ACT Government | Canberra Health Services

Model of Care

Liaison and Navigation Service (LaNS)

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Contents

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Approvals

Position	Name	Signature	Date
Director, Integrated Care Program	Kirsty Cummin		25/06/2023
Chief Operating Officer	Grant Howard		3/07/2023

Document version history

Version	Issue date	Issued by	Issued to	Reason for issue
V1	4.5.23	Liaison and Navigation Service (LaNS) Coordinator	Stakeholders	Feedback, input and advice
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1. Introduction

This Model of Care (MoC) for the Liaison and Navigation Service (LaNS) sets out the evidence-based framework for describing the right care, at the right time, by the right person / team and in the right location.

LaNS places people with complex health care needs at the centre of their own care; listening to them as the experts in their own health. LaNS is responsive to each consumer's individual situation and needs. LaNS partners with consumers in care planning, anticipates and removes barriers to care, and assists people to make durable connections to the services and supports they need. LaNS will help people with complex health care needs solve problems, coordinate clinical care, and improve the flow of information to improve the experience and outcomes of their health care.

The aim of this MoC is to define and clearly articulate the principles, objectives, and approach of the new service to ensure that all health professionals are 'viewing the same picture', working towards common goals, and evaluating performance on an agreed basis.

This MoC:

- outlines the principles, benefits and elements of care,
- provides the basis for how we deliver evidence-based care to every patient, every day, through integrated clinical practice, education and research; and
- contains information about patient flow (how patients enter, move through, and exit the service) and service coordination that provide the linkages required for seamless patient treatment.

A MoC is a dynamic document and will be updated over time to support new evidence and improved ways of working. Any updates will include relevant change management principles and processes to ensure clear engagement and communication.

This MoC should be stored on the Canberra Health Services (CHS) 'Models of Care' intranet site. It will be reviewed and updated regularly through consultation and relevant communication.

2. Principles

Our vision and role reflect what we want our health service to stand for, to be known for and to deliver every day. The vision and role are more than just words, they are our promise to each other, to our patients and their families and to the community. We all have a role to play in delivering on this promise:

- Vision: Creating exceptional health care together
- Role: To be a health service that is trusted by our community

Our values together with our vision and role, tell the world what we stand for as an organisation. They reflect who we are now, and what we want to be known for. They capture our commitment to delivering exceptional health care to our community. Our values:

- We are reliable - we always do what we say
- We are progressive - we embrace innovation
- We are respectful - we value everyone
- We are kind - we make everyone feel welcome and safe.

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Our Strategic Plan sets out our path forward as an organisation for the next three years. It is values driven—it outlines how we will deliver against our vision of 'creating exceptional health care together' for our consumers, their families, and carers.

Our Partnering with Consumers Framework provides clear principles for a shared understanding of our approach and what is required from all team members for effective partnerships with consumers and carers in line with our organisational values. The principles have been developed in collaboration with our consumer and carer organisations and underpin this Framework.

Our service's principles:

Trustworthy – LaNS works with each person to build a relationship in which the client is comfortable sharing information about their health and wellbeing. LaNS is understanding, patient and kind, recognising that it may take time to build this trust. LaNS will be clear about what the service can offer, only promise what can be delivered, and follow through on what is promised. LaNS acknowledges that there may be lack of trust in the health system due to previous experiences, or concern about the consequences of seeking help, and will work to build or re-build trust in the system.

> "Clear communication about the function and limitations of the service is needed to prevent additional experiences that may be traumatising."

Trauma-responsive – The LaNS approach to delivery of care acknowledges that trauma can have pervasive impacts on people's lives, shaping the way they seek help, partner in their own care and interact with health services. LaNS is responsive to trauma resulting from previous experiences with the health system as well as trauma from other sources (e.g., intergenerational trauma, violence, abuse), taking an approach that supports safety, trustworthiness, choice, collaboration, and empowerment.

Person-centred – LaNS recognises clients, their family, and carers as partners in the planning, decision making and provision of care and empowers clients as managers of their health. LaNS works flexibly to coordinate care around a client's needs and to provide culturally responsive care. LaNS anticipates future care needs, facilitates individualised services across care settings, and supports care in the most clinically appropriate environment. LaNS is committed to the ongoing co-design of the service to meet individual and community needs and to evaluation through client reported outcome and experience measures.

