

# We're with them every step of the way

Introducing CareComplete, a suite of support programs to assist GPs and their patients to better manage chronic conditions



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# Meeting the healthcare challenge



A large number of Australians and their families are affected by one or more chronic conditions, including asthma, type 2 diabetes, coronary heart disease, stroke, arthritis, osteoporosis, chronic obstructive pulmonary disease (COPD), depression and high blood pressure.

The latest national figures indicate seven million Australians have at least one of these conditions, with the proportion increasing with age. The fact a large proportion of the health budget is dedicated to these patients, demonstrates chronic conditions are one of the biggest challenges for the Australian healthcare system.

Substantial evidence shows prevention and better management of chronic conditions in the community leads to improved patient outcomes. Enabling patients to manage their conditions in their own home and avoid preventable hospital admissions, also takes pressure off the healthcare system.

This is why Medibank is working with stakeholders in the primary care sector to deliver integrated care and chronic disease management programs, for those in the community who are most in need.

CareComplete is part of Medibank's broader commitment to improve the healthcare outcomes of Australians living with chronic conditions.



# CareComplete

## Providing an extended support system to patients with chronic diseases

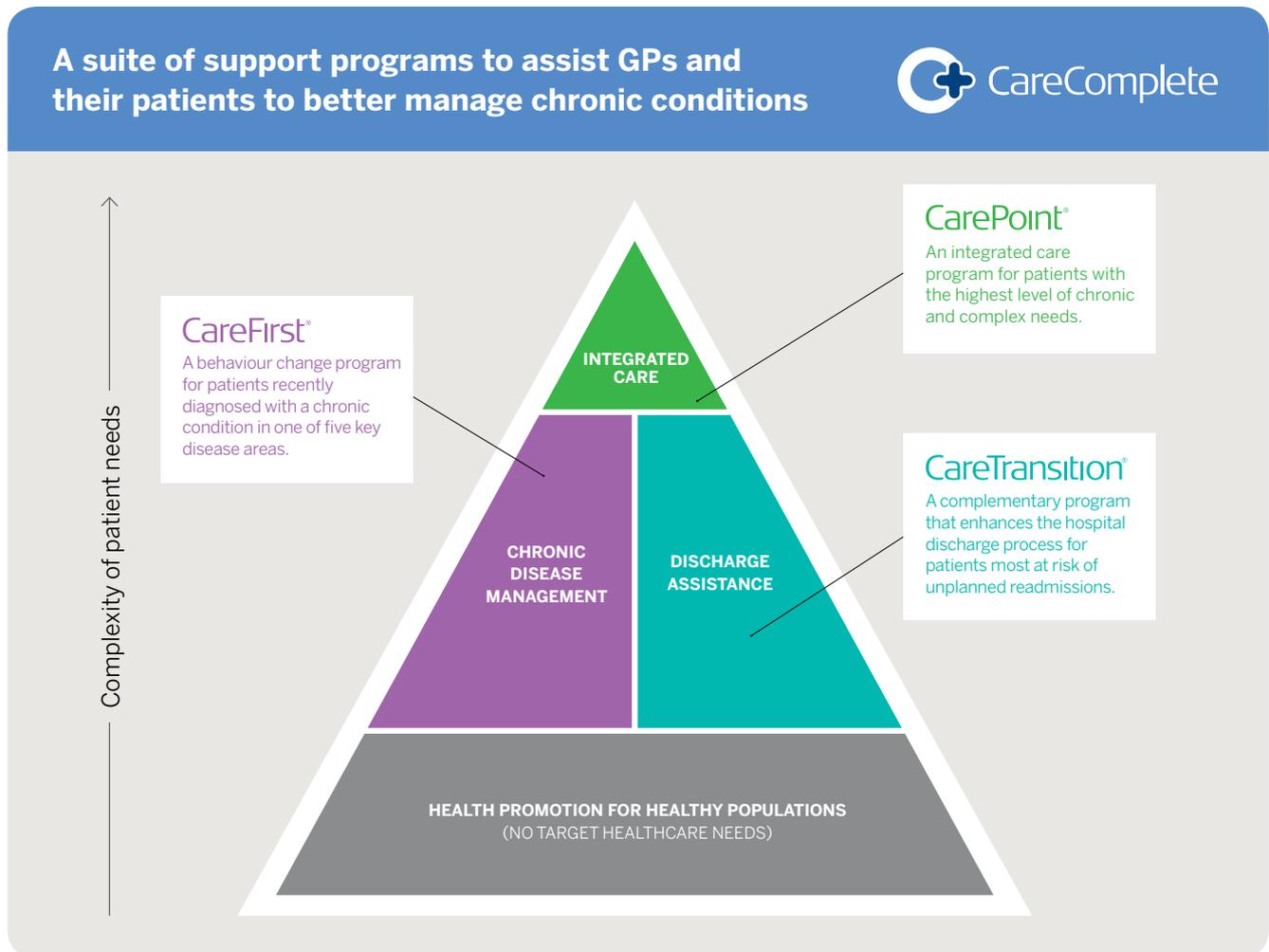
Chronic conditions and complex health issues require significant self-management and a high level of care. However, patients can find it difficult to manage their conditions and navigate their way through the healthcare system, often resulting in preventable disease progression, hospitalisation or re-admissions.

