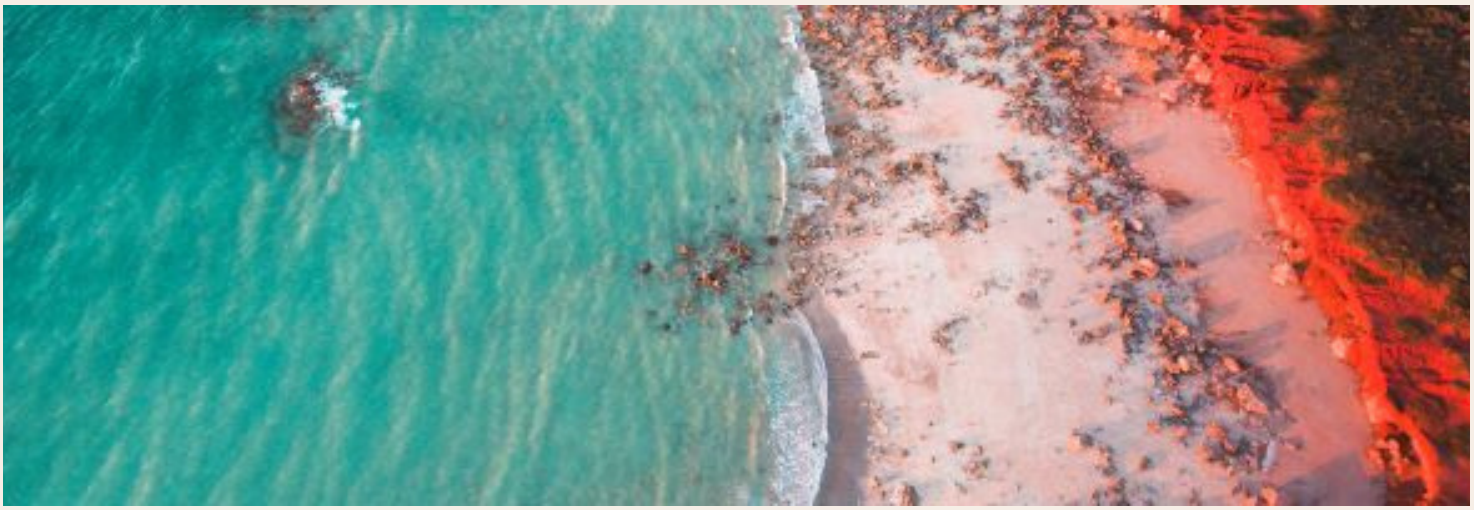

Social and Emotional Wellbeing:

Exploring the foundations for appropriate and usable clinical terminology and coding practice

WORKSHOP SUMMARY

Transforming Indigenous Mental Health and Wellbeing
www.TIMHWB.org.au

CONTENTS

INSTRUCTIONS FOR USE

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Executive Summary

Introduction

In May 2024, a two-day workshop, Social and Emotional Wellbeing: Exploring the foundations for appropriate and usable clinical terminology and coding practices, was held in Rubibi (Broome, WA). The workshop was hosted by the Wellbeing Informed Care - Kimberley (WIC-K) research project, a partnership between The University of Western Australia (UWA), and the Kimberley Aboriginal Medical Services (KAMS).

The workshop brought together over 40 participants from over 14 different organisations including Aboriginal Community Controlled Health Services (ACCHS), the Commonwealth Scientific and Industrial Research Organisation (CSIRO), and UWA (appendix 1). The workshop was generously supported through the inaugural Igniter Fund provided by the UWA Suicide Prevention and Resilience Research Centre (SPARRC) and funding made available by CSIRO.

ACCHS Model of Care

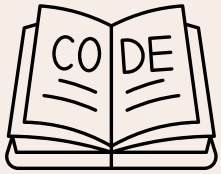
The ACCHS model of care is holistic. It recognises that Aboriginal people achieve and sustain health when their physical, social, emotional, and spiritual needs are met. To this effect health care for Aboriginal people, must be holistic and appropriately respond to the breadth of people's needs, including their social and emotional wellbeing (SEWB).

