Health Care Home bundled payments — enrolled patient case studies

These case studies have been prepared by the Department of Health in response to questions raised by general practices and Aboriginal Community Controlled Health Services about the scope of the Health Care Home bundled payments.

The case studies identify a varied range of health services that a person with chronic and complex conditions might access over a defined period and indicate which of these services are covered by the Health Care Home bundled payment. Whether the services are considered to be covered by the bundled payment or not is informed by the modelling for the stage one trial, and is consistent with advice on bundled payment inclusions/exclusions in the Health Care Homes Handbook and FAQ documents. The case studies do not fully reflect the broad range of innovative and flexible services that stage one Health Care Homes will deliver, or the new workforce roles made possible under the bundled payment approach.

Case Study 1: Isabel, an 85 year old, Tier 2 Health Care Home patient

Isabel is an 85 year old widow who lives alone in a major Australian city. Isabel has atrial fibrillation that was unrecognised before she suffered a right-sided CVA two years ago. Isabel is now is on an anticoagulant and her AF rate is well controlled. She also has osteopenia, a BMI of 22, and osteoarthritis in her hands, hips, and knees but remains independent. Isabel has been admitted to hospital twice in the last two years. This occurred once before she was a Health Care Home patient. She experienced pain with breathing resulting from a fractured left rib from a fall in her home, and the second time she was treated in hospital for pneumonia.

Isabel lives in an old, single-level terrace house with minimal family support. She takes her dog for a short walk every day. Mostly, she is managing independently with an aged care home care package which provides her assistance with shopping, gardening, basic personal care and transport to appointments, plus a daily phone call to check on her welfare from Telecross volunteers.

Isabel has been enrolled in a Health Care Home as a moderate complexity or Tier 2 patient, with a bundled payment of $1,267 per annum.

She received the following services over her first 12 months as an enrolled patient, all of which were covered by the Health Care Home bundled payment:

- a comprehensive health assessment undertaken by Isabel's GP and a practice nurse.
- collaborative development of a shared care plan led by Isabel's GP and the practice nurse, and informed by other members of the Health Care Home team including the exercise physiologist, podiatrist, geriatrician and community pharmacist.
- six-monthly reviews and updating of the shared care plan by all members of Isabel's Health Care Home team, including consultation with the aged care service provider.
- care coordination by the practice nurse, including follow up post hospital discharge and facilitating referrals to geriatrician, specialist medical practitioner and allied health providers.

- treatment provided by Isabel's GP related to her chronic conditions, including regular INR monitoring.
- treatment provided by another GP in the Health Care Home for hip pain when Isabel's GP was absent from the practice.
- administration of the seasonal influenza vaccine in autumn.
- a Home Medicines Review (HMR) undertaken by Isabel's GP in collaboration with her community pharmacist. (Community pharmacist participation in the HMR is covered under the 6CPA, not the Health Care Home bundled payment.)

Isabel also received the following services which were not covered by her Health Care Home bundled payment. Of these services, those related to Isabel's chronic conditions were coordinated through her Health Care Home and/or outlined in her shared care plan. These included:

- suturing of a small lesion under her left eye by a GP in a nearby practice after a fall while shopping.
- treatment by an exercise physiologist and a podiatrist for benefits which are payable under the MBS Chronic Disease Management Allied Health service items.
- review by a private geriatrician.
- provision of aged care services.
- twice-weekly visits from a community nurse for two weeks post hospital discharge for pneumonia.
- Community pharmacist's participation in a HMR, which is funded under the 6CPA.
- medications dispensed by a community pharmacy.
- analysis of blood samples undertaken by a private pathology lab.
- bone densitometry testing by the local hospital radiology department.

Case Study 2: Keith, a 47-year-old, Tier 3 Health Care Home patient

Keith is a 47 year old farmer who lives with his wife and teenage children just outside a major Australian city. Keith smokes on average 10 cigarettes a day. His favourite past time is racing pigeons. Keith is moderately obese and has type 2 diabetes (managed through diet and exercise), chronic pain related to osteoarthritis, and chronic hypersensitivity pneumonitis with mild lung fibrosis, pulmonary hypertension and emphysema. Keith suffers frequent episodes of bronchitis and pneumonia, and has had three hospitalisations related to lung infections over the last two years.

Keith has been enrolled in a Health Care Home as a high complexity or Tier 3 patient, with a bundled payment of $1,795 per annum. Keith received the following services over his first 18 months as an enrolled patient, all of which were covered by the Health Care Home bundled payment:

- a comprehensive health assessment undertaken by Keith's GP and a practice nurse.

- collaborative development of a shared care plan led by Keith's GP and the practice nurse, and informed by other members of the Health Care Home team, including the physiotherapist, diabetes educator, dietician and Keith's respiratory physician.
- care coordination by the practice nurse, including follow-up post hospital discharge and facilitating referrals to specialist medical practitioners and allied health care providers.
- three monthly care plan reviews (including monitoring Keith's adherence to his COPD action plan and HbA1c levels by the practice nurse), and updating of the shared care plan by all members of Keith's Health Care Home team.
- conduct of one quarterly review and provision of repeat prescriptions by a different GP in the Health Care Home together with the practice nurse when Keith's GP was absent from the practice.
- treatment provided by Keith's GP for his chronic diseases, including provision of repeat prescriptions in between visits to the practice.
- treatment provided by other GPs in the Health Care Home for acute exacerbations of chronic conditions, specifically acute episodes of pneumonia and bronchitis, when Keith's GP was absent from the practice.
- spirometry performed as necessary by the Health Care Home practice nurse and reviewed by Keith's GP.
- administration of the seasonal influenza vaccine each year and pneumococcal vaccination as per guidelines.
- an ECG administered by the Health Care Home practice nurse and reviewed by Keith's GP.
- diabetes annual cycle of care services provided by members of the Health Care Home team.

Keith also received the following services that are not covered by his Health Care Home bundled payment. Of these services, those that related to Keith's chronic conditions were coordinated through his Health Care Home and/or outlined in his shared care plan.

- treatment by an interstate GP for an acute episode of bronchitis while Keith was on holiday.
- removal of a non-cancerous skin lesion by Keith's GP.
- treatment for severe gastroenteritis by Keith's GP.
- treatment for a broken arm caused by a quad bike accident by a different Health Care Home GP.
- treatment for his arthritis and for advice on maximising lung function provided by a private physiotherapist, for which benefits are payable
- under the MBS Chronic Disease Management Allied Health service items.
- participation in a group diabetes education program provided by a diabetic educator, for which benefits are payable under the MBS items for Group Allied Health Services for people with Type 2 Diabetes.
- assessment by a respiratory physician.
- a bronchoscopy undertaken at the local hospital.

- education support aimed at assisting Keith with symptom management related to chronic hypersensitivity pneumonitis and minimising his exposure to antigens, provided by a nurse practitioner who works with Keith's respiratory physician and who was therefore not engaged by his Health Care Home.
- participation in a 10-week pulmonary rehabilitation program conducted by the local hospital.
- services provided by the local hospital while Keith was an in-patient.
- quit smoking support provided by a local community based organisation.
- medications dispensed by a local pharmacy.