Cover Note

Effective management of chronic conditions requires a range of disciplines to be involved (both directly and indirectly) in the delivery of care to comprehensively address patient needs. This requirement presents a challenge to health care delivery, which has traditionally been episodic and based on separate encounters with a number of independent providers. This episodic fragmented care is associated with poor communication between providers, which together with inconsistencies of approach, leads to poor outcomes and duplication.

GMHBA Ltd Health Insurance is excited to have the opportunity to provide input into the Parliament of Australia Inquiry into Chronic Disease Prevention and Management in Primary Care. The inclusion of the Health Insurance Industry is a vital step in invigorating a holistic primary health care system. We feel that there is great opportunity for Insurers to work in collaboration with both the primary and acute care sector in delivering an outcome focused primary care model.

In summary GMHBA Ltd;

Recommend:

- The introduction of a blended payment structure (fee-for service, block funding and performance or outcome based incentive payments) that focuses on a coordinated multidisciplinary approach will produce better long term patient outcomes.
- That the Medicare Benefits Schedule service coding approach to primary care item numbers be overhauled.
- Government assist and financially support the Primary Health Networks (PHN) to universally adopt Health Pathways.
- The larger cultural issue of breaking the barriers that prevent collaboration between providers be addressed.
- Inclusion of patient-reported outcomes as a part of quality outcomes and used to incentivise providers.

- The development of technology that allows providers to share and support each other in providing best practice.
- Better sharing of clinical data (with consent) permitting the identification of people with or at risk of developing chronic illness before a major event occurred.
- Health Insurers be enabled to work more closely with the primary care sector to more effectively identify those at risk and who have chronic diseases.
- Care Coordination and health coaching be facilitated other settings not just general practice.
- Access for allied health, nurses and care coordinators (not just GPs) to MBS item numbers.
- Patient authorised access to *My Health Record.*
- Any changes to primary care funding be phased over time to enable GP practices the opportunity to alter their business models.

Dr Sarah Leach
General Manager of Health
GMHBA

Megan Somerville
Benefits and Provider Relations Manager
GMHBA

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

Current funding and service models do not promote an interdisciplinary approach to patient care and consequently impact on patient outcomes. Current fee for service models are effective in the way they direct effort in the intended area however they do not address quality and a consistent way in which the care is delivered. Take GP care plans for example, a patient will have a much different experience depending on the practitioner and or practice. This unwarranted variation is a significant issue across all aspects of care provision and needs to be addressed more broadly and as apriority with the care pathways for those with chronic conditions.

The introduction of a blended payment structure (fee-for service, block funding and performance or outcome based incentive payments) that focuses on a coordinated multidisciplinary approach will produce better long term patient outcomes. This would allow clinicians to be financially viable to provide service, but ensure the performance outcomes have enough impact to drive behaviour change. Payments should recognise and incentivise:

- Use of multidisciplinary teams (including care coordinators)
- Utilisation of shared record *My Health Record*
- Connectedness between different providers
- Quality of data collection and utilisation
- Participation of patients in chronic disease management and screening
- Demonstration of health outcomes (including patient self-assessed)
- Health promotion in practice population

Care Coordination along with Health Coaching are serious gaps in the primary health care system. The primary care sector delivers great services, but without communication and coordination with the acute, private, public and community sectors patient treatment pathways are less than optimal. Services are duplicated and or missed. It's widely identified that health practitioners generally do not know how central they are in their patient's health care. For example, the GP does not often know if they are their patients' primary GP or if that patient sees GPs in other practices. Sometimes they don't know if their patient has been in hospital, or what happened while they were there or when they were discharged. Although there is a lack of consolidated patient record the issue is more fundamental in that there is no one person or coordinator that is spending sufficient time with the patient to gain a holistic view. There is therefore little or no lasting assistance with the navigation of

our complex health system environment. On the other hand utilised well, Care coordinators are able to gain a greater understanding of the person, not just their illness or chronic disease, which allows for more effective management.

Although care coordination is effective in its own right at improving navigation and data sharing, when combined with health coaching it provides a 'supportive relationship that empowers patients with focus on facilitation, rather than prescription. The patient takes responsibility, feels more confident as they experience small successes and ultimately achieves more significant change than they would on their own'[1]. GMHBA believes that coordination and health coaching should be considered in other settings not just general practice. An MBS item number for Care Coordination/Health Coaching is required for accredited providers to allow for vital health coordination. This should not be limited to general practice.