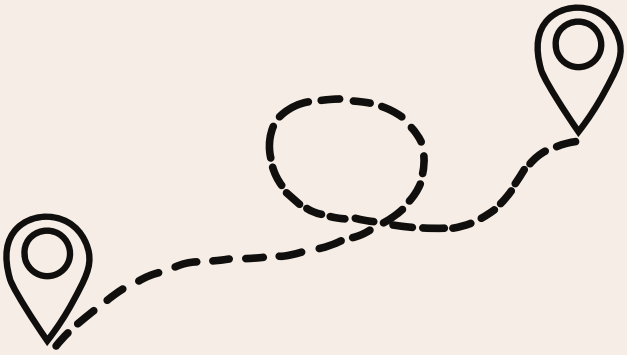
The Aboriginal developed SEWB model (1) positions an Aboriginal persons experience of health within historical, social, cultural, and political determinants, their individual life experiences, and the interconnectedness of their 'self' across the domains of Body, Mind, Family, Community, Culture, Country, and Spirit. It is a conceptual model that offers a strengths-based approach to improving health through individual and collective approaches to strengthening the interconnecting domains, truth telling, self-determination, and access to appropriate care and support. The SEWB framework is often visualised and referred to as the SEWB wheel (fig 1).

Figure 1. Social and Emotional Wellbeing Model

Improving SEWB clinical terminology and coding

There are currently no protocols or standards to guide ACCHS' clinical decision making on how, when, or why to record (or code) information about a person's SEWB within their electronic medical record. Research within the Kimberley ACCHS (2) suggests that information about a person's SEWB is not regularly recorded using standardised clinical terminology. This makes it difficult to qualify or quantify the role of SEWB in a person's health journey and their outcomes. Mainstream primary health care is also impacted by a similar lack of guidance on how to record non-medical factors, such as the social determinants of health (SDoH; e.g., housing, food security, social connectivity). This is despite a nuanced understanding of the impact of the social determinants on individual and population health outcomes (3).





For ACCHS it is not only clinicians who are grappling with coding patient information but also the SEWB teams. SEWB teams are a common feature of ACCHS across Australia and generally work with Aboriginal people and communities providing culturally secure community development, psycho social support, targeted interventions, and supported co-ordinated care (4) . These teams are increasingly using ACCHS electronic medical records to document client's SEWB service engagement and store their client's case notes. For many SEWB teams, selecting clinical terminology to correspond with a client's engagement is challenging.

Systematized Nomenclature of Medicine, Clinical Terms (SNOMED CT) is the preferred clinical terminology for Australian primary health care; it is an international terminology, with an Australian (AU) core that is managed by the Australian government. SNOMED CT is available within electronic medical record systems such as Communicare and MMEx. Using standardised clinical terminology within electronic medical record systems improves communication amongst health care providers and facilitates the availability of important health information. It has broader benefits associated with interdisciplinary care, reporting, research, data analytics, and management. However there are over 500,000 clinical terms in the SNOMED CT system, and many terms appear duplicated or ambiguous, in other instances there is no appropriate terminology available (5).

Purpose of Workshop

The SEWB clinical terminology and coding workshop aimed to start a conversation amongst the delegates to explore:

1. Why clinical terminology and coding of patients SEWB is important in the ACCHS sector.
2. How are ACCHS currently using clinical terminology and their future aspirations.
3. How we can improve the use and relevance of SEWB clinical terminology and approaches to coding within the ACCHS sector.

Summary report methodology

This summary report captures the workshop's key activities, reflections, and proposed next steps. The data that informs this summary includes notes taken by UWA and KAMS scribes, information collected on white boards over the two days, facilitator notes, the butcher's paper used during the group activities, and participant feedback forms. The data has been organised and categorised based on relevance to corresponding workshop agenda items (appendix 2). The compiled data was then analysed by the WIC-K team to identify patterns, trends, or significant findings. These findings have been interpreted in the context of the workshop and its broader goals.

Key Findings

1. There are commonly experienced challenges and concerns with reporting, recording, and recalling SEWB related information using electronic medical record systems.

2. Principles around why and how ACCHS code for SEWB are important and need to inform and accompany any SEWB clinical terminology and coding initiatives and resources.

3. Numerous potential benefits of adopting SEWB clinical coding practices were identified by workshop participants. Benefits have been identified at the client, service, and population level.

4. SEWB clinical terminology, associated definitions, and use suggestions must be culturally secure, designed with Aboriginal people, and centre an Aboriginal world view.

5. Where there are gaps in culturally secure and responsive SEWB clinical terminology these should be built and made available within the SNOMED CT AU core.

6. ACCHS should be supported to adopt SEWB clinical coding; and use and impacts should be monitored and evaluated.

7. Enhancing SEWB clinical terminology and coding practices is a new and complex initiative. There is in principle support from workshop participants to progress the development of a SEWB clinical terminology reference guide in partnership with additional ACCHS representation.

