Australian Government

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EASTERN MELBOURNE

An Australian Government Initiative

Core Funding

UPDATED ACTIVITY WORK PLAN 2016–2018

Overview

This Activity Work Plan is an update to the 2016-18 Activity Work Plan submitted to the Department in May 2016.

1. (a) Strategic Vision

Our vision: Better health outcomes. Better health experiences. An integrated health care system.
Our mission: With our partners, we facilitate health system improvement for people in eastern and north-eastern Melbourne

Our Strategic priorities:

1. **Addressing health inequities and gaps**
2. **Enhancing primary care**
3. **Leveraging digital health, and information technology**
4. **Partnerships for integrated health care**

Enabler:

1. **High Performing Organisation**

Our values:

- Leadership
- Understanding
- Collaboration
- Outcomes

EMPHN Operating Model and the Commissioning Framework

In its role as a facilitator of primary care system improvement and redesign, EMPHN has adopted an operating model made up of a continuous improvement approach to commissioning, and governance structures geared towards collaboration and co-design.

Commissioning Framework

Commissioning is a cycle. Needs and priorities are assessed through community consultation and solutions designed in partnership with stakeholders. Transparent processes are used to promote the implementation of these solutions, including the identification of providers from whom services may be purchased. Solutions are then evaluated and the outcomes used for further assessment and planning.

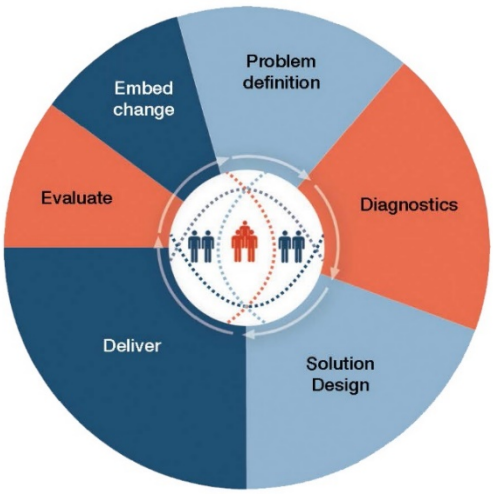

Figure 1. Commissioning cycle

Underpinning the phases of the Commissioning Cycle is a focus on ongoing relationships with consumers, providers and other stakeholders.

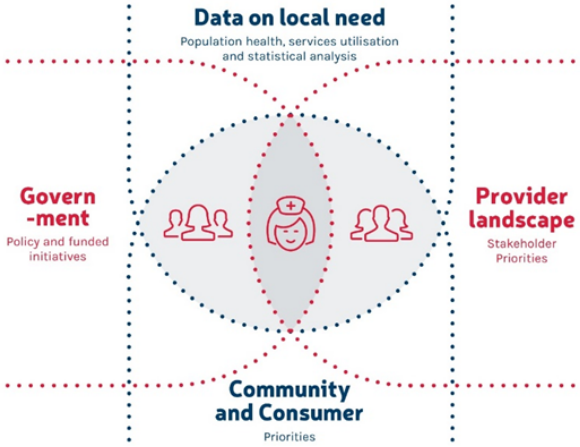

Figure 2. Prioritisation approach

Commissioning principles

1. **Understand the needs of the community** by engaging and consulting with consumer, carer and provider representatives, peak bodies, community organisations and other funders.
2. **Engage potential service providers** well in advance of commissioning new services.
3. **Focus on outcomes** rather than service models or types of interventions.
4. **Adopt a whole of system approach** to meeting health needs and delivering improved health outcomes.

5. **Understand the fullest practical range of providers** including the contribution they could make to delivering outcomes and addressing market failures and gaps.

6. **Co-design solutions;** engage with stakeholders, including consumer representatives, peak bodies, community organisations, potential providers and other funders to develop outcome focused solutions.

7. **Consider investing in the capacity of providers and consumers**, particularly in relation to hard to reach groups.

8. **Ensure procurement and contracting processes are transparent and fair**, facilitating the involvement of the broadest range of suppliers, including alternative arrangements such as consortia building where appropriate.

9. **Manage through relationships; work in partnership,** building connections at multiple levels of partner organisations and facilitate links between stakeholders.

10. **Ensure efficiency and value for money.**

11. **Monitor and evaluate** through regular performance reporting, consumer, community and provider feedback and independent evaluation.

Consultative structures

The EMPHN Board will receive strategic advice on engagement and participation from key groups:

- Clinical Council
- Community Advisory Committee

Collaborative structures

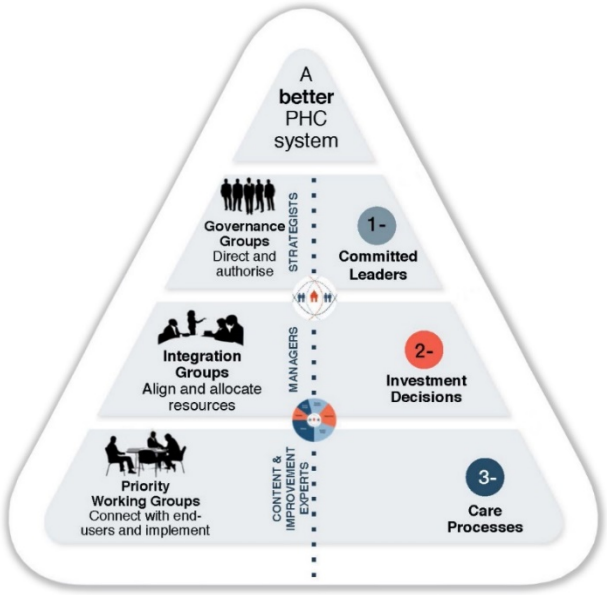

Figure 3. Collaborative Structures

In addition to this, the EMPHN catchment is divided into sub-catchments for the purposes of shared planning and governance. The sub-catchments align with the large public health services boundaries in the catchment:

- Austin Health – Better Health North East Melbourne
- Eastern Health – Eastern Melbourne Primary Health Care Collaborative
- Monash Health - TBD
- Northern Health – Shared Vision of the North

Each sub-catchment will have three similar levels of collaborative structures:

1. **Governance Group**: Strategists who "direct and authorise"
2. **Health System Integration Group**: Managers who "align and allocate resources"
3. **Priority Working Groups**: Content experts who "connect with end users and implement"

These structures provide a shared governance platform to identify, develop and authorise key systems change work that will be committed to in time, support and resources to enact significant systems redesign work. Projects defined by these collaboratives now feature in the 2017-18 Activity Work Plan.

Internal structures

The EMPHN organisational structure includes programs that support and develop primary care practitioners, and that support primary care improvement and integration.

In addition to the formal governance structure, EMPHN staff work across teams within specialty area streams such as Indigenous Health, Aged Care, Refugee Health and Mental Health.

EMPHN staff also work across teams to participate in improvement and innovation initiatives.

Priority & Activity Summary

For 2017-18 a revised set of priorities were devised based upon a refresh of the Needs Assessment in November 2016. These priorities include:

- Improving experience and health outcomes
    - Keeping people well
    - Addressing identified risk
    - Responding to identified chronic illness
- Improving the health system
    - Workforce
    - Cultural competence
    - Consumer engagement
    - Infrastructure
    - Appropriate service and system design

Figure 4 below defines how when distributing flexible funds, activities relate to identified priorities captured in the Needs Assessment.

