

CHRONIC CONDITIONS MANAGEMENT SERVICES REDESIGN REPORT

November 2025



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Executive summary

The Department of Health, Disability and Ageing requires regular review of commissioned services and models of care. Larter Consulting was engaged by Murray PHN to support the review of its Chronic Conditions Management (CCM) Services Program and make recommendations to inform changes. This report presents redesign recommendations to improve access, equity, integration and sustainability across Murray PHN's catchment.

The redesign has been grounded in a multi-method review of regional data, policy, and extensive engagement with providers, consumers and advisory groups. It confirms strong commitment across the system, alongside persistent workforce shortages, uneven service availability, and barriers that disproportionately affect people in outer regional and rural communities.

Two complementary models were proposed:

- Regional Access Model for larger towns with established clinical infrastructure, offering coordinated one-to-one care and structured group programs.
- Outreach Access Model for remote, outer regional and underserved populations, combining visiting clinicians with telehealth enabled care, supported by practical enablers such as reliable digital access and appropriate delivery spaces.

The proposed models were adapted and used by Murray PHN to inform the CCM services redesign.

Integration efforts prioritise care navigation, acknowledging that many providers already undertake care coordination within services. Stakeholders identified navigation across services and systems as the greater gap. Place based navigator roles are therefore recommended over a central hotline, as vulnerable consumers are unlikely to initiate phone contact or persist without local, proactive support.

Program focus remains on chronic obstructive pulmonary disease (COPD), diabetes and cardiovascular disease, with the option to phase in arthritis and osteoarthritis in future commissioning cycles given their burden and cost. Service delivery shifts to include group education and scheduled follow ups at three-, six, and 12-months to sustain outcomes. Digital and system enablers include strengthened HealthPathways, shared care planning and alignment with MyMedicare and other national reforms.

Workforce sustainability is addressed through minimum capability standards, cultural safety and trauma-informed training, supervision, professional development and communities of practice. Funding recommendations maintain free access for consumers while introducing compliant hybrid models such as shared funding, capped sessions and variation agreements, alongside outcome focused key performance indicators (KPIs) and recognition of travel and administrative time.

Equity is advanced by directing commissioning to high need locations identified through Murray PHN's health needs assessment data, partnering with Aboriginal Community Controlled Health Organisations (ACCHOs), actively linking with bicultural support and translated resources, and delivering flexible, trauma-informed care in trusted community settings. A refined Minimum Data Set (MDS) was recommended to reduce reporting burden while adding fields that reveal patient and service outcomes, equity, timeliness and workforce effort, aligned with national frameworks.

Together, these changes provide a practical, scalable pathway to deliver consistent, person-centred chronic conditions management care, that is locally responsive and demonstrably effective.

Recommendations summary

The following recommendations translate project findings into clear actions for strengthening and sustaining chronic conditions management (CCM) services across the Murray PHN region. They focus on six strategic priorities to ensure equitable, coordinated and enduring care across the catchment: Program focus, service models, integration, equity, workforce and funding.

Program focus and prioritisation

- Continue prioritising COPD, diabetes, and cardiovascular disease as core program areas
- Consider including arthritis and osteoarthritis in future funding rounds, given rising prevalence and health system impact
- Use of updated population health data to guide evidence-based commissioning
- Maintain flexibility for providers to address emerging priorities such as multimorbidity and physical–mental health intersections.

Service delivery and models of care

- Implement two complementary models:
 - Regional access model for larger towns with existing clinical infrastructure
 - Outreach access model for remote or outer regional towns and underserved populations, such as those experiencing housing insecurity, where access to GPs and health infrastructure is limited
- Adopt group-based programs as the default model of care for diabetes education, reserving one-to-one sessions for clients with clinical or accessibility barriers
- Introduce follow-up contact at three-, six-, and 12-months post-program to support sustained outcomes
- Expand telehealth and hybrid outreach and explore social prescribing to address psychosocial determinants of health.

Integration and coordination

- Fund place-based care navigators to assist consumers in accessing and staying engaged with services
- Continue to update and promote the use of HealthPathways to support referral consistency, including integration with mental HealthPathways
- Implement processes within Murray PHN to ensure coordination, unified communication and avoid duplication
- Create local interdisciplinary forums and cross-sector networking events (including pharmacy) to share learning and improve collaboration.

Access and equity

- Direct commissioning to identified high-need areas using relevant data
- Promote partnering with ACCHOs to fund culturally led health promotion and increase 715 Health Check uptake
- Support multicultural access through bicultural workers, multilingual resources and community-based engagement
- Deliver flexible, trauma-informed services in accessible community settings for people experiencing disadvantage or housing insecurity
- Embed equity metrics in reporting to track reach and outcomes.

Workforce sustainability and development

- Establish minimum capability standards for providers, including cultural safety and trauma-informed care training. Enable professional development, supervision and training, such as motivational interviewing, trauma-informed care or mental health first aid
- Establish communities of practice and encourage shared workforce models to stabilise supply
- Develop regional training pipelines through partnerships with tertiary institutions and placements i.e. Connecting the Docs.

Funding and accountability

- Maintain free consumer access
- Explore compliant hybrid funding models, such as:
 - Shared funding – PHN covers initial and group sessions; MBS covers ongoing one-on-one consultations
 - Capped sessions – Consumers receive a fixed number of PHN-funded sessions (e.g. six total: one initial, two individual, three group); additional sessions billed via MBS
 - Funding agreements – define PHN- vs MBS-funded components for transparency
- Replace contact-based KPIs with outcome-based measures focusing on self-management, reach and coordination
- Include travel and administrative time as eligible delivery costs to recognise true service effort.

Introduction

Murray PHN commissions programs to improve chronic conditions health outcomes across its catchment. Consistent and fit-for-purpose data are required to evaluate program reach, coordination, quality and equity. This paper outlines the data currently collected, assesses its relevance, identifies gaps and provides evidence-based recommendations for a refined minimum data set.

The current Chronic Conditions Management (CCM) Services Program funds community-based services across four subregions, with priority given to patients with chronic obstructive pulmonary disease (COPD), diabetes and cardiovascular disease (heart failure). All services are provided free of charge to consumers. Providers are not permitted to bill Medicare for the same appointment and PHN funding cannot be used to cover Medicare gaps or private co-payments.

The Murray PHN region covers approximately 100,000 square kilometres and includes a diverse mix of urban, rural and remote communities with a population of approximately 650,000 people. The region faces significant health challenges in the prevention and management of chronic conditions, such as asthma, heart disease, diabetes and kidney disease. Rates of multimorbidity are notably higher than national averages, particularly in subregions such as Robinvale, Mildura and Wodonga. Chronic conditions are more prevalent among Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse groups (including Italian and Greek speaking communities), and people experiencing socioeconomic disadvantage or homelessness.

Despite the involvement of 24 service providers under Murray PHN's CCM Program, challenges remain in delivering coordinated, accessible, and culturally appropriate care, especially in rural and underserved areas. Workforce shortages and difficulties with health system navigation continue to exacerbate the burden for people living with chronic conditions.

To address these systemic issues, Murray PHN and its partners have implemented initiatives such as the Integrated Health Network Alliance, Sustainable Rural Healthcare Hubs and nurse practitioner outreach models. While these efforts have strengthened local capacity, fragmented service delivery and limited multidisciplinary collaboration persist. This redesign project builds on previous work to support more integrated, sustainable, and equitable models of care tailored to the needs of the Murray PHN region.

Larter Consulting's role

Larter Consulting (Larter) was engaged by Murray PHN to support the review and redesign of the Chronic Conditions Management (CCM) Services Program. Larter's role was to assess current service delivery and data collection processes, identify opportunities to improve integration and evaluation, and guide the development of new models of care that reflect regional needs and national best practice.

This work included reviewing program structures, analysing service models against the Quintuple Aim Framework, engaging stakeholders and developing an Evaluation Plan and Minimum Data Set (MDS) to monitor client outcomes and performance over time.

