COORDINARE

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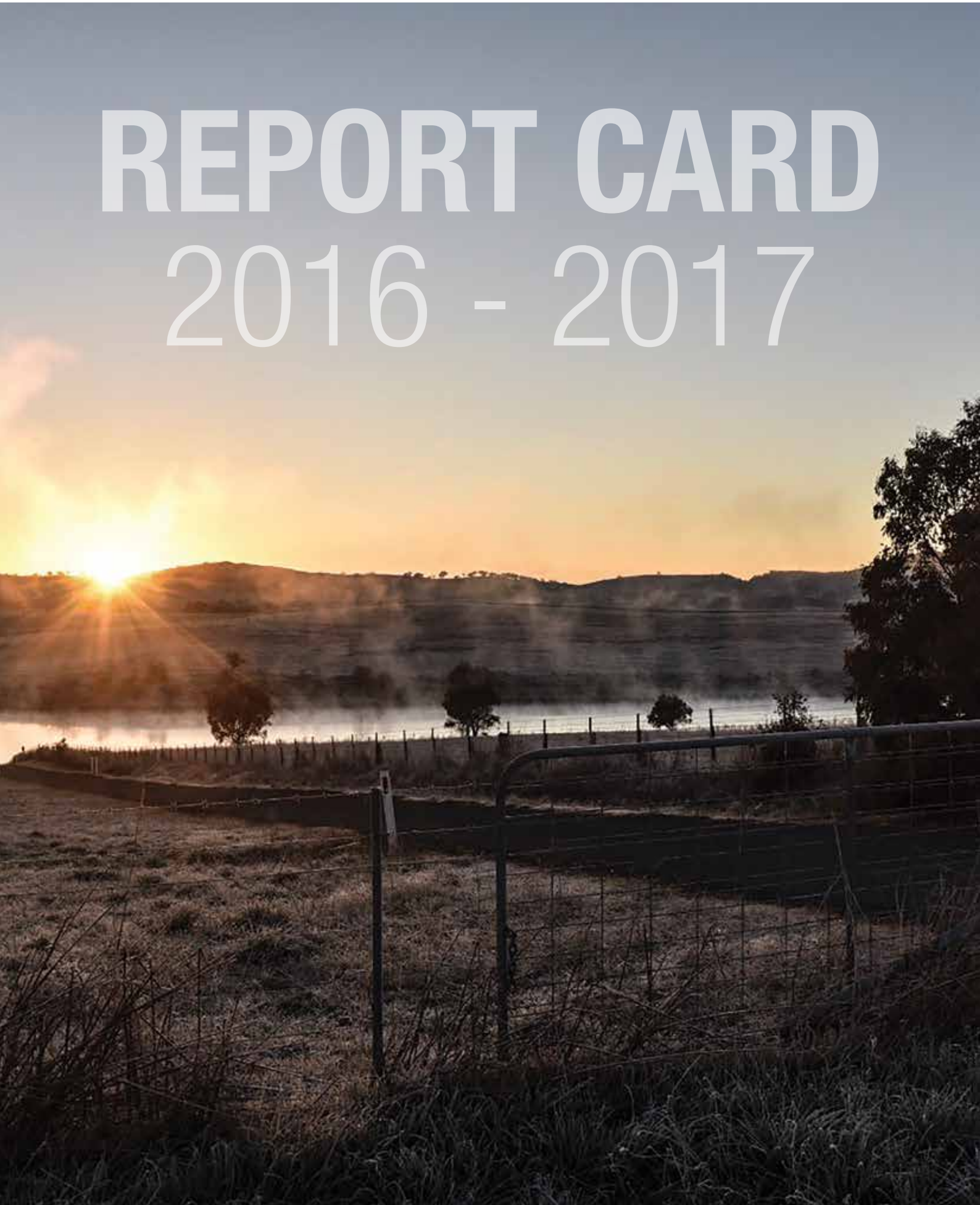
SOUTH EASTERN NSW
An Australian Government Initiative



REPORT CARD
2016 - 2017

Message from our Chair and CEO

As the Chair and CEO of COORDINARE - South Eastern NSW PHN, it is a great pleasure for us to present our second Report Card.

It has been an exciting year and we would like to thank our partners, stakeholders and local health professionals for working with us towards our vision for a more coordinated regional health system which provides exceptional care, promotes healthy choices and supports resilient communities.

