LinkMyCare – Chronic Obstructive Pulmonary Disease
General Practice Grants
Industry Briefing and Q&A

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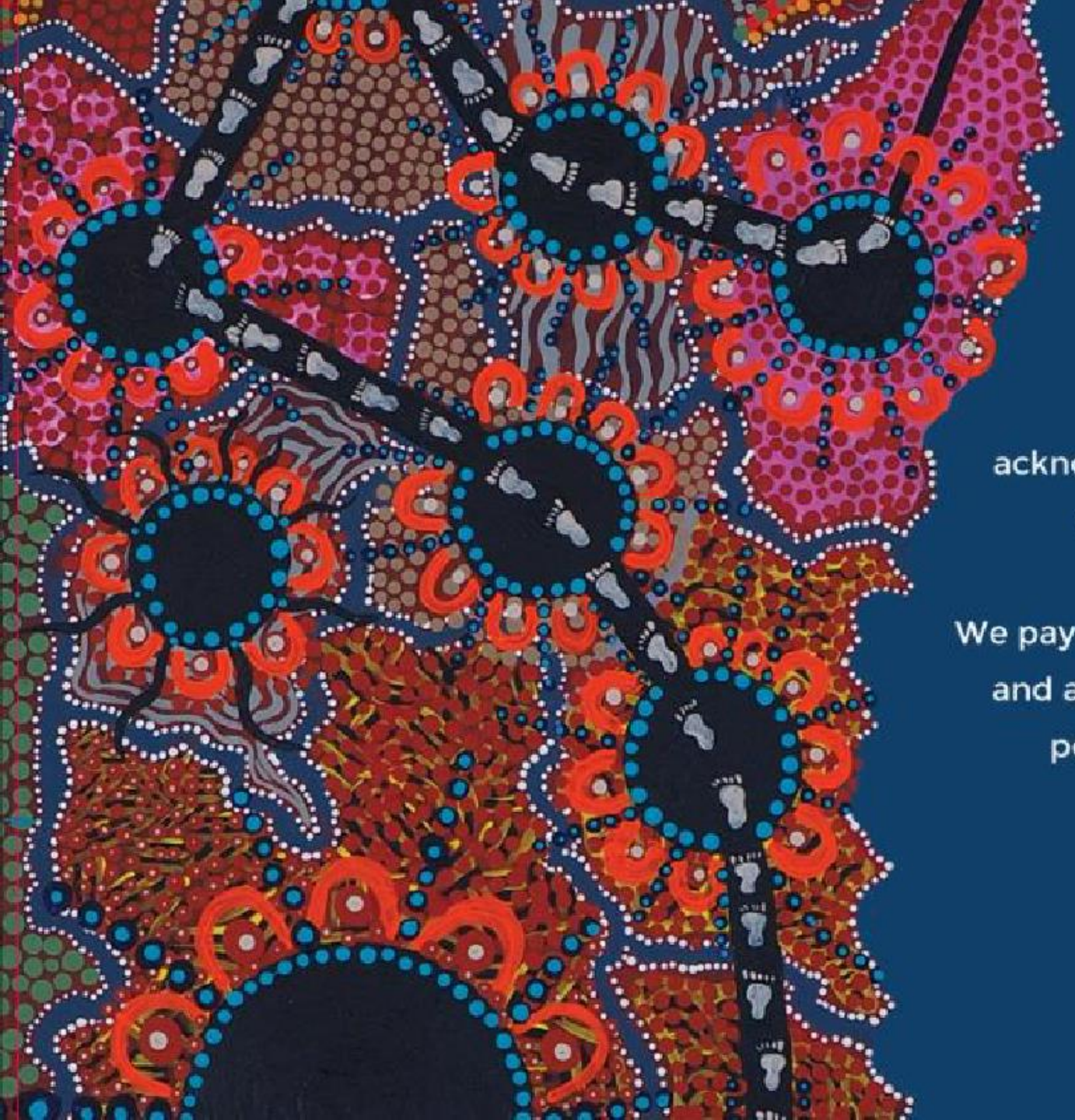
Wednesday 09 April 2025



COORDINARE – South Eastern NSW PHN acknowledges the Traditional Owners and Custodians of the lands across which we live and work.

