Gippsland PHN – Core Funding Schedule
2026 – 2027 Activity Work Plan Annual Update

Submitted: 30 April 2026 Approved: September 2026

Dementia Consumer Pathway Resource

Activity Priorities and Description	
Program Key Priority Area	Population Health
Aim of Activity	The overarching purpose of Gippsland Pathways and the development of Dementia Consumer Resources is to reduce variation in assessment and management of dementia
Description of Activity	This activity continued into 2025/26 to finalise activities, utilising approved carry-forward of funds. All activity was completed by 30 September 2025. The activities completed in 2025/26 included: • Continued review of the content of consumer resources to ensure currency of information and links within remained operational. • Promotion and sharing of the consumer resource and translated resources to General Practitioners and local community • Promotion of resources occurred through newsletters, targeted social media campaign, and General Practice visits. • Continued housing of the resource on Gippsland PHN website. Impact: General Practitioners and other local health professionals have access to local resources to support patient care. Data Collection: Gippsland PHN collected unique user and traffic data on the Gippsland PHN website for the consumer resources and directory page.

Needs Assessment Priorities		
Needs Assessment	Gippsland-NA-2024/25-2026/27-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	Community, General Practice, Health services, Clinicians, Allied health providers, Clinical Councils, Social and Community Services
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 all general practices through direct virtual and face -to-face consultation, Pathways updates and information is included in the quarterly visits to general practice in Gippsland. Engagement with Gippsland PHN's Clinical Councils and the Community Advisory Committee ensures clinical leadership and patient-centred approach is considered on all Pathways planning. The Gippsland PHN Community Advisory Committee is the centre of the organisation's community engagement strategy and is a strategic community leadership group who drives community involvement through a range of mechanisms. Gippsland PHN's Clinical Councils comprise of health professional's representative of the sub-region they cover – enabling each group to recommend and advise on issues that are specific to their sub-region across many disciplines. Gippsland PHN also have an Executive Team member as a non-voting member on each council which assists with direct communication to the organisation, as well as the Board through its Board member sponsor. Gippsland PHN utilises these key governance mechanisms as the first point for consultation regarding service development and implementation.	
Collaboration	Gippsland PHN developed pathways with input from Dementia Australia, through attendance at the PHN drop in sessions and by expressing interest in participating in the National working group to work with Dementia Australia throughout the engagement period, to ensure collaboration with Dementia Australia occurs to support development of both the consumer resource and dementia Pathways. Gippsland PHN continues to collaborate with the Vic-Tas Pathways leads to explore promotion of the Dementia Consumer resource.	
Activity Milestone Details/Duration		
Activity Start Date	19/05/2022	
Activity End Date	30/09/2025	
Other Relevant Milestones		
Activity Commissioning (intended procurement approach for commissioning services under this activity)		
Procurement Approach	NA – not a commissioned service	
Is this activity being co-designed?		
Is this activity the result of a previous co-design process?		
Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?		

Has this activity previously been co-commissioned or joint-commissioned?	
Decommissioning	
Decommissioning details?	
Co-design or co-commissioning comments	

My Medicare	
Activity Priorities and Description	
Program Key Priority Area	Workforce
Aim of Activity	Identify and assist unaccredited practices in the Gippsland catchment to work towards accreditation thereby increasing the number of general practices accredited to at least 95% or registered for accreditation under the National General Practice Accreditation Scheme, which is a prerequisite for participation in MyMedicare and other Commonwealth incentives programs. This includes creating resources and support mechanisms to assist general practices in achieving and maintaining accreditation throughout each accreditation cycle.
Description of Activity	Gippsland PHN collaborate with unaccredited General Practices which as of March 2026, sits at a total of five practices (95% of Gippsland Practices are accredited). Quality Improvement (QI) activities and resources are used to support not only unaccredited General Practices, but also those undergoing re accreditation. Gippsland PHN have commenced applying "QI for Practice transformation" and working with the whole Program Delivery Team in engaging General Practices within Gippsland to work collaboratively on Quality Improvement projects. This is embedded as business as usual practice moving forward. Program Delivery Officers work with practices to identify activities through the POLAR extraction tool and work with them to complete a QI project. The Quality Improvement Projects further develop the capacity of General Practices to implement activities which support My Medicare implementation and work to improve patient outcomes. My Medicare resource web page is available for all practices. A regular newsletter also supports with training and resources to further equip practices to deliver patient centred care. All resources that have been developed by the VTPHNA MyMedicare working group and departmental resource groups. All information and resources on our webpage link to the respective department websites. Practices are supported by program delivery officers, working one on one to address requirements of accreditation including, but not limited to: • Improvements in safety and quality within General Practice settings. • Creating resources and support mechanisms to assist general practices in achieving and maintaining accreditation throughout each accreditation cycle. • Increasing General Practices participating in the NGPA scheme to allow them to register for Commonwealth funded programs such as MyMedicare. Gippsland PHN is currently looking into an accreditation Education Series to guide Practices through the accreditation process. Gippsland PHN support General Practice across the region with quarterly visits either face to face or online. Accreditation and other relevant topics are spoken to. The Program Delivery Officers support the unaccredited Practices and speak to the benefits of accreditation. Education events on the upcoming changes to MyMedicare and the importance of quality improvement have been scheduled for all practices.

	Through activity reporting, Gippsland PHN will demonstrate they have contacted 100% of unaccredited practices to provide practical support to help the practice achieve accreditation. Engagement with Local Hospital Networks (LHN) and/or State government: Engagement occurs with the Gippsland Local Health Services Network, the Gippsland Region Public Health Unit, State Department of Health and Department of Health, Disability and Ageing. Collection of data: Gippsland PHN maintains records of general practice accreditation, which will be updated accordingly. Data will be collected on engagement activities and QI activities. Impact: Improving access for general practice to Commonwealth funded programs such as MyMedicare, therefore improving safety and quality in healthcare. This activity is discussed at both clinical and community advisory meetings, internally and externally, to further understand and increase the knowledge.
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
Health Workforce	
Activity Demographics	
Target Population Cohort	All
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 with unaccredited General Practices to encourage and support them to register and accredit to the National General Practice Accreditation Scheme.
Collaboration	Collaboration between Gippsland PHN and unaccredited General Practice and General Practices who are reaccrediting. Collaboration with RACGP regarding guidelines and policies and Procedures to 6th Edition accreditation guidelines. Collaboration with accreditation bodies such as AGPAL, QPA and ACRMM. Collaboration occurs with the Local Health Services Network, the Gippsland Region Public Health Unit, State Department of Health and Department of Health, Disability and Ageing.
Activity Milestone Details/Duration	
Activity Start Date	01/06/2024
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?	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?	NA
Co-design or co-commissioning comments	-

GP in Aged Care: GP Matching	
Activity Priorities and Description	
Program Key Priority Area	Aged Care
Aim of Activity	The aim of the activity is to implement and manage the matching of residents in residential aged care homes (RACH) and ensure residents receive regular clinical services via General Practice (GP) and/or Aboriginal Community Controlled Organisations (ACCO)
Description of Activity	Gippsland PHN have a team of 7 dedicated Program Delivery staff who actively support General Practice in Gippsland. This is provided to all 100 general practices and 53 RACHs across Gippsland. Our team of Program Delivery officers have supported the GPs with extensive information, education and support to promote the uptake of General Practice in Aged Care Incentive (GPACI). This has resulted in excellent uptake of the initiative and ensuring that 100% of residents living in residential aged care homes are matched with a GP. Gippsland PHN will continue to work in collaboration with residents, and/or their nominated guardians, Residential Aged Care Homes (RACHs) and GP practices to continue matching residents with a preferred GP in MyMedicare if it is identified they do not have one. **What will be delivered and how** Gippsland PHN has undertaken a needs analysis of the region to inform the design, implementation and monitoring of the program. This included the mapping of all 100 general practices (13 sub sites included) and 53 RACHs in Gippsland to ensure all residents in RACHs are linked with a GP. To ensure the success of the program Gippsland PHN engaged and will continue to engage with the following stakeholders: • All 100 general practices and all GPs in Gippsland to support the registration of MyMedicare as a starting point of the General Practice in Aged Care Incentive roll out • All 53 RACHs across Gippsland and all 100 general practices to ascertain the uptake of the General Practice in Aged Care Incentive is over the duration of the funded period. • The six Aboriginal Community Controlled Organisations (ACCOs) Ramahyuck Morwell, Ramahyuck Sale, GEGAC Bairnsdale, Moogji Orbost, Lakes Entrance Aboriginal Health Association, Lake Tyers Community Health Service to promote General Practice in Aged Care Incentive and share resources, in the event they do support RACHs in the future. This will include identifying and or developing culturally safe and appropriate pathways for First Nation RACH residents who request care within the Gippsland region. • Gippsland PHN has established a RACH Community of Practice (CoP) offering a strong platform for receiving information, education and training. These CoP are offered bi-monthly with high attendance from RACH across Gippsland along with a variety of guest speakers. This will assist in identifying and sharing examples of best practice arrangements between practices, GPs, ACCOs and RACHs. Previously Gippsland PHN developed a process to support matching of residents at a GP level if a residents preferred GP is not available. The residents requiring support were tracked through excel spreadsheets. This will continue to be used to track residents who require support with matching. Gippsland PHN has supported RACH with

	contact details of mobile GP who have been able to support these RACHs. All RACH have employed strategies to ensure all residents are matched with a GP. This work continues and is discussed quarterly through Quarterly General Practice visits. Activity with GPACI uptake is tracked through our internal system FOLIO. This is an effective mechanism to generate reporting to identify any gaps and to update when a match is made. Gippsland PHN have developed a project plan to steer and guide the deliverables associated with this portfolio. This has been a useful tool to track the uptake of GPACI. This work will continue as the landscape changes with GP and RACH. Furthermore, Gippsland PHN will: • Support the promotion of all MyMedicare and General Practice in Aged Care Incentive material to all 100 general practices and 53 RACHs in Gippsland • Support with the ongoing distribution of GPACI Guidelines, Toolkits and GPACI MBI billing items and processes and other associated resources to support and encourage the uptake with all key stakeholders • Support, guide and offer strategies to GPs with the scheduling of regular visits to RACHs patients to encourage continuity of care and eligibility for the General Practice in Aged Care Incentive. Gippsland PHN has developed and will continue to maintain strong partnerships with Department of Health, Disability and Ageing to ensure activities are complimented and not duplicated. In addition, Gippsland PHN will continue to liaise with Gippsland Local Health Services Network on this initiative. In addition, Gippsland PHN works collaboratively with a number of key stakeholders to support RACHs. These are Residential In Reach, DHDA Regional Stewards, Palliative Care Consortium and VATPHNA (Victorian, Adelaide and Tasmanian PHN Alliance) to ensure strategies are complementary with a spirit of collaboration and reduce the risk of duplication. Gippsland PHN has established a by-monthly Community of Practice (CoP) for RACHs to support with the roll out of General Practice in Aged Care Incentive and other initiatives. This CoP has proven to be a very effective conduit for engaging with RACH to support various initiatives and will remain ongoing for the program duration. To date our team have engaged with 100% of GP and 100% of RACH across Gippsland to share relevant resources, training, education and have actively supported with the update of GPACI. As of February 2026, there are 48 GP participating in GPACI and 52 who decline the scheme. Of those who are participating in the scheme, 90% have fully registered their residents for GPACI. Our team will continue to work with General Practices to support full registration for GPACI. Recently the team phoned all RACHs in Gippsland to see how many residents were matched with a GP. All RACHs in Gippsland confirmed that 100% of residents living in RACH were matched to a GP. As this is a changing environment, work will continue to ensure all stakeholders are supported in the event of any changes to existing arrangements. Additional intended impact: • Increased knowledge of GPs, practices, ACCOs of the incentive and benefits to RACH residents in Gippsland and providers.

	• Improved reciprocal relationships between GPs and RACHs to facilitate delivery of quality and continuous primary care services • Improved capacity of GPs and practices, and ACCOs engaged where possible to deliver quality and continuous care through learning networks. This includes the bi-monthly COP. This will include discussions of formal and informal arrangements, such as MOUs, partnership agreements and sharing knowledge relating to Best Practice Guidelines.
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+) Aboriginal and/or Torres Strait Islander health and wellbeing Health workforce Chronic conditions Access to primary care for marginalised communities	
Activity Demographics	
Target Population Cohort	Residents living in RACHs and General Practice staff
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 will continue to work extensively with all 100 general practices and 53 RACHs across Gippsland to support the implementation of GP ACI. This includes promotion, education, resources, consultation and collaboration regarding GP ACI activities. This will be further enhanced at quarterly GP visits across Gippsland.
Collaboration	The National PHN MyMedicare Leads group collaboration is supporting and leading a collaborative approach to the General Practice in Aged Care Incentive activities. There has been and continues to be extensive collaboration and engagement with VATPHNA (Victorian, Adelaide and Tasmanian, Primary Health Network Alliance) to ensure consistency of practice and learnings are shared. This will continue for the duration of funding for this activity within the funding schedule. Gippsland PHN is an active member of the Victorian, Adelaide and Tasmanian PHN Alliance (VTPHNA) which is a supportive of useful initiatives and strategies to assist with the uptake of GPACI.

