phn
EASTERN MELBOURNE
An Australian Government Initiative

Eastern Melbourne PHN
Annual Report 2018-19

Transforming Primary Healthcare

ONLINE VERSION

An online version of this Annual Report is available at www.emphn18-19ar.com

Australian Government

We acknowledge funding from the Australian Government as 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 out 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.

THANK YOU TO THE CONSUMERS, STAFF, PARTNER ORGANISATIONS AND OTHERS WHO HAVE CONTRIBUTED TO THIS REPORT.

*Names have been changed to protect the anonymity of consumers.

Contents

Welcome

Eastern Melbourne PHN is a Primary Health Network primarily funded by the Australian Government to improve the care and support people receive from health services. We aim to improve the health of our community by ensuring people receive the right care, in the right place, at the right time.

We work closely with health professionals, consumers and carers to scope the gaps, identify emerging community needs and purchase services that address these needs.

We invest in a range of initiatives to make a difference in our priority areas including chronic disease, mental health, alcohol and other drugs, digital health, Aboriginal and Torres Strait Islander health, immunisation and general practice support.

From our Chair and CEO

Chair message

CREATING A FIT-FOR-PURPOSE PRIMARY CARE SYSTEM

What the public is asking from our primary healthcare system is changing. People are living longer and there is a greater burden of chronic disease especially associated with mental health and overweight and obesity. Changing workforce engagement means there are fewer family carers for our elderly and for people with injury, ill health or disability.

Yet despite these changes in needs and context, our primary care system arguably hasn't changed much in 50 years. The same model of fee-for-service practice dominates. Sure we have had some really important changes over the last 50 years, including the introduction of Medicare in 1984. We have bulk billing now, which didn't exist in 1969. General practices are larger now too, but there is still a significant proportion of one and two person practices.

Four years ago Primary Health Networks (PHNs) were developed to integrate our primary care system, with the emphasis on the word *system*. The old model of mono-disciplinary practice, loosely connected with referral networks, is not where the future model needs to be. Indeed, the old model is already changing, but it is our job to help the system change faster and to support GPs, community health, hospitals and other providers to make this change.

We are working across five broad fronts to achieve this change, and we have set very audacious transformative goals about what we are trying to do. In essence, we want, with our partners, to build a better primary care system, so people in eastern and north-eastern Melbourne have better health experiences and better health outcomes.

We want to improve the primary care and secondary care interface. We want to expand services, filling in the gaps. This latter can only be done in line with the funding priorities of the Commonwealth Government, which provides us the overwhelming amount of our funding. We have to carefully target that funding so it does not duplicate existing services, but builds better relationships within the primary care system in our community and is sustainable in the longer term.

Over the last 12 months our focus has been on finalising our Strategic Plan for 2020 to 2025. Many of you were engaged in the consultations to develop this plan. We are now engaged on the much harder task of implementation – and many of you have been part of the implementation consultations as well. We're attempting to make serious and significant change in each of the five domains of our plan. Watch this space - Will it be 2020, 2021 or 2022 when we axe the fax?

We are also improving our commissioning processes. We have done this by improving the efficiency of what we do, and we are now looking closely at how we approach commissioning with our partners. In the next couple of years there will be a greater emphasis on relationship commissioning to help build the capacity of the primary care system in our region. We are hoping to develop a more collaborative mindset with our partners.

None of this is easy! We are hindered in our processes by the tightly constrained, highly managed budget that we have to work with. There are some positive signs that the Commonwealth Department of Health recognises that its current control processes inhibit innovation, and are not consistent with the broader directions of the PHN program nationally. We are actively engaged in discussions about improving the monitoring of our performance, especially the data we need to evaluate how primary and secondary care interface, and how this balance changes over time.

Whilst we only have a tiny amount of spare cash to kick-start the big changes we want to make, the Board has allocated funding to identify where and how our journey should start. Many of our partners are already wanting to be on this journey with us, which is really welcome. What we're talking about is not something that is going to happen tomorrow. This is something that is

happening for the longer term as it's a big transformative journey that we are embarking on. It will be an exciting one, and one which we are convinced will lead to improvements in health and health care across our region.

We look forward to you being part of that journey.

Dr Stephen Duckett
Chair

CEO's message

THIS PAST YEAR EASTERN MELBOURNE PHN HAS TRULY COMMITTED TO TRANSFORMING PRIMARY HEALTHCARE. THIS YEAR'S ANNUAL REPORT FOCUSES ON OUR TRANSFORMATIVE VISION OUTLINED IN OUR *STRATEGIC PLAN 2020-2025* DEVELOPED IN CONSULTATION WITH STAKEHOLDERS DURING 2018-19.

Our transformative vision of a redesigned and reinvigorated primary care system, holds the key to the wellbeing of people with high needs and the sustainability of the broader health care system.
Integrated care is not just a buzz term. There are already great examples in the services we commission to build on.

Addressing health gaps and inequalities

The Integrated Diabetes Education and Assessment Service has made great strides to support people with type two diabetes in the community. More than 800 patients are being treated annually and the service has been effective at supporting people to manage and lower their blood sugar levels.

Our Mental Health Stepped Care Model is now available throughout our community, where more than half of people surveyed showed significant improvement in paired outcome measure scores.

The stepped care approach underpins all the work we are doing in the mental health, alcohol and other drugs and suicide prevention space. A few examples are scattered throughout this report and will inform how we design new chronic disease management approaches as we deliver our Strategic Plan over the next five years.

Our CarePoint initiative demonstrates how empowering people to manage their own health and providing coordinated care with general practitioners at the centre, can decrease the risk of patients' type 2 diabetes worsening, requiring hospitalisation.

Partners working as a single service system

On our own, we have limited capacity to create a truly integrated, comprehensive, and people-focused primary healthcare system. Together with our partners, working together as one system, we can make real change.

An important focus of our work has been creating the Regional Integrated Mental

Health, Alcohol and Other Drugs and Suicide Prevention Plan for our community.

Together with local hospital networks, we have led targeted consultation of consumers, carers, key service providers, clinicians and peak bodies to ensure the Plan delivers improved outcomes and experiences.

Stemming from this plan, we've also undertaken a co-design process to develop integrated alcohol and other drug services to meet the needs of our community.

Leveraging digital health, data and technology

We've also made big strides forward in digital health. A 2018 survey by EMPHN found around 95 per cent of general practices still use fax to send and receive referrals to hospitals and specialists, and we have called to 'axe the fax' from our healthcare system by 2025.

An ambitious target but necessary if we are going to make a real impact on primary health. The results of the eReferral pilot have been encouraging with the volume of eReferrals received increasing from 4,500 to 13,667 this year.

Eastern Melbourne PHN was one of 31 PHNs around Australia engaged to deliver the My Health Record expansion. Through provider readiness and consumer awareness as the Regional Lead for My Health Record in Victoria and Tasmania we helped pave the way for every Australian to have a My Health Record, unless they don't want one.

A high performing organisation

We are proud to be leading the way in quality and governance. In late 2018, we received recognition as the first Victorian PHN, and one of only a few nationally, to achieve full certification against the internationally recognised AS/NZS ISO 9001:2015 Quality Management Systems standard across our entire operations.

Building workforce capacity

Underpinning these initiatives is an ongoing focus on supporting general practice, as the cornerstone of good primary health care, to become future-ready and embed continuous quality improvement.

Our work with general practices presents one of our greatest opportunities and challenges in transforming primary healthcare.

We have to do things differently to make transformative change possible at a larger scale than has previously been achieved.

Thank you to the Board, our partners and staff who have worked with us to deliver these and other outstanding outcomes.

We look forward to sharing our progress on our ambitious transformative plans in the coming year.

Robin Whyte
Chief Executive Officer

Our CEO and executive team

ROBIN WHYTE,
CHIEF EXECUTIVE OFFICER

Robin has over 20 years' experience as a senior executive and consultant in the healthcare and related sectors, including CEO roles with primary care, hospital, aged care, and disability organisations. Robin led Frankston-Mornington Peninsula Medicare Local as CEO from its establishment in 2012 until the formation of Eastern Melbourne PHN in 2015. Robin has a passion for building successful organisations that deliver great outcomes.

ANNE LYON,
EXECUTIVE DIRECTOR MENTAL HEALTH & AOD

Anne is an experienced senior executive having worked across diverse settings including health, education, government and community sectors. In 2017 Anne joined EMPHN bringing experience including leading and overseeing multi-disciplinary teams in primary health, community, and aged care settings, delivering a broad range of services.

HARRY PATSAMANIS,
EXECUTIVE DIRECTOR INTEGRATED CARE

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.

JAMES SCOTT,
EXECUTIVE DIRECTOR STRATEGIC OPERATIONS

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 Moreland Energy Foundation Limited (MEFL).

Our Board

Eastern Melbourne PHN has a talented and experienced group of professionals who lead the direction and governance of the organisation.

DR STEPHEN DUCKETT

ROBYN BATTEN

PROFESSOR JANE GUNN

DR LEONIE KATEKAR

ELIZABETH KENNEDY

DR LINDSAY MCMILLAN

TONY MCBRIDE

DR PETER TRYE

ANNE HEYES
Independent Member
Nomination Remuneration and People Committee

GABRIELLE BELL
Independent Member
Nomination Remuneration and People Committee

Board representation on Eastern Melbourne PHN committees

Community Advisory Committee: Tony McBride (Chair) and Robyn Batten

Clinical Council: Dr Peter Trye (Chair), Prof Jane Gunn and Dr Leonie Katekar

Finance and Audit Committee: Dr Lindsay McMillan (Chair) and Elizabeth Kennedy

Nomination, Remuneration and People Committee: Stephen Duckett (Chair), Robyn Batten Gabrielle Bell (Independent member) Anne Heyes (Independent member)

Strategy and Commissioning Committee: Professor Jane Gunn (Chair) Dr Stephen Duckett Tony McBride Dr Leonie Katekar

Quality, Risk and Safety Committee: Elizabeth Kennedy (Chair) Robyn Batten Dr Peter Trye

Collaborative groups and Board advisory committees

Community Advisory Committee: The committee provides a community perspective and advice to the Eastern Melbourne PHN Board to ensure that decisions, investments, and innovations are patient centred, cost-effective, locally relevant, and aligned to local care experiences and expectations.

Clinical Council: The council is an advisory group to Eastern Melbourne PHN's Board and comprises talented clinicians from across our catchment representing general practitioners, pharmacy, nursing and mental health clinicians among others.

Better Health North East Melbourne: A primary health care collaborative of representatives from organisations based in north eastern Melbourne.

Eastern Melbourne Primary Care Collaborative: A primary health care collaborative of representatives from organisations based in eastern Melbourne.

