phn
EASTERN MELBOURNE
An Australian Government Initiative

Partnering for better community care

Annual Report 2021

The Australian Government is the principal funding body for Primary Health Networks (PHN).

We acknowledge and pay our respects to the Wurundjeri people and other peoples of the Kulin Nation on whose unceded lands our work in the community takes place. We respectfully acknowledge their Ancestors and Elders past, present and emerging.

We recognise and value the knowledge and wisdom of people with lived experience, their supporters and the practitioners who work with them. We celebrate their strengths and resilience in facing the challenges associated with their recovery and acknowledge the important contribution that they make to the development and delivery of health and community services.

Eastern Melbourne PHN values inclusion and diversity and is committed to providing safe, culturally appropriate and inclusive services for all people, regardless of ethnicity, faith, disability, sexuality, gender identity or health status.

Names have been changed to protect the anonymity of consumers.

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Message from our CEO

Janine Wilson
Chief Executive Officer

In my first year as CEO of EMPHN, I was honoured to work alongside our passionate and dedicated team as we continued to drive the organisation's transformational strategy whilst responding to the COVID-19 pandemic.

Early in FY21, our team was providing COVID-19 outbreak support for Residential Aged Care Facilities (RACFs) in our community, at the height of Melbourne's 2nd COVID lockdown. This support was tailored to the needs of individual RACFs, with a focus on resident well-being during a time of significant community anxiety and frequently changing information. We were also working with our health partners in local health networks, community health and general practices to develop and utilise clinical pathways for those community members who did not require hospitalisation with their COVID-19 infection. This ensured wrap-around support that covered health and social needs.

As Melbourne emerged from the major 2020 lockdown where the focus was on managing COVID-19 outbreaks, the Commonwealth's vaccination initiative commenced, with PHNs being tasked with facilitating the on-boarding of general practices to the program. Between February and June 2021, EMPHN worked closely with more than 300 local general practices – providing on-boarding support, troubleshooting advice and ongoing communications regarding vaccine supply and policy changes. We take our hats off to these incredible health professionals in general practices everywhere, who have gone over and above to ensure that our communities are safe and that a return to some kind of post-COVID "normal" can be achieved.

Concurrent with these critical roles in support of the COVID Response, EMPHN distributed more than 1 million items of Personal Protective Equipment (PPE) to primary care providers in our community who could not otherwise access them. We also worked alongside our Victorian PHN colleagues in the establishment of the Commonwealth-funded HeadtoHelp service, which was designed to respond to the rising demand for mental health support as a result of the pandemic and associated social restrictions. This required a concerted collaborative effort across the state and was a highlight for myself and the EMPHN team as we saw the benefits of working together and aligning our clinical models, communication approaches and use of data.

Like organisations everywhere, EMPHN was required to fulfil its mission and support the COVID response while working remotely and managing the stress of living through a pandemic. Our team was able to achieve great outcomes for our community whilst home-schooling, enduring isolation, managing the mental health of themselves and their loved ones, and so on. I am immensely proud of the supportive environment that the team has created for each other and for those that we work with every day in our partner organisations.

Testament to this has been the organisation's commitment to EMPHN's Values, which we revised and launched during the FY21 year. Our new Values of Courage, Working Together and Integrity were developed during lockdown with great input and engagement from the whole team.

We also launched our Innovate Reconciliation Action Plan this year. Our vision for reconciliation is to embark in genuine and empowering partnerships that foster and support wellbeing, self-determination and resilience in the Aboriginal and Torres Strait Islander community, using a multigenerational, equitable and a dignified approach.

EMPHN revised its Commissioning Framework, incorporating changes that will drive greater outcomes for our community – including a greater focus on cultural awareness and the use of evidence and data to drive decision-making. One critical element of commissioning is that of evaluation. We use monitoring and evaluation to help ensure that what we commission delivers the required services and outcomes for our community, and provides value for money. A significant evaluation during this year was that of our Stepped Care Model commissioned services, which were established in 2018 with a vision to enable truly integrated mental health services for those in most need in our community. The recommendations of the evaluation have been adopted and we are in the process of applying them to the program and ensuring that we continue to improve outcomes.

All of this would not have been possible without the commitment, expertise and support of EMPHN's Board. I would like to thank Dr Stephen Duckett as our Chair, for his thought leadership for the team and for his support of me in my first year as CEO.

Message from our Chair

Dr Stephen Duckett
Chair

For almost two years the work of EMPHN has been about helping the primary care system respond to the ravages of SARS-CoV-2. Our staff have dealt with the trials and tribulations of the vaccine rollout and stepped-up time and time again to mitigate inadequate supply and help maximise the number of people vaccinated, especially residents and staff of residential aged care. We also moved quickly to support general practice — redeploying staff from other projects into the COVID response, distributing personal protective equipment and providing testing assistance. Our not-for-profit structure meant we didn't have to focus on financial returns to shareholders, but rather our support to stakeholders and the community.

COVID brought many stresses onto the primary care system and created opportunities. I want to highlight one: telehealth. Our new infectious environment caused a pivot to telehealth with payment systems – and sometimes practice systems – not ready. Telehealth policy must strengthen good primary care, not weaken it. It needs to encourage continuity of care and facilitate responsiveness to a patient's need. This is an important design task which still requires more work on the Commonwealth's behalf to get the Medicare Benefits Scheme (MBS) telehealth settings right.

The 2019-20 federal budget included an allocation for a voluntary patient registration system for people over 70. Late in 2020, the government released the final report of its MBS review, including recommendations about primary care which again referred to voluntary patient registration/enrolment. Then there was a discussion paper about a 10-year primary health care plan. This paper again refers to voluntary patient enrolment, this time as a 'building block for reform, helping formalise a single health care reference point'. This policy direction is not new: the 2009 final report of the National Health and Hospitals Reform Commission supported voluntary enrolment, as did a 2015 report on primary care.

I agree with this policy, as do the *RACGP*, *AMA* and *College of Rural and Remote Medicine*. Unfortunately, these reports are not cumulative — they simply reiterate the same idea without progressing it in a meaningful way. Sometimes the idea is voluntary patient registration — no money changes hands but the patient may get access to telehealth items. There is a big difference between a patient enrolment scheme which pays a practice or practitioner an enrolment fee of $10 a year and one which pays $10,000. The most likely (eventual) amount will lie between these two extremes but one closer to the lower end will involve lower expectations of what the practice must provide to the enrolled person compared to a payment at the higher end. However, any shift to patient registration or enrolment is to be welcomed. Such a shift creates a patient population which is linked to the practice and provides the basis for measurement of, and improvement in, quality of primary care. It has the potential to reduce waste, for example, ensuring that care plans are developed by the GPs who know the patient best.

My own view is that primary care will be stronger with a bigger enrolment fee rather than a smaller one, with concomitantly greater expectations on the practice. This scenario is key to ensuring good quality primary care management of chronic disease.

With a larger fee we could see expectations about telehealth availability, multi-disciplinary practice, employing nurses for pro-active care and calling patients to see how they are going, enhanced expectations about recall systems for preventive care, and better engagement about mental illness.

What does this all mean for a PHN? An enhanced emphasis on enrolment funding could be accompanied by more local accountability in accreditation, and more feedback to practices, and this could be a key role for EMPHN.

Enrolment funding should be substantial and in addition to existing primary care funding to help redress the current underfunding of primary care. It would help make general practice a more attractive career choice, benefiting all primary care professionals and patients alike. It would also help the PHN in its emphasis on both improving primary care and the health of our population.

Enrolment funding won't fix everything, of course, and needs to be supplemented by systems to encourage practices to take on more complex services, such as complex wound dressings or fracture care, which require costs to be passed on to patients at present.

Finally, I would like to congratulate Janine Wilson on her first year as our CEO. Starting as CEO in lockdown has been hard, but Janine is leading the improvement in EMPHN's culture and capability extremely well. A great start.

Thanks are also due to the EMPHN staff who dropped everything and got their hands dirty distributing masks and hitting the phones to ensure vaccines weren't wasted, amongst a myriad of other contributions throughout the year.

I also acknowledge our clinical and consumer stakeholders. Although we had some engagement events (and thanks to those who attended those virtually) our priorities were the immediate challenges of the pandemic and we have not been as consultative as I would've liked. We'll do better next year.

