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MURRAY

An Australian Government Initiative

Report to the Community 2018

About Murray PHN

Murray PHN is funded by the Commonwealth Department of Health to help improve primary health outcomes across our region through health systems improvement and the commissioning of efficient and effective primary health services.

With a population of 644,000 people spread over almost 100,000 sq kms, Murray PHN has 55 hospital services, 195 general practices and covers 22 Local Government Areas.

Featuring both rural and regional centres, our major towns include Bendigo, Shepparton, Mildura and Albury-Wodonga, where Murray PHN has regional team locations.

Our catchment has more than 175,000 people aged 45-64, almost 82,000 aged 5-14 and more than 13,600 people identifying as Aboriginal or Torres Strait Islander.

Murray PHN acknowledges the traditional owners of the lands we work on and would like to pay our respects to their elders past and present and extend that respect to all Aboriginal and Torres Strait Islander people.

This Report and the programs and initiatives outlined within it, have been made possible through funding provided by the Australian Government under the PHN Program.

Leadership Collaboration Knowledge Innovation Accountability

Report to the Community 2018

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Measuring our achievements

Murray PHN is proud of its achievements in delivering the strategic goals of the 2016-2018 Strategic Plan. We can report that 11 of our 15 strategic actions have been successfully completed, with the 12th well underway. Our final three actions have been reviewed and modified to ensure they are both achievable and effective. These objectives have been integrated into our 2018-2021 Strategic Plan and work continues to achieve these and many more.

Strategic Goal 1

We will ensure that the coordination of care is targeted and tailored to our communities and that innovation and engagement are core to our efforts in improving healthcare systems and service delivery.

Murray PHN has developed and embedded an innovation strategy and is well progressed on strong engagement strategies to support general practice, other key health services partners and health consumers. Specific engagement with GPs will be a major focus during 2019.

This goal helped us to embed engagement, innovation and collaboration into our strategy, integration and regional delivery functions.

We have partnered with key stakeholders including the State and Commonwealth Governments, to develop key preventative health campaigns linked to our priorities, including cancer screening, real-time prescription monitoring, eHealth and My Health Record implementation.

Strategic Goal 2

We will address national priority areas as well as explore emerging health and healthcare issues with our communities, and work with service providers pursuing opportunities based on evidence and expertise, and being clear about how we will measure shared success.

This goal was fully achieved. We have established our clinical and community advisory councils, with strong retention of membership in a refreshed structure.

The population health planning framework is operational, producing our needs assessments and market analyses. We have established the Murray Exchange as a trusted source of accessible population health data, that has expanded to become the PHN Exchange, with co-investment from other PHNs around Australia.

Our commissioning framework has proved effective in commissioning both chronic illness and primary mental health services. With independent testing and analysis, we continue to refine and build the framework to support mature relational commissioning that supports our communities.

We have established Health Voices, on online community of health consumers, who are surveyed throughout the year to inform our local health service planning.

Finally, a significant project on avoidable hospital admissions continues to develop with four major hospitals and multiple rural health services.

Strategic Goal 3

We will strengthen our organisational capability so that we are responsive, accountable and productive with what we know, in what we provide, and in how it contributes to improved health outcomes.

This goal supports the continuing development and evolution of Murray PHN. We are pleased to report that four of our five actions have been achieved, with the final action (workforce culture and capability strategy) ongoing. We have established accountable organisational leadership, planning and reporting frameworks, alongside strong organisational systems and structures increasingly linked to performance goals.

Our extensive quality and risk management framework has been designed specifically to be integrated across all areas of the company. A whole of company system has also been the hallmark of our knowledge and information management framework, which integrates major business processes, key software applications and data/knowledge management across the organisation.

For a new entity, engaged in the formation of an effective organisation and moving from service provision to relational commissioning, we are delighted to have completed the key planks in each of our three strategic goals for 2016-2018. With our first Strategic Plan now behind us, we are looking forward to the future with our Strategic Plan for 2018-2021.

Planning for future success

Murray PHN Strategic Plan 2018-2021

The work of Murray PHN is guided by our values of Leadership, Collaboration, Knowledge, Innovation and Accountability, our Strategic Vision for *Better Health*, *Better Care*, *Better Systems*, and by our Strategic Plan, which in 2018-2021, requires us to "Make a Difference" to our regional community.

Connecting the health system to respond to patient needs and improving health outcomes is complicated work in a complex environment. We believe that our second three-year Strategic Plan provides a succinct description of our work, in a visual format that helps explain our goals and focus.

Combined with our Needs Assessment and Activity Work Plans, *Better Health*, *Better Care*, *Better Systems* will guide the work of our organisation as we invest in improved community health outcomes for the next three years.

PHNs were established by the Commonwealth Government with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.

In this, our second Strategic Plan, our vision is for Murray PHN to contribute to *Better Health*, *Better Care* and *Better Systems* across our region, through five distinct focus areas.

Those areas are **DIFFERENCE**, **BETTER**, **HAPPEN**, **TOGETHER** and **STRONGER**.

Murray PHN's strategic health priorities include the health issues that have the greatest impact on the lives of our community, Commonwealth Government priorities, and the areas for targeted health improvement activities across our region.

This year, we have a strong focus on general practice, which is at the heart of primary health care, and chronic diseases, which include diabetes, heart disease, chronic obstructive pulmonary disease (COPD) and cancer.

Murray PHN functions

Our national PHN objectives activities are to increase the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes and improve the coordination of care to ensure patients receive the right care in the right place at the right time.

PLANNING

- Leadership of strategy, planning and commissioning
- Population health planning
- Health systems planning
- Knowledge management systems
- Strategic project collaborations

DESIGN

- Commissioning services and strengthening workforce
- Primary mental health
- Chronic disease
- Aboriginal health
- Annual work planning and reporting
- Engagement, including clinical and community advisory councils

DELIVERY

- Regional leadership in primary health coordination and commissioning
- Primary health service engagement
- Primary health system improvement
- Integrated care
- Workforce development and support
- Consumer and community engagement

CORPORATE

- People and culture
- Communication
- Governance, quality and risk
- Performance reporting
- Finance and budgeting
- Procurement
- Administration

To read Murray PHN's full Strategic Plan 2018-2021, please go to murrayphn.org.au/about/corporate-documents

Our Board

Dr Chris Atkins
Dr Atkins is a GP and director of Brooke Street Medical Centre, Woodend. Dr Atkins is involved in acute and emergency care, paediatrics, aged care, adult health and chronic disease management. Dr Atkins is also a qualified lawyer, practicing in health law and tutors at Monash Rural Medical School, Bendigo.

Ms Sue Clarke
Ms Sue Clarke has held senior positions in health and community services over the past 37 years including community health, Local Government, State Government and the private sector. Ms Clarke holds board positions as Director of Bendigo Health Care Group, Chair of Haven; Home, Safe, and a Director of Zonta Club of Bendigo.

Mr Ted Rayment
Ted Rayment has been the chief executive officer of Swan Hill District Health for the past 11 years. Mr Rayment has held many CEO positions including Royal Hobart Hospital and Canberra Hospital. Mr Rayment is currently on the boards of Primary Care Partnership and is deputy chair of the Loddon Mallee Rural Health Alliance. He was previously a director of the Health Roundtable and Royal Hobart Hospital Research Foundation.

Dr Talitha Barrett
A private general practitioner and GP associate with the Eaglehawk Medical Group for 24 years. Dr Barrett has 21 years experience as a director, with 14 years as Chair of various boards and committees. Dr Barrett has worked in Aboriginal health, prison health and community health, as well as GP vocational training and teaching medical students.

Dr Alison Green
Dr Alison Green has been a GP associate in Wodonga since 1991. She is a GP obstetrician and has provided maternity services to Albury Wodonga Health for over 25 years. Alison has a long history as a GP supervisor educating medical students, GP registrars and GP obstetric registrars. She has over 10 years of experience contributing to a number of boards and committees.

Professor Hal Swerissen
An expert on health policy and program development, Hal Swerissen has researched extensively in the design and development of primary health and community services. Professor Swerissen is a research fellow at the Grattan Institute and emeritus professor of public health at La Trobe University, publishing more than 150 books, articles, reports and conference papers.

Ms Leonie Burrows
Leonie Burrows is a management consultant and company director, with 25 years experience in Local Government. Ms Burrows also has experience in regional development, agriculture, education and strategic planning. Ms Burrows is also Chair of Sunraysia Community Health Services and a member of the Loddon Mallee Regional Development Australia Board.

Mr Victor Hamit
Lawyer and director of Wentworth Lawyers in Echuca and Melbourne, Victor Hamit practices in commercial and taxation matters. Mr Hamit previously sat on the boards of SBS Community Board, Rural Ambulance Victoria and the Riverine Herald group. He was a Commissioner for the Shire of Campaspe and is also an experienced company chairman.

L-R back to front: Dr Chris Atkins, Dr Talitha Barrett, Dr Alison Green, Victor Hamit, Ted Rayment, Sue Clarke, Leonie Burrows, Fabian Reid, Professor Hal Swerissen and Matt Jones

Message from the Chair
Fabian Reid

Albert Einstein, perhaps one of humankind's greatest minds once said:

"Imagination is more important than knowledge, for knowledge is limited whereas imagination embraces the entire world, stimulating progress, giving birth to evolution."

Over the life of Murray PHN, we have been in a state of constant change, of evolving priorities and directives, steering a maturing organisation and an increasing emphasis on commissioning and partnering with health services large and small.

As an organisation, we are seeking new ideas, new ways and new paths to tap into the wisdom of our communities. Our purpose is to deliver better health outcomes for those many and varied communities and the test we apply is simple - "Is the system better for our consumers and communities; are we helping our health professionals to deliver the right care, in the right place at the right time?"

The signs are now that we have completed our first strategic plan, we are beginning to reap the rewards of our work. While much of our complex work is still in its early stages, we believe we have begun to lay the foundations for a better primary health system.

Our Strategic Plan 2018-2021 was launched this year, with our vision of *Better Health*, *Better Care* and *Better Systems*. In that, we record our intention to: Make a difference, Make it better, Make it happen, Make it together and Make us stronger.

There are significant challenges for primary health in our region, which stretches from the Mallee to the Alps, from the Murray to the Great Dividing Range. We cover huge distances, with health professionals too often spread too thinly.

But if we can imagine a better health future for our region, and seek to find better pathways to care, we may – in the words of Einstein – be able to stimulate the process of system change that our communities need.

Perhaps one of our greatest challenges is to support our Aboriginal communities to improve the health outcomes of our first nation peoples. I am proud that, from an organisational perspective, the Murray PHN Reconciliation Action Plan Working Group is approaching this task with respect, understanding and a burning desire to work with our Indigenous communities.

We do not pretend that any of these challenges is simple or easy. It has been, and I suspect always will be, difficult to make significant system change. So if we are to achieve our goals of *Better Health*, *Better Care* and *Better Systems*, we must invest wisely and with imagination to improve health outcomes in our region over the next three years.

I would like, on behalf of the Board, to express our gratitude for the commitment and hard work of the Murray PHN team and its executive, who work tirelessly across our extensive region. Their ongoing efforts are deeply appreciated by the Board and the wider community.

I also thank the Commonwealth Government, the major funder of our activities, and the State Government, for their support in our work. I look forward to achieving improved levels of cooperation from all levels of government to deliver better health outcomes for our communities.

It is a great honour to Chair an organisation such as Murray PHN.

Fabian Reid

Fabian Reid grew up in regional Victoria and began his professional career in education before moving into politics as an advisor in the 1980s.

Mr Reid has tertiary qualifications in agricultural science and education and has consulted to organisations including Haven; Home, Safe, VicRoads and the City of Greater Bendigo.

Mr Reid is a director of Bendigo Access Employment and Chair of Bendigo Youth Coordination Group. He has served as chair of the Bendigo Regional Advisory Board for La Trobe University, Chair of the Goldfields Local Learning and Employment Network, a Director of the Golden Dragon Museum and convenor of the Bendigo - A Thinking Community Reference Group.

Our Executives

Ms Elizabeth Clear
Executive Director Corporate

Elizabeth Clear has over 30 years experience in organisational development, change management, finance, quality and risk management and governance, with leadership roles in the public, private and not for profit sectors. She is a CPA with a Bachelor of Commerce and a Graduate Diploma of Applied Corporate Governance.

Elizabeth is driven to ensure that the company is appropriately governed, and that stakeholders trust our ethical and transparent actions. We invest as much as possible into our communities to ensure we can make a difference.

Ms Janice Radrekusa
Executive Director Regional

Janice Radrekusa has 30 years experience in the health sector, spending many years in management at Bendigo Health in a variety of roles across inpatient, outpatient and community care.

Janice values the strength of relationships. Our engagement enables co-creation and shared action. Working together helps to leverage off each other's strengths, building local systems and enduring networks.

Ms Anne Somerville
Executive Director Strategy

Anne Somerville has experience in the health sector with overseas aid organisations, youth services, women's and community health and family welfare services. She has worked with all levels of Government and her governance work includes board memberships across the health and vocational education and training sectors.

Anne looks at system, service and patient needs and gaps, making strategic decisions and trialling innovative methods to create change. Efficiency, effectiveness and collaboration drive improvements that make the system better.

Ms Penny Wilkinson
Executive Director Integration

Penny Wilkinson has worked in both the private and public sectors shaping the development of civic spaces, and has consulted for local and State Governments. Penny is Chair of the Community Foundation for Central Victoria.

Penny works to make it happen through systems that are strong and supported. Education, evidence based, quality improvement activities and purpose-built tools, help to strengthen the capability of the workforce.

Pictured L-R: Anne Somerville, Elizabeth Clear, Matt Jones, Janice Radrekusa, Penny Wilkinson

Message from the CEO

Matt Jones

PHNs have the important dual focus of connecting the primary care system and improving health outcomes within our respective regions. In essence, the role is primary care coordination. The Murray PHN region is a large geographical area with communities of diverse size, needs and capacity. The role of a PHN is to develop local solutions that are targeted to address needs and tailored to the respective regional context. Murray PHN draws upon the engagement and input of providers and consumers of healthcare to inform the design of models of care developed specifically to address needs within our regions. The delivery of models of care relies upon the partnerships of health providers working collaboratively across a region through a shared approach and focus.

Over the course of the past 18 months, Murray PHN has commissioned models of care for chronic disease and introduced a stepped model of care for primary mental health services. This approach represents substantial changes for the primary health care sector and provides greater coordination and integration of services for communities across our region. These localised models of care are primary care coordination in action. They generate system change, improve health service integration and coordination across a region and improve the provision of care by a practitioner with a patient.

