phn
MURRAY

An Australian Government Initiative

Report to the Community

2019

About Murray PHN

Murray PHN is funded by the Commonwealth Department of Health to commission primary health care services in our region.

Our work is focused on making sure that people living in our region get the most effective care, where and when they need it.

The services that we fund are based on the greatest health needs, which are likely to get the best outcomes. To determine needs, we continuously collect and analyse information and data, and consult with community through mechanisms like our Advisory Councils and online Health Voices platform.

Our local health priorities add to our national targets and we work to improve Aboriginal and Torres Strait Islander health, cancer screening rates, chronic illness complications, mental health, workforce sustainability and digital health connectedness, among others.

With a large rural and regional area covering almost 100,000 square kilometres, Murray PHN has teams located in Bendigo, Shepparton, Mildura and Albury/Wodonga.

For more information about our projects and partnerships, please go to murrayphn.org.au

Our values

At Murray PHN, five organisational values drive the way we do business, the way we influence the health system and the way we interact with each other and our stakeholders.

Those values – Leadership, Collaboration, Knowledge, Innovation and Accountability – were developed by Murray PHN staff and have been incorporated into everything we do.

They are included in our strategic plan, our individual position descriptions, our performance indicators and much more. Our values are not descriptions of the work we do, they are the unseen drivers of our behaviour as individuals, as employees and as an organisation.

This year, we have structured our *Report to the Community* around those five values, to demonstrate the key role that each plays in the work of Murray PHN.

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

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

Leadership

Collaboration

Knowledge

Innovation

Accountability

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90%
General practices use telehealth

91%
General practice accreditation

73%
General practices share data with Murray PHN

486
General practice meetings

52
General practice support plans

1353
General practice interactions

15,000
eReferrals

22
Doctors in Secondary Schools

PHN Exchange expansion

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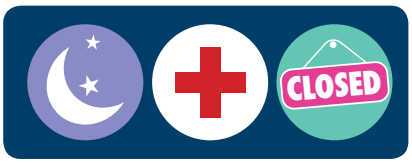

After hours support

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My Health Record

Strong engagement

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Murray Health Pathways

100,000
Page views

3800
Active users

474
Local pathways

Integrated health network development

Page 46

$26.5m
Commissioned services

16,108
Funded mental health appointments

2286
People attended 119 CPD events

740
ITC support services

Stop Stigma awareness continues

Page 16

Psychosocial support program implemented

Page 21

44.9%
Bowel cancer screening

60.8%
Cervical cancer screening

56.4%
Breast cancer screening

96%
Childhood immunisation at 5 years

Community mindfulness

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Bushfire support

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Improved reporting

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Dual diagnosis approach

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We commit to lead effective change in primary health care

leadership

Strengthening primary health care in our region

Australia's national investment in the health of its citizens in 2017/18 was estimated by the Australian Institute of Health and Welfare at $185.4 billion. The majority of expenditure was focused on hospitals (40%) and primary health care (34%).

As a primary health network distributing $26.5 million for commissioned services over the past year, Murray PHN is not a small organisation. Yet when our annual budget represents just one per cent of health expenditure in our region, it is vital that our funds are focused on services that support the evolution of primary care.

Health economists increasingly agree that, without a modernisation of our primary health care system, Australia's ability to deliver universal access to primary health care is under threat.

We know that complex or chronic health conditions can significantly impact on individuals and their communities, so it is vital that we are able to provide those people with high quality and coordinated care.

Changing patient needs, changes in practitioner expectations and challenging service delivery issues all need to be understood and accommodated in our efforts to ensure both improved patient outcomes and sustainability of the primary health care system.

This is even more important for those of us outside Australia's major cities. Health needs are disproportionately higher in rural areas, yet the capacity to provide multi-disciplinary care for complex needs is limited by scale, volume and distance.

As the care demands of Australians increase, and the supply of health professionals changes year by year, we must look to new models – financial and workforce – to meet the health needs of our communities.

At Murray PHN, we work to provide locally relevant leadership in a range of areas that help improve rural health outcomes. Our leadership includes our work on PHN Exchange, for health data; HealthPathways, to support general practice; Stop Stigma, to increase awareness of the impact of mental health discrimination; and our connection with local networks through community and clinical advisory councils.

As a primary health network distributing $26.5m for commissioned services over the past year, Murray PHN is not a small organisation. Yet when our annual budget represents just one per cent of health expenditure in our region, it is vital that our funds are focused on services that support the evolution of primary care.

We issued more than 200 contracts, with a total value of almost $27 million, for services tackling a range of national and local health priorities. Mental health for example is a key priority for our communities. This year we commissioned more than $12 million to fund services such as headspace, psychological services, child and early interventions in general practice.

Murray PHN has also been exploring and developing the concept of Integrated Health Networks (IHNs) to address demand and supply across the primary health care system, particularly in rural settings. We know that care coordination, based in general practice, is effective in reducing emergency department admissions and health care costs for patients with complex or ongoing conditions.

IHNs have the ability to further improve care delivery and coordination and align state, federal and private health systems by formalising partnering networks between health providers across communities.

Challenges with recruitment, retention and continuation of general practice services are jeopardising access to primary care and, acute and aged care services in many rural communities. While some of these challenges have been addressed by workforce role redesign, care coordination models and telehealth, the reality is that rural people already have poorer health outcomes.

Driven by the conviction that a person's postcode should not be a determining factor in their health status, Murray PHN has adopted a commissioning-for-outcomes framework that aims to support our regional primary health care system to deliver the right care, in the right place, and at the right time.

Through 2018 and into 2019, Murray PHN funded a range of services through our relational commissioning processes. These enabled us to work with local service providers to build stronger networks to deliver priority services in some of the regional areas that needed the greatest help.

We issued more than 200 contracts, with a total value of almost $27 million, for services tackling a range of national and local health priorities. Mental health for example is a key priority for our communities. This year we commissioned over $12 million to fund services such as headspace, psychological services, child and early interventions in general practice.

Our General Practice Investment Strategy resulted in more than $3 million being contracted to 31 providers for 44 distinct projects. For people living with chronic illness, $2.7 million went into funding services that included new rehabilitation programs for people living with lung and heart conditions in our region.

INTEGRATED HEALTH NETWORKS

- Aligns a local network of health providers
- Across a geographic region, serving a population of 20,000-50,000 patients
- Primary health care providers working together to improve access and outcomes for patients with complex or ongoing conditions
- Providers working within agreed strategies for care coordination and referral pathways
- Based on a blended funding model, including fee-for-service, chronic disease complex need packages and block funding.

Clinical

- Improved clinical outcomes for patients, as they receive increased access to a greater range of services
- Greater flexibility with resources to manage patient needs on a local basis

Sustainability

- Greater support for solo practitioners
- Increased incentives for practices that join the network
- Risk sharing among providers
- Support for local autonomy and ownership of system of care

Community

- Improved access and equity of service delivery
- A greater focus on community and population prevention

Commissioning for outcomes

The Australian Department of Health describes commissioning as:

"A strategic approach to purchasing that seeks to ensure that services meet the health needs of the population and contribute towards service and system improvement and innovation."

Commissioning is a policy shift in thinking about how to build collaborative service systems in primary care. We know that change will happen when we focus simultaneously on patient experience, service system capability and underserviced populations in communities of greatest needs.

Through its commissioning processes, Murray PHN works to understand the health needs of its region and from there, to determine effective strategies for tackling those needs, in collaboration with the health sector and consumers.

Murray PHN is introducing the concept of outcomes-based commissioning into our region, with efficient procurement processes aimed at effective collaboration with health services and other stakeholders. Our move from simply providing funding for services to commissioning new models of care in health service networks is aimed at helping to improve patient outcomes, while driving sustainable changes in our primary health care system.

While commissioning is our core business, it can be described as being more akin to change management than contract management. System improvement and redesign are central to the work of PHNs and, at Murray PHN, the ongoing development of our performance reporting mechanisms (including client and clinical experience) is building a strong evidence base that will underpin future commissioning and procurement cycles.

This year, Murray PHN has commissioned almost $27 million in primary health care services across our region to support people with chronic illnesses, mental health issues (both low intensity, youth and severe) and alcohol and other drug use. We have also funded after hours services in regional centres and Doctors in Secondary Schools.

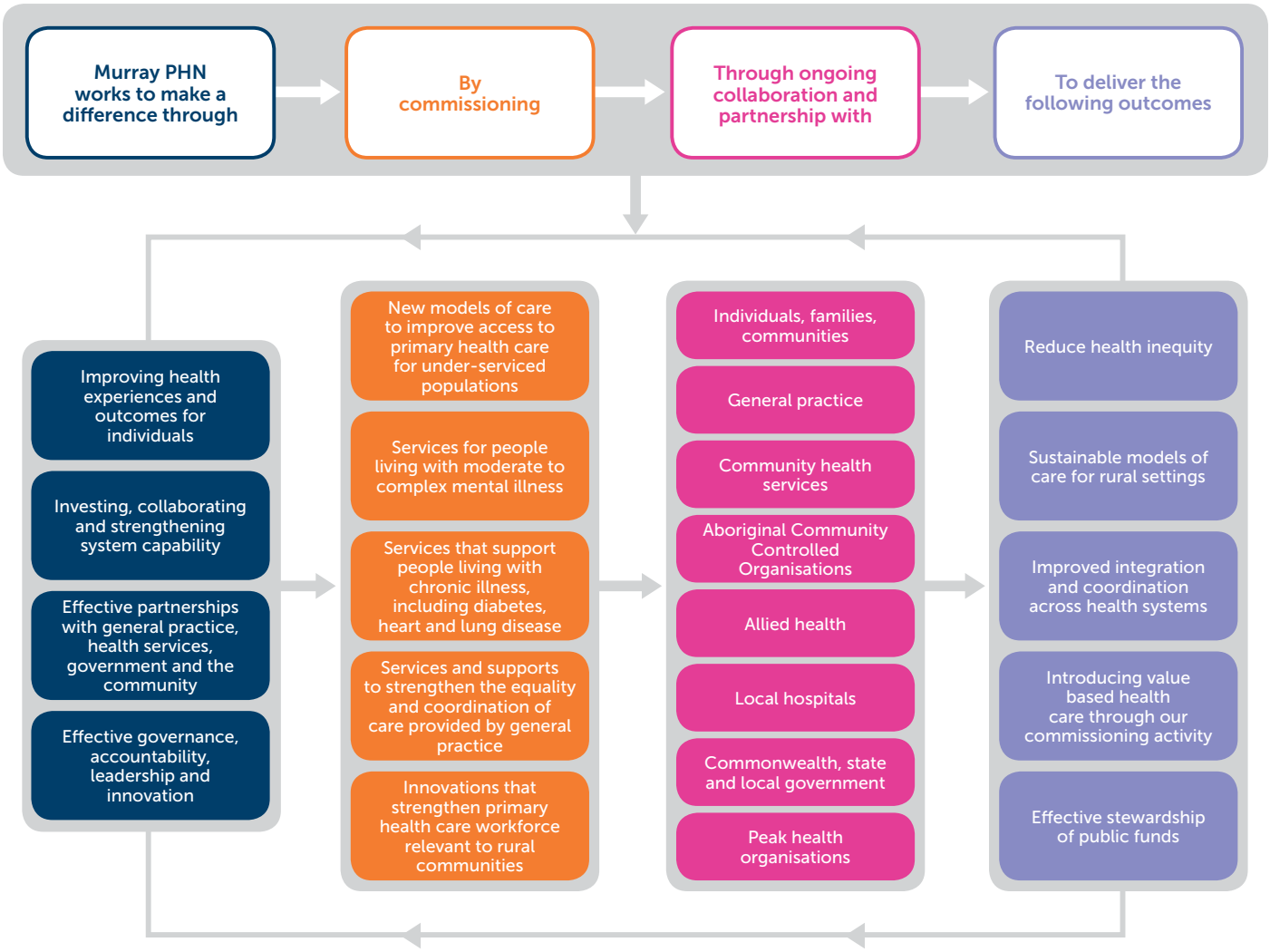
Needs	A description of what is missing, or acts as a barrier to wellbeing
Input	The resources required to deliver an activity eg: funds, staff, time, equipment
Activity	Actions taken to respond to an identified need of a particular patient group
Output	The direct and measurable products of an activity or service, in terms of volume or units delivered eg: number of treatment sessions delivered.
Outcome	The changes that occur for people for the better, that are attributable to a health intervention. Outcomes can be short, medium or long term and may include a positive change in attitudes, behaviours, clinical conditions or physical capabilities
Outcome indicators	Measurable, quantifiable and independently verifiable markers that show whether progress is being made on a certain condition or circumstance

Outcome-based commissioning supports the wider system change agenda for PHNs

THE PAST	THE FUTURE
Commissioning for activity	Commissioning for outcomes
Contract management focus	Change management focus
Confrontational	Collaborative
Competitive	Strategic
Fragmented, ring-fenced budgets	Integrated, whole system budgets
Organisational fortresses	Health and social care systems
Curative models of care	Preventative models of care
Contentious decisions avoided	Contentious decisions owned
Commissioner cost exceeds value	Commissioner value exceeds cost

Courtesy of Rebbeck Consulting

Driving sustainable change



Improving performance data reporting

On 1 October, Murray PHN launched an electronic business reporting portal for commissioned services. The Folio portal has been established to ensure a reliable and streamlined method of information gathering, monitoring, storage and analysis for Murray PHN, to improve consistency for stakeholders and to allow both Murray PHN and service providers to access data that can provide information on a trend basis.

Stakeholder input was a vital element to success and ensured our approach was well informed by the end users. A User Acceptance Testing (UAT) process, to verify that a solution works for the user, was adopted with collaboration from six service providers in the following funding streams:

- Primary mental health
- Chronic disease management
- Integrated Team Care (chronic disease funding for Aboriginal and Torres Strait Islander communities).

Testing took place over a two-week period and resulted in a significant pass rate for Folio's functionality, with a number of suggested enhancements being adopted.

It is anticipated the new system will enable a more robust central repository of information, allowing for consistent analysis and a more consolidated, less confusing and streamlined process for our stakeholders.

Partnering with general practice

General practice is at the heart of patient care in the primary health care setting. Murray PHN's general practice support program partners with general practices to focus on practice quality and business sustainability.

Our goal is to help build a strong workforce through education and training, while also supporting practices to deliver better patient care through a range of quality improvement activities.

We provide each practice in our catchment the opportunity to work with us on support plans tailored to their needs and at the level of participation they choose. We have three levels of participation from standard, progressive and advanced, that are available to all practices in our region.

Murray PHN's inaugural prospectus (*pictured*) was created to explain the support program, as well as the major issues within our region and what was required for change. It outlined the eligibility and scope of our $3 million investment in the areas of child mental health, alcohol screening, after hours care and the coordination of services for people living with chronic and complex disease.

General practices submitted thoughtful projects that focused on building relationships, networks and data, in addition to improving access to services for Aboriginal and Torres Strait Islander patients, increasing people's ability to self-manage their disease, and using digital technologies.

We provide each practice in our catchment the opportunity to work with us on support plans tailored to their needs and at the level of participation they choose. We have three levels of participation from standard, progressive and advanced, that are available to all practices in our region.

Coordinating chronic illness care

Marong Medical Practice is rapidly growing, as the outer Bendigo suburb they are situated in expands. They also provide a service to a neighbouring town 30kms away in Inglewood, which has an urgent care centre and aged care home, that their doctors also help to service.

Murray PHN funded an increase in their practice nursing hours to keep up with the growing demand and provide a service that was both more coordinated and flexible, to structure assessments, coordinate care with other team members such as allied health professionals and to complete chronic health management plans, whether they be in the clinic, in the patient's home or aged care facility.

"Seeing patients in the clinic environment does not always give the nurse the big picture as to how a person is coping. We hope the home visits in particular, keep people safe and well enough to live independently for longer."
Julie Dickinson, Practice Manager

Judy Allen, Practice Nurse

Funding new models of care

Through our General Practice Investment Strategy, we have supported local GPs to design and deliver new models of care. Murray PHN awarded more than 30 contracts valued at almost $3 million in July 2019. The funding is helping to provide primary health care services where they are needed most, while strengthening the region's capability in priority health areas.

Identifying risky drinking behaviours

Sunraysia Community Health Services knows that there are many medical, social and emotional issues attached with high alcohol use.

Murray PHN funding is helping to embed a nurse-led alcohol screening and brief intervention program that will work with other practices and upskill a range of local practitioners. A standard toolkit will be developed and implemented and will include a mental health component, to ensure that any co-occurring alcohol and mental health issues are addressed.

"We want this program to build knowledge and capacity within local general practices to enable them to be self-supporting. We hope that once the toolkit is developed we can also share it more broadly in the community."
Shelley Faulks, Clinic Programs Manager

Helping disadvantaged children

Euroa Medical has identified a need for children, particularly those from families that cannot afford specialist services or have transport difficulties, in accessing mental health services.

Euroa Medical has been working with Euroa Primary School to secure a paediatrician and psychologist for children to visit within school hours.

Murray PHN has funded this model with the aim of improving mental health outcomes, along with improved attendance rates and engagement in school activities.

"We believe that addressing early social, emotional and academic problems in a child's adolescence will reduce children's behavioural problems and learning difficulties as they progress through their schooling and education."
Jane Garrett, Practice Manager

Providing a hospice in the home service

Indigo Family Medical Clinic saw that people diagnosed with a terminal illness were unable to receive help when they needed it the most, locally in Barnawartha. They began providing a palliative care service for their patients 12 months ago. Since then they have supported eight people to die a good death at home, surrounded by the people they loved.

Murray PHN's funding is helping to pilot the model offering a 24-hour, seven-day-a-week service, and ensuring that families have the right supports in place.

"We are the only GP clinic I know of that provides its own 24-hour hospice service. By piloting a program, our hope is that more people will get involved talking about death and dying." – Helen Barter, Practice Nurse

Colin Cameron, Juliana Sheridan and Helen Barter of Indigo Family Medical Centre are coordinating a 24/7 "hospice in the home" service with funding. Photo: Mark Jesser, courtesy of The Border Mail

We build enduring relationships that lead to better health

collaboration

Achieving health equity and outcomes together

Australian rural communities experience a higher burden of chronic disease, which needs high-quality integrated and coordinated primary health care.

Collaboration between health and social services, clinicians and other health providers is vital to achieving health equity and positive outcomes for Australians living outside major population centres.

Gaps in health care for rural patients include longer wait times for local health services, higher out-of-pocket expenses, long distances to specialists, a changing and unstable workforce and an increase in potentially avoidable hospitalisations.

