phn
EASTERN MELBOURNE

An Australian Government Initiative

E096 REOI Part D Attachment 2 Unified Program Cohort Roadmaps

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.

Purpose of Part D Attachment 2: Unified Program Cohort Roadmaps

The purpose of this attachment is to provide some guidance as to what Eastern Melbourne Primary Health Network (EMPHN) anticipates will result from the Unified Program. We would like to offer this as a starting point for a more detailed program logic that will be presented as part of a Request for Tender (RFT) and refined based on provider tender responses and contract negotiations.

Evaluation of the Unified Program

We would like to understand the impact of the Unified Program in a number of ways, including:

- How delivery of an integrated place-based commissioning model affects the way in which the health service system in the EMPHN catchment is organised.
- Whether providing a more flexible commissioning model assists with innovation and workforce responsiveness.
- Whether economies of scale provide better value for money.
- The impact on equity and health outcomes for each of the cohorts.
- Which models of care work for different cohorts.
- Whether innovation can be shared and scaled across regions for best impact and value.
- Whether an EMPHN team focused on partnership brokerage, quality improvement and support provides better system stewardship and guidance to providers.

The Cohort Roadmaps below frame these questions across six areas; this includes four patient cohorts, the region, and the Unified Program overall.

Partnering for evaluation and quality improvement

We intend to work alongside universities and research partners to help evaluate and understand the impact of the UPA from a range of angles (fidelity, process, impact, economic, qualitative). By partnering with academic teams, we can look deeper into what's working, why, and how we can improve over time. Together, we'll use evidence and real-world insights to strengthen local care and share what we learn with others across the health system.

Data linkage to development a more mature data-driven environment

To support meaningful insights into the Unified Program and other EMPHN work, we're building a linked data set that brings together information from across programs, general practice, tertiary and systems to help us see the bigger picture. We are in the process of seeking ethics approval and can update potential providers further as part of the Request for Tender.

This linked data will support regional planning, help set meaningful and realistic KPIs and targets, and help evaluate what's really working. Over time, it will also guide quality improvement and predictive algorithms, giving EMPHN and our partners a stronger evidence base for smarter, more equitable decision-making.

People with chronic conditions and complex needs

What is the need?

Chronic conditions affect many in EMPHN's catchment. This cohort often experience fragmented care, limited self-management support, and difficulty navigating care (including general practice, hospital, and community services), leading to poorer outcomes and greater inequity for vulnerable groups. Chronic conditions also account for over 53% of all potentially preventable hospitalisations in EMPHN's catchment, putting significant strain on the system.

What is the goal?

People with chronic conditions and complex needs have equitable access to holistic and integrated care, leading improved care coordination, fewer avoidable complications and better health and wellbeing outcomes.

Our Theory of Change

By enabling primary and tertiary care providers to work together in delivering integrated, coordinated, and person-centered support for people with chronic conditions and complex needs, including prevention, early intervention, and ongoing management, we can empower individuals to live healthier lives and ease the burden on the healthcare system.

Challenges

- Multimorbidity
- Functional impairment
- Frequent interaction with services
- Multiple care providers
- Potentially preventable escalations of care
- Fragmented and inconsistent care pathways

Key interventions

- Proactive identification and risk stratification
- Care coordination and navigation, including shared care planning and case conferencing.
- Integrated, multidisciplinary care.
- Self-management and prevention
- Equity-focused design ensuring culturally safe, accessible services for priority populations.

Outcomes

- Positive experiences of service delivery resulting in greater trust and appropriate engagement
- Improved health and wellbeing
- Equitable, culturally safe access for all
- System integration and seamless care coordination
- Reduction of crisis episodes and avoidable escalations of care

Evidence to support our approach

- Prevention-focused care reduces complications and avoidable hospitalisations.
- Multidisciplinary, team-based care improves patient outcomes, continuity, and satisfaction.
- Equity-centered strategies increase access and improve outcomes for priority populations.
- Integrated systems and digital tools enhance coordination across systems and services.

Key Indicators

- # people with chronic conditions engaged in services
- # consumer-related hours
- % of people with chronic conditions from priority populations
- % of people with chronic conditions with paired outcome measures
- % of people with chronic conditions demonstrate positive outcomes (e.g.,EQ-5D-5L)

Older People

What is the need?

Older adults in the community often struggle with chronic illness, isolation, and complex care systems. Barriers such as affordability, digital exclusion, and lack of cultural safety limit access to supports that maintain health and wellbeing. In aged care settings, grief, distress and loneliness are common, yet timely psychological support is often lacking.

What is the goal?

Older people live well, supported by coordinated, culturally safe, and person-centred care that promotes physical, mental, and social wellbeing – whether at home or in residential aged care.

Our Theory of Change

By strengthening partnerships across aged, primary, and community care, and investing in care navigation, early intervention, and emotional wellbeing, older people can stay connected and maintain their health and independence. These supports also promote smooth transitions and stronger mental wellbeing as people age.

