Primary care is the hub of diabetes management
How do we do more with less?
Effective diabetes models of care can be win-win

Dr Malcolm Clark
Camberwell Road Medical Practice
Medical Director Victoria, IPN Medical Centres
Honorary Clinical Fellow, Department of General Practice
University of Melbourne.

Camberwell Road Medical Practice

13 GPs, 6 PNs, 1 CP, 4 AH, 1 PN, 6 RS
Onsite and offsite community medicine
Aged care 300+ residents
4 GP teachers
Medical students from UoM, MonMS, UK & Asia

Research:

Diabetes & Metabolic Group

PC4

PhD, Honours projects, Scholarly Selective.

Clinical Trials Site Management Organization (SMO)

SONIC CLINICAL TRIALS

"Local Management. Global Advantage."

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IPN Medical Centres

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IPN is a small part of Sonic

26 Practices in Victoria

Is Patient Engagement The key?

Can we change the dynamic?
Patient-clinician partnership
Patient curated medical record
Better connected clinicians
Less searching around for information
Patient record on the patient's mobile device

Australian Government
Australian Digital Health Agency
My Health Record

MediTracker

Is this the key to doing more with less?

Planned care & a formal contract ?

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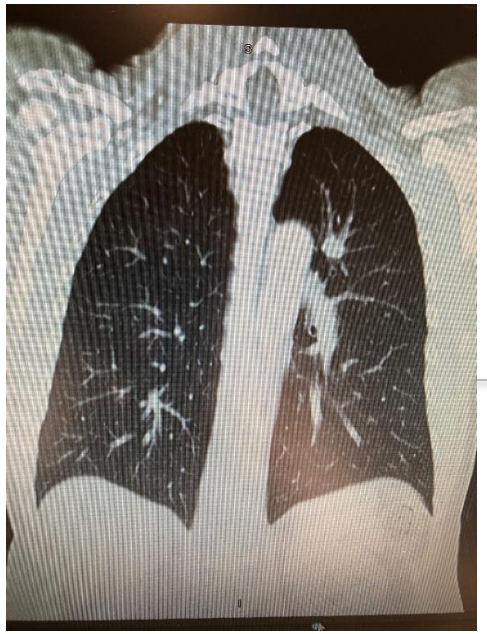
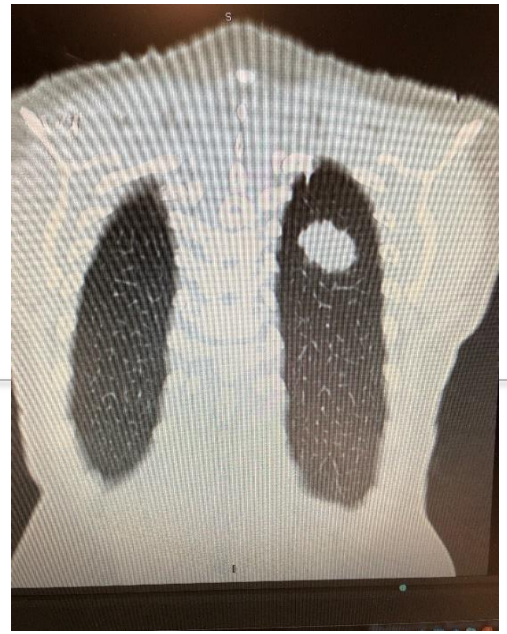
Sarah’s story





How could we have engaged her better?

Theory:

"Patient engagement is an increasingly important component of strategies to reform health care"

Judith H. Hibbard, University of Oregon[1] and Jessica Greene
https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2012.1061

"There is a growing body of evidence showing that patients who are more activated have better health outcomes and care experiences…"

"…but there is limited evidence to date about the impact on costs." to health sector.

"…patients who start at the lowest activation levels tend to increase the most."

"The focus on activation and engagement rather than compliance recognizes that patients manage their health on their own the vast majority of the time, making decisions daily that affect their health and costs."

"The evidence linking patient activation with health outcomes, patient experience, and costs has grown substantially over the past decade."

"…people who score higher on the Patient Activation Measure are significantly more likely…to engage in preventive behaviour…regular check-ups, screenings, and immunizations, eating a healthy diet and getting regular exercise."

Judith H. Hibbard, University of Oregon[1] and Jessica Greene
https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2012.1061

“Less activated patients are also three times as likely to have unmet medical needs and twice as likely to delay medical care, compared with more activated patients.”

“Chronically ill patients with higher activation levels are more likely than those with lower levels to adhere to treatment; perform regular self-monitoring at home; and obtain regular chronic care, such as foot exams for diabetes”

“When Patient Activation Measure scores increased, multiple behaviours improved, regardless of the…activation level at baseline.”

