Australian Government
Department of Health

phn
EASTERN MELBOURNE
An Australian Government Initiative

Primary Health Networks Core Funding
Primary Health Networks After Hours Funding

Activity Work Plan 2016-2018

Eastern Melbourne Primary Health Network

Operational & Flexible Funding Activity Work Plan

Introduction

Overview

The key objectives of Primary Health Networks (PHN) are:

- Increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- Improving coordination of care to ensure patients receive the right care in the right place at the right time.

Each PHN must make informed choices about how best to use its resources to achieve these objectives.

Together with the PHN Needs Assessment and the PHN Performance Framework, Eastern Melbourne PHN has outlined activities and measurable performance indicators to provide the Australian Government and the Australian public with visibility as to the activities of our PHN.

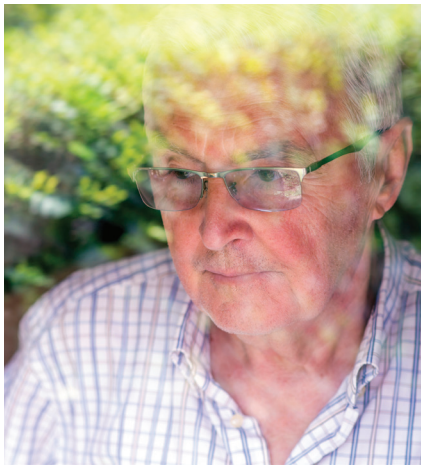
This document, the Activity Work Plan template, captures those activities.

This Activity Work Plan covers the period from 1 July 2016 to 30 June 2018. To assist with PHN planning, each activity nominated in this work plan can be proposed for a period of 12 months or 24 months. Regardless of the proposed duration for each activity, the Department of Health will still require the submission of a new or updated Activity Work Plan for 2017-18.

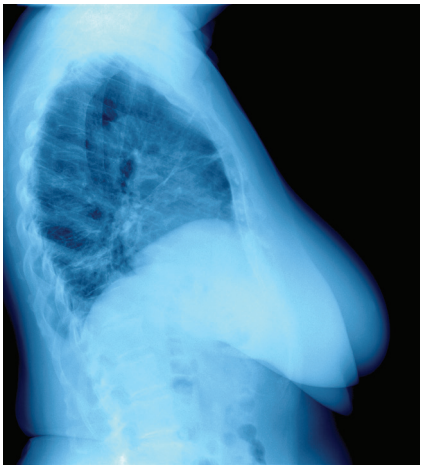
The Activity Work Plan template has the following parts:

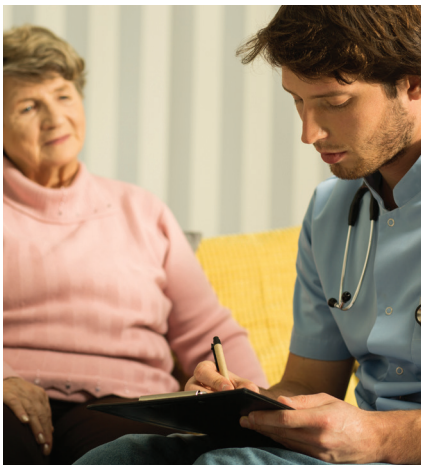
1. The Core Funding Annual Plan 2016-2018 which will provide:
   a) The strategic vision of each PHN.
   b) A description of planned activities funded by the flexible funding stream under the Schedule – Primary Health Networks Core Funding.
   c) A description of planned general practice support activities funded by the operational funding stream under the Schedule – Primary Health Networks Core Funding.
2. The After Hours Primary Care Funding Annual Plan 2016-2017 which will provide:
   a) The strategic vision of each PHN for achieving the After Hours key objectives.
   b) A description of planned activities funded under the Schedule – Primary Health Networks After Hours Primary Care Funding.








Annual Plan 2016-2018

Annual plans for 2016-2018 intend to:

- provide a coherent guide for PHNs to demonstrate to their communities, general practices, health service organisations, state and territory health services and the Commonwealth Government about what the PHN is going to achieve (through performance indicator targets) and how the PHN plans to achieve these targets;
- be developed in consultation with local communities, Clinical Councils, Community Advisory Committees, state/territory governments and Local Hospital Networks as appropriate; and
- articulate a set of activities that each PHN will undertake, using the PHN Needs Assessment as evidence, as well as identifying clear and measurable performance indicators and targets to demonstrate improvements.

Activity Planning

The PHN Needs Assessment has identified local priorities which in turn informs and guides the activities nominated for action in the 2016-2018 Annual Plan.

Primary Health Networks After Hours Funding

From 2016-17, PHNs will have greater flexibility to commission programme specific services, having completed needs assessments for their regions and associated population health planning. PHNs are funded to address gaps in after hours service provision and improve service integration within their PHN region.

Measuring Improvements to the Health System

National headline performance indicators, as outlined in the PHN Performance Framework, represent the Australian Government's national health priorities.

In addition, Eastern Melbourne PHN has identified local performance indicators to demonstrate improvements resulting from the activities we are undertaking. These will be reported through the six and twelve month reports and published as outlined in the PHN Performance Framework.

Activity Work Plan Reporting Period and Public Accessibility

The Activity Work Plan will cover the period 1 July 2016 to 30 June 2018. A review of the Activity Work Plan will be undertaken in 2017 and resubmitted as required under Item F.22 of the PHN Core Funding Agreement between the Commonwealth and all Primary Health Networks.

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 are assessed through community consultation and solutions are 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 to further assessment and planning.