Challenges

- Limited cultural safety or affordable services
- Social isolation and reduced confidence
- Multimorbidity and frailty
- Limited mental health supports in aged care
- Workforce gaps in older persons' health, mental health, and navigation skills

Key interventions

- Care navigation and outreach for vulnerable older people (Care Finder model)
- Early intervention and prevention to support healthy ageing and social connection
- Low intensity in-reach psychological therapies in residential aged care
- Culturally safe, trauma-informed, inclusive care

Outcomes

- Positive experiences of service delivery resulting in greater trust and appropriate engagement
- Improved health and wellbeing
- Equitable, culturally safe access for all
- Seamless transitions across home, community, and hospital care
- Reduction of crisis episodes and avoidable escalations of care

Evidence to support our approach

- Early intervention and social connection reduce frailty and hospital
- Care navigation and outreach improves access, continuity, and confidence for older people and carers
- In-reach psychological therapies improve resident wellbeing and staff capability
- Multidisciplinary, inclusive models strengthen equity and quality of life

Key Indicators

- # of older people engaged in outreach and navigation
- # consumer-related hours
- % of older people from priority populations
- % of older people with paired outcome measures
- % of older people demonstrating positive outcomes

Child and Youth Wellbeing and Resilience

What is the need?

Children and young people in EMPHN's catchment experience increasing rates of mental distress, self-harm, substance use, and psychosocial challenges. Many face fragmented service pathways, long waits, and inconsistent coordination between mental health, AOD, and community supports. Families and carers often lack guidance, and transition points (e.g. school-to-work or child-to-adult services) are significant risk periods.

What is the goal?

Young people have equitable access to integrated, youth-friendly services that promote emotional wellbeing, resilience, and social connection. Enabling them to thrive at home, in school, and in their communities.

Our Theory of Change

By providing early, equitable, and developmentally appropriate supports that integrate mental health, family, and community services, children and young people are better able to build resilience, thrive within their environments, and strengthen wellbeing into adulthood. Through youth participation, family engagement, and cross-sector collaboration, these supports drive sustained improvements in wellbeing and reduce the long-term impacts of mental health and social challenges.

Challenges

- Fragmented or delayed access to youth-appropriate services
- Rising rates of complex presentations, anxiety, depression, and self-harm
- Limited navigation and coordination support
- Family and carer stress and lack of inclusion in services
- Limited early intervention and prevention opportunities
- Poor transitions between child, youth, and adult services

Key interventions

- Youth-friendly, evidence-informed and multidisciplinary model of practice
- Integration of mental health, AOD, psychosocial and suicide prevention supports
- Early Intervention, social prescribing, outreach, harm minimisation and wraparound family/ carer support
- Culturally safe and inclusive service models

Outcomes

- Positive experiences of service delivery resulting in greater trust and appropriate engagement
- Improved health and wellbeing
- Equitable, culturally safe access for all
- System integration and seamless care coordination
- Reduction of crisis episodes and avoidable escalations of care

Evidence to support our approach

- Early, community-based intervention improves long-term recovery outcomes
- Youth-specific, multidisciplinary services enhance trust and engagement
- Family and peer involvement improve continuity and self-management
- Integrated systems reduce duplication and prevent crisis escalation

Key Indicators

- # of young people engaged in services
- # consumer-related hours
- % of young people from priority groups
- % of young people with paired outcome measures
- % of young people demonstrating positive outcomes

Adult Wellbeing and Resilience

What is the need?

Adults across the EMPHN catchment experiencing mental health challenges, AOD harms, or psychosocial distress often navigate fragmented and poorly coordinated systems of care. Limited recovery supports and barriers related to cost, stigma, and cultural safety contribute to inequitable access and poorer wellbeing outcomes.

What is the goal?

Adults have access to holistic, person-centred and recovery-oriented services that strengthen mental wellness, resilience, and social participation, and reduce avoidable crisis and hospital use.

Our Theory of Change

By delivering integrated, recovery-oriented, and person-centred care that addresses both clinical needs and psychosocial factors, adults are supported to achieve sustained recovery, improved quality of life, and reduced crisis presentations. Through the inclusion of peer workforce and continuous improvement practices, services become more responsive, inclusive, and effective.

