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NORTH WESTERN
MELBOURNE

An Australian Government Initiative

COVID-19: Response to recovery

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North Western Melbourne Primary Health Network

nwmphn.org.au

ABN 93 153 323 436

Telephone: (03) 9347 1188

Fax: (03) 9347 7433

Street address: Level 1, 369 Royal Parade, Parkville, Victoria 3052

Postal address: PO Box 139, Parkville, Victoria 3052

Email enquiries: nwmphn@nwmphn.org.au

Disclaimer

Acknowledgements

We acknowledge the people of the Kulin nations as the traditional custodians of the land on which our work in the community takes place. We pay our respects to their Elders past and present

We also recognise, respect and affirm the central role played in our work by people with lived experience, their families and/or carers.

COVER: Community volunteers filmed for COVID-19 Stay Safe, Stay Home videos in 18 languages.

Photo: Matt Jasper/Jasper Picture Company

Right: COVID-19 vaccinations began in Australia from late February 2021.

Photo: Unsplash

Contents

Executive Summary

Caring in a crisis

On 11 August 2020 there were nearly 8,000 known active cases of COVID-19 in the Victorian community, most of them in inner, northern, and western Melbourne. While attention was centred on the state's overwhelmed contact tracers and the hospitals treating patients with severe COVID-19, there were also thousands of patients with milder COVID-19 symptoms who needed treatment and support. How could all these people and their households be cared for through COVID-19 while also being kept isolated to protect the rest of the community?

Primary care, led by local general practice, was needed more than ever before to fill the breach. To respond to this novel virus in an ever-changing environment, GPs had to be kept up to date with the latest treatment guidance and stay connected to acute health services so they could act quickly if things got worse for their patients. But people didn't just need their GP – they needed food, medicines, mental health support and simple human connection. COVID-19 required a holistic response to ensure people were able to stay safe and stay home.

That is why the development of the North Western Melbourne COVID-19 Care Pathway program was so important for our community and the whole state. North Western Melbourne Primary Health Network was a key partner in the development, pilot and implementation of the pathway, working with state government, local hospital services and community health to directly support hundreds of local general practices. This enabled these practices to better care for COVID-19 positive patients in the community, maintaining continuity of care between patients and their usual GP wherever possible. This pilot informed the establishment of Victorian guidelines for all regions across the state to implement to ensure people with COVID-19 get the best treatment and support available.

The pathways empowered local GPs to proactively manage and monitor their COVID-19 patients who were able to be treated in the community and provided clear processes for transition to hospital care when necessary. Critically, the social and welfare needs of patients were also managed within the pathways, and communication between different providers was enhanced to ensure patients were receiving consistent information and care.

80 percent of COVID-19 positive patients enrolled in the North Western COVID-19 Care Pathway program were able to be cared for in the community by GPs. This meant patients were able to recover more comfortably in their own homes, already burdened hospitals were spared further admissions, and the risk of further transmission was greatly reduced at a time when infections were hitting record highs.

There were many other important aspects to NWMPHN's COVID-19 response which will be touched on in this White Paper, from engaging diverse communities to enhancing the local mental health system. But the COVID-19 Care Pathway program encapsulates some of the critical health lessons that need to be taken forward out of the COVID-19 pandemic. By providing consistent, clear communication to patients and health professionals, coordination between providers, and taking a holistic view of a person's needs and circumstances, rather than narrowly focusing on only the clinical situation, we can provide excellent care to our community under even the most trying of circumstances.

Adjunct Associate Professor
Christopher Carter
CEO
NWMPHN

Janelle Devereux
Executive Director, Health Systems Integration
NWMPHN

Key lessons from the COVID-19 primary care experience in North Western Melbourne:

- Primary care is critical to COVID-19 prevention, care and recovery: Care within the community, led by general practices integrated with other health and social services, can deliver strong health and social outcomes even in the middle of a once in a generation pandemic. This approach connected and coordinated existing resources to help keep people safe at home while maintaining appropriate monitoring and rapid access to hospital care when needed.
- Public health planning should have primary care at its core: For both communicable and non-communicable diseases, Primary Health Networks (PHNs) bring critical capabilities including the ability to leverage local knowledge, established relationships and data-driven insights to rapidly stand-up local primary care and integrated responses. For emergency preparedness, primary care should have a seat at the table early with clear processes, roles and accountabilities in place.
- Evidence-driven insights underpin good decision making: Having access to comprehensive and up-to-date data allows for rapid, effective and targeted health responses. This was shown in the establishment of the HeadtoHelp mental health service in our region – our response was successful because we knew where the virus was most affecting our region, and we understood the population health needs of those communities, targeting responses to meet local needs.
- Integrated care is better care: In North Western Melbourne, the clinical care and welfare support for COVID-19 patients was coordinated across general practice, community health and hospitals, leveraging their skills and resources to provide people with COVID-19 and their families with a seamless care experience. We can expand this model for chronic conditions and mental health care, providing better access to care and overall health outcomes for our community.
- Information and data sharing are critical enablers to success: Timely data sharing and access to information across care providers enables early intervention and underpins integrated care to ensure a seamless patient and provider experience. Reform is needed to ensure providers are able to access data critical to a patient's care, while ensuring appropriate privacy and data sharing provisions.
- Communities should be at the heart of the health system: engaging early with communities and targeted populations in need ensures healthcare is community-led and promotes patient-centric outcomes, allowing for a more seamless rollout of health programs. It also ensures more people have the information they need to make good health choices and protect themselves and their families. Relationships with trusted local leaders and champions is key to timely, relevant communication and local action.

