Latrobe Chronic Disease Action Plan 2022 – 2027

November 2022

CONTENTS

Introduction and background 3

Action Plan development and structure 7

Actions

Early detection and intervention 10

Self-management 16

Community-based treatment and care 21

Moving Forward 26

References and appendices 28

Disclaimer

This report contains amended details from the Latrobe Chronic Disease Action Plan which was originally developed in 2019. These changes reflect the evolving nature of the plan and changing environment surrounding chronic disease in the Latrobe Valley, as well as being responsive to changes and reforms occurring at a statewide and federal level. Actions within this report marked with * have been amended from the original plan.

Introduction

Purpose

The Latrobe community is engaged and invested in the health and wellbeing of its people. Significant events over recent years have impacted the health and social outcomes of the community, however, there remains a determination and desire to improve the health experience for individuals, in particular those with chronic disease.

Local health services together with community representatives in Latrobe have worked together to develop this action plan. The plan itself seeks to bring people together to take action on areas that will improve the experience of chronic disease in Latrobe over the next five years (2022-2027). It builds on existing successes and considers new ways of working when needed.

The plan itself is one component of work being undertaken across Latrobe. Initiatives in other sectors (e.g. education, transport and social services) will be delivered in parallel, and also aspire to improve health and wellbeing outcomes for the Latrobe community.

The Vision

To understand the vision for the Action Plan, we invited key stakeholders across Latrobe to tell us what the future of Latrobe should be like for people with chronic disease.

The vision of the 2022-2027 Chronic Disease Action Plan is:

> **“To create an inclusive and integrated service network for all people with chronic disease. The voice of the individual or carer is heard, and they can access what they need at the right time to live a healthy and fulfilling life in Latrobe”**

Terminology

In this Action Plan, the term ‘chronic disease’ is used. This is in line with the Australian Institute of Health and Welfare (AIHW) National Strategic Framework 2017[1], which acknowledges the use of the terms ‘chronic conditions’, ‘non-communicable diseases’ and ‘chronic diseases’ as a broad range of chronic and complex health conditions across the spectrum of illness, including mental illness, trauma, disability and genetic disorders. This broad definition is intended to move the focus away from a disease-specific approach and is adopted as a definition for this Action Plan[1].

The terms ‘person’, ‘people’, ‘consumers’ or ‘individual’ are used to refer to people at risk of developing/or with one or more chronic diseases.

Providers of services are referred to as ‘practitioners’ to encompass all disciplines, specialties and clinicians from all types of services.

‘Latrobe’ refers to the Victorian local government area of Latrobe City on which this action plan is focused.

Audience and role of the Action Plan

The Action Plan provides a roadmap for the Latrobe community, stakeholder organisations, private providers, industry and groups that advocate and offer care and education for people with chronic disease and their carers and families. The plan offers both achievable and ambitious actions to drive improvements in Latrobe.

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Living with chronic disease in Latrobe

Steps have been taken to improve the experience of living with chronic disease in Latrobe, but there is more to be done. The proportion of people with chronic disease is above the Victorian state average. This creates challenges for the local service system where demand exceeds the available support.

Many factors are currently contributing to the over-representation of chronic disease. They occur across three levels:

Individual

People living in Latrobe are typically older and the prevalence of risk factors for chronic disease, including behaviours that are commonly associated with chronic diseases, impact the communities' health and wellbeing. These include smoking tobacco, eating a poor diet and physical inactivity. Supporting people with or at risk of developing chronic disease is extremely important for their health in the long term.

Community

A healthy community is supported by access to health care, recreation opportunities, transportation, family and environments that encourage people to live healthy lives. These factors enable individuals to understand, engage and use services that will support their health in the long term in Latrobe.

Service

Health service availability in Latrobe is a known challenge due to a range of physical access and capacity issues within the local area. Specialist medical services, in particular, have significant waiting periods and, for many people, the metropolitan and/or private services they may be offered are not accessible. Enabling collective impact across the health system in Latrobe is key in improving the experience for the community.

Across all three levels there is a complex interplay between the social determinants of health such as education, economic stability, housing, and job security. While some actions in this document will address these indirectly, there is widespread commitment in Latrobe to improve the social determinants through a range of initiatives.

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A snapshot of chronic disease in Latrobe

77, 318
people live in Latrobe LGA (2021)

26 general practices
across the Local Government Area of Latrobe City[2]

For every 100 people in Latrobe, **26 experience very high disadvantage** which significantly impacts their health and wellbeing[3]

1,212
Potentially preventable hospitalisations in one year in Latrobe[3]

1 in 4 people in Latrobe is aged 65 years or older[5]

Aboriginal people are **Twice** as likely to have a hospital admission or emergency department presentation than a non-Aboriginal person in Latrobe[5]

33.5%
of people in Latrobe are living with two or more chronic diseases[6]

14.1%
of persons in Latrobe are providing assistance to persons with a disability (i.e. carers)[7]

22%
of adults in Latrobe are current smokers[6]

11%
of all deaths in Latrobe is from Coronary heart disease, which is the areas leading cause of death[8]

36%
of adults in Latrobe have a diagnosis of anxiety or depression[6]

38%
of adults in Latrobe are insufficiently physically active[6]

43%
of respondents reported problems accessing a GP during business hours in the past 12 months[2]

54%
of people living in Latrobe are overweight[6]

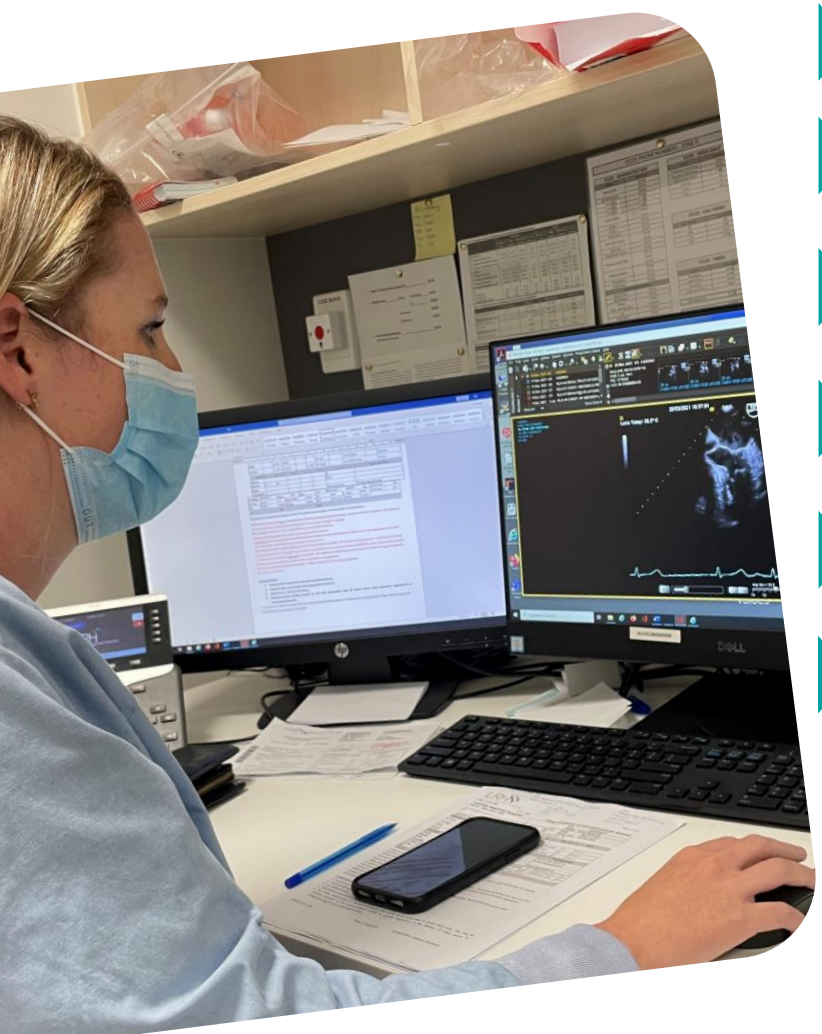
64%
of adults in Latrobe are at an increased lifetime risk of alcohol-related harm[6]

Taking coordinated action in Latrobe

This Action Plan complements existing work from federal, state and local governments, as well as local health and other services, where chronic disease is a priority.