Equitable and inclusive – LaNS provides a welcoming, compassionate, culturally safe, and appropriate environment. LaNS recognises the additional barriers that clients may face due to disability, identifying as Aboriginal and Torres Strait Islander, cultural and linguistic diversity, identifying as LGBTIQ+, or experiencing socioeconomic hardship. Where previous experiences with services have been challenging, LaNS will advocate for the client and foster positive and effective relationships.

Dignity – LaNS is respectful and supportive of people through vulnerable times, providing understanding, kindness, and assistance when clients are not feeling their best. LaNS acknowledges the stigma experienced by some clients with a wide range of conditions and identities, and provides assurance that it's OK to seek and receive help for any issue. Regardless of history or complexity, LaNS will maintain open and non-judgmental interactions, approaching the current situation without prejudice. LaNS respects the privacy of individuals and ensures consent and decision-making regarding information sharing remains with the client.

Strength-based – LaNS listens to clients and, where appropriate, their family and/or care supports as the experts in their situation, recognising their personal strengths and existing social and community networks. LaNS works with clients and their supports to utilise their strengths in goal setting and care planning.

Capacity building – LaNS empowers clients to develop the skills and strategies they need to be confident in managing their health. This includes working with clients to improve health literacy and form plans to manage likely scenarios or changes in their health. Through sharing information and learnings, skills development, and fostering connections between people and organisations, LaNS also empowers service providers to increase their capacity to provide care and support to clients with complex health needs.

Integrated and collaborative – LaNS coordinates services as part of a single individually tailored care plan that may include general practice, hospitals, community-based health services, and social services support. LaNS will partner with existing services and focus on optimising their service expertise and avoid duplication. LaNS works alongside clients and their carers or other supports to share information and support smooth transitions between different components of care and services.

Evidence informed best practice and continuous quality evaluation – LaNS uses data, evidence, research and consumer experiences of care to create and ensure a continuously improving service with an agile feedback loop between research, clinical practice and the outcomes for clients, their families, and their carers.

3. Benefits to be realised

> "Three appointments in one day. Can't work out in my head how I'm going to manage that. Need someone to shuffle them or space them out or walk through a strategy for managing. Or be available to call, text or come along."

The Liaison and Navigation Service will provide person-centred navigation and support the coordination of care for people with complex health care needs. The service aims to:

1. Improve the coordination of care for clients and their supports,

2. Support clients and their families/carers to navigate the complexities of primary, secondary, and tertiary services,
3. Provide information, guidance and coaching to empower clients to sustain their health,
4. Provide clear pathways for clients and their supports to escalate concerns about their health, wellbeing, or care, and
5. Make connections to community, social, and other services required to support health and wellbeing.

The key elements to improve outcomes within the LaNS model are:

- **Advocacy -** *LaNS will advocate with and for clients and their supports, to better coordinate care and help remove barriers to care.*
  LaNS will:
  - Listen to what clients and their supports say about their goals, priorities and needs,
  - Be creative and persistent in helping clients and their supports anticipate and overcome barriers to coordinated care,
  - Acknowledge the additional challenges that disabilities, culture or social situations may have for clients and their supports navigating the health system,
  - Believe the client's story and symptoms, and advocate for them if others don't,
  - Be a single point of contact in the health system for clients and their supports,
  - Be a single point of contact for colleagues providing care to the client,
  - Promote person-centred care (within LaNS and beyond), and
  - Provide personalised, holistic, person-centred assessment and planning recognising clients and their supports as experts in their own health.
- **Linkage -** *LaNS will facilitate partnerships with everyone involved in the care of the client and their supports.*
  LaNS will:
  - Connect clients and their supports to the services and resources they need,
  - Seek and identify opportunities to improve information sharing within the care team,
  - Provide coordinated care, and
  - Build professional relationships (within and beyond LaNS) to coordinate care.

> "Most people don't understand how many free or low-cost services are available in the community. Hospital staff don't know what is out there."

