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CONFERENCE ABSTRACT

Care Coordination partnerships: promoting patient choice in primary care

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Introduction: Navigating the Australian health system can be an overwhelming and challenging experience, and even more so for complex patients with high medical needs. At nib, we have seen patterns in repeat hospitalisations by patients who, if given the proper care coordination in the community and education on self-management, may help avoid the next hospitalisation by linking them to the appropriate services in the outpatient setting. The nib Care Coordination Program (CCP), in partnership with Hunter Primary Care (HPC) is a unique program in the Hunter, Newcastle and Central Coast area: promoting collaboration between a private health insurer, primary care, and hospitals, with the patient, GP, and family/carer central to the model. The aim of the nib HPC CCP is to offer a program/support to help integrate services around the patient: helping them access services that they, or their health care team, may not be aware of, and by giving them choice on available services such as health, lifestyle and wellbeing programs.

Methods: The National Health Performance Authority paper on Preventable Hospitalisations 2013 – 2014[4] published data that at a PHN level, there is an opportunity to work with conditions such as COPD, diabetes complications, etc, through appropriate coordination of care, referral to the right services at the right time, and effectiveness of these services in the primary care level. Patients who have frequent hospitalisations and with complex and chronic health care needs are invited into the program. The nib Care Coordination team liaises with the HPC care coordination team, in referring patients to the appropriate services through a nurse assessment and working with the GP, and a multidisciplinary team review. A collaborative care coordination plan is put in place; putting critical value on patient-directed goals and outcomes as part of the successes of this plan. This plan focuses on self-management, ensuring there is appropriate care, support and programs in place to continue servicing the patient long after the pilot is finished. Program recommendations that provide patient choice include utilising MBS items such as 721 General Practice Management Plan (GPMP), community programs and packages, outpatient allied health service as an alternative to inpatient care (such as using the Whitecoat app to locate available services in the area), health and wellbeing coaching programs offered by nib such as Cardiac COACH program, Osteoarthritis Be Good To Yourself, etc, or to the general public such as the Get Healthy Program, Quitline, etc as well utilising technology based services such as online Cognitive Behavioural Therapy (CBT) (eg MindStep) for patients with mild anxiety and depression. The

Whitecoat app was developed to allow all Australians to search and compare healthcare providers to allow them to make better and more informed choices when selecting healthcare providers. Whitecoat is particularly useful for people who have moved to a new area or need treatment for a specialist service for the first time, as well as those wanting a recommendation from patients who have already visited a healthcare provider.

Results: We would like to present the challenges, successes, and lessons learned at the conference. We are continually working with HPC and the Hunter Medical Research Institute (HMRI) in evaluating the program, and developing clinical and cost-effective methods of managing chronic diseases. Through the review of the nib HPC CCP, we are hoping to identify strategies in teaching patients self-management strategies, and demonstrate significant impact benefits on high-risk groups. We have two examples of early program successes that we are keen to share with the audience. These two case studies demonstrate the successes, challenges and clinical outcomes of the programs on patients with complex health needs, and the collaboration between private health insurers (PHI), primary care, and PHN.

Conclusion: We want to challenge the norm: what is the current transition from tertiary care to primary care, and how can we improve the patient experience? The involvement of PHI in care coordination is a new concept, with acceptance of change remain a challenge, and we need all health levels to work together in order to provide the most appropriate care and achieve the best health outcomes – accessing the right care, at the right place and time, for the right patient.

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