Integrated primary health care goes beyond health and social care integration to approaches that are person-centred, multi-sector, and focused on the improved health and wellbeing of both people and populations.

Although a model of integrated care can be different in every community, its aim is the same: to design and deliver quality services that improve health outcomes for people living with chronic conditions.

A health system-based definition is:
"Integrated health services – managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course."

With our increased focus on collaboration, chronic disease commissioning at Murray PHN has encouraged separate and independent organisations to work as a set of collaborating services, aligned through a model of integrated care.

This collaboration can connect health and community services and systems in a local setting with a common set of outcomes that align with the needs of people with chronic illness. Ongoing collaboration with providers will lead to the establishment and implementation of a standard set of indicators to measure impact and sustainability.

PHN collaboration

As one of 31 PHNs in Australia, Murray PHN works closely with other primary health networks, particularly those in our state and geographical region, and often those with similar rural characteristics.

PHNs collaborate regularly on an operational level, sharing research and population health data, best practice, models of care and stakeholder communications.

More formally, Murray PHN is part of the Victorian and Tasmanian PHN Alliance (VTPHNA), a grouping of the one Tasmanian PHN and all six Victorian PHNs. In 2019, our CEO Matt Jones served as Deputy Chair of VTPHNA, which looks for collective opportunities to foster collaboration, learning and knowledge transfer across the PHN sector, establishes key relationships and communication channels with partners, including State Government, and helps to develop shared infrastructure and methodologies.

Working to improve rural health outcomes

The Buloke, Loddon, Gannawarra Health Network has been working to share resources and develop a plan to address local health priorities. An implementation plan was launched in August 2019, building on the earlier work of the 2016 Loddon Gannawarra Health Needs Analysis, now with the inclusion of Buloke Shire.

The network consists of: Gannawarra, Buloke and Loddon Shires, Northern District Community Health, Kerang and Boort District Health services, Cohuna District Hospital, East Wimmera Health Service, Mallee District Aboriginal Service, Dingee Bush Nursing Centre, Inglewood and Districts Health Service, Bendigo Loddon and Southern Mallee Primary Care Partnerships and Murray PHN.

Doctors in secondary schools

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

The program is guided by a range of key principles including:

- equity of access
- no cost to the student
- youth friendly, with staff trained in adolescent-health
- student confidentiality
- cultural safety

Twenty-two schools in the Murray PHN region are part of the initiative, which began in 2017 and has been extended to 2021.

Murray PHN's role has been to engage and support local GPs, who have been selected based on their interest and experience in adolescent health.

We commend our GPs and nurses who have contributed to working in this setting.

A passion for rural health

At just 24 years old, Krystal Green will graduate with a Doctor of Medicine at the end of 2019.

Krystal moved back to her home town of Shepparton to study at the University of Melbourne's Department of Rural Health two years ago after completing a three-year Bachelor of Science in Melbourne.

One of Krystal's most rewarding experiences last year was returning to Shepparton High School to be part of the Doctors in Secondary Schools program.

It was there that she discovered her passion for adolescent health. ''It was brilliant to be in a school setting and listen to students as they face and share their concerns.

"Teenagers can experience a whole range of physical, emotional and mental changes that can be both

confusing and challenging, so it's important that they speak up if they need to.

"Having a GP available within a school setting, allows them to easily do that."

Krystal has since been accepted into the Murray to Mountains program and will complete internships at Benalla Church Street Surgery and Northeast Health Wangaratta in 2020.

Improving mental health and wellbeing

While the mental health service sector continues to undergo significant change at both Commonwealth and State levels, Murray PHN is focusing on improving equity and access to services in all areas of our region to improve people's wellbeing.

We have commissioned more than $12 million in mental health services over the past year, but we cannot improve mental health outcomes through services alone. Murray PHN is working with services providers to build capacity to strengthen the safety and quality of services, including providing access to training, assisting with wait list management processes and ways to streamline access to care, and implementing methods to prevent barriers to access services.

The Murray PHN region has a diverse population with significant communities of Aboriginal and Torres Strait Islanders, newly arrived humanitarian settlers, ageing communities, rurally isolated people and those experiencing financial disadvantage. People experiencing poor mental health are more likely to experience poor physical health, homelessness, poor oral health, and comorbidities such as chronic disease and alcohol and other drug dependencies.

The introduction of the stepped care approach to mental health has been another significant transition in the sector in recent years. Stepped care is a consumer-centred model of care that integrates mental health services within communities and supports general practitioners to help those who may be vulnerable to developing mental illness.

The availability of a continuum of primary mental health services within a stepped care approach ensures a range of service types, matched to individual and population levels of need.

The stepped care model is endorsed and encouraged at both Commonwealth and State levels of government.

Murray PHN is delivering place-based suicide prevention trials in both Mildura and Benalla, part of the Victorian Suicide Prevention Framework 2016-2025, which aims to halve the state's suicide rates by 2025 (see page 18).

We have also connected with residential aged care facilities to provide psychological therapies and counselling to residents of those facilities referred with a mental illness, or with emerging symptoms.

Murray PHN continues to consult with community, consumers and service providers, to strengthen local systems by building capacity, determine service gaps, inform the review of the Murray PHN Needs Assessment and analyse data.

However, we face a range of challenges in the mental health space. These include ensuring our large region has fair and equitable access to mental health services, broadening the scope of headspace services across the region, being creative with regionally based models of care, and strengthening partnerships with health services to manage mental health across the lifespan. As with most regional locations, we face challenges maintaining a credentialed workforce in areas where recruitment and retention are both significant issues.

Murray PHN is working with its partners to develop new ways to improve outcomes. Some examples include:

- creating innovative services that deliver wellbeing for everyone, such as use of digital health platforms to establish phone support, for anyone at any time
- a GP psychiatry line that provides access to specialists in hard-to-reach areas
- developing mental health navigator consumer pathways, including services commissioned by Murray PHN and other reputable digital platforms
- providing cultural competency training for providers to help them deliver culturally appropriate services to Aboriginal and Torres Strait Islander people
- working with Menzies School of Health Research, which has been commissioned by Orygen (National Centre of Excellence for Youth Mental Health) to develop a practice guide to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander youth with severe and complex mental health needs
- regional mental health planning to identify additional opportunities and strengthen existing systems
- intake and assessment project – Murray PHN has been selected as one of eight PHNs to roll out a pilot project, working with GPs to improve access to mental health services through a generic referral form and decision support tool.

Stepping towards more responsive mental health services

In 2018, Murray PHN implemented a range of new primary mental health services to help GPs support disadvantaged individuals to access care, at no cost, and close to home where possible.

The services that continue to be offered are psychological therapy services (PTS) and primary mental health clinical care coordination (PMHCCC). These services assist people with both mild or severe and complex mental illnesses.

Because everyone has different needs at different times, the services are designed to fit within a stepped care model, meaning that people can step their care up or down, when they need to.

The care provided can range from teaching self-help methods such as mindfulness (page 41) to team-based care approaches, which could include a specific combination of a GP, psychiatrist, psychologist, mental health nurse or allied health professionals.

Introduced as part of the Commonwealth Government's reform, stepped care aims to provide the best possible care for people experiencing mental illness.

Echuca Regional Health (ERH) has been delivering stepped care for more than 12 months through funding provided by Murray PHN.

The ERH Social Services department has integrated the model into a variety of programs including family services, counselling, acute services and the emergency department.

Fiona Clark, ERH Manager of Social Services, said that the introduction of stepped care had given ERH the opportunity to increase and tailor the services that they provide to the community.

Leanne McCallum and Fiona Clark, Echuca Regional Health

"Clients receive care based on a detailed assessment and can be easily referred to other programs and services in the community. We have established strong links with GPs and services such as housing support and community mental health, providing further wraparound support for patients."

Ms Clark said that the service had received an average of 40 new referrals a month since July 2017.

"To address the increase in referrals, we've developed a demand management strategy, including employing an intake worker and keeping an active waiting list," she said. "Patients who can't be seen straight away receive a plan with online strategies and resources to assist them in maintaining their mental health and wellbeing while waiting."

Because everyone has different needs at different times, the services are designed to fit within a stepped care model, meaning that people can step up or down their care when they need to.

"Jane" - Castlemaine District Community Health

The sexual abuse that Jane suffered as a child still haunts her almost 50 years later. Not only does she battle with post traumatic stress disorder, but anxiety and depression too. Due to these conditions, she doesn't manage her diabetes as well as she could, and her obesity means that she is at higher risk of complications.

Jane's GP referred her to Castlemaine District Community Health's Suicide Prevention Counsellor, where she was offered a range of holistic support. Jane was taught several techniques to use when she was feeling stressed, such as self-talk and mindfulness, which she found very helpful. Her social connection and interactions also increased, through group therapy and by encouraging her to enjoy the things she likes to do, such as outings with friends.

"Sue" - Albury Wodonga Health

Sue lives with her husband and in-laws. The imminent birth of their second child was increasing her anxiety and depression. This added to her Bipolar II and Borderline Personality Disorder diagnosis, which significantly impacts her personal and professional life.

Sue's psychiatrist referred her for PTS psychological therapy due to her increased negative thoughts and paranoia, trouble regulating emotions and participation in self-harming and suicidal ideation behaviours.

Sue was able to put the skills she learned into practice, without resorting to self-harm. She felt less anxious and worried and as a result has since become more socially active. Sue has been connected with family services and a mother's support group, and continues to remain engaged with her psychiatrist and local doctor.

Stopping mental health stigma

First sporting groups to sign charter

Fear of being stigmatised or "labelled" can be a major barrier to seeking help for people living with a mental illness. In rural areas, where individuals are more visible and confidentiality is less assured, the fear of stigma can make people even less likely to look for help.

In July 2019, the Ultima Football Netball Club, Moulamein Football and Netball Club, Central Rivers Umpires and Central Rivers Board in the north-west of Victoria, became the first sporting groups to sign the Stop Mental Illness Stigma Charter.

The charter was signed at the first 'A Chance for Change Manning Up Cup'. Both events brought a focus to men's mental health, encouraging people to stop stigma and seek the help they need.

While the charter was developed by Murray PHN to help health organisations create safe and supportive places for employees and patients, the charter has now been adopted nationally by more than 70 organisations, including local councils, community and homelessness organisations, government departments and now, sporting groups.

Members from The Ultima Football Netball Club, Moulamein Football and Netball Club, Central Rivers Umpires and Central Rivers Board.

As mental health is more widely discussed and the benefits of adopting the charter are becoming clearer, the Stop Stigma message continues to grow. Whether it be individually, organisationally or as a community, we can commit to breaking down the barriers, challenging the stereotypes, and encouraging help-seeking behaviours.

National award for mental health advocacy

Murray PHN was delighted this year when our Strategic Projects Coordinator, Jo Rasmussen, was awarded the 2019 National Mental Health Advocate of the Year.

Jo, who has worked tirelessly on Murray PHN's Stop Mental Illness Stigma Charter for the last four years, was presented with her award in Canberra in October 2019 at an event attended by the Minister for Health, Greg Hunt MP and Shadow Minister for Health, Chris Bowen MP.

Together with her experience as a consumer representative, Jo has also been appointed as a member of the National Stigma Report Card project advisory panel.

The project will be the first large-scale survey of the impact of stigma on Australians with a severe mental illness and their carers. This project is driven by the National Mental Health Commission and the feedback will inform a national strategy on ways to address the stigma of mental illness.

Alan Tudge MP presents Jo with her award at the 2019 National Mental Health Awards in Canberra

headspace for young people

It is estimated that one in five young Australians aged 16-24 will experience mental illness in any given year. With a focus on early intervention, headspace provides young people (12-25 years old) and their families with support at a crucial time in their lives – to help get them back on track and strengthen their ability to manage their mental health in future.

In March 2019, Federal Member for Nicholls, Damian Drum announced a new headspace centre for Echuca, following a meeting facilitated by Murray PHN to bring together all headspace centres from across our region - Albury, Bendigo, Swan Hill, Shepparton and Mildura. As there had been an increase in local emergency department presentations, the meeting discussed the most effective ways to address the mental health needs of young people in Campaspe and southern NSW regions.

Damian Drum, Federal Member for Nicholls, Peter Walsh, Leader of the Nationals, John Quirk, Board Chair Echuca Regional Health, Matt Jones, CEO Murray PHN and Nick Bush, CEO Echuca Regional Health.

"Poppy", aged 17 - headspace Youth Severe

"Poppy" is 17 and had to move home and schools when she and her mother moved in with mum's new partner and his children. Adjusting to her new family environment took its toll and the highly motivated Poppy lost her appetite and found it hard to sleep at night, due to stress and anxiety. While she had support from her school friends, the new family dynamics were complicated and Poppy was asked to leave home.

At risk of homelessness, Poppy sought help from a headspace pop-up at her school, where she was provided with professional assistance from a youth access worker. Poppy and her worker set some clear goals, including learning stress and anxiety techniques and consulting her GP on sleep and appetite. Poppy is now managing school, community activity and employment and continues to be supported by headspace as required.

Along with the Echuca headspace centre, Murray PHN is also supporting the establishment of a headspace satellite centre in Wangaratta. The Wangaratta headspace satellite implementation team, consisting of Albury Wodonga headspace, the lead agency Gateway Health, headspace national and Murray PHN met in October 2019.

The implementation team spoke with stakeholders including local councils, Victoria Police, TAFE, schools, non-government agencies and other health and private organisations, to gain local perspectives and ensure that all planning decisions were representative of community need.

All members of the implementation team are determined that young people's voices and opinions will remain front and centre of the new satellite service, opening in 2020.

Attendees pictured at the Wangaratta headspace establishment consultation meeting

"Anna", aged 13 - headspace Youth Severe

By the age of 10, "Anna" had attended six different primary schools. Raised by a single mother and exposed to serious drug use and domestic violence throughout her short life, Anna was placed by authorities with her grandmother.

But the impact of her disrupted and traumatic early years continued to impact on Anna's wellbeing and last year, she began experiencing anxiety, refusing to go to school and thinking about suicide. Referred to headspace Swan Hill, it took time and patience for the clinician to break down Anna's initial service distrust. The flexibility of home visits and support from a range of local agencies and case workers have helped to engage Anna and to increase her part-time attendance at school.

She is beginning to understand the impact of her early trauma on both her behaviour and her view of the world, while her increased engagement with friends at school has improved her social and emotional wellbeing. Anna has identified personal goals including "to be happy with myself and step outside of my comfort zone" and "to understand my worry thoughts". Long-term, she hopes to re-engage further with school and to "process" her trauma. Anna is continuing to be supported through the headspace Youth Severe funding program.

Supporting suicide prevention in our communities

Suicide remains the leading cause of death for Australians aged between 15 and 44, with each death by suicide affecting families, friends, colleagues and communities. Murray PHN has partnered with the Victorian Government to develop and deliver place-based suicide prevention strategies in Mildura and Benalla, part of the Victorian Suicide Prevention Framework 2016-2025 that aims to halve the state's suicide rate by 2025.

Place-based approaches are grounded in evidence demonstrating the importance of delivering the right services, at the right time, and close to where people live. But to understand the complex factors influencing suicide rates, it is vital for us to work closely with communities experiencing a higher prevalence of suicide or with particular risk factors. Murray PHN's place-based suicide prevention trial sites were selected based on local need and capacity, including suicide rates, socio-economic disadvantage, Aboriginal and Torres Strait Islander population, rates of psychological distress and recent crisis, such as drought.

Mildura

Early evaluation of the Mildura trial (by Sax Institute and Monash University) shows that strong and engaged relationships have been formed with stakeholders across the region.

But the issue of prevention remains challenging and in 2018-2019, the Mildura place-based suicide prevention trial focused on initiatives across the LifeSpan system, the Black Dog Institute framework that was developed to guide systems approaches to community suicide prevention.

Work is also continuing on "post-vention" resources to support people and organisations in the aftermath of a suicide.

Key highlights to date include:

- Distribution of a wallet-sized information card that includes local and national help information, prevention and support details, and ideas to help start a conversation with someone who may be feeling suicidal
- Ongoing engagement with local media, towards safe and purposeful reporting and coverage of trial activity
- Growth in lived experience recruits – increased leadership and capacity to drive informed work in the region
- Expansion of community involvement through launch of the Sunraysia Mallee Community Suicide Prevention Network, supported by Wesley LifeForce
- Identification of additional ASIST (Applied Suicide Intervention Skills Training) facilitator trainees, supported by their organisations with ongoing resourcing

- *Question. Persuade. Refer.* online training launched with 3000 licences available to the Sunraysia Mallee community with 130 registering in its first six weeks.
- Completion of Part A of the commissioned research (Monash and La Trobe Universities) towards 'Improving Emergency and Follow Up Care for Suicidal Crisis in Mildura LGA'.

Suicide prevention in the community

"Southern Cross Farms has been closely affected by suicide and it has been a challenge for us to ensure we are having open and honest conversations with our team members. Keeping in regular contact with each farm and its team members is vital. We have developed a really positive relationship with the Mildura suicide prevention trial staff members at Murray PHN who have provided tools in supporting those who have suffered, or are suffering, from poor mental health. I think it is great that speaking out about having poor mental health is now seen as a sign of strength and helps with the healing process. We can also make the discussion about suicide more open and making it a real topic for discussion can only improve things."

Peter O'Donnell, Business Owner

(Photo: Darren Seiler)

Benalla

Benalla's place-based suicide prevention trial has had a strong focus on community since its beginning, with a community action plan developed and a community campaign taskforce established in the early stages of the trial.

In June 2019, community members were invited to attend an art exhibition which encouraged people to seek help and to reduce the stigma associated with suicide. The *Community Connections* exhibition at the Benalla Library was hosted by Murray PHN, Benalla Rural City Council and Central Hume Primary Care Partnership, with artwork by local Aboriginal artist Chris Thorne.

A Connect Benalla resource card was launched as a quick reference guide to support services, available both locally and online. The wallet-sized information card was informed by community members, with more than 10,000 distributed throughout Benalla and surrounds.

Benalla hosted the inaugural live-stream of Albury's Winter Solstice, held by Survivors of Suicide and Friends, to give community members the opportunity to participate in the event, talk about mental health and suicide and hear from guest speakers and live musicians.

A 2020 Connect Benalla calendar will be distributed across Benalla later this year to raise awareness of suicide prevention, provide individuals with support services and information, and strengthen community connection. This new resource has been developed with community input throughout the planning process and a number of locals have been photographed for the calendar.

