboriginal and Torres Strait Islander peoples, people with mental illness, people from culturally and linguistically diverse backgrounds, and those living in rural and remote areas.

More sustainable use of health system resources is critically important, since national health care costs continue to grow at a rate faster than the national economy. With the health care system now constituting 10% of the total economy and demand increasing at rates three times economic growth, the pressures on health care to remain responsive and affordable have never been higher.

The Primary Health Care Advisory Group suggested that better integrated and coordinated primary health care services for patients with chronic and complex conditions are the best way to achieve improved outcomes for patients and ensure a sustainable health system into the future. This new model will complement the existing primary care delivery of accessible, acute and preventative care.

The Primary Health Care Advisory Group recommended changes to the funding model in order to allow our health system to evolve and deliver more coordinated care. In response, the stage one trial of Health Care Homes was announced with the first 20 practices set to commence in October 2017.

One of the many components of this program is the commissioning of an evaluation. A range of data will be collected over the two years of the stage one trial of Health Care Homes. One of the necessary datasets is information on the nature of activity delivered by practices using the bundled payments. Categorisation of activity types, providers and modes of delivery needs to be built and used by participating practices in order for this data exchange to occur.

3. Rationale

The Health Care Homes program will formalise a model of integrated care underpinned by a funding model that supports that model of care for enrolled patients with complex and chronic disease. It will be a change involving practices identifying and enrolling patients and moving away from the current fee-for-service model which differs from the model of care for enrolled patients. This will provide practices with greater flexibility to shape care around an individual patient's needs whilst maximising access to available system resources. A key intention of the program is to encourage patients to actively partner in their own care.

The bundled payment approach will enable Health Care Homes to innovate in the areas of use of technology and enhanced health care team member roles to both provide and monitor comprehensive and coordinated care services. This systematised approach will provide more proactive and targeted care to those who need it most.

The Health Care Home program offers greater flexibility to shape care to fit population health needs, patients, their families and carers. While this flexibility means no two practices may be alike, all Health Care Homes will share a set of key characteristics:

- voluntary patient enrolment;
- patients nominating a preferred clinician;
- patients (and families and their carers when appropriate) engaged as partners in care;
- enhanced access and flexibility in care provision;
- team-based care aimed at coordinating activity across a continuum;
- a commitment to care that is safe, high quality and comprehensive; and
- data collection and sharing.

The Health Care Home is an approach to health care that puts patients at the centre of a model of team-based care that is based on the needs and goals of the patient. The patient's care team in their Health Care Home will coordinate the partnerships between the patient (and their families and carers) and the extended health care team in their health care neighbourhood. This will strengthen primary care's role as the focus for coordination of comprehensive patient care. Most importantly, Health Care Homes will encourage more proactive care. The increased focus on managing care transitions and addressing escalations of care will support patients to remain in the community and reduce potentially avoidable hospital presentations and admissions.

This patient-centred model of care will allow the Health Care Homes to:

- offer innovative, timely access to appropriate care and advice;

- improve the quality of the care guided by evidence-based practice;
- provide patients with greater choice, support and information;
- develop localised care pathways with other providers across the care neighbourhood to best utilise available services;
- customise service delivery informed by knowledge of those local resources;
- provide greater care coordination, education and proactive intervention; and
- manage relationships and access across the health and social care continuum.

This guide may also be used to provide consistent data for the evaluation of the Health Care Home program to:

- understand the patterns of service utilisation by patient tier;
- compare service provision for enrolled and non-enrolled patients; and
- understand the financial implications of the Health Care Home model for funders and providers.

4. Implementation

This section provides practices with information about how their existing practice software systems could be used to record, monitor and report on Health Care Home activities. This guide also identifies codes that can be used by practices to support the recording of Health Care Home activities which, if used consistently, will enable accurate reporting of data for evaluation purposes.