(The policy views here are my own and not necessarily shared by my Board colleagues or staff at EMPHN).

Our CEO and executive team

JANINE WILSON
Chief Executive Officer

Janine is an accomplished executive with 25 years' experience in the health sector, where she has held strategic, operational, marketing and general management roles. Prior to joining EMPHN in 2020, Janine oversaw the establishment and ongoing operation of Telstra Health's National Cancer Screening Register (NCSR), operated on behalf of the Commonwealth Department of Health and supporting screening for cervical and bowel cancer. Prior to this, Janine held a number of executive roles with the Australian Red Cross Blood Service (now "Lifeblood") and in the American healthcare system as Director of Strategy for the New York Blood Center. Janine holds an MBA from Melbourne Business School, where she was the recipient of the Helen McPherson-Smith Scholarship.

HARRY PATSAMANIS
Executive Director Primary Health Integration and System Design Unit

Harry has worked in healthcare for more than 26 years developing a comprehensive understanding of the health system and the challenges associated with providing true patient centred quality care. Prior to joining Eastern Melbourne PHN in 2018, Harry held a senior role with the Heart Foundation, where he was instrumental in implementing key campaigns in prevention, heart attack awareness, cardiac rehabilitation and heart failure. Harry is a co-author of nine publications and has held advisory roles at a state level in cardiac care. After more than four years with EMPHN Harry resigned his position in August 2021 to take up new challenges.

Harry Patsamanis

James Scott

Nadia Marsh

Narelle Quinn

Christopher Wheatley

JAMES SCOTT
Executive Director Corporate Services Unit

James is a Chartered Accountant and has worked for commercial organisations in the airline and financial consulting sectors and in local government. Prior to joining Eastern Melbourne PHN in 2018, he was the Director Corporate Services at Moreland City Council where he drove significant improvements in financial outcomes and long-term financial planning, implemented major technology upgrades and led large, diverse teams. In addition, he is a board director of the Australian Energy Foundation (AEF).

NADIA MARSH
Executive Director Governance. Risk and Compliance Unit

Nadia is a management professional with 20 years of experience gained with health and research institutions in corporate, university and not-for-profit sectors. Nadia is highly experienced in organisational start up, including organisational design, staff recruitment, infrastructure and info tech establishment, and strategic planning. She has held Company Secretary roles within the not-for-profit sector, and senior management roles within the Australian university sector. She holds a Masters of Public Health and is a graduate of the Australian Institute of Company Directors.

NARELLE QUINN
Executive Director Program Delivery and Service Enhancement Unit

Narelle is a senior program manager with extensive experience in the primary care sector. She is known for her ability to strategically plan, lead, support and develop capacity with teams and the health care sector. Narelle successfully engages stakeholders across organisational types and all levels of staffing. Her comprehensive project management skills include planning, implementing and evaluating. Over nine years in the Medicare Local/PHN sector Narelle has gained experience in beginning to end commissioning, including implementation and ongoing performance management to realise optimum outcomes for the community.

CHRISTOPHER WHEATLEY
Executive Director System Improvement and Development Unit

Christopher's experience is in leading a range of teams responsible for strategy implementation and planning, whole-of-organisation performance measurement (including across strategy, operations and finances, and outcome measurement), information technology, people and culture, and legal and compliance. He has held a number of roles in the health and social services sectors, including Australian Red Cross and Medibank Private, and in the Australian Government. Christopher has a Bachelor of Science degree with first class honours in Psychology and an MBA from UNSW.

Our Board

Eastern Melbourne PHN is governed by a Board in accordance with its Constitution.

DR STEPHEN DUCKETT

Board Chair; Chair, Nomination, Remuneration and People Committee; Member, Strategy and Risk Committee; Member, Clinical Council; Member, Community Advisory Committee

Stephen is Director of the Health and Aged Care Program at Grattan Institute. An economist, he is a Fellow of the Academy of the Social Sciences in Australia, the Australian Academy of Health and Medical Sciences, and the Australian Institute of Company Directors. He is an Honorary Enterprise Professor in the Department of General Practice at The University of Melbourne.

ROBYN BATTEN

Board Member; Member, Nomination, Remuneration and People Committee

Robyn has held CEO and executive director positions in health, local government, community and aged care in Victoria, South Australia, Queensland and the Northern Territory. She is the Chair of Western Health, a non-executive director of Uniting Victoria and Tasmania and Uniting Housing Australia, the Executive Chair of Leap in! and the Vice Chairman of MIM China Pty Ltd. Robyn holds a Bachelor of Social Work, Masters of Social Work, Masters of Business Administration and is a Fellow of the Australian Institute of Company Directors.

PROF. JANE GUNN

Board Member; Chair, Strategy and Risk Committee; Member, Clinical Council

Jane is a distinguished clinician scientist with extensive experience in primary care research as well as hospital and not-for-profit governance. Since 2018 she has held the position of Deputy Dean in the Faculty of Medicine, Dentistry and Health Sciences (MDHS) at the University of Melbourne, and in February 2021 commenced as Dean. She is a past Board member of the Peter MacCallum Cancer Centre and a current Board Director of Melbourne Health, The Florey Institute of Neuroscience and Mental Health, The Murdoch Children's Research Institute, The Melbourne Academic Centre for Health, The Walter and Eliza Hall Institute (WEHI) and Dental Health Services Victoria.

ELIZABETH KENNEDY

Board Member; Member, Finance, Audit and Value Committee

Elizabeth was formerly the General Counsel and Corporate Secretary of Peter MacCallum Cancer Centre, having previously held Corporate Counsel roles at a number of health organisations including Epworth HealthCare, The Royal Women's Hospital, The Royal Children's Hospital and Southern Health. Elizabeth is a Director of Western Health and the Australian Psychological Society, and the lawyer member of the Victorian Pharmacy Authority, and Council member of Janet Clarke Hall.

TONY MCBRIDE

Board Member; Member, Strategy and Risk Committee; Member, Community Advisory Committee

Tony has had a long involvement in advocacy for a more equitable health system, especially stronger primary health and more accessible oral health care, and more consumer-centric care. He is Board Chair of Your Community Health and the Spokesperson for the Victorian Oral Health Alliance, and sits on a number of State and national committees. He was previously Chair of the Australian Health Care Reform Alliance and CEO of Health Issues Centre. He is a Graduate of the Australian Institute of Company Directors.

TERRY SYMONDS

Board Member; Member, Strategy and Risk Committee

Terry has held senior leadership positions in government and worked closely for over a decade with Boards of public health services across Victoria. He was the Deputy Secretary, Health and Wellbeing at the Victorian Government's Department of Health and Human Services for several years before his appointment as CEO of Yooralla in March 2021. He is a Graduate of the Australian Institute of Company Directors (GAICD).

Our Board

TIM FLOWERS

Board Member; Chair, Finance, Audit and Value Committee; Chair, Community Advisory Committee

Tim has extensive expertise in financial reporting, enterprise management and governance and a passion for supporting organisations to successfully work within the NDIS. He has extensive experience working with the disability and community health sector as well as peak bodies, funders and government departments.

DR CAROLINE JOHNSON

Board Member; Member, Strategy and Risk Committee; Chair, Clinical Council

Caroline is a practicing General Practitioner, Senior Lecturer at the University of Melbourne's Department of General Practice and provides vocational training for GP registrars. She is actively involved in mental health advocacy work through the Royal Australian College of General Practitioners.

JASON MIFSUD

Board Member; Member, Finance, Audit and Value Committee

Jason is a proud and active member of the Kirrae Wurrung, Peek Wurrung and Tjab Wurrung people of the Gunditjmara nation in south-west Victoria. He is an experienced non-executive director and has led significant cultural and organisational change through a number of high-profile positions over the past 20 years. He is currently the Head of First Nations Affairs & Enterprise at Wesfarmers and is a tireless advocate for social justice, Indigenous rights and reconciliation.

