phn MURRAY

An Australian Government Initiative

2025

# Report to the Community

## Acknowledgement of Country

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 listening 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.

## Our commitment to being an anti-racist company

**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 (PHNs) are funded by the Australian Government to support national healthcare reform implemented at a local level, cognisant of local community need and workforce capability.

By harnessing and driving local innovation to meet specific health needs and supporting consistent delivery of national and co-commissioned programs, PHNs aim to keep people well and reduce avoidable hospital presentations.

Health outcomes in the Murray PHN 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 our communities.

The work of Murray PHN, its Board and Executive, and all its team members, is underpinned by five important organisational values – leadership, collaboration, respect, accountability and innovation – all of which help us work towards strengthening the capacity of the rural health system and investing in the sustainability of different primary healthcare models.

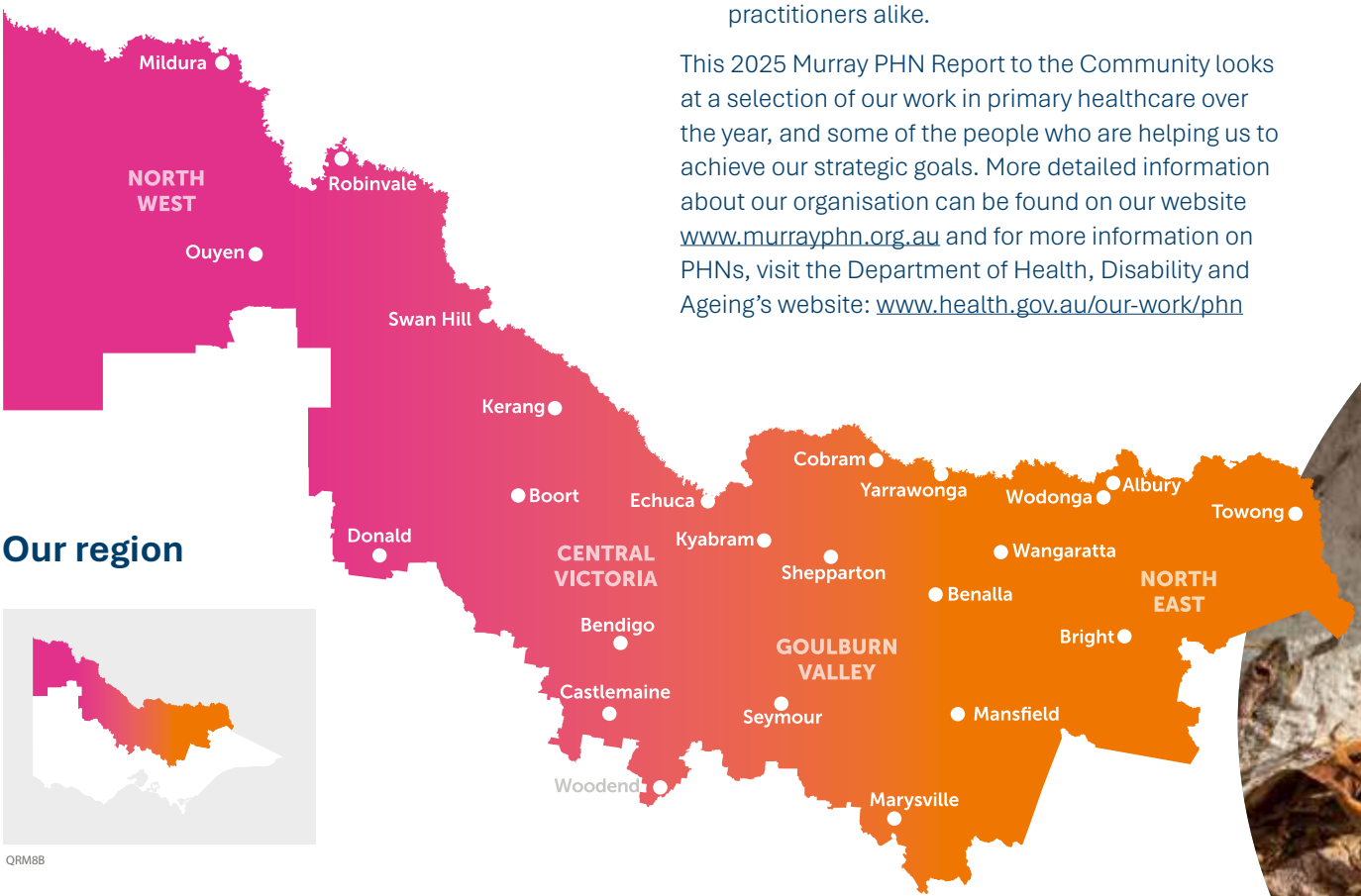
By increasing access to high-quality, culturally responsive and sustainable primary healthcare services, we support our communities to manage and improve their health and wellbeing, so that fewer people need to seek acute healthcare, and more care can be provided closer to home.

The three key aspects of the work we are proud to do at Murray PHN are coordination, capacity building and commissioning – all aimed at supporting the vital work of primary healthcare services and clinicians in our region

- **Coordination** means we work with the providers of healthcare to enable the most effective use of their services and responsiveness to the needs of our communities
- **Capacity building** describes 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.

This 2025 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 are helping us to achieve our strategic goals. More detailed information about our organisation can be found on our website www.murrayphn.org.au and for more information on PHNs, visit the Department of Health, Disability and Ageing's website: www.health.gov.au/our-work/phn

## Our region

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## Murray PHN health priority areas

Population health

General practice

Mental health

Alcohol and other drugs

Child health

First Nations

Health workforce

Digital health

Chronic disease

Aged care

# Our Board

Leonie Burrows OAM - Chair

Dr Alison Green - Deputy Chair

Andrew Baker

Bob Cameron

Ella Cannon

Dr Manisha Fernando

Joanne Kinder

Matt Sharp

Steve Tinker

Jacki Turfrey

Detailed information about our Board members can be found in our Financial Report: https://tinyurl.com/MurrayPHN-finance-report-2025

# Our Executive

Matt Jones,
Chief Executive Officer

Elizabeth Clear,
Chief Corporate Officer
(Until 31 July 2025)

Jacque Phillips OAM,
Chief Operations Officer

Nick Shaw,
Chief Strategy and
Performance

Aileen Berry,
Executive Director
Communications

## REMEMBERING DR ALISON GREEN

In October this year, as we were preparing this publication, Dr Alison Green, our esteemed Deputy Chair and Board member of eight years, died tragically in a cycling accident in Albury.

Alison was an outstanding contributor to the Board of Murray PHN and its executive and staff. She chaired the Murray PHN Programs and Quality Committee, and supported the work of Murray PHN's advisory council network, committing significant time and effort to these roles.

A GP Obstetrician and University of Sydney graduate, Alison had been a key member of the team at Central Medical Group in Wodonga for more than 30 years.

Away from her busy practice, Alison was the devoted and dearly loved wife of Tom Weatherall and mother of Claudia, Harrie and Risdon. She was well-known and respected across her community where she supported and mentored trainee doctors and expectant mothers with the same degree of care, compassion and patience.

Alison's vibrant and engaging approach to life, primary healthcare and the representation of rural medicine will be greatly missed, as we celebrate all that she achieved in her professional and personal lives.

We join with all who are grieving Alison's unexpected and untimely death.

# Message from the Chair

It has been my privilege to be a member of the Board of Murray PHN since its inception in 2015, and to serve as Chair for the last two years. This year, I write my retiring Chair's message, reflecting on a remarkable journey for both the organisation and the communities it serves.

We have grown from 54 employees in our early days to more than 135 now, with staff working in Mildura, Shepparton, Swan Hill, Bendigo and Albury. These dedicated professionals are committed to helping primary healthcare practitioners as they work together to improve the health outcomes of their communities, right across our 100,000 sq km catchment.

We are fortunate at Murray PHN to enjoy an average staff tenure of almost 4.5 years, meaning the stability and underlying knowledge base we offer our region remains strong. It is worth noting that across the Australian workplace, the average is 3.3 years.

In the last 10 years, there have been many changes to the way we think about and deliver healthcare, not least those that emerged from the COVID years, where Murray PHN played such a significant part in supporting our region.

The pandemic was a difficult experience for many people in so many regional areas but we also emerged with great medical and social leaps, as both telehealth and working from home were born through those years.

In the last decade, our communities have benefited from the evolution of multidisciplinary care, often spearheaded by general practitioners, but with appropriate and high-quality clinical care being delivered by nurses, physiotherapists, dietitians, pharmacists and other allied health professionals.

Most health services in our communities, beyond the bigger cities and towns, still face significant challenges in recruiting and retaining workforce. Murray PHN is working in some of our more isolated areas to find sustainable multidisciplinary solutions that make the best use of the professionals who are available, and to support them with sophisticated models of care that help to deliver effective services, when and where they are needed.

I would like to express my ongoing gratitude to the Murray PHN Board and its members over the years. I am particularly grateful to the current Board for their remarkable and diverse skill sets, which are provided generously to support our work.

As we prepared for the publication of the 2025 Report to the Community, we were devastated to lose our long-term Board member, Dr Alison Green, who died tragically in Albury in October. Alison was a steadfast friend and mentor to Murray PHN and its staff; a highly respected GP Obstetrician for more than 30 years and an esteemed contributor to regional general practice training. Her advice was always considered and practical, with the wellbeing of community at the forefront of her thinking.

I am also grateful to the staff and Executive team, led by our CEO Matt Jones, for their dedication and ability to change with the times, the needs of community and our funding models. I am confident I leave the organisation in good hands, with strong leadership and an active and passionate Board, and my continued good wishes for the future.

There are great opportunities ahead for our communities, as we strive to deliver the right care, in the right place, at the right time.

Leonie Burrows OAM -
Chair

***"In the last decade, our communities have benefited from the evolution of multidisciplinary care, often spearheaded by general practitioners, but with appropriate and high-quality clinical care being delivered by nurses, physiotherapists, dietitians, pharmacists and other allied health professionals."***

# Message from the CEO

As Primary Health Networks around Australia mark 10 years of operation, and with a recent national review suggesting new ways forward, it is worth considering the remarkable evolution of primary healthcare coordination and integration over the years.

From 1 July 2015, Primary Health Networks (PHNs) were established with the concept of building scale and capacity at a system, service and patient level. PHNs were required to work across a range of national health priorities, but just two national objectives – to improve health outcomes for vulnerable populations and provide the right care, in the right place, at the right time.

The place-based nature of our work enabled us to focus our activities, within the restrictions of budget, on the areas where we could see the greatest opportunity for a more effective and integrated system, with quality measures that could be achieved at a primary health level.

While the COVID years completely changed our environment and activity, they increased the government's appreciation of the role of PHNs to reach and engage with general practice, and the realisation of general practice that PHNs could support them with benefits and opportunities.

Since our inception in 2015, we have grown from an organisation with a budget of $35 million to one with nearly $90 million per annum.

Across Australia, the PHN network has grown from $400 million to more than $2 billion per annum.

While this is only a small percentage of the annual national expenditure on healthcare, it is a very significant sum of money, so it is appropriate that the Department of Health, Disability and Ageing is considering the Review of Primary Health Network Business Model for ways to make this expenditure work harder to help achieve national health reform. We look forward to the steps to strengthen primary care coordination in coming years.

I would like to thank everyone involved at Murray PHN for a strong year of support for our region's clinical workforce and the communities they serve. At every level of our organisation, we find ways to support general practice, allied health, aged care and our mental health providers through national reform and local insights.

As part of marking our 10th anniversary, we recognised the contribution of those employees who have been with us since the beginning 10 years ago, and a few who have been with us through Divisions of General Practice and Medicare Locals.

My thanks go to our Board for their constant guidance and wisdom, our retiring Chair Leonie Burrows OAM for her support over the last decade, and Murray PHN's Executive team for carrying out their responsibilities with diligence, dedication and an underpinning sense of commitment to community.

I would particularly like to mark the contributions of our former Chief Corporate Officer, Elizabeth Clear, who helped establish a rigorous financial and governance structure for our maturing organisation, and who has departed Murray PHN after 10 remarkable years with our thanks and best wishes for her future.

Finally, I would like to mark with great sadness, the death of our second-longest serving Board member Dr Alison Green. We will miss Alison's informed and incisive contributions to our work, but I will personally miss her vibrant and engaged support over the last eight years.

I commend our 2025 Report to the Community to you, and trust you will enjoy reading about the impact of Murray PHN activities over the past year.

Matt Jones -
Chief Executive Officer

# Mental health

Murray PHN commissions a range of primary mental health, psychosocial recovery and alcohol and other drug services for people located across our catchment. This includes psychological therapy services for adults and children, including older people who live in residential aged care homes.

This year, we introduced the Social and Occupational Functioning Assessment Scale (SOFAS) for commissioned service providers to use alongside other psychological distress and patient experience measures. SOFAS is a method of tracking how an individual is in relation to social and occupational functioning at every visit from the worker's perspective, which also helps to determine that they are continuing to receive the right level of care.

For Murray PHN, outcome and experience measures provide strong insights into a person's mental health as they engage with commissioned services, as well as a holistic view of an individual's recovery. Mental health measures primarily evaluate psychological symptoms and distress, while social and occupational functioning tools assess the ability to participate in daily activities and fulfill meaningful roles.

Case study

## DEVELOPING POSITIVE STRATEGIES TO BETTER MANAGE EMOTIONS AND BEHAVIOURS

Amelia*, a primary school student, was referred to the program by her mother after she started to show symptoms of anxiety following a family separation which began impacting on her feelings towards attending school.

Due to her young age and limited understanding of emotions, Amelia found it hard to communicate what she was feeling. Despite this, she regularly attended sessions, enabling the practitioner to build a positive connection and help Amelia open up.

The practitioner developed positive strategies to help Amelia better manage her emotions and behaviours when feelings of anxiety arose, particularly the ones she was having towards school.

Both Amelia and her mother noticed an improvement in her emotional health, with her anxiety and worry decreasing over time and new friendships formed, leading to a growth in self-esteem and confidence in attending school, including entering the school grounds on her own in the mornings.

*name changed

# A collaborative approach to mental healthcare

Access to healthcare is more difficult in rural and regional areas, however the introduction of extra state-funded mental health services in Victoria has resulted in a considerable increase in available supports across the region.

Murray PHN used this opportunity to review where there was overlap in services (and potential needs and gaps) to ensure that we were enabling greater equity of access to care with our funding.

In June 2024, we released a tender for primary mental health service delivery in the Mitchell and Murrindindi local government areas and were pleased it resulted in a new innovative and place-based partnership.

The Lower Hume Primary Mental Health Partnership is led by Yea and District Memorial Hospital, together with local partners Alexandra District Health, Seymour Health, Northern Health and Goulburn Valley Health.

As well as developing a new model of care and a clinical governance framework, the partnership provides people with non-urgent mental health related issues with free face-to-face support with a mental health clinician in Yea, Alexandra, Seymour, Kilmore and rural locations around these towns.


*Official launch event in Yea on 29 July 2025.*

*Pictured L - R: Linda Romano, Chief Operating Officer Northern Health; Belinda Scott, Executive Director Mental Health Northern Health; Matt Jones, CEO Murray PHN; Jane Poxon, CEO Alexandra District Health and Ward Steet, CEO Seymour Health*

# Delivering creative therapies to boost mental health supports

Murray PHN is one of three PHNs nationally commissioned to provide music and art therapy services for people living with moderate to severe mental health conditions. The pilot, which is part of the Australian Government's Creative Therapies Pilot Program 2025-2027, will be independently evaluated by the University of Queensland's Institute of Social Science Research.

Following an extensive consultation process with stakeholders and communities, we are commissioning new creative therapies services in Albury Wodonga, Castlemaine and Robinvale. Consultation included face-to-face community focus groups, stakeholder interviews, yarning circles and a digital survey that received almost 100 responses. There was strong engagement throughout the consultation process, including by many people with lived experience of mental health conditions, carers and the local creative therapy workforce.

Creative therapy services have started at Dhelkaya Health in Castlemaine and Gateway Health in Wodonga, with Robinvale set to begin before the end of the year. Consultation data contributed directly to designing the place-based service delivery models specific to each of the three locations.

We are continuing to work to raise awareness of the opportunities to engage with the creative therapy workforce across a range of primary health services in our region.


*Focus group at Aspire with Catherine Threlfall, Project Lead Creative Therapies Pilot Program*

# Innovative strategies to support the mental health of aged care residents

In Australia, almost a quarter of a million older adults now live permanently in residential aged care homes (AIHW 2024) and the prevalence of some mental health conditions is substantially higher in these than in the general community, with almost 70 per cent of residents having significant levels of depression, anxiety or suicidal ideation (AIHW 2025).

Having multiple physical health conditions, such as incontinence or impaired mobility, is often associated with an increased risk of having a mental health disorder. While moving into aged care brings a period of emotional adjustment, with grief and loss common as people leave behind their homes, routines, relationships and familiar surroundings, this separation can trigger sadness or distress, especially when the move is a result of a decline in health or happens suddenly. Adjustment disorder is also common during this time, highlighting the challenges of adapting to a new environment and way of life.

More often than not, the primary treatment for mental health issues is antidepressant and antipsychotic medication, despite studies showing that non-drug treatments can be effective and carry less risk of harm.

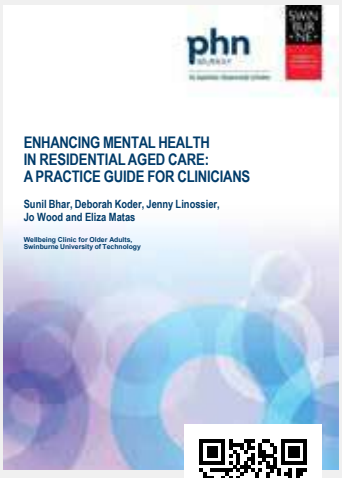
To support mental health clinicians in providing care to older adults transitioning to residential aged care and adjusting to changing health status, medical conditions and functional disability, Murray PHN commissioned Swinburne University of Technology Wellbeing Clinic for Older Adults to develop a practice guide focusing on psychological strategies, rather than medication-related ones.

The document, which has also been audio-described, offers an overview of practical approaches for supporting the mental health of aged care residents. It provides practical, innovative and evidence-based recommendations, insights, strategies and step-by-step protocols for adapting and delivering psychological treatments to overcome multiple barriers to care.

The guide tells people how to do things, as well as why they matter, translating research into practice, while also considering practicalities and challenges. To further support clinical decisions and development of sound treatment plans, case-based examples highlight common mental health difficulties and demonstrate how management techniques can be applied.

***"Like many places around the world, Australia is facing an increasingly ageing population. There is much that mental health clinicians can offer older adults in aged care homes. It is imperative that we train the workforce with the tools they need to protect everyone's mental health."***

Professor Sunil Bhar, Director of Swinburne's Wellbeing Clinic for Older Adults and practice guide author




**Download the guide:**
https://tinyurl.com/AgedCare-PracticeGuide

Murray PHN funds local health services to provide Psychological Therapy Services (PTS) to older people living in residential aged care who are at risk, have mild to moderate symptoms or a diagnosis of mental illness. Through this service, a variety of tailored programs and resources are available to address concerns including relocation, transition and adjustment stresses, grief, loss and bereavement, and depression and anxiety.

# Building confidence and knowledge to support people in distress

Research indicates that up to 45 per cent of individuals who died by suicide saw their GP within one month prior to death, and up to 20 per cent within one week before [i].

To build the capacity and confidence of general practice to identify and support patients experiencing suicidal thoughts - recognising that they are often the first point of contact for people in crisis - Murray PHN opened an expression of interest for a new practice education program.

The program enabled practices to complete one of two Black Dog Institute evidence-based training programs and receive coaching support, a six-month quality improvement PDSA (Plan, Do, Study, Act) initiative with support of a quality improvement consultant and receive a $10,000 financial incentive in recognition of staff time dedicated to the program.

The training covered how to complete a detailed risk assessment and management plan using a collaborative, team-based approach, as well as providing practical tools for health professionals.

Nineteen general practices participated and while the training was aimed at GPs, frontline staff (including receptionists and non-clinical positions) were encouraged to take part due to their regular interactions with community.

Of the staff who participated, 63 per cent had never undertaken suicide prevention training before, with confidence and knowledge increasing by more than 50 per cent and 95 per cent stating that they would recommend the training to a colleague.

Some of the quality improvement activities implemented as a result of the program include embedding screening tools in patient management systems, displaying triage charts in reception, putting mental health brochures in waiting rooms and role play activities at meetings to reinforce learning.

[i] Pfaff, J. J., Acres, J. G., & McKelvey, R. S. (2001). Training general practitioners to recognise and respond to psychological distress and suicidal ideation in young people. Medical Journal of Australia, 174, 222-226.

***"I would like to extend a heartfelt thank you to Murray PHN and Black Dog Institute for their invaluable support in helping us provide suicide prevention training to our frontline administration and nursing teams.***

***Participating in the Talking About Suicide in General Practice training has been truly transformative. It has empowered our team with the confidence to engage in some of the most difficult conversations we can encounter in healthcare - with compassion, clarity and care. Knowing we have the tools to support someone in a moment of crisis brings not only comfort to our patients, but also to our team, who can go home each day reassured that they did their best.***

***Recently, just before closing the clinic, we received a call from a patient who shared that they were thinking about suicide. Because of the training, our team was able to respond with calmness and confidence, offering meaningful support in a critical moment - without carrying the weight of doubt or fear long after the conversation ended.***

***This experience has only deepened our belief that suicide prevention training should be extended to all members of the healthcare team - not just the GPs and other clinical staff, but also our often-overlooked frontline administration staff who are so frequently the first point of contact. I strongly encourage all medical centres to invest in this vital training. It truly can make all the difference."***

# Blending humour and heartfelt stories

Men's mental health issues often go unrecognised and there are a range of barriers that prevent them from seeking support.

To help normalise conversations around mental health and encourage men in particular to seek help earlier, Murray PHN funded free community events this year in Bright, Bendigo, Mildura, Swan Hill, Wangaratta and Wodonga.