Locally, the 2014 Hazelwood Mine Fire Inquiry [9] initiated work to develop improved coordination pathways for people with chronic disease in Latrobe. Since that time, other key milestones have included the establishment of the Latrobe Health Innovation Zone in 2016, community consultations on chronic disease (2018-2019) [10] and the 2020 Listening to Latrobe Report [11].

To build on this work, the Latrobe Chronic Disease Action Plan has been designed to promote a coordinated, whole-of-system approach to bring the relevant stakeholders and initiatives together.



This Action Plan considers and seeks to align with policies and plans at a local, state and national level including:

- Australian Health Ministers Advisory Council- National Strategic Framework for Chronic Conditions 2017[1]
- Central West Gippsland Primary Care Partnership- Creative Community Consultation Workshops in Chronic Illness 2019
- Latrobe City Council- Latrobe City Council Disability Action Plan 2018-2021
- Latrobe City Council- Living Well Latrobe- Our community's Municipal Public Health and Wellbeing Plan 2022-2025
- Latrobe Community Health Service - Focussed on the Future - Strategic Plan 2022-2027
- Latrobe Health Advocate- Improving access to services in Latrobe 2021
- Latrobe Health Advocate- Engagement Inspiration from People Living with Chronic Conditions in Latrobe 2020
- Latrobe Health Assembly- Strategic Plan 2020-2025
- Latrobe Regional Hospital - Strategic Plan 2020-2024 Latrobe Regional Hospital
- PHN Gippsland- Gippsland PHN Priorities 2022-25
- PHN Gippsland- Latrobe Chronic Disease Workforce Consultation Report February 2020
- The Victorian public health and wellbeing plan 2019-2023

Developing the Plan

The Action Plan has been developed together with key stakeholders representing consumers and carers as well as health and community services within Latrobe. It has sought to validate the ongoing relevance of the *Listening to Latrobe*[11] themes since the onset of the COVID-19 pandemic, and to confirm priority areas for focus in the Action Plan.

Between June and August 2022, stakeholders were engaged in a series of consultations, community forums and workshops to collaboratively design the Latrobe Chronic Disease Action Plan.

When describing the actions in subsequent pages, we use acronyms for each agency which are shown below.

Consumers and carers

Department of Families, Fairness and Housing (DFFH)

Department of Health (DH)

Gippsland PHN (Gippsland PHN)

Latrobe Community Health Service (LCHS)

Latrobe City Council (LCC)

Latrobe Health Advocate (Advocate)

Latrobe Health Assembly (LHA)

Latrobe Regional Hospital (LRH), including Gippsland Regional Public Health Unit (GRPHU)

Ramahyuck District Aboriginal Corporation

The design of the Action Plan occurred iteratively and with the active and engaged support of both community and practitioner representatives. The time and input by workshop participants is acknowledged and has enabled a robust and consumer-centred approach to be applied to the development process.

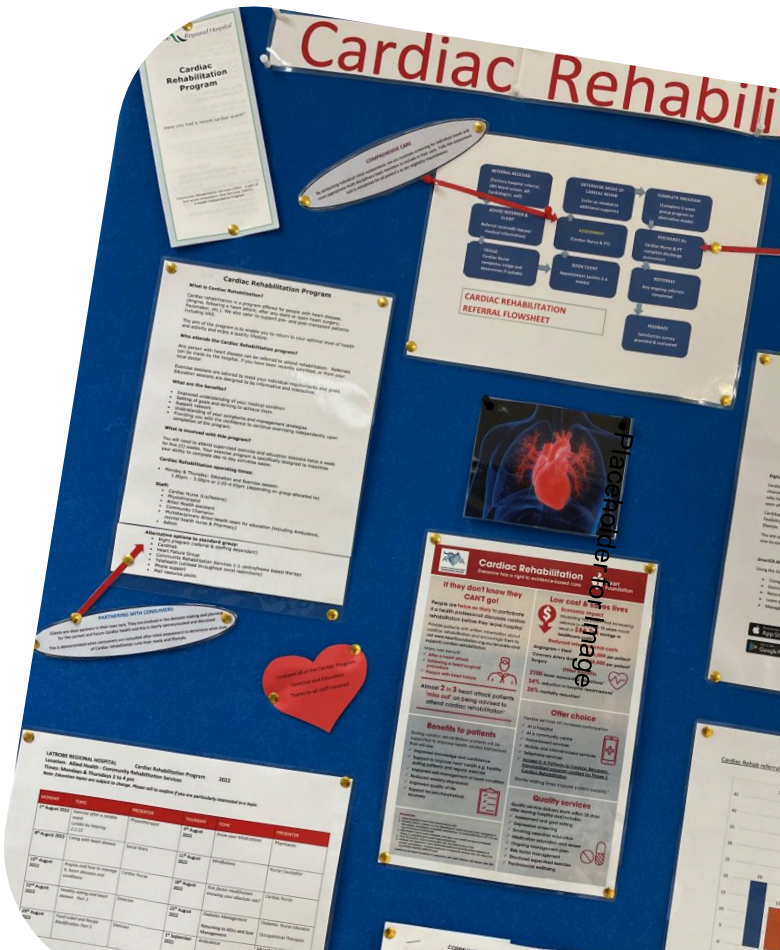
In the time between workshops, stakeholders supported the testing and validation of emerging action areas within their organisations to broaden feedback and engagement with the Action Plan overall.

Together with the Latrobe Health Assembly (LHA), the Gippsland PHN (Gippsland PHN), Latrobe Community Health Service (LCHS) and Latrobe Regional Hospital (LRH) have taken a leading role in endorsing this plan, and collectively committing to implementation.

Furthermore, this plan has been endorsed by local people, professionals and leaders across the health system in Latrobe.

The delivery of actions under this Action Plan will be actively monitored by LHA. Further detail regarding implementation and future steps are detailed on page 26 - Moving forward.

The plan recognises that responses to chronic disease can be conceptualised as a continuum from prevention, early detection and through different levels of care. This is described on the next page and is the lens through which the delivery of actions should be interpreted.



Chronic disease continuum of care

The Action Plan has been structured around the chronic disease continuum of care. The plan recognises that responses to chronic disease can be conceptualised as a continuum through different levels of treatment and care. Throughout their life, a person may move between phases and require different supports to meet their needs. Their pathway through these phases and subsequent experience of chronic disease is a complex interplay of medical and social determinants of health such as education, access to healthcare, economic stability, housing, and job security.