Also serving as a director during 2020-21 –
DR LEONIE KATEKAR (retired 13 November 2020)

Independent Board Committee members:

GABRIELLE BELL

Nomination, Remuneration and People Committee

Gabrielle is a corporate lawyer with broad experience working in Australia and South East Asia. During her career she has specialised in corporate advisory, including corporate governance, mergers and acquisitions and capital markets. She is an experienced non-executive Director and Company Secretary, and is currently serving on the boards of South East Water Corporation and Aware Super. Gabrielle holds a Bachelor of Law and Bachelor of Engineering (Chemical) from the University of Melbourne and is a graduate of the Australian Institute of Company Directors.

ANNE HEYES

Nomination, Remuneration and People Committee

Anne has over 35 years of experience in human resources having worked in both private and public enterprise and more recently in the NFP sector heading up the People and Culture function for the Australian Red Cross Blood Service. She has led HR functions and been part of the Executive team for the last 20 years, guiding organisations through transformational and cultural change in response to ever-changing market conditions.

TARYN RULTON

Member, Finance, Audit and Value Committee

Taryn leads commercially focused reform projects at La Trobe University, building on a successful career as CFO and COO in the public health, justice and education sectors. She has an extensive background in financial management, being a former State Chair of Chartered Accountants ANZ's Regional Council and board member of the AASB. Taryn has held governance positions within the alcohol and other drugs and Community Health Sector and is a Board Member at Possability Group, a large multi-state disability services provider, and the International Federation of Accountants.

Clinical Council Members:

Dr Emrana Alavi, Carolyn Bates, Dr Malcolm Clark, Michelle Cornelius, Dr Penny Gaskell, Dr Shelly McIllree, Dr Dean Membrey, Andrew Robinson.

Community Advisory Committee Members:

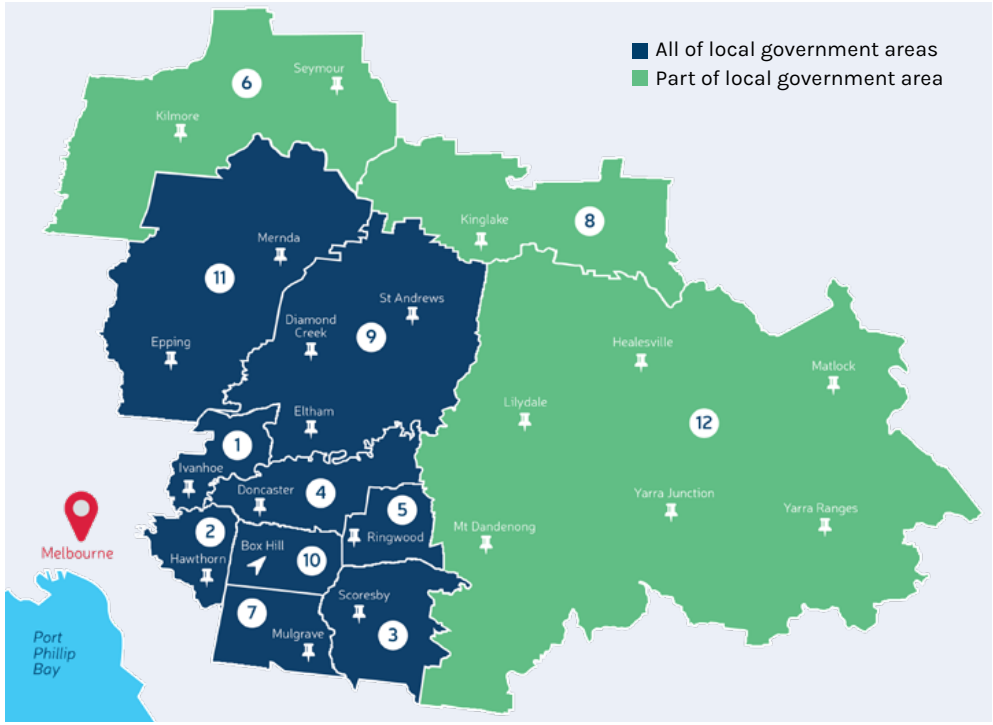
Sophy Athan, Kevin Feeney, Wina Kung, Heather McMinn, Marie Piu, Hamish Russell, Amelia Walters.

More than a third (36%) of our population was born overseas and 33% speak a language other than English at home.

Our Community

The Eastern Melbourne PHN catchment covers people living in the east and north east of Melbourne. It has a diverse mix of ethnicities, socio-economic status and health needs among its residents. There are areas of high need that require a focused primary health response. These include:

- pockets of entrenched socioeconomic disadvantage in West Heidelberg and parts of Knox.
- concentrations of non-English speaking groups in the inner east, particularly Monash. More than a third (36%) of our population was born overseas and 33% speak a language other than English at home.
- The Eastern Melbourne PHN catchment population is approx. 1.62 million (24% of the Victorian population). It is estimated to grow to 1.85 million by 2031.
- More than 7,300 Aboriginal and Torres Strait Islander peoples live in the catchment, mostly within Knox, Banyule, Whittlesea-Wallan and Yarra Ranges.
- The top three languages spoken are Chinese, Indo Aryan and Greek.
- In the past 12 months mental health care has overtaken cardiovascular disease as the number one chronic health condition.
- More than 70,000 people require assistance on a daily basis.
- 431 GP clinics operate in our catchment.
- Seven public hospitals operate in our catchment.
- 121 mental health service providers operate in our catchment.



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

24%
of the Victorian population live in the catchment area

431
GP clinics operate in our catchment

33%
speak a language other than English at home

121
mental health service providers operate in our catchment

What we do

Our primary healthcare providers and services

Eastern Melbourne PHN engages regularly with a range of health professionals and organisations including:

- general practice staff – general practitioners, nurses and practice managers
- local hospitals
- allied health professionals
- community health organisations
- mental health and alcohol and other drug (AOD) organisations
- pharmacists
- peak professional and consumer bodies
- federal, state and local governments
- social service agencies
- Aboriginal health organisations.

Commissioning

By working closely with health professionals, consumers and carers and using health related data, we identify emerging community health needs and gaps in the health care system. We develop our commissioning plans informed by our stakeholder engagement and the best evidence available.

Increasingly we are 'co-commissioning' – working with partner organisations to develop new services that address these needs and gaps that we commission together. In all our work we are contributing to the evidence about what works to improve health experiences and outcomes.

Supporting General Practice

We support General Practices with quality improvement, whether that be through professional development, providing practices with summary data reports, or helping practices become future-ready.

Digital health

We use technology to make the broader health system work more efficiently. This includes implementing electronic referral systems, supporting the rollout of electronic prescribing, telehealth and providing resources, such as HealthPathways Melbourne for practitioners to use.

EMPHN's Strategic Plan

TRANSFORMATIVE STRATEGY

Listen to the consumer voice and design new mental health and chronic disease management approaches that are truly person-centred

Indicator

Consumers with mental health and AOD concerns experience care that meets their needs and supports recovery

Target

60% of patients report improvement in PROMS

80% of patients rate good or above on PREMs score

Outcomes

- Improved access to the right care, in the right place, at the right time, particularly for at-risk and vulnerable groups
- More effective care for people with chronic complex diseases and those at risk of poor health outcomes

TRANSFORMATIVE STRATEGY

Build a positive culture of high performance

Indicators

Continuous year-on-year improvement in organisational culture

External recognition of a high performing PHN

Targets

2% improvement in organisational culture

Positive stakeholder engagement survey results

Outcomes

- EMPHN is recognised a nd highly valued by funders, partners and our community
- A healthy, highly skilled and sustainable organisation
- Accountable governance and effective stewardship of commissioned funds and contracts
- Our business systems, processes and infrastructure enable highly effective ways of working together

TRANSFORMATIVE STRATEGY

Ensure commissioning and system change strategies encourage integration from a consumer perspective

Indicators

Number of significant demonstration projects with pooled Commonwealth and State funding

Increase in practices participating in an integrated care network

Targets

Three projects

Integrated care networks adequately meet consumer needs

Outcomes

- Joint planning and co-ordinated investment results in better integrated, person-centred, service delivery
- Service system improvement occurs through co-design processes that are person-centred, clinician-led and provider informed
- Strategic commissioning delivers better outcomes for people and an improved service system

Our Values

- Integrity
- Working together
- Courage

Our Mission

With our partners, we facilitate health system improvement for people in eastern and north eastern Melbourne.

