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MURRAY

An Australian Government Initiative

Report to the **Community** 2022

Murray PHN aspires to be an anti-racist organisation, embedding cultural humility as a daily practice to improve health outcomes and health equity in our communities. We recognise cultural humility as a lifelong commitment to self reflection, personal growth and redressing power imbalances in our society.

Murray PHN acknowledges its catchment crosses over many unceded First Nations Countries following the Dhelkunya Yaluk (Healing River).

We pay our respects and give thanks to the Ancestors, Elders and Young People for their nurturing, protection and caregiving of these sacred lands and waterways, acknowledging their continuation of cultural, spiritual and educational practices.

We are grateful for the sharing of Country and the renewal that Country gives us.

We acknowledge and express our sorrow that this sharing has come at a personal, spiritual and cultural cost to the wellbeing of First Nations Peoples.

We commit to addressing the injustices of colonisation across our catchment, and to listen to the wisdom of First Nations communities who hold the knowledge to enable healing.

We extend that respect to all Aboriginal and Torres Strait Islander Peoples.

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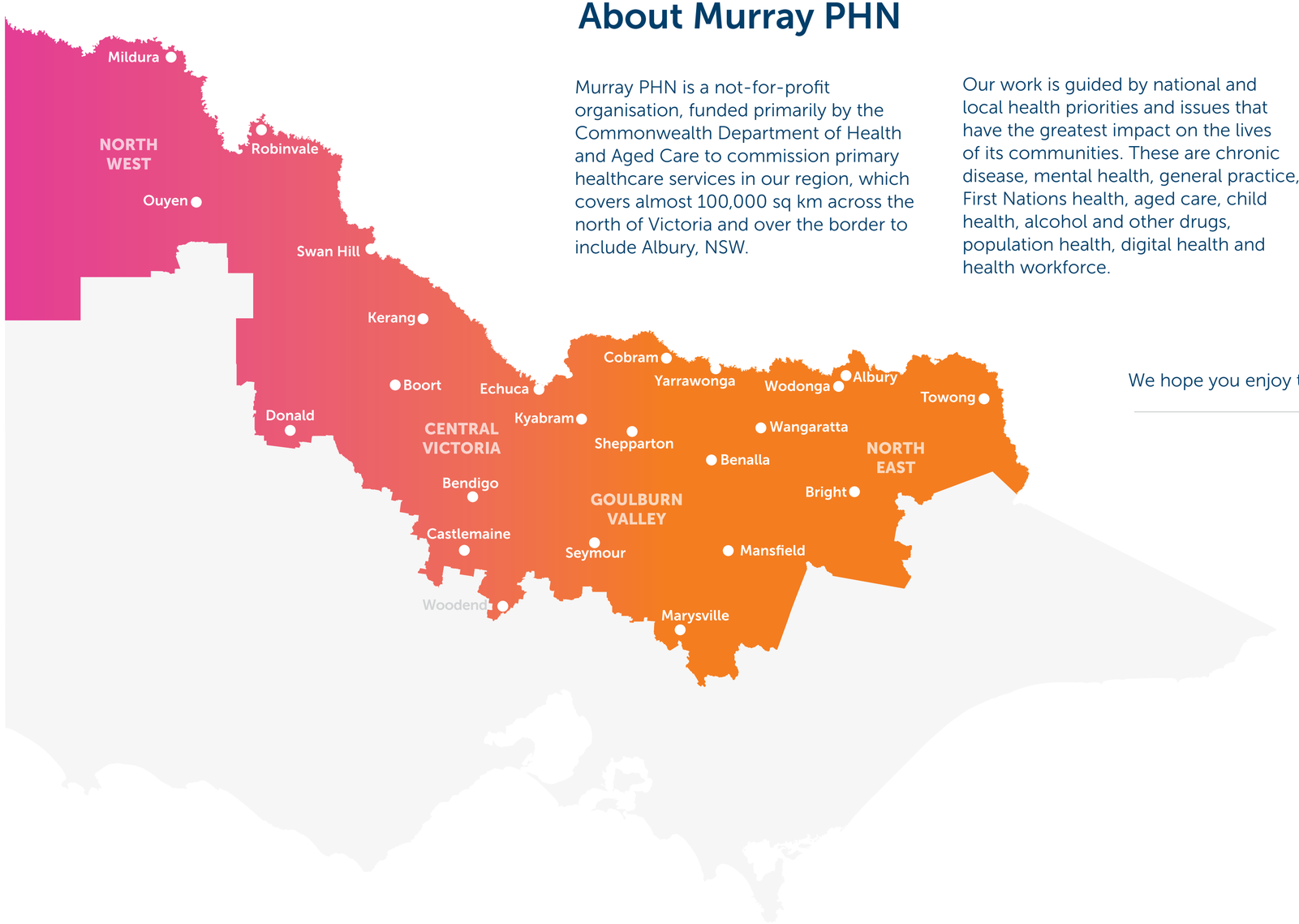


Murray PHN is a not-for-profit organisation, funded primarily by the Commonwealth Department of Health and Aged Care to commission primary healthcare services in our region, which covers almost 100,000 sq km across the north of Victoria and over the border to include Albury, NSW.

Our work is guided by national and local health priorities and issues that have the greatest impact on the lives of its communities. These are chronic disease, mental health, general practice, First Nations health, aged care, child health, alcohol and other drugs, population health, digital health and health workforce.

When communities are supported to manage and improve their health and wellbeing, fewer people need to seek acute healthcare and more quality care can be provided closer to home.

Through partnerships and collaboration, Murray PHN is better able to deliver to our communities on the changes we need to foster good health and wellbeing and prevent avoidable disease or illness.

We hope you enjoy this, our seventh annual Report to the Community.

To read earlier reports, visit:
murrayphn.org.au/keydocuments

Our Board

Fabian Reid, Chair
An experienced Chair and Board director, Mr Reid has extensive knowledge of regional Victorian communities. He is a Director of Bendigo Access Employment.

Andrew Baker
Mr Baker has 30 years' experience in leading IT organisations and business change programs. Most recently, he was CIO of agribusiness GrainCorp, managing the company's IT functions.

Leonie Burrows
Ms Burrows is a management consultant and company Director. She is the Chair of the Strategic Advisory Panel at the Mallee Regional Innovation Centre and former Chair of Sunraysia Community Health Services.

Bob Cameron
Mr Cameron is a lawyer, former Victorian State Minister of 11 years, former Member for Bendigo West and former Chair of Bendigo Health. He is current Chair of Coliban Water and Worksafe Victoria.

Dr Manisha Fernando
Dr Fernando is a rural GP and holds fellowships in general practice and rural general practice, a Masters of Public Health, a Certificate of Clinical Education, and a Diploma in Obstetrics and Gynaecology.

Dr Alison Green
Dr Green has been a GP associate in Wodonga since 1991. A GP obstetrician providing maternity services to Albury Wodonga Health, she has also been a GP supervisor.

Joanne Kinder
Former Operations Manager at the University of Melbourne, Shepparton Medical Centre, Ms Kinder has experience in the strategic planning, management and governance of a primary health service.

Matt Sharp
Mr Sharp is the Chief Executive at Goulburn Valley Health, a position he has held since 2018. He has strong relationships with governments at local, state and federal levels.

Professor Hal Swerissen
An expert on health policy and program development, Professor Swerissen is a research fellow at the Grattan Institute and Emeritus Professor of public health at La Trobe University.

Jacki Turfrey
Ms Turfrey, a proud Palawa woman, has been admitted to practise law for more than 22 years. She also has experience working in the mining sector, at various First Nations-led organisations and as a mediator.

Murray PHN has two Board committees that ensure there are robust and effective processes to assist the Board in its work. The Governance Committee looks at legal, ethical and functional responsibilities, and the Programs and Quality Committee examines services, projects and engagement activities funded by Murray PHN.

Message from the CEO

MATT JONES - CEO

It seems that since 2020, the most optimistic description of each year has been "challenging," and 2022 has not broken that mould.

But regional and rural Australia is no stranger to significant challenges and we recognise that those challenges create a unique kind of resilience that often makes communities stronger, closer and increasingly resourceful.

We know however the toll taken by the heartbreaking floods that continue to impact our river communities, the ongoing bushfire recovery efforts in the north east, widespread COVID surges and the emerging viruses of Japanese Encephalitis and Monkeypox. This toll is devastating for communities and particularly hard on our region's health professionals.

Our data and research activity demonstrate clearly that our primary health care system is under severe stress; both for patients who have too often postponed their own care, and for clinicians dealing with changing patient demographics and funding systems that do not support the type of care that is urgently needed.

Yet at the same time, we are buoyed by the resilience of our communities, whose members band together to support one another in adversity and who look together to recovery.

We also acknowledge the commitment and dedication of our health professionals, who continue to deliver for the people in those communities, even as they face significant stress and financial strain of their own.

I am gratified that at Murray PHN, our teams have continued to support the primary healthcare system through the year's challenges.

As they work seamlessly from their homes or our offices, our staff have managed the added workload created by disaster and disruption, while continuing our core business of supporting primary healthcare services, unabated.

Our organisation has also become more robust and resilient, with growing numbers of team members engaged to support the increasing numbers of programs that we are asked to commission and manage.

We have also introduced a new Strategy and Performance Unit, whose innovative work is changing the way that we assess the effectiveness of our decisions and ensure that our work is delivering outcomes for our communities. You can read more about the unit from page 11 in this report.

Our work to improve health outcomes is all the more successful through the contribution and involvement of our partner organisations, be they individual practitioners, small health organisations, large hospitals, teaching universities or government – local, state and national.

Health outcomes at a population health level can only be improved through conversation, collaboration, commitment and partnership across communities and the country. We are pleased to be taking part in some of the most encouraging conversations since the creation of Medicare almost 50 years ago.

I have noted the inspiring work of our staff through 2022 and I thank every staff member at Murray PHN for their dedication to our organisation.

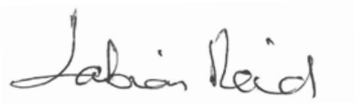
Their flexibility in the face of adversity and the high-quality delivery of the projects with which they are tasked helps us make a vitally important contribution to our region.

I would also like to acknowledge the strong leadership, intellectual rigour and camaraderie of our executive and senior leadership team members, who make it a pleasure to come to work each day.

Finally, my personal thanks go to our Chair, Fabian Read, and the highly competent and experienced members of the Murray PHN Board for their vision, guidance and support in these challenging times.

We all hope that you will enjoy reading our 2022 Report to the Community, understanding a little more of the work we do, and see opportunities to engage further with us in 2023.

Message from the Chair



FABIAN REID - BOARD CHAiR

Barely a week has passed this year without a media mention of the pressures facing our health system, its workforce challenges and the impact on the dedicated professionals who work within it.

There is no doubt after almost three years of COVID and the changing nature of the health needs of our communities, that our health system – both primary care and acute – is under significant duress across the nation.

In our own region, the increasing demand for healthcare assistance has been intensified by the continuing impacts of COVID, and right now, the once-in-a-hundred-year floods that, with climate change, seem to be arriving at least once in a decade.

Our health services and providers are stretched far beyond what is sustainable in the longer term. As people's needs and care complexity increase, system capacity is effectively decreasing, creating a perfect storm that has meant they have been forced to shoulder more and more responsibility for care.

The most dedicated of health professionals find themselves questioning how long they can continue without effective change. It is heartening to see governments and health system experts alike reflect on the need for a systemic review, to ensure that our world class healthcare network can continue to deliver for everyone in it.

At Murray PHN, we recognise that Medicare was established half a century ago to manage illness and injury. Since then, the needs of people in our communities have become more complex. Chronic diseases, like diabetes and heart and lung diseases, are now common among our ageing populations and people can live for much longer and more productively with those diseases than they did in the past.

The new Strengthening Medicare Taskforce has been exploring ways to improve the Medicare system so that it can continue to meet universal healthcare goals, hopefully giving all our communities access to the specialty care they need, whether they are city residents or rural and regionally based.

We know that a flexible, strengthened, primary healthcare system is best placed to support people with chronic illness, to keep them healthy and well within their communities, making them less likely to present to emergency departments in hospitals with disease complications that can be debilitating and expensive to treat. Prevention and early intervention through the primary healthcare system is a much more cost-effective model.

Murray PHN is committed to bolstering our region's health system in the most effective ways, strengthening general practice and allied health, exploring innovative primary healthcare models that work across multiple communities and advocating for equally innovative funding streams.

As a regional PHN, we continue to work towards the integration of our health networks, primary and acute, whether state or Commonwealth funded. I am proud that our team continue to show clear leadership in piloting and developing sustainable models of care delivery and engaging in national advocacy. They work every day to canvas regional approaches with Commonwealth and state health departments, and collaborating with local providers to develop innovative, place-based solutions.

I would like to acknowledge the leadership of the Murray PHN Executive team, led by CEO Matt Jones, and the staff across our region and beyond, who work each day to deliver our work in the primary healthcare system.

I also acknowledge and thank my fellow Board members for their wisdom, their contribution, and their dedication to our shared goals. Together, we are committed to strengthening the work of Murray PHN to encourage reform and help improve health outcomes for our communities.

A three year roadmap

Murray PHN was pleased to release its new 2023-2025 Strategic Plan in July this year.

The plan was developed through extensive engagement with community members, health practitioners, advisory councils and regional health services. It puts a renewed focus on prevention and early intervention, managing complex care in the community and targeting sustainable rural healthcare.

The strategy is a three-year roadmap, that describes the range of roles Murray PHN has within the local health system – connecting and funding services, advising and building system capacity, co-designing models of care and forecasting future need. We plan to enable innovation, research, engagement, collaboration and advocacy, to generate health systems change and service improvement.

Our Organisational Development Plan identifies a step-by-step approach to how Murray PHN will use the Strategic Plan to develop its work to improve our capacity to report our value to community, as a purposeful design and outcomes-orientated focused organisation. By monitoring systems, and improving and integrating processes, we will use our new Strategic Plan to drive continuous improvement in decision-making, strategy and commissioning activities.

OUR VISION:

HEALTHY RURAL AND REGIONAL COMMUNITIES WITH TIMELY ACCESS TO THE PRIMARY CARE THEY NEED

Our vision is our ultimate aspiration. It articulates what our efforts are working towards. For us, this is about all people in our catchment being healthy and well, and having access to high-quality primary healthcare that meets their needs and prevents disease.

OUR PURPOSE:

WE STRENGTHEN PRIMARY HEALTHCARE TO KEEP PEOPLE WELL AND OUT OF HOSPITAL

Our purpose communicates, at a high level, where we will focus our efforts to achieve our vision. We strengthen primary healthcare through integration, coordination and capacity building. Working in partnership is at the heart of our purpose; we cannot and do not want to work in isolation – it simply won't be effective or impactful. By increasing access to high-quality, culturally responsive and sustainable primary healthcare, we support our communities to manage and improve their health and wellbeing, so that fewer people need to seek acute healthcare and more care can be provided closer to home.

OUR VALUES:

	LEADERSHIP: We commit to lead effective change in primary healthcare and the broader health system
	COLLABORATION: We build enduring relationships that lead to better health outcomes
	RESPECT: We value the voices and participation of every individual and respect the knowledge and wisdom our communities hold about their health needs
	ACCOUNTABILITY: We are accountable to our communities, partners, funders and co-workers
	INNOVATION: We foster new and better ways to improve health outcomes

Strategic Plan - Our story of change

Our story of change diagram describes the impact we seek to create with and for our communities. It shows how we seek to make change happen in the context of broader healthcare sector trends and disruptions, from the prevention of disease or illness, through to better health outcomes in our communities.

OUR CONTEXT

Our **unique community** and catchment has incredible strengths and proven resilience...

...but the **demand for primary healthcare and wellbeing** services is outstripping supply in our region.

The primary healthcare **funding landscape** comes with constraints and complexities...

...and the **government and political landscape** is also complex and fast-moving.

These and other factors contribute to a **fragmented healthcare system**...

...responding to the **COVID-19 pandemic** and a myriad of other health and wellbeing needs...

...in the context of major **digital and data** developments and disruptions.

OUR ROLES

CONNECTOR
We collaborate through partnerships, and coordinate and integrate stakeholders and systems.

CAPACITY BUILDER
We build primary health capacity and equitable access, scaling up innovation.

CO-DESIGNER
We co-design evidence-informed models of care that meet community needs.

ADVISOR
We identify and advocate for change that benefits our communities.

FUNDER
We build and manage funding relationships for the greatest impact.

FORECASTER
We respond today, and plan and provide for tomorrow to prevent and control disease.

THE CHANGE WE SEEK

HEALTH SYSTEM BENEFITS

EQUITABLE ACCESS
Communities can access primary healthcare and wellbeing services as and when they are needed. Healthcare services are aligned with relative need and delivered with cultural humility.

HIGH QUALITY
Primary healthcare and wellbeing services are high-quality, culturally responsive, person-centred and integrated around relative needs to deliver holistic healthcare experiences.

GREATER SUSTAINABILITY
The healthcare system is designed to meet community needs, with sustainable funding arrangements and a stable workforce to support scalable rural models of care for long-term impact.

SYSTEM EFFICIENCIES
Primary healthcare and wellbeing services create efficiencies in the broader health system by reducing avoidable hospitalisations and acute healthcare costs.

COMMUNITY BENEFITS

A strengthened primary healthcare system that supports rural and regional communities.

Relevant, effective and integrated healthcare and wellbeing services and information systems, underpinned by an anti-racist approach, are available to people across our catchment. This means people are supported to promote wellbeing and good health, prevent illness, disease and injury, and recover when sickness, accidents or adversity strike.

