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EASTERN MELBOURNE
An Australian Government Initiative

E096 REOI Unified Program Part D Attachment 1 Unified Program Essentials

Eastern Melbourne Healthcare Network Limited trading as Eastern Melbourne PHN

Acknowledgement

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.

Recognition of lived experience

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 that they make to the development and delivery of health and community services in our catchment.

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Purpose of Part D Attachment 1: Unified Program Essentials

The purpose of this attachment is to provide an outline of the new commissioning approach developed by Eastern Melbourne Primary Health Network, currently known as the 'Unified Program'. Note that the Unified Program concept was designed specifically to drive flexibility and innovation for providers, and a more integrated experience for consumers.

As such, you will see that the Unified Program does not prescribe a specific model or models of care. We want to recognise providers' expertise in this area and enable the ability to build the Unified Program on to existing evidence-based care that you may already be delivering.

About Eastern Melbourne Primary Health Network

Eastern Melbourne Primary Health Network (EMPHN) is one of the 31 Primary Health Networks (PHNs) in Australia. PHNs are funded by the Australian Government to:

- improve the efficiency and effectiveness of health services for people, particularly those at risk of poor health outcomes, and to
- improve the coordination of health services and increase access and quality support for people.

We do this by commissioning services that address identified health gaps, supporting the mental health and physical wellbeing of our communities.

The EMPHN catchment

Our catchment in Melbourne's east and north-east spans nearly 4,000 square kilometers and includes a mix of urban, suburban, and semi-rural communities. Approximately 1.6 million people live in the catchment, which is about 25% of Victoria's population.

We serve a diverse community that represents both the lowest and highest socio-economic groups in the state. One in three people who live in the catchment speak a language other than English at home, reflecting the cultural diversity in our region. The Whittlesea corridor, one of Australia's largest growing areas, is projected to see significant population growth over the next five years, particularly among young families. As the catchment grows and ages, demand for aged care services is also rising. EMPHN has more aged care homes within its catchment than any other PHN in the country.

EMPHN's broader transformation

EMPHN's Strategic Plan (2025–2028) sets out a clear direction: driving equitable access and outcomes, connecting partners and communities to enable integration and change, and using insights to improve outcomes, demonstrate impact and deliver value.

We have ambitious goals for this period, such as improving outcomes for hardly reached populations, ensuring commissioned programs are safe and appropriate, strengthening service integration around consumers and practitioners, embedding team-based care, and using monitoring, evaluation and learning to improve service quality, value and impact.

To achieve this, we are:

- Using commissioning as a lever to drive system change, aligning funding and service design with outcomes that matter to our communities.
- Leveraging our relationships with general practice to embed integrated, person-centered models of care.

- Partnering with hospitals to co-design pathways that reduce fragmentation and shift the system towards more integrated, joined-up care.

All of this is underpinned by a strong data-driven approach and stakeholder engagement, using both to generate insights that inform commissioning decisions, strengthen accountability, and track progress across primary and acute care.

The vision for a Unified Program

Most of us who work in the health system recognise that it's fragmented. We work hard each day to improve the health and wellbeing of who we serve. At EMPHN, we can see an opportunity to better meet local needs and reduce this fragmentation, by exploring a structural shift in how we commission services. This shift will mean many small, standalone programs will be replaced with a single, place-based framework.

By commissioning services through defined regions with fewer, longer-term contracts, we aim to support better outcomes and experiences for consumers and providers. We hope that a place-based framework will simplify access, strengthen collaboration, reduce duplication and create better value for money for our funders, primarily the Australian Government. For the purposes of this Request for Expression of Interest (REOI), we are calling this new approach 'Unified Program' (this will be replaced by a program name that is in development). We believe in this innovative approach and are excited to work with the right partners who can share and deliver on the vision with us. This is a journey that we want to go on *together*.

This document sets out a proposed model for Unified Program. The specifics of the information in this document are indicative and intended to support provider engagement in the REOI process. Final design elements, including the finer detail around funding mechanisms and performance measures, will continue to be refined and confirmed at the Request for Tender (RFT) stage, in partnership with providers and stakeholders.

EMPHN is also working with the Department of Health, Ageing and Disability (DHDA) to finalise future year Deeds and specifications to have greater clarity during the RFT process.

What is Unified Program?

Aligned to our strategic direction, we are implementing a structural shift in how we commission services. We want to build on the strengths of providers and communities across our catchment, and address some of the challenges in the way we currently commission individual programs.