In response, CareComplete is designed to provide patients with chronic conditions an extended support

system and high quality care, helping them to better manage their conditions in the comfort of their own home and avoid preventable hospital admissions.

Importantly, CareComplete empowers patients to take positive steps towards improving their health and quality of life.

At the same time, it aims to support primary care teams and take pressure off the healthcare system.



## Open to Australians who need support the most

CareComplete is open to Australians with chronic conditions, who meet certain criteria that indicate they would benefit from one of the programs.

Eligibility is different for each program and is based on the type, severity and complexity of a patient's condition. Patients are identified in cooperation with

their GPs, who can refer them to the program that best suit their needs.

Importantly, there must also be a funder who is paying for the program (usually a state government, a primary health network or a health fund).



## Supporting GPs in offering the best care

CareComplete provides general practitioners and their practices the opportunity to offer and oversee additional support services to patients with chronic conditions.

As an integral part of the programs, the CareComplete teams work closely with the GPs to provide a 360-degree view of the management of a patient's care. They also ensure all steps are aligned with the GPs management and care goals.

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## Creating value for the healthcare system

CareComplete is designed to offer a growing number of Australians with chronic conditions the level of care required to prevent disease progression and hospitalisation, without increasing the workload of GPs and their practices. In consequence, Australians successfully participating will live healthier lives and require less support from the healthcare system.

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## Designed based on evidence

The three CareComplete programs are based on international evidence from similar programs. Initial findings in Australia are already demonstrating their success. Evidence includes:

- CareFirst is based on the Wagner Model for Chronic Illness Care, one of the most extensively adapted chronic disease management models in the US, UK and Australia.
  - International trials involving over 5,000 patients have showed a coordinated approach to care, similar to that employed in CarePoint, can reduce hospitalisations of patients with heart failure by 25 per cent.
  - CareTransition has been developed by the University of Colorado and two randomised control trials involving about 850 people showed that patients who received this program were significantly less likely to be readmitted to hospital.
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## Continuously assessed

The programs are continuously reviewed by some of Australia's leading universities and consulting firms, including the School of Public Health and Community Medicine at the University of NSW, the University of Western Australia and the Boston Consulting Group. This ensures they are evaluated independently, and provide the very best patient outcomes.

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## Funded by a unique and open public/private model

CareComplete is provided via a unique public/private funding model, open to governments, Primary Health Networks and private health insurers who wish to fund patients in their communities who are most at need. CareComplete is not exclusive to those Australians with private health insurance.

**For more information on how to become part of this unique initiative, please contact 1300 729 684.**

# CarePoint®

An integrated care program for patients with  
the highest level of chronic and complex needs



# CarePoint

This is an evidence-based program that aims to facilitate a smoother journey for patients through the healthcare system, and to keep chronically ill Australians as healthy as possible, so they can manage their condition at home and avoid hospital admissions.

## Available for patients with complex needs

CarePoint is available for people with chronic conditions who had either four or more hospital admissions in a two-year period, two admissions in the last six months, or a sentinel event leading to an unplanned admission related to diabetes, asthma, heart failure or chronic obstructive pulmonary disease.

