Listening to Latrobe:

Towards improved health outcomes for people living with chronic disease

Latrobe Health Assembly
An initiative of the Latrobe Health Innovation Zone

Shaping The Valley

CENTRAL WEST GIPPSLAND
Primary Care Partnership

phn
GIPPSLAND
An Australian Government Initiative

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Larter.

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Contents.

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Introduction.

The Latrobe Valley[1] has a proud and strong community.

The Latrobe community's resilience, initiative and determination to resolve issues has been demonstrated in recent years, when significant events have devastated the community. This includes fires and drought and stress, anxiety, anger and frustration resulting from the Hazelwood mine fire. The ongoing health and financial impacts are still felt by the community and individuals.[2]

The Latrobe Valley community is less prosperous and less healthy overall than the rest of Victoria, even though it contributes significantly to Victoria's economic wealth. Median household incomes are significantly lower than the Victorian average and there is a much higher proportion of low-income households in Latrobe than in Victoria.[3]

Two of the top five causes of death and disability in Latrobe are chronic diseases - cardiovascular disease and chronic respiratory disease. Latrobe has the highest percentage of people reporting high blood pressure in Victoria and the percentages of people reporting type 2 diabetes and osteoporosis are among the highest in Victoria.[4]

Furthermore, Latrobe has the highest rate in Gippsland of potentially preventable hospitalisations. Rates of hospitalisation for the chronic diseases and chronic disease complications and rates of avoidable deaths for cardiovascular disease and respiratory diseases are significantly higher than the Victorian averages.[5]

To respond to this situation and contribute to improved quality of life for people living with chronic disease in Latrobe, Gippsland Primary Health Network (GPHN) established the Latrobe Chronic Disease Forum Advisory Group. The purpose was to design and develop care pathways to improve coordination for people with chronic disease[6] and in doing so, work with the Latrobe Health Assembly and involve local and state-wide providers and experts.[7]

To identify appropriate interventions the Central West Gippsland Primary Care Partnership was commissioned by the Latrobe Health Assembly to consult with community members, and Larter Consulting was commissioned by GPHN to consult with health sector stakeholders.

This report has combined the emerging themes and findings from the following two aligned reports:

- Central West Gippsland Primary Care Partnership in partnership with the Latrobe Health Assembly (2019), Creative Community Consultations Workshops in Chronic Illness Report. Refer to Appendix 1 for an overview.
- Larter Consulting (2020), Latrobe Chronic Disease Workforce Consultation Report. Refer to Appendix 2 for an overview.

The community consultation workshops engaged 302 community members between May and October 2019, either through face-to-face conversations with a peer facilitator or a survey.

96 stakeholders from public health organisations, general practices, pharmacies, peak industry bodies, the CWGPCP and external Primary Health Networks with a chronic disease focus, were consulted through the workforce consultations. Each set of data was independently analysed to identify emerging themes.

The data from both reports was then compared and analysed, so as to make the recommendations in this report.

While many community members stated they were happy with current services to support chronic diseases, between two thirds and one half were not happy or did not feel they were managing well.[8]

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1 The Latrobe Valley is between the Strzelecki Ranges and Baw Baw Ranges in Gippsland, Victoria. It has a population of approximately 125,000 people with three major urban centres: Moe, Morwell, and Traralgon. It covers three local government areas administered by the Latrobe City Council, Baw Baw Shire Council and Wellington Shire Council. State Government of Victoria (2020) *Latrobe Valley Authority*

2 Parliament of Victoria (2014) *Hazelwood Mine Fire Enquiry* Accessed on 18 April 2020 at: http://report.hazelwoodinquiry.vic.gov.au/part-one-introduction-inquiry/background.html

3 *ibid.*

4 Central West Gippsland Primary Care Partnership in partnership with the Latrobe Health Assembly (2019), *Creative Community Consultation Workshops in Chronic Illness, Final Report*

5 *ibid.*

6 Deliverable 78 of the Hazelwood Mine Fire Inquiry Implementation Plan.

7 In response to the Hazelwood Mine Fire Inquiries, the Victorian Government designated the Latrobe Valley as a Health Innovation Zone (LHIZ), the first of its kind in Australia. The formation of the Latrobe Health Assembly is a key component of LHIZ and is a mechanism for increased community engagement leading to health improvement and integration of services. The Latrobe Health Assembly provides an opportunity for a much stronger community voice in identifying health and wellbeing issues, gaps and barriers and also identifying solutions that best meet the needs of Latrobe Valley residents. For more information go to: State of Victoria (2020) Latrobe Health Assembly, Accessed on 20 July 2020 at https://www2.health.vic.gov.au/about/health-strategies/latrobe-health-innovation-zone/latrobe-health-assembly

8 Central West Gippsland Primary Care Partnership in partnership with the Latrobe Health Assembly (2019), op cit.

Based on the central themes, community and service providers desire the following outcomes:

- improved access to primary and allied health services - most notably timely access to appropriately experienced and well-resourced GPs, and medical and psychological specialists.
- improved communication between clients and service providers and between different service providers
- affordable services
- improved information and support provided to reduce isolation and loneliness and enhance self-management
- improved chronic disease and disability-friendly local infrastructure
- simplified programs and funding mechanisms.

By addressing the desired outcomes and by working collaboratively with community and key service providers, an exciting opportunity arises to create a shared vision, further strengthen community's voice, improve the community's health outcomes[9], build capacity, strengthen partnerships, bring about service and system change and implement integrated population focused actions.

Key considerations for the next phase are provided, including:

- aligning with existing values, frameworks and plans
- defining chronic disease and identify priority chronic diseases
- implementing plans and measuring success. Refer to Appendix 3.

