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1. **Health Care Homes for care teams**

This handbook has been designed to introduce the Health Care Home model to health care providers who are outside the Health Care Home, and members of the patient care team. It aims to explain how care delivered by general practices or Aboriginal Controlled Community Health Services (ACCHS) involved in stage one of the Health Care Homes trial may change, and the impact this may have on providers working with Health Care Homes and their patients.

It is important to note that while the model of payment for Health Care Homes will change to a monthly bundled payment system for enrolled patients, payments for services performed outside the Health Care Home such as allied health, specialist services, diagnostic imaging and pathology will essentially remain unchanged.

These services will continue to be billed using the current Medicare Benefits Schedule (MBS), along with episodic care unrelated to a patient’s chronic condition.

Access to Medicare funded allied health services currently triggered by a GP Management Plan, Health Assessment for Aboriginal and Torres Strait Islander People or GP Mental Health Treatment will be automatically activated when a patient enrols in a Health Care Home and develops a shared care plan.

While funding for health care providers outside of the Health Care Home will not change, the model offers these providers a number of benefits, including increased flexibility to better support the provision of integrated, coordinated team-based care to their patients.

2. **What is a Health Care Home?**

A Health Care Home is a general practice or ACCHS that has agreed to commit to a systematic approach to chronic disease management — an approach that supports accountability for ongoing high quality patient care.

It uses an evidence-based, coordinated, multi-disciplinary model of team-based care that aims to improve efficiency and promote innovation in primary care services.

It is consistent with similar models adopted successfully around the world, including the United Kingdom and New Zealand, and reflects and formalises the attributes of many high performing practices here in Australia.

The Health Care Home model is designed to provide patients with chronic and complex disease with comprehensive, coordinated and continuous care. The model provides health care professionals with greater flexibility to shape care around an individual patient’s needs and goals, and encourages patients to actively partner in and direct their own care. Patients will agree to participate in the Health Care Home trial and enrol with a Health Care Home, nominating a preferred GP or nurse practitioner who will lead the patient’s care team. This extends to include other health care providers such as allied health professionals, pharmacists, specialists, and community care providers who will most likely practise outside of the Health Care Home. This is referred to as the health care neighbourhood.

Each Health Care Home will share key characteristics, including:

- **Voluntary patient enrolment.** Practices will select eligible patients and facilitate their enrolment with the practice and registration in the program.
- **Patients nominate a lead clinician.** The nominated GP/nurse practitioner will lead the team providing the ongoing care.
- Patients, families and their carers are partners in their care. This ensures cultural preferences and values are respected, and that they are genuine partners in their health care.
- Enhanced access and flexibility, through timely advice, and access to options enabled by a bundled payment model.
- Team-based care from a range of clinical providers, through shared information and care planning.
- A commitment to care which is high-quality and safe, through the enhancement of systematic and quality approaches to support evidence-based decision making.
- Data collection and sharing to continuously and transparently monitor and improve performance, quality and service.

How is this different to the current general practice and ACCHS model?
The following figure will give you an understanding about how this model of care aims to change or adjust the approach to care that is currently offered. You may wish to consider how these principles will impact upon the care you deliver or how you can apply some of these approaches to care in your practice.

<table>
<thead>
<tr>
<th>Care currently</th>
<th>Care within a Health Care Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>My patients are those that make appointments to see me.</td>
<td>Our patients are those who are registered in our Health Care Home.</td>
</tr>
<tr>
<td>Patients’ chief complaints or reasons for visit determines care.</td>
<td>We systematically assess all our patients’ health needs to plan care.</td>
</tr>
<tr>
<td>Care is determined by today’s problem and time available today.</td>
<td>Care is determined by a proactive plan to meet health needs, with or without visits.</td>
</tr>
<tr>
<td>Care varies dependent on memory and scheduled time of doctor.</td>
<td>Doctors have access to evidence-based guidelines to build the right care plan.</td>
</tr>
<tr>
<td>Patients are responsible for coordinating their own care</td>
<td>A prepared team of professionals coordinates all patients’ care.</td>
</tr>
<tr>
<td>I know I deliver high quality care because I’m well-trained.</td>
<td>We measure our quality and make changes to improve it.</td>
</tr>
<tr>
<td>It’s up to the patient to tell us what happened to them.</td>
<td>We track tests and consultations, and follow-up after visits to other services (e.g. ED visits or specialist appointments).</td>
</tr>
<tr>
<td>The clinic’s operations centre on meeting the doctors’ need.</td>
<td>An interdisciplinary team works at the top of their professional capacity to support patients.</td>
</tr>
</tbody>
</table>