Paul, Wayne and Pamela from the community taskforce

Inspector David Ryan, Chris Thorne and Senior Constable Mark Kennedy. Photo: Central Hume PCP

Free online suicide prevention training

Both Mildura and Benalla launched online training, *Question. Persuade. Refer.*, designed to provide everyday people with three simple steps to help save a life from suicide. More than 3000 free licences have been made available to community members, in order to learn the warning signs of suicide, how to ask the suicide question, common myths and misconceptions about suicide, and how to persuade someone to stay alive.

Medical students expand their skills

Last summer, Murray PHN commissioned research into improving emergency and follow-up care for suicidal crisis in the Mildura Local Government Area. The research provided the opportunity for two medical students to expand their skills and learn more about suicide prevention.

David Motorniak and Jacqueline Bredhauer (*pictured*), were awarded Monash School of Rural Health summer scholarships to work on the project, part of Murray PHN's Mildura place-based suicide prevention trial.

David is a John Flynn Scholar who had just finished his second year of a Monash degree in medicine. His work over the summer focused on analysis of data surrounding suicidal presentations to Mildura Base Hospital.

"Starting off, I had very little idea of what research involved or how to approach any sort of meaningful analysis. Thankfully, there have been staff at Monash and La Trobe who have been excellent mentors and helped improve my creativity and initiative to solve problems and discover new solutions. It's definitely provoked an interest in research and given me skills that I can translate onto future projects."

Jacqueline's experience came at the end of her third year of study and a year of clinical placements at Mildura Base Hospital. She contributed to the literature review and learned skills that she believes will help her become a better doctor.

"I've gone from knowing nothing at all about research, to understanding how to use scientific databases, procedures for searching the literature and how to collaborate professionally. I'm interested in becoming a rural GP, so it's been great to learn that there is plenty of high-quality research going on outside of the city."

Medical students David Motorniak and Jacquie Bredhaver

Community resources for mental health

Earlier this year, Murray PHN visited the 8 Olinda Street Centre to provide a range of books on mental health issues, including useful information for both children and adults.

The Centre, run by Bendigo Health Mental Health Services, provides a free lending library of more than 3000 resources - ranging from books, to DVDs and CDs and games.

The resources are available to consumers, those caring for a person living with mental illness, family, friends, students, professionals and other health services within the region.

Karyn Bath, 8 Olinda St Centre Coordinator with Sue McConnachie, Murray PHN mental health team member

Focusing on recovery and hope

Partners in Recovery

The Partners in Recovery (PIR) program ended in mid 2019, changing the way psychosocial support services were delivered across Australia.

Our Loddon Mallee Murray and Hume PIR teams are proud to have assisted hundreds of participants with severe mental illness in the six years the programs operated.

Many participants and their carers told us that before the program, they felt lost in a complex system. But by having the right support to help them navigate a range of services, they were able to get their lives back on track.

To celebrate the conclusion of PIR, participants and mental health workers came together to share stories and take part in activities focused on hope and recovery.

Feedback from workshop participants

What recovery means to me. It is:

- individual
- a journey
- ongoing
- hope
- control
- defining/re-defining self
- belief in self
- having the support of others
- connection/re-connection with people/community

Who or what has been important to my wellbeing:

- non-judgemental support
- being organised and having a routine
- having meaning through a job or hobbies
- being treated equally
- family support
- animals
- nature – sunshine and fresh air
- balance
- physical health
- hope

First regional community of practice meeting, September 2019

Psychosocial Recovery Services

Psychosocial support is a term used to describe programs and activities that are designed to support people with severe mental illness achieve their recovery goals. For example, to find and look after a home or to exercise to remain physically well.

The Commonwealth's new Psychosocial Recovery Services (PRS) program has been influenced by the strengths of PIR as a catalyst for change in the mental health sector.

Three support streams make up Murray PHN's $6.5m Psychosocial Recovery Services: National Psychosocial Support Measure (NPSM), Continuity of Support (COS) and Extended Transition Arrangements (ETA).

PRS is intended to support people who are not eligible for the National Disability Insurance Scheme (NDIS) or who have not yet had their eligibility confirmed. In the next 12 months we anticipate that more than 800 participants and 40 mental health workers will be supported and employed across the region.

Personal recovery is a unique process that can include a change in attitudes, values, feelings, goals, skills and roles, but in essence is about recovering a life and identity beyond the experience of mental illness.

Before the new PRS services were implemented, Murray PHN felt it was important to pilot the model of care, to test and tweak our thinking, before rolling it out across the catchment. Greater Shepparton and Moira local government areas were selected, as they had no previous psychosocial supports available.

The pilot provided opportunities for collaboration, as representatives from organisations who generally worked in isolation, came together to share resources and knowledge.

Because of the value this provided, a community of practice has now been established, to promote communication, and importantly, to provide a consistency in service delivery across the region.

A set of guiding principles was also developed in consultation with people with a lived experience of mental illness, their carers, GPs, service providers and academics with expertise in psychosocial interventions. For example, the use of peer workers has now been mandated, along with a prescribed standardised base salary for all mental health workers.

Pilot participants feedback:

"I now have a physio, dietician, etc all in place. I knew I needed these services, but I was in no state to have any direction back then. Since being referred to this program, everything has opened up for me."

"I wasn't previously able to go to group programs but now I come to 'My Recovery' every Monday and am able to participate and talk with other people. I have never been able to talk about my problems before."

Decreasing substance use through group support

The Recovery and Support Program (RaSP) is a post-withdrawal alcohol and other drugs group program for people living in the Greater Hume region.

Originally developed by St Vincent's Hospital Melbourne's Nexus program, RaSP uses evidence-based interventions, focused on harm-reduction and recovery, while also supporting a person's psychosocial needs.

Murray PHN funded Gateway Health to establish and implement a 12-month pilot program. St Vincent's Nexus worked in partnership with Gateway Health during this time to provide support, training and access to specialist consultations through their addiction medicine specialists.

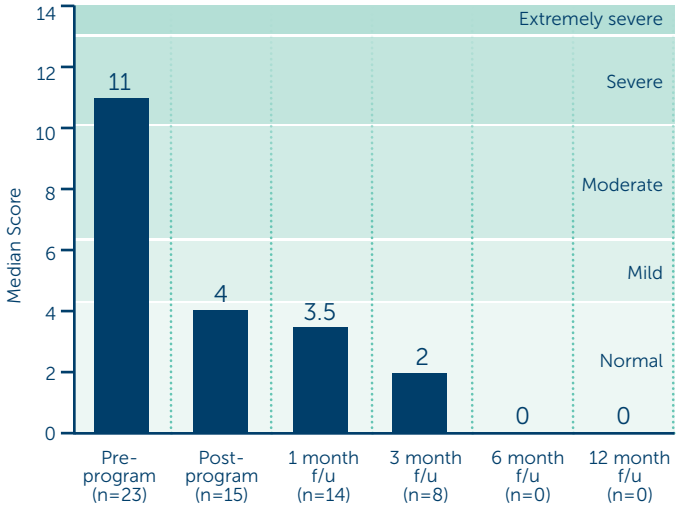
"Access to highly specialised services such as the addiction specialist is rare in regional areas. Our staff have a real passion for the program and how it can improve outcomes for people." – RaSP Group Facilitator Gateway Health

RaSP is offered four times a year in Wangaratta and Wodonga and consists of two full days of activities each week, for eight weeks and includes 12 months of follow-up phone support.

Initial results from the five group programs that have been delivered, have shown a decrease in substance use, and improvement in mental and physical health, as well as overall quality of life.

RaSP program group activities

Depression Score (DASS21)



Profile of median depression (EOC 1-3) based on the DASS21 at different time points

"I would recommend RaSP to anyone suffering addiction as well mental health issues. I had both, but I am hoping I now only have one (as mental health diagnosis is for life but addiction can be controlled). Lucy and Deoki are amazing facilitators and the support I have received has been invaluable. I have met some great like-minded people through our groups. It's very comforting coming to a safe place where you can be yourself and feel understood."

"It might seem daunting coming to your first group but by the end of it, these people will be your support system. They will notice things about you and strengths within you that you can't see and likewise you will be able to offer support and perspectives that will help people more than you thought you could."

A READI response

The Regional Employers Alcohol and Drug Initiative (READI) was established in 2017 to help employers to support staff experiencing difficulties with substance use.

READI is a not-for-profit organisation established to support employers and employees and their families who want to work together to provide workplaces that are free from alcohol and drug-related harm.

A punitive response to a positive alcohol and other drug (AOD) test result in the workplace has a ripple effect across any community but is magnified in smaller regional and rural communities where there are fewer employment options.

READI takes a holistic treatment approach to a positive drug test result, providing the employee with a non-judgmental response and supporting them to reduce AOD use.

The integrated READI model of care uses community-based primary health care providers (GPs, pharmacists, nurse practitioners) as well as industry-based programs with more specialist treatment providers. Early outcomes have included positive employee health behaviours, measurable health improvements and cost efficiencies for employer and employee. The pilot also demonstrated the benefits to the local community and health system, with care provided closer to home and reduced avoidable hospitalisations.

In focusing on developing a harm minimisation policy and culture in the workplace, this model of care:

- acknowledges that alcohol and drug misuse is impairment-based
- requires an educational component
- is non-punitive and supportive
- involves rehabilitation
- ensures that all parties have responsibility in creating positive change.

Embedding alcohol and drug prevention as a key component of the model provides a platform to address societal and community implications of the escalation of alcohol and drug usage.

Murray PHN included the development of READI in our Innovations Plan 2016-2019 after being approached by regional industry leaders over their concerns about employee AOD use and the impacts of that use on the organisation and community.

READI is an ASIC-registered public company, limited by guarantee, and is a registered charity with the Australian Charities and Not-For-Profit Commission.

Designing sustainable health services

Murray PHN is working with Flinders University in South Australia on research to guide development of a resource to commission dual diagnosis services for people with both mental illness and alcohol and/or other drug use disorder. The evidence-informed, decision-making framework for complex health programs project aims to understand the contextual and causal mechanisms which affect the effectiveness of health programs, using the Delphi method to engage stakeholders to prioritise program features.

Service providers with local experience in dual diagnosis have been invited to participate in the research. Their knowledge and experience will inform the relative importance and value of the proposed program features and will assist in designing a health program that is relevant and applicable to the local context.

"It's important to commission health services that are not only effective and feasible, but also sustainable and acceptable to the local community. Working together with Murray PHN, mental health and alcohol and other drugs service providers, and consumers with 'lived' dual diagnosis experience, we are currently conducting a research trial of a developed framework to co-create a dual diagnosis health service. The framework, termed in-DEPtH: evidence-informed, co-creation framework for the Design, Evaluation and Procurement of Health services, is a systematic approach that incorporates research evidence, contextual realities, and stakeholder considerations to co-create health services that are locally relevant and appropriate. At the moment, the trial is still ongoing and so far, we have received positive feedback and active engagement from the various stakeholders. Through this research project, we hope to improve not only the acceptability of commissioned health services by providers and communities, but also, ultimately, the level of care and health outcomes of patients and consumers."

Kenneth Lo, Flinders University

Connecting health to all aspects of life

The Murray PHN region is home to a diverse population of Aboriginal and Torres Strait Islander people. There are more than 14 different Aboriginal language groups in our catchment and a range of community-led Aboriginal organisations.

Aboriginal and Torres Strait Islander health is one of Murray PHN's priorities, with Aboriginal people viewing health as something that connects all aspects of life. It is "not just the physical wellbeing of the individual but the social, emotional, and cultural wellbeing of the whole community in which each individual is able to achieve their full potential" (*National Aboriginal Health Strategy, 1989*).

Describing the health of Aboriginal people involves looking at individual characteristics and behaviours, as well as the broader social, economic and environmental factors that influence health. It is also important to understand the impact of a history of colonisation and the subsequent disadvantage experienced by Aboriginal people over more than two centuries.

Our Aboriginal health partners have reinforced with us that their needs are best approached in terms of relationships, family and community, as health-related decisions will be influenced by culture, social connections, racism, communication, choice, and distrust of service providers.

Health data establishes that four preventable chronic conditions - cardiovascular disease, diabetes, cancer and mental illness - are the most significant direct contributors to the life expectancy gap between Indigenous and non-Indigenous people.

Murray PHN is working with Aboriginal Community Controlled Health Organisations and communities to meet the needs of Aboriginal and Torres Strait Islander people, through programs including Integrated Team Care (ITC).

There are more than 14 different Aboriginal language groups in our catchment.

New resource launched in Echuca

Earlier this year, Njernda Aboriginal Corporation's Wellbeing unit developed a mental health and drug and alcohol services resource, through Murray PHN's drug and alcohol funding. The *Drug and Alcohol Detox and Rehabilitation, Mental Health Inpatient and Counselling Services* directory is a comprehensive collection of support services and referral information for people living in and around Echuca. Since its launch, more than 100 copies have been distributed throughout the region, linking community members to a wide range of services.

"Cheryl" - Rumbalara Aboriginal Cooperative

With cardiovascular disease and sleep apnoea, "Cheryl", 48, found it difficult to get to and from her medical appointments and pharmacy. Her unplanned hospital visits were increasing, and she thought that an electric scooter was her only mobility option. But after a recommendation from a family member, Cheryl overcame her concerns, and agreed to meet with Rumbalara's outreach workers.

Now Cheryl is being supported with help to arrange vital medical and specialist appointments, transport to visit her podiatrist, her pharmacist and for sleep studies. She has even been to visit the dentist, which was a service she needed, but was previously too anxious to seek out.

Regular health checks have assisted Cheryl with a weight loss of almost 14kg and she can feel the improvement in both her breathing and walking. Best of all, she hasn't been back to hospital and her GP is delighted with her progress.

Cheryl was nervous about meeting the team from Rumbalara, but now says she feels happier, lighter and better than she did when she joined the Integrated Team Care program, which is funded through Murray PHN. She is now recommending the ITC program to her friends and family.

"Karen" - Bendigo and District Aboriginal Cooperative (BDAC)

"Karen", 45, was referred to Bendigo and District Aboriginal Cooperative (BDAC) with existing mental health issues and newly diagnosed Type 2 diabetes. To prevent any complications from her diabetes, Karen was linked with services including diabetes education, podiatry and optometry.

Following Karen's initial appointments, it was identified that her diet in particular needed to change. With the help of her partner, Karen made major changes to her eating habits and with the assistance of her diabetes medication, lost 10kg in two months.

At times, some of Karen's services were not culturally appropriate, however the majority of services were provided in the home, helping Karen feel more comfortable and come out of her shell. For the first time in many years, Karen has engaged in social activities that have enhanced her confidence and reconnected her to her culture.

Karen said: "I feel like all you mob have helped me to feel better in my body and in my head. I've just got to keep losing weight and I'm sure things will get better."

Improving paediatric care

While lifetime health care is important, good care from pregnancy through to three years of age has the greatest impact on a child's future. A growing body of evidence shows that the foundations of a person's lifelong health - including their predisposition to obesity, poor mental health and certain chronic diseases - are largely set during the first 1000 days of their lives.

Murray PHN's Needs Assessment and information gained from Hands Up Mallee's extensive community consultation, highlighted children's health and wellbeing as a major concern for the Mildura and surrounding community, and a priority area for future work. In particular, addressing the health needs and service gaps for Aboriginal and Torres Strait Islander children.

From July to December 2018, Murray PHN worked closely with key stakeholders, health professionals, local services, community leaders and members of the public, to pilot a community-based paediatric health service, that would demonstrate community use and need, and inform future practice design.

The project's aim was to understand local needs and develop a place-based model of community paediatric health care. As gathering health needs information is often experienced as a one-way process, the project employed a paediatric fellow to provide an additional level of service for some families using the two health services, Mallee District Aboriginal Services (MDAS) and Sunraysia Community Health Services.

The focus on community paediatrics was to provide holistic care to families, while supporting existing services and health professionals to build local capabilities.

The initial stages involved collating local data, gathering background evidence for intervention and undertaking targeted consultation with professionals to understand the local experience. This information shaped the model of care and incorporated direct clinical consultation, secondary consultation, local capacity building and collaboration across the service system. The key requirements for the model were that any clinical service be accessible, affordable and culturally safe. Active engagement and leadership from local providers will underpin the long-term success and sustainability of any model.

During the clinic period there was high demand for appointments, particularly at MDAS, reinforcing the very high need for services in this area:

- A total of 38 children and young people were seen for 63 appointments (38 'new' client appointments and 25 'review' appointments) across 19 clinic sessions
- Many children seen had high levels of complexity and psychosocial needs.

We would like to acknowledge the support of staff at Mallee District Aboriginal Services Mildura and Sunraysia Community Health Services, and the families who participated in the pilot clinic. We also received valuable input from Mildura Rural City Council Maternal Child Health, Hands Up Mallee and from the broader Mildura community.

Holistic care for Indigenous people with mental health and alcohol and other drug concerns

Illicit drugs have been estimated to cause 3.4 per cent of the burden of disease and 2.8 per cent of deaths in Aboriginal and Torres Strait Islander people, compared with 2.0 per cent and 1.3 per cent among the non-Indigenous population.

Through our commissioning approach, we have sought collaborative design of new models of care for Brief Intervention and Dual Diagnosis services in Aboriginal Community Controlled Health Organisations.

Dual diagnosis is one or more diagnosed mental health problems occurring at the same time as problematic drug and/ or alcohol use.

Screening and brief interventions aim to identify current or potential problems with substance use and motivate those at risk to change their substance use behaviour.

The new model of care ensures the client understands:

- *Who is responsible*
- *What is being done*
- *Why - the outcomes they are wishing to achieve*
- *When it will occur*

Albury Wodonga Aboriginal Health Service Model of Care

Many of the clients presenting to the Albury Wodonga Aboriginal Health Service (AWAHS) AOD program suffer multiple illnesses, including mental health and alcohol and other drug issues, in addition to social, financial and situational issues. The complexities associated with this mean that every client must be seen with a holistic care approach.

AWAHS has extensively reviewed all practices provided by their existing AOD program and examined all relevant Indigenous and mainstream research and current models.

The new model of care developed by AWAHS includes a duty officer position, staff training, care plans, a new referral form, a wait list policy and home detox process. Having all of these items in place helps to provide consistent care and ensures that the client is aware of the Who, What, Why and When (see panel left). This helps both the client and staff to see when changes take place.

To ensure cultural security, the model of care includes elements such as spirituality, connection to country, family, kinship networks and the community.

The inequalities of economic, social and emotional needs are considered, along with the wellbeing needs of a client in a culturally aware, safe and secure manner. The goal of AWAHS is to provide the best care for Aboriginal and Torres Strait Islander people.

Investigating ways to strengthen aged care

Aged care has been ranked as one of the top five issues affecting community members in the Murray PHN region.

