Supplementary FAQs July 2017

This information was released in July 2017, in response to questions participating Health Care Homes raised during information sessions with their local PHNs. These FAQs should be read in tandem with the FAQ booklet version 1.2 June 2017.

1. If a nurse practitioner is part of the patient's HCH care team, are their services covered in the bundled payment?

Yes. Refer to Question 3.1 in the FAQ booklet version 1.2 June 2017 (page 7).

2. Has a decision been made as to which data extraction tool HCH practices will be required to use?

The Department is considering a range of options for the extraction of practice data, including leveraging existing mechanisms so as to not create an additional impost on participating practices. A decision is expected to be made by the end of August.

3. Does the bundled payment include MBS item 2700 for a GP Mental Health Treatment Plan?

Yes. Refer Question 3.1 and 3.5 in the FAQ booklet version 1.2 June 2017 (page 7 and 9). MBS billing of item 2700 is not required to enable an enrolled patient to access allied health services that are currently triggered by a GP Mental Health Treatment Plan. The enrolment of a patient in the Health Care Home will trigger access to allied health services.

4. When does the enrolment period end for enrolling patients in the HCH Stage 1 Implementation?

During the stage one trial, up to 65,000 patients will be enrolled across 200 Health Care Homes. While no end date has been specified for the enrolment period, full enrolment is expected to be achieved by 30 November 2018. This is to enable all patients to receive 12 months of service delivery during the trial. Enrolment will be monitored and if necessary practices will be advised when to cease enrolling patients.

5. Are the cycles of care for asthma & diabetes included in the bundled payment? If so, how is the SIP payment triggered?

The MBS items associated with the completion of the Annual Diabetes Cycle of Care and with the completion of the Asthma Cycle of Care are included in the Health Care Home bundled payment. Solutions to enable the incentive payments associated with these cycles of care to include interactions with Health Care Home patients will be implemented.

6. Are there any specific rules/regulations around co-payments other than informing the patient prior to enrolment?

Many patients with chronic and complex conditions are 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.

7. Can you confirm that the bundled payments will not impact on payments such as PIP, PNIP, SIP?

Yes. Health Care Homes will be able to participate in these incentive programs where they meet eligibility requirements. Any incentive payments will be in addition to the Health Care Home bundled payment. Where incentive payments depend on MBS billing, solutions to enable these payments to include interactions with Health Care Home patients will be implemented.

For more information, refer to the response to Question 5 above and Question 2.7 in the FAQ booklet version 1.2 June 2017 (page 6).

8. Can a patient change their mind on their nominated clinician after enrolment? If yes, is this easily changed directly in HPOS?

Yes, a patient can change their nominated clinician, which can be easily updated in HPOS.

9. If a HCH patient attends the practice for a consult directly related to their chronic condition as well as an unrelated chronic condition consult, how is the unrelated consult billed?

MBS items can be claimed for routine care not related to the management of the patient's chronic conditions.

10. Will HPOS training will be available to practice staff?

Yes. HPOS training is included in the Health Care Home education and training modules and materials. Practice staff can also access detailed guidance on accessing and using HPOS on the DHS HPOS page.

11. Can a HCH GP Registrar be nominated as a patient's clinician?

The nominated clinician is expected to be able to provide long term support. A GP Registrar undertaking an approved program placement for a period of for example 6-12 months could take on the role as a patient's nominated clinician, as it would enable them to experience the full range of learning opportunities available in the Health Care Home.

12. If a patient is on a GPMP/TCA and the practice has already received payment for this, and then enrols the patient into the HCH, what is the implication on the bundled payment?

There is no implication for the Health Care Home bundled payment. Once a patient is enrolled, the Health Care Home bundled payment will cover all general practice health care associated with the patient's chronic conditions from that date onwards. Practices will need to ensure that existing patient care plans and allied health referrals are updated, monitored and revised, as required, to reflect the Health Care Home model of care and requirements.

13. Can you clarify whether pathology and diagnostic services are included in the bundled payment?

Where diagnostic services are provided in house by a Health Care Home as part of the monitoring and management of an enrolled patient's chronic and complex conditions, they should be funded through the bundled payment.

Pathology services are not included in the bundled payment, and will continue to be funded through the MBS.

14. HCH will have an impact on ACCHO nKPI reporting; there are two KPIs likely to be impacted - PI07 GP Management Plan (MBS item 721) and PI08 Team Care Arrangement (MBS 723). Is the Department looking at an alternative way for ACCHOs to report against these indicators?

As shared care planning and team care referrals are core Health Care Home services and will no longer be billed against MBS items for enrolled patients, the department is working on solutions that will enable recognition of Health Care Home enrolment as a proxy for chronic disease management for nKPI reporting purposes. This will also be considered as part of a review of the nKPIs which is anticipated to commence towards the end of 2017.

