Health Care Homes care delivery case study – mental illness

This case study has been prepared in response to requests from mental health stakeholders on how the Health Care Home model can benefit patients experiencing mental illness.

The case study identifies a range of health services that a person with chronic and complex conditions might access over a defined period, and identifies which of these services can be achieved via innovative use of 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 trial and is consistent with advice on bundled payment inclusions/exclusions in current Health Care Home materials, for example, the Handbook and Frequently Asked Questions documents.

This case study is not based on an 'actual' patient and has not been designed to fully reflect the broad range of innovative and flexible services that the Health Care Homes model can deliver, nor all of the new workforce roles made possible under the bundled payment approach.

Case study: Tim, aged 41 years

Tim is a 41 year old man who was diagnosed with bipolar disorder at age 20 while training as an apprentice plumber, and has a history of hypertension. Tim was prescribed a mood stabiliser some years ago by a psychiatrist during one of his hospital admissions for acute mania. Tim previously opted into the My Health Record system but has never accessed it. Tim is a heavy smoker (reportedly since 15 years of age), has a history of Marijuana use (not recent) and is overweight (BMI 34).

Tim routinely presents to a general practice near his home for repeat prescriptions (currently every six months), at which time his GP performs a clinical examination, monitors his blood pressure and weight and orders blood and urine testing to check for risk factors associated with the medication he is prescribed. Tim has been adhering to his prescribed medication regimen and his mental health symptoms have been well controlled for close to 7 months.

Tim is currently unemployed and is a holder of a low income health care card. He lives alone in stable community housing, which was arranged approximately five years ago by his mental health case manager (an employee of the local state funded community mental health service). Tim has been able to retain this housing despite experiencing a number of hospitalisations for episodes of acute mania or depression. After each admission, Tim was followed up briefly by his mental health case manager.

Tim's Health Care Home Journey

The practice manager at Tim's Health Care Home (HCH) ran the risk stratification tool (RST) software, which flagged Tim as being at risk for future hospitalisations. During Tim's next appointment, his GP gave him a copy of the HCH patient brochure, and explained the Health Care Home program and the model of care that could be provided to Tim if he enrolled. Tim commented that the program sounded helpful and agreed for his GP to conduct an eligibility assessment.

With input from Tim, his GP and practice nurse then completed the questionnaire in the RST to accurately determine Tim's risk tier and the level of care that he required. Tim was assessed as requiring a high level of care as a 'Tier 3' HCH patient. After considering the HCH Patient Information Statement and further discussions with his GP and the practice nurse, Tim signed the HCH Enrolment and Consent Form, a copy of which was placed on his clinical records and noted on his shared health summary (which was uploaded to his My Health Record). Tim was given a copy of the HCH Patient Handbook and a time was made with his GP and the practice nurse for Tim's first appointment as a HCH enrolled patient.

Tim's first appointment with his Health Care Home

At his first HCH appointment, it was explained that Tim's Health Care Home team would be comprised of his GP as the team leader, the practice nurse and other health care providers outside the Health Care Home as required, such as Tim's mental health case manager. A comprehensive health assessment was then undertaken by Tim's GP and practice nurse. During this assessment, information about Tim's current circumstances were noted, including that Tim:

- is drinking large quantities of soft drink and eating mostly processed food,
- has had a recent blood test result indicating impaired fasting glycaemia,
- reports smoking up to 1.5 packets per day after a brief period of abstinence while using nicotine replacement therapy that was not sustained,
- has poor social support and says he is lonely, with his only family being an elderly mother who lives interstate and keeps in regular contact via phone, and
- is unable to meet out-of-pocket costs associated with Medicare-subsidised allied mental health services.

Tim's GP and practice nurse then led Tim through the collaborative development of an electronic shared care plan, which incorporated a mental health treatment plan. (N.B. A separate GP Mental Health Care Treatment Plan is not required for enrolled patients to access allied mental health services.) Tim was shown how to access and modify his plan online as well as invite or restrict different care team members from accessing his plan. With Tim's permission, his mental health case manager was also invited to participate in his shared care plan.

Tim's HCH team conducted baseline outcome measurements to capture his current perception of his health, and experience measurements to understand his current experience with health services. The team learned that Tim had a number of goals he wanted to achieve including: getting a job, quitting smoking and reducing his loneliness. Tim's GP identified some referral and treatment options available and, with Tim's agreement, explained that the practice nurse would seek input from his mental health case manager before arranging referrals to appropriate service providers. To better support Tim to achieve his goals, his GP also suggested that Tim come into the practice initially every three months to review how he was managing his health and wellbeing, and to discuss his progress.

The practice nurse then explained to Tim how the practice would interact with him now that he was enrolled as a Tier 3 HCH patient. Tim was provided with an email address and dedicated phone number for the practice, as well as after-hours contact details. The practice nurse also explained to Tim that the practice was a bulk billing practice and, consistent with the practice's policy, he would not incur any additional out-of-pocket expenses for services he received from the Health Care Home that were for the treatment or management of his chronic conditions. Before he left, a time was made for Tim's next routine review appointment and his GP uploaded an updated shared health summary to Tim's My Health Record. The practice nurse also scheduled a reminder call in response to Tim's request for assistance with remembering to attend his appointments.