	Engagement occurs with the Gippsland Local Health Services Network, the Gippsland Region Public Health Unit, State Department of Health and Department of Health, Disability and Ageing.
Activity Milestone Details/Duration	
Activity Start Date	01/07/2024
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 Commissioning associated with this funding
Is this activity being co-designed?	No
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?	NA
Co-design or co-commissioning comments	-

Workforce Incentive Program – Practice Stream

Activity Priorities and Description	
Program Key Priority Area	Workforce
Aim of Activity	The aim of this activity is to understand the current utilisation of Workforce Incentive Program-PS (WIP-PS) in the Gippsland region to provide additional support to practices to address gaps in WIP-PS knowledge and implement effective models of multidisciplinary team care.
Description of Activity	Gippsland PHN work with General Practices within Gippsland to: • identify and provide additional support to practices to address gaps in WIP-PS knowledge. • identify different models of multidisciplinary care supported by the WIP-PS to address community need, and the key factors that enable or inhibit these models and to share learnings. • identify the range of activities nurses and allied health professionals undertake in primary care supported by the WIP-PS. • increase general practice participation in WIP-PS. • improve patient outcomes by improved access to multidisciplinary care in communities. • identify best practice models of care supported by WIP-PS. • have General Practices providing sustainable, quality multidisciplinary team care. Gippsland PHN engage with practices to implement or modify delivery of multidisciplinary care in their practice to achieve best outcomes for patients in their region by developing strategies to address gaps in WIP-PS knowledge or participation in their region. Gippsland PHN have identified that the majority of General Practices in Gippsland do not employ any Allied Health Professionals. Gippsland PHN continue to capture this data and identify areas with gaps. This will enable Gippsland PHN to work with Practices to implement multi-disciplinary teams. Identification of how the nursing staff liaise with Allied Health Professionals to support patients in their multi-disciplinary care will allow Gippsland PHN to work on quality improvements for better patient outcomes. Gippsland PHN will continue to research examples of effective multidisciplinary care in primary health and learn through communities of practice and pilots currently occurring. In addition, learnings from the Multidisciplinary Team Care and Community Led Integrated Healthcare activities will continue to occur. The Pilot Multidisciplinary Team Care Model (Activity CMDT-1) has seen establishment of closer working relationships between local cardiology services, General Practices and allied health providers in Latrobe, an area identified with a high risk of cardiovascular disease, including heart disease. Specific funding for WIP-PS has ended, however Gippsland PHN continue with the above activities as part of their activity within HSI-8 General Practice Support and HSI-3 Regional Development Program. This activity, as a standalone activity ends at 30/6/2026.
Needs Assessment Priorities	
Needs Assessment	Gippsland-NA-2025/26-2027/28-V1(UPDATED)

Priority – *refer to **DOC/25/1618**: Health Needs Assessment 2025-28 Opportunities and Priorities for guidance when selecting the correct priority*	Page reference
Aboriginal and Torres Strait Islander health and wellbeing Access to care that meets people's needs Chronic Disease Digital health Health Workforce	
Activity Demographics	
Target Population Cohort	This activity is across all cohorts but specifically patients that require multidisciplinary care.
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 with General Practices within Gippsland to identify any gaps in General Practices knowledge of the WIP-PS and if they are utilising multidisciplinary care models of care.
Collaboration	Collaboration with General Practice, Allied Health Providers, and community to identify best practice models of care to implement or modify delivery of multidisciplinary care in their practice to achieve best outcomes for patients in the Gippsland region. Engagement occurs with the Gippsland Local Health Services Network, the Gippsland Region Public Health Unit, State Department of Health and Department of Health, Disability and Ageing.
Activity Milestone Details/Duration	
Activity Start Date	01/06/2024
Activity End Date	30/06/2026
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?	No
Do you plan to implement this Activity using co-commissioning or joint-	No

commissioning arrangements?	
Has this activity previously been co-commissioned or joint-commissioned?	No
Decommissioning	yes
Decommissioning details?	Standalone, specific activity has ended, but activity continues via HSI-8 and HSI-3.
Co-design or co-commissioning comments	-

CF 2 - Gippsland Pathways

Activity Priorities and Description	
Program Key Priority Area	Population Health
Aim of Activity	The purpose of Gippsland Pathways is to reduce variation in assessment and management of clinical conditions including local referral guidance: - Enhance clinical knowledge and promote best practice guidelines. - Reduce the number of patients referred to specialist care who could be managed in a primary/community care setting. - Build collaboration and reduce fragmentation across the health service network. - Improve health outcomes by enabling consumers to access the right care, in the right place at the right time.
Description of Activity	Gippsland PHN launched a new website interface for Gippsland Pathways in April 2025 and now run a process of continual improvement on the Gippsland Pathways website, identifying and implementing website enhancements to support reporting capabilities and user experience of the website. The Gippsland Pathways website enables improved coordination of patients ensuring patients receive the right care in the right place at the right time. This will be achieved through: • Commitment of key stakeholders to participate in pathway development, through mechanisms such as workgroups, regional reference groups and Clinical Advisors/subject matter experts engaged to support pathway development. • Building on existing clinical guidelines, referral pathways and service listings that have been developed. • Continued focus on better health outcomes for patients through shared, comprehensive knowledge of the local service system. • Ensuring the information required to manage a patient in a primary care setting is available for clinicians when they need it. Gippsland PHN funded subscription to Therapeutic Guidelines for clinicians and pharmacies Engagement with Local Hospital Networks and/or State government: Gippsland PHN continues to engage with local health services to support the update and maintenance of local referral pathways. Recruitment of additional Clinical Advisors (11 Advisors) has occurred during 2025/2026 to further expand the capacity of the program. We are also continuing to look at how Gippsland Pathways may be embedded in a region wide eReferral solution post completion of the eReferral solutions document development and local business case to identify requirements for a Gippsland solution that is being designed in partnership with Gippsland hospital and health services. We continue to engage with local health services to support pathway development in Gippsland. Data Collection: Gippsland PHN is collecting unique user and traffic data on the Gippsland Pathways website at a pathways level. Impact: General Practitioners and other local health professionals have access to the Gippsland Pathways website and local service directory to improve referral pathways and treatment information.
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
Mental Health and Wellbeing, including Suicide Prevention Healthy Ageing (people aged 65+) Health Workforce Growing Up Healthy (0-25 years) Family violence Connected Care Chronic Conditions Alcohol and other Drugs Access to Primary care for Marginalised Communities Aboriginal and/or Torres Strait Islander Health and Wellbeing	

Activity Demographics	
Target Population Cohort	General Practice, Health services, Clinicians, Allied health providers, Clinical Councils, Social and Community Services
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 all general practices through direct virtual and face-to-face consultation, Pathways updates and information is included in the quarterly visits to general practice in Gippsland. Gippsland PHN's Clinical Council, comprised of health professionals, is consulted about the direction of Gippsland Pathways. Gippsland Pathways seeks ongoing feedback from Gippsland Pathway users with a survey of users planned for 2026/27.
Collaboration	Gippsland PHN continues to collaborate with Clinical Advisors, Commissioned Service Providers, local hospitals and other health professionals to support the review and update of information included within Gippsland Pathways. Collaboration occurs through project advisory groups, clinical councils and other health professionals and service providers to within the Gippsland region to address and improve integrated care pathways and the delivery of seamless, effective and efficient care.

Activity Milestone Details/Duration	
Activity Start Date	01/06/2015
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. We are currently undertaking a specific mental health pathways upgrade project which also uses codesign to inform the changes

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?	NA
Co-design or co-commissioning comments	Consultation with local GPs, and other health professionals to contribute to the localisation of locally identified pathways for development

Clinical Referral Pathways - Dementia	
Activity Priorities and Description	
Program Key Priority Area	Population Health
Aim of Activity	Review existing and update dementia specific pathways for use by local GPs and other health professionals, supporting the assessment and referral to available services and supports. Support GPs and other health professionals' access to the Gippsland Pathways website and the localised dementia pathways and local services available through the referral pathways.
Description of Activity	This activity has been undertaken in collaboration with Dementia Australia, through attendance at the PHN information sessions to ensure pathways for Gippsland Dementia services are both nationally consistent and reflective of individual services and supports within the Gippsland PHN catchment. Monitoring and update of clinical and referral pathways developed continues as required. Promotion including consumer resources is planned to continue throughout the duration of the activity within the funding schedule. Gippsland PHN promote the resources through radio, newsletters, social media, General Practice visits, meetings and collaborations as applicable. Collaboration across Gippsland PHN teams through internal working groups supports expanded reach and promotion through other key stakeholder groups. Engagement with Local Hospital Networks and/or State government: Gippsland PHN continues to engage with local hospitals and community health services in Gippsland to support the review and maintenance of referral pathways. We continue to engage with local health services to support pathway development in Gippsland. With local pathway updates supported by local Clinical Advisors. Data Collection: Gippsland PHN is collecting user traffic data on the new Gippsland Pathways site at a pathway level. Impact: Practitioners have access to localised dementia clinical and referral pathways, enabling access to information on best-practice assessment and management supported by local referral pathways inclusive of local, State and National services available to support patients experiencing cognitive decline and/or dementia inclusive of families and carers. Gippsland Pathways has an inbuilt service directory of local specialists and other health professionals to support access to local referral information for best practice dementia care.
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+) Chronic Conditions	
Activity Demographics	
Target Population Cohort	General Practice, Health services, Clinicians, Allied health providers, Clinical Councils, Social and Community Services
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 all general practices through direct virtual and face -to-face consultation, Pathways updates and information is included in the quarterly visits to general practice in Gippsland. The Gippsland PHN Community Advisory Committee is the centre of the organisation's community engagement strategy and is a strategic community leadership group who drives community involvement through a range of mechanisms. Gippsland PHN's Clinical Councils comprise of health professional representatives from across Gippsland. Local Health Services are consulted to inform local referral pathways information further supporting local health professionals' access to current service information.
Collaboration	Gippsland PHN has a published suite of Dementia pathways with input from Dementia Australia. Gippsland PHN continued to collaborate with Dementia Australia through the planned information sharing sessions throughout 2025/2026. These sessions supported the initial development of the dementia Pathways. Gippsland PHN collaborates with the Victoria, Adelaide and Tasmania PHN alliance (VATPHNA) on this topic.
Activity Milestone Details/Duration	
Activity Start Date	19/05/2022
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?	Yes
Do you plan to implement this	No

Activity using co-commissioning or joint-commissioning arrangements?	
Has this activity previously been co-commissioned or joint-commissioned?	No
Decommissioning	No
Decommissioning details?	N/A
Co-design or co-commissioning comments	Consultation with local GPs, Dementia Australia and other health professionals to contribute to the localisation of locally identified pathways

Clinical Referral Pathways - Aged Care

Activity Priorities and Description	
Program Key Priority Area	Aged Care
Aim of Activity	The overarching purpose of Gippsland Pathways is to reduce variation in assessment and management of clinical conditions including referral guidance. The Aged care pathways activity aims to: Review pathways for older people and Aged Care for use by local GPs and other health professionals, supporting health professionals' access to evidence based guidelines and referral to services and supports for the Gippsland Aged Care population.
Description of Activity	The aged care pathways identified align with the Gippsland PHN needs assessment to ensure pathways developed support the needs of the Gippsland region and aged care population. Activity continues to review and update clinical and referral pathways for Aged Care. Through the development and review of localised clinical and referral pathways, General Practitioners and other local health professionals have access to clinical guidelines and referral pathways via the Gippsland Pathways website. The website aims to guide best-practice assessment and management and support access to local services through referral pathways. Gippsland Pathways has an inbuilt service directory of local specialists and other health professionals to support access to local referral information. Gippsland PHN continues to collaborate with local hospitals and community health services in Gippsland to support the development of content published on Gippsland Pathways. We continue to engage with local health services to support pathway development in Gippsland. Data Collection: Gippsland PHN is collecting user traffic data on the new Gippsland Pathways site at a pathway level. Impact: Through the development and review of localised clinical and referral pathways, General Practitioners and other local health professionals have access via the Gippsland Pathways website aims to guide best-practice assessment and management and local referral pathways for aged care. Gippsland Pathways has an inbuilt service directory of local aged care-relevant specialists and other health professionals to support access to local referral information.

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	General Practice, Health services, Clinicians, Allied health providers, Clinical Councils, Social and Community Services
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 all general practices through direct virtual and face -to-face consultation. Pathways updates and information is included in the quarterly visits to general practice in Gippsland. Engagement with Gippsland PHN's Clinical Councils and the Community Advisory Committee ensures clinical leadership and patient-centred approach is considered on all Pathways planning. The Gippsland PHN Community Advisory Committee is the centre of the organisation's community engagement strategy and is a strategic community leadership group who drives community involvement through a range of mechanisms. Gippsland PHN's Clinical Councils comprise of health professional representatives across the region.
Collaboration	Clinical Working Groups participants include General Practitioners, relevant state and local peak bodies, local subject matter experts, representatives from local health services, private practice, medical specialists, allied health and other relevant health professionals. GP Advisors support development of pathways. Collaboration with relevant primary and mental health service providers to address and improve integrated care pathways and the delivery of seamless, effective and efficient care: Clinical working groups are formed to support development of new pathways as required.

Activity Milestone Details/Duration	
Activity Start Date	19/05/2022
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?	Yes
Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?	No
Has this activity previously been co-commissioned or	No

joint-commissioned?	
Decommissioning	No
Decommissioning details?	NA
Co-design or co-commissioning comments	Consultation with local GPs, and other health professionals to contribute to the localisation of locally identified pathways for development

Community Led Integrated Health Care (CLIHC)	
Activity Priorities and Description	
Program Key Priority Area	Population Health
Aim of Activity	The aim of the Program is to respond to specific national health priorities determined by the Australian Government, and to local health priorities identified in the Gippsland PHN Population Health Needs Assessment. Healthcare providers and consumers in Gippsland recognise that the current healthcare system is not adequately addressing all needs for health services in the community. Therefore, a future-focused primary health care system in Gippsland needs to include new models of healthcare to address access barriers and disparities in health outcomes, especially in rural settings. This requires: • Innovation. • Collaboration. • Local solutions that address local need and provide local care. • Integrated services that involve multiple providers. • Virtual care delivery. • Sustainable approaches.
Description of Activity	The current services within this Community Led Integrated Health Care activity include: • Latrobe Community Health Service work in partnership with Berry Street Victoria to deliver an integrated health and welfare service for vulnerable children and families in Latrobe. This model of care works with the child and family in a holistic way by developing an assessment clinic for children from disadvantaged backgrounds. This clinic through care coordination, a multi-disciplinary approach, and transport assistance, addresses some of the social determinants of health that can impact on people's ability to access health services. The service allows children and their families to be seen at one place at one time rather than the need to attend multiple appointments at multiple sites. The service includes a full-time care coordinator and social service navigation role supported by administration resources. There is a plan to increase to include another part time Care Coordinator to assist with increase in demand for service and to support working more closely with local Aboriginal Community Controlled organisation Ramahyuck. • Orbost Regional Health partnering with Deddick Valley Isolated Community Group deliver care coordination services to residents in the remote rural community of Deddick Valley as well as Bendoc, Tubbut and Goongerah. Their service model leverages the multidisciplinary team at Orbost Regional Health service, effectively expanding the service's footprint and allowing existing resources to be connected to remote communities. The Community Care Coordinator: ○ Provides basic nursing services, continuity of care and builds trusting relationships to support referrals, health promotion, preventative and primary care activities; ○ Is as a vital link between primary, tertiary and specialist health care services and navigate cross-border health system referrals; ○ Performs point-of-care testing and monitoring of chronic conditions; Both providers will be offered a contract extension. It is intended, subject to ongoing funding and ongoing review of local health needs and providers' performance to contract deliverables/KPIs, to continue to recontract both providers.