Methodology

The redesign process for the Murray PHN Chronic Conditions Management (CCM) Services Program followed a multi-method approach integrating desktop review, service data analysis and stakeholder engagement. The methodology ensured that the redesign recommendations were grounded in evidence, co-design principles, and regional realities.

Desktop review

A comprehensive desktop review was undertaken to identify best practice approaches and contextualise chronic condition management across the Murray PHN catchment. The review drew on:

- national and state policy frameworks, including the National Strategic Framework for Chronic Conditions and national digital health initiatives
- Murray PHN strategic and operational documents, such as the Chronic Health Conditions Health Needs Assessment (2024), Needs Assessment 2025–28, Population Health Series Reports (Homelessness, Multicultural Populations, First Nations Health and Healing), Program Guidelines: Chronic Conditions Management Services 2025–26, and the Digital Health Maturity Assessment for Allied Health (Semantic Consulting)
- commissioned research and case studies, including internal care coordination analyses, CCM client experience and outcome surveys, and service-level case studies across multiple sites (e.g. Robinvale, Albury and Ouyen)
- public health datasets, including AIHW, Victorian Population Health Survey and PHIDU data
- academic and technical sources, including O'Neill et al. (2025). Investigating high-risk rural regions for potentially preventable hospitalisations: A method for place-based primary healthcare planning.

Stakeholder engagement and codesign

Stakeholder engagement was central to the redesign process. Larter worked closely with Murray PHN's internal working group, commissioned service providers, clinical and consumer advisory groups to ensure that findings and recommendations reflected lived experience and local context. Larter sought to be as inclusive as possible throughout the consultation process, ensuring that engagement opportunities were accessible and representative within the available scope and timeframe.

Steering group

A Project Steering Group was established to guide the redesign process. Membership included representatives from:

- Murray PHN's Complex and Integrated Care team; Senior Manager - General Practice and Reform; Program Lead – Allied Health and Primary Care Engagement; Senior Manager – Planning, Projects & Insights; Senior Manager - Digital Health and Connected Care; and Medical Advisor
- Larter Consulting project team.

The Steering Group met on average, fortnightly from May to October 2025. Larter presented emerging findings and sought feedback at each meeting. These discussions informed refinements to the methodology and directly influenced the development of the proposed service model designs.

Broader engagement

Complementary engagement activities included:

- allied health provider survey (n = 30): capturing perspectives on service access, workforce, coordination and client needs
- consultations with commissioned providers across the four subregions (n = 15)
- four advisory (clinical and consumer) workshops (September 2025): Mildura, Bendigo, Shepparton and Wodonga
- four community workshops (September 2025): Heathcote, Albury, Ouyen and Shepparton.

Together these activities provided a rich mix of quantitative and qualitative insights, testing system performance, capturing practical examples, and exploring local innovations in service delivery.

Subregional focus

Early insights highlighted that the four Murray PHN subregions of Central Victoria, Goulburn Valley, North East and North West; each demonstrated distinct characteristics, needs and data patterns. This was consistent across both service data and stakeholder feedback.

Consequently, the project approach was refined to assess each subregion individually, ensuring that the analysis and recommendations reflected local variation and that proposed service models were appropriately tailored to each subregion's context.

Service model and evaluation planning

A key component of the methodology was the review and refinement of the existing Minimum Data Set (MDS) used across Murray PHN's chronic condition management program. This process examined the consistency, relevance, and use of data collected by commissioned service providers to evaluate reach, quality and outcomes. The review was guided by national chronic condition management frameworks and the Quintuple Aim principles, ensuring alignment with best practice in performance measurement and program monitoring. The analysis identified opportunities to:

- strengthen data capture on equity, access and outcomes
- simplify reporting while maintaining accountability
- improve visibility of regional variation to support responsive commissioning.

Recommendations from this analysis informed proposals for a refined MDS, ensuring that administrative demands do not detract from clinical service delivery.

Synthesis

The desktop review, service data analysis and engagement findings were triangulated to identify consistent patterns, regional nuances, and practical levers for change. This synthesis informed the design of two proposed integrated models of care and recommendations to strengthen workforce, coordination and funding frameworks across the catchment.

Headline findings

What we heard: Experiences and perspectives

Consultation and survey feedback revealed a health system that is dedicated but overstretched, working hard to deliver chronic condition care despite persistent structural barriers. Across the catchment, providers, community members and advisory council participants described similar challenges: workforce shortages, service gaps, inequitable access and rising psychosocial complexity.

Cost and distance were repeatedly cited as the biggest barriers to care, especially for people living in outer-regional and rural areas. Workforce shortages and burnout are widespread, with many services reporting that they routinely, “see more people than we’re funded for”. Stakeholders consistently said that chronic conditions management relies heavily on goodwill and local relationships rather than on system design or sustainable funding.

These perspectives were consistent across multiple sources and confirm that the region’s challenges are systemic, not isolated. They point to a system striving to deliver high-quality care but operating under increasing strain, with limited workforce capacity, fragile coordination and uneven digital readiness.

- *“Almost nine in ten providers say clients have unmet needs ... hardest to reach are Aboriginal and Torres Strait Islander communities, CALD communities, and people with mental illness.” - Provider survey*
- *“Distance and transport are the main barriers - we lose people between referral and first appointment.” - Service Provider, North West Victoria*
- *“Recruitment in small towns is almost impossible. We need shared staff models and peer support.” - Program Manager*
- *“Consumers need a person, not a phone number. A navigator who walks alongside them makes the difference.” - Advisory Committee Workshop*
- *“Hospitals should be referring back to community health services to help people manage after surgery.” - Advisory workshop, North East*
- *“We need stronger prevention programs, otherwise demand just keeps growing.” - Regional workshop, Goulburn Valley*
- *“Interpreters are slow and hard to access ... people resort to Google Translate.” - Workshop, North West outreach.*

System-wide insights

Workforce under pressure

Workforce fragility emerged as the single greatest constraint. Recruiting and retaining skilled staff, especially in smaller LGAs is difficult and burnout is common. Nearly half of survey respondents (44%) said workforce issues have a moderate to extreme impact on service delivery. Some providers reported long waitlists, including one service in Swan Hill with more than 100 people waiting for diabetes education. Annual funding cycles exacerbate instability. Staff leave between contracts, disrupting continuity of care and institutional knowledge.

Rising demand, static funding

Eighty-seven per cent of surveyed providers said their clients have unmet needs, and 83 per cent said clients need more support than they can currently offer. Several services reported that urgent care clinics are increasingly being used for chronic conditions that should be managed in primary care.

Waitlists are now a routine part of service operations, rather than an exception.

Care coordination: Valued but fragile

Care coordination is widely viewed as critical to achieving continuity of care, yet it remains patchy and often depends on local relationships or individual champions. Three-quarters of survey respondents rated coordination as good or excellent, but consultations showed that this often relies on GP-led coordination, which is limited by time, funding and bulk-billing availability.

Where coordination works well, such as navigator roles in Goulburn Valley or multidisciplinary teams (MDTs) in Robinvale, it is because of local innovation, not system design.

Digital readiness

Digital solutions such as HealthPathways and telehealth are strong enablers of efficiency and reach, but digital readiness is uneven across the Murray PHN catchment. Connectivity, device access and digital confidence vary widely, especially among older people and in low-income or remote communities. In Central Victoria, poor internet connectivity limits the reliability of telehealth; in the North West, older consumers often prefer in-person care due to discomfort with technology.

System enablers and constraints

Enablers:

- Navigation and coordination roles that guide consumers through the system
- Multidisciplinary teams (MDTs) with internal referral pathways that reduce drop-off between appointments
- Telehealth and HealthPathways, improving consistency and reach where digital capacity allows
- Pharmacies acting as accessible local points of care for medication management and prevention.

