



Creative Community Consultation Workshops in Chronic Illness

Final Report – December 2019

Central West Gippsland Primary Care Partnership

In Partnership with the

Latrobe Health Assembly

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Executive Summary

This project was initiated 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 / barriers, and
- 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, DHHS, LHA 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 entailed the following elements:

- Engagement of agencies providing services to people with chronic illnesses in the Latrobe Valley.
- Recruitment 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.
 - Community engagement and project promotion via social media/print media/online.
 - Town based conversations in the four major Latrobe Valley towns.
 - Conversations at Pharmacies and GP Clinics within the Latrobe City LGA.
 - Conversations at community members' locations of choice (e.g. in a café at a time that suited them).
- Data analysis and reporting.

A total of 302 community members were engaged in the project, 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, collation and thematic analysis of the data was undertaken. Individual results were generated for each of the five chronic conditions as well as common results across all five conditions.

Results covered the areas of:

- 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 information and support regarding the chronic illness.

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 / transport.
- Need for more information and support / isolation and loneliness.
- Need for more disability-friendly local infrastructure.

It is hoped that the findings and common themes identified through this project will provide a basis for local health services and providers to inform their discussions around future actions and priorities to improve the experience of people living with chronic conditions and help them 'live well'.

Background

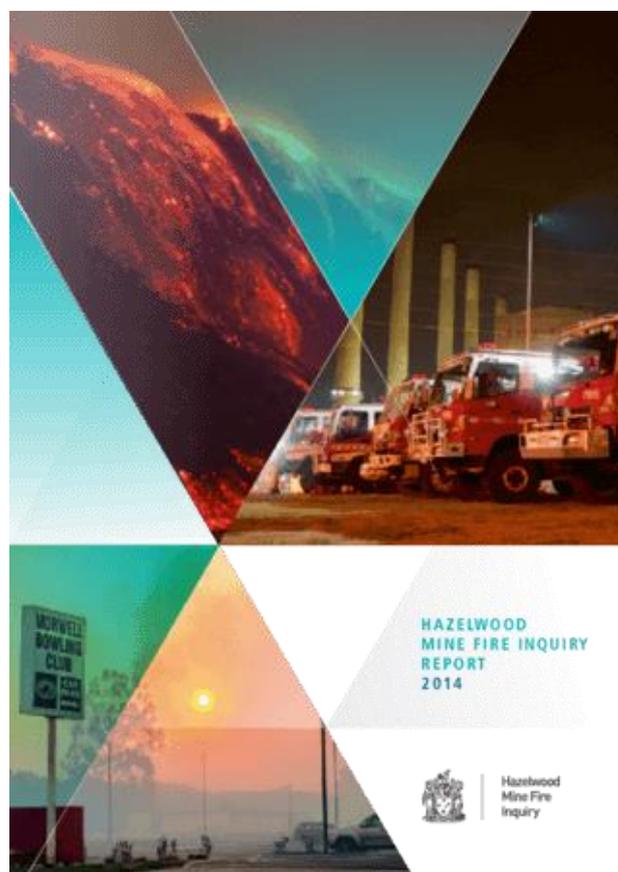
The report from the Hazelwood Mine Fire Inquiries contains several recommendations to improve the health and wellbeing outcomes for residents of the Latrobe Valley.

Currently two of the top five causes of death and disability in Latrobe are chronic diseases; cardiovascular disease and chronic respiratory disease². In Latrobe, the percentage of people reporting high blood pressure is the highest in the state, and the percentages of people reporting type 2 diabetes and osteoporosis are among the highest in the state¹.

Furthermore, Latrobe has the highest rate in Gippsland of potentially preventable hospitalisations. With hospitalisation for the chronic diseases and chronic disease complications all being higher than the Victorian averages³. Lastly the rates of avoidable deaths for cardiovascular disease and respiratory diseases are significantly higher than the Victorian averages¹.

These statistics show that chronic diseases have a heavy impact on the Latrobe Valley community and that more can be done to improve the quality of life for those living with a chronic disease. Given the higher than average rates of a number of chronic diseases and hospitalisation from these diseases it is important for the service system to understand why this is occurring and what we can do to improve upon these current statistics.

The project has been funded by the Latrobe Health Assembly and the Department of Health and Human Services and is an initiative of the Latrobe Health Innovation Zone. Central West Gippsland Primary Care Partnership was contracted by the Latrobe Health Assembly to deliver this project over 2019.



An Initiative of the Latrobe Health Innovation Zone

Project Aims, Objectives, Deliverables and Stakeholders

Aims:

The aims of the project were to conduct community consultation and engagement with people living with chronic illness and their carers to:

1. Understand their current service knowledge / usage / barriers, and
2. Identify ways in which service providers can improve their services to enhance quality of life of people living with a chronic illness.

Objectives:

1. Engage and obtain a response with 100% of service providers identified to participate in process.
2. Up-skill local community members to deliver community consultations.
3. Undertake innovative community consultations where the community feel heard and that their opinions and stories are valued.
4. Meaningfully engage with a diverse range of the community ensuring to capture information from people from different cultural and socio-economic backgrounds and with different chronic conditions.
5. Encourage service providers who participate to act on the learnings from the report and implement changes in their organisation.
6. Long-term improved health and/or wellbeing of those living with a chronic illness.

Deliverables:

1. Six to eight peer facilitators trained.
2. One project launch event.
3. Town based face-to-face consultations in four major Latrobe Valley towns.
4. Place-based consultations undertaken in one Pharmacy and one GP clinic.
5. Social media /media strategy implemented.
6. Detailed final report including project findings.
7. Video produced capturing community members' stories to support the findings in the final report.

Stakeholders:

- Central West Gippsland Primary Care Partnership (CWGPCP)
- Latrobe Community Health Service (LCHS)
- Latrobe City Council (LCC)
- Latrobe Regional Hospital (LRH)
- Latrobe Health Assembly (LHA)
- Latrobe Health Advocate
- Department of Health and Human Services (DHHS)
- Primary Health Network (PHN)
- Health Issues Centre (HIC)

Method

Consultation and engagement activities were undertaken within the Latrobe Valley with a focus on the towns of Moe, Morwell, Churchill and Traralgon.

Due to the wide range of chronic diseases, it was determined that this project needed to focus on a select few to ensure enough data was gathered about each condition to provide robust results. After consultations with local health professionals, DHHS, LHA 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.

Whilst data suggests that Latrobe Valley has higher rates of mental health issues comparative to other locations, mental health was out of the scope of this project due to other specific projects with a mental health focus occurring across Latrobe at the same time and the project stakeholders wanting to ensure we were not over-consulting with certain groups within the community. **See Appendix 1** for the full list of mental health projects and other similar projects occurring at the time of this consultation.

Asthma was also excluded from the consultation due to the active project being led by the LHA, LCHS and LRH through the [Scarfie Campaign](#), which included community engagement and education about asthma prevention and asthma management plans.

The consultation period was time limited, taking place between 15 May and 15 October 2019 with reports to be submitted by December 2019.

The project broadly entailed the following elements:

- A. Service provider engagement.
- B. Recruitment and up-skilling of volunteers.
- C. Community engagement and consultation.
- D. Data analysis and reporting.

The methodology for each element is detailed below:

1. Service Provider Engagement

Service provider engagement activities were undertaken with relevant organisations identified as providing services to people with chronic illness in Latrobe Valley. These agencies were:

- Central West Gippsland Primary Care Partnership (project lead)
- Latrobe Health Assembly
- Latrobe Health Innovation Zone
- Department of Health & Human Services
- Latrobe City Council

- Latrobe Community Health Service
- Latrobe Regional Hospital
- Latrobe Health Advocate
- Gippsland Primary Health Network

Identified agencies were initially engaged via a formal 'Chronic Disease Community Consultation Project Meeting' which took place on 21 January 2019. A Service Provider Consultation Group was formed at that meeting with representation from all of the agencies.

Key agencies were further engaged via provision of expert advice with regard to conversation guide/survey development, invitations to and attendance at launch and consultation events, collaboration regarding promotion of the project, participation in volunteer recruitment and training activities, identification of consumers who might participate in the project. It is envisaged that these agencies will also be involved in system reform and internal quality improvement as a result of the project.

2. Recruitment, up-skilling and management of volunteers

The role of the volunteers was to act as 'Peer Facilitators' to conduct face-to-face conversations with community members regarding their experiences of living with a chronic illness and engaging with the chronic illness service system.

Volunteer recruitment was undertaken by the CCC Project Coordinator in collaboration with the Latrobe Community Health Service Volunteer Program Coordinator. A 'Volunteer Peer Facilitator' Position Description was developed and the positions advertised on the LCHS, Go Volunteer, Volunteers Victoria and Seek Volunteer websites, as well as in local Latrobe Valley print media. The positions were also promoted by key stakeholders via their networks, newsletters, social media etc.

Applicants were interviewed by a panel including the CCC Project Coordinator and the LCHS Volunteer Coordinator. Initially, it was hoped that six to eight members of the Latrobe Valley community could be recruited to the volunteer positions but ultimately only four of the applicants were found to be suitable. Since there was insufficient time to re-advertise and the community members selected were of a very high calibre, a decision was made to go ahead with the four volunteers. All volunteers were inducted into the LCHS Volunteer Program and were required to adhere to all relevant LCHS policies and procedures.

The four Volunteer Peer Facilitators were provided with up-skilling training conducted by the Health Issues Centre in conjunction with the CCC Project Coordinator on 25 March 2019. The training covered the following areas:

- Interviewing for information gathering.
- Consulting with people from different backgrounds.
- Facilitating conversations.
- Co-design.
- Stimulating ideas for co-design.
- Latrobe Chronic Disease programs and services.

A second meeting with the four volunteer Peer Facilitators was then organised on 15 May to discuss arrangements for commencement of the community consultation process. At the meeting the volunteers, CCC Project Coordinator and CWGPCP Executive Administration Officer worked through the 'Volunteer Information Kit' which included the following:

- 'Latrobe Chronic Illness Community Consultation Processes and Procedures' booklet. **See Appendix 2.**
- Overview of the five chronic illnesses selected for the project. **See Appendix 3.**
- Fact Sheet for each of the five chronic illnesses (sourced from an Australian peak body for each illness e.g. COPD Fact Sheet produced by Lung Foundation Australia).
- 'Volunteer Conversation Guide for Peer Facilitators' (developed with input from the volunteers).
- Hard-copy version of the 'Latrobe Living Well Conversations' survey for volunteers to provide to community members and/or distribute at locations across Latrobe City.
- Copies of promotional postcard for the project (which included a link to access an online version of the 'Latrobe Living Well Conversations' survey).
- 'Ideas and Planning' document listing community events scheduled in the Latrobe Valley during the consultation period and other potential locations to conduct face-to-face community conversations.
- 'We are Latrobe' t-shirts.
- Identification tags and lanyards.
- LCHS Volunteer Hours Sign-in Sheets.
- 'Living Well with Chronic Illness' pull-up banner to display at locations where the volunteers were undertaking community conversations.



Volunteer Peer Facilitator Helen with the 'Living Well with Chronic Illness' pull-up banner

The volunteers commenced their community consultations from 15 May 2019 and were mentored, supported and supervised throughout the project by the CCC Project Coordinator.

Through their involvement in the project, the volunteer Peer Facilitators were also invited by local agencies to participate in other relevant events and research:

- Latrobe Community Health Service: 'Deep Dive into chronic disease management' event.
- [Gippsland Primary Health Network / Latrobe University: Early Detection and Screening - Social Network Analysis Project.](#)
- [Latrobe Health Advocate: 'Community Voices' Project.](#)

3. Community Engagement and Conversations

Community engagement was conducted by various methods to ensure a wide reach, including:

- a. A public launch event and theatrical production including a Q&A session with a panel and audience discussion about chronic illness.
- b. Community engagement and project promotion via social media / print media / online.
- c. Town based conversations in major Latrobe Valley towns (i.e. Moe, Morwell, Churchill, Traralgon).
- d. Conversations at Pharmacies and GP Clinics within the Latrobe City LGA.
- e. Conversations at community members' locations of choice (i.e. at a café at a time that suited them).

The key questions the community members were asked during the Conversations included:

- Their experiences living with chronic illness.
- What they currently know about chronic disease programs in Latrobe.
- Why they do / do not attend these programs.
- How the service system can better help them to manage their chronic conditions.

Three versions of a tool were developed (with input from the volunteers) for collecting and recording this information:

- 'Volunteer Conversation Guide for Peer Facilitators' – designed for use by the volunteers when conducting face-to-face conversations with community members. **See Appendix 4.**
- 'Latrobe Living Well Conversations' hard-copy survey – a version of the Conversation Guide designed to be distributed at locations across Latrobe City or for the volunteers to provide to community members who wished to share their story but not to participate in a face-to-face conversation. Reply-paid envelopes were provided. **See Appendix 5.**
- 'Latrobe Living Well Conversations' online survey – a 'SurveyMonkey' version of the hard-copy survey which could be accessed and completed via the internet.

a. Project launch and theatrical production

The project was launched at a free public event held at the Latrobe Performing Arts Centre in Traralgon on the evening of on 2 April 2019. 'Health Plays' were contracted to deliver their production '[Six Degrees of Diabetes](#)', a 30 minute play by Alan Hopgood that delivers real messages about diabetes risks in men in a humorous and engaging way.

The event was promoted to all residents of Latrobe City via a range of methods including print advertising in local newspapers; direct distribution of flyers at GP clinics, aged care facilities and community events (including the 'We are Latrobe Festival'); extensive website and social media advertising and local television, radio and community noticeboards. Latrobe Performing Arts Centre also undertook event advertising and administered bookings and complimentary tickets.

Six Degrees of Diabetes
a play by Alan Hopgood

Living well with Chronic Illness

**Free Community Event
for Latrobe Valley**

Do you (or someone you know)
have diabetes, osteoporosis,
arthritis, heart failure
or COPD?

Come along to an evening of food, entertainment and
information about these common chronic illnesses.

Six Degrees of Diabetes, an informative and hilarious HealthPlay, written
by Alan Hopgood, will be performed. **Inspired by true stories.**
Q&A on chronic illnesses with health professionals follows performance.

Where: Latrobe Performing Arts Centre: Traralgon Little Theatre
(Corner Grey & Breed Streets, Traralgon)

When: Tuesday 2nd April 2019.
5:30 pm arrival with finger food;
play starts at 6:00 pm sharp.

CENTRAL WEST GIPPSLAND Primary Care Partnership
Latrobe Health Assembly
Shaping The Valley

This project is an initiative of the Latrobe Health Innovation Zone

TUESDAY 2 APRIL, 5.30PM
LATROBE PERFORMING ARTS CENTRE
Bookings Online: www.latrobe.vic.gov.au/LPAwhatson | Phone: 5176 3333

LatrobeCity
a new energy in the arts

Approximately 105 people attended the launch, including community members and a number of representatives from local health services.

Finger food was provided upon arrival, and representatives from local health services were available to provide information on chronic illnesses. A range of agencies were invited to display information relating to their services and programs for people with chronic illness, with the following agencies having an information table at the event:

- Latrobe Community Health Service
- Latrobe Regional Hospital
- Latrobe City Council
- Diabetes Victoria

In addition to providing relevant written information, a representative from each service was available to chat with community members and respond to any questions they had regarding services available.

The play 'Six Degrees of Diabetes' was then performed, after which a panel of health professionals was convened to answer any community questions. The panel comprised five representatives from local services:

- Latrobe Community Health Service (Respiratory Educator /Complex Care Coordinator and Clinical Nurse Consultant / Diabetes Educator)
- Latrobe Regional Hospital (Nurse Unit Manager Health Independence Programs (HIP) and HIP Clinician)
- Latrobe City Council (Aged and Disability Services Officer).

Questions asked of the panel included the following:

- Availability of exercise groups.
- Lack of hydrotherapy pool in Traralgon (and lack of inclusion of hydrotherapy in the new aquatic centre plans).
- Services for younger people with disabilities.

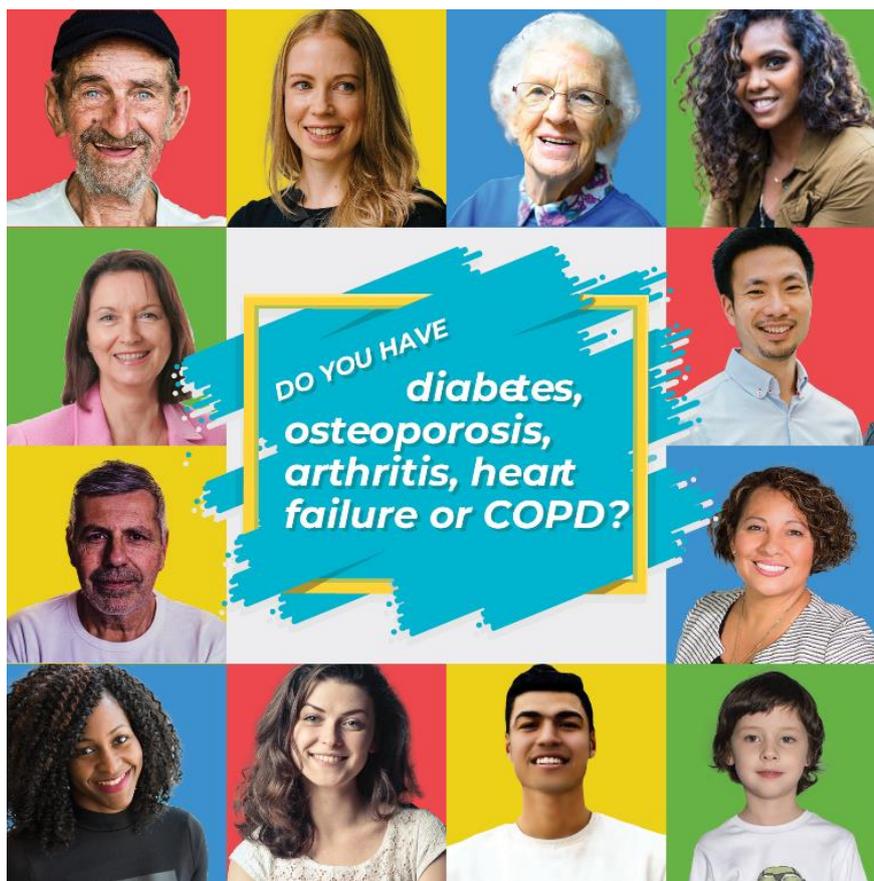
Panel members were able to provide comprehensive responses to all questions asked, after which community members took the opportunity to discuss issues of relevance with local health service representatives.

At the close of the event, attendees were also offered the opportunity to provide their contact details if they were interested in participating in a one-on-one conversation with a volunteer Peer Facilitator to share their experiences of living with a chronic illness.

b. Social media / media / online community engagement and project promotion

A social media / media / online strategy was developed and delivered utilising several targeted platforms. These included Facebook, local newspapers (media releases and paid advertisements), a promotional postcard and key agencies' newsletters / webpages (e.g. Latrobe Community Health Service, Latrobe Regional Hospital, Latrobe Health Assembly, Latrobe City Council). These platforms were used to promote the project, put key messages out to the community, publicise locations where volunteers would be conducting face-to-face conversations and provide the link to the 'Latrobe Living Well Conversations' online version of the survey.

Four rotating posts published on the Latrobe Health Assembly Facebook page can be seen below (each post was accompanied by the image):



1. Do you have diabetes, osteoporosis, arthritis, heart failure or COPD?
Live in the Latrobe Valley?
Click here to have your say about improving health and support services for people living with your chronic illness: www.surveymonkey.com/r/latrobe
2. Have COPD, heart failure, arthritis, osteoporosis or diabetes?
Live in the Latrobe Valley?
Interested in being in a video to share your story about living with a chronic illness?
Contact Central West Gippsland Primary Care Partnership on Ph. 5127 9156 or Email cwgpcp@gmail.com for more information.
3. Want to have your say about improving health and support services to help people with chronic illness live well?
Have arthritis, heart failure, osteoporosis, diabetes or COPD and live in Latrobe Valley?
Contact Central West Gippsland Primary Care Partnership on Ph. 5127 9156 or Email cwgpcp@gmail.com to arrange a confidential discussion with one of our volunteers.
4. Osteoporosis, COPD, arthritis, heart failure or diabetes?
Interested in sharing your story about living with a chronic illness?
Look out for our 'Living Well with Chronic Illness' banner in libraries, GP clinics, pharmacies, health services, community centres and at community events.
Chat confidentially to one of our friendly volunteers!

Some of the local print media publications used to promote the project can be seen below:



A link to a short video produced in conjunction with Latrobe Community Health Service for publication on their Facebook page can be viewed here:

<https://www.facebook.com/latrobecommunityhealthservice/videos/784697395282450/>

The postcard developed to promote the project and publicise the link to the online version of the 'Latrobe Living Well Conversations' survey can be seen below:

A Latrobe Valley Community Consultation:

- to find out how people manage their health.
- focusing on common chronic illnesses including diabetes, osteoporosis, arthritis, heart failure and COPD.
- to identify ways to improve health services.

Community Feedback Options:

- Confidential discussion with our volunteers
- Complete the online Survey (closing 30/9/19): www.surveymonkey.com/r/latrobe
- Express interest to participate in a video to share your health journey - contact: Central West Gippsland Primary Care Partnership: Ph: (03) 5127 9156 Email: cwgpccp@gmail.com

c. Town based conversations

Community conversations were held in a variety of locations across each of the four major towns within the Latrobe Valley (Moe, Morwell, Churchill and Traralgon). These included libraries, shopping centres, support/self-help groups, Planned Activity Groups (PAGs), leisure centres and RSL clubs. Visits to these locations by the project volunteers were promoted to the community beforehand to inform people about the purpose of the project and where to look out for the volunteers with their 'Living Well with Chronic Illness' banner if they wished to share their stories about living with a chronic illness.

The project also sought to identify large local events scheduled to occur during the project timelines (i.e. large township markets, shows, expos etc.) where conversations with community members could take place. Ultimately, however, very few suitable events were scheduled during the consultation period and volunteers were not available to attend those that were identified.

d. Conversations at GP Clinics and Pharmacies

Two pharmacies and a GP practice with multiple clinic locations were selected for participation in the project. Selection was based on:

- The likelihood of the clinic/pharmacy having a high number of clients with a chronic disease and a varied demographic of clients.
- Willingness of the owners/managers to participate in the project.

Where possible, a private room was made available for the volunteers to conduct one-on-one interviews with community members who were attending the clinic/pharmacy.

e. Conversations at flexible times in locations of community members' choice

Community members who were interested in participating in the project but who did not wish to share their story at one of the public locations attended by the volunteers were offered one-on-one conversations in a location and at a time of their choice. For example, over the phone or at a café.

Latrobe Living Well Conversations – List of Locations

The table below shows the locations where the face-to-face conversations were held and the locations the surveys and postcards were delivered to:

Location	Face-to-face conversations	Surveys / postcards distributed
Traralgon	<ul style="list-style-type: none">• GP Clinic / foyer, Latrobe Community Health Service, Traralgon.• Traralgon Library.• Stockland Plaza Shopping Centre, Traralgon.	<ul style="list-style-type: none">• Revolution Spin Fit, Traralgon.• Gippsland Physio Group, Traralgon.• Latrobe Valley Physio, Traralgon.• Regional Imaging, Traralgon.• McMillan Chiropractic, Traralgon.• Traralgon Chiropractic, Traralgon.• mBrace Chiropractic and Orthotics, Traralgon.• Traralgon Library.• Latrobe Community Health Service, foyer/waiting area at Traralgon site.

<p>Morwell</p>	<ul style="list-style-type: none"> • GP Clinic, Latrobe Community Health Service, Morwell. • Planned Activity Group, Latrobe Community Health Service, Morwell. • Advantage Pharmacy, Morwell. • Chemist Discount Centre, Morwell. 	<ul style="list-style-type: none"> • Aboriginal Health & Wellbeing Centres: <ul style="list-style-type: none"> ○ Central Gippsland Aboriginal Health Service, Ninde Dana Quarenook, Morwell (Ramahyuck). ○ Brayakooloong Community Wellbeing Centre, Morwell (GEGAC). ○ The Gathering Place, Morwell (incl. Koorie Leaders providing surveys directly to Koorie Elders Groups and Koorie Support Groups). • Latrobe Leisure Centre, Morwell: <ul style="list-style-type: none"> ○ Latrobe Leisure Leader also passed on surveys directly to Latrobe Leisure Arthritis Hydrotherapy Group. • Latrobe City Council foyer, Morwell. • Latrobe Community Health Service, foyer/waiting areas at Morwell site (GP Clinic, General, Dental).
<p>Churchill</p>	<ul style="list-style-type: none"> • Planned Activity Group, Latrobe Community Health Service, Churchill. • GP Clinic / waiting area, Latrobe Community Health Service, Churchill 	<ul style="list-style-type: none"> • Latrobe Leisure Centre Churchill: <ul style="list-style-type: none"> ○ Latrobe Leisure Leader also passed on surveys directly to Latrobe Leisure Arthritis Hydrotherapy Group and registered clients with chronic illness identified. • Churchill Community Hub. • Churchill Library. • Federation University, Churchill. • Latrobe Community Health Service, foyer/waiting area at Churchill site.
<p>Moe / Newborough</p>	<ul style="list-style-type: none"> • GP Clinic, Latrobe Community Health Service, Moe. • Planned Activity Group, Latrobe Community Health Service, Moe. • Moe Library. • Moe RSL. • Arthritis Support Group, Moe. • Moe/Newborough Senior Citizens. • Latrobe Leisure Centre, Moe/ Newborough. 	<ul style="list-style-type: none"> • Arthritis Support Group, Moe. • Newborough Senior Citizens. • Keenagers Table Tennis Group (over 55s), Moe/ Newborough. • Latrobe Valley Village Independent Living Units, Moe. • Latrobe Leisure Centre, Moe/Newborough. • Private chiropractors, physios, podiatrists, pathology collection centres, optometrists and GP Clinics in Moe. • Laundrettes in Moe. • Moe V/Line Railway Station. • Latrobe Community Health Service, foyer/ waiting areas at Moe site.

	<ul style="list-style-type: none"> • Keenagers Table Tennis Group (over 55s), Moe/ Newborough. • Latrobe Valley Village Independent Living Units (incl. residents' visitors), Moe. 	
<p>Other within and/or across Latrobe City LGA</p>	<ul style="list-style-type: none"> • Relatives and friends of volunteers (various locations). 	<ul style="list-style-type: none"> • Latrobe City Council: <ul style="list-style-type: none"> ○ 1400 hard-copy surveys provided to 94 LCC Support Workers for distribution to home/ personal care clients across Latrobe City. • Latrobe Community Health Service: <ul style="list-style-type: none"> ○ Chronic Disease Management clinicians provided directly to clients with diabetes, osteoporosis, arthritis, heart failure and COPD across entire Latrobe LGA. • Latrobe City Council Events Page online. • Latrobe Valley Express Feature advertisements across the month of September 2019.

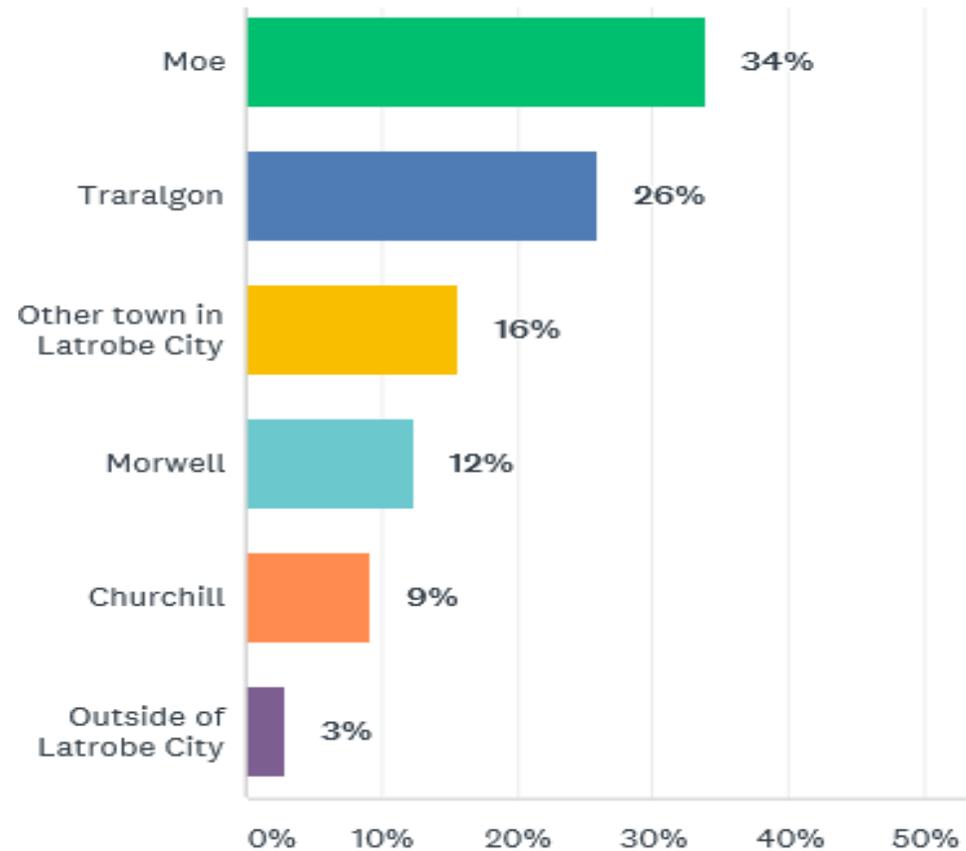
Results

Collation and thematic analysis of the data was undertaken. In total 302 people shared their stories of living with chronic illness. From these 302 responses 1,184 comments were analysed and themed. Results for the 5 conditions can be seen below.

A. General Demographic Data

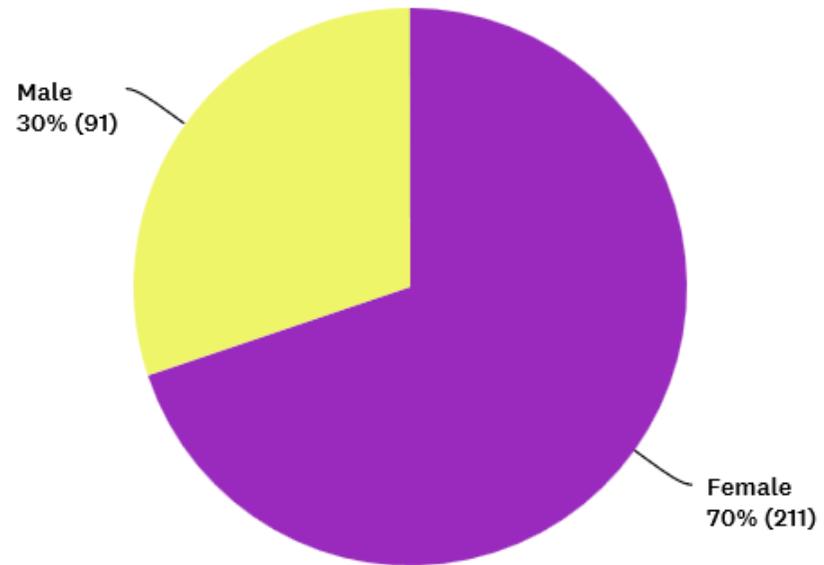
Q.1 Which town do you live in? (n=301)

- ❖ 81% of respondents were community members living in one of the four Latrobe Valley towns which were the major focus of the project i.e. Moe, Morwell, Churchill or Traralgon.



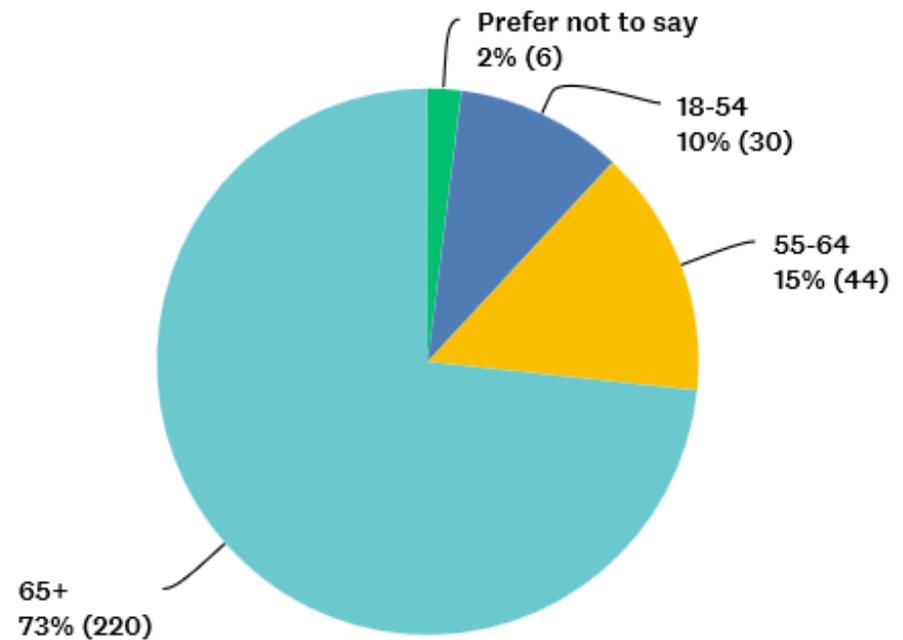
Q.2 What is your gender? (n=302)

- ❖ A large majority of respondents (70%) were female.