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[9] Health outcomes include improvements in quality of life, function, independence, equity mortality and morbidity. Source: Department of Health and Human Services (2003) *Measuring health promotion impacts: A guide to impact evaluation in integrated health promotion.*

What we heard: Central themes.

This section combines and summarises the emerging themes and findings from two aligned Latrobe chronic disease consultation reports.[10]

The issues and barrier themes identified in both reports were broadly consistent.[11]

Unless otherwise stated, opinions were shared by both consumers and service providers.

Current supports are generally well received

A significant proportion of community members indicated they were happy with their current services and managing their condition well (diabetes 58 per cent, osteoporosis 52 per cent, heart failure 45 per cent, arthritis 42 per cent, chronic obstructive pulmonary disease (COPD) 33 per cent).[12]

> “*The staff at Latrobe Community Health Service Moe have been very supportive and have given me great assistance with dealing with diabetes.*”
>
> - community member

Service providers said they have the knowledge and skill to provide excellent multi-disciplinary care and are pleased with their efforts to improve chronic disease care, including implementing care pathways, developing information and education resources and delivering client care plans.[13]

> “*We have been working closely with LCHS [Latrobe Community Health Service] to support patient transition following the intensive intervention of HIP [Health Independence Programs] to community-based programs, including developing a video for patients introducing community staff and programs.*”
>
> - Manager, Latrobe Regional Hospital

> “*We participated in the Australian Primary Care Collaboratives. We developed a systems model to identify patients with particular diseases. We became a lot more proactive – data cleansing, developing the right templates, ensuring we document patient goals, improving recalls etc. Little changes made a big difference for patients.*”
>
> - GP

> “*Thanks to the chronic pain management clinics attended at both Moe Community Health and LRH [Latrobe Regional Hospital] I have changed my attitude to pain and I’ve been able to get rid of all the pain medication my GP had me on for years, I really recommend both programs.*”
>
> - community member

> “*We have very committed staff who are working together to expand and provide more integrated care. We have expanded diabetes and respiratory programs and we are getting a lot more GP referrals and acute referrals to these services.*”
>
> - Manager, Latrobe Community Health Service

Improve access to primary and allied health clinicians, especially GPs, medical and psychological specialists

Health outcomes improve with better access to services.[14]

The low number of GPs, difficulty accessing GPs and medical clinics’ difficulties in recruiting and retaining GPs were identified as significant issues. There is a desire for:

- clients to be offered more appointments, especially with their preferred GP
- an increase in GP clinic opening hours
- longer GP appointments
- improved continuity of care, which has been lacking due to GP turnover
- strategies to retain a GP workforce, reduce local GPs frustration and time spent consistently training and orientating new GPs.

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[10] Central West Gippsland Primary Care Partnership in partnership with the Latrobe Health Assembly (2019) *op cit* and Larter Consulting (2020) *Latrobe Chronic Disease Workforce Consultation Report* (see Appendix 1 and 2 for overviews).

[11] All except for a need for more information and support; isolation and loneliness; the complexity of government and agency programs and funding mechanisms.

[12] Central West Gippsland Primary Care Partnership in partnership with the Latrobe Health Assembly (2019) *op cit*

[13] Larter Consulting (2020) *op cit*

[14] Healthypeople.gov (2020) Access to Health Services, Accessed on 18 April 2020 at: https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

"The workforce gap is medical practitioners who are highly experienced and willing to stay in town. If that happened, chronic disease management would improve a lot."

- GP

"Many of our clients don't have a regular GP because of the high turnover of GPs. Some of the GPs who have been around for a long time are not taking new patients and have long waits for appointment times for patients that they are seeing."

- Clinician, Latrobe Community Health Service

"Lack of monitoring and follow up from GPs due to lack of GP availability. [It's] not their fault, they are under-resourced."

- Pharmacist

The lack of timely access to local specialists and therefore the need to travel to Melbourne to see a specialist was highlighted by consumers and service providers. Increased access to the following specialist services was specifically mentioned:

- psychologists experienced in chronic disease management and respiratory services
- specialists, including rheumatologists, cardiologists, endocrinologists, orthopaedic surgeons and ear, nose and throat surgeons
- allied health community supports, for example self-management and psychosocial support.

Time constraints on GPs, specialists and clinicians was also raised, and service providers felt the lack of time meant they may not be meeting client needs.

"Specialists are limited in the Valley and there are not a lot of choices to find someone you are comfortable with or anyone for second opinions. There are also limited appointments and it's hard to work around work schedules."

- community member

"Our practice needs a care navigator who has time to understand and then use the health pathways, as well as understanding My Aged Care, NDIS [National Disability Insurance Scheme], Centrelink requirements, mental health reform… keeping track of these in the context of a heavy workload and making recommendations to patients in a consult is really difficult."

- GP

"It may be perceived that we are not interested [in what patients are saying]; in reality, we are time poor due to internal and external pressures."

- Occupational Therapist, Latrobe Regional Hospital

"Time constraints may create an environment in which there are less than ideal conditions for information exchange."

- Practitioner, Latrobe Community Health Service

"*Psychologists are all very busy – several weeks wait list. Clinical psychologists – there are plenty around but again, there are wait times… there are a couple of ENT [ear, nose and throat] surgeons, but we need more. The hospital is really getting better [in providing access to medical specialists].*"

- GP

"*Limited opening hours are the most difficult for me.*"

- community member

The services identified that could help meet client needs and reduce people's levels of anxiety, depression and isolation included:

- home care and home maintenance services - community members wanted more services, and providers wanted to be able to facilitate faster access to My Aged Care-funded services
- hydrotherapy classes and more infrastructure for hydrotherapy throughout the region
- community supports following rehabilitation, including peer-led programs
- service providers also specifically identified the need for more palliative care services for people with terminal illnesses other than cancer, and additional skilled mental health workers such as clinical psychologists and mental health occupational therapists.