About Eastern Melbourne PHN

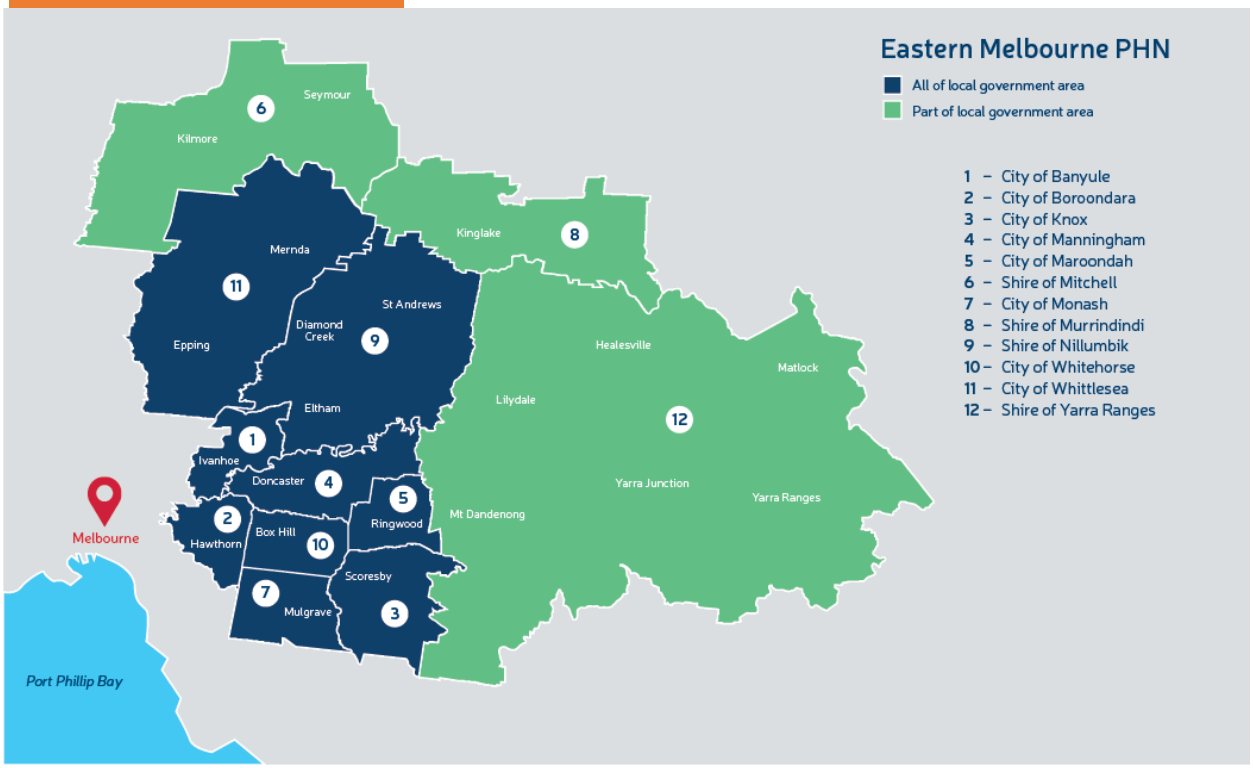
Our community

Our community of 1.5 million people live in Melbourne's east and north east, from the inner-eastern suburbs of Melbourne, to the Yarra Valley in the east, and semi-rural communities as far north as Kinglake.

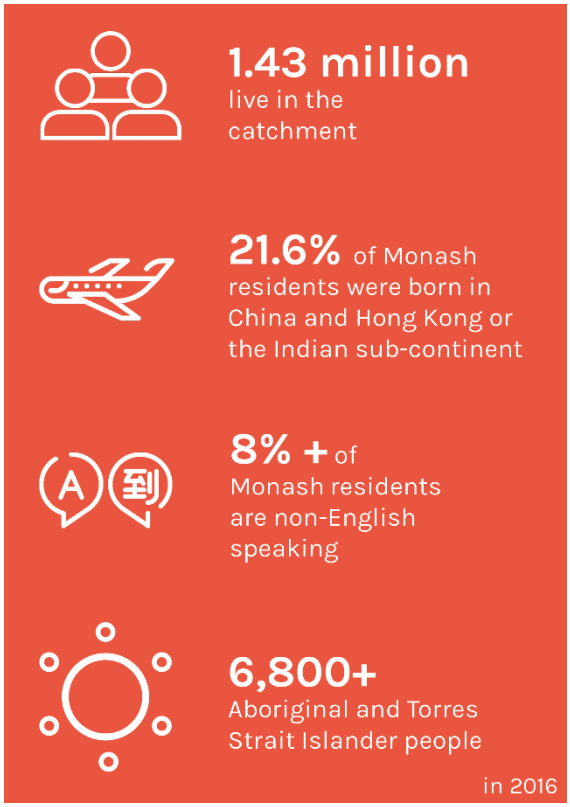
OUR COMMUNITY'S HEALTH AT A GLANCE

Eastern Melbourne PHN has a very mixed catchment. Among some suburbs of high affluence are hot spots of very high need that require a focused response such as:

- pockets of entrenched socioeconomic disadvantage including West Heidelberg and parts of Knox
- Aboriginal and Torres Strait Islander communities in Whittlesea-Wallan, Yarra Ranges, Knox and Banyule
- concentrations of non-english speaking groups in the inner east, particularly Monash
- lag in access to services in the rapidly expanding northern growth corridor of Whittlesea-Wallan and the Yarra Ranges in the outer-east.



POPULATION DIVERSITY



- The Eastern Melbourne PHN catchment population was 1.43 million in 2016 (24% of the Victorian population).
- More than 6,800 Aboriginal and Torres Strait Islander people live in the catchment, particularly in Knox, Banyule, Whittlesea-Wallan and Yarra Ranges.
- A higher than average number of people born in countries where English is not the first language live in Monash (China 12.7%, Indian sub-continent 8.9%), Whitehorse (China and Hong Kong 12.9%), and Manningham (China and Hong Kong 11.9%).
- More than 8% of the Monash population are non-English speaking, almost twice the Victorian average (4.5%).

Our strategy

Our Strategic Plan 2020-25 provides our clearly articulated strategy for achieving our vision under our five strategic priorities:

1. Addressing health gaps and inequalities
2. Enhancing primary care
3. Leveraging digital health, data and technology
4. Partners working as a single service system
5. A high performing organisation

Under each strategic priority are transformative strategies to achieve the strategic priorities.

Linked to each transformative strategy is an indicator to track performance on important measures that reflect the joint ambitions of Eastern Melbourne PHN and our partners, and a target to aim towards between now and 2025.

The outcomes demonstrate the value to people using our healthcare system and our healthcare system as a whole, by achieving transformational change.

By deliberately setting an aspirational agenda, we recognise we may not achieve all of our targets. If transformation is the goal, targets must be ambitious and not achieving them yet is not (necessarily) failure.

Our primary healthcare providers and services

We aim to improve the health of our community by ensuring people receive the right care, in the right place, at the right time.

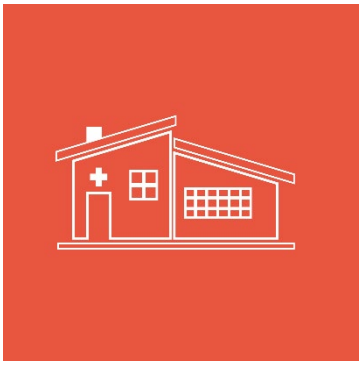
HOW DO WE DO WE DO THIS?

Eastern Melbourne PHN engages regularly with a range of other 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 AOD organisations
- pharmacists
- peak professional and consumer bodies
- federal, state and local governments
- social service agencies
- Aboriginal health organisations.

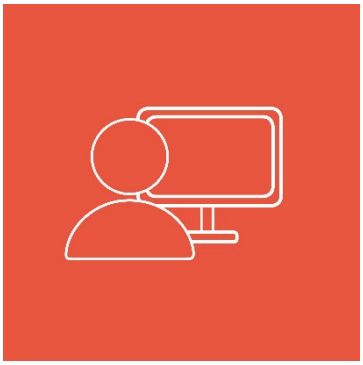
COMMISSIONING

By working closely with health professionals, consumers and carers and using health related data, we identify emerging community 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 which 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 My Health Record, and providing resources, such as HealthPathways Melbourne for practitioners to use.

Key initiatives and highlights

Strategic priority: Addressing health gaps an inequalities

Key activities 2018-19	Outcomes
Mental Health Stepped Care Model	• 2,304 referrals and average of 192 referrals per month • 12,363 treatment sessions • 47.5% showed an improvement in mental health where paired outcome of assessment was available.
To the streets: influenza immunisations go mobile	• 3,000+ people were vaccinated • 61% of those surveyed said they didn't have the influenza vaccination the previous year • 59.64% were from refugee or asylum seeker background • 46.71% would not have been vaccinated if it was not offered through the project
Integrated diabetes care for Lilydale	• An average reduction in HbA1c of 1.16% over six months for patients starting with a HbA1c greater than 7%, from a sample group of 59 patients • 94.2% of patients reported a good, very good or excellent experience
Steps to Wellbeing	• 62% of consumer have improved wellbeing as per the K10 scores • 40% of consumers requested live experience health workers • 476 referrals • 260 self-referrals
Medication Support and Recovery Service	• 22% self-referred online, 15% by health professional online, 8% GP referral online • 62% reported outcomes of reduced risk, reduction in use and abstinence • 109 clients engaged for therapeutic counselling, 37 for withdrawal nursing, 83 for nurse practitioner episode of case and 21 participants for peer support • Average clinical episode of care in the MSRS is 85 days
Drug and alcohol program	• Principle drug of concern for 61.9% of clients was alcohol, followed by cannabis, nicotine and amphetamines • The biggest age group representation was 26-35 year olds

Sons of the West in the North

Thirty men from Melbourne's north are now better equipped to manage their physical and mental health after graduating from the Sons of the West in the North men's health program.

The unique approach was successful in bringing men together in a comfortable setting to discuss wellbeing and mental health, when they otherwise would struggle to ask for help.

PROGRAM OUTLINE

- Six-week program
- Two hours of physical activity and health education each week, tackling topics on physical and mental health, and wellbeing
- Delivered in partnership between Eastern Melbourne PHN, Whittlesea City Council and Western Bulldogs Community Foundation
- Partly funded by the Victorian Government Department of Health and Human Services' (DHHS) Place Based Suicide Prevention initiative which Eastern Melbourne PHN has partnered with DHHS to deliver the initiative in Whittlesea

GORDON'S STORY: COMRADERY IMPROVES HEALTH

In July last year, Gordon developed prostate cancer. Post-surgery it was discovered he had Lymphoma and then he developed two post-surgery hernias.

Earlier this year Gordon was really struggling as another round of sinus infections compounded things, when he received a flyer that Sons of the West were coming to his area.

"Being retired it is so easy to stay in bed the extra while or not go out because it is cold or hot or raining or whatever," he said.

"Along came Sons of the West to show how you should stretch muscles and feel a bit of pain, and then get out there and keep doing a bit every day.

"Sons of the West in the North is fabulous for men's health and wellbeing."

Mental Health Stepped Care Model

In January 2018, EMPHN started transitioning to the Mental Health Stepped Care Model; an evidence-based, clinical staged system of care that includes a range of mental health interventions, from the least to the most intensive.

Following consultations and co-design forums with stakeholders in 2016-17, the phased implementation of the model is complete, with the third and final phase starting in the inner-east in January 2019.

Services include:

- group and individual psychological interventions
- suicide prevention support
- care coordination
- dual diagnosis services
- online support.

The whole-of-person is considered, including physical health needs and social supports such as housing, financial and employment and education.

