WELLNET INTEGRATED CARE PROGRAM

SUPPORTING CHRONIC DISEASE MANAGEMENT THROUGH THROUGH PRIVATE-PUBLIC PARTNERSHIPS

WellNet
Integrated Care Network

An alternate Chronic Disease Management system

Dr Eleanor Chew
Clinical Lead Integrated Care
Sonic Clinical Services

Evidence-Based

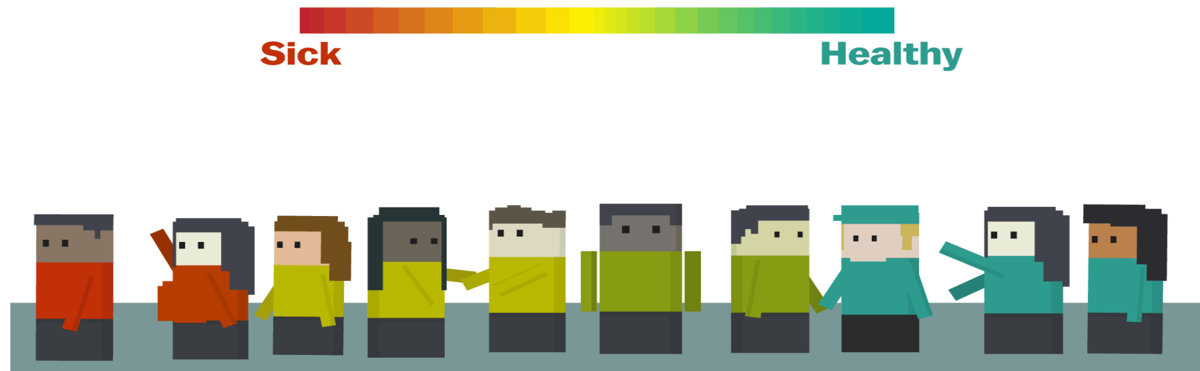
Outcomes-Based

Tailored for patients

Stepped-Care Model

Target Groups

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



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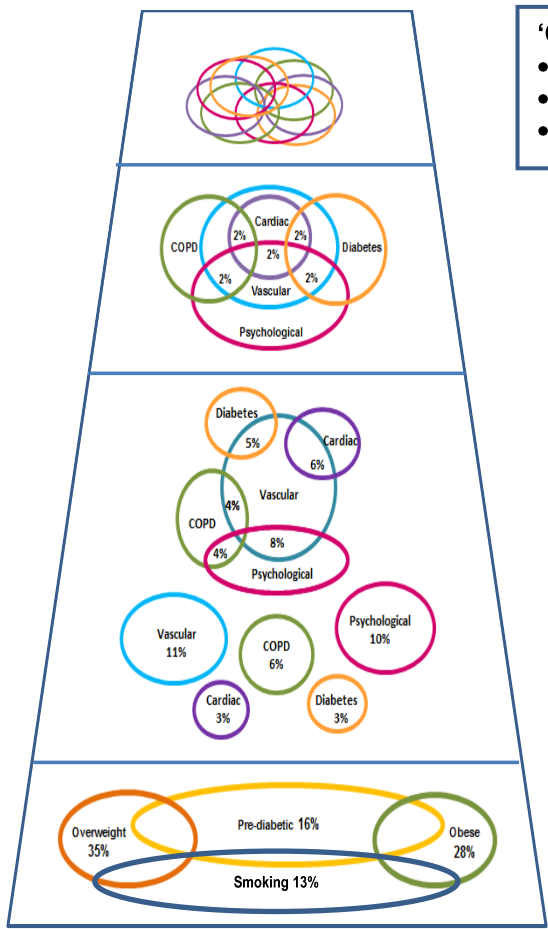
GetWell
Individual Care Program

FeelWell
Progressive Care Program

BeWell
Coordinated Care Program

StayWell
Chronic Care Program

LiveWell
Preventative Care Program



'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

GetWell
Individual Care Program

FeelWell
Progressive Care Program

BeWell
Coordinated Care Program

StayWell
Chronic Care Program

LiveWell
Preventative Care Program

Home care & individualised care

High level care coordination

Tailored interventions

Care coordination

Personalised CDM care plan

Shared e-health record (cdmNet)

Preventive Care

Smart phone app

Patient education

Patient Centred Medical Home

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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….