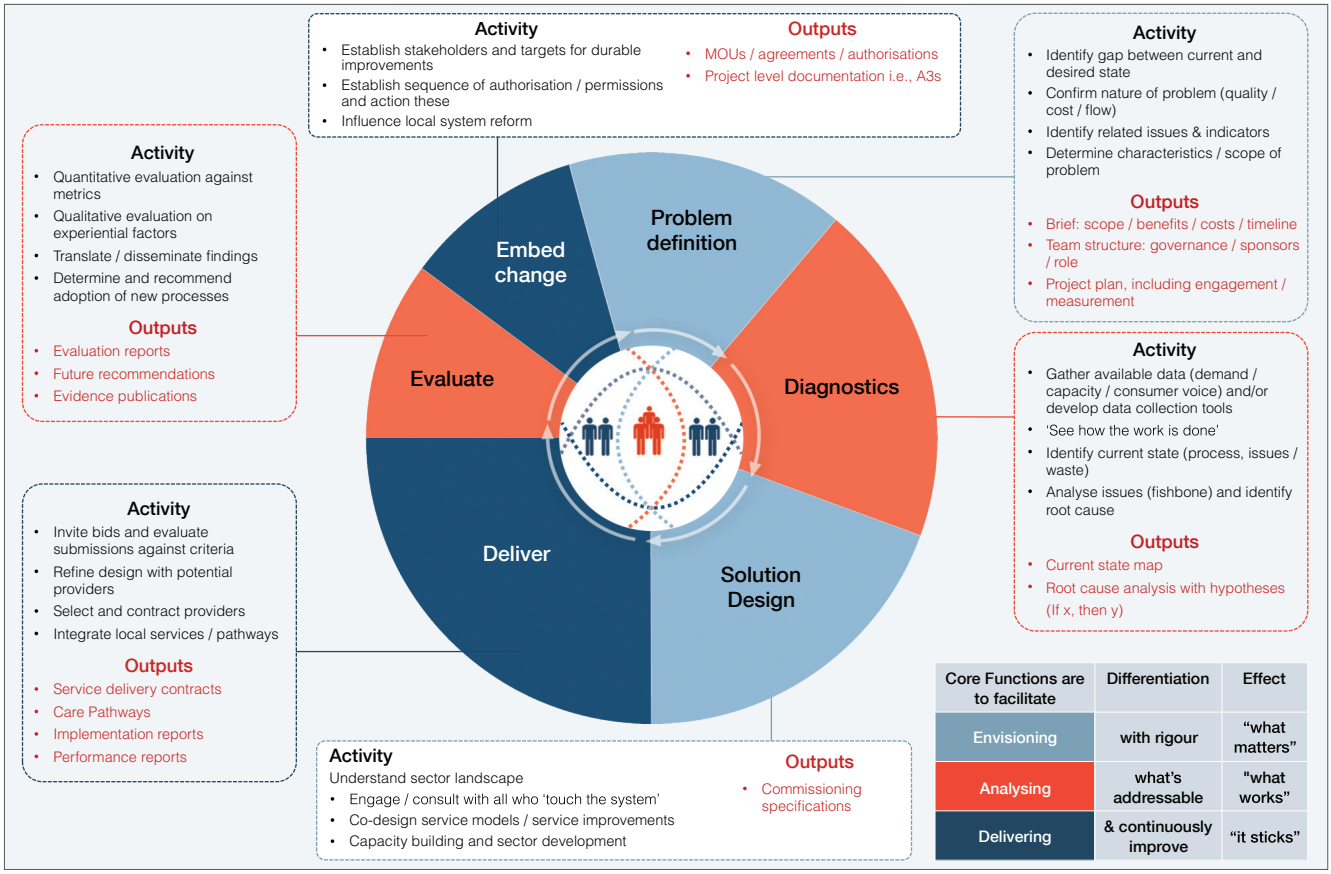


Figure 1. Commissioning cycle

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

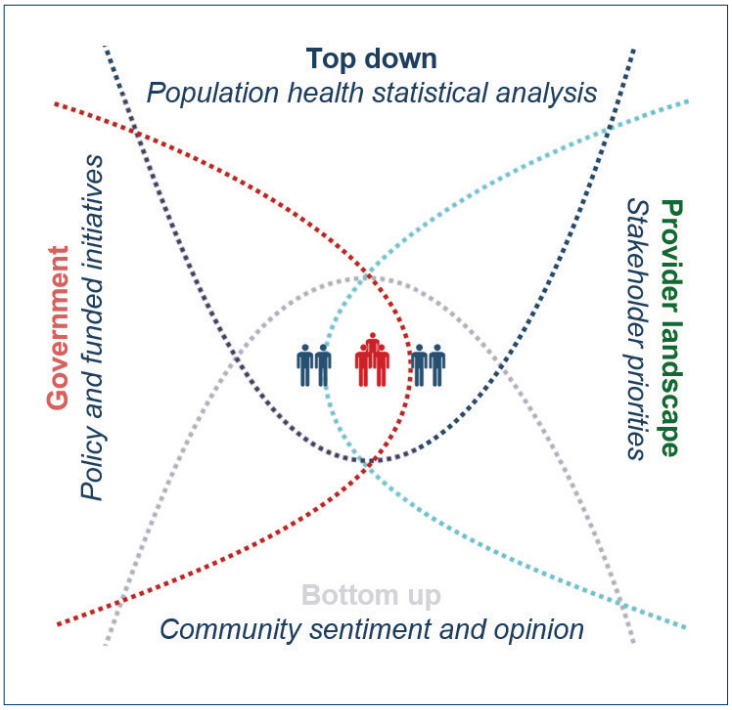


Figure 2. Prioritisation approach

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 to key groups:

- Clinical Council
- Community Advisory Committee

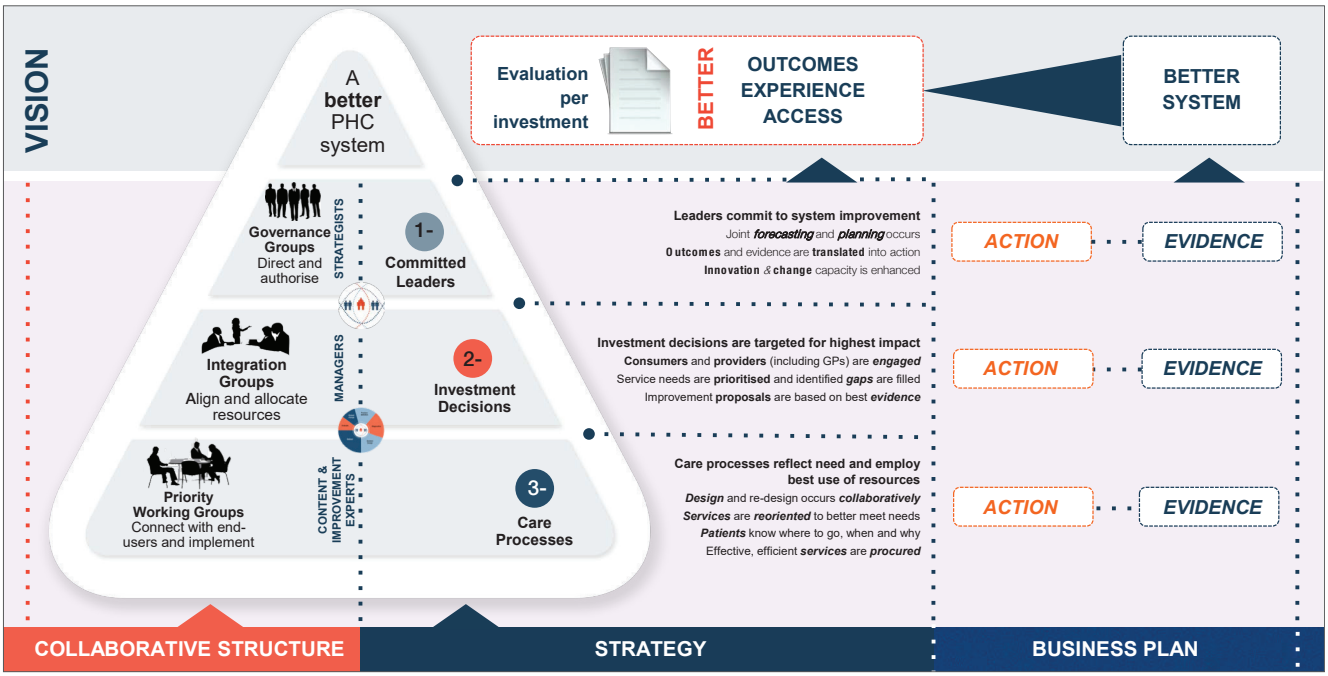


Figure 2. Collaborative Structures

The EMPHN catchment will be divided into four sub-catchments for the purposes of shared planning and governance. The sub-catchments will align with the large public health services in the catchment:

- Austin Health
- Eastern Health
- Monash Health
- Northern Health

Each sub-catchment will have three 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"

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.

1. (b) Planned activities funded by the flexible funding stream under the Schedule – Primary Health Networks Core Funding

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2016-18. These activities will be funded under the Flexible Funding stream under the Schedule – Primary Health Networks Core Funding.

Note 1: Please copy and complete the table as many times as necessary to report on each activity.

Note 2: Indicate within the duration section of the table if the activity relates to a two year period (2016-2018) or a one year period (2016-2017).

Proposed Activities	
Priority Area (e.g. 1, 2, 3)	1. Avoidable hospital admissions from Ambulatory Care Sensitive Conditions (ACSCs).
Activity Title / Reference (e.g. NP 1.1)	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 ofsolutions 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.
Collaboration	Undertaken in collaboration with: • Service users – such as community members with chronic illness and mental health clients as per demographic findings of Activity 1.1) • Local Health Networks (LHNs), Community Health Services (CHSs), Primary Care Partnerships (PCPs), GP representation via focus groups, EMPHN advisory groups: Clinical Council (CC), Community Advisory Group (CAG).
Duration	Activities 1.1 – 1.3 July 2016- June 2017

	Activity 1.4 July 2017 – June 2018
Coverage	Entire PHN region, however may be refined according to the findings of 1.1 and 1.2.
Commissioning approach	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 Solution Design components of the methodology. The solutions may require procurement of services for Delivery and appropriate options for procurement will be assessed at that time and advised to the Department. Where services are purchased – such as the delivery of an education campaign jointly purchased with partners – a clear brief will be developed and performance metrics built into contracts.
Performance Indicator (Process, Output or Outcome indicator)	1.1 Establish for each collaborative: (Output) • Shared objectives and work plan • Shared current state picture • Work specifications / commissioning specifications • Deliverable programs of work, e.g. service contracts, resources developed 1.2 Deeper dive tabled with Collaborative Platforms to share data and develop a deeper understanding of populations affected (Process) 1.3 a) Solutions designed to target the early intervention of diabetes and reducing acuity of diabetes complications in the EMPHN population (Process) b) Reduction in hospital ACSC admissions and bed days for diabetes (Outcome) 1.4 Lessons learned documented for application to hypertension and/or pyelonephritis (Process).
Local Performance Indicator target	1.1 Collaborative Structure and working groups established 1.2 Co-authored reports with recommendations developed 1.3 a) Plan developed

	1.3 b) Reduction in avoidable diabetes complications as a proportion of hospital admissions (reviewed according to LGA, gender and age) 1.4 Lessons learned and recommendations developed for extrapolation to further ACSCs
Data source	1.1 Collaborative structure meeting minutes 1.2 Planning drafting 1.3 a) planning drafting 1.3 b) VEAD Dataset (Victorian) 1.4 Evaluation findings

Proposed Activities	
Priority Area (e.g. 1, 2, 3)	2 Reducing ED presentations for primary care type conditions
Activity Title / Reference (e.g. NP 1.1)	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 NP2.4 Alternative care option community education NP2.5 HealthPathways support to increase primary care capacity to reduce ED presentations NP2.6 Co-design and delivery of pilot programs to reduce ACSCs presenting to ED NP2.7 Supporting testing of POLAR DIVERSION Risk Algorithm

