NNSW INTEGRATED CARE

NEWSLETTER

ISSUE 5, NOVEMBER/DECEMBER 2016

NNSW Integrated Care Focus for 2017:

- IC Collaborative Wave 2, Clarence Valley
- The Joint Approach Project
- End of Life Care Project
  - Last Days of Life Toolkit pilot
- Orion Shared Care planning tool
- Health Literacy Workshops
- Building Partnerships
  - Acute
  - Community
- NCPHN Digital Health Strategy
- Mental Health GP Clinic for complex care needs patients
- Enhancing CDM Service and GP relationships
- eMR quality improvement
- Safe Clinical Handover and transfer of care
- Streamlining of access to LHD services
- Centralised intake for Aboriginal people with chronic disease
- Patient Centred Medical Home
- HealthPathways
- Electronic discharge summaries
- Quality of referrals

It's a Big Issue

As we look back on 2016, we can reflect upon a year of great achievements for Integrated Care (IC) in Northern NSW (NNSW).

IC initiatives are widely becoming "business as usual" across a range of services in both public and private services and **we are dedicated in our commitment to deliver integrated care that reflects the whole of a person's needs efficiently and effectively from prevention to end of life.**

This issue of the NNSW IC Newsletter is a big one as we will be covering events and updates from the last 2 months of 2016 in preparation for the Christmas break.

The beginning of 2017 will see final preparations for the second wave IC Collaborative in Clarence, the launch of the Orion Shared Care Tool pilot as well as the official launch of the new NNSW IC website.

Of course there will be various other initiatives underway in early 2017 and we will be updating you on those in the first newsletter of 2017 in February, so stay tuned for that issue which is expected to be another big one. A list of the main areas of focus for Integrated Care in 2017 can be found to the left of this article.

Merry Christmas and a big **THANKYOU** to everybody who contributes to the NNSW IC initiative; to all of our stakeholders i.e. the patients, staff, GPs, Clinicians as well as our local partners North Coast Primary Health Network, Aboriginal Medical Services and NSW Ambulance.

Happy Holidays!

Integrated Care Collaborative Wave 2

General Practice recruitment is underway for the second wave of the Integrated Care Collaborative (ICC Wave 2) to be run in the Clarence Valley region.

The Northern NSW Local Health District and North Coast Primary Health Network (NCPHN) are currently recruiting General Practices to be involved. An EOI has been distributed to GPs in the local Clarence area and interest is being garnered with practices from Maclean, Grafton and Yamba signed up.

For more information please contact Rachel Gorman, NCPHN GP Support Officer at rgorman@ncphn.org.au or by phone, on 0448 852 902.

Integrated Care Website

Check out the new Northern NSW Integrated Care Website

http://integratedcare.nnswlhd.health.nsw.gov.au/

This site is still under construction with the main aim of showcasing the various integrated initiatives underway in our local area.

The website will provide the latest integrated care news and updates from the Far North Coast as well as state-wide.

Contact details for the local partners will be available on the site as well as the latest training and education opportunities.

You can even sign up to receive this newsletter.

The official launch of the NNSW Integrated Care website will occur in early March 2017.

Pop online to stay up to date and if you would like to provide feedback on the site email integratedcare@ncahs.health.nsw.gov.au

2016 NSW Rural Health & Research Congress

The Health Education and Training Institute (HETI), Australian Rural Health Research Collaboration, the Northern NSW Local Health District (NNSWLHD) and other congress partners presented the 2016 NSW Rural Health and Research Congress (RHRC) at Twin Towns Resort in Tweed Heads from 9-11 November 2016.

The fifth RHRC invited people working in rural health, researchers and service providers to share their knowledge and experience around the theme:

"The Rural Health Vision- translate, integrate and innovate!"

The morning of day one began with a welcome on behalf of NNSWLHD by Mr Wayne Jones, Chief Executive, NNSWLHD.

In the evening of day one, Dr Vahid Saberi, Chief Executive, North Coast Primary Health Network (NCPHN) was the sponsor for the official opening of the RHRC.