	Gippsland PHN had a number of activities planned in FY2024-25 that ultimately did not proceed due to either market failure in competitive procurement processes and/or a change in strategy: • CF13B - Extending Community Led Integrated Health Care • CF13F - Access to Geriatrician Services • CF13G - Titration Clinic • CF13H – Live Life Get Active Gippsland PHN pooled the funding allocation for the discontinued activities into an open competitive tender in February 2025, seeking applications from one or more providers to establish an additional Community Led Integrated Healthcare service. The successful tenderer from that process was Latrobe Community Health Service. Gippsland PHN contracted Latrobe Community Health Service (LCHS) to establish a new additional CLIHC service. LCHS partnered with Latrobe City Council (Latrobe Leisure) and Victoria YMCA Community Programming PTY LTD - (Gippsland Regional Aquatic Centre) to provide a Hub and Spoke model that will provide greater value for money for service and reach a larger proportion of the Gippsland community. This program works within leisure centres in Latrobe to expand community reach, improve chronic disease management, and enhance early intervention through Care Coordination and allied health services. By providing education and support, the program seeks to prevent the progression of chronic conditions. The primary focus areas include cancer, adults over 65, chronic diseases, and cardiac conditions, with the overarching goal of reducing preventable hospital admissions and promoting proactive health management. As with the initial two Community Led Integrated Health Care programs, this program includes care coordination and a flexible model that incorporate various modes of delivery to support the community needs. By prioritising prevention, this program will contribute to long-term community health improvements, recognising that proactive intervention is more effective than managing chronic conditions once they have developed. The program commenced service delivery in August 2025 and subject to ongoing funding and ongoing review of community needs and providers' performance to contract deliverables/KPIs, PHN will continue to recontract this provider. In FY26-27, Gippsland PHN intend to consolidate the Olivia's Place Program into the Community Led Integrated Healthcare program and cease operating that program as a standalone program from 30 June 2026. Olivia's Place provides a Family Support Program, supporting young families throughout pregnancy, birth and a baby's first 12 months of life to help them form loving caring relationships with their children. Olivia's Place Family Support program offers personal, one-on-one guidance tailored to each family's journey. They provide essential resources, emotional support and parenting education to help parents build their own support networks, fostering resilience and mental wellbeing. Olivia's Place Family Support Program offers service navigation, linkages and referrals such as, to maternal and child health services, financial counselling, birth support, assessments for perinatal depression, domestic violence support services. Olivia's Place support community across Gippsland via face-to-face appointments and telehealth supports. Olivia's Place will work in partnership with another provider (currently under development for the 2026/27 financial year). **Engagement with Local Hospital Networks and/or State government:** Engagement occurs with the Local Health Services Network, the Gippsland Region Public Health Unit, State Department of Health and Department of Health, Disability and Ageing.

	Gippsland PHN has an ongoing communications plan in place to share outcomes, successes and barriers of the programs, via local media, social media platforms, Gippsland PHN webpage. Gippsland PHN engaged Larter Consulting to complete a full review of the program from inception through to December 2024 (supported by and contributed to PRIMM grant). The evaluation report was shared at the end of 2025 to all Gippsland health networks, inclusive of local hospitals/Health Services and State Government as indicated within our approved Human Ethics Application Form. Activities to promote and improve the update of practice accreditation: • All Gippsland PHN commissioned services are required to have, or be working towards, current accreditation. • Staff undertake mandatory training for cultural, diversity competency and safety, this aids them in achieving/maintaining accreditation. • Staff have undertaken IAR training to better support their cohort of clients. **Collection of data** Data is collected monthly from the providers via a spreadsheet which includes both population health, and occasions of service data sets. Qualitative data is collected on a monthly basis as per the Service Order Agreement Key Performance Indicators which requires submission of a monthly Case Study and annually via Qualitative report submitted via Folio. Key Performance Indicators (KPIs) are outcomes-based across the five outcome themes in the Gippsland PHN Performance and Quality Framework: Addressing Needs, Quality Care, Improving Access, Coordinated Care, and Capable Organisations. KPIs are assessed quarterly through a rigorous contract review process and Program/Provider level outcome dashboards. To ensure Value for Money assessment is conducted at all stages of the commissioning cycle, Gippsland PHN is restructuring contract KPIs and mapping them against the Quintuple Aim across all commissioning activities. Contract KPIs are being restructured to reflect each of the five elements of the Quintuple Aim and from 1 July 2026 all Clinical Service Order Agreements will have contract KPIs against each of the five elements of the Quintuple Aim. **Impact:** The program's main outcome is improved health equity by providing guided care coordination that helps community members access primary health services in Gippsland, through both face-to-face and telehealth services, in response to needs identified during stakeholder engagement. The challenges of rural and remote care have increased confidence among providers and community members to improve access to general practice and multidisciplinary services, including digital solutions, through expanded telehealth. The provision of care coordination and continuity of care aimed at patients with complex issues at risk of hospital admission supports better outcomes. Providing consumers supported access to other health and community support services makes them feel confident and in control of their own or their family's health. With Care Coordination it is often possible to see several healthcare team members in the same place at the same time, improves experience of care an cost effectiveness, for both consumers and providers.
Needs Assessment Priorities	
Needs Assessment	Gippsland-NA-2025/26-2027/28-V1 (updated)

Priority – *refer to **DOC/25/1618**: Health Needs Assessment 2025-28 Opportunities and Priorities for guidance when selecting the correct priority*	Page reference
Mental Health and Wellbeing, including Suicide Prevention Aboriginal and/or Torres Strait Islander health and wellbeing Healthy ageing (65+) Alcohol and other drugs Mental health and wellbeing, including suicide prevention Health workforce Connected care Growing up healthy (0-25 years) Chronic conditions Family violence Access to primary care for marginalised communities	

Activity Demographics	
Target Population Cohort	Rural and Remote Communities Chronic conditions Growing up Healthy (0-25 years)
In Scope AOD Treatment Type	No
Indigenous Specific	No
Indigenous Specific Comments (if answered yes to above)	-
Coverage Whole Region?	No

SA3 Name	**SA3 Code**
Latrobe East Gippsland	

Activity Consultation and Collaboration	
Consultation	The Gippsland PHN Community Advisory Committee is the centre of the organisation's community engagement strategy and is a strategic community leadership group who drives community involvement through a range of mechanisms. 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. Gippsland PHN utilises these key governance mechanisms as the first point for consultation regarding service development and implementation.
Collaboration	Gippsland PHN have developed a monthly Community of Practice (CoP) meeting with representatives from Gippsland PHN, Contracted Service providers and their partners and nominated community representatives from the communities being serviced. The purpose of the meeting is for collaboration across Gippsland PHN teams, Community Led Integrated Health Care commissioned service providers, provider partners and community representatives to assist with crossover, co-design and evaluation of the program. The CoP meetings have additionally been utilised to develop the new program specific guidelines. Attendees move in and out of CoP as required according to Terms of Reference. Commissioned service providers and relevant Gippsland PHN teams (determined by

	the stage of the program/project) work together to keep the program/project on track and develop a strong collaborative approach to ensure program/project success. Engagement occurs with the Local Health Services Network, the Gippsland Region Public Health Unit, State Department of Health and Department of Health, Disability and Ageing. Gippsland PHN utilises Gippsland Pathways to help support integrated care pathways with all commissioned services having an active profile on the site. Gippsland PHN encourages partnerships between organisations to increase cross referrals of clients across services based on clinical need and waiting list availability. Gippsland PHN also supports program promotion via our communications channels and quarterly meetings with commissioned service providers and General Practices.
Activity Milestone Details/Duration	
Activity Start Date	01/07/2023
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
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	Two tender co-design workshops were held, one with health sector professionals and one with community members. The co-design workshops aimed to consolidate the priorities identified during the stakeholder consultation phase, determine a workable model and develop Request for Tender specifications. The co-design workshops also recommended the program name be updated to “Community Led Integrated Health Care (CLIHC)

Olivia's Place	
Activity Priorities and Description	
Program Key Priority Area	Population Health
Aim of Activity	The aim of the Core Flexible Program is to respond to specific national health priorities determined by the Australian Government, and to local health priorities identified in the Gippsland PHN Population Health Needs Assessment. Healthcare providers and consumers in Gippsland recognise that the current healthcare system is not adequately addressing all needs for health services in the community. Therefore, a future-focused primary health care system in Gippsland needs to include new models of healthcare to address access barriers and disparities in health outcomes, especially in rural settings. This requires: • Innovation. • Collaboration. • Local solutions that address local need and provide local care. • Integrated services that involve multiple providers. • Virtual care delivery. • Sustainable approaches. The aim of Olivia's Place service is a client-led approach to holistically support young families, through pregnancy, birth and a baby's first 12 months of life to help them form loving caring relationships with their children.
Description of Activity	Olivia's Place provides a Family Support Program, supporting young families throughout pregnancy, birth and a baby's first 12 months of life to help them form loving caring relationships with their children. Olivia's Place Family Support program offers personal, one-on-one guidance tailored to each family's journey. They provide essential resources, emotional support and parenting education to help parents build their own support networks, fostering resilience and mental wellbeing. Olivia's Place Family Support Program offers service navigation, linkages and referrals such as, to maternal and child health services, financial counselling, birth support, assessments for perinatal depression, domestic violence support services. Olivia's Place support community across Gippsland via face-to-face appointments and telehealth supports. Gippsland PHN extended these services into 2025/26 executing a deed of variation to the existing provider. This activity will cease as a stand-alone program at 30 June 2026 and will transition in FY26-27 into Gippsland PHNs Community-Led Integrated Healthcare Program. **Engagement with Local Hospital Networks and/or State government:** Olivia's Place engages with West Gippsland Hospital Maternity ward, maternal health centres and mother/baby units. Additionally, they have engagement and referral networks in place with state funded programs Orange Door, LCHS and Koori Maternity Service. **Activities to promote and improve the update of practice accreditation:** • All Gippsland PHN commissioned services are required to have, or be working towards, current accreditation. • Staff undertake mandatory training for cultural, diversity competency and safety, this aids them in achieving/maintaining accreditation. • Staff have undertaken IAR training to better support their cohort of clients. **Collection of data**

	Data is collected monthly from the provider via Fixus for both the submission and review of data; which includes both population health and occasions of service data sets. Qualitative data is collected on a quarterly basis as per the Service Order Agreement Key Performance Indicators and an annual qualitative report submitted to Gippsland PHN via Folio. Key Performance Indicators (KPIs) are outcomes-based across the five outcome themes in the Gippsland PHN Performance and Quality Framework: Addressing Needs, Quality Care, Improving Access, Coordinated Care, and Capable Organisations. KPIs are assessed quarterly through a rigorous contract review process and Program/Provider level outcome dashboards. **Impact:** The Family Support Service with the inclusion of the mothers group gives attendees the opportunity to connect and feel safe to share their journey and help each other with goal setting. This group also provides families on the waitlist another option for supports prior to receiving 1 on 1 supports. Referrals are predominately from the Latrobe LGA but the service provides supports across Gippsland via telehealth. There has also been a noted increase in referrals from case workers. Olivia's Place has delivered: • FY2022-2023: 974 occasions of service • FY2023-2024: 1035 occasions of service • FY2024-2025: 958 occasions of service • FY2025-2026: 710 occasions of service (Year to Date as at January 2026)
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
Mental health and wellbeing, including suicide prevention Health workforce Growing up healthy (0-25 years) Family violence Access to primary care for marginalised communities	
Activity Demographics	
Target Population Cohort	Parents, Caregivers and children across Gippsland
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	The Gippsland PHN Community Advisory Committee is the centre of the organisation's community engagement strategy and is a strategic community leadership group who drives community involvement through a range of mechanisms. Gippsland PHN's Clinical Councils comprise health professional representatives of the sub-region they cover – enabling each group to recommend and advice on issues that are specific to their sub-region across many disciplines. Gippsland PHN also have an Executive Team member as a non-voting member on

	each council which assists with direct communication to the organisation, as well as the Board through its Board member sponsor. Gippsland PHN utilises these key governance mechanisms as the first point for consultation regarding service development and implementation.
Collaboration	Gippsland PHN utilises Gippsland Pathways to help support integrated care pathways with all commissioned services having an active profile on the site. Gippsland PHN encourages partnerships between organisations to increase cross referrals of clients across services based on clinical need and waiting list availability. Gippsland PHN also supports program promotion via our communications channels and quarterly meetings with commissioned service providers and General Practices. All services report collaborations with their consumers and carers to co-design health and wellbeing care plans and other Gippsland PHN commissioned service providers and other organisations within Gippsland, including: • Connect Well East Gippsland and Wellington partnership (collaboration of community and health organisations who deliver Orange Door); • Youth Support Advocacy Service (YSAS); • Australian Community Support Organisation (ACSO); • Wellways • Department of Justice and Corrections • Victoria Police • Ambulance Victoria • General Practice Clinics • Community Services • Local Hospital Services • LifeLine • Mental Health Wellbeing Network facilitated by the East Gippsland Primary Care Partnership • East Gippsland Youth Focus Network • Noah's Ark • Quantum Support • Save the Children • Schools, to complement existing resources within school environment, support parents and families, enable teachers and staff to access for advice and support • headspace Gippsland for any Youth referrals that may be appropriate, promoting the services in this activity aimed at children and collaborating with the local student support service teams • Aboriginal Controlled Community Organisations • Victorian Mental Health and Wellbeing Hubs located in Bass Coast (Cowes), / South Gippsland (Wonthaggi) for cross referrals • Local Health Services Network, the Gippsland Region Public Health Unit, State Department of Health and Department of Health, Disability and Ageing
Activity Milestone Details/Duration	
Activity Start Date	01/07/2023
Activity End Date	30/06/2026
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?	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	Yes
Decommissioning details?	The activity will cease as a stand-alone program; however the contract and service will continue within Gippsland PHN Community Led Integrated Healthcare program).
Co-design or co-commissioning comments	

