HSE Integrated Care Programme for the Prevention and Management of Chronic Disease

Issue 6
July 2025

Integrated Care Programme for the Prevention and Management of Chronic Disease

Welcome to Issue 6 of the ICP CD Newsletter – July 2025

We're delighted to bring you the latest edition of the Integrated Care Programme for Chronic Disease newsletter. This issue highlights the incredible progress being made across the country to deliver person-centred, integrated care in our communities. From innovative approaches in diabetes and pulmonary rehabilitation, to empowering education programmes like DAFNE and the Best Health Programme, our teams continue to demonstrate how collaboration and commitment drive real impact in patient outcomes.

In this issue, you'll meet recently appointed members such as Dr. Elsheikh Ali at Naas Diabetes Hub, read about the successes of the Virtual Pulmonary Rehab initiative, and explore valuable findings from recent audits and patient satisfaction surveys.

We also share insights from nationwide ICPCD opportunities for staff, and exciting updates from the Limerick Integrated Cardiology team improving outcomes for patients with heart failure.

As always, this newsletter is a testament to the dedication of multidisciplinary teams working across acute and community settings, supported by national clinical programmes and ICPCD, to improve access, quality, and outcomes in chronic disease management.

Thank you for your ongoing support and commitment.

Dr Sarah O Brien NCAGL

Celebrating Successes!

Susan Curtis, Programme Manager at the National Clinical Programme (NCP) Respiratory, and Maireád Gleeson, General Manager of the NCAGL Office, had their poster shortlisted for this year's Spark Summit Showcase.

Their project, titled *"Empowering Asthma and COPD Patients Through Collaborative Self-Management Strategies,"* is a joint initiative involving the NCP Respiratory, the Integrated Care Programme for Chronic Disease (ICPCD), the Enhanced Community Care (ECC) programme, and patient advocacy groups including the Asthma Society of Ireland and COPD Support Ireland.

This work centres on enabling patients to better manage their conditions through co-designed self-management supports. These supports were developed collaboratively by the NCP Respiratory and the advocacy organisations, ensuring that patient voices were integral to the process. Use of PDSA (Plan-Do-Study-Act): encourages a structured, data-driven approach to problem-solving within our quarterly progress meetings with ASI and COPD Support Ireland. Promotes continuous learning and iterativerefinement for service improvement.. The project serves as a model for other National Clinical Programmes under the remit of NCAGL Chronic Disease, with the aim of applying these learnings more broadly.

The Spark Summit took place on Wednesday, 11th June, at the Dublin Royal Convention Centre, One Le Pole Square, Dublin 8. This annual event celebrates the innovation and ingenuity of healthcare professionals who are transforming how we think, work, and care.

It was encouraging to see this collaborative effort, bringing together patients, advocacy groups, and healthcare professionals being recognised at a national level as part of a celebration of frontline creativity and healthcare improvement.

Pictured: Susan Curtis, Programme Manager at the National Clinical Programme (NCP) Respiratory, and Maireád Gleeson, General Manager of the NCAGL Office

Patient Testimonials

Asthma Advice Line

"Great advice with positive results!"

"This service is worth its weight in gold"

"A game changer for me, I have recommended it to others."

"I learned so much from the nurse call."

"Since receiving nurse advice, we have avoided emergency visits."

COPD Support Groups

"Weekly exercise classes are life-changing."

"It has kept me fit and active and not so dependent on people to do things for me."

"I felt isolated before joining, now I have ongoing support."

"Learning from the group and witnessing their efforts is inspirational."

"The social and physical benefits are enormous."

Results

COPD Support Groups data (2024):

- **2,014** in-person classes across **47 groups**
- **144 online** classes with **939 total participants**
- **19,152 total attendees**
- **20.4% growth in attendance (Q4 vs. Q1)**
- **182 referrals** via new **e-referral form**
- **6,101 resources** distributed

Asthma Advice Line data(2024):

- **3,134 total calls**, including **503 first-time callers**
- **130 e-referrals** processed since launch (46% from respiratory hubs)
- **8,752 resources** distributed by the Asthma Society of Ireland

Fostering Connections in Type 1 Diabetes Healthcare: HSE National Clinical Programme for Diabetes and UCC School of Public Health Knowledge Exchange DAFNE Event

On October 25th, 2024, the School of Public Health, University College Cork, hosted a diabetes healthcare knowledge exchange event, aimed at fostering connections and co-operation among diabetes healthcare professionals. The event, entitled "Building on experience: practice and progress in DAFNE diabetes education" was held in the Radisson Blu Hotel, Athlone. The focus of the day was knowledge sharing between all attendees.

