phn EASTERN MELBOURNE

An Australian Government Initiative

2021 Health Needs Assessment Summary

Eastern Melbourne Primary Health Network

Updated October 2023

Acknowledgment

Eastern Melbourne PHN acknowledges the Wurundjeri people and other people of the Kulin Nations on whose unceded lands our work in the community takes place. We pay our respect to Aboriginal and Torres Strait Islander cultures; and to Elders past and present. EMPHN is committed to the healing of country, working towards equity in health outcomes, and the ongoing journey of reconciliation.

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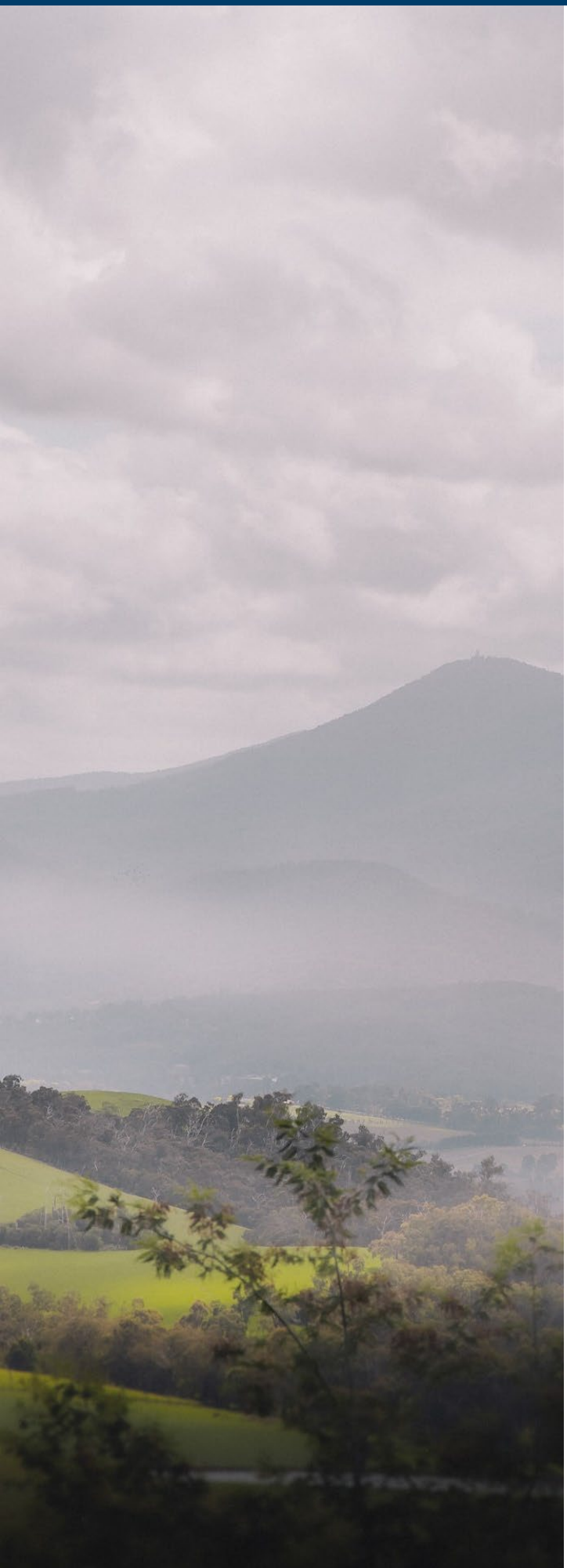


About EMPHN

Eastern Melbourne PHN (EMPHN) is a Primary Health Network principally funded by the Australian Government to **improve** the **care** and **support** people receive from health services.

Specifically, EMPHN aims to increase the **efficiency** of medical services, **reduce fragmentation** of care, and improve health **outcomes** for everyone, especially for the most vulnerable.

EMPHN achieves these goals by **improving access** to existing services, **commissioning** services to improve health outcomes and **supporting GPs** and other health professionals to innovate and further improve local health care.

EMPHN's purpose is to ensure people receive the **right care**, in the **right place**, at the **right time**.

