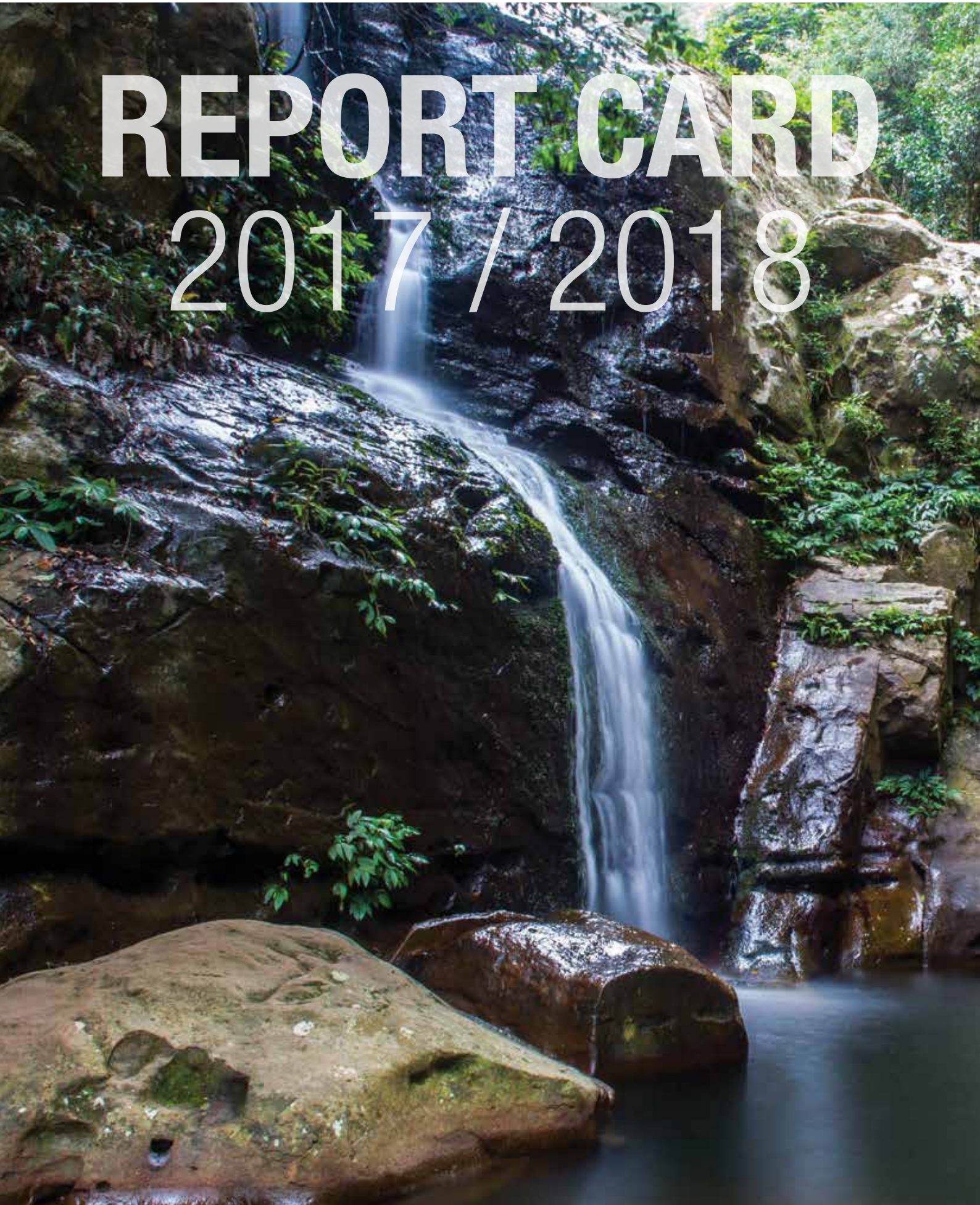
COORDINARE

phn
SOUTH EASTERN NSW
An Australian Government Initiative

REPORT CARD
2017 / 2018



Message from our Chair and CEO

As the Chair and CEO of COORDINARE – South Eastern NSW PHN, we are delighted to present our third annual Report Card.

2017/18 has seen our PHN continue to evolve and mature, consolidating our relationships across the region and building on collaborative efforts with our partners.

Without a doubt, our most significant achievement has been the launch of our new strategic plan. This was developed in consultation with our stakeholders and staff, and workshopped intensively with our governance groups at a joint meeting in September 2017. The highly valued input of our Clinical Councils and Community Advisory Committee members ensured that we now have a strong plan with clear strategic and health priorities through to 2020.

Since Board sign off in December, the executive have been working closely with staff on implementation to ensure that we deliver on the vision to have a 'coordinated regional health system which provides exceptional care, promotes healthy choices and supports resilient communities'.

Our strategic alliances with the two Local Health Districts are critical to achieving this vision. There is genuine commitment to work collaboratively from Board level down, with joint planning and co-design of initiatives such as GP liaison roles in Southern NSW and co-commissioning of a care coordination program in the Illawarra Shoalhaven. A further testament to our strong working relationships is the significant progress made on developing a shared Regional Mental Health Plan, with a final draft ready for external consultation.

