phn
MURRAY

An Australian Government Initiative

2023
REPORT TO THE COMMUNITY

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

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

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

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

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

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

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

Contents

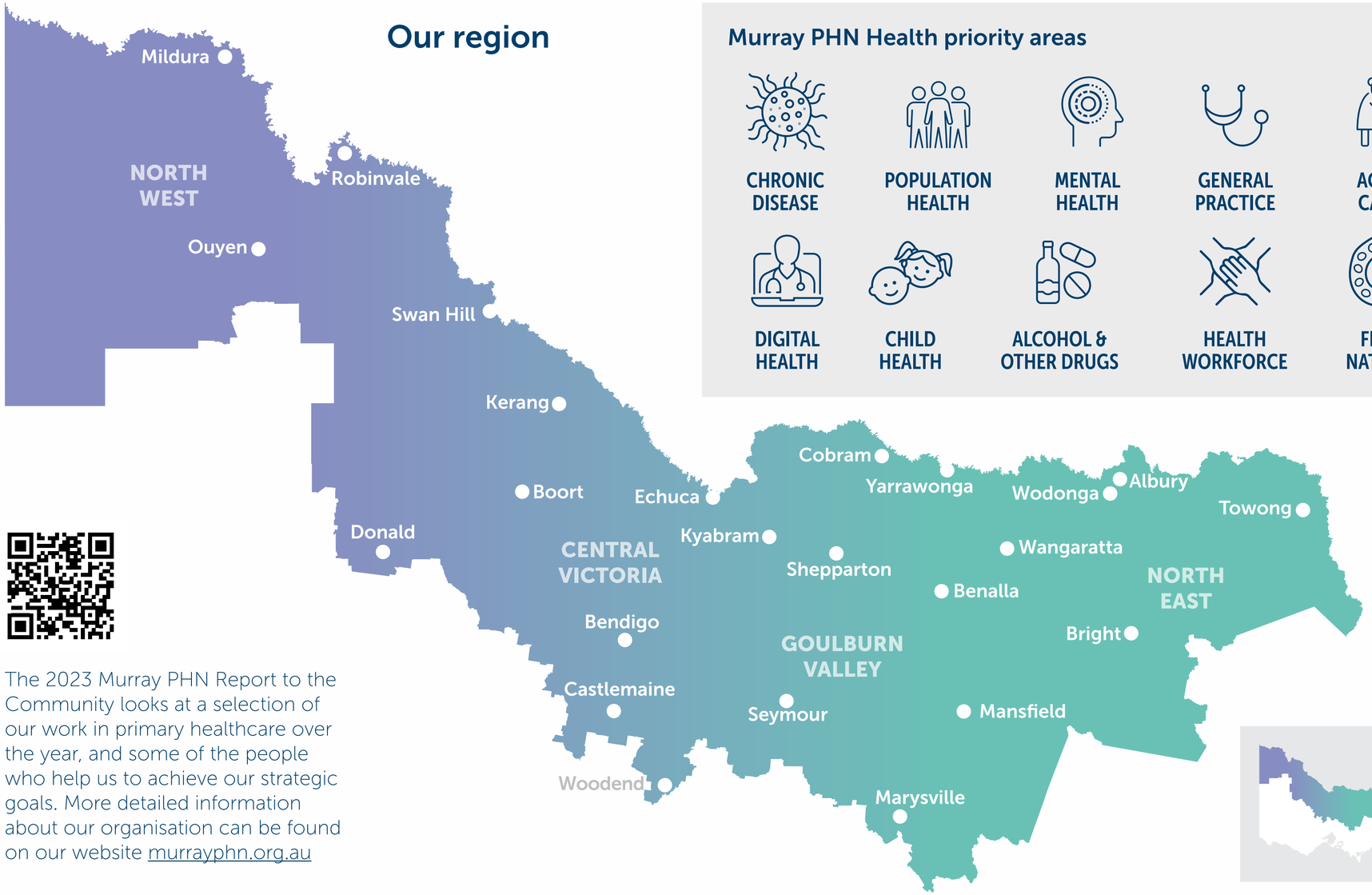
About Murray PHN

Primary Health Networks have a crucial role in supporting health reform across Australia, by driving local innovation to meet specific health needs and supporting consistent delivery of national and co-commissioned programs to keep people well, particularly those with chronic health conditions and mental illness, and to reduce avoidable hospital presentations.

This year, the Department of Health and Aged Care collaborated with PHNs to produce a draft annual PHN strategy for 2023-2024, which outlines the three key aspects of the work we are proud to do at Murray PHN – coordination, capacity building and commissioning:

- **Coordination** means we work with the providers of healthcare to enable more effective use of their services and responsiveness to the needs of our communities
- **Capacity building** is how we try to connect and strengthen the system through our data, evidence, engagement, relationships, resourcing, and most importantly, our local knowledge
- **Commissioning** covers the capability we have developed to fund and support targeted primary healthcare services that make a difference to the lives of our community – patients and practitioners alike.

Our region



The 2023 Murray PHN Report to the Community looks at a selection of our work in primary healthcare over the year, and some of the people who help us to achieve our strategic goals. More detailed information about our organisation can be found on our website murrayphn.org.au

Murray PHN Health priority areas

Our Board

More information about our Board can be found in our detailed Financial Report

Fabian Reid, Chair

Andrew Baker

Leonie Burrows

Bob Cameron

Dr Manisha Fernando

Dr Alison Green

Joanne Kinder

Matt Sharp

Professor Hal Swerissen

Jacki Turfrey

Our Executive

Matt Jones, CEO

Elizabeth Clear, CCO

Dr Belinda O'Sullivan
Until 30 November 2023

Janice Radrekusa

Aileen Berry

Message from the Chair

As my eight-year term of being Chair of Murray PHN comes to a close, I have had time to reflect on our challenges and achievements since our inception in 2015.

It is always difficult to get somewhere if you don't know where you are going, so we have remained focused on improving the health outcomes of individuals in our communities. This is what drives us and this is what produces outcomes.

Murray PHN is an impressive organisation, well lead by an outstanding CEO and Executive team. Our staff are passionate and highly skilled, dedicated to improving those community health outcomes.

Nothing could demonstrate that more effectively than our committed response to adversity over the last few years. We have continued to support the people of the communities in our catchment through COVID and the devastating bushfires and floods that affected so many. That response has been first-rate and reflects highly on our staff.

Our regional offices in Mildura, Shepparton, Albury and Bendigo are hundreds of kilometres apart, but it has never failed to impress me when I have visited those offices, that the atmosphere has always been calm and happy – and this is what drives great outcomes.

Outside our region, Murray PHN is highly regarded around Australia for its willingness to collaborate, share and seek better ways to improve the health of communities. Our First Nations Health and Healing Strategy and our Purposeful Design and Outcomes Thinking Framework are both areas of policy that are the envy of many of the country's better performing PHNs.

Murray PHN is in the business of relationships; often the most difficult and challenging of all businesses, as it is based on trust, integrity and respect, which all take time to build.

We have made great progress in this most difficult of endeavours with a solid foundation being built through the great work of our staff. At the same time, we are prepared to be innovative and bold, and we have the skills and intellectual capacity to be trailblazers in our work.

I believe our openness to new ideas and our curiosity about developing better ways to deliver primary healthcare to our communities will play an essential part in the organisation's long-term success.

The strengths of those ideas often come from the insights and lived experience of our communities, helping us to explore and implement better ways of doing things.

At a Board level, our great advantage is that we have avoided the dangers of "group think." Concepts and policy items are always discussed fully, and decisions are made in a robust, respectful and insightful manner. I have taken great pride in the fact that we have not been a "know all" Board. We listen, discuss, think and then make our decisions in the best interest of our communities.

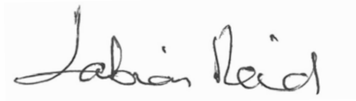
On an even more personal note, the development of our First Nations Health and Healing Strategy has been an extraordinary learning and personal growth experience for me.

The realisation that I held unconscious bias – and then the acceptance of this fact – was one of my great moments of truth. I know I have a long way to go on this journey, but I am so grateful that Murray PHN and our First Nations team provided me with the opportunity to take the first step.

It has been a most enjoyable time. I have met some extraordinary people and I believe we have always strived for Murray PHN to be the well-mannered, kind and intellectually rigorous organisation that we have today.

I am grateful for the support, calm, intelligence and friendship that I have received from all my fellow directors and from the executive staff of Murray PHN.

I am confident the organisation is in great hands and as it matures and grows, so will the health outcomes of our communities.



FABIAN REID - BOARD CHAIR

Message from the CEO

When Primary Health Networks (PHNs) were introduced on 1 July 2015, Australia's 31 PHNs were given two straightforward directives – to work to ensure the right care could be provided, at the right time and in the right place, and to ensure a focus on improving the health of people at risk of poor health outcomes.

We've been doing both of those things for the last eight years, while building our understanding of the needs of our providers and communities and building the recognition of the value of primary care coordination. We have also needed to demonstrate the value that comes from putting resourcing and effort into trying to connect the primary care system.

In determining the best ways for us to provide our contribution, we have kept one eye on our communities and providers, and the other on the broader health system, the policymakers and our funders. Our aim was that the value of PHNs could be recognised and therefore warrant additional, ongoing investment.

In 2023, we have seen the first significant investment in primary care reform in 20 years. The federal budget in May provided 29 strengthening Medicare budget measures; not just to improve the provision of healthcare, but also to begin the move to a different model of sustainable primary healthcare.

The recognition and resourcing of PHNs to help implement those measures is a gear change in the primary health system, and the role of each PHN is to translate those national reforms into localised capability – something Murray PHN is proud to do.

We are committed to working to strengthen the capacity of rural health, encouraging place-based integration and invest in the sustainability of different primary healthcare models. You will read about many of these efforts in this report.

Much of the success of Murray PHN developing into a high-performing Primary Health Network is directly attributable to our retiring Chair Fabian Reid, who has led the Board with his abiding appreciation and commitment to the notion that our health system should be responsive to the needs of the individual and our communities. Fabian's constant reminder of ensuring we put people at the centre of our place-based approach has been embedded in our planning and endures as a legacy of his contribution to Murray PHN.

From his very first day in the role, Fabian impressed in me the need to keep our focus on "the poor bloke at the end of the line". His empathy and compassion for people experiencing ill-health in areas with limited primary healthcare has never wavered; his measure of success has been what we have been able to do to make life better, easier and more equitable for our community members through the increasing provision of high-quality healthcare, close to home.

Fabian's particular commitment to the health, welfare and culture of our First Nations communities has driven Murray PHN to become a strong advocate for self-determination and to adopt an anti-racist approach through all our work.

I will personally miss his wise counsel and collegial friendship.

I would like to thank our entire Board for their support and collective wisdom; and my Executive team for their diligent commitment to our work and supporting me in my role.

We have a hardworking staff of 127 talented individuals and each one of these has my heartfelt thanks for their considerable efforts to support our communities in a constantly busy year.

MATT JONES - CEO

COMMISSIONING

Commissioning is one of the fundamental roles of Primary Health Networks around Australia. We conduct health needs assessments, with input from our partners, other health providers, our Advisory Councils and our communities. We use these assessments, along with our understanding of the local healthcare landscape, to commission many millions of dollars' worth of primary care and mental health services that are targeted to the needs of our communities. Our special focus is on funding and supporting local services that improve the quality and availability of care for community members with the greatest need, while supporting local service providers in sustainable practice. In rural and regional areas, innovation is key, along with robust evaluation of our services, to demonstrate success and give us the ability to share our models of care with government and other PHNs.

Improving reporting and performance goals

Commissioned service providers are required to regularly report data back to Murray PHN. The information helps us to monitor, track and discuss with providers, service performance, levels of service access and demand and the number of services delivered.

After extensive external and internal engagement, new reporting dashboards using Microsoft Power BI software have been developed this year. These dashboards not only present information more clearly, but are also interactive and accessible to mental health and chronic disease service providers. The dashboard features provide improved insight into trends, monitoring of performance goals and allow identification of service improvement opportunities. Clearer reporting in this manner also enhances Murray PHN's evaluation of current services and enables better planning for future services for our communities.

Enhancing mental health supports

Murray PHN puts in place a suite of mental health and suicide prevention services according to a stepped care framework, which is aimed at providing the best possible care for people and makes that care available in a way that best suits the individual.

headspace: a place for young people to go

Most headspace centres this year saw a significant funding increase, in line with the Commonwealth and Victorian Government's Bilateral Schedule on Mental Health and Suicide Prevention. This increase acknowledges the growing demand for youth mental health services since the COVID-19 pandemic.

headspace services focus on early intervention and support for young people aged 12 to 25 years old and their families. Each centre is unique and has been designed with input from local services and young people. They act as a one-stop-shop for those who need help with mental, physical and sexual health, alcohol and other drugs, or work and study.

Echuca headspace celebrates its first birthday

Despite floods postponing its official opening, headspace Echuca formally celebrated its first birthday in April this year.

Through the challenges caused by floods, the pandemic and construction delays, Echuca Regional Health continued to engage with young people as they brought the first youth mental health centre to Echuca, following years of advocacy efforts in the community.

With support from a strong consortium of local providers, headspace Echuca has now delivered more than 2000 services to more than 400 young people since its opening, and engaged with all local schools in the region.

Pictured right: Jason Trethowan headspace National CEO; Lucas McClean, headspace Echuca Youth Reference Group Member; Cynthia Opie, Echuca Regional Health Executive Director Community Services; Meaghan Sully headspace Echuca Centre Manager; Matt Jones, Murray PHN CEO

Top (from left): Juliet Jobi-Ejioqu (The Bridge), Jenny Cook (The Bridge), Melinda Lawley (The Bridge), Paige Lock (Murray PHN), Craig Hamilton (Orygen), Sophie Prober (Orygen), Rebecca Davenport-Thomas (Orygen)

Bottom: Cameron McGregor (The Bridge), Amber Kelsey (The Bridge), Adrian Woodhouse (Former employee, Murray PHN), Sian Lloyd (Orygen)

Supporting young people with severe mental health conditions

The Bridge Youth Service has been operating a standalone Youth Enhanced Service since 2021 and an alcohol and other drugs program since 2020. These two programs run side-by-side to form the Early Intervention Program.

In 2023, the program was one of only seven Youth Enhanced Services programs across Australia to take part in the Orygen Implementation Lab, a 6-12 month project that develops capacity to deliver mental healthcare to young people with complex needs.

The Lab program will culminate in The Bridge giving a presentation at the national Orygen Youth Enhanced Services forum in 2024.

In October, Murray PHN opened a tender opportunity for Youth Enhanced Services, offering $710,726 in funding to help young people aged 12 to 25 years who have, or are at-risk of, complex or severe mental health conditions. These services are expected to run from January 2024, in one or more of the following locations: Robinvale and Buloke, Gannawarra, Loddon, Mt Alexander, Macedon Ranges, Murrindindi and Mansfield local government areas.

It's OK if you're not feeling OK

HEAD TO HEALTH

1800 595 212

Transition of mental health hubs

This year, Head to Health centres in Bendigo, Mildura, Shepparton/Seymour and Wodonga have continued to provide safe and welcoming spaces for people to find the right mental health support.

Preparation for the transition of service to state-funded Mental Health and Wellbeing Locals is occurring at all sites, except Wodonga, which will follow in 2024.

Benalla-Wangaratta-Mansfield Mental Health and Wellbeing Local was the first to open in the region, with Murray PHN hosting a forum in July to introduce local GPs to the staff, service model and referral pathways. Greater Bendigo-Loddon-Campaspe, Greater Shepparton-Strathbogie-Moira and Mildura will be the next Locals to open.

A way to better mental health through psychosocial support

Some people living with severe mental health need extra support to help them with day-to-day activities, which includes things like improving their social skills, gaining further education, and help with finding and looking after a home.

In 2022, three different psychosocial support programs were combined into one called Psychosocial Recovery Services. Given the changing landscape in the sector with mental health reforms, an internal review of psychosocial services was conducted this year to provide insights and suggestions for future commissioning and service delivery.

The review looked at program documents and data, a literature scan and use of the National Mental Health Service Planning Framework, and consultations were held with commissioned service providers, service users, other services and PHNs.

The review found that the Psychosocial Recovery Services program is providing high-quality support, but that there is increasing complexity of referrals.

Consumers said that the best things about the service were the ease of use and referrals, the professionalism and promptness of support, which made them felt listened to.

Since the review, Murray PHN has facilitated the first of what will be regular community of practice meetings for funded providers to come together and network, share experiences and learnings, and to participate in training.

Assisting people to participate in social activities

In October 2020, the City of Greater Bendigo (CoGB) and Murray PHN began working together to find ways to address the difference in physical activity and nutrition status of people living in CoGB, compared with those living in metropolitan areas of the state.

The work developed a model for social prescribing to be delivered to residents from 2021-2023.

The key goals of a social prescribing program are to provide improved social connectedness and quality of life for participants, show improved health outcomes for those accessing the program and help reduce preventable disease burden for the larger health system.

Health professionals could refer eligible patients into a program run by a link worker, who would then support the patient's physical and mental health needs through community activity and social connection.

Eligible participants included those with a chronic or complex health condition, sufferers of low-level anxiety or those who experienced social isolation. The program used local library centres where the link worker would meet with the person to understand their goals and challenges. They then helped link them with local activities that could help increase their social connections and wellbeing.

Almost 200 participants were introduced to art, music, book clubs, neighbourhood houses, physical activity, and lunch or coffee groups to build friendships.

By taking part in social prescribing activities, communities can aim for their citizens to be better connected to culture and community and have community members who are active, healthier and well.

Psychosocial recovery service case studies

"Sue" had a sad upbringing, having lost more than one person close to her from death by suicide. She lived alone and had diagnosed mental and physical health conditions. No longer able to cope with overwhelming and ongoing pain, Sue reported to the mental health team that she had a plan and means to end her life.

