Gippsland PHN – Integrated Team Care Program (ITC) 2026 – 2027 Activity Work Plan Annual Update

Submitted: 30 April 2026 Approved: 8 July 2026

ITC1 Care coordination and Supplementary Services	
Activity Priorities and Description	
Program Key Priority Area	Aboriginal and Torres Strait Islander Health
Aim of Activity	This activity contributes to improving health outcomes for Aboriginal and/or Torres Strait Islander people with chronic health conditions through better access to care coordination, multidisciplinary care, support for self-management and supplementary services funding. It also aims to build a health system that continually improves quality and is responsive to the health needs of Aboriginal and/or Torres Strait Islander people.
Description of Activity	This activity provides primary health care services, including chronic condition prevention, detection and management. Care coordinators support access to specialist and allied health professionals by arranging the services required, assisting the patient to attend appointments, ensuring medical records are complete and current, and ensuring regular reviews are undertaken by the patient's primary care providers. Additionally, Care Coordinators access Supplementary Service funding when services are not able to be funded through any other program in a clinically acceptable timeframe and where the need is documented in the client's care plan. To maximise outcomes, Gippsland PHN takes a self-determination approach wherever possible to support Indigenous community and Aboriginal Medical Service / Aboriginal Community Controlled Organisation involvement in co-design of models for commissioning decision making. In 2025-26, four Aboriginal Community Controlled Health Organisations (Ramahyuck District Aboriginal Corporation; Lakes Entrance Aboriginal Health Association; Gippsland and East Gippsland Aboriginal Cooperative; Lake Tyers Health & Children's Services) that operate as Aboriginal Medical Services in the Gippsland catchment have been commissioned by Gippsland PHN to provide Integrated Team Care (ITC) services. Previously, a fifth service, Moogji Aboriginal Council East Gippsland, was contracted however declined to continue with the contract for 2025-26. The contracted organisations provide appropriate, culturally sensitive clinical care via face to face, telehealth, individually or with other community members as required to meet the needs of the patient and have strong links to the local community. Gippsland PHN intend to extend these contracts via a Deed of Variation through until 30 June 2027. The funds carried forward from 2024/25 into 2025/26 were utilised in part, to support the program and provide cultural training through 3 initiatives including: • 6 small grants that enabled each ACCO to participate in specialised online (free) training delivered by Cancer Council Victoria on The Prevention and Early Detection of Skin Cancer in General Practice. This training is strengthening clinical capacity and strengthening early intervention practices within community health settings. Upon successful completion of the training, each ACCO will be able to purchase their own Dermatoscope to support practical application of the skills gained, enhancing their ability to

	conduct thorough skin checks and improve health outcomes for Aboriginal and/or Torres Strait Islander communities. • 6 small grants that are enabling each ACCO to access and complete specialised online training designed to upskill their Care Coordinators in best-practice Chronic Disease Management. By strengthening the knowledge and capability of Care Coordinators, this initiative aims to enhance the quality of care, improve coordination of services, and deliver better health outcomes for Aboriginal and/or Torres Strait Islander clients living with chronic conditions. • 10 small grants with a targeted initiative that aims to strengthen cultural awareness and inclusiveness within mainstream health services providers. These grants are enabling providers to implement targeted activities that create welcoming environments for Aboriginal and/or Torres Strait Islander peoples, with a particular focus on chronic disease prevention and health promotion. This initiative recognises the importance of culturally safe care in improving health outcomes and reducing disparities. By supporting mainstream services to embed cultural competence, the program seeks to ensure that Aboriginal and/or Torres Strait Islander communities feel respected, understood, and supported when accessing health services. An EOI Process will be completed to General Practices across Gippsland In addition to the three activities above, the balance of 2024-25 underspend carried forward into 2025-26 was added to the Supplementary Services funding pool, held by Gippsland PHN. Supplementary Services includes a flexible funding pool which is used by the Care Coordinators when they need to expedite a patient's access to an urgent and essential allied health or specialist service (including certain approved medical aids), where the services are not otherwise available in a clinically acceptable timeframe. Supplementary services are used to fund the necessary local transport to access the service, where not publicly available. Care Coordinators are located within the Local Government Areas of East Gippsland, Wellington and Latrobe. Aboriginal and/or Torres strait Islander peoples who are not located in these sub-regions or who choose not to access services via ACCOs have access to Supplementary Services via their General Practice and Gippsland PHN. In these cases, the Supplementary Services are accessed by the Clinician submitting a request directly to Gippsland PHN, with all relevant documentation, for approval. In 2026-27, a Gippsland PHN Program Delivery Officer will continue to implement the objectives and aims of the Integrated Team Care Activity. This position works with all relevant stakeholders in Indigenous health and in collaboration across Gippsland PHN teams. The role focuses on: • Coordination and promotion of the Integrated Team Care Activity; • Providing guidance, training and mentoring to the Care Coordinators and Outreach Workers; • Identifying and contributing to development of referral pathways and resources to support and enable the coordination of services at a regional level including cross-sectoral and integrated approaches; and • Identifying key issues, including patient management, data and discussion points for Gippsland PHN to explore with its Clinical Council and Community Advisory Committee. • Engaging with mainstream health services to support access to supplementary services funding for Aboriginal people receiving health care support via a mainstream service.