Short-term Intervention Program (STIP)	
Activity Priorities and Description	
Program Key Priority Area	Alcohol and Other Drugs
Aim of Activity	This activity aims to increase the direct treatment service delivery of the drug and alcohol treatment sector through improved regional coordination and the commissioning of drug and alcohol treatment services in line with local need. It also aims to improve the effectiveness of drug and alcohol treatment services for people requiring support and treatment by increasing coordination between various sector members and improving sector efficiency.
Description of Activity	The Short Term Intervention Program supports vulnerable and isolated persons seeking AOD treatment and/ or who are experiencing barriers to AOD treatment or service access via a program that supports continued treatment across the sector. Services are tailored to each person's ongoing needs via a range of brief and short term supports including care coordination, brief intervention, relapse prevention, counselling, harm minimisation, education and referral to other services. This service relies on partnerships with State funded AOD services, community and health service providers. Gippsland PHN were originally able to commission Short Term Intervention Program (STIP) via unspent funds arising from contracts that were mildly underperforming within the AOD schedule in both NIAS and Mainstream funding streams. In 2023/24 these services were performing at 100 per cent meaning there were no unspent funds to dedicate to STIP. There is a recognised high need for the current long term AOD services delivered under the AOD schedule. STIP has been successful in providing much needed service to the vulnerable community while waiting for long term appointments. Case studies have demonstrated the beneficial impact to client outcomes by having the STIP service to engage with, in the interim. Core/Flex has allowed us to commission services that meet priority based needs in Gippsland, and STIP meets the needs of patients waiting for AOD services in Gippsland. STIP program has continued to be run through this Core Flex funding stream. In FY25-26 Gippsland PHN decided to withdraw a tender within the PMHC and AOD funding schedules while the outcome of the DHDA review of those programs and resulting changes and updates to commissioning strategy were adjusted. To ensure continuity of care and stability for consumers across Gippsland, Gippsland PHN intend to continue funding the STIP program and have offered an extension via a Deed of Variation to the current service provider, Australian Community Support Organisation (ACSO). **Engagement with Local Hospital Networks (LHN) and/or State government:** State based services are benefiting from STIP, as they are experiencing increased engagement and attendance from people who have been supported by the STIP program. STIP also provides support to people who are on waitlists for State based services. Engagement also occurs with the Local Health Services Network, State Department of Health and Department of Health, Disability and Ageing. **Collection of data**: Data is collected monthly from the provider which includes both population health and episode of care data sets. Key Performance Indicators (KPIs) are outcomes-based across the five outcome themes in the Gippsland PHN Performance and Quality Framework, currently: Addressing Needs, Quality Care, Improving Access, Coordinated Care, and Capable Organisations. To ensure Value for Money

	assessment is conducted at all stages of the commissioning cycle, Gippsland PHN is restructuring contract KPIs and mapping them against the Quintuple Aim across all commissioning activities. Contract KPIs being restructured to reflect each of the five elements of the Quintuple Aim and from 1 July 2026 all Clinical Service Order Agreements will have contract KPIs against each of the five elements of the Quintuple Aim. KPIs are assessed quarterly through a rigorous contract review process and Program/Provider level outcome dashboards. **Impact**: The Short Term Intervention Program (STIP) supports high risk clients who are at risk of disengagement while they await a place within state funded acute services. The program provides brief interventions, short term counselling sessions and care coordination to mitigate the risk of further harm while the consumer is on a waitlist with acute services. Case studies provided by the contracted service providers as part of contract reporting requirements provide evidence of the impact of the programs on the individual, their families and communities. Some outcomes shared within these case studies include clients reducing and/or discontinuing substance use, higher engagement with services, stronger connections with family and returning to work and/or studies. Gippsland PHN commissioned service provider has delivered in the STIP program: • FY2022-2023: 1,465 occasions of service/brief interventions • FY2023-2024: 1,351 occasions of service/brief interventions • FY2024-2025: 1,521 occasions of service/brief interventions • FY2025-2026: Complete YTD data is currently not available due to a change in the provider's client management system (submission of the providers MDS data has been delayed)

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
Aboriginal and/or Torres Strait Islander health and wellbeing Alcohol and other drugs Mental health and wellbeing, including suicide prevention Health workforce Growing up healthy (0-25 years)		
Activity Demographics		
Target Population Cohort	People misusing substances, including youth and Aboriginal and/or Torres Strait Islander people and their families and carers	
In Scope AOD Treatment Type	Yes	
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	Commissioned service providers work collaboratively within the AOD sector to foster robust working relationships, which in turn strengthen community and client outcomes. Community Advisory Committee at Latrobe Regional Health on an occasional basis. This strengthens the input gathered from our local community and provides access to greater diversity of perspectives. Commissioned service providers engage actively in broad community consultation and provide client focused reviews of treatments, services and programs delivered. These consultations take place on a regular basis and inform programs to be delivered to the community.
Collaboration	The Gippsland Alcohol and Drug Service Providers Alliance (GADSPA) is convened by the Victorian Department of Health as a regional partnership, working in collaboration to improve access to the AOD service system. This is a key external network used as a consultation and collaboration mechanism by Gippsland PHN. The GADSPA membership consists of representatives from the following key stakeholder groups: • Department of Health; • All Gippsland AOD service providers; • Catchment Based Planner; • Local Health Service Networks; • Aboriginal Community Controlled Health Organisations; • Community/consumer/carer representation; and • Peak bodies. • Gippsland Mental Health Alliance The GADSPA continue to have strong connections that include presentations, learnings and collaborative planning for gaps within the AOD sector. This includes successes of programs, barriers, collaboration and opportunities for consultation. Information is shared regarding such things as developments in Pharmacotherapy, updated Acts and service delivery guidelines, and Workforce Development and planning. They are connected to consumer groups, providing further information about service gaps and consumer and carer needs. Gippsland PHN is a member of the Latrobe Local Drug Action Team and collaborates with members to provide preventions services, education and information to young people from ages 16-25 with the aim to minimise the harm caused by alcohol and other drugs in the Latrobe local government area. In addition to GADSPA, Gippsland PHN actively seek additional collaboration from the Aboriginal Community Controlled Health Organisations, Local Hospital Networks and General Practice with relation to the Increased Service Delivery activity.
Activity Milestone Details/Duration	
Activity Start Date	01/07/2023
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?	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	No

Remote Patient Monitoring	
Activity Priorities and Description	
Program Key Priority Area	Digital Health
Aim of Activity	The remote patient monitoring project aims to improve the health status and outcomes for people who have complex needs and multiple chronic diseases that would benefit from additional support for early intervention of any deterioration in their chronic disease. The project is delivered through a remote monitoring software platform – Care at Home using Lifeguard, with the aim of supporting chronic disease early intervention, the detection of deteriorating patients and the avoidance of unplanned hospitalisations.
Description of Activity	Activities associated with implementing this project include: • Commission new and existing general practices as part of the Gippsland remote care coordination using Lifeguard program. Practices implement a chronic disease remote patient monitoring model of care through funded practice nurse care coordination activities that supports recruitment and care coordination of patients with chronic disease using the Lifeguard mobile application. • Development and implementation of a model of care inclusive of patient monitoring, clinical care and coordination and self-management principles • Development of monitoring templates inclusive of patient reported outcome measures, vital signs and clinical thresholds, expanding into risk-based monitoring. • Provision of education and training to health services. Gippsland PHN will continue to work with general practices and other health services to deliver remote patient monitoring in Gippsland for patients with chronic health conditions in 2026/27. This includes identifying opportunities for further integration in healthcare delivery when supporting patient care in the home, exploring preventative care through the remote monitoring of patients to promote healthy behaviours and minimise likely progression of chronic disease. Gippsland PHN's Quality Improvement strategy is centred on the Model For Improvement and Quintuple Aim methodologies. Gippsland PHN continues to engage in co-design with all stakeholders for the development of digitally enabled models of care to develop successful use cases to model change management. This activity is an example of this approach. Throughout the activity, Gippsland PHN facilitates community of practice sessions with participating practices to enable access and reduce barriers to sustainable implementation. The outcome of this activity will be the development of a Quality Improvement Toolkit to act as a resource for future uptake throughout Gippsland. **Engagement with Local Hospital Networks (LHN) and/or State government:** Gippsland PHN will advocate for the increase usage of the Australian Digital Health Agencies initiatives (telehealth, Provider Connect Australia, Healthdirect, My Health Record, and the My Health app) as tools for chronic disease management and prevention. In 2025/26 Gippsland PHN collaborated with Monash University and General Practices in Gippsland to implement a remote patient monitoring proof of concept activity to have general practices remotely monitor post-stroke survivors. This supported the monitoring and support offered to community-based stroke consumers who have been discharged from hospital and are beyond the post-acute

	care phase to monitor for post-stroke needs that required medical intervention in a timely manner. Gippsland PHN continues to engage with local health services to support the update and maintenance of our Remote Patient Monitoring templates. Recruitment of Clinical Advisors has occurred during 2025/2026 to further expand the capacity of the program. During 25/26, the Remote Patient Monitoring Program was independently evaluated by the University of Melbourne Centre for Digital Transformation of Health. Based on the evaluation it was determined that the Remote Patient Monitoring has benefits for the community, but the current delivery needs to be reviewed. The program will continue in 26/27 but the delivery method will be reviewed and modified to increase effectiveness. **Collection of data:** The remote patient monitoring program collects performance data that includes number of general practices, general practitioners, general practice staff (care coordination and triage staff) and a large array of patient reported outcomes measures. These self-reported patient outcomes measures (PROMS) are input into the mobile app on a daily or weekly cycle relevant to their specific chronic disease (e.g. diabetes, depression, hypertension and more). When a PROM exceeds a pre-determined threshold, a clinical alert is provided to the general practice which indicates a need for intervention and management review for the specific patient. Data collected includes numbers of PROMs, alerts generated (by patient and condition), alerts viewed by general practice to support early intervention. **Impact:** This activity can assist those in the Gippsland area who may be isolated from face-to-face care due to distance and/or accessibility of health services. This includes people who are unable to travel due to lack of access to fuel due to either shortages or cost of fuel. Enabling improved access to comprehensive clinical decision making and care coordination within or close to a person's home will assist with reducing the geographical and social barriers to accessing services. Increase in access to general practitioners and other healthcare professionals including mental health in rural and remote areas using remote patient monitoring infrastructure. Increased connection between patient, carer and their healthcare provider using virtual care models such as telehealth and remote patient monitoring. Active monitoring of patients has the capability to prevent deterioration through early identification enabling community-based management. Enabling improved access to comprehensive clinical decision making and care coordination within or close to a person's home will continue to assist with reducing the geographical and social barriers to accessing services.
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 Chronic conditions Access to primary care for marginalised communities	

Activity Demographics		
Target Population Cohort	People living with chronic disease Rural and remote communities	
In Scope AOD Treatment Type	No	
Indigenous Specific	No	
Indigenous Specific Comments (if answered yes to above)	N/A	
Coverage Whole Region?	Yes	
SA3 Name		**SA3 Code**
Gippsland wide		
Activity Consultation and Collaboration		
Consultation	Gippsland PHN consults widely with State government departments, local health networks, Ambulance Victoria, Colleges of General Practitioners, Nurses Board, General Practitioners and other health professionals, Gippsland Advisory Council and with community for valuable feedback.	
Collaboration	Local Health Networks, health services, Health Professionals, Gippsland PHN Advisory Groups.	
Activity Milestone Details/Duration		
Activity Start Date	01/07/2023	
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?	No	
Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?	Yes	
Has this activity previously been co-commissioned or joint-commissioned?	No	
Decommissioning	No	
Decommissioning details?	N/A	
Co-design or co-commissioning comments	A collaborative and co-designed approach brings together health professionals, local expertise and subject matter experts to support the development of projects. Gippsland PHN facilitates community of practice session to with participating practices to learn enable and barriers to sustainable implementation in the development of models of care.	

Health Systems	
Activity Priorities and Description	
Program Key Priority Area	Population Health
Aim of Activity	The Health Systems activity supports monitoring and evaluation standards and capabilities that ensure Commissioned Services are effective and efficient and meet the needs of the community.
Description of Activity	**GP Data Extraction Tool (POLAR)** POLAR is a cloud based clinical general practice data intelligence platform. It stores a range of health data and provides platform interfaces (for both Gippsland PHN staff and general practices) to access dashboards and to analyse data to support general practice quality improvement activities, that improve health outcomes, at a practice and population health level. Gippsland PHN will continue to support healthcare providers to establish workflows, identify target populations and deliver integrated service responses targeting at-risk and priority areas including but not limited to eye health, heart failure, chronic disease and palliative and end-of life care. **Primary Health Insights** Primary Health Insights (PHI) is a secure national storage and analytics platform that hosts de-identified general practice and other primary health data. Gippsland PHN completed the onboarding process during 2023/24 and 2024/25. Gippsland PHN are actively using this system as its primary data storage and reporting platform. Gippsland PHN are using PHI to automate and streamline reporting for commissioned service providers and data-rich insights to support service performance monitoring. **FIXUS** FIXUS Client Information Management Software (CIMS) enables the collection and reporting of Primary Mental Health Care Minimum Data Set (PMHC MDS) to the Commonwealth Department of Health, Disability and Ageing for Commissioned Services from the Primary Mental Health Care Program. This software is purchased by Gippsland PHN under license agreement and used by Commissioned Services providers to collect and maintain their data. FIXUS Technologies Pty Ltd own the license that is purchased for use annually by Gippsland PHN. FIXUS is web-based and hosted in the cloud in Australia. The ISO 27001 standard verifies that the FIXUS Information Security Management System is officially audited, implemented according to best practices and that FIXUS Technologies has clear and defined procedures for managing security-related risks. **Cyber Security** Gippsland PHN commission Cyber Security services to ensure our systems, devices, networks and data programs are protected from cyber-attacks and has implemented Essential Eight controls that meet maturity level 1 or above. Gippsland PHN was accredited for ISO27001 certification and will maintain accreditation with annual audits. **Engagement with Local Hospital Networks and/or State government**: Where relevant engagement occurs with LHNs and State government. For example, data collected and used to support the development of the annual Gippsland PHN Health

	Needs Assessment supports engagement and partnership with Local Hospital Networks and/or State Government. **Activities to promote and improve the update of practice accreditation**: Supporting healthcare providers to extract, interpret and use GP Data Extraction Tool, PHI and FIXUS data can inform the quality improvement activities in the delivery of healthcare required for Practice Accreditation. **Impact**: The GP Data extraction tool allows demonstration of general practice performance against National Practice Incentive Payment Quality Improvement Measures (PIP-QIMs) at a regional level. This allows PHN benchmarking at a regional level against the National PHN performance indicators and enables targeted and localised practice support of general practices to facilitate quality improvement activity opportunities. Benchmarking further allows identification of areas where regional performance is below the national average that can be prioritised with training and events activities delivered by Gippsland PHN. The benefit of using FIXUS is it ensures mandatory data elements are collected. FIXUS enables the extract of a validated MDS file for upload to PMHC MDS. Cyber Security allows Gippsland PHN to prevent, detect and respond to cyber security threats including attacks on the data held within the Health Systems discussed above.
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
Access to Primary Care for Marginalised Communities Chronic Care Health Workforce	

Activity Demographics	
Target Population Cohort	General Practice, Healthcare services, Clinicians, Allied health providers, Clinical Councils, Social and Community Services
In Scope AOD Treatment Type	No
Indigenous Specific	No
Indigenous Specific Comments (if answered yes to above)	N/A
Coverage Whole Region?	Yes

SA3 Name	**SA3 Code**
Gippsland wide	

Activity Consultation and Collaboration	
Consultation	Gippsland PHN provides implementation, set-up, training and ongoing support for general practice and health services on Health Systems. We work closely with general practices, commissioned health services, other health services, RACHs and software vendors to enable efficient and effective administration and operation of the systems including efficient and quality data collection.