You can read more about our progress and results throughout this report. It showcases our key achievements and highlights some of the work we have undertaken as part of our commissioning and partnerships.

We could not have achieved so much without the support of our Board, two Clinical Councils, Community Advisory Committee, and (of course) our staff. We congratulate and thank everyone for their efforts. We are proud to be working alongside such a great team and look forward to the ongoing successes we can achieve together.

Richard Spencer
Chair of Board

Dianne Kitcher
CEO

Governance

COORDINARE's 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.

COORDINARE's governance structure embeds strong links between the Board, our Councils and Committee, enabling these to have a high degree of input into Board discussions.

This year, our:

- Board met eight times
- two Clinical Councils met quarterly
- Community Advisory Committee met quarterly.

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

The Sentinel Practices Data Sourcing (SPDS) project commenced in 2013 and more than 100 practices (52.7%) have 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 and regional performance.

Bega Valley Medical Practice has been participating in the SPDS project and has incorporated clinical data auditing into their daily operations, with some significant benefits to the practice and population care. Dr Duncan Mackinnon, General Practitioner shares his thoughts…

"We established a long time ago that unless we measure what we do, we don't have any real insight into how effective our health care delivery is. So we joined the Sentinels project – we were one of the early adopters – and we set about cleaning up our data using the tools available and this has helped to significantly improve the delivery of care to our patients.

Our Health Coordination Consultant shares the de-identified data with us which we use to benchmark our practice against other local practices in the region, and make decisions about where to target our efforts for improvements.

We also use it to improve patient clinical care as it gives us an accurate snapshot of where our patients are at in terms of their own health journey. For example, we recently used it to look at our patients who are on mental health medications and realised that 75% of them did not have a recorded BMI which is critical health information.

It has been also really beneficial in developing how our practice works and encouraging staff to work together to improve the outcomes for our patients."

Supporting general practice

COORDINARE's role is to assist the 200+ general practices in our region in attaining the highest standards in safety and quality.

Quality and safety, workforce, learning and development, and financial incentives all play an important role in building the capacity of general practice, improving efficiency, minimising risk and most importantly, enhancing patient and staff safety.

Over the past year, we:

- continued quality improvement activities, with more than **61%** of practices engaged in one or more activity
- supported practices to achieve and maintain accreditation, with **75%** of practices now accredited
- offered more than **170** professional development activities, with **77%** of practices represented at more than one of these events
- continued the Sentinel Practices Data Sourcing (SPDS) project, a population health and planning initiative, with **52.7%** of practices now signed up – an increase of **13.6%** from June 2016
- supported the meaningful use of My Health Record with:
  - **17.7%** of the resident population registered with My Health Record
  - **78.5%** of practices registered
  - **68.3%** of practices uploading Shared Health Summaries
  - **69.8%** of practices viewing My Health Record
  - **65.4%** of practices provided assisted registrations.

Integrating services and systems

COORDINARE has been working in collaboration with local health providers to design system improvement and optimise pathways for consumers and coordinate care.

By doing this, we aim to stop, slow, reverse or divert the flow of patients across the health continuum. We seek to deliver more healthy people staying well; more people free of risk factors such as obesity; more people with well-coordinated community care and consequently fewer visits to hospital.

Over the past year, we:

1. continued to work closely with the two Local Health Districts in our region through our Strategic Alliances
   - Illawarra Shoalhaven
     - agreed on terms of reference, seven meetings held
     - endorsed joint Integrated Care Strategy and five priorities agreed, implementation commenced
   - Southern NSW
     - agreed on terms of reference
     - agreed to co-fund four GP liaison positions
     - collaborated around regional workforce issues in Bombala
2. continued to support HealthPathways initiatives
   - HealthPathways Illawarra Shoalhaven – a collaboration between COORDINARE and Illawarra Shoalhaven Local Health District
     - **255** pathways live, **25** under development
     - more than **2,780** users and **44,100** page views – **57%** increase in the number of sessions over the previous year, **31%** increase in users and **34%** increase in page views
   - ACT/Southern NSW HealthPathways – a collaboration between COORDINARE, Southern NSW Local Health District, ACT Health and ACT PHN
     - **317** pathways live, **85** under development
     - more than **2,290** users and **70,200** page views – **60%** increase in the number of sessions over the previous year, **61%** increase in users and **55%** increase in page views
3. extended the Geriatrician in the Practice project, a new model of care, with more than **160** patients seen across nine practices in the Shoalhaven, achieving positive feedback from consumers, carers and clinicians
4. partnered with Southern NSW Local Health District, ACI and St Vincent Hospital's Pain Clinic to provide a chronic pain specialist outreach and telehealth service for consumers in Southern NSW. Between January and April 2017, 82 telehealth consultations were undertaken, with 97% of patients and providers reporting a positive experience.

