My Care Partners

Shared Vision | Shared Care | Shared Outcomes

Information Booklet

phn SOUTH WESTERN SYDNEY

An Australian Government Initiative

NSW GOVERNMENT Health

South Western Sydney Local Health District

Contents

Introducing My Care Partners

What is My Care Partners?

The My Care Partners Program adopts a 'medical neighbourhood' model of care, co-designed by South Western Sydney Primary Health Network (SWSPHN), South Western Sydney Local Health District (SWSLHD) and members of the community.

The goal of My Care Partners is to:

- Improve coordination between the patients' medical home, primary and community services and acute care
- Improve outcomes for patients with complex and chronic conditions who are at risk of potentially preventable hospitalisations
- Improve patient and provider experience by encouraging continuity of care and team-based care to reduce the risk of omission or duplication of services

My Care Partners practices will receive ongoing support to transform into a Patient-centred Medical Home (PCMH). Practices will be supported to complete models for improvement to improve key areas within the PCMH model; patient-centred care, coordinated care, comprehensive care, accessible care and safe, high-quality care. Practices will also receive ongoing support from SWSPHN to implement My Care Partners into their workflow processes.

What is involved?

General practitioners will identify and enrol patients with complex and chronic conditions who have been identified as at risk of potentially preventable hospitalisation.

To become a My Care Partners practice, you commit to;

- Working with a SWSPHN Care Enabler and SWSLHD Care Coordinator to continue to provide team-based care to identify patient needs
- Completing set activities for each enrolled patient
- Completing a Practice Self-Assessment Tool (PSAT) to identify the practice's strengths as well as areas for improvement. Based on the results, the practice will complete action plans to help them work towards becoming a Patient-centred Medical Home
- Providing protected time to allow for staff training and innovation
- Identifying eligible patients for My Care Partners and enrolling them into the program
- Installing and enabling digital health software to improve communication between providers and to track patient journeys
- Reviewing reports and working with patients and their care team to identify needs that can assist in reducing a patient's risk of potentially preventable hospitalisations
- Contributing to the evaluation of My Care Partners

Benefits for the practice

My Care Partners practices will be supported to become a Patient-centred Medical Home (PCMH) through access to;

- Ongoing support from SWSPHN My Care Partners Project team, Care Enabler team and SWSLHD Care Coordinators to improve outcomes for patients living with complex chronic conditions
- Training in digital health readiness and enrolment readiness from the SWSPHN team and Care Enabler team
- Access to 'shared cost savings' distributed across the 'medical neighbourhood'
- Payments to set up as a My Care Partners practice, and ongoing patient enrolment and activity payments
- Opportunities to network with other My Care Partners practices and external providers in your 'neighbourhood' to improve communication and enhance relationships

Benefits for practice staff

Administration Staff	**Quality improvement in the practice** » Opportunities to suggest and work on quality improvement initiatives within the practice » Increasing opportunities for autonomy in your work **Team-based and patient-centred care** » Improving communication throughout the practice » Team-based approach leading to a well-utilised team to meet appointment demands and improve access for patients **Reduced administrative load** » Increasing usage of digital health software, reducing the need for fax » Improving communication, resulting in less frequent need to chase results with external providers » Opportunities to reduce wait times for patients **Learning opportunities** » Opportunities to learn new systems internally through My Care Partners training » Opportunities to join networking sessions

Practice Nurses	**Quality improvement in the practice** » Opportunities to suggest and work on quality improvement initiatives within the practice **Learning opportunities** » Support from the SWSPHN Clinical Support team for practice nurses to work to the top of their scope » Opportunities to attend networking sessions and join the SWSPHN New to General Practice Nursing Program which contributes to CPD points **Team-based and patient-centred care** » Opportunities to work to the top of scope, to provide more integrated and team-based care » Opportunities to provide health education and promotion to patients to encourage self-management of conditions » Opportunities to build a regular patient base through routine complex chronic patient care » Opportunities to provide more clinical care and reduce administrative load » Improving the overall patient experience at the practice
General Practitioners	**Team-based and patient-centred care** » Encouraging and enabling team members within the practice to work to scope thereby reducing the burden on GPs » Improving relationships with external providers, ensuring more timely communication and access to patient information as needed » Access to digital health software to improve communication throughout the medical neighbourhood and ensuring access to current patient information » Improving the patient experience through continuity of care, leading to improved patient feedback » Improving patient experience and outcomes to improve their ability to self-manage their care » Improving appointment systems to provide predictability, continuity of care and improve patient and GP experience by running on time **Learning opportunities** » Networking opportunities to discuss and learn from other practices which can contribute to self reported CPD

