Health Care Homes and the quadruple aim
QandA with Dr Steve Hambleton

Dr Steve Hambleton is a practising GP, the former president of the Australian Medical Association and the former chair of the primary health care advisory group (PHCAG) which informed the design of the Health Care Homes model. Here he discusses the clinical and practice-level strengths of Health Care Homes.

Q: In the Health Care Home model, how do you see the quadruple aim (enhancing patient experience, improving population health, reducing costs and improving the work life of health care providers) working?
A: All general practitioners want to work in a system that enables us to provide the highest standards of care to our patients. In the Health Care Home our patients don't have to wait for the next available appointment to have a question answered. If their home monitoring and routine investigations show they are stable they can get access to repeat medications and their test results and speak to the practice nurse when needed.

With better data collection at the practice level, shared and de-identified at the primary health network (PHN), providers can prove their worth and contribute to population health. PHNs can seek and distribute resources according to need. Practices can operate more efficiently with shorter waiting times for patients who are acutely unwell. Over time, fewer and fewer patients with chronic disease present when they are unwell, as care plans are properly implemented.
Stable chronic disease patients are supported by the team while the doctor deals with more complex and acute issues.

No longer is revenue dependant on rapid throughput or opportunistic care plans. Clinicians begin to feel more valued. Nurses, pharmacists and allied health providers, work to the top of their skill sets. Doctors have time to discuss options with the patient's care team and can set goals for their care coordinators. Practices can demonstrate their worth as they compare their own results against their peers.

Q: Regarding training for the Health Care Homes model, why is a whole-of-practice approach necessary? Isn't integrated care something that GPs and practices do instinctively?
A: We don't work in integrated teams instinctively. We have been trained to work alone and to accept risk. We rarely take time to explore the strengths of our practice team. No patient will attend a surgery today without passing by the doctor so a rebate is triggered. Up until recently we have not had the IT tools to set up dashboards to monitor our patients. We rarely communicate outside of face-to-face visits and almost never get together for a case conference in the interests of our patients.

Training will help each of us learn about each other. Training can provide us with access to the tools we need to communicate and how to best use them. Training can help us shamelessly steal the best ideas from our colleagues.

Q: Why are both clinical leadership and practice leadership important for this model of care?
A: This is a new way of doing business. It will take clinical leadership. The default setting for us is to resist change and to go back to what we have always done. Change will require investment and support. There needs to be a measurable aim and a value proposition that can be articulated and that is real. The changes that are required to achieve the aim need to be mapped so the team works together. Then we need to action the change. Measurement is important so we know if the change is happening and in the end whether it is effective.

Q: Why is it important for Australia to start now to adapt and implement the best aspects of these models into primary health care in this country?
A: Now is the time for change. There is growing spend in our health care system. There are growing numbers of people with chronic disease. There is under-investment in general practice and we have almost no data to both show we are doing a good job and to demand more resources. For the first time we will have the information technology to measure what we do and demonstrate the outcomes we can deliver. We are about to implement a model of care that has been proven in pockets in Australia, New Zealand and the USA. We need to engage and activate our patients and their carers as partners in their care, and help them to help themselves.

The PHCAG-recommended Health Care Home is just the start of the journey. The Royal Australian College of General Practitioners has a much broader vision for the whole of primary care, so we need to take a long-term view and begin the journey. Stage one of Health Care Homes involves 200 practices out of 7,500 nation-wide, and 65,000 patients out of the 5 million Australians with chronic and complex conditions. This means that most of us will be doing exactly what we are doing, while those stage one practices iron out the bugs, before the rest of us can embrace the opportunity. We know the model is correct. We know our practice teams are underutilised today. We know we operate in silos. We know we operate in an information vacuum. We know we are inefficient.

Our patients deserve a better deal and it's time for us to demand the conditions that we need to deliver it – and it's not more of the same!