- **Empowerment -** *LaNS values the knowledge of clients and their supports about their health and their care needs and will support them to build skills and confidence to manage the health conditions that affect them.*
  LaNS will:
  - Provide the information that each client needs, at the right time, and in the way that suits each client and their supports best,
  - Involve clients and their supports in decisions, setting goals and developing care plans,

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- Provide health literacy coaching to improve client's skills and confidence in managing the health conditions that affect them, and
- Support clients and their families/carers to manage their health at home, and to access care in the community, where this is safe and appropriate.

- **Health system improvement –** *LaNS will actively contribute to service and system improvement.* LaNS will:
  - Assess and monitor systems for improvement,
  - Enhance existing services,
  - Work with and support service providers across primary, secondary and tertiary settings to improve coordination and integration of care,
  - Ensure succession planning,
  - Promote research, and
  - Advocate for broader system improvements based on the experience and feedback of LaNS clients.

These key elements are adapted from HCCA's 2018 Patient Navigation Model for the ACT[1] with advice from members of the Paediatric Navigation Service Consumer Reference Group and chronic and complex disease community organisation participants in HCCA-facilitated workshops.

4. Description of service

The LaNS is a service that provides information, coordination, and navigation for consumers with complex health care needs with a focus on opportunities to improve a consumer's experience and health outcomes through information sharing and integration of primary, secondary, and tertiary services.

The service will have dedicated staff who will work across the breadth of existing CHS and external services to improve the interdisciplinary approach to coordination of care and outcomes for these consumers.

The service will facilitate the integration of health, community and other support services that are involved in the care of these consumers, recognising the impact social determinants of health have on the individual's health outcomes and their wellbeing. The MoC is informed by research, best practice and the lived experience of consumers and their supports.

> "The issues that sit behind the health problems are the areas we need to focus on."

The service will be multidisciplinary with team members from nursing, allied health, and administrative workstreams.

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The scope of LaNS includes:

- A centralised point of contact for clients and their supports seeking information, support, and navigation in the coordination of care.
- A liaison function to proactively facilitate the sharing of information between all organisations, units and clinicians involved in the client's care.
- A patient navigator function to:
  - provide a single point of contact for clients and their supports,
  - clarify the role of specialists and specialised units involved in care, and
  - provide information and referral to appropriate clinical, wellbeing and psychosocial support services.
- Advocacy and support for the individual needs of the client within the context of their supports and community.
- Cultural competence and safety to ensure that Aboriginal and Torres Strait Islander, culturally and linguistically diverse and LGBTIQ+ clients and their supports receive quality services and equity of care.
- Care planning to support seamless transfer of care and transition between services.
- Provision of health literacy coaching.
- Outpatient/outreach nursing care, to prevent avoidable ED presentations or hospital admission for minor/non-acute health issues.

The service will operate from flexible locations including Community Health Centres, home visits, and other locations convenient for clients. LaNS staff are also able to meet with the client alongside a familiar health professional (e.g., GP) or other client support person.

5. Patient/client journey

Eligibility

A consumer will be eligible for the LaNS if they are aged 18 or over and have complex health care needs and/or involvement of multiple agencies. Complexity may be related to physical, emotional, or psychosocial issues impacting on the consumer and their supports.

In the first twelve months the service will seek to assist a) consumers who are high-intensity users of the Emergency Department (i.e., 10 or more visits in a 12-month period), and b) consumers with a mental health diagnosis and two or more additional health conditions.

The service is available at no cost to residents of the ACT and surrounding NSW who are Medicare eligible. The service is available to residents who an non-eligible for Medicare however, may incur a cost as determined by the organistaion.

