WINTER STRATEGY - COORDINARE

Program Overview

The Winter Strategy is a program where COORDINARE will support general practice teams to:

lead heightened quality and intensity of care for a group of patients that clinicians think are at high risk of being unstable or vey unwell or admitted to hospital during the 2019 flu season.

The program has four phases.

PHASE 1 – Practice Readiness - Some ideas to get your practice ready (March)

1.1. *Obtain commitment from Practice Owner(s):* The Winter Strategy needs commitment from the practice owner(s) and staff. In particular the Practice Principal needs to be able to ensure protected time for staff to undertake winter strategy activities. They also need to be satisfied with arrangements for patient consent and privacy and confidentiality, where appropriate

1.2. *Go to the COORDINARE Winter Strategy link:* fill out an expression of interest.

1.3. *Identify Winter Strategy Team members:* Clarify roles, responsibilities and time frames within the practice's Winter Strategy team. Communication is key to the success of any new activity. Consideration should be given to how protected time will be arranged, how the team will meet and facilitate internal communication throughout the practice team.

1.4. *Ensure the practice has a sound data quality process*: It is strongly recommended that practices are part of COORDINARE's data quality initiative (Sentinel Practice Data Sourcing program). You may need to undertake data cleansing activities prior to running CAT4 queries to accurately identify target patient groups. Some exemptions apply, please speak to your HCC.

1.5. *Plan for any potential surge in flu vaccinations or cold and flu exacerbations*: How will you manage increased demand? You might want to think about what your system will be, whether there are existing arrangements you can use, and how everyone will know what to do.

1.6. *Plan your model of service delivery*: Some suggestions could be to do it in conjunction with flu vaccination and or GPMP/TCA review, as they come in for Drs Appointments. You may choose to run a nurse led clinic or you might have another method. It is important to know who will do this and when.

1.7. *Review the evaluation template with your Health Coordination Consultant*

1.8. *Identify your "at risk" patients.* COORDINARE will provide a series of CAT4 queries to identify patients at risk of being impacted during the flu season. Clinicians may also choose to target an alternate cohort based on their knowledge of who they think is most at risk of hospitalisation, and who would benefit most. To help practices, COORDINARE will provide a choice of modules that will support clinicians to choose their patient cohort for the Winter Strategy.

1.9. *Ensure practice electronic messaging details are correct and up to date* for all relevant clinicians in the LHD data base. This is required to receive discharge summaries and admission/ discharge notification messages about 'Winter Strategy' patients.

PHASE 2: Engaging Patients: Some ideas to get your patients on board (April-May)

2.1. Contact patients and invite them to be involved.

2.2. Inform patients about what to expect, including a few questions before and after your consultation to see what they thought about being part of your winter strategy. Patient experience measures could be used for this.

2.3. Gather and document patient/ participant consent.

2.4. Add patients to 'winter strategy register' to track and monitor progress.

2.5. Collect patient experience measures at the earliest point of contact. COORDINARE can assist with this.

2.6. Collect clinician experience measures at the earliest point of contact. COORDINARE can assist with this.

2.7. For relevant patient cohorts, commence Care Planning. Does the person have an up to date GPMP, if relevant? What does the individualised care plan look like for each patient this winter? See Phase 3 below for approaches to including care planning this winter.

PHASE 3 Provision of Services (May - September)

Individualised care for the winter flu season draws on the following:

3.1. Person Centred Care

3.1.1. Care is tailored to each patient's individual needs and patients are actively involved in making decisions about what the care looks like.

3.1.2. Practices have the option to access the Patient Activation Measure (PAM) tool. The PAM tool supports clinicians to identify how activated / engaged the patient is to manage their own health. This gives the user insight to more effectively tailor care based on individual need. Practices who choose this option will have access to staff training on how to effectively use the PAM tool.

3.1.3. Ensure all communications including Care plans and Exacerbation/Action Plans are in everyday language that make sense to the individual patient and carer.