Murray PHN successfully acquitted our first three year funding contract at the end of the 2017/18 year. During that time, Murray PHN has developed the systems, structures, processes and capability to enable the delivery of effective localised models of care. We are a knowledge-based organisation with a strong commitment to generating and using quantitative and qualitative data, not only to measure the effectiveness of our models of care, but also to measure our performance. The focus of our next three-year funding period is to measure the effectiveness of the investment in our models of care, to inform their refinement and support our partners in the delivery of primary care service provision.

Murray PHN has developed a General Practice Investment Strategy that supports the coordination of care for patients and the delivery of healthcare by practitioners, practice staff and general practices across our region. The focus of this strategy is to work with general practice to improve quality of care and care coordination, business and practice support, and workforce development.

The challenges of maintaining access to primary care services in rural Australia are well documented. Due to the culmination of a number of coinciding factors, there is a fragility in the current system to enable the continuation of services to several communities in our region. Over the course of this year and for the time ahead, Murray PHN will be supporting communities, general practice, health services and providers to explore and implement new models of service delivery.

Finally, I would like to thank the team at Murray PHN, for their hard work over the course of this past year. We are fortunate to have such capable and dedicated staff. I also thank the Executive Team for their tireless efforts and commitment to Murray PHN. I would also like to thank the Murray PHN Board for their continuing vision, strategic guidance and support through this very successful year.

Matt Jones

Matt Jones has a long and experienced rural health management career in primary health, acute public health and Aboriginal health settings in Victoria, Queensland, Northern Territory and Western Australia.

Previously CEO of Loddon Mallee Murray Medicare Local and two Divisions of General Practice, he believes the key to improved health outcomes in regional areas lies in collaboration and effective community and provider engagement.

Planning and commissioning priority health services

A catchment-wide needs and service analysis is a key component of the commissioning cycle for Murray PHN. This detailed analysis identifies the problems or service gaps and considers options and opportunities that underpin the organisation's strategic actions.

Murray PHN began this process in September 2015, with a significant update in November 2017, and a 2018 review and update to inform the 2018-19 prioritisation and planning process.

The Murray PHN Needs Assessment involves staff working with key stakeholders, colleagues and consumers to help determine current health and service needs of the region. The Needs Assessment is organised across Murray PHN's 10 health priority areas. These include national priorities (set by the Commonwealth Government), and local priorities (determined by our Needs Assessment). We also track a series of national indicators, which include rates of potentially avoidable hospitalisations, childhood immunisation and cancer screening.

As we analyse health needs, we also analyse service needs to highlight gaps in service provision, innovative approaches, rural challenges and the service needs of our diverse communities.

Murray PHN has strengthened its capability in knowledge management with the design and development of the population health knowledge base, known as Murray Exchange.

The Exchange has been a significant milestone in the assembly of quality health-related information, designed to be as contemporary, meaningful and accessible as possible for broad stakeholder and community consideration. The development of other key functions of the knowledge base is now underway, including community and consumer engagement, specific market anaylsis and a library of relevant sites, sources and key documents. All of these will have interactive spaces for open and transparent engagement. (See page 30)

The Exchange compiles indicator and risk factor data for each Local Government Area within the Murray PHN catchment, with automatic 'hotspot' identification built in to allow the production of specific profiles for each Murray PHN region.

Initial market analyses have begun on chronic disease conditions in our region, with the first being an in-depth analysis on diabetes. The market analysis process is strengthened by the establishment of the Population Health Advisory Council (representatives from universities) and the Population Health Planning Network (representatives from service provider organisations).

Murray PHN needs assessment activity has also been supported by the establishment of Aboriginal and Torres Strait Islander, clinical and community advisory councils across the catchment. A new initiative, Health Voices (page 32) deepens our understanding of health at the local level and give us the "community voice".

The needs assessment involves a range of steps and questions:[1]

1. **Scanning: What is happening?**
2. **Analysis: What seems to be happening?**
3. **Assessment: What is really happening?**
4. **Prospection: What might happen?**
5. **Priority setting: What might we need to do?**
6. **Validation and planning: What will we do?**
7. **Strategy implementation: How do we do this?**

Murray PHN understands that positive change requires more than a snapshot approach to health needs. Developing health and service needs data over multiple years will better inform future decision making that will impact desired health outcomes. As our area of influence is primary health care, GP data being collected through specialised tools can provide considerable insight.

To drive improvements in GP data quality, Murray PHN is now in phase two of its automated report, *Closing the Loop*. Accessible online by practices sharing data with us, the report displays 15-month trends, regional and catchment-wide comparisons and has the ability to introduce benchmarks for relevant data sets over time.

We welcome the opportunity to work with stakeholders and consumers within the catchment to collaborate on building better health outcomes for all our communities.

1. Voros, Joseph ; 2001. Reframing environmental scanning: an integral approach, Foresight: the Journal of Future Studies, Strategic Thinking and Policy, Vol. 3, no. 6 (Dec 2001), pp. 533-551

Investing in general practice

Murray PHN is committed to investing significantly in activity to strengthen general practice while supporting longer term, deeper change across the primary health system.

From the days of Divisions of General Practice, to the Medicare Locals that preceded Primary Health Networks, change has been constant for general practice and other stakeholders, despite a relatively unchanged policy environment.

Our goal is to work strategically with general practice in the five "practice friendly" areas of practice support, practice quality, practice engagement, workforce development and business support.

Our general practice investment strategy aims to build relationships, networks and data to help general practice deliver the 'right care, in the right place, at the right time'.

Early general practice engagement, including with our own medical advisors, has uncovered some common themes where support is needed. These include:

- population health planning
- strong communications
- professional development
- training and network needs
- personalised support at a practice level
- systems and partnerships to test new models and to share tools and resources
- business model support in a rapidly changing environment
- optimising financing models
- incentive arrangements
- adoption of digital health resources

It is clear that the most pressing issue for general practice is recruitment and retention of workforce. The trends in workforce supply show growing pressures around an ageing GP workforce, with retirement without replacement by younger GPs due to lifestyle preferences and the challenges of rural practice.

The Murray PHN catchment has approximately 750 GPs across 195 general practices. Nine practices have been lost since February 2017, due to practice closure or mergers. Likely GP retirements within 10 years have significant implications for our region and this impact will be felt even more in under-serviced communities.

Of the 195 practices in the Murray PHN region, more than half have agreements with Murray PHN to share data collected through clinical data tools. Our automated GP Data Report has recently been redesigned in response to feedback from general practices using the report, providing vital information for practice and patient management.

While the PHN's capacity to invest financially is limited, the significant increase in funding dedicated to general practice will generate many major multi-year strategic investments.

From 2019, Murray PHN will invest significantly in building capacity in general practices by funding new roles to perform patient-centred coordinated care. This will involve a range of program initiatives across Activity Work Plans covering after hours, mental health, suicide prevention, alcohol and other drugs, and Aboriginal health programs.

Many projects will be open directly to general practices. The current estimated budget across these activities is more than $3 million, which adds to other significant investments in telehealth, software and connectivity opportunities for general practices.

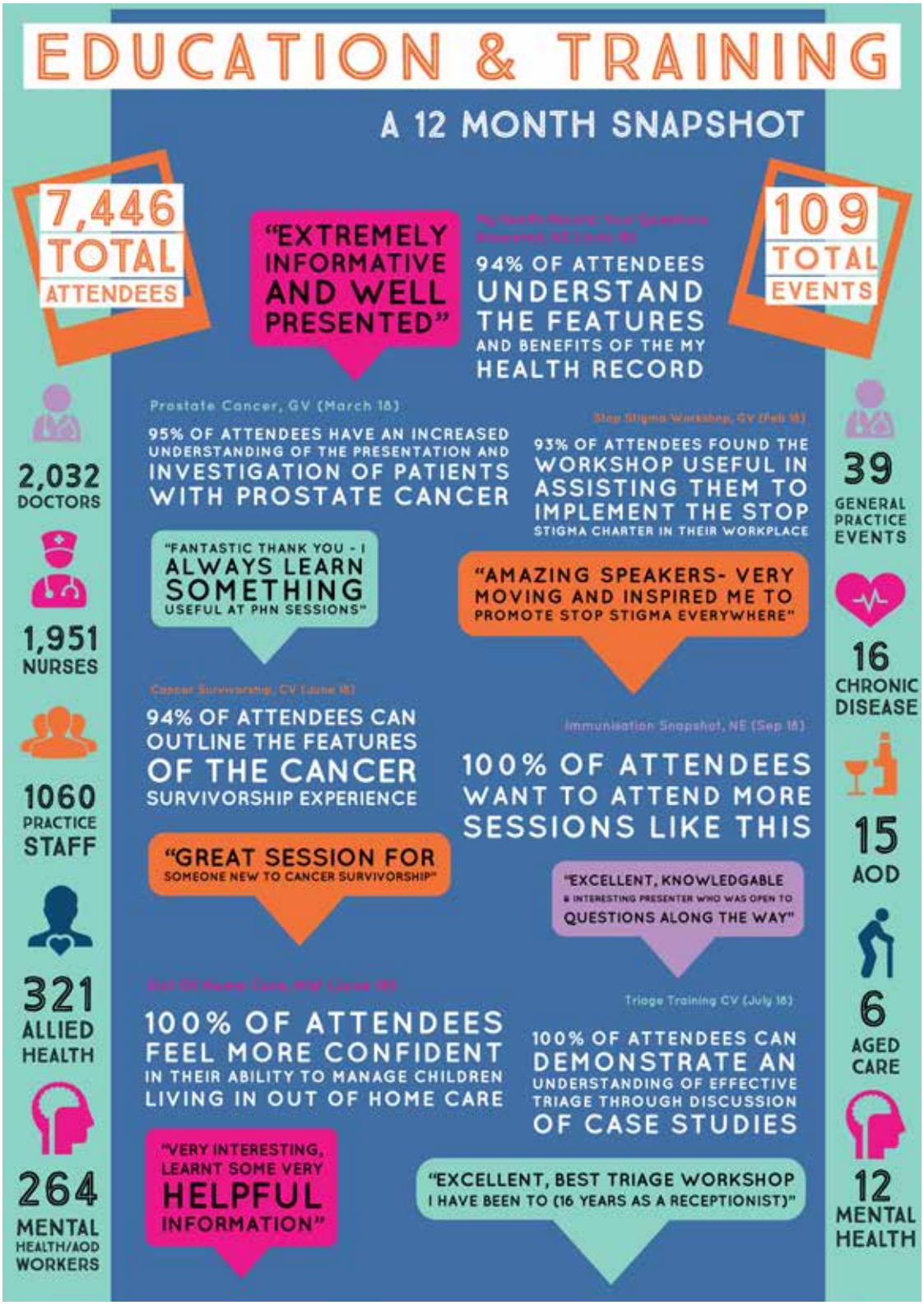
With the expansion of our eReferral project (page 36) and the 'Murray Connect' remote aged care monitoring pilot with Bendigo Health (page 38), Murray PHN will continue to foster improved ways for hospitals and rural health services to liaise with general practices.

Murray PHN is also working to streamline continuing professional development opportunities to ensure they fit the increasingly pressurised GP workforce environment.

Developing an effective workforce

Murray PHN recognises that supporting and developing an effective and efficient health workforce, will enable us to deliver the right care in the right place and at the right time. Without a highly skilled, affordable and sustainable primary healthcare workforce, people living with illness and chronic conditions would be less likely to live a good quality of life.

We work together with many different partners to help us deliver education from, the Royal Flying Doctors Service Victoria, to Mental Health First Aid, Cancer Council Victoria and the Black Dog Institute. Not only does the training provide health professionals the opportunity to update their knowledge and skills, but it improves partnerships and communication between organisations and across the health sector. To view our events calendar visit murrayphn.org.au/events



Poster created by our CPD team demonstrating the data and feedback from our education and training events

Stepping up to primary mental health

Murray PHN has been commissioned by the Commonwealth of Australia to improve the health outcomes for people living within the Murray PHN catchment. In addition to funding services, we work closely with health services, clients, carers and communities to develop models that address needs to suit the local context and capability.

Core to our approach is to design and strengthen a primary mental health system that is aligned to a stepped care approach. This means that services and supports need to be available across a continuum of care that matches client needs – and not a one size fits all approach. We support health services to work together and coordinate care. We do this by working with clinicians so that they know the available local pathways and service options to make sure the patient has access to the right support at the right time.

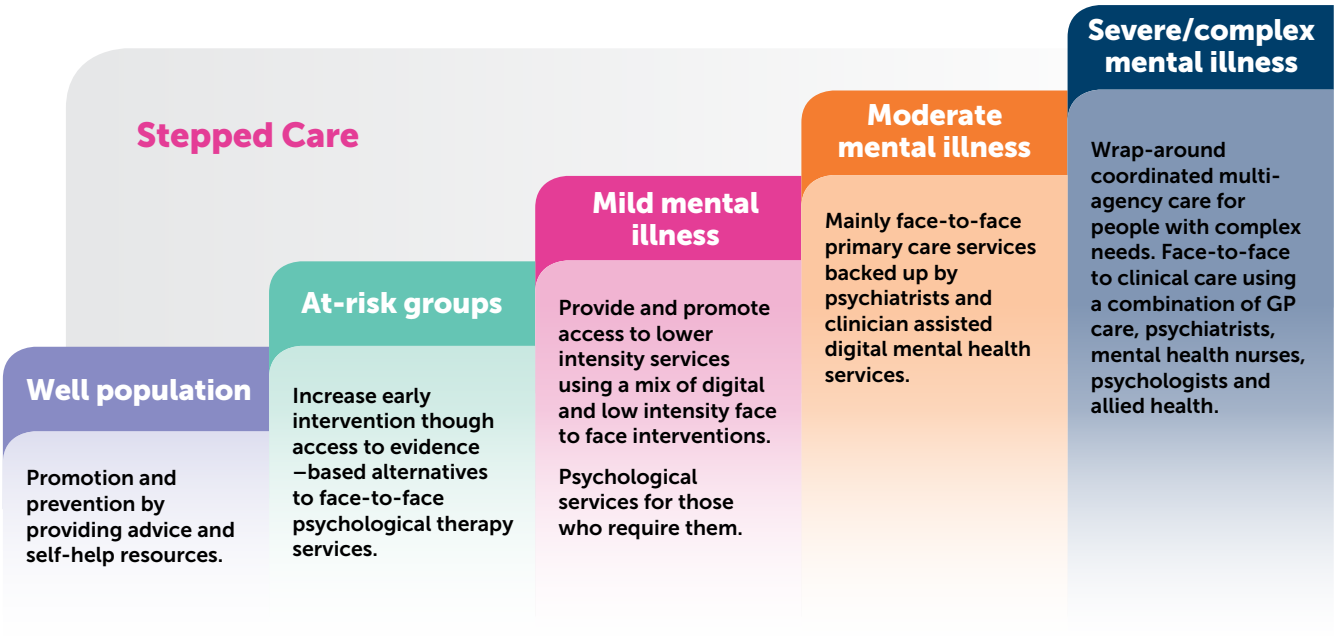
GPs have a key role. They are the key referring agent for individuals to access these services. Once identified as potentially having a mental health issue or issues, the GP will prepare a clinical assessment. This includes identifying the needs of the patient i.e. gauging whether the mental health issue/s presentation is mild, moderate or severe. This process then informs the type and level of supports that can be provided to that individual in keeping with the Stepped Care continuum. The State and Commonwealth Government all play a role in funding mental health services. Services that are funded by Murray PHN fall in two broad categories:

Psychological Therapy Services (PTS)

PTS supports people with mild to moderate mental illness. It provides brief interventions by qualified clinical and non-clinical staff. Services are provided face-to-face and can also be supported through phone and/or Skype. These services are prioritised for priority populations who cannot access Better Access funded by the Medicare Benefits Schedule and is provided to clients at no cost. Included within PTS services are specialist streams to support suicide prevention, perinatal services, child mental health (for children under 12 years) and services for Aboriginal and Torres Strait Islander people.