Figure 1: Care transformation when delivered through the Health Care Home

Source: Adapted with permission from F. Daniel Duffy, MD, MACP, Senior Associate, Dean for Academics, University of Oklahoma School of Community Medicine
3. **What are the benefits of the Health Care Home model?**

Health Care Homes will bring an enhanced patient-centred, coordinated and targeted approach to the management of patients by all members of the care team.

One of the key aspects of this model of care will be the inclusion of all health care providers necessary for delivering patient’s care, as a member of the patient’s care team. These care team members will be located both within the Health Care Home and across the health care neighbourhood.

This will benefit the patient, the Health Care Home and the broader care team by enhancing communication within the care team, ensuring the timeliness and accuracy of shared information leading to improvements in the quality and appropriateness of patient care.

The quadruple aim is an approach to optimise health system performance. The quadruple aim is an essential vision for the Health Care Home approach and Health Care Homes are encouraged to focus on this vision throughout their Health Care Home transformation.

Health care providers in the health care neighbourhood can make a significant contribution to support the vision of the quadruple aim. Appendix 1 includes examples of how different allied and other health professionals outside the Health Care Home might experience the benefits represented by the quadruple aim.
4. **Team-based care**

Patients with chronic and complex conditions require ongoing care and support to manage their long-term conditions. As such, specialists, allied health professionals, pharmacists and other health care providers outside the Health Care Home play a vital role in delivering the care needed by patients with chronic and complex conditions and should be included and encouraged to actively participate as members of the care team. These providers are considered part of the health care neighbourhood and an extension of the patient’s care team.

The range of care providers available to form care teams within Health Care Homes will vary greatly. For example, a solo GP practice might rely entirely on care providers within the health care neighbourhood to support their patients’ care needs. Other large practices may have access to a broad range of care providers to draw upon as care team members within their Health Care Home. However, even in the case of large practices, it is unlikely that any single Health Care Home will have the full range of specialists, allied health and other health care providers available to them within their organisation. Thus, the role of care providers in the health care neighbourhood is vital to the success of the Health Care Home model.

These following three diagrams show examples of what a patient’s care team might look like, drawing on services from both within the Health Care Home and the broader health care neighbourhood.
Patient care delivered by well-organised high performing care teams that are inclusive of all of a patient’s care providers, the patient, their family and carers, will provide improvements in patient care leading to enhanced patient satisfaction, reduced cost of care, improved experience of the care team and improved patient health outcomes.

High-performing care teams allow for the distribution of tasks amongst all members of the care team, ensure that they are performing tasks aligned with their skills, knowledge and expertise. This also provides them with the ability to focus upon the delivery of patient care that is directly relevant to their role, whether they are a specialist, community pharmacist, allied health or other health care provider.

Well-functioning care teams have been shown to improve efficiency, quality of care, and increase provider and patient satisfaction. Health Care Homes will draw on the expertise of a variety of care team members to ensure that patients get the care they want and need.\(^{23}\)

As Health Care Homes will not be restricted by a fee-for-service, GP-focused model of care for their enrolled patients, they will have more flexibility to design care around the needs of the patient. A range of innovative care delivery options may be considered, including telephone, email and video-conferencing and group education sessions and clinics. Members of the expanded care team may be invited to participate in these activities, to improve the comprehensiveness and coordination of care.

It should be noted that, aside from the Community Pharmacy in Health Care Homes Trial Program (see factsheet), stage one of the Health Care Homes trial will not include specific funding to support the involvement of care team members in the health care neighbourhood in these activities.