The small rural multipurpose service she had approached did not have the infrastructure or resources to monitor clients one-on-one if they are at-risk of suicide. The area does not have after hours services, or GPs on call, and no safe room or security to help keep people protected.

After refusing to go to a larger hospital during an over-the-phone psychiatric consultation, Sue was brought into the urgent care centre.

Still very distressed, she was admitted and provided with emotional support, pain relief and antipsychotics, and monitored every 15 minutes by the mental health clinician who stayed overnight to keep Sue safe.

The pain was resolved with appropriate analgesia and Sue did not harm herself, nor experience any perceptual disturbance or hallucinations. She was well enough to be discharged the next morning.

Initially provided with close ongoing support, Sue now has weekly visits.

It is hoped that surgery will soon resolve Sue's pain and further reduce her risk of suicidal ideation in the future.

"Frank" was in distress and called his local Aboriginal Community Controlled Health Organisation (ACCHO) for help with his mental health. Despite living with untreated schizophrenia for many years, he lived in an isolated area and had very little in the way of supports, apart from his regular GP and being known to Area Mental Health Services.

As Frank was reluctant to engage with mental health services, a careful approach was taken to build his confidence by giving him the agency to make his own decisions.

Through fortnightly home counselling visits, Frank was provided with coping strategies for his hallucinations and help so he could set goals that would improve functioning.

He was unsuccessful in applying for NDIS support, but the provider was able to assist in the donation of a hospital bed to support his physical health issues.

He joined an exercise program at the local gym to help improve his social connectedness, and on his first visit commented, "Finally, I am going to be doing something."

His reluctance to take anti-psychotic medications was overcome by addressing side effect concerns, encouraging him to trial and document the differences his medication made. To make sure he took his medication regularly, alarm reminders were set on his phone.

During Frank's time with the service, he did not cancel an appointment and regularly thanked his support worker. He clearly enjoyed the catch ups, making cups of tea during chats and by demonstrating interest in all aspects of his life.

Now three-and-a-half months into his medication 'trial', Frank is finding that his distress has lessened. This result, like the initial engagement, was achieved by empowering him in his own decision-making. The Area Mental Health Service has described these achievements as a remarkable outcome for Frank.

"Finally, I am going to be doing something."

"Joy" lived with multiple and chronic physical co-morbidities in a residential aged care facility (RACF) in Shepparton. She had limited contact with family, who did not live locally.

Staff had noticed a significant drop in Joy's mood and increasing bouts of tearfulness and hopelessness; in part attributable to the impact of COVID lockdowns.

Joy was referred for psychological support, which included assessing her mental health and psychotropic medication needs. She responded well to counselling, with staff reporting improved outcomes post sessions, and her GP and family were updated throughout.

As Joy's physical health declined, she was provided a safe space to express and engage in spiritually significant conversations about her end-of-life wishes.

The psychological therapy services program afforded Joy with a level of dignity and comfortability near the end-of-life, which would otherwise not have been met due to other demands on RACF staff.

The support provided throughout the program likely prevented a more acute exacerbation of mental health symptoms as Joy's physical health declined.

Spotlight on alcohol and other drugs

As part of an internal evaluation conducted in the 2023 financial year of Murray PHN's commissioning in alcohol and other drugs (AOD), all current providers were asked to highlight the aspects of services that were going well and identify potential areas for improvement in the commissioning of AOD services.

Murray PHN met with nine providers in December 2022 to ask questions about successes, problems, needs and integration in the AOD sector. A final report was produced in July 2023 and Murray PHN is now considering this evaluation, alongside a recent mental health and AOD needs assessment, to influence our future commissioning.

What's working well

- Coordinated local responses/ plans with other providers or councils, connections and information-sharing including through communities of practice, connections with schools and services such as family violence, child and youth-specific health services, housing and child protection
- Service adjustments and integrated models with multidisciplinary teams that provide consults or supervision for complex cases
- Dual diagnosis (mental health and AOD) as a combined service in AOD service settings
- Early intervention programs, particularly for youth AOD
- Outreach to communities and having a consistent presence
- Nurse practitioner support, as they can be more available and accessible than GPs
- A commitment to employing local people and wanting to support the upskilling of staff and provide ongoing supervision.

Biggest challenges, barriers and gaps

- Community stigma and poor community indicators such as family cycles of AOD and young people not being engaged in school. Services are usually adult-focused and young people need a different model: more health promotion is needed in schools and for young people not in school, and support for parents
- Small workforce pool and high turnover of staff; some of who require investment to upskill due to inexperience
- More training on vaping, AOD/ trauma work, DBT (dialectical behaviour therapy), emotional regulation/distress management and ACT (acceptance and commitment therapy)
- Cross-sector engagement; GPs especially need to be involved with complex cases such as withdrawal, co-occurring mental health, and prescribing medication assisted treatment for opioid dependence (MATOD), as many people needing AOD support cannot access a GP or do not have a regular GP
- Lack of prescribers and access to pharmacotherapy. A desire for pharmacies to do LAIB (long-acting injectable buprenorphine) injections and be willing to dispense
- Mental health sits with AOD but the mental health sector does not always understand AOD, and there are still difficulties navigating both systems due to complexity and lack of clear pathways. There is a need for more family violence/behavioural programs
- More residential options are needed for detox and rehabilitation, including complex homebased withdrawal and youth-specific options.

Commissioning opportunities

- **For individuals:** simplifying processes would improve user experience and health outcomes
- **For providers:** longer funding cycles, simplified reporting and continued contract flexibility would better enable recruitment
- **For the system:** greater alignment between state and federal programs, including data measures would increase efficiencies for providers
- **For Murray PHN:** increased workforce development and connections between providers would strengthen relationships, enhancing opportunities for collaboration.

Providing urgent, non-emergency care

A growing burden of chronic disease, combined with doctor shortages and deferred care through COVID, means it can be hard to see a GP urgently. Increasing pressures on emergency departments also result in long wait times for anyone who is not an emergency case.

State and federal governments have funded additional primary care services to help people get the care they need quicker and ease the pressure on busy hospitals.

In October 2022, Murray PHN was advised by the Victorian Department of Health that the Murray PHN catchment would have four Priority Primary Care Centres (PPCCs). The four services were commissioned in Bendigo, Shepparton, Wodonga and Mildura.

In July 2023, a Medicare Urgent Care Clinic (UCC) opened in Albury, funded by the Commonwealth Government.

PPCCs and UCCs are staffed by doctors, nurses and reception staff, to provide urgent but non-emergency care for low acuity conditions such as fractures, burns and mild infections. The services are free for everyone, including those without a Medicare card.

Murray PHN has helped each site with set-up, including data specifications and requirements, service models and clinical governance. We have convened local working groups, consisting of hospital representatives, local pathology and radiology providers, Ambulance Victoria and Ambulance NSW; advertised for expressions of interest for workforce; and created branded materials including building signage and posters.

PPCCs and UCCs are staffed by doctors, nurses and reception staff, to provide urgent but non-emergency care for low acuity conditions such as fractures, burns and mild infections. The services are free for everyone, including those without a Medicare card.

Priority Primary Care Centres

Each PPCC is partnered with a busy emergency department (ED) to help keep ED services free for those people who need them most.

Shepparton and Wodonga opened in February, Mildura in April and Bendigo in June.

Shepparton PPCC will continue as a co-branded site for a further two years to 2026, funded by the State Government and the Commonwealth Government as part of the Commonwealth Medicare Urgent Care initiative.

Each of the PPCCs is performing above average when compared to other centres across the state. Between them, they have assisted more than 17,000 patients in 42 weeks to 19 November 2023.

The most common reasons for people attending a PPCC are:

- Respiratory infections
- Lacerations
- Minor fractures
- Urinary tract infections
- Other infections and rashes.

Of the people presenting to a PPCC, 35 per cent have been children and four per cent did not have a Medicare card. After attending a PPCC, patients are asked to complete a satisfaction survey about their visit.

All sites have had a focus on providing education and upskilling for their clinical and non-clinical staff, supported by their partnering hospital and Murray PHN.

Bendigo:
Operated by Bendigo Primary Care Centre in partnership with Bendigo Health.

Mildura:
Operated by Sunraysia Community Health Services in partnership with Mildura Base Public Hospital.

Shepparton:
Operated by The University of Melbourne Shepparton Medical Centre in partnership with Goulburn Valley Health.

Wodonga:
Operated by Sarkon Medical Centre in partnership with Albury Wodonga Health.

Urgent Care Clinics

The Albury Medicare Urgent Care Clinic, which was one of the first of 58 clinics to open nationally, is operated by Border General Practice as the Albury Medicare Urgent Care Centre.

The UCC has now seen more than 800 patients since opening and developed strong links with the Mungabareena Aboriginal Corporation to support the local community.

Of those attending the clinic, 43 per cent have been aged 25 to 64 years old, 28 per cent aged under 15 years of age, with viral illnesses and sinusitis among the most common conditions presenting for treatment.

Data quality reviews collected by the Commonwealth Government show Albury's data quality is well above national average.

For more about the after hours and urgent care services available, visit: murrayphn.org.au/afterhours

Clinical Director, Dr Ferencz Baranyay and Practice Manager, Heather Paterson.

Helping older people most in need

The aged care system can be complex and some people find it more difficult than others to access the services they need.

In January 2023, 12 care finder organisations were commissioned to provide localised face-to-face support to people most at-risk of falling through the gaps.

These services assist older people who have no family or trusted carers to engage with My Aged Care and other local health and community services. Since they began, the services have delivered almost 3000 services to 564 clients. Of these, 307 have received support to interact with My Aged Care services. Of all client experiences completed to date, 100 per cent felt satisfied with the outcome of the care finder process and would recommend the service to others.

Murray PHN used a commissioning approach, working with existing providers of Assistance with Care and Housing (ACH) programs to identify local needs. This provided the data and evidence needed to optimise use of local workforce and build the capacity to expand services in some areas, and enabled ACH providers to transition to become providers of care finder services. This meant a continuity of care for people experiencing or at-risk of homelessness was able to be provided, while supporting the retention of a skilled and experienced workforce, equivalent to 15 full-time workers.

The care finder program is part of the Australian Government's response to the recommendations of the Royal Commission into Aged Care Quality and Safety.

Before the services began, Murray PHN convened a leadership group to provide direction and drive continuous improvement and integration initiatives. The group contributed to the design of an active community of practice. Based on the success of this group, Murray PHN helped in the establishment of a statewide PHN community of practice for care finders.

Murray PHN also developed a referral and intake tool for providers, including eligibility checklist and alternative referral pathways for access and navigation services for people who are assessed as ineligible for care finder services. The referral tool has been shared across the region and with advocacy organisations such as Elders Rights Advocacy Victoria and the Older Persons Advocacy Network.

Almost 3000 services have been delivered to 564 clients, with client surveys showing a 100 per cent satisfaction rate

Alternate care during the after hours period

My Emergency Doctor is a virtual consultation service provided by emergency physicians to support rural workforce in urgent care settings and residents in an aged care facility in the after hours period.

In the year to 30 June 2023, the service supported 54 facilities and delivered 5078 consultations.

More than 85 per cent of consultations were able to be managed without the need to attend a hospital emergency department.

The highest users of the service were those aged between birth to 30 years old, with the second highest user group being 61-75 years old.

Some of the main reasons for using the service were for chest, abdominal and stomach pain, coughs, colds and fevers. Aged care support included assistance after a fall, end-of-life palliative support, wound and infection care.

Using telehealth models of care in regional and rural communities can help ease the burden on the health system, with no long trips to hospitals or extended waiting times at an emergency department.

Following the expansion of the Victorian Virtual Emergency Department, and a range of government reviews and evaluation, funding for My Emergency Doctor ended in December. After hours funding will continue supporting access to primary care services in the after hours period.

After hours care in general practice

Through our general practice investment strategy (GPIS), Murray PHN commissions tailored models of care to address gaps in after hours service arrangements and to improve the integration of services.

Since 2018, the general practice after hours program has been helping community members access urgent care for non-life-threatening conditions, helping to reduce the demand on emergency departments and the risk of a person's condition deteriorating.

Through this funding, 17,182 consultations have been provided from July 2022 to May 2023.

Twenty-six per cent of patients said that they would have gone to the emergency department if they hadn't attended the service, with 47 per cent saying it was essential, and 94 per cent satisfied with the healthcare they received.

Twenty-six per cent of patients said that they would have gone to the emergency department if they hadn't attended the service

After hours toolkit for residential aged care

A key objective for PHNs is to increase residential aged care home (RACH) knowledge on the types of general practice and other services that are available in the after hours period, to help reduce unnecessary hospital presentations.

Following consultation with RACHs, our partner PHNs, North Western Melbourne and South Eastern Melbourne, developed a toolkit with Ambulance Victoria and the Victorian Virtual Emergency Department.

The toolkit aims to inform RACH staff on the available options and their processes, and procedures for action care plans and keeping of medical records up-to-date. This toolkit supports engagement between RACHs and the health system, for the benefit of aged care residents. To access it, visit: murrayphn.org.au/afterhoursrachtoolkit/

Managing chronic disease

Murray PHN commissions chronic disease services to target patients who are at-risk of presenting to hospital, by providing a focus on self-management and action planning.

In the year to 30 June 2023, Murray PHN commissioned services supported 13,844 individuals, through 24,886 consultations and 1328 group sessions in the areas of podiatry, diabetes education, dietetics, chronic disease nursing and cardiopulmonary rehabilitation.

Of the 981 people who completed a client experience survey, 98 per cent agreed or strongly agreed that the treatment they received was of high quality, and 99 per cent said that they were satisfied with the healthcare they received.

This year, Murray PHN has focused on fostering integration and collaboration among providers and internal teams, to improve information sharing and service delivery, and importantly, to lift health outcomes in the community.

For example, one health service identified a gap in the community for a chronic disease management nurse. With their dietitian going on maternity leave, they were supported to repurpose their funds to recruit a chronic disease management nurse and to connect with another rural provider to learn more about how their nursing model was integrated into services.

Spotlight on podiatry

Podiatry is one of several allied health services that Murray PHN supports to help people living with diabetes and other chronic conditions. It is an important part of holistic care and is far more complex than just cutting toenails. There is a great demand for this service locally, with more than 6500 sessions provided in the year to June 2023.

Case study

"Mandy" is a mature age woman who lives with multiple long-term health conditions. Several of these conditions impact the healing of wounds and infections, and she was at risk of losing her foot.

Without a regular doctor or other healthcare practitioners, Mandy lacked formal support services, was unable to afford private care and often did not attend appointments. She reported that practitioners often told her what they wanted her to do for her health, but she was either unable to, or didn't understand why she should do it.

When she first attended The Foot Centre, she reported feeling anxious, and the podiatrist's initial goals were to establish rapport, by listening to Mandy's concerns and providing consistency of care.

Despite Mandy's history of not attending appointments due to prior poor experiences, she attended 90 per cent of her weekly appointments. Because staff listened to her concerns and adjusted treatments accordingly, she said she was inspired to do her best and follow their instructions.

Being supported to set small, achievable goals was something that helped Mandy become more confident and active in her own healthcare to be more accountable for her outcomes. The trust that was built also supported referrals to other health professionals. She established relationships with a local GP, specialist physician and credentialed diabetes educator.

Once Mandy was very engaged in her own care, her foot health and wound healing capacity greatly improved, along with her diabetes and overall health and wellbeing.

Many clients with chronic health conditions – and in particular poor foot health conditions – become overwhelmed and frustrated. Supporting Mandy has helped staff to improve their health coaching and self-management support skills and highlighted the importance of listening to a client, rather than assuming what they might want or need.

Student-led model of care at Charles Sturt University: case study

Recognising the scarcity of podiatrists, the School of Allied Health, Exercise and Sports Sciences at Charles Sturt University established a student-led podiatry pilot clinic at Westside Community Centre in Albury in 2021.

Seed funding from the Three Rivers Department of Rural Health enabled the initial set up and employment of a podiatrist as clinical educator, with Murray PHN now providing funding for 2023-24.

By the end of June 2023, the service had provided care for 139 community members and generated 441 community workplace learning hours for third- and fourth-year podiatry students.

Around 17.5 per cent of patients identified as Aboriginal and Torres Strait Islander and feedback from all people receiving care at the podiatry clinic was unanimously positive.

This project demonstrates the value of a community and university partnership through which non-Indigenous and First Nations colleagues partner to listen to community and create a culturally-responsive service.

The podiatry clinic is providing an innovative model of healthcare that meets community need, addresses workforce challenges, enables students to experience culturally-responsive practice and ensures continued care for people who need it. Murray PHN has also been able to build connections between the university and local providers who have been interested in learning more about this unique model.

To further support the demand for podiatry services in the region, the university has also developed an Undergraduate Certificate in Foot Health, designed to upskill applicants to become a podiatry assistant who can treat 'low risk' clients under the supervision of a registered podiatrist. This course will begin in 2024 and more details can be found at https://study.csu.edu.au/courses/undergraduate-certificate-foot-health

"This project demonstrates the value of a community and university partnership through which non-Indigenous and First Nations colleagues partner to listen to community and create a culturally responsive service."

Julie Nguyen, Charles Sturt University Lecturer in Podiatry; Jovie Ingram, Murray PHN Contract Manager; Caroline Robinson, Charles Sturt University Associate Professor in Podiatry and Associate Head School of Allied Health, Exercise and Sports Sciences

Strengthening Medicare

The Strengthening Medicare Taskforce got to work in July 2022 to build on Australia's Primary Health Care 10 Year Plan (2022-32). The taskforce's role was to provide advice to government on how to improve patient access to general practice, including after hours and GP-led multidisciplinary team care, including nursing and allied health. The taskforce also included recommendations on how to make primary care more affordable for patients, and how to improve prevention and management of ongoing and chronic conditions, reducing pressure on hospitals.

The taskforce released its report in February 2023, highlighting the need for modernisation of digital systems and significant improvements in the way patients' information is accessed and shared across the health system.

In May, the Commonwealth Government announced $750 million to deliver investments in line with the recommendations of the Strengthening Medicare Taskforce.