Multi-disciplinary care teams (including GPs) work with consumers, carers and families to identify needs and develop collaborative, tailored care plans.

OUTCOMES

- **2,304** referrals and average of **192** referrals per month
- **12,363** treatment sessions
- **47.5%** showed an improvement in mental health where paired outcome of assessment was available.

MAX'S STORY: NEW MENTAL HEALTH PROGRAM GIVES MAX A LIFT

Whittlesea resident Max, aged 43, was referred to the Mental Health Stepped Care service, LIFT, delivered in the north-east after attempting suicide. He had recently been discharged from an acute psychiatric unit with a diagnosis of depression and agoraphobia.

"Over time, my LIFT team has gained a better understanding of my needs," he said.

"While I still need treatment, my physical and emotional pain has lessened and the modifications to my home and connection to people and places has greatly improved my overall health and wellbeing.

"I feel I'm getting the level of care I need, when I need it, without having to tell my story again and again."

The LIFT team works closely with a consumer's GP and other key support people to link them to a wide range of services to address other needs.

The service can support people through online support groups and apps, group programs, individual therapy, care coordination and peer support, so people get the right care when they need it.

Wrap-around services may include housing, employment, family violence, gambling, family and social functioning, and alcohol and other drug harm reduction.

LIFT is delivered by Banyule Community Health with partners healthAbility and Nexus Primary Care.

To the streets: influenza immunisations go mobile

Improving influenza immunisations rates is one of Eastern Melbourne PHN's priorities. Eastern Melbourne PHN funded EACH to provide a mobile immunisation service for vulnerable communities in Maroondah, Knox and the Yarra Ranges local government areas.

By collaborating with key stakeholders, the service was able to reach communities in need of support including:

- regional refugee/asylum seeker services (Migrant Information Centre)
- Indigenous Gathering places (Mullum Mullum Indigenous Gathering Place)
- emergency/crisis support agencies (Wesley Mission and the Winter Shelter Program)
- neighbourhood houses
- churches
- winter shelters
- schools
- kindergartens
- libraries
- community meals/food pantries.

The City of Whittlesea was also funded to vaccinate people in their community.

OUTCOMES

- **2,942+** people were vaccinated by EACH
- **61%** of those surveyed said they didn't have the influenza vaccination the previous year
- **59.64%** were from refugee or asylum seeker background
- **28.57%** were unemployed
- **7.29%** were pensioners or retired
- **46.71%** would not have been vaccinated if it was not offered through the project

Integrated Diabetes Education and Assessment clinic Lilydale opens

The Integrated Diabetes Education and Assessment (IDEAS) program provides greater access to local services for people living with type 2 diabetes to improve and manage their condition in the community.

The care team comprising an endocrinologist, diabetes nurse educator, podiatrist and a dietetic, provide individualised care and education for patients covering physical health, diet and other lifestyle factors.

The program has been successful in reducing levels of diabetes distress, improving sense of self-efficacy supporting people to manage and lower their blood sugar levels, which means an increased sense of control and better quality of life.

In February 2019 the service expanded to Lilydale to meet the needs of people living in the Yarra Ranges area, where rates of preventable hospital admissions for type 2 diabetes is one of the highest in east and north-east Melbourne.

IDEAS is provided by Carrington Health, Inspiro, Eastern Health, EACH and Access Health and Community.

OUTCOMES

- An average reduction in HbA1c of 1.16% over six months for patients starting with a HbA1c greater than 7%, from a sample group of 59 patients
- 94.2% of patients reported a good, very good or excellent experience with IDEAS.
- Around 800 patients are treated annually
- 95 per cent of people referred by their GP to the Eastern Health Endocrinology and Diabetes clinics are now having their diabetes managed closer to home at an IDEAS clinic

Mental health support for young people

2018-19 saw the announcement of more local mental health services for young people in our community, where people aged 18 to 24 have the highest prevalence of mental illness of any age group.

In April 2019, the Australian Government announced:

- headspace centre in Monash
- headspace satellite in Whittlesea
- headspace satellite in Lilydale.

These services will improve access to local mental health services for young people in the community. Services are planned to start in 2020.

We also played a role in forming the Eastern Melbourne Region Youth Suicide Postvention Network; a group of services that work with young people in our region. When a young person under 25 years of age suicides, the Network coordinates service support for the community quickly.

A new Psychosocial Support Service

From April 2019, Eastern Melbourne PHN funded Neami National $3.4 million over two years to support people experiencing severe, episodic mental health problems who are currently ineligible for the National Disability Insurance Scheme (NDIS).

With the arrival of the NDIS, consumers are now transitioning from a range of existing programs to newly funded psychosocial support services.

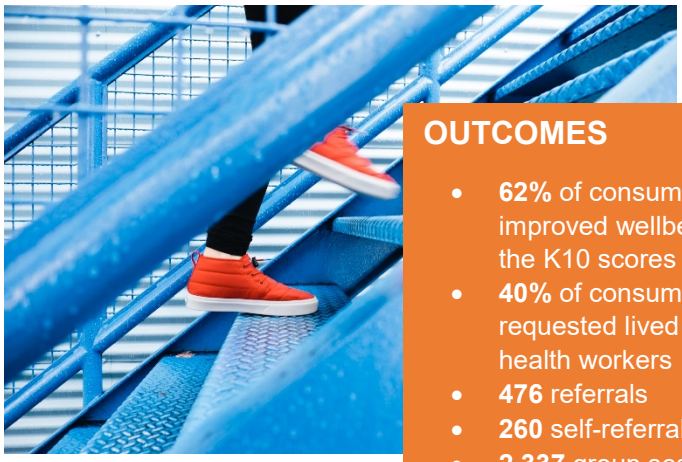
The service will help those people who have not transitioned to NDIS and provide flexible services for up to 12 months for people experiencing mental health issues at a time when they need it most.

The service will provide practical help and community connections that people with severe mental illness need for ongoing support.

The service is funded by the Australian Government's National Psychosocial Support (NPS) measure under the PHN program.

Steps to Wellbeing

Steps to Wellbeing is a low intensity service as part of our early intervention approach to mental health support.



Steps to Wellbeing offers support to people experiencing increased stress, life challenges or emerging signs of anxiety or depression, through six one-on-one wellbeing coaching sessions. People needing longer and more intensive support can transition to our Mental Health Stepped Care Model.

Fifty-per cent of Steps to Wellbeing coaches are people with lived experience, who are trained to provide support around topics such as understanding and identifying early signs of stress, anxiety or depression, developing strategies to support and improve your wellbeing and identifying supports and resources that can assist your wellbeing in the future.

OUTCOMES

- **62%** of consumers have improved wellbeing as per the K10 scores
- **40%** of consumers requested lived experience health workers
- **476** referrals
- **260** self-referrals
- **2,337** group sessions
- **1,750** individual sessions
- Brochures in **9** languages

HEATHER'S STORY: HEATHER TAKES BIG STEP TOWARDS WELLBEING

Heather*, 64, had her first Steps to Wellbeing coaching session in July 2018.

Reporting a long-term experience of anxiety, depression, memory impairment and feelings of isolation, Heather also lost her job three years ago – which has been the most challenging period.

Prior to the program, she was not accessing any mental health supports and relied on the help of a few close friends.

Heather also has a complex health history including several thoracotomies (one which damaged her vocal chords and required intensive speech pathology to enable her to speak again) and chronic pain.

As a carer for her mother who has dementia, and two siblings, one with an ABI and another with an intellectual disability, Heather has been trying to access support from the National Disability Insurance Scheme and Centrelink, with the aid of her friend.

With the support of her Wellbeing Coach, Heather undertook a number of activities to identify her strengths and values, identify unhelpful thinking patterns and strategies to support herself around these, understanding her current situation and stressors and breaking down simple steps focusing on what she could control, and strategies to support herself around anxiety.

Heather's Wellbeing Coach also referred her to Arbias for a neuro-psychological assessment around her acute memory difficulties she had been experiencing and to Partners in Recovery for ongoing community-based support after the completion of her coaching sessions.

She has also been avid attendee of our Wellbeing Workshops, including our 6-week Flourish and Self-Compassion program.

Heather's wellbeing has improved, including a drop in K10 score indicating a decrease in depressive and anxiety symptoms, and an improvement in her sense of self-efficacy.

Heather's improvement

Outcome measure	Assessment	At completion
Kessler-10 Plus (K10+)	36 (Maximum score of 50)	25
General Self-Efficacy Scale (GSE)	21 (Maximum score of 40)	29

Launch of mental health and AOD atlas

In August 2018, EMPHN released the Eastern Melbourne PHN Integrated Mental Health and AOD Service Atlas, an important planning tool to assist in identifying gaps and opportunities to inform planning for mental health and alcohol and other drugs (AOD) services.

Acknowledging that local needs vary depending on region, the Atlas will allow for comparisons to be made between similar regions, to provide Eastern Melbourne PHN with a deep understanding of the sector to better plan local health solutions.

The Atlas was developed by Associate Professor John Mendoza from ConNetica on behalf of Eastern Melbourne PHN, utilising a standardised classification system and his wealth of experience in mental health and AOD research and integrated health care.

Information in the Atlas was collected from 22 eligible non-government organisations (NGOs) as well as 13 consortia or partnerships and five public health sector organisations.

The Atlas can be accessed on Eastern Melbourne PHN's website at **https://bit.ly/2o1kGtR**

Aboriginal and Torres Strait Islander health

Mental health support

EMPHN funds organisations such as Banyule Community Health, Eastern Health's Yarra Valley Community Health Aboriginal Service, HICSA and Bubup Wilam to deliver culturally appropriate mental health services to Aboriginal and Torres Strait Islander people.

JEFF'S STORY: SUPPORT AT THE RIGHT PLACE; AT THE RIGHT TIME

Up until recently Jeff*, 21, was living with his ex-partner, their two year-old daughter and his ex-partner's mother, who he refers to as his mother-in-law. Both of Jeff's parents are deceased and he has little contact with his biological family, leading his mother-in-law to be identified as the closest person to him.

Jeff's ex-partner recently started a new relationship with a man who Jeff doesn't get along with and receives threatening messages from, affecting his emotional wellbeing and making it difficult for him to continue living in the house. This situation was causing him to experience bouts of depression and anxiety.

Despite being unhappy with his living situation, Jeff did not want to explore alternative accommodation as he did not want to disappoint his mother-in-law after all she had done for him. Instead, the youth counsellor at Eastern Health worked with Jeff to develop coping strategies.

In January the Eastern Health Aboriginal Health Team organised a three day family camp in for families. Jeff chose to take his mother-in-law and daughter and provided them with the opportunity to engage in family therapy.

An upcoming interstate holiday for his mother-in-law posed as a potential trigger for possible conflicts. As suggested by the counsellor, Jeff and his ex-partner attended a counselling session together to put a plan in place that would help support them to co-parent effectively while the mother-in-law was away. The Department of Human Services were also involved in brainstorming ideas to reduce risk to the family.

Despite this, an argument between Jeff and his ex-partner ensued, resulting in his ex-partner calling the police and an Apprehended Violence Order (AVO) lodged against him.