5. Patients as partners in care

High functioning team-based care requires a shift away from a GP-centric model and includes explicit efforts to build trust, respect, and value for any new roles that are included in the team, and for including patients as partners in their care.
Building collaborative partnerships with patients allows them to take a more active role in decisions about their care and helps them develop the skills and confidence necessary to manage their health. An effective partnership recognises the expertise that patients bring to the medical encounter as well as the evidence base and medical judgment of all health care providers who are included in the patient’s care team.

Patients are not told what to do but are engaged in shared decision making that respects their personal goals, encourages patients to work towards and achieve those goals, regardless of how simple they may seem to the care provider. For patients with chronic conditions, the focus of the team broadens to provide a framework for self-management support. The members of the patient’s care team in the health care neighbourhood are essential in this regard, particularly when they are seeing patients for treatments on a very regular basis, perhaps more often than the care team in the Health Care Home.

6. Improved communication and governance

In order for the health care neighbourhood to work effectively within the Health Care Home model, all health care providers need to ensure that the following elements are incorporated in their day-to-day practice governance:

Establish relationships

Strong and respectful relationships among all members of the patient’s care team will allow for clear and timely communication and provide an enhanced experience for all concerned. Health Care Homes will play a key role in establishing these relationships and building care teams around the needs of each patient.

Providers in the health care neighbourhood will also have a role in establishing these relationships by advising Health Care Homes of the services they provide and maintaining them through effective communication.

Agreements

Whether participating in the Health Care Home program or not, general practices and providers in the health care neighbourhood can both benefit by establishing agreements about how they will operate and share information. Your practices may have agreements in place to work with Health Care Homes that outline principles for timely provision of patient care and the care team’s commitment to these. The agreements may indicate points such as:

- roles and responsibilities
- regularity and methods of communication
- areas of accountability
- referral guidelines and exchange of information to expedite timeliness and appropriateness of referrals and improve coordination of patient care.

In addition, agreements may include other indicators such as:

- appointments are offered within the timelines requested by the Health Care Home
- the care team will discuss and review shared care plans and treatment goals
- patients, their family and carers are provided with information in an accessible and easy to understand form regarding their diagnosis and treatment options
- accurate and up-to-date findings from referrals or tests will be sent to the Health Care Home within an agreed time-frame where the information is not able to be communicated using a shared care planning tool.
- Health Care Homes staff are available to be contacted by care team members, if not immediately, within a reasonable (as agreed by both parties) timeframe.

**Well-trained staff**

Having well-trained staff who understand the principles of Health Care Homes is a key enabler of effective team-based, patient centred care. Sound governance principles suggest that should include:

- defined roles for clinical and nonclinical team members
- verification of clinical staff credentials to ensure they have current national registration (where applicable); have accreditation/certification with their relevant professional association and actively participate in continuing professional development
- provision or support of training to staff members appropriate to their role (e.g. upskilling on Health Care Home elements, high quality evidence-based care)
- provision of evidenced based care to patients.

**Recording of patient information**

The ability to record information about patient care in a secure and easily accessible format simplifies the sharing of information with other health care providers, in particular the patient’s extended care team and their Health Care Home. To this end, care providers in the health care neighbourhood would ideally:

- Contribute to a patient’s shared care plan and My Health Record to ensure all members of the care team have access to up-to-date information;
- Use an internal electronic patient record system to record clinical and nonclinical data for all patients, and can extract data for sharing with all members of the patient’s care team.

**Privacy, security and confidentiality**

Fundamental to the provision of patient care under any circumstances is for any health care provider to ensure that they have a privacy policy in place and documented procedures to manage health information and adhere to the Australian privacy principles.

**Enhanced communication**

Effective care coordination involves helping patients find and access high-quality service providers, ensuring information flows between the Health Care Home and across the health care neighbourhood, as well as tracking, following up and supporting patients through the process.

This can be achieved using technology to safely share appropriate and timely information through secure messaging, electronic consultations (telehealth), shared care planning software and the My Health Record. These advances have the ability to change not only the mode and speed of communication, but also to improve the quality of the information that is being exchanged, ensuring all members of the care team get the information they need when they need it, ultimately leading to better outcomes for patients. While some of these services may not be directly reimbursable for the providers in the health care neighbourhood, this enhanced communication will improve the quality of information available to all providers, increase efficiency and support better patient outcomes.