Recognising the need for different approaches, South Australian comedian and suicide prevention advocate Marc Ryan, also known as The Beautiful Bogan, was engaged to deliver his unique performance in which he shares his experiences of post-traumatic stress disorder and living with thoughts of suicide.

People with lived or living experience can provide others with hope through shared understanding and awareness, and when humour is blended with heartfelt stories, it provides a light-hearted way of reminding people that mental health is an experience that many share and they are not alone in their struggles.

Marc's performances were part of a region-wide suicide prevention campaign funded through the Targeted Regional Initiatives in Suicide Prevention program. The program's intention was to reach people who were possibly in distress but unlikely to attend a more formal workshop, to hopefully start them on their path towards recovery.

More than 230 people attended, some of which took home Question. Persuade. Refer. suicide prevention training cards.

# Helping headspace to grow

headspace provides physical health, mental health, work and study, and drug and alcohol support to young people aged 12 to 25 years old and their families, with support at a crucial time in their lives. This helps get them back on track and strengthen their ability to manage their lives in the future.

In our region, headspace centres are located in Albury Wodonga, Bendigo, Echuca, Mildura, Shepparton, Swan Hill and Wangaratta.

This year, Murray PHN helped to secure $4.6m of funding for local headspace centres through the Australian Department of Health, Disability and Ageing's headspace Demand Management and Enhancement Program.

In this round of funding, the following centres were successful:

- headspace Albury Wodonga will conduct building works, including a major renovation of the centre, creating improved therapeutic spaces and furnishings, such as carpet, furniture, soundproofing and lighting upgrades. Resources will also be developed and a dedicated cultural worker employed to bridge the gap with culturally and linguistically diverse communities.
- headspace Swan Hill will extend its current building to add a multipurpose group room, family and consult rooms, and additional staff workstations. Additional workforce will also be employed to provide more services and reduce wait times.
- headspace Shepparton will renovate its facility to create a flexible workspace to host more staff and improve the waiting room. Wi-Fi internet access will also be improved to support telehealth and digital engagement.
- headspace Mildura will focus on enhancements to its digital front door and client management system, to improve the access and experience of young people and their families as they seek support.

# Breaking silence to end suicide

Murray PHN launched a new campaign, His Story. End Silence. End Suicide, in a bid to reduce the rate of men's suicide.

The campaign emphasises the critical effect of silence around men's mental health by highlighting stories that too often go untold. It seeks to encourage men to reach out and seek help, and for their supports to reach in and have a conversation.

Importantly, it is built on hope, responsibility, urgency, and the knowledge that through open conversation and connection, no man's story should ever be lost to silence.

The tagline is a powerful call to action designed to reinforce the message that by breaking the silence, we can keep men and their stories alive.

Knowing that men are typically less likely than women to reach out for support, the campaign has been developed with the help of a consumer reference group to increase awareness and encourage help-seeking behaviours among men.

The strength of the campaign comes from involving people with lived and living experience, with their unique perspectives helping to create something authentic and bold.

Consumer reference group members felt it was important to focus on silence because it feeds isolation, stigma and shame. They wanted a strong campaign that openly talked about the issue - one that would make people stop, watch and act.

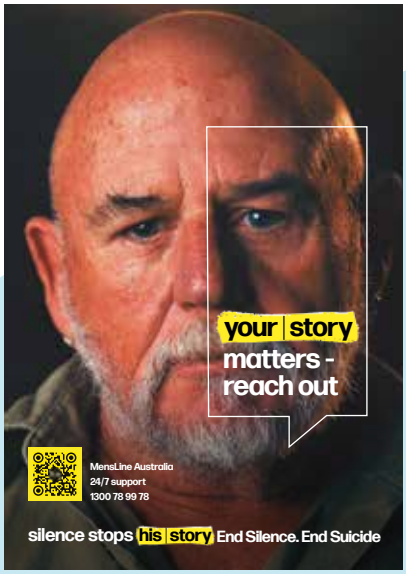
The men featured in the campaign also have lived and living experience, bringing a strong, real and emotive visual to the messaging.

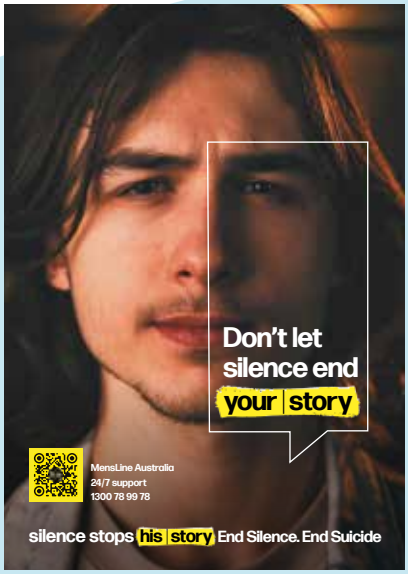
Throughout the campaign's development, participants shared some helpful advice:

- *"Talk about it all the time, check in on those around you."* - Alison, consumer reference group
- *"Don't back away from hard topics or strong emotions. If you don't know what to say, just be there and keep listening."* - Anthony, consumer reference group
- *"We need to normalise conversations about mental health, especially among men, and remind people that vulnerability is a strength, not a weakness."* - Luke, consumer reference group
- *"If people are struggling - speak up, not shut up."* - Buddy Oldman, a proud Wiradjuri man and campaign talent.

The campaign is appearing around the region on television and radio, in social media and public restrooms, such as at licensed venues and petrol stations. It is supported by a dedicated micro-website that includes information and resources for people seeking help: hisstory.com.au

By breaking the silence, we can help to keep these stories going.





Use the QR codes to view the three videos:


Don't let
silence end
his | story
MensLine Australia
24/7 support
1300 78 99 78
silence stops his | story End Silence. End Suicide

# Q&A

## Q&A with Buddy Oldman

Buddy Oldman is a Masters Boxing champion currently holding both Australian and World titles. A proud Wiradjuri man, he uses his boxing as a platform to break down the stigma faced by people struggling with their mental health, his own included. Buddy is one of the men featured in the His Story men's suicide prevention campaign. He shares his experiences and insights in his own words.

**Who is Buddy Oldman?**

Buddy Oldman is a person who has trauma, has mental health issues, but has the guts to stand up and say, hey, I'm not that tough that I don't need help. I'm a boxer and alleged tough guy, but I've needed help and I'm not afraid to ask for it. I say quite often that the best thing I ever did was ask for help with my mental health because of a failed suicide attempt.

**Part of the reason Murray PHN reached out to you for this campaign is because we knew of your advocacy work and heard about your world record boxing attempt. Can you tell us a little about it?**

I've got this platform where people are following me through my boxing and it's best I do something proactive with it and speak up, not shut up. That's where the world record attempt comes in.

I was in a ring punching a boxing bag for 90 continuous hours. Under the Guinness World Records you get five minutes break for every 60 minutes you accumulate. We broke the record, but unfortunately, we lost two hours of footage, so it's not officially recorded. I'll have to do it again one day, that's the intention hopefully.

However, the whole purpose of the exercise was to raise awareness for mental health, and it became a fundraiser. We raised $41,000 for Lifeline and 13 YARN. That makes it well and truly worth the effort. I was extremely grateful for that because the money helps people and that's the most important thing.

Every time I get in the ring, I spend a few minutes talking about mental health, to give a bit of my story really quickly, and talk about why I'm doing this stuff. I do it because I want to help save lives. I do it because I care about people's lives.

**As a proud First Nations man, why is sharing your lived experience so important to you?**

Because black fellas are notorious for keeping quiet and not saying anything. Because one in 18 suicides are black fellas. Because the trauma of Aboriginal people is horrendous. That's hard to cop. And I need people to understand that, as an older fella, I'm not afraid anymore. That's the important thing. My lived experience gives me the ability to be a voice to my people and for my people.

**The campaign is built on the premise that breaking the silence will help save men's lives. Why is this so crucial?**

My father taught me that the only thing I can take to Dreamtime is my honesty and integrity. And that's really important to me. So, if people can hear my story, and understand that my honesty is me telling you what happened, and my integrity is telling you how I fixed it and continue to fix and maintain it, then that can help save lives.

My work is to help people speak up, not shut up. I want them to know fixed doesn't mean cured. Fixed means keeping running, keeping going, being a 'project in motion', so to speak.

**You're one of the men featured in the advertising campaign. Why did you get involved? What was it like to be on set? How has it made you feel now it has launched?**

I got involved because I am who I am and not ashamed of it. I live with mental health issues. Some days are bad, and some days are good. Being exactly who I am was the biggest thing to bring to the campaign.

I had my wife with me on set. And the lady who was there at the shoot, she was deadly. She was unbelievable. What you see in the TV commercial and on the poster, that's raw, that's me. My story is real. The lady said she could see it in my eyes. And you know, there's that's the old saying, that the eyes are the window to the soul.

The one thing that doing this campaign has really made me aware of is to realise people are taking notice and that I do have a level of impact on people. It means I have a level of responsibility to do the right thing by myself so I can do the right thing by others. It's a knock-on effect. I've got to practice what I preach. That's important to me.

**The campaign is hard-hitting, gritty, authentic and heartfelt. Why is this important?**

Because I'm not a paid actor. The others are not either. It's so rare. It's a big thing. What people see is the real me. This means it's got the potential to cut through to the people who really need to see and hear the message.

**From the perspective of someone who has struggled with their mental health, what would you like to share with the families and friends of someone who is struggling? How can they help their loved one?**

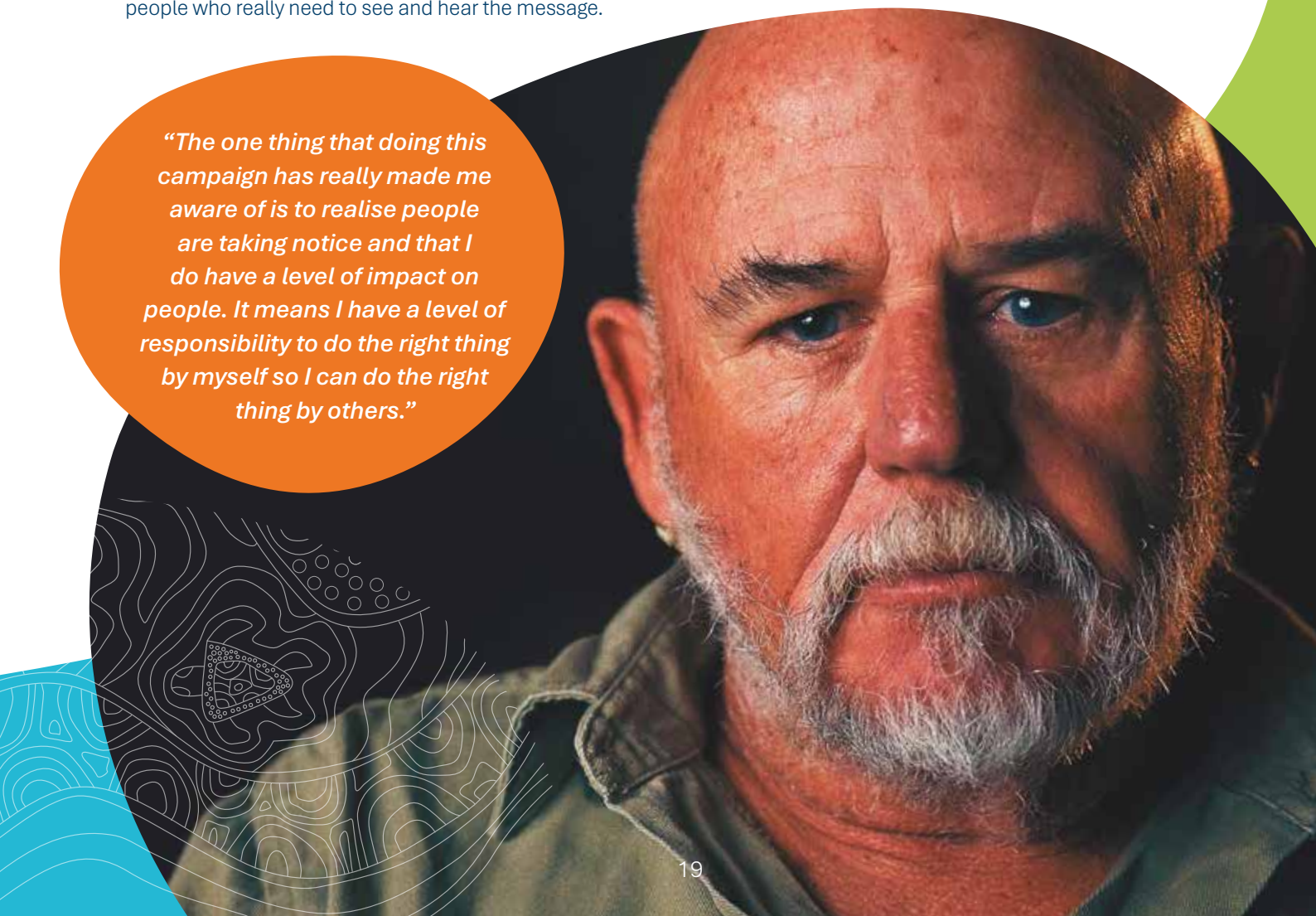
I'd like to say to those not affected by mental health issues, to do a little bit of research. It may help you understand what your loved one is going through. Because unless you've gone through it yourself, or you live with it, you don't automatically understand.

**What is the one piece of advice you'd give to a man or boy who is struggling with his mental health?**

If I can, you can. That's it. If I can, you can too.

I was, and probably still am if you asked my wife, stubborn. I'm an alleged tough guy. I hold a current world boxing title, and multiple Australian titles. But if I can, YOU can too.

*"The one thing that doing this campaign has really made me aware of is to realise people are taking notice and that I do have a level of impact on people. It means I have a level of responsibility to do the right thing by myself so I can do the right thing by others."*



## Fostering good club culture

Between March and May, local sporting clubs were supported with funding to hold Tomorrow Man's More than the Game workshop onsite.

Ten events were held across the region in Albury, Bendigo, Corryong, Mansfield, Mitta Mitta, Mount Macedon, Wangaratta and Wodonga.

The workshops were attended by 462 men and enabled participants the time and space to come together and have conversations that focused on building self-confidence and resilience, improving team morale and a greater sense of belonging.

During the workshops, participants were supported to:

- unpack the outdated gender stereotypes that are often destructive to team and club culture
- build awareness around the impact of gender stereotypes on the team dynamic and individual behaviour
- learn how to build trust both on and off the field to strengthen the fabric of the team through connection, empathy and understanding
- build the muscle of speaking up with gravity, holding space and curiosity over judgment.

Our thanks to local organisations who supported these workshops: Mallee Sports Assembly Inc., Sports Focus, Sport North East and Valley Sport.

## Developing healthier views of masculinity

Outdated gender stereotypes can prevent some men from seeking the support they need. Murray PHN funded five A Night with the Blokes workshops around the catchment to provide a space for men to connect in a casual but supported environment.

Led by Tomorrow Man, the workshops explored and challenged ideas of masculinity to empower men, while also helping them to develop greater and real connections, emotional muscle and tools to have more meaningful conversations.

# Survey results indicate high level of satisfaction

Murray PHN relies on the feedback of the people who access and use the services we commission to ensure we meet the needs of our communities and embed a culture of continuous improvement.

The national Your Experience of Service (YES) survey ensures that people who have contact with public mental health services can have a say about their experiences. The YES survey provides both qualitative and quantitative data, and results provide key information at state and local levels towards the improvement of safety and quality of services.

Results from the most recent YES survey indicated a consistently high level of satisfaction among service users. Using a scale of 1-10, participants reported especially positive experiences in areas such as feeling welcome (9.7), feeling safe (9.7), respect for individuality and values (9.7) and being supported in decision-making (9.6). These scores reflect strong person-centred care and a respectful, inclusive service environment.

A significant majority of respondents reported a positive effect on their overall experience in the past three months (87%), alongside high levels of improvement in hopefulness for the future (78%), ability to look after their health and wellbeing (76%) and capacity to manage day-to-day life (72%).

Staff support emerged as the strongest theme. People consistently highlighted the emotional support and empathy, encouragement and non-judgmental presence of staff as central to their recovery journeys, using terms such "fantastic", "brilliant", "very knowledgeable" and "professional" to describe staff.

Mostly positive feedback was also given in the category of accessibility, including access to workers, easy access to services and activities, transportation and receiving services at no cost, as well as simple appointment booking.

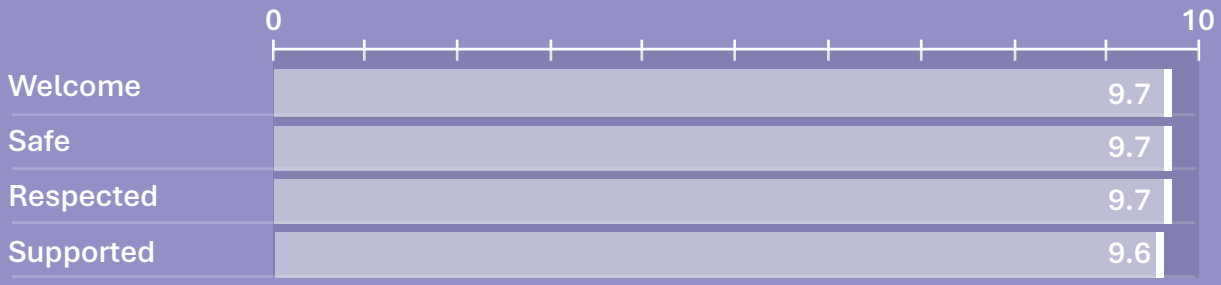
The results will inform how Murray PHN works with providers to further improve people's experiences of the services we commission.

**87% had a positive effect on their overall experience in the past three months**

**78% had an improvement in hopefulness for the future**

**76% had the ability to look after their health and wellbeing**

**72% had capacity to manage day-to-day life**




*"The nature of our work at Murray PHN means the team and I don't often get to see the direct impact of our work in terms of the outcomes to individuals. That's what makes the YES survey so important. We received responses from 158 people from across the primary mental health services we fund. Ninety-one per cent of respondents reported a satisfactory or better experience from the services. This is a good result. It gives the team and I confidence that we are doing something right on which to build. I'm excited we have a depth of suggestions from people about what we can do better to inform quality improvement."*

- Alistair Bonsey, Senior Manager Mental Health and Wellbeing Reform

# GPs help reach significant mental health training target

The Initial Assessment and Referral – Decision Support Tool (IAR-DST) was developed by the Australian Government to provide GPs and other health professionals with a resource that assists them in determining the most appropriate level of care an individual needs when first seeking mental health support.

In 2022, PHNs began offering training to GPs and clinicians in their respective regions. Since then, Murray PHN has delivered 123 training sessions, both in-person and online, with 372 local GPs trained in the IAR. Consequently, Murray PHN met a significant milestone, reaching a 76 per cent completion rate for an ambitious GP KPI training target set for this initiative - the highest percentage across all PHNs nationally.

**Nov 2022 - Oct 2025:**

| Discipline | Total people trained | Services |
|---|---|---|
| **GPs** | 372 | 149 general practice clinics |
| **Other health professionals** | 481 | 82 other services |
| **Total** | **853** | |

# Free training to support people in crisis

- **More than 700 people have completed the training**
- **84 per cent of participants would recommend the program to others**

To create a local safety net and help more members in the community recognise and respond to suicidality, Murray PHN funds free access to an online, evidence-based suicide prevention training.

Endorsed by the Black Dog Institute's LifeSpan trials, Question. Persuade. Refer. (QPR) helps people to identify the warning signs of someone at risk of suicide, builds confidence to speak to them about their thoughts and provides the tools to connect them with professional care. Visit murrayphn.org.au/qpr to register.

# Improving knowledge of mental health services

Murray PHN regularly completes data analysis and evaluation activities to improve service planning, care pathways and options, so that commissioned services continue to be appropriate for local needs.

Following a review of psychological therapy services (PTS) and psychosocial recovery services (PRS) - which revealed that self-referrals were higher than GP referrals in some instances, poor linkages existed between sectors and some patients with complex care needs find it difficult to access the right support - Murray PHN organised dedicated education and consultation sessions for GPs and GP registrars around the region, starting in June.

The sessions were held at local practice clinics and larger venues and not only aimed to increase GP understanding of available Murray PHN funded services and how to access them, but improve our understanding of current use, challenges or gaps in access and referrals, presentations and ongoing patient care to inform future commissioning decisions.

Increasing awareness was particularly important in local government areas where service provision was limited and because Murray PHN funded PTS and PRS services are available at no cost to patients who don't have private healthcare.

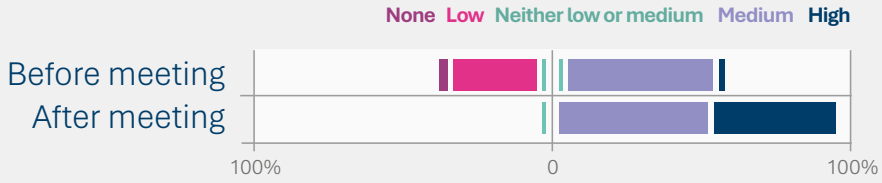
The different criteria were explained for each of the services across the life stages, from children to older adults living in residential aged care homes, and for the levels of care from low or mild, to moderate and severe symptoms.

Because of the range of support available through the various commissioned programs and providers, Murray HealthPathways – an online clinical and referral tool – was promoted as an easy way for GPs and GP registrars to know what was available to their patients and how to refer them.

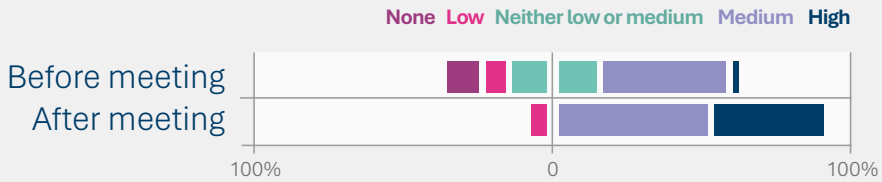
As at September, 75 GPs were consulted from 32 practices in 10 local government areas, with two additional sessions scheduled for October and November. From the sessions, GPs have anecdotally said that up to 50 per cent of their patients are presenting with mental health concerns every day.

