My Care Partners
Shared Vision | Shared Care | Shared Outcomes

My Care Partners

Patient Information

My Care Partners helps you better understand your health condition and how to manage it. A supportive and dedicated care team, led by your GP, will get to know you and help you set achievable health goals.

This 12-month program is available to eligible patients who will receive enhanced support at no additional cost. Eligible patients are invited to participate by their GP.

Your GP will:

Sign you up to the program.

Support you through your allocated care program. *See overleaf.*

Work with you to develop a management plan and care team plan to help you reach your health goals.

Engage with other health professionals to become your care team.

Periodically review your care plan.

Answer your questions and listen to feedback about your health or the My Care Partners program.

You will:

As a formality, you need to consent to the program, allowing a dedicated care team to securely access your health information.

Attend all appointments or reschedule appointments you cannot attend.

Accept calls from the practice and care team. This may mean answering phone calls when you don't recognise the phone number.

Participate in surveys. Your feedback helps your GP and care team meet expectations and gives insights for program improvements. Your privacy is protected using a secure survey platform.

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South Western Sydney Local Health District

Care pathways

You will be assigned one of three care pathways, providing different levels of intensity. Consultations may take place by telehealth or in-person.

Navigate

For the first three months you will have regular check-ins with your new **care navigator** who will be the liaison between your GP and public hospital services.

The care navigator will link you with local contacts and supports based on the goals set out in your care plan, for example, home care package assessments, or your local diabetes management team.

The remaining nine months will be primarily in the care of your GP and practice staff.

Coordinate

For the first three months you will have regular check-ins with your new **care coordinator** who will start by developing your care plan in collaboration with you and your GP.

The care coordinator will act as a liaison between your GP and services at the public hospital.

Your care coordinator will actively coordinate services you may need, for example Meals on Wheels, community transport, counselling, podiatry, disability or aged care services.

The remaining nine months will be primarily in the care of your GP and practice staff.

Enhanced usual care

You will receive an elevated level of care from your GP and practice staff for the full 12 months of the program.

Your GP will work behind the scenes with a range of other care team members, including specialists and allied health professionals, and refer you to services when recommended.

You will be expected to attend regular appointments with your GP or practice nurse.

My Care Partners is a South Western Sydney PHN and South Western Sydney Local Health District collaboration to help patients improve their chronic or complex health conditions and avoid hospitalisation. The program is currently available at select medical practices in South Western Sydney.

South Western Sydney PHN | PO Box 90, Macarthur Sq, NSW 2560 | Ph: 4632 3000