Dr Issuru Premawardhana: A Southern NSW GP's experience with HealthPathways

Dr Issuru Premawardhana is a GP practicing at Tuross Health and Surf Beach Surgery and a Clinical Editor for HealthPathways ACT and Southern NSW. Here is what Issuru had to say about developing HealthPathways and using it in his day-to-day practice with patients…

"I have been working and living in the Southern NSW region for over three years now. HealthPathways has been a wonderful tool in helping me settle in to the region, and I encourage new doctors and registrars who are moving to the area to use it.

HealthPathways has assisted me with finding specialist services available to my patients in a rural isolated setting. Knowing that I can find a local surgeon who does thyroid, breast, bowel and hand surgery has been very beneficial.

I appreciate that the pathways are constantly updated to reflect ongoing changes in treatment methodologies."

Geriatrician in the Practice project: Challenging us to review, rethink and renew existing models of care

Funded by the NSW Ministry of Health and led by the Illawarra Shoalhaven Local Health Distrct (ISLHD), the Geriatrician in Practice project continues in the Shoalhaven. This integrated care project involves a geriatrician and clinical nurse consultant accompanying a GP and practice nurse in their rooms, providing a joint, integrated GP/specialist appointment.

Worrigee Street Medical Centre was one of the practices to pilot the Geriatrician in the Practice program. The practice saw it as a unique opportunity for GPs, GP registrars and practice nurses to upskill by learning more about screening for dementia, cognitive assessment tools, and treatment options for patients with a cognitive decline.

Kathy Godwin, Practice Nurse at Worrigee Street Medical Centre, reflects on her experience with the Geriatrician in the Practice project…

"Our patients have certainly benefited from this experience through early geriatrician assessment and intervention. The familiar practice environment has also reduced some anxiety associated with seeing a new specialist," said Kathy.

"Practice staff have also gained further competence and confidence in the screening and referral processes for dementia, while building a greater rapport with patients."

The ongoing evaluation of the project has highlighted a number of other benefits including:

- increased number of people receiving initial dementia assessment and reduced number of assessment reviews
- more timely recognition of cognitive impairment
- improved patient attendance of patient groups who would not attend hospital based clinics
- improved linkages and referral mechanisms across services and settings
- less travel required as they are receiving more local care
- increased advance care planning
- increased service referral to local dementia services
- fewer ED presentations
- 32 GPs and 15 practice nurses upskilled

The outcomes of the project have been recently presented at National Australian Practice Nurse Association Conference and the International Conference on Integrated Care. The project was also one of the ISLHD 2017 Quality and Innovation Award winners.

Fostering change and innovation

Patient Centred Medical Home – Innovation Project

While the South Eastern NSW region was not selected to take part in the Department of Health's trial of the Health Care Home (HCH) model, we have been successful in our application for innovation funding to support and fund activity which will incrementally build the capacity and capability of general practices within our region to 'get ready' to be a Health Care Home over the next two years. This initiative aims to ensure that practices know what their capability is and what is required to more efficiently transform to a Health Care Home when this is rolled out nationally.

Over the past year:

- phase 1 commenced – two workshops held with **58** attendees, **37** practices represented
- PCMH symposium held, with over **130** attendees from across the region
- consultation completed with over **173** interviews conducted, Aboriginal and consumer consultations ongoing
- logic model and report completed and being finalised for distribution, with Expressions of Interest (EOI) for funding to help general practices move towards a PCMH mode of care released in July 2017.

Putting the patient at the centre of care: International symposium

There was such a great vibe at our 'Putting the Patient at the Centre of Care' Symposium held in Wollongong in April.The event, which featured a number of high-profile speakers who shared their perspectives and emerging work on the Patient Centred Medical Home (PCMH) model of care.