We pay our respects to Elders past, present and emerging, and acknowledge Aboriginal and Torres Strait Islander peoples' continuing connection - both physical and spiritual - to land, sea and sky.

COORDINARE

phn
SOUTH EASTERN NSW
An Australian Government Initiative

Housekeeping

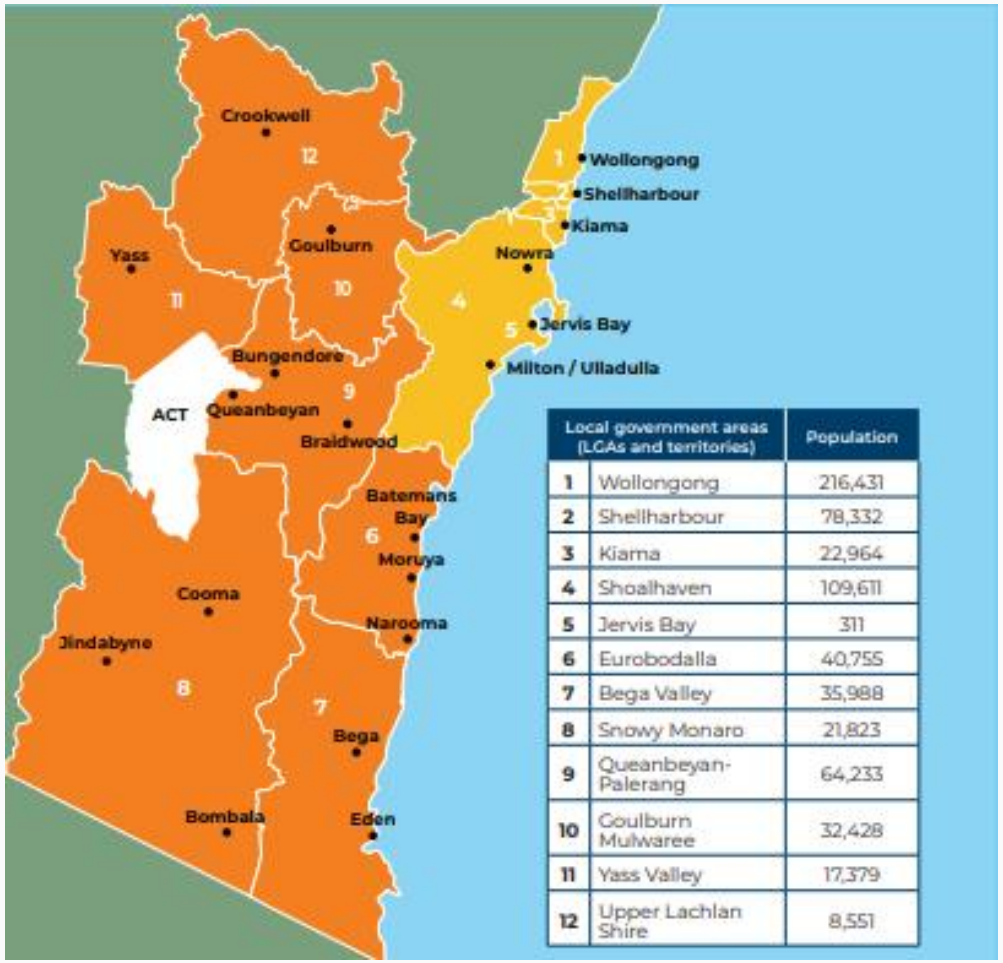
All participants will be kept on mute throughout today's presentation

Questions can be submitted through the Q&A section at anytime throughout the presentation

All questions will be addressed at the end of todays presentation

All questions and answers, as well as a recording of today's session will be uploaded onto Tenderlink

COORDINARE – South Eastern NSW Primary Health Network (SENSW PHN)