Recognising the unique challenges in rural and remote Australia, the report called for a greater role for Primary Health Networks, including to commission nursing and allied health services to bolster general practice teams in these areas.

General practices take up Medicare grants

The Commonwealth Government allocated $220 million in grants in April, as part of the Strengthening Medicare – General Practice Grants Program.

The grants were the first step in the government's commitment to recommendations made by the Strengthening Medicare Taskforce.

The funding provided essential support to general practices and eligible Aboriginal Community Controlled Health Organisations with the primary goal to expand patient access and ensure the delivery of safe, accessible and high-quality primary healthcare services.

One-off grants of $25,000, $35,000 and $50,000 (depending on practice size and other measures) allowed practices to invest in innovation, training, equipment upgrades and minor capital works.

Throughout, Murray PHN's primary healthcare, contracts and finance teams played a pivotal role in facilitating the distribution of grants to 173 general practices, or just over 95 per cent of the 182 clinics deemed eligible for the grant process.

Given the considerable financial commitment involved, this work would have been taxing on internal resources if handled conventionally. Recognising the need for speed and efficiency, Murray PHN worked to digitise processes and enhance our operational effectiveness.

Manual administrative processes were replaced by automated systems, significantly reducing bureaucratic hurdles, and ensured a more streamlined and sustainable foundation for managing a large number of contracts, all of which had to be delivered within a short timeframe.

With the support of our corporate team, we made substantial improvements to our contract management system, resulting in the most efficient allocation and use of the grants.

Importantly, this modernised approach to digitised processes for grant distribution was designed to ensure that the community benefited fully, with funds delivered quickly and efficiently.

The uptake of the grants demonstrated the significant needs of rural and regional practices, with the percentage of practices applying being significantly higher than some PHN regions and the national average.

Practices could select one or more program streams for the use of the funds, with 134 choosing to enhance their digital health capacity and capability, 128 wanting assistance with maintaining or achieving accreditation against the RACGP Standard for General Practices (5th edition) and 107 electing to upgrade infection prevention and control arrangements.

The grants that were made available between May and June 2023 are continuing to support general practices to make patient-centred improvements to their operations to provide better, safer and more accessible quality care.

"The GP grant program was the most timely and helpful support we have received in a long time. The turnaround time was short, the criteria for use of the grant were flexible. The grant contributed towards us being able to update our ageing and out-of-date IT system, though we note it was not enough to cover all the costs (as it only covered approximately two-thirds of the total outlay)." – North West Victorian GP Principal (Small, 2-5 GP practice)

Other projects

Providing transport in rural areas

A lack of transport in rural areas means that some people can't access the care they need.

Murray PHN has partnered with the Royal Flying Doctor Service (RFDS) to deliver a volunteer-led community transport program in three new locations. The first opened in Numurkah late 2022 and extended into the Cobram community in March, with Robinvale services starting in August.

The new sites have been built on the success of existing Heathcote and Rochester programs, which celebrated their fifth anniversary this year.

Of those community members who have used the service, 95 per cent would very likely and four per cent likely recommend the RFDS community transport service to other people in their community.

Heart failure in general practice project

Heart failure is a complex condition that is estimated to affect 480,000 Australian adults.

To better assess and manage people at risk of heart disease in the primary health sector and create a blueprint for cardiac services reform, the Victorian Department of Health funded Eastern Melbourne PHN to lead a statewide PHN project.

In the Murray PHN region, five general practices were invited to implement a heart failure model from January to August of this year.

At one practice, more than 70 heart health checks were completed. At the same time, an increase in the number of coronary artery calcium scoring tests were ordered by GPs, resulting in the identification of patients that would benefit from chronic disease management support. The number of younger patients that had not had their cardiovascular disease risk calculated was reduced and the recording of risk factors increased from 47 to 64 per cent.

Increasing health literacy through digital technologies

Between 2017-2019, Murray PHN established a remote patient monitoring trial to see if it could help reduce potentially avoidable hospitalisations in seven residential aged care facilities.

The program allowed for individual patient care plans, wireless and connected monitoring devices for patients' vital signs and a web-based monitoring platform for the healthcare team.

In 2020-2022, the program expanded to 20 monitoring hubs with more than 220 patients, helping to build greater health literacy through the patients' understanding of their chronic conditions, and intervention from a person's healthcare team if their observations were outside of normal ranges.

In the final implementation phase this year, Murray PHN worked with two regional health services, 10 general practices and one Aboriginal Community Controlled Health Organisation. Eighty-five patients were enrolled, with 90 per cent actively engaged in monitoring their condition for up to six months.

This program shows that remote monitoring can be a viable option in rural areas and that older people can embrace technology with support. Working with people with poorly managed chronic illness, technology can be a useful early intervention tool for health services, easing the burden and cost on the health system associated with hospital admissions.

Remote monitoring services have now transitioned across to local hospitals.

"The blood pressure (BP) monitor allowed me to keep track of my BP easily on a daily, sometimes twice daily, basis. This was handy to see how the other heart failure medications were affecting me and to keep track of any changes. It [the program] also gave the nurses the ability to message me if they noticed changes in my observations." - Remote patient trial participant

"The support received, especially with joint GP and specialist appointments, takes the pressure off my wife and helps me take responsibility for my own health. I have had one ED presentation, but no unplanned admissions related to my chronic illness since enrolment." – Remote patient trial participant

Researching ear, nose and throat conditions

As an industry partner of La Trobe University, Murray PHN supports Mildura-based researcher Susan O'Neill with her PhD project investigating ear, nose and throat (ENT) care and access in the region.

Over the past four years, Susan has been building on the Grattan Institute's 'Perils of Place' report, which identified Donald and Swan Hill as 'hotspots' or high-risk areas for potentially preventable hospitalisations from ENT conditions.

In the project's first study with audiologists, the main barriers to care revealed were access, long wait times and lack of local healthcare professionals.

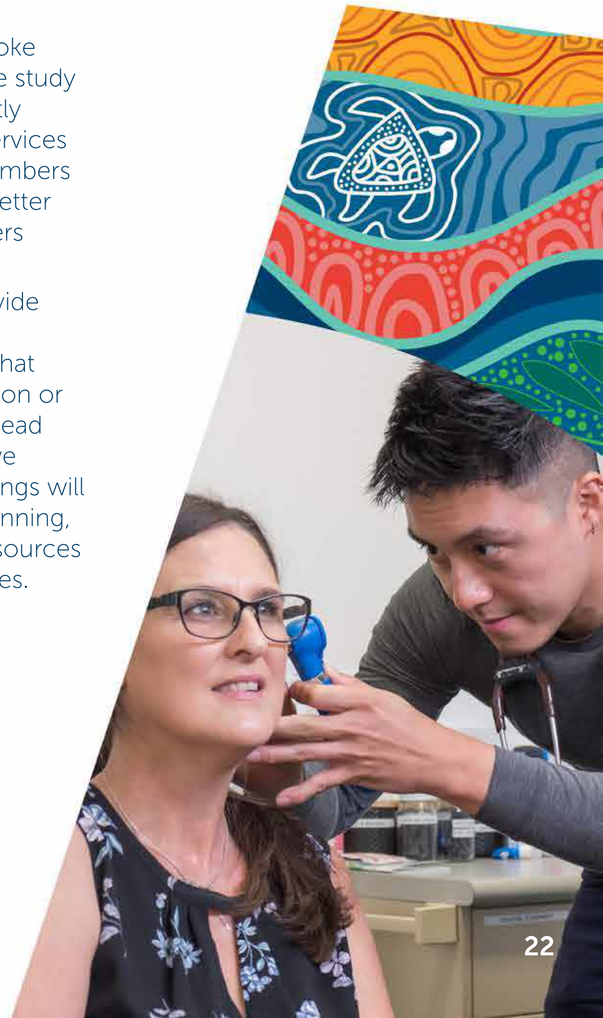
In the second phase of the study, hospital presentation data was analysed, showing 15 postcodes with higher-than-normal hospital presentations for upper respiratory tract infections, 14 postcodes for acute tonsillitis and 12 postcodes for otitis media in the Murray PHN region.

Birchip ranked highly for upper respiratory conditions and acute tonsillitis, with 50 per cent of tonsillitis hospital presentation cases being in people 15 to 19 years old, which is unique in comparison with other hotspots.

Given these findings, the Buloke region was selected as a case study site in the third phase currently underway, to map existing services and speak to community members and health professionals to better understand access and barriers to care.

The hotspot analysis will provide a new method of examining preventable hospitalisations that can be applied to any condition or region, which will ultimately lead to more timely and responsive healthcare services. The findings will also inform future service planning, clinical referral processes, resources and health promotion activities.

The people most likely to be hospitalised were aged birth to nine years, from culturally and linguistically diverse backgrounds or First Nations Communities.



COORDINATION

Coordination is one of the three key aspects of Murray PHN's work, right across our region. Through our coordination activities, we work to help integrate local healthcare services with one another and with local hospital networks to help improve quality of care, people's experiences and to support the most efficient use of health and emergency resources.

By building connections across general practice, allied health, mental health, First Nations, pharmacy, nursing, aged care and other primary care services, we help to strengthen the multi-disciplinary team care pathways that support people experiencing poor health and disease.

We gather data and evidence on prevalent and emerging health needs in our populations, which in turn informs our planning for additional or improved services and future workforce requirements.

Over time, and with the increased use of digital health and virtual triage services, a more coordinated health system has the potential to deliver improved healthcare and equity for individuals, enhanced conditions for health providers and the most efficient use of our growing health expenditure.

Consultation and engagement

Murray PHN recognises the value that can be unlocked when practitioners and communities have the opportunity to contribute their insights on local issues and potential solutions.

Community members are best placed to inform us where access, quality and sustainability of primary healthcare can be improved. Clinicians can identify opportunities for collaboration, partnership and advocacy to strengthen the service system.

Advisory councils give us a direct line of communication that ensures we consider a greater mix of perspectives across different geographies, interests and sectors of our region.

Listening to community and clinical members

We use our advisory councils to inform our strategic planning and commissioning processes in areas that the Commonwealth Government funds. A major initiative this year has been the Australian General Practice Training – Workforce Prioritisation and Planning project. Through which, we gathered local perspectives of the service needs, strengths and opportunities in primary care workforce and education, feeding them into our workforce needs and training capacity reports, to help inform placement priorities of future GP trainees in the Murray PHN catchment.

In addition, council members have contributed to specific needs assessments in the areas of after hours, mental health and alcohol and other drugs, chronic disease and digital health.

This year, Murray PHN has also focused on enhancing the capability and capacity of advisory council members, through staff presentations on the organisation's First Nations Health and Healing Strategy, mental health and other drugs commissioning reviews, and sustainable models of rural healthcare. Deepening council member knowledge in these areas aims to better support thinking and contribution to future consultations, particularly around multi-disciplinary team care and Strengthening Medicare initiatives.

Murray PHN advisory councils

Online community shapes health planning

While Murray PHN regularly consults with Clinical and Community Advisory Council members, our online collective of Health Voices gives us an even greater reach into the views and experiences of the people living in the catchment.

This year, we learned that while 54 per cent of Health Voices rarely or never needed to use after hours services, seven per cent used them weekly or monthly. We also learned that 44 per cent had discussed mental health and alcohol and other drugs concerns with their GP in the last five years.

To register to be a Murray Health Voice, click here. Encourage your friends, family, work mates and networks to register and share their thoughts and experiences with us too.

By registering, you will receive surveys from time-to-time and help us to understand the things that make access to health services difficult for you or someone you care for. We also want to know what is working well (or not) at a health service you use, along with your ideas for improvements.

Integrating general practice perspectives

Murray PHN employs three locally-based GPs as Medical Advisors.

With their clinical and community experience, they bring general practice and primary healthcare perspectives on health system issues, gaps and improvements to inform strategic and operational planning across programs and activities.

As well as being available and accessible to staff for advice, our Medical Advisors are routinely involved in a wide range of activities from workforce and education events and planning, accredited quality improvement initiatives for GPs, to governance groups such as the Targeted Regional Initiatives for Suicide Prevention (TRISP) program and participating in regional and national PHN program reviews.

Dr Susan Furphy, Goulburn Valley Medical Advisor

Dr Wendy Connor, North East Medical Advisor

Dr Philip Webster, North West Medical Advisor

"...they bring general practice and primary healthcare perspectives on health system issues, gaps and improvements to inform strategic and operational planning across programs and activities."

Multidisciplinary team-based care

Most people receive care from a range of different health professionals, but the way services are organised and funded can be disjointed and many of us in the system find them hard to navigate; particularly those with multiple or complex conditions that require long-term support.

These were some of the issues emphasised by the Strengthening Medicare Taskforce report, which recognised that high-quality primary care delivery depends more and more on healthcare teams.

Team-based care harnesses the full strengths and skills of our diverse health workforce, which includes GPs, nurses, nurse practitioners and midwives, pharmacists, allied health professionals and Aboriginal and Torres Strait Islander health workers, among others.

Enabling a nurse-led clinic in Murchison

Murchison Medical Clinic received funding through Murray PHN's General Practice Investment Strategy to see whether nurse-led clinics could increase their capacity for care planning and health prevention appointments.

Practice manager Rachel Smith led the project, alongside practice nurses, Keira Birchmore and Ellen Wright. While the transition from a GP to nurse-led clinic took longer than anticipated, a typical staff day now looks very different to what it once was.

The clinic now has a dedicated chronic disease management nurse and GP schedules are planned to ensure adequate time is allocated to patients. The patient's documentation is reviewed and updated before they are seen, and advanced bookings are made with the doctor's recommendations. The practice ensures the patient is supported with a recall system and the use of PenCAT, a GP clinical audit tool.

With more time dedicated to care planning, the nurse-led model has enabled a more thorough approach to patient wellbeing. The number of care plans and reviews has increased, and patients have reported improvements in their understanding of their chronic conditions.

Pictured L-R:, Rachel Smith, Ellen Wright, Keira Birchmore.

As part of the project, three patient 'edutainment' videos - Preventative health, Care planning and Tips when seeing your doctor - were also developed and shared with other practices at the Goulburn Valley Practice Networking meeting in Shepparton on 3 October 2023. To watch the videos, go to: murrayphn.org.au/murchisonmedicalclinic/

Coordinating care in general practice

Murray PHN commissions care coordination services in general practices to improve patient experience and health outcomes for people living with chronic and complex conditions, and to help build workforce capacity.

This year, several models of care have been funded across the region, including multidisciplinary teams for:

- disability in-reach services
- high-risk cardiovascular patients
- a cardiovascular pulmonary rehabilitation program
- a personalised chronic disease prevention and patient screening program
- nurse practitioner-led models for patients who need assistance with drugs of dependence and for aged care in-reach
- a further nurse-led clinic that works with pharmacy and allied health, particularly for medicinal cannabis training and support.

Providing clinically consistent care pathways

HealthPathways aims to support medical professionals in the best-practice assessment and management of common medical conditions, including when and where to refer patients for further care.

October 2022 - October 2023

- **789 localised pathways**
- **62 new pathways**
- **438 pathway reviews:**
  - 124 whole review only
  - 314 partial update and review
- **168,570 pathway pages viewed**
- **4 clinical working groups:**
  - 2 perinatal mental health with a total of 23 participants
  - 2 palliative care, with a total of 27 participants
- **449 people requested pathway access**

Creating a national suite of pathways

In January, Murray PHN applied to lead a review and localisation of the first ever suite of national pathways. In partnership with other PHNs and GPs, 11 pathways were developed as part of a rural health suite. The pathways aim to assist GPs and their patients with conditions that more commonly occur in rural and remote areas, such as snake and spider bites, heat-related illnesses and exposure to chemicals.

From some of the team involved in the review:

"Around 28 per cent of the Australian population live in rural and remote areas and face particular challenges due to their location. This suite aims to address some of these challenges and equip GPs with information and resources that are tailored to the specific needs of these communities."
- Dr Ann-Marie McKinnon, Murray HealthPathways Senior Clinical Editor

"Rural primary care can be quite different to urban practice in terms of conditions, clinical priorities and resources/ management options. Pathway sharing produces a robust clinical pathway, and standardised care pathways are a step in improving health equity across different geographic regions."
- Dr Helen Pedgrift, Far North Queensland Clinical Editor

"In Victoria, living outside of a metropolitan area equates to having two years less in life expectancy. This statistic really stands out for me, especially when we look at preventable and premature deaths in the rural population and how we as health professionals can make an impact."
- Dr Kate Graham, Western Victoria PHN HealthPathways Clinical Editor and COVID Clinical Advisor

"It is important to address the major issues affecting rural communities due to the worse health outcomes experienced by those communities, as well as addressing those issues that are unique to rural communities, such as the risks of accidental injection from animal vaccinations."
- Dr Brendan Condon, Western Victoria PHN HealthPathways Clinical Editor

"Agricultural populations have specific needs and health vulnerabilities compared to urban counterparts. Therefore, it's important to create cultural competence and context for health professionals with farmers, farm workers and their families as patients. These pathways are not just useful for GPs but for nurses, allied health professionals, Aboriginal health workers and the non-clinical team."
- Dr Richard Lunz, Rural GP working with the National Centre for Farmer Health

New dementia resources make it easier to find information and advice

Almost half a million people are estimated to live with dementia in Australia and, as people live longer, this number is expected to increase.

For some people, there are barriers to diagnosis that can include the belief that memory problems are a normal part of ageing, the perceived stigma attached to dementia and fear about the future.

But early diagnosis is important to enable a person with dementia and their family to receive help in understanding and adjusting to the diagnosis.

As part of the response to the Royal Commission into Aged Care Quality and Safety, the Commonwealth Government provided funding for resources to support people diagnosed with dementia or experiencing cognitive decline, their family and carers.

Earlier this year, six PHNs – Eastern Melbourne, Gippsland, North Eastern Melbourne, Murray, Tasmania and Western Victoria – developed resources in partnership with Dementia Australia.