Constraints:

- Short-term contracts and annual funding undermine workforce retention and service continuity
- Contact-based KPIs and heavy reporting requirements reduce clinical time and do not reflect complexity
- Poor hospital discharge and feedback loops weaken post-acute care coordination
- Interpreter shortages and digital exclusion further limit access for priority populations.

Regional variation: Same issues, different realities

Early analysis and consultation confirmed that the four subregions of the PHN catchment each have distinct needs, data profiles and health system challenges. The Murray PHN (2024) Chronic Health Conditions Health Needs Assessment identified the North West and Goulburn Valley subregions as having the highest need and lowest supply of chronic conditions management services:

- Goulburn Valley has the largest population in the catchment, the highest rates of heart and lung disease and the largest population experiencing homelessness
- North West Victoria is the most socioeconomically disadvantaged subregion, with the largest multicultural and First Nations populations and the highest disability rates

These quantitative findings align closely with what providers and consumers told us through consultations and surveys: the same system-wide issues, workforce shortages, access barriers and inequity, manifest differently depending on geography, population and service configuration.

Central Victoria

Affordability and GP availability dominate in this subregion. Annual funding cycles make staff retention difficult, and poor internet connectivity limits telehealth reliability. Coordination often depends on GP referrals, but awareness of chronic condition management programs varies between practices. Several providers also noted growing diabetes prevalence and difficulties linking clients to preventive education early in their disease journey.

Goulburn Valley

Recruitment is the key pressure here, compounded by transport challenges and the diverse needs of CALD and refugee populations. Providers described urgent care being used for routine chronic conditions management, reflecting both affordability and workforce barriers. CALD and refugee clients commonly present with chronic pain and diabetes, conditions not fully covered by current CCM program scopes. The PHN-funded refugee health system navigator program stands out as a strong enabler for improving access and continuity.

North East Victoria

Cross-border fragmentation between Victoria and New South Wales, particularly around Albury–Wodonga, creates service gaps in hospital discharge and follow-up. Many older people live alone, experience loneliness and face digital exclusion when trying to use My Aged Care or telehealth platforms. Providers described mixed levels of integration and limited communication between hospitals and community health services. A pharmacist–diabetes educator noted that recent MBS wording changes excluding pharmacists from CCM plan claiming have reduced their ability to contribute to multidisciplinary care.

North West Victoria

The most severe pressures are concentrated here. Long waitlists, extreme workforce shortages and vast travel distances make service delivery difficult. For example, in Ouyen, the only optometrist visit occurs once a year via the Royal Flying Doctor Service, otherwise residents must travel 100km to Mildura. Digital connectivity is poor and psychosocial needs are acute.

Providers emphasised that, “we see more than we’re funded for”, has become the norm. High diabetes prevalence, limited specialist access and isolation make this subregion the most vulnerable to service collapse if workforce gaps persist.

Implications for equitable commissioning

These regional findings are reinforced by Figure 1, which maps the types and distribution of current Murray PHN commissioned chronic condition management services across the catchment. The map highlights variation in service availability by LGA. For example, Swan Hill has only Murray PHN commissioned diabetes education and chronic disease nurse services, with no allied health provision, such as podiatry or dietetics. This spatial gap analysis suggests an opportunity for review during the next commissioning cycle to ensure more equitable access across the region. Differences highlight that while the drivers of inequity are common, the solutions must be localised, balancing system-wide frameworks for workforce, coordination and funding with subregion-specific approaches that reflect each area's population, service footprint, and access realities.

Figure 1. Murray PHN Chronic Conditions Management Service types across the catchment area.



Implications and priorities for redesign

The synthesis of data, engagement and review points to a clear conclusion: the Murray PHN region needs a coordinated, flexible and equitable model of chronic conditions management that strengthens workforce sustainability, integrates mental and physical health and makes digital care more inclusive.

Priority directions for redesign

- Prioritise early intervention
- Strengthen care coordination
- Bridge digital and cultural divides
- Integrate mental and physical health
- Expand and support the allied health workforce
- Reform funding and KPIs.

Detailed recommendations and implementation considerations

The following recommendations expand on the summary provided earlier, outlining the operational steps, rationale and implementation considerations to support delivery of the Regional Access and Outreach Access Models across the Murray PHN catchment. They are structured around six key domains: program focus, service delivery, integration, equity, workforce and sustainability.

1. Program focus and prioritisation

Recommendation summary

Continue prioritising chronic conditions of highest regional impact, COPD, diabetes and cardiovascular disease, while progressively integrating arthritis and osteoarthritis in future commissioning cycles, guided by data on prevalence and burden.

Actions

- Maintain COPD, diabetes and cardiovascular disease as core chronic condition priorities
- Consider arthritis and osteoarthritis as a fourth core chronic condition in future funding models, supported by robust prevalence and cost-of-illness evidence
- Use updated population health data to guide investment, ensuring equity and alignment with local need
- Retain flexibility for providers to respond to emerging and co-occurring conditions such as multimorbidity and mental–physical health intersections.

Rationale

These conditions represent the greatest morbidity and service burden within the Murray PHN region. Incorporating up to date relevant data ensures commissioning is data-driven, equitable and responsive to population health needs. The flexibility to address multimorbidity and mental health comorbidity allows services to remain adaptive as regional profiles evolve.

Supporting evidence

See Appendix A for information supporting potential changes in future commissioning priorities.

2. Service delivery and models of care

Recommendation summary

Adopt two complementary models, the Regional Access Model and the Outreach Access Model, to optimise reach, equity, and efficiency, with an emphasis on group-based programs and sustained client engagement.

Actions

- Implement the Regional Access Model in larger towns with existing clinical infrastructure
- Implement the Outreach Access Model in remote or outer regional towns and underserved populations such as those experiencing housing insecurity, where access to GPs and health infrastructure is limited
- Default to group-based diabetes education as the primary model. Individual one-on-one sessions should be offered only where clinically justified (e.g. literacy, cognitive or complex health needs)
- Maintain group-first delivery for exercise physiology

- Introduce structured follow-ups at three-, six-, and 12-months post-program. This may be a brief phone check-in if the client is stable, or a short re-engagement intervention (such as a refresher group session or 1:1 review) if new issues or deterioration are identified
- Expand telehealth and hybrid outreach to reduce regional inequities and travel barriers
- Explore social prescribing within future funding models to address psychosocial determinants and improve wellbeing.

Rationale

Group-first approaches enhance peer learning, self-efficacy and cost efficiency. Scheduled follow-ups maintain client engagement and prevent deterioration, while telehealth ensures reach and flexibility. Social prescribing acknowledges that chronic condition care outcomes are influenced by social and environmental determinants.

3. Integration and coordination

Many providers and clinics already provide some degree of care coordination within their own services. However, stakeholder feedback suggests that the key gap lies not in increasing coordination within single services, but in strengthening care navigation across the broader system. Care navigation focuses on helping consumers understand their options, overcome access barriers and move through referral pathways.

A central hotline model was also considered. However, feedback from service providers, consumers and the Murray PHN Health Needs Assessment indicated that many vulnerable consumers are unlikely to initiate contact or remain engaged through phone-based support alone. This reinforces the need for locally based, proactive navigation roles that provide hands-on assistance within communities.

Recommendation summary

Strengthen coordination across providers and sectors through place-based navigation roles, HealthPathways enhancement and interdisciplinary collaboration.

Actions

- Fund place-based navigator roles to support consumers in accessing care and remaining engaged in care
- Continue to update and promote HealthPathways to support referral consistency, including integration with mental HealthPathways
- Improve internal coordination within Murray PHN to ensure unified communication and avoid duplication
- Broaden networking events to include pharmacy and allied health disciplines, using them for education, awareness and feedback loops
- Establish local interdisciplinary forums or communities of practice to share learning and streamline outreach activities.

Rationale

Vulnerable consumers rarely self-refer or complete referrals without proactive, local assistance. Place-based navigation increases follow-through and continuity and reduces missed appointments. Enhanced coordination and shared learning reduce fragmentation, which improves both efficiency and consumer experience. While a central hotline was considered, consultation and the Health Needs Assessment suggest it would have limited impact for priority cohorts who are less likely to initiate calls or act on advice without hands-on support. Navigator roles embedded within communities are therefore preferred. They can provide practical help to identify services, arrange referrals and transport, address barriers and maintain engagement in care.