### A 360 degree view of a patients' care



**There is substantial evidence to suggest more coordinated, improved care leads to a reduction in hospital admissions, because patients access more appropriate care which can meet their needs. CarePoint uses best practice evidence, which demonstrates substantial reductions in hospital admissions and average length of stay.**

### Studies into the impact of a coordinated care approach:

- An analysis of 29 international trials including over 5,000 patients showed a coordinated approach to care can reduce hospitalisations of patients with heart failure by 25 per cent.<sup>1,2</sup>
- A similar program from the US reported 50 per cent fewer hospital days and 45 per cent fewer admissions per 1,000 patients.<sup>3</sup>
- In 2012 a study investigated recent Medicare Coordinated Care Demonstration sites in the US were successful in reducing hospitalisations by up to 33 per cent among patients at high-risk of near-term hospitalisation. The study also found the most successful programs targeted patients with a high-risk chronic condition (congestive heart failure, coronary artery disease or chronic obstructive pulmonary disease) and a hospitalisation in the past, and patients with one or more of nine chronic conditions and two or more hospitalisations in the previous two years.<sup>4</sup>
- A project in Colorado has shown a coordinated approach to chronic care decreased the hospitalisation rate in patients transitioning from a nursing home to home from 14 per cent to 2.4 per cent, which equals an 82 per cent reduction in the intervention population. Additional findings from this study show a reduction in ED presentations from 16 per cent to 7 per cent.<sup>5</sup>
- A program implemented by the Veterans Health Administration, which included telehealth and care coordination, recorded a 19.7 per cent reduction in hospital admissions in a cohort of 17,025.<sup>6</sup>
- The results of the Hospital Admission Risk Program (HARP) project in Victoria showed 35 per cent fewer ED attendances and 53 per cent fewer emergency admissions.

References: 1. Scott IA. Public hospital bed crisis: too few or too misused?, 2010, Aust. Health Review 34, 317–324. 2. McAlister FA, *et al.* Multidisciplinary strategies for the management of heart failure patients at high risk for admission: A systematic review of randomised trials, 2004, Journal of the American College of Cardiology, Vol 44 (4): 810–819. 3. Claffey TF, *et al.* Quality In Maine Medicare Advantage Plan Health Affairs, 31, no.9 (2012): 2074–2083. 4. Brown, R.S., *et al.* Six Features Of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions Of High-Risk Patients. Health Affairs, 2012, 31(6): p. 1156–66. 5. McCarthy D, *et al.* Kaiser Permanente: Bridging the Quality Divide with Integrated Practice, Group Accountability, and Health Information Technology, Commonwealth Fund pub. 1278 Vol. 17. 6. Darkins A, *et al.* Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions Telemedicine and e-Health. December 2008, 14(10): 1118–1126. 7. Victorian Government Department of Human Services: Improving care Hospital Admission Risk Program. Public report, 2006.

## CAREPOINT \*CASE STUDY\*



BELLE

**Belle is a confident and organised 81 year old woman. She has a history of falls, osteoarthritis, osteoporosis, bilateral knee joint replacements and recurrent urinary tract infections. Belle lives with her elderly husband and spends most of her day in bed.**

### Home visit

- Revealed a history of falls and a wrist fracture (Belle's GP was unaware of frequent recent falls).
- Frequent urinary tract infections – Belle does not usually report these to her GP until she is acutely unwell.

### Interventions



An urgent occupational therapy (OT) home assessment was organised within three days of referral and funded by CarePoint (the wait list for community OT was 8–12 weeks). The OT recommended implementation of falls minimisation education and strategies.



The OT recommendations were implemented by the Care Coordinator, which included a referral for council funded personal care support to help conserve energy and minimise falls risk due to fatigue including the introduction of a walking frame to support mobility and reduce falls risk.



Provision of OT recommended equipment to reduce risk of pressure areas and increase Belle's comfort and safety whilst in and out of bed. Funding to be provided by community services and additional health providers.



Care Coordinator received a call from Belle, reporting she had a temperature, no appetite and thought she should go to hospital because she had no way to get to the GP.

### Results

Care Coordinator consulted with the GP who arranged for a Practice Registrar to visit Belle at home that day. Antibiotic therapy was commenced and further investigations scheduled as an outpatient. Hospital presentation was avoided.

Belle was unaware of support available to her, including urgent GP appointments, after hours GP visits and a nurse on-call. CarePoint was explained to Belle and her husband, with supporting brochures and fridge magnets placed in prominent positions in the home.