Eastern Health supported Jeff through the court process, having decided to have the court hearings in the Magistrates Court as opposed to the Koori Court. Jeff decided not to contest the AVO stating that he had come to the realisation that it will be better for his mental health to not live with his ex-partner.

Eastern Health assisted Jeff to obtain several pieces of furniture and household goods required for his new accommodation.

Jeff's mental health has improved since living in his new environment. Jeff's counsellor is now working with him to develop new goals which include going for his driver's licence, beginning to paint and to plan a holiday with his family in October.

Jeff also has chronic end-stage kidney disease, and was referred to an Aboriginal health nurse by his youth counsellor to manage his complex health condition and support with things such as transport to and from appointments. His counsellor assisted him in lodging paperwork to secure himself a position on The Big Red Kidney Bus so he can receive dialysis during this holiday.

Yarra Valley Community Health Aboriginal Health Service offers culturally appropriate counselling, youth support, primary to secondary school transition, psychiatric outreach support and community development.

This service is delivered by Eastern Health.

Health and Wellbeing program

The Aboriginal Health and Wellbeing Program aims to support Aboriginal communities in eastern and north eastern Melbourne through initiatives that provide better access to health and wellbeing services and which provide greater opportunities for Aboriginal communities to develop services to their communities' requirements.

The framework for achieving this is aligned to wider efforts to close the gap in life expectancy and health outcomes between Aboriginal peoples and non-Indigenous Australians.

Reconciliation Action Plan

Eastern Melbourne PHN's recently developed Reconciliation Action Plan (RAP) has been submitted to Reconciliation Australia for endorsement.

The program:

- identifies and acts on local Aboriginal Communities' knowledge of their needs and their understanding of how to address those needs
- addresses the care coordination needs of Aboriginal people living with ongoing conditions such as diabetes and asthma
- supports access for Aboriginal Communities to primary health, alcohol and other drug treatment, mental health and other types of services

- contributes to building a health system that provides high quality, accessible and culturally safe and appropriate health care
- supports communities to access after-hours primary care, cancer screening and childhood immunisation and
- collaborates with other governments and non-government organisations to develop united approaches to service development that continue to increase Aboriginal Community control over the provision of services and support for their communities.

Eye health

Eastern Melbourne PHN is partnering with local Indigenous eye health specialists to facilitate better eye health outcomes for Aboriginal communities.

EMPHN is working with the:

- Indigenous Eye Health Unit at Melbourne University, and Eastern Metropolitan Melbourne Aboriginal Eye Health Regional Stakeholder Group,
- North and West Melbourne Indigenous Eye Health Stakeholder Group.

These stakeholder groups are working towards:

- raising community knowledge of eye health services
- clearer and more coordinated referral paths
- providing better eye health information
- identifying service gaps.

Medication Support and Recovery Service

The Medication Support and Recovery Service (MSRS) is a unique service which caters specifically for people who are at-risk of medication misuse or dependency.

The community-based service delivered by Access Health and Community and partners, helps people who identify as having problems with their use of prescription or over the counter medication.

The service helps people who want to reduce or come off current medications, but do not know how, or who to turn to.

The MSRS provides an integrated multidisciplinary program delivered by nurses, nurse practitioners, counsellors and peer support workers.

MSRS collaborates with an individual's GP to create a plan for staged medication tapering.

In addition, the MSRS offers one-on-one of group peer support, for those who would prefer to use non-clinical services.

This service is delivered by Access Health and Community, Link Health and Community, Banyule Community Health, Whittlesea Community Connections, Carrington Health, Inspiro Community Health and HealthAbility.

OUTCOMES

- 80% of all substances used by MSRS consumers are prescription or over-the-counter medications.
- 20% of consumers reported using illicit drugs in conjunction with prescription or over the counter medication
- 50% of referrals made were via telephone, 22% self-referred online, 5% family referral online, 15% health professional online, 8% GP referral online
- Following treatment, 62% of consumers reported outcomes of reduced risk, reduction in use, and abstinence
- The program engaged 109 clients for therapeutic counselling, 37 for withdrawal nursing, 83 for nurse practitioner episode of care and 21 participants for peer support
- The average clinical episode of care in the MSRS is 85 days from initial contact with a clinician, until the consumer's discharge date

Drug and alcohol program

SONIA'S STORY: TEN WEEKS CLEAN AND COUNTING

> "I have now been totally clean for about 10 weeks. I am currently in the best mental and physically shape I have been for about three years ..."

The Drug and Alcohol Program delivered by Link Community Health works with Chinese and CALD community to reduce AOD substance use and associated harms. This is done through counselling, group intervention and referral to family support services.

LEARNINGS

- The highest number of clients came from China
- The principle drug of concern for **61.9%** of clients was alcohol, followed by cannabis, nicotine and amphetamines
- The biggest age group representation was **26-35** year olds

Prior to being referred to my case worker from Link Health by the Monash University Health Services, I had been consuming Cannabis on a daily basis without exception. I felt stuck in my own world and could not cope with the hectic demand of a full-time job and my postgraduate studies without what I thought was a magical herb. I would even smoke before sitting for exams, class presentations and doing my assignments at night, to the extent that I would achieve my best academic results and finish first in class.

Seeking help from my case worker has, however, showed me an alternative path to cannabis by building and discovering my neural pathways to happiness through activities that I already knew and were readily available to me, such as playing guitar, meeting people through Uber driving, going to gym, meditation, riding to the beach and making new friends and socialising. Most strikingly, I was taught how to find closure and cut ties with friends who were of bad influence, including my cannabis dealer. I was also advised how to be creative and rearrange my room so that I could stay inside it without being tempted to smoke. In one of our six sessions, I was encouraged to imagine how I would get rid of 7 grams of cannabis that I had kept in my cupboards for weeks. I decided to treat it like faeces and flushed it through the toilets when I got home that night.

Despite my initial fears, I believe that seeking professional help from an AOD counsellor such as my case worker is a worthy exercise. I had made several unsuccessful attempts at withdrawing before our first meeting. Perhaps the most important aspect of her counselling, in my view, was the way she prepared me for the mental rigours and stress associated withdrawal, without which I would undoubtedly never have been able to come out on the other side. I quit smoking within two weeks of our first session. I have now been totally clean for about 10 weeks. I am currently in the best mental and physically shape I have been for about three years and will be forever grateful to my case worker and Link Health for it.

Strategic priority: Enhancing Primary Care

Key activities 2018-19	Outcomes
Building Workforce Capacity	• 865 GPs attended events • 934 continuing professional development events
Quality Improvement in general practice	• Launch of online self-guided QI learning module • QI videos viewed 232 times in six months
Fracture Diversion Project	• 1,619 total diversions from emergency department to fracture clinics from January-April 2019
Managing diabetes in the community	• 81 clients commenced the program in April 2019 • 45% of participants are 65+ and over half are on a health care or pension card • 77% of participants were rural residents
Psychiatric Consultation and Advice Service	• 100% felt their request or question was understood by the service provider • 92% said they benefited from the service • 100% would recommend the service to colleagues
Pharmacists based in GP clinics	• 303 patient consultations from September 2018-May 2019 • 104 medication reviews from September 2018-May 2019

Building workforce capacity

EVENTS BREAKDOWN

- **865** GPs attended events
- **377** practice managers attended
- **573** nurses attended
- **934** events were continuing professional development (CPD) events

Eastern Melbourne PHN is committed to building capacity of general practices and primary health care practice staff, including general practitioners, practice managers, primary care nurses and administrative staff.

EMPHN can support general practices and their staff by:

- providing resources and information to optimise patient health care and quality business outcomes
- facilitating professional development sessions through coordination of educational events and webinars on various topics
- visiting practices to educate on a particular topic or a general visit to update practices on topical issues and current programs and services offered.

EMPHN supports general practices by providing high quality resources and education opportunities.

EMPHN can also support general practices to:

- meet practice accreditation requirements
- adopt best practice and take up quality improvement initiatives
- use their data to improve patient care
- set-up and implement digital health innovations such as telehealth or eReferral.

Preparing general practices for the future

Practice 2030 aims to build a network of practices who have a vision for the future, are ready for change and have the strategies to implement and sustain changes. The vision is to support a network of high performing, comprehensive general practices providing quality care to all in our community.

Practice 2030 aligns general practices to the 10 building blocks of high performing practice − an internationally accepted template for the future of general practice.

Tranche 2 begun in July 2018 for 12 months.

- At the beginning of the project, seven out of 11 participating general practices scored low on the Primary Care Practice Improvement Tool (PC-PIT) however after intense work with support from the team, all practices have made improvements.
- Some general practices ensured continued improvement through embedding learnings in documentations and policies.
- Their understanding of working collaboratively and using the Plan Do Study Act (PDSA) cycle as a quality improvement tool has shown to be successful.

Quality Improvement in general practice

With the announcement of the new Practice Incentive Payment (PIP) Quality Improvement (QI) starting on 1 August 2019, in 2018-19 EMPHN lay the foundations needed in readiness to support general practice with this transition.

Activities included:

- Development of the quality improvement learning module:
  - EMPHN's self-guided QI learning module contains online training videos supported with practical guides, checklists and resources that aim to guide general practice teams through the quality improvement journey.
  - From December 2018 to June 2019 the videos were viewed 232 times.
- Quality improvement in general practice data quality workshops provided participants practical strategies on how to
  - recognise and understand the importance of data quality in their practice
  - learn to interpret practice data
  - use data to identify and track areas of improvement
  - develop data quality plans.

Fracture Diversion Project

EMPHN funded the Fracture Diversion project: a collaborative pilot program between Austin Health, Eastern Health and Northern Health, and general practitioners (GPs) interested in managing simple fractures in primary care. The project commenced in July 2017 with the aim to reduce the number of patients presenting to emergency departments (EDs) being referred to hospital fracture clinics for management of simple fractures.

Results from Phase 1 of the project (July 2017-March 2019) demonstrate the benefit of this new model.

- **18 GPs** completed 15 hours of supervised clinical attachments and 12 hours of workshop participation.
- Peak hospital diversion rates were between **70-85%.**
- The average diversion rates also increased significantly from baseline.
- Patients were positive about their care with **97%** (n=237) happy to be treated by a GP in the future. The top reasons for this were convenience, reduced waiting time and receiving individualised care.

EMPHN has funded the program for an additional 12 months to embed the model in hospitals. Phase 2 of the project is in progress.

SUMMARY OF SIMPLE FRACTURE DIVERSIONS RATES (PHASE 1-BASELINE) JANUARY 2019-APRIL 2019

Health services	Total diversions	Average monthly diversions	Highest diversions in a month	Percentage average monthly diversions
Northern Health	567	141	62%	60%
Eastern Health	1,052	263	89%	85%
Total	1,619			

Data from the first quarter of 2019

Managing diabetes in the community

Diabetes Diversion Partnership Project (DDPP) works toward the long-term goal of improving patient outcomes for residents of Whittlesea, Mitchell and Murrindindi and reducing demand on acute services.

The partnership, led by Nexus Primary Health (Nexus), includes DPV Health, Precedence Health Services and Hume Whittlesea Primary Care Partnership (HWPCP), provides type 2 diabetes diversion initiatives that encourage innovative integrated models of care.