The event consisted of keynote talks, as well as panel discussions, all centred around DAFNE (Dose Adjustment for Normal Eating). DAFNE is a course delivered by trained healthcare professionals for people with type 1 diabetes. Its aim is to empower them to make informed choices about their carbohydrate intake and insulin doses. It was attended by nurses, dietitians and doctors delivering or intending to deliver DAFNE, as well as research partners and members of the diabetes community.

The first keynote address, entitled "Being human in the age of digital diabetes care" was delivered by Dr Rose Stewart, Consultant Clinical Psychologist, Betsi Cadwaladr University Health Board, Wales, & Adult Diabetes Psychology lead for BCUHB & NHS Wales. The talk included her perspective on diabetes management as a clinical psychologist, and advice on integrating new technology into care.

Two panel talks were held later in the day; one with a group of DAFNE graduates (people with diabetes who completed DAFNE) to learn about the service user perspective of DAFNE and one with a group of new and established DAFNE centres sharing their experience of organising and running DAFNE.

Researchers from UCC's School of Public Health also shared their findings related to their research on DAFNE. Dr Sheena McHugh of the Health Implementation Research Hub, School of Public Health, UCC, presented her team's research looking at the implementation of DAFNE in Ireland, working with different diabetes centres around Ireland to develop tailored strategies to address specific enablers and barriers to support DAFNE implementation at their hospital.

The day concluded with a keynote talk by Dr Jackie Elliott, Chair of the DAFNE UK Executive Board, entitled "Developments in DAFNE Education." In her address, Dr Elliott discussed statistics and updates from central DAFNE management including results from patient-reported outcome measures collected in England.

The event was seen by participants as a helpful networking opportunity and a positive space to learn from one another. The day also helped the healthcare professionals to understand the impact DAFNE has had on people with diabetes:

"The support that DAFNE provides through education is invaluable for people with diabetes. Therefore, as a graduate, to be able to participate in the event and to be able to share your experience was very satisfying and enjoyable."
- Gosia Carroll, DAFNE Graduate Panellist

"I think the stories we heard show the powerful impact DAFNE, coupled with CGM [continuous glucose management], has had on the lives of people with diabetes"
- John O'Farrell, DAFNE Graduate Panellist

Health professionals involved in type 1 diabetes management and those involves in national service development found the event useful to share challenges and solutions among teams around the country across :

"We've had a 250% increase in DAFNE availability in Ireland since 2016 with 22 sites now offering the programme to people living with Type 1 diabetes. This event was such an important opportunity for the clinical teams to meet and reflect on how we can best support ongoing implementation and delivery. I'm looking forward to continue working on this with DAFNE, the clinical teams, advocates and our academic partners in Ireland in the years to come" - Cathy Breen, Interim Dietetic Lead, National Clinical Programme for Diabetes

Pictured: Back row left to right - Dr Cathy Breen, Dr Claire Kerins, Dr Kate Gajewska, Dr Michael Lockhart, Dr Sheena McHugh, Prof Sean Dinneen, Ms Margaret Humphreys, Ms Julia Banisiak, Dr Aoife O'Mahony. Front row left to right: Dr Jackie Elliott, Dr Rose Stewart, Ms Louise Holland

Naas Diabetes Hub: Exciting Updates! New Consultant, Strengthening Diabetes Care and Patient's Satisfaction Insight

Welcome

We're delighted to welcome Dr. Elsheikh Ali, our new Integrated Consultant Endocrinologist, to Naas Diabetes Hub. With extensive expertise in diabetes care, he is dedicated to strengthening integrated services and collaboration between primary and secondary care. Since joining in October 2024, he has established a rapid access and multidisciplinary clinic, improving patient support and reducing hospital waiting times. We look forward to his positive impact on our team and community.