Feedback was provided to Belle's GP regarding the falls, who reinforced the recommendations of the OT and physiotherapist and suggested a neurological review.

# CareFirst<sup>®</sup>

A behaviour change program for patients recently diagnosed with a chronic condition in one of five key disease areas



# CareFirst



CareFirst focuses on patients living with chronic heart failure, chronic obstructive pulmonary disease, osteoarthritis, type 2 diabetes and cardiovascular disease. It provides health coaching and support to help patients proactively prevent further disease progression.

## Provides support services to encourage behaviour change

CareFirst uses a number of different evidence-based support services to encourage compliance. These include a tailored care plan, disease specific education and health coaching that is steered by the GP and supported by a trained practice nurse. A dedicated Care Navigator also provides additional telephone support to help keep patients on track.

The program provides patients with a personal patient kit including their personalised care plan, disease-specific information and healthy lifestyle information. In addition, the patient receives health coaching, assistance with medicine adherence, access to digital content, access to a community service directory and telephone access to a Care Navigator.



**CareFirst is based on the widely adopted 'Chronic Care' or 'Wagner Model' developed by the MacColl Institute for Healthcare Innovation and describes the elements essential for the improvement of care of people with chronic conditions.<sup>1</sup>**

**Most importantly, these include:**

- The design of the delivery system i.e. the structure of the medical team and care plan
- Self-Management Support (SMS) which supports the skills and knowledge of patients and carers to manage their condition
- Clinical Information Systems (CIS) to improve compliance with guidelines, feedback for performance measures and registries for planned care
- Community resources which link educational and community-based support resources and Care Coordinators.

The model has been used to inform successful chronic disease management interventions not only in the US, but also in the UK<sup>2</sup> and in Australia.<sup>3</sup> An analysis of 29 international trials including over 5,000 patients has shown that chronic disease management programs that systematically use evidence-based guidelines, personalised patient

self-management strategies and multidisciplinary care including specialist nurses reduce hospitalisation by up to 25 per cent in patients with heart failure. Similar programs in Germany have reduced hospitalisation for stroke by 34 per cent.<sup>4,5</sup>

Self-management is one of the key features in successful, high-performing chronic care programs.<sup>6</sup> A systematic review in Australia found that patient self-management support, including educational sessions and counselling in combination with multidisciplinary teams in particular practice nurses, was the most effective intervention to improve patient outcomes.<sup>3</sup>

A 2012 study looked at Medicare Coordinated Care Demonstration sites in the US that were successful in reducing hospitalisation by up to 33 per cent. It found that programs using behaviour change techniques and regular face-to-face conversations to improve self-care were most successful.<sup>7</sup>

References: 1. Bodenheimer T, *et al.* Improving primary care for patients with chronic illness: The chronic care model, part 2. *JAMA*, 2002. 288(15): p. 1909–1914. 2. Singh, D. and C. Ham, Improving care for people with long-term conditions: a review of UK and international frameworks. 2006: University of Birmingham. Health services management centre. 3. Zwar, N., *et al.* A systematic review of chronic disease management. The University of New South Wales. Australian Primary Health Care Research Institute: Sydney, 2006. 4. Scott IA. Public hospital bed crisis: too few or too misused?, 2010, *Aust. Health Review* 34, 317–324. 5. McAlister FA, *et al.* Multidisciplinary strategies for the management of heart failure patients at high risk for admission: A systematic review of randomised trials, 2004, *Journal of the American College of Cardiology*, Vol 44 (4): 810–819. 6. Coleman, K., *et al.*, Evidence on the Chronic Care Model in the new millennium. *Health affairs*, 2009. 28(1): p. 75–85. 7. Brown, R.S., *et al.* Six Features Of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions Of High-Risk Patients. *Health Affairs*, 2012. 31(6): p. 1156–66.

## CAREFIRST \*CASE STUDY\*



M A R G

Marg is 69 and has been diagnosed with asthma, coronary heart disease, type 2 diabetes, osteoarthritis and a BMI of 37.

**My motivation:**  
**“I want to lose weight so I can be more mobile and healthy.”**

This was Marg's priority 1 goal as she completed the six month CareFirst program. Marg said that she was willing to change her diet as per the dietician's advice and the exercises recommended by the physiotherapist.