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.
Collaboration	Activities will be undertaken in collaboration with the following: • Service users—such as parents of children 0-5 years, mental health clients of low acuity (general practice type presentations) as per demographic findings of Activity 1. • Local Health Networks (LHNs), Community Health Services (CHSs), Primary Care Partnerships (PCPs), GP representation via focus groups, EMPHN advisory groups: Clinical Council (CC), Community Advisory Group (CAG) • Universities, via partnerships with their research centres, e.g. Deakin Faculty of Health (6 research centres [e.g. SEED for youth AOD], +/- health economist.
Duration	Anticipated activity start and completion dates (excluding the planning and procurement cycle): Activities 2.1 – 2.2 to commence 1st July 2016 – 30th June 17 Activity 2.3 1st July 2016 - ongoing Activities 2.3- 2.6 to comment 1st October 2016 to 20th June 2018.
Coverage	Entire EMPHN region.
Commissioning approach	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 Solution Design components of the methodology. The solutions may require procurement of services for Delivery and appropriate options for procurement will be assessed at that time and advised to the Department. Where services are purchased – such as the delivery of an education campaign jointly purchased with partners – a clear brief will be developed and performance metrics built into contracts.
Performance Indicator (Process, Output, Outcome)	2.1 Deeper dive tabled with Collaborative Platforms to share data and develop a deeper understanding of populations affected (Process) 2.2 Agreed drivers to address via 2.6 (Output) 2.3a Communication plan developed in partnership with stakeholders addressing drivers of ED presentations in relation to populations at higher risk (Output) 2.3b Post-campaign analysis of metrics to determine reach (Outcome) 2.3 c Decreased Category 4 & 5 ED presentations as a proportion of total presentations (Outcome) 2.4 Issue of new pathways for outstanding ACSCs and Mental Health, with focus on options for outer regions (Output) 2.5 Pilot programs designed with consumers and stakeholders as innovative approaches to reduce ED admissions (Process) 2.6 a) Partnership developed to trial algorithm and report within practices in the region (Output) b) Successful engagement of agreed number of practices (estimated 20) with feedback regarding the accuracy of the algorithm and suitability of the reporting process (Process).
Local Performance Indicator target	2.1 Working group established 2.2 Co-authored reports with recommendations developed 2.3 a) Plan released b) Post campaign analysis of metrics determine

	c) 10% proportional decrease in Category 4 & 5 ED presentations for campaign target group from baseline 2.4 Issue of new Health Pathways for outstanding ACSCs, Mental Health, with focus on options for outer regions 2.5 Dependent on nature of project brief for 2.4 2.6 a) MOU developed with MEGPN to partner in the trial of the algorithm b) Trial undertaken with agreed number of practices and feedback provided to MEGPN.
Data source	2.1 Collaborative/Working group meeting minutes 2.2 Report drafting 2.3 a) Planning drafting b) Metrics associated with method of campaign (social media, local media distribution, etc) c) VAED data via POLAR – disaggregated by gender, location, RACF and Business Hours vs After Hours 2.4 Health Pathways developed and metrics of use reported 2.5 Planning drafting 2.6 a) MOU document b) Trial monitoring

Proposed Activities	
Priority Area (e.g. 1, 2, 3)	3 Integrated Care for Chronic Disease Prevention & Management
Activity Title / Reference (e.g. NP 1.1)	NP3: Integrated care for Chronic Disease Prevention & Management NP3.1 Roll-out of a Clinical Audit Tool in general practice for Chronic Disease patient population auditing NP3.2 Develop a deeper understanding of a proposed Patient-Centred Healthcare Home Model NP3.3 Commissioning of self-management programs based on evidence 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: 3.1 Roll-out of POLAR within general practice for internal clinical auditing of chronic disease of the practice patient population 3.2 Development of a proposed model for the Patient Centred Healthcare Home

	3.3 Procurement of self-management programs based upon best evidence of existing successful models and innovative approaches 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)
Collaboration	Activities will be undertaken in consultation and collaboration with Hospitals, CHSs, PCPs, [Collaborative Platforms], peak bodies, VicHealth, consumers, GPs, practice staff, pharmacist, allied health, specialists, RACFs, [disability / youth / homeless / CALD services], carers, private health insurance, community nursing, MEGPN.
Indigenous Specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? (~~YES~~/NO) No – but considered within scope as a target group for activities.
Duration	3.1 July 2016 onwards 3.2 August 2016 – February 2017 3.3 February 2017 – June 2018 3.4 July 2016 – June 2017 3.5 July 2016 – June 2017 3.6 July 2016 – June 2018
Coverage	Entire EMPHN region
Commissioning approach	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 Solution Design components of the methodology. The solutions may require procurement of services for Delivery and appropriate options for procurement will be assessed at that time and advised to the Department. Where services are purchased – such as the delivery of self management and health promotion programs – a clear brief will be developed and performance metrics built into contracts.
Performance Indicator	3.1 a) Number of practices participating in data quality program (Process) b) Improved data quality within General Practice through quality improvement visits by GP Improvement and Integration Facilitators (Outcome) 3.2 Proposed Patient Centred Health Care Home developed in consultation with consumers and clinicians (Output) 3.3 Procurement of self management program/s that provide evidence of reach, effectiveness and efficacy through agreed performance measures that will include number of referrals received, patient participation, drop-out profile, completion, patient experience and clinical outcomes (Process to lead to Outcome measures in evaluation). 3.4 Current pathways reviewed for coverage of chronic disease profile of the region with planning underway for remaining topics (Output) 3.5 Workforce supports developed, with input from consumers and clinicians (Output) 3.6 a) CPD calendar planning includes condition specific training in consultation with General Practice and subject matter experts (Output) b) Improved clinician knowledge and confidence to address chronic disease identification, early intervention and prevention within General Practice (Outcome)
Local Performance Indicator target	3.1 Total 70 practices (currently 0) in the region with POLAR GP by 30th June 2018 3.2 Proposed Patient Centred Medical Home developed in consultation with consumers and clinicians and based upon local and international evidence

	3.3 Performance metrics to be set with provider, however evidence of and/or improvement sought across the areas of; number of referrals received, Patient participation, drop-out profile, completion, patient experience and clinical outcomes. 3.4 Pathways developed, or planned to be developed, for key chronic diseases experienced by the EMPHN population including; Type 2 Diabetes, Obesity, Hepatitis B & C, Bone & Joint Disease and Respiratory Disorders 3.5 Workforce supports developed and determined by those consulted to meet the needs of the community and clinicians (who are undertaking the training) 3.6 a) CPD calendar planning incorporates training with learning objectives related to identified deficits in clinician skillsets b) Improved self-reported knowledge and confidence compared to pre-training to address chronic disease identification, early intervention and prevention within general practice
Data source	3.1 EMPHN CRM tracking 3.2 Planning drafting 3.3 Commissioning Process and Evaluation findings 3.4 Health Pathways metrics 3.5 Support materials 3.6 a) Number of GPs / practices participating b) Improved self-reported competency on evaluation forms 3.7 Commissioning process and evaluation findings.

Proposed Activities	
Priority Area (e.g. 1, 2, 3)	4 Healthy Ageing
Activity Title / Reference (e.g. NP 1.1)	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 NP4.4 QUM rollout with focus on polypharmacy and falls, and antibiotic resistance NP 4.5 Review evidence of falls prevention approaches for recommendations for action NP 4.6 Review evidence on reducing polypharmacy/de-prescribing and develop recommendations 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. 4.7 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.
Collaboration	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
Indigenous Specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? No
Duration	4.1 July 2016 – June 2018 4.2 November 2016 – June 2018 4.3 July 2016 – June 2017 4.4 August 2016 –June 2018 4.5 November 2016 – November 2017 4.6 September 2016 – September 2017 4.7 August 2016 – June 2018
Coverage	Entire EMPHN region, with a particular focus on the Northern and Austin LHN catchments
Commissioning approach	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 Solution Design components of the methodology. The solutions may require procurement of services for Delivery and appropriate options for procurement will be assessed at that time and advised to the Department.
Performance Indicator	4.1 Increased number of urology, geriatric and endocrinology services that have telehealth capacity across the region 4.2 Plan established with Public LHNs to undertake an Interim Medication Chart Improvement Project based upon prior learnings of MLs 4.3 Pathways designed with relevant stakeholders, including feedback from community palliative care providers 4.4 Improved provider confidence and knowledge in reducing polypharmacy and antibiotic resistance 4.5 Review paper and recommendations developed to inform future action regarding falls prevention 4.6 Review paper and recommendations developed to inform future action regarding de-prescribing 4.7 Proposed model developed for early intervention of key ageing issues with activation of monitoring post 45-49 year-old health check to prevent and reduce burden of disease.
Local Performance Indicator target	4.1 Total 24 consultations supported resulting a $ target saving achieved though avoided patient transfers 4.2 Plan developed in consultation with LHNs, GPs, RACFs and locums 4.3 Palliative Care Pathways designed with subject matter expertise and demonstration of uptake within first 3 months of launch 4.4 20% improvement from pre-training intervention scores 4.5 Review paper developed with local and international findings and shared with appropriate network/Collaborative Platform 4.6 Review paper developed with local and international findings and shared with appropriate network/Collaborative Platform

	4.7 Model developed and prepared for trial.
Data source	4.1 MBS telehealth consultations 4.2 Plan Drafting 4.3 Pathways developed and Health Pathways Melbourne usage metrics 4.4 Provider pre- and post-assessment from in-practice education 4.5 Review paper development 4.6 Review paper development 4.7 Model drafting