Nationally, the sector has been undergoing a review through a Royal Commission, while locally health services and aged care facilities have described issues with accessing general practitioners. Our general practitioners have also told us that it is becoming more difficult to provide a comprehensive service to residents in aged care facilities, due to the growing demand in their primary practices and the increasing needs of aged care clients.

Leading a collaborative approach to finding and implementing solutions, Murray PHN conducted a survey that was used to inform two working group forums and helped us to further understand the extent of this concern, the impact on families, facilities, GPs and models of care.

Factors contributing to the current issues include the GP workforce shortage; reduction or cessation of incentive payments and medical deputising services; nurse staffing levels and the time it takes to appropriately manage a resident who can have complex needs due to frailty.

We are working with our stakeholders to understand the models of care that could work in this sector and in rural communities. While these challenges cannot be addressed quickly, we are continuing to investigate ways to help strengthen and support the system. For example, we have created a resource for GPs to know which Medicare items they can claim when visiting residents in aged care facilities.

Dr Ewa Piejko, Murray PHN Medical Advisor pictured speaking to GPs and residential aged care facility staff at one of the forums

Mental health support for people in aged care

Psychological treatment services are being established, through Murray PHN mental health commissioning, to address the mental health needs of people living in residential aged care facilities (RACF). These services will help residents with mental illness to access support services similar to those available through the MBS Better Access Initiative.

Of more than 6000 people living in residential aged care facilities across the Murray PHN region, 12 per cent are identified to be at risk of, or suffering from, low to moderate mental illness.

Nationally, 86 per cent of people in permanent residential aged care in 2018 had at least one diagnosed mental health or behavioural condition, with depression the most common diagnosis (49%) (AIHW).

As of October 2019, Murray PHN is in the process of commissioning eight service providers to deliver this model of care, along with upskilling of staff in the early detection of deterioration, in Echuca, Seymour, Shepparton, Albury, Yackandandah, Wangaratta and East Wimmera.

The new psychological treatment services are being designed and implemented through collaborative approaches that engage residential aged care facilities, general practice, clients and carer representatives. They aim to:

- improve the quality of life and wellbeing for residents
- enable early identification and care planning
- improve client reported outcomes pre and post-intervention
- increase ability for clients and family support to self-manage
- improve service delivery and coordination of care
- create new referral pathways
- improve the capacity of the RACF workforce to identify and source timely referrals.

Managing chronic disease together

While we have specific priority areas of diabetes, cardiovascular and chronic obstructive pulmonary disease (COPD), our focus is to strengthen integrated and coordinated services that are accessible irrespective of a person's postcode.

In Australia, many people who have chronic conditions also have multi-morbidities including mental health. For this reason, integrated models of care that provide targeted patient-centred primary health care services are preferred, rather than services that are targeted towards a particular disease or condition, with the end goal of supporting people to transition to self-management.

For 2019, Murray PHN invested $2.7 million in services to support people living with chronic illness, including new services that provide rehabilitation programs for people living with COPD and cardiovascular disease.

Rural communities experience a higher burden of chronic disease than regional and metropolitan areas. Health disparities arise, in part, through gaps in health care for rural people. This includes longer wait times, higher out of pocket expenses and gaps in accessible workforce.

Healthy heart and lung participants

One example of this is within Northern District Community Health (NDHC) in Kerang. NDCH's Healthy Heart and Lungs Program provided clients living in Loddon and Gannawarra shires, with education and exercise sessions to improve their current lifestyle and learn techniques to self-manage their chronic illness effectively, prevent flare-ups or further illness.

"Feeling better each week!"

"We only wish the program could go for longer than eight weeks."

"Fantastic program!"

"Feeling great and slowly gaining more flexibility."

"Becoming more motivated and inclined to exercise at home."

Healthy heart and lungs January – June 2019 outcomes

Knowledge of exercises they can and can't do increased from a score of five, up to a score of 12 points

Knowledge of healthy eating and foods from a score of four, up to 11 points

Knowledge of their health condition rose from a score of five, up to 22 points

Eleven participants had an improvement in their resting oxygen statistics

Eight participants' resting blood pressure improved

Seven participants increased the distance they walked in the six minute walk test

Eleven participants saw an improvement in arm strength in one, or both arms

Six participants improved their leg strength from pre to post-assessment results

Nine participants improved their mobility and agility score

Optimal cancer care

This year, Victorian PHNs are working to increase the use of Optimal Care Pathways (OCPs) for melanoma, head, neck and pancreatic cancers.

The OCP guidelines were created to show ideal cancer care across the cancer journey, from prevention and early detection to end-of-life care.

The OCPs recognise the complexity of the cancer pathway and the importance of effective communication between primary and acute health sectors.

OCPs:

- provide a mandate for service improvement
- are useful in deciding how to organise service delivery to achieve the best outcomes for patients
- can drive service improvement priorities such as reducing unwanted variations in practice
- are relevant across all jurisdictions and have been adopted nationally
- are not intended to be, or to replace, detailed clinical practice guidelines.

There are now a range of OCPs, covering some of the most common to some of the rarest cancers. As doctors may only see one or two rare cancer cases a year, the OCPs offer an easy and practical resource. OCPs are available in three versions: a detailed clinical guide, a quick reference guide and a 'what to expect' guide for patients and their families.

The seven steps outlined in OCPs are:

Stage 1 Prevention and early detection
Stage 2 Presentation, initial investigations and referral
Stage 3 Diagnosis, staging and treatment planning
Stage 4 Treatment
Stage 5 Care after initial treatment and recovery
Stage 6 Managing recurrent, residual and metastatic disease
Stage 7 End-of-life care

Murray PHN has worked to increase awareness of OCPs, through education and training opportunities, and other projects such as cancer survivorship and HealthPathways.

1 in 14 men will be diagnosed with melanoma, making it the third most common cancer in men, after prostate and bowel

Most patients with pancreatic cancer present with non-specific symptoms. The five-year survival rate therefore is a low 8.7 per cent

More than 5000 new cases of head and neck cancers will be diagnosed in any given year, however there is currently no screening available for them.

Improving screening to find cancer earlier

Australia's breast, bowel and cervical cancer screening programs can detect early signs of disease, either before a cancer has developed or in its early stages before any symptoms occur, when early interventions can be most successful.

Success rates of screening programs depend on participation, which is variable across the region with lower participation rates for Aboriginal communities, some culturally and linguistically diverse groups and people living in areas of socio-economic disadvantage.

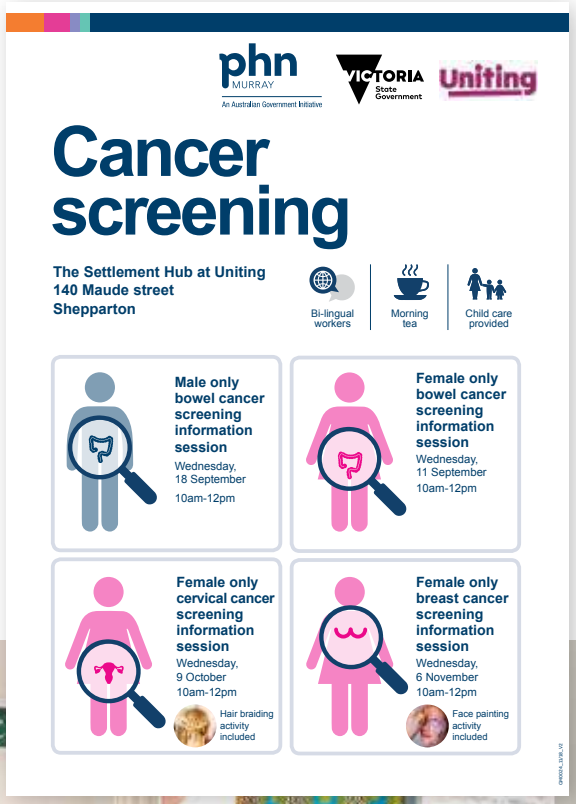
The Victorian Department of Health and Human Services has funded a three-year community-led cancer screening program (2018-2020) aimed at increasing early detection of bowel, cervical and breast cancer by building capacity to increase participation in screening programs, primary health care settings and through targeted community-led interventions.

With this funding, Murray PHN has supported a number of general practices to implement quality improvement initiatives driven by local need. Some of these activities include:

- establishing women's clinics to access cervical screening
- health professional attendance at local events to provide information and follow up screening appointments
- reviewing recall and reminder systems to ensure patients know when their routine screening is due.

Murray PHN is also working with culturally and linguistically diverse communities in Shepparton to improve understanding and awareness of screening programs. Information sessions are underway with 50 people attending the first two events.

Overall, the sessions have been positively received with plenty of questions on topics such as healthy eating to reduce the risk of cancer and ways to prevent melanoma.



Donna Rumbiolo, Primary Care Nurse Practitioner and Sara, bilingual speaker Uniting Care in Shepparton

System support for cancer survivors

Victorians living in regional and remote locations commonly have a five-year cancer survival rate lower than those in urban areas. As the population is increasing and getting older, cancer diagnosis rates will only increase, and more support will be needed.

A cancer survivor refers to any person who has been diagnosed with cancer. Murray PHN was funded to investigate the gaps in cancer survivorship care and identify ways to improve services for patients and their carers, across the Campaspe, Loddon and Southern Mallee regions.

The project was run in partnership with: Kerang District Health Services, Boort District Health Services, Southern Mallee Primary Care Partnership, Swan Hill District Health Services, Bendigo Health Services, Echuca Regional Health and Loddon Mallee Integrated Cancer Services.

Cancer survivorship was, and still is, a new concept for many health services, professionals, individuals and their families that have, or have had cancer. Because of this, the project required significant investment in education and the re-designing of care pathways.

This project was funded by DHHS, to redesign the capability of the workforce and health services, which required a significant amount of resources. It focused on four main areas of capacity building, IT, care planning and community.

A key enabler of the project was the shared vision of the main participants, particularly the members of the working groups, to improve access to survivorship services in rural locations.

Cancer survivors in the project locations are now the beneficiaries of improved care pathways between the acute, primary and community sectors.

Improving bowel cancer screening in Donald

Donald Medical Practice completed a Cancer Survivorship Incentive Grant project, which included a review of their bowel cancer screening processes and the way they recorded bowel cancer results in their software. Not only did the staff at Donald participate in training at Peter MacCallum Cancer Centre, but they introduced Cancer Survivorship Care Plans into practice, increased their communities' screening rates and successfully completed a quality improvement and accreditation activity.

Margot Paynter, Practice Nurse and Kim Westerland, Practice Manager at Donald Family Clinic

Opportunities and challenges for Aboriginal people

Mallee District Aboriginal Health Service also learned about implementing Cancer Survivorship Care Plans through Peter MacCallum Cancer Centre training. While they told us that many community members did not speak of cancer due to it being associated with death, often due to late diagnosis, the team has worked to include cancer as a chronic disease under the Integrated Team Care funding arrangements and to provide their clients with wrap around support.

Health professionals who came together in Swan Hill to enhance their knowledge and skills for cancer survivorship care

Establishing a Kerang cancer support group

Murray PHN established a cancer support group in Kerang to provide a safe space for people affected by cancer. The group enables people to develop local connections, providing emotional and other supports including the sharing of resources, experiences and ideas.

Providing workforce development training

Murray PHN funded a number of workshops and one-on-one placements in Swan Hill, Echuca and Kerang to improve links between primary health care professionals and hospital-based oncology teams, and also to improve the knowledge and confidence in managing the health needs of cancer survivors.

Kerang Support Group

Quality improvement in general practice

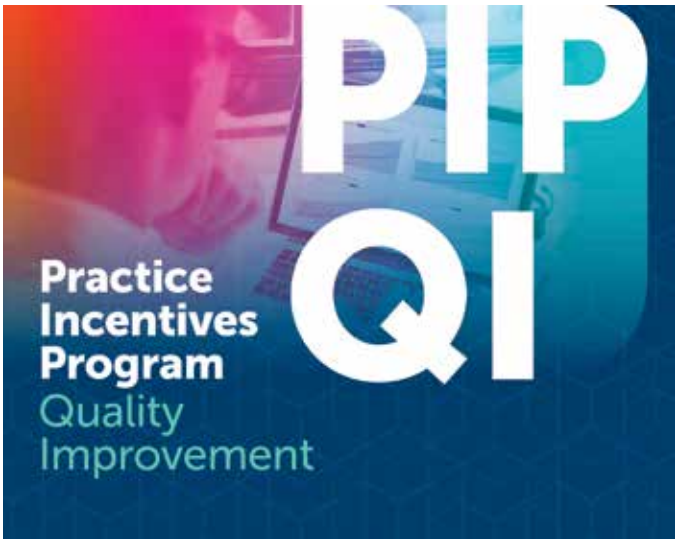
On 1 August this year, a new Commonwealth general practice incentive, the Practice Incentives Program Quality Improvement (PIP QI), came into effect. It aims to recognise and support practices that commit to improving the care they provide to their patients, including delivering continual improvements, quality care, enhanced capacity and improved access and health outcomes for patients.

Murray PHN is supporting general practices to engage with the new incentive by providing information and support to register, navigate and use systems to meet PIP QI requirements, including reporting compliance to the Department of Health.

Practices will be supported with access to a data report that demonstrates practice performance against PIP QI benchmarks, designed to give a visual snapshot of a practice. The report, designed by Murray PHN, is easy-to-read, tracks trends over time and provides benchmarking.

Resources have also been developed to assist with the new incentive, including a handbook, presentation for practice managers, frequently asked questions, a PIP QI readiness checklist and sample quality improvement data quality activity.

Murray PHN is still receiving enrolments for the new incentive and is currently tracking above the national average.



To qualify for a PIP QI incentive payment, general practices in our region must:

- participate in continuous quality improvement focused on specific improvement measures, in partnership with Murray PHN
- share a minimum set of aggregated data with Murray PHN, in accordance with 10 improvement measures, to assist in supporting improvement and understanding health needs.

PIP QI improvement measures

1. Proportion of patients with diabetes with a current HbA1c result
2. Proportion of patients with a smoking status
3. Proportion of patients with a weight classification
4. Proportion of patients aged 64 and over who were immunised against influenza
5. Proportion of patients with diabetes who were immunised against influenza
6. Proportion of patients with chronic obstructive pulmonary disease who were immunised against influenza
7. Proportion of patients with an alcohol consumption status
8. Proportion of patients with the necessary risk factors assessed to enable cardiovascular disease assessment
9. Proportion of female patients with an up-to-date cervical screening
10. Proportion of patients with diabetes with a blood pressure result

Partnering with La Trobe University on local issues

The Grattan Institute's 2016 '*Perils of Place*' report, identified that the Murray PHN region has two 'hotspot' areas for ear, nose and throat issues in Donald and Swan Hill.

A hotspot is described as a 'small area with relatively high risk or incidence of a particular health problem.'

Murray PHN is collaborating with La Trobe University to provide a student the opportunity to participate in a three-year PhD research project.

The project will help to increase knowledge of the extent of the challenge of the local communities, not only providing a basis for upskilling local health care professionals but improving regional care provision. It will also help to inform health planning across the entire Murray PHN region and beyond.

Federal Member for Mallee Dr Anne Webster, La Trobe Mildura Head of Campus Deb Neal and Murray PHN Regional Lead Donna Sedgman

Students designing population health indicators

Murray PHN collaborated with La Trobe University to provide a 10 week project-based learning experience for three final-year Occupational Therapy students.

The aim of the project was to develop a suite of population indicators using frameworks that defined, described and predicted the health needs of the Murray PHN region. These frameworks focused on three strategic priority areas of mental health, children and older adults.

Population health planning aims to improve the health and wellbeing of whole populations. The development of a Health Indicator Framework for Murray PHN contributes to improving the health status of the population, acknowledging the impact of factors external to the health system, and actions broader than addressing personal risk factors.

Natalie Tremellen, Madie Vale, Claire McClenaghan, Kye Pearce and Kate McIntosh

Final frameworks will be uploaded onto PHN Exchange to enable the primary health care workforce across the region to access important health-related data about their local population. This will assist primary health care providers to tailor their services where needs or gaps exist.

For information on PHN Exchange, visit phnexchange.com.au or see page 48.

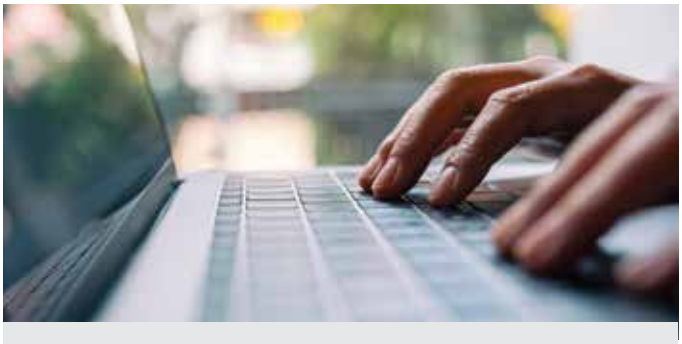
Supporting emergency response in general practice

Rural and regional general practices play a significant role in a community's response to any emergency, so it is important for them to consider the impact of emergency events on business continuity and the vital need to provide health care during emergencies, with potentially increased demand.

General practices across our region this year took part in a pilot program that provided free access to the Emergency Response Planning Tool (ERPT), an online template that helps improve planning to prepare for, respond to and recover from the impacts of emergencies such as fire, flood and cyber-attack.

Funded by the Victorian Department of Health and Human Services (DHHS), the pilot program provided free access to the ERPT, which is managed by Healthpoint ANZ and developed in collaboration with the Royal Australian College of General Practitioners.

Murray PHN partnered with Healthpoint ANZ and DHHS to encourage practices across our region to sign up to access the ERPT. By September this year, 78 general practices (52%) in the Murray PHN region had registered for the pilot program with 49 completing their plans and 24 undertaking training on how to use the system.



"Setting up the Emergency Response Planning Tool (ERPT) for our practice was an easy process. We were provided informative and helpful support in the setup stage, and the system as a whole is very user friendly. Prior to the ERPT, we had some emergency policies and procedures in place; however I felt this would be a more extensive tool. We haven't had to use it yet, but I'm confident that if put into action, any staff member would be able to pick it up and take action. It's a valuable tool that has given me peace of mind."

Anna Pezzaniti, Practice Manager
Ontario Family Practice

Reducing harm from prescription medicines

The increasing harmful use of prescription medicines, such as opioids and benzodiazepines, is a major public health concern. In 2017, 1612 people died from drug-related causes, and of those 33 per cent were due to the overuse of opioids.