## Interventions



Medication review resulting in a new diabetes medication with stabilised blood glucose levels.



Marg attended three consultations and has made improvements to control her carbohydrate intake and eat smaller portions. Marg also reported a better understanding of the correct food types and proportions.



Marg engaged with a physiotherapist, dietitian, ophthalmologist and podiatrist during the course of the program.



Through her coaching sessions with the practice nurse, Marg developed a better understanding of her health conditions and her confidence in managing them has increased.



Marg started personal training sessions, including organised pool sessions to help with movement in the context of pain. Marg also reports following an exercise video at home that her trainer provided.

## Results

- Marg has achieved weight loss of more than 3 kilograms.
- Exercise has increased from no activity per week to 240 minutes.
- Healthy food choices are now being made five days per week.
- Marg has established ongoing plans for organised physical activity.
- Risk of hospitalisation (HARP tool) reduced from 20 (med-high) to three (low).

Patient's name and photo have been changed for privacy purposes.

# CareTransition<sup>®</sup>

A complementary program that enhances the hospital discharge process for patients most at risk of unplanned readmissions



# CareTransition



CareTransition focuses on the all-important transition from hospital to home with the aim of improving a patient's ability to manage their own recovery and ongoing conditions. It spans pre-hospitalisation (where possible), in-hospital discharge planning and the early post-discharge period.



For patients with complex health conditions, the risk of unplanned readmissions is highest during the first 30 days after hospital discharge, as they and their carers often struggle on their own to deal with the challenges following a hospital stay.



To improve the continuum of care post-discharge, the program offers comprehensive patient follow up and provides discharge support services over 30 days.

CareTransition supports a patient's post-hospital care by providing discharge information and plans directly to their practice. A CareTransition Coach then works with the patient to ensure follow up appointments are made and attended.

## Available for medium to high risk patients

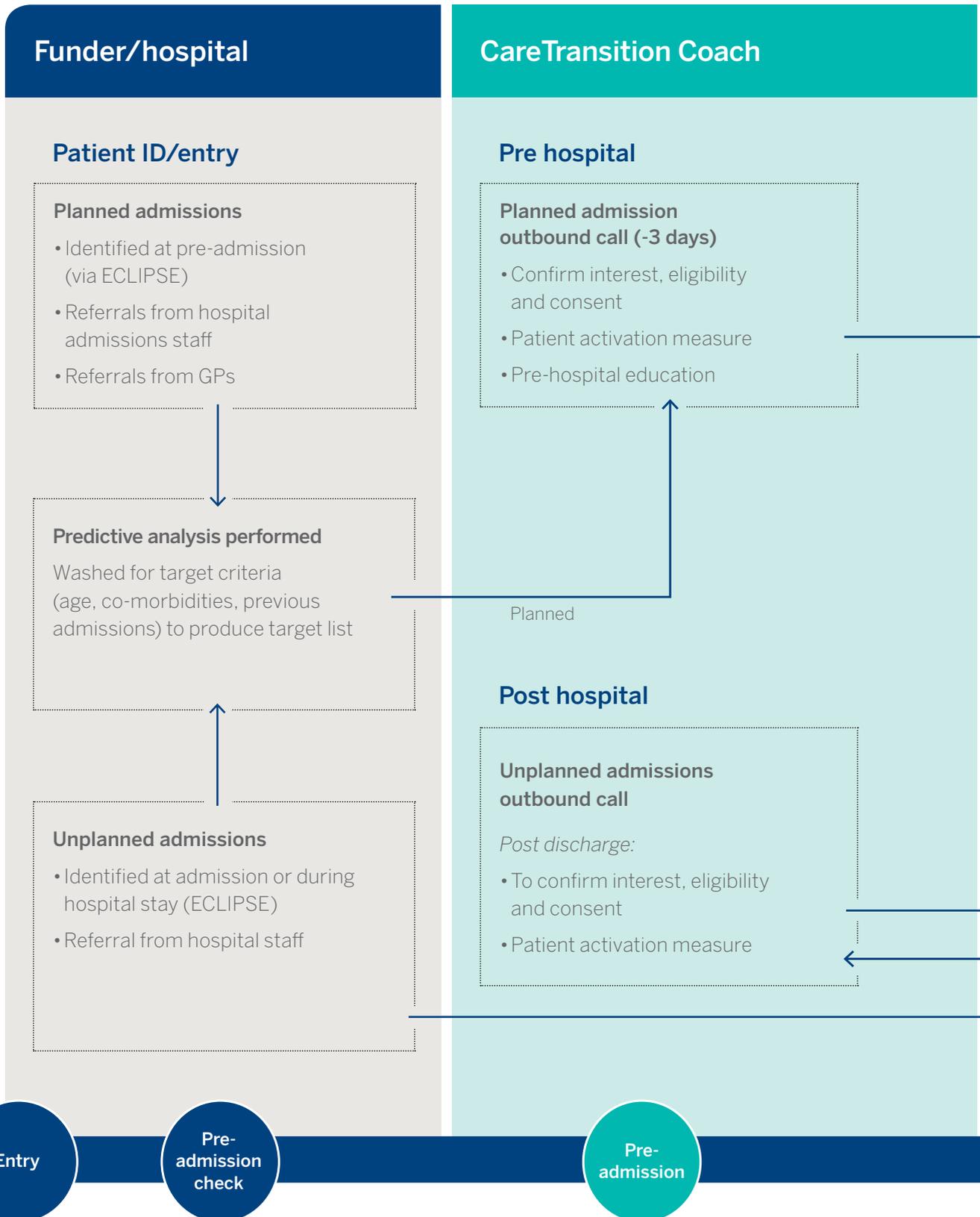
The program is designed for patients who have a medium-to-high risk of an avoidable readmission after discharge from hospital. Eligible patients are identified by a predictive analysis based on their medical history.