## Feedback from survey: 23 respondents

**Rate your level of knowledge of local Murray PHN commissioned primary mental health services:**




**Rate your level of knowledge of Murray PHN's role in strengthening primary mental healthcare in your region:**




**Rate the degree to which the following aspects of the meeting met your expectations:**



| | |
|---|---|
| 8 (35%) | Very satisfied |
| 12 (55%) | Satisfied |
| 1 (5%) | Neither satisfied nor dissastisfied |
| 0 | Dissatisfied |
| 1 (5%) | Very dissatisfied |

*Below L-R: Dr Ahmed Al-Obaidi, Dr Zin Ye Naung, Dr Kesha Bhattarai, Dr Katharina Cameron, Dr Jolien Dorgelo, Dr Candice Baker from Brooke Street Medical Centre and, Louise Scheidl (Murray PHN)*

# General practice

Murray PHN is committed to providing general practices with support, resources and education. Our team of Quality Improvement Consultants work with practice staff to develop meaningful, data-informed quality improvement plans to help keep improvements on track and integrated in daily practice. In addition, they help and guide practices with access to innovative tools and resources to deliver best practice care.

# Funding general practice to help improve health outcomes

In January, Murray PHN released a tender for $1 million in funding through its General Practice Investment Strategy to support local general practices and Aboriginal Community Controlled Health Organisations with medical services to deliver primary care services to their communities.

The funding was awarded to 10 organisations for resources and projects to implement or embed models of care focusing on heart and lung diseases, diabetes, complex care coordination and early intervention programs.

## HEALTHY HEARTS PROGRAM REFERRAL LEADS TO LIFESAVING TREATMENT

Case study

Brian*, a man in his mid-60s, was referred for a heart health check through the Healthy Hearts Program due to being an ex-smoker, having a family history of ischaemic heart disease and previous hypertension.

While Brian had no overt cardiac symptoms, he scored above the 90th percentile for risk of coronary artery disease. The screening process identified hypercholesterolaemia and dyslipidaemia, as well as a heart murmur on clinical exam. His blood pressure was also noted as raised.

A review with the cardiologist resulted in CT coronary angiogram and stress echocardiogram referrals, through which Brian was diagnosed with significant severe triple vessel coronary artery disease with mild left ventricular dysfunction.

As the coronary artery disease was so severe, Brian was referred to a cardiothoracic surgeon and later underwent a quadruple coronary artery bypass graft and mitral valve repair. This was all quite a shock to Brian, and so time was also taken to support his emotional wellbeing throughout treatment.

Brian made an excellent recovery and afterwards was followed up by the surgeon, cardiologist, his regular GP, Healthy Hearts Program GP and by the Pulmonary and Cardiac Exercise and Education (PACE) program in Myrtleford which has a specialist cardiac nurse, accredited exercise physiologist and dietitian.

Since recovering, Brian has been able to self-manage his condition and has successfully completed the PACE program. Both his cardiologist and cardiothoracic surgeon agree that the program has helped to identify an asymptomatic patient with significant cardiac disease who benefited from lifesaving treatment.

**name changed*

# Myrtleford doctor awarded for rural provision

This year, Dr Julian Yeoh from Austin Health and Alba Health in Myrtleford won the Victorian Rural Health Outstanding Contribution to Rural Outreach Provision Award for his work in Alba Health's Healthy Hearts Program, funded by Murray PHN. As part of the program, Dr Yeoh travels from Melbourne to Myrtleford to deliver in-person, bulk-billed cardiology clinics, ensuring rural patients can access care close to home.

*Pictured L-R: Dr Justin Donaldson, Greta Donaldson, Rebecca Piazza, Dr Julian Yeoh, Roslyn Bloomer and Dr Alison Mahoney*

# Wodonga practice wins national award

Hospital Street Doctors was announced winners of the national 2024 PenCS data-driven, quality improvement Patient-centred Care Award. The practice was recognised for outstanding work in its multidisciplinary lymphoedema and cancer survivorship clinic, which was initially set up and supported by funding from Murray PHN through the General Practice Investment Strategy.

*Pictured L-R: Practice staff Sachini Thamvawita, Shannon Manley, Murray PHN's Sue Keane, Dr Anu Tillekeratne, Dr Pushkara Epa, Dr Rukshani Wijesekera and Dr Wasanthi Dharmadasa*

# Making after hours care accessible

Murray PHN receives funding to extend service availability to communities during the after hours period, aimed to increase equitable access across regions, particularly for vulnerable and rural populations.

After conducting an assessment of local urgent care presentations, it was found that a high level of patients were presenting with semi-urgent or non-urgent conditions to local emergency departments, which can often be managed in the community by patients' elected general practice services. In the Campaspe region in particular, a lack of GP services being available during regular and after hours was identified. In order to supplement this service gap, Kyabram District Health Service has been commissioned to pilot a GP health hub. The bulk-billed service launched in April this year and provides general practice services to people in the local vicinity and neighbouring towns of Rushworth, Rochester and Echuca with point-of-care treatment at night, on the weekends and public holidays for urgent but non-life threatening conditions.

## ETERNALLY GRATEFUL FOR THE CARE AND SUPPORT

Case study

Dianne* is an older woman who has hypertension and lives in a caravan in the Goulburn Valley region.

After not being able to secure an appointment with her regular GP, Dianne attended the after hours GP service in Kyabram for a repeat script.

After Dianne's medical history was taken, she shared that she'd undergone a significant life change following a workplace injury many years ago and that she was living on a Disability Support Pension. She also raised several clinical issues that had concerned her for some time, including facial numbness and tinnitus, resulting in new referrals to radiology and pathology.

Dianne's social history was equally extensive and included significant grief and loss, financial challenges, having to give up hobbies and her friendship circles dwindling. These resulted in longstanding mental health issues, however referrals for Dianne to access social support services were declined.

Unfortunately, Dianne's CT scan results showed that she had a brain aneurysm. Dianne was "eternally grateful" for the care and support that resulted in this diagnosis which consequently led her to making some significant life changes to try and improve her overall health.

As someone living with financial hardship, being able to access a bulk-billed service significantly benefited Dianne who has also since changed her primary GP as a result of "feeling not heard nor listened to".

The model of care developed and implemented also highlights benefits of a 20-minute appointment that enabled the consulting GP to take a comprehensive medical history and explore more diverse care needs when they arose.

**name changed*

# New screening program to help detect lung cancer earlier

Lung cancer is the fifth most common cancer and leading cause of cancer death in Australia, with 15,100 cases and 9000 deaths estimated in 2024 alone.

The National Lung Cancer Screening Program (NLCSP) launched in July 2025 and is the first new nationwide cancer screening program introduced in two decades. The program was prioritised due to lung cancer's high mortality rate and tendency for late-stage diagnosis.

This important initiative aligns with Murray PHN's strategic focus on cancer prevention and care, and reflects the known risk related to the region's high smoking prevalence.

Researchers estimate that successful implementation of the screening program could save up to 12,000 lives in Australia in the next 10 years.

To support general practices across our region to implement and embed the NLCSP, Murray PHN developed a comprehensive and region-specific project plan, focusing on consultation, engagement, quality improvement and resource development. This includes a dedicated webpage, webinar for GPs and GP registrars, and an in-person event in Mildura with presenters from the Royal Melbourne Hospital and Victorian Comprehensive Cancer Centre.

This collaborative and strategic approach to implementation was further enhanced by Murray PHN staff attending the Lung Foundation Conference 2025 and participating in the Victorian Tasmanian PHN Alliance and Department of Health, Disability and Ageing consultation to ensure advocacy for the unique challenges faced by rural primary health providers. This has resulted in strengthened ties with integrated cancer services and acute health providers across the region.

Even though it's only a short time since the program's launch, clinic-specific targeted efforts led to a 3.6 per cent increase in National Cancer Screening Register uptake in four months.

To enhance operational efficiencies and increase providers' capacity to identify patients at risk of lung cancer and eligible for the screening program, Murray PHN has commissioned Healthily to deliver an innovative proof-of-concept model. This model leverages patient experience reporting measures to assess smoking risks and will offer general practices and Aboriginal Community Controlled Health Organisations (ACCHOs) in regions with the highest cancer burden access to GoShare - a platform that uses patient-reported experience measures to evaluate lung cancer risk through self-assessment of smoking habits and symptoms.

This initiative will support providers in recalling patients for follow-up appointments and clinical assessments, while also helping clinicians to identify eligibility criteria for the NLCSP.

Looking ahead, Murray PHN will continue to work with general practices as the NLCSP rollout advances, with plans to engage in a formal evaluation of the program's impact and effectiveness in mid-2026.

# Improving the quality of life for women with endometriosis

In 2018, the National Action Plan for Endometriosis was developed with the aim to improve public awareness, patient understanding, treatment options and research for this condition.

As part of the 2022-2023 budget, the Australian Government announced a four-year $17.4 million investment to establish 22 clinics across Australia to improve the provision of diagnosis, treatment, and management of endometriosis and pelvic pain.

The Murray PHN catchment has one clinic operated by Bendigo Community Health Services that officially opened in March 2024.

In its first year, the clinic has provided care to 94 patients, delivering 332 occasions of service, which means on average that each patient is seen 3.5 times.

# Young people continue to benefit from schools program

The Doctors in Secondary Schools (DiSS) program embeds adolescent health-trained GPs and nurses in secondary schools, providing free, accessible and youth-friendly healthcare to students. Designed to help identify and address health problems early, as well as reduce pressure on working parents, the program is available at 100 Victorian secondary schools considered most in need, with 21 of those located in the Murray PHN region. Indicating its ongoing success statewide, by the end of 2025, the program will have reached the milestone of 100,000 GP consultations.

# Mildura home to Australia's practice of the year

Sunraysia Medical Centre was named RACGP's 2025 Australian General Practice of the Year. Receiving the award for its patient-centred, community-minded and multidisciplinary approach, the clinic's Dr Mehdi Sanatipour OAM described it as a great honour.

***"The innovative approach to healthcare with the support from Murray PHN allowed Sunraysia Medical Centre to provide world-class care to rural patients who would otherwise be missing out. Examples of these innovations are remote patient monitoring, a nurse-led heart failure clinic and chronic disease care coordination for frequent emergency department visitors."***

*Pictured L-R: standing: Jess White, Dakotah Rosebottom, Julieanne Davey, Larissa Panaretos, Ece Tunali. L-R sitting: Dr Reyhan Hussain, Dr H. Yassin, Dr Donald Hartley, Dr Mehdi Sanatipour and Dr Anuja Pathak*

# Q&A

## Q&A with Amanda Summers - Doctors in Secondary Schools School Program Lead

Kyneton High School and Campaspe Family Practice have been part of the Doctors in Secondary Schools (DiSS) program since its inception in 2017. The program is well embedded and considered a part of the fabric of the school, offering support to students and relieving pressures on families. Amanda Summers has been the DiSS School Program Lead from the start and has seen the impact it has had on individual students and the school community as a whole. She reflects on the ongoing success of the program in her own words.

**Why is the Doctors in Secondary Schools Program so important to students' health and wellbeing at Kyneton High School?**

A happy, healthy student leads to better social and educational outcomes. DiSS is a necessary part of the wellbeing program at Kyneton High School, supporting as many students as possible, especially around mental health. It also relieves financial and time pressures so many of our families face.

DiSS allows for referrals to external providers such as paediatricians, psychologists and occupational therapists. It also supports the screening of students with suspected ADHD and autism, as well as addressing any medical and psychological issues.

**This program is about empowering young people to learn to take care of their health. Can you share your perspective on that?**

The program has been instrumental in helping our students gain independence around making decisions about their physical and mental health, how to make appointments, manage referrals, fill prescriptions and freely discuss topics without feeling rushed or judged.

They learn to take the lead on managing and advocating for themselves and how to prioritise their health and mental wellbeing. And over time, they develop a sense of trust in the staff of the clinic. They have learned how to discuss difficult topics and how to seek help and support.

**You have been part of the DiSS program at Kyneton High School since its inception. What are some of the longer-term outcomes and impacts of the program?**

The DISS space is recognised as a place where you can come and feel supported and heard. Its visibility in the school reminds students how important it is to look after their physical and mental health. It's become a recognised health hub for students and families.

The program gives students confidence to access healthcare, as evidenced in students returning to the service throughout their high school years. Dr Claire and Nurse Ash have built many lasting relationships with our students, who continue to access them long after Year 12.

**What do you find most rewarding about being part of this program?**

It's been a privilege to work alongside the doctor and nurse over the years. I've learned a lot by sharing the space with them. We've formed a strong and trusting bond that not only supports each other but also helps our students with a continuation of care and familiar faces that welcome everyone.

*Pictured L-R: Helen Richards (Practice Nurse), Amanda Summers (DiSS School Program Lead), Dr Claire Barrington (GP)*

# First of its kind event a resounding success

Murray PHN's General Practice and Reform team identified an opportunity to design and host a workforce development event different to any it had planned before by taking a multidisciplinary approach.

The team determined how beneficial it would be to bring health practitioners together to hear and learn from each other to put a spotlight on frailty, and how a multidisciplinary approach to providing care could be used to help improve outcomes for patients.

Frailty as a condition is becoming more common as life expectancy increases. Sarcopenia (deterioration) of normal muscle tissue - potentially leading to deterioration in physical and mental health and impacting on an older person's ability to live independently – affects a quarter of all people aged 70 years and older but is often not diagnosed until a health event occurs.

Recognising that GPs, nurses, occupational therapists, physiotherapists, dietitians, geriatricians and other health practitioners all have a role to play in providing patient-centred frailty care, health professionals of all disciplines were invited to a round table event in Albury in November 2024.

Held in the evening over a sit-down meal, 36 health professionals heard a case study presentation with individual responses relating to the case from a range of different professional perspectives, including those of a chronic disease nurse consultant, physiotherapist, geriatrician, GP, dietitian, practice manager and pharmacist. Murray PHN Medical Advisor Dr Wendy Connor provided a summary, and the panel presenters took multiple insightful questions from the floor.

The response both during and after the event was incredibly positive; so much so, the team plans to hold more face-to-face multidisciplinary workforce development events in the future.

*Pictured below: 'Frailty - a multidisciplinary team approach' brought a diverse range of health professionals together as both audience and panel members*

*"Quality, evidence-based information that was applicable to many."*

*"Different aspects of multidisciplinary care all rolled into one."*

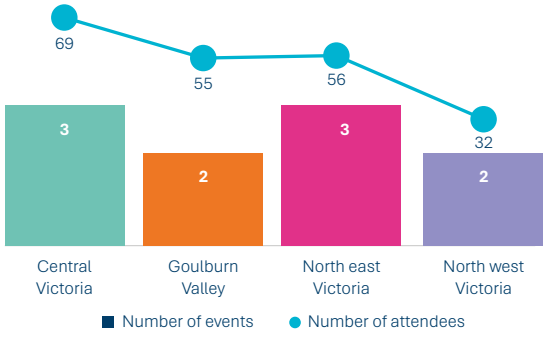

# Encouraging practice staff to network

***Of the practice staff who completed an event evaluation survey, 100 per cent said they would recommend these meetings to a colleague and 99 per cent said they were likely to attend another.***

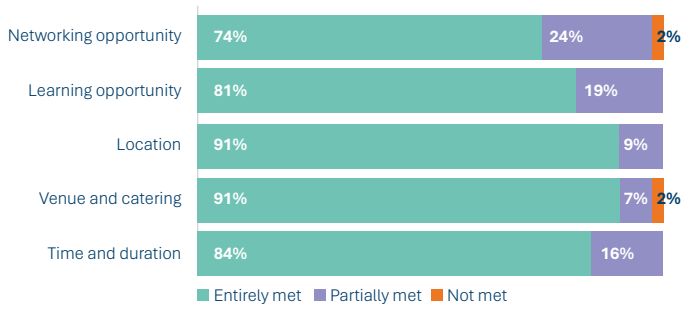
***Some of the feedback received highlights that the content is well delivered in a friendly atmosphere and is seen as engaging and relatable.***

Over the last 12 months, our General Practice and Reform team has hosted 10 network meetings across the Murray PHN region, with more than 200 general practice staff attending. The regular meetings provide an opportunity for practice staff to learn about and discuss important initiatives such as MyMedicare, as well as collaborate, share knowledge and problem solve together. Topics have included reception triage, managing difficult and aggressive patients, preparing for accreditation, practice succession planning, general practice reform initiatives and changes. Guest presentations have also been showcased from local mental health service providers, Rural Workforce Agency Victoria, Australian Health Care Nurses Association and the Australian Association of Practice Management.

**General Practice Network Meetings**
**2024-25 meetings and attendees by region**




**Expectation rating of the meeting**




*Pictured top: Doctors, practice managers and nurses at a Goulburn Valley Practice Network Meeting earlier this year*

# New training pathway helping young doctors expand their skill set

Urgent Care Clinics (UCCs) play an important role in healthcare service provision by partnering with nearby hospital emergency departments and providing free care for people with conditions that require urgent attention but not an emergency response, such as infections, burns and suspected broken bones.

Murray PHN supports five UCCs across its catchment in Albury, Bendigo, Shepparton, Mildura and Wodonga. The clinics opened between February and June 2023, and this year collectively recorded more than 100,000 patient presentations. In March, Albury Medicare UCC opened its new redeveloped site.

The top three presenting conditions are cough/respiratory illness, urinary tract infection and abdominal pain, and data indicates that 57 per cent of patients are women, 42 per cent are men and the 25-44 age group is the most common group presenting for treatment.

This year, Bendigo Medicare UCC became the first site in the state to be accredited by the Royal Australian College of General Practitioners (RACGP) to provide Australian General Practice Training (AGPT) registrar extended skills placements in the discipline of urgent care. Murray PHN and Bendigo Medicare UCC worked together to gain this accreditation so that from January, registrars could complete a full-time training program at the UCC, attaining an extra certificate while still working full-time. Dr Georgia Carter, the first full-time registrar, began her six-month placement in August, with more of these placements planned soon.

This training stream is helping to build the future GP workforce through structured, real-world training by providing the opportunity to expand their skill sets beyond everyday patient care to experience urgent and emergency patient care situations. This is invaluable for doctors intending to practise outside our major cities and supports retention of skilled GPs in our region.

***"A dedicated urgent care training stream for GP registrars is giving early-career doctors the chance to develop their skills in a fast-paced, community-based setting. The program is supported by the Royal Australian College of General Practitioners through its Extended Skill Training initiative and is another example of how the UCC is contributing to sustainable healthcare in the region."***

Callum Wright, Bendigo Medicare UCC General Manager

*Pictured: Dr Georgia Carter is the first full full-time registrar to undertake her six-month placement in urgent care at Bendigo Medicare UCC*

What UCC patients around the region are saying:

*"I was able to have my child seen by a doctor without an appointment."*

*"Kudos for being inclusive on your intake form. As a transgender man, I appreciate this."*

*"Not too long to wait and no out of pocket expense."*

*"Quick and efficient. Were really good with young kids."*

*"All staff were very respectful, attentive and warm."*

*"I could comfortably explain my condition without feeling being rushed."*

*"Receptionist, doctor and nurse were all amazing. We got excellent care and support."*

*"The staff are wonderful."*

*"It's easy to get an appointment."*

*"I just want to say thank you to all staff for their excellent service."*

*"The receptionist, nurse and doctor were kind and compassionate."*

# Strengthening Medicare

In May 2023, the Australian Government committed to improving primary healthcare for all Australians, subsequently announcing an $11.8 billion investment toward Strengthening Medicare. These reforms have been introduced to change how care is funded and delivered to enable high-quality, integrated and person-centred care.

In July 2023, we saw the introduction of MyMedicare - a voluntary patient registration system aimed at formalising the relationship between a patient, their general practice and GP to support continuation of care with the same provider and practice. As of mid-October 2025, 89 per cent of all practices in the region were registered for MyMedicare.

In August 2024, the first MyMedicare incentive (General Practice in Aged Care Incentive) was introduced and changed the way primary care is incentivised to provide services to residents in residential aged care homes (RACHs).

Among other reform strategies, chronic condition management items incorporating MyMedicare came into effect on 1 July, followed by the new MyMedicare General Practice Bulk Billing Incentive and Better Access Mental Health Treatment Plans changes from November this year. These strategies aim to increase community access to primary healthcare services, while decreasing the need for out-of-pocket payments from patients. PHNs have received funding to support 19 activities linked to four priority areas for primary care reform:

- Increase access to primary care – 15 activities
- Modernising primary care – five activities
- Encouraging multi-disciplinary team-based care – seven activities
- Supporting change management and cultural change – two activities.

Murray PHN's General Practice and Reform team has been working closely with practices to support overall understanding and adoption of the initiatives. This includes supporting services with their capacity and capability to embed these reforms. Among supporting strategies, the team tailored a targeted quality improvement activity, embedded access to education and training, developed additional resources and provided broader communications via Murray PHN engagement channels.

# Chronic disease

Murray PHN currently funds 28 providers – allied health, general practices and Aboriginal community controlled health organisations - that deliver chronic disease management primary care services, including diabetes education, dietetics, podiatry, chronic disease nursing and community-based cardiopulmonary rehabilitation.

Our work focuses on supporting system and service integration and care coordination to improve patient experience and health outcomes. Our dedicated Complex and Integrated Care team aims to ensure the provision of person-centred, trauma-informed and culturally safe care for people with complex needs.

This year, chronic disease management services were delivered to 3234 people, with 96 per cent reporting an improvement in health outcomes.

## GAINING CONFIDENCE TO SELF-MANAGE HEALTH AND WELLBEING

Case study

Frank* is in his 60s and lives in a small rural town with limited public transport to the nearest regional centre, located an hour away. He lives with type 2 diabetes, an unhealed diabetic ulcer on his foot, epilepsy, sleep apnoea, a heart condition, obesity and leg pain that affects his mobility and daily living activities.