EMPHN Priorities and Activities		
PRIORITY		ACTIVITY
Improving Experience and Health Outcomes	Keeping People Well	NP-1 Immunisation
	Addressing Identified Risk	LP-6 Data Linkages
	Responding to identified Chronic Illness	LP-3 Chronic Disease Self-Management LP-7 Diabetes Diversion Program LP-8 End of Life Care LP-10 Chronic Disease High Risk Intervention LP-11 Chronic Disease Risking Risk Intervention
Improving the Health System	Workforce	NP-2 Cancer Screening LP-12Primary Care Improvement and Integration
	Cultural Competence	(Integrated Care Schedule)
	Infrastructure	
	Consumer engagement	
	Appropriate Service and System Design	LP-4 Reducing Variations in Care LP-9 Improving Pathways for Planned and Unplanned care

Figure 4. Flexible Fund Activities as they relate to EMPHN priorities

1. (b) Planned PHN activities – Core Flexible Funding 2016-18

Proposed Activities	
Activity Title / Reference (e.g. NP 1)	**NP-1: Immunisation** NP1.1 Improve suboptimal childhood immunisation rates NP1.2 Address myths associated with immunisation resulting in ideological conscientious objection NP1.3 Support workforce to respond to demand generated by government immunisation initiatives. NP1.4 Work collaboratively with boarder health care system to increase childhood immunisation rates NP 1.5 Extend mobile influenza vaccination services across 5 more LGAs following the successful trial in Whittlesea in 2016-17
Existing, Modified, or New Activity	NP1.1 Modified Activity- As evident in the EMPHN needs assessment there is a rapid shifting of immunisation rates across municipalities, age ranges and quarters due to changes in government policy ("no jab, no pay and no jab, no play"). In response to this EMPHN will not focus specifically in a particular LGA whist the data is still in flux. NP1.2 Existing activity NP1.3-Existing Activity NP1.4 New Activity: AIR data shows that approximately 50% of all childhood immunisations are delivered though municipal providers. EMPHN will establish a collaborative working relationship with municipal providers and DHHA to continue to understand the local data, address systemic barriers to data collection and optimal childhood immunisation. NP 1.5 Modified (previously funded from reducing avoidable ED presentations).
Program Key Priority Area	Population Health
Needs Assessment Priority Area (e.g. 1, 2, 3)	Improving Experience & Health Outcomes – Keeping People Well : Possible option 3, page 75)

Description of Activity	Catchment-wide childhood immunisation coverage rates are broadly on par with national rates. SA3 data from 2015 indicated that immunisation coverage rates for children at age 1 were 91.6% (national 91.3%), age 2 were 90.0% (national 89.2%) and age 5 were 92.4% (national 92.2%). Coverage for all children aged 2 was well below the national average at 81.5% (national was 86.7%) and for children aged 5 was 91.3% (compared to a national coverage rate of 93.5%). This indicates that a dual approach of ensuring correct data across providers to affirm this, as well as activity that has a focus on the ages with suboptimal rates is necessary. Available June 2016 data shows LGAs with the current lowest coverage rates for 1-year-olds are Boroondara (90.2%), Manningham (91.5%), and Monash (92.3%). The only LGAs meeting the aspirational childhood immunisation rate of 95% in the 5-year age group were the outer metropolitan/semi-rural areas of Nillumbik (95.6%) and Mitchell (95.6%) where crude numbers were somewhat lower than other LGAs in the catchment. Manningham had the lowest proportion of children fully immunised at 5 years of age (90%). Childhood immunisation activities below centre around improvement of the above suboptimal rates in our region and equipping the primary care workforce and partners to address common myths associated with conscientious objection on ideological grounds. 1.1. To improve identified suboptimal immunisation rates across catchment, support: • Support to immunisation providers to maintain current levels. • Deeper dive into levers at systemic and local areas to push immunisation rates towards 95% • Work collaboratively with regional immunisation networks (Eastern and Northern) • Work with other PHNs, Municipal providers and DHHS through VPHNA to address systemic immunisation issues (e.g. cold chain breach reporting). 1.2. To support addressing of ideological conscientious objection, particularly in Nillumbik and Yarra Ranges and deeper dive into levers and drivers for parents deciding not to immunise, support: • Environment scan for innovative models to address community views • Capacity building for general practice in talking about conscientious objections.

	1.3. To support providers to respond to demand generated by government initiatives (e.g. 'no jab no pay', 'no jab no play') for improving immunisation rates, support • Sector and community education re 'No jab no pay' policy and how to respond • Capacity building and resources to support immunisation reconciliation. 1.4 EMPHN will establish a collaborative working relationship with municipal providers, other PHNs and DHHS to: • Continue to understand the local data, address systemic barriers to data collection and achieving optimal childhood immunisation. 1.5 2016-17 saw the highest influenza presentations to Emergency Departments and highlighted a need to target community members for influenza vaccination that may not regularly access a GP. The mobile influenza vaccination project with Whittlesea Council saw a high number of vaccinations in places of congregation such as lifestyle classes, community hubs, etc. There was high uptake of the service and the Council reported that there were many communities that they had not engaged with before by using a mobile model. It is proposed that this model be extrapolated to6 local government areas.
Target population cohort	The target population of this intervention are children 0-5 years of age and their families. 1.5 Influenza – vulnerable groups, particularly those who are not engaged with a regular GP.
Consultation	Regional immunisation (Northern and Eastern) networks- ongoing membership Immunisation Forum with Municipally providers of immunisations and Vic DHHS-Dec 2016 Victorian PHN Immunisation Community of Practice (PHN and Vic DHHS)– established Dec 2016 and ongoing Stakeholder interviews with local councils.
Collaboration	Activities will be undertaken in collaboration with: GPs, practice nurses, Local Government (immunisation coordinators), parents and community, Vic DHHS Central Branch and regional divisions, RCH (communicable diseases and immunisation specialists), refugee settlement services, migrant resource services and local media.

Indigenous Specific	No
Duration	Anticipated activity start and completion dates (excluding the planning and procurement cycle). 1.1 a) October 2016 - June 2018 b) July 2016 - October 2016 c) July 2016 - June 2018 1.2 a) October 2016 - May 2017 b) October 2016 - June 2018 1.3 July 2016 - June 2017 1.4 Dec 2016- June 2018 1.5 January 2017- June 2018
Coverage	Entire PHN Region
Commissioning method (if relevant)	Activities will follow the EMPHN Commissioning process outlined in section 1a, to include: Problem Definition, Diagnostics, Solution Design, Delivery, Evaluation and Embedding Change. The current activities listed fit within the Problem Definition to Delivery components of the methodology.
Approach to market	Open approach

	EMPHN will undertake an EOI process for small grants to Local Government/Municipal immunisation providers to address issues as identified in co-design workshop.
Decommissioning	Not applicable

Proposed Activities	
Activity Title / Reference (e.g. NP 1)	**NP2 - Cancer Screening** NP2.1 Continued roll out of the Screening to Survivorship work package to general practices NP2.2 Building capacity in General Practice for increased uptake of cancer screening in the community. NP2.3 Partner with Integrated Cancer Services leverage off activity to promote the awareness and uptake of Optimal Cancer Pathways and Shared Care in cancer survivorship
Existing, Modified, or New Activity	Modified
Program Key Priority Area	Population Health
Needs Assessment Priority Area (e.g. 1, 2, 3)	Improving Experience & Health Outcomes: Keeping People Well (possible option 2, page 75) Improving the health system – Workforce (possible option 8, page 77)
Description of Activity	Cancer screening for EMPHN will have a focus on general practice cancer screening rates. Activities will be undertaken in collaboration with subject matter expertise from peak cancer organisations and integrated cancer services and there may be replicability across PHN boundaries. Activities will work to increase capacity and raise local cancer screening participation rates through: 2.1 Continued roll out of a package of supports to General Practice that cover the patient journey from screening to survivorship. This aims to promote cancer screening, referral pathways to services when malignancy is detected, management of cancer and support during remission. Review of appropriate approaches for community engagement to encourage cancer screening