Funding models for Allied health and Nurse Practitioners are also absent in the primary care sector. Many Allied Health professionals significantly rely on the 5 subsidised GP management plans visits, without this allied health practitioners will not only struggle to support primary care but to be financially viable. The recent Productivity Commission Research Paper *Efficiency in Health* (2015) has identified the opportunities of integrated payment models and the cites a number integrated care models that demonstrate improved quality of care and reduced costs in primary care settings[2] . In addition, the Multi Purposes Services Model operating Australia since the 1990's demonstrates success in pooling of funding for a range of health and aged care services. The Report notes the importance of trialling new initiatives and the important role PHI can play in preventive health[3].

The unintended consequence of the abolishment of nursing Item MBS numbers and replacement with block funding (per nurse) in 2011 was that practices moved many procedures back to the GP consultation room. For example, pap smear clinics were run by nursing teams and practices invested money in training their nurse work force in this area. Because there is no item number for nurses to use, practices have rationally from an economics viewpoint moved this procedure back to the revenue source- the GP. This has not only increased the work load for GPs but it has de skilled the nursing workforce. It is acknowledged that block funding was made available to practices intended for nurses to become more flexible, however it has stifled the progress of nurse lead clinics. Many acute sector trained nurses are being attracted to the primary care environment, however this will

[1] Wellness Coaching Australia - http://www.wellnesscoachingaustralia.com.au/What-is-wellness-coaching/what-is-wellness-coaching
[2] Productivity Commission 2015, *Efficiency in Health*, Commission Research Paper, Canberra, pp. 35-37
[3] Ibid pp 43

not continue in the long term if nurse wages remain lower compared to that of acute nurses and scope of practice is limited.

Additionally, the current Medicare Benefits Schedule service coding approach should be overhauled. Unlike the coding approach for hospitals, surgeons and dentists, which describes the service provided, current GP service coding only identifies the length of the service provided. GP item numbers need to include diagnosis indicator and treatment indicators. This would also assist in the early identification of patients at risk of developing chronic diseases.

3. Opportunities for the Primary Health Networks to coordinate and support chronic disease prevention and management in primary health care;

GMHBA welcomes collaboration with Primary Health Networks in the role out the 'health care home' model for not just our members but for the community.

GMHBA support patient enrolment with a health care home for people with chronic and complex conditions. We do not necessarily believe that this needs to be within the General Practice or public health setting. Patients should be able to have choice regarding their 'health care home', it's important to avoid a one size fits all approach. For some people this maybe their GP, but for others it maybe an independent allied health practice, psychiatrist, National Disability Insurance Scheme (NDIS) or Private Health Insurer (PHI).

Health Insurers are ideally positioned to act as a health care home for members. GMHBA is currently embarking on the creation of a Care Coordination Service run by Registered Nurses that possess health coaching qualifications. This service will be initially made available for members that are at highest risk of readmission into hospital, however overtime will grow to assist all of our members in their health care journey. Having a PHI as a home base could be very advantageous for a member in that they have the ability to work with their care coordinator in accessing a larger range of public and private services to ensure they are fully supported in their chronic conditions. The utilisation of the scale of insurers will be particularly relevant in regional and rural areas where the lack of scale of individual care practices will make it difficult for them to service population health level initiatives.

In terms of enrolment into a health care home, GMHBA supports the notion of supporting a Primary Health Network (PHN) to be the promotor and referrer of this concept. The PHN would be ideally

located to act as a referral and information hub for providers either wanting to be accredited and also promoting patient choice in their decisions around their health care home. As an insurer we see great value in supporting our local PHN support primary care clinicians to plan patient care through primary, community and secondary health care systems. We encourage the government to universally adopt this initiative by supporting a centralised support structure and funding model.

There is no central system to allow providers to share best practice. There are various successful existing initiatives already in existence, however no ability to facilitate knowledge transfer or learning. We believe PHNs play a strong role in enabling this through technological application. Government do not currently reward this behaviour. An incentive system that rewards this sharing and innovation would encourage and enable health care teams better access to best practice application.

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

As funders of largely private and public hospital based care, private health insurers are all too familiar with the cost of hospital admissions resulting from poorly managed chronic disease. As these costs continue to climb insurers possess strong financial motivation to assist their members with chronic and complex health conditions to access effective and cost efficient care; in fact many insurers are already an important part in the members' heath care team.

In 2007 a raft of legislative reforms were made to private health insurance arrangements with the passage of the *Private Health Insurance Act 2007*. In addition to consolidating private health insurance provisions under one Act, these reforms also introduced the concept of Broader Health Cover (BHC). BHC includes programs designed to assist patients better manage chronic diseases through chronic disease management plans (CDMPs). It requires the health insurer to arrange for the coordination of services and the monitoring of patient compliance. CDMPs can be either directly provided by health insurers or contracted out to a service provider on behalf of the health insurer. The sorts of conditions CDMPs cover include cardiovascular disease, diabetes, and mental health. Typically, services that can reduce risk factors, such as smoking cessation programs and weight loss programs are also covered. Services can be delivered by a range of health and allied health professionals, including dieticians, physiotherapists and psychologists.