SafeScript is Victoria's real-time prescription monitoring system. It came into effect in April 2019 and is aimed at reducing the growing harm from prescription medicines.

Murray PHN has been working with local health services and pharmacotherapy networks to determine gaps and opportunities and potential new models of care. By increasing alcohol and other drug (AOD) prevention and early intervention, it will reduce the impact on individuals and communities and the demand for acute and specialist AOD treatment.

To assist clinicians, Murray PHN has held more than 20 CPD events - from Castlemaine to Barooga and Swan Hill to Wangaratta - on preparing for SafeScript, pain management, and safer opioid and suboxone prescribing. Several referral pathways have also been developed to assist GPs, pharmacists and AOD professionals. For further information, visit: murrayphn.org.au/safescript

Addressing bushfire trauma

Ten years have passed since the 2009 Victorian Black Saturday bushfires, with 2019 marking a significant anniversary of what has been recognised as one of Victoria's most devastating tragedies.

Anniversaries of trauma-related events can often trigger uncomfortable symptoms such as difficulty sleeping, excessive worry, moodiness, nervousness, poor concentration and fear. Traumatic events affect the whole of people's lives and everyone copes and recovers differently.

The Bushfires of 2009 Community Support Committee formed in response to the approach of the 10th anniversary. The objective of the committee was to ensure appropriate and trauma-informed mental and community health supports, broad communication of services available and capacity building to support communities and service providers. Committee members attended over 30 commemorative events and organised for mental health first aid training to be delivered in four locations.

The committee was composed of representatives from Murray PHN, the Department of Health and Human Services (DHHS), Alexandra District Health, Nexus Primary Health, the Australian Primary Mental Health Alliance (APMHA), Eastern Melbourne PHN, Murrindindi Shire Council, Mitchell Shire Council, Lower Hume Primary Care Partnership and Goulburn Valley Health.

The project was established by the DHHS in response to the possible need for increased community-based mental health, medical support and community capacity building - in Mitchell, Murrindindi, Yarra Ranges, Whittlesea and Nillumbik regions - in the lead up to, during, as well as after the commemorations of the 2009 bushfires. APMHA was engaged to help connect people with local services.

Outcomes:

- 2000+ people offered support
- 100 per cent health professional packs distributed
- 39 people accessed mental health counselling
- 28 community-run commemorative events
- Six telephone counselling sessions
- Four mental health first aid sessions
- Four health provider webinars
- Two media training events

Monique Ataryniw, APMHA Education and Marketing Coordinator with Renee Hayden APMHA CEO

Providing support beyond the bushfires

APMHA CEO Renee Hayden says that the experience of trauma can typically last days, weeks or even years. Experiencing recurrence of trauma is also not unusual, and people will often require additional support during times of anniversaries and commemorative events.

On the 10th anniversary of the Victorian Black Saturday Bushfires, APMHA had five teams attend 30 commemorative events, with more than 1200 community members estimated to have taken part.

"Our team was welcomed and accepted everywhere we went. People found our resources, particularly our tailor-made self-help book called '*Beyond the Bushfires*' and our support cards. With Murray PHN's support, we were extremely humbled and honoured to be able to provide support and promote ongoing counselling services in the region during such an emotionally charged time."

We use knowledge to improve health and shape our health care system

knowledge

Determining local health needs

Murray PHN generates a full Needs Assessment every three years and updates it annually to reflect emerging or changing issues. The Needs Assessment is a population health-based analysis of the health needs of our communities.

Combined with the national health priorities set by the Commonwealth Government, our Needs Assessment helps Murray PHN determine our region's local health priorities. Those priorities in turn inform our Activity Work Plans, which are the 'blueprints' for our work and the effective distribution of funding.

From this point, individual projects are planned, designed and delivered to meet the goals set in each of the Activity Work Plans. When a new project starts, staff involved are responsible for developing a project brief, project plan and other documents that reflect on and state how the project aligns with our Strategic Plan.

By doing this, all projects and their associated activities and tasks work together to fulfil the purpose of the strategic directions and values of the organisation – all with the aim of improving health outcomes in our community.

The leading issues identified across the catchment include:

- higher avoidable mortality rates, poorer cancer survival rates, and lower life expectancy than metropolitan areas
- high rates of psychological distress, self-harm and suicide; limited access to specialist mental health services and targeted mental health care
- ageing rural population within the Murray PHN catchment placing pressure on access to health services to support healthy ageing; limited access to geriatricians and GPs in aged care
- emerging health service access issues in refugee health, women's sexual and reproductive health services and child health
- health needs of diverse local Aboriginal and Torres Strait Islander communities
- high numbers of potentially avoidable hospitalisations for chronic obstructive pulmonary disease (COPD) and diabetes complications
- improved multidisciplinary coordination of care is required for people experiencing chronic disease, especially at the interface between acute and primary health care services
- changing landscape of general practice such as working conditions (on-call and after-hours), MBS billing changes, and patient expectations having disproportionate impacts in rural areas
- digital health challenges, with system limitations including internet reliability and software incompatibility.

Seasonal populations and their impact on the health system

The Murray PHN region covers 100,000 sq km of land bordered by the Murray River and home to the Victorian ski fields, both of which enjoy significant seasonal inflows of tourists and temporary residents. Our region also has grape, citrus and other agricultural areas which host a substantial seasonal workforce.

This population variability across the Murray PHN region is a persistent challenge for population health and other service-based planning.

Tourism Research Australia recognises 17 Local Government Areas (LGAs) in the Murray PHN region with a tourist profile. This means there are significant visitor numbers compared to resident population. Based on this data, the LGAs of Greater Bendigo, Albury, Macedon Ranges, Greater Shepparton, and Campaspe all have annual visitor numbers of more than 1,000,000 per year. However, when visitor numbers are compared with resident populations, the LGAs of Murrindindi, Mansfield and Alpine all report more than 50 visitors per resident each year.

The impact of seasonal and tourist populations, and inaccurate estimates of residential populations, result in an increased and unplanned demand on in-hours and after-hours primary care, urgent care centres and emergency departments.

A recent population estimation exercise by Swan Hill Rural City Council aimed to find a more accurate measure of the daily residential population of Robinvale, given the substantial evidence that the town's actual population is higher than the official Estimated Residential Population (ERP) calculated by the ABS.

Modelling of the actual population was based on bank and water usage data – bank data reviewed regular transactions of goods and services within Robinvale, and water data used residential water consumption – to estimate population based on a typical per capita consumption in a comparable rural area.

The modelling indicated a population of approximately 7900 residents – more than two and a half times the ERP of 3359.

Understanding general population health

The populations of the Murray PHN region are diverse with significant communities of Aboriginal and Torres Strait Islanders, newly arrived humanitarian settlers, ageing communities, rural isolation and those experiencing financial disadvantage. A significant proportion of the catchment is rural, leading to additional vulnerability related to climate events such as drought, flood and bushfires, all of which have occurred in the region in the last decade.

There is diversity in the services, stakeholders and places (regional and rural centres and outlying communities) within the Murray PHN region. All of these characteristics contribute to the range of health and service needs identified across the health priorities and captured by our Needs Assessment.

This general population health section provides an overview of the health of our population, with a specific focus on the social determinants of health, health-related risk factors and behaviours, prevention activity such as cancer screening and immunisations, and vulnerable population groups. Most of the information presented here relates directly to the prevalence of our health priorities and should be considered in a comprehensive approach to primary health care. These factors can strengthen or undermine the health and welfare of individuals and communities.

Key issues:

- The age distribution in the Murray PHN region demonstrates an older population when compared with the Victorian and Australian averages
- Fifty-five of the 68 Statistical Areas (SA2 level) in the Murray PHN catchment have SEIFA scores less favourable than the Victorian average, and 19 areas are classified as extreme in terms of SEIFA and remoteness
- There are emerging issues regarding women's health across the catchment
- New settler and refugee arrivals are significant for our region
- The Murray PHN region as a diverse range of Aboriginal and Torres Strait Islander communities representing approximately 28 per cent of the total Victorian Aboriginal and Torres Strait Islander population
- Higher avoidable mortality rates (compared to the Victorian rate) exist for 15 of the 22 LGAs within the Murray PHN catchment and life expectancy in the Murray PHN region is lower than the national average
- Victorians living in regional and remote locations have a poorer cancer survival expectancy: approximately four per cent lower than those who live in Melbourne
- More than 50 per cent of LGAs within Murray PHN's catchment have cancer screening participation rates that are lower for breast, cervical and bowel cancer compared with the Victorian average
- Fourteen of the 21 LGAs within the Murray PHN region have higher rates of people delaying visits to dental professionals due to cost, and timely access to public dental clinics is limited in our region.

Climate change and its impact on health

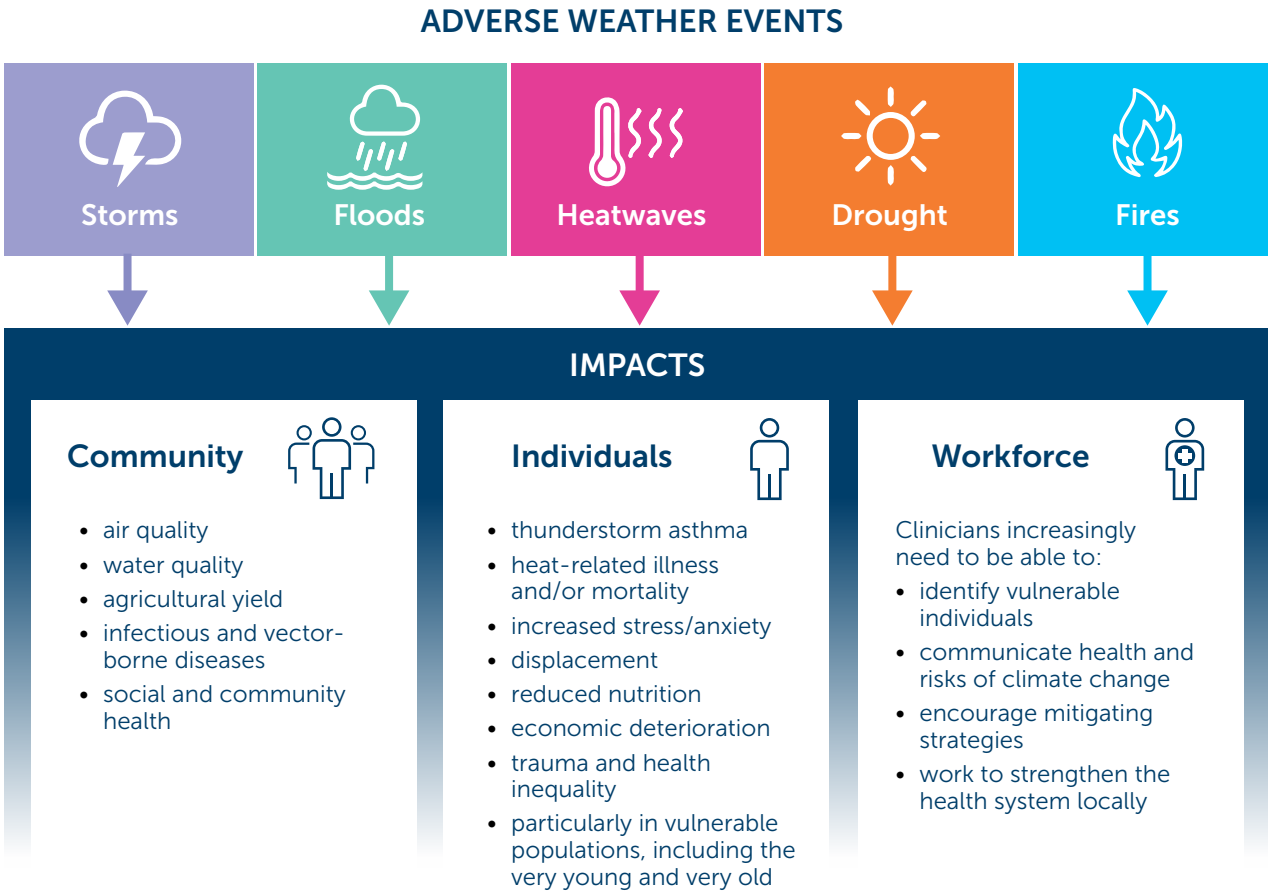
The rural and regional communities within the Murray PHN region are vulnerable to the impact of climate change and the effect on human health through both direct and indirect environmental changes. Direct climate change will impact health through increased morbidity and mortality resulting from higher temperatures and heatwaves. Vulnerable groups include infants and young children and the elderly as well as those with pre-existing cardiovascular and respiratory diseases.

Analysis of the Victorian heatwave of January 2014 demonstrated increases in all of the following indicators during, or immediately after, the four-day heatwave:

- Emergency department presentations
- High acuity emergency department (ED) presentations
- Deaths in, and prior to, arrival at public hospital EDs
- ED presentations involving:
  - Heat-related conditions
  - Diseases of the circulatory system
  - Mental and behavioural disorders
- Ambulance emergency dispatches
- National Home Doctor Service heat-related consultations
- Nurse-on-Call heat-related consultations
- Deaths reported to the coroner
- Death admissions to the Victorian Institute of Forensic Medicine
- Total deaths (24 per cent greater than expected).

The indirect impacts of climate change result from the effect of climate and climate events on other areas such as agriculture, bushfire, infectious disease distribution (via mosquitos and other vectors), along with social change such as migration, conflict and impairment of livelihoods due to drought and flood. Vulnerability to climate change will therefore impact rural and regional communities disproportionately and highlights the emerging role of the rural health workforce in identifying, reducing and managing the adverse health effects of climate change.

Both the Royal Australian College of General Practitioners (RACGP) and the Australian Medical Association released position statements in 2019, acknowledging the consequences of climate change on health, and the subsequent impact on the health system and workforce. The RACGP statement identifies key roles for general practitioners and promotes a framework for primary health care to improve health by mitigation and adaptation to climate change.



Health Voices

Specific health knowledge and experience helps us to work together and achieve our goal of improving health outcomes for the people in our region.

While not everyone can be an advisory council member, anyone can be a Health Voice. Join the online community at: murrayphn.org.au/healthvoices

"I'm passionate about being a Health Voice as regional communities tend to be marginalised. It's important that our standard of health care and access to services be the same as metropolitan areas."
Karina Walker, North East Community Advisory Council

"People don't seem to be concerned about health until they're sick. We need as many people as possible to register to be a Health Voice and have input into the types of services that we develop for our community."
Peter Hopper, North East Community Advisory Council

What we heard about health navigators

We know that many people find it difficult to access the health system due to its complexity. It's a system with multiple moving parts, including intricate funding models, patients with complex, chronic and diverse needs, and numerous interventions and treatment options.

In April 2019, we asked our Health Voices for their thoughts on a new model of care that could put 'health navigators' into local communities.

Health navigators are knowledgeable people who would help community members access or evaluate health information. They would be locally accessible an help create better links to community and health-based resources.

What we heard was that while most people were confident in filling out medical forms, a quarter of Voices said that they sometimes needed help with understanding medical information.

Overwhelmingly, Voices felt that those who would benefit most from the service would be vulnerable groups and people without strong support networks, while those who are carers felt it could take some pressure off their load.

Maintaining confidentiality of information, particularly in smaller towns was a key concern. While health professionals were seen to be the most appropriate choice for health support, 41 per cent believed a health navigator could be anyone in their community, provided that people's information was kept private.

"This kind of service is desperately needed for our community for all ages but especially the elderly."

"Health literacy is the key. That might be professionals but given regional workforce challenges, volunteers might be the only option in some areas."

Advisory councils sharing knowledge

Clinical Advisory Council

The Murray PHN Advisory Council structure supports the primary health care sector by providing a forum to test, understand potential impact and seek feedback on the commissioning work of Murray PHN, from a clinical and community perspective.

On 1 March 2019, Murray PHN was pleased to host all six Advisory Councils in our annual joined up event. Clinical, community and Indigenous council members came together to hear about complexities of the local health system landscape, issues and opportunities in primary health care, and to share knowledge, plan and set priorities for the coming 12 months.

Murray PHN's Clinical Advisory Council is made up of a range of health professionals from across our catchment, including GPs, chronic disease nurses, specialists and mental health professionals.

Their significant observations and reflections, provided to the Murray PHN Board, have this year included the impact of climate change on the health of our community, mental health and suicide prevention activities, local issues related to child health, opportunities for collaboration, and commendation for coordinating aged care forums (page 27) and leading integrated health networks (page 46).

As council matures, workplans will build to include clinical governance, helping us to ensure the programs that we fund are delivering consistent, safe and quality health care across the region.

Kathryn Cunning, Dr Chris Atkins, Angela Lawrence, Dr John Buckley, Emma Williamson, Dr Wendy Connor, Dr William Walton and Matt Jones, Jade Cartwright, Catherine Sambell, Susan Watson, Susan Kennett, Janice Radrekusa and Penny Wilkinson. Absent: Dr Naomi Malone, Dr Richard Bills, Dr Mark Savage and Paula Noble.

CEO Matt Jones speaking at the Murray PHN annual joined up event

Community Advisory Councils

In late 2018, council members gathered more than 800 responses to questions about primary health care and the primary health care system to help Murray PHN understand the local issues and opportunities that exist in our rural and regional communities.

Between January and March 2019, Community Advisory Council members had conversations with their communities about care coordination, technology and telehealth. The feedback provided a variety of opinions, concerns and the participants' own ideas for Murray PHN to consider in its subsequent deliberations.

Helping communities learn mindfulness

Murray PHN engaged Smiling Mind, one of Australia's leading mindfulness organisations, to deliver eight mindfulness meditation workshops for residents across our region in Benalla, Cobram, Cohuna, Numurkah, Seymour, Shepparton, Swan Hill and Woodend.

Smiling Mind's program was suggested by Goulburn Valley Community Advisory Council chair Jo Kinder, with the three other community advisory councils further committing their support to the program. Jo helped organise a 'sold out' event in Shepparton, which was live-streamed to four other locations and more than 200 community members. Jo focused on inviting people connected to early years education, sports and volunteer groups. She hoped to help young people learn practical skills, particularly as one in three young Australians experiences high or very high levels of psychological distress.

Council chair Jo Kinder with Smiling Mind facilitator Ben Robbins

There are so many stresses in our small allied health team, which leads into strained staff meetings. We have now introduced self-compassion and mindfulness, which we practice for five minutes before each meeting and you can actually feel everyone's breathing starting to calm in the room.

Providing pathways to quality care

HealthPathways is an online portal designed to be used by general practice at the point of care to guide best practice assessment and management of common medical conditions, including when and where to refer patients. It's also available to medical specialists, nurses, allied health and other health professionals for use within their scope of practice.

