Annual Report 2023-24

Shaping health services for the future

phn
EASTERN MELBOURNE

An Australian Government Initiative

Acknowledgements

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

Eastern Melbourne PHN (EMPHN) 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.

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A message from our Board Chair

It's been another big year in the policy environment of PHNs. The Commonwealth government has started to roll out the policy directions of the Strengthening Medicare taskforce with the launch of MyMedicare. Although the value proposition for signing up is not clear, 372 out of the 444 practices in this PHN are on board.

A Discussion Paper from the review of general practice incentives outlined how new funding for multi-disciplinary teams would work, whereby practices signed up to MyMedicare would be eligible for a payment to allow them to establish teams comprised of a range of health professionals and others, including peer workers. If implemented, these changes will lead to an enhanced role for PHNs in supporting and monitoring the transition. Another review which will affect primary care is looking at scope of practice and is expected to recommend a wide range of policy changes to allow health professionals to fulfil a broader role, removing some legislative constraints.

I made representations to the State Treasurer about changes to payroll tax and, although not everything I proposed was taken on board of course, revisions to the rules appear to protect bulk-billing. The payroll tax threat, however, seems to have stimulated changes to contractual forms in some practices - general practitioners becoming tenants - which in my view is not good for long term holistic care for a community.

The scope of practice changes will lead to a very different primary care system a decade from now. We will see a mix of styles of provision and care, some general practices will look like they do now, some will have a much greater proportion of other professionals in the practice (as community health centres do already), some will be led by nurse practitioners, and some might be an avatar, although the latter is a bit speculative. The local pharmacy will be a source of care for a wider range of conditions than it is now.

EMPHN's environment is changing and so too are we. We're focusing on improving our processes and ensuring we are delivering value for taxpayer money.

I'd like to thank the Board and staff for their engagement, support and commitment to ensuring we make a positive impact on care provision in Eastern Melbourne over the past year.

Dr Stephen Duckett AM
Board Chair

Note, the views expressed here are my own.

A message from our CEO

As Eastern Melbourne Primary Health Network's (EMPHN) CEO, I am proud of the progress made in the last financial year. I am grateful to work with a dedicated team of staff members, as well as our partners and stakeholders, who have all contributed to the year's outcomes.

Over this last year, we've had a strong focus on stepping out and forward to engage far more proactively with our stakeholders and partners in the east and north-east of Melbourne.

We have worked hard to become more outcomes-focused, and value-for-money driven in the way we consider the commissioning we undertake. This will continue into future years as we work collaboratively with our partners to innovate and build on the ways we can serve the communities most in need.

The success of our work and our commissioning activity relies on strong and impactful relationships with our healthcare system partners and our provider network. In the last year, we have placed an even stronger emphasis on working with these key partners to provide insights that inform our work. We revitalized, rebuilt and renamed the Clinical and Practice Council – now consisting of multi-disciplinary professionals – as well as the Consumer and Community Council, who bring their deep lived experience and expertise to our work. I would like to take this opportunity to thank them for their contribution to the work of our team over this year.

At a First Nations forum held in August, EMPHN committed to establishing a First Nations Reference Group that would work to support a self-determined future and do its part in Closing the Gap.

Comprising of the Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Community Controlled Organisations (ACCOs) within the EMPHN catchment, this group will lead the development of an EMPHN First Nations health and wellbeing strategy and roadmap to self-determination. The commencement of the 2023-24 year saw the delivery of the first phase of the Federal Government's Strengthening Medicare reforms aimed at embedding the relationship between patients, their general practice and other primary care providers. EMPHN supported general practices to register with MyMedicare, while providing training and information towards better understanding of the program and patient registration process. Through this work, we are well positioned to deliver on the next phase of the scheme, General Practice in Aged Care Incentive (GPACI).

Our work in primary care continues to facilitate the accessibility and quality of primary health care delivered by general practices through educational initiatives, training programs, and the implementation of digital health initiatives. We continued to promote and improve the uptake of practice accreditation and reaccreditation, with 85% of practices in the catchment now being accredited. We also supported enhanced primary care and early intervention services for priority communities. A policy and funding focus on women's health enabled EMPHN to establish two targeted Endometriosis and Pelvic Pain specialised clinics (Epping and Ringwood) to reduce delays in diagnosis, and to promote early intervention, care and treatment for women experiencing the effects of endometriosis and pelvic pain. In the area of youth mental health, EMPHN established its seventh headspace youth mental health service (the fifth headspace service centre, as well as two satellite services), which was launched in Box Hill to meet the needs of the culturally diverse young people within Whitehorse, Manningham and Boroondara.

Our role as integrators and connectors was in focus via several events bringing together key stakeholders to hear about developments in the health sector. This included, in December, hosting the first of an Innovation Series; Breakfast with Dr Kate Taylor, recognised as one of Telstra Health's Brilliant Women in Digital Health, and in May, A Conversation with Deputy Secretary, Community Health at the Victorian Department of Health, Professor Zoe Wainer.

In the final year of delivery of our **2020 - 2025 Strategic Plan**, we embarked on a process to develop our new plan for 2025 and beyond. This significant piece of work provided an important opportunity for EMPHN to critically examine its environment and to ensure that our plans are aligned and responsive to community need and reflective of the substantial changes occurring in the primary care sector.

Our achievements this year reflect the commitment of our team, the strength of our partnerships, and the effectiveness of our strategic initiatives. No doubt, in a constantly changing system facing ever increasing demands, there is more to do. However, our team has worked diligently all year to deliver what's documented in this Annual Report. Together with the Executive team, I express gratitude for their mutual support, dedication to primary care, and service to the community.

Janine Wilson
CEO

Eastern Melbourne PHN's executive team

Janine Wilson
Chief Executive Officer

Janine is an accomplished executive with 25 years' experience in the health sector, where she has held strategic, operational, marketing and general management roles. Prior to joining EMPHN on 1 June 2020, she oversaw the establishment and ongoing operation of Telstra Health's National Cancer Screening Register (NCSR), operated on behalf of the Commonwealth Department of Health and supporting screening for cervical and bowel cancer. Prior to her tenure with Telstra Health, Janine held a number of executive roles with the Australian Red Cross Blood Service (now "Lifeblood") and in the American healthcare system as Director of Strategy for the New York Blood Center. Janine holds an MBA from Melbourne Business School, where she was the recipient of the Helen McPherson-Smith Scholarship.

Narelle Quinn
Executive Director, Primary Care Innovation and Development

With an extensive operational background in the primary care sector, Narelle is a strategic thinker and leader, gifted in developing capacity within internal teams and the wider health care sector. With more than 19 years' experience in the Primary Health Care sector, Narelle understands the intricacies of the end-to-end commissioning cycle and can skillfully leverage its capacity to affect real and positive change to realise optimum patient-centred services delivering better outcomes for health consumers in the EMPHN catchment.

Jane London
Executive Director, Strategy and Service Design

Jane is a behavioural scientist with over 20 years' experience in guideline development and delivering complex multi-faceted behaviour change programs in healthcare. Experienced in designing and delivering focused change programs to both clinicians and healthcare consumers in over 17 therapeutic areas, Jane has designed programs that have resulted in over $120M YOY in medicines adoption. Jane's areas of expertise are using applied behavioural models in healthcare, and the design and implementation of data driven interventions. She is a Board member of the Audit and Feedback MetaLab - an international group of researchers who seek to build the science around use of data to change clinical behaviour, and is a published author in the area. Having previously held senior management positions at the Royal Australian College of GPs, Royal Australian and New Zealand College of Psychiatrists and NPS MedicineWise, Jane understands the real-world barriers faced by different players in the health system when trying to create sustained change.