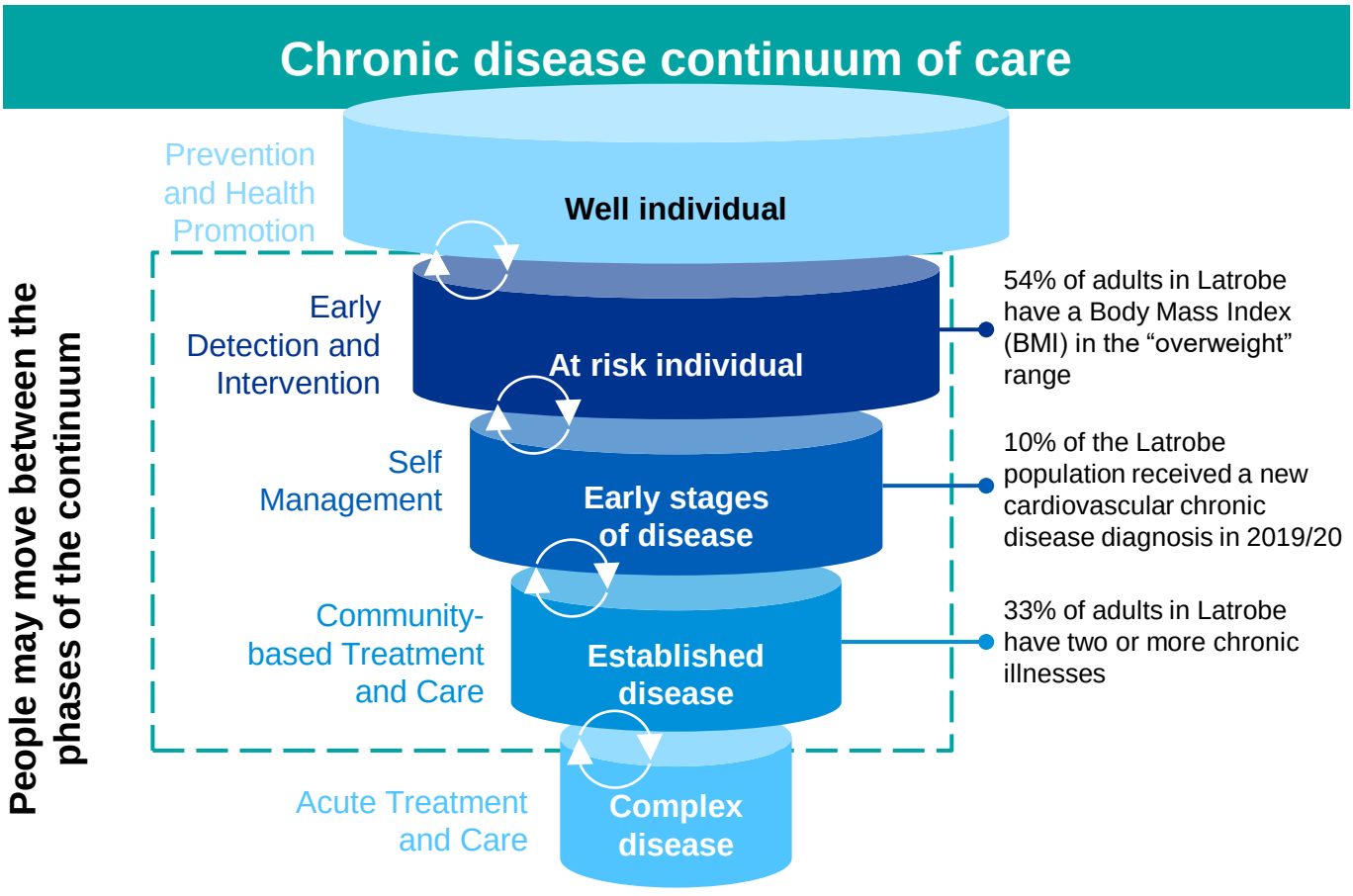
At the beginning of the continuum, there is an active focus on prevention and health promotion for all people. This is essential for supporting communities to stay happy and healthy. The *2022-25 Living Well Latrobe - Community Municipal Public Health & Wellbeing Plan* [12] has a strategic objective focused on community health and disease prevention initiatives. With this focus, prevention and health promotion activities within Latrobe are underway.

Some people are at higher risk of developing chronic disease and systems are needed to monitor and detect onset. This allows intervention and for any existing risk factors to be managed or reduced where possible. Once disease has been diagnosed, individuals move into a self-management phase of the continuum. This is where an individual takes ownership of navigating the medical, social and emotional impacts of chronic disease in their daily lives.

For some people, their care needs may escalate in acuity or in complexity. This may be due to physical health or other social factors impacting their access to care. Ongoing and active engagement with community based services to receive treatment and care becomes necessary support for some people. This phase aims to prevent or delay the worsening of disease, and ensure best practice care and management is provided in the community whilst maintaining the quality of life for people thus reducing the likelihood of more intensive acute healthcare intervention.

Acute treatment and care occurs where the management of chronic disease requires a further escalation in care. This care type, and part of the continuum, is an essential priority for Latrobe Regional Hospital and, as such, it is identified in its *2020-2024 Strategic Plan*. [13] This end of the continuum is well-resourced from the perspective of chronic disease management and, for most individuals, does not represent an ongoing care component.

With initiatives underway in the prevention and promotion space, as well as existing investment in the acute phase of care, the middle three stages of the continuum were the identified priorities for coordinated action in this plan. The Action Plan will therefore seek to enhance the early detection and identification, self-management and community-based treatment and care phases of the chronic disease continuum of care.



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Action Plan principles and structure

The principles focus this Action Plan on what matters. The principles were collaboratively designed with key stakeholders across the region and assisted in highlighting Latrobe's strengths and priorities for the next five years. They were used to shape the actions detailed in the Action Plan, encouraging achievable and ambitious activity for chronic disease in Latrobe. These principles should be front of mind for the implementation of the Action Plan itself.

Consumer at the centre

Ensure the consumer's voice is at the heart of the work

Latrobe focused

Prioritise local solutions where possible

Sustainable and feasible

Seek to create change that can be sustained and evaluated for progress

Accessibility

Enable service access at the right time, in the right place, with the right people

Education and communication

Share information in a meaningful way to empower and connect

Innovation

Continuously improve and remain open to new ideas, opportunities and technologies

Partnerships and collaboration

Codesign and share solutions to achieve the same goals

Integration and continuity of care

Establish seamless connection across and between services

Action Plan structure and layout

The actions in this Plan are identified across the three middle phases of the chronic disease care continuum (see page 8). This document has been structured with the following sections:

1. **Introduction** — Establishes the purpose, vision and context of the Action Plan
2. **Background** — Provides an overview of chronic disease in Latrobe and the approach to developing the Action Plan
3. **Chronic disease care continuum** — Details the chronic disease care continuum and summarises the key scope elements of the Action Plan
4. **Early detection and intervention** — Identifying people at risk of developing, and those in the early stages of, chronic disease
5. **Self-management** — Individuals having the ability to navigate the effects of chronic disease on their daily lives
6. **Community-based treatment and care** — Active and ongoing support for people to live their everyday lives, partnering to improve outcomes

- Provides an overview of the function of each stage of the continuum
- Summarises the key areas in which it is effective
- Lists the agreed action areas, activities, measures, timeframes and responsible action owners

7. **Moving forward** — Details the vital enabling factors as well as a summarised list of all actions for stakeholders

How agency roles are described in this Action Plan

The Action Plan lists an initiating agency in bold text for every activity. This agency is responsible for starting the activity, but may not be responsible for delivery. Collaborating agencies are listed with the initiating agency

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1. Early detection and intervention

Early detection and intervention identifies people at risk of developing, and those in the early stages of, chronic disease. This is achieved by ensuring people are aware of risk factors, participate in screening, and establish connections to early intervention programs and services.