First quarter report revealed early success of the program:

- HBA1C readings dropped during the program, with the percentage of people in group one with a HBA1C reading of 9 dropping from 30% to 14%.
- **100%** feel more information and better able to manage their diabetes.
- **100%** of GPs felt the program contributed to their confidence in managing type 2 diabetes.

The partnership works closely with Northern Health, Kilmore and District Hospital and other stakeholders

CLIENT DEMOGRAPHICS

- **81** clients commenced the program in April 2019
- **45%** of participants are 65+ and over half are on a health care or pension card
- **77%** are rural residents

Psychiatric Consultation and Advice Service

100% of GPs would recommend this service to colleagues.

The Melbourne Clinic provides specialist psychiatric consultation and advice to GPs and EMPHN-commissioned mental health and AOD service providers.

The service is staffed by psychiatrists providing specialist support/advice and secondary consultation. Primary consultation may also be available for complex cases, on a case-by-case basis.

Clinic-based education to general practice teams can also be arranged.

OUTCOMES

- The first six months of the service has been successful in servicing hard to reach groups:
  - **6%** are from culturally or linguistically diverse background
  - **3%** are aged 65+
  - **28%** are 12-25 years old
  - **15%** are 13-17 years old
- **56%** of patients (where age is known) were under 35
- **55%** of patients (where gender is known) are female
- **39%** of referrals are from the Inner East LGAs
- **Education:**
  - **100%** of referrer agreed or strongly agreed sessions were relevant and presenter was clear
  - **98%** agreed or strongly agreed information presented was applicable to their practice
  - 87% agreed or strongly agreed information increased their knowledge
- **Service satisfaction:**
  - **92%** found the service easy and convenient to access
  - **100%** felt comfortable to use the service
  - **100%** felt their request or question was understood by the service provider
  - **92%** said they benefited from the service
  - **92%** would use the service again
  - **100%** would recommend the service to colleagues

Pharmacists based in GP clinics

As people age and develop chronic health conditions, they are likely to use more medicines. However, using a greater number of medicines can lead to medication-related harm: people taking more than five medications are at greater risk of an adverse effect.

To reduce this risk and help older people use medicines well, EMPHN funded Blackburn Clinic and Nillumbik Medical to each employ a clinical pharmacist in their practice.

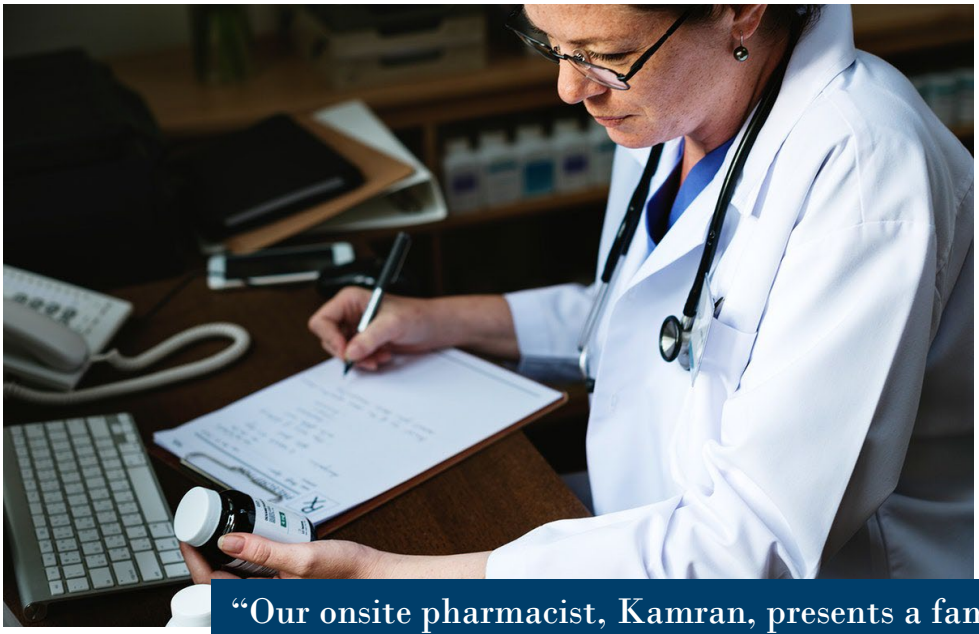
The pharmacist provides expert medicine advice and support to reduce possible side effects – to particularly help those with multiple prescriptions, such as the elderly and people with chronic illness.

OUTCOMES FROM SEPTEMBER 2018-MAY 2019

- **303** patient consultations
- **104** medication reviews
- **51** patient education engagements
- **11** discharge medication reviews
- **26** device technique run-throughs

The project aims to:

- improve medication management in patients attending general practice
- provide support to GPs and practice nurses in managing patients with complex medication plans
- increase the review of medications and patient support activities.



"Our onsite pharmacist, Kamran, presents a familiar face when providing readily accessible knowledge into medication awareness and support for our patients. Kamran is also a valuable training resource for our nurses and doctors."

- *Nillumbik Clinic Clinical Care Manager Felicity Emery.*

Strategic priority: Leveraging digital health, data and technology

Key activities 2018-19	Outcomes
HealthPathways Melbourne	• Increased GP engagement has generated 12,047 users in 2018-19 • 36.77% increase in users compared to previous year • 129 new pathways
My Emergency Dr	• 3,398 calls were managed through MED since July 2018. 40% were related to children. • Calls to MED decreased emergency department (ED) attendances by 36.7% • 97.1% of users rated the service 4 or 5 stars out of 5
POLAR GP	• 66% of compatible general practice have POLAR GP installed as of May 2018 • 305 practice reports have been presented to general practices to assist with quality improvement
EMPHN axing the fax	• 68% of eligible practices are participating in the pilot • 1,000+ eReferrals were sent each month
My Health Record	• 150+ organisations were engaged with by telephone and email • 675 meaningful engagements in one week • 2,567,866 estimated reach throughout regional activities
SafeScript roll out	• 6 face-to-face joint training events for prescribers and pharmacists • 16 general practices received in-practice accredited training (84 GPs)

HealthPathways Melbourne

HealthPathways Melbourne provides clinicians with a single website to access clinical and referral pathways, and resources.

Each pathway is written for use during a consultation, providing clear and concise guidance for assessing and managing a patient with a particular symptom or condition.

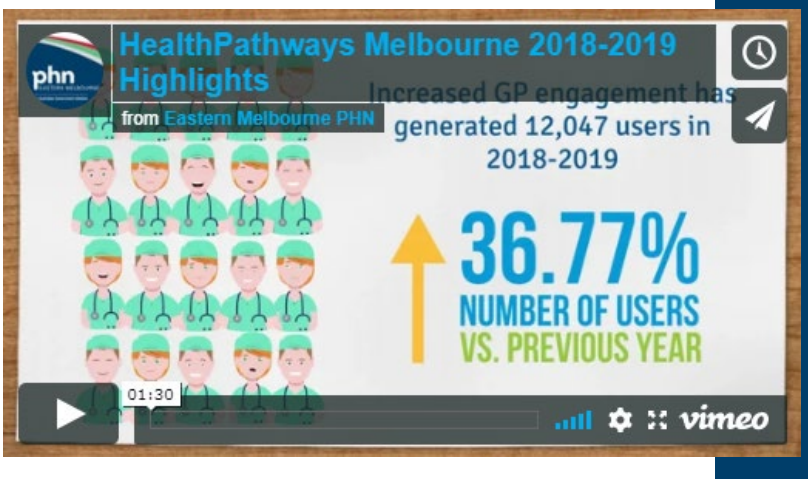
HealthPathways Melbourne highlights in 2018-19 include:

- Increased GP engagement has generated 12,047 users in 2018-19
- 36.77% increase in users compared to previous year
- 129 new pathways
- provided automatic login for organisation to increase ease of use – 460 organisations have automatic login
- Successful HealthPathways Melbourne eReferral Integration commenced this year. The eReferral integration allows general practices referring to Austin Health, Eastern Health and Northern Health and using compliant clinical software to access HealthPathways Melbourne referral pathways from the electronic referral template. 1,137 pageviews have resulted from this integration since March 2019
- Number of page views has almost doubled from 2016-17 period
- Top viewed localised page is Polycystic Ovarian Syndrome
- Top search terms: Diabetes, Gout, Diabetes, Gout, Hypertension, Back pain, Shingles consistently in the top 10 frequently used search terms.

HEALTHPATHWAYS MELBOURNE AIMS TO:

- enhance clinical knowledge and promote best practice care
- reduce the number of patients referred to specialist care who could be managed in a primary/community care setting
- build collaboration and reduce fragmentation across the health service network
- improve health outcomes by enabling consumers access to the right care, in the right place, at the right time

HealthPathways Melbourne is a collaborative program run by the EMPHN and North Western Melbourne PHN (NWMPHN), and is supported by local hospitals, council, and other health organisations in both the EMPHN and NWMPHN regions.



My Emergency Dr

My Emergency Dr is an app that facilitates a video consultation with an Australian-registered specialist emergency doctor within minutes when a person's usual GP isn't available after-hours.

The service fills a gap where communities located on the urban fringe cannot access the urgent advice and care they need, as home visiting doctors may not be available or take too long to get to a patient.

Even in metropolitan areas, patients can wait long periods for a home doctor to attend, resulting in many patients attending emergency departments unnecessarily.

Through Eastern Melbourne PHN's funding, the service is free for residents living in Melbourne's east and north-east in the after-hours period, and is also available at cost to people Australia-wide.

Since the implementation of the initiative in July 2018, patients have provided overwhelmingly positive feedback for the service with calls to the service growing at a rapid rate.

OUTCOMES

- **3,398** calls were managed through MED. 40% were related to children
- Calls to MED decreased emergency department (ED) attendances by **36.7%**
- Highest usage of service was in the urban fringe LGAs of Whittlesea and Yarra Ranges, where there is limited service availability
- **88.2%** of cases were advised to remain at home. **11.8%** were advised to attend the ED and only 1.1% were advised to call an ambulance
- **48.5%** advised they would have attended ED if they had not called MED. **7.1%** would have called 000
- **97.3%** of survey respondents said they would call the service again
- **97.1%** rated the service **4 or 5 stars out of 5**

POLAR GP

POLAR GP stands for Population Level Analysis and Reporting for general practice. POLAR GP is useful for insight and planning across the areas of clinical, business and accreditation. It enables general practices to analyse their own patient data which is presented in an easy to use graphical format. EMPHN provides POLAR GP free for general practices of all sizes within its catchment.

POLAR GP can be used to:

- analyse clinical and billing data
- run self-directed reports on numerous queries
- identify MBS opportunities
- build business development strategies
- meet accreditation requirements.