Intervention Pathways

There are two intervention pathways a patient may be enrolled in depending on their care needs. Patients will be enrolled into the appropriate pathway as determined by the Care Coordinator following a comprehensive health assessment. If the patient is not eligible for these pathways a recommendation for enhanced usual care will be provided.*

These pathways are as follows:

1	**MCP + Care Coordination (CC)**	**Aim:** Deliberate person-centred organisation of patient care activities between providers to facilitate self-management, appropriate care, health outcomes and greater efficiency, to empower patients to self-manage, understand their illness, and seek additional support and intervention when required. This may include activities such as working with organisations to support the consumer in the community, improving the appropriateness, coordination and consistency of services and/or enhancing choice and flexibility in service delivery.
2	**MCP + Care Navigation (CN)**	**Aim:** To facilitate access to services for the care of a patient, their carers and family for a defined episode of care, in order to improve the timeliness and appropriateness of care, reduce barriers to access to care, reduce failure to follow up, and/or support patients to navigate the health system.

*Enhanced Usual Care (EUC) is not a MCP intervention pathway. For patients not eligible for MCP coordination or navigation EUC may be recommended, along with suitable services. Patients will benefit from chronic disease management activities as part of their usual care, including case conferencing.

Role of Care Enabler and Care Coordinator

What is a Care Enabler and Care Coordinator?

The Care Enabler is a new role introduced to My Care Partners. Care Enablers are SWSPHN staff who will work with your practice to monitor your My Care Partners patients' journeys. Care Coordinators are SWSLHD staff who will facilitate your My Care Partners patients' care for a defined period of time.

The Care Enabler and Care Coordinator will form part of the patient's care team to:

- Assist patients in navigating the healthcare system
- Identify additional support for the patient, such as:
  - Mental health services
  - Disability services
  - Aged care services
  - Nutrition supplementation services (e.g. Meals on Wheels)
  - Community transport services
- Manage supplementary services funds if barriers to accessing certain services are identified
- Facilitate communication and appointments with the care team
- Assist in improving health literacy to empower patients in their health care

Overview of Care Enabler and Care Coordinator support

Timeframe	Tasks
0-3 months **Intervention**	**Care Enabler tasks** » Confirm patient eligibility for assessment » Register patient enrolment and communicate to your practice and Care Coordinator » Monitor patient hospitalisations » Monitor supplementary services funding » Monitor patient journey and completion of patient activities as per MCP contract » Facilitate multidisciplinary case conferences with your practice and the care team

0-3 months **Intervention**	**Care Coordinator tasks** » Conduct comprehensive assessment pre-enrolment » Determine suitable intervention pathway for patient » Communicate assessment outcomes and recommendations to your practice. » Participate in MCP activities as required e.g. clinical huddles, care planning, case conferences » Follow-up with the patient and the care team regarding unexpected patient hospitalisations » Follow-up with patient where clinically indicated » Re-assess patient and prepare Transfer of Care and communicate outcomes with your practice » Assess, review and coordinate supplementary services funds if barriers to access are identified » Complete patient-screening to reassess risk of potentially preventable hospitalisation » Follow-up with the patient and the care team after unexpected hospitalisations » Transfer care back to the regular GP after three months of intensive support
3-12 months **Monitoring**	**Care Enabler tasks** » Monitor unexpected hospitalisations and notify your practice if the patient has been hospitalised » Participate in MCP activities e.g. case conferences » Liaise with Care Coordinator on additional supplementary services if requested by the GP » Participate in post-MCP care planning discussion with the GP » Monitor completion of patient activities » Coordinate communication between members of the Care Team

Practice Eligibility and Payment Summary

Practice eligibility criteria

Eligibility	What's required
1. Practice located in eligible LGAs	» SWSPHN will recruit practices in waves, commencing in certain LGAs. Eligible LGAs will be communicated to practices at the start of recruitment
2. Accredited	» Practice needs to be accredited against the RACGP 5th edition standards » Practice intends to maintain accreditation status
3. Committed to ongoing quality improvement	» Participating in the Quality Improvement in Primary Care (QIPC) Program » Ongoing active participation and utilisation of the clinical audit tool provided by SWSPHN