Mask wearing was one of the many major changes people in our region had to adapt to quickly.

Photo: Leigh Henningham

Recommendations

There are five key recommendations of this report for all levels of government and the health system to address:

- Empower PHNs and primary care (including community health) as core partners with Public Health Units and local hospital networks (LHNs) in emergency management and public health responses, including the COVID-19 vaccination rollout
- Commission PHNs to drive integrated system reform in partnership with LHNs
- Authorise PHNs to co-commission mental health and wellbeing services with LHNs and other state health bodies, consistent with the findings of the Royal Commission into Victoria's Mental Health System
- Engage PHNs early to understand local community needs and promote health equity, particularly among priority populations
- Enable PHNs to support implementation of recommendations from the Royal Commission into Aged Care Quality and Safety

PHNs in Australia are a unique asset, able to enhance the quality and capacity of the primary care sector, bind together sometimes disparate parts of the health system to create better integrated care, and innovate to address service gaps. Throughout the pandemic NWMPHN has demonstrated PHNs can also play a critical role in public and population health responses during a crisis, facilitating access to services and supports in timeframes that would not have been thought possible before.

Remembering the lessons and enacting the recommendations of this paper will help ensure the good work and positive system changes of this time are not consigned to history with the end of the pandemic.

Melbourne's CBD empited almost entirely during the second wave between June and November 2020.

Photo: Leigh Henningham.

COVID-19 in our region

Nowhere in Australia was hit harder by COVID-19 than our region of inner, north and western Melbourne. As at 1 March 2021 there were 12,171 confirmed COVID-19 cases in the NWMPHN area, accounting for 59% of the total Victorian cases and 42% of total Australian cases. This included multiple outbreaks in public housing towers and residential aged care facilities with 432 deaths in aged care across the region.

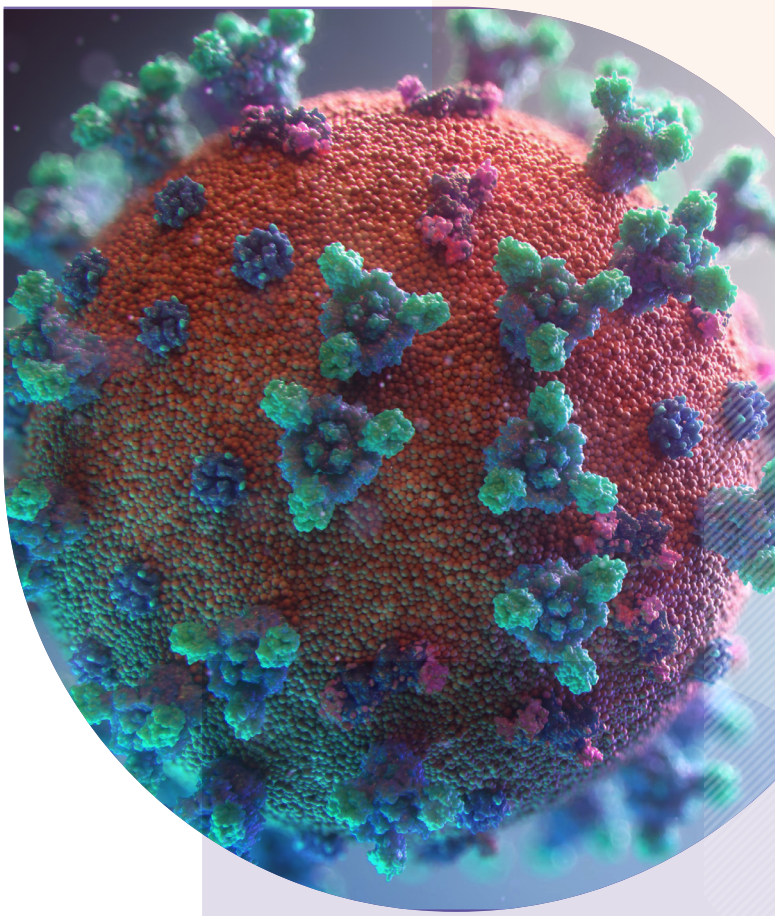
Wyndham had the highest number of confirmed COVID-19 cases out of any local government area (LGA) in Australia, followed by Brimbank – both LGAs in our region. Brimbank experienced major meatworks outbreaks at Cedar Meats, JBS Abattoir and Somerville Retail Services, while Wyndham was home to over 200 infections at Al-Taqwa College and some of the deadliest nursing home clusters.