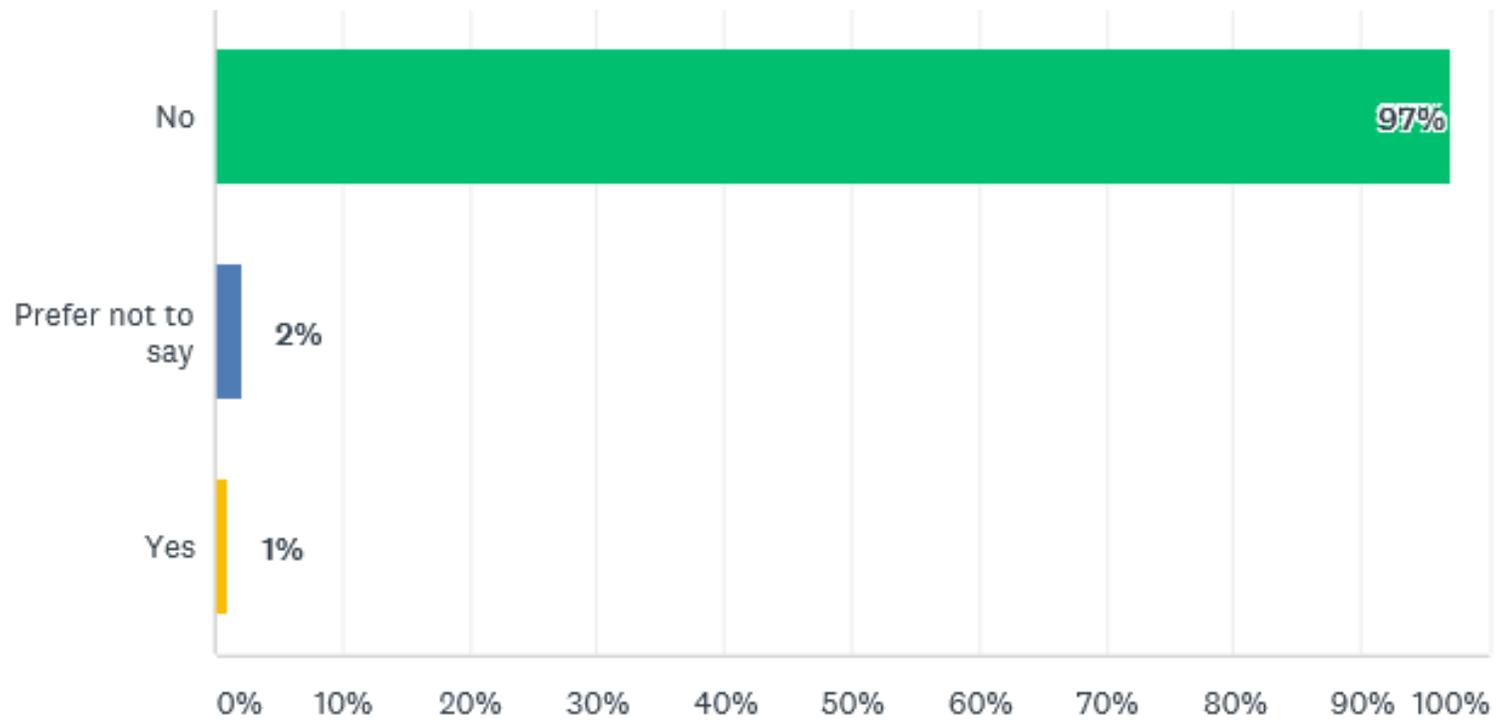


Q.3 What is your age group? (n=300)

- ❖ A large majority of respondents (73%) were from the 65+ age group.



Q.4 Are you Aboriginal or Torres Strait Islander? (n=301)



- ❖ Despite surveys and/or postcards being distributed across a number of indigenous organisations, only 1% of respondents identified themselves as Aboriginal or Torres Strait Islander, with a further 2% preferring not to say.

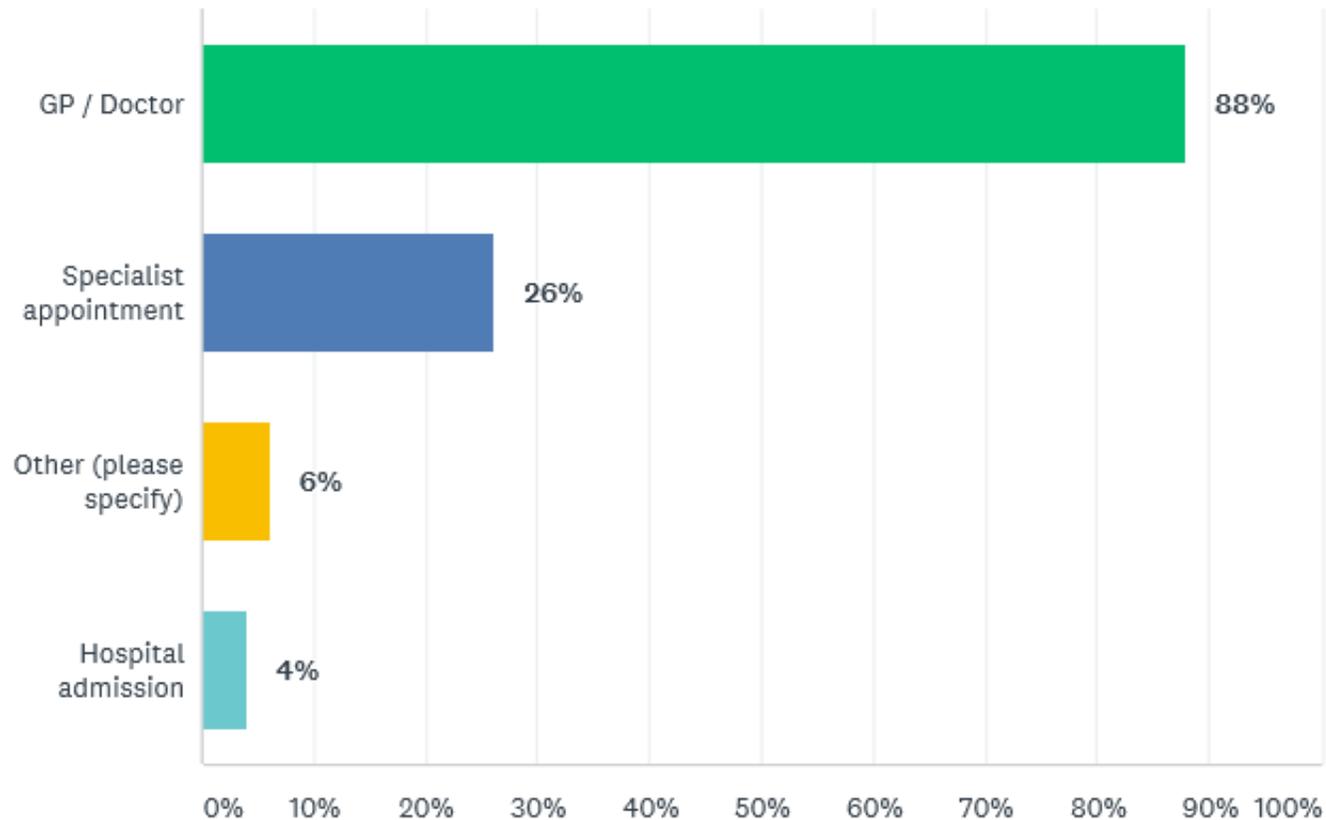
B. Arthritis

Q.5 Have you been diagnosed with Arthritis?

Yes: 156

Q.6 How did you find out you have Arthritis? (n=149)

Note: respondents were able to tick more than one box.

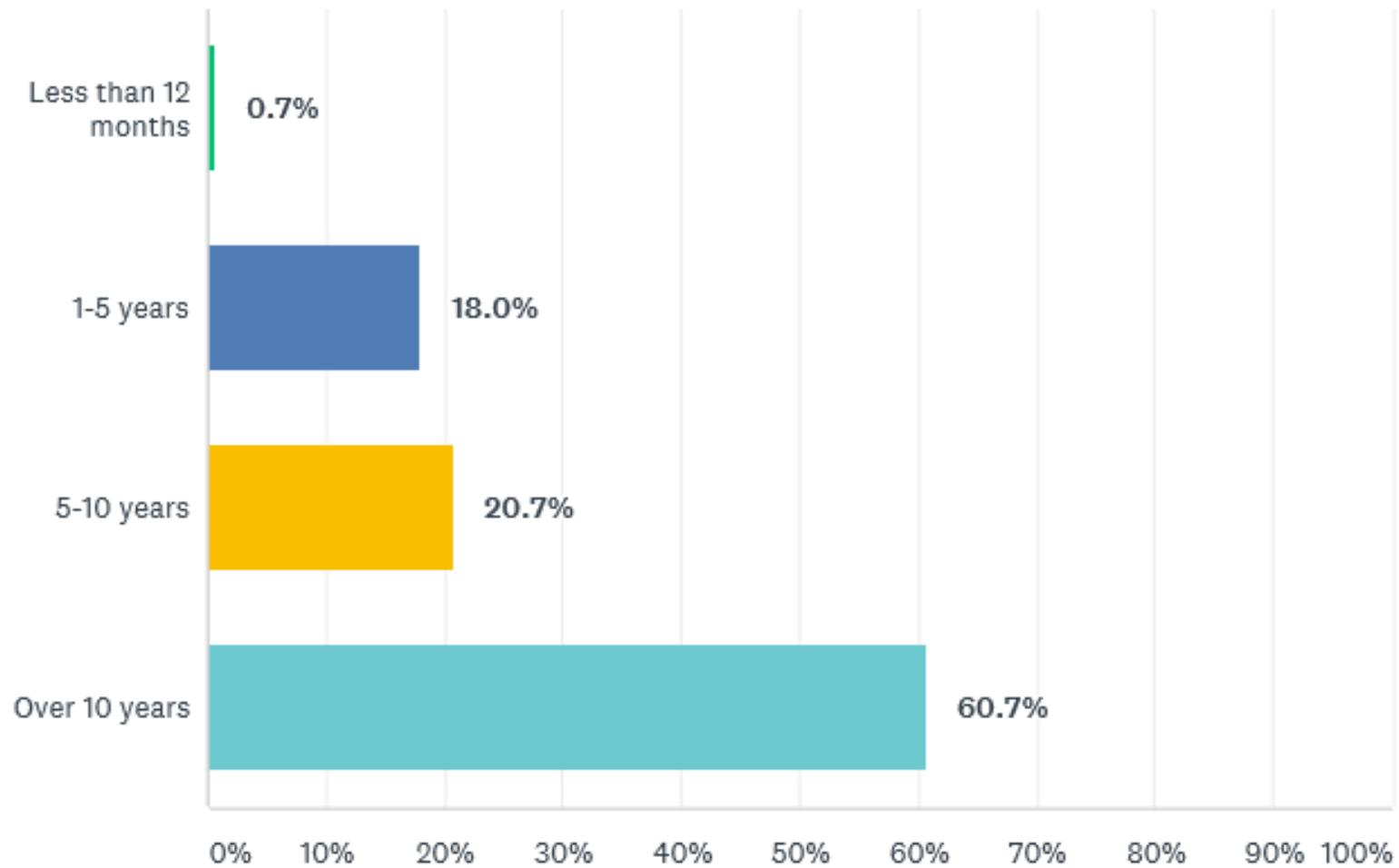


Other:

- MRI / CT / Radiography (3)
- Before or after surgery (2)
- After a fall / car accident (2)
- Pain / self-diagnosis (2)

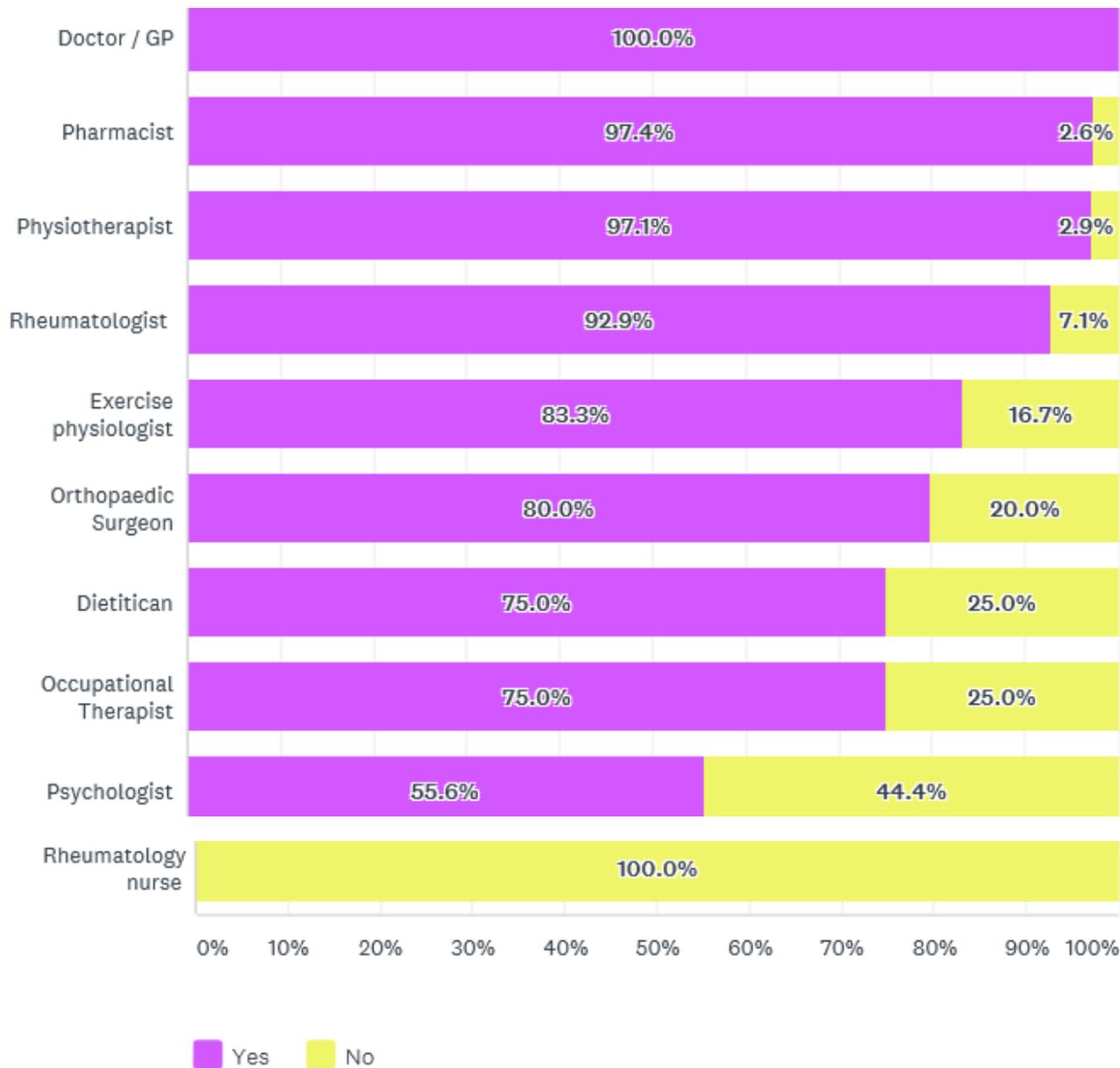
- ❖ The vast majority of respondents (88%) found out that they had arthritis from their GP / Doctor.
- ❖ In about a quarter of cases, diagnosis was in conjunction with / as a result of an appointment with a Specialist.

Q.7 When were you diagnosed with Arthritis? (n=150)



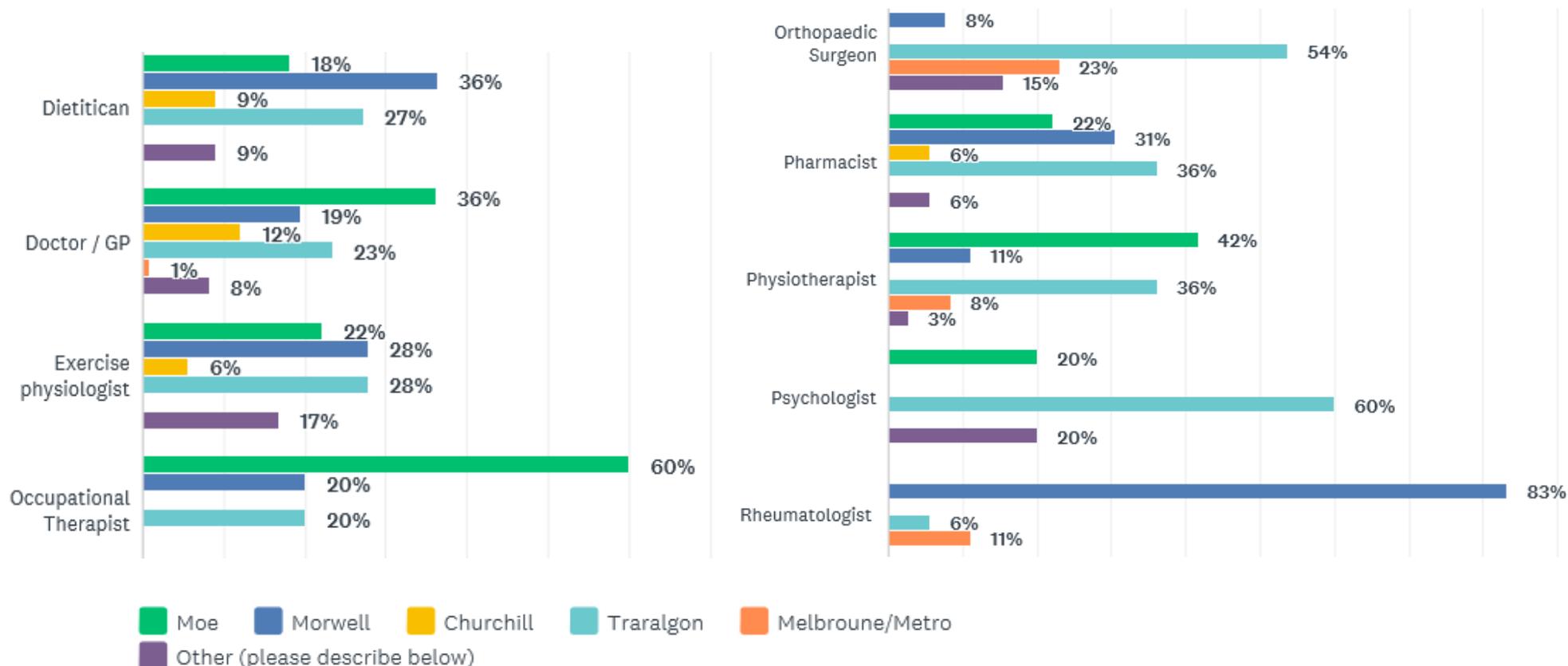
- ❖ Over 60% of respondents had been living with their arthritis for over 10 years.
- ❖ Only a very small percentage (less than 1%) were newly diagnosed i.e. under 12 months.

Q.8 Which health professionals do you see for your Arthritis? (n=150)



- ❖ Respondents reported seeing a wide range of health professionals for their arthritis.
- ❖ All respondents indicated that they saw their Doctor/GP.
- ❖ Over 90% indicated that they saw a pharmacist, physiotherapist and/or rheumatologist.
- ❖ Over 75% indicated that they saw an exercise physiologist, orthopaedic surgeon, dietitian and/or occupational therapist.
- ❖ Over 55% saw a psychologist.
- ❖ None of the 150 respondents to this question saw a rheumatology nurse.

Which town do you see them in for your Arthritis? (n=150)

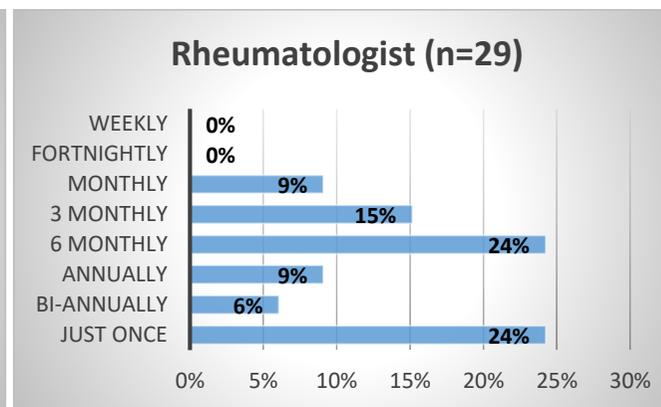
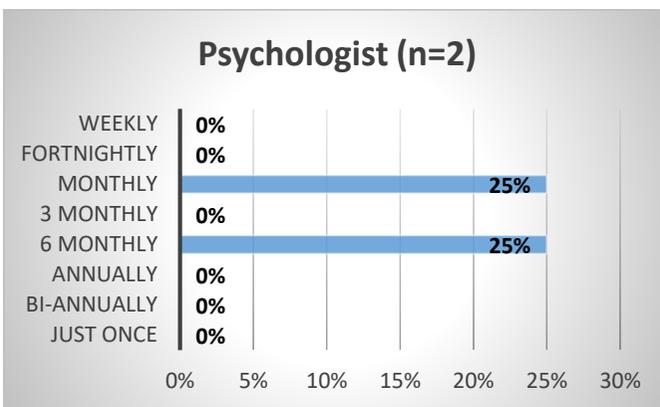
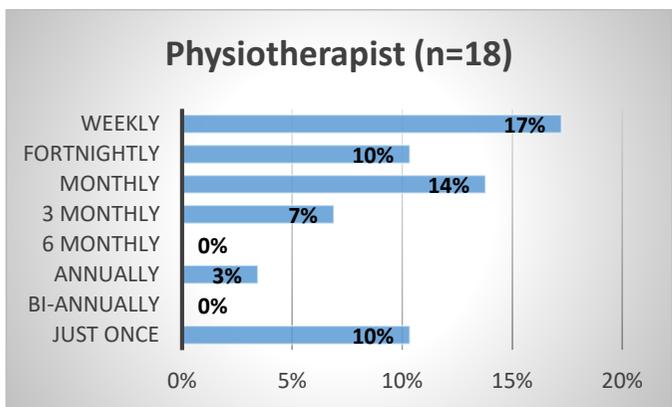
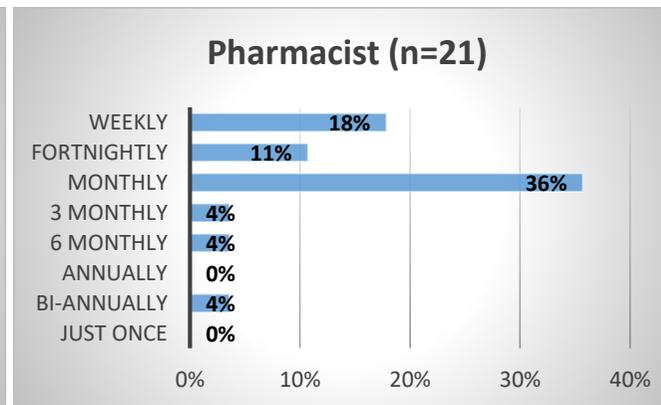
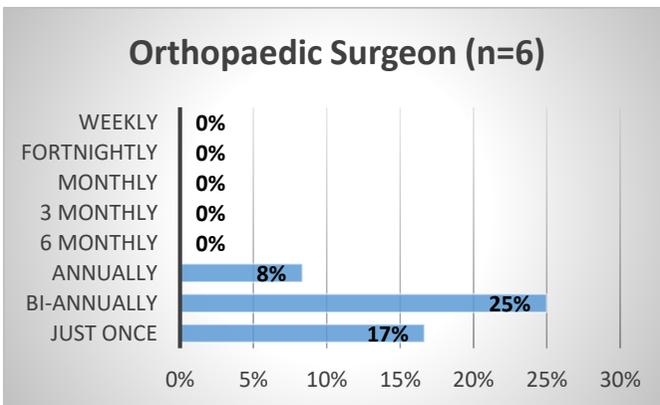
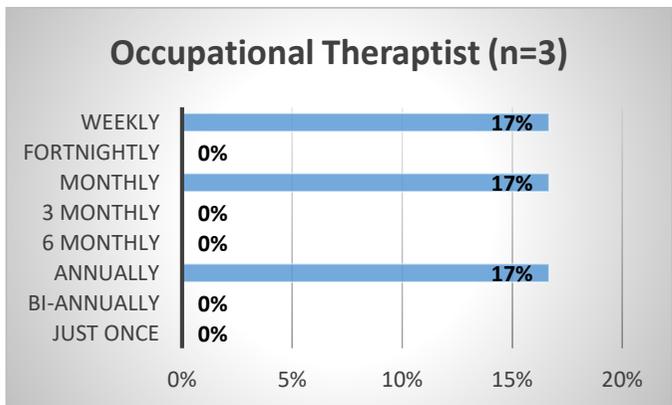
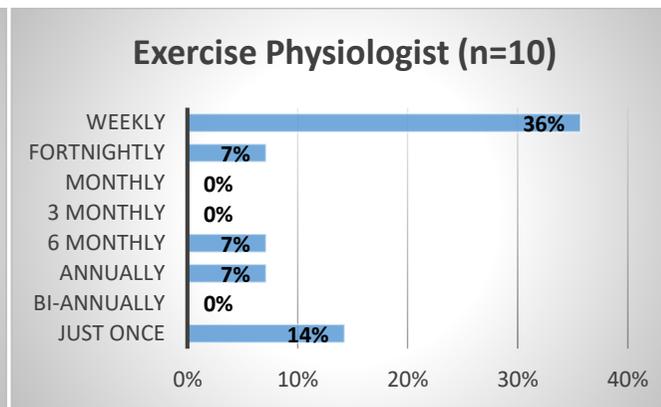
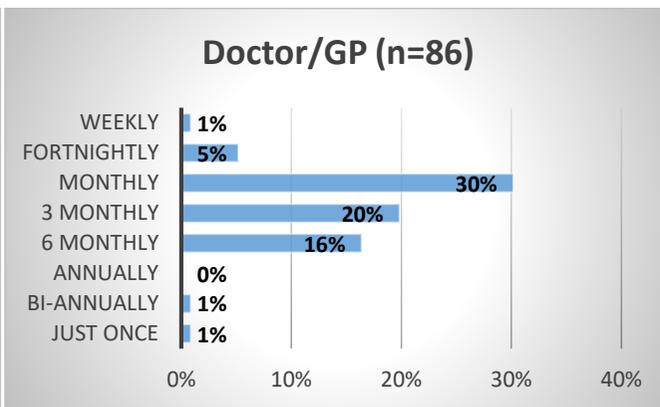
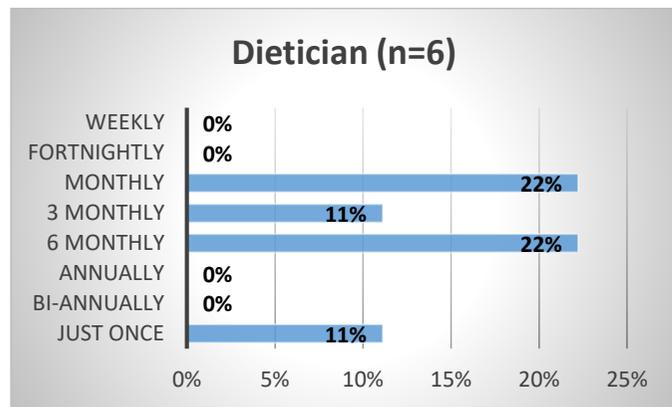


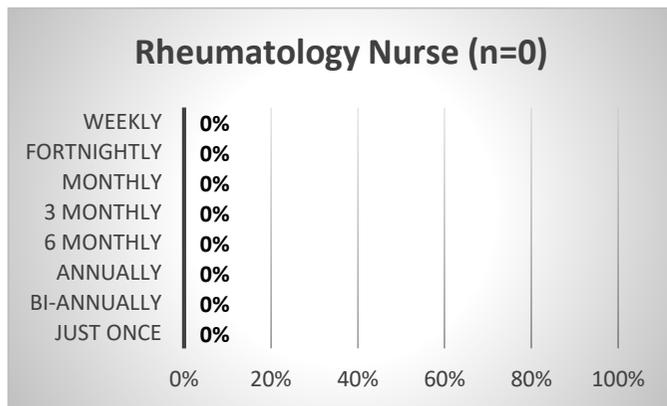
Other towns:

- Newborough 5 (masseur 2, exercise physiologist 1, GP 1, health professional unknown 1).
- Warragul 4 (specialist 1, GP 1, osteopath 1, physiotherapist 1).
- Carrum Downs 2 (GP); Dandenong 2 (podiatrist 1, physiotherapist 1); Town not specified: 2 (pharmacist).
- Drouin 1 (GP); Yinnar 1 (GP); Bunyip 1 (GP); Neerim South 1 (GP); Trafalgar 1 (GP); Berwick 1 (physiotherapist); Pakenham 1 (psychologist); Sale 1 (specialist); Narre Warren 1 (health professional unknown); Korumburra 1 (health professional unknown).

- ❖ The vast majority of respondents saw all of their health professionals within Gippsland (Moe, Morwell, Churchill, Traralgon or another Gippsland town).
- ❖ The only health professionals a significant number of respondents reported going to Melbourne/Metro to see were their orthopaedic surgeon (23%), rheumatologist (11%) or physiotherapist (8%).

How often do you see them for your Arthritis? (n=150)





- ❖ Frequency of visits varied widely across almost all of the health professionals that the respondents reported seeing for their arthritis.
- ❖ However, without further information it is not possible to ascertain whether the longer gaps between visits are due to a lack of clinical need, lack of availability, cost or some other factor.

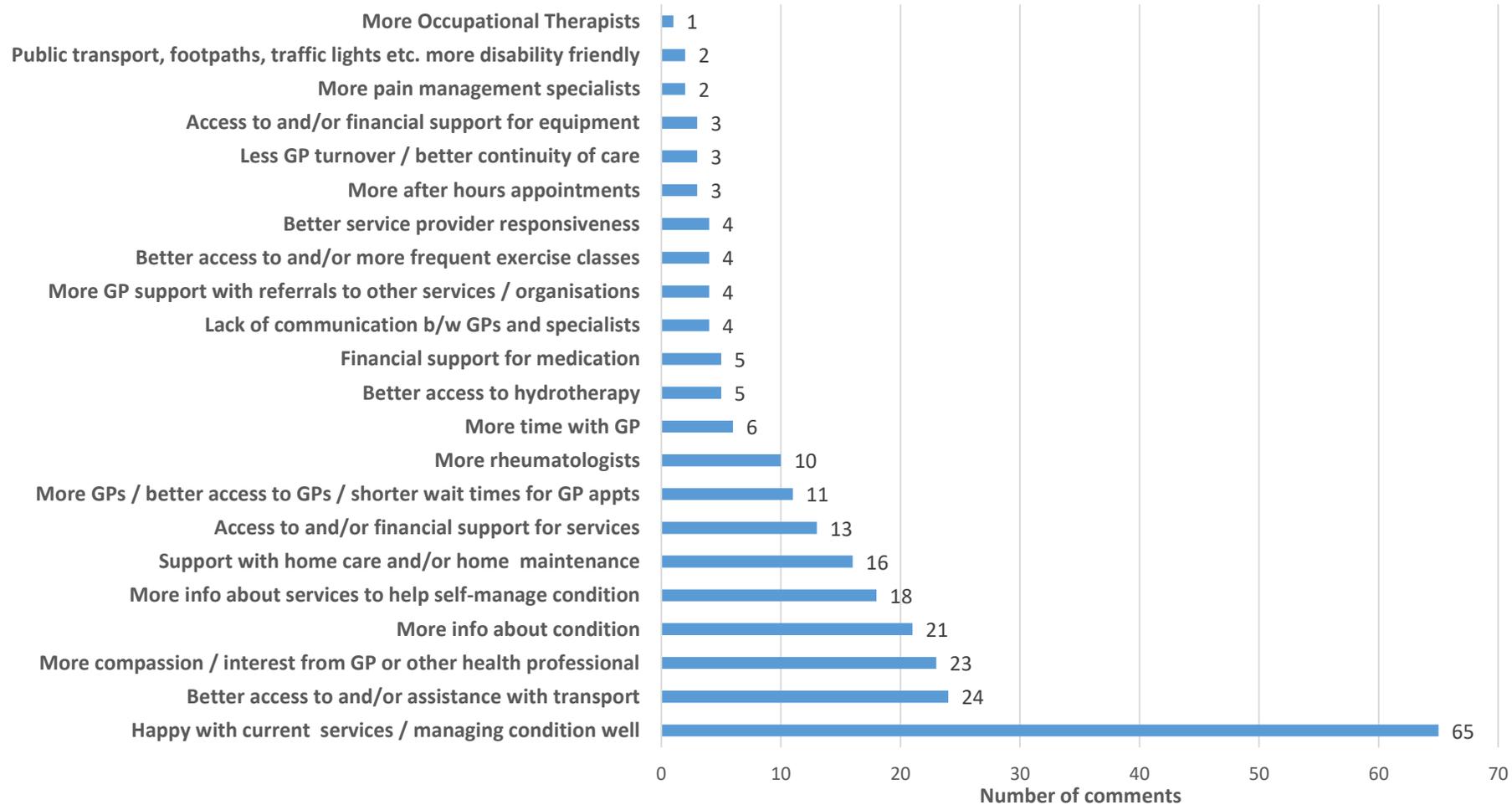
Answer Choices	Weekly	Fortnightly	Monthly	3 monthly	6 monthly	Annually	Bi-annually	Just once	Total
Dietician	0%	0%	22%	11%	22%	0%	0%	11%	6
Doctor / GP	1%	5%	30%	20%	16%	0%	1%	1%	86
Exercise physiologist	36%	7%	0%	0%	7%	7%	0%	14%	10
Occupational Therapist	17%	0%	17%	0%	0%	17%	0%	0%	3
Orthopaedic Surgeon	0%	0%	0%	0%	0%	8%	25%	17%	6
Pharmacist	18%	11%	36%	4%	4%	0%	4%	0%	21
Physiotherapist	17%	10%	14%	7%	0%	3%	0%	10%	18
Psychologist	0%	0%	25%	0%	25%	0%	0%	0%	2
Rheumatologist	0%	0%	9%	15%	24%	9%	6%	24%	29
Rheumatology nurse	0%	0%	0%	0%	0%	0%	0%	0%	0

Q.9 How well do the current supports work for you and why? Is there anything that makes it harder for you to manage? (e.g. transport, time, family commitments, knowledge, lack of response from service providers, opening hours, bad experience etc?)