4. Have a practice nurse employed	» Employed practice nurse committed to:
	  » Networking sessions
	  » Work minimum 12hrs 40min per week upholding the WIP standards
	  » Participate in patient care coordination and multidisciplinary case conferencing
	» Nurses have the option to enrol into *New to General Practice Nursing Program* for additional support

5. Use of eligible clinical software, billing software	» Using software Best Practice OR Medical Director **and** » Corresponding billing software i.e. BP Management OR PracSoft » Willing to update relevant systems to be compatible

6. Completion of digital health readiness requirements	» Willing to install and enable required software to meet digital health readiness requirements. This includes **ALL** of the following: » My Health Record and ePrescribing » iRAD (Integrated Real Time Active Data) » POLAR including Walrus » Participation in Lumos » Secure Message Delivery (SMD) and HealthLink » eDischarge summaries » Practice will allow protected time for staff to receive in-house staff training delivered by SWSPHN
7. Established provider relationship and SMD	» Have an established relationship with local providers that are willing to set up Secure Message Delivery (SMD) and participate in My Care Partners. This includes: » Allied health providers » Specialists » Pharmacies » Willing to assist SWSPHN to engage with external providers to build a network of providers participating in My Care Partners and secure messaging

Implementation summary

The following table provides a summary of My Care Partners implementation in general practice including fixed and ongoing payments for the participation in the My Care Partners program.

Practices are responsible for reviewing ongoing payments at the end of each quarter.

Phase 1

Description	Amount	Due date
1. Sign on » The practice will receive $500 for reviewing and signing the contract » The three months set up phase commences from the day the contract is signed » Nominate one GP, one practice nurse and one administration staff member as your My Care Partners practice team » Nominate a My Care Partners practice lead from within the practice team	$500	Orientation Week

2. Staff are required to register for HealthChat to complete the Practice Self-Assessment Tool » Five staff members including the My Care Partners practice team (GP, nurse, administration staff) are required to complete the Practice Self-Assessment Tool questionnaire » The My Care Partners practice team must participate in the results discussion with guidance from the SWSPHN project team	$400	Weeks 1-3
3. Digital Health installation » Practices will receive $600 reimbursement for the time and involvement required for the installation of the below software, with the help of the SWSPHN Digital Health Team: » iRAD » Polar and Walrus » Secure Messaging Delivery (SMD) » Enable eDischarge Summaries » My Health Record » Participation in Lumos » Enable ePrescribing	$600	Weeks 1-6
4. Completion of two Models for Improvement (MFI) per quarter » Practices will receive $250 per quarter for two successfully implemented MFIs per quarter. A total of eight shall be completed within 12 months » Facilitation of MFIs will commence in the first in-house training session	$1,000	Over 12 months
5. Five in-house training sessions » A project officer will deliver five in-house training sessions to your practice » The in-house training sessions are vital to the success of the program being delivered within your practice » Practices will be reimbursed for providing approximately 8-10 hours protected time within work hours to the My Care Partners practice team to complete the training. Every My Care Partners team member is required to attend all sessions throughout the three-month set up period	Total of $2,500	Weeks 1 -12

The My Care Partners practice team is also expected to attend Community of Practice meetings throughout the program. These meetings provide valuable information that will assist in the practice's performance in My Care Partners, and offer opportunities for practices to network and troubleshoot with fellow My Care Partners practices.

