phn MURRAY

An Australian Government Initiative

FY25 ACTIVITIES SUMMARY

Leadership | Collaboration | Respect | Accountability | Innovation

THE MURRAY PHN REGION

Murray PHN is a not-for-profit organisation, funded primarily by the Commonwealth Department of Health and Aged Care to commission primary healthcare services in our region, which covers 22 local government areas across the north of Victoria and over the border to include Albury, NSW. Our work and communities run along the Murray River and into the centre of the state, in a diverse and beautiful area covering almost 100,000 square kilometres of mountains, semideserts and vibrant regional cities. We have 130 staff working from offices located in Bendigo, Shepparton, Swan Hill, Mildura and Albury/Wodonga.

Our estimated population is 650,000 and is projected to continue to grow steadily for at least the next decade. With almost one third of all Victorian First Nations Peoples living in the Murray PHN catchment, we live and work on the lands of many different Traditional Owners and Aboriginal language groups.

A significant number of population groups in our region have been identified as "underserviced" – people who experience health inequality and health inequity.

Health outcomes in our region lag behind those in city and suburban areas of our state and country.

To determine the needs of our region and its people, we continuously collect and analyse information and data and consult with community. Our local health priorities add to our national targets, and we work to improve First Nations health, cancer screening rates, chronic illness complications, mental health supports, workforce sustainability and digital health connectedness, among others.

As a primary healthcare commissioning organisation, we work closely with general practice, allied health and primary mental health providers across our catchment to understand the issues they face in caring for their communities. Our annual budget is approximately one per cent of the total yearly health expenditure in our region.

In a complex system with finite funds, our capacity to improve health outcomes lies within an ability to build partnerships and collaboration across the sector and with providers. This is a core element of our approach to commissioning, which is relational commissioning.

OVERVIEW OF FUNDING SCHEDULES

FY25

Everything we deliver in our annual work plans, we do with purpose.

- We increase effective and efficient primary care services across our communities
- We contribute to better health outcomes for our communities, including vulnerable populations
- We improve health access and equity, through advocacy and action.

Core corporate governance*	$2,364,405
Core health system improvements*	$8,075,326
Core flexible (inc. COVID-19)*	$5,598,521
Core practice projects*	$2,520,999
Aged care	$4,095,904
PHN pilot and targeted programs	$1,260,038
Primary mental health	$21,693,967
Alcohol and other drugs	$3,251,658
Commonwealth psychosocial support	$4,134,787
National bilateral program	$2,097,221
Integrated team care	$2,084,497
After hours	$2,051,486
Urgent care clinics	$1,443,752
Other funders	$15,967,745

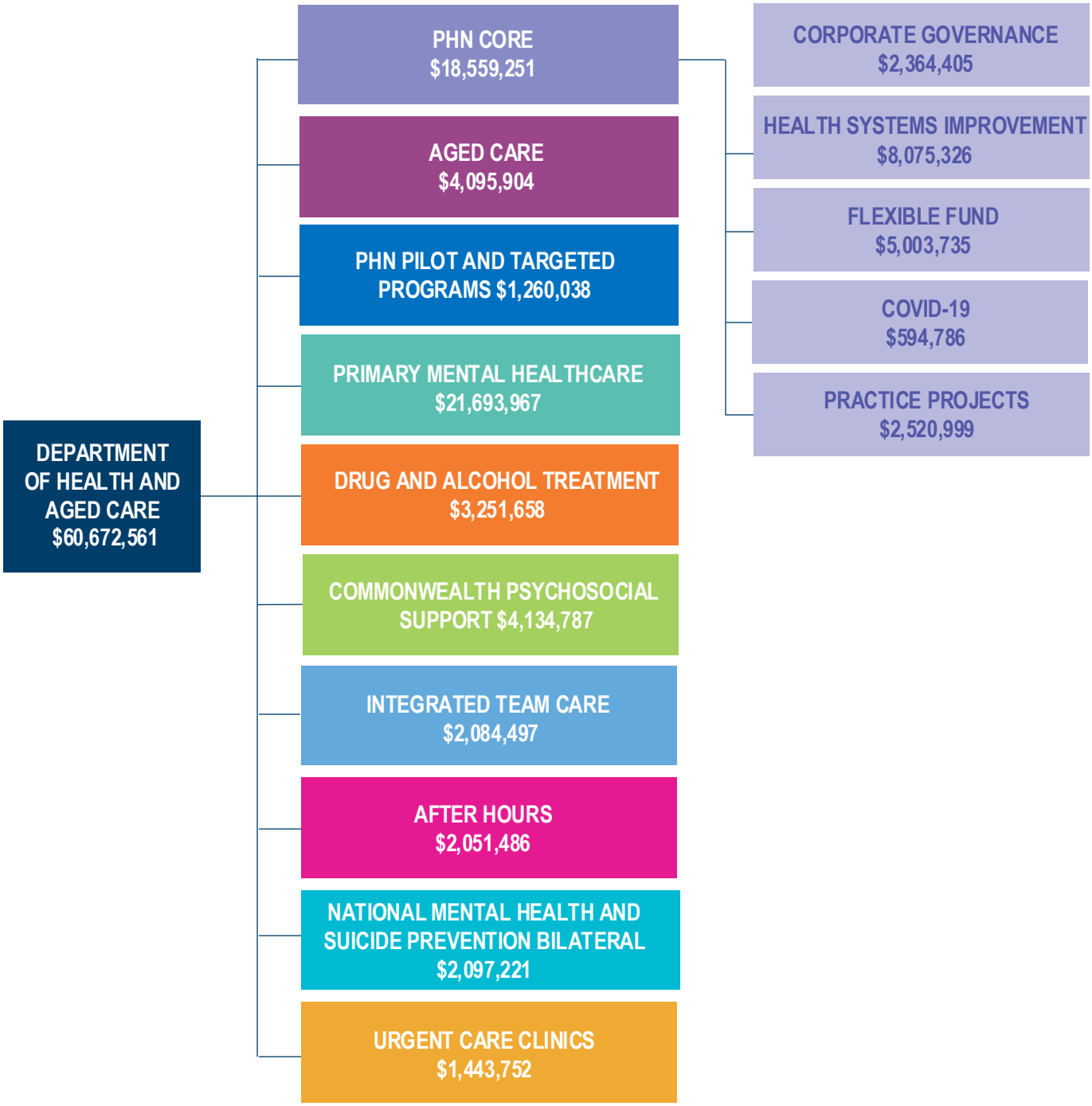
** These four items form Murray PHN's core funding schedule*