EMPHN works across three key domains:

1. **Commissioning:** EMPHN works closely with health professionals, consumers, carers and data to identify emerging community needs and gaps in the healthcare system. Programs and services are then funded to address these.
2. **Supporting general practice:** EMPHN supports general practice with quality improvement through professional development, summary data reports, and support to become future-ready.
3. **Digital health:** EMPHN supports primary care by funding digital solutions that make the health system work more efficiently.

What is a health needs assessment?

Conducting a health needs assessment helps EMPHN better understand local health needs

Primary Health Networks operate across Australia to improve the efficiency, effectiveness, and coordination of primary health services.

Each PHN regularly conducts **health needs assessments** (HNAs) to investigate the health challenges facing communities and inform **understanding of local needs and priorities.**

An HNA involves **detailed and systematic investigation** using both quantitative and qualitative data to understand:

1. The characteristics of the population living within a catchment
2. Their health experiences
3. The availability and access of health services

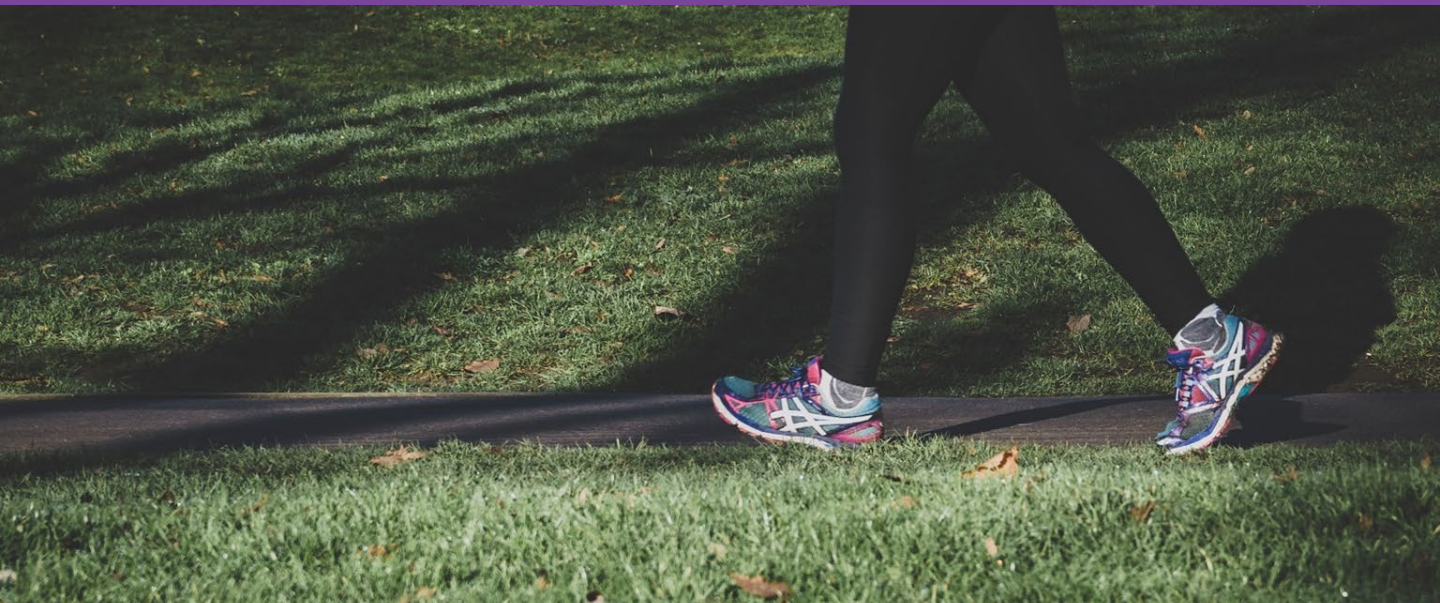
These health and health service needs are then **synthesised** and **prioritised**.

EMPHN's HNA is a foundation of the organisation's **annual planning** and is used to inform **investment decisions**. It is also a key tool in **collaborating** with neighbouring

This report **summarises the main findings of EMPHN's 2021 HNA, and the actions EMPHN is taking to address these findings.**

A HNA is a method of identifying the health needs of a population. It informs a PHN's understanding of their region by ensuring they undertake a detailed and systematic assessment of the regional population's health needs, the local health care services, and engages in stakeholder and community consultation. This process identifies service gaps, key issues, and sets the regional priorities.