1. Early detection and intervention

Individuals at risk of developing, or currently experiencing, chronic disease typically have one or more risk factors. Individual risk factors can be behavioural or biomedical, with many shared across common chronic diseases. These risk factors are mainly treatable and modifiable, and those experiencing them can gain significant health and wellbeing benefits in return[14]. If chronic disease develops, there are equally significant benefits to early action. Early detection and intervention activities focus on identifying and modifying risk factors, diagnosing chronic disease, and establishing early connections with practitioners.

Behavioural risk factors

For example
- physical inactivity
- poor nutrition
- smoking tobacco
- risky alcohol consumption

Biomedical risk factors

For example
- overweight and obesity
- high blood pressure
- high blood cholesterol

Societal and individual costs reduce significantly through investment to detect and provide early intervention for risk factors and chronic disease itself. [15] There is significant opportunity to optimise these services in Latrobe across the lifespan.

The Gippsland PHN has recently identified that tobacco use, physical inactivity, harmful use of alcohol and unhealthy diets, high blood pressure and high blood glucose are the lead contributors to the local burden of disease.[5] Additionally, Aboriginal and Torres Strait Islander people and those experiencing challenges or disadvantages against social determinants of health (i.e. lower economic status, limited personal safety and complex social situations) have higher rates of chronic disease risk factors and disease in Latrobe.[5]

Supporting early detection and intervention in Latrobe

Focusing activity on early detection and intervention will create a healthier community and reduce the health service demand in Latrobe over the long term. Before and during development of this Action Plan, the Latrobe community voiced challenges with health education, as well as access and timeliness of care. The actions in this section use a range of education, screening, social and health focussed approaches to improve early detection and intervention activities in Latrobe.

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1.1 Expand access to wellbeing checks in the community

These activities focus on providing greater accessibility for the people of Latrobe to complete health and wellbeing checks. They include consideration of existing initiatives that can be used to inform change or evolution in scale to achieve the overarching objective.

Item #	Activities	Markers of success	Timeframe	Agencies
1.1.1	Convene an advisory group to oversee exploration of possible initiatives to expand access to wellbeing checks in Latrobe, including planning and piloting a mobile wellbeing clinic. This group should include consumers, carers and practitioners.	Advisory group terms of reference and established meeting schedule	2023	**LHA** with Gippsland PHN, LCHS, LRH, GRPHU (LRH)
1.1.2	Identify implementation considerations for the mobile clinic and any additional initiatives identified from activity 1.1.1 above, learning from previous and existing work: - Scan for similar local and international services, including in published literature, grey literature and case studies - Consolidate previous evaluations of local early detection and intervention programs.	Completed review report submitted to advisory group	2023	**LHA** with Gippsland PHN, LCHS, LRH
1.1.3	Plan, pilot and evaluate the mobile clinic and additional initiatives identified. Planning should consider target population, geographies, activities, workforce, and communication with community members.	Completed plan agreed by advisory group Increased number and geographic reach of wellbeing checks	2024 2026+	**LHA** with agencies identified as appropriate to the initiatives

Existing work to monitor, learn and collaborate with

- Gippsland PHN's Community Led Multidisciplinary Models of Care program
- Gippsland PHN's Risk Assessment and Opportunistic Screening
- GRPHU's *Chitty Chitty Jab Jab* COVID-19 mobile vaccination bus
- The Latrobe Health Advocate's Improving Access to Services Plan

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1.2 Increase awareness of chronic disease screening and detection services and programs

These focus on the provision of consistent and accessible information across the Latrobe community. Activities seek to consolidate existing programs and ensure service providers and consumers/carers build their understanding of services available.

Item #	Activities	Markers of success	Timeframe	Agencies
1.2.1	Identify consistent health information resources to be displayed in publicly accessible digital screens.	Agreed list of resources to be displayed	2023	**LHA** with LCHS, LCC, LRH, Gippsland PHN
1.2.2	Display health information resources on publicly accessible digital screens. This could include council and health service facilities.	Number of terminals with information displayed	2023	**LCC** with LCHS, LRH, Gippsland PHN
1.2.3	As part of Gippsland PHN GP training activities, explore funding opportunities to deliver an education program for GPs on chronic disease screening and detection tools. The specific tools will be determined by the participating agencies at the time of program development.	Enrolments in education program Increased knowledge of and access to identified screening and detection tools	2024	**Gippsland PHN** with LCHS, LRH
1.2.4*	Increase education and awareness for practitioners and community members of chronic disease screening and detection options. This includes the promotion and uptake of GP and nurse-led screening.	Increased number of referrals to early detection and intervention programs i.e. the Life! Program Increased number of GP and/or nurse-led health checks (MBS)	2024	**LCHS** with LRH, LHA, Diabetes Victoria, GRPHU (LRH)

* Indicates a change from the original Plan.

Existing work to monitor, learn and collaborate with

- Diabetes Victoria's Life! Program
- The Royal Australian College of General Practitioners' Chronic Disease Guidelines
- Gippsland PHN's regular newsletter to GPs, and education and training events

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1.3 Embed a service planning approach that integrates consumer experience and population data

The focus of this activity area is to establish and embed a coordinated service planning approach to chronic disease early detection and intervention services in Latrobe. It seeks to draw together elements of the consumer experience with population based demand.

Item #	Activities	Markers of success	Timeframe	Agencies
1.3.1	Understand the consumer experience of early detection and intervention for priority disease groups to determine service gaps and strengths from the consumer perspective. Share findings with community members and practitioner agencies to inform service planning and navigation, including updating established resources such as Gippsland HealthPathways.	Updates to established service planning and navigation resources Increased journey mapping capability among agencies	2023	**LCHS** with LHA, LRH, Gippsland PHN, GRPHU (LRH)
1.3.2	Develop a service plan for chronic disease early detection and intervention services in Latrobe. This should integrate population and disease data, consumer experience, and practitioner perspectives.	Iterative service plan document regularly reviewed and adjusted	2024 and 2027	**LHA** with LCHS, LRH, Gippsland PHN
1.3.3	Re-establish and increase participation at a regular forum for LCHS and LRH to discuss and review early detection and intervention service offerings, aiming to increase the integration of services. This should be informed by the service plan from 1.3.2 above. This could be the same forum as identified in activity 3.2.3 on page 24. Once re-established, this could be expanded to include Gippsland PHN, Maryvale Private Hospital, medical clinics, and other private providers.	Regular forum with attendance from all agencies Relevant Gippsland HealthPathways have up-to-date information	2023+	**LRH** with LCHS, Gippsland PHN

Existing work to monitor, learn and collaborate with

- Gippsland PHN's Health Needs Assessment
- Gippsland PHN's Gippsland HealthPathways

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1.4 Apply alternative health workforce models

Within Latrobe there are existing models which offer innovative approaches to care delivery using alternative workforces. Activities within this area will build on and provide opportunities to scale these initiatives.