TOTAL FUNDING FY25 - $76,640,306

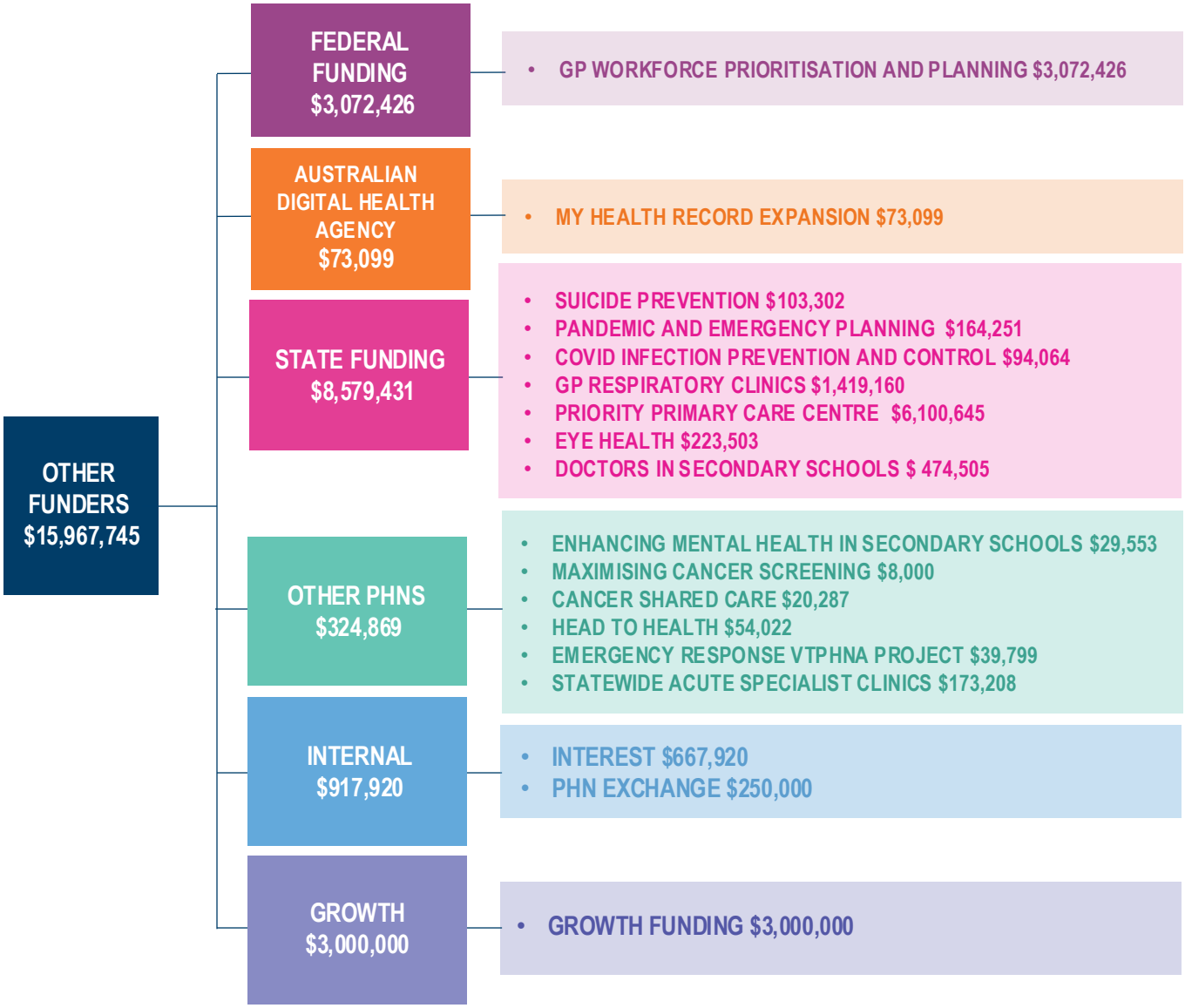
DEPARTMENT OF HEALTH AND AGED CARE
FY25 FUNDING SCHEDULES

The Commonwealth Department of Health and Aged Care has issued 11 funding schedules to Murray PHN. Each funding schedule outlines the aim of funding, specific obligations to be delivered and reporting accountabilities.

While funding schedules apply over multiple years, Murray PHN is required to submit annual work plans (AWP) against each schedule for each forward year, and report against progress as part of the 12-month performance reports.



OTHER FUNDERS
ACTIVITY SUMMARY



PERFORMANCE MONITORING

Our vision is for healthy rural and regional communities with timely access to the primary care they need

PHNs were established by the Commonwealth Government in 2015 with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly at risk of poor health outcomes, and improving coordination of care so patients can receive the right care, in the right place, at the right time.

Murray PHN aligns its Strategic Plan and Business Plan to address the national seven health priorities for PHNs and the regionally identified needs described in the Murray PHN Health Needs Assessment. Murray PHN also delivers a small range of activities funded by the Victorian State Government which complement and enhance PHN program delivery.

PHN performance is assessed by the Commonwealth's Program Performance and Quality Framework. In FY24, a new set of performance indicators came into effect. The Performance Measure Reporting Framework (PMRF) replaced the Program Performance and Quality Framework (PPQF), which PHNs have been reporting to since 2018. Examples of the PPQF are provided in this document against relevant activities.

Murray PHN also has its own Performance Reporting Framework which categorises the large set of indicators that Murray PHN collects to monitor organisational performance and the impact of commissioned activities. Over the next year, Murray PHN will implement quality improvement initiatives to improve performance reporting processes.

CORE FUNDING SCHEDULE

GOVERNANCE

Corporate governance funding is provided to assist PHNs to fund their corporate functions.