The way we work now

At present, EMPHN commissions 43 programs through 98 contracts with around 30 providers. These programs are tied to separate funding Deeds from the DHDA, each with its own objectives and reporting requirements. While this ensures accountability, it also creates challenges including:

- Fragmented services and confusing pathways for consumers and clinicians.
- Limited flexibility to respond quickly to local needs.
- Small, short-term contracts that limit sustainability and collaboration.
- Limited scope for providers to innovate and design integrated service models that cut across individual programs.
- High administrative burden for both providers and EMPHN.

While our current approach to commissioning has enabled the delivery of effective programs, it has become increasingly constrained in its ability to support integrated, responsive, and sustainable system-level outcomes. A more flexible and coordinated approach is needed to meet the evolving and diverse needs of the catchment. The importance of this approach will only grow as the population ages and increases in complexity (mentally, physically and socially).

Stakeholder engagement to inform Unified Program

Since early 2025, we have worked closely with consumers and community members, service providers, general practices and advisory councils to design a new approach to commissioning in our catchment. Engagement has been broad and deep: 72 consumers took part in workshops and 55 completed surveys; and 99 provider representatives participated in workshops.

We also sought insights from our Consumer and Community Council, Clinical and Practice Council, and members of the Aboriginal Consultative Council.

Through this process, we tested ideas and shaped key design decisions with our stakeholders, and this has directly influenced this new way of commissioning a unified program.

Where we are heading

Moving away from commissioning fragmented, standalone programs, EMPHN is seeking to implement a unified, place-based program that brings together multiple funding streams to deliver integrated services for our communities. The program will be commissioned in defined regions that seek to drive planning, coordination and integrated service delivery at a local level.

Through this approach, we aim to:

- Enable better outcomes – shifting from program-specific funding and reporting to a model that drives demonstrable improvements in community health.
- Make care easier to navigate – commissioning through place-based regions so consumers experience clearer pathways and smoother handovers (however consumers will have access across boundaries and throughout the catchment).
- Work as one system – embedding collaboration across providers, general practice, hospitals and community services to build joined-up care pathways.
- Strengthen partnerships - supporting deeper collaboration across the system.
- Advance equity – directing investment and culturally safe approaches to priority populations and hardly-reached communities.
- Support innovation and sustainability – giving providers flexibility to design locally meaningful delivery models that reflect community needs and strengths.
- Measure and understand impact – streamlining data and reporting requirements to capture, learn from, and share meaningful insights about our services and communities.
- Reduce complexity – streamlining administration so more time and resources go directly to care.

How services will be delivered under Unified Program

Regions

To strengthen equity and integration, EMPHN has grouped Local Government Areas (LGAs) into three distinct regions. Broadly, these regions seek to align with other system networks and areas, reflect existing service and referral patterns and local communities, while striking a relative balance of population and needs between each region.

By balancing population distribution and aligning services geographically, we aim to design place-based models that respond to local needs, reduce inequities, and maintain system-wide consistency.

Importantly, regions are not eligibility boundaries — consumers can access care wherever it makes sense for them and their preferences. Instead, the defined regions provide a pragmatic framework for collaboration, funding allocation and planning.

The regions are:

1. **North:** Banyule, Mitchell, Murrindindi (a), Nillumbik, Whittlesea,
2. **East:** Maroondah, Manningham, Murrindindi (b), Whitehorse and Yarra Ranges, and
3. **Inner South:** Boroondara, Knox and Monash.

Figure 1 depicts the geographical coverage of these regions.