PHN Program Needs Assessment Policy Guide 2021. Canberra: Australian Government Department of Health; 2021



The EMPHN 2021 HNA was developed using a structured methodology

A structured methodology is the backbone of a HNA, providing the framework for collecting, analysing, and interpreting data in a systematic and reliable manner. It ensures that the resulting outcomes accurately reflect the health needs of a population and provides a solid foundation for effective decision-making and resource allocation.

The data used for EMPHN's 2021 HNA was sourced from general practices (over 80%), hospitals, the 2011, 2016 and 2021 ABS censuses, Turning Point AODstats March 2023, noting data from Mitchell, Murrindindi and Yarra Ranges includes the entire LGA rather than just the EMPHN proportion. A catchment-wide community member survey was conducted about health service usage, barriers to accessing services and their health and well-being.

Patient-level hospital admission and emergency department (ED) presentation data was sourced from the Victorian Admitted Episodes Dataset, and the Victorian Emergency Minimum Dataset. All general practice and hospital data is de-identified.

A summary of the methodology and governance used for the 2021 HNA is below.

1. **De-identified** patient data from **general practice, hospital admissions, and emergency department presentations**, and population data from the **2011, 2016 and 2021 ABS Censuses** was collected and analysed
2. Interpretation of analytics was supported and guided by an **epidemiologist** with extensive primary health care experience.
3. Findings from a **catchment-wide** community member survey about **health service usage**, **barriers** to accessing services and **health and wellbeing** over the previous 12 months were included.
4. Key needs assessment findings were presented to the EMPHN **Clinical Council** and **EMPHN Community Advisory Committee** for critical review.
5. Key needs assessment findings were presented to the EMPHN **Board**, who **reviewed** and **approved** all findings.

EMPHN catchment overview

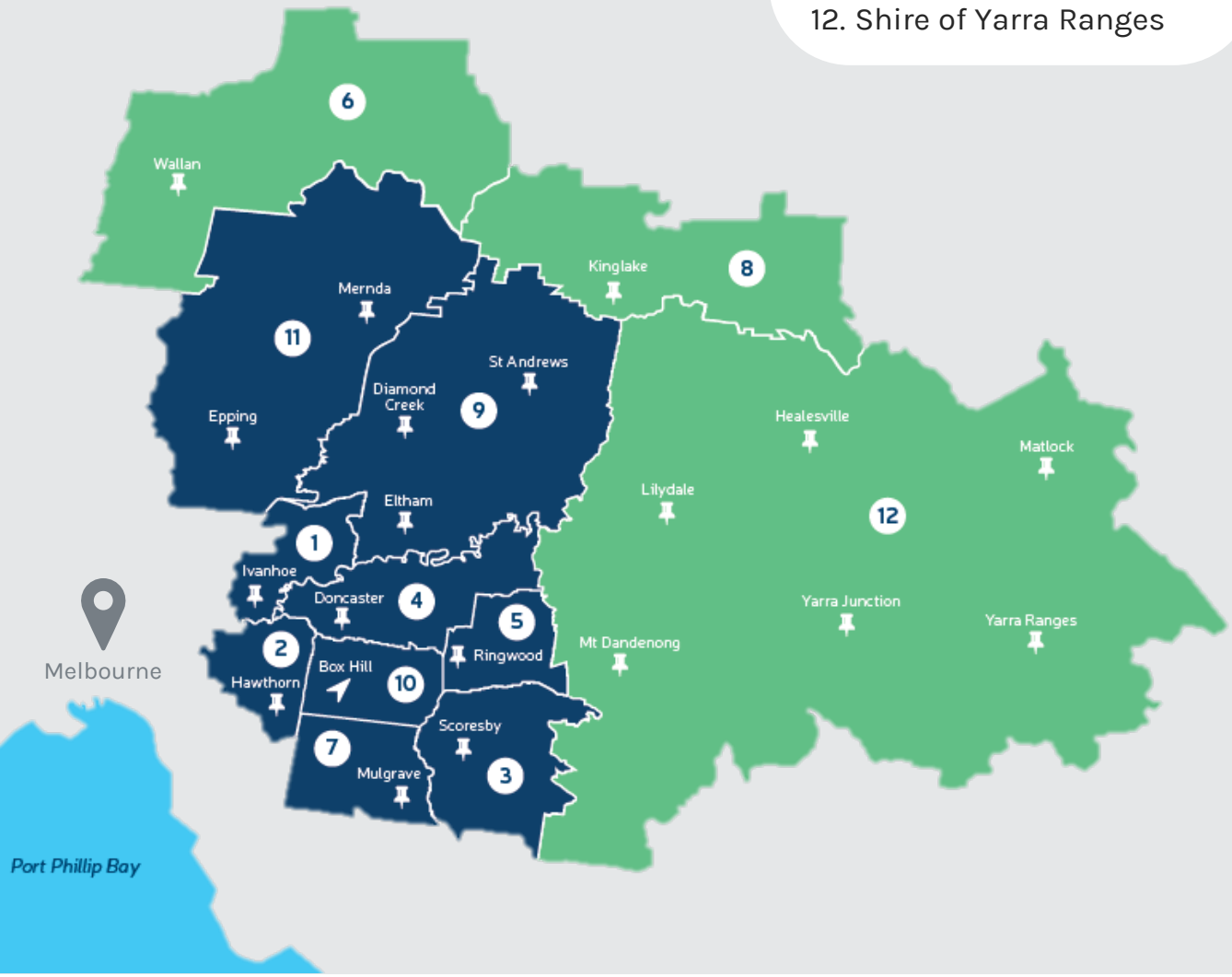
The EMPHN catchment spans across **12 Local Government Areas** and covers almost **4,000 square kilometres**.