Local government areas (LGAs and territories)		Population
1	Wollongong	216,431
2	Shellharbour	78,332
3	Kiama	22,964
4	Shoalhaven	109,611
5	Jervis Bay	311
6	Eurobodalla	40,755
7	Bega Valley	35,988
8	Snowy Monaro	21,823
9	Queanbeyan-Palerang	64,233
10	Goulburn Mulwaree	32,428
11	Yass Valley	17,379
12	Upper Lachlan Shire	8,551

Population

648,806 total population

21.6% aged over 65 years

> 33,180 (5.2%) people identify as Aboriginal and Torres Strait Islander

Region is home to **3.4%** of Australia's Aboriginal population, and **9.8%** of the total Aboriginal population in NSW

62,349 (9.7%) culturally and linguistically diverse people

Top 3 non-English speaking countries of birth
1. India
2. North Macedonia
3. Italy

10.4% non-English speaking at home

Top 3 non-English languages spoken at home
1. Macedonian
2. Italian
3. Arabic

12.3% projected population growth between 2020-2030

Who are we and who do we work with?

We are one of the 31 Primary Health Network (PHNs) established throughout Australia.

We work directly with GPs, other primary care providers, secondary care providers, and hospitals to bring improved outcomes for patients.

We aim to address local health needs, as well as national health priorities, particularly in Aboriginal health, alcohol and other drugs, mental health and suicide prevention, chronic diseases, after-hours services, healthy ageing and end of life care.

Commissioning is central to COORDINARE's ability to achieve these objectives and address

local and national priorities.

Local COPD Needs

Clear and holistic care pathway for COPD patients.

Concise care pathway.

Patient comfortable with managing exacerbations in the community.

Improved health outcomes for COPD patients.

Higher number of COPD patients with Action Plans and Management Plans.

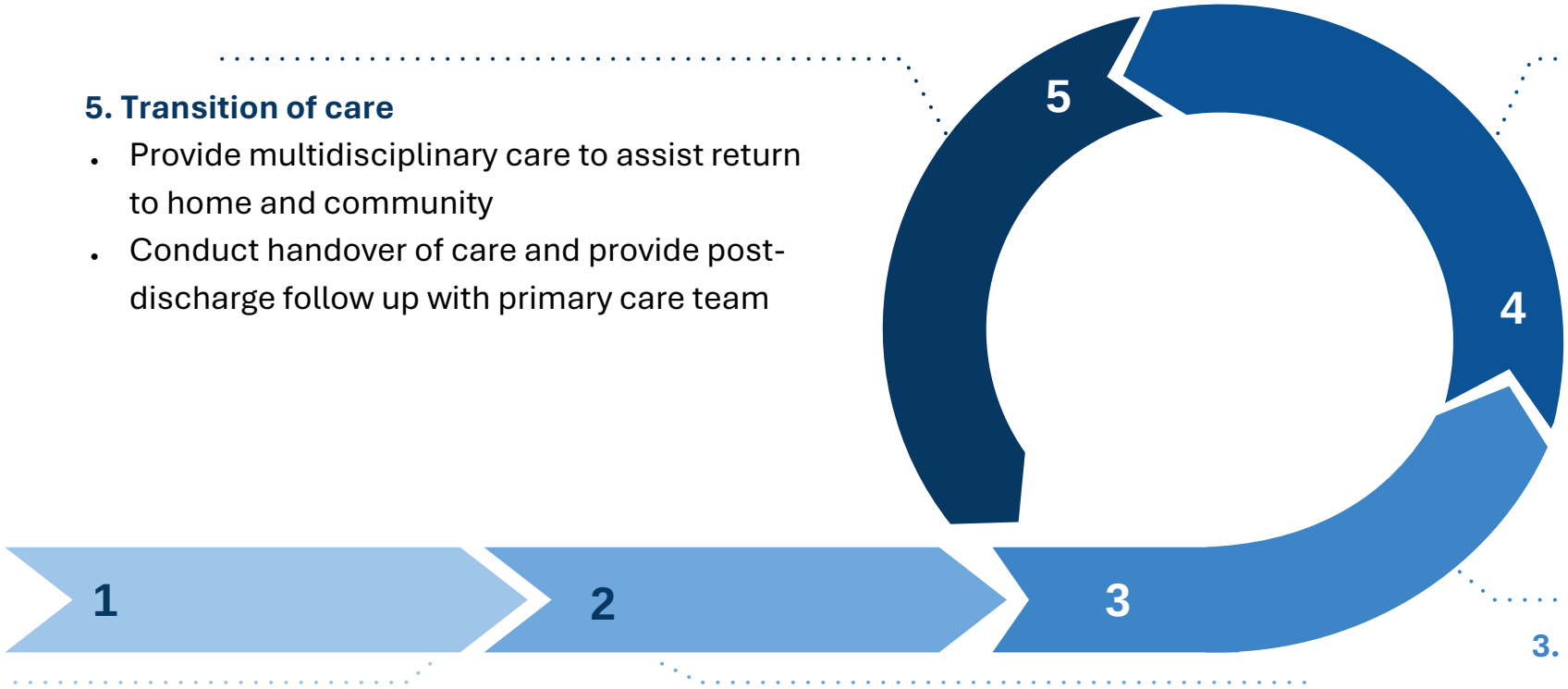
Greater care options within the community.