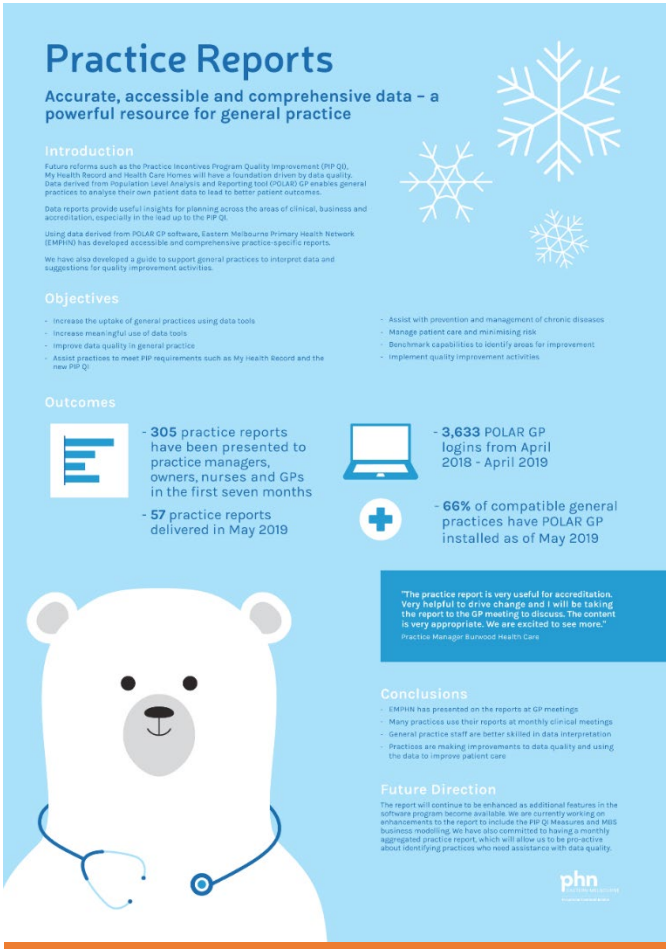
Since the program's installation, Watsonia General Practice has become familiar with current practice data and uses various risk stratification tools on a regular basis to determine active clinic patients at risk of chronic illness and have worked as a team to put in place preventative care strategies to benefit patient care. This includes a new Practice Recalls and Results Quality Procedure incorporating the use of POLAR to assist with patient follow up and preventative care.

The general practice also use this program to understand other general clinic data that is of benefit to the practice operations and patient care.

The use of POLAR has allowed Watsonia General Practice to actively participate in other programs such as the Rising Risk Project commissioned by EMPHN, and have been commended by the Chair of the group for their active engagement in the pilot.

Future reforms such as the Practice Incentives Program Quality Improvement (PIP QI), My Health Record and Health Care Homes will have a foundation driven by data quality.

Using data derived from POLAR GP software, EMPHN has developed accessible and comprehensive practice-specific reports.



OUTCOMES

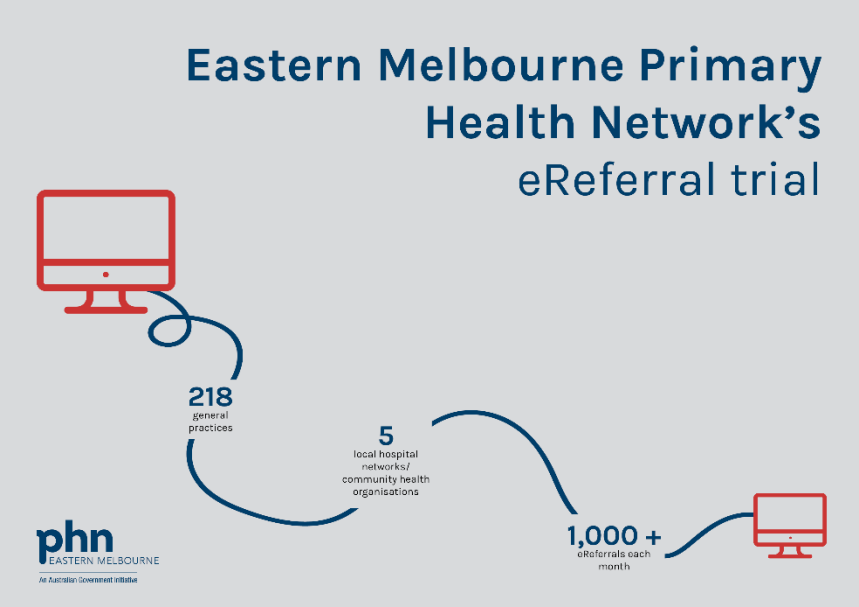
- **66%** of compatible general practice have POLAR GP installed as of May 2018
- **305** practice reports have been presented to practice managers, owners, nurses and GPs in the first seven months to assist with quality improvement

> "The practice report is very useful for accreditation. Very helpful to drive change and I will be taking the report to the GP meeting to discuss. The content is very appropriate. We are excited to see more."
>
> *Practice Manager Burwood Health Care*

EMPHN axing the fax

In early 2019, EMPHN called to axe the fax from our primary healthcare system by 2025.

A 2018 survey by EMPHN found around 95 per cent of general practices still use fax to send and receive referrals to hospitals and specialists, while only 42 per cent send and 74 per cent receive referrals via secure messaging.



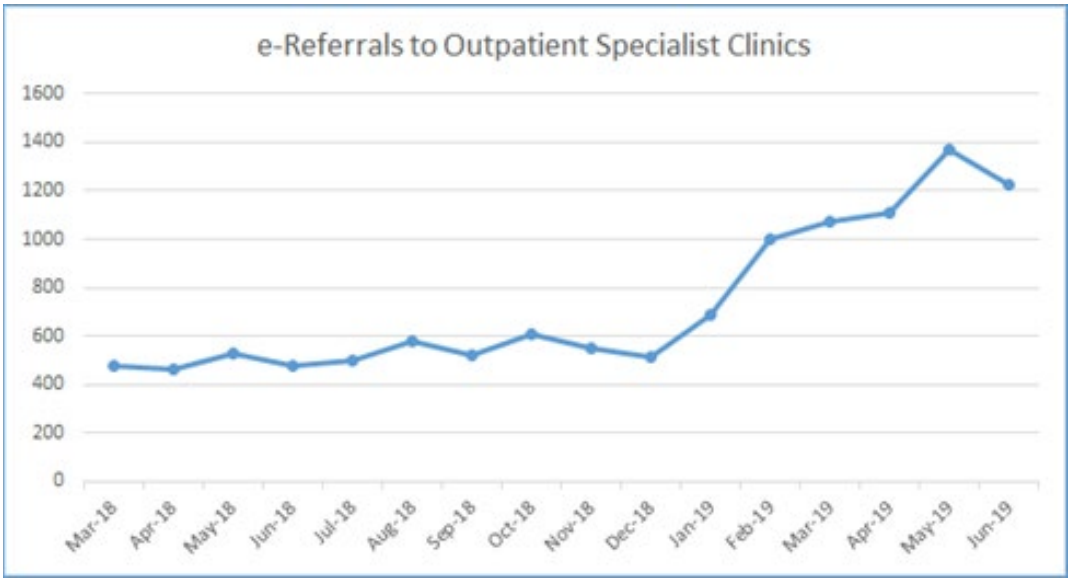
EMPHN has collaborated with Eastern Health, Austin Health, Carrington Health and Banyule Community Health to deliver the Eastern Melbourne Primary Health Network eReferral Project and increase the number of general practices using BPAC's SeNT eReferral and HealthLink's SmartForms eReferral technologies to electronically refer from within their clinical workflow.

It is one of the largest implementations of its kind Australia-wide to date, aiming to digitally transform eastern and north-eastern Melbourne's primary healthcare system.

68 per cent of eligible practices are participating in the pilot.

The trial was originally funded by the DHHS and is now being supported by the Australian Digital Health Agency (ADHA).

REFERRAL VOLUMES



Volume of e-Referrals received increased from 4,500 to 13,667 from July 2018-June 2019

My Health Record

Eastern Melbourne PHN was appointed as Regional Lead for My Health Record for Victoria and Tasmania which includes the six Victorian PHNs and Primary Health Tasmania.

EMPHN was responsible for two objectives:

1. To inform the community in our region that a My Health Record will be created for them in 2018 unless they tell the Agency they do not want one, and the opt-out provisions if they do not wish to have one.
2. To ensure healthcare providers are aware of communications.

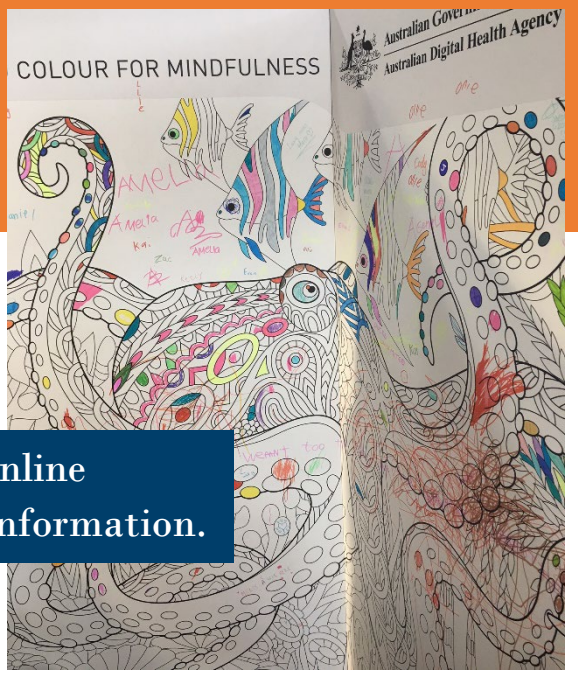
EMPHN implemented local community engagement, stakeholder engagement and communication activities to support these objectives.

For 12 out of 18 weeks EMPHN facilitated five or more community engagements. The engagements were a product of primary outreach, as well as requests from individuals in the community.

The Digital Health team consulted with 100% of healthcare providers (GPs and pharmacists) within the catchment. They delivered numerous successful forums and meetings, and customised provider packs, and often returned for additional face-to-face interactions to explain complicated and complex situations about My Health Record.

HIGHLIGHTS AND SUCCESSES

- Face-to-face presentations were hugely successful
- The 10-day activation at the Royal Melbourne Show was extremely successful. A stunning mural was coloured in by children and adults over the duration and a range of fun activities children and adults took pleasure in participating in
- Over **150** organisations were engaged with by telephone and email
- **675** meaningful engagements in one week
- **2,567,866** estimated reach throughout regional activities
- **97%** of people in regional areas were positive or neutral about My Health Record
- **369 out of 384** general practices in our catchment are uploading to My Health Record as well as 240 pharmacies and 27 specialists
- 274 GPs, 69 nurses and 68 practice managers received face-to-face My Health Record training



My Health Record is an online summary of your health information.

SafeScript roll out

SafeScript is software that allows prescription records, for certain high-risk medicines, to be transmitted in real-time to a centralised database and monitored.

From April 2020, it will be mandatory for clinicians in Victoria to check SafeScript when writing or dispensing a prescription for a medicine monitored through the system. These are all Schedule 8 medicines, Schedule 4 benzodiazepines, z-drugs (zolpidem and zopiclone) and quetiapine.

The roll-out of SafeScript has uncovered the prevalence of people who are at-risk of prescription medication misuse.

It's reported more than 27,000 people have already been identified by SafeScript to be at-risk. This is a far greater number than previously anticipated, and demonstrates the need for adequate support services.