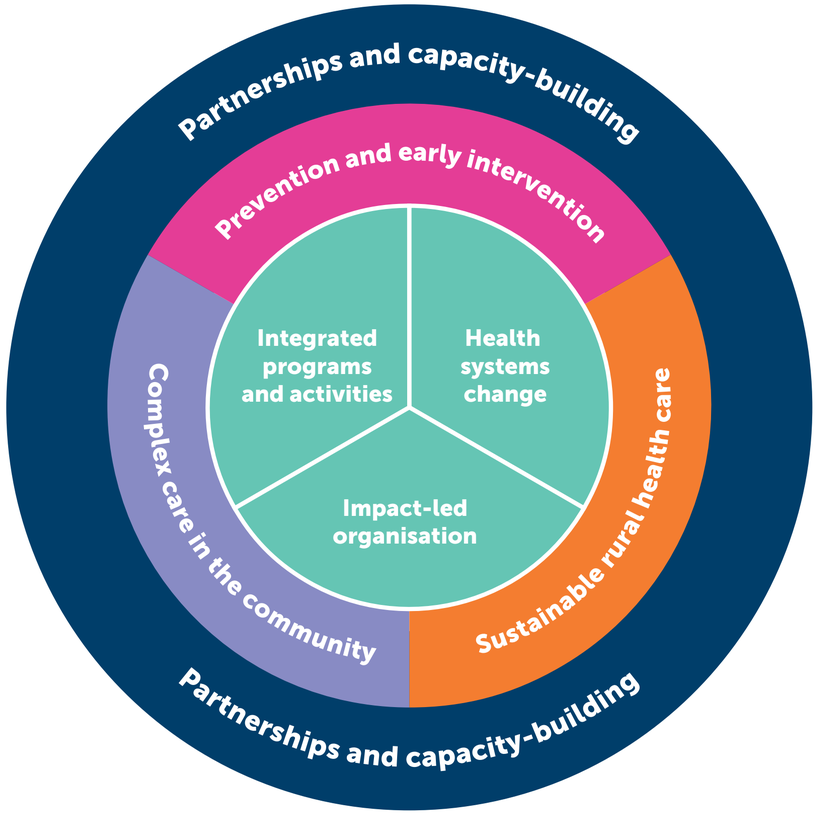
Healthy and well communities with timely access to the primary and preventive healthcare they need.

Improved health and wellbeing for all members of our community, including underserviced population groups.

Our inside-out change model

We support holistic community health and wellbeing through strategic organisational and thematic priorities that integrate the following 10 interrelated focus areas:

- CHRONIC DISEASE
- POPULATION HEALTH
- MENTAL HEALTH
- GENERAL PRACTICE
- AGED CARE
- DIGITAL HEALTH
- CHILD HEALTH
- ALCOHOL & OTHER DRUGS
- HEALTH WORKFORCE
- FIRST NATIONS



Our approach to promoting good health and controlling preventable diseases is depicted in the diagram (right), which visually represents our inside-out change model. Through sustained focus on our three organisational priorities (represented in the green circle), we aim to support development of projects and initiatives that respond to need in the three thematic streams of health and wellbeing represented in the coloured segments of the circle. We deliver to our communities through partnership and collaboration.

Strategy and performance

DR BELINDA O'SULLIVAN -
CHIEF OF STRATEGY AND PERFORMANCE

As part of our commitment to understanding how we can drive value to our communities, this year Murray PHN formed a new Strategy and Performance Unit.

Much of the work of the unit has been focused on our new Strategic Plan, which sets a clear path for the organisation to grow, to drive both effectiveness and efficiency, and to work more strongly in partnerships with the other stakeholders involved in primary and preventative care in our region.

The unit has begun an exciting program of activity, with specific initiatives that include working with our First Nations Health and Healing team on self-determination in commissioning, with our rural health services to build sustainable models of rural healthcare, and increasing our advocacy work to promote rural health system developments. We are advocating for communities through meetings with the National Rural Health Commissioner, state and Commonwealth governments, and rural partners like our local universities and training programs, as well as through presentations at peak national conferences like Rural Medicine Australia and the National Rural Health Conference.

Our role is to reflect and learn, so this year's devastating floods have also given us the opportunity to work on our emergency surveillance and reporting systems, to build data and reporting which supports real-time decisions during emergency situations. We will continue to refine this system for its application in future emergencies.

Possibly the most exciting project we have begun this year, is one connected with a new policy development of the Commonwealth Government to try to build more socially accountable medical programs, to promote doctors, training and staying in the regions where they are needed. Our team is leading the state-wide effort (of all Victorian PHNs) to advise where GP training opportunities could be expanded to enable quality training experiences, as well as meeting the needs of Victoria's towns and regions.

Health priorities that matter most

The Murray Health Report is published twice a year to provide information to our communities on the health priorities that matter most to them.

The most recent November 2022 edition focuses on sustainable workforce in our region, which has never been more important than the wake of the COVID-19 pandemic and recent floods.

People living in the country should be afforded the same level of healthcare as people living in metropolitan areas. But we need workforce models to be more flexible and make it more attractive for people to come and work in regional areas, like ours.

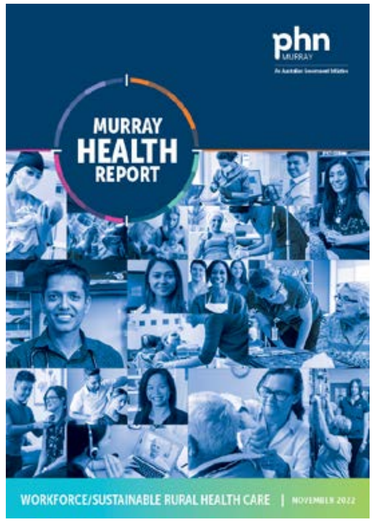
The report looks at some of the current issues, options and models being trialled to help provide solutions to quality primary healthcare, closer to home.

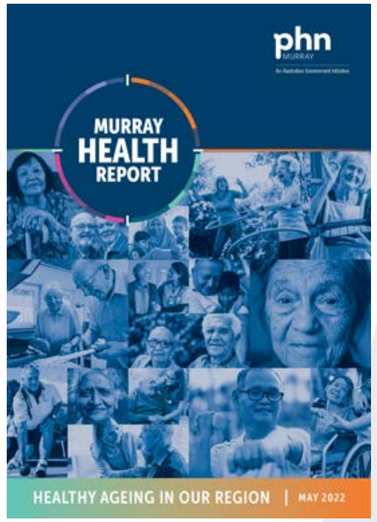
Because an ageing population creates additional pressures on an already stretched healthcare system, May's edition of the Murray Health Report focused on healthy ageing.

This coincided with Murray PHN's first allocation of Commonwealth funding aimed at addressing some of the complex issues faced in the sector, as highlighted by the Royal Commission into Aged Care Quality and Safety.

The report discusses a range of topics, including the impacts of ageism, the importance of local environments, and the social, physical and other supports available that can help older people to feel valued, remain independent and importantly, age well.

To read all editions, visit: murrayphn.org.au/murrayhealthreport





Needs Assessment

Understanding community health needs and strengths is foundational to developing services and programs that are best suited to supporting communities to manage and improve their health and wellbeing.

Every three years, Murray PHN conducts a major Health Needs Assessment with expert analysis, supported by community consultation.

The Strategy and Performance Unit has recently expanded their team to include the expertise required to enhance the quality and direct relevance of our needs assessment processes and systems, so that we are able to collect and use data from a broader range of sources.

These sources include community voice and our advisory councils, as well as a broad range of primary and secondary data sources.

Together with supplementary Health Needs Assessments and other key reports, a more nuanced understanding of the needs of the communities across our catchment will help us to prioritise activity to address need.

To access this and other key documents, visit: murrayphn.org.au/about/keydocuments

Community and practitioner insights

Advisory councils help to inform to Murray PHN's work, including where and how we invest our funding to address community need.

This year, advisory councils took part in the development of the new Strategic Plan, provided input into our Healthy Ageing Investment Strategy, developed a process for succession planning in line with revised terms of reference, and reviewed memberships, policies and selection criteria for a new recruitment campaign.

The mix of practitioner and community insights that councils bring to local issues and potential solutions also helps to inform Murray PHN's health workforce strategy.

Council members generally view their roles as a great opportunity to serve their communities and this year, they took part in a survey measuring progress in improvements that had been implemented to support their work.

- *"It is a good forum of people who are very much interested to focus on community health issues and services."*
- *"As someone who has been an advisory council member for quite some time, it's exciting and reinvigorating to see the changes be suggested and then happening."*
- *"Overall it's been great to see the improvements made to the support of the advisory councils and really pleasing to see the value placed on these groups."*

With the appointment of new council members and orientation in August 2022, Murray PHN was delighted to welcome both new and returning members, bringing an inspiring mix of skills, experience and ideas to our advisory councils.

Our Clinical Advisory Council covers the entire Murray PHN region and has 13 members drawn from general practice, regional hospitals and health services, clinical specialists and allied health practitioners.

Our four Community Advisory Councils each have up to seven members and are based in our Central, North West and East Victoria and Goulburn Valley regions.

To learn more, visit: murrayphn.org.au/about/advisory-councils

Carmel Hicks, Lavington NSW, North East Community Advisory Council Chair

"I have a long-term interest in health. First with a nursing background, then many years as a volunteer in palliative care, which led to being on an early group of the North East on Advanced Care Planning. My coordinator at the time recommended that I apply to be on the Murray PHN Community Advisory Council.

"Community advisory members are in-tune with the general public they associate with, be it young people, school children, elderly, those with mental health issues. By listening to the concerns of those around us, we can advise the Murray PHN Board of those concerns the community think are more urgent. This way the Board can target their precious funds to where it will do the most good while following government stipulations.

"A good example of this is in the past years where money was spent on mental health in Benalla to set up programs. Wangaratta had a card system for travelling nomads and people with COPD/ Emphysema so that they could get continuity of care wherever they may be. Vaccination rollout support during the pandemic has also been essential."

Jack Forbes, Mildura, North West Community Advisory Council Chair

"For more than 40 years I have been interested in the delivery of health services. My interest was awakened by my observation of the extremely poor mental health services available in North West Victoria. I have also observed the distress of those caught in the waiting list queue for non-urgent health procedures. While some medical issues may be non-urgent, they can leave people in pain and in some cases, unable to work.

"The advisory councils provide an opportunity for grass root voices to be heard. It is important that decision makers are provided with examples or case studies of exactly what impact poor health services are having.

"I am very proud that advisory councils have been part of the push to destigmatise and improve mental health services. I look forward to advisory councils ensuring that government tackles rural GP and allied health shortages, the lack of aged care services, our overburdened hospital emergency department services and begins to seriously fund preventative medical strategies/healthy living.

"I believe that the PHN can improve, enhance and fill the gaps in health care provision across the north west of Victoria."

Shaping new services and strategies

Sustainable Rural Health Project
BULOKE | LODDON | GANNAWARRA

To address health system and workforce issues in the Buloke, Loddon and Gannawarra region, Murray PHN, Boort District Health, Inglewood & Districts Health Services, East Wimmera Health Services and Northern District Community Health formed the Integrated Health Network (IHN) Alliance.

The IHN Alliance is a representative working group of the Buloke Loddon Gannawarra Health and Wellbeing Executive Network, a broader health, community and government sector partnership using collaborative approaches to improve health outcomes for communities across the region.

The IHN Alliance launched its Sustainable Rural Health Project earlier this year, to begin addressing gaps caused by workforce shortages.

Monash University has been engaged to help conduct the research and provide support for gathering local perspectives from health professionals and community members.

The feedback is helping to shape new services and strategies that will be trialled over the next two years. The first is a new nurse practitioner rural outreach model, which was awarded a La Trobe University partnership grant in July that will provide expanded clinical care to places where there are limited GPs, such as Pyramid Hill, Quambatook and Boort.

Occupational therapy students from La Trobe University have also helped to develop a health workforce recruitment booklet for the region, which profiles each of the three local government areas with the services and local lifestyle options available. It will be released in 2023 to support a regional health workforce recruitment campaign.

The IHN Alliance hopes that learnings from the project can be taken and used across other rural regions to encourage doctors, nurses and allied health professionals to live and work in rural areas over the longer term.

Buloke, Loddon Gannawarra (BLG) Health and Wellbeing Executive Network, Kerang, August 2022

To learn more and subscribe to project updates, visit:
murrayphn.org.au/sustainableruralhealthproject/

AGPT training assessment grant

The Commonwealth Government is strengthening GP training by transitioning to a training model led by the two Australian GP colleges – ACRRM (the Australian College of Rural and Remote Medicine) and the RACGP (Royal Australian College of General Practitioners).

This means that GP training will be developed and implemented by the colleges from February 2023, replacing an earlier model that was led by regional training organisations.

As part of this transition in Victoria, the Commonwealth has asked the state's six PHNs, led by Murray PHN, to assist by making recommendations on the community needs and training capabilities in metropolitan, regional and rural areas.

Each year, PHNs conduct detailed health needs assessments in their communities, based on qualitative and quantitative data, local knowledge and daily engagement with general practice.

So it is a natural step for the government to ask PHNs to provide workforce needs assessments that will enable the colleges to make evidence-based decisions on where GP trainees might best be placed.

Across Australia, PHNs are working to support the colleges with standardised measures and local knowledge, based on existing data and with a "deep-dive" into the gaps and opportunities in our regions.

Consumer focused dynamic planning

National Rural Health Commissioner, Professor Ruth Stewart visited Murray PHN's Bendigo office in July, to meet with key staff and discuss planning for the local health context, co-design, community engagement, setting priorities and consumer-focused dynamic planning.

Photo - Pictured L-R: Dr Nerida Hyett - Integrated Health Network Project Lead, Dr Catherine Lees - Director Integrated Projects & Partnerships, Professor Ruth Stewart, Matt Jones - CEO and Dr Belinda O'Sullivan - Chief of Strategy & Performance

ENT in primary care

Murray PHN Industry PhD student Susan O'Neill took part in the Three Minute Thesis (3MT) Competition for the International Association for Conflict Management (IACM) conference in July, highlighting the strengths of rural communities in our catchment and priority needs in relation to managing ear, nose and throat (ENT) presentations in primary care to prevent avoidable hospitalisations.

Photo - Steve Begg, Susan O'Neill, Evelien Spelten, Dr Nerida Hyett

Operations

JANINE HOLLAND -
CHIEF OPERATIONS OFFICER

Over the past year, our Operations unit has demonstrated increased stability and innovation, working on our core business of commissioning and coordination while rising to the twin challenges of ongoing COVID outbreaks and devastating floods across our region. Internally, we have realigned reporting lines and updated position descriptions to better reflect our teams' roles and responsibilities, as we continue to consolidate the way we need to do our business going forward.

Our priorities are clear and incredibly diverse – mental health, suicide prevention, alcohol and other drugs, aged care, cancer prevention, general practice support, quality improvement, professional development and digital health – topics that demonstrate the wide range of work that Operations staff undertake.

We have refined our work from transactional commissioning to relational commissioning, which has helped us to co-design models for working in partnership with general practice, allied health, pharmacies, mental health and residential aged care, with a shared understanding of local needs.

At the same time, we have worked even more closely with the five other Victorian PHNs to produce statewide healthcare approaches, particularly in residential aged care, eye health, palliative care and cancer care.

Our teams understand the changing needs of our rural and regional workforce and are considering contemporary primary health service delivery models that meet the needs of workforce and our communities.

Our work is centred on improving the health of our communities and more than ever we understand that this work must be done by all sectors together, while delivering accessible and timely primary health services.

We will continue to have important conversations in our communities, to co-design services that can be sustained and deliver on our strategic plan by addressing the needs of our communities.

To watch our RPM video:
https://youtu.be/Ra9kI9L04Rs

Greater knowledge to stay well

PACE program

The Pulmonary and Cardiac Exercise and Education (PACE) program has been developed by Alpine Health and Murray PHN, in partnership with Equilibre Health, Kiewa Valley Sports and Spinal Physiotherapy, and Ovens Valley Physio and Pilates. Established in 2018, the program has been delivered to more than 500 patients in Mount Beauty, Bright and Myrtleford.

Following the 2019–20 Black Summer bushfires and COVID pandemic, the PACE team adapted their services to continue to help people living with heart and lung conditions to improve their health through individually tailored assessment, education, exercise classes and home–based activity plans.

While many programs ceased during this time, the PACE team's ability to provide alternate support meant patients weren't falling behind, but progressing their physical activity despite lockdowns. Because of this, the program was awarded a prize for Excellence in Clinical Practice at the 2022 Australian Cardiovascular and Rehabilitation Association conference.

Remote Patient Monitoring

Diabetes, lung and heart diseases are responsible for a high number of potentially avoidable hospital admissions. To help reduce these, Murray PHN has funded a remote patient monitoring (RPM) program and is working with local regional hospitals, general practices and Aboriginal Community Controlled Health Organisations.

RPM helps people to self-monitor their chronic health condition at home, using devices such as a glucometer, blood pressure monitor and oxygen saturation probe. The information is sent via the patient's smart phone to an online portal, which health professionals can access and monitor remotely.

The health team is made up of nurses, specialists and GPs, who can intervene when a patient's health readings are outside normal ranges. Health professionals working together provides a person with all the tools and support they need to make sure that their condition does not worsen.

Data from one of the programs showed that most patients stayed in the program for nine months and reported not only an improvement of their condition, but greater knowledge about what they can continue to do to stay well.

Further analysis of the data received from health providers involved in the program showed a statistically significant reduction in emergency department (ED) and hospital admissions as an outcome of using the RPM program. Of 24 patients that completed one program, ED presentations were reduced from an initial 60 incidences before using RPM, to 17 once enrolled in the program.

"The program has provided self-assurance that my health is tracking along well and takes away the worry from my wife who is also my carer. The support received, especially with joint GP and specialist appointments, takes the pressure off my wife and helps me take responsibility for my own health."

"I believe that the program has been crucial in my quick and significant recovery from heart failure. When I started the program, I had an ejection fraction (EF) of 20%. When I finished, my EF was up to 56% (the normal range is from 55-75%). The ability to actively manage my weight and blood pressure daily was a key player in this recovery. It allowed me to keep track of how much fluid I had retained in my body and alter my diuretics to keep my weight at an acceptable level, which in turn helped my breathing and allowed my heart to recover without pressure from excess fluid. The beauty of being on the program is being able to see results from days and weeks prior, to keep track and monitor any changes. It also gave the nurses the ability to message me if they noticed change in my observations and question whether I was ok, why it had changed and tell me how to fix the changes."