Challenges

- Fragmented and limited integration across mental health, AOD, and psychosocial supports
- Services have limited capability to appropriately support underserved and at-risk groups
- Inconsistent inclusion of carers and supports
- Limited intervention targeting recovery, relapse prevention, and self-management

Key interventions

- Culturally safe and inclusive, evidence-based and multidisciplinary models of practice
- Integration of mental health, AOD, psychosocial and suicide prevention supports
- Prevention, outreach, social prescribing, harm reduction and wraparound family/carer support
- Coordinated pathways between acute, community, and primary care

Outcomes

- Positive experiences of service delivery resulting in greater trust and appropriate engagement
- Improved health and wellbeing
- Equitable, culturally safe access for all
- System integration and seamless care coordination
- Reduction of crisis episodes and avoidable escalations of care

Evidence to support our approach

- Recovery-oriented models improve long-term wellbeing and functioning
- Peer-led services enhance engagement and reduce stigma
- Culturally safe and inclusive approaches improve access for priority groups
- Integrated, multidisciplinary care reduces hospital demand and crisis recurrence

Key Indicators

- # of adults engaged in services
- # consumer-related hours
- % of adults from priority populations
- % of adults with paired outcome measures
- % of adults demonstrate positive outcomes

Regions

What is the need?

The regions within the EMPHN catchment have different needs and experience unique challenges. Services are often fragmented and poorly coordinated, creating challenges for consumers to access the care and supports they need, especially for those with multiple and co-occurring conditions. Access to services and outcomes are also experienced inequitably across the regions.

What is the goal?

Take a place-based approach to service planning, design and delivery that is responsive to unique local needs, leverages the strengths of the service system, supports the development of the workforce, and builds collaboration between system partners to improve integration, experiences for consumers and value for money.

Our Theory of Change

By planning, designing and delivering integrated services that are responsive to local needs and drive collaboration, we can deliver holistic services that provide better consumer experiences and meet the needs of priority populations, to improve the population health outcomes of the region.

Challenges

- Fragmented services create confusion for consumers and clinicians
- Siloed services may not consider the holistic needs of consumers
- Limited collaboration between providers and other system partners, including GPs, creates barriers
- Inequitable access and outcomes
- Limited visibility of whole-of-system outcomes, impact and sustainability

Key interventions

- Scalable cultural safety and inclusion models
- Intake and navigation support enables consumers to access the care they need
- Collaboration, including specialist providers, general practices and hospitals
- Workforce capacity and capability building
- Data and insights to drive continuous improvement

Outcomes

- Sustained improvements in whole-of-person outcomes and access
- Improved experiences through coordinated and integrated care
- Efficient use of resources and value for money
- Strengthened partnerships and collaboration
- Improved workforce capability and capacity
- Services continuously improved through insights and innovation

Evidence to support our approach

- Multidisciplinary, collaborative and integrated approaches deliver better care for people with complex and co-occurring needs
- Safe and appropriate services targeted to priority populations improve equity of access and outcomes
- Care coordination and service navigation support enables consumers to access the care they need when they need it

Key Indicators

- # of people accessing services
- % of people from priority populations accessing services
- % of adults with paired outcome measures
- % of adults demonstrating positive outcomes
- Unit costings

Unified Program

What is the need?

Across the EMPHN catchment, communities experience unequal access to care. Healthcare faces ongoing pressures, such as fragmented service systems, workforce challenges, inconsistent collaboration, avoidable hospitalisations and poor consumer experiences and outcomes – particularly for hardly reach populations.

What is the goal?

To utilise the influence that EMPHN has to improve health and wellbeing outcomes for people in the east and north of Melbourne by commissioning integrated and equitable services that respond to local needs, strengthen system collaboration, and enhance flexibility and innovation.

Our Theory of Change

By commissioning via an integrated, data-driven place-based framework, providers will be empowered to deliver more innovative and flexible services. This will build a focus on equity, cross-system collaboration, quality improvement and value. This will lead to better consumer and clinician experience, value for money, and improved health outcomes, particularly for priority and hardly reached populations.

Challenges

- Fragmented health and social care systems result in poor value, coordination and access
- Fragmented funding driving fractured services
- Inequities for priority populations
- Workforce shortages
- Limited use of data and consumer insights to inform service improvement
- Workforce divisions impeding high quality multidisciplinary teamwork

Key interventions

- Place-based integrated commissioning model
- Blended funding model to drive value for money and a focus on equity
- Targets set and improved on through the commissioning cycle in partnership with providers
- Greater focus on collaboration and innovation
- Shared data and insights
- More strategic support for providers

Outcomes

- Improved experience, smoother, more coordinated care across providers and sectors
- Equitable access to safe, high-quality, and culturally responsive care
- Providers collaborate effectively, supported by a skilled and confident EMPHN workforce
- Data and consumer insights drive continuous improvement, innovation, and system sustainability
- Better line of site of value, equity and relative weightings across the catchment

Evidence to support our approach

- Integrated, team-based care reduces duplication, improves outcomes, and enhances patient satisfaction
- Early intervention and equitable access improve health outcomes and reduce hospital demand
- Workforce capability and cultural safety training enhance quality and consumer trust
- Data-driven commissioning enables value for money and responsive service design
- Consumer co-design increases relevance, uptake, and sustainability of services

Key Indicators

- % of people from priority populations accessing services
- Consumer experience, engagement, and satisfaction
- Evidence of data-driven service redesign or improvement
- Demonstrated inclusion of consumer voice in program governance and co-design