Community Based Care Coordination for High Risk Clients
Medibank: Who we are

...placing the customer at the centre of the service experience...

COMPLEMENTARY SERVICES
- Population Health Management
- Corporate Health Services
- Telehealth
- Diversified Consumer Businesses

ACTIVE PROVIDER ENGAGEMENT
INSIGHTS & ANALYTICS

HEALTH INSURANCE

For Better Health
CarePoint Pilot Study: Aim of the Trial

To:

- test the effectiveness of an integrated service model across primary and tertiary health settings to manage chronic disease patients in the lowest acuity setting that ensures optimal secondary and tertiary prevention.

- improve patient experience and patient outcomes and reduce overall healthcare costs for the patient group by reducing avoidable hospital admissions.

Reduce hospital admissions

- Improve experience of care
- Improve health for people with chronic conditions
- Improve health system utilisation
CarePoint Matched Control

Funded by Medibank Private and VIC DoH (HBF in WA)

2500 Patients enrolled over 2 years

External evaluation by Boston Consulting Group (BCG) (VIC) and University of Western Australia (UWA) (WA)

Intervention participants matched with controls, drawn from VIC population 1500
CarePoint Pilot Details

Patients funded by the Department

- **849**

Eligible to be enrolled for 2 years then ‘rolled off’

- **1600** Patients in total.

General Practitioners

- **239**

GP Clinics

- **239**
CarePoint Program

- Eligible patient consents to participate
- Care Coordinator home visit: Baseline Home Needs Assessment (BHNA)
- Patient issues/gaps identified & actioned
- Monthly or bimonthly follow up calls by phone-based “Care Navigator” (health support officers)
- Regular ongoing review by Care Coordinator, as required
- Discretionary funding to provide extra support/resources when required
- Duration of program – 2 years
Results

Mortality
- Improved Mortality rates

Hospitalization
- Higher hospitalization rates
- More hospital bed days,
  However;

Life Impact
- Cost effective wrt “total life years gained” (LY at cost effectiveness of $82000 per LY gained)
Refinements

Staff
• Defining the role of a Care Coordinator (CC)
• Choosing the Care Coordinator competency based recruitment, soft skills important
• Maximizing the Care Coordinator and Care Navigator interface (communication is key)
• Maximizing staff/client ratios: work flow, avoid CC burnout (possible benefits of a complexity tool)

Program
• Range of programs
• Program duration
• Care Plans
• All patients offered a medication reconciliation, falls risk assessment and vaccination review
• Risk assessment training and evidence based pathways to choose appropriate interventions

GP Engagement
• Always difficult; small No. relevant patients, busy GP’s
• Always valuable
• Solution: GP visits with clients.
• Interaction with myHealthRecord moving forward
Application to More Complex Cohorts

**Integration**
Complemented by integration with a hospital discharge team who identify eligible patient based on a range of algorithms

**Access**
Access for care coordinators to the hospital record

**Visibility**
Tracking hospital admissions, discharges, ED attendances and missed OPD appointments

= **Improved Results**
CarePoint Public Cohort: Participant Condition* Profiles

* Some participants have more than one condition

Public patients have an average of 3.6 conditions compared to 2.7 for MP patients
60% of patients experience high impact, 38.5% low impact
and 1.7% experience no Impact
Public Cohort Compared to Medibank Private Cohort

- Younger
- Less likely to have had a flu-vax (61% vs 77%)
- Isolation is similar (26% vs 27% live alone)
- Psychosocial factors have greater impact
- Much higher rates of CALD 17% vs 4%
- Higher rates of diabetes, heart disease including CHF, asthma, COPD, stroke
- On fewer medications
CarePoint Public Cohort: Participant Demographics

Flu Vaccination status at enrolment

- Yes: 61.0%
- No: 28.8%
- Unsure: 10.2%

Number of Medicines

- 0-4 medicines: 36.0%
- 5-10 medicines: 46.1%
- 11-15 medicines: 13.3%
- More than 15 medicines: 4.5%

40% of patients do not or are unaware of Influenza Vaccination status
64% patients taking more than 5 medications
Active and Withdrawn Patients for a Cohort of 88 Public Patients

Deceased patients account for 57% of attrition post written consent.

92% of participants remain active post written consent.
Each point increase in PAM score correlates to a 2% decrease in hospitalization risk and a 2% increase in Medications adherence.
Key Benefits of the HARP for CareComplete:

✓ Results and evaluation – gives a measure of program effectiveness

✓ Can help prioritise urgency of interventions

✓ Results can be used to inform and improve patient care e.g. psychosocial variables can indicate areas for increased focus within a specific cohort
Pre and Post PAM and HARP
Results: Public Cohort (n=5)

<table>
<thead>
<tr>
<th>Patient</th>
<th>Initial PAM</th>
<th>Final PAM</th>
<th>Initial HARP</th>
<th>Final HARP</th>
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<tbody>
<tr>
<td>1</td>
<td>2 (53.2)</td>
<td>4 (80.9)</td>
<td>21 (medium)</td>
<td>12 (medium)</td>
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<td>3 (55.6)</td>
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<td>19 (medium)</td>
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<td>4 (72.5)</td>
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<tr>
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<td>4 (90.7)</td>
<td>11 (medium)</td>
<td>5 (low)</td>
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<td>5</td>
<td>3 (58.1)</td>
<td>4 (100)</td>
<td>15 (medium)</td>
<td>8 (low)</td>
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</table>

**PRE/POST PAM SCORES**

- **Final PAM**  
- **Initial PAM**

**PRE/POST HARP SCORES**

- **Final HARP**  
- **Initial HARP**

![Graphs showing pre and post scores for PAM and HARP](image-url)
Challenges of our Complex Cohort

**Participant**
- Communication
- CALD issues

**Clinician**
- Identifying and harnessing all care providers
- Moving from case management to care coordination
- Workforce safety and burnout

**Outcomes**
- Transitioning off the program
- Sustainable outcomes
Questions ?