Primary Mental Health Clinical Care Coordination (PMHCCC)

PMHCCC services are for people with moderate to complex disorders requiring assertive support within a team approach. Eligibility criteria requires diagnosis of an enduring mental illness. Individuals will also have experienced one or more previous admissions to a psychiatric facility or be at risk of such an admission. Individuals currently admitted to an inpatient facility are ineligible for PMHCCC. Priority populations for PMHCCC are those with a diagnosis of an enduring mental illness and who are: homeless, or at risk of homelessness; Aboriginal and Torres Strait Islander people; culturally diverse populations, and/or people with an intellectual disability.



For more information on Stepped Care visit murrayphn.org.au/steppedcare

Providing mental health support

Partners in Recovery (PIR) is a Commonwealth Government program aimed at supporting people with severe and persistent mental illness with complex needs as well as their carers and families. It links them with multiple sectors, services and supports to help them sustain optimal health and wellbeing.

Murray PHN leads two Partners in Recovery programs – one located in Hume in the North East and the other in Loddon Mallee Murray, based in Central Victoria.

Participant profile:
David Henry

David had been living on the streets, struggling with major alcohol abuse and psychological problems. David attended a careers expo and by chance saw PIR, who were at a community event nearby.

An initial conversation, led David to be assigned a support facilitator at Mind Australia, who managed to do the 'impossible' in six months (what he had been unable to do in 18 months).

David's support worker Emma, has helped him to get a disability pension, be accepted into the National Disability Insurance Scheme (NDIS) and find stable accommodation at an affordable rate.

That's not all Emma helped David with. David has attended financial counselling and been linked up with supports for cognitive health, such as cooking and drumming classes.

David says, "I feel like I've broken the absolute poverty cycle that comes from trying to function with medical difficulties, particularly when you're on Newstart allowance.

I had previously put in an application to get the disability support pension, but it was immediately knocked back. PIR helped me to provide the right information to Centrelink, which included getting brain tests completed by a professional to determine what damage had been done over time.

I have been going around in circles for the better part of two years, not being able to get all of these services and supports pulled together. PIR has been such an amazing change to my life. I can't even measure it."

"I feel like I've broken the absolute poverty cycle that comes from trying to function with medical difficulties, particularly when you're on Newstart allowance.

I have been going around in circles for the better part of two years, not being able to get all of these services and supports pulled together. PIR has been such an amazing change to my life. I can't even measure it."

Participant profile:
Marissa McNair

Marissa has been diagnosed with borderline personality disorder, anxiety, depression and chronic post-traumatic stress disorder.

Marissa has bee accessing the PIR program for approximately four years. Marissa's support facilitator Jo from Anglicare, has been assisting her with managing her health, because there are a lot of specialists, such as doctors and mental health workers involved in her care.

Marissa says, Marissa says, "PIR have been great at helping me to understand more about how the NDIS works and are helping me to transition over to the scheme.

PIR has made a huge difference to my life, because before I went with PIR I felt alone, and never felt supported. I didn't have the confidence to go out and do social things, so I isolated myself. I wasn't even dealing with my medical issues in the end, I just shut myself out."

Marissa says her support worker Jo, has helped to boost her confidence so much so, that she was able to apply for and successfully interview for a new job (something that she wouldn't have been bothered to do previously).

"PIR have been great at helping me to understand more about how the NDIS works and are helping me to transition over to the scheme"

Participant profile:
Darren Stacpoole

Darren has been accessing assistance through PIR for approximately six months.

He suffers from schizophrenia, including audio hallucinations, and also has a painful lower back condition that impacts his mobility.

Through the program he has access to home cleaning services, as well as home visitors who talk to him and give him support, including helping him to access services under the National Disability Insurance Scheme (NDIS).

He says that this program has improved his quality of life and his support worker, Jo, has been wonderful.

Over three and a half years ago I was a participant in the Loddon Murray Mallee Partners in Recovery (PIR) program.

I had a number of major issues in my life, as a result of an intense and lengthy episode of mental illness which rendered me unable to function.

Despite my professional skills and education, I couldn't formulate a plan to address the issues and I had no designated carer in my life to help. I was also the sole parent of a young child, which compounded the difficulties I was experiencing.

Accessing PIR helped me to turn things around. It's designed so that the support facilitator's role is to assist you in building your own capacity to manage your life. I can say without hesitation that I wouldn't be where I am today, if it wasn't for the assistance offered through PIR.

I am very pleased and proud to say that I have come a long way in my recover journey. In fact, I have been employed to assist in the delivery and evaluation of PIR for three years at Murray PHN. It has been another significant step in my recovery and provides the opportunity for me to make a positive difference in the mental health sector.

My experience as a PIR participant and user of other mental health services provides an important component into the commissioning of mental health programs at Murray PHN.

Although my mental illness will never disappear, I am grateful for the experiences, knowledge and opportunities it has provided.

I share this story to highlight the benefits of the PIR program and with the possibility of offering some hope to those who experience severe mental illness.

Jo's fellowship journey

Jo Rasmussen, Murray PHN's Strategic Projects Coordinator, has recently been awarded a prestigious Australian Mental Health Leaders Fellowship.

Developed and led by the National Mental Health Commission, the program is the first of its kind in Australia designed to meet the needs of emerging leaders with a passion and commitment to mental health.

Jo will graduate in April 2019.

Minister for Health, Greg Hunt and Murray PHN Strategic Projects Coordinator, Jo Rasmussen

Measuring Partners in Recovery impact

A recent analysis of the Loddon Mallee Murray program has revealed the change that the program can have for participants. This analysis has focused on the outcomes recorded through the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) assessments, which classifies life domains as either met, unmet, no problem or unknown.

The CANSAS assessment helps both the participant and their support facilitator to create an action plan to address unmet needs.

Focusing on participants who have completed the program, we identified a remarkable 74% reduction in unmet needs from intake to exit. When we consider that on average the Loddon Mallee Murray PIR program has been able to address nearly three out of four unmet needs, this represents a significant positive change in a participant's life.

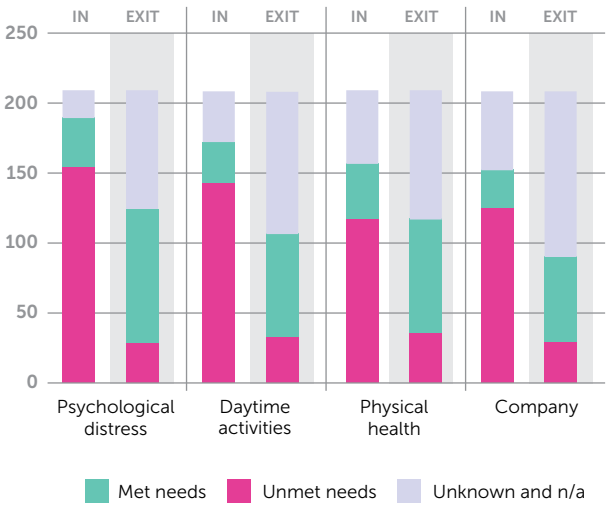
Four domains have consistently been shown as the main areas of concern for a PIR participant. They are:

1. Psychological Distress (have you recently felt sad or low?)
2. Daytime Activities (how do you spend your day?)
3. Physical Health (how well do you feel physically?)
4. Company (are you happy with your social life?)

This information will continue to shape Murray PHN's work in the PIR programs and assist in the commissioning of new psychosocial support services in the future.

PIR client experience

* For exited clients only



Supporting young people

PHNs commission primary mental health care services for children and young people with, or at risk of mental illness, who are being managed in primary care, including the delivery of headspace centres nationally.

Founded in 2006, headspace is an enhanced primary care model which provides young people aged 12-25 years and their families, with a range of integrated mental health, alcohol and other drugs, physical and sexual health and vocational supports.

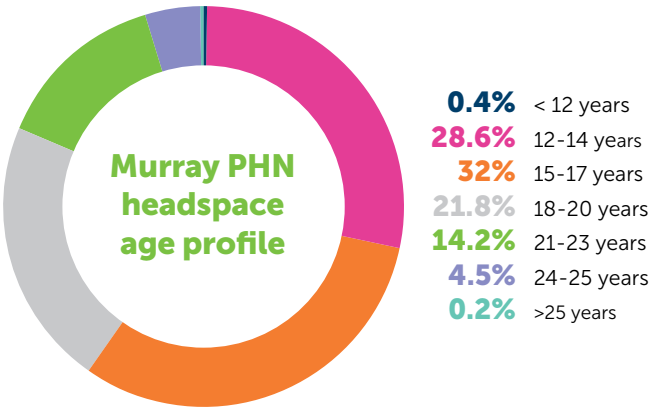
headspace is designed to make it as easy as possible for a young person and their family to get the help they need for problems affecting their wellbeing.

Research shows that 75 per cent of mental health disorders emerge before the age of 25. By treating these issues early and providing a holistic model of support, the risk of them developing into more serious problems, including suicide, is greatly decreased.

headspace
National Youth Mental Health Foundation

Murray PHN works closely with the centres, lead agencies, their consortia partners in our region - Bendigo, Mildura Shepparton, Swan Hill and Wodonga - and Orygen, the Centre of Excellence in Youth Mental Health, in supporting ongoing improvements to accessibility, integration, quality and effectiveness.

Nationally, more than 2 million occasions of service (help over the phone, online or face-to-face) have been provided at headspace centres. Locally, 8,000 young people have accessed 33,000 occasions of service in the past two years.



Murray PHN headspace gender profile:

63.2%	35.2%	1.6%
Female	Male	Other

Ian Johansen, headspace Swan Hill Manager with Ted Rayment, CEO Swan Hill District Health & Murray PHN Board member.

CASE STUDY

"Kaitlyn" lives at home with her parents in a small rural town in the Murray PHN region. Kaitlyn first noticed that she was experiencing low moods in 2016. It was during this time that she experienced a number changes in her life, including moving to a new house in a new town and starting high school.

Since commencing episodes of care with headspace, there has been a significant improvement in Kaitlyn's presentation, mood, mental state and risk. Kaitlyn no longer experiences intrusive thoughts of suicide and she has re-engaged in activities that she previously avoided such as playing guitar, baking and spending time with friends.

Kaitlyn has developed capacity to sit with strong emotions and allow them to pass, with help from adaptive strategies she has been able to learn. Her sleep, appetite and motivation have also improved. Kaitlyn is now compliant with her medication and feels this has also improved her overall presentation, something she was initially hesitant to do.

The Youth Enhanced Program offered Kaitlyn and her family a specific and targeted setting to work with her multiple and complex needs, a capacity to sit with a higher level of risk and acuity and to engage her in evidence-based, best practice interventions that would assist in the management of her mood and the improvement in her overall wellbeing and functioning.

Treatment for alcohol and other drugs

Murray PHN is working to improve the integration and coordination of alcohol and other drug (AOD) services across our region and in 2017/18 invested in planning, research and commissioned AOD treatment services. Our goals are to determine the needs of patients, health services and systems to strengthen models of care.

Murray PHN is partnering with peak bodies and health services to deliver AOD system improvement, workforce development and access to treatment services. Workforce development activities include education and support around screening, harm reduction, brief intervention, dual diagnosis (supporting people with co-occurring AOD and mental health concerns), referrals and cultural responsiveness.

Alcohol consumption, especially at high levels, can increase the risk of developing a range of chronic diseases including cardiovascular disease, type 2 diabetes and chronic kidney disease. As GPs are usually the first port of call for people needing help, GPs are being supported to ask their patients if they are involved in risky drinking behaviour. There is work to be done in challenging the stigma associated with AOD use, to empower people to feel more comfortable to seek out the help they need.

New ways to support people who need treatment, recognising not everyone requires the same level of care, or that the level of care can change at different times, also need to be trialled. Murray PHN is looking to implement the stepped care model that works in mental health to see how it can be applied in an AOD context. Other projects include:

- People who use methamphetamines, their families and communities can access information and localised referral pathways on our website, which have been developed in partnership with the Alcohol and Drug Foundation.
- The Rural Recovery Support Program, part of St Vincent's Hospital NEXUS program, is being supported at Gateway Health to ensure clients in Wodonga and Wangaratta with co-occurring AOD and mental health concerns receive care, which meets their needs and is delivered by suitably trained staff.
- The Addiction Medicine Specialist Program is being supported by Goulburn Valley Health alcohol and drugs team in Shepparton, to build a skilled workforce and develop a community of practice.
- Models of care that target community need have been developed in Aboriginal Community Controlled Health Organisations across the catchment, providing front line services to the community.
- Murray PHN is also working with the Youth Support & Advocacy Service (YSAS) to extend the reach of their rural youth AOD nurse practitioner from Bendigo to the Loddon Shire. The 12-month pilot is delivering AOD and mental health assessment and treatment for young people aged 12-25, including support for parents, families and caregivers. Targeting young people across our region is key to reducing the long-term impact of AOD use on them and their families.

