NNSW INTEGRATED CARE

NEWSLETTER

ISSUE 2, AUGUST 2016

VMO List Goes Live

NNSW LHD staff can now access a comprehensive list of VMOs via the intranet.
This recent Integrated Care initiative will assist staff at the Tweed Hospital to improve communication with other service providers.
Undoubtedly this would be a great initiative to mirror in the Richmond Clarence area also.

The VMO list is available to NNSW LHD staff via this link: http://int.nnswlhd.health.nsw.gov.au/health-service-groups/vmo-contact-list/

ICC Survey Closed

A big thank you to the Integrated Care Collaborative participants who took time from their busy schedules to complete the ICC Clinician Survey.
The closing date for the survey was extended to 31st August after an initial slow response. The response rate quadrupled following the extension and your answers will provide invaluable insight moving forward with the ICC wave 2 in the Clarence Valley.

No health without mental health:

the link between chronic disease & mental illness

http://www.acmhn.org/chronic-disease-elearning

Many physical health conditions increase the risk of mental illness, while poor mental health is known to increase the risk of diseases such as heart disease, stroke and cancer. Comorbidity of physical illness and mental health issues impacts on whether people seek help, diagnosis and treatment, and impacts on their physical and mental recovery. Good mental health is a protective factor in prevention and self-management of chronic disease.

To address the issue of unacceptably poorer health outcomes of people with chronic disease and the associated mental illnesses, nurses and midwives need to have the knowledge and skills to identify manage and refer their patients.

As such, the Australian College of Mental Health Nurses has released a series of online resources aimed at improving the knowledge and skills of online resources aimed at improving the knowledge and skills of nurses to identify and manage mental health conditions associated with chronic disease.
This free interactive eLearning program uses video vignettes and a range of activities to highlight the key issues related to mental health, for nurses working with people who live with chronic disease.

- Improve your knowledge and skills
- Earn CPD points in your own time, at your own pace
- Patient stories have been developed by an Expert Reference Group of nurses from Mental Health and chronic disease specialty areas of Cancer, Diabetes, Respiratory and Cardiovascular Nursing
- 5 x 20 minute topics demonstrating skills related to communication, identifying mental health issues, managing difficult situations and understanding grief and loss.
- Interesting video stories, photos, quizzes and links

Source: ACMHN's CPD Portal

HealthChange® Training Evaluation

Evaluations have been collected from the attendees of the first and second two-day Clinician's HealthChange® training sessions as well as the one-day manager's session.

Results for Tuesday 21 June (Manager's)
The first manager's session was evaluated and of the 17 managers surveyed 10 rated it as above average or excellent.7 rated the overall training as average.

All but one manager who did not respond would recommend the training to a colleague.

59% found the content above average to excellent in terms of relevance and usefulness to their current work the remaining 41% found it average.

With regard to presentation/facilitation 76% rated this above average to excellent.

Results for Thursday 30 June-Friday 1st July
Attended by NNSW LHD staff the first session received an overall rating of above average to excellent for both days.

Attendees were asked if they would recommend the training to colleagues and all indicated that yes they would.

When asked to rate the content relevance and usefulness to their current work the average out of five for day one was 4.35 and for day two was 4.30.

Results for Friday 29-Saturday 30 July
Participants gave the training an overall rating of above average or excellent for each day.

When asked if they would recommend the training to colleagues all agreed that yes they would, with the exception of 2 non responses on day one.

Attendees were asked to rate the content relevance and usefulness to their current work out of five for both days. The average rating was 4.67 on day one and 4.31 on day two.

HEALTH CHANGE AUSTRALIA®

Participants Have Their Say:

"A fantastic investment of 2 days for my skill set and client care."

"New way of thinking. Helping clients to achieve outcomes rather than giving them answers."

"Would be great to see this methodology used across the board."

"This would be particularly useful for GPs in my practice to attend."

"Good handouts, books and tools."

"I would recommend this workshop because it works."