A two-page brochure and four-page booklet provide information on where people can go for further help and advice. The resources include a new online Dementia Directory, making it easier for people to find trusted sources of information and advice. With information all in one place, the directory lists the contact details for regional assessment services and support groups,

The booklet briefly outlines the process of getting a dementia diagnosis, options for initial and ongoing management, and tips such as having a support person at appointments, taking notes and common questions that people might ask their doctor.

Aiming to make them easily accessible, the brochure and booklet were distributed to local general practice clinics, council offices, carer groups and others, and the information can also be viewed online at murrayphn.org.au/dementiapathways/

As part of this project, clinical management and referral pathways were updated and training provided to support health professionals in caring for their patients with dementia.

Delivering on our vision to enable reconciliation and healing

The First Nations Health and Healing Strategy enables Murray PHN to deliver on our strategic vision of enabling reconciliation and healing with and for First Nations Peoples in our region. It enables strong, healthy and vibrant First Nations communities to access best practice models of care.

This is being achieved through privileging the knowledge, strength and wisdom held by First Nations people, acknowledging that it is together we will find the way forward. This commitment targets our sphere of influence within the primary health sector, ensuring access to appropriate, respectful and timely healthcare.

Pivotal to this work is strong, respectful, reciprocal relationships with Aboriginal Community Controlled Health Organisations (ACCHOs) who deliver interconnected, whole-of-life services to Aboriginal communities. These partnerships have and continue to result in the commissioning of services that strengthen First Nations self-determination underpinned by First Nations worldviews on health and healing.

Equally important is ensuring access to health services that deliver the right care, in the right place, at the right time for First Nations Peoples, which requires service delivery underpinned by cultural safety. Murray PHN has key focuses on cultural safety capacity building in our commissioned Western services. This is addressed through collaboration and investment in strengthening our primary health sector's capability in addressing and reducing racism and supporting an uplift of the sector to one of anti-racism, resulting in increased access to primary health services delivering healthcare that is respectful and safe.

As we continue to strive for business excellence, underpinned by leadership and innovation, Murray PHN, through our internal Dhelkunya Yaluk cultural humility journey, is undertaking key steps to be a culturally inclusive, equitable and reflective organisation committed to authentic reconciliation with First Nations Peoples.

Providing post-referendum support

Murray PHN was proud to join other Victorian PHNs in supporting the important Gathering of Mob organised by the Victorian Aboriginal Community Controlled Health Organisation in November 2023. It was a vital opportunity for Elders, youth, and leaders from clans across the state to heal, yarn, and share stories to forge the way forward from the referendum.

Photos: Leroy Miller, courtesy of VACCHO.

Providing culturally safe chronic disease management

The Integrated Team Care (ITC) program is an innovative best practice wrap-around chronic disease management program. It takes a holistic all-of-person approach and enables not only extremely specialised care coordination, but access to Aboriginal outreach workers who form an integral part of the program, walking alongside the client as they navigate their health journey. Clients receive culturally safe care, and are supported in self-determination and self-management. In the last 12 months, the ITC program delivered to 1732 clients:

- **7755 care coordination services**
- **1203 supplementary services**
- **4731 clinical services**

This is a phenomenal achievement, particularly considering this level of service was delivered from only six ACCHOs with a total of 12 staff.

To be eligible for the program, people must be of Aboriginal and Torres Strait Islander origin, have a chronic disease and a current care plan. The program supports First Nations Peoples with chronic disease at all stages of life and disease progression.

ITC workforce development forum

In May 2023, Murray PHN hosted the inaugural Integrated Team Care workforce forum. This was a result of identification from the care coordinators working in the ITC program across our catchment (Mildura to Albury) of the need for, and importance of, coming together to share knowledge, network and support each other through capacity building. As a collective, key topics for discussion were identified with the most pressing being better support in managing and walking alongside ITC clients in end-of-life, and self-care as a professional working in a role with a highly complex client load.

Initially organised for ITC coordinators from each ACCHO, attendance was expanded to include ITC outreach workers, managers and care coordinators, following feedback on the importance of maximising the event's reach.

The forum was planned, coordinated and facilitated by Murray PHN's First Nations Health and Healing team, with assistance from PHN program support staff.

The forum enabled collective discussions about key improvements to the program, reporting on joint shared issues, as well as enabled access to the wisdom from attendees on the day-to-day practices as part of their roles. A keynote speaker delivered a session on selfcare when in a health role and supporting First Nations people in culturally safe ways through end-of-life.

The only negative aspect of the day was that it was too short and to address this, the forum planned for next year will be held over two days.

ITC workforce staff from each of the region's six ACCHOs participated:

- Bendigo and District Aboriginal Co-operative
- Mallee District Aboriginal Services
- Njernda Aboriginal Corporation
- Albury Wodonga Aboriginal Health Service
- Rumbalara Aboriginal Cooperative
- Murray Valley Aboriginal Cooperative

Creating stronger connections

In June, Murray PHN and local Aboriginal Community Controlled Health Organisation (ACCHO) staff from Albury Wodonga Aboriginal Health Service; Bendigo and District Aboriginal Co-operative; Njernda Aboriginal Corporation; Mallee District Aboriginal Services; Mungabareena Aboriginal Corporation and Rumbalara Aboriginal Co-operative came together at the second annual ACCHO and Murray PHN Gathering in Moama on Yorta Yorta Country.

With the shared aim of improving First Nations health and wellbeing, the meeting strengthened and deepened partnerships and relationships across organisations.

Aboriginal Community Controlled Health Organisation and Murray PHN gathering in Moama

Integrated Team Care making a difference

Case study

"Leigh," a young person with a mental health diagnosis, was referred to the ITC program for support with his malignant cancer.

Working in partnership with Leigh's GP, counsellor, social worker, oncologists, palliative care nurses and the Cancer Council, the ITC team held regular care coordination meetings about Leigh's care.

Being physically impaired due to his cancer, Leigh was supported with the hiring, and later purchasing, of a wheelchair, ramp, shower chair, electric bed and mattress.

Leigh's family received fuel and accommodation support to travel to Melbourne for hospital visits and for radiation appointments at Albury Cancer Hospital.

In June, Leigh was discharged from hospital with no further treatment offered and now continues to attend the Aboriginal service regularly.

Recently, Leigh's family was offered to move out of a caravan into permanent housing, a nebulizer was purchased and NDIS assistance provided.

Leigh is comfortable and receiving the best care possible. He and his partner are very happy with the holistic care they have been provided.

Aboriginal Therapeutic Day Rehabilitation

Case study

"Sophie," a young Aboriginal woman, was referred into the Dual Diagnosis program to address her poly-substance dependence issues.

In addition, Sophie received support for her depression and complex trauma that was a result of past violent relationships.

Sophie was craving more positive supports in her life, which she wanted to achieve by getting clean, improving her physical health, social and family connections and gaining employment.

Her family issues impacted on her session attendance: although she always contacted the case manager on the days she missed.

Through a flexible one-on-one case management approach, the worker reinforced the importance of harm-minimisation principles, patience and non-judgemental and reflective practices.

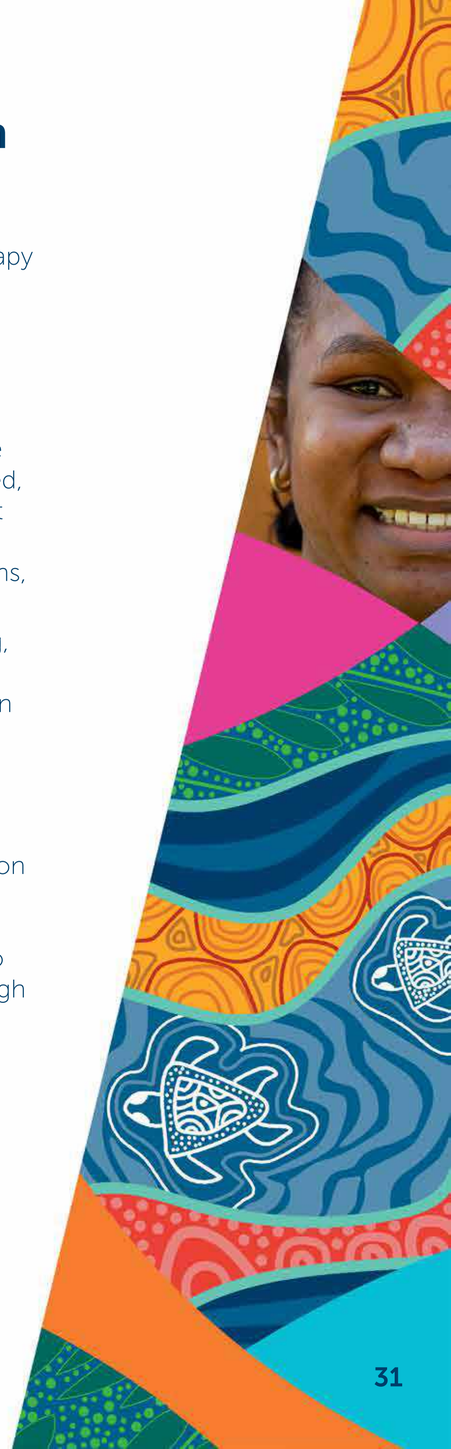
Sophie was engaged in group therapy and spoke about her issues with increased self-belief and insight, becoming an informal leader and motivating factor for other participants.

With her improved confidence, she persuaded her family to get involved, which not only improved their trust but engagement with medical and mental health teams for medications, health checks and plans.

Sophie finished the program saying, "I feel comfortable talking to you guys. I've never really been a person to open up to people. I have been clean for nine days and that's the longest I've been clean for in 10 years."

Sophie identified that her connection with Country, Culture, family, kinship, body, mind and emotions had improved and that she plans to continue accessing supports through women's and wellbeing groups.

"I feel comfortable talking to you guys. I've never really been a person to open up to people. I have been clean for nine days and that's the longest I've been clean for in 10 years."



First Nations pilot program already making significant impact

baringgurrak means 'our journey' in the Dja Dja Warrung language. It's also the name of Bendigo and District Aboriginal Cooperative's (BDAC) new Therapeutic Rehabilitation Day Program, now more than halfway through its 18-month pilot.

baringgurrak is the first Alcohol and Other Drugs (AOD) Therapeutic Rehabilitation Day Program in Victoria designed by and implemented for First Nations people. The passion and dedication of those working in this pilot is palpable as they share the program's healing journey and positive impacts.

Daniel Fawkner is Program Manager of Wellbeing at BDAC. He explains that a lot of people he had worked with had accessed mainstream rehabilitation programs, but participants and Community said there was a gap, and they would prefer a more culturally focused program.

"This program is a first for us. People said they wanted more Culture, something more hands-on. We identified that we could improve on multiple things compared to the current model of program design. We have focused on creating a healing program."

BDAC came to Murray PHN with their proposal for a pilot program designed to better meet the needs of First Nations people and evolve and develop with each round of participants. Structured to include conventional activities such as AOD and mental health sessions, it's the focus on activities centred on Culture, connection, family, healing and Country that set this innovative program apart.

Murray PHN's First Nations Health and Healing Strategy prioritises self-determination in First Nations commissioning so First Nations communities can access best practice models of care.

Paige Lock is AOD Coordinator at Murray PHN. She says that BDAC put together a strong proposal that stepped everything out.

"We agreed to that. It covered all the bases we needed. So now, I'm enjoying seeing the program succeed and grow."

Four rounds of participants have completed the program, with several still to come. After each, yarning circles and other First Nations designed and led evaluation processes have been used to improve and evolve the program. Both the staff and participants contributed their feedback to a mid-term evaluation report by Kowa Collaboration, a First Nations-led organisation focused on impact measurement, evaluation, and learning.

Chris McGhee is *baringgurrak* Coordinator. He says that the cultural safety and a focus on healing are at the heart of program.

"The program suits our clientele better. In fact, for many people it's been life changing. Participants have got jobs, got their licence, lowered their substance abuse, focused on their health by seeing the nurse or doctor regularly, improved their family relationships, reconnected with Community and Country, the list goes on."

Jade Davey is *baringgurrak* Female Case Manager and Facilitator. She says some of the outcomes and impacts have not been seen in previous programs.

"We have participants forming connections and saying to each other I really want to keep catching up with you guys, which is not common in rehabilitation programs. Elders are telling us it's a great program and they want to continue to participate and get more involved with new activities such as spiritual healing and bush medicine. Magistrates are keen to support the work of the program."

"For me, one of the most rewarding aspects is participants are bringing families to their graduation. They are proud and standing up in front of their kids. Some kids are old enough to know what's going on and are accepting and proud too."

Daniel, Chris and Jade agree that this Victorian one-of-a-kind pilot is not only making a difference to participants' lives, the flow-on effects are also impacting BDAC. Daniel says they are learning too.

"With each round of feedback, with each yarning circle, we reflect and gain greater insights into how the program can better meet our clients' needs. We are also upskilling our workforce, as this program is a first for them as well."

When asking about what hopes and aspirations the team have for the program beyond the pilot, Daniel sums up succinctly.

"We want it to be sustainable. To keep connecting. This program is not only a Therapeutic Rehabilitation Day Program. It's more than that. It's a healing program. For clients. And the Community as a whole."

"The program suits our clientele better. In fact, for many people it's been life changing."

Advocacy and partnerships

Murray PHN seeks to promote the best investment possible for rural communities. We engage in shared and direct advocacy to inform relevant models and policies for our community, and showcase excellent examples of rural multidisciplinary care.

Our Rural Health System Advocacy Framework, developed this year, addresses three priorities, which are to:

1. Describe primary care service models that are effective in different rural contexts to inform scalability
2. Advocate for high-quality integrated policies to support a strong rural health system
3. Engage and communicate effective local solutions, tools and resources.

With significant developments now taking place in primary healthcare system reform, Murray PHN sees an important role in continuing to promote the need of rural communities to access high-quality and responsive healthcare.

We have now built significant evidence about the priorities for our advocacy, and are setting objectives, identifying and meeting with partners and audiences, and developing and refining key messages.

As part of this work, members of our team mapped 75 different national rural healthcare models, analysing them to find barriers and enablers. Our analysis has shown that there is lots of work being done, but very little being shared between levels of the health system. While some is evaluated, a great deal is not published. To address this, we are now advocating for a central repository and annual events that will showcase this work.

Bringing sectors together to collaborate

The 2022 National Mental Health and Suicide Prevention Bilateral Agreement between the Commonwealth and Victoria sets out the shared intentions of the respective governments to support collaborative regional planning.

Recognising the opportunity the agreement offers to improve the integration of mental health, AOD and suicide prevention services (including family violence and community services), Murray PHN partnered with Mildura Base Public Hospital to establish the Northern Mallee Integrated Mental Health Leadership Network in February.

Through sector leadership representation and governance structures, the network has been established to take a strategic approach to addressing current and future challenges, to provide an authorising environment for activities in key areas of opportunity for improved mental health planning and service provision.

The network aims to align local, state and federal strategies and services, including state reform activities; foster an environment of collaboration, and share a future focus and actions to build a sustainable service system for the region.

Murray PHN has played a coordination role in supporting its development and by providing chair and secretariat support for the first two meetings.

Invited member organisations included health, education, housing, government and emergency services.

Convening a health forum in Mildura

In April, local health services and community leaders in Mildura met to share their perspectives on the challenges of providing healthcare in regional communities. The discussion was chaired by Murray PHN CEO Matt Jones and attended by Emma McBride, the Federal Assistant Minister for Mental Health and Suicide Prevention and Assistant Minister for Rural Health and Regional Health.

Pictured L-R: Emma Harradine, Murray PHN; Matt Jones, Murray PHN; Terry Welch, Mildura Base Public Hospital; Federal Assistant Minister for Mental Health and Suicide Prevention and Assistant Minister for Rural Health and Regional Health, Emma McBride; Teresa Cavallo, headspace Mildura; David Kirby, Mildura Base Public Hospital.

Sharing the work of PHNs

In September, Murray PHN met with the Victorian Parliamentary Secretary to talk about the work of PHNs and Murray PHN in mental health, particularly the learnings from the suicide placed-based trials in Benalla and Mildura.

Pictured L-R: Tim Richardson, Parliamentary Secretary for Mental Health and Suicide Prevention; Matt Jones, Murray PHN CEO; Ian Johansen, Murray PHN Director Mental Health and Wellbeing

THE Caring CIRCLE

Greater Choices for At Home Palliative Care

Palliative care

Supporting rural people to die at their preferred place

"Death is a natural and an inevitable part of life, but a good death is achievable, as long as we talk about it and plan ahead."

– Ebony Lewis, researcher and nurse

Death is often viewed as a taboo topic, surrounded by fear and denial, and not usually discussed in our daily lives. But when asked, most people express a preference to die at home.

People living in regional and remote areas have close connections to their community and land, which makes them more likely to consider dying in the country, rather than at a health service in the city. However, some of these people are still dying in metropolitan hospitals, away from what matters most to them, without knowing that in some circumstances, dying at home is possible.

The Caring Circle project aims to improve the health outcomes of people living with an end-of-life condition in the Goulburn Valley and North East areas of the Murray PHN region, by building the capacity and capability of those involved in their care – their carers, families, health services and communities.

Now at the halfway point of a four-year project, Murray PHN's palliative care team, in partnership with local, state and federal organisations, has delivered meaningful palliative care activities throughout 2023.

Community palliative care empowerment, education and capability building:

- ***Carers' wellbeing information sessions, in partnership with FamilyCare Shepparton, Merri Health and CarerGateway:*** empowering end-of-life carers with information on where to access wellbeing strategies and support services when caring for others. Sessions were delivered in Cobram, Beechworth, Seymour and Shepparton.
- ***Grief, loss and bereavement in dementia forums, in partnership with Dementia Australia:*** building awareness and empowerment of dementia carers to feel better equipped to access support, from diagnosis to end-of-life, including bereavement. Sessions were delivered in Wodonga and Shepparton.
- ***Introduction to dementia workshops, in partnership with Dementia Australia:*** building awareness and education among carers, community members and people living with dementia of the most common symptoms of the condition and how to plan ahead when life circumstances change. Sessions were delivered in Wodonga and Shepparton.
- ***End-of-life carers, consultations, in partnership with GV Hospice and The Groundswell Project:*** consultation and needs assessment on the most important support aspects required to enhance end-of-life carers' wellbeing and quality of life. Workshops were held in Shepparton and the findings will inform carer-focused activities in the second half of this project.
- ***Palliative care AUSLAN information resources, in partnership with Bendigo Deaf Hub:*** development of palliative care and advance care planning community information sheets translated in AUSLAN and shared state-wide, including in the Victorian Department of Health's Health translations directory.