Frank was referred to a Murray PHN-commissioned diabetes educator at a community health centre connected to the local rural hospital, due to being on a waiting list for surgery but with blood glucose readings too high to proceed, in addition to not eating or exercising well and experiencing challenges with managing his medications.

While Frank initially did not realise that his level of diabetes control was not optimal and getting worse, fortnightly appointments with the diabetes educator helped him to understand changes he could make to benefit his health. He completed glucose monitoring trials, started exercising and learned about healthy eating and nutrition. In coordination with Frank's GP, referrals were also made for him to a physiotherapist, dietitian and podiatrist at a high-risk foot clinic.

With intensive treatments and support, Frank's blood glucose level reduced to within the target range, his foot ulcer healed, mobility improved and his surgery was scheduled. Importantly, he gained confidence to self-manage his condition, his mental health improved and he's now considering joining a type 2 diabetes exercise group.

## REGAINING QUALITY SLEEP

Case study

Joy*, a middle-aged woman, was diagnosed with obstructive sleep apnoea that was affecting her ability to gain quality sleep and lose weight.

While incarcerated in a low security prison on Dja Dja Wurrung Country, the Integrated Team Care program received a request for assistance from the prison to help Joy gain access to a CPAP device to treat her sleep apnoea.

With help of the facility's registered nurses, the Aboriginal Community Controlled Health Organisation's chronic care coordinator was able to get a GP chronic condition management plan for Joy, as well as a referral to a sleep lab to have a sleep study completed.

Joy now has a correctly fitted CPAP device, enabling her to self-manage her condition.

**names changed*

# Increasing access to interpreter services

The Murray PHN region is home to more than 55,000 people who speak a language other than English at home, with Punjabi, Italian, Mandarin, Arabic and Malayalam being the most commonly spoken languages.

Language barriers can make it difficult for people to access the healthcare they need, leading to poorer health outcomes. This year, Murray PHN launched a pilot program to support multicultural communities to access more timely interpreter services and translated health information.

Private allied health professionals and others previously ineligible to access free interpreter services can now access these services at no-cost through the pilot program.

The interpreting services are available until June 2026 in-person, on the phone and via video in more than 150 languages.

The program aims to assist local clinicians in communicating more clearly with their patients from non-English backgrounds, to ensure informed consent and increase understanding of their medical conditions, treatment and management plans to improve their health and wellbeing.


# Creating inclusive environments

This year, Murray PHN funded an educational course to support primary care services - general practice teams, pharmacists, allied health and mental health workers - to work effectively across cultures and increase their confidence to use interpreters and translated materials.

Delivered by the Centre for Culture, Ethnicity and Health, the Introduction to Cultural Competence course provided participants with the skills and knowledge to effectively engage with people from diverse cultural and linguistic backgrounds, including learning how to minimise misunderstandings that arise due to cultural or language barriers, and other strategies to create inclusive environments for people from refugee and migrant backgrounds.

# Help to navigate to the health system

Murray PHN commissions Health System Navigator services in Bendigo, Shepparton and Robinvale. These services employ bilingual workers who work alongside healthcare workers to support people from refugee, asylum seeker and other migrant backgrounds to navigate the health system and access primary care services when needed.

This year, 67 community education sessions have been delivered and 5341 hours of support provided to 765 clients across the three services.

The PHN Multicultural Access to Primary Care Program aims to support service access by addressing challenges and barriers faced by multicultural communities when accessing primary healthcare and improving service integration in the Murray PHN region.

Activities align with the PHN Multicultural Health Framework that was released last year and the principles of which are cultural responsiveness, localised and tailored activities, meaningful partnerships and a commitment to continuous improvement.

**Case study**

## IMPROVING HEALTH LITERACY IN ROBINVALE

Multicultural communities in Robinvale face significant barriers in accessing healthcare services due to language difficulties, lack of trust and awareness about available services and complexities associated with navigating health systems, including specialist referrals, appointment bookings, immigration status and Medicare eligibility.

To address some of these barriers, the Health Navigator program created and distributed multilingual flyers and resources to explain available healthcare services and held information sessions for community, in collaboration with local community groups.

A dedicated contact point was also created to make it easier for people to access services and have any questions answered promptly. Proactive outreach via routine check-ins, particularly for those facing immigration or Medicare challenges, was conducted to monitor progress and offer immediate assistance.

In addition, clear referral pathways and multilingual patient registration processes were developed and regular meetings held with stakeholders to review and improve these, strengthening partnerships and resulting in less missed appointments.

From October 2024 to April 2025, 88 people were assisted to improve their confidence and independence in accessing health services.

Positive client feedback has indicated significantly improved health literacy and reduced anxiety when accessing services. Healthcare providers report clearer communication channels, reduction of service duplication and increased efficiency.

## STRENGTH AND RESISTANCE TRAINING PROGRAM

Case study

Bendigo Community Health Services developed a six-week strength and resistance training program for the local Karen refugee community.

With guidance from their allied health and exercise physiology teams, and cultural and language support from Murray PHN commissioned Health System Navigators, the program became more than a fitness program - it became a shared journey of personal empowerment.

Each week, participants joined Exercise Physiologist Joel for a series of light exercises and stretches. The bilingual navigators ensured every instruction was clearly understood.

By the final week, significant improvements were made to participants' physical and emotional heath and Bendigo Community Health Services now plans to invite local Afghan refugee community members to participate in the program.

For Mu Kaw Say and Eh Kaw Htoo, who both live with diabetes, the benefits were profound. ***"The exercise helped us control our blood sugar levels. We feel stronger, less dizzy and more in control of our health."***

Per Kaw, who lives with schizophrenia, reported improved mental health, ***"I feel happier, and the pain in my body is gone."***

***"I feel happier. My sleep is better and the pain in my muscles has gone."*** Bu Hla

***"I didn't like it at first. I used to feel weak. But now, I feel young again! Please tell me if there's another chance to join something like this."*** Than Tin

## FEELING SUPPORTED, INFORMED AND SAFE

Case study

Ellie*, a woman of refugee background living in Bendigo, was referred for a diagnostic procedure. She spoke very little English and had no family locally to support her.

The diagnostic service told Ellie that she needed to bring her own interpreter to her appointment and preferably a family member. When she could not do so, Ellie's appointment was cancelled, leaving her embarrassed, uncertain of what to do and without essential care.

The local women's health clinic and a refugee health nurse were alerted to Ellie's situation and referred her to the Health System Navigator program. Together, they advocated for Ellie to access the procedure safely and appropriately. This included helping Ellie to understand what to expect during the procedure and explaining that she had rights to an interpreter.

Unfortunately, the local diagnostic service continued to refuse to book an interpreter due to it being seen as too time-consuming. However, an appointment was secured with another diagnostic service that agreed to providing an interpreter. The navigator accompanied Ellie to the appointment, helping to prepare questions and ensuring that she understood the outcomes afterwards. This enabled Ellie to undergo the procedure with her dignity and privacy intact. She expressed her relief and satisfaction, saying she felt supported, informed and safe.

Without this support, it's likely that Ellie may have either received sub-optimal care or disengaged altogether, compromising her health and wellbeing. The journey reinforced the importance of advocacy, culturally responsive health services and the need for systemic change. The outcome showed that with the right support, including to navigate complex health systems, clients can receive the care they need, when they need it.

Murray PHN is rolling out awareness, education and training for primary healthcare providers and funding access to improve the use of interpreter services.

## HELPING BUILD TRUST AND SUPPORTING ENGAGEMENT WITH HEALTH SERVICES

Case study

Marley*, a young man of refugee background, arrived in Central Victoria less than two years ago, speaking very little English and with no family supports and almost no understanding of the health system.

Soon after arrival, Marley was diagnosed with a rare and life-threatening heart condition, requiring specialist cardiac and respiratory care, mostly in Melbourne. Marley did not know how to book appointments or public transport, why medication was important for him or how to call an ambulance if he needed one.

The local community health service's refugee health team referred Marley to the Murray PHN commissioned Health Systems Navigator program, where staff worked intensively with him to build trust and support his engagement with health services.

The navigator worked with Marley to build his confidence in managing his appointments and treatments, supported him with how to use the train system, connected him with traveller aid services and even used photos to help him remember key places. They explained Marley's condition and medications to him in clear, simple terms, reinforcing the importance of following treatment plans. They also supported him through applying for the Disability Support Pension and NDIS, though delays in gathering evidence proved challenging in completing this.

Over time, Marley became more confident and learned how to take his medications safely, when to call an ambulance and how to independently navigate transport to attend specialist appointments.

The navigator's consistent presence and culturally responsive support were critical in building trust with Marley. While the case was demanding because of the complexity of medical needs and level of support required, it reinforced the importance of advocacy and persistence in ensuring vulnerable clients can access essential healthcare.

Marley expressed his gratitude and acknowledged that he could not have managed any of these challenges alone. He continues to work towards his health and independence goals. While he still faces some challenges, especially the 155km journey to Melbourne for his care, Marley is engaged with services and improving his health literacy.

**names changed*

## A NEW ROADMAP TO MANAGE HEALTH

Case study

When Nigel* first engaged with the Health Navigator program, he was facing a complex and overwhelming set of challenges. Living with an autoimmune condition, experiencing financial and relationship hardship and no personal transport meant that he was overwhelmed and struggling to keep up with the demands of accessing ongoing medical care.

Through the program, Nigel's goals were transformed from inaccessible and out of reach, to achievable from a more coordinated and timely approach. Not only did it provide a roadmap for managing Nigel's health goals, but the advocacy and brokerage required to make those goals achievable.

A major breakthrough came when funding was secured to support specialist follow-up for Nigel's autoimmune condition - care he would never have been able to afford otherwise - and advocacy efforts extended to help secure a specialist letter to support a Centrelink claim.

With Nigel's autoimmune condition requiring ongoing electrolyte balance, a partnership was formed with a local compounding pharmacy to formulate a custom electrolyte drink and ensure its cost remained affordable to ensure a sustainable, long-term solution to support his condition.

Other supports provided included a timely skin check that led to the early detection of a potentially cancerous lesion, help to successfully apply for a computer through the Laptop Initiative to assist Nigel to maintain employment and addressing chronic dental pain through access to bulk-billed care.

By accessing the program, Nigel has not only received care that he once believed was impossible, but regained a sense of control, started and continued employment, and importantly, has the confidence to maintain his health and future.

**name changed*

Nigel's gratitude has been forthcoming with him commenting, ***"I really appreciate it more than you know"*** and ***"You do so much,"*** reflecting the impact that support, advocacy, holistic and coordinated care can have on someone's life.

# Addressing the challenges of experiencing homelessness

Addressing homelessness and the needs of people experiencing homelessness are key priorities for Primary Health Networks. In October this year, the PHN Cooperative developed a Homelessness Health Framework to provide high-level guidance for a national approach to addressing these challenges in respective PHN regions.

A reliable roof over your head is one of the basic necessities of life, yet homelessness rates are growing due to a housing supply shortage and limited social housing, combined with the challenges of buying or renting an affordable home.

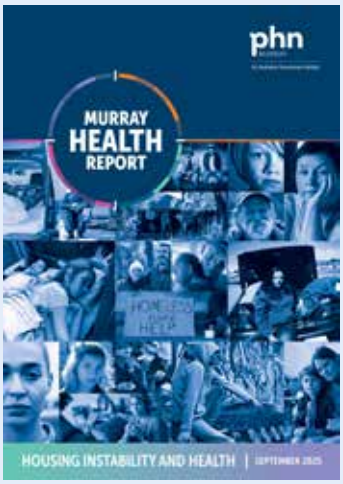
Homelessness doesn't discriminate – it affects men, women, older people, young adults and families. People who are experiencing homelessness or unstable housing situations often find it difficult to break a poor health cycle. The lack of safe, secure and stable housing, along with complex psychosocial factors, a lack of nutrition and hydration are some of the factors that contribute to poor health in people experiencing or at risk of homelessness.

Building on Murray PHN's in-depth Health Needs Assessment, this year's Murray Health Report, released in September, provides some of the key insights into the threat of housing insecurity in our region and their associated impacts.

People experiencing or at risk of homelessness in Bendigo, Shepparton and Albury/Wodonga can continue to receive support to access primary care services commissioned through the Australian Government's Homelessness Access to Primary Health Care Program.

Each service model has been adapted to the local organisational and community context, requiring tailored support, monitoring and evaluation approaches, and which demonstrate that a holistic approach is needed to address the health needs and access barriers of people experiencing or at risk of homelessness. A community of practice has also been established to support providers in learning from each other and refining their practice and respective service models.

Bendigo Community Connectors and a nurse practitioner provide direct health support to rough sleeping populations, while the Shepparton GP outreach model attends two community centres to deliver direct healthcare, and the pilot program in Wodonga is with a housing support service that is helping to embed health assessment and linkages into housing services.




**Read the report:**
https://tinyurl.com/MHReport-homelessness

**Homelessness is not a problem confined to cities**

**Homelessness goes hand-in-hand with health issues**

**The fastest growing group of people experiencing homelessness is in people over 65**

**People aged 10-25 have the highest proportion of homelessness of any age group**

**Life expectancy for people experiencing homelessness is greatly reduced, with people dying as much as 40 years younger than other Australians**

# Q&A

## Q&A with Rhiannon Engi - Community Connector

Murray PHN is working with several services in our region to help improve access to healthcare for people experiencing or at risk of homelessness. Community Connectors are vital to this work. Rhiannon Engi works at Bendigo Community Health Services and shares her passion, commitment and insights in her own words.

**What's your background and why were you drawn to work as a Community Connector?**

I have always worked with vulnerable people in different capacities and positions, supporting those who are often misunderstood, not listened to or respected, and am passionate about advocating for people not able to advocate for themselves. I previously worked in the dementia specific area of aged care for many years. As a Community Connector, I was again drawn to supporting people who have been misunderstood, under-represented and not treated with dignity and respect to access services that everyone is entitled to. You could say I am a sucker for cheering for the underdog.

**What kinds of barriers do people experiencing or at risk of homelessness face when it comes to accessing healthcare?**

For people experiencing or at risk of homelessness, barriers to healthcare appear at multiple levels, even before they can access care.

At the practical level, something simple like not having a safe place to store documents such as a Medicare card or ID can block access altogether. Everyday challenges such as unpredictable transport, no phone credit or lack of safe storage for medication are also barriers.

At a systemic level, health services are built on rigid processes that assume people can put aside their trauma response, mental health or disability. A missed appointment is often interpreted as disinterest or 'non-compliance', when it may in fact reflect the daily realities of living on the streets.

At a human level, stigma and bias play a huge role. Behaviours shaped by pain, trauma, psychosocial disability or neurodiversity are quickly and frequently interpreted as aggression, such as a person struggling to regulate their emotions in a waiting room. Too often this ends with being banned from a service, instead of a service reflecting inwards on what they could have done to support the individual.

**It could be described that you 'walk alongside people' who need support. Can you describe this process and what it means to you?**

To walk alongside someone is to be their point of contact, their advocate, their health access coordinator and their ally. It is about holding space for people to rebuild trust in a system that has too often let them down. It means meeting them where they are, without expecting the process to be linear. It is about removing pressure and conformity and instead allowing support to unfold at a pace that feels attainable and safe. The first step is to build trust.

It can also mean negotiating with a service that has refused further care because a person was deemed 'too complex'. On the day of an appointment, we never just drop someone at the door. We sit with them or arrange for the clinic to call when they are ready, so waiting in a public space can be avoided, or reschedule if the person is not in the right headspace. Sometimes, the best option is shifting to telehealth. Whatever the format, the person knows they are not alone. Reaching the clinic, or even making it partway through an appointment represents growth, persistence and courage. We celebrate the small wins.

**In what ways does this program bridge the gap between homelessness and healthcare and other services?**

If I can be honest, and I think that's one of the things we need to be in this space, we should acknowledge that the reason we need a bridge in the first place is because the system created the problem, has often been the source of trauma and is not a place that incentivises connection. The system wasn't built around the needs of our most vulnerable and misunderstood community members.

From the individual's side of the bridge lie years and years of being let down by systems and the stark realities of daily reinforcement of the narrative of being too complex or hard for any system and not worth supporting. My role as bridge is to be real and honest. To acknowledge the truths of both sides. And to find ways to encourage connection. This looks different every day and for every person.

**How does taking a person-centred and flexible approach impact the health and wellbeing of people seeking support?**

A person-centred approach means recognising behaviours have meaning, and everyone has good and bad days. It's about showing up and proving through action that support isn't fickle.

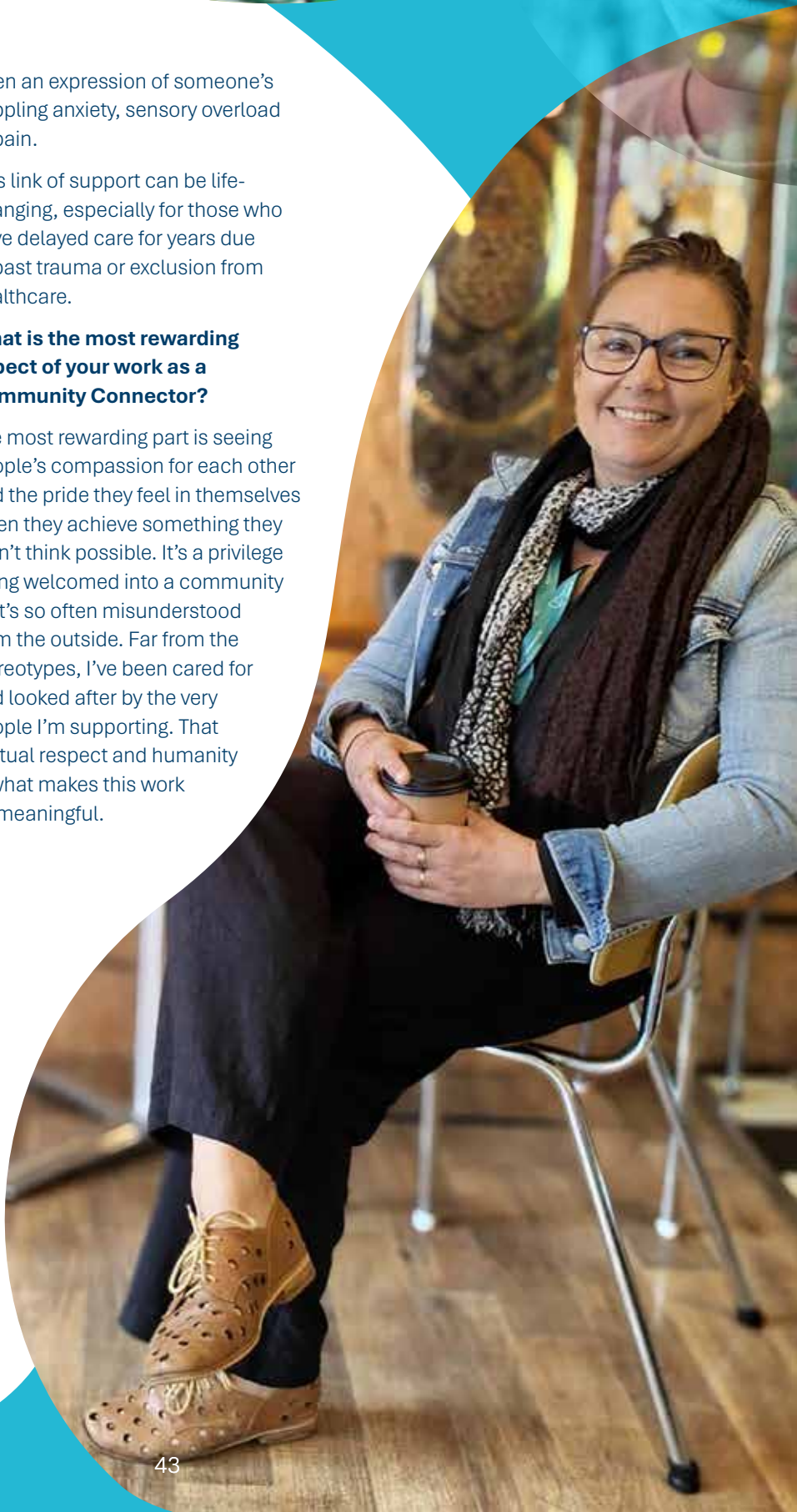
For many, this is the first time they've had someone consistently in their corner. In a doctor's appointment, anxiety and the power imbalance can make people go blank or fear saying the wrong thing. By being there and centring the individual, I can be their anchor, provide prompts and ensure their concerns and voice are heard.

Strangely enough, the most common time I deploy my de-escalation training is to calm health providers, to get them to see that the loud voice is not directed at them, but more often an expression of someone's crippling anxiety, sensory overload or pain.

This link of support can be life-changing, especially for those who have delayed care for years due to past trauma or exclusion from healthcare.

**What is the most rewarding aspect of your work as a Community Connector?**

The most rewarding part is seeing people's compassion for each other and the pride they feel in themselves when they achieve something they didn't think possible. It's a privilege being welcomed into a community that's so often misunderstood from the outside. Far from the stereotypes, I've been cared for and looked after by the very people I'm supporting. That mutual respect and humanity is what makes this work so meaningful.



## FROM DAY-TO-DAY SURVIVAL TO RECOVERY

Case study

In North East Victoria, Nicole*, a woman in her 40s, is being supported to reclaim control of her health and wellbeing.

After years of surviving family and sexual violence, rough sleeping and disconnection from her family and community, Nicole was offered more than just a roof over her head - she was offered a chance to begin addressing her complex health needs.

After moving into transitional housing, Nicole's focus began to shift from day-to-day survival to recovery. She was living with untreated high blood pressure, nerve damage from past trauma, chronic infections, declining mental health and had no regular GP or trusted healthcare providers.

With the support of a Health Access Navigator who is also a community nurse, Nicole was able to connect with a bulk-billing GP, access urgent care for a serious infection, attend an optometry appointment to receive her first pair of glasses in years, and begin recovery for anxiety and alcohol dependence issues.

Working in partnership, the navigator offers consistent, trauma-informed support to walk alongside clients as they re-engage with the healthcare system. The support is more than making appointments - it's about creating a safe, non-judgmental space where trust can be rebuilt, particularly for those who carry deep fears around healthcare settings.