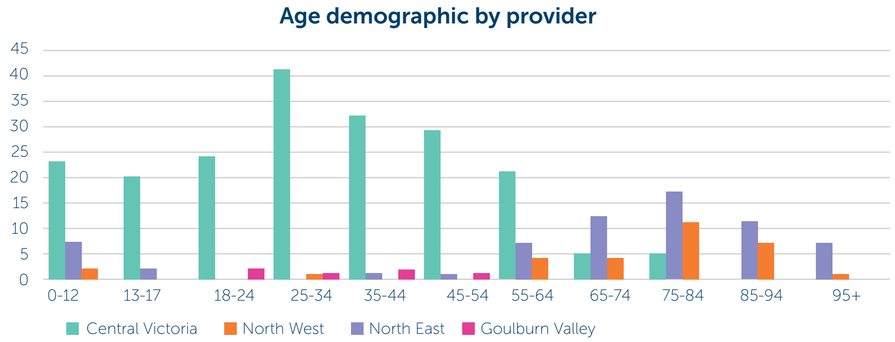
"I find these devices excellent value. When I have a low reading, I use my action plan and monitor myself regularly during the day, even with a good reading. I don't leave home without them. When I have a low reading, someone from the program will contact me to check up to make sure all is well and offer their advice and support."

Work to connect patients

Health System Navigators report - May 2022

Four providers in the Murray PHN region deliver Health System Navigator programs. Two sites support refugees and people with chronic or complex care needs and two have an ageing and complex care focus.

Health navigators work to connect patients to the care and services they need. Despite COVID restrictions, 760 people received help between April 2021 and March 2022.



Reasons for using the health navigator service included seeking assistance with understanding health information, catch up immunisations, help for developmental delays in children, to find out and connect with local services, and support to help care for a family members with conditions such as cancer and dementia.

Referrals were made to a range of services including emergency housing, the National Disability Insurance Agency and to GPs, dentists, paediatricians, radiologists and opticians.

My Emergency Doctor

In the 12-month period to 30 June 2022, 3530 consultations were provided by My Emergency Doctor across urgent and residential aged care facilities (RACFs). Around 80 per cent of these were managed on-site without needing to transfer patients and residents to other health facilities.

Through consultation with Urgent Care Centres (UCC) and RACFs using the service as part of the Murray PHN after hours program, feedback was collated as part of an evaluation report published in May 2021 that indicated:

- Both UCCs and RACFs value the ability to access prescriptions through My Emergency Doctor where video assessments can support better assessment compared with telephone
- Many RACFs have welcomed the support but have yet to begin using the service or embedding it into routine care. Of those using My Emergency Doctor routinely, some are using the service as a back-up only, while others are using it to actively fill gaps in after hours primary care
- While many RACFs are not high-volume users of My Emergency Doctor at this stage, its inclusion in their models of care and escalation pathways is highly valued and has resulted in better outcomes for residents, nurses and GPs.

3530
consultations

80%
managed on-site

"A local GP initiated access to My Emergency Doctor for Myrtleford RACF and UCC, as fewer local GPs are able to provide after hours support. My Emergency Doctor is currently being used to provide small breaks in on-call rosters for GPs, one to two times per month. Alpine Health staff at Myrtleford, including RACF staff, have high acceptability of telehealth with long-term prior experience in other health services, and their transition to My Emergency Doctor has been seamless."

Myrtleford campus UCC and RACF, Alpine Health

Improvement in competence and confidence

RIPERN

The rural and isolated practice endorsed registered nurse (RIPERN) scholarships support acute nursing staff in rural communities to expand their scope of practice, to provide urgent and primary care to those who need it, without waiting for a doctor.

Murray PHN invests in full scholarships through The Cunningham Centre that enables registered nurses to complete a 12-month training program. This program equips them with the advanced decision-making and diagnostic skills required in rural and remote primary care, when practising in the generalist expanded practice role of initiating patient care (including use of medicines).

Since Murray PHN began providing scholarships in 2017, 79 registered nurses have been RIPERN-trained across rural and remote urgent care centres, with another 16 set to complete their training by the end of 2023.

Kerang District Health Nurse Manager Suzanne Gray said RIPERN training has resulted in an enormous improvement in the competence and confidence of the service's junior staff.

"Patients are often able to be assessed and treated by the RIPERN nurses without requiring attendance by on-call medical staff. This has improved relationships between our medical and nursing staff, as the medical staff have a higher degree of confidence in the nurse's abilities. It also improves work-life balance for on-call medical staff as they are not called upon as often and improves job satisfaction for the nurses who are treating patients. Patients do not have to wait as long to be seen, assessed and treated, which improves community attitude and confidence in the organisation. I currently have three more junior members of nursing staff completing the course." - Suzanne Gray, Kerang District Health Nurse Manager

Community transport

Getting to health and medical appointments can be difficult when there are limited transport options available locally.

This year, regional PHNs have partnered with the Royal Flying Doctor Service (RFDS) to fund eight new Flying Doctor Community Transport services in the areas of highest need.

Building on the success of sites already operating in Heathcote and Rochester, Numurkah was selected as one of two new sites in the region (second site to be determined). NCN Health and RFDS are supporting the community of Numurkah and surrounds.

Led by a local program coordinator and a team of highly trained volunteer drivers, Flying Doctor Community Transport is a free service offering eligible community members transportation to health appointments.

To find out more about Flying Doctor Community Transport or to apply to be a volunteer driver, call 1300 887 678.

Promoting health and wellbeing

Social prescribing

Social prescribing is an approach to promoting health and wellbeing for lonely and isolated people by linking them to social activities to improve their connection to community.

Murray PHN funds the City of Greater Bendigo to deliver a social prescription program for people who live with a chronic or complex health condition, and who would benefit from increased social interaction.

More than 150 referrals for the program have now been received, helping people to access more than 50 different types of activity in the Bendigo region. The most popular activities include social groups such as morning coffees, art-based pursuits and neighbourhood house programs.

Many of the participants have enjoyed bringing their own skills to their chosen activity. For example, a computer specialist has been able to assist older people with learning how to use technology and a local writer is helping to mentor young authors.

The program can be accessed by referral from a health professional. To learn more, visit: bendigo.vic.gov.au/Services/Community-and-Care/Social-prescribing

"I have made so many connections from this program that I would not have made if it were not for this art class" - Art program participant

CASE STUDIES:

- "Alice" was new to town after fleeing a domestic violence situation. With no support network, Alice was struggling with her mental health. Through the program, Alice has been attending a social group at her neighbourhood centre and is taking cooking classes through her local church.
- "Beverly," also new to town, was suffering from both physical and mental health challenges. She was introduced to a volunteer-run community hub that offers a range of activities, including gardening and dancing. She has also become a social member of a sporting group that she is passionate about and really enjoys attending.
- "Clare" struggled to access a range of activities during COVID, as she did not want to tell people if she was vaccinated or not. She has since been able to connect with her local neighbourhood centre to participate in gentle exercise classes and is enjoying getting out and about and socialising more.

Note: Names have been changed to protect people's privacy

To watch our video:
https://youtu.be/JfEeIATIBU8

New shared focus in mental health

In April this year, the Victorian and Commonwealth governments signed a bilateral agreement to improve mental health and suicide prevention services in Victoria.

The agreement focuses on the range of initiatives where the governments have agreed to partner in the support of Victorians who need mental health support.

Head to Health services were established to provide a more responsive mental health system for Victorians and they are staffed by multidisciplinary teams of clinicians who are available to support people directly or refer them onto a range of different services, depending on the level of care they need and what they can afford to pay.

Under the agreement, funding of Head to Health services in Victoria will continue until the new Local Adult and Older Adult Mental Health and Wellbeing Services (Local Services) are established. Seven of the Local Services will be located in our region, in Wangaratta/Benalla/Mansfield, Bendigo, Echuca, Mildura, Shepparton, Castlemaine, Robinvale, Swan Hill and Wodonga.

Given the new shared focus of state and federal governments, our Together: A Regional Approach to Mental Health, Alcohol and Other Drugs and Suicide Prevention Foundation Plan work has started to scale back.

Murray PHN is now working to build providers in our region to continue mental health and alcohol and other drugs services to help people stay well and out of hospital.

In 2021:

7509
People accessed a Murray PHN commissioned service

8192
Referrals/episodes of care

53,867
Service contacts

286
Practitioners delivering services

52%
Had a mental health treatment plan

9%
Experienced or at risk of suicide

Services commissioned by Murray PHN

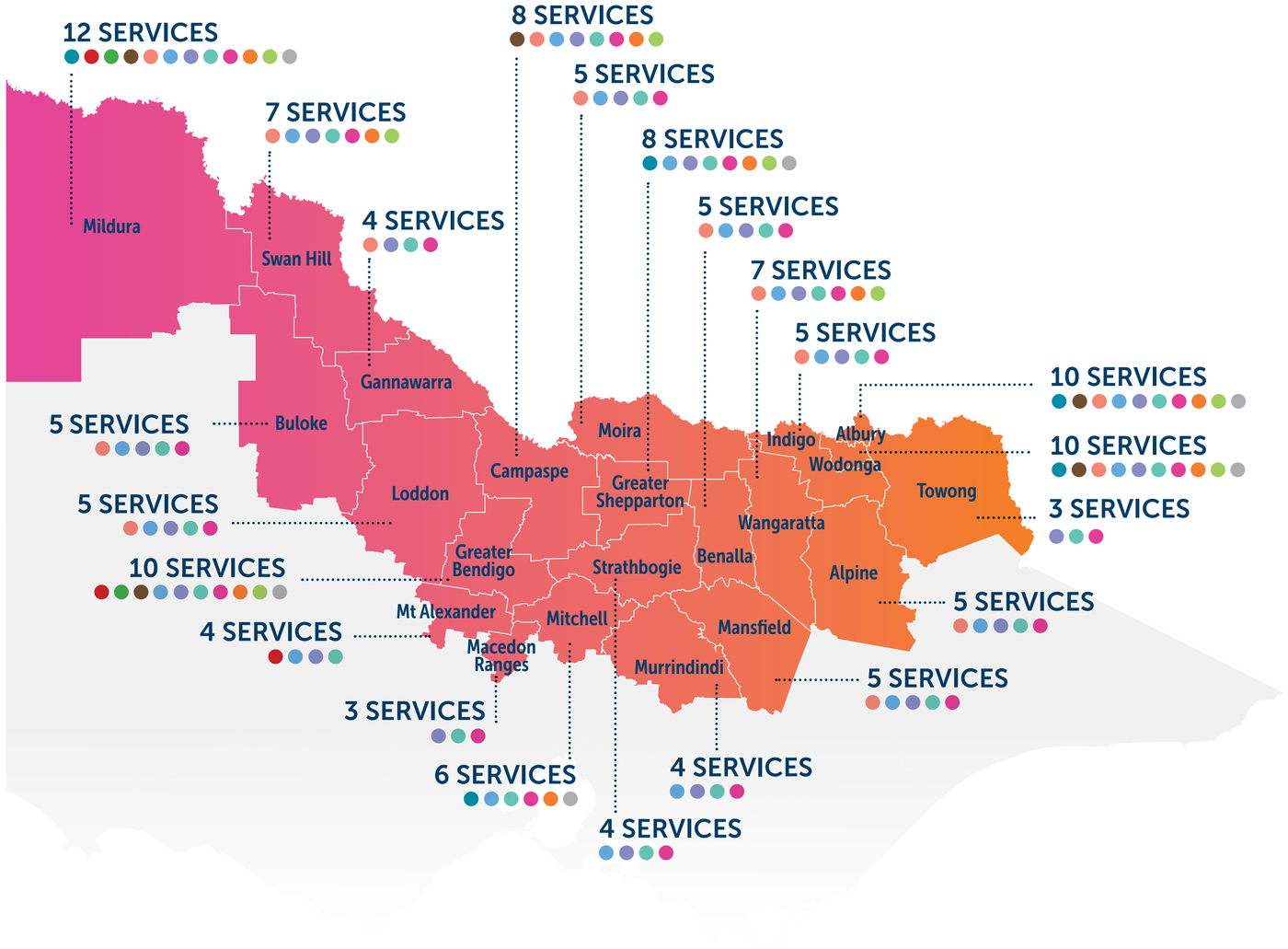
- 20-29 years (20%)
- 30-39 (18%)
- 40-49 (15%)

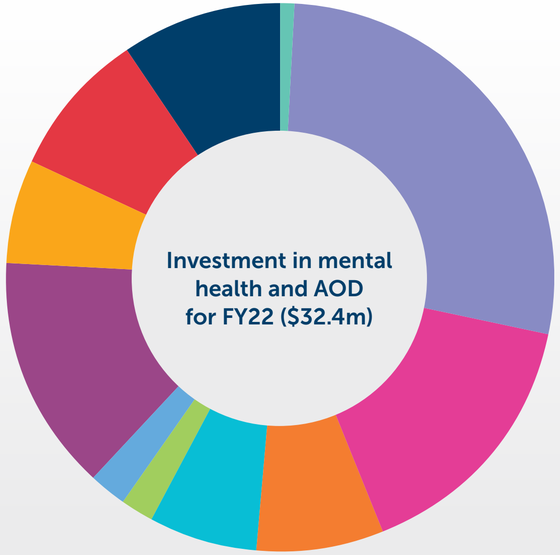
3%
Homeless

8%
First Nations

63%
Female

33%
Anxiety





- Low intensity $0.3m
- Child and youth mental health (inc. headspace) $8.9m
- PTS $5.1m
- PMHCCC $2.4m
- Suicide prevention $2.1m
- First Nations $0.6m
- headspace Demand and Enhancement program $0.7m
- Mental health for COVID-19 $4.5m
- Mental health for bushfire $2m
- Drug and alcohol treatment $2.8m
- National Psychosocial Support $3m

- Head to Health
- headspace
- Youth enhanced
- Primary Mental Health Clinical Care (PMHCCC)
- Psychosocial Recovery Services

Psychosocial Therapy Services (PTS):

- General
- Child
- Residential Aged Care Services
- First Nations services
- Perinatal
- Suicide prevention
- The Way Back

Psychological Therapy Services and Primary Mental Health Clinical Care Coordination

Primary mental health services funded by Murray PHN fall into two broad categories - Psychological Therapy Services (PTS) and Primary Mental Health Clinical Care Coordination (PMHCCC).

PTS provides services for adults, children and young people with a clinical diagnosis of mild or moderate mental illness who would benefit from short-term, focused psychological therapy.

Sessions are provided by a qualified mental health professional, and people should have a mental health review by the referring GP after every six sessions if ongoing treatment is required.

PMHCCC provides clinical care coordination for clients with a severe mental illness, aiming to reduce the likelihood of hospital admissions and improve their physical health through assessment, management and onward referral, in collaboration with other members of their healthcare team.

To learn more, visit:
murrayphn.org.au/mentalhealth

CASE STUDY: PTS

"Emma" lives with her family, one hour from the nearest regional town. She hasn't long transitioned to secondary school, though has rarely attended classes this year.

Referral into the PTS Child program allowed Emma, her parents and teacher to receive intake and psychometric assessments which revealed that Emma's parents were subconsciously enabling the school refusal and feeding Emma's anxiety.

The two treating clinicians, together with their therapy dog, worked directly with Emma, her parents and teacher to develop a plan for managing school attendance.

One of the clinicians used The Cool Kids Program, a cognitive behavioural therapy-based anxiety program for children, enabling the rapid stabilising of Emma's anxiety and an increase in school attendance.

With distance initially a barrier to accessing services, and the parents' need for support that required two clinicians working with the family at the same time, PHN funding was integral to provide effective services to both Emma and her parents.

Supports provided to Emma's school will also ensure long-term success and help them to manage future situations with other students.

Note: Names have been changed to protect people's privacy

CASE STUDY: PTS

"Brad" is completing his final year of schooling. Struggling with Year 12 and the impacts of isolation caused by COVID lockdowns and remote learning, he was finding himself losing motivation, having negative thoughts and withdrawing from social situations.

Brad visited his GP and was diagnosed with depression and referred to additional mental health supports. His psychotherapy assessment determined that Brad would benefit from acceptance and commitment, and cognitive behavioural therapies. Together, these approaches would help him to develop improved self-esteem and coping mechanisms.

The mental health nurse worked with Brad's GP and psychologist to monitor treatment, including the use of online supports, and progress towards Brad's goals. He attended five psychological therapy appointments over eight weeks, mostly after hours so not to negatively impact his schooling and enabling him to retain a level of anonymity.

Brad's family has noticed his improved mood and increased social interaction. Brad also feels a greater emotional awareness and better understanding of his feelings, and is now confident to reach out to people when he needs support.

CASE STUDY: PMHCCC

"Nancy" is in her 50s and lives on the outskirts of Mildura. She has multiple chronic diseases, including heart and lung disease, as well as sleep apnoea, alcohol disorder and severe depression that increased when her son died by suicide.

Nancy's conditions have impacted her work and everyday tasks, exacerbating the compounding grief that led her to her own suicide attempt.

The chronic health team referred Nancy for mental health support, where together, the teams worked with her GP to organise and provide social support, counselling and referral to other services such as financial, disability and psychiatry.

Nancy was visited weekly, with phone support at other times. Her counsellor even helped out in the garden while providing psychotherapy. Nancy's medication was reviewed and increased, and she is trialling a sleep machine, which has helped to stabilise her mental health and allow her to be ready to talk about her grief and loss, and address her alcohol intake.

Now that she is receiving a disability support pension, Nancy's finances are more under control, and she is no longer at immediate risk of eviction and homelessness.

Without the intensive and coordinated support between the different clinicians and agencies, particularly during times of increased risk, Nancy's current and future outlook may have not been so positive.

A future model is proposed

Stepped care review

The 2021 Royal Commission into Victoria's Mental Health System and the 2019-2020 Federal Productivity Commission Inquiry Report into Mental Health highlight the ongoing and significant task in addressing mental health issues and the key role that PHNs have in this process.

In 2015, the Commonwealth Government, through the Department of Health and Aged Care (DoHAC), provided guidance for PHNs to adopt a stepped care approach to their mental health services. Stepped care provides access to a range of care options that are relevant to people's needs and gives them the opportunity to step their care up, or step it down, depending on their health needs changing.