EMPHN is home to a diverse population of over **1.6 million people**, making it one of the largest PHNs by population size. EMPHN accounts for more than a **quarter** of the Victorian population.

1. City of Banyule
2. City of Boroondara
3. City of Knox
4. City of Manningham
5. City of Maroondah
6. Shire of Mitchell
7. City of Monash
8. Shire of Murrindindi
9. Shire of Nillumbik
10. City of Whitehorse
11. City of Whittlesea
12. Shire of Yarra Ranges

EASTERN MELBOURNE PHN

- All of local government area
- Part of local government area



EMPHN has a diverse and rapidly growing population

The EMPHN population is growing rapidly, particularly in Whittlesea and Mitchell LGAs. The overall EMPHN population increased by 6.5% between 2016 and 2021, which is faster than Victoria's 5.1% population increase over the same period. With any population growth comes an abundance of health and service challenges which EMPHN will continue to prioritise.

The median age of the EMPHN population (40.2) has also increased, with 18.3% of people now **aged over 65 years.**

Significant variation also exists in **socio-economic status** between LGAs; The EMPHN catchment contains some of the most advantaged and most disadvantaged postcodes in Australia.

EMPHN is characterised by **diversity**; over half a million of the 1.6 million people living in the catchment were born overseas, and 26% speak a language other than English. 10,099 people living in the EMPHN catchment identify as Aboriginal and Torres Strait Islander Peoples (First Peoples). EMPHN is committed to a more meaningful analysis of the health needs of First Peoples, in partnership with community. This will be explored in the coming year.

Rapid population growth

The EMPHN population **increased by 6.5%** between 2016 and 2021. **Whittlesea** and **Mitchell** LGAs had the largest population increases.

Ageing population

There has been a rise in the median age of the population. **18.3%** of the EMPHN population is now aged over 65 years and this is projected to increase further.

Varied socio-economic status

EMPHN has significant variability in **socio-economic status**. **Mitchell**, **Murrindindi**, and **Whittlesea** are the LGAs experiencing the most disadvantage.

High cultural diversity

EMPHN has **high cultural diversity**, with **36.3%** of people born overseas and an average of **26%** speaking a language other than English (LGAs range from 4-52%).

Growing First People's population

0.8% of the EMPHN catchment identify as First Peoples. This is lower than the proportions in Victoria and Australia, but it is steadily increasing.

Priority needs in the EMPHN catchment

Priority socio-demographic needs were identified in the EMPHN catchment

Sociodemographic needs

Sociodemographic needs relate to a population's social, demographic and cultural aspects. The main findings from the HNA include:

EMPHN has a growing number of **older persons**, who have specific health and social needs.