Tim's ongoing support by his Health Care Home Team

Within the Health Care Home practice

24 hours prior to his next appointment, Tim received a reminder phone call from the practice nurse. The practice nurse also used the phone call as an opportunity to follow up with Tim on his experiences and progress since his last appointment, and identify any issues or barriers that may need to be addressed at his appointment.

At his next appointment, Tim provided his GP with an update on progress towards his shared care plan goals and talked about his experience of the services to which he had been referred by his HCH team. Tim's GP conducted a clinical examination and ordered blood and urine testing. Tim's GP also provided him with advice on the current safety profile of the medicine he is taking and explained the

importance of maintaining his regular review appointments to monitor for risk factors associated with this medication. The GP also suggested that Tim seek advice from his local pharmacist (in consultation with Quitline) on which over the counter smoking cessation aids would be appropriate for Tim to use in his situation. Minor adjustments to Tim's shared care plan were made and an updated shared health summary was uploaded to Tim's My Health Record.

Over the next 12 months, the following services were provided by Tim's Health Care Home.

- A multi-disciplinary case conference organised by Tim's GP and involving members of Tim's Health Care Home Team, including his mental health case manager, which enabled a planned and coordinated approach to meeting Tim's multidisciplinary care needs.
- Treatment provided by Tim's GP related to his chronic conditions, three monthly review appointments and uploading of updated shared health summaries to Tim's My Health Record.
- Regular blood and urine tests.
- A six monthly review and updating of the shared care plan by all members of his HCH team, including input provided by Tim's allied health professionals.
- Administration of the seasonal influenza vaccination* (Tim incurred a $15 co-payment charged by the practice to cover the cost of the vaccine as he is not eligible for free vaccinations under the National Immunisation Program.)
- Treatment for a swollen knee caused by a fall.*
- Follow up phone calls by the practice nurse, including after Tim presented to the hospital emergency department with depression but was not admitted.
- A telephone call with the practice nurse initiated by Tim when he felt unstable and depressed. This was followed up with a same day long appointment with Tim's GP and a discussion session between the nurse and GP prior to the appointment.
- Assistance filling out paperwork for Centrelink regarding Tim's chronic condition.
- Regular reminder phone calls and emails from practice administrative staff regarding upcoming HCH appointments.
- Participation in a weekly walking club that was recently set up by the practice to support patients who might benefit from encouragement to exercise and/or who are socially isolated.

Treatments marked * above were billed against Medicare Benefit Schedule (MBS) items, while all other treatments were covered by the HCH bundled payment. As Tim's practice is a bulk billing practice, Tim was not aware of the different billing arrangements between services.

Within the Health Care Home Neighbourhood

Also over that 12 month period, the practice nurse (in consultation with his GP and mental health case manager where appropriate) coordinated Tim's care via texts, emails and phone calls, and facilitated access to:

- Mental Health Care services commissioned by the local Primary Health Network (PHN) matched to Tim's needs, which included sessions with a clinical psychologist to provide more specialist support to help Tim achieve his goals. These sessions were provided at no additional cost to Tim.
- Appointments with a local dietician and exercise physiologist (registered to deliver services through Medicare and for which benefits are payable under the MBS Chronic Disease Management items) for guidance on managing his blood sugar, hypertension and weight. These services were selected by Tim's GP as the providers had agreed to bulk bill Health Care Card holders on arrangement and therefore would not require a gap payment from Tim. With Tim's permission, the dietician was granted limited access to his shared care plan.
- A Disability Employment Service provider registered with the Department of Social Security that specialises in providing people with mental health conditions with job readiness and interview skills training, and assistance in finding and retaining employment. The service provider was recommended by Tim's mental health case manager.

- The state Quitline call-back service.
- A local NGO funded social support group program for people with severe mental health conditions, also recommended by Tim's mental health case manager.

Tim's 12 month HCH review

Just after 12 months, Tim was reviewed by his HCH team. At this appointment, Tim reported that over the past year he:

- continued to adhere to his prescribed medication regimen,
- had not been admitted to hospital,
- was enjoying the practice walking group and that he met up regularly with people he had met through the NGO funded social support group,
- was averaging 25 hours a week working as a plumber with a previous employer, with support provided by his Disability Employment Service provider,
- had lost 8 kilos (and was continuing to lose weight), and
- was still struggling with smoking – although he had recently gone several weeks without a cigarette.

Tim's GP then re-ran the RST with Tim present, which determined Tim as being a moderate complexity or 'Tier 2' HCH patient. After completing new outcome and experience measures, Tim reflected with his GP and practice nurse on his previous measurements to see how his care and health had changed over the year. With Tim's agreement, his shared care plan was reviewed and adjusted, where appropriate, and his review appointments were reduced to six monthly. An updated version of his shared health summary was uploaded onto Tim's My Health Record.