FUTURE HEALTHCHANGE® TRAINING

Date	Session	Location
August Tuesday 30th	**Managers'** ½ day Workshop	**Tweed Heads**
October Monday 17 & Tuesday 18	**Clinicians'** 2 day Workshop	**Tweed Heads**
October Friday 21st	**Allied Health** 1 day Workshop	**Maclean**
November Monday 21st & Tuesday 22nd	**Clinicians'** 2 day Workshop	**Lismore**

Building Partnerships

An integrated approach to improving the care for the older person with complex health needs experiencing early cognitive decline

Building Partnerships is an Agency for Clinical Innovation initiative focusing upon improving the health journey for older persons with complex health needs. A project team has been created between North Coast Primary Health Network, Alzheimer's Australia NSW, Community Services Tweed Shire Council and the Northern NSW LHD.

Older people with complex health needs are at greater risk of suffering from cognitive decline, dementia or delirium. General Practitioners often suspect cognitive issues early but report that engagement can be difficult as their patient may withdraw if they attempt intervention. Consumers and carers report a reluctance to discuss cognitive change with their GP due to fear and stigma of possible dementia diagnosis. This delay in investigation can compromise the older person's care in the community or in the event of hospitalisation.

Building Partnerships will implement integrated care strategies including Health Change Methodology that will increase consumer and carer health literacy on the benefits of cognitive screening. The project also aims to streamline the communication of baseline cognitive scores between health providers in the acute, primary and community services. This will be achieved by including cognitive results in the GP Health Summary, Powerchart Discharge Summaries and the use of a Yellow Envelope between community services providers. The General Practitioner is further supported to investigate and find appropriate support services for their patient by referring to the "Cognitive Impairment and Dementia Health Pathway".

The overall goal is to offer an integrated approach that will improve the older person with complex health needs journey from the early onset of symptoms of cognitive decline to the end of life care. For more information or to become involved in this project, please contact Bill Sexton bill.sexton@ncahs.health.nsw.gov.au

GPs Register to Have the CHAT

Lung Foundation Australia reminds GPs to register for exacerbation prevention program
It's not too late to register for their Have the CHAT campaign aimed at increasing awareness of COPD exacerbations and promoting best practice management in primary care.

The 'CHAT' acronym highlights common symptoms associated with a COPD exacerbation:
Coughing more than usual
Harder to breathe than usual
Any change in sputum (phlegm) colour or volume, and
Tired more than usual.

Health professionals are invited to register online and download resources to help in the management of COPD.
To register for the Have the CHAT campaign visit
http://lungfoundation.com.au/have-the-chat/register/

ADNs Report April – July 2016

Key Takeaways/Summary:

- July performance improved: the number of failures markedly down on June.
- Remaining failures relate to one practice (HPIO issues, certificate lapses on GP side. Currently remedying between practice and Medical Objects (secure message broker).
- 3 month survey sent out.

Costs:

- Cost for all messages so far (based on Med Objects average cost of 14c per message):
  - May $4.90 (35msgs)
  - June approx $3.22 (23 msgs)
  - July approx $4.34 (31msgs)

GP Data:

- 103 ADNs in 15 weeks.
- 22 GPs out of 50 ICC GPs receiving ADNs.

Insights into GPs/visitation:

- Some GPs have not had an ICC patient admit, since ADNs were turned on mid-April.
- There have been approximately 56 encounters (transfer to ward, direct admission, surgical), across 189 patients, in 15 weeks.
- The ADN Trigger rate (excluding ED/recurring) - as a proxy visitation rate - is 29% in 15 weeks, or ~2%/week. Does not take into account multiple visits by same patients.

EXPRESSION OF INTEREST

ORION SHARED CARE PLATFORM PARTICIPATION

Opportunity for practices who participated in the Integrated Care Collaborative

General Practices have long identified frustrations communicating in a timely and effective way with LHD clinicians and other private medical specialists, private allied health and service providers, particularly for their complex patients.
Many of you participated in consultations in late 2015 with other clinicians involved in the Integrated Care Collaborative (ICC) regarding the potential trial of a Shared Care Planning and Secure Messaging platform called Orion.
After very extensive consultation with GPs, LHD clinicians and other stakeholders, I am pleased to report this shared care platform will be trialed for twelve months and invite your participation.
The system will provide:

- Secure messaging between all clinicians using the platform: GPs, LHD clinicians, private allied health, specialist medical providers and other service providers in a patient's care team;
- Live, adaptable shared care planning amongst a patient's care team; and
- Proactive task and patient goal management, just to name a few features.