Judith H. Hibbard, University of Oregon[1] and Jessica Greene
https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2012.1061

"Many of the findings have been replicated in studies conducted in different countries, including Denmark, Germany, the United Kingdom, Japan, Norway, Canada, the Netherlands, and Australia."

"The emerging evidence suggests a potentially new quality goal: increasing patient activation as an intermediate outcome of care that is measurable and linked with improved outcomes."

Judith H. Hibbard, University of Oregon[1] and Jessica Greene
https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2012.1061

A Social Prescription.

Where are the problems, where are the enablers?
What's home like?
Financial problems?

Tailoring to the person's Activation Level

"Smaller manageable steps for less activated people."
"More activated, more substantial behavioural changes."

Judith H. Hibbard, University of Oregon[1] and Jessica Greene
https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2012.1061

A structural change

First level engagement – Shared Decision Making

Second level and Third level engagement - health care organizations structure themselves to meet patients' needs and preferences

(Carman and co-authors)

"Many public and private health care organizations are employing strategies to better engage patients, such as educating them about their conditions and involving them more fully in making decisions about their care.

Julia James

https://www.healthaffairs.org/do/10.1377/hpb20130214.898775/full/

70% of National Health Service (NHS) spending being for patients with long-term conditions.

Targeted intervention was of most benefit to those "…living in areas of high socioeconomic deprivation or those with mental health conditions"

"Objective: Measure patient self-management capability using the Patient Activation Measure (PAM) and compare healthcare utilisation across a whole health economy.

Conclusions: Self-management capability is associated with lower healthcare utilisation and less wasteful use across primary and secondary care.

Isaac Barker, Adam Steventon, Robert Williamson, Sarah R Deeny
https://qualitysafety.bmj.com/content/27/12/989

IPN Medical Centres

POSTERA CRESCAM LAUDE
THE UNIVERSITY OF MELBOURNE

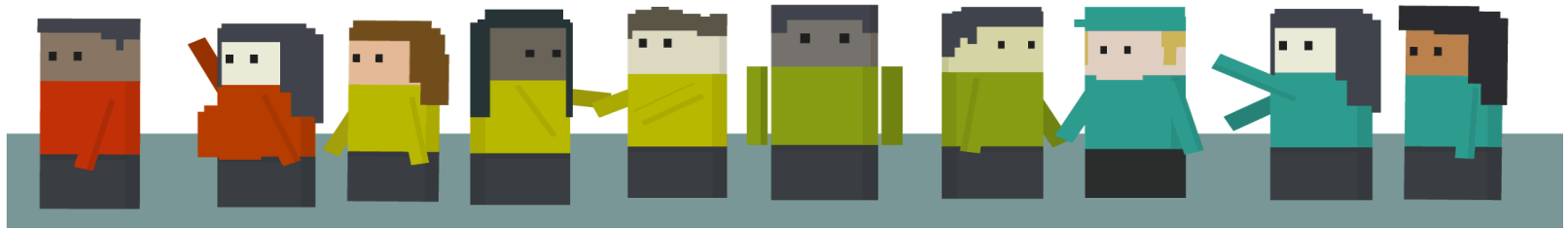
WellNet trial sites:

North Sydney – 3 IPN 3 non-IPN practices
Victoria – 6 IPN practices
Hunter -

Victorian Partners:

Target Groups

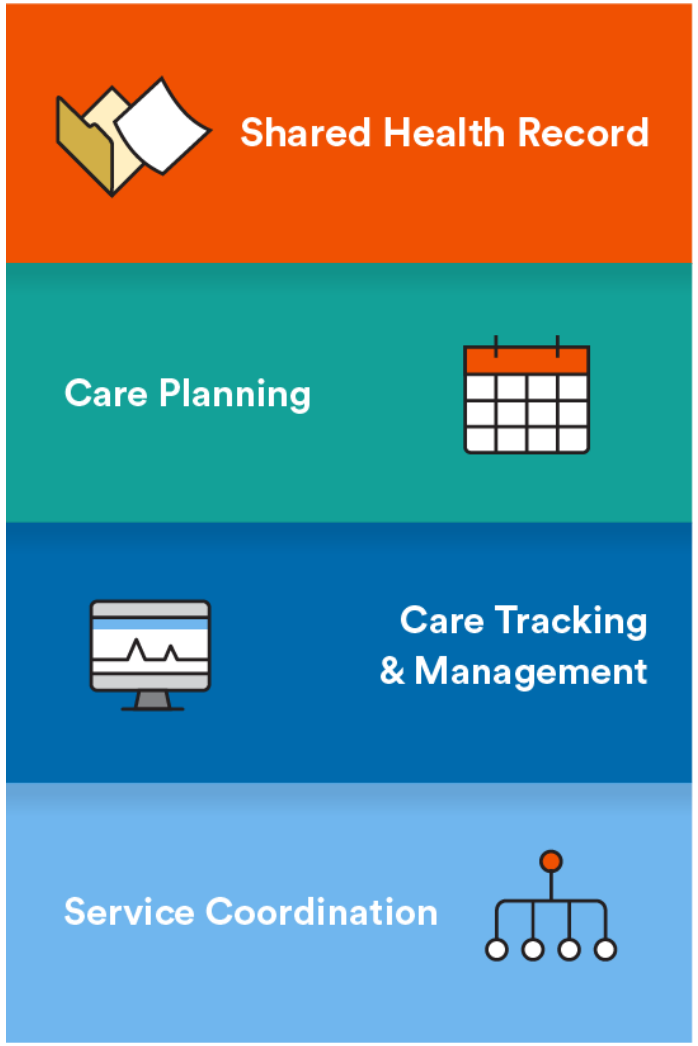
- Complex patients
- Multi-morbid patients
- Uncomplicated patients
- At risk patients