Strengthening on Diabetes Care

Following the success of last year's event, the Naas Diabetes Hub recently welcomed over 70 attendees to its second **Integrated Chronic Disease Study Day** for practice nurses. This interactive session focused on strengthening the role of practice nurses in integrated diabetes care, fostering collaboration between primary and secondary services to enhance patient outcomes.
The day featured expert-led discussions, case studies and hands-on workshops, offering valuable insights into best practices in chronic disease management. We are proud to support ongoing education and collaboration, empowering practice nurses to deliver high-quality, patient-centred care.

Patient's Satisfaction Insight

Congratulations to the integrated diabetes team in completing a patients experience survey with over 90 respondents (69% response rate). The survey aimed to gather meaningful data that can improve the quality of care, address patients' needs and enhance their overall experience within the diabetes integrated care service. The patient satisfaction survey highlights high satisfaction with accessibility, quality of care, and well-being as illustrated in Figure 1 & Figure 2.

Objectives:
•To assess quality of care
•Measure accessibility of care
•Evaluate patient experience in the care provided
•Promote continuous improvement

Integrated Diabetes Team NaasL-R: Back Row: G. Cully OP Lead, R Mulcahy Dietitian, T. Botha Dietitian, J. Begley CNS, K Foley cANP, S Cronan, Administrator, D. Heal, CS Podiatrist, A Coffey Podiatrist. Front Row: : Dr. Elsheikh Ali, U. O'Neill ANP, A Maloney Podiatrist.

Fig 1. Quality of Care

Fig 2. Service Accessibility & Health & Well-being

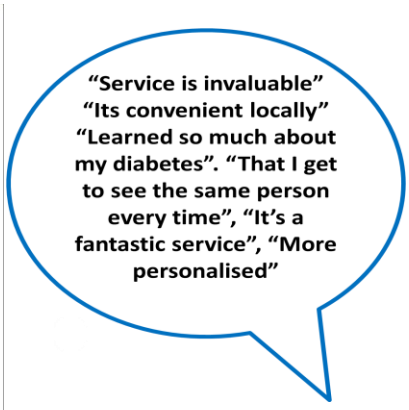


Fig 3. Participant Feedback

Conclusion & Quality Improvement

The patient satisfaction survey highlights high satisfaction with accessibility, quality of care and well-being. Patients valued the coordinated approach, improving self-care and outcomes. However, areas for improvement include involving patients more in their decision about their diabetes, advocating for phlebotomy services in the community and continuous glucose monitoring devices for people with complex diabetes. Addressing these gaps will strengthen the service, ensuring a more patient-centred approach and better diabetes management.

The Integrated Pulmonary Rehabilitation Journey

Throughout the country, pulmonary rehabilitation teams have been exploring innovative and collaborative ways of working to deliver patient centred integrated care, capturing the essence of enhanced community care.

Collaboration equals Innovation in North Tipperary

In North Tipperary, the community and acute hospital respiratory teams have joined forces to ensure all patients have timely access to Pulmonary Rehabilitation (PR), supported by Respiratory Consultants Prof Aidan O Brien and Dr Brian Casserly in UHL.

PR based at Nenagh hospital has been established in this area for over a decade. With the introduction of dedicated teams to deliver PR in the community, and the addition of direct-access GP referrals, there was an uneven volume and often duplication of referrals across both services. With the ethos of integration in mind, a cross-site PR programme was established in 2024, amalgamating waiting lists via a shared electronic folder.

The third integrated PR programme has just commenced. Programmes are delivered twice a week for eight weeks and staffed by two acute hospital staff and three community staff. To date a total of 90 patients have been enrolled in the programme.

The integrated PR team L to R: Máire O Doherty (Senior Physiotherapist CDM), Ciara McDonnell (Senior Physiotherapist Nenagh Hospital), Sarah Cunneen (Clinical Specialist Physiotherapist CDM), Olivia Quinn (Respiratory CNS Nenagh Hospital), Sinéad Cleary (Senior Physiotherapist CDM).