General practice capacity and capability building in palliative care coordination - a partnership with Gippsland and Western Victoria PHNs

- ***Regional Victoria Palliative Care Quality Improvement Pilot:*** embedding of data audit, quality improvement (QI) driven palliative care strategies across general practices in regional Victoria, through a newly developed QI toolkit. Practices will be commissioned to pilot this new resource aimed to augment their palliative care coordination.
- ***Palliative care webinar series:*** regional Victorian general practices were given the opportunity to participate in a capacity development program focused on managing regional and remote patients living with dementia, including opportunities for sustainable palliative care practice.

The project's community engagement strategies attracted more than 160 participants, as well as 80 general practice staff across regional Victoria. For more information, visit: murrayphn.org.au/thecaringcircle

Ensuring access to information for deaf and hard of hearing people

Hilary Callaghan is Communications and Stakeholder Engagement Officer at Deaf Hub Bendigo. She worked with Murray PHN to translate palliative care information flyers into Auslan, to ensure these important resources also reached deaf and hard of hearing people throughout our region.

Q: Can you tell us a little about Deaf Hub Bendigo and its purpose?

A: Deaf Hub Bendigo is a deaf-led community not-for-profit organisation that was established in 2019. The primary purpose is to empower regional Victorian deaf and hard of hearing people across all walks of life.

One of the biggest aims of Deaf Hub Bendigo is making information accessible, as English is usually a second language to the majority of us. Even then, because it has a whole different grammar, structure and syntax to Auslan, in some cases our understanding of written English can be that of a primary school aged child.

It is important to have information translated into Auslan, so that it can be unpacked and the true meaning of everything is conveyed and understood. That empowers the individual to do what they want with the information they now understand.

Q: What is your role in the organisation?

A: My official title is Communications and Stakeholder Engagement Officer, however I do a bit of everything across all aspects of the organisation.

I initiate and continue contact with outside organisations and individuals, organise and promote workshops and events, set up projects and ensure they are completed, work with others to take their written English information and translate it into Auslan, create flyers and posters for both print and digital use, and create accessible online videos to add to print media via QR codes.

I could go on and on, but when it comes down to it, my role is to make things accessible and to encourage others to continue making them accessible.

Q: Can you explain the process of translating Murray PHN's palliative care information resources into Auslan?

A: In this situation, I was provided with flyers that had all the information on them, so they were my starting point for video creation. What I typically do is break down the text to simplify it a little, because in Auslan there isn't a sign for everything and so some things need to be explained in more depth to convey the meaning.

I went through all the text and then typed up an 'Auslan script' on a teleprompter, which I then used when filming. The video was then edited, captions added and uploaded to YouTube.

Once on YouTube, I was able to create a QR code linking to the video which could then be added to the flyer artwork. This makes the Murray PHN palliative care information flyers instantly accessible for the deaf and hard of hearing community without them having to redesign the whole thing.

Hilary Callaghan of Deaf Hub Bendigo

Q: What feedback did you receive from deaf and hard of hearing people about these resources?

A: Feedback regarding any health-related resources has always been the same. Time and again, people say such things as, "I had no idea those services were available," "I didn't know that I was meant to do that/ those checks" and "I didn't realise that wasn't normal."

Being able to make any resource accessible to the deaf and hard of hearing community is always a privilege, but especially so when it is life-saving information. Deaf people have a higher mortality rate due to inaccessible information, so the more things we can make accessible, the more we can get the information out there, the lower that rate will eventually become.

Click here to view the videos or use the QR code above

Case studies

A year after she received a diagnosis of dementia, "Noelene" was admitted to hospital and then moved to a residential aged care home, where she became bedridden with little interaction with others. Noelene's husband "Don" and daughter "Sally" attended an Introduction to dementia information session, with Sally significantly concerned about her own risk of developing dementia, due to the fast progression of her mother's condition and increasing frailty.

Both Sally and Don were referred to the dementia helpline, and Don has accessed carer respite services to enable him to manage his own wellbeing, while continuing to visit Noelene daily. Sally was encouraged to discuss her own risk of developing dementia with her GP. At the session, Sally connected with a neighbour whose husband also has dementia. She said, "Thank you for all the work put into the dementia event. I got a lot out of it and will share what I learned with others. Really appreciated!"

"Susan", who is aged in her 60s, lives in a border community with her husband who has lived with dementia at home for the last five years. Susan's husband was hospitalised in the city, following a fall, with Susan travelling back and forth to visit three times a week.

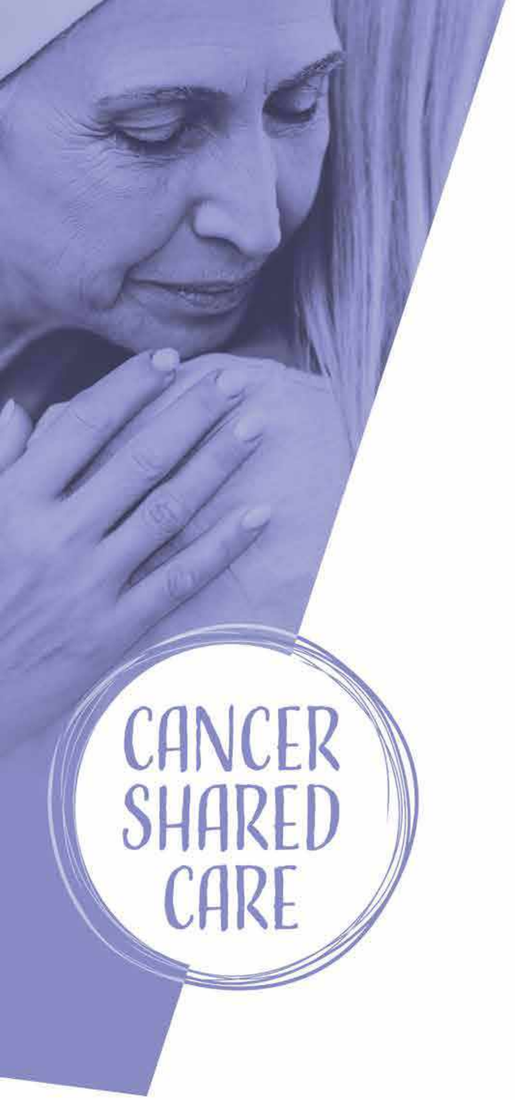
Exhaustion from travelling, the cost of fuel and Susan's role as a carer increased the burden on her mental health. Susan's daughter noticed changes in her mother's wellbeing and registered her to attend the carers' wellbeing event.

At the event, Susan was grateful for the opportunity to meet other members of her community experiencing the same caring role, and also struggling to cope. Susan also met her local Carer Gateway provider, self-referred to walking and networking groups, and sought respite for her husband after he was discharged from hospital.

Susan found the session challenging, but left feeling empowered, and with new local community connections to support her and her husband through his dementia journey.

"Thank you for all the work put into the dementia event. I got a lot out of it and will share what I learned with others. Really appreciated!"

Palliative Care Lead Vitor Rocha speaking about The Caring Circle project on ABC local radio, Palliative Care Project Coordinator Veronica Denton presenting at a carers' wellbeing event, Vitor Rocha attending a palliative care conference and resources at a community event.



Cancer shared care project

Enhancing general practice participation in cancer care coordination

Shared survivorship is considered an effective care coordination strategy to support patients to live as well as possible for as long as possible, during and after active cancer treatment. Shared cancer follow-up care involves the joint participation of specialist oncology clinicians and GPs in the planned delivery of cancer care from diagnosis, discharge or, in some cases, until end-of-life. The care is based on the grassroot value of patient wellbeing, and focuses on strengthened collaborative communication and patient-centred practices.

Funded by the Victorian Department of Health, the Cancer shared care project aims to improve the health outcomes of people living with cancer, cancer survivors and their carers, with a focus on coordination and communication between services.

In the Murray PHN region, the City of Wangaratta and Shire of Gannawarra have the highest burden of cancer incidence and mortality, especially for breast, colorectal, prostate and low-risk endometrial cancers (Murray PHN Needs Assessment 2022), which identified them as communities of focus for this project.

In consultation with people with a lived experience of cancer, health professionals and other key stakeholders, a rural cancer shared care model has been developed and is being piloted, with care shared between the hospital-based oncology team and general practice.

Throughout 2023, practices have embedded the co-designed patient-centred care model. The findings of the pilot will inform a potential expansion of this model, with applicability across other regions.

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

Health provider case study

"At my first discussion through the cancer shared care project with my patient "Maggie," post-breast cancer diagnosis and mastectomy, I met with a young woman who understandably was both scared and devastated.

Maggie's culturally diverse background presented some barriers in her understanding of treatments and procedures and what it all meant for her. It was an incredibly stressful time.

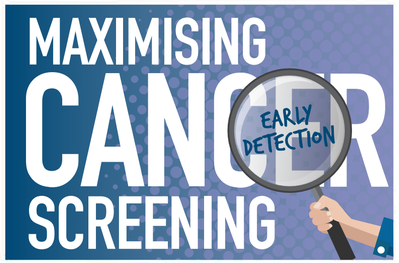
Maggie was always very open in her conversations about how she was feeling, how her husband was coping and how their children were processing her diagnosis. At different times, they were all struggling with the unknown and that the busy life they led had been turned upside down.

It seemed a listening ear, especially during Maggie's chemotherapy regime, was helpful - it was a particularly tough experience for her. Having a nurse to bounce ideas off and suggest solutions, in conjunction with her breast care nurse was beneficial.

During her radiation treatment, Maggie was linked with yoga sessions and other activities that have given her a positive outlook and created self-care opportunities that she may not have accessed herself.

I was most pleased after our recent discussion that Maggie felt well, positive and had a short and long-term plan for the future post-treatment. Maggie's familial relationships were strengthened, and they could all see that a challenging chapter was coming to a positive end.

- Goulburn Valley doctor



Cancer screening project

Maximising cancer screening participation

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

The COVID-19 pandemic affected many areas of peoples' lives, including their access to, and use of, health services such as cancer screening programs. When screening is delayed or missed, it is possible that a precancerous abnormality may progress to cancer, or a cancer may develop to a stage that is more difficult to treat.

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

The Maximising Cancer Screening Project (MCSP) was undertaken during the 2021-2023 financial years and focused on improving cancer screening awareness and participation through enhanced primary care and community health systems.

Given that primary healthcare is key to addressing delays in cancer diagnosis, Murray PHN engaged 17 general practices and two bush nursing centres to focus on improving screening rates in under-screened and never-screened populations, between January to June 2023.

The project supported providers to link with national screening registries, accurately identify never-screened and under-screened patients, access evidence-based information for patients, develop screening initiatives, and promote the importance and awareness of cancer screening. Throughout the project, cancer screening statistics from practices demonstrated a positive, upward trend, with large numbers of patients participating in screenings.

Working closely with the Cancer Council Victoria and Murray PHN, one bush nursing centre provided training to their registered nurse, enabling the provision of a new cervical screening service in their local community.

A great legacy of the project is the ongoing commitment from providers to cancer screening initiatives. After achieving a significant increase in liver cancer screening throughout the project, Albury Wodonga Aboriginal Health Service arranged for the mobile breast screening van to attend their service, promoting it as part of an event providing free bra fittings and a bra giveaway, to encourage participation of Aboriginal women aged 40-74.

Evaluation of the project showed it was helpful in educating staff and promoting the need for cancer screening in the community. The main enablers of its success were resources, practice staff support, cancer screening systems and structures, cultural safety and technology.

Albury Wodonga Aboriginal Service set an all-time high breast screening result of 80 per cent in their region - the highest in the state - and significantly higher than the state average of 35 per cent.

In addition, the effectiveness of their campaign targeting the never-screened and under-screened was demonstrated, with 64 of the 89 women (72 per cent) being first time screeners and the majority of the remaining participants being overdue for screening.

Ladies' night out to increase screening

In May, Lockington and District Bush Nursing Centre held a ladies' night out to increase awareness of breast and cervical cancer screening, as numbers declined during the pandemic.

As part of the event, a community member shared her story of having breast cancer and there were educational talks on cervical and breast screening.

Murray PHN, along with Cancer Council Victoria, provided funding to assist the centre to increase screening rates and to upskill a nurse in cervical screening so that the service can be offered on an ongoing and regular basis.

More than 100 women attended the event, with many attendees booking an appointment for screening.

12 RIVERINE HERALD

FRIDAY, MAY 12, 2023

Ladies Night Out proves a hit

Lockington and District Bush Nursing Centre held a "Ladies Night Out" on May 3.

The night was staged to increase awareness of rates for breast and cervical screening, due to numbers dropping off during COVID.

Murray PHN in conjunction with the Cancer Council Victoria provided some funding to assist with the project.

Organisers were pleased with the turnout as more than 100 ladies attended the free, fun and informative night.

The ladies were welcomed with a glass of bubbles and tables of grazing plates.

There was fun games and entertainment with the best dressed.

Talks on cervical screening and breast screening were done by nurse Priscilla Landy.

A story was shared from an extraordinary lady's journey with breast cancer.

A raffle was held on the night with funds raised going to the cancer council.

"Some of the Murray PHN funding provided, we also used to train Priscilla on cervical screening so we can offer the service to our area ongoing on regular basis," Lockington and District Bush Nursing Centre manager Kim McDonald said.

"We have had wonderful positive feedback from the night and already have people booked in for screening. That is the outcome we were looking for."

A reason to smile: Sue Stewart took out the best dressed prize.

Stylish: The best-dressed nominations at the Ladies Night Out fundraiser in Lockington earlier this month.

Information: Nurse Priscilla Landy speaks at the event about cervical and breast screening.

Team effort: Meagan Brentnall, Kylie Floyd and Deb Taylor at the event.

Proud: Centre manager Kim McDonald.

Big turnout: More than 100 ladies attended Ladies Night Out in Lockington.

Other projects

A model for paediatric care

Outside metropolitan areas, it can be hard for parents to access the care their child needs. In 2022, Murray PHN provided short-term funding for a paediatric project pilot in general practice.

St Anthony Family Medical Practice developed a model to provide early and timely access to coordinated care in the Bendigo region. Key elements were a central intake panel where team members – GP, nurse, family liaison coordinator, allied health practitioner and paediatrician – would meet weekly to discuss and triage referrals, reviews and case management, providing "one door" for families to communicate with all of the people involved in their child's care.

You can read more in the practice's Australian Journal of Rural Health submission (paid access): https://onlinelibrary.wiley.com/doi/10.1111/ajr.13006?af=R

Helping refugees to navigate the health system

Knowing who to see or where to go to get the care you need can often be confusing or overwhelming, particularly if you are not well, or your language skills are not strong.

Health system navigators assist people from underserviced groups, including refugees and people from cultural and linguistic diverse backgrounds, and those with multiple and complex, chronic conditions who repeatedly present to hospital or experience barriers in accessing health services.

Health navigator organisations – Primary Care Connect Shepparton and Bendigo Community Health Services - work closely with general practice and community services to provide direct, non-clinical support, health education and referral for people. This year, they have delivered more than 2165 hours of support to 849 clients, of which 85 per cent had one or more complex health needs.

Improving mental health referrals

The Initial Assessment and Referral (IAR) program is a national initiative that focuses on establishing effective systems for assessing and referring people presenting to primary care services and seeking mental health support.

The IAR-Decision Support Tool (DST) provides clinicians with a standardised framework for decision-making when matching a person's mental health needs with the appropriate level of service intensity, at the right level and time. It aims to enhance transparency in referral decisions and to establish a common language across the mental health sector.

In 2023, Murray PHN held 30 free, two-hour workshops both online and face-to-face across the catchment, providing training to more than 267 local health professionals, with more than 100 of these professionals being GPs and GP Registrars.

Feedback from the training sessions indicated strong support for the tool and its potential to improve decision-making and communication in mental health referrals.

To learn more, visit: https://www.murrayphn.org.au/iar/

"Good initiative, looking forward to using it." – GP

Putting doctors and nurses in schools

Wodonga Middle Years College is one of 21 Doctors in Secondary Schools (DiSS) program sites in the Murray PHN region and 100 in Victoria. The program provides funding for a GP and nurse on site one day a week to provide free and accessible healthcare to students, reducing pressure on working parents, and helping to identify and address health problems early.

Originally available at the college's Huon campus, the DiSS program has extended to the Felltimber campus in 2023, with the service alternating weekly between sites.

Dr Jess Madden has been with the program since its inception. She currently sees more than 250 students in years 7, 8 and 9, and enjoys connecting with and providing healthcare to students who may not otherwise have had the resources to access services. Dr Madden also works at a second DiSS school – Wodonga Senior Secondary College – providing healthcare to students in years 10, 11 and 12.

Dr Madden says, "There is no substitute for being onsite at the school for ease of access, while also being a part of the school community. I enjoy working with young people and their families and being able to provide adequate care, thorough follow up and continuity of care throughout a student's middle and senior school education."

Kristy Szabolics is the practice nurse at Wodonga Middle Years College (and also Wodonga Senior Secondary College) and when not working at the school, works as a midwife at Albury Wodonga Health.

Bringing more than 15 years of experience and knowledge in the health and medical field, Kristy says, "I really enjoy being a part of the program and find the outcomes for students very rewarding."