Priority 5: Culturally appropriate care for Aboriginal & Torres Strait Islander Communities will be addressed through the Indigenous Australians Program Activity Work Plan

Proposed Activities	
Priority Area (e.g. 1, 2, 3)	6 Access to Care for Refugee and CALD Communities
Activity Title / Reference (e.g. NP 1.1)	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).
Collaboration	6.1. a) Work with interpreter services to establish availabilities, reach and contacts of interpreters needed to address language group needs across catchment b) engage with GPs to promote availabilities and benefits of booking interpreters c) work with practice managers to support workflow processes that facilitate timely booking of services 6.2. Work with GPs and practice managers directly in promoting awareness and ensuring they have facility and capacity to cater to this population. Ensure HealthPathways offers potential referral pathways and promote this HP with GPs. 6.3. Work with general practice to ensure linkage for their CALD carer patients to have access to appropriate aged care services, CHSs, and CALD and refugee support groups and assist with supporting access to available, culturally appropriate services.
Indigenous Specific	No
Duration	6.1 July 2016- June 2017 6.2 July 2016 – June 2018 6.3 January 2017 – June 2018
Coverage	6.1. Whole of catchment

	6.2. Whole of catchment, focus on northern growth corridor in Whittlesea catchment 6.3. Whole of catchment scan with focus on key areas likely to include older, overlaid with CALD, demographic.
Commissioning approach	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 Solution Design components of the methodology. The solutions are expected to relate to core functions of general practice engagement and participation in existing networks.
Performance Indicator	6.1. Materials Developed to support general practice to appropriately utilise interpreter services (Output) Post-intervention implementation of workflows in general practice to utilise interpreters as usual practice for CALD patients (Outcome) 6.2. Dissemination of information GPs and alternative referral pathways identified (Process) 6.3. Opportunity to support carers scoped and appropriate commissioning response enacted (Process) Agency engagement metrics, stakeholder feedback (Outcome)
Local Performance Indicator target	6.1. Dissemination of information to general practice 6.2. Raised awareness of appropriate care, referrals to appropriate care, access to appropriate care 6.3. Engagements via CRM, reporting feedback from stakeholder groups.
Data source	6.1 CRM interaction statistics 6.2 CRM interaction statistics 6.3 Meeting materials and commissioning process.

Proposed Activities	
Priority Area (e.g. 1, 2, 3)	7. Immunisation
Activity Title / Reference (e.g. NP 1.1)	NP7: Immunisation NP7.1 Improve suboptimal childhood immunisation rates (particularly Monash LGA) NP7.2 Address myths associated with immunisation resulting in ideological conscientious objection NP7.3 Support workforce to respond to demand generated by government immunisation initiatives.
Description of Activity	No LGA meets the aspirational childhood immunisation rate of 95%. With childhood immunisation rates across the catchment running at 89.1-93.7% across one or other of the age 1, 2 and 5 immunisation bands, Monash is the standout area for low rates consistently across the three immunisation milestones and presents a strategic target for improvement activities. Objection on ideological grounds contributing more strongly in Yarra Ranges and Nillumbik LGAs rates presents a further opportunity for improved immunisation coverage. Childhood immunisation activities below centre around improvement of suboptimal rates in our region and equipping the primary care workforce and partners to address common myths associated with conscientious objection on ideological grounds. 7.1. To improve identified suboptimal immunisation rates across catchment, noting Monash as standout, support: • Targeted intervention in LGA and SLA areas with lower immunisation rates. • 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 through VPHNA to address systemic immunisation issues (e.g. cold chain breach reporting). 7.2. 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. 7.3. 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.
Collaboration	Activities will be undertaken in collaboration with: GPs, practice nurses, Local Government (immunisation coordinators), parents and community, RCH (communicable diseases and immunisation specialists), refugee settlement services, migrant resource services, local media.
Indigenous Specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? (~~YES~~/NO) No
Duration	Anticipated activity start and completion dates (excluding the planning and procurement cycle). 7.1 a) October 2016 - June 2018 b) July 2016 - October 2016 c) July 2016 - June 2018 7.2 a) October 2016 - May 2017 b) October 2016 - June 2018 7.3 July 2016 - June 2017

Coverage	Entire PHN Region with a particular focus in the following LGAs: • Monash (increasing immunisation rates) • Nillumbik and Yarra Ranges (reducing conscientious objection)
Commissioning approach	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 Solution Design components of the methodology. The solutions are expected to relate to core functions of general practice engagement and participation in existing networks, however, if the need to commission activity is highlighted through this work, 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.
Performance Indicator	7.1. a) Capacity building/education uptake by General Practice (Process) b) Briefing paper on systemic and local levers including GP to population ratio in areas of low immunisation, % conscientious objectors and numbers of child humanitarian arrivals where possible (output) c) Childhood immunisation increases 1% per annum towards 95% per SA2 area, per age group (outcome) Baseline: All LGAs at 1, 2 and 5 years are above 90%. 7.2 a) Resources and community engagement collateral developed with input from consumers, council and GPs (Output) b) % of conscientious objectors reduces by 0.5% in target areas of Nillumbik and Yarra Ranges (Outcome 2 years) 7.3. Capacity building for general practice to reconcile data for child humanitarian arrivals and international immunisation is developed and disseminated to GPs (Process) .
Local Performance Indicator target	7.1. a) Uptake of support in minimum 20 Monash-region general practices b) Briefing paper developed to inform action c) Increase of 1% childhood immunisation rate per SA2 area, per age group, per annum towards 95%.

	7.2. a) Resources and community engagement collateral developed with input from consumers, council and GPs b) 1% reduction in conscientious objectors by June 2018 7.3 Dissemination of reconciliation support materials via web, practice visits and email to all practices.
Data source	7.1 a) CRM interaction statistics b) Briefing paper drafting c) ACIR Dataset (compared to baseline) 7.2 a) Collateral materials b) ACIR Dataset (compared to baseline) 7.3. a) Web click rate and CRM statistics.

Local Priority 8 will be undertaken by the Population Health team as standard business. In recognising that there are existing regional initiatives with strong leadership by Women's Health Organisations, the activities are limited to the sphere of influence of the PHN and working with the capacity of primary care to respond and aim to compliment these regional initiatives.

Local Priority area 9 (screening for sexually transmitted infections) is dealt with under General Practice Engagement (OP 2)

Proposed Activities	
Priority Area (e.g. 1, 2, 3)	Cancer Screening
Activity Title / Reference (e.g. NP 1.1)	NP10: Cancer Screening

	NP10.1 Partnership to develop GP Workforce Support Module and diverse community engagement strategy NP10.2 Reviewing expansion and capacity of peer support networks NP10.3 Building capacity in General Practice for increased uptake of cancer screening in the community.
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 there may be replicability across PHN boundaries. Activities will work to increase capacity and raise local cancer screening participation rates through: 10.1 Partnering with peak body organisations to develop : 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) 10.2 Review/expansion of current peer support networks for cancer survivorship 10.3 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.
Collaboration	Activities will be undertaken in collaboration with: • Peak cancer bodies • LHNs • PHN Alliance • Diverse Community Support Services • Department of Health (State/Federal)
Indigenous Specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? (YES/~~NO~~) Yes – Broader population approach however working with the Aboriginal Health team to increase breast cancer screening rates in Aboriginal women in our community.

Duration	10.1 July 2016 - April 2017 10.2 July 2016 -June 2018 10.3 April 2017 - June 2018.
Coverage	Entire EMPHN Region.
Commissioning approach	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 Solution Design components of the methodology. The solutions may require procurement of services for Delivery and appropriate options for procurement will be assessed at that time and advised to the Department. It is anticipated that activity 10.1 may highlight the need to commission services from a peak organisation for the development of the package. Where services are purchased a clear brief will be developed, the appropriate commissioning process will be identified and undertaken and performance metrics built into contracts.
Performance Indicator	**Process** 10.1 Initial Project Plan developed with peak cancer organisations for: - work package to deliver to General Practice to increase capacity for cancer screening - diverse community engagement strategy and suite of resources for cancer screening promotion 10.1 Evidence of key partners engaged **Outputs** 10.1 Cancer screening work package developed by EMPHN collaboration with peak bodies and stakeholders to deliver in practices. 10.2 Report on efficacy of current peer support networks and how PHN can better assist.

	Outcome 10.3 Aim to reach the following cancer screening rates by June 2018: Bowel Cancer Screening 50% Cervical Screening 75% for eligible women, with first year improvement Breast Cancer Screening 75% for eligible women, with first year improvement of minimum 5% from baseline per local government area See also 9.6 regarding Hepatitis B & C
Local Performance Indicator target	10.1 Project controls 10.2 Report created with peer network consultation with clear recommendations on PHN act required 10.3 Bowel cancer screening rates at 50% Cervical Screening 75% for eligible women, with first year improvement Breast cancer screening rates at 75% for eligible women, with first year improvement of minimum 5% from baseline per LGA.
Data source	10.1 Project controls 10.2 Report drafting 10.3 Cancer screening rates (ABS)

1. Planned core activities funded by the operational funding stream under the Schedule – Primary Health Networks Core Funding

PHNs must use the table below to outline core activities (excluding administrative and governance related activities) funded under the Operational Funding stream as described in section 1.5.1 of the PHN Grant Programme Guidelines.