The health navigator said, "This isn't just about healthcare. It's about restoring dignity, trust and hope, one connection at a time."

**name changed*

***"This isn't just about healthcare. It's about restoring dignity, trust, and hope - one connection at a time."***

Case study

## REDUCING STIGMA AND INCREASING UNDERSTANDING

Gina*, a middle-aged unemployed woman who had experienced homelessness for several years and not seen a regular health professional for more than four years, referred herself to the homelessness health access program.

Gina presented with multiple and complex issues including poor oral hygiene, a dual diagnosis of mental health and substance use, and Hepatitis C on blood screening.

Due to not having regular health checks, there was a lack of documentation on Gina's medical history and health conditions. While some services were hard to coordinate, due to Gina's memory problems and not owning a mobile phone, she successfully completed three months of hepatitis medication, had her teeth removed and dentures fitted, was referred to a GP for ongoing care and mental health support, and was assisted with and successful in her application for a Disability Support Pension.

Despite the complexities of Gina's situation, the health professionals involved in her care found her pleasant to work with. One of them attributes not having expectations or judgment, particularly when it came to missed appointments, which meant Gina was able to build trust with the worker to overcome obstacles and had better adherence to treatment to improve her health. Also, the ability to speak on behalf of Gina to another service prior to attendance, helped reduce stigma and increase understanding of Gina's situation which subsequently improved the experience for all involved.

**name changed*

# Program connects older people to aged care services

The Care Finder program, which began in January 2023, continues to complement My Aged Care by assisting eligible older people experiencing access barriers and without family or trusted carers to engage the My Aged Care service, as well as local health and community services.

Care Finder providers in the Murray PHN region offer free localised, face-to-face support to help people to navigate the aged care system, engage with services and stay connected. Since its inception, providers have delivered more than 13,000 service activities to 1891 clients across the catchment.

The program has received positive evaluations highlighting its strong support from providers, the aged care sector and clients, demonstrating its effective delivery of much-needed support to older Australians. Funding for the program has been extended until June 2029.

*Pictured L-R: Care Finders Paul and Danielle, Nexus Primary Health*

**Case study**

## ADVOCATING FOR URGENT SUPPORT

Mark*, an elderly man with multiple chronic and complex health conditions, lives in a small rural village in North East Victoria. Despite the dedication and care of his partner - who manages his personal care, transport and medical appointments – increasingly, the need for additional supports was identified.

Mark's health challenges included an amputation, spinal injury, chronic pain, incontinence, COPD, asthma, arthritis, and a history of cancer and stroke. He was underweight, awaiting surgery for haemorrhoids and experiencing significant discomfort when sitting.

Mark had attempted to contact My Aged Care (MAC) but had a mistrust of government agencies, feeling discouraged by the response he previously received and lacking confidence to advocate for himself.

In April 2025, Mark's occupational therapist referred him to the Care Finder program for assistance with obtaining MAC approval for goods and equipment funding for a pressure care cushion, which he could not afford as a pensioner.

Care Finder liaised with MAC to secure an urgent referral for the cushion, which reduced Mark's pain and enhanced his quality of life; facilitated a dietitian referral to improve his nutritional intake; referred Mark's partner to Carer Gateway for support; and provided coaching to help Mark understand the importance of open communication to build his confidence and improve his engagement with the aged care system.

Care Finder played a critical role in navigating systemic barriers, advocating for urgent support, and empowering both Mark and his carer, leading to tangible improvements in comfort, confidence and access to services. Mark now welcomes periodic check-ins from Care Finder, which ensures he has continuity of care and ongoing support.

**name changed*

# Strategy

Murray PHN uses its local knowledge, understanding and skills to improve the health outcomes of our communities.

Through research and evaluation, strategy and innovation, and integrated partnerships and projects, our Strategy and Performance team oversee and guide our strategic planning processes to align our performance, partnership and program areas with our strategic organisational objectives.

# Optimising ear, nose and throat care

In August 2025, Susan O'Neill completed a Murray PHN industry funded PhD in collaboration with La Trobe University. Susan's research investigated the higher than state average rates of potentially preventable hospitalisations (PPH) for ear, nose and throat (ENT) conditions in rural Victoria. Two communities in the Murray PHN region were identified as hotspots, indicating sub-optimal access to primary healthcare services for these conditions.

The research involved four studies that included focus groups with audiologists, analysis of hospital presentation data, a systematic literature review and case study in a high-risk community. From these studies, it was identified that:

- education and training in primary care are essential for effective ENT care and referral pathways
- there are three key ENT conditions disproportionately affecting children aged 0–9 years, First Nations people, and culturally and linguistically diverse (CALD) groups
- key ENT conditions were acute tonsilitis, otitis media and upper respiratory tract infections
- community-based screening and alternative healthcare models are highly valuable
- barriers to healthcare access included availability, affordability, appropriateness and acceptability.

These findings led to the development of an investigative method to identify high-risk communities for various PPHs, including acute, chronic and vaccine-preventable conditions. This method has been adopted by Murray PHN and integrated into the health needs assessment reporting, which informs government resource allocation and funding decisions. This research has strengthened stakeholder engagement and contributed to the development of sustainable healthcare models in rural communities.

Policy implications noted in Susan's thesis include the need for PHNs to implement standardised evaluations of PPHs at the community level; and the improved use of existing datasets in collaboration with local Public Health Units, which may enhance program planning and evidence gathering. The research also recommends the development of a standardised online training program for ENT detection and management, particularly for multidisciplinary teams in primary care settings. These programs could improve early disease management and support accessible quality care.

Looking ahead, future directions include evaluating the effectiveness of telehealth, expanded scopes of practice, community health programs and tailored referral pathways. Murray PHN intends to apply the investigative method to other high-risk communities to support decisions around workforce distribution and the sustainability of proposed healthcare solutions. This research has had tangible impacts beyond academia, contributing solutions to real world challenges.

# Facilitating heart health checks at home

Murray PHN is partnering with La Trobe University for a pilot study that will assess the acceptability of an active heart health check program in rural populations. The project is part of the 2024 Medical Research Future Fund Survivorship Care and Collaborative Research Prioritisation Grant that was awarded in March this year.

To overcome barriers to accessing care such as long wait times, cost and travel, the model aims to significantly increase the number of checks by enabling individuals to self-administer tests in their own home or at a community pharmacy, using a co-designed Heart Health Check Kit.

The H2Check-Kits are equipped with Therapeutic Goods Administration-approved portable devices for measuring blood pressure, fasting glucose and cholesterol. Results are then delivered by an automated freephone or traditional postal service.

Those with elevated cardiovascular disease risk will be connected to risk reduction programs and receive referrals to the primary care system where required. Their usual GP will also be kept informed.

The project is focusing on people living in the rural and remote communities of Mildura in the Mallee region of Victoria, Lockington in Northern Victoria, Wentworth Shire and the Far West Local Health District covering the far south-west Riverina region of New South Wales.

# Partnering to improve skin cancer care

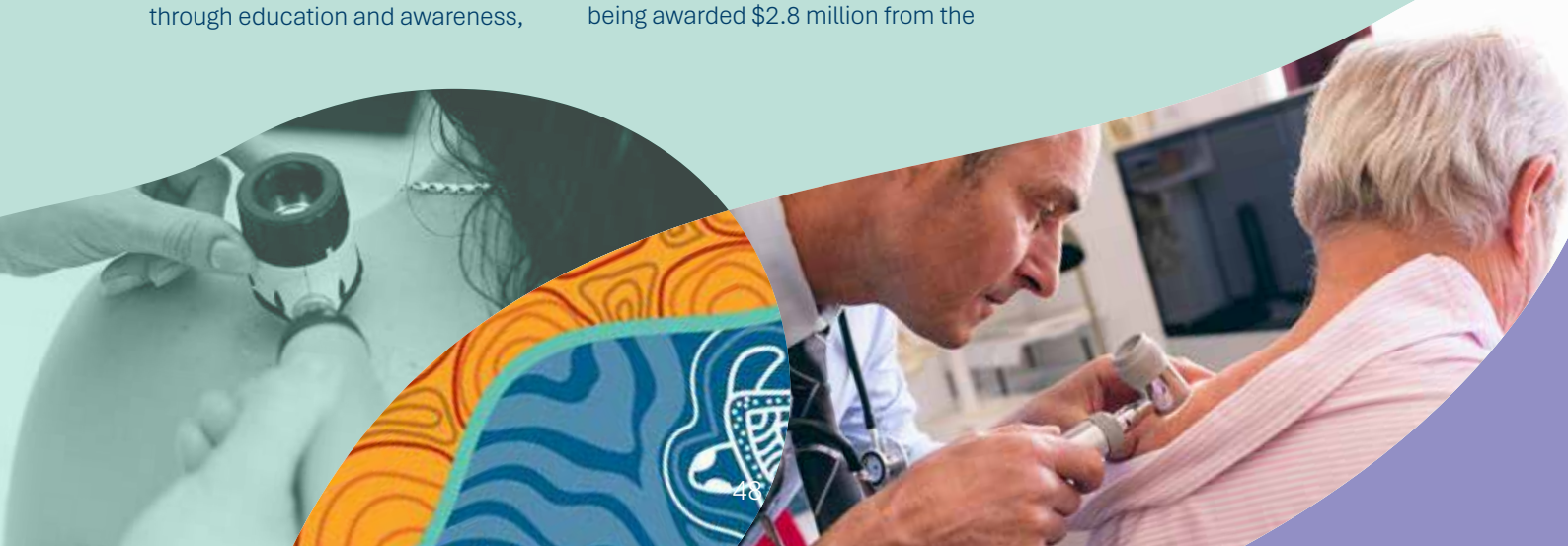
People in the Loddon Mallee region experience higher levels of skin cancer and melanoma than other areas, with residents reporting that barriers to care include cost, wait times, distance and a lack of communication between health services.

During 2024-2025, Murray PHN worked with Loddon Mallee Integrated Cancer Service on a project to map skin cancer services and identity gaps in the region.

In addition to improving cancer care through education and awareness, the project supported opportunities for collaboration. This included establishing a shared skin check promotion platform, supporting nurses to complete dermoscopy training and connecting skin cancer check nurses in Robinvale, Kyabram and East Wimmera.

The project findings from this partnership were used by La Trobe University in a research funding submission this year for a five-year ‘RISE4SkinCancer’ project. We are pleased that they were successful in being awarded $2.8 million from the Australian Government through the Medical Research Future Fund.

La Trobe’s research project brings together a range of organisations including Loddon Mallee Integrated Cancer Service and Murray PHN, together with Loddon Mallee Aboriginal Reference Group and Bendigo Community Health Services, with the overall goal of improving timely access, diagnosis and treatment to care by developing and testing models that build primary care capacity.



# Building a sustainable workforce

Since 2022, Murray PHN has been providing assessment of GP workforce need and training capacity to the Department of Health, Disability and Ageing and GP training colleges, the Australian College of Rural and Remote Medicine and the Royal Australian College of General Practitioners. These reports, developed as part of the DHDA-funded Workforce Planning and Prioritisation program, guide the placement of GP trainees (registrars) and the investment needed to support and train them in our region.

For the 2025 report, we focused on directly engaging with medical professionals and communities to build a comprehensive view based on not only 'hard' quantitative data (including population, workforce, service and Medicare indicators), but also local intelligence (qualitative data) that captures the unique dynamics and challenges of rural and regional communities.

Our approach is not only about consultation, but about encouraging the development of a sustainable workforce. As well as using surveys, consulting with community and industry forums, and talking directly to individuals in our communities, we have played a role in facilitating and coordinating awareness and networking events that encourage the attraction, recruitment and retention of GPs to regional Victoria. These have provided doctors and their families with opportunities to build relationships with peers, meet potential employers and explore the benefits of regional living. An example of a highly successful collaborative event is the Swan Hill Regional Round-up held in April (see right).

We continue to build opportunities for workforce interest groups, communities and medical professionals to work together more effectively. Our focus expands beyond GPs to include how we can build a broader primary care workforce and infrastructure to ensure our communities have confidence in access and continuity of care in the future.

## Regional Round-up showcases the best of regional medicine

In April 2025, Murray PHN supported the Connecting the Docs Regional Round-up in Swan Hill that welcomed medical students, junior doctors, GP registrars, supervisors, health leaders and their families to the heart of northern Victoria.

The two-day event offered a unique opportunity for attendees to network with peers and health leaders, explore local attractions and lifestyle benefits, and discover the rich career opportunities in regional and rural medicine.

More than 70 people attended, including around 40 doctors and their families, along with representatives from peak bodies and health organisations.

This successful event was made possible through the collaborative efforts of Connecting the Docs (an initiative of the Loddon Mallee Region health services), Murray PHN, the Royal Australian College of General Practice, General Practice Supervision Australia, Regional Workforce Agency of Victoria and the Victorian Rural Generalist Program.

*L-R: Dr Annemarie Newth, CMO & Executive Director Medical Services, Echuca Regional Health (ERH); Dr Kathryn Schultz, Director of Clinical Training, ERH; John Bray, Project Lead Workforce Planning and Prioritisation, Murray PHN; Carla Taylor, CEO General Practice Supervision Australia; Lauren Cordwell, CEO Rural Workforce Agency Victoria; Kellie Byron-Gray, CEO Kerang District Health; Dr Nerida Hyett, Senior Manager Planning, Projects and Insights, Murray PHN; Trevor Adem, CEO East Wimmera Health Service.*

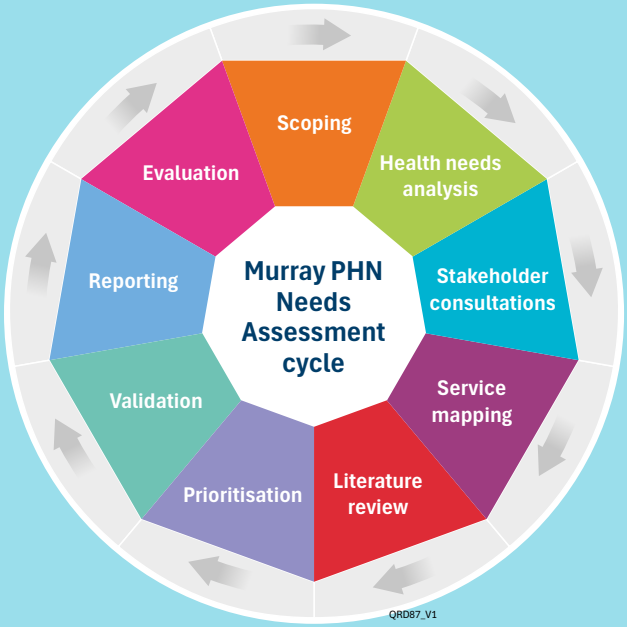
# Reporting on local health needs

The Health Needs Assessment is a critical part of Murray PHN's ongoing efforts to understand the unique health challenges faced by our communities and identify key areas for prioritised health system improvement.

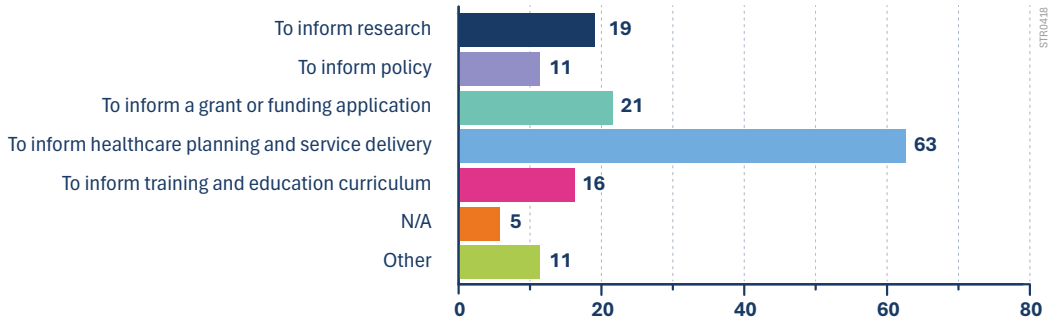
It informs our strategic planning and the development of targeted health programs that are responsive, sustainable and focused on improving health outcomes. We encourage others to use it to understand how they may be able collaborate in implementing its recommendations, to ensure the region's healthcare services best meet the evolving needs of our diverse population.

The latest 2025-26 to 2027-28 Health Needs Assessment was published at the beginning of the year and provides a detailed analysis of local health data and stakeholder consultations. It not only outlines in-depth findings on health priorities and includes social factors that impact health, but identifies gaps in healthcare access and suggests strategies for more equitable service delivery.

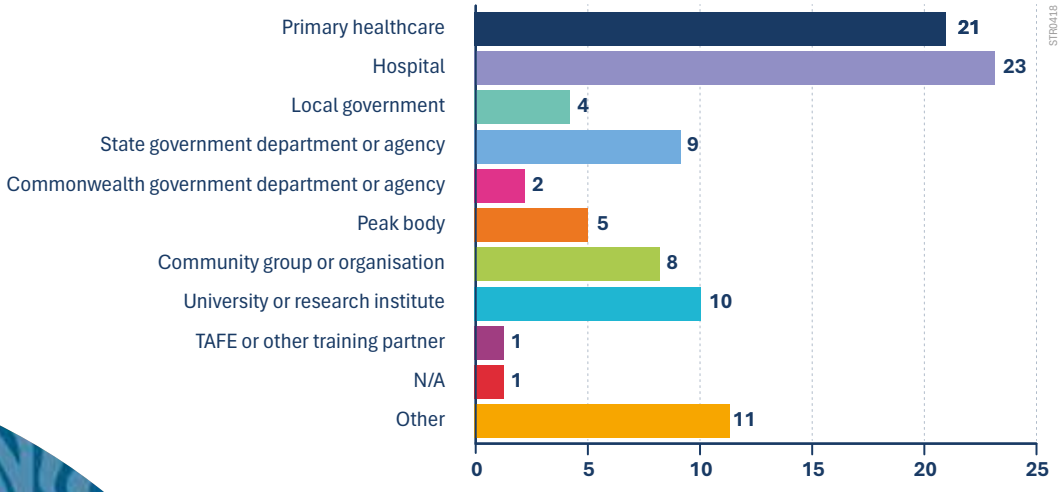
This year, we introduced a download form to help us understand who is accessing the report and how it is being used.




**How do you intend to apply the findings of the Murray PHN Needs Assessment?**




**Which best describes your organisation/ work setting?**



This year, we also released a collection of population and sub-region reports that offer a deep-dive into some of the more important health priority areas, providing key insights and recommendations to improve health outcomes. The population reports are extensive and other organisations are encouraged to use them in their planning and advocacy efforts to collectively meet the needs of these important groups in our communities.




## First Nations Health and Healing

This report highlights the vital role of Aboriginal Community Controlled Health Organisations in providing Culturally Safe healthcare, the need for more outreach models that provide care on Country, early intervention and culturally strong health promotion. It emphasises the importance of involving First Nations Peoples in healthcare planning, enabling self-determination, and addressing racism, funding limitations and workforce shortages.

## Homelessness

This report has identified areas in our catchment that have the highest rates of homelessness and marginal housing, that females are more at risk, and teenagers and young adults aged 10-29 account for about a third of the total homeless population. Key recommendations include enhancing primary healthcare access through in-reach and outreach models and after hours services, and by building capacity in the non-health sector to support access to services.

## Multicultural populations

For multicultural populations, local data insights include the need to prioritise language support services and other resources in local government areas and that diabetes is a priority chronic condition for Italian, Greek, Tongan, Turkish, Tagalog, Nepali, German and Arabic speaking people in our region. The report recommends that workforce planning should include strategies to increase the number of bilingual workers in rural regions.

Access the reports at:
murrayphn.org.au/about-us/key-documents

During August and September, we asked our online Murray Health Voices community to participate in a survey to support planning for our annual needs assessment update. This included helping to understand the current demographics across our region.

Health voices also helped us to identify where we can focus efforts to increase registrations and participation in future surveys, so that our planning and funding decisions are as targeted as possible.

Learn more and register at:
https://murrayphn.org.au/community/health-voices/

# Coordinated healthcare closer to home

Sustainable Rural Healthcare Hubs help people to better manage their health closer to home by providing access to a team of professionals that includes a GP or nurse practitioner, allied health professionals, specialists and a care coordinator.

Initially starting with four hub sites – Boort, Kerang, Pyramid Hill and Quambatook – the hubs model expanded this year to include Inglewood.

Funded through the Department of Health, Disability and Ageing's Innovative Model of Care grant and led by the Integrated Health Network Alliance, this trial model of care is available at Boort District Medical Centre, Charlton Medical, Northern District Community Health and Inglewood and Districts Health Service.

To increase awareness for the service locally and of the innovative model of care nationally, Murray PHN led the development of promotional materials, including consumer brochures, posters and signs for the clinics, and a brand new website: www.ruralhealthcarehubs.org.au

# Gathering local input and insights

Murray PHN clinical and community advisory councils play an important role in informing our strategic planning and helping us work towards better health outcomes for people in our region.

Through 'on the ground' input and insights from community and clinical perspectives, members provide us with timely and comprehensive intel to enhance planning, design and implementation of our programs, activities and projects.

Councils were established in the second year of Murray PHN's operation in 2016, with a number of founding members still serving and reaching, or about to reach, a milestone.

**Founding members since 2016**

- Angela Lawrence, Clinical Advisory Council
- Catherine Sambell, Clinical Advisory Council
- Carmel Hicks (current chair), North East Community Advisory Council
- Jack Forbes (current chair), North West Community Advisory Council
- Jade Cartwright, Clinical Advisory Council
- Dr John Buckley, Clinical Advisory Council
- Kathleen Wright (current chair), Goulburn Valley Community Advisory Council
- Menon Parameswaran, Goulburn Valley Community Advisory Council.

**Five or more years' service**

- Lucy Mayes, Central Victoria Community Advisory Council
- Leo Tellefson, North West Community Advisory Council
- Jane Garrett, Goulburn Valley Community Advisory Council.