EMPHN is a catchment characterised by **cultural and linguistic diversity**, which requires investment in culturally appropriate and tailored services.

There could be higher utilisation of some MBS funded health checks designed for **First Peoples**, suggesting a need to increase local practitioner awareness or cultural safety of services.

Older persons

Feelings of **loneliness** and **isolation** are common among older people and the local health system needs to adjust to meet their health needs.

Culturally & linguistically diverse populations

Services need to better support community members with low English proficiency and low health literacy. There is a need for more **culturally safe** services.

First Peoples

There is a need for more **culturally safe services** for the growing population of First Peoples, and to increase the uptake of prevention and early detection **health checks**.

Priority health needs were identified in the EMPHN catchment

Health needs

Health needs refer to the **prevalence of health conditions** in a population or community, their **severity,** and their **impact** on long-term wellbeing.

General practice, hospitalisation, ambulance, and emergency department data provide insights into the severity of health needs. Potentially preventable hospitalisation (PPH) data can provide insights regarding health system accessibility and effectiveness and are strongly influenced by social determinants. The highest rates of PPH admissions were vaccine preventable conditions including pneumonia and influenza, followed by iron deficiency anaemia, diabetes and cardiac failure.

The main health needs findings from the 2021 HNA include:

The prevalence of common chronic diseases such as cardiovascular disease, diabetes, respiratory disease, osteoporosis and arthritis are broadly the same as (or lower than) the Victorian average and **increasing over** time. Survey data indicates 3 out of 4 people are **concerned about chronic disease**. PPHs related to chronic disease in EMPHN are likely related to social determinants of health.

In 2021 **mental health was the most prevalent chronic condition** in general practices, overtaking cardiovascular disease. In areas of higher GP visits for mental health (MH) concerns, such as Mitchell LGA, there tends to be lower ED MH presentations.

The rate of hospitalisation associated with **substance misuse** increased 25% between 2017-2019. More recent data indicate a reduction in hospitalisations due to alcohol and other drugs, which may be due to pandemic response measures. In 2021 people aged 45-54 had the highest rates of alcohol-related hospitalisation, while people aged 25-34 had the highest rates of hospitalisations for pharmaceutical and illicit drugs. This indicates a need to **build capacity in primary care** to address alcohol and other drug issues, particularly in these age groups.

Chronic conditions

Chronic conditions have increased. There is a high rate of **potentially preventable hospitalisations** relating to chronic conditions in the most socioeconomically disadvantaged LGAs.

Mental health

There has been an increase in mental health presentations at **general practices** and **emergency departments**, compared to previous years. This has likely been influenced by the COVID-19 pandemic.

Alcohol and other drugs

More support is needed to reduce high and increasing rates of alcohol and illicit drug-related **ambulance** presentations and **hospitalisations**.

Priority health service needs were identified in the EMPHN catchment

Health service needs

Health service needs relate to the supply and characteristics of health care services within a population or community.

The main findings of health service needs from the 2021 HNA include:

Workforce shortages, compounded by the pandemic and **inequality in access** to primary care health professionals, including general practitioners and mental health professionals, in areas of higher socio-economic disadvantage across EMPHN. Modelling indicates that such areas should have a larger workforce to support higher need.

Data quality and digital communication between service providers could also be improved, particularly between GPs in Monash LGA and Monash LHN.

General practice workforce

Primary care workforce shortages continue to be a challenge, particularly in areas of higher socioeconomic disadvantage

Digital health

Higher usage of electronic referrals along with more complete and effective use of primary care data would improve workflows and efficiency

EMPHN actions to address priority needs

EMPHN is acting in response to the identified priority socio-demographic needs

The main findings from the 2021 HNA have been instrumental in informing EMPHN decision-making around investment and priority initiatives over the past two years.

EMPHN has prioritised several actions and initiatives to address the priority **socio-demographic needs** identified in the 2021 HNA that were described on page 8.

Older persons

- EMPHN's **Care Finder Program** has a strong social support focus. There is a tailored version for people who identify as First Peoples
- EMPHN's **Healthy Ageing Service Response Program** provides focused support for mild to moderate mental health issues in residential aged care homes and the community.