### 7. The importance of shared care planning

Shared care planning is a critical element of the Health Care Home model. It ensures that multidisciplinary team based care is delivered in a coordinated way, centred on the needs and goals of
the individual patient. Shared care plans aim to increase a patient’s participation in their own care and improve the coordination of the services that they receive, both inside and outside the Health Care Home.

What is exciting is that the Health Care Home initiative aims to encourage the electronic sharing of information between the Health Care Home, patients and the other care team members through the use of shared care planning software. The use of an electronic shared care plan has the capacity to improve access to the care plan for everyone involved, allowing all members of the team to share information in real time, in a dynamic and interactive way. Shared care plans also offer the potential to increase a patient’s participation in their own care.

What is the shared care plan?
To participate in the Health Care Homes model, all enrolled patients must have and be able to access a tailored and dynamic shared care plan. This plan must be developed and managed under the direction of the patient’s nominated clinician and is used by the care team and the patient for the management of their health care needs.

A shared care plan outlines a patient’s agreed current and long-term goals for care, identifies coordination needs, and addresses potential gaps in their health care. It enables real time opportunities for care providers involved in the care of a patient to assess progress against goals, monitor activities of the wider care team and dynamically share other relevant information. The care plan should also explain how the patient will reach the goals and who is responsible for implementing each part of the plan, e.g. the GP, specific members of the care team or health care neighbourhood, or the patient.

While the shared care plan is initiated and managed by the patient’s nominated clinician, the contributions of the entire care team, including health care providers from within the Health Care Home and across the health care neighbourhood, are essential for the effective management of the patient’s health care needs.

While the software used to create and participate in shared care planning may vary across Health Care Homes, the core elements of a good shared care plan are universal.

Shared care plan elements include:

- effective transfer of information between health care practitioners supporting patient care
- real-time information to enable evidence based decision making
- an outline of the patient’s agreed current and long-term needs and goals
- identification of coordination requirements
- approaches to achieve the goals
- who is responsible for each activity, including the patient’s activities
- electronic format for access and tracking ease
- electronic format for sharing with and providing feedback from the health care neighbourhood (which may include pharmacists, allied health professionals, specialists and other community support service providers who contribute to addressing the health needs and goals of the patient).

Shared care planning software
The Department of Health has developed a set of minimum requirements for shared care planning software to be used by Health Care Homes. Health Care Homes can select any software product that meets those minimum requirements.
All care providers outside the Health Care Home will have access to the shared care plan via a web-based portal and secure login details. This means that care providers in the health care neighbourhood can view, edit and upload information to the shared care plan without purchasing and installing the program on their computers.

The shared care software is designed so that, on completion of the shared care plan, it is forwarded as an electronic link to all the health care providers in the health care neighbourhood who are identified in the plan. The providers will then electronically accept an invitation to gain access and participate in the shared care plan. Care team members in the health care neighbourhood will have access to a web portal where they enter their secure login details and are able to view the shared care plan.

The GP and Health Care Home team may assign role-based permissions so that all care team members in the health care neighbourhood can contribute relevant information to the plan following the patient visit. Examples of relevant information may include progress notes on treatment or consultation, additional or new goals and recommendations for the GP regarding proposed changes to treatment.

A factsheet on shared care planning software and the minimum requirements is available from the department’s website.

A list of software programs that have self-declared as meeting the minimum requirements is available on the Medical Software Industry Association website.

**The shared care planning process**

The process for developing and maintaining a shared care plan is as follows:

1. Health Care Home care team develops an electronic shared care plan in consultation with the patient and carer if appropriate, identifying the most appropriate specialist and allied health providers in the health care neighbourhood to meet patient care needs.
2. Specialist and allied health providers review and accept the invitation to participate in the electronic shared care plan as members of the patient’s care team. They understand the patient’s care needs and their role in that care from the information contained in the shared care plan. The GP and Health Care Home team may assign role-based permissions so that all care team members in the health care neighbourhood can contribute relevant information to the plan following the patient visit.
3. Specialist and allied health care team members offer opportunities for appropriate access to care for Health Care Home patients, establish a strong relationship with the Health Care Home and exchange comprehensive and relevant information. Referrals include diagnostic and other tests results that are necessary to support efficient and effective transfer of patient care.
4. The patient attends appointments with the specialist or allied health provider and, as members of the care team, those care providers update the shared care plan with details of treatment and recommendations for ongoing care and add information to areas of the shared care plan as necessary for the care they are responsible for.
5. As members of the patient’s care team, specialist and allied health providers participate in telephone case conferencing where required to discuss ongoing patient care management and to support the Health Care Home in the coordination of appropriate patient care.
6. As care progresses, information is shared amongst all members of the patient’s care team using the shared care plan, ensuring all team members have access to the most recent information.
7. At an appropriate time, patient care is transferred back to the Health Care Home care team on completion of care by specialists and allied health care team members.
Case Study: how shared care plans can improve the coordination of services

James is a young adult living with chronic health issues since childhood, including Crohn’s disease, chronic fatigue, and asthma. His health has deteriorated to the point where he can no longer pursue his degree and he is unable to work. He is finding it hard to arrange and keep track of his health care appointments. He enrolls in a Health Care Home where the health care team recognize his challenges and assess his activation as Level 3\(^1\), which suggests that James has some confidence and ability to self-manage his condition but still requires some support and guidance from his care team. James and his nominated GP develop a shared care plan, reflecting his needs and goals, the main one of which is to manage his conditions well enough to allow a return to his studies.

Through use of the shared care planning software, a gastroenterologist, pharmacist, physiotherapist and exercise physiologist in the health care neighbourhood are invited and agree to join James’ care team. All care team members in the Health Care Home and in the health care neighbourhood have access to and can contribute to James’ shared care plan and can see the information contributed by other members of the care team.

Based on the goals of the care plan, a telephone consultation with a gastroenterologist is arranged and changes to his medication are initiated and then monitored by his GP. An asthma review conducted by James’ community pharmacist, who is integrated into the Health Care Home team, shows that James’ inhaler technique partly explains why he regularly wakes up in the night short of breath.

An appointment is organised, by the Health Care Home receptionist, for James to have an individual assessment with the physiotherapist. During the appointment, the physiotherapist is able to access the shared care plan and discuss James’ goals and care needs, and they agree to a treatment plan. The physiotherapist then updates the shared care plan with information about James’ treatment, so that it is available to all other members of the care team.

James attends an appointment with his exercise physiologist, who can also access the shared care plan, reviewing the information provided by the physiotherapist. It is agreed that James will join a group exercise program, run by the exercise physiologist, to improve his asthma and his energy levels. The exercise physiologist updates James’ shared care plan with this information.

When James returns to his Health Care Home, the care team members are able to view details of the care James has received and discuss with him whether his goals and targets should be reviewed and updated. The update to the shared care plan is then available to all of the members of James’ care team, supporting his ongoing care.

\(^1\) Patient activation refers to the level of knowledge, skills and confidence a patient exhibits in managing their own health and care. Instruments that measure patient activation, such as the Patient Activation Measure (PAM), readily assess the patient’s level of current activation, ranging from levels 1–4.
8. **How the My Health Record system assists both patients and the care team**

All enrolled patients are encouraged to have a My Health Record, enabling providers in the care team and health care neighbourhood to view, upload and share a patient’s clinical information with other treating health care providers. Unlike electronic shared care plans, the My Health Record system is accessible to all health care providers, including those not normally involved in their care. This has many advantages for Health Care Home patients. For instance, in an emergency a patient’s record can be accessed by medical and nursing staff. Health Care Homes and the extended care team can also benefit from this improved information flow through access to hospital discharge summaries, diagnostic results, event summaries and advanced care directives.

*The shared health summary*

A key document in the My Health Record is the shared health summary. It represents the patient’s status at a point in time, providing health care professionals with a concise summary of a patient’s key data and medical history, including allergies, medications, immunisations and current (active) and past diagnoses. It is a requirement of the Health Care Homes program that all enrolled patients must have a My Health Record with a current shared health summary within one month of enrolment. Following creation or formal revision of a patient’s shared care plan it is recommended that the patient’s nominated clinician in the Health Care Home review and update a patient’s shared health summary. However, amendments can be made to the shared health summary at any time, and it should be updated when there is a change to a patient’s medication, health status or a significant change to their treatment plan.