In 2016 - 2017:

4,400+ people were estimated to have sought treatment for Alcohol and Other Drug concerns:

60% were aged between 20-39 years

66% were male

14% identified as Aboriginal and/or Torres Strait Islander

Three of the most common drugs of concern were:

27% Alcohol

21% Cannabis

20% Amphetamines

Lee, a nurse practitioner for the YSAS program said "Young people and adolescents have unique pressures, developmental considerations and various stressors which can impact on their mental state and wellbeing.

In many cases young people are new to treatment or accessing support at an early stage in their life, so it's crucial that we provide them with a welcoming and positive experience.

With our service and this model, the ease of access is one of its strengths because it removes barriers to treatment. For example, anyone can call and speak directly with the clinician: there are no reception staff or even waitlist barriers.

The nurse practitioner calls or texts the young person or vice versa and the appointments can be conducted anywhere the client feels comfortable.

This role is by far the most rewarding and client focused position I have ever worked in."

Stopping stigma

It's reality for most people living with mental illness, that stigma and discrimination are part of their lives. Stigma involves a variety of myths, prejudices, and negative stereotyping of people with mental health issues.

Many people with mental illness recover and can lead fulfilling lives in the community – when they receive appropriate ongoing treatment and support. However, only about half of those affected receive treatment.

Murray PHN created the Stop Mental Illness Stigma Charter with Hume and Loddon Mallee Murray Partners in Recovery (PIR) programs, to encourage organisations to adopt the right behaviours and practices and build an environment where employees and customers feel supported and understood.

Reducing stigma isn't easy but it is "the single most important barrier to overcome" according to the World Health Organisation.

The Charter contains seven commitments, which when addressed, help to reduce stigma. They are:

1. **We will be informed**
   We will learn the facts about mental illness to educate ourselves and those around us.
2. **We will listen**
   We will hear from and support those people who have a mental illness story to share.
3. **We will be mindful of our language**
   We will choose our words carefully and not reduce people to a label or their diagnosis.
4. **We will be inclusive**
   We will not exclude people with mental illness but instead learn from their experiences.
5. **We will challenge the stereotypes**
   We will challenge inappropriate names and descriptions of people with a mental illness.
6. **We will be supportive**
   We will treat people who have experienced mental illness with both dignity and respect.
7. **We will promote recovery**
   We will encourage help seeking behaviour and talk positively about regaining wellness.

Over 65 organisations, groups and clubs have adopted the Stop Mental Illness Stigma Charter. Pledge to stop mental illness stigma: murrayphn.org.au/stopstigma

Pledging to stop stigma in Queensland

Murray PHN's Stop Mental Illness Stigma Charter has gained support from organisations well outside its catchment area including a Queensland health service.

West Moreton Hospital and Health Service (West Moreton Health) launched a Stop Mental Illness Stigma campaign in December 2017.

At an event, West Moreton Health's executive team and Board signed the pledge to reduce mental illness stigma and to support positive environments for consumers and staff.

The organisation's Mental Health and Specialised Services Division and corporate communications team have developed an action plan to extend the campaign across all areas of the hospital and health service.

Leading up to Mental Health Week in October, West Moreton Health promoted the seven commitments and each month launched a personal story linked with each commitment.

L-R: Dr Leeane Geppert, Executive Director, Mental Health and Specialised Services, Associate Professor John Allan, Executive Director, Mental Health, Alcohol and Other Drugs Branch, Department of Health, and Dr Kerrie Freeman, Health Service Chief Executive.

Practical help

Early in 2018 we held our first Stop Mental Illness Stigma Charter workshops in Albury, Bendigo, Mildura and Shepparton.

Around 150 people from 50 organisations across our catchment came together to discuss practical ways to reduce the stigma of mental illness in their organisations and communities. People with lived experienced shared their stories - reflecting on the use of language as a barrier to regaining wellness.

One speaker commented that it is now easier to talk about mental health than it was five years ago, however ignorance still bred stigma, which itself is a nicer word for discrimination

The reason behind the Charter is simple - by understanding and listening to those who experience mental illness, offering support and encouraging recovery, all the while by being mindful of our language and challenging others who aren't mindful of theirs - we can work towards a supportive environment, where stigma doesn't exist.

50%
of attendees were from organisations who had already signed the Charter.

84%
of attendees said that the Charter made a difference in their organisation.

94%
of attendees who were from organisations who hadn't signed the Charter, said they would adopt or encourage their organisation to adopt the Charter after the workshop.

Participant feedback included:

"I have very limited access to examples and the stories helped challenge my views and behaviour."

"The Charter offers hope for a better future – especially for newly-diagnosed and younger community members. Hope is often all an individual has to hold on to."

Comments like these make us so passionate about stopping the stigma of mental illness.

Left: Murray PHN CEO, Matt Jones with some of the Bendigo team and guest speaker Ric Raftis.

Below L-R: Workshops held in Shepparton, Bendigo, Albury and Mildura.

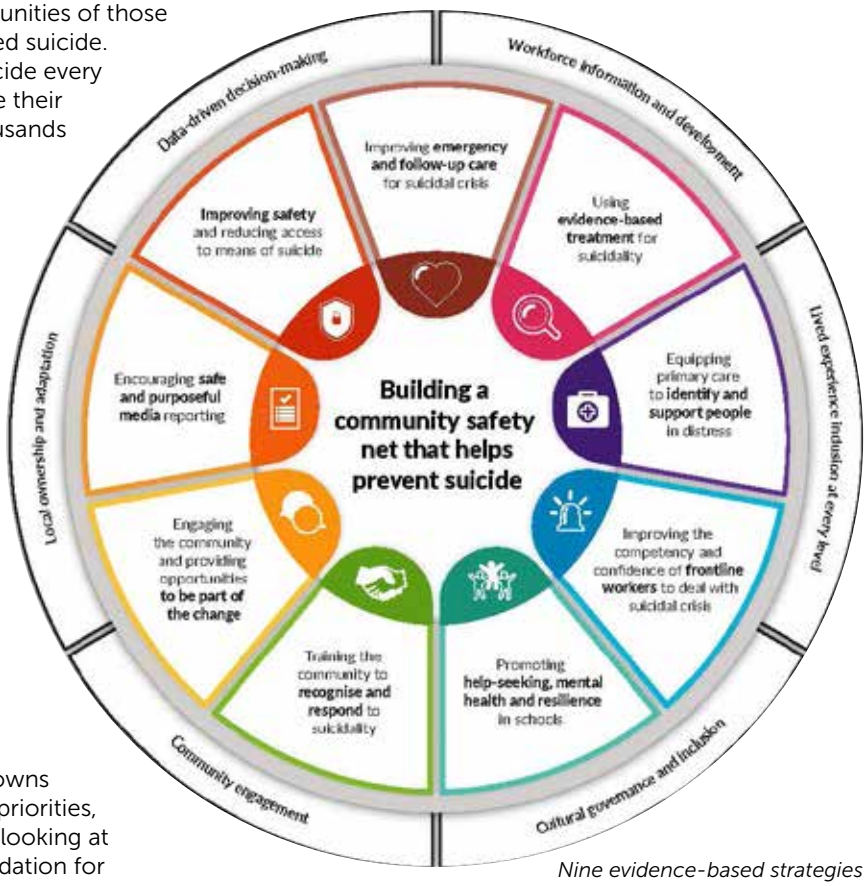
Local approaches to suicide prevention

Suicide is more than just a mental health issue – it's a community one. It affects so many people, including families, friends, colleagues and the communities of those who have taken their own lives or attempted suicide. In Australia, almost eight people die by suicide every day. Annually, more than 2,800 people take their own lives, 65,000 attempt suicide and thousands more consider it.

There is evidence that shows working with local communities to develop and deliver community-driven suicide prevention plans that address local priorities and build on existing services and supports can help to reduce rates of suicide, reduce the number of suicide attempts, improve individual resilience and wellbeing and improve systems to prevent suicide in an ongoing way.

Murray PHN has partnered with the Victorian Government to develop and deliver place-based suicide prevention strategies in Mildura and Benalla – two of 12 sites where the State Government is trialling this initiative. It forms part of the Victorian Suicide Prevention Framework 2016-2025 that aims to halve the state's suicide rate by 2025.

Project officers are working in those two towns to coordinate strategies that address local priorities, engaging and consulting with community, looking at data and using an evidence-base as a foundation for decision-making.



Nine evidence-based strategies identified by the Black Dog Institute

Benalla activity highlights

- Established Community Campaign Taskforce and working to establish an Aboriginal and Torres Strait Islander Taskforce
- 32 community members and 60 parents and carers trained in Mental Health First Aid
- 29 people from local football team and the University of the Third Age attended a suicide bereavement awareness workshop
- 109 local tradespeople attended a talk from HALT (Hope Assistance Local Tradies)
- 78 volunteers attended safeTALK training, to better identify when someone may be struggling, by listening to what they say and what they do
- School-based program 'Live4Life' was successfully piloted in Benalla during 2017 and will continue operating with funding from this project for a further 12 months
- Year 8 and 11 students across Benalla have been trained in Teen Mental Health First Aid
- 'Pathways to Care' workshop was delivered to local healthcare providers to improve the confidence of frontline workers to deal with suicidal crisis

Mildura activity highlights

- Established a project steering committee
- Steering committee members and 50 community leaders completed Leadership in Complex Systems training to build their understanding of systems and how to create system change
- 75 people attended a suicide bereavement awareness workshop
- 12 people with lived experienced of suicidality explored their lived experience to identify ways in which they can help others
- 102 people who are likely to come into contact with at-risk individuals, attended one of four targeted gatekeeper training sessions to learn influencing skills
- Participating in activities e.g. 'R U OK?' day, World Suicide Prevention Day and The Great Vanilla Slice Triumph
- This project is funding a La Trobe and Monash University research project to identify ways for improving emergency and follow-up care for suicidal crisis within the Mildura Local Government area
- GPs and practice nurses attended training in suicide prevention

Sensitive storytelling

In 2018, Murray PHN met with media outlets in Mildura and Benalla to talk about the place-based suicide prevention trials in those cities and the importance of responsible reporting around suicide. Encouraging the safe and purposeful reporting of suicide in the media is one of the key priorities of the LifeSpan framework that is underpinning the local suicide prevention trials.

Research from more than 100 international studies suggests that reporting about suicide deaths has been associated with increased rates of suicide and suicide attempts, particularly where the death has been glamourised, glorified or the location and method is detailed. However, some studies show that media reporting can contribute to a reduction in rates when suicide is framed as a tragic waste and avoidable loss, focuses on the devastating impact of suicide's aftermath or explores an individual's experience of overcoming suicidal thinking.

Journalists were familiarised with the Mindframe National Media Initiative which provides up-to-date, evidence-based information to support the reporting, portrayal and communication about suicide and mental illness. Mindframe guidelines can be accessed at mindframe-media.info

Staff from the ABC in Mildura, the Sunraysia Daily, the Mildura Midweek and the Benalla Ensign all took time out of their busy schedules to talk about the important issue. Strong and enduring local partnerships are a key to the success of place-based suicide prevention strategies.

Ashlee Falvo – Sunraysia Daily Journalist:

"As a reporter for the Sunraysia Daily, I have reported on more suicides in my own community than I would like to remember.

The first death by suicide interview I did, I had been working as a journalist for just one month.

I sat and cried with a local mum who told me the story of her son, in his 20s, who died by suicide as a result of extensive use of the drug ice.

I thought it was a one-off. I thought that as time went on I would "toughen up" and I would be able to report on suicide without the emotional attachment. I was wrong.

Journalists are expected to be pretty staunch characters, but deep down we carry the burden and pain of those we interview into our private lives.

The training provided by Murray PHN shone a light on this, it provided a path for journalists to follow in order to be able to report on suicide in a sensitive, respectful and effective way.

The stories of community members who have died by suicide are important. They need to be told so that we, as a region, can start having conversations about suicide and mental health.

Ashlee Falvo

The training gave my colleagues and I the confidence to be able to tell these stories in a way that honours the life of our community members who died by suicide. No sensationalising, no exaggeration, no headline-grabbing hoopla – just the truthful, dignified stories of those who succumbed to mental health issues."

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In August 2018, Murray PHN convened a round table discussion, in conjunction with headspace national office about youth suicide and self-harm in Wangaratta.

Participants from health, education, police, ambulance and Local Government, along with other support agencies in the region attended and identified ways to strengthen local prevention and education support.

Murray PHN has also funded the Central Victorian Primary Care Partnership to develop a local, evidence-based, integrated suicide prevention action plan in Mount Alexander with the aim of reducing suicides, suicide attempts and to improve community capacity to look after themselves and others.

Improving Indigenous health

Improving Aboriginal and Torres Strait Islander health is one of the key priorities for Murray PHN. Aboriginal and Torres Strait Islander people experience a burden of disease two-and-a-half times that of other Australians, with 70 per cent of the health gap due to chronic diseases such as cardiovascular disease, diabetes, cancer, chronic respiratory disease, chronic kidney disease and mental health issues.

The Murray PHN region is home to more than 13,600 people who identify as being Aboriginal or Torres Strait Islander. Murray PHN is working with Aboriginal Community Controlled Health Organisations and communities to improve access to health services that meet the needs of Aboriginal and Torres Strait Islander communities. Ensuring that Aboriginal and Torres Strait Islander people can access safe and appropriate health services is a step towards closing the gap in health outcomes and life expectancy.

Murray PHN is developing a Reconciliation Action Plan to guide and underpin its work across all priority areas. The development of this key plan is being guided by community and staff engagement, and it will recognise the important role Murray PHN plays in the region in promoting reconciliation and improving health outcomes for Aboriginal and Torres Strait Islander people.

In 2018, Murray PHN celebrated important events including Reconciliation Week and NAIDOC Week. We partnered with the Victorian Aboriginal Community Controlled Health Organisation to provide Aboriginal Cultural Safety and Dual Diagnosis in Practice training to health professionals working in the area of alcohol and other drugs. Other collaborations included working actively with the Menzies School of Health Research on the National Indigenous Bowel Cancer Screening Project and Melbourne University Indigenous Eye Health Unit on Closing The Gap For Vision By 2020.

We have continued to work with our Indigenous Health Advisory Council, which provides the opportunity to share research, best practice, innovation and enhance our decision-making. We have also continued to work actively to improve the health outcomes for Aboriginal and Torres Strait Islander people in the areas of chronic disease, child health, suicide prevention, mental health and alcohol and other drugs.

