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EASTERN MELBOURNE
An Australian Government Initiative

EMPHN Strategic Plan 2025-2028

Acknowledgements

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

Eastern Melbourne PHN acknowledges the Wurundjeri People and other peoples of the Kulin Nation on whose unceded lands our work in the community takes place. We pay our respect to Aboriginal and Torres Strait Islander cultures; and to Elders past and present.

EMPHN is committed to the healing of Country, working towards equity in health outcomes, and the ongoing journey of reconciliation.

We recognise and value the knowledge and wisdom of people with lived experience, their supporters and the practitioners who work with them; and celebrate their strength and resilience in facing the challenges associated with recovery.

We acknowledge the important contribution they make to the development and delivery of health and community services in eastern and north-eastern Melbourne.

A message from our Chair and CEO

Eastern Melbourne Primary Health Network's (EMPHN) Strategic Plan 2025-28 sets out our strategic intent, priorities and the outcomes we aim to achieve over the coming years.

It is an ambitious plan that reflects our appetite to do more, to better improve the health system for the people and communities in eastern and north-eastern Melbourne. We recognise the challenges and opportunities that exist in the health system today and that are anticipated in the future have identified priorities and outcomes on which we believe we can have a positive impact.

We know that not everyone in our region experiences the same level of access to healthcare services, or the same health outcomes. We will target investment to where and who needs it most, and design and deliver safe and appropriate services that enhance equity of access and outcomes for our communities.

We also recognise the challenges faced by service providers and clinicians operating within a fragmented health system that continues to experience significant change. We believe that we play a critical role in the system as a connector and capability builder, and we will continue to drive partnerships and integration. We will also work closely to support general practices and other primary care providers to respond to the complex and shifting policy environment. The communities we serve are also at the centre of everything we do, and we will enhance the way we collaborate and engage with them to enable an integrated health system that is responsive to their needs and aspirations.

There is also a significant opportunity to better leverage the use of data to develop actionable insights that can inform practice.

This includes driving improvements in quality and outcomes through research and evaluation, as well as contributing to evidence and sharing learnings and insights.

Better use of data also enables us to increase the impact and reach of our services through a focus on value for money. In all of this, we recognise that data safety and sovereignty are paramount.

In responding to these challenges and leveraging these opportunities, our strategy is centred on three core priorities that will be the focus of our efforts over the next three years;

1. **Drive equitable access and outcomes for communities**
2. **Connect our partners and communities to enable integration and change**
3. **Leverage insights to improve outcomes, drive value and demonstrate impact**

We know the level of change required is significant and complex, and we are committed to genuinely collaborate with our partners and communities to collectively enhance the health system and drive better and more equitable outcomes for people in eastern and north-eastern Melbourne.

Dr Stephen Duckett AM
Board Chair

Janine Wilson
CEO

About Eastern Melbourne PHN

Primary Health Networks (PHNs) are a vital part of the health ecosystem.

Established by the Commonwealth government in 2016 to improve the efficiency and effectiveness of healthcare, you can think of PHNs as the 'gap filler' of the system. It is our job to identify health needs that aren't properly addressed by other parts of the healthcare system and standup services or activities that seek to deliver the right care to the right people. We focus on people with poor health who have trouble accessing appropriate services.

We do this through our roles as a coordinator, commissioner and capability builder.

What we do

Coordination

The healthcare system is often unnecessarily complex. Even with high health literacy, consumers can be daunted by the patchwork of services and information. At EMPHN, we work closely with local health system stakeholders to understand needs, understand what services are already out there, then work to coordinate and integrate these services. The aim of this is to: improve the quality of care, improve our community's experience in the health system, and to efficiently use resources. Coordination and integration work includes collaborating with primary, secondary, tertiary, aged and disability care, social services, and emergency services.

Commissioning

We use data to identify health needs, we then collaborate with our system partners, consumers and clinicians, to co-design and commission evidence-based services that seek to address these health gaps. Increasingly we are 'co-commissioning' – working with system partners to develop new and integrated services that address these needs and gaps together. In this work we contribute to the evidence about what works to improve health experiences and outcomes.