Natasha Levy
Executive Director, Communications and Engagement

Natasha brings 25 years' of experience working across the full spectrum of marketing, communications and engagement with a focus on behaviour change in the health sector. Prior to her most recent stint in the corporate world, Natasha spent 10 years leading marketing, communication and engagement functions in the health sector, including five years on the agency side, as Group Account Director, Health for Fenton Communications, with clients in Federal and State government, hospitals, diabetes, cancer screening and not for profits. She has led marketing and communication functions at BreastScreen Victoria, VicHealth and Red Cross Blood Service before joining Specsavers where she led the marketing strategy and implementation for audiology, launching it into the Australian market. She also held global and general business management roles in her six years with Specsavers. Natasha started her working life as a writer and is passionate about work that makes a difference to the health and wellbeing of our community.

Also serving as an Executive Director during 2023 – 2024:
Dinah Rowe-Roberts, Chief Operating Officer

Eastern Melbourne PHN's board

Eastern Melbourne PHN is governed by a Board in accordance with its Constitution.

Dr Stephen Duckett AM
Board Chair; Chair, Nomination, Remuneration and People Committee; Member, Strategy and Risk Committee; Member, Clinical and Practice Council; Member, Community and Consumer Council

Stephen Duckett has a reputation for creativity, evidence-based innovation and reform in health care. An economist, he is a Fellow of the Academy of the Social Sciences in Australia, the Australian Academy of Health and Medical Sciences, and the Australian Institute of Company Directors. He is an Honorary Enterprise Professor in the School of Population and Global Health and in the Department of General Practice and Primary Care in The University of Melbourne. In 2023 he was a member of the Strengthening Medicare Task Force and the Mental Health Reform Group (both chaired by Minister Mark Butler). He is currently a member of the Expert Advisory Panel for the Review of General Practice Incentives.

Dr Kelly Huang
Board Member; Member, Strategy and Risk Committee; Member, Clinical and Practice Council

Kelly Huang is a practising General Practitioner, who has extensive experience working with diverse communities across both primary and tertiary health care services. She is a Graduate of the Australian Institute of Company Directors as well as a Medical Educator for the Royal Australian College of General Practitioners. She is passionate about advancing the future of primary care and driving positive change for our wider community.

Robyn Batten AM
Deputy Board Chair; Member, Nomination, Remuneration and People Committee

Robyn Batten has held CEO and executive director positions in health, local government, community and aged care in Victoria, South Australia, Queensland and the Northern Territory. Robyn served as the Chair of Western Health and as a non-executive director of Uniting Victoria and Tasmania. Currently Robyn is the Executive Chair of Leap in! and the Vice-Chair of MIM China Pty Ltd. Robyn has a Bachelor and Masters of Social Work, a Masters of Business Administration and is a Fellow of the Australian Institute of Company Directors.

Associate Professor Dr Caroline Johnson
Board Member; Chair, Strategy and Risk Committee; Chair, Clinical and Practice Council

Caroline Johnson is a General Practitioner who has worked in EMPHN's catchment for over 25 years. She is an Associate Professor in the Department of General Practice and Primary Care at the University of Melbourne, with current roles as Director of Teaching and Learning, membership of the Primary Care Mental Health research team and Associate Investigator with the Alive National Centre for Mental Health Research Translation. Caroline is also co-director of Clinician-Educator Pathways for the Melbourne Medical School and is actively involved in mental health advocacy via the RACGP.

Chris Altis
Board Member; Member, Strategy and Risk Committee; Chair, Community and Consumer Council

Chris Altis holds Bachelor of Commerce and Master of Arts (Public Policy) degrees from the University of Melbourne and is a Graduate of the Australian Institute of Company Directors. He has worked in the health sector for thirty years in a policy, advisory and non-executive capacity at Victorian and national levels. As then Chair of the North Richmond Community Health Service he oversaw the establishment of Melbourne's first medically supervised injecting facility, and he was formerly a director of the Northern Melbourne Medicare Local. He was also the founding Executive Manager of The New Daily national online news service. Chris is also a non-executive director at the Peter MacCallum Cancer Centre and the William Angliss Institute and consults in health policy.

Jason Mifsud
Board Member; Member, Finance, Audit and Value Committee; Member, Community and Consumer Council

Jason Mifsud is a proud and active member of the Kirrae Wurrung, Peek Wurrung and Tjab Wurrung people of the Gunditjmara nation in south-west Victoria. He is an experienced non-executive Director and is known as a forward thinker and visionary having led significant cultural and organisational change through a number of high-profile positions over the past 20 years. Jason is currently the Head of First Nations Affairs and Enterprise at Wesfarmers, and his career has been underpinned by fearless leadership and tireless advocacy and negotiation of social justice outcomes, Indigenous rights, and reconciliation.

Justine Raczkowski
Board Member; Member, Finance, Audit and Value Committee

Justine Raczkowski is a senior lawyer with over 25 years' legal experience. She is currently a Principal at Health Law Partners Pty Ltd where she advises public and private healthcare organisations, aged care and general practitioners. Prior to Health Law Partners, Justine held General Counsel and Senior Legal Counsel roles at The Royal Victorian Eye and Ear Hospital, The Royal Children's Hospital, Zenitas Healthcare and Healthscope, and also read at the Victorian Bar with Dr Ian Freckleton AO KC. With a Master of Laws from the University of Melbourne and a Bachelor of Arts/Laws from Monash University, Justine is passionate about supporting the delivery of world-class healthcare for all Victorians and has a particular interest in children's health, mental health, healthcare innovation and problem solving.

Taryn Rulton
Board Member; Chair, Finance, Audit and Value Committee

Taryn Rulton has held executive roles in health, emergency services, State Treasury and education. In addition to her executive role, she is a non-executive Director of Possability Group and the International Federation of Accountants and chairs the Victorian Electoral Commission's Audit and Risk Committee. Taryn is a graduate of the Australian Institute of Company Directors and a Fellow of both Chartered Accountants ANZ and CPA Australia. Taryn is committed to improving outcomes for vulnerable people through ensuring effective use of public funding.

Also serving as directors during 2023-2024:

Tim Flowers
Board Member; Chair, Finance, Audit and Value Committee; Chair, Community & Consumer Council (retired December 2023)

Elizabeth Kennedy
Board Member; Member, Finance, Audit and Value Committee (retired November 2023)

Terry Symonds
Board Member; Chair, Strategy and Risk Committee (retired February 2024)

Independent Committee Members

Anne Heyes
Member, Nomination, Remuneration and People Committee

Anne Heyes has over 35 years' of experience in human resources having worked in Private Enterprise (Bank of Melbourne/ Westpac, Coles Myer), Public Enterprise (Telecom, OTC, Sydney Waterboard, the City of Melbourne and the Victorian Workcover Authority) and more recently in the NFP sector heading up the People and Culture function for the Australian Red Cross Blood Service. She has lead HR functions and been part of the Executive team for the last 20 years, guiding organisations through transformational and cultural change in response to ever-changing market conditions. More recently Anne has transitioned from full-time employment to a portfolio career including consultancy services. Anne holds a Bachelor of Arts (Honours) from the University of Sydney and a Master of Commerce from UNSW Sydney.