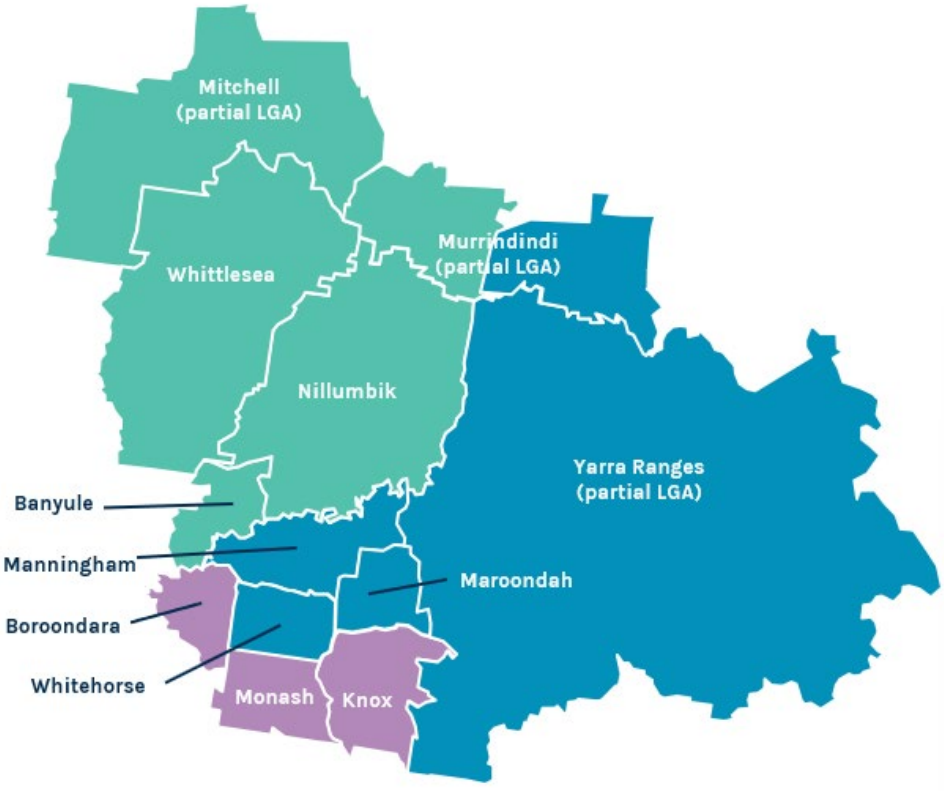

Figure 1: Map of Regions for the Unified Program

Region profiles and health needs

Understanding the health needs of our population is central to the design of Unified Program. Across the EMPHN catchment, population size and distribution, burden of disease, and service availability vary significantly between regions. These differences shape the way services must be planned and delivered to build equity and effectiveness.

Each region will be expected to draw on both EMPHN-level data and local intelligence to shape models of care, inform commissioning decisions, and guide collaboration across providers and territories. Note that EMPHN will continue to develop data assets over the coming years that will link various data and enable an increasingly accurate view of health provision and outcomes. This will be shared with providers to enable planning and quality improvement.

The following tables provide a snapshot of the EMPHN catchment, offering insights into population growth, diversity, and health system demand:

- **Table 1** – Projected population of EMPHN's catchment
- **Table 2** – Socioeconomic and cultural diversity characteristics
- **Table 3** – Number of emergency department presentations
- **Table 4** – Prevalence of hospitalisation

This regional profile information forms a foundation for planning and highlights the importance of flexible, place-based approaches that can adapt to local population health needs.

Table 1. Projected population of EMPHN's catchment
(Source: 2021 Census: Estimated Resident Population (ERP))

Region	LGAs	Total population (2021 ERP)	Population projections (2030)	Persons, 0-14 years (2023 ERP)	Persons, 15-24 years (2023 ERP)	Persons, 25-44 years (2023 ERP)	Persons, 45-64 years (2023 ERP)	Persons, 65 years and over (2023 ERP)
East	**Murrindindi (b)**	568	655					
	Manningham	125,821	140,440	20,970	15,851	31,607	32,892	28,194
	Maroondah	116,075	119,322	21,146	13,557	33,115	28,932	20,684
	Yarra Ranges	157,421	164,830	29,720	18,868	40,284	41,169	28,653
	Whitehorse	171,077	193,233	27,265	26,536	51,570	41,570	31,698
	Total East	***570,962***	***618,480***	***99,101***	***74,812***	***156,576***	***144,563***	***109,229***
North	**Nillumbik**	63,450	62,423	11,538	8,838	12,901	18,826	11,161
	Murrindindi (a)	3,634	4,024	622	414	809	1,317	1,159
	Mitchell	19,708	33,058	4,553	2,555	6,006	5,023	3,161
	Banyule	127,370	134,543	22,780	14,932	36,186	31,601	24,103
	Whittlesea	231,831	289,140	51,258	30,399	79,372	52,927	31,073
	Total North	***445,993***	***523,188***	***90,751***	***57,138***	***135,274***	***109,694***	***70,657***
Inner South	**Knox**	160,481	163,676	27,197	19,853	43,494	41,830	29,392
	Monash	184,928	219,020	29,123	32,197	58,548	42,147	33,140
	Boroondara	169,789	179,186	26,400	27,777	44,766	44,219	31,375
	Total Inner South	***515,198***	***561,882***	***82,720***	***79,827***	***146,808***	***128,196***	***93,907***

Nb. Age breakdown for Murrindindi (b) currently not available

Table 2. EMPHN Socioeconomic and Cultural diversity characteristics of EMPHN's catchment
(Source: PHIDU 2023, ABS Census 2021)