As a result of BHC insurers have considerable experience in developing and implementing chronic disease management programs on a large scale. This includes analysis, identification of candidate patients, building and managing relationships with patients and providers, purchasing and

contracting services, developing health literacy and coaching, provision and evaluation and building effective relationships with providers.

It is important to identify that the principles of BHC significantly align with the care planning that is delivered in the primary care sector, however primary care providers are hesitant to share this space with insurers. Traditionally the benefits of Insurer managed chronic disease management programs have concentrated on insured people by way of better health and reduced pressure on premiums, however increasingly the benefits are being shared with non-insured people.

A significant gap, especially for insurers, is the absence of data to identify people at risk of developing chronic diseases. Whilst many PHI are trying to make headway in the primary care space and offer sophisticated primary care programs to its members, members can only be identified through self-reporting (rare) or more commonly only once they have had an acute admission to hospitals where by a chronic disease can be identified through hospital ICD10 coding. Better sharing of clinical data (with consent) would permit the identification of people with or at risk of developing chronic illness before a major event occurred. Eventually this would lead to the use of predictive analytics to identify people well before illness took hold enabling more clinically and cost effective treatment paths to be provided.

GMHBA Pilot

GMHBA ltd is currently conducting a Health and Wellbeing Pilot with 10 local (Geelong region) GP Practices that assists their patients/our members with Chronic Disease. Practices identify GMHBA members with chronic disease that typically have a GP management plan and require more support than the 5 subsidised allied health visits extend. Each practice has 'ReferralNet' encrypted messaging embedded in their practice software that allows them (with patient consent) to alert GMHBA of a member requiring extra CDM support. GMHBA checks eligibility and then sends onto a third party CDMP provider 'Remedy Healthcare' (with patient consent). Remedy assess the request and liaise with the practice regarding extra allied health support and then let GMHBA know what the estimated cost to gain approval. With the GP practices that have their own allied health teams, Remedy contracts with the practice to promote continuity of care and a 'home base' model. Where GP practices do not have their own co located allied health team, Remedy contracts with the practices frequently referred or preferred allied health providers. This Pilot program has not just been successful from a patient access point of view but has begun to foster some sound

relationships with health providers that traditionally would not have a relationship purely due to funding arrangements.

Health Technology

Insurers are already piloting with health technology companies to test health devices that allow for remote monitoring. GMHBA is currently completing a Diabetic pilot with Remedy Healthcare that hopes to see reduced acute admission to hospital as a result of this monitoring. The opportunities are endless for health insurers to fund home monitoring health devices, however this cannot be done in isolation. Government need to provide the IT infrastructure and the networks to support the back end of these technologies. The private sector has the expertise and advanced technological solutions in terms of consumer facing application and websites to support patient usage and uptake. All parties benefit from the use of health technology, including technology providers. Only when all parties that have a stake in patient care share in the cost and reward in a more equal fashion (including primary care) will true effective and efficient adoption occur. It is also key importance that these health technologies encourage health literacy and assist people in making informed decision about their health care[4].

We support the use of telehealth and video conferencing to address service gaps. In this context it is important that it's not just GPs that have access to MBS item numbers to perform such consults, allied health, nurses and care coordinators should also have access. Case review is a vital part of care coordination, whereby the entire health care team are in the same room with the patient discussing treatment and care pathways. It not usually possible to get the entire team in the same room as the average patient accesses a variety of health professionals from a variety of locations. Videoconferencing is key in enabling this review to complex conditions to occur.

A central data system such as *My Health Record* or CDMnet requires support by all sectors to enable the health care team to create a holistic view of the patient. This also means timeliness of information transfer. The continued delay in discharge summaries from private and public hospitals will make this difficult to achieve unless there is commitment to improve. In the current environment, even if GPs do receive a timely discharge plan they are usually too busy to review and consult with their nursing teams about possible follow up. Again a Case Coordinator could adopt this role.

[4] McKinsey and Company - http://www.health.gov.au/internet/main/publishing.nsf/Content/9FCABAF426AFF486CA257E93001F2ADC/$File/background.pdf

As identified in McKinsey and Company's Background paper on '*How can Australia improve its primary health care system to better deal with chronic disease*?' the creation of a prominent role for health insurers in primary care is internationally recognised[5].

[5]McKinsey and Company - http://www.health.gov.au/internet/main/publishing.nsf/Content/9FCABAF426AFF486CA257E93001F2ADC/$File/background.pdf