	2.2 Capacity building in general practice through education, business and process modelling to encourage a rigorous approach across the catchment for breast, bowel and cervical cancer screening. 2.3 Leverage of activity to promote adoption of Victorian Optimal Cancer Pathways and shared survivorship care models including data collection, education and capacity building. This creates a whole of life focus on the role of primary care in preventing and treating cancers. Activities will aim to increase capacity and raise local cancer screening participation rates through in our community. This approach will complement the work being undertaken in the general practice and integrated cancer service areas
Target population cohort	Women aged 18 + Men aged 50+
Consultation	General Practice Survey Clinical Council & Community Advisory Committee DHHS – Cancer Screening Unit Cancer Screening GP Reference Group
Collaboration	Activities will be undertaken in collaboration with: • Peak cancer bodies • LHNs & Integrated Cancer Services • PHN Alliance • DHHS • Diverse Community Support Services Department of Health (State/Federal)
Indigenous Specific	Yes – Broader population approach however working with the Aboriginal Health team to increase breast cancer screening rates in Aboriginal women in our community.
Duration	2.1 Ongoing 2.2 July 2016 –December 2016

	2.3 December 2016 – December 2017
Coverage	Entire EMPHN Region.
Commissioning method (if relevant)	Activities will follow the EMPHN Commissioning process outlined in Strategic Vision section 1a.
Approach to market	Not applicable for Activities 2.2 – 2.4 Activity 2.1 – Limited Approach to identified peak cancer organisations for community engagement.
Decommissioning	Not applicable

Proposed Activities	
Activity Title / Reference (e.g. NP 1)	**LP-4: Reducing Variations in Healthcare**
Existing, Modified, or New Activity	Modified
Program Key Priority Area	Other – system integration, supporting implementation of clinical guidelines, supporting demand management approaches
Needs Assessment Priority Area (e.g. 1, 2, 3)	Improving the health system – appropriate service and system design (possible option 5, page 76 and possible option 14 page 78))

Description of Activity	The activity enables General Practitioners access to on-line evidence-based guidelines and referral pathways to enable the right care for the patient, in the right place, at the right time. It will improve the health system through the development, design and maintenance of pathways that align with key priority areas and drive system redesign, the promotion of meaningful use of Health Pathways to more General Practitioners, the expansion of pathways to cover the entire EMPHN catchment and through the design and implementation of a workable e-referral solution. It will also continue to support the development of state wide pathways that align with clinical practice guidelines, including paediatrics. EMPHN will also lead the development of mental health pathways across the region. (In Previous AWP this underpinned activity across programs, but will be consolidated into an activity for reporting in this AWP)
Target population cohort	General Practitioners, and clients accessing General Practice.
Consultation	Stakeholder engagement is a core component of this activity and is regularly undertaken with: - Clinical working groups - Events/Training activity - Online feedback mechanisms - Practice demonstrations Key external stakeholders are included in the governance structure.
Collaboration	General Practitioners, subject matter experts and consumers provide input in the problem definition and diagnostics stages, and develop pathways to address identified gaps. Local Health Networks, Community Health Services, nurses and private specialist and allied health provide subject matter expertise to support solution design (agree on management and referral

	guidelines), deliver (promote and encourage use of pathways), embedding change (work towards enforcing agreed referral criteria within their services). Pharmacists and non-general practice team clinicians are secondary users of pathways. State government representatives are kept informed, fund state-wide pathway development and are becoming increasingly involved in pathway development and endorsement of pathways for which they have a responsibility (e.g. out of home care, immunisation). PHNs in other regions are working together to develop more of a coordinated state-wide approach.
Indigenous Specific	No
Duration	Ongoing
Coverage	EMPHN region, NWMPHN region with scoped works for state-wide collaboration with other PHNs.
Commissioning method (if relevant)	Not applicable
Approach to market	Renewal of current contract with Streamliners
Decommissioning	Not relevant,
Funding from other sources	NWMPHN and EMPHN share costs associated with pathways development activities across our catchments. DHHS provides specific funding to progress state-wide paediatric, cancer and hepatitis pathway development.

Proposed Activities	
Activity Title / Reference (e.g. NP 1)	**LP-6: Data Linkages Project**
Existing, Modified, or New Activity	New
Program Key Priority Area	Population Health
Needs Assessment Priority Area (e.g. 1, 2, 3)	Improving experience and health outcomes – addressing identified risk

Description of Activity	The BHNEM and EMPHCC have identified priority projects to commission activity targeting risking risk populations who, unless appropriately identified and supported, are at risk of becoming frequent users of hospital services. A process will be undertaken to further develop predicative data analytics to identify patients within the rising risk cohort, and investigate options for this data to be available across both primary care and the hospital system. Intended outcomes include the development of a system to identify and escalate patients in rising risk groups, and links with more appropriate community supports. It is recognised that whilst NP11 will look at the top 2% of those at risk of readmission that are active frequent flyers in acute services, this activity provides the opportunity to address that cohort one step down who are engaged with General Practice and are at current and rising risk. Further developing the predictive model in the General Practice setting provides the opportunity to integrate with acute care to flag these clients and engage them in appropriate interventions within the community. By targeting this group, the intended outcome is to stem the increasing morbidity of disease and demand on acute services, increase capacity for self-management and health literacy for a healthier population.
Target population cohort	Patients at risk and at high risk of unplanned hospital presentation.
Consultation	Significant consultation will be undertaken with the Local Hospital networks and General Practitioners, as well as a range of service providers as part of the market analysis stage of the commissioning process.
Collaboration	Through the Better Health North East Melbourne Collaborative: • Austin Health • Mercy Health • HealthAbility • Banyule Community Health Service • Darebin Community Health Service • Department of Health and Human Services • Darebin Council • Banyule Council • Nillumbik Council • General Practitioners

	Through the Eastern Melbourne Primary Health Care Collaborative: • Connect 4 Health • Department of Health • and Human Services • EACH • Eastern Health • Eastern Melbourne PHN • General Practitioners
Indigenous Specific	No
Duration	Until June 2018
Coverage	EMPHN catchment
Commissioning method (if relevant)	EMPHN's commissioning methodology is described in Section 1a. Consultation has commenced and the problem has been defined by the EMPHC and BHNEM Collaboratives. The appropriate approach will be identified during the solution design process and the Department will be advised.
Approach to market	Dependent on early commissioning stages
Decommissioning	Nil

Proposed Activities	
Activity Title / Reference (e.g. NP 1)	**LP-7 Expanding and Supporting Diabetes Diversion Programs – Phase 2**
Existing, Modified, or New Activity	Modified - Phase 1 from Priority 1 - Avoidable Hospitalisations 16/17 funding

