phn MURRAY

An Australian Government Initiative

HEALTH CONNECTIONS AND CHRONIC CONDITIONS MANAGEMENT PROGRAM

CLINICAL SERVICES

June 2026

Leadership | Collaboration | Respect | Accountability | Innovation

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.

We aspire 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 life-long commitment to self-reflection, personal growth and redressing power imbalances in our society.

About this document

This document provides guidance for service providers and staff commissioned by Murray PHN under the **Health Connections and Chronic Conditions Management Program** (HCCCM), which began on 1 July 2026. It outlines key aspects and operational requirements to support day-to-day service delivery, quality assurance and program reporting for the clinical component of the HCCCM program, including scope, consumer eligibility, service delivery and reporting requirements.

These guidelines complement, but do not supersede, any terms, conditions and contractual obligations outlined in your HCCCM Murray PHN provider agreement and associated Schedule 1 (the 'Schedule'). Therefore, it is important to review and understand this guideline alongside those documents. Providers delivering navigation components of the model should also refer to the HCCCM Regional Health Navigator Service Guideline.

This is the first version of the **Health Connections and Chronic Conditions Management Guideline;** further iterations will be developed in collaboration with commissioned services and partner organisations. This guideline aligns with the Australian Government's priority areas and PHN funding requirements, and is also informed by relevant legislative obligations, and state and national practice standards.

A note on terminology: The terms 'client,' 'patient' and 'consumer' may be used interchangeably in this document, depending on the context. For the purposes of this guideline, they refer to the same thing.

For further information or clarification on any aspect of this document, contact your nominated Murray PHN representative. You can also email HCCCM@murayphn.org.au with questions about the program.

Contents

Program overview

Background

Murray PHN is part of a national network of 29 Primary Health Networks (PHNs) across Australia. The Murray PHN catchment covers 22 Local Government Areas across four sub-regions of: Central Victoria, Goulburn Valley, North East Victoria (which includes Albury NSW), and North West Victoria.

The Australian Government established PHNs to improve the efficiency and effectiveness of primary healthcare services, particularly for underserved populations and those at greater risk of poor health outcomes.

Murray PHN's Health Connection and Chronic Condition Management Program (HCCCM) was developed in 2025 to continue to target available funding to address priority chronic conditions across the catchment – diabetes, chronic obstructive pulmonary disease (COPD) and chronic heart failure. The HCCCM Program provides ongoing clinical support in local government areas (LGAs) where prevalence and hospitalisation rates for priority chronic conditions remains high, and four regional navigation roles to support people to navigate the health system and services.

HCCCM model

The HCCCM program has two coordinated components, both to be delivered in specified LGAs:

- **Direct clinical services** – individual and/or group interventions delivered in person and/or via telehealth for consumers with COPD, diabetes, and/or chronic heart failure. Clinical services include dietetics, podiatry, diabetes education, chronic disease nursing, cardiac and pulmonary exercise groups.
- **Non-clinical services** - Regional Health Navigator (RHN) services – place-based navigation and support across Central Victoria, Goulburn Valley, North East and North West sub-regions of the Murray PHN region to help consumers who face significant barriers to accessing and engaging with relevant health services. The RHN will work with individuals and assist them to navigate the health and social system to remain engaged or engage in required services.

Program objectives

Coordinated chronic condition management remains a key health priority for Murray PHN, as our region continues to face significant access and equity challenges across our diverse and ageing population. There are people, population groups and communities where higher rates of preventable illness and exacerbation of disease persist, leading to preventable hospitalisations and poor quality of life.

The HCCCM program supports the health needs of people with chronic conditions of highest regional impact – COPD, diabetes and chronic heart failure, who are underserved due to their location and/or other social determinants of health.