4. Access and equity

Recommendation summary

Direct commissioning and outreach should focus on areas and populations with the highest chronic disease burden, ensuring that services are culturally safe, inclusive and responsive to local needs. Where appropriate, these activities may be supported through Murray PHN's population health or prevention funding streams, or through partnership allocations under the Indigenous Health Stream, rather than relying solely on the CCM Services Program budget.

Actions

- Prioritise commissioning in highest-need locations using population health data and other indicators
- Strengthen partnerships with ACCHOs to deliver culturally led prevention and health promotion
- Increase uptake of 715 Health Checks through community awareness and provider referral support (via HealthPathways)
- Improve links to existing bicultural workers and navigation services (Bendigo, Robinvale, Shepparton)
- Expand use of multilingual health resources such as Health Translations and Australian Government Department of Health, Disability and Ageing's translated resources
- Support cross-sector outreach for people experiencing homelessness or housing insecurity, delivering care in trusted, non-clinical settings (e.g. libraries, neighbourhood centres)
- Apply trauma-informed, person-centred principles across all engagement models
- Include equity metrics in reporting frameworks to track reach, access and outcomes.

Rationale

Equity-focused commissioning ensures resources flow to the communities with the highest need. Embedding cultural and linguistic inclusivity improves trust, participation and outcomes, particularly for Aboriginal, multicultural and vulnerable populations. Cross-sector collaboration maximises reach and minimises service duplication.

Supporting evidence

See Appendix B for population profiles, equity data and regional insights.

5. Workforce sustainability and development

Recommendation summary

Build and sustain a skilled, connected and supported chronic conditions management workforce through capability standards, professional development and collaborative networks.

Actions

- Establish minimum capability standards for providers, including:
 - registration or accreditation with the relevant governing body
 - completion of cultural safety (mandatory) and trauma-informed care training (desirable).
- Encourage advanced skills development in Motivational Interviewing, Mental Health First Aid and digital systems familiarity (HealthPathways, My Health Record)
- Enable professional development, supervision, and training, such as motivational interviewing, trauma-informed care or mental health first aid
- Create multidisciplinary communities of practice to support peer learning and problem-solving
- Partner with tertiary institutions to strengthen regional training pipelines and clinical placements
- Embed workforce wellbeing and retention in commissioning frameworks.

Rationale

A well-trained, supported workforce underpins service quality and sustainability. Building shared learning environments reduces isolation and turnover, while clear capability standards ensure consistent, safe, person-centred care across providers.

6. Funding and accountability

Recommendation summary

Maintain free consumer access while implementing hybrid funding models that ensure compliance, efficiency and long-term viability.

Actions

- Continue free access for consumers; no gap fees or dual billing with Medicare for the same encounter
- Explore compliant hybrid funding models, such as:
 - shared funding – PHN covers initial and group sessions; MBS covers ongoing one-on-one consultations
 - capped sessions – Consumers receive a fixed number of PHN-funded sessions (e.g. six total: one initial, two individual, three group); additional sessions billed via MBS
 - variation agreements – define PHN- vs MBS-funded components for transparency.
- Replace contact-only KPIs with outcome-based metrics (e.g. improved self-management, reduced inequity, better coordination)
- Include travel and administrative time as eligible contract costs to recognise true service effort.

Rationale

Sustainability depends on balancing free access with financial viability. These models allow scaling without compromising equity. Outcome-based KPIs better reflect impact, while covering travel/admin costs ensures provider participation and fairness.

7. Implementation and monitoring

Next steps

- Develop an implementation roadmap aligned with funding cycles and regional readiness
- Establish monitoring dashboards linking performance data to population health and outcome indicators
- Hold annual review workshops with providers, consumers, and partners to assess progress
- Integrate findings into ongoing Murray PHN planning cycles to ensure continuous quality improvement.

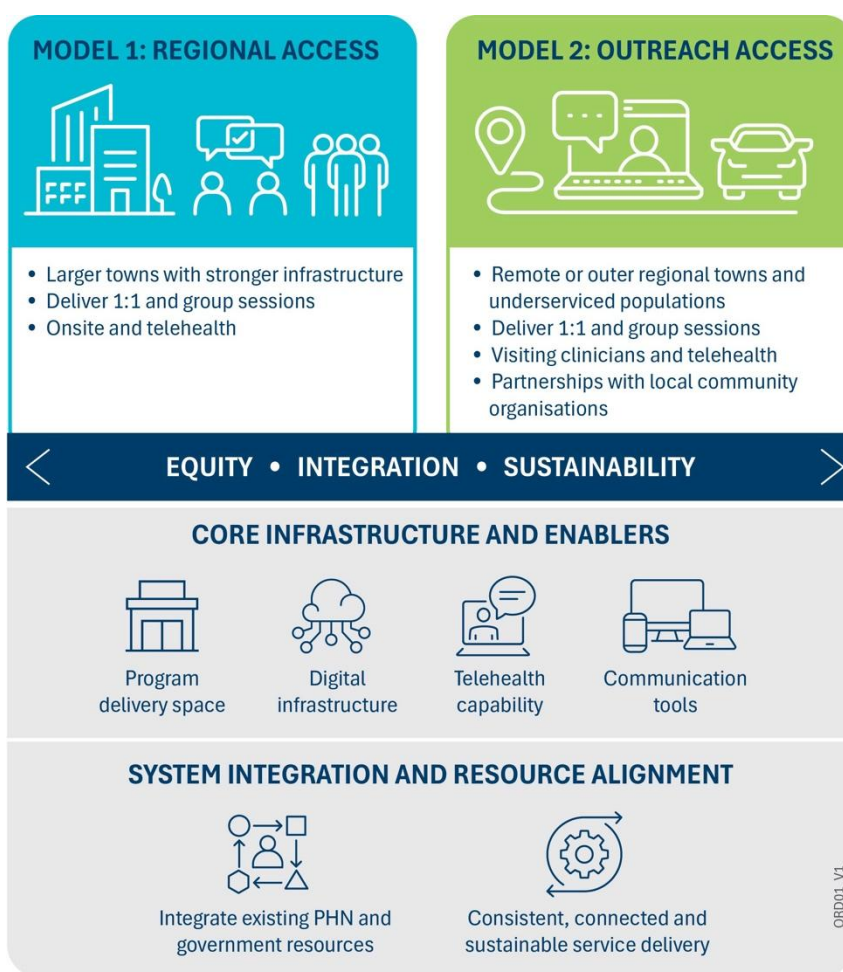
Rationale

Embedding monitoring within commissioning ensures iterative improvement and responsiveness to evolving needs, maintaining accountability while supporting innovation.

Proposed models of care

The review recommends changes to the current model to better support underserved populations, enhance awareness and engagement, and explore opportunities for more cost-effective service delivery. Two complementary models were proposed to improve access, integration and sustainability across the PHN region (Figure 2). Together, these models aim to strengthen service equity, ensure continuity of care and make better use of local workforce capacity and digital connectivity. The proposed models have been adapted by Murray PHN.

Figure 2: Recommended models of care for CCM Services



Several core infrastructure elements would be required for the models to work effectively:

- **program delivery space** – providers would need access to a suitable space to run sessions, such as a room within a community health centre, GP clinic, pharmacy or another community venue. Where no such facility exists, hiring space may be necessary
- **digital infrastructure** – a computer or laptop with secure data access and a reliable internet connection is essential for reporting, communication and virtual service delivery
- **telehealth capability** – telehealth-enabled spaces, supported by basic technical assistance, would allow for flexible service delivery and improve access for consumers who face travel barriers
- **communication tools** – reliable phone access, and in some rural or remote areas, a satellite phone, would support continuity of care and provider safety.

