2015/16 REPORT CARD

COORDINARE commenced operations as the South Eastern NSW Primary Health Network (PHN) on 1 July 2015 and is proud to present our first Report Card.

Community, consumer and clinical input

Skills-based Board established with **nine Directors** including Independent Chair

2 x Clinical Councils established including **14 local GPs, 8 primary care representatives** and **4 Local Hospital Network representatives**

1 x Community Advisory Committee established; **three** meetings held

Population health strategy

Baseline Needs Assessment undertaken; key issues drawn from the prioritisation process:

high rates of potentially preventable **hospital admissions** for chronic conditions

variability in **childhood immunisation** rates within particular locations and community groups

low participation in national cervical and bowel **cancer screening** programs; decreasing participation in BreastScreen

disproportionate burden of **chronic disease** in the Aboriginal population and high prevalence of chronic disease risk factors

the need to promote **healthy ageing:** keeping people well and living independently

limited access to **culturally appropriate health services,** and limitations in access to affordable and accessible health services

limited knowledge of services and access/referral points

limited access to, and low awareness of, **after hours service options**

high rates of **mental and behavioural disorders** and psychological distress amongst adults and Aboriginal and Torres Strait Islander populations, and relatively high rates of suicide and self-harm

For more information on the Baseline Needs Assessment go to: www.coordinare.org.au/baselineneedsassessment

8 priority areas identified for South Eastern NSW:

chronic disease (and potentially preventable hospitalisations)	immunisation	cancer screening	mental health
drug and alcohol	Aboriginal health	after hours services	healthy ageing

COORDINARE will develop a regional strategy for each priority area, setting out the actions to be undertaken at a practice, community and system level to address the agreed priorities

Work has commenced on **interactive scenario modelling**, with mental health the first area for development.

Data and performance

Sentinel Practices Data Sourcing Project (SPDS)

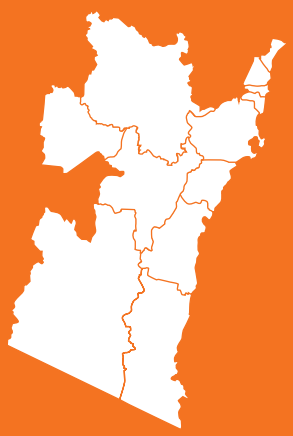
Findings from phase two of the Sentinel Practices Data Sourcing (SPDS) project **published** in one Australian and two international peer-reviewed journals.

Phase 3 of project rolled out across the entire region, with **more than 85 general practices** signed up, **representing 50% of eligible practices**. Four training sessions were held with **more than 100 GPs, PNs and practice staff** in attendance.

Supporting general practice

GP Clusters

- **12 GP Clusters** established across the region
- **77** GP Cluster meetings held with more than **830 GP attendances**



Practice Managers and Practice Nurse workshops/network meetings

- **> 50 workshops** held across the region, with more than **470 attendees,** representing **55% of practices**

Practice visits

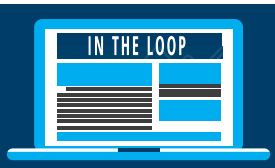
- **> 430 practice visits** re: data cleansing, HealthPathways, AIR website, and input into immunisation strategy

Improving immunisation coverage rates

- 2 workshops held in Illawarra Shoalhaven with **150 attendees**
- **17 practices** involved in the Immunisation Quality Initiative in Southern NSW
- **6 sessions** held in Southern NSW with **66 nurses** in attendance, representing **46% of practices**

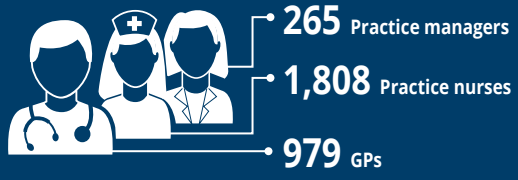
Meaningful use of My Health Record

- **> 74,000 consumers registered**
- **145 general practices** uploading shared health summaries
- **> 1160** shared health summaries uploaded



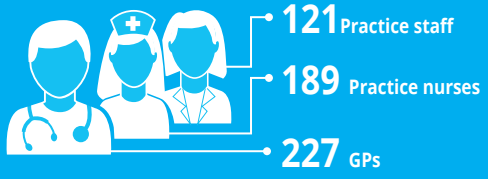
IN THE LOOP eNewsletter

- **19 editions** distributed to > 1730 unique stakeholders
- Practice nurses most engaged but GPs accounted for **32%** of general practice interactions



COORDINARE portal

- New portal launched in October for health professionals to register for events, download certificates and update contact details
- >660 people across 200 organisations have signed up including:



COORDINARE website

- New website launched via staged approach between July and October
- **> 12,240 users** have visited the site in more than 20,790 sessions

Service delivery - working with local communities

As the South Eastern NSW PHN, COORDINARE will work within local communities to commission services and initiatives that are focused on people who are at greatest risk of poor health outcomes.

In our first year, we were committed to service continuity as part of the transition from Medicare Locals. Some highlights included:

Mental health and suicide prevention programs

- **> 7,900 sessions** were delivered to more than **1,550 consumers**
- **4%** of sessions were delivered to people who identify as Aboriginal and Torres Strait Islander
- **13%** of sessions delivered to children 12 years and younger
- **95%** of consumers referred to suicide prevention programs had reduced levels of suicide risk by the end of treatment

Other mental health services in rural areas

- **1,670 sessions** delivered to **394 consumers** across six Local Government Areas (LGAs) in Southern NSW

Provision of integrated care for Aboriginal and Torres Strait Islander people living with chronic disease

- **> 750 patients** receiving care coordination and supplementary services
- **190** specialised medical aids purchased

Initiatives focused on healthy ageing

- **1,000 nutrition consultations** to residential aged care facility (RACFs) residents
- **359 group classes** targeting falls prevention to more than **1,400 residents**
- **14 education sessions** delivered to almost **100 RACF staff**

Health services and promotion targeting chronic disease

- continuation of the Connecting Care partnership with Illawarra Shoalhaven Local Health District, providing services to people at risk of admission and/or readmission to hospital
- provision of specialised services including dietetic, podiatry and physiotherapy services
- provision of health promotion action targeting obesity

COORDINARE also worked with local communities to improve the provision of **after hours primary care.** This included:

- development of clinical referral pathways for after hour period to support a better flow of care between providers
- rollout emergency decision guidelines and ISBAR training in residential aged care facilities (RACFs), with more than 95 RACF staff attending six education workshops
- greater use of eHealth during after hours period
- further development of a sustainable service delivery model for the medical deputising service within the Illawarra region, with more than 4,280 patients accessing the service from southern Illawarra

COORDINARE will draw on the knowledge gained from Baseline Needs Assessment to ensure services and initiatives commissioned over the course of 2016/17 are more closely aligned to local needs, as well as PHN program objectives.

Health system improvement

COORDINARE has focused on designing system improvements to optimise pathways for patients and coordinate care. Highlights include:

- Strategic alliances formed with Illawarra Shoalhaven Local Health District and Southern NSW Local Health District
- Continuation of the Ease-e Referral initiative with the Illawarra Shoalhaven Local Health District's Diabetes service
- Pilot of the Specialised Geriatric Outreach Service project, enabling treatment of older persons in their place of residence
- Continuation of HealthPathways initiatives in Illawarra Shoalhaven and Southern NSW
- Pilot of the Geriatrician in the Practice project, involving a geriatrician and clinical nurse consultant accompanying a GP and practice nurse and providing a joint, integrated GP/specialist appointment
- Development of a rapid model of care in Eurobodalla for clients with chronic and complex conditions