	Care Coordination is provided by qualified health workers (e.g. specialist nurses/or nurse, Aboriginal Health Practitioners) to ensure that patients are accessing services consistent with the care plan prepared by their General Practitioner (GP). The Care Coordinators work within the ITC Guidelines. The Care Coordinators work with clients in accordance with the GP Management Plan (GPMP) or Team Care Arrangement (TCA) Care Plan. This includes providing support in a culturally appropriate manner when attending appointments and services. They also arrange transport and medical aids via supplementary funds and work with family to understand and support the clients on their medical journey. Services are delivered via face to face, telehealth, individually or with other community members as required to meet the needs of the patient. The Care Coordinators deliver health promotion services such as Diabetes Awareness and work with the clients for self-determination and understanding of their chronic health condition and how it is best managed. They work to establish connection and links with surrounding services and stakeholders. Community members are recruited from the local community to fill the Care Coordinator roles, many of whom are not initially qualified and take on Aboriginal health worker/practitioner training to meet the role requirements. This provides the opportunity to upskill the community and build the Aboriginal Torres Strait Islander health workforce. The Outreach worker positions provide an integral connection to the local community and provide essential transport, advocacy, and support for ITC consumers. The placement of both clinical and non-clinical staff is based on the population of Indigenous people per Local Government Area and in consultation with the Aboriginal Community Controlled Organisations (ACCOs), mainstream services and identified need in the local regions. Throughout our recent needs assessment process, Gippsland PHN has confirmed no service duplication for the 2026/27 activities. These arrangements also ensure that the ITC activity and supports are available throughout the whole of Gippsland. **Workforce development:** • ITC Network Gathering: At these quarterly events, the Care Coordinators and Outreach Workers have an opportunity to come together in a group environment to encourage networking and collaboration. The Care Coordinators and Outreach workers bring any challenges or barriers to practice and troubleshoot strategies together to improve service delivery. • Cultural Awareness Training provided over four sites and via online access across Gippsland each year since FY2022-23, enabling Mainstream services to provide culturally appropriate services. This will continue to be offered to providers as a training option in 2026/27. • Care Coordinators and Outreach Workers are provided opportunities to access any relevant national education provided; and • Care Coordinators and Outreach Workers are supported to attend education events provided by Gippsland PHN. **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 Healthcare Group: Aboriginal Health Unit • Gippsland South Hospital - Korumburra: Koorie Liaison Officer • South Gippsland Hospital - Foster: Koorie Liaison Officer Gippsland PHN utilise a variety of engagement styles to ensure a wide range of connections occur. For example, 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 are also provided to understand PIP QI incentives and processes in accordance with accreditation requirements. **Collection of MDS data includes collection of data extensions or tags for service activity:** Data is collected monthly from the providers via Fixus for both submission and review, which includes both population health and occasions of service data. Qualitative data is collected on a quarterly basis as per the Service Order Agreement. Key Performance Indicators and an annual qualitative report is 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. 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 implementing 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 KPI's against each of the five elements of the Quintuple Aim **Impact:** Impacts of this activity include: • Increased and better collaboration between the ACCOs and mainstream services, an increase in the delivery of and uptake of cultural safety training