It attracted more than 130 attendees, including a good representation of GPs, practice nurses and practice managers across the region - some from as far as Bega! It also included a broad-cross section from Local Health District Board members and staff, to health insurers, academics from a range of institutions, consumers, and some of our commissioned providers.

The feedback we received was extremely positive: the presentations and subsequent discussion were energising, informative and thought provoking.

New approach to suicide prevention to be implemented in Illawarra Shoalhaven

COORDINARE is a member of the Illawarra Shoalhaven Suicide Prevention Collaborative which was established in August 2015 to address the high rates of suicide within the region.

The collaborative consists of representatives of more than 30 significant organisations, as well as lived experience advocates.

This year, the Collaborative was successful in its application for the Illawarra Shoalhaven to be a trial site for the Black Dog Institutes's LifeSpan program, a new evidence-based, integrated approach to suicide prevention. LifeSpan combines nine strategies that have strong evidence for suicide prevention into one community-led approach, and has the potential to reduce suicide deaths by 20% and suicide attempts by 30%.

This is great news for the region as suicide rates remain higher than NSW averages, with latest data reporting more than 40 suicides in the region in 2014.

LifeSpan aims to build and strengthen the local suicide prevention safety net, and empowers the community to take action using approaches that have been shown to have a real effect on suicide rates.

The Collaborative is well positioned to lead this work. Five working groups have already been established, each focused on a specific area of suicide prevention including health, community and school interventions, restricting access to means, and Aboriginal and Torres Strait Islander suicide prevention.

The working groups involve a range of services and sectors, as well as people with their own personal experiences of suicide and mental health recovery.

Engaging with consumers

As the South Eastern NSW PHN, we believe that everything we do should create a better patient experience and improve patient health outcomes. Understanding patient journeys will allow us to design care pathways that include the patient's perspective and enable us to better identify where patient self-management and health literacy can be enhanced.

This year we have:

- developed a Consumer Engagement Framework
- launched an online Consumer Health Panel in December 2016
- introduced a pilot for Patient Reported Measures (PRMs) into six general practices
- developed eight stories shared by people with lived experience of mental illness
- had high representation of consumers and carers (154) at our mental health co-design workshops
- built consumer feedback and experience measures into all new service agreements.

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

The Consumer Health Panel was established in December 2016 and has been positively received by local residents.

The Panel provides an exciting opportunity for residents to have a say on a range of health care issues that impact on them, their family or friends.

Volunteers are asked to respond to a short online survey, once a month. We then let people know how their answers are helping with our planning, how they may influence decision making or how they are being used to make a difference. All responses are confidential.

In March 2017, for example, our survey focused on advance care planning, with all panel members (100%) reporting that it was 'very important' for them to be involved in decisions around the management of their health care.

Interestingly though, only 31% of people who responded have an advance care plan for themselves or the person they care for.

The vast majority of people (81%) have not discussed an advance care plan with their GP and of those who had (29%), they said they had initiated the conversation themselves.

This suggests that there is an opportunity to educate the general public about the process and value of creating an advanced care plan. There is also work to be done with general practices to consider initiating discussion about advance care planning as part of everyday practice.

To date the feedback about the panel has been very positive, and some have used it as an avenue to explore other ways to contribute and get involved with local health initiatives. For example, a couple of panel members attended the PCMH symposium in April, another went to an ACI patient experience symposium in Sydney and others have agreed to be interviewed as part of our self-management consultation.

