South Eastern Melbourne - Core Funding

2019/20 - 2022/23

Activity Summary View

CF - CF1 – Improving Cancer Screening in the Community

Activity Metadata

Applicable Schedule *
Core Funding

Activity Prefix *
CF

Activity Number *
CF1

Activity Title *
CF1 - Improving Cancer Screening in the Community

Existing, Modified or New Activity *
Existing

Activity Priorities and Description

Program Key Priority Area *
Population Health

Aim of Activity *
To increase cancer screening rates in the SEMPHN catchment.

Description of Activity *

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. 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.

Outcomes:

1. At least 7,000 additional people screened across the SEMPHN catchment compared to baseline.
2. Increased number of eligible people screened from within the three targeted LGAs (Mornington Peninsula, Casey, and Greater Dandenong).
3. Increased GP knowledge, confidence and intention to promote the National Bowel Cancer Screening Program (NBCSP).

Needs Assessment Priorities *
SEMPHN Needs Assessment 2019/20-2021/22

<table>
<thead>
<tr>
<th>Needs Assessment Priority</th>
<th>Page Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Screening (Core)</td>
<td>62</td>
</tr>
</tbody>
</table>

Activity Demographics

Target Population Cohort *

The target population cohort will be those in the recommended age ranges for bowel, cervical and breast cancer screening.

Coverage *

Whole Region
Yes

Activity Consultation and Collaboration

Consultation *

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. SEMPHN has previously consulted and engaged with Cancer Council Victoria and BreastScreen Victoria to identify need, and targeted approaches including co-designed programs. SEMPHN has previously coordinated an advisory group comprising local cancer screening leaders.

Collaboration *

Collaboration is being undertaken with Breast Screen Victoria and Cancer Council Victoria, multiple Local Government Areas involved in the commissioning of services, NBSCP, Melbourne University (GP Academic detailing) and CALD communities.
Activity Metadata

Applicable Schedule
Core Funding

Activity Prefix
CF

Activity Number
CF2

Activity Title
CF2 - Childhood Immunisation

Existing, Modified or New Activity
Modified

Activity Priorities and Description

Program Key Priority Area
Population Health

Aim of Activity
Increase immunisation coverage rates for targeted groups.

Description of Activity
Following a review of the latest SEMPHN Needs Assessment and Australian Immunisation Register data, literature on the barriers and enablers to immunisation, relevant policy and potential models of service delivery, market analysis and broad stakeholder consultation, it is proposed SEMPHN commence an approach to increase immunisation coverage rates for children 0 to 5 years of age in the LGA of Port Phillip.

Strategies to achieve this include:
- Developing and implementing a collaborative Model of Care between COP’s MCH and Immunisation Services
- Providing outreach immunisation to vulnerable families within their current place of residence
- Providing opportunistic vaccination and regular immunisation education at key local services, including early years providers
- Developing and implementing a comprehensive SMS, email and postal recall/reminder system

Needs Assessment Priorities

SEMPHN Needs Assessment 2019/20-2021/22

Priorities

<table>
<thead>
<tr>
<th>Needs Assessment Priority</th>
<th>Page Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunisation (Core)</td>
<td>64</td>
</tr>
</tbody>
</table>
Activity Demographics

Target Population Cohort

Children 0 to 5 years of age in the LGA of Port Phillip.

Coverage

Whole Region

No

<table>
<thead>
<tr>
<th>SA3 Name</th>
<th>SA3 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Port Phillip</td>
<td>20605</td>
</tr>
</tbody>
</table>

Activity Consultation and Collaboration

Consultation

Council immunisation and MCH services (within and outside of catchment), key stakeholders working within housing, domestic violence, primary health care sectors.

Collaboration

SEMPHN will continue to engage with local General Practice and Pharmacies and other community organisations to provide access to vulnerable populations.
**Activity Metadata**

**Applicable Schedule**
- Core Funding

**Activity Prefix**
- CF

**Activity Number**
- CF3

**Activity Title**
- CF3 - Chronic Conditions

**Existing, Modified or New Activity**
- Existing

**Activity Priorities and Description**

**Program Key Priority Area**
- Population Health

**Aim of Activity**
- Reduce the Potentially Preventable Hospitalisation rates for patients with complex chronic conditions.