Rural Health and Research Congress – Day 2

On 10 November; day two of the of the Rural Health and Research Congress (RHRC), one of the concurrent session topics was:

Aboriginal Health: Improved Outcomes Respectful Partnerships

Integrated Aboriginal Chronic Care (IACC)was showcased by Emma Walke and Robert Monaghan, IACC Project Officer, NCPHN. Karen Winkler, Nurse Manager, Casino Hospital ED presented the Good to go program.

Dr Saberi was a keynote speaker on the critical role of health funding models in achieving care integration and improved patient outcomes.

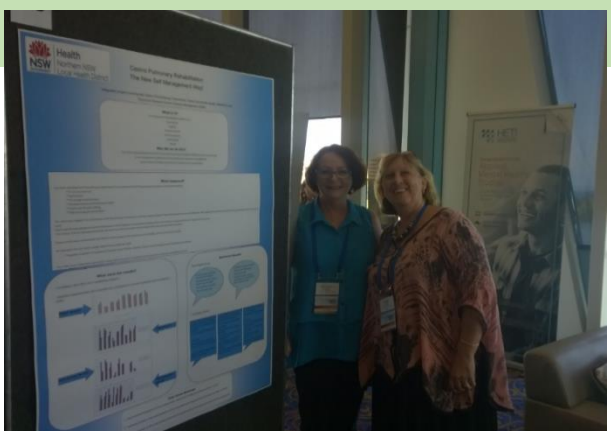
As part of the second concurrent session under the topic of:
Innovation in Health Care: The Lived Experience

Shirley Walker, Whole of Health Project Officer and Ryan Armstrong, NUM, The Tweed Hospital, NNSWLHD presented their project "An Angio a day won't keep the doctor away".

Nicole Rappell, Speech Pathologist, Byron Bay, NNSWLHD also presented under this topic on "Rolling-group model for early years stuttering treatment: half the clinical time and twice the fun".

The third concurrent session of the day under the topic:
Integrated Care and Partnerships: Rethinking Relationships

The Northern NSW Integrated Care strategy was presented by Vicki Rose, Executive Director, NNSWLHD and Sharyn White and Dr Tony Lembke, NCPHN.



LAST DAYS OF LIFE TOOLKIT PILOT

Staff at the Lismore Base Hospital (LBH) have been discussing and implementing new processes to improve the End of Life experience for patients and their families.

The NSW Clinical Excellence Commission - End of Life Toolkit is being introduced as a pilot program to assist clinicians in this quest.

The purpose of the toolkit is to ensure that patients receive optimal symptom control, have social, spiritual and cultural needs addressed; these forms will replace the current end of life pathway.

Last Days of Life Toolkit (Adult) was launched on 28th November 2016 throughout all adult wards at LBH – including ED.

The Last Days of Life Toolkit (Adult) pilot has two main forms: -

1. **"Initiating Last Days of Life Management Plan (Adult)"**
2. **"Comfort and Symptom Assessment Chart (COSA)".**

There are also Medication flipcharts to aid in appropriate end of life medication prescribing.

Anna Law has been seconded to the End of Life Project Officer Role thanks to generous funding from the Agency for Clinical Innovation and is leading the introduction of the Toolkit. If you have any questions, please contact Anna on 0418 797 478

Tweed "Joint Approach" Project

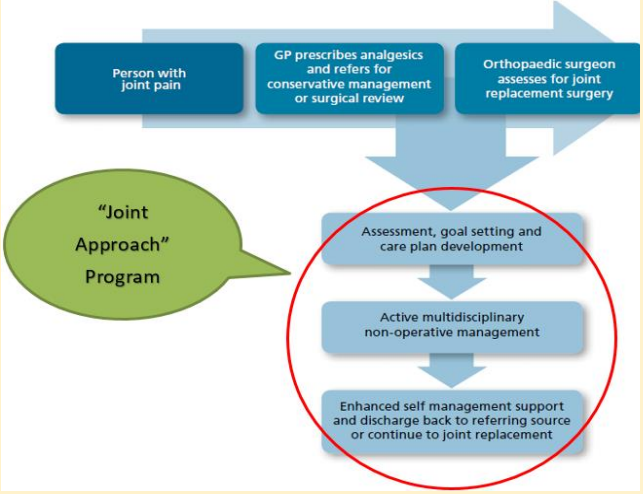
Nationally osteoarthritis (OA) provides the highest burden of disease in terms of direct and indirect costs to the health system.