Culturally and linguistically diverse populations

- All EMPHN-commissioned services have **multicultural support requirements**, including cultural awareness training.
- Commitment to **cultural safety** is now a key criteria when assessing tenders
- EMPHN commissions **multicultural-specific services** where possible, for example the Migrant Information Centre.

First Peoples

- EMPHN's **Integrated Team Care Program** seeks to increase the uptake of prevention and early detection health checks in mainstream services.
- **Wrap-around services** are funded through communities such as Bubup Wilam Aboriginal Child and Family Centre and Oonah Health and Community Services.

EMPHN is acting in response to the identified priority health needs

The priority health needs identified through this HNA are the result of a complex interplay of factors. The actions taken by EMPHN to address these needs are focused on prioritising **care in the community**, **evidence-based programs**, and services that are cognisant of the **social determinants of health** as well as the biomedical aspects of health.

Chronic conditions

- EMPHN commissions the **Right Care = Better Health** care coordination program for complex chronic condition management in the community.
- EMPHN is conducting an **evidence review** to understand the characteristics of programs that best help people with chronic and complex conditions to manage their health better in the community, and prevent hospitalisations.

Mental health

- EMPHN supports an **after-hours mental health liaison service** that diverts crisis care from emergency departments.
- EMPHN is re-designing the **Mental Health Stepped Care Model** in consideration of the emergence of the State–funded Adult and Older Persons' Health and Wellbeing Hubs.
- EMPHN is reviewing all mental health programs to understand important **service gaps** and inform future EMPHN services.

Alcohol and other drugs

- EMPHN continues to deliver multiple diagnosis, peer-support, treatment and recovery programs focused on supporting people experiencing issues with **alcohol** or **drug use**.
- EMPHN is exploring how alcohol and other drug programs can **integrate with other mental health programs** to provide better consumer experiences and outcomes.

EMPHN is acting in response to the identified priority service needs

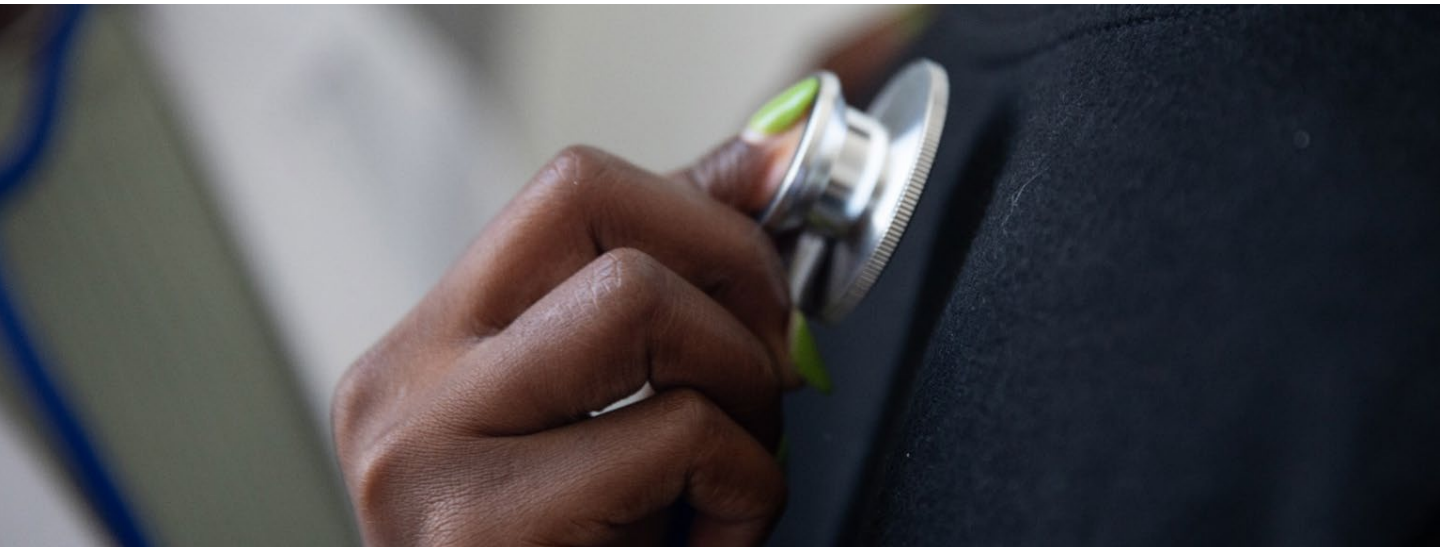
EMPHN has taken several actions to address the priority service needs identified in the 2021 HNA, including **workforce shortages** in areas of higher socio-economic disadvantage and **low electronic referral use**.