While our contribution has significantly grown over our 10 years of operation, we have remained true to the concept underpinning the role and structure of PHNs – localised decision-making and local responsiveness. The capacity for Murray PHN to fulfil these objectives is greatly enhanced and strengthened by the input and perspective of our clinical and community advisory councils.

In August and September, members came together for the first face-to-face meetings in two years to participate in a Larter Consulting-led workshop on chronic disease management. The collaborative workshops built on the provider survey released in July, sparking fresh ideas and strengthening connections for health system improvement and future models of care.

This year, consultations have focused on digital health tools and the workforce planning and prioritisation project, and providing progress updates of programs that council members have previously provided input into including population health planning, general practice, mental health and inclusion.

As we do each year, members are invited to participate in a survey to track and gather feedback on how meetings and consultations are progressing and how they can be improved. From this, it's clear to us that members continue to value the contribution they make to informing our work.

***"I believe council activities have significantly contributed to both my capability and capacity as a council member. The structured discussions and collaborative environment have enhanced my strategic thinking, decision-making, and understanding of policy development. Engaging with diverse viewpoints has strengthened my communication skills and broadened my perspective on community needs. Furthermore, being actively involved in consultations has deepened my confidence in representing stakeholders effectively and advocating for initiatives that align with our shared goals. Overall, the experience has been empowering and has encouraged continuous learning and growth in my role"***
- 2025 advisory council member survey feedback

*Pictured L-R: Goulburn Valley members - Brett Gordon, Kathleen Wright and Menon Parameswaran OAM*

*Pictured L-R: Central Victorian members - Steve Tinker (Board member), Dr Robert Mann, Lucy Mayes, Ian Gould, Dr Candice Baker, Vicky Mason, Susan Randall, Lisa Hanson, Ashlee Lance, Dr Naveen Tenneti, Amy Brown and Dr Tali Barrett*

*Pictured L-R: North East members - Dorothy Chua, Tracey Farrant, Angela Lawrence, Carmel Hicks, Jade Carwright, Catherine Sambell and Emma Williamson*

*Pictured L-R: North West members - Jack Forbes, Amanda Holdsworth, Leonie Burrows OAM (Board member), Kanaka Devineni, Dr John Buckley, Charles Albanese, Michelle Thompson and Brooke Shelly*

# Q&A

## Q&A with Associate Professor Rex Prabhu

Murray PHN has collaborated with Associate Professor Rex Prabhu as part of several workforce development projects and initiatives in recent years. Moving to Victoria seven years ago to take up the position of Executive Medical Director at Swan Hill District Health, and recently starting at Bendigo Health as Chief Medical Officer, Rex has brought vision and energy to building a stronger and more sustainable workforce in the region and reflects on this experience in his own words.

**What originally attracted you to working in regional Victoria?**

I moved for career progression from my previous role. I realised that metro was getting very saturated and positions in my specific skill set were limited. There's only one specialist medical administrator or chief medical officer per hospital. Sydney traffic was getting to me too. In 2018, several opportunities in regional areas came up where there was a shortage of specialist medical administrators. I thought, I'm going to make a move. I had to convince my wife she's a city slicker. But I had a gut feeling the position at Swan Hill District Health was the right one. It was.

**How did you go about building and strengthening the rural health workforce at Swan Hill District Health?**

I walked in to literally no staff. Four doctors. I was the fourth employed by the health service. The only other doctors were interns from St Vincent's on rotation. The entire ED workforce, from the seniors to the juniors, were fly in/fly out temporary contracts or drive in/drive out locums. I was called in to a shift in ED because an intern was alone there. My heart sank for them. The shift went well, but it led me to think about recruitment differently and to think about changing the culture. It needed to be about building relationships. I clearly saw we needed to develop a workforce strategy and try different things, and we did.

I encouraged a non-traditional approach to recruitment and retention. For instance, I'd ask locums to try a permanent role for one or two years and give it a go. Leadership roles too. I'd ask a person to try it out for six months, see whether they like it. This worked. They did like it. People stayed. And then there was a trickle-down effect, and others came too. It meant I could build capacity around the juniors because the seniors were stable.

We also enhanced training pathways. It means someone can land in Swan Hill as a third-year medical student through Charles Sturt University and do all their training. There's now a landscape for GP training. We built a pipeline.

But you never stop building the pipeline in rural areas. I developed a lot of relationships with a lot of executives in the region building this workforce pipeline for the benefit of the whole region, not just Swan Hill District Health. For example, Kerang. Four of Kerang's GPs come from Swan Hill training pathways.

**What community and patient impacts have you seen as a result of the workforce becoming more sustainable and stronger?**

I think access to a broader set of services and care has improved significantly. GP appointment waiting times have improved. More specialist services became available. For example, with a geriatrician in town, not only did he run a subacute ward, he also did clinics for dementia and cognitive screening for the elderly. Another example is the chronic pain service we introduced in collaboration with St Vincent's. We also introduced the only public ENT service in the region.

**Building success though collaboration is at the heart of all you do. Can you share why connection and relationship building is so important to you?**

My dad was a professor of sociology, so I learned a lot of sociology growing up. I've applied some of that to healthcare management. Investment in social capital matters a lot. Investment in social relationships matters a lot. The only way you can do that is by building connection, building your networks, especially in a public facing role like mine. Because you never know when you might need help.

*"...take a leap of faith and explore because there's so many opportunities. It will help grow your skill set and your career. Pick a town that sustains the kind of life you want. There are so many advantages to living regionally and in a well-connected environment."*

And it's not just about relationships in your field. It should be outside your field. I can clearly say I have more connections outside healthcare than I have within healthcare, and that's important.

**You have just started in the position of Chief Medical Officer at Bendigo Health. How do you see your commitment to rural medicine evolving and developing in this role?**

I think it's about connecting at that medical higher leadership level, from Castlemaine to Mildura. This benefits the workforce and it benefits patients. I see my role as one that brings ideas together, brings people together, harnessing the skills of the workforce, and moving capacity when and where needed.

I am looking at the big picture when it comes to staff deployment and movement. The reality is we can't have all services everywhere, but we can consolidate. We can consolidate effectively if we have the right workforce. One of the first projects I'm working on is a regional credentialling system for the workforce. This will streamline a more effective response to various situations such as emergency response or surge scenarios.

**What would you say to inspire students and young doctors thinking about forging a career path based in the regions?**

I would say take a chance, take a leap of faith and explore because there are so many good opportunities. It will help grow your skill set and your career. Pick a town that sustains the kind of life you want. There are so many advantages to living regionally and in a well-connected environment. You'll find the community values your professionalism and the care you deliver, and that you make connections you cannot make in big cities. In my experience, it's been a blessing. So, if you want blessings, come to the country.

# Aged care

Murray PHN funds a range of projects, programs and resources to assist health services, residential aged care facilities and older people in our communities to live well.

PHNs have a role in assisting residential aged care homes to use digital platforms and equipment to access services virtually, have effective after hours action plans in place to reduce potentially avoidable hospital admissions, provide training and education to increase the knowledge and skills of the workforce in caring for residents and improve the coordination of care, particularly between general practice and residents of aged care facilities.

# Syringe driver safety and end-of-life training upskills aged care staff

The Hume Palliative Care Consortium, in partnership with Murray PHN, has successfully delivered free, practical training to aged care staff in 32 residential aged care homes (RACHs) across the Hume region.

This training has been designed to help staff safely use syringe drivers - devices that deliver medication to ease pain and other symptoms for people nearing the end-of-life.

It includes expert guidance, a skills check for nursing staff and resources to support best practice in everyday care.

The training is part of the Medicines Imprest Project, which aims to improve access to essential medications and strengthen palliative care in aged care homes. Importantly, the initiative also supports aged care homes embed the new Aged Care Standards that rolled out on 1 July 2025, particularly in areas such as safe medication use, staff education and respectful, person-centred care.

This work is being provided and extensively supported by existing community palliative care teams, helping to strengthen partnerships between services in our region and ensure consistent, high-quality and sustainable care.

# Supporting local solutions and national incentives

The General Practice in Aged Care Incentive (GP ACI) was introduced nationally in August 2024 as a new way to incentivise primary care delivered to patients living in residential aged care homes (RACHs).

Prior to the launch of GP ACI, we undertook a mini needs assessment to understand the current delivery and needs of primary care in RACHs. This included a survey to both general practices (74 per cent completed) and RACHs (61 per cent completed).

Murray PHN works to support general practices in understanding and adopting the GP ACI, including through the development and sharing of resources, and funding to design and implement place-based solutions to increase coordination and access to primary care for residents.

Since August 2024, we have provided weekly updates in our newsletter, created a webpage, held four webinars and our Quality Improvement Consultants have shared resources with practices at in-person visits.

Also last year, the Australian Government released a targeted, competitive application-based grant opportunity to 18 select PHNs with Murray PHN successful in our submission for Greater Shepparton and Mildura local government areas.

The overall objective of the grant was to identify regional gaps in the delivery of primary care services to RACH residents and to work in collaboration with local RACHs, GPs, general practices and Aboriginal Community Controlled Health Services to design, implement and manage locally informed solutions.

One practice was supported to implement a patient satisfaction survey, after having seen 450 residents. Of the residents who completed the survey:

- 98 per cent were satisfied with their healthcare
- 96 per cent agreed or strongly agreed that the medical care received from the doctor was of high quality
- 84 per cent felt included in decision-making and planning of their medical care.

Another practice was supported to implement a flowchart to assist administration personnel and doctors with completing resident admission paperwork in a new system, including checking that medical history, medication, health checks, immunisations records and statuses were available, up-to-date or arranged, with positive feedback received from nursing homes. Another clinic received funding to help coordinate meetings, develop management plans, medications and referrals.

Case study

## DEMONSTRATING THE POWER OF ADVOCACY, PERSISTENCE AND THE STRENGTH OF WORKING AS A TEAM

George*, aged in his late 70s with a multicultural background, recently moved into an aged care facility when his family was unable to continue caring for him at home, following his advanced dementia diagnosis and behavioural and psychological symptoms of dementia (BPSD).

George's behaviour became worse, and he began entering other resident's rooms and throwing furniture. The aged care facility did not have a memory support unit and was not set up to manage a wandering patient with BPSD. Attempts to redirect George escalated and he began to refuse medication.

George was referred to the program for assistance with managing episodes of agitation and aggression. Time was spent coordinating meetings with relevant care providers, new and old providers, developing management plans, medications and referrals, including to Dementia Australia and the Aged Care Psychiatric Assessment Team.

Many non-pharmacological strategies were attempted but ineffective. There was one week where the ambulance, police and hospital in-reach team were called four times due to George's behaviour and so, a further referral was made to the Dementia Behaviour Management Advisory Service.

George's family, who had become estranged, agreed to re-engage with him to try and assist with medications, which were changed to liquid form and disguised in foods and fluids. George remained unsettled if the family wasn't there, but he was less aggressive.

Despite increased nursing care, the aged care home was unsuitable for a patient with these behaviours and it was agreed to move George to the psychogeriatric unit at the hospital where he would be safe and have appropriate care and management. Following this move, George's behaviour continued to settle.

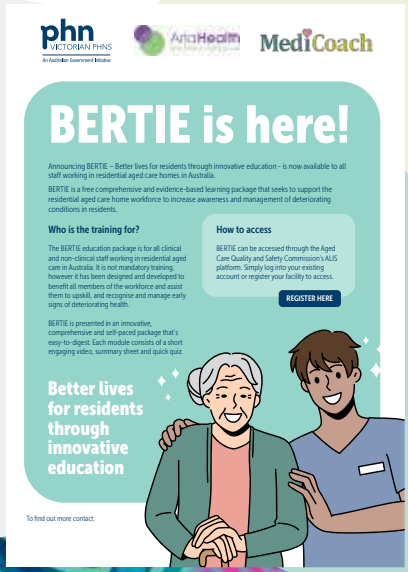
The program demonstrates the power of advocacy, persistence and the strength of working as a team. This model is an effective tool for bringing multiple teams together for the sole purpose of improving patient outcomes in a positive and professional manner.

**name changed*

# Aged care education package available Australia wide

Last year, Murray PHN developed and launched BERTIE - Better lives for residents through innovative education - on behalf of all Victorian PHNs. This comprehensive self-paced education package was designed to upskill the aged care workforce with engaging, varied and flexible content that meets the needs of busy people.

For both clinical and non-clinical staff, the broad ranging modules help to recognise and manage early signs of deteriorating health of residents. Hosted on the Aged Care Quality and Safety Commission's ALIS platform, BERTIE is available to all aged care workers across Australia. To date, 348 people have completed all 19 modules in the suite, and 784 people have begun the course, completing various modules according to individual learning needs.



# Connecting aged care residents with a GP

To complement the rollout of the General Practice in Aged Care Incentive, Murray PHN launched the GP Aged Care Connect Service in September 2024. The service assists permanent residential aged care home (RACH) residents, their carers and health professionals to connect residents to a GP/general practice clinic if they don't currently have one.

In order to develop an effective service, we held face-to-face forums for RACHs in May 2024 where we sought input to help co-design the service model. Following the forums, feedback and key themes were consolidated, and further refinements were made to the model, including incorporating feedback from our community and clinical advisory councils.


| GP Aged Care Connect enquiries | Contacts/ interactions | Matched | Resolved | Pending |
|---|---|---|---|---|
| 47 | 290 | 41 | 6 | 0 |

| Source of enquiry | Family/carer | RACH staff | General practice | Other |
|---|---|---|---|---|
| | 19 (41%) | 15 (32%) | 2 (4%) | 11 (23%) |

| Geographical regions | Central Victoria | | North East | North West |
|---|---|---|---|---|
| | 28 (60%) | 2 (4%) | 10 (21%) | 7 (15%) |

## LIFTING THE BURDEN ON FAMILY TO FIND A GP FOR AN URGENT RESIDENTIAL AGED CARE ADMISSION

Case study

A family in regional Victoria recently called the GP Aged Care Connect number seeking help to find a doctor willing to take on the care of their loved one to enable their admission into a residential aged care home. Here's what they had to share about their experience.

*"My father's usual GP was devastated that he could not continue his care and was relieved that another GP was able to be put in place so quickly.*

*It was time critical as we thought he only had a few days to live but he lived for two months.*

*Murray PHN dealt with this so professionally, as we were feeling quite emotionally exhausted.*

*I felt listened to and this is not always the case when speaking to a different service.*

*Without the support of Bendigo Health and the support of Murray PHN, he probably wouldn't have made his 100th birthday and received his message from the King.*

*It was unexpected how quickly GP Aged Care Connect were able to achieve an outcome. Connection to a GP was within 24 hours. If I tried to do this myself, I would've struggled.*

*The burden on the family to find a GP is hard and it was a relief to know that we could call a service to support us and most importantly, ensure that Dad's end-of-life program was in place for admission.*

*It is a great service to have available for families. The doctor we were connected to was magnificent.*

*Murray PHN is doing a great job, thank you very much."*

Case study

## CARE TAILORED TO THE INDIVIDUAL NEEDS OF COMMUNITY MEMBERS

A local Aboriginal Community Controlled Health Organisation (ACCHO) regularly hosts culturally appropriate events with a focus on improving social, emotional and mental health, including outings for elders, raising awareness about elder abuse, how to access local legal services and celebrating events such as International Women's Day.

An education session on dementia was held for 22 community members, followed by a BBQ and yarning circle at which one elder, Aunty Betty*, spoke of her struggles.

On identifying that Aunty Betty needed support due to having no transport and limited social and formal assistance in place, the team worked on exploring eligibility for securing referrals for in-home support and transportation through the Commonwealth Home Support Program.

Aunty Betty's health declined, and further help was provided to move her into a private room at a local nursing home. Time was spent getting Aunty Betty used to her surroundings and introducing cultural items to make her room feel safe and like home, as well as discussions undertaken with nursing staff on how they could make the facility more culturally appropriate and safe.

The ACCHO continues to provide care tailored to the individual needs of community members. Recently, they gained a client who was experiencing homelessness and in hospital at the time. They assisted the client to feel more connected to Country by providing art supplies and having yarns to lift their spirits and mental health during their lengthy stay in which they were coming to terms with the amputation of a limb.

Another family was supported with end-of-life care through assistance with paperwork, as well as the gifting of a possum skin, which was gratefully received and provided comfort through the person's journey into Dreamtime.

**name changed*

# Helping to put pharmacists into aged care

The Aged Care On-site Pharmacist (ACOP) initiative was introduced in July 2024 as a key recommendation of the Royal Commission into Aged Care Quality and Safety. The initiative provides funding for a credentialled pharmacist to be part of an residential aged care home's clinical care team.

Murray PHN has a dedicated staff member who provides support to aged care homes, pharmacists and pharmacies who are interested in learning more, connecting with others or accessing resources, guidance and support for program implementation.

Benefits of an on-site pharmacist:

- Improve medication use and safety, including the safe use of high-risk medications
- Provide continuity in medication management with day-to-day reviews and prompt issue resolution
- Offer easy access to pharmacist advice for residents and staff
- Integrate pharmacists with the healthcare team, including local GPs, nurses and community pharmacies
- Increase understanding and response to individual resident needs.

***"Having an ACOP enhances our ability to provide patient-centred care for our residents."*** – Alison Flengle, CEO/DON Nagambie Health Centre

***"I am thoroughly enjoying the diversity of the onsite role. I'm now working at two different aged care homes, each with different needs and requirements, so it makes my days very interesting."*** – Toni Riley, Credentialled pharmacist, Bendigo region

# Bringing the aged care workforce together

As part of the new General Practice in Aged Care Incentive rollout, Murray PHN hosted four community of practice (CoP) events this year in Bendigo, Shepparton, Mildura and Albury to assist in building, strengthening and maintaining relationships between health professionals who work in and provide services to residential aged care homes.

The Shepparton and Mildura events welcomed local geriatricians Dr Femi Afolayan and Dr Stephen Campbell and together with a panel of experts, they discussed multidisciplinary team approaches to care.

The Bendigo and Albury events were popular, with more than 100 health professionals registering to attend to learn more about older adults and mental health from Professor Sunil Bahr from Swinburne University of Technology. On completion of the post-event evaluation, 96 per cent of attendees said that they would recommend these events to colleagues.

*RACH Albury CoP: L to R: Professor Sunil Bahr with the Murray PHN team - Liz Welch, Maryanne Stivactas, Rebekah McNamara, Janis Bull and Dr Wendy Connor*


*RACH Bendigo CoP: Professor Sunil Bahr and multidisciplinary panel of experts*

*RACH Mildura CoP: Local aged care and health professionals and Murray PHN staff members*


*RACH Shepparton CoP: L to R: Dr John Guymer, Dr Nawal Hood, Jacinta Kennedy, Maryanne Stivactas , Dr Wendy Connor and Dr Alam Yoosuff*

# A best practice model of care

The aged care system in Australia is complex, multifaceted and complicated to navigate for older people, their families and those services providing support outside the aged care system.

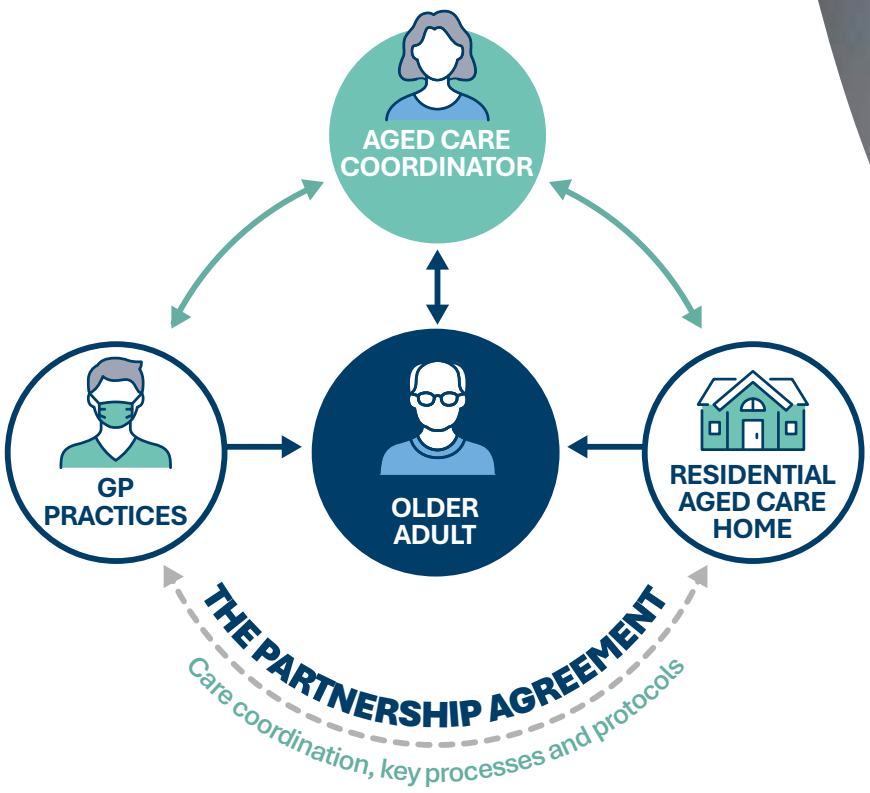
The Royal Commission into Aged Care Quality and Safety brought numerous systemic issues to light, including significant gaps in care coordination, poor clinical governance and a lack of integration between primary healthcare services. These gaps can result in fragmented care, increased hospital admissions and diminished quality of life for residents.

To respond to the declining level of service by general practices at residential aged care homes (RACHs) in the catchment, Murray PHN commissioned a general practice clinic to trial a new, innovative approach to supporting people living in RACHs in April 2023.

Initially, the plan was to engage multiple general practices to provide a collective approach to using a nurse practitioner to support 12 local RACHs. However, workforce challenges impeded the capacity to recruit to this position. A unique opportunity then arose and a dedicated aged care nurse position within the general practice was hired to support GPs in the provision of care.