The company must fund the following from these funds:

- Board and advisory council functions.
- All corporate processes required under the Department's capable organisation in the Program Performance and Quality Framework (PPQF)
- Mandatory reporting to the department six-monthly and 12-monthly; AWP preparation and Performance and Quality Framework
- Murray PHN funds this work with Department grant money plus internal charges to other funding schedules, including non-department, as in corporate income.

PERFORMANCE INDICATORS

The PHN has a commissioning framework
PHNs use commissioning to address the prioritised needs of their region. The Framework helps PHNs to fulfil their commissioning role in a strategic way.

PHN Clinical Council (CC) and Community Advisory Committee (CAC) membership
The PHN CC and CAC provide expertise and advice to the Board on how the PHN can meet the needs of the region. A wide range of skills ensures the quality of advice.

Quality management system
A quality management system supports the effective and efficient delivery of an organisation's objectives by providing a means to review and continually improve processes and procedures.

Cultural awareness training
PHNs must ensure that their staff are culturally aware and able to respond appropriately, confidently and respectfully to all persons in the PHN region.

CORPORATE EXPENDITURE

Councils – clinical and community	$519,709
Board, consultancy and marketing costs	$522,752
Office and people	$1,321,944
TOTAL expenditure	**$2,364,405**

CORPORATE INCOME

Corporate governance funding	$2,333,141
Interest and other income (included)	$31,264
TOTAL income	**$2,364,405**

RESOURCING

Term:	31 December 2025
FY25 value:	$2,364,405 ($2,033,141 grant funding + $300,000 carryforward + $31,264 interest)
FY25 value:	$2,083,141
Contact:	Chief Corporate Officer
Last updated:	August 2024

CORE FUNDING SCHEDULE

HEALTH SYSTEMS IMPROVEMENT

Health systems improvement funding enables the integration and coordination of health services in their regions through population health and service planning and workforce support, including general practice support.

PERFORMANCE INDICATORS

Number of formal PHN care pathways (HealthPathways)
Provides availability of HealthPathways resources for primary health providers to support evidenced best practice and referrals within the local health system.

Rate of accredited practices
General practices are required to meet the requirements of the RACGP Standards for General Practice (Standards). The Standards promote improvements in patient safety and care built on a practices' own information systems.

Rate of accredited practices sharing PIP QI data with PHN
General practices are encouraged to share their data with the PHN as part of quality improvement activities and to inform future planning.

Rate of accredited practices receiving quality improvement feedback
Murray PHN ensures practices undertaking quality improvement activities receive feedback as part of the quality improvement process.

Number of clinical professional development events
Murray PHN provides events to general practice and the broader primary healthcare sector to support sharing information, facilitating access to or providing training, and conducting workshops.

My Health Record: Rate of discharge summaries uploaded
This reflects the coordination between hospitals and GPs about patients' conditions.

Cultural humility in Western health services
Supporting our commissioned health services to progress towards cultural humility.

ACTIVITY AT A GLANCE

Primary healthcare development This activity aims to improve patient health outcomes and business sustainability through quality improvement activities and working collaboratively with primary healthcare providers.	**$1,462,636**
Workforce development This activity aims to build the capability and capacity of the primary healthcare workforce, through coordination and delivery of continuing professional development and collaborative programs.	**$836,279**
Population health This activity aims to effectively address population health needs and disparities through evidence-based primary care service improvement planning, strategic stakeholder engagement, and rigorous performance monitoring, reporting, and evaluation of Murray PHN activities.	**$648,000**
Digital health, systems and connected care This activity aims to improve access to primary care through the effective use of digital health such as telehealth, e-prescribing, e-referral, e-pathology and My Health Record, and integrated care at a local level.	**$1,448,121**
Sustainable rural healthcare The Integrated Health Network identifies sustainable models of primary healthcare and financing through integrated approaches between services in the Buloke, Loddon and Gannawarra rural communities.	**$154,713**
HealthPathways and redesign HealthPathways brings together local experts to research, collaborate and agree on best practice care and local referral options for patients.	**$745,786**
First Nations Health and Healing The aim of the First Nations Health and Healing Strategy is to apply a system-wide all-of-organisation strategic approach to addressing and meeting the Close the Gap priority reform areas, underpinned by First Nations world views, acknowledging that First Nations Communities hold the wisdom and knowledge to enable healing across our catchment. Ongoing delivery of capacity and capability building for ACCHOs and First Nations health workforce.	**$531,316**

CORE FUNDING SCHEDULE

HEALTH SYSTEMS IMPROVEMENT

PERFORMANCE INDICATORS

Rate of shared health summary uploads to My Health Record (MHR)
PHNs play a role at a system level to encourage primary healthcare providers to use MHR. The full implementation of MHR supports the patients' continuity of care across healthcare providers.

Rate of team care arrangements and case conferences per 100,000 population
Team care provides patients with access to Medicare benefits for relevant allied health services and improves continuity of care. Case conferencing combines clinical skills to coordinate care for patients with chronic and complex conditions.

Rate of people aged 75 and over with a healthcare assessment
This indicator looks at whether access to appropriate GP health services for people aged 75 and over has improved.

Rate of First Nations population receiving annual health check
This indicator looks at whether our First Nations Peoples access appropriate GP health services for early intervention.

Reduced potentially preventable hospitalisations of First Nations Peoples
This indicator looks at preventable hospitalisations by all, vaccine-preventable conditions, acute conditions and chronic conditions for First Nations Peoples that may have been avoided by timely and effective healthcare, usually delivered in primary care and community-based care settings.

ACTIVITY AT A GLANCE

Dementia HealthPathways and consumer resources HealthPathways have been localised and consumer resources developed to support people living with dementia to live well in the community for as long as possible. Providing support to clinicians, primary care and the allied health workforce to enhance the care and support provided to people living with mild cognitive impairment or dementia, as well as their carers and family.	**$601,792**

RESOURCING

Term: 31 December 2025

FY25 value: $8,075,326 ($6,915,852 grant funding + $843,132 carryforward + $316,342, interest and other revenue, include operational portion)

FY26 value: $6,915,852 grant funding

Contact: Director of Operations

Last updated: August 2024

CORE FUNDING SCHEDULE

FLEXIBLE

PERFORMANCE INDICATORS

Consumer experience/outcomes collected for each commissioned service
Level of consumer satisfaction with the service provided and the outcome may provide insight into effectiveness/appropriateness of service and potentially identify areas for improvement.