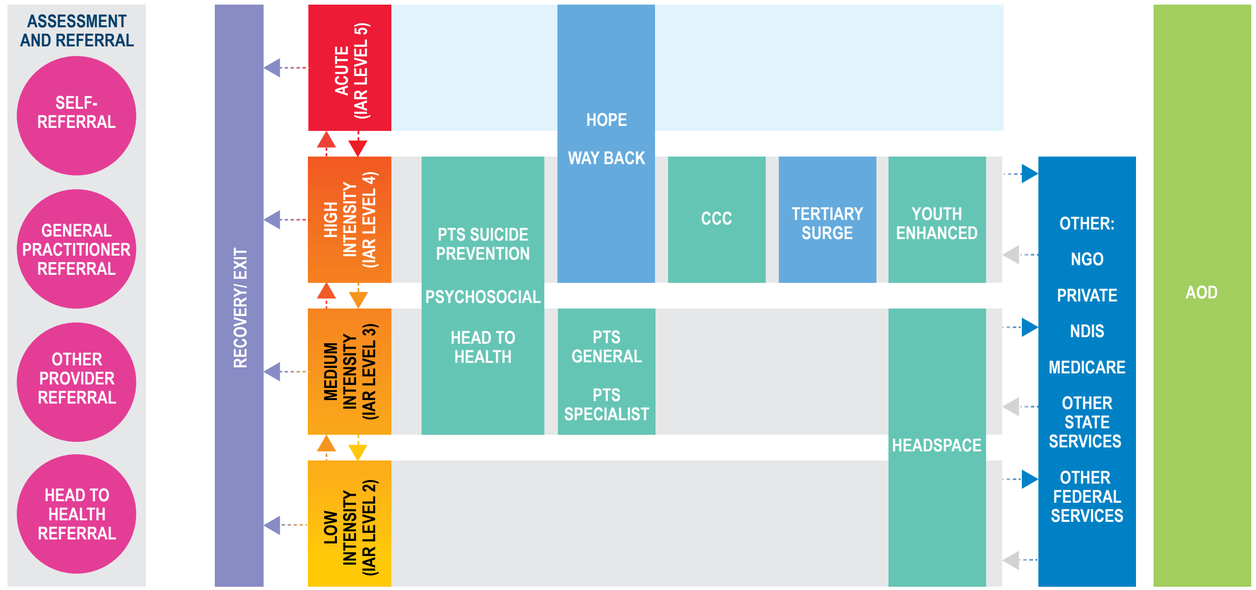
All of Murray PHN's mental health funding is directed at stepped care options at some point on the care pathway relative to severity and at times, for specific cohorts. While a number of changes have been made to the way the organisation has implemented stepped care over the seven years of operating, this year marked the first formal review of the overall model and commissioned services.

The report sought to summarise the findings of an initial review of Murray PHN's Stepped Care Model and the services commissioned by Murray PHN's Mental Health and Alcohol and Other Drugs (AOD) Team, with 19 recommendations to inform our commissioning approach for the 2024 financial year.

The Stepped Care program was evaluated in five domains: appropriateness, effectiveness, efficiency, equity and quality, with more specific questions underpinning each of these areas. A range of data sources were used including internal data reports, contracts, policies, surveys of Medical Advisors, internal staff, other PHNs and consultants.

A future model is proposed to contain the following components: team-based regional hubs with outreach elements, models of care that incorporate First Nations' world views delivered by ACCHOs, capability building to ensure provision of culturally responsive care, improved intake system, clear criteria for step up/down, linkages to other interventions suited to improving outcomes, and embedded monitoring and clear evaluation to inform and refine design.

MURRAY PHN STEPPED CARE MODEL



Head to Health now available nationally

HeadtoHelp was established during Victoria's lockdown in September 2020, to provide people with access to multidisciplinary teams, including psychologists, mental health nurses and social workers.

In December 2021, HeadtoHelp transitioned to Head to Health to bring Victorian services in line with a national government rollout into NSW and the ACT, and to complement the Commonwealth's existing mental health resources website headtohealth.gov.au

In 2021, the average wait time for Head to Health hubs in the Murray PHN region was five days and there was a total of 13,394 service contacts.

The service is now available nationally by phoning 1800 595 212 and continues to provide a front door to a range of services, using the initial assessment and referral clinical triage framework developed by Victorian PHNs, to capture and understand a person's clinical and social circumstances and needs, and where needed, give a "warm handover" to another service that is able to assist the person further.

"This service has assisted me to completely change my life for the better. I feel like a different person."

"My Wellness Support Worker was excellent and gave more than 100%. She had excellent customer service. She knew her job but she also knew how to communicate and I highly recommend that this service be available to more people. It saved me."

"This service was incredibly beneficial. It assisted me to understand process of what I went through. It allowed a safe space for me to speak with someone and overcome my trauma."

Bendigo Community Health Services staff visit local shopping centres to promote Head to Health

A consistent review and treatment process

IAR DST training

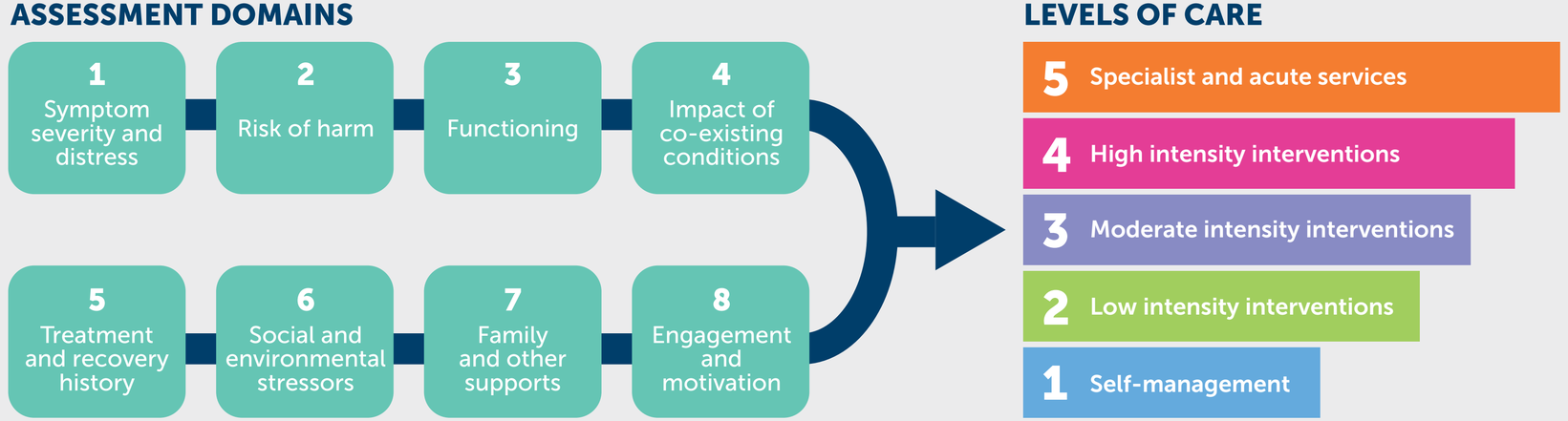
People seeking mental health support may present with a range of factors that can make it challenging for health professionals to determine the most appropriate level of care required.

Currently, there are several different referral and assessment tools being used, with little or no consistency, and varying levels of validity.

In the 2021-22 Budget, the Australian Government allocated $34.2 million to make a new mental health tool, already in place in Head to Health services, available in all primary care settings.

The Initial Assessment and Referral – Decision Support Tool (IAR-DST) complements clinical judgement and provides GPs and mental health clinicians with a standardised, evidence-based approach to providing care recommendations.

Widespread uptake of the IAR-DST aims to create common language across the mental health sector and a consistent review and treatment process for patients.



It is expected that around half of the national GP workforce will be trained in the use of the IAR tool by June 2025. GPs and GP registrars who complete the workshop can receive a $300 once-off incentive payment. For more information and to register for the training, visit: murrayphn.org.au/iar

Addressing unique barriers

headspace

headspace is an enhanced primary care model that addresses the unique barriers that young people face accessing mental health support. With a focus on early intervention, headspace provides young people aged 12 - 25 years and their families with support at a crucial time in their lives.

In our catchment, headspace centres can be found in Albury Wodonga, Bendigo, Echuca, Mildura, Shepparton, Swan Hill and Wangaratta.

Murray PHN works closely with the seven local centres, lead agencies and their consortia partners in our region, in supporting ongoing improvements to accessibility, integration, quality and effectiveness.

This year, Murray PHN's mental health team assisted headspace Bendigo, Swan Hill and Mildura in their applications for Demand Management and Enhancement grants, allowing the services to complete renovations to increase service capacity.

headspace centres can be found in Albury Wodonga, Bendigo, Echuca, Mildura, Shepparton, Swan Hill and Wangaratta.

Echuca headspace opens

headspace Echuca opened its doors in March this year, following an earlier survey of more than 1000 young people who input into the types of services they would like to receive locally.

Billie Taylor, a young woman with a passion for mental health, was an integral part of Murray PHN's implementation team, assisting the appointed operator of headspace Echuca, Echuca Regional Health, with recruitment, building design and fit out. A member of headspace Bendigo's Youth Reference Group, Billie also provided assistance with youth consultations and the establishment of an Echuca Youth Reference Group.

Headspace national said that Murray PHN was leading the way by having Billie involved in executive level conversations, on tender and interview panels. Other PHNs have since sought guidance for how they can do the same.

The headspace centre in Echuca offers support for mental health, physical and sexual health, vocational (work, school and study), and alcohol and other drugs at 451 High Street.

For contact details of all local headspace centres, visit: headspace.org.au

CASE STUDIES:

"Mitch" is 25 and lives in Bendigo with his young family. He initially self-presented to headspace with longstanding depression, anxiety, PTSD, ADHD and suicidal ideation that had resulted in previous attempts at ending his life.

Mitch's initial treatment goals were to work on his anxiety and trauma. However, during his treatment, Mitch experienced a relationship breakdown and with the impacts of COVID on his work and his inability to see his parents in Melbourne, his thoughts about suicide increased.

Mitch was referred to a short-term psychiatric facility and received treatment, alongside family system supports that helped him to reconcile with his family.

The key goal of sessions was to build rapport with Mitch, as anything too therapeutic could cause him to shut down and end sessions early. His partner and parents also attended sessions to provide Mitch with additional support.

Fortnightly appointments eventually became monthly, as Mitch began using behavioural and cognitive strategies to better manage his wellbeing.

Although Mitch has now sourced a job, he continues appointments via phone to help manage anxiousness about his new job and routine.

While Mitch doesn't like talking, the friendliness of the staff and the ability to change workers to enable a better fit has helped him immensely.

"Olivia" is in her early 20s and lives with her family. She migrated to Australia as a refugee when she was nine years old.

Olivia has had several admissions to emergency departments and mental health facilities for multiple and complex mental health diagnoses, and the impacts of past trauma.

Olivia was referred to headspace Swan Hill three years ago and placed on the Young Person Complex Needs Program to receive fortnightly psychotherapy support. She identified her goals as reducing intense emotions, developing a more positive body image and "staying alive every day".

Olivia's collaborative clinic plan helped to develop a consistent approach to her treatment, provide clarity about the roles and responsibilities of the clinicians involved, and included risk planning and support information.

Olivia has since been able to improve her self-esteem and coping strategies, which has resulted in her longest period of remission from self-harm and a reduction in hospital admissions. The collaborative approach to and ensuring that she remained at the centre of her own care has helped to maintain her wellbeing and ongoing success.

"Sarah" is in her late teens and originally went to headspace with anxiety and relationship issues with her father. Her father died not long thereafter, so she then needed additional support for her grief and loss.

A psychosocial assessment recommended interpersonal therapy, general supportive counselling and acceptance-based strategies for Sarah who identified her own goals as opening up to get everything out, in order to get on top of things.

Sarah received a mix of in-person and telehealth support to accommodate her living between the country and city for study, and because of the impact of returning home during COVID lockdowns.

Sarah has since developed a greater awareness and understanding of her emotional responses and values, and how these guide her behaviour, as well as self-care strategies and boundary setting.

Sarah has received offers to multiple universities and says she has achieved her goals: "headspace helped me gain a better understanding of the emotions that I didn't even know were affecting me and how to cope with them."

Note: Names have been changed to protect people's privacy

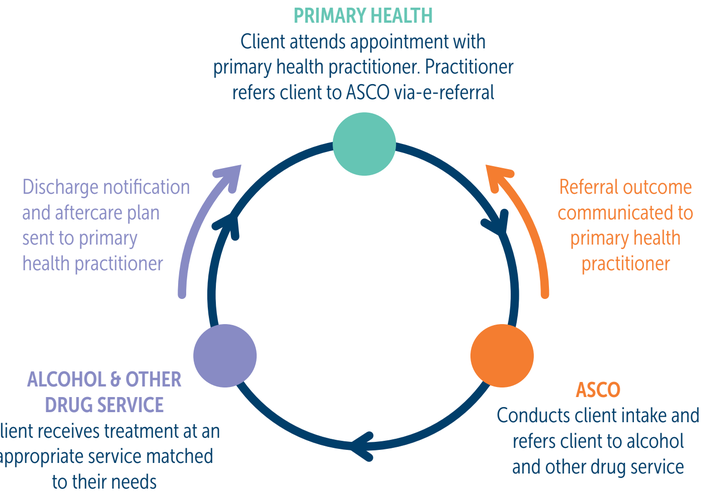
Increasing connectivity

Murray PHN engaged 360Edge, a health consultancy specialising in the alcohol and other drug (AOD) sector, to undertake a range of activities to improve the capacity of the local primary health sector to respond to AOD needs.

Through consultation, 360Edge found that local practitioners did not always engage the state-wide provider of AOD intake services, the Australian Community Support Organisation (ACSO), meaning that direct referrals could limit access to a range of services and risk duplications in intake procedures, where clients could disengage from one service but engage with another.

Referrals to ASCO can improve the visibility of where and what treatment clients are receiving and what the primary health role in aftercare should be. ASCO can also provide at-risk clients with a pre-admission support service and brief interventions where there is a long waitlist for services.

Increasing the connectivity, communication, improved resources and referrals between ASCO, primary and specialist sectors, aims to help people get the care they need, where and when they need it.



Life skills support

Psychosocial Recovery Services

To help people living with severe mental illness and their carers, Murray PHN provided $3 million in funding this year for new Psychosocial Recovery Services.

Psychosocial recovery services provide non-clinical, life skills support to vulnerable people living with severe mental illness who are unable to access the National Disability Insurance Scheme.

The services help people with anxiety, mood, personality, psychotic, eating, substance use and trauma related disorders, to manage their daily living needs.

Assistance provided can include alcohol addiction support, financial management assistance, educational and training goals, but above all, support that helps people to stay well.

Wellways Australia Limited and Stride Mental Health were selected after an expert panel, that included a representative with lived experience of mental illness, evaluated all submissions.

The tender evaluation was based on a range of factors relating to client experience, workforce capacity, value for money and the ability to implement and support a peer workforce.

To learn more and for service contact details, visit: murrayphn.org.au/prs

CLIENT FEEDBACK

The Your Experience of Service (YES) survey is designed to gather information from consumers about their experiences of care. During May-October, 63.2 per cent of PRS clients rated the services they received as excellent and 36.2 per cent rated them as very good.

"Having Damien from Wellways as my support person has been the best experience in my life. He is a very positive and easygoing person, who I highly respect. He has helped me tremendously. I don't trust people, but with Damien I felt from the beginning that he was trustworthy and he proved me right." – PRS client

"I am feeling hopeful that I can finally get the help that I've been needing for a long time, thanks to Stride." – PRS client

"Before Stride came into my life, I felt no one could help me, but Stride has changed my opinion and is helping me so much." – PRS client

Note: Names have been changed to protect people's privacy

CASE STUDY: Psychosocial Recovery Services

"Alex" is a late teen and lives with his family in Bendigo. He was referred to psychosocial support services at Stride Mental Health by his mother, for extreme depression and anxiety.

Growing up with one parent who had her own mental health concerns, living in public housing and with no car, meant that Alex did not have a stable foundation of social, emotional, mental or financial supports to experience the social norms of his peers and to finish schooling. The impact of COVID and his mother not believing in the benefits of vaccination didn't help Alex's severe social isolation situation.

These challenges combined to impact Alex's confidence, independence and maturity. Alex could not access government support payments without a bank account and could not open a bank account without identification, so these were Alex's initial support goals.

Alex now has an income and is able to enhance his life and way of living. He is looking forward to the future and considering a career in the disability sector to help others.

Safe, supportive and non-judgemental

Youth early intervention

The Early Intervention Program is funded by Murray PHN and offered through The Bridge Youth Service. It supports young people living in the Goulburn Valley region who are experiencing distress because of poor mental health or substance misuse issues. By improving emotional regulation and impulse control, young people can access the care they need through the assertive outreach, comprehensive assessment and access treatment through an on-staff psychologist.

CASE STUDY: Youth early intervention

"Quinn" is a tween who identifies as non-binary and lives in the small shire of Murrindindi.

They struggle with managing their anxiety, low and fluctuating moods, suicidal ideation and self-harm that has led to an overdose attempt.

Quinn was referred to The Bridge Youth Service where they learned coping strategies to manage strong emotions, better accept their thoughts and feelings without being overwhelmed by them and improving their own self-care.

Face-to-face appointments were offered fortnightly with a case manager in Wallan who called or texted on the opposite week, and once a month with a psychologist in Seymour. The ERIC (Emotion Regulation and Impulse Control) skills program was used, in addition to encouraging Quinn to engage with their existing GP.

Quinn has stated that their mood has since improved, along with their self-care and hygiene routines, which have positively impacted their relationships, including with their school and future career aspirations.

Note: Names have been changed to protect people's privacy

'The Men's Table' wellbeing services

Many men find it difficult to open up and talk. The Men's Table is an organisation that aims to change that.

Once a month, men get together over dinner, to build friendships and share openly about their lives in a safe, supportive and non-judgmental environment.

Murray PHN has supported the establishment of four local The Men's Table community groups to help improve men's mental, emotional and social wellbeing.

The groups are co-funded with the National Suicide Prevention Leadership and Support Program Funding.

They have a preventative and wellbeing focus and are supported with clinical supervision and safety net protocols. While informal, they aim to teach life skills and men who are identified with complex needs are offered additional support.

To find out more and to attend a table, visit: themenstable.org

Connecting and sharing

Suicide prevention

Transitioning to community-led activities

This year, with the end of the suicide prevention state-funded trials in Mildura and Benalla, efforts focused on transitioning to community-led models. In Benalla, the Benalla Suicide Prevention and Awareness Network has been established, supported by Wesley LifeForce and Murray PHN, and is working to support suicide prevention and awareness activities in Benalla Rural City and surrounds. Some of the activities undertaken during the trial include leadership development, community forums, resource development, and training for community members, businesses and health professionals.