TRANSFORMATIVE STRATEGY

Support and encourage primary care to adopt collaborative interdisciplinary care approaches that are person-centred

Increased use of practice-based evidence

Indicators

Consumers report improved experience with their convenient, multidisciplinary, coordinated care

Tier 1 and 2 general practices participating in PHN-led, data informed quality improvement

Targets

80% of patients rate good or above on PREMs score

100%

Outcomes

- Primary care providers deliver person-centred integrated services
- Primary care providers deliver timely, high quality and safe health care

TRANSFORMATIVE STRATEGY

Encourage health information continuity between providers

Indicators

Axe-the-fax, electronic referral communications between general practice and hospitals/specialists

Targets

100%

Outcomes

- Health data, economic analysis, planning and evaluation drives impactful service and system development
- Improved use of data and technology to support providers in delivering high quality co-ordinated care, and people in managing their own health

Strategic Priorities

- Addressing health gaps and inequalities
- Enhancing primary care
- Leveraging digital health, data and technology
- Partners working as a single service system
- A high performing organisation

EMPHN's COVID-19 Response

COLLABORATION AND COVID-19 – HOW PARTNERSHIPS AND A PROACTIVE APPROACH HELPED KEEP OUR COMMUNITY SAFE

When the pandemic first started impacting Melbourne in early 2020, both federal and state government health departments sought EMPHN's help with the local response. To ensure we could make an effective and timely contribution to supporting our partners, our staff put aside other projects, frequently contributing over and above their usual capacity for extended periods – often without additional funding.

The relationships we have been fostering with key partners (including local health networks, community health providers and general practices) meant we already had a good understanding of their strategic goals and ways of working. This, combined with our team's proactive approach, enabled us to successfully support our partners' COVID response initiatives and vaccine rollouts – and continue to do so.

Assisting RACFs through tough times

A key aspect of EMPHN's work involved assisting residential aged care facilities (RACFs) to support resident wellbeing and manage the constantly changing situation. Charlene Quinn, EMPHN Portfolio Manager – Chronic and Complex Conditions, explains relationships developed during previous work with RACFs – such as managing influenza vaccinations and maintaining accurate GP and RACF details – meant EMPHN was well placed to help. "In the worst outbreak cases during 2020, for example, residents were being taken en masse to hospitals. As residents returned to their facilities, our up-to-date database helped ensure smooth handovers back into the care of their GPs."

EMPHN's COVID-19 Response

158

vaccine rollouts facilitated across the region.

85%

This united effort meant every facility had a first and second dose clinic completed by 2 July 2021, with an average 85% resident vaccination consent.

EMPHN also facilitated the vaccine rollout across 158 Commonwealth RACFs in its region. This necessitated finely balancing wider program goals with each facility's circumstances, Charlene says. "Our team was constantly busy working closely with individual facilities to ensure they got the help they needed."

In the week before a facility's vaccination clinic, EMPHN hosted a webinar with clinical and nonclinical staff and at least one other RACF that had been through the process, Charlene explains. This helped facility staff know what to expect on the day and how to manage things like obtaining consent from residents or their families.

They also provided up-to-date policy and clinical information, helped with myth-busting to reduce vaccine hesitancy, and worked alongside vaccine workforce providers to ensure clinics ran smoothly. EMPHN's local knowledge proved invaluable for these tasks, Charlene says. "In culturally and linguistically diverse communities, for instance, we were able to provide resources in different languages." Her team also dropped everything to manage emerging issues. "Where residents had missed doses, for example we organised roving clinics on weekends."

This united effort meant every facility had a first and second dose clinic completed by 2 July 2021, with an average 85% resident vaccination consent. "That was a real moment of pride for us," Charlene says. "Seeing the difference we made on the ground was our biggest success."

One such facility is BlueCross The Boulevard in Mill Park, who EMPHN worked with to provide staff vaccinations. Residence Manager Carmel Hartley says they were at the "frustrating stage where we thought staff would need to organise vaccinations themselves" when she received a call from EMPHN. "That was at the end of one week, and by Monday morning we had a vaccination team here. I'm sure there was a lot of effort on EMPHN's part, but it was effortless for us. Our staff were very grateful for the opportunity to be vaccinated in the workplace. It just took all that pressure off."

The Boulevard became the first BlueCross site where most staff had received a first dose, Carmel notes.

"I'm really proud of that. It also means about 98% of our staff are now fully vaccinated. I don't think we would be at that stage if this program hadn't been available."

EMPHN's COVID-19 Response

EMPHN staff were very professional and helpful, Carmel says. “They had every angle covered – even security for the day. Residents who hadn’t been vaccinated were also able to receive doses.”

Charlene explains EMPHN’s work continued after clinics.

> **“We contacted each facility on clinic days to see how things had gone and whether there had been any issues. We also followed up 40 hours post vaccination to discuss concerns such as adverse events or missed doses. We were always looking for information to share with workforce providers and the Department of Health to improve future clinics.”**

Importantly, her team arranged a solution to minimise vaccine wastage. In partnership with workforce providers and given cold chain management could be proven, unused doses were transferred to the Austin Pfizer hub.

Charlene adds relationships with EMPHN’s partners have been cemented through this collaboration. “The foundations we’ve laid have paved the way for future work, especially for the broader reform agenda coming out of the Royal Commission.”

Carmel agrees the stronger ties will help during ongoing sector changes. “Our relationship will be invaluable in the future because we know EMPHN is responsive to community needs. With all the changes, every day can feel like stepping on eggshells. The fact we have health networks that are sensitive to the needs of aged care helps.”

PARTNERING WITH GENERAL PRACTICES TO SUPPORT LOCAL COMMUNITIES

In another vital alliance, from late January 2020 EMPHN's General Practice team supported the COVID responses of the 426 practices in their network.

"It began with distributing personal protective equipment (PPE) to general practices, and that was extended to pharmacies and allied health professionals," explains Kathy Tepper, Program Manager – General Practice. Between February 2020 and June 2021, EMPHN distributed 1,073,045 masks, 10,693 goggles, 41,560 gowns, 4,660 coveralls and 240 bottles of hand sanitiser.

"We also gave out 119 grants of up to $2000 each to help practices improve infection control and conveyed information from state and federal governments about changes to PPE guidelines, infection prevention and control, and other government requirements."

426

our team supported the COVID responses of the 426 practices in their network

119

grants of up to $2000 each to help practices improve infection control and conveyed information

In 2021, EMPHN played a significant role in the primary care vaccination rollout program. "From February, we started taking expressions of interest from practices wanting to join the program," Kathy explains. "As practices were approved, we supported them through the onboarding process.

"Our team has done a lot of work at short notice. For example, during vaccination program onboarding, a team member spends up to an hour on the phone with each practice manager and responds to any further queries about the program.

"I'm proud of the team's passion for supporting general practices and the public health response. They did really go above and beyond. We now have about 80% of our practices on the program, providing two different vaccines."

One of these is Forest Hill Family Clinic. Cass Quilty, clinic owner and nurse, engaged EMPHN's help before submitting her expression of interest. "I wanted to get a better understanding of what was required and I was anxious about committing to specific days and times if things didn't work out," she says. "But I rang my EMPHN contact, and she allayed my concerns."

Her clinic was one of the first to receive rollout approval, and Cass says the onboarding packages were fantastic. "Everything was very well documented and there were good support processes." Her practice, which started giving 50 doses per week in April, is now delivering 400 per week. "It's a lot of work but I'm really proud of our program. Our team of admin, nurses and GPs have done an incredible job with EMPHN's support. One of their staff, who had her vaccination here, even volunteered to come down and make cups of tea."

Cass explains she has been particularly impressed with the quality of EMPHN's communication. "I can't fault them – there's always someone available to help you." In addition to phone calls, Cass uses EMPHN's BaseCamp community forum and local HealthPathways website. "Having all those avenues to gain support has made the rollout pretty smooth."

Dr Kirsten Van Haaster, a GP at Monbulk Family Clinic, agrees HealthPathways is a great clinical resource. "They've got pages on anything from vaccine eligibility to how to manage suspected myocarditis after Pfizer to what steps you need to take if someone tests positive, so that's been really useful." Her clinic, which is now delivering 300 doses per week each of Pfizer and AstraZeneca, also receives PPE through EMPHN.

