GOVERNMENT OF WESTERN AUSTRALIA

Sustainable Health Review

Public Submission Cover Sheet

Please complete this sheet and submit with any attachments to the Sustainable Health Review Secretariat

Your Personal Details ***This information will be used only for contacting you in relation to this submission***	
Title	Mrs
Organisation	MediCoach
First Name(s)	Kim
Surname	Poyner
Contact Details	

Publication of Submissions

Please note all Public Submissions will be published unless otherwise selected below

I consent to my submission being published

Submission Guidance

You are encouraged to address the following question:

In the context of the Sustainable Health Review Terms of Reference listed below, what is needed to develop a more sustainable, patient centred health system in WA?

- Leveraging existing investment in Primary, Secondary and Tertiary healthcare, as well as new initiatives to improve patient centred service delivery, pathways and transition;
- The mix of services provided across the system, including gaps in service provision, sub-acute, step-down, community and other out-of-hospital services across WA to deliver care in the most appropriate setting and to maximise health outcomes and value to the public;
- Ways to encourage and drive digital innovation, the use of new technology, research and data to support patient centred care and improved performance;
- Opportunities to drive partnerships across sectors and all levels of government to reduce duplication and to deliver integrated and coordinated care;
- Ways to drive improvements in safety and quality for patients, value and financial sustainability, including cost drivers, allocative and technical efficiencies;
- The key enablers of new efficiencies and change, including, research, productivity, teaching and training, culture, leadership development, procurement and improved performance monitoring;
- Any further opportunities concerning patient centred service delivery and the sustainability of the WA health system.

Submissions Response Field

Please type your response into the field below. Alternatively you may provide your submissions as a separate attachment (Suggested Maximum 5 pages).

The Key enabler of new efficiencies and change, including research, productivity, teaching and training, culture, leadership development and improved performance monitoring.

This is a strategy to engage, empower and build self-efficacy in patients attending chronic disease clinics in the primary health setting. A health and wellness coach is trained, mentored and employed to deliver behaviour change intervention.

The International Consortium of Health and Wellness Coaches defines coaching as:

"Partnering with clients, seeking self-directed, lasting changes, aligned with their values and enhance wellbeing. In their work, coaches use unconditional positive regard for their patients and a belief in their capacity to change."

Our experience demonstrates that nurses are well positioned to be trained and utilised as coaches within their existing general practice settings, community, hospital and aboriginal medical services.

Patients are informed of the coaching service during their nurse led chronic disease consultation or from their GP during the consent and referral process for care planning. Patients are referred to the wellness coach using an internet portal such as "Referralnet" .

Using a determinants of health wheel, the patient informs the holistic discussion whereby short-term goals & a long term plan, are formulated while the wellness coach facilitates the process. The patient is in control of the decisions, discussions and frequency of their visits. This is an important step for patients taking ownership and engaging in their own health and wellbeing.

The coach uses the patient's HARP tool to assess a patient's "readiness to change". if the patient is appropriate for 1:1 coaching (HARP score < 24) or is to be referred into case conferencing with the collaborating, interdisciplinary team. The coach can then support and advocate for the patient while the team can ensure the patient has all the support they require to assist them to achieve their health outcomes.

For a patient appropriate for 1:1 intervention, the coach facilitates the discussion and helps the patient develop SMART goals between each session and a confidence score to achieve that goal is established. The SMART goals are reviewed at the beginning of each session and the coach facilitates a discussion on how the patient evaluates their progress.

The tools and measurements used during coaching sessions include: PROMIS 43 tool, Health Literacy Questionnaire, along with the biometrics, such as blood pressure, Hba1c, waist circumference, weight, waist and hip ratio; and cholesterol results. These can be measured at the beginning, middle and end of coaching sessions to evaluate the effectiveness of the interventions from a behavioural and health perspective.

Referencing the Health Care Home model and illustration of the tiers , we are utilising existing MBS items to engage patients with more complexities – Tier 2 and Tier 3 patients.

There is good evidence to state that care planning for patients with chronic diseases is effective in improving patient outcomes. Wickramasinghe et al showed that "There were significant improvements in process and

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clinical outcomes for patients on a GPMP or a GPMP and TCA, particularly when these were followed up by regular reviews."

Currently tier 2 and tier 3 patients would engage with the care planning generally once a year and have their EPC allocated.

MBS Item number 721+ 723 + 10997 = $300 per patient

The coaching sessions are employed to engage a higher risk patient using the Wagner Model. "E H Wagner's revision of non-communicable disease management aimed to support patients in self-management of their condition by enhancing their own skills; this required engaging a broader team that includes links with community care agencies, tracking systems to monitor patient progress, and delegation of the central organizational role from physician to a case manager."

The judicious use of the MBS item numbers allows the patient the frequency of support along with the healthcare navigation they require to make sustainable life changes.

Full use of MBS = $1200 per patient per year

This attention to billing detail increases revenue for the practice in the order of $900 per patient while regular care plan reviews enhance the patient's health outcomes. After all this is what the Medicare care planning and case conference item numbers were intended to achieve.

By identifying those patients that require more social, allied health or specialist support we can use the case conferencing item numbers whereby we can bring the team and patient together for a meeting to create a comprehensive strategic healthcare plan. This ensures that patient and their carer can have access to their whole care team in one session. It allows the care team to develop a plan and a strategy to best care for this patient without disengaging the patient from the health service team and creating an unnecessary hospital admission.

Case Conferencing per patient* allows for $291.65 for a 45-min consultation inclusive of GP, Nurse, coach and whoever else is involved, any member can participate via a phone call
*no restrictions on how often you can use these per year.

Chronic disease Nurse Item Numbers MBS 10997 are utilised to Educate, engage and motivate patients

MBS 10997 = $12 + rural remote loading $9 + GP handover item number 23 = $36.00

There are 5 opportunities to utilise 10997 item numbers in addition to the usual care planning of 4 times a year for a patient.

Medicoach can assist with the integration and adoption of this model throughout WA. We are currently involved in pilots in the WVPHN, Murrumbidgee and Hunter New England utilising this above model. Firstly providing the education required to deliver the model and secondly providing the necessary mentorship required to provide this as a sustainable model long term for WA.