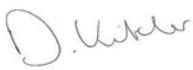
Our work 'supporting general practice as the cornerstone of primary care' remains central to our purpose. We are pleased to see engagement with the suite of tailored initiatives on offer to the 205 general practices across the region continues to strengthen.

Our role as commissioners is also growing with $22.4m of our total annual funding going out to local providers to address inequality and service gaps for those most at risk of poor health outcomes in our six health priority areas: chronic conditions, prevention initiatives, mental health and suicide prevention, drug and alcohol, Aboriginal health and end of life care.

Finally, we created a new executive position to drive the strategic priority of 'putting consumers front and centre in all that we do', recognising that involving consumers at both an individual and organisational level really does matter. We look forward to seeing the impact of their contribution in the years to come.

We hope that you enjoy reading the highlights of our achievements presented in this Report Card. We could not have achieved so much without the support and leadership of the Board, and the dedication, talent and commitment of our staff. We congratulate and thank them for their efforts.

Richard Spencer
Chair of Board



Dianne Kitcher
CEO

Governance

Our two GP-led Clinical Councils and Community Advisory Committee advise the Board, ensuring there is community, consumer and clinical input and influence in the planning, prioritisation and evaluation of our strategy and performance.

Our governance structure embeds strong links between the Board, our Councils and Committee, enabling a high degree of input into Board discussions.

This year, our:

- Board met six times, plus took part in two strategic thinking and planning sessions with our executive team, and one combined governance meeting with our Clinical Councils and Community Advisory Committee
- two Clinical Councils met quarterly
- Community Advisory Committee met quarterly.

Special thanks to Nieves Murray (former CEO of IRT and founding member director representative) and Dr Sue Storrier (inaugural Chair of the Southern NSW Clinical Council) for their contribution to the Board. Craig Hamer has replaced Ms Murray as the IRT representative and Dr Amanda Barnard will replace Dr Storrier.

Putting consumers front and centre in all that we do

We are committed to working with consumers, involving them in decision-making at both an individual level – around their own health literacy, treatments and illness management, and at an organisational level – around strategic planning, service design, delivery and evaluation.

Our approach aims to ensure that consumer and carers are active participants, not just sources of endorsement or information.

This year:

- our Consumer Health Panel continued, with **145** participants having their say every month on a range of topics
- became the first PHN to enter into an agreement to use the Patient Activation Measure (a validated tool determining patient knowledge, skills and confidence to engage in their own health care) through commissioned services, to ensure that services are more focused on the specific needs of each patient
- increased awareness of My Health Record within local communities through a program developed in partnership with six local Councils including Wollongong, Kiama, Eurobodalla, Yass Valley, Queanbeyan-Palerang, and Snowy Monaro
- created opportunities for people with lived experience of mental health issues to tell their stories and be listened to, and by understanding these experiences, we hope to make changes for the better
- increased consumer representation across all aspects of the organisation's work by creating opportunities for participation both at a system and a service level. This included:
  - **26** consumers involved in corporate and project governance groups
  - **182** consumers involved in targeted community planning initiatives
  - sponsored opportunities for **9** consumers to take part in leadership training initiatives such as the Choosing Wisely Conference and Patient Engagement Symposium
- consumer involvement in qualitative data collection with **60** people participating in focus groups across the region to better understand the challenges of chronic disease self-management
- worked with service providers to include consumer representation and reporting of consumer experience across all aspects of commissioned services.

Consumer Health Panel: Helping to shape the future of health services

Our Consumer Health Panel has now been going for more than 18 months. So far, we have covered topics including after hours health care, cancer screening, advance care planning, seeking help for mental or emotional illness, chronic conditions, experiences with general practice, influenza, medication use, self-managed care, telehealth and more.

In January 2018, we asked our panel to provide feedback on what was working and what could be improved.

Responses showed 9 in 10 panel members found the survey topics interesting and felt that views on a wide range of matters were being captured.

The majority of respondents like the survey reports we send out each month, saying these were informative, interesting to read, easy to understand and allowed them to see other people's views on various issues.

Pleasingly, more than 80% of panel members said they would recommend the Consumer Health Panel to a friend or family member, with one panel member saying:

"I really feel that even this questionnaire is so much in the right direction. You are asking the right people. We are not generally the most highly educated, nor maybe, the exalted in the community. But we are the most qualified to offer advice. So you are asking the question. I hope you get some good responses."

Partnership with local Council: Spreading awareness about My Health Record in the community

We have supported the expansion of My Health Record across the region.

My Health Record is an online summary of an individual's key health information and it's easy to see how a person can benefit from having their key health information shared between the providers involved in their care.

We partnered with six local Councils over a three month period to develop a network of consumer leaders – people in local communities willing to advocate for the health needs of their communities – to raise awareness and share important information about My Health Record.

This partnership approach was extremely successful, thanks to the strong reputation and ongoing relationships that local Councils and consumer champions have within their local communities.