Tasmanian and Victorian PHN HealthPathways staff

Three of our Murray HealthPathways staff - Chris Fishley, Dr Ann-Maree McKinnon and Annie Bence - attended a regional forum in Geelong in March 2019. The forum brought together all seven Victorian and Tasmanian PHNs and the company behind the pathways platform - Streamliners. The teams meet three times a year to share and collaborate, helping to improve efficiency across the system.

Cardiology pathways suite

A suite of 50 cardiology pathways was localised to our region in March 2019, covering 18 topics with 32 subpages. The pathways cover hypertension, heart murmurs, warfarin management, and rehabilitation. They incorporate new guidelines, particularly for cardiac failure and atrial fibrillation.

The suite represents more than 12 months of hard work by the clinical group and aims to help address one of the leading burdens of disease in our region – heart disease.

Clinical working group members:

- Dr Voltaire Nadurata, Cardiologist, Bendigo Health
- Jenny Miko, Cardiac Liaison Nurse, Bendigo Health
- Dr Ewa Piejko, Murray PHN Medical Advisor and GP
- Megan Carroll, Allied Health Team Leader, Cobaw Community Health Service
- Antoinette O'Shaughnessy, Manager Complex Care, Castlemaine Health
- Christine Gibbons, Health Services Coordinator, Bendigo and District Aboriginal Co-operative
- Kathryn Cunning, Practice Nurse, Golden City Medical Practice

Dr Voltaire Nadurata: *"HealthPathways provides an excellent guide in the management of cardiac conditions with focus on the local setting. It should also help streamline investigation and the referral process, thereby improving patient experience in treatment of their condition."*

Dr Ann-Marie McKinnon has been a Clinical Editor with Murray PHN since the implementation of HealthPathways more than three years ago and was the lead editor for the cardiology pathways*: "My favourite feature of HealthPathways is the patient resources (from peak bodies and interest groups etc), which can be printed from a single source, rather than visiting individual websites. I am a fan of whatever saves me, as a practitioner, time. The resources are designed to be accessed by a GP during a consultation with their patients however, they can also be used by doctors in local hospitals, nurses, pharmacists and allied health staff."*

Active users:
3779

Total page views:
99,978

Total localised pages:
474

Pages in review:
20

Currently localising:
45

Pathways contributors:
225

Top 10 page views

Non-urgent Adult Mental Health Referrals	557
Contraception	332
Mental Health Referrals	306
Hypertension	304
Rhinosinusitis	264
Antenatal - First Consult	234
Heavy or Irregular Menses	225
Inflammatory Arthritis	225
Menopause	217
Polycystic Ovarian Syndrome (PCOS)	211

Top 5 suites viewed

Mental Health	482
Women's Health	373
Medical	339
Child Health	280
Cardiology	261

Top 10 search terms

Hypertension	206
Diabetes	151
Gout	142
Sinusitis	110
Asthma	107
Contraception	83
Hyperthyroidism	80
Shingles	76
Haematuria	75
Migraine	73

Understanding end of life care

Victoria became the first state to offer voluntary assisted dying (VAD) in June this year.

Voluntary assisted dying means that a person in the late stages of advanced disease can take a medication prescribed by a doctor, to bring about their death at a time the patient chooses. Only people who meet the conditions and follow the process set out in the law can access the voluntary assisted dying medication.

Murray PHN respects VAD as a personal choice for patients, doctors and other health professionals. Our role, as with all the work we do, is to help facilitate partnerships between different parts of the health system and work towards equity of access in the provision of excellent health care for our rural and regional communities.

Our Murray HealthPathways team has created a VAD pathway to help health practitioners navigate the new VAD Act, which includes guidance, support and resources for health professionals and patients. To access the pathway visit: murrayhealthpathways.org.au

Maintaining a skilled rural health workforce

More than 215 GPs in our region have been given a free subscription to access 5000 recorded lectures and almost 2500 hours of content, through a Murray PHN fully subsidised Armchair Medical TV subscription.

Murray PHN is aware of how busy GPs are and the flexibility to view lectures on a phone, tablet, computer or chromecast enabled TV, allows GPs to expand their knowledge in their own time and place.

Lectures are regularly added, enabling GPs to receive the most up-to-date information in their field of interest without the need to leave home. Lectures can be browsed by area of disease e.g. addiction, allergy, arthritis or asthma or by conference name.

Conferences include the Australasian Melanoma Conference and the National Diabetes Forum, and from presenters from organisations such as the Peter MacCallum Cancer Centre and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

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

Top five videos

1. No Jab No Pay Play Immunisation: Is the juice worth the squeeze?, Associate Professor Julie Leask
2. Risky Patient Billing: A Case Study, Dr Anchita Karmakar
3. Of mice and medical regulators, David Gardner Lawyer
4. The consequence of asking a simple question, Anchita Karmakar Doctor and lawyer
5. Dementia diagnosis and current treatment recommendations, Professor Sue Kurrie

Improving the timeliness of referrals

Since the implementation of the electronic referral system at Bendigo Health in 2017, eReferral numbers have continued to grow each month. More than 14,000 eReferrals have now been sent through the system. Due to its success, eReferral is expanding from the initial Loddon Mallee pilot site and into the Hume and North West regions.

The Loddon Mallee Rural Health Alliance has worked to help other local hospitals get on board, with Castlemaine, Echuca, Kerang, Kyabram and Rochester health services now able to send and receive electronic referrals.

Boort, Cohuna, Inglewood, Kyneton, Maryborough, Ouyen, Robinvale and Swan Hill are in the process of setting up their systems, with others expressing interest in joining.

Murray PHN continues to work with the pilot agency, Bendigo Health, and other health services across our catchment to assist GPs to install and use the software to refer patients to services electronically.

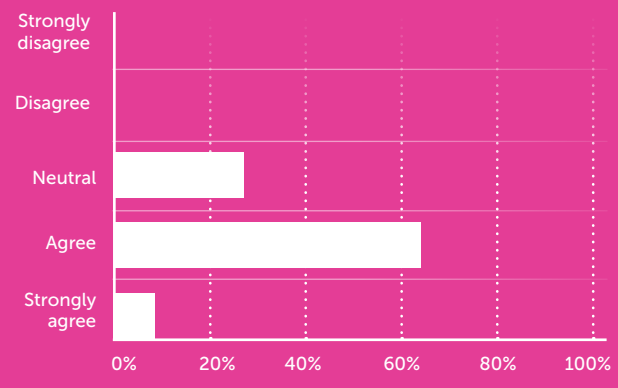
Most Central Victorian general practices are now live for sending eReferrals and are working towards a paper-free system, before an NBN upgrade and fax system changes.

After feedback from the initial pilot, a number of changes have been implemented, such as sending a receipt of referral and creating specific referral templates, including mental health and gynaecology.

Benefits

1. GPs save time filling out referrals
2. Hospitals don't have to chase up incomplete information
3. Patients' waiting time decreases

Has eReferral improved the quality of information provided about the patient being referred?



From a survey conducted by Bendigo Health to general practices

Support and capacity building

In our rural and regional communities, we know that health outcomes are disproportionately lower than areas of higher population density and that access to effective health services and skills remains a major issue.

Many small towns in our catchment are unable to recruit and sustain workforce to deliver the range of integrated services required to keep people with chronic disease well and out of hospital.

Key issues include labour and skills shortages, capacity and availability, work/life balance, emerging and growing industries and technologies, lack of training opportunities and sustainability in rural and regional areas.

Innovative and alternative workforce approaches are necessary to enable quality, timely and cost-effective care. The establishment of integrated health networks (page 46) and rostered GP after hours networks (page 50) are just some of the models that we are investing in to help avoid burnout, provide a better work/life balance and help spread the workload.

Health workforce support and capacity building through continuing professional development is also an important component of supporting and building a skilled and dedicated network.

In the past 12 months, we have provided a range of workshops, forums and continuing professional development training events from cultural safety, to the Medical Treatment Act changes, cybersecurity, suicide prevention and cancer survivorship.

CPD events:

Priority area	No. of events
Aboriginal and Torres Strait Islander health	4
Aged care	3
Alcohol and other drugs	16
Child health	7
Chronic disease	11
Digital health	11
General practice	27
Health workforce	16
Immunisation	5
Mental health	19

Murray PHN partnered with La Trobe University in November 2018, to bring Emeritus Professor Paul Worley - Australia's first National Rural Health Commissioner - to Mildura, to discuss rural health workforce challenges and opportunities within regional Victoria

Campaspe pharmacotherapy clinical network launched in March 2019. In October, we supported Professor Ed Ogden, Addiction Medicine Specialist to lead a discussion with GPs, pharmacists and Aboriginal health workers in Echuca on ways to manage clients locally

In September 2019, Murray PHN joined with Good Talent Media to offer a digital marketing workshop to help health professionals learn about using technology to reach target audiences, ensuring accreditation compliance and understanding website development and search engine optimisation

We foster new and better ways to improve health outcomes

innovation

Integrating health networks for better health outcomes

Australia's primary health care system is a fragmented collection of small-scale private practices, working in parallel with community-based services. The system developed through the 20th Century to manage infectious disease, accidents and episodic care but increasingly, the complex care management required to service chronic disease has challenged the transactional nature of the Medicare system.

While Australians are living longer and have more years in good health, the proportion of Australians with chronic illnesses has risen considerably over the last 20 years. In 2016, 50 per cent of Australians reported having at least one of eight common chronic conditions: arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease (COPD), diabetes, and mental health. In people over the age of 65, 75 per cent have at least one chronic disease.

Improving health outcomes for people in rural areas requires the development of a new way of providing primary care. To meet the needs of the rural communities in our region, Murray PHN has this year begun working with a range of stakeholders across government and health on the Integrated Health Networks (IHNs) concept. The IHNs imagine an aligned network of health providers across communities within a region, working together to improve access to primary care and deliver coordinated care for patients with complex or ongoing conditions. IHNs need locally responsive systems, robust clinical and corporate governance and incorporate technological and digital health enablers. Importantly, they are supported by a blended funding model.

We believe that IHNs will encourage development of a regional workforce model for future needs that does not rely on the local succession-based arrangements typical of the traditional general practice/private business model.

Care demand	Service supply
Complex chronic diseases requiring team based, multi-disciplinary care and care coordination	Difficulty in accessing the full team of health professionals required to deliver multi-disciplinary care
Expectation of localised and responsive in hours, medical and procedural, After Hours and emergency services	Ageing workforce where emerging health professionals are not attracted to the multi-dimensional nature of rural health care
Access to regionally based tertiary and specialist care	Ineffective incentives and structural barriers to enable remote and telehealth-based solutions
Patient expectations of quality, safe and evidence-based care independent of location of residency	Fragmented health care system and structural impediments to digital health solutions and information exchange

Organised regionally and delivered locally, IHNs can provide a platform for investment in primary and multi-disciplinary care, mental health and care coordination. Blended funded models based on fee-for-service, incorporating chronic disease complex care packages and activity-based block funding, can support and incentivise a flexible and mobile workforce to operate across primary and hospital settings.

We believe that IHNs will encourage development of a regional workforce model for future needs that does not rely on the local succession-based arrangements typical of the traditional general practice/private business model. An integrated team-based workforce model also provides greater opportunities for training, supervisory support, flexibility and career pathways.

Developed according to local context, an IHN facilitates local autonomy and ownership of the system of care, with a greater focus on community need, patient care coordination and population-based prevention strategies.

In many small communities, the prospect of replacing a retiring general practitioner is extremely unlikely.

A barely viable business coupled with relative professional isolation is not attractive for health professionals. Small rural hospitals rely on GPs for Visiting Medical Officer (VMO) and procedural services.

Locum services can fill short-term gaps but are extremely inefficient solutions that can compromise quality and continuity of care to patients.

The core group of primary health care services that all Australians should be able to access includes 24-hour medical care, maternal and child health, a range of allied health services such as physiotherapy, occupational therapy, psychology and counselling, aged and disability services, and public health and prevention services. Access to all of these services is variable, due to disjointed funding and accessibility, particularly in rural areas.

The current crisis in primary health care provision in rural areas is complex. While a lack of workforce is a key contributor to the crisis, there are other important factors to take into consideration, including the best ways to support a small, dispersed population, the opportunities for increased support, both clinically and in business solutions for solo or small group health professionals practising in the same region, the existing interdependency between the primary and acute system, and the importance of integration and care coordination for positive patient outcomes.

Murray PHN is committed to developing viable options to support improved health outcomes in our communities.

Scale

- 20-50k population
- Voluntary affiliation
- Commonwealth/ State funding

Functions

- Prevention
- Acute care
- Complex care
- Business support
- Capacity building

Systems

- Pathways
- Referrals
- Coordination
- Commissioning
- Monitoring

The evolution of PHN Exchange

When Murray PHN was established in 2015, it soon became clear that the organisation needed an effective way of aggregating and analysing large amounts of publicly available State and Commonwealth health data.

With additional data locally available, Murray PHN needed a system that would guide health planners to the most effective ways of commissioning health services to improve the health of our community.

In 2017, we launched Murray Exchange, a data portal that enabled our population health team to interrogate this data and pinpoint areas of increased rates of chronic or other priority illness (hotspots), and areas where health services were not available to meet these local needs (blackspots). These hotspots and blackspots give other health planners in our area additional resources, at no extra cost, to aid their important work.

Murray Exchange also offered permissioned access to general practitioners in our region, to help them with practice quality measurements in the lead up to the introduction of the Commonwealth's Practice Incentives Program Quality Improvement (PIP QI) measures (see page 32).

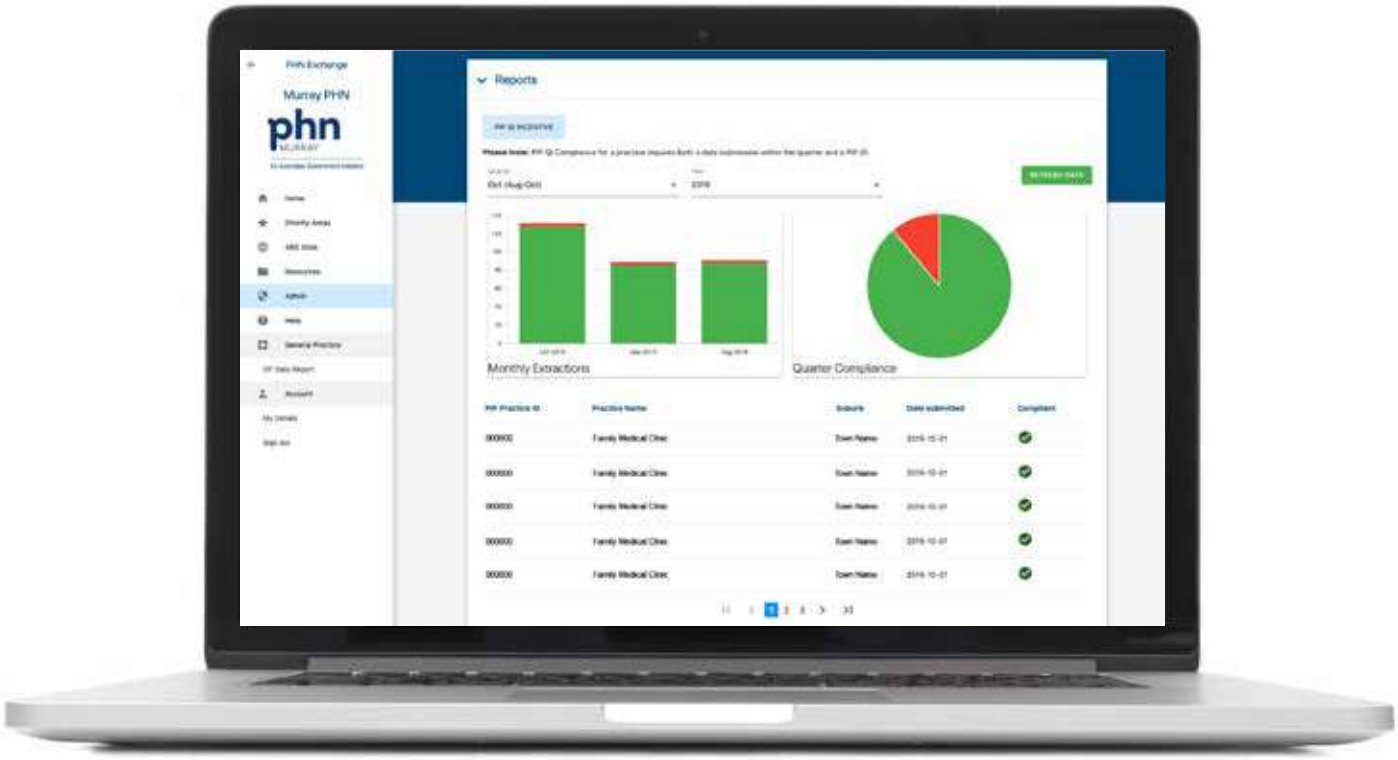
The open access, continued evolution and sophistication of the Murray Exchange brought this powerful system to the attention of other PHNs around Australia. Murray PHN recognised there was potential to assist PHNs that had yet to establish their own population health systems and to assist general practice across Australia through local PHNs.

During 2018 and 2019, Murray Exchange evolved into PHN Exchange, which is now being used operationally by four other PHNs – North Western Melbourne PHN, Darling Downs and West Moreton PHN, Western Victoria PHN and Primary Health Tasmania – with other PHNs interested to take part, as our capacity to expand the service also increases.

As a living needs assessment tool, PHN Exchange is specifically designed to localise data and information and deepen understanding about communities in a given region. It draws from a diverse range of more than 300 government and peak body data sets, providing views customisable by the user.

PHN Exchange is a web-based platform that blends information processing, data management and a range of extra resources to provide powerful visual representations that enable population health and other allied data to be presented in a user-friendly and easy-to-understand format.

The continued evolution of PHN Exchange has produced additional service offerings specifically for PHNs, including configuration of Microsoft Dynamics 365. This work draws heavily on Murray PHN's advanced development of its internal business processes and systems. Partner PHNs receive guidance from lessons learned by Murray PHN in the design and implementation of the PHN Exchange, including the change management involved in launching the GP Data Report.



GP Data Report

Designed and implemented by Murray PHN, the GP Data Report is an innovative web-based data reporting system accessible to GP practices in our region. Practices have made agreements to share de-identified clinical data with Murray PHN and in return access multi-benefit automated reporting.

Specific functionality has been built into PHN Exchange to support general practice, creating opportunities for PHNs and practices to participate in activities targeting shared priorities.