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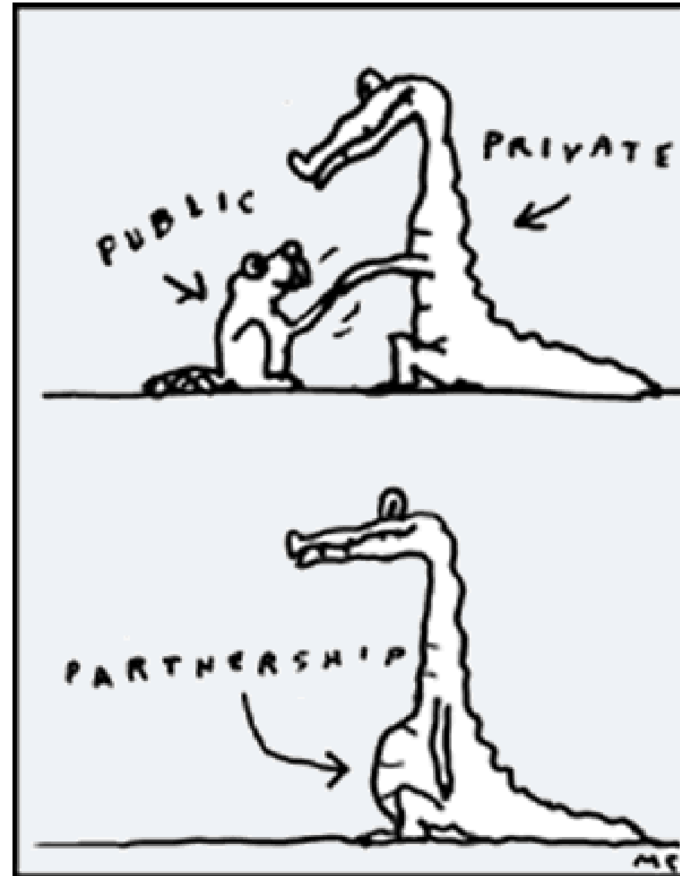

Integrated care value chain > $40 Billion p.a.

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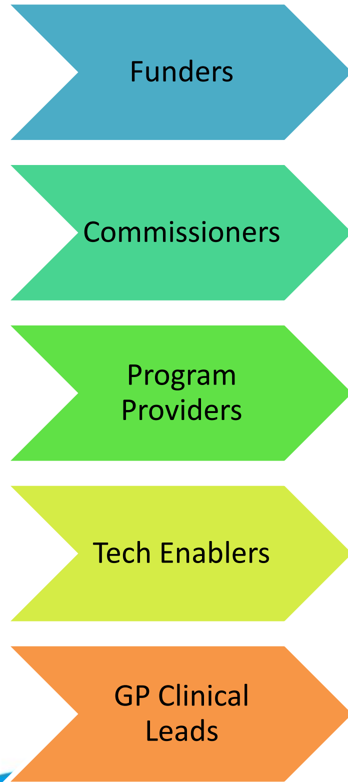

Other PHIs

Local hospital districts

phn

Other GP Practices

Understanding Value in a Pooled Funding Model

Provider
Sonic

- •Receive resources, training and IT infrastructure to drive integrated care

- •Achieves commercial scale & creates business value by leveraging assets.
- •Easier to partner with multiple funders and service providers

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

GPs
(Private & Corp)

- •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

- •Better use of MBS
- •Patient access

The Patient

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

Integrated Care Pooled Funding

PHIs
Bupa, HCF, nib, THF

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

- •Easy way to engage with Primary Care
- • Gives traction in market where any one PH 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.

Commission & Pay for services for patients to access integrated care services in the community

- •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.