Next Steps

1. Support ongoing advocacy and stakeholder engagement in relation to improved SEWB clinical terminology.
2. Collaborate with ACCHS to identify and determine appropriate SEWB clinical terminology using a structured consensus seeking approach known as a Delphi study.
3. Co-design a SEWB clinical terminology reference and implementation guide.
4. Support SEWB clinical coding terminology implementation and evaluation within ACCHS.
5. Co-design a continuous quality improvement approach to support ACCHS in adopting ongoing use of SEWB clinical coding.

Further Information

For further information please contact Dr Emma Carlin, Senior Research Fellow, University of Western Australia, and Senior Research Officer Kimberley Aboriginal Medical Services on emma.carlin@rcswa.edu.au.

DAY ONE SUMMARY

- Facilitators discussed and clarified key terms of SEWB clinical terminology and coding.
- ACCHS participants showcased their current and aspirational use of SEWB clinical terminology and coding.
- Participants worked in small groups and explored approaches to coding. Each group designed and applied their own clinical terms, based on a pre-prepared case study, before presenting information back to the broader group for discussion.
- Delegates participated in small and large group discussions which focused on the anticipated benefits of SEWB clinical terminology and coding.

Key terms overview

Clinical Terminology:
Standardised language and vocabulary used to describe medical conditions, procedures, treatments, and other aspects of healthcare. Designed to be precise, consistent, and widely understood within the healthcare community. Ensures accurate communication and documentation of patient information across different healthcare providers.

Clinical Coding:
Process of translating clinical information, documented using clinical terminologies, into standardised numeric codes. These codes are used for various purposes, such as billing, reimbursement, analysis, research, and reporting in healthcare. Clinical coding ensures that healthcare data is structured and categorised in a consistent format, facilitating data analysis, exchange, and interoperability.

Interoperability:
The ability of computer systems or software to exchange and make use of information, both:

- Within systems - like 715 (Aboriginal and Torres Strait Islander Peoples Health Assessment) information talking to the rest of the electronic medical record system and,

- Across systems - information can be shared across different systems that might not use the same software (e.g., ACCHS to hospital).

Defining 'social and emotional wellbeing' clinical terminology

Facilitator Emma Carlin clarified that this workshop is framed by the Aboriginal developed model of SEWB (1). It was noted that SEWB is not the same as mental health and mental illness, but they can interact and influence each other. It was confirmed that the focus of the workshop was on the broader non-medical drivers of health and wellbeing, not on diagnosed mental health conditions.

It was also noted that SEWB and the social determinants of health are separate models that may interact with and influence each other, but they each represent a distinct health lens, or positionality. For this workshop it was important to note that the SDoH do not account for the historical, cultural, and political determinants of health which, in turn are central to Aboriginal expressions, experiences, and outcomes of health.

Key reflections from the ACCHS showcase

Many thanks to Kimberley Aboriginal Medical Services (WA), Derby Aboriginal Health Services (WA), Victorian Aboriginal Community Controlled Health Organisation (VIC), and Danila Dilba Medical Service (NT) for sharing their current and aspirational approaches to using SEWB clinical terminology and coding. From these presentations, and the group conversations they promoted, we captured several key themes. We have used illustrative participant quotes that were scribed by the UWA note taker to help explore each theme:

SEWB data capture and recall could be improved

"We have difficulty translating SEWB practice into clinical data– what we do with data doesn't tell our peoples' stories accurately or meaningfully".

"There is a great need to recognise SEWB demands, trends, and issues at client, and community and service level – want to be able to pull client and community journeys and tell good, meaningful data stories. We want our clients and communities to be able to reflect on the change throughout their journeys, and as services show policy makers and funding bodies what we do in SEWB, and what it means on the ground".

Clinical terminology relating to SEWB is confusing and is being applied inconsistently

"At the moment different codes mean different things. Or when people are putting things into Communicare they might be using different codes, even though they are coding for the same thing. There is an inconsistency, it's not a shared approach for SEWB".