A 12-month community paediatrics research project is underway in Mildura, focused on developing a community-based paediatric clinic within a collaborative and integrated model of care for Aboriginal and Torres Strait Islander children and their families.

This year Murray PHN has employed Aboriginal Access Advisors who are working closely with local communities, Aboriginal Community Controlled Health Organisations and mainstream health services to understand the barriers for Aboriginal and Torres Strait Islander people accessing services. The staff also play a key role in helping Murray PHN implement strategies to remove barriers and make health services across our region safe and accessible for all Aboriginal and Torres Strait Islander people.

Murray PHN has funded Bendigo and District Aboriginal Cooperative (BDAC), to deliver a model of care, that works to support people who experience co-occurring mental health and substance misuse issues, which is also referred to as dual diagnosis.

The model of care

As part of the model of care, intensive case management is delivered to a maximum of 10 participants.

This care is delivered in a harm minimisation philosophy, which includes: providing assessment, referral, advocacy, therapeutic counselling, care planning and a wide range of holistic supports.

A small case load enables a continuity of care that isn't always possible under more conventional case management models.

The extra time enables the worker to tailor support, advocate for, and attend all appointments with the participant. This builds the relationship, creating a sense of trust and respect that helps encourage change.

BDAC is also delivering Integrated Team Care (ITC) services, which aim to improve health outcomes for Aboriginal Torres Strait Islander people with chronic health conditions, by working in a team-based approach. The dual diagnosis workers, collaborate with the ITC team to ensure that participants are having all of their health needs met and are therefore more likely to overcome, or appropriately manage, their co-occurring illnesses.

Danny Fawkner, BDAC Dual Diagnosis worker

Case study

"Barbara" has depression and anxiety that she doesn't manage well. A history of family violence and several medical complications are two of the reasons behind her choice to use drugs. Before long she becomes a heavy ice user. She can no longer afford things she used to enjoy. She can no longer afford a place to live. Her four children are taken from her and put under the care of the Department of Health and Human Services (DHHS).

As addiction takes over her life, Barbara finally reaches rock bottom and knows that she has to make a change. She has to reach out for help if she's ever going to see her children again.

Barbara had not been an active user of the health system and hadn't engaged much with BDAC before entering the dual diagnosis program. She had tried several services but sometimes, it was just too painful having to tell and re-tell her story.

The rapport and trust that Barbara built with her dual diagnosis worker, meant that she didn't have to worry about telling her story anymore and she didn't have to worry about trying to understand it all, or keeping required appointments and meetings.

This model of care provided the support and encouragement that she needed to get her life on track. As part of the program, Barbara was referred to the Centre for Non-Violence, DHHS, a detox facility and a housing service.

Barbara has now successfully finished her detox. She has secured her own private rental and been reunited with her children. She is feeling much better after her health complications have been treated and her mental health managed through appropriate medications. She has a new lease on life, and has even joined a fitness club and is seeing a dietician.

VACCHO

Victorian Aboriginal Community Controlled Health Organisation

Murray PHN was excited to partner with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) this year, to bring four free, two-day cultural safety training sessions to health professionals who deliver alcohol and other drug (AOD) services to Aboriginal and Torres Strait Islander patients across our region.

The training aimed to develop a skilled workforce better equipped to:

- self-reflect on their practice,
- tailor engagement strategies,
- understand guiding principles for co-occurring mental health and AOD issues for Aboriginal people, and
- understand socio-emotional, wellbeing and recovery frameworks.

100 per cent of participants from the Bendigo and Robinvale workshops rated the training as useful or very useful.

'It broke down unconscious bias I had and gave me a better understanding of how to effectively engage with members of the Aboriginal community.'

'I have a better understanding of Aboriginal culture and practices and how we can identify these practices to work together, as opposed to not understanding and having conflicting opinions and behaviours.'

'I now understand the complexity of Aboriginal history and its impact on presentations in alcohol and other drug use and mental health.'

Keeping people healthy and well

Sunraysia consortium develops diabetes annual care checklist

A new consortium of healthcare professionals formed in Sunraysia and using Diabetes Australia's recommended **Diabetes Annual Cycle of Care,** has developed an innovative checklist for their clients.

The group identified that clients often don't remember important information such as who their diabetes educator is or when they last had a foot check-up. In consultation with stakeholders including general practitioners, clients, carers, diabetes educators and other health professionals, the group designed a checklist to help clients manage their diabetes.

The checklist allows for an "any door" approach where a client can visit any of the recommended health professionals and then subsequently be referred to the next. This allows them to ultimately complete the Diabetes Annual Cycle of Care and facilitate effective and timely care of people with diabetes. It is hoped that this cycle of care will help reduce preventable hospital admissions for diabetic complications in the Sunraysia area.

The free checklist will be distributed to local general practitioners and allied health practitioners involved in the care of people with diabetes. It is hoped that it will improve client education, encourage clients to be involved in the management of their diabetes and help general practitioners keep track of the Diabetes Annual Cycle of Care for each client. Another advantage will be improved communication between (at times isolated) health professionals in the Sunraysia area.

Members of the consortium include staff from Irymple Foot Clinic, Kinetic Exercise Physiology, Michelle's Diabetes Education Services, Irymple Pharmacy, Blue Frog Optics, Life Resolutions Mildura and consultant dietician Laura Roberts. They have invested their own funds, time, and expertise in this project with the goal of improving outcomes for people with diabetes in the Sunraysia region.

L-R: Consortium members Rebecca Newman, Alex Look, Tracey Meyer, Kirsty Telfer, Lauren Pipicella

Giving Joyce a chance to walk on air

Joyce Reddick, 81, is a client of the Irymple Foot Clinic which is funded by Murray PHN to assess and treat people living with diabetes and prevent unnecessary hospitalisations.

Joyce had been suffering from recurrent diabetic foot ulcers for several years and is seeing podiatrist Kirsty Telfer for treatment. Joyce would often need weekly appointments to successfully heal each ulcer. This was an ongoing issue for Joyce as she would develop a new ulcer not long after the previous one had healed.

Successful treatment has been a joint effort by both Joyce and Kirsty, who have developed a great rapport together over the years. Ongoing treatment was made possible due to the Murray PHN program, enabling Joyce to attend appointments free of charge, removing the financial burden.

"I don't know what I would've done without the funding. I wasn't sure if I would be able to come and have my feet seen to if I had to pay the full amount each week. I am a pensioner and often find it hard to pay the bills at times, so this program has helped greatly and removed any stress from the process."

Joyce is now free from any diabetic foot ulcers and continues to attend Irymple Foot Clinic under the Murray PHN program for regular check-ups and routine foot care.

by Kirsty Telfer - Podiatrist at Irymple Foot Clinic

Lung and heart health program success

Funded by Murray PHN, the Pulmonary and Cardiac Exercise and Education (PACE) program has been successfully delivered in each major town of the Alpine Shire since its launch in mid-March 2018.

The innovative and flexible service model has ensured that local people have had the opportunity to access health services locally.

The program offers weekly sessions for chronic disease management, focusing on heart and lung health. These include one-on-one assessments, education sessions, exercise classes and individual home-based exercise plans, delivered and supervised by health professionals. As a result of the PACE program the nearest large regional hospital has reduced its rehabilitation waiting times from six weeks to two weeks.

As part of the free program participants receive personalised advice and support with the aim of feeling more confident in everyday activities.

From 13 March to 30 September 2018:

110 referrals received

83 participants assessed

63 participants started a program

27 participants completed a program

"I feel like everything is better. So many things have improved. I am happier. I have bipolar and I have been much, much better. I have more confidence. I always worried about doing everything, even walking. My balance has improved and I enjoy going for a walk. I don't feel anxious anymore coming to PACE." - PACE participant

Participants of the PACE program in action

Heart failure management forum

A heart failure management forum held in Bendigo in September, provided the opportunity for general practice clinical staff to learn from leading cardiologist Dr Voltaire Nadurata and the Heart Foundation.

Participants reviewed the role of primary care health services in the prevention, detection and management of heart failure, with a focus on best practice guidelines to detect and manage heart failure factors across rural communities.

Delivered in partnership with the National Heart Foundation of Australia, the forum formed part of the Nurse Ambassador Project that was developed to reduce potentially avoidable hospitalisations due to chronic heart failure. Feedback from a participant noted the forum included "very comprehensive coverage of heart failure management, medical theories and imaging options".

Sharing health information

My Health Record

The Federal Government announced in the 2017 Budget a commitment to continue to expand the My Health Record system. By the end of 2018, every Australian will have a My Health Record unless they choose not to have one.

Through the My Health Record system, health professionals can access timely information about patients such as shared health summaries, discharge summaries, prescription and dispensing records, pathology reports and diagnostic imaging reports.

The Australian Digital Health Agency (ADHA) is working closely with a range of stakeholders to implement a variety of programs to support this digital health change and to measure benefits of the My Health Record system.

As more people use the My Health Record system, Australia's national health system will become better connected. The result is better coordinated care, as health professionals will be able to communicate more easily with one another and know and understand what treatment and medication patients have been prescribed.

Murray PHN has partnered with the ADHA to support health professionals with registration, usage and to provide consumer awareness about the My Health Record system.

Three key benefits

	HEALTH PROFESSIONAL BENEFITS
1	More time spent with patients and less time chasing clinical information and investigations
2	Complements existing local patient records, enabling better informed clinical decisions
3	Improved information sharing between all healthcare providers involved in a patient's care

	CONSUMER BENEFITS
1	Personally controlled, individuals have a say in what gets uploaded and who can see it
2	Healthcare access in an emergency situation can provide potentially life-saving information
3	Better access as your information is available 24/7 from anywhere and protected by law

Murray PHN's My Health Record team members were involved in attending or organising over 150 local events and meetings where over 5,000 meaningful engagements took place with people from all backgrounds and with different interests.

The Australian Digital Health Agency visited Murray PHN and a number of health services and consumer groups in Albury, to listen and learn more about how the My Health Record is being used locally.

L-R: John Galvin - Central Medical Group (CMG) Practice Manager, Dr Alison Green - Murray PHN Board member, Professor Meredith Makeham - ADHA Chief Medical Advisor, Dr David Tillett - CMG GP, Tim Kelsey - ADHA CEO, Matt Jones - Murray PHN CEO.

142,948
consumers in the Murray PHN region have a My Health Record

56% females (80,790) are more likely to have a My Health Record than males (62,158)

38% of young people aged 19 or less are most likely to have a My Health Record

24% of 40-64 year olds have a My Health Record

20% of 20-39 year olds have a My Health Record

18% of 65+ year olds have a My Health Record

375 healthcare providers are registered for the My Health Record system in the Murray PHN region:

- **191** general practices
- **101** pharmacies
- **65** other healthcare providers
- **13** public hospitals and health services
- **4** private hospitals and clinics
- **1** aged care provider

L-R: Tammie Long and Juliette Begg Murray PHN, Sharryn Ward AWAHS, Matt Jones Murray PHN, Professor Meredith Makeham and Tim Kelsey ADHA and David Noonan AWAHS.

Clinical decisions made easier

Patients in our communities who live with complex and chronic conditions require a range of services from primary, community and secondary healthcare systems. It is these people, and their health professionals, who benefit most from the use of Murray HealthPathways.

The web-based portal is available free to general practitioners, hospital specialists, nurses, allied health and other health professionals.

In the past 12 months, more than 200 referral pathways have been localised to the Murray PHN region.

HealthPathways provides up-to-date information on the best practice assessment and management of common clinical conditions. It provides health professionals with referral guidance, plus resources to help patients understand or manage their condition at the time of consultation.

Designed and written for use during a consultation, clinical reminders of the 'red flags' and pitfalls in specific presentations are included under a number of conditions.

Suites of pathways include common clinical diagnosis and referral streams including: allied health, diabetes, gastroenterology, infectious diseases, mental health, oncology, palliative care, respiratory and urology.

Pathways integrate local health service information, providing current details of providers, agencies, services and groups, that GPs can refer to. Having patients referred to the correct specialist and in the correct way, contributes to the patient receiving the care they need more quickly and makes for a more connected health system.

362 localised pathways

143 pathways in development

32 clinical working groups

4,743 registered users

168 clinicians involved in developing pathways

70,456 viewed pages

Popular pathways in order of most views:

- **Mental health**
- **Medical**
- **Acute chest pain**
- **Women's health**
- **Aboriginal and Torres Strait Islander health**
- **Emergency departments**

Special thanks to Murray PHN's Clinical Editors: Dr Ann-Marie McKinnon, Dr Christie Rodda, Dr Claire Simpson, Dr Jane Neyland, Dr Manisha Fernando, Dr Margi Gould, Dr Philip Webster and Dr Una Kennedy.

Murray HealthPathways

Dr Christie Rodda, Murray PHN Clinical Editor and GP at The Beechworth Surgery.

Primary mental health pathways

This year, one of our main focuses was to complete a suite of over 35 pathways for mental health and alcohol and other drug conditions. The pathways were released in March 2018 to coincide with the new primary mental health arrangements that came into effect across our region.

Clinicians can find pathways on acute, primary health, early intervention and preventative information and are able to offer their patients pathways for stepped care approaches such as telehealth, community support, specialist care and self-management.

The mental health pathways are our most accessed pathways and since their release, there has been an 8.3 percent increase in use across the entire pathways platform.

An example of some of the pathways are:

Alcohol and Drug Use

- Alcohol Screening and Brief Intervention
- Opioid Replacement Therapy
- Drug and Alcohol Referrals

Mental Health

- Antidepressants for Older Persons
- Acute Bipolar Disorder
- Depression in Adults
- Pregnancy and Postpartum Mental Health
- Suicide and Self Harm
- Non-urgent Mental Health Referrals

Register at: murray.healthpathways.org.au

State-wide paediatric pathways

The Victorian Primary Health Network Alliance is working with Safer Care Victoria's Paediatric Clinical Network to translate the Royal Children's Hospital's clinical practice guidelines into state-wide paediatric HealthPathways.

The project's primary aim is to reduce unwarranted variation in paediatric care across Victoria, by providing GPs with access to reliable assessment, management and referral information.