Capability building

Healthcare moves fast. There is a fast rate of change, with new policies, guidelines and ways of working that clinicians and other healthcare staff have to stay abreast of. We support general practices and other health service providers in our region to stay up to date with these new advancements. This helps improve quality, continuity and integration of care. This includes activities like supporting professional development, sharing data and helping practices to be culturally capable and future ready, particularly through the adoption of digital health systems. We bring people together from across a sometimes fragmented sector to find solutions to wicked problems and to find out what we can learn from other places who've faced the same challenges.

A snapshot of the community

Younger people (under 25)
31%
Source: PHIDU, 2023

Older adults (65+)
18%
Source: PHIDU, 2023

First Nations
0.6%
Source: PHIDU, 2023

LGBTQIA+
5.7%
Source: Victorian Population Health Survey, 2017

Language spoken at home

CHINESE*	INDO ARYAN*	GREEK
11%	5%	2.5%

Source: ABS, 2021

Born in non-English speaking country
28%
Source: PHIDU, 2023

Low English proficiency
5%
Source: ABS, 2021

Whittlesea LGA is projected to grow at over twice the rate of the rest of the catchment
Source: PHIDU, 2023

Unemployment rate
3%
Source: Jobs and Skills Australia, 2023

Low individual income (<$41.6K)
46%
Source: ABS, 2021

Low household income (<$65K)
30%
Source: ABS, 2021

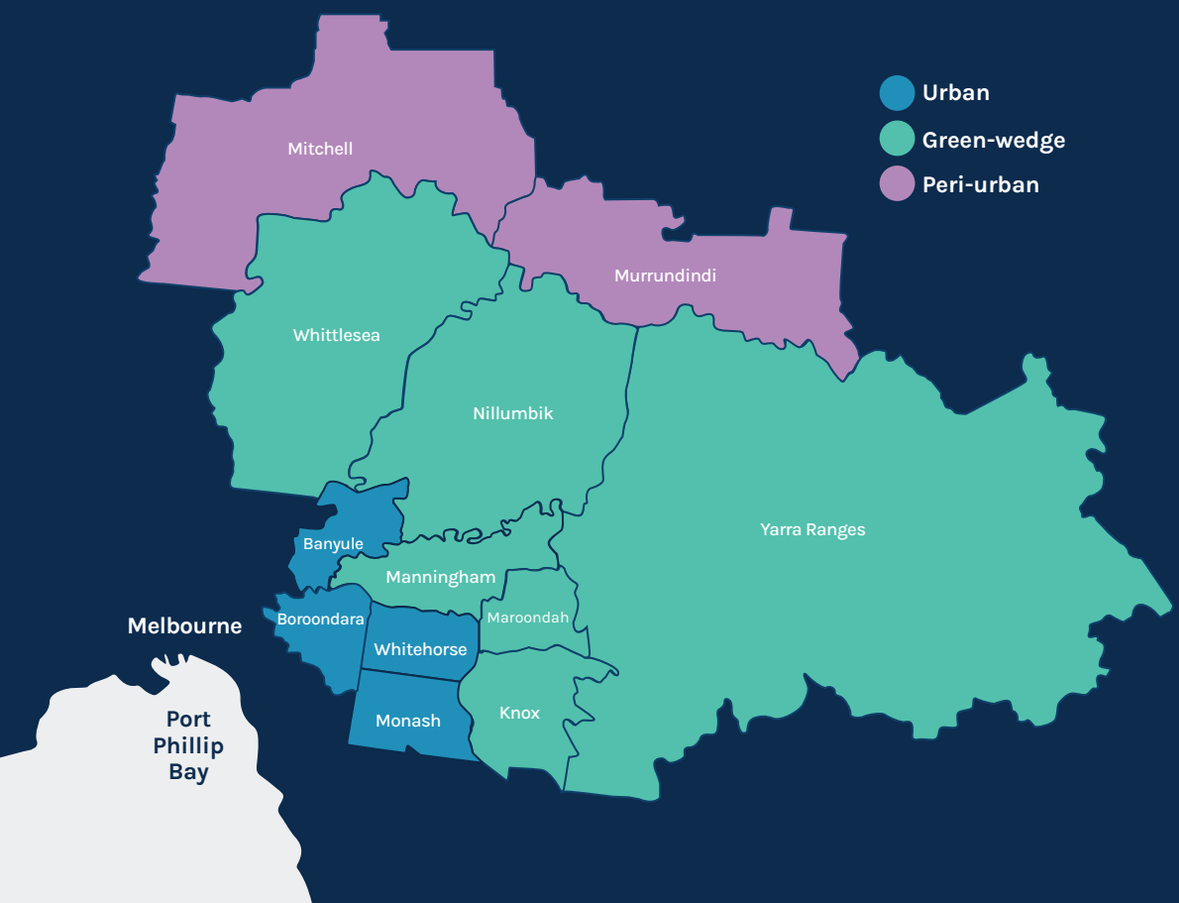
Experiencing homelessness
0.4%
Source: ABS, 2021