- •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

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WellNet Trial Locations

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

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

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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

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Learnings to date

Patient enrolments

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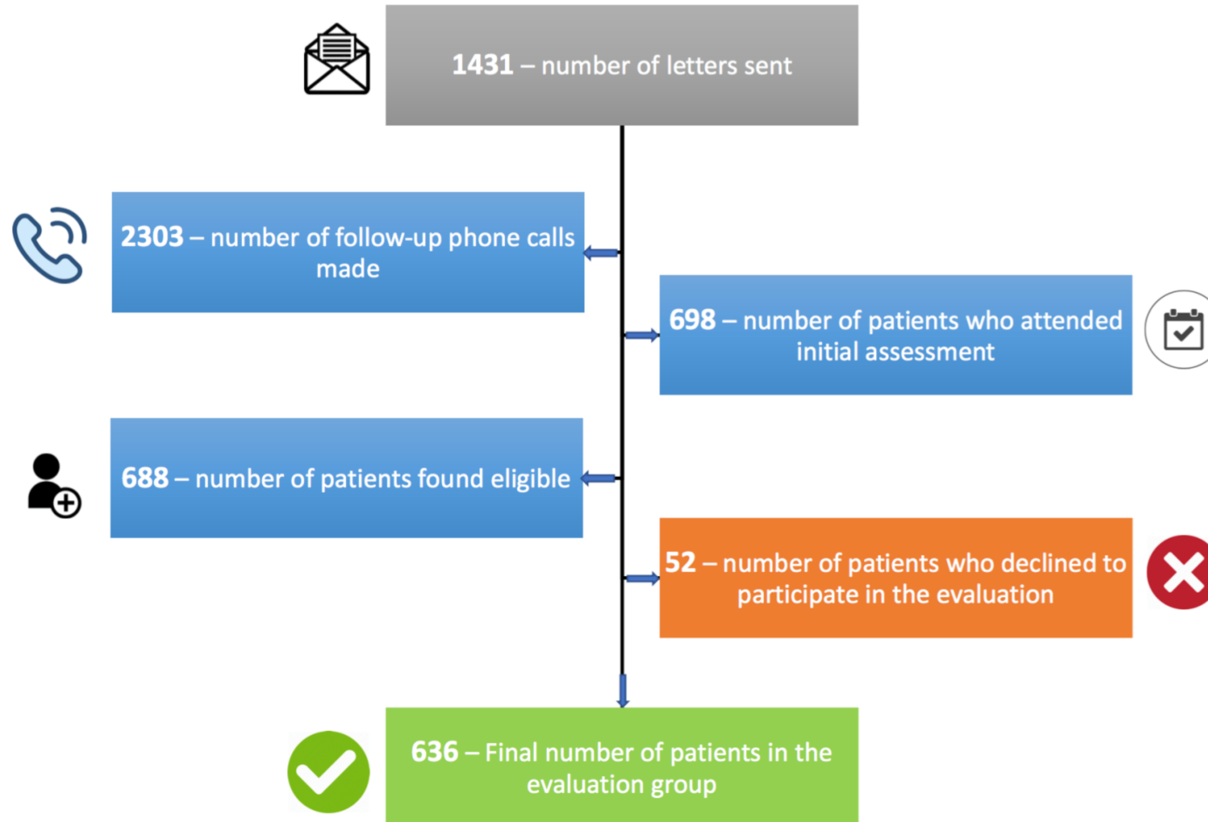
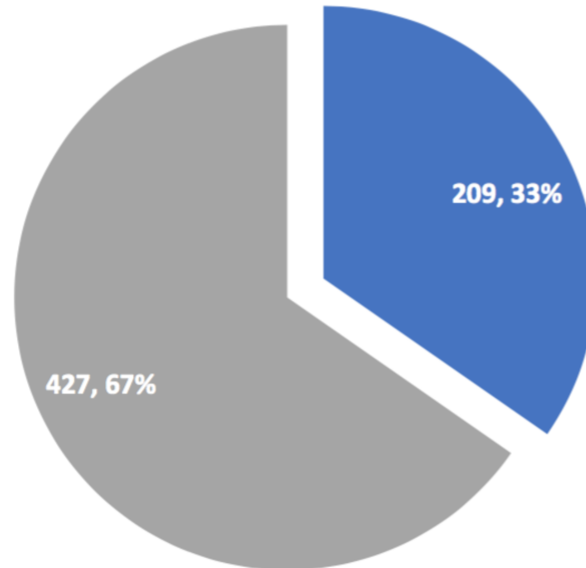


