HEALTH CARE HOMES
Patient-centred | Coordinated | Flexible

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

Health Care Homes for Allied Health Providers

What is Health Care Homes?

Health care homes (HCH) are a General Practice or Aboriginal Community Controlled Health Services (ACCHS) that are caring for patients with multiple chronic and complex health conditions. These practices are working to administer better coordinated and flexible healthcare. HCH is a primary healthcare initiative that aims to improve patient's health outcomes and reduce the total number of hospitalisations of at risk patients. Ultimately the HCH program aims to empower patients to become active participants in the management of their health.

Some key features of the HCH program include:

- Voluntary participation
- The patient nomination of their preferred general practitioner (GP) to lead the care-team
- Patient's family and carers are included as partners in their care
- The HCH takes a team-based approach in administering patient centred care focusing on improved communication and coordination
- HCH aims to enhance access and increase flexibility of provided services

The HCH initiative strives to address the Quadruple Aim of Health by improving patient and provider satisfaction, improving population health outcomes, and improving cost efficacy and sustainability.

A core component of the HCH program is the effective use of Shared Care Planning (SCP) to help improve communication between GP and the broader Healthcare Neighbourhood (HCN). The HCN incorporates healthcare providers and social services outside of the Health Care Home. As an allied health professional you are included as a part of the HCN and are and integral part of patient's care team.

How are patients selected and stratified?

Patients enrolled in the HCH program are stratified according to their risk of future hospitalisation. To be eligible for the program, patients must have two or more chronic health conditions. They are flagged by their GPs and then stratified using the HARP Risk Stratification Tool. The tool sorts patients into three tiers based on their future risk of hospitalisation. Below is a general summary of what you can expect of patients in different tiers.

Tier 1	These patients have multiple chronic conditions and are largely self-managing.
Tier 2	These patients have multiple chronic conditions and moderate needs. They need assistance to self-manage.
Tier 3	These are high risk patients with multiple chronic and complex conditions. These patients require high levels of assistance to manage their conditions.

What is your responsibility as an Allied Health Provider?

As an Allied Health Provider your responsibility is still to the patient and the provision of timely and effective care. Patients with ongoing chronic and complex health conditions require persistent care and support, therefore your active participation in the development and maintenance of the SCP is vital. This can be done by uploading notes into the patients SCP, so that the GP can remain updated on the patient's progress and the patient have easy access to the plan you have set out for them.

What is Shared Care Planning (SCP) and why use it?

Shared Care Planning is a central element of the HCH program. A patient's SCP is electronic and can be accessed and updated by the patient's GP and their elected allied health providers. This SCP is also accessible by patients, helping to empower them to take control of their health outcomes.

A SCP outlines a patients agreed current and long-term health goals, it also works to address any gaps in a given patient's health care. It offers patients and members of their healthcare team real time access to a patients plan to monitor progress and share relevant information. Goals within the SCP will be broken into achievable sections and be allocated to a member of the care team, such as the nurse, podiatrist, physiotherapist, dietitian, etc. Once the GP has allocated a goal to you, you will receive an electronic referral via email.

How will SCP referrals be received?

SCP referrals are received via an email that will contain a link to access the patient's SCP. You can accept or decline the referral. Once you have received the referral and a patient has made an appointment it is important to read through the health information contained in the SCP and the goals that have been allocated to you before seeing the patient.

How is SCP used?

All providers in the HCN, you will have access to SCP software via a web-based portal with secure login details. It is free for providers in the HCN to access the SCP.

After you have seen a patient you should upload any notes and important information to the SCP so that the doctor, patient and other relevant health professionals can see them. Please note that patients will be accessing the information you upload and therefore information should be written in easy to understand language. Whenever you see a patient and update their current plan, you should upload to the SCP.

In preparation for receiving referrals, it is recommended Allied Health Providers sign up to the relevant SCP software that will be used by the referring HCH practioners.

What support will you be offered?

The Nepean Blue Mountains Primary Health Network (NBMPHN) are here to support you in the implementation of the HCH program. We will be providing assistance with education about the HCH program and assistance with SCP signup and use.

Please don't hesitate to contact Laura Downs Tuck if you have any queries lauradt@nbmphn.com.au