Phase 2

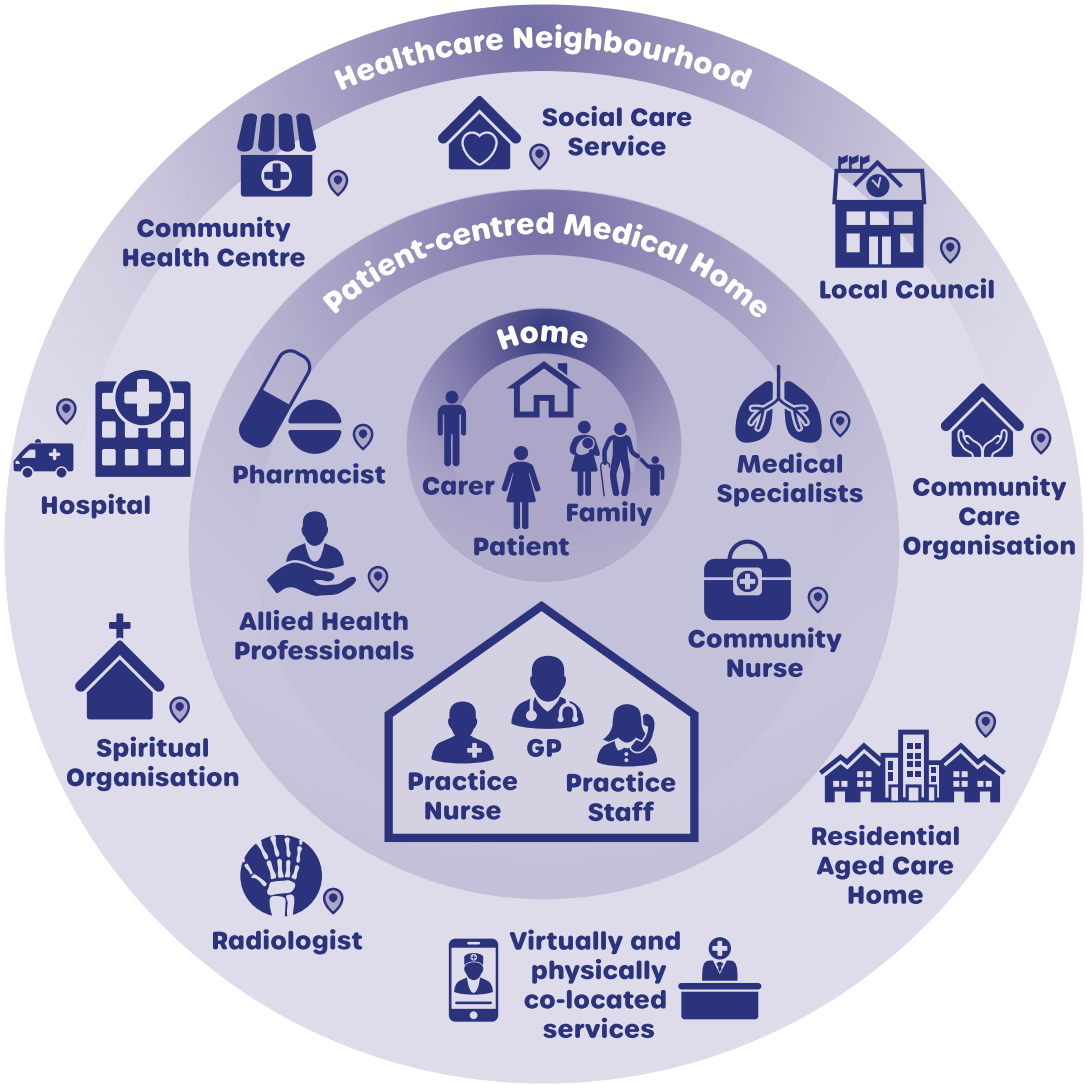
Description	Amount	Due date
6. Patient enrolment Enrol patients into My Care Partners. The process of enrolment includes the GP encouraging the patient to: » Consent to registering for iRAD » Consent to 'patient tracking' through iRAD and at SWSLHD » Consent to having case conferences conducted and information shared to relevant providers (incl Care Enabler, Care Coordinator) » Agree to attend the assigned primary general practice for all chronic disease management related activities » Agree to having a My Health Record and having Shared Health Summaries uploaded » Agree to complete patient experience surveys for program evaluation	$100 per patient	Ongoing after all deliverables of Phase 1 are complete
7. Patient activities Completion of minimum activities within nine months of patient enrolment: » GP Management Plan in place » Team Care Arrangement in place (if eligible) » Two Shared Health Summary uploads (if MHR exists) » GPMP/TCA review » Two Multidisciplinary Case Conferences	$150 per patient	Ongoing after all deliverables of Phase 1 are complete
8. Patient outcomes $30 is placed in a funding pool quarterly for each enrolled patient that was not hospitalised for a potentially preventable condition(s) in the preceding quarter. Payments are aggregated and apportioned amongst participating practices according to the number of enrolled patients on the register that avoided hospitalisation.	$120 per patient per year	Ongoing after all deliverables of Phase 1 are complete

Patient-centred Medical Home (PCMH)

What is a patient-centred medical home?