Patient enrolments

Method of Enrolment

■ opportunistic ■ letter recall



N=636

Patient demographics

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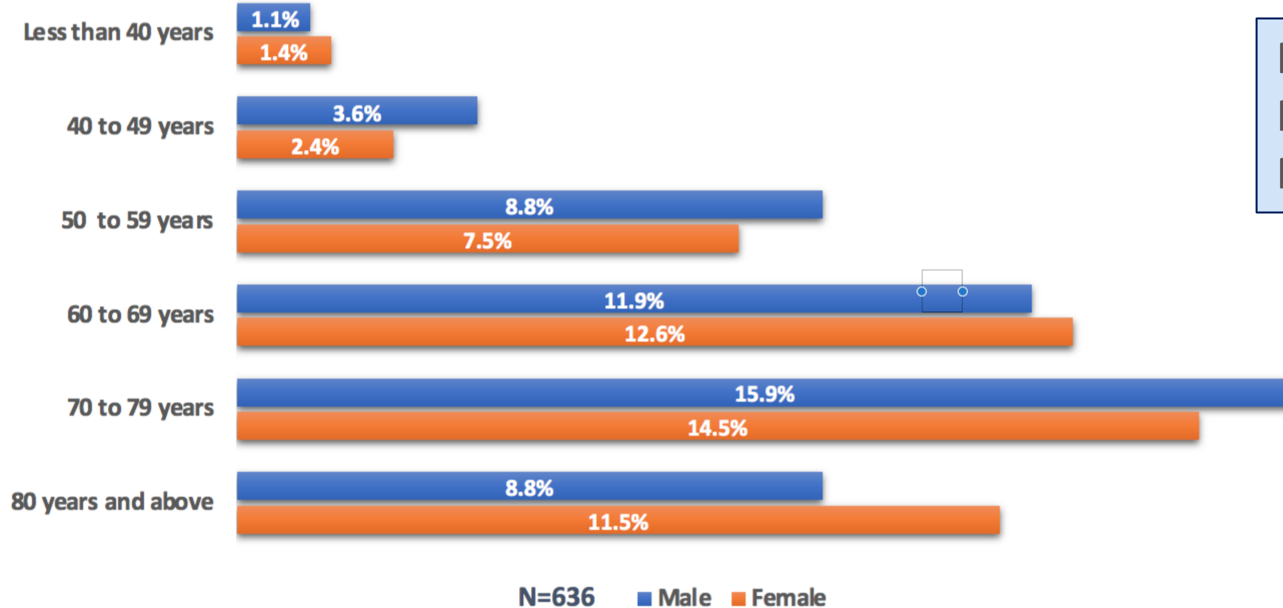
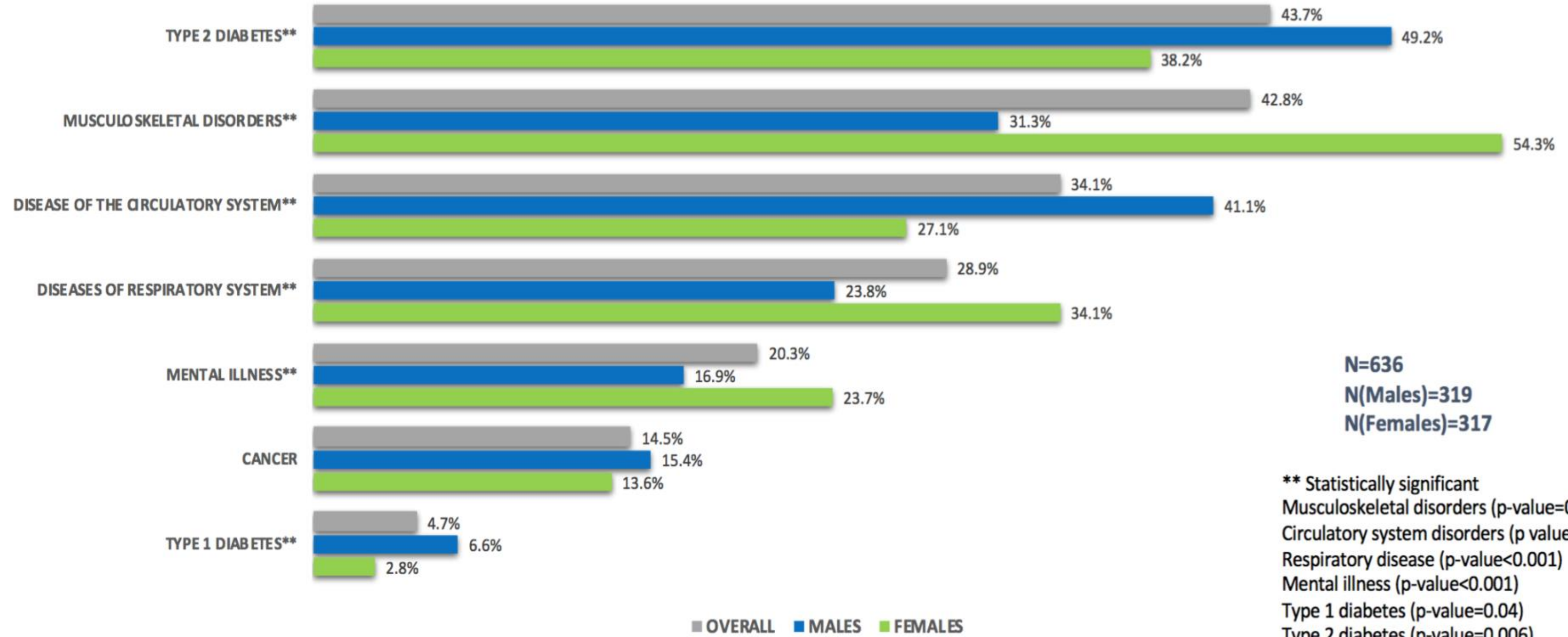