Region	LGAs	2021 Index of Relative Socio-economic Disadvantage (IRSD)*	% of LGA that speak a language other than English at home %	% of people born in a predominately NES country**
East	Yarra Ranges	1,041	8%	5%
	Murrindindi (b)	1,005	4%	9%
	Whitehorse	1,043	41%	9%
	Manningham	1,056	46%	37%
	Maroondah	1,041	20%	27%
North	Mitchell	1,000	11%	39%
	Banyule	1,058	22%	19%
	Murrindindi (a)	1,005	4%	9%
	Whittlesea	990	45%	10%
	Nillumbik	1,093	10%	35%
Inner South	Knox	1,042	29%	46%
	Monash	1,042	52%	19%
	Boroondara	1,090	29%	26%

**IRSD is a socio-economic index reflecting the overall economic and social conditions of an area. Lower scores indicate higher disadvantage. **NES = Non-English-Speaking*

Table 3. Number of emergency department presentations
(Source: Victorian Emergency Minimum Dataset, DH, FY2020/21-FY2022/23 1)

Region	LGAs	N of all ED presentations	N of avoidable ED presentations (% change from FY2021/22)	% of ED presentations
East	Yarra Ranges	41,769	9,596 (-11.1%)	23%
	Murrindindi (b)	34,546	8,023 (11.8%)	23%
	Whitehorse	25,723	5,875 (-0.3%)	23%
	Manningham	26,175	5,854 (-7.1%)	22%
	Maroondah	473	100 (-34.2%)	21%
North	Mitchell	473	100 (-34.2%)	21%
	Banyule	6,932	1,487 (4.6%)	21%
	Murrindindi (a)	34,286	7,815 (-16%)	23%
	Whittlesea	78,191	17,850 (-4.8%)	23%
	Nillumbik	12,538	2,866 (-14.9%)	23%
Inner South	Knox	43,070	9,639 (-11.2%)	22%
	Monash	34,793	7,053 (9.8%)	20%
	Boroondara	25,774	6,596 (-2.9%)	26%
EMPHN		364,270	82,754 (-5.1%)	23%
Victoria		1,858,990	464,212 (-3.5%)	25%

Nb. Data for Murrindindi has not been proportionally attributed to the population split.

Table 4. Prevalence of hospitalisation by LGA FY21 to FY23
(Source: Victorian Admitted Episodes Dataset 2020/21-2022/23; PHIDU, 2023)

Region	LGA	2022/23		
		Number	% change from 2021-22	Rate per 1,000 population
East	Yarra Ranges	42,201	5.7	268
	Murrindindi (b)	34,046	2.6	197
	Whitehorse	26,811	12.3	212
	Manningham	24,830	-1.2	215
	Maroondah	529	2.7	123
North	Mitchell	529	2.7	123
	Banyule	8,042	16.5	393
	Murrindindi (a)	33,801	7	265
	Whittlesea	87,536	11.6	369
	Nillumbik	12,352	19.9	196
Inner South	Knox	43,768	4.4	274
	Monash	40,079	3.3	215
	Boroondara	25,033	4.4	148
EMPHN		379,028	6.9	245
Victoria		1,967,677	6.5	297

Cohorts

A key objective of Unified Program is to streamline reporting requirements while sharpening the focus on outcomes and value for money. Instead of funding multiple stand-alone programs, providers in each region will be commissioned to deliver services across the four cohorts. Providers will be expected to use available funding to meet the service requirements, activities, and outcomes for each cohort. This means providers will have greater flexibility to utilise funding to meet the defined objectives and targets for all cohorts in the most appropriate way. The scope of the cohorts is outlined in Table 5 below.

The definition of these four cohorts is intended to align and clearly define service and reporting requirements. Cohorts are not intended to restrict providers from innovation or fragment services for consumers who may be part of more than one cohort. Service models may be designed that 'cut across' and meet the needs of multiple cohorts if this is viewed as a more efficient way to deliver on the prescribed KPIs and outcomes.

As noted, EMPHN currently funds a range of programs, one or more of which your organisation may already deliver. If you would like to incorporate elements of existing programs into a model, you may do so. Should you want to move away from a current model of care as you see opportunities for innovation or believe this will more effectively deliver the prescribed outcomes, this is also permitted. The key is to deliver evidence-based care to the requirements, activity and outcomes of each cohort, as described.

Note: Age ranges are provided as general descriptors of similarities and needs within each age group. They do not represent eligibility criteria.