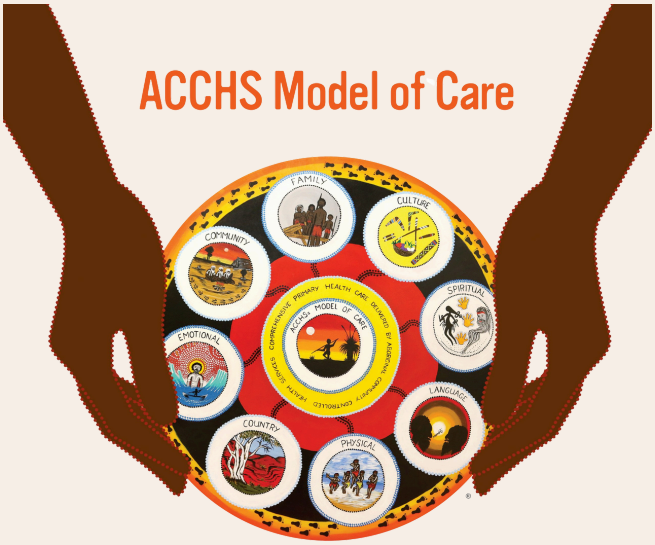
"It's straight out confusing, we are using terms that are not acknowledging the scope and range of work that we, SEWB do. It doesn't line up with our model of care, we want to use coding to help keep track of important client data and not dig around in the case notes, also to accurately report on the work we do but the clinical terms are not giving us that".

SEWB is missing from the broader ACCHS health story

"Currently we can't extract data on how many people who being seen for SEWB related issues, this is probably the same for high prevalence mental health disorders, sure we could look through our SEWB teams and look at their numbers, but I mean in the clinic. For the service as a whole, we just don't have that data. So our clinical data, only tells part of the health story for our mob".

Current data landscape is not capturing all elements of the ACCHS model of care

"When looking at the SEWB framework, things like supporting a person's connection to culture and country aren't represented. Maybe we can find that information in client notes or progress notes but it is hard to pull data around this. It's hard to report on it and hard to pull it to the front of the patient's file so everyone can see 'so and so has a challenge with this but this connection to Country or work with an Elder helps them to manage'. Aboriginal health [services]need to also consider coding as something strengths based".



"How many of our Aboriginal people are coming in with SEWB concerns, and really what are we doing about it? We don't have this data across the board, I this we need it".

"To talk about SEWB work in prevention, early intervention, community development, treatment, after care, all the pillars of SEWB in a way that is well understood by everyone in the primary health care setting is a challenge– we need to find an easy way to communicate within interdisciplinary teams and when we do that, we can show the value of SEWB and capture the holistic picture of what is happening for clients. Then we can build data on how SEWB underpins all health, for all people. I think consistently coding for SEWB in all our ACCHS work is one part of the answer".

Key terms and definitions

Minimal approaches
An approach to coding that prioritises essential elements of the patients story and minimises complexity in coding. Risks include excluding certain variables or information from coding which leads to incomplete or biased conslusions.

Maximal approaches
An approach to coding that prioritises recording everything about the presentation to be as comprehensive as possible. Has a focus on relationship between variables and patterns in data. Risks collecting a large ammount of data that requires analysis.

Data aggregation
Refers to the process consolidating information to a certain level of detail. The aim is to simplify data and provide meaningful insights but at a certain point aggregation can risk losing important detail.
Example:

- A clinical term that specifies ‘suicide attempt’ but not the type of attempt (drugs, hanging, etc)
- A clinical term that specifies ‘At risk of violence’ but does not specifying who from (parent, partner, self)
- A clinical term that specifies ‘sexually transmitted infection’ but does not specify the type i.e. chlamydia or syphilis

Designing clinical terminology case study activity

The participants were broken up into smaller groups and each group and given a pre-prepared case study (Appendix 2). Groups were asked to use the case study to determine what information would they code, what codes would they use, how would they code (e.g., were they using minimal or maximal, aggregated, non- aggregated approaches or a mix.). Groups were also asked to reflect on the reasons why SEWB coding is important.
Clinical terms that identified by the groups during the case study activity will be disseminated in late 2024/early 2025 as part of the Delphi study. A summary of the discussion is presented below.