	across the health sector including general practice, mainstream service providers and allied health providers; • Care Coordinators are increasing support and access to specialist and allied health professionals by arranging the services required, assisting the patient to attend appointments, ensuring medical records are complete and current and ensuring regular reviews are undertaken by the patient's primary care providers; and • Supplementary Service funding is used, as per guidelines, when services are not able to be funded through any other program in a clinically acceptable timeframe and where the need is documented in the client's care plan. This includes an increase in mainstream services accessing funding for eligible supplementary items. • When funding Aboriginal Controlled Organisations to deliver the ITC program, the contract value includes an amount for supplementary services funding that the contracted organisation holds and uses to support their ITC participants. This supports a self-determination approach that empowers Aboriginal and/or Torres Strait Islander people and community to take control over their health and wellness decisions whilst respecting cultural values, therefore improving health outcomes through culturally and holistically relevant care. **Alignment to Closing the Gap Priority Reforms:** Priority Reform Two – Building the Community-Controlled Sector This activity contributes to the Closing the Gap Priority Reform Two by contributing to development of a dedicated and identified Aboriginal and Torres Strait Islander workforce. The activity additionally provides a source of funding designed to suit the types of services required by the community. As this activity works directly with five of the Aboriginal and Torres Strait Islander community-controlled organisations within Gippsland, it contributes to building the community-controlled sector. Work continues to increase 715 health checks both within ACCOs and mainstream services. Additional detail on this work is outlined in the Activity ITC2: Culturally competent mainstream 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*	
Aboriginal and/or Torres Strait Islander health and wellbeing Healthy ageing (65+) Alcohol and other drugs Health workforce Chronic conditions Family violence Access to primary care for marginalised communities Health Workforce	
Activity Demographics	
Target Population Cohort	Aboriginal and/or Torres Strait Islander people with a diagnosed chronic condition/s
In Scope AOD Treatment Type	No
Indigenous Specific	Yes
Indigenous Specific Comments (if	The ITC program works directly with Aboriginal and/or Torres Strait Islander communities.

answered yes to above)	
Coverage Whole Region?	Yes

SA3 Name	**SA3 Code**
Gippsland wide	

Activity Consultation and Collaboration	
Consultation	• Regular formal and informal attendance and communication with key Indigenous groups and elders, ACCO CEOs and local government Aboriginal community groups. • Meeting between Gippsland PHN, ITC Care Coordinator's and Outreach workers held quarterly, stakeholders listed below are invited to engage and speak at the meetings.
Collaboration	• Gippsland PHN Reconciliation Action Plan Working Group includes two indigenous persons to provide advice and guidance to the working group to ensure planned activities align and continue to align with the interests of the local Aboriginal and/or Torres Strait Islander community in Gippsland. There is one member from Gunaikurnai country and one from Bunurong country. • 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. • Discussion and collaboration with Outcome Health around colocation arrangements within Ramahyuck District Aboriginal Corporation as well as cultural safety education between the two parties. • Regular engagement meetings with commissioned service providers, including Latrobe Regional Mental Health Service allowing for opportunity to share the process for and how to access supplementary services through the ITC program. • Contracting Gippsland general practices in Baw Baw, Bass Coast and South Gippsland LGAs to deliver a nurse led care coordination to Aboriginal and or Torres Strait Islander patients with one practice confirmed and more to come. • 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.

Activity Milestone Details/Duration	
Activity Start Date	01/07/2016
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-	No

commissioning or joint-commissioning arrangements?	
Has this activity previously been co-commissioned or joint-commissioned?	No
Decommissioning	No
Decommissioning details?	NA
Co-design or co-commissioning comments	As part of our commitment to a self-determination approach, Gippsland PHN codesign contract KPIs and targets with the providers and revisit these regularly throughout the contract period