Using data to plan and develop local strategies

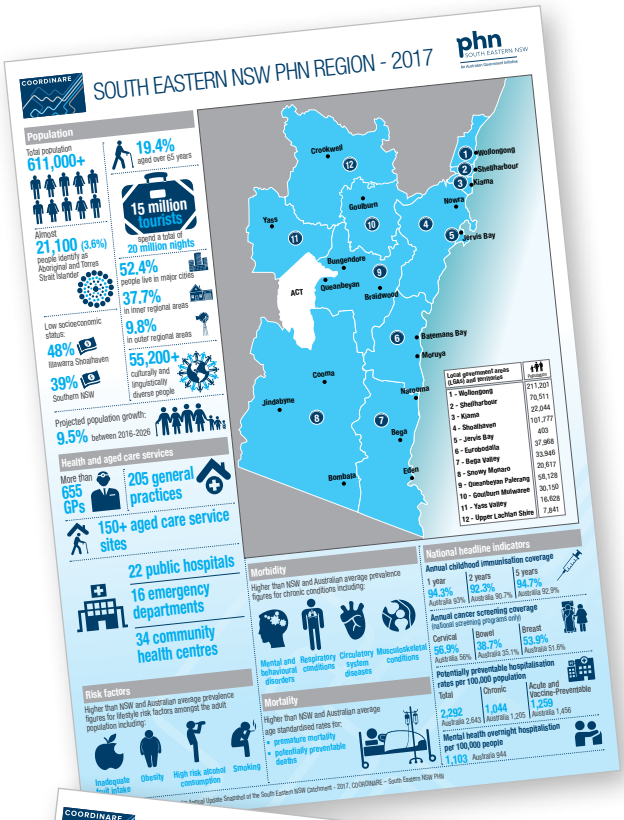
A key role as a PHN is to undertake population health planning and regional needs assessments, identify system issues and gaps in services then develop and implement strategies to address, in collaboration with our Local Health Districts, communities, population groups and service providers. It is essential to develop local strategies to improve the operation of the health care system for consumers and facilitate effective primary healthcare provision to reduce avoidable hospital presentations and admissions within the region.

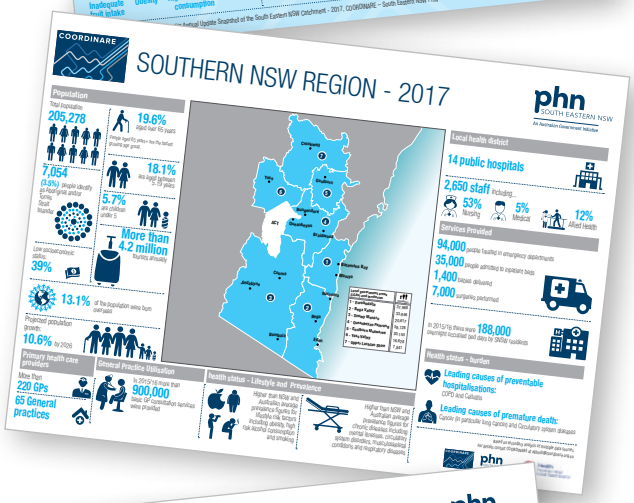
Over the past year, we developed more than 110 population health information and data snapshots including:

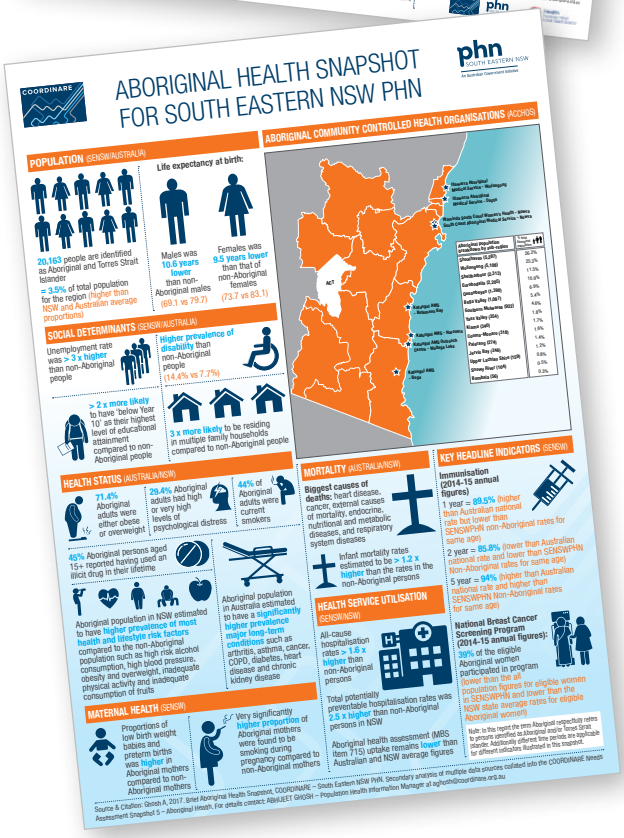
- mental health
- Aboriginal health
- after hours emergency departments
- overweight and obesity
- chronic pain

Established regular population reporting and services monitoring measures for key indicators such as:

- cancer screening
- digital health
- childhood immunisation
- mental health nursing







Commissioning to meet the health needs of local communities

As a commissioning organisation, we work with service providers and local communities to design and commission services to address population need, with a focus on those most at risk of poor health outcomes.