Beyond these physical and digital enablers, the success of the models will depend on how well existing government and PHN resources are integrated and made accessible. There are already many valuable initiatives, including digital health tools, mental health programs and service navigation supports available across the system. However, these resources are often dispersed across different platforms. Bringing them together, for example by embedding direct links or summaries within the chronic disease management services program guidelines, would make it easier for providers to locate and use them. This approach would support consistency, reduce duplication and ensure existing government investments are fully leveraged to strengthen implementation rather than creating new, parallel systems.

Sustainable funding models

Financial sustainability is a critical enabler of the proposed Regional Access and Outreach Access Models. As outlined in the detailed recommendations and implementation considerations sections of this report, a suite of compliant hybrid funding options has been identified to maintain free access for consumers while ensuring long-term program viability.

Under the current approach, all Murray PHN funded CCM services are free to consumers, with no gap fees or Medicare co-billing permitted. This ensures equity of access but limits providers' ability to expand services or include additional disciplines, such as pharmacists, within existing budgets.

The proposed shared funding and capped sessions models (previously described) provide mechanisms for balancing compliance, scalability and efficiency. Within the context of the two proposed care models, these approaches can be applied flexibly. Embedding clear funding parameters within commissioning contracts will maintain compliance while giving providers the flexibility to tailor delivery to local workforce capacity and consumer need. In this way, funding models become an integral design feature, supporting the sustainability, scalability and equity objectives of the overall model of care, rather than a separate financial mechanism.

Workforce model

Delivering high-quality, equitable and sustainable CCM services across the Murray PHN catchment depends on a skilled, connected and supported workforce. The proposed workforce model builds on the existing framework set out in the PHN program guidelines and incorporates enhancements recommended through this review to strengthen capability, integration and flexibility.

Core workforce

Where practical, the CCM service workforce should comprise a mix of clinical and non-clinical roles that collectively enable coordinated, person-centred care.

Role category	Key functions
Chronic disease nurse	Delivers client assessment, develops/participates in shared care planning, monitoring and education; provides individual and group sessions in collaboration with allied health and general practice.
Allied health professionals (exercise physiologist, dietitian, podiatrist etc)	Delivers client assessment, develops/participates in shared care planning, monitoring and education, coordinated discipline-specific interventions and group programs that support lifestyle modification, risk-factor management and self-management education.
Navigator role (new)	In line with shared care plan, supports consumers to find, access and remain engaged with appropriate services; bridges clinical care and community support, especially for consumers experiencing access barriers.
Administrative and technical support	Ensures reporting compliance and efficient scheduling, outreach delivery, data entry and telehealth facilitation.

Workforce standards and capability requirements

To ensure safe and consistent service delivery, staff engaged to deliver funded clinical services must:

- hold relevant qualifications, training and experience consistent with their role, position description, and professional scope of practice
- maintain current registration or accreditation with the relevant state or national authority and meet continuing professional development (CPD) requirements
- be members of their professional association where applicable
- have completed cultural safety (mandatory) and trauma-informed care training (desirable)
- clinical services must not be delivered by staff who do not meet these qualification requirements without prior approval from Murray PHN.

Beyond individual qualifications, workforce sustainability should be supported by professional development, supervision and/or participating in communities of practice.

Navigator role

The introduction of a navigator role responds directly to stakeholder feedback about access barriers and care fragmentation, particularly for people experiencing socioeconomic disadvantage, geographic isolation or complex psychosocial needs. Navigators complement, rather than duplicate, clinical coordination roles by focusing on engagement, system literacy and sustained participation in care. Suggested qualifications and experience are in Appendix C.

Flexible workforce approaches

Where recruitment challenges persist, Murray PHN may work with commissioned providers to develop flexible workforce models such as shared positions, telehealth-enabled delivery and upskilling local staff under supervision. This flexibility ensures continuity of care in workforce-shortage areas while maintaining service quality and compliance.

Engagement strategies for underserved populations

Targeted engagement strategies are essential to ensure that CCM services are equitable, culturally safe and responsive to the diverse populations within the Murray PHN catchment. The following approaches are recommended for priority population groups identified through the data review and consultation process.

First Nations Peoples

- Strengthen partnerships with ACCHOs to deliver culturally-led health promotion and chronic disease education
- Increase awareness and uptake of 715 Health Checks through local campaigns and provider incentives
- Incorporate yarning circles and other culturally safe engagement methods to build trust and encourage participation
- Provide cultural safety training and ongoing education for mainstream providers to enhance responsiveness to Aboriginal and Torres Strait Islander clients.

Multicultural communities

- Employ or partner with bicultural workers to deliver health information in culturally familiar ways and build community trust
- Ensure consistent and appropriate interpreter use during consultations and group sessions
- Promote use of Health Translations and Department of Health, Disability and Ageing's translated resources to improve health literacy
- Deliver programs in trusted community venues such as cultural organisations, community centres and places of worship to increase participation and comfort.

People experiencing homelessness or housing insecurity

- Provide care in safe, non-clinical community settings (e.g. neighbourhood houses, libraries, homelessness hubs) to reduce access barriers
- Offer flexible service delivery, including supported telehealth and face-to-face options tailored to client needs
- Build cross-sector capacity through training and partnership frameworks linking health, housing and community organisations
- Embed trauma-informed care principles in all service interactions to support safety and trust.

Older adults and people with low digital literacy

- Establish supported telehealth hubs in accessible community locations such as libraries and community houses
- Provide print resources and plain-language materials for clients with limited digital access or vision impairments
- Facilitate volunteer or peer technology support to assist clients in using digital tools and telehealth.

Coordinated care and navigation

With the consumer's consent, the GP and wider care team should be notified and included after each referral or major change in care. Ongoing communication helps ensure continuity, shared goals and coordinated support across all providers.

Where accessible and appropriate, My Health Record should be used to share care plans, medication lists and diagnostic results. This supports integrated care and ensures that those with access are working from consistent, up-to-date information. For consumers with complex or multiple needs, case conferences should be scheduled to review progress, address barriers and refine care strategies.

The navigator role is prioritised for consumers who are more vulnerable or underserved such as those with limited health literacy, complex social circumstances or barriers to accessing services. Navigators provide focused support to help these consumers link with health, mental health, social care, transport and housing services, ensuring their broader needs are recognised and addressed.

Consumers should be supported to set small, achievable goals and encouraged to use self-management techniques. The teach-back method can be used to confirm understanding and strengthen health literacy. Follow-up reviews at three and six months (or as clinically indicated) should be scheduled to assess progress and adjust care plans as required.

Emerging initiatives - multidisciplinary team-based care

Recent national reforms present important opportunities to strengthen team-based chronic disease management within general practice and community settings. Rather than creating new silos, these reforms can be strategically leveraged alongside PHN commissioning to embed allied health, pharmacy and nursing roles as part of integrated, multidisciplinary care pathways.

Workforce incentive program

The Australian Government's Workforce Incentive Program (WIP) supports general practices to engage a broader range of health professionals, including allied health practitioners, pharmacists and nurses, to improve access and coordination for patients with chronic and complex conditions. Within the Murray PHN CCM Services Program, WIP can be positioned as a practice-level system enabler, not a duplicate funding source.

- Encourage commissioned service providers to liaise with WIP-eligible practices to co-locate services or coordinate patient care, especially for follow-up visits or medication management
- Pharmacists engaged under WIP can work closely with PHN-funded CCM providers through shared care plans, providing medication reviews, adherence support, and education on polypharmacy, without billing for the same encounter

- Reference to pharmacist referral pathways should be included in PHN Program Guidelines and care coordination templates
- Promote appropriate use of Home Medicines Review (HMR) for eligible consumers to improve medicines safety and address polypharmacy, with navigators and providers prompting GP referral and coordinating follow-up
- Embedding these connections enhances continuity of care, reduces duplication, and ensures consistent communication between CCM providers, GPs, and practice-based teams.