WHAT WE DID

- **6** face-to-face joint training events for prescribers and pharmacists hosted by experienced GPs and pharmacists
- **16** general practices received in-practice accredited training (**84 GPs**)
- Presentations at practice manager training days (Bundoora and Nunawading)

Strategic priority: Partners working as a single service system

Key activities 2018-19	Outcomes
Better Health North East Melbourne	• Reducing the wait time for children to see an Austin Hospital paediatrician from 365 days to 90 days.
Doctors in Secondary Schools	• 30.12% visits by new patients • 1,299 young people were seen in 3,706 consultations
CarePoint	• 31 participants downgraded from 'high' risk of hospitalisation • 84% of participants reported an improvement in knowledge, skills and confidence in managing their own health and healthcare

Co-designing the future of our AOD service

In June 2018, Eastern Melbourne PHN engaged 360 Edge to provide expert consultancy to:

- undertake an analysis of the Victorian AOD service sector, including needs and gaps in the Eastern Melbourne PHN catchment, and
- facilitate a co-design process to shape the future of AOD services in the region.

The consultation forums, needs analysis, literature review and service mapping identified three key priorities:

1. Whole-of-person care
2. Integration and access
3. Needs of families and carers

The key priorities from the *Shaping the Future of Alcohol and Other Drug Responses* in the EMPHN catchment will be addressed as part of a commissioning process in 2019-20 that aims to complement the AOD service system, and over the next five years as part of the Regional Integrated Mental Health, Alcohol and Other Drugs and Suicide Prevention Plan.

EMPHN will also continue to liaise with DHHS on how the Federal and State resources can achieve the best outcomes for consumers, carers and service providers.

Collaboratives

BETTER HEALTH NORTH EAST MELBOURNE

The Better Health North East Melbourne (BHNEM) is a collaboration of health system leaders across the LGAs of Darebin, Banyule and Nillumbik. EMPHN is a key member of the collaborative.

BHNEM has developed a five-year strategy that will focus its energy on two vulnerable cohorts – older people who are frail, and children under five with developmental delay.

BHNEM's focus on children with developmental delay has already delivered its first outcome, reducing the wait time for children to see an Austin Health paediatrician from 365 days to 90 days. This is an important component of children receiving the right care at the right time in the right place to optimise their school readiness.

Work in 2018-19 in the area of 'frail aged' laid the foundations for a new specialist, integrated service in the community. This will come to fruition in late 2019, incorporating mechanisms to hear, capture, and build plans based on 'patient reported outcomes' and 'patient reported experience'. This is one of the strategies to reduce people's unnecessary hospital admissions, and to improve their quality of life and wellbeing.

Over the next five years, BHNEM will continue to engage key stakeholders to address issues facing these two groups to improve quality of life and wellbeing.

EASTERN MELBOURNE PRIMARY HEATH CARE COLLABORATIVE

The Eastern Melbourne Primary Heath Care Collaborative (EMPHCC) has made some great in-roads for people living with diabetes. Integrated Diabetes Education and Assessment Service (IDEAS) clinics have been progressively rolled out across the catchment to bring outpatient services into the community, embracing a multidisciplinary approach. These learnings will now be applied to chronic disease management more broadly as we seek to transform the system.

Doctors in Secondary Schools

From January to June 2019, nine general practices were engaged to deliver services under the Doctors in Secondary School (DiSS) program to 11 schools in the catchment. The service provides students with timely and quality healthcare from a general practitioner.

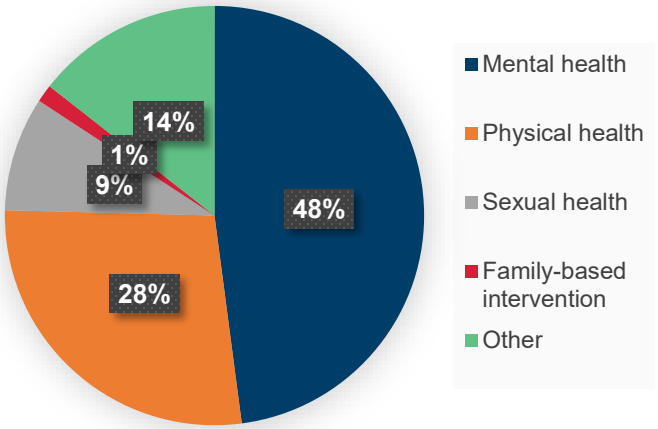
In the first half of 2019, nine general practices were engaged to deliver services. Overall, 82% of catchment schools were matched with a general practice. Of this nine, six will continue until December 2021.

Mental health continues to be the main reason for students visiting DiSS clinics, highlighting the importance of appropriate referral options to support students with their mental health.

OUTCOMES

- **30.12%** of visits were for new patients. Seeing new patients is important for the sustainability of the program
- **1,299** young people were seen in **3,706** consultations
- **926** referrals were made
- DiSS clinicians were provided with one-to-one training on HealthPathways Melbourne resources

REASON FOR VISIT



Regional Integrated Mental Health, AOD and Suicide Prevention Plan

Guided by the Fifth National Mental Health and Suicide Prevention Plan, the Australian and Victorian Governments asked Primary Health Networks (PHNs) to work in partnership with Local Hospital Networks (LHNs) across Australia to develop Regional Integrated Mental Health, AOD and Suicide Prevention Plans to improve services.

EMPHN and its stakeholders have continued to develop the Regional Integrated Mental Health, Alcohol and Other Drugs and Suicide Prevention Plan (the Plan) for the local community.

The Plan is being developed to improve outcomes for consumers and carers by:

- addressing fragmentation of mental health services and pathways for consumers
- preventing parts of the service system operating in isolation from each other
- identifying gaps, duplication in roles and system failure in local service pathways
- supporting mental health and suicide prevention reform priorities at a regional level, aiming to achieving more effective, person-centred care.

The draft plan will be available in late 2019.

VIEW THE PLAN WEBSITE >

CarePoint

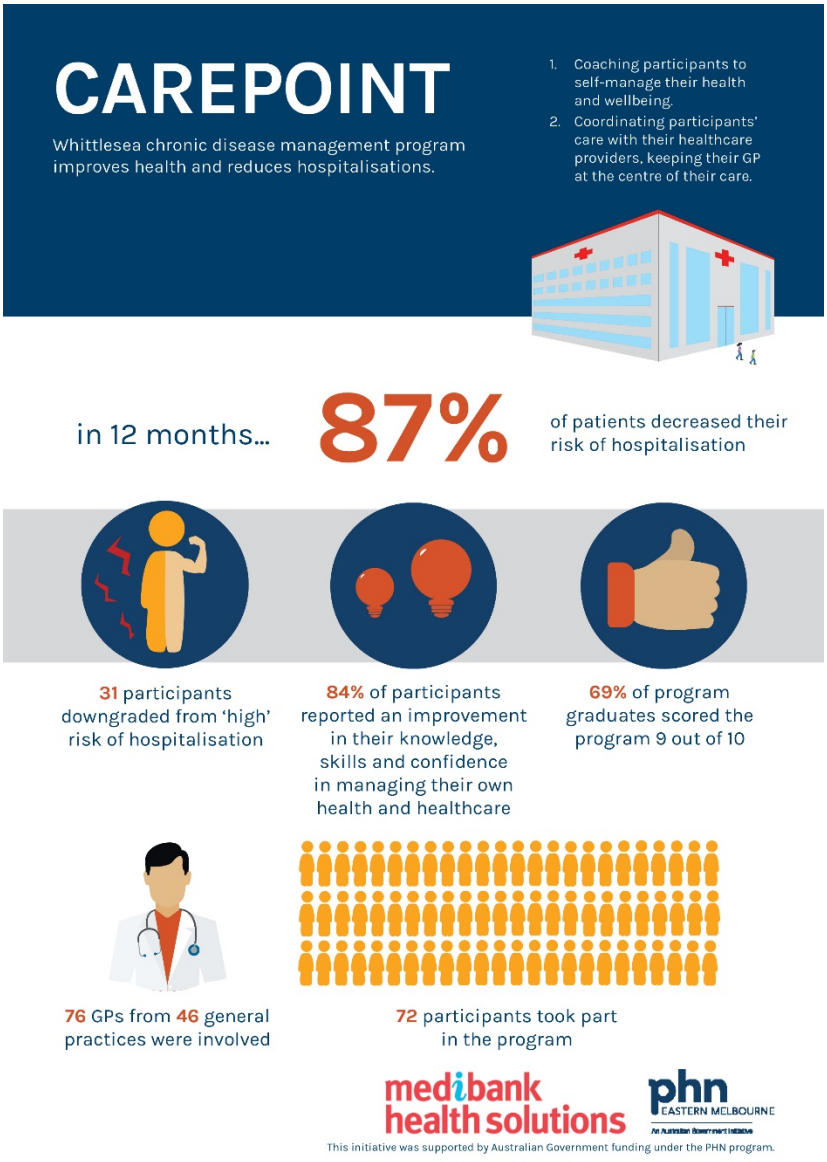
People in Whittlesea living which chronic and complex illnesses are living better after graduating from a chronic disease care management program, CarePoint, delivered by Medibank Health Solutions and funded by Eastern Melbourne PHN and Northern Health.

The program saw 72 Northern Health patients with complex and chronic conditions, such as type 2 diabetes and heart disease, referred to participate in a 12-month community based program.

The program focussed on two key areas:

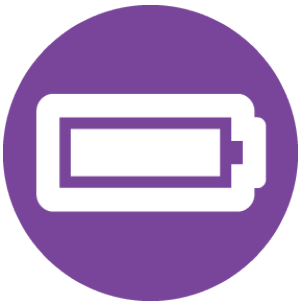
1. Coaching participants to self-manage their health and wellbeing.
2. Coordinating participants' care with their healthcare providers, keeping their GP at the centre of their care.

Due to great outcomes, the program will expand.



OUTCOMES

- **84%** of participants reported an improvement in their knowledge, skills and confidence in managing their own health and healthcare, which reduces the likelihood of their symptoms becoming worse
- **87%** of participants reduced their risk of hospitalisation, which means they are more likely to be well and less likely to experience symptoms requiring emergency treatment or hospitalisation



Strategic priority: A high performing organisation

Key activities 2018-19	Outcomes
Working at Eastern Melbourne PHN	• Training activities rolled out to employees
ISO Accreditation	• EMPHN achieved full certification against the internationally recognised AS/NZS ISO 9001:2015 Quality Management Systems standard
Stakeholder engagement survey	• Eastern Melbourne PHN's overall performance among allied health providers improved 5% on the previous survey • 57% of GPs rated our support 'high' or 'very high' • Education and website performance exceeds benchmarks

Working at Eastern Melbourne PHN

Eastern Melbourne PHN employs 72 people (64.2 full time equivalent) who work across our three directorates – Mental Health & AOD, Integrated Care and Strategic Operations. Our highly qualified, professional workforce has breadth of experience across a range of disciplines such as psychology, nursing, medicine, occupational therapy, social work and science as well as business.

To assist our workforce and further build on our commissioning capabilities, during the year we invested in a range of training activities for our employees including:

- commissioning training
- stakeholder engagement training
- risk management training
- contract management training.

Our workplace environment at Eastern Melbourne PHN is important as we seek to build a positive culture of high performance. For the second year in a row we conducted an Employee Alignment and Engagement Survey to understand how we can continue to improve and engage our people. The outcomes from the survey were considered and an improvement plan implemented. In addition we have an established employee consultative committee who come together to inform and develop plans for the positive engagement of all employees and an active social club who organises many self-funded entertaining activities throughout the year.