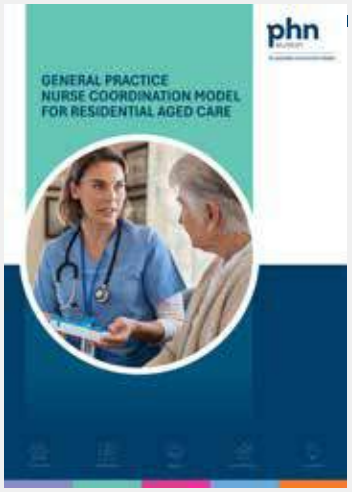
In July 2024, we had the model evaluated and shared it with other PHNs and general practice clinics in January of this year.

The best practice General Practice Nurse Coordination Model for Residential Aged Care draws on the learnings from the general practice trial. It aims to foster collaboration and is designed to build the capacity of general practices to facilitate care coordination, communication and clinical governance between a practice across multiple RACHs, at the same time reflecting the unique local contexts of the practice, the RACHs and the community.




General practices that would like to consider how the model may fit their context and what they need to consider can access the document, which lists the core elements, necessary procedures and standard operating practices that enable the model to be clinically effective and financially sustainable. It also includes a draft memorandum of understanding, an aged care coordinator position description and an example 'day in the life' workflow.

The aged care coordinator position within the original general practice continues today, with funding secured until 2027 through a successful application for an Australian Government General Practice in Aged Care Incentive Thin Market Grant.




**Download:**
https://tinyurl.com/coordination-model-rac

# Enhancing aged care with digital tools

Digital health can improve healthcare delivery and outcomes through more efficient, safer and secure access to and exchange of information.

This year, we created a new toolkit to assist residential aged care homes to learn more about the range of digital health tools available, with links to trusted resources and further information.


**Download:**
https://tinyurl.com/digitalhealth-aged-toolkit

# Digital health

Digital health technologies can help improve the delivery and management of care for patients by increasing access, improving care coordination, streamlining information and making it easier to communicate.

Part of Murray PHN's role is to help build the capacity of primary care, mental health and aged care providers, including maximising the use of digital health systems.

# Encouraging the safe use of medicines

To assess the current levels of adoption and understanding of electronic prescribing and Active Script List (a digital list of a patient's electronic prescriptions) in general practices across the region, a 16-question survey was distributed to general practices this year.

The survey also looked at barriers and facilitators that may be influencing implementation and adoption levels among practices and consumers, and approaches and resources that may encourage an increase in uptake.

Results indicated strong uptake of electronic prescriptions among clinicians and patients. However, awareness and use of Active Script List (ASL) remains limited, highlighting the need for a targeted approach towards ASL education and training to support broader adoption.

Several recommendations have been identified, including visual prompts in general practice and pharmacy settings, targeted marketing across a range of platforms, improvements in workflow practices, and engagement and education.

For digital health support and resources, visit: https://murrayphn.org.au/focus-areas/digital-health/

### Electronic prescriptions

- 100 per cent of responding general practices use electronic prescriptions
- The majority of practices reported at least 50% of their prescriptions are issued electronically
- Reduced paperwork and improved efficiency were cited as the main benefits for practices
- A majority of practices felt patients are most likely to resist due to technical literacy, a lack of awareness or a preference for paper-based scripts
  - An interesting note that age is often assumed as a barrier to digital technology, yet older people are adopting technology at an increasing rate.

### Active Script List (ASL)

- 22 per cent of responding general practices knew that patients were using ASL in their practice
- Reduced paperwork and better medication management were cited as the main benefits of adopting practices
- The majority of practices stated adoption levels were impacted by a lack of awareness, education and training for both practitioners and patients
  - The Australian Digital Health Agency has a range of resources, including online learning modules.

# Preparing for emergencies

Digital health tools can help healthcare providers to stay connected with staff, stakeholders and patients, and enable continuity of care by mobilising resources quickly e.g. running virtual health clinics by offering remote medical consultations and using My Health Record and electronic prescribing.

To help general practices be aware, prepared and digitally ready to enable continuity of care when practice environments cannot be accessed, two new resources were released this year:

- Digital health emergency and natural disaster toolkit: https://tinyurl.com/DH-emergency-toolkit
- The role satellite internet plays in business continuity and disaster recovery Q&A guide – investing in better preparedness: https://tinyurl.com/satellite-internet-QA

# First Nations

Our goal is to ensure that primary health services and the health service system across the Murray PHN region are responsive to the needs of our First Nations communities. This includes building knowledge, understanding, collaboration and relationships, while also working to reduce racism and discrimination.

# Improving health outcomes for First Nations Peoples

The Integrated Team Care (ITC) program is designed to improve health outcomes for Aboriginal and Torres Strait Islander people living with chronic conditions by providing access to care coordination, multidisciplinary care and support for self-management. It focuses on improving access to culturally appropriate mainstream primary care services and aims to help individuals better manage their conditions and live independently.

In the 2024/25 financial year, the ITC program delivered to 3488 clients:

- 7472 care coordination services
- 1602 supplementary services
- 3488 clinical services.

The top three chronic conditions supported through the program were type 2 diabetes, chronic pain and cancer, and the top three allied health services accessed were physiotherapy, podiatry and optometry. The top three specialist services accessed were ophthalmology, cardiology and sleep management.

The program supports clients through seven of the region's Aboriginal Community Controlled Health Organisations:

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

**Case study**

## CULTURALLY SENSITIVE SUPPORT DRIVES SUSTAINABLE, LIFE-CHANGING HEALTH OUTCOMES

Having previously faced challenges in controlling her type 2 diabetes, Chloe* returned to an Aboriginal medical service with hesitation due to low confidence and motivation.

Under the attentive and compassionate care of a GP, Chloe began attending regular consultations, further assisted by the wraparound support of culturally appropriate care coordinated by an Aboriginal health practitioner and outreach worker through the ITC program. This included transport to appointments and regular follow-ups to address both medical and social needs.

By removing barriers to access and providing consistent encouragement, the ITC program ensured that Chloe remained engaged and well-supported throughout her health journey.

Over the following six months and through consistent monitoring, tailored medical advice and practical lifestyle guidance, Chloe began to steadily regain control of her health, maintaining consistent blood sugar control. More importantly, Chloe experienced a meaningful transformation in her overall wellbeing, reporting that she felt significantly happier and healthier.

What started as a reluctant return to care has evolved into a story of renewed trust, personal progress and empowerment, highlighting the profound impact of empathetic, continuous and patient-centred care, and the structure and culturally sensitive support of the ITC program in driving sustainable, life-changing health outcomes.

**name changed*

Case study

## IMPROVED MENTAL, SOCIAL, EMOTIONAL HEALTH AND MOBILITY

Rose*, an older Aboriginal woman, recently moved into public housing. She hadn't previously engaged much with health services, had poorly controlled diabetes, osteoarthritis, was overweight and had to be moved around in a wheelchair with help from her granddaughter, which made everyday life difficult.

Rose was referred to the Integrated Team Care program and on assessment by a GP, referrals were made for cardiology, optometry, endocrinology and radiology to address her immediate needs.

As the team got to know more about Rose, additional issues impacting her health were discovered and included painful knee arthritis, which limited activities and affected her memory; using the wheelchair made shopping and cooking a painful chore; poor vision which was due to cataracts requiring surgery; anxiety and poor mental health; and limited family support.

Rose was provided with assistance to appropriate dietary meals five days a week, cleaning and garden maintenance, and access to art and craft activities. She also had a home medicine review, psychologist introduction and referrals to a podiatrist, optometrist, audiologist, dietitian, diabetes educator, orthopaedic surgeon and eye surgeon, with outreach support to help with transport to appointments.

Rose had cataract surgery and can now see well, has reduced her weight (which is also helping with her knee arthritis) and her diabetes is under control. She has also started a gym program to increase muscle strength and balance. Her mental, social and emotional health has improved, particularly as she no longer needs to use a wheelchair, and is more mobile using a walking stick and very occasionally, a walking frame.

**name changed*

# Increasing dementia awareness

With a shared vision of building an aged care workforce that is empowered to provide quality dementia care, Murray PHN was proud to partner with Dementia Australia and Rumbalara Elders Facility in June to deliver training funded by the Department of Health, Disability and Ageing.

The virtual reality programs, Enabling EDIE and Dine with TED, enable participants to not only see the world through the eyes of a person living with dementia, but explore strategies to support them to live more confidently.

*Pictured L-R: Norma Sahhar (Dementia Australia), Shannon Firebrace (Rumbalara Elders Facility), Maryanne Stivactas (Murray PHN) and Keanu Scott (Rumbalara Elders Facility)*


# Projects and activities

To build the capability and capacity of the healthcare workforce, Murray PHN provides a range of tailored resources, education and events for health and aged care workforce across our region.

# Capacity building through education and engagement

To strengthen our local primary healthcare workforce and help to deliver improved patient care, Murray PHN supports continuous professional development (CPD) through a range of mostly free education events. In the 2024-25 financial year, our program included:

- 150 CPD events delivered across the region, including in-person, online and hybrid
- 1781 attendees
- Communities of Practice across the region for GPs and GP Registrars, for staff working in primary mental health services and psychosocial recovery services, and health professionals working in residential aged care
- A range of topics including spirometry, dual diagnosis, communication, general practice accreditation, Aboriginal cultural safety, mental health first aid, Applied Suicide Intervention Skills Training (ASIST), chronic kidney disease, gout, oncology, dementia, wound management, motivational interviewing, palliative care, infection prevention and control, immunisation, perimenopause and menopause, trauma awareness, medication management in aged care, frailty, My Health Record and diabetes
- Collaboration with a variety of organisations to deliver CPD events including peak bodies, local health services, state and federal government departments, primary care providers, universities and other PHNs
- 18 recorded webinars with more than 705 views
- 50 editions of the Events update distributed to more than 440 subscribers, sharing education and training opportunities provided by Murray PHN.

In addition to the CPD program, an additional 53 engagement events involving 415 attendees were held which provided community, primary and other healthcare professionals with opportunities to network and participate in focus groups, workshops, meetings and information sessions focused on strengthening primary care in the Murray PHN region.

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

# Engaging with allied health workers across our region

Murray PHN recognises the importance of strong rural health teams that include allied health workers, to improve access to and the delivery of care in rural and regional areas such as ours.

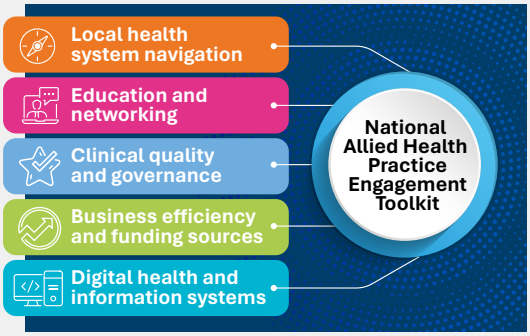
This year, we employed a dedicated role to increase our engagement with the allied health sector, in addition to establishing a monthly newsletter, hosting an online networking forum and holding initial community of practice events.

The online and in-person platforms aim to strengthen local networks and enable allied health practitioners the opportunity to come together to share knowledge and tackle the health challenges that matter most to our communities.

| | |
|---|---|
| **10** | services received Innovation grants for chronic disease management (CDM) |
| **16,741** | CDM services delivered to 3234 consumers |
| **18** | Allied health professionals enrolled for Murray PHN funded interpreter services pilot |
| **1004** | Allied health newsletter subscribers |
| **3149** | opens and 919 links clicked from four allied health newsletters |
| **2361** | Allied health webpage views (21 May - 21 Oct) |
| **217** | Allied health professional attendance at CPD training events |
| **46** | Attended community of practice events |

*Far right (L-R): Jess Ough, Paediatric Team Lead; Nicole Nitschke, Physiotherapist, Tiana Couch, OT and Hand Therapist, Lime Therapy, with Michelle Rickard, HealthPathways Coordinator, Murray PHN*

Building on the National PHN Allied Health in Primary Care Engagement Framework that launched in 2022, a new dedicated toolkit was released in May of this year. Informed by consultation with more than 500 clinicians, the comprehensive resource provides links to practical guides and information to enhance understanding, skills, business management and integration in the primary healthcare system.




**Download the toolkit:**
https://tinyurl.com/Allied-Health-Toolkit

*Left (L-R): Paul Skipper, Ashay Mudholkar and Dr Lisa Hanson*

# Developing the allied health workforce

In late 2024, Murray PHN partnered with Rural Workforce Agency Victoria (RWAV) to host a roundtable discussion on future models of early career allied health workforce support in the Goulburn Valley region. Representatives in attendance included Shepparton-based public and private health providers, the education sector, national peak bodies, and leadership and workforce staff from Murray PHN and RWAV.

Insights to better attract, retain and provide positive experiences for allied health professionals in primary care in the region were shared and the group discussed strategies currently being trialled to address barriers, build opportunities and contribute to future planning for the local allied health workforce. Through partnerships, a collaborative methodology to workforce development can be generated to bring together private and public primary care facing stakeholders and generate place-based and local solutions ready for government investment.

RWAV and Murray PHN hope to see the momentum from the discussion continue to build and positively impact care availability and delivery.

# Helping nurses transition to working in general practice

During 2024-25, Murray PHN funded nine nurses who were new to working in general practice to complete the eight-month Australian Primary Healthcare Nurses Association's Transition to Practice Program (TPP). The program aims to increase the confidence, competencies, skills and knowledge of nurses through online education, resources, support and mentoring.

***''(It) was a fantastic overview of primary health for a new to (the) area nurse."***

***''TPP provided a timely introduction to primary care nursing without being too technical or complicated for someone new to primary care and being able to complete learnings at own pace, as well as the availability of the mentor."***

# Emergency response across the region

This year, Murray PHN funded several initiatives to help primary care providers in emergency response. This included access to the Emergency Response Planning Tool (ERPT); a cloud-based application that assists general practices to better prepare for, respond to, and recover from the impacts of emergencies and pandemics. The tool guides users through a series of planning prompts from which the information generated is used to create an emergency response plan individually tailored to the practice. More than 110 practices and pharmacies accessed the ERPT through this initiative, with funding ending at the end of September 2025.

In order to expand access to COVID vaccinations, Murray PHN commissioned primary care providers - including general practices, pharmacies and residential aged care homes - to facilitate local solutions to vaccinate vulnerable populations who may experience difficulty accessing vaccination appointments. During 2024-25, more than 1900 COVID vaccinations were delivered across onsite and offsite clinics, and home-based and mobile vaccination appointments.

To ensure primary care professionals are educated and embed correct infection prevention and control (IPC) practices, we also commissioned mask fit test training, with 23 primary care organisations accessing the program. Throughout the life of the program (2023-25), 2496 fit mask tests were completed, which included 600 during 2025 for 273 individual health professionals.

# Safely navigating grief and loss for young people

This year, Murray PHN partnered with Palliative Care Tasmania (PCT) to bring their Learning Through Loss program to our region, in collaboration with the Victorian Paediatric Palliative Care Program (VPPCP) at the Royal Children's Hospital.

Most young people will encounter grief and loss for the first time before they turn 18. The free Learning Through Loss training program is for professionals and volunteers working with young people in schools and provides participants with tools to support young people to safely navigate grief and loss.

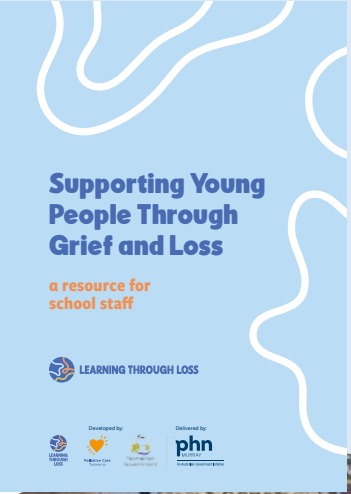
Exploring themes of grief, loss and change, the program features topics including understanding the nature of grief and its impact on young people, strategies for supporting a young person through grief and loss, and the importance of self-care.

The training incorporates the lived experiences of young people and has been delivered to schools across the Murray PHN region by experienced social workers with a background in paediatric palliative care from VPPCP and Murray PHN. So far, 15 sessions have been delivered, with an additional five sessions booked for the remainder of the year.

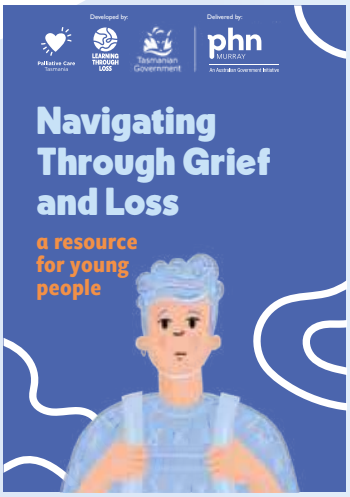
Supplementary resources, such as the children's book "What is Grief?", teen resource "Navigating Through Grief and Loss" and posters linking to digital tools extend the program's reach.

Murray PHN and PCT are in discussions about extending the reach of Learning Through Loss throughout Victoria and adapting it to different audiences.


*Book illustrations by Stephanie Spartels for Palliative Care Tasmania*




| | |
|---|---|
| **100 per cent** | of training participants said they would recommend the training to their colleagues |
| **97 per cent** | of participants said they were "very likely" or "somewhat likely" to apply all five skills |
| **78 per cent** | of training participants supported a student navigating grief and loss in two months following the training |


*"A great perspective to see grief through a child's eyes. Very well presented."*

*"Practical help that will have an immediate positive impact on students' lives."*

Anxiety

Regret

Panic

Confusion

Relief

Joy

Hopefulness

Deep sadness

A feeling of numbness and being 'hollow'

Fear

Envy

Irritability

Anger

Guilt

*"Thank you for travelling all the way to our school. Each of us learned something new and we appreciated learning all the different kinds of grief and how it connects with our school."*

*"Today's session was informative and well delivered. I can definitely see myself using a number of these strategies in the future."*

*"These books were so important to our family to receive, my child reads 'What is Grief?' regularly and connects with the children in the book. We don't have access to bookstores or libraries in our small town, so we appreciate these free books so much!"*

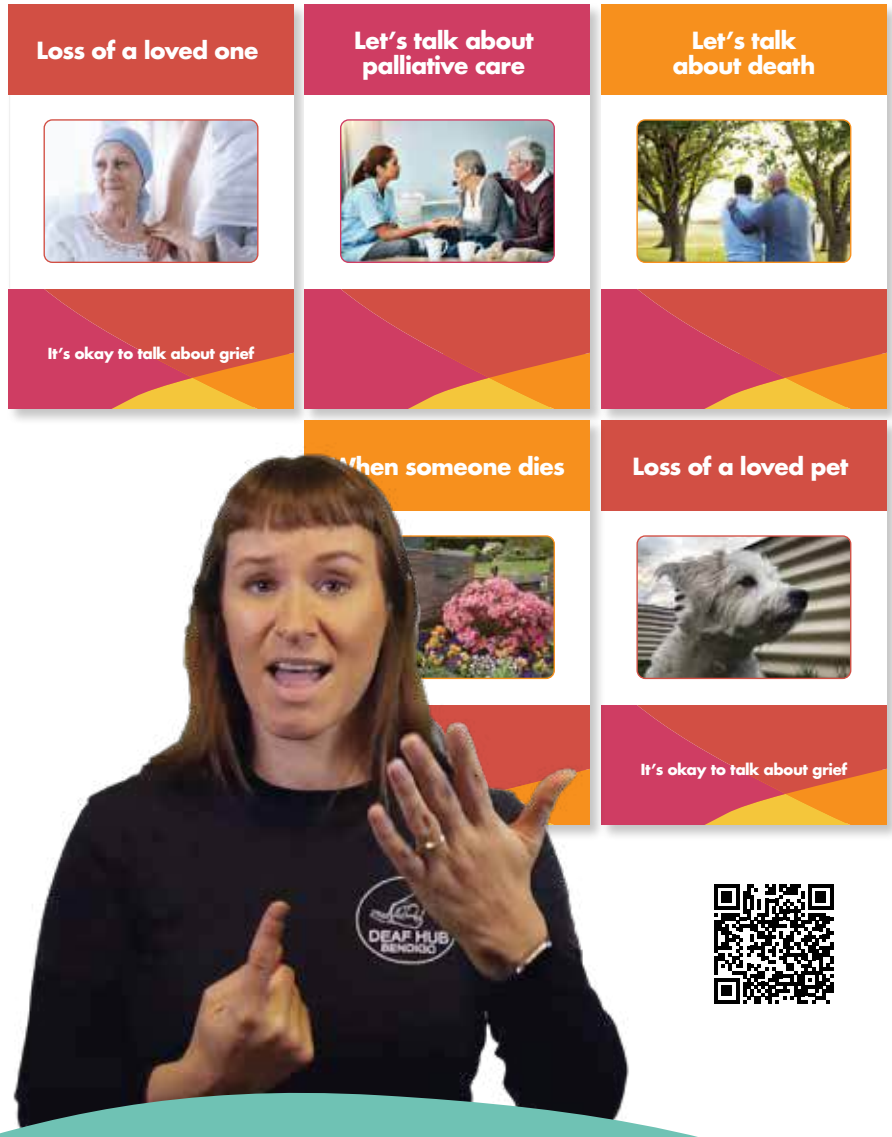
# New palliative care, death and grief resources for the deaf community

In late November 2024, Murray PHN, in partnership with Palliative Care Victoria (PCV), released a series of AUSLAN videos focusing on palliative care, death and dying, and grief and loss. The video translations, created by Deaf Hub Bendigo, accompany five Easy English booklets that were initially developed by PCV and the Victorian Advocacy League for Individuals with Disability (VALID).

These free resources aim to empower the deaf community by providing reliable and understandable information on topics often difficult to discuss. They address significant life events and concepts such as loss of a loved one and pet, palliative care and when someone dies.

By making this information available in AUSLAN, Murray PHN and PCV are helping to break down barriers, ensuring the deaf community can access important, often complex information in their preferred language.

To download the resources, visit: https://murrayphn.org.au/community/palliative-care/




# Culturally appropriate information on dementia

Murray PHN's dementia resources help individuals, families and carers navigate a new diagnosis.

To support diverse communities in our catchment, the 4-8 page booklets were translated into additional languages this year and are now available in German, Greek, Italian, Punjabi, Simplified Chinese, Tagalog (Filipino), Vietnamese, Karen, Swahili and Nepali.