Critical question	Indicative response from small groups	Summary of group discussions
Why do we want to code for SEWB?	We got stuck on what was motivating us to code, and therefore we weren't sure on what we should be coding. With this exercise I now understand how coding can be difficult –this was a kind of a straightforward case and we were struggling to holistically code. It showed us in the group how this quite common thing that happens in our communities is actually complex when deciding what to code and why. Coding should not be driven by funding and reporting requirements, but it will help in telling funders what we are doing, and how we are responding to our place based priority areas.	We code for SEWB for the following reasons: To improve patient/ client health outcomes by recording the important information in a way that can support continuity of care, interdisciplinary care, and monitoring of health outcomes. To quantify what has been historically captured qualitatively or not at all. This has important implications for reporting, service planning, resource allocation, policy development and advocacy. To support continuous quality improvement and research. To better understand, monitor, and respond to population health trends and needs. To help monitor and evaluate service impact on health outcomes.
What are the high-level ethics and privacy considerations with coding for SEWB?	We started out with so many clinical terms and then we really thought about the case study and the information provided to us. We cut a lot out after considering ethics, privacy and what was essential in providing care for that person at that time and in the immediate future. In our case study, looking at family violence, we put in child safety concerns as a code and then took it out because from what we knew from the case study is that the children were safe at the time of the violence. A full assessment from the GP or specialist would be needed before things like that can be determined. We also thought about what it would be like to have family violence coded on your medical file. Should everyone be able to see this? There are privacy issues here and maybe those codes and progress notes should only be available to some in the clinic? For us there was the implication of drug use but it needed to be queried and confirmed so we said in the progress notes this client needed screening and assessment for drug use, and we coded suspected drug use.	Important not to code information as a 'fact' when the information is implied, or suspected. In some instances, the implication of the unverified information is very important (suspected drug overdose, suspected suicide attempt) and the client is unable to verify. In these instances use codes that clearly indicate suspected. As a general rule don't code what you don't talk to your patient/ client about. All patients have the right to access their health care records and clinical terminology associated with their record should not come as a surprise. This could impact on health care service access and limit their trust in a health care professional. Ensure terminology is not stigmatising, for example 'family domestic violence survivor' not 'victim'. Organisations to consider controlling level of access/privacy settings to client files (e.g., differing level of access for GP as opposed to SEWB or reception) while balancing the need to present a holistic health and wellbeing profile to ensure the patient/client receives the right support.

Critical Question	Indicative response from small groups	Summary of group discussions
Level of detail in clinical terminology (minimal/ maximal and aggregation of clinical terms)	Code what is necessary and meaningful for client care, in the immediate. Clinical coding does not need to delve into every aspect of a client's life. It's not about minimal or maximal for me it is about being comprehensive. Some detail is important, there is not much point coding if we are going to be too broad, then it just becomes a tick and flick, a meaningless code that says 'SEWB issues were present. We need some detail for this work to be meaningful, to drive client and community change but obviously we don't want to be splitting hairs. You just need to know that your client has positive family connection, or code that part of the management plan is on-Country activities. You don't need to know who the family member is or what the cultural activity is. It's too much detail for a code and some cultural activities it wouldn't be appropriate. If it is appropriate, tell the story in progress notes but not in the code.	Code what is happening for the patient at that presentation or service engagement. Listen, enquire, and record comprehensively. Developing or using clinical terminology for specific cultural practices should be at the broadest level- aggregation of this type of information is a culturally safe approach to recoding Indigenous practices and knowledges. Patterns and detail for many SEWB presentations is important. For example, ACCHS want to record what type of violence a client is experiencing. This has important patient and service impacts, and this information is important at the population level. Developing and designing a set of SEWB clinical terms needs to be undertaken in alignment with the SEWB wheel. The terms need to be mapped against the SEWB domains and then reviewed and modified by a group of experts to make sure the terms within the categories have appropriate levels of detail/ aggregation. This is complex because it is not a one size fits all rule. Consensus on level of detail for clinical terms can be achieved through engaging practise-based wisdom (ACCHS staff), Aboriginal leadership, and lived experience.
What information would be coded and what information should be in a progress note?	If its not coded it doesn't get analysed or reported on. Reported on in the team meetings or in funding reports. I would say if it is not coded it is invisible. Say I am seeing a person with a chronic disease and I ask about SEWB and they say they have recently lost their husband and they are stressed out and grieving and why don't you know. The Health Worker knows, she passed on her condolences. The nurse knew and she even wrote it down last time. The patient is upset and doesn't want to keep telling her story. Coding this information, recent death of husband, grief and loss is important clinically on a whole lot of levels. We lose it in a progress note but we need to balance SEWB coding with other patient and biomedical priorities.	In principle agreement across the group that the coding is a high-level summary or 'highlights' of a patient's presentation/ engagement with the service. The progress note has the details, the story, and the plan for moving forward. The progress note can include more subjective information about the presentation/session with appropriate qualifications. For example, you can record how the client felt and your own clinical observations.

Key Finding

Principles around why and how ACCHS code for SEWB are important and need to inform and accompany any SEWB clinical terminology and coding initiatives and resources.

Anticipated benefits of SEWB clinical coding

Support client's health journey though consistent, understandable, and accessible information being available to all health and wellbeing staff.