Technology supporting CDM

- Risk stratification
- Shared electronic medical records
- Mobile app
- Digitally enabled education
- Big time saving

Shared electronic health records



cdmnet

- Web based e-record shared & used by whole of care team including AHP
- Digital care plans – guidelines based
- Care coordination - assigns tasks & responsibilities to care team members
- Tracking – team members contribute to care plan on completion of tasks

Patient mobile app

MediTracker 12+

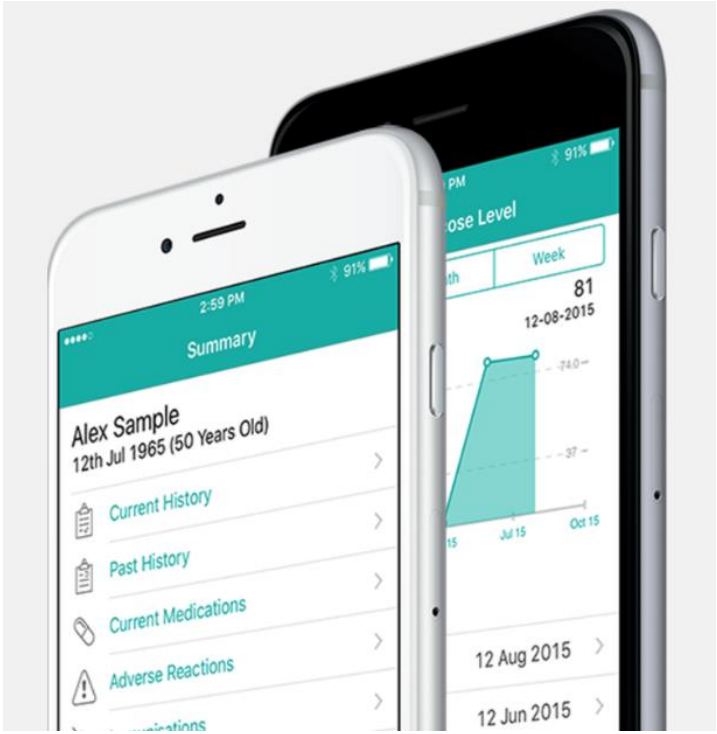
Your GP Medical Summary

Precedence Health Care Pty Ltd

#153 in Medical

★★★☆☆ 3.0, 15 Ratings

Free · Offers In-App Purchases



Health Summary

See your up-to-date medical history, as well as your prescribed medications, allergies, and immunisations.

Care Team

Helps you keep track of the people in your care team, providing you with accurate contact information.

Measurements

Track, graph and monitor important measurements and pathology tests ordered by your GP.

WellNet Objectives:

Increase patient involvement in the self-management of their CDM and to create enhanced physician engagement in the primary care model

Improving the outcomes and quality of life of patients with multimorbidity, reducing the likelihood of developing CV disease and diabetes, and reducing patients' risk of hospitalisation.

