FACTSHEET: STAGE ONE MODELLING

Patients

- In stage one, approximately 12,000 patients are expected to be enrolled.
- Around 55 patients are expected to enrol per full-time GP, based on a practice of five full-time equivalent GPs. This figure may change depending on the profile of the practices selected to be involved in the stage one trial.
- We project a steady on-boarding of patients, with all patients enrolled by 30 June 2019.
- Of the population participating in stage one, we estimate that approximately 9.5 per cent will be tier three; 45 per cent will be tier two; and 46 per cent will be tier one.
- Patients will be expected to agree to share their health data for the purposes of the evaluation and participate in surveys of their experience and other activities relevant to the evaluation.

Practices

- Up to 170 general practices and Aboriginal Community Controlled Health Services are expected to participate in stage one.
- Practices will need to review their business models to ensure their current arrangements support or are modified to support Health Care Home payments being made to the practice.
- Practices will be expected to operate as a Health Care Home in accordance with Health Care Home guidelines, and participate in activities related to training, evaluation and compliance.

Payment assumptions

- The average patient receives approximately $351 of general practitioner services per annum.
- The average Chronic Disease Management Plan unique patient receives $862 of general practitioner services per annum.
- Payment values for the three patient tiers were developed from best practice clinical models. They were progressed through a payments working group and have been tested against individual clinician data outside of the ten selected PHN regions.
- Some patients will fall below the payment value; some will sit above the value. Practices are not required to return unspent funds.

- A fully operational model of clinical services is expected to provide an additional 10 per cent in funding for clinical services above current MBS expenditure for these patients.

  This does not include diagnostic imaging performed outside of the Health Care Home, pathology, allied health, specialist services, all of which continue to be available through existing MBS arrangements.

- Routine MBS services unrelated to a patient's chronic condition will also continue to be accessed through the MBS as usual. However, the expectation is that the majority of services provided will be covered by the tiered payment.

- Actual funding increases will be influenced by the size and model of practice, and the demographics of patients in the local area accessing their services.