Council engagement from March through to June 2018 reached more than 9,180 community members via 279 face-to-face sessions and an additional 32,440 were reached via newsletters, websites, blogs, radio and social media.

Councils have also provided positive feedback, with Jessica Bourke from Eurobodalla Shire Council saying:

"We found this to be a valuable project for the local community, services and groups. The face-to-face contact allowed community members to ask questions and receive a more individualised and personal approach."

Supporting general practice as the cornerstone of primary care

Our role is to assist the 200+ general practices in our region to provide care which is person-centred, comprehensive, population orientated, coordinated, accessible, safe and high quality.

Our approach is modelled on the 10 building blocks of high performing primary care. It involves working with general practice to incrementally build capacity and capability to move towards a patient centred medical home model of care.

Over the past year, we have:

- provided more than **$500,000** in funding to support **15** local practices trial new models of patient centred care, develop their workforce capacity and identify leaders for change. This resulted in improved patient outcomes and enhanced clinician experience
- continued quality improvement activities, with more than **87%** of practices engaged in one or more activity including:
  - **16 practices** used the Primary Care Practice Improvement tool as a starting point for practice improvement, resulting in enhanced patient experience and care
  - **35 practices** focused on quality improvement in immunisation and **14** on cancer screening. This commitment to immunisation rates has helped ensure those most vulnerable in our community are not as susceptible to the spread of disease, while the cancer screening initiative ensures patients are treated earlier, facilitating the best possible patient outcome
  - **6 practices** trialled Patient Reported Measures (PRMS), providing patients with the opportunity to be heard and to help the future of our local health care system
  - **41 practices (20%)** in place-based initiatives including Geriatrician in the Practice, mental health nurse program, shared medical appointments for obesity and overweight, and Black Dog Institute StepCare program. These initiatives brought together local networks, focusing on shared priorities and building long-term improvements in health outcomes
- supported practices to achieve and maintain accreditation, with more than **76%** of practices in the region accredited or registered for accreditation. Adherence to the standards promotes a culture of patient safety and high quality clinical care, and results in improved patient outcomes
- supported practices to meet their Practice Incentive Program (PIP) eHealth Incentive, with more than **64%** now compliant. By connecting the points of care, health information can be shared securely, enabling health professionals to deliver safer, more efficient, and better quality healthcare
- continued the Sentinel Practice Data Sourcing Project (SPDS), a population health and planning initiative, with **117 practices (57%)** now signed up. Improving the management of information and data can reduce the likelihood of medical errors, improve access to care and information, increase the efficiency of the practice as well as enhance communication between GPs, patients and others within the health care sector.

Innovation project: Supporting practices to trial new models of patient centred care

We announced more than $500,000 in funding to support 15 local general practices in trialling new models of patient centred care, with an additional $50,000 for GP leadership and practice support staff training.

The funding was part of a broader project aimed at incrementally building the capacity and capability of general practices within our region. All practices were invited to submit an expression of interest to participate in the project, with the following projects receiving funding:

- Bega Valley Medical Practice rolled out a Teen Clinic service into multiple practices including, Curalo Medical Centre (Eden), Lighthouse Surgery (Narooma), Main Street Medical (Merimbula) and Kiama Medical Practice. The clinics are provided with ongoing support and mentoring from Bega Valley Medical Practice
- Jindabyne Medical Practice implemented a system using secure technology to provide their local families with access to top pediatricians from Canberra
- Marima Medical Clinic (Goulburn) implemented an osteoporosis clinic with a plan to reduce hospital admissions from preventable fractures and other complications
- Moss Street Medical Practice (Nowra) piloted an integrated care approach for patients with chronic respiratory disease
- Dr Chandran's Surgery (Albion Park) developed a nurse-led respiratory disease management clinic to assist patients in better managing asthma and chronic obstructive pulmonary disease
- Illawarra Family and Medical Centre (Wollongong) enhanced its nurse-led diabetes management program involving the creation of a 'high risk' patient stream
- Lakeside Medical Practice (Warilla) implemented a nurse-led clinic to improve the level of care provided to diabetes patients through clinical review
- Market Street Medical Practice (Wollongong) included a consultant pharmacist and credentialed diabetes educator to focus on multidisciplinary care around medication review, focusing on de-prescribing and medication optimisation
- Russell Vale Family Medical and Acupuncture Centre introduced bilingual trauma counselling for local Syrian refugee families with complex needs as a result of grief and loss, helplessness and fear from war and impacts of the refugee experience
- Bulli Medical Practice implemented a nurse-led weight management clinic to improve patient overall health and chronic disease management
- Sharp Street Surgery (Cooma) implemented a telehealth support service for patients discharged from hospital.

Sentinel Practices Data Sourcing (SPDS) project: Using data to identify opportunities for quality improvement

The Sentinel Practices Data Sourcing (SPDS) project commenced mid-2013 and as of June 2018, there were 117 general practices signed up.

Practices have been conducting regular 'clinical data audits' aiming to make meaningful use of their practice data, with the purpose to improve patient outcomes and practice performance.