While practice involvement is voluntary, the Federal Government's Practice Incentives Program Quality Improvement (PIP QI) drives an incentive for more practices to be involved.

The GP Data Report is tailored for each practice and displays practice trends and regional and catchment-wide comparisons, so GPs can make informed decisions about their patients, workforce and practice. The automated reporting at an incidence level is unique to the GP Data Report and can interface with any of the multiple software programs currently used in the primary health care sector.

We are now in the testing phase of the GP Hub, a single place for a general practice to manage their data report, sign agreements, upload manual data, see their successful upload/data sharing rate and access a range of other resources.

Also in development, PHN Exchange will soon be able to generate an automated, printable population health snapshot, either by Local Government Area, or priority area.

phn eXchange

Our PHN 'in a Box' product for PHNs includes:

1. User accounts
2. GP profile
3. Controlled document register
4. Legislation register
5. Data dictionary
6. Enterprise-wide risk register and system
7. Counterparty risk register and system
8. Asset register

Future releases will include:

1. Project management
2. Request for service system
3. SharePoint configuration

The ABS Atlas is a web application designed and developed by Murray PHN that provides exploration and geographical visualisation of Australian Bureau of Statistics (ABS) data. The ABS Atlas allows users to define both the data set and type of region of any publicly released ABS data, in a user-friendly format.

A variety of licences allow registered users to customise location and dashboards or industry specific views to be able to share data and receive automated reports and to access other features of the PHN Exchange that are not publicly available.

As a living needs assessment tool, PHN Exchange was specifically designed to localise data and information and deepen understandings about communities in a given region. It draws from a diverse range of more than 300 government and peak body data sets, providing views customisable by the user.

Strengthening after hours services

Access to after hours primary health care is impacted by the shift in GP workforce towards a better work/life balance and the increased challenges of current business models to support on-call arrangements.

In 2019, we invested $648,000 as part of our GP Investment Strategy in after hours services. We asked general practices to work together to build partnerships across a defined regional area, to share after hours responsibility and offer a more sustainable option for communities.

Funding was available to general practice to increase, bolster or strengthen after hours services including use of assistive telehealth services. Successful practices could also use the funding for hardware/software systems, an 'on-call' retainer, extended clinic times, nursing triage and business support for the model.

Telehealth helping to improve after hours services

Some rural health services can't access GPs when they need to, due to availability, absence, or leave. It can mean they have no choice but to send patients to larger regional hospitals.

To provide improved access to after hours services and build capacity and support for workforce in rural communities, Murray PHN has provided Alpine Health (Bright), Boort District Health, NCN Health (Nathalia, Cobram and Numurkah), Cohuna District Hospital, Kerang Hospital, Mallee Track Health and Community Service (Ouyen and Sea Lake) and Numurkah District Health Service, Robinvale District Health Service, Rochester and Elmore District Health Service and Yea and District Memorial Hospital, with 'virtual access' to registered specialist emergency physicians through the My Emergency Doctor service.

During a 12-month pilot program, patients who arrive at one of the 10 pilot sites will be assessed and treated by a nurse. If needed, the nurse can receive real-time advice from an emergency physician, the most senior doctor in charge of a public hospital emergency department. Prescriptions, diagnostics such as x-rays, and referrals can then be emailed to the nurse.

Being one-hour from a regional hospital means that NCN Health's Cobram site has almost 5000 people present to their urgent care centre each year.

While Cobram residents have good access to GPs during business hours, many 'local' doctors live out of town.

With increased pressure on the after hours GP roster and to support the work of their RIPERN nurses (see page opposite), NCN Health didn't hesitate to apply to be part of the My Emergency Doctor pilot.

Cobram has been the largest user of the My Emergency Doctor service, with nurses finding it very quick and easy to use.

Patient feedback has also been positive, particularly as treatment can begin straight away, rather than waiting for the doctor and/or pharmacy to open the next day.

Michelle Collis, Nurse Unit Manager Acute, NCN Health Cobram

After hours helpline

The Healthdirect GP advice and support line is a health promotion program funded by the Commonwealth Government. It is aimed at reducing unnecessary emergency department presentations by advising community members of the alternative services available when their usual doctor or health service is closed.

Each year, Murray PHN leads a communication campaign aimed at raising immediate awareness but also longer-term retention. In 2019, we chose the Easter and school holiday period as the ideal time to launch a campaign and with it, a refreshed look.

The helpline is available to people living in, or travelling to country areas from:

- 6.00pm - 7.30am Monday to Friday
- midday on Saturday
- all day Sunday and on public holidays.

At the end of a call, a care advice summary will be offered, sent either by SMS or email, so people can easily recall the details of the advice given.

A summary of the call can also be sent to a person's regular GP practice overnight, so they are aware of the call when they open their surgery the following day. A summary can be uploaded to a person's My Health Record if agreeable.

Nursing staff expand care

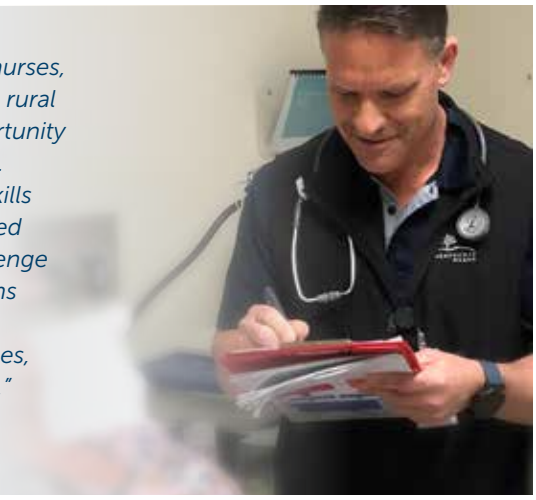
The RIPERN (rural and isolated practice endorsed registered nurses) scholarship grant program enables health services to expand their nursing workforce's care, particularly in regional areas where there is no or limited access to doctors, nurse practitioners, paramedics and/or pharmacists. RIPERN nurses can administer and supply a range of approved medicines for low risk conditions such as ear infections, small burns or tonsillitis.

Last year, Murray PHN funded two nurses from Heathcote Health through this program, doubling their number of RIPERN trained staff. After completing the training, the nurses have been able to treat patients quickly, reduce the time a patient has to wait to see a GP at hospital, or remove the need for a patient to have to travel to a doctor if one isn't available locally.

In June 2019, a new round of RIPERN scholarships worth $283,000 was awarded to 40 nurses across 15 health services in our region.

"Knowing how the role had been successful through our existing RIPERN nurses, the scholarships were viewed as a very good option for our staff, in a small rural health service, to expand their scope of practice. Staff jumped at the opportunity to apply for the scholarships to build on their existing skills and experience. Following completion of the RIPERN training, the nursing staff have new skills in administering and supplying a range of approved medicines and improved clinical assessment skills and documentation recording. The greatest challenge for our nursing staff is to be able to make clinical assessments and decisions while chasing advice from on-call GPs via telephone. Now there's less of a reliance on our on-call GPs, improved relationships between GPs and nurses, and increased skills, confidence and clinical leadership of endorsed nurses."

Gerry Canny, Director of Clinical Care Heathcote Health



My Health Record engagement

Between November 2018 and February 2019, Murray PHN facilitated and/or attended five or more local community events across the catchment each week, providing people with My Health Record information and exceeding the Australian Digital Health Agency's monthly engagement requirements.

Our digital health team went to a range of events to ensure that as many people as possible were aware of the benefits of having a My Health Record. My Health Record information was made available at agricultural shows, refugee and Indigenous-specific events, men's and women's groups, youth and sporting events, university and TAFE events, public libraries and shopping centres, community houses and groups, health events and shows, local councils, markets, fairs, forums and conferences.

Community engagement statistics to Feb 2019

- 169 engagement activities
- 92 presentations across the Murray PHN catchment
- 3346 discussions with individuals
- 1279 engagements in one month alone

Engaging allied health

Murray PHN hosted five free breakfast networking events in Albury/Wodonga, Bendigo, Mildura, Shepparton and Swan Hill for more than 80 allied health professionals during April and May 2019. The events included tips on how to register for the My Health Record, and copies of case studies designed to help allied health professionals understand how My Health Record could benefit their patients.

We created case studies focused on podiatry, psychology and the diabetic patient - showing how all parts of the care team can benefit from using My Health Record.

Natalie Tremellen, Murray PHN My Health Record team member

Potentially avoidable hospitalisations

Chronic diseases and their complications are key contributors to potentially avoidable hospitalisations (PAH).

Targeting a reduction in PAH is a specific objective of health care reform in Australia, with the goal of improving patient outcomes, reducing pressure on hospitals and enhancing health system efficiency and cost effectiveness.

Murray PHN has funded Benalla Health, Echuca Regional Health, Kerang District Health, Seymour Health, Swan Hill District Health and Northeast Health Wangaratta to identify and understand causes of potentially avoidable hospital admissions associated with chronic conditions, and work to understand and address local system issues.

Preventing multiple presentations

The Swan Hill area faces significantly higher rates of people with Potentially Avoidable Hospitalisations (PAH) for chronic conditions, compared with Victorian averages, and increasing each year for the past five years. Challenges for the local community include waiting periods to see GPs and medical specialists, and poor public transport options.

Swan Hill District Health was funded to:

- complete audits of their admissions, assessments, referrals and discharge forms
- strengthen partnerships to collaborate across acute, community and primary health care sectors to improve patient care transitions, understand and address barriers/opportunities, identify required support, and access available data to inform project recommendations
- engage with consumers accessing services to determine what their admissions were for and inform opportunities for improvement.

From the project, they found:

- the total of ED presentations in 2018 for clients with chronic obstructive pulmonary disease, chronic cardiac failure and diabetes was 452.

From the review, several recommendations have been adopted, including: engaging with clients who present multiple times to encourage participation in chronic disease programs; more thorough screening; providing resources at discharge; educating new staff and providing updates. They are also working more closely with general practice and specialists to promote local programs, improve referrals and reduce the likelihood of unplanned presentations in the future.

Kate Corrie, Paula Keane, Cobie Miller, Michelle Blohm, Helen White, and Luke Phelan from Swan Hill District Health

The Beechworth Health team with Francis Cheong from HealthBeats

Empowering patients

Murray PHN has partnered with health technology company Propell to deliver a pilot program that uses new wearable devices linked to a smart phone app, to reduce avoidable hospital admissions and improve patient health outcomes for people living with chronic disease.

Eligible patients living in Albury, Wodonga, Alpine, Benalla, Indigo, Mansfield, Towong or Wangaratta local government areas, are being offered an individualised care plan - available to them on their smart phone or tablet through the HealthBeats app. Eligibility includes patients who have been admitted to hospital or presented at an Emergency Department in the last six months for the relevant condition.

Over time, this technology will give patients far greater awareness of their condition, understanding what 'normal' looks like and what they can do to gain control - for example, patients with chronic obstructive pulmonary disease who have a high blood pressure reading, will be able to identify that they need to do their breathing exercises to lower their next blood pressure reading.

People will be given the option to purchase the equipment to help them continue with self-monitoring after the trial concludes. Supporting people to recognise and develop their own strategies to monitor their health conditions, will help them to live more independent and fulfilling lives.

The trial is being delivered in collaboration with Upper Hume and Central Hume Primary Care Partnerships and Northeast Health Wangaratta. A number of other health services, including Alpine Health, Albury Wodonga Aboriginal Health Services, Albury Wodonga Health, Beechworth Surgery, Beechworth Health Service, Benalla Health and Mansfield District Hospital, are also involved in the pilot.

We are accountable to our communities, partners, funders and each other

accountability

Governance and leadership

Murray PHN's operations are governed externally through the regulatory and operational landscape, primarily the Commonwealth Government Primary Health Network Guidelines, the Australian Charities and Not-for-profits Commission Act and the company's governing rules, outlined in key governance documents such as the Constitution, Board Charter and Code of Conduct and Board-approved policies.

Murray PHN is a public company limited by guarantee and a registered health promotion charity. The key governing document of the company is its Constitution, which was updated and approved in April 2019.

Murray PHN's primary objective is to "promote the prevention and control of illness and disease in human beings and to achieve measurable outcomes in the community".

All PHNs must adhere to the Department of Health's PHN guidelines, which contain several mandates that include establishing GP-led clinical councils, analysing local health needs, achieving value for money in commissioning decisions and employing a skills-based Board.

Every three years the Board approves a Strategic Plan that sets the company direction (page 54). This direction must always be in accordance with the company primary purpose and objectives, as per the company's Constitution.

Annually, the company reviews its operations to ensure compliance with the Australian Charities and Not-for-profits Commission governance standards.

Clinical governance

While Murray PHN is not directly involved in the provision of clinical services across our catchment area, we recognise the responsibility we have to ensure that the whole of our organisational effort and responsibility is aligned to support quality and safe health care through our commissioning and non-commissioning activities.

In recognition of our commitment to quality and safe health care, we developed a Clinical Governance Framework that was approved by the Board and implemented in September 2018.

The framework outlines the people, structures, systems and processes that provide the assurance that services and initiatives funded by Murray PHN are both safe and of high quality. It draws on the components of the National Model Clinical Governance Framework and applies these across the commissioning cycle of the organisation, to build a cohesive, whole-of-company orientation to improved quality and safe health care services. Implicit to quality and safe health services provided through commissioned services and projects, is collaboration with health services and a shared vision to work to high standards of safety and quality.

As the framework has now been in place for 12 months, we are conducting a review to evaluate how it has been embedded across the organisation, address any improvements required and ultimately, ensure it is strengthening safety, quality and continuous improvement in our work with service providers.

Our organisational effort and responsibility is aligned to support quality and safe health care.

Board

Ms Yvonne Wrigglesworth
Yvonne Wrigglesworth is Director of Governance & Strategy and Regional Strategic Planning Consultant at Bendigo Health. A former City of Greater Bendigo councillor, Ms Wrigglesworth also has 20 years' experience in the health sector, having worked in general practice management, the acute health sector, clinical trials and research.

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

Ms Leonie Burrows
Leonie Burrows is a management consultant and company director, with 25 years' experience in local government. With extensive experience in regional development, agriculture, education and strategic planning, Ms Burrows is also Chair of Sunraysia Community Health Services, and the Mallee Regional Innovation Centre.

Mr Ted Rayment
Ted Rayment has held many CEO positions including Swan Hill District Health, Royal Hobart Hospital and Canberra Hospital. He has been deputy chair of the Loddon Mallee Rural Health Alliance and director of the Health Roundtable and Royal Hobart Hospital Research Foundation. This year, Mr Rayment completed a three-month locum as Director of Public Health Services & Government and Chief Medical/Health Advisor to the St Helena Government. He has now accepted a one-year term in this position from January 2020.

Mr Fabian Reid (Chair)
Fabian Reid began his professional career in education before moving into politics in the 1980s, where he held a senior advisor role to the Premier of Victoria. An experienced Chair and Board director, Mr Reid has extensive understanding of regional and rural communities. He has consulted to organisations including Haven; Home, Safe, VicRoads, City of Greater Bendigo and is a director of Access Australia Group and has served as Chair of Bendigo Youth Coordination Group, the Bendigo Regional Advisory Board for La Trobe University, and the Goldfields Local Learning and Employment Network. Mr Reid was also a Director of the Golden Dragon Museum and convenor of the Bendigo - A Thinking Community Reference Group.

Message from the Chair

Our role is to improve health outcomes. It is important to remind ourselves that, by international standards, Australia has a very good health system. While that system is based on the concept of universal access to health care, there is great variability across Australia in the quality, equity and accessibility of health services.

We rely on what can be a fragmented health care system with Commonwealth, state and privately funded services operating independently of each other. Add to that the evolving nature of health care needs associated with significant increases in chronic disease and mental health, our capacity to ensure the right care is provided at the right time and place is challenged.

We need primary care coordination that supports responsive health care that is targeted to needs and tailored to regional capacity and context. That is the responsibility and the opportunity that Murray PHN is embracing.

As one of 31 PHNs across Australia, our contribution is to provide improvements simultaneously at three distinct levels of health care within our region. We strive to deliver system change that increases integration and coordination of health care across our region. We support service delivery improvements at a community level. We provide avenues for improved patient care at an individual practitioner and patient level through access to quality and evidence-based information to improve clinical care. Our approach is to engage our partners and communities in devising health care improvements at all three levels across our catchment region. I want to thank all the members of our four Community Advisory, Clinical Advisory and Indigenous Health Advisory Councils for their input and contributions to our planning efforts.

We need primary care coordination that supports responsive health care that is targeted to needs and tailored to regional capacity and context.

Fabian Reid (Chair)

Our commitment to role and responsibilities is evidenced in our strategic plan. We support change to Make a Difference to our communities. We are accountable to our communities, our funders and ourselves. Murray PHN invests significant time and effort to ensure our strategic direction is supported by robust governance systems and processes. I thank the members of the Murray PHN Board for their commitment to our organisation and their focus on our communities. Our people are our strongest asset and I express my gratitude to the Murray PHN team and our Executive for their continuing and tireless efforts.

I regard it as a great honour to chair an organisation like Murray PHN, which accepts and embraces the opportunity to Make a Difference to our communities.

Dr Talitha Barrett
Dr Tali Barrett is a private general practitioner and GP associate with Eaglehawk Medical Group since 1994. She has 22 years' experience as a director, with 14 years as Chair of Boards including the Loddon Mallee Medicare Local, the Central Victorian GP Network, Bendigo Division of General Practice, and Victoria Felix Medical Education. Dr Barrett is a supervisor of GP registrars within general practice and has also served on various AMA Victoria committees. In 30 years of general practice, Dr Barrett has worked in community health, prison health and Indigenous health.

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

Dr Chris Atkins
Dr Chris Atkins is a GP and director of Brooke Street Medical Centre, Woodend. Dr Atkins is involved in acute and emergency care, paediatrics, aged care, adult health and chronic disease management. He is also a qualified lawyer, practising in health law and tutoring at Monash Rural Medical School, Bendigo and chairs the VMO group at Kyneton Health.

Dr Alison Green
Dr Alison Green has been a GP associate in Wodonga since 1991. A GP obstetrician providing maternity services to Albury Wodonga Health for 25 years, Dr Green has also been a GP supervisor educating medical students, GP registrars and GP obstetric registrars. She has more than 10 years' experience on boards and committees.

Yvonne Wrigglesworth, Professor Hal Swerissen, Leonie Burrows, Ted Rayment, Fabian Reid, CEO Matt Jones, Dr Talitha Barrett, Victor Hamit, Dr Chris Atkins, and Dr Alison Green

Executive team

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

Making it happen can only work when we have strategic relationships with our primary health care services. Penny leads how we translate health priorities and strategy to deliver better access to quality service delivery and collaboratively build service system improvement.