This requires a robust understanding of population need, strong engagement from stakeholders at each stage, supporting service providers to develop and implement new models of care, and monitoring and evaluating service outcomes to ensure effectiveness and value for money are achieved.

This year, we:

- undertook **11** approaches to market, with 48 associated contracts executed
- **90%** of commissioned work is for new services and new models of care.

Addressing health priorities

As the South Eastern NSW PHN, 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 relate directly to the national priorities and funding programs. These include:

Chronic conditions

COORDINARE is working with local primary care providers and consumers to identify and implement locally appropriate initiatives to increase consumers' capacity to manage their own chronic conditions.

We announced funding for five new programs to try new approaches to reducing overweight and obesity levels amongst our local population.

These evidence-based physical activity, nutrition and weight loss initiatives include:

- **Programmed shared medical appointments: Australasian Society for Lifestyle Medicine (ASLM)** – eight practices selected across the region to trial shared medical appointments in weight control for more than 320 patients
- **Rural and regional service gaps: Grand Pacific Health** – a series of evidence-based physical activity and nutrition programs to tackle the issue of overweight and obesity in South Eastern NSW
- **Active8, Peer Coaching and Eat, Plant, Learn: Neami National** – program 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** – a centralised obesity service for 150-200 people in the Shoalhaven region to access weight management, assessment and screening. Also provides 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
- **Pair up: Behaviour Design Works** – a program to increase the physical activity levels of more than 1,000 adults aged between 18 and 65 years in the Eurobodalla, Shoalhaven, Bega Valley, Bombala and Snowy River Shires.

This year we also:

- commissioned a self-management initiative to ensure evidence-based change
  - Sax Institute – rapid review of self-management programs for people with chronic conditions including Aboriginal and Torres Strait Islander people, and culturally and linguistically diverse (CALD) people undertaken and used to inform future planning
- ensured service continuity and transition: initiatives for redesign in rural communities
  - podiatry, physiotherapy and men's health services – Gunning
  - footcare Yass, Murrumbateman and Moruya – Grand Pacific Health
- commenced a general practice research partnership with the University of Wollongong with a successful project focused on screening for metabolic syndrome and cardiovascular disease risk factors in patients taking anti-psychotics
- expanded the chronic pain specialist telehealth outreach service in Southern NSW to include Goulburn and Far South Coast, with 82 patients referred to the service and 97% reported positive experience.

New model of care to address obesity: Programmed Shared Medical Appointment (PSMA)

A new form of medical consultation whereby a doctor and obesity expert consults with up to 10 overweight men and women at a time, is being trialled in South Eastern NSW.

The trial, known as Programmed Shared Medical Appointment (PSMA), is being offered at eight selected medical centres in Milton, Wollongong, Merimbula, Cooma, North Nowra and a local Aboriginal medical service.

Participants receive a medical consultation, special measures and prescriptions, and evidence-based weight loss advice in six group sessions over six months, but also get to help each other with their experiences of weight loss and gain.

Some men at Milton Medical Centre, where the initial program was started, have lost up to 15kg since beginning the program.

Immunisation

As the South Eastern NSW PHN, we have been working in collaboration with primary healthcare providers, Local Health Districts and other community service organisations to support and promote high immunisation rates in the region.

Overall vaccination rates for children in South Eastern NSW remain higher than the NSW state and Australian national averages, with 94.9% of one year olds, 90.9% of two year olds, and 95.1% of 5 year olds fully immunised as at June 2017.

Keeping coverage above 90% provides 'herd immunity' for most infectious diseases, ensuring those most vulnerable in our community are not as susceptible to the spread of disease.

Over the past year, we:

- worked with **29** practices in immunisation quality improvement initiatives across the region
- delivered **6** immunisation updates in collaboration with Local Health District's Public Health Units across the region, with **46%** of practices represented
- supported primary healthcare professionals to report to the Australian Childhood Immunisation Register (ACIR) accurately and on time
- maintained ongoing support for primary healthcare providers in the areas of immunisation resource distribution, knowledge sharing and communication.

Cancer screening

COORDINARE has been working with the local community and health care providers to see what we can do together to improve cancer screening rates in South Eastern NSW.