UNWELL CHILD
- Acute abdominal pain
- Fever
- Urinary Tract Infection (UTI)

NEUROLOGY
- Febrile seizures
- Head injuries
- Headaches

ALLERGY CONDITIONS
- Rash in unwell children
- Eczema
- Adverse food reactions

EAR, NOSE AND THROAT
- Paediatric audiology referral
- Post-operative grommets care
- Urgent or routine paediatric ENT and hearing assessment
- Ear discharge
- Snoring and obstructive sleep apnoea
- Sore throat

Our Regional Reference Group: Dr Scott Parsons - Clinical Editor and Laura Collins - Program Officer Health Pathways from North West Melbourne PHN. Lisa Callipari - Integrated Care Consultant and Dr Philip Webster - Clinical Editor from Murray PHN. Samantha Cooke – Registered Nurse, Maternal Child Health Nurse and Community Health Coordinator Mildura Rural City Council, A/Prof Michael Marks - General, Behavioural and Developmental Paediatrician, Melbourne Paediatric Specialists (also consulting at Mildura) and Kathy Stidwill - Speech Pathologist Sunraysia Community Health Services.

Sexual health pathways

Murray PHN has partnered with the Department of Health and Human Services and our Victorian PHN partners, to create state-wide sexually transmitted infection pathways. The suite of pathways include gonorrhoea, chlamydia, sexual health services and urgent or routine infectious diseases referrals.

Murray PHN's Clinical Editor Dr Una Kennedy has led the STI pathway development. Una is a practicing GP who specialises in women's sexual and reproductive health and has a post-graduate degree through the Family Planning Association of Australia.

Una undertook her placements at Family Planning Victoria, Melbourne Sexual Health Centre and The Action Centre (young person's sexual health).

Una says that the STI pathways are an online resource aimed to be used by GPs, doctors in local hospitals, nurses, pharmacists and allied health staff.

Dr Andrew Mahony, infectious diseases specialist at Bendigo Health Care Group, Elise Kornman, sexual health nurse at Women's Health Loddon Mallee, Peter Strange and Louise Holland, sexual health nurses at Bendigo Community Health and numerous advocates from Aboriginal and Torres Strait Islander, AIDs, LGBTIQ and refugee communities, also contributed their knowledge and expertise to localising these pathways to the Murray PHN region.

A platform for population health

Murray Exchange is a data platform that gathers information from multiple sources and presents an integrated view for health planners, health providers and PHN staff to access.

Exchange is a blend of information processing, data management and resources. It provides powerful visual representations of data and enables data to be presented in an easily digestible format for various stakeholders.

De-identified general practice and patient information is a data source unique to Murray Exchange. It helps not only to provide us with another layer of understanding about our communities, but ways in which we can further support practices.

With several PHNs observing the benefits and pledging their investment, Murray Exchange has been able to evolve in scale and depth, to soon include the mapping of other PHN areas.

Exchange will use multiple data feeds from State and Federal Government, and peak bodies, providing up-to-date and comprehensive combination of 200-300 data sets. It will enable layered mapping of social determinants of health in specific geographic boundaries. This will deliver standardisation of processes, business efficiency gains, supporting business systems and reduction in risk, but most importantly it initiates common dialogue and shared understanding between agencies.

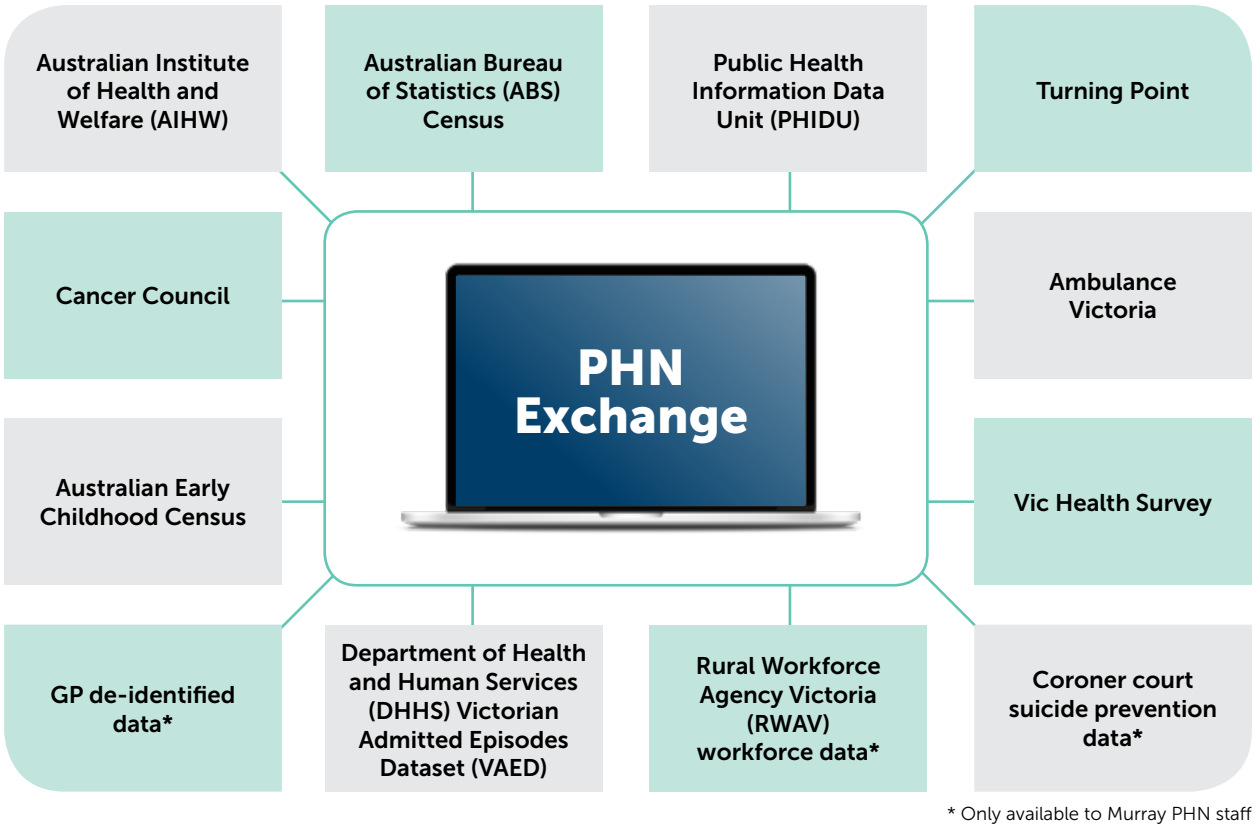
PHN Exchange, as it is now branded, is not a data warehouse but rather a living needs assessment. It has the potential to become a primary population health service planning platform for the sector across Australia.

New features that are currently either being investigated or designed, include:

- **providing near real time data feeds and mapping**
- **ability to download each data set by Excel or map view**
- **map views of 'hot spots' and 'black spots' by Local Government Areas**
- **the potential of supporting predictive analysis**
- **providing a narrative to introduce the data including highlighting of high and low incidence areas**
- **integration of consumer input, such as Murray PHN's Health Voices**
- **a shared learning management system with common PHN and health system topics.**

The system is being used by health services to aid development of strategic plans and support tender writing.

With the introduction of additional community data sources, PHN Exchange will create one place for local service providers to access and contribute to key information about a community's population health needs.



* Only available to Murray PHN staff

Closing the loop in healthcare

In November 2017, Murray PHN initiated *Closing the loop: The GP data report*, a web-based data reporting system accessible to GP practices who have agreements to share de-identified clinical data with Murray PHN.

There are now 106 general practices across our region sharing data, which provides GPs with individual, automated reports via a secure login on the PHN Exchange website. These reports display practice trends, regional and catchment-wide comparisons, which allow GPs to make decisions in the best interests of patients, workforce and the practice.

The GP data report helps with future planning and decision-making that can improve patient health outcomes, enhance data quality at a local level and increase business revenue. The automated reporting of primary care data at an incidence level is unique and the system can interface with any of the multiple software programs currently used in the primary care sector.

The dashboard reports display constant 15-month trends and are updated monthly. Its automated process saves time in producing individual reports and can be used by practices as evidence of data monitoring in accreditation processes.

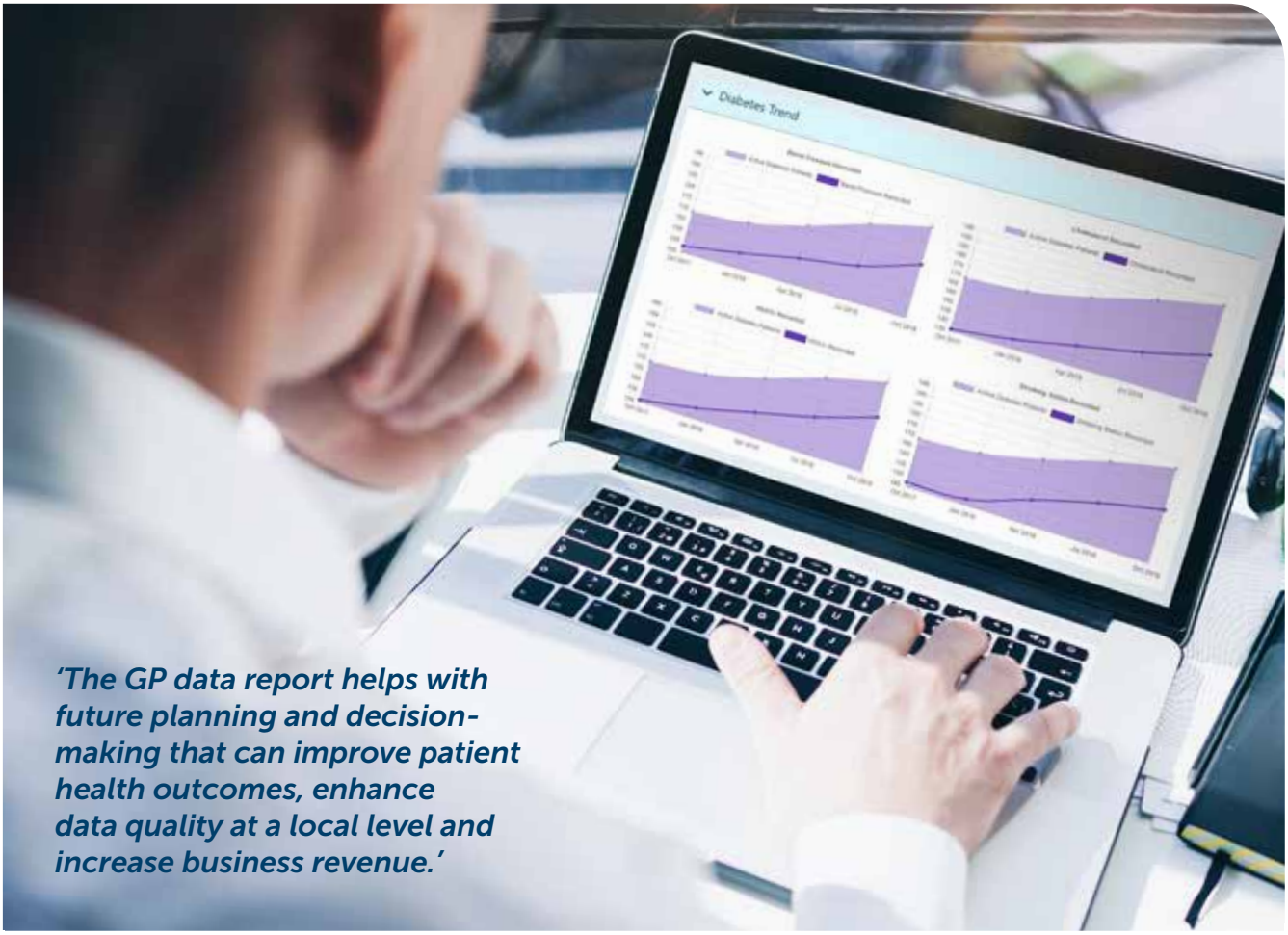
The graphical data monitors areas such as demographics, prevalence of disease, immunisation status, cancer screening rates and activities of patients diagnosed with a chronic disease.

For example, it can display the number of patients in a practice who identify as Aboriginal or Torres Strait Islander and their level of access to specific health assessments, enabling opportunities to identify gaps, improve detection rates, use early interventions and achieve better health outcomes.

Reports also include patient indicators across focus areas including cardiovascular disease, respiratory disorders and diabetes. It can show patients' diabetes cycle of care activities and where there may be a gap in services provided. Murray PHN also provides free practice software that helps GPs identify individual patients to provide specific assistance.

For GP practices, the report provides an indication of their data collection quality and the scope to improve the quality of their future data. It is a point of engagement between practices and PHNs, enabling collaboration on quality improvements.

The GP data report has driven the improvement in data sharing rates in 2018, with the data upload success rate more than doubling from 40 to 85 per cent. Version three of the GP data reporting system is in development, with a focus on improved design and functionality. The new version will include updated graphing presentation and the ability to single out specific measures.



'The GP data report helps with future planning and decision-making that can improve patient health outcomes, enhance data quality at a local level and increase business revenue.'

Engaging the community

Murray Health Voices

Our online Health Voices community has been assisting us with our understanding of health needs since June 2017.

As PHNs work largely behind the scenes to support general practices and other primary health providers, many patients are unaware that they are attending a Murray PHN funded service.

Our work is informed through the collection and analysis of data, which is not always current at the time of its release. It may also take many pieces of data to build a complete picture and understand the reasons behind data.

While we undertake community consultations, we cannot visit every town and not everyone is always available to meet with us. These are some of the reasons why Murray Health Voices was formed.

Before planning or funding health services, we ask our Voices about their thoughts and local experiences of the health system. Our Voices can respond online, anytime and from anywhere.

The real-time information and insight we receive from our Voices enables us to make our decisions much more effective. This ensures that our funding is as targeted and tailored as possible, and that we are investing in communities where it's needed most.

Register at murrayphn.org.au/healthvoices

WE LEARN THINGS LIKE:

30.7% of Voices have not participated in every cancer screening request they have received

BUT

98% of Voices have received a cancer diagnosis or have a family member who has

AND WE HEAR THINGS LIKE:

"I can't work out why you are asking about an endocrinologist (a medical specialist who treats people with a range of conditions that are caused by problems with hormones, such as diabetes). I have never heard of this."

– Health Voice, who lives with diabetes

"Stop focusing on what is wrong with people, and start looking at what has happened, the experiences that cause distress, and the strengths people have. If we all sat in a circle and focused on each other's vulnerabilities, who wouldn't start to feel like rubbish? Doing things that utilise our strengths, offer us a chance to contribute, and give us a sense of belonging and being valued is what we all need."

– Health Voice, who has a mental health diagnosis

"My condition is managed from Melbourne, and I am very satisfied with the overall help I receive. If check-ups could be done via telehealth it would help enormously. I can only get in to see my GP by booking well ahead. Any unforeseen problem means visiting whichever doctor has an appointment available, which is not my preferred option."