Consistent coding could generate localised aggregated data pertaining to the nature and prevalence of adverse SEWB and the impacts on health at the population level.

Inform evidence-based health priority setting, drive advocacy efforts, and catalyse the development of data-driven health promotion strategies and population health interventions.

Support and streamline program reporting.

Key Finding

Numerous potential benefits of adopting SEWB clinical coding practices were identified by workshop participants. Benefits have been identified at the client, service, and population level.

DAY TWO SUMMARY

Small groups developed clinical terminology for strengths and protective factors using the SEWB wheel and presented back to the larger group.

Participants worked in groups and developed their own case study based on various clinical and SEWB topics (e.g. problematic alcohol use, chronic disease, family violence, routine clinical presentation). Participants then developed codes to code their case study, justified codes, and presented back to the bigger group.

Facilitator discussed next steps for the SEWB clinical coding project.

Presentations from CSIRO and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO).

Clinical terminology for strengths and protective factors

Clinical terminology was identified as largely being deficit-based and participants had spoken about the need to develop clinical terminology for a person's strengths and protective factors. This was seen as a critical element in developing and discussing SEWB clinical terminology. Strengths based clinical coding practices were seen to support:

- **Holistic assessment of needs:**

By documenting strengths and protective factors, it was identified that clinicians receive a more comprehensive understanding of the patient's overall well-being. This supports the development of a more holistic health plan that addresses both a patient's challenges and resources. It was identified that treatment and/or case management planning can leverage off those resources to promote resilience and healing.

- **Reframing everyone's focus**

Including strengths and protective factors shifts the focus to what is working well for the patient, promoting a more positive and balanced representation of the client. It was suggested that it is important for patients to see they are not just seen as a 'cluster' of problems and helpful for staff to identify and consider the strengths and protective factors that patients have.

The participants were broken up into smaller groups and each group was asked to reflect on people they had seen in the clinic or their SEWB program and develop strength-based terms for a person's protective factors.
The full list of strengths-based codes identified by the groups during the activity will be disseminated in early 2025 as part of the Delphi study. An example of some codes and key reflections is presented below.

"It can boost their self-esteem and motivation, as they see themselves not just as sufferers, but as self-determining individuals".

Example of strengths-based clinical terminology and its relationship to the SEWB wheel

SEWB domain	Examples of potential clinical terminology
Connection to body and behaviours 	Exercise/ movement/fitness Eating health/healthy diet Hunting/Bush tucker Regularly taking medicines Listening to body/body awareness
Connection to Country 	Country connections - feeling Country connections - activity Country connections - historical Fishing, hunting, camping Lore/ceremony
Connection to Spirt, Spirituality, Ancestors 	Belonging/identity Connect to Elders, language and skin groups Traditional healing requested/provided Spiritual support explored Connection to Culture
Connection to Culture 	Cultural connection – art, language, dance, traditional practices Lore (Women's or Men's Business) Time on Country Fishing, hunting, camping Ceremonies
Connection to Community 	Access to/ support from culturally secure services Safe and inclusive spaces Community events and celebrations Healing focussed activities Sense of safety
Connection to mind and emotions 	Self awareness Self regulation Access to healing/therapeutic services Strong role models Sense of resilience
Connection to family and kinship 	Family support Connection to Elders Sense of belonging/identity Sense of safety Pride and self determination

Key Finding

SEWB clinical terminology, associated definitions, and use suggestions must be culturally secure, designed with Aboriginal people, and centre an Aboriginal world view.

"We wanted to add more details, especially around traditional healing methods as there is such a range and variety of methods and types of healing. It feels very generic to refer to it as 'cultural healing', but then we thought it is about consistency. Knowing the client has these things or wants access to them. The detail is its important can be in the notes if you want some record of what things they are using and who facilitating these things".

Designing a case study for clinical terminology and coding activity

For the last activity of the workshop participants worked in small groups to first design their own case study and then code it. Groups presented back to the larger group on their case study, the decisions they made around coding, and shared the clinical terms.A summary of the key reflections and themes is recorded below.

"Some of the stuff is easy to come up with, a lot of it is the same as the social determinants of health and it shines a light that we could code for better and be able to be used to demonstrate complexity of the people we see".

"We talked about background info and what we wanted to code for, we had a discussion around connection, and how to measure that – is connection a parent code, then child codes such as disconnection, partial connection? Another thing for this activity is fear of family separation and removal. Our case study was about a survivor of the stolen gen – but then didn't want to put that there for fear of labelling, we wanted to 'un-label'. Could there be general SEWB label – could it be its own one, indicating a non-specified SEWB issue?"