Example implementation:

A PHN-commissioned diabetes educator working in a GP clinic can refer to a WIP-funded pharmacist for medicines reconciliation. The pharmacist's recommendations are documented in the shared care plan and communicated to the GP. This maintains clear funding boundaries while improving medication safety and patient self-management.

Strengthening Medicare reforms

The Strengthening Medicare initiative provides further mechanisms to integrate chronic condition management across settings by promoting:

- MyMedicare registration, allowing consumers to nominate a regular practice and improving continuity for patients with chronic or complex needs
- voluntary patient registration and bundled funding that reward proactive, coordinated care rather than episodic visits
- new funding streams for multidisciplinary team-based care, particularly for nurse-led and allied health integration.

Within the CCM redesign, PHN-funded services can align with these reforms by:

- encouraging providers to link clients with registered MyMedicare practices, ensuring seamless information sharing and follow-up
- supporting GPs and practices to use Murray PHN commissioned CCM programs as extenders of their multidisciplinary capacity, particularly in high-need local government areas (LGAs)
- including shared communication protocols between PHN-funded providers and registered practices within contractual requirements.

Digital and system integration enablers

Emerging national initiatives in digital health and data connectivity can further strengthen team-based care:

- My Health Record expansion provides a common platform for sharing care plans, medication summaries and discharge information
- HealthPathways should include cross-references to local pharmacist referral options, social prescribing programs and PHN-funded services

Murray PHN can explore developing templates or embedded links within electronic health records to guide providers on when and how to refer to CCM services.

Practical integration pathways

- Provide training sessions or workshops with WIP-funded practices and PHN-commissioned providers to build local relationships
- Include shared evaluation indicators (e.g. number of cross-service referrals, case conferences held, joint care plans developed)
- Promote pharmacist engagement through Murray PHN newsletters, provider portals and guidelines to raise awareness among commissioned providers.

Comparison: Current vs proposed models of care

The following table summarises the key differences between the current and proposed models of care and the intended benefits of the redesign.

Feature	Current	Proposed model	Improvement
Program focus	Disease-specific services (COPD, diabetes, cardiovascular)	Consider adding arthritis and osteoarthritis in future funding rounds, given high prevalence and health system impact	Regional responsiveness
Service delivery	Individual and group based	Regional and outreach models tailored to needs	Efficiency, access, peer support
Workforce	Independent providers	Multidisciplinary teams with navigator and administrative roles	Continuity, collaboration, sustainability
Funding model	Fully PHN-funded, no MBS integration	Hybrid funding maintaining free access	Sustainability and scalability
Data and evaluation	Activity-based reporting	Minimum Data Set capturing outcomes and equity	Outcome evaluation and improvement
Consumer engagement	Limited structured input	Advisory engagement and surveys	Stronger consumer voice
Equity focus	Broad regional delivery	Subregional targeting based on need	Alignment with local priorities

By incorporating enhanced data collection, coordinated care roles and regionally tailored delivery mechanisms, these models position Murray PHN to better meet the diverse needs of its communities and demonstrate measurable impact.

Enabling the models

Enabling infrastructure and system supports

Successful implementation of both models will require:

- access to suitable delivery spaces within community or primary care settings
- reliable digital infrastructure and telehealth capability
- clear referral and feedback pathways between CCM providers, general practice and hospitals
- ongoing professional development and communities of practice to strengthen workforce capability and retention
- streamlined data collection and reporting using the refined Minimum Data Set (MDS) to support evaluation and accountability.

Minimum Data Set and evaluation plan

Murray PHN already collects a solid operational dataset across its commissioned chronic conditions management programs. For cardiopulmonary rehabilitation, monthly reporting covers the number of: unique consumers who started the program, the number of group sessions delivered, the number of unique consumers who exited, the recorded reasons for exit using a multiple choice list, the number who completed the full six to eight week program, and the number of cancellations or did not attend for scheduled individual initial consults. Together, these items describe program reach, throughput, completion and early engagement.

For non-cardiopulmonary programs such as dietetics, diabetes education, podiatry and chronic disease nursing, monthly reporting captures: the number of new consumers, the number of unique consumers who received an occasion of service, the total occasions of service delivered, and the number of these delivered via telehealth. It also records cancellations within 24 hours or did not attend and includes qualitative commentary on variation between targets and activity, emerging issues or risks and other relevant notes. These items describe service volume, modality mix and operational constraints.

For new client activity fields, the following dataset is not routinely collected: year of birth, gender, postcode, Indigenous status, chronic or complex health needs if known, whether the person has a regular GP, the timing of the last GP visit, and the main reasons for requiring assistance from the program.

The currently collected data enables month-to-month tracking of commencements, service delivery, engagement and cancellations, but does not provide core demographic context that supports equity analysis at a basic level.

Introducing the proposed additions to the MDS

The current dataset is strong for activity and reach, but decision makers also need a clear view of impact, coordination, equity and sustainability. The proposed additions are intentionally light, focus on the few fields that change decisions and can be captured at intake, review and completion using Murray PHN's existing reporting tools. They standardise definitions, reduce free text and connect what services did to what changed for consumers.

Guiding principles

- Keep burden low by using existing monthly sheets and survey tools
- Collect only what informs commissioning and quality improvement, including basic demographic data
- Align with FY26 plan and contract definitions to ensure consistency
- Capture timing so access and flow can be monitored
- Integrate patient experience and simple outcomes to show impact
- Add basic equity and barrier fields to see who is missing out
- Record minimal workforce and coordination signals to assess sustainability.

How evaluation will work

Evaluation questions

1. Are consumers accessing care in a timely and equitable way across subregions and priority cohorts?
2. Do services improve knowledge, confidence, self-management and attendance at planned care over time?
3. Does local navigation reduce drop off between referral and completion, and increase continuity?
4. Is delivery sustainable for providers, given workforce capacity, coordination effort and travel time?

Core indicators and sources

- **Access and flow:** Wait time from referral to first contact, time from first contact to first appointment, did not attend and cancellation rates, completion rate.
- **Equity reach:** Proportion of consumers in priority cohorts: Aboriginal and Torres Strait Islander, CALD, rurality band, low-income proxy, frequent hospital users
- **Outcomes:** Two PROM items and one PREM item at completion, with optional three- and six-month check-ins for group first programs.
- **Coordination and navigation:** Navigator involvement, number of external handoffs, shared care plan used.

Consider implementing an annual outcomes review: A region level synthesis against FY26 outcomes and key results, with hotspot analysis and workforce risk signals. Purpose is strategy, contracting, and investment shifts.

Detailed proposed additions and enhancements are located in Appendix D.

Alignment with Australian frameworks

Anchoring the MDS to nationally recognised frameworks ensures consistency, comparability and future readiness for data sharing and performance reporting. Australian frameworks to align with:

- AIHW – Primary health care data work and Chronic Conditions Reporting Framework. Use for core domains (access, quality, outcomes, equity) and standard definitions
- Australian Health Performance Framework (AHPF). Use for required disaggregation (Aboriginal and Torres Strait Islander status, remoteness, CALD/preferred language, age/sex) and for aligning indicators to the pillars of access, effectiveness, safety, equity and efficiency
- PMHC-MDS (Primary Mental Health Care MDS). Use as the proven PHN data model (Client, Episode, Service Contact, Outcomes) and submission cadence/governance; mirror this structure for chronic conditions
- Department of Health, Disability and Ageing / PHN contracting and performance guidance. Use for cadence (monthly via Folio; surveys via Forms; quarterly acquittals) and contract-aligned definitions (occasion of service, episode of care, care coordination)
- Current chronic condition management (CCM) policy and value-based care direction. Use to justify timeliness fields, shared care plan/coordination flags and light outcome measures.

Why it matters

It shows impact, not just activity. Counts of visits and sessions do not reveal whether people improved or whether coordination reduced avoidable hospital use. Linking activity to outcomes and transitions lets decision makers see what worked, for whom, and at what intensity (Cheung et al., 2019; Coorey et al., 2022).