Reduction in hospital presentations and admissions.

Timely referral to MDT and delivery of required service.

Timely GP meetings upon discharge from hospital.

Outcome of Stakeholder Meetings



5. Transition of care

- Provide multidisciplinary care to assist return to home and community
- Conduct handover of care and provide post-discharge follow up with primary care team

4. Managing exacerbations

- Support patients to manage exacerbations at home, while recognising the signs and symptoms to escalate care
- Provide safe alternatives to ED and hospital admission where appropriate

1. Awareness, prevention and screening

- Promote community awareness of risk factors and lifestyle changes to prevent COPD
- Support early detection and diagnosis of COPD

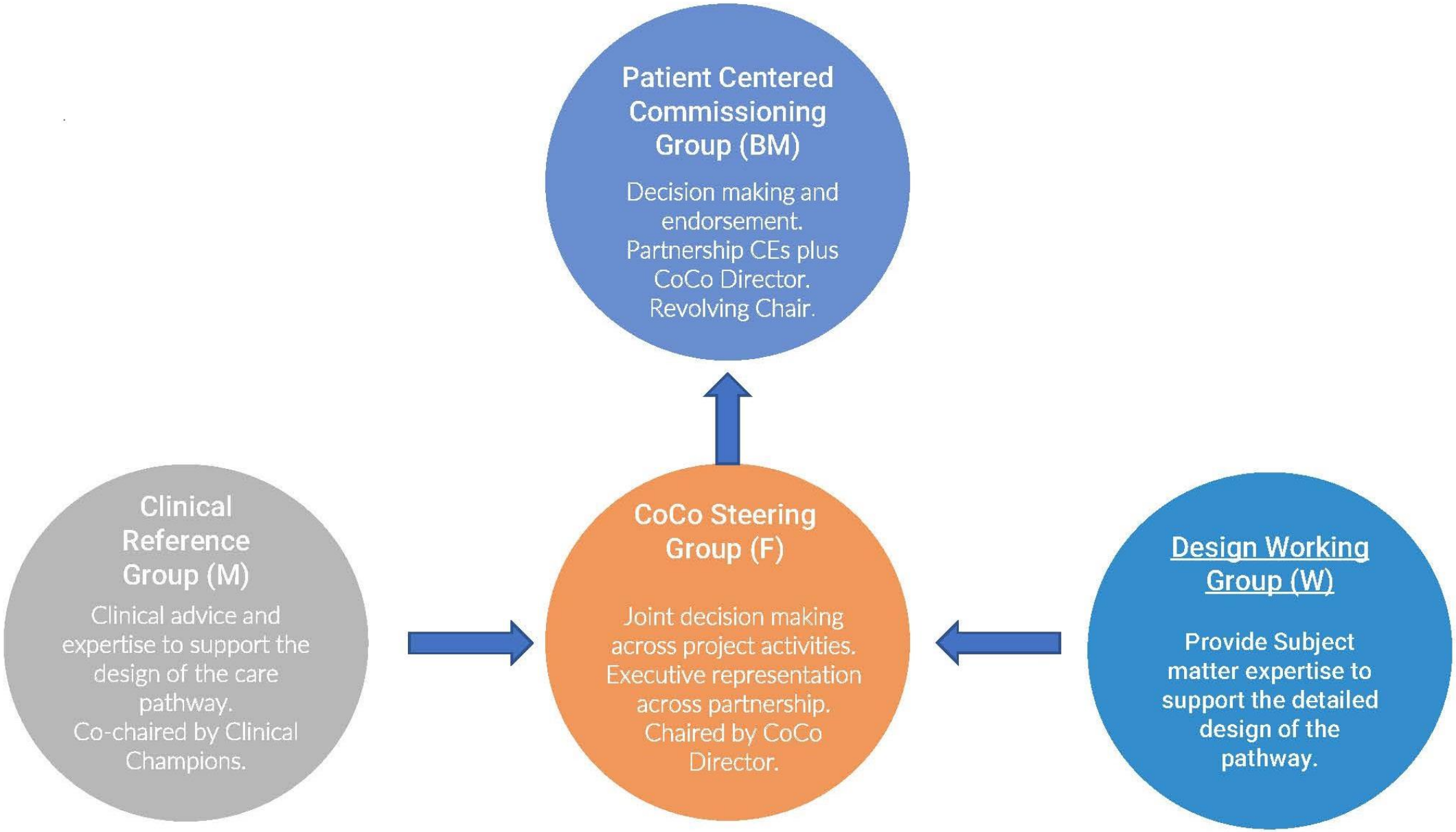
2. Diagnosis and initial intervention

- Early diagnosis to detect COPD before symptoms appear
- Early engagement with services to encourage timely lifestyle interventions

