phn MURRAY

An Australian Government Initiative

HEALTH CONNECTIONS AND CHRONIC CONDITIONS MANAGEMENT PROGRAM

REGIONAL HEALTH NAVIGATOR SERVICE

June 2026

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 Regional Health Navigator (RHN) service providers and staff commissioned by Murray PHN under the Health Connections and Chronic Conditions Management (HCCCM) Program, which began 1 July 2026. It outlines key aspects of Regional Health Navigator services, 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 Murray PHN provider agreement and associated Schedule 1 (the 'Schedule'). Therefore, it is important to review and understand this guideline alongside those documents.

This is the first version of the **Murray PHN Regional Health Navigator Service Guideline**; further iterations will be developed in collaboration with commissioned services and partner organisations. The 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,' 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 contact HCCCM@murrayphn.org.au with questions about the program.

Contents

Program overview ... 5
Background ... 5
HCCCM model ... 5
Program objectives ... 6
Guiding principles ... 6
Regional Health Navigation program ... 7
Target population ... 7
Service scope ... 7
Approach ... 7
Consumer eligibility and referrals ... 8
Eligibility ... 8
Exclusions ... 8
Communities of practice ... 8
Promotion and marketing ... 8
Referrals, intake and demand management ... 9
Consent and privacy ... 9
Qualifications and skills ... 10
Role and function ... 10
Reporting notifiable events ... 11
Program implementation ... 12
Data and Information collection ... 12
Service provider obligations ... 15
Safeguarding children and vulnerable persons ... 15
Frequently asked questions (FAQs) ... 16
References ... 17
Appendix A ... 18
HCCCM service provision ... 18

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.

Regional Health Navigation program

The HCCCM Program commissions a full-time Regional Health Navigator (RHN) role across each of the four Murray PHN sub-regions.

The RHN program addresses healthcare access challenges for eligible consumers with complex health conditions, that have identified issues accessing health and community support services and information.

RHNs provide direct, non-clinical assistance, information and support for eligible individuals with complex chronic conditions. RHNs collaborate closely with health service providers, general practices, and community organisations, so that referred consumers can access pathways to receive the support and care they need to achieve their care goals.

Collaboration, capacity building, and information sharing are facilitated through the RHN Community of Practice (CoP), which will be aligned with other relevant Murray PHN CoPs and networks, enhancing the overall effectiveness of the services provided.

Regional Health Navigators provide essential, **non-clinical support**. They do not diagnose illnesses, offer medical interventions, or create dependency. Instead, they empower consumers and communities, improve health outcomes, and help people to navigate the complexities of the healthcare system.

Target population

The RHN program supports individuals with priority chronic diseases of diabetes, chronic heart failure and/or COPD to access primary healthcare. Its focus is those who have complex needs and experience difficulties navigating the healthcare system. Priority groups include:

- people living in remote or rural areas.
- vulnerable populations including First Nations, older people, isolated people
- people with limited health literacy
- non-English-speakers with limited English proficiency.

Service scope

The RHN program assists eligible consumers to navigate the Australian healthcare system by providing essential non-clinical and non-crisis support.

The RHN will provide direct support to help people to find entry points and pathways into services and building service awareness and capacity to engage with the health system as needed.

This is a non-clinical support role, working directly with providers and referred consumers. It is designed to address the current barriers that people experience in navigating the health system, improve their journey and experience, thereby positively impacting health outcomes. Service provision is as part of a shared care plan, is place-based and outreach focused, delivered face-to-face as well as by digital/tele support as appropriate.

Approach

The preferred service approach is centred around a holistic, person-centred model of care, which is designed to break down barriers that often complicate a person's navigation of the healthcare system.

By prioritising the needs and preferences of individuals, RHN services ensure that consumers are active participants in their own care, while also fostering a collaborative and empowering environment with consumers and service providers.

The focus is on supporting consumers to access care outside of hospital settings, reducing strain on hospitals and supporting individuals to actively managing their health within the community, with the aim of preventing exacerbations and more costly or intensive interventions.

Consumer eligibility and referrals

<table>
<tr><td rowspan="2">Eligibility</td><td>To be eligible for RHN services, a consumer should:
• have one or more of the HCCCM priority chronic diseases – diabetes, chronic heart failure, COPD.
• experience barriers to accessing or navigating primary health care services (e.g. location, cost, transport, literacy, language, physical or mental illness, trauma).
• reside in a local government area (LGA) within the Murray PHN region*, or a town specified in your Schedule.
• be referred to the RHN at any stage during their care if this need was not apparent during their initial assessment.
• require support to participate in or implement chronic condition management plans or recommendations.</td></tr>
<tr><td>Priority may be given to consumers who:
• frequently access acute services or experience unnecessary hospitalisations
• live in rural or remote locations.
• lack family or other community supports.
• are from a vulnerable cohort
• are non-English speakers with limited English proficiency.</td></tr>
<tr><td>Exclusions</td><td>• Consumers with non-prioritised chronic illnesses
• Consumers outside specified LGAs – see below re consumers on LGA borders
• Consumers living in residential aged care or admitted to a residential care facility
• Consumers receiving funded services for the same needs from another source (duplication)</td></tr>
<tr><td>Communities of practice</td><td>Providers should actively participate in relevant Murray PHN communities of practice (CoP) or peer support networks once established. The CoP aims 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.</td></tr>
<tr><td>Promotion and marketing</td><td>As a new service, providers will need to undertake promotional activities to ensure referrals. Promotion should be monitored and planned to ensure that only eligible consumers are referred, referral sources are monitored and that demand is managed.</td></tr>
</table>

**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 contact to discuss.*

Referrals, intake and demand management

Consumers can be referred by a HCCCM commissioned provider, GP or community health organisation. RHN service providers are responsible for promoting straightforward referral pathways to their RHN services.

To ensure integrated care, it is recommended that the goals identified in a consumers care plan are shared with the RHN on referral along with key demographic data (minimum dataset/Consumer Information Form) to reduce the need for consumers to re-tell their story and re-share information. The RHN provider should also ensure the consumer's regular GP or care team are notified of any referrals and included in communications (with the consumer's consent). For consumers not currently under the care of a health team to manage their illness, this presents an opportunity to help them connect or reconnect, with appropriate care.

RHN providers should also seek to establish streamlined referral pathways for referred consumers to access local community health programs, relevant multicultural services and community support programs, such as Neighbourhood Houses. All services provided under the RHN program are free-of-charge, and no gap payments may be charged to consumers. Participation in the service is entirely voluntary, and consumers may exit the program at any time, without obligation.

If demand for services exceeds supply, a secondary level of eligibility should be implemented to prioritise consumers facing economic hardship, such as individuals who hold a health care card or pensioner card. Service providers are responsible for determining consumer eligibility and prioritising access accordingly.

Once a consumer's goals have been achieved, they are discharged from the service with follow up check ins required at three- and six-months. This may be done in conjunction with the consumer's HCCCM provider if relevant and if discharge timeframes align. Discharge planning should be in place from intake and is essential to ensure the service remains accessible to those who need it. If relevant, a consumer may be re-admitted to the RHN program post discharge if required.

Consent and privacy

The service provider must obtain informed consent from the individual and/or their legal guardian before any navigation support begins. 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

Qualifications and skills

To ensure high-quality service delivery, it is desirable that RHNs possess the following experience, skills, and attributes:

- experience in a relevant field e.g. community services, social work, nursing or a health-related occupation. While not essential, a degree or formal qualification is an advantage.
- demonstrated cultural competency and experience working with people from diverse backgrounds.
- key 'soft skills' such as having empathy, patience and initiative, effective communication and problem-solving skills and able to maintain confidentiality.
- the ability to work with vulnerable individuals and families, including relevant police checks and Working with Children Checks (as required).
- commitment to ongoing professional development.

To address recruitment challenges, providers should consider flexible workforce models that align with program objectives and consumer needs. For clarification on qualifications and attributes for navigator roles, please contact your Murray PHN representative.

Role and function

Successful navigation relies on collaboration between client, carers, family members and healthcare providers. Navigators should have a good and comprehensive understanding of the health system, detailed knowledge of local and regional services, and the skills needed to foster connections and navigate referral processes.

The RHN role is 1.0 FTE but may be split across two people if relevant. Please ensure your Murray PHN contact is aware and that this is reflected in your Work Plan.

RHNs support consumers to achieve their care plan goals by:

- Working with both providers, consumers and carers/families to assist in effectively navigating the health system.
- Working within an integrated model of care with health care providers, GPs and social supports as needed, to ensure consumers can access the right care, in the right place and the right time.
- Linking consumers to identified services and supporting their access through a strong understanding of available local/regional services, access points, pathways and resources.
- Providing assistance via face-to-face, telephone or video conferencing.
- Providing resources based on language, literacy level, learning style, cultural norms and readiness for change.
- Using strong communication and networking skills that allows collaboration with providers in the region.
- enhance consumers' capacity for effective engagement with healthcare services and support the development of self-management skills tailored to individual needs e.g. language, literacy, cultural norms.
- Contribute to care coordination by participating in collaborative networks and complementing existing programs and services.
- Facilitate opportunities for consumers and communities to engage with health providers and information.

Note: Via agreement with Murray PHN, functions may need to vary between services based on regional context.

Navigators should **not**:

- diagnose medical conditions or provide medical/health advice i.e. they may provide general health promotion advice and service system information only
- administer medications, treatments or perform medical examinations
- provide psychological therapy or counselling. They may offer general emotional support or incidental counselling within their scope
- offer financial, legal or ethical advice related to the client's care
- provide direct care or hands-on assistance e.g. bathing, food preparation, wound dressing
- make decisions for consumers or undermine their self-determination
- provide formal care coordination, clinical referrals or clinical decision making.

Reporting notifiable events

All commissioned service providers must report Notifiable Events to the relevant authorities and directly to Murray PHN. Non-clinical notifiable events include:

- Professional misconduct or malpractice e.g. unethical behaviour or actions by staff.
- Notifiable data breach involving sensitive information or unauthorised data access.
- Changes to the controlling entity of your organisation that may impact governance.
- Investigations into serious offences such as corruption, fraud, misappropriation or other criminal activity.

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

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 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):

- Consumer Information Form (Minimum Data Set)
- Occasions of service and unique consumers
- Number of consumers discharged and re-entering the service
- Number of new consumers
- Number of services provided in person
- Consumer Outcomes Survey – impact of program
- Consumer Case Study
- Systems Case Study
- Number of Community Engagement Sessions - providers identified in their HCCCM models that RHNs could undertake community engagement sessions as one way to promote knowledge of services available for support, access pathways etc. These sessions could be co-facilitated with local service providers across the subregion to include specific health information and education. Numbers of community engagement sessions held are reported through the Folio checklist, and outcomes could be reported as part of a case study.

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. Contact Murray PHN with any questions.

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. The frequency and duration of these meetings is determined by negotiation and adjusted as needed, such as for new contracts or when risks to service delivery are identified. • **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 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. • **Systems Case Study** – one per year (template provided and submitted in Folio) describing integration and systems improvements and changes delivered through the program. • **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. • When a consumer is referred from a HCCCM provider, the completed MDS information should be provided as part of the referral for the RHN organisation to record, so the consumer does not have to repeat information. The RHN should then use this information to complete and submit the MDS. • For consumers referred from other providers, the MDS will need to be completed in full and submitted by the RHN. The MDS only needs to be collected once for each consumer per organisation (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 • **Consumer Outcomes Survey** - All consumers participating in RHN services should be offered the survey (accessible via link sent to providers) on discharge. The purpose of the survey is to gather information from consumers point of view about the impacts and benefits of the service. The survey is anonymous to support open consumer feedback. Providers should assist consumers to complete the survey if required. It is a simple survey that asks whether the RHN service has: – improved their understanding of what health services are available and how to access them – provided them with the help needed to access or connect with health services and other supports in the community. – enabled them to be more confident looking after their health since working with the Regional Health Navigator service. • A target of '70 per cent or greater of surveyed consumers report improved outcomes' is applicable.

Budget and use of funds

As part of entering into an agreement with Murray PHN, service providers must submit a detailed budget outlining income and expenses related to the delivery of the RHN service. This budget must be on the provided template and be approved by Murray PHN prior to the start of services. The budget should clearly reflect the financial resources required to effectively conduct the service, including personnel costs, operational and administrative expenses, and program-specific costs. In kind costs can be noted as comments in the template but are not included a part of the approved budget. Acquittals against the approved budget are required as part of quarterly reporting.

Providers will be given a standard budget template to populate at start 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 spent 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 Checklists.

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.

Frequently asked questions (FAQs)

Who is considered a 'new client'?	A new client refers to individuals who underwent intake with the RHN service during the reporting period, including those who were previously discharged and later readmitted.
What is a 'unique' client?	A unique client is an individual person who receives services within a specified period. Each person is counted once, regardless of the number of times they access healthcare services during that period.
What is an 'occasion of service'?	An occasion of service is a consultation, support, or service provided to a consumer or a group of consumers, on each occasion that such a service is provided. A service does not have to be provided in person, but the client must be 'directly' assisted.
What do we mean by 'directly' assisted?	This refers to consumers who receive *direct* tailored, person-centred support from the program which can be by digital means.
What is 'direct' service delivery?	Direct service delivery involves direct interaction between the RHN provider and the consumer. Examples include: • **one-on-one support:** assisting consumers with appointments, referrals, and access to services • **appointment support:** attending appointments to advocate, clarify instructions, and provide emotional support • **coordination activities:** linking consumers to services, arranging transport, or ensuring follow up • **client-related administrative tasks:** case notes, referrals and support letters.
What is 'indirect' service delivery?	Indirect service delivery includes tasks that support the service but do not involve direct client contact. Examples include: • **non-client administrative tasks:** general paperwork or preparing reports • **networking:** building relationships and referral pathways with providers and services • **resource development:** creating resources like flyers, videos or translating health information • **community engagement:** facilitating sessions for community members to provide information to support improving health literacy and chronic disease self-management • **data and reporting:** collecting and analysing data to identify care gaps or guide service improvement, or to meet obligations (e.g. Murray PHN reporting).
What do we mean by face-to-face?	A face-to-face interaction refers to a direct, in-person exchange between the navigator and the consumer. This allows for enhanced verbal and non-verbal communication, such as body language, facial expressions, and eye contact where appropriate. It does not include services delivered via telephone, video/online platforms, or email/messaging.

Who do we consider to be discharged from the program?	A client is typically considered suitable for discharge once their mutually identified goals have been met. This may include the client's capacity to navigate the health care system independently, or the improvement or stabilisation of their health condition/s to a point where personalised support is no longer required or beneficial. A client is considered formally discharged when they request or mutually agree to end the service, or when they are informed that the service will cease. They should be invited to complete the voluntary **Consumer Outcomes Survey** at the time of discharge.
Other pointers for completing the reporting checklist	• **Numeric responses:** Folio checklist questions require a numeric response (a number), unless otherwise specified. Ensure that you input only numerical values where required. If a specific range or set of values is indicated, make sure your response aligns with those instructions. For questions where a precise number cannot be provided, choose the most accurate estimate. • **Detailed explanations:** if any response requires additional clarification or further details, provide a thorough explanation in the 'Other Comments' field. This is particularly important if the answer is based on an estimate, interpretation, or if there are nuances that cannot be fully captured by the numerical value alone. Comments should clearly outline any assumptions, context or factors that influenced the answer to ensure full transparency and understanding.

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
- National Strategic Framework for Chronic Conditions
- Department of Health Victoria. Supervision and Delegation Framework for Allied Health Assistants

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.

Region	Services
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)