	Modified (December edit) – additional funds to support further roll out of service into North East region, increasing scope of Phase 2.
Program Key Priority Area	Chronic Illness
Needs Assessment Priority Area (e.g. 1, 2, 3)	Improving experience and health outcomes – addressing identified risk (possible option 4 page 75)
Description of Activity	*PHASE 1(2016-17): To expand existing successful Eastern Melbourne PHN catchment service system responses to diabetes, and provide eligible patients with integrated wrap-around support that will reduce hospital outpatient wait lists* PHASE 2(2017-18): EMPHN will be developing the market through a competitive tender process for the establishment of a diabetes hospital diversion program and extrapolation of existing successful clinic models to other areas of the PHN catchment, to address outpatient appointment demand. It has been recognised that whilst NP3 will have a focus on early intervention and a broader range of chronic illness, diabetes complications remains as the highest cause of ACSCs in our catchment. Many consumers with an established diagnosis and progressing condition require diversion from long endocrinology outpatient waiting lists for support in the community and primary care setting.
Target population cohort	Patients with poorly controlled Diabetes needing access to an integrated and community based multi-disciplinary service model.
Consultation	Significant consultation will be undertaken with the Local Hospital networks and General Practitioners, as well as a range of service providers as part of the market analysis stage of the commissioning process.
Collaboration	• Local Health Networks • General Practice • Consumers • Community Health Services • Specialist medical staff
Indigenous Specific	No

Duration	Until June 2018
Coverage	EMPHN catchment
Commissioning method (if relevant)	EMPHN's commissioning methodology is described in Section 1a above. Market development has already commenced through a pilot in 2016-17. A clear brief will be developed, an open tender process will be undertaken and performance metrics will be built into contracts. Evaluation findings will be reviewed and reported.
Approach to market	Open tender approach
Decommissioning	Nil

Proposed Activities	
Activity Title / Reference (e.g. NP 1)	**LP-8:– End of Life Care- EMPHC Collaborative Project**
Existing, Modified, or New Activity	New Modified December to include Respite Palliative Care Funding, seeking co-investment from partners
Program Key Priority Area	Aged Care
Needs Assessment Priority Area (eg. 1, 2, 3)	Improving experience and health outcomes – responding to identified chronic illness Improving the health system - Appropriate service and system design, page 78
Description of Activity	Problem: This system orientated activity seeks to redesign elements of the service system to ensure more people experience end of life care how, and where, they choose, and that resources and supports across the end of life support system are used more appropriately.
Target population cohort	• End of life care services

	• Patients at end of life and their families
Consultation	A working group formed from members of the EMPHCC and a range of stakeholders delivering end of life support services together with general practice and consumer representatives will undertake this project. GP's and Consumers will also be involved at all stages of the design and delivery of any intervention developed. Consultation has indicated the need for respite palliative care services to support carers. Thus underspend and reallocated funds from other activities not expected to expend will be used to invest in respite palliative care as a solution to an identified root cause for readmission to hospital
Collaboration	Through the Eastern Melbourne Primary Health Care Collaborative: • Connect 4 Health • Department of Health • and Human Services • EACH • Eastern Health • Eastern Melbourne PHN • General Practitioners Additionally, content experts from specific aged care services and networks, such as Eastern Palliative Care, Cemetery Trust, Health Issues Centre will form part of the collaborative working groups.
Indigenous Specific	No
Duration	Planning will commence shortly to further define the priority problems, and undertake rigorous data analytics. Stakeholders will then be consulted with to co-design potential solutions prior to procurement and the commencement of service delivery, which will continue until June 30 2018.
Coverage	Eastern Melbourne region.
Commissioning method (if relevant)	EMPHN's commissioning methodology is described in detail in section 1a. The collaborative entities will undertake diagnostics and solution design activity prior to the procurement phase.

	A clear brief will be developed, an open tender process to enact the proposed solutions will be undertaken and performance metrics will be built into contracts. Evaluation findings will be reviewed and reported.
Approach to market	Open tender approach
Decommissioning	Nil

Proposed Activities	
Activity Title / Reference (e.g. NP 1)	**LP-9: Improving pathways for planned and unplanned care in the community**
Existing, Modified, or New Activity	New
Program Key Priority Area	Other – system infrastructure and redesign
Needs Assessment Priority Area (eg. 1, 2, 3)	Improving the health system – appropriate service and system redesign (Possible Option 14, pg.78)
Description of Activity	This activity is in the service planning, solution design phase, in response to the pressures being placed on emergency departments in the EMPHN catchment due to unexpected events (unplanned) and rising acuity in those on ambulatory waiting lists (planned).. 9.1 Scoping to identify innovative and effective model of care to divert services away from emergency departments and educating local communities about system redesign efforts has indicated ongoing support of the fracture management clinic to enable hospital led diversion to support the GP related fracture management training and readiness will continue into 2017-18. 9.2 AH Determine demand and availability of after-services that can be delivered in primary care settings and procure solutions which facilitate after-hours pathway alternatives to emergency department attendance in targeted areas of need. -
Target population cohort	Patients requiring urgent care across the EMPHN catchment

Consultation	Extensive consultation will be undertaken with health care consumers (a behavioural insights research project) to develop an understanding of consumer behaviours relating to emergency department and primary care service usage. General Practitioners and Hospital networks will also be consulted extensively to inform the development of this activity.
Collaboration	Through the Collaborative: • Local Health Networks • Department of Health and Human Services • Community Health Services • Local Councils • Consumers
Indigenous Specific	No
Duration	This activity is entering an extensive planning phase, the results of which will inform future steps.
Coverage	Entire catchment
Commissioning method (if relevant)	This activity will be wholly commissioned. A clear brief will be developed, the appropriate commissioning process will be selected and undertaken and performance metrics built into contracts. Evaluation findings will be reviewed and reported.
Approach to market	Open tender approach
Decommissioning	Nil
Proposed Activities	
Activity Title / Reference (e.g. NP 1)	MODIFIED ACTIVITY –Investment in an innovative heart failure model is indicated as a targeted means of addressing heart disease which has significant burden in the health of our population and accounting for high ambulatory care sensitive condition admissions.

	LP-10 Chronic Disease Management high risk intervention .
Existing, Modified, or New Activity	Modified December edit – modified with a narrowed focus on heart failure innovation model
Program Key Priority Area	Other – development of community based model
Needs Assessment Priority Area (eg. 1, 2, 3)	Improving experience and health outcomes – addressing identified risk (Possible Option 7 pg.76) Improving the health system – consumer engagement (Possible Option 10, pg. 77)
Description of Activity	Northern Health, Eastern Health and Austin Health are each involved in varying capacity in Health Links project funded by the Department of Health and Human Services (State Government), a project that involves the application of an algorithm to identify patients at high risk of re-presentation to hospital. This activity aims to address the top 2% of clients identified through acute care systems at risk of readmission by the DHHS based algorithm through the Health Links project. Through the collaborative, an integrated approach to developing an appropriate solution to engage and work with this cohort will be developed. A commissioning process will be undertaken to develop and then procure an intervention for the heart failurecohort, an evidence based model of care in the community, with strong links to General Practice and access to specialty medical services. This activity will provide access to integrated and comprehensive interventions to high risk populations in the EMPHN catchment, ultimately reducing the risk of unplanned hospital presentations and admissions.
Target population cohort	Patients at risk and at high risk of unplanned hospital presentation due to heart failure.
Consultation	Significant consultation will be undertaken with the Local Hospital networks and General Practitioners, as well as a range of providers as part of the market analysis stage of the commissioning process. It is anticipated that consultation with agencies such as the Heart Foundation will be undertaken with the renewed scope to focus on heart failure.
Collaboration	DHHS Northern Health

	Monash Health Barwon Health North Western Melbourne PHN Through the Better Health North East Melbourne Collaborative: • Austin Health (control site in Health Links project) • Mercy Health • HealthAbility • Banyule Community Health Service • Darebin Community Health Service • Department of Health and Human Services • Darebin Council • Banyule Council • Nillumbik Council • General Practitioners Through the Eastern Melbourne Primary Health Care Collaborative: • Connect 4 Health • Department of Health • and Human Services • EACH • Eastern Health • Eastern Melbourne PHN General Practitioners
Indigenous Specific	No
Duration	Intervention likely to be implemented January 2017– July 2018
Coverage	LGAs in the EMPHN catchment with higher rates of rising risk and high risk populations. Outer metro North and East likely to be areas of focus but dependent on location or capacity of successful tenderer.