This comprehensive collaborative service bridges the divide between hospital and community care and has improved access to specialist oxygen assessment services for patients in the community. All patients regardless of disease severity have equitable and timely access to PR, and a greater volume of patients can be enrolled, reducing waiting times.

The North Tipperary and Nenagh hospital teams have demonstrated how an efficient, and sustainable, integrated model of care can be achieved through a patient-centred approach of information sharing, collaboration, and pooling of resources.

North Dublin – Share your screen

COVID necessitated exploring novel care delivery pathways. One of the most successful initiatives was Virtual Pulmonary Rehabilitation (VPR). Not only is VPR an ideal model to support respiratory PR services during periods of service disruption, it continues to be a viable alternative for patients who are unable to attend face-to-face traditional PR (TPR). However, as the demand for TPR has increased, combined with staff shortages, it has been challenging for community PR teams to continue to deliver both programmes. To maintain VPR, a cross-hub collaborative approach was piloted in 3 hubs in North Dublin.

Each hub triaged for VPR and completed initial in-person assessments in the patient's own respiratory integrated care area. Where needed, patients were provided with I.T. training and support.

Classes incorporating exercise and education sessions were delivered twice a week on a rotational basis shared between staff using the Cisco Webex platform. In addition, speakers from the HSE Dublin and North East region contributed including dietetics, self-management support, respiratory clinical nurse specialists and mental health specialist teams.

A shared drive facilitated collation of patient assessment, exercise recording, class education schedules, and outcome measures data. A specific PDF exercise record sheet was created for patient class recording and progress notes.

Positive clinical outcomes were achieved for those who completed the programme. Feedback was positive, in particular patients enjoyed the variety of physiotherapists and would recommended the programme to others. Additionally, staff reported benefits through shared learning experiences.

Maeve Sorohan CSP, Ciara Feeney CCP, Eimear Ward CSP Dublin North Integrated Care Centre, Majella O'Reilly CSP Dublin North Central Integrated Care Centre, Clodagh O'Meara CSP Dublin North West Integrated Care Centre.

By taking an innovative and collaborative approach to service delivery, the teams in HSE Dublin North Central, Dublin North and Dublin North West ICCs have ensured that the Sláintecare vision of 'Right Care, Right Place, and Right Time' is preserved.

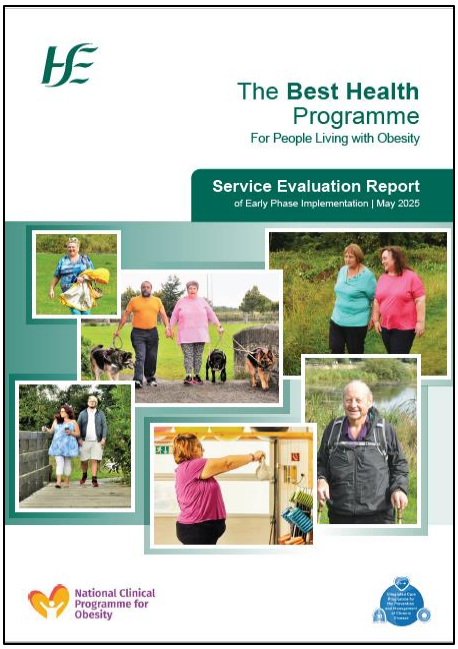
Promoting Virtual Pulmonary Rehabilitation

A similar experience of Integration of Virtual Pulmonary Rehab services is in operation across North Tipperary, Limerick, and Clare and provides more choice and expands access for patients in the region. Mairghread Moynihan a Senior Physiotherapist working in Respiratory Integrated Care has been involved in the development of a short video highlighting this collaboration with the support of the telehealth and technology team. Virtual Pulmonary Rehab.

Evaluation of early phase implementation of The Best Health Programme: a community service for obesity management in the Irish healthcare system

The recently published Best Health Programme Service Evaluation Report examines early phase implementation of 17 programmes (3 delivered in person, 14 online), delivered across 6 sites between October 2021 and March 2024. 193 participants who attended the initial assessment and at least one session of the programme were included.
The Best Health programme is the new national self-management education (SME) programme for people living with obesity.