"The community forums were a really massive part of this whole place-based trial. These forums gave people the opportunity to come in and listen. I think those forums were one of the greatest things that ever happened to Benalla."
– trial participant

In Mildura, the Sunraysia Mallee Suicide Prevention Network was established by a group of people with lived experience and operated independently to the trial, providing community leadership to address suicide in the community. Examples of activities during the trial include training community members to recognise and respond to suicidality; an aftercare research project to improve emergency and follow-up care for suicidal crisis; reviewing and strengthening the Northern Mallee Suicide Postvention Protocol and developing new perpetrator-focused practice guidelines for family violence – projects completed with a range of stakeholders, including Victoria and NSW Police, Mildura Base Public Hospital, headspace Mildura and Sunraysia Community Health Services.

"The most significant thing has been the bringing together of sectors across the lifespan system with a resource that sits behind that to do the joint planning and action, so it's that sort of collective impact approach." – trial stakeholder

Sporting Clubs Guide: Response to suicide

As part of the Northern Mallee Suicide Postvention Protocol, a guide for sporting clubs was developed to assist clubs in responding to a suspected death by suicide in their sporting community.

To download, visit: murrayphn.org.au/suicideprevention/postvention/

Sporting clubs and their representatives were further supported with free mental health first aid courses in Mildura. Richmond Institute, an education arm of the Richmond Football Club, was funded to run the courses in February and May. Coaches, players and club volunteers were invited to attend to gain the knowledge and skills to offer first aid to people experiencing a mental health issue.

Grit and Resilience Program progresses

The Grit and Resilience Program is a community-led initiative aiming to improve mental health and wellbeing, and support for people affected by suicide in Wangaratta. The program is led by the Rural City of Wangaratta and commissioned by Murray PHN with funding from the Commonwealth Government.

In February, Murray PHN funded training that was supported by The Grit and Resilience Program for 15 people to become peer support group facilitators. The training gave participants the knowledge, skills and confidence to become effective group leaders and run valuable self-help groups, including suicide bereavement support groups.

On World Mental Health Day in October, the program's first Grit and Resilience Festival was held at King George Gardens in Wangaratta. There were more than 20 stallholders and 200 community members in attendance, connecting and sharing in wellbeing-focused activities such as yoga and live music. The festival aimed to raise awareness of the importance of mental health, locally available services and forming community connections.

To find out more about the program, visit:
www.wangaratta.vic.gov.au/Residents/Grit-Resilience

Healthy Ageing Investment Strategy

While understanding the issues of our ageing population has been a health priority for the seven years of Murray PHN's existence, this year we were pleased to receive more than $11 million in funding over three years as part of the Commonwealth's response to the Royal Commission into Aged Care Quality and Safety.

As this is the first specific aged care funding that PHNs have received, we have worked with health services and advisory councils to determine priorities and help guide our investment activities.

Our strategy is built around four main priorities.

1. Target positive experiences and outcomes for people, centred on person, family and community

- Ability to access quality services close to home, fully informed of options (self-determination and consent of person and their family)
- Culturally responsive care
- Multi-dimensional needs are supported by health interventions
- Early intervention and prevention are used to mitigate unnecessary hospitalisations

2. Coordinate complimentary programs around the problem/need

- Murray PHN coordinates its investments for efficiency and value
- Murray PHN considers other sector investments and integrates with these for efficiency and value

3. Build the capacity of the system to deliver

- Build workforce and its stability, staffing levels, volunteer systems, orientation, training
- Organise sustainable funding for health providers (face-to-face and digital)
- Integrate digital options for healthcare where they are suited
- Address strong governance
- Foster referral systems for coordinated care

4. Improve partnerships between health and aged care sectors

- Engagement with providers across the sector (health and social systems)
- Coordination of sector resources around the problem
- Advocacy for systems change where needed

Enhancing mental health outcomes

Virtual reality goggles

Echuca Regional Health's wellbeing and primary health department received funding to enhance mental health outcomes in aged care residents.

The purchasing of virtual reality googles has allowed residents from Glanville Village to visit 24 countries, during a time when travel restrictions were imposed due to COVID-19.

While staff initially found it challenging to explain the concept of virtual reality, residents have thoroughly enjoyed the ability to "escape".

Echuca Regional Health's Wellbeing and Mental Health Manager, Fiona Clark, says that technology can help to support positive mental health and reduce social isolation.

"When people participate in virtual reality, it allows for memories to come to the surface, for reminiscent therapy to occur and it encourages the individual to connect with stories of their past."

Photo: Jim and Sue from Glanville Village using goggles funded by Murray PHN

Care finders

The Australian aged care system is complex and some people find it more difficult than others to navigate and access the services they need, especially if they do not have family, friends or health professionals to help with that navigation.

Primary Health Networks across Australia are commissioning care finder programs to help these people from 1 January 2023, including the transition of existing Assistance with Care and Housing providers.

As part of this process, PHNs completed a needs assessment to help to determine gaps in services and highlight areas of greatest need.

The care finders needs assessment collected information including current providers' experience of caring for high intensity clients who require support to access relevant aged care and community services. Specifically, we looked at those people who face substantial isolation, homelessness or cultural barriers and marginalised groups who would need face-to-face help to connect to services of at least 15 hours per person, each year.

Aged care finders will deliver intensive support to help clients with special needs, so that they can understand and access aged care and connect with other relevant supports in the community. This will include:

- supporting clients to interact with My Aged Care so they can be screened for eligibility and referred for assessment
- explaining and guiding clients through the assessment process
- assisting clients to find the aged care supports and services they need and to connect with other relevant supports in the community
- high-level check-ins and providing follow-up support once services have begun to make sure clients are still receiving services and needs are being met.

To find out more, visit: murrayphn.org.au/carefinders

Increasing the quality

Using telehealth in aged care

The Telehealth Enhanced Aged Care (TEAC) project aims to increase the provision of out of hours assessment and triage for residential aged care facilities (RACFs) via telehealth, while also increasing the quality of digital healthcare - for both social connection and access to shared plans and electronic health records by firstly understanding the current equipment, training and education needs of facilities and staff.

A survey of facility managers, clinical care coordinators and lifestyle/activities coordinators generated more than 50 responses. The survey captured three elements of access to healthcare – general access, provision via telehealth and after-hours.

Of those who responded, 38 per cent said their facilities' access to external health practitioners was poor, with the most difficult to access being GPs, mental health and allied health professionals.

Resident conditions requiring the most support were identified as behaviours and psychological symptoms of dementia (19%) and chronic disease and comorbidity (18%).

Following on from review of feedback received in the survey, aligning with our aged care schedule and workplan, training plans are in development, along with equipment grants to address some of the technology needs identified in facilities across the region.

"It is particularly challenging for us in the regional areas. We seldom get help when we need it. The few doctors around are overworked. Getting specialised care is usually difficult, as we rely on the skeleton staff available for our location and others have to travel once a month or once every three months. In between, we are left with no help at all.

This in turn leads to poor outcomes for our residents and stress for staff who are left with only few options. Likewise, the residents have expressed a feeling of dejection and others become depressed and angry; this again is usually taken out on staff (and) the cycle continues." - Clinical care coordinator

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"Technology is great; we learned how handy and necessary telehealth and video calls are in lockdowns. But sometimes video calls cannot replace face-to-face consultations, especially when assessments are required."
- Clinical care coordinator

Self-determination in program and service design

Murray PHN is committed to supporting the Aboriginal Community Controlled Health Organisations (ACCHOs) in our catchment to deliver services that First Nations communities find valuable. We are working to achieve this by applying principles of self-determination in program and service design and commissioning.

In June, Murray PHN's executive and senior leadership teams met with all levels of staff from the seven ACCHOs in our region: Albury Wodonga Aboriginal Health Service; Bendigo and District Aboriginal Co-operative; Njernda Aboriginal Corporation; Mallee District Aboriginal Services; Mungabareena Aboriginal Corporation; Murray Valley Aboriginal Cooperative and Rumbalara Aboriginal Co-operative.

The meeting marked the beginning of Murray PHN walking together with First Nations communities, to act meaningfully on our commitment to self-determination and cultural humility. Everyone had time to listen and to talk about the important work that could be done together. Practical responses to local community needs and strengths were developed, and importantly relationships were both built and strengthened.

"The spirit and recognition in the room was powerful, and people left feeling energised and committed to continuing this journey together. We are grateful for the leadership of Murray PHN's First Nations Health and Healing team and for the time and generosity ACCHOs both gave and shared." - Murray PHN CEO, Matt Jones

The First Nations Health and Healing team at Murray PHN, supported by the Strategy and Performance Unit, is working with ACCHOs to co-design a model of care that is aimed at supporting healthy ageing for First Nations Peoples, underpinned by First Nations worldviews and self-determination.

The co-design approach ensures that ACCHOs are enabled to deliver a model of care that responds to local community context, positioning the importance of Country, Community and Culture at its heart. In addition, it will support ACCHO staff to monitor progress and evaluate program outcomes.

Self-determination

One ACCHO identified Youth Support Service aims to engage vulnerable young people in the community who are disengaged from education due to trauma and associated intergenerational health conditions. The program targets Aboriginal youth aged 8 to 18 that reside in Robinvale and surrounding areas. This project includes cultural leadership, mentoring and referral. Cook and yarn, culture, art, music and dance workshops will be offered to the young adults improving cultural identity, awareness and communication.

ITC overview

Integrated Team Care programs support First Nations Peoples living with chronic health conditions. The care provided can include helping people to better understand their disease, to follow their care plan, to receive help in making and getting to health appointments, and linking with other services.

CASE STUDY:

"James" is in his late 60s and lives alone.

James presented to his ACCHO 10 years ago, unaware of the supports available to help manage his health. As James has Type 2 Diabetes, he was referred into the chronic illness program. Here, he received an Aboriginal health check, diabetes management plan, regular blood sugar testing and referrals to other allied health services, including podiatry and optometry. He was also provided with assistance to access an aged care package and to reduce his alcohol and nicotine consumption.

Two years ago, James was diagnosed with prostate cancer. The outreach worker has been supporting James to attend regular cancer treatment appointments. James has since stopped drinking and cut down his smoking. With his cancer diagnosis, it has been vital to help him to maintain a positive mindset and continue to manage his diabetes.

With no family support, James said that he would have been lost without the ongoing help of his ACCHO. It has particularly been important to him to be able to access a culturally safe and local Aboriginal service and be supported by Aboriginal people.

Note: Names have been changed to protect people's privacy

An integrated approach to planning

This year, Australia's borders reopened to the world and winter had the potential for high numbers of both COVID-19 and influenza.

To prepare for the potential increased demand on the local health system, Murray PHN worked with state and federal governments, hospitals and the primary and aged care systems, to implement an integrated approach to winter planning.

The winter plan identified the most vulnerable members of our community, such as those living with chronic disease, people without a Medicare care, those who were home-bound and living in residential aged care facilities.

To ensure continued access to care and vaccinations, general practices, Aboriginal Community Controlled Health Organisations and pharmacies were able to apply for several small grants.

Murray PHN's living with COVID and community care pathways were updated in January, following the requirement for individuals to report their positive rapid antigen (RA) test results. This helped COVID positive people living in our rural areas, such as Quambatook and Robinvale, to manage their symptoms at home and avoid hospital with the help of virtual and home monitoring assessment services.

This year, mandated third COVID doses for healthcare workers were introduced, 16-17 year olds became eligible for their boosters and the timing of booster dose intervals were reduced, with some populations recommended to have a fourth dose. Five to 11 year olds also became eligible for their primary vaccination course.

Victoria announced free influenza vaccines in June, with NSW shortly following suit and COVID and influenza vaccines were approved for administration on the same day. New COVID vaccines became available and Murray PHN assisted in the transfer of vials between practices where supplies were limited.

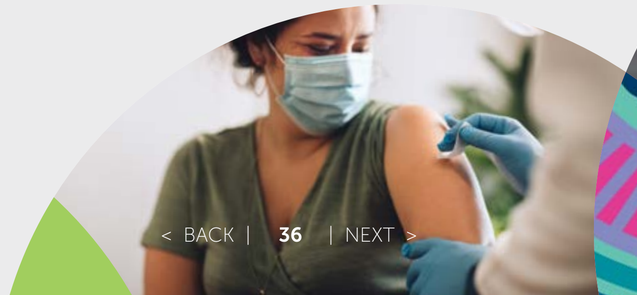
In addition to holding several webinars on the evolving changes, webinars for other respiratory diseases such as asthma and Respiratory Syncytial Virus and on infection, prevention and control practices for cleaning instruments and ventilation were held.

High vaccination rates and increased pressure on our health system saw the Victorian Department of Health transition from a crisis response to an ongoing public health response in July. Consequently and in addition to RA tests replacing PCRs, most state-led vaccination sites closed.

Murray PHN recognised that while it was necessary for the department to scale back its COVID-19 response, primary care providers were not afforded this luxury. We sought feedback from providers on the changes to help us understand the support needed to inform our approach to advocacy and resourcing. Later publishing the results of the survey, we described it as a "perfect" winter storm for primary care.

In August, the Victorian model of care changed to focus resources on supporting those most at risk of becoming seriously unwell, maximising the uptake of COVID anti-viral medicines and connecting those who were less unwell and at lower risk with GP care. Murray PHN's list of pharmacies stocking antivirals sought to assist health professionals in finding local supply.

Over the course of the past year, more than 100 email updates have been sent to residential aged care and disability providers, general practices, pharmacies and health services. Recognising the change to COVID normal, the Primary Care Update replaced the COVAX Update in June to include a broader range of information to support primary care providers.



Working together to create a plan

Heathcote Health nurse practitioner-led disability model of care

The Nurse Practitioner-Led Disability Model of Care project, for people with an intellectual or physical disability, aimed to improve the coordination of services, increase access to primary healthcare assessments and screening, help with the early identification of issues, and prevention of functional decline and exacerbation of existing physical and psychosocial issues.

Almost 500 episodes of care were delivered in the Greater Bendigo area during the project that ended in June 2022, with all clients receiving their initial review at home to assess day-to-day functioning, activities of daily living and potential health gaps.

Most clients were aged 40-49 years old and were predominantly male. Eighty-three per cent had complex medical conditions and 96 per cent had complex psychological health needs, with many having gaps in their healthcare plans.

The clinical nurse consultant was available to attend appointments and assist clients with communicating with health professionals. Many clients had previous traumatic experiences with healthcare providers, were abused by people in power and had poor health literacy, leading to high anxiety over health appointments.

The top five clinical demands for the service were case management, wellbeing checks, liaison with GPs, health education and building health literacy.

"Many of the clients felt they never had enough time with the GP to speak about their concerns (as there were multiple or they were complex) and lacked the health literacy/ education to break the cycle in their poor health outcomes.

By talking with clients about their likes/ dislikes and gradually building up to how they got to this point in their lives, what they'd like to change, their goals in health … we were able to work together to create a plan. Many had never been asked those questions before by a healthcare provider." – Clinical Nurse Consultant

CASE STUDY:

"Arthur" presented with a complex history. He was a long-term drug and alcohol user who suffered a range of medical conditions including a chronic and progressive movement disorder, memory loss and multiple seizures.

He could not say goodbye to his long-time partner who died during COVID's toughest lockdown period and was estranged from his children, in and out of work and housing, with no support network.

His main concerns were the increased number of seizures that were affecting his mobility, increasing drug use and physical health issues.

Arthur was initially supported to talk about his partner. As trust was established, Arthur participated in general health screening, had his blood pressure and skin checked. His local GP was supportive and happy to work collaboratively. A telehealth consult with a specialist was arranged, along with pathology samples collected from his home.

Over the six months that Arthur used the service, staff noticed that he became happier and more engaged in conversations. He began spending more time with neighbours and was re-engaging with the community. He also recognised that his drug use had increased due to his grief and so reduced his intake.

Note: Names have been changed to protect people's privacy

Natural disasters and communicable diseases

Coping with natural disasters such as fires and floods is very challenging for any community and continued access to primary healthcare services during these times is critical.

At Murray PHN, we are working to develop an improved Disaster Surveillance and Reporting System that aims to improve the timeliness and quality of the support we offer to primary healthcare service providers during these times.

A range of specialist skills will be focused on developing this system over the next six months, which aims to incorporate information from a range of sources to deliver the close to real-time reporting required to support disaster response decision-making.

At the time of writing this Report to the Community, our region continues to be deeply affected by the flood situation and its ongoing risk and impact to homes, health and infrastructure.

Murray PHN's emergency response has included supporting our staff in flood impacted areas including Echuca/Moama, Shepparton, Rochester, Benalla, Kerang, Castlemaine, Tongala, Elphinstone, Macedon, Bridgewater and Swan Hill, and managing our affected office in Shepparton.

Importantly, we have played a strong role in supporting our communities through normal business communications, but also through additional channels including our newsletters, social media and website.

During the peak, our emergency response team met regularly to cross-brief and coordinate efforts, including checking in with local GP practices, ACCHOs, pharmacies and health practitioners to determine their needs and provide assistance where we could.

We liaised with public health units to coordinate effective public health measures, and with state agencies to remain abreast of ongoing environmental health and emergency response issues.

Our teams gathered information on the impact on supply chains, especially where there was a need for medications and other medical equipment.

We supported access to healthcare through staffing of emergency response clinics in Echuca and Shepparton and, where electricity was able to be restored, promoted the use of technology including My Health Record, telehealth services and the Emergency Response Planning Tool, available to Victorian general practices.

Eligible pharmacies were also contacted and offered state-funded grants administered by Murray PHN to assist with any staffing needs.

Japanese Encephalitis virus

In February 2022, Japanese Encephalitis (JE) virus was detected in Victorian pigs and subsequently, the first local human cases were confirmed.

JE virus had not previously been detected in southern states, but a wet and humid summer provided the virus with optimal conditions to travel.

A comprehensive response across human and animal health sectors was shortly underway, to better understand the spread of this emerging virus and to implement effective control measures.

In March, Murray PHN hosted a state-wide JE virus webinar for GPs, together with the Victorian Department of Health, Western Victoria PHN and Agriculture Victoria.

Shortly thereafter, we called for expressions of interest from general practices to support vaccinations for piggery staff who were at highest risk.

With limited supply of vaccines and as more locations and eligibility criteria expanded, our role has continued with coordinating additional JE vaccination sites across the region, including outreach clinics.

As well as regular dissemination of information and resources, a new clinical HealthPathway was made available to provide health professionals with guidance on the assessment, management and referral of mosquito-borne diseases.