It strengthens coordination. Shared care plans, case conferencing, and timely handover from hospital to community are core features of effective integrated care, and routinely measuring these steps drives practice improvement (Cheung et al., 2019; O'Callaghan et al., 2025)

It protects workforce sustainability. Recording who delivers care and how much time is required makes visible the real cost of delivery and the trade-offs providers face between administration and clinical care (Ghosh et al., 2016)

It improves equity. Standard demographic fields plus simple barrier flags, such as transport and language, allow Murray PHN to see who is missing out and where targeted commissioning or outreach is needed (De Morgan et al., 2022; Cornell et al., 2022)

It accelerates quality improvement. Routine capture of a small number of patient reported outcomes and experience measures creates rapid feedback loops to providers and the PHN (Murray PHN Client Experience Surveys, 2023–2025).

How the proposed MDS aligns

- Client and equity fields (age, sex/gender, postcode/remoteness, Aboriginal and Torres Strait Islander status, CALD/preferred language, interpreter need) are consistent with AHPF disaggregation and AIHW equity domains
- Episode and timeliness (referral received, first contact, completion; wait time and completion rate) reflect AIHW/Department of Health, Disability and Ageing (DHDA) emphasis on access and flow and match contract schedules
- Service contacts and mode (occasion of service; in-person/phone/video) follow the PMHC-MDS structural pattern and PHN reporting guidelines
- Care coordination (for example, shared care plan created/reviewed; referrals sent/completed; case conference held) reflects DHDA policy/contracting expectations and integrated-care practice
- Light outcomes (PROMs) and optional clinical marker (goal attainment or self-rated change; HbA1c/BP/6MWT where feasible) align with AIHW outcomes domains and PHN evaluation guidance, placed similarly to PMHC outcomes.

Conclusions

Murray PHN and partners have a clear opportunity to stabilise and strengthen chronic conditions management care by pairing regional consistency with local flexibility. The proposed complementary models, anchored by place-based navigation, group first delivery with structured follow-up and smarter hybrid funding, will improve engagement, continuity and value for consumers and communities that face the greatest barriers. Implementing a Minimum Data Set and monitoring framework will show not only what services are delivered, but what changes for people, where and at what intensity. With targeted commissioning to hotspot LGAs, supported workforce capability and tighter integration via HealthPathways and shared care planning, the region can move from goodwill dependent effort to a more deliberate, equitable and sustainable system. The immediate next steps are to confirm phasing and local readiness, embed the recommended contract settings, update provider tools and HealthPathways, and stand-up navigation capacity in priority locations.

Glossary

Abbreviation	Meaning
ACCHO	Aboriginal Community Controlled Health Organisation
A&TSI peoples	Aboriginal and Torres Strait Islander peoples
AHP	Allied Health Professional
AHPF	Australian Health Performance Framework
AIHW	Australian Institute of Health and Welfare
CALD	Culturally and Linguistically Diverse

CCM	Chronic Condition Management
CIS	Composite Index Score, a weighted score used to identify need and prioritise commissioning across regions
COPD	Chronic Obstructive Pulmonary Disease
CPD	Continuing Professional Development
CoP	Community of Practice, a local interdisciplinary forum for shared learning and improvement
DHDA	Department of Health, Disability and Ageing
DNA	Did Not Attend, a scheduled appointment missed without notice
ED	Emergency Department
Equity reach	Proportion of consumers from priority cohorts reached by a program (for example A&TSI, CALD, rurality band, low-income proxy)
Evaluation Plan	Plan that sets evaluation questions, indicators, data sources, and timelines for the program
FY26 Plan	The Murray PHN financial year 2026 plan that defines program outcomes and key results
GP	General Practitioner
Health Needs Assessment (HNA)	Murray PHN assessment that identifies population health needs, gaps, and priorities
HealthPathways	Web-based clinical guidance platform outlining assessment and management pathways and local referral options
KPI	Key Performance Indicator
Larter	Larter Consulting, the consultancy engaged to support the review and redesign
LGA	Local Government Area
MBS	Medicare Benefits Schedule
FY26 Plan	The Murray PHN financial year 2026 plan that defines program outcomes and key results
MDS	Minimum Data Set, the essential data elements collected to support monitoring, evaluation, and accountability
Murray PHN	Murray Primary Health Network
My Health Record	Australia's national digital health record system
MyMedicare	Voluntary patient registration model that supports continuity and blended funding for primary care
Navigator	Designated role that guides consumers across services and systems, including referrals, barrier solving, and follow-up
Occasion of service	Single consumer interaction with a service, including telehealth
PHIDU	Public Health Information Development Unit
PHN	Primary Health Network
PMHC	Primary Mental Health Care
PREM	Patient Reported Experience Measure, a short item capturing consumer experience of care
PROM	Patient Reported Outcome Measure, a short item capturing change in knowledge, confidence, or function

RAP	Reconciliation Action Plan
Referral source	The channel from which a consumer was referred, captured using a standard list (for example GP, hospital, self, community service)
Regional hotspots	LGAs or subregions identified with higher composite need and access barriers
Rurality band	A standardised rurality category used for equity analysis (for example major regional, inner regional, outer regional, remote)
Self-management	Consumer skills and confidence to manage health conditions day to day
Shared care plan	A care plan visible to and used by multiple providers to coordinate care
Telehealth	Clinical care delivered via phone or video
Travel time band	A banded estimate of provider travel time related to program delivery for sustainability monitoring
VPHS	Victorian Population Health Survey
Wait time to first contact	Days from referral receipt to the first attempted or successful contact with the consumer
WIP	Workforce Incentive Program
Workforce coordination time band	A banded estimate of non-face-to-face coordination time related to program delivery

Appendices

- A. Supporting evidence for future prioritisation
- B. Summary data
- C. Navigator role qualifications and experience
- D. MDS questions and evaluation

Appendix A: Supporting evidence for future prioritisation

Consideration:

In future commissioning and funding models, Murray PHN may wish to consider formally including arthritis and osteoarthritis as additional core chronic conditions alongside COPD, diabetes and cardiovascular disease.

Future commissioning of chronic disease services should prioritise LGAs and subregions with the greatest need for services. Aligning funding allocation to these hotspots will reduce geographic inequities and improve access to multidisciplinary care.

Justification:

Population health data from the Public Health Information Development Unit (PHIDU) and the Victorian Population Health Survey (VPHS) indicate that musculoskeletal conditions have the highest prevalence across the Murray PHN catchment. This aligns with the National Strategic Framework for Chronic Conditions, which identifies musculoskeletal disorders as one of Australia's leading chronic conditions priorities.

According to the Australian Institute of Health and Welfare (2024), estimates of allocated healthcare spending in 2022–23 show that cancer, cardiovascular disease and musculoskeletal disorders were the three most costly health condition groups, with expenditures of approximately \$18.9 billion, \$16.2 billion and \$15.9 billion, respectively. Within these groups, the highest-spending conditions were injuries from falls (\$5.1 billion), osteoarthritis (\$4.9 billion), and back pain and problems (\$3.9 billion) - all exceeding coronary heart disease (\$3.8 billion) and dental caries (\$3.3 billion).

These data highlight the considerable burden and cost associated with musculoskeletal conditions in both national and regional contexts, supporting their inclusion in future chronic conditions management planning and commissioning frameworks.

Appendix B: Summary data

First Nations Health and Healing Report overview

The Murray PHN (2024) First Nations Health and Healing Report identified low engagement with 715 Health Checks and variable collaboration between Aboriginal Community Controlled Health Organisations (ACCHOs) and mainstream services. Strengthening culturally-led prevention and care pathways is a key opportunity for improvement.

Key findings

- Limited awareness and promotion of 715 Health Checks among First Nations community members
- Many mainstream providers are unclear about their role in promoting or delivering 715 Health Checks through bulk-billing clinics
- Cultural safety training uptake is inconsistent across commissioned services
- Aboriginal and Torres Strait Islander peoples in the Murray PHN region experience higher rates of chronic conditions onset at younger ages compared to non-Indigenous populations.