Note 2: Indicate within the duration section of the table if the activity relates to a two year period (2016-2018) or a one year period (2016-2017).

Proposed activities	
Activity Title / Reference (e.g. OP 1)	OP1: Population Health
Description of Activity	The Population Health 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.

	A key assessed priority for the EMPHN catchment to be undertaking using the above responsibility framework is that of the prevention of violence against women. The principle activity in relation to that priority will be: OP1.1 Active participation in our region in prevention of violence against women initiatives aimed at reducing violence against women through planning, co-design and supportive activities. The initiatives will be led by Women's Health East and Women's Health in the North.
Collaboration	This activity will be primarily internal capacity building and assist with our collaborative arrangements. Collaboration on Prevention of violence against women activities will be via regional networks currently led by Women's Health East and Women's Health in the North and where appropriate, consultation with General Practice and Victims of Violence via Women's Health East Speaking Out Program
Duration	Ongoing. In respect of Prevention of violence activities, the anticipated activity start and completion dates (excluding the planning and procurement cycle) are: July 2016-June 2017.
Coverage	Entire EMPHN region
Expected Outcome	Activities are expected to assist in achieving the following EMPHN Strategic Objectives: 1. Leaders commit to system improvement 1a. Joint forecasting and planning occurs 1b. Investment decisions are targeted for highest impact 2. Investment decisions are targeted for highest impact 2c. Improvement proposals are based on best evidence 3. Care processes designed for need and best use of resources 3b. Services are reoriented to better meet needs 3d. Effective, efficient services are procured With regard to OP1.1, the EMPHN Population Health team will attend a minimum of 90% of Regional Network meetings and demonstrate participation by the inclusion of actions within regional plans relating to General Practice engagement and workforce development in prevention of violence against women/family violence.

	PHN objectives: The organisation maintains a population health understanding 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.

Proposed general practice support activities	
Activity Title / Reference (e.g. OP 1)	OP2: General Practice Engagement & Support
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 and supporting practices in quality improvement activities to improve primary health care outcomes based on the available data collection. - General Practice Improvement & Integration- assisting with the development and implementation of innovative activities, integrated with other program areas, which will support general practice in adding value to and enhancing their clinics. Practice grants program to achieve demonstration sites for the practice of the future “practice 2020”

	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 relate to a range of Flexible Fund activities. In addition, the priority identified in the needs assessment of sexually transmitted infections will be incorporated into the daily functions of the engagement team. STIs represent an area in which solid gains can be made in ensuring adequate screening in our region and enabling its monitoring through notification data. An identified local need, regional initiatives are underway in the North and East regarding sexual and reproductive health on which there are platforms for collaboration and opportunity for a collective impact approach for our region. GP collaborative activities to be undertaken by EMPHN include: OP 2.1 Increase capacity for opportunistic screening in general practice and assess risk for STI in young people through workforce supports co-designed with general practice and the EMPHN Clinical Council OP 2.2 Develop STI Health Pathways for improving the patient journey where risk is identified or a diagnosis made. OP 2.3 Develop partnerships to promote STI screening in young people. Partnering with stakeholders to provide youth promotion, and screening, including the piloting of a guide for youth sexual health screening for general practice developed by Family Planning Victoria will add to the suite of support activities aimed at improving screening rates.

	OP 2.4 Develop a deeper understanding of HIV infection in our region by working collaboratively with key stakeholders to develop that understanding and establish its impact on chronic disease management in relevant communities (particularly in key areas of Knox and Boroondara) OP 2.5 Promote Hepatitis B and C screening in general practice by leveraging off cancer screening work package (Activity 10.4) to promote hepatitis B & C screening in practices with relevant migrant communities. OP 2.6 Involvement in regional sexual and reproductive health initiatives. This will be supported through developing a background paper in partnership with a Deakin student placement to support advocacy for a national screening program for STI as part of the Eastern Region Sexual & Reproductive Health Strategic Working Group
Collaboration	Internal support to General Practice and as enabler for Flexible Funded activity. Collaboration regarding STI screening improvement activities to be undertaken with the following groups: • Family Planning Victoria • Peak cancer bodies • Local Hospital Networks • PHN Alliance • Diverse Community Support Services • Department of Health (State/Federal) • Youth services and Headspace
Duration	Ongoing. Anticipated activity start and completion dates related to STI screening activities (excluding the planning and procurement cycle) are: OP 2.1 October 2016- June 2017 OP 2.2 January 2017 – May 2018

	OP 2.3 December 2016 – June 2018 OP 2.4 October 2017- June 2018 OP 2.5 April 2017 – June 2018 (as per 10.4) OP 2.6 August 2016 – December 2017
Coverage	Entire PHN region, with STI activities to focus on key areas of Maroondah, Banyule, Boroondara and Monash
Expected Outcome	What is the expected outcome of this activity as it relates to the PHN objectives? Activities are expected to assist in achieving the following EMPHN Strategic Objectives: 1. 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 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 Assist in the achievement of the following indicators of the Flexible Funded activities: Local performance indicators specifically related to the STI activities and outside the process outcomes related to areas requiring commissioning, which are explicated elsewhere in the document, are: OP 2.1 Increased notification rates of STIs (HIV, Chlamydia, Syphilis, Gonorrhoea and HPV) from baseline due to increased screening by LGA and gender OP 2.2 Health Pathways developed in line with recommendations from Family Planning Victoria OP 2.3 Pilot conducted with Family Planning Victoria of the Guide for GPs once it is compiled by FPV

	OP 2.4 Scoping undertaken and co-developed recommendations for future action developed OP 2.5 Hepatitis B and C notifications increase from baseline OP 2.6 Annotated bibliography developed with Deakin University student and brief paper compiled. Evaluation findings will be reviewed and reported.

Proposed general practice support activities	
Activity Title / Reference (e.g. OP 1)	OP3: Digital Health/eHealth
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.
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: MEGPN, Gippsland and South East Melbourne PHN
Duration	Anticipated activity start and completion dates. ePIP support: July 2016-June 2018 eReferral: July 2016 – June 2017 Telehealth: July 2016-June 2018 Clinical Audit Tool support: July 2016 -
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 MyHealthRecord, 100% of pharmacies with eHealth-capable software registered for MyHealthRecord, 100% of RACFs with eHealth-capable software registered for MyHealthRecord 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 general practice support activities	
Activity Title / Reference (e.g. OP 1)	OP4: Workforce Education & Clinical Placements
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.
Collaboration	Collaboration in the development and delivery of education with a range of organisations and services includes at this time: Delmont Private, Turning Point, Eastern Health, Peter MacCallum Cancer Institute, Monash Hospital, and Royal Children's Hospital. 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 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.

After Hours Activity Work Plan

3. (a) Strategic Vision for After Hours Funding

Please outline, in no more than 500 words, an overview of the PHN's strategic vision for the 24 month period covering this Activity Work Plan that demonstrates how the PHN will achieve the After Hours key objectives of:

- increasing the efficiency and effectiveness of After Hours Primary Health Care for patients, particularly those with limited access to Health Services; and
- improving access to After Hours Primary Health Care through effective planning, coordination and support for population based After Hours Primary Health Care.

In 2016-17 and onwards, your organisation is required to:

- Implement innovative and locally-tailored solutions for after-hours services, based on community need; and
- Work to address gaps in after-hours service provision.

Our vision: Better primary healthcare for Eastern and North-Eastern Melbourne.

Our role: We facilitate primary care system improvement and redesign.

Our purpose: Better health outcomes. Better experience. Better system efficiency.

Our strategic objectives

4. Leaders commit to system improvement

   1a. Joint forecasting and planning occurs

   1b. Investment decisions are targeted for highest impact

   1c. Leadership and change capacity is enhanced

5. 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

   2c. Improvement proposals are based on best evidence

6. 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

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 are assessed through community consultation and solutions are 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 to further assessment and planning.