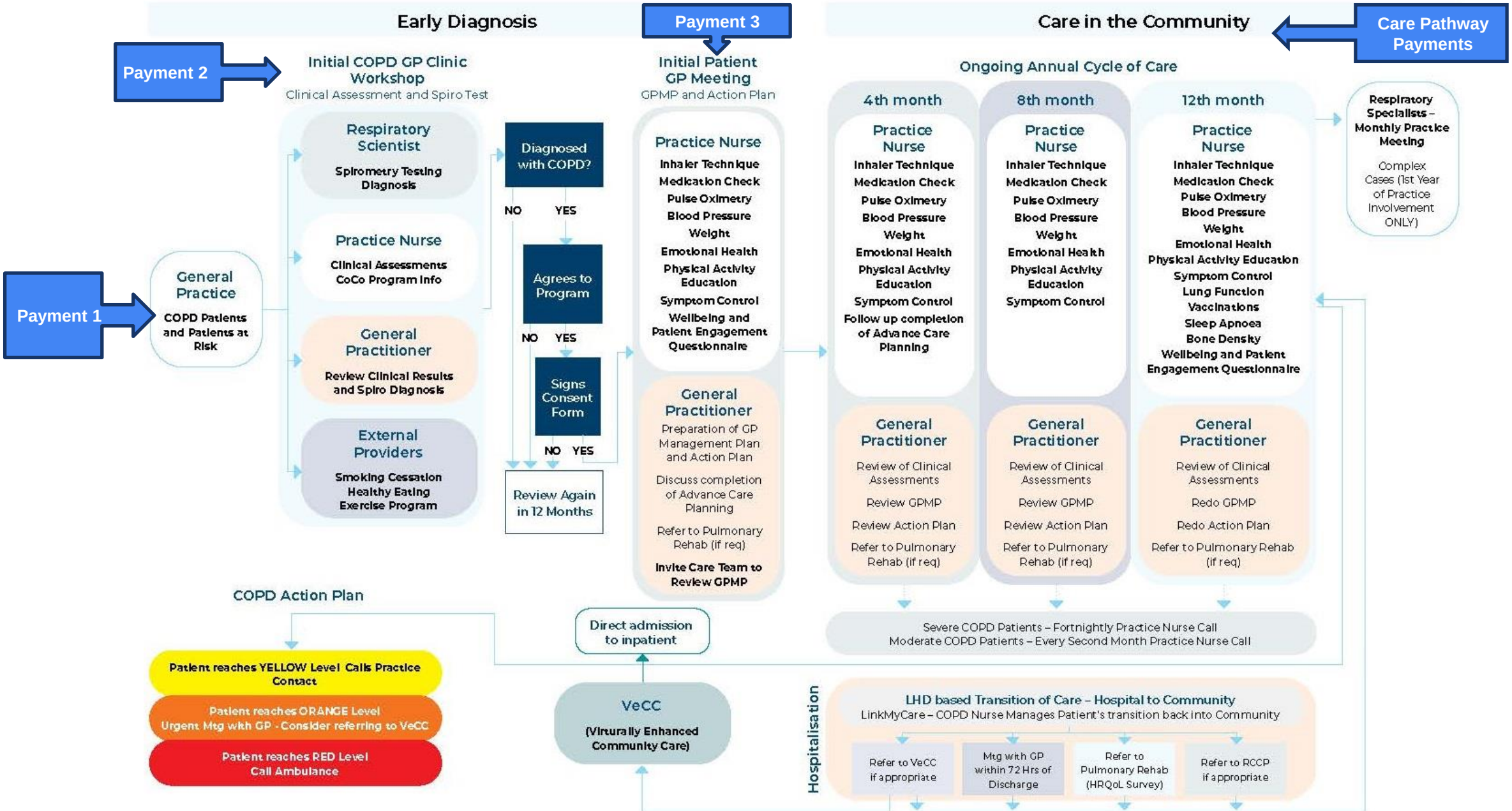
3. Care planning and coordination

- Enable self-management of COPD and other comorbidities in line with care plan
- Provide support to coordinate services and navigate the system

LinkMyCare – COPD - Governance



Care pathway flowchart



General Practice Funding

Stage	One-Off Payment	New Patient Setup	Annual Cycle of Care	Yearly Retention Bonus Payment
Implementation **Payment 1**	$2,000 per practice			
Implementation **Payment 2** (Paid when patient attends the *Initial COPD General Practice Clinic Workshop*)		$ 90 per patient		
Implementation **Payment 3** (Paid when a patient, who has signed the consent form, attends the *Initial Patient General Practitioner Meeting*)		$60 per patient		
Care Pathway Payments (Paid for each of the annual cycle of care meetings a patient attends)			$75 per patient	
Yearly Retention Bonus Payment (Paid at the end of the 12-month cycle for a patient who attended all 3 cycle of care meetings)				$20 per patient

General Practice Stage Funding – What's Expected…

Payment 1

A set amount of **$2,000 per practice** will be paid once the contract is signed.
This payment will cover:

a. the cost of your practice staff to undertake initial data cleansing as per the Preparing for Collaborative Commissioning – COPD Toolkit, to identify the targeted cohort i.e. those already diagnosed with COPD and those that are deemed to be at-risk of having or getting COPD.

During this stage, additional funding will be provided for:

a. purchase of a spirometry machine - if required (paid on invoice).
b. attendance at spirometry training – if required (paid on invoice – see training suite).
c. attendance at smoking cessation training – if required (paid on invoice – see training suite).

Payment 2

$90 per targeted patient who attends the ***Initial COPD General Practice Clinical Workshop***.
This payment will cover:

a. the cost of your Practice Nurse's involvement in contacting patients from the cohort and inviting them to the *Initial COPD General Practice Clinical Workshop* (see attached care pathway flowchart).
b. the cost of the Practice Nurse's involvement in the *Initial COPD General Practice Clinical Workshop*. This includes explaining the program to patients and having them sign a consent form.

This payment will be made quarterly based on the number of patients who attended the *Initial COPD General Practice Clinical Workshop* in the previous quarter.

General Practice Stage Funding – What's Expected…

Payment 3

$60 per targeted patient who attends the ***Initial Patient General Practitioner Meeting***.