COVID-19

Throughout the year, we have continued distributing personal protective equipment (PPE) from the National Medical Stockpile to general practices, Aboriginal Community Controlled Health Organisations (ACCHOs), pharmacies and allied health professionals.

In early September, after two and a half years of the pandemic, our team packed the final piece of medical PPE to be sent from our central office. While we will continue to process PPE requests from health services until at least 31 December, it is now sent directly from the Department of Health and Aged Care's distribution centre in Melbourne.

This year, Murray PHN delivered more than 485,000 items of PPE which included face masks, respirators, goggles and disposable examination gowns to more than 250 health services across our region.

Rebecca Evans,Corporate Services Support, packing the last box of PPE

314,560
MASKS

89,500
GLOVES

32,262
GOWNS

3700
SYRINGES

1946
GOGGLES

355
THERMOMETERS

882
PULSE OXIMETERS

765
HAND SANITISER

45,170
FACE SHIELDS

Infection Prevention and Control helpline

Two years on and multiple COVID waves later, the Infection Prevention Control Helpline continues to provide free support to Victorian general practices, pharmacies and Aboriginal Community Controlled Health Organisations.

Delivered by the Australian Primary Health Care Nurses Association and supported by subject matter experts, the service provides a range of support, including hands-on help with developing or reviewing guidelines and policies, and practical advice such as ventilation and sterilisation processes and protocols.

The project has also supported the creation of videos. This year Murray PHN worked with the First Nations-owned production company, Little Rocket, to produce a new video that focuses on information and support specifically for Aboriginal Community Controlled Health Organisations to help keep their workforces safe. It outlines everyday actions that staff can take for reception areas, home visits and car travel.

For more information, visit murrayphn.org.au/ipc/ or call the Infection Prevention Helpline directly on 1800 312 968 or 03 9956 1046 between 9am and 5pm, Monday to Friday.

Double trouble campaign

With the onset of winter and the risk of both COVID and flu to our communities, Murray PHN's Communications team developed a new community engagement campaign.

The Double trouble campaign encouraged people to boost their protection over winter by getting their influenza vaccination and a COVID booster if eligible. Free resources including social media tiles, posters and flyers were shared with general practices, health services, community groups and organisations via our website. The campaign was also adapted for the Victorian and New South Wales governments' free flu vaccinations in June and July, and featured in local media.

Over the course of the campaign, we Reached more than:

140,000
Facebook users

with our campaign being seen on-screen on the platform almost

244,000
times (impressions)

Resilience Project (May 2022)

The Resilience Project has been delivered to 31 primary and secondary schools in Wodonga, Towong and Mansfield LGAs as part of the bushfire response. In addition, more than 500 community members attended online sessions. Alpine Shire successfully engaged more than 1300 residents in community recovery events held in March, with plans to conclude the program with several teacher and community wellbeing sessions delivered by The Resilience Project.

CASE STUDY: PTS Natural Disaster Response

The Alpine Natural Disaster Recovery Service, delivered by Alpine Health and funded by Murray PHN, supports adults living in the Alpine Shire who may have been directly or indirectly negatively impacted by adverse events in the community.

People who are experiencing low mood, reduced interest in activities, who are feeling isolated, irritable or have increased worry can self-refer themselves to receive free and confidential support from a qualified rural mental health worker. The support provided can be delivered over the phone or in person, in Bright, Myrtleford and Mt Beauty.

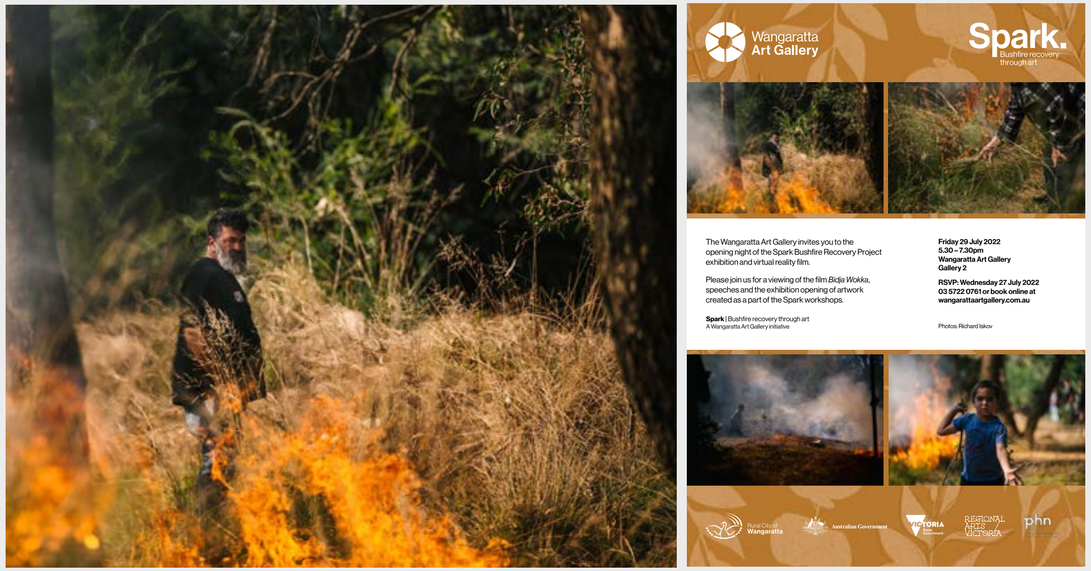
To learn more, visit:
murrayphn.org.au/bushfirementalhealth

Bushfire grants

Murray PHN's Bushfire Community Recovery Grants have supported local community groups and organisations to deliver grassroots activities to 2019-20 bushfire affected areas to help strengthen social connectedness, reduce social isolation, promote mental health and physical wellbeing, and provide a step toward rebuilding community resilience.

Last year, the Rural City of Wangaratta received a bushfire community recovery grant to host events that strengthened social connectedness and supported mental health and healing.

As part of the Spark Bushfire Recovery project, nature inspired artworks and a virtual reality film Bitja Wokka (Fire Country) that showed local Bpangerang cultural burning practices and caring for Country that cares for us, were made available for viewing this year.



Pictured: Bangerang man, Darren Atkinson at the Cultural Burn. Image © Richard Iskov

To view the Spark video trailer, go to: https://www.wangarattaartgallery.com.au/files/assets/artgallery/video/bitja-wokka-trailer-wide-screen-16.9-v3.mp4

CASE STUDY: Bushfire grants - Cudgewa events

The Cudgewa Hall and School Park were destroyed in the 2019-20 bushfires and while the local committee and community secured funding for their rebuild, they wanted the opportunity to bring community together and celebrate their reopening.

The Cudgewa Hall Committee used the funding from Murray PHN to hold a formal evening function in the hall where dignitaries and organisations were served hot meals and warm deserts on a winter's night.

Showcasing the rejuvenated hall has since resulted in bookings for music nights, exercise classes, social groups and even a wedding.

The park opening attracted more than 100 people, from babies to grandparents. Music and play activities such as rock painting was on offer for the kids, prizes and thank you presents were alongside a light luncheon.

"It's been a tough couple of years since the fires. Having the kids' park back in use and even better than before, is great! No one wants to remember it being burnt and closed for ages. The opening day was lovely, with pressies for all the kids and lots of happy families. It will be really good in the summer. Thanks to everyone who helped build it."

"The opening of the Cudgewa playground and hall has had an immensely positive impact on the wellbeing of both my family and community as a whole. Over the past two and a half years following the events of the Black Summer bushfires, our community has been working towards rebuilding and reconnecting with one another and the wider Upper Murray area. Navigating through the emotional, social and logistical challenges brought on by this event has taken its toll on the mental health of many, if not all, members of our community. The impacts of COVID-19 have further added to this load. Seeing the community come together to celebrate the opening of the new playground and the refurbished hall has brought an optimistic energy and a reminder of connectedness. It sent the message that our town has not been forgotten about and will continue to prosper in future. We now have two modern, functional facilities to host events and enjoy the beautiful area in which we live."

"Becoming involved with these Murray PHN sponsored celebrations, has assisted me greatly in my own personal recovery. Our farm was 90 per cent burnt, with great loss of cattle, infrastructure, fencing, fodder and machinery. We were helped by many organisations and volunteers. Being able to help my local community enjoy a rejuvenated hall and park precinct with a great celebratory weekend was me paying it back. The joint celebrations gave us all confidence for the future of Cudgewa's community. Cudgewa is now on fire, without being on fire!"

CASE STUDY: Bushfire grants – Corryong Mural

The Corryong & District Memorial Public Hall received a bushfire recovery grant for a painting of a mural.

The mural gave community, including local school groups, an opportunity to engage with the mural's painter Simon White, and promoted the benefits of reflection and story-telling.

Upper Murray grazier and historian Honor Auchinleck, whose property was destroyed in the Black Summer bushfires, believes that creativity is vital to sustaining good mental health for both young and old.

"As Simon White began to paint the narrative of the muster described in those well-loved lines from Paterson's poem 'The Man from Snowy River', the beauty of the scene and the power of the story began to replace the tension that had plagued me since the fires.

The painting reminded me of my need for stories, and of the beauty in our landscape that would surely return. It reminded me of others who have managed their challenges, giving me hope and optimism that our community would also overcome the sense of loss and trauma resulting from the fires.

When I look at the mural, I am grateful for all the pleasure it has and continues to give me, our community and visitors."

Support is ongoing

The primary care system has been under significant stress and strain as evidenced during the COVID pandemic.

A Murray PHN survey of general practice in July 2022 clearly showed that our fragile system was indeed in crisis.

Workforce issues, staff burnout and illness, complex patient presentations, financial strain and patient aggression all contributing to an estimated 45 per cent decrease in practice capacity.

Murray PHN will continue to support local general practices, including to build capacity and capability, to strengthen systems and ultimately be more sustainable.

During 2021-2022, general practice support has focused on quality improvement activities aligned to chronic disease, older person's health, at-risk COVID populations, deferred care, childhood immunisations, mental health and suicide prevention, with more than 300 face-to-face and virtual engagements, delivering training and helping to develop 12-month work plans.

Communication has been delivered through a variety of channels, including online Microsoft Yammer forums for GPs, practice nurses and managers, where updates have been read almost 20,000 times.

Emergency response management assistance has been provided for Japanese Encephalitis virus and Monkeypox, floods and ongoing support for those living with COVID, general practice respiratory clinics, influenza and COVID vaccination programs.

Support for general practice investment projects is ongoing, including for the delivery of care coordination models for refugee populations, after hours care and pharmacist in general practice services. In addition to a strong focus on mentoring and the sharing of projects that are easy to replicate in other practices.

195
general practices

178
accredited practices

163
data sharing practices

Priority primary care centres

PHNs are assisting the Victorian Government to commission 25 Priority Primary Care Centres (PPCCs) across the state.

The centres will ease pressure on nearby hospital emergency departments, by providing GP-led care for urgent but non-life-threatening conditions such as mild infections, fractures and burns, and offer pathology and imaging services. Care will be available to anyone with or without a Medicare card, at no cost to the patient.

In the Murray PHN region, Priority Primary Care Centres will open near hospitals in Bendigo, Mildura, Shepparton and Wodonga.

Improve capability and capacity

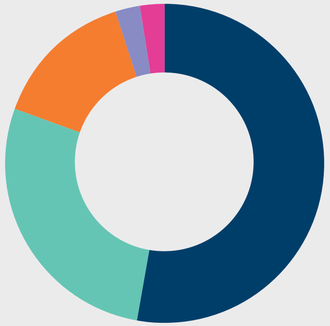
GPIS - After hours

Murray PHN's General Practice Investment Strategy (GPIS) has a focus on supporting general practice to implement best practice care while improving access to services in the after hours period.

Murray PHN collects and measures patient experience covering a range of topics, such as service inclusivity, ease of understanding and access, and a person's overall satisfaction with the quality and professionalism of the service delivered.

The after hours patient experience survey received 83 responses across eight providers, with the average patient experience rated 47 out of 50.

If the services weren't available, the patient said that they would have:



53% waited to see their usual GP

27.7% gone to the closest hospital emergency department

14.5% unsure

2.4% called 000

2.4% visited a pharmacy.

GPIS mentorship program

General practices that implemented new or enhanced models of care coordination within their practice through the 2020 General Practice Investment Strategy (GPIS), were invited to submit a proposal outlining their interest and capacity to build on service delivery, consolidate learnings and mentor another local practice to adopt enhanced models of care or system innovation.

The GPIS mentorship program was designed to provide care coordination and chronic disease management services, and improve capability and capacity of general practice through adopted learnings by:

- improving adoption of new or enhanced models of care in other general practices across the region
- building skill, knowledge and experience with other general practices and multidisciplinary teams
- enhancing networking opportunities with practice staff across the region
- building evaluation skills to support evidence-based care
- enhancing workforce satisfaction across the broader primary healthcare sector.

Six general practices were funded for 2022 to continue to implement their existing care coordination service model for vulnerable populations to improve care coordination, while mentoring another practice in the Murray PHN region. The program has proved to be a success in providing learnings for future projects.

The care coordination patient experience survey received 655 responses across 19 providers, with the average patient experience rated 43.84 out of 50.

APNA Transition to Practice Program

This year, Murray PHN funded eight local nurses to participate in the Australian Primary Healthcare Nurses Association's (APNA) 12-month Transition to Practice Program.

The program includes clinical and professional mentoring to guide and support the foundational orientation and induction of recently graduated or experienced nurses who have moved into primary healthcare for the first time.

As well as developing foundational knowledge, skills, confidence and competencies, the program improves access to resources and information, and team-based approaches to primary healthcare service delivery.

"I have spent lots of time learning from the APNA online modules.These have been invaluable in my transition so far." – Participant

"I have enjoyed participating in the program, being able to share and guide new nurses in the hope that they too will come to love general practice nursing with the same passion and dedication." - Mentor

715 health checks

Aboriginal and Torres Strait Islander people of all ages can get a free 715 health check to help identify whether they are at risk of illnesses or chronic conditions.

During 2021-2022, there were 2208 715 health checks completed in data sharing practices, which represents 15.52 per cent of our First Nations population. This does not include Aboriginal Community Controlled Health Organisations (ACCHOs), where the majority of the 715 health checks are undertaken.

ACCHOs share their data directly with Victorian Aboriginal Community Controlled Health Organisations (VACCHO). However, Murray PHN funds self-determined approaches through ACCHOs to improve access to services and health assessments for their communities. Examples of funded programs and their uptake include paediatric services for which there were 423 occasions of service; youth early intervention programs that delivered 332 occasions of service and 141 secondary consults, and Koori maternity services which delivered 922 occasions of service.

Focus on cancer screening

The COVID pandemic has had a huge impact on cancer screening rates and many people are now overdue for these important health checks.

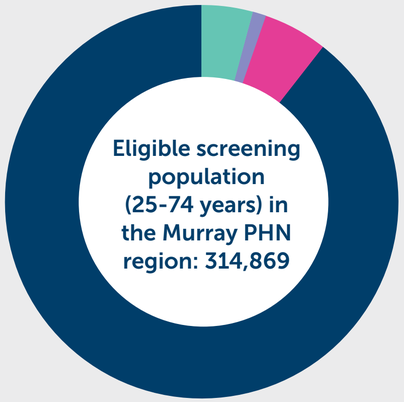
Murray PHN is working to support general practices and health services, who play a key role in monitoring patients, promoting screening for early detection, and encouraging individuals to implement healthy lifestyle behaviours.

During 2021-2022, 158 general practices who data share with us recorded cancer screening participation rates and 33 of these undertook quality improvement activities to improve cancer screening rates.

In September, our general practice team released a Focus on Cancer resource to highlight quality improvement activities that could be undertaken in a bid to help improve uptake to pre-pandemic levels.

Cervical cancer screening

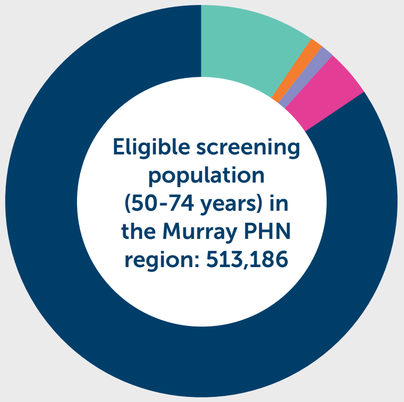
Cervical screening is important for all women, even those who have had the human papillomavirus (HPV) vaccine. Cervical screening should be completed every five years from the age of 25. This year, a new self-collection test was approved to provide more choice for women.



- HPV vaccinated **4.17 %**
- Pap (no HPV) **0.03%**
- Opted out/no longer requires screening **1.11%**
- Screened **5.31 %**
- **Unscreened 89.38%**

Breast cancer screening

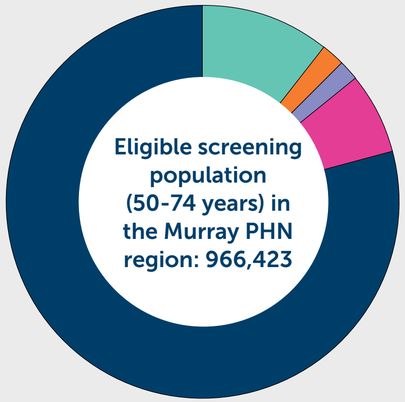
Mammogram screens for breast cancer are recommended for all women aged 50-74 every two years. Women aged 40-49 and those aged over 74 are also eligible to receive a free mammogram, but do not receive an invitation.



- Screened 0 - 2 years **9.49%**
- Screened 2 - 3 years **1.20%**
- Screened 3 - 4 years **1.18%**
- Screened > 4 years **3.89%**
- **Unscreened 84.24%**

Bowel cancer screening

A faecal occult blood test (FOBT) is a simple test that is carried out in the privacy of people's homes and is sent to a laboratory for testing. People aged 50 to 74 will receive a free FOBT in the mail every two years.



- Screened 0 - 2 years **10.60%**
- Screened 2 - 3 years **2.09%**
- Screened 3 - 4 years **1.72%**
- Screened > 4 years **6.67%**
- **Unscreened 78.92%**

Cancer awareness outreach

Victoria has some of the best cancer outcomes globally, but it has been identified that First Nations Victorians, people living in rural and regional Victoria and/or low socio-economic areas experience later stage diagnosis.