Program lead and wellbeing coordinator at Wodonga Middle Years College Felltimber campus, Rachel Miller, worked closely with Dr Madden, Kristy and the PHN to advocate for the Felltimber campus to have its own DiSS clinic, so that students did not have to travel to the Huon campus, located on the other side of town, to receive medical care.

"It has been great to see the program's growth over the past six years," she says.

The health and wellbeing team at the school work collaboratively with Dr Madden and Kristy to ensure the best outcomes for students. Students can be referred for diagnostic tests and to other health specialists if required.

Pictured L-R: Kristy practice nurse and Dr Madden at the Huon Campus Clinic.

Pictured L-R: Kristy practice nurse, Rachel DiSS program lead, Amelia year 9 student and Dr Madden at the Felltimber Campus Clinic.

"There is no substitute for being onsite at the school for ease of access, while also being part of the school community... being able to provide adequate care, thorough follow up and continuity of care throughout a student's middle and senior school education"

Strengthening rural workforce planning

In June, Rural Workforce Agency Victoria interim CEO, Lauren Cordwell and key staff visited Murray PHN executive leadership and team members in Bendigo to discuss opportunities for collaboration in rural workforce recruitment, development and planning.

"RWAV and Murray PHN share several common interests in rural health and, in particular, supporting sustainable health workforce models to support our communities. We look forward to continuing to work together across a number of aligned portfolios including workforce strategy, planning and prioritisation, and development."

- Murray PHN's Dr Nerida Hyett

Pictured L-R: RWAV interim CEO Lauren Cordwell, Murray PHN Integrated Health Network Project Lead Dr Nerida Hyett, Murray PHN Director of Operations Janice Radrekusa, Senior Manager Healthcare Access Joanne Willatts, RWAV Senior Manager Health Workforce Solutions Kate Temby, Murray PHN former Chief Strategy and Performance Dr Belinda O'Sullivan and RWAV Manager Analytics, Reporting and Business Systems Dr Monika Jones.

CAPACITY BUILDING

In an era of workforce shortages in almost every clinical field, PHNs have a key role in supporting high-quality health service and sustainable healthcare businesses, while working with providers to allow them to work to the full scope of their practice and capabilities.

Healthcare providers can find it challenging to put aside time to improve their business practices or introduce new and innovative models of care.

Part of Murray PHN's role is to help build the capacity of primary care practices and mental health providers to undertake quality improvement projects, integrate care with other providers, and maximise the use of data and digital health systems.

As with all our roles as a PHN, we look to find innovate ways to improve healthcare system quality, and to test and pilot effective healthcare models that can be used in other parts of our region, and by other PHNs.

Strengthening and supporting our workforce

Generally, the more remote a place is, the fewer health professionals will be working there.

In rural areas, there are growing pressures for primary healthcare, and it has never been more important for us to support medical professionals to work in satisfying and sustainable jobs. Murray PHN supports existing GPs and other primary healthcare clinicians in our region, while at the same time, piloting innovative solutions that can help attract – and retain – more clinicians to our region.

Read more in our 2023 Murray Health report: the importance of primary healthcare.

Workforce Prioritisation Planning

As part of the Commonwealth Government's national workforce planning, Murray PHN is leading the Victorian PHN consortium to prepare a range of Australian General Practice Workforce Planning and Prioritisation (WPP) reports for the Department of Health and Aged Care.

The project is aimed at supporting the transition to college-led general practice training, through the provision of planning and prioritisation advice on GP training placements.

The primary goal of this work has been to identify the regions with the most significant demand for healthcare professionals and those that have the necessary training capacity to accommodate AGPT GP registrars.

The Victorian consortium applied the following approach to developing the report:

1. Confirmation and agreement of the data indicators required to prepare the Workforce Need and Training Capacity analysis at a national level
2. Methodology development and quality improvement for both Workforce Need and Training Capacity analysis
3. Quantitative data extraction and analysis to prepare preliminary Workforce Need and Training Capacity findings
4. Local intelligence and qualitative data gathering from key state-based groups (registrars, supervisors and practice managers) by the centralised working group to further inform analysis
5. Local intelligence and qualitative data gathered by local consortium teams to face validity check and identify discrepancies
6. Refinement of ratings based on local validation
7. Consultation with the Victorian stakeholder advisory committee and Victorian PHN CEOs to test analysis
8. Preparation of final Victorian WPP ratings (including a pilot regional training pathway analysis)

In Victoria, there are 153 catchments which are a mix or regional, rural and metropolitan areas. This work has revealed that 50 per cent of these experience moderate to high GP workforce need and the GP catchments with the highest workforce need are all located in rural Victoria.

Piloting new models of rural healthcare

The Integrated Health Network (IHN) Alliance was formed in 2019 to focus on addressing the health needs of the Buloke, Loddon and Gannawarra region. These include chronic conditions like diabetes, heart, respiratory, mental and oral health, and other needs of the ageing population. In 2022, the IHN Alliance launched its Sustainable Rural Health Project to begin addressing the gaps caused by workforce shortages.

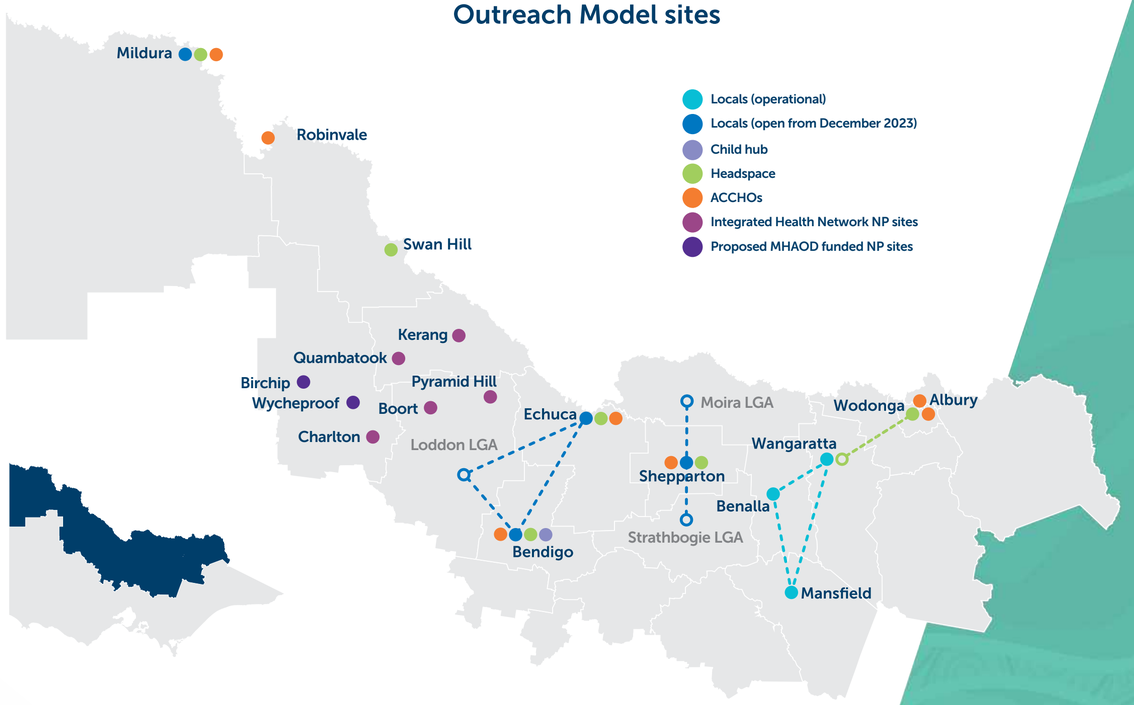
After months of research interviews with health professionals, consumers and carers, the alliance released its first The Way Forward to Sustainable Rural Health report in May, to demonstrate the importance of co-design in understanding local health priorities and perspectives. In June, the project and report findings were shared at the National Rural Health Alliance, Rural & Remote Scientific Symposium in Canberra.

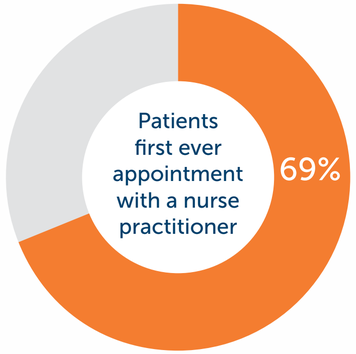
A new Nurse Practitioner Rural Outreach Model pilot program began earlier this year. The pilot is one of a series of trial models to help local health organisations work with community to create and test new services and strategies.

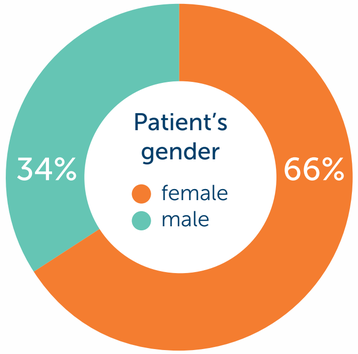
Mid-way results snapshot to June 2023

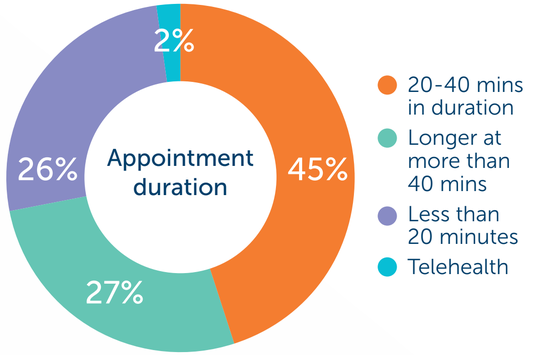
- Four sites are operating at Charlton Medical, Boort District Medical Centre, Northern District Community Health in Kerang and Quambatook
- A total of 28 clinic days and 284 patient consultations have been delivered by the nurse practitioners and care coordinators across the four sites
- Majority of patients were from towns within the Buloke, Loddon and Gannawarra regions
- Patients reported very-high satisfaction with the service:
  - *"No travel and good to have a female practitioner."*
  - *"When the doctor is not available, I am able to see the nurse practitioner and feel confident."*
  - *"Availability on short notice for an urgent issue. Excellent understanding of female health issues and excellent with young children."*
  - *"The nurse was very understanding; I suspect we will need her to visit more than once a fortnight. The service will take a lot of pressure off our overworked doctor."*

Outreach Model sites









Advocating for mental health needs

Pictured L to R: Dr Nerida Hyett, Murray PHN Integrated Health Network Project Lead, Dallas Coghill, Inglewood & Districts Health Service CEO, Donna Doyle, Boort District Health CEO; Mandy Hutchinson Northern District Community Health (former) CEO, Trevor Adem, East Wimmera Health Service CEO, and Dr Cath Lees, Murray PHN Director Integrated Projects and Partnerships.

In July, Murray PHN and Northern District Community Health organised a special listening tour with the Loddon Mallee Interim Regional Body for Mental Health & Wellbeing in Kerang.

The event discussed the advocacy paper Increasing Access to Mental Health Supports in the Buloke, Loddon, Gannawarra region, and informed partnership and place-based planning activities.

Read the paper and learn more about the Sustainable Rural Health Project at: murrayphn.org.au/sustainableruralhealthproject/

Building nurse capacity

The Murray PHN region is home to 34 urgent care centres, 18 of which are in towns with populations of 2000 to 4000 people and only one general practice.

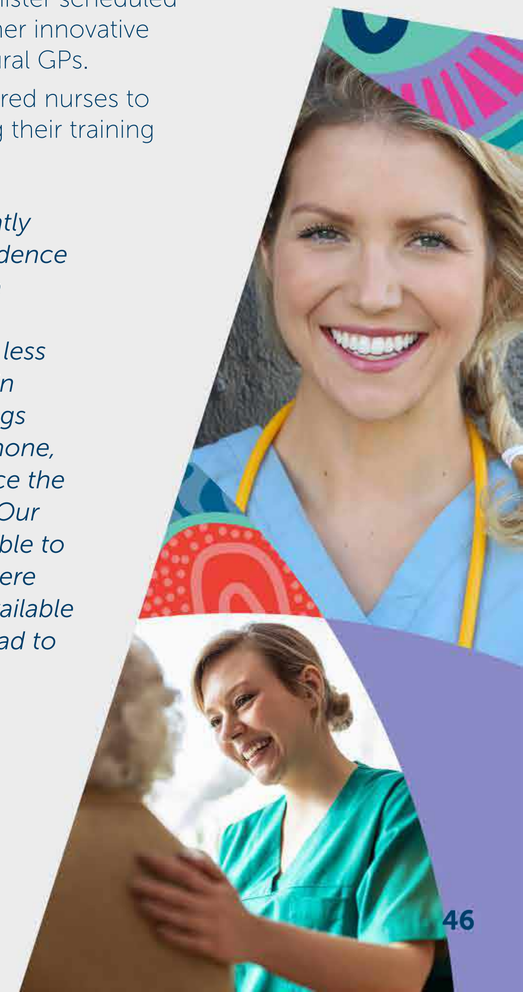
To support the expanded scope of practice of acute nursing staff in regional services and rural urgent care centres, Murray PHN provided scholarships for entry into the accredited Rural and Isolated Practice Registered Nurse (RIPRN) course through the Cunningham Centre.

A trained RIPRN nurse has additional training to supply and administer scheduled medicines. They can work in urgent care centres and support other innovative approaches to reduce the after hours demands and burden on rural GPs.

Since 2019-20, Murray PHN has supported more than 120 registered nurses to attain RIPRN qualifications, with the final two cohorts undertaking their training in November 2023 and February 2024.

"Having RIPRN trained nurses can potentially assist with some interventions at times when there are staffing shortages with the doctors from the GP clinic adjacent to the hospital. Nurses taking on extra training are highly valued as they can bring much needed relief when other healthcare professionals are finding it difficult to meet the needs of patients in a timely manner due to other patient commitments."
– Stephen, RIPRN applicant

"The RIPRN model has greatly improved our nurses' confidence and skills in the urgent care centre. Our on call Visiting Medical Officers (VMO) are less fatigued as they are called in less often – with many things being managed over the phone, supported by the confidence the VMOs have in our RIPRNs. Our community members are able to access timely care when there are no GP appointments available at the clinics, which may lead to decreased admissions."
– Amanda, RIPRN applicant



Supporting new practice managers

General practices in our region have experienced a high turnover of staff, especially practice managers. In the last 12 months, more than 30 practice managers have left their roles. In response, Murray PHN's practice engagement team has created online forums for practice managers new to general practice. The forums provide a place to enable discussion and share information and resources, including quality improvement, accreditation, MBS item numbers, GP registrars, events and training.

Practice manager events across the Murray PHN region

Continuing professional development

To strengthen our local workforce and help to deliver improved patient care, Murray PHN supports continuous professional development (CPD) through a range of mostly free education and network events. In the last financial year, our program included:

- 60 events incorporating general CPD, communities of practice, industry briefings, network meetings and engagement forums
- A range of topics such as immunisation, clinical governance, infection prevention and control, dementia, aged care, flood preparedness, infectious disease, health coaching, asthma, spirometry, mental healthcare, chronic kidney disease, mosquito-borne diseases, palliative care, cancer shared care and wound management
- 861 attendances
- 184 general CPD evaluations received, with an average of 91 per cent of respondents indicating their learning needs were entirely met
- 11 recorded webinars, with more than 500 views on YouTube
- 33 Events updates were sent and were clicked more than 380 times.

General Practice Engagement Lead Sophie Bond

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

Attendee feedback

"Clear and informative webinar, very useful in my practice"

"Excellent presentation and up-to-date information"

"Fantastic concise presentations. Good to reinforce knowledge and new knowledge gained"

A real sense of community in small rural town

Small rural towns are known for their tight-knit communities, their resilience and their willingness to work together to achieve common aims.

All these things have contributed to the long-term success of Wycheproof Medical Centre, a solo GP practice. Owner Dr Ken Mulligan has worked in the town for close to 25 years. Not only is he dedicated to the health and wellbeing of the area's local people, his support staff are a small group who are also passionate about embedding quality improvement measures in the practice, to ensure patients receive the best care possible.

The Practice Incentives Program Quality Improvement Incentive, or PIP QI as it is commonly known, is designed for general practices to encourage changes that are relevant to their patient populations. It focuses on improving patient outcomes and access to care while also developing a more effective business.

For Wycheproof General Practice, their focus and hard work has paid off, with the team now in the top five practices in the Murray PHN catchment in eight of the 10 PIP QI measures. A remarkable achievement in any circumstance, but perhaps even more so in such a small practice.

Prue Southey is a Quality Improvement Consultant with Murray PHN. She says that while each practice she works with is unique and has its own culture and priorities, the Wycheproof crew is motivated and resourceful.

"The team clearly love working together, and making their practice the best it can be. Dr Mulligan trusts his team to do the extra work involved in providing great patient care in their small rural community."

Joy Morrison is committed to her role as practice manager. She says the practice uses some great tools, but they are only as good as the information you put into them. She emphasises it's the working relationships that the staff share and their strong work ethic that has resulted in such good outcomes.

"The great results are a shared effort. The girls and I are always looking for something to do. We talk together to work out what needs to be done, what measure needs to be worked on. Someone gets it done. Someone else checks it. We talk about it in our team meetings. Next time, another person takes responsibility for completing a measure, so we all contribute, and everybody gets to do a little bit of everything."

Quality improvement measures the team has worked on include influenza immunisation status, cervical screening status and alcohol consumption status. When asked whether one measure stood out as an achievement that has made a difference for their patient cohort, Joy says that although it's not one of the 10 mandated PIP QI measures, the bowel screening measure was the one the team is particularly pleased with.

"They are all good improvements, but we wouldn't have been able to achieve this one without the programs Murray PHN has supported and funded as part of this measure."

Joy says that the results of each of the measures they have completed are then used to alert the nurse or GP to prompt health prevention activities at patient appointments.

"For instance, we make sure the nurse has the bowel cancer screening kit ready for her appointments with the patients that have been identified through our quality improvement work."

Prue believes the relationship between Murray PHN and the practice has built a level of trust that is reaping strong results.