However, whilst these were considered services that would be of benefit, challenges to implementing some of these were also raised. For example, providers said it was difficult to facilitate access to home care services due to bureaucratic requirements and paperwork.

"*Sick and tired of waiting for a pain management appointment.*"

- community member

"*Service delivery is very limited in Gippsland. Support for quarterly appointments at The Alfred would make life easier, particularly transport - over three hours each way, plus five to six hours at The Alfred make it a tough and tiring day.*"

- community member

"*[During rehabilitation] a lot of patients say 'why don't we have any support groups in the community for my condition?' They lack confidence and money to get community supports going…*"

- Latrobe Regional Hospital, Health Independence Program group consultation

"*Home Help is a life saver but one hour once a fortnight is not enough.*"

- community member

Improved communication needed

Consumers see a wide range of health services and professionals for their condition, in addition to their GP and specialists. All play a vital role in providing clear, effective communication regarding treatment options, the ongoing management of their condition and referral to other health professionals and services.[15]

Service providers indicated they had the necessary skills to manage chronic conditions within their scope of practice, but that internal and external processes were impacting on their ability to meet client needs. Clients were also looking for increased and improved communication.

Effective communication and providers' demonstrated compassion and interest in their patients were highlighted as significant issues. Both consumers and service providers desire:

- improved communication and information exchange between service providers and between service provider and client
- care pathways to support referral processes and transition of care between GPs and other service providers
- improved care coordination between GPs, specialists and other health professionals
- increased awareness of providers, professionals, services and programs across the regions, especially for mental health
- increased awareness regarding how to manage chronic health conditions and mental health issues in a coordinated and integrated way
- improved health services and providers responsiveness
- community members to feel heard by their GP and specialists
- service providers to demonstrate compassion and interest
- increased training and awareness raising about appropriate behaviour towards clients
- community members to receive adequate information about their condition and available treatments and resources
- GPs and specialists to facilitate referrals to other health professionals or services
- improved medication management through effective communication and client monitoring.

> "*I'd like health providers to get better training in face to face communication with patients. I'd like people who answer the telephone for appointments etc. to be pleasant and helpful and not rude and abrupt and treat callers as though they are ignorant or a nuisance. Whoever chooses the staff should be more aware of the personalities of who they are choosing. People with health conditions may be uncertain and worried and may need a little understanding and help. Be kind to us!*"
>
> - community member

> "*I'd like more attention and time from ALL providers – not enough information from health professionals which leaves me confused and afraid.*"
>
> - community member

> "*My GP is not helpful in referring or telling me about resources or help. It is hard to find out these things yourself.*"
>
> - community member

> "*Psychiatrists won't communicate with me about what they are doing. It can impact on chronic illness management because of the constant medication changes, and we rely on patients to tell us.*"
>
> - GP

> "*We don't have [consistent] pathways that transition clients between the hospital and community health.*"
>
> - Podiatrist, Latrobe Community Health Service

> "*Different organisations, different processes, different exit and entry points – mean people fall through the cracks and without an advocate for that person, things can go amiss.*"
>
> - Latrobe Regional Hospital, Health Independence Program group consultation

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[15] Larter Consulting (2020) *op cit.*

Affordable services needed

High costs and fees for services, particularly specialists, are impacting community members' ability to access supports for their chronic condition, health and wellbeing needs. There is a desire for:

- increased assistance to cover costs, for example with wound dressings and support stockings
- low-cost services, including for clients under the age of 65 with chronic disease
- more bulk-billing services.

> "*People are charged in the community. People can't afford it. They bounce back to us… re-present to ED [emergency department].*"
>
> - Latrobe Regional Hospital, Health Independence Program group consultation

> "*I have severe clinical depression and used to benefit from psychotherapy, medication and weekly visits to a mental health nurse. Because of Federal funding cuts, the visits to the mental health nurse ceased. They were very useful to keep me on track. If the depression deepens it's hard indeed to keep control of the diabetes because motivation to do blood tests, take medication, get exercise and eat properly disintegrates.*"
>
> - community member

Improve information and support provided to reduce isolation and loneliness and enhance self-management

GPs and other health professionals play a key role in providing information about chronic conditions and facilitating access to services. For many people, self-help support groups and peer and social networks are important ways to share and discuss information about their chronic health condition. If adequate and appropriate information is not provided it can lead to mismanagement of their chronic disease and impact on their level of anxiety, loneliness and isolation.[16]

Community members and service providers are open to a wide range of strategies to enable clients to self-manage their condition, including:

- improved information about chronic conditions, self-management and preventative health care strategies, covering topics such as:
    - taking prescribed medications or supplements
    - healthy diet, weight management and the impacts of smoking and drinking alcohol
    - flu vaccination
    - sleep management.
- increased awareness of the support services that already exist in the area
- improved information regarding other programs and initiatives, for example National Disability Insurance Scheme (NDIS) and My Aged Care
- increased support to facilitate seeing an allied health professional, for example, to falls and balance classes or to have an occupational therapy home assessment
- increased social activities and social inclusion, including support to see friends, attend groups and clubs and explore hobbies
- improved access to allied health services and alternative care, for example, physiotherapy, pilates, chiropractic, meditation, massage and dry needling
- increased exercise and physical activity, in groups or at home
- diverse range of information delivered in different ways and tailored to population demographics, for example, face-to-face, newsletters, email, social media or video chat.