Victoria's far more deadly and widespread 'second wave' of COVID-19 cases was seeded by the virus escaping from two Melbourne quarantine hotels. Workers at these hotels, many of whom lived in north and western Melbourne, were infected by returning travellers and then unknowingly spread the disease among friends and family.

The virus was then rapidly transmitted across the region, its spread exacerbated by the high proportion of vulnerable people in our community. This included essential workers in places like hospitals and nursing homes; people working in casualised jobs and in high-risk industries such as meat processing; and residents of high-density housing with shared amenities, which facilitated spread among family groups and neighbours.

The same factors which fuelled the rapid spread of the virus also placed barriers to bringing infections under control. Variable access and engagement with health and social services and a lack of a coordinated whole-of-system response made arranging widespread testing, treatment and isolation more challenging. People in casual and insecure work faced losing essential income or even their job by missing work while sick. Language and cultural barriers meant many people may not have known what to do to avoid contracting COVID-19 or what to look for and how to get tested if they did get infected.

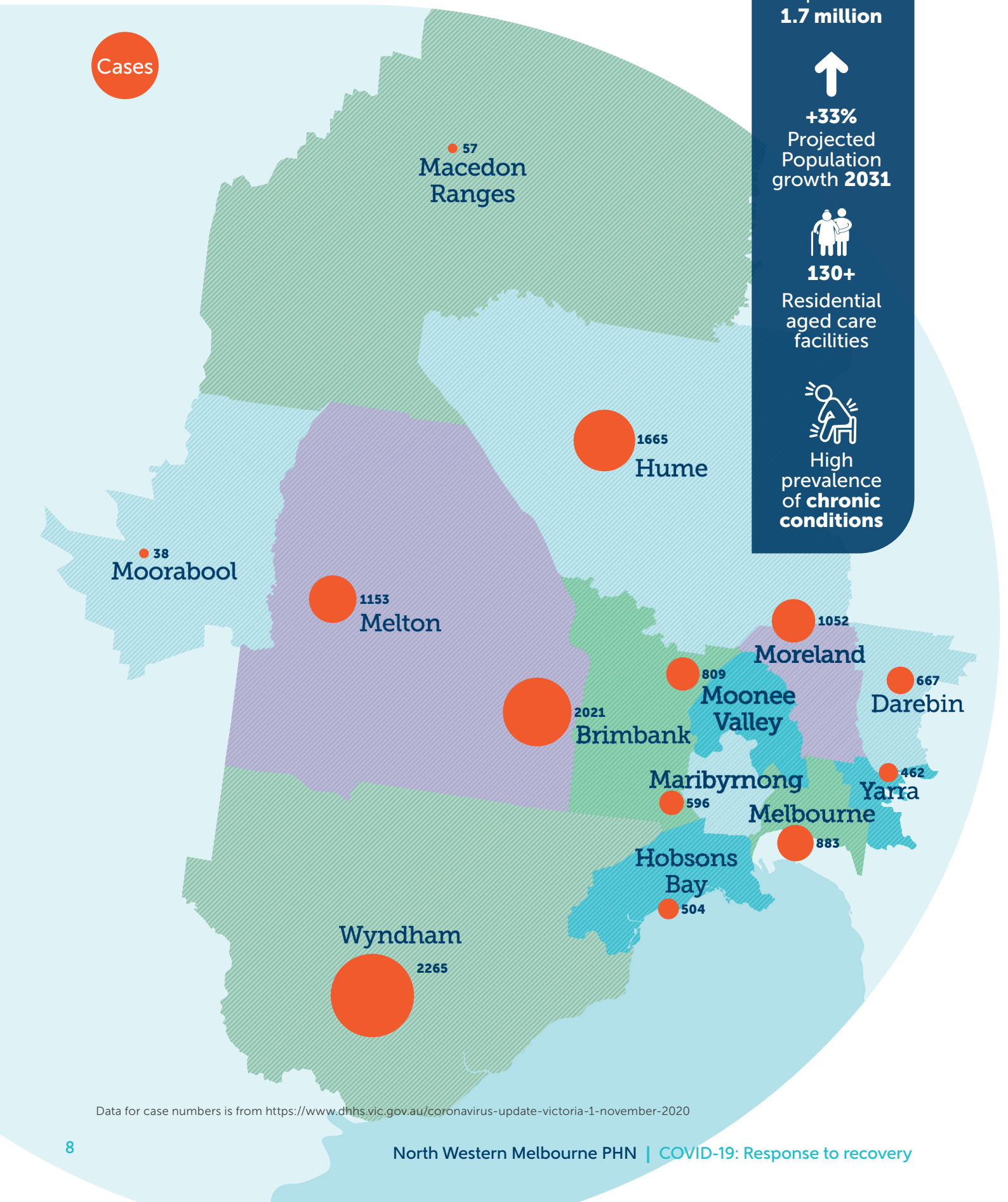
The pandemic did not create any of the health access and equity issues that contributed to its severity in our region. Rather it cast a harsh light on systemic failures and barriers which have been a feature of the local health system for many years, demanding an immediate response.