The resources provide clear, culturally appropriate information about dementia, local services and support options. They can be downloaded and printed from: https://tinyurl.com/MurrayphnDementia

# Personalised accounts for pathways

This year, personal accounts were introduced for HealthPathways to enable users to easily manage their preferences and gain access to exclusive features as released. Thesee include a new AI-powered Smart Search to help clinicians find the information they need fast and the ability to track HealthPathways usage for continuous professional development hours. Cross-border and travelling professionals can now also use the same credentials to login to other HealthPathway sites that have individual account access.


# Health Hub Day pilot a resounding success

Westside Community Centre (WCC) in West Albury provides a variety of social services to help support local community members. Even though it's not a health service, staff noticed people were coming to the centre with medical presentations or seeking medical advice. Not medically trained, staff often referred those seeking care to the local emergency department.

Knowing this was not sustainable or desirable, WCC management reached out to Murray PHN to discuss the possibility of health support for their community members. That initial discussion has resulted in an innovative pilot program named Health Hub Day. The goal was to bring health services to a place where community members already felt comfortable and trusted staff, and to provide resources to help empower them to better understand their health and access affordable local care options.

To achieve this goal, Murray PHN commissioned Albury Wodonga Health (AWH) to provide a health advocacy/coordination service onsite at WCC. Each Monday became Health Hub Day, and a team from WCC and AWH met with community members to help prioritise their main health concerns and provide practical ways to navigate the health system.

Health coaching techniques were used to encourage self-advocacy and active self-management strategies. Several community members with intensive needs were provided with further support to ensure their needs were met.

Health Hub Day also supported people through referral processes, helped build confidence and shared knowledge through seven group information sessions with the assistance of local health professionals.

Feedback has been overwhelmingly positive, with 100 per cent of community members who completed a Health Hub Day patient experience survey indicating both very high levels of satisfaction with their health service experience, and improvements in understanding and managing their own health. Following on from such a successful pilot, another round of Mondays will continue as Health Hub Day at WCC with further funding provided by Murray PHN.

*Pictured L-R: Liz (Albury Wodonga Health), Tracy (Westside Community Centre) and Kylie (Albury Wodonga Health) worked together at Health Hub Day*

# Corporate

Our organisation is operated by highly competent and capable people who are committed to providing opportunities to strengthen primary care services, connect our healthcare system and develop place-based solutions.

# Building an inclusive and diverse organisation

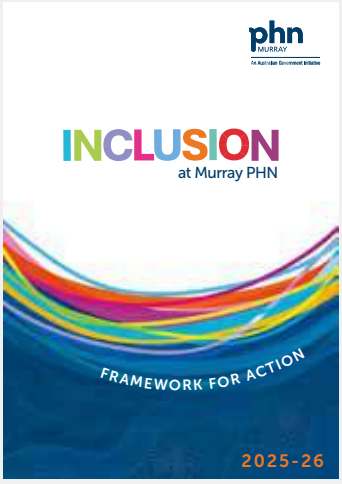
In May, we launched the Inclusion at Murray PHN: Framework for Action 2025-26 - an important development in our continued commitment to advancing diversity, inclusion and anti-racism.

The framework was developed in consultation with our employees, advisory councils and stakeholders through workshops, interviews, reviewing population data and undertaking research.

We are already committed as an organisation to three main concepts that guide our work and governance: Cultural Humility, Cultural Responsiveness and Cultural Safety. The Inclusion at Murray PHN framework aims to build on the foundational work that has been undertaken with our First Nations Health and Healing Strategy, broadening our commitment to reflect our employees and communities.

The framework supports practical improvements in how we work. The actions we are taking will strengthen our ability to champion disability and neurodiversity inclusion, improve gender equity through an intersectional lens and build cultural capability. Equally, it focuses on identifying and removing systemic barriers to employment by enhancing inclusive recruitment practices and delivering training to counter unconscious bias across Murray PHN.

Additionally, as part of Murray PHN's inclusion journey, our goal is to support the work undertaken through the First Nations Health and Healing Strategy that is in parallel (as it relates to the organisational development activities) to develop a truly inclusive workplace.




**Find out more about inclusion at Murray PHN by reading our framework:**
https://tinyurl.com/inclusion-framework

# Inviting your feedback

We welcome feedback from our stakeholders and community members, with each submission recorded and responded to. Compliments, complaints and suggestions can be submitted in a variety of ways, including through our website. We enjoy receiving feedback as it helps us understand where we are adding the most value and how we can improve to support our region's clinicians and health of our communities. This year, we've received a variety of feedback on our programs, services and employees, including:

*"My sincere thanks for all the help and guidance you've provided today regarding the MyMedicare GPACI program. Your support in demonstrating how the program works was incredibly helpful, and I truly appreciate the time you took to ensure I understood everything. Your help has been invaluable, and I am grateful for your support."*

*"I want to take a moment to extend my heartfelt thanks for the invaluable contributions you've made to the Initial Assessment and Referral (IAR) for mental health project. Your expertise, dedication and unwavering commitment have been pivotal in implementing and evolving the IAR across the Murray region. It's clear that your efforts have made a meaningful difference and your professionalism has not gone unnoticed. Thank you for your time, insight and generous collaboration."*

*"The resources, education and support from your team relating to MyMedicare are on point. There just seems to be so much to get our heads around. I really appreciate all your help."*

# Murray PHN turns 10

Primary Health Networks (PHNs) began operating across Australia on 1 July 2015, taking over from the Medicare Locals that preceded them.

When they were introduced, the 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 maintain a focus on improving the health of people at-risk of poor health outcomes.

As new Primary Health Network organisations, their key functions were commissioning, coordination and capacity building. In our region, the work was challenging, with many twists and turns along the way, including COVID-19, bushfires and floods.

We started with 54 employees and a budget of $35m, to now having more than 135 employees and a budget of almost $90m per annum.

The beating heart of Murray PHN is the great people who do our work. Our staff are passionate, skilled and dedicated to delivering our commitments to our funders, providers and communities in which we live and work.

Our teams took a break to celebrate the organisation's 10-year anniversary with morning tea at our Shepparton, Bendigo, Mildura and Albury offices on Tuesday 1 July. We also took the opportunity to send our thanks to our many partners for all they have done to help people living in the Murray PHN region to remain well and receive care as close to home as possible.

Murray PHN looks forward to continuing to support our providers and communities through our place-based approach to commissioning, coordination and capacity building, and by working at system, service and patient care levels to strengthen, shape and deliver better health outcomes for people living locally.




10
phn
MURRAY


10 years
of Murray
PHN

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# Murray PHN recognises staff service milestones

To coincide with our 10-year anniversary, we were pleased to launch our Employee Service Recognition Program in July.

This program recognises and celebrates the valued ongoing contribution and achievements of employees who have completed the significant service milestones of seven, 10, 15, 20 and 25 years working with Murray PHN.

10+ year milestones were celebrated across all locations as part of our 10-year anniversary celebrations on 1 July. Service milestones will now be celebrated annually as part of the organisation-wide end of year celebrations.

Employees who have been with Murray PHN for 10 years (and in some instances, even longer as employees of Loddon Mallee Murray Medicare Local) have each shared insights into why they have continued to be part of and contribute to the organisation's work.

*Pictured L-R: Some of the Central Victoria team celebrating service milestones - Ros Bester, Katrina van Dillen, Emma Healion, Sharlene Green, Chris Fishley and Alistair Bonsey*

### Aida Escall - 11 years

**What is the most rewarding aspect about your work in community engagement?**

What I find most rewarding about being involved in community engagement is the opportunity to strengthen human connections to the PHN work. Meaningful and impactful work begins with listening, tapping into the experiences of people. These insights shape our planning and design of initiatives aimed at improving health outcomes for those in our catchment. Through many consultations, I've seen powerful transformations occur almost every time. What begins as an individual perspective often evolves into a shared narrative, a 'story of us'. That shift, that collective understanding, is what I find most fulfilling.

### Sharlene Green - 10 years

**Do you have a personal highlight of your time working at Murray PHN?**

In 2016, through Partners in Recovery funding, I worked with Mental Health Victoria to offer the Certificate IV in Mental Health Peer Work in Bendigo to people with a lived experience of mental illness. Previously, people living in our region had to travel to Melbourne and pay significant fees to do this course. I also worked with local organisations to set up volunteer placements, so all the course's practical requirements could be met. Murray PHN supported people who lived out of Bendigo with travel and accommodation costs, making the course even more accessible. It's a personal highlight that many went on to gain employment from this opportunity.

### Cherrona Chambers - 11 years

**What do you like most about working at Murray PHN?**

What I like most is the people. My co-workers are friendly, easy to talk to and fun to work with. The overall vibe is positive and relaxed, and the culture encourages teamwork, respect and just being yourself.

### Emma Healion - 12 years

**What do you enjoy most about living and working in a regional/ rural area?**

I'm fortunate to have a role that includes travel, so I get out and about. I enjoy the diversity of nature found across the catchment and appreciate that it's so accessible. From watching pelicans glide along the Murray at Mildura, to the small wildflower treasures seen on a bushwalk at Leanganook, there's natural beauty around every corner.

**Alistair Bonsey - 12 years**

**Of all the programs you have been part of, which outcomes or impacts have brought you the most personal satisfaction?**

A few things stand out. Murray PHN led the development and implementation of the Stop Stigma Charter that encouraged organisations to embed evidence-based actions to tackle stigma in mental health. I'm proud of the way that we have oriented the mental health services we commission to increase equity of access to services for people living rurally, or who otherwise experience barriers in accessing services, such as an inability to pay. And currently, I'm really enjoying working with the team to establish creative therapy services in Albury/Wodonga, Castlemaine and Robinvale, with the goal of building in creative therapies to Murray PHN's suite of mental health services.

**Ros Bester - 16 years**

**What is the most interesting part of your work at Murray PHN?**

The most interesting part of my work is seeing the new initiatives and funding coming from the department and how the organisation proactively reshapes its priorities and focus to effectively implement them.

**Matt Jones - 20 years**

**How has the focus of our work at Murray PHN grown and evolved over the last 10 years?**

The focus of our work at Murray PHN has grown and evolved over the past 10 years in three ways. Organisationally we have grown in breadth of activity, scale and quantum of funding and sophistication in our processes and capability - so many more moving parts coming together in different areas simultaneously. This means we have increased scope and capacity to do more and do it effectively. Our responsibilities have expanded from a focus on integrating coordination between primary care and acute care to now also include increasing roles and requirements to enhance service provision and integration in mental health and aged care. Consequently, growth in our funding and responsibilities is evidence that governments have recognised our value and capacity for connecting services into place-based local health systems. Our role is to implement national programs in our communities and tailor the Australian healthcare system to respond to local needs.

# First Nations Elder engaged to lead artwork project

This year, Murray PHN engaged First Nations art curator and Yorta Yorta Elder, Aunty Janet Bromley to help catalogue our Aboriginal artwork collection and ensure it's displayed appropriately and with the correct artist information.

As part of this project, Aunty Janet visited each of Murray PHN's buildings to review our artwork and office layouts.

Chief Strategy and Performance Nick Shaw said, "It was lovely to see Aunty Janet in the North East region as part of the project to understand the First Nations artwork that Murray PHN holds. This is a lovely project - registering the work we have throughout our locations and broadening our knowledge of the artists whose work we enjoy. Looking forward to the sharing of Aunty Janet's work."

*Pictured L-R: Erin Vassallo, Aunty Janet Bromley and Nick Shaw*

# Murray PHN welcomes review of PHN Program

In December 2024, the Department of Health, Disability and Ageing announced a review to examine the PHN Program business model in the context of the changing operating environment since the inception of PHNs in 2015, and to ensure the program is structured to meet government objectives. These included improving the efficiency and effectiveness of health services for people, particularly those at risk of poor health outcomes; and improving the coordination of health services, and increasing access and quality support for people.

Murray PHN welcomed the opportunity to contribute to the review, which we saw as a critical prompt to strengthen the ability of PHNs to deliver effective, place-based primary healthcare.

Our submission in January 2025 strongly advocated for a PHN model that recognises the importance of the regional context and prioritised place-based care that empowers PHNs to connect local services with those who need them most.

We saw this review as an opportunity to address the challenges within our existing PHN model, but also to strengthen PHN capacity to address the inverse equity gap that exists throughout regional Australia, between need and access to care.

Murray PHN maintained that investing in PHNs would help uphold and strengthen the availability of universal access to healthcare for all Australians, wherever they may live, and offered four main recommendations:


**Recommendation 1**
Address unique rural health challenges through regional PHN models that provide place-based solutions


**Recommendation 2**
Empower PHNs to coordinate services to enable localised healthcare systems at a community and regional level


**Recommendation 3**
Invest in flexible, long-term funding for place-based care


**Recommendation 4**
Build a connected, preventative and community-centred regional mental health system

At the time of writing, the Department of Health, Disability and Ageing had yet to publicly announce its response to the review. To read the full Murray PHN submission, visit: https://tinyurl.com/PHN-Review

# Continuously improving our information security

Murray PHN has continued to strengthen our commitment to information security over recent years with a deliberate investment in people, processes and technology as we move toward a mature Information Security Management System aligned with international best practice.

All Primary Health Networks across Australia, including Murray PHN, are progressing toward certification against the ISO27001:2022 international standard for information security.

The work to achieve this certification includes implementing and improving access controls, data protection, incident response planning, monitoring and management of cybersecurity threats, and most importantly, building staff capability.

As Murray PHN is the custodian of anonymised health data from the provision of primary care services and other sources, it is critical we effectively safeguard all the information we gather and analyse.

By embedding robust security controls, clear governance and routine testing, our PHN protects the privacy and confidentiality of the data we hold, preserves continuity of essential services, and reduces operational and financial risk for local providers and the PHN.

Final certification against the globally recognised ISO27001:2022 is planned for early 2026.

# Launching our first Reconciliation Action Plan

In December 2024, Murray PHN received endorsement of its first Reflect Reconciliation Action Plan (RAP) by Reconciliation Australia. This achievement aligns us with a network of organisations across Australia that have RAPs to advance reconciliation with First Nations Peoples.

To launch this significant milestone, employees were invited to participate in eight in-person Learning Circles held across the catchment. This created a space for deeper conversations and collaboration, where we explored reconciliation in meaningful and creative ways, and determined how we can embed reconciliation in our daily work and sphere of influence.

The RAP is an integrated deliverable created and designed from the First Nations Health and Healing Strategy and our next steps will focus on embedding reconciliation into everyday practice across the organisation, including strengthening relationships with First Nations communities, incorporating learning into policies and processes, and continuing to explore opportunities in procurement, professional development and community engagement.


**Download:**
https://tinyurl.com/MurrayPHN-Reflect-RAP

# Finance

This year, Murray PHN has continued to grow, with revenue of $74m and 116 full-time equivalent (FTE) employees.

From the $74 million funding we received in the 2025 financial year (FY25), we delivered 73 per cent directly to our communities and providers through commissioned service activities in our catchment - a significant $54 million. During the FY25 year, we funded 161 providers, through a total of 281 contracts, across 87 unique activities.

The dedication and passion of our employees in reaching this outcome reflects our shared commitment to the work as a Primary Health Network. Our funding enables vital initiatives in coordination and capacity building, delivered by the experienced and capable teams operating throughout our region.

The year saw us secure new funding from the Australian Government Department of Health, Disability and Ageing - the General Practice Incentive Fund initiative to co-design and implement a comprehensive plan for improving access to primary care in rural communities in the Loddon Mallee with a focus on Swan Hill, Rochester and Stanhope. The whole-of-system plan developed with professional and community stakeholders includes embedding sustainable models of multidisciplinary team-based care, with wraparound workforce supports and expanded training pathways. Murray PHN has also secured additional funding to begin scoping for a new project site based in the Wimmera region that will be completed through partnership with Western Victoria PHN.

We were successful in securing funding under a new Department of Health, Disability and Ageing grant to commission Youth Mental Health headspace Demand Management and Enhancement activities aimed at reducing wait times and funding for capital enhancements across four headspace locations in our catchment.

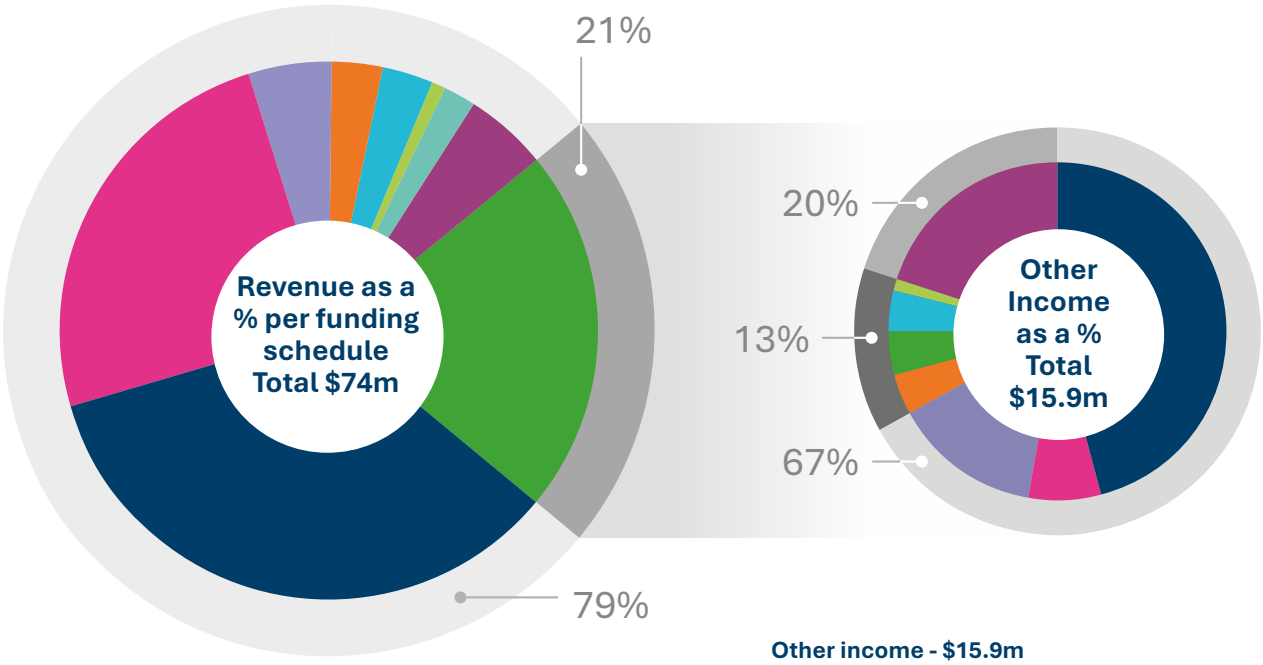
Murray PHN has consistently strengthened and expanded the professional workforce essential to our organisation, guided by our core objective: to improve the health outcomes for the people who live in our communities.

We have taken a strategic approach to building financial equity, establishing a solid foundation that equips us to navigate potential challenges and sustain the vital work we undertake across our region.

| | |
|---|---|
| Total Revenue | $74,013,448 |
| Total Expenditure | $73,768,332 |
| Operating Surplus | $245,116 |
| Equity | $6,554,868 |

| **Total Revenue:** | **$M** |
|---|---|
| Core | $18.5 |
| Primary Mental Health & Alcohol and Other Drugs | $25.7 |
| Commonwealth Psychosocial Support | $3.9 |
| Aged Care | $3.8 |
| Integrated Team Care | $2.0 |
| After Hours | $2.0 |
| Medicare Urgent Care Clinic | $1.6 |
| PHN Pilots & Targeted Programs | $0.6 |
| Total Department of Health, Aged Care and Disability | $58.1 |
| Other Income | $15.9 |
| Total | $74.0 |

| | |
|---|---|
| The work we commission | $53.8M |
| Our People | $16.9M |
| Administration | $2.9M |
| Our Operating Surplus | $0.2M |




**DHDA - $58.1m**

| | |
|---|---|
| 35 | Primary mental health and alcohol and other drugs |
| 25 | Core |
| 5 | Commonwealth psychosocial support |
| 3 | Integrated Team Care |
| 3 | After hours |
| 1 | PHN pilots and targeted programs |
| 2 | Medicare Urgent Care Clinics |
| 5 | Aged care |

**Other income - $15.9m**

| | |
|---|---|
| 21 | Other Income |

**Other income - $15.9m**

State Funding

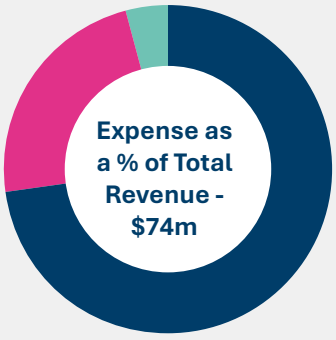
| | |
|---|---|
| 46 | Priority Primary Care Centres |
| 7 | Department of Education |
| 14 | Other Programs |

Other Funders

| | |
|---|---|
| 4 | Other PHN Funders |
| 4 | Community |
| 4 | Interest |
| 1 | PHN Exchange |

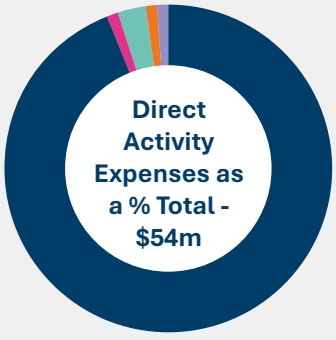
Federal Funding

| | |
|---|---|
| 0 | Australian Digital Health Agency |
| 20 | Workforce Prioritisation and Planning |




| | |
|---|---|
| 73 | Direct Activity |
| 23 | Employee Expenses |
| 4 | Administration |
| 0 | Operating Surplus |

For our detailed Financial Report, visit: https://tinyurl.com/MurrayPHN-finance-report-2025




| | |
|---|---|
| 94 | Commissioned Services |
| 1 | Direct Integrated Team Case Activity Costs |
| 3 | Building Capacity and Capability |
| 1 | Needs Assessment, planning and evaluation |
| 1 | Direct patient costs |

phn MURRAY

An Australian Government Initiative

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