Workforce satisfaction and experience survey
Level of workforce satisfaction with delivering the service and implementation support is measured with each commissioned service.

Rate of chronic disease plans per 100,000 population
A General Practice Management Plan (GPMP) describes a patient's healthcare needs, health problems and relevant conditions; and includes the management goals, treatments, reviews and actions that the patient needs.

Reduced potentially preventable hospitalisations, people aged 65 years and over
This indicator looks at preventable hospitalisations by all, vaccine-preventable conditions, acute conditions, and chronic conditions, people over 65 that may have been avoided by timely and effective healthcare, usually delivered in primary care and community-based care setting primary and community-based healthcare sector.

Rate of general practices that are culturally appropriate
This indicator looks at practices that meet RACGP 5th Edition Standard C2.1.

ACTIVITY AT A GLANCE

HealthPathways HealthPathways is a web-based portal for healthcare providers. An online resource, it provides best practice assessment and management of common medical conditions including localised referral pathways for patients.	**$300,517**
Supporting system integration for Aboriginal and Torres Strait Islander health Applying self-determination principles, Murray PHN works with the seven Aboriginal Community Controlled Health Organisations (ACCHOs) in our region to improve access to care coordination services and outreach to Aboriginal and Torres Islander people with chronic conditions.	**$414,817**
Health system navigators This activity bases health system navigators in communities with identified populations of increased need or complexity. System navigators provide direct non-clinical support to link clients to the health and community services they need.	**$270,300**
Chronic disease management This activity commissions direct allied healthcare, primarily in rural locations, for people living with chronic disease, integrating local coordinated primary healthcare services.	**$3,017,424**
Care coordination in general practice This activity aims to improve patient experience and health outcomes for those identified with chronic and complex conditions through the commissioning of care coordination services in targeted general practices supporting workforce capacity building.	**$1,000,677**
COVID vaccination roll-out and vaccination of vulnerable populations This activity ensures primary care services are engaged as critical partners in the COVID-19 vaccination program and supports local solutions to vaccinate vulnerable populations.	**$594,786**

RESOURCING

Term: 31 December 2025

FY25 value: $5,598,521 ($4,954,957 grant funding + $643,564 carryforward)

FY26 value: $4,754,957 grant funding

Contact: Chief Operations Officer

Last updated: August 2024

CORE FUNDING SCHEDULE

PRACTICE PROJECTS

The key objectives of the schedule are to respond to the Strengthening Medicare Taskforce recommendations and Government-introduced initiatives to:

- improve patient access to general practice, including after hours
- improve patient access to GP-led multidisciplinary team care, including nursing and allied health
- making primary care more affordable for patients
- improve prevention and management of ongoing and chronic conditions
- reduce pressure on hospitals
- build on Australia's Primary Health Care 10 Year Plan 2022-32.

PERFORMANCE INDICATORS

Rate of accredited practices
General practices are required to meet the requirements of the RACGP Standards for General Practice (Standards). The Standards promote improvements in patient safety and care built on a practices' own information systems.

Reduced potentially preventable hospitalisations
This indicator looks at preventable hospitalisations by all vaccine-preventable conditions, acute conditions and chronic conditions that may have been avoided by timely and effective healthcare, usually delivered in primary care and community-based care setting primary and community-based healthcare sector.

Rate of chronic disease plans per 100,000 population
A General Practice Management Plan (GPMP) describes a patient's healthcare needs, health problems and relevant conditions; and includes the management goals, treatments, reviews and actions that the patient needs.

My Health Record: Rate of discharge summaries uploaded
This reflects the coordination between hospitals and GPs about patients' conditions.

ACTIVITY AT A GLANCE

Strengthening Medicare – MyMedicare Activity aims to introduce a system of voluntary patient registration for general practice, delivering stronger relationships between patients and their care teams and support blended payments for person-centred care. **MyMedicare – Accreditation support for general practice** This activity aims to support unaccredited practices to work towards accreditation/increase the number of practices participating in the national scheme to enable them to access Commonwealth programs such as MyMedicare. Also to create resources and support mechanisms to assist general practices in achieving and maintaining accreditation throughout each accreditation cycle.	**$21,990**
Workforce Incentive Program (WIP) Practice Stream (PS) The objectives are to understand the use of WIP-PS and identify and provide additional support to practices to bolster multidisciplinary care to the community and increase general practice participation.	**$51,065**
Commissioning of multidisciplinary teams This activity is aimed at developing and implementing a co-designed model of care that improves access to multidisciplinary team-based care for the management of chronic conditions, within areas of need identified.	**$1,238,821**
General Practice Aged Care Incentive – Thin markets This activity identifies existing gaps in the delivery of primary care services to residential aged care residents within the region. Commissioning services to work in collaboration with local residential aged care homes, general practices and/or Aboriginal Community Controlled Health Organisations to design and implement a place-based solution to increase resident access to primary care services.	**$796,302**
General Practice Aged Care Incentive – GP matching Support aged care residents living in residential aged care homes to receive quality and continuous primary care services from a regular general practitioner and practice or Aboriginal Community Controlled Health Organisation.	**$412,821**

RESOURCING

Term:	31 December 2025
FY25 value:	$2,520,999 ($2,490,178 grant funding + $30,821 interest and other income)
FY26 value:	$627,080 grant funding
Contact:	Chief Operations Officer
Last updated:	August 2024

AGED CARE

The key objective of this schedule is to improve outcomes for senior Australians at risk of poor health outcomes by undertaking and commissioning dedicated activities which support better health, wellbeing and primary care access.

PERFORMANCE INDICATORS

Rate of residential aged care homes using digital platforms and equipment to access services virtually
PHNs provide support to residential aged care homes to embed virtual consult technology to improve the delivery and experience of healthcare for residents. This indicator can provide a measure of how effective education and training has been in encouraging the use of these systems.