Item #	Activities	Markers of success	Timeframe	Agencies
1.4.1	Investigate funding options to ensure sustainability and possible expansion of Nurses in Schools program.	Completed business case for expanded program Increased delivery of school nurse activities	2024 2025	**LHA, LCHS**
1.4.2	Partner with Federation University to explore initiatives for student-led wellbeing check clinics, seeking to identify improved or innovative methods of delivery.	Rate of recruitment to early intervention programs (i.e.. Life!) from wellbeing checks	2024	**LHA** with LCHS, Fed Uni
1.4.3	Collaborate and connect with the Latrobe Valley Authority to ensure the Latrobe community contributes to strategies and initiatives which impact the local health workforce.	Number of contributions or engagements with the Latrobe Valley Authority	2023+	**LHA** with LCHS, LRH, DH, Gippsland PHN, GRPHU (LRH)
1.4.4	Collaborate and connect for strengthened partnerships between ACCHOs (such as Ramahyuck and Gippsland & East Gippsland Aboriginal Co-Operative – GEGAC), Aboriginal Liaison Officers and other agencies to increase self-determination along the chronic disease continuum.	Percentage of agencies with partnerships and visible presence of Aboriginal Health Workers/Aboriginal Liaison Officers	2024	**GRPHU (LRH)** with Ramahyuck, LCHS
1.4.5	Explore possible approaches to pharmacists delivering wellbeing checks, aiming to increase access to early detection and intervention services. - Scan for similar local and international services, including in published literature, grey literature and case studies - Plan, pilot and evaluate a program of pharmacist-led wellbeing checks	Rate of recruitment to early intervention programs (ie. Life!) from wellbeing checks	2025	**LHA** with Gippsland PHN, LCHS, LRH, DH

Existing work to monitor, learn and collaborate with

- LHA and LCHS's Community Health Nursing in Primary Schools Program
- Federation University's Student-led Wellbeing Check Program
- Ramahyuck's Strategic Plan 2020 – 2025

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2. Self-management

Self-management is a process through which people have the confidence and skills to navigate the medical, social and emotional challenges of chronic disease in their daily lives.

2. Self-management

Self-management is more than just understanding one's health, although that is a crucial first step. Self-management can look different for each person, and can change over time. An example of well-known self-management activity includes a person with diabetes actively monitoring their blood sugar levels and raising any abnormalities with a practitioner.

The role of practitioners in self-management

People who are actively engaged in their health care, with appropriate involvement of carers and families, are empowered to take greater control in managing their health and optimise their quality of life. [16] The responsibility for self-management does not sit with the individual and carer alone. The ability to self-manage is directly affected by the social, economic and environmental context of a person, so support from practitioners is essential to overcome any barriers.

The role of practitioners and service systems is to welcome, enable and encourage self-management. This occurs through two broad strategies: enabling a portfolio of techniques and tools that help individuals choose healthy behaviours, and fundamentally transforming the individual-practitioner relationship into a collaborative partnership.[16]

- Medical management
- Role management
- Emotional management

- Problem solving
- Decision making
- Resource utilisation
- Patient-provider partnership
- Action planning
- Self tailoring

Source: Llorig, Halsted and Homan, 2003 [17]

Supporting self-management within the Aboriginal community of Latrobe will be strongly informed by the Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017–2027 [18]. The plan recognises the importance of Aboriginal people taking ownership, carriage and responsibility for designing, delivering and evaluating policy and services on their terms. Partnerships with key organisations such as Ramahyuck, and leaders of the Aboriginal community in Latrobe will lead activities in this space.

Supporting self-management in Latrobe

When effectively implemented, self-management enables individuals with chronic disease to retain control and power over their lives. They take ownership for management of their disease, with subsequent health and social benefits. This requires supportive service systems and environmental factors, to which there are specific challenges in Latrobe. In developing this plan, we heard that there could be improvements to service accessibility and integration. The actions in this section seek to empower self-management by addressing both environmental and service system challenges.

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2.1 Improve access to groups and facilities that support self-management

A key component of effective self-management is connecting the individual with groups and facilities that can improve health outcomes, such as public exercise facilities and community support groups. Activities within this action area seek to create a more accessible system and empowering individual choice.

Item #	Activities	Markers of success	Timeframe	Agencies
2.1.1	Expand social prescribing programs, seeking to grow and learn from existing pilot underway: - Scan for similar local and international services, including in published literature, grey literature and case studies - Consolidate previous evaluations of local early detection and intervention programs, including existing pilot underway - Develop and deliver an agreed service plan for expanded social prescribing programs.	Completed review report Completed business case for expansion Increased delivery of social prescribing activities	2023 2025 2025+	**LHA** with LCHS, Gippsland PHN
2.1.2	Deliver orientation and welcome sessions for people at council facilities (e.g. library and recreation centres). The design of these sessions should be informed by people with lived experience of chronic disease.	Attendance at welcome sessions	2023	**LCC** with LCHS, LHA
2.1.3	Explore possible approaches to providing reduced-fee or free access to facilities and groups that support self-management, aiming to minimise cost as a barrier to access. - Scan for similar local and international services, including in published literature, grey literature and case studies - Partner with relevant local agencies - Plan, pilot and evaluate a program of reduced-fee or free access.	Completed review report and pilot plan Increased number of individuals accessing eligible groups and facilities	2023 2023 2024	**LHA** with LCC, LCHS, Gippsland PHN, LRH
2.1.4	Increase the delivery of clinical services in non-clinical facilities, for example hydrotherapy in local public pools.	Increased number of services offered in n on-clinical spaces	2025	**LCHS** with LCC, Gippsland PHN, LHA

Existing work to monitor, learn and collaborate with

- LHA's Social Prescribing Program
- Latrobe City Council's Disability Action Plan
- Latrobe City Council's Municipal Public Health and Wellbeing Plan
- Gippsland PHN's initiatives to establish virtual care facilities in clinics and community spaces

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2.2 Enable carers/family members to support individuals with chronic disease at a level of involvement appropriate for them

This area focuses on providing opportunities to better understand the ways carers can offer support throughout the chronic disease care continuum. These activities seek to promote the role of carers, while ensuring their level of involvement is appropriate for them and the people for whom they offer care.

Item #	Activities	Markers of success	Timeframe	Agencies
2.2.1	Explore opportunities to design and develop a pilot for carer inclusion training for public facing staff. Carers/family members should be included in the design and delivery of this training.	Development and delivery of carer inclusion training	2024	**LHA, LCHS, LRH** with Carers Victoria
2.2.2	Ensure carer/family member representation on advisory groups related to chronic disease, and communicate their involvement more widely within the Latrobe community.	All partner agencies have appropriate carer representation in advisory groups	2023	**Gippsland PHN, LHA, LRH, LCHS**
2.2.3	Ensure the level of carer/family member engagement is considered as part of the evaluation criteria when commissioning services and pilot projects.	Embedded as formal evaluation criteria in commissioning policies and procedures	2023	**Gippsland PHN, LHA**
2.2.4	Where not already in place, practitioner agencies offer individuals to nominate a second person (e.g. carer/ family member) to receive correspondence. Where already in place, apply continuous improvement principles to ensure this information is updated annually.	Increased percentage of policies, procedures, and documentation featuring a correspondence nominee with a relevant review cycle.	2024	**LRH, LCHS**
2.2.5	Develop and distribute Latrobe-specific communication materials about support services and groups available to carers/family members of people with chronic disease.	Increased number of carers/family members from Latrobe accessing services and supports	2024	**LCHS** with LHA, LRH, Gippsland PHN, Carers Victoria

Existing work to monitor, learn and collaborate with

- Carers Victoria's workshops and programs
- Latrobe Health Advocate's Engagement Inspiration Reports

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2.3 Increase services at consumer-centred times and locations

Accessibility of services is an ongoing consideration within Latrobe. Activities in this area seek to build on existing work to understand opportunities to expand the provision of out-of-business-hours services. It also intends to embed a transparent approach to scheduling and communication about waiting times for services.