"We have access to data and a raft of quality improvement tools that we help practices understand and use. But the most satisfying part is meeting each team member, finding out about the practice, their patient cohort, and working with them to improve the work they do and the outcomes they get for their patients."

About Murray PHN, Joy says, "They are a friendly lot, and I can call Prue or one of the others with anything. They are very knowledgeable and I feel very comfortable talking something through when we have a problem. I don't think I've ever been let down by the PHN."

This respect is mutual, and Prue sums it up perfectly when she explains why she loves getting out and visiting the small and more geographically isolated practices like Wycheproof Medical Centre.

"Their staff live and work in their community, so they are invested in wanting to make sure their friends, families, and others get the highest level of care. This clinic is the perfect example of that. They care deeply and keep working towards providing excellent care".

"...the relationship between Murray PHN and the practice has built a level of trust that is reaping strong results."

Joy Morrison, practice manager at Wycheproof Medical Centre

Building resilience in general practice

The final component of our two-year Business Resilience Program saw 40 general practices participate in one-to-one consultations with Larter Consulting, to enhance staff knowledge of key business themes, including change management and business continuity.

Funded by Murray PHN to support general practice to develop strategies to build resilience in changing environments, the three-part program, 'Insight, Learn, Develop' launched in 2021. It included a webinar series focused on business viability, the use of digital technology to enhance business and health outcomes, and reconfiguring roles to retain staff. The program also featured a small group learning program for practices to develop, consolidate and elevate management skills.

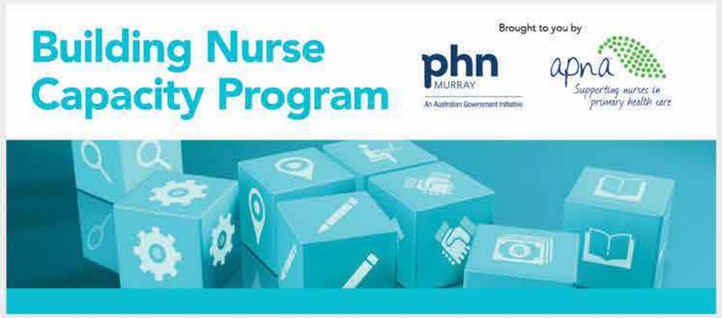
Strengthening the alcohol and other drug sector

In February, Murray PHN provided local alcohol and other drug organisations an opportunity to attend the two-day Victorian Alcohol and Drug Association conference in Melbourne and hear from a large line-up of speakers.

More than 120 people from across our region, including rural locations such as Swan Hill and Mildura, accessed the allocated tickets within a matter of days.

The attendees shared extremely positive feedback, with many noting that attending conferences and training opportunities in capital cities was generally prohibitive due to distance and cost borne by service providers. They also highlighted the need to attend high-calibre conferences to continue to improve their services and professional skills. These events helped keep them abreast of the impacts and opportunities in key policy areas, such as the Victorian mental health reforms, as well as helping them to build networks and discuss opportunities with other organisations.

> "Thanks to the support of Murray PHN, we had four team members attend the VAADA conference. It was so nice to see so many people attending and networking after the years of COVID preventing such events as this" – NESAY, Wangaratta



Supporting nurses new to general practice

Murray PHN funded eight nurses who were new to general practice to complete the Australian Primary Healthcare Nurses Association's (APNA) 12-month Transition to Practice Program, with the program concluding in June this year.

"Great program with amazing support and lots of education activities to support knowledge and skills" – Participant

"Mentor assistance – it was great to talk to someone; learnt a lot from the education modules" – Participant

See following page for a participant Q&A

Supporting nurses to transition into primary healthcare

Angela Larkin is a practice nurse at Federation Clinic in Wodonga and a recent participant in the APNA Transition to Practice Program.

Q: What's your background?

A: For the first 16 years of my career, I worked as a psych nurse at a community mental health service. When I decided that it was time for a change, the thought of going into a hospital setting and doing any nursing other than psych was terrifying. I was lucky enough to be offered a GP nurse position which was also terrifying, humbling too, as I'd come from a specialist area where I had years of experience, to a whole new world of nursing. I even needed a reminder on how to take a BP (blood pressure reading)!

Q: What drew you to apply for a place in the Transition to Practice Program?

A: Just prior to starting my new GP job, the practice manager sent me an email about the Transition to Practice Program. It was a real lifeline for me as I was going into unknown territory and needed all the support I could get.

Q: What skills have you gained by participating in this program?

A: The online training was my go-to for the first six months of my new job. It really underpinned all my new skills in wound care, immunisation, care planning and health assessments. I've been very fortunate in my new job to have other nurses and GPs around me who've provided endless guidance and support. This was critical while I was at work and in the middle of dressing a tricky wound or doing immunisations.

Q: What benefits did having a mentor bring to your experience of the program?

A: Having a mentor was very helpful for reflective practice and to get a perspective from someone who wasn't in my clinic in a supervisor role.

Q: What aspect of the program did you like the best?

A: The online learning was useful, as I could access it any time of the day or night and refer back to it if required. It was also relevant and up-to-date.

Q: How do you see the program enhancing your career?

A: The Transition to Practice Program gave me a solid basis for my knowledge, which I'm so grateful for. In a new job, it's so easy to pick up other people's short cuts or habits without knowing the correct way of doing things. The program has given me the underpinning knowledge for much of my practice and has informed my decision-making. I've also been better equipped to question and challenge my colleagues on their practice.

Q: Are there any other insights you'd like to share?

A: I was so overwhelmed when I started in general practice. I was so fortunate to have the Transition to Practice Program for the first six months of my GP nurse job. It gave me confidence and support to stay in the job long enough to start enjoying it.

Angela Larkin, practice nurse at Federation Clinic, Wodonga

"The program has given me the underpinning knowledge for much of my practice and has informed my decision-making. I've also been better equipped to question and challenge my colleagues on their practice."

Q&A

Quality care in general practice

Murray PHN worked with 89 practices on a range of quality improvement activities, developing dedicated resources for data cleansing, asthma and smoking cessation, men's health, immunisation, diabetes and eye health

Murray PHN's quality improvement consultants (QICs) work closely with general practice and other primary healthcare providers to reach the highest standards of quality and safety in our communities.

Our consultants are available to provide one-on-one support, guidance and coaching, with data reviews and quality improvement activities that help providers meet accreditation standards and improve business viability. They also support the adoption of evidence-based and best practice models of care that can improve practice efficiencies and patient outcomes.

Supporting up to 30 practices each, and some having worked previously in general practices, our QICs have a deep understanding of the sector, its challenges and opportunities.

As part of their role, they work together to share information, to connect practice peers, and undertake benchmarking exercises to determine our highest performers and to understand who might benefit from some extra support.

Most practices (167) in our region share data with Murray PHN. The data is compared with data from other PHN regions to provide national averages on quality improvement measures. While local practices are above average in most areas, this year we have been focused on the recording of a person's alcohol use and glycated haemoglobin (HbA1c) for type 2 diabetes, which are just below the national average.

In 2023, Murray PHN worked with 89 practices on a range of quality improvement activities, developing dedicated resources for data cleansing; asthma and smoking cessation; men's health; immunisation; diabetes; and eye health.

New 'Practice matters' resources were introduced to assist with specific business areas, such as accreditation, funding models, general practice fellowship, nurse scope of practice, pathways to general practice and international medical graduates, and MyMedicare.

Our 'Focus on' resources continued to be released with new material developed for physical and heart health, older person's, LGBTQIA+, women's and children's health issues, and cancer screening.

This year, several practices registered for accreditation, leaving just four unaccredited practices in the whole of the Murray PHN region.

"The support through Murray PHN is amazing and very helpful, and always puts us on the right track if we are not sure of something."
– Central Victorian practice manager (Small, 2-5 GP practice)

"I know I can contact Murray PHN anytime and get friendly, helpful and efficient support. And if they don't know, they'll find out."
- Goulburn Valley practice manager (Small, 2-5 GP practice)

"Our quality improvement consultant is excellent and always continues to provide the practice with her support. I am very grateful to her. Our general practice engagement lead is also excellent, supportive and follows up with us regularly. We are very lucky to have excellent people to work with at Murray PHN."
– North East Victoria practice manager (Medium, 6-15 GP practice)

General practice support team back row L-R: Kate O'Kell, Gretel Crutchfield, Prue Southey, Lisa Collins, Natalie Tremellien, Megan Connelly, Sue Keane, Sophie Bond

Front row L-R: Kimberley Harlock, Emma Ebery

Wodonga supported to become top performing practice

Opening their business at the start of the COVID pandemic created many obstacles for GPs on Vermont in Wodonga, including low numbers of influenza vaccinations and the challenges of immunisation fatigue.

Understanding the risks to a person who might contract COVID and flu at the same time, the practice implemented an educational strategy to increase vaccination figures. Using their CAT4 software, the practice identified high-risk groups and were able to encourage nine per cent more of their patients aged 65+ and patients with diabetes to have their annual flu shot.

Practice staff undertook CAT4 training to help them do more quality improvement and were able to determine which patients were eligible for care plans and health assessments, and use recall reminders to help with the ongoing management of each patient's chronic conditions.

From the work they completed between July to October, GPs on Vermont became the top practice across the Murray PHN region for weight classification recording. The practice is also in the top five for achieving high rates in six of the Australian Government's 10 quality improvement measure areas:

- QIM01: 86% of patients with diabetes with a current HbA1c result
- QIM03: 65% of patients with a weight classification
- QIM04: 82% of patients aged 65 and over who were immunised against influenza
- QIM05: 80% of patients with diabetes who were immunised against influenza
- QIM07: 98% of patients with an alcohol consumption status
- QIM10: 89% of patients with diabetes with a blood pressure result

The practice has maintained high levels of data quality during the last 12 months, with the following measures for active patients sitting constantly between 98 and 100 per cent – allergy, alcohol, smoking and Indigenous status.

To ensure data is accurate, reliable and fit-for-purpose, the practice has embedded processes into workflows, which help team members to deliver consistent and quality care to their patients.

Creating an efficient practice in Albury

Border General Practice opened early last year in Albury NSW. The practice found that, having been previously affiliated with another practice in another location, their data was not giving a clear view of local patient numbers and associated health status.

When the new practice manager started, she contacted her local Murray PHN QIC for assistance, as she understood that splitting and cleansing this data was going to be a major exercise.

Through many phone calls and visits, including in-person presentations and meetings, practice staff were educated on the importance of data and how to use the associated CAT4 and PATCAT software.

Once they were equipped with the right tools and knowledge, staff became committed to implementing the necessary changes. They discussed it at every staff meeting, and posters were regularly put up in the staff room to highlight progress. To further celebrate their achievements, a monthly prize was awarded to a quality improvement champion.

Between July 2022 and June 2023, the practice was able to sort the original 25,000-patient database. With the number of inactive patients reduced from 53 per cent down to just eight per cent, they were left with a much more manageable and accurate recording of active patients.

- Cervical cancer screening participation and recording was increased from 21 to 74 per cent
- Increases were made for influenza vaccinations for people aged 65 years or older (30 to 66 per cent)
- Diabetes status increased (28 to 59 per cent)
- Chronic obstructive pulmonary disease status increased (25 to 63 per cent)
- Therefore chronic disease management plans increased (21 to 69 per cent)
- Slight improvements were also made to the recording of smoking status (72 to 86 per cent)
- Alcohol status increased (75 to 95 per cent)
- Weight classification increased (13 to 29 per cent)

Dedicating time to implement and embed these changes has resulted in greater quality care for patients and improved incentives available to the practice.

The benefits of building connected relationships

General practices in small regional and rural towns are often geographically distant from each other and in the past, have tended to work in isolation, given the tyranny of distance.

To help create a community of practice and a platform to meet regularly, share information and resources, and develop and support relationships, the GP Practice Support team at Murray PHN has set up quarterly face-to-face meetings for practice managers and other support staff from the 12 general practices in the Buloke, Loddon and Gannawarra region to get together in a way they hadn't regularly before.

Emma Ebery is a quality improvement consultant at Murray PHN and explains the motivation for setting up the group.

"It was obvious to me that most of the clinics that I was taking care of at that time were all experiencing very similar issues, and we needed to do something better than ad-hoc visits here and there. So, I thought let's try and see if we can get everyone together so practices can build relationships with one another, as well as with Murray PHN."

Now, every three months, face-to-face cluster meetings occur in different locations around the region and after clinic hours to give the maximum number of people the opportunity to attend. The group has been meeting for a year and the response has been incredibly positive, with high attendance numbers and importantly, flow on effects that ripple out beyond the group's quarterly meetings. Amber Wood is Practice Manager at Boort District Medical Centre and one of the people attending these regular gatherings. As a health professional working in a practice with one GP and a small staff, as well as being fairly new to her role as a practice manager, she says she loves the cluster meetings.

"I think they are fabulous. I love talking with other practice managers and staff from other clinics, and to see how they are feeling, especially with everything that has happened with clinics over COVID and the floods."

Emma explains that these meetings provide her and other PHN colleagues the opportunity to share resources and information relevant to everyone, invite guest speakers the group can learn from, and perhaps most importantly, help facilitate conversations that have a reach and relevance far beyond the meetings themselves.

Amber says that as a practice manager still learning the ropes, the relationships she has formed with other practice managers in the cluster are invaluable.

"Sometimes I might be unsure of something. Now that I know other practice managers, I can simply give one a phone call, and they can help me straight away to do things that I need a little bit of help with. Or I can email, knowing the person I'm sending the email to. One of the most experienced practice managers in our cluster has said to me to feel free to email her any time if I need help with things. I really value this relationship."

Emma is planning CAT4 training for the cluster's next meeting. However, she says the purpose of forming the Buloke, Loddon and Gannawarra cluster has in many ways already been realised.

"We set the meeting up to really focus on getting to know the practices and get a better understanding of shared needs and goals so we can be as useful as possible. However, the most rewarding aspect has been bringing people together for peer support and learning. That's the very best outcome."

Practice managers from the Buloke, Loddon and Gannawarra region and Murray PHN staff are regularly meeting to build relationships and share knowledge.

"One of the most experienced practice managers in our cluster has said to me to feel free to email her any time if I need help with things. I really value this relationship."

Improving diabetes care in Bright

Bright Medical Centre has been doing impressive work with their quality improvement (QI) projects. For six months, they have focused on improving the management of their patients with diabetes.

Regular quality improvement meetings were held with their local QIC and the practice staff who were involved in the QI process. Through data cleansing exercises, data mapping issues were identified with their clinical software, leading to workflow processes being changed to ensure the currency and accuracy of data.

As a result, the practice has been able to increase their active diabetics patients with a waist measurement from 38 to 87 per cent and cholesterol recordings from 38 to 92 per cent.

Understanding and recording these factors provides the practice with a whole-person evaluation that can improve a person's health and quality of life.

Commitment to improving First Nations health in Shepparton

In September 2022, Family Medical Centre in Shepparton discovered that, of their active patients, only a quarter who were aged 75 years and older and just seven per cent of First Nations Peoples who were eligible for health assessments had had one in the previous 12 months.

The team recognised the need for a structured approach to both cohorts in order to conduct health assessments and to continue providing quality patient-centred care.

As a commitment to the health and wellbeing of First Nations People, the practice made access to healthcare more affordable by offering bulk-billed consultations to all First Nations patients who had a health assessment at the clinic.

With their older patients, they recognised many were not comfortable resuming face-to-face care post-COVID. Rather than sending text message reminders, they devoted time to calling each one personally and inviting them to the practice for their annual health assessment.

By March 2023, 29 per cent of eligible Aboriginal and Torres Strait Islander patients had completed a health assessment at the clinic - an improvement of 22 per cent. The recording of Indigenous status improved by nine per cent and is now recorded for 94 per cent of all patients. At the same time, 56 per cent of eligible patients aged 75 years and older had a health assessment – an improvement of 31 per cent.

They also experienced improvements in the recording of other health status measures, including patients with a weight classification (20 per cent improvement); alcohol consumption status (12 per cent); diabetics with a blood pressure result in the previous six months (11 per cent); BMI status recorded (10 per cent); smoking status (seven per cent) and 45-49 year old health assessments (five per cent).

Over the course of nine months, the local Murray PHN QIC presented the deidentified PATCAT data during meetings with the clinic to highlight their progress, while practice staff used their clinic's CAT4 software with the guidance of the CAT4 recipes, to pull patient data. Subsequently, a reminder system was set up and the practice was able to use their data to recall patients.

The clinic's team-based approach is the reason for the significant improvements to their data quality. From reception staff to the practice manager, and nurses and to senior GPs, everyone worked together to agree on activities and goals, and tracked achievements to provide the motivation that kept them achieving great results. This great work resulted in the clinic being a finalist in the 2023 Pen CS Awards for the 'Closing the Gap' category.

L to R: Practice Manager Tracey Morrow and GP Dr Kaushala Perera at the Pen CS Awards

Digital health systems and connected care

Digital health technologies can help improve the delivery and management of care for patients, by providing access to safer, connected and quality healthcare, no matter where a person lives.

Health information all in one place

Through the My Health Record system, authorised healthcare professionals can access timely information about their patients, such as shared health and discharge summaries, prescription and dispense records, pathology and diagnostic imaging reports. This allows them to have the most up-to-date information on their patients which is important, especially in an emergency situation.

In the Murray PHN region, 652 organisations are registered with My Health Record including a mix of general practices, pharmacies , aged care residences, allied health professionals and specialists.

Each month, 167,000 My Health Record pages are viewed by local health professionals.

The number of prescriptions uploaded has increased by 22 per cent in the last 12 months, from 183,926 to 233,792, with half of all general practices in the catchment ePrescribing regularly.

One-hundred general practices have been supported by the digital health team to transition to NASH SHA-2 certificates, which allows them to securely access and share health information, including for electronic prescribing and My Health Record.