Rate of residential aged care facilities that have effective after hours action plans in place
PHNs provide support to residential aged care homes to address any awareness or use issues of available local out-of-hours services. The measure will contribute to the reduction of unnecessary hospital presentations among residents during the out-of-hours periods.

Rate of MBS service provided by primary care providers in residential aged care per place
PHNs have opportunities through their networks and commissioning to take steps to facilitate and minimise acute admissions through the uptake of residential aged care health service consultations.

ACTIVITY AT A GLANCE

Support residential aged care homes to increase availability and use of telehealth care for aged care residents This activity will embed the use of digital health equipment in residential aged care homes to enable virtual access to healthcare in a structured and effective approach. Training and education will also be provided to compliment activity 2 deliverables to encourage use of national solutions (My Health Record) for transfer of healthcare information between providers of care.	**$383,203**
Enhanced out of hours support for residential aged care This activity provides education, training and support to enable the residential aged care home workforce to recognise and manage deteriorating conditions in residents, while accessing local in and after hours services to support residents where necessary to avoid unnecessary hospital admissions. Complimenting this will be embedding the use of an After Hours Action Plan and Toolkit to improve the coordination of care between the health workforce, residents and their families.	**$152,330**
Commissioning early intervention initiatives to support healthy ageing and ongoing management of chronic conditions This activity will focus on commissioning services through ACCHOs to co-design and implement early intervention programs for First Nations Peoples who are risk of developing a chronic disease or who have an early diagnosis of a chronic disease.	**$534,267**
Care Finder Program This activity is to commission a network of Care Finders across the Murray PHN catchment to provide intensive and specialised support to aged community individuals who require assistance with accessing aged care, health and community services.	**$3,026,104**

RESOURCING

Term:	31 December 2025
FY25 value:	$4,095,904 ($3,828,717 grant funding + $208,311 carryforward + $58,876 interest)
Contact:	Director of Operations
Last updated:	August 2024

PHN PILOTS AND TARGETED PROGRAMS

The key objectives of the schedule are to increase the efficiency and effectiveness of medical services for patents, particularly those at risk of poor health outcomes; and improving coordination of care to ensure patients receive the right care, in the right place, at the right time through diagnosis, death and during grief and bereavement.

PERFORMANCE INDICATORS

Increased general practice palliative care capability, capacity to timely respond to the needs of patients and their carers

Activities include increasing general practice workforce awareness of palliative care systems through professional development and clinical placements; implement quality of life care models to identify patients living with life-limiting illnesses; embed quality improvement activities at the practice level to improve palliative care management of patients; and leverage PHN collaborative activities to meet the needs of patients living in the Murray PHN catchment.

Enhanced community death education and literacy of palliative care services

Increase number of palliative and end-of-life awareness building resources and activities tailored to the needs of regional and remote communities; and strengthen existing community death skills, their confidence and resources available to support those dying in community.

Leverage community-led networks of support for carers and patients with life-limiting illnesses

Establish evidence and life-experience informed carer support groups for increased opportunities of peer connection and support; and enhance carers' awareness of services available to support their carer journey.

ACTIVITY AT A GLANCE

Strengthening Medicare – General Practice Grants Program The GP grants program will provide one-off grants between $25,000 -$50,000 to support general practices and ACCHOs to expand patient access, and provide better, safe and accessible quality care. The GP practice can choose one or more investment stream: - Enhance digital health capability - Upgrade infection prevention and control arrangements - Maintain and/or achieve accreditation against RACGP Standards.	**$677,489**
Palliative care at home The program aims to develop and implement innovative initiatives to improve awareness, access and coordination of quality palliative care services at home and support end-of-life care in primary and community settings. Activities include reviewing local provision, capacity building, education and training and continuous improvement activities.	**$376,527**
Endometriosis and Pelvic Pain Clinic The aim is to commission one provider to set up and deliver a multidisciplinary care clinic, with a focus on improving diagnostic delay and early access to interventions, care and treatment options for endometriosis and chronic pelvic pain.	**$206,022**

RESOURCING

Term:	31 December 2025
FY25 value:	$1,260,038 ($496,764 grant funding + $755,635 carryforward + $7,639 interest)
FY26 value:	$938,764 grant funding
FY27 value:	$755,000 grant funding
Contact:	Director of Operations
Last updated:	August 2024

PRIMARY MENTAL HEALTH

The key objective of this schedule is to put in place a suite of mental health and suicide prevention services according to a stepped care framework. Services improve outcomes for people with, or at risk of, mental illness/suicide. This activity includes a review of Murray PHN's stepped care approach and service system.

RESOURCING

Term:	31 December 2025
FY25 value:	$21,693,967 $17,233,728 grant funding + $4,195,229 carryforward + $265,010 interest, including operational portion)
FY26 value:	$17,177,953 grant funding
Contact:	Director of Mental Health and Wellbeing
Last updated:	August 2024

PERFORMANCE INDICATORS

Rate of regional population receiving PHN commissioned low intensity psychological interventions

Enabling access to low intensity services is fundamental to building a stepped care model of mental health service delivery. Low intensity mental health services are evidence-based psychological interventions for people with or at risk of mild mental illness who do not require traditional services.

Rate of population receiving PHN-commissioned clinical care coordination services for people with severe and complex mental illness

PHNs commission clinical mental health services to meet the needs of people with severe mental illness whose care can be appropriately managed in a primary care setting. This includes making optimal use of the available and new mental health nursing services funding to support clinical coordination.

Proportion of people referred to PHN commissioned services due to a recent suicide attempt or because they were at risk of suicide followed up within seven days of referral

PHNs commission psychological therapy services that can support people who are experiencing suicidal ideation. In these services, a prompt response to referral is paramount.

Completion rates for clinical outcome measures

A key objective of funding PHNs is to commission mental health services to improve outcomes for those receiving mental health and suicide prevention services in primary care. Standardised outcome measures, collected at the first and last occasions of service at a minimum, provide the means for assessing effectiveness of services and are included in the PMHC MDS as mandatory requirements.

