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Best practice in chronic disease prevention and management in primary health care

I am a consultant anaesthetist and medical administrator at Sir Charles Gairdner Hospital in Western Australia. These views are my own and **do not** represent the views of my organisation.

I will be addressing the Standing Committee on Health (Federal House of Representatives) enquiry into the best practice for chronic disease management and prevention in primary health care.

Best practice in chronic disease prevention and management in primary health care

Managing the burden of chronic disease is an enormous challenge that will require great change in the Australian healthcare system. Evidence from around the world tells us to change in a stepwise fashion and use the lessons they have learnt. To bring the best of practice to chronic care management in Australia we must first add new payments to Medicare to enable primary care to participate.

This should just be the start of introducing integrated care to the Australian system, and the aim should ultimately be to improve quality and reduce costs with added new programmes over time. Fortunately in Australia we have a strong private health system and there are many possibilities to involve them in chronic disease management and prevention. We have the opportunity as a whole health system to introduce a high quality, cost effective system to manage chronic disease.

Terms of reference 2, 4 and 6 are addressed in this submission. These three terms of reference were chosen because they can be linked to each other to form a complete vision for the Australian healthcare system. The other terms of reference were not addressed due to a limit on the word count for this submission.

2. Opportunities for the Medicare payment system to reward and encourage best practice and quality improvement in chronic disease prevention and management

Fee for service (FFS) payment systems like Medicare are widely accepted to be expensive and not suited to all patient circumstances (1-9). FFS is considered to be suitable for short, acute care illnesses, but ill suited to chronic disease management (10).

USA Medicare has introduced a new payment system called the “Chronic care management payment” that Australia should look to emulate (9). This newly introduced system is unique to a solely FFS system, because it pays for non-visit based activities such as co-ordination and planning. Another unique feature is that it pays for clinical staff time that need only be directed by a physician, like nurses and allied health staff.

Every registered practice is required to work on the plan for 20 minutes a month and develop an annual plan that obtains consent from patients, and informs them of services and care that are available (11). On a monthly basis practices are rewarded for caring and co-ordinating care for patients who account for almost 2/3 of Medicare (US) beneficiaries (9). Not surprisingly about 2/3 of Australian Medicare beneficiaries also have chronic disease (12, 13).

This new US payment system has yet to deliver results, but health reformers around the world are watching with interest. It is an example of a pay-for-co-ordination system, and will financially incentivise primary care / general practice and begin the change to move co-ordination of care to them (10).

Criteria for access to this new payment system are readily available (9), and could be adapted to Australia (14). One of the major criteria for access is use of an electronic medical record. Immediately this is likely to be an issue in Australia (15). With the criteria reworked to suit Australia, payment like this could work and bring definite advantages.

The advantages that are expected of care co-ordination for complex medical patients include reduction of costs, reduced hospital admissions and better health (14). One of the key findings of evidence about a variety of chronic care programmes is that multifaceted care is essential (16). Another key finding is that meaningful annual plans are important. The chronic care management payment would fulfil this important element. The payment also requires 24/7 access to a staff member or care when required. This may be challenging for some practices but newly formed primary health networks could assist for example in forming on-call networks (17).

The key aims of the Primary Health Networks include "increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time"(17). A Medicare payment like the one proposed would help GP's achieve these objectives.

The Medicare Benefits Schedule (MBS) Australia already has two items that reward co-ordination and planning. This can be by GP's, or by a team, and there is also an item number to pay for practice nurse support to patients. Unfortunately these item numbers have been relatively underutilised compared to others.

Some of the barriers to their use have included the administrative burden, complexity to claim these benefits and changing ground rules (18, 19). Taking into account the complexity, low use of these payments, and low rates of practice nurse retention it is a good time to revise these to the simpler chronic care management payment. A broader payment that is simpler will allow primary care to access the payment, engage nurses as part of the team and provide better care to patients.

The Chronic Care Management Payment is not the only pay-for-co-ordination payment used in the USA. Another initiative was introduced by Medicare (USA) in 2013, that is payment for Transitional Care Management (20).

Primary care physicians are paid to co-ordinate and transition care back into the community after patients have spent time in a hospital, nursing home or other high-care facility (20). These two initiatives have established the trend for Medicare (USA) to pay for non face-to-face time. These new payments could result in an increase in income for some general practices, and incentivise them to participate

(20). These increases could be offset by cost reductions in the hospital and high care sector.

An example of the savings per patient: One patient admitted to hospital with an exacerbation of Chronic Obstructive Pulmonary Disease (COPD) costs the system about A$5489. If Australia follows the USA's lead and pays about $40/ month for the Chronic Care Management Payment, this is about A$480/ year. If the goals of reduced admission and better health are achieved then the savings to the health system from one saved hospital admission will be substantial.