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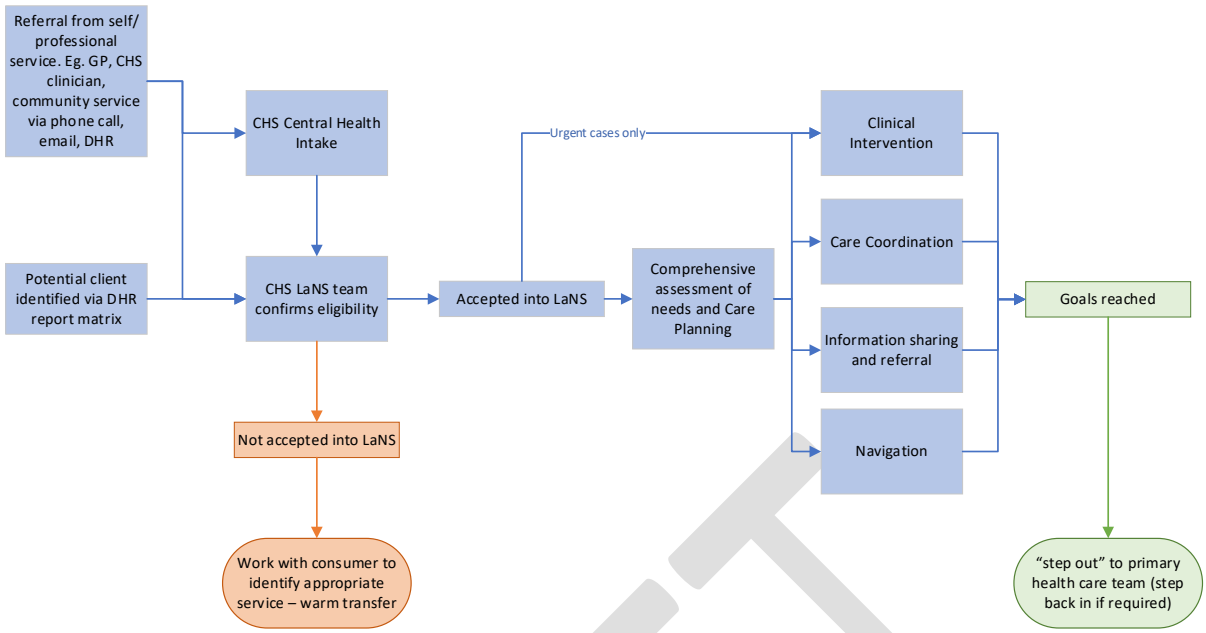


Entry

The consumer, their supports, or a service provider working with the consumer, can access LaNS through the Central Health Intake service. This may be via phone, electronic referral, or email. All contacts will be reviewed by the Liaison and Navigation Intake Hub and, if eligible, the consumer will be registered as a client of LaNS. If the referral does not meet the service criteria the staff in the LaNS Intake Hub will assist with information, warm transfer, or redirection to an appropriate service.

A direct phone line for LaNS has been established for health professionals and service providers for enquiries, referrals and case management and will be provided to clients and/or their supports once the client has been registered with the service.

In addition to receiving referrals into the service, the LaNS will proactively seek out consumers who are likely to benefit from the involvement of the LaNS based on literature and data. In such cases, involvement with the service will be at the discretion of the consumer.

Assessment of need

Following registration, an interview will be held with the client and their supports with a full needs assessment undertaken by the Liaison Officer or Care Navigator. This assessment will include medical and psychosocial aspects, and identification of services already involved in the care of the client. If required, the LaNS worker will engage with providers outside of CHS in line with the agreed care plan. The service will triage and prioritise involvement of the LaNS team based on this assessment.

Care planning

Care Planning will be undertaken in partnership with the client and their supports. The process will be based on the individual's goals and will develop strategies and identify tasks to achieve these goals. All care plans will include:

- Goals set in partnership with the client, their supports, treating teams and those involved in their care and support.

- Management plans for specific conditions, devices, emergency response or predictable health events.
- Key people involved in the care of the client including their roles, such as direct service provider, case management or coordination.

Care Plans will be available in the client's Digital Health Record (DHR) so that they are accessible to a range of healthcare providers. A copy of the Care Plan can also be printed or emailed for clients who do not wish to use MyDHR.

Care Plans will have a standard review period of six months however this can be adjusted for individual client needs.

"Sometimes you need a break from stressing about your health. Someone else to take carriage of it."

Care coordination

The level of care coordination, support and/or clinical interventions by LaNS will vary based on the needs of the client, care coordination providers already involved, existing services providing care to the client, and the client's social context. Levels of involvement will likely vary across the period the client is involved with the service dependent on their health and psychosocial needs. LaNS will not duplicate other services but will provide improved linkage and coordination between services to improve integration of care for the client.