> *"There needs to be information provided to many isolated elderly people in the region who are struggling with day to day activities and have no idea what services are available or how to apply for services."*
>
> \- community member

> *"...new GPs sometimes refer people to Melbourne when we have programs here at LRH."*
>
> \- Latrobe Regional Hospital, Health Independence Program group consultation

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[16] Central West Gippsland Primary Care Partnership in partnership with the Latrobe Health Assembly (2019) *op cit*

Provide chronic disease and disability-friendly local infrastructure

Poor community infrastructure and public transport impacts significantly on the ability of people with chronic illnesses, disabilities or limited mobility to access services. Consumers and service providers would like to see:

- better access to affordable public transport, which will reduce anxiety about how difficult it would be if they could not drive to attend services or afford a taxi, especially to specialist services only available outside their town
- increased, improved and well-maintained infrastructure and facilities, for example, an increase in availability and monitoring of disability parking, better footpaths and public seating.

"With our disability, the traffic lights change too quickly to cross safely."

- community member

"Transport by bus with a mobility scooter or walker is impossible. Therefore, I have to walk with a shopping trolley which causes pain and fatigue."

- community member

"Since I stopped driving it has been difficult. The bus to the shops doesn't take me back home and also finishes by 7pm, so I can't get things easily/cheaply."

- community member

"A lot of our patients don't want to go anywhere else because it is too costly and/or difficult to get to the service due to distance/poor mobility or transport issues."

- Chronic Disease Management Nurse, GP clinic

Simplify programs and funding mechanisms

The complexity of government and agency programs and funding mechanisms make it difficult for both providers and community members to access the care and support that they need.[17]

Feedback from the service provider consultations suggested that simplifying complex government and agency program processes, procedures and funding mechanisms would increase system and process efficiency and improve access to services. The following interventions would also reduce frustration experienced by service providers and members of the community:

- simplified processes for recruiting GPs from outside of Victoria
- introducing care pathway navigators
- reducing the administrative burden of having to use different referral forms and processes when using different funded programs
- increasing the time allowed for service providers to deliver care, whilst reducing time spent completing complex bureaucratic processes
- improving processes to support navigation of the service system and organisations.

"We are eligibility navigators with handcuffs! We just want to refer to someone that we trust. We have to jump through bureaucratic hurdles."

- GP, Latrobe Community Health Service

"[We need a] care pathway navigator. This is someone who understands My Aged Care, NDIS, Gippsland Health Pathways, community health intake… help us sort all these out for our patient CDM [chronic disease management] reviews… it's a bit like a travel agent."

- GP

"Disability parking needs to be monitored better by parking officers. Can't access disability parking when needing to."

- community member

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[17] Larter Consulting (2020) *op cit*

Towards improved health outcomes.

The findings of this report creates exciting opportunities for the community and key regional stakeholders to:

- create a shared and creative vision to meet the needs of people with chronic disease and their carers
- increase opportunity for community voices to be heard
- enable clients to be active partners in their care and have an increased awareness of, and control over, their wellbeing, their quality of life and disease management
- create more accessible, responsive, efficient and tailored services to meet diverse client and community needs, including people from marginalised backgrounds such as Aboriginal and Torres Strait Islander people and culturally and linguistically diverse people
- create systemic change through strengthened partnerships and collaborations
- improve service planning, design, delivery and evaluation approaches
- enable more efficient and effective use of services and improve pathways to meet community needs and make a client's journey easier
- enhance service quality, safety and consumer satisfaction.

Key considerations

It is recommended that stakeholders consider how best to align action arising from this report with the values and guiding principles of the Latrobe Health and Wellbeing Charter[18], including:

- the values of collaboration; integrity; innovation; access; equity and inclusion
- using a community-led approach and a co-design model to empower communities to shape their own future and enable sustainability and effective targeting of activities
- working with the Aboriginal and Torres Strait Islander community and those who are vulnerable and marginalised to improve the health, wellbeing and safety of communities
- trying new approaches, build on existing work and Australian and State government directions, utilise current organisation's resources and learn from mistakes
- being open, meeting commitments and sharing findings with community and stakeholders to ensure ongoing accountability, successes are built upon and any arising issues are addressed
- communicating in simple language[19]
- enabling everyone to achieve their full health and wellbeing potential by considering health inequality, the social model of health framework, social and economic circumstances, diverse population groups and settings
- strengthening partnerships and collaborations, particularly with GPs, to make a bigger impact on health outcomes across diverse sectors.[20]

Latrobe Chronic Disease Plan (or another name)

A Latrobe Chronic Disease Plan (or another name) developed in conjunction with community and stakeholders is suggested to provide a clear direction and enable people to come together and share responsibilities to implement sustainable actions based on the findings of this report.

Define chronic disease

Chronic disease is a broad term and can include multiple and varied diseases. It is suggested to clearly define chronic disease and identify priority chronic diseases to focus on, noting that:

- The Hazelwood Mine Fire Inquiry Report[21] stated cardiovascular, diabetes and respiratory diseases were high priority areas
- The Creative Community Consultations Workshops in Chronic Illness report focused on arthritis, COPD, diabetes heart failure and osteoporosis.

Potential actions

To assist with next steps, potential actions and measures of success that could be included in a plan are provided in Appendix 3.

The potential actions are based on the central themes identified and suggestions provided from community and service provider consultations.

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[18] State of Victoria (2020) Latrobe Health and Wellbeing Charter, Accessed on 20 July 2020 at: https://www2.health.vic.gov.au/about/health-strategies/latrobe-health-innovation-zone/latrobe-health-and-wellbeing-charter

[19] World Health Organisation (2020) Health Promotion, Accessed on 21 July 2020 at: http://www.who.int/healthpromotion/conferences/7gchp/track2/en/

[20] VicHealth (2000) VicHealth Partnerships Analysis Checklist and Tool, Accessed 21 July 2020 at: https://www.vichealth.vic.gov.au/media-and-resources/publications/the-partnerships-analysis-tool

[21] Inspector-General for Emergency Management (2017) Hazelwood Mine Inquiry Annual Report, p. 44 Accessed on 5 September 2020 at: https://www.vic.gov.au/hazelwood-mine-fire-inquiry-victorian-government-response-and-actions

Appendix 1.

