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EASTERN MELBOURNE

An Australian Government Initiative

# Annual Evaluation Report FY 2024 - 2025

Eastern Melbourne PHN
September 2025

## 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.

We would like to extend our gratitude and appreciation to consumers, carers, and general practitioners who contributed to these evaluations. We thank them for their time and insights and trust that their views are adequately represented in this report.

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# About EMPHN

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.

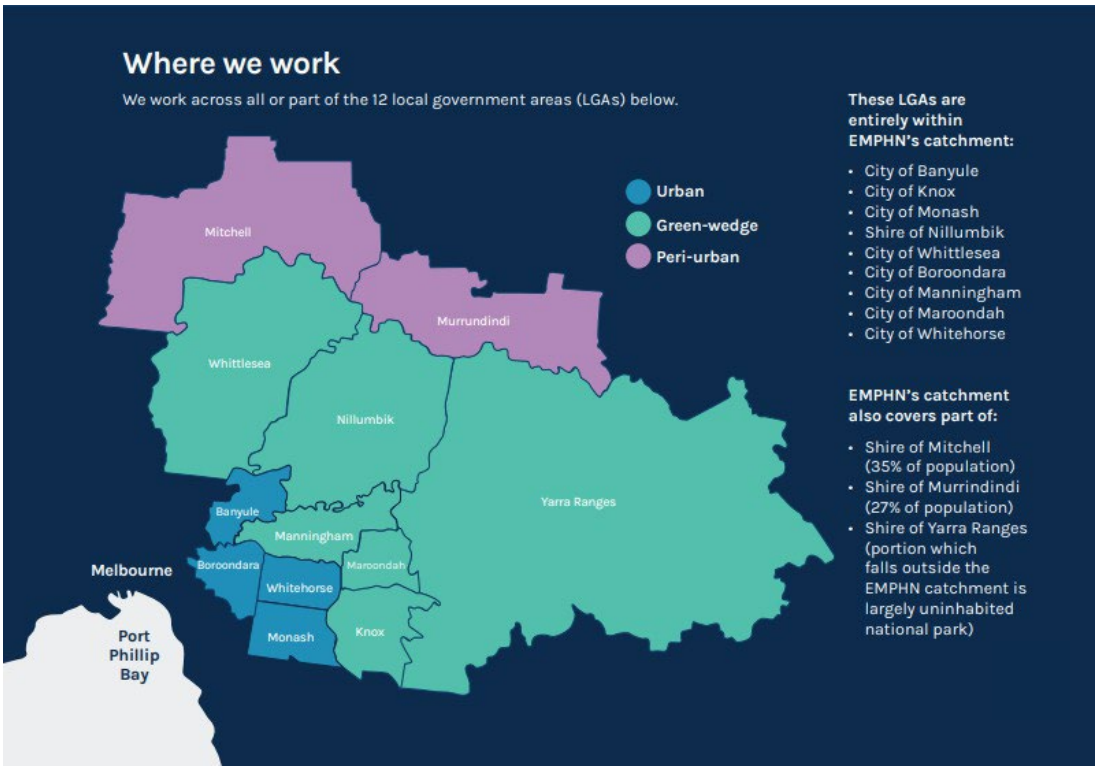
We do this by commissioning services that address identified health gaps, supporting the mental health and physical wellbeing of our communities.

Our three strategic priorities for 2025- 2028 are:

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

The EMPHN catchment spans across 12 Local Government Areas and covers almost 4,000 square kilometres.

It is home to a diverse population of over 1.6 million people, making it one of the largest PHNs by population size. EMPHN accounts for more than a quarter of the Victorian population.



# Reframing monitoring and evaluation at EMPHN

## Embedding the Monitoring and Evaluation Framework across EMPHN

EMPHN's FY 2023-2024 Annual Evaluation Report highlighted our review of the Monitoring and Evaluation Framework (see Figure 1 below) as a significant milestone in strengthening our approach to accountability and evidence-informed practice.