Commissioning method (if relevant)	EMPHN's commissioning methodology is described in detail in Section 1a. Consultation has commenced and the problem has been defined. Stakeholders are currently being engaged to assist with solution co-design. A clear brief will be developed and an open tender process will be undertaken. Performance metrics will be built into contracts. Evaluation findings will be reviewed and reported.
Approach to market	Open tender approach
Decommissioning	Nil

Proposed Activities	
Activity Title / Reference (e.g. NP 1)	MODIFIED ACTIVITY LP-11 Chronic Disease Management Rising Risk Intervention
Existing, Modified, or New Activity	New December Edit – Modified
Program Key Priority Area	Chronic Disease
Needs Assessment Priority Area (e.g. 1, 2, 3)	Improving experience and health outcomes – responding to chronic illness (Possible Option 7-Pg 76)
Description of Activity	Targeting consumers with identified chronic disease and providing tailored service response, including for diabetes, cardiovascular disease, respiratory, disease, Hepatitis, and renal disease. This work is to undertaken in partnership with our collaborative partners, with an expected outcome of reduced hospitalisations.
Target population cohort	Patients with identified chronic disease (Rising Risk) patients

Consultation	Focus groups, quantitative and qualitative surveys will be conducted with providers and consumers. EMPHN needs analysis, POLAR and ABS data will be accessed. A commissioning process will be undertaken to develop and then procure a comprehensive intervention for this cohort, an evidence based model of care in the community, with strong links to General Practice and access to specialty medical services. This activity will provide access to integrated and comprehensive interventions to rising risk populations in the EMPHN catchment, ultimately reducing the risk of unplanned hospital presentations and admissions.
Collaboration	Collaborative agencies will be invited to help define problems and co-design local solutions.
Indigenous Specific	No
Duration	July 2017 – June 2018
Coverage	Across the entire EMPHN catchment
Commissioning method (if relevant)	EMPHN's commissioning methodology is described in detail above.
Approach to market	Open tender approach
Decommissioning	Nil

Proposed Activities	
Activity Title / Reference (e.g. NP 1)	**LP-12: Primary Care Improvement and Integration**
Existing, Modified, or New Activity	Modified
Program Key Priority Area	
Needs Assessment Priority Area (eg. 1, 2, 3)	Improving the health system - workforce (Possible Option 8, pg. 77) Improving the health system – appropriate service and system design (Possible Option 14, pg.14)

Description of Activity	The development and implementation of innovative activities, integrated with other program areas, which support general practice to add value to the health system and enhance care within their own practice and outer in the wider system. Including a practice benchmarking program to achieve demonstration sites for the practice of the future "Practice 2030", continued quality improvement in the practice and techniques to facilitate integrated and coordinated patient centred care. The activity will include a number of complementary programs of work that all aim to build practices capacity to respond to future directions in health care.
Target population cohort	All
Consultation	Consultation will be ongoing with key groups across the catchment
Collaboration	The program will collaborate with: • General Practice • Community Health • LHNs • DHHS • VPHNA • Clinical specialists
Indigenous Specific	No
Duration	Ongoing
Coverage	Entire PHN region
Commissioning method (if relevant)	Unknown
Approach to market	Unknown
Decommissioning	*Unknown*

Proposed Activities	
Activity Title / Reference (e.g. NP 1)	**LP-13 Ageing**
Existing, Modified, or New Activity	Modified December edit – modified to also include aged mental health stepped care model development and Northern area coordination
Program Key Priority Area	*Population Health*
Needs Assessment Priority Area (eg. 1, 2, 3)	Improving experience and health outcomes – keeping people well (possible option 3, pg.75) Eastern Melbourne PHN has undertaken significant work in mental health, initiating a stepped care model of mental health provision. In undertaking this system redesign EMPHN has identified a need to provide additional support to the older persons (over 65 years of age (over 50 years of age for Aboriginal and Torres Strait Islander people) with mental health concerns.
Description of Activity	Healthy ageing is a key issue for the EMPHN region with a high number of RACF beds and an ageing population, particularly in the inner, more densely populated areas. Activities to support healthy ageing have a natural overlap with avoiding hospital presentations by seeking to: increase quality of life and reduce acuity, improve service coordination and information, support general practice through Health Pathways and innovative models of early intervention, and increased access to services, including specialist telehealth. Activity includes: LP-13.1 QUM rollout with focus on polypharmacy and falls, and antibiotic resistance

	LP-13.2 Review evidence on reducing polypharmacy/de-prescribing and develop recommendation LP13.3 Eastern Melbourne PHN (EMPHN) is seeking to improve the mental health care of older persons in the EMPHN catchment, recognising that pre-existing mental health issues continue through all stages of life and that new mental health conditions can occur with older age and that the needs of older people should be considered as new models are implemented. LP13.4 Expansion of local area mental health coordination in the North Eastern region The Eastern region enjoys the benefit of the Eastern Mental Health Care Services Alliance (EMHCSA) that will have an important role in the implementation of Stepped Care Model Changes. As the roll out of the model has commenced in the North East region, there is a need to support the same dedicated systems change role and platform. This work will align with the Better Health North East Melbourne Collaborative and help to scope the aged care component within the first phase of the roll out in the North East region.
Target population cohort	Aged population across the catchment
Consultation	The program will consult with: • General Practice • Community Health • LHNs • DHHS • RACF • Pharmacies
Collaboration	The activity will collaborative with: • Better Health North East Melbourne and Eastern Melbourne Collaboratives

	• Mental Health Services
Indigenous Specific	No
Duration	12 months ongoing
Coverage	All catchment
Commissioning method (if relevant)	Not Applicable at this stage
Approach to market	NA
Decommissioning	NA
Funding from other sources	

Proposed Activities	
Activity Title / Reference (e.g. NP 1)	**LP-14 Collaborative Projects**
Existing, Modified, or New Activity	New
Program Key Priority Area	*Population Health*
Needs Assessment Priority Area (eg. 1, 2, 3)	Applicability across all priority areas:

Description of Activity	There are currently two Collaboratives (Eastern Melbourne Primary Health Care Collaborative and Better Health North East Melbourne Collaborative) in operation which include high level representation from PHN, Local Hospital Networks, Community Health, Department of Health and Human Services (State Government) and General Practice. These collaborative platforms enable prioritising and commitment of resources and effort to cross systems change work. It is proposed that underspending in other activities identified in December be allocated to a small resource pool for projects. -
Target population cohort	Community members at risk of frequent readmission, falling through the gaps and utilising multiple areas of the system for their care.
Consultation	Collaboratives as per described above
Collaboration	Collaboratives as per described above
Indigenous Specific	No
Duration	12 months ongoing
Coverage	All catchment
Commissioning method (if relevant)	Not Applicable at this stage
Approach to market	NA
Decommissioning	NA

Proposed Activities

Activity Title / Reference (e.g. NP 1)	**LP-15 Capacity support for self-determination in Aboriginal Community Services**
Existing, Modified, or New Activity	New
Program Key Priority Area	*Population Health*
Needs Assessment Priority Area (eg. 1, 2, 3)	Improving experience and health outcomes – keeping people well (possible option 3, pg.75)
Description of Activity	EMPHN through its recent annual planning process, community consultation and literature review has identified that a self-determination approach is key to effectively engaging community in PHN funded services. EMPHN has an existing contract with Bubup Wilam to deliver an integrated package of services regarding community education and services across Mental Health, AOD and After Hours. Use of this underspend will help further support the implementation of internal processes to work effectively with us on these areas into the future.
Target population cohort	Aboriginal community members in the North East region of the catchment (Whittlesea, Banyule, Nilumbik)
Consultation	The program will consult with: • Bubup Wilam
Collaboration	The activity will collaborative with: • Bubup Wilam a community controlled community service