**Description of Activity**

This activity will build upon previous capacity building and care coordination activities in General Practice (see 2016-18 Activity Work Plan Ref CD1.1), our commissioned Chronic Disease Service Mapping exercise, and the care coordination and activity substitution principals of the Health Care Homes program.

SEMPHN has commissioned organisation/s to deliver a program of services that provides care coordination to targeted group/s of patients.

SEMPHN has commissioned General Practice providers to deliver care coordination activities using a combination of Chronic Disease, Refugee Health and After Hours funding. General Practices have been commissioned to improve care coordination for patients with chronic conditions and/or those who identify as a Refugee. It has been ensured all patients will have their after hours health care needs identified and planned (to meet After Hours funding requirements).

An optional “on call” after hours component formed a separate funding pool for applicant practices. This after hours ‘on call’ funding provides access to a GP from within the practice, for all patients enrolled in the care coordination services.

Care Coordination 6 has the following two packages on offer for applicants and both require an After Hours aspect to the funding.

**Care Coordination Implementation:**
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. Attachment “A” details patient and practice requirements.
Care Coordination Enhancement:
The Care Coordination Enhancement package is for General Practices that have demonstrated care coordination is already established within their practice. This package has allowed for further advancement of care coordination (for chronic disease and/or refugee patients) within the practice.

In addition, SEMPHN proposes another potential approach to commissioning chronic disease funding based on the consultation and research mentioned previously.

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 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 their health care team.

The preferred applicant would possibly be a consortia led by one major organisation. The consortia must have the capability to engage with all care providers for a patient particularly with General Practitioners.

Refugee Health:
SEMPHN has one of the largest concentrations of newly arrived refugees and asylum seekers in Australia.

Activities in this area initially focused on identifying, developing and commissioning services that improve the health outcomes of refugees and asylum seekers. Particular focus is placed on those with chronic and transmittable diseases with a view to preventing unnecessary hospitalisation.

As described above, General Practices in SEMPHN have been commissioned to improve care coordination for patients with chronic conditions and/or those who identify as a Refugee. SEMPHN continues consultation processes which has included 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.

Commissioned activities take into account the capacity of both General Practice and other primary care providers to ensure 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.

### Needs Assessment Priorities *

SEMPHN Needs Assessment 2019/20-2021/22

<table>
<thead>
<tr>
<th>Needs Assessment Priority</th>
<th>Page Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Disease (Core)</td>
<td>58</td>
</tr>
<tr>
<td>Potentially Preventable Hospitalisations PPH (Core)</td>
<td>62</td>
</tr>
<tr>
<td>Refugee and asylum seekers (Core)</td>
<td>64</td>
</tr>
<tr>
<td>Health system alignment (Core)</td>
<td>65</td>
</tr>
<tr>
<td>Intelligent Commissioning (Core)</td>
<td>66</td>
</tr>
</tbody>
</table>

**Activity Demographics**

**Target Population Cohort** *

Patients in the catchment with complex chronic conditions/multi-morbidities, including refugees.
### Coverage

| Whole Region | Yes |

---

### Activity Consultation and Collaboration

#### Consultation

Those consulted will include, but not be limited to:
- Community of Practice – Refugee Health members
- Primary Care Partnerships
- Local Government
- Resettlement agencies
- Asylum Seeker Resource Centre
- Mental Health service providers
- Victorian Refugee Health Network
- Monash Health Refugee Services
- National PHN groups involved in current work with refugee groups
- General Practice
- Local Health Networks
- Community health services
- Community representative groups

#### Collaboration

Continue to collaborate with:
- State and Federal funded agencies to develop a coordinated approach to PPHs
- LHNs to identify and 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
Activity Metadata

Applicable Schedule *
Core Funding

Activity Prefix *
CF

Activity Number *
CF4

Activity Title *
CF4 – Simple Telehealth (Nellie) – Licence Fee

Existing, Modified or New Activity *
Existing

Activity Priorities and Description

Program Key Priority Area *
Digital Health

Aim of Activity *
Improve the management of Chronic Conditions to reduce unnecessary hospitalisations.

Description of Activity *
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.

Needs Assessment Priorities *
SEMPHN Needs Assessment 2019/20-2021/22

Priorities

<table>
<thead>
<tr>
<th>Needs Assessment Priority</th>
<th>Page Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Disease (Core)</td>
<td>58</td>
</tr>
<tr>
<td>Potentially Preventable Hospitalisations PPH (Core)</td>
<td>62</td>
</tr>
<tr>
<td>Health system alignment (Core)</td>
<td>65</td>
</tr>
<tr>
<td>Intelligent Commissioning (Core)</td>
<td>66</td>
</tr>
</tbody>
</table>

Activity Demographics

Target Population Cohort *
Patients in the catchment with Complex Chronic Conditions.
Coverage *

Whole Region
Yes

Activity Consultation and Collaboration

Consultation *

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). The protocols can be informed by patient suggestions and, where appropriate, patients can write messages (either for themselves or for patients/cohorts like them). Measurement activities and workflow processes are developed in conjunction with program managers and reception staff.

Collaboration *

Clinicians – initiating protocols, and defining purpose and scope.
Clinic administration staff – improving processes.
Patients – defining purpose and writing messages.
SEMPHN System Outcomes team – to support the Nellie team to measure outcomes.
GPS - GPS1 – General Practice Support - Workforce Development, Support and Capacity Building

**Activity Metadata**

- **Applicable Schedule**
  - Core Funding

- **Activity Prefix**
  - GPS

- **Activity Number**
  - GPS1

- **Activity Title**
  - GPS1 - General Practice Support - Workforce Development, Support and Capacity Building

- **Existing, Modified or New Activity**
  - Existing

**Activity Priorities and Description**

- **Program Key Priority Area**
  - Workforce

- **Aim of Activity**
  - That the support provided to General Practice enables them to provide optimal health outcomes for their patients. 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.

  General Practice support is focused, as needed, on supporting General Practices to implement commissioned activities around chronic disease care and care coordination.

- **Description of Activity**
  - SEMPHN has previously undertaken a range of workforce development and capacity building activities including:
    - Practice Coaching Learning System for General Practices within the region
    - Digital Health including the development of POLAR GP (a General Practice clinical information systems and financial systems data extraction and reporting tool)
    - Investigation and implementation of telehealth programs including but not limited to interoperable secure text messaging services (Nellie)
    - Capacity building for General Practice in the management of patients with complex chronic disease
    - Capacity building for General Practice in business management
    - Practice Manager and Practice Nurse networking/education meetings and dedicated online forum

  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.

  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.
These teams will continuously engage with our General Practice stakeholders to understand their needs, and share current best practice and innovative opportunities regarding:

- Clinical knowledge and expertise to provide high quality clinical care
- Organisational and business expertise to take advantage of new funding models and opportunities
- Quality improvement to evolve and adapt to new models of care and changes in the population’s clinical profile
- 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
- Use of technology and information

We will do this through:

- Face to face visits
- Direct phone and email communication and support
- Opportunistically through other events and intelligence
- Robust collation using the CRM as a key tool
- Interpretation and translation of knowledge in collaboration with GPs, Practice Nurses, Managers, Allied Health and community members
- Supporting Practice Networking Groups and their online forums
- 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.)
- Online education and information

The team will work in a “whole of organisation” approach to address the needs of General Practices utilising:

- An online learning management system (currently “Practice Coaching”) for General Practices
- Targeted education and training events
- Pop-up and other multi-disciplinary events
- Pathways development
- Service coordination quality cycles
- Encourage the effective adoption of suitable technological solutions
- Local practice networks, issue focussed networks, special interest groups and/or forums both short term as needed and ongoing

### Needs Assessment Priorities *

SEMPHN Needs Assessment 2019/20-2021/22

**Priorities**

<table>
<thead>
<tr>
<th>Needs Assessment Priority</th>
<th>Page Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service system capacity (Core)</td>
<td>64</td>
</tr>
</tbody>
</table>

**Activity Demographics**

**Target Population Cohort** *

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).

**Coverage** *

**Whole Region**

Yes
**Activity Consultation and Collaboration**

**Consultation**

Feedback is routinely sought as part of practice visiting and engagement on how SEMPHN can better support General Practice.

The enhanced Practice Networks was 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).

**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.
HSI - HSI1 – Digital Health and Polar Licence

Activity Metadata

<table>
<thead>
<tr>
<th>Applicable Schedule *</th>
<th>Core Funding</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Activity Prefix *</th>
<th>HSI</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Activity Number *</th>
<th>HSI1</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Activity Title *</th>
<th>HSI1 - Digital Health and Polar Licence</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Existing, Modified or New Activity *</th>
<th>Existing</th>
</tr>
</thead>
</table>

Activity Priorities and Description

<table>
<thead>
<tr>
<th>Program Key Priority Area *</th>
<th>Digital Health</th>
</tr>
</thead>
</table>

| Aim of Activity * | Run programs and projects to improve outcomes through the effective and complementary use of technology. |

| Description of Activity * | 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. 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. |

Needs Assessment Priorities *

| SEMPHN Needs Assessment 2019/20-2021/22 |

<table>
<thead>
<tr>
<th>Needs Assessment Priority</th>
<th>Page Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health system alignment (Core)</td>
<td>65</td>
</tr>
</tbody>
</table>
## Activity Demographics

### Target Population Cohort *

Patients attending General Practices.
Patients with chronic conditions or seeking to prevent a chronic condition (Nellie).

## Coverage *

### Whole Region

Yes

## Activity Consultation and Collaboration

### Consultation *

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.

Communities of Practice will continue to be nurtured for specific programs such as POLAR and Nellie.

GPs, nurses, and administration staff are always sought to collaborate on improving the usability and functionality of POLAR. Nellie algorithms are often initiated by GPs and nurses, and the messages for the algorithms are developed with patients.

### Collaboration *

- Patients - Nellie message development
- GPs and nurses - collaborate on resource development, usability improvements, and Nellie algorithm development
- Other healthcare providers - where applicable, for collaboration on general digital health projects
- SEMPHN System Outcomes team - measurement of outcomes
- Other PHN staff - POLAR enhancement and general digital health collaboration
- Peak bodies - as needed for My Health Record support, and Nellie algorithm development
# Activity Metadata

**Applicable Schedule**

Core Funding

**Activity Prefix**

HSI

**Activity Number**

HSI2

**Activity Title**

HSI2 - Stakeholder Engagement and Practice Education

**Existing, Modified or New Activity**

Existing

---

## Activity Priorities and Description

### Aim of Activity

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.

### Description of Activity

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.

### Needs Assessment Priorities

SEMPHN Needs Assessment 2019/20-2021/22

### Priorities

<table>
<thead>
<tr>
<th>Needs Assessment Priority</th>
<th>Page Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service system capacity (Core)</td>
<td>64</td>
</tr>
</tbody>
</table>

### Coverage

**Whole Region**

Yes
Activity Consultation and Collaboration

Consultation*

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.

Collaboration*

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.
HSI - HSI3 – Corporate Services (including Finance/Facilities/ICT services)

Activity Metadata

<table>
<thead>
<tr>
<th>Applicable Schedule *</th>
<th>Core Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity Prefix *</td>
<td>HSI</td>
</tr>
<tr>
<td>Activity Number *</td>
<td>HSI3</td>
</tr>
<tr>
<td>Activity Title *</td>
<td>HSI3 - Corporate Services (including Finance/Facilities/ICT services)</td>
</tr>
</tbody>
</table>

Existing, Modified or New Activity *
Existing

Activity Priorities and Description

Aim of Activity *
Efficient and effective corporate support for SEMPHN.

Description of Activity *

- Facilities rental and outgoings including utilities and maintenance of the corporate office.
- 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.
- Corporate Services Salaries: COO/CFO/GM HR and support staff costs excluding CEO and Board Support
- Other Goods and Services costs: Insurance, stationery and supplies, motor vehicle expenses, consultants and contractors.

Needs Assessment Priorities *

SEMPHN Needs Assessment 2019/20-2021/22

<table>
<thead>
<tr>
<th>Needs Assessment Priority</th>
<th>Page Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health system alignment (Core)</td>
<td>65</td>
</tr>
</tbody>
</table>