Principles

In supporting activity monitoring at practice level, a number of principles will be used as guidance:

- practices will need to implement a system for recording activity delivered for enrolled patients;
- the approach should leverage existing practice management system functionality;
- the system will need to generate reports on activity;
- a nationally consistent approach to data collection is necessary for the program evaluation;
- new modes of service delivery developed by practices are supported;
- ongoing reporting capacity will be available to guide practice innovation; and
- the activity categories will be sufficiently broad to allow ongoing evolution in models of care.

Health Care Home Activities

Practices will be able to use their bundled payments to direct effort where patients need care and support. Over time practice capability, new technology and partnerships are likely to emerge, which can further transform care possibilities. Therefore, rather than defining care in terms of episodes of care which may change markedly over the next decade, this guide will support recording based on activity categories.

Integral to Health Care Homes is the delivery of consistent quality care which encompasses care coordination and allows ongoing innovation. Care is not constrained by the current model of real time face-to-face care that is the only care currently reimbursable under the Medicare Benefits Schedule (MBS). This means practices have much more flexibility over the models of care that they can implement to better support the needs of different groups of their patients.

The potential to include new activity categories also recognises that Health Care Home activities may be undertaken by more than one care team member. The suggested activity codes may be entered

into the fee schedule model in the practice management software and used to indicate delivery of particular services by different types of health care providers.

It is up to practices to define roles based on local decisions about scope of practice, availability, patient acceptability and delivery of quality care. This breaks the current link between revenue generation and provider type, freeing up the practice to explore new and more effective ways of delivering care.

GST

It is important to note that Health Care Home bundled payments do not attract GST when:

- 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.

Practice Administration

When dealing with the bundled payments system, Health Care Home practice administrators will need a way to analyse activity patterns and manage finances. Utilisation of the facilities of commonly used practice management software programs will ease introduction of the new supports required for practice management. In most cases practices can use functionality in their existing practice management and clinical information systems to record the type, value and the provider of services delivered to Health Care Home patients. This will allow practices to track and report on the array of activities undertaken by each provider. This data will enable practices to appropriately share the bundled payments. It will also ensure that information is accessible to practices and providers to make informed decisions to guide ongoing innovation.

Exactly how models of care and consequential payment flows will evolve is entirely at the discretion of practices, within the parameters of the program. Being able to access good quality data will assist practices in making decisions made about the most efficient way to deliver the right care in the right way at the right time for each patient. It will also assist in identifying patients with common needs and will allow practices to develop business models relevant to the care being planned and provided. Aligning providers and their workflows to address these needs is a core management function of Health Care Homes and one which current practice management and clinical information systems can be used to support.

The possible range of activities that a Health Care Home might implement is broad. **Appendix C** provides a listing of possible activities with corresponding activity codes that Health Care Homes may implement that should be incorporated into their practice management systems.

Under the Activity category in **Appendix C**, a code for “other” has been included to support a practice employing a novel solution to meet their patient needs which cannot be reflected in the standard codes. Practices using the “other” code may be contacted as part of the evaluation and asked to describe what the particular activity is so that this guide can be updated to more accurately represent the spread of activities being engaged by Health Care Homes.

Health Care Homes will evolve. With an increased ability to focus on the quality of care, which patients require, practices will be able to experiment with innovative ideas as their teams become

increasingly confident. Overseas and other Australian providers indicate that the right environment will encourage innovation.

For this reason, this guide is not prescriptive of any particular solution and can be amended as more practices contribute innovative ideas.

It is important for practices to record how each activity (with its unique code) is delivered. The headings (reproduced below) are from **Appendix C**:

In person	Telephone	Video	Digital	Non-contact
Face-to-face	Phone calls	Telehealth	Email	Non-clinical care
		Videoconference	SMS	Device enabled care

Examples of Health Care Homes outputs

It will be important to identify each of the roles/health care providers who are providing different services, to enable appropriate reporting and monitoring.