Table 5: Brief cohort description

Cohorts	Scope
Child and Youth Wellbeing and Resilience	Services supporting children and young people experiencing mental health, Alcohol and Other Drug (AOD) use or psychosocial challenges. Ages: 4-25.
Adult Wellbeing and Resilience	Services supporting adults with mental health, AOD or psychosocial challenges. Ages: 18+.
Older People	Services supporting older people at home or in aged care Ages: 65+ (non-Indigenous), 50+ (Aboriginal and Torres Strait Islander), 50+/45+ (low-income, homeless or at risk of).
Chronic and Complex	Services supporting people with chronic conditions and complex health needs Ages: 18+.

Note: Age ranges are provided as general descriptors of similarities and needs within each age group. They do not represent eligibility criteria.

Cohort roadmaps

We have developed roadmaps for each cohort to guide service delivery and outcomes for each cohort. Each roadmap covers EMPHN's strategic indicators, Commonwealth requirements, and program KPIs, creating a consistent framework for planning, monitoring, and evaluation.

The cohort roadmaps are underpinned by a draft program logic (not provided at REOI stage) and seek to show how inputs and activities connect to outputs and outcomes, providing a direct line of sight between investment and impact, with the intent to keep focus on delivering meaningful results for consumers across all cohorts.

See Part D Attachment 2 for Cohort Roadmaps.

Phased requirements

The Unified Program will be implemented in phases. Phase One will commission a core set of activities across the four cohorts. Elements to be commissioned for are outlined in the table below.

You will see in the table both 'general requirements' and 'specified programs'. This description integrates the range of Commonwealth Deed requirements as it relates to each cohort across EMPHN's 72 funding streams. This pulling together of Commonwealth requirements is intended to give more scope and flexibility to providers in the way you may choose to deliver a service.

'Specified' funding calls out any programs that have a set 'size and shape' that is required to align with Commonwealth operating guidelines. Note that providers can innovate across general requirements and specified programs. If the Commonwealth operating guidelines are adhered to, you should feel free to design and resource across these elements.

As the model matures, future phases will broaden the scope and seek to bring in additional specified programs, building towards a fully integrated primary health care system over time. Examples of activities that future phases might incorporate are outlined below.

Table 6. Activity requirements by phase and cohort

Cohort	Phase One	Future phases (subject to further exploration)
Child and Youth Wellbeing and Resilience	**General requirements:** Deliver services to youth that offer flexible AOD services and stepped mental health services at Initial Assessment and Referral (IAR) levels 3-4. Services will target underserved populations, complex challenges, and include suicide prevention initiatives. This should be informed by the Orygen model.	**General requirements:** Delivery of mental health and AOD care to people in secondary schools **Specified Programs:** Headspace

Cohort	Phase One	Future phases (subject to further exploration)
Adult Wellbeing and Resilience	**General requirements:** Deliver services to adults that offer flexible AOD and stepped mental health services at IAR levels 3-4. Services will target underserved populations, complex challenges, and suicide prevention. Psychosocial support for people with severe mental illness and associated psychosocial functional impairment. **Specified programs:** Medicare Mental Health Service	**Specified Programs:** Medicare Mental Health Phone Line
Older People	**General requirements:** Provide services that help older people stay healthy, manage long-term conditions, and avoid or slow down health problems. Offer support to help them find and use aged care services, especially for those who need extra help, and make sure mental health support is available for people living in aged care homes. **Specified programs:** Care finder – navigation support for vulnerable older people to access aged care and community services, with a focus on priority populations.	None planned at this stage.
Chronic and Complex	**General requirements:** Provide personalised care in the community for people with chronic or complex health needs, including in the after hours. This means focusing on prevention, early help, proven ways to manage long-term conditions, teamwork among health professionals, and better coordination between services—especially for communities that need extra support.	**General requirements:** Delivery of physical and sexual health care to people in secondary schools **Specified Programs:** Medicare Urgent Care Clinics Endometriosis and Pelvic Pain Clinics

Specialist provider network

In addition to commissioning Phase One of the Unified Program aligned to the needs of the four identified cohorts, we also recognise the importance of continuing to support specialist providers who deliver critical services for priority and hardly reached populations in our region. In future phases of the Unified Program, EMPHN will look to commission a 'Specialist Provider Network' (working title only). The Specialist Provider Network is intended to provide specialist services for priority populations, provide secondary consultations and act as a warm referral site, and build the capacity and capability of Unified Program and other primary care providers in the catchment.

In recognition that further co-design is needed to refine the design of the network, it is intended to be established in future phases of the Unified Program. This is in the planning and design stage.

Notwithstanding the establishment of the network, services delivered in Phase One of the Unified Program will be expected to be safe and appropriate for all priority populations, and to maintain a focus on the equitable delivery of services within their region. The successful provider/s for each region will also be expected to collaborate with the Specialist Provider Network once it is established.