- It is delivered by dietitians in the level 2 chronic disease community specialist teams.
- Adults with a BMI ≥ 30kg/m2 with two or more co-morbidities are accepted.
- The programme is delivered online or in person over 12 months and includes an initial 1:1 assessment (IA) and 14 group sessions.
- The philosophy includes a person-centered, health gains approach, embedding behaviour change techniques



At end of Programme (1 year):
70% Lost or maintained weight

3% mean overall weight loss
6% weight loss in programme **'completers'**
40% lost ≥ 5-10%, average weight change -12.5 ± 9.3 kg (10%)

"The dietitian really listened, and they really took time to understand where I was coming from."

"No judgement. Never felt that you were being preached at."

Health Behaviours

- ↑ increase in daily fruit and vegetable consumption
- ↓ reduction in screen time while eating
- ↑ increase in daily breakfast consumption
- ↑ increase in physical activity levels

Methodology

Socio-demographic, clinical and attendance data was collected by at baseline (T1), mid-way (T2) and end of programme (T3). Participants completed questionnaires on health behaviours, mental well-being and satisfaction levels at each time-point. 'Completers' were defined as attending at least 50% of the programme including 1 core session (1-6) and 1 ongoing follow up session (7-14).

Results

The overall findings of the evaluation are very positive, with high levels of engagement and positive health outcomes related to mental wellbeing and cardio-metabolic health, specifically triglycerides reductions (↓ 12%) along with improvements in health behaviours. Weight change was also clinically significant with 70% of participants having weight maintenance or reduction during the programme with weight loss of ≥ 5% occurring in 40% of the cohort (where weight data available at the T1-T3 time-points). There was excellent ratings of participant satisfaction of their overall experience of participating in the programme, this is down to the educators and their expertise in group facilitation of this clinical intervention.

Discussion

Improvements in health, well-being and behavioural outcomes as well as clinically meaningful weight reduction in line with international standards has been demonstrated. Ongoing engagement with stakeholders and service users is needed to address gender imbalance and uptake by hard to reach groups.

The Best Health Programme is a QISMET accredited, core clinical intervention for the treatment and management of obesity as part of HSE ICPCD services. The development of the programme and ongoing delivery of SME in chronic disease is a team effort including ICPCD SME Office and Obesity NCP. The report will support advocating for dietetic staffing and business cases for service developments. The full report is accessible on the HSE Land, hubs and resources site.

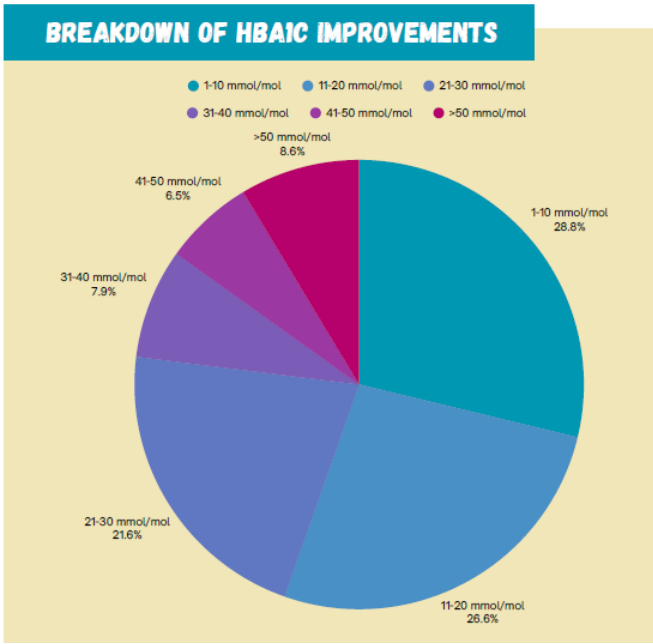
People can access the Best Health Programme via GP referral to the community dietitian in the community specialist teams.