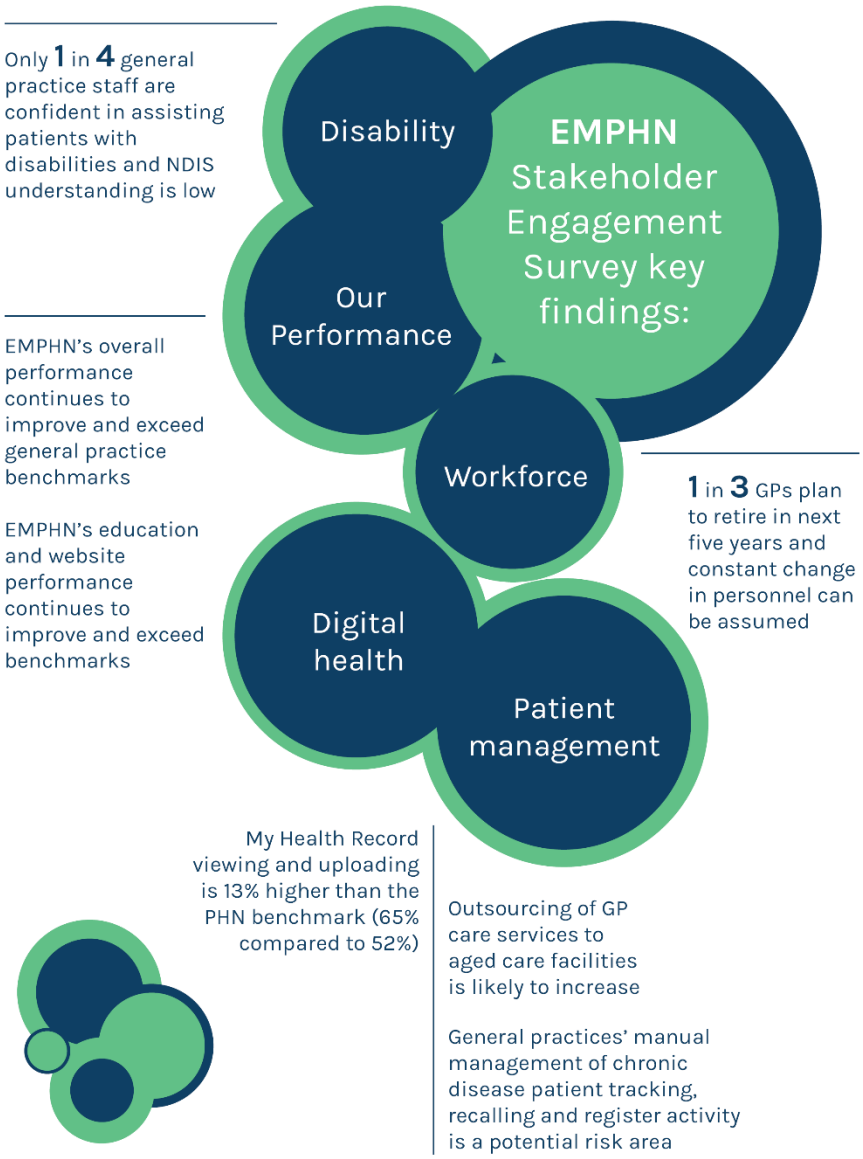
ISO Accreditation

In December 2018, EMPHN achieved full certification against the internationally recognised AS/NZS ISO 9001:2015 Quality Management Systems standard at its first attempt.

ISO (International Organization for Standardization) is the world's largest developer and publisher of International Standards.

Eastern Melbourne PHN is the first Victorian PHN and one of only a few nationally to achieve certification across its entire operations. Working towards or attaining certification against a recognised quality management standard is now a commonwealth requirement for PHNs.

Stakeholder engagement survey findings



In 2018-19, Eastern Melbourne PHN sought feedback from stakeholders on how we can better support primary care practitioners, and opportunities for capacity building and integration across primary healthcare services in our community.

Survey responders included:

- 440 general practice staff (GPs, practice managers and practice nurses)
- 226 allied health providers.

Findings are benchmarked against Eastern Melbourne PHN's first Stakeholder Engagement Survey conducted in 2017-18 and other PHNs Australia-wide.

We have begun actioning these recommendations and the feedback is informing Eastern Melbourne PHN's strategy.

1. WE HEARD THE SUPPORT WE PROVIDE TO GENERAL PRACTICE AND ALLIED HEALTH IS IMPROVING.

Providing general practices with a range of opportunities to work with us has improved performance by 2% on the previous year, and satisfaction with our practice support is 2% higher (57% rated support high or very high) than the benchmark comparison to other PHNs (55%).

Practice Managers report the highest level of satisfaction with Eastern Melbourne PHN's support (74% respondents rated our support high or very high).

Eastern Melbourne PHN's overall performance among allied health providers improved 5% on the previous survey

What does this mean?

Recent initiatives to improve general practice performance and skills, such as developing future-ready practices under Practice 2030, quality improvement, integrated patient centred care for nurses and e-Referral, among others, are working. We will continue to empower general practices to meet your goals and adapt to changes.

We will continue to work on how we best communicate and engage with general practitioners in the work we do to increase understanding of wider work occurring in the sector and opportunities for collaboration.

We are developing a General Practice Engagement Plan to provide a range of program offerings to suit different types of practice needs and capacity, from the basic to more intensive. These programs will be designed to help build practice capability and foster continuous improvement over the coming years.

2. WE HEARD CHANGE CAN BE CHALLENGING.

Taking into consideration changes in the mental health sector implemented during the past 18 months, allied health rated Eastern Melbourne PHN's support quite highly (39% rated high or very high in 2018-19, compared to 36% in 2017-18).

There was low awareness and uptake of Eastern Melbourne PHN funded mental health and alcohol and other drug (AOD) services.

There is interest from providers to build their capacity to manage people presenting with mental health and AOD issues.

What does this mean?

We need to improve understanding and awareness of Eastern Melbourne PHN funded mental health and AOD services, and communicate effectively and more frequently about ongoing reform in these sectors to ensure health professionals are able to link people into services

We will support general practitioners, other general practice staff and allied health providers to build their capacity to support people with mental health and AOD issues through continuing professional development (CPD) and other education events, and commissioning services such as the Psychiatric Advice and Consultation Service and AOD@theGP.

We will continue to develop clear navigation pathways for GPs and other health providers to assist people to access mental health and AOD services when they need them. This includes single navigation access points such as our Mental Health Referral and Access Team, updated HealthPathways for mental health and AOD, and simple reference material.

3. WE HEARD YOU STILL AREN'T CLEAR ON WHAT WE DO AND OUR COMMISSIONING ROLE.

We recognise the commissioning role PHNs are undertaking is still a relatively new concept for our stakeholders. We want to develop the market's capacity (service sector) to take advantage of the funding opportunities we can offer through commissioning and to work with us to ensure services are delivered where and to whom they are needed most.

What does this mean?

We will provide opportunities to learn how to work with us such as further commissioning workshops for general practice, and mental health and AOD providers. We are working hard to simplify our commissioning activities to make

them more accessible and appropriate, given the diverse range of providers in our catchment.

4. WE HEARD YOU WANT TO KNOW WHAT WE CAN DO FOR YOU AND WHO TO CONTACT.

We provide a range of supports, fund a range of services and undertake many initiatives. We understand, especially as busy professionals, it can be difficult to stay across all the things we can offer.

What does this mean?

We will target our communications to you via a range of channels because we know people have different communication preferences and often need to hear things a few times for it to sink in.

We have improved communication via our website with the single phone line and email address general practice can use to contact the PHN.

Our Mental Health Referral and Access team is a single point of contact to support consumers and providers with referrals and service navigation.

We have initiatives that support service delivery such as our Psychiatric Advice and Consultation Service.

5. WE HEARD YOU WANT US TO INFORM YOU ON LOCAL NEEDS.

Eastern Melbourne PHN develops a comprehensive Needs Assessment published on our website and has great insight into the needs of the people in our catchment. We have continually improved the format of our Needs Assessment to capture key highlights and insights. We could do better to communicate findings from our Needs Assessment and other research and analysis so it better informs service delivery and planning.

What does this mean?

Rather than provide all the information at once, which can be overwhelming, we will summarise a key area of our Needs Assessment in upcoming editions of our eNewsletter News from EMPHN. We will also provide findings to those that indicated they would be interested in being involved in future consultation or co-design opportunities on relevant topics.

6. WE HEARD GP/ALLIED HEALTH PROVIDER REFERRAL EFFECTIVENESS CONTINUES TO NEED SUPPORT TO IMPROVE PEOPLE'S HEALTHCARE JOURNEY QUALITY.

Allied health providers said 49% of the time they provide a complete report with all relevant information when a GP has referred a patient to them. However, only 16% of general practice say they receive this when they have referred a patient to an allied health provider.

There was also a significant difference in how often allied health providers say they provide information on recommended changes for care plans and information that is timely and available when needed, in comparison to what GPs say they receive.

Financial Statements

Statement of profit or loss and other comprehensive income for the financial year ended 30 June 2019

	2019	2018
	$	$
REVENUE		
Rendering of services	41,933,243	41,965,906
Other income	1,817,645	1,305,439
Total	**43,750,888**	**43,271,345**
EXPENSES		
Service delivery expenses	32,767,962	31,910,285
Occupancy	743,138	823,176
Employee benefits	7,188,990	7,614,153
Depreciation	97,831	150,314
Computer licenses and support	1,054,606	1,027,474
Other expenses	1,422,225	1,448,999
Total	**43,274,752**	**42,974,401**
Surplus before income tax	476,136	296,944
Income tax expense	-	-
Net surplus for the year	**476,136**	**294,944**
Other comprehensive income	-	-
Total comprehensive income for the year	**476,136**	**296,944**

Statement of financial position as at 30 June 2019

	2019	2018
	$	$
ASSETS		
Current Assets		
Cash and cash equivalents	15,206,160	3,308,483
Investments	18,000,000	20,000,000
Trade and other receivables	269,553	877,533
Other assets	719,012	412,178
Total Current Assets	**34,194,725**	**24,598,194**
Non-Current Asset		
Equipment and furniture	153,754	257,657
Non-Current Assets	153,754	257,657
TOTAL ASSETS	**34,348,479**	**24,855,851**
LIABILITIES		
Current Liabilities		
Trade and other payables	1,768,333	1,759,850
Other liabilities	27,334,536	17,341,938
Provisions	2,614,063	3,791,595
Total Current Liabilities	**31,716,932**	**22,893,383**
Non-Current Liability		
Provisions	304,257	111,314
Total Non-Current Liability	**304,257**	**111,314**
TOTAL LIABILITIES	**32,021, 189**	**23,004,697**
NET ASSETS	**2,327,290**	**1,851,154**
MEMBER FUNDS		
Accumulated Surplus	2,327,290	1,851,154
TOTAL MEMBERS FUNDS	**2,327,290**	**1,851,154**

ONLINE VERSION

An online version of this Annual Report is available at www.emphn18-19ar.com

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An Australian Government Initiative