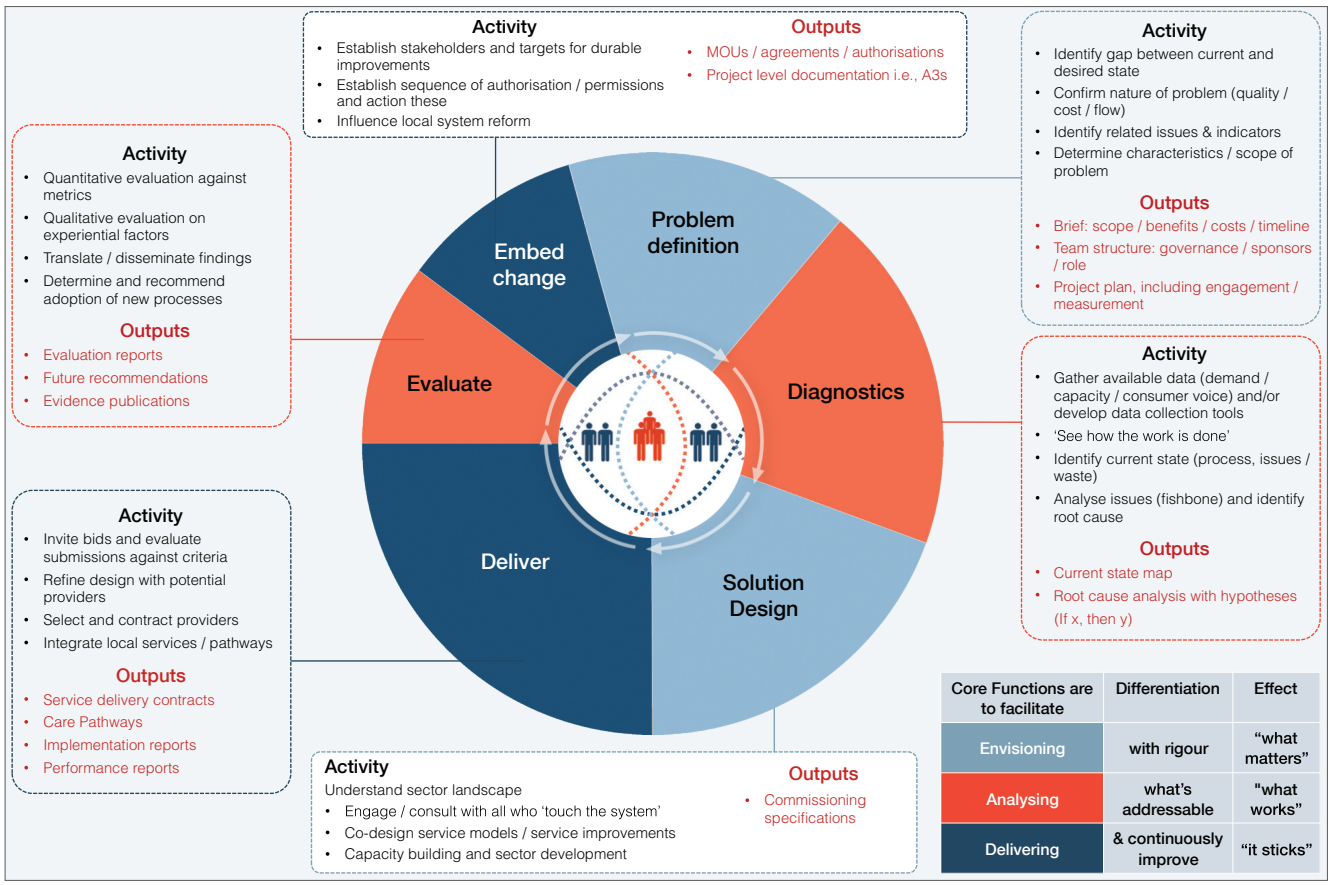


Figure 1. Commissioning style

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

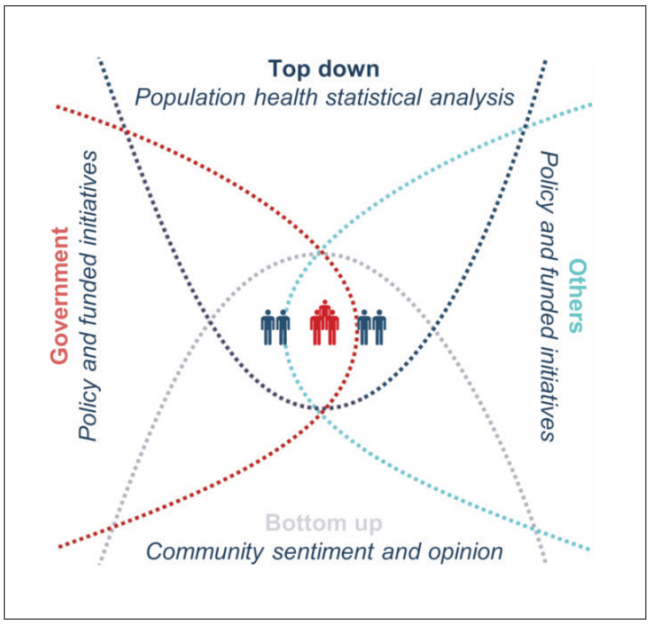


Figure 2. Prioritisation approach

Commissioning principles

12. Understand the needs of the community by engaging and consulting with consumer, carer and provider representatives, peak bodies, community organisations and other funders.

13. Engage potential service providers well in advance of commissioning new services.

14. Focus on outcomes rather than service models or types of interventions.

15. Adopt a whole of system approach to meeting health needs and delivering improved health outcomes.

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

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

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

19. 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.

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

21. Ensure efficiency and value for money.

22. 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 to key groups:

- Clinical Council
- Community Advisory Committee

Collaborative structures

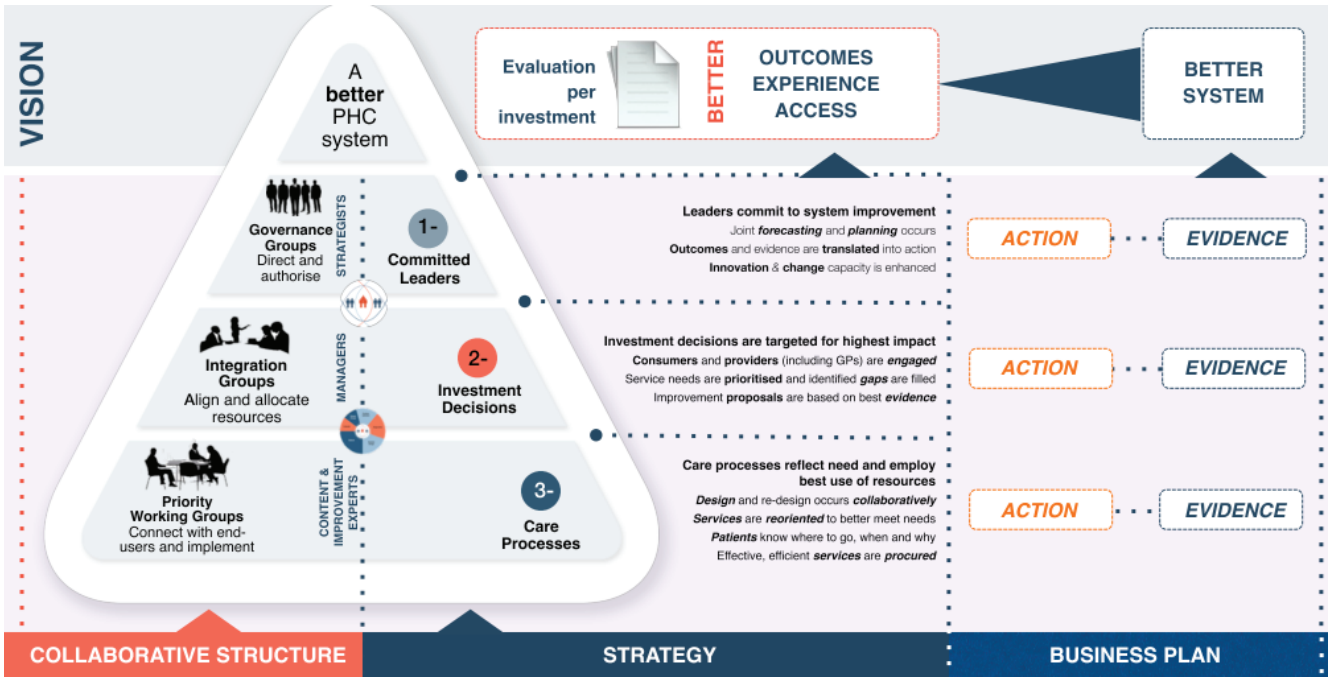


Figure 2. Collaborative Structures

The EMPHN catchment will be divided into four sub-catchments for the purposes of shared planning and governance. The sub-catchments will align with the large public health services in the catchment:

- Austin Health
- Eastern Health
- Monash Health
- Northern Health

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

4. Governance Group: Strategists who "direct and authorise"
5. Health System Integration Group: Managers who "align and allocate resources"
6. Priority Working Groups: Content experts who "connect with end users and implement"

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.

3(b) Planned activities funded by the Primary Health Network Schedule for After Hours Funding

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2016-18. These activities will be funded under the Primary Health Networks After Hours Funding.

Note 1: Please copy and complete the table as many times as necessary to report on each activity.

Note 2: Indicate within the duration section of the table if the activity relates to a two year period (2016-2018) or a one year period (2016-2017). Please note, although PHNs can plan for activities in the 2017-18 financial year, at this stage, current funding for PHNs After Hours is confirmed until 30 June 2017 only. PHNs must not commit to any part of the funding beyond 30 June 2017.