As well as the shared health summary, providers will be able to share and access additional patient information via My Health Record, such as hospital discharge summaries, diagnostic reports, end of life care planning and patient entered health information.

Conformant software gives providers in the health care neighbourhood the capability to link directly to the My Health Record and download documents that have been uploaded by other health care providers and organisations. Health care providers with conformant software will upload this information using an event summary that details information about the care provided, changes to medications, immunisations and other important information. The patient’s nominated clinician in the Health Care Home will then upload this information to the patient’s shared health summary. Health care providers that do not have software that is compliant with the My Health Record may still register and have access to their patients’ My Health Records via the national provider portal with the ability to download and save or print documents for their use.

Information for health care providers about My Health Record can be found on the My Health Record web site.
Case Study: How My Health Record can improve care coordination

James attends an appointment with his gastroenterologist, Dr Cameron, for care of his Crohn’s disease. Dr Cameron is part of James’ care team in the health care neighbourhood, with access to his shared care plan.

James complains of recent nausea and vomiting and Dr Cameron discusses the medicines James is taking. However he is unable to recall a recent dosage change to his anti-depressant medication. Dr Cameron accesses James’ shared health summary, showing the dose of his anti-depressant is 150mg per day.

Dr Cameron then accesses James’ My Health Record through the provider portal and looks at James’ current medicines list. The medicines list shows that James has been having all of his medicines regularly dispensed and that his anti-depressant medicine was last dispensed two weeks ago, with the dose being increased from 100mg to 150mg per day. This coincides with the onset of James’ current symptoms.

Dr Cameron downloads a copy of the medicines list for his records, which he can either print or import into his clinical information system. At the same time he reviews James’ most recent shared health summary, which also includes details of the change in the dose of the medication.

He prescribes James a short-term course of corticosteroids, for relief of his symptoms, and asks him to return in two weeks and to telephone him if he has any concerns.

Dr Cameron then updates the shared care plan with details of his consultation with James, the medicine he has prescribed and that James will return to see him in two weeks.

Because Dr Cameron does not have conformant software, he is unable to upload an event summary with details of his consultation to the My Health Record. When James returns to see his GP a new shared health summary will be uploaded, detailing the change in medicine.
9. Will the funding process change for the care team outside of the Health Care Home?

Funding for services provided by allied health professionals, nurse practitioners and specialists as well as pathology and diagnostic imaging services are not included in the Health Care Homes bundled payment and will continue to be funded through Medicare, private health insurance or the patient.

Health Care Home-enrolled patients will have multiple chronic conditions and, as such, would have been eligible to access MBS-funded allied health services that are currently triggered by a GP Management Plan and Team Care Arrangement. They may also have been eligible to access MBS-funded allied health services that are currently triggered by a Health Assessment for Aboriginal and Torres Strait Islander People or a GP Mental Health Treatment Plan.

Eligibility to access MBS-funded allied health services previously triggered by the completion of these MBS items will now be triggered by the patient’s enrolment with the Health Care Home and preparation of a shared care plan. Health Care Home-enrolled patients no longer need to have a GP Management Plan and Team Care Arrangement or a Health Assessment for Aboriginal and Torres Strait Islander People or a GP Mental Health Treatment Plan to access MBS-funded allied health services.

It should be noted that other prerequisites as defined under the Health Insurance (Allied Health Services) Determination 2014 will continue to apply for enrolled patients to access allied health MBS benefits. These prerequisites include the need for a valid referral form or, where appropriate, Aboriginal or Torres Strait Islander descent status. Eligibility for allied health group sessions will also be triggered by enrolment for eligible patients with Type 2 diabetes.

The number of Medicare benefits for allied health services that an enrolled patient may access each calendar year remains the same as is currently available under the MBS. If an existing patient enrolls as a Health Care Home patient, this does not restart the number of Medicare-funded allied health services available to that patient in a calendar year, i.e. if rebates are available for up to five allied health services in a calendar year and the patient has already received two services, the patient will have three services available for the remainder of the calendar year.