Despite growing evidence in support of conservative management of OA, this disease is still largely managed by pharmaceuticals and joint replacement surgery.

The evidence shows that progression of the disease can be slowed, pain can be relieved, disability can be minimised and the need for surgery may even be postponed or avoided with appropriate multi-disciplinary treatment.

This treatment may include exercise, weight loss and other chronic care interventions that address the needs of these people holistically.

The ideal OA journey:



NNSW LHD - Integrated Care in partnership with the North Coast Primary Health Network are looking to establish services to support primary health management of OA in the Tweed area.

Project Officer, Luke Schultz is looking to support local GP services by providing:
- A comprehensive assessment and care management service for clients suffering with lower limb OA.
- Report on patients physical, functional and psychological wellbeing.
- Considerations for referrals under the CDMP/TCA to assist the client to manage their OA in the primary health setting.
- Exercise and education program for clients (where appropriate)
- Ongoing support and review of clients to self-manage their OA condition in their community.

Luke Schultz has been seconded to the Fitness for Joint Replacement Surgery role thanks to generous funding

SAFE TRANSFER OF CARE

eMR Quality Improvement Workshop

On Thursday 17 November approximately 40 staff from the NNSW LHD including, Chief Executive, Wayne Jones, Executive staff, Allied Health Managers, Health Information Managers, Junior Medical Officers, Emergency Department Directors and Specialists and Clinical Information Coders attended a workshop in Ballina to workshop electronic medical records (eMR) quality improvement.

On the Agenda:

- Welcome and Introduction (**Wayne Jones** - CE NNSWLHD)
- Coding of records from the EMR (**Matt Long** - CIO & **Alison Lollback** - Health Information Manager)
  - Alison coded a pre-prepared/identified eMR record and Matt sought input from those present, especially coders on the issues identified.
- Comprehensive Medical Record (**Matt Long** – CIO, **Dr Tien Khoo** - Senior Medical Officer & **Dr David Hutton** - Executive Director Clinical Governance)
  - Discussion of the comprehensive medical record notably: What would it look like? What do we currently have? And What are the key gaps? The attendees were asked to identify constraints / issues with achieving this.
- Demonstration of Patient Journey through eMR (**Matt Long** – CIO, **Dr Rob Davies** – Network Director for Emergency Medicine & **Dr David Glendinning** – RMO)
  - Using the eMR a walk-through was demonstrated through the patient journey for the record coded earlier. The Doctors were asked to highlight those aspects (root causes) that lead to the issues identified earlier in the discussion of coding and comprehensive medical record.
- Discharge Summaries (**Matt Long** – CIO & **Dr David Glendinning** – RMO)
  - Dr Glendenning demonstrated how a discharge summary is created and the issues that exist.
- Summary and priorities (**Matt Long** – CIO)
  - The findings were summarised and Matt asked the workshop participants if there was a consensus regarding priority issues and potential solutions.
- Wrap-up and next steps (**Vicki Rose** – Executive Director Allied Health and Chronic & Primary Care)
  - Outlined the process to take this project forward and identify the importance of governance and working parties to prioritise solutions and implement change.

Project Proposal

- The project is to be entitled the Safe Transfer of Care
- In scope are all inpatients and emergency departments within NNSWLHD
- Project Overview:
  1. Improve the quality of the comprehensive medical record
  2. Improve the information collected in the eMR
  3. Improve safe clinical handover in and out of hospitals
- Improving workforce satisfaction and sustaining change

Next Steps

- ➢ Confirm Governance structure
- ➢ Confirm scope with NNSWLHD Executive
- ➢ Establish high level schedule
- ➢ Establish working party (if needed)
- ➢ Identify/name stakeholders

For more information on the next stage of this exciting project please contact project lead Di Goldie, Safe Transfer of Care Project Officer.
di.goldie@ncahs.health.nsw.gov.au

Respiratory Education Day 2016

Taking time from their busy schedules, almost 40 clinicians from the NNSW LHD participated in the 2016 Respiratory Education Day, held this year on Friday 4 November in Ballina.

Evaluations collected from participants on the day revealed a positive response from the majority of attendees. The successful planning for the day was undertaken by the presenters and Julie Kirk, Manager Respiratory Services Program.