	Gippsland PHN regularly requests feedback from users about the systems. We work closely with commissioned services and the FIXUS Technologies team to enable efficient and quality data collection.
Collaboration	Health Systems enable us to work alongside other PHNs, Australian Institute of Health and Welfare and other stakeholders to draw insights from multiple data sets, informing health needs assessments, commissioning activity, insights and reporting to our funders.
Activity Milestone Details/Duration	
Activity Start Date	01/07/2023
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?	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?	N/A
Co-design or co-commissioning comments	Ongoing codesign occurs with vendors of health systems to ensure the products are fit for purpose and developed to meet regulatory needs.

Population Health and Commissioning Design

Activity Priorities and Description	
Program Key Priority Area	Population Health
Aim of Activity	Population Health and Commissioning Design program is a collaborative concept developed by Gippsland PHN as a dedicated resource demonstrating competency in health planning (including stakeholder and community communication and engagement), service mapping, research, evaluation, data analysis, data governance, monitoring and reporting. The aim of the program is to operate across the entire Gippsland PHN catchment, to provide a systematic and evidence-based approach to identifying the need for primary healthcare services, identifying funding, embedding an integrated service model and supporting health services including general practices. Population Health and Commissioning Design program contributes to core functions of Gippsland PHN where data is gathered to determine unique priorities for the region such as: • system integration where work is undertaken with health services and professionals to create efficiencies and connectedness in the local health system, • place based responses for service system innovation and development, • general practice and other support services, • addressing needs of vulnerable communities and population groups. As a health planner and commissioner, Gippsland PHN, supports the development of markets so that they are sustainable, and provide scalable solutions that leverage local workforces.
Description of Activity	This activity is resourced by applying a skills-based approach of population health planning, commissioning, project management, service modelling, data analysis, data governance, business intelligence reporting, research, evaluation and monitoring. Gippsland PHN staff, including those supporting general practices, form part of the program. The program consists of staff that can undertake: • Local and regional health planning. • Research into best practice and innovative service models for a location and/or region. • Population health data analysis. • Monitoring and reporting of data to describe outcomes. • Research and evaluation of programs. Commissioning of primary health services is supported by Population Health Planning. Gippsland PHN has completed the migration from a secure local server analytics environment based on Microsoft architecture to the PHI Azure cloud environment. Please see CF12 for further information about this software. Key data sets include de-identified general practice data extracted using data extraction tool, the Primary Mental Health Care Minimum Data Set (PMHC MDS) and Victorian Department of Health datasets (including admitted and emergency department activity). Public data sets are accessed via the Australian Bureau of Statistics (ABS), the Australian Institute of Health and Welfare (AIHW), the Public Health Information Development Unit (PHIDU) and other agencies. Access to data extracts, reports and assessments are facilitated for Gippsland PHN stakeholders as appropriate.

	Engagement with Local Hospital Networks (LHN) and/or State government: Gippsland PHN will continue to work with a range of regional stakeholders such as local governments, Victorian Government Departments, Gippsland Public Health Unit, health services, universities and others in health planning roles. The purpose will be to ensure best use of limited planning resources, and a shared and integrated approach to health planning activities in the region. Gippsland PHN will continue to implement its strategy around ongoing community, consumer and carer involvement into population health planning. This will include involvement by the Community Advisory Committee and regional collaboration to collect consumer and community information that will help inform stakeholders across the region. Direct community engagement with marginalised communities and people with lived experience, including as family and carers, is seen as a critical component to inform planning and commissioning. **Collaboration with relevant primary and mental health service providers to address and improve integrated care pathways and the delivery of seamless, effective and efficient care:** Addressed above **Activities to promote and improve the update of practice accreditation:** All Gippsland PHN commissioned services are required to have, or be working towards, current accreditation. **Data Collection:** During 2026-27, a community engagement project is planned with the aim of Gippsland PHN and partners having an improved understanding of the health needs among people in Gippsland, including the healthcare journeys of those at risk of the poorest health outcomes. Findings will inform the 2027 Health Needs Assessment update. **Impact:** Gippsland PHN will continue to implement its strategy supporting on-going professional stakeholder input into population health planning. This includes input from Clinical Councils, regional clinical networks, and local service providers to ensure multidisciplinary input from stakeholders across the region. Gippsland PHN staff work with the service system to implement commissioning activities. This will result in measurable improvements across a range of domains including service outputs, care coordination, model/design, location, service integration, improved clinical outcomes, and increased reach to the most disadvantaged and vulnerable populations in the catchment.
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
Aboriginal and/or Torres Strait Islander Health and Wellbeing, page 54 Healthy Ageing (People Aged 65+), page 84 Alcohol and Other Drugs, page 99 Mental Health and Wellbeing, Including Suicide Prevention, page 115 Health Workforce, page 155 Connected Care, page 183 Growing Up Healthy (0-25 years), page 197 Chronic Conditions, page 219 Family Violence, page 239	

Access to Primary Healthcare for Marginalised Communities, page 247		
Activity Demographics		
Target Population Cohort	Whole of Gippsland PHN	
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	Ongoing consultation occurs with key stakeholders such as community, clinicians, health services, community services and partner organisations. Where possible, co-design methods are used to develop service models; consultation occurs according to Gippsland PHN's Community and Stakeholder Engagement and Communication Governance Framework, and the Community Engagement Strategy. Gippsland PHN Advisory Groups provide support to consultation activities.	
Collaboration	The Gippsland Population Health and Commissioning program continues collaboration with a diverse range of stakeholders: Victorian State Department of Health and Department of Families, Fairness, Housing: The State Government plays a critical role in primary health provision in Gippsland through its hospital and community network. Victorian, Adelaide and Tasmanian PHN Alliance: support collaborative data exploration and analysis on state dataset. Local Health Networks and other health services and organisations: Gippsland PHN has established a strong working relationship with Gippsland Local Health Service Network, through regular engagement, collaboration on improving modes of care, and a co-commissioned project to develop a new mode of care. Gippsland PHN also liaises with Latrobe Regional Health through a number of networks for mental health. Gippsland PHN Advisory Groups: Provide advocacy and expertise to Gippsland PHN representing a broad range of Health Services, clinicians, community and consumers. General Practitioners: • GPs remain the cornerstone of primary health care in Gippsland and their involvement in planning is critically important to hear their views about primary health services capacity outside the hospital system • Support the use of the GP Data Extraction Tool supporting improvements in efficiency and effectiveness of medical services. Consumers, carers and community: Provide unique insight into barriers and challenges of accessing health services in Gippsland.	
Activity Milestone Details/Duration		

Activity Start Date	01/01/2015
Activity End Date	30/06/2027
Other Relevant Milestones	-
Activity Commissioning (intended procurement approach for commissioning services under this activity)	
Procurement Approach	Direct engagement. Community engagement with marginalised communities and people with lived experience is undertaken to inform planning and commissioning. Professional stakeholders are also invited to be involved in health planning and commissioning activities, including priority setting.
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?	NA
Co-design or co-commissioning comments	Where possible, co-design methods are used to develop service models

Digital Data and Insights	
Activity Priorities and Description	
Program Key Priority Area	Population Health
Aim of Activity	The Digital, Data and Insights team at Gippsland PHN aims to support: • Healthcare providers with data analysis that improves data insights, business intelligence and clinical outcomes for consumers. • Quality improvement activities that improve responsiveness, access and integrated care to individuals, families and carers. • Strengthen adoption and use of digital health within the healthcare sector. • Develop new, patient and caregiver-centred virtual models of care that drive engagement, accessibility, quality, safety, efficiency and sustainability across health system domains. • Improve workforce capability and confidence in the delivery of digital health as part of health care delivery. • Empower primary care health organisations and health providers to encourage and lead individuals, families and carers to access virtual models of care that meet their healthcare needs. • Improve health provider and health service knowledge of clinical and local referral pathways through Gippsland Pathways.
Description of Activity	Gippsland PHN will enhance system capability through the delivery of targeted digital health initiatives, leveraging data-driven insights to support early intervention, improved coordination of care and more efficient models of service delivery to help drive a contemporary, quality health system that is outcomes-focused and values-based. Gippsland PHN will measure digital health maturity across Gippsland Primary Health providers and develop appropriate resources to ensure general practices are able to support digital health solutions while having appropriate cyber security knowledge and systems in place. Gippsland PHN work collaboratively with healthcare providers in Gippsland to develop models of care utilising video telehealth, to support the uptake of video telehealth throughout Gippsland by providing promotion, support and training and registration with Healthdirect Video Call platform (currently funded to 30 June 2026). Further, telehealth support and training made available to RACH and primary care providers who support the care of residents. Gippsland PHN will continue to support healthcare providers to establish workflows, identify target populations and deliver integrated service responses targeting at-risk and priority areas. This will occur via the use of data to inform quality improvement activities in the delivery of healthcare by supporting healthcare providers to extract, interpret and use extracted GP Data. Gippsland PHN will deliver Australian Digital Health Agency (ADHA) initiatives that improve meaningful use of My Health Record, National Health Services Directory and Provider Connect Australia to support improved coordination of care and drive consumer led health through community uptake of the 1800Medicare App and awareness of service. Gippsland PHN will deliver training, support and awareness activities annually. **Engagement with Local Hospital Networks and Commissioned Services Providers:** The Digital, Data & Insights (DDI) team at Gippsland PHN regularly engage with the Gippsland Local Health Services Network which comprises representation of all

	hospitals and acute care centres in Gippsland to identify opportunities to strengthen integrated, virtual care to outpatient and specialist services, this engagement supports the update of local referral pathways. The DDI team engage with multiple health providers involved in the Remote Patient Monitoring Program to support and drive better health outcomes. Gippsland PHN provides direct engagement and in-service support to pharmacies, general practices, allied health, specialist practices and hospitals for research, Connected Care and Pathways. Activities to promote and improve the update of practice accreditation: Gippsland PHN support general practices through a range of activities including quarterly general practice reports to inform quality improvement activities to optimise care delivery for their patient cohorts. These activities align with the Model For Improvement and Quintuple Aim to embed sustainable change in care delivery. Continual training in the use of the data extraction tool to support quality improvement activities is undertaken regularly for the uptake of data driven care. Collection of data includes utilising a multitude of data collection platforms such as a GP data extraction tool, remote patient monitoring applications, surveys designed to capture digital maturity, discussion points and feedback forms. **Impact:** Increased access to general practitioners and other healthcare professionals including mental health in rural and remote areas through the delivery of telehealth applications. Increased connection between patient, carer and their healthcare provider using virtual care models such as telehealth and remote patient monitoring. Improved digital health literacy to support general practices moving forward to deliver digitally enabled models of care. Improved communication and integration between providers through secure messaging.
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
Mental Health and Wellbeing, including Suicide Prevention Connected Care Workforce	
Activity Demographics	
Target Population Cohort	General Practice, Health services, Clinicians, Allied health providers, Clinical Councils, Social and Community Services, RACH
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 all general practices in Gippsland communities through direct face -to-face consultation, digital health and Pathways is included in the quarterly practice support visits. Engagement with Gippsland PHN's Clinical Councils and the Community Advisory Committee ensures clinical leadership and patient centred approach is considered on all digital health and system integration planning. Consultation occurs with key stakeholders from across Gippsland and Victoria, for example via the Victorian Agency Digital Health Forum and VATPHNA Pathways forums. The Gippsland PHN Digital Health Strategy continues to be delivered and updated to ensure outcomes and emerging needs are met.
Collaboration	Gippsland PHN collaborates with a diverse range of stakeholders for this activity including: Victorian State Department of Health: The State Government plays a critical role in primary health provision in Gippsland through its hospital and community network supported by their policy document - Rural and Regional Health System Design, Service and Infrastructure Plan Local Health Networks and other health services and organisations: Facilitate coordination of care to ensure patients receive the right care, in the right place, at the right time, in a timely and efficient manner. Gippsland PHN Advisory Groups: Provide advocacy and expertise to Gippsland PHN representing a broad range of Health Services, clinicians and consumers. General Practitioners: - GPs remain the cornerstone of primary health care in Gippsland and their involvement in planning is critically important to hear their views about primary health services capacity outside the hospital system - Support the use of the GP Data Extraction Tool supporting improvements in efficiency and effectiveness of medical services. Consumers: Consumers provide unique insight into barriers and challenges of accessing health services in Gippsland. Gippsland PHN team collaborates with the Gippsland Health Alliance to strengthen use of My Health Record, and electronic referral pathways to support improve access to patient records, timely and secure referrals, and communication across the acute, sub-acute and primary healthcare sectors. Gippsland PHN works collaboratively with the Victorian Tasmanian Primary Health Network Alliance on digital health, Australian Digital Health Agency Initiatives, Aged Care Telehealth and After-hours programs. Gippsland PHN also collaborates with several Victorian PHNs and a range of peak bodies to deliver state-based projects. Further, Gippsland PHN consult and collaborate with specific providers in the development of care plans to support remote patient monitoring including mental health services, drug and alcohol as well as general practitioners and allied health to name a few.