This year, we:

- had 10 practices participate in cancer screening quality improvement initiatives
- had 25 practices participate in cancer screening updates delivered in collaboration with stakeholders including NSW Cancer Institute, BreastScreen NSW and Illawarra Shoalhaven Local Health District (ISLHD)
- commissioned Waminda to develop cancer prevention and coordination programs in partnership with the Shoalhaven Cancer Care Centre, targeting Aboriginal people
- worked with Katungal and BreastScreen NSW to coordinate group breast screening appointments for Aboriginal and Torres Strait Islander women in Moruya and Bega
- worked with a practice in Goulburn and BreastScreen NSW on a pilot project to identify women who have not had a regular breast screen
- worked in partnership with South Coast Aboriginal Medical Service to ensure Aboriginal men receive cancer screening, prevention, awareness raising, intervention and treatment.

Working together to coordinate group breast screening appointments for Aboriginal women

The teams at Katungul Aboriginal Corporation Batemans Bay, Narooma and Bega in conjunction with COORDINARE, have commenced a breast screening initiative for their clients.

Working with BreastScreen NSW, Katungul Aboriginal Corporation has arranged block bookings for their Aboriginal and Torres Strait Islander women to attend breast screening in a supportive environment with friends or family members.

This is an important initiative to address the high proportion of under screened Aboriginal and Torres Strait Islander women in Southern NSW given that 39% of eligible Aboriginal women participate in BreastScreen, compared to 53.9% of non-Aboriginal women.

So far the initiative has resulted in more than 20 Aboriginal women being screened and the bookings have now become a regular occurrence at Moruya and Bega BreastScreen.

Mental health and suicide prevention

Mental health is a significant issue for people living in South Eastern NSW and COORDINARE, as the South Eastern NSW PHN, has been funded to commission services that are in line with an evidence-based, integrated primary mental health stepped care approach.

This year, we:

- undertook a comprehensive review of mental health and suicide prevention services including extensive consultation with consumers, carers and service providers
- developed a person-centred stepped care approach
- developed a mental health and suicide prevention commissioning plan
- undertook an approach to market to ensure new mental health and suicide prevention services would be ready to transition from 1 July. This includes:
  - psychological therapies for hard to reach groups
  - support for complex mental health needs
  - suicide prevention activities
- recruited a Mental Health Peer Coordinator to support a local peer workforce
- commenced work on the formation of a suicide prevention collaborative in Southern NSW to develop and lead a local Suicide Prevention Action Plan
- officially opened headspace Goulburn, giving young people aged 12 to 25 access to youth friendly, free and confidential mental health and wellbeing services in their local area
- were successful in application for funding for new headspace service to be established in Bega Valley to provide vital mental health services and support to local young people.

headspace Bega: Young people to benefit from vital mental health services

Young people in Bega and surrounding towns will benefit from access to vital mental health services and support following our successful application for a new headspace service in Bega.

The headspace model is based on early intervention with the knowledge that adolescence and early adulthood is a critical time in a person's life, with research showing that 75% of mental health disorders emerge before the age of 25. By ensuring help is accessed in those early stages, young people can get things back on track and reduce the likelihood of developing a mental illness later in life.

The new headspace service will be one of five centres in South Eastern NSW funded by COORDINARE.

In making the announcement The Hon Greg Hunt, Minister for Health said:

"Under the proposal, headspace Bega will become a 'hub' for young people in the region, however the PHN will work with the local community to develop a flexible model which might allow for the provision of outreach services to young people in surrounding towns.

The new service will help to address some of the current challenges experienced by young people living in this area, which in some cases lead to mental ill-health, self-harm and suicide.

These services will make a marked difference in ensuring that young people get the right support, at the right time."

© Bega District News

Aboriginal health

The need to support Aboriginal and Torres Strait Islander people to choose and adopt culturally appropriate healthy lifestyles and to manage chronic conditions is important to COORDINARE, as the South Eastern NSW PHN.

Developing strong partnerships with both Aboriginal and Torres Strait Islander communities and key service providers will be critical to supporting better health outcomes for these members of our community.