Creative Community Consultation Workshops in Chronic Illness Summary of Final Report

The Creative Community Consultation Workshops in Chronic Illness project undertaken by Central West Gippsland Primary Care Partnership[22] was commissioned by the Latrobe Health Assembly in response to recommendations from the Hazelwood Mine Fire Inquiry Report to improve the health and wellbeing outcomes for residents of the Latrobe Valley.

The aims were to conduct community consultation and engagement with people living with a chronic illness in the Latrobe Valley to:

- understand their current service knowledge, usage, and access barriers
- identify ways in which service providers can improve their services to enhance quality of life of people living with a chronic illness.

After consultations with local health professionals, Department for Health and Human Services, Latrobe Health Assembly and the Latrobe Health Advocate, the following five conditions were selected for inclusion in the project:

- arthritis
- chronic obstructive pulmonary disease (COPD)
- diabetes
- heart failure
- osteoporosis.

Consultation and engagement activities were undertaken between 15 May and 15 October 2019, with a focus on the towns of Moe, Morwell, Churchill and Traralgon.

The project included:

- engaging agencies providing services to people with chronic illnesses in the Latrobe Valley
- recruiting and up-skilling of volunteer ‘peer facilitators’ to conduct face-to-face conversations with community members regarding their experiences of living with a chronic illness
- community engagement and consultation by various methods including:
  - a public launch event and theatrical production including a Q&A session with a panel and audience discussion about chronic illness
  - engagement and project promotion via social media, print media and online
  - town-based conversations in the four major Latrobe Valley towns
  - conversations at pharmacies and GP clinics within the City of Latrobe
  - conversations at community members’ locations of choice, such as in a café at a time that suited them.
- data analysis and reporting.

A total of 302 community members were engaged, either through a face-to-face conversation with a peer facilitator or completing a hard-copy or online survey.

At the conclusion of the consultation period, the data was collated and thematically analysed. Individual results were generated for each of the five chronic conditions as well as common results across all five conditions.

Scope and results

The scope of the consultation incorporated:

- initial diagnosis – including method and length of time since diagnosis
- ongoing care – including variety of health professionals seen, location of health services and frequency of visits
- effectiveness of current supports - how well those supports are working and why, factors making it harder to manage, what would make it easier to manage
- self-management of the condition – current strategies to make life easier, methods of managing the condition
- preferred methods for service providers to provide infoation and support regarding the chronic illness.

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[22] The Central West Gippsland Primary Care Partnership (CWGPCP) is an established network of 23 local health human service organisations (health, welfare, disability, local government, mental health), across the local government areas of Baw Baw Shire and Latrobe City. Working together, we aim to find smarter ways to make the health system work better so it improves the health of our communities. The CWGPCP strategy is funded by the Victorian Government to improve the health and wellbeing of community members by strengthening relationships between primary care providers across a catchment area so they are able to implement improved system integration, prevention planning and joint programs. As one of 28 Primary Care Partnerships across Victoria, CWGPCP has worked at a local level for 18 years bringing health and human service organisations together to find new ways of collaborating, to plan for the health needs of their communities and to create robust partnerships that deliver better health outcomes for the unique communities across Gippsland.

From the 302 responses, 1,184 comments were analysed and themed. Common themes across all of the conditions fell into five broad categories:

- shortage of GPs and specialists; difficulty getting appointments; continuity of care
- communication with and between GPs, specialists, other health professionals and services
- access to, cost or availability of support, services, equipment or transport
- need for more information and support, and isolation and loneliness
- need for more disability-friendly local infrastructure.

Comments and suggestions

Comments and suggestions made by community members are categorised by theme below.

1. GP and specialist shortages, access and accessibility and continuity of care
   - more GPs, better access to GPs, shorter wait for GP appointments
   - less GP turnover, better continuity of care
   - more time with GPs
   - more specialists and specialist services (diabetes specialists, endocrinologists, cardiologists, rheumatologists, psychologists experienced in chronic disease management, respiratory services)
   - more after-hours appointments
   - support with home care and/or home maintenance
   - better access to and/or more frequent exercise classes
   - better access to hydrotherapy
   - access to portable alarms.
2. Communications
   - more compassion and interest from their GP or other health professional
   - improve lack of communication between GPs and specialists
   - more GP support with referrals to other services and organisations
   - better service provider responsiveness
   - medication management issues.
3. Access to affordable services
   - reduced costs or access to financial support for services
   - reduced costs or access to financial support for equipment
   - financial support for medication, such as with a health care card.
4. Information
   - more information about their condition
   - more information about services to help self-manage their condition.
5. Infrastructure and transport
   - bus stop at Latrobe Regional Hospital should be closer to the hospital entrance door
   - more disabled parking spots in towns and better monitoring of these spots
   - more seats in town
   - footpaths and pedestrian crossings improved and more disability friendly
   - disability friendly public transport
   - better access to and assistance with transport.

Videos

Two videos from the project have been published:

Click here for full version
https://bit.ly/LivingWell-Long

Click here for short version
https://bit.ly/LivingWell-Short

Appendix 2.

Latrobe Chronic Disease Workforce Consultation 2020, Summary of Final Report

Larter Consulting was commissioned by the Gippsland Primary Health Network to undertake a project involving consultation with health sector stakeholders in the Latrobe Valley.