This payment will cover:

a. practice nurse involvement in:
   i. preparation of the initial GP Management Plan and COPD Action Plan, if one not prepared in the past 12 months,
   ii. review of the GP Management Plan and COPD Action Plan, if one completed in the past 12 months.

b. practice nurse involvement in the *Initial Patient General Practitioner Appointment*.

c. purchase of spirometry testing disposables used during the initial spirometry test.

This payment will be made quarterly based on the number of patients who attended the *Initial Patient General Practitioner Meeting* in the previous quarter.

Care Pathway Funding

$225 per annum per enrolled patient. This equates to **$75 per patient per cycle of care meeting attended**.

This will provide funding to support the Practice in following the 12-month care pathway. The funding will cover:

a. continual upskilling of practice nurse in spirometry testing.

b. delivery of spirometry testing (noting a Respiratory Scientist will be commissioned to deliver this service in year 1).

c. purchase of spirometry testing disposables.

d. ongoing data analysis.

e. practice nurse involve sucment in *4th, 8th, and 12th Annual Cycle of Care Appointments*.

f. patient's key practice contact calls to severe and moderate COPD patients.

g. patient's key practice contact taking calls from patient when they reach the yellow and orange section of the COPD Action Plan.

h. arrangement of a General Practitioner meeting within 72 hours of discharge from hospital.

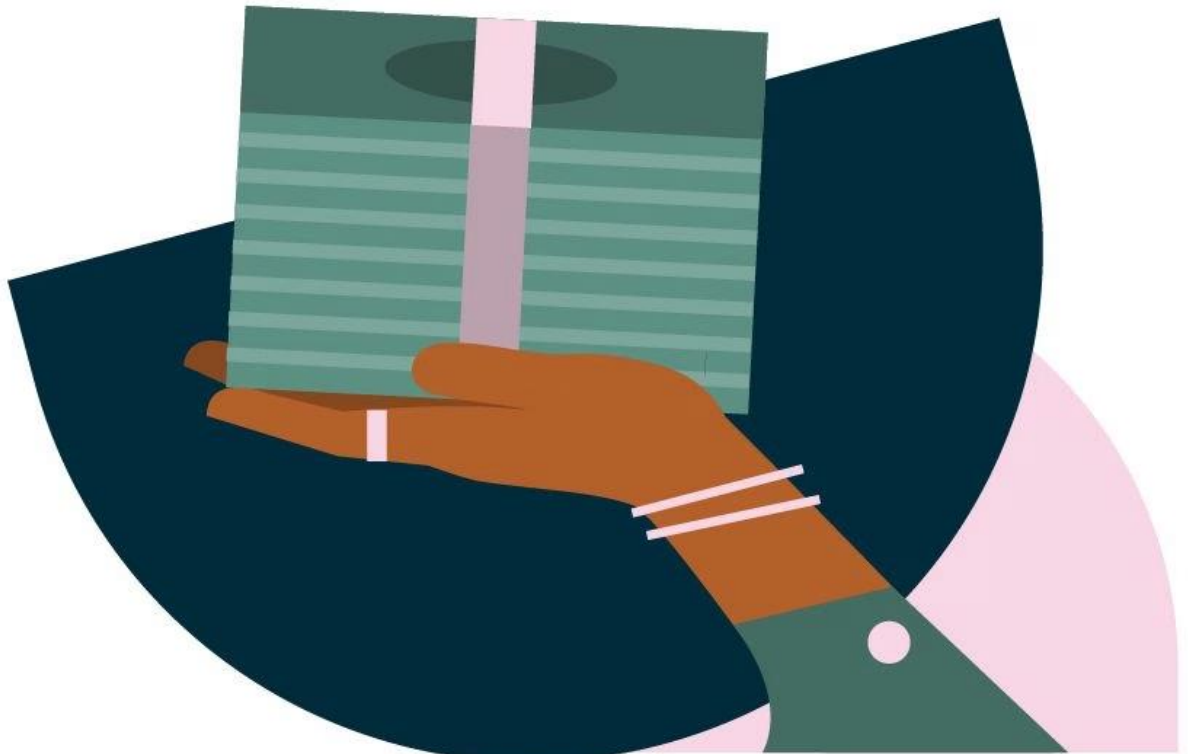
i. attendance at the monthly Respiratory Specialist meeting – first year only.