Kathy says many benefits have come from their work with practices during the pandemic. "Our relationships have generally improved, which will be helpful during future projects."

Cass says she already had an excellent partnership with EMPHN, which will only get better.

> **"I think seeing how successful we've been providing the COVID vaccine helps, so hopefully there will be more opportunities going forward. Anything we can do to improve primary care is a good thing."**

Indigenous health

OUR RECONCILIATION ACTION PLAN (RAP)

The RAP was developed to support our reconciliation journey in order to foster well-being, self-determination and resilience in Aboriginal and Torres Strait Islander communities. It was launched officially in August 2020 and will enable a wide range of actions, including:

1. Supporting Aboriginal and Torres Strait Islander communities to be self-determining in their health and wellbeing
2. Training EMPHN staff in cultural awareness
3. Ensuring that Aboriginal and Torres Strait Islander community members can access health care and other supports which are culturally safe
4. Revising policies, processes and practices which create barriers for equitable health outcomes and full participation for Aboriginal and Torres Strait Islander community members

Since the launch of the EMPHN RAP, staff members have had opportunities to engage with it through activities such as webinars, cultural workshops, online events and presentations. EMPHN has commissioned an Aboriginal and Torres Strait Islander Cultural Framework, which will inform and guide our work within the organisation and in stakeholder engagement. The EMPHN commissioning framework has also been aligned with the RAP and the Cultural Framework will be finalised shortly. We continue to build capacity in this area with a dedicated resource to work exclusively on the implementation of the RAP.

“Our commitment to implementing the Innovate Reconciliation Action Plan (RAP) means that the important work of reconciliation is always front of mind in the programs we fund and support. We know well the ongoing challenges faced by Aboriginal and Torres Strait Islander peoples in accessing healthcare and other support services in our region and the critical role EMPHN can play in ensuring that health services are culturally safe and support the strengths and aspirations of the community. Additionally, we provide all our staff opportunities to be involved in supporting reconciliation, and the RAP provides an invaluable guiding framework for this work.”
Janine Wilson, CEO

EMPHN commissioned local artist and Palawa-woman Amanda Wright to create this artwork in celebration of its Innovate Reconciliation Action Plan.

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PROGRAMS

Eastern Melbourne PHN has worked with Aboriginal organisations across our region to fund services and provide support to Aboriginal and Torres Strait Islander peoples focussing on programs implemented and developed by local Aboriginal and Torres Strait Islander communities.

EMPHN provides funding for several Aboriginal and Torres Strait Islander programs, including:

- Bubup Wilam Aboriginal Child and Family Centre's comprehensive wrap around services for children and families to provide Aboriginal and Torres Strait Islander children with the best possible start to life.
- Oonah Health and Community Services Aboriginal Corporation's comprehensive outreach case management services that support people to reconnect with community, link into support networks and overcome social and emotional issues.
- The Victorian Aboriginal Health Service's care coordination and outreach for Aboriginal and Torres Strait Islander peoples with chronic health conditions that provides integration of support and care in a cultural and community embedded approach.

Each of these organisations has delivered services that have benefited Aboriginal and Torres Strait Islander communities through their unique connections that enhance service access, utilisation, delivery and outcomes.

Overall, EMPHN funding has provided support which helps build on community initiatives including support for Aboriginal and Torres Strait Islander children and their families to break the cycle of generational trauma and generational disadvantage, enhancing health and social and emotional wellbeing through relationship based wrap around support, connection to community, mentoring, counselling, culturally safe referral, and support for service providers to integrate services in a culturally sensitive way.

Aboriginal Community Controlled Organisations (ACCO) in our region are achieving incredible results and further support is required to meet emerging demand.

EMPHN is responding by modifying its approach to commissioning with Aboriginal and Torres Strait Islander communities through three key areas: the EMPHN RAP; the development of an Aboriginal and Torres Strait Islander Cultural Framework; and the Aboriginal and Torres Strait Islander Programs Evaluation Framework which will strengthen our approach to planning and increase the focus on engagement and collaboration with Aboriginal and Torres Strait Islander Communities to support their leadership and governance and the self – determination of their health and wellbeing needs. This will include working with all Aboriginal organisations in our region so that funding is aligned to Aboriginal and Torres Strait Islander communities' expectations.

Primary Healthcare Programs and Initiatives

RIGHT CARE = BETTER HEALTH

Right Care = Better Health (RC=BH) is a new, ongoing service designed to support patients with complex and chronic needs, recognising the importance of wrap-around services to support people who need it most. The service, delivered by DPV Health and EACH, provides complex health coordination and linkage workers integrated within participating general practices.

The program provides patients with appropriate and timely individually tailored, person-centered care, which aims to improve quality of life and lower rates of avoidable hospital admissions.

The RC=BH program outcomes, activities and evaluation framework has been developed to align with four aims: improving patient experience, improved population health outcomes, increased system efficiency (reducing per capita cost of health care) and improved clinician experience.

Since October 2020, 268 patients have been referred from general practice with approximately 216 patients enrolled in the service. Over 1750 contacts such as phone support and face to face consultations have been completed with over 220 local service referrals initiated. The RC=BH service team have linked patients to a variety of community and health services with up to 27 different types of connections been made. The program is currently funded until August 2022.

> **“Remi (Care Coordinator, EACH) has been instrumental in making my journey with my health issues more doable. He has gone over and above helping me through the processes, and making the necessary referrals. Remi has been terrific and I feel I have someone looking out for me. Life feels easier.”**
>
> Right Care = Better Health patient

268
patients have been referred from general practice

216
patients enrolled in the service

1750+
contacts such as phone support and face to face consultations

> **“The best part is, it feels like the Right Care = Better Health program is successful... not only in improving patients' quality of life and independence, but successful in injecting a new sense of hope, trust and faith in the health system, no matter how big or complex one’s health problems are!”**
>
> Remigiusz Siemianow, Care Coordinator EACH

HEALTH COACHING

The 'Health Coaching program for practice nurses' was designed to enhance current capacity and support capability building within the primary care nursing workforce. Training and mentoring is aimed at building skills that enable nurses to work effectively as health coaches, educators, chronic care managers and care coordinators.

Twelve clinics were recruited to the program where each clinic nominated a practice nurse to attend training, mentoring and implement their coaching model. The clinic also nominated a GP and practice manager to support the nurse and ensure a whole of clinic approach. Each clinic recruited 10-20 patients who had a BMI of 30>, and provided health coaching and care coordination for 12 months, with a focus on weight loss and improved quality of life.

The COOP/WONCA tool was used to measure patient functional status (measure of an individual's overall wellbeing) at baseline 3, 6, 9 and 12 months. These surveys were de-identified and submitted to EMPHN throughout the program.

Some of the clinic's models were aligned to facilitate and enhance use of MBS items, such as Health Assessments, heart health checks and care plans while others focused on vulnerable and socially isolated patients. All patients received one-on-one coaching and some clinics took the opportunity to develop group sessions which created an opportunity to share ideas, experiences, successes and challenges. Monthly support and feedback was also available to the clinics themselves.

117 patients were recruited in total across the program, with 75 completing the program, of which 55 attended every review throughout the program. The average age of patients attending all reviews was 56 years.

The health outcomes for patients have been positive. Nurses were encouraged to have the patient set small, achievable changes, ie '1% changes', in order to encourage good, sustainable lifestyle habits. The average BMI of participating patients lowered from 38.5 to 36.2 ,an overall reduction of 2.3. The program got underway when the pandemic began and as a result needed to adjust. Some clinics moved to a telehealth model, meaning coaching was done either over the phone or via video conferencing. Some data was unable to be recorded and many patients avoided presenting to general practices due to fear of infection. This was a highly reported challenge by the participating nurses.

> **"Some of our doctors were happy to support the program, but I was keen to really empower the nurses to show the benefits of them being involved in chronic disease management. I feel that this program not only gives the nurse skills, but also the confidence to be able to do more in the space of nurse-led clinics and chronic disease management alongside our GPs. This program was a way of showing GPs that there is an untapped resource there and highlighting the skills nursing staff have to improve integration and effective health management."**
>
> Practice Manager

117
patients were recruited in total across the program

75
patients completed the program

2.3
There was a 2.3 reduction in BMI

ORIENTATION TO GENERAL PRACTICE

The Orientation to General Practice Program was designed to build the capacity of primary care nurses and improve practice systems and processes, ensuring full potential for patient health care and quality business outcomes.

