2024

Report to the Community

phn MURRAY

An Australian Government Initiative

Acknowledgement of Country

Murray PHN acknowledges its catchment crosses over many unceded First Nations Countries following the Dhelkunya Yaluk (Healing River).

We pay our respects and give thanks to the Ancestors, Elders and Young People for their nurturing, protection and caregiving of these sacred lands and waterways, acknowledging their continuation of cultural, spiritual and educational practices.

We are grateful for the sharing of Country and the renewal that Country gives us. We acknowledge and express our sorrow that this sharing has come at a personal, spiritual and cultural cost to the wellbeing of First Nations Peoples.

We commit to addressing the injustices of colonisation across our catchment, and to listening to the wisdom of First Nations communities who hold the knowledge to enable healing.

We extend that respect to all Aboriginal and Torres Strait Islander Peoples.

Our commitment to being an anti-racist company

Murray PHN aspires to be an anti-racist organisation, embedding cultural humility as a daily practice to improve health outcomes and health equity in our communities. We recognise cultural humility as a lifelong commitment to self reflection, personal growth and redressing power imbalances in our society.

Contents

About Murray PHN

Primary Health Networks have a crucial role in supporting health reform across Australia, by harnessing and driving local innovation to meet specific health needs and supporting consistent delivery of national and co-commissioned programs to keep people well, particularly those with chronic health conditions and mental illness, and to reduce avoidable hospital presentations.

The work of Murray PHN, its Board and Executive, and all team members, is underpinned by five important organisational values – Leadership, Collaboration, Respect, Accountability and Innovation. These values are embedded in our three-year Strategic Plan, which guides and directs all of our activities.

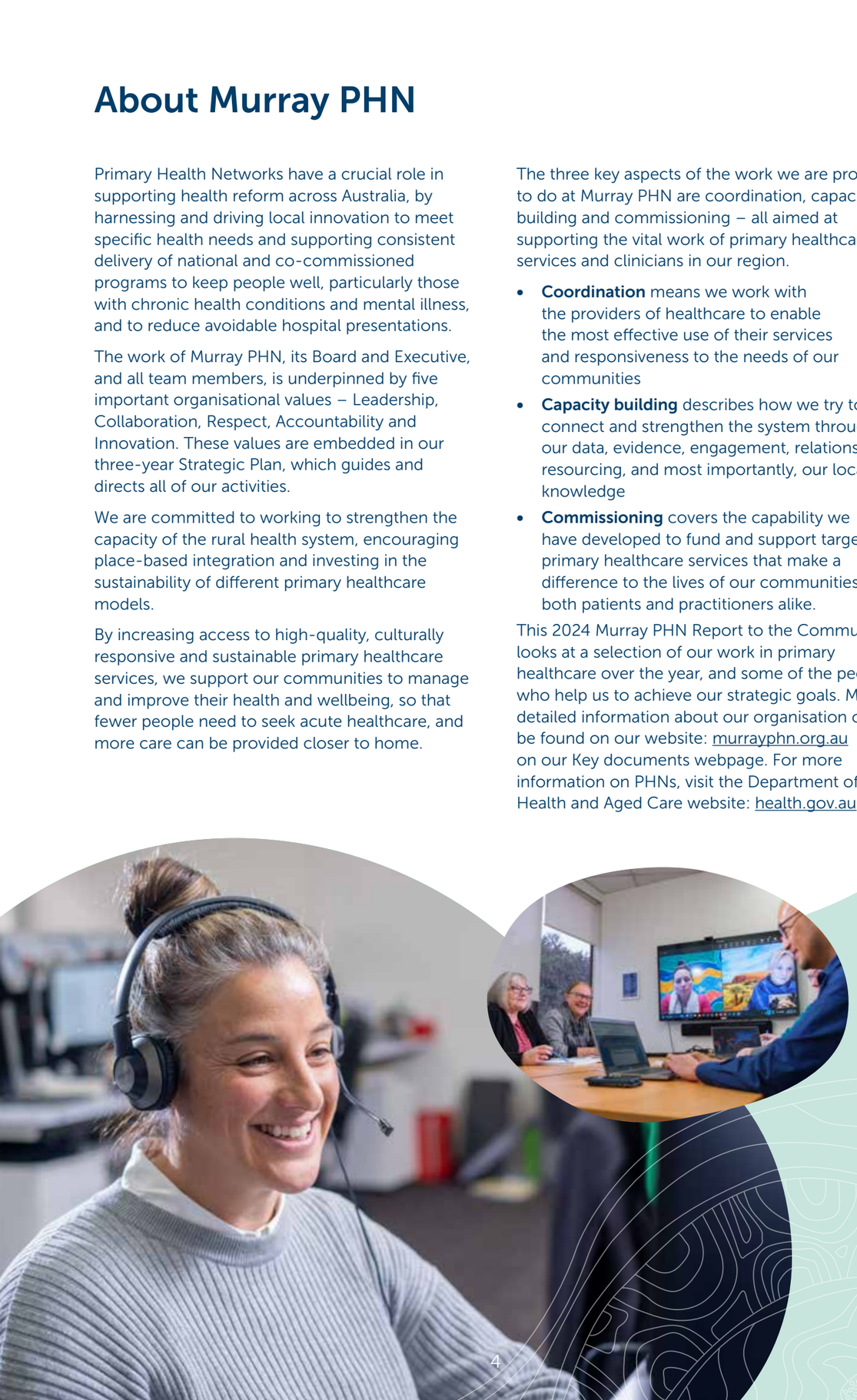
We are committed to working to strengthen the capacity of the rural health system, encouraging place-based integration and investing in the sustainability of different primary healthcare models.

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

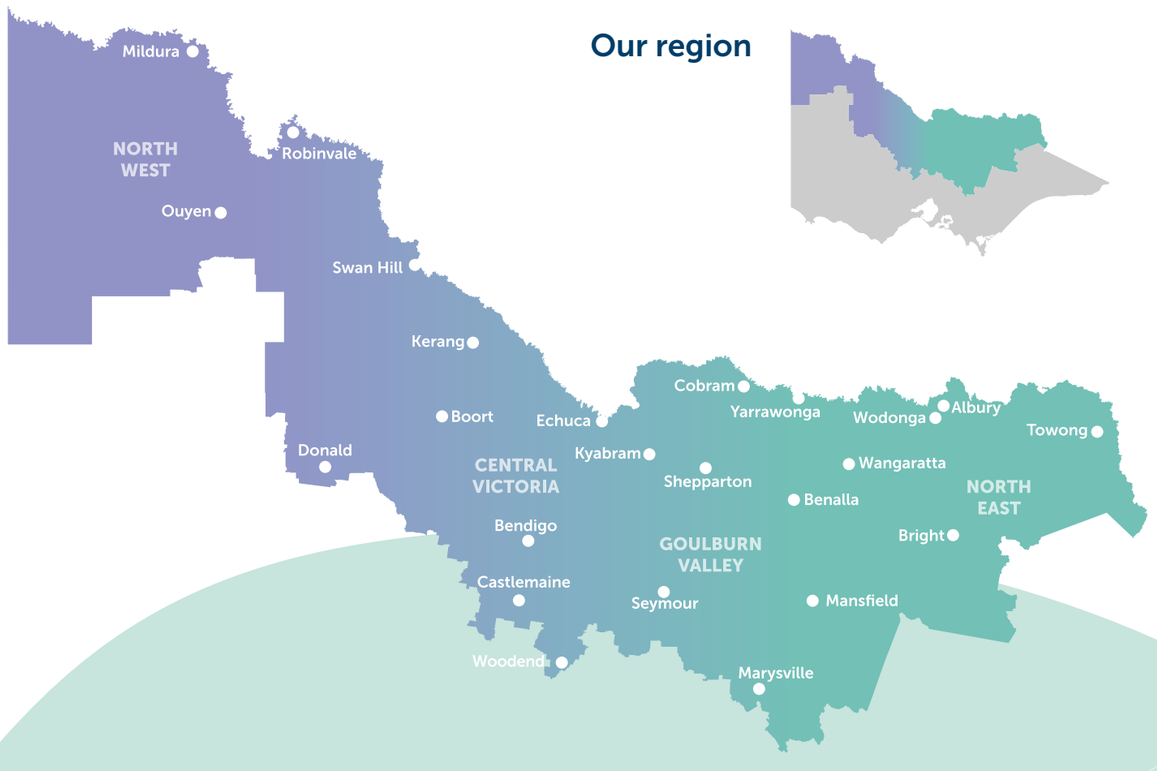
The three key aspects of the work we are proud to do at Murray PHN are coordination, capacity building and commissioning – all aimed at supporting the vital work of primary healthcare services and clinicians in our region.

- **Coordination** means we work with the providers of healthcare to enable the most effective use of their services and responsiveness to the needs of our communities
- **Capacity building** describes how we try to connect and strengthen the system through our data, evidence, engagement, relationships, resourcing, and most importantly, our local knowledge
- **Commissioning** covers the capability we have developed to fund and support targeted primary healthcare services that make a difference to the lives of our communities, both patients and practitioners alike.

This 2024 Murray PHN Report to the Community looks at a selection of our work in primary healthcare over the year, and some of the people who help us to achieve our strategic goals. More detailed information about our organisation can be found on our website: murrayphn.org.au on our Key documents webpage. For more information on PHNs, visit the Department of Health and Aged Care website: health.gov.au



Our region



Murray PHN health priority areas

Population health

General practice

Mental health

Alcohol and other drugs

Child health

First Nations

Health workforce

Digital health

Chronic disease

Aged care

Our Board

Leonie Burrows OAM - Chair

Andrew Baker

Dr Manisha Fernando

Dr Alison Green

Joanne Kinder

Matt Sharp

Bob Cameron

Jacki Turfrey

Ella Cannon

Steve Tinker

Fabian Reid
(retired 22 Nov 2023)

Detailed information about our Board members can be found in our detailed Financial Report on our website: https://bit.ly/24finreport

Our Executive

Matt Jones,
Chief Executive Officer

Elizabeth Clear,
Chief Corporate Officer

Jacque Phillips OAM,
Chief Operations Officer

Nick Shaw,
Chief Strategy and
Performance

Aileen Berry,
Executive Director
Communications

Leonie Burrows OAM - Chair

Message from the Chair

As we look back on another challenging and yet exciting year, the Board and I are delighted to introduce the 2024 Murray PHN Report to the Community - a snapshot of some of the inspiring work that our teams have carried out in support of the primary healthcare sector and the people who live in our region.

While the primary health environment is not without challenges, there are always opportunities for our sector to work together to make a difference for our communities. This year, we have continued to build the capacity of providers in our region with innovative models of care that help integrate health networks, while piloting models that can help break down some of the cross-state border issues faced by so many.

Workforce remains an ongoing issue in Australia, and particularly in rural and regional areas. We recognise that this is where championing place-based and innovative models of care can deliver effective primary healthcare – and to demonstrate to others how regional primary healthcare communities can often do more, with less.

In April this year, we began a review of our current Strategic Plan, considering what has been and what is still to be achieved as we begin our 2025-2028 strategic planning. We are delighted with progress to date – more than 90 per cent of our activities are on track for completion, with the remaining 10 per cent already complete ahead of time.

Pictured above L-R: Matt Sharp, Peter Breadon (Grattan Institute), Steve Tinker, Dr Manisha Fernando, Ella Cannon, Leonie Burrows OAM, Matt Jones, Joanne Kinder, Bob Cameron

We have also fine-tuned the plan's focus for the coming year, in line with recent changes in our health policy environment, while continuing our organisation's focus on the priority areas of integrating programs and activities, fostering health systems change and developing our organisation and people to impact our communities positively.

The ongoing development of our valuable Community Advisory Committees (four, dotted across our region) and the Clinical Advisory Committee (a variety of clinicians working in all parts of our region) has been outstanding. Increasingly, they are in the position of providing even more valuable insights and feedback on issues affecting their communities. This helps us ensure that service planning and commissioning are targeted effectively, and in line with the issues highlighted in our vital health needs assessments.

While I have been a board member since the organisation's inception, this has been my first year as Chair, filling the very big shoes of our long-term Chair, Fabian Reid. We have now renewed the contract of our Chief Executive Officer, Matt Jones, and were pleased he was able this year to visit key overseas health services on the short study tour we first considered in early 2020, before the world closed around us. We are grateful that Matt has continued to build a strong, multidisciplinary Executive team to take the organisation forward, and for all of the leadership team and staff.

I encourage you to read this report to understand the breadth and complexity of work that Murray PHN undertakes every day. We look forward to 2025 and beyond with optimism.

Message from the CEO

Matt Jones - CEO

In its recent report *Mirror, Mirror 2024, A Portrait of the Failing US Health System*, the US-based Commonwealth Fund compared the healthcare systems of 10 advanced countries with a variety of public health systems.

Those countries were Australia, Canada, France, Germany, Netherlands, New Zealand, Sweden, Switzerland, the United Kingdom and the United States of America. The fund's experts measured each country's healthcare system against factors including the quintuple aims of health system performance – access to care, quality of care, administrative efficiency, equity and health outcomes.

In this particular survey, Australia came out on top of all 10 countries, followed by the Netherlands, and with the United Kingdom in third place.

While this international leadership is something of which we can be justifiably proud, it is a reality that our world-first health service is not experienced equally by everyone in Australia. In our own region, people may have to travel hundreds of kilometres to get access to the right kind of care and in remote parts of the country, it is far worse.

According to the National Rural Health Alliance, each person living rurally is missing out on $848 of healthcare funding each year, despite the huge economic contribution from our rural communities to Australia's economy. At the same time, the lack of access to basic healthcare means they experience higher mortality and greater disease burden than their city counterparts.

We know that access to primary care can be difficult in capital cities. But in rural and regional areas, where we have increasing population and declining numbers of professionals in the primary healthcare workforce, access can be significantly delayed or geographically unavailable, with a major barrier being the cost of services that aren't bulk-billed.

We know – and the survey recognised – that people who do not choose or cannot afford to purchase health insurance have to wait longer to receive hospital or allied health services, with GP availability and affordability being a significant issue for many of the more vulnerable in our society.

Our healthcare system is in desperate need of renovation and reform. In Australia, we have the inverse situation where people in rural and regional areas with proportionately greater health need have less access to healthcare than in healthier metropolitan communities.

Financially, we have the perverse situation where people won't access healthcare because of the cost implications, yet the cost of providing care for providers is increasingly unsustainable. We need models of care provision that reflect and respond to the needs of our community, are accessible and sustainable, and are attractive settings for career and employment choice and fulfilment. Murray PHN is playing its role in developing these models and encouraging their implementation in areas that have lack of access to services and need for multidisciplinary team-based care.

Murray PHN has an Executive team and staff that are highly competent and capable. Our commitment to providing opportunities to strengthen primary care services, connect our healthcare system and develop place-based solutions is built on the skills, knowledge and professionalism that are the hallmarks of Murray PHN staff. I would like to give my heartfelt thanks to the whole Murray PHN team and our Board for their support throughout 2024.

Pictured: Socialstyrelsen's (Sweden) Irene Nilsson Carlsson - Senior Policy Officer Primary Care, Maria Hilberth - Division Director of Integrated Care and David Ylitalo - International Consultant with Matt Jones

Our key frameworks and strategies

Commissioning takes place within a complex environment shaped by changing policy and social landscapes.

It involves a wider range of processes, skills and capabilities than procurement and contracting alone.

It incorporates the tasks and decisions that translate government policy into services and systems that are responsive to community needs and seeks to achieve clear outcomes that reflect the aspirations of the community. It puts people at the centre of services and recognises the specialist knowledge and value of the service sector.

Murray PHN uses various methods of commissioning dependent on the intended outcome, and where appropriate, where we can see, understand and influence stakeholder connections across our catchment in a way that facilitates achievement of our strategic goals.

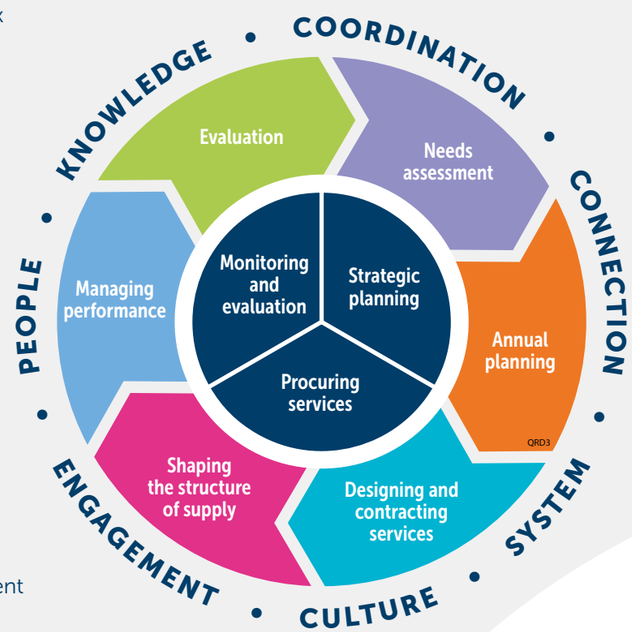
Evidence and experience tell us that change will happen when we focus simultaneously on:

- patient outcomes and experience
- service system capabilities, including workforce
- underserviced populations in communities of greatest need
- quality implementation of well-designed interventions to address need.

We also know that change does not happen through the action of one; it is the product of the combined and sustained efforts of many who share a common vision.

Fundamental to the values and vision of Murray PHN is our commitment to improving the outcomes and experiences of our community, with a focus on access and equity in primary healthcare.

We acknowledge systemic change is required to influence the disparity of health outcomes for First Nations Peoples. Our foundational First Nations Health and Healing Strategy has been endorsed by the Board and provides direction for commissioning to improve the health and wellbeing of First Nations Peoples.

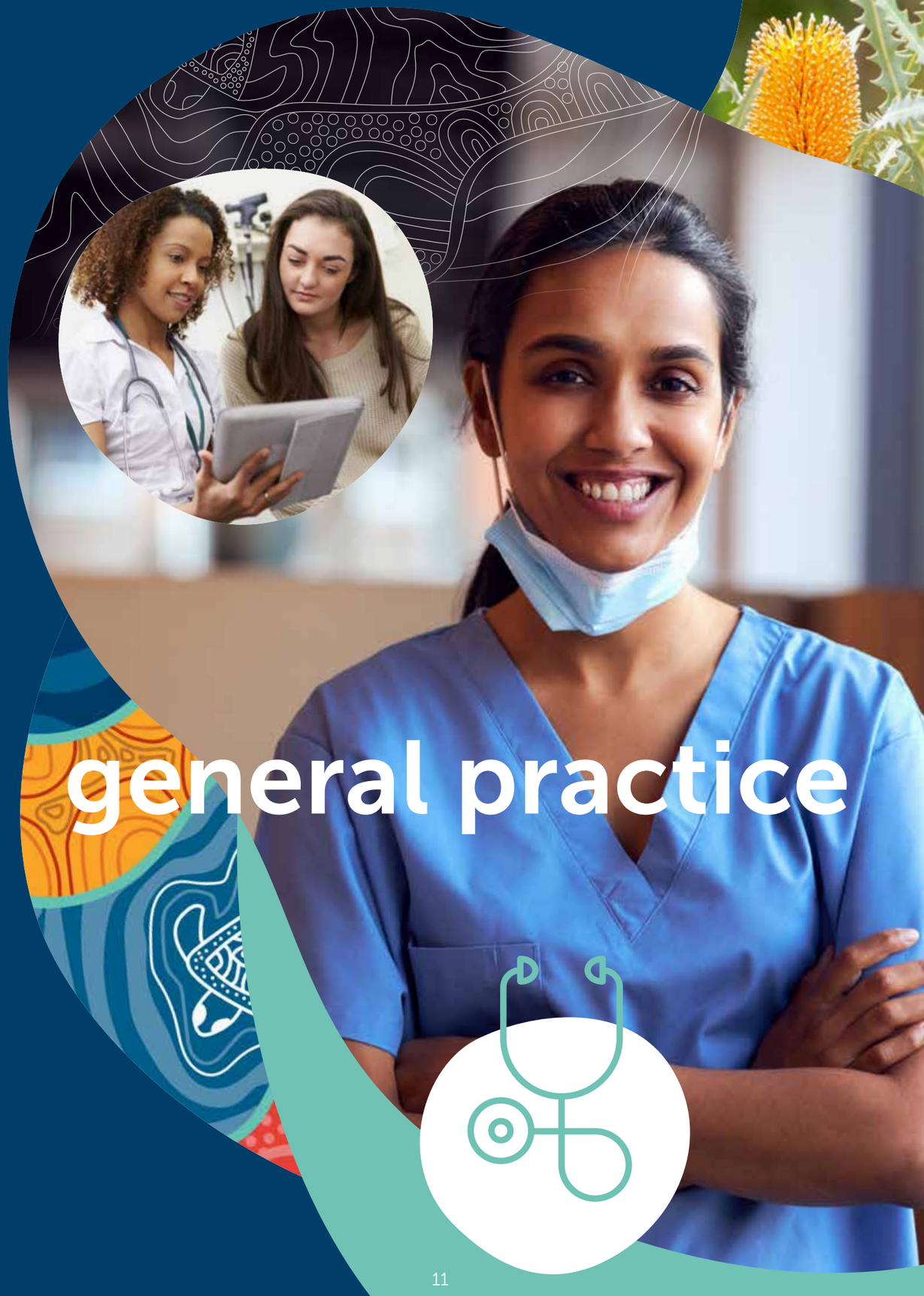


Our Commissioning Framework outlines the approaches, structures and policies that guide this work, underpinned by a commitment to support full involvement of First Nations Peoples in shared decision-making and self-determination.

It shows how we partner with consumers, carers and communities, as well as clinical and non-clinical health professionals and government organisations, to improve outcomes and experiences for those in greatest need in rural and regional areas.

Our Strategic Plan determines that we work to strengthen primary healthcare in our region to keep people well and out of hospital, underpinned by our values of Leadership, Collaboration, Respect, Accountability and Innovation. Our priority areas are integrated programs and activities, health system change and impact-led organisational development.

We are key custodians of rural and regional primary healthcare system development, providing quality primary care and equity of access for all people that will drive value across the system.



general practice

Helping to implement Medicare reforms

Based on the recommendations of the Strengthening Medicare Taskforce and building on Australia's Primary Health Care 10 Year Plan 2022-2032, several significant funding initiatives for primary healthcare were announced in the May 2023 Federal budget. These included changes to Medicare Benefits Schedule (MBS) funding and additional blended funding payments through the MyMedicare program.

An important enabler for continuity of care and health equity, the introduction of the voluntary MyMedicare patient and general practice registration system officially began in October 2023.

To support practices with the new system, Murray PHN developed step-by-step processes, resources and toolkits, such as a data cleansing quality improvement activity, to assist with the transition to MyMedicare. Three webinars were held, discussions had at local practice networking events and business consultations offered through a practice development program.

As of June 2024, 80 per cent of practices (81% in Goulburn Valley region, 88% in Central Victoria, 85% in North East and 48% in North West) were registered, leaving just 38 practices not yet registered for the MyMedicare system.

Supporting a growing number of accredited general practices

Last year, the Australian Government provided PHNs with funding to distribute to general practices as part of Strengthening Medicare initiatives, with 173 practices choosing to apply.

One hundred and thirty-two practices selected to use this funding to help maintain or achieve accreditation against the RACGP Standards for General Practices (5th edition).

In September 2023, Murray PHN's general practice team developed an accreditation strategy. At the time, 187 practices were accredited and seven practices were registered for accreditation. Over the course of the year, our support staff have helped reduce the number of practices registered for accreditation to four, which includes three newly opened practices.

Paired with our general practice team's goal to support practices in becoming accredited, seven practices reached the minimum safety and quality standards and were awarded their accreditation.

On 30 June 2024,
97.94 per cent
of practices, or 190 out of the 194 practices in the Murray PHN region, were accredited or registered for accreditation, which is a fabulous achievement, particularly when compared to the national accreditation rate of 83.8 per cent
(2019 data)

Working together to enhance proficiency and quality care

Murray PHN's team of Quality Improvement Consultants developed a dedicated program for general practices and Aboriginal medical services to enhance the proficiency and quality of care provided in the region.

Initially, 45 practices were offered one-on-one support from their local Murray PHN consultant, in addition to a Larter consultant in a key business area of their choice. Additional funding was provided to support another 65 practices to participate in the program.

Up to three sessions per practice were available, with a total of 110 sessions conducted, along with post-session support and guidance. These encouraged participants to listen carefully, think deeply and work together to identify areas to help practices achieve their individual and organisational goals, and to ensure continued learning and application of quality improvement activities.

Consultation themes

Practice manager support
95% *addressed education, focusing on the importance of best practice and effective practice management.*

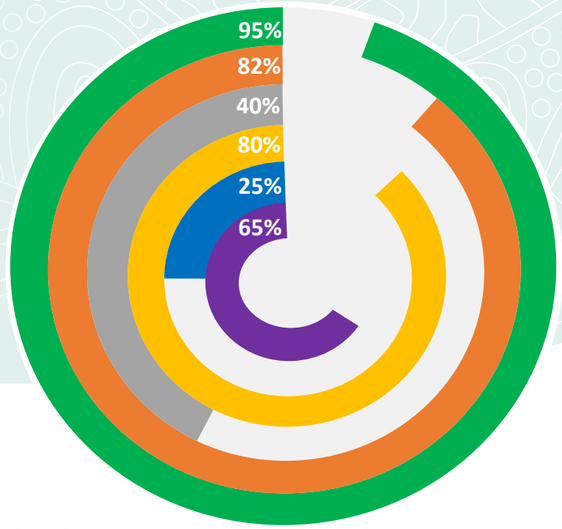
Optimisation of MBS
82% *provided knowledge on optimising MBS and enhancing care through the implementation of nurse-led clinics, chronic illness care plans and health assessments.*

Practice funding models
40% *focused on promoting the sustainability of general practices by addressing various internal challenges.*

Understanding PIPs and WIPs
80% *addressed knowledge gaps relating to Practice Incentives Program and Workforce Incentive Program.*

Effective use of digital health
25% *provided training on the active use of digital health tools to improve practice efficiency.*

Miscellaneous supports
65% *related to staff wellbeing, recruitment, PRODA, MyMedicare and general practice accreditation.*



"I am a new practice manager from a different industry and these sessions have been crucial to the success of my role."

"Our local consultant's ability to recognise and expand on opportunities was really useful."

Investing in general practice

Murray PHN commissions care coordination services in general practices to improve patient experience and health outcomes for people living with chronic and complex conditions, and to help build workforce capacity.

Last year, Murray PHN released $1 million in funding through its General Practice Investment Strategy (GPIS), to support 20 local practices to undertake sustainable projects that focused on chronic disease and providing people with access to early intervention, and care planning to prevent and reduce further complications arising from their conditions. Projects took place between 1 July 2023 and 31 July 2024.

Strong connections right around the region

During the 2023-24 financial year, quality improvement staff provided support to 169 data-sharing practices and recorded 237 quality improvement activities.

These activities aligned to accreditation, aged care, business operations, data cleansing and coding, digital health, chronic disease management, prevention, Aboriginal and Torres Strait Islander health, cancer, immunisations, mental health, medication reviews, and alcohol and other drugs.

In September/October 2023, Murray PHN's general practice quality improvement team re-established in-person networking meetings.

Held on a quarterly basis, the meetings form a core part of practice engagement, covering topics such as MyMedicare and government incentives, practice and workforce incentive payments, and artificial intelligence in general practice.

The events provide the opportunity for peer connection, the sharing of challenges and opportunities, and to hear from Murray PHN teams and representatives from the Royal Australian College of General Practitioners, the Australian Primary Health Care Nurses Association, the Australian College of Rural and Remote Medicine, Mind Australia and Medical Business Services, as well as Larter Consulting.

Sixteen events held over the course of the past year were attended by more than 200 people from practice managers to GPs, receptionists and nurses – with more than 90 per cent stating that their learning requirements were 'entirely met' and that the content was 'entirely relevant' to their practice.

Pictured L to R: Murray PHN Quality Improvement Consultants Lisa Collins, Megan Connelly, Sue Keane and Kate O'Kell

Helping to reduce emergency department pressures

Murray PHN supports five urgent care clinics across its catchment:

- Albury Medicare Urgent Care Clinic
- Shepparton Medicare Urgent Care Clinic (previously a Priority Primary Care Centre [PPCC])
- Bendigo Medicare Urgent Care Clinic (previous PPCC)
- Mildura Urgent Care Clinic (previous PPCC)
- Wodonga Urgent Care Clinic (previous PPCC).

In the last financial year, the top presentations were acute respiratory illnesses, urinary tract infections, rashes, fractures and lacerations.

There have been
44,242 presentations
to urgent care clinics, with 28 per cent of these being in the after hours period.

Of the patients treated:

- 33 per cent were under 16 years of age
- Six per cent identified as Aboriginal and Torres Strait Islander
- 82 per cent were referred back to their GP for ongoing care
- Only five per cent needed to be referred to an emergency department (ED)
- 48 per cent of patients reported that they would have gone to an ED if the urgent care clinic was not there.

Patient satisfaction survey comments:

"It means you can have treatment while being seen by the doctor. It means you aren't having to go to ED for non-life threatening matters. It is fantastic for parents like myself for urgent matters that aren't ED urgent."

"I always felt comfortable and respected."

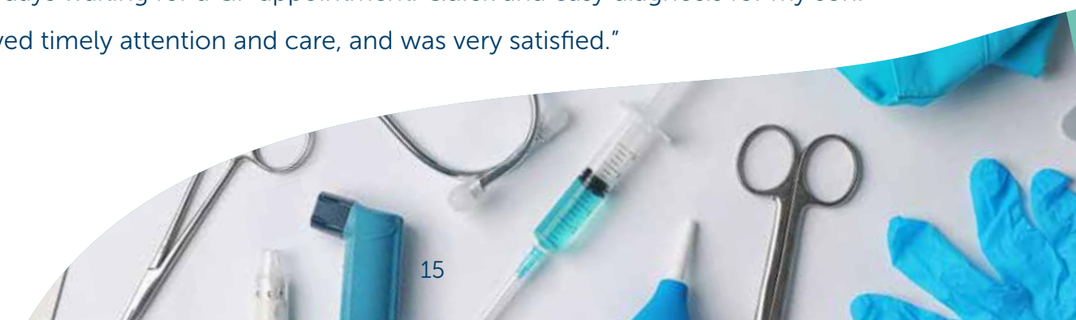
"The receptionist was friendly and I didn't have to wait long to see the doctor."

"Doctor was great with explaining what the problem was and offering a range of treatment options."

"Less waiting time than ED at the hospital."

"I found the service quick and easy to use. Saved me waiting hours upon hours in ED and days waiting for a GP appointment. Quick and easy diagnosis for my son."

"I received timely attention and care, and was very satisfied."



Improving care for aged care residents by supporting general practices

In 2022-23, Medicare data showed that the Murray PHN region had lower rates of GP attendances per residential aged care patient compared with national, other regional and metropolitan averages.

General practitioners also tend to provide care to their own patients living in an aged care facility, which can be problematic for some facilities when they need to liaise with multiple practices and practitioners – with one facility in the Murray PHN region reporting that they communicate with up to 30 individual GPs.

To support the General Practice in Aged Care Incentive, Primary Health Networks could apply for funding to develop local solutions to increase the consistency and quality of general practice-based primary care services in aged care facilities.

Based on local health needs assessment consultations, stakeholder feedback and data, Murray PHN identified three local government areas of being in highest need, with two of these – Mildura and Greater Shepparton – accepted for almost $2 million in federal funding.

In Greater Shepparton, we wanted to ensure the continuity of service provision by extending an existing pilot program that would have left 250 vulnerable people without essential care once it wrapped up in June 2024.

Mildura was identified as requiring additional workforce support, due to full-time equivalent GP numbers per 100,000 population being lower when compared to the rest of the catchment and the Victorian average, exacerbated by its geographical remoteness, high use of locums and delays in accessing GPs to support admissions that is resulting in aged care beds being empty.

The funding is anticipated to support at least 270 residents who don't have access to regular primary care services, across 15 residential aged care homes, and will provide 2200 or more occasions of service.

Through this, evidenced-based support will be provided to older people to proactively manage geriatric syndromes and other primary healthcare needs. Early recognition and management of deteriorating conditions, including care planning and case conferencing with residential in-reach, mental health, allied health and other teams, such as the Victorian Virtual Emergency Department, will also be supported to help reduce the risk of hospitalisations. Workforce capability and capacity will be strengthened through the use of My Health Record, and after hours and palliative care planning resources and tools.

Connecting aged care residents with GPs

Some aged care facilities have difficulty in maintaining GP access for residents, particularly those living with complex care needs.

The General Practice in Aged Care Incentive measures, introduced by the Australian Government this year, aim to support general practices to deliver more regular, proactive services and care planning to older people living in residential aged care homes.

To support the incentive, Murray PHN launched the GP Aged Care Connect service, which aims to help connect residents with general practices and GPs in MyMedicare.

Residential aged care homes, residents and family members, GPs and practices can contact our team to request support to find a practice and GP registered in MyMedicare who are able to take on the care of new residents living in an aged care home.

You can access this service by calling 03 5448 0300 or emailing gpagedcareconnect@murrayphn.org.au

A new endometriosis and pelvic pain clinic for Bendigo

Endometriosis is a complex and debilitating chronic condition that can be hard to diagnose, with those suffering waiting an average of seven years before diagnosis. The Australian Government is funding endometriosis and pelvic pain clinics through PHNs to improve access for patients to diagnostic, treatment and referral services for endometriosis and pelvic pain, build the capability of the primary care workforce to manage this chronic condition, and improve access to new information and care pathways. In March, Assistant Minister for Health and Aged Care Hon Ged Kearney visited Bendigo Community Health Services to officially open the new clinic in Bendigo.

Pictured L-R: Shirein Henry, Pelvic Physiotherapist; Emma Johns, Murray PHN; Mary Sandilands, Clinical Psychologist; Anne-Marie Kelly, Senior Adviser Strategy, Planning & Analysis; Karishma Kaur, GP; Ella Westblade, Lead, Sexual & Reproductive Health Hub; Mary-Anne McCluskey, Clinical Nurse Consultant.

100 per cent positive patient feedback for cancer survivorship centre

Hospital Street Doctors in Wodonga applied and were successful for GPIS funding to provide a wraparound service for patients with cancer, and to extend a newly created lymphatic massage service, not only to their own patients, but for any patient living in the surrounding area.

The idea was born because the local health service – the only dedicated and publicly funded specialist service in the region – had long wait times, in part due to there being limited and affordable private services available.

Establishing this new service meant that patients did not have to wait eight weeks or more to get the care they need; instead, only one or two weeks to be seen.

A dedicated referral portal was established to track referrals, wait times and discharge information, and to triage patients in greatest need. Regular provider and patient feedback was sought to assist in continuous refinement of the model and quality improvement opportunities – with 100 per cent of patient feedback being of a positive nature.

One of the challenges that local patients with lymphoedema experienced was accessing affordable compression garments when they needed them, so to address this, the practice established an agreement with a local provider to make them available to patients at the clinic and at affordable prices.

In the 12-month funding period, the clinic assisted 57 patients with a cancer diagnosis. During this time and through the project, the scope of the practice nurse increased and the GP also received training and certification on how to use ultrasound - which is now helping provide diagnostic and treatment options to non-cancer patients. A general practice registrar specialising in palliative care was also welcomed to the clinic to offer additional tailored care.

Because the model has been successful, the service is continuing with a small out-of-pocket cost to patients. The Hospital Street Doctors team has also been announced as a 2024 PenCS Award finalist in the patient-centred care category, for their data driven quality improvement success with this project.

Supporting nurses new to general practice

Murray PHN funded 19 nurses who were new to working in general practice to complete the Australian Primary Health Care Nurses Association's eight-month Transition to Practice Program. The program aims to increase the confidence, competencies, skills and knowledge of nurses through online education, resources, support and mentoring.

"Open communication with my mentor has been great."

"Putting things into practice. Things that I have learned, I have either seen or used immediately."

Case study:

"Betty*", an older woman, was referred by her GP to the clinic to help improve her lymphoedema symptoms. She lived alone, didn't drive and used a wheelie walker to keep mobile, as the lymphoedema was causing severe physical impairment and in turn, resulting in psychological distress.

Betty presented with long-standing bilateral leg swelling and described her legs as "heavy" and the skin as "thick and burning". Her left lower leg symptoms started more than 25 years earlier without any obvious cause, and various prescribed diuretic dosing regimens over the years resulted in minimal improvements. Multiple ultrasounds had ruled out blood vessel diseases, and tests for liver disease and congestive heart failure checks were negative. Betty's medical history included an overactive bladder, obesity and osteoarthritis.

The short-term goals of treatment were to reduce Betty's symptoms and discomfort. Long-term was to prevent re-accumulation of fluid, improve mood and quality of life. Initially, the prospect of travelling for treatment five days of the week for a few weeks was a challenge but Betty's friends volunteered to take turns in driving her to appointments.

On physical examination, Betty had bilateral nonpitting leg oedema. Her left lower leg was larger than the right, and the ankle anatomy obscured. The skin of both lower legs was thick and rigid, with deep skin creases, areas of hyperkeratosis and mycosis on one toenail. There were no signs of venous thrombosis and bilateral leg ultrasonography showed normal and competent peripheral veins.

A course of decongestive therapy was initiated, beginning with daily 60-minute manual lymph drainage sessions for the left leg, followed by compression bandaging. The treatments were performed five times per week and decongestive exercises completed every day. Standardised circumference measurements were taken in 4cm increments and used to calculate each limb's volume and monitor reduction. The therapies lasted two weeks.

On reaching the maximum volume reduction, Betty was prescribed custom-made flat-knitted compression stockings, taught to self-bandage and given regular exercises to do. The treatment resulted in a four kilogram weight loss, the skin condition of her legs improved and fibrotic tissue softened. Betty reported an alleviation of the "burning" and heaviness in her legs, and had noticeable improvement of her mobility.

Additional to the lymphoedema care received, Betty was referred back to her GP for a chronic disease plan and a physiotherapist to manage her osteoarthritis.

The two-month follow-up appointment showed that Betty's bilateral leg volume was well controlled by the wearing of compression garments 14–16 hours a day and by performing the prescribed exercises. Betty's mood had improved, she was feeling more confident to go out in public and was looking forward to starting volunteering.

Betty also inspired and increased the practitioner's confidence in their skills and abilities in managing a complex patient with lymphoedema and other comorbidities.

** name changed*

Focusing on good health in Barnawartha

Indigo Family Medical Centre received funding through the GPIS to implement a 12-month project to develop a care coordination clinic and improve the care of people living with complex or chronic disease.

The clinic chose to focus on identifying and reaching patients living with obesity. Using practice software - CAT4, PATCAT, Best Practice – they enrolled 145 patients in the program between July 2023 and July 2024. In doing so, they discovered that a large number of patients in the 75 plus age bracket were either overweight or at high-risk with chronic conditions, such as diabetes.

The program included regular clinical meetings to discuss individual patients and work out strategies to best support their needs.

Tracked recall and reminder systems were used to ensure patients were followed up and allied health referrals made to dietitians, exercise physiologists, cardiologists and podiatrists as needed.

Some home-based health assessments were also conducted to reach more vulnerable community members and improve the equity of care.

All staff enjoyed being part of the project and improved their recording of high-risk patient health metrics.

Practice manager Helen Barter said the project was particularly rewarding because it improved health outcomes and had the real ability to change lives.

"Working regularly with Murray PHN's Quality Improvement Consultant, we were able to better understand and improve our ability to collect and interpret data, which will not only have an ongoing impact on the way we manage patients in the future but measure the success of any quality improvement project we do.

The weight loss journey can be bewildering, sometimes dangerous and often fraught with failure. Refining our processes and targets enabled us to reach more patients.

That we booked regular appointments for them and focused on self-identified health goals helped to keep them accountable and on track.

Using existing chronic disease management Medicare Benefit Schedule items, we linked patients with allied health providers and worked collaboratively, including with the local pharmacist, to treat and support people on their health trajectory – without any additional costs to them and the added benefit of increasing the scope of practice of clinic staff.

The real success of this program was not just from the medication support, but the one-on-one consultations and behavioural education provided, and none of it would have been possible for a small practice like ours if it weren't for PHN funding."

Helen Barter
Practice manager

- 100 per cent of active 75+ Aboriginal and Torres Strait Islander patients had appropriate aged-based health assessments and chronic disease management (CDM) items claimed
- Previously underserviced patients, such as those of Aboriginal and Torres Strait Islander and culturally and linguistically diverse origins, were offered services and provided with CDM plans and allied health referrals
- Previously inaccessible patients aged 75 years and older were seen for aged-based health assessments at home with CDM documents updated and referrals arranged

Understanding digital health use in general practice and allied health

This year, Murray PHN invited general practices, Aboriginal medical and allied health services to complete a digital health maturity assessment. The assessment enabled us to not only know how and what technology is being used and what support was needed, but also enabled organisations to look at their own needs and gaps, and generate evidence for future grant submissions.

Building on previous years' assessments for residential aged care homes and community pharmacies, this information has provided us with greater understanding of how digital health tools are being used across all stakeholder groups, and given us the ability to identify common themes to plan for more coordinated support to increase digital maturity across the region – not leaving some behind and creating a larger digital divide.

	General practice	Allied health
Communications platforms used for telehealth	Skype, Zoom and Microsoft Teams are not fit for purpose because they lack appropriate security for use in healthcare.	
Cyber security	Cyber security and disaster recovery knowledge needs to be improved.	
Digital literacy	Digital literacy among practice staff could be improved to support them to use technology to its full potential.	
Survey participation	98 out of 193 practices participated, with two practices not consenting to share their responses with us.	43 allied health providers completed the survey, with all consenting to share their responses with us.
Digital maturity	The average maturity score was 70.8 out of 100 – while the standard deviation score was 7.6, which is slightly lower than other PHN regions. Larger general practices and practices with younger GPs are more digitally mature, while bulk billing and small or solo practices are less digitally mature. A small proportion of practices reported having insufficient internet connection and ICT equipment for performing their roles without regular disruption.	The average maturity score was 62.1 out of 100 – while the standard deviation score was 10.6, which is higher than other healthcare groups. Allied health practices that have been in operation for less time and that have younger clinicians are more digitally mature, as are those that provide osteopathy services.
Fax machine usage	Fax machine usage is high at 92% particularly for referrals, however 64% do use eReferrals.	Fax machine usage is moderate at 58%, particularly for case communication with general practice and 20% rely on paper or cards for record keeping.
Murray HealthPathways	68% use Murray HealthPathways and more than half have clinicians who actively use pathways.	While 16% use Murray HealthPathways, many expressed their interest in learning more about it.
My Health Record	80% of practices are registered for My Health Record and 82% have a secure messaging service installed.	28% are registered for My Health Record and 33% have a secure messaging service installed.
Intelligence tools	There is modest use of practice intelligence tools - PHN Exchange is the most used; 81% use PenCS, 33% use TopBar and 25% use none - with practices noting barriers such as lack of time, confidence, staff changes and system compatibility issues.	

In conversation with:
Brooke Shelly, Consultant Pharmacist

"I really love being a pharmacist, and I love using those skills wherever I can. This is exactly where I am meant to be," said Brooke Shelly with a broad smile.

Brooke is the Pharmaceutical Society of Australia's 2024 Credentialed Pharmacist of the Year, as well as a finalist in the 2023 Victorian Rural Health Awards. She is a consultant pharmacist working in general practice as a member of a multidisciplinary healthcare team at Ontario Medical Clinic in Mildura. Her passion for this role is clearly evident.

Brooke gave some background as to how and why she found it rewarding to have forged a career path so suited to her skills and personality. She said, "I've been a registered pharmacist for 15 years and took a traditional route after university into community pharmacy. This led to a management role overseeing 30 pharmacies in Gippsland and Melbourne early on in my career. But when I started my family and my dad suffered a major health scare, I chose to come back home to Mildura."

"I thought that might be the end of an exciting career path, but hindsight is a wonderful thing. It actually helped me stay engaged with the profession, led me to post graduate study and my work as a credentialed pharmacist going into patients' homes and residential aged care homes to perform Home Medicines Reviews - something I really enjoy. That then led to my work as a pharmacist embedded in a general practice setting.

While she was not the first to do this, Brooke's work with Ontario Medical Clinic has "helped pave the way to making it more of an accepted practice".

Brooke explained that a multidisciplinary model to primary healthcare provision has many patient benefits, especially in regional and rural settings. She thinks "a lot of it's to do with access to care in a timely way".

"Wait times can be horrendous up here. Access to coordinated care can be too. Distance plays a part as well. With healthcare professionals working together in one place, there's no fragmentation. Patients' information and care needs are shared. My role as a pharmacist within this model of care means I've got a patient's full picture, can answer questions promptly, and practise with an overall context of working together to improve that person's health outcomes. It's both a patient facing and a colleague facing approach."

Brooke said that "this is where it fits in with Murray PHN really quite nicely".

"About five years ago, as part of the General Practice Investment Strategy, the clinic approached me to come on board as a staff member, having already built a relationship with them doing their Home Medicines Reviews. The concept of the grant was to build a multidisciplinary team to change the way chronic disease was managed in general practice. There was a list of all the different allied health professionals that Murray PHN were happy for the clinic to engage with and fund, and pharmacists were one of them.

"At the time, this concept was more common overseas, particularly the UK. And it was something that had just started to be bandied about in the pharmacy media. It was new and exciting, something I really wanted to be part of, and here I still am.

"With healthcare professionals working together in one place, there's no fragmentation. Patients' information and care needs are shared. My role as a pharmacist within this model of care means I've got a patient's full picture, can answer questions promptly, and practise with an overall context of working together to improve that person's health outcomes."

"It's a very different style of providing healthcare and of practising pharmacy. I like that I've had the opportunity to build really strong, beautiful relationships with a lot of our patients, as well as with my colleagues."

Brooke has also worked with Murray PHN as a subject matter expert within the Home Medicines Review stream of HealthPathways, and has recently taken up a position on the Clinical Advisory Committee.

"I don't find relationship building difficult, which is probably part of growing up in the country. I enjoy leaning into things. I want to contribute to the work that is caring for my community.

"The way I see it, it's a big part of my responsibility as a healthcare professional living and working in regional Australia."

Collaboration is key

Murray PHN attended the Rural Workforce Agency of Victoria's annual conference in Ballarat in February, to discuss the challenges facing the rural health workforce and to listen to those at the frontline. The overwhelming message was that together we can build strong collaborative relationships to develop innovative solutions to the issues we face.

Pictured L to R: Sophie Bond, General Practice Engagement Lead; Jacque Phillips, Chief Operations Officer; Matt Jones, CEO; Catherine Lees, former Director Integrated Projects and Partnerships and Emma Harradine, Primary Health Care Development Lead.

Improving skin cancer care in the Loddon Mallee region

The Cancer Council says that approximately two in three Australians will be diagnosed with some form of skin cancer before the age of 70.

While the Loddon Mallee region is home to many healthcare professionals involved in the care of skin cancer patients, a clear list of available services and practitioners didn't previously exist.

This year, Loddon Mallee Integrated Cancer Service (LMICS), with the support of Murray PHN and Bendigo Health, mapped skin cancer services in the Loddon Mallee region, via a GP survey and site visits.

We knew that primary care services captured a large proportion of skin cancer presentations, and therefore capturing GP feedback and data was vital to any skin cancer project.

From the consultations, it was clear that barriers existed for involving GPs in skin cancer management and the main themes identified were GP and nurse practitioner availability, pressures of general practice patient loads and MBS renumeration.

To provide stronger, safer and more efficient skin cancer care across the Loddon Mallee region, a skin cancer community of practice was established to bring together GPs, medical and radiation oncologists, nursing and allied health staff.

To reduce wait lists in specialist outpatient clinics at the local hospital, the LMICS team is now planning for a primary care skin excisions clinic in Bendigo and hopes the model will be scalable, so that it can implemented in other regional areas.

Skin cancer admitted patients by type of skin cancer and year in the Loddon Mallee Region 2018 – 2022

Year	Melanoma	Other skin	All skin cancer
2018	275	1772	2047
2019	256	1975	2231
2020	274	1984	2258
2021	300	2549	2849
2022	289	2398	2687

Source – Compiled from VAED data.

Nurse practitioner-led care enhances students' health access

The Doctors in Secondary Schools (DiSS) program embeds adolescent health-trained GPs and nurses in secondary schools, providing free and accessible healthcare to students, reducing pressure on working parents, and helping to identify and address health problems early. The program is available at 100 Victorian secondary schools considered most in need, with 21 of those located in the Murray PHN region.

Due to some areas in the Murray PHN region facing severe GP workforce shortages, an innovative solution was sought to address service needs, leading to the implementation of a nurse practitioner-led model for the DiSS program.

Established in Kerang and Swan Hill secondary schools, the model sees nurse practitioners working within their scope of practice, referring to GPs or specialists as needed. Nurse practitioners play a crucial role in the broader primary care team within local health services, ensuring students at these schools receive timely healthcare appointments.

The DiSS program, now enriched by the nurse practitioner-led model, exemplifies a collaborative approach to student healthcare; nurse practitioners can help bridge service gaps and promote holistic wellbeing, providing positive health outcomes for students.

Pictured above L to R: Michaela Costa (nurse), Natalie Tremellen (Murray PHN), Bree McLeod (Murray PHN), Hollie Timmins (nurse practitioner), Samantha Hellsten (practice manager) - Swan Hill College

Pictured right L to R: DiSS team at Kerang Technical High School; Shannon Laursen (practice nurse), Heather Spence (nurse practitioner) and Zoe Ferrier (DiSS School Program Lead)

Maintaining infection prevention and control

In March 2021, the Victorian Department of Health (DH) engaged Murray PHN to lead the development, procurement and implementation of the Victorian statewide COVID-19 Infection Prevention and Control (IPC) program. Due to less face-to-face healthcare visits during COVID outbreaks, negative impacts to public health - including deferred primary care prevention and screening - were anticipated. To support primary care to maintain continuity of services, the department funded a dedicated infection prevention and control consultancy resource for general practice, community pharmacy and Aboriginal health services, with Murray PHN funded to lead its statewide implementation.

During its two years of operation, the service provided phone and online assistance to all Victorian general practices, pharmacies and Aboriginal health services and supported 25 DH-funded Urgent Care Clinics (UCCs), to ensure they were established and maintained within a best practice IPC framework, including ongoing audits to maintain infection prevention and control.

Funding for the consultancy service ceased in September 2023, however the need for sustainability was acknowledged with the decision made to continue IPC audits of UCCs in line with the Royal Australian College of General Practitioner's accreditation guidelines.

Last year, a software platform called the Healthcare Infection Prevention and Control Audit Tool (HIPCAT) was developed by Murray PHN, under the guidance of an IPC consultant. The tool provides a repository for UCCs to store accreditation evidence relating to the IPC requirements, as well as a reporting platform for PHNs to monitor UCCs' progress.

HIPCAT was made accessible to UCCs in March 2024 and has proven to be a valuable resource to UCCs and PHNs, as it provides support to UCCs in achieving their accreditation status while enabling PHNs to provide more robust clinical governance oversight.

HIPCAT
Healthcare Infection Prevention Control Audit Tool

Increasing support for the LGBTIQA+ community

Although many people in the LGBTIQA+ community live healthy and happy lives, research has shown that a disproportionate number experience poorer health outcomes, particularly mental health outcomes, due to stigma, prejudice and discrimination.

Murray PHN's 2022-2025 Health Needs Assessment identified a need to support people who identify as lesbian, gay, bisexual, trans and gender diverse, intersex, queer and/or asexual across all local government areas in our catchment.

This year, the Murray HealthPathways team completed a review of five clinical pathways and three referral pages, including pathways with a focus on alcohol and other drugs, fertility and planning, mental and sexual health, and transgender health, to enhance local health professionals' knowledge and support of LGBTIQA+ people to help them get the care they need.

Local clinical working groups were held with 17 health professionals including GPs, counsellors, a social worker, peer support worker, health promotion officers, medical directors, child and family health manager, and gender service, community development and wellness support coordinators.

We worked closely with Transcend Australia – a national community-led organisation that provides family and peer support services, education, resources and advocacy program - because of their work in mapping Victoria-wide LGBTIQA+ services which helped to ensure that our referral pages were relevant and up-to-date.

Murray HealthPathways Clinical Editor Dr Amy Greene led the review, in collaboration with a local subject matter expert and GP, who specialises in sexual and reproductive health and work includes supporting LGBTIQA+ patients with their health needs and testing, monitoring and treating HIV, Hepatitis A, B and C patients and for sexually transmitted infections.

Continuous professional development through education and events

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

- **133 CPD events** delivered across the region, including in-person, online and hybrid
- **1354 attendees**
- **680 CPD evaluations received**, with an average of 86% of respondents indicating that their learning needs were entirely met
- Topics included Aboriginal cultural safety, antenatal and maternity shared care in general practice, asthma, cervical self-screening, chronic kidney disease, communication, cyber security, dementia, domestic and family violence, immunisation, infection prevention and control, mental healthcare, MyMedicare, oncology, palliative care, spirometry, suicide intervention and wound management
- During the 2023-24 financial year, **12 webinars** were recorded and shared, which have had **706 views**
- **44 Events Update emails** were sent to subscribers.

Some of our CPD collaborators have included:

- Australian Centre for the Prevention of Cervical Cancer
- Bendigo Health
- BreastScreen Victoria
- Cancer Council Victoria
- Central Highlands Rural Health
- Dementia Training Australia
- Department of Health Victoria
- Eastern Melbourne PHN
- Gippsland PHN
- Goulburn Valley Health
- Goulburn Valley Public Health Unit
- Hume Region Palliative Care Consortium
- Kidney Health Australia
- Loddon Mallee Integrated Cancer Service
- Loddon Mallee Public Health Unit
- Monash University
- National Asthma Council Australia
- North Western Melbourne PHN
- Northeast Health Wangaratta
- Ovens Murray Public Health Unit
- South Eastern Melbourne PHN
- The Royal Women's Hospital
- Western Victoria PHN.

CPD feedback from attendees:

"Very well presented, relevant information"

"The PD session is most useful, have learnt an enormous amount of knowledge"

"Very contemporary and valid to my practice"

"Great real life work examples, useful suggestions"

In addition to the core CPD program, an additional **39 engagement events involving 400 attendees** were held across the region, providing primary and other healthcare professionals with the opportunity to network and participate in focus groups, meetings and to receive information.

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

Understanding the health needs of First Nations Communities

Murray PHN's region encompasses 22 local government areas (LGAs) and is home to almost 20,000 First Nations Peoples, with the majority living in the Goulburn Valley region (27%). By LGA, most residents live in Greater Bendigo (15%), followed by Greater Shepparton (14%) (PHIDU, 2021).

During 2024, Murray PHN undertook a First Nations health needs assessment with input from our partners, other health providers and stakeholders, and our communities. The data from the health needs assessment, along with our understanding of the local healthcare landscape, is being used to commission health services that are targeted to the needs of our communities.

Key themes and insights from the First Nations health needs assessment:

- ACCHOs play a vital role in their communities. They are integral in providing holistic care that aligns with First Nations traditions and fosters social and emotional wellbeing.
- Further support to expand and sustain outreach models that provide healthcare on Country is needed. They strengthen connections to family and Community.
- There is a trend of the First Nations population presenting with a high prevalence of both acute and chronic health issues. There is a strong call for system reform, including increased investment in early intervention and preventative care services to address this and support improved First Nations health outcomes.
- Initiatives that enable culturally strong and place-based health literacy may empower First Nations Peoples and Communities to navigate complexities in the system and engage with health promotion and preventative care.
- Culturally appropriate mental health and social and emotional wellbeing support is crucial across all stages of life, with particular emphasis on young people and older people.
- Financial limitations, transportation issues, long wait times for allied health services and limited availability of after hours care are significant hurdles for First Nations people when accessing healthcare. These are common experiences in rural and regional areas and compounded for First Nations Peoples.
- On average, First Nations residents in the Murray PHN region were 36 per cent more likely to have three or more long-term health conditions compared to the national rate (5.5 vs. 4.0 per 100 people) (Impact Co, 2024)
- First Nations residents (aged 0-14 years) in the Murray PHN region were 91 per cent more likely to have multiple longer-term health conditions compared to the national rate (2.5 vs. 1.3 per 100 people) (PHIDU, 2021).

Recommendations gained from the health needs assessment:

1. Ensure Community input in holistic commissioning, coordination and capacity-building decisions
2. Pool PHN funding to enable place-based and collaborative responses
3. Address the rising demand for social and emotional wellbeing services
4. Increase access to services that respond to First Nations People with dual diagnosis through commissioning, coordination and capacity-building activities
5. Build on existing national and state reform to co-design a localised First Nations workforce strategy
6. Invest in innovative outreach and community-based models
7. Address service gaps through commissioning, coordination and capacity-building activities
8. Increase accountability, coordination and capacity building for mainstream services providing culturally safe services
9. Ensure two-way data sharing with ACCHOs and relevant service providers to continue to build understanding of First Nations health and wellbeing needs.

First Nations Message Stick to Murray PHN

The First Nations Message Stick to Murray PHN framework facilitates and empowers a two-way relational engagement approach to all work with and about First Nations Peoples. Using the First Nations concept of Dadirri, the framework provides guidance for governing and stewarding our current work and future directions, with the objective of achieving effective and sustainable outcomes, and enabling healing for Communities, Country and First Nations Peoples.

As part of the framework, we facilitate quarterly Aboriginal Community Controlled Health Organisation (ACCHO) and Murray PHN advisory committee meetings and annual gatherings with ACCHOs, bringing together senior leadership employees from each of the seven ACCHOs in our region and Murray PHN. Other meetings we participate in include the ACCHO peer network, Vic/Tas Aboriginal community of practice, First Nations contract management meetings, and engagement with Traditional Custodian organisations and groups.

First Nations engagement is reciprocal with Murray PHN, sharing knowledge, expertise and experience, enabling shared reflection and learning for mutual benefit.

In conversation with:

Jill Edens, First Nations Health and Healing Coordinator, Murray PHN

"Listening. Building trust. Building relationships. That's what my role is all about," said Jill Edens when asked to pinpoint the core function of her work.

Jill joined Murray PHN just over a year ago. She said her primary role as the First Nations Health and Healing Coordinator is "to build relationships and support commissioned programs, which provides me with a very diverse day".

"My role is about building relationships with our Aboriginal Community Controlled Health Organisations (ACCHOs) and understanding their ways of working. We have seven across the catchment and each is on different Country, so it's about understanding what each Community needs as opposed to putting everyone in the same bucket."

Jill passionately described her work with 'Strong Spirit, Strong Elders, Strong Communities', the healthy ageing program looking to understand what ageing well means and building capacity and empowering each Community.

"This program is co-designed with our ACCHOs. It's been a privilege to come together and be on that journey with them, to find out what success means to them, what the challenges or barriers are and to work with each ACCHO to best support them.

"Each Community is different and that's why it's so great to have a program that's been developed that isn't one size fits all. I'm a facilitator, not a holder of knowledge. It's about listening to each ACCHO and supporting self-determination models of care."

Another program Jill is part of is Flexible Funding. "It's fantastic because it's also driven by the needs of the provider. They identify where they've got gaps in service provision or where they need support. Examples include funding a diabetes educator, or a maternal child health service that might need a paediatrician. Each ACCHO has a different version of how they use that Flexible Funding."

While Jill is a country person through and through, having spent her childhood and teenage years in regional Victoria, her previous work life took her all over Australia and overseas, very much informing her insights, ways of working and the things she is passionate about.

"I joined the military at 18 and wanted to become an army medic. After basic training, I went to the School of Army Medics in Wodonga. Over the years, I was posted in several places, took on primary health and intensive care roles and was exposed to many different situations."

Jill explained two early experiences in her military career cemented the path she is now on.

"Every year, the defence forces deploy personnel to rural and remote communities as part of Project AACAP (Army Aboriginal Community Assistance Program) to support local First Nations Communities with infrastructure – to build airstrips, maintain roads and provide health support. I was detached to the 17th Construction Engineer Regiment to Mailuni, between Katherine and Kununurra. As a medic, my role was centred on emergency and primary healthcare provision for the regiment, but it was also very much about health support and health promotion in the Community itself.

"I was 19. I'd never been so far from home. I'd never been that far north. There were so many firsts. I learned about tribal law, local language, and saw firsthand the significant access barriers, including the cost of fresh produce and how health is influenced by so many factors. It was an awe-inspiring, eye-opening opportunity. It was a hands-on experience that connected to my mind, to my heart and to my understanding.

"And at 22, I was deployed to East Timor for seven and a half months as part of UNMil Hospital 6. My regimental extra was organising and attending orphanage visits, and this was the next part of my learning. It was hard. But it put me on the trajectory of where I wanted to be and where I fitted in the world."

Jill said she has developed a lot of skills and expertise from these lived and learned experiences.

"That's what I feel I bring to my community and to my work."

Strong Spirit, Strong Elders, Strong Communities

The Strong Spirit, Strong Elders, Strong Communities program aims to support older people to live at home for longer (including those not currently receiving aged care services), through the commissioning of early intervention initiatives that promote healthy ageing and the ongoing management of chronic conditions.

In 2022, seven Aboriginal Community Controlled Health Organisations (ACCHOs) in the Murray PHN region were commissioned to develop and implement the codesigned program as part of a two-phase model.

Initial workshops were held and brought together essential providers, and 12 journey milestones that formed part of the model of care were determined:

1.	Healthy ageing staff
2.	Program awareness and access
3.	Self-determination of care and participation
4.	Program engagement, relationship and trust building
5.	Support service access and engagement
6.	Healing connections
7.	Continuity of care
8.	Soul pain
9.	Ageing well
10.	Sustained or improved quality of life
11.	Impacts on community aged care and health services
12.	End-of-life Sorry Business

Each of the programs would use a culturally informed approach and be individualised to the ACCHO's local needs, sitting alongside existing programs and services.

Shared principles:

- First Nations informed and led healthy ageing programs that are holistic, incorporating First Nations values and cultures that promote healing and wellness in First Nations Peoples
- Employment of a Healthy Ageing Connector at each ACCHO
- Integration with the ACCHO's Integrated Team Care services (ITC) and other chronic disease and aged care programs
- The collective model of care developed seeks to enrol eligible First Nations individuals who are aged 45 years old or older to maintain independence to live in Community, reduce risk of chronic disease deterioration, and age well physically, mentally and spiritually
- Each client will have an up-to-date annual health check, be offered a care plan and referred into new or existing programs that support the client's identified goals
- Each client will continue to be supported by the Healthy Ageing Connector while enrolled in the program
- The connector will provide a mix of case coordination, outreach, and cultural connection for the client. This may include attendance at appointments, and referral or access to activities that promote wellbeing.

Since its implementation, 320 participants across the Murray PHN region have accessed the program. Support has included care coordination, connection to culture, health promotion, outreach support, advance care planning, independent living assessments, Brain Fit dementia training, basket weaving, art sessions, Yarning sessions, exercise programs, bone density and diabetes education, language classes, 'Traditional' cooking and the Generations of Love project, connecting Elders with new mums and bubs.

Case studies

"Ronald*" has been accessing the program since he was diagnosed with cancer and declared palliative. He has been supported with care coordination, practical items such as continence aids and meals, as well as ensuring he feels comfortable and culturally supported when attending medical appointments. Ronald's Connector is also there for him when he needs to have a yarn about what's been happening or confide in someone to let his frustrations out.

When Ronald was told his diagnosis was terminal, he became distressed and withdrawn. After connecting with his worker and discussing what they could do moving forward to ease Ronald's burden, he became more engaging and positive, and his health habits picked up, including his eating. Ronald has discussed the possibility of returning to Country where his family members live before he becomes too sick to travel, as well as how to support his end-of-life wishes, through the completion of a cultural care plan.

"Frank*" went to his local Aboriginal health service for support with his diabetes. He had reached out to other health services, however, was unable to afford treatment for the ongoing management of his condition, which had caused him to have one foot amputated and suffer from ulcers on the other. Due to the ulcers, Frank was unable to walk well, impacting on his daily activities which also affected his physical and mental health.

Frank was referred to the Strong Spirit, Strong Elders, Strong Communities program, which assisted him to access a podiatrist and with brokerage to purchase a prosthetic foot, as well as new shoes which prevented him from needing to have his second foot amputated. His ulcers have now improved, and he's able to do unsupported daily activities again including mowing lawns, as well as walk comfortably. His physical and mental health have also improved significantly, as well as his socialisation.

**names changed*

Delivering culturally informed, responsive and safe services

Murray PHN is committed to making a difference for First Nations Communities, with part of this commitment including the development of a Cultural Humility Framework.

Released in October and developed in partnership with Dr Shirley Godwin (Guwanda Education), the framework outlines initiatives for building and strengthening the capacity of the local primary health workforce to work in partnership with First Nations Peoples and deliver culturally informed, responsive and safe services, free of racism.

The framework, a key deliverable of our First Nations Health and Healing Strategy, recognises that the development of cultural humility and culturally responsive and safe service delivery is an ongoing journey of listening and learning, and that people and services will be at different stages depending on their individual and organisational needs, strengths and resources.

At the centre of the framework are the core concepts of cultural humility, cultural responsiveness and Cultural Safety, which represent ways of working to create health services that First Nations Peoples judge as safe to approach and use. The three core concepts are interlinked with shared features for working with and for First Nations Peoples and should be firmly grounded in Country, Culture, Community and Connections. Supporting the operationalisation of the core concepts are four interrelated key elements, each featuring a number of defined focus areas.

Operationalising the framework's core concepts are four interrelated key elements:

Governance

Identification of governance mechanisms for embedding cultural responsiveness, Cultural Safety and anti-racism into core business as whole-of-organisation approach

Inclusive care

Centres cultural considerations and prioritises service user preferences, needs and aspirations

Partnerships

Increased capacity to engage in respectful, mutually beneficial and self-determined collaborative relationships with local First Nations Communities, organisations and service users

Workforce

Development of a culturally capable workforce and workplace that is better equipped to meet the needs of First Nations employees, users and Communities

A user guide accompanies the framework to support its practical application by providing guidance, implementation of targeted strategies, examples and recommended resources. It aims to enhance ongoing learning and development for both the individual and organisation.

A self-assessment tool will act as an ongoing quality improvement activity for all Western service primary care providers, launching in January 2025, with ongoing refinement part of the implementation. Although not mandated, it is a key requirement of the Department of Health and Aged Care that all commissioned services providers are culturally safe, and a key requirement of RACGP accreditation for general practices.

As part of the application of the framework, Murray PHN will be looking to link general practices with local ACCHOs to foster collaborative care and relationship opportunities. An example of this has occurred with the Urgent Care Clinic (UCC) in Albury where local ACCHO staff are active members of the UCC's working group, providing governance of services and contributing to supporting solutions when issues arise in the clinic.

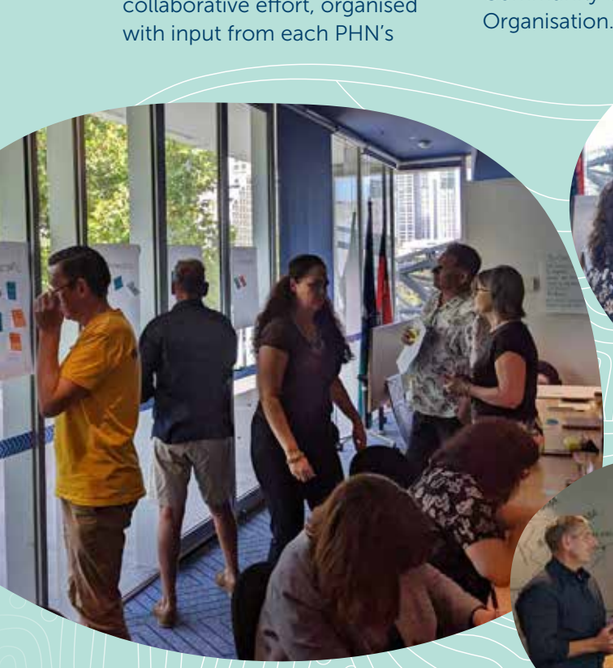
To access the framework and user guide, visit: https://murrayphn.org.au/focus-areas/first-nations-health-and-healing/cultural-humility-framework/

Working to improve First Nations health

In March, staff came together in Naarm (Melbourne) for the first Victorian Tasmania PHN Aboriginal health face-to-face forum.

The event was a true collaborative effort, organised with input from each PHN's First Nations team. The day's activities included a Welcome to Country, exploration of opportunities for ongoing collaboration and a presentation from the Victorian Aboriginal Community Controlled Health Organisation.

The group continues to share and learn from one another as they work towards improving the health outcomes of First Nations Peoples.



Helping chronic disease clients on their health journey

The Integrated Team Care (ITC) program is an innovative best practice wraparound chronic disease management program. It takes a holistic all-of-person approach and enables specialised care coordination and access to Aboriginal outreach workers who form an integral part of the program, walking alongside the client as they navigate their health journey. Clients receive culturally safe care, and are supported in self-determination and self-management.

In the last 12 months, the ITC program delivered to 1604 clients:

- 5907 care coordination services
- 1407 supplementary services
- 4311 clinical services.

The top five chronic illnesses supported through the program are type two diabetes, chronic pain, sleep disorders, cancer and respiratory conditions. The top five allied health services accessed are physiotherapy, podiatry, optometry, dietetics and exercise physiology.

Support and activities to assist young people find their way

The Early Intervention for Young People program, funded by Murray PHN and delivered by Murray Valley Aboriginal Cooperative (MVAC) in Robinvale, was designed through a consultation process led by MVAC with the local school, Swan Hill police and the Department of Families, Fairness and Housing. It aims to address the issue of young people who are not engaging in school and who are at-risk of unhealthy behaviours such as drugs and alcohol use.

The program addresses these risks by providing support and activities in schools and during school holidays to help keep young people engaged in school or TAFE and increase attendance. Activities are intended to promote positive behaviours and outcomes, and include cultural activities such as cooking, art and music, as well as school holiday excursions during which students have the opportunity to engage in cultural activities. Health promotion activities focusing on areas such as fitness, mental health and sexual health are also provided in the program.

In FY24, the program had:

1131 service contacts

901 secondary consultations

Case studies

"Nathan*" is in his late teens and lives in a rural town with a small population of Aboriginal people. Nathan was referred to the service to receive support for his low school attendance and involvement in multiple family violence disputes at home.

The goals that Nathan identified were to get his driver's licence, find a job, build personal positive relationships in the community and increase his school attendance. The service allocated Nathan a youth worker who provided personal support, and he was involved in cultural activities, including a camp that provided a break from his home environment. Nathan's other supports included his mother and a Koorie Engagement Support Officer through his school.

Nathan is on his way to achieving his goals with the most significant indication being his new connection to his peers and culture.

Nathan said, "The service assisted in me learning about my culture and how strong Aboriginal people are. I feel better about my home situation now as I know that others in my community are dealing with the same thing. I am happy to have my worker and the youth hub."

"Ryan*" was referred to the service by his school after experiencing domestic violence issues at home and social issues at school. He had poor school attendance, mental health concerns, was being aggressive to his peers, and was generally struggling. Ryan identified his goals were to be independent, obtain his driver's licence, receive his own financial support and seek assistance for his alcohol and other drug (AOD) use.

Ryan has been supported by the service, as well as the Koorie Engagement Support Officer at his school, the local Aboriginal service and local health service, accessing programs such as the after school program, AOD support and domestic violence counselling.

Since engaging with the service, Ryan has been more stable and is working towards achieving his goals. While he's been challenged by his day-to-day living situation and lack of support from family, Ryan has used the service multiple times a week for support with basic needs and emotional support.

**names changed*

In conversation with:

Chana Orloff, Coordinator - First Nations Commissioning Implementation, Murray PHN

"It's an exciting space to be working in," said Chana Orloff, as she began to describe her role and the work she loves and feels connected to.

Chana is Coordinator – First Nations Commissioning Implementation at Murray PHN. She said her role started as a conventional commissioning one, but after joining the First Nations Health and Healing team, "there are now so many more opportunities to work on, lots of different projects to be part of, and partnerships being developed".

"My work feeds into the work Murray PHN is doing around its commitment to First Nations people, which is about empowering Communities and fostering capability and capacity building."

Chana explained that building strong relationships with the Aboriginal Community Controlled Health Organisations (ACCHOs) is at the core of her work.

"I'm managing several ACCHO contracts across the Murray PHN catchment. I work with each of them to develop contracts that meet the needs of First Nations Peoples, that empower Communities, while at the same time ensuring that we as an organisation are doing things that are increasing cultural humility and responsiveness. It's all about helping to transform the primary healthcare sector to meet the needs of First Nations Peoples, and what's exciting is I get to be a participant in that."

Quite some years ago, Chana held the role of Aboriginal Access Advisor at Murray PHN. She left to complete her Master of Public Health and worked in a clinical setting in Wollongong for several years. She then returned to Murray PHN to the role she now holds.

"I returned home to Victoria to be on Country, to be with family and Community after personal tragedy struck my life. I lost two significant people. To be supported in my grief by aunties and uncles and Elders gave me strength. My cousin was the one to tell me I needed to find a way to carry on, to help me heal.

"So, not only did I come back to Murray PHN at this time, which in one way was like almost coming back to family, I also started my own business as a way to honour and memorialise my son and my mother."

Chana said she has always been interested in natural minimalist skin care, and her passion, knowledge and research led her to create a range centred around "nature's realm" of Indigenous ingredients.

"I use extracts from native plants that regenerate skin cells and address skin concerns. Plants such as quandong, desert lime and wattle seed. I hand blend a range of face, body and hand creams, body washes and so forth. I also wanted to manufacture something that was good for the environment, using little water and energy, and in recyclable, compostable or biodegradable packaging.

"Taking care of the earth is something that's always been important, to me, my family and my ancestors. Creating this range is my pride and joy and has been a healing transformation."

Chana said she was also proud to be working at Murray PHN, an organisation committed to "addressing the injustices of colonisation".

"The First Nations Health and Healing Strategy is an absolute brilliant piece of work that is still moving and evolving and developing. And I think that around that strategy, there's lots of things that staff can be involved in. What I see is a real commitment from people. There's a real respect for self-determination."

> "My professional and personal lives intersect here. This is what I would like to see as an Indigenous person – for my people, for my family, for my loved ones, for their children and their children's children."

mental health

Supporting people to head to health

The Head to Health phone service, established in Victoria during the COVID pandemic and expanded nationally in 2022, helps people to find the best available mental health supports near them, including Murray PHN funded services.

People who call the service talk to a mental health clinician about their situation, which helps to determine the level of help needed - from information or advice, counselling or support from a specialist service.

Between 1 July 2023 and 30 June 2024, the service was accessed by 7161 people, including 611 (8.5%) who identified as being Aboriginal and Torres Strait Islander.

To access support, simply call 1800 595 212 between 8.30am and 5pm, Monday to Friday, except on public holidays.

For more information, help and resources, you can also visit the headtohealth.gov.au website.

In FY24, the service was accessed by **7161** people including **611** who identified as Aboriginal and Torres Strait Islander

A new mental health coalition in Lower Hume

The introduction of the Victorian Government Mental Health and Wellbeing Locals has resulted in a considerable increase in the provision of mental health services across our region. This investment has allowed Murray PHN to repurpose Australian Government funding to avoid duplicating services in some areas, and to support identified health needs and gaps in the region. This has meant that we have been able to increase service provision in some local government areas (LGAs) across our catchment, while not reducing overall service provision in any given LGA. Ultimately, this is enabling greater equity of access, so that all consumers can obtain the services they need, regardless of their location.

In June, Murray PHN invited service providers to apply for a closed tender opportunity to provide primary mental health services in Mitchell and Murrindindi LGAs.

The successful tender applicant was Yea and District Memorial Hospital, as lead agency for the newly formed Lower Hume Primary Mental Health Partnership (LHPMHP). Murray PHN is extremely pleased to be supporting this new and innovative place-based partnership which includes Alexandra District Health, Seymour Health, Goulburn Valley Health and Northern Health.

As part of these new primary health services, the LHPMHP is developing a new model of care and clinical governance framework, resulting in a short service gap before the start of new face-to-face services. However, service access is continuing through the region-wide Murray PHN-commissioned telepsychology service, in addition to working closely with current providers of psychosocial recovery services and youth enhanced services in these areas.

Health professionals can subscribe to Murray PHN's eNewsletter to stay informed of updates and use Murray HealthPathways to access local referral details for all mental health services funded through the PHN.

Psychological therapy and clinical care

Murray PHN commissions primary mental health, psychosocial recovery and alcohol and other drug services for people located across the Murray PHN catchment.

Changes to commissioned primary mental health services were introduced in July, so that services now align to the levels of care in the national Initial Assessment and Referral Decision Support Tool (IAR-DST): low-intensity (level two), moderate-intensity (level three) and high-intensity (level four).

Commissioned service providers now complete the IAR-DST at the start of the episode of care and use the recommended level of care, along with their clinical judgment, to provide services aligned with the consumer's needs and wishes.

Services at the two other levels in the IAR-DST: self-management (level one) and specialist and acute care (level five) are not commissioned by Murray PHN but are recommended or referred to if required.

Psychosocial recovery services help those with a severe mental illness to access non-clinical community based support such as to develop and build relationships, manage money and find and look after a home.

Case study: Primary Mental Health Services

"Barb*", a middle aged woman, was referred by her GP for mental health counselling to help with anxiety and post-traumatic stress disorder.

Barb presented with a long history of trauma, including experiencing family violence. She had difficulty managing conflict and her emotions, which affected her relationships. She struggled with a range of agoraphobia symptoms, with the most debilitating being difficulty in leaving the house. She was also experiencing financial stress and had heavy alcohol and other drug use.

Barb usually attended weekly or fortnightly appointments, but sometimes would not come in for a month or two, particularly after she returned to a previous violent partner and increased her alcohol and drug use to cope with her situation.

The team members who supported Barb continued to maintain a flexible and creative approach. While she declined family violence supports and police involvement, she was supported to work towards improving independence, holding boundaries and increasing her emotional resilience.

Barb's anxiety symptoms began to subside through the use of psychoeducation, which helped her to better understand and deal with her issues. Slowly, she exposed herself to new environments and navigated busier places like the supermarket. She also began volunteering and returned to TAFE studies.

Through the support provided, Barb gained increased awareness and insight into her own behaviour, communication skills and emotional dysregulation. Using the techniques she learned, she managed to overcome some conflicts, developed friendships and reconnected with family members - acknowledging that the psychological support she received was a major factor in her improved mental state and assisted greatly in her recovery journey.

**name changed*

Personal client story: Psychosocial Recovery Service, Stride

"When I first met (my support worker) Helena two years ago, I was housebound most of the time. I had a chronic fear of human interactions and avoided most people. Even rolling my bins out to the nature strip each week was distressing and half of the time impossible.

I was sleeping during the day and emerging from bed in the late afternoon to watch TV and eat. I knew things weren't going well and that I needed help. But due to a complex history of trauma, I find it very difficult to trust people.

For many years, I had mostly been isolated by myself at home. I thought the rest of my life was going to stay like that.

From my first meeting with Helena, I felt seen, heard and safe. I was able to open up, communicate my thoughts and feelings. The main goal was to get me onto the NDIS and I was able to go through new mental health assessments, with results providing several missing 'pieces of the puzzle' for me.

Helena was there for me through the whole process, and we worked together on other goals, including linking with additional services such as counselling; regular access to food support; getting out and about in the community; applications for more affordable housing, and identifying future goals and dreams.

I began to start to leave my house more and notice the positive interactions I had with people in public. My confidence was growing. I even decided to join the local choir. I was scared but I had fun, and later performed on stage at a community carols event.

I'm now on the NDIS and living in more affordable housing in a whole new town close to several beaches - something I had always dreamt about.

All of these positive things have happened because I reached out for help and an amazing support worker came in to my life. Thank you, Helena, for everything and thank you, Stride. I now know that I can reach out when I need help, that I am worthy and that I am not alone."

Being responsive to mental health needs

A key role of PHNs is to review service and population health needs and commission services to fill gaps, so that people can get the care they need, where and when they need it.

With the establishment of the Victorian Government's Adult and Older Adult Mental Health and Wellbeing Services (Locals), including four already in the Murray PHN region, our team took the time to look at where there was duplication of effort and where our funding could best be repurposed.

Our review included extensive evaluations of primary mental health, alcohol and other drugs, psychosocial recovery and other PHN-commissioned programs and services.

A dedicated needs assessment also occurred with eight focus groups, two interviews and a public survey, in addition to looking at almost 50 datasets to consider important elements such as risk factors and priority population groups.

The redirection of funding was considered carefully and implemented in a measured way from 1 July 2024. Additional mental health service offerings include child psychological therapy services, services to underserviced rural areas, low intensity supports, and telehealth services that will be rolled out progressively.

Primary mental health agreements have also changed this year to capture consumer feedback through the YES (Your Experience of Service) survey across all our programs, have local government area-based targets to drive equity of access in more rural areas, support face-to-face service delivery when a consumer wants it – wherever they are, and to encourage developmental workforce models with quality measures and safeguards in place.

Supporting and increasing care for young people

In October 2023, Murray PHN invited proposals from prospective services, including existing headspace services, that were interested in providing new youth enhanced services (YES) in more isolated locations across the catchment, where young people with complex mental health needed support closer to home.

In January 2024, two new providers started delivering YES to help young people who have or are at-risk of complex or severe mental health conditions. Macedon Ranges Shire Council is undertaking a youth participation initiative to identify youth friendly spaces in and around the region that can provide a safer and more engaging environment. The Bridge Youth Service will provide supports to young people living in Mitchell and Murrindindi local government areas, while headspace Swan Hill will provide outreach to Buloke and Gannawarra local government areas.

In our region, headspace services are located in Shepparton, Bendigo, Swan Hill, Mildura, Echuca, Albury Wodonga and Wangaratta. headspace supports young people aged 12 to 25 years and their families who need help with work, study, physical and mental health.

Murray PHN also supported an application for Demand Management and Enhancement Funding for headspace Bendigo to complete building works this year. The centre's expanded footprint will enable an increase in staffing and the capacity to support more young people living in Central Victoria.

Pictured: Bendigo headspace team members and Ian Johansen, Murray PHN Director Mental Health and Wellbeing, at the national headspace forum held in Brisbane in June.

Since opening its doors in March 2022, headspace Echuca has now received more than 1000 referrals for young people living in the surrounding region. The largest age groups accessing supports at the centre are those aged 12-14 years at 37 per cent, and 15-17 years at 31 per cent.

This year, headspace Swan Hill and Albury Wodonga have also been successful in their application to participate in Orygen's Implementation Lab program. Funded by the Australian Government, Orygen's Service Implementation and Quality Improvement team provide 12-months of support to up to six PHNs and local service providers across Australia, with the design, implementation, evaluation and ongoing improvement of youth enhanced services (YES).

The primary aim of the Lab program is to build the capacity of YES providers to deliver effective mental healthcare to young people with complex needs. Lab program activities include needs analysis, collaborative goal setting and action planning, service development and capacity building workshops, reflective practice sessions, online events to share challenges, a community of practice, peer supervision and evaluation. Participants also receive up to four days of onsite visits and consultations, monthly support calls and pilot quality improvement activities using a Plan, Do, Study, Act cycle.

To further support headspace and YES providers, Murray PHN now hosts community of practice forums throughout the year to increase integration, share best practice approaches and problem solve challenges.

Mental health issues impacting rural communities

People living in rural areas face many barriers to accessing health services. The theme for the 2023 National Rural Mental Health Conference held in Albury in November was Justice and equity: Issues and solutions for Rural and Remote Mental Health.

The event provided the opportunity to connect with peers, professionals, community leaders and decision makers, to listen to and discuss the issues and possible solutions to improve the mental health and wellbeing of rural communities.

Pictured L to R:
Jack Smith, Loddon Mallee Mental Health and Wellbeing Interim Regional Body Member; Kevin Mack, Hume Mental Health and Wellbeing Interim Regional Body Member; Ian Johansen, Murray PHN Director Mental Health and Wellbeing; Emma Reid, Hume Mental Health and Wellbeing Interim Regional Body Chair and Anita McRae, Murrumbidgee PHN Senior Manager System Integration.

Roundtable discussions with federal minister

Assistant Minister for Mental Health and Suicide Prevention and Assistant Minister Rural and Regional Health, the Hon Emma McBride MP, visited Murray PHN's Bendigo office in April 2024 to talk about primary mental health service delivery, the challenges experienced in regional and rural healthcare, and potential solutions to help increase access to primary care through innovative multidisciplinary service and workforce models.

The Assistant Minister also visited Sunbury Cobaw Community Health in Kyneton to discuss local issues and mental health services in the Macedon Ranges Shire, and headspace Bendigo to meet with their youth advisory group.

Pictured L to R: Nerida Hyett, Acting Director Integrated Projects and Partnerships; Jacque Phillips, Chief Operations Officer; Matt Jones, CEO and the Hon Emma McBride MP.

Training to create community safety net

Sometimes people may feel unsure about what to say or do when someone is acting out of the ordinary or admits they are "not ok".

In September, Murray PHN extended access to the evidence-based Question. Persuade. Refer. (QPR) suicide prevention training course for all people living in the region to gain the skills required to have these important conversations. To date, 623 people (including those from the health, education and family services sector, and community members and leaders) have completed the training.

The more people who are trained to understand and identify people who may be in distress, the more chance that communities can create a safety net and help prevent deaths by suicide.

The free, online training takes only 60 minutes to complete and helps people to identify the warning signs of someone at risk of suicide gain, the confidence to speak to them about their thoughts and learn about the tools to connect them with professional care. For more information and to register, visit: murrayphn.org.au/qpr

Using Community, Culture and healing to tackle substance abuse

Murray PHN has funded Bendigo and District Aboriginal Cooperative (BDAC) to deliver baringgurrak, Victoria's first alcohol and other drugs (AOD) therapeutic rehabilitation day program designed by and implemented for First Nations people.

The 12-week program, consisting of six sessions (morning and afternoon) three days a week and post-care, has been designed using an integrated harm minimisation model founded on centring Culture, Knowledge, Change and Sustainability.

baringgurrak embraces Aboriginal ways of knowing, doing and being. It acknowledges the ongoing impacts of colonisation, intergenerational trauma, disempowerment, inequity and overcrowding, and prioritises healing and connection to Culture and Country. It incorporates holistic concepts of physical health and social and emotional wellbeing when providing care for Aboriginal people with substance use issues and/or dual diagnosis.

BDAC commissioned Kowa Collaboration to conduct an evaluation of baringgurrak, which includes feedback from participants of the program in 2023.

Participant feedback included:

- "I have ceased methamphetamine use and am confident in not using anymore."
- "My family were so proud of me when completing the program. Family relationships have really improved."
- "I'm actually doing something useful these days. This program helped me to believe in myself and work towards goals."
- "Being more culturally connected has helped me to be more positive and this has been good for my overall recovery."
- "This program made me want to live again, made me want to get up in the morning."
- "I would 100% recommend the program."

An innovative project helping young people

Funded by a small grant under the Targeted Regional Initiatives for Suicide Prevention (TRISP) program, Anglicare Victoria initiated the Podcast Challenge Project as an early intervention model aimed at enhancing help-seeking skills among young people in various settings, including secondary schools and rehabilitation programs.

Recognising the prevalence of co-occurring issues like mental health problems, gambling harm and substance use disorders, the initiative targets the barriers that prevent young people from seeking timely support, with the broader goal of reducing future harms.

Bendigo, Indie and Castlemaine Secondary Colleges participated in three educational sessions focused on the themes of gaming to gambling, mental health, and drug and alcohol misuse. Each session culminated in a podcast workshop where students led interviews with lived experience speakers and clinicians, which aimed to increase their confidence in discussing matters of mental health and accessing support services. A promotional resource developed from these interviews will be launched in late 2024, accompanied by a competition to encourage awareness of the resource.

Survey results reflect participants' growing awareness of gambling-related issues, mental health indicators and available support services. Notably, knowledge of gambling harm increased significantly post-educational sessions, with students expressing a higher willingness to access support and communicate with wellbeing workers. Baseline data indicated 41 per cent felt knowledgeable about recognising signs of gambling harm before the session, rising to 69 per cent afterwards. Similar trends were observed in mental health and substance abuse presentations, wherein students reported increased confidence in reaching out for support.

Teachers provided positive feedback, with 86 per cent finding the presentations engaging and valuable. Recommendations for improvement included enhancing interactivity and addressing specific concerns like medical marijuana.

Despite some challenges in engaging students due to various factors, the overwhelmingly positive response suggests the podcast project effectively impacts student attitudes toward seeking help. Moving forward, adapting the program and evaluation methods will be essential to maintain engagement and ensure ongoing positive outcomes. Future iterations are anticipated, signalling commitment from both educators and students toward addressing these crucial issues collaboratively.

Equipping general practice in suicide prevention

Under the Targeted Regional Initiatives for Suicide Prevention (TRISP) funding, Murray PHN is delivering a suicide prevention workforce capacity building project aimed at equipping general practice to better identify and support people in suicidal distress.

Through this project, Murray PHN is providing suicide prevention capacity building training to general practice clinics, service providers and community groups across our region. Training aims to enable participants to be able to:

- undertake a suicide risk assessment effectively
- develop a collaborative safety plan
- implement a team approach to treatment planning
- provide effective management following a suicide attempt.

Black Dog Institute is delivering the training and is a leading body in suicide prevention, well-placed to provide strong evidence-based content. Black Dog Institute was highly involved in the Victorian place-based suicide prevention trials and has incorporated learnings from the trials into the training package.

Through an expression of interest process, general practices were invited to participate in a quality improvement program suicide prevention activity, with practices in areas with high rates of suicide encouraged to apply. As part of the program, practices are also participating in an online discussion group to consolidate their workshop learnings using case study examples.

There are 20 practices participating - with places double those originally funded due to an overwhelming response - and 100 people registered to undertake the workshop sessions.

GPs an integral piece of the system

Research indicates that people with suicidal behaviour frequently visit primary care physicians in the weeks or days before suicide, with up to 45 per cent of individuals who died by suicide seeing their GP within one month prior to their death, and up to 20 per cent within one week before death.

(Canadian Journal of Psychiatry-Revue, 2009)

Supporting flood-affected communities

In late 2022 and early 2023, areas of the Murray PHN region experienced one of the worst flood disasters on record.

Murray PHN received funding from the Department of Health and Aged Care to increase our capacity to provide immediate mental health supports arising from the trauma and loss associated with the floods.

Through the provision of mental health and resilience grants, funding was offered to community groups to implement localised activities to engage their communities and help improve wellbeing, reduce mental health issues, support suicide prevention, build resilience and provide social connectedness.

In two tender rounds, 24 community organisations and health services received funding grants of up to $10,000 with 46 per cent of the Flood Community Wellbeing Resilience grants located in the Shire of Campaspe, a region severely impacted by the floods.

Other local government areas that benefited from the grants:

- Loddon Shire
- Shire of Strathbogie
- Mitchell Shire
- City of Greater Shepparton
- Gannawarra Shire
- Rural City of Mildura
- Rural City of Swan Hill
- Moira Shire
- Murrindindi Shire.

More than 12,000 individuals across the 10 LGAs were assisted to restore connectedness, reduce mental health issues and improve awareness of mental health resources.

Common themes among resilience building and community connectedness events were morning tea gatherings where individuals could debrief and support peers, and events designed to bring communities together that included mental health services attending to open self-referral pathways for individuals requiring support.

Unique activities to engage with culturally and linguistically diverse populations included water awareness training and swim lessons for more than 350 people of the Shepparton Congolese community, and cultural dance lessons attracting more than 258 enthusiastic dancers in Greater Shepparton.

Moira Community Food Share assisted 3300 people through its Barmah Food Shack program, reporting the flood relief funding built a positive community culture, empowering volunteers to expand the food share program and enabling Barmah residents to seek support from businesses in neighbouring Echuca/Moama to become more self-sufficient into the future. The program now supports more than 500 residents each month and has helped individuals and families through flood recovery, and easing the cost-of-living crisis.

More than 180 community members attended a special event at Wedderburn Hall in Loddon Shire to see sports personality Jelena Dokic speak. Blaze Aid recruited 56 volunteers to assist in the repair of 37 properties with damage to fencing and general post-flood clean-up across the Mitchell, Murrindindi and Strathbogie Shires over 54 days.

Looking into the health needs of our multicultural communities

Australia is a strong and diverse country and while First Nations Peoples are its original inhabitants, waves of immigration since colonisation mean that almost half of our current population was either born overseas or has at least one parent born overseas.

In May 2023, the Australian Government allocated funding to PHNs to support improved multicultural access to primary healthcare services for culturally and linguistically diverse (CALD) populations.

In February 2024, the national PHN Cooperative released its multicultural framework, which acknowledges that people who come from non-English speaking backgrounds often face additional difficulties in accessing and navigating the Australian healthcare system.

In line with the framework and our obligations to the Australian Government, Murray PHN completed dedicated health needs assessments for people from CALD and First Nations backgrounds.

Using this data and feedback, this year's Murray Health Report looks into the impact of multiculturalism across our region.

Multiculturalism across the catchment

In the 2021 census, 88,217 people in our region reported they were born overseas, and of those, almost two-thirds came from mainly non-English speaking backgrounds. The top three local government areas (LGAs) with the greatest number of overseas-born residents are Greater Shepparton, Greater Bendigo and Mildura. Overseas-born residents are often highly skilled, with many contributing to our healthcare sector as medical practitioners, nurses, aged care workers and others.

In 2021, 55,305 people across the Murray PHN catchment reported using a language other than English (LOTE) at home. Of the 110 top five languages across our 22 LGAs, 27 different language groups are covered with some unique pockets of Auslan, Bisaya, Polish and Sinhalese.

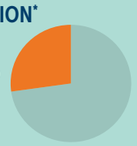
BORN OVERSEAS

MURRAY PHN REGION POPULATION

11.7 %

AUSTRALIAN POPULATION*

27.6 %

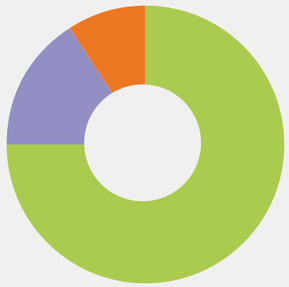


*Australian Population - ABS Census 2021

TOP 5 COUNTRIES OF BIRTH
(PREDOMINANTLY NON-ENGLISH SPEAKING COUNTRIES)

AUSTRALIAN POPULATION*	MURRAY PHN REGION POPULATION
INDIA	INDIA
CHINA	PHILIPPINES
PHILIPPINES	MALAYSIA
VIETNAM	ITALY
MALAYSIA	GERMANY

Over the past 10 years, the highest number of permanent skilled migrants have settled in the LGAs of Greater Shepparton, Greater Bendigo, Albury/Wodonga, Mitchell and Mildura.



The greatest number of permanent settlers in 2022-23 were:

- Skilled migrants (75%)
- Family (16%)
- Humanitarian settlers (9%)

The health of our multicultural communities

The rates of self-reported long-term health conditions were lower for all conditions in the CALD population, compared with the whole population, for various reasons. Self-reporting relies on factors such as health literacy, English proficiency, an understanding of the potential care available for conditions, or perhaps the fear or stigma of being seen to be unwell, particularly with mental health issues.

Infectious diseases, including tuberculosis, HIV, Hepatitis B and C and a range of sexually transmitted diseases are more common in some parts of the CALD community. Chronic pain, family and gendered violence, exploitation, and alcohol and other drug (AOD) use disorders are also notable issues.

TOP 5 LONG-TERM HEALTH CONDITIONS REPORTED IN THE CALD COMMUNITY:

1. OTHER LONG-TERM HEALTH CONDITIONS (64 per 1000 people)
2. ARTHRITIS (56)
3. DIABETES (53)
4. ASTHMA (48)
5. MENTAL HEALTH CONDITIONS (45)

How services can support multicultural communities

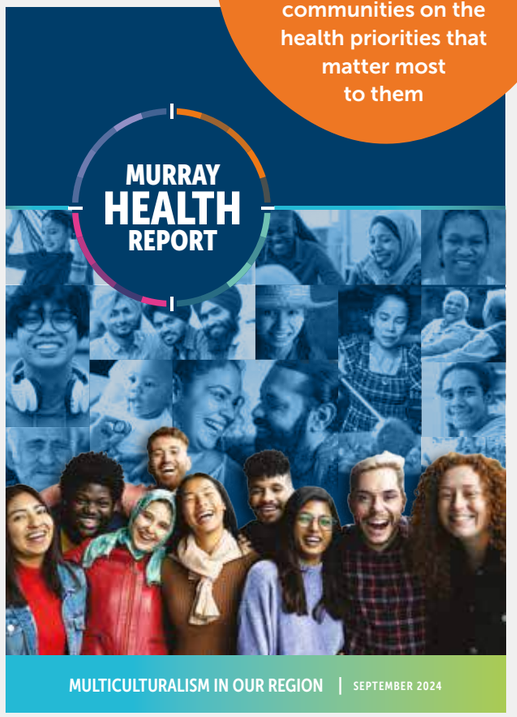
The dominant health needs of our CALD communities are based around three related areas – interpreter services and translated health information, support to navigate our health system and access to culturally safe primary healthcare.

Primary care providers have a range of quality resources to help them deliver optimum patient care, including access to free telephone interpreting services which helps both provider and patient to communicate more easily.

Primary health providers are also encouraged to consistently, and sensitively, collect the five key CALD data fields of country of birth, language spoken, interpreter required, ethnicity/cultural background and year of arrival in Australia. This information can help to tailor services and programs for person-centred care and begin to address the often misunderstood systemic racism that can impact people's access to health and their healthcare outcomes.

Read the report at: https://bit.ly/3UJl00c

The Murray Health Report is published annually to provide information to our communities on the health priorities that matter most to them



Healthcare for those experiencing homelessness

Two primary healthcare programs for people experiencing, or at risk of, homelessness are now available in Shepparton and Bendigo, with an additional housing support pilot to be provided in Albury and Wodonga until June 2025.

With data demonstrating gaps in primary healthcare service arrangements, Murray PHN issued a tender for a Homelessness Access to Primary Healthcare Program in May 2024. Funded by the Department of Health and Aged Care, the new program aims to address barriers to accessing services and improve service integration in this area of great need in our region.

As part of a needs assessment process, Murray PHN conducted extensive consultation with health and social services that helped us better understand the needs and challenges facing people experiencing homelessness.

In Shepparton, Wyndham House Clinic has primary healthcare staff providing direct patient care at the Salvation Army Shepparton Corps and Community Centre located at 99 Nixon Street, every Thursday from 10am-2pm.

Bendigo Community Health Services is implementing access to primary healthcare services through partnering with other programs such as Community Connections and Specialist Homelessness Services.

Junction Support Services' specialist homelessness services staff are strengthening relationships with local health services across Albury and Wodonga, to understand health needs and enhance health service integration and referral pathways, with funding available to support health access and reduce costs of items such as prescription medicines, gap fees and travel to appointments.

Walk-in appointments are available and services provided at no cost to people experiencing homelessness, whether or not they are eligible for Medicare.

Primary care practitioners can access Murray HealthPathways for information on housing support and health assessments for people experiencing homelessness are now in development.

Pictured above L to R: Scott Smallacombe Shepparton Corps, Corps Officer; Petro Liebenberg Wyndham House Clinic Practice Manager; Suezanne Martin Murray PHN Coordinator - Complex and Integrated Care and Omen Ndlovu Salvocare Homelessness Services Manager. Photographer: Megan Fisher, Shepparton News.

Enhancing health system navigation

The Health System Navigator service is a Murray PHN initiative designed to enhance health system navigation for vulnerable individuals with chronic conditions. It aims to achieve systemic improvements in health access and outcomes by implementing shared best practices, promoting patient engagement in preventive and primary care, and optimising resources, ultimately benefiting others with similar needs.

Our navigators specifically support underserviced populations - particularly newly settled refugees and other migrants - and those with multiple or complex chronic conditions. These individuals often experience avoidable hospitalisations, meaning they may seek care at acute and emergency services for issues that could be managed in primary healthcare settings. This situation highlights the significant barriers these populations face in accessing essential health services, including language barriers and health literacy. By providing targeted, culturally appropriate navigation support, we aim to reduce the need for acute care and improve overall health outcomes for vulnerable community members.

In addition to existing services in Greater Bendigo and Greater Shepparton, we have recently commissioned a new service in Robinvale, in the Swan Hill local government area, that is further extending the program's reach, particularly for the significant seasonal migrant worker population. We have also established a community of practice to foster collaboration and share best practice service delivery among health professionals and navigators working with these groups.

Our navigator organisations provide direct, non-clinical support, health education and referrals for individuals in targeted regions in the Murray PHN catchment. Since the program began in 2020, Health System Navigator providers have delivered more than 6658 hours of support, facilitated more than 50 education sessions, and assisted 2025 clients.

By collaborating closely with other health services, general practices and community organisations, we strive for an accessible and equitable healthcare system for all community members.

Pictured L to R: Trish Fotheringham (Sunraysia Mallee Ethnic Communities Council Inc [SMECC]); James Selby (Robinvale District Health Services); Maree Buckingham (SMECC); Diez Kouadio (Robinvale District Health Services); Catherine Mather (Murray PHN); Akesa Kei (SMECC); Brett Sanderson (Murray PHN); Paige Clutterbuck (Murray PHN).

Case studies

"Judy*" is in her 40s and lives with type 2 diabetes and several other long-term health conditions. She had lost contact with her regular GP and other health supports for several years, stating she 'felt confused by the medical information previously received'.

Judy was reluctant to approach health professionals as she felt ashamed that her diabetes management was not under control. She tried to manage her diabetes by looking for information on the internet, but realised it was important to again try seeking professional help.

Initiating contact with her local community health service, Judy met regularly with a Murray PHN funded diabetes educator and a dietitian at the service and over several months, her health improved and her confidence was restored.

Judy sought health professionals who could explain where she was at with her diabetes, explain what an ideal lifestyle would look like, and offer advice and choices; not simply be told what to do. Rather than receiving a treatment plan she was expected to blindly follow, Judy wanted to know the reasoning behind and have some input and control over her own healthcare management.

Judy said, "I leave the appointments feeling quite empowered and confident that I'm achieving my goals. My confidence and happiness in myself have dramatically increased."

"Bob*", aged in his 80s, lives with his wife in a rural town. Bob has a severe long-term lung condition and was referred to see a Murray PHN-funded dietitian by his GP.

Travel was an issue for Bob due to where he lives, so he agreed to see his dietitian using telehealth via his home computer. Maintaining a stable weight was an important goal for Bob to help reduce muscle loss and enable him to continue moving around as much as possible. However, due to the severity of his illness, Bob had a poor appetite and little interest in food, so his dietitian worked carefully with him to develop a plan that would suit Bob's situation and make every mouthful count calorie-wise.

Bob's situation stabilised for the first time in a while and due to this, the number of times Bob needed to go to hospital declined, which he was very happy about. Accessing dietitian appointments via telehealth helped Bob to access a service that would otherwise been difficult to reach and in Bob's case, age was not a barrier to receiving personalised, beneficial healthcare.

**names changed*

Face-to-face support with Care Finder

The Care Finder program has been complementing My Aged Care by assisting older people eligible for aged care services who have no family or trusted carer to engage with My Aged Care and other local health and community services. There are 12 Care Finder providers operating in the Murray PHN region that provide localised, face-to-face supports to clients. They have successfully delivered more than 8460 service activities to 1250 clients, well integrated in the aged care sector with 96 per cent of referrals being for the target population.

The program began in January 2023 and has since had its first evaluation conducted. The evaluation report was released in March 2024, and highlighted the strong support for the program among care finders, PHNs and clients. Its findings clearly demonstrated the program's effective delivery of much needed support to the older population.

Care Finder Geri Gardner, Sunbury Cobaw Community Health

Case study

"Dot*" is in her late 60s and living with stage 4 cancer. She lives on an isolated rural farm, is estranged from her daughter and has limited social connections. As she had no current support services, Dot was referred to Care Finder for help with her daily tasks, including cooking, cleaning and laundry. Care Finder goals were supporting Dot to access My Aged Care for approval of support services, allied health supports to increase Dot's safety in her home so she can remain there for as long as possible, reengagement with medical services to get help with pain and nausea, assistance to change her will, and to facilitate and increase Dot's social connections.

Dot was approved for physiotherapy, occupational therapy and allied health assistant supports, meals, domestic assistance and transport supports. As part of the program, Dot was provided with a wheelie frame and shower seat, sensor lights, a personal alarm and over-the-toilet frame to support her safety at home. Dot has reengaged with her GP and oncologist, and was introduced to palliative care and district nursing services to help her to remain at home. The care finder was also able to support Dot's goal of updating her will and facilitate opportunities to develop social connections in her local community.

Care Finder intervention means Dot is now well supported to live as safely as possible in her own home, for as long as possible. She said that the program has led to her meeting and connecting with people she otherwise wouldn't have, which she has enjoyed.

**name changed*

Strengthening collaboration, communication and care to improve cancer patient wellbeing

Regional Victorians are 10 per cent more likely to develop cancer in comparison with their metropolitan counterparts, with cancer in women 1.25 times higher than that in men. People in the Murray PHN region receive more new cancer diagnoses than the national average (region 504; Aus 497), while people in the Rural City of Wangaratta and Gannawarra Shire have the highest prevalences of cancer death in the Murray PHN region, particularly for breast, colorectal, prostate and low-risk endometrial cancers (AIHW, 2021; Cancer Council Victoria, 2022).

General practice plays a key role in the promotion and awareness of cancer screening and is integral to connecting patients with a cancer diagnosis to specialists that are as close to home as possible. Shared survivorship is considered an effective care coordination strategy to support patients to live as well as possible for as long as possible, during and after active cancer treatment. Shared cancer follow-up care involves the joint participation of specialist oncology and GPs in the planned delivery of cancer care from diagnosis, discharge or until end-of-life. This includes a focus on strengthening collaboration, communication and care that puts the patient at the centre and supports their wellbeing, as demonstrated in the diagram that follows.

To improve the health outcomes of people living with cancer, cancer survivors and their carers, Murray PHN's Cancer Shared Care Project aimed to extend care coordination during the delivery of high-quality, safe and sustainable shared care between oncologists and patients' general practices.

Funded by the Victorian Department of Health between 2021-23, the project identified the Rural City of Wangaratta and Gannawarra Shire as regions of focus, due to their high burden of new cancer diagnoses. The project ended in December 2023, and at its conclusion, it had successfully co-designed two general practice-centred, self-directed, region-specific stepped models to support services in responding to patient cancer needs, in partnership with their specialist oncology services.

The models equip general practices with tools to:

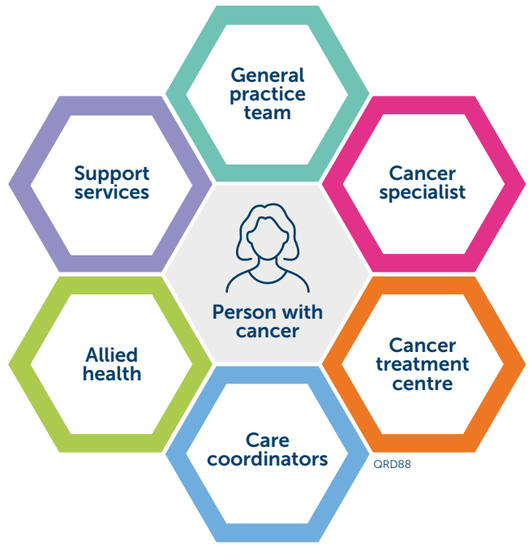
- increase screening of patients at risk of poorer cancer outcomes (colorectal, lung and breast)
- enhance cancer shared care management
- ensure timely management of unmet needs.

The co-design process involved a series of consultation/workshop sessions with consumers and multidisciplinary clinicians (60 attendees) across the two regions. Following development, usability testing of the model and its accompanying toolkit was undertaken via a nine-month pilot across three general practices.

During the pilot, there was an increased number of new referrals from general practices to specialist services (n=24), enhanced direct contact between sectors (n=23 interactions), and self-reported increased knowledge of local cancer referral pathways by participating general practices (51.5%), including enhanced relationship building between specialist-generalist (from 44% to 67%).

Other benefits have included an increase in providers' confidence to support carers and patients' non-clinical needs via social prescribing to support groups, social activities and respite services.

The models are available for interested general practices, and can be downloaded from: https://bit.ly/3Of1CV8



digital health

Increasing digital health literacy through general practice

Digital health has the potential to help people overcome healthcare challenges, such as equitable access to healthcare and for chronic disease management and prevention.

In March, Murray PHN opened an expression of interest for general practices to take part in a ready-made consumer awareness campaign titled, "Your doctor's digital toolbox can help improve your care – ask at your next appointment."

Twenty-seven general practices across the catchment took up the offer and received a $1000 incentive payment to help manage social media campaigns through their own practice pages, which took place each fortnight for two months.

This campaign was supported by in-practice materials including posters, a patient brochure and the offer to create content for waiting room TVs, and covered digital health tools: My Health Record, my health app, ePathology, e-scripts/active script lists and telehealth.

Murray PHN also ran advertisements to support practices with four ads reaching 75,087 people and receiving 395 clicks to find out more information.

Providing information on the different kinds of technologies available to assist with the delivery and management of safe, secure and connected primary healthcare services not only helped to increase the digital health literacy of patients, as they searched for more information on all topics, but practitioners as well.

"It was great to have planned content to support our social and print media that provided consumers with information from definitive sources, and which also encouraged our team to ensure they were comfortable with the topics. The ePathology content was something that we will continue to follow up with our providers. We would be welcoming of a similar program to save us the time from having to come up with all the content ourselves. Thanks so much."

Central Victorian practice manager

Important message about after hours care in aged care

Eastern and North Western Melbourne PHNs collaborated with Ambulance Victoria to produce an eight-minute video for residential aged care home staff and GPs, on behalf of Victoria's six PHNs.

Through the voices and experiences of aged care staff, a resident, family member, GP, paramedic and emergency physician, the video discusses the after hours toolkit that PHNs developed for aged care and how the kit works in practice.

With high demand on ambulance services and sometimes limited availability of medical assistance in rural areas, the video also talks about the Victorian Virtual Emergency Department and what people can expect when using the service.

To watch the video, visit: https://bit.ly/4i0gJ2z

To find these resources and others, visit: https://murrayphn.org.au/focus-areas/healthy-ageing-and-aged-care/

Virtual dementia education sessions

It can often be challenging to see the world through the eyes of a person living with dementia. But the virtual reality experience, Enabling EDIE (Educational Dementia Immersive Experience), helps staff providing support to people living with dementia with a better understanding of that world.

Murray PHN funded Dementia Australia to deliver six Enabling EDIE workshops in Albury, Bendigo, Echuca, Mildura, Shepparton and Wangaratta in June. Participants wore the immersive technology to gain a greater knowledge of dementia, while exploring strategies to support a person with dementia to live more confidently.

Sixty-six participants attended, including allied health professionals, pharmacists, practice managers, registered and enrolled nurses, disability liaison officers and personal care workers.

On average, attendees' knowledge and confidence to provide dementia-related care increased before and after the workshop, with 93.4 per cent stating that it would help improve their practice.

Engaging education package for aged care workforce

Seeing the need to focus on ensuring residents are always at the centre of aged care and to help upskill the aged care workforce to improve the lives of residents, Murray PHN launched an innovative education package in May.

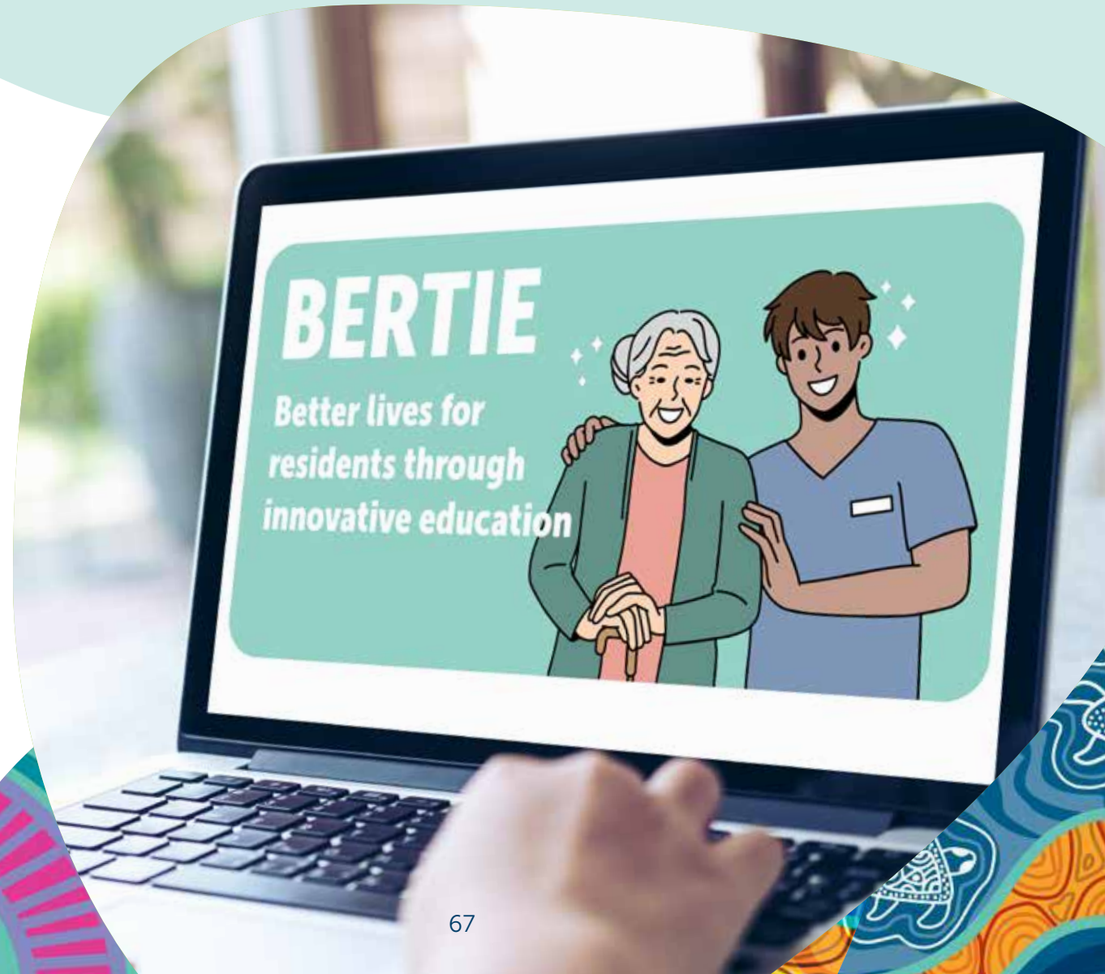
BERTIE – Better lives for residents though innovative education – was produced on behalf of Victoria's six PHNs and developed in response to the Royal Commission into Aged Care Quality and Safety.

The large project team included subject matter experts, including 16 geriatricians, two First Nations clinicians/academics, a registered nurse/health coach and a resident/consumer expert.

The training was designed to be free to access and easy to follow, to help build capacity and capability in the residential aged care workforce – supporting both clinical and non-clinical staff to recognise and manage early signs of deteriorating health of residents.

It features 20 modules, each one has a short and engaging video, a summary sheet and quick quiz, with topics from communication, pain assessment, palliative care and advanced care planning, to how to assess acute deterioration, movement and mobility.

Residential aged care workers across Australia can access BERTIE via the Aged Care Quality and Safety Commission's ALIS platform.



In conversation with:
Dr Jesse Zanker, Geriatrician

Dr Jesse Zanker wears quite a few hats. A geriatrician who works as a clinician, researcher and educator, and whose time is spent in both regional and metropolitan locations and in public and private settings, his scope of practice makes for varied days and busy weeks.

While knowing he wanted to be doctor since his teenage years growing up in Echuca, it wasn't until a regional hospital rotation as a student when he worked on an acute aged care ward that his interest in geriatric medicine took hold. "That rotation allowed me to really understand what geriatric medicine meant, and what it meant to me," Jesse said.

"It's person-centred, it's goal orientated, it's about quality of life, and it's a great intersection of human rights and individual ethics."

He explained in more detail, "A person sits within the context of their environment, culture, family. They may have complex medical conditions that you need to manage. That's put through a lens of what's important for that person now, what's most important for them to achieve in the future, how do we minimise the impact of the diseases or illnesses they've acquired, and how much medical intervention they need to optimise their goals, as well as their values and preferences. I really like that. And I also like the integration of complex medicine with the ethical questions that are grappled with."

Undertaking rotations in Ballarat, Shepparton and Echuca also cemented his passion for regional and rural healthcare. Jesse said that medicine is very different in the country, and that people are welcoming.

"I really enjoy the continuity you get with doing rural geriatrics consulting. You get to know people. It can be a difficult time of life and being able to support people and their families through it, provide a familiar face, and be with them for the long haul is a rewarding part of my work."

Working in residential aged care facilities in rural and regional areas also means Jesse sees the importance and benefit of connection to community. "There's a great level of familiarity. It's likely a resident has known others in their facility for years, has known the staff as well, as they too are more likely to be firmly established living and working in a particular region.

"There's typically more continuity of care and relationships in the country and that's a great advantage. Staff typically use that as a therapeutic tool to help make people happier and try to give them the best quality of life they can."

Jesse said that one of the knock-on aspects of both working as a clinician and a researcher is the invitation to get involved in education. One such project is BERTIE – Better lives for residents through better education – an innovative online learning package that aims to build capacity and capability in the residential aged care workforce and supports both clinical and non-clinical staff to recognise and manage early signs of deteriorating health of residents.

Murray PHN led the collaborative project with involvement of the other Victorian PHNs, as well as a large team of geriatricians including Jesse, nurse educators, sector experts and peer reviewers. The result is a range of engaging and easy to digest learning modules covering diverse topics with day-to-day relevance.

Jesse said that the vast majority of the aged care workforce is very willing, and that people work in it because they like being around people and providing good care for them.

"BERTIE provides a platform to inspire people's curiosity and to give some ideas about things that they might see regularly, or their residents might be experiencing. It encourages them to take the next step, to have a conversation, or how to escalate concerns they have to their colleagues.

"And given it's delivered online, BERTIE is easily accessible to aged care workers in rural and regional areas, ensuring that the tools to upskill are available to the entire workforce, no matter where they work and live."

"I see that in my work as a geriatrician. Staff are exposed to such a wide variety of situations and circumstances. They work together to solve problems. They are multi-skilled. They learn by being around one another. It's part of the reason I enjoy working in regional areas so much."

Supporting safe telehealth in aged care

Virtual primary care services can help to protect frail older people from the potential harm and distress caused by travel.

Last year, Murray PHN provided grants to 75 aged care homes across our region to help them purchase or update IT equipment and hardware.

This year, we joined 14 other PHNs - Western Victoria, Gippsland, South Eastern Melbourne, Eastern Melbourne, North Western Melbourne, Tasmania, Coordinare (NSW), Western NSW, Murrumbidgee, Healthy North Coast (NSW), Gold Coast, Brisbane North, Northern QLD and Darling Downs West Moreton – to support the development of a free telehealth training package.

The package offers 62, six-minute long modules and is accompanied by checklists and resources. It aims to upskill professionals and help to keep unwell and frail residents from having to leave their homes when they don't need in-person care at a general practice or hospital.

Staff who work in, or provide services to, residential aged care homes, can access the training to learn how to deliver safe and effective telehealth services – with CPD accredited educational hours available for GPs and nurses.

Topics start with the basics of choosing the right location and device, managing privacy and confidentiality, to more intricate and practical considerations, such as how to best support people during end-of-life care and technology troubleshooting tips.

To learn more and access the new telehealth training package, visit: https://murrayphn.org.au/focus-areas/healthy-ageing-and-aged-care/telehealth-training/

palliative care

Connections with country: dying in regional Victoria

A close-knit connection to community and the land sees regional and remote communities considering the country a more contemplative and comfortable setting in which to die, rather than at metro-based services. Palliative care supports people, communities and their families to die at their place of choice surrounded by those important to them, whenever possible.

General practices and primary healthcare providers play a key role in supporting patients living with a life-limiting illness (such as dementia, chronic heart failure and cancer) to have their wishes and goals at their end-of-life respected.

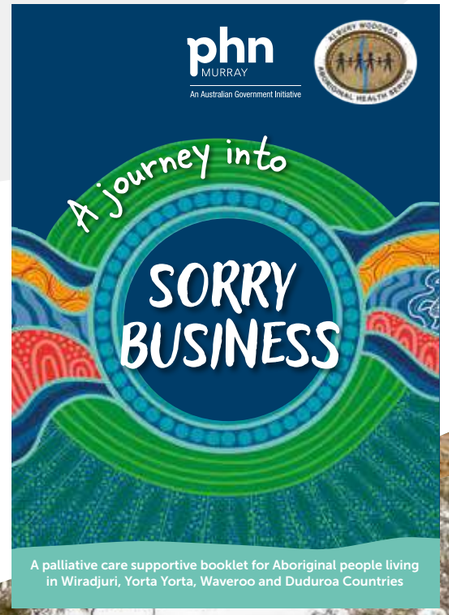
In the last three years, Murray PHN's The Caring Circle project has been supporting communities in the Goulburn Valley and North East Victoria to die in their place of choice, with a focus on improving their quality of life in this journey. Among strategies, building communities' (and carers') palliative care awareness and access to support services, while increasing general practices' capability to support them have been at the cornerstone of our model.

Palliative care resources support Aboriginal people and their carers

Murray PHN partnered with Albury Wodonga Aboriginal Health Service to co-develop an easy-to-read information booklet for Aboriginal people in need of palliative care and their carers. 'A journey into Sorry Business' supports Aboriginal people to share their wishes and preferences for their end-of-life care through 'sorry business' - cultural practices and protocols associated with death. It provides culturally appropriate, respectful and mindful information to encourage Aboriginal people to yarn about their rights, wishes and how to plan ahead when circumstances change through their lives. The booklet was developed with input received from Community members from Wiradjuri, Yorta Yorta, Waveroo and Duduroa Countries, the lands the booklet encompasses.

Fiona Bradbury, Chronic Disease Coordinator at Albury Wodonga Aboriginal Health Service said, *"The release of the booklet was a casual yarn that delivered the key message 'Don't wait until you're old or sick to attend to your journey into sorry business; have your voice heard with what matters to you."*

The free booklet can be downloaded from: https://bit.ly/4eKWFi9



Sharing conversations about dementia

In response to community interest in learning more about dementia as an end-of-life condition, we partnered with Dementia Australia to deliver two Introduction to Dementia sessions in Wangaratta and Shepparton. Attended by 45 participants, the sessions provided the opportunity for community members to build their awareness of the condition, while connecting with others experiencing similar journeys.

"There were many conversations where participants were able to share their experiences and realise that they weren't alone, with some participants helping each other with practical tips, including how to create an advance care plan."

Lucinda Fraser, Palliative Care Coordinator

Connecting carers through wellbeing activities

One in 10 Australians (2.65 million) are carers and in Victoria, there are more than 730,000 people providing 40+ hours of unpaid care a week (Victoria State Government, 2015; Carers Australia, 2021). Murray PHN has commissioned GV Hospice, a community palliative care service in Shepparton, to deliver a wellbeing program for carers of someone at their end-of-life. The End-of-Life Carers Support Program was designed after extensive consultation with carers in the Goulburn Valley region and began in February. The program offers carers weekly sessions where they can discuss life, death and everything in between over a cuppa, followed by a wellbeing activity to support connection. By June, six wellbeing sessions were held to more than 20 local carers.

Activities ranged from information sessions on local services available to carers, wellbeing and social activities such as tai chi, art therapy, therapy dog visits and trips to local museums and community centres.

In conversation with:

Jess Holmes, Carer Wellbeing Project Coordinator

"The genuine, authentic, lived connections that I make, that's the best thing about my role, I just love it," said Jess Holmes as she began to share her experiences as a carer herself, as well as someone now working to support carers.

It would be hard to meet a person as engaged and open about their role as Jess. She is the Carer Wellbeing Project Coordinator at GV Hospice, a community palliative care service in Shepparton that Murray PHN has funded to deliver a wellbeing program for carers of someone at the end-of-life.

Jess explained that this pilot program was designed after consultation with carers in the region, as "there's a real gap in caring for carers and making sure that they're okay".

Her role as coordinator of the program is informed by her lived experience as a carer. "It's like I was made for this job," she said.

"I was a carer for both my mother and father. I was also carer for my son Henry who passed away when he was six and a half in 2013. He had a stroke in utero and fell under the umbrella of cerebral palsy which literally gave him superpowers. He couldn't quite leap tall buildings in a single bound, but he climbed mountains most of us couldn't even contemplate. Wheelchair-bound and nonverbal, he was born with cataracts and developed epilepsy and scoliosis. We went on a journey together, Henry and I, and the whole family."

Jess said the connections she made over several years with the staff at the Royal Children's Hospital including the ICU team, Developmental Medicine Paediatrician and the palliative care team were built on love, respect and understanding.

"We formed incredible relationships. I thought the day I walked out of the Royal Children's Hospital, I'd lost more than my son; I thought I'd also lost all the connections I'd made. Incredibly, I've maintained them, and have been able to be involved in resources to assist families on a similar journey to ours. I've done a podcast produced by the Royal Children's Hospital about end-of-life and funerals, an education module for teachers about supporting kids with life-limiting illnesses to go to mainstream kinder and school, and a video funded by the Paediatric Palliative Care National Action Plan. I also support parents with terminally ill children and mentor newly bereaved parents.

"It's all these experiences that I bring to GV Hospice's Carer Wellbeing Support Program. It's my capacity as an active listener, my ability to create space for carers so they feel safe and heard."

The six-week program cycle is designed to foster connections – between carers, the local community and local health services, with the aim of reducing social isolation, and increasing the wellbeing and sense of self of those caring for a loved one at the end-of life, as "sometimes these carers can be forgotten about".

Jess will often meet carers in their home to listen to their stories and experiences, and tell them about the program. She asks them what their interests are, what they might like to get involved in, plans activities to best meet the needs of the people participating, and "word is spreading that the initial six-week cycles have been successful".

Program activities have so far been many and varied, including tai chi, massage, chair Pilates, art therapy, bowling, a therapy dog visit, BBQ, mosaic activities and wood turning. Even an informal café set-up for "a cuppa and a chat, and cake of course".

"What's rewarding to be part of is the connections people make during these activities, to themselves and to other carers."

To explain the benefits of this, Jess shared the experience of seeing one carer in the program change before her eyes. In fact, Jess lit up herself as she told the woman's story.

"We have one carer who has been looking after her very elderly mother for many years, as well as another family member who is ill, so her life has been on hold. She came in, had her mask on and sat hunched over. We got talking and she told me she loved art but there wasn't enough room at home, and she doesn't get to do it anymore. It got me thinking.

"The first thing I did was take her to a local education activity centre that has art classes. We both joined in at the start. Now she goes every week by herself and has been for months. She's found her people. She's blossomed. Recently, at one of our programs and with pencils and sketchpads I'd bought for the group, she led an 'informal' art class encouraging and showing others how to draw.

"It was amazing to watch. Seeing her confidence grow, seeing her come out of her shell. She told me that her life has changed since being a part of the program and she is a better carer for it. That's the reason I love my work so much."

Jess said that she formally reports on the program's data after each six-week cycle, but her personal satisfaction is measured by the direct feedback of participants.

"I ask them before and after each session to reflect on their quality of life. They may have had a terrible time the night before and come in feeling low, but then there's the camaraderie and discussions and connections they make with other carers. If their score goes up, my work is done.

"Sometimes there's even a 10," Jess beamed.

"What's rewarding to be part of is the connections people make during these activities, to themselves and to other carers."

Inspiring the palliative care workforce

In February, Murray PHN's Palliative Care Lead, Vitor Rocha, attended the 2024 Palliative Care Victoria Summit, which provided a platform for a diverse range of perspectives and strategies to be heard by an audience of more than 150 people. Vitor proudly joined the expert panel alongside distinguished colleagues from the Victorian palliative care sector, to discuss workforce strategies for sustainable service provision and address the summit's theme of Inspiration, Innovation and Integration. Victorian Primary Health Networks were also able to talk, share and showcase their collaborative and regional strategies via a central stall.

The event was one of many attended by our palliative care team throughout the year, demonstrating our commitment to voice the palliative care needs of our regional communities.

Pictured L to R: Simon Waring - Master of Ceremonies; Adj A/Prof Kelly Rogerson, Palliative Care Victoria - Board Chair and CEO - Palliative Care South East; Vitor Rocha, Murray PHN - Palliative Care Lead; A/Prof Mark Boughey, St Vincent's Hospital - Director of Palliative Medicine; Kate Johnson, MND Victoria - CEO, Adj A/Prof Violet Platt, Palliative Care Victoria - CEO.

THE **Caring** CIRCLE

For more information on the project, visit murrayphn.org.au/thecaringcircle

Pictured L to R - Back row: Emily Buchanan WVPHN - Primary Care Projects Lead; Jasmine Peldys WVPHN - Primary Care Project Manager; Vitor Rocha Murray PHN - Palliative Care Lead; Catherine Lambert Gippsland PHN - Statewide Project Coordinator, Cancer Shared Care; Jen Francis NWMPHN - Lead Older Adults and Palliative Care; Meg Boyle EMPHN - Program Manager - Aged & Palliative Care and Kay Stephenson Gippsland PHN - Project Officer Health Innovation & Integration, Palliative Care. Front row: Donna McCosker SEMPHN - Project Coordinator and Sonya Imbesi EMPHN - Program Facilitator.

The importance of tailored palliative care

Enhancing primary care systems for tailored palliative care management in general practice is an important aspect of The Caring Circle project. A cross-regional Victorian PHN collaborative was formed in 2022 between Murray, Gippsland and Western Victoria PHNs to support general practices to improve their existing palliative care systems and resources. The collaborative aims to:

- build sustainable palliative care practices in regional primary health settings
- facilitate primary care access to education for end-of-life patient care needs
- leverage existing knowledge and skills of regional primary care practitioners to enhance capability
- increase opportunities for information sharing and collaboration between regional general practices.

A series of strategies has been implemented, including the pilot of a new toolkit that embeds palliative care quality improvement strategies in general practice. Seventeen practices across regional Victoria are implementing this resource following completion of foundational palliative care training. System improvements include reviewing patients on multiple medications with risk factors while creating their advance care plan, improving symptom management of palliative care issues including anticipatory medications, and ensuring all patients in residential aged care homes have an advance care plan or goals of care document in their file and uploaded to their My Health Record. The pilot will continue until December 2024 when evaluation of outcomes will define a dissemination strategy for the model.

"I've really enjoyed working with the primary healthcare services and the two other regional Victorian PHNs on this palliative care quality improvement activity. Many practice staff identified end-of-life care and palliative care wasn't an area they felt confident in, but they were very passionate about ensuring their patients experience good quality end-of-life care, in addition to high-quality health prevention and treatment. The quality improvement project has seen many interesting and successful localised initiatives, improved patient family/carer experiences and building the capacity and confidence of practitioners." - Prue Southey, Quality Improvement Consultant

In conversation with:

Vitor Rocha, Palliative Care Lead, Murray PHN

"I work to reestablish humanism as a core value across communities and healthcare settings," said Vitor Rocha (he/him) with poignant summation about his role.

Vitor is Palliative Care Lead at Murray PHN. He said that his work is "about building and empowering community's social capital to be able to advocate for their own wishes and goals at end-of-life, so they feel equipped to share what's most important to them with family and healthcare providers".

Vitor went on to explain that there are multiple stakeholders involved in the capacity and capability building of services to support people in their end-of-life journey and that information sharing and trustworthy partnerships are at the heart of it all.

"Our biggest stakeholders are community members who are passing through an end-of-life journey. Others include the carers of those people, healthcare professionals, GPs, practice nurses and allied health, local health networks, and national organisations and peak bodies, such as Palliative Care Australia - all connected with the shared goal of promoting quality of life to people during the most difficult times of someone's life."

Vitor is a general practitioner himself, and it was his work in the healthcare system in his birth country of Brazil with motor neurone diseases at the end-of-life stage that was a trigger that led him to further interest in the palliative care space.

"Palliative care for me is an opportunity to embed the values of humanity, compassion and patient-centred care while promoting system change."

Vitor moved to Australia seven years ago. He was drawn to the regions and settled in Bendigo for both professional and personal reasons.

"Coming from Brazil, I could see that regional and rural Australians face very similar challenges in relation to accessibility to healthcare services but also health promotion and health education access. I saw my skill sets coming from the low-middle income community as an asset that could add to the public policy change to the rural communities of Australia.

"I was also looking for a work/life balance and a better quality of life so I would feel less of an expat. Regional areas are easier to establish community networks and to feel a sense of belonging."

Connection to community is very important to Vitor. He said it's been a life changing thing as an expat who has gone through a settlement into a new society and a new country.

"Compassionate communities are when people notice when you are not your usual self, reach out and provide support. I think the beauty of human connection, that caring approach, is naturally embedded into human interaction within regional communities."

When asked what he likes best about his work at Murray PHN, Vitor gave his answer in several parts.

"The PHNs are really well positioned to help glue so many different stakeholders into the same healthcare improvement trajectory. My role is part of this work. The opportunity to be part of public policy change is rewarding.

"What is also rewarding is to have the opportunity to be involved in contributing to many other governance aspects of Murray PHN not directly related to my role, such as the Reconciliation Action Plan, the Diversity and Inclusion policies, the focus on becoming an anti-racist organisation.

"As a LGBTQIA+ person from a culturally and linguistically diverse background and humble beginnings, I can contribute beyond my position description. I think having the safety to express my intersectionality is the most valuable aspect of why I continue to work for the organisation.

"Otherwise, I wouldn't feel safe to enact my skill set."

"The PHNs are really well positioned to help glue so many different stakeholders into the same healthcare improvement trajectory. My role is part of this work. The opportunity to be part of public policy change is rewarding."

strategy

Local rural health pilot receives funding

The Sustainable Rural Health Project

BULOKE | LODDON | GANNAWARRA

This year, the Integrated Health Network Alliance was one of six applicants selected from a pool of 80 from across Australia to receive $1.4 million in funding through the Department of Health and Aged Care's Innovative Model of Care grant.

Northern District Community Health is leading the four-year primary health pilot, with partners Murray PHN, Inglewood and District Health Service, East Wimmera Health Service and Boort District Health, to establish the Healthcare Hubs program in six communities across Buloke, Loddon and Gannawarra shires.

Building on the local community and health sector co-design research that took place through the Sustainable Rural Health Project in 2022-2023, the Healthcare Hubs program will be led by general practitioners and nurse practitioners, and staffed with multidisciplinary team members that may include physiotherapists, occupational and speech therapists, podiatrists, dieticians and mental health counsellors.

Hubs will provide these comprehensive services onsite and via telehealth and outreach into schools, residential aged care homes and hospitals to address service gaps for people with chronic conditions, including chronic pain, diabetes and cardiovascular disease and mental illness, plus those needing palliative care.

The hubs program hopes to help reduce workload pressures and create more supportive work environments through the sharing of resources between services and creation of a pooled workforce and supervision opportunities, to attract new health and medical professionals into the region.

The trial will be evaluated and adapted each year as needed, and it is anticipated that the hubs will be more financially stable by year-three to then be able to offer more services. At the end of the pilot period, Monash University will produce an independent evaluation with the hope of being able to replicate the same model in similar small, isolated communities with thin workforce markets.

Nurse practitioner pilot proves successful

A key component of the Sustainable Rural Health project, the Nurse Practitioner Rural Outreach Model delivered nurse practitioner primary care clinics in general practice settings to support GPs working in the region and increase healthcare access for communities.

Funded by the Violet Vines Marshman Centre for Rural Health Research, La Trobe Rural Health School and Murray PHN, the proof of concept study concluded in April 2024.

The 12-month pilot program offered both short and long primary healthcare appointments with the support of a care coordinator, providing almost 700 consultations to patients (31% male and 69% female) at 71 clinics in Kerang, Quambatook, Charlton, Boort and Pyramid Hill.

Because the pilot proved successful, it is continuing and being expanded through the Sustainable Rural Healthcare Hubs program trial to include multidisciplinary teams with allied health professionals and additional sites. To ensure it has sufficient funding to continue, a small patient co-payment was introduced for nurse practitioner consults, as nurse practitioners cannot access the same Medicare rebates as general practitioners.

Nurse practitioner, Simone O'Brien with Dr Chris Olise at Boort District Medical Centre

Empowering rural nurse practitioners

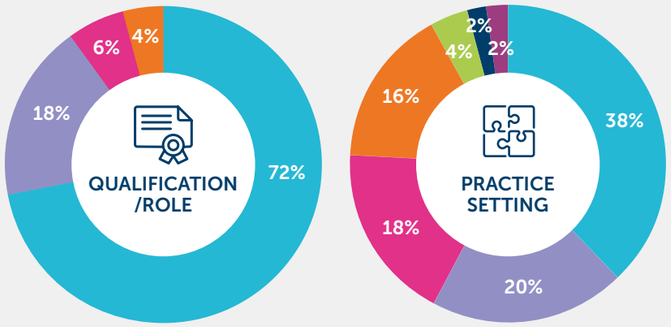
Last year, Murray PHN re-established the online Loddon Mallee Nurse Practitioner Network to help connect peers, discuss challenges, education and other opportunities.

In March of this year, Murray PHN worked collaboratively with the Australian College of Nurse Practitioners to help develop a tailored program for their event in Echuca.

The event brought together 45 professionals from across the Loddon Mallee and Hume health service catchments, in primary healthcare settings, and advanced scope nurses interested in training to become nurse practitioners.

Loddon Mallee Nurse Practitioner Network

Our membership



PRIMARY PRACTICE LOCATION

Town	Number
Bendigo	20
Kerang	4
Mildura	4
Echuca	3
Swan Hill	3
Heathcote	2
Mildura	2
Castlemaine	1
Cohuna	1
Kilmore	1
Maldon	1
Maryborough	1
Robinvale	1
Other (outside region)	6

Addressing workforce needs in general practice

The Workforce Planning and Prioritisation program provides evidence-based, independent planning and prioritisation reports to inform the distribution and placement of general practice registrar training in the Australian General Practice Training (AGPT) program.

This analysis culminates in the delivery of workforce need and training capacity reports, which are used by the Royal Australian College of General Practitioners and Australian College of Rural and Remote Medicine as a supplemental reference for determining AGPT distribution, as well as designing strategies to incentivise registrars to train in areas of workforce need and address training capacity. The Department of Health and Aged Care also use these reports to inform annual distribution targets for the AGPT program nationally.

To inform Workforce Need and Training Capacity Report #3, Victorian PHNs conducted stakeholder consultations across the state to collect data and gain insights on local workforce issues. This latest report has been endorsed by the Statewide Advisory Committee, which includes key state and national peak bodies such as the Rural Workforce Agency Victoria, General Practice Supervision Australia, General Practice Registrars Australia and the Victorian Rural Generalist Program.

Murray PHN is the lead agency for the Victorian PHN Consortia with our role being to establish and maintain the jurisdictional governance groups and provide leadership and direction for planning, data and reporting, project implementation and stakeholder engagement.

Murray PHN's catchment covers 50 of 155 Victorian GP catchment areas (geographical areas). For report #3, the assessment indicated that 94 per cent of the Murray PHN catchment rated between moderate to high workforce needs. The report is emerging to be a key workforce planning tool that can inform future commissioning and capacity building initiatives.

Encouraging health professionals to live and work in the country

A partnership of health and community services in the Loddon Mallee region has come together to develop a new program that aims to address the issues confronting rural and regional hospitals, community health services and primary care clinic providers in recruiting and retaining medical staff and general practitioners.

Connecting the Docs is implementing new workforce recruitment and retention models that cover different medical specialties and organisations required for rural GP training and is working towards developing multi-year employment contracts to allow trainee GPs to work and gain valuable learning experiences in a blend of primary, secondary and community care services.

To ensure easy integration into communities, the program also offers mentorship and education opportunities, and family supports that include relocation assistance and connection to local groups and organisations, such as schools and religious institutions.

Healthcare professionals came together in Swan Hill in April to officially launch the innovative support program.

Pictured L-R: Marie Griffiths MDAS former Acting CEO, Rex Prabhu Swan Hill District Health, Craig Canham VRGP, Louise Litten Mildura Base Hospital CMO, Gemma Bilardi Connecting the Docs, Trevor Adem East Wimmera Health Service CEO, Nerida Hyett Murray PHN, Kelly Dart MDAS, Kellie Byron-Gray Kerang District Health CEO, Margaret McDonald Northern District Community Health former Acting CEO.

Improving performance reporting helps us to continuously improve the quality of our service and enables better business intelligence, a process of organising data to get insights to inform decision-making.

Ensuring effective performance reporting

A whole-of-organisation project to improve performance reporting was undertaken this year, culminating in a revised Performance Reporting Framework. The framework applies to all transformations of data held by Murray PHN for monitoring, analysing and reporting our activities. This includes monitoring day-to-day operations, assessing performance against targets and identifying areas for development.

Improving performance reporting helps us to continuously improve the quality of our service and enables better business intelligence, a process of organising data to get insights to inform decision-making. This, in turn, ensures informed decision-making, improves clarity and transparency, and provides accountability to our funders, our communities and within our organisation.

The objectives of our Performance Reporting Framework are to:

- ensure oversight of and compliance with performance reporting requirements of relevant legislation, regulations, funding agreements and government guidelines
- align all performance metrics and reporting processes with Murray PHN's strategic goals and objectives, enabling timely monitoring of progress and evidence-based decision-making
- enable benchmarking and evaluation of value for investment, demonstrating the impact and outcomes of our activities, and ensuring clear and transparent accountability to funders and key stakeholders.

Outcomes indicators for clinical commissioning contracts

The Murray PHN Board endorsed two common internally nominated 'value for investment' outcome indicators that are now standard in all commissioned clinical service contracts:

1. Targeted outputs and outcomes achieved aim to demonstrate assurance that contracts were fulfilled, achieving what we set out to achieve
2. Service provider workforce satisfaction aims to understand the issues, barriers and opportunities to support local workforce capability and capacity to deliver services. Specifically in the 2024/25 financial year, that there is an appropriate alignment of program services to workforce capability, and local workforce has access to opportunities for growth and development.

The implementation of these two outcome indicators has started. They will be monitored and evaluated for how useful they are to decision-making and their value in understanding the effectiveness of our commissioned services.

Performance reporting at Murray PHN is a process of continuous improvement and aligns with the Department of Health and Aged Care's PHN Strategy and its performance reporting arrangements.

Achieving our strategic goals

Murray PHN's 2023-2025 Strategic Plan is now in its final months. Earlier this year, the Board and Executive took the opportunity to review progress against the plan and consider any fine-tuning necessary to deliver the plan for our communities, in light of the changing face of primary healthcare in Australia.

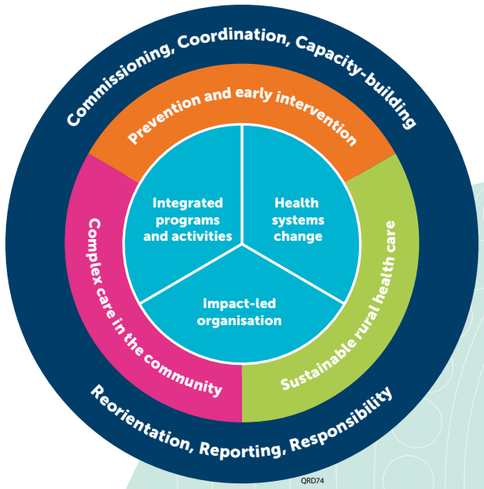
In the last year, the Australian Government's focus on Strengthening Medicare initiatives and the release of a new National PHN Strategy required us to pivot our operations to further align with national primary healthcare reform.

Our overall strategic approach has not changed - we continue to focus on understanding and promoting the management and treatment of disease. We work directly with our health system partners to assist in linking and connecting providers of healthcare services, using models of care that are regionally tailored, targeted to local needs and, importantly, sustainable.

Our three main strategic priority areas are: integrated programs and activities, health systems change and impact-led organisation.

At the time of our review in April, more than 60 per cent of the 29 initiatives were complete or on track to be achieved by mid-2025. Some were behind schedule, with our teams working to bring them back on track to full achievement.

Now, we can advise that ALL of the initiatives in our updated Strategic Plan are on track for full achievement. This is a testament to the work and commitment of our teams and partners.



PRIORITY AREA 1: INTEGRATED PROGRAMS AND ACTIVITIES

1.1	Keep informed about rural and regional primary healthcare needs.
1.2	Regularly review primary healthcare activity and performance to deliver our strategy and objectives.
1.3	Build partnerships and models of care based on trust and collaboration to advance regional primary healthcare as part of national reforms.

PRIORITY AREA 2: HEALTH SYSTEMS CHANGE

2.1	Advocate for the needs of our communities and primary healthcare system at regional, state and national levels.
2.2	Collaborate with partners for shared and sustainable investment in our regional primary care system.
2.3	Advance anti-racist, culturally responsive policy and practice within the primary healthcare system.

PRIORITY AREA 3: IMPACT-LED ORGANISATIONAL DEVELOPMENT

3.1	Develop a capable and engaged workforce.
3.2	Advance anti-racism, diversity and inclusion across our team.
3.3	Use our data and outcomes-focused approach to drive decisions, increasing our impact and accountability to funders and our community.
3.4	Enhance our systems technology and processes to support strategy implementation.
3.5	Increase our financial sustainability and resilience.

A timely reminder on the importance of vaccination

With high numbers of winter viruses circulating this year, Victoria's PHNs worked together to develop a state-wide vaccination campaign.

The engaging "It's Time" imagery was developed to encourage community members aged 65 years and older to book a COVID-19 vaccine with their local GP or pharmacist using the national health services directory (healthdirect.gov.au).

This group was chosen because they are more vulnerable to the ill effects of COVID than younger groups but has experienced some degree of vaccination fatigue.

The campaign features real people celebrating life, aiming to remind people of the things that they enjoy doing and that having COVID would prevent, such as cooking with grandchildren and travelling on holiday.

The campaign was shared freely with healthcare providers, residential aged care homes and community groups for them to use.

Immediately prior to the campaign launching in June 2024, Victoria had a lower vaccination rate (4766 per 100,000, 65+) compared to June 2023 (6468 per 100,000, 65+).

In a six week period, local Facebook ads in the Murray PHN region reached 136,065 people and received 2855 clicks on the link to the health service directory.

By August 2024, vaccination rates were higher (2060 per 100,000, 65+) than the same month in 2023 (1338 per 100,000, 65+).

This translates to an increase of more than 16,000 people (aged 65+) receiving vaccinations during July and August 2024, compared with the same time in 2023.

New hub in Goulburn Valley opens

In August, we opened a new office hub in Shepparton, designed to create a modern, welcoming and effective space for our work.

GV Hub provides the opportunity to pilot the creation of collaborative workspaces across Murray PHN's office network, with a view to designing our workspaces for the future. The office space accommodates 20 employees, with a flexible design to enable a variety of workspace approaches to suit a contemporary environment, to meet the varying needs of our teams and enhance productivity.

The space includes several different areas, including conventional open-plan desk areas, meeting rooms for collaboration, a board room for larger and more formal meetings, hot desks for visitors, private offices, a gather room for informal discussions in a more relaxed style and a breakout/parent room for quiet reflection and privacy. The office was officially opened with a Welcome to Country and Smoking Ceremony by local Elder Damien Saunders.

Listening to our communities

Advisory councils inform Murray PHN's strategic planning and while some PHNs have one combined community and clinical advisory council, Murray PHN has four geographically-based community advisory councils and one clinical council that draws from clinicians across our region.

Community advisory councils provide a community perspective to ensure that decisions, investments and innovations are patient-centred, cost effective, locally relevant, and aligned to local care experiences and expectations. Clinical advisory councils provide clinical and health system perspectives to ensure that decisions, investments and innovations are culturally safe, patient-centred, cost effective and reinforce the ongoing need for collaborative planning and service systems.

We rely on the contribution that our councils provide to our operational and strategy teams. In the past year, council members have provided local insight to inform planning on:

- general practice workforce prioritisation and planning including workforce need, issues, challenges and opportunities
- culturally and linguistically diverse communities and homelessness
- sustainable rural health model of care
- chronic disease and digital health
- multidisciplinary team care
- the General Practice in Aged Care Incentive program.

Key insights from the advisory councils have been integrated into Health Needs Assessment reports, with member feedback validating quantitative data and enriching qualitative findings. These integrated insights also informed the content of the recent Murray Health Report, which focused on multiculturalism in our region. Insights provided about the key barriers in providing responsive and quality care to this population group were particularly helpful, as well as specific sub-population groups at increased risk of poor health outcomes.

Feedback from advisory councils has been integrated into the soft launch of GP Aged Care Connect, specifically communication materials to promote the new service and key data fields to assist locating a general practice with capacity to take on new residents. Recommendations are also informing the establishment of Community of Practices to enable general practices and aged care residential homes to come together. Insights provided on the barriers associated with MyMedicare and the new General Practice in Aged Care Incentive were helpful to clarify areas that require further promotion, information and efforts.

Pictured: Murray PHN CEO, Matt Jones with some of the North East Community Advisory Council

Community advisory council members

North West Victoria

- Jack Forbes, Irymple (Chair)
- Charles Albanese, Mildura
- Amanda Holdsworth, Manangatang
- John Okaroh, Murrayville
- Kanaka Devineni, Mildura
- Leo Tellefson, Donald
- Michelle Thompson, Irymple

Central Victoria

- Vicky Mason, Castlemaine (Chair)
- Amy Brown, White Hills
- Kerry Parry, Long Gully
- Lucy Mayes, Castlemaine
- Nerida Dye, Leitchville
- Remon Eskander, Strathfieldsaye
- Simone O'Brien, Quarry Hill
- Ian Gould, Muckleford – starting December 2024

Goulburn Valley

- Kate Wright, Cobram (Chair)
- Jane Garrett, Euroa
- Dr Menon Parameswaran, Shepparton
- Fern Summer, Shepparton
- Nicole Wells, Waaia
- Viv Jeffery, Pine Lodge

North East Victoria

- Carmel Hicks, Lavington NSW (Chair)
- Emma Williamson, Killawarra
- Judith Peterkin, Wodonga
- Lucille Milne, Wangaratta
- Sarah Blatchford, Wirlinga
- Tracey Farrant, Wodonga
- Virginia Lovell, West Wodonga

Clinical Advisory Council

- Dr Talitha Barrett (Chair), general practitioner (CV)
- Angela Lawrence, hospital pharmacist (NE)
- Ashlee Lance, paediatric physiotherapist (CV)
- Brooke Shelly, general practice pharmacist (NW)
- Cameron McGregor, psychologist (GV)
- Dr Candice Baker, general practitioner (CV)
- Catherine Sambell, occupational therapist (NE)
- Jade Cartwright, chronic disease nurse (NE)
- Jenny Boak, research officer (CV)
- Dr John Buckley, general practitioner (NW)
- Kim Ling Ching, pharmacist (NE)
- Lisa Hanson, senior lecturer, physiotherapy (CV)
- Russell Maher, mental health nurse practitioner (NE)

Outgoing members

We farewell and thank the following members whose terms have finished for their contributions:

Community advisory councils

- Kim Fitzgerald
- Dianne Bowles
- Heather Macklin
- Wendy Buteaux
- Sarah Symes
- Sharon Walsh
- Mary-Ellen Gilmour
- Mitchell Dunn
- Melanie Fennell

Clinical advisory council

- Mark Savage
- Dr Ewa Piejko

"I think we have a very important role in informing the organisation and the government through our grass roots input about areas where there needs to be improvement or fine tuning, and where the health needs are being met."

Leo Tellefson, North West community advisory council member

Progressing our Reconciliation Action Plan

Murray PHN has developed a Reconciliation Action Plan (RAP) to continue to strengthen our capacity to develop culturally appropriate policies, programs and projects that embed respectful, long-term engagement with First Nations Peoples, organisations and Communities.

Reconciliation Australia's Reconciliation Action Plan program's strength is its framework of relationships, respect and opportunities, allowing an organisation to strategically set its reconciliation commitments. With our own RAP, Murray PHN will be joining a network of more than 1000 corporate, government and not-for-profit organisations that have made a formal commitment to reconciliation through the program.

Our first RAP, Reflect, is an integral element of our anti-racism journey, bonding our First Nations Health and Healing Strategy at an organisational level and with our future operations.

In October 2023, we submitted our draft Reflect RAP to Reconciliation Australia. Following receipt of a first round of feedback, we amended the draft to address Reconciliation Australia's recommendations and we also updated our deliverable timeframes for the plan's implementation.

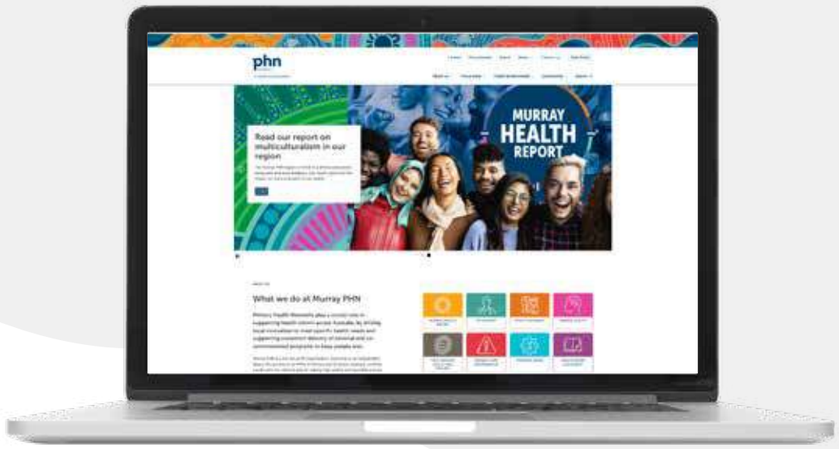
Our Reconciliation Action Plan Working Group held consultation workshops across all levels of the organisation to ensure staff could see where and how the RAP will relate to their work.

"Being part of the Reconciliation Action Plan working group has been such a privilege. For me, the journey has been as important as the destination, and as much about the heart as the mind. I have learned so much, opened to new ways of thinking, expanded to effectively collaborate, and most important of all, deepened my understandings of First Nations perspectives."

Simone Lukacs, Reconciliation Action Plan Working Group member

New and improved website

Developed in response to user interactions and staff feedback, Murray PHN launched a new website in May. The refreshed site was created so that it is now easier to navigate and search for content, and has greater accessibility features, such as readability, responsive to all screen sizes and the ability to work with immersive readers. As part of the refresh, our events calendar evolved to accept and publish external events that align to our main stakeholder groups. You can visit our website at murrayphn.org.au



eNewsletter

eNews, our stakeholder enewsletter, is distributed weekly on Thursdays to more than 3000 healthcare professionals across the region. Its purpose is to inform subscribers about current Murray PHN, government and other health industry news and information, resources and relevant health industry events.

Content ranges from information relevant to health professionals in the Murray PHN region that focuses on our health priorities; announcements, news and stories e.g. partnerships, new practitioners, awards; health programs and services; events, training, employment vacancies, surveys, grants, scholarships and local research; health promotion campaigns, programs, resources and results.

Subscribe and read past editions at: https://murrayphn.org.au/news/enewsletter/

Submissions are welcome and can be sent to enews@murrayphn.org.au

Murray HealthPathways

HealthPathways is an online clinical management and referral resource designed for health professionals to use during consultations with their patients. It aims to guide best practice assessment and management of common medical conditions, including when and where to refer patients, with guidance on what information is needed to maximise the quality of referrals and reduce waiting time for patients. Having locally relevant and reliable information, including resources, together and accessible in one place saves health professionals' time.

Doctors, medical students and specialists, nurses and allied health practitioners, along with other health professionals who are working in the Murray PHN region, can receive no-cost access to this resource to use within their scope of practice.

To learn more and register, visit: https://murrayphn.org.au/focus-areas/digital-health/healthpathways/

Connecting to Country

As part of Murray PHN's Dhelkunya Yaluk cultural humility journey and First Nations Health and Healing Strategy, we committed to creating a learning experience for our employees to improve their connection to First Nations Peoples from the communities in which we live and work. With leadership and co-design by our First Nations team members, we connected with First Nations organisations to deploy cultural immersion activities across our region. The program was designed so that every employee had the opportunity to participate in on-Country immersions with Traditional Custodians, including Yorta Yorta nations (Goulburn Valley), Dja Dja Wurrung Country (Central Victoria), Wiradjuri Country (North East) and Paakantji, the Ngyiampaa and Barkinji peoples of Mungo National Park (North West).

The success of this inaugural program was measured by the feedback received from our employees who shared the positive impact it created as a personal learning experience.

The impact and success of the program has encouraged the organisation to expand it in future years, as it delivered an experience outside of a traditional classroom practice and put Murray PHN's employees in and on First Nations Country, with First Nations Peoples giving a firsthand account of the importance of our connection to Country.

"This tour was a vivid reminder of the depth and resilience of Indigenous cultures. It underscored the importance of preserving and respecting these traditions and the land that holds their stories. I feel the experience left all those who participated with a profound appreciation for the Dja Dja Wurrung people's enduring connection to their Country and a renewed sense of responsibility towards honouring and preserving their rich cultural heritage." - Rebecca Evans

"It was a beautiful, layered and moving experience to share with each other, and lessons on balance, reciprocity, regeneration and attunement will stay in my heart." - Lucinda Fraser

"The experience was invaluable and allowed me to gain some wonderful insights to support my personal cultural humility journey." - Kate O'Kell

"The (tours) would hands-down be the most valuable sessions I have attended, along with the Guwanda training as part of Murray PHN induction." - Danielle Trezise

"I loved the immersive experience of the 'On Country' cultural walking tour. For me, time expanded, and so much knowledge, wisdom and personal perspective were woven together by the Dja Dja Wurrung facilitators as we walked between the scar trees, sacred sites, and incredible public artworks. It was mind-opening and heart-opening."
- Simone Lukacs

Finance

In its 10 years as a Primary Health Network, Murray PHN has seen enormous change since FY16 when the organisation had revenue of $25m and only 70 full time equivalent (FTE) employees, to FY24 where we had revenue of $73m and 112 FTE.

Throughout this time, we have continued to evolve to the changing primary healthcare environment, always working to achieve our core goal of using the funding we receive to benefit and improve the health outcomes of our communities.

From the $73 million funding we received in the 2024 financial year (FY24), we delivered 72 per cent directly to our communities and providers through commissioned service activities in our catchment - a remarkable $53 million.

The drive and enthusiasm of our staff to achieve this outcome shows our common commitment to our work as a primary health network. Our funding also supports our streams of work in coordination and capacity building, which are carried out by the skilled and knowledgeable teams that work across the Murray PHN region.

During the FY24 year, we funded 190 healthcare providers, through a total of 412 contracts, across 85 unique healthcare activities. The year saw us secure new funding initiatives that allowed us to focus on the high need area of after hours care. The Homelessness Access program gave us the opportunity to support after hours access to primary healthcare for people who are experiencing or at risk of homelessness in our communities. The Multicultural Access program allowed us to support after hours access to primary healthcare for people from culturally and linguistically diverse backgrounds.

We were successful in securing funding under a new Department of Health and Aged Care grant to commission works in our multidisciplinary teams program, which aims to foster and support team-based organisations wanting to provide high-quality care for patients, particularly those with chronic disease.

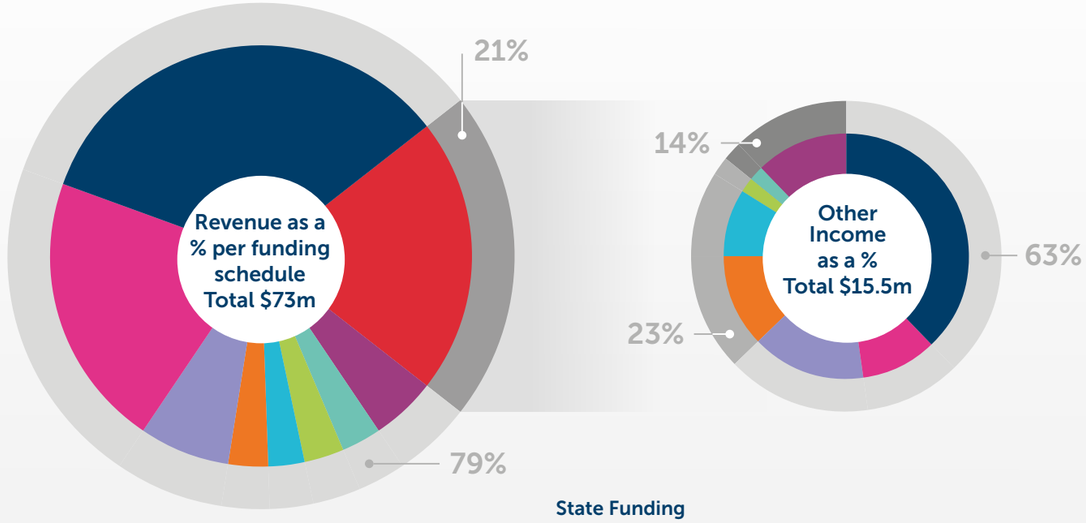
General Practice in Aged Care Incentive funding was also rolled out to our communities, with funding provided to areas to support innovative and local solutions to address the lack of primary care services for residents in residential aged care homes.

Since its inception, Murray PHN has continued to expand and grow the professional workforce that our organisation needs, always with the key goal in mind, to improve the health outcomes for the people who live in our communities.

We have also worked strategically to build our equity to a healthy level - a robust financial foundation that will enable the company to weather challenges that could otherwise impact on the work we do for our communities.

Total Revenue	**$72,981,853**
Total Expenditure	**$72,331,639**
Operating Surplus	**$650,214**
Equity	**$6,309,752**

Total Revenue:	**$M**
Core	**$15.3**
Primary mental health and alcohol and other drugs	**$24.9**
Commonwealth psychosocial support	**$5.3**
Integrated Team Care	**$2.0**
Medicare Urgent Care Clinics	**$1.9**
After hours	**$1.9**
PHN pilots and targeted programs	**$2.4**
Aged care	**$3.8**
Total Department of Health and Aged Care	**$57.5**
Other Income	**$15.5**
Total	**$73.0**



DoHAC - $57.5m

34	Primary mental health and alcohol and other drugs
21	Core
7	Commonwealth psychosocial support
3	Integrated Team Care
3	After hours
3	PHN pilots and targeted programs
3	Medicare Urgent Care Clinics
5	Aged care

Other income - $15.5m

21	Other Income

State Funding

38	Australian State Funding - Priority Primary Care Centres
10	State Funding - Department of Education
15	State Funding - Other Programs

Other

12	Other PHN Funders
9	Interest
2	PHN Exchange

Federal Funding

2	Federal Funding - Australian Digital Health Agency
12	Federal Funding - Workforce Prioritisation and Planning

Expense as a % of Total Revenue - $73m

72	Direct Activity
19	Employee Expenses
3	Corporate Governance
4	Administration
0.7	Operating Surplus

Direct Activity Expenses as a % Total - $52.3m

95.5	Commissioned Services
0.6	Direct Integrated Team Case Activity Costs
1.3	Building Capacity and Capability
0.9	Needs Assessment, planning and evaluation
1.6	Direct patient costs

Our people	**21.2%**
Administration	**3.3%**
The work we commission	**71.6%**
Corporate governance	**2.9%**
Our operating surplus	**0.9%**

For our detailed Financial Report visit our website: bit.ly/finreport24

In conversation with:
Frances Andrews, Director Finance and Reporting, Murray PHN

"A typical day? No, I don't have one," Frances Andrews smiled when asked. While the nature of the work is cyclical, no two days are ever the same, and that's part of the reason she enjoys her role so much.

As Director Finance and Reporting, Frances is responsible for overseeing everything from accounts receivable and payable, reviewing budgeting, funding expectations, contracts and tenders, all the organisation's performance and reporting requirements, including reporting to the Department of Health and Aged Care, and working closely with the Operations team.

Frances said that accounting functions differently at a not-for-profit like Murray PHN.

"It's a completely different mindset to normal accountancy where you're trying to make a surplus. We want to make sure that we're getting funding to our commissioned service providers to ensure services are delivered to our communities and funding can be acquitted within the financial year."

To provide a detailed perspective, Frances said that in the last financial year "we had 86 different (primary healthcare) activities, which meant we looked after 86 different P&Ls, which all cascade up to our total company position."

Her enthusiasm and commitment to her role is evident.

"While there are monthly and yearly cycles of activity, I'm constantly jumping between tasks on any given day. It's a real challenge, and I love a challenge, love a fast pace, and I thrive on that need to pivot. Something comes in, and you have to solve the problem quickly. I enjoy it."

When asked about the benefits and satisfactions of living and working in a regional setting, Frances was clear.

"I am a country person and like working with country people. They are down to earth and willing to help out. It's a better lifestyle. It's healthier, and you end up with a better work-life balance, which makes you happier."

Frances grew up on a small cattle farm in central Victoria, and while she has travelled a lot throughout her life, family ties brought her back to the region. For the last seven years, she has built up a herd of South Devon cattle, an English heritage breed known for their large size and quiet and gentle temperament. Concentrating on building up her breeding females, the herd has grown, and she has moved to a new, larger property in northeast Victoria.

The flexibility Murray PHN offers has given her the opportunity to have a work-life balance to passionately pursue her cattle operation, while also contributing to the work of an organisation focused on providing access to services to help improve people's lives.

"My days are busy, and even though I put in lots of hours at my desk, I can head outside to the paddock in my lunchbreak or at the end of the day and switch off and check on the cattle. I'll go for a walk and they'll follow me. They are so curious and friendly. It's good for the soul.

"Combined with working with such great people, such dedicated people right throughout the organisation, makes it really enjoyable to be at work."

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