652
registered organisations

167,000
pages are viewed locally

50%
GPs ePrescribing daily

100
General practices supported by the digital health team

233,792
prescriptions uploaded in last 12 months

Improving communication, coordination and collaboration

Strong collaboration between local GPs, hospitals - Bendigo Health, Goulburn Valley Health, Mildura Base Public Hospital and Swan Hill District Health - and Murray PHN's digital health team have been integral to the successful roll-out of the SeNT eReferral program.

SeNT eReferral provides valuable patient information directly to specialist practitioners. The information is extracted from a patient's electronic file to enable a faster, more streamlined and secure management of referrals to public hospitals.

In February, we were pleased to welcome Swan Hill District Health to the program.

In May, we worked with software provider BPAC Australia on enhancements that were requested from GPs. Local doctors wanted to identify where their referral was in the journey, to ensure it had been received (and not misplaced or duplicated), while the hospitals wanted to communicate back direct to GPs through the system regarding their referral status.

Murray PHN is now working with hospitals to expand the program to include allied health, radiology and mental health service referrals.

In the last 12-months, the number of eReferrals has increased 30 per cent to 1303 per month, and since the program was introduced in 2017, a total of 63,085 eReferrals have been sent.

Sending eReferrals

A quarter of all general practices in the Murray PHN region are solo practices, and Wycheproof Medical Centre is one such practice. With a population of 610 people, this small vibrant town is located on the edge of the Mallee, midway between Melbourne and Mildura.

Wycheproof Medical Centre was one of the first practices to register their interest and has been a consistent user of Sent eReferral.

"BPAC SeNT eReferral is a great resource for our doctor and staff. Murray PHN provides us with excellent digital health support for eReferral and are always very obliging with their time. We recently had an issue with our IT system that affected SeNT, and as we are a small busy practice, we certainly appreciated a member of the digital health team visiting the practice to ensure all workstations were up and running. We are very keen to try any of the programs provided as we know excellent support is always available." – Joy, Wycheproof Medical Centre practice manager

Helping residential aged care homes to be more culturally safe

Murray PHN has been working with Guwanda Education, a First Nations owned and managed organisation that privileges Aboriginal and Torres Strait Islander voices in co-creating decolonised spaces of new knowledge, insight and understanding.

Guwanda's online education is designed to increase the capacity of health professionals and service providers to meet registration and accreditation standards, through the development of culturally safe ways of working.

This year, Murray PHN invited all residential aged care homes in our catchment to express their interest (EOI) in participating in Guwanda's cultural safety training.

While we originally allocated funding for 500 places, we received 572 EOIs. As we did not want anyone to miss out, all 572 were able to participate. A waitlist has also been created in case we can provide this again in future.

Increasing virtual care for residents

This year, Murray PHN has supported residential aged care homes to increase their capacity and capability to access virtual primary care services in and out of hours where face-to-face care is not available, reducing unnecessary transfers to hospital and providing timely care for residents.

Through a series of $5000 and $10,000 grant opportunities, 42 homes were provided with a portable telehealth cart system, and another 33 homes purchased and upgraded IT equipment, including:

Hardware:

- Virtual reality headsets
- Overhead projectors for interactive games
- Laptops, tablets and mobile phones
- Devices e.g. otoscopes, ECG devices, video glasses, scales, blood glucose meters and bladder scanners

Software and infrastructure:

- Clinical information system subscriptions
- Telehealth software licenses and additional servers
- WiFi upgrades and installations
- Ethernet wiring and mobile network boosters

Other activities:

- Policy development for use of telehealth equipment
- Telehealth training
- Consultation with clinics/ doctors regarding telehealth capability

Stella and Sianne from Princes Court Homes in Mildura with their newly assembled All-In-One Telehealth System

"Having easier access to telehealth has been a major contributor to reduced hospital emergency transfers for our residents, who have been able to have access to healthcare with a doctor out of hours"

- Jacqui McEwan, Facility Manager of Moyola Aged Care in Tatura

Improving eye health

The embedding eye health preventative care into primary care project aimed to improve eye screening and detection of eye conditions and disease for at-risk groups across Victoria. The project's goal was to reduce the prevalence of avoidable blindness and vision loss.

General practice plays a crucial role in reducing avoidable blindness and vision loss and its associated burden of disease, including identifying those at higher risk of eye disease.

While eye disease can occur at any age, the risk factors include:

- being aged 40+
- smoking
- hypertension
- diabetes
- having a family history of eye disease.

The Victorian Department of Health funded Murray PHN to partner with Eastern Melbourne PHN to lead the development and implementation of the project, which was conducted in partnership with Vision 2020 Australia, as well as Gippsland, North Western Melbourne and Western Victoria PHNs.

Across the various PHN regions, 48 practices were funded to take part. This included completing training developed by Vision 2020 Australia, implementing a sustainable quality improvement system or changes to identify, refer and manage at-risk patients for eye screening. It also includes the collection of data on referrals to and correspondence received from optometrists and ophthalmologists.

Resources developed by Vision 2020 included online educational training modules and webinars that can be accessed by all Victorian health professionals and in particular, support the practices and health professionals participating in the project.

Project implementation with practices began in March 2023 and to date, there have been more than 3500 referrals sent to optometrists and ophthalmologists, with correspondence relating to more than 1200 of those referrals being received back.

The project concluded at the end of October for practices and for remaining stakeholders, at the end of December, with a comprehensive report on the project to then be produced.

More than 3500 referrals sent to optometrists and ophthalmologists

Education topics include:

- Common eye conditions
- Advanced eye care
- Ocular emergencies
- Glaucoma
- Macular degeneration
- Diabetes and eye health
- Children's vision
- Cataracts

Encouraging grassroots solutions

Regional initiatives for suicide prevention

This year, Murray PHN is supporting the coordination and delivery of initiatives to reduce the incidence and impact of suicide in the region, through the Commonwealth Government's Targeted Regional Initiatives for Suicide Prevention Program.

While suicide prevention is complex, with many contributing factors, this work by PHNs takes a community-led, systems-based approach to addressing gaps in services and building community capability to prevent and respond to suicidal distress, and by implementing prevention and early intervention activities.

To help guide the focus of activities, we invited services, organisations and networks delivering suicide prevention activities and support services to online consultation sessions in October.

In November, applications opened for community-based grants with up to $10,000, $50,000 and $150,000 available for local grass-roots activities, designed by and for local communities.

Dhelkunya Yaluk cultural humility journey

Murray PHN is undertaking the Dhelkunya Yaluk cultural humility journey, enabling us to be a culturally inclusive, equitable and reflective organisation committed to authentic reconciliation with First Nations Peoples, a workplace of choice and a leader in our sector. To support this, we have been working closely with two First Nations training providers: Weenthunga Health Network has been walking alongside us as we navigate this path, providing training and guidance at all levels of our organisation in anti-racism, two-way working and critical consciousness; and Guwanda Education has provided foundation-level online training to build a culturally safe health workforce through the co-creation of decolonised spaces of new knowledge, insight and understanding in health education.

Our commitment to reconciliation

Murray PHN is committed to the RAP process, to bring to life our commitment to reconciliation. As an organisation, we understand the critical need for reconciliation to occur in Australia. We are cognisant of our privileged position as a commissioner of health services and view our responsibility to be change agents in the primary health sector seriously; to actively dismantle racism while shining a light on First Nations ways of being and doing in health and wellbeing, knowing that First Nations Peoples hold the wisdom to bring healing across our region.

Murray PHN is linking our past intentions with our current strategy and our future actions by creating, developing and enacting our Reconciliation Action Plan (RAP).

This RAP is an integral element of our organisation's anti-racism journey. It bonds the First Nations Health and Healing Strategy at an organisational level and with the future operations of the organisation.

Carefully considered and approached with a level of organisational maturity, the RAP is a well thought out component of Murray PHN's vision for achieving improved health outcomes for all people in our region.

It is an important accountability measure and a commitment to the Reconciliation Action Plan Framework of Reconciliation Australia. It takes concrete steps to be constantly growing and learning, aligns with the organisation's big picture, and displays an ongoing commitment to the journey we are on as we work towards being a culturally humble and anti-racist organisation.

Weenthunga Health Network

Guwanda Education
Privileging First Nations voices to build a culturally safer health workforce

Finance

As we progress into our ninth year as a Primary Health Network, we have continued to grow and adapt to our changing environment, never wavering from our core purpose of using the funding we receive to benefit and improve the health outcomes of our communities.

From the $68 million funding we received in the 2023 financial year (FY23), we delivered a remarkable $49 million in commissioned services in our catchment – 73 per cent of all our funding. Our remaining funding supported our streams of work in coordination and capacity building, which are carried out by our skilled and knowledgeable professional teams.

In FY23, Murray PHN had a full-time equivalent (FTE) staff of 112, all working towards delivering on our commitments to our funders, providers and communities.

The year also saw us secure new funding that allowed us to commission a new national care finder program across our region, to provide support for older people with intensive needs.

We were also successful as the lead PHN in Victoria, supporting the Commonwealth Government's national workforce planning and prioritisation for general practice. Our ground-breaking work will determine the regions with the most significant demand for healthcare professionals and those that have the necessary training capacity for GP registrars aiming to become fully qualified general practitioners.

Victorian PHNs also supported the introduction of the Victorian Government's extensive Priority Primary Care Centres (PPCCs), which provide GP-led care to people who need urgent care, but not an emergency response. In the Murray PHN region, we have PPCCs in Bendigo, Wodonga, Shepparton and Mildura, which are each partnered with a local, busy emergency department.

Over the full year, we funded 259 healthcare providers through a total of 538 contracts – our largest contractual commitment since we began our operations as a Primary Health Network in 2016.

Through all those years, Murray PHN's funding has continued to expand annually, along with the professional workforce that the organisation needs to ensure these benefits reach our communities.

We have also worked strategically to grow our equity to a healthy level – a robust financial foundation that will enable the company to weather any future storms that could otherwise impact on the work that we do for our communities.

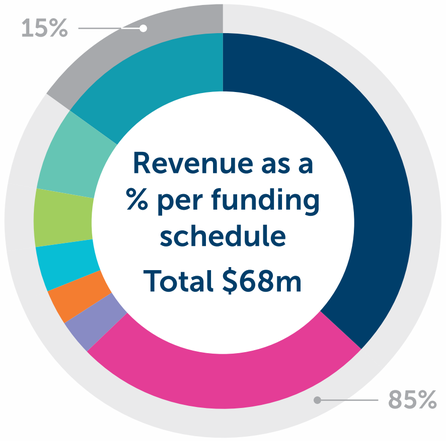
In FY23, we also focused on refining our business processes to better align with the revised national PHN strategy and with our new Purposeful Design and Outcomes Thinking Framework, which ensures we determine the right design for our programs from the start.

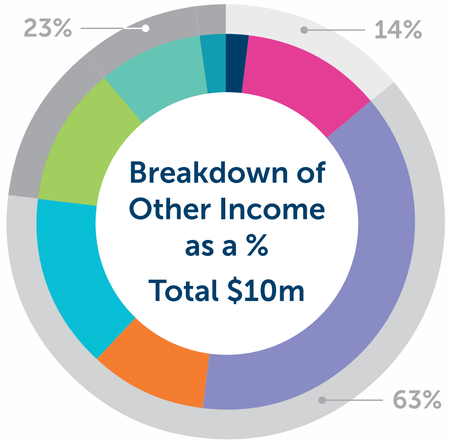
This has helped streamline our work, ensuring we are always directing the maximum effort to our regional coordination, commissioning and capacity building.

For more detailed information on our funding and expenditures, please see the Murray PHN 2023 Financial Report

Total Revenue	**$68,049,427**
Total Expenditure	**$67,359,996**
Operating Surplus	**$689,431**
Equity	**$5,659,538**

Total Revenue:	**$M**
Core	**$17.9**
Primary Mental Health and Alcohol and Other Drugs	**$25.5**
Commonwealth Psychosocial Support	**$2.0**
Integrated Team Care	**$1.9**
After Hours	**$2.5**
PHN Pilots and Targeted Programs	**$3.3**
Aged Care	**$5.0**
Total Department of Health and Aged Care	**$58.1**
Other Income	**$10.0**
Total	**$68.1**





DoHAC - $58m

37	Primary Mental Health & Alcohol and Other Drugs
26	Core
3	Commonwealth Psychosocial Support
3	Integrated Team Care
4	After Hours
5	PHN pilots and targeted programs
7	Aged Care

Other income - $10m

15	Other income

Federal Funding

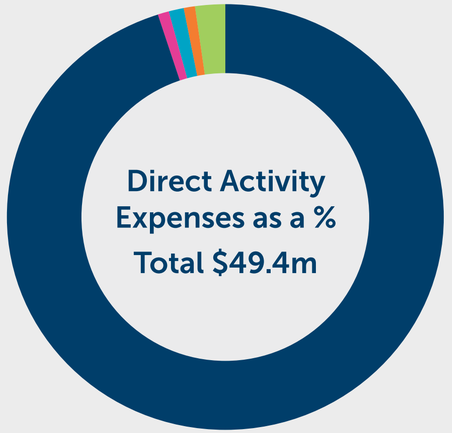
2	Australian Digital Health Agency
12	Workforce Prioritisation and planning

State Funding

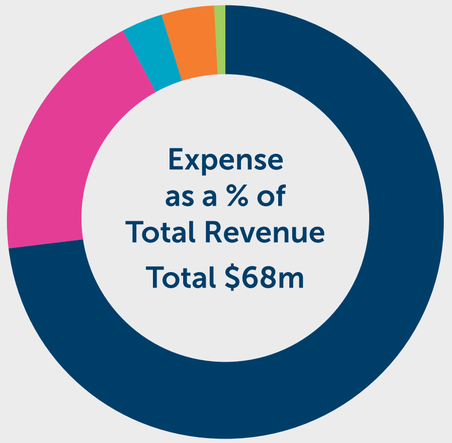
38	Priority Primary Care Centres
10	Department of Education
15	Other programs

Other

12	Other PHN funders
9	Interest
2	PHN Exchange



95	Commissioned Services
1	Direct Integrated Team Case activity costs
1	Building capacity and capability
1	Needs Assessment, planning and evaluation
2	Direct patient costs



73	Direct activity
19	Employee expenses
3	Corporate governance
4	Administration
1	Operating surplus

2016-2024 Roadmap

Revenue growth:
FY16 $25M - FY23 $68M

FY16 - Yr 1

Funding: $25m

Providers: 82
Contracts: 109

Frameworks:
- Commissioning
- Enterprise-wide Risk Management Policy

FY17 - Yr 2

Funding: $35m

Funding new:
- Mental Health and Alcohol and Other Drugs
- Doctors in Secondary Schools

Performance Quality Framework: 25/29

Providers: 104
Contracts: 191

People: FTE 70.3

Commissioning:
- Mental Health tender

ICT:
- Murray Docs
- Murray Exchange

FY18 - Yr 3

Funding: $35m

Performance Quality Framework: 26/29

Activities: 63*

Providers: 119
Contracts: 309

People: FTE 75.1
New executive structure

Frameworks:
- Performance and Reporting
- Quality Management

ICT: PHN Exchange pilot

* Financially acquitted funder activities

FY19 - Yr 4

Funding: $39m

Funding new:
- headspace demand management

Performance Quality Framework: 52/54

Activities: 86*

Providers: 155
Contracts: 290

People: FTE 82.4
Behavioural competencies Framework

Commissioning:
- General Practice Investment Strategy

Frameworks:
- Governance and Accountability
- Clinical Governance
- Data Governance
- Privacy audits
- Folio Contract Management System

ICT: Contract Management Folio implementation

FY20 - Yr 5

Funding: $43m

Funding new:
- COVID
- HeadtoHelp
- Bushfire

Performance Quality Framework: 48/54

Activities: 73*

Providers: 148
Contracts: 216

People: FTE 85.6

Commissioning:
- headspace
- COVID
- HeadtoHelp
- Wayback

Governance:
- Cybersecurity Framework
- Data Breach Response Plan

ICT: Murray HUB

FY21 - Yr 6

Funding: $47m

Funding new:
- Pilots and targeted program

Performance Quality Framework: 52/54

Assurance Framework baseline assessment

Activities: 84*

Providers: 150
Contracts: 274

People: FTE 81.9

Commissioning:
- Psychological Therapy in Residential Aged Care Facilities

Governance:
- COVIDsafe Plans and Protocols

ICT: Power Platform (BI automation)

FY22 - Yr 7

Funding: $56m

Funding new:
- Aged Care schedule

Performance Quality Framework: 48/54

Activities: 89*

Providers: 169
Contracts: 385

People: FTE 93.6
Introduction of Strategy and Performance Unit

Commissioning:
- Psychosocial support tender
- Wayback to Hope

Governance:
- COVIDsafe Workplace
- ICT Disaster recovery
- Business Continuity Policies

ICT:
- Systems Strategy
- Systems Steering Group

FY23 - Yr 8

Funding: $68m

Funding new:
- Workforce prioritisation and planning
- Priority Primary Care Centre

Activities: 85*

Providers: 259
Contracts: 538

People: FTE 112

Commissioning:

Aged Care - Care Finder

Governance:
- Redesigned compliance/ contracts area in Folio

ICT: Systems upgrade: Financial, SD/WAN

FY24 - Yr 9

Funding: $80m

Funding new:
- Urgent Care Centre
- Strengthening Medicare

Activities: 78*

Providers: 272
Contracts: 460

People: FTE 128

Governance:
- Data Governance
- Learning Management System
- Board portal
- Systemised unspent funds reporting

ICT:
- Purposeful Design and Outcomes Thinking Framework implementation
- Commissioning Systems Upgrade
- Foundational Systems Upgrade
- Data Governance
- ICT Governance
- ISO 27001 Accreditation

ACTIVITY WORK PLANS

For a detailed view at our 2023 Activity Work Plans (AWP) go to:
https://bit.ly/3tSaMjN or use the QR code

phn MURRAY

An Australian Government Initiative

T: 03 4408 5600
3-5 View Point, Bendigo VIC 3550
murrayphn.org.au

Leadership | Collaboration | Respect | Accountability | Innovation