Providing culturally appropriate and safe mental health services for Aboriginal and Torres Strait Islander Peoples

Proportion of PHN commissioned mental health services delivered to the regional Aboriginal and Torres Strait Islander population that were culturally appropriate. PHNs are funded to increase access to integrated, culturally appropriate and safe mental health services for Aboriginal and Torres Strait Islander Peoples.

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PRIMARY MENTAL HEALTH

ACTIVITY AT A GLANCE

Mental Health Services (P1) Low Intensity The delivery of low intensity mental health services has been integrated within primary mental health service models from 1 July 2024 as a new service element.	**$540,000**
Child and youth mental health services. Targeting people aged 25 and under We commission mental health services for young people with a range of mental health needs. headspace centres provide a significant proportion of these services.	**$7,662,148**
Psychological therapy services for under-serviced and priority populations We commission psychological therapy services aligned to IAR level 3 needs, including for First Nations Peoples, children, people in residential aged care and people who cannot otherwise afford services. Funding has been redirected to priority locations in response to the introduction of duplicated services by state funded Mental Health and Wellbeing Locals, including a reduction in IAR3 services in 'Local' service provision areas, and an increase of resourcing to child psychological therapy services. Changes have been commissioned in service and funding models for continuing services, using same provider, to deliver bundled care using IAR-DST tool with a more diverse workforce, and to generate greater understanding of consumer experience and outcomes.	**$3,658,699**
Primary mental health services for people with or at risk of suffering from severe or complex mental illness We commission clinical services for people with severe mental illness, with IAR level 4 needs who are being supported in primary care settings. This includes the provision of high intensity psychological services and clinical care coordination to address both mental health and physical health needs. From 1 July 2024, there has been a reduction in funding to locations where service is duplicated by new state funded Adult and Older Adult Mental Health and Wellbeing Locals, with funding redirected to other priority areas.	**$1,967,549**
Primary mental health services for Aboriginal and Torres Strait Islander people We commission culturally appropriate and safe services designed to meet the mental health and wellbeing needs of Aboriginal and Torres Strait Islander people.	**$669,141**
Mental health clinics We commission a 'Head to Health' clinic in Wodonga to provide mental health services for people with moderate to severe mental illness, and separately, a phone intake service as part of the Head to Health National Phone Service. Responsibility for three of the Head to Health programs moved to the Victorian Government at the end of June 2024.	**$1,046,851**
Initial Assessment and Referral Murray PHN has employed an Initial Assessment and Referral Training and Support Officer who trains general practitioners and mental health service providers to learn about, use and embed the IAR in clinical practice.	**$41,538**
Targeted Regional Initiatives for Suicide Prevention (TRISP) A team of dedicated Suicide Prevention Coordinators will support the coordination and delivery of initiatives to reduce the incidence and impact of suicidality in the Murray PHN catchment.	**$1,814,793**
Investing in community-led suicide prevention initiatives In addition to the time-limited Targeting Regional Initiatives for Suicide Prevention (TRISP) program, we are continuing to build and develop a sustainable regional approach to community-based suicide prevention, leveraging learnings from the national suicide prevention trials, LifeSpan place-based suicide prevention models and emerging best practice and investments by the Australian and Victorian governments.	**$816,095**
Psychological Therapy Services in RACF This activity aims to provide in-reach psychological therapy services targeted at older people residing in residential aged care facilities presenting with mild to moderate mental health issues, or who are assessed to be at risk of developing a mental illness.	**$1,428,419**

DRUG AND ALCOHOL TREATMENT

Murray PHN's alcohol and other drug activity seeks to improve sector efficiency and support better patient management across the continuum of care; including commissioning services to reduce the impact of methamphetamines - on individuals, their families and the community.

PERFORMANCE INDICATORS

Evidence that all drug and alcohol commissioned services are culturally appropriate for Aboriginal and Torres Strait Islander Peoples
PHNs will report on how mainstream and Aboriginal and Torres Strait Islander services have been delivered in recognition of the six domains and focus areas of the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026.

Rate of drug and alcohol treatment service providers with suitable accreditation
All specialist drug and alcohol treatment service providers are accredited or working towards accreditation.

PHN support for drug and alcohol commissioned health professionals
This indicator reflects how PHNs demonstrate support for health professionals in the management of drug and alcohol dependence and related morbidities.

Rate of drug and alcohol commissioned providers actively delivering services
PHNs are helping to address demand for treatment services through commissioning providers to deliver services. This measures how the PHN and providers are moving from design to delivery of services.

Partnerships established with local key stakeholders for drug and alcohol treatment services
This indicator measures the range of partnerships established in the PHN region in relation to the delivery of drug and alcohol services.

ACTIVITY AT A GLANCE

Commissioned treatment services We commission pharmacotherapy, non-residential rehabilitation, withdrawal, alcohol and other drug (AOD) counselling and care and recovery services. Pharmacotherapy targets people at increased risk of harm from drug use. Non-residential rehabilitation provides intensive AOD support to people in their community and is part of the stepped care approach. Under this activity, AOD workforce development is also included.	**$1,569,034**
Integrated models for First Nations People Murray PHN commissions dual diagnosis services for First Nations Peoples including direct client services and care coordination to consumers living with co-occurring mental health and AOD conditions. Services include brief interventions, case management and care coordination with associated supports from primary health and social services.	**$322,875**
Transitional Services and Drug and Alcohol Treatment Services Maintenance Funding from this stream supports the sustainability of AOD commissioned activities and enhances access to quality care.	**$1,133,562**

RESOURCING

Term:	31 December 2026
FY25 value:	$3,251,658 ($2,689,427 grant funding + $520,875 carryforward + $41,356 interest, including operational portion)
FY26 value:	$1,966,673 grant funding
Contact:	Director of Mental Health and Wellbeing
Last updated:	August 2024

PSYCHOSOCIAL RECOVERY SERVICES

This program provides non-clinical, holistic mental health supports to people with severe mental illness, to enable them to tackle life factors that impact on and are impacted by, mental illness.

ACTIVITY AT A GLANCE

Service delivery **$4,134,787**

Services are commissioned to deliver strengths-based, recovery focused, trauma-informed psychosocial supports to eligible clients with criteria targeting people with severe mental illness and associated psychosocial disability. Programs are made up of both individual and group supports and provide a range of non-clinical community-based supports. Clients will have needs that are responsive to low intensity support and can be met within three to 12 months.