"Coming up with right language is tricky for presenting problem. We came up with 'family worries', 'help seeking', and we wanted to specify these were grandparent worries. We wanted to capture disharmony in the home. For coding, we kept it simple, 'family worries', and a focus on strengths 'help seeking', 'supportive connected family'."

Key Finding

Where there are gaps in culturally secure and responsive SEWB clinical terminology these should be built and made available within the SNOMED CT AU core.

Next steps for enhancing SEWB clinical terminology and coding

Confirm project steering committee and apply for relevant Aboriginal health ethics (October 2024)

Map and gap clinical terms generated through the workshop against SNOMED CT terminology (Nov/Dec 2024).

Use information from the workshop to create working definitions for mapped and gapped terms and provide use suggestions and principles to inform use (January 2025).

Send proposed clinical terms, definitions, and use suggestions to workshop participants and other key stakeholders for feedback and commence a structured approach to achieving consensus. This will be done through a Delphi study (February-July 2025).

Advocate for gap terms to be built into SNOMED (July–September 2025).

Codesign and disseminate a SEWB clinical terminology reference guide through ACCHS peaks (October 2025-February 2026).

There was broad in principle support for this work to commence.

"A SEWB terminology guide seems like an important first step. It will be important to allow ACCHS to self-determine how or if they choose to use it".

"We are grappling with complexity of culturally appropriate framework within an already dominant, medical framework and system – so many limitations, so many competing demands. But this is something practical, a starting point..."

Key Findings

ACCHS should be supported to adopt SEWB clinical coding and use and impacts should be monitored and evaluated.

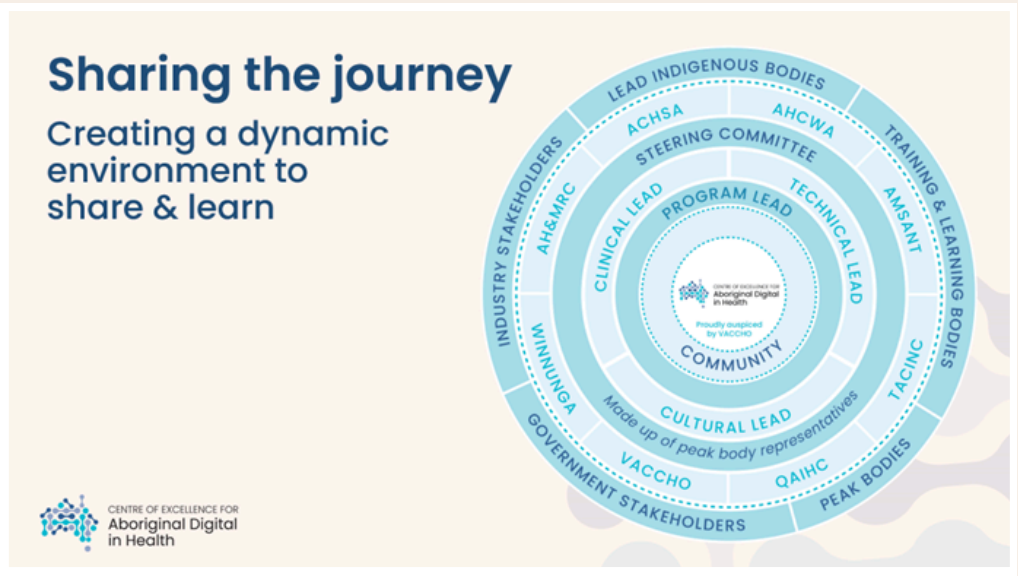
Enhancing SEWB clinical terminology and coding practices is new and complex initiative, there is in principle support from workshop participants to progress the development of a SEWB clinical terminology reference guide in partnership with the workshop participants and additional ACCHS representation

Guest Presenters

CSIRO guests **Kate Ebrill** and **Kylynn Loi** presented on **Sparked**. Sparked is working with clinicians, industry, and government, forming a collaborative community to develop health data standards (terminology, clinical data, and technical exchange specifications). Its goal is to enable real-time health information sharing across the entire digital health ecosystem.