As the PHN, we have been undertaking quarterly analysis of this data for all participating practices, and providing data quality and performance reports to promote improvements in patient care and the overall population health of the region. This data allows participating practices to benchmark their performance against their cluster colleagues and monitor regional performance.

Windang Beach Family Medical Practice has been participating in the SPDS project since February 2016 and has incorporated clinical data auditing into their daily operations, with some significant benefits to their patients.

Margaret Beveridge, Practice Nurse, shares her thoughts:

"We established some time ago that data management was essential if we were to achieve improved health outcomes for our patients, especially those with diabetes.

We work hard to ensure all patient information is up-to-date and recorded correctly, and that our recall and reminder system is well managed. Working with patients to schedule upcoming appointments and ensuring we undertake reminder phone calls is particularly important for our diabetes patients who require ongoing and regular care.

In addition, we actively encourage patients to participate in and make decisions about their care. This has been enhanced by our point of care testing of HbA1c which means that we are now able to give patients immediate feedback on their test results and provide more timely treatment or care.

Our benchmarking data shows that we have been extremely effective in managing our patients with diabetes. We have results for the 10 basic SPDS indicators which are amongst the best in the PHN catchment. More than 93% of our patients with diabetes have had HbA1c testing done in the last six months (compared to an average of 53.4% across the region) and more than 75% diabetic patients have recorded a result of <7% which is regarded as good glycemic control. This compares to the average for the region of about 60%."

Partnering to integrate services and systems

We have been working in partnership with local health providers to ensure greater service and system integration between primary and acute care. This reflects our belief that effective management of people's health conditions within a primary care setting is a key component of service integration.

This year we have:

- built strategic alliances with our Local Health District (LHD) partners and developed joint plans for system improvement including the Illawarra Shoalhaven Integrated Care Strategy, and the Regional Mental Health and Suicide Prevention Plan
- jointly established GP Liaison roles with the Southern NSW Local Health District
- continued to support HealthPathways initiatives to document clinical referral pathways
  - HealthPathways Illawarra Shoalhaven – a collaboration between COORDINARE and Illawarra Shoalhaven Local Health District
    - **333** pathways live with **96** pathways under development
    - more than **3,840** users and **62,570** page views – **10%** increase in users over the previous year and **42%** increase in page views
  - ACT and Southern NSW HealthPathways – a collaboration between COORDINARE, Southern NSW Local Health District, ACT Health and ACT PHN
    - **425** pathways live with **85** pathways under development
    - more than **2,757** users and **86,600** page views – a **54%** increase in users over the previous year and **63%** in page views
- supported providers to be ready for the new opt-out arrangements under the Federal Government's My Health Record expansion with:
  - **100%** of general practices aware and **83%** registered
  - **97%** of pharmacies aware and **54%** registered
  - **20%** of the resident population registered with My Health Record
  - **24,446** Shared Health Summaries uploaded, an increase of **22%** over the previous period
- trialled new models of integrated care such as the Geriatrician in the Practice program in the Illawarra Shoalhaven and chronic pain management in Southern NSW.

Regional Mental Health and Suicide Prevention Plan: A positive step forward for mental health services in the region

In partnership with Illawarra Shoalhaven Local Health District and Southern NSW Local Health District, we developed a consultation draft Regional Mental Health and Suicide Prevention Plan which is set to bring about positive change for local consumers, their families and carers.

This plan is intended to provide a blueprint for collaborative action for mental health service delivery over the next five years. It has been prepared jointly by a working group comprising senior mental health managers, planning staff and people with lived experience of mental illness from across the region.

It focuses on the ways in which our organisations can work together with consumers, carers and other stakeholders to reduce fragmentation, address shared priorities and establish joint systems and pathways.

The draft plan has been informed by the results of recent consultation undertaken by all three organisations on other mental health initiatives, and notes the gaps from the perspective and experience of consumers and carers.

Challenges have been identified around fragmentation, lack of communication between services and the lack of timely and appropriate pathways to care across the spectrum of need and across the lifespan.

It identifies nine priority areas against which key actions are identified that involve working together across the health system, and with consumers and other stakeholders, to provide better integrated care for people with mental illness.

GP Liaison Officers: Making a difference in our health system

As the GP Liaison Officer for the Monaro region (including Queanbeyan, Cooma, Snowy Mountains and Bombala), Dr Melanie Dorrington is keen to improve the patient journey through the health system.

Here Dr Dorrington shares her thoughts:

"I believe in 'right person, right place, right time', and that if we can improve appropriate access to care, we will improve patient experience, patient health, and also the working conditions for medical professionals. I am a GP Clinical Editor with ACT and Southern NSW HealthPathways, but I wanted to have more reach into the health system.

There are many barriers to accessing health care in regional areas. In areas with highly mobile workforces, professionals may not feel supported, and there is a lack of knowledge around the services which are available.

Hopefully by clarifying information on the services provided by the Local Health District and making the information easily available, patients will have some barriers removed. An improvement in health care delivery and access is so important in improving health outcomes."

Building local networks and place-based leadership

We are committed to building strong local networks to help identify local issues and bring together the right people and services to create unique solutions.