The Australian Primary Health Care Nurses Association (APNA) was engaged to provide expert content for and to develop and deliver a 12 month orientation and training program for nurses who are new or recent to working in general practice in the EMPHN catchment.

Thirty-one nurses completed self-paced online learning, attended webinars and communities of practice and were able to access unlimited peer support. They were provided with access to six pre- core online education modules (total of 17.5 hours) and three additional, optional modules.

The program was implemented as planned with only minor disruption to momentum due to the pandemic. This did not decrease retention or completion rates significantly. 97% of program participants completed all three self-assessments. All nurses (100%) completed the six education modules and 84% of nurses completed at least one of the three optional modules. 90% of nurses retained in the PHN catchment provided opportunities to build further capacity. The webinars resulted in improved knowledge and skills with 97% of participants viewing webinar 1 and 90% of participants viewing webinar 2. Nurses are initiating and implementing change and quality improvement as a result of the program.

97%
of program participants completed all three core learning modules and self-assessments

97%
of participants viewing webinar 1

90%
of nurses retained in the PHN catchment provided opportunities to build further capacity

NURSE WATCH

In response to the COVID-19 pandemic, the Nurse Watch program offered practice nurses training, networking and mentoring to strengthen and extend their role in managing and supporting patients with complex and chronic conditions in a telehealth environment.

The establishment of the Practice Nurse Network groups provided a collaborative environment and an opportunity for shared learnings to transform the management of complex and chronic conditions in a telehealth environment.

The Nurse Watch program ran for 12 weeks, engaging 16 practice nurses to access to eLearning courses, individual mentoring session and created virtual networking groups which provided a collaborative environment and opportunity for shared learnings. The program helped to develop and set up clear pathways of care within general practice, increase confidence to engage, plan and coach patients via telehealth consultations, increase confidence to communicate effectively with patients via telehealth consultations and maximising chronic disease management nurse consultation MBS items.

“I have been able to increase my nursing practice scope about patient centred care, not just about the care plan, but the holistic view. It has helped me build my confidence about patient holistic assessment and communication techniques with telehealth consultations.”
Practice Nurse participant

MY EMERGENCY DOCTOR

My Emergency Doctor provides urgent, high-quality phone and video consultations with a specialist emergency doctor in the after-hours period for residents within the EMPHN catchment, including residents living in residential aged care facilities (RACFs).

During the last financial year, the My Emergency Doctor (MyED) service provided 5765 after hours consultations across the EMPHN catchment. Analysis of data revealed that MyED provided a high percentage of consultations to residents living in the outer east and outer north of the catchment. These areas have limited access to after-hours services, including Medical Deputising Services (MDS) and will often present to Emergency Departments (ED) as a result of not being able to access care after-hours.

5765

after hours consultations across the EMPHN catchment

440

MyED provided 440 consultations to RACFs in the catchment

MyED provided 440 consultations to RACFs in the catchment, many of which accessed this service for their residents rather than calling an ambulance to transport their residents to an ED for care. A component of the commissioned service includes engaging with RACFs to promote this service as an alternative to ED. During lockdowns, this service exceeded its KPIs with consultation numbers increasing each month.

A preliminary analysis of the cost showed that utilising the My Emergency Doctor service is significantly less than patients presenting to the emergency department of a hospital. The program is looking to expand the service with Local Hospital Networks. MyED is currently engaged in a pilot project to provide virtual triage to Eastern Health, Box Hill and Maroondah emergency departments.

“Just an amazing service, I cannot believe it! My daughter put me onto it so I cannot thank you enough. Both my daughters use this service, and it's great for their children. This is such a great service especially with the lockdowns going on and off. I love this service so much!”

IDEAS (INTEGRATED DIABETES EDUCATION AND ASSESSMENT SERVICE)

IDEAS provides patient-centred, integrated, multi-disciplinary Type 2 diabetes care in the community.

The IDEAS project changed the way clients received services, putting them at the centre of their care. Diabetes care was previously fragmented across care settings and disciplines. IDEAS addressed the need for comprehensive, integrated, team-based care for a highly prevalent and costly chronic disease in the EMPHN catchment. IDEAS delivered diabetes education and assessment services by a team including hospital endocrinologist and/or registrar, and community-based diabetes nurse, dietitian and podiatrist in the same community setting at the same time.

For the 2021 financial year

564
new appointments attended

2944
review appointments attended

The objectives and key indicators of success are: improved patient experience (94% positive), improved clinical outcomes (HbA1c, diabetes distress & weight), reduced specialist clinic wait-times, reduced hospital admissions and length of stay, reduced emergency presentations, reduced acute care costs, improved clinician experience (89% positive) and enhanced integrated care systems.

For the 2021 financial year there were 564 new appointments attended and 2944 review appointments attended. The project expanded to six community health clinics making it more accessible. The project is working towards providing an evidence base of cost savings through partnership with health economists and Monash University researchers. The project is working towards financial sustainability and achieving long-term funding solutions. The current EMPHN funding for the program has concluded.

YOUR VOICE, YOUR CHOICE

Your Voice, Your Choice utilised technology to create awareness about Advance Care Planning and generate discussions in the community using digital storytelling to engage its audience.

The project produced short videos where storytellers shared their personal story, knowledge and thoughts around Advance Care Planning and End of Life Care and was published to social media during Palliative Care Week in May 2021. The storytellers created their own video using their phones which were then professionally edited through Cinefly, a digital storytelling app service engaged by Eastern Melbourne PHN.

The project was a collaborative project as part of Greater Choices for at Home Palliative Care measure, (GCfAHPC), led by Eastern Melbourne PHN, and includes Adelaide PHN, Country WA PHN, Central Queensland Wide Bay and Sunshine Coast PHN, and Brisbane South PHN, working with Advance Care Planning Australia. EMPHN received content from 11 storytellers in four states.

The content featured primarily through EMPHN social media pages and was shared widely. The first video story released reached more than 2,000 people. A final video from the collected stories was produced with plans to use it to campaign for Advance Care planning in the community in the coming year.

> **“So glad that you are highlighting the importance of good palliative care.”**
>
> Facebook comment

DOCTORS IN SECONDARY SCHOOLS

The Victorian Department of Education funds EMPHN to support the Doctors in Secondary Schools (DiSS) program whose objectives include making primary health care more accessible to students, providing support to young people through the early identification of health problems and reducing pressure on working families. There are 12 schools enrolled in our region. During 2020, 683 consultations took place.

204
students were referred on to other mental health services, including headspace and psychology services

683
consultations took place during 2020

Mental health was the main reason for consultation, but students also accessed the program for physical health, sexual health and other health concerns. 204 students were referred on to other mental health services, including headspace and psychology services.

The DiSS program was particularly challenged by the pandemic with school closures during lockdown periods. Some clinics offered telehealth as an option, but students often struggled to access telehealth from home while in lockdown. Some clinics reported a surge in presentations following each lockdown, demonstrating the need for the service as well as the need for the service to be delivered face-to-face and on site at the school. It provides a safe, available alternative for students to access health care and advice.

The DiSS program supports some of our most vulnerable students and is integral to ensuring students understand their health care needs, setting them up for a good relationship with a GP and primary care options as they transition to adulthood. The Victorian Department of Education has confirmed the program will continue to be funded.

“The DISS Program has been an incredibly valuable service in our school – not just for students but the wellbeing team in general. Students have been able to not just get their health concerns addressed but actually start building positive relationships with their GP and nurse. I have seen an increase in student understanding of the role of a GP. Many students were under the impression that you only saw a doctor if you had a physical illness but they are now seeing that a GP can assist with monitoring and referrals in regards to mental health concerns. Students are building trust with doctors thanks to this program which in turn results in further engagement with the school as well.”
School Wellbeing Coordinator

HEALTHPATHWAYS MELBOURNE

HealthPathways Melbourne is an online resource that provides General Practice with evidence-based guidelines and referral pathways to reduce hospital presentations of patients who could be reasonably managed in primary care, reduce unnecessary variation in care, and to help patients receive timely and appropriate care (right care, right place, right time).