N=636
N (Males) = 319
N (Females) = 317

Disease profile



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Patient Activation

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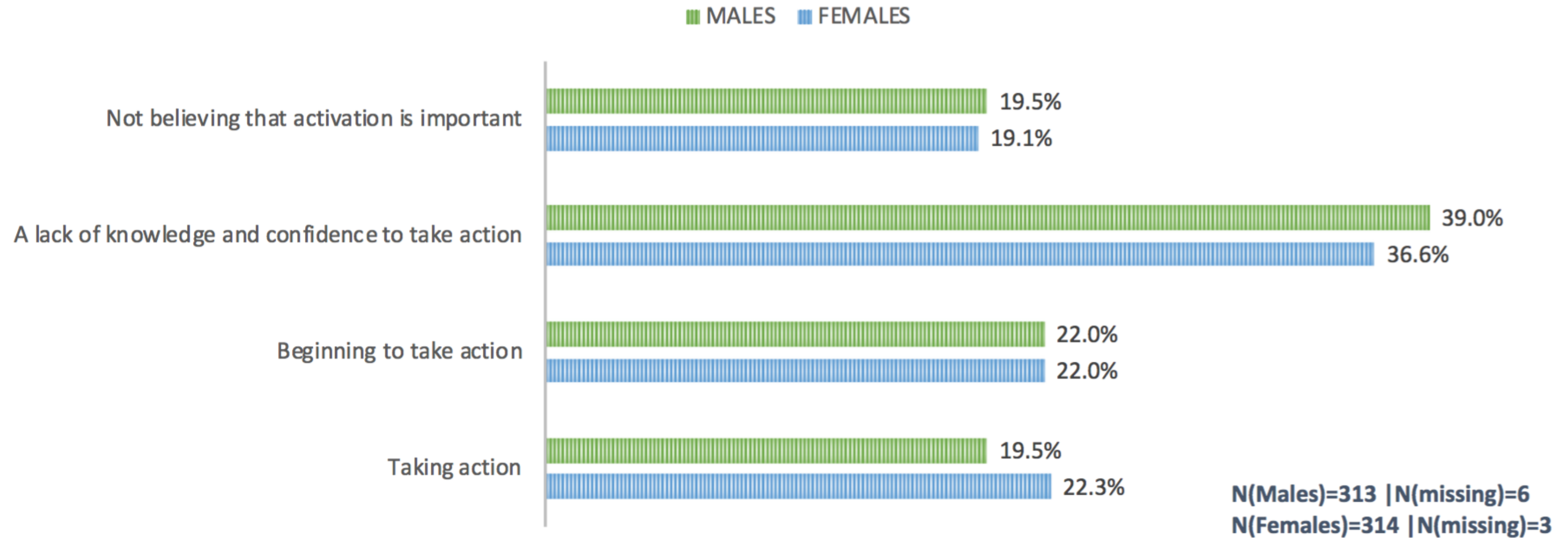