RESOURCING

Term:	30 December 2025
FY25 value:	$4,134,787 ($3,662,386 grant funding + $416,083 carryforward + $56,318 interest)
Contact:	Director of Mental Health and Wellbeing
Last updated:	August 2024

INTEGRATED TEAM CARE

The ITC Program has two principal aims, to contribute to:

- improving health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to coordinated and multidisciplinary care
- closing the gap in life expectancy by improved access to culturally appropriate mainstream primary care for Aboriginal and Torres Strait Islander people.

PERFORMANCE INDICATORS

Rate of population receiving specific health assessments

This indicator shows the degree to which Aboriginal and Torres Strait Islander people are accessing a range of primary healthcare services designed to both identify and prevent healthcare problems, and to plan and manage treatment in a multidisciplinary manner.

1. Average number of supplementary services requests each month
2. Average number of clients supported per month.

ITC improves the cultural competency of mainstream primary healthcare services

ITC commissioned services work to improve the cultural competency of mainstream primary healthcare services.

PHN provides support for Aboriginal and Torres Strait Islander identified health workforce

Improving the capacity, capability and proportion of Aboriginal and Torres Strait Islander identified health workforce to improve the quality of services offered to Aboriginal and Torres Strait Islander people.

ACTIVITY AT A GLANCE

$2,084,497

Aboriginal and Torres Strait Islander people have higher rates of chronic illness compared with non-Indigenous Australians. Access to comprehensive, affordable and culturally appropriate primary healthcare is critical for closing this gap.

Care coordination and supplementary services

The ITC program enables delivery of care coordination to First Nations Peoples within our catchment with a chronic disease. Ensuring that First Nations Community has access to best practice, culturally safe and appropriate chronic disease management and support. It also addresses gaps in services access through outreach workers/ transport/ accommodation, as well as ensuring timely access to specialist and allied health services. Lastly, it ensures those who need access to medical aids and equipment and who would otherwise not have access can access these.

Culturally competent mainstream services

ITC commissioned services work to improve the cultural competency of mainstream primary healthcare services through a variety of activities, including delivering or organising cultural awareness training for staff; encouraging uptake of relevant MBS items; helping practices create a more welcoming environment for Aboriginal and Torres Strait Islander people.

RESOURCING

Term:	31 June 2025
FY25 value:	$2,028,647 ($1,976,198 grant funding + $77,910 carryforward + interest $30,389, including operational portion)
Contact:	Director of Operations
Last updated:	August 2024

AFTER HOURS

The After Hours Primary Health Care Program Funding Schedule aims to address gaps in after hours service arrangements, increase effectiveness and address fragmentation of after hours care, particularly for vulnerable and rural populations. The program has recently been reviewed and subsequently revised to include Primary Access Program for Homelessness and Multicultural communities.

PERFORMANCE INDICATORS

Rate of GPs receiving payment for after hours services

The Commonwealth Government's Practice Incentive Payment (PIP) aims to improve access to care, detection and management of chronic conditions, and quality, safety, performance and accountability where PHNs can play an important role. Practices must register for the PIP. The PIP After Hours incentive aims to ensure that patients have access to care throughout the after hours periods.

Reduction in preventable/ avoidable ED presentations

One of the intended outcomes of the Primary Care Access and After Hours program is to reduce preventable emergency department presentations and admissions to health services, this is achieved through enhanced coordination of care and connections through health system navigation and access to primary care clinical services where clinical services have not been available/ accessible to the community. Previously, the only alternative has been to present to an emergency department. Access to clinical services will also support standard health assessments, including cancer screening and heart health checks as examples.

ACTIVITY AT A GLANCE

General practice models of after hours service a) Continue to support existing after hours services in general practice with face-to-face and telehealth models of care b) Commission innovative models to meet after hours services for patients of residents of aged care facilities c) Build scope of general practices to provide nurse-led urgent after hours services for palliative patients d) Providing First Nations specific after hours services in areas of need identified by the health needs assessment.	**$1,224,356**
Homelessness access to primary care a) Commission direct health services to support primary care access by people experiencing or at risk of homelessness b) Identify and support homelessness support services to address barriers to primary care access c) Promote coordination between services at a local level, including capacity building that leads to effective integrated care d) Work with primary care services to increase access, efficiency and effectiveness of these services for people experiencing or at risk of homelessness.	**$459,450**
Multicultural access to primary care a) Commission Health System Navigators to support people from CALD backgrounds experiencing barriers to access primary healthcare in the Robinvale region b) Build sector capacity through the establishment of a Multicultural Health System Navigator Community of Practice c) Promote coordination between services at a local level, including capacity building that leads to effective integrated care d) Work with primary care services to increase access, efficiency and effectiveness of these services for people from CALD backgrounds.	**$317,680**

RESOURCING

Term:	30 June 2025
FY25 value:	$ 2,051,486 ($1,713,730 grant funding + $311,403 carryforward, +26,353 interest including operational portion)
Contact:	Director of Operations
Last updated:	August 2024

NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION AND BILATERAL PROGRAM

This schedule aims to achieve systemic, whole-of-government reform to deliver a comprehensive, coordinated, consumer-focused mental health and suicide prevention system with joint accountability and clear funding arrangements across all governments.

ACTIVITY AT A GLANCE

Regional planning, commissioning and governance We work with other commissioning bodies and stakeholders in the region to develop, strengthen and implement a joint regional mental health and suicide prevention plan. This planning is informed by the national guidelines on joint regional planning and commissioning and the Bilateral Agreement between the Commonwealth and Victoria.	**$320,744**
headspace enhancement We provide additional funding to headspace centres to increase access to coordinated, multidisciplinary care for young people and improve workforce attraction and retention.	**$1,776,477**

RESOURCING

Term:	31 December 2026
FY25 value:	$2,097,221 ($1,306,597 grant funding + $769,815 carryforward from FY24 + $20,809 interest)
FY26 value:	$2,471,611
FY27 value:	$2,407,693 grant funding
Contact:	Director of Mental Health and Wellbeing
Last updated:	August 2024

MEDICARE URGENT CARE CLINICS

The key objectives of the schedule are to establish and deliver Medicare Urgent Care Clinics (Medicare UCC) in the region. Medicare UCCs will ease the pressure on hospitals and give Australian families more options to see a healthcare professional when they have an urgent, but not life-threatening need for care. In FY25, the Bendigo and Shepparton PPCCs have been transitioned to Medicare Urgent Care Clinics, funding flows from the Commonwealth to the State Government.

