



Activity Work Plan 2019-2022:

Core Funding

GP Support Funding

This Core Activity Work Plan template has the following parts:

1. The Core Activity Work Plan for the financial years 2019-20, 2020-2021 and 2021-2022. Please complete the table of planned activities funded under the following:
 - a) Primary Health Networks Core Funding, Item B.3 – Primary Health Networks – Operational and Flexible
 - b) Primary Health Networks General Practice Support, Item B.3 – General Practice Support.
2. The Indicative Budget for the financial years 2019-20, 2020-21 and 2021-22. Please attach an excel spreadsheet using the template provided to submit indicative budgets for:
 - c) Primary Health Networks Core Funding, Item B.3 – Primary Health Networks – Operational and Flexible
 - d) Primary Health Networks General Practice Support, Item B.3 – General Practice Support.

South Eastern Melbourne PHN

When submitting this 2019-2022 Activity Work Plan to the Department of Health, the PHN must ensure that all internal clearances have been obtained and the Activity Work Plan has been endorsed by the CEO.

Overview

This Core Activity Work Plan covers the period from 1 July 2019 to 30 June 2022. To assist with PHN planning, each activity nominated in this work plan can be proposed for a period of up to 36 months. Regardless of the proposed duration for each activity, the Department of Health will require PHNs to submit updates to the Activity Work Plan on an annual basis.

Important documents to guide planning

The following documents will assist in the preparation of your Activity Work Plan:

- Activity Work Plan guidance material;
- PHN Needs Assessment Guide;
- PHN Program Performance and Quality Framework;
- Primary Health Networks Grant Programme Guidelines;
- Clause 3, Financial Provisions of the Standard Funding Agreement.

Formatting requirements

- Submit plans in Microsoft Word format only.
- Submit budgets in Microsoft Excel format only.
- Do not change the orientation of any page in this document.
- Do not add any columns or rows to tables, or insert tables/charts within tables – use attachments if necessary.
- Delete all instructions prior to submission.

1. (a) Planned PHN activities for 2019-20, 2020-21 and 2021-22

– Core Flexible Funding Stream

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2019-2022.

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Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	<i>CF1 - Improving Cancer Screening in the Community</i>
Program Key Priority Area	<i>Population Health</i>
Needs Assessment Priority	<i>Outcomes of the Health Need Analysis. Cancer Screening incidence and mortality on pages 17, 18, and 19.</i>
Aim of Activity	<i>To increase cancer screening rates in the SEMPHN catchment.</i>
Description of Activity	<p><i>SEMPHN has commissioned BreastScreen Victoria to work within the local government areas of Dandenong, Stonnington and Casey (2018-19), Port Phillip, Frankston and Mornington Peninsula Shire (2019-20), to provide mobile breast screening services to under screened women in defined target groups. Work within communities and workplaces to increase awareness of mobile screening opportunities. Use the BreastScreen database to identify eligible women in defined target groups who have disengaged from the BreastScreen program. Use interpreters to re-engage with eligible women in CALD communities to increase the rate of breast screening in this population.</i></p> <p><i>SEMPHN has commissioned Cancer Council Victoria to increase participation in the National Bowel Cancer Screening Program in the SEMPHN catchment by at least 7,000 eligible people over two years.</i></p> <p><i>Outcomes:</i></p> <ol style="list-style-type: none"> <i>1. At least 7,000 additional people screened across the SEMPHN catchment compared to baseline.</i> <i>2. Increased number of eligible people screened from within the three targeted LGAs (Mornington Peninsula, Casey, and Greater Dandenong).</i> <i>3. Increased GP knowledge, confidence and intention to promote the National Bowel Cancer Screening Program (NBCSP).</i>
Target population cohort	<i>The target population cohort will be those in the recommended age ranges for bowel, cervical and breast cancer screening.</i>
Indigenous specific	<i>No</i>

Coverage	<p><i>This project is intended to cover the entire SEMPHN catchment. It will however target particular 'hot spot' areas that will be identified through a detailed Needs Assessment based upon available data regarding screening rates.</i></p> <p><i>LGA's of Port Phillip, Stonnington, Greater Dandenong, Frankston and Casey were identified as areas with relatively low screening rates, particularly for breast and bowel cancer.</i></p> <p><i>Cities of Port Phillip, Casey and Greater Dandenong have been identified as areas with low bowel cancer screening rates in comparison to the rest of the catchment.</i></p>
Consultation	<p><i>To improve cancer screening rates in under screened communities or areas, SEMPHN will engage with key local stakeholders including local councils, community health services, community groups, key providers and consumers.</i></p> <p><i>SEMPHN has previously consulted and engaged with Cancer Council Victoria and BreastScreen Victoria to identify need, and targeted approaches including co-designed programs.</i></p> <p><i>SEMPHN has previously coordinated an advisory group comprising local cancer screening leaders.</i></p>
Collaboration	<p><i>Collaboration is being undertaken with BreastScreen Victoria and Cancer Council Victoria, multiple Local Government Areas involved in the commissioning of services, NBSCP, Melbourne University (GP Academic detailing) and CALD communities.</i></p>

Proposed Activities - copy and complete the table as many times as necessary to report on each activity

ACTIVITY TITLE	<i>CF2 - Adult Immunisation</i>
Program Key Priority Area	<i>Population Health</i>
Needs Assessment Priority	<i>Outcomes of the Health Need Analysis. Cancer screening, incidence and mortality on page 19.</i>
Aim of Activity	<i>Increase the rate of influenza vaccination for targeted groups.</i>
Description of Activity	<p><i>As per the previous Needs Assessment, vaccine preventable conditions accounted for 2,056 preventable hospitalisations with an average length of inpatient stay of 7.9 days. The rate of influenza notifications in the region (153.9/100,000) was significantly higher than the Victorian average (113.1/100,000) and ranged from a high of 239.5 in Bayside to a low of 112.7 in Frankston.</i></p> <p><i>SEMPHN will expand existing activity to target at risk groups and regions with low immunisation rates. The current activity with Monash Health has successfully expanded the number of locations serviced and patients vaccinated, compared to prior years, which provides evidence for continuing the program.</i></p> <p><i>Outreach Influenza Program 2019 to increase immunization rates amongst hard to reach and disadvantaged populations (1,400) in the SEMPHN catchment. Vaccinations will predominantly be influenza immunisations but pertussis vaccine will be provided to pregnant women.</i></p> <p><i>Outreach immunisation program for hard to reach and disadvantaged populations falling within the Monash Health catchment area of SEMPHN:</i></p> <ul style="list-style-type: none"> <i>• Increase client number vaccinated by 30% [1,050 to 1,400].</i> <i>• Predominately influenza immunisations but expansion to include other vaccines in well- defined populations; such as pertussis for pregnant women.</i> <i>• Key population is adults but with expansion to include paediatric influenza vaccination in well- defined sites (with information provided and referral for catch-up of other vaccines if indicated).</i> <i>• Increase number of sites throughout the Monash Health catchment, in the nominated areas of increased need which include Pakenham, Cranbourne, Clarinda, and Hallam.</i> <i>• Include 19 sites from 2018; and add additional 5 new sites recently engaged.</i> <i>• Continue attempts to engage Aboriginal and Torres Strait Islander Populations, pregnant women, refugee/asylum seekers and those in crisis (homeless, financial etc.); excludes Frankston, Mordialloc, Rosebud West and Hastings, and Port Phillip sites.</i>

	<i>SEMPHN will also evaluate and likely continue with immunisation promotion programs currently being undertaken with General Practice and Pharmacies.</i>
Target population cohort	<i>Adults in at risk populations.</i>
Indigenous specific	<i>No</i>
Coverage	<i>Increase number of sites throughout the Monash Health catchment, in the nominated areas of increased need which include Pakenham, Cranbourne, Clarinda, and Hallam.</i>
Consultation	<i>LHNs, RACFs, other consumers and stakeholders</i>
Collaboration	<i>SEMPHN will continue to engage with Monash Health, local General Practice and Pharmacies and other community organisations to provide access to vulnerable populations.</i>

Proposed Activities - copy and complete the table as many times as necessary to report on each activity

ACTIVITY TITLE	<i>CF3 - Chronic Conditions</i>
Program Key Priority Area	<i>Population Health</i>
Needs Assessment Priority	<i>Hospital Admissions; Need to Adopt a more Collaborative, Integrated and Streamlined Approach to Care; and Need for Targeted and Client Centred Services on pages 45 to 50.</i>
Aim of Activity	<i>Reduce the Potentially Preventable Hospitalisation rates for patients with complex chronic conditions.</i>
Description of Activity	<p><i>This activity will build upon previous capacity building and care coordination activities in General Practice, our recently commissioned Chronic Disease Service Mapping exercise, and the care coordination and activity substitution principals of the Health Care Homes program.</i></p> <p><i>It is proposed to commission organisation/s to deliver a program of services that provides care coordination to targeted group/s of patients.</i></p> <p><i>This proposal aims to commission General Practice providers to deliver care coordination activities using a combination of Chronic Disease, Refugee Health and After Hours funding. General Practices will be commissioned to improve care coordination for patients with chronic conditions and/or those who identify as a Refugee. The proposal also ensures all patients will have their After Hours health care needs identified and planned.</i></p> <p><i>Care Coordination 6 will have the following two packages on offer for applicants and both will require an After Hours aspect to the funding.</i></p> <p><i>Care Coordination Implementation</i></p> <p><i>The Care Coordination Implementation package is for General Practices who want to implement care coordination (for chronic disease and/or refugee patients) in their practice.</i></p> <p><i>Care Coordination Enhancement</i></p> <p><i>The Care Coordination Enhancement package is for General Practices that can demonstrate care coordination is already established within their practice. This package will allow further advancement of care coordination (for chronic disease and/or refugee patients) within the practice.</i></p> <p><i>In addition to and dependant on the total amount commissioned in the above process to General Practice, SEMPHN proposes another approach to commissioning chronic disease funding based on the consultation and research mentioned previously.</i></p> <p><i>The approach is to potentially commission a Patient Centred Stepped Care type of model for people effected by chronic disease with key elements as outlined by the PwC Optimal Model of Care Framework. This model which is still to be refined, may involve the stratification of patients based on the complexity of their chronic condition. Components could include an intake service for referrals from multiple entities (including SEMPHN Mental Health and AOD providers) and inclusion of a Chronic Disease Lead that will support the patient work with</i></p>

	<p><i>their health care team.</i></p> <p>Refugee Health</p> <p><i>SEMPHN has one of the largest concentrations of newly arrived refugees and asylum seekers in Australia.</i></p> <p><i>Activities in this area will initially be focussed upon identifying, developing and commissioning services that improve the health outcomes of refugees and asylum seekers. Particular focus will be placed on those with chronic and transmittable diseases with a view to preventing unnecessary hospitalisation.</i></p> <p><i>As described above, General Practices in SEMPHN will be commissioned to improve care coordination for patients with chronic conditions and/or those who identify as a Refugee. SEMPHN will also continue consultation processes which will include a review of current, past and proposed known projects within SEMPHN and the Australia wide PHN Community of Practice for Refugee Health (which SEMPHN coordinates) to potentially leverage new activities.</i></p> <p><i>Commissioned activities will need to take into account the capacity of both General Practice and other primary care providers to ensure that they are able to effectively deliver appropriate clinical services, coordinated care, integrated care, appropriate referrals, and similar. SEMPHN has an ongoing project focused on increasing the rate of screening and treatment of active and latent tuberculosis. The target group for this activity is the refugee and asylum seeker community. An extension of this project could be a component of ongoing work in this space.</i></p>
Target population cohort	<i>Patients in the catchment with complex chronic conditions/multi-morbidities, including refugees.</i>
Indigenous specific	<i>No</i>
Coverage	<i>Whole SEMPHN catchment focus.</i>
Consultation	<p><i>Those consulted will include, but not be limited to:</i></p> <ul style="list-style-type: none"> <i>• Community of Practice – Refugee Health members</i> <i>• Primary Care Partnerships</i> <i>• Local Government</i> <i>• Resettlement agencies</i> <i>• Asylum Seeker Resource Centre</i> <i>• Mental Health service providers</i> <i>• Victorian Refugee Health Network</i> <i>• Monash Health Refugee Services</i> <i>• National PHN groups involved in current work with refugee groups</i> <i>• General Practice</i> <i>• Local Health Networks</i> <i>• Community health services</i> <i>• Community representative groups</i>

Collaboration

Continue to collaborate with:

- *State and Federal funded agencies to develop a coordinated approach to PPHs*
- *LHNs to identify, research and explore models of care through sector engagement*
- *General Practices*
- *Community health services*
- *Corporate providers*
- *Health Insurers*
- *Other community services that provide social connection and health enhancing activities*

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
<i>ACTIVITY TITLE</i>	<i>CF4 – Simple Telehealth (Nellie) – Licence Fee</i>
<i>Program Key Priority Area</i>	<i>Digital Health</i>
<i>Needs Assessment Priority</i>	<i>Coordination of care on page 48, and Potentially Preventable Hospitalisations (PPH) high rates for chronic disease on page 48.</i>
<i>Aim of Activity</i>	<i>Improve the management of Chronic Conditions to reduce unnecessary hospitalisations.</i>
<i>Description of Activity</i>	<i>Nellie is a persona that patients engage with through their mobile phone, allowing them to take an active role in their health and the care team to intervene, when necessary.</i>
<i>Target population cohort</i>	<i>Patients in the catchment with Complex Chronic Conditions.</i>
<i>Indigenous specific</i>	<i>No</i>
<i>Coverage</i>	<i>Whole of SEMPHN catchment.</i>
<i>Consultation</i>	<p><i>The methodology behind Nellie (Simple Telehealth) is fully dependant on being led by clinicians. Protocols are initiated only by clinicians (i.e. what they want) and developed in conjunction with their input (i.e. how they want it).</i></p> <p><i>The protocols can be informed by patient suggestions and, where appropriate, patients can write messages (either for themselves or for patients/cohorts like them).</i></p> <p><i>Measurement activities and workflow processes are developed in conjunction with program managers and reception staff.</i></p>
<i>Collaboration</i>	<p><i>Clinicians – initiating protocols and defining purpose and scope.</i></p> <p><i>Clinic administration staff – improving processes.</i></p> <p><i>Patients – defining purpose and writing messages.</i></p> <p><i>SEMPHN System Outcomes team – to support the Nellie team to measure outcomes.</i></p>

1. (b) Planned PHN activities for 2019-20 to 2021-22

- Core Health Systems Improvement Funding Stream
- General Practice Support funding

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2019-2022.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	<i>HSI1 - Digital Health and Polar Licence</i>
Aim of Activity	<i>Run programs and projects to improve outcomes through the effective and complementary use of technology.</i>
Description of Activity	<p><i>Strategic use of digital health principles, knowledge, and technology to augment and complement healthcare, improve patient outcomes and experience of care, and improve clinician satisfaction.</i></p> <p><i>Includes general digital health advice, information, and support given to external providers and to internal teams (particularly for commissioning); the use of tools such as Nellie to promote patient self-care and improve health literacy; implement the POLAR data extraction tool and help General Practice staff to use POLAR and processes for data-informed quality improvement.</i></p>
Target population cohort	<p><i>Patients attending General Practices.</i></p> <p><i>Patients with chronic conditions or seeking to prevent a chronic condition (Nellie).</i></p>
Coverage	<i>Whole of SEMPHN catchment.</i>
Consultation	<p><i>Resources (e.g. for POLAR and My Health Record) will be developed using the design thinking methodology, which means working together with community members and healthcare professionals on identifying the actual problem and iterating designs. In addition to design thinking, people using resources will always be asked for feedback.</i></p> <p><i>Communities of Practice will continue to be nurtured for specific programs such as POLAR and Nellie.</i></p> <p><i>GPs, nurses, and administration staff are always sought to collaborate on improving the usability and functionality of POLAR.</i></p> <p><i>Nellie algorithms are often initiated by GPs and nurses, and the messages for the algorithms are developed with patients.</i></p>

Collaboration	<ul style="list-style-type: none">• <i>Patients - Nellie message development</i>• <i>GPs and nurses - collaborate on resource development, usability improvements, and Nellie algorithm development</i>• <i>Other healthcare providers - where applicable, for collaboration on general digital health projects</i>• <i>SEMPHN System Outcomes team - measurement of outcomes</i>• <i>Other PHN staff - POLAR enhancement and general digital health collaboration</i>• <i>Peak bodies - as needed for My Health Record support, and Nellie algorithm development</i>
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Proposed Activities - copy and complete the table as many times as necessary to report on each activity

ACTIVITY TITLE	<i>HSI2 - Stakeholder Engagement and Practice Education</i>
Aim of Activity	<i>The aim of our stakeholder engagement activities is to inform, engage, educate and build capacity with stakeholders to better understand SEMPHN's role in commissioning of activities and the opportunities for funding for improved consumer outcomes.</i>
Description of Activity	<i>Stakeholder engagement occurs at all levels of the organisation and across the SEMPHN catchment. The activities include ongoing engagement with General Practices around our programs, funding and services; building awareness for General Practices about our Access and Referral Services; conducting RACGP accredited Education Programs for GPs; conducting consultations with communities and consumers to inform changes to the Mental Health, and Alcohol and Other Drug services throughout our catchment; local federal MP updates as required; engagement with DHHS on LHN initiatives and Mental Health and Suicide Prevention Regional Planning; amongst many others.</i>
Coverage	<i>Stakeholder engagement occurs across the entire SEMPHN catchment, though some engagement is specific to communities, as appropriate.</i>
Consultation	<i>Consultation is a large part of this activity, particularly with communities and consumers which inform changes to the Mental Health, and Alcohol and Other Drug services throughout our catchment and DHHS on LHN initiatives and Mental Health and Suicide Prevention Regional Planning.</i>
Collaboration	<i>Collaboration occurs at a macro and micro level with DHHS, the Department of Health, LHN's and other PHN's, as part of the Vic/Tas PHN Alliance.</i>

Proposed Activities - copy and complete the table as many times as necessary to report on each activity

ACTIVITY TITLE	<i>HSI3 - Corporate Services (including Finance/Facilities/ICT services)</i>
Aim of Activity	<i>Efficient and effective corporate support for SEMPHN.</i>
Description of Activity	<ul style="list-style-type: none"> • <i>Facilities rental and outgoings including utilities and maintenance of the corporate office.</i> • <i>Information Technology and Communications costs including Managed Service Providers costs for IT infrastructure, Voice and Internet services, application support costs for mission critical systems (Finance/Stakeholder engagement/Contracts etc.), hardware and software equipment and licences.</i> • <i>Corporate Services Salaries: COO/CFO/GM HR and support staff costs excluding CEO and Board Support</i> • <i>Other Goods and Services costs: Insurance, stationery and supplies, motor vehicle expenses, consultants and contractors.</i>

Proposed Activities - copy and complete the table as many times as necessary to report on each activity

ACTIVITY TITLE	<i>GPS1 - General Practice Support - Workforce Development, Support and Capacity Building</i>
Needs Assessment Priority	<i>The SEMPHN Core Needs Assessment 2018 highlights multiple geographic areas that require additional focus of activity due to higher burden of disease and social disadvantage, as well as areas of workforce shortage. In particular, the LGAs of Greater Dandenong, Frankston City, Cardinia and Casey are shown to need attention. General Practice support functions at SEMPHN are utilised to support commissioned General Practice programs, some of which are directly targeted at these LGAs.</i>
Aim of Activity	<p><i>That the support provided to General Practice enables them to provide optimal health outcomes for their patients.</i></p> <p><i>This includes support to reach sustainable business practices that improve equity of care delivery across the geographic region, and quality clinical care available to all, independent of financial capacity.</i></p> <p><i>General Practice support is focused, as needed, on supporting General Practices to implement commissioned activities around chronic disease care and care coordination.</i></p>
Description of Activity	<p><i>SEMPHN has previously undertaken a range of workforce development and capacity building activities including:</i></p> <ul style="list-style-type: none"> <i>• Practice Coaching Learning System for General Practices within the region</i> <i>• Digital Health including the development of POLAR GP (a General Practice clinical information systems and financial systems data extraction and reporting tool)</i> <i>• Investigation and implementation of telehealth programs including but not limited to interoperable secure text messaging services (Nellie)</i> <i>• Capacity building for General Practice in the management of patients with complex chronic disease</i> <i>• Capacity building for General Practice in business management</i> <i>• Practice Manager and Practice Nurse networking/education meetings and dedicated online forum</i> <p><i>In 2019-2022 SEMPHN will continue to support General Practice capacity and workforce development by building upon previous activities, while also ensuring General Practice can take part in co-design and commissioning activity.</i></p> <p><i>We will do this by providing and continuously improving a Workforce Support function that includes Provider Support Officers, Digital Health Support Staff, and an expert Education Officer.</i></p> <p><i>These teams will continuously engage with our General Practice stakeholders to understand their needs, and share current best practice and innovative opportunities regarding:</i></p> <ul style="list-style-type: none"> <i>• Clinical knowledge and expertise to provide high quality clinical care</i> <i>• Organisational and business expertise to take advantage of new funding models and opportunities</i> <i>• Quality improvement to evolve and adapt to new models of care and</i>

	<p><i>changes in the population's clinical profile</i></p> <ul style="list-style-type: none"> • <i>Adoption of best practice models of care for people with chronic disease, including care coordination and ensuring General Practice staff work to their full scope of practice</i> • <i>Use of technology and information</i> <p><i>We will do this through:</i></p> <ul style="list-style-type: none"> • <i>Face to face visits</i> • <i>Direct phone and email communication and support</i> • <i>Opportunistically through other events and intelligence</i> • <i>Robust collation using the CRM as a key tool</i> • <i>Interpretation and translation of knowledge in collaboration with GPs, Practice Nurses, Managers, Allied Health and community members</i> • <i>Supporting Practice Networking Groups and their online forums</i> • <i>Holding forums and Communities of Practice for particular initiatives (i.e., Chronic Disease Management commissioned activities, Health Care Homes, QIPiP, and My Health Record Expansion etc.)</i> • <i>Online education and information</i> <p><i>The team will work in a "whole of organisation" approach to address the needs of General Practices utilising:</i></p> <ul style="list-style-type: none"> • <i>An online learning management system (currently "Practice Coaching") for General Practices</i> • <i>Targeted education and training events</i> • <i>Pop-up and other multi-disciplinary events</i> • <i>Pathways development</i> • <i>Service coordination quality cycles</i> • <i>Encourage the effective adoption of suitable technological solutions</i> • <i>Local practice networks, issue focussed networks, special interest groups and/or forums both short term as needed and ongoing</i>
Target population cohort	<i>All General Practices, but in particular those in areas with poor access to care, or providing care to the more vulnerable (i.e., low socioeconomic status, chronic and complex conditions, newly arrived, and Aboriginal and Torres Strait Islander communities).</i>
Indigenous specific	No
Coverage	<i>Whole of the SEMPHN catchment.</i>
Consultation	<p><i>Feedback is routinely sought as part of practice visiting and engagement on how SEMPHN can better support General Practice.</i></p> <p><i>The enhanced Practice Networks will be evaluated in 2019 and further modified as required to expand reach and utility (in January 2019 the Practice Networks were extended in duration with added education elements).</i></p>

Collaboration

We will continue to communicate and engage with the Local Health Network GP Liaison Units/Teams as a key touch point. We endeavour to align education activities delivered through the LHN's with those by SEMPHN, to avoid conflicts and maximise impact. We provide the opportunity for providers from the LHNs to present and connect at the Practice Network meetings on an as needs basis.

The SEMPHN led Refugee Health in Primary Care working group has an ongoing role in engaging and collaborating with providers and GPs in this space.

The Victorian Department of Health and Human Services funds various additional activities that enhance the resources available to General Practices, in particular the Optimal Care Pathways (Cancer) projects.