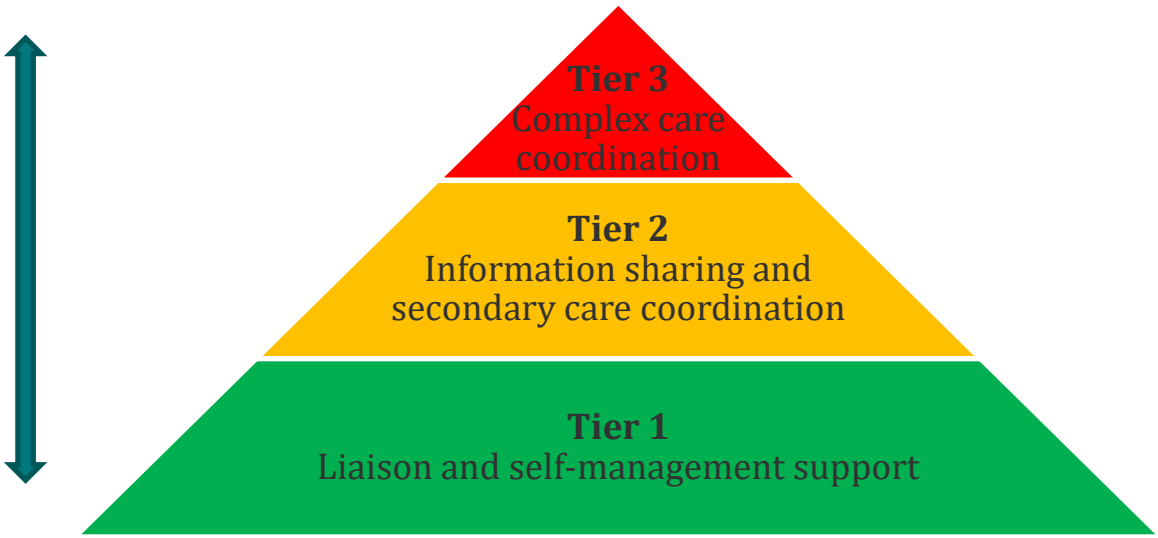
If a client has an established care coordinator working with them, LaNS will work with the provider to assist in the sharing of information and navigation of services to improve the client's care and experience.

Where there is no care coordinator identified, LaNS will provide a care coordination role, working with the client and their supports to identify if there is a preferred care coordination provider to work with them.

For clients enrolled in the LaNS service, the GP will continue to be advocated as the key primary care coordination point. The focus of the LaNS team service delivery will be on ensuring the client and their supports remain connected with their GP and information, knowledge and care planning is shared between all services.

Tiers of service

Tier levels reflect the changes in support, navigation and care coordination that will occur for clients and their supports. While the aim is for clients to move towards Tier 1, it is acknowledged that clients will move between the levels depending on their current circumstances. Descriptors for each level provide an indication of the level of involvement by the LaNS team once initial assessment and care planning have been completed and immediate needs have been addressed.



Tier 3
Client has time-critical needs that require intensive involvement of the LaNS team. This is likely to be where no care coordinator has been identified and there are limited care pathways established. There may be issues across primary, secondary, and tertiary services requiring LaNS involvement for the client. Frequent contact will be required between client/supports, care team and the LaNS.

Tier 2
Client requires regular contact and support by the LaNS team whilst care coordination is being established with long term care provider and identified goals are being addressed.

Tier 1
Client needs are being managed through care coordination and self-management. LaNS contact is moving towards a regular check-in on monthly, 3 monthly and 6 monthly timeframes. Determination if further involvement of LaNS is required and consideration of discharge planning from service with acceptance back into LaNS if client's needs escalate or become unstable.

Exiting and transitioning from LaNS

An individual can remain a client of the service whilst they require it and meet the eligibility criteria, however the service is designed to be a temporary measure to establish more permanent skills or supports. Once a client's care coordination is stable and active involvement is not required by the LaNS team, discussion will occur with the client and their supports regarding their option to leave the service, with the ability to re-enter if there are escalating concerns regarding care or coordination.

Clients of the Paediatric Liaison and Navigation Service (PLaNS) may choose to transition to the LaNS once they reach 18 years of age. Transition planning will occur for adolescents approaching 18 ensuring there is a smooth, supported, and informed process for transition to adult services. PLaNS will support the adolescent and family whilst they are establishing relationships and successfully transitioning to LaNS.