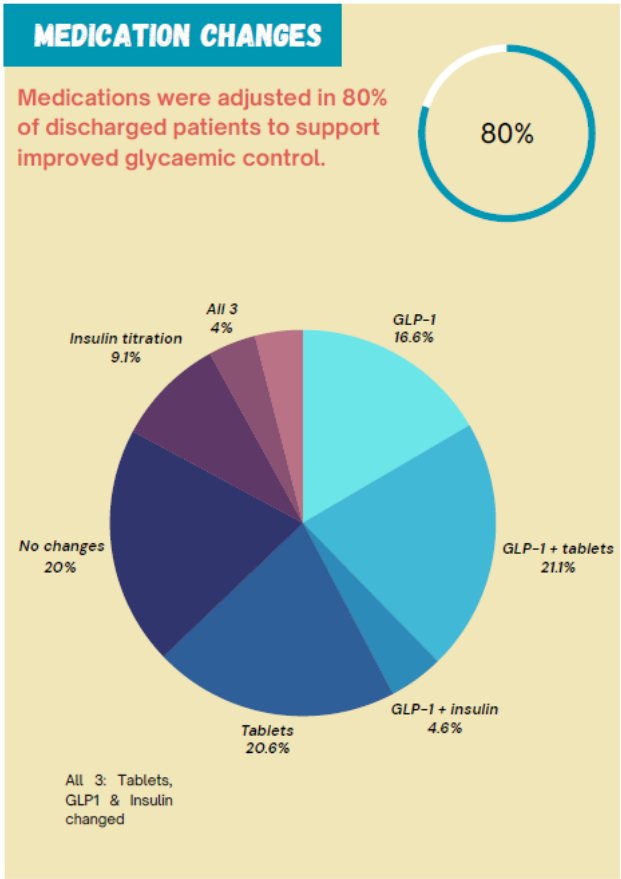
An audit of patients with Type 2 Diabetes discharged from the Diabetes Nurse Led Clinics in HSE Mid West

Clinical Nurse Specialists Diabetes Integrated Care Brid Collins and Karen Guico, completed an audit of patients discharged from HSE Mid West Networks 4, 6, 7 & 8 between January and December 2024. The purpose was to evaluate the discharge processes, outcomes, and follow-up care of patients and identify areas of good practice, assess adherence to clinical guidelines, and highlight opportunities for service improvement. Due to the absence of an IT system, data collection was conducted manually. Of the 190 patients discharged, 175 were included in the audit. 15 were excluded as they didn't attend after two appointment offers.

HbA1c Changes

- **79% of patients showed an improvement in their HbA1c.**
- **71% of individuals who showed improvement experienced a reduction in their HbA1c of more than 11 mmol/mol,** notable as a 10 mmol/mol reduction in HbA1c is associated with a significant decrease in the risk of diabetes-related complications (UKPDS, 1998).
- **5% of patients showed an increase in their HbA1c.**
- This was attributed to either being discharged to secondary care or having achieved patient safety thresholds (hypoglycaemia avoidance).
- **16% of patients showed no change in their HbA1c,** as they either attended solely for education, immigrated, passed away, had no HbA1c done on follow up or were discharged to secondary care.





Discharge reason	No. of patients
HbA1c < 58mmol/mol	86
Discharged to secondary care	45
DNA x 2 (Attended at least two appointments)	19
Died	6
Declined further care	6
Discharged after education/safety	12
Immigrated	1

100% of patients made some form of lifestyle change during their time with the service.

This audit demonstrates the vital role of the Diabetes nurse specialists in the primary care setting

- Conducting holistic assessments
- Supporting lifestyle interventions
- Optimising pharmacological therapy

Dietitians spring into action, upskilling online

So far this year, dietitians working in the chronic disease hubs nationally have been offered a wide range of CPD webinars to support their development and delivery of evidence-based services. Delivering online has enabled access to a range of national and international experts and reduced time and cost to all. All webinars had excellent attendance and feedback.

Chronic Kidney Disease

In February 2025, Dr Cathy Breen, Dietetic Lead on the National Clinical Programme for Diabetes led a webinar for CST dietitians to increase clinical skills in the management of clients with T2DM and CKD Stage 3b, with the overall aim of supporting implementation of the T2DM Model of Care (2024) and more complex T2DM.