Item #	Activities	Markers of success	Timeframe	Agencies
2.3.1*	Convene a regular forum attended by all relevant agencies to progress existing work to increase out-of-hours services.	Advisory group terms of reference and established meeting schedule	2023	**LHA** with Gippsland PHN
2.3.2	Map the existing out-of-hours services for people with chronic disease to identify specific areas of service gaps and strengths. - Consider previously conducted mapping, seeking to update existing work - Communicate findings with community members - Communicate findings with practitioners, seeking to update and redeploy initiatives previously developed by Gippsland PHN	Completed current state service map Number of interactions with campaign materials	2023 2024	**LHA** with LCHS, LRH, Gippsland PHN
2.3.3	Practitioners to share estimated waiting time until next appointment with consumer at time of receiving referral, to enable informed self-management decisions: - Develop a shared policy or position statement agreeing to share waiting times - Seek official organisational endorsement for policy or position statement.	Number of services endorsing policy or position statement	2024	**LCHS** with Gippsland PHN, LRH

* Indicates a change from the original Plan.

Existing work to monitor, learn and collaborate with

- The Latrobe Health Advocate's Improving Access to Services Plan
- The Victorian Government priority primary care services

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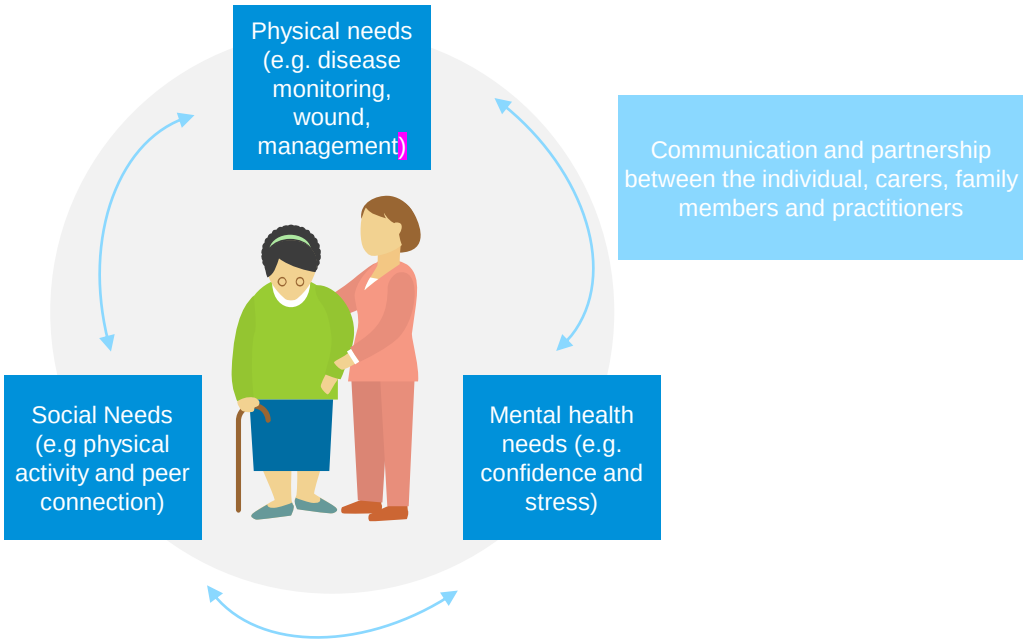
3. Community-based treatment and care

Community-based treatment and care involves multidisciplinary services providing active and ongoing support for people to live their everyday lives, partnering with them to improve health outcomes.

3. Community-based treatment and care

People living with chronic disease may have varying levels of complexity due to individual and social factors. People with higher complexity may have multiple co-occurring conditions, disabilities and environmental challenges that result in the need for more intense support from services. While receiving this active and ongoing support, there is a need for greater connection and coordination between practitioners, while maintaining the individual at the centre of their care.

To optimise experience and outcomes, community-based treatment and care should meet the social, physical and mental health needs of the individual. Communication and partnership between the individual, their carers and family members, and the multiple involved provider agencies is critical to success. These agencies can include allied health professionals, general practitioners (GPs), medical specialists, and support workers.



Delivering community-based treatment and care for chronic disease in a clinically appropriate, evidence-based, safe and accessible way [1]:

- Slows disease progression
- Helps to prevent and delay the onset of additional chronic conditions, complications, and associated disabilities
- Improves health and wellbeing
- Enhances quality of life.

Additionally, delivering collaborative and trusting practices from services with consumers, their families and carers have been seen to [1]:

- Establish a foundation for improved communication
- Strengthen continuity of care
- Improve information sharing.

Supporting community-based treatment and care in Latrobe

With known challenges to service accessibility, affordability and connectivity, there are many opportunities to improve community-based treatment and care in Latrobe. The actions detailed in this section aim to improve the coordination, communication and delivery of community-based treatment and care services for people with chronic disease in Latrobe.

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3.1 Enable delivery of culturally and psychologically safe services

To ensure services within Latrobe are truly accessible for all people, this action area has a focus on driving cultural and psychologically safe services and practices. Activities in this area seek to upskill and empower capability to deliver safe and appropriate responses to care.

Item #	Activities	Markers of success	Timeframe	Agencies
3.1.1*	Conduct an assessment to understand what is being done by health organisations to enable delivery of culturally and psychologically safe services across Latrobe. This reflective assessment will enable a baseline understanding of practice in Latrobe to identify current strengths and gaps to inform future activities.		2024	**GRPHU (LRH)** with LHA, LCHS, Gippsland PHN
3.1.2	Where not already in place, deliver cultural diversity training to relevant staff, including partnering with ACCHOs (e.g. Ramahyuck and GEGAC) for Aboriginal cultural safety training.	Percentage of staff who have completed training	2024	**LCHS, LRH** with Ramahyuck
3.1.3	Collaborate to share successful attraction and retention strategies/initiatives in place to support a culturally diverse workforce that mirrors the Latrobe community (e.g. within an overall workforce strategy).	Increased number of dedicated initiatives focussed on culturally diverse workforces	2025	**LRH, LCHS, LCC**
3.1.4	Advisory groups related to chronic disease include culturally diverse representation.	Supporting documentation and processes for advisory groups include cultural diversity (e.g. diversity statement in terms of reference)	2024	**Gippsland PHN, LRH, LCHS, LCC**
3.1.5	Ensure cultural safety of services delivered is considered as part of the evaluation criteria when commissioning services and pilot projects.	Embedded as formal evaluation criteria in commissioning policies and procedures	2024	**Gippsland PHN, LHA**

* Indicates a change from the original Plan.

Existing work to monitor, learn and collaborate with

- Latrobe Health Advocate's Engagement Inspiration Reports

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3.2 Improve continuity of care for community-based services

Individuals participating in community-based treatment and care often have multiple providers involved over extended periods of time. These activities focus on improving a sense of ongoing connection to create a clearer, more integrated and seamless care experience.