Q.12 What would make it easier for you to manage your Arthritis?

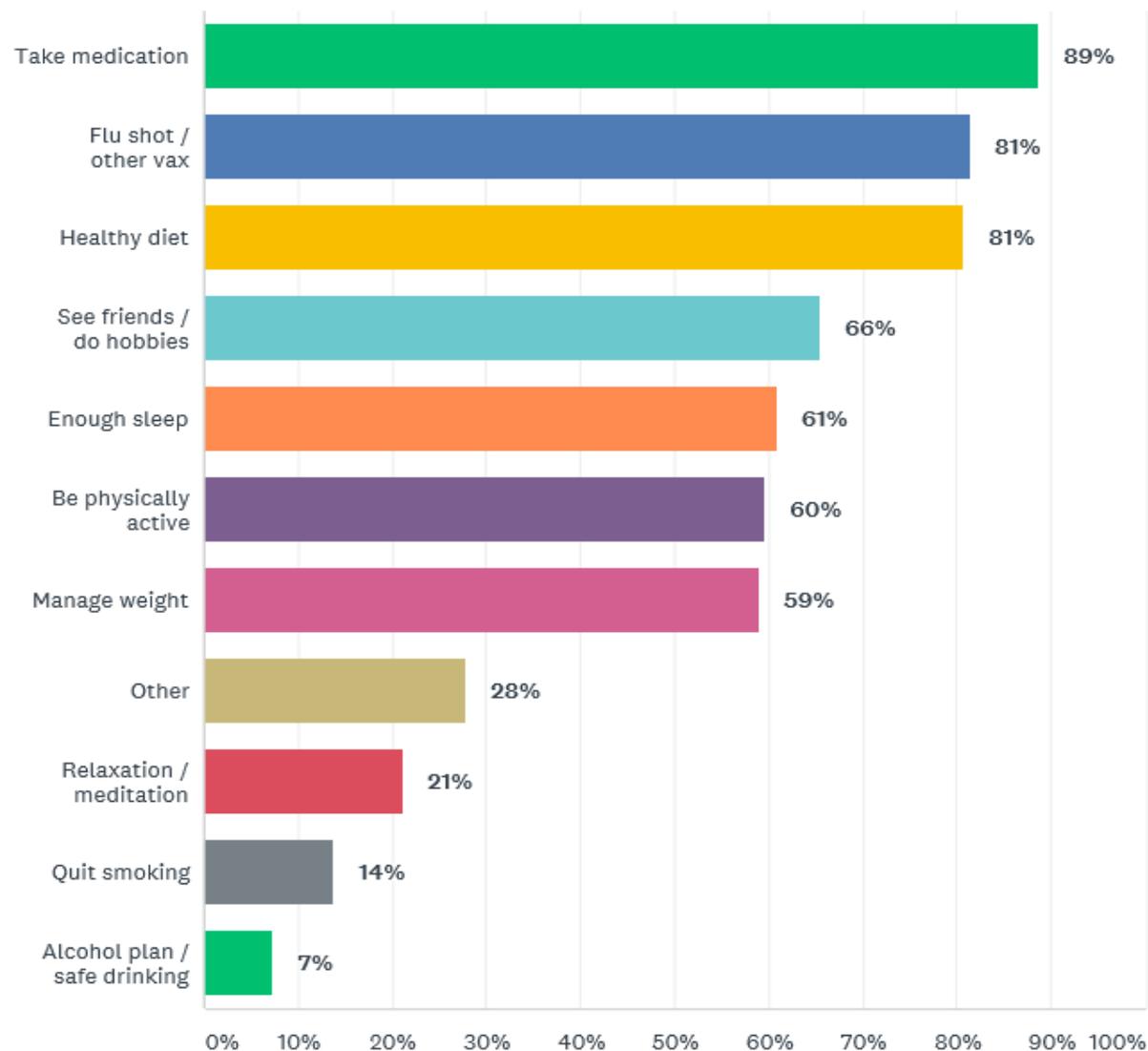
- Theming for Q.9 & Q.12 has been collated

Total no. of comments re Q.9 & Q.12: 121 + 114 = n=235



- ❖ 65 of the 156 respondents with arthritis (42%) indicated that they were happy with their current services and managing their condition well.
- ❖ Suggestions for things that would make it easier for the respondents to manage their arthritis fell into 21 main themes.
- ❖ The most frequently mentioned themes (i.e. identified by over 10% of the 156 respondents) were:
 - Better access to and/or assistance with transport (15%),
 - More compassion / interest from their GP or other health professional (15%),
 - More information about their condition (13%),
 - More information about services to help self-manage their condition (11.5%),
 - Support with home care and/or home maintenance (10%).

Q.10 What are you currently doing to make life easier with your Arthritis? (n=151)

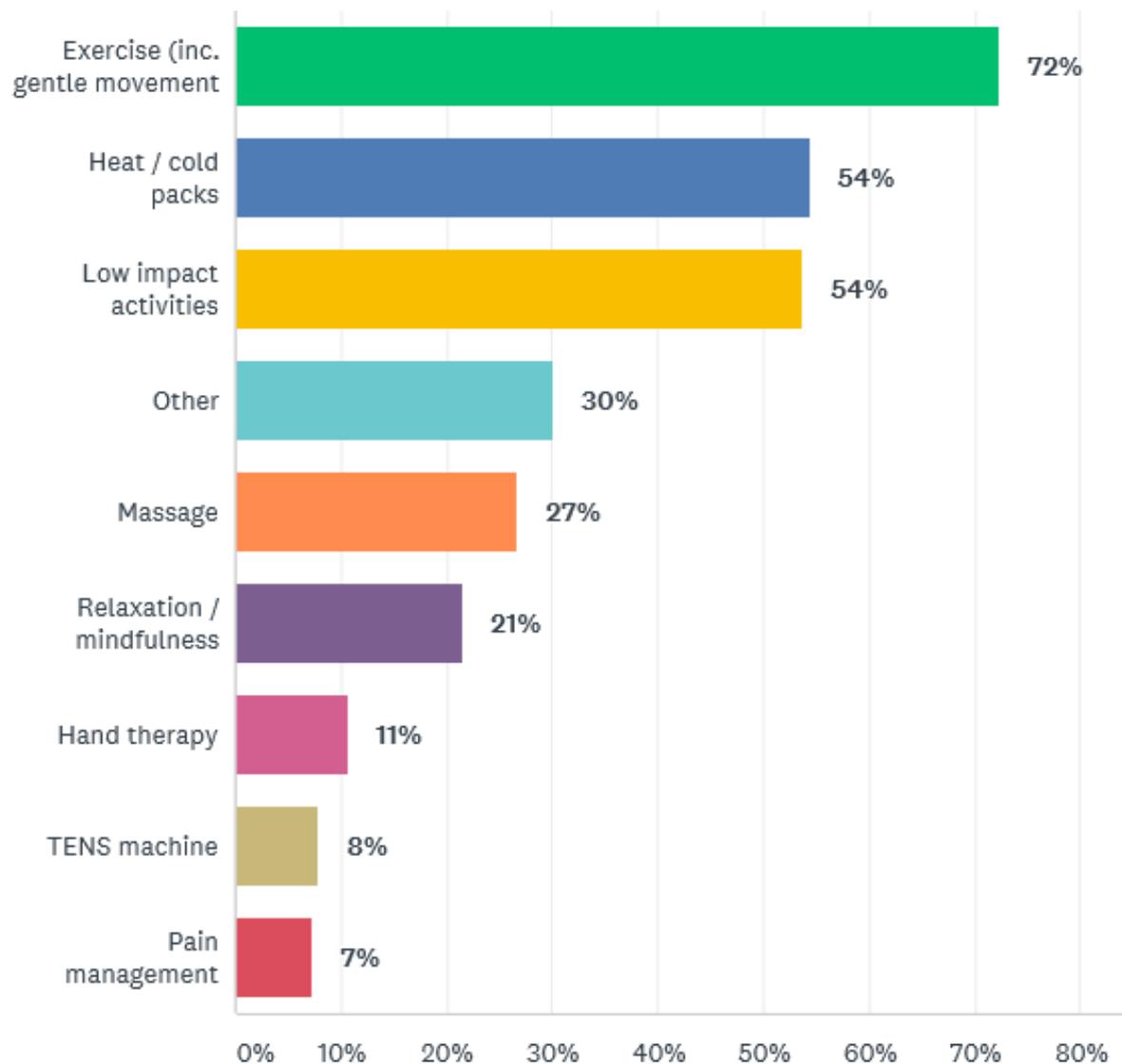


Other included:

- Massage (4)
- Don't smoke (4)
- Attend Arthritis Self-Help Group (3)
- Don't drink alcohol (3)
- Weekly injections / cortisone shots (2)
- Physiotherapy / chiropractic / Pilates (2)
- Acupuncture (2)
- Music (2)
- Heat / cold packs (2)
- Knitting (1)
- Attend Planned Activity Group (PAG) (1)
- Natural remedies (1)
- Attend church (1)
- Hydrotherapy (1)
- Attend Exercise (Falls & Balance) Group (1)
- Keep up-to-date on medical research and treatments (1)
- "Embrace misery" (1)

- ❖ Respondents reported using a wide variety of methods (usually in combination) to make life easier living with their arthritis.
- ❖ The most frequent (over 80%) were 'taking medication regularly', 'getting a flu shot and/or other vaccinations' and 'eating a healthy diet'.
- ❖ Over 60% also listed 'see friends/do hobbies', 'get enough sleep' or 'stay physically active e.g. walking group, gym, exercise group'.

Q.11 How do you manage your Arthritis? (n=149)



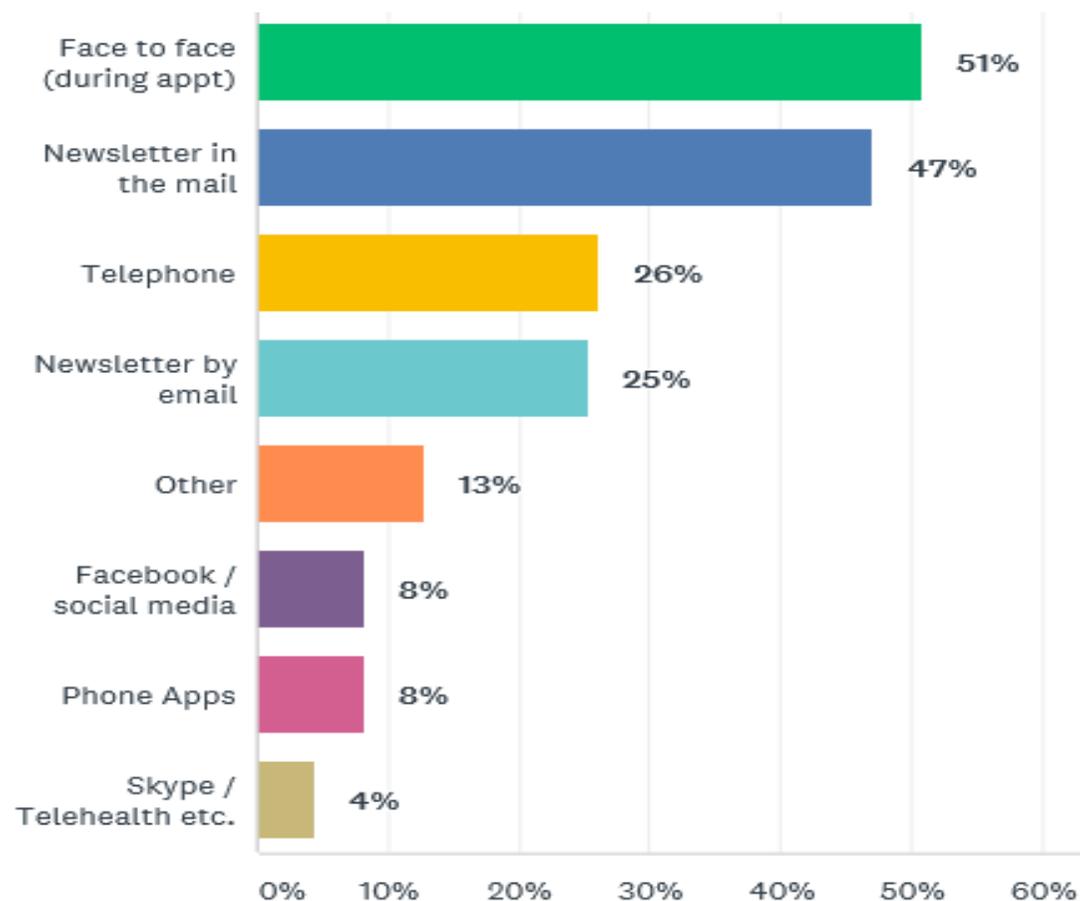
Other included:

- Pain medication (14)
- Home exercises / “keep moving” (5)
- Physiotherapy (3)
- Massage / self-massage (3)
- Acupuncture / dry needling (3)
- Water aerobics / swimming / hydrotherapy (2)
- Chiropractor (2)
- Knitting / crochet (2)
- Natural remedies / vitamin supplements (2)
- Relaxation / breathing exercises (2)
- Pilates (1)
- Cooking / baking (1)
- Smoke marijuana (1)
- Heat gloves (1)

- ❖ Respondents reported using a wide variety of methods (usually in combination) to manage their arthritis.
- ❖ The most frequent (over 70%) was ‘exercise including walking/gentle movement’.
- ❖ Over 50% also listed ‘using heat/cold packs on painful spots’ and ‘doing activities in a way to save energy/look after my joints’.

Q.13 What is the best way for health services to provide support to you with your Arthritis? (n=134)

Note: respondents were able to tick more than one box.



Other included:

- Face-to- face at home (4)
- Through arthritis self-help group (1)
- Through my doctor (1)
- SMS appointment reminders (1)

- ❖ The majority of respondents identified 'face-to face during an appointment' (51%) and/or a 'newsletter in the mail' (47%) as the best ways for health services to provide support to them.
- ❖ There was also some support for 'telephone' (26%) and/or a 'newsletter by email' (25%).

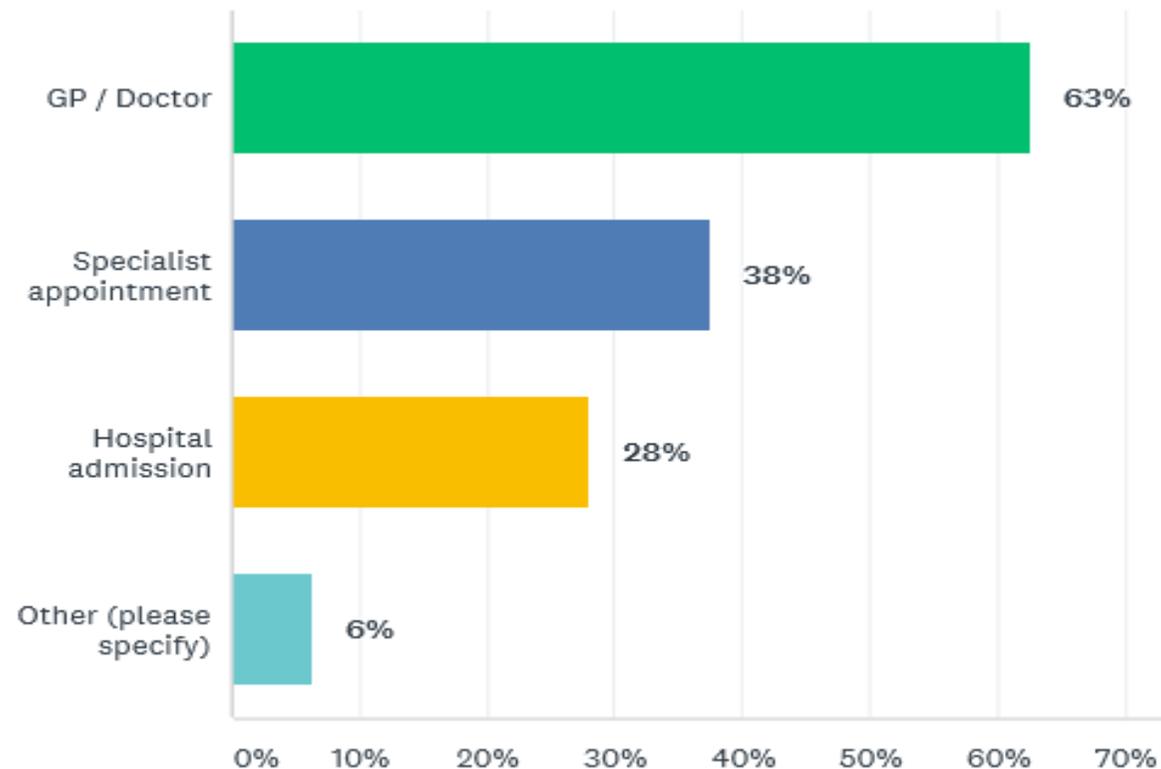
C. Chronic Obstructive Pulmonary Disease (COPD)

Q.14 Have you been diagnosed with COPD?

Yes: 33

Q.15 How did you find out you have COPD? (n=32)

Note: respondents were able to tick more than one box.

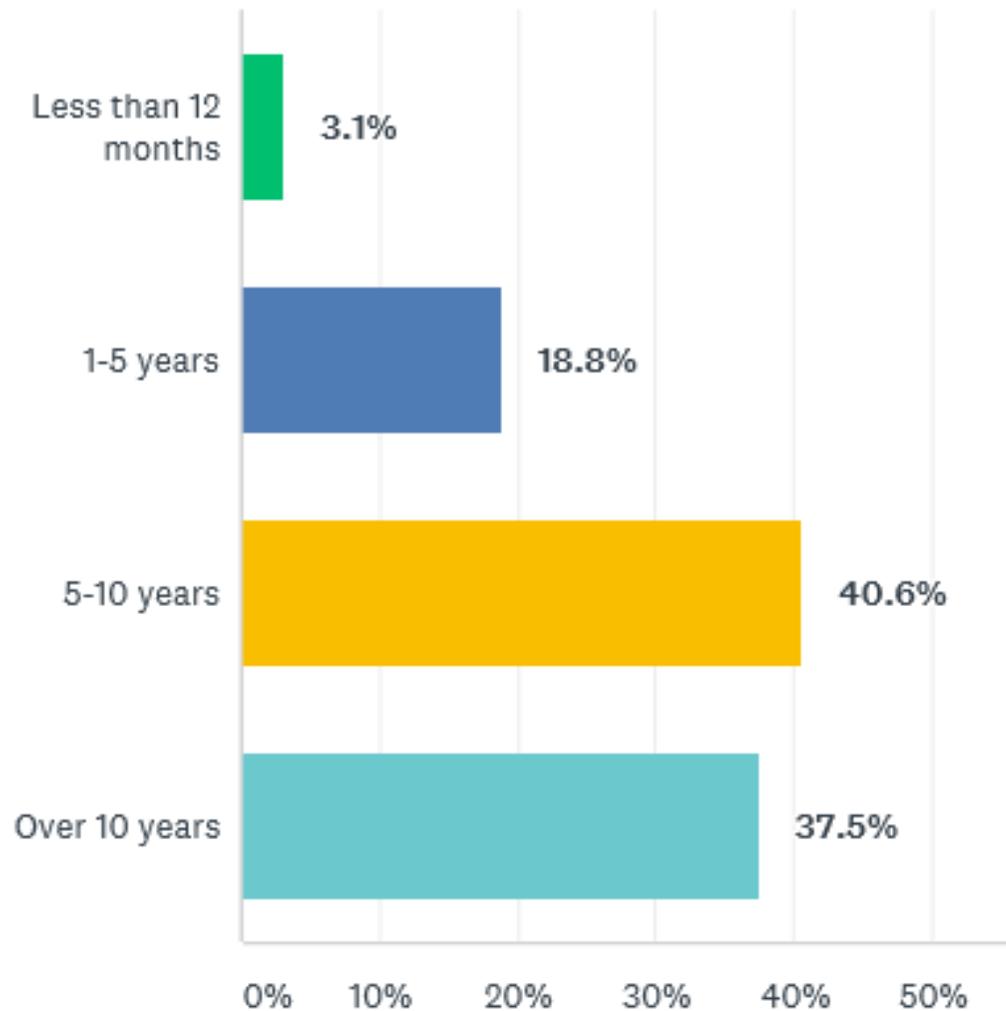


Other:

- When diagnosed with another lung disease (1)
- Combination of multiple GP visits due to trouble breathing and acute hospital admission (1)

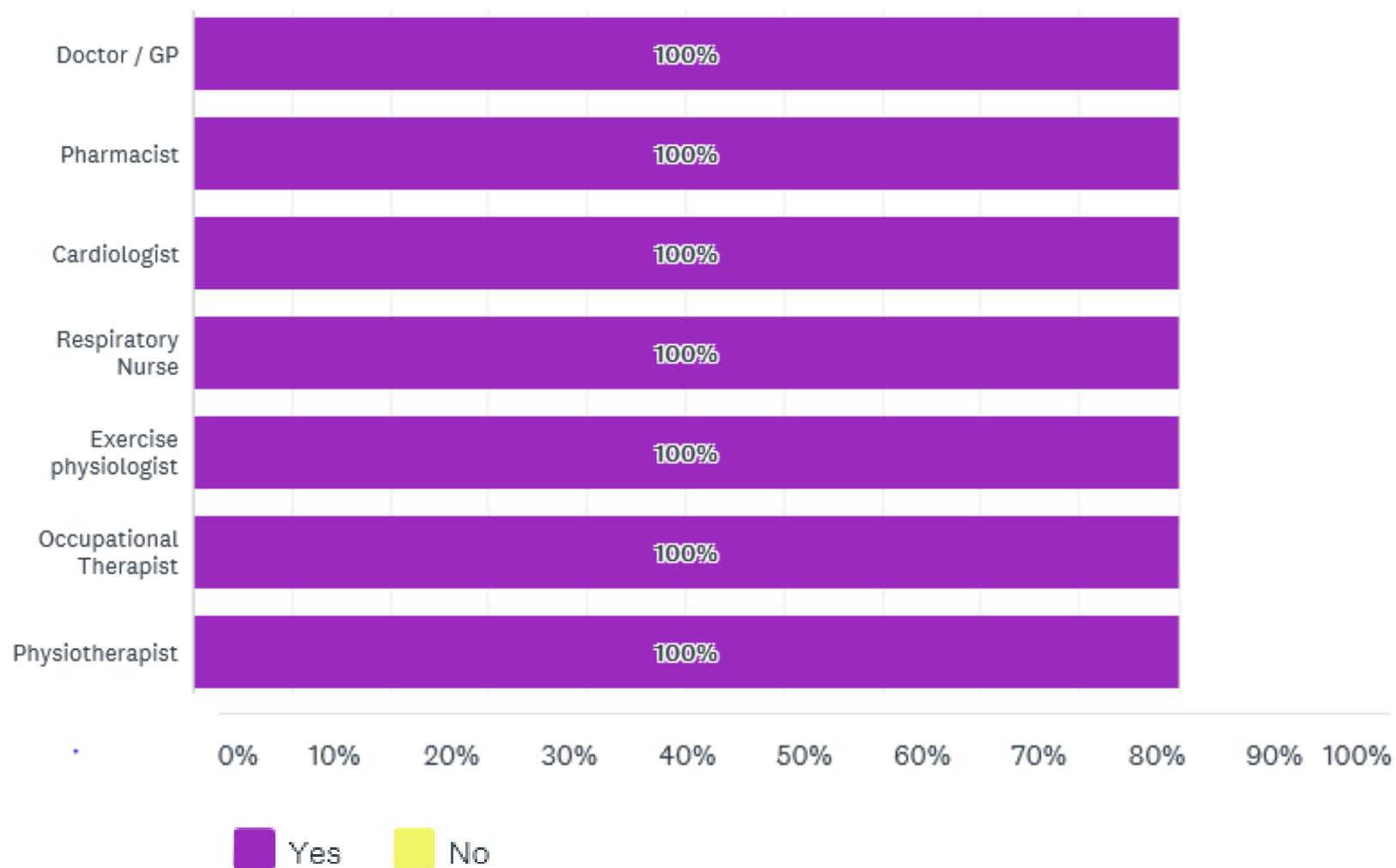
- ❖ A large majority of respondents (63%) found out they had COPD from their GP / Doctor.
- ❖ In almost 40% of cases, diagnosis was in conjunction with / as a result of an appointment with a Specialist.
- ❖ A significant number (28%) were diagnosed as a result of a hospital admission for some lung/respiratory related event or condition.

Q.16 When were you diagnosed with COPD? (n=32)



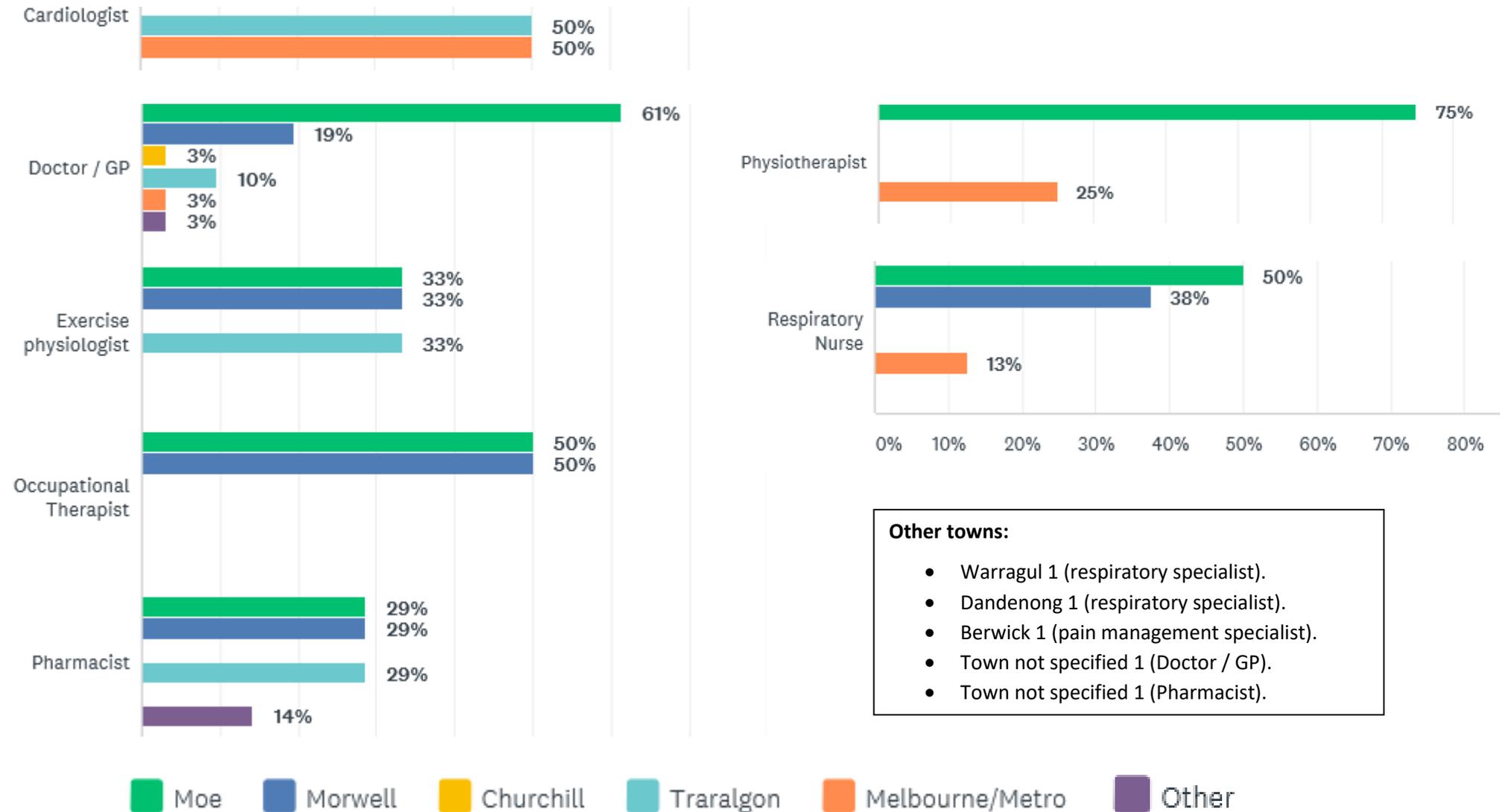
- ❖ The majority of respondents (40.6%) had been living with their COPD for between 5 and 10 years.
- ❖ A further 37.5% had been living with the condition for over 10 years.
- ❖ Only a very small percentage (3.1%) were newly diagnosed i.e. under 12 months.

Q.17 Which health professionals do you see for COPD? (n=32)



- ❖ All 32 respondents to this question reported seeing a range of health professionals for their COPD.
- ❖ 100% of those respondents indicated that they saw a Doctor/GP, pharmacist, cardiologist, respiratory nurse, exercise physiologist, occupational therapist and physiotherapist.

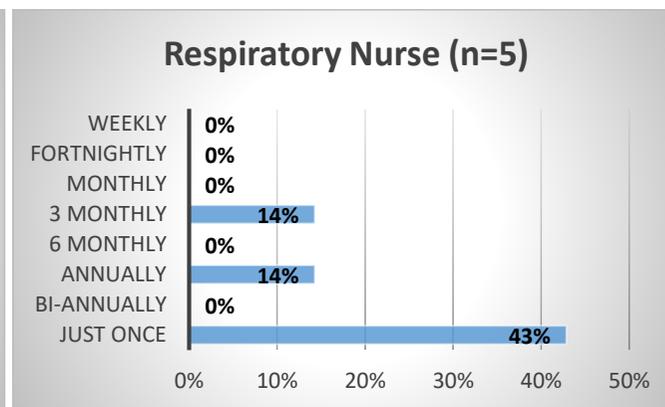
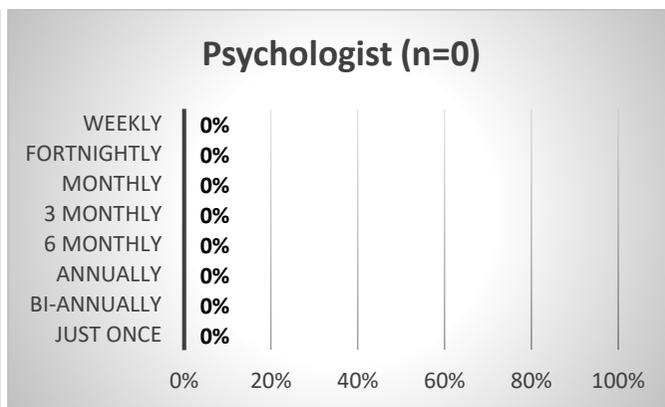
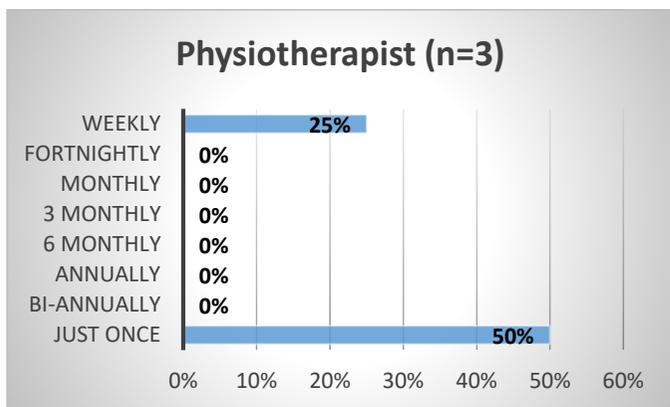
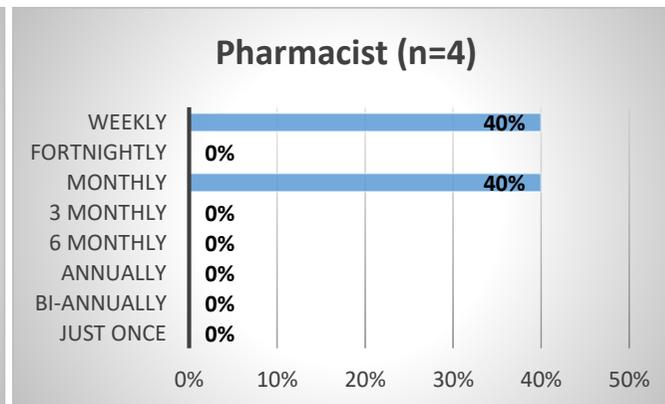
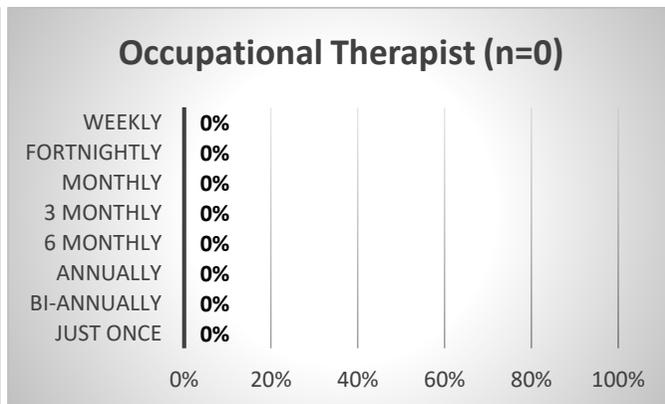
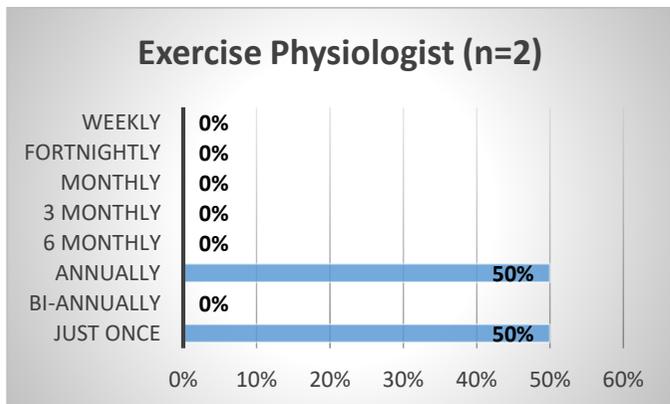
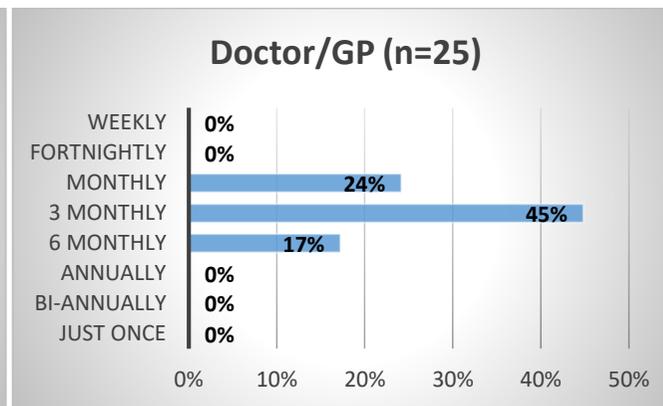
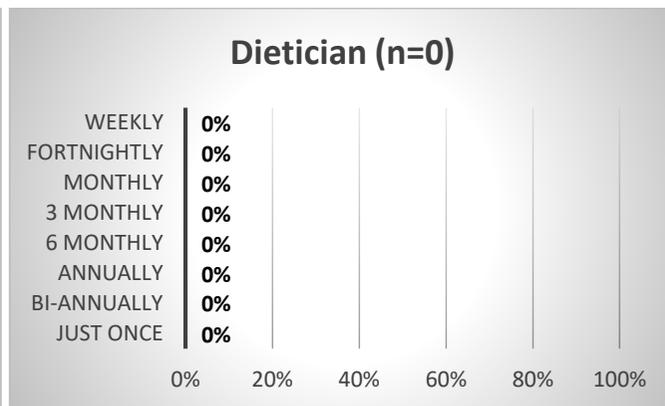
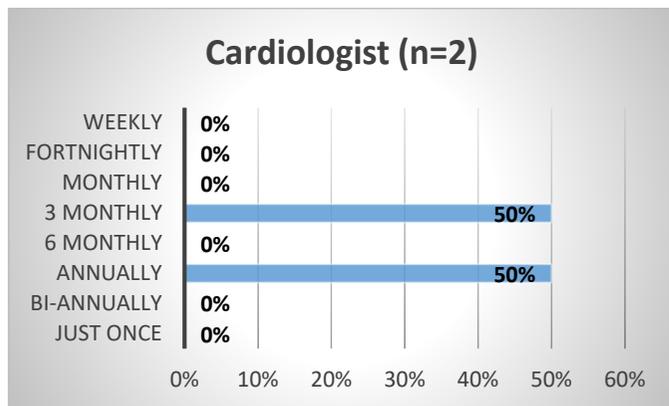
Which town do you see them in for your COPD? (n=32)



- Other towns:**
- Warragul 1 (respiratory specialist).
 - Dandenong 1 (respiratory specialist).
 - Berwick 1 (pain management specialist).
 - Town not specified 1 (Doctor / GP).
 - Town not specified 1 (Pharmacist).

