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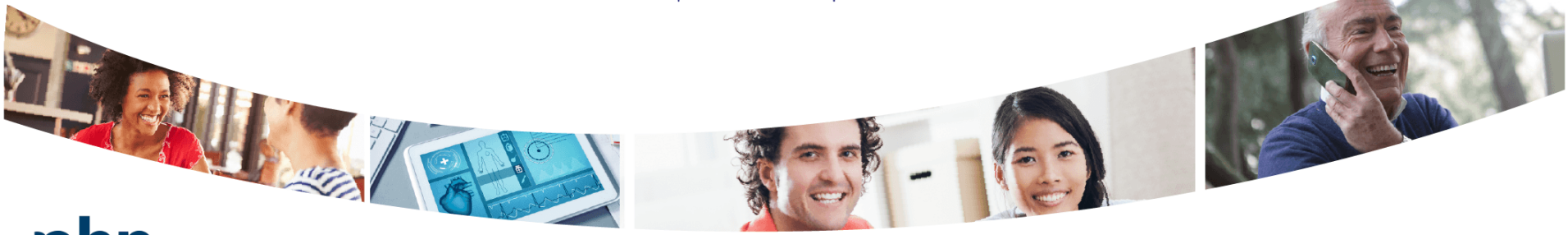
My Care Partners

Shared Vision | Shared Care | Shared Outcomes



phn SOUTH WESTERN SYDNEY
An Australian Government Initiative

NSW GOVERNMENT Health
South Western Sydney Local Health District

Patient Story

Background

My Care Partners

Age: 77

Gender: Male

IC Intervention: Referred via GO for MCP Care Coordination

Past medical history includes:

- Rheumatoid arthritis
- T2DM
- HTN
- Anxiety
- Ischaemic heart disease
- GOUT
- R) knee replacement
- Melanoma at the back of the head

Patient Story

Situation

My Care Partners

- Lives alone in rental property
- Supported by 2 x daughters
- Formal services in place for personal, transport & domestic services
- No longer drives (finds it too difficult due to his arthritis)
- Mobilises using 4WW
- Relies on meals provided by TLC
- Daughter has power of attorney

Shared Vision

What was the issue?

- Patients with complex conditions experience fragmented care
  - Poor communication between members of the patient care team
  - Unmet social needs
  - At risk of frequent Potentially Preventable Hospitalisations (PPH)

Shared Vision

What was the issue?

My Care Partners

- Fundamental challenge to integration is the misalignment of current financial incentives between the primary and acute care sectors.
- The benefits of reductions in PPH favour the hospital funder, but not necessarily the general practices most likely to influence this outcome

Shared Vision

What is the goal?

My Care Partners

- 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

Shared Vision

What did we do?

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- Stakeholder consultation forum
- Working groups formed to develop and implement a medical neighbourhood model of care
- Funded equally by SWSPHN and SWSLHD the model focuses on shared responsibilitv for outcomes.
- Expression of interest sent out to general practices and information webinars held

Shared Care

Key Features of My Care Partners

My Care Partners

GP-led multidisciplinary care coordination built on risk stratification and patient tracking

Introduction of a Care Enabler to help facilitate delivery of care

Integrated information and communication technology

Ongoing general practice capacity building

Shared cost savings back to general practices

Shared Outcomes

Commissioned Services

- Co- design
- Direct engagement with South Western Sydney LHD to deliver “care enabling” services
- Engagement with general practices after expression of interest
- Closed tender for evaluation partner
- Management and monitoring cycle

Shared Outcomes

General Practice Payments

My Care Partners

- Practice seed payment
  - made when practices agree to become a My Care Partners practice and commit to completing a series of capacity building activities
- Patient enrolment and activity payment
  - made per patient enrolled, after completing a series of patient care activities
- Patient outcome payment
  - made when enrolled patients have avoided hospitalisation over a set period of time. Generated from a pool of cost savings achieved by reductions in PPH, which is shared amongst participating general practices in addition to usual care.

Patient Outcome Payment

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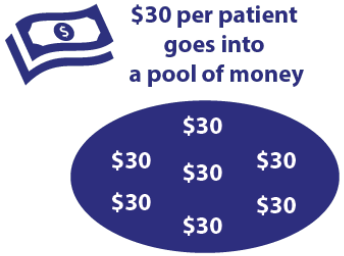

The pool of money total is placed in an equation every 3 months

EQUATION

Pts enrolled (by your practice) X Pts avoided PPH (neighbourhood) X 30 ÷ Pts enrolled (neighbourhood)

Medical Neighbourhood

Shared cost savings are distributed amongst practices within the medical neighbourhood for that quarter through the % of the total patient enrolments each practice contributes

General Practice A	General Practice B	General Practice C
20 x 35 x 30 / 80 = $263	15 x 35 x 30 / 80 = $197	45 x 35 x 30 / 80 = $590

Example: 80 patients enrolled in the medical neighbourhood, 35 avoided hospitalisations

Patient Story

Issues and Strategy

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Issue	Strategy
1. Lives alone	• Personal alarm and monitoring systems information provided • Increased visits by daughter
2. Shortness of breath (SOB) on exertion	• Medication compliance • Completing tasks in manageable chunks
3. High BMI	• Importance of exercising • Maintaining a balanced and healthy diet • Eat a high fibre, low fate, low salt diet
4. Falls (12 falls in 6 months)	• GP made aware of falls • Need for Physiotherapy and Exercise Physiologist referral • Falls prevention strategies discussed (4WW, footwear)
5. Requiring equipment with rails to assist with getting on/off toilet	• OT home visits organised to access environment and recommend equipment • Over toilet aid ordered as recommended

Patient Story

Issues and Strategy cont.