The patient-centred Medical Home (PCMH) facilitates a partnership between individual patients, their usual treating General Practitioner (GP), and extended healthcare team, to enable better targeted and effective coordination of clinical resources to meet patients' needs.

It provides the GP or practice with clarity, through information sharing and collaboration, regarding the patient's treatment, testing, and diagnosis outside of the general practice, including adverse events and hospitalisations.



Defining the key elements of the PCMH

The RACGP has elementary standards that are built on the areas in the RACGP's 'Vision for general practice and a sustainable health care system'.1 The PCMH standards cover care for all patients in the practice, not only those with chronic and complex conditions.

The following table is an extract from the RACGP's 'Vision for general practice and a sustainable healthcare system'1 white paper that describes each element that aligns with the standards.

RACGP vision for general practice and a sustainable healthcare system

Feature	Description
	**Patient centred:** Patient centred care empowers the patient to be involved in decisions regarding their healthcare. It takes into consideration the patient's culture and background, wishes and circumstances, and fosters an ongoing relationship between a patient and their GP.
	**Continuous:** General practice is centred on the continuous therapeutic relationship between a patient and their GP. Continuous care fosters a coordinated approach to the management of a patient's health requirements based on the GP's access to information about past events and understanding of the patient's personal circumstances. Patients who have continuity of care with a regular GP: » report high levels of satisfaction with their experience of care » have lower rates of hospitalisation and emergency department attendances » have lower mortality rates
	**Comprehensive:** Comprehensive care involves the availability of a wide range of services that can respond to the changing needs of a patient over their lifetime, as well as the changing needs of the broader community. Comprehensive care in the general practice context usually takes the form of a multidisciplinary team of care providers who are wholly accountable for the care requirements of the patient.
	**Coordinated:** Coordinated care involves effective communication and a smooth patient journey through the various levels and settings within the healthcare system, including hospitals, other specialists, disability services and the social sector. Coordinated care takes place both inside and outside of the practice. A well-coordinated health system will ensure that: » health resources are targeted to patients who would benefit most from services (such as those with chronic or complex conditions) » practices can provide a central point of coordination and integration to reduce duplication of effort across sectors and subsequent waste and inefficiencies » patient information (stored in electronic health records) is integrated across service providers, improving communication across the sector » there is better support for transition from hospitals to community-based care, allowing patients to leave hospitals safely and sooner, freeing hospital beds

High quality: In general practice, safe and high-quality care encompasses:

- quality improvement
- encouraging safe practice structures and systems
- clinical governance
- research
- reducing inefficiencies

Safe, high-quality care involves engaged leadership and the participation of the entire practice team.

Accessible: In general practice, accessible care is defined by the ease with which patients can obtain appropriate care. It is dependent on adequate infrastructure and effective management systems supporting GPs and their teams.

Accessible care encompasses elements of cultural appropriateness and ensuring that the care provided to a patient is culturally safe, sensitive and responsive.

Accessible care also involves offering alternative types of clinical encounters for patients who are unable to attend the practice, including phone, email, video or online consultations and home visits. Cost of services to patients will also affect how accessible they are.

Practice Self-Assessment Tool (PSAT)

What is the practice self-assessment tool?

The Practice Self-Assessment Tool (PSAT) was developed by SWSPHN to support general practices working towards a PCMH to support the implementation of the My Care Partners program.

What is the aim of the tool?

The tool provides a focus for discussion between general practice staff on becoming a PCMH. If your general practice has already begun incorporating aspects of becoming a PCMH, the PSAT is a useful resource to assess where you are on the journey of practice transformation. Responses from the PSAT are collated and provided back to your practice in the form of a report.

Who is the tool for?

The tool is for any person working in general practice such as administrative staff, practice managers, nurses, general practitioners, specialists and allied health professionals who would like to engage the practice in becoming or enhancing a person-centred approach.