Exploring weight stigma and the psychosocial determinants of behaviour change in chronic conditions

Also in February 2025, Dr. Michael Vallis a registered health psychologist, Health Behaviour Change Consultant and Associate Professor in Family Medicine at Dalhousie University, Canada, led a workshop. This interactive session supported educators' confidence and competence in exploring the psycho-social determinants of behaviour change for people living with obesity.

Pregnancy Planning and Type 2 Diabetes

In February, Dr. Rita Forde, PhD is a senior lecturer in the School of Nursing and Midwifery in UCC and Hilary Devine, Clinical Specialist Dietitian in the Rotunda Maternity Hospital, Dublin delivered a webinar examining the evidence on pregnancy outcomes for women with type 2 diabetes, the importance of ensuring optimal nutrition pre-pregnancy and delivering quality dietetic care pre-pregnancy. It also included resources currently available to use in this cohort and how to refer a woman on to tertiary services once she becomes pregnant.

Delivering the DPP to women post GDM

In April Prof. Sharleen O'Reilly, PhD, RD and Associate Professor, School of Agriculture and Food Science in UCD, Catherine Chambers, Clinical Specialist Dietitian, National Maternity Hospital, Dublin and Ciara McGowan, Senior Dietitian, ICPCD, Self-Managment Education Office delivered a webinar to support DPP and type 2 diabetes educators to help them understand the importance of diabetes prevention in this cohort. It also provided guidance on the delivering the Diabetes Prevention Programme (DPP) to this high-risk group. the webinar was developed with the assistance of Hilary Devine, Clinical Specialist Dietitian, Rotunda Maternity Hospital, Dublin. The webinar included an engaging patient perspective from a recent DPP pilot.

hseland.ie

Webinar Playback

Recordings are available via HSE Land, select 'Hubs and Resources', select the 'Enhanced Community Care Hub', click on 'ICPCD' drop down menu and select 'Type 2 Diabetes' and staff learning.

Demonstrating Impact – Limerick Integrated Care Cardiovascular Clinical Nurse Specialist Team – Majella Kennedy & Sarah Ryan

One of the integral aims of the Integrated Care community-based model is to expediate patients' discharge from acute hospitals and holistically manage their care in the community. Until the implementation of the Integrated Care Model, care for patients with heart failure in the Limerick region was primarily within the acute hospital setting. Hospital based Heart Failure Units were at high capacity and there was a lengthy waiting list for new patients to be seen in out-patient follow up clinics.

In addition to taking patients from University Hospital Limerick's long waiters list and accepting direct GP and Consultant referrals, the Integrated Care Cardiology Hub also created a follow up pathway for Virtual Ward heart failure patients. This aimed to facilitate rapid follow up of patients in the vulnerable period post discharge after an acute decompensation of their heart failure. It also aimed to effectively implement heart failure guidelines in a more patient friendly environment outside of acute hospitals.

Method: 35 patients treated on the virtual ward for heart failure were followed up in the IC Cardiology Clinic in Limerick over a 6-month period.

Findings:

1. Median follow up time from discharge to first visit in the IC hub was 1.5 weeks (IQR (25, 75); 0.57, 2.5)- less than National KPI of two weeks (National Heart Programme, Heart Failure Model of Care 2021).

2. Cost savings: The average length of stay for heart failure admissions in Ireland is 10.58 days.
Our data; 6.25 days in the acute setting, 9 days on the virtual ward
= average 4.33 acute in inpatient bed days saved.
= an average saving of €6,278.50 per patient per inpatient stay.