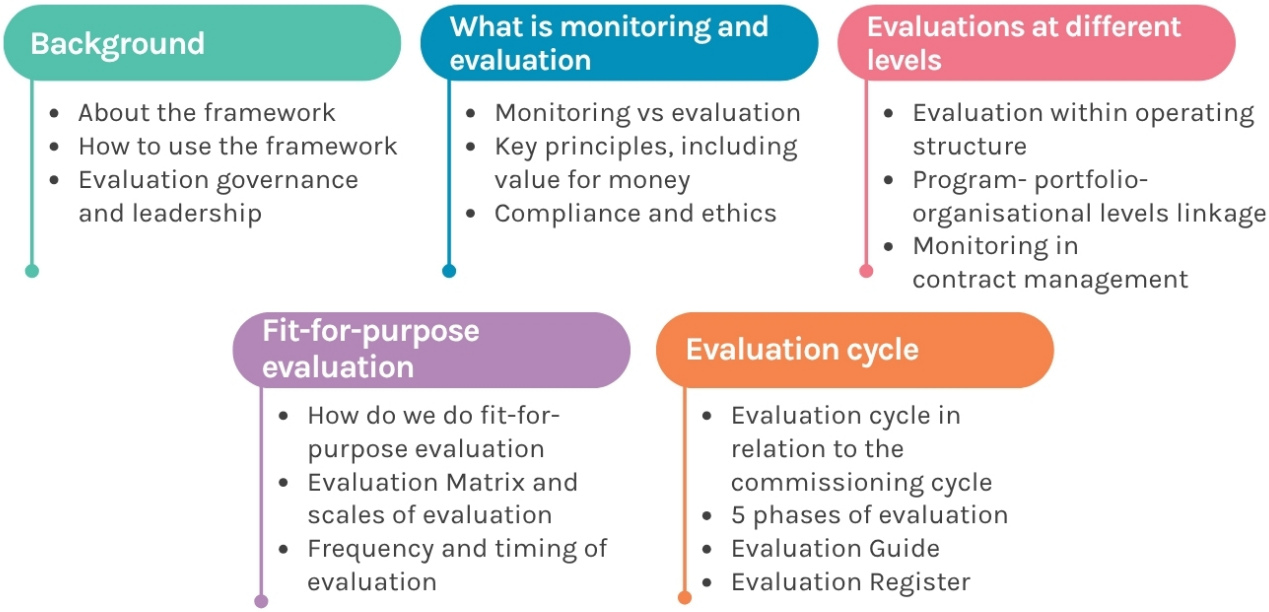



*Figure 1: EMPHN's Monitoring and Evaluation Framework 2024*

In FY 2024-2025, we focused on implementation of the Framework (see Figure 2 below). This work ensures that evaluation practices remain focused, consistent, and aligned with our strategic priorities of driving equitable outcomes, enabling integration and change, and leveraging insights to demonstrate impact.


*Figure 2: EMPHN's Monitoring and Evaluation Framework Implementation timeline*

A staged implementation approach was adopted to ensure the Framework is consistently applied.

**1. Governance and Leadership**

- Define clear accountability for monitoring and evaluation.
- Embed M&E in program design and reporting to leadership.

**2. Capability Building**

- Provide training and tools to build staff skills in monitoring and evaluation.
- Establish internal M&E champions to support consistent practice.

**3. Integration with Commissioning and Operations**

- Embed M&E into service planning and delivery.
- Use standard reporting and measures aligned with EMPHN's data and insights framework.

**4. Systems and Tools**

- Use EMPHN's data and insights systems for ongoing monitoring and analysis.
- Track evaluation activities and outcomes in a central register.

**5. Continuous Improvement and Learning**

- Share findings internally and externally.
- Apply lessons to strengthen service models and system performance.

*Figure 3: EMPHN's Monitoring & Evaluation Framework Implementaion*

## The Monitoring and Evaluation Framework in Practice

The revised Monitoring and Evaluation Framework is not a stand-alone tool — it is operationalised through EMPHN's broader business transformation initiatives. By aligning with our Value for Money, Contract Management, and Data and Insights Toolkit, it ensures evaluation is embedded into everyday decision-making and service delivery.

| Value for Money (VFM) | Contract Management | Data and Insights |
|---|---|---|
| Evaluation evidence informs investment choices by assessing efficiency, effectiveness, and equity of programs.<br><br>Measuring unit costs and outcomes ensures resources are used wisely to achieve the greatest impact | Monitoring activities are built into provider contracts to track performance, identify risks early, and support continuous improvement.<br><br>Data collected through contract management feeds directly into evaluation and decision-making. | Standardised performance indicators and metrics enable consistent monitoring across programs.<br><br>By linking data collection with evaluation planning, EMPHN strengthens the evidence base used to assess outcomes and report progress. |

Together, these elements make the Monitoring and Evaluation Framework practical and actionable — moving from high-level principles to operational tools that guide commissioning, provider performance management, and organisational learning.