General Practice Stage Funding – What's Expected…

Yearly Retention Bonus

The yearly retention bonus amount will be **$20 per patient**, paid at the end of the 12-month annual cycle of care for all patients who:

a. signed the consent form and
b. attended the three care pathway meetings held every quadrimester.



MBS Numbers and Definition - GPs

Item No 721

Attendance by a GP for **preparation** of a **GP management plan** for a patient. Every 12 Months from date of initial plan.

Fee: $152.50 **Benefit:** 75% = $114.40 100% = $152.50

(Can be used in conjunction with 723 if development of team care arrangements done during same meeting)

Item No 723

Attendance by a GP to **coordinate** the development of **team care arrangements** for a patient. Must be GP and two allied health providers (not PN). Five Allied Health Chronic Condition Referrals (not just COPD) are Calendar based.

Fee: $120.85 **Benefit:** 75% = $90.65 100% = $120.85

Item No 732

Attendance by a GP to **review** or **coordinate** a review of: Every 3 months

A GP management plan prepared by a general practitioner (or an associated general practitioner) to which item 721 applies; or

Team care arrangements which have been coordinated by the general practitioner (or an associated general practitioner) to which item 723 applies.

Fee: $76.15 **Benefit:** 75% = $57.15 100% = $76.15

(Can be claimed twice for the same meeting, one related to the review of item number 721, and the other in relation to the review of item number 723)

MBS Numbers and Definition - PNs

DO NOT USE
Item No 10997
Funding will be provided through Collaborative Commissioning

Service provided to a person with a chronic disease by a **practice nurse** or an **Aboriginal and Torres Strait Islander health practitioner** if:

(a) the service is provided on behalf of and under the supervision of a medical practitioner; and

(b) the person is not an admitted patient of a hospital; and

(c) the person has a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place; and

(d) the service is consistent with the GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan

to a maximum of 5 services per patient in a calendar year

Funding: $13.20

Item 10997 will assist patients who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the patient's usual GP. Item 10997 may be used to provide:

- checks on clinical progress;
- monitoring medication compliance;
- self management advice, and;
- collection of information to support GP/medical practitioner reviews of Care Plans.

The services provided by the practice nurse or Aboriginal and Torres Strait Islander health practitioner should be consistent with the scope of the GP Management Plan, Team Care Arrangements, or Multidisciplinary Care Plan.

Why do I have to be a Lumos Practice?

Lumos is a 'whole of system' linked data set, meaning we can measure the impact of the intervention across care settings.

This will allow us to measure cost savings delivered by the project even if they do not occur in the community where the intervention takes place.

The program will be comprehensively evaluated to allow a business case for scaling to be considered by government at the end of the 3 year funding cycle.

This will also minimise any burden on providers to collect data locally.

Outcomes

Health outcomes that matter to patients

Overall improvement in patients' wellbeing
- decrease in the overall K10 survey scores.
- decrease of 10% in the overall CAT survey scores.
- increase in the overall EQ-5D-5L survey scores.

Effectiveness and efficiency

Reduction in category 4 – 5 ED presentations
Reduction in unplanned all cause re-admissions
Reduction in COPD related hospital admissions.
Reduction in LoS related to unplanned admissions.
Reduction in the number of unplanned total bed days within 12 months of completing Pulmonary Rehab

Experiences in receiving care

Improved patient experience

Experiences providing care

Improved staff experience
Self-efficacy in delivery of COPD care

Implementation

August 2024

Community transition service
LHDs commence service

EOI and onboarding
Engage five practices and begin onboarding and commissioning process

Quarter 4 2024

First patients enrolled
Practice staff of tranche one reach out to targeted cohort .

Quarter 1 2025

Pulmonary Rehab
Services commissioned and enrolling patients

Quarter 1 2025

Tranche two practices
Additional 5 practices join the pathway

May 2025

Exit Collaborative Commissioning

June 2027

Questions