These two new Medicare payments would be the beginning of integrated care. Integrated care has been used to describe a range of approaches that have been used to improve co-ordination, continuity of care, quality and communication between different areas of health (10). Around the world there are a wide range of programmes that have been introduced to integrate care and many could be adopted into the Australian healthcare system. There is increasing evidence about the effect of these programmes.

A critical review of payment systems and their effect on integrated care has highlighted some important points about the introduction of integrated care (10). The main features of new payment systems that have made them more likely to succeed are adequate financial incentives, flexible work roles e.g. doctor or nurse and stakeholder cooperation (10). These are features of the Chronic Care Management payment.

Tsiachristas' review identified three different kinds of payments: pay for co-ordination, pay for performance and bundled payments. The Chronic Care Management and Transition payments from above are examples of pay for co-ordination payments. The UK's quality and outcomes framework (QOF) aims to improve the quality of care and is a pay for performance programme. In the Netherlands a bundled payment aimed to improve co-ordination between different providers, strengthen the quality of medical records, promote the use of disease management programmes (DMP's) and the adherence to medical guidelines. It was first piloted with diabetes and then expanded to other conditions (10).

Lessons learned from these systems demonstrate that payment systems are valuable tools in stimulating integrated chronic care. In Europe stakeholders who could have the most impact were targeted with financial incentives, and this was found to be an effective way to stimulate collaboration across different sectors. By first introducing pay-for-co-ordination payments it has been found that subsequent pay-for-performance and bundled payments are more likely to succeed in improving further quality and integration of care (10). Adequate financial incentives for stakeholders are so important that it has been recognised as a major facilitator of integrated care (10).

The choice of pay-for-performance or bundled programmes will likely change as evidence becomes available or changes, and as such no particular programmes should be committed to at this time.

The best fit for Australian Medicare is to adopt a payment system that rewards non face-to-face activity in primary care. Rather than eliminating fee-for-service from primary care a chronic care management regular payment could reduce the need for repeated primary care visits.

The role of private health insurers in chronic disease prevention and management

Private health insurers have been signalling their desire to participate in the primary care market for some time. Examples include Medibank Private's experiment to provide access to their clients to GP appointments (21), and HCF's idea to provide GP home visits for their clients (22).

These signals demonstrate that the timing is right and there is opportunity to bring private health insurers to the primary care sector. As private insurers have always followed Medicare in supporting the FFS payments for acute illness and hospitalisation, it would seem logical that they follow Medicare into a new transitional and chronic care management payment system.

There are a number of different ways private insurers can participate. The first is to offer their clients gap cover payments. For example, if a GP chooses to charge a gap over and above the chronic care management monthly payment, the insurer could cover that gap. This could ensure equity as currently exists within Medicare. Some GP's bulk bill and some charge a gap/ out of pocket payment. All patients would be able to access this scheme, but choice of GP would be available.

Similarly, private insurers could cover gap/ out of pocket payments to transition payments. To ensure their patients have a safe transition out of hospital or high care.

There is of course a financial benefit to private health insurers to participate in schemes that keep their clients well and out of hospital. Health insurers will save money by keeping chronically ill patients out of hospitals that are expensive.

A second way private health insurers can participate in the care of chronically ill people is in preventive and chronic care management activities. They have long participated in this space. Examples of this include HBF's Heart Care and Active Connect Programmes. They also offer HBF coach which is an online coaching programme (23). Medibank Private has offered a Better Health programme that included health coaching, case management and online health information (24).

A number of different approaches could be taken to increase the volume of preventive services and activities offered by health insurers. The first could be to allow health insurers to increase fees to cover these services. Second, health

insurers could offer preventive health or other health packages on their own. That is, without having to offer hospital insurance. By doing this, many people could access relatively cheap preventive health, even those who may not be able to afford hospital cover. By doing this we may see innovative ideas that contribute even further to good health.

One of the innovations mentioned in detail in the section below, is Health Pathways or Map of Medicine (25, 26). Encouraging private hospitals or private specialist practices to develop clinical pathways that can be used by primary care/ general practice will help broaden the choice for patients and GP's.

Private Health Insurers could facilitate or co-ordinate programmes like this. They could charge a small subscription rate to cover their costs. Not just private health insurers may want to participate. Providing a service like this could encourage business for specialists or private hospitals in the form of referrals. Of note many private hospitals are either not-for-profit or have strong philanthropic beliefs (27, 28). Besides increasing their business, they may be happy to partner with private health insurers to provide service to GP's and the community.