The project goal was to present a report to the Department of Health and Human Services and the Latrobe Health Assembly that recommends how care pathways and processes could be changed to improve the coordination of care for people with chronic disease in the City of Latrobe.

The project objectives were to:

1. Identify local and state-wide providers and experts in chronic disease management.
2. Facilitate conversations with the identified providers and experts to:
    a. understand the current chronic disease care pathways in Latrobe including enablers and barriers, shortfalls and gaps
    b. identify chronic disease service provision capacity and capability across Latrobe
    c. explore the design and steps to develop modified and or new chronic disease care pathways, if required.
3. Undertake joint report writing with the Central West Gippsland Primary Care Partnership (CWGPCP) and present the project's findings to the Department of Health and Human Services and Latrobe Health Assembly for consideration.

The report presented findings in relation to project objectives 1 and 2 only.[23]

96 individual stakeholders were consulted, from public health organisations, general practices, pharmacies, peak industry bodies, the CWGPCP and chronic disease project officers/managers within other Victorian Primary Health Networks.

The stakeholder consultation project was undertaken in four phases:

1. Project initiation
2. Stakeholder consultation – obtain input from local providers and expert groups using a range of strategies
3. Analysis and reporting – collate and review data collected to identify key themes
4. Provide written report outlining key findings and recommendations.

Larter Consulting worked with Latrobe Chronic Disease Forum Advisory Group members to:

- clarify the project objectives, scope and methodology
- identify local and state-wide providers and experts of chronic disease management to be consulted
- design consultation questions and prompts to guide consultations.

Following direction from the advisory group, the project started with a focus on care pathways and evolved to a consultation process more broadly on the quality of chronic illness care coordination.

All stakeholders were asked: "How confident do you feel that you are able to provide care that meets the needs of your clients'/patients' that have one or more chronic illnesses?"

Factors that were reported as supporting good chronic disease care included practitioners' knowledge and skills, dedicated staff, multidisciplinary teams and dedicated roles, programs and care plans for chronic care.

In general respondents indicated that they had the necessary skills to manage chronic conditions within their scope of practice, but that internal and external systemic issues were impacting on their ability to meet client needs. The barriers were:

- time constraints linked to workforce shortages
- discontinuity of care due to GP workforce turnover was also identified
- issues with timely access to services, particularly specialist medical services and community supports for both self-management and psychosocial support
- difficulties in information exchange between agencies for people accessing a range of services
- cost and travel barriers
- the complexity of government and agency programs and funding mechanisms.

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[23] The outcome of objective 3 of the Latrobe Chronic Disease Workshop Project is this report, Listening to Latrobe: Towards improved health outcomes for people living with chronic disease.

Comments and solutions

Though it was not an aim of the project to seek solutions, some solutions were included. Stakeholders emphasised the need to build on existing programs and processes to improve care and the importance of involving the community in identifying solutions to the issues that they see as having the greatest impact on their capacity to manage their conditions.

The main solutions suggested by local stakeholders were:

- Invest in 'care navigators' that could assist either clinicians or patients to navigate the complexity of health programs and systems. These navigators would be responsible for keeping abreast of the services and programs available locally, skills in helping clinicians and patients make choices and skills in efficiently meeting programs' bureaucratic needs such as confirming eligibility and processing paperwork. Examples elsewhere include nurse navigators in Queensland's public health sector and the aged care navigator specialist support workers being piloted through the Council of the Ageing.
- Invest in community (peer-led) support groups particularly following a diagnosis or hospital rehabilitation and health education in community settings where people who are ill will see it, such as plazas, schools, homes (television).
- Have a more strategic approach to care pathways – care delivered or coordinated from chronic disease management hubs or centres so that people do not have to travel between sites and so that clinicians are more easily able to understand what is available. This might involve capital works and providing incentives to encourage providers to work together at larger campuses. Examples of similar efforts include the Australian Government providing general practice incentives to amalgamate in the early 2000s, the Commonwealth GP Super Clinic Programme and capital works investment for community health services.
- Advocacy and additional recruitment and retention support to build a more stable GP workforce.
- Promote the more extensive use of My Health Record to support timely sharing of important information between multiple agencies.
- A catchment-wide, strategic interagency chronic disease management plan with additional accountability for chronic illness care across Latrobe, and regional forums.
- Improve access to specialist services by addressing transport and cost barriers through telehealth, outreach and after-hours services.

Larter also spoke to peak bodies and Primary Health Networks (including Gippsland) who suggested:

- supporting general practice nurses to work to their full scope of practice, such as by funding Nurse Clinics (specialist primary care clinics with a nurse lead)
- establishing 'communities of practice' that local health services can attend to discuss implementing change and quality improvement
- funding and promoting innovative software such as Nellie, an automated SMS-based persona that promotes patient self-care
- building more localised health pathways, including for mental health care, due to the complexities of Commonwealth, State and Primary Health Network stepped-care systems
- mandating e-referral to hospital – not accepting fax.

Appendix 3.

Potential actions for a Latrobe chronic disease plan

To assist next steps and the potential development of a plan, actions and their measures of success are provided for consideration.

The potential actions are based on the central themes identified following the review of the two aligned reports and suggestions provided from community and service provider consultations. The measures of success can be further refined once the actions are agreed.

Governance and project management

A united governance and leadership group can facilitate effective working relationships and ensure quality, integrated strategies are successfully implemented, especially when working across organisations and jurisdictions and their differing systems and processes. It could simplify policies and processes and improve efficiency of the chronic disease system. The governance group could also demonstrate leadership by advocating for change to improve health outcomes and meet community needs and expectations.

Experienced project management and coordination, that is appropriately resourced, is also required to provide oversight and ensure activities remain on track.

Potential actions are provided below.