The objectives of the HCCCM program are to:

- Improve access to place-based chronic condition care for underserved populations via individual and group clinical and support services
- Empower consumers to actively participate in their health and wellbeing
- Provide holistic, culturally safe, person-centred and coordinated care
- Provide timely, appropriate interventions to reduce preventable hospitalisations and/or disease severity of priority chronic conditions
- Improve health outcomes through enabling digital integration through service delivery options, information sharing and coordination
- Assist demand management and sustainability by capping occasions of service per episode of care
- Build consumer self-management capability and health system literacy to support safe discharge and sustained outcomes.

Guiding principles

Principles underpinning the HCCCM Program are:

Seamless and integrated care pathways	Supporting shared, goal directed care and actively promoting the consumer voice in care choices. Complement existing systems within the context of locally available services.
Collaboration	Building and maintaining strong linkages and partnerships with local clinical and social/human services to streamline referral pathways and facilitate service access for consumers.
Flexibility	Enabling flexible delivery of required support, including face-to-face, outreach and digital modes to meet the needs and preferences of consumers and ensure access without barriers.
Trauma-informed	Acknowledge the impact of trauma and promote dignity, safety, and empowerment throughout the healthcare journey
Culturally appropriate	Tailor services to align with the cultural values and beliefs of individuals and communities.
Consent and agency	Empower consumers by providing information needed to make informed health decisions.
Sensitive and discreet	Respect the emotional, cultural, and personal needs of consumers, ensuring privacy and confidentiality when handling health information.

Target population

The target population/s for this program is people living in the community with chronic diseases of highest regional impact i.e. COPD, diabetes and chronic heart failure.

The target population group may further be prioritised for services based on any of the following characteristics:

- First Nations peoples
- Migrant and refugee communities; people with low English proficiency
- People experiencing homelessness or housing insecurity
- Rural/remote residents, particularly those at higher risk of preventable hospitalisations and unplanned emergency department presentations
- Older adults
- People with low health literacy (including digital health) who need assistance to understand and navigate health services.

Consumer eligibility and referrals

Eligibility	An eligible person for HCCCM services is a person living in the community who: • Lives in a Murray PHN LGA specified in your Schedule. • Has an established diagnosis of COPD, diabetes and/or chronic heart failure. It is up to each provider to be satisfied that a consumer meets this requirement as diagnostic evidence will not be required by Murray PHN. • Experiences barriers to accessing or navigating primary health care services (e.g. location, cost, transport, literacy, language, physical or mental illness, trauma). • Requires support to participate in or implement chronic condition management plans or recommendations. • Is not receiving the same service from another funding source (e.g. NDIS, My Aged Care, Department of Veteran's Affairs, other state/federal funding). It is important to note: – Funded services may be used to assist consumers who have exhausted their allocation of Medicare Benefits Schedule (MBS) funded services under a GP chronic condition management plan (GPCCMP). – If a clinical need exists, interim services may be provided while waiting for other funding sources to be approved and started. – If a health professional is providing a Murray PHN funded service to a consumer, they cannot claim MBS items for the same occasion of service. – Murray PHN funding cannot be used to cover the gap between what is covered through the MBS rebate and out-of-pocket expenses for the consumer. – All services provided under the Murray PHN program are provided free-of-charge to consumers, and no gap payment may be made by consumers. In addition to the above eligibility criteria, a consumer may also be eligible for RHN services if they require extra and/or intensive assistance to navigate health and social services to help meet care plan goals. This could include requiring support to identify and link with local services, identifying and addressing individual/systemic barriers to access, transport options etc.

Exclusions	• Consumers with non-prioritised chronic illnesses. • Consumers outside specified LGAs – see below regarding consumers on LGA borders*. • Consumers living in residential aged care or are admitted to a residential care facility. • Consumers receive funded services for the same needs from another source (duplication).
Communities of Practice	Providers should actively participate in relevant Murray PHN communities of practice (CoP) or peer support networks once established. The CoP aim to enhance the development, effectiveness and accessibility of services for consumers and providers. By drawing on the expertise and experience of providers, the CoP fosters opportunities for sharing resources, learning from peers, and developing skills that promote continuous improvement. Additionally, the CoP advocates for system changes to address barriers identified by service providers and the communities they serve.
Promotion and marketing	As a new service, providers will need to undertake promotional activities to ensure referrals are received. Promotion should be monitored and planned to ensure that only eligible consumers are referred, referral sources are monitored and that demand is managed.

**In certain cases, it may be appropriate to provide services to individuals living outside the Murray PHN region or the defined LGA(s) in your schedule. This could include those in border towns or neighbouring LGAs who travel into the specified LGA for health services that are unavailable, inaccessible, or inappropriate in their locality. Reach out to your Murray PHN CCI to discuss.*

Referrals and initial assessment

Clinical services referrals

Consumers may be referred to HCCCM clinical services by medical practitioners, hospital staff, other health professionals, community services, family/friend/carer, self-referral and internal program transfers.

Regional Health Navigator (RHN) referrals

- Eligible consumers may be referred to a RHN if they require extra/intensive assistance to navigate health and social services to help meet care plan goals.
- Consumers may initially only be referred to the RHN service by an HCCCM clinical provider. To ensure integrated care, it is recommended that the goals identified in a consumer's care plan are shared with the RHN on referral along with key demographic data (Consumer Information Form) to reduce the need for consumers to re-tell their story and re-share information.
- As the RHN service is established, other referrals may be accepted – from GPs, community health organisations or other primary care provider within the capacity of the RHN provider. Any changes to the referral criteria for the RHN service will be communicated to HCCCM providers.
- A consumer may be referred to the RHN at any stage during their care if this need was not apparent during their initial assessment.
- If relevant, clarify the difference between clinical services and RHN, so consumers understand how the services work together.
- Use secure information sharing practices and structured, warm handovers.

Initial comprehensive assessment (mandatory content) for clinical services

An initial comprehensive health and risk assessment to enter the program will include the following:

- Identification of existing GP chronic conditions management plan/any other care plan in place (to ensure coordination and avoid duplication).
- Identification of other health conditions, related co-morbidities and/or risk factors for the same and support needs.
- Clarifying any other social or health services consumer is currently using.
- Development and prioritisation of consumer goals. With consumer consent, share their care plan and/or updates with relevant providers, as part of a coordinated approach to care.
- Allocation of estimated number of group sessions and/or individual occasions of service up to the **maximum allowable six individual occasions of service (per discipline) and/or eight group sessions in 12 months**. Note, the actual number of required sessions/occasions of service for a consumer may change (up to the maximum allowable) during program delivery if clinical needs/individual circumstances/goals of care change
- Decisions regarding referral to Regional Health Navigator, GP or other health provider.
- Completion of Consumer Information Form (Minimum Data Set) (see Service Delivery – reporting section below).

Consent and privacy

The service provider must obtain informed consent from the individual and/or their legal guardian before any interventions begin or referrals are made. Consent should be obtained and documented in accordance with relevant legislative and funding agreement requirements, including the Australian Privacy Principles | OAIC, Victorian Privacy and Data Protection Act (2014), the Victorian Public Records Act (1973) and the Victorian Health Records Act (2001).

- Sharing of de-identified information with Murray PHN and the Department of Health, Disability and Ageing for the purposes of service reporting and evaluation should be included in consent process.
- Consent forms, as part of client intake or registration processes, should be clear and easily understood by the consumer.
- To support an integrated care model, consumer information may be shared with service provider organisations. Consumers should be informed of this and consent to the information-sharing approach. Confidentiality and consumer privacy must always be upheld.

Workforce standards and scope of services

Qualifications

To ensure a high-quality 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 relevant professional development (CPD) requirements.
- Be members of their discipline-specific professional association where applicable.
- Have completed cultural safety training (mandatory).
- Undertaken 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.

Scope of services

- Health professionals working in the HCCCM program will provide primary care-based clinical services to eligible consumers as per their professional scope of practice.
- All professional services must be delivered according to best practice guidelines, as described in your program workplan. For example, cardio-pulmonary rehabilitation programs should ensure they are delivered in line with current clinical recommendations, such as those referenced in CSANZ Position Statement or Lung Foundation Australia Introduction | Pulmonary Rehabilitation Toolkit, including reference to Safety Issues Relating to Exercise Assessment and | Pulmonary Rehabilitation Toolkit.

Clinical service delivery, service caps, discharge and follow-up

Individual clinical service delivery

Occasion of Service

Definition: Any examination, consultation, treatment or other health service provided to a consumer, or group of consumers, on each occasion that such a service is provided.

- An Occasion of Service should involve the HCCCM clinician, the consumer, and if relevant and required, a third party, such as a carer. An Occasion of Service may be delivered in person and supported by digital platforms or telephone as relevant and preferred by the consumer.
- It is expected that most Occasions of Service involve an interaction with the consumer. For consumers with more complex needs, time spent undertaking clinical care coordination or multidisciplinary team care, without the consumer present, may be reported as an Occasion of Service.
- An Occasion of Service may only be reported if it is relevant to the clinical condition of the consumer. This means that it does not include services of an administrative nature e.g. telephone contact to schedule an appointment.
- The duration of occasions of service within the clinical service cap may vary depending on the need and complexity of the consumer.

Group programs

- Group programs are a structured, collaborative learning method where a small group of individuals work together to achieve specific education, behavioural or development goals. For the HCCCM Program it includes evidence-informed education and, where applicable, supervised exercise to support participants living with COPD, chronic heart failure and/or diabetes (including relevant comorbidities and risk factors). The group program should aim to improve self-management capability, lifestyle and risk-factor management, symptom management and health literacy, and to reduce the risk of preventable hospitalisation through timely and appropriate intervention.
- Group programs are led or supervised by an appropriately qualified health professional. They should contain a minimum of four consumers and are delivered in line with current clinical recommendations for management of heart failure, COPD and diabetes.
- Group program sessions are predominantly delivered in person and supported by relevant digital platforms where this helps consumers to access or engage with the group program (for example, where Virtual group programs have been approved in your Work Plan).

Service caps

- Clinical service caps per 12 months: **up to six individual occasions of service and up to eight group sessions per consumer** (allocation based on need and goals identified during initial assessment).
- If a consumer is receiving more than one service type, they are capped at six individual occasions of service, per service type, per 12 months. They may receive fewer than six occasions of service for any service type to meet their clinical needs.
- The 12-month service period commences on the date of the first occasion of service/group session following the initial assessment. Initial and exit assessments are not included in the service caps.

Discharge and follow-up

Discharge planning starts at entry to the program. A consumer is discharged from the program once they have completed their allocated occasions of service/group sessions and/or achieved their goal/s. Discharge also occurs if they withdraw from the program or are no longer able to attend (e.g. illness, change of location).

- Discharged consumers **must receive scheduled follow-up check-ins** (e.g. Brief telephone consultation) to check progress at three-, six- and 12-months post-discharge, unless a check-in call is not appropriate (e.g. consumers specifically request no further check-ins).
- If check-ins suggest further intervention is required (e.g. exacerbation of medical condition), the consumer may be reassessed and readmitted to the program as a unique client, and service caps within 12 months would start again. A consumer may be readmitted for a short re-engagement such as one or two occasions of service if clinically indicated then discharged again; there is no requirement for the consumer to attend another six individual or eight group sessions.
- Similarly, if clinically indicated, a consumer may be reassessed and readmitted to the program following discharge, prior to a scheduled follow-up check-in.

Program implementation

Data and information collection

Work plan

A work plan outlining your service delivery model as per your approved HCCCM submission, must be submitted electronically via Folio to Murray PHN for approval before services begin. The work plan should typically include:

- Key personnel and their FTE (number of hours they work)
- Geographic location(s) of service delivery
- Activity plan, including the model of care and how it supports consumers.
- A plan for service integration and coordination
- Clinical governance and risk management plan
- A plan for managing referrals, intake and consumer discharge.

Providers must notify Murray PHN of any changes to the work plan, such as personnel updates or service location changes.

For assistance, contact your Murray PHN representative or visit the website for helpful resources, which include:

- Workplan and Budget-Guide for Completion video
- Workplan Instruction document.

Outcomes and key results

Section 3 of the Schedule lists the annual (unless otherwise specified) targets for the number and type of services you are contracted to deliver, as well as other requirements such as survey response rates and case studies.

Providers will need to collect and report on the following key information (where applicable):

- Occasions of service, by service type and modality
- Number of services provided in person
- Number of eligible consumers receiving services
- Group sessions delivered and completion rate
- Patient experience survey
- Consumer case study
- Consumer Information Form (Minimum Data Set).

Relevant documentation must be submitted to Murray PHN via the Folio Platform or Microsoft Forms and is outlined in more detail below. Contact your Murray PHN representative if you need help accessing or using Folio or Microsoft Forms.

Reporting

The Schedule outlines the reporting obligations for Murray PHN funded services. The following provides a guide to assist with completing some of these reports and the collection of performance data.

Monthly	• **Verbal report meeting** with Murray PHN (usually via Microsoft Teams, with occasional onsite visits to provider's workplace arranged by mutual agreement) to discuss service delivery progress, highlights and achievements and any other relevant issues (e.g. risks, staff changes, waitlists). Providers can contact Murray PHN at any time with questions or service delivery concerns. • Performance and reporting data ('Checklists') submitted online via Folio, Murray PHN's reporting platform. Contact Murray PHN if you need help accessing or using Folio.
Quarterly	**Financial Acquittal to Budget** (PHN template provided and submitted via Folio).
Yearly	• **Consumer Case Study** – one per clinical service type per year (template provided and submitted in Folio). – The consumer case study is an important piece of qualitative information to help demonstrate service impacts and outcomes at a consumer level. Multiple clinicians can submit a combined case study on the same person; however, the case study must clearly articulate each clinician's role in the care of the consumer. A combined case study will need to be uploaded to Folio against each relevant 'service type' Checklist, otherwise it will show up as an 'overdue' Checklist if it is only uploaded once. • **Commissioned Service Provider Satisfaction Interview** – Provider participation in our annual, online Satisfaction Interview will provide an opportunity for you to provide feedback regarding program support provided by Murray PHN.
Ongoing throughout contract duration	• **Consumer Information Form (MDS)** – Completed forms to be submitted via Microsoft Forms within one month of each new consumer's initial assessment. The MDS only needs to be collected once for each consumer per organisation, regardless of the number/type of clinical services they receive (the data does not need to be collected again if a consumer re-enters the program after discharge). • The MDS collects the following data: – Referral source – Consumer year of birth – Aboriginal and/or Torres Strait Islander identity – Country of Birth – Year of arrival in Australia (if applicable) – Cultural or ethnic background – Language spoken at home – Need for an interpreter – Gender – Postcode – Town/area of residence – Aboriginal and/or Torres Strait Islander status – Access to a regular GP – Availability of current GP chronic conditions management plan – Most recent GP visit

	• **Patient Experience Survey The Patient Experience Survey** (accessible and submitted via Microsoft Forms: Patient Experience Survey | Chronic Condition Management - Fill out form) aims to gather information from patients about how satisfied they are with their healthcare experience, and whether that care has enabled them to better look after their health. All patients attending for clinical services should be offered the survey on discharge. Note, the term 'patient' is used in this discussion as that is the term by which consumers are addressed in the survey. • Consumers can be provided with the above Microsoft Forms link for self-completion of the survey, or you can submit the answers on their behalf via the Microsoft Forms link. • A target survey response rate of 50 per cent is included in the Outcomes and Key results table of the Schedule. This will be calculated by dividing the number of completed surveys by the number of people offered the survey. • Providers will be able to see their results from the Patient Experience Survey through a PowerBI dashboard (contact Murray PHN for further information).

Budget and use of funds

Providers will be given a standard budget template to populate at commencement of a contract and submit via Folio. The template has been set up with standard lines for completion. The items listed in Column A have been locked by Murray PHN so that there is consistency in budget responses.

The Column L (Commentary) can be used where multiple items exist on the same row, or you need to include further detail or itemise the costs.

Budget Template	Annual Budget	Q1 Actuals	Q2 Actuals	Q3 Actuals	Q4 Actuals	YTD Actuals	% YTD spend against budget	Trend	Commentary (where multiple revenue or expense items exist on the same row, an itemised description is required in the commentary column)
	FY<XX>	FY<XX>	FY<XX>	FY<XX>	FY<XX>	FY<XX>		FY<XX>	
REVENUE									
Grant Funding/Contract Value						$ -	#DIV/0!		
						$ -	#DIV/0!		
		$ -				$ -	#DIV/0!		
TOTAL OPERATING REVENUE	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!		
SALARY AND DIRECT SERVICE COSTS (Minimum of 80% of Grant Funds)									
Direct Employment Expenses:	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!		
Direct Staffing Costs						$ -	#DIV/0!		
Direct Management and Administration Costs						$ -	#DIV/0!		
Staff Training and Development Cost						$ -	#DIV/0!		
External Supervision (for staff if required)						$ -	#DIV/0!		
Other (itemise in commentary)						$ -	#DIV/0!		
TOTAL DIRECT ACTIVITY COSTS	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!		
% of budgeted direct activity costs to grant funding	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!				
OPERATING COSTS									
Program Management Fees:	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!		
Corporate Cost Recovery (Executive management support, Payroll, HR, Finance, Governance and Administration etc.)						$ -	#DIV/0!		
Facilities:	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!		
Lease cost (building, copier etc.)						$ -	#DIV/0!		
Occupancy Costs (Utilities, phones, internet, cleaning etc.)						$ -	#DIV/0!		
Other (please specify in commentary)						$ -	#DIV/0!		
Marketing Cost:	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!		
Awareness Campaigns						$ -	#DIV/0!		

Eligible expenditure

Funding can be used for:

- Direct employment of staff to deliver free-of-charge services to eligible consumers (no gap fees).
- Program administration, including clinical governance, management, data collection and reporting.
- Costs associated with outreach service delivery.
- Costs associated with professional development, supervision and attendance at Murray PHN communities of practice.

At least 80 per cent of total funding must be allocated to salaries and direct service costs.

Ineligible Expenditure

Funding cannot be used for:

- Purchase of assets over $5000.
- Co-payments for people with private health insurance.
- Service delivery for non-prioritised chronic illnesses.
- Service delivery outside specified LGAs.
- Service delivery for consumers in residential aged care or admitted to a facility.
- Service delivery where consumers receive funding for the same services from another source (duplication of service).

Acquittal

Quarterly Financial Acquittal to Budget – Providers will need to acquit funds spent each quarter in a Financial Acquittal Report, which can be found under Folio Checklist.

Service provider obligations

Safeguarding children and vulnerable persons

By entering into an agreement with Murray PHN, your organisation commits to legal and ethical responsibilities to maintain child-safe environments when delivering RHN services. This includes:

- Protecting children from abuse or harm and responding to any incidents, disclosures or suspicions of abuse or neglect.
- Conducting relevant screening e.g. police checks, Working with Children Checks, as appropriate.
- Ensuring no legal prohibitions prevent your organisation or staff from engaging with vulnerable persons and comply with applicable laws related to engaging with vulnerable persons.
- Immediately providing Murray PHN with any documents or information related to actions taken by regulatory authorities regarding child safety issues affecting your organisation.

Reporting notifiable events

All commissioned service providers must report Notifiable Events to the relevant authorities and directly to Murray PHN.

- For full details, refer to Murray PHN's Policy – Notifiable Event - Clinical
- To report a notifiable event, complete Notifiable Event (Clinical) Reporting Form

References

The following resources helped inform the development of the Health Connection and Chronic Conditions Management Program Guidelines.

- Murray PHN - Our region
- Health Needs Assessment and Population Health Series Report
- Privacy and Data Protection Act 2014
- Australian Privacy Principles | OAIC
- Office of the Victorian Information Commissioner (2021). Information Privacy Principles.
- Health Records Act 2001
- Lung Foundation Australia
- A Clinical Guide for Assessment and Prescription of Exercise and Physical Activity in Cardiac Rehabilitation. A CSANZ Position Statement
- Allied Health Professions Australia (AHPA)
- National Strategic Framework for Chronic Conditions
- Department of Health Victoria. Supervision and Delegation Framework for Allied Health Assistants.
- Murray PHN. Clinical Incident and Notifiable Event Reporting
- Murray PHN. Contract Management Guideline: Guidelines for Monitoring and Managing Performance of Commissioned Services and Activity. (Murray PHN internal guidelines).

Appendix A

HCCCM service provision

The following organisations are providing services for the HCCCM program in 2026/2027. Further access and intake information will be provided by each organisation and will be available on Health Pathways.

North West	• **Regional Health Navigator**: – *Mallee Track Health and Community Service*. T: 03 5092 1111. (LGAs: Buloke, Mildura, Swan Hill) • **HCCCM clinical services:** – *East Wimmera Health Service* – Dietetics, Diabetes Education, Diabetes Education Group. T: 03 5477 2222. (LGA: Buloke) – *Swan Hill District Health* – Chronic Disease Nursing (towns within 100km radius of Swan Hill in LGAs: Buloke, Swan Hill) and Diabetes Education (LGA: Swan Hill). T: 03 5033 9337.
Central Victoria	• **Regional Health Navigators**: – *Bendigo Community Health Service*. T: 03 54061200. (LGAs: Greater Bendigo, Macedon Ranges, Mt Alexander) – *Northern District Community Health*. T: 03 5451 0200. (LGAs: Campaspe, Loddon, Gannawarra) • **HCCCM clinical services:** – *Swan Hill District Health* – Chronic Disease Nursing. T: 03 5033 9337. (LGA: Gannawarra) – *Inglewood District Health Services* – Dietetics, Diabetes Education, Cardiopulmonary Rehabilitation, Chronic Disease Nursing, Dietetics Group Program, Diabetes Education Group Program. T: 03 5431 7000. (LGA: Loddon)
Goulburn Valley	• **Regional Health Navigator:** – *Primary Care Connect*. T: 03 5823 3200. (LGAs: Mitchell, Murrindindi, Moira, Strathbogie, Greater Shepparton) • **HCCCM clinical services:** – *NCN Health* – Cardiac Respiratory Diabetes Groups – onsite, virtual and outreach. T: 03 5871 0944. (LGA: Moira) – *Primary Care Connect* – Dietetics Education, Chronic Disease Nursing, Pulmonary Rehabilitation Group, Dietetics Education group. T: 03 5823 3200. (LGA: Strathbogie)
North East	• **Regional Health Navigator:** – *Gateway Health*. T: 1800 657 573. (LGAs: Albury, Benalla, Indigo, Alpine, Mansfield, Towong, Wodonga, Wangaratta) • **HCCCM clinical services:** – *Benalla Health* – Podiatry, Dietetics, Diabetes Education, Chronic Disease Nursing, Multidisciplinary Education and Exercise Group (Diabetes focus). T: 03 5761 4500. (LGA: Benalla) – *Charles Sturt University* and *Westside Community Centre* – Podiatry, Podiatry Group. T: 02 6051 9050. (LGA: West Albury) – *Mansfield District Hospital* – Heart Failure Group Education, Chronic Disease Nursing. T: 03 5775 8800. (LGA: Mansfield)