Intake and navigation

To deliver the outcomes set out in the program logics, the Unified Program will require an embedded intake and navigation function for each region, designed to remove fragmented entry points and reduce barriers for people with multiple needs.

Intake and navigation will:

- Collaborate with other Unified Program region providers to provide a seamless intake and navigation experience across the EMPHN catchment.
- Provide aligned and collaborative intake and referral services for each region that supports consumers from anywhere in the EMPHN catchment.
- Offer a holistic, consumer-centred intake experience that responds to the full range of individual needs.
- Adopt a no-wrong-door approach, ensuring all consumers can access the right service regardless of where they enter.
- Promote equity and inclusion, with culturally responsive practices to support CALD communities and other priority populations.
- Sustain workforce and systems through periods of change, ensuring continuity and stability
- Uphold safety and quality standards, including consistent staff training across all cohorts.
- Improve efficiency by reducing duplication and enabling scalable, cost-effective workforce models.

We recognise that providers in the region are best placed to say how this kind of function will work with their existing intake and navigation functions, and how this may link with existing systems to create a seamless experience.

Current activity levels

Current activity and demand levels across the four cohorts reflect both the ongoing needs of our communities and the evolving service landscape in the EMPHN catchment. Each cohort shows distinct patterns of service use, influenced by demographic trends, local health priorities, and system capacity.

These numbers are provided as *indicative* volume to help assessment of the Unified Program opportunity. More information on how minimum service levels are calculated is provided further below and in Table 10. This continues to be refined with further details to be provided in a future Request for Tender.

In particular EMPHN understands that by introducing a focus on equity, that this may affect possible consumer throughput due to the requirements for outreach and additional engagement.

Table 7. Number of Consumers that commenced services in FY25 by Cohort

Cohorts	Number of consumers that commenced services in FY25
Child and Youth Wellbeing and Resilience	555
Adult Wellbeing and Resilience	2,412
Older People	1,939
Chronic and Complex	815
Total number of consumers	**5,721**

Funding model, payment mechanisms and key performance indicators

Available funding will be distributed amongst the regions using an algorithm informed by EMPHN's Health Needs Assessment (HNA) completed in November 2024. The allocation model applies weighted factors, including projected population size, burden of disease, service access and utilisation, socioeconomic disadvantage, and health risk factors. The resultant allocation is:

Determined by HNA weighting				
	Region 1	**Region 2**	**Region 3**	**Total**
Area	North	East	Inner South	
Funding proportion	**40.0%**	**34.5%**	**25.5%**	**100%**

Total available funding, to be distributed according to these weightings, is anticipated to be in the vicinity of **$24M-$29M** per annum, noting this remains subject to availability of funding to EMPHN (i.e. receipt of relevant funding Deeds from the DHDA).

As noted above, this envelope is an amalgam of funding received for different cohorts. The division of funding per cohort is 14%, 48%, 28%, and 10% across Child and Youth Wellbeing and Resilience, Adult Wellbeing and Resilience, Older Persons and Chronic Conditions and Complex respectively. This breakdown is provided to give an *indication* of relative focus but should not restrict your thinking in terms of innovation or flexibility of resourcing or delivery.

Contracts under Unified Program will use a blended funding model that combines base, activity, and outcome payments. The indicative funding percentages and associated KPIs outlined below may be refined prior to contracting.

We acknowledge that this is a new way of funding services for EMPHN and for service providers. We look forward to working with the successful service providers to refine, formalise and implement this in partnership.

Note that future year weighting is provided to show the intent to review and refine each year. The exact weighting in these years will be discussed and agreed with successful providers in each successive year.

Base payments:

Foundational funding to support provider sustainability and standard services in line with the contract. These will form the majority of contractual payments and will be paid quarterly, following completion of service delivery and submission of deliverables, data, and KPIs (see Table 9).

Activity payments:

Funding linked to consumer-related service hours, patient throughput, and delivery to priority populations. Payments are 'risk based' and made proportionally according to the relevant payment scale below. Activity levels will be reviewed quarterly and payments made accordingly, with shortfalls able to be recovered in subsequent quarters.

Outcome payments:

Reward-based payments linked to consumer outcome achievements. These unlock future funding for pre-approved innovative activity and/or additional tranches of activity. Outcomes are tied to relevant consumer cohort outcome measures (as per Table 8) and are paid annually, based on performance in the previous year.