Proposed Activities			
After Hours Priority Area 1	Limited access to GPs and other primary health care services in the after-hours period		
After Hours Activity Title / Reference (e.g. AH 1.1)	**AH 1.1 Expansion and development of new service models for the delivery of Medical Services in areas not currently serviced by a MDS.**	**AH 1.2 Support the continuation of after-hours GP clinics in the outer north and outer east of the region, where there are limited or no MDS services available.**	**AH 1.3 Determine demand and availability of ancillary services such as Radiology and Pathology during the after-hours period, and commission additional after hours services where appropriate.**
Description of After Hours Activity	• Commission an expansion of Medical Deputising Service	• Support current after hours GP clinics to continue, and expand	• Comprehensive mapping the availability of After Hours Radiology and Pathology

	(MDS) beyond the current MDS delivery boundaries. • Scope a new service delivery model (to be developed) in areas where MDS do not operate	hours to meet community demand if required.	services, complete cost benefit analysis and commission additional services where required with a focus on RACFs. Explore mobile options that can attend the patient's bedside. (* see below)
Collaboration	• In suburbs bordering other PHNs such as the Dandenong Ranges a joint collaboration will be developed with South Eastern Melbourne PHN. The key partners for the service may include current MDS and/or General Practice.	Work with the identified clinics to ensure service continuity. Possible partners include: • Local GP Practices • Local Hospital Network • Community Health Service (*) A comprehensive business review was conducted in March 2016 in readiness for commissioning process	• Collaboration with ancillary services, General Practice, Hospital Networks and MDS services.
Duration	12 months	12 months	12 months
Coverage	• Outer East including LGAs of Yarra Ranges • Outer North including LGAs of Whittlesea, Murrindindi, Mitchell, Nillumbik	• Catchment wide but specifically targeting areas of identified need.	• EMPHN Catchment
Commissioning approach	• The commissioning process will involve direct engagement with MDS and General Practice	• The commissioning process will involve an approach to market method. The development and	• The commissioning process will involve an approach to market method.

	where a Request for Tender (RFT) will be developed and consequently advertised. The RFT will include regular reporting requirements.	continuation of services has been progressing and stakeholder engagement will continue to ensure an appropriate After Hours model of care is implemented at all sites.	
Performance Indicator	• MDS Service Delivery Reporting including Minimum Data set Included in the contract. Minimum Data set includes DOB, Suburb, Indigenous status, Primary GP, reason for referral and outcome of consultation • Level of engagement and participation with young families in the Yarra Ranges. • Securing an MDS to participate in the pilot project • MDS service delivery reporting, rates of service delivery and fluctuations. • Number of families participating in the pilot • Number of telehealth sessions completed. • Level of satisfaction in the service delivery from both families and MDS service.	• Reported opening hours outlining consistency and availability of the service, and if there are workforce shortages • Patient throughput indicating the need/demand for the service from the community • The number of patients reported to be diverted from the Emergency Department • The number of patients referred on to additional services such as X Ray and Specialists. • The number of low cost after hours services available, baseline and variation over a 12 month period. • Analysis of age, gender, ATSI, CALD and refugee status. • Outcomes to be determined when fully scoped	• Reduction in ED Admissions (VMED data) for conditions requiring routine Pathology and Radiology • To be determined once fully scoped. • Outcomes to be determined when fully scoped

	• Measures for new service delivery model will be progressed when the service model is further developed • Outcomes to be determined when fully scoped		
Local Performance Indicator target	• Target of 1200 consultations by MDS to the areas of the region without MDS coverage. • Access to timely out of hours medical care for 95% of EMPHN population	• Supporting a minimum of three clinics to deliver after hours services across the region • Increasing the number of patients attending the after hours clinics by 5%	• To be determined when scoped
Data source	Contract reporting Victorian Emergency Minimum Data (VEMD) MDS Minimum Data set Community awareness strategy To be determined	Contract reporting Victorian Emergency Minimum Data set Contract Reporting Evaluation framework Community engagement/awareness strategy	Contract reporting Victorian Emergency Minimum Data set

Proposed Activities			
After Hours Priority Area 2	Limited RACF access to GPs and other primary health care services in the after-hours period		
After Hours Activity Title / Reference (e.g. AH 1.1)	**AH 2.1 Continuation of the After Hours Visiting GP Service to outer east and north RACFs, and complete a scoping exercise and pilot for in hours model of care utilising MDS to provide more timely access to GP services in RACFs.**	**AH 2.2 Expansion of Hospital based Residential In Reach Program, and deliver Training to RACF Staff via the Residential In Reach programs**	**AH 2.3 RACF De -prescribing Project**
Description of After Hours Activity	• Continuation of the Medical Deputing Service – Visiting GP, to provide After Hours Care in RACFs where there is currently minimal or no MDS services available. • Complete a scoping exercise and pilot an "in hours model of care" utilising General Practice to address issues prior to the after-hours period and reduce after hours presentations to ED.	• Support the provision of RIR services in the after-hours for RACFs with access to high quality, multi-discipline care through the Residential In Reach Services operating in the region. Expand the service where an identified need. • Commission Local Hospital Networks to provide a targeted education campaign for RACFs focussing on hospital avoidance related medical conditions	• Commission Hospital Network to work with RACFs to identify and reduce polypharmacy in RACFs
Collaboration	• Collaboration between MDS, General Practice, Community Health Services, RACFs	Collaboration with some of the Hospital Networks within the EMPHN Catchment including; • Eastern Health	Collaboration with some of the Hospital Networks and the PHN within the Northern Part of the EMPHN Catchment including;

		• Northern Health • St Vincent's Hospital • Austin Health • Southern Health	• Northern Health • St Vincent's • Austin Health • North West Melbourne PHN
Duration	12 months	12 months	12 months
Coverage	Outer East including the suburbs of: • Montrose, Lilydale Healesville, Yarra Junction, Warburton Outer North Suburbs of: • Epping • Mill Park • South Morang • Thomastown • Eltham • Whittlesea • St Helena Scoping exercise and pilot will focus RACFs with high rates of ED transfer for cat 4 and 5 in the after-hours period.	EMPHN Catchment wide	LGAs including: • Whittlesea • Melbourne • Banyule • Nillumbik
Commissioning approach	• The commissioning process will involve direct engagement with MDS and General Practice where a Request for	• The commissioning process will involve direct engagement with the Hospital Networks following consultation to determine gaps in	• The commissioning process will involve direct engagement with the Hospital Networks.

	Tender (RFT) will be developed and consequently advertised. • The contract will include regular reporting requirements.	the areas of service in the after hours. • The commissioning process will involve direct engagement with the Hospital Networks. • A contract will be developed following identification of the topics and method for the targeted education program.	• The contract will include deliverables outlining number of reviews conduct, effects of intervention and evaluation
Performance Indicator	• MDS Service Delivery Reporting including Minimum Data set • Deliverables as outlined in the contract • Engagement with RACFs and MDS services to deliver the In-hours MDS pilot	• After Hours Consultations conducted by RIR, and hours of additional RIR service delivery • Review of ED Presentations and RIR attendance data from Eastern Health, Austin Health and Northern Health to harmonise collection of data and review common presentations to target in education sessions as outlined in the Contract. • Number and type of education sessions delivered by the RIR services • Evaluation of both the service delivery and education delivery by RIR	• Number of comprehensive Resident Medication Management Reviews conducted (RMMR) • Reaudit residential files that receive RMMR • Completion of educational component at RACFs • Review of ED Data pre and post intervention
Local Performance Indicator target	• MDS reporting data • Incidence rate of issues addressed in hours at RACFs To be determined	• 12 education modules developed. • 12 education sessions conducted with RACFS and MDS, and a minimum of 10 attendees per session	• Engage 10 facilities in the project • 100% of resident medication charts audited with a succinct,

		• Reduction in ED presentations through a Retrospective review and post intervention ED Dataset • Funded hours for RIR services matches demand.	evidence-based, initial screening tool • Those identified as being 'high risk' will be referred for a comprehensive RMMR • Those residents receiving the RMMR will have their medication appropriately rationalised to improve quality of life and prevent complications • Improved GP awareness of polypharmacy and subsequent prescribing behavior • RACF nursing staff awareness will be increased through targeted education sessions regarding the impacts of polypharmacy
Data source	Contract reporting Victorian Emergency Minimum Data (VEMD) MDS Minimum Data set Pilot evaluation framework Community awareness strategy MDS Data Set	Contract reporting Victorian Emergency Minimum Data (VEMD) Education evaluation framework Australian Atlas of Healthcare Variation, November 2015	Contract reporting Project evaluation framework

Proposed Activities				
After Hours Priority Area 3	Increase quality and capacity of after-hours primary health care services			
After Hours Activity Title / Reference (e.g. AH 1.1)	**AH 3.1 Quality Service provided by MDS, GPS and RACF Staff, including upskilling in Emergency Decision Making.**	**AH 3.2 Extension of Pharmacy Opening hours in the after-hours period**	**AH 3.3 Targeted Grants Program**	**AH 3.4 Improve quality of information provided on the NHSD**
Description of After Hours Activity	• Provide education and support to General Practice, locum Doctors and RACF Staff on delivering a primary care response to identified clinical issues in the After Hours period. • Assist RACFs, MDS and General Practice to Implement emergency decision making guidelines at RACFs • Promotion of Diversional and substitution programs such as Hospital Admissions Risk Program,	• Target and work with pharmacies to expand their operating hours in areas of identified need. • Provide support to pharmacies to enable the provision of after hours medications to RACFs.	• Implementation of a grants program to maximise after -hours primary carel service availability to support the community	• Implement a project to assist General Practices to update service information on the NHSD on a regular basis.