The LGAs of **Whittlesea**, **Murrindindi** and **Mitchell** experience the greatest burden of disadvantage
Source: ABS, 2021; PHIDU, 2023

* Chinese is combined of Mandarin, Cantonese, Other.
* Indo Aryan is combined languages: Indo-Aryan languages include: Bengali, Gujarat, Hindi, Nepali, Punjabi, Sinhalese, Urdu, Other.

Where we work

We work across all or part of the 12 local government areas (LGAs) below.



These LGAs are entirely within EMPHN's catchment:

- City of Banyule
- City of Knox
- City of Monash
- Shire of Nillumbik
- City of Whittlesea
- City of Boroondara
- City of Manningham
- City of Maroondah
- City of Whitehorse

EMPHN's catchment also covers part of:

- Shire of Mitchell (35% of population)
- Shire of Murrindindi (27% of population)
- Shire of Yarra Ranges (portion which falls outside the EMPHN catchment is largely uninhabited national park)

Our strategy

Our Strategic Plan for 2025 to 2028 articulates our three strategic priorities.

A set of outcomes have been defined for each priority to articulate where the organisation wants to be by 2028. These outcomes are ambitious and aim to stretch us to work towards our objectives. A range of supporting initiatives and indicators to track our performance for each priority area have been detailed in the following pages.

	1.	2.	3.
Strategic priorities	**Drive equitable access and outcomes for communities**	**Connect our partners and communities to enable integration and change**	**Leverage insights to improve outcomes, drive value and demonstrate impact**
Strategic outcomes	Commissioned services in our region deliver improved outcomes for hardly reached populations	The service system is better connected and integrated around consumers and practitioners	The impact and quality of services has improved through monitoring, evaluation and learning
	All of our commissioned programs are appropriate and safe	Our commissioned programs are integrated with primary care and local hospital networks	Our commissioned programs are achieving greater value for money
	Affordable services are available in areas where they are needed most	General practices in our region are enabled to deliver team-based chronic and complex care across settings	We share learnings, research and evidence that drive improved models of care and better consumer outcomes
	First Nations people and communities in our region have access to appropriate services and choice about where and how to access services	Our commissioned programs are informed by active consumer and community participation	

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

Values Integrity | Working Together | Courage

1. Drive equitable access and outcomes for communities

We know that not everyone experiences the same level of access to healthcare services, or the same health outcomes. Access and outcomes are influenced by a wide range of factors, including an individual's socioeconomic status, race, ethnicity, religion, age, ability, gender or sexual orientation. Access is also impacted by the availability, affordability, appropriateness, and safety of services.

We want our investment in healthcare to land where it is needed most, and where it is likely to have the greatest impact. This is complex and relies on a comprehensive and evidence-based understanding of needs, good data to inform our understanding, and effective engagement and co-design with the communities across our region. Initially, we will look to target investment to address socioeconomic disadvantage.