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Patient engagement

- 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

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- 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

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"(cdmNet) saves on faxing and emailing"

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

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

GoShare

- Not hitting the mark – need to explore why

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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

GP survey

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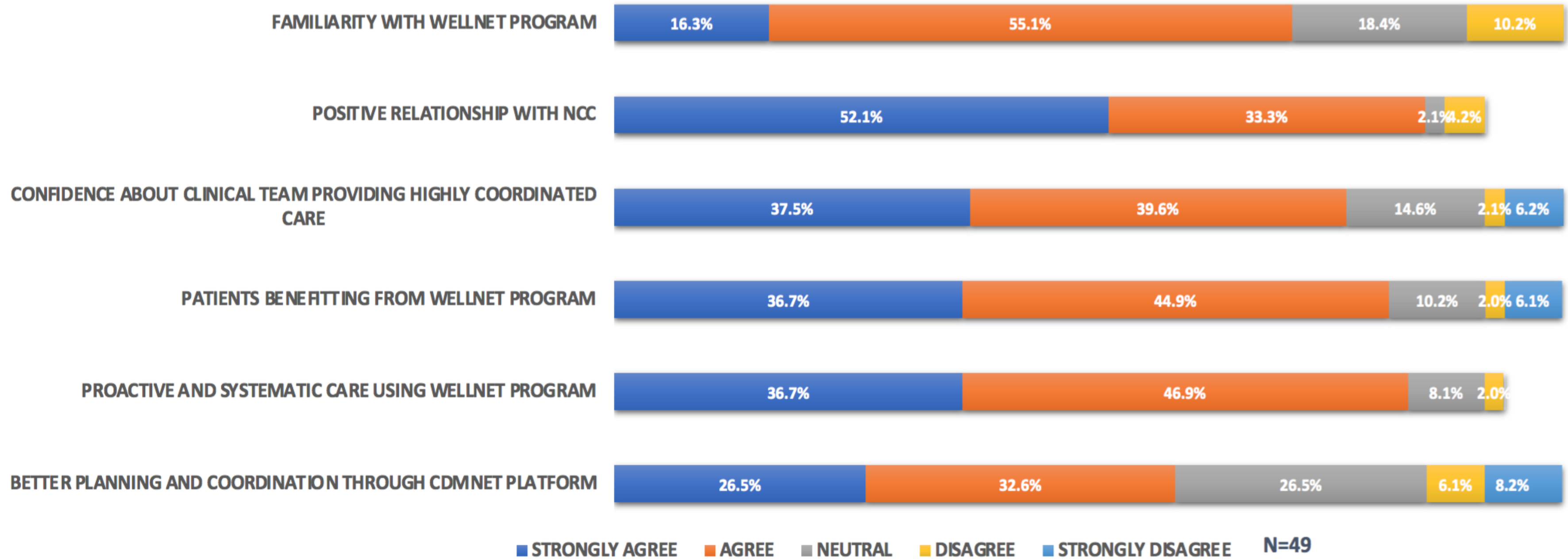

WellNet

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.

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.

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.

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 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.

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Thank you

Questions?