General practice workforce

- Regular **capacity building** services for general practices including practice development, accreditation, using data for practice population health and quality improvement.
- Partner with hospitals services to provide **primary and acute care integration programs**, where hospital specialists support GPs in care provision.
- Digital health team provides **access** to education to build practice capabilities in digital health, practice management and clinical management.

Digital health

- Provide ongoing **support for MyHealthRecord,** for general practices, specialists, registered Aged Care Facilities and consumers.
- Implementing a project for community health providers to support consistent use of **patient-centred eHealth tools**
- Provide support for **digital enablement** in general practice and residential aged care facilities.



Illustrative personas

These illustrative personas are inspired by the priority needs identified within the EMPHN catchment, current EMPHN interventions and how these interventions are expected to lead to positive outcomes

EMPHN initiatives interrupt cycles of socio-demographic and health needs

Name: **Bailey**
Age: **40 years old**
Lives in: **Whittlesea LGA**

Bailey is **unable** to work to full capacity due to **unstable type 2 diabetes**. They are experiencing **high rental stress** due to rapid population growth in their LGA. Bailey is not currently able to afford **fresh fruit and vegetables**.

Bailey has **low English proficiency** and **health literacy**. Bailey is a **daily smoker** and does not have **private health insurance**.

EMPHN interventions

EMPHN investment in **after-hours primary care** supports Bailey to access affordable care around their irregular schedule. Here, they can connect to a **smoking cessation program** and access support to **increase** their **health literacy**.
Bailey attends the **Integrated Diabetes Education and Assessment Service (IDEAS)** clinic to better manage their diabetes.

EMPHN investment in **HealthPathways** and **digital health** supports Bailey's GP to make referrals and easily **communicate** with other services.

EMPHN's commitment to services for **culturally** and **linguistically diverse populations** supports Bailey's clinicians to provide **culturally-responsive** and **respectful care**.

Bailey confidently self-manages their type 2 diabetes and attends **regular checkups with a GP they can relate to**. They can now return to **work full-time**. They are experiencing **reduced rental stress** and can afford **fresh fruit and vegetables**.

Bailey has **increased** their **health literacy** and **actively participates** in their care decisions. Bailey has **successfully** stopped smoking.

EMPHN initiatives support priority health and service needs

Name: **Alex**
Age: **75 years old**
Lives in: **Nillumbik LGA**

Alex has previously been well and independent, however, recently began to experience **anxiety** and **depression**. Alex **lives alone** and is now struggling to take good care of himself.

Alex has **limited family** and **social supports** and often finds he has not interacted with anyone for over a week. If Alex's mental health **deteriorates,** he will present to an ED and require **acute** treatment.

EMPHN interventions

Alex presents at a **Priority Primary Care Centre** for a laceration and is referred to a local GP for after care.

Alex accesses the EMPHN **Healthy Ageing Service Response** program and receive **multi-disciplinary support** to improve his mental health. He also attends community **capacity-building** sessions.

Alex is supported by the EMPHN **Care Finder** program, which connects him with **social supports** in the local community. The Care Finder also supports him to improve his **quality of life** so that he can continue to live **independently**.

Alex **confidently manages** his anxiety and depression and seeks help when needed. He can continue **living independently** and healthily in his own home and he receives regular check-ins from his Care Finder.

Alex now has social supports in his local community, established through Care Finder, and has **weekly meaningful interactions** with others.
Alex has a **GP he trusts** and no longer requires acute care for his mental health.

EMPHN is committed to investing in initiatives that continue to meet the needs identified in the 2021 HNA

EMPHN is using health-related data and working closely with health professionals, consumers and carers to identify **emerging community needs** and **gaps** in the healthcare system. EMPHN is committed to investing in a range of initiatives that meet the diverse needs of the EMPHN community and **make a difference** in identified priority areas. EMPHN health needs assessment data will be updated in 2024-2025.