HealthPathways Melbourne has been an invaluable resource for GPs keeping up to date with guidance throughout the pandemic outbreaks and throughout the rollout of the COVID-19 vaccine.

HealthPathways also plays a key role in the implementation of the Statewide Referral Criteria for Specialist Clinics. Clinical and referral pathways align with statewide referral criteria to improve the outpatient experience through improved quality and appropriateness of referrals.

In response to the pandemic, a suite of tailored pathways was developed to reflect latest guidance on testing, management of patients, post-COVID conditions and vaccination. HealthPathways Melbourne support metropolitan Public Health Units in the management of COVID-19+ patients in the community by providing management advice to GPs. HealthPathways Melbourne continues to be an invaluable resource for GPs to keep up to date with guidance throughout the different outbreaks, and throughout the rollout of the COVID-19 vaccination.

HealthPathways is recommended as a GP resource for the management of COVID-19 Vaccine-induced Thrombosis with Thrombocytopenia Syndrome (TTS) and management of Myocarditis and Pericarditis.

“The infant pathways are a rich and practical way to bring evidence into practice and are a much needed "point of care" resources for health practitioners.”

Paediatrician, Royal Children’s Hospital

TELEHEALTH

The pandemic has seen a shift in the uptake and use of telehealth, which aims to improve patient experience, clinician experience and increase system efficiency.

The introduction of COVID-19 MBS items for general practices has enabled GPs to provide patient consultations using telehealth (both telephone and video). In the last year, EMPHN's GPs have made 2,404,872 claims for phone telehealth consults and 30,098 video telehealth consults. In addition, EMPHN's RACFs have made 21,981 claims for phone telehealth consults and 1,604 video telehealth consults.

> **"Telehealth is fun, efficient, time saving and (with our PHN and Healthdirect support) very easy."**
>
> Dr. Arthur Zulman
> (GP – Macedon Medical Centre)

General practices saw a decrease in face-to-face patient consultations during the pandemic. EMPHN supports the onboarding and use of healthdirect's free telehealth platform, Video Call. Ongoing, the majority of general practices are still using telephone for telehealth, and are encouraged to use video as the preferred mode of telehealth.

> **"A recent study clearly showed the value of telehealth across the entire scope of GP practice, both in community consultation and within RACFs. Having access to this real time data helps us respond more quickly to emerging needs in our community and instigate changes to existing programs, inform new program design and advocate with evidence-based advice to the Department of Health."**
>
> Dr Precious McGuire, clinical advisor to EMPHN and GP – Deepdene Surgery

ELECTRONIC PRESCRIBING

EMPHN supports GPs and pharmacies in the ongoing rollout of Electronic Prescribing, whose aim is to improve patient experience and increase system efficiency. As of 30 June, more than 2,000 GPs in EMPHN catchment have prescribed an electronic 'token' prescription and over 1,534,778 original prescriptions and repeats have been dispensed.

Data available highlights an ongoing increase in the number of 'token' electronic prescriptions being prescribed and dispensed. Since October 2020, there has been an increase of 1,390,128 prescriptions delivered via electronic delivery. Under the National Health Plan for COVID-19, the Australian Government accelerated the delivery of electronic prescribing to help protect people most at risk from COVID-19 and support consumers to access medications during lockdowns.

> **"E-prescribing saves time for both doctors and patients, allowing them to have repeat scripts done and sent directly to themselves instead of needing to enter the clinic, especially in these current times. I also appreciate not having to print unnecessarily!"**
>
> Dr Prathana Kunwar KC,
> East Doncaster Medical Group

PRACTICE INCENTIVE PROGRAM QUALITY IMPROVEMENT (PIPQI) INITIATIVE

The PIPQI initiative was launched by the Australian Government Department of Health (DOH) in August 2019 and supports more than 5,700 general practices across 31 Primary Health Networks to help improve patient care and outcomes, and improve planning for the health needs across Australia.

More than 346 general practice clinics in the EMPHN catchment have signed up and are rewarded to undertake quality improvement activities and provide a copy of their de-identified PIP Eligible data set to EMPHN. PIPQI captures information in 10 quality improvement measures (QIMs) that represent a significant burden on the health of Australians. These include immunisation against influenza among vulnerable populations, cardiovascular disease assessments, and cervical screening.

De-identified data is collected quarterly from practices, and is aggregated, collated and provided to the DOH national data custodian — Australian Institute of Health and Welfare (AIHW).

EMPHN supports practices for PIPQI with education, training and insights including with updated website resources, regular POLAR Practice Reports, Facilitator support and guidance, CPD training courses and training videos on YouTube.

Mental Health Initiatives

SUPPORTCONNECT TEAM (FORMERLY REFERRAL AND ACCESS TEAM)

SupportConnect is a centralised point of entry into EMPHN commissioned mental health and Alcohol and Other Drugs (AOD) services. Team members support consumers, carers, GP's, community health and service providers to access the right care, at the right place in the right time within the EMPHN catchment. The team also supports commissioned MH and AOD service providers in the implementation and ongoing delivery of services across the catchment.

The SupportConnect team received more than 1964 calls from people seeking support and processed 1656 referrals to EMPHN commissioned services (Stepped Care, Psychosocial Support Services, HeadtoHelp Hubs). There were 448 referrals received from general practice, 388 self referrals, 345 referrals from tertiary mental health services and 475 referrals received from the broader sector.

The roll out of HeadtoHelp across the state highlighted the strengths of the SupportConnect team. Additionally, over the last 12 months EMPHN commissioned the development and launch of a navigation website to complement the work of the SupportConnect team. This platform will assist people to access available MH and AOD services, or be linked through to a clinician who can better assess and understand their needs.

"I want to thank everyone so far, everyone that I have been in contact with so far has helped me to feel like I'm not alone and they are here to help. This means the world to me I don't often feel like people understand me."
Consumer

1964+
calls for people seeking support

448
referrals received from General Practice

"The service is excellent and I felt that the service person listened to my needs and feeling."
Consumer

HEADSPACE

headspace centres provide early identification, intervention strategies and holistic care for young people aged 12 to 25 years and their families or carers who are at risk or showing early signs of developing mental health, physical health and/or drug and alcohol problems.

Reporting data received from three (Knox, Greensborough and Hawthorn) centres, the following results have been achieved – 13,112 occasions of service have been provided, 3,317 young people have been seen and 2,366 of these were new to the service in this period.

87%
of clients were satisfied with the service received

75%
were happy with how long they waited for service

Surveys and feedback showed increased happiness with the level and type of service provided, greater diversity amongst young people involved, reduced dissatisfaction with wait times and greater social media engagement. 87% of clients were satisfied with the service received and 75% were happy with how long they waited for service.

New centres within the EMPHN catchment that commenced planning and/or opened during the 2021 financial year included a new site in Syndal, a satellite service in Lilydale and final preparations for the opening of a new site at Plenty Valley. A specific COVID re-engagement subcontract was developed to ensure that young people who had withdrawn from services due to COVID were successfully re-engaged. This was implemented in 2021 and while still in its infancy, has provided service to 63 young people, providing 196 occasions of service and has successfully re-engaged 36 young people into ongoing counselling/programs.

STEPPED CARE

The Stepped Care Model aims to enable service users to receive the right care, in the right place, at the right time. This unique support ensures the needs of each individual are responded to via the provision of a range of support types and levels of intensity of intervention.

Services provided included a combination of one-on-one support, Group Support and Care Co-ordination, delivered by a range of workers including Peer Support Workers, Psychologists, Mental Health Nurses, Counsellors, Social Workers, Welfare Workers and Occupational Therapists.

During 2020-21 the Stepped Care program in the North East, Inner East and Outer East regions of the EMPHN catchment provided care to a total of 1,902 consumers, delivering a total of 36,328 sessions of support. This support enabled consumers to better manage their mental health and wellbeing via the development of a range of self-management skills and linkages to a range of resources and additional support options within the community.

The existing Stepped Care services are funded to provide support to June 30 2022, including resourcing for a child specialist worker in response to demand for support of children and young people referred to the service.

