

A close-up photograph of a smiling Black woman with short hair, wearing a white lab coat and a stethoscope. She is looking directly at the camera with a warm, friendly expression. The background is blurred, showing other people in a clinical setting.

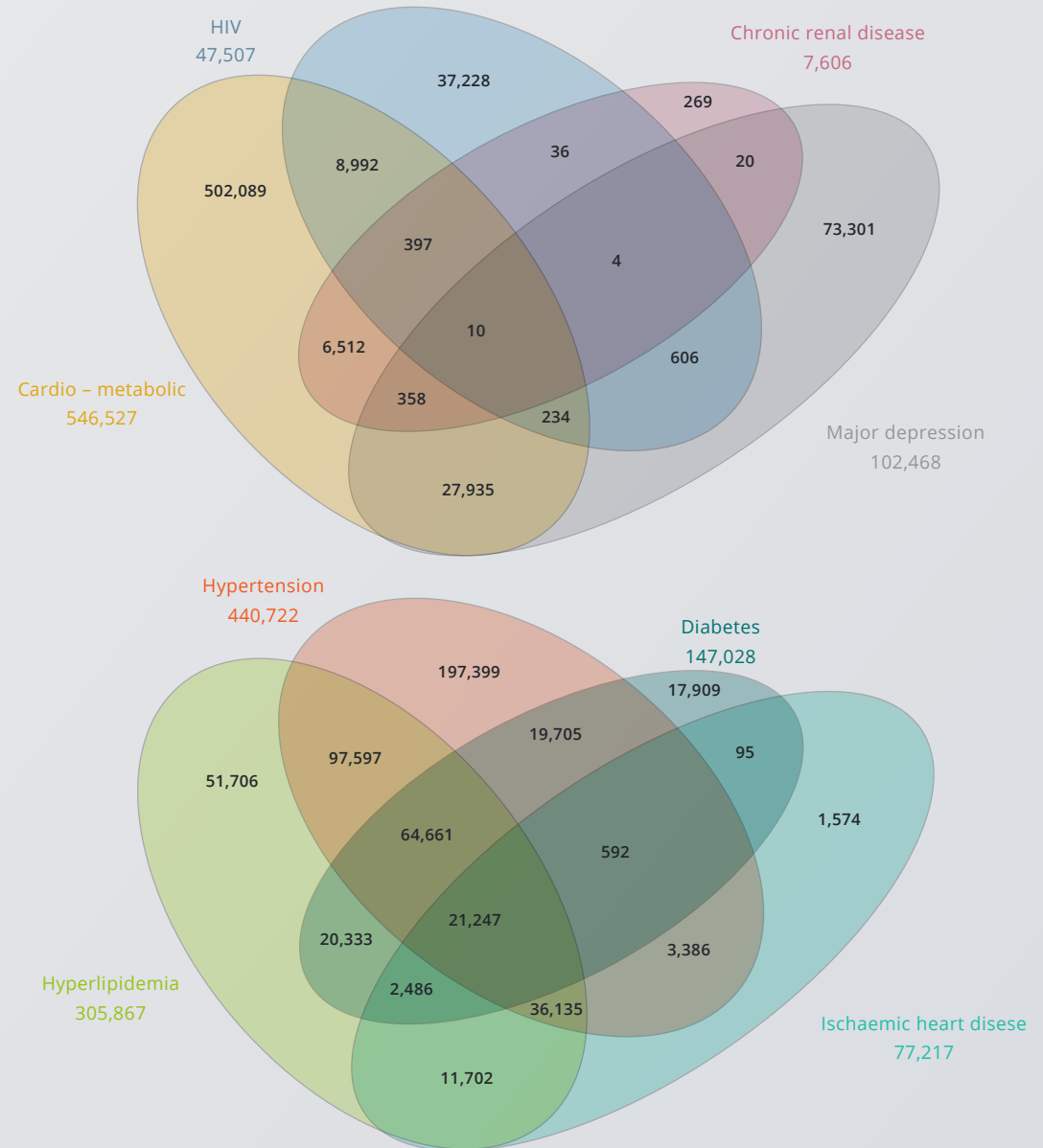
Healthcare professional guide
to the Discovery Health
care programmes 2024



We know that the prevalence of non-communicable diseases (NCDs) is one of the largest global public health crises of the 21st century. To make things worse, South Africa is not only experiencing an increase in NCDs but we also have an epidemic of HIV infections and a rising prevalence of mental health conditions¹. As you know, there is a large overlap in NCDs, HIV^{2 and 3} and mental health conditions⁴ amongst members of schemes administered by Discovery Health due to common underlying risk factors (Figure 1).

September 2023 Overlap of chronic conditions and comorbidities

Figure 1: This graph shows how many members of the schemes we administer have more than one of these conditions and which conditions overlap.



¹ Bradshaw D, Norman R, Schneider M. A clarion call for action based on refined DALY estimates for South Africa. S Afr Med J 2007; 97: 438-440.

² Narayan KM, Miotti PG, Anand NP, Kline LM, Harmston C, Gulakowski R, et al. HIV and non-communicable disease comorbidities in the era of antiretroviral therapy: a vital agenda for research in low- and middle income country settings. J Acquir Immune Defic Syndr. 2014; 67:S2-S7.

³ Magodoro IM, Esterhuizen TM, Chivese T. A cross-sectional, facility-based study of comorbid non-communicable diseases among adults living with HIV infection in Zimbabwe. BMC Res Notes (2016) 9:1-10

Care programmes improve care for patients **with non-communicable diseases**

We are partnering with general practitioners (GPs) to develop centres where members with chronic conditions can get excellent healthcare management for their conditions. These centres are then the designated service providers for our care programmes.

The care programmes are designed for conditions that can be managed in a primary care setting. The Premier Plus GP is the primary care provider and they coordinate the holistic patient care. This involves the GP's care, medicine, tests and added care from specialists, allied healthcare professionals and support services. This model of care places the Premier Plus GP at the centre and ensures that you, together with your patient, are responsible for the selected conditions with the ultimate aim of improving population health.



What is in it for you and for your patients

Your role as a primary healthcare provider is critical to ensure early diagnosis and coordinated care for the growing number of patients living with chronic conditions. This is why we would love your involvement in our care programmes.

As a GP on the Premier Plus Network, you can register your patients on condition-specific care programmes that give you and your patients extra benefits. You also have access to numerous digital services to help you to monitor and manage your patients' chronic conditions.


The benefits for you as a Premier Plus GP

01 

You get a monthly patient management fee of R25 per patient

We pay you a monthly patient management fee of R25 per patient for each of your patients who are enrolled in a care programme. This amount is for your continuous monitoring of patient outcomes and for the active management of your patients' chronic conditions.

We pay you this amount regardless of how many care programmes the patient is registered on. For example, if your patient is registered on the Diabetes Care Programme and on the Cardio Care Programme, we pay you R25 per month for the management of that patient's conditions.

02 

You get an extended consultation fee

We recognise that patients who have chronic diseases of lifestyle need significant self-management of their condition. This is why we have a code for an extended consultation (XCONS) to give you time to:

- Educate your patient about their disease and treatment.
- Do counselling.
- Teach and monitor your patient's lifestyle modification.
- Discuss the treatment plan with the patient and their family.

This additional time will allow you to assess your patient's confidence and readiness to adopt the proposed treatment plan and to make sure your patient understands their joint responsibility with you, as their treating doctor.

The benefits for your patients

- Proper condition management by one provider
- Extra benefits and fewer co-payments
- Access to online patient communities
- Health coaching.

Online patient communities are patient-led, online groups where patients, caregivers, doctors, researchers and others come together with a focus on a particular disease. These online communities share stories and offer support and information and even develop solutions where needed.

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Health coaching is available for qualifying patients with certain chronic conditions. The coaching programmes promote a happier, healthier lifestyle by giving people knowledge, support and easy-to-implement strategies, encouragement and take control of their own health.

How the care programmes work

The care programmes are designed on the principles of prevention, early diagnosis and treatment and ongoing management to reduce disease progression.

What ongoing management entails

Ongoing management of your patients is made easier through HealthID.

You can manage patients with chronic conditions (and those without) at practice-level, population-level and patient-level.

All activities employed in ongoing patient management are aimed at **primary**, **secondary** and, as far as possible, **tertiary prevention**. The intensity with which these activities are applied depends on the severity, disease progression, available resources as well as patient buy-in. The activities include those used for screening as well as those used for treatment.

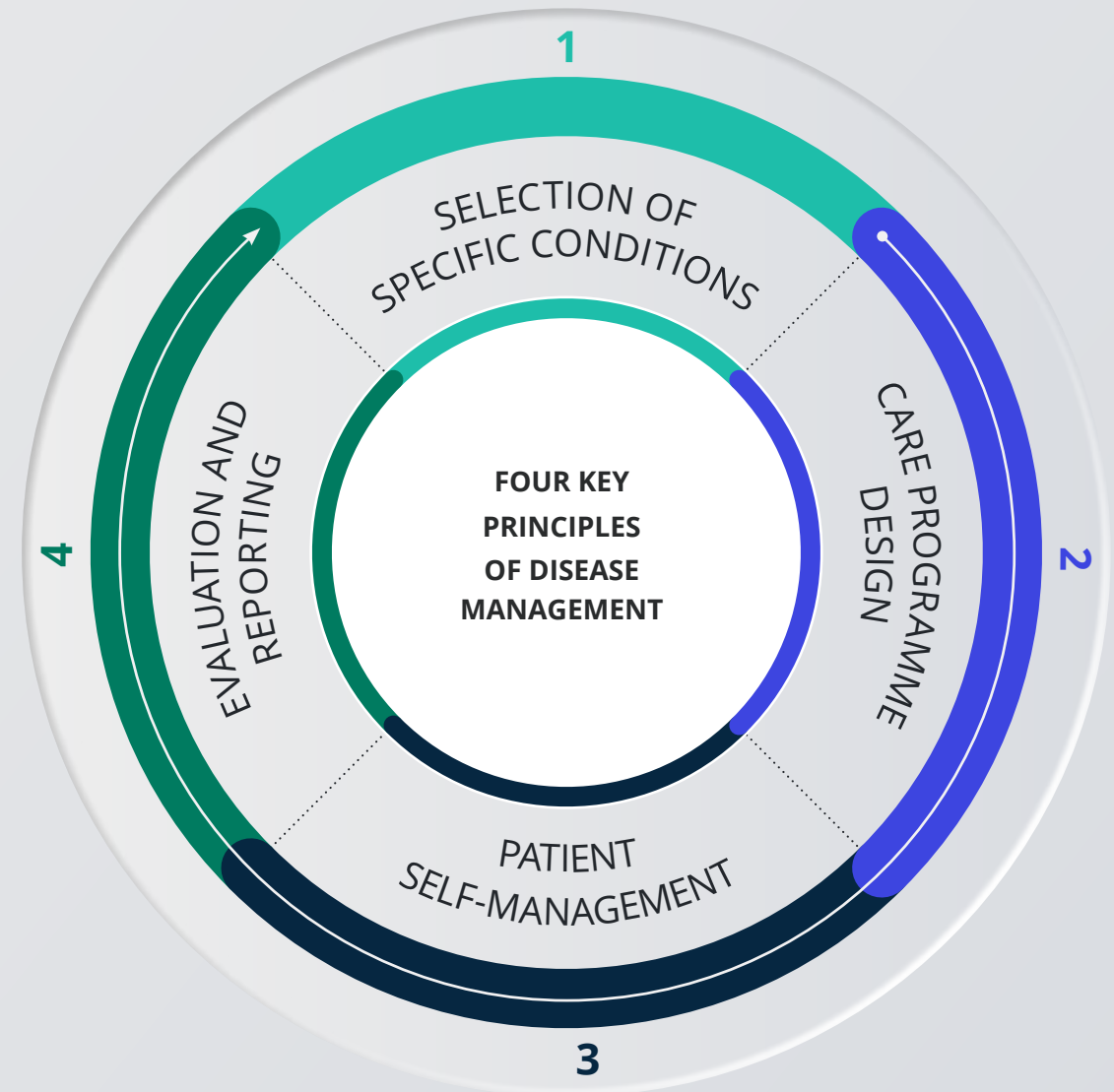
Screening assessments include:

- Risk stratification scores
- Interviews
- Allied healthcare professional engagement
- Patient intuition

Treatment options include:

- Lifestyle modification activities
- Medicine prescription

To make sure that the support from the care programmes is useful to you, please complete the patient's standard metrics and review their prescribed medicine at each consultation. Continuous motivational interviewing is required to empower patients to adapt, adopt and persist in self-managing their chronic condition. Motivational interviewing will also assist in diagnosing and treating depression early on.



Your admin and duties **for the care programmes**

As a Premier Plus GP, you get access to quality, condition-specific patient-management scores and incentives for increasing patient engagement in healthy behaviours that lower their lifestyle risk factors.

You need to register your patients on HealthID

You can click [here](#) for more information on how to register your patient on the Diabetes Care Programme. You can use the same registration process to enrol your patients on all other care programmes through a care consultation. You can enrol qualifying patients on more than one care programme.

Helping your patients to achieve their prescribed disease management goals

You play an essential role in assisting patients to **achieve their prescribed disease management goals**. This includes:

- Educating and motivating the patient to take responsibility for the management of their conditions.
- Bringing about a positive change in the patient's treatment compliance.
- Improving the patient's knowledge and understanding of their conditions.
- Assisting and supporting patients to make good lifestyle choices.

Evaluation and reporting

We measure and report on quality of care at population-level through GP Quality Practice Profile reports. Doctors also have access to patient-level information through patient-management scorecards.



These care programmes are already active

We choose chronic conditions for inclusion into the care programmes where populations are well-defined and where clear evidence-based practice guidelines are in place for the prevention of primary and secondary complications.



01 | Diabetes Care Programme

This programme is available to your patients with diabetes who are registered on the Chronic Illness Benefit. The Diabetes Care Programme assists patients to better manage their blood glucose, blood pressure and cholesterol and engages patients in self-management of their condition in-between doctor visits.

The patients on the programme get access to additional benefits paid for by the Scheme, including:

- A consultation with a dietitian



02 | Mental Health Care Programme

This programme is designed for your patients with newly diagnosed or episodic major depression. The Mental Health Care Programme assists with early identification and holistic treatment of the patient's mental and physical health. To get the additional programme benefits the **member will need to be registered on the Mental Healthcare programme.**

This includes:

- GP consultations
- Antidepressants (SSRI)
- Referral for psychotherapy where necessary
- Behavioural Therapy (iCBT) up to one Internet-Based Cognitive Behavioural Therapy (iCBT) course, accessible 24/7 for 12 months. iCBT will be paid in the place of one of the defined number of psychotherapy consultations, subject to a health professional recommendation, scheme benefit criteria and available benefits.



03 | HIV Care Programme

This programme is available to patients who are registered on the Chronic Illness Benefit for HIV. The HIV Care Programme gives your patient access to comprehensive care that engages and retains patients along the entire continuum of HIV prevention and treatment. It makes integrated management for patients with HIV and other chronic conditions possible and gives patients access to additional benefits that the scheme pays for, including a referral to a social worker. You will need HIV-specific consent to register a patient on the programme.



04 | Cardio Care Programme

Available to patients who are registered on the Chronic Illness Benefit for hypertension and/or ischaemic heart disease (coronary artery disease) and/or hyperlipidaemia. The Cardio Care Programme aims to reverse the disease, which requires significant patient self-care and early treatment to prevent the reoccurrence of the disease and prolong the lives of patients with pre-existing ischaemic heart disease.



05 | Disease Prevention Programme

The Disease Prevention Programme will support patients that are at high risk for diabetes or cardiovascular disease. The programme uses an advanced predictive model to identify patients who are eligible for the programme and supports them for 12 months with comprehensive clinical care, coaching support and enriched scheme benefits to improve their health.

How we pay you to care for your patients on the care programmes

- **You get a monthly patient-management fee of R25 per patient**
- **You get an extended consultation fee once a year per patient**

You can claim one extended consultation fee per patient, per year. This extended consultation (on code XCONS) replaces a standard consultation (it is not in addition to standard consultations). The yearly XCON consultation is linked to the registered provider or the primary care provider.

We have a capitation arrangement for providers on the Discovery Care Coordination Network (DCCN) based on the patient's specific chronic conditions. get more information about this from your account manager.



Medical schemes we administer that take part in the care programmes

Care Programmes




	Diabetes Care Programme with Premier Plus GP	Diabetes Care Programme with Diabetes Care Coordination Network	Cardio Care Programme with Premier Plus GP	HIV Care Programme with Premier Plus HIV GP	Mental Health Care Programme with Premier Plus GP and/or psychologists from the Discovery Health Network	Disease Prevention Programme
AMS	No	No	Yes	No	Yes	Yes
ANGLOVAAL	No	No	No	No	Yes	No
BANKMED	Yes	Yes	Yes	Yes	Yes	Yes
BEMAS	Yes	No	No	No	Yes	No
DISCOVERY HEALTH MEDICAL SCHEME	Yes	Yes	Yes	Yes	Yes	Yes
EMBF	Yes	Yes	Yes	No	Yes	Yes
GLENCORE	No	No	No	No	Yes	No
LA HEALTH						
LA Active, LA Core, LA Comprehensive and LA Focus	Yes	Yes	Yes	Yes	Yes	Yes
LA KeyPlus	Yes	No	Yes	Yes	Yes	Yes
LIBCARE	No	No	No	No	No	No
LONMIN	No	No	No	No	No	No
MALCOR	Yes	Yes	No	No	Yes	No
MMED	Yes	Yes	Yes	Yes	Yes	Yes
NETCARE	Yes	No	Yes	Yes	No	No
REMEDEI	Yes	Yes	Yes	Yes	Yes	No
RETAIL	Yes	Yes	Yes	Yes	Yes	Yes
SasolMed	Yes	No	Yes	Yes	Yes	Yes
TFG	Yes	Yes	Yes	Yes	Yes	No
TSOGO SUN	Yes	No	Yes	Yes	Yes	Yes
UKZN	Yes	Yes	Yes	Yes	Yes	No

How to contact us

If you have any questions or need any further information about the care programmes, email us at healthpartners@discovery.co.za. You can also call us on **0860 44 55 66**.

References

- 01 | Bradshaw D, Norman R, Schneider M. A clarion call for action based on refined DALY estimates for South Africa. *S Afr Med J* 2007; 97: 438-440.
- 02 | Narayan KM, Miotti PG, Anand NP, Kline LM, Harmston C, Gulakowski R, et al. HIV and non-communicable disease comorbidities in the era of antiretroviral therapy: a vital agenda for research in low- and middle income country settings. *J Acquir Immune Defic Syndr*. 2014; 67:S2-S7.
- 03 | Magodoro IM, Esterhuizen TM, Chivese T. A cross-sectional, facility-based study of comorbid non-communicable diseases among adults living with HIV infection in Zimbabwe. *BMC Res Notes* (2016) 9:1-10
- 04 | Clarke DM, Currie KC. Depression, anxiety and their relationship with chronic diseases: a review of the epidemiology, risk and treatment evidence. *Med J Aust*. 2009;190(7 Suppl.): S54-60.

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