The Orion Shared Care system is free to use and fully supported across the entire project (including a helpdesk) and we anticipate that participants will be able to start using the system in early 2017. Between now and then the project team will work with you and your practice team to pave the way for a smooth introduction of the platform and to provide training.
Key Benefits identified by GPs include:

- Fit for purpose: designed by clinicians for clinicians
- Integrated with Best Practice and Medical Director
- Easier sharing of information: communicate with others in the patients care team securely and directly, and share care plans more easily
- Less wasted time (for clinicians and patients), less rework, less administrative overhead
- GPs decide which clinicians/services they want involved in care teams
- MBS-aligned for care plans/team care arrangements, and alignment with recommendations from the Commonwealth Primary Health Care Advisory Group and RACGP
- Visibility of care team invite acceptance, read receipt on messages
- Safe and fully auditable, will meet RACGP requirement for security (system in the process of receiving RACGP tick of approval), meets State and Federal security and privacy requirements
- Access care plan anywhere with common view of patient, information instantly updated

The system will be offered to all GPs in any practice that participated in the ICC; however it is not a requirement for a GP in a practice to use the system. The system will also be made available to any private service providers you wish to be involved, as well as LHD services.
Practices can use the tool for any adult patients with chronic and complex care needs (including mental health) for whom you would like to share a care plan and communications with other service providers. There is no limitation on patient numbers.
NSW Health's eHealth team, the NNSW Local Health District and North Coast Primary Health Network are committed to supporting clinicians participating in this trial and have a dedicated project team. The team will work with you and all the clinicians you nominate to be included in the care team, ensuring they can all use the system once it goes live. You will be provided with installation support and training resources to prepare you to use the system.

What we need from you

- Participation in an evening introduction to the system just before it's ready to go-live (currently scheduled for early 2017)
- Up to 1 hour of training showing you how to use the system (we will provide training face to face, and provide written materials and online how- to videos)
- Completion of short surveys at intervals during the 12 month operation period. The surveys will provide us with feedback as to what is working well and opportunities for improvement.

How do you get involved?

If you are interested in participating in the trial you will need to complete an EOI form by 16th September 2016. Please contact Kelli Babovic via email kbabovic@ncphn.org.au or phone (07) 55890500.

NNSW INTEGRATED CARE

Integrated Care in NSW – The Bigger Picture

NSW Integrated Care Strategy

The NSW Government has committed $180 million over six years to implement innovative, locally led models of integrated care across the State to transform the NSW healthcare system. The Integrated Care Strategy is across three closely related areas:

- Three Integrated Care Demonstrators: Central Coast, Western Sydney and Western NSW Local Health Districts which have begun to implement large scale integrated care initiatives in partnership with other sectors to join up services for local populations.
- The Innovators: All Local Health Districts and Specialty Health Networks that are not Demonstrators have been funded for local, discrete integrated care initiatives. Seventeen projects in total have been funded as Integrated Care Innovators.
- The Statewide Enablers for integrated care including the information structure such as HealtheNet - the information technology system that links patient information between hospitals and primary care and tools to support integrated care such as patient reported measures and risk stratification tools.

Innovators

- Part of the $180 million NSW Government investment in new, innovative models of integrated care was allocated to a Planning and Innovation Fund to support discrete and innovative integrated care initiatives run by Local Health Districts and Specialty Health Networks with their partner organisations.
- The Fund was tendered in 2014, with seventeen initiatives funded from across all Local Health Districts and Specialty Health Networks. The initiatives cross a wide range of themes, patient groups, geographical areas and partnership models.

Source: NSW Health, Integrated Care in NSW website

Integrated Care Partnership Contacts

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