Indigenous Specific	Yes
Duration	January to June 2018
Coverage	North East area of catchment.
Commissioning method (if relevant)	As per Section 1
Approach to market	Direct – utilisation of underspend to support increased capacity in existing contract
Decommissioning	NA

1. (c) Planned PHN activities – Core Operational Funding 2016-18

Proposed activities	
Activity Title / Reference (eg. OP 1)	OP1: Population Health
Existing, Modified, or New Activity	Existing
Description of Activity	The Performance and Planning team has responsibility for equipping the organisation and its programs with: - Continually updating needs assessments to inform program and commissioning activity in health needs, service access trends, service mapping and forecasting - Undertaking deeper dives on issues to inform the organisations and its stakeholders it is collaborating with - Providing the Collaborative Platforms with briefings of the key issues on which to focus through the Collaborative Structure

	- Assisting and increasing the capacity of the organisation to source an evidence base and appropriately evaluate projects and programs This will ensure the organisation maintains a population health understanding of the health care needs of the PHN communities through analysis and planning, knowing what services are available and helping to identify and address service gaps where needed, including in rural and remote areas, while getting value for money.
Supporting the primary health care sector	The Population Health function will support the primary care sector through the sharing of key data and findings to promote collaborative activity, help provide direction and context to the consolidation of investments and best impact targeting for action. Findings highlight the driving population health needs experienced by the primary care workforce to then influence education, initiatives and supports planned and provided.
Collaboration	This activity will be primarily internal capacity building and assist with our collaborative arrangements. Stakeholder engagement of local government and Primary Care Partnerships will be maintained by the Performance and Planning Team
Duration	Ongoing.
Coverage	Entire EMPHN region
Expected Outcome	Activities are expected to assist in achieving the following EMPHN Strategic Objectives: 1. Investment decisions are targeted for highest impact

Proposed activities	
Activity Title / Reference (eg. OP 1)	OP2: General Practice Engagement & Support
Existing, Modified, or New Activity	Modified
Description of Activity	EMPHN aims to provide support to General Practice to enable a better primary health care system and ensure the programs and projects of EMPHN have strong engagement with General Practice.

	General Practice Engagement is split into two key functions for EMPHN: General Practice Engagement –by taking a development approach to a caseload of practices, deliver high quality education and support packages in the areas of practice management, practice nursing, vaccine management and immunisation, data quality, MBS, clinical software and accreditation This includes delivery of in-practice education on a range of topics relevant to both the identified priorities and the needs of general practice itself, and supporting practices in quality improvement activities to improve primary health care outcomes based on the available data collection. - These teams will work in collaboration with programs across the organisation and maintain strong connections with General Practice in our region. Whilst activities of support will look to address the priorities identified in the needs assessment, they will also look to support the emerging workforce development needs of General Practice and work closely with the Workforce Development and Education team to inform calendars of activity. This activity will support PHN objectives through: Supporting general practices in attaining the highest standards in safety and quality through showcasing and disseminating research and evidence of best practice. This includes collecting and reporting data to support continuous improvement; providing practice support services so that GPs are better placed to provide care to patients subsidised through the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), and help patients to avoid having to go to emergency departments or being admitted to hospital for conditions that can be effectively managed outside of hospitals. General Practice Engagement activities are the mechanism that will enable a range of Flexible Fund activities.
Supporting the primary health care sector	The program will support the primary health sector in attaining the highest standards in safety and quality through showcasing and disseminating research and evidence of best practice. The program will support the development of the primary health care system to be able to respond to the fast changing landscape including changes to policy and funding requirements and community expectations. For example EMPHN will support practices to develop towards being a patient centred

	Health Care Home (PCHCH) according to the current building blocks identified by the Commonwealth as underpinning the current PCHCH model.
Collaboration	Internal support to General Practice and as enabler for General Practice Engagement and Flexible Funded activity. The program will collaborate with: • General Practice • Community Health • LHNs • Peak bodies (e.g. Cancer Council Victoria, Diabetes Vic) • Accreditation agencies • Medical software vendors • DHHS • VPHNA • Clinical specialists
Duration	Ongoing.
Coverage	Entire PHN region
Expected Outcome	Activities are expected to assist in achieving the following EMPHN Strategic Objectives: 2. Investment decisions are targeted for highest impact 2a. Consumers and providers (including GPs) are engaged 2b. Service needs are prioritized and identified gaps are filled PHN objectives providing practice support services so that GPs are better placed to provide care to patients that is based on best practice, subsidised through the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), and help patients to avoid having to go to emergency departments or being admitted to hospital for conditions that can be effectively managed outside of hospitals

Proposed activities	
Activity Title / Reference (eg. OP 1)	OP3: Digital Health/eHealth.
Existing, Modified, or New Activity	*This is an Existing activity (2016-18 Activity Work Plan)*
Description of Activity	eHealth is a key mechanism by which improvements in the primary health care system can be sought by EMPHN. The Digital Health Team has expertise to support the following activities relating to eHealth including: - Supporting practices in the uptake of the ePIP - Increasing telehealth capacity in the region - Working in partnership with LHNs and Community Health in eReferral Projects - Internal Information Systems such as CRM and SharePoint that can be used for internal information management and electronic platforms by which to share information with Collaborative Platforms and Committees - Support for the roll out of My Health Record - Support for the roll out of the POLAR GP Clinical Audit Tool The Digital Health team will support a range of internal teams and external organisations by providing practical support and education to understand the processes and systems that underpin the delivery of eHealth services in Australia. This team as the subject experts will build internal capacity and engage directly with external organisations to assist them achieve the required eHealth objectives and provide the primary care interface to ensure a cross-system approach. Promotion and engagement with key national infrastructure and service providers will be critical to enable the effective deployment and expansion of eHealth initiatives across the EMPHN region.

	This activity will assist general practices in understanding and making meaningful use of eHealth systems, in order to streamline the flow of relevant patient information across the local health provider community.
Supporting the primary health care sector	The Digital Health/eHealth program will support the primary health sector in learning and pursuing the highest standards in quality data capture/ storage and reporting through the education/training and assistance of best practices and workflows. The program will also support the development of the primary health care system to be able to respond to the fast changing landscape including changes to policy and funding requirements and community expectations. An example would include EMPHN supporting practices to develop workflows and practices to ensure compliance with current and future PIP requirements, eReferral, My Health Record uploads-meaningful use and preparations towards being a patient centred Health Care Home.
Collaboration	Whilst this program enables internal capacity across a range of activities, a specific activity in this space will be undertaken in collaboration with: eReferral: General Practice, LHNs – Eastern Health, Austin Health Telehealth: General Practice, Specialists, LHN Outpatients/Specialists Clinical Audit Tool: Outcomes Health, Gippsland and South East Melbourne PHN
Duration	Anticipated activity start and completion dates. ePIP support: July 2016 -June 2018 eReferral: July 2016 – July 2017 Telehealth: July 2017-June 2018
Coverage	Entire PHN region
Expected Outcome	Activities are expected to assist in achieving the following EMPHN Strategic Objectives: 1. Leaders commit to system improvement

	1c. Leadership and change capacity is enhanced 2. Investment decisions are targeted for highest impact 2a. Consumers and providers (including GPs) are engaged 3. Care processes designed for need and best use of resources 3a. Design and re-design occurs collaboratively 3b. Services are reoriented to better meet needs 3c. Patients know where to go, when and why 3d. Effective, efficient services are procured PHN objectives will be achieved by: Providing practice support services so that GPs are better placed to provide care to patients subsidised through the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), and help patients to avoid having to go to emergency departments or being admitted to hospital for conditions that can be effectively managed outside of hospitals A key metric to assist in improving service coordination across flexible activities includes: All Public LHNs within the region and a minimum of 60% private hospitals registered for My Health Record (2 years), 100% of PIP-registered general practices in the region registered and uploading to My Health Record, 100% of pharmacies with eHealth-capable software registered for My Health Record, 100% of RACFs with eHealth-capable software registered for My Health Record This will be monitored internally through supports provided as currently the PHN does not have access to a centralised listing of organisations registered to upload for My Health Record.