ITC2 Culturally competent mainstream services

Activity Priorities and Description	
Program Key Priority Area	Aboriginal and Torres Strait Islander Health
Aim of Activity	Improve access to culturally appropriate mainstream primary care services including but not limited to general practice, allied health, and specialists for Aboriginal and/or Torres Strait Islander people
Description of Activity	Gippsland PHN Program Delivery Officer will continue to effectively implement the objectives and activities of the Integrated Team Care Activity. This position works with all relevant stakeholders in Indigenous Australians health, in collaboration with Gippsland PHN teams. The Indigenous Health Project Officer role will be a person employed by Gippsland PHN under the title Program Delivery Officer. This role focuses on: • Establishment and implementation of a culturally appropriate, regionally focused Reconciliation Action Plan (RAP); • Assisting the wider mainstream primary care sector through the provision of information, training and resources encouraging the engagement of Indigenous patients; • Promotion of mainstream primary care providers to the Indigenous community • Identifying and contributing to development of referral pathways and resources to support and enable the coordination of services at a regional level including cross-sectoral and integrated approaches; • Identifying key issues, including patient management, data, and discussion points for Gippsland PHN to explore with Clinical Councils and Community Advisory Committee • Increasing Cultural Awareness, • Updating Black Pages directory • Working with General Practices to be welcoming to the community by offering cultural safety training. In 2025/26, work to increase 715 assessments and awareness has been completed and will continue as an ongoing promotional activity. This work has included: • Culturally specific short films and information sheets were created in 2024 and will continue to be utilised during 2026/27 to increase mainstream primary care provider knowledge of Aboriginal and/or Torres Strait Islander MBS item numbers; and • A short film titled ‘Ask the Question’ was developed and disseminated by Gippsland PHN and is available to view on the Gippsland PHN website These videos have continued to be promoted with all mainstream services via face-to-face quarterly visits, Gippsland PHN’s communications channels including web and social media platforms, external providers including WIN News and TRFM local radio, via email to providers and advertised in regular fortnightly and monthly newsletter publications to the Gippsland health sector. In 2026/27, Gippsland PHN will continue to develop resources where gaps are identified to support mainstream services to deliver culturally safe services to Aboriginal and/or Torres strait islander community members. Gippsland PHN intends to work with GPs in Gippsland to increase the rate of 715 checks via: • Internal coaching and education with our Program Delivery Officers (PDO) who support General Practice in Aboriginal and/or Torres Strait Islander Health including: closing the Gap initiatives, CTG Prescriptions and 715 health checks. The aim of the increased education and coaching is to strengthen the PDO confidence in discussing and answering queries

	relating to 715 assessments, why they are important and the value to the GP (financially and socially) of increasing the rate of 715 checks. • Developing and providing information packs (utilising existing resources where available and applicable) for new GPs and Registrars around Aboriginal and/or Torres Strait Islander Health. • Reviewed General Practice data and developing information sheets around MBS items and revenue opportunities for GP practices in increasing Aboriginal and/or Torres Strait Islander specific services. • Providing support to General Practices who wish/intend to focus on increasing 715 checks and other Aboriginal Health items as part of their Quality Improvement initiatives. **Work Development:** Gippsland PHN will continue to commission Aboriginal consultancies to deliver free cultural awareness/safety training annually to mainstream services across Gippsland in face-to-face and online sessions to meet the needs of providers. Uptake for the previous sessions has been highly successful with full registration across all sessions. **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 • Quarterly engagements occur with these organisations at commissioned services meetings, Clinical Council meetings and Community Advisory groups. In 2023/2024, Gippsland PHN met with Koori Liaison teams and allied Health professionals at all Gippsland hospitals and several mainstream medical services in the Bass Coast and South Gippsland regions to promote the ITC program and its benefits. With a positive impact and connection to support the regions, that do not currently have an Aboriginal Community Controlled Organisation. The impact of that engagement has continued and is expected to continue into 2026/27 with regular communications and meetings with Koori Liaison teams and health professionals within the Bass Coast and South Gippsland region. **Activities to promote and improve the update of practice accreditation:**

Gippsland PHN provides ongoing support to Aboriginal Health practices with training on accreditation processes and requirements including sharing of updated materials through the RACGP standards. Support and training are also provided to understand PIP QI incentives and processes in accordance with accreditation requirements.

Data collection: Cultural Safety Training.
The approach for collection is for all participants in the training being invited to complete a survey which aims to measure:

- The satisfaction of the training;
- An increase in understanding of cultural safety;
- An understanding on how to implement changes to support the Aboriginal and/or Torres Strait Islander community;
- Increased understanding of relevance to organisation; and
- Degree to which learning needs were met.