“The benefit of the stepped care model, which provides access to a diverse range of support, has been evident again in the past 12 months. We’ve seen increased requests for support with navigating the health and welfare system in response to financial hardship and distress, family violence, worsening of mental health symptoms and carer burnout, amongst many other challenges individuals and families have faced during this particularly stressful period.”

Lara Jackson, General Manager Wellbeing & Support. Banyule Community Health

1902
consumers, delivering a total of 36,328 sessions of support

36,328
The Mental Health Stepped Care programs collectively delivered 36,328 sessions of support to a total of 1,902 consumers.

PSYCHOSOCIAL SUPPORT SERVICE (PSS)

The PSS provides non clinical support for people with a severe mental illness and associated psychosocial functional impairment who are not supported through the NDIS.

Its key features include a focus on capacity building, integration with clinical services, time limited interventions and recovery and trauma-informed focus. The service is delivered by two service providers; Neami National (delivered the service for entire 12 months) and Wellways Australia (commenced delivery in April 2021).

In the 12 months from 1 July 2020 — 30 June 2021, 565 new consumers were referred into program and supported, plus 412 existing consumers from 2019-2020. 23% of new consumers experience socioeconomic disadvantage. A total of 16,560 sessions were delivered (11,532 via telephone due to COVID-19 restrictions). 241 referrals were made out to other services. Neami National delivered the Psychosocial Transition Program (PTP) within their PSS service and from this program, 30 consumers transitioned into the NDIS.

"The endless amount of support I received from my worker made it possible to achieve the goals I had."

LIFECONNECT

LifeConnect is a suicide prevention and support after suicide program, delivered by Neami National. Support is provided via two streams - support after bereavement and suicide prevention.

It works to build individual resilience and capacity for self-help, improve community and workforce capacity to prevent suicide, provide targeted suicide prevention programs and activities to those at risk, take a coordinated region-wide approach to suicide prevention, provide support for people impacted by a suicide and improve the evidence base and understanding of suicide prevention.

In the past year, there were a total of 243 workshops and training sessions delivered to 2179 participants on suicide prevention. This included 60 wellbeing sessions included mindfulness and life skills workshops as well as suicide prevention training, 'Reach Out and Connect.' These training sessions were presented to 592 participants in community groups across 41 sessions, 471 participants in the workforce across 42 sessions and to 728 participants in the 'at risk' category across 100 sessions. On average, 95% of participants found the training was useful and helpful to their work and/or community and 94% of participants had greater confidence in recognising when a person may be at risk of suicide or responding to a person who is at risk of suicide.

For suicide 'postvention' (support after suicide), LifeConnect provided 118 new clients with 1236 sessions. There were six community debriefing sessions for 128 people.

243
workshops and training sessions delivered

2179
training sessions to participants on suicide prevention

CROSSROADS TO COMMUNITY WELLBEING

The Crossroads to Community Wellbeing suicide prevention group has been working together to guide the collective efforts to understand, prevent and reduce suicide in the South Asian community in the City of Whittlesea.

It gathers local intelligence to inform a strategic direction for a response in the local community; investigate the presenting issue; and engage with local community leaders to develop a tailored suicide prevention response. EMPHN's role in this working group is to provide the backbone support which entails subject matter expertise, coordination and secretariat support for the working group as well as the management of stakeholder relationships.

From this project, an action plan was developed providing an analysis of the presenting issue, policy context, socio-demographic information about the City of Whittlesea, an evidence informed model of suicide prevention, high level strategic actions capturing the actions of Crossroads, related projects, and opportunities for future work. The work led to tailored suicide prevention training for South Asian community leaders and GPs in collaboration with LifeConnect. Two additional pieces of work were also funded - Roads to Driving program (a pilot program providing an opportunity for South Asian women in the City of Whittlesea to work towards their Victorian driver's licence) and Beyond Cultural Competency Training (support for mainstream organisations and professionals to understand, engage with and provide the framework to ensure more accessible services to people from a Culturally and Linguistically Diverse (CALD) community).

"I commend the actions of the Crossroads to Community Wellbeing Group in promptly responding to concerns in the community, and for working collaboratively to identify service gaps and subsequent prevention opportunities that would help to reduce isolation and increase access to services for South Asian women in the Whittlesea area. The Crossroads to Community Wellbeing Group is well placed to progress the necessary research and planning required to inform future work, including further inquiries into the broader issues faced by South Asian women in the City of Whittlesea that do not form part of the coronial jurisdiction."

Victorian Coroner, Audrey Jamieson

HEADTOHELP

HeadtoHelp was the result of the coordinated mental health response to Victoria's second lockdown and officially launched in September 2020.

The free service was pulled together through a coordinated working group of all six Victorian PHNs. It offers a holistic approach to mental health services where people can be connected with suitable existing services, receive care at a HeadtoHelp hub (either onsite or through telehealth) or be connected to specialist or acute mental health services, including into emergency care.

HeadtoHelp is the first state-wide step towards integrating the mental health system and coordinating care for people, when and where they need it most.

The multidisciplinary teams in HeadtoHelp hubs include psychologists, mental health nurses, social workers, occupational therapists, peer workers and alcohol and drug workers. The hubs work closely with existing providers including GPs and hospitals, referring people to more intensive mental health care or social supports if needed.

HeadtoHelp offers a supported handover from intake to referral, generally in the first call, reducing the pressure on individuals to have to call a different service at a different time.

Since the service commenced 1,408 people called or made an enquiry to HeadToHelp with 836 people referred to an appropriate service: 69% to HeadToHelp hubs, 31% to other services. 576 people received services like counselling or psychology from HeadtoHelp hubs.

> “You made me feel heard - particularly after not feeling this way from many services or professionals. I wanted you to know how grateful I was, and still am.”

1408
people called or made an enquiry to HeadToHelp since the service commenced

69%
people referred to HeadToHelp hubs

576
people received services like counselling or psychology

Financial statements

STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME FOR THE FINANCIAL YEAR ENDED 30 JUNE 2021

	2021 ($)	2020 ($)
REVENUE		
Rendering of services	50,627,665	45,632,902
Other income	1,562,082	2,582,570
Total revenue	**52,189,747**	**48,215,472**
EXPENSES		
Service delivery expenses	38,945,598	37,220,739
Occupancy	159,850	730,091
Employee benefits	9,618,974	8,140,810
Depreciation	522,538	76,687
Computer licences and support	1,123,418	688,432
Finance costs	69,998	6,567
Other expenses	1,224,528	1,126,726
Total expenses	**51,664,904**	**47,990,052**
Surplus before income tax	524,843	225,420
Income tax expense	-	-
Net surplus for the year	**524,843**	**225,420**
Other comprehensive income	-	-
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	**524,843**	**225,420**

STATEMENT OF FINANCIAL POSITION AT 30 JUNE 2021

	2021 ($)	2020 ($)
ASSETS		
Current Assets		
Cash and cash equivalents	8,325,723	10,163,548
Investments	30,000,000	24,000,000
Trade and other receivables	833,342	546,666
Other assets	378,131	1,031,228
Total Current Assets	**39,537,196**	**35,741,442**
Non-Current Asset		
Property, plant and equipment	875,536	935,396
Intangibles	628,002	470,000
Right of use assets	1,510,284	1,754,205
Total Non-Current Assets	**3,013,822**	**3,159,601**
TOTAL ASSETS	**42,551,018**	**38,901,043**
LIABILITIES		
Current Liabilities		
Trade and other payables	5,023,620	4,814,202
Lease liabilities	351,993	335,507
Contract liabilities	31,369,311	28,282,812
Provisions	857,874	734,885
Total Current Liabilities	**37,602,798**	**34,167,406**
Non-Current Liabilities		
Lease liabilities	1,809,819	2,112,643
Provisions	60,848	68,284
Total Non-Current Liabilities	**1,870,667**	**2,180,927**
TOTAL LIABILITIES	**39,473,465**	**36,348,333**
NET ASSETS	**3,077,553**	**2,552,710**
MEMBERS FUNDS		
Accumulated Surplus	3,077,553	2,552,710
TOTAL MEMBERS FUNDS	**3,077,553**	**2,552,710**

phn
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