An important component of driving equitable outcomes is safe and appropriate care for First Nations people and communities. First Nations people experience inequitable health outcomes. In line with the commitments to reform made in the Closing the Gap and the National Aboriginal and Torres Strait Islander Health Plan, we are committed to supporting the development of the Aboriginal Community Controlled Health sector and enabling the move towards self-determination.

Target outcomes

- Commissioned services in our region deliver improved outcomes for hardly reached populations.
- All of our commissioned programs are appropriate and safe.
- Affordable services are available in areas where they are needed most.
- First Nations people and communities in our region have access to appropriate services and choice about where and how to access services.

Initiatives

1.1 We will strengthen our focus on equity in data collection, engagement, monitoring and evaluation to enhance our understanding of needs and monitor the impact of our activities.

1.2 Across all programs and services, we will target our investment to enhance access and quality of care for hardly reached populations, with an initial focus on communities with lower socioeconomic status.

1.3 We will drive the design and delivery of safe, appropriate and accessible care across our region, including supporting innovative approaches and models of care.

1.4 We will work closely with the Aboriginal health sector to support and enable the move towards First Nations self-determination.

1.5 We will build relationships and collaborate with partners across the health and broader services sectors to collectively enhance equity for communities.

Indicators of success

- Increased utilisation of our services by hardly reached groups
- Improved health outcomes for hardly reached groups
- Increased cultural capability of services

Mitch – Improving access by targeting services where they are needed

Mitch is a 41-year-old living in Murrindindi and experiencing poor mental health. He is currently between jobs, causing financial stress, but also means that he can't afford to see a psychologist to help him manage his mental health. He does see a regular GP who spoke to someone at SupportConnect who helped him find a PHN-funded service in his area. Through the program, Mitch is able to see a psychologist for free, and was also linked to an employment service to help him find a job.

James – Enabling First Nations self-determination

James is a Yorta Yorta man who has lived on Wurundjeri land all his life. He is 45 years old and is living with diabetes. He visited his Aboriginal Community Controlled Health Organisation (ACCHO) to access a PHN-funded health and wellbeing program specifically for First Nations peoples. The ACCHO has been able to self-determine their programs with their community in mind.

2. Connect our partners and communities to enable integration and change

The delivery of integrated care relies on connections and partnerships across the health and broader services system. We believe that we have a critical role to play in enabling these connections and building effective working relationships between our partners. This includes driving integrated models of care, as well as exploring and trialling innovative approaches that improve the experience and outcomes for consumers. In doing so, we recognise the critical role that general practices play at the centre of care for consumers, and the importance of designing models that effectively connect and integrate the service system around consumers.

We believe our role as a connector in the system will become increasingly important over coming years. We will play a key role in enabling the transformation of primary care, including by translating policy into practice with the voice of general practice at the centre. More broadly, we recognise that the success of our work and our commissioning activity relies on strong and impactful relationships, including with our system partners and our provider market. This means that we will maintain a strong focus on relationships, particularly in our approach to commissioning, that enables us to support the development and sustainability of the local service system.

Our role connecting the system in our region also includes connecting with consumers and communities, as well as other stakeholders. In coming years, we will continue to enhance our approaches to co-design and consultation, so that we are able to engage with and hear from communities and stakeholders in ways that are meaningful, appropriate, safe and impactful.

Target outcomes

- The service system is better connected and integrated around consumers and practitioners.
- Our commissioned programs are integrated with primary care and local hospital networks.
- General practices in our region are enabled to deliver team-based chronic and complex care across settings.
- Our commissioned programs are informed by active consumer and community participation.

Initiatives

2.1 We will drive localised models of integrated care and funding that are consumer-centred.
2.2 We will work closely with general practices and other service providers to respond and share information to support change.
2.3 We will take a relationship-based approach to commissioning, working collaboratively with partners and providers to enable the development of the service system in our region.
2.4 We will enhance our approaches to co-design and engagement to develop meaningful and innovative programs.
2.5 We will enable coordination and planning across the sector including through increased information sharing.

