WELLNET INTEGRATED CARE PROGRAM

SUPPORTING CHRONIC DISEASE MANAGEMENT THROUGH THROUGH PRIVATE-PUBLIC PARTNERSHIPS
An alternate Chronic Disease Management system

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Clinical Lead Integrated Care
Sonic Clinical Services
Target Groups

- Complex patients
- Multi-morbid patients
- Uncomplicated patients
- At risk patients
‘Complex’ target group
- High care needs
- High risk of re-admissions
- High level clinical care coordination

‘Multi-morbid’ target group
- Complications of chronic disease
- At risk of hospitalisation
- Targeted care coordination

‘Uncomplicated’ target group
- Controlled or low risk of complications
- Low risk of hospitalisation
- Supported self-care

‘At risk’ target group
- Personalised patient education
Stepped care approach

Personalised CDM care plan
Shared e-health record (cdmNet)

Preventive Care
Smart phone app
Patient education
Patient Centred Medical Home

Tailored interventions
Care coordination

High level care coordination

Home care & individualised care
Pooled Funding approach
Public Private Partnerships & Pooled Funding

Dr Amit Vohra PhD
Executive General Manager
Strategy, Health Solutions & Government Relations
To P or Not to P....
Integrated care value chain > $40 Billion p.a.
Understanding Value in a Pooled Funding Model

- Enables GPs to get involved with Integrated Care
- GPs can align with one program as opposed to multitude of programs for different funders
- Unlocks new sources of revenue
- Promotes good medical practice
- Administratively simple
- Provides equity for public and private patients

- Preventive care
- Proactive care
- Care coordination and personalised support
- Joined-up care (better team care)
- Equal access across public and private
- Patient App.

- Public Private Partnership in line with strategic approach.
- Supports government Integrated care agenda
- Assures government funding is effective
- PHI eases pressure on public funding and delivery
- Benefits from better access and reduced hospital costs.

- Easy way to engage with Primary Care
- Gives traction in market where any one PHI is only a fragment of the market
- Better targeting of interventions
- Early detection and intervention with high risk members
- Can offset costs with risk equalisation
- Prevents adverse selection risk
- Achieves cost efficiencies for care provided due to scale.

- Evidence Based Program
- Risk Stratification
- IT infrastructure
- Initial GP network

- Funding to support members
- Membership
- Claims data & hospital relationships

- PHNs and LHDs find it easier to interact with industry vehicle as opposed to individual funds and multitude of GPs and integrated care service providers
- Access to resources for patients that would be otherwise difficult to achieve and is not funded via MBS
- Enables joint planning and commissioning across a region

Commission & Pay for services for patients to access integrated care services in the community.
# WellNet Trial Locations

<table>
<thead>
<tr>
<th>Current Locations</th>
<th>Size &amp; Mix</th>
<th>Target Cohort</th>
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</thead>
<tbody>
<tr>
<td>North Sydney Trial</td>
<td>• 3 IPN &amp; 3 non-IPN Practices. • LHD, PHN, BUPA, HCF, nib, Teachers &amp; DoH on Steering Committee.</td>
<td>• 1050 Tier 2 and Tier 3 Patients. • 600 in evaluation cohort • Public &amp; Private Patients</td>
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<tr>
<td>AHSA Victoria Trial</td>
<td>• 10-15 IPN &amp; non-IPN Practices. • AHSA, AU, GMHBA, Defence Health, People Care on Steering Committee.</td>
<td>• Target 400-600 Private Patients.</td>
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<tr>
<td>SEMPHN Victoria Trial</td>
<td>• 6-8 non-IPN practices</td>
<td>• Target 800 Public patients • Separate cohort of 40-50 Frequent Flyers</td>
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<tr>
<td>Hunter PHN &amp; nib Trial</td>
<td>• 5-6 IPN and non-IPN practices</td>
<td>• Target 800-1000 patients • Greater focus on obesity related chronic disease</td>
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SCS WellNet Trials

- 20%-30% Overall costs funded via existing MBS billings
- 40%-50% Funded by private health insurers
- 30%-40% Funded by public health ie PHNs/Hospitals/LHDs
- 60% Enrolled patients are private
- 40% Enrolled patients are public
Formal evaluation

- Conducted by CMCRC
- Full ethics approval by university...
- Detailed consent forms signed by patients
- Longitudinal cohort study
- Data extraction from cdmNet and practice management systems.
- Results by mid 2019
Learnings to date
Patient enrolments

1431 – number of letters sent

2303 – number of follow-up phone calls made

698 – number of patients who attended initial assessment

688 – number of patients found eligible

52 – number of patients who declined to participate in the evaluation

636 – Final number of patients in the evaluation group
Patient enrolments

Method of Enrolment

- Opportunistic: 427, 67%
- Letter recall: 209, 33%

N=636
Patient demographics

How old are the participants in WellNet group?