– Health Voice, who lives with chronic liver disease

Advice from our region

To achieve effective change in primary health care, we need to foster enduring relationships, use knowledge effectively, and look for new and better ways to improve health outcomes. Our advisory councils play an important role in each of these goals, in the areas of community, clinical, Indigenous and population health.

We would like to acknowledge former Clinical and Community Advisory Council members who finished their two-year terms in June of this year. The work that they assisted us in helped to ensure that our decisions, investments and innovations were patient-centred, locally relevant, cost effective and aligned to local health priorities.

2015-2018 Advisory Council Achievement Highlights

CENTRAL VICTORIA
Heart, lung and Indigenous health programs were a focus. Council also provided advice on the diabetes model of care, to inform planning for 2018/19 commissioning rounds and chronic disease management strategies.

GOULBURN VALLEY
Infant and child health, with particular emphasis on 'the first 1000 days' was identified as a local need. Murray PHN initiated a partnership with State Government departments for health, education and justice.

NORTH EAST
Low levels of health literacy were identified as a barrier to health service access and uptake, and health self-management. The council started a collaboration with the local Primary Care Partnership to develop a health literacy strategy.

NORTH WEST
Chronic disease tenders were informed by council, resulting in an emphasis on increased spirometry services, GP spirometry training, more cardiac and pulmonary clinics and rehabilitation/maintenance programs.

In August this year we were also pleased to welcome the newly appointed members of our 2018-2020 Clinical and Community Advisory Councils. Our new advisory council structure consists of one clinical and four community councils that will support us in our work for the next two years. We are delighted to have both new and returning council members, with an inspiring mix of skills, experience and ideas.

Our advisory councils play an important role in helping us work towards better health outcomes for people in our catchment.

North East Community Council members, L-R: Jill Craig and Carmel Hicks. Photo credit: Mark Jesser, Photographer at The Border Mail newspaper, Albury.

Central Victorian Community Council members, L-R top: Sarah Blatchford, Jeff Bray and Geoff Barrett. L-R bottom: Sharon Walsh, Emily Condon and Dianne Bowles.

Planning for health services in the Alpine Shire

Around 45 community members, volunteers and service providers attended Alpine Health's Future Directions Forum in Myrtleford in May of this year.

They examined the early research data from the Community Health Priorities Survey carried out by Alpine Health and Murray PHN, and what that could mean for the direction of health services in the Alpine Shire over the next five years.

Recognising how important it is to have input into not only the delivery but longevity of local health services, more than 150 local residents also signed up to be a Murray Health Voice. Alpine Shire now has a strong voice in letting Murray PHN know the health needs of their community.

Murray PHN Population Health Systems Lead, David Whitrow, Facilitator, Susan Benedyka and Alpine Health CEO, Lyndon Seys.

Delivering projects in partnership with the state of Victoria

Doctors in Secondary Schools

Murray PHN has partnered with the Victorian Department of Education and Training to deliver adolescent health trained GPs to 22 secondary schools in the region, to assist young people to get the health and wellbeing support they need.

It's part of a state-wide project where 100 schools are participating in a pilot aimed at making primary health care more accessible to students, to provide assistance to young people so they can identify and address health problems early and reduce pressure on working parents and community-based GPs.

Doctors and nursing staff attend schools up to one day a week to provide medical advice and healthcare to those students who might not have the same access to doctors as others, seeing students in custom-built facilities provided by the Department of Education.

Our role is to recruit GP clinics within the community to provide the school-based clinics, manage the contracts and provide support. All schools have now had a GP clinic allocated and have been operational over the last 12 months. The first 11 clinics commenced by October 2017, while the remaining 11 became operational during 2018.

Murray PHN collaborated with headspace, the University of Melbourne and the Department of Education to produce two Doctors in Secondary Schools Forums in Mildura and Shepparton in August 2018.

Participants in the forums included GPs and practice nurses involved in operating the school clinics as well as school principals and wellbeing coordinators. It was an opportunity to bring clinicians together from across the region to discuss the program best practice, network with other service providers and contribute to planning for the future of the program.

142 people in total attended the forums, including:

21 GPs and

21 practice nurses

Doctors in Secondary Schools operates in the following schools:

- Kyneton Secondary College
- Crusoe 7-10 Secondary College (Kangaroo Flat)
- Wedderburn College
- Yarrawonga College
- Wodonga Senior Secondary; Wodonga Middle Years College
- Shepparton High School
- Red Cliffs Secondary College
- Eaglehawk Secondary College
- Seymour Secondary College
- Benalla P-12 College
- Alexandra Secondary College
- McGuire College (Shepparton)
- Numurkah College
- Rutherglen High School
- Weeroona College (Bendigo)
- Kerang Technical High School
- Swan Hill College
- Ouyen P-12 College
- Robinvale College
- Merbein College
- Irymple College

Cancer Survivorship

Murray PHN was successful in Phase II of the Victorian Cancer Survivorship Program Grants Scheme through the Victorian Cancer Survivorship Program, which was established by the Department of Health and Human Services.

The cancer survivorship project, which focuses on communities within Campaspe, Loddon, Buloke, Gannawarra and Swan Hill regions, began in 2016. It has seen the establishment of working groups, workforce development events, including placement opportunities for general practice within health service oncology teams. A research project is currently underway, as is the development of tools and protocols that will be embedded in the health system by mid-2019 to improve outcomes for cancer survivor patients. To participate visit murrayphn.org.au/cancer-survivorship

CANCER SURVIVOR CASE STUDY

Judith, a 62-year-old cancer survivor from the Campaspe region, has received three cancer diagnoses over the past eight years.

"Chemotherapy was going to be a long process, so I was advised to have this closer to home. My treatment still continues every three weeks in Kyabram. The staff are so knowledgable, caring and do everything they can to make this very difficult time as trouble free and comfortable as possible.

I have recently joined an exercise class led by an Exercise Physiologist who is conducting a weekly group at our local hospital. Through this program I have gained more endurance to get through most days now without having a 'nanna nap' on the couch. It would be good if this program also included some education on nutrition and psychology relating to feelings associated with survival, treatment, the fear of the cancer returning/uncertainty of the future, work and treatment, and dealing with other persons' reactions towards the people living with cancer.

I hope that participating in this research helps those facing a similar situation and will assist in closing any gaps in treatment for others, particularly where it has not been possible to have their treatment close to home. I do feel anxious about the care following the completion of my treatment in January 2019 and not having the regular contact with those who have become such a huge part of my life."

Optimal Cancer Care

Murray PHN is working with the Victorian PHN Alliance, the Department of Health and Human Services and the Regional Integrated Cancer Services network to improve the quality of cancer care and patient experiences by implementing the Optimal Care Pathways (OCPs) for specific cancers in primary health settings.

Prostate and oesophagogastric cancer OCPs have been this year's focus. Prostate cancer because it is the most common cancer diagnosed in men in Australia and oesophagogastric cancer due to its poor prognosis and low survival rate.

RECOGNISING OESOPHAGOGASTRIC CANCER SYMPTOMS

Given that a GP may only see one or two patients with oesophagogastric cancer in their career, it's important that they are aware of the most common symptoms, which are:

- dysphagia (difficulty swallowing)
- persistent epigastric
- pain/dyspepsia
- pain on swallowing
- food bolus obstruction
- unexplained weight loss or anorexia
- haematemesis (vomiting blood) and/or melena
- early satiety
- unexplained nausea/ bloatedness or anaemia

Some of the individual symptoms for oesophagogastric cancer can be quite non-specific however, pairings of different symptoms with dysphagia give red flags that can help GPs detect those rare cases early.

Improved efficiency with eReferrals

The Loddon Mallee region was one of three pilot sites chosen to deliver a secure electronic medical eReferral system in Victoria. The Department of Health and Human Services and the Australian Digital Health Agency awarded the Loddon Mallee eReferral Project funds to improve the coordination of referrals between primary and secondary healthcare providers.

The Loddon Mallee eReferral Project has four key partners: Murray PHN, Loddon Mallee Rural Health Alliance, Bendigo Loddon Primary Care Partnerships and Bendigo Health, who are the lead agency.

The project partners came together to implement an electronic referral (eReferral) solution for the Central Victoria, Campaspe, Gannawarra, Loddon, Macedon and Mt Alexander regions, to address issues that existed with paper-based referral systems.

Common issues across the Loddon Mallee region for referral senders and receivers included:

- Disparate referral sending methods (email, phone, fax, mail)
- Time and resource allocated to creating, sending, triaging and processing a referral
- Limited integration with clinical software to create/send a referral
- Increasing referral templates for speciality services
- Limited standardised referral templates across the Loddon Mallee region
- Uncertainty surrounding referral pathways impacting regional service coordination

eReferral works by connecting with a general practitioner's clinical software system to populate some of the required clinical and demographic patient data, while also prompting the user for the additional information particular to the referral. A copy is written back into the clinical software for record keeping purposes. This integration helps to reduce an already busy GP's workload, as they can quickly create a patient referral from their desktop, select a destination and instantly send and then receive acknowledgement that the referral has been received.

Since the inception of the project, over 9,000 eReferrals have been generated by 53 general practitioners, demonstrating how general practitioners are willing to embrace new technology that saves them time and improves service for their communities. Due to the success of the project, Murray PHN will continue to fund the product and work alongside our partners to extend across the Loddon Mallee region while also including demonstration sites within the Hume region.

"The system is very easy to use compared to the traditional way of printing a referral and then faxing it. I can add as much information/notes/ results to the referral, which makes the referral more comprehensive and assists the specialist in assessing the urgency of the referral."

- Dr Fady Henry

Dr Fady Henry, White Hills Medical Practice

0% referrals being rejected due to incomplete information reduced completely, from 5% to 0%

100% GPs received referral confirmation through the eReferral program compared to only 5% previously

2-3 min GP referral processing time has been halved, from 7 steps taking 5-10 minutes to 4 steps taking 2-3 minutes

2-10 min Administrative staff have saved 2-10 minutes per referral, as no input is required from them with eReferrals

SafeScript

In 2016, there were 372 Victorian drug overdose deaths involving pharmaceutical medicines. This is higher than the number of overdose deaths involving illicit drugs (257), and higher than the road toll (291).

SafeScript will come into effect in 2019, following a trial in Western Victoria PHN's catchment area. The system is aimed at reducing the growing harm from prescription medicines and will enable a more informed and safer decision about prescribing or dispensing.

After an 18-month introductory period, it will be mandatory for clinicians in Victoria to check SafeScript when writing or dispensing a prescription for all Schedule 8 medicines and Schedule 4 benzodiazepines, z-drugs (zolpidem and zopiclone), quetiapine and codeine.

Refugee community health needs

Many refugee people arriving in Australia suffer from multiple and complex physical and psychological health issues that are influenced by both pre and post arrival experiences.

In the past 12 months, Victoria has become home to 13-15 per cent of people arriving in Australia through the Australian Government's Humanitarian Settlement Program. Five of the seven major regional and rural refugee settlement areas are within the Murray PHN catchment.

Murray PHN's Refugee Community Health Needs Assessment, has focused on identifying the level of health in refugee communities. A Hazara community member with a background as a doctor, was employed to undertake this project.

People of Hazara background - the third largest ethnic group in Afghanistan - make up a significant proportion of the refugee and asylum seekers who have resettled in Victoria. The 2016 census data showed more than 1,200 people from Afghanistan origin lived in the Murray PHN catchment. However, the consultation process undertaken during the project showed that the population was closer to 3,500. As part of this project, 250 Hazara people attended community meetings and 70 Hazara adults (48 male and 22 female) completed verbal health assessments.

The health assessments found that almost half of attendants had various levels of depression and anxiety and many were suffering from physical conditions. A number of community members were assisted with gaining referrals to local health services, including one urgent referral.

The community meetings and health assessments were conducted in both English and Hazaraghi, which has enabled a deeper understanding of the Hazara community's health needs.

The largest barriers to healthcare for the Hazara community members were:

- health literacy
- health service awareness
- access to and trust of interpreters
- incorrect self-management of health conditions
- the impact of mental health concerns on all areas of a person's health and wellbeing.

Understanding the barriers and the subsequent impact on the community will allow for targeted activities to be planned, such as a cancer screening project in the Greater Shepparton area.

This project was undertaken by Murray PHN with thanks to Primary Care Connect Shepparton, Ethnic Council of Shepparton, New Arrival Support Services Shepparton, Community Issues Group Swan Hill, Mallee Family Care Swan Hill, headspace Swan Hill, Sunraysia Community Health Services and Bendigo Community Health Services.

"We would like to thank Murray PHN for paying attention to our community, our health condition and needs. It is a kind of encouragement to the community members to consider their health, take care of it and seek help for it."

- Hazara community member

Andrew Rankin, Sunraysia Mallee Ethnic Communities Council Program and Development Manager and Ahmed Kheradyar, Murray PHN Population Health Coordinator.

Storylines: Her Voice Matters

The Storylines project invites women to share their stories about sexual and reproductive health experiences in the health system.

Each story becomes part of a bigger story that will help build a picture of how to improve the quality, access, and type of health support for women.

Stories will also be used to tell us where things are working well and where things are not working properly. From gathering experiences of women from across our region, we will have a clear picture of what women really need for great sexual and reproductive health.

Sexual and reproductive health is an important issue for all women, affecting them at every life stage.

It influences how women develop and maintain meaningful relationships, appreciate their bodies, interact with others, express affection, love, and intimacy and by choice, bear children.

The project is led by Women's Health Loddon Mallee in partnership with Women's Health Goulburn North East and Murray PHN.

Submit your story:
hervoicematters.org

Storylines HER VOICE MATTERS

Choose Well, Feel Better

People from outlying rural towns often travel to a regional emergency department (ED) for low complexity urgent care. *Choose Well, Feel Better* helps people make the right decision when they have a health concern. Choosing the right healthcare helps them avoid uncertainty, unnecessary travel and wait times. It also it helps our community healthcare system to work at its best.

The *Choose Well, Feel Better* project involves four rural communities, five health services, Ambulance Victoria and seven general practice clinics. Through targeted communication strategies, it aims to provide people with information about local options for urgent care and treatment.

This community-based initiative is led by the Numurkah District Health Service, in partnership with Goulburn Valley Health, Nathalia District Hospital, Cobram District Health, Murray PHN, Kyabram District Health Service and Ambulance Victoria.