Proposed activities	
Activity Title / Reference (eg. OP 1)	OP4: Workforce Education & Clinical Placements

Existing, Modified, or New Activity	Existing
Description of Activity	The Workforce Education and Clinical Placement team aim to provide support and increase the capacity of the primary care workforce through workforce development and education activities. Workforce Development activities include: - Clinical Placements to increase the capacity of the General Practice workforce through attraction of medical graduates to the industry and build the supervisory capacity of General Practice - General Practice (GP, Nurse, Practice Manager) Education through webinars and events relating to areas of workforce development need - Primary Care Provider education to Pharmacy and Allied Health - International Medical Graduate preparation to increase General Practice workforce capacity in outer metro areas This aims to meet PHN objectives by providing practice support services so that GPs are better placed to provide care to patients subsidised through the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), and help patients to avoid having to go to emergency departments or being admitted to hospital for conditions that can be effectively managed outside of hospitals.
Supporting the primary health care sector	The above activities help to attract workforce into areas of need, support the current workforce to meet demand and ensure they are upskilled to respond to population health needs.
Collaboration	Collaboration in the development and delivery of education with a range of organisations and services includes at this time: A formal alliance “Eastern Melbourne GO Education alliance with 6 public hospitals to support the delivery of high quality and localised GP education. Additional collaboration with Peak bodies, VPHNA, DHHS, Community Health Centres and other PHNs. Planning will be undertaken with key health organisations in line with identified priorities and related activities that are flexibly funded.

Duration	Ongoing
Coverage	Entire PHN region
Expected Outcome	Activities are expected to assist in achieving the following EMPHN Strategic Objectives: 1. Leaders commit to system improvement 1c. Leadership and change capacity is enhanced 2. Investment decisions are targeted for highest impact 2a. Consumers and providers (including GPs) are engaged 2b. Service needs are prioritized and identified gaps are filled 3. Care processes designed for need and best use of resources 3b. Services are reoriented to better meet needs PHN objectives will be supported to be achieved Providing continuing professional development and workforce supports so that GPs are better placed to provide care to patients based on best practice, subsidised through the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), and help patients to avoid having to go to emergency departments or being admitted to hospital for conditions that can be effectively managed outside of hospitals.

1. (d) Activities submitted in the 2016-18 AWP which will no longer be delivered under the Core Schedule

Please use the table below to outline any activities included in the May 2016 version of your AWP which are no longer planned for implementation in 2017-18.

Many of these activities noted as not continuing are now being undertaken within new or modified activities within this plan.

Planned activities which will no longer be delivered -	
Activity Title / Reference (eg. NP 1/OP 1)	Partnering with peak body organisations to develop : (Previously NP10 Cancer Screening in previous AWP – now removed from NP2) 10.1 A work package for roll out in General Practice to support increased cancer screening A diverse community engagement strategy regarding the promotion of cancer screening (CALD, Refugee & ATSI) NP10.4 Reviewing expansion and capacity of peer support networks
Description of Activity	10.1 A work package for roll out in General Practice to support increased cancer screening A diverse community engagement strategy regarding the promotion of cancer screening (CALD, Refugee & ATSI) 10.4 Review/expansion of current peer support networks for cancer survivorship (as part of cancer screening activity from 2016-17 AWP
Reason for removing activity	10.1 The work package has been developed based on collation of existing resources and streamlining to a whole patient journey approach – screening to survivorship. Continued roll out of the package will continue via activity 2.1. Community engagement approaches will continue to be explored in collaboration with other PHNs and DHHS.

	10.4 Review of activity concluded. Further activity not warranted for peer support networks for cancer survivorship. Cancer survivorship is included in new activity :
Funding impact	Nil impact as new activity has replaced activity no longer delivered

Planned activities which will no longer be delivered -	
Activity Title / Reference (eg. NP 1/OP 1)	NP1: Avoidable hospital admissions from Ambulatory Care Sensitive Conditions NP1.1 Establish collaborative structures NP1.2 Deeper dive into sub-catchment experience of preventable admissions NP1.3 Co-design and delivery of solutions to reduce preventable admissions NP1.4 Review and extrapolate findings of pilot to high risk ACSCs.
Description of Activity	The following activities will be undertaken to look at innovative and collaborative cross-system approaches to addressing potentially avoidable hospitalisations. In recognition of diabetes complications being the clear front runner for Ambulatory Care Sensitive Conditions, activities will commence with diabetes as the pilot model: 1.1 Establish collaborative governance structure in the outer north, the north east and the east. 1.2 Deeper dive into each sub-catchment including: a) Population health data b) Service mapping c) Community attitudes d) Clinician attitudes 1.3 Co-design and deliver solutions based on findings, including: - Service development

	- Clinician engagement and resources including clear referral pathways (i.e. HealthPathways) - Community engagement and resources including community mobilisation / activation, health literacy, health system / pathway knowledge 1.4 Review and consider extrapolation for other high risk ACSCs. Cross reference: Activity NP2.7 Trialling of predictive modelling, risk stratification to reduce avoidable hospitalisation.
Reason for removing activity	This activity for 2016-17 provided the foundational activities in establishing the collaborative and exploring further co-design. As a result of this process and the learnings of initial solutions design and in the process of delivery, the Collaboratives have now nominated key projects from their platform that have been incorporated into the 2017-18 AWP.
Funding impact	Funding for 2017-18 redistributed to more targeted collaborative driven projects

Planned activities which will no longer be delivered -	
Activity Title / Reference (eg. NP 1/OP 1)	NP2: Reducing ED presentations for primary care type conditions NP2.1 ED presentation population data deeper dive NP2.2 Data review of ED presentation drivers NP2.3 Support for eReferral and My Health Record uptake (continuing within Digital Health) NP2.4 Alternative care option community education NP2.5 HealthPathways support to increase primary care capacity to reduce ED presentations (continuing as Reducing Variations in Healthcare) NP2.6 Co-design and delivery of pilot programs to reduce ACSCs presenting to ED NP2.7 Supporting testing of POLAR DIVERSION Risk Algorithm (Continuing as Data Linkages)

Description of Activity	The following activities will be undertaken to ensure a deeper understanding of the drivers of ED presentations for Category 4 & 5 conditions and develop a collaborative, cross-system approach to addressing potentially avoidable hospital use. 2.1 Agreeing on the problem: Deeper dive with collaborators into **available data** to develop shared understanding and determine what can be learned about complexities, specific issues, demographics and localities, and relationships between them, to support targeted projects (see 1, 3, 4). 2.2 Collaborate with academic research centres to validate and prioritise to address localised drivers for ED presentations e.g. attitudinal beliefs about cost, perception of workforce capacity (especially paediatrics) and convenience (key factors known to be driving some ED presentations for Category 4 & 5 conditions). 2.3 Support for the use of eReferral and uptake of My Health Record within the region. 2.4 Collaborate with academic institutions, PCPs, LHNs to develop a regional plan for **communicating to the public** their care options and health behaviour change messages. 2.5 Improve system navigation knowledge for GPs and other primary care providers--expand and promote access to **HealthPathways**, addressing identified need of part-time, low experience and locum GPs for system pathways and referral information. 2.6 Based on 2.4 (above), co-design specific issue pilot programs aimed at reducing ACSCs presenting to ED and pilot these in key target locales. Examples: • Support GPs and practices to manage more target area low acuity and paediatric consultations with specialty education and programs to trial in-practice nurse practitioners. • Investigation of procuring additional diagnostic support for General Practice, so that referral to ED is not necessary.