Mean PAM score (420 patients completed the WellNet program) significantly increased from 57.8 to 64.6 (11.8%)

25.3% increase in GPs' engagement with the care team in their patient's chronic disease management after one-years'

WellNet secondary objectives:

Assessments	N	Baseline mean (SD)	12-months mean (SD)	mean difference (95%CI)	p-value
PAM	420	57.87 (13.02)	64.69 (15.36)	6.82 (5.39, 8.25)	**<0.001**
HARP	430	15.9 (3.88)	14.01 (4.58)	-1.89 (-2.31, -1.47)	**<0.001**
EQ5D	417	0.79 (0.18)	0.82 (0.18)	0.03 (0.02, 0.05)	**<0.001**
K10	208	18.14 (6.96)	17.4 (7.10)	-0.74 (-1.45, -0.03)	**0.04**
DASS21	218				
Mean depression scale		7.18 (9.14)	5.4 (7.85)	-1.78 (-2.72, -0.84)	**<0.001**
Mean anxiety scale		6.33 (6.64)	5.01 (6.25)	-1.32 (-2.17, -0.47)	**0.002**
Mean stress scale		9.02 (8.16)	7.2 (7.95)	-1.82 (-2.78, -0.86)	**<0.001**
CVD Risk	320	12.18 (7.42)	11.28 (6.95)	-0.90 (-1.29, -0.51)	**<0.001**
AusDrisk	137	16.04 (4.82)	15.24 (4.31)	-0.80 (-1.31, -0.28)	**0.003**

Out of 49 GPs surveyed, more than 80 % reported that WellNet provides proactive and systematic care for their patients' CDM.

Patient engagement

- Patients engaged with program
- Positive patient outcomes
- Program generated patient loyalty

"patients love the program because of its comprehensive care"

"patients are so much more motivated to take charge of their lifestyle issues and health"

"it definitely improves practice reputation"

GP engagement

- Takes time and investment in change management
- GP leaders and early adopters are critical
- GPs see value of comprehensive nature of program
- 250% increase in CD item number billings

"many silent or unattended to issues are uncovered and dealt with".

"identification of clinical issues which clinicians ordinarily don't have time to delve into"

Technology

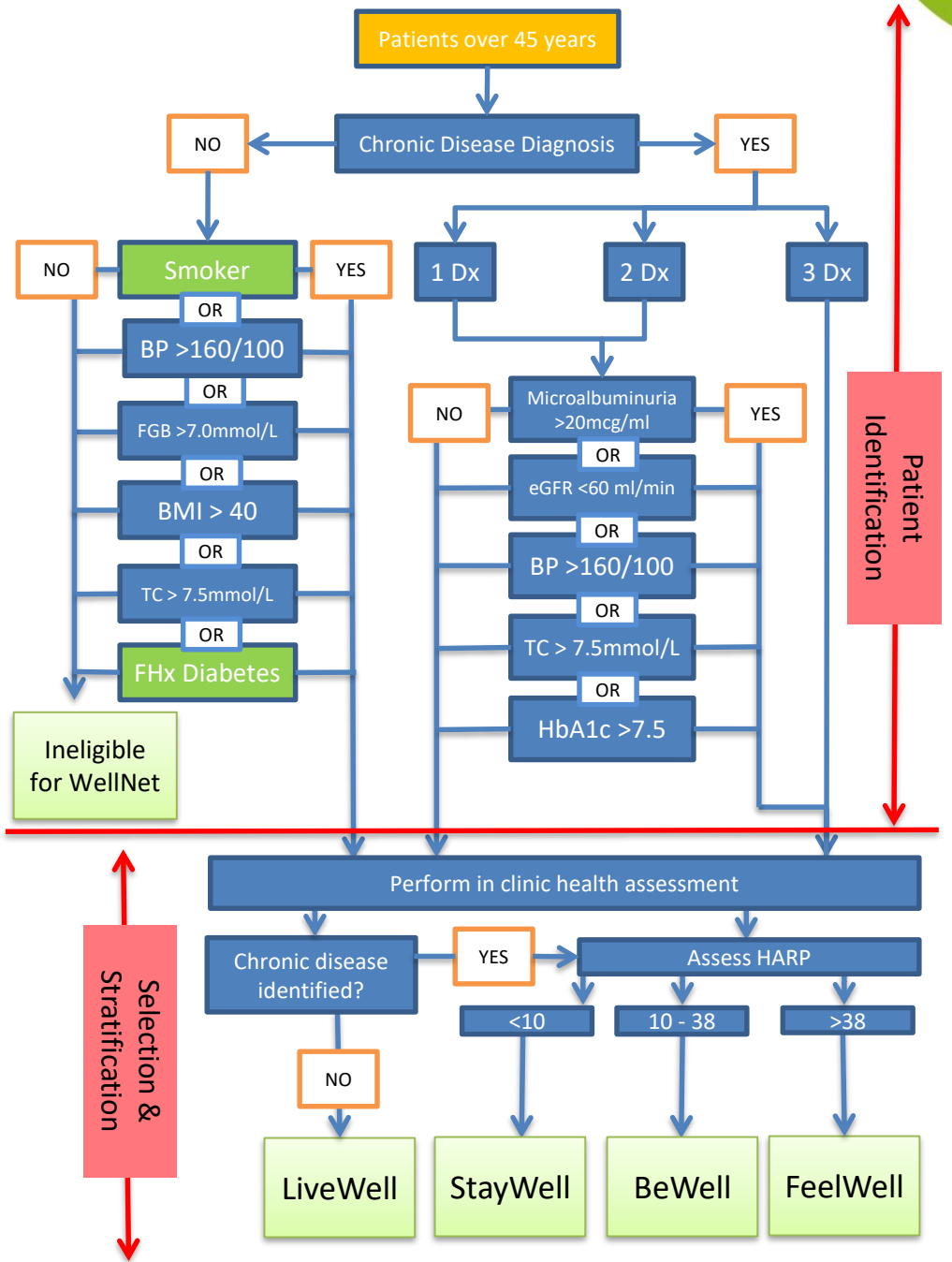
cdmNet

- Enables shared care planning and engagement
- Sits outside of GP clinical practice system
- Can be confusing for GPs not familiar with it
- Requires dedicated training

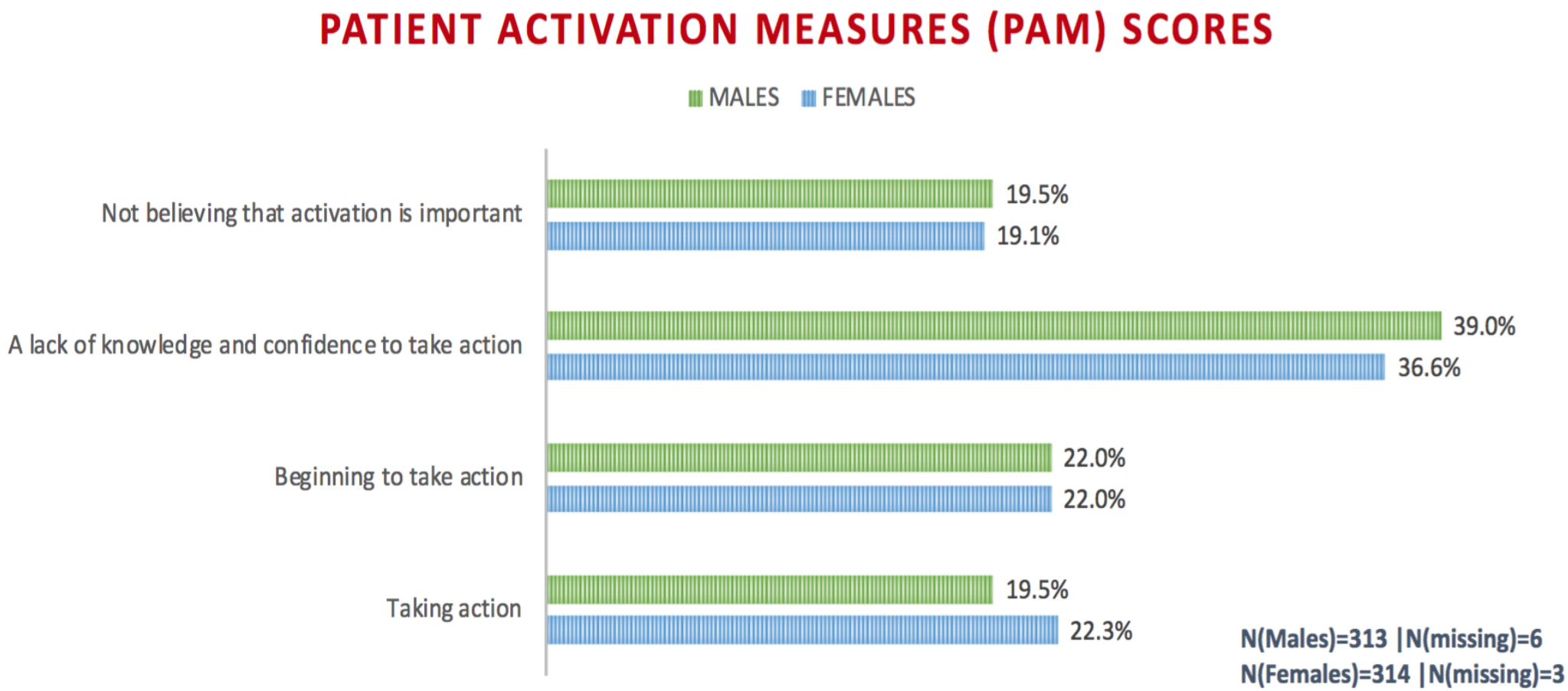
"(cdmNet) saves on faxing and emailing"

Risk Stratification

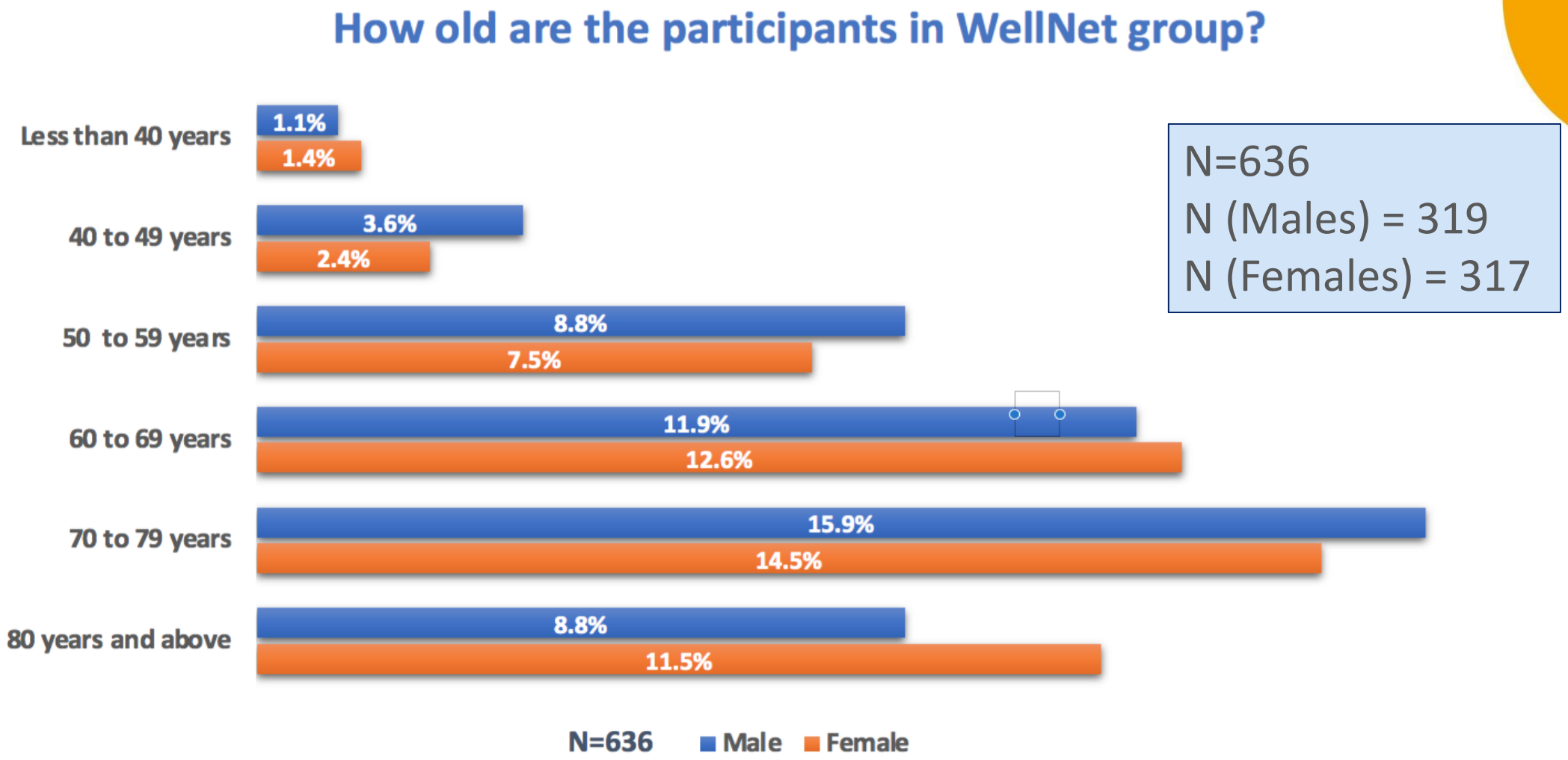
- Data extraction tool
- Risk factors/diagnoses
- Patient identification
- Health assessment
- Stratification
- Selection



Patient Activation

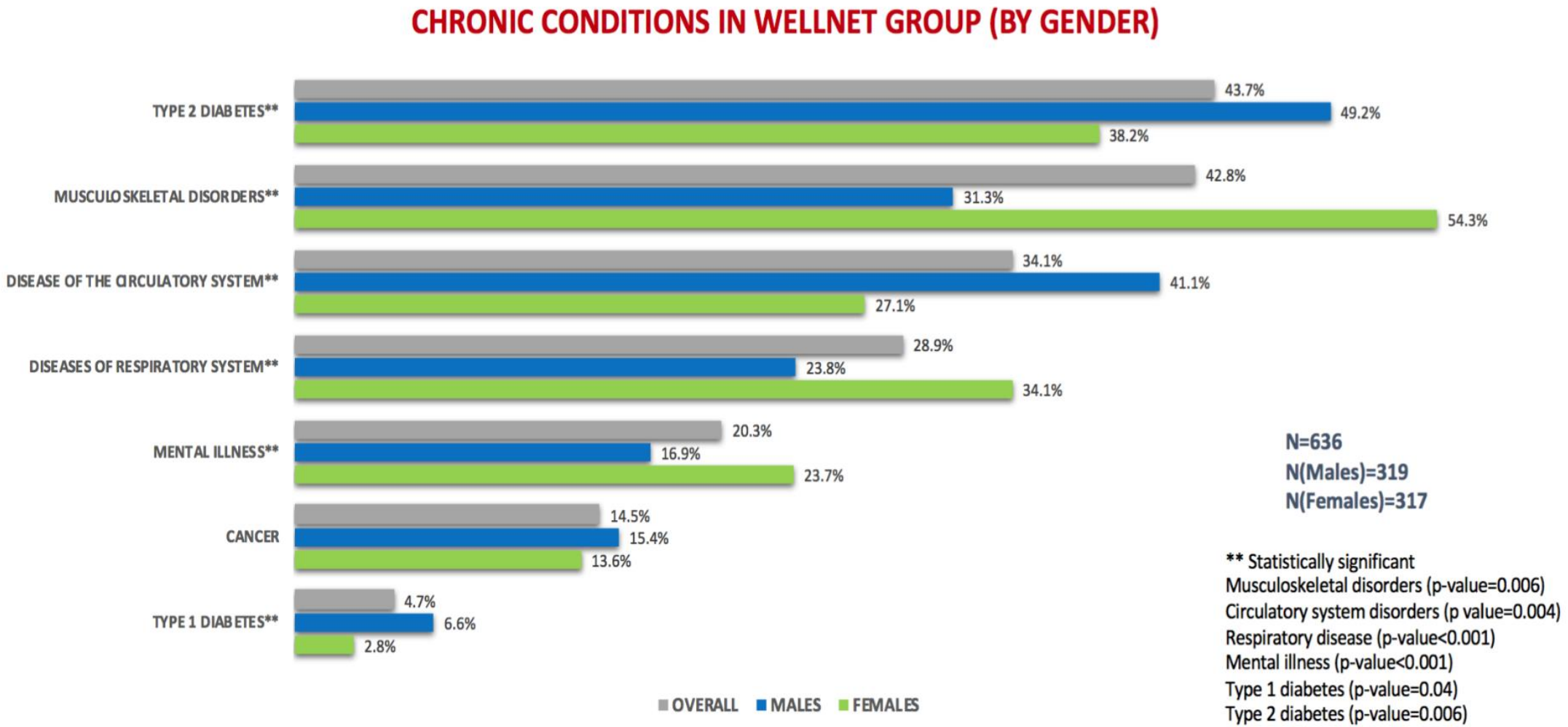


Patient demographics



N=636
N (Males) = 319
N (Females) = 317

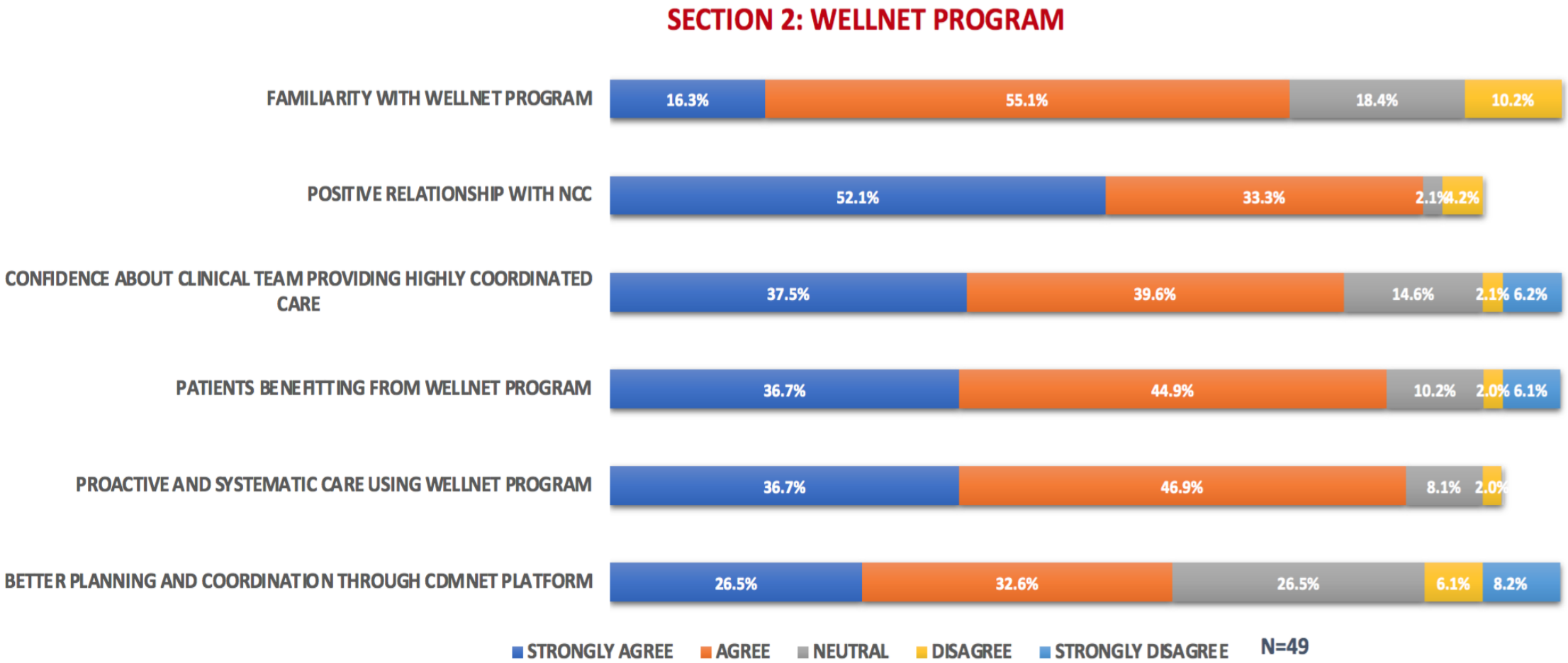
Disease profile



N=636
N(Males)=319
N(Females)=317

** Statistically significant
Musculoskeletal disorders (p-value=0.006)
Circulatory system disorders (p value=0.004)
Respiratory disease (p-value<0.001)
Mental illness (p-value<0.001)
Type 1 diabetes (p-value=0.04)
Type 2 diabetes (p-value=0.006)

GP survey


SECTION 2: WELLNET PROGRAM
FAMILIARITY WITH WELLNET PROGRAM
16.3%
55.1%
18.4%
10.2%
POSITIVE RELATIONSHIP WITH NCC
52.1%
33.3%
2.1%
4.2%
CONFIDENCE ABOUT CLINICAL TEAM PROVIDING HIGHLY COORDINATED CARE
37.5%
39.6%
14.6%
2.1%
6.2%
PATIENTS BENEFITTING FROM WELLNET PROGRAM
36.7%
44.9%
10.2%
2.0%
6.1%
PROACTIVE AND SYSTEMATIC CARE USING WELLNET PROGRAM
36.7%
46.9%
8.1%
2.0%
BETTER PLANNING AND COORDINATION THROUGH CDMNET PLATFORM
26.5%
32.6%
26.5%
6.1%
8.2%
STRONGLY AGREE
AGREE
NEUTRAL
DISAGREE
STRONGLY DISAGREE
N=49

"It's been a good journey with my coordinator , [she's] friendly and professional. My GP is the best , very calm , knowledgeable and professional".

"Thoroughly enjoyed my monthly visits with S*** , will miss our many laughs !!"

PATIENT FEEDBACK

"The program is really helpful for me to keep my health and improve my problem in many ways".

"I think this program helps me focus and take of my health regularly . I would like to continue with the same".

"I feel I have personally benefited immensely by this program"

"The WellNet service is an innovation idea to tackle Australia's diabetic epidemic and should be located in every large GP practice as a necessity"

"working in the team framework is the way things should be done".

"patients love the program because of its comprehensive care"

"feedback from patients very positive especially with care coordination set up via nurses".

"patients are so much more motivated to take charge of their lifestyle issues and health"

"many silent or unattended to issues are uncovered and dealt with".

"identification of clinical issues which clinicians ordinarily don't have time to delve into"

Be brave.

“The department of health have told us that they are comfortable with GPs using CDM item numbers as long as they are clinically indicated”

Dr Amit Vorha Executive General Manager, Health Solutions & Government Relations, Sonic Clinical Services

- Let’s change the way we organize our day
- Planned CDM sessions
- Urgent care sessions
- Single problem clinics?

Mixed CDM billing is a better service.

Six organized CDM visits per year
900, 23, 721, 723, 732 x4, 739, 10997 x5

for pensioners: $924.70 ($x154.12 per visit)
for private patients: $1174.50 ($195.75 per visit),
assuming $80 private item 23 visit fee (gap $254.40 pa)

We have to financially be able to make this work.

Next step for your practice?

There is a two tiered GP system in Australia.

Where do you belong?