PERFORMANCE INDICATORS

- Total number of approved UCCs in a catchment area per PHN
- Total number of EOI issued by PHN
- Total number of EOI received by PHNs
- Total number of contracts offered by PHNs to a UCC
- Total number of contracts accepted and signed by PHN
- Location of UCCs
- How many UCCs opened per month
- How much was actually paid to UCC per month
- Number of PHN Urgent Care commissioned services
- PHN Urgent Care Commissioned Services: Number of occasions of service
- PHN Urgent Care Commissioned Service: Number of ED presentations avoided
- Reduction in lower acuity ED presentations
- Reduction of lower acuity ED presentations within hours
- Reduction in lower acuity ED presentations after hours
- Reduction in lower acuity ED presentations by First Nations Peoples

ACTIVITY AT A GLANCE

Medicare Urgent Care Clinic – Albury **$1,443,752**

The aim of this activity is to provide short-term, episodic care for non-life-threatening urgent conditions requiring same day assessment or treatment, with the aim to reduce pressure on nearby emergency departments and redirect patients to primary care.

RESOURCING

Term:	31 December 2026
FY25 value:	$1,443,752 ($1,270,100 grant funding + $154,121 carryforward + $19,531 interest)
FY26 value:	$1,270,100 grant funding
Contact:	Director of Operations
Last updated:	August 2024

OTHER FUNDERS Activity at a glance

AUSTRALIAN DIGITAL HEALTH AGENCY (FEDERAL)	**My Health Record Expansion** Activities include promotion of My Health Record registration and use in primary care and specialist medical services, promotion of eRequesting of pathology and ePrescriptions.	**$73,099**
OTHER FEDERAL	**GP Workforce Prioritisation and Planning** Activity supports the transition to college-led general practice training by delivering robust, independent and evidence-based recommendations to the Department of Health and Aged Care to inform training placement priorities. The activity will include data collection and analysis to inform the reports: Workforce Needs and Placement Prioritisation report; Training Capacity report and stakeholder engagement.	**$3,072,426**
DEPARTMENT OF HEALTH (STATE)	**Suicide prevention** Place-based projects to reduce rates of suicide and suicide attempts, and improve individual and community wellbeing and systems using the Black Dog Institute LifeSpan approach.	**$103,302**
	Pandemic and emergency planning A strategic approach to reduce the social and economic impacts of pandemics and other emergencies, with activities including audits of preparedness and capacity of primary care, development of operational plans and protocols and coordination with the wider health system.	**$164,251**
	Diabetes Victoria This activity is aimed at supporting 10 general practices to implement a data driven model for identifying patients at risk of developing diabetes. The project aims to increase general practice education of risk factors, increase referrals of patients at risk of diabetes into the *Life!* Program and increase knowledge of MBS items for identification of diabetes and preventative care.	**To be confirmed**
	Infection Prevention Helpline This commissioned service was being delivered by nurses from the Australian Primary Health Care Nurses Association (APNA) and was available free of charge to Victorian general practices, ACCHOs and community pharmacists to help keep their staff and patients safe. The service has transitioned to business as usual with APNA providing general advice as required. Remaining funds have been used to developed a web-based platform to guide Urgent Care Clinics in the management and monitoring of accreditation status relating to mandatory IPC requirements.	**$94,064**
	Urgent Care Clinics (previously known as Priority Primary Care Centre (PPCC)) The funding is to commissioned four Urgent Care Clinics (UCCs) across the catchment to provide urgent but not life-threatening care and to support emergency department diversions of low acuity patients. Two UCCs have been extended to June 2025 – Mildura and Wodonga and two sites in Bendigo and Shepparton have been renamed as Medicare UCCS and will be extended to June 2026, funded directly from DoHAC. The funded services partner with community, local health services, ACCHOs, Ambulance Victoria, NSW Ambulance, and local pathology and radiology providers.	**$6,100,645**
DEPARTMENT OF EDUCATION	**Doctors in Secondary Schools** The program aims to make primary healthcare more accessible to students, assist young people to identify and address any health problems early and reduce pressure on working parents.	**$474,505**

Contact: Director of Operations **Last updated:** August 2024

OTHER FUNDERS CONT. Activity at a glance

PHNs	**Enhancing mental health supports in secondary school (North West Melbourne PHN)** This project, funded by Department of Education with NWMPHN as the lead PHN, provides enhanced mental health services to young people in Victorian school communities and to build capacity and capability of the government school workforces.	**$29,553**
	Maximising Cancer Screening (Western Victoria PHN) Maximise cancer screening participation of populations made more vulnerable by COVID-19 pandemic.	**$8,000**
	Cancer shared care and Cancer Survivorship (Gippsland PHN) Implementing co-developed regionally relevant cancer shared care models with consumers for enhanced holistic survivorship practices in general practices. Project with a focus on capability and capacity building of health service providers built on existing tools, education and referral systems.	**$20,287**
	Statewide Acute Specialist Clinics Reform (North West Melbourne PHN) The overall aim of this project is to improve primary health workforce capacity, and the consistency and transparency of access to specialist clinics, to ensure patients have a better healthcare experience, including equitable access to specialist services.	**$173,208**
	State-wide Emergency and Disaster Response Collaborative (Murray PHN/ Victoria and Tasmania PHN Alliance) Development and delivery of shared principles and activities, policies and tools, and identification of areas of advocacy for PHN role in Victorian and Tasmanian emergency preparedness, response and recovery panning.	**$39,799**
	Head to Health (Victoria and Tasmania PHN Alliance) Activity enabling booking of treatment appointments direct from social networking service (SNS).	**$54,022**

Contact: Director of Operations **Last updated:** August 2024