Recommended focus areas

- Promote and strengthen 715 Health Checks as a core preventive measure
- Fund ACCHOs to lead culturally informed health promotion and outreach
- Integrate culturally safe referral pathways through HealthPathways
- Increase mainstream provider awareness through education and partnerships.

Data Source: Murray PHN (2024) Population Health Series – First Nations Health and Healing Report.

Multicultural Populations Report overview

The Murray PHN (2024) Multicultural Populations Report identified key LGAs where culturally and linguistically diverse (CALD) communities experience barriers to accessing chronic conditions management services.

Priority LGAs

Swan Hill, Mildura, Shepparton and Mitchell.

Key health conditions

- Arthritis and diabetes were the most frequently reported chronic conditions among CALD populations
- Mental health, trauma-related issues, and chronic pain are also prevalent, often co-occurring with physical health concerns.

Barriers to care

- Cost and transport limitations
- Low health literacy and limited interpreter access
- Lack of awareness of available health services and navigation pathways.

Recommended focus areas

- Strengthen cultural navigation through bicultural workers and targeted outreach
- Improve access to translated health materials, including:
 - Health Translations (Victorian Government)
 - Australian Government Department of Health and Aged Care – Translated Resources
- Promote cross-cultural workforce capability and cultural safety training for providers.

Data Source: Murray PHN (2024) Population Health Series – Multicultural Populations Report.

Homelessness Report overview

The Murray PHN (2024) Population Health Series – Homelessness Report identified high rates of homelessness and marginal housing in several LGAs across the PHN catchment, with rates exceeding the Victorian average.

Priority LGAs

- Greater Shepparton
- Mildura
- Greater Bendigo
- Swan Hill
- Campaspe.

Key findings

- The North West subregion (Mildura and Swan Hill) has the highest concentration of homelessness and housing instability
- People experiencing homelessness are more likely to have multiple chronic conditions, limited access to general practice and disrupted continuity of care
- Additional at-risk populations include older single women, refugees and migrants, people on low incomes and individuals with trauma or mental health histories.

Recommended focus areas

- Prioritise outreach and flexible delivery models for people experiencing or at risk of homelessness
- Build cross-sector partnerships between health, housing, and community services to support access and coordination
- Embed trauma-informed and person-centred principles across all service interactions
- Use non-clinical community spaces such as libraries, neighbourhood centres and drop-in hubs to improve accessibility.

Data Source: Murray PHN (2024) Population Health Series – Homelessness Report.

Appendix C: Navigator role qualifications and experience

The following outlines appropriate qualifications and experience for a Navigator along with a rationale.

Essential:

- Certificate IV (or higher) in Health, Community Services, Aboriginal and/or Torres Strait Islander Primary Health Care, Health Promotion or a related discipline
- Demonstrated experience in chronic conditions management or care coordination within a health or community setting
- Understanding of primary healthcare principles, referral pathways and local service networks
- Experience working with individuals experiencing access barriers (e.g. socioeconomic disadvantage, isolation, complex needs)
- Strong communication, advocacy, and interpersonal skills with the ability to work collaboratively within multidisciplinary teams
- Sound organisational and problem-solving skills, and proficiency in data entry and electronic health record systems.

Desirable:

- Diploma or Bachelor qualification in Nursing, Allied Health, Social Work, Public Health or Community Development
- Knowledge of chronic conditions self-management frameworks (e.g. Flinders Program, Stanford Model)
- Understanding of trauma-informed and culturally safe practice
- Current First Aid and CPR certificate, driver's licence, and National Police Check
- Experience working with Aboriginal and Torres Strait Islander or CALD communities.

Rationale for the selection criteria of the Navigator role:

Qualification area	Reason for inclusion
Certificate IV in Health/Community Services	Reflects the national minimum standard for non-clinical navigation roles and ensures foundational health-system knowledge.
Experience in chronic conditions or care coordination	Provides practical understanding of long-term condition management and multidisciplinary teamwork.
Understanding of primary care and referral pathways	Essential for bridging GPs, specialists, allied health and community services.
Experience with disadvantaged populations	Builds capacity to address social determinants and improve equity.
Communication and advocacy skills	Central to effective consumer engagement and navigation.
Organisational and IT capability	Necessary for managing caseloads, documentation and data integrity.
Higher-level qualification (desirable)	Adds clinical or psychosocial depth, strengthening holistic care planning.
Knowledge of self-management frameworks	Aligns with evidence-based approaches to consumer empowerment.
Cultural safety and trauma-informed practice	Ensures responsiveness to diverse and complex client experiences.
Compliance and safety requirements	Standard across Australian health and community roles.

Appendix D: MDS questions and evaluation

This appendix sets out the evidence and rationale for each proposed Minimum Data Set element that could be used to monitor and improve potential future Murray PHN commissioned chronic conditions management programs. The table shows what is already collected, whether it remains relevant, the minimal extra fields that unlock better decisions and a short explanation of why they matter. It is designed to be light touch and consistent with existing monthly sheets and survey tools. Use it with the implementation crosswalk in Appendix F to know exactly where and how to capture each field.

How to read the columns

- Current lists the item in use now, grouped by program where helpful
- Is it relevant confirms if the current item should be kept as is or refined
- What is missing identifies the smallest number of additional fields or flags that change commissioning or quality decisions
- Why and evidence gives the decision logic for adding or refining the item.

Current	Is it relevant?	What is missing?	Why and evidence
Cardiopulmonary rehab: unique consumers Started (monthly)	Yes	Baseline risk profile, referral source, wait time from referral to first contact	Reach and throughput are important, but without wait time and referral source there is limited visibility on access and equity.
Cardiopulmonary rehab: group sessions delivered (monthly)	Partly	Attendance and completion rate	Volume does not reflect effectiveness. Pairing with attendance and completion allows dose response assessment.
Cardiopulmonary rehab: unique consumers exited (monthly)	Yes	Exit reason standard list, shared care plan used	Standard exit reasons and shared care plan use connect activity to continuity and coordination quality.
Diabetes education: unique consumers Started (monthly)	Yes	Group first flag, follow ups completed at three-, six-, and 12-months	Confirms adherence to the model and shows sustained engagement beyond initial education.
All programs: unique consumers with an occasion of service	Yes	DNA count and late cancellations within 24 hours	Shows access and flow barriers that reduce impact and waste clinician time.
All programs: occasions of service	Partly	Split by mode and setting where useful to interpret change	Simple splits help understand changes in delivery without large reporting burden.
All programs: telehealth occasions	Yes	Digital barriers tick box at intake for device, data and digital literacy	Helps interpret telehealth use and target digital support where needed.
All programs: consumers exited (monthly)	Yes	Exit reason standard list	Standardisation improves comparability and downstream actions.
New client activity: demographics and context	New	Priority cohort flags for A&TSI, CALD, rurality band, low-income proxy, frequent hospital user	Enables equity analysis and targeted commissioning by cohort and place.

Current	Is it relevant?	What is missing?	Why and evidence
Coordination activity	New	Navigator involved this month, number of external handoffs completed	Minimal coordination signals test whether navigation is associated with improved completion and continuity.
Shared care planning	New	Shared care plan used	Indicates integration across providers and supports continuity.
Timeliness fields	New	Wait time to first contact, time from first contact to first appointment	Shows whether consumers experience timely access and where delays occur.
Workforce and delivery effort	New	Travel time band per month, coordination time band per month, staffing stability this month	Tracks sustainability pressures without detailed timesheets.
Outcomes at completion	New	Two PROM items on knowledge and confidence	Low burden items show what changed for consumers at completion.
Experience at completion	New	One PREM item on understanding next steps	Captures a simple experience signal tied to navigation and clarity.
Diabetes education follow-up	New	Follow ups completed at three-, six-, and 12-months	Checks maintenance of gains for group first programs.

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