VACCHO -Balit Durn Durn Centre guests **Aidan Baginski** Gunditjmara man, **Nikki Foy** Gunditjmara woman, and **Dr. Nyree Taylor** presented on the emerging **Centre of Excellence for Aboriginal Digital in Health (CEADH)**. This new initiative is Aboriginal community controlled and working with ACCHOs to:

- Realise an increase in digital in health capacity and capability across the country.
- Improve cultural sensitivities in providing care for Aboriginal people.
- Improve the design of systems and data that 'makes sense' to Aboriginal communities.
- Improve systems, data and infrastructure that is necessary for ACCOs to connect and remain connected with mainstream service provision.
- Improve quality of all Aboriginal care.
- Offer informatics career opportunities for Aboriginal People.



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Appendix 1 - Attendance List

Aboriginal Health Council of WA (AHCWA)

Aboriginal Medical Services Alliance Northern Territory (AMSANT)

Broome Regional Aboriginal Medical Service (BRAMS)

Central Australian Aboriginal Congress (CAAC)

Commonwealth Scientific and Industrial Research (CSIRO)

Danila Dilba Health Service

Kimberley Aboriginal Medical Service (KAMS)

Katherine West Health Board

Moorditj Koort

Ord Valley Aboriginal Health Service (OVAHS)

Pilbara Aboriginal Medical Service (PAMS)

Sunrise Health Service

University of Western Australia (UWA)

Victorian Aboriginal Community Controlled Health Organisation (VACCHO)

Appendix 2 - Workshop Agenda

Day 1: May 8th 2024 - Social and Emotional Wellbeing: exploring the foundations for appropriate and usable clinical terminology	
Time	**Agenda**
Session 1: Introduction and welcome	
8:30 am - 9:00 am	Registrations
9:00 am - 9:30 am	Welcome to Country
9:30 am - 9:40 am	Open & housekeeping
9:40 am - 10:00 am	Introductions
10:00 am - 10:20 am	Morning tea
Session 2: Clinical terminology in the ACCHS	
10:20 am - 10:50 am	**Wellbeing Informed Care - Kimberley presentation** • Clinical terminology in the ACCHS • Table discussion: What are the barriers to using clinical terminology?
10:50 - 11:00 am	Shake break - VACCHO
11:00 am - 12:30 pm	**VACCHO, DAHS, DDHS, KAMS, Mooditj Koort presentations** • ACCHS Showcase of current practice
12:30 pm - 1:15 pm	Lunch and networking
Session 3: Foundations for improving clinical SEWB terminology	
1:15 pm - 1:45 pm	**Wellbeing Informed Care - Kimberley presentation** • Scope of SEWB clinical terminology • Table discussion: List why it is important to do better with SEWB coding within the ACCHS
1:45 pm - 1:55 pm	Shake break - KAMS
1:55 pm - 2:25 pm	**Wellbeing Informed Care - Kimberley presentation** • Building blocks of clinical terminology • Different approaches in using clinical terminology
2:25 pm - 3:00 pm	Activity 1: Part A - Minimal vs Maximal approaches
3:00 pm - 3:20 pm	Afternoon tea
3:20 pm - 3:40 pm	Activity 1: Part B - Looking at your ideal approach
3:40 pm - 4:20 pm	Present back
4:20 pm - 4:30 pm	Close

Day 2: May 9th 2024 - Social and Emotional Wellbeing: exploring the foundations for appropriate and usable clinical terminology	
Time	**Agenda**
Session 1: Introduction to day 2	
8:30 am - 8:40 am	Housekeeping
8:40 am - 9:10 am	Concluding presentations from day 1
9:10 am - 9:30 am	Recap day 1
9:30 am - 9:50 am	Icebreaker: Protect the egg - VACCHO
Session 2: Towards SEWB clinical terminology	
9:50 am - 10:00 am	Wellbeing Informed Care - Kimberley presentation • Clinical coding using natural language approaches
10:00 am - 10:30 am	Activity 2: Part A - Developing a case study to build SEWB terminology
10:30 am - 11:00 am	Morning tea
11:00 am - 11:15 am	Activity 2: Part B - Code and analyse case study
11:15 am - 12:30 pm	Case presentations back to the group
12:30 pm - 1:15 pm	Lunch and networking
1:15 pm - 1:45 pm	Terminology and principles • Reflecting on what we have learnt: principles and practice
1:45 pm - 1:55 pm	Working towards a SEWB Reference Guide
1:55 pm - 2:00 pm	Shake break - KAMS
Session 3: The bigger picture	
2:00 pm - 3:15 pm	Presentations • CSIRO: Data standards/digital health strategy • VACCHO: Digital health equity/ACCHS advocacy
3:15 pm - 3:30 pm	Afternoon tea
Session 4: Next steps	
3:30 pm - 4:30 pm	Car park, clarify next steps, evaluation and close