Allied health services provided to a Health Care Home-enrolled patient should be billed to the MBS in line with current arrangements. Where the MBS rebate is less than the cost of the service, the patient will have out-of-pocket costs to meet.

Specialists and allied health providers, or other health care providers contributing to the care of Health Care Homes enrolled patients, may wish to consider strategies to support their participation in patient care activities where these fall outside of existing funding through the Medicare Benefits Schedule. It will be the responsibility of Health Care Homes to determine if their business model will include additional or expanded roles or additional specialist and allied health services.

For community pharmacists, in May 2017 the Australian Government signed a compact with the Pharmacy Guild which included a $30 million investment to incorporate medication management programs within Health Care Homes. Through the program, Health Care Homes’ patients are able to develop a medication management plan and access a number additional services and support through their local community pharmacist. To access the Community Pharmacy in Health Care Homes Trial Program, a patient’s Health Care Home needs to refer the patient to their local community pharmacy through the patient’s shared care plan. Further information on the Community Pharmacy in Health Care Homes Trial Program is available in a separate fact sheet on the Department of Health website.
For information about the funding changes to Health Care go to the Health Care Homes for health professionals page on the department’s website.

10. Additional information

For easy access, bookmark these pages from the department’s website:

- Health Care Homes for health professionals
- Resources for general practices
- Resources for ACCHS
- Health Care Homes for consumers
- More information for consumers
Appendix 1
This table outlines examples provided by health care providers of how the work they do in the health care neighbourhood can make a significant contribution towards achieving the quadruple aim.

<table>
<thead>
<tr>
<th>Improved patient experience of care</th>
<th>Improved health outcomes and population management</th>
<th>Improved cost efficiency and sustainability in health care</th>
<th>Improved health care provider experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHARMACY</strong></td>
<td><strong>PHARMACY</strong></td>
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<tr>
<td>Pharmacists work with patients, carers and GPs to meet patients’ medication related needs. Often open after hours, they are among the most accessible primary care providers. Pharmacists provide medication packing to help patients remember to take their medicines correctly, alter dosage forms to overcome difficulties and help patients and carers to manage prescriptions. As medicines experts, pharmacists help ensure that patients use medicines safely and effectively, and educate them about interactions and side-effects with prescribed, over-the-counter and complementary medicine. Helping patients set goals around their medications and managing medication summaries within shared care plans, pharmacies can assist patients and carers in improving the skills required to manage their own care. Pharmacies will support patients in safe and effective use of medicines across the continuum of care, and support other members of the patient’s care team through professional collaboration.</td>
<td>Pharmacies play an important role in supporting patients in the management of complex and chronic diseases. Pharmacies ensure easy access to products and services to help patients manage their conditions. Pharmacists can provide patients with evidence based clinical advice without the need for an appointment and often at times more convenient for the patient. Pharmacies provide advice on a range of preventive health issues. They provide health advice in the context of holistic care that sees people improve their attitudes to health and health behaviours. Pharmacists recognise that they practice within a collaborative primary care setting working in partnership with other health care professionals, including GPs and allied health practitioners to meet patients’ clinical needs and goals of therapy.</td>
<td>Pharmacies play a vital role in managing minor complaints and ailments, reducing the demand on other health professionals and the hospital system. Timely access to pharmacist advice means that pharmacies collaborating in Health Care Homes as a member of the care team can help patients manage medication and chronic conditions. Medication management coordinated through the pharmacy can improve cost efficiency, reducing the number of episodes of care for routine repeat prescriptions. This can free up other members of the care team to address other aspects of patient care. Medication management, including for example prescription management, administration aids and medication reviews can help minimise medication-related hospitalisations, thereby improving the sustainability of health care.</td>
<td>Pharmacy has long embraced collaboration with other members of the health care team to improve patient outcomes and build positive inter-professional relationships. Widespread technological enablement within the pharmacy sector makes communication and collaboration more timely and productive. Pharmacists forming an integral part of the care team should lead to further strengthening of professional relationships and improvements in satisfaction and the pharmacist’s overall experience when caring for patients.</td>
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## Appendix 1: How allied health providers can contribute to the quadruple aim

