

An Introduction to Carepoint:  
A Community Based Care Coordination  
Project for High Risk Clients  
2014-17

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# Carepoint

## Background

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- Many projects set up about ten years ago to try and improve chronic disease management by integrating care provision. Clinical improvement and cost control were the drivers. Generally involved care planning and closer oversight of those with chronic disease
- Carepoint project was a partnership between Medibank Private and DHHS and was based on an investigation by BCG into frequent flyers into hospital system and burden of chronic disease on hospitals – across both private and public 2012/13
- Public - 126K patients had more than 4 IP admissions per year
- Medibank Private - 98K 4+ IP admissions
- Chronic illness 1/3 of hospital costs

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- Model of care designed by Medibank Private with DHS represented
- Inclusion and exclusion criteria established. e.g. Cancer and Dementia patients excluded
- Initially FF's targeted but cohort eligibility expanded to include IP admission for established chronic disease, e.g Heart failure
- Trial will be described but essentially composed of use of care coordination (14), care navigators(7), funding of home services and was based around general practices and certain hospitals.
- Involved management through IT system interaction with GP practices - cdmNet

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- BCG provided statistical and control group guidance
- Lot of discussion about control groups but decision made to define matched controls from State databases, main issue being ethical aspects and project size
- Project oversight by Steering Committee chaired by Medibank and activity carried out by Medibank Private contractors with DHS support
- Presented to House of Representative Standing Committee on Health 2016

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- Some 50 GP practices were offered services across Mornington Peninsula, Frankston and Eastern Melbourne region,
- Frankston and Box Hill hospitals involved
- Complex project involving sometimes difficult interactions with GPs and Hospitals, cohort collected from both, but GP's endorsed planning exercises and coordination processes.
- Baseline assessments, Care Plans, review calls, polypharmacy reviews, hotline call service- were components of the intervention
- SC had regular updates on progress including practice enrolment, client accrual and assessments and provision of clinical vignettes
- Dr Judith Hammond, GP will take us through the project