Activity Milestone Details/Duration	
Activity Start Date	01/06/2015
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?	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?	NA
Co-design or co-commissioning comments	Through strong collaborative approaches, co-design will bring together health professionals, local expertise and subject matter experts to support the development of projects.

General Practice Support	
Activity Priorities and Description	
Program Key Priority Area	Population Health
Aim of Activity	General Practice support aims to support general practices to: • Adopt best practice methods to improve quality of care • Promote and improve uptake of practice accreditation • Implement digital health solutions to streamline patient information across the local health provider community • Develop systems to inform quality improvement activities • Liaise with General Practice and support MyMedicare implementation.
Description of Activity	The Training and Events program: The program provides informed education and training to support Gippsland primary health workforce including GPs, Practice Nurses, Nurse Practitioners, Practice Managers, Allied Health and other primary care workforce. The program activity is informed by the Gippsland PHN priority areas, emerging trends, priorities and reforms in primary healthcare, funded programs within Gippsland PHN and feedback from health workforce stakeholders working in Gippsland that align with the priority health areas. The program provides in-person and online education activities through live webinars, face to face events, online education modules and opportunities to upskill with formal qualifications. Additionally, hybrid events are delivered to provide and encourage wider access and high-quality facilitators to deliver education across the whole of Gippsland region. The GP education programs are accredited against the RACGP and ACRRM programs. The Training and Events program collaborate with all Victorian PHNs workforce development teams to identify areas of shared interest in training and events for a combined approach and shared resources where relevant to do so. Education sessions are advertised through a fortnightly Training and Events newsletter which is distributed to over 600 subscribers. Comprehensive event details are available through Gippsland PHN's website. Participants register online. Events are usually free and open to all stakeholders. Hosting the events in different locations across Gippsland increases opportunity for access and Gippsland PHN adopts solutions such as assistance to attend events and webinar access for health professionals living and working in remoter locations such as Omeo, Orbost and Mallacoota. **General support:** Gippsland PHN provide additional support to general practices inclusive of, but not limited to: quarterly practice support meetings and ad hoc support via phone and email, a dedicated weekly practice manager newsletter, subsidised data analysis tool subscription, training on an as-needs basis to aid in clinical data extraction for quality improvement activities, resources to support best practice consumer care, MBS item usage, linkages to other health services including ACCOs, LHSNs and allied services for seamless referral pathways, resources and activities to support accreditation, a dedicated positions vacant page on our website to support workforce recruitment, resources to support tender applications and grant writing and support where general practices are contracted to deliver commissioned service programs.

	Gippsland PHN collaborate with Australian Primary Health Care Nurses Association in promotion of placement of nursing students into general practice. This collaboration helps to encourage students to look at general practice as an option post-graduation and helps to encourage students to consider the opportunities that primary health presents. Gippsland PHN will continue to promote the Gippsland Pathways and Black Pages to improve referral pathways, promote current mental health commissioned service providers during practice visits, via social media, newsletters and via our website. Additionally, commissioned mental health contract providers are expected to integrate with the consumer's regular general practitioner. Activities to promote and improve the update of practice accreditation: Gippsland PHN support general practices to improve uptake of practice accreditation by promoting the importance of quality improvement activities, best practice care, registration for the PIP QI and other PIP payments, CPD points for training and events. Gippsland PHN additionally require all commissioned service providers to hold, or be working towards, current accreditation. Data collection: Gippsland PHN uses a data extraction tool (POLAR) to support population health planning and quality improvements. Statistical data is collected on engagement, number of education sessions per quarter and type of education session. Additionally, qualitative data is collected on participant feedback of education / training session. Impact: Continuing Professional Development (CPD) is how health professionals maintain their knowledge and skills related to their professional lives. CPD obligations are common for most professions; it is a structured approach to learning to help ensure competence of practice, taking in knowledge, skills and practical experience. Health professionals and other people working in Gippsland's general practices and health services actively seek training and education opportunities to maintain professional standards, influence clinical practice and develop skills and expertise. This program enables many primary care sector staff to achieve their CPD requirements without travel to Melbourne or interstate. For professionals serving our rural and remote communities, this is an important consideration. Gippsland PHN are supporting General Practices with quality improvement projects. In 2025/26 there are six practices undertaking various QI projects with a further 16 practices undertaking a Cervical Screening QI activity. These projects will lead to further work with General Practice in quality improvement including a QI activity on palliative care and further QI activities on the QIMS. As part of the MyMedicare program, Gippsland PHN will support General Practices to engage in quality improvement projects to promote better outcomes for their patients and communities.

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
Aboriginal and/or Torres Strait Islander health and wellbeing Healthy ageing (65+) Alcohol and other drugs		

Mental health and wellbeing, including suicide prevention Health workforce Connected care Growing up healthy (0-25 years) Chronic conditions Family violence Access to primary care for marginalised communities	
Activity Demographics	
Target Population Cohort	General Practitioners, other medical professionals, nurses, Immunisation nurses, Allied Health, Pharmacists, Aboriginal health workers, practice managers, administration
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	Education events are planned with a strategic focus on the priority health areas identified in the Gippsland PHN Needs Assessment, emerging trends, priorities and reforms in primary healthcare, funded programs within Gippsland PHN and feedback from health workforce stakeholders working in Gippsland that align with the priority health areas. Engagement with general practice occurs from consultation with general practice, surveys are sent out to gage their satisfaction with our engagement.
Collaboration	Gippsland PHN undertake a number of collaborative initiatives with General Practices. Collaboration includes Victorian State Department of Health, Local Health Service Networks and services, Gippsland PHN Advisory Groups, Australian Primary Health Care Nurses Association (APNA) and other stakeholders as required. Gippsland Region Public Health Unit and the Department of Health, Disability and Ageing. A number of annual events are run in collaboration with other education providers and other Victorian PHNs. GP Advisors provide specialist advice when planning education events while Clinical Councils provide feedback and advice when planning for future events and calendars.
Activity Milestone Details/Duration	
Activity Start Date	01/06/2015
Activity End Date	30/06/2027
Other Relevant Milestones	-
Activity Commissioning (intended procurement approach for commissioning services under this activity)	
Procurement Approach	Direct engagement - engage subject matter expertise to develop and deliver education and training events.
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?	NA
Co-design or co-commissioning comments	A collaborative and co-designed approach brings together health professionals, local expertise and subject matter experts to support the development of projects.

COVID-PCS – COVID-19 Primary Care Support

Activity Priorities and Description	
Program Key Priority Area	Population Health
Aim of Activity	To assist with the provision of COVID-19 Primary Care Support. This includes developing and implementing innovative, locally appropriate initiatives to improve awareness and facilitate coordination of health services to provide a quality, safe response to the COVID-19 pandemic.
Description of Activity	**Previous activities:** Gippsland PHN continued to coordinate COVID vaccination for RACH residents and provide up to date information to primary care providers regarding COVID-19 over the 2025/26 financial year. We worked collaboratively with Local Hospitals, the Victorian Department of Health (DH) and the Commonwealth Department of Health, Disability and Ageing (DHDA) to support COVID-19 vaccinations. Activities included capacity building, education and training, and continuous improvement within the workforce to support the COVID-19 response. Specifically: • Assisting with connections to primary care providers for RACHs to provide COVID vaccination to Residential Aged Care Home (RACH) residents and staff • Assisting other at-risk populations with primary care providers for COVID boosters. • Engaging with RACHs that have less than 10% COVID-19 vaccination rates and monitor those that have a booster rate between 11 to 30%. • Liaising with local hospitals and the Gippsland Region Public Health Unit to provide support for primary care with COVID-19 related issues. • Identifying any barriers in Gippsland around COVID-19 vaccination and booster rates. • Training and capacity building for primary care including upskilling nurses to become nurse immunisers. Gippsland PHN offered the Immunisation Endorsement Pathway Grant and Quality Improvement Program in the 2025/26 financial year, which offered training and incentives to upskill registered nurses to become nurse immunisers as part of a general practice-led quality improvement initiative. The initiative aimed to enhance immunisation coverage across Gippsland and improve access within general practice by integrating nurse immunisers into general practice and increase efficiency and vaccination rates for children, families and priority populations in the local community. This activity ceased on 31 December 2025 and will not be renewed. **New activities:** As funding has ceased, there will be no further activity past 30 June 2026. **Activities to promote and improve the update of practice accreditation**: Not relevant for this activity. **Engagement with Local Hospital Networks and/or State government:** Gippsland PHN engage with Local Councils, Local MPs, and the Gippsland Region Public Health Unit (GRPHU) to reach vulnerable populations. Collaboration has occurred with primary care providers as well as local hospitals.

	Data Collection: When, and if, we commission any providers under this funding de-identified data will be collected. **Impact:** This work contributed to the ongoing efforts and management of COVID-19 in Gippsland, and enabled providers to have the capacity to continue COVID vaccinations and upskill staff to provide a comprehensive service to the community.
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
Aboriginal and/or Torres Strait Islander health and wellbeing Healthy ageing (65+) Health workforce Growing up healthy (0-25 years) Chronic conditions Access to primary care for marginalised communities	
Activity Demographics	
Target Population Cohort	All residents and visitors to Gippsland
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	Ongoing consultation occurs with key stakeholders such as community, clinicians, health services, community services and partner organisations. Consultation has occurred with several stakeholders relevant to vulnerable populations including commissioned providers, Gippsland Region Public Health Unit, Royal Flying Doctors Service, Latrobe Community Health Service, Aboriginal Community Controlled Organisations, Uniting Care, Gippsland Women's Health. Quantum, Healthpoint ANZ Pty Ltd, Residential Aged Care Homes and local General Practices. Where co-design is required to develop service models, consultation occurs according to Gippsland PHN's Community and Stakeholder Engagement and Communication Governance Framework, and the Community Engagement Strategy. Gippsland PHN Advisory Groups provide support to consultation activities.
Collaboration	Collaboration has occurred with a diverse range of stakeholders and will continue to occur. **Victorian State Department of Health:** The State Government plays a critical role in primary health provision in Gippsland through its hospital and community network supported by their recent Health Services Plan reform and Rural and Regional Health System Design, Service and Infrastructure Plan.

	Local Health Service Networks and other health services and organisations: Facilitate coordination of care to ensure patients receive the right care, in the right place, at the right time, in a timely and efficient manner. **Gippsland PHN Advisory Groups:** Provide advocacy and expertise to Gippsland PHN representing a broad range of Health Services, clinicians and consumers **General Practitioners:** GPs remain the cornerstone of primary health care in Gippsland and their involvement in planning is critically important to hear their views about primary health services capacity outside the hospital system. Support the use of the GP Data Extraction Tool supporting the identification of Vulnerable Vaccination consumers. **Consumers:** Provide unique insight into barriers and challenges of accessing health services in Gippsland. Specific collaboration has also occurred with; Gippsland Region Public Health Unit, Latrobe Community Health Service, Royal Flying Doctors Service, Disability Liaison Officers, Aboriginal Community Controlled Health Services. Neighbourhood Houses Gippsland, Healthpoint ANZ Ptd Ltd and Gippsland Regional Health Services Partnership.
Activity Milestone Details/Duration	
Activity Start Date	01/04/2021
Activity End Date	30/06/2026
Other Relevant Milestones	-
Activity Commissioning (intended procurement approach for commissioning services under this activity)	
Procurement Approach	N/A
Is this activity being co-designed?	No
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?	Funding ceases on 30 June 2026, at which time the activity concludes.
Co-design or co-commissioning comments	

Regional Development Program	
Activity Priorities and Description	
Program Key Priority Area	Population Health
Aim of Activity	The Regional Development Program is a proactive business and service program aimed at supporting continuous quality improvement with general practitioners and related primary healthcare providers. The Program will provide expertise in the development and delivery of placed based initiatives and quality improvement techniques to bring about small and large system changes and health improvements.
Description of Activity	The Regional Development Program supports the primary health sector by providing evidence based, consistent and quality resources. It enables improved collaboration, communication and understanding between hospital specialists and GPs/primary health sector within localised areas. The program provides opportunities for multiple disciplines to collaborate and work together to identify barriers and opportunities for system redesign. The Regional Development Program reviews sub regional primary health service plans applicable to the localised catchments. The key elements of the program are to: - Provide data and financial analysis, business support and service modelling to general practice to assist them to expand their service models and facility capacity. - Support the design and implementation of continuous quality improvement principles and practices in general practice. - Develop and deliver of place based and integrated service models at a local level. - Build capacity and skill development of primary healthcare staff enabling their contribution to the design of the local primary health service system. Gippsland PHN provide extensive support to all 100 General Practices across Gippsland. The team of Program Delivery Officers undertake Quarterly Practice Manager visits to provide support and guidance with • Data Analysis and PIP – QI activities, • Provide support and advice regarding MBS billing items, • Support and provide information on educational opportunities and training events, • Assist with COVID-19 Pandemic pathways and strategies, • Support General Practices to collaborate with key stakeholders, • Promotion of Local initiatives with which General Practices may want to engage. The Program Delivery Team have developed very strong and robust working relationships with all general Practices across Gippsland. Engagement with Local Hospital Networks and/or State government: Engagement occurs with the Local Health Services Network, the Gippsland Region Public Health Unit, State Department of Health and Department of Health, Disability and Ageing. Collaboration with relevant primary and mental health service providers to address and improve integrated care pathways and the delivery of seamless, effective and efficient care: addressed below Activities to promote and improve the update of practice accreditation: addressed in General Practice Support activity

	Data Collection: Gippsland collect statistics regarding engagement however MDS data is not relevant to this activity. Impact: Integrated health systems that support quality improvements within health services for improved 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
Aboriginal and/or Torres Strait Islander Health and Wellbeing Healthy ageing (65+) Alcohol and other drugs Mental health and wellbeing, including suicide prevention Health workforce Connected care Growing up healthy (0-25 years) Chronic conditions Family violence Access to primary care for marginalised communities	

Activity Demographics	
Target Population Cohort	All of Gippsland PHN. General Practice staff including general practitioners, practice nurses, business and operational managers. Health services, Specialist Clinicians, Allied health providers, Clinical &Advisory Councils, Social and Community Services
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 widely with State government departments, local health service networks, Ambulance Victoria, Colleges of General Practitioners, Nurses Board, General Practitioners and other health professionals, Gippsland PHN Clinical and Community Advisory and community for valuable feedback. Gippsland PHN undertake extensive consultation with General Practices within Gippsland, to strive toward better health outcomes for our community.
Collaboration	Gippsland PHN collaborates with a diverse range of stakeholders for this Program including: **General Practitioners:** - GPs remain the cornerstone of primary health care in Gippsland and their involvement in planning is critically important to hear their views about primary health services capacity outside the hospital system - Support the use of the Data Extraction Tool supporting improvements in efficiency and effectiveness of medical services.