Table 8. Proposed payment mechanisms

Payment type	Payment Requirements	Weighting	Payment Scale
Base payment requirements	Meet standard contractual requirements and submit all deliverables, including: Non-Activity/Outcome KPIs (see Table 9) and other data specification requirements Budgets and acquittals Clinical governance, insurance and accreditation requirements (initial and attestation) Cultural safety requirements Integration and networking requirements Deliverables not received/requirements not met by the due date may result in a withheld payment in full until deliverables are received and accepted.	FY27 = 90% FY28 = 80% FY29 = 70% (Paid quarterly)	N/A
Activity payment KPIs	# consumer related hours # consumers % of consumers from priority populations (priority populations = consumers identifying as Aboriginal and/or Torres Strait Islander, consumers identifying as LGBTQIA+, consumers from culturally and linguistically diverse communities, consumers from low socioeconomic status areas)	FY27 = 10% FY28 = 20% FY29 = 30% (Paid quarterly)	80-100% of target = 100% of payment 60-80% of target = 80% of payment <60% of target = 0% of payment (Targets TBC and to scale up to full-service delivery over time)

Payment type	Payment Requirements	Weighting	Payment Scale
Outcome payment KPIs	% of consumers with paired outcome measures complete % of consumers demonstrating improvements/significant improvements in outcomes	FY27 = 0% FY28 = Bonus 5% FY29 = Bonus 10% (Paid annually based on prior year performance)	80-100% of target = 100% of payment 60-80% of target = 80% of payment <60% of target = 0% of payment

Other Key Performance Indicators

In addition to the activity- and outcome-based KPIs described above, a further set of indicators will apply to base payments. These KPIs focus on regional performance and contractual requirements that are not tied to service volume or outcomes but remain essential for accountability and quality.

They are listed in Table 9.

Some cohorts may also be subject to additional Deed or Departmental requirements. In addition, EMPHN requires specific data reporting to support monitoring and evaluation; these data specifications are mandatory but sit separately from KPIs. Detailed data specifications will be provided with an RFT.

Table 9. Non-payment Key Performance Indicators (indicative only)

KPI type	KPI
Activity	# Occasions of Service delivered % consumers providing experience data % of consumers that were seen within target service wait time
Consumer experience	% consumers reporting positive experiences of service % consumers reporting ease of access to services % consumers who feel respected and involved in decisions % consumers reporting care was culturally appropriate
Provider/workforce	% staff completing required training
Value for Money	$ / service hour $ / consumer $ / improved outcome
Equity	% consumers with improved outcomes from priority populations

KPI type	KPI
Integration and Coordination	# established referral pathways # referrals made # shared care plans # co-located services

Target setting

Service volume expectations and targets

Given the Unified Program is a new approach to service provision, pre-existing unit costs and targets are not directly applicable. We recognise this. It is our intention to continue to refine targets in consultation with providers as we together learn about best practice and benchmarks in the new model.

Target expectations will grow as the model matures. This is particularly true in the areas of value, equity and outcomes. Where possible, metrics will have minimums and broad range targets to foster flexible, adaptive and innovative responses to consumer needs and trends.

Consumer related hours

The primary activity target (upon which activity payments will be measured) is 'consumer-related hours'. Consumer-related hours are defined as the number of hours spent directly with a consumer and other consumer related approved activities, such as secondary consultations, case conferencing and referrals.

In the first year of the Unified Program, this will be set at 70% of consumer facing staff member time, constituting 1140 hours per 1.0 FTE per annum (as per Table 10). For this indicator, it is required that a minimum of 50% of the total region budget needs to be spent on consumer facing staff.

In future years, hour targets will be recalculated using unit costs per cohort and informed by data. These will have weightings for complexity, rurality and priority populations. This will occur in consultation with service providers, using benchmarks from the first year of service delivery, as well as relevant external comparators.

Consumer numbers

Consumer numbers and occasions of service expectations will proportionally vary by region and cohort in alignment with funding variation. With the Unified Program we want to create service models that are flexible and responsive to need. To help with this, targets will have minimums (or 'ranges') that will drive care for each cohort but allow for scaling up and down in response to consumer needs and demand.

Priority populations

Equity is a key priority for EMPHN and to reflect this, relevant targets will grow over time (Table 10). Given that delivery to priority populations has not been a historic focus for EMPHN, initial targets will be set based on FY25 service levels for priority populations, noting we do not currently collect LGBTIQA+ status and Low SES status.

We expect these targets to vary appropriately by region and cohort, given different population profiles. In future years, these targets will be reviewed based on existing performance, best practice and any innovation implementations designed to improve equity and access for priority populations.