Murray Connect in aged care

As part of an avoidable hospitalisation project, Murray PHN partnered with Bendigo Health's Geri-Connect Service, Loddon Mallee Rural Health Alliance, Tunstall Healthcare and seven local residential aged care facilities, to provide an innovative electronic remote health monitoring system.

Up to 100 people with chronic diseases - heart disease, lung disease and diabetes - were given the opportunity to participate in the free trial across the Mallee and Central Victoria regions.

Murray Connect was designed to help nurses monitor the health of residents more closely. Information about vital signs, such as blood pressure and heart rate, were taken and uploaded to a computer. By having the information available digitally, it was also accessible to the resident's GP, even if they were consulting remotely.

The Geri-Connect team at Bendigo Health also monitored the data and were able to alert the resident's care team to follow up, if the readings went outside their normal limits. By monitoring vital signs more closely, it was hoped that a patient would be noticed and attended to before they became unwell and it escalated to a hospital stay.

Governance at Murray PHN

Murray PHN is governed with the support, collaboration, advice and feedback of a range of qualified and experienced people. Murray PHN governance processes are led by the Board of Directors and the Board sub committees: The Governance Sub-Committee and the Programs and Quality Sub-Committee, the CEO and the Executive Team. The organisation is additionally advised by four community and one clinical advisory council, to guide and help the organisation determine the most effective use of our funding budget delivering on our objectives and achieving measurable outcomes in the communities within our defined geographic region.

Our relational commissioning work means we communicate regularly with primary care organisations, acute services, other healthcare organisations, and community and consumer networks across our region. Murray PHN's commitment to the relational commissioning of effective and efficient health services is built on well controlled (probity) procurement policies, procedures and processes as well as the relational commissioning guiding principles.

Murray PHN has a quality management system that is supported by a focus on continuous improvement in everything thing we do. To deliver on this commitment, we have robust, standardised, documented processes supported by a strong and engaged finance system. During the year, the key business processes were finalised and the company's accountability structure was updated to align with the agreed key business processes. By re-designing processes, we are now better able to focus our human and financial resources on value-adding activity such as sustainable planning, forecasting, business modelling and analysis.

Commissioning processes were further enhanced by the development of a clinical governance framework and independent review of our procurement process during the year.

These activities have assisted and enhanced our capability as an effective and efficient commissioner of health services.

Commissioning

Commissioning at Murray PHN is a strategic approach to procurement and denotes a proactive strategic role in planning, designing and implementing the range of services required, rather than a more passive purchasing role. Murray PHN, as a commissioning organisation, decides which services or healthcare interventions should be provided, who should provide them and how they should be paid for and may work closely with the provider in implementing changes. It is informed by baseline needs assessment, associated market analysis and allows procurement of medical and healthcare services that are appropriate to the needs of communities within Murray PHN's region.

Murray PHN conducts its commissioning processes under a series of six guiding principles:

1 Organisational capability

- Good governance
- Financial sustainability
- Transparency, communication and accountability

2 Leadership and change management

- Ambitious leadership
- Lead by example

3 Co-design and community engagement

- Engage with the community through a number of Murray PHN sources being Health Voices, service provider engagement and advisory councils

4 Population health

- Use population health data to identify areas of need and align with under-serviced population and priority needs
- Person-centered, place-based and health outcomes focused

5 Collaborative arrangements

- Market support and engagement before, during and after procuring
- Encourage innovation
- Market collaborative in all aspects of planning

6 Market management

- Strengthen market and services providers and as a result improve the overall system

Financial summary

Murray PHN is funded predominantly by the Commonwealth Department of Health. Additional funding received is comprised of other Federal Government agencies, State Government and various health organisations.

We take considerable pride in our financial accountability to the communities we serve and our funders, ensuring we deliver on agreed Activity Work Plans.

In the 2018 financial year, Murray PHN recorded an operating surplus of $774,883.

Revenue of $35.7 million has seen a slight growth from $35.5 million in 2016/17 and Murray PHN is expecting this growth to continue. The 2018 financial year has focused on commissioned services for health priorities such as mental health, alcohol and drugs, chronic disease and Indigenous health that have been evidenced to benefit the communities in our catchment.

Budgeted revenue for 2018/19 is forecast to be $46.7 million representing an increase of approximately $11 million from 2017/18. $9.8 million of this increase is monies received in 2017/18 that will be expended in 2018/19.

To ensure accountability to the Department of Health, other funders and the communities we serve, Murray PHN's Board sets and monitors financial key performance indicators (KPIs) to ensure the company achieves its strategic objectives and delivers on performance targets.

One of these KPIs is that 70 per cent or more of our total revenue must be expended in direct services to communities. The graphic below on "Direct activity costs by expense category" shows how this $23.8 million of direct service was expended in 2017/18.

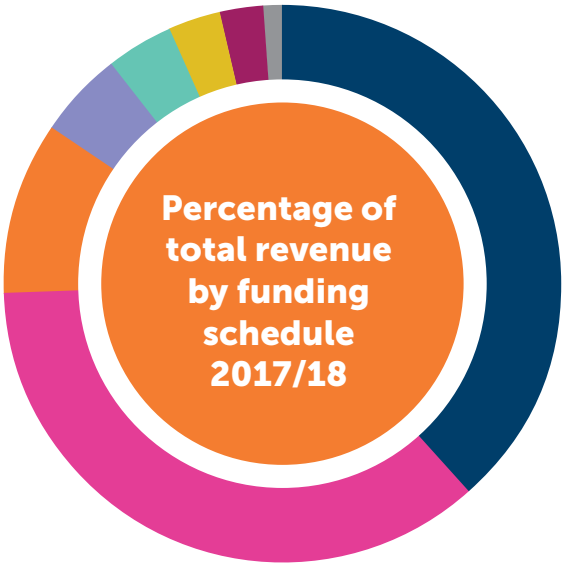
During 2017/18 the Department of Health confirmed the Core and Flexible agreement for an additional three years to 2020/21. The new schedule has similar funding levels with a move to a greater percentage of funding moving to directly commissioned health services.

Murray PHN has six main funding schedules with the Department of Health. The dollar value of each as a percentage of total revenue is detailed in the graphic below "Percentage of total revenue by funding schedule".

All funding received by Murray PHN have approved Activity Work Plans, which are budgeted and monitored monthly by the responsible manager. This ensures that Murray PHN stays on target to achieve exactly what we have been funded to achieve. These activities are then reported and evaluated to ensure the community gains from the work we have commissioned.

The unearned grant figure of $9,798,935 in the balance sheet, is money that has been received by Murray PHN in 2017/18 and not expended against its granted purpose in that year, but which will be expended against the agreed purpose in 2018/19.

93% Commissioned services
2% Building capacity and capability
2% Working groups
1% Direct patient costs
1% Direct activity Integrated Team Care costs
1% Needs assessment, planning and evaluation



38.6% Operating, flexible and innovation
36% Mental health
10% Partners in Recovery
5% Integrated Team Care
4% Drug and alcohol
3% After hours
2.4% Interest and other
1% Non-Department of Health

Limited Statement of Profit or Loss and other Comprehensive Income

	2018 ($)	2017 ($)
Income		
Revenue	35,710,077	35,480,646
Total income	**35,710,077**	**35,480,646**
Expenditure		
Employee benefits expense	8,710,568	8,211,580
Depreciation, amortisation and impairment expenses	127,613	164,634
Rental and occupancy expenses	585,052	630,573
Program expenses	23,831,498	24,129,875
Motor vehicle expenses	173,506	157,196
Administration	1,247,718	1,029,089
Other expenses	259,239	123,612
Total expenditure	**34,935,194**	**34,446,559**
Profit before income tax	**774,883**	**1,034,087**
Income tax expense	-	-
Profit for the year	**774,883**	**1,034,087**
Other Comprehensive Income for the year	**-**	**-**
Total Comprehensive Income for the year	**774,883**	**1,034,087**

Statement of Cash Flows

	2018 ($)	2017 ($)
Cash flows from Operating Activities		
Grants revenue and other receipts	36,728,651	36,391,297
Interest received	557,569	507,235
Payments to employees, directors and suppliers	(34,594,534)	(33,241,105)
Net cash provided by Operating Activities	**2,691,686**	**3,657,427**
Cash flows from Investing Activities		
Payments for plant and equipment	(16,292)	(134,291)
Net cash provided by/(used in) Investing Activities	**(16,292)**	**(134,291)**
Net increase in cash held	2,675,394	3,523,136
Cash and cash equivalents at the beginning of the financial year	14,981,605	11,458,469
Cash and cash equivalents at the end of the financial year	**17,656,999**	**14,981,605**

Statement of Financial Position

	2018 ($)	2017 ($)
Current assets		
Cash and cash equivalents	17,656,999	14,981,605
Trade and other receivables	92,412	4,663
Other assets	336,119	309,146
Intangible assets	12,883	25,767
Total current assets	**18,098,413**	**15,321,181**
Non-current assets		
Property, plant and equipment	11,182	109,619
Total non-current assets	**11,182**	**109,619**
Total assets	**18,109,595**	**15,430,800**
Current liabilities		
Employee entitlements	769,036	623,597
Trade and other payables	3,404,212	4,251,743
Interest bearing liabilities	4,526	11,248
Grants refundable	503,438	1,018,305
Unearned grants	9,798,935	6,738,950
Total current liabilities	**14,480,147**	**12,643,843**
Non-current liabilities		
Employee entitlements	228,428	160,820
Provisions	110,000	110,000
Total non-current liabilities	**338,428**	**270,820**
Total liabilities	**14,818,575**	**12,914,663**
Net assets	**3,291,020**	**2,516,137**
Members' equity		
Retained surplus	3,291,020	2,516,137
Total members' equity	**3,291,020**	**2,516,137**

Statement of Changes in Equity

	Retained earnings ($)	Total equity ($)
Balance at 1 July 2016	**1,482,050**	**1,482,050**
Profit for the year	1,034,087	1,034,087
Total other comprehensive income for the year	-	-
Balance at 30 June 2017	**2,516,137**	**2,516,137**
Balance at 1 July 2017	**2,516,137**	**2,516,137**
Profit for the year	774,883	774,883
Total other comprehensive income for the year	-	-
Balance at 30 June 2018	**3,291,020**	**3,291,020**

Partner organisations

These are Murray PHN's partner organisations for 2017 and 2018. Our required focus on preventable hospitalisations has meant some contracts for non-aligned services have concluded. We look forward to continuing work with our partner organisations providing services for chronic illness and the other health priorities of our region.

Albury After Hours Clinic
Albury Wodonga Aboriginal Health Service
Albury Wodonga Health
Alcohol and Drug Foundation Inc
Alexandra Family Medical Centre
Alpine Health
Anglicare Victoria
Australian Primary Mental Health Alliance
Ballarat Community Health
Barefoot Nutrition Fitness Lifestyle
Beechworth Health Service
Benalla Church Street Surgery Pty Ltd
Benalla Health
Benalla Rural City Council
Bendigo and District Aboriginal Co-Operative
Bendigo Community Health Services
Bendigo Health Care Group
Black Dog Institute
Bleuler Pty Ltd
Boort District Health
Border Dietitians
Brooke Street Medical Centre
Calder Counselling & Psychotherapy
Campaspe Family Practice
Cappela Consulting
Castlemaine District Community Health Limited
Castlemaine Health
Centacare South West NSW Ltd
Centracare South West NSW Ltd
Central Medical Group - Wodonga
Cindy Condon
Cobaw Community Health Services Limited
Cobram District Health
Corryong Health
Coster Street Medical Practice
Daintree Medical Centre
Donnelly Consultants
Dowdy's Well Being
East Wimmera Health Services
Echuca Moama Family Medical Practice
Echuca Regional Health
Elizabeth McDonald
Elmore Medical Practice
Elmwood Medical Centre
Euroa Medical Family Practice
Federation Clinic Administration Unit Trust
Gateway Health
Golden City Support Services
GV Health
Heathcote Health
Incolink Foundation Ltd
Indigo North Health Inc.
Inglewood District Health Services
Intrahealth Australia Limited
Irymple Foot Clinic
Janette Tregenza
Jesuit Social Services
Kelly Creamer Podiatrist
Kerang District Health
Kilmore Medical Practice
Kyneton District Health Service
Larter Company
La Trobe University
Learn PRN
Lime Medical Clinic
Loddon Mallee Mental Health Carers Network
Lung Foundation Australia
Lynette Flavel
Mallee District Aboriginal Services
Mallee Track Health and Community Service
Mansfield District Hospital
Megan Rackley
Melinda Roffey
Mental Health First Aid Australia
Merbein Family Medical Practice
MI Fellowship
Mildura Base Hospital
MIND Australia
Monash University
Mooroopna Medical Management Pty Ltd
Mount Beauty Medical Centre
Mt Hotham Alpine Resort Management
Murchison Medical Clinic
Nagambie Medical Centre
National Heart Foundation of Australia
Njernda Aboriginal Corporation
North East Health Wangaratta
North West Melbourne PHN
Northern District Community Health Service
Numurkah District Community Health Service
Ochre Health Medical Centre Clinic
Orygen
Outcome Health
Ovens Valley Podiatry
Primary Care Connect
Psychology & Wellbeing Worx Pty Ltd
Quinn Street Medical Clinic
Rapid Impact
Robinvale District Health Services
Rochester and Elmore District Health Service
Roses in the Ocean
Royal Flying Doctor Service Victoria
Rumbalara Aboriginal Cooperative
Safety Link
Seymour Medical Clinic
South Wangaratta Medical Centre
Spring Gully Primary Health
St John Of God Health Bendigo Hospital Raphael Centre
St Vincents Hospital Melbourne
Stepping Stones Medical Centre
Sunassist Volunteer Helpers Inc
Sunraysia Community Health Services Limited
Swan Hill District Health
Tandem Inc
The Baudinet Centre Psychological Practice
The Foot Centre
The Trustee for 360Edge Trust
Toni Riley Reviews
Trace Research
Tristar Medical Group Pty Ltd
Tunstall Australasia Pty Ltd
Ultimate Nutrition Mildura - Karen Bulman
University of Melbourne
University of Melbourne Shepparton Medical Centre
Victoria University
Victorian Aboriginal Community Controlled Health Organisation Inc
Walwa Bush Nursing Centre
Wendy M Bolch
White Hills Medical Practice
Women's Health Loddon Mallee
Yarrawonga Denis Medical Group
Yarrawonga Medical Clinic
YSAS Pty Ltd
Zenith Medical Practice

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