	Local Health Service Networks and other health services and organisations: Facilitate coordination of care to ensure patients receive the right care, in the right place, at the right time, in a timely and efficient manner. **Gippsland PHN Advisory Groups:** Provide advocacy and expertise to Gippsland PHN representing a broad range of Health Services, clinicians and consumers **Consumers:** Consumers provide unique insight into barriers and challenges of accessing health services in Gippsland.
Activity Milestone Details/Duration	
Activity Start Date	01/06/2015
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?	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?	NA
Co-design or co-commissioning comments	A collaborative and co-designed approach brings together health professionals, local expertise and subject matter experts to support the development of projects.

CF13D Flexible - Multidisciplinary Team Care in ACCOs	
Activity Priorities and Description	
Program Key Priority Area	Aboriginal and Torres Strait Islander Health
Aim of Activity	The aim of this activity is to support smaller East Gippsland Aboriginal Controlled Community Organisations to implement a multi-disciplinary approach into their clinics to enhance the patient care experience.
Description of Activity	In 2024-2025, Gippsland PHN identified a need for the three smaller ACCOs in East Gippsland (Moogji Aboriginal Council, Lake Tyers Health and Children's Services [LTHCS] and Lakes Entrance Aboriginal Health Association [LEAHA]), to be supported in mapping their collective need for multidisciplinary allied health teams and to plan a service delivery model for shared multidisciplinary team workforce to address those gaps. In Q2 of FY 2024-25, Gippsland PHN commissioned LEAHA as lead agency for the three ACCOs via a non-clinical service order agreement to support the mapping and program design of a multidisciplinary model of care for allied health services across the three participating ACCOs. At the completion of the mapping/establishment phase it was identified that due to the 3 ACCO medical practices being at different service delivery levels, different models would be required. LTCHS and Moogji have progress with a model (led by LTCHS) that is focused on the implementation of a Diabetes Educator to coordinate service supports for patients with diabetes. LEAHA have progressed with an allied health-based model that utilises a podiatrist, physiotherapist and diabetes educator to deliver services directly out of LEAHA. The program complements the Integrated Team Care program already established within each of the ACCOs and provides allied health services to fill gaps that the ITC program cannot address within those program guidelines. Subject to ongoing review of providers performance to contract deliverables/KPIs, Gippsland PHN will renew contracts to 30 June 2027. **Service type** Multidisciplinary Team Care via Face to Face within each clinic. **Engagement with Local Hospital Networks and/or State government:** Gippsland PHN's Program Delivery team engages with a wide range of networks including: • Bairnsdale Regional Health Services: Aboriginal Health Unit, Allied Health Services, Diabetes Practitioner, Continence Nurse, Medical Specialists such as Cardiac Surgeon, Ophthalmologists, endocrinologists, via regular meetings with the Koorie liaison team and eye health teams scheduled throughout the year; • Orbost Regional Health: Koorie Liaison Officer, Allied Health, Diabetes Educator, Doctors, Specialists, via quarterly engagement meetings; • Central Health Service: Koorie Liaison Officer, Allied Health, Diabetes Educator, Medical Specialists such as Cardiac Surgeon, Ophthalmologists, endocrinologists, via quarterly engagement meetings. Eye health meetings are also scheduled throughout the year;

	• Latrobe Regional Health: Aboriginal Health Unit, Allied Health Services, Diabetes Educator, Medical Specialists such as Cardiac Surgeon, Ophthalmologists, Endocrinologists, via regular engagement meetings; and • West Gippsland Healthcare Group: Aboriginal Community Health Nurse via regular contact to discuss Supplementary Services and meetings as required. • Bass Coast Health: Aboriginal Health Unit • West Gippsland Hospital: Aboriginal Health Unit • Gippsland South Hospital - Korumburra: Koorie Liaison Officer • South Gippsland Hospital - Foster: Koorie Liaison Officer Gippsland PHN seek and utilise a variety of engagement styles to ensure a wide range of connections occur, this includes quarterly commissioned services meetings, Clinical Council meetings, Community Advisory groups, and stakeholder consortiums as listed above and within this activity. **Activities to promote and improve the update of practice accreditation:** Gippsland PHN provides ongoing support to Aboriginal Community Controlled Health practices with training on accreditation processes and requirements including sharing of updated materials through the RACGP standards. Support and training is also provided to understand PIP QI incentives and processes in accordance with accreditation requirements. **Collection of data:** In addition to the mandatory data provided by all PHNs, Gippsland PHN will also look at data specific to the codesign activity including throughput and qualitative data, service delivery data such as hospitalisation rates, patient reported outcome and experience measures, pattern of health service utilisation, cultural safety, demographic data, staff retention and satisfaction. The data sets and collection mechanisms will be further determined and finalised during the codesign process with consideration to principles of data sovereignty and reporting burden. **Impact:** The MDT ACCO program will seek to address service gaps and manage risk in primary settings by providing a team based, patient centred approach where practitioners are working to their full scope of practice. This activity will also enhance the following: • Population health by improving management of patients within a multidisciplinary team care model. • Patient experience by responding to opportunities for improvement identified via Patient Reported Experience Measures. • Health equity by providing free services. • Provider experience through enhanced collaboration and communication between healthcare providers.
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
Aboriginal and/or Torres Strait Islander health and wellbeing Health workforce	
Activity Demographics	
Target Population Cohort	Aboriginal and Torres Strait Islander people aged between 0 to 70+ years.
In Scope AOD Treatment Type	No

Indigenous Specific	Yes
Indigenous Specific Comments (if answered yes to above)	This activity aims to engage Aboriginal and/or Torres Strait Islander communities and continues to be designed and delivered in consultation with local Aboriginal Community Controlled Organisations.
Coverage Whole Region?	No

SA3 Name	**SA3 Code**
East Gippsland	

Activity Consultation and Collaboration	
Consultation	Gippsland PHN have meet with all three ACCOs via teams regarding the multidisciplinary team care model and had multiple discussions around how this model of care could support their practices with up skilling/ education of current staff and provide and maintain access to allied health and primary care services based on the identified health needs of their communities; including building of workforce to include Allied Health Practitioners. The Gippsland PHN Community Advisory Committee is the centre of the organisation's community engagement strategy and is a strategic community leadership group who drives community involvement through a range of mechanisms. Gippsland PHN's Clinical Councils comprise health professional representatives of the sub-region they cover – enabling each group to recommend and advise on issues across many disciplines. Gippsland PHN also have an Executive Team member as a non-voting member on each council which assists with direct communication to the organisation, as well as the Board through its Board member sponsor. Gippsland PHN utilises these key governance mechanisms as the first point for consultation regarding service development and implementation. Consultation occurs with the five Aboriginal Community Controlled Organisations located in Gippsland: • Lake Tyers Health and Children's Services • MOOGJI Aboriginal Council East Gippsland Inc • Gippsland Lakes Complete Health as auspice for Lakes Entrance Aboriginal Health Association (LEAHA) • Gippsland and East Gippsland Aboriginal Cooperative Ltd (GEGAC) • Ramahyuck District Aboriginal Corporation (RDAC) Consultation occurs with the following Aboriginal and/or Torres Strait Islander specific networks: • Clinical Council membership, previously Gippsland PHN has an Indigenous person as a member of Gippsland PHN's Clinical Council, this person has resigned however when recruiting new members look to have a diverse council including Aboriginal and Torres Strait Islander representation; • Gippsland PHN has membership on the Gippsland Aboriginal Health Advisory Committee, convened by Victorian Department of Health, which provides access to guidance for co-design and self-determination for commissioning priorities for indigenous communities; • Regular formal and informal attendance and communication with key indigenous groups and elders, e.g., quarterly 'Round Table Yarn' between Gippsland PHN and ACCO CEOs, local government Aboriginal community groups; Three Community members sit on the Gippsland PHN Reconciliation Action Plan working group and provide advice and feedback on Gippsland PHN Indigenous Health programs and activities.

Collaboration	Gippsland PHN have been guided by the three ACCOs to develop the activities best suited to their identified community health needs. • Clinical Council membership, previously Gippsland PHN has an Indigenous person as a member of Gippsland PHN's Clinical Council, this person has resigned however when recruiting new members look to have a diverse council including Aboriginal and Torres Strait Islander representation. • Gippsland Aboriginal Health Advisory Committee (convened by Victorian Department of Health), with membership from ACCOs, Gippsland PHN, Victorian Department of Health and health services to discuss and advise on Indigenous health services in Gippsland. • With Gippsland Allied Health Services, via stakeholder engagement meetings and supplementary services requests. • Gippsland PHN staff networking with Aboriginal Liaison Officers and allied health services in Local Health Networks to share information about this activity, 715 health checks and other relevant activity. Engagement also occurs with the Gippsland Local Health Services Network, the Gippsland Region Public Health Unit, State Department of Health and Department of Health, Disability and Ageing.
Activity Milestone Details/Duration	
Activity Start Date	01/01/2025
Activity End Date	30/06/2027
Other Relevant Milestones	-
Activity Commissioning (intended procurement approach for commissioning services under this activity)	
Procurement Approach	Direct engagement; Gippsland PHN identified a need for the three smaller ACCOs in East Gippsland (Moogji Aboriginal Council, Lake Tyers Health and Children's Services and Lakes Entrance Aboriginal Health Association), to be supported in mapping their collective need for multidisciplinary allied health teams and to plan a service delivery model for shared multidisciplinary team workforce to address those gaps. Each of these organisations has either recently received accreditation or are actively working towards accreditation to better service their local communities and has little to no funding available to map and develop a standalone multidisciplinary team and require support in working together to map and develop a shared multidisciplinary team model.
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?	NA
Co-design or co-commissioning comments	Gippsland PHN worked collaboratively with the 3 ACCOs to support them to map their shared allied health needs and to co-design a shared model of care to address their identified need.

CF13I - Flexible Commissioning Projects - Falls, Strength and Balance Clinic	
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 Falls, Strength and Balance program that supports healthy ageing and reduces pressure on local health services
Description of Activity	In 2024-2025 Gippsland PHN went to open competitive market to procure falls prevention, strength and balance programs and initiatives to support the Healthy Ageing of older people living in Gippsland. This resulted in a service agreement with Live Life Get Active from 2024 – 2026. Gippsland has a larger population of people aged 65 years or older (24.8%), compared to 22.4% in Victoria and 23% Australia wide (ABS 2021; Gippsland PHN's Health Needs Assessment highlights that in 2023/24, 10% of Emergency Department presentations for persons aged 65+ were related to falls. Falls for older Australians presents as a serious risk to the health and well being of the community. According to data analysis; • Gippsland has the highest rate of accidental falls causing death of Australian PHNs (16.4 per 100,000 people of all ages compared to 10.2 in Australia). • 1 in 3 people aged 65 and over fall each year. • Falls can be due to a number of factors, such as gradual physical changes that affect the way older people move, or hazards in and around the home, new medication, balance issues, malnutrition, dehydration • Falls can have serious health impacts and cause hip fractures and other serious injuries that may need longer hospital care and have long term effects. • Falls can often trigger a loss of confidence, and this can lead to a less active lifestyle. • There are many ways to prevent falls, including keeping active and making the home safer. The competitive, open market approach resulted in a successful tender process and Gippsland PHN commissioned Live Life Get Active to deliver the Live Younger Longer (Falls, Strength, Balance and Social connections) program in Gippsland to the 29 of May 2026. • This program is delivered for 90 days, including pre and post data, and includes a number of programs such as • Cognitive Health, Social health, Nutritional health, Mental health, Physical health. This is delivered over a 7-week period, • The program then expands to the Activity program which involves a number of physical activity, social connections classes where participants commence their journey to improved cognition, social connections and work towards changing behaviours to live independently for longer. This program has been delivered in Baw Baw Shire, Wellington Shire, East Gippsland and South and Bass Coast programs are scheduled for early 2026. These programs will be delivered face to face and on-line for those who cannot attend. The Live Life Get Active program will conclude in fy2025-26 on conclusion of the final scheduled program. Any specific issues or gaps the activity will address.

	This supported the communities of Gippsland to access Fall, Balance and Strength training programs tailored to consumer needs. Engagement with Local Hospital Networks (LHN) and/or State government: Program promotion by the provider occurred with and referrals were received from all key stakeholders including community members, GP's and hospitals. Collection of data: Monthly quantitative data was collected from the provider to track uptake of the program. Quarterly outcomes based data was collected from the provider. Impact: Participants within the programs were supported to reduce the likelihood of falls via tailored programs that increased balance and strength. This will allow them to remain at home longer and reduce unnecessary and burden on the health system.
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+) Health workforce Chronic conditions	
Activity Demographics	
Target Population Cohort	Older people aged over 65 years
In Scope AOD Treatment Type	No
Indigenous Specific	No
Indigenous Specific Comments (if answered yes to above)	-
Coverage Whole Region?	No
SA3 Name	**SA3 Code**
Baw Baw Shire, Wellington Shire, East Gippsland and South and Bass Coast.	
Activity Consultation and Collaboration	
Consultation	Gippsland PHN has consulted with local aged care sector, local health services network, 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
Collaboration	With similar aged care portfolios Gippsland PHN will continue to collaborate with the Vic/Tas PHNs regarding these initiatives. Collaboration has occurred with Gippsland Community Care Alliance, Allied Health, Aboriginal Community Controlled Organisations, GPs, Health Services, chronic disease care providers, multidisciplinary service providers, Gippsland Local Health Services Network, the Gippsland Region Public Health Unit, State Department of Health and Department of Health, Disability and Ageing.
Activity Milestone Details/Duration	
Activity Start Date	23/06/2025
Activity End Date	30/06/2026

Other Relevant Milestones	-
Activity Commissioning (intended procurement approach for commissioning services under this activity)	
Procurement Approach	Open tender
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	YES This activity was decommissioned 29 May 2026.
Decommissioning details?	NA
Co-design or co-commissioning comments	Co-design was a feature of this procurement along with broad community consultation and promotion.

HSI–10 - Emergency Preparedness and Coordination

Activity Priorities and Description	
Program Key Priority Area	Population Health
Aim of Activity	Build capacity to manage emergency preparedness, planning and coordination functions across primary care in the Gippsland region.
Description of Activity	Gippsland PHN: • **Publication of role:** Gippsland PHN have an emergency response page on our website which includes a 'Primary Care Emergency Pathways' document. This document outlines the role of primary care and Gippsland PHN's roles and responsibilities. It is designed to help primary care providers better understand emergency management systems, strengthen support for vulnerable groups, and improve local disaster resilience • **Health emergency preparedness communications:** Gippsland PHN communicate health emergencies with primary care providers as needed, including regular communications before seasons. This includes communications before bushfire season, thunderstorm asthma, COVID/influenza, measles and flood and storm. • **Prepare and maintain emergency preparedness protocols considering infectious disease and natural disaster**: Protocols are currently in place for the following emergencies: bushfire, storm & flood, heatwave, epidemic & pandemic, as well as a general emergency preparedness and response procedure. These procedures are updated every two years, or as required. Protocols are stored in an accessible location, digitally and physically in each office location. Protocols are tested through twice yearly desktop-based scenario reviews. The 2025/26 scenario used a measles outbreak as its test. Gippsland PHN conduct regular review of protocols in line with Department guidelines. • **Engage regularly with local/regional/jurisdictional emergency management committees relating to emergency preparedness, planning, response, and recovery:** Gippsland PHN attend regional emergency management planning committee meetings and regular meetings with the State Department of Health, as well as local municipal emergency management meetings were possible. Gippsland PHN also attend local relief and recovery sub-committees. Other local stakeholders are engaged where required, including the Gippsland Region Public Health Unit, local councils, Local Health Services Network, ACCOs and primary healthcare providers. Gippsland PHN sit on the Regional Emergency Management Committee as a non-voting member for Gippsland. In 2025/26 Gippsland PHN took part in a Gippsland wide scenario test about earthquakes. • **Integrate and coordinate health services in your local region to prepare for the event of a natural and/or health emergency situation:** Gippsland PHN maintain mapping of health service capacity in the region, as well as a list of primary healthcare providers willing to volunteer in an emergency. Local health and climate-related alerts are regularly shared with providers, who are also encouraged to maintain their own business continuity and emergency management plans. Resources to support preparedness activities are also available on the Gippsland PHN website. • **Continuous improvement:** Gippsland PHN conduct a de-brief after each major emergency to review processes and protocols. An action plan has been put in place based off learnings and based off our twice yearly scenario testing. **Engagement with LHNs and/or State:**

	Gippsland PHN meets with the State Department of Health on a quarterly basis, is engaged with the Gippsland Region Public Health Unit and sits as a non-voting member on the Gippsland Regional Emergency Response Planning Committee. Gippsland PHN are also engaged with the two Local Health Services Networks and Local Councils. **Data collection:** Gippsland PHN have processes in place to collect data pertaining to local emergencies and disasters, including SITREP templates and stakeholder engagement logs. **Impact:** • Improved safety and wellbeing of the community • Improved healthcare service continuity • Stronger inter-agency collaboration and coordination • Enhanced staff confidence and capability • Build long-term system resilience • Reduces the impact on the acute sector when an emergency occurs.
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
Health workforce Access to primary care for marginalised communities	
Activity Demographics	
Target Population Cohort	All Gippsland residents, including those with chronic and complex health needs
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 continues to occur with local primary healthcare providers, the Gippsland Region Public Health Unit, municipal and regional emergency management planning committees, Local Health Services Network, and the State Department of Health.
Collaboration	Gippsland PHN continues to collaborate with the Victoria, Adelaide and Tasmanian PHNs on these initiatives through a joint Community of Practice.
Activity Milestone Details/Duration	
Activity Start Date	01/07/2025
Activity End Date	30/06/2027
Other Relevant Milestones	NA
Activity Commissioning (intended procurement approach for commissioning services under this activity)	
Procurement Approach	No

Is this activity being co-designed?	No
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?	NA
Co-design or co-commissioning comments	NA

HSI-11 - EPP Care Navigator Program

Activity Priorities and Description	
Program Key Priority Area	Population Health
Aim of Activity	EPP Care Navigator funding supports the provision of care coordination, system navigation and referral support for eligible patients with endometriosis and pelvic pain, enabling timely access to appropriate services and supporting integration across the primary care system, delivered in a person-centred and trauma-informed manner.
Description of Activity	Gippsland PHN have commissioned the existing Gippsland Endometriosis and Pelvic Pain Clinic run by Latrobe Community Health Service to provide a dedicated PHN Care Navigator to provide clinical expertise and local service knowledge and act as a central, trusted point of contact for affected patients of Dr Simon Gordon. The Care Navigator will act in collaboration with Gippsland PHN and relevant Commonwealth, state and territory services and initiatives to ensure person-centred support across the care pathway. The Care Navigator role will work in collaboration with the broader EPPC team within LCHS to ensure access pathways to supports are clear and workload is supported if and when needed. This role would include: • Initial clinical triage and consolidation of patient history and relevant information. • Ongoing case management, including liaison across primary care, specialist tertiary care (public and private), and community sectors. • Supporting the development of individualised care plans, with clear advice on available supports such as: ○ Linkages to tertiary specialist services (public and private) and hospital programs ○ Linkages to primary care supports, including but not limited to Endometriosis and Pelvic Pain Clinics and Medicare funded mental health services ○ Providing consumer education and peer support services ○ Maintaining records and reporting to Gippsland PHN of the primary care, specialist tertiary care (public and private) and community supports in your local area (and broader region as appropriate), including key supports for this complex patient group such as availability, services, billing options – to ensure trauma informed care. ○ Maintain awareness and connection with Commonwealth and Victorian Government initiatives related to the former patients of Dr Gordon. For example, connection with the Victorian Women's Health clinics or Women's Health Victoria national phoneline. ○ Active follow up to monitor progress, ensure recommended care is accessed, and identify urgent or high-risk needs. • Program reporting to Gippsland PHN to support oversight and evaluation. Gippsland PHN will collaborate with the Lead Site, Eastern Melbourne PHN, to support coordinated delivery of the PHN Care Navigator initiative, including engagement with local services, contribution to shared governance arrangements

	and resource development/sharing, and participation in agreed reporting and evaluation activities. Gippsland PHN will develop, in consultation and collaboration with the Lead PHN (Eastern Melbourne PHN) and Victorian PHNs reporting mechanisms that will • distinguish new patients accessing the service for the first time from existing patients receiving ongoing Care Navigator support • Report on referral information • Summary of service provided and details of session amounts and duration. Gippsland PHN have, in consultation and collaboration with the Lead PHN (Eastern Melbourne PHN) and Victorian PHNs, a Position Description for the Care Navigator role which has been included within the contract to the commissioned service provider to ensure consistency across the Victorian PHNs in how the EPP Care Navigator will manage workload, reporting activities and transition arrangements back to regular GP when ongoing support is no longer required. Gippsland PHN will engage with the Local Health Services Network, the State Department of Health, Department of Health, Disability and Ageing, Gippsland Region Public Health Unit, Women's Health Victoria, Medicare Mental Health Intake line, centres and existing Head to Health hubs. Gippsland PHN will collect de-identified demographical data via Fixus as well as number of people who have accessed the service, how many contacts and where they have been referred to. Gippsland PHN will provide reporting to the Lead PHN (Eastern Melbourne PHN) monthly during implementation and then quarterly for the duration of the funding period.
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
Health Workforce Growing Up Healthy (0-25 years) Chronic Disease Access to Primary Care for Marginalised Communities	
Activity Demographics	
Target Population Cohort	Gippsland residents who are affected patients of Dr Simon Gordon
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	
Activity Consultation and Collaboration	
Consultation	Gippsland PHN will consult with Southern PHN Alliance members to share learnings and collaborate on engagement strategies. Gippsland PHN will engage with the Local Health Services Network, the State Department of Health, Department of Health, Disability and Ageing, Gippsland Region

	Public Health Unit, Women's Health Victoria, Medicare Mental Health Intake line, centres and existing head to health hubs. LCHS has a strong partnership with Gippsland Women's Health, local hospital networks and other health services.
Collaboration	Gippsland PHN will collaborate with the lead PHN (Eastern Melbourne PHN) and with Southern PHN Alliance members to share learnings and collaborate on engagement strategies. LCHS has a strong partnership with Gippsland Women's Health, local hospital networks and other health services.
Activity Milestone Details/Duration	
Activity Start Date	29/04/2025
Activity End Date	30/06/2027
Other Relevant Milestones	NA
Activity Commissioning (intended procurement approach for commissioning services under this activity)	
Procurement Approach	Direct Approach Gippsland PHN have directly approached the existing contracted provider of the Gippsland Endometriosis and Pelvic Pain Clinic, Latrobe Community Health Service, to deliver this activity. The provider has the clinical experience, knowledge and expertise to provide person centred care to affected patients including clinical triage, consolidation of patient history and provide ongoing case management.
Is this activity being co-designed?	No
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?	NA
Co-design or co-commissioning comments	NA

CF-23 Flexible - Short-Term Initiatives to support local Health Priorities	
Activity Priorities and Description	
Program Key Priority Area	Population Health
Aim of Activity	These short term initiatives have been put in place to address local community health priorities and to improve services to consumers.
Description of Activity	Gippsland PHN undertakes a number of small, time-limited initiatives utilising Core Flex funding to target health priorities and support improved front-line services to consumers. **<u>In FY25-26, these initiatives included:</u>** **Trauma informed training** A small amount of funding has been utilised to offer trauma informed training to all health care professionals, including allied health and general practice. With multiple projects including the Homelessness Access Program, the Multicultural Access Program, Supporting Recovery and Supporting Outreach, it has been identified that when referring out, providers being referred to may have undertaken trauma-responsive skills building in order to respond in ways that promote healing, safety and dignity. People often face stigma when accessing services therefore we saw a need to strengthen primary care providers' capability in providing trauma informed care. **My Health Record and 1800Medicare app – community support** Gippsland PHN have commissioned Neighbourhood Houses across Gippsland to assist the community with accessing their MyHealthRecord and to register and use the 1800Medicare app, and in doing so to build digital health literacy. Gippsland has a lower than national average digital ability score. **Multidisciplinary teams training** Gippsland PHN have commissioned Prestantia Health to support Gippsland PHN Commissioned service providers to increase their capability and capacity to work with and across multidisciplinary teams. The program takes a Quality Improvement based approach to capacity and capability program. The program supports participants who are struggling to progress their MDT care approach as well as participants wishing to strengthen an existing MDT model. **Falls and balance program** To bolster availability of falls prevention programs in Gippsland and address a shortfall of services compared to need, Gippsland PHN commissioned MyPhysio to deliver two short-term falls preventions programs in South Gippsland / Bass Coast from May – June 2026. **Aboriginal Suicide prevention** Funding from Core Flex was used to provide additional reach and capacity building in the development of an Aboriginal Suicide Prevention Plan for East Gippsland. Engagement with 3 local ACCOs advised that training needed to be included in the plan development, with funds from core flex used to develop a fit-for-purpose culturally appropriate and sustainable training package (to bolster the TRISP funding for the broader plan development). **Stigma reduction program** To align with best practice approaches in stigma reduction and co-design, Gippsland PHN engaged a panel of ten Lived Experience advisors from across Gippsland, representing diverse backgrounds and perspectives, to inform and strengthen the effectiveness of the stigma reduction campaign. To ensure that the Suicide Prevention funding allocated to the Stigma Reduction campaign was maximised toward funding the campaign itself, Gippsland PHN utilised Core Flex funding to

	support the coordination of the Lived Experience Advisory group and remunerate the participants for their expertise. **After Hours Support – Leongatha Community** To support the community of Leongatha after the unexpected closure of Leongatha Healthcare in January 2026, Gippsland PHN utilised Core Flex funding to commission the existing After Hours commissioned service provider, HealthAccess to temporarily increase their operating hours to include week days. This temporary increase was for a period of six weeks and mitigated a range of clinical, safety and system-level risks arising from the closure. The temporary increase supported patients of Leongatha Healthcare to access continued healthcare and management of ongoing and chronic conditions, management of medication and access test results and referrals while locating and transferring to an alternative healthcare provider. The temporary increase also reduced pressure on other health services, such as Leongatha Hospital emergency department and general practices immediately following the closure and while the local healthcare system adjusted to the change. **Cost Benefit Analysis Evaluation – Community Led Integrated Healthcare** During 25/26 a cost benefit analysis of the Community Led Integrated Health Care program was completed. The purpose was to assess benefits (financial and non-financial) against the cost of delivering services to ensure the investment into the program is achieving sufficient benefits for the consumers. The evaluation will be completed in June 2026 and the program will be reviewed based on the results with a goal of maximising benefits. An action plan focused on maximising the benefits we can achieve against the cost of delivery will be written in Q1 26/27. **<u>In FY26-27, Gippsland PHN have planned:</u>** **Suicide Postvention - Suicide Response Coordination** In the 2026-27 financial year Gippsland PHN are combining a small portion of the core funding with the Gippsland Suicide Prevention – General Services to commission Wellways to provide coordination, training and support of local postvention support volunteers in accordance with the Community Postvention Response guidelines developed by Gippsland PHN. This group provides non-clinical supports following a suicide, guiding and supporting the impacted groups, businesses, or organisations. This is part of the provider's broader Suicide Postvention support. **Falls Prevention** Gippsland has a high rate of preventable hospitalisations caused by falls and so will potentially commission falls preventions programs utilising Core Flex funding in FY26-27. However, Gippsland PHN await funding advice for Early Intervention Initiatives within the Aged Care schedule, as this may provide an opportunity for Gippsland PHN to pursue falls prevention activity if funding is extended. If this happens, Gippsland PHN will redirect funding into other activities that address local health needs and priorities.
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
Activity Demographics	
Target Population Cohort	
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 continues to occur with local primary healthcare providers, the Gippsland Region Public Health Unit, municipal and, Local Health Services Network, and the State Department of Health.
Collaboration	Collaboration occurs with Local Health Services Networks, primary care, Neighbourhood houses and commissioned providers.

Activity Milestone Details/Duration	
Activity Start Date	01/07/2025
Activity End Date	30/06/2027
Other Relevant Milestones	NA

Activity Commissioning (intended procurement approach for commissioning services under this activity)	
Procurement Approach	No
Is this activity being co-designed?	No
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?	NA
Co-design or co-commissioning comments	NA