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male (%)</th>
<th>Female (%)</th>
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</thead>
<tbody>
<tr>
<td>Less than 40 years</td>
<td>1.4%</td>
<td>1.1%</td>
</tr>
<tr>
<td>40 to 49 years</td>
<td>2.4%</td>
<td>3.6%</td>
</tr>
<tr>
<td>50 to 59 years</td>
<td>7.5%</td>
<td>8.8%</td>
</tr>
<tr>
<td>60 to 69 years</td>
<td>12.6%</td>
<td>11.9%</td>
</tr>
<tr>
<td>70 to 79 years</td>
<td>14.5%</td>
<td>15.9%</td>
</tr>
<tr>
<td>80 years and above</td>
<td>11.5%</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

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

**CHRONIC CONDITIONS IN WELLNET GROUP (BY GENDER)**

- **Type 2 Diabetes**
  - Overall: 49.2%
  - Males: 43.7%
  - Females: 38.2%

- **Musculoskeletal Disorders**
  - Overall: 54.3%
  - Males: 42.8%
  - Females: 31.3%

- **Disease of the Circulatory System**
  - Overall: 41.1%
  - Males: 34.1%
  - Females: 27.1%

- **Diseases of Respiratory System**
  - Overall: 34.1%
  - Males: 28.9%
  - Females: 23.8%

- **Mental Illness**
  - Overall: 23.7%
  - Males: 16.9%
  - Females: 20.3%

- **Cancer**
  - Overall: 15.4%
  - Males: 14.5%
  - Females: 13.6%

- **Type 1 Diabetes**
  - Overall: 6.6%
  - Males: 4.7%
  - Females: 2.8%

**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)
Patient Activation

PATIENT ACTIVATION MEASURES (PAM) SCORES

- Not believing that activation is important: Males 19.5%, Females 19.1%
- A lack of knowledge and confidence to take action: Males 39.0%, Females 36.6%
- Beginning to take action: Males 22.0%, Females 22.0%
- Taking action: Males 19.5%, Females 22.3%

N(Males)=313 | N(missing)=6
N(Females)=314 | N(missing)=3
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

GoShare
• Not hitting the mark – need to explore why

“(cdmNet) saves on faxing and emailing”

60% of GPs reported that cdmNet platform assists in providing better planning and care coordination
Team based care

• Care coordination a valued component
• Care coordinators build up an extensive network
• GP and practice staff exposed to team based care

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

“working in the team framework is the way things should be done”.
Care coordinators

• Role must be specific to avoid competing priorities
• Patient caseloads must be managed
• Use of care navigators should be explored
SECTION 2: WELLNET PROGRAM

- Familiarity with WellNet Program: 16.3% Strongly Agree, 55.1% Agree, 18.4% Neutral, 10.2% Disagree
- Positive Relationship with NCC: 52.1% Strongly Agree, 33.3% Agree, 2.1% Neutral, 2.1% Disagree
- Confidence about Clinical Team Providing Highly Coordinated Care: 37.5% Strongly Agree, 39.6% Agree, 14.6% Neutral, 6.2% Disagree
- Patients Benefiting from WellNet Program: 36.7% Strongly Agree, 44.9% Agree, 10.2% Neutral, 6.1% Disagree
- Proactive and Systematic Care Using WellNet Program: 36.7% Strongly Agree, 46.9% Agree, 8.1% Neutral, 2.0% Disagree
- Better Planning and Coordination Through CDMNet Platform: 26.5% Strongly Agree, 32.6% Agree, 26.5% Neutral, 6.1% Disagree

N=49
WellNet

LiveWell: Preventative Care Program
Designed for patients who are at risk of developing a chronic disease, such as smokers, the overweight and obese and those with ‘pre-diabetes’. Patients receive targeted educational interventions and GP support to improve their risk profiles and live well.

StayWell: Chronic Care Program
Specifically designed for patients with 1-2 uncomplicated chronic diseases. This program aims to keep people well and ensure they have the right support to self-manage their conditions and stay well.

BeWell: Coordinated Care Program
A coordinated care program for patients with multiple chronic or complicated chronic diseases. This program aims to support some of the sicker people in the community that have not yet become frequent users in the hospital system and are currently being managed in general practice.

FeelWell: Progressive Care Program
Designed for complex chronic disease patients with complex health needs, who are at a high risk of hospitalisation or re-hospitalisation. These are some of the sickest people in the community who can benefit most from targeted interventions that are closely managed by the entire care team.

GetWell: Individual Care Program
GetWell is an extension of the FeelWell program and has been designed to support patients on their road to recovery from an illness or a health intervention. GetWell improves the patient experience and shortens the length of hospital stay, and assists in avoiding hospital primary admissions as well as re-admissions for situations that can be treated in the community.
Thank you

Questions?