	Measures of success	
Potential actions	Outputs	Outcomes
1. Hold community forums and/or individual meetings with community groups to discuss findings of the report and next steps, including with the Aboriginal and Torres Strait Islander community. 2. Confirm LHA Board as the governance group. Consider: – confirming LHA as project manager or independently commission a project manager – engagement with GPs, as crucial partners – confirming or identifying additional partner organisations and their willingness to work together – purpose and nature of the governance group and desired partnership, for example, partnerships in health promotion may range on a continuum from networking through to collaboration[24] – establishing links with advisors, for example from Heart Foundation, Diabetes Victoria. 3. Hold a chronic disease forum/s involving both local and state-wide providers and experts and consult with stakeholders to: – identify existing or previous chronic disease projects and to reflect on past successes and learnings – discuss a way forward and actions. 4. Develop a chronic disease plan. Consider: – engaging an external facilitator – vision, objectives, outcomes, projects, resource allocations, responsibilities (utilising existing staff where possible and the best placed organisation to take the allocated actions forward), timelines, achievable KPIs – building on existing work and Commonwealth and State policy directions – alignment with partners work including other LHIZ work (for example social prescribing), GPHN, CWGPCP, Latrobe City Council, Latrobe Health Advocate, LCHS and LRH – alignment with any existing disease specific plans. 5. Confirm and enable adequate staffing and resourcing.	• Community engagement was effective. • GPs participate and contribute at governance group. • Organisations commit to LHIZ Charter and/or sign a governance group Memorandum of Understanding, if required. • Senior governance group representatives are active participants. • The chronic disease plan outlines the vision, purpose and desired outcomes. • A project manager is appointed to support governance group leadership and activities. • Strategies and activities developed are evidence based. • Formal feedback and acknowledgement systems are established for those undertaking programs and activities. • Dissemination strategies are implemented to communicate the governance group successes. • Senior advocates are identified within the governance group. • Access to appropriate expertise and allocation of resources is provided when required, for example resourcing of research and evaluation. • Organisation resources are combined or pooled to undertake projects or programs.	• Increased community engagement and feeling of empowerment. • Successful annual governance group review, including critical feedback and implementation of recommended improvements. • Successful project management, including meeting key performance indicators and implementing agreed actions. • Findings from monitoring and evaluation is contributing to continual improvement. • Feedback is appropriately managed and responded to, and proportion of positive feedback is increasing over time. • Ongoing resources and funding secured.

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[24] *ibid.*

Access to services

Access to comprehensive, quality health care services can improve peoples' overall physical, social and mental health status and quality of life. Having a preferred service provider is especially important for clients as it can assist in the development of trust, improved communication and delivery of appropriate care. Enhancing timely access to services may also decrease client and provider stress, reduce the number or severity of clients' complications, reduce the cost of service delivery, and reduce preventable hospitalisations.

	Measures of success	
Potential actions	Outputs	Outcomes
1. LHA to meet with GPHN, GPs, Latrobe Advocate, Latrobe Valley Authority and others as identified, to discuss: – GP engagement and participation at governance group – issues and solutions required, including but not limited to: o GP and specialist recruitment and retention o better utilisation of Medicare Benefits Schedule items to support chronic illness management to enhance care o increasing awareness of funding available to enable chronic disease management guidelines and processes to be followed, for example telehealth o improving effective communication practices with clients o improving effective working relationships between GPs, specialists and service providers o opportunities to work with the Australian Primary Health Care Nurses Association to support general practice nurses o resources available to support GPs, for example, Health pathways or Guidelines for preventive activities in general practice.[25] 2. Undertake a chronic disease services project that includes: – collating a list of services required to meet community needs and seek service funding – undertaking financial analysis and modelling for organisations interested in providing after hours care to increase number of programs, for example exercise classes – drafting funding submissions and proposals seeking investment in services and programs, in particular, hydrotherapy pools, community (peer-led) support groups and health education programs in community settings. 3. Pilot a mobile clinic to provide primary care services and preventive care services from a van, truck, or bus equipped with all the necessary technology. 4. Pilot a walk-in clinic for minor health needs with clear triage protocols at a GP clinic, shopping centre or pharmacy, with services by skilled nurses. 5. Investigate logistics to establish virtual chronic disease management hubs[26] to reduce travel to different services and increase awareness of available services.	• GP and specialist recruitment and retention strategies implemented. • Reporting systems are implemented to accurately track roles and time taken to respond to referrals or service requests. • Tools and models, such as cost-benefit analyses, are used to inform decision making on resource allocation.	• Increase in GPs and specialist services provided. • Clients report agreed timing for referral and assessment are achieved. • Increase in number of clients participating in and attending targeted services and programs. • Clients report that health education activities are relevant, interesting and easy to access. • Improved skill and knowledge of health professionals, resulting from resources and training provided.

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25 The Royal Australian College of General Practitioners (2020) *Guidelines for preventive activities in general practice*, Accessed on 23 July 2020 at: https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/red-book

26 A virtual hub is a nonphysical centre or network that connects independent chronic disease services and programs. It may be coordinated and accessed remotely.

Coordination of care

Care coordination can improve communication, collaboration and integration between hospital and community-based services.[27] Effective and efficient coordination of care enables improved health outcomes, safer delivery of care, and reduction in health care costs.