Cover: A visualisation of the SARS-COV-2 virus, showing the distinctive spike protein.

Photo: Fusion Medical Animation on Unsplash

NWMPHN snapshot



Population **1.7 million**

+33% Projected Population growth **2031**

130+ Residential aged care facilities

High prevalence of **chronic conditions**

Data for case numbers is from https://www.dhhs.vic.gov.au/coronavirus-update-victoria-1-november-2020

Systemic failures in the healthcare system

In addition to the challenges posed by the demographic complexity of the NWMPHN region, systemic issues hampered the ability of the healthcare system as a whole to respond to the pandemic rapidly and effectively.

Lack of clear, timely, coordinated and accessible communication

Communication about COVID-19 was initially disjointed and inconsistent, being provided by a wide range of sources and channels without any clear overall coordination or quality control. In particular, the lack of accessible communication for at-risk populations and culturally and linguistically diverse groups made it challenging for them to respond to public health measures.

Later in the pandemic there became an over communication problem, because different providers and parts of the health response were not communicating with each other effectively. This resulted in people with COVID-19 being contacted by multiple people and sometimes being provided conflicting advice or directions.

Difficulties with data access, quality and transfer

In many cases local health services did not know who had tested positive for COVID-19 in their community, making it extremely difficult to provide those people with timely treatment and support them safely isolate to limit the spread of the virus. When available, data quality was often poor, which contributed to fragmented care and communication difficulties.

Over-emphasis on clinical needs

The initial response primarily focused on the acute clinical needs of people with COVID-19, which failed to consider their other often complex social, welfare and survival needs. This was particularly important for people who had milder symptoms not requiring hospital care, but who needed to isolate in their homes to protect the rest of the community. A more holistic response combining clinical, mental and social support within a household or community context, such as the COVID-19 Care Pathways model, was found to be more effective in providing immediate care while reducing risk of COVID-19 transmission.

Complex and poorly integrated healthcare ecosystem

The fragmented nature of the healthcare ecosystem limited collaboration. This was characterised by competing priorities and incentives (e.g. funding), a lack of recognition of the role of primary care, and a culture of siloed care. Additionally, the healthcare response to the pandemic initially lacked clear, coordinated and collaborative governance, including adequate representation from relevant stakeholders in response planning, including primary care and PHNs. Local collaborations were needed to address this system failing.

Failing aged care system

As highlighted by the Royal Commission into Aged Care Quality and Safety, the sector is fragmented, unsupported and underfunded. This has resulted in substandard care, a strained workforce and stifled innovation, all of which contributed to making aged care facilities particularly vulnerable to COVID-19 outbreaks. Several of the most deadly and persistent outbreaks took place in aged care facilities in our region.

NWMPHN's COVID-19 response

North Western Melbourne PHN has been at the forefront of the COVID-19 response, undertaking a range of important roles to protect and support our community and health care providers (see Diagram 2 below)

Supporting primary care

From early 2020 it was obvious that primary care would have to play a major role if we were to manage and avoid the worst impacts of the COVID-19 pandemic in our community. General practice in particular would be needed to not only treat the majority of COVID-19 patients in the community, but also act as a key source of trusted advice and guidance about testing, infection control and isolation guidelines.

Our task was clear: to ensure primary care had the information, resources and support they needed throughout the pandemic.

The COVID-19 Care Pathways program was one of the most successful ways we did this, building on our existing HealthPathways Melbourne platform and working with local acute and community health services to create an integrated care pathway for GPs to use with their COVID-19 diagnosed patients.

Our key partners included:

- **Community health** – Local community health organisation cohealth provided clinical and social risk assessment, coordinated social and welfare needs for patients and also delivered general practice services
- **Local Hospital Networks** – The Royal Melbourne Hospital led a group of local hospitals including Western Health, Djerriwarrh Health Services and Mercy Health, in the development of the pathways and supporting care within the community

More than 270 GPs from over 210 local general practices participated in the project, enabling thousands of patients to receive quality care in their own homes while reducing the chance of wider infection.