This year we have:

- supported **12** local GP Clusters across the region, with **64** meetings convened
- offered **109** professional development activities, with more than **1,860** health professionals, practice staff and medical students in attendance
- recruited experienced practice managers and practice nurses to facilitate new Communities of Practice
- provided practice data quarterly reports with cluster-level information
- provided population health information reports/snapshots to **25** key external stakeholders.

Communities of Practice: An opportunity to share your stories, ideas and learnings

We recently introduced two new Communities of Practice for local practice managers and practice nurses to share their stories, ideas and learning with their peers.

Facilitated by experienced local practice managers and nurses, the groups aim to bring together practice managers and practice nurses in our region for a common purpose and provide an opportunity to collaborate, solve problems, share knowledge, cultivate best practice and foster innovation.

Influencing the market through provider engagement and commissioning

Our role is to support regional planning and drive innovation and integration through the commissioning of services.

As a commissioner, we are uniquely positioned to create new alliances, explore new service models as well as influence system change to improve the way health care is delivered to our population.

Over the past year we have:

- worked collaboratively with other PHNs and PwC Australia to facilitate the development of guidance material and associated toolkits for PHNs to support market engagement
- delivered **2** commissioning information sessions in Wollongong and Queanbeyan, with **19** providers in attendance
- undertook **5** approaches to market, with **27** associated contracts executed
- increased consumer participation on tender evaluation panels.

Addressing health priorities

We aim to maintain and improve the health of the region's population by addressing inequalities and service gaps for those most at risk of poor health outcomes.

A number of priority areas have been identified for South Eastern NSW which also relate to the national priorities.

Chronic conditions

We have an important role to play across the broader health and social care sectors to improve development of coordinated and comprehensive care for the prevention and management of chronic conditions.

This year we have:

- increased the reach and scope of the St Vincent's Hospital pain telehealth outreach service in Southern NSW
  - **27** GP referrals received and **124** telehealth sessions completed
  - trained **21** health professionals as chronic pain management facilitators who have subsequently run **10** small group pain education and self-management programs in Southern NSW
  - conducted **4** education events across Southern NSW, with **117** GPs, practice nurses and allied health professionals in attendance
- commenced development of programmed shared medical appointments for chronic pain to complement the existing community-based education and self-management program
- continued a general practice research partnership with the University of Wollongong which focused on managing cardio-metabolic risk in patients with severe mental illness
- pooled funds and co-commissioned in partnership with the Illawarra Shoalhaven Local Health District, the Connecting Care in the Community program – a care coordination program for people with chronic and complex needs. The new service will commence in July 2018
- worked with local GPs and the two Local Health Districts to develop regional specific winter strategies which focus on raising community awareness on how to reduce the spread of flu, encourage free flu shot amongst community members and provide opportunities for proactive media around the flu
- presented at the first International Asia Pacific Conference on Integrated Care in November 2017 and had an abstract published in the International Journal of Integrated Care.

Group pain education and self-management programs: Making a difference for consumers in Southern NSW

In conjunction with NSW Agency for Clinical Innovation (ACI) and Southern NSW Local Health District, we ran 10 small group education programs in chronic pain management in Southern NSW.

One of the Chronic Pain Management Facilitators, Josephine, shares Mabel's story:

"Mabel presented to one of our chronic pain management programs with a long history of lower back pain. Her pain relief regime put her in the 'red flag' category, as she was taking over 40mg daily equivalent dose of opioids. She appeared in a foggy haze, dragging her aching body around and with a set grimace and an awkward, unbalanced gait.

Both the physiotherapist, and myself, initially viewed Mabel as our biggest challenge within the group of 12 gathered at our first chronic pain management program. The good news was that she had a dream, a realistic goal that 'lit her up' and something that I felt sure we could help her achieve. We introduced movement gradually through a step-by-step pacing program and complemented this with relevant education on chronic pain and self-management.

Her goal, for the six-week intensive chronic pain program, was to walk her beloved dog along the lane behind her house. If she could do that she felt she would be well satisfied. She couldn't stand to see his sad, begging face anymore.

Part of the program focuses on 'desensitisation' through a combination of light exercise circuit (or dance) applied relaxation and, most importantly, 'core muscle' activation and nasal breathing. By the end of the program, she had walked the dog along the cobbled lane and gradually reduced her medication.

Her progress in such a short time seems quite extraordinary. The whole group applauded her achievement and I know it gave others great hope, as well as us. She went on to dream bigger dreams and the grimace is now long gone!"

Connecting Care in the Community: An innovative approach

In early 2018, we partnered with Illawarra Shoalhaven Local Health District to seek expressions of interest for the delivery of the Connecting Care in the Community program – integrated care for people with chronic conditions.

According to Dianne Kitcher, CEO of South Eastern NSW PHN, the Connecting Care program commenced as a chronic disease management program for patients of Ilawarra Shoalhaven Local Health District in 2011, and has provided a foundation for enhanced patient-level integration between the acute sector and primary care across the region.

"The program has continued to evolve and has extended to include people experiencing a wider range of longer term health conditions and complex health needs," said Ms Kitcher.