Innovations

A number of innovations for chronic disease management exist around the world. The first innovation to mention as above is Health Pathways or Map of Medicine (23, 25). These two programmes both function as online health information portals for GP's or other specialists (29). They are normally developed between GP's and specialists. The aim is to provide information on how to assess and manage medical conditions, and how to refer to specialists. These clinical pathways provide information that can allow GP's to use specialist knowledge to treat their patients, and improve referral information for specialists.

An evaluation of Health Pathways in the Hunter New England LHD showed changes in referral quality and improvement in timeliness of patient access (30). Yet, a different evaluation of Health Pathways performed for the Australian Medicare Local Alliance has not found measurable impacts on service yet (31).

The outcomes they were looking for were reduced hospital waiting times and discharge from hospitals to ambulatory or primary care (31). They did find evidence that there is better collaboration between the acute and primary care sector, improved clinician's experience of patient care and enhanced support for GP's (31). The one theme that comes through from all sources is the enthusiasm for this programme that is establishing itself across Australia. Information like this will allow GP's to treat a wider variety of conditions with quality care, and to refer to specialists with more information.

There have been a number of programmes developed to try and address management of chronic disease. These include broad frameworks and examples of

service delivery (16). Some of the most quoted chronic disease include programmes like the patient centred medical home (USA) (32).

Patient Centred Medical Home Initiatives have been used in the USA for a number of years and have received mixed reviews. They are thought to have achieved modest success. The principles of the medical home include: access to a personal physician, physician-directed medical practice, care co-ordination or integration, enhanced care availability after hours and an electronic medical record (15). The major advantage of the chronic care payment is the ability for team members other than doctors to carry out some of the work.

The lesson that we should learn from others is that innovation is essential, but isolated programmes are unlikely to succeed. To have a significant impact on chronic disease management the structure of our healthcare system is going to need to change so innovation can thrive. This is supported by the World Health Organisation's (WHO) Innovative Care for Chronic Conditions (ICCC) framework (33). This framework saw many innovative programmes developed to care for chronic disease.

Australia should make the decision to work towards integrated care for chronic disease in a stepwise fashion. The first step should be to introduce the chronic care payment and transition payments as Australia's pay-for-co-ordination programmes. Following this, pay-for-performance or bundled payments should be used to support programmes that are selected using the best available evidence at the time.

To support the change the Australian healthcare system can utilise one of the chronic disease broad frameworks. These include the Chronic Care Model from the UK or the expanded chronic care model, or the WHO's ICCC framework or the Continuity of Care Model (16). The point is that there are a number of frameworks used internationally that could be used to support change in Australia. The choice of which should be informed by evidence (16).

The first step is for Australia to commit to restructuring the healthcare system to allow better care and more efficient service for people with chronic disease.

- 1. R. A. Berenson, E. C. Rich. US approaches to physician payment: the deconstruction of primary care. Journal of General Internal Medicine. 2010 Jun;25(6):613-8. 20467910
- 2. A. B. Bindman, J. D. Blum, R. Kronick. Medicare payment for chronic care delivered in a patient-centered medical home. JAMA. 2013 Sep 18;310(11):1125-6. 23929029
- 3. Medicine Blue Ribbon Panel of the Society of General Internal. Redesigning the practice model for general internal medicine. A proposal for coordinated care: a policy monograph of the Society of General Internal Medicine. Journal of General Internal Medicine. 2007 Mar;22(3):400-9. 17356976

- 4. D. M. Bott, M. C. Kapp, L. B. Johnson, L. M. Magno. Disease management for chronically ill beneficiaries in traditional Medicare. Health Aff (Millwood). 2009 Jan-Feb;28(1):86-98. 19124858
- 5. R. P. Cant. Patterns of delivery of dietetic care in private practice for patients referred under Medicare Chronic Disease Management: results of a national survey. Australian Health Review. 2010 May;34(2):197-203. 20497733
- 6. J. Capko. The patient-centered movement. J Med Pract Manage. 2014 Jan-Feb;29(4):238-42. 24696963
- 7. D. A. Conrad. Lessons to apply to national comprehensive healthcare reform. Am J Manag Care. 2009 Dec;15(10 Suppl):S306-21. 20088635
- 8. Peter Sivey. Phase out GP consultation fees for a better Medicare. 07/06/2015. Available from: https://theconversation.com/phase-out-gp-consultation-fees-for-a-better-medicare-13690.
- 9. S. T. Edwards, B. E. Landon. Medicare's chronic care management payment--payment reform for primary care. New England Journal of Medicine. 2014 Nov 27;371(22):2049-51. 25427110
- 10. A. Tsiachristas, C. Dikkers, M. R. Boland, M. P. Rutten-van Molken. Exploring payment schemes used to promote integrated chronic care in Europe. Health policy. 2013 Dec;113(3):296-304. 23937868
- 11. Medical Economics. Getting Paid for Chronic Care. 07/06/2015, Available from: http://medicaleconomics.modernmedicine.com/medical-economics/news/getting-paid-chronic-care?page=full.
- 12. World Health Organisation. Chronic Diseases and Health Promotion. 14/6/2015. Available from: http://www.who.int/chp/en/.
- 13. Stephen Boyages. Australia's challenge: chronic disease and health care. Diversity Health Institute- Clearing House, 2010.
- 14. J. Fuller, P. Harvey, G. Misan. Is client-centred care planning for chronic disease sustainable? Experience from rural South Australia. Health & Social Care in the Community. 12(4):318-26. 15272887
- 15. Tina Janamlan, Claire Jackson, Nicola Glasson, Caroline Nicholson. A systematic review of the challenges to implementation of the patient-centred medical home: lessons for Australia. Medical Journal of Australia. 2014 201(3):569-73.
- 16. D Singh, C Ham. Improving Care for people with long-term conditions: A review of UK and international frameworks. 2006.
- 17. Australian Government: Department of Health. Primary Health Networks (PHNs). 07/06/2015. Available from: http://www.health.gov.au/internet/main/publishing.nsf/content/primary_health_networks.
- 18. M. J. Taylor, H. Swerissen. Medicare and chronic disease management: integrated care as an exceptional circumstance? Australian Health Review. 2010 May;34(2):152-61. 20497727
- 19. H. H. Afzali, J. Karnon, J. Beilby, J. Gray, C. Holton, D. Banham. Practice nurse involvement in general practice clinical care: policy and funding issues need resolution. Australian Health Review. 38(3):301-5. 24870661

- 20. Medical Economics. Transitional care management codes: what physicians should know. 07/06/2015. Available from: http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/coding/transitional-care-management-codes-what-physicians-should-know.
- 21. Sean Parnell. Medibank Private to pick up GP costs in trial. The Australian. 2014 January 10, 2014;Sect.
- 22. HCF. HCF brings after-hours GPs directo to members- at no cost, a first for Australian private health insurance. 2012.
- 23. HBF. Living Well. 10/6/2015. Available from: https://www.hbf.com.au/living-well/get-support/health-programs.
- 24. Medibank Private. Medibank's health management approach. 10/6/2015. Available from: http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/221-interim/$FILE/221 - Submission - Medibank Private (Attachment B).pdf.
- 25. Hunter New England Local Health District. Health Pathways. 11/6/2015. Available from: https://hne.healthpathways.org.au/LoginFiles/Logon.aspx?ReturnUrl=%2f.
- 26. Map of Medicine. Map of Medicine: The pathway to improved care. 09/06/2015. Available from: http://mapofmedicine.com.
- 27. St John of God Healthcare. Welcome to SJOG healthcare. 11/6/2015. Available from: http://www.sjog.org.au.
- 28. Ramsay Health Care. The Ramsay WAy. 11/6/2015. Available from: http://www.ramsayhealth.com/About Us/Values.
- 29. Hunter New England Local Health District. About Health Pathways. 11/6/2015. Available from: https://hne.healthpathways.org.au.
- 30. Hunter & New England Health Pathways Evaluation Steering Committee. Evaluation of Hunter & New England Health Pathways: Phase 2 Report. 2014.
- 31. Alison Boughey Consulting. Health Pathways: An evaluation of its implementation in five Australian Medicare Locals. 2014.
- 32. L. M. Kern, A. Edwards, R. Kaushal. The patient-centered medical home, electronic health records, and quality of care. Annals of internal medicine. 2014 Jun 3;160(11):741-9. 24887615
- 33. Roberto Nuño, Katie Coleman, Rafael Bengoa, Regina Sauto. Integrated care for chronic conditions: The contribution of the ICCC Framework. Health policy. 2012 4//;105(1):55-64.

Appendix 1

Multiple literature searches were conducted of the Medline ® database, University of Sydney library and internet.

The following search terms were used:

- General practice
- Family practice
- Chronic disease
- Payment/ Physician payment review commission/ Medicare payment advisory committee
- Financing/ government/ health planning
- Case management/ disease management
- Prevention/ secondary prevention/ tertiary prevention
- Organisational innovation/ innovation
- Efficient
- Access
- Aged/Adult/ Middle Aged/ Insurance Coverage/ Medicare/ United States/ Insurance, health/ private insurance/ health services accessibility
- United States/ Health Care Reform/ Health Expenditures/ Insurance coverage
- Delivery of health care, integrated/ Integrated Care
- Patient Centred Care/ Patient Centred Medical Home
- Managed Care Programs/ Health Maintenance Organisations
- Value based healthcare
- Chronic disease management UK
- Health Pathways
- Health Pathways New Zealand
- WHO Integrated Care
- Transitional care