Item #	Activities	Markers of success	Timeframe	Agencies
3.2.1	Expand a chronic disease diary program, seeking to grow and learn from existing work: - Complete and consolidate evaluations of previous local programs - Develop and deliver an agreed plan for an expanded chronic disease diary program.	Completed business case for expansion Decrease number of appointment non-attendances	2023 2023	**LCHS** with LHA, Gippsland PHN, LRH
3.2.2	Explore approaches to increasing practitioner completion of care management plans for priority diseases. These include diabetes, asthma and cardiovascular disease. - Consider data and consumer experience to confirm the gap in plan completion - Partner with relevant agencies to identify barriers to completion - Plan and pilot a program to increase completion of care management plans	Completed review report Increased number of completed care plans	2024 2026	**LHA** with Gippsland PHN, LCHS, LRH
3.2.3	Re-establish and increase participation at a regular forum for LCHS and LRH to discuss and define their community-based treatment and care service offerings, aiming to increase the integration of services. This could be the same forum as identified in action 1.3.3 on page 14. Once re-established, this could be expanded to include Gippsland PHN, Maryvale Private Hospital, medical clinics, and other private providers.	Regular forum with attendance from all agencies List of services provided, continuously updated to minimise unnecessary overlap	2023+	**LRH** with LCHS, Gippsland PHN
3.2.4	Expand care navigator roles and programs, seeking to learn and grow from existing work: - Scan for similar local and international services, including in published literature, grey literature and case studies - Complete and consolidate evaluations of previous local programs - Develop a business case for expanded roles and programs - Develop and deliver a service plan for an expanded care navigator program.	Completed review report Completed business case for expansion Increased number of individuals accessing eligible groups and facilities	2023 2023 2025	**LCHS** with LRH, LHA, Gippsland PHN

Existing work to monitor, learn and collaborate with

- LHA and LCH's Chronic Disease Diary Program
- The Latrobe Health Advocate's Improving Access to Services Plan
- Gippsland PHN's Trial Project on Improving Quality of Discharge Summaries
- LCHS' Care Navigator Program

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3.3 Optimise the use of technology to deliver care

Technology has a role to play across the care continuum, however activities have been focused within the community-based treatment and care phase as they will be driven by practitioners. They seek to build technology uptake and literacy to support care delivery, ultimately improving individual access and experience of care.

Item #	Activities	Markers of success	Timeframe	Agencies
3.3.1	Explore approaches to trial innovative communication and engagement approaches to decrease non-attendance at identified target programs. This could build on the example from LRH in the existing work box below	Piloted new communications and engagement approaches for services.	2025	**LHA, LRH, LCHS**
3.3.2	Explore approaches to the design and delivery of digital literacy training for clinicians and other relevant staff. This training could focus on use of technology and apps, including those listed in the existing work box below	Number of training completions Increased digital literacy of staff Increased use of technology and apps	2023	**LHA** with Gippsland PHN, LRH, LCHS
3.3.3	Explore approaches to providing free-to-access physical spaces with technology for telehealth services.	Number of telehealth appointments in space	2025	**LHA** with LRH, LCHS, LCC
3.3.4	Deliver digital literacy training to community members that includes skills to support community-based chronic disease care, such as accessing telehealth appointments or using apps.	Increasing attendance rates at regular training sessions	2023	**LCC** with LCHS, LHA
3.3.5	Expand technology-enabled remote monitoring services, seeking to grow and lean from existing work: - Scan for similar local and international services, including in published literature, grey literature and case studies - Consolidate and complete evaluations of previous local programs - Develop and deliver further pilots and programs for technology-enabled remote monitoring.	Completed review report Completed business case for expansion Increased access to health monitoring	2023 2023 2024	**Gippsland PHN** with LCHS, LRH, LHA

Existing work to monitor, learn and collaborate with

- Gippsland PHN's Lifeguard – Remote Patient Monitoring Program
- Gippsland PHN's Health Pathways Program
- LRH's improvement project to increase foot clinic attendance through targeted phone calls
- The HotDoc app
- The Royal Children's Hospital My RCH Portal app
- Gippsland PHN's initiatives to increase use of My Health Record

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4. Moving forward

Ongoing work across practitioners and community is needed to support implementation of this Action Plan.

Moving forward

The Hazelwood mine fire inquiry called for a coordinated approach to improve the experience of chronic disease in 2014, and this Action Plan is a significant step towards that. It is a demonstration of progress and shared commitment to address challenges faced by people and services in Latrobe. Publishing this plan won't end the conversation, and ongoing work with local people and community organisations is required to coordinate the implementation of both the achievable and ambitious action areas.

Ensuring success

To ensure this Action Plan achieves its goals, a range of supports (enablers) will be required to increase the chances of successful implementation. These supports have been identified by the people and services within Latrobe and are universal across the whole Action Plan.

Workforce

Latrobe faces several workforce challenges also affecting health services across Victoria. This includes attracting and retaining health workers.

To support this plan, attention will also be placed on:

- Developing new ways of working
- Taking innovative approaches to recruitment of staff.

Strategic partnerships

With many practitioner and community agencies in Latrobe, coordinated action is essential. To enhance and strengthen relationships, lead and collaborating agencies are identified in this Action Plan.

Ongoing efforts will include:

- Co-delivering activities where possible
- Commitment to creating a more integrated and energised service sector in Latrobe.

Effective communication

Ensuring open, two-way, inclusive communication will support effective information sharing in Latrobe.

Efforts will focus on:

- Maintaining an accessible person-centred approach
- Creating systems to facilitate effective communication, collaboration and teamwork within services.

Governance and responsibilities

This Action Plan has been developed with key stakeholders in the Latrobe community. It links with initiatives already underway and builds upon them where appropriate. The Action Plan underwent a period of refinement and testing with those who helped shape it.

For each activity, an initiating agency has been identified and will be responsible for taking first steps. Many activities will require a source of ongoing resourcing, and it is not necessarily the role of the initiating agency to provide this. Many activities feature an exploration or pilot phase to discuss what might be possible. To strengthen this, organisation endorsement has been provided by Latrobe Health Assembly, Latrobe Community Health Service, Latrobe Regional Hospital and Gippsland PHN. This reflects a five-year commitment to progress and complete actions by each organisation.

Latrobe Health Assembly have ultimate oversight of the Action Plan. To assist in the process, the working group who collaboratively developed the Action Plan will also meet half yearly to ensure the Action Plan achieves its intended aims, support ongoing implementation and share progress.

Communicating updates

Keeping Latrobe updated on the progress of this Action Plan will be completed by LHA. This will include direct feedback to consultation groups, online bulletins and communications by the action owners.

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5. References and appendices

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Appendix A: Full list of activities

Our vision:

To create an inclusive and integrated service network for all people with chronic disease. The voice of the individual or carer is heard, and they can access what they need at the right time to live a healthy and fulfilling life in Latrobe.