"The existing contract was to conclude so we saw it as the perfect opportunity for our two organisations to partner together and co-commission this key integration work."

The co-commissioning process encouraged innovative proposals to expand and evolve the current care coordination service to develop a flexible, coordinated care service that provides a place-based, efficient and accessible service for those with chronic and complex conditions. This is consistent with the shared vision of Illawarra Shoalhaven Local Health District and South Eastern NSW PHN within the Illawarra Shoalhaven Integrated Care Strategy 2017-2020.

Prevention initiatives

Our approach to prevention focuses on promoting health and preventing illness, and detecting and treating the early signs of disease. Our prevention initiatives are organised and systematic responses that take into account the social determinants of health.

This year, we have:

- worked with **35** practices in immunisation quality improvement initiatives across the region
- delivered **8** immunisation updates in collaboration with the Local Health Districts' Public Health Units across the region with **111** practices (54%) represented
- worked with **14** practices participating in cancer screening quality improvement activities
- delivered **12** cancer screening updates across the region, with **68** practices (33%) represented
- worked in partnership with Katungul Aboriginal Corporation to deliver targeted immunisation programs for local Aboriginal and Torres Strait Islander people
- worked in partnership with Katungul Aboriginal Corporation and BreastScreen NSW to coordinate group breast screening appointments for Aboriginal and Torres Strait Islander women
- continued to commission **5** programs to help reduce overweight and obesity levels amongst our local population:
  - **programmed shared medical appointments:** Australasian Society for Lifestyle Medicine (ASLM) – **13** general practices along with Waminda South Coast Women's Health and Welfare Aboriginal Corporation ran shared medical appointments in weight control
  - **rural and regional service gaps:** Grand Pacific Health ran a series of evidence-based physical activity and nutrition programs in our region
  - **Active8, Peer Health Coaching and Eat, Plant, Learn:** Neami National ran programs to address the poor physical health, particularly the high incidence of overweight and obesity, commonly experienced by people who have a mental illness
  - **obesity service:** Shoalhaven Family Medical Centres offered an obesity service for clients in the Shoalhaven region to access weight management, assessment and screening. It also provided training opportunities by specialists in the field of weight loss and obesity to health providers to build knowledge and skills in obesity engagement in the local area.

Peer Health Coaching: Addressing the poor health of people who have a mental illness

To respond to the poor physical health and significantly reduced life expectancy of people with a mental illness when compared to the general population, we funded Neami National's Peer Health Coaching program. The program aims to increase health literacy, improve skills and understanding in health improvement through six one-hour coaching sessions with a peer worker.

Peer health coaches are not health professionals, instead bringing their lived experience to model recovery and use coaching techniques to encourage positive lifestyle change.

In the first year, two part-time peer health coaches have assisted 21 consumers to complete the program, with 17 consumers currently enrolled. This program is complemented by Eat, Plant Learn – a group nutrition education program conducted over a number of weeks with 104 participants completing the program.

Here is Kylie's story:

"Kylie weighed more than 125kg but since joining the Peer Health Program in December 2017, she has been much more focused on her physical health.

She really enjoyed the telephone coaching. It encouraged her to return to the pool – she's now swimming more than 40 laps per week. She's also seeing an exercise physiologist once a week, has increased her walking and plays golf with her son on weekends.

Regular text messages have been helpful for Kylie and she has developed strategies to keep her exercise regime going. Her partner and son are supporting her with this and have scheduled golf weekends, walks and times at the pool together.

Kylie is very proud of her achievements – she's slowly lost more than 10kg as well as centimetres from around her waist.

Since completing the program, her son has stepped into a mentoring and coaching role and will continue to encourage her!"

Mental health and suicide prevention

Mental health and suicide prevention is a key priority for our organisation, and we have been funded to commission services that are in line with an evidence-based, localised stepped care approach.

This year we:

- held **4** mental health full day workshops with Black Dog Institute providing valuable training to **31** GPs and **3** practice nurses
- held **2** mental health focused cluster meetings for GPs and practice staff which included presentations from a range of service providers in the region
- announced more than **$4.3 million** in funding for mental health and suicide prevention services including:
  - **psychological therapies for hard to reach groups**: Grand Pacific Health provided individually tailored, flexible psychological therapies primarily through face-to-face consultations across the region. Royal Far West have complemented this service by providing telehealth mental health services to children aged 0-15 years and their families in Southern NSW
  - **support for complex mental health needs**: Shoalhaven Family Medical Centres provided mental health nursing support to people with complex mental health needs in the Shoalhaven region. Grand Pacific Health have provided mental health clinical support and peer worker support to people with complex mental health needs for the remainder of the Illawarra and Southern NSW regions
  - **suicide prevention activities**: Grand Pacific Health provided support and intervention to people presenting to emergency departments after a suicide attempt through clinical and peer workers in Southern NSW
- linked **7** organisations and more than **60** peer workers by establishing **2** new regional peer worker networks, and providing support to an existing network in South Eastern NSW
- undertook an approach to market with Capital Health Network (ACT PHN) to co-commission headspace services in Queanbeyan, Canberra and Bega
  - Grand Pacific Health was awarded the role of lead agency of headspace Bega Valley
  - Marathon Health was awarded the role of lead agency of headspace Queanbeyan and Canberra
- contracted Grand Pacific Health to deliver headspace services in Wollongong, Nowra and Goulburn and headspace Services Limited in Queanbeyan, providing more than 3,020 young with 13,331 occasions of service
- commenced the establishment of headspace complementary projects such as the GP Support Program through headspace Wollongong (to increase the retention rate of GPs in headspace) and the Aboriginal Health Worker Traineeship Program through headspace Queanbeyan
- worked collaboratively with the Illawarra Shoalhaven and Southern NSW Local Health Districts to develop a Regional Mental Health and Suicide Prevention Plan
- led the approach to market with **5** other PHNs to co-commission a psychiatry support line for GPs from 2 July 2018
- commissioned Lifeline South Coast to improve the coordination uptake, awareness and availability of gatekeeper training throughout South Eastern NSW
- developed promotional cards to promote the Head to Health website which includes a range of low-intensity mental health online therapies
- established the Bushfire Recovery Psychological Support Service in April 2018 to provide free and confidential mental health support for residents of Tathra and Districts affected by the bushfires.