# Case studies: Evaluation summaries from FY 2024-2025

## The Healthy Ageing Service (HAS) provides support t oolder people with low to moderate mental health concerns

| Evaluation focus | Process<br>Value for money<br>Outcome |
|---|---|

### Program description

The Healthy Ageing Service (HAS), delivered by St Vincent's Hospital, supports older adults aged 65+ and Aboriginal and Torres Strait Islander peoples aged 55+ who are experiencing or at risk of mild to moderate mental health concerns. The program targets both community-dwelling individuals and residents of Residential Aged Care Homes (RACHs), where mental illness prevalence is significantly higher than in the general population.

HAS comprises three components:

1. Phone advice line for clinicians – provides General Practitioners (GPs) and RACH staff with diagnostic clarification, medication advice, therapeutic strategies, and referral pathways.
2. Face-to-face or telehealth intervention – offers short-term individual care for people with moderate symptoms that are impacting daily functioning, which involves assessment, action planning and collaborative support involving the person, their care team and family members.
3. Capability building – delivers CPD-accredited interventions on mental illness in older adults and advice for healthy ageing.

### Evaluation goals and approach

The evaluation was initiated in response to an upcoming contract renewal (October to December 2024) and aimed at assessing:

- Effectiveness – how well the HAS program meets its intended outcomes.
- Appropriateness – how suitable the services are for the target population.
- Efficiency – how well resources are used, including cost per service hour and budget allocation.
- Sustainability – ability to maintain and scale services over time.
- Scalability – potential for broader implementation or adaptation.

In particular, there was a focus on the key performance indicators (KPIs) of HAS, on how the data metrics align with these KPIs, and on how HAS compares to benchmarks or national standards.

A mixed-methods approach was used in the evaluation, drawing from various data sources including internal reporting, provider feedback, administrative datasets, and benchmarking with national programs.

- Quantitative data: KPIs, provider reporting, administrative data, unit costing, and benchmarking (e.g., cost per service hour and other benchmarks were used to assess efficiency and effectiveness).

- Qualitative data: surveys, consultations, internal workshops, and provider feedback.

Two major workshops (May and August 2024) were conducted to develop program logic, evaluation questions, and review findings.

**Evaluation learnings**

Evaluation findings **led to a redesign of service reporting**.

- The evaluation found that secondary consultations were not delivered as intended, with low demand from GPs and RACH staff leading the provider to reinterpret them as collaborative care planning. These were subsequently redesigned and classified as either consumer-related or non-consumer-related activities, in line with other EMPHN mental health programs.
- The evaluation identified the need to separate capacity building as a distinct component, leading to new design and contracting processes.

KPIs **were refined and reduced based on the co-developed program logic.**

- The evaluation resulted in a reduction of 20 KPIs to 12 (5 of which were new). 14 KPIs and 6 metrics were removed from reporting templates and 2 KPIs and 2 metrics became deliverables in the contract, reducing duplication and quarterly and six-monthly reporting burden.
- Iterative Improvement: Workshops and feedback loops facilitated the continuous refinement of KPIs and reporting templates, ensuring alignment with program logic and enabling easier future evaluations of the program.

An equity lens was applied, using stratification to identify RACHs that required additional support.

- RACH residents are a hard-to-reach group, with facilities varying in preparedness. A stratification process from the telehealth grants project was used to identify homes that needed extra support and was shared with providers. Reporting also included a non-core KPI to capture additional data.

Data was successfully used to drive **decision-making**.

- Analysis of internal and provider data, benchmarking, and unit costing informed recommendations and contract negotiations.
- Collaborative design was central, involving facilitators, providers, design and data teams, and executive leadership throughout the evaluation process.
- Benchmarking against national standards and cost comparisons provided context for assessing performance and value for money.

# The Complex Trauma Initiative enhances the capability of primary care professionals in supporting people with complex trauma and suicidal distress

| Evaluation focus | Planning |
|---|---|

## Program description

The Complex Trauma and Suicidal Distress Initiative aims to enhance support for individuals with complex trauma histories who are experiencing suicidal distress. This pilot aims to build the capability and confidence within primary care settings to better address the needs of this population.