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 implementing 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

Impact:
Gippsland PHN have conducted yearly cultural awareness/safety training sessions to mainstream health services with satisfaction rates above 90% each year.

General practice data extracted from POLAR shows an increase in both the number of unique patients and the number of attendances at general practice of Aboriginal and/or Torres Strait Islander people each year. This increase shows the impact cultural safety training and "Ask the question" promotional activity undertaken by Gippsland PHN is having at general practice level.

Calendar Year	Activities	Patients
2022	51,436	5,309
2023	63,170	5,878
2024	69,466	6,318
2025	80,991	6,868

Black Pages continue to be updated because of the work undertaken with services which will aid in increasing available referral pathways. Following feedback from local community members, Gippsland PHN have reviewed the Black Pages to determine its appropriateness as a Gippsland PHN controlled resource and have commenced improvement updates including to navigation and listing reviews/audits to ensure services listed are providing culturally safe practices and are seen as such by the community.

Each year Gippsland PHN see an increase in the needs for the support of supplementary services. Gippsland PHN will continue to hold supplementary services for mainstream providers not contracted within the ITC program.

Alignment to Closing the Gap Priority Reforms:
Priority Reform Two – Building the Community-Controlled Sector

	This activity contributes to the Closing the Gap Priority Reform Two by improving access to the ITC program and improving referral pathways. The activity also supports mainstream services to develop and improve culturally safe practices by providing Indigenous health specific education and resources.
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*	
Aboriginal and/or Torres Strait Islander health and wellbeing Healthy ageing (65+) Alcohol and other drugs Health workforce Chronic conditions Family violence Access to primary care for marginalised communities Health Workforce	
Activity Demographics	
Target Population Cohort	Aboriginal and/or Torres Strait Islander people with a diagnosed chronic condition/s
In Scope AOD Treatment Type	No
Indigenous Specific	Yes
Indigenous Specific Comments (if answered yes to above)	This activity is targeted at people working in both the health sector both mainstream and Aboriginal and/or Torres Strait Islander, community and other relevant stakeholders.
Coverage Whole Region?	Yes
SA3 Name	**SA3 Code**
Gippsland wide	
Activity Consultation and Collaboration	
Consultation	Consultation includes: Regular formal and informal attendance and communication with key indigenous groups and elders, Aboriginal Controlled Community Organisation (ACCO) CEO G5 network, local government Aboriginal community groups; Regular consultation and collaboration with local Aboriginal community-controlled services. This occurs quarterly at Quarterly commissioned services meetings and ITC gatherings and via a round table yarn held quarterly between Gippsland PHN executive and ACCOs. Regular contact is also maintained via email and telephone communication between meetings Rural planning sessions held regularly with Indigenous health focus groups e.g. Gippsland Region Network for Aboriginal Disability and Aged Care (NADAC), Aboriginal Eye Health Working Group. Culturally specific resources, such as short films and information sheets are provided to local Gippsland General Practices to promote and improve uptake of Indigenous MBS items. The resources were developed and disseminated to all mainstream health services and ACCOs via email, Gippsland PHN newsletters, Gippsland PHN webpage and social media platforms.
Collaboration	**Collaboration includes:** • 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; • Gippsland PHN works in collaboration with health services to provide supplementary services to the Indigenous Community; • Education and resource support are provided to local Gippsland General Practices to promote and improve uptake of indigenous MBS items.; • Latrobe Regional Mental Health Service via regular stakeholder meetings; • With Gippsland general practices via Quarterly stakeholder meetings, Gippsland PHN newsletters and email correspondence; • Gippsland Allied Health Services via regular stakeholder meetings and Gippsland PHN newsletters; • Gippsland PHN disseminated program information at Quarterly contract management meetings for other funded services; and • Quarterly meetings with the eight members of the VIC/TAS PHN Alliance in regard to upcoming trends/ health issues across Victoria, Tasmania and Adelaide and share resources.
Activity Milestone Details/Duration	
Activity Start Date	01/07/2016
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?	NA
Co-design or co-commissioning comments	N/A