Examples of the outputs, which Health Care Home practices may deliver for their enrolled patients include:

a) care planning and care plan reviews;
b) end of life planning;
c) care coordination;
d) patient education in disease self-management;
e) screening and preventative health checks*;
f) social prescribing (e.g. prescribing activities such as exercise or meditation);
g) more specialised care i.e. some practices may focus on COPD, aspects of mental health, etc. rather than referring patients to hospital based providers;
h) enabling devices for short term use to keep patients in the community (e.g. Aids and equipment for independent living); and
i) streamlined pathways into community care so that patients are connected into complementary, non-medical support (e.g. Community services such as meals on wheels).

(**Note**: Only Health Assessments for Aboriginal and Torres Strait Islander People (MBS Item 715) are excluded from the Health Care Home bundled payment.)

Health Care Home models of care, provider types and payment tiers

Many of the Health Care Home activities lend themselves to being performed by a range of providers and provider types. It is up to each practice to determine which mix of activities, provider types and providers will support the models of care instituted. This information can then be populated into the practice management system to reflect these choices. In essence, practices will build their own matrix of data to reflect their own delivery processes.

This can be modified at any time as new providers and activities are added by practices simply by adding in the providers and the codes to be assigned to each new activity. The next report generated by the practice management system will collect data in those fields for use by the team in reviewing their care.

Patient Tiers

Every enrolled Health Care Home patient needs to have their enrolment status and tier level clearly recorded in both practice management and clinical information systems. This will ensure that:

- all practice staff are aware of a patient's enrolment status;
- services provided are in line with the patient's agreed care plan and tier level;
- care related to an enrolled patient's chronic conditions is not incorrectly billed against MBS items; and
- reporting of Health Care Home activities is enabled.

System differences

Each practice management system will require a slightly different process for recording enrolment status and tier level. See **Appendix D** for details on how the four commonly used practice management software programs can be used for this purpose.

Payer codes

In addition to this step, practices will need to define three new institutional payers in their practice management system. The following new codes can be used to define an enrolled patient's tier status.

1. Health Care Homes 1 will relate to payments for patients receiving tier 1 payments;
2. Health Care Homes 2 will relate to payments for patients receiving tier 2 payments; and
3. Health Care Homes 3 will relate to payments for patients receiving tier 3 payments.

Patients may move between tiers over time, therefore, whenever a patient's tier changes, the associated institutional payer will also need to be changed.

Practices will determine how care for different patient tiers and diagnoses will be organised. Based on these internal decisions, the practice should enter the names of providers for each of those activities related to their preferred models of care into their practice management system. It is not expected that every practice will have all of the providers against each area of activity identified in the list of activities at **Appendix C**.

Evaluation Data

Some practices may be asked to provide data on activity for Health Care Home enrolled patients. These data will be used by the program evaluators. Given that practice management software systems are all slightly different, the submission of these reports to the evaluators will likely be a manual process, at least initially. The use of the same codes to reflect activity types across different practices and software systems, as identified in **Appendix C**, will enable the evaluators to collate the data provided by practices.

5. Distribution of Health Care Home funding

The use and allocation of the bundled payment is a decision for practices and there are many ways that this could be managed. This chapter provides Health Care Homes with information which may assist in the distribution of the bundled payment.

The following principles underpin the process for applying a value to Health Care Home activities:

1. practices need to determine their own bundled payment distribution model;

2. practices control their own fee schedules;
3. practices can collect private fees; and
4. practices can create an activity recording system to account for Health Care Home revenue and expenditure.

In implementing the prescribed activity components, practices may also decide to apply a financial value to each activity. This value will not be visible to the Health Care Home evaluation process and is purely an optional internal mechanism. When the activity is recorded through the practice's management system, the value ascribed will be applied. An account for that service will then be created, which can be grouped in a number of ways to support income distribution within practices.

Practices may wish to consider different methods, or a combination of methods, for determining the value of Health Care Home activities. Ultimately, the ideal outcome is for the method to be fair for the practice, fair for the practitioner and acceptable to the enrolled patient.