	• Investigate trialling a specialist hotline for use by GPs. • Co-develop process and outcome measures specific to determining wins, gaps and learnings from the pilots. 2.7 Partner to validate within general practice the POLAR Diversion project to address GP capacity to prevent avoidable ED presentations by brokering test general practice sites to validate the algorithm and provide input on the reporting process. POLAR Diversion is an algorithm of risk which will be trialled in general practice by analysing their data to highlight a report of at-risk patients and presenting that report to General Practice to validate based on clinical opinion.
Reason for removing activity	This activity for 2016-17 provided the foundational activities in establishing the collaborative and exploring further co-design. As a result of this process and the learnings of initial solutions design and in the process of delivery, the Collaboratives have now nominated key projects from their platform that have been incorporated into the 2017-18 AWP.
Funding impact	Funding for 2017-18 redistributed to more targeted collaborative driven projects

Planned activities which will no longer be delivered -	
Activity Title / Reference (eg. NP 1/OP 1)	NP3: Integrated care for Chronic Disease Prevention & Management NP3.2 Develop a deeper understanding of a proposed Patient-Centred Healthcare Home Model NP3.4 Review of Chronic Disease Health Pathways according to chronic diseases experienced in the EMPHN population NP3.5 Increasing uptake of ePIP, eReferral and My Health Record in the EMPHN region NP3.6 Workforce supports for culturally safe practice in primary care NP3.7 Chronic Disease CPD

Description of Activity	A multifaceted approach to chronic disease management will be applied with this suite of activities. This includes working with general practice to build data quality and a population profile of service use in general practice and quality of care in reaching clinical outcomes, developing innovative models with consumers and stakeholders for chronic disease care, ensuring adequate workforce supports through education, eHealth support and Health Pathways and the procurement of services to increase capacity for prevention and early intervention in our region. These activities include: 3.2 Development of a proposed model for the Patient Centred Healthcare Home 3.4 Review/audit of the current HealthPathways developed relating to chronic disease emerging from data 3.5 Workforce supports for culturally safe practice to primary care designed with input from providers and consumers for CALD and ATSI consumers ***Support to Indigenous Australian's Program Activity Workplan 3.6 Chronic Disease continued professional development in line with emerging chronic conditions (Hepatitis B, Diabetes, Asthma, COPD)
Reason for removing activity	Consolidation of activities include: 3.2 An agreed model has been developed by the Department within the PCHCH trial. Supportive activity will continue through the Innovation funding work in 2017-18 3.4 Review of health pathways for chronic disease to be completed in 2016-17 3.5 Cultural safety workforce supports already within the ITC AWP 3.6 into general workforce development CPD planning
Funding impact	Redistributed to NP3 and other targeted collaborative driven projects

Planned activities which will no longer be delivered -	
Activity Title / Reference (eg. NP 1/OP 1)	NP4: Ageing NP4.1 Increasing telehealth capacity for Urology, Geriatrics and Endocrinology NP4.2 Interim Medication Improvement Project with LHNs NP4.3 Develop Palliative Care Health Pathways NP 4.5 Review evidence of falls prevention approaches for recommendations for action NP 4.7 Early Intervention Model for healthy ageing
Description of Activity	Healthy ageing is a key issue for the EMPHN region with a high number of RACF beds and an ageing population, particularly in the inner, more densely populated areas. Activities to support healthy ageing have a natural overlap with avoiding hospital presentations by seeking to: increase quality of life and reduce acuity, improve service coordination and information, support general practice through Health Pathways and innovative models of early intervention, and increased access to services, including specialist telehealth. Activity includes: 4.1 Supporting increased telehealth capacity within the specialties of urology, geriatrics and endocrinology 4.2 Interim Medication Chart improvement projects with LHNs 4.3 Undertake to develop Palliative Care Health Pathways and promote to general practice and locums 4.4 Quality Use of Medicines program roll-out with a particular focus on polypharmacy and antibiotic resistance 4.5 Review findings of current falls programs and Benetas Frailty Research Project to determine recommendations of action to address frailty and falls. 4.6 Review current research and models of care regarding de-prescribing and reducing polypharmacy in older populations. Develop a model of early intervention for healthy ageing at 45-49 year-old health check to 75 year-old health check to promote healthy ageing and decreased risk of chronic disease, including consideration of commissioning cardiologist access to general practice for ongoing monitoring of

	patients at risk of heart failure and commissioning community education in the Whittlesea/Wallan region regarding heart health. Activities to be undertaken with the following stakeholders: Northern Hospital and other LHNs, in-reach services, specialists, palliative care services, pharmacies (supply and community), general practice, RACFs, allied health, local councils, Council of the Ageing, Benetas, Heart Foundation, Community Health Services
Reason for removing activity	In recognising the significant overlap in activities that are disease driven versus age cohort driven, a different approach has been taken with this iteration of the AWP. An age cohort lens will instead be applied to activities listed in the plan where the needs assessment indicates the experience of the priority health issue is significant for healthy ageing and the older persons cohort.
Funding impact	Redistributed to targeted collaborative driven projects

Planned activities which will no longer be delivered -	
Activity Title / Reference (eg. NP 1/OP 1)	LP6: Access to Care for Refugee and CALD Communities LP6.1 Support to general practice in better use of interpreters LP6.2 Workforce awareness and preparation to support refugees with a disability LP6.3 Broker supports for CALD carers as per National Ageing and Aged Care Strategy
Description of Activity	As the EMPHN region contains a diverse population, and have existing communities of humanitarian arrivals as well as more settlement incoming, the capacity to delivery culturally appropriate care to engage these populations and address their needs will be key to addressing the increased risks of ill health. Activities will be a combination of equipping general practice to respond and working with stakeholders to improve the patient experience for CALD and refugee populations. These include: 6.1. Supporting general practice in better use of interpreters (develop and disseminate in-practice workflows to ensure interpreter bookings, etc.)

	6.2. Raising awareness of humanitarian arrival ineligibility for the NDIS to GPs and developing and providing alternative pathways of care 6.3. Supporting general practice services engaged in locating and assisting CALD carers facing cultural and other barriers in accessing carer support services (as per National Ageing and Aged Care Strategy, p. 2).
Reason for removing activity	As a priority project/condition approach versus a cohort approach has been adopted, a refugee lens will be applied to other activities to ensure where the refugee and CALD populations have been identified as at risk (particularly for chronic disease and ED Diversion), the procurement process encourages proposals which include engaging effectively with these populations.
Funding impact	Nil impact as new activity has replaced activity no longer delivered

3. (a) Strategic Vision for After Hours Funding

See section 1a.

After Hours activities retained from the previous AWP are detailed below.

FOR MORE INFORMATION

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