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<thead>
<tr>
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<th>Improved health care provider experience</th>
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<td>Accredited exercise physiologists (AEP) have well developed skills to coach and motivate patients to self-manage. For example, AEP can apply knowledge and skills using models of behaviour change to facilitate adherence to a program, devise strategies to further engage patients using motivational interviewing and offering lifestyle management advice. AEP are trained in facilitating exercise and health based programs to reduce the risk of chronic conditions. AEP can recognise the key signs and symptoms of target chronic conditions.</td>
<td>AEP are able to provide interventions for target conditions such as T2DM through group exercise classes. In addition, AEPs are trained in prevention of chronic conditions and considers the presenting chronic condition/s and risk of further comorbidities. Exercise interventions have been shown to reduce weight/BMI, decrease blood pressure, cholesterol levels and improve mood among other benefits. As described above, adherence is key to achieving health outcomes. Face to face supervision, building trust with the patient and family, considering lifestyle circumstances, barriers and likes and dislikes and facilitation of self-management strategies are critical to helping patients achieve positive change in their health status. AEPs have well developed skills to coach, teach and motivate patients and facilitate self-management accounting for socio cultural and individual factors. AEPs work with patients to engage them in their health care and establish habits for a healthier lifestyle. This may include establishing a regular physical activity routine, adapting to new ways of performing activities of daily living, encouraging a change in food choices, helping patients engage their friends and family in their healthcare.</td>
<td>AEP have been shown to contribute to reduced health system costs, lost productivity and well-being gains through lifestyle interventions they are able to deliver for patients. In addition, AEP interventions for patients living with depression, type 2 diabetes, CVD, COPD and asthma lead to improved wellbeing, greater patient productivity, and reduced patient AEP have a broad knowledge of health care - understanding the pathophysiological basis of chronic conditions and the medical, surgical and allied health treatments and the effects on clinical status. By working closely with other members of the care team to tailor and implement the care plan, positive patient outcomes can be achieved more quickly. Evidence of the positive effects of exercise interventions in patients with mental health conditions is gaining momentum. In collaboration with allied health and specifically psychologists, care teams can develop innovative approaches to a patient’s care. AEP especially are likely to gain satisfaction from a holistic care model. Health Care Homes will enable AEP to advocate that exercise is medicine - an important strategy in achieving positive patient outcomes.</td>
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**ACCREDITED EXERCISE PHYSIOLOGIST**
## Appendix 1: How allied health providers can contribute to the quadruple aim

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<td><strong>PHYSIOTHERAPIST</strong></td>
<td>Physiotherapists are able to teach patients to improve their self-management capability through the use of appropriate rehabilitation exercises. Patients are able to access physiotherapists locally or using telehealth. The physiotherapist is well placed to collaborate in coordination of patient care as a member of the care team with other health care providers to improve patient outcomes.</td>
<td>Physiotherapists are well placed to reinforce good habits of regular exercises and awareness of its effect on chronic diseases. This will support patients with knowledge around how to prevent relapses of their condition.</td>
<td>Patients will be a more engaged in managing their own condition and this results in better outcomes and satisfaction for the treating physiotherapist.</td>
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<tr>
<td><strong>ACCREDITED PRACTISING DIETITIAN</strong></td>
<td>A visit to an Accredited Practising Dietitian (AED) using a health coaching patient centred care model would use food knowledge maps to help patients to identify gaps in knowledge and dietary areas to work on for behaviour change. This increases patients’ confidence and skills in how to manage food and cooking meals in areas such as diabetes, cardiovascular health, and weight management. The model also improves problem solving skills around barriers to change and thereby improving patients’ skills.</td>
<td>An AED is able to offer cooking or education sessions with a group of patients with chronic and complex conditions such as diabetes or cardiovascular disease leading to an improvement in patients’ cooking skills, a healthier diet and improved overall wellbeing.</td>
<td>An AED is able to work with malnourished patients to improve their protein and energy intake to prevent hospitalisation from the consequences of malnutrition. Research has shown that visiting a dietitian can result in a lower HbA1c for people with diabetes which reduces the risk of health complications. Patients with irritable bowel disease can get a 50-70% improvement in symptoms by trialling dietary manipulation with an AED, potentially reducing hospital admissions for colonoscopies.</td>
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