Whilst enabling evaluation is the primary objective of creating a list of standardised activities, this can also assist practices to organise data to enable appropriate distribution of bundled payments to the practice and its providers.

Just as each practice will define how care is delivered, each practice will determine how the bundled payments are distributed. Some practices may choose to engage the majority or even all of their providers as employees. In this case, the activities will be a mechanism for looking at productivity and monitoring the models of care. In the majority of practices, funds will be shared with sub-contracted providers. If implemented as intended, identification of activities by provider together with the nominated fee can assist practices to substantiate:

- the level of activity being undertaken by paid practice staff that also needs to be recouped from the bundled payments;
- the activity levels of individual providers; and/or
- mechanisms for distributing the bundled payment.

Note: In determining how the bundled payments will be distributed within the practice, practices should seek their own independent advice on any potential employment taxation implications from the approach taken. Practices can also access information on this issue prepared by KPMG at (http://www.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes-information).

Patient Contributions

Practices can also apply a patient contribution for Health Care Home services. To do this the practice would need to create a specific item to record the patient contribution, e.g. HCHGAP. When the patient account is processed, the Health Care Home activity will be allocated to the respective Health Care Home tier level.

This revenue will then be able to be identified in the practice's item number report.

It is important to note that many patients with chronic and complex conditions are currently bulk billed for primary health care services. Health Care Homes are strongly encouraged to continue to bulk bill for enrolled patients. However, consistent with current approaches in many practices, enrolled patients will be able to contribute towards their health care costs. The determination and management of patient contributions will be up to each Health Care Home and must be agreed with the patient at the time of enrolment.

In addition to internally recording a patient contribution to their Health Care Home services, an MBS item (Item 6087) should be claimed for any out-of-pocket contributions, to enable the flow-through of these contributions to the patient's Medicare Safety Net benefit/entitlement.

6. REPORTING

Budget Management

The reports currently available to practice managers can be generated for Health Care Home activities. This means reports can be generated to reflect Health Care Home activity across the practice or by individual providers. It will be critical to monitor how the services delivered to patients as reflected in the activities delivered to them each month or period, compares to the payments received for that patient and tier cohort. It is entirely possible that practices will generate models of care, which see peaks and troughs in activity planned for each tier and this will be reflected in costs rising and falling. What is important to track is how costs accumulate and compare to the payments received over periods of time relevant to the practice's model of care, rather than simply look for surplus or deficit each month.

How to use Practice Management Software

Appendix D includes instruction guides on how to use different practice management software to record and report on Health Care Home activity. The instruction guides will show how to:

- identify the Health Care Homes patient in the management and clinical aspects of each software product;
- set up the fee module to apply the Health Care Homes activity;
- manage the billing process;
- report on banking; and
- produce activity reports by tier level.

Guides have been created for:

- Medical Director/Pracsoft
- Best Practice
- Zedmed
- Communicare

Practices that are not using any of these products are advised to consider the approach that is demonstrated in the guides for the other products and adapt that same approach for their own software.

7. WHERE TO SEEK ADVICE

PHN Practice Facilitators are funded by the Commonwealth Department of Health and trained specifically to support practices with the implementation of Health Care Homes activities.

The AAPM website has a Health Care Home page for visitors containing direct links to the Department of Health's resources for professionals about the Health Care Home Program.

These resources include:

Financial Information:

- Funding
- Bundled payments

Advice on Specific Aspects of the Program:

- If a practice is not registered for ePIP can they still become a Health Care Home?
- How are Health Care Homes different?
- Shared care plan

On-going Advice and Support:

- More information e-newsletters, fact sheets and booklets
- Advisory groups

AAPM and the Commonwealth Department of Health have both produced informational webinars about the Health Care Home Program:

- View AAPM webinar
- Download the presentation slides (pdf format)
- Presenter information
- Department of Health Webinars