Andrew Saunders
Member, Strategy and Risk Committee; Member, Finance, Audit and Value Committee

Andrew Saunders has a background in leading major business transformations leveraging digital technology in Health, Government and the Financial Services sector, and has a professional background in strategic planning, corporate governance, digital enablement, change management, risk management and benefits realisation. He was previously the Health Chief Information Officer and Director of Digital Health for the Victorian Department of Health & Human Services. Andrew is currently a Board Director for Eastern Health and Chair of its Community Advisory Committee; a Board Director for Victorian Legal Aid and Chair of its Audit & Risk Committee; a Board Director for Care Connect and Chair of its ICT Committee; and an independent Committee member for Health Share Victoria.

Gabrielle Bell
Member, Nomination, Remuneration and People Committee

Gabrielle is a corporate lawyer with broad experience working in Australia and Southeast Asia. During her legal career, she has specialised in corporate advisory, including corporate governance, mergers and acquisitions and capital markets. She is an experienced non-executive Director and Company Secretary, and is currently also serving on the boards of Yarra Valley Water Corporation, BCI Minerals Ltd and Aware Real Estate Management Pty Ltd. Gabrielle holds a Bachelor of Law and Bachelor of Engineering (Chemical) from the University of Melbourne and is a graduate of the Australian Institute of Company Directors.

Our Advisory Groups

We value the knowledge, perspectives, and backgrounds of people involved in both providing and using primary healthcare services within the eastern and north-eastern Melbourne catchment. The Community and Consumer Council and the Clinical and Practice Council are advisory groups to the Board and provide critical input into EMPHN's strategy, work planning and evaluation.

Clinical and Practice Council

Our Clinical and Practice Council is comprised of clinicians and health professionals across the full spectrum of health care. This includes general practice, pharmacy, nursing and allied health. The Clinical and Practice Council plays a pivotal role in advising and assisting us to effectively listen to and respond to our community's priorities and concerns.

Clinical and Practice Council members:

- Associate Professor Dr Caroline Johnson
- Dr Stephen Duckett AM
- Dr Kelly Huang
- Lauren Barker
- Dr Malcolm Clark
- Dr Penny Gaskell
- Dr Sunny Krishna
- Cathy Ngo
- Kylie Payne
- Dr Pallavi Prathivadi
- Cass Quilty
- Dr Tamsin Short

Also serving on the Clinical and Practice Council during 2023-2024:

Dr Emrana Alavi, Dr Shelly McIlree, Dr Dean Membrey and Andrew Robinson.

Community and Consumer Council

Our Community and Consumer Council is an active group of people with diverse experience, who provide subject matter expertise, insights and advice to support our organisation's strategy and the way in which we design our services.

Community and Consumer Council members:

- Chris Altis
- Dr Stephen Duckett AM
- Jason Mifsud
- Sophy Athan
- Katherine Cummings
- Judith Drake
- Adrian Feegar
- Lara Gliana
- William Lau
- Deanne McKenzie
- Heather McMinn
- Hamish Russell
- Kirsty Young

Also serving on the Community and Consumer Council during 2023-2024:

Tim Flowers, Wina Kung, Marie Piu and Amelia Walters.

The people who live in EMPHN's region are from a diverse mix of ethnicities and socio-economic backgrounds with a wide range of health needs that require a targeted primary health response.

1.62M
people in the EMPHN catchment

205
different languages spoken at home

Source: ABS census data, 2021

Eastern Melbourne PHN's community

The east and north-east of Melbourne catchment spans nearly 4,000 square kilometers, encompassing a mix of urban, suburban, and semi-rural communities across a diverse region of Victoria.

Our community is also growing. By 2030, EMPHN's population is projected to increase by 22% to approximately 1.9 million people, one of the largest growth corridors in the country.

The region is marked by a blend of densely populated urban areas, growing suburban developments, and expansive natural landscapes, offering a wide range of community needs and healthcare challenges.

How we work

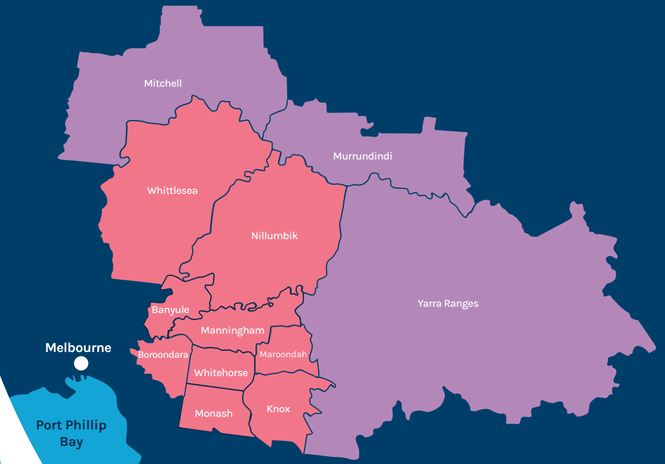
We work across all or part of the 12 local government areas (LGAs) below.

These LGAs are entirely within EMPHN's catchment:

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

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)



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

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

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

Within the community that EMPHN operates, there is:

18.6% estimated people living with **one** health condition*

2.5% estimated people living with **three or more** chronic conditions*

The top three chronic conditions within the catchment are*	Highest prevalence within the EMPHN catchment*	
Mental health conditions (an average of **8.3%** across the catchment)	Yarra Ranges	10.4%
	Mitchell	10.2%
	Murrindindi	10.1%
Asthma (an average of **7.9%** across the catchment)	Mitchell	9.9%
	Yarra Ranges	9.1%
	Murrindindi	9.5%
Arthritis (an average of **8.2%** across the catchment)	Mitchell	9.8%
	Murrindindi	9.5%
	Yarra Ranges	9.6%

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

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

*ABS census data, 2021

The role of EMPHN

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 poorer 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 the 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 the 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.

EMPHN is committed to Closing the Gap in health outcomes for **Aboriginal people** in the community by enabling self-determination and elevating the community's voice.

Aboriginal and Torres Strait Islander health

EMPHN recognises the importance of working with Aboriginal and Torres Strait Islander communities to close the still significant gap in health outcomes.

EMPHN has been on a journey to work towards improved Aboriginal and Torres Strait Islander health outcomes in a way that aligns with State and Federal Government approaches – with community, for community.

EMPHN has supported the development and expansion of Aboriginal Community Controlled services across the region. The organisation has started to build deeper relationships with the key communities within the catchment and recognise that this requires a long-term commitment.

A pathway towards self-determination

Transition to a community-driven approach

This year, EMPHN transitioned from a Reconcilliation Action Plan (RAP) to a community driven approach. The organisation established a First Nations reference group made up of Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Community Controlled Organisations (ACCHOs) within the EMPHN catchment.

The group will play a pivotal role in developing an Aboriginal Health and Wellbeing Strategy and roadmap to self-determination.

The work of the group builds on the foundations established by EMPHN's Reconciliation Action Plan Steering Committee and expands the scope included in the Reconciliation Action Plan (RAP). This new approach marks a significant shift in approach and underscores EMPHN's commitment to closing the gap, the right of Indigenous self-determination, and the community voice at the centre of planning.

Aboriginal and Torres Strait Islander programs:

- Providing wrap-around, whole-of-life, support services for children and families at **Bubup Wilam Child and Family Centre**, which builds on strengths and supports children to have the best start to life during their most formative years.
- Working with **Oonah Health and Community Services Aboriginal Corporation** to provide access to a range of culturally safe services. These services support First Nations communities through community engagement and cultural connection. Services include youth programs, outreach, social and emotional wellbeing supports and outreach support for self-medication and substance use issues.
- Providing holistic, responsive mental health support with **Banyule Community Health** through their Psychological Support program. This flexible model has been designed to support clients in a culturally specific and safe environment, providing case management and care co-ordination, as well as running cultural groups such as the Heart and Soul group, the Djiak Djirri Playgroup and a FoodShare program.
- Providing **cultural training** for primary care on improving services to provide better access, utilisation and outcomes for Aboriginal and Torres Strait Islander peoples.
- **Working with Community to navigate access** to after-hours primary care, cancer screening and childhood immunisation services.
- **Working with mainstream services to develop culturally safe services** that meet Aboriginal and Torres Strait Islander Peoples' expectations.
- Supporting eligible First Nations People with chronic diseases to be active participants in their care plan to improve their overall health and wellbeing through the **Integrated Team Care Program**.