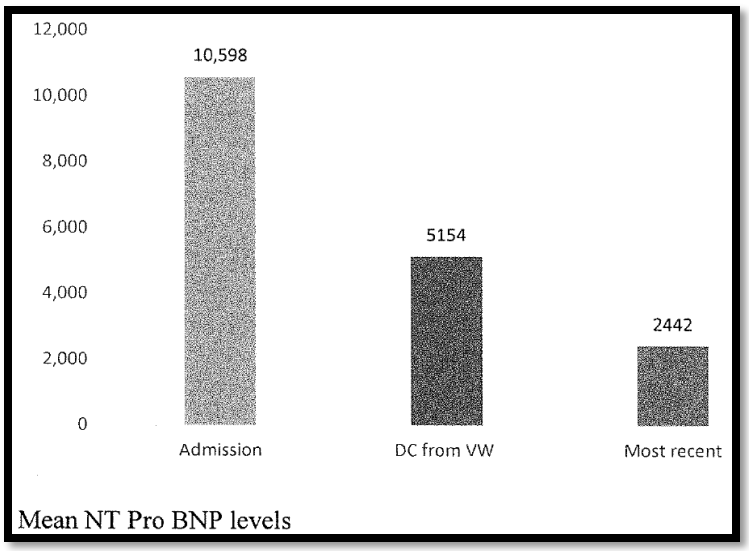
3. 90-day readmission rates: Research shows that approximately 30% of patients are readmitted within 90 days (National Heart Programme, Heart Failure Model of Care 2021).
Our data; 17% of patients were readmitted within 90 days – a 13% reduction from average national predictions.

4. Patient outcomes:
4 pillars of guideline directed medical therapy (GDMT) (RAASi, MRA, BB, SGLT2i)

- On first visit in the hub: 12 of the 16 patients (75%) were on all 4 pillars.
- 3 (19%) were on 3 pillars - 2 of whom were optimised further in the hub onto the 4 pillars
- (an MRA was contraindicated on one case due to renal function).
- 1 patient (6%) was on 2 pillars of GDMT – limited due to severe renal impairment (on dialysis).

Change in ejection fraction: Mean diagnostic EF on admission was 26 +/- 9% with significant improvement to a mean EF 42 +/- 11% on repeat (P<0.001).

Also, there was a significant reduction of NT pro BNP on discharge from the virtual ward as compared to admission (P=0.009). Continued reduction in NT pro BNP at follow-up reflective of ongoing clinical improvement.

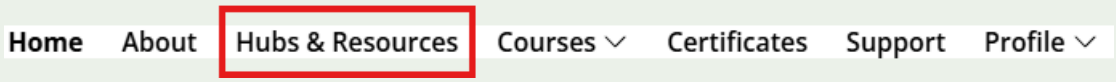
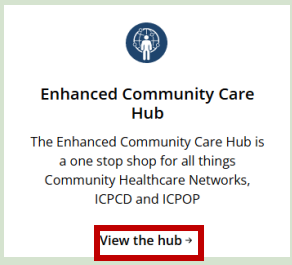
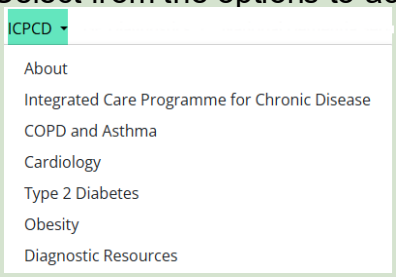


Acute ward care at home with timely follow-up in the IC Cardiology Hub leads to reduced hospital inpatient length of stay and subsequent cost to the Health Service Executive. It offers an opportunity to rapidly up titrate important guideline-directed medical therapy and diuretics in a safe manner.

This study has shown the initiative led to significantly improved patient outcomes including NT pro BNP and LVEF with a further reduction in HF readmission rates.

ICP CD Hubs and Resources

The Hubs and Resources web page is your go-to source for all things related to the ICP CD. The Hub will support your professional development and enhance your knowledge of the Programme. Some key features include the latest news and comprehensive up to date information and resources.

	How to access the ICP CD Hubs and Resources web page
Step 1	Search www.hseland.ie and log in to your account.
Step 2	Select 'Hubs & Resources' from the options across the top of the screen. 
Step 3	Select 'View the hub' on the Enhanced Community Care Hub tile. 
Step 4	Select the 'ICPCD' dropdown menu from the options. Be sure to explore the other options too! 
Step 5	Select from the options to access information and resources in each section. 
Step 6	Explore! The Hubs & Resources page is updated regularly to include the most up to date information, resources and news!