The program was co-designed with a range of stakeholders, including Victoria's specialist service for Personality Disorders and Complex Trauma, a community health service, Ambulance Victoria, a lived experience of suicide peak body, tertiary mental health crisis services and general practitioners. The objectives are to:

1. Develop, test, and iterate interventions that build system responsiveness for people experiencing suicidal distress and complex trauma.
2. Pilot a model that strengthens the primary care sector's ability to support this cohort in the community, thereby reducing the need for emergency responses.
3. Improve system integration, stakeholder communication, and organisational efficiency through better resource allocation and coordination.
4. Improve stakeholder communication and coordination within the catchment area.

The initiative's scope is on capability building—encompassing program design, education and skills development, service system coordination, and on-team support—rather than direct service provision. Patient experience and outcomes were outside the scope of this pilot phase, with the focus instead on workforce and system-level changes.

## Evaluation goals and approach

The evaluation plan for the Complex Trauma Initiative was developed internally by EMPHN and co-designed with participating provider organisations.

The overarching goals are to:

1. Gather feedback during development and early implementation to improve program design and delivery.
2. Assess the fidelity of implementation, ensuring the program is delivered as intended and identifying operational issues.
3. Determine short-term effects on participants, particularly in terms of increased knowledge, skills, and confidence among primary care professionals.
4. Explore value for money and sustainability to inform future commissioning decisions.

The evaluation approach is structured around several key activity tranches, including education/skills development, service system coordination, and on-team support. For each, the plan outlines formative, process, outcome, and impact evaluation questions, with corresponding indicators and data sources.

For example:

- Education/Skills Development: Are training materials relevant and understandable? Is training delivered as scheduled and reaching the intended audience? Have participants increased their knowledge and skills?
- Service System Coordination: Are collaboration meetings occurring regularly? Has communication and continuity of care improved? Is there a sustained network for coordination beyond the pilot?
- On-Team Support: Do primary care teams find on-team support helpful? Is it being integrated into team routines? Has team capability increased?

The evaluation will use a hybrid approach, combining quantitative data (e.g., attendance, completion rates, pre/post knowledge assessments) and qualitative feedback (e.g., participant surveys, case studies, co-design team reflections). The plan also includes economic evaluation elements, such as assessing value for money and the contribution of each program component to overall outcomes.

| Evaluation learnings |
| --- |
| The co-design process enabled a focused, practical, and stakeholder-aligned evaluation approach, resulting in a refined program logic and a robust foundation for future evaluation.<br><br>Collaborative co-design<br><br>• The evaluation plan was developed through a series of co-design workshops with providers and key stakeholders, ensuring that evaluation questions, indicators, and methods were directly relevant to the realities of primary care and the needs of those delivering and receiving support.<br><br>Refined program logic<br><br>• Iterative feedback loops allowed the program logic to be clarified and streamlined. This mapped clear pathways from activities (such as training, secondary consultation, and resource development) to intended workforce and system outcomes, making the evaluation framework both practical and meaningful.<br><br>Alignment on what matters:<br><br>• Through co-design, the team agreed on what was most pertinent to evaluate—prioritising capability building, system coordination, and on-team support—while acknowledging that patient-level outcomes were out of scope for this pilot phase.<br><br>Evaluation framework ready for procurement:<br><br>• The internally developed and co-designed evaluation plan provided a strong, shared foundation for procuring external evaluation services.<br>• The plan specifies a hybrid approach (quantitative and qualitative), clear metrics, and practical data collection strategies, ensuring readiness for a focused and actionable evaluation.<br><br>This approach is expected to reduce duplication, streamline reporting, and enable continuous improvement by embedding feedback mechanisms and practical measurement tools from the outset. |

# The Right Care Better Health (RCBH) program provides better care coordination for patients with complex chronic conditions

| | |
| --- | --- |
| **Evaluation focus** | **Process**<br>**Outcome**<br>**Value for money** |

| Program description |
| --- |
| The Right Care Better Health (RCBH) program is an integrated care initiative designed to improve health outcomes for adults with complex and chronic health conditions. It does so through person-centred navigation, enhanced health literacy, and tailored self-management support. The program targets individuals with conditions that frequently result in avoidable hospital presentations—such as cardiovascular diseases (e.g. heart failure, hypertension, atrial fibrillation), respiratory conditions (e.g. COPD, asthma), and those considered frail or at high risk of falls.<br><br>Commissioned by EMPHN in 2020, RCBH has been delivered by three community service providers across the north and east of EMPHN's catchment area since 2021. As of FY 2024-25, the program operates in 24 general practices—14 in the east and 10 in the north.<br><br>Patients enrolled in RCBH receive structured, collaborative care over a four-month episode. This includes patient-reported outcome measurement (PROM) and patient-reported experience measurement (PREM) tools, development of tailored care plans, access to educational resources, and referrals to external services where |

appropriate. Upon completion, patients are transitioned back to their GP for ongoing management.