3.1.4. Care plans should include goals that the patient has come up with, and its best if these are written in the patient's own words. Patients and carers (if relevant) are given a copy of, or access to, their health summary.

3.1.5. Ensure you are providing culturally safe care. Useful resources include:

- National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health
- Cultural Safety Framework
- Cultural competency in the delivery of health services for Indigenous people
- National Aboriginal and Torres Strait Islander Health Plan 2013-2023

- Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health

3.2. Comprehensive Care

3.2.1. Care plans and Exacerbation/Action plans are developed with patients and they receive a copy of the plan. Plans are reviewed regularly to ensure patients understand them and are still relevant. Patients and carers receive ongoing coaching and support to exercise self-management and use their Exacerbation/Action plan when needed.

3.2.2. Where relevant, patients are referred to the Chronic Disease Management Team (or similar e.g. 'Connecting Care' or Integrated Team Care (ITC) from the Local Health District to assist in education and self-management coaching.

3.2.3. Patients' broader health and well-being needs are considered, and they are referred to social support or other clinical services as required. This can be done by accessing HealthPathways Illawarra/Shoalhaven or ACT / Southern NSW

3.3. Access to Care

3.3.1. Patients know who their main primary care clinician is and how to contact them.

3.3.2. Plan how patients can access support when needed, especially as indicated in their care and Action plans.

3.3.3. Plan how the practice will manage any potential surge in flu vaccinations, you may consider inviting patients to a planned clinic or vaccination day.

3.4. Coordinated Care

3.4.1. Ensure the patients' My Health Record health summaries are current and uploaded- and include a care plan and where necessary patient action plans.

3.4.2. Care Plan - would be for all patients who have others involved in their care and or have ongoing health issues to make sure that everyone is on the same page as to what matters to the patient – goals, values and preferences

3.4.3. Action plan – also known as Acute plans are part of the patients care plan that will provide written information reminding the patient what to do when things go wrong or symptoms occur

3.4.4. Communication with other services supporting patients (e.g. allied health professionals, aged care services) is effective so that the care is coordinated and properly documented.

3.4.5. Ambulance Care Plans are in place to avoid ED presentation

3.4.6. Consider whether the patient would benefit from a Home Medication Review (MBS item 900) with a pharmacist.

3.4.7. Where relevant, referral to Connecting Care Program in Illawarra Shoalhaven for patients requiring home visits/follow up in the community.

3.4.8. There may be opportunity for practices to work in collaboration with local LHDs. Please discuss this option with your Health Coordination Consultant.

3.5. Quality Improvement and Safety

3.5.1. Ensure that Shared Health Summaries are accurate, current and include medication lists.

3.5.2. Plan your model of service delivery. This could be via simple recall and reminder systems, in conjunction with flu vaccination and/or GPMP/TCA review, as they come in for Drs Appointments. You may choose to run a clinic or you might have another method. COORDINARE can support you with identifying and developing the most suitable model that meets the MBS requirements for your practice.

3.5.3. Collect patient experience measures. COORDINARE can assist with this.

3.5.4. It is important to track your patient progress. COORDINARE has resources to support you with this.

3.5.5. Practices can apply for a one off payment for participating in the Winter Strategy to cover quality improvement activities including:

- Data cleansing around specific indicators
- Planning meetings and initial set up of processes
- Evaluation and Report writing (5 page template)
- Time paid to undertake regular practice meetings and meetings with COORDINARE
- Practices will be able to access a variety of education and training opportunities

3.6. Program evaluation and learning/ sharing

3.6.1. Participate in a monthly check in with your HCC to see how things are going and if any support is needed. This could be done face to face or even by phone or email if things get busy.

PHASE 4 Evaluation and Review, Lessons for 2019 (Oct)

4.1. If you ran a specific program and / or clinic with patients, let them know it is now finished for 2019.
4.2. Ensure all patients and clinicians have completed their experience measure questions
4.3. Collate outcome measures
4.4. Complete and submit your final report. COORDINARE will provide you with a short template to help you do this.