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Discharge from the LaNS service will occur if a client moves permanently interstate and is not accessing services in the ACT. The service will ensure that when a discharge occurs the client is well supported with appropriate referral to interstate services.

6. Interdependencies

> "Many of the issues are chronic problems that an acute hospital stay doesn't help."

Consistent with an integrated care model, there are a wide range of interdependent functional relationships to enable the MoC. These include all areas of CHS, private specialists, interstate health services, GPs and other primary health care providers, government, and non-government community services (including non-health services). Each of these services have a critical role to play in the provision of coordinated, collaborative and integrated care for people with complex needs. LaNS will work with all services to ensure each client receives integrated and coordinated care.

> "NDIS is about disability and not health however the two intersect wholly. A lot can be catered for through NDIS however people aren't aware or don't know how to ask."

7. Workforce

The LaNS is an interdisciplinary service funded to provide nursing, allied health and administrative/family support liaison and navigation roles. The service will commence with an Operational Manager to oversee both the LaNS and the already established PLaNS.

The LaNS staffing is outlined below and has the potential for an increase of 1 FTE in 2024/25

Operational Manager (Working across paediatric and adult services)	HP5	1 FTE
Administration and Operational Coordinator (Working across paediatric and adult services)	ASO5	1 FTE
Care Navigator	RN3.1	1 FTE
Care Navigator	HP4	1 FTE
RN 2 Care Navigator/Liaison Officer	RN2.1	2 FTE
Care Support Officer (working across paediatric and adult services)	EN2/AHA3	1 FTE

The service will ensure there is appropriate clinical supervision, professional development, and training opportunities to support the LaNS team to deliver client-centred care and maintain their own wellbeing.

The capability of the workforce will be matched to the needs of the client base and the required tasks. This will include the areas of mental health, social work, trauma-informed care and cultural awareness and competency, including capacity to work effectively within the cultural context of each client and their supports. The service will develop the relevant knowledge, skills, and experience of their workforce to deliver appropriate services to a diverse range of clients including people with disability, of culturally and linguistically diverse and refugee backgrounds, LGBTIQ+ and Aboriginal and Torres Strait Islander people.

The workforce will possess a high level of emotional intelligence and critical thinking to understand the needs of clients, engage in creative problem-solving, and communicate with all levels of health and other services to meet client needs. The workforce will be proactively engaged in self-care and debriefing, acknowledging that the work involves managing difficult situations and facing systemic barriers that are not always easily overcome.

> "The cohorts who need this service will be dealing with a lot of emotional distress. The workforce needs a degree of capability in that area."

8. Accreditation and Training

All staff working in the LaNS will be appropriately qualified and will maintain their professional accreditation and competency standards as required by their relevant professional body under legislative and organisational requirements. All staff will undertake specific training as relevant, to ensure they are able to practice and delivery care consistent the service principles and gaols.

Through the Director of Integrated Care, a Community of Practice will be established to facilitate continued and shared learning to improve practice and the experience and outcomes for clients and their supports.

9. Monitoring and Evaluation

Monitoring and evaluation of the LaNS will occur through a range of qualitative and quantitative mechanisms. Key indicators will be identified to measure client experience and outcomes as well as service and system level performance. These will be monitored through:

- CHS's Clinical Governance Structure and Committees
- CHS's Risk Management Processes

- CHS's Partnering for Exceptional Care Framework
- Operational and management performance monitoring processes
- National Safety and Quality Health Service (NSQHS) Standards set by the Australian Commission on Safety and Quality in Health Care.

To ensure that a consumer focus is taken in the monitoring and evaluation, the HCCA will participate in the development of the performance measures and be engaged in the data review process, using a co-design method.

10. Records management

Following the relevant consultation, this finalised document and any further updates will be electronically stored on the Canberra Health Services intranet site – 'Models of Care', to ensure accessibility for all staff.