Indicators of success

- Increased accessibility and ease of navigation for consumers
- Improved engagement between EMPHN and stakeholders

Rima – Enabling practices to support patients with complex conditions

Rima is 59 years old and living in Knox with heart failure. Her GP recently advised her that she was eligible for a PHN-funded program which provides additional support to manage her condition. She has an individualised care plan which was developed in collaboration with her GP and a care coordinator based at the practice. Rima receives support from her practice team to achieve her goals, including through education to improve her knowledge about her condition and the services available to her. They also support her to access community allied health services and community social groups.

Aisha – Enabling the coordination of care between hospitals and primary care

Aisha is a GP in Banyule with a patient who recently saw a respiratory physician at an outpatient clinic due to their Chronic Obstructive Pulmonary Disorder (COPD). Upon discharge from the clinic, the hospital provided a discharge summary in a format that had been co-designed with GPs and hospital staff in a recent PHN-hospital integration project. Aisha was pleased to receive timely, accurate and relevant information from the discharge summary. This enabled her to easily take the information provided and construct a meaningful chronic disease management plan. Happy consumer, happy GP.

3. Leverage insights to improve outcomes, drive value and demonstrate impact

In order to drive enhanced outcomes and quality of care, we need a data driven understanding of what works. As such, we need to increase our ability to utilise quantitative and qualitative research and data to develop insights that can inform our approaches. This means developing our own capability, as well as leveraging external expertise and exploring opportunities for efficiencies through collaboration with the broader PHN network.

But data is only useful if it is used. This means capturing or accessing the right kinds of data that can produce insights, and to feed back to clinicians and providers so they can create meaning too. We want to work as part of a learning health system. Improving together. And together contributing to the evidence of what works.

More effective use of data and insights also supports us to better understand the value we are getting for the programs and services we commission, as well as better understanding the value and impact of our work overall.

Central to all of this will be a strong focus on maintaining the safety and security of data, with recognition of cybersecurity risks and the need to protect sensitive information. This may mean limiting the data we hold, and exploring options to ensure all data is securely held.

Target outcomes

- The impact and quality of services has improved through monitoring, evaluation and learning.
- Our commissioned programs are achieving greater value for money.
- We share learnings, research and evidence that drive improved models of care and better consumer outcomes.

Initiatives

3.1 We will enhance our approach to capturing and accessing quantitative and qualitative data.

3.2 We will be leaders in producing actionable insights that drive improvements in outcomes and quality.

3.3 We will cultivate a learning health system with our partners by sharing insights, research and evaluations.

3.4 We will increase impact through enhanced value for money.

3.5 We will ensure the responsible use of data by managing cyber security and data safety and sovereignty.

Indicators of success

- Increased information and data sharing with general practices and other providers
- Greater impact though improved value for money for commissioned services

Michael – Leveraging data for insights to inform practice

Michael is a GP practice owner who has been working with the PHN on a program that utilises practice data and a decision support algorithm to identify eligible mental health patients for linkage with a care navigator who is co-located with the practice. Through participating in the PHN program, Michael has received extra support in managing patients with complex mental health needs as well as met a significant portion of his annual CPD requirements. The PHN also provides Michael with de-identified benchmark reports to understand his practice's performance compared to others in the region. This has helped Michael to improve the way he works with patients and supports his staff to improve business processes.

Kitty – Sharing information that assists in system planning

Kitty works at a local hospital in Maroondah and has noticed that there are lot more patients presenting for mental health support at their Emergency Department after a suicidal crisis. In her role, Kitty has been involved in joint planning with the PHN, which has helped her realise there is a service gap in their area compared to other hospitals in the region. Kitty and her team worked with the PHN to develop an integrated model of care for aftercare services which supports consumers to access appropriate services and supports in the community and reduce the demand on the Emergency Department.

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