This had direct benefits for both improving care for patients and protecting the broader community. Some examples included:

- A patient working in an aged care facility continued working despite having COVID-19. Support was provided by working with her employer to allow the patient to stop going to work without fear of losing her job.
- International students in shared housing were supported to enter hotel quarantine, protecting their household and reducing their risk of becoming homeless.
- A patient using heroin was linked with a GP to start an opioid substitution therapy, enabling the patient to stay at home during their isolation period.

Feedback from COVID-19 Care Pathway consumers

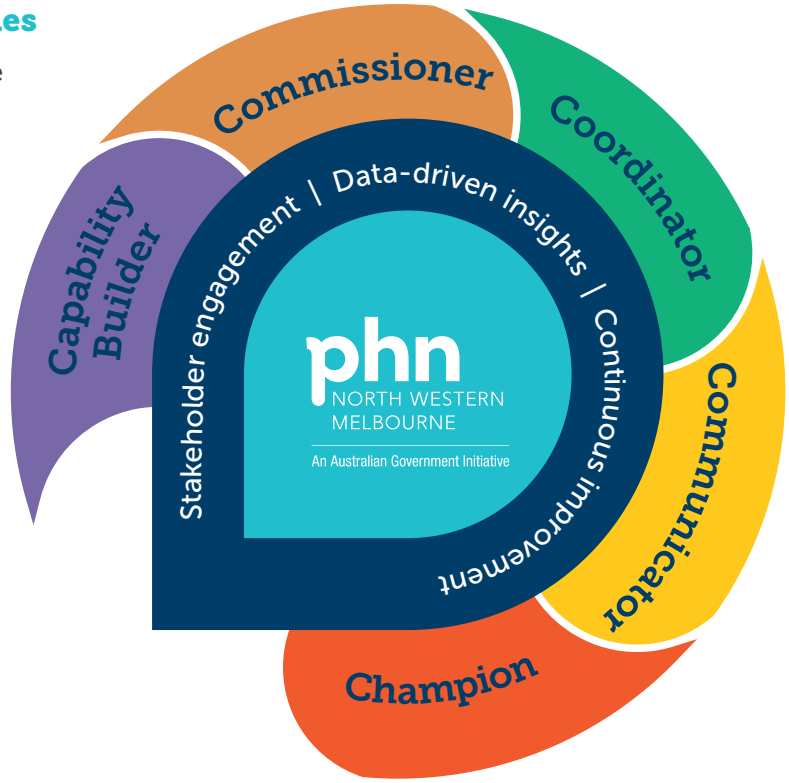
"Overall, it was a good experience getting healthcare, hotel accommodation and financial support from the program. The facilities that were included in the program made me feel even more comfortable and it has boosted my confidence to fight against the illness mentally as well as physically."

"cohealth and my GP were amazing throughout the whole process my only down fall was support from my own work company where I got covid, I'm grateful for these guys that got me through it."

We have been at the forefront of the COVID-19 response

NWMPHN Roles

Demonstrating the Value of NWMPHN in the COVID-19 Response.



Capability Builder

Enabled primary care providers to work at the top of their scope of practice, and drive a primary care-led response.
For example:

- HealthPathways and other communications
- proactive practice support
- telehealth support
- Personal protective equipment distribution
- education
- professional development

Champion

Advocated for local communities, aged care, general practice and other primary care providers to State and Federal Governments to improve the way care was delivered and ultimately save lives. For example:

- primary care involvement in COVID-19 response
- improved communication
- data sharing

Communicator

Developed clear, timely and accessible communication for the community including priority groups and healthcare professionals.
For example:

- HealthPathways
- COVID-19 webhub
- newsletters
- social media
- multilingual videos

Coordinator

Created linkages between primary, acute, specialist, State and Federal Governments, and community groups to optimise network capability and ensure continuity of patient care. For example:

- COVID-19 Positive Pathway
- GP-Aged Care-Hospital forums

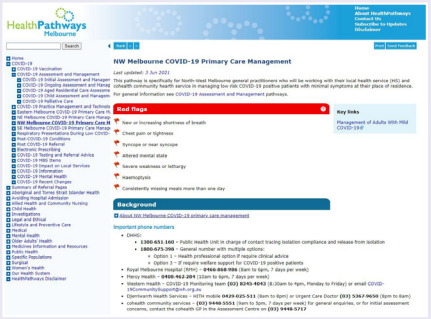
Commissioner

Commissioned a range of services to meet local needs.
For example:

- HeadtoHelp
- ensured contracted providers innovated during COVID-19 to maintain continuity of care for people across the region

COVID-19 Care Pathways Program Case Study – Dr Elizabeth Williams

Dr Elizabeth William's practice managed a large number of COVID-19 positive patients during 2020, beginning from early June as the second wave of infections was building across Melbourne.



This included both existing patients of the practice, as well as patients referred to the practice as part of the COVID-19 Care Pathways Program.

"I personally managed quite a number of COVID-19 positive patients through that time, using the program primarily... which I found excellent," Dr Williams said. "[It was] easy to use, and very helpful in terms of both having a clear understanding of what to look out for and what to ask for."

Dr Williams said the written pathways were very clear and detailed, which gave her confidence in managing a large number of COVID-19 positive patients in the community.

"I thought it was very well done, and very well put together. The red flags were clearly defined. So I felt confident that I wasn't going to miss signs of deterioration, or things that should be escalated.

"But also, I just found the patients that we were dealing with were very reassured to have regular contact with someone who was committed to helping them through it. There's a great deal of anxiety about it, and what was going to happen and what their outcomes would be. And having a program like this just helped tremendously in giving us a framework of what to do."

Dr Williams extended the principles of the pathways to all her COVID-19 patients, whether they were referred to her through the COVID-19 Care Pathways program or via other acute care or pathways programs from other regions. As COVID-19 outbreaks continue to occur, it is a model she will carry forward.

"We just use the model anyway, in terms of the daily contact, the sorts of questions, keeping in mind the red flags, what to escalate. So it's actually applicable to managing all our COVID-19 patients, not just those who were formally in the program."

The COVID-19 Care Pathways Program has given Dr Elizabeth Williams a template for all COVID-19 care at her practice.

Photo: Supplied

Other support

Beyond the pathways we took a multi-faceted approach, filling gaps in the broader response and acting as coordinator and facilitator between governments and local health services and communities.

Key activities included:

- Providing regular communication updates to primary care providers highlighting and summarising the most important new information, sometimes multiple times per day
- Directly providing resources such as masks and other items of personal protective equipment to general practices and other eligible providers
- Supporting the establishment of GP respiratory clinics to boost local testing capacity and access
- Assisting the shift to telehealth service delivery with a range of webinars and other training activities, protecting both providers and their patients while maintaining high quality care
- Working as a direct point of contact between practices, aged care facilities and health departments, local hospitals and other health providers to support the vaccine rollout in the community.

The planning and delivery of all these activities was guided by an extensive review of local data to ensure responses were evidence-based and carefully targeted. This included real-time mapping of COVID-19 cases, building in reporting and data collection tools to track engagement within the COVID-19 Care Pathway program and utilising a data-driven approach to determine appropriate providers and locations for HeadtoHelp clinic-based mental health services.

Addressing the mental health impacts of COVID-19

The impacts of the COVID-19 pandemic have gone far beyond the physical health impacts caused by the virus. Both the fear of getting COVID-19 and the restrictions and lockdowns put in place to limit transmission have had far reaching consequences for the mental health and wellbeing of our community.

Responding to the mental health impacts of the pandemic has required the same flexibility and innovation shown in our support of the primary care sector. We quickly moved to provide our commissioned providers in mental health, alcohol and other drug and related fields with training and support to shift service delivery away from face-to-face models. We increased capacity of existing services and expanded into new areas, including targeted mental health supports for care providers most impacted by the pandemic, such as aged care. We partnered with the PHNs across Victoria to rapidly implement the HeadtoHelp service incorporating an intake model connecting people to the right care across the mental health system and service delivery hubs for people needing a higher level of care via a multidisciplinary team.

The Commonwealth funded HeadtoHelp initiative in particular has been critical for our region, which suffered the most not only in terms of COVID-19 cases and deaths, but also through the early introduction and severity of restrictions during the second wave in Victoria. It has provided a lifeline for people who needed mental health services and support for the first time during the pandemic, as well as those whose pre-existing conditions exacerbated by the situation.

Between September 2020 and February 2021, NWMPHN received 37% of all HeadtoHelp intake calls across Victoria. Most of these were self-referrals (47%) vs GP referrals (25%), with the majority requiring moderate intensity care and referral to either a HeadtoHelp hub or other clinical service providing multidisciplinary care.

Beyond the direct clinical outcomes, HeadtoHelp has also provided a template for how mental health and related treatment services can be better coordinated for our community into the future. The intake service provides easy access for clients, without the need for a referral and through an initial assessment connects them to the appropriate service type. This is supported by integration between different mental health services and links to broader social, health and welfare services to provide a more holistic approach to care.

HeadtoHelp client case study – Mei

Mei originally contacted HeadtoHelp (H2H) as she was anxious and frightened to leave her house due to what she perceived to be racism and discrimination aimed towards her. This coincided with an increase in discrimination towards people of Chinese heritage at the start of the COVID-19 pandemic.

The intake service through the initial assessement was able to determine the needs and services that Mei needed and by sharing, with her consent, that assessment information with other relevant health professionals so Mei did not have to tell her story repeatedly. The H2H team worked with her to develop a care plan to suit Mei's individual needs.

H2H was able to provide Mei with a safe and confidential environment where she could speak openly about her concerns and anxieties. Mei felt comfortable enough to disclose that her husband had a long-standing drug addiction but was receiving treatment. Mei reported that one of her primary fears was that her husband would relapse.

H2H connected with Mei's local GP to support her mental health plan, and was also provided with psychosocial education and counselling to assist with her anxiety and was given a 'warm' transfer to a support group for family members of alcohol and other drug users.

With Mei's consent H2H was also able to engage with her husband and make a warm referral for him to attend AOD counselling and collaborated with his treatment clinic for a holistic approach to his care.

Mei reported that the support she has received from H2H has been beyond her expectations; she is no longer frightened to leave her home and has developed self-confidence. She no longer feels alone and has developed trust.

Victorian Chief Health Officer Brett Sutton became a household name during the second wave.

Photo: Leigh Henningham

Enhancing community engagement

By developing timely, accurate and targeted COVID-19 information delivered through a range of communication mechanisms, NWMPHN was able to increase community awareness of COVID-19 prevention, testing and treatment.

This included the creation of multimedia community campaigns and targeted communications in different languages, including campaign involvement of our own community members

It's OK to see your GP – case study

The 'It's OK to see your GP' campaign was launched after the first wave of COVID-19 in Melbourne and was one of the earliest campaigns on this issue. Reporting from local GPs, backed up by reviews of cancer screening and other routine testing, showed that people were avoiding regular check-ups and investigations for fear of catching COVID-19.

While concerns were understandable, avoiding regular appointments can have very serious consequences, particularly for people with chronic health conditions.

Practice Nurse Emma Thompson from Bacchus Marsh Medical Centre shared her experience as part of the campaign, noting her clinic had drop-off in regular patient visits after the pandemic began.

"You're more likely to suffer from complications of your disease rather than consequences of coming in to the doctor. You're less likely to catch COVID-19 from the doctor than you are to have a secondary complication [from your existing illness]."

The communications campaign combined an easy to understand message that 'It's OK to see your GP', with detailed information about safety measures put in place by local general practices and interviews with GPs about the risks of not keeping up with your general health.

The campaign sparked widespread engagement through our digital channels, and was taken up by Prevention Victoria for dissemination across Victoria.

Improving outcomes for aged care residents

No part of our community has been hit harder by COVID-19 than people living in residential aged care. Of the 910 people who have died from COVID-19 in Australia, 655 of them lived in residential aged care facilities in Victoria. The impact went far beyond the devastating toll of deaths and infections, as all aged care facilities were locked down for large periods of 2020, with residents unable to see family members and often entirely confined to their rooms.

Many factors played a role in the spread of COVID-19 in aged care care, from poor access to and use of personal protective equipment, to staff working across multiple facilities and in other high-risk jobs, and a reactive and disjointed response to protecting residents and staff in the early days of the pandemic.

We took a multi-pronged approach to improving the COVID-19 response in aged care in our region:

1. Coordination: We improved coordination of care by facilitating case conference discussions with the facility, GPs and residential in-reach services.

2. Communication: We created a regular COVID-19 update for aged care providers and staff, and also contacted facilities within our region directly around critical issues.

3. Champion: Our advocacy at a state and national level was critical to the establishment of the Victoria Aged Care Response Centre, as well as improved pathways of care being put in place.

4. Commission: We identified that the toll of COVID-19 went beyond physical health, with mental health services for aged care residents being expanded, and new services being made available targeted to aged care staff. A program targeting improving physical conditioning for residents affected by COVID-19 lockdowns will also be implemented during the second half of 2021.

5. Capability building: NWMPHN has played a key role in the rollout of COVID-19 vaccines in aged care since the vaccination program began in late February. We supported facilities to prepare for the vaccine roll out and facilitated communication between the Australian Government, its contracted vaccine providers and the private aged care facilities. We have acted as a trouble-shooter, advocating for follow up clinics when residents have been missed and disseminating alternative vaccination pathways for staff, providing essential local intelligence and a voice for a particularly vulnerable population.

Taken together, these actions have improved care outcomes for aged care residents in our region, while better connecting facility management and staff to local primary care and mental health services.

Melbourne's great cultural centres were empty for most of 2020.

Photo: Leigh Henningham.

Lessons learned and opportunities for primary care

1. Primary care-led COVID-19 recovery: Integrate a primary care-led response within existing structures to ensure long-term sustainability.

Lessons learned

- A primary care-led response model in prevention and early intervention is not only feasible, but effective in achieving better health outcomes, and improving patient and provider experience
- GPs are more than capable of managing patients in the community, and ensuring integration between primary and acute services if the right pathways and supports are established
- Mental health support is integral to any COVID-19 response, and should be integrated with primary care services
- PHNs are critical in supporting primary care to rapidly translate evidence into practice and improve quality of care

2. Public health preparedness: Collaborate with the region to ensure primary care is a core part of public health planning for both communicable and non-communicable diseases.

Lessons learned

- Early engagement and participation supported by a bi-lateral authorising environment is critical in outbreak planning and management
- The role, relationships and capabilities of PHNs – such as the ability to leverage local knowledge and established relationships into a rapid and targeted response – have been shown to be beneficial and effective, with the opportunity to facilitate the primary care response at scale
- Having clear processes, roles and accountabilities across health and social care systems is crucial in emergency preparedness and outbreak management

3. Integrated care models beyond COVID-19: Apply lessons from the development of the COVID-19 Positive Care Pathway and HeadtoHelp to design and implement integrated care models for other use cases (eg chronic care).

Lessons learned

- An integrated model for stepped care between primary and acute services (e.g. COVID-19 Positive Care Pathway, HeadtoHelp) is feasible, and improves access to care and overall health outcomes
- Maintaining continuity of care improves overall patient experience
- Coordinated operations and communications within and between federal and state governments promotes rapid rollout of health programs
- Provision of care should take a holistic approach, including clinical, mental and social needs

4. Commission for targeted outcomes: Use data-driven insights to inform service commissioning (e.g. strategic planning, implementation, evaluation) and better navigate appropriate supports.

Lessons learned

- Data-driven insights assist in identifying areas requiring service access or enhancement, including funding allocation
- Real-time reporting and tracking enables rapid program evaluation for continuous improvement, including operational efficiency, service gaps, patient and provider experience
- Rapid establishment of HeadtoHelp demonstrates capability of PHNs to respond rapidly and innovate to meet the needs of communities across the region

5. Better data access and shared digital platform: Advocate for seamless safe communication and further collaboration across the network.

Lessons learned

- Improved data access promotes ability to provide timely care (i.e. early intervention), improving overall patient outcomes
- Digital solutions enable timely clinical oversight providing assurance to health services of the quality of patient care
- Seamless data sharing increases network visibility, promoting a more integrated care model and improving patient and provider experience
- Data-driven insights drive continuous system improvement and inform timely decision-making

6. Connect with and enable communities: Engage with communities, particularly priority populations, to drive patient-centred healthcare for more equitable outcomes.

Lessons learned

- Early community engagement promotes more patient-centric outcomes and allows for a more seamless rollout of health programs
- Establishing and maintaining relationships with local and regional communities, including trusted leaders and peer champions, enables more timely and relevant communication and local action

Creativity and a focus on community has helped keep people in Melbourne connected throughout the pandemic.

Photo: Leigh Henningham.

Recommendations

In order to deliver on key opportunities identified through the pandemic, there are five key recommendations for immediate action.

Recommendations	Next Steps
1. Empower PHNs as core partners with public health units and local health networks in emergency management and public health responses (e.g. COVID-19 mass vaccination rollout)	• Expand PHN role in emergency management and public health responses from implementation and coordination to strategic planning, and communicate this to federal, state and local government stakeholders • Advocate for PHNs a strategic role, including co-designing innovative solutions with primary care • Embed PHNs in public health unit and local hospital network governance structures
2. Commission PHNs to drive integrated system reform, in partnership with local health networks	• Ensure bilateral agreements provide adequate authorising environment to enable integrated care, and flexible funding arrangements to drive value- based outcomes via integrated pathways • Support PHNs to drive integration between primary, secondary and tertiary systems and achieve improvements against the quadruple aim – supporting the key recommendation of the Primary Health Reform Steering Group. • Endorse PHN's core role in designing and implementing integrated care models together with newly established newly established health service partnerships • Embed PHNs in public health unit and local health network governance structures
3. Co-commission federal- and state- funded mental health services with PHNs, consistent with the findings of the Royal Commission into Victoria's Mental Health System	• Endorse PHN's role in regional co-commissioning of federal- and state-funded mental health and wellbeing services • Actively engage PHNs in the planning of catchments for the new regional commissioning boards • Align key performance indicators and target outcomes for all stakeholders involved to drive a coordinated mental health response • Embed PHNs in commissioning governance structures (e.g. Regional Mental Health and Wellbeing Boards)
4. Engage PHNs early to understand local community needs and promote health equity, particularly among priority groups	• Endorse PHN's role in advocating for and playing an active role to service local community needs, particularly in emergency management and public health responses, from prevention to care. This should include community engagement with the COVID-19 vaccination rollout
5. Enable PHNs to support implementation of recommendations from the Royal Commission into Aged Care Quality and Safety	• Clearly articulate role of PHNs in RACFs, and communicate this to federal, state and local government stakeholders • Approve additional funding to enable PHNs to assume articulated role in aged care • Embed PHNs in governance structures (e.g. Aged Care Advisory Council)

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