CASE STUDY

The Integrated Team Care Program

Over 10,000 Aboriginal and Torres Strait Islander Peoples live in the catchment in which EMPHN operates*.

The Integrated Team Care (ITC) Program, funded by EMPHN and delivered by EACH, supports Aboriginal and Torres Strait Islander Peoples in the community with complex and chronic conditions through personalised care coordination.

Linda**, a 39-year-old Aboriginal woman from the outer eastern suburbs, is one of the many community members who has benefited from the delivery of the ITC program.

Linda lives with chronic and complex conditions, including an ovarian cancer diagnosis in 2021, early onset menopause, lumbar spinal stenosis with nerve compression due to radiation treatment, chronic back pain and impaired mobility. She has also been impacted by domestic violence, resulting in a frozen shoulder, and suffers from mental health concerns such as post-traumatic stress disorder (PTSD), anxiety and depression.

After visiting an Aboriginal GP clinic, an Aboriginal and Torres Strait Islander Peoples Health Assessment was conducted, which helped the GP determine that she could benefit from care coordination. Linda was referred to the Ngarrang Gulinj-al Boordup (NGB) team at EACH, who are part of the ITC program.

Upon assessment, it was found that Linda was receiving care from various services but had missed many appointments and needed help reconnecting. She was assigned a nurse coordinator and outreach worker to help with ongoing engagement. Over six months, the team helped Linda organise and attend several appointments, including with a spinal orthopaedic surgeon, an oncologist for review, an orthopaedic surgeon for steroid injections to her shoulder, access to the Ambulatory Pain Management service, a podiatry assessment with funded orthotics, an exercise physiologist, access to hydrotherapy, acupuncture, a physiotherapist, and a pain management practitioner for medical marijuana.

Over three months, Linda developed a trusting relationship with the NGB team and disclosed ongoing family violence and safety concerns for herself and her children. She requested individual and family counselling, and her nurse coordinator referred her to Boorndawan Wilam Aboriginal Healing Service, which provides culturally relevant programs for those affected by family violence. A referral was also made to Oonah Aboriginal Health and Community Services, where a mental health nurse began supporting Linda.

Recognising Linda's need for alternative housing, her outreach worker referred her to Ngwala Willumbong Aboriginal Corporation for housing support and assisted with applications to Centrelink and the National Disability Insurance Scheme (NDIS) for ongoing funding. Since Linda does not drive, the NGB team also organised transport for her health appointments to maintain continuity of care.

Since joining the program, Linda has accessed services to address her chronic and complex needs in a supportive and culturally safe environment. With the right services and health professionals in place, the NGB team have continued to support Linda in meeting her health goals, managing her conditions, and gaining more independence in the community.

*ABS census data, 2021
**Name changed to protect identity

Chronic and complex health conditions

Chronic conditions can affect individuals throughout their lives, requiring long-term management by the individual and their carers, as well as ongoing and proactive support from a team of health professionals.

If not managed well, chronic conditions can lead to serious consequences or disability and typically cause a deterioration in well-being as people age.

Chronic and complex health conditions are a growing focus for the catchment in which EMPHN operates. Data shows that an estimated 38,432 people in the catchment live with three or more chronic conditions.*

Chronic conditions, such as arthritis and asthma, are also more prevalent in the EMPHN catchment community than the state average.* We prioritise consumers with high-complexity health needs within the region and work with community members and service providers to design and commission effective and responsive health services. Through early intervention, care coordination and multidisciplinary approaches, and by promoting equity of access outcomes, this area of our work supports effective condition management and can prevent hospital admissions.

*ABS census data, 2021

Programs EMPHN funds for chronic and complex care:

Breathe Easy

Delivered by Banyule Community Health, the Breathe Easy program used a human-centered approach to reduce avoidable ED presentations of Chronic Obstructive Pulmonary Disorders (COPD). The program focused on coordinated care for people with COPD, following best practice guidelines to improve experience, health outcomes, and quality of life.

Musculoskeletal wellness

Delivered by Northern Health, this program was designed for patients in the community with painful hip and knee osteoarthritis who were referred for specialist orthopaedic input. The program optimised a multi-disciplinary approach to improve care, reduce waitlist times, enhance patient outcomes and improve quality of life.

160
patients had completed the program

Right Care Better Health

Delivered by nurse care coordinators from EACH in selected general practices in eastern Melbourne, this program focuses on people living with complex long-term health conditions, providing care navigation and coaching to improve health outcomes and help lower the risk of hospitalisation.

95%
of patients had a positive experience of the Right Care Better Health Program

70%
of patients had increased confidence with managing their chronic condition

CASE STUDY

Right Care Better Health

Within the catchment, there are approximately 129,000 people living alone*, and an estimated 38,432 people living with three or more chronic conditions*. Living alone can be challenging, especially when you are living with complex conditions that require compassionate, multidisciplinary care. This is the case for Ravi, an 86- year-old living in the catchment with a complex history of health issues.

Ravi** lives with lymphoedema, hypertension, GORD, hypercholesterolemia, and bowel cancer. Recently, he was admitted to the hospital for pneumonia and received new diagnoses of atrial fibrillation and heart failure. Ravi has also struggled with his mental health since his daughter passed away several years ago, which impacted him greatly.

Given the complexity of Ravi's physical and mental health, his GP referred him to the Right Care Better Health program. Funded by EMPHN and delivered by EACH, the program provides wrap-around services to support people in the region with chronic and complex conditions, aiming to improve quality of life and lower rates of avoidable hospital admissions.

Ravi was assigned an EACH nurse care coordinator, who visited him at home. The nurse identified that despite a home care package and domestic support already in place, there were some areas that could be improved so that Ravi could live a healthier life at home and be armed with the information he needed to manage is complex conditions.

Upon his initial assessment, it was determined that Ravi's main areas of concern were his mobility, confusion about his recent diagnosis of heart failure and how to manage the condition, difficulty using steps at his home to access the garden, and difficulty accessing transport to appointments.

During his four months with the Right Care Better Health Program, the nurse care coordinator worked closely with a multidisciplinary team to organise several referrals, appointments and education sessions, to help Ravi feel empowered at home.

This first involved the recommendation of a 75+ Health Assessment, which gave valuable insight into how Ravi was managing at home to his GP, who could utilise this as a baseline for future comparisons.

A referral was then organised by the nurse care coordinator for a Home Medication Review, which enabled a better understanding of medications for Ravi.

Due to Ravi's recent diagnosis of atrial fibrillation and heart failure, the nurse care coordinator also liaised with Ravi's GP for a cardiology referral and pathology, to ensure he was receiving regular specialist care. On top of this, it was also organised that he receives heart failure education from another Right Care Better Health Nurse with a cardiology background, so that he could be armed and informed with the right knowledge to manage his condition.

Because Ravi did not drive, he had trouble accessing his medical appointments, and faced difficulty getting outside due to his mobility. The nurse care coordinator arranged and assisted Ravi to submit a Multipurpose Taxi Program application and also for an Occupational Therapy assessment for an accessibility ramp outside of his house, which was promptly installed. This access to accessibility allowed Ravi to have physical ease and a sense of independence in his own home.

Recognising that Ravi was living with grief and mental health concerns, the nurse care coordinator also offered referral for a Mental Health Care Plan.

Since joining the program, Ravi has gained a better understanding of his conditions and medication management, connected with specialists and allied health workers, accessed transport for appointments, received mental health support for grief and family concerns, used the accessibility ramp to access his garden, and developed an ongoing plan with his GP.

With the right plan in place and a multidisciplinary team, Ravi's health and wellbeing has been greatly improved to allow him to live a healthier life in his community.

*ABS census data
**Name changed to protect identity

> "I enjoy having the time to thoroughly listen and assess my clients, resulting in a comprehensive care plan that will maximise their health and wellness."
>
> **Nurse Care Coordinator, Right Care Better Health**

EMPHN understands the importance of **mental health services** that focus on individual needs, takes a whole-of-person approach and delivers multidisciplinary care.

Mental health, alcohol, other drugs, and suicide prevention

A large proportion of EMPHN's work is focused on mental health.

Finding the right mental health, alcohol, drug, or suicide prevention service in the catchment is essential to the health needs of the community. EMPHN's goal is to provide care that makes individuals feel heard – and not 'lost in the system'.

Services aim to address each person's individual needs, ensuring patients are at the center of their healthcare, involved in decision-making, and treated with respect and dignity.

It is recognised that the community has a diverse range of needs, which require collaborative support from service partners, general practitioners, specialists, support staff and peer workers.

EMPHN's work across the region involves:

- **Commissioning** - Identifying gaps in services across the region and working with the community to design and fund services that improve care and support.
- **A stepped care approach** - Delivering person-centered care by offering a range of support options.
- **Partnerships and alliances** - Partnering with Local Hospital Networks, peak mental health bodies, community organisations, consumers and carers, and other key stakeholders.

Mental health programs:

Stepped Care Program

The Stepped Care Program, commissioned by EMPHN, aims to ensure those in the catchment experiencing mental health concerns and/or psychological distress, and who are not able to afford or access other services to meet their needs, have equitable access to high quality support so that they could live their lives to their best potential.

> "The holistic support and involvement of external supports helped me to reach my goals."
>
> **Stepped Care client**

Stepped Care encompasses a range of services and care levels delivered locally by multidisciplinary teams from Access Community Health and Banyule Community Health. This includes peer support workers, psychologists, mental health nurses, counsellors, social workers, welfare workers and occupational therapists.

The mental health Stepped Care program also aims to engage with under-represented communities, including children, young people, LGBTIQA+ people, culturally and linguistically diverse people, and Aboriginal and/or Torres Strait Islander people.

1,104 community members received care

21,888 hours of support delivered

Head to Health Hubs

The Head to Health program was the result of a coordinated mental health response to Victoria's second COVID lockdown, offering individual and group-based support via multidisciplinary teams. These teams collaborate with other community-based providers, including GPs, allied health professionals and hospitals. EMPHN's Head to Health services are delivered by Access Health & Community, Inspiro Community Health, healthAbility and Banyule Community Health.

15,291 sessions of support delivered

Head to Health Phone Services

The Head to Health phone service is a national telephone service that supports community members and carers to navigate the right services for their needs, and according to their preferences. The team provide support to consumers, carers, GPs and health professionals in both the EMPHN and Murray PHN catchment areas. The team of clinician and practitioners are experienced mental health professionals, who support consumers to connect with suitable services, appropriate to their needs.

5,657 phone sessions undertaken

Wellbeing and resilience grants

Recognising the impact of natural disasters on mental health, EMPHN provided community grants to fund activities that helped to build resilience, social connectedness and and enhance wellbeing. These grants allowed communities to choose their own responses to these challenges and prepare for future events.

5,320 people attended community events or activities developed and delivered by community partners

Youth mental health services

EMPHN commissions a range of services for young people with mental health issues, alcohol, and other drug issues, taking both a stepped care and whole-of-person approach.

headspace

headspace centres provide early identification, intervention strategies and holistic care for young people aged 12 to 25 years and their families/carers who were at risk or showing early signs of developing mental health, physical health and/or drug and alcohol problems.

EMPHN partners with Access Health and Community (Hawthorn centre), Alfred Health (Syndal centre), EACH (Knox Centre and Lilydale satellite) and Mind Australia Ltd. (Greensborough Centre, Plenty Valley satellite and Box Hill centres). EMPHN was proud to launch an additional service to the community in 2023, with headspace Box Hill opening in December 2023.

17,947
occasions of service provided by headspace

3,781
new young people accessing services within the EMPHN catchment

Enhancing mental health services in secondary schools (EMHSS)

Delivered by Access Health and Community (headspace Hawthorn), Alfred Health (headspace Syndal) and Each Social and Community Health (headspace Knox and headspace satellite Lilydale), the EMHSS program was aimed at young people currently enrolled in secondary schools who would benefit from access to mental health services.

365
young people serviced through the EMHSS program

1,057
sessions delivered

Psychosocial programs

Psychosocial support program

Delivered by Neami National and Wellways Australia in partnership with healthAbility, this program supports people with severe mental illness who were not eligible for the National Disability Insurance Scheme.

The service included helping people build social skills, navigating relationships, managing money, finding for and looking after a home, building skills and qualifications, and developing work goals.

23,331
hours of service delivered

Alcohol and Other Drugs (AOD)

EMPHN's commissioned services aim to reduce harms caused by alcohol, illicit drugs, and prescription medication misuse. Services within the catchment are built on the best available knowledge and involve collaboration with various service partners.

Dual diagnosis and recovery

These programs offer short or long-term one-to-one therapy, peer support or structured recovery groups to individuals struggling with drug or alcohol addiction – who are also experiencing a mental health condition.

In partnership with Anglicare Victoria (eastern Region), the **Dual Diagnosis Program** supported individuals, and their families, to address substance use and their mental health in the community or at inpatient units at Eastern Health. The Dual Diagnosis Program delivered 370 episodes of care and 846 hours of service.

The Hope and Thrive Programs, delivered by EACH, offers short or long-term one-to-one therapy, peer support or structured recovery groups to individuals struggling with drug or alcohol addiction – who were also experiencing a mental health condition.

The Northeast Recovery and Support Program (NeRASP), delivered by Banyule Community Health, provides an eight-week recovery-oriented group program with individual and peer support to enhance AOD treatment outcomes.

825
sessions were delivered to participants by NeRASP

Family Support Programs

The Family Alcohol and Drug Service (FADS), delivered by EACH and Anglicare Victoria (eastern region), supports families with children under 25 facing substance use issues. It also aids individuals affected by a family member's alcohol or drug use. Focusing on harm minimisation and relapse prevention, the program was underpinned by integrated family therapy, including individual counselling and family therapy.

239
Episodes of care and **695** hours of service were delivered

100
people accessed the service

The Family Focus Program, delivered by EACH, provides individual and family counselling, supporting individuals, couples and families with, or connected to, a person with an alcohol and/or drug dependency.

This program focused on comprehensive family-concentrated interventions, assisting to navigate the complexities of mental health crises and substance use disorders.

> "You've been an anchor for us – so important when everything has felt so overwhelming."
>
> **Family Focus Program client**

AOD Primary Health Programs

Delivered by Access Health & Community, the **Medication Support and Recovery Service (MSRS)** addresses prescription or over the counter medication abuse. The service provides individual or family counselling, nursing and withdrawal support, peer support groups, brief interventions and harm reduction services.

73%
of clients interviewed reported greater control over their medication use

82%
of clients interviewed reported increased stability and balance in their lives, such as building routines and self-care practices, financial stability, maintaining employment or completing tertiary study

AOD Relate, delivered by Banyule Community Health, identifies and supports people with complex AOD issues within primary health care. The program offered peer support, dual diagnosis care coordination and psychological intervention, enabling direct client care and secondary consultation.

Youth Alcohol and Other Drugs Programs

Delivered by Youth Projects, the **Youth Northern Outreach Team (YNOT 2.0)** provides personalised, confidential outreach counselling, support, education and referrals for young people with alcohol and/or other drug abuse or dependence issues living in the City of Whittlesea.

52
young people accessed the YNOT 2.0 service

Delivered by EACH, **Yarra Ranges Youth Outreach (YRYO)** is an outreach drug and alcohol counselling service for young people and their families who live in isolated, under-serviced communities in the Yarra Ranges. The service involved individual counselling, AOD education programs in schools, and assistance with referrals to other AOD services as required.

The SHERPA Program, delivered by Youth Support & Advocacy Service (YSAS), offers therapeutic recreation and adventure-based group activities in conjunction with one-on-one case management and care coordination to young people (aged 12-21) experiencing problematic substance use.

56
recreation activities with 158 young people delivered

Also delivered by YSAS, **The Youth Primary Health Support and Coordination Service (YPHSCS)** provides vulnerable young people aged 12-21 with substance use management and holistic treatment. The service involved high-quality, tailored and timely community-based psychosocial support along with safe, supervised and clinically appropriate home-based AOD withdrawal support.

Older persons and palliative care

Older persons

Improving the health and wellbeing of the region's ageing population is a priority area for EMPHN.

EMPHN's commissioning focus seeks to support, improve access to, and coordinate high-quality primary health care for older people living in the community and those living in Residential Aged Care Homes (RACHs).

Through assessment of the health, social and functional needs of our older community members, EMPHN aims to build a sustainable and consumer driven system – delivering more choice, easier access and better care.

In the second year of program delivery within the aged care system, the organisation has partnered with service providers to develop a suite of initiatives to improve services in both aged care and palliative care.

Aged care programs:

Care Finder

The Australian aged care system provides essential support to our ageing population but can be complex to navigate. The Care Finder program specialises in providing intensive assistance to older community members, helping them connect with aged care services and relevant community supports. Care finder is delivered by a range of service partners; including, Care Connect, DPV Health, healthAbility, Migrant Information Centre, Merri Outreach Support Services, the Salvation Army, Villa Maria Catholic Homes, Wintringham, and Housing for the Aged Action Group (HAAG) – intake only.

4,632
people have accessed the Care Finder program

Healthy Ageing Service (HAS)

Delivered in the community by St Vincent's Hospital Melbourne (SVHM), the HAS aims to improve the mental health and quality of life for older adults by providing a mild to moderate response for clients residing in RACHs and older people in the community. An innovative component of this program builds the capacity and capability of RACH staff and GPs to immediately respond to patients experiencing mental health issues, and access to a secondary consultation by the program's psychiatrist for expert advice. The Healthy Ageing Service involves a 'whole-of-person' approach, taking into consideration other support needs, including alcohol and drug treatment, suicide prevention, psychosocial support, housing and physical health.

3,322
HAS program consultations with community members

Enhanced after-hours planning in residential aged care homes

RACH residents can experience rapid health deterioration during the after-hours period, but immediate transfer to hospital is not always clinically necessary. To improve awareness and utilisation of available local out-of-hours services in the community, EMPHN partnered with Ambulance Victoria to provide various educational initiatives related to telehealth and after-hours planning in aged care homes. Along with other PHNs, the After-Hours Toolkit has been developed, a suite of resources to educate RACH staff on practical ways to improve after-hours care and encourage quality improvement in line with aged care reforms.

83
homes within the catchment received in-person education on aspects of the After-Hours Toolkit

Video Telehealth in Residential Aged Care Homes

To support RACH residents in the region with access to appropriate telehealth care, a round of grants was made available to improve facility's devices, video capabilities, infrastructure and minor capital works projects. Grants of up to $20,000 were made available, resulting in 61 facilities being funded to improve telehealth offerings to residents and their health services.

> "Thank you so much for the high-quality care you provided to my father. The support was personalised and practical, and I know that your services contributed to his ability to continue to participate in daily activities and life."
>
> **Family member of HAS client**

Dementia consumer resources

In collaboration with North Western Melbourne PHN (NWMPHN), EMPHN developed dementia resources for people with lived experience of dementia and their support network. These resources aim to help make informed care choices and increase visibility of relevant local services. Resources included information sheets available in five languages, as well as a hub, www.dementiadirectory.org.au, which lists dementia supports and services across the EMPHN and NWMPHN catchments.

Palliative care

Greater Choices for At Home Palliative Care

EMPHN works in partnership with the Eastern Metropolitan Region Palliative Care Consortium, including Eastern Palliative Care (EPC), Eastern Health, St Vincent's Health and Bolton Clarke, along with Banksia Palliative Care, to educate and support palliative care services in primary health and community care. This program aims to raise awareness ensure timely, appropriate care, reducing unnecessary hospital visits. EMPHN continues to work on enhancing the capacity of the primary care workforce and improving coordination between primary care and palliative care providers.

444

general practices
within the catchment

EMPHN's work with primary health care providers supports their capacity to effectively address the needs of the community and improve health outcomes.

Primary care innovation and development

General practices are the cornerstone of primary healthcare in the community.

As we look to improve healthcare services for the future, EMPHN is committed to supporting the enhancement of primary care, with a particular focus on general practice and strengthening primary care systems and capabilities.

EMPHN supports improved accessibility and quality of primary health care delivered by general practices through educational initiatives, training programs, and the implementation of digital health systems. Our work with primary health care providers supports their capacity to effectively address the needs of the community and improve health outcomes.

The organisation's approach involves:

- Collaborating closely with primary care providers to understand and identify their needs and the appropriate supports.
- Delivering training to build capability.
- Equipping primary care providers with innovative tools and resources designed to facilitate the delivery of optimal care practices.

Over the 2023-24 financial year, the EMPHN team have run a number of training events within the catchment to help enhance primary care in general practices. This included:

59
events on a variety of clinical and non-clinical topics

1,885
people in attendance

General Practice Development

Our support for general practice includes:

- Providing tailored support to develop and implement local solutions, to improve care quality and build capacity.
- Promoting and improving the uptake of practice accreditation and assisting practices with reaccreditation.
- Encouraging the engagement, participation and understanding of compliance obligations of general practices in Practice Incentives Programs.
- Supporting practices with the implementation of new government programs and facilitating training events for GPs, nurses, practice managers and administration staff.

Over the year, EMPHN has worked with practices in the catchment to operationalise MyMedicare, the voluntary patient registration model. This model formalises the relationship between patients, their general practice, general practitioner and primary care teams for improved continuity of care.

85%
of EMPHN general practices are accredited in the catchment

84%
of EMPHN general practices are registered for MyMedicare

Digital enablement and Quality Improvement (QI)

Digital health is helping to improve our health system by streamlining referral pathways and providing better integration between services including data capture for improving patient care, electronic health records, electronic referrals, secure messaging between providers, and telehealth. We understand there is an increasing need for smarter solutions that offer people and communities more choice and control over their care and personal information. EMPHN supports practices within the catchment to assist with their digital health for greater integration between services.

Data Analytics (POLAR and Walrus)

Data analytics tools (POLAR and Walrus) extract data from General Practice Clinical Information Systems to improve quality and patient care, and for business development. General practices can employ the tools to analyse their own data and be proactive with at-risk patients who have chronic disease and/or may be at risk of hospitalisation.

POLAR is used to promote health prevention activities such as immunisation, health screening and health assessments. Specific projects maximising these digital tools have enabled planned and effective primary prevention care responses to conditions such as viral hepatitis and liver cancer, reducing patient risk.

83%
of general practices access data analytical services from EMPHN

EMPHN provided support for POLAR and Walrus utilisation, with over
1,269 interactions with practices over the year

Practice Incentive Program Quality Improvement (PIPQI) Incentive

The Practice Incentive Program (PIP) Quality Improvement (QI) Incentive supports general practice in continuous improvement and achieving better health outcomes. EMPHN's QI model guides practices in enhancing data management, improving processes, and positively impacting patient health outcomes. The team mentored and supported practice staff in using their data to identify patients with chronic health needs and implement improvement activities. For example, the Health Assessment Quality Improvement activity delivered from Aug-Oct 2023 revealed that from the 96 participating practices, there was a 30% increase in completed health assessments.

Delivering the Australian Digital Health Agency (ADHA) workplan

By promoting digital health platforms and technology, EMPHN's team facilitate an integrated and connected healthcare system with community practices.

Through collaboration with all Victorian Primary Health Networks, our team co-delivered a series of educational webinars and events to raise awareness and promote digital health platforms such as My Health Record, the new My Health APP, Secure Messaging and Provider Connect Australia. These webinars drew in over 700 attendees, helping to improve the use of digital platforms within the catchment.

General Practice Improvement Support

MyMedicare

MyMedicare is the voluntary patient registration model that aims to strengthen the relationship between patients, their general practice, general practitioners and primary care teams. The EMPHN General Practice Improvement team is supporting general practices within the catchment, providing information and resources to encourage registrations. This information has led to practices having access to incentives to improve patient care, and more information about regular patients, enabling continuity of care.

84% of EMPHN general practices are registered for MyMedicare

Embedding eye health preventive care into primary care

By working with general practices and developing their role in patient eye health management, the EMPHN team assisted in the development of a systematic, cost-effective and sustainable approach to the delivery of preventative eye health care, leading to an increase in eye screening, referral and detection of eye conditions/disease for at risk groups in the community.

Across the five Victorian PHNs who participated in the program:

83%
of participating practices were referring more often to optometry and ophthalmology than before

3,599
patient referrals for an eye assessment

HealthPathways Melbourne

HealthPathways Melbourne is a collaborative online platform between EMPHN and North Western Melbourne Primary Health Network (NWPHN), that provides health practitioners with access to localised assessment, management and referral information for a large number of health conditions. The platform helps GPs make informed decisions with their patients about the care that is right for them. In a survey with EMPHN GPs in 2023, GPs rated HealthPathways as their most preferred channel for pandemic communication.

47%
of GPs recently surveyed reported that HealthPathways improves the referral process

916
clinical and referral pathways covering almost 40 specialties

The Initial Assessment and Referral Decision Support Tool (IAR-DST) for mental health

The IAR-DST assists general practitioners and clinicians to recommend a level of care for a person seeking mental health support. The tool brings together existing assessment results rather than replacing or requiring additional clinical assessment scales and processes. The IAR-DST provides a framework for general practitioners and clinicians to consider a patient's presentation and acts as a prompt for information to gather. EMPHN supports the use of the tool in general practice and the mental health sector by facilitating education, training, and networking.

Doctors in Secondary Schools (DISS)

The DiSS initiative makes sure young people are getting the health support, advice, and treatment they need to reach their full potential. The initiative aims to make primary health care more accessible to students within the school setting, provide support to young people through early identification of health problems and reduce the pressure on working parents. Service partners include headspace (Collingwood, Glenroy, Knox), Canterbury Clinic, Get Well Clinic, Manningham General Practice and Whittlesea Medical Clinic.

1,550
consultations have occurred across the catchment's 12 active schools

Eastern Melbourne General Practice Engagement Alliance

The Eastern Melbourne General Practice Engagement Alliance, a consortium of the six Local Hospital Networks (LHNs) and the north-eastern Public Health Unit, aims to enhance general practice engagement with LHNs to improve clinician experience and patient outcomes. Re-launched in July 2023, the Alliance received funding to expand collaboration opportunities between LHNs and general practices, improve care integration through co-design, and demonstrate leadership in the local health care system. The funding has supported various activities, including GP education by hospital specialists, the establishment of GP reference groups, and direct consultation with GPs at general practices.

Managing patients with heart failure in primary care

Supported by the Victorian Department of Health, EMPHN led a Quality Improvement (QI) project to enhance management of patients with heart failure in primary care. 22 clinics across five PHNs received funding, education, and QI support. Education was provided by cardiologists and a heart failure clinical nurse consultant. The project achieved the primary outcome of improving clinician knowledge and clinic capacity to better assess and manage patients. The education and QI resources will be used to create a learning module for the EMPHN QI website.

CASE STUDY

Collaborating with Dr Dan's Medical Clinic for Quality Improvement in Cervical Cancer Screening

It is estimated that 70% of Australians who develop cervical cancer have either never engaged in screening or are not attending regular screenings.[1]

On top of this, only 37.15% of regular female clients within catchment have an up-to-date cervical screening test record in their GP record within the previous 5 years.[2]

Faced with these challenges, EMPHN created a Cervical Screening Quality Improvement (QI) campaign for general practices within the catchment. This activity provided practical steps and ideas for practice teams to implement improvement activities at their own pace, based on the needs of the practice.

The EMPHN team collaborated with Dr Dan Jeyaseelan, a local general practitioner at Dr Dan's Medical Clinic in Monbulk, along with his practice team, for the creation of this activity.

Harnessing Dr Dan's passion for improving health outcomes, as well as his prior experience in improving uptake of cervical screening self-collection tests within his patient cohort, the EMPHN team engaged his practice in a co-design project. Together, key areas were recognised to improve and streamline the identification of never screened or under-screened patients.

This co-design activity provided general practice insights to inform and guide the design and delivery of a comprehensive Cervical Screening QI campaign across the EMPHN catchment. Over a 3-month period, the team collaborated with Dr Dan to:

- Create achievable goals and measures for the practice.
- Map out the patient journey to identify improvement areas.
- Coordinate an approach to develop accurate cervical screening registers – to allow for accurate and up-to-date data.
- Identify strategies to increase patient awareness and education.

Together with Dr Dan and his practice team, the EMPHN team developed the Cervical Screening QI Toolkit and resources, as well as delivering a Cervical Screening QI webinar series, where Dr Dan shared his valuable insights and learnings with peers.

Dr Dan and his team shared practical tips, such as mapping practice workflows for identifying eligible patients and encouraged staff input for continuous feedback. This collaborative environment sparked new ideas and solutions, leading to improved processes for his practice.

Through this collaboration with EMPHN, Dr Dan's clinic was able to increase accurate recording of cervical screening rates for his clinic from 67% to 88%. This campaign has now been implemented across the catchment and has yielded initial positive results.

> "Our goal was to reduce the amount of time taken for the team to accurately identify under-screened patients including what type of cervical screening test (CST) they require and, where, possible, promote self-collection as an empowering, easy and less invasive option."
>
> **Lead nurse at Dr Dan's Medical Clinic**

1. Australian Institute of Health and Welfare, Analysis of cervical cancer and abnormality outcomes in an era of cervical screening and HPV vaccination in Australia, 2019
2. AIHW PIP QI measures data update 2021-2022

Emergency management

Priority Primary Care Centres (PPCCs)

Priority Primary Care Centres are designed for people who require urgent – but not critical – care for conditions such as mild infections, fractures and burns. Led by General Practitioners and supported by nursing and administrative staff, these centres aim to alleviate the pressure on hospital emergency departments by offering timely care for non-life-threatening conditions. The centres operate 14-hours a day, 7 days a week, to make care more accessible to the community. Services are operated by Interconnect Healthcare (Glen Waverley, Heidelberg, Monash Children's), ForHealth (Epping & Forest Hill) and M3 Health (Maroondah).

74,922
patients were seen across these PPCC sites

41%
of patients seen at PPCCs were children

> "I'm so grateful that an after-hours care service like this is available in the area;it was a great help."
>
> **PPCC client**

Vulnerable Vaccination Program General Practice Grants

EMPHN supported general practices within the catchment to target patients from vulnerable populations with information about seasonal vaccinations and winter planning.

The aim of this was to:

- Provide information and support
- Enable access to COVID-19 and influenza vaccinations
- Plan for early testing and treatment

67
general practices participated in the Vulnerable Vaccination program

2,523
appointments were booked for further vaccination information

1,364
appointments resulted in COVID-19 vaccinations

2,046
appointments resulted in influenza vaccinations

Vulnerable Vaccination Program Pharmacy Grants

In addition to general practices, EMPHN also supported pharmacies to help increase community knowledge about COVID-19 vaccination and winter planning. The program consisted of staff training and providing health promotion resources to encourage conversations and raise awareness with customers.

22
pharmacies participated in the grant

876
conversations with customers took place

433
customers in total were linked with a GP and / or health services

Endometriosis and Pelvic Pain Clinics

The Endometriosis and Pelvic Pain Clinics are led by experienced general practitioners, who are supported by a skilled multidisciplinary team including nurses and allied health professionals.

These clinics strive to provide appropriate and timely care for endometriosis, aiming to improve patient outcomes through early diagnosis and a collaborative approach to treatment.

The clinics aim to:

- Improve access to diagnostics, treatment, and referral services for endometriosis and pelvic pain.
- Build the primary workforce to manage this chronic condition.
- Improve access to new information, support resources, care pathways, and networks.

Services are operated by EACH Ringwood and Epping Plaza Medical and Dental Centre.

914
patient visits recorded to date at Endometriosis and Pelvic Pain clinics in the catchment

CASE STUDY

Endometriosis and Pelvic Pain Clinics

The Federal Government's commitment to establishing 22 endometriosis and pelvic pain clinics across Australia was realised in the region in the second half of 2023, with the opening of the Epping Plaza Medical and Dental Centre and EACH Ringwood.

Endometriosis is a complex and debilitating chronic condition that profoundly impacts individuals. Notably, endometriosis affects 1 in 9 girls, women, and those assigned female at birth, and it can take an average of 7 years to receive a diagnosis*. The 2024 Victorian Government's inquiry into women's pain shed further light into the requirement to deliver services that are appropriate and culturally safe.

The endometriosis and pelvic pain clinics are designed to provide greater access to appropriate and timely care, working toward early diagnosis and a collaborative approach to treatment for patients. Endometriosis and pelvic pain clinics are led by experienced GPs and supported by a skilled multidisciplinary team, including nurses and allied health professionals. These clinics also aim to help build the primary care workforce in the community to manage this chronic condition for years to come.

The response from users of these services has been overwhelmingly positive, with clinics within the catchment having a total of 914 patient visits and providing wrap-around care and support for those in the community.

Our service partners also continue to share patient stories like Amy's:

Twenty – three-year-old Amy** decided to visit the endometriosis and pelvic pain clinic in Epping Plaza Medical and Dental Centre and EACH Ringwood, after struggling with pain for years. Amy had previously tried to get a diagnosis and management plan for pelvic pain and had presented at the emergency department for pelvic pain in the past.

During Amy's first visit, the GP conducted several diagnostic tests to gain a greater understanding of her condition and pain. After receiving the results, a clinical assessment determined the likelihood of endometriosis. An ENDO scan was then conducted, and Amy was prescribed medication for management of her pain.

Within a month of her first visit, Amy received the results of the ENDO scan and was newly diagnosed with adenomyosis, endometriosis, and polycystic ovaries. The GP worked with Amy on a management plan, which involved contraception to help hormone control, and the consideration of pelvic pain physiotherapy, with a six-week review scheduled to check in on symptoms.

At the two-month mark, Amy reported an improved quality of life, with symptom relief, and was armed with ongoing strategies to help avoid the emergency department in the future.

Amy's story highlights the comprehensive approach to diagnosing and managing endometriosis and pelvic pain. The integration of diagnostic tests, medical intervention, and ongoing assessment works towards a holistic strategy to address the multifaceted nature of the condition.

*Jean Hailes, 2024
**name changed to protect identity

Statement of profit or loss and other comprehensive income for the financial year ended 30 June 2024

	2024 ($)	2023($)
Revenue		
Rendering of services	75,321,600	80,056,850
Other income	3,559,630	3,082,581
Total	**78,881,230**	**83,139,431**
Expenses		
Service delivery expenses	62,151,981	67,748,356
Employee benefit expenses	13,235,302	11,372,525
Depreciation expenses	597,400	1,002,607
Finance costs	61,763	53,706
Other expenses	2,556,948	2,592,682
Total	**78,603,394**	**82,769,876**
Surplus before income tax	277,836	369,555
Income tax expense	-	-
Net Surplus for the year	**277,836**	**369,555**
Other comprehensive income	-	-
Total comprehensive income for the year	**277,836**	**369,555**

Statement of financial position at 30 June 2024

	2024 ($)	2023($)
ASSETS		
Current Assets		
Cash and cash equivalents	9,417,849	6,752,739
Investments	24,000,000	36,000,000
Trade and other receivables	3,026,070	3,996,687
Other assets	840,640	647,696
Total Current Assets	**37,284,559**	**47,397,122**
Non-Current Asset		
Property, plant and equipment	410,016	604,554
Intangibles	-	62,800
Right of use assets	596,704	903,616
Total Non-Current Assets	**1,006,720**	**1,570,970**
TOTAL ASSETS	**38,291,279**	**48,968,092**

	2024 ($)	2023($)
LIABILITIES		
Current Liabilities		
Trade and other payables	7,141,088	6,417,747
Lease liabilities	470,216	440,785
Contract liabilities	25,601,440	36,797,907
Provisions	817,582	871,726
Total Current Liabilities	**34,030,326**	**44,528,165**
Non- Current Liabilities		
Lease liabilities	482,568	952,783
Provisions	67,509	54,104
Total Non-Current Liabilities	**550,077**	**1,006,887**
TOTAL LIABILITIES	**34,580,403**	**45,535,052**
NET ASSETS	**3,710,876**	**3,433,040**
Members Funds		
Accumulated Surplus	3,710,876	3,433,040
TOTAL MEMBERS FUNDS	**3,710,876**	**3,433,040**

Full financial statements are lodged with the Australian Charities and Not-for-profits Commission (ACNC).

phn
EASTERN MELBOURNE

An Australian Government Initiative

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Eastern Melbourne PHN is primarily funded by the Australian Government to improve the care and support people receive from health services. We aim to support the health of our community by ensuring people receive the right care, in the right place, at the right time.

We work closely with health professionals, consumers and carers to identify health care gaps and emerging community needs, and commission or fund services that address these needs.

We invest in a range of initiatives to have an impact within our priority areas of Aboriginal and/or Torres Strait Islander health, chronic and complex disease, mental health, alcohol and other drug addictions, older people and palliative care and primary care improvement and development.