LifeSpan: New approach to suicide prevention launched in Illawarra Shoalhaven

The Illawarra Shoalhaven Suicide Prevention Collaborative officially launched the Black Dog Institute's LifeSpan project in the Illawarra Shoalhaven in September 2017.

According to Alex Hains, Regional Manager of the Illawarra Shoalhaven Suicide Prevention Collaborative, LifeSpan is a new evidence-based, integrated approach to suicide prevention.

"It combines nine strategies that have strong evidence for suicide prevention into one community-led approach, and is expected to reduce suicide deaths by 20% and suicide attempts by 30%," said Dr Hains.

The Illawarra Shoalhaven was selected as a pilot site for LifeSpan as suicide rates in the region remain higher than NSW averages, with the latest data reporting 44 suicides in the region in 2016.

"LifeSpan is about working together to prevent suicide by implementing the strategies that work, and helping people in the local community be better informed and connected. It aims to build a safety net for the community by connecting and coordinating new and existing interventions and supports, and building the capacity to better support people facing a suicide crisis," he said.

LifeSpan has been implemented in the Illawarra Shoalhaven as part of the work to be undertaken by the Illawarra Shoalhaven Suicide Prevention Collaborative.

Psychiatry Support Line: six PHNs co-commissioning to establish new service

During 2017/18, we led an exciting new collaboration with five other PHNs – Northern Sydney, Central and Eastern Sydney, Hunter New England and Central Coast, Murrumbidgee and Western NSW – to co-commission a Psychiatry Support Line for GPs.

According to Dianne Kitcher, CEO of South Eastern NSW PHN, GPs have said they would like timely access to psychiatry expertise to assist them in managing the care of their patients with mental health problems.

"There were no psychiatry advice services for GPs in NSW. There was also limited psychiatrists practising outside the metropolitan areas so it's crucial that regional GPs are supported," said Ms Kitcher.

"It is anticipated that more mental health consumers will remain in general practice if GPs have access to a telephone advice line staffed by specialist psychiatrists," she said.

"It is not about triaging or referring consumers to a psychiatrist, but rather keeping consumers whose conditions are able to be treated within primary care under the care of their GP," she said.

The new telephone advice line will commence in July 2018 and will be available to all GPs in the geographical catchment of the co-commissioning group of PHNs.

"This is the first time that six PHNs have joined together to co-commission a service and we are delighted with the outcome," said Ms Kitcher.

Aboriginal health

We aim to support Aboriginal and Torres Strait Islander people to have better access to primary care which is culturally appropriate, sensitive and respectful, and believe there is a role for all services, whether Aboriginal community-controlled or mainstream, to work together to improve health outcomes for Aboriginal people across the region.

This year we have:

- continued to convene the CEO Aboriginal Health Advisory Group, with three meetings held
- funded Katungul Aboriginal Corporation, South Coast Aboriginal Medical Service, Illawarra Aboriginal Medical Service, Waminda South Coast Women's Health and Welfare Aboriginal Corporation, and Grand Pacific Health to continue to deliver the Integrated Team Care (ITC) program, with **10** care coordinators working across the region to support better management of chronic conditions and provide better access to allied health and specialist services for Aboriginal and Torres Strait Islander people
- contracted the **4** Aboriginal Community Controlled Health Organisations within the region – Waminda, South Coast Aboriginal Medical Service, Illawarra Aboriginal Medical Service and Katungul Aboriginal Corporation to deliver culturally appropriate mental health services
- undertaken considerable consultation and co-design with Waminda and South Coast Aboriginal Medical Service regarding a new after hours service model in the Shoalhaven, with Waminda taking the lead
- funded Waminda as the lead organisation to deliver a brokerage alcohol and other drug service model for Aboriginal women in the region on behalf of all four Aboriginal Medical Services
- funded Lives Lived Well to build service capacity with the Djirringanj Aboriginal Men's Group, and deliver alcohol and other drug first aid to the community and family service sector.