11. Abbreviations

ACSQHC	Australian Commission on Safety and Quality in Health Care
ACT	Australian Capital Territory
CHI	Central Health Intake
CHS	Canberra Health Services
DHR	Digital Health Record
GP	General Practitioner
HCCA	Health Care Consumer's Association
LaNS	Liaison and Navigation Service
MoC	Model of Care
NSQHSS	National Safety and Quality Health Service Standards
NSW	New South Wales
PLaNS	Paediatric Liaison and Navigation Service

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12. Glossary

Case management: Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes. [(2)]

Capacity building: Capacity building (or capacity development) is a process of managed change in which people and organisations strengthen their skills, processes, and resources so they can set and achieve goals and sustain their work and impact. Capacity building involves fostering a shared vision and ways of working, building partnerships to use resources effectively, ongoing learning and skills development (which may include mentoring, training, education, and reflective practice), monitoring and evaluation, and working collaboratively with a range of partners.

Chronic conditions: Long-term and persistent conditions, that often lead to gradual deterioration of health and loss of independence, not often immediately life threatening, though they may have acute stages. [(3)]

Complex health care needs: A combination of health care needs across medical and psychosocial issues, that require access and support from multiple health services within the health and community sectors.

Community of Practice: A group of people who share the same interests, set of problems or professional work who come together to share learnings, best practice, and knowledge. The aim is to focus on sharing experiences and learnings, creating new knowledge and advancing the area of professional practice.

Holistic approach: To provide support and care that looks at the person in the context of their physical, emotional, social, psychological, and cultural wellbeing.

Integrated care: Creating relationships, structures, and infrastructure to drive seamless provision of the right care, at the right time, at the right place by the most appropriate provider in partnership with health care consumers and their supports. It is characterised by a high degree of communication, coordination, and collaboration in partnership with the consumer and across health and other care providers. It involves the sharing of information and development and management of a comprehensive care plan to address the physical, emotional, social, psychological, and spiritual needs of a health consumer.

Patient navigation / Patient Navigator: While there are many definitions of a patient navigator, they share a common goal to anticipate and identify barriers to good patient care and help patients to remove them. In doing so they improve patient outcomes and the overall quality of health care delivery. [(4)]

Warm transfer: Involves actively communicating with the other service to which the health consumer is connected, to provide essential information about their needs before transferring their care. Support is maintained for the consumer until they are received by the other service.

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13. Reference List

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5. Allison Pedersen and Thomas F Hack, "Pilots of Oncology Health Care: A Concept Analysis of the Patient Navigator Role". Oncology Nursing Forum, Volume 37, Issue 1. January 2010.

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14. Model of Care Development Participants

Position	Name
Deputy Director, Health Care Consumers' Association Inc	Kate Gorman
Research Officer, Health Care Consumers' Association Inc	Shivana Chandra
CEO, Arthritis ACT	Rebecca Davey
CEO, Epilepsy ACT	Fiona Allardyce
Community Engagement Coordinator, Diabetes ACT	Kat King
Health Projects & Partnerships Coordinator, Asthma Australia	Janine Lourenz
Health Projects & Partnerships Officer, Asthma Australia	Diane Percy
Co-ordinator, Canberra Lung Life Support Group	Marina Siemionow
Manager of HIV and Client Services, Meridian ACT	Marcus Bogie
Interim CEO, Alcohol Tobacco and Other Drug Association (ATODA)	Susan Helyar
Manager, Policy and Advocacy, Carers ACT	Kamla Brisbane
CEO, Huntingtons NSW/ACT	Lewis Kaplan
Executive Director, Canberra Alliance for Harm Minimisation & Advocacy	Chris Gough
Health Promotion and Research Officer, Women's Health Matters	Merri Andrew
Health Promotion and Research Officer, Women's Health Matters	Romy Listo
CEO, Directions Health Services	Bronwyn Hendry
Director Service Delivery, Directions Health Services	Stephanie Stephens
Patient Navigation, Liaison and Navigation Operations Manager	Phyo Courtis
Integrated Care, Program Director	Kirsty Cummin
Integrated Care, Liaison and Navigation Service Coordinator	Natalie Zuber
Integrated Care, Project Officer	Lindsay Ottaway
Integrated Care, Clinical Director	Walter Abhayaratna

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ACKNOWLEDGMENT OF COUNTRY

Canberra Health Services acknowledges the Traditional Custodians of the land, the Ngunnawal people. Canberra Health Services respects their continuing culture and connections to the land and the unique contributions they make to the life of this area. Canberra Health Services also acknowledges and welcomes Aboriginal and Torres Strait Islander peoples who are part of the community we serve.

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