Early detection and intervention	
1.1.1	Convene an advisory group to oversee exploration of possible initiatives to expand access to wellbeing checks in Latrobe, including planning and piloting a mobile wellbeing clinic. This group should include consumers, carers and practitioners.
1.1.2	Identify implementation considerations for the mobile clinic and any additional initiatives identified from activity 1.1.1 above, learning from previous and existing work: - Scan for similar local and international services, including in published literature, grey literature and case studies - Consolidate previous evaluations of local early detection and intervention programs.
1.1.3	Plan, pilot and evaluate the mobile clinic and additional initiatives identified. Planning should consider target population, geographies, activities, workforce, and communication with community members.
1.2.1	Identify consistent health information resources to be displayed in publicly accessible digital screens.
1.2.2	Display health information resources on publicly accessible digital screens. This could include council and health service facilities.
1.2.3	As part of Gippsland PHN GP training activities, explore funding opportunities to deliver an education program for GPs on chronic disease screening and detection tools. The specific tools will be determined by the participating agencies at the time of program development.
1.2.4	Ensure ongoing education and awareness for practitioners and community members of chronic disease screening and detection whereby the LCHS health promotion team will support agencies to develop health promotion chronic disease plans and increase the uptake of the Life! Program.
1.3.1	Understand the consumer experience of early detection and intervention for priority disease groups to determine service gaps and strengths from the consumer perspective. Share findings with community members and practitioner agencies to inform service planning and navigation, including updating established resources such as Gippsland HealthPathways.
1.3.2	Develop a service plan for chronic disease early detection and intervention services in Latrobe. This should integrate population and disease data, consumer experience, and practitioner perspectives.
1.3.3	Re-establish and increase participation at a regular forum for LCHS and LRH to discuss and review early detection and intervention service offerings, aiming to increase the integration of services. This should be informed by the service plan from 1.3.2 above. This could be the same forum as identified in activity 3.2.3 on page 24. Once re-established, this could be expanded to include Gippsland PHN, Maryvale Private Hospital, medical clinics, and other private providers.
1.4.1	Investigate funding options to ensure sustainability and possible expansion of Nurses in Schools program.
1.4.2	Partner with Federation University to explore initiatives for student-led wellbeing check clinics, seeking to identify improved or innovative methods of delivery.

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Early detection and intervention	
1.4.3	Collaborate and connect with the Latrobe Valley Authority to ensure the Latrobe community contributes to strategies and initiatives with impact on the local health workforce.
1.4.4	Collaborate and connect for strengthened partnerships between ACCHOs (such as Ramahyuck and Gippsland & East Gippsland Aboriginal Co-Operative – GEGAC), Aboriginal Liaison Officers and other agencies to increase self-determination along the chronic disease continuum.
1.4.5	Explore possible approaches to pharmacists delivering wellbeing checks, aiming to increase access to early detection and intervention services. - Scan for similar local and international services, including in published literature, grey literature and case studies - Plan, pilot and evaluate a program of pharmacist-led wellbeing checks
Self-management	
2.1.1	Expand social prescribing programs, seeking to grow and learn from existing pilot underway: - Scan for similar local and international services, including in published literature, grey literature and case studies - Consolidate previous evaluations of local early detection and intervention programs, including existing pilot underway - Develop and deliver an agreed service plan for expanded social prescribing programs.
2.1.2	Deliver orientation and welcome sessions for people at council facilities (e.g. library and recreation centres). The design of these sessions should be informed by people with lived experience of chronic disease.
2.1.3	Explore possible approaches to providing reduced-fee or free access to facilities and groups that support self-management, aiming to minimise cost as a barrier to access. - Scan for similar local and international services, including in published literature, grey literature and case studies - Partner with relevant local agencies - Plan, pilot and evaluate a program of reduced-fee or free access.
2.1.4	Increase the delivery of clinical services in non-clinical facilities, for example hydrotherapy in local public pools.
2.2.1	Explore opportunities to design and develop a pilot for carer inclusion training for public facing staff. Carers/family members should be included in the design and delivery of this training.
2.2.2	Ensure carer/family member representation on advisory groups related to chronic disease, and communicate their involvement more widely within the Latrobe community.
2.2.3	Ensure the level of carer/family member engagement is considered as part of the evaluation criteria when commissioning services and pilot projects.
2.2.4	Where not already in place, practitioner agencies offer individuals to nominate a second person (e.g. carer/ family member) to receive correspondence. Where already in place, apply continuous improvement principles to ensure this information is updated annually.
2.2.5	Develop and distribute Latrobe-specific communication materials about support services and groups available to carers/family members of people with chronic disease.
2.2.6	Develop and distribute Latrobe-specific communication materials about support services and groups available to carers/family members of people with chronic disease.
2.3.1	Convene a regular forum attended by all relevant agencies to progress existing work to increase out-of-hours services.
2.3.2	Map the existing out-of-hours services for people with chronic disease to identify specific areas of service gaps and strengths. - Consider previously conducted mapping, seeking to update existing work - Communicate findings with community members - Communicate findings with practitioners, seeking to update and redeploy initiatives previously developed by Gippsland PHN

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Self-management	
2.3.3	Practitioners to share estimated waiting time until next appointment with consumer at time of receiving referral, to enable informed self-management decisions: - Develop a shared policy or position statement agreeing to share waiting times - Seek official organisational endorsement for policy or position statement.
Community-based treatment and care	
3.1.1	Explore opportunities to build on existing community of practice/networking meetings for practitioners in health promotion and prevention to include practitioners involved in community-based treatment and care. This is a forum to share knowledge, experience and reflect on practice to increase understanding of diverse perspectives. It could be further developed to an annual conference with larger attendance.
3.1.2	Where not already in place, deliver cultural diversity training to relevant staff, including partnering with ACCHOs (e.g. Ramahyuck and GEGAC) for Aboriginal cultural safety training.
3.1.3	Collaborate to share successful attraction and retention strategies/initiatives in place to support a culturally diverse workforce that mirrors the Latrobe community (e.g. within an overall workforce strategy).
3.1.4	Advisory groups related to chronic disease include culturally diverse representation.
3.1.5	Ensure cultural safety of services delivered is considered as part of the evaluation criteria when commissioning services and pilot projects.
3.2.1	Expand a chronic disease diary program, seeking to grow and learn from existing work: - Complete and consolidate evaluations of previous local programs - Develop and deliver an agreed plan for an expanded chronic disease diary program.
3.2.2	Explore approaches to increasing practitioner completion of care management plans for priority diseases. These include diabetes, asthma and cardiovascular disease. - Consider data and consumer experience to confirm the gap in plan completion - Partner with relevant agencies to identify barriers to completion - Plan and pilot a program to increase completion of care management plans
3.2.3	Re-establish and increase participation at a regular forum for LCHS and LRH to discuss and define their community-based treatment and care service offerings, aiming to increase the integration of services. This could be the same forum as identified in action 1.3.3 on page 14. Once re-established, this could be expanded to include Gippsland PHN, Maryvale Private Hospital, medical clinics, and other private providers.
3.2.4	Expand care navigator roles and programs, seeking to learn and grow from existing work: - Scan for similar local and international services, including in published literature, grey literature and case studies - Complete and consolidate evaluations of previous local programs - Develop a business case for expanded roles and programs - Develop and deliver a service plan for an expanded care navigator program

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Community-based treatment and care	
3.3.1	Explore approaches to trial innovative communication and engagement approaches to decrease non-attendance at identified target programs. This could build on the example from LRH in the existing work box below
3.3.2	Explore approaches to the design and delivery of digital literacy training for clinicians and other relevant staff. This training could focus on use of technology and apps, including those listed in the existing work box below
3.3.3	Explore approaches to providing free-to-access physical spaces with technology for telehealth services.
3.3.4	Deliver digital literacy training to community members that includes skills to support community-based chronic disease care, such as accessing telehealth appointments or using apps.
3.3.5	Expand technology-enabled remote monitoring services, seeking to grow and lean from existing work: - Scan for similar local and international services, including in published literature, grey literature and case studies - Consolidate and complete evaluations of previous local programs - Develop and deliver further pilots and programs for technology-enabled remote monitoring.

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