Integrated Team Care: Making a difference for our local Aboriginal people

The Integrated Team Care (ITC) initiative has been funded by our organisation to provide services for Aboriginal and Torres Strait Islander people who have chronic conditions.

Annie, a Care Coordinator from South Coast Aboriginal Medical Service shares Aunty P's story:

"Aunty P first heard about the ITC program through a family member, and approached me at the Clinic, wanting to know more.

She suffered from multiple chronic diseases, breast cancer and sleep apnoea, and was struggling to manage her conditions on her own. She hadn't had an Aboriginal Health Check in years so the first step was to arrange a doctor's appointment for her.

The doctor completed the health check and a GP management plan, referring her to the ITC program for care coordination. I was then able to assist her to make a number of specialists including a cardiologist, endocrinologist, ophthalmologist, a general surgeon, podiatrist and a sleep physician.

The ITC program was able to pay for all specialist appointments and to support the purchase of medical aids such as a pair of podiatry shoes. This was a huge relief for Aunty P because she could not afford these expenses.

With the support of the program, Aunty P has also made some significant life changes which have improved her health and wellbeing. She has shared her story with others and encouraged them to seek help. This has resulted in others requesting health checks so they can start their own health journeys.

All this could not have happened without the ITC program supporting our local community."

Drug and alcohol

We have a crucial role in planning and commissioning drug and alcohol treatment services. Our aim is to reduce the harms associated with drugs and alcohol, with a focus on limiting methamphetamine use in the community.

This year we:

- organised four GP Cluster meetings to build enhanced capacity and capability within general practice to respond to primary drug and alcohol issues
- coordinated a forum in Narooma in conjunction with Southern NSW Local Health District to bring together GPs, health professionals and non-government organisations which deliver alcohol and other drug services in the region, with a focus on strengthening collaboration
- funded Directions Health Services to operate a new drug and alcohol treatment service for people who live in the Monaro, Eurobodalla and Goulburn regions, providing early intervention for individuals at risk through to more intensive case management for people with a higher level of substance use and more complex needs
- funded ACON to provide training, coaching and case review support that will build the capacity of the sector to appropriately and successfully respond to LGBTIQ people seeking support for alcohol and other drug use.

New funding for local drug and alcohol treatment services in Southern NSW

Directions Health Services has been funded to operate a new Pathways program in Southern NSW, providing early intervention through to more intensive treatment and support for residents who may be concerned about their level of alcohol use, or use of prescription or illicit drugs, as well as for family members concerned about a loved one.

One of the case workers from Pathways Monaro shares Scott's story:

"Scott had been suffering from long-term alcohol dependence which was having a major impact on his life and emotional wellbeing. He experienced a relationship breakdown, was homeless, and faced several charges for incidents that had incurred while he was intoxicated. His physical health was also severely impacted and he was regularly admitted to Cooma Hospital.

After receiving a referral from Mission Australia and completing an initial assessment, Pathways Monaro staff worked with Scott to identify his treatment goals which included improving his housing and health, entering rehabilitation and ceasing his alcohol consumption completely.

Pathways Monaro used evidence-based therapies to assist Scott to identify and achieve his treatment goals, including motivational interviewing and cognitive behavioural therapy. His case manager also assisted Scott to address his housing and health needs which involved working with his family and other agencies, as required.

Due to Scott's history, it was identified that the physical complications of withdrawal could pose a risk to his health. As a result, Pathways Monaro initiated an admission to Cooma Hospital for detox from alcohol, followed by entry to Arcadia House, Directions' residential rehabilitation facility. Scott successfully completed the 12 week program at Arcadia House.

Following his graduation from Arcadia House, Scott was supported by Pathways Monaro to re-engage in his local community and continue to address his health and housing needs. He now supports other people in the local area through running a peer-led support group in Cooma which he initiated.

Scott's mental and physical health has improved significantly and he has received a good behaviour bond for charges that could have incurred a custodial sentence, enabling him to continue his recovery journey in his own community. The magistrate stated that Scott had made incredible efforts to change his life and enter recovery, and credited Pathways Monaro with providing Scott the treatment and support he needed to achieve these outcomes."

End of life care

Palliative and end of life care is one of our six health priorities. We want to ensure that all people in South Eastern NSW have an optimal end of life experience, building on the strengths of care delivery and ensuring care and services are equitable, accessible, coordinated and culturally appropriate as the person experiences end of life.

This year we have:

- listened intently to the sometimes difficult stories of people and sought views and experience from experts in order to take the next step
- commissioned the development of a model of care to support the role of primary care providers in palliative and end of life care in South Eastern NSW
- invited organisations to apply for funding to implement initiatives that support increased understanding and uptake of advanced care planning, and sought expressions of interest for innovative models of care that build capacity of primary care including but not limited to general practice, aged care and community pharmacy.

phn
SOUTH EASTERN NSW
An Australian Government Initiative

For more information:

COORDINARE – South Eastern NSW

Phone: 1300 069 002

Website: www.coordinare.org.au

Email: info@coordinare.org.au