15. What information can be we provide to allay fears of GPs that they won't be disadvantaged in regard to GPRIP if they participate in Health Care Homes?

Medical practitioners participating in the stage one trial of Health Care Homes in MM3-7 locations will be able to have the services they deliver to Health Care Homes patients acknowledged toward their General Practice Rural Incentives Program (GPRIP) eligible activity and payments. There will be a mechanism for participating medical practitioners to be able to ensure that all eligible activity under the GPRIP can be considered in an assessment of their eligibility and a subsequent payment amount. More information will be included in a future update of the GPRIP Program Guidelines available on the Department of Health website.

16. Some practices and ACCHS have a large number of patients who have GP Management Plans and who are most likely to fall into tier 3 in the risk stratification process, is this going to be a problem if they are all enrolled?

During the stage one trial, up to 65,000 patients will be enrolled across 200 Health Care Homes. It is expected that practices will enrol patients at all tiers and this is necessary to inform refinement and evaluation of the Health Care Home model. The Department has provided indicative estimates of the distribution of tiers across populations but recognises that the distribution of risk tiers may differ for some communities.

It is anticipated that overall patient enrolment will resemble the broader population; however, recognising that communities of the APY Lands experience significant hardship in relation to their health as well as social and economic engagement, it is possible that the proportion of the population that is eligible for Health Care Homes and the distribution of tiers is different.

The rate and distribution of patient enrolment will be monitored during the stage one trial by the department and where enrolments are considered higher than expected, the department will work with general practices and ACCHs to ensure enrolment levels match GP and practice capacity.

17. Can you confirm whether a patient's medical treatment that is covered by the Transport Accident Commission (TAC) conflicts with the bundled payment?

All general practice health care associated with an enrolled patient's chronic conditions, previously funded through the MBS, will be funded through the Health Care Home bundled payment. In line with this, for the stage one trial, the Health Care Home bundled payment should not be claimed for a patient whose medical treatment (or where a majority of their medical treatment) is currently covered by an alternative funding source and not Medicare, such as the Transport Accident Commission, as this could be considered duplicate funding. This issue will be reviewed as part of the evaluation of the stage one trial.

18. Can you clarify whether patient contributions for Health Care Home services count towards a patient's Medicare Safety Net?

Note: The answer to this question is currently under review.

19. Can you advise what data will be collected as part of the Health Care Home Evaluation?

An evaluation fact sheet is being prepared to provide further clarification on the types of data being collected and associated timeframe.

20. Can you provide an estimate of the time required to read and undertake the modules as a minimum?

The 11 training modules are designed to be worked through at an individual's own pace, and the order of the modules has been developed to ensure that the core elements which underpin the Health Care Homes transformation process are earlier in the order, with later modules building on these activities and concepts. Reading through each module should take approximately one to two hours.

To ensure that they are ready, practices should focus on:

- Module one, which is aimed at all practice staff and provides an overview of the Health Care Homes model;
- Module three, which provides details on the patient enrolment and payment processes; and
- Modules five and six, which focus on team-based care and the development and implementation of a Shared Care Plan, which all enrolled patients are required to have.

The Health Care Home Assessment Tool, which is addressed in module one, and with the support of local PHN Health Care Homes Practice Facilitators, will assist practices in identifying priority areas for improvement and focus.

Ideally, over time all of the modules and activities should be completed, to embed the learning and progress towards longer-term transformation. Practices may decide to do some of the activities or sections of the modules in groups. The PHN Practice Facilitators, knowing the reality of practices and the composition of staff, will be able to provide guidance on which modules or sections of modules are most important for all members to complete and suggest which sections are suitable to do as a group.

21. Currently for a patient to be eligible for the five MBS funded Allied Health sessions and their referral forms, Allied Health need to have a two way communication with the GP. Will this still be needed? Do the Allied Health providers need to see the care plan prior to agreeing to participate / accept the referral? Or do they just get a referral form?

Consistent with current arrangements, there will be a requirement for Health Care Homes to include the following information in their written referrals to allied health providers. It is expected that Health Care Homes will have flexibility in the format of the written referral and how it is provided to allied health providers. This information should also be reflected in the patient's shared care plan.

- The name of the business or allied health professional
- The reason for the referral and purpose/goals of treatment
- The number of treatments/services to be provided.

Two way communication between Health Care Homes and allied health providers is a core component of the shared care planning and review processes, and will continue

to be a requirement for Health Care Homes.

22. Is the date identified in the letter of agreement of 21 July 2017 the final date by which the letter of agreement and declaration can be returned?

While the department encourages applicants to return the signed letter of agreement and declaration by the 21 July 2017, if further time is required an additional grace period to 31 July 2017 is offered. If practices do not agree to participate by this stage there may be an impact on the practices ability to commence training and delays in preparation for service commencement.