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

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

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

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

Penny Wilkinson, Janice Radrekusa, Matt Jones, Anne Somerville, Elizabeth Clear

Message from the CEO

In their simplest form, PHNs are primary health care coordinating organisations.

Funded predominately by the Commonwealth Government, PHNs develop models of care that improve health outcomes in areas of specific, prioritised need. The intention behind the establishment of 31 PHNs providing primary care coordination across Australia was to recognise the variability of need and capacity in our respective regions and to enable local context that would support local decision-making capability.

So PHNs are in the business of developing place-based solutions. By their very nature, place-based solutions must be responsive to local need and in regional and rural Australia, they must incorporate existing capability through collaborative models that support partnerships and integration.

The challenge for enabling effective place-based solutions in many of our communities is that our starting points need to be based in building capacity before we can generate opportunities for greater primary care coordination.

Murray PHN's approach to developing place-based solutions comes through our fundamental commitment to building partnerships between providers of health care.

Our efforts to address the complex needs of chronic disease patients depend on the ability of the primary care health system to provide team-based care.

An effective, coordinated primary mental health system needs to be able to provide access to a stepped model of care that in turn enables health care to correspond to the specific and changing mental health needs of our patients.

Providing improved access, equity and quality of place-based care draws on the ability of multiple providers working collaboratively across a region, within their communities, to improve care to those communities.

This approach moves the health system away from a purchaser-provider model. It also moves us away from one-stop-shop, one-size-to-fit-all approaches, to new

Murray PHN's approach to developing place-based solutions comes through our fundamental commitment to building partnerships between providers of health care.

Matt Jones (CEO)

or refreshed models of care designed according to local and regional need and context. These new models must incorporate and build on local capacity in an organised, connected and integrated manner.

The Australian health care system has never been under more pressure in its ability to address the needs of regional, rural and remote Australians. Our health system works best in areas of high economic capacity that comes from large populations, living in close proximity. These are not the characteristics of regional Australia nor much of the Murray PHN region.

We must continue to develop approaches in regional Australia that address the complex needs of our communities, the evolving nature of workforce capacity and the expectations of our health professionals. To that end, Murray PHN has developed a concept known as Integrated Health Networks, that builds partnership between providers of health care across a region, enabling greater investment of team-based care, in team-based working environments, at a community level.

Across our organisation, Murray PHN understands that effective primary care coordination in our region is much more than the allocation of funding for improved models of care. We have a strong Board, an engaged team and a clear commitment to generating place-based solutions for our communities, working in partnerships and investing in building capacity to improve the access, quality and equity of health care in our region.

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

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

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

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

Setting our vision for better health

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

Those objectives have underpinned the development of our strategic plans since 2015. Our current 2018-2021 Strategic Plan defines our vision to make a difference to the health of our community, by making it better, making it happen, making it together and making our organisation stronger. Our full Strategic Plan document can be read on our website at murrayphn.org.au/about/corporate-documents/

The Board and Executive of Murray PHN are committed to achieving our strategic aims, which combine to deliver on our purpose of improving health outcomes and our understanding of how we have achieved this.

As we reach the midpoint of our plan, the Board has undertaken a review to evaluate and recalibrate our strategic direction in 2020 and 2021. Our "traffic light" evaluation of progress against our actions can be seen below. While we are pleased with results to date, we understand that we still have significant work to undertake to fully achieve all 15 strategic actions.

The overarching vision statements in the Strategic Plan are supported by our Needs Assessment, a population health-based analysis of the health needs of our communities. This in turn informs our Activity Work Plans (AWPs), which are the 'blueprints' for our work and the effective distribution of funding.

From this point, individual projects are planned, designed and delivered to meet the goals set in each of the AWPs. By doing this, all projects and their associated activities and tasks work together to fulfil the purpose of the strategic directions and values of the organisation.

Our progress

MAKE IT BETTER

●	B1:	Develop, implement and embed a clinical governance framework to support patient experience and outcomes
●	B2:	Undertake a review of procurement and business support process to improve on the implementation of models of care
●	B3:	Develop a collaborative research program to present our knowledge and findings

MAKE IT HAPPEN

●	H1:	Strengthen and implement our relational commissioning practice and embed it into our planning system
●	H2:	Strengthen our capability in population health needs assessment and uptake of localised evidence; workforce strategy including professional development and education, quality improvement, redesign initiatives and financing and funding models including co-commission and co-investment
●	H3:	Increase access to and measure effectiveness of our digital health strategy including HealthPathways
●	H4:	Strengthen our population health planning effort to shape the research agenda, identify collaboration opportunities and integrate through a primary health advocacy lens

MAKE IT TOGETHER

●	T1:	Co-design with general practice a strategy to support each practice in their quality system improvements
●	T2:	Develop, resource and implement a health consumer plan; and implement a new/revised advisory structure based on review
●	T3:	Design and implement a stakeholder relationship project to broaden and diversify co-funder relationships and co-commissioning opportunities

MAKE US STRONGER

●	S1:	Establish our leadership culture through an Organisational Development strategy
●	S2:	Review and adapt our governance and accountability framework to be fit-for-purpose
●	S3:	Develop and implement a change and adoption strategy for business system and continuous process improvement
●	S4:	Develop a clear social purpose with measurable outcomes
●	S5:	Investigate the feasibility of a sustainable business enterprise

● Completed ● Moderate ● Significant

Ensuring financial accountability

Murray PHN prides itself on accountability and transparency, and on delivering improved health outcomes to the communities we serve. We operate an activity-based costing financial structure that ensures transparency to the work we commission.

Murray PHN has seven main funding schedules with the Department of Health. The dollar value of each as a percentage of total revenue is detailed in the graphics below.

Revenue of $38.9 million in FY 2019 grew slightly from $35.7 million in FY 2018, with $55.6 million in FY 2020. The 2019 financial year focused on commissioned services for health priorities including mental health, alcohol and drugs, chronic disease and Indigenous health. The Department of Health confirmed our Primary Mental Health agreement for an additional three years to 2021/22.

We take pride that at least 68% of our money goes straight to commissioned services, with 24% spent on our own people working across our large catchment, just 7% in corporate governance costs and 1% operating surplus. All funding has approved Activity Work Plans, budgeted and monitored monthly, to ensure we achieve exactly what we have been funded to achieve. Activities are reported and evaluated to ensure the community gains from the work we have commissioned.

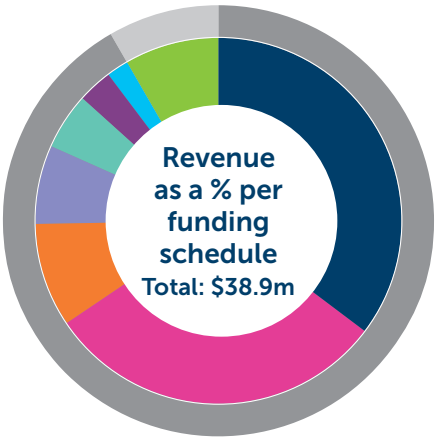
The unearned grant figure of $12.9 million in the Statement of Financial Position is money received by Murray PHN in 2018/19 to be expended against the agreed purpose in 2019/20.

ONE COMPANY	ONE TEAM	DELIVERED IN SYNC
$38.9m TOTAL REVENUE 2018-2019		

Core	$11.6m
Primary Mental Health	$13.8m
Alcohol and Other Drugs	$2.9m
Partners in Recovery	$3.7m
National Psychosocial Support Measure	$0.7m
Integrated Team Care	$1.9m
After Hours	$1.3m
Total Department of Health	**$35.9m**
Other income	**$3.0m**
Total	**$38.9m**

Our People	$9.2m
The work we commission	$26.5m
Corporate Governance	$2.7m
Our Operating Surplus	$0.5m

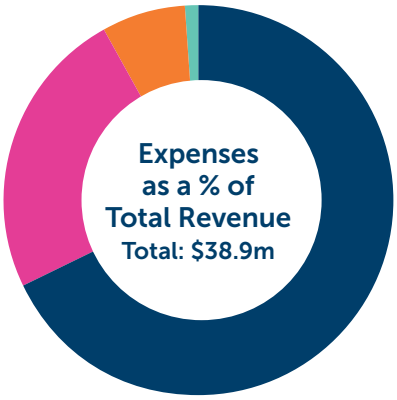
DELIVERED IN SYNC



35% Mental health
30% Core
10% Partners in Recovery
7% Drug and alcohol
5% Integrated Team Care
3% After Hours
2% National Psychosocial Support Measure
8% Other income

Federal Department of Health
Other

28% State Funding - Department of Health and Human Services
22% State Funding - Department of Education
20% Interest income
16% Other PHN Funders
12% Federal Funding - Australian Digital Health Agency
2% Other income



68% Direct Activity
24% Employee expenses
7% Corporate governance
1% Operating surplus

94% Commissioned services
2% Building capacity and capability
2% Direct activity Integrated Team Care costs
1% Needs Assessment, planning and evaluation
1% Direct patient costs

Limited Statement of Profit or Loss and other Comprehensive Income

	2019 ($)	2018 ($)
Income		
Revenue	38,859,401	35,710,077
Total income	**38,859,401**	**35,710,077**
Expenditure		
Employee benefits expense	9,247,551	8,710,568
Depreciation, amortisation and impairment expenses	43,734	127,613
Rental and occupancy expenses	636,333	585,052
Direct activity expenses	26,460,337	23,831,498
Motor vehicle expenses	178,866	173,506
Administration	1,383,099	1,247,718
Other expenses	457,302	259,239
Total expenditure	**38,407,222**	**34,935,194**
Surplus before income tax	**452,179**	**774,883**
Income tax expense	-	-
Surplus for the year	**452,179**	**774,883**
Other Comprehensive Income for the year	**-**	**-**
Total Comprehensive Income for the year	**452,179**	**774,883**

Statement of Cash Flows

	2019 ($)	2018 ($)
Cash flows from Operating Activities		
Grants revenue and other receipts	41,005,572	36,728,651
Interest received	604,946	557,569
Payments to employees, directors and suppliers	(36,254,598)	(34,594,534)
Net cash provided by Operating Activities	**5,355,920**	**2,691,686**
Cash flows from Investing Activities		
Payments for plant and equipment	(254,109)	(16,292)
Payments for intangibles	(157,674)	-
Net cash used in Investing Activities	**(411,783)**	**(16,292)**
Net increase in cash held	4,944,137	2,675,394
Cash and cash equivalents at the beginning of the financial year	17,656,999	14,981,605
Cash and cash equivalents at the end of the financial year	**22,601,136**	**17,656,999**

Statement of Financial Position

	2019 ($)	2018 ($)
Current assets		
Cash and cash equivalents	22,601,136	17,656,999
Trade and other receivables	207,742	92,412
Other assets	458,236	336,119
Intangible assets	157,674	12,883
Total current assets	**23,424,788**	**18,098,413**
Non-current assets		
Property, plant and equipment	234,440	11,182
Total non-current assets	**234,440**	**11,182**
Total assets	**23,659,228**	**18,109,595**
Current liabilities		
Employee entitlements	796,005	769,036
Trade and other payables	5,534,675	3,404,212
Interest bearing liabilities	4,403	4,526
Grants refundable	263,785	503,438
Unearned grants	12,905,158	9,798,935
Total current liabilities	**19,504,026**	**14,480,147**
Non-current liabilities		
Employee entitlements	322,003	228,428
Provisions	90,000	110,000
Total non-current liabilities	**412,003**	**338,428**
Total liabilities	**19,916,029**	**14,818,575**
Net assets	**3,743,199**	**3,291,020**
Members' equity		
Retained surplus	3,743,199	3,291,020
Total members' equity	**3,743,199**	**3,291,020**

Statement of Changes in Equity

	Retained earnings ($)	Total equity ($)
Balance at 1 July 2017	**2,516,137**	**2,516,137**
Surplus for the year	774,883	774,883
Total other comprehensive income for the year	-	-
Balance at 30 June 2018	**3,291,020**	**3,291,020**
Balance at 1 July 2018	**3,291,020**	**3,291,020**
Surplus for the year	452,179	452,179
Total other comprehensive income for the year	-	-
Balance at 30 June 2019	**3,743,199**	**3,743,199**

Partner organisations

These are Murray PHN's partner organisations for 2018/19. Our required focus on preventable hospitalisations has meant some contracts for non-aligned services have concluded. We look forward to continuing work with our partner organisations providing services for chronic illness and the other health priorities of our region.

360Edge Pty Ltd
Albury After Hours Clinic
Albury Wodonga Aboriginal Health Service
Albury Wodonga Health
Alexandra District Health
Alexandra Family Medical Centre
Alpine Health
Alpine Valleys Community Leadership
Anglicare Victoria
APMHA Pty Ltd
Australian General Practice Accreditation Ltd (AGPAL)
Ballarat Community Health
Barefoot Nutrition Fitness Lifestyle
Beechworth Health Service
Beechworth Surgery
Benalla Church Street Surgery Pty Ltd
Benalla Health
Benalla Rural City Council
Bendigo and District Aboriginal Co-Operative
Bendigo Community Health Services
Bendigo Health Care Group
Bendigo Primary Care Centre Limited
Bleuler Pty Ltd
Boort District Health
Border Dietitians
BPAC Informatics Pty Ltd
Brooke Street Medical Centre
Calder Counselling & Psychotherapy
Campaspe Family Practice
Castlemaine District Community Health Limited
Castlemaine Health
Centacare South West NSW Ltd
Central Medical Group - Wodonga
Cobaw Community Health Services Limited
Cobram District Health
Cohuna District Hospital
Corowa Medical Centre
Corryong Health
Coster Street Medical Practice
Daintree Medical Centre
East Wimmera Health Services
Eastern Melbourne PHN
Echuca Moama Family Medical Practice
Echuca Regional Health
Elizabeth McDonald
Euroa Medical Family Practice
Federation Clinic Administration Unit Trust
Flinders University
Gateway Health
Gippsland PHN
Golden City Support Services
Goulburn Valley Health
HALT (Hope Assistance Local Tradies)
Heathcote Health
Hospital Street Doctors
Impact Collaborative
Indigo Family Medical Centre
Indigo North Health Inc.
Inglewood District Health Services
Irymple Foot Clinic
Janette Tregenza
Kelly Creamer, Podiatrist
Kerang District Health
Kilmore Medical Practice
Kyneton Medical Centre
La Trobe University
Lung Foundation Australia
Lynette Flavel
Mallee District Aboriginal Services
Mallee Family Care Inc
Mallee Track Health and Community Service
Mansfield District Hospital
Marong Medical Practice
Merbein Family Medical Practice
MI Fellowship
Michelle's Diabetes Education Services
Mildura Base Hospital
Mind Australia
Monash University
Mooroopna Medical Management Pty Ltd
Mount Beauty Medical Centre
Mt Hotham Alpine Resort Management
Mungabareena Aboriginal Corporation
Murchison Medical Clinic
Murray Valley Aboriginal Cooperative
My Emergency Dr
Nathalia Medical Clinic
National Heart Foundation of Australia
NCN Health
Nexus Primary Health
Njernda Aboriginal Corporation
North East Support and Action for Youth
North Western Melbourne PHN
Northeast Health Wangaratta
Northern District Community Health
Ontario Medical Clinic
Ovens Valley Podiatry
Primary Care Connect
Psychology & Wellbeing Worx Pty Ltd
Quinn Street Medical Clinic
Robinvale District Health Services
Rochester & Elmore District Health Service
Rumbalara Aboriginal Cooperative
Rural Workforce Agency, Victoria Limited
Seymour Health
Seymour Medical Clinic
South Eastern Melbourne PHN
South Wangaratta Medical Centre
St John Of God Health Bendigo Hospital Raphael Centre
St Vincent's Hospital Melbourne
Sunraysia Community Health Services Limited
Sunraysia Medical Centre
Swan Hill District Health
Tallangatta Medical Centre
The Baudinet Centre Psychological Practice
The Foot Centre
The Trustee for Propell Trust
Theresa Moriarty
Toni Riley Reviews
Trace Research
Tristar Medical Group
Tunstall Australasia Pty Ltd
Ultimate Nutrition Mildura
University of Melbourne
University of Melbourne Shepparton Medical Centre
Victoria University
Victorian Aboriginal Community Controlled Health Organisation Inc
Victorian Alcohol & Drug Assn Inc
Victorian and Tasmanian PHN Alliance
Walwa Bush Nursing Centre
Wangaratta Rural City Council
Wesley Community Services
Western Victoria PHN
White Hills Medical Practice
Wodonga West Medical Clinic
Yackandandah Health Medical Centre
Yarrawonga Denis Medical Group
Yarrawonga Medical Clinic
YSAS Pty Ltd
Zenith Medical Practice

Murray PHN region

The importance of rivers

The Murray PHN catchment is home to several significant river systems including the Murray, Goulburn, Ovens, Coliban, Campaspe and Kiewa rivers. These rivers play a significant role in the identity and economic development of our region and are central to the cultural and spiritual wellbeing of our Aboriginal communities.

The traditional culture of our Aboriginal communities revolved around their relationship to land and water. The rivers provided, and continue to be places of significance, places to camp, hunt, fish and hold ceremonies. The rivers are central to Aboriginal creation stories, burial and birthing sites and provide spiritual connection to ancestors and dreaming stories.

The cover of this year's Report to the Community is a small part of a very special artwork by artist Madison Connors, who was commissioned by Murray PHN in 2019 to create a work that would be featured in our Bendigo office and used in various corporate publications in coming years.

The complete artwork – *Dhelkunya Yaluk (Healing River)* – will be officially launched at Murray PHN in 2020, but in the interim, we are delighted to be able to use elements of this work to illustrate our annual report. Maddy describes the story of her work, with the Murray River as the focal point.

"My name is Madison Connors (nee Saunders) and I am a 29-year-old Dja Dja Wurrung, Yorta Yorta and Kamilaroi woman. Originally from North East Victoria (Shepparton), I now reside in the eastern suburbs of Melbourne.

"I come from a strong bloodline and walk in the footsteps of those who came before me, advocating and aspiring to create positive changes for Aboriginal people. In identifying as Aboriginal, this is something that is within me and comes from the heart. Our connection to country is our bloodline and vein to this country and the community which surrounds us.

"I have been an artist for as long as I can remember and have always shared stories through my art with those around me. I want to continue to share this with those around me and in particular with my three-year-old son Marley and my future children."

Madison Connors, 2019

phn
MURRAY

An Australian Government Initiative

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