- ❖ The vast majority of respondents saw all of their health professionals within Gippsland (Moe, Morwell, Churchill, Traralgon or another Gippsland town).
- ❖ The only health professionals a significant number of respondents reported going to Melbourne/Metro to see were their cardiologist (50%), physiotherapist (25%) and respiratory nurse (13%).

How often do you see them for your COPD? (n=32)



Answer Choices	Weekly	Fortnightly	Monthly	3 monthly	6 monthly	Annually	Bi-annually	Just once	Total
Cardiologist	0%	0%	0%	50%	0%	50%	0%	0%	2
Dietician	0%	0%	0%	0%	0%	0%	0%	0%	0
Doctor / GP	0%	0%	24%	45%	17%	0%	0%	0%	25
Exercise physiologist	0%	0%	0%	0%	0%	50%	0%	50%	2
Occupational Therapist	0%	0%	0%	0%	0%	0%	0%	0%	0
Pharmacist	40%	0%	40%	0%	0%	0%	0%	0%	4
Physiotherapist	25%	0%	0%	0%	0%	0%	0%	50%	3
Psychologist	0%	0%	0%	0%	0%	0%	0%	0%	0
Respiratory Nurse	0%	0%	0%	14%	0%	14%	0%	43%	5

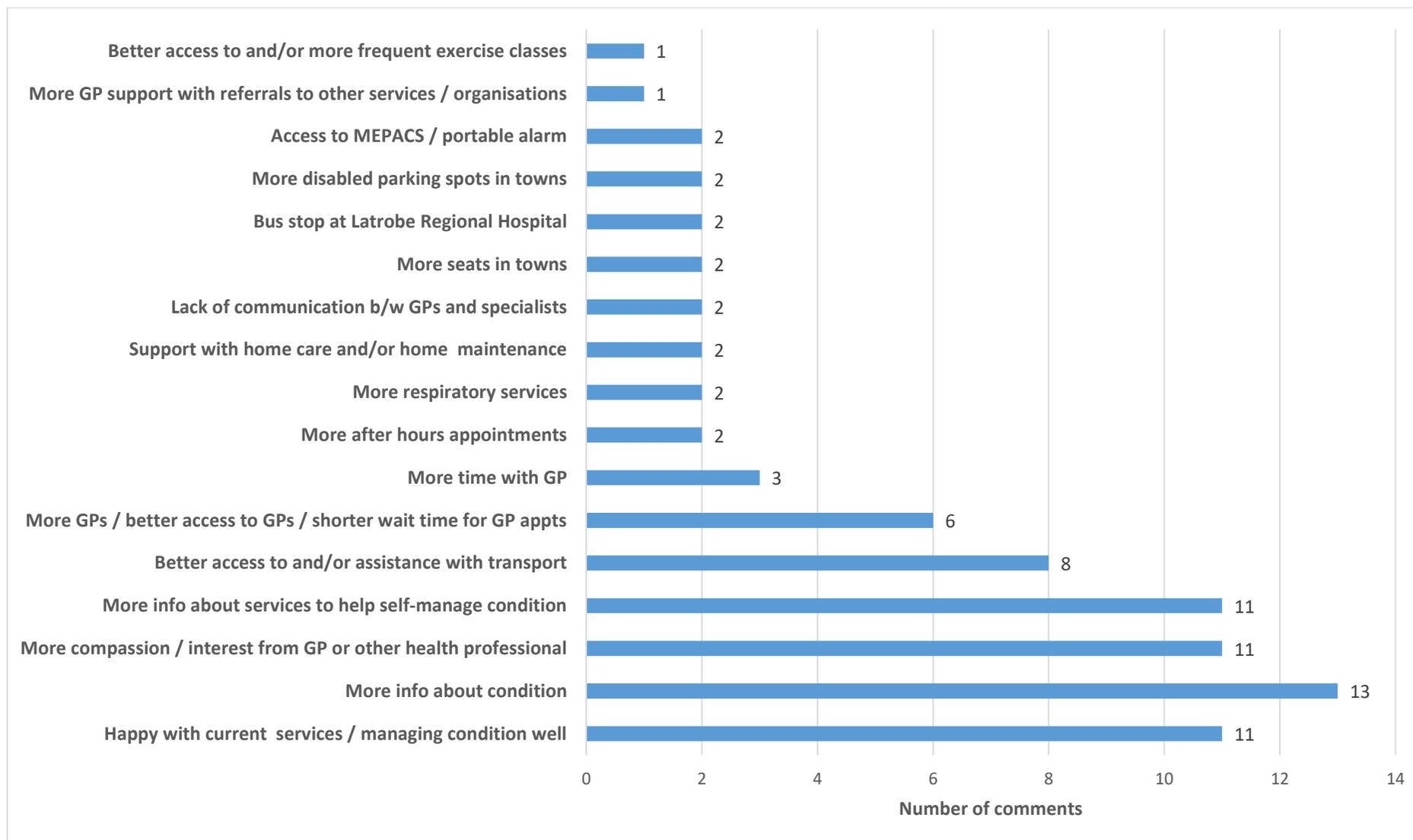
- ❖ Frequency of visits varied across most of the health professionals that the respondents reported seeing for their COPD.
- ❖ However, without further information it is not possible to ascertain whether the longer gaps between visits are due to a lack of clinical need, lack of availability, cost or some other factor.

Q.18 How well do the current supports work for you and why? Is there anything that makes it harder for you to manage? (e.g. transport, time, family commitments, knowledge, lack of response from service providers, opening hours, bad experience etc?)

Q.21 What would make it easier for you to manage your COPD?

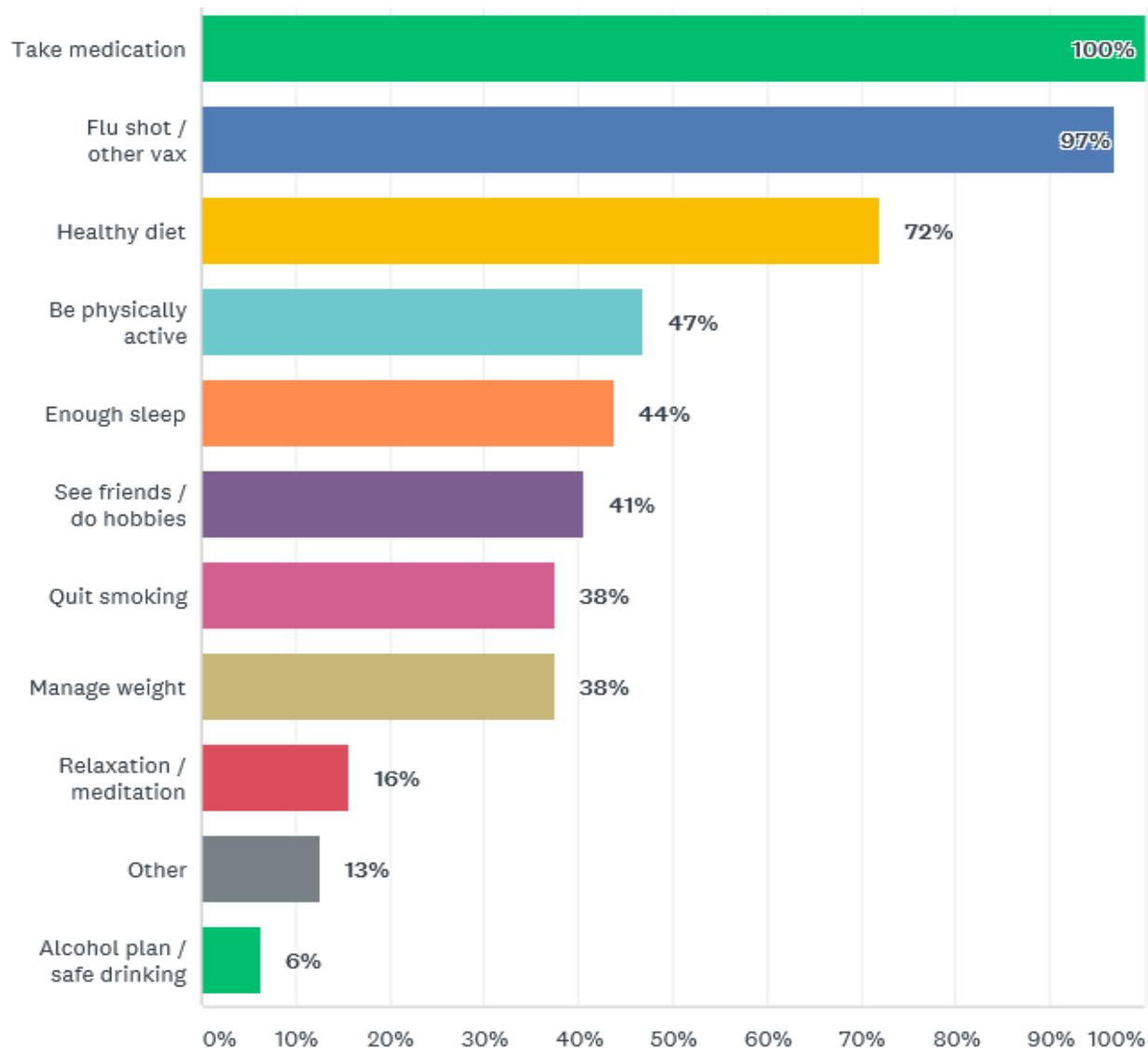
- Theming for Q.18 & Q.21 has been collated

Total no. of comments re Q.18 & Q.21: 29 + 26 = n=55



- ❖ One third of the 33 respondents with COPD indicated that they were happy with their current services and managing their condition well.
- ❖ Suggestions for things that would make it easier for the respondents to manage their COPD fell into 16 main themes.
- ❖ The most frequently mentioned themes (i.e. identified by over 10% of the 33 respondents) were:
 - More information about their condition (39%),
 - More compassion / interest from their GP or other health professional (33%),
 - More information about services to help self-manage their condition (33%),
 - Better access to and/or assistance with transport (24%),
 - More GPs / better access to GPs / shorter wait time for GP appointments (18%).

19. What are you currently doing to make life easier with your COPD? (n=32)

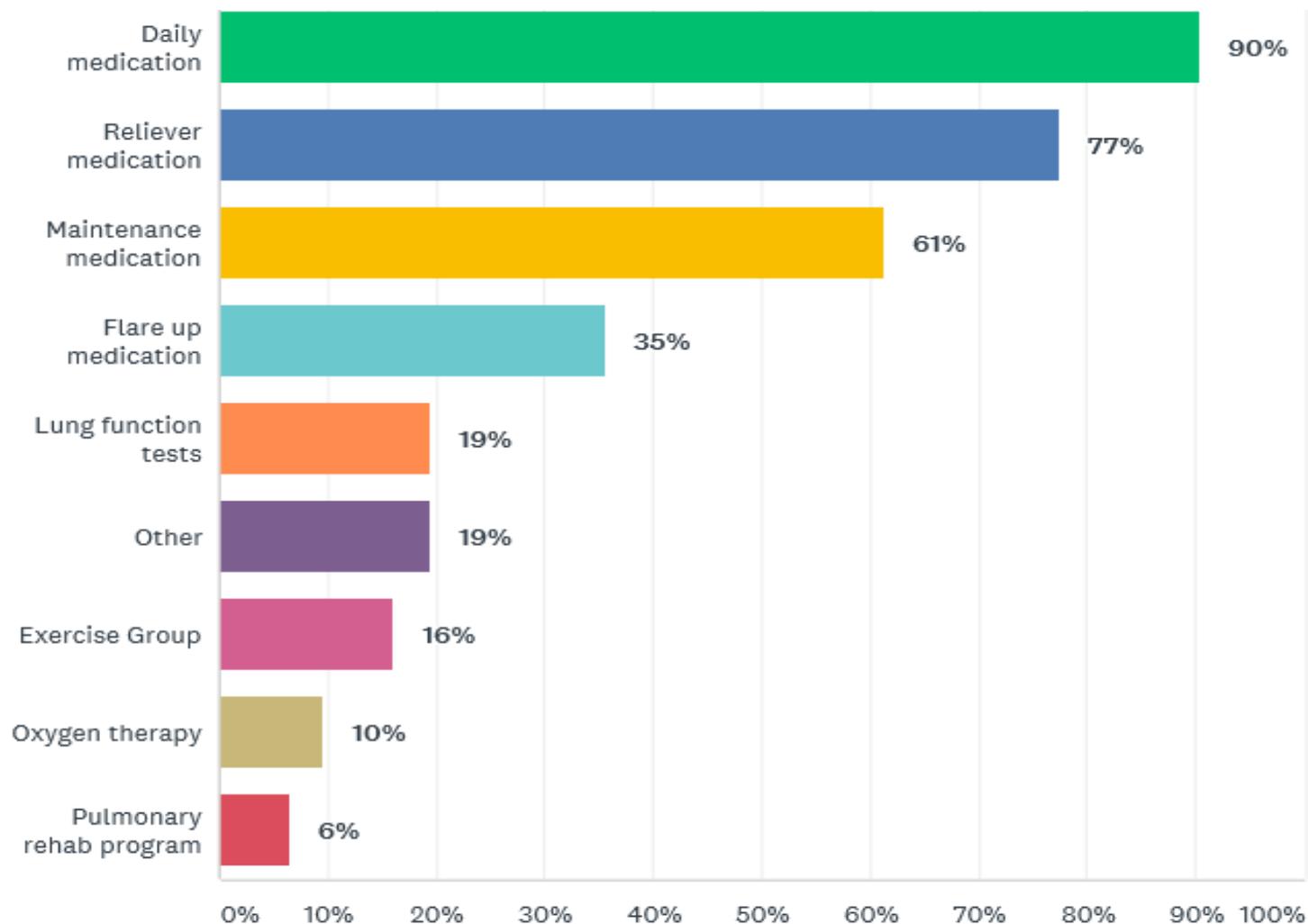


Other included:

- Attend Exercise Group (1)
- Attend Planned Activity Group (PAG) (1)
- Oxygen (1)

- ❖ Respondents reported using a wide variety of methods (usually in combination) to make life easier living with their COPD.
- ❖ The most frequent (over 95%) were ‘taking medication regularly’ and ‘getting a flu shot and/or other vaccinations’.
- ❖ Over 70% also listed ‘eating a healthy diet’.

Q.20 How do you manage your COPD? (n=31)



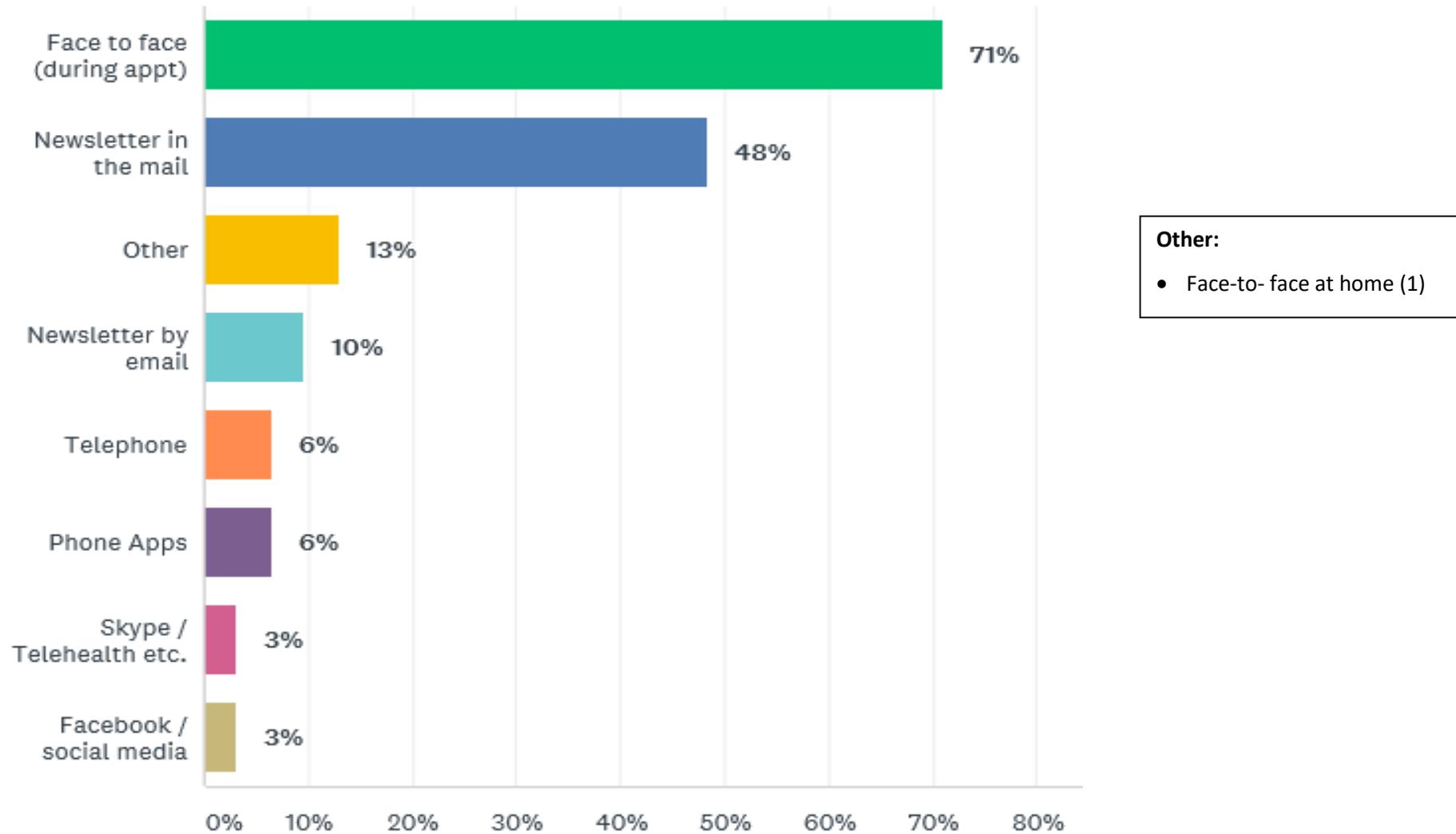
Other included:

- Swimming (1)

- ❖ Respondents reported using a wide variety of methods (usually in combination) to manage their COPD.
- ❖ The most frequent (over 75%) were ‘taking medication each day prescribed by the doctor even if I feel well’ and ‘taking reliever medication for quick relief if I feel breathless’.
- ❖ Over 60% also listed ‘taking maintenance medication to help control symptoms and prevent flare ups’.

Q.22 What is the best way for health services to provide support to you with your COPD? (n=31)

Note: respondents were able to tick more than one box.



- ❖ The vast majority of respondents identified 'face-to face during an appointment' (71%) and/or a 'newsletter in the mail' (48%) as the best ways for health services to provide support to them.

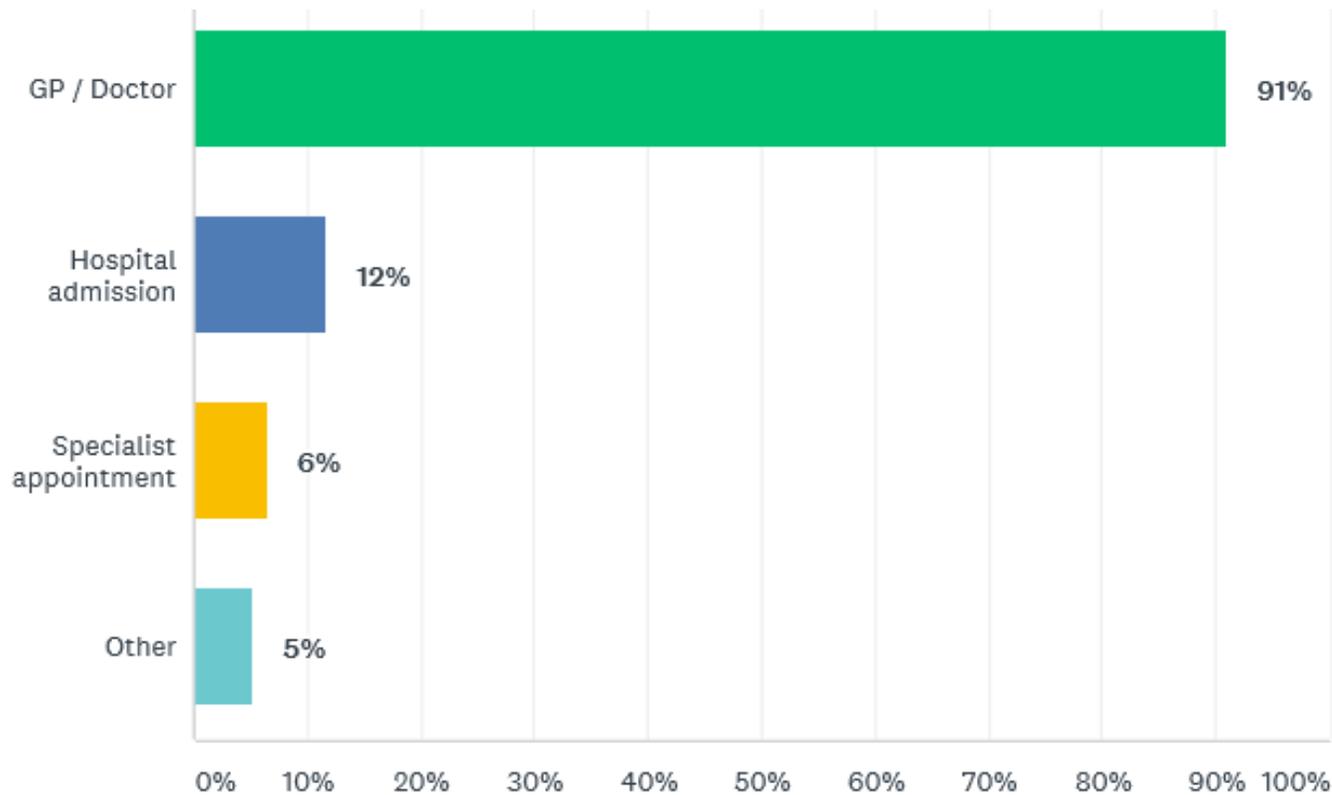
D. Diabetes

Q.23 Have you been diagnosed with Diabetes?

Yes: 80

Q.24 How did you find out you have Diabetes? (n=77)

Note: respondents were able to tick more than one box.

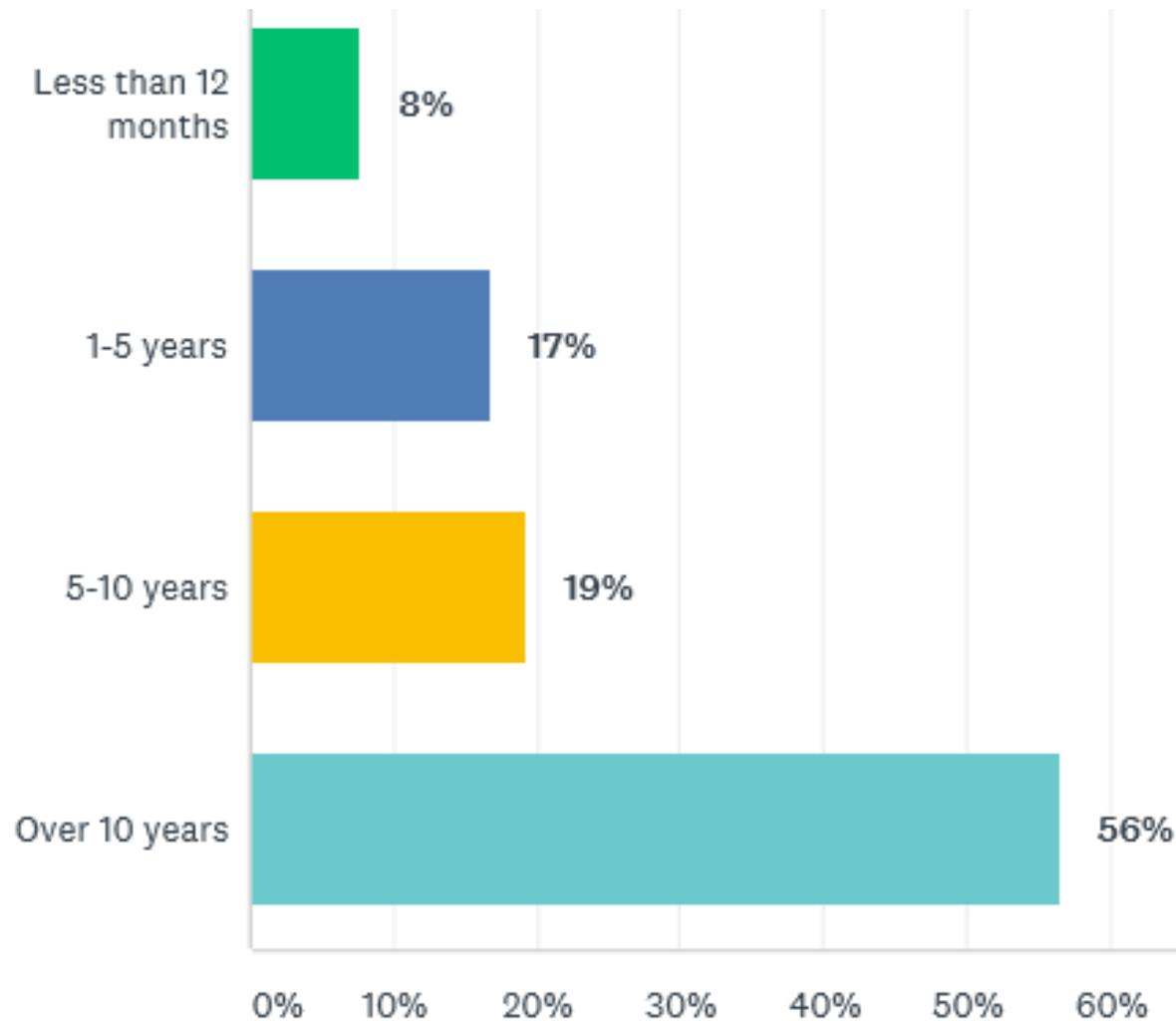


Other:

- “Horrible drink & fasting” (1)
- Work medical checks (1)
- “Noticed symptoms & demanded doctor test” (1)
- Pathology (1)

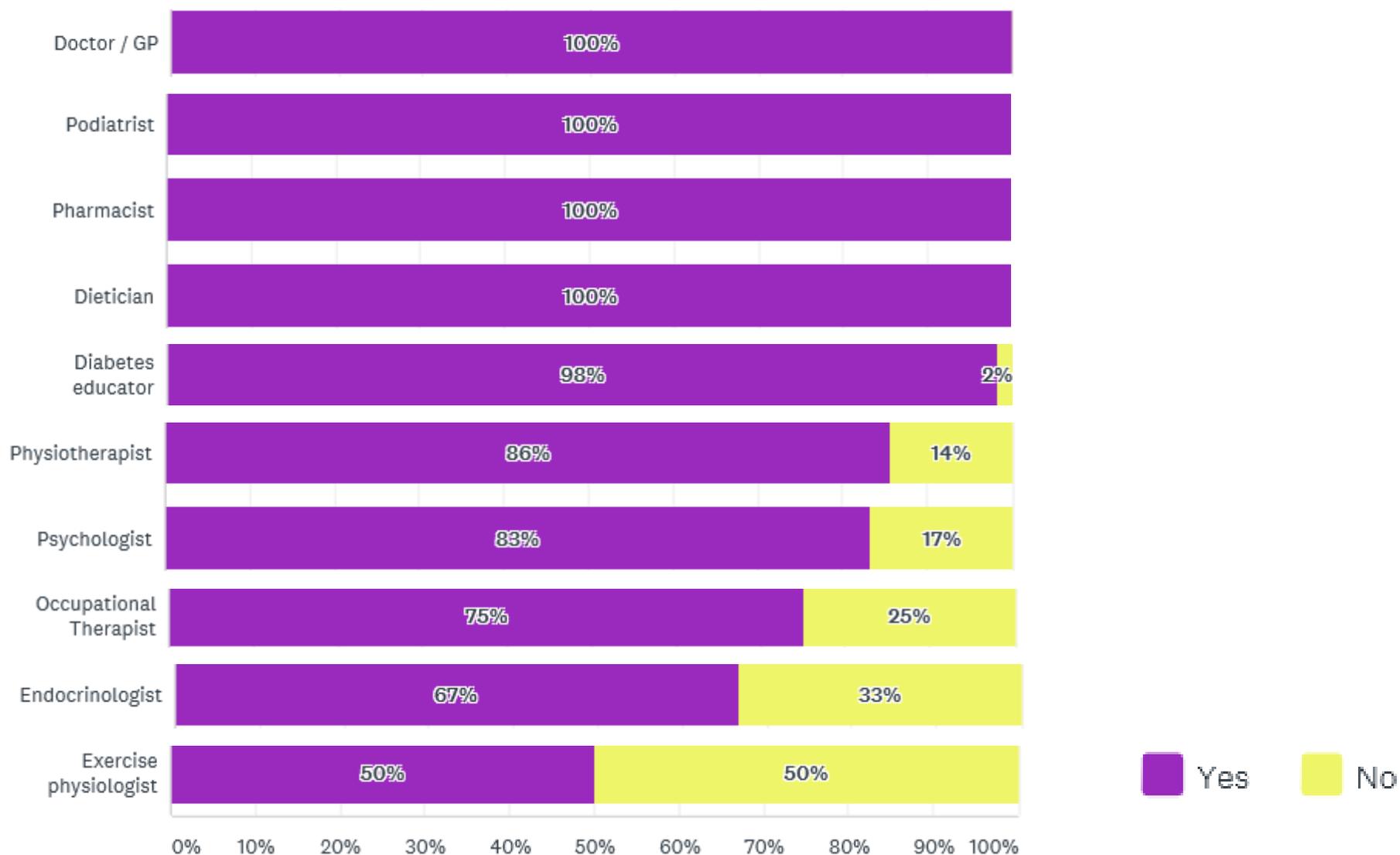
- ❖ The overwhelming majority of respondents (91%) found out they had diabetes from their GP / Doctor.
- ❖ In a small number of cases, diagnosis was through, or in conjunction with, a hospital admission (12%) or an appointment with a Specialist (6%).