	Measures of success	
Potential actions	Outputs	Outcomes
1. Undertake a catchment-wide, strategic project to develop a comprehensive inter-agency chronic disease model, that builds on current work and includes: – referral criteria and processes, such as e-referral – chronic disease specific care plan templates and pathways – information and resources – a 'no wrong door' approach, that includes the development of 'scripts' for receptionists to use at each organisation – communication mechanisms and response timeframes, including utilisation of telehealth and access to Nellie, an automated SMS-based persona for promoting patient self-care – client management records and information sharing systems, for example increased utilisation of My Health Record by community members and clinicians – linking to related projects, such as: o social prescribing project o alignment with any existing disease specific projects o remote patient monitoring project. 2. Establish a community of practice or regional forum to review newly established processes and facilitate communication and accountability. Offer CPD points, such as with the Royal Australian College of General Practitioners (RACGP). 3. Upskill and train health professionals in care coordination practices. 4. Explore investment required for 'care navigators' for specific chronic diseases, to assist clinicians or patients to navigate the service systems and to be an ongoing contact for clients, including by phone, after hours, teleconference. 5. Build on and integrate with current programs that work with people who have chronic conditions and complex care needs, for example, the Health Independence Program.	• Systems are developed to support service and organisational commitment to the chronic disease model. • Increase in the number of staff and organisations participating in the regional workshops and forum. • Care coordinator roles established to support clients and clinicians.	• Increase in clients' knowledge in risk factors for their chronic disease. • Increase in clinicians' knowledge of risk factors and self-management strategies for chronic diseases. • Increase in clients and service providers taking responsibility to adhere to the chronic disease model.

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[27] Health.Vic (2020), Care Coordination, Accessed on 18 April 2020 at: https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/health-independence-program/care-coordination

Purpose-driven communications

Social marketing and appropriately targeted health information can change and influence the behaviours of targeted audiences. It can also raise public awareness about a health issue, shift attitudes and change lifelong habits, values or behaviours.[28]

Organisations often need assistance and resources to implement communication and marketing strategies to increase awareness of and promote their services. If implemented well they can be used to enable community members to take responsibility for their care and actively identify challenges and solve problems associated with their illness which ultimately leads to better quality of life and improved health outcomes. Communications written in easy and simple language will ensure people are empowered and effectively able to access, understand, evaluate and use health-related information and services.[29]

	Measures of success	
Potential actions	Outputs	Outcomes
1. Develop a communications and marketing plan that builds on existing work[30] and includes: – strategic and measurable outputs and outcomes based on health prevention and promotion goals and audience profiling – a self-management communication toolkit for community and service providers that includes: o overview of the chronic disease model o services and programs available and referral requirements o simple English and translated resources, that meet accessibility requirements – diverse use of distribution channels, as appropriate to the audience, such as websites, social media, videos and printed pamphlets and flyers – advertising and promotional material, including targeted campaigns on key issues, for example, the use of Medicare Benefit Schedule items.	• Health information and evidence-based resources are available and accessible in a range of formats. • Increase in types of media used to produce health information, including use of interactive technologies via the internet. • Access to information, tools, data and internet is negotiated and share through governance group agencies. • Information is disseminated across networks and to other partners so they become engaged in chronic disease activities.	• Health information has improved people's understanding about the causes of chronic disease and services available to maintain or improve health.

Tools to manage service costs

Cost can prevent people from accessing health goods and services, particularly people who are vulnerable or disadvantaged. Clients need to be given information that they can understand and tools that assist them to make choices about accessing services that may come with a personal financial cost. They also need to understand how to access the range of federal and state schemes that may help to cover the cost of health goods and services.

	Measures of success	
Potential actions	Outputs	Outcomes
1. Undertake a service cost assistance project to: – link clients to more health and service information to take control of their care – provide clients access to financial support for services, including medications and equipment and to plan ahead.	• Targeted information developed and disseminated to different socio-economic groups. • Resources are appropriately and transparently allocated to chronic disease programs.	• Clients report an increase in understanding of how to appropriately manage service costs and access financial support.

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[28] Department of Health and Human Services (2003) Integrated health promotion: A practice guide for service providers, page 47

[29] Australian Commission on Safety and Quality in Health Care, National Statement on Health Literacy: Taking actions to improve safety and quality

[30] For example, a significant amount of work has been undertaken by the CWGPCP which can easily be accessed and utilised, including the Gippsland Guide to becoming a Health Literate Organisation. The Guide provides tools and resources to support organisations to become more health literate. Go to: Central West Gippsland Primary Care Partnership (2020) Health Literacy, Accessed on 21 July 2020 at: https://www.centralwestgippslandpcp.com/projects/health-literacy

Public infrastructure and transport

Improved infrastructure, particularly public transport, seating and walkways, enables community members to feel supported and empowered, remain independent and access services to support the management of their chronic health condition.

	Measures of success	
Potential actions	Outputs	Outcomes
1. Submit a request to relocate the Latrobe Regional Hospital bus stop closer to the hospital entrance door by contacting Public Transport Victoria. 2. Seek a commitment from local government to: – increase number of disability parking spots – increase number of park benches – maintain pedestrian pathways and crossings. 3. Establish and/or undertake a review of volunteer driver program, to assist with transporting clients to appointments or shopping.	• Requests for relocating and upgrading infrastructure successful. • Volunteer driver program enhanced to better meet community need.	• Number of community members using volunteer driver program. • Community members report improvement in public transportation access.

Advocacy and political engagement

The sustainable delivery of appropriate support to community members living with chronic disease requires political and policy support and, in some instances, systemic change.

	Measures of success	
Potential actions	Outputs	Outcomes
1. Develop and implement a political engagement and advocacy strategy that is led by the governance group to support the implementation of its work. This could include Victorian and Australian Government engagement on: – funding and resourcing to improve service availability and access in Latrobe – simplifying complex government program processes – infrastructure improvements, reduction in restrictions and increased enforcements of disability access.	• Advocacy strategy with clear outcomes, goals, target audience, messaging and timeline is in operation.	• Measured increase in target audience engagement. • Policy and practice changes, as related to advocacy goals.

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