Over the past year, we:

- worked closely with our Aboriginal Medical Service organisations in the region to establish a CEO Aboriginal Health Advisory Group, with quarterly meetings held
- funded 10 Care Coordinators under the Integrated Team Care (ITC) initiative, to provide services for Aboriginal and Torres Strait Islander people who have chronic conditions
- commissioned four Aboriginal Community Controlled Health Organisations (South Coast AMS, Waminda, Illawarra AMS and Katungul Aboriginal Corporation) to provide culturally appropriate mental health services and community capacity building for the local community
- commissioned Waminda as the lead agency to establish and provide a community-based brokerage and support service specifically for Aboriginal women and their children experiencing substance misuse across our region.

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

The Integrated Team Care (ITC) initiative has been funded by COORDINARE to provide services for Aboriginal and Torres Strait Islander people who have chronic conditions. One of our Care Coordinators, Angela, shares Freeda's story:

"Freeda was referred to me with a number of presenting life threatening issues some including sleep disorder, chronic respiratory disease, diabetes, and chronic kidney disease. She had been struggling to gain support for quite a while.

Given the high number of presenting issues, I liaised closely with her GP to prioritise her issues, developing a care plan that suited her most pressing needs.

Of major concern was her obstructive sleep pattern so I contacted a sleep study specialist. A week-long sleep study was conducted and the results showed she was often choking, regularly snoring, had ongoing fatigue and sleeplessness, hypertension, diabetes and heart disease. She had a sleep efficiency of 81% with a prolonged sleep latency of 33 minutes, and often stopped breathing. Severe respiratory disturbances were noted, with urgent treatment recommendation stating she would require a CPAP machine and mask. We also developed some weight reduction strategies.

I have maintained ongoing communication with this client, given the severe nature of her presenting issues, with all feedback being positive."

Freeda said: "Heartfelt thanks for Angela and the ITC program – you have given my life back to me and my family. From someone who was unable to drive, I am now looking forward to driving my niece back to Nowra. I had a follow-up appointment with my respiratory and sleep physician and she was pleased with my progress. I will not need to see her for another nine months."

© Katungal

Healthy ageing

As the South Eastern NSW PHN, COORDINARE is working with consumers and other stakeholders to identify the most appropriate approaches to support healthy ageing and maximise the independence and self-care abilities of older people.

Last year we:

- funded three programs to promote healthy and active ageing to residents to enable them to stay well and remain living in their communities as they age:
  - **Preventing Falls, Promoting Life: Grand Pacific Health** – programs to prevent falls and harm from falls, in targeted locations
  - **Grey Medallion: Royal Life Saving NSW** – offering **400-500** older people the opportunity to undertake the Grey Medallion program and develop water safety and lifesaving skills
  - **Malnutrition screening: University of Wollongong** – routine screening for malnutrition in older adults to be rolled out to **12** general practices
- identified and prioritised ageing related HealthPathways for development and implementation with **10** pathways localised for ACT and Southern NSW, and **14** localised for Illawarra Shoalhaven.

© Royal Life Saving NSW

Drug and alcohol

COORDINARE has been funded to commission drug and alcohol treatment services across South Eastern NSW, including Aboriginal-specific services, based on what is necessary and appropriate to the needs of our local communities.

This year, we:

- funded two new drug and alcohol treatment services in areas where no services previously existed, from March 2017 to 30 June 2018:
  - **Directions Health Services** – will operate new services across Eurobodalla, Monaro 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. Family sensitive services to support family members and carers also available.
  - **ACON** – will 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 needs.

Urgent care

The after hours program aims to increase the efficiency and effectiveness of after hours primary healthcare for patients, particularly those with limited access to health services, through effective planning, coordination and support.

Over the past year, we:

- launched a comprehensive communication campaign to raise awareness amongst residents and tourists of after hours options across the region
- extended the contract with Radio Doctor Illawarra to continue its extended coverage to Northern Illawarra and Kiama, with more than 22,300 calls to the service, 16.8% from residential aged care facilities (RACFs)
- held 13 capacity building workshops across the region for residential aged care providers, with a total of 165 participants attending
- developed new online learning module, focusing on updates in palliative care for general practice in the Illawarra Shoalhaven
- consulted with local GPs, RACFs and specialists on improved palliative and end-of-life care models in Illawarra Shoalhaven. The project extended to include Southern NSW, with focus group to be established to test ideas for new models
- extended the 'Driven to change: Making medications work' project to Shoalhaven region, providing support for those primary care patients who are linked with the Local Health District's palliative care service for end of life care.

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COORDINARE – South Eastern NSW PHN is supported by funding from the Australian Government under the PHN Program.