The COVID-19 pandemic presented further challenges by delaying patients' cancer screening and diagnostic appointments, impacting the early detection of cancer and participation in cancer screening programs across the state. This has contributed to a significant 30 per cent reduction in cancer notifications since 2020, particularly impacting those who are in already vulnerable under-screened communities.

With funding from the Victorian Government, Murray PHN and the other Victorian PHNs are working in partnership with key stakeholders, including the Victorian Department of Health, University of Melbourne, Australian Centre for the Prevention of Cervical Cancer, Cancer Council Victoria, Breast Screen Australia, VACCHO and the National Cancer Screening Register, to improve cancer screening awareness and participation in response to the COVID-19 pandemic.

The project is being undertaken over the 2021-2023 financial years and will build on the success of a pilot model implemented by North Western Melbourne PHN during 2021 that focused on improving cancer screening awareness and participation through enhanced primary care and community health systems. It fits within the Victorian Cancer Plan 2020-2024, has been added as a priority under the Victorian Cancer Screening Framework and will use existing governance arrangements.

Primary care settings are well placed to address delays in cancer diagnoses and as part of the project, Murray PHN will engage and support 20 general practices, health services and Aboriginal Community Controlled Health Organisations (ACCHOs) across the Murray PHN region to focus on improving cancer screening rates in under-screened populations that have delayed screening due to the COVID-19 pandemic.

The first wave has been engaged and all activity will begin between January and June 2023. Murray PHN is looking forward to working with practices to improve cancer screening awareness and participation rates, while maximising patient engagement through targeted cancer screening outreach activities and helping to embed sustainable screening practices in the primary healthcare system.

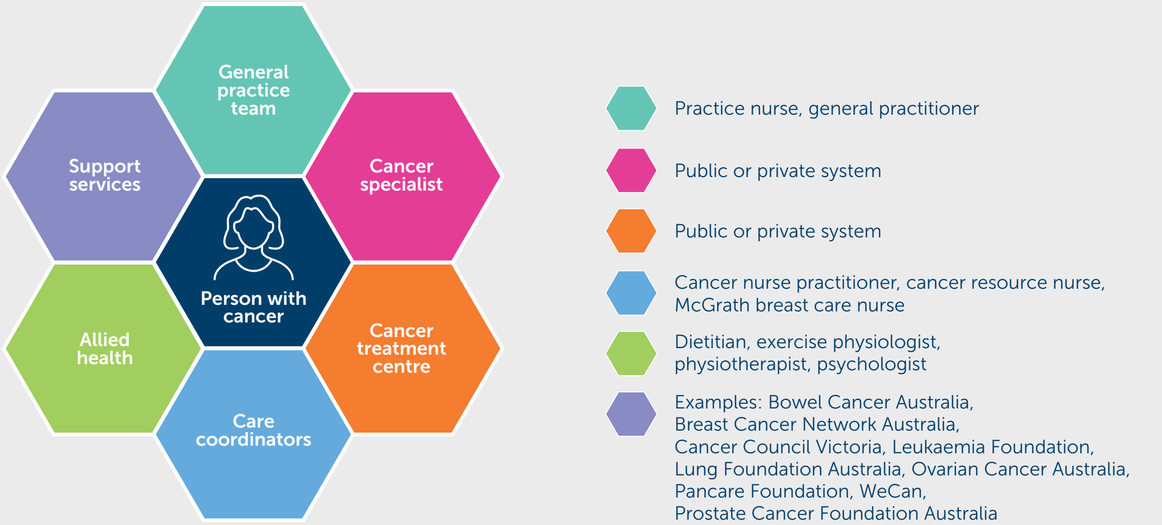
Cancer shared care

The Cancer Shared Care Project, funded by the Victorian Department of Health, is working with GPs, practice nurses and other general practice staff to deliver a rural cancer shared care pilot model where follow-up care is shared between the hospital-based oncology team and general practice.

Practices in the City of Wangaratta and Shire of Gannawarra have been invited to participate, as these areas have the highest incidence and mortality for breast, colorectal, prostate and low-risk endometrial cancers. The project began in October 2022 and runs through to August 2023 with the expression of interest opening for interested practices in October.

A consultant has been engaged to conduct co-design workshops to guide development of the shared care model, with consumer workshops planned for late November and stakeholders in early December.

A cancer projects advisory group has been established with membership from Murray PHN, Loddon Mallee Integrated Cancer Services and Hume Integrated Cancer Services. The purpose of the advisory group is to inform and provide advice to both Cancer Shared Care and Cancer Screening projects, including Murray PHN project staff.



Meaningful change for patients

Murray PHN Quality Improvement Consultants support practices to participate in quality improvement activities that lead to meaningful change for staff and patients.

This includes assisting practices to work towards accreditation standards, by meeting their Practice Incentives Program Quality Improvement (PIP QI) incentive payments, that also help practices with purchasing new equipment, upgrading facilities and increasing wages.

Much of this work is obtained by linking de-identified data, clinical audit tools and clinical software to look at figures and trends, identify new projects and importantly measure progress.

It also allows the benchmarking of other practices to work out regional percentages.

Once projects are identified, plans are put into place using the Plan-Do-Study-Act process to ensure they are a valuable learning exercise.

This helps to maximise professional development opportunities, adoption of best practice methods and the meaningful use of digital systems to improve the flow of information and health outcomes.

To connect with your local Quality Improvement Consultant, email gpsupport@murrayphn.org.au

View the Quality Improvement video:
https://youtu.be/sRhQXNb-wvg

CASE STUDY: Quality improvement

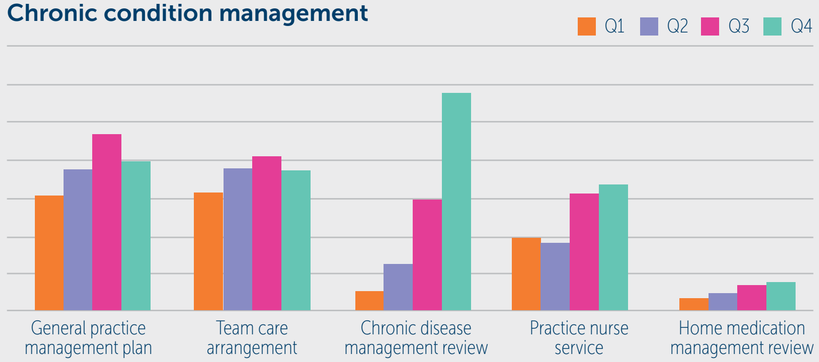
Quality Improvement Consultant, Sophie Bond, has been assisting Lyttleton Street Medical Clinic in Castlemaine to review the number of patients with chronic conditions, particularly diabetes, and determine how many of them had an up-to-date care plan and medication review. The practice has also been ensuring older patients are having regular health assessments to identify any medical issues that may arise.

This has resulted in improved patient care and an increase in revenue, as the practice has been able to claim the associated Medicare items on behalf of its patients.

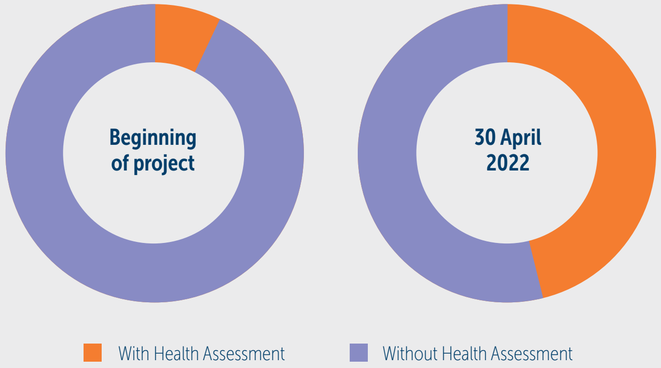
Sophie was so impressed by Lyttleton's continuous data-driven quality improvement activities and the resulting quality care and patient outcomes that she nominated them for the 2022 Pen CS Awards. Lyttleton was one of 26 finalists from a pool of more 100 applications!

The practice is now looking forward to undertaking additional quality improvement projects, including osteoporosis and diabetes management.

Patient-centred care
Chronic condition management



Patient-centred care
75+ health assessments < 12 months



Pictured: Practice Nurse Michelle Pascoe, student Lahni Jackson and GP Dr Johanna Dennis at Wedderburn College

Doctors in Secondary Schools

The Doctors in Secondary Schools program makes primary healthcare more accessible to students, helping to identify and address any health problems early and to reduce the pressure on working parents and community GPs.

The Murray PHN region is home to 21 of the 100 schools involved in the program, which provides a GP and nurse on site one day a week.

The program began in 2017 and is serviced by 15 local general practices who are on target to deliver more than 3000 GP consultations throughout 2022.

This year, Wedderburn Secondary College, serviced by Bendigo Community Health Services, featured in a new state-wide promotional video to engage new GPs and practice nurses to participate in the program.

Michelle Pascoe is the practice nurse at the Wedderburn clinic and while she has worked in community health and acute care, she really enjoys the time she spends working in the school community.

Michelle says it can sometimes take younger people longer to come out with their health concerns.

"They might come in with a sprained wrist but it's actually mental health they want to talk about. Because it doesn't cost the kids anything, it helps them to get beyond that barrier."

Dr Johanna Dennis from Bendigo Community Health Services works alongside Michelle to put her passion for adolescent health to use. *"As doctors we really like to help and know that we're making a difference.*

"Anyone who is interested in being a part of the program, even if you haven't worked with teens before, it's a really great way to learn more about it in a supportive environment."

To learn more or to express your interest in working at a local school clinic, visit: murrayphn.org.au/doctors-in-secondary-schools

Supporting Tristar Mildura patients

Tristar Medical Group entered voluntary administration this year, which saw practices closing their doors on 19 August. Although many of the practices were purchased by another corporate practice, Tristar Mildura was not.

Murray PHN and Tristar Mildura patients were notified on the same day of closure, which left more than 16,500 patients without access to primary care services, with limited, if any, capacity of other local general practice clinics to provide a service to their community.

Murray PHN convened a forum on 23 August with local general practitioners and practice nurses, health services, pharmacists, the Royal Flying Doctor Service and Anne Webster MP to discuss solutions including collaborating to support the short, medium and long- term needs of the community.

Our teams spoke with existing practices to see if they were able to absorb the GPs who intended to stay in the region, with the possibility of a short-term clinic with support from local health services and the need to triage patients to ensure their care was not compromised as other local solutions were sought.

The doctors in the Tristar practice continued to work behind the scenes to help manage patients with immediate health concerns, demonstrating the commitment of so many GPs to their patients, no matter the circumstances.

From 7 September, and with support from a national virtual public health information service, Murray PHN helped to establish the Mildura Response Helpline. Initially, the service was available 12 hours a day, seven days a week, for former Tristar Mildura patients to call if they required support.

Murray PHN developed a localised frequently asked questions document, for the helpline staff to use, including how to access medical records and how to refer to services, such as pharmacy, pathology and the nurse and GP after hours on-call services. Murray PHN also placed paid advertisements on social media platforms to ensure people knew that they had somewhere to go to for advice.

Continuing professional education and development

HealthPathways

HealthPathways contains evidenced-based clinical information to help medical professionals provide quality and consistency of care for patients.

GPs, GP registrars and medical students in training, or those who are new to a geographical area, can benefit from using pathways, as can practice and aged care nurses, diabetes and asthma educators, physiotherapists and other allied health professionals, ambulance officers, Aboriginal liaison workers and pharmacists.

This year, we produced a new introductory video, with thanks to local health professionals who generously shared their perspectives on how HealthPathways benefit them in practice.

"It provides a toolbox for clinicians. I call it the encyclopedia of clinical guidelines." – MaryJane Hulls, Nurse Practitioner and Credentialled Diabetes Educator

"I find HealthPathways easy to use because they have lots of dropdowns and toggle boxes, so it's very simple and you are not bombarded with information when you open it." – Julia Bridge, GP

"As a health professional I don't have to refer to the one person that I know. I can think ok, I know that they are really busy, let me have a look at HealthPathways and see who else is local to my patient." – Debbie Hawthorn, GP Pharmacist

"I recommend that people look at HealthPathways. It is a fantastic resource. You have got all of that information there and you don't have to research it. We've already done all the work for you, so get in there and have a look and I think you'll find that you'll never look back. – Dr Anne-Marie McKinnon, GP and Senior Clinical HealthPathways Editor

To view the video go to, https://youtu.be/dw9T--rc0wg

To learn more and request access, visit: murrayphn.org.au/pathways/

- **71 new pathways**
- **296 pathway updates**
- **106 pathway page reviews**
- **6193 total users**
- **168,138 pathway page views**
- **48 clinical working groups**

Top 10 viewed pathways

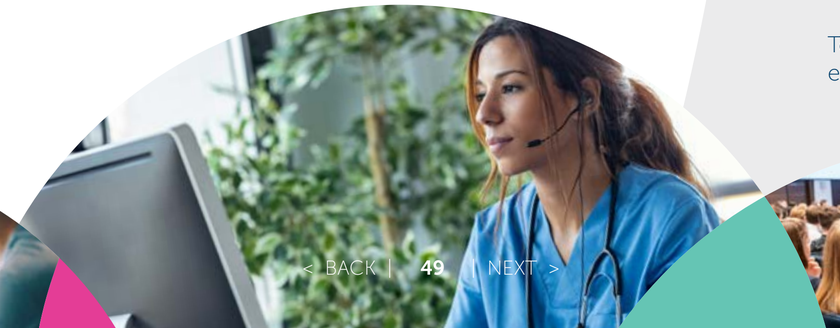
1. Antenatal Care – First Consult
2. Hypertension
3. Headaches in Adults
4. Abdominal Pain in Adults
5. COVID-19 Positive Care in the Community
6. Non-urgent Adult Mental Health Referrals
7. Post-COVID-19 – Long COVID
8. Drug and Alcohol Referrals
9. Thyroid Investigations
10. COVID-19 Initial Assessment and Management

2021-2022 education program

To strengthen our local workforce and help to deliver improved patient care, Murray PHN supports continuous professional development (CPD) through a range of mostly free education and network events. This year we delivered:

- **46 events** comprising of general CPD and engagement forums with topics including infection prevention and control, COVID, immunisation, digital health, chronic disease, wound care, triage in general practice, mental health and aged care.
- **23 recorded webinars** made available for later viewing, receiving **3122 video views**.
- **Worked collaboratively with peak bodies, colleges and health services to provide local workforce development opportunities.** This year, our partners have included Albury Wodonga Health, Bendigo Health, Goulburn Valley Health, Mildura Base Public Hospital, Australian Primary Health Care Nurses Association, Australian Digital Health Agency, Australasian Institute of Clinical Governance, Department of Health Victoria, Kidney Health Australia, National Asthma Council, Royal Australian College of General Practitioners, Sydney North Health Network and Eastern Melbourne, Gippsland, North Western Melbourne, South Eastern Melbourne, Western Victoria and South Western Sydney PHNs.
- **1060 attendances**
- **83% of respondents from 325 evaluations** (one third of attendees) recorded that their learning needs were entirely met.

To access upcoming and recorded CPD events and to subscribe to the events update, visit: murrayphn.org.au/education



Digital tools improving patient care

e-Referrals

Murray PHN is currently working across its region to provide an improved alternative to paper-based referrals, by introducing general practices and health services to electronic or e-Referrals.

Electronic referrals are sent securely, reducing processing and wait times for patients, while increasing legibility and the accuracy of information provided.

Central Victorian general practices have been supported to use e-Referrals since 2018, with the Goulburn Valley region joining the rollout this year.

Our Digital Health team members are now working with North West Victorian hospitals in Swan Hill and Mildura to bring them online in 2023. North East Victoria will be our final region to join and will ensure catchment wide coverage.

- **63 general practice sender sites**
- **45 hospital/health service receiving sites**
- **4981 e-Referral averages per month**
- **49,822 e-Referrals from Jan 2022-Nov 2023.**

For support with digital health systems, contact digitalhealth@murrayphn.org.au

My Health Record

More than 22 million My Health Records now have some level of data in them, allowing people to access their health information securely and online - whenever they need, no matter where they are.

With information that includes immunisation status, pathology and diagnostic imaging reports, prescription and dispensing information, and hospital discharge summaries, My Health Record can be useful during times of emergency, such as bushfire or floods.

This year, Murray PHN's Digital Health team has been working to increase the uptake of My Health Record by specialists. During the past 12 months in the Murray PHN region, GP views have quadrupled, while specialist registrations and local pharmacy and specialist record views have doubled.

e-Prescribing

Electronic prescriptions or e-Scripts are reshaping the way medications are prescribed and dispensed, with almost all pharmacies now accepting electronic prescriptions.

e-Scripts are a digital version of a paper prescription, sent by a doctor to a patient's phone. They usually contain a QR code or 'token', which the pharmacist can scan.

e-Scripts allow patients to track medications, receive reminders and have automated script refills. They also offer the management of medications for family members who do not have a phone or email address.

Murray PHN has been assisting pharmacies and GPs with guidance through the initial setup and where to access materials and further support.

Telehealth

Telehealth appointments via video and phone can reduce travel times and ensure care can continue to be provided during times of emergency.

Murray PHN has partnered with healthdirect to provide general practices with free licenses to the healthdirect video call service platform.

Maintaining national cyber security guidelines and privacy safeguards, healthdirect Video Call is a purpose-built and secure video conferencing system.

The platform is available to patients from their home, work or wherever is convenient and where there is a good internet connection. No software or application downloads are necessary.

- **30,000+ MBS telehealth sessions were delivered by GPs**
- **300+ clinicians delivered 8400+ appointments across 3600 hours via the HealthDirect Video Call platform**

The Caring Circle

Palliative care is recognised as a fundamental part of healthcare that needs to be incorporated into routine practice. It doesn't only apply to people in terminal care – palliative care is about giving anyone with a life-limiting illness, such as dementia, the right to live as well as possible, for as long as possible.

The Caring Circle project aims to improve the health outcomes and end-of-life care journey of people living with a life-limiting illness (non-cancer) in rural and remote Victoria.

The project, funded under the Australian Department of Health and Aged Care's Greater Choices for at Home Palliative Care measure, embeds early advance care planning discussions and integrated patient-centred palliative care strategies.