	Hospital in the Home and RIR			
Collaboration	• A collaboration with LHN, General Practice, MDS and RACFs to implement educational programs including emergency decision making training.	• Collaborate with local pharmacies in areas of need, including GPs, RACFs, and the general community.	• Collaborate with local GP Practices and Community Health Services	• Collaborate with local GP Practices
Duration	12 months	12 months	12 months	12 months
Coverage	Across EMPHN Catchment	Selected areas within the catchment	Selected areas within the catchment	Catchment wide
Commissioning approach	Direct engagement	Direct Engagement Procurement approach to be determined	Direct Engagement	Direct engagement
Performance Indicator	• TBD	• Number of additional hours open between baseline at the commencement of the project and at the end of the project • Additional services provided in the 24hr period it is open	• Grant process completed include the development of successful application criteria. • Approved grants illustrate value for money, diversity, sustainability , focus on particular population groups and demonstrate a	• Establishment and implementation of pilot project. • Upload guidelines developed • Up take of program • Audit of information on the NHSD pre

			• reduction in ED admissions. • Grants approved meet deliverables as outlined in contract	and post intervention
Local Performance Indicator target	• Implementation of an awareness strategy about diversional programs and services. Review of skill set improvement for participants. • Number of education sessions completed as per the project plan. Feedback from educational sessions.	• An increase in the number of opening hours in the After Hours period across the EMPHN catchment.	• An increase in the number of opening hours in the After Hours period across the EMPHN catchment.	• 80% of Practices are aware of the procedure for uploading information to the NHSD • Increased accuracy of information provided on the NHSD website.
Data source	Pre and post educational session VEMD 2014-15 Australian Atlas of Health Care Variation, 2015	Contract Reporting	Contract Reporting VEMD Data	NHSD Pilot Project Report

Proposed Activities	
After Hours	

Priority Area 4	Increased community awareness of after hours services and options
After Hours Activity Title / Reference (e.g. AH 1.1)	**AH 4.1 Plan and deliver a catchment-wide community education campaign and completion of a health literacy study**
Description of After Hours Activity	Plan and deliver a catchment wide community education campaign to inform the community of all available after hours services, through the following activities: • Development of resources both paper and digital based to be disseminated to relevant community and health organisations. It is anticipated that a comprehensive digital campaign will include e- billboards, television commercial CSA and app. • Collaboration with other metropolitan PHNS to deliver a metro wide media campaign • Deliver the after hours messaging in languages other than English, and with culturally engaging design and resources. Develop a model for the delivery of information on after hours care options in all Emergency Departments. Where data indicates a high number of primary care type presentations, EMPHN will work with the identified Hospital to develop the most appropriate communication tool to provide information to the community on alternative afterhours options. • Develop sub-strategy for particular catchments within the PHN for ATSI, paediatric and CALD populations, and regions that do not have access to MDS • Health Literacy study by sub population to focus on a designated cohort to assess individual's knowledge, skill and confidence for managing their own health and healthcare**. Following the study,** implement recommendations developed. • Complete a comprehensive evaluation of the communications strategy including obtaining data from sources such as health direct, google analytics and the community pre and post campaign to identify the effect on a reduction in primary care types to emergency department. A number of community consultation sessions and focus groups will be conducted to determine the impact of the community awareness campaign.
Collaboration	Incorporate consultation with relevant stakeholders including Community Groups. Potential collaboration with University to conduct trial and evaluation.

	Metropolitan wide PHN Strategy collaboration with other PHNs
Duration	12months
Coverage	Entire EMPHN Catchment
Commissioning approach	Direct Engagement Approach as well as Approach to Market for design and printing of marketing material
Performance Indicator	Develop of a region wide Communications Strategy Review of NHSD data
Local Performance Indicator target	Evaluation of Communications Strategy through the following data sources: • Proportion of Primary Care Type ED Presentations referred by Nurse on Call, GP Helpline/MDS • Portion of calls to Nurse on Call and GP Helpline in the After Hours Period from people within the EMPHN catchment • Development and distribution of Materials • Qualitative and Quantitative Survey (telephone) examining reach and comprehension of messaging. Health Literacy study recommendations. Review of NHSD data
Data source	Contract reporting ie through evaluation of information sessions ABS (2006) Health Literacy, Australia; ABS (2011) Proficiency in Spoken English (ENGP) Health Literacy Project Evaluation

Proposed Activities	
After Hours	

Priority Area 5	Culturally safe and accessible primary health care services for Aboriginal and Torres Strait Islander, and CALD and Refugee people	
After Hours Activity Title / Reference (e.g. AH 1.1)	**AH 5.1 improve access of after-hours primary care for CALD communities**	**AH 5.2 Explore the viability of transportation support services to after-hours clinics for vulnerable populations**
Description of After Hours Activity	• Work with culturally and linguistically diverse community leaders/representatives to design community initiated strategies that will improve access to after-hours primary care. • Build workforce capacity to enable more people to work with CALD communities in the after hours	• Explore the viability of transportation support services such as extending volunteer transportation services after hours or trialling reimbursements for taxi-based transportation to certain after hours clinic for vulnerable groups.
Collaboration	• Collaboration with the EMPHN, GPs, MDS and CALD services including Migrant Information Centre, Spectrum Migrant Resource Centre and Community Health Services	• Collaboration with Local Government GPs and Primary Health Care Organisations
Duration	12 months	12 months
Coverage	EMPHN Catchment	Outer East and Outer North suburbs located in the LGA of Yarra Ranges, Nillumbik and Whittlesea
Commissioning approach	• Direct Engagement with key stakeholders and GPs	• Direct engagement with relevant organisations.
Performance Indicator	• Key Strategies developed in conjunction with consultation from relevant stakeholders. • Development of relevant activities which include deliverables as outlined in contract.	• Identification of factors affecting access to after-hours services • Baseline**:** Number of potential clients who could utilise service

Local Performance Indicator target	• Implementation of projects designed to incorporate identified strategies. • Development of a set of key priorities to address identified issues • Increased available workforce and additional points for referral	• Increased number of patients attending After Hours Clinic because of increased access to Service
Data source	• Project Reporting template • ABS Socioeconomic Indices for Area • ABS (2006) Health Literacy, Australia; ABS (2011) Proficiency in Spoken English (ENGP)	• VAED via Polar

Proposed Activities		
After Hours Priority Area 6	Increased access to mental health services in the after hours period	
After Hours Activity Title / Reference (e.g. AH 1.1)	**AH 6.1 Increased access to After Hours mental health care for young people** **Work with the EMPHN mental health team to improve the service system in the After Hours**	**AH 6.2 Improve the capacity of GPs and MDS to provide mental health services in the After Hours**

Description of After Hours Activity	• Work with community health services and youth-friendly GP services to increase access to after hours services for youth • Work with the EMPHN mental health team to improve the service system response for residents experiencing mental health issues after hours. • Determine best strategies for integrated co-located After Hours Mental health services	• Scoping project to determine current services available after hours. • Explore viability and if appropriate, trial a mental health advice line for use after hours for General Practice and MDS . • Improve capacity for MDS to provide quality After Hours Mental health care by providing Mental Health training
Collaboration	Collaboration with GPs and key mental health agencies Collaboration internally and with external stakeholders	Collaboration with Mental Health Organisations such as Headspace, MIND, Community Mental Health Services and Beyond Blue
Duration	12 months	12 months trial
Coverage	Across the EMPHN Catchment	Across the EMPHN catchment
Commissioning approach	• Direct engagement with key stakeholders and community groups	• Approach to Market to implement telephone response system. Evaluation completed by the EMPHN.

Performance Indicator	• Establishment of a working party to address access to mental health services in the After Hours, in particularly integrated co-located After Hours Mental health services. Resulting in a geographic shift of services into areas that experience the greatest barrier to access	• Trial health professional mental health phone line, established, operating and evaluated • Contract Deliverables met
Local Performance Indicator target	• Development of a number of recommendations to improve access to mental health for young people in the After Hours • Geospatial mapping of services with areas of need overlay	• Dataset detailing target group, gender, age utilising the system, GP/MDS Usage data • Evaluation of training provided • GPs and MDS report more appropriate access and reduced wait times for services
Data source	• Eastern Metropolitan Region Mental, Drug and Alcohol and Drugs Catchment Planning Report	• Psychological distress indicator data (PHIDU)

FOR MORE INFORMATION

18-20 Prospect Street
(PO Box 610) Box Hill, Vic 3128

Phone 9046 0300
www.emphn.org.au