Table 10. Payment KPI targets and proportions (indicative only)

KPI	Target	Proportion of payment
Consumer related hours	FY27= 1140 hours per consumer facing staff member (1.0 FTE) FY28/29 = Unit cost per cohort.	80% of Activity payment
Consumer numbers	Consumer numbers will not have a specified maximum target but will ensure an appropriate balance of hours are being delivered per consumer, with 'baseline' expectations per cohort and service type to be shared in the RFT.	0% (minimum requirements per cohort to 'unlock' the consumer related hours payment)
Priority populations	This will vary by region and priority cohort, with initial minimum expectation to match FY25 levels. As an indicator, all regions and cohorts combined in FY25 produced: CALD: 9.16% Aboriginal/Torres Strait Islander: 5.75% (LGBTIQA+ and Low SES status are not currently collected and will initially be based on population data by region and cohort).	20% of Activity Payment
% of consumers with paired outcome measures	70% of consumers have paired outcome measures	50% of outcome payment
% of consumers with improvements in outcomes	Varied, based on cohort and outcome type (typically 50-70% improvement/significant improvement)	50% of outcome payment

Collaboration

We listened to the feedback from the design process, that – for Unified Program to work – effective collaboration and integration require investment, time and effort. True collaboration takes genuine partnership, whether this be formal or informal. And collaboration is important to drive not only good outcomes, but positive consumer, clinician and provider experiences.

Regardless of whether a provider responds to this REOI as interested in delivering as a solo provider or in a consortium, collaboration will be key.

So, as part of the base funding for the Unified Program, a number of collaborative activities will be supported: with EMPHN, across regions, and within regions. Examples of these activities are provided in Table 11 below. Note that all activities will be proactively supported by EMPHN in partnership with providers.

Table 11. Required collaboration activities (indicative only)

Collaboration	Activities
EMPHN	Monthly data quality assurance Quarterly performance review meetings with multidisciplinary team (Executive, contract, data)
Within region	Annual stakeholder and communications plan development Communications activities as determined Stakeholder partnership development (e.g. workshops, pathway development) Development of partnership agreements
Across region	Annual cross-region planning and innovation day Annual health sector conference Quarterly quality improvement workshops

Data and reporting

One of the key objectives of the Unified Program is to simplify reporting requirements and reduce the administrative burden that reporting against multiple and varied requirements can place on service providers. This also serves to enhance the type, quality and accuracy of data that is captured as part of monitoring and reporting, enabling us to develop more meaningful insights that can drive further service improvements and innovation in future.

To support these objectives, EMPHN will provide a detailed data specification as part of the RFT that will set out all expected data and reporting requirements. Wherever possible, data and reporting requirements will be streamlined across all cohorts to support consistency. The data specification will also align to the Key Performance Indicators outlined above, as well as any additional Deed or Departmental requirements.

As part of the RFT, providers will be expected to demonstrate their capability and capacity to meet these data and reporting requirements. Should a response be made by a partnership of multiple organisations, a lead provider will have responsibility for collecting, collating, ensuring the coverage and accuracy of all data and reporting on behalf of the partnership.

As part of the Unified Program, EMPHN will provide detailed reporting back to providers to ensure that there is an agreed set of reporting and that providers (individually and collectively) can utilise performance reporting data for quality improvement and innovation. We will also explore data support for the Unified Program providers, should this be needed.

Transition expectations

The transition to the Unified Program model will be phased to maintain continuity of care and minimise disruption of services within the catchment. Providers will be expected to work closely with EMPHN, sector partners, and the broader health system to support a smooth transition through joint planning and service integration.

Clear, timely communication with consumers and staff will be essential. Providers must collaborate with EMPHN to identify transition pathways, manage handovers and address service gaps. Collaboration with other providers will also be required to build integrated service networks.

During the transition, existing services will gradually reduce service activity and intake, while UPA activity scales up in a measured way to ensure consumer safety, workforce readiness and strong community partnerships. Funding will also be scaled up in line with service volume targets, noting that funding will need to move ahead of targets to ensure appropriate budget for various establishment activities. Final transition targets will be confirmed through the procurement process and contract negotiations with successful providers.

The Table below shows the indicative timelines for the Expression of Interest (EOI), Request for Proposal (RFP), and program commencement phase (Phase One).

Table 12. Indicative Timeline for Phase One of Unified Program

	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Q1 Jul - Sep 26	Q2 Oct - Dec 26	Q3 Jan - Mar 27	Q4 Apr - Jun 27
Expression of Interest													
EoI Open													
Industry Briefing													
EoI Evaluation													
Request for Tender													
RFT Open													
RFT Evaluation and contract negotiation													
Service Delivery													
Current commissioned programs													
New service delivery													