In parallel, the program invests in clinician capability building. This includes a community of practice focused on chronic disease topics, and protected time for Nurse Care Coordinators and GPs to strengthen care coordination and chronic disease management skills. The program also promotes multidisciplinary team care within general practice, fostering collaboration among Nurse Care Coordinators, Practice Nurses, GPs, and allied health professionals.

## Evaluation goals and approach

In FY 2024–25, EMPHN undertook two key evaluation activities to assess the program's sustainability and cost-effectiveness:

1. **Sustainability Evaluation**
   - Identify the costs associated with the program and relevant benchmarks.
   - Explore recommended changes that could enhance sustainability within general practice settings.
   - Determine how such changes could be implemented within existing funding models.
2. **Economic Evaluation Strategy**
   - This strategy was developed to guide future assessments of the program's cost-effectiveness in improving patient outcomes. The recommended approach informed the design of the FY 2025–26 evaluation.
   - Both evaluations were designed to support continuous improvement, financial viability, and scalability of the RCBH program.

## Evaluation learnings

**The program strengthens clinician capability and patient support**

- RCBH has demonstrated success in building capability among general practice staff, particularly Practice Nurses and GPs. Clinicians reported increased confidence in managing chronic conditions and coordinating care.
- Patients with chronic health conditions expressed feeling more supported and better equipped to manage their health, contributing to improved health literacy and engagement.

**Continuous improvement mechanisms are effective**

- Program logic co-design with service providers and regular workshops enabled refinement of reporting templates and service delivery models.
- Patient criteria were updated to focus on frequent hospital users with cardiovascular, respiratory, or frailty-related conditions, ensuring resources were directed to those priority cohorts.
- Data collection enhancements included tracking GP visits, ED presentations, outreach travel time, and reasons for patient withdrawal.
- Reporting templates were refined to reduce duplication and improve clarity.
- Socioeconomic profiling was introduced using Health Care Card status as a proxy, with further refinements underway.
- Practice Nurse had influence over their own capability building in the form of co-design.
- Community of Practice sessions provided ongoing input into program design and delivery.
- Contract extensions reflected updated expectations and deliverables for practices and providers.

**Data collection inconsistencies limited evaluation depth**

- While PROMs and PREMs were used to assess patient outcomes, inconsistent data collection across practices and providers posed challenges. Gaps were identified in tracking patient withdrawals, referral pathways, and care plan overlaps. These limitations hindered the ability to assess the program's impact and cost-effectiveness fully.

**Provider and participant engagement remains a challenge**

- Some providers faced challenges that limited their ability to engage fully with the program. Similarly, patient enrolment and sustained engagement were variable, particularly among those with complex needs. These factors influenced program reach and effectiveness.

The FY 2025–26 evaluation will assess:

- Whether RCBH is cost-effective and appropriately targets patients most in need.
- Elements that support sustainable implementation.
- Program scalability and performance using the RE-AIM framework (Reach, Effectiveness, Adoption, Implementation, and Maintenance).

# The Vulnerable Vaccination Program identifies and engages with at-risk communities to increase COVID-19 and influenza vaccination rates

| Evaluation focus | **Process**<br>**Outcome** |
|---|---|

**Program description**

In 2024, as part of the Australian Government's Vaccination of Vulnerable Populations (VVP) program, EMPHN provided funding support for general practices and community pharmacies to actively engage with at-risk communities, increasing the uptake of COVID-19 and influenza vaccinations.

The VVP targeted individuals who face barriers to accessing routine vaccination services.

This included:

- People experiencing homelessness
- those without Medicare access
- Individuals with disabilities
- Older adults aged 65+
- First Nations Peoples
- Culturally and linguistically diverse communities (including asylum seekers and refugees)
- Children aged 5–11 with complex needs
- homebound individuals
- residents of Residential Aged Care Homes (RACHs)
- other groups identified as requiring dedicated support.