Q.25 When were you diagnosed with Diabetes? (n=78)



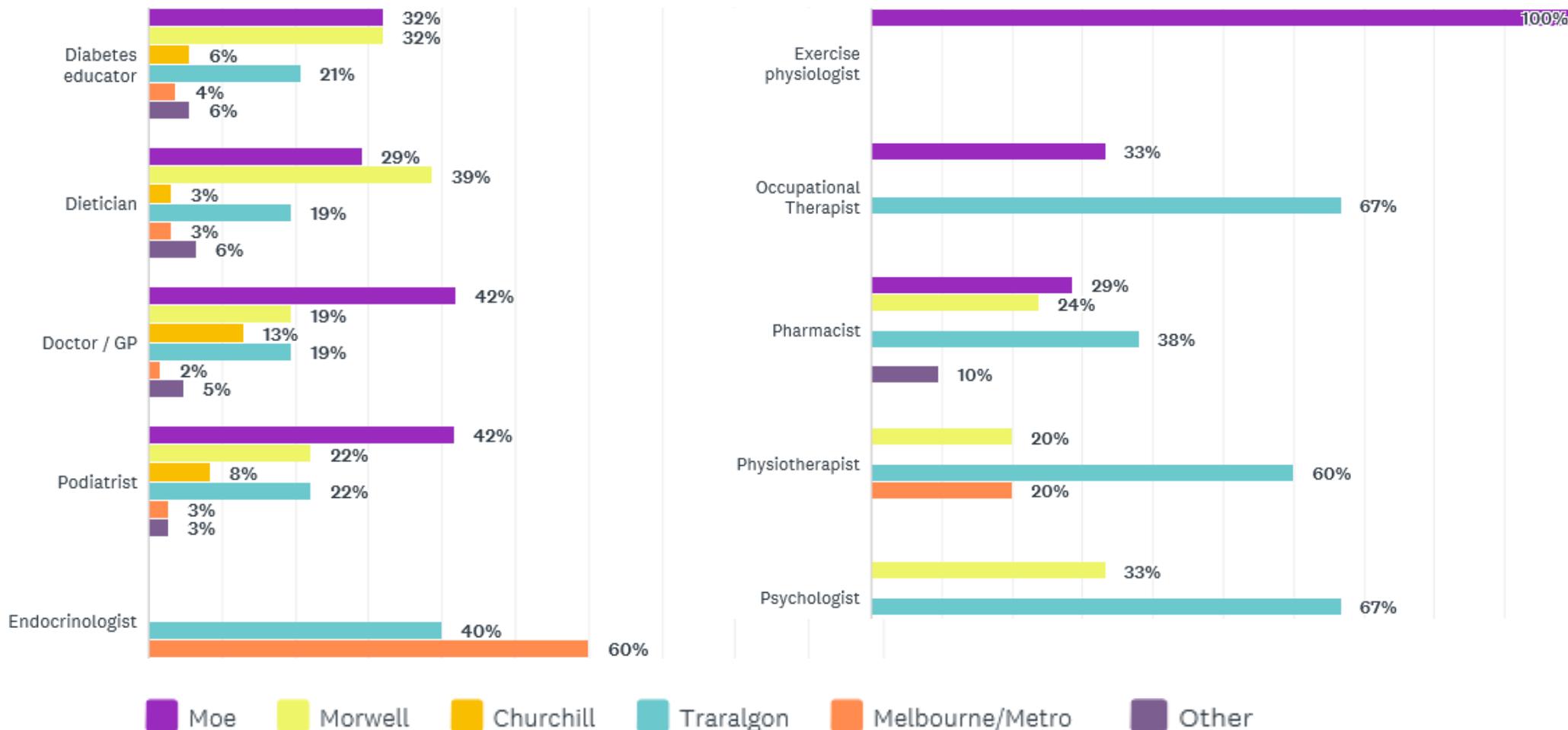
- ❖ The majority of respondents (56%) had been living with their diabetes for over 10 years.
- ❖ Only a small percentage (8%) were newly diagnosed i.e. under 12 months.

Q.26 Which health professionals do you see for your Diabetes? (n=77)



- ❖ All 77 respondents to this question reported seeing a range of health professionals for their diabetes.
- ❖ 100% indicated that they saw a Doctor/GP, podiatrist, pharmacist and/or dietician (and 98% a diabetes educator).
- ❖ Only two thirds of respondents said they saw an endocrinologist.

Which town do you see them in for your Diabetes? (n=77)

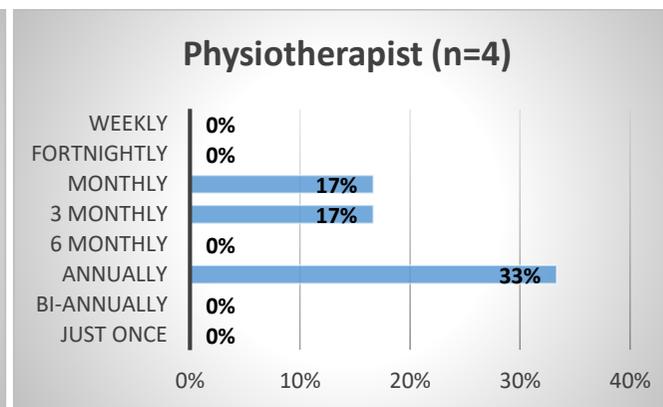
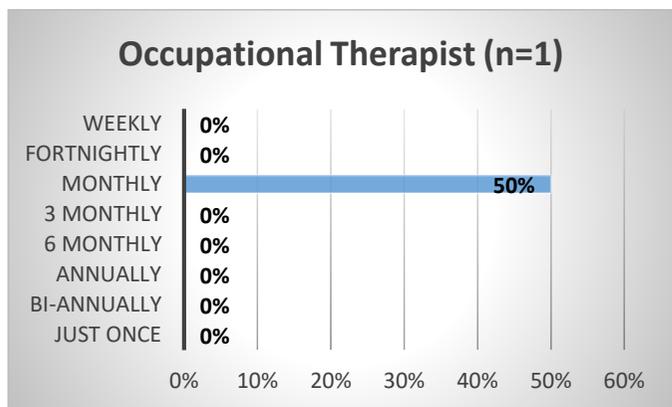
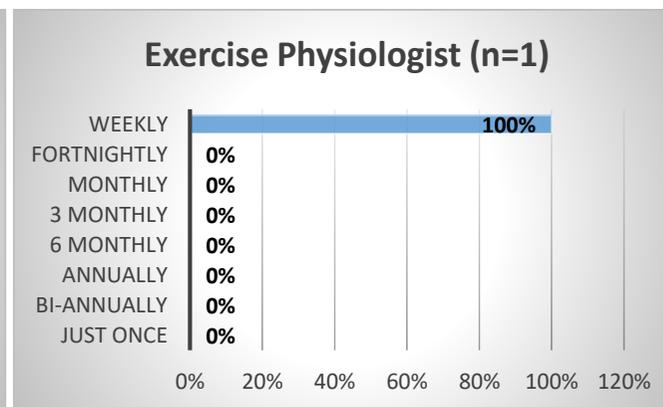
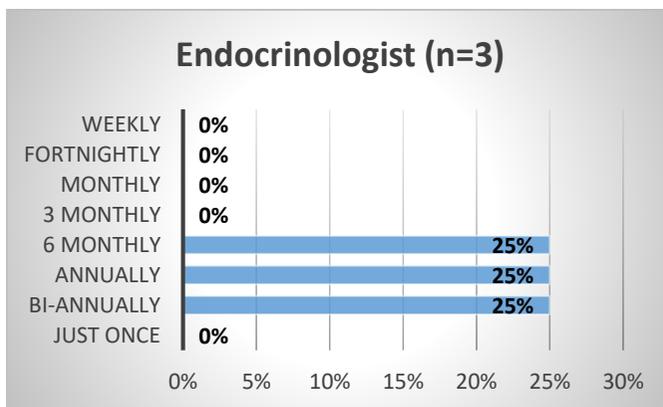
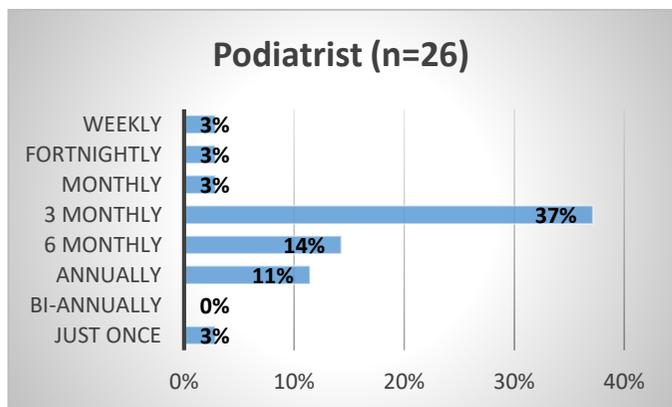
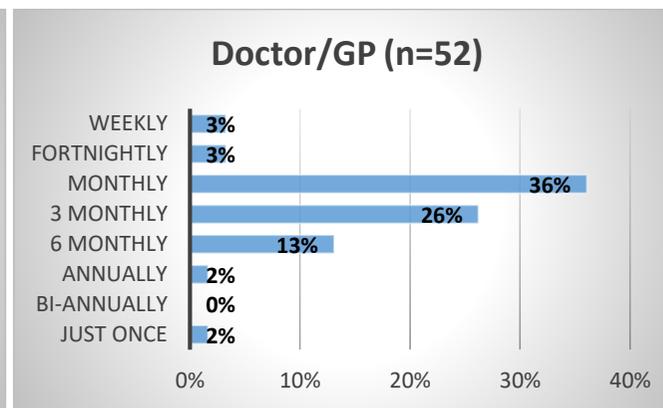
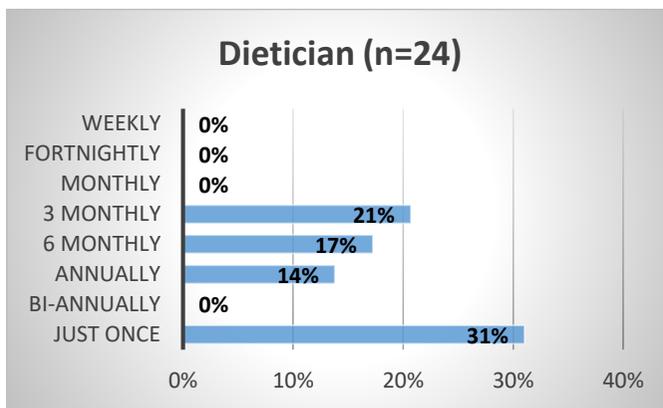
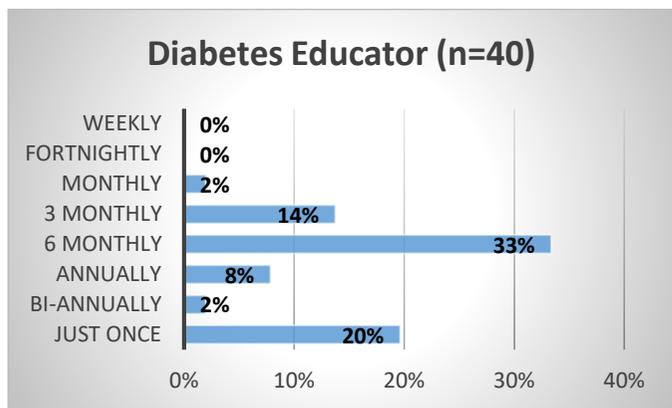


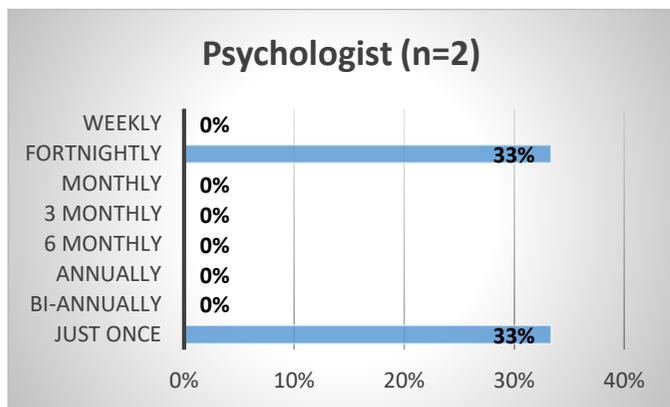
Other towns:

- Dandenong 2 (podiatrist, specialist); Newborough 1 (masseur); Trafalgar 1 (GP); Warragul 1 (endocrinologist); Wonthaggi 1 (podiatrist); Carrum Downs 1 (GP); Town not specified: 8 (diabetes educator 3), (dietician 2), (pharmacist 2), (GP 1).

- ❖ The vast majority of respondents saw all of their health professionals within Gippsland (Moe, Morwell, Churchill, Traralgon or another Gippsland town).
- ❖ The only health professionals a significant number of respondents reported going to Melbourne/Metro to see were their endocrinologist (60%) and physiotherapist (20%).

How often do you see them for your Diabetes? (n=77)





Answer Choices	Weekly	Fortnightly	Monthly	3 monthly	6 monthly	Annually	Bi-annually	Just once	Total
Diabetes educator	0%	0%	2%	14%	33%	8%	2%	20%	40
Dietician	0%	0%	0%	21%	17%	14%	0%	31%	24
Doctor / GP	3%	3%	36%	26%	13%	2%	0%	2%	52
Podiatrist	3%	3%	3%	37%	14%	11%	0%	3%	26
Endocrinologist	0%	0%	0%	0%	25%	25%	25%	0%	3
Exercise physiologist	100%	0%	0%	0%	0%	0%	0%	0%	1
Occupational Therapist	0%	0%	50%	0%	0%	0%	0%	0%	1
Pharmacist	10%	15%	30%	20%	10%	0%	0%	0%	17
Physiotherapist	0%	0%	17%	17%	0%	33%	0%	0%	4
Psychologist	0%	33%	0%	0%	0%	0%	0%	33%	2

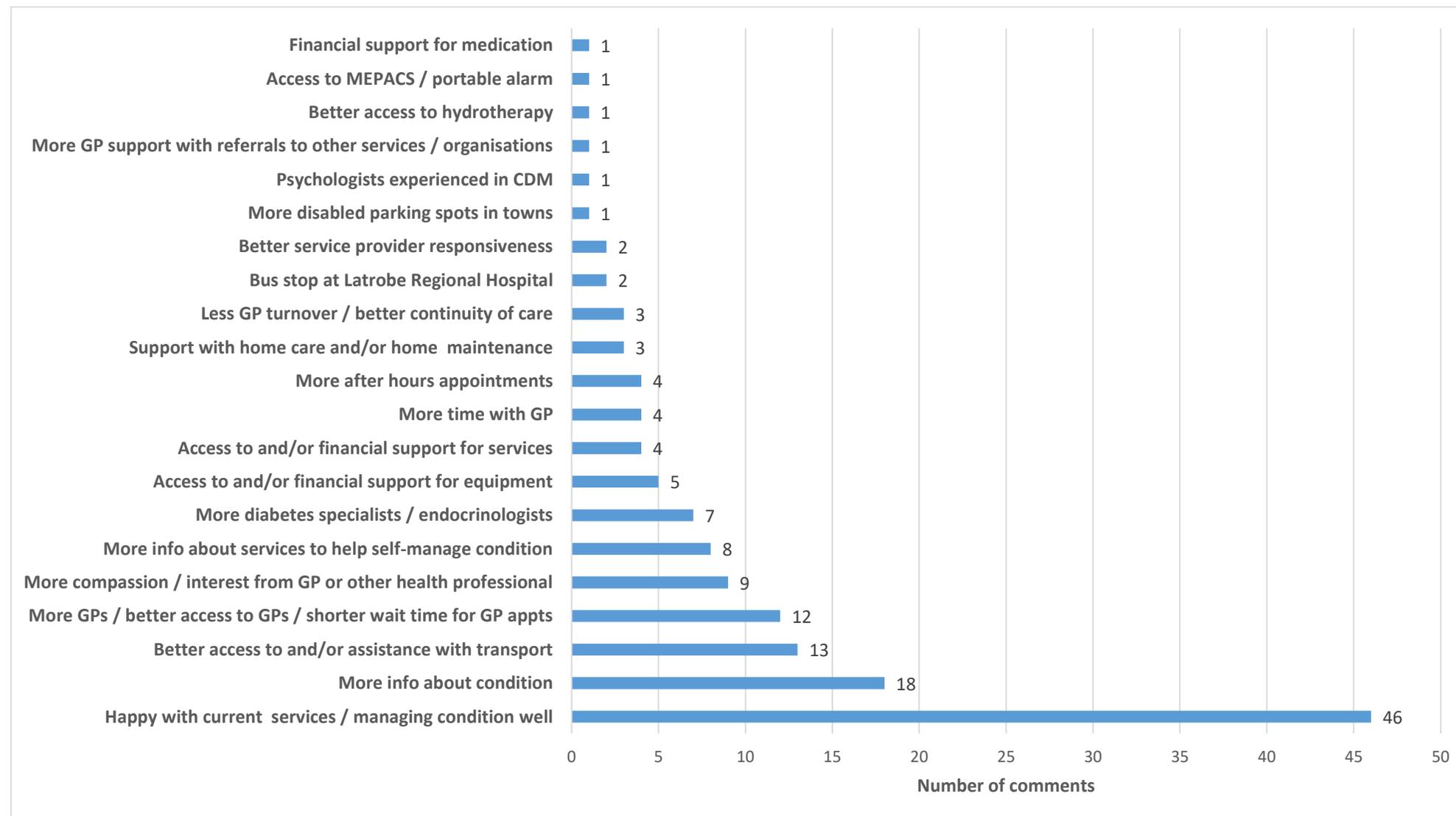
- ❖ Frequency of visits varied widely across almost all of the health professionals that the respondents reported seeing for their diabetes.
- ❖ However, without further information it is not possible to ascertain whether the longer gaps between visits are due to a lack of clinical need, lack of availability, cost or some other factor.

Q.27 How well do the current supports work for you and why? Is there anything that makes it harder for you to manage? (e.g. transport, time, family commitments, knowledge, lack of response from service providers, opening hours, bad experience etc?)

Q.30 What would make it easier for you to manage your Diabetes?

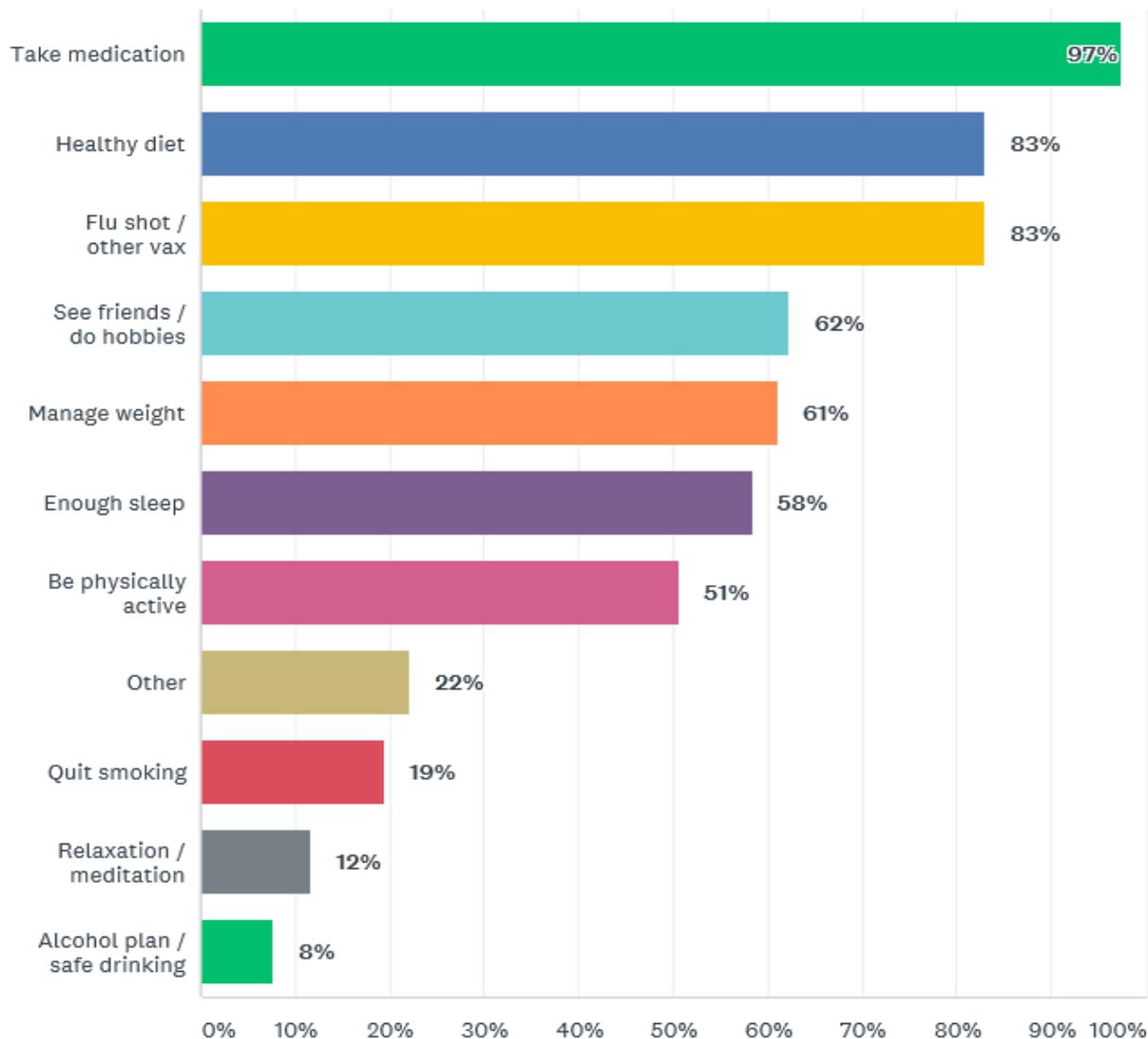
- Theming for Q.27 & Q.30 has been collated

Total no. of comments re Q.27 & Q.30: 64 + 57 = n=121



- ❖ Almost 58% of the 80 respondents with diabetes indicated that they were happy with their current services and managing their condition well.
- ❖ Suggestions for things that would make it easier for the respondents to manage their diabetes fell into 20 main themes.
- ❖ The most frequently mentioned themes (i.e. identified by over 10% of the 80 respondents) were:
 - More information about their condition (22.5%),
 - Better access to and/or assistance with transport (16%),
 - More GPs / better access to GPs / shorter wait time for GP appointments (15%),
 - More compassion / interest from their GP or other health professional (11%).

Q.28 What are you currently doing to make life easier with your Diabetes? (n=77)

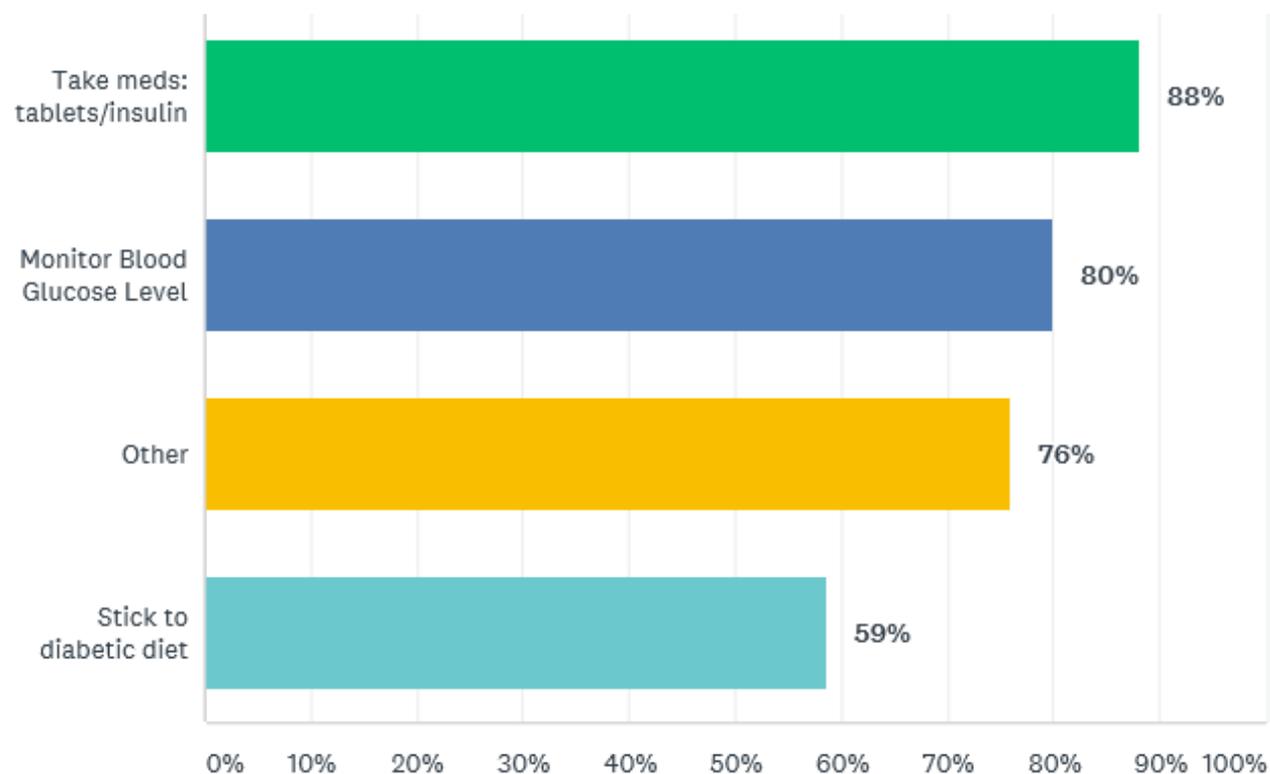


Other included:

- Walking / walking the dog (3)
- Don't smoke (2)
- Don't drink (1)
- Knitting (1)
- Table tennis competitions (1)
- Gardening (1)
- Attend Planned Activity Group (PAG) (1)
- Attend Health & Wellness Group (1)
- Get Meals on Wheels (1)
- Attend community lunches (1)
- Exercise at home (1)
- Check / record blood sugar and BP daily (1)

- ❖ Respondents reported using a wide variety of methods (usually in combination) to make life easier living with their diabetes.
- ❖ The most frequent (over 80%) were 'taking medication regularly', 'eating a healthy diet' and 'getting a flu shot and/or other vaccinations'.
- ❖ Over 60% also listed 'see friends/do hobbies' and 'stay within a healthy weight range/manage my weight'.

Q.29 How do you manage your Diabetes? (n=75)



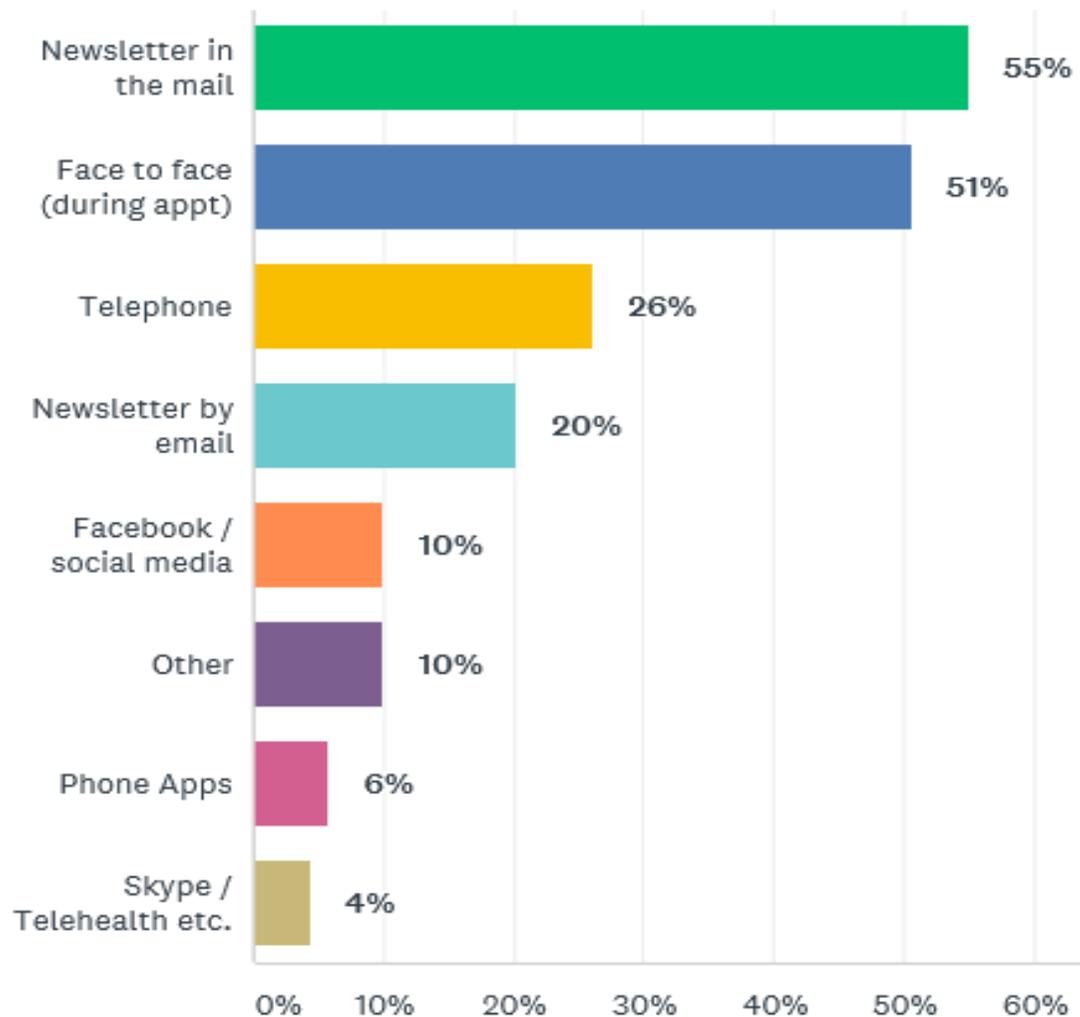
Other included:

- Eat well / healthy diet (4)
- Exercise / walking / walk the dog (4)
- HbA1c tests (1)
- Insulin pump and CGM (Continuous Glucose Monitoring) (1)

- ❖ Respondents reported using a variety of methods (usually in combination) to manage their diabetes.
- ❖ The most frequent (over 80%) were 'take medication each day that the doctor prescribed (e.g. tablets, insulin)' and 'monitor my Blood Glucose Level (BGL) at home'.
- ❖ Almost 60% also reported that they 'stick to a diabetic diet as advised'.

Q.31 What is the best way for health services to provide support to you with your Diabetes? (n=69)

Note: respondents were able to tick more than one box.



Other included:

- One-on-one in home conversations / support (2)
- “Give the TIME & interest and information! Answer my questions” (1)
- A Latrobe City or even Australia-wide booklet for all health services / accessibility maps (1)
- Reminder text messages before appointments (1)

- ❖ The majority of respondents identified ‘newsletter in the mail’ (55%) and/or ‘face-to face during an appointment’ (51%) as the best ways for health services to provide support to them.
- ❖ There was also some support for ‘telephone’ (26%) and ‘newsletter by email’ (20%).

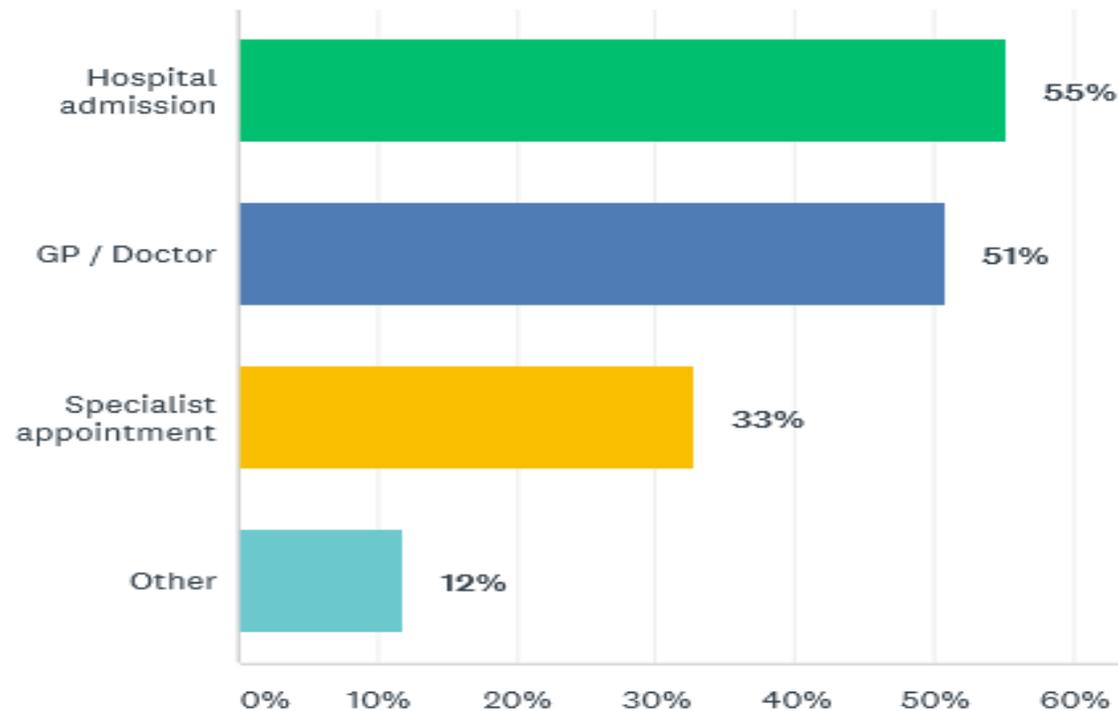
E. Heart Failure

Q.32 Have you been diagnosed with Heart Failure?