- ✓ The overall opinion of the day was – 52% rated it excellent and 48% rated better than average.
- ✓ 49% found the day very informative, 41% rated extremely informative whilst 10% were indifferent.
- ✓ All comments made were positive.

EVIDENCE-BASED AND UPDATED INFORMATION ON VARIOUS ASPECTS OF RESPIRATORY CONDITIONS.

Respiratory Education Day 2016 (Continued…)

Dr Joe Churton, Respiratory Physician presented on Idiopathic Pulmonary Fibrosis, offered coaching to staff and invited all to participate in Lung Function Testing.

Allison Eastman, Respiratory Coordinator CNS2, TTH & CH discussed the Tweed Hospital – Pilot ACI COPD Audit

Donna Lloyd, Coordinator, Health Equity, Health Promotion represented the Tobacco Cessation Support Team in introducing the Tobacco Cessation Support Clinics, a 3-6 month pilot which will begin this month and offers various tobacco cessation services including phone consultation.

Craig Knox, Fracture Liaison Coordinator, Osteoporosis Refracture Prevention Program talked about Inhaled Corticosteroids (ICS) and Osteoporosis as well as promoting the osteo-exercise pamphlet.

Julie Kirk presented on behalf of Karen Walsh, Acting Nursing Unit Manager, Community Nursing, the topic was how Hospital in the Home (HITH) assists with Chronic Respiratory Patients.

Vicki Denyer, CNC Infection Control, gave a humorous yet informative point of view of Influenza A and Respiratory Hygiene

Amanda Carney, Chronic Care for Aboriginal People (CCAP), brought along her client and presented from the patient's perspective.

Taya Prescott discussed the joint NCPHN and NNSWLHD project of Health Literacy with focus on the readability scales and importance of applying this to all consumer correspondence. She offered in-service workshops for anyone interested.

Dr David Bihari, Intensive Care Physician, explained recent advances in Respiratory Intensive Care in particular the importance of oxygen therapy, steroids in Community Acquired Pneumonia and other advances.

Rocco Mico, Physiotherapist and Lyn Menchin, Respiratory CNS2, led a rousing presentation which included song and dance, well at least song and light-heartedly yet informatively talked of the importance of exercise in Lung Disease; the physical benefit of exercise as well as the psychosocial, emotional and psychological.

Emma McDonald, Physiotherapist presented a talk on the self-management model of Pulmonary Rehabilitation Program at Casino Physio' department which utilises the current CDM staff and is the second program with a third planned for next year with good collaboration from the local Aboriginal Medical Services.

The last session of the day included a panel discussion on current respiratory services within NNSWLHD. Panel members were the present Respiratory Clinicians.

Thank you to everyone who participated and contributed to this successful day. Some of the presentations will be made available for distribution in the near future.

Above: Expert panel members from the Respiratory Service (From left to right); Karen Powell; Elspeth Findlay; Linda Whitehurst; Lyn Menchin; Kristine Berry; Jane Millard; Allison Eastman; and Kate Armstrong.

At the end of November, the Centre for Healthcare Knowledge & Innovation in partnership with the North Coast Primary Health Network (NCPHN), Northern NSW Local Health District (NNNSLHD), International Foundation for Integrated Care (IFIC), Agency for Clinical Innovation (ACI) and Bulgarr Ngaru Medical Aboriginal Corporation hosted an event Series entitled:

TRANSFORMERS
CHANGING THE HEALTH SYSTEM FOR BETTER

The event series hosted guest expert speakers from around the world who presented at various information sessions and workshops and attended dinners. Staff and management from General Practice and NNSWLHD across Far Northern NSW were invited to attend and participate.

A bit more about the expert speakers who made this event series such a success

Professor Anne Hendry, MB ChB FRCP, Clinical Lead for Integrated Care, Scotland

Anne works with the Scottish Government as clinical lead for Integrated Care where she supports professionals to improve outcomes for older people and people with multiple conditions through person centred care and support that fully integrates health, social care, housing, community and voluntary sectors, and is co-designed and delivered with people in local communities.

She has over 20 years' consultant experience in geriatric and stroke medicine including extensive experience of service redesign, leading managed clinical networks and developing community hospitals and intermediate care across Scotland.