The 6-month program was designed with three arms:

1. General practice and pharmacy vaccination hubs – 8 general practices and 5 pharmacies across each EMPHN Local Government Area were awarded grants to deliver vaccinations and outreach activities
2. Victorian state-wide COVID-19 campaign – EMPHN contributed multimedia assets (e.g. video, posters, postcards, press ads and social ads) to a PHN-wide campaign encouraging vulnerable individuals to stay up to date with COVID-19 vaccinations
3. Nurse-immuniser scholarships – scholarships were awarded to general practice nurses to undertake accredited nurse-immuniser training, enhancing general practice capacity to deliver vaccinations

Each hub committed to:

- proactive outreach
- database searches

- referrals
- on-site and off-site clinics
- RACH and homebound visits
- pop-up information stalls
- sensory clinics
- education activities
- promotional efforts.

Vaccination records were uploaded to the Australian Immunisation Register (AIR), and providers submitted monthly reports and case studies.

## Evaluation approach

The evaluation aimed to determine whether the VVP met its objectives to:

1. Actively engage with vulnerable communities and provide tailored vaccinations.
2. Provide information and support to vulnerable patients.
3. Improve access to COVID-19 and influenza vaccinations for vulnerable populations.

Evaluation included consumer and provider components:

- Consumers provided feedback via a pharmacy vaccination hub questionnaire.
- Providers completed monthly reporting and case studies with activities and data undertaken.

## Program learnings

**The VVP engaged with vulnerable communities to provide vaccinations, information and support**

- 2,608 COVID-19 and 903 influenza vaccines administered. Conducted 110 on-site and 109 off-site vaccination activities.
- 21% survey respondents (n=87) lacked a regular GP. 71% preferred pharmacies for convenience and 41% received vaccines based on pharmacist recommendation.
- High demand for nurse-immuniser scholarships resulted in 40 scholarships offered.

**Vaccination benefits for vulnerable communities motivated provider participation and outreach efforts**

- Education and information sharing helped these communities to understand the importance of vaccination and where they could access it.
- Outreach efforts also connected individuals with services that could meet their broader health needs, helping to build trust and improve engagement with healthcare providers.
- No-cost access with health professionals who can speak their language encouraged them to seek this service.
- The program connected individuals with broader health services, improving overall health system navigation.
- Empowering local stakeholders to design outreach activities enhanced program relevance and uptake.

**Rapid changes in the COVID-19 landscape is a barrier to the program**

- Vaccination demands were reducing due to lower statewide COVID-19 hospitalisation rates and people becoming complacent and fatigued about the perceived need, risks, and benefits of vaccination.
- Assertive outreach fatigue was reported by providers and communities.

# Monitoring and evaluation focus for the future

## Shaping a Consistent Approach

EMPHN has moved from design to active implementation. Our updated Monitoring and Evaluation Framework serves as the foundation for a consistent and practical approach to evaluation across the organisation. Guided by our strategic priorities and new ways of working, the Framework will shape how we collaborate, make decisions, and drive continuous improvement.

The four case studies helped us refine the Framework, offering practical insights on how to strengthen its application and laying the groundwork for embedding it successfully across all EMPHN programs and functions.

### 1. Towards a Unified and Effective Health Future

We are evolving to serve communities across our catchment better.

Our transformation is anchored in three strategic pillars: Shared Purpose, where our teams align around a clear mission and deliver consistent, community-focused services; Greater Efficiency, which ensures collaborative, streamlined operations that are adaptable to change; and Impactful Outcomes, where every action is connected to measurable improvements in health and wellbeing.

These pillars reflect our commitment to working smarter and more cohesively with partners to drive meaningful change in the health system.

### 2. Data-driven evaluation

Evaluation will be guided by evidence and supported by EMPHN's Data and Insights Toolkit.

Standardised indicators, performance metrics, and value-for-money analysis will enable consistent tracking of outcomes across programs.

This ensures comparability, strengthens accountability, and supports strategic investment decisions.

### 3. Stakeholder-Informed evaluation

Evaluation will be co-designed with input from providers, consumers, and partners.

By embedding stakeholder perspectives, EMPHN ensures evaluation findings are contextually informed, meaningful, contribute to continuous improvement and more importantly, meet the needs of our community.

At its core, the Monitoring and Evaluation Framework is about more than tracking progress—it ensures we improve community health in the most cost-effective way, investing responsibly and directing resources where they are needed most.

In doing so, we advance our strategic priorities—driving equitable access and outcomes, connecting partners and communities to enable integration and change, and leveraging insights to improve outcomes, drive value, and demonstrate impact. This keeps us firmly aligned with our mission of delivering better health for the people we serve.