Yes: 69

Q.33 How did you find out you have Heart Failure? (n=67)

Note: respondents were able to tick more than one box.

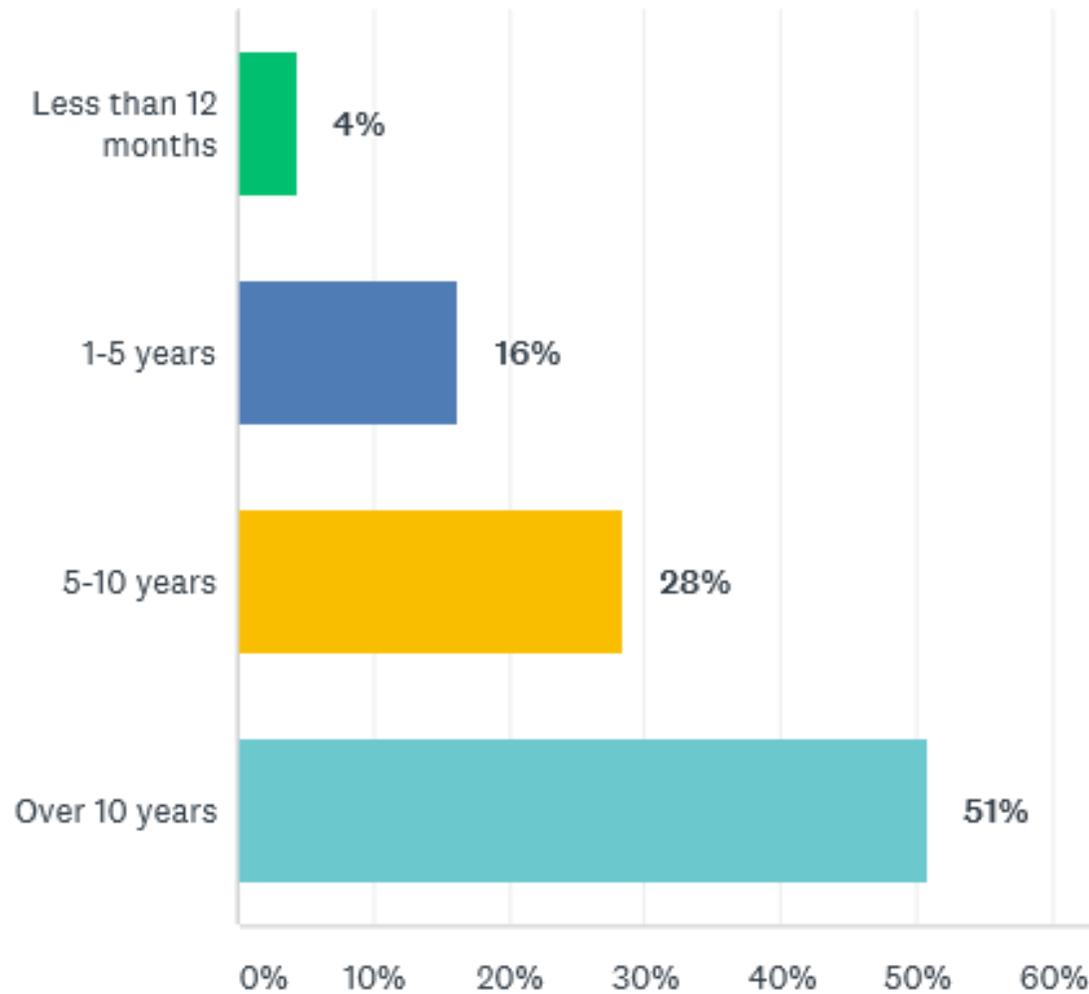


Other:

- Heart attack (4)
- Pacemaker check-up (1)
- Congenital (1)
- Self-diagnosis (1)
- Chronic heart disease (1)

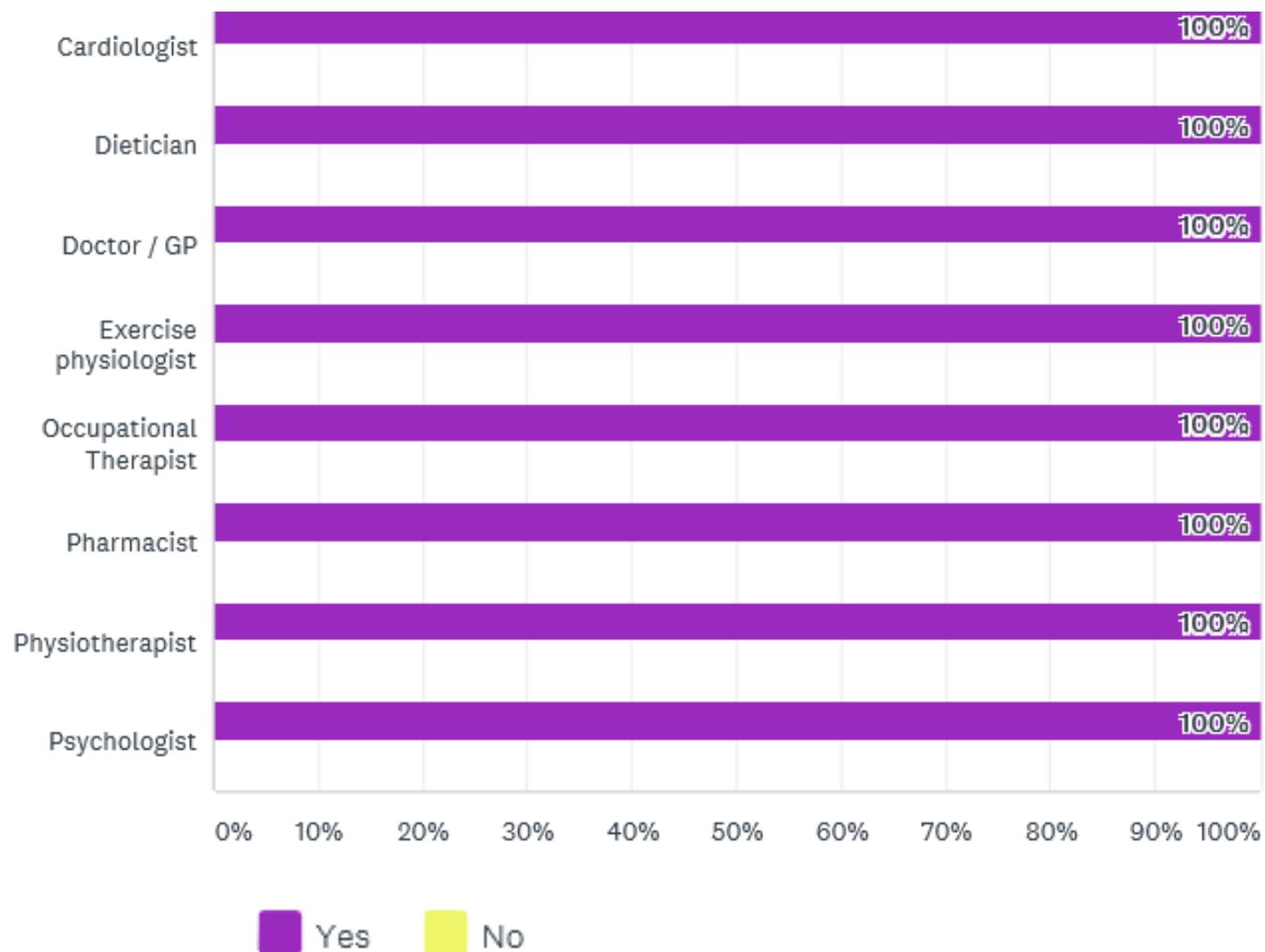
- ❖ This was the only one of the 5 chronic illnesses where a large majority of respondents did not find out they had heart failure from their GP/Doctor.
- ❖ 55% were diagnosed as a result of a hospital admission (generally for a heart-related event or condition), while a slightly lower percentage (51%) found out from their GP / Doctor.
- ❖ In one third of cases, diagnosis was in conjunction with / as a result of an appointment with a Specialist.

Q.34 When were you diagnosed with Heart Failure? (n=67)



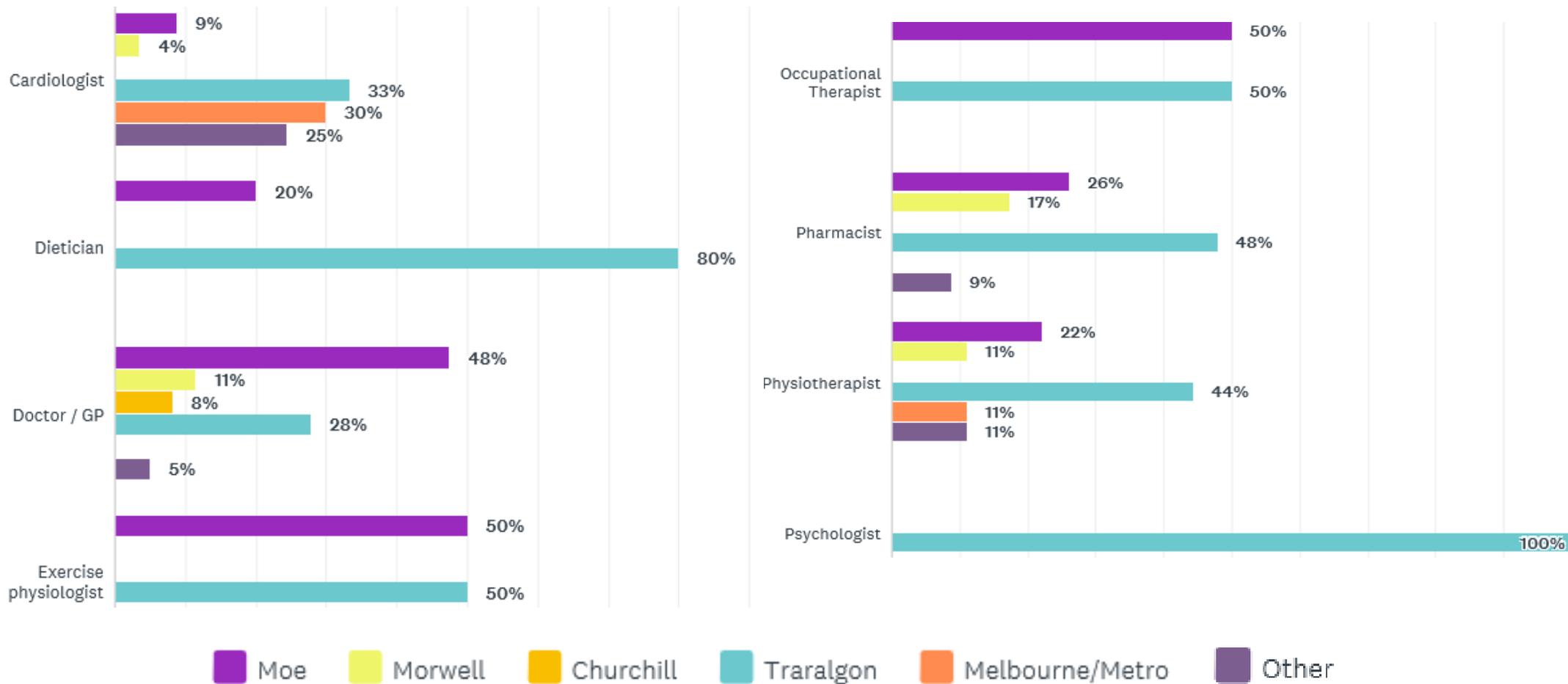
- ❖ The majority of respondents (51%) had been living with their heart failure for over 10 years.
- ❖ Only a small percentage (4%) were newly diagnosed i.e. under 12 months.

Q.35 Which health professionals do you see for your Heart Failure? (n=67)



- ❖ All 67 respondents to this question reported seeing a range of health professionals for their heart failure.
- ❖ 100% of those respondents indicated that they saw a cardiologist, dietician, Doctor/GP, exercise physiologist, occupational therapist, pharmacist, physiotherapist and/or psychologist for the condition.

Which town do you see them in for your Heart Failure? (n=67)



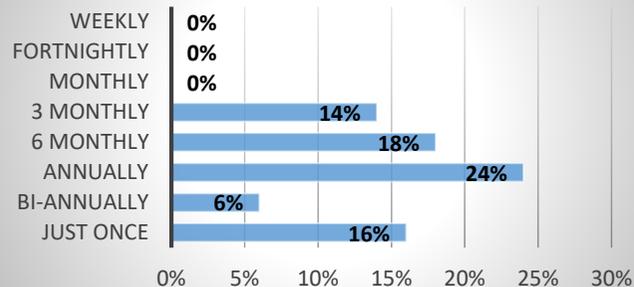
Other towns:

Warragul 6 (cardiologist 2, specialist 2, health professional unknown 2); Trafalgar 1 (GP); Dandenong 1 (health professional unknown); Newborough 1 (health professional unknown); Town not specified: 15 (cardiologist 10), (GP 2), (pharmacist 2), (physiotherapist 1).

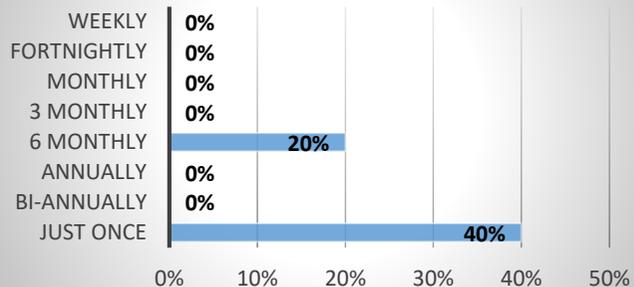
- ❖ The vast majority of respondents saw all of their health professionals within Gippsland (Moe, Morwell, Churchill, Traralgon or another Gippsland town).
- ❖ The only health professionals a significant number of respondents reported going to Melbourne/Metro to see were their cardiologist (30%) and physiotherapist (11%).

How often do you see them for your Heart Failure? (n=67)

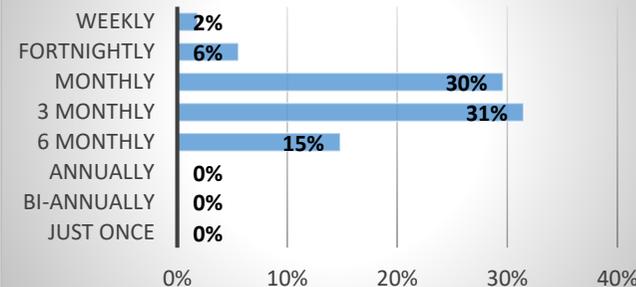
Cardiologist (n=39)



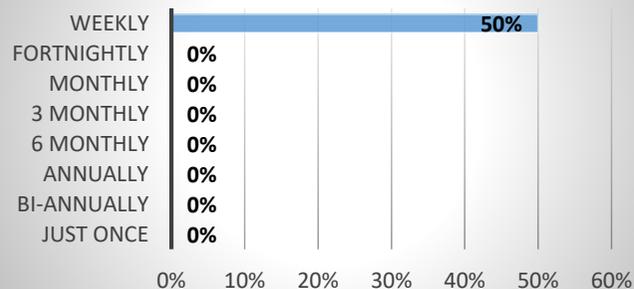
Dietician (n=3)



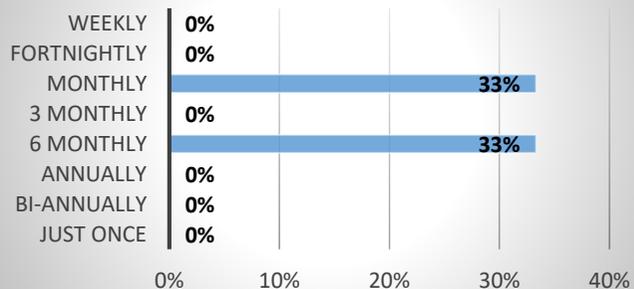
Doctor/GP (n=45)



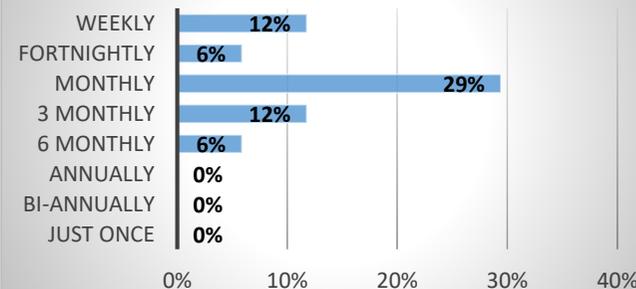
Exercise Physiologist (n=1)



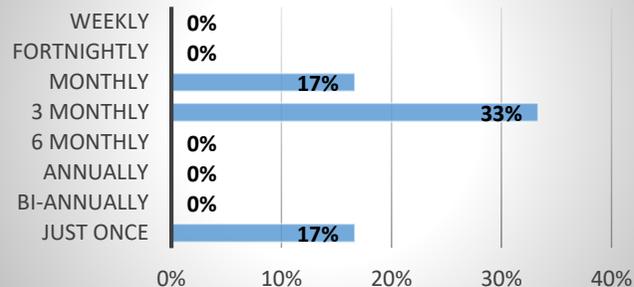
Occupational Therapist (n=2)



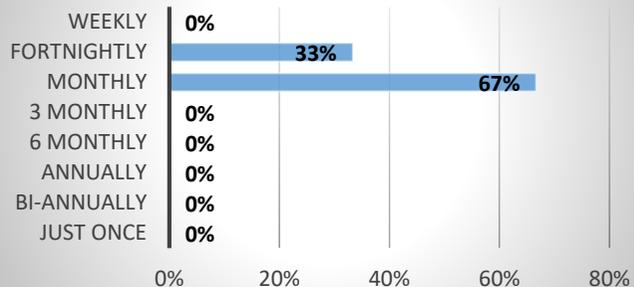
Pharmacist (n=11)



Physiotherapist (n=4)



Psychologist (n=3)



Answer Choices	Weekly	Fortnightly	Monthly	3 monthly	6 monthly	Annually	Bi-annually	Just once	Total
Cardiologist	0%	0%	0%	14%	18%	24%	6%	16%	39
Dietician	0%	0%	0%	0%	20%	0%	0%	40%	3
Doctor / GP	2%	6%	30%	31%	15%	0%	0%	0%	45
Exercise physiologist	50%	0%	0%	0%	0%	0%	0%	0%	1
Occupational Therapist	0%	0%	33%	0%	33%	0%	0%	0%	2
Pharmacist	12%	6%	29%	12%	6%	0%	0%	0%	11
Physiotherapist	0%	0%	17%	33%	0%	0%	0%	17%	4
Psychologist	0%	33%	67%	0%	0%	0%	0%	0%	3

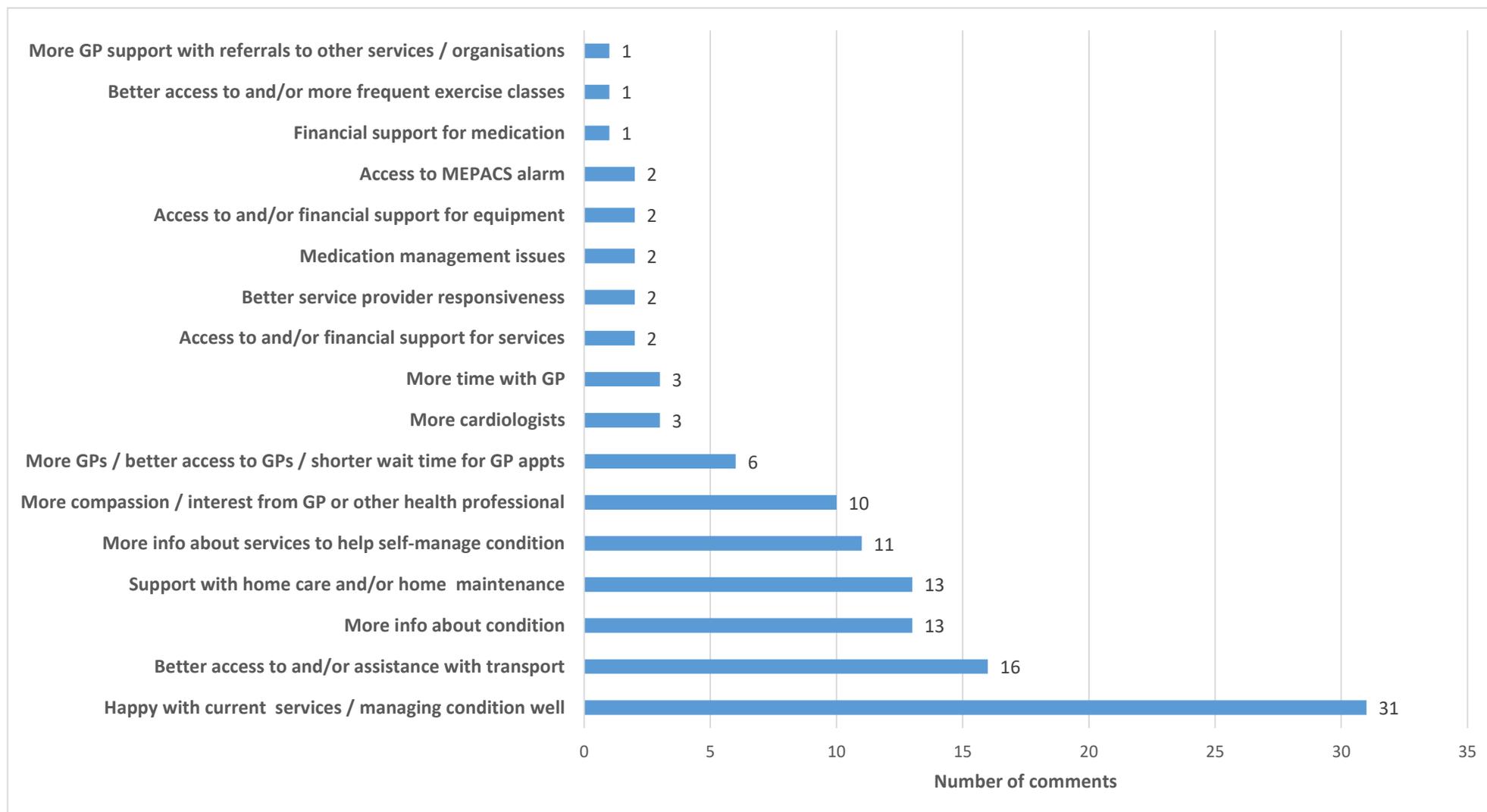
- ❖ Frequency of visits varied widely across most of the health professionals that the respondents reported seeing for their heart failure.
- ❖ However, without further information it is not possible to ascertain whether the longer gaps between visits are due to a lack of clinical need, lack of availability, cost or some other factor.

Q.36 How well do the current supports work for you and why? Is there anything that makes it harder for you to manage? (e.g. transport, time, family commitments, knowledge, lack of response from service providers, opening hours, bad experience etc?)

Q.39 What would make it easier for you to manage your Heart Failure?

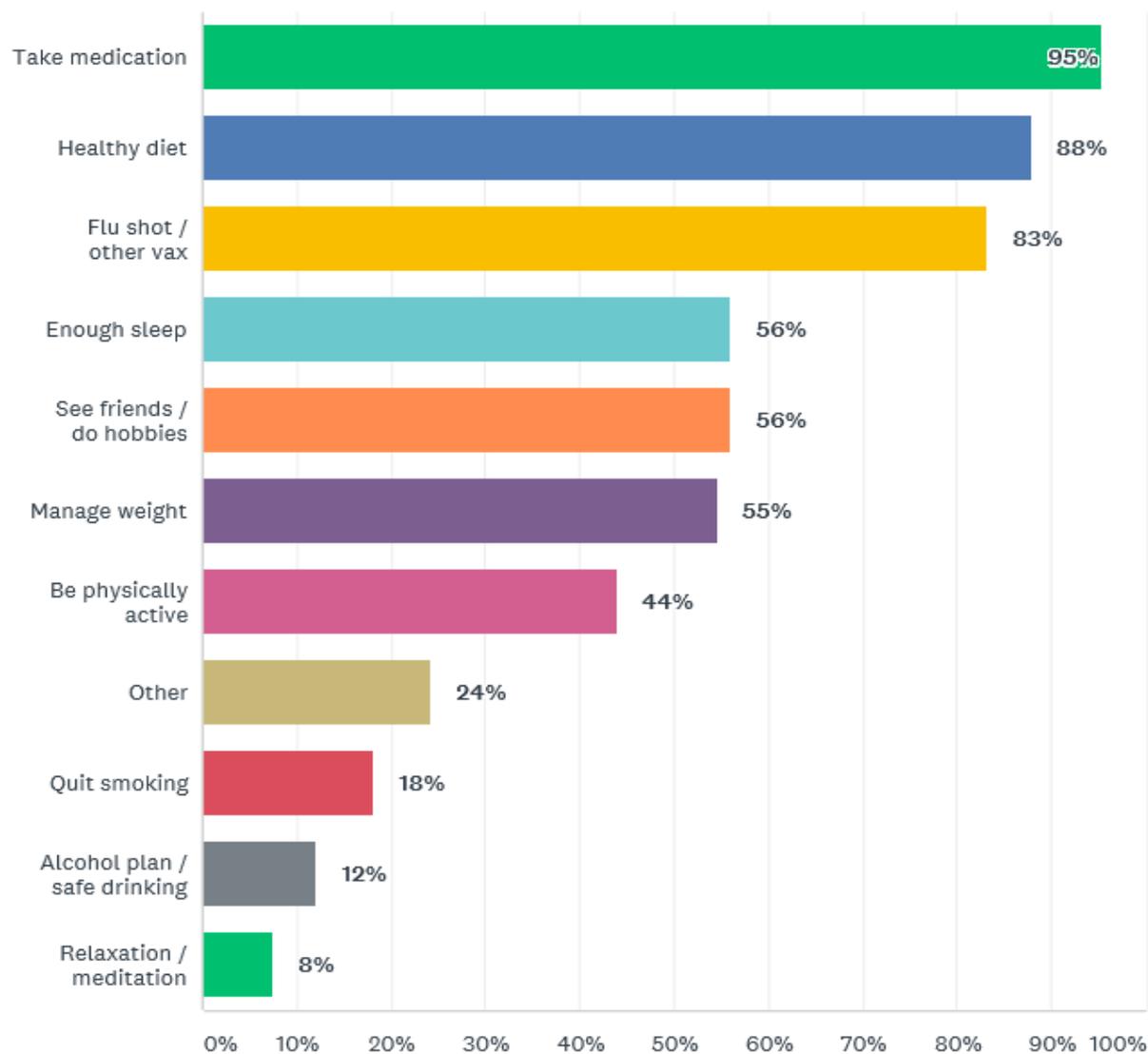
- Theming for Q.36 & Q.39 has been collated

Total no. of comments re Q.36 & Q.39: 60 + 50 = n=110



- ❖ 45% of the 69 respondents with heart failure indicated that they were happy with their current services and managing their condition well.
- ❖ Suggestions for things that would make it easier for the respondents to manage their heart failure fell into 16 main themes.
- ❖ The most frequently mentioned themes (i.e. identified by over 10% of the 69 respondents) were:
 - Better access to and/or assistance with transport (23%),
 - More information about their condition (19%),
 - Support with home care and/or home maintenance (19%),
 - More information about services to help self-manage their condition (16%),
 - More compassion / interest from their GP or other health professional (14.5%).

Q.37 What are you currently doing to make life easier with your Heart Failure? (n=66)

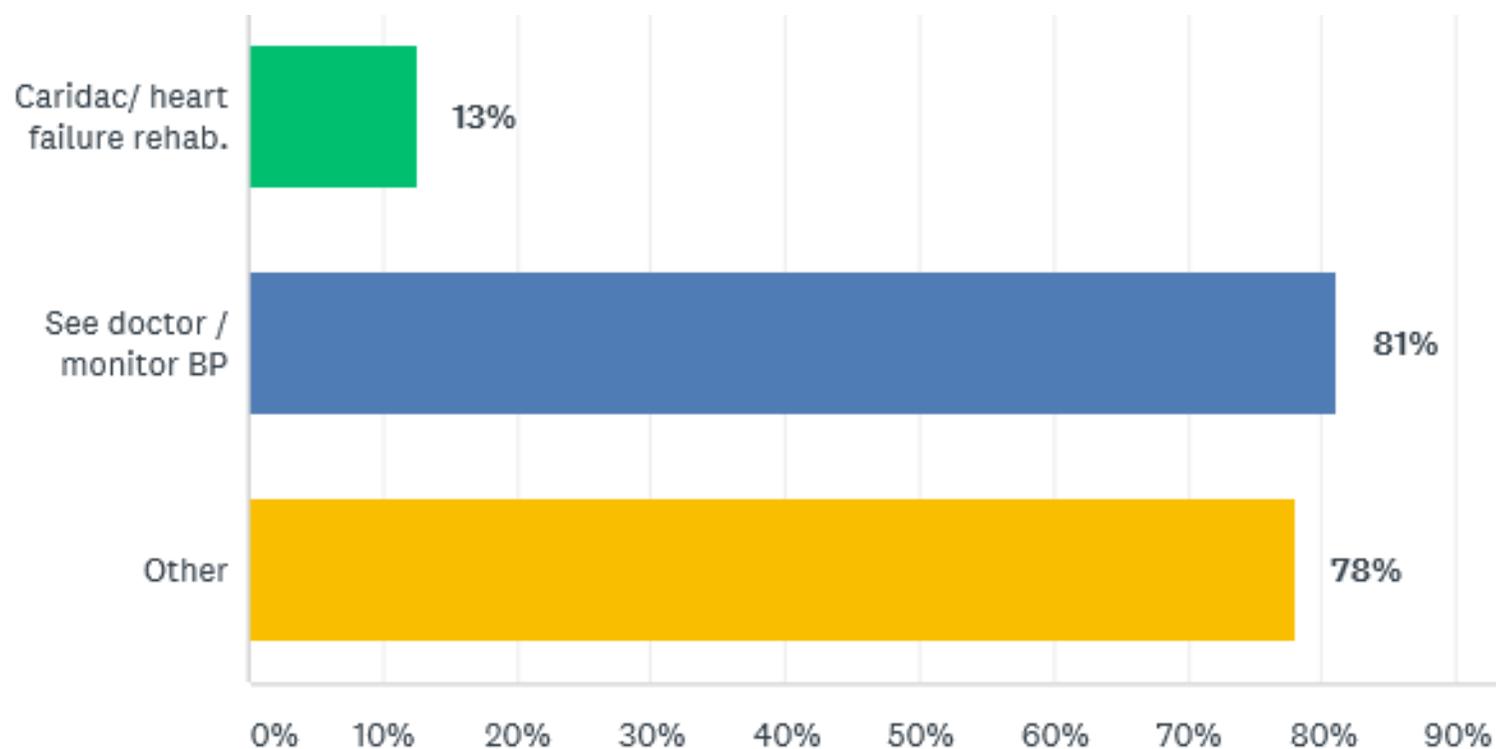


Other included:

- Walking / walk the dog (3)
- Don't smoke (2)
- Attend Masons, Probus, Men's Day Club, RSL (1)
- Attend Planned Activity Group (PAG) (1)
- Play 9 holes of golf twice weekly without using buggy (1)
- Ride a pushbike (1)
- Stay mentally alert and active (1)
- Hydro rehabilitation exercises (1)
- Don't drink (1)

- ❖ Respondents reported using a wide variety of methods (usually in combination) to make life easier living with their heart failure.
- ❖ The most frequent (over 80%) were 'taking medication regularly', 'eating a healthy diet' and 'getting a flu shot and/or other vaccinations'.