In the case of planned admissions, the CareTransition Coach will contact the patient pre-admission to confirm eligibility and interest, as well as provide pre-hospital education and develop an action plan.

Emergency admissions are identified in hospital by hospital staff. Once identified the CareTransition Coach attempts to engage the patient during their hospital stay and in the immediate post-discharge period to confirm eligibility and interest.



## Improves the continuum of care



## Hospital staff

### During hospital

#### Patient attends hospital

Enhancing transition processes and increasing health literacy

#### In-hospital visit

Patient is visited by hospital staff to go through key program targets and to set up a time for a home visit

#### Patient receives information kit

- Transition checklist
- Hospital transition booklet
- Personal health record

#### Data transfer

Discharge plan and med info communicated to patient and CareTransition team

Unplanned patient visit by hospital staff with program information and referral consent gained

Hospital admission

## CareTransition Coach

### Post hospital

#### Post hospital visit

Enhanced early follow up services

#### Transition coaching

Patient sets personal goal for transition

#### Discharge instruction

Review and coaching

#### Medication

Medication review and coaching

#### Red flags

Condition/symptom management review and coaching

#### Primary care follow up

Prepare patient for follow up visit with their GP

#### Outbound call (day 10)

Continued support and monitoring

#### Goal review

- Medication self-management
- Condition/symptom management
- Attending health service

#### Outbound call (day 30)

#### Program review/exit call

- Connect back to GP
- Patient activation measure

GP follow up

Exit

## Care Transitions Intervention® (CTI)

The program is based on the Care Transitions Program®, developed by the University of Colorado. In contrast to traditional case management approaches, the Care Transitions Intervention is a self-management model that complements existing discharge processes and helps patients take an active role in their care.

In two randomised control trials of the Intervention including approximately 850 people, patients who received this program were significantly less likely to be readmitted to hospital, and the benefits were sustained for five months after the end of the one-month intervention period.<sup>1,2</sup> The Care Transitions Intervention was implemented by over 900 organisations in 44 states. Results include:

- The John Muir Physician Network, California, demonstrated reduced 30 day readmissions by 5.6 per cent and 180 day readmissions by 13.9 per cent.<sup>3</sup>
  - Health East Hospital, Minnesota, demonstrated reduced 30-day readmission rate from 11.7 per cent vs 7.2 per cent.<sup>3</sup>
  - A study conducted in the Hawaiian Islands using the CTI reported: Significant difference was observed in the 30-day, 60-day, and one-year readmission rates between the intervention and baseline periods. Compared to baseline (fiscal year 2010), 30-day readmission rate was reduced by 61.4 per cent, from 12.5 per cent at baseline to 4.8 per cent during the intervention period. 60-day readmission rate was reduced by 53.6 per cent, from 17.7 per cent at baseline to 8.2 per cent during the intervention period. Readmission rate within a year was reduced by 42.8 per cent, from 28.1 per cent at baseline to 16.0 per cent during the intervention period.<sup>4</sup>
  - Using the CTI, a 2012 pilot program with Bay Ageing (a community based organisation) and three Riverside hospitals led to a 20 per cent drop in all-cause readmissions.<sup>5</sup>
- There are also a number of single interventions that have been shown to reduce readmission rates. A 2010 review of programs found there is consistent evidence to show intense self-management and transition coaching of patients at high risk of readmission, and the use of home visits and telephone support, are effective in reducing readmissions.<sup>6,7</sup> A 2001 study has shown that follow up phone calls by nurses resulted in fewer emergency room visits and a trend towards fewer readmissions in patients with CHF.<sup>8</sup>
- A 2011 literature review<sup>9</sup> and a 2012 review of successful Medicare care coordination programs in the US<sup>10</sup> support the effect of interventions directed at medication management on hospitalisation rates.

References: 1. Coleman EA, *et al.* The Care Transitions Intervention: Results of a Randomised Controlled Trial. *Archives of Internal Medicine*, 2006, vol. 166, pp. 1822–1828. 2. Parry C, *et al.* Further Application of the Care Transitions Intervention: Results of a Randomised Controlled Trial Conducted in a Fee-For-Service Setting. *Home Health Care Services Quarterly*, 2009, vol. 28, pp. 84–99. 3. Care Transition. Evidence and Adoption. Available online: [www.caretransitions.org/documents/Evidence\\_and\\_Adoptions\\_2.pdf](http://www.caretransitions.org/documents/Evidence_and_Adoptions_2.pdf) last accessed: 4 Nov 2015. 4. Fenfang Li, *et al.* The Kauai Care Transition Program at Kauai Veterans Memorial Hospital. Hospital Discharge Planning Grant Final Evaluation Report, Report to the twenty-eighth legislature state of Hawaii, 2013. 5. Maureen McKinney: Aging agencies help cut readmits, *Modern Healthcare*, 2014. Available online: [www.modernhealthcare.com/article/20140315/MAGAZINE/303159994](http://www.modernhealthcare.com/article/20140315/MAGAZINE/303159994) last accessed: 4 Nov 2015. 6. Scott IA. Public hospital bed crisis: too few or too misused?, 2010, *Aust. Health Review* 34, 317–324. 7. McAlister FA, *et al.* Multidisciplinary strategies for the management of heart failure patients at high risk for admission: A systematic review of randomised trials, 2004, *Journal of the American College of Cardiology*, Vol 44 (4): 810–819. 8. Jerant AF, *et al.* Reducing the cost of frequent hospital admissions for congestive heart failure: a randomised trial of a home telecare intervention. *Medical care*, 2001, 39(11): 1234–1245. 9. Simoons, S., *et al.*, Review of the cost-effectiveness of interventions to improve seamless care focusing on medication. *International journal of clinical pharmacy*, 2011, 33(6): 909–917. 10. Brown, R.S., *et al.* Six Features Of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions Of High-Risk Patients. *Health Affairs*, 2012, 31(6): p. 1156–66.

## CARETRANSITION \*CASE STUDY\*



BERNICE

**Bernice is an 84 year old independent woman who lives alone in her apartment. She has severe asthma and a history of hospital admissions.**

### Home visit

- Revealed an unreliable support network after recent hospital discharge
- No means of transport to do shopping
- No adequate medication system in place.

### Working with her coach, Bernice decided to:

- Talk to her daughter or contact the local council to arrange community transport
- Make an appointment with her GP clinic
- Confirm her post hospital medication regime
- Call her library to see if they would deliver books to her home.

At the follow up calls Bernice told the coach she had a conversation with her daughter who has now committed to doing a weekly shopping trip with her.

She went to her GP and it was confirmed she should cease her discharge medication. Her GP was also able to assist her in developing a medication management system.

### Results

- Bernice's symptoms have improved and she is now confident getting herself to the library and enjoying her passion for reading.

Patient's name and photo have been changed for privacy purposes.



For further information please call  
the CareComplete team on 1300 729 684  
or visit [www.carecomplete.com.au](http://www.carecomplete.com.au).