My Care Partners

Issue	Strategy
6. Patient not wanting further treatment for his melanoma (had recent excision earlier in the year)	• Discussed importance of care and ongoing paint management and strategies (informed decision making) • Support provided regarding decision • Regular follow up with GP discussed
7. Anxiety	• Discussed triggers and avoidance strategies • Need for medication compliance • Reassurance and support provided • Need for GP Mental Health Care Plan. Care Enabler to discuss with GPO

Patient Story

Outcomes

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- Enhanced Primary Care (EPC) referral organised for physio – commenced exercise therapy
- OT home assessment and over toilet aid supplied – able to get on/off toilet easier
- Reduced risk of falls – no falls past month
- Increased patient awareness, knowledge and informed decision making
- Improved medication compliance
- Self-reports more energy, reduced SOB and feels safer
- Feels supported by MCP team (Care Enabler and GP)

Data Capture

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What	Where
Patient demographics	eMR and GP referrals
Patient health stats (e.g. RoH, CCoPS, HARP)	Manual tracking
Hospital admissions (focus on PPH)	eMR and PFP
Number of enrolments	PFP (or eMR)
Number of referrals	• PFP or eMR (for new enrolments only) • Manual tracking to capture referral details)
Number of discharges and reason	• eMR • Manual tracking (for discharge reason)
Service activity	eMR and PFP
Average time between patient enrolment to initial assessment	Manual tracking
Usage of supplementary funding	Manual tracking

Challenges

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- Care Enablers document in three different systems
- Six different reports required to collate monthly data
- Reliant on documentation processes being followed
- Reliant on ‘error free’ data input
- Time consuming +++

Evaluation with Lumos

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- **Ability for researchers to access Lumos**
- **Example evaluation metrics in Lumos:**
  - **Patients / practices / facilities**
  - **Integrated Care Program in ICD table**
  - **Potentially Preventable Hospitalisations in APDC table**
  - **Bed days**
  - **Patient activation NSWPS.Patient Survey table + additional surveys**
- **Return on investment**
- **Patient Quality of Life, PREMs and PROMs**
- **Health care provider (including Enabler and program staff) experiences**

My Care Partners

Mentimeter

What are some of your current programs that could benefit, current state and challenges?

- Community based integrated care models
- Urgent Care Services
- Coco - Commonwealth commitment to innovative funding models
- Statewide Initiative for Diabetes Management
- Population health needs assessment
- Needs assessment
- I think Lumos is great however having patient identifiable data for gp's would be of greater benefit
- Leading better value care chronic wound initiative
- Social prescribing

My Care Partners

Mentimeter

What are some of your current programs that could benefit, current state and challenges?

National Cancer screening programs improve cervical screening outcomes

Aboriginal chronic care program

Care transitions from hospital to home and community - read mission reduction

Care finders

Chronic disease management

challenge - GP buy-in, even with the incentive payment? do you foresee this being difficult in regional areas, where medical neighbourhoods will be rather wide?

Work out what the quick wins are and how to future proof a road map for future

Better understanding ED challenges - population cohorts etc

Urgent care services

My Care Partners

Mentimeter

What are some of your current programs that could benefit, current state and challenges?

Palliative care programs

Joint statement

Cancer screening programs, other QI initiatives around chronic disease management

Work on sustainable small town primary care, looking to map cost to hospital systems as they close

Decision making - needs assessment

Diabetes collaborative commissioning program. Alliancing.

Quantifying effectiveness of PHC interventions, current state largely service utilisation and aggregate outcomes with no attribution

Challenges in bringing patient reported measures data from commissioned services and linking it with LUMOS to track impact of commissioned services

Joint governance

My Care Partners

Mentimeter

What are your next steps?

Can I have the data you have collected? Queeny

Collaborative commissioning

Access the shared dashboards and explore data for our region

Prepare a pack on the 'how' to pave a plan forward for a lumos style model in our region

Develop a business case for new models of care that support frail elderly

Collecting evidence

Support joint needs assessment

Support providers with use of available Lumos PowerBI tools to dive into the data

Commissioning wound care with general practice that removes the commercial cost of wound products for the patient and the gp

My Care Partners

Mentimeter

What are your next steps?

Work on Lumos data, understand it better and utilise to our needs

Joint planning at a state and local level

Raearch

Access Lumos data, use the dashboards

Find out more about My Care Partners - sounds really exciting

Explore the LUMOS data to understand how we can use it

Seek your support

Electronic data collection

Use for needs assessment

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Mentimeter

What are your next steps?

Explore shared savings!

My Care Partners

Shared Vision | Shared Care | Shared Outcomes

Find out more

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