Q.38 What do you do to manage your Heart Failure? (n=64)



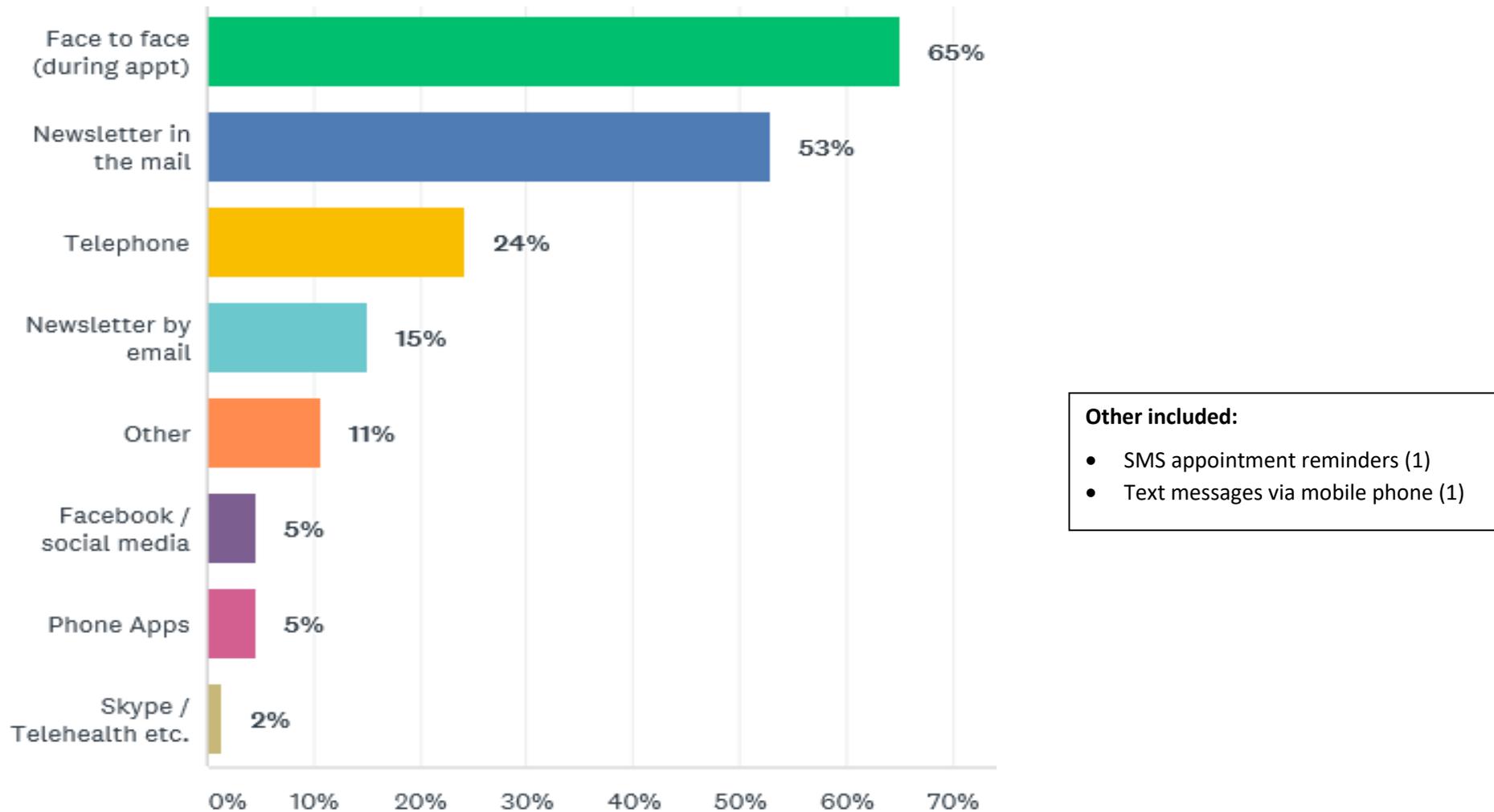
Other included:

- See specialist / cardiologist (5)
- Self-monitor blood pressure at home (3)
- Pacemaker / stents (3)
- Medication e.g. for blood pressure, blood thinning, cholesterol (3)
- Regular exercise (1)

- ❖ Respondents reported using a variety of methods (usually in combination) to manage their heart failure.
- ❖ The most frequent (81%) was to 'see a doctor regularly and have my blood pressure monitored'.
- ❖ 13% also reported that they 'go to cardiac / heart failure rehabilitation classes'.

Q.40 What is the best way for health services to provide support to you for your Heart Failure? (n=66)

Note: respondents were able to tick more than one box.



- ❖ The majority of respondents identified ‘face-to face during an appointment’ (65%) and/or ‘newsletter in the mail’ (53%) as the best ways for health services to provide support to them.
- ❖ There was also some support for ‘telephone’ (24%).

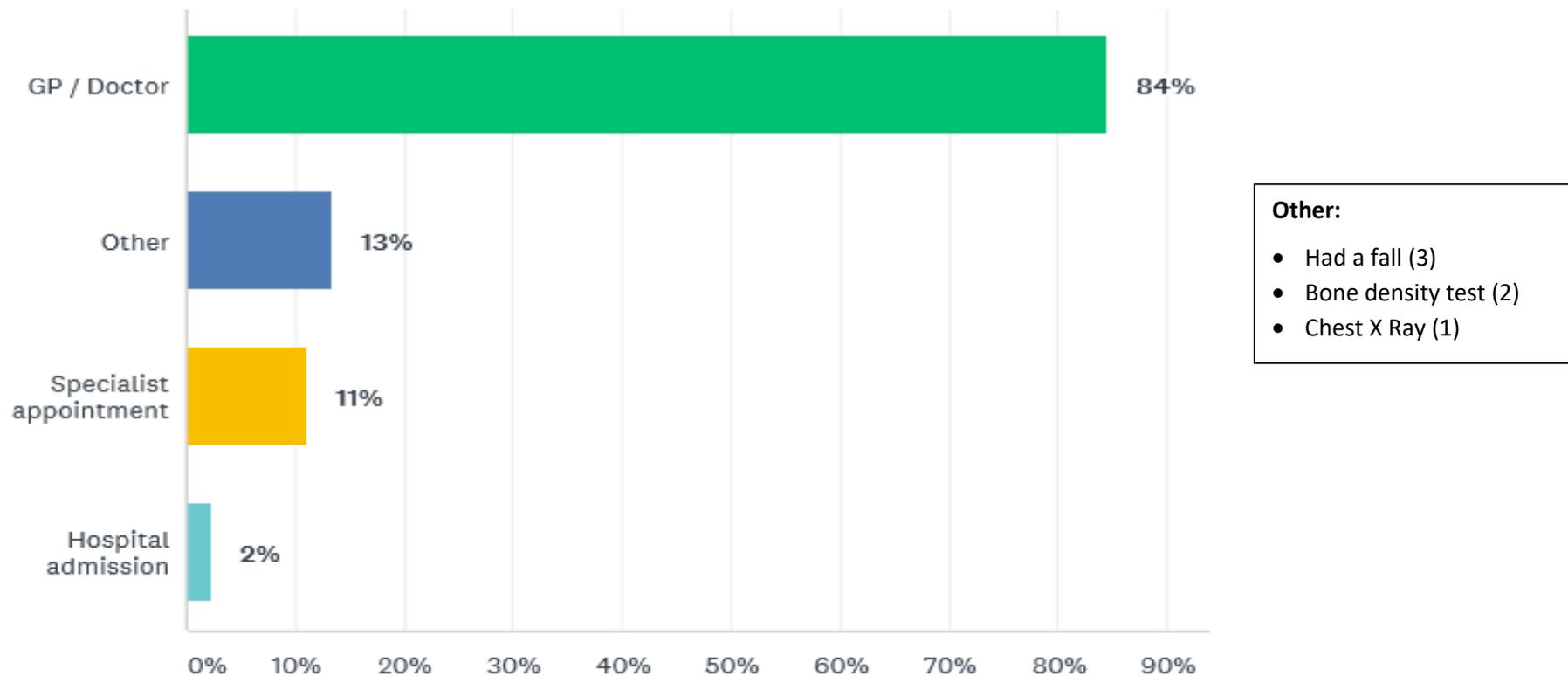
F. Osteoporosis

Q.41 Have you been diagnosed with Osteoporosis?

Yes: 46

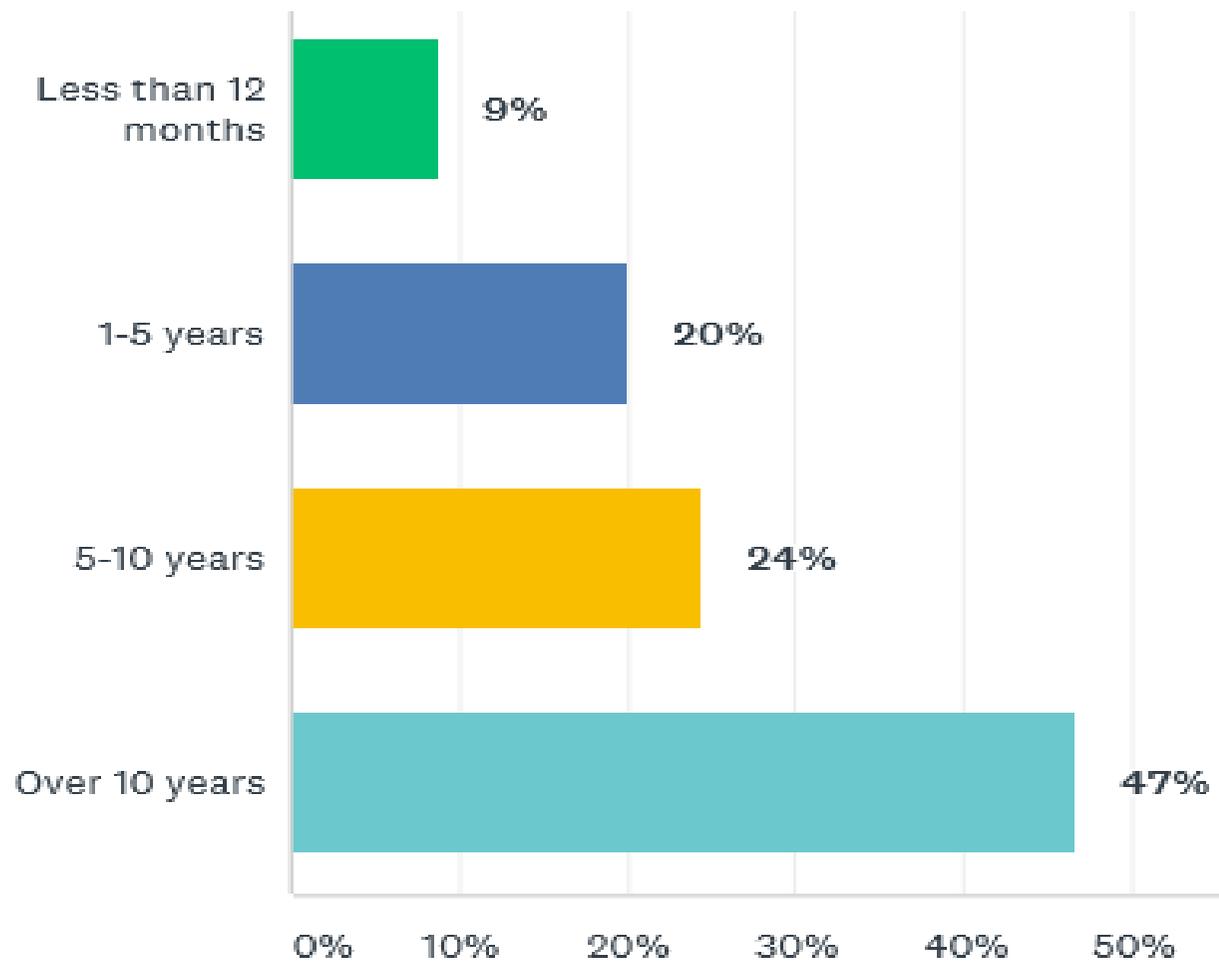
Q.42 How did you find out you have Osteoporosis? (n=45)

Note: respondents were able to tick more than one box.



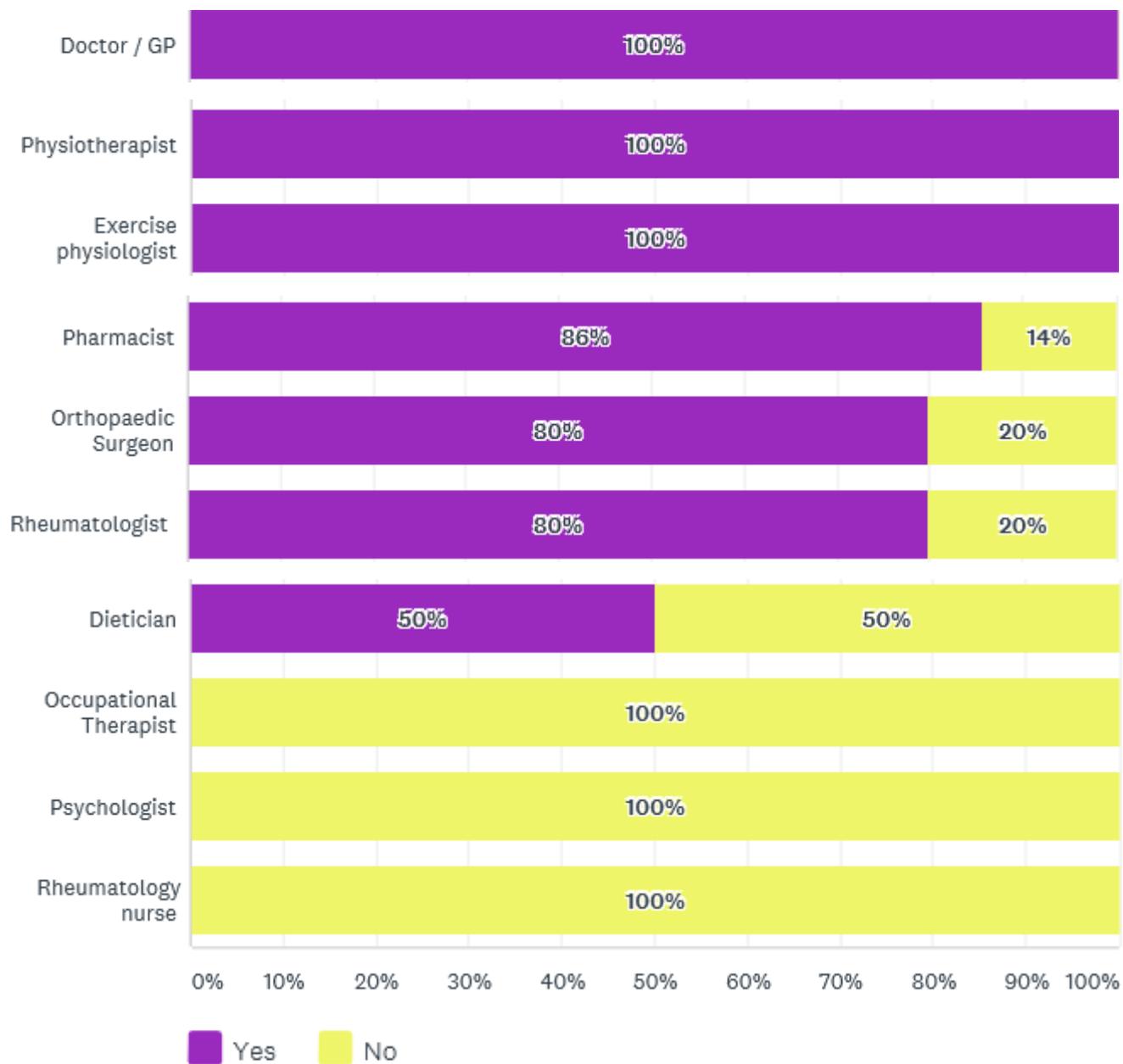
- ❖ The vast majority of respondents (84%) found out that they had osteoporosis from their GP / Doctor.
- ❖ In only 11% of cases, was diagnosis in conjunction with / as a result of an appointment with a Specialist.

Q.43 When were you diagnosed with Osteoporosis? (n=45)



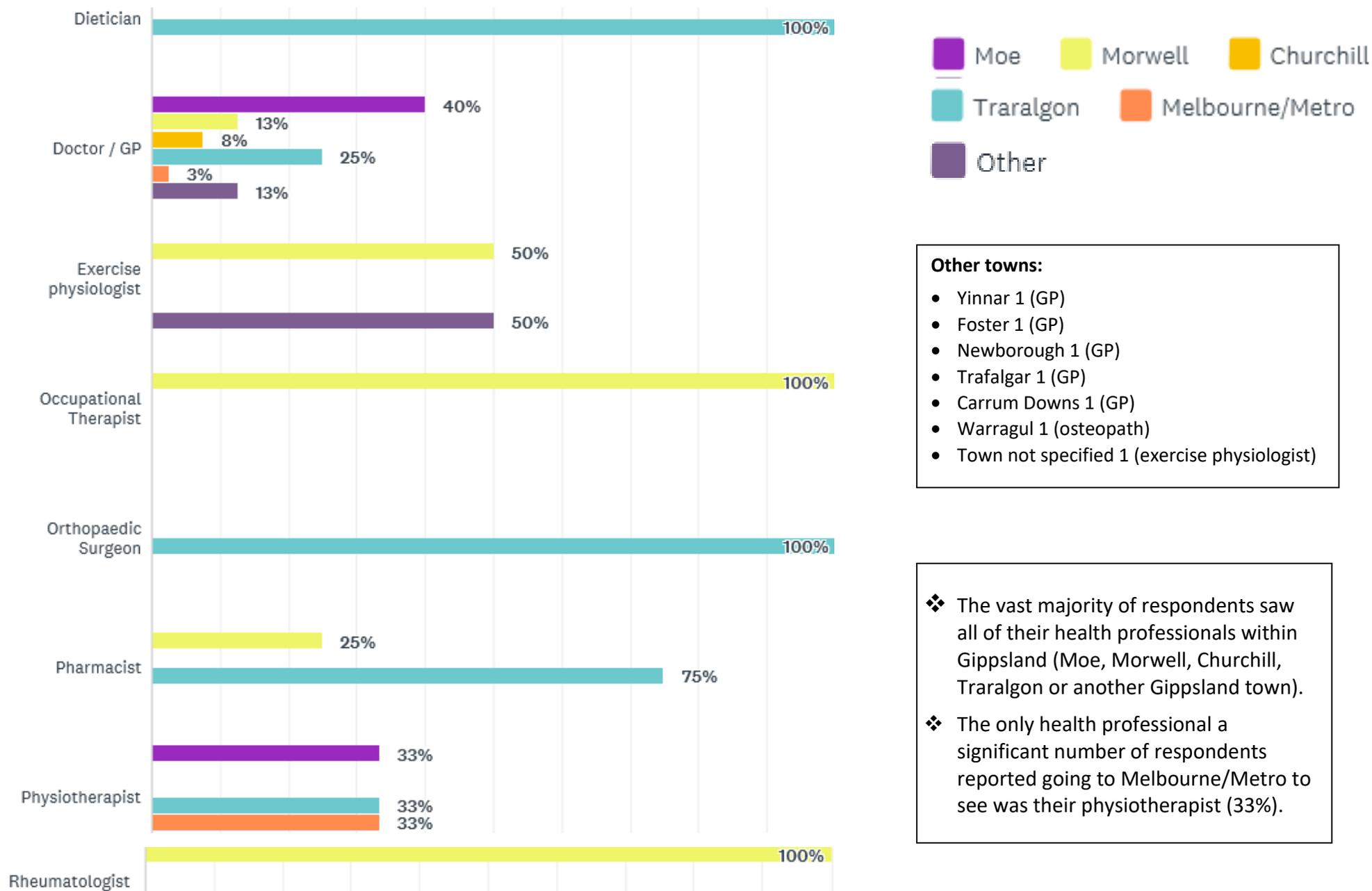
- ❖ The majority of respondents (47%) had been living with their osteoporosis for over 10 years.
- ❖ Only a small percentage (9%) were newly diagnosed i.e. under 12 months.

Q.44 Which health professionals do you see for your Osteoporosis? (n=43)



- ❖ All 43 respondents to this question reported seeing a range of health professionals for their osteoporosis.
- ❖ 100% indicated that they saw a Doctor/GP, physiotherapist and/or exercise physiologist.
- ❖ Over 80% indicated that they saw a pharmacist, orthopaedic surgeon and/or rheumatologist.
- ❖ 50% reported seeing a dietician.
- ❖ None of the respondents to this question indicated that they saw an occupational therapist, psychologist or rheumatology nurse.

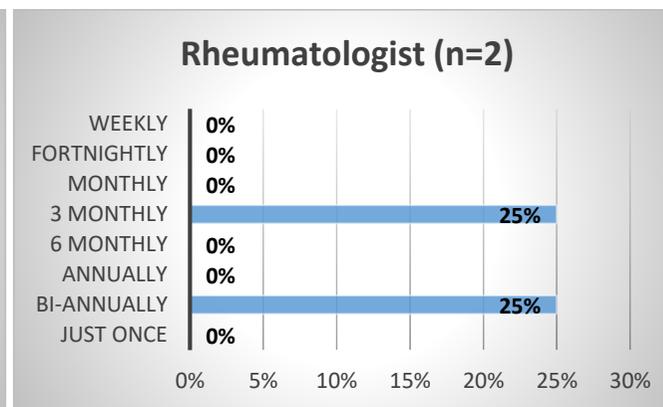
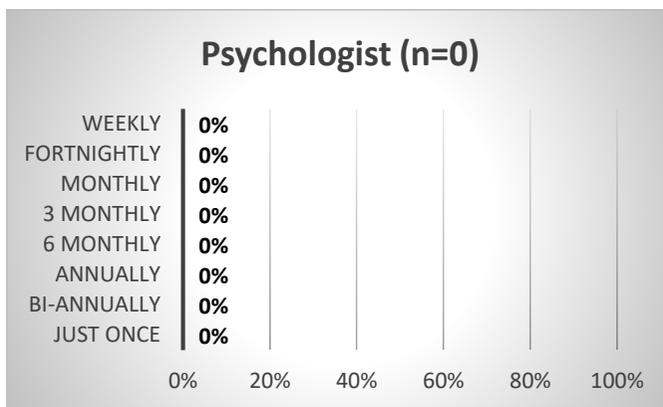
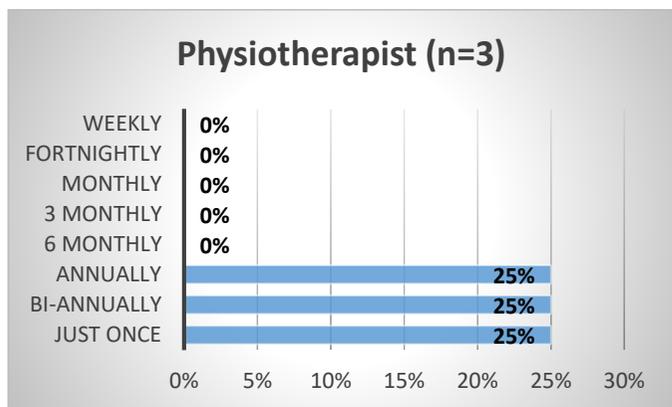
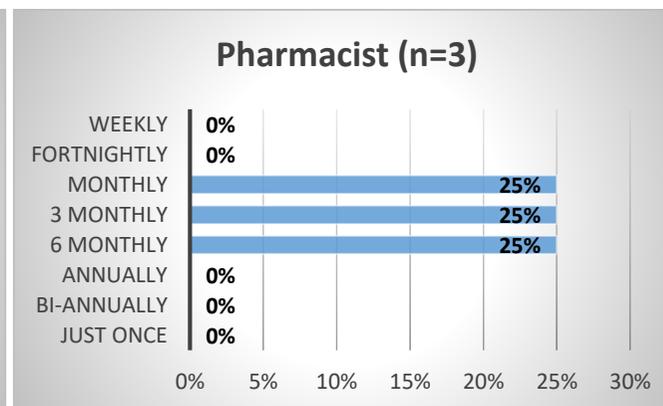
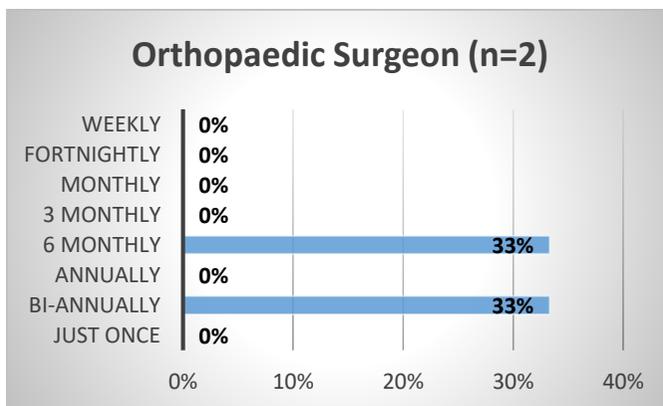
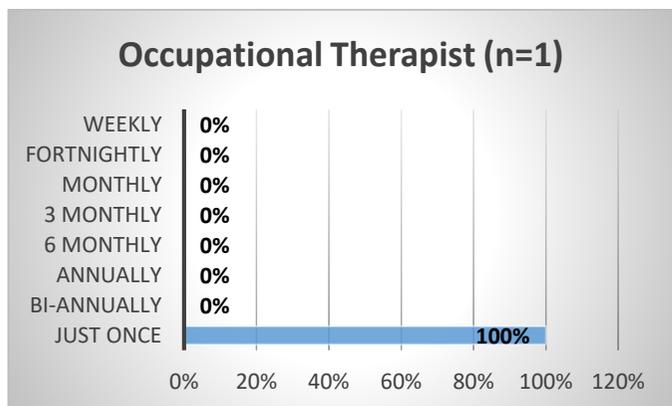
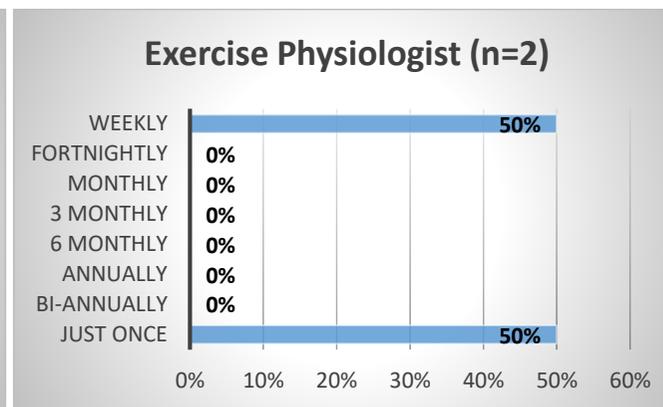
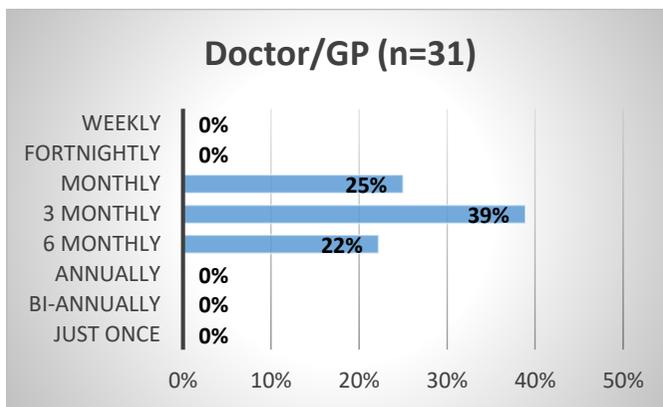
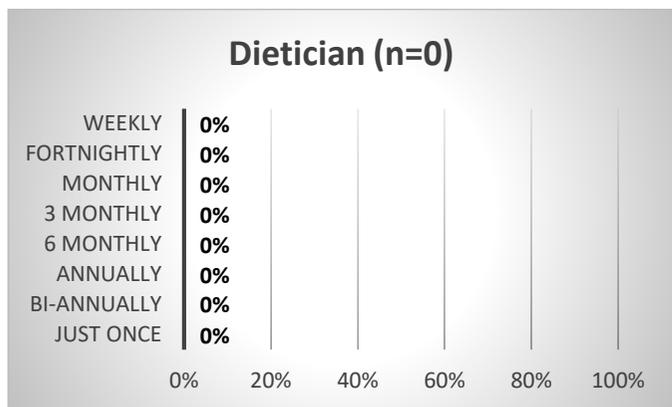
Which town do you see them in for your Osteoporosis? (n=43)

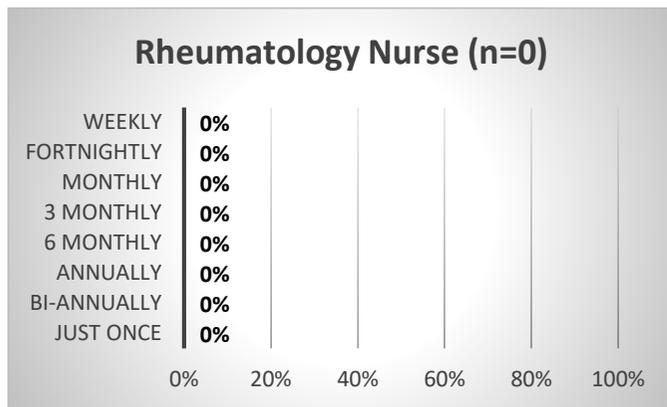


- Other towns:**
- Yinnar 1 (GP)
 - Foster 1 (GP)
 - Newborough 1 (GP)
 - Trafalgar 1 (GP)
 - Carrum Downs 1 (GP)
 - Warragul 1 (osteopath)
 - Town not specified 1 (exercise physiologist)

- ❖ The vast majority of respondents saw all of their health professionals within Gippsland (Moe, Morwell, Churchill, Traralgon or another Gippsland town).
- ❖ The only health professional a significant number of respondents reported going to Melbourne/Metro to see was their physiotherapist (33%).

How often do you see them for your Osteoporosis? (n=43)





Answer Choices	Weekly	Fortnightly	Monthly	3 monthly	6 monthly	Annually	Bi-annually	Just once	Total
Dietician	0%	0%	0%	0%	0%	0%	0%	0%	0
Doctor / GP	0%	0%	25%	39%	22%	0%	0%	0%	31
Exercise physiologist	50%	0%	0%	0%	0%	0%	0%	50%	2
Occupational Therapist	0%	0%	0%	0%	0%	0%	0%	100%	1
Orthopaedic Surgeon	0%	0%	0%	0%	33%	0%	33%	0%	2
Pharmacist	0%	0%	25%	25%	25%	0%	0%	0%	3
Physiotherapist	0%	0%	0%	0%	0%	25%	25%	25%	3
Psychologist	0%	0%	0%	0%	0%	0%	0%	0%	0
Rheumatologist	0%	0%	0%	25%	0%	0%	25%	0%	2
Rheumatology nurse	0%	0%	0%	0%	0%	0%	0%	0%	0

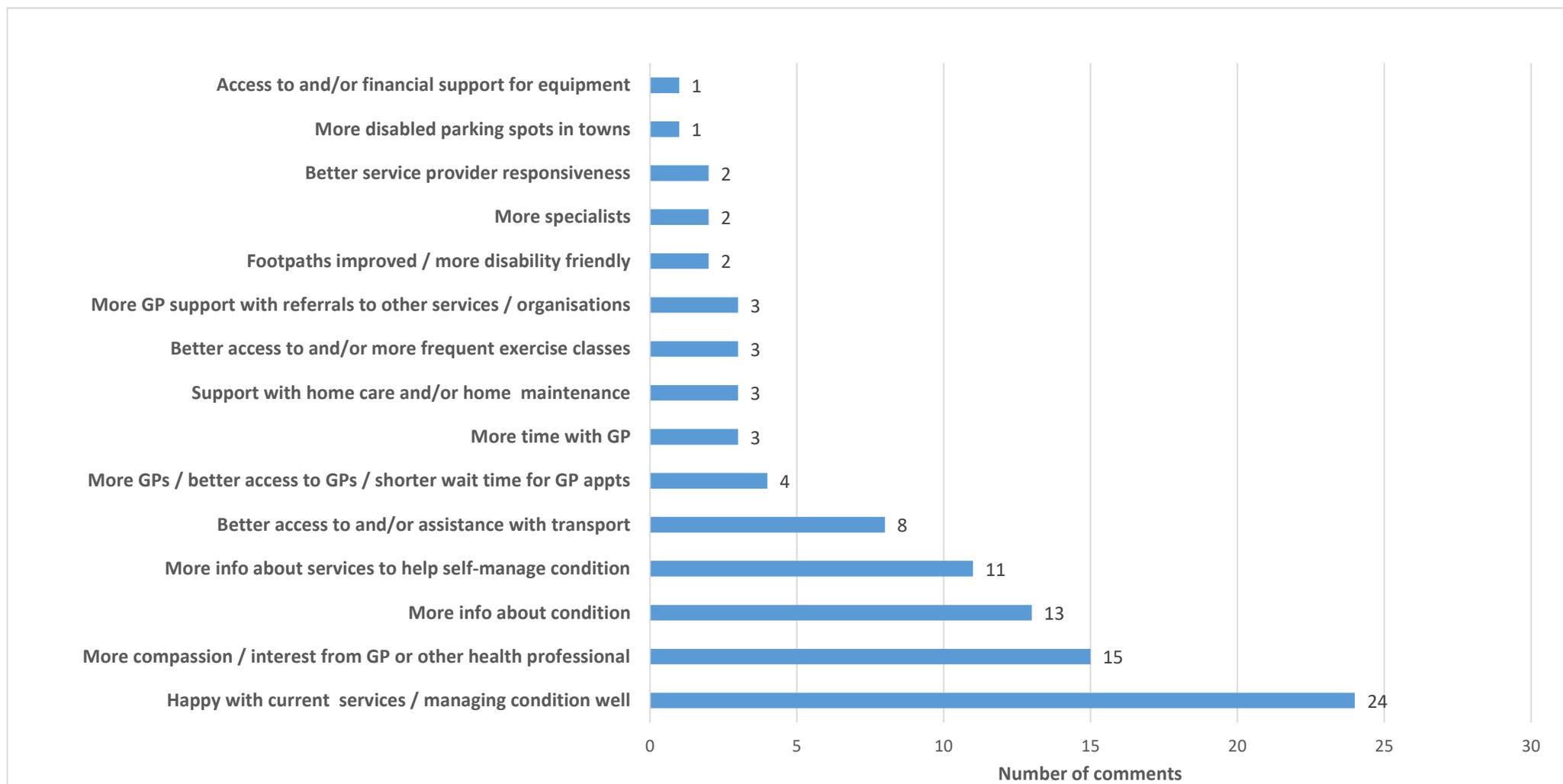
- ❖ Frequency of visits varied widely across most of the health professionals that the respondents reported seeing for their osteoporosis.
- ❖ However, without further information it is not possible to ascertain whether the longer gaps between visits are due to a lack of clinical need, lack of availability, cost or some other factor.

Q.45 How well do the current supports work for you and why? Is there anything that makes it harder for you to manage? (e.g. transport, time, family commitments, knowledge, lack of response from service providers, opening hours, bad experience etc?)

Q.48 What would make it easier for you to manage your Osteoporosis?