Linked with health needs addressed in the Murray Health Report – Healthy ageing in our region, The Caring Circle is focused on a series of strategies for the next three years, to:

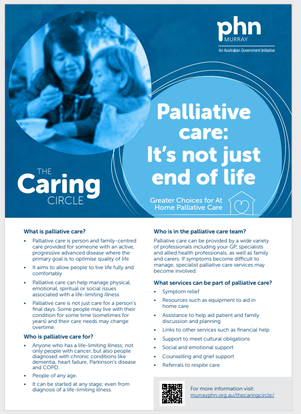
- promote community education and awareness to raise the importance of planning ahead and having people's end-of-life wishes respected and documented
- enhance early identification of people living with life-limiting illnesses accessing general practice services
- engage early advance care planning discussions and care planning in the community
- expand professional development opportunities in palliative care for health service providers to improve system capacity
- identify existing care enablers for holistic care planning for patients.

Since the project launched, community events have been held in Cobram and Wodonga focusing on carer wellbeing and dementia for awareness raising and building community death literacy. A project webpage has also been launched to keep people informed of the project's activities, including new resources and upcoming events, and promotion of campaigns such as National Palliative Care Week and Advance Care Planning Week.

For more information, visit: murrayphn.org.au/thecaringcircle

Above: Palliative Care Lead Vitor Rocha at a community event in Cobram

Top right: Palliative Care Project Coordinator Veronica Denton and Palliative Care Lead Vitor Rocha at the Australian Association of Gerontology Conference



Corporate

ELIZABETH CLEAR -
CHIEF CORPORATE OFFICER

Murray PHN's team of more than 100 dedicated staff work to ensure the delivery of vital services through our network of 169 primary healthcare providers. It's been a challenging year for us and for our providers, with workforce issues, the COVID-19 pandemic and natural disasters.

This year, the Corporate team - comprised of people and culture, governance, finance, legal, procurement, contract management, quality, risk, administration and ICT systems - has built on our strong foundational base with key strategies in finance, organisational development and ICT.

Our major funder is the Commonwealth Department of Health and Aged Care (DoHAC) and our total revenue for the year was $56 million. As we work hard on our relational approach to commissioning, to ensure we meet both the needs of our communities and our compliance obligations, we are thrilled to have delivered 73 per cent of our revenue ($41m) in direct services to our region. It was very pleasing to note the Commonwealth added a new funding schedule in FY22 covering our work in the aged care sector.

On financial sustainability, we added $355,000 to our equity, ending the year with equity of $4.97 million. In 2023, we will develop and implement the Murray PHN Investment Strategy in line with our approved reserves policy.

The key pillars of our Organisational Development Plan are leadership, building resilience, culture, capability and performance, working as one team, strengthen system capability, evidence-based and agility guided and directed work.

Our operational governance structure is designed to foster a culture of integrity throughout the organisation by having a clear focus on external and internal governance, ensuring accountability for all compliance obligations while focusing the company on the performance and leadership required to achieve our strategic and commissioning goals.

This year, we have made a significant investment in developing the organisation's leadership capacity, while our flexible working arrangements and policies have given staff the structure to continue a hybrid model of working from home and office locations.

Significant work on First Nations learning and cultural awareness of First Nations Peoples has continued through our Dhelkunya Yaluk training, and we have strengthened our First Nations team by appointing a First Nations Contract Manager. We have also enhanced our workspaces, with our amazing First Nations artwork now featured in each of our four regional offices.

With increased cybersecurity attacks across the health sector, we engaged an external consultancy to formally review our ICT systems and help develop a strategic ICT roadmap for the next two years.

A systems steering group is now guiding the development and strengthening of our business continuity, customer relationship and contract management systems. We successfully implemented a major upgrade to our finance systems and are now planning for integration of an upgraded budget and forecasting system.

The implementation of Primary Health Insights, the leading data security storage and analytics platform for PHNs, has enabled an increase in accredited general practices sharing de-identified data with us, to better identify areas for health improvements for their patients.

Communications

As part of the Office of the CEO, Murray PHN's Communications team provides internal support for project communications planning, reports, publications and presentations with a growing focus on video production and visual storytelling.

Externally, content is developed for the website, newsletters, social and regional media, and support provided to program partners and commissioned service providers on strategy, branding and communications as needed.

eNews

Murray PHN sends out a weekly newsletter to communicate local and national news, resources and opportunities for both health professionals and community members. Read past editions, submission guidelines and subscribe at: https://www.murrayphn.org.au/news/newsletter/

"It is always informative to receive the weekly PHN newsletter." – advisory council member.

"I thoroughly enjoy reading the newsletters from Murray PHN, always gives me new information." – health professional

"What amazing quantity and quality of factual information contained in this most recent newsletter. A credit to everyone who has worked on the compiling, fact-checking, production and publishing of the newsletter. I will be watching for further editions." – community member

47 media interviews
119 media mentions

170,695 webpages viewed
68,693 website users

183 electronic direct mail (EDM)
182,371 EDM opens
57,372 EDM clicks

205 Facebook posts
2297 Facebook links clicked
1,544,996 Facebook views

504.7 hours videos/ CPD watched on YouTube

People and Culture

The past year has been a year of growth and development for Murray PHN. Our workforce grew by 14.7 per cent due to resourcing our new Strategy and Performance unit and several new program areas, particularly relating to the COVID-19 pandemic.

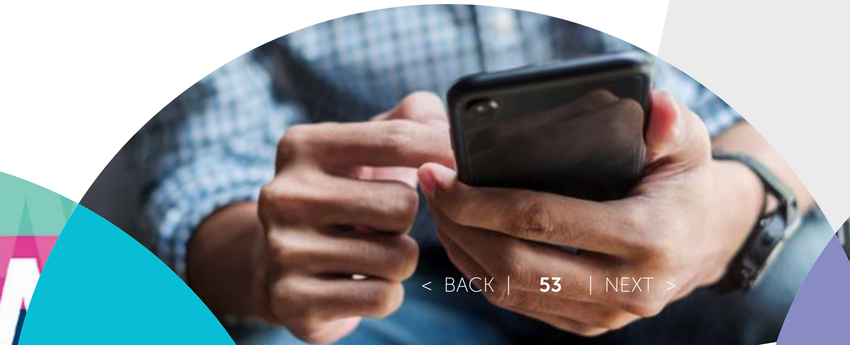
Worker wellbeing has been an important focus, with a change in our employee assistance program provider and an ongoing commitment to flexible working arrangements that effectively balance between organisational and individual working requirements and preferences, and demonstrate the maturity of our workforce. Our Workplace Services team has also ensured the adequate positioning of air purifiers for those people working back in our offices.

To support both new and existing staff, there was a substantial investment in leadership development that will continue into 2023. The opening of borders saw many staff be able to once again attend individual development education and conferences to expand on or showcase their work.

Enterprise bargaining agreement discussions have been fruitful and aim to support the development of an agreement that is contemporary, fair and reasonable, clear to read and apply, legislatively compliant, sustainable, encourages employee retention and supports Murray PHN to be an employer of choice.

A new organisational value of respect has been introduced, following strategic plan workshops and a staff survey, because as an organisation we value the voices and participation of every individual and respect the knowledge and wisdom our communities hold about their health needs.

Work is progressing on our new Reconciliation Action Plan (RAP) with the appointment of a person to lead its implementation and staff members having joined a RAP working group.

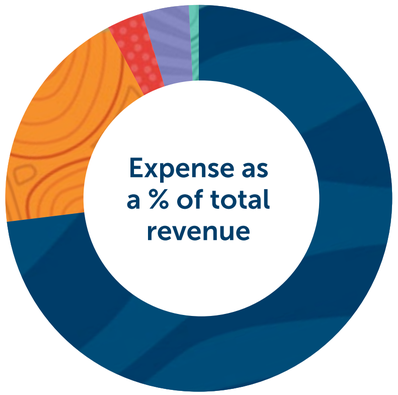


A year of growth

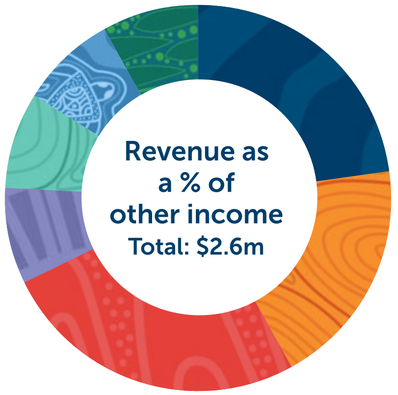
Total Revenue FY22

Core	$16.4m
Primary mental health Alcohol and other drugs	$27.4m
Commonwealth psychosocial support	$3.0m
Integrated team care	$2.0m
After hours	$2.2m
PHN pilots and targeted programs	$0.4m
Bushfire Relief Funding	$2.0m
Total Department of Health and Aged Care	**$53.4m**
Other income	**$2.6m**
Total	**$56m**

Our people	$10.5m
Administration	$2.2m
The work we commission	$40.8m
Corporate governance	$2.1m
Our operating surplus	$0.4m



73% Direct activity
19% Employee expenses
3.3% Corporate governance
4% Administration
0.7% Operating surplus



23% State funding - Department of Health and Human Services
19% Other PHN funders
26% State funding - Department of Education
8% Interest
8% PHN Exchange
8% Federal funding - Australian Digital Health Agency
8% Other income

96% Commissioned services
1% Direct integrated team case activity costs
1% Building capacity and capability
1% Needs Assessment planning and evaluation
1% Direct patient costs

DoHAC funding:
49% Primary Mental Health & Alcohol and Other Drugs
29% Core
5% Commonwealth Psychosocial Support
4% Integrated Team Care
4% After Hours
1% PHN pilots and targeted programs
4% Bushfire relief funding
4% Other income

Finance

Limited Statement of Profit or Loss and Other Comprehensive Income

	FY22 ($)	FY21 ($)
Revenue		
Revenue	56,046,684	47,151,726
Expenses		
Commissioning expenditure	(40,769,772)	(33,705,995)
Employee benefits expense	(12,257,241)	(10,671,550)
Depreciation, amortisation and impairment expenses	(433,753)	(499,173)
Finance costs	(67,776)	(49,785)
Rental and occupancy expenses	(241,869)	(181,889)
Motor vehicle expenses	(40,845)	(29,778)
Administration	(1,399,397)	(1,111,733)
Other expenses	(449,575)	(476,555)
Loss on disposal of asset	(30,570)	(23,801)
Surplus before income tax	**355,886**	**401,467**
Income tax expense	-	-
Surplus after income tax expense for the year attributable to the members of Murray PHN Limited	**355,886**	**401,467**
Other comprehensive income for the year, net of tax	-	-
Total comprehensive income for the year attributable to the members of Murray PHN Limited	**355,886**	**401,467**

Statement of Financial Position

	FY22 ($)	FY21 ($)
Current assets		
Cash and cash equivalents	32,075,852	29,062,717
Trade and other receivables	1,075,575	784,850
Other assets	173,436	543,327
Total current assets	**33,324,863**	**30,390,894**
Non-current assets		
Right-of-use assets	1,365,848	751,717
Property, plant and equipment	110,741	129,897
Intangible assets	-	38,958
Total non-current assets	**1,476,589**	**920,572**
Total assets	**34,801,452**	**31,311,466**
Current liabilities		
Trade and other payables	5,433,285	4,479,622
Unearned grants	21,081,961	19,530,815
Lease liability	311,055	298,403
Employee entitlements	1,228,845	1,070,678
Interest bearing liabilities	14,353	17,655
Total current liabilities	**28,069,499**	**25,660,958**
Non-current liabilities		
Lease liability	1,113,466	490,416
Employee entitlements	540,377	455,868
Provisions	108,000	90,000
Total non-current liabilities	**1,761,843**	**1,036,284**
Total liabilities	**29,831,342**	**26,697,242**
Net assets	**4,970,110**	**4,614,224**
Members' equity		
Retained surplus	4,970,110	4,614,224
Total members' equity	**4,970,110**	**4,614,224**

Statement Of Cash Flows

	FY22 ($)	FY21 ($)
Cash flows from operating activities		
Grants revenue and other receipts	56,849,914	50,698,779
Interest received	193,406	271,034
Payments to suppliers, employees and directors	(53,516,115)	(43,197,580)
Interest paid on lease liabilities	(67,776)	(49,785)
Short term and low-value lease payments	(61,656)	(65,951)
Net cash from operating activities	**3,397,773**	**7,656,497**
Cash flows from investing activities		
Payments for plant and equipment	(50,541)	(20,000)
Net cash used in investing activities	**(50,541)**	**(20,000)**
Cash flows from financing activities		
Repayment of lease commitments	(334,097)	(415,043)
Net cash used in financing activities	(334,097)	(415,043)
Net increase in cash and cash equivalents	3,013,135	7,221,454
Cash and cash equivalents at the beginning of the financial year	**29,062,717**	**21,841,263**
Cash and cash equivalents at the end of the financial year	**32,075,852**	**29,062,717**

Statement Of Changes In Equity

	Retained surplus $	Total members equity $
Balance at 1 July 2020	**4,212,757**	**4,212,757**
Surplus after income tax expense for the year	401,467	401,467
Other comprehensive income for the year, net of tax	-	-
Total comprehensive income for the year	**401,467**	**401,467**
Balance at 30 June 2021	**4,614,224**	**4,614,224**
Balance at 1 July 2021	**4,614,224**	**4,614,224**
Surplus after income tax expense for the year	355,886	355,886
Other comprehensive income for the year, net of tax	-	-
Total comprehensive income for the year	**355,886**	**355,886**
Balance at 30 June 2022	**4,970,110**	**4,970,110**

Provider list

Murray PHN acknowledges and thanks the service providers and partners we worked with during October 2021-2022, including:

360Edge
A Life Simply Lived Psychology Pty Ltd
Albury Wodonga Aboriginal Health Service
Albury Wodonga Health
Alexandra Family Medical Centre
Alexandra Medical Centre Pty Ltd
Alpine Health
Alpine Shire Council
APMHA Healthcare Ltd
Australian Primary Health Care Nurses Association Ltd
Barefoot Nutrition Fitness Lifestyle
Beechworth Health Service
Benalla Health
Bendigo and District Aboriginal Co-Operative Ltd
Bendigo Community Health Services Ltd
Bendigo Health
Bendigo Primary Care Centre Ltd
Benalla Church Street Surgery
Better Health Medical Centre
BPAC Informatics Pty Ltd
Bright Medical Centre
Campaspe Family Practice
Castlemaine Health
Centacare South West NSW Ltd
Central General Practice Mansfield
Charles Sturt University
Cohuna District Hospital
Connected Medical Solutions Pty Ltd
Corowa Medical Centre
Corryong & District Memorial Public Hall
Corryong Health
Coster Street Medical Practice
Cudgewa Hall Committee Inc
Darling Downs Hospital and Health Service
Eaglehawk Medical Group Unit Trust
East Wimmera Health Service
Eastern Melbourne Healthcare Network
Eastern Melbourne PHN
Echuca Regional Health
Euroa Medical Family Practice
Falls Creek Alpine Resort Management Board
Family Care Pharmacy Shepparton
Family Doctor Pty Ltd
Federation Clinic
Gateway Health
Gippsland PHN
Goulburn Valley Health
GPs On Vermont Pty Ltd
Greater Bendigo City Council
Heathcote Pharmacy
Heathcote Health
iHealth Albury
Indigo Family Medical Centre
Indigo North Health Inc
Indigo Shire Council
Inglewood & Districts Health Service
Irymple Foot Clinic
Kerang District Health
Kyabram Family Medicine
Kyneton Medical Centre
Lister House Medical Centre
Loddon Mallee Housing Services Ltd
Mallee District Aboriginal Services Ltd
Mallee Family Care Ltd
Mallee Track Health and Community Service
Mansfield District Hospital
Mansfield Guardian Pharmacy
Mansfield Medical Clinic Pty. Ltd.
Mansfield Shire Council
Merbein Family Medical Practice
Mildura Base Public Hospital
Mildura Rural City Council
MIND Australia
Mitchell Shire Pharmacies Pty Ltd
Mivo Park Medical Clinic
Monash University
Mooroopna Medical Management Pty Ltd
Mount Beauty Medical Centre
Mount Beauty Pharmacy
Mount Buller And Mount Stirling Resort Management Board
Mungabareena Aboriginal Corporation
Murchison Medical
Murray Valley Aboriginal Co-Operative
Nagambie Medical Centre
Nathalia District Hospital
Nathalia Pharmacy
NCN Health
Nexus Primary Health
Njernda Aboriginal Corporation
Northeast General Practice Service
Northern District Community Health
North Western Melbourne PHN
Ontario Medical Clinic Unit Trust
Ovens Valley Podiatry
Paul Wickham Pharmacy
Pen CS Pty Ltd
Petaurus Education Group Inc
Phillipson Street Clinic
Priceline Pharmacy Market Place Shepparton
Primary Care Connect
Princess Park Clinic
Propell
Quinn Street Medical Clinic
Rehoboth Medical Centres
Richmond Football Club Ltd
Robinvale District Health Services
Rumbalara Aboriginal Co-Operative Ltd
Sarkon Medical Centre Albury
Self Help Addiction Resource Centre Inc
Seymour Medical Clinic
Shepparton Centre Pharmacy
Shire Of Towong
Silverline Health Care Pty Ltd
Somerville Street Clinic
South Eastern Melbourne PHN
Springs Medical Pty Ltd
St Anthony Family Medical Practice
St John Of God
Standish Street Surgery
Step Psychology
Stride Mental Health Ltd
Sunbury and Cobaw Community Health
Sunraysia Community Health Services Ltd
Sunraysia Medical Centre
Sunraysia Podiatry
Swan Hill District Health
Tangam Pharmacy
Terry White Chemmart Mooroopna Pharmacy
The Baudinet Centre Pty Ltd
The Bridge Youth Service Inc
The Foot Centre
The Men's Table Ltd
The Resilience Project
Thowgla Recreation Reserve Committee Of Management
Towong Hall Reserve Committee Of Management
Triple M Medical Group Pty Ltd
Tristar
Umbrella Health Wodonga Pty Ltd
University Of Melbourne Teaching - Shepparton
Victorian Alcohol and Drug Association
Vision 2020 The Right To Sight Australia
Walwa Bush Nursing Centre Inc
Wangaratta Rural City Council
Wellways Australia Ltd
Wesley Community Services Ltd
Western Victoria PHN Ltd
White Hills Medical Practice
Wodonga City Council
Wodonga Medical Centre
Wodonga West Medical Clinic
Yarrawonga Denis Medical Group
YSAS