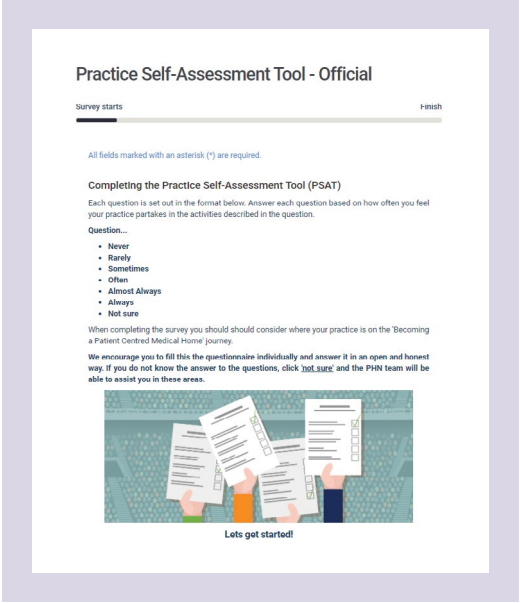
How was the tool developed?

The PSAT was developed through an in-depth analysis of Australian and American PCMH questionnaires, as well as comprehensive research of the 'RACGP Standards for Patient-Centred Medical Home'2 and the 'RACGP Vision for general practice and a sustainable healthcare system'.1 This included linking and developing questions in conjunction to the mandatory indicators of the RACGP Standards for Patient-centred Medical Home.

The concepts of 'The 10 Building Blocks of high performing care'3 and the 'Quadruple Aim' are also reflected in the SWSPHN Practice Self-Assessment Tool questions.

The PSAT consists of questions grouped into the following sections:

1. Patient-centred care
2. Coordinated care
3. Comprehensive care
4. Accessible care
5. Safe and high-quality care



Defining a Neighbourhood

What is a My Care Partners 'medical neighbourhood'?

When you join My Care Partners, you **become part of a 'medical neighbourhood'**. This neighbourhood includes other general practices participating in My Care Partners who are geographically close to your practice. Throughout your participation in My Care Partners you will have the opportunity to connect with practices in your medical neighbourhood, both online and through community of practice sessions.

Shared vision

My Care Partners has been created on a shared vision across health organisations, health professionals and community members throughout South Western Sydney.

This shared vision began with the quadruple aim:

As an active member of your medical neighbourhood you will work collaboratively with other participating practices to reach a shared goal - improving the outcomes of your shared cohort of patients. Under My Care Partners, this shared vision focuses on providing patient-centred, high quality care, and reducing potentially preventable hospitalisations (PPH) for those with complex and chronic conditions.

For a hospitalisation to be deemed potentially preventable:

- SWSLHD uses the coding system 'International Statistical Classification of Diseases and Related Health Problems' to code each patient's hospital encounter
- The Care Enabler team reviews the codes to confirm the type of admission and if it was a potentially preventable hospitalisation

Shared care

As part of My Care Partners, your practice will be encouraged to attend Community of Practice meetings with other practices in your neighbourhood.

Communities of Practice encourage an environment of shared learning and provide you with an opportunity to:

- Share your experiences in My Care Partners
- Discuss Model for Improvement ideas
- Discuss de-identified patient data
- Work with practices in your neighbourhood to enhance communication strategies

These enhancements throughout your neighbourhood can help to improve patient self-management and reduce the burden on hospitals and emergency departments through the reduction of potentially preventable hospitalisations and presentations.

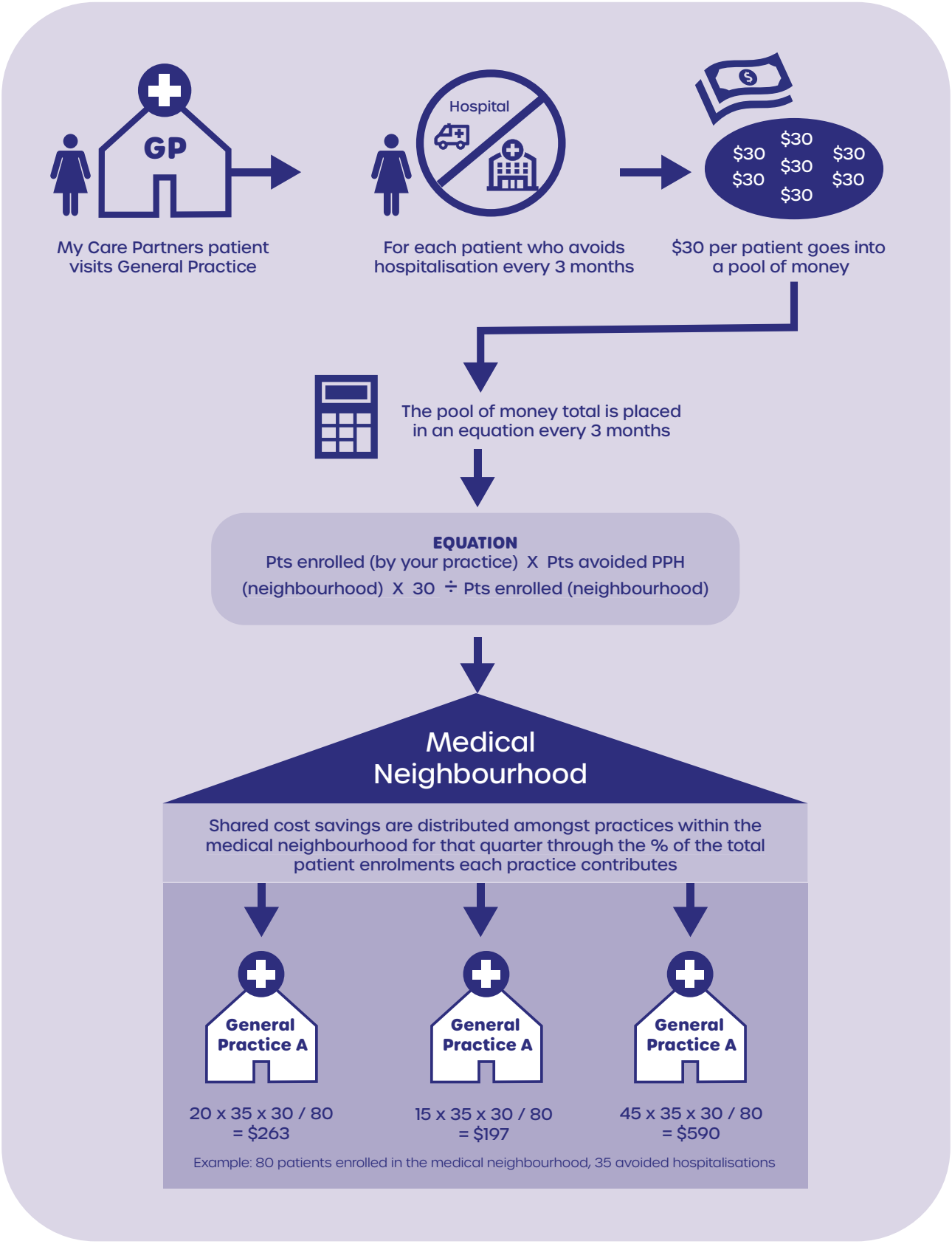
Shared outcomes

As a result of shared care, your 'medical neighbourhood' can achieve shared outcomes. Each practice will receive patient outcome payments as a result of a 'medical neighbourhood' reduction in potentially preventable hospitalisations.

In your medical neighbourhood, a **shared cost savings model will be applied to patient outcome payments**. This will not affect other payments you receive as part of the program.

Shared cost savings mean your neighbourhood will receive a funding pool based on the number of patients enrolled that avoid potentially preventable hospitalisations. From that funding pool, your practice will receive a percentage based on your current enrolment contribution to the neighbourhood.

My Care Partners - shared cost savings diagram



Digital Health Information

Information and communication technology

Information and Communication Technology play a significant role in supporting the effective implementation of My Care Partners. Participating practices will be guided to maximise the use of enabling tools and technology that support integrated and coordinated care. As part of My Care Partners, practices will be provided with the below tools to ensure good practice workflow.

Shared clinical information

iRAD

Allows critical patient data to be shared in real-time between participating healthcare providers with general practice at the centre.

swsphn.com.au/irad

My Health Record (MHR)

Allows a summary of patient health information to be shared securely to patients and their health professionals across the country. Information shared includes shared health summaries, discharge summaries, prescription and dispense records, pathology reports and diagnostic imaging reports.

myhealthrecord.gov.au

Secure message delivery

HealthLink Connect

HealthLink Connect is a secure web-based server that allows secure message delivery without the need for specific software compatible with HealthLink.

au.healthlink.net

Kiteworks

Kiteworks is a secure email and file transfer portal that enables the sending and receiving of secure information of general practice, care enablers, care coordinators and other NSW Health staff involved with patient care for My Care Partners.

www.kiteworks.com

Data extraction and analytics

POLAR - Population Level Analysis and Reporting tool

A data analysis tool using health analytics to understand and respond to population health trends, support quality in primary health services and provide insights into the local business drivers for general practice.

polargp.org.au/about

Walrus

A point of care tool that prompts the user about missing data, clinical/screening prompts, risk scores, PIP-QI or MBS items for the patient on-screen.

polargp.org.au/primary-health-networks/walrus

Lumos

Lumos is a NSW Ministry of Health program in partnership with NSW PHNs that securely links encoded data from general practices to other health data in NSW, including hospital, emergency department, mortality and others. Lumos presents an opportunity to improve patient care through generating insights into patients journeys across the healthcare system.

health.nsw.gov.au/lumos

In-house Training Sessions

These in-house training sessions have been developed to support and prepare your practice for enrolling patients in the My Care Partners program. You will receive extensive training, outlined below, as well as resources to assist in the implementation of My Care Partners. Each session will require attendance from your My Care Partners practice team. These sessions will be delivered by members of the SWSPHN team and Care Enabler.

SWSPHN and SWSLHD aim to deliver training and ongoing support to your practice through a team-based approach, as this is such a vital component of My Care Partners delivery. As a My Care Partners practice you are encouraged to have a team-based approach to all activities within your practice.

Session plan	
Session 1 » Overview of MCP and key concepts » Defining MCP and lead roles » Review Practice Self-Assessment Tool Report » Establish Models for Improvements 1 and 2.	**1-hour session**
Session 2 » Overview of Model of Care » Introduce Role of Care Enabler and Care Coordinator » Demonstrate use of iRAD and document naming conventions » Identify, refer and enrol eligible patients » General practice role in patient activities. » Create Process Map for MCP	**2-hour session**
Session 3 » Digital health readiness » Prepare for your first patient enrolment » Prepare process map for MCP » Customise training plan for training session 4 and 5 » Establish support huddles	**2-hour session**

Session 4 » Patient centred care planning, motivational interviewing and patient goal setting	**1-hour session**
Session 5 » My Care Partners case conferencing requirements » Case conferencing MBS requirements » External providers required for a case conference » How the Care Enabler will assist you with case conferences » Supplementary services for My Care Partners patients including: patient eligibility for funding, how to access funding, and the Care Enabler and Care Coordinator roles in the funding process	**1-hour session**

Evaluation of My Care Partners

To continually improve My Care Partners, we are engaging with expert evaluators to gain insight and provide feedback on the program. As a My Care Partners practice, your contribution to the evaluation ensures the program is constantly improving and reaching performance outcomes that benefit your practice, and the health care system as a whole.

Any team member from your practice who is actively participating in the My Care Partners program may be asked to participate in aspects of the evaluation.

The evaluation will focus on how the My Care Partners program impacts on the quadruple aim:

Population health 	Potentially preventable hospitalisations and length of stay information on patients enrolled in My Care Partners will be compared between primary care interventions before and after program implementation. Patient Reported Outcome Measures (PROMs) surveys will be collected to capture a patient's perspective of their health outcomes as a My Care Partners patient.
Patient experience 	Patient Reported Experience Measures (PREMs) surveys will be collected to capture a patient's views on the healthcare they have received as a My Care Partners patient.
Provider experience 	Changes in provider satisfaction along with primary care capacity, communication and team-based care within general practices will be evaluated. This helps to inform the type of training and support required for future roll-out.
Sustainable cost 	The sustainability of this shared cost savings model will be assessed to determine its impact on both primary care and the hospital system. The evaluation will also provide insight into how this model can be transferred and scaled up to include more primary care services and different cohorts of patients.

As a My Care Partners practice, your participation in evaluation may include:

- Setting up PREMs and PROMs in your practice for patients to access
- Completing surveys, questionnaires or interviews to describe your experience in the program
- Sharing de-identified data that may be used for publication purposes

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My Care Partners is a joint initiative between South Western Sydney Primary Health Network and South Western Sydney Local Health District

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