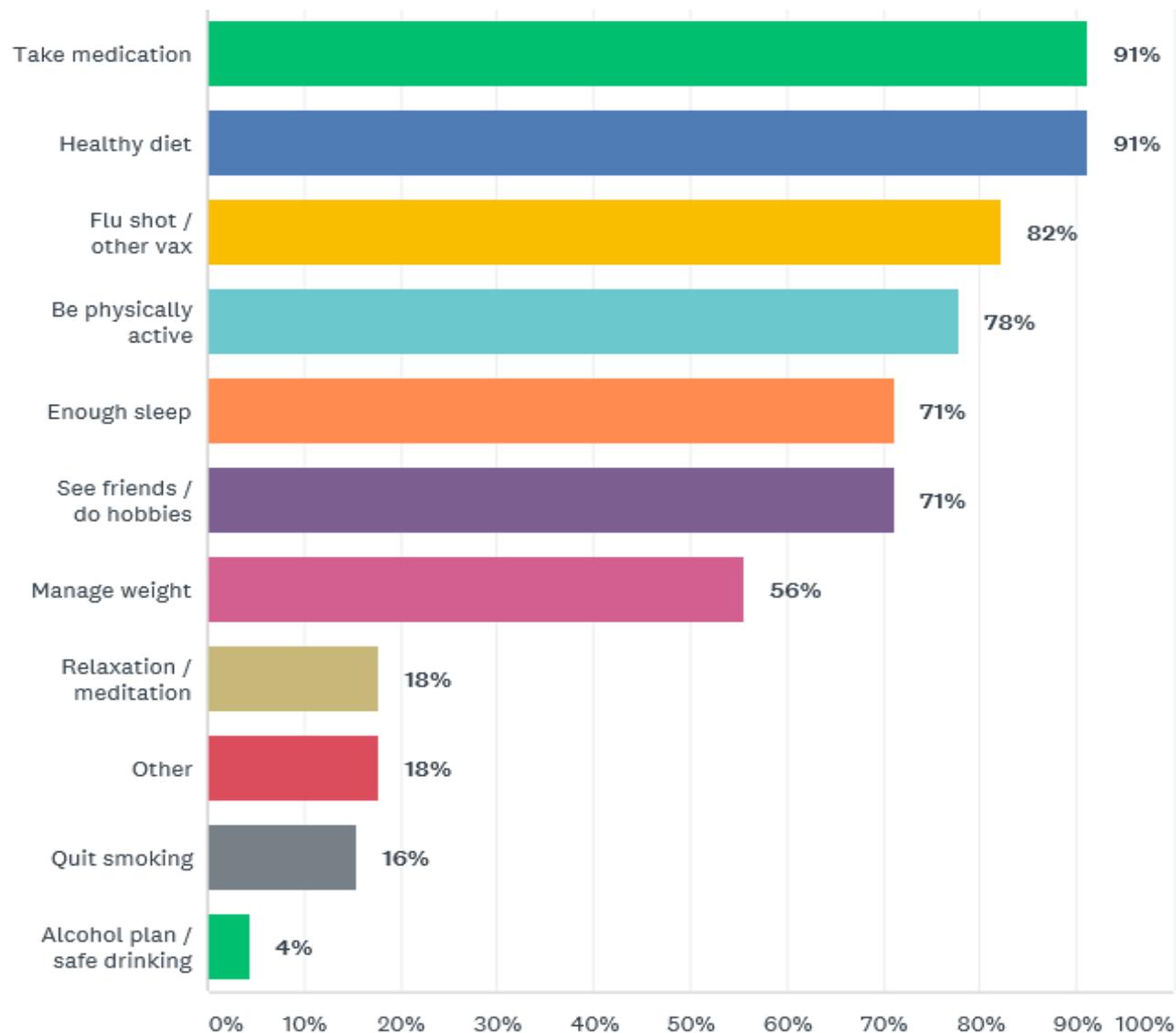
- Theming for Q.45 & Q.48 has been collated

Total no. of comments re Q.45 & Q.48: 38 + 39 = n=77



- ❖ 52% of the 46 respondents with osteoporosis indicated that they were happy with their current services and managing their condition well.
- ❖ Suggestions for things that would make it easier for the respondents to manage their osteoporosis fell into 14 main themes.
- ❖ The most frequently mentioned themes (i.e. identified by over 10% of the 46 respondents) were:
 - More compassion / interest from their GP or other health professional (33%),
 - More information about their condition (28%),
 - More information about services to help self-manage their condition (24%),
 - Better access to and/or assistance with transport (17%).

Q.46 What are you currently doing to make life easier with your Osteoporosis? (n=45)

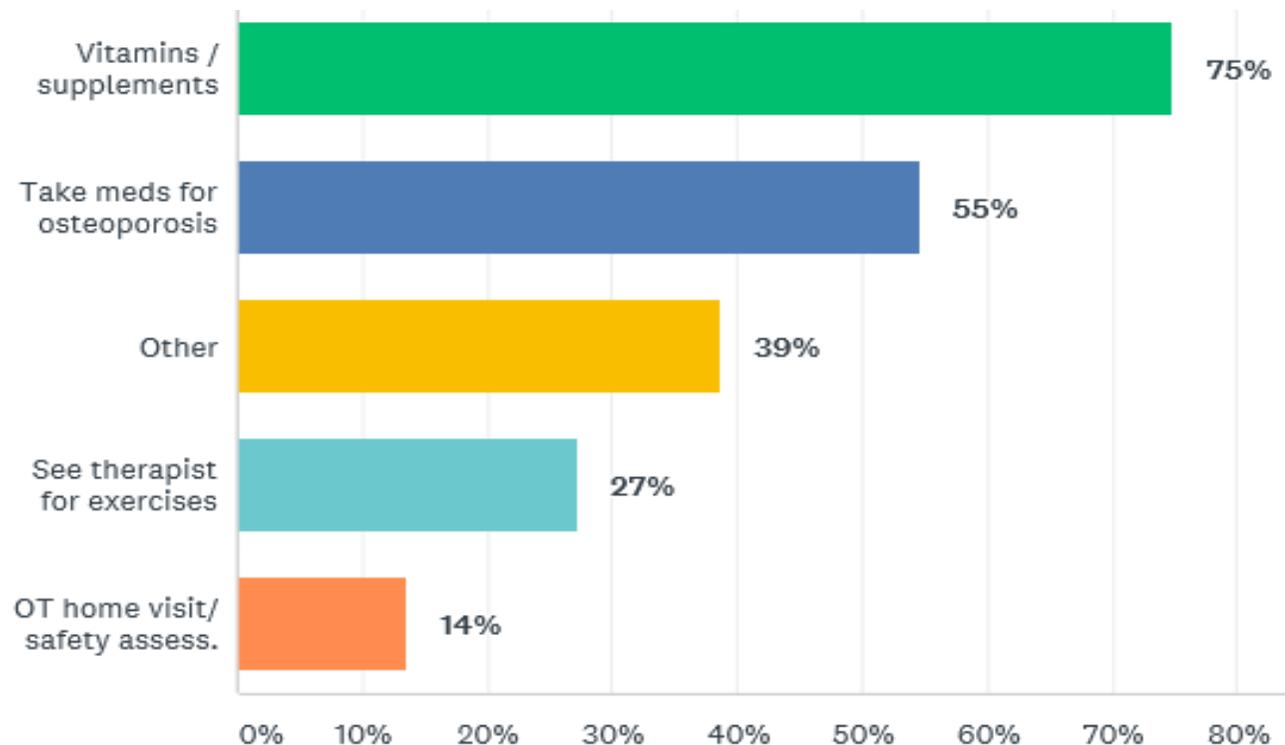


Other included:

- Attend church (1)
- Personal trainer (1)
- Exercise bike (1)
- Walk around home (1)
- Winter vacation to Queensland (1)
- Don't drink alcohol (1)
- B12 injections (1)
- Vitamin supplements (1)
- Prolia injections (1)
- Attend Planned Activity Group (PAG) / Seniors Group (1)

- ❖ Respondents reported using a wide variety of methods (usually in combination) to make life easier living with their osteoporosis.
- ❖ The most frequent (over 80%) were 'taking medication regularly', 'eating a healthy diet' and 'getting a flu shot and/or other vaccinations'.
- ❖ Over 70% also listed 'stay physically active e.g. walking group, gym, exercise group', 'get enough sleep' or 'see friends/do hobbies'.

Q.47 How do you manage your Osteoporosis? (n=44)



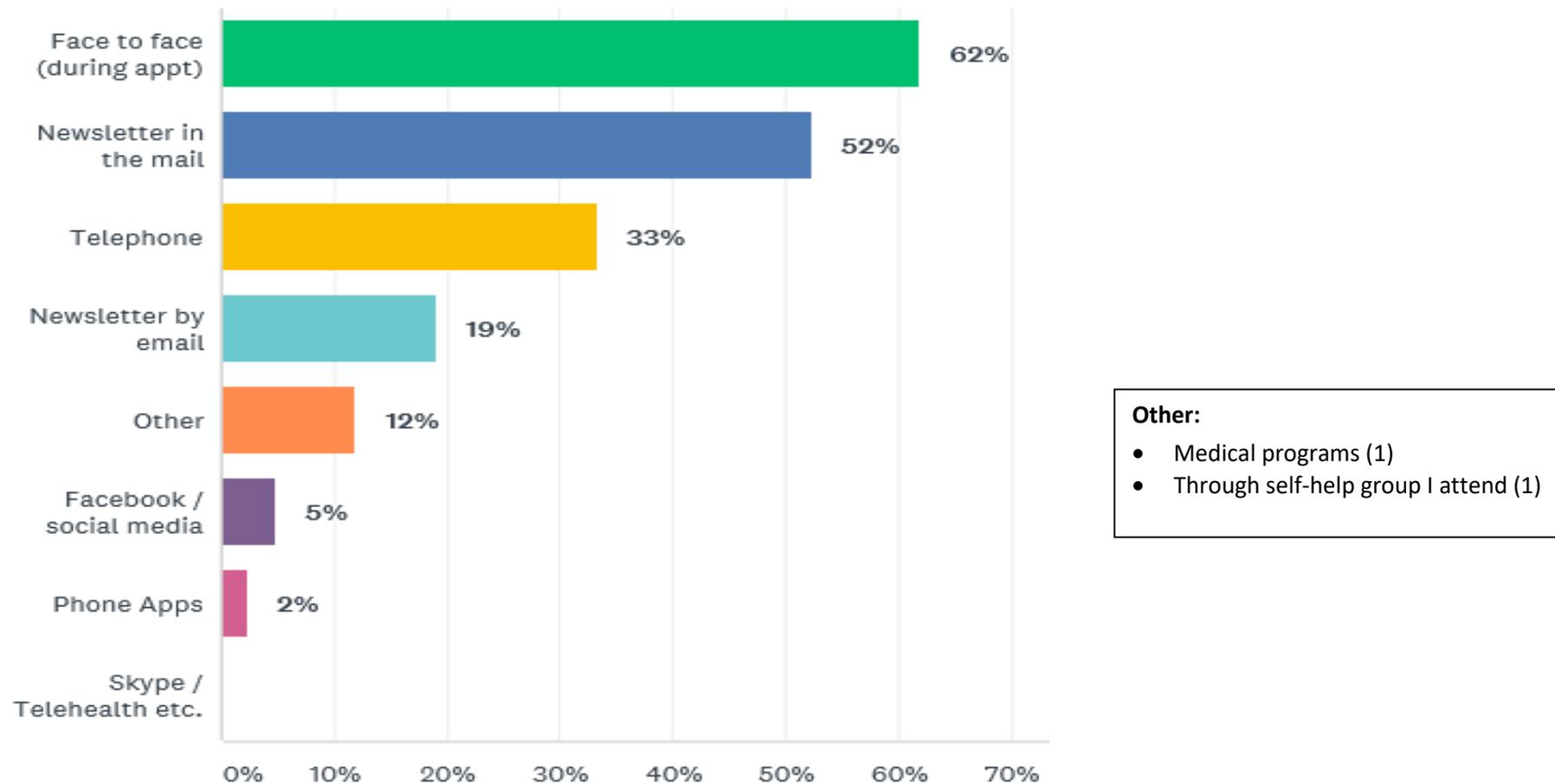
Other included:

- Exercise: gym, yoga, skipping, walking, bowls (4)
- Massage (2)
- Visit osteopath (1)
- Practice Feldenkrais technique (1)
- Attend self-help group (1)
- Heat and cold packs (1)

- ❖ Respondents reported using a variety of methods (usually in combination) to manage their osteoporosis.
- ❖ The most frequent were 'take vitamins / supplements e.g. vitamin D, calcium' (75%) and 'take medication for osteoporosis' (55%).
- ❖ Over a quarter of respondents also reported that they 'see a therapist to do exercises to help with balance / muscle strength'.

Q.49 What is the best way for health services to provide support to you with your Osteoporosis? (n=42)

Note: respondents were able to tick more than one box.



- ❖ The majority of respondents identified ‘face-to face during an appointment’ (62%) and/or ‘newsletter in the mail’ (52%) as the best ways for health services to provide support to them.
- ❖ There was also some support for ‘telephone’ (33%).

Discussion

A total of 302 community members were engaged in the project, either through a face-to-face conversation with a Peer Facilitator or completing a hard-copy or online survey in their own time.

A. General Demographic Data

Location:

- 81% of respondents were community members living in one of the four Latrobe Valley towns which were the main focus of the project i.e. Moe, Morwell, Churchill or Traralgon.
- The highest number of respondents were from Moe (34%) and Traralgon (26%). This was most likely due to the geographic location and availability of the Peer Facilitators to conduct face-to-face conversations and distribute surveys/postcards, rather than reflecting any particular concentration of community members with a chronic illness.

Gender:

- A large majority of the respondents were female (70%).
- The female/male disparity could potentially be due to a number of factors including:
 - More women than men frequenting the types of locations visited by the Peer Facilitators to conduct conversations or distribute surveys/postcards.
 - All of the Peer Facilitators being female (a suitable male applicant was unable to be recruited).
 - Greater willingness of women to share their stories of living with a chronic illness.
- Without further information, it is not possible to determine which of the above may have been the primary reason or whether there is another explanation.

Age:

- A large majority of the respondents were from the 65+ age group (73%).
- This was most likely due to:
 - Locations visited by the Peer Facilitators being predominantly frequented by older people e.g. Senior Citizens Centres, Retirement Villages, Planned Activity Groups.
 - Higher numbers of older people living with one or more of the five chronic illnesses.

Aboriginal or Torres Strait Islander respondents:

- Only 1% of respondents identified themselves as Aboriginal or Torres Strait Islander, with a further 2% preferring not to say.
- Surveys and/or postcards were distributed across a number of indigenous organisations, however response rates may have been improved if it had been possible to:
 - Engage Peer Facilitators from the indigenous community.
 - Look at alternative ways to engage indigenous community members in the project.

B. Arthritis

- 156 community members shared their story of living with arthritis.

Diagnosis:

- The vast majority of people (88%) found out that they had arthritis through their GP (in conjunction with a specialist in about a quarter of cases). This illustrates the central role of GPs in initial diagnosis and communication with the patient regarding treatment and management of their condition, as well as referral to other services.
- The majority of respondents (61%) had been living with the condition for over 10 years and a further 21% for between 5 and 10 years. The project was therefore able to obtain significant insight into how people manage to 'live well' with arthritis over a long period of time and the barriers or challenges they may face to doing so.

Ongoing care:

- Respondents reported seeing a wide range of health professionals for their arthritis, which appears to indicate a good level of knowledge and access to available services.
- Health professionals seen included pharmacists, physiotherapists and rheumatologists (over 90% of respondents), as well as exercise physiologists, orthopaedic surgeons, dieticians and occupational therapists (over 75%).
- Over 55% of people said they saw a psychologist for their condition, which demonstrates the impact that living with a chronic illness can have on mental health as well as physical health.
- All respondents indicated that they saw their doctor, which again illustrates the vital role of GPs in the ongoing care of people with arthritis.
- None of the 150 respondents indicated that they saw a rheumatology nurse, which may indicate a service gap in the Latrobe City LGA.
- The vast majority of respondents were able to see all of their health professionals either in Moe, Morwell, Churchill, Traralgon or another Gippsland town. This indicates the availability of a range of local services and health professionals for people with arthritis.
- The only health professionals a significant number of respondents reported going to Melbourne or the Metro area to see were their orthopaedic surgeon (23%), rheumatologist (11%) or physiotherapist (8%), which may indicate some service gaps.

Effectiveness of current supports:

- A significant proportion of community members with arthritis (42%) indicated that they were happy with their current services and managing their condition well.
- However, a number of suggestions were made for things that would make it easier for the respondents to manage their arthritis and/or areas identified where current supports were not working so well.
- These fell into 21 main themes, which generally fitted within the broad categories of:
 - Access to or availability of support/services/equipment/GPs/specialists;
 - Need for more information about services/their condition;
 - Communication with and between health professionals and services;
 - Need for more disability-friendly local infrastructure.
- The most frequently occurring individual themes were:
 - Better access to and/or assistance with transport (15% of the 156 respondents),
 - More compassion / interest from their GP or other health professional (15%),
 - More information about their condition (13%),

- More information about services to help self-manage their condition (11.5%),
- Support with home care and/or home maintenance (10%).

Self-management of arthritis:

- Respondents reported using a very wide variety of methods (usually in combination) to self-manage their condition and make life easier living with arthritis.
- These strategies included:
 - General self-care / preventative health-care (taking medication regularly, healthy diet, flu vaccination, not smoking/drinking, enough sleep, weight management).
 - Social activities / inclusion (seeing friends, attending groups, hobbies).
 - Exercise / staying physically active (in groups or at home).
 - Allied health (physiotherapy, Pilates, chiropractic).
 - Complementary / alternative healthcare (natural remedies, acupuncture, massage, relaxation/mindfulness, smoking marijuana).
 - Increasing their own knowledge / awareness of the condition.
- It is unclear whether these methods were suggested by health professionals, learnt of through support/self-help groups, discussed within social/peer networks or discovered via the person's own research. However, the breadth and variety of methods mentioned shows that most people are willing to utilise multiple services to manage their condition.

Providing support to people with arthritis:

- People indicated that they would prefer to receive information 'face-to face during an appointment' (51%) and/or via 'a newsletter in the mail' (47%).
- There was also some support for 'by telephone' (26%) and 'a newsletter by email' (25%).

C. Chronic Obstructive Pulmonary Disease (COPD)

- 33 community members shared their story of living with COPD.

Diagnosis:

- The majority of people (63%) found out that they had COPD through their GP (in conjunction with a specialist in 38% of cases). As with arthritis, this illustrates that GPs have a central role in initial diagnosis and communication with the patient regarding treatment and management of their condition, as well as referral to other services.
- A large majority of respondents (78%) had been living with the condition for over 5 years. The project was therefore able to obtain significant insight into how people manage to 'live well' with COPD over a long period of time and the barriers or challenges they may face to doing so.

Ongoing care:

- Respondents reported seeing a range of health professionals for their COPD, which appears to indicate a good level of knowledge and access to available services.
- All respondents reported seeing their GP as well as a pharmacist, cardiologist, respiratory nurse, exercise physiologist, occupational therapist and physiotherapist.
- The vast majority were able to see all of their health professionals either in Moe, Morwell, Churchill, Traralgon or another Gippsland town. This indicates the availability of a range of local services and health professionals for people with COPD.

- The only health professionals a significant number of respondents reported going to Melbourne or the Metro area to see were their cardiologist (50%), physiotherapist (25%) and respiratory nurse (13%), which may indicate some service gaps.

Effectiveness of current supports:

- One third of the community members with COPD indicated that they were happy with their current services and managing their condition well. This was still a significant proportion although not as high as for arthritis (42%).
- However, a number of suggestions were made for things that would make it easier for the respondents to manage their COPD and/or areas identified where current supports were not working so well.
- These fell into 16 main themes, which generally fitted within the broad categories of:
 - Access to or availability of support/services/equipment/GPs/specialists;
 - Need for more information about services/their condition;
 - Communication with and between health professionals and services;
 - Need for more disability-friendly local infrastructure.
- The most frequently occurring individual themes were:
 - More information about their condition (39% of the 33 respondents).
 - More compassion / interest from their GP or other health professionals (33%).
 - More information about services to help self-manage their condition (33%).
 - Better access to and/or assistance with transport (24%).
 - More GPs / better access to GPs / shorter wait time for GP appointments (18%).

Self-management of COPD:

- Respondents reported using a very wide variety of methods (usually in combination) to self-manage their condition and make life easier living with COPD.
- These strategies included:
 - Taking prescribed daily, reliever, maintenance and flare-up medication.
 - Lung function tests / oxygen therapy / pulmonary rehabilitation program.
 - General self-care / preventative health-care (taking other medication regularly, healthy diet, flu vaccination, not smoking/drinking, enough sleep, manage weight).
 - Social activities / inclusion (seeing friends, attending groups, hobbies).
 - Exercise / staying physically active (in groups or at home).
 - Complementary / alternative healthcare (relaxation/meditation).
- It is unclear whether some of these strategies were suggested by health professionals, learnt of through support/self-help groups, discussed within social/peer networks or discovered via the person's own research. However, it is clear that most people are willing to try a wide variety of methods to manage their condition.

Providing support to people with COPD:

- Most people indicated that they would prefer to receive information 'face-to face during an appointment' (71%).
- There was also significant support for 'a newsletter by email' (48%).

D. Diabetes

- 80 community members shared their story of living with diabetes.

Diagnosis:

- The overwhelming majority of people (91%) found out that they had diabetes through their GP. This proportion was even higher than for arthritis (88%) and COPD (63%) and diagnosis was only in conjunction with a specialist in a very low 6% of cases.
- For diabetes, therefore, it is clear that GPs are absolutely central in initial diagnosis and communication with the patient regarding treatment and management of their condition, as well as referral to other services.
- A large majority of respondents (75%) had been living with the condition for over 5 years. The project was therefore able to obtain significant insight into how people manage to 'live well' with diabetes over a long period of time and the barriers or challenges they may face to doing so.

Ongoing care:

- Respondents reported seeing a wide range of health professionals for their diabetes, which appears to indicate a good level of knowledge and access to available services.
- 100% of respondents reported seeing their GP, as well as a podiatrist, pharmacist and dietician for their diabetes.
- There was also an excellent level of awareness of and access to diabetes educators, with 98% of people reporting that they saw one.
- However, only two thirds of respondents indicated that they saw an endocrinologist. This may be due to an availability issue in the Latrobe Valley, since 60% of respondents reported that they saw their endocrinologist in the Melbourne/Metro area. The other 40% saw them in Traralgon, with no other towns listed.
- The vast majority were able to see their other health professionals either in Moe, Morwell, Churchill, Traralgon or another Gippsland town. This indicates the availability of a range of local services and health professionals for people with diabetes.
- Apart from their endocrinologist, the only health professional a significant number of respondents reported seeing in Melbourne/Metro was their physiotherapist (20%).

Effectiveness of current supports:

- Almost 58% of the 80 community members with diabetes indicated that they were happy with their current services and managing their condition well. This proportion was significantly higher than for arthritis (42%) and COPD (33%).
- However, there were still a number of suggestions for things that would make it easier for the respondents to manage their diabetes and/or areas identified where current supports were not working so well.
- These fell into 20 main themes, which generally fitted within the broad categories of:
 - Access to or availability of support/services/equipment/GPs/specialists;
 - Need for more information about services/their condition;
 - Communication with and between health professionals and services;
 - Need for more disability-friendly local infrastructure.
- The most frequently occurring individual themes were:
 - More information about their condition (22.5% of the 80 respondents).
 - Better access to and/or assistance with transport (16%).
 - More GPs / better access to GPs / shorter wait time for GP appointments (15%).
 - More compassion / interest from their GP or other health professional (11%).

Self-management of diabetes:

- As for arthritis and COPD, respondents reported using a wide variety of methods (usually in combination) to self-manage their condition and make life easier living with diabetes.
- These strategies included:
 - Taking prescribed diabetes medication (tablets/insulin), monitoring Blood Glucose Level (BCG), HbA1c tests and sticking to a diabetic diet.
 - General self-care / preventative health-care (taking other medication regularly, healthy diet, flu vaccination, not smoking/drinking, enough sleep, manage weight).
 - Social activities / inclusion (seeing friends, attending groups, hobbies).
 - Exercise / staying physically active (in groups or at home).
 - Complementary / alternative healthcare (relaxation/meditation).
- It is unclear whether some of these strategies were suggested by health professionals, learnt of through support/self-help groups, discussed within social/peer networks or discovered via the person's own research. However, it is clear that most people are willing to try a wide variety of methods to manage their condition.

Providing support to people with diabetes:

- People indicated that they would prefer to receive information by 'a newsletter in the mail' (55%) and/or 'face-to-face during an appointment' (51%).
- There was also some support for 'by telephone' (26%) and 'a newsletter by email' (20%).

E. Heart Failure

- 69 community members shared their story of living with heart failure.

Diagnosis:

- In contrast to arthritis, COPD and diabetes, the majority of respondents (55%) found out that they had heart failure through a hospital admission – generally for a heart-related event or condition.
- However, the person's GP was also involved in 51% of cases, so they still played a significant role in initial diagnosis and communication with the patient regarding treatment and management of their condition, as well as referral to other services. Diagnosis was through or in conjunction with a specialist in one third of cases.
- A large majority of respondents (79%) had been living with the condition for over 5 years. The project was therefore able to obtain significant insight into how people manage to 'live well' with heart failure over a long period of time and the barriers or challenges they may face to doing so.

Ongoing care:

- All respondents reported seeing a range of health professionals for their heart failure, which appears to indicate a good level of knowledge and access to available services.
- 100% of respondents reported seeing their GP, as well as a cardiologist, dietician, exercise physiologist, physiotherapist, occupational therapist and pharmacist.
- 100% also said they saw a psychologist for their condition, which demonstrates the impact that living with a chronic illness can have on mental as well as physical health. This was a much higher proportion than for arthritis at 55%.

- The vast majority were able to see their other health professionals either in Moe, Morwell, Churchill, Traralgon or another Gippsland town. This indicates the availability of a range of local services and health professionals for people with heart failure.
- The only health professionals a significant number of respondents reported seeing in the Melbourne/Metro area were their cardiologist (30%) and physiotherapist (11%), which may indicate some service gaps.

Effectiveness of current supports:

- 45% of the 69 respondents with heart failure indicated that they were happy with their current services and managing their condition well. This proportion was higher than for arthritis (42%) and COPD (33%) but significantly lower than for diabetes (58%).
- However, there were still a number of suggestions for things that would make it easier for the respondents to manage their heart failure and/or areas identified where current supports were not working so well.
- These fell into 16 main themes, which generally fitted within the broad categories of:
 - Access to or availability of support/services/equipment/GPs/specialists;
 - Need for more information about services/their condition;
 - Communication with and between health professionals and services;
 - Need for more disability-friendly local infrastructure.
- The most frequently occurring individual themes were:
 - Better access to and/or assistance with transport (23% of the 69 respondents).
 - More information about their condition (19%).
 - Support with home care and/or home maintenance (19%).
 - More information about services to help self-manage their condition (16%).
 - More compassion / interest from their GP or other health professional (14.5%).

Self-management of heart failure:

- Similarly to arthritis, COPD and diabetes, respondents who had experienced heart failure reported using a wide variety of methods (usually in combination) to self-manage their condition and make life easier living with heart failure.
- These strategies included:
 - Taking prescribed medication e.g. for blood pressure, blood thinning, cholesterol.
 - Seeing a doctor regularly to have their blood pressure monitored, going to cardiac/heart failure rehabilitation classes, seeing a specialist/cardiologist and self-monitoring blood pressure at home.
 - General self-care / preventative health-care (taking other medication regularly, healthy diet, flu vaccination, not smoking/drinking, enough sleep, manage weight).
 - Social activities / inclusion (seeing friends, attending groups, hobbies).
 - Exercise / staying physically active (in groups or at home).
 - Complementary / alternative healthcare (relaxation/meditation).
- It is unclear whether some of these strategies were suggested by health professionals, learnt of through support/self-help groups, discussed within social/peer networks or discovered via the person's own research. However, it is clear that most people are willing to try a wide variety of methods to manage their condition.

Providing support to people with heart failure:

- People indicated that they would prefer to receive information 'face-to face during an appointment' (65%) and/or via 'a newsletter in the mail' (53%).
- There was also some support for 'by telephone' (24%).

F. Osteoporosis

- 46 community members shared their story of living with osteoporosis.

Diagnosis:

- As with arthritis, COPD and diabetes, the vast majority of respondents (84%) found out that they had osteoporosis through their GP/Doctor, with a specialist being involved in only 11% of cases.
- The person's GP therefore played the central role in initial diagnosis and communication with the patient regarding treatment and management of their condition, as well as referral to other services.
- A large majority of respondents (71%) had been living with the condition for over 5 years. The project was therefore able to obtain significant insight into how people manage to 'live well' with osteoporosis over a long period of time and the barriers or challenges they may face to doing so.

Ongoing care:

- All respondents reported seeing a range of health professionals for their osteoporosis, which appears to indicate a good level of knowledge and access to available services.
- 100% of respondents reported seeing their Doctor/GP, as well as a physiotherapist and an exercise physiologist.
- Over 80% saw a pharmacist, orthopaedic surgeon and/or rheumatologist, with 50% seeing a dietician.
- In contrast to arthritis and heart failure, none of the respondents said they saw a psychologist for their condition. It is unclear whether this may be due to a lack of awareness of the service, access/availability problems, a lower rate of mental health issues amongst people living with osteoporosis or some other factor.
- The vast majority were able to see their other health professionals either in Moe, Morwell, Churchill, Traralgon or another Gippsland town. This indicates the availability of a range of local services and health professionals for people with osteoporosis.
- The only health professional a significant number of respondents reported seeing in the Melbourne/Metro area was the physiotherapist (33%), which may indicate a service gap.

Effectiveness of current supports:

- 52% of the 46 respondents with osteoporosis indicated that they were happy with their current services and managing their condition well. This was significantly higher than for heart failure (45%), arthritis (42%) and COPD (33%) but lower than for diabetes (58%).
- However, there were still a number of suggestions for things that would make it easier for the respondents to manage their osteoporosis and/or areas identified where current supports were not working so well.
- These fell into 14 main themes, which generally fitted within the broad categories of:
 - Access to or availability of support/services/equipment/GPs/specialists;
 - Need for more information about services/their condition;
 - Communication with and between health professionals and services;
 - Need for more disability-friendly local infrastructure.
- The most frequently occurring individual themes were:
 - More compassion / interest from their GP or other health professional (33%).
 - More information about their condition (28%).
 - More information about services to help self-manage their condition (24%).
 - Better access to and/or assistance with transport (17%).

Self-management of osteoporosis:

- As for arthritis, COPD, diabetes and heart failure, respondents reported using a wide variety of methods (usually in combination) to self-manage their condition and make life easier living with osteoporosis.
- These strategies included:
 - Taking prescribed medications for osteoporosis or vitamins / supplements (e.g. Vitamin D, Calcium).
 - Seeing a therapist to do exercises to help with balance and muscle strength and/or having an occupational therapist come to their home to do a safety assessment.
 - General self-care / preventative health-care (taking other medication regularly, healthy diet, flu vaccination, not smoking/drinking, enough sleep, manage weight).
 - Social activities / inclusion (seeing friends, attending groups, hobbies).
 - Exercise / staying physically active (in groups or at home).
 - Complementary / alternative healthcare (e.g. relaxation/ meditation, massage, visiting osteopath, practicing Feldenkrais technique).
- It is unclear whether some of these strategies were suggested by health professionals, learnt of through support/self-help groups, discussed within social/peer networks or discovered via the person's own research. However, it is clear that most people are willing to try a wide variety of methods to manage their condition.

Providing support to people with osteoporosis:

- People indicated that they would prefer to receive information 'face-to face during an appointment' (62%) and/or by 'a newsletter in the mail' (52%).
- There was also significant support for 'by telephone' (33%).

G. Common Findings and Themes Across All Conditions

The following findings and themes were common across all five chronic illnesses:

Diagnosis:

- For arthritis, COPD, diabetes and osteoporosis, the vast majority of respondents found out that they had their chronic condition through their GP/Doctor, with the percentage ranging from a massive 91% in the case of diabetes to a still substantial 63% for COPD.
- The only exception was heart failure. However, even then, over half of respondents (51%) still reported finding out through their GP/Doctor.
- It is therefore very clear that GPs have a vital and central role not only with regard to initial diagnosis but also clear, effective communication with the patient regarding treatment options, the ongoing management of their condition and referral to other health professionals and services.
- Specialists also play a central role, having been involved in the diagnosis in an average of 23% of cases across the five chronic conditions (ranging from 38% for COPD to only 6% for diabetes).

Length of time since diagnosed:

- A large majority of respondents with all 5 conditions had been living with their chronic illness for over 5 years. This ranged from 88% for diabetes to 71% for osteoporosis.

- This meant that the project was able to obtain significant insight into how people manage to 'live well' with their chronic illnesses over a long period of time and the barriers or challenges they may face to doing so.
- However, only a small percentage were newly diagnosed (i.e. less than 12 months), with the proportion ranging from 9% for osteoporosis to a tiny 0.7% for arthritis.
- This meant the project was less able to report on the experiences and concerns of community members who had only recently been diagnosed with their chronic illness.

Variety of health professionals:

- Respondents with all 5 conditions reported seeing a wide range of health professionals.
- In the case of arthritis, over a dozen different health professionals were regularly reported to be involved in people's care and for all conditions there were at least eight.
- As with initial diagnosis, results for the involvement of the GP/Doctor in the respondents' ongoing care were extremely high (100% for all five conditions).
- Results were also very high across the board for pharmacists (86%-100%) and physiotherapists (86%-100%), while for other types of health professionals involvement was obviously specific to certain conditions e.g. diabetes educators, particular specialists.
- This appears to indicate a good level of knowledge and access to available health services and professionals for each of the chronic conditions.
- Interestingly, the involvement of a psychologist in respondents' care varied very widely, from 100% for heart failure, 83% for diabetes and 56% for arthritis down to zero for COPD and osteoporosis.
- It is unclear whether this disparity may be due to a lack of awareness of mental health services/psychologists, access/availability problems, a lower rate of mental health issues amongst people living with certain chronic conditions (or a greater reluctance to acