Gippsland PHN –Aged Care
2026-2027 Activity Work Plan Annual Update
Submitted: 30 April 2026 Approved: 22 July 2026

AC-CF4 Care Finder Program - Newly commissioned services	
Activity Priorities and Description	
Program Key Priority Area	Aged Care
Aim of Activity	The aim of the Care Finder program is to establish and maintain a network of care finders to help people in the target population to understand and access aged care and connect with other relevant supports in the community.
Description of Activity	Gippsland PHN maintains a network of care finders to provide specialist and intensive assistance to help people within the care finder target population to understand and access aged care and connect with other relevant supports in the Gippsland community. Gippsland PHN has: • Commissioned two care finder organisations based on local needs in relation to care finder support (Latrobe Community Health Service and MiCare); • Developed, implemented and maintained processes to meet data collection and reporting requirements; • Supported the integration of the care finder network into the local aged care system; • Supported continuous improvement of the care finder program; and • Continued to identify and address opportunities to enhance integration between the health, aged care and other systems at the local level. The care finder program improves outcomes for people in the care finder target population in Gippsland, including: · improved coordination of support when seeking to access aged care · improved understanding of aged care services and how to access them · improved openness to engage with the aged care system · increased care finder workforce capability to meet client needs · increased rates of access to aged care services and connections with other relevant supports · increased rates of staying connected to the services they need after service commencement. The current services delivering this activity include: · Latrobe Community Health Service (LCHS) · MiCare These contracts have been in place since 1 January 2023 and have been extended until 30 June 2027. Latrobe Community Health Service continue to have staff members in all six local government areas of Gippsland. MiCare Ltd provides a care finder service in East Gippsland, Baw Baw Shire and Latrobe areas, with a good geographical spread across Gippsland. MiCare Ltd have a homelessness and housing speciality, however can and will support people referring from the broader care finder target group. **Eligibility:** • people need to be eligible for aged care services to fall within the care finder target population in Gippsland • the care finder target population specifically focusses on people who need intensive support

	• some people in the care finder target population may be under 65 years. **Integration:** Gippsland PHN continues to engage extensively with the aged care sector regarding the benefits of the Care Finder program. Since the start of the program Gippsland PHN has facilitated 16 local Community of Practice (CoP) meetings featuring a variety of guest speakers. Guest speakers include: Regional Assessment Service, Salvation Army Housing Limited, Department of Veterans Affairs, Latrobe Valley Housing Limited, Anglicare, Quantum, Senior Rights Advocacy Service, Live Up Program, Dementia Australia, Federation University, Department of Health, Disability and Ageing and Benetas Home Support Services. These COP meetings discuss: service integration, referrals between agencies, program promotion and elements of the care finder programs. Commissioned Care Finder staff attend these, and activities contribute to supporting each other as the program develops. In 2026–27, these Community of Practices will continue with the same effective model of inviting guest speakers and providing a forum for the Care Finder teams to collaborate, share learnings, experiences and to problem solve difficult systemic issues. Since the start of the Care Finder program, Gippsland PHN extended the invitation to the Gippsland Elder Support program to attend our local CoP. Members of the Elder Support program have engaged regularly, thus supporting the integration between First Nations navigators and the Care Finder program. The integration of the Elder Support program into the Care Finder Community of Practice, is proving to be a significant benefit for all participants, providing valuable support to navigate the aged care sector and fostering better integration between the agencies. It is anticipated this will continue. Gippsland PHN actively support the integration with local health service providers by • Extensive promotion of the Care Finder program to all General Practices across Gippsland, • Extensive promotion of the Care Finder program to Aged Care Access & Support networks in the region, Sector Development teams, Gippsland Best Practice forums, Gippsland LGBTIQA+ forums, Anglicare, Quantum, Community Housing Limited and Senior Rights Advocacy, • Gippsland PHN undertake extensive marketing of the program, along with each Care Finder agency who has undertaken extensive outreach to health services and community support agencies. This promotion included all local Health Services in Gippsland, Food Banks, Senior Citizens Centres and Opportunity Shops. The Gippsland care finder agencies work collaboratively together and receive and share referrals as appropriate with a view to supporting each other. The Care Finder teams continue to face ongoing challenges with referring to aged care support services. Since the introduction of the new Aged Care Act in November 2025, there are many challenges with lengthy delays with the single assessment intake, waitlists for many Commonwealth Home Support Program (CHSP) programs and Support at Home packages (SAH) which is impacting the care finder program. Locally we are working with providers to see how we can leverage and fast-track referrals to enable positive results for clients, which is important work that will continue into 2026-27 to support referral pathways. **<u>Engagement with Local Hospital Networks (LHN) and/or State government</u>**: Gippsland PHN continues to engage with local aged care sector, local health services, local hospitals, Gippsland Local Health Service Network, Local Government, Gippsland

	Community Care Alliance, the Department of Health-funded Sector Development team and non-government authorities who deliver supports to older Australians. **Impact:** The care finder program improves integration between the health, aged care and other systems at the local level. The Care Finder program has been in operation for over 3 years. Both LCHS and Micare are delivering excellent services to our community and have employed experienced and qualified staff who strive to achieve positive outcomes for the community. Since the start of the program, 1,181 older vulnerable people have been supported with a total of 9,437 total services delivered from the Care Finder team, up to 31 December 2025. This has resulted, and is anticipated to continue to result, in vulnerable older people being connected into essential aged care services. Some of these older people have been at risk of homelessness and poor living conditions and lack of regular treatments for existing chronic conditions. This service enables older vulnerable people to navigate the complex aged care sector and receive support services mitigating the risk of homelessness, poor living conditions, and spiralling symptoms of chronic disease conditions. **Data Collection** Care Finder organisations submit quarterly data through the Australian Healthcare Associates (AHA) portal, then a dashboard report is sent by AHA to Gippsland PHN. This report was previously monthly and is now quarterly. Gippsland PHN has introduced an additional report to capture Quarterly demographic data. This demographic report supports gathering essential data to ensure services are delivered across the catchment area and are reaching all vulnerable members of our community. This report is already proving to be valuable in conjunction with the AHA quarterly report
Needs Assessment Priorities	
Needs Assessment	Gippsland-NA-2025/26-2027/28-V1
Priority – *refer to **DOC/25/1618**: Health Needs Assessment 2025-28 Opportunities and Priorities for guidance when selecting the correct priority*	Page reference
Healthy ageing (65+) Aboriginal and/or Torres Strait Islander health and wellbeing Health workforce Access to primary care for marginalised communities	
Activity Demographics	
Target Population Cohort	Older people who are eligible for aged care services and have one or more reasons for requiring intensive support to interact with My Aged Care and access aged care services and/or to access other relevant supports in the community
In Scope AOD Treatment Type	No
Indigenous Specific	No
Indigenous Specific Comments (if answered yes to above)	-
Coverage Whole Region?	Yes
SA3 Name	**SA3 Code**
Gippsland wide	
Activity Consultation and Collaboration	

Consultation	Gippsland PHN engages with key stakeholders in the aged care sector to ensure there is awareness of the Care Finder program and to ensure vulnerable members of the Gippsland community are actively supported to link into support services. Gippsland PHN's Clinical Council is comprised of health professional representatives enabling the group members to recommend and advise on primary care issues that are specific to Gippsland across many disciplines. Gippsland PHN also have an Executive Team member as a non-voting member on the Council which assists with direct communication to the organisation, as well as the Gippsland PHN Board through its Board member sponsor. The Care Finder teams continue to engage key stakeholders such a local library, Food Banks, community groups, hearing centres, Bush Nursing Centres, GP clinics and community health services. Extensive outreach ensures that all community groups are targeted, and program promotion is reaching all services within Gippsland. This is resulting in referrals received from a variety of sources
Collaboration	Gippsland PHN will continue to undertake extensive collaboration with VTPHNA and attend all State Care Finder meetings to ensure the Care Finder program is delivered consistently across Victoria. Gippsland PHN engages with the Gippsland Local Health Services Network (LHSN) and Department of Health, Disability and Ageing. PHN Collaborative is focusing on contractual requirements to ensure the compliance requirements are more standardised across PHNs and not too onerous for the providers. The Gippsland Elder Care program attends the quarterly Care Finder Community of Practice, and this partnership is supporting integration across the aged care sector.
Activity Milestone Details/Duration	
Activity Start Date	01/01/2023
Activity End Date	30/06/2029
Other Relevant Milestones	-
Activity Commissioning (intended procurement approach for commissioning services under this activity)	
Procurement Approach	Continuing service provider/contract extension Gippsland PHN has issued deeds of variation for LCHS and Micare to deliver Care Finder services in Gippsland from 1 July 2025 – 30 June 2027.
Is this activity being co-designed?	No
Is this activity the result of a previous co-design process?	Yes
Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?	No
Has this activity previously been co-commissioned or joint-commissioned?	No
Decommissioning	No
Decommissioning details?	NA

Co-design or co-commissioning comments	Previous activities supporting the development of the Care Finder Program were in conjunction with COTA and Vic/Tas PHNs via a working group. This included: • Review and feedback of the Care Finder Competency Framework; and • Review and feedback of the Aged Care Engagement Readiness Tool (ACERT). Gippsland PHN has undertaken extensive collaboration with the Vic/Tas PHNs regarding this activity to co-design tender specifications, demographic deliverables and coordination the State Care Finder forums. This will continue into 2026-27. Gippsland PHN is an active member of the VTPHNA Care Finder working group and collaborative activities, such as contract review, coordination of the State care Finder forums and sector support are key deliverables from this working group

AC-VARACF1 Support RACHs to increase availability and use of telehealth care for aged care residents	
Activity Priorities and Description	
Program Key Priority Area	*Aged Care*
Aim of Activity	To support participating Residential Aged Care Homes (RACHs) to have the appropriate virtual consultation facilities and technology so their residents can access clinically appropriate telehealth care with primary health care professionals.
Description of Activity	Gippsland PHN has a project officer to support access to telehealth for aged care residents. The project officer is currently supporting the implementation of activity requirements, as per the Schedule, which includes: 1. Assisting RACHs by providing advice on appropriate telehealth facilities and equipment to enable residents to virtually consult with their primary health care professionals. 1. Providing training opportunities to participating RACH staff to support them to assist residents in utilising telehealth. 2. Promoting the enablers such as My Health Record and the use of the 1800 Medicare App for residents. Telehealth: 1. Environmental Scan: Gippsland PHN has engaged with all 53 RACHs in Gippsland, delivering an Aged Care Telehealth and After-hours survey and follow-up engagement activity through a combination of in-service visits and online meetings with Homes to complete in-depth interviews. This outreach activity helped Gippsland PHN to understand RACHs virtual care readiness, current state, infrastructure needs, digital capability of the aged care sector workforce and training needs. Only 8% of all RACHs in Gippsland were found to have adequate virtual care infrastructure and connectivity through this engagement activity. Telehealth access and support will continue to be provided to RACHs throughout 2026/27 which will include outreach activities to RACHs in Gippsland. 2. Training and Education: Promotion of existing Training and Education modules is ongoing. A survey was distributed to all 53 RACHs in February 2026 to seek areas of need and how Gippsland PHN can support with Telehealth education planning and activity. This survey will assist with directing areas of effort over 2026/27. It is anticipated the continued impact and combination of these activities will support RACHs to further demonstrate compliance against the ACQSC Aged Care Quality Standards, particularly *Standard 3.Personal and clinical care*, including residents being able to access safe and effective clinical care and timely and appropriate referrals to other care and service providers. 3. My Health Record: Gippsland PHN facilitated and supported connections between the Australian Digital Health Agency (ADHA) and Commonwealth-funded Homes to support registration and adoption of My Health Record alongside promotion activity directing aged care providers and Gippsland health practitioners to My Health Record education and training events. This will continue as part of Gippsland PHN's role in increasing registration and uptake of digital health solutions in the region and further establishing and embedding virtual service models in aged care homes. It is anticipated the uptake of My Health Record by RACHs will improve the secure

	transfer of resident's health care information between RACHs, primary care providers and acute settings. The RACH After Hours Toolkit also references My Health Record which will support the uptake of this service alongside work of the ADHA. 4. Duplication Check: The collaboration with VTPHNA and PHNs in other States and Territories allows the sharing of information and knowledge about alternate programs for the benefit of our PHN. To date Gippsland PHN has not identified any duplication of efforts and confirmed this activity is supporting consistency given that some RACHs operate across regions. Engagement with Local Hospital Networks (LHN) and/or State government: Gippsland PHN have communicated with all RACHs in Gippsland including those that are run and are managed by state-run LHNs. Collection of data: Through the initial survey and in-depth in-service audit, data was collated on the infrastructure, connectivity and capability of RACHs to deliver telehealth support to residents. Participation Agreements stipulate requirements by RACHs to acquit on all activities outlined in their grant applications. Data will be collected that will demonstrate RACH participation and impact of virtual capability. Usage of the telehealth training online modules from the Learning Management Systems hosting the training was available to support implementation in 2025/26 and awareness of training use; completion and gaps will be further targeted in 2026/27. Impact: The grant program has seen 75% of Gippsland PHN registered aged care homes participate in and establish improvements to access to better virtual care services for residents. At this stage, it can be noted that current engagement activities and grant program briefings have already impacted awareness and understanding of virtual care improvement opportunities in Gippsland's RACHs. Gippsland PHN continues to work with RACHs to support telehealth delivery and to gather evidence to evaluate impact of program.
Needs Assessment Priorities	
Needs Assessment	Gippsland-NA-2025/26-2027/28-V1
Priority – *refer to **DOC/25/1618**: Health Needs Assessment 2025-28 Opportunities and Priorities for guidance when selecting the correct priority*	Page reference
Connected Care Healthy ageing (65+) Chronic conditions Access to primary care for marginalised communities	
Activity Demographics	
Target Population Cohort	Aged Care, General Practice, Allied Health, Pharmacy
In Scope AOD Treatment Type	No
Indigenous Specific	No
Indigenous Specific Comments (if answered yes to above)	-

Coverage Whole Region?	Yes
SA3 Name	**SA3 Code**
Gippsland wide	
Activity Consultation and Collaboration	
Consultation	Gippsland PHN consults with key stakeholders from across Gippsland and Victoria to support project activities including local General Practitioners (GPs), Residential Aged Care Homes (RACHs), HealthDirect Australia, the Australian Digital Health Agency, Gippsland Health Alliance and Gippsland PHN Clinical Councils and Community Advisory Committee.
Collaboration	Gippsland PHN continues to collaborate with the Vic/Tas PHNs regarding this activity as well as the Department of Health, Disability and Ageing. Gippsland PHN also collaborates with General Practitioners and General Practice staff, participating Residential Aged Care Homes to support implementation, and virtual care service providers such as the Victorian Virtual Emergency Department (VVED), Healthdirect Australia, and Ambulance Victoria's Residential Aged Care Enhanced Response (RACER) program. Collaboration is continuing with the Australian Digital Health Agency (ADHA) and Australian College of Rural and Remote Medicine (ACRRM).
Activity Milestone Details/Duration	
Activity Start Date	01/12/2021
Activity End Date	30/06/2027
Other Relevant Milestones	-
Activity Commissioning (intended procurement approach for commissioning services under this activity)	
Procurement Approach	Not yet known
Is this activity being co-designed?	No
Is this activity the result of a previous co-design process?	Yes
Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?	No
Has this activity previously been co-commissioned or joint-commissioned?	Yes
Decommissioning	No
Decommissioning details?	-
Co-design or co-commissioning comments	This activity was previously co-designed with RACH to support the delivery of the grants process. For 26 – 27 there will not be a co-design activity associated with this grant

AC-AHARACH2 Enhanced out of hours support for residential aged care	
Activity Priorities and Description	
Program Key Priority Area	Aged Care
Aim of Activity	Residential Aged Care homes (RACH) residents can experience rapid health deterioration during the after-hours period, but immediate transfer to hospital is not always clinically necessary. This activity supports Gippsland PHN to address any awareness or utilisation issues of available local out of hours services among participating RACHs in Gippsland. The intended outcome of this activity is to help reduce unnecessary hospital presentations among RACH residents.
Description of Activity	Gippsland PHN have an aged care team who support RACHs by: a. providing guidance to assist participating RACHs in the Gippsland region to develop and implement after-hours action plans which will support residents to access the most appropriate medical services out-of-hours; b. educating participating RACH staff in out of hours health care options and processes for residents; c. encouraging participating RACHs to implement procedures for keeping residents' digital medical records up to date, particularly following an episode where after hours care was required; and d. supporting engagement between RACHs and their residents' GPs (and other relevant health professionals), as part of after hours action plan development. **Current Activities** In 2023, Gippsland PHN commenced extensive engagement with RACHs in Gippsland. All RACHs were surveyed to ascertain after hours supports that are in place and what support is required for residents in the after hours timeframe. Gippsland PHN received responses from 72% of RACHs and 66% of respondents confirmed they had a documented after hours plan in place. Gippsland PHN will compare to current RACH aged care survey results received and will make adjustments to the activities as required. After-Hours Toolkit: When surveyed, an after-hours toolkit was valued by RACH as a beneficial tool along with the partnerships with VVED, Ambulance Victoria and the aspiration for a monthly RACH Community of Practice. Gippsland PHN will continue to promote the after-hours toolkit along with additional training in medication management and My Health Record to support staff and residents. The after-hours toolkit will be updated as needed including addition of the 1800MEDICARE after hours line in the service directory. Resources: With the knowledge gained from the environmental scan, Gippsland PHN hosted monthly meetings to co-design consistent themes relating to after hours action plans. There was representation from more than 50% of RACHs in Gippsland PHN's co-design meetings, across both Public and Private Homes. To ensure there is consistency across catchment areas, extensive collaboration has taken place with Victorian/Tasmanian PHN Alliance (VTPHNA). Six resources were developed and released in August 2023. These resources are:

	• An after hours action plan draft; • Communication tools between RACH and emergency services/ after-hours medical support services; • Family brochures; • Person-centred after hours action plan; • RACH Audit tool; and • Gippsland Service directory. Since the release of the resources, Gippsland PHN have undertaken extensive promotion and education of the toolkit, thus supporting a consistent approach across Gippsland. This will continue over the 2026/27 financial year. Gippsland PHN have undertaken extensive collaboration with Ambulance Victoria and Victorian Virtual Emergency Department (VVED) to ensure resources have been co-branded and that messaging is consistent. This toolkit has the flexibility to be modified and branded to each individual RACH and it is anticipated that this toolkit will work in conjunction with existing after hours support mechanisms. This work will greatly support our RACHs in the after hours time-period and complement existing after-hours action plans, process and policies already in place. Gippsland PHN continue extensive engagement with RACHs to promote the after-hours toolkit in conjunction with VTPHNA via engaging Corporate RACHs. Gippsland PHN has co-hosted corporate meetings to support the uptake of tools and resources which will support the wellbeing of residents in RACHs and reduce the prevalence of avoidable transportation to emergency departments. This work will continue for the duration of the funding schedule. Digital Medical Records: As part of the after-hours toolkit, the audit tool supports RACHs with implementing procedures and policies for updating resident records, particularly after a medical incident. The resident After Hours Action Plan and the Medical Support Checklist supports with capturing this information, which is then uploaded into the resident file. As part of promoting the After Hours Toolkit, Gippsland PHN has also promoted Digital Medical Records and will continue to do so throughout the duration of the funding via updates in aged care newsletters, targeted training and information via the RACH Community of Practice. These updates will include any new Digital Medical Records tools currently available such as the Electronic National Medication Chart (eNMC) and those that become available throughout the duration of funding. The promotion of Digital Medical Records aligns with Gippsland PHNs engagement with GPs when promoting MyMedicare and General Practice Aged Care Incentive changes. Gippsland PHN have also mapped which General Practices are supporting RACHs in Gippsland. From this, we ascertain gaps and work towards a targeted engagement in these areas. After Hours:

	Extensive collaboration has taken place with Ambulance Victoria to support the reduction of resident transfers to Emergency Departments. This involves co–presentations to RACHs in Gippsland and promotion of the after-hours toolkit. Collaboration took place with the Gippsland Health Service Partnership and will continue engagement as the Gippsland Local Health Services Network. Collaboration also took place with Residential In Reach programs in Gippsland via toolbox meetings, support for the development of the RACH CoP and an appetite to ensure funded initiatives do not duplicate existing activities. Gippsland PHN continue to monitor and review resources and update where needed and then re-distribute. Gippsland PHN has developed a YouTube video to support RACH staff with the use and knowledge of the afterhours toolkit. Engagement and collaboration will continue throughout the duration of the funding schedule. Education: Gippsland PHN in conjunction with VTPHNA and Murray PHN as Lead, rolled out a series of 20 webinars on the deterioration of a resident. This webinar series is and will continue to be available to all staff at RACHs across Gippsland and includes: · Performing an acute assessment of a deteriorating resident (clinical); · Identifying symptoms that require immediate action; · Eating, drinking and elimination; · Communication; · Movement and mobility; · Skin; · Breathing; · Mental awareness; · End of life. This webinar series supports RACH staff to upskill on the deteriorating resident to adequately respond as required. Gippsland PHN will continue to support the series with the education, promotion and encourage uptake of these modules throughout the duration of the funding schedule. Gippsland PHN is working with Gippsland Palliative Care Consortium to establish training for registered nurses who work in the after-hours time period. This training will support nurses with Resident Action Plans and their agencies After Hours Action Plans. It is anticipated that this training will support learning of RACH nurses and assist with the development of after-hours action plans. This training will commence from 2026 – 2027 and support all RACH Senior Nursing staff with the essentials to detect the deterioration of a resident. Engagement Support: Gippsland PHN will continue to work with RACHs, both public and private, in ongoing face-to-face and virtual meetings and via email and telephone to encourage them to engage with residents' GPs and other alternate after-hours providers in the development of their after-hours action plans. **Engagement with Local Hospital Networks (LHN) and/or State government**: Gippsland PHN continues to engage with Gippsland Local Health Services network, local aged care sector, local health services, local hospitals, Local Government, Gippsland Community Care Alliance, the Department of Health-funded Sector Development team and non-government authorities who deliver supports to older Australians. **Impact:**

	In 2024, to gauge the impact of the after-hours toolkit, post its release, a survey was conducted to test uptake. The survey results concluded of all 53 RACH surveyed, 50% of RACH were aware of the toolkit and using tools within the toolkit. The resident after hours action plan was the most favoured resource and greatly supported RACH. Gippsland PHN have recently conducted a further survey in March 2026, distributed to all 53 RACH in Gippsland. The survey results have been received with a 45 % return rate from our RACHs. From those who responded there was strong support for the after hours toolkit. Gippsland PHN will continue to promote this to all RACHs in Gippsland. Our RACHs expressed interest in additional training in: • Identifying deteriorating residents • Palliative care resources and training • After hours options to staff with clinical interventions Gippsland PHN will address these interests in the ongoing CoPs and will look into offering training for identifying deteriorating residents. Gippsland PHN will continue to support via the RACH CoP, the monthly newsletters and support with on-site visits as appropriate.
Needs Assessment Priorities	
Needs Assessment	Gippsland-NA-2025/26-2027/28-V1

Priority – *refer to **DOC/25/1618**: Health Needs Assessment 2025-28 Opportunities and Priorities for guidance when selecting the correct priority*	Page reference
Healthy Ageing (people aged 65+) Connected care Chronic conditions Access to primary care for marginalised communities	

Activity Demographics	
Target Population Cohort	Residential aged care homes. The target audience for this schedule is staff from residential aged care homes. This intervention supports the development of after-hours tools to support the care of residents in the after-hours timeframe.
In Scope AOD Treatment Type	No
Indigenous Specific	No
Indigenous Specific Comments (if answered yes to above)	-
Coverage Whole Region?	Yes

SA3 Name	**SA3 Code**
Gippsland wide	

Activity Consultation and Collaboration	
Consultation	Gippsland PHN consults with Residential Aged Care Homes (RACHs), local aged care sector, General Practices, General Practitioners, other health professionals, Gippsland PHN Clinical Councils and Community Advisory Committee. Gippsland PHN also engages with training providers such as ACRRM, RACGP, AGPAL regarding training opportunities; and chronic disease and multidisciplinary program providers to identify areas of possible collaboration. Gippsland PHN are involved in a Community of Practice with the Victoria/Tasmania PHN Alliance (VTPHNA) and continue to actively collaborate regarding Aged Care funding and looking towards uniform initiatives to support this activity.

	Extensive consultation is taking place with RACHs, Residential in Reach, Gippsland Health Service Partnership, Ambulance Victoria and the Gippsland Palliative Care Consortium and VTPHNA to ensure there is coordination of activities that support RACHs in Gippsland. Extensive consultation continues to shape this activity to ensure interventions are of value to our RACH sector.
Collaboration	Gippsland PHN continues to collaborate with the Vic/Tas PHNs regarding this activity along with the other aged care funded activities. Gippsland PHN collaborated with South Eastern Melbourne PHN and North Western Melbourne PHN to develop shared resources and are contributing towards the cost of their development. Gippsland PHN are also collaborating with Murray PHN on the development of education resources for staff in RACHs. These are currently in the development stage and will provide staff in RACHs with a series of educational webinars to support their education, resulting in additional supportive quality of care of residents in the after hours timeframe. Gippsland PHN partnerships also extends to the Gippsland Palliative Care Consortium for targeted training for RACH registered nurses in the future. In 2024 Gippsland PHN established a by-monthly RACH Community of Practice (COP) to offer RACHs a platform to engage with GPHN, other RACHs and hear about relevant industry updates. In attendance is Residential in Reach (RiR), DHDAC, Gippsland Palliative Care Consortium, representation from 53 RACHs in Gippsland and GPHN. To date Gippsland PHN have hosted 9 RACH CoPs on a monthly and more recently, bi-monthly cycle. This is proving to be a great success with high attendance and engagement from RACH, key stakeholders, DHDA (who provide updates) and guest speakers who present on topics of interest. In 2026 – 2027, Gippsland PHN will continue collaboration with VTPHNA aged care Leads, all key stakeholders within Gippsland (such as Residential in Reach programs, Palliative Care Consortium, Department of Health State based programs and Health Services Partnership) and continue to facilitate the RACH CoP. These activities will ensure broad collaboration with associated aged care initiatives.
Activity Milestone Details/Duration	
Activity Start Date	10/12/2021
Activity End Date	30/06/2027
Other Relevant Milestones	-
Activity Commissioning (intended procurement approach for commissioning services under this activity)	
Procurement Approach	N/A
Is this activity being co-designed?	Yes
Is this activity the result of a previous co-design process?	Yes
Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?	No

Has this activity previously been co-commissioned or joint-commissioned?	No
Decommissioning	No
Decommissioning details?	-
Co-design or co-commissioning comments	Gippsland PHN worked with the Vic/Tas PHN alliance to co-design approaches to this work. Gippsland PHN has also engaged with Ambulance Victoria, Palliative Care Advice Service, Gippsland Palliative Care Consortium, National PHN Aged Care Alliance, Commonwealth representatives, and public and private RACHs during co-design and implementation. These partnerships continue to support the delivery of this activity.

AC-EI3 Commissioning early intervention initiatives to support healthy ageing and ongoing management of chronic conditions	
Activity Priorities and Description	
Program Key Priority Area	Aged Care
Aim of Activity	This activity supports senior Australians to live at home for as long as possible through commissioning early intervention activities and models of care for chronic disease management that supports healthy ageing and reduces pressure on local health services. This activity also supports the empowering of General Practitioners (GPs) and other primary health care workers through the provision of training, tools and resources which contribute to their ability to provide improved health and care outcomes for older people.
Description of Activity	Gippsland PHN continues to deliver the following activities: a. 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. Commissioned services ensure transparency and are based on findings from the current Needs Assessment; b. Increase awareness in the local primary health care workforce of the needs of the local senior Australian population and of the availability of these initiatives; and c. Implement monitoring and evaluation standards and capabilities to ensure that commissioned Services are effective and efficient and meet the needs of the community in line with the Gippsland PHN Performance Monitoring and Evaluation Framework. A detailed project plan has been developed to guide the delivery of this project, ensuring delivery within scope and in accordance with program guidance. <u>Supporting Older People to live at home for longer - Analysis and Literature Review:</u> Gippsland PHN has undertaken extensive literature review of prevention activities and early intervention initiatives that support healthy ageing. Consolidating the evidence and data from the Gippsland PHN Health Needs Assessment, the literature review and key stakeholder consultations, the following issues have been highlighted for early intervention initiatives that support healthy ageing: • Social connectedness to address loneliness and improve mental health; • Falls prevention. 75% of hospital admissions of people aged over 65 years result from a fall. Falls prevention clinics and access to strength and balance programs are designed to address this, including continence and nutrition which have been identified as contributing factors to falls; • Intergenerational programs; and • Supporting consumer digital literacy to facilitate access to early intervention and health promotion. <u>Commissioning:</u> In 2024 – 2025, Gippsland PHN commissioned four providers using attributed funds and funds carried forward from 2023/24 into 2024/25 to continue to deliver early intervention services in Gippsland. With the release of additional funding to 30.6.2027, these four activities will continue into 2026 – 2027: • <u>MyPhysio Sports and Injury Clinic</u> to provide in-clinic physiotherapy support strength, balance and falls exercise programs. They also deliver the GLAD program . GLAD is an education and exercise program developed by researchers in Denmark for people with hip or knee osteoarthritis

	symptoms. This program supports great outcomes for clients. By strengthening and improving confidence with exercise, participants develop better capacity to become or stay active, prevent symptom progression and reduce pain. • Omeo District Health to deliver a Chronic Disease Clinic; • South Gippsland Hospital to deliver a Healthy Ageing Program which includes access to a dietician, an advocate and an exercise program in two catchment areas; and • Healthlinks Gippsland to deliver a Healthy Ageing service with access to a physiotherapist to facilitate strength, balance and falls prevention programs in Baw Baw Shire, Latrobe and East Gippsland. Engagement with Local Hospital Networks (LHN) and/or State government: Gippsland PHN continues to engage with local aged care sector, Gippsland Local Health Service Network, local health services, local hospitals, Local Government, Gippsland Community Care Alliance, the Department of Health-funded Sector Development team and non-government authorities who deliver supports to older Australians. Monitoring and Evaluation standards/Collection of data: All programs have recently changed from the RAND SF 36 to the RAND SF 20 assessment scale, a recommended assessment tool from ICHOM, which is a shorter more appropriate assessment tool. This will ensure there is consistent pre- and post-activity data captured across all programs, standardised across the Gippsland Region. This model has resulted in excellent client outcomes with positive scores received on the RAND SF 20 scale. Awareness and Education: These four diverse community interfacing intervention programs continue raising awareness of chronic disease for seniors across Gippsland, as well as health care providers delivering services to this cohort. Impact: It is intended that the activities will continue to support older people across Gippsland to live at home for as long as possible by increasing their strength and mobility via physiotherapy sessions, chronic disease management programs, positive ageing advisors and strength and balance programs. Since the program started there have been 1,601 people supported and 7,976 hours delivered. These programs will further benefit health outcomes which is evidenced by the RAND SF 20 scale assessment. The recent RAND results showed all participants involved in the program scored 89.2 % improved or sustained outcome.
Needs Assessment Priorities	
Needs Assessment	Gippsland-NA-2025/26-2027/28-V1
Priority – *refer to **DOC/25/1618**: Health Needs Assessment 2025-28 Opportunities and Priorities for guidance when selecting the correct priority*	Page reference
Healthy Ageing (people aged 65+) Health workforce Chronic conditions	
Activity Demographics	
Target Population Cohort	The target population for this activity is senior members of our community living in their own home within the Gippsland Region. Gippsland PHN have commissioned services in Baw Baw Shire, Latrobe City, Wellington, East Gippsland, South Gippsland to ensure there is adequate access support

	Older community members with managing chronic disease conditions in their local area.
In Scope AOD Treatment Type	No
Indigenous Specific	No
Indigenous Specific Comments (if answered yes to above)	-
Coverage Whole Region?	Yes

SA3 Name	**SA3 Code**
Gippsland wide	

Activity Consultation and Collaboration	
Consultation	Gippsland PHN continue to consult with local aged care sector, local health services, local hospitals, Local Government, Gippsland Community Care Alliance, the Department of Health-funded Sector Development team, non-government authorities who deliver supports to older Australians (Anglicare and Quantum), General practices, General Practitioners, Gippsland PHN Clinical Councils and Community Advisory Committee and other health professionals; as well as ACRRM, RACGP and AGPAL regarding training opportunities and chronic disease and multidisciplinary program providers to engage and identify areas of possible collaboration.
Collaboration	Gippsland PHN will continue to collaborate with the Victorian/Tasmanian PHNs regarding this activity as well as consultation that has been occurring between the PHN CEOs and the Department of Health. Gippsland PHN also collaborates with GPs, Gippsland Community Care Alliance, Allied Health, Aboriginal Community Controlled Organisations, chronic disease care providers and multidisciplinary service providers. Extensive collaboration and program promotion takes place with all aged care sector key stakeholders, including Service Clubs, Probus, Lions Club, Returned Services League (RSL), Rotary, Senior Citizens Clubs and University of the Third Age (U3A) to ensure is maximum exposure of this initiative and community buy in. Extensive promotion of this activity takes place across all media channels to raise awareness of funded programs accessible for all older members of the community.
Activity Milestone Details/Duration	
Activity Start Date	10/12/2021
Activity End Date	30/06/2027
Other Relevant Milestones	-
Activity Commissioning (intended procurement approach for commissioning services under this activity)	
Procurement Approach	Continuing service provider/contract extension
Is this activity being co-designed?	No
Is this activity the result of a previous co-design process?	Yes, for some programs – extensive co-design was in place to ensure this activity met the needs of the community.
Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?	No

Has this activity previously been co-commissioned or joint-commissioned?	No
Decommissioning	No
Decommissioning details?	-
Co-design or co-commissioning comments	All commissioned providers are required to co-design elements of their service delivery to ensure it is reflective of community needs. This is included in all contracts as a reportable deliverable

Aged Care On Site Pharmacist Measure	
Activity Priorities and Description	
Program Key Priority Area	Aged Care
Aim of Activity	The Aged care onsite pharmacist activity aims to: a) increase uptake of aged care on-site pharmacists by RACHs around Gippsland and b) improve access to aged care on-site pharmacists in RACHs.
Description of Activity	The Aged Care Onsite Pharmacist program (ACOP) will support Gippsland PHN to assist Residential Aged Care Homes (RACHs) to engage aged care on-site pharmacists to work in a clinical role to improve medication management for residents under the ACOP Measure. The ACOP Measure provides funding to community pharmacies and RACHs to employ on-site pharmacists to work in RACHs. Gippsland PHN has undertaken an environmental scan of RACHs in Gippsland to determine their interest for participating in the ACOP activity. This included identifying trends and gaps. This scan included a range of methods (email, phone and through a bi-monthly Community of Practice with RACHs in Gippsland, which commenced in 2025-26). Information, education and support training to with improve medication management is shared with Gippsland RACHs. The ACOP Measure is a direct response to recommendation 38 of the Final Report of the Royal Commission into Aged Care Quality and Safety, which stated that aged care providers should actively seek to engage allied health practitioners, including pharmacists, by no later than 1 July 2024. From 2026 – 2027, Gippsland PHN will continue to: • Coordinate information to RACHs in Gippsland PHN region about the ACOP measure. • Continue to manage requests for support from RACHs seeking to engage eligible pharmacists to work on-site • Identify eligible pharmacists who are available to work on-site in RACHs as part of the Measure. This will be done by mapping eligible RACH and Pharmacies. • Review the plan to guide and manage the delivery of this work. • Undertake broad communication of this initiative via direct email, newsletters and the RACH bi-monthly Community of Practice to RACH and Pharmacies. • Identify and document eligible pharmacists who are available to work on-site in RACHs as part of the ACOP Measure, via our FOLIO database. • Ensure that pharmacists seeking to participate in the ACOP Measure meet the eligibility requirements. • Coordinate the provision of information to RACHs in the PHN's region about the ACOP Measure. • Manage requests for support from RACHs seeking to engage eligible pharmacists to work on-site. Monitor and map the uptake from RACHs. • Provide participating RACHs with current and targeted information about eligible pharmacists seeking to be employed by RACHs under the ACOP Measure. • Support participating RACHs to engage eligible pharmacists to work on-site. • Support engagement between RACHs, their pharmacists employed under the ACOP Measure, their residents' general practitioners and other relevant health professionals utilising the connections of the PHN. • Engage with all pharmacies and RACH to share information regarding this initiative, including the requirement to complete a weekly timesheet and

	activities summary to ensure they meet the guidelines on working arrangements and undertake the required activities to support this initiative. For those Gippsland RACHs who are already participating in the ACOP Measure, Gippsland PHN will assist them as needed with furthering their understanding and avenues available. Gippsland PHN has identified one RACH who is part of the ACOP scheme and will support with ongoing information and education **Engagement with Local Hospital Networks (LHN) and/or State government:** In 2026 – 2027, Gippsland PHN intends to continue to engage with the local aged care sector, RACH, Community Pharmacies, local health services, local hospitals, Local Government, Gippsland Community Care Alliance, the Department of Health-funded Sector Development team and non-government authorities who deliver supports to older Australians. **Collection of data:** Gippsland PHN will use the FOLIO system to capture, track and manage linkages between RACH and Community Pharmacies. This information will be updated in the project plan which will ensure the project stays on track. **Impact** The outcomes of this activity to date has been : • 100% of RACH have received comprehensive information about the Aged Care on-site pharmacy program. • Presentations on the ACOP have been delivered at RACH CoP • 100% of pharmacies have received comprehensive information about the Aged Care on-site pharmacy program via newsletters • 100% of Pharmacies have received a direct email with information about the ACOP • Work continues to promote and link RACH and pharmacies. The intended impact of this initiative will result in RACH residents experiencing improved medication management, thus supporting better patient health outcomes.

Needs Assessment Priorities	
Needs Assessment	Gippsland-NA-2025/26-2027/28-V1

Priority – *refer to **DOC/25/1618**: Health Needs Assessment 2025-28 Opportunities and Priorities for guidance when selecting the correct priority*	Page reference
Healthy Ageing (people aged 65+)	

Activity Demographics	
Target Population Cohort	Over 65 years
In Scope AOD Treatment Type	No
Indigenous Specific	No
Indigenous Specific Comments (if answered yes to above)	-
Coverage Whole Region?	Yes

SA3 Name	**SA3 Code**
Gippsland wide	

Activity Consultation and Collaboration	
Consultation	Consultation will take place with all 53 RACH in Gippsland via the bi-monthly RACH Community of Practice meetings, emails and newsletters. One on one engagement will also occur where required.
Collaboration	Collaboration takes place with pharmacy, RACH, aged care providers and peak bodies. Broad consultation will take place with VTPHNA to consider consistent practice and look for opportunities to employ uniform strategies across Victoria.
Activity Milestone Details/Duration	
Activity Start Date	01/04/2025
Activity End Date	30/06/2027
Other Relevant Milestones	-
Activity Commissioning (intended procurement approach for commissioning services under this activity)	
Procurement Approach	Other approach N/A
Is this activity being co-designed?	Yes
Is this activity the result of a previous co-design process?	No
Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?	No
Has this activity previously been co-commissioned or joint-commissioned?	No
Decommissioning	No
Decommissioning details?	-
Co-design or co-commissioning comments	Further development of this activity will be undertaken with RACH, Pharmacists and co-design elements will be implemented with the roll out.