Anne represents Scotland in the European Innovation Partnership on Active and Healthy Ageing (EIP-AHA) and collaborates in two European Joint Actions: Chronic Diseases and Promoting Healthy Ageing across the Life Cycle; and Prevention and Management of Frailty.

Dr Viktoria Stein, PhD, Senior Fellow & Head of the Integrated Care Academy©

Viktoria joined the International Foundation for Integrated Care (IFIC) from WHO Europe in September 2015 to take on the position as Head of its Integrated Care Academy© that is providing and developing a range of education and training courses and tools to support knowledge transfer, skills development and adoption strategies to individuals and teams leading and managing integrated care initiatives world wide. She is also supporting key EU research and development including SUSTAIN and project INTEGRATE.

Viktoria holds a PhD in health economics and in her work focuses on health systems and their organisation, specifically how to design coordinated and integrated models of care that centre on people and take into account the contextual social, economic, legal and cultural factors.

Viktoria specialises also in the understanding and development of workforce competencies that support integrated care. Viktoria continues to work as a consultant with the WHO Regional Office for Europe in developing the framework for action on coordinated/integrated health services delivery.

Dr Harry Pope, GP, Fairfield, NSW, Australia

I have been a general practitioner in Fairfield, NSW, Australia, for 35 years. During this time, I worked initially in solo practice, developed my own medical centre and improved it by adding nursing and specialist staff. I then moved into a corporate organisation.

I am passionate about helping patients from disadvantaged backgrounds. Fairfield has a low socioeconomic demographic and is a suburb next to the Villawood immigration detention centre. The transition of refugees and asylum seekers through these suburbs has guided my career towards patient advocacy, mental health and refugee health.

Throughout my career I have been actively involved in working collaboratively within the health industry. Over the years, the Divisions of General Practice evolved into the Medical Locals and have now become the Primary Health Networks. With each of these entities I have been involved in continuing professional development and standard committees. With my passion for imparting knowledge within the profession, I joined the University of Western Sydney staff as a tutor for GP students.

During the last 12 years I have worked as a GP with Primary Health Care Limited (Primary), an organisation listed on the Australian stock exchange. I worked as an executive clinician in assisting GPs and non-clinical staff to improve their standards through risk analysis, education and quality improvement. I was also exposed to high level business and financial analysis within the Medical Centres division. I have recently returned to being a fulltime GP and have assumed an active role in working on the Integrated Care committee which is a collaborative initiative between the South Western Sydney Local Health District and the Primary Health Network.

Richard Antonelli, Medical Director of Integrated Care, Medical Director of Physician Relations and Outreach, Boston Children's Hospital/ Harvard Medical School

Richard Antonelli, MD, MS is the Medical Director of Integrated Care at Boston Children's Hospital and Assistant Professor of Paediatrics at Harvard Medical School. He began his research career by publishing data about the activities, outcomes and cost of care coordination services for children and youth with special health care needs and their families in primary care settings. Over the last decade, he has expanded this work to look at measuring care integration and care coordination activities and outcomes across systems of care, including community, subspecialty, primary care, and hospital-based settings. Since care coordination is so central to the effective transformation of the American health care system, Dr. Antonelli's work has been used to inform both adult and paediatric health care delivery system development. In 2009, he co-authored Making Care Coordination a Critical Component of the Paediatric Health System: A Multidisciplinary Framework, supported by The Commonwealth Fund. It laid out a framework and potential measures for comprehensive, family-centred, multi-disciplinary care coordination. This work continues to inform system design, performance, financing, and evaluation methodologies.

Dr. Antonelli has extensive experience working at the national level and in many American states in re-designing systems of health care delivery, supporting the transformation of both primary and subspecialty care providers into integrated delivery models. In his current position as Medical Director of Integrated Care for the Boston Children's Hospital enterprise, his efforts focus on developing methodologies, tools, procedures, and measures to evaluate care coordination and integration activities and outcomes. This includes linkages between families, youth, primary care providers, subspecialists, government agencies and community-based organizations.

He has been appointed to the Standing Committee on Care Coordination at the National Quality Forum (United States), where he also serves as the Child Health Subject Matter Expert on the Measure Applications Partnership Steering Committee. He has provided consultation on care coordination and integration methodologies and measures to multiple states in the US, to federal agencies, and to some international stakeholders. Most recently, his tools and training materials are being used across the United States for both adult and paediatric care delivery systems.

Dr. Antonelli is co-leader of the Innovation Academy of the Boston Combined Residency Program in Paediatrics. He has general paediatrics clinical responsibilities, with a strong focus on care integration for patients with complex needs at Boston Children's Hospital where he teaches residents, students, and fellows. He also mentors students, residents, fellows, and junior faculty on child health quality and policy development.

Dr Robin Miller, Snr Fellow and Director Evaluation, Health Services Management Centre, University of Birmingham, UK. Co-Editor-in-Chief, Journal of Integrated Care

Robin is a Senior Fellow and Director of Evaluation at the Health Services Management Centre and a fellow of the school for Social Care Research. Robin is Co-Editor of the Journal of Integrated Care, An Associate Editor of the International Journal of Integrated Care and an advisory group member of the European Primary Care Network. He leads on a variety of applied research projects within health and social, with a particular focus on evaluation and learning from change initiatives. Current projects include local evaluations of new models of care programme, the national longer-term evaluation of the Integrated Care Pioneers, and the impact on quality of partnering between organisations.

Prior to his academic career Robin was a practitioner, manager and commissioner, and has served as a non-executive director and chair of trustees within housing and charitable sectors. Robin specialises in: new models of primary and integrated care; collaboration between public, private and community sectors; organisational change and service improvement; commissioning and purchasing of health and social care services; and evaluating external and internal impacts of projects and services.

Dr Nick Goodwin, PhD, Co-Founder and CEO, International Foundation for Integrated Care (IFIC)

Dr Nick Goodwin is the co-founder and CEO of the International Foundation for Integrated Care (IFIC), editor-in-chief of The International Journal of Integrated Care, and Senior Associate at the King's Fund.

Dr Goodwin holds a range of research, educational and consultation roles worldwide. Including: Agency for Integrated Care, Singapore; the Pan American Health Organisation, Washington; the WHO's Western Pacific Regional Office; NHS England's Better Care Fund Support Programme and several European R&D projects. Dr Goodwin has worked as a Senior Lecturer at the London School of Hygiene and Tropical Medicine where he directed MSc and DrPH courses and worked as a lead academic for the National Institute for Health Research commissioning key studies into the service delivery and organisation of health care.

Working with the WHO he has supported the development of its Global Strategy on People-Centred Integrated Health Services. He is on the Expert Advisory Team to WHO Regional Office for Europe's Framework for Action Towards Coordinated/Integrated Health Services Delivery (CIHSD) leading work on change management and adoption of integrated care in policy and practice.

In January 2016, Dr Goodwin received the Avedis Donabedian International Award for his contribution to Healthcare Excellence and Integrated Health and Social Care.

The North Coast Primary Health Network will be uploading the presentation slides and info from the workshops via this link

http://ncphn.org.au/transformers-2016/

Centre for healthcare
KNOWLEDGE & INNOVATION
COLLABORATE • LEARN • ADVANCE

HealthPathways
Mid & North Coast of NSW

November 2016

Colorectal Cancer Screening HealthPathways

How many of a patient's family members need to have been screened positive for bowel cancer before you recommend a colonoscopy? Finding it difficult to remember which people are being targeted for screening by the National Bowel Cancer screening program? Have you ever wondered about how the timing for recalls for follow up colonoscopies are worked out? Would you like a repository for accurate and evidenced based information for patients about their need for a colonoscopy?

If, like me, you have ever pondered these deep questions, then you will find the recently developed HealthPathways for Colorectal Cancer (CRC) Screening will be an excellent reference.
This suite of pathways has been designed to answer common questions about screening for colorectal cancer and indications for colonoscopy in the assessment and management of patients at risk of CRC. The pathways contain clear guidelines for indications for colonoscopy, links to local providers of colonoscopies, and excellent information for patients.

The opening page for these pathways can be found by entering Colorectal Cancer Screening into the search function on the HealthPathways home page at https://manc.healthpathways.org.au/ (User name: **manchealth** Password: **conn3ct3d).** You can then follow the links to the following pathway pages:

- **National Cancer Bowel Screening Program**
- **Positive Faecal Occult Blood Test (FOBT)**
- **Colorectal Cancer Symptoms**
- **Screening and Surveillance Colonoscopy**
  - **Assessing Family History Risk for Colorectal Cancer (CRC)**
  - **Previous Colorectal Polyp Colonoscopy Surveillance**
  - **Previous Colorectal Cancer Colonoscopy Surveillance**
  - **Inflammatory Bowel Disease Colonoscopy Surveillance**

The HealthPathways team hope that you will find these new pathways helpful. As always, if you have and feedback about the pathways, please send it to us via the "Send Feedback" button at the top right hand corner of every HealthPathways page. – *written by Dr Hilton Koppe*

Latest Published HealthPathways

- Angioedema
- National Bowel Cancer Screening Program
- Positive Faecal Occult Blood Test (FOBT)
- Colorectal Cancer Symptoms
- Screening and Surveillance Colonoscopy
- Assessing Family History Risk for Colorectal Cancer
- Previous Colorectal Polyp Colonoscopy Surveillance
- Previous Colorectal Cancer Colonoscopy Surveillance
- Medication Options for Chronic Pain
- National Disability Insurance Scheme (NDIS)
- Elective Procedures and Patients with Diabetes and Insulin
- Problem Gambling
- Problem Gambling Counselling
- Personal Protective Equipment (PPE)
- Waste Management in General Practice
- Hand Hygiene

Integrated Care - Technology Update

Orion Shared Care Tool Project

The 36 GPs participating in the Orion Shared Care Planning Tool pilot nominated around 200 services and clinicians that they would like added to the system from both public and private sectors.

Around 116 invitations were sent to a mix of individual providers and organisations in November. Of these, around 200 have signed up to participate. The Private Service Providers comprise Private Allied Health, Pharmacies, Consultant Pharmacists and Private Medical Specialists.

Scheduling of training for around 270 users (GPs, Practice Nurses/Managers, LHD staff and Private Services Providers) is now commencing with the first groups scheduled for late January.

The Orion shared care system has completed final testing and has been accepted for operation. The system – a Live and Training environment – are being migrated onto our servers over Christmas before final security testing and general testing in the early New Year.

The first go-live and training is scheduled for the end of January 2017, which will be a mini trial of the system by one GP practice and a small number of other clinicians. A general rollout is scheduled for February 2017.

You can now visit the Integrated Care Website to view updates and information about the Orion Shared Care Tool project. The website contains Frequently Asked Questions (FAQs), a support helpdesk, privacy and legal information (including a downloadable patient information/privacy pamphlet) and lots more information.

To see why we're doing this project, check out the project video: https://www.youtube.com/watch?v=rmF2Wxvydzw&feature=youtu.be

If you have any questions about Orion, please contact the project team from the website or contact Tim Marsh, Senior IT Project Coordinator, Integrated Care on 02 6620 0829.

ADNs

The Admission/Discharge Notifications (ADNs) evaluation survey has closed and a report is being collated.

Evaluation of the ADNs is important in ensuring version 2 of the service addresses any issues and informs state-wide solutions of lessons learnt.

Northern NSW Integrated Care would like to extend thanks to all the GPs who participated in the survey, your feedback is invaluable.

NSW Ambulance is changing the way they work with Primary Health Care.

NSW Ambulance has been working to enhance primary health care in the community by improving links between paramedics and general practice. Recent changes to paramedic protocols provide paramedics with an intuitive and realistic treatment and referral framework to support clinical decision making for managing low acuity patients, with patient centred care as its focus.

Local paramedics now have greater scope to treat patients on scene and/or refer suitable patients back to General Practice in order for them to receive the right care, in the right place, at the right time.
P5 protocol is the term used by NSW Ambulance to describe a pathway for patients where assessment and treatment within the Emergency Department (ED) is not clinically required. Collaborative decision making with the patient, paramedic and general practitioner (GP) provides opportunity for improved patient outcomes.

Clinicians and practices will shortly receive a letter from NSW Ambulance outlining the paramedic protocol P5 referral pathway. Please read the letter and the FAQ fact sheet which accompanies it to ensure you and your practice are in a position to accommodate and support patients referred by a Paramedic from NSW Ambulance. You can view the letter to GPs and FAQ fact sheet here

A health provider feedback from is available and all feedback can be provided to ambulance-clinicalintegratedcare@health.nsw.gov.au.

For further information contact Claire Walker, Coordinator Primary and Community Care, Clinical Services, NSW Ambulance; Claire.walker1@health.nsw.gov.au

Health Literacy Project Launch

On Friday 16 December the official Health Literacy Project Launch was held in Ballina.

Key stakeholders including the CEs and staff from NNSWLHD and NCPHN, Managers and consumers were also in attendance at the event held over Breakfast at the Ramada.

Mr Wayne Jones and Dr Vahid Saberi introduced and endorsed the project. This was followed by a project overview and an informative demonstration of the new Health Literacy website.

The website is able to be accessed by staff and consumers alike with designated areas for each.

Check out the website here:
http://healthliteracy.nnswlhd.health.nsw.gov.au/

Pictured left, back row L-R: George Thompson, Dr Vahid Saberi, Wayne Jones, Chris Crawford, Sharyn White, Jillian Adams. Front row L-R: Melva Thompson, Hazel Bridgett, April Margieson, Taya Prescott.

Workshop Success

The very first Northern NSW Health Literacy workshop was a great success, with more than 30 health literacy projects now underway.

The workshop was opened by Jillian Adams, Manager Health Promotion NNSW LHD and Sharyn White, Manager of Systems and Service Integration NCPHN, introducing the joint Northern NSW Health Literacy Project.

Participants were lucky to be joined by Liz Meggetto, who has led health literacy work in the Central West Gippsland region of Victoria for the past six years. Liz shared stories of her health literacy successes and challenges. Everyone present was inspired to get started on their own health literacy work in Northern NSW.

36 attendees from across Northern NSW Local Health District, Primary Care and community members learned and practiced health literacy skills to improve the way health services provide written and verbal communication. Every single person then planned a health literacy project to implement in their service.

Some of the projects now underway include:

- Undertaking an audit to ensure all brochures in a service meet health literacy standards by the beginning of 2017.
- Conducting staff training in Teach-Back to check for understanding when providing health information or medication instructions.
- 'Dropping the jargon' and using plain language in all interactions, including staff meetings.
- Holding community workshops on finding reliable health information online.

To book a health literacy workshop for your service in 2017, contact taya.prescott@ncahs.health.nsw.gov.au

Workshops can be tailored to meet your service needs and available time, and held at a location that is convenient for you.

Patient Reported Measures (PRMs) ACI Newsletter

The ACI PRMs Program supports clinicians to understand and respond more effectively to the patient's experience of complex and chronic conditions. Our program works with local sites to design and implement PRMs, supporting local, ground up, sustainable models of care in the collection of these measures. In the future PRMs will become part of business as usual and AACI PRMs looks forward to supporting the spread and adoption of PRMs across clinical services and practices. This will enable all services to use PRMs to benefit all involved in health care, including those who use it, leading to better health outcomes and improved delivery of services by collecting, measuring, tracking and providing direct timely feedback to clinicians and patients on PRMs across the system.

PRMS Proof of Concept Site Update: Northern NSW
Implementing PRMs in a variety of community, integrated care and primary health care environments. Currently completing education and scoping of work.

There are several Tweed sites which have met with the ACI and are ready to progress this in 2017.

Proposed PRMs include:
PROMIS 10
PREM

An interesting read highlighted within the ACI PRMs Newsletter: Training clinicians in how to use patient-reported outcome measures in routine clinical practice. Santana MJ, Haverman L, Absolom K, Takeuchi E, Feeny D, Grootenhuis M, et al. Quality of Life Research. 2015;24 (7):1707-18. This paper from 2015 describes the development and implementation of three programs for training clinicians in the use of PRMs as part of routine practice. http://bit.ly/2fZ0ruu

To view the latest ACI PRMs Newsletter follow this link:

http://aci-patientreportedmeasures.cmail19.com/t/ViewEmail/r/778CA2CF827575322540EF23F30FEDED/7A69B2EF673224797F4E5A579FEBB2E9

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