Precedence Health Care

Funding-future, health care homes and more

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Extent of the problem

Chronic disease is a major burden on the health system:

- Australia > $70 billion spent per annum (2006): roughly two thirds of the total health budget which is over $160 billion.
- 35% of Australians have a chronic disease
- 20% have **two** chronic conditions

It has a drastic effect on quality of life, morbidity and mortality

Risk:

- Two thirds (67.0%) of Australian adults were overweight or obese and this is increasing

GP practice data – ‘Beach 2016’

40% of GP consultations included the management of at least one chronic condition

Multimorbidity defined as having two or more diagnosed chronic conditions:

- 51.6% of GP consultations included the management of two or more diagnosed chronic conditions, **(8% with diabetes**)
- These patients make up 31.5% of a average practice’s active patient population

Ref: Britt H, Miller GC, Henderson J, Bayram C, Harrison C, Valenti L, Pan Y, Charles J, Pollack AJ, Wong C, Gordon J. General practice activity in Australia 2015–16. General practice series no. 40. Sydney: Sydney University Press, 2016

CDM funding models per patient

MBS CDM items - GPMP, TCA, Reviews, AH Referrals, ACoC

- $547 pa (2 reviews)
- $946 pa (3 reviews + HMR + PIP and Swpe)

Health Care Homes – trial

- Tier 1 $591 pa
- Tier 2 $1,267 pa
- Tier 3 $1,759 pa

DVA CVC program: GP with PN

- $2,228 year 1
- $1,798 year 2

What works for chronic disease management?

Track

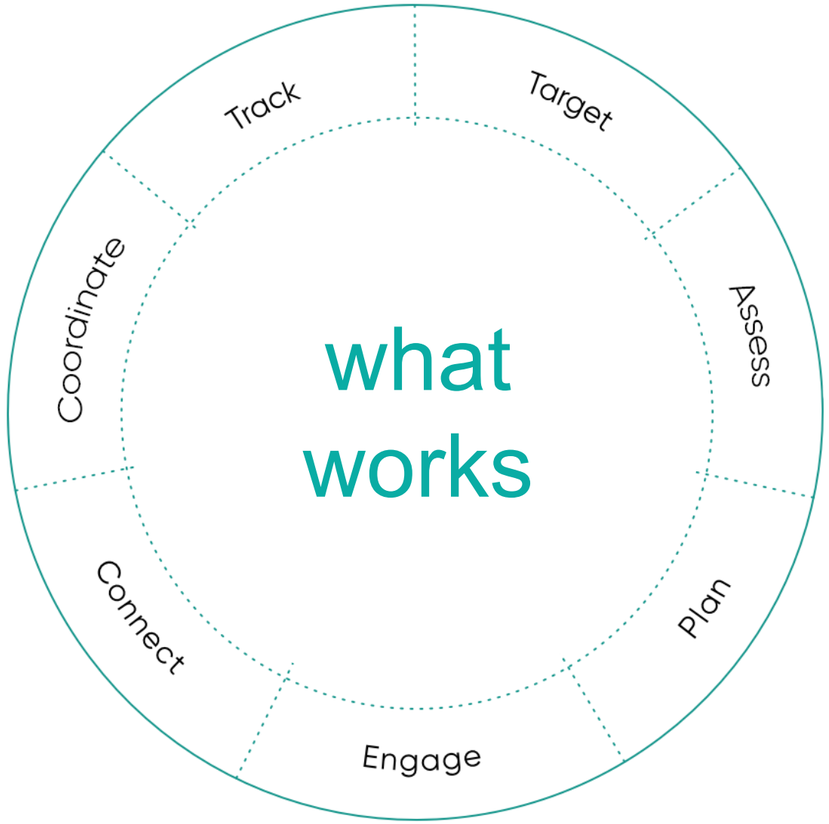
Monitor patient progress, follow up and review

Coordinate

Make sure everyone on the care team knows what everyone else is doing

Connect

Keep the communication flowing across the entire care team



Target

Identify patients most likely to benefit from better coordinated care

Assess

Assess patient's health risks and needs

Plan

Develop a unique care plan for each patient centred on their needs and preferences

Engage

Involve patients and their families in managing their own care

Adapted from the Report of the Primary Health Care Advisory Group 2017;
McCarthy, D., J. Ryan, and S. Klein, *Models of care for high-need, high-cost patients: an evidence synthesis.* Issue brief (Commonwealth Fund), 2015. 31: p. 1-19

Digital plans helps manage the cycle of care

- MBS CDM model of care, supporting
  - All types of GP practices and all regions: metro, rural, remote

Challenges to delivering effective care for practices

- Care planning processes are challenging due to the complexities of the Medicare requirements
  - this can lead to either different interpretations, poor implementation or not doing them at all
- Lack of dedicated or protected time to take on anything ‘new’ or change their processes
- It is difficult to track care to ensure patients do not “fall between the cracks”
- Empowering patients or their communities to help better manage their own care is strongly associated with better patient outcomes but is difficult to achieve

Change coming? CDM MBS Task force recommendations (1)

1. Move to a **patient-centred primary care model** supporting GP stewardship
2. Introduce a new voluntary patient enrolment fee
3. Introduce flexible access linked to voluntary patient enrolment
4. **Combine GP Management Plans (GPMPs) and Team Care Arrangements (TCAs) and strengthen GPMPs**
5. Link allied health items to GPMPs
6. **Equalise the rebate for GPMPs and GPMP reviews**
7. Increase access to care facilitation services for patients
8. **Activate and engage patients in their own care planning**
9. Rebate participation in case conferencing for non-GP health professionals
10. Build the evidence base for Health Assessments and ensure that the content of Health Assessments conforms to appropriate clinical practice guidelines

Change coming? CDM MBS Task force recommendations (2)

10. Delete Health Assessments less than 30 minutes and **expand the at-risk groups who are eligible for Health Assessments**
11. Link Medication Management Reviews (MMRs) to GPMPs and reduce the schedule fee
12. Increase the rebate for home visits for patients with a GPMP
13. Introduce a 6 minute minimum time for a Level B consultation item
14. Introduce a new Level E consultation item at 60 minutes or more
15. Increase access to primary health care in Residential Aged Care Facilities
16. Update language across the MBS to better reflect the role of registered and enrolled nurses
17. Amend the specialist consultation telehealth items to make clear that GPs are able to claim the items

Digital plans helps manage the cycle of care

- Health Care Homes – new model of care and funding (Commonwealth trial)
  - Provides continuity of care, coordinated services and a team based approach tailored to the needs and wishes of the patient

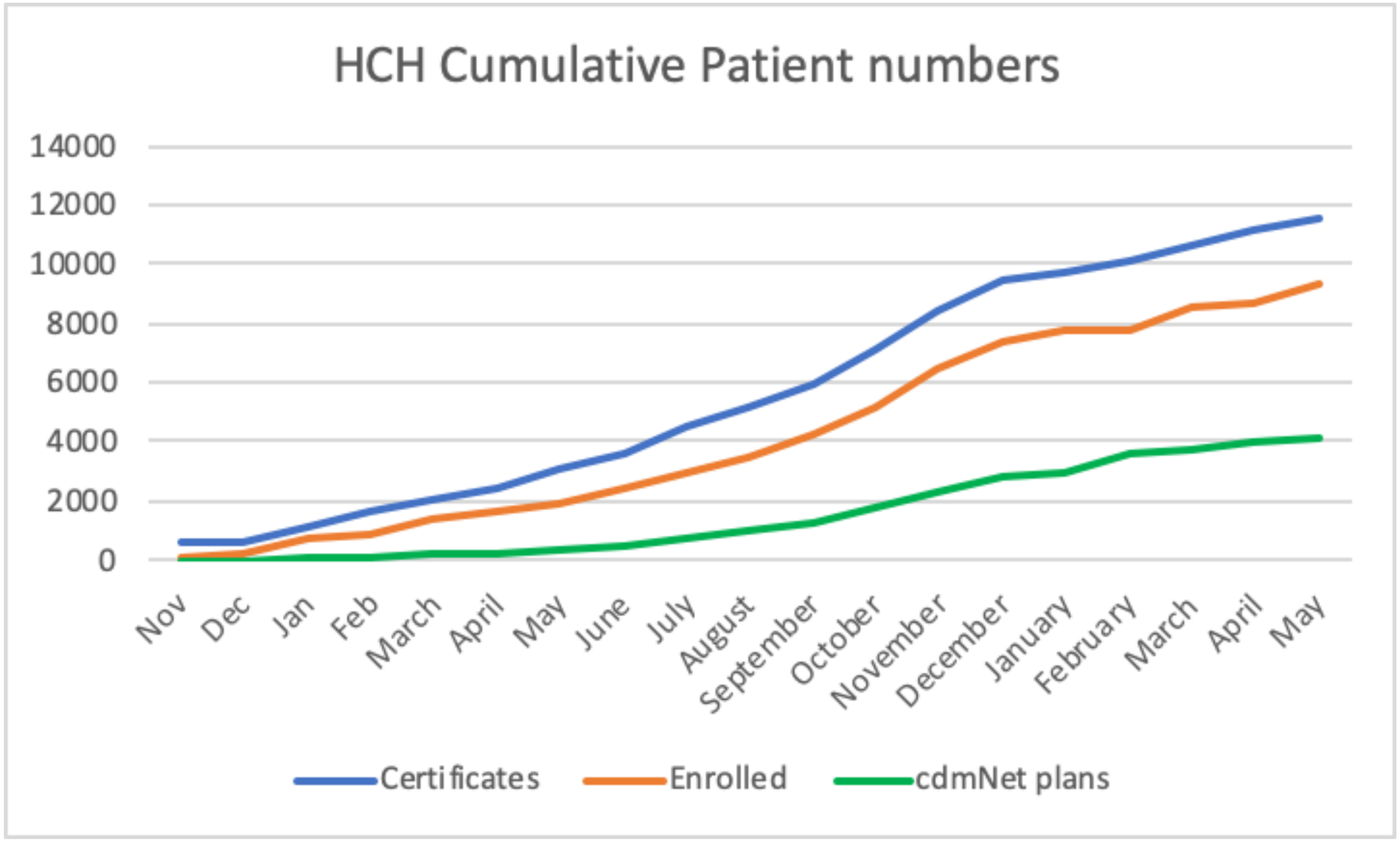
The Health Care Homes trial

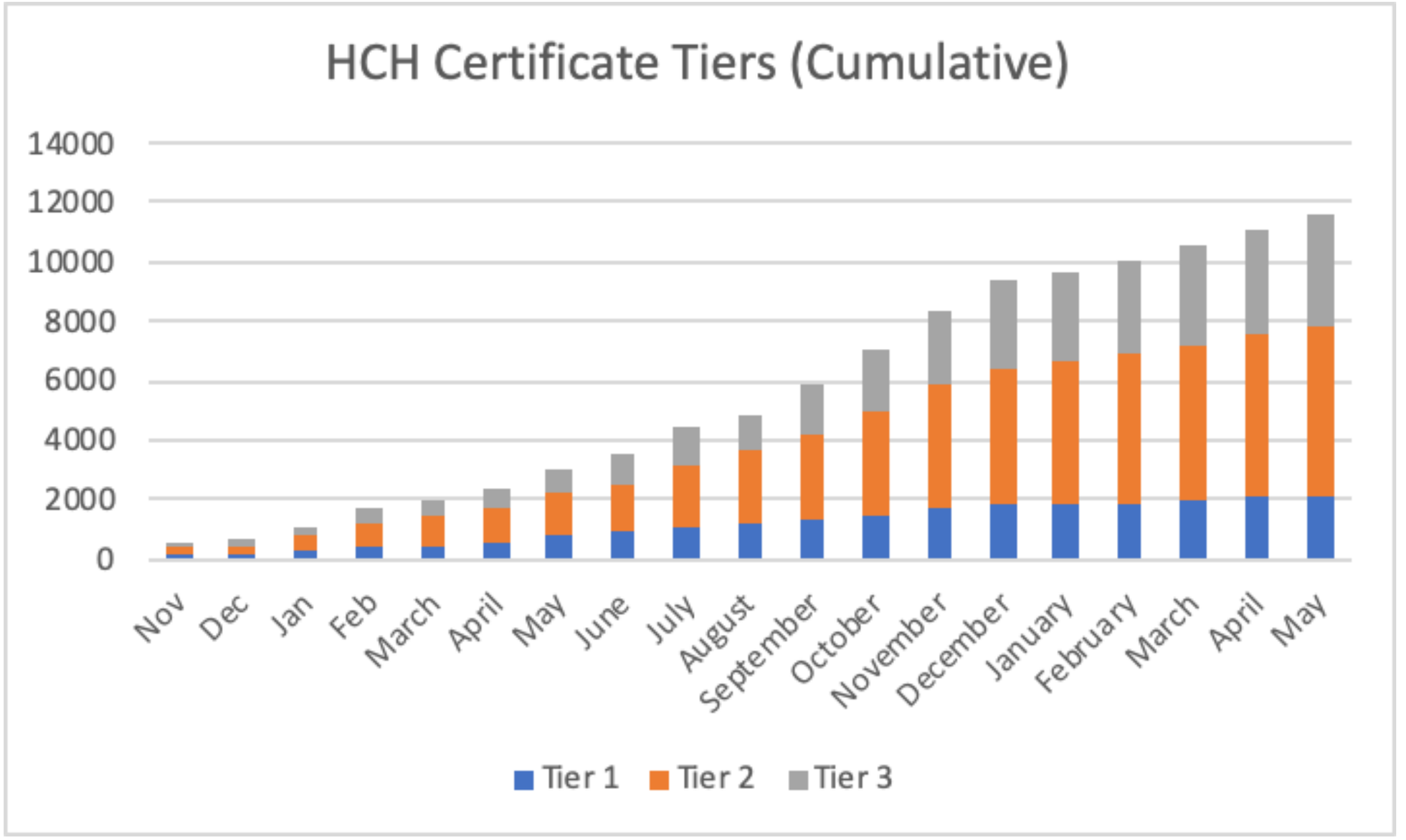
- 10 PHNs across Australia, October 2017 to June 2021
- For eligible people with chronic and complex conditions:
  - **Care team** —a committed care team, led by their usual doctor.
  - **Shared care plan** — a digital care plan*, with the support of their care team, the Health Care Home will coordinate the care.
  - **Access and flexibility** — with a care team support there is better access to care
  - **Coordinated care** — the care team will coordinate the care with the usual doctor, specialists and other health professionals.

* Practice choose shared care plan technology

HCH Numbers so far

- By May 2019, about 150 practices and ACCHS participating
- Precedence Risk Stratification Tool (RST) used to stratify patients
  - 11,500 certificates created across the three tiers
  - 9,336 patients enrolled across three tiers
    - Tier 1 1,613 (17%)
    - Tier 2 4,670 (50%)
    - Tier 3 3,053 (33%)
- 70 practices using Precedence for shared care planning*
- Digital plans created for 3,872 patients using Precedence


HCH Cumulative Patient numbers
14000
12000
10000
8000
6000
4000
2000
0
Nov
Dec
Jan
Feb
March
April
May
June
July
August
September
October
November
December
January
February
March
April
May
Certificates
Enrolled
cdmNet plans


HCH Certificate Tiers (Cumulative)
14000
12000
10000
8000
6000
4000
2000
0
Nov
Dec
Jan
Feb
March
April
May
June
July
August
September
October
November
December
January
February
March
April
May
Tier 1
Tier 2
Tier 3

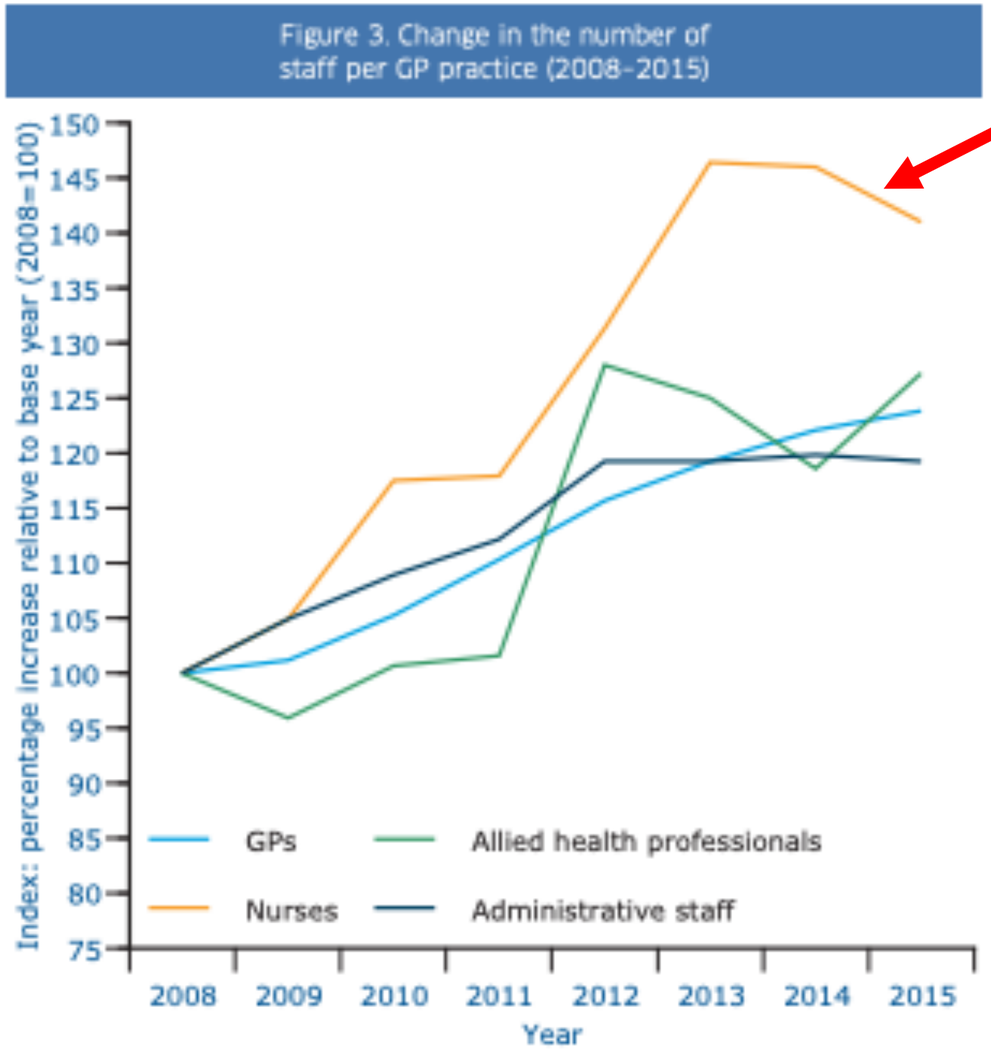
Key innovations in HCH shared ongoing care

- Smart algorithm developed (CSIRO) for identifying patients at risk of hospitalisation in the following 12 months
- Risk stratification over the practice population and at the point of care
- Whole of practice and team care approach
- Shared care plans – which digitally allows tracking and follow-up

But - change management in the practices takes time!

Khanna S, Rolls DA, et al. A risk stratification tool for hospitalisation in Australia using primary care data. Scientific Reports. 2019 Mar 21;9(1):5011.

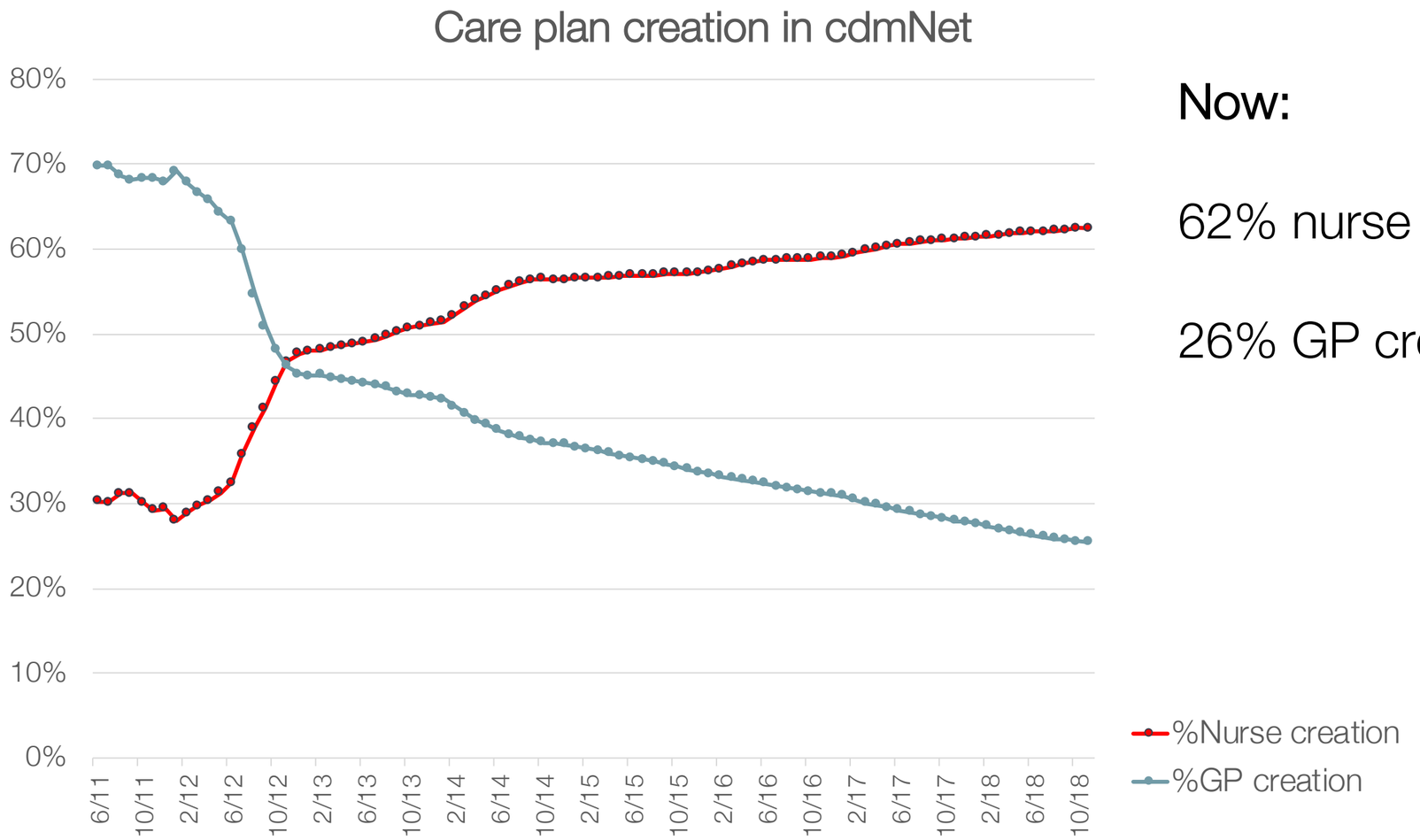
The practice workforce is changing



- 40 per cent increase in practice nurses
- Practice nurses increased from 0.39 to 0.45 per GP

Ref: ANZ – Melbourne Institute Health Sector Report General practice trends. Anthony Scott. Melbourne Institute of Applied Economic and Social Research, The University of Melbourne, 2017

cdmNet helps nurses manage the cycle of care



Now:

62% nurse created structured care plans

26% GP creating plans

Digital plans helps manage the cycle of care

- Patient centred care
  - ..lots of evidence it is an effective model to keep patient as well as possible

.. ‘chronic disease is not like a raging house fire. It’s like a smouldering fire in a pile of leaves that slowly reaches the point of flame.’

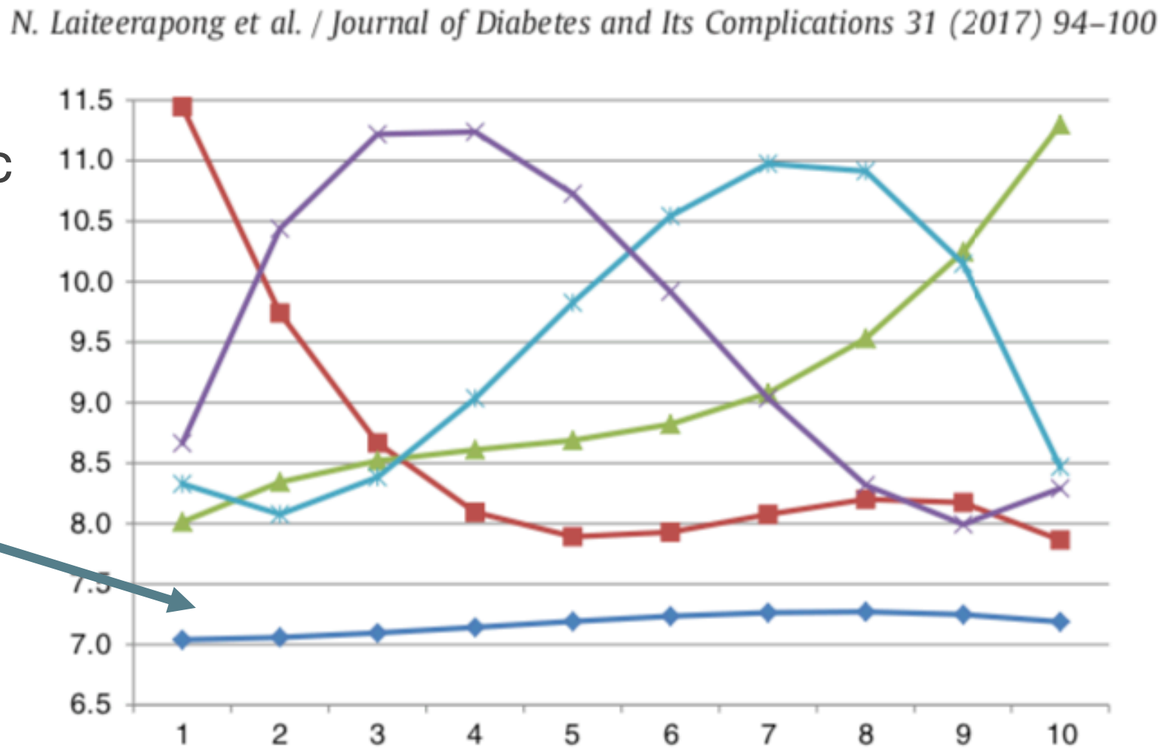
  - …life sometimes gets in the way

1. Patient journeys : The Diabetes and Aging study*

Follow-up > 10 years post diagnosis

- 5 distinct groups – trajectories of HbA1c

- 82% were low stable
- 6% each other group who:
  - Higher risk of microvascular disease
  - Higher risk of mortality



* Laiteerapong, N et al.; Ten-year hemoglobin A1c trajectories and outcomes in type 2 diabetes mellitus: the Diabetes and Aging Study J. Diabetes and its complications. 31 (2017) 94-100.

2. Patient journeys: UK Prospective Diabetes Study

- Intensive glycaemic treatment post diagnosis
  - Follow-up > 10 years post diagnosis
  - At 10 years – less microvascular events
  - At 20 years – less microvascular, less macrovascular and less mortality
    - ‘metabolic memory’

Microvascular: end-stage renal dz, diabetic eye dz, lower extremity amputation

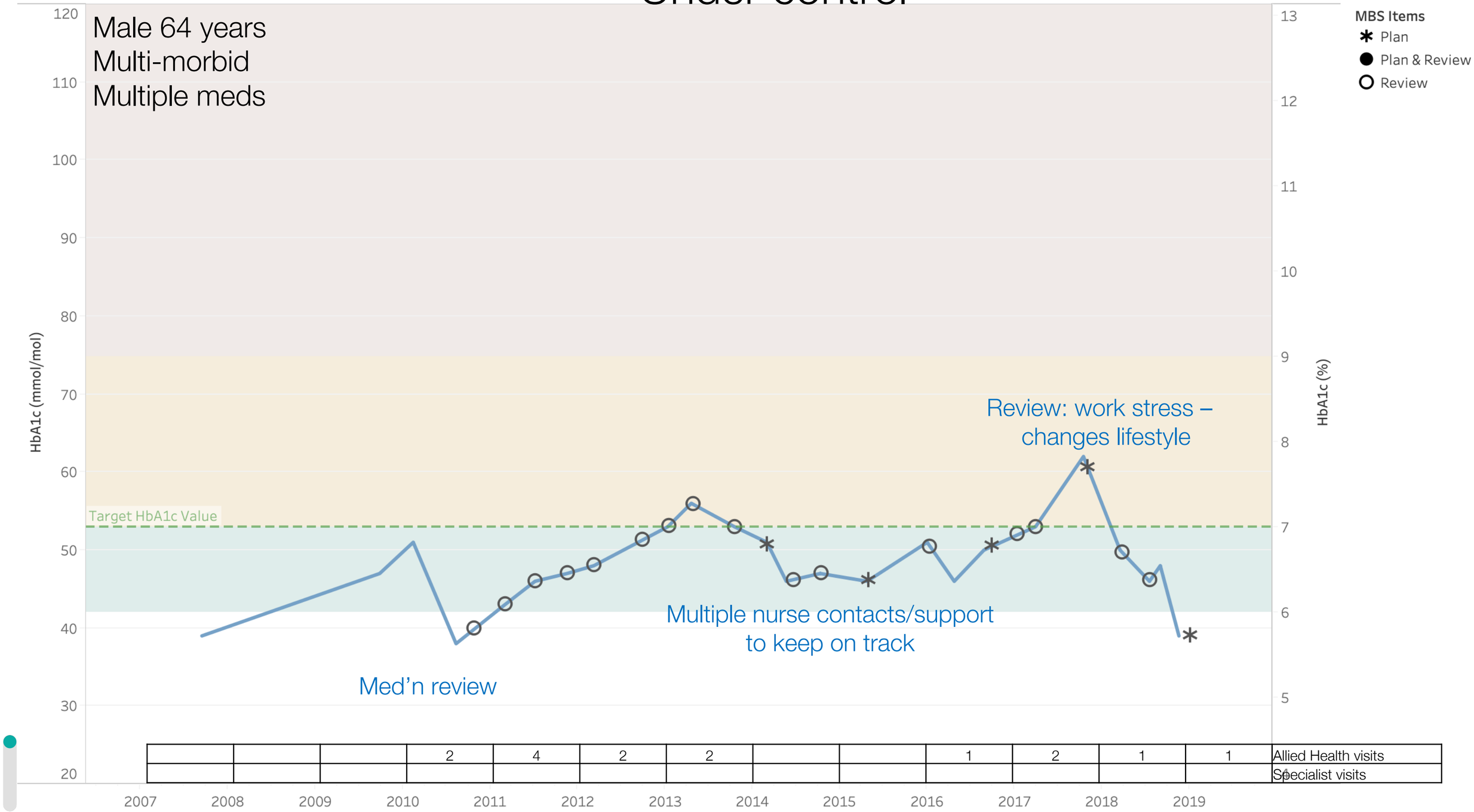
Macrovascular: coronary artery dz, cerebrovascular dz, congestive heart failure, vascular dz

https://www.dtu.ox.ac.uk/ukpds/

Holman, RR, Paul, SK, Bethel, MA, Matthews, DR, & Neil, HA (2008). 10-year follow-up of intensive glucose control in type 2 diabetes. The New England Journal of Medicine, 359(15), 1577–1589.

Case Study - keeping diabetes in control

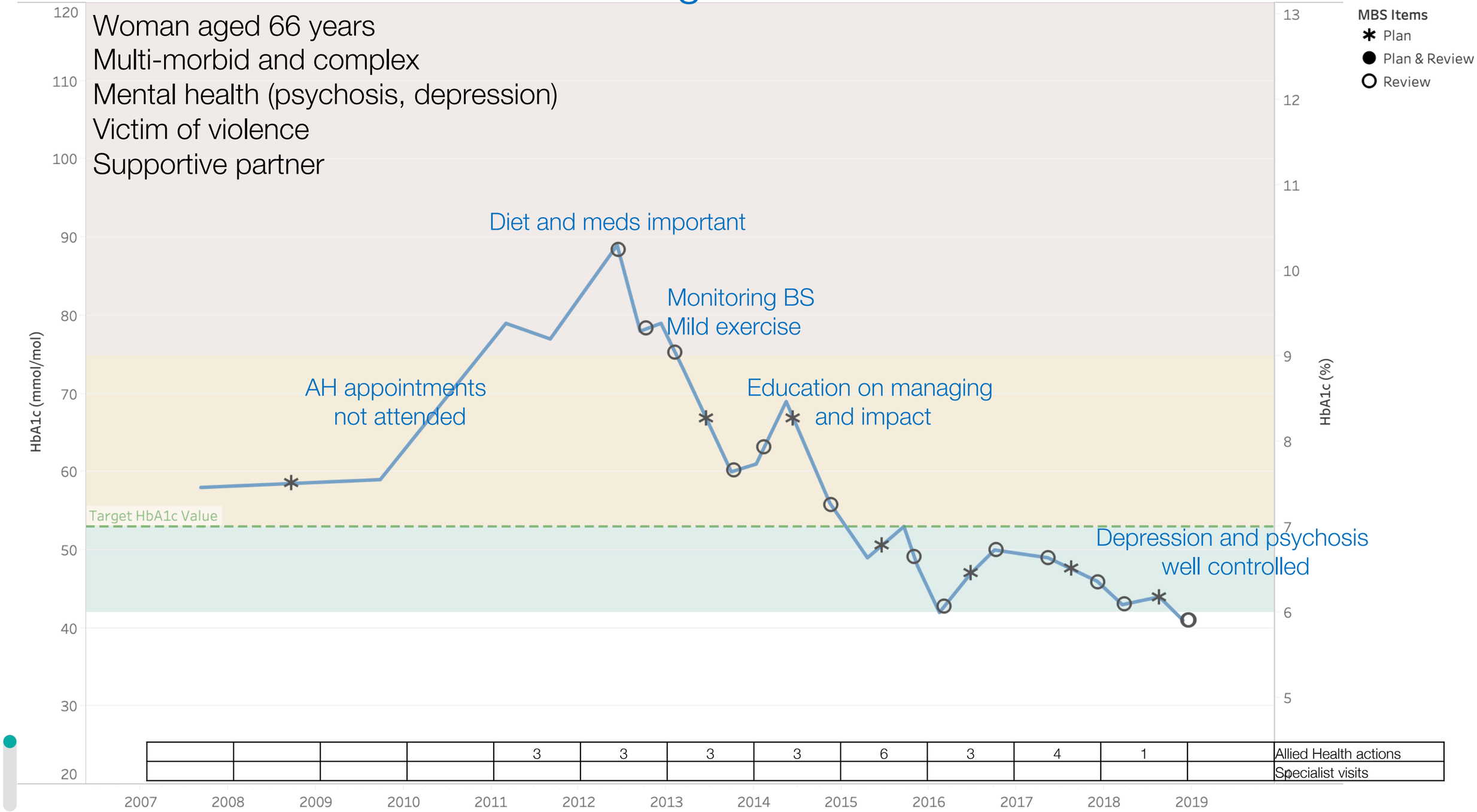
Under control



			2	4	2	2			1	2	1	1	Allied Health visits
													Specialist visits

Case Study - keeping diabetes in control

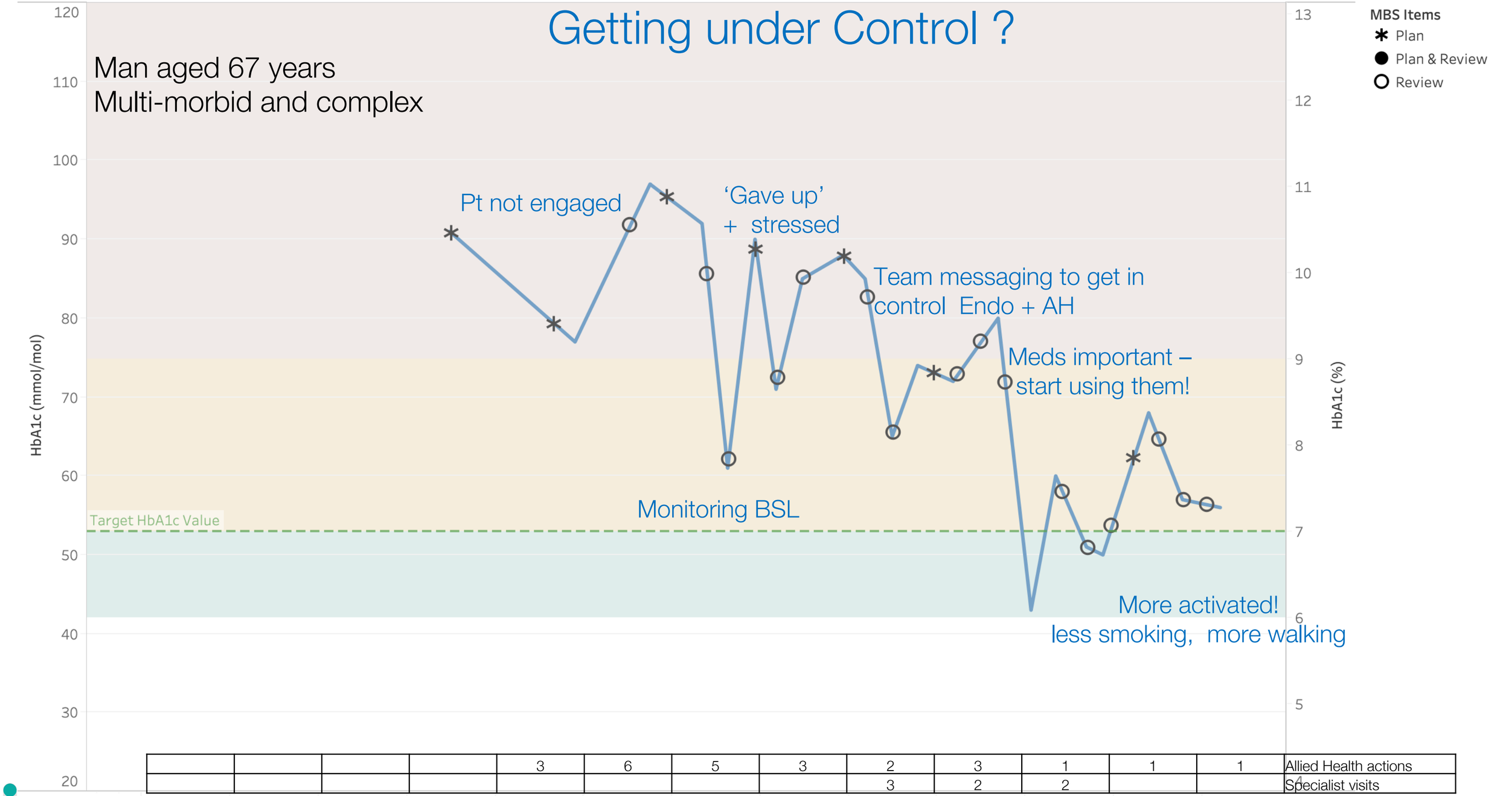
Getting under control



				3	3	3	3	6	3	4	1		Allied Health actions
													Specialist visits

Getting under Control ?

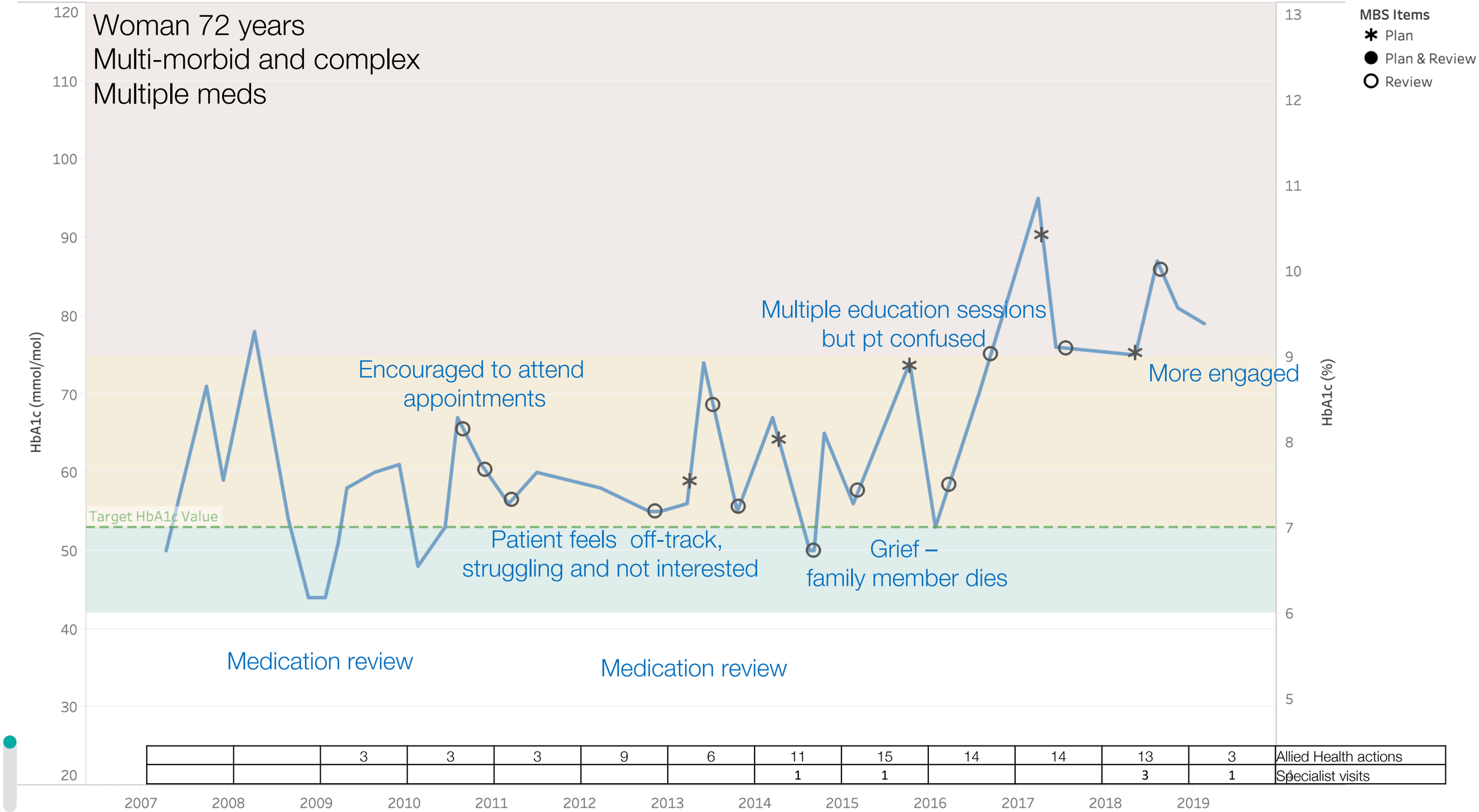
Man aged 67 years
Multi-morbid and complex



				3	6	5	3	2	3	1	1	1	Allied Health actions
								3	2	2			Specialist visits

Case Study - keeping diabetes in control

Unstable



		3	3	3	9	6	11	15	14	14	13	3	Allied Health actions
							1	1			3	1	Specialist visits

Summary

- MBS, CVC and HCH fund planning, multidisciplinary care, and ongoing follow-up
- Persistent coordination and care team support required to keep patients on-track
- Nurse driven CDM clinics efficient and effective
- Keeping diabetes on track requires early glycaemic control and great personal effort and support

The future

- Create sustainable Chronic Disease Management by identifying the model of care / healthcare context appropriate for each practice
- Invest in the practice work-force, run nurse-led CDM
- Consider the effective use of MBS billing or other funding model
- Use digital coordinated care technology to simplify care delivery and increase the effectiveness of care to:
  - Engage and activate the patient
  - Improve health outcomes
  - Improve team coordination
  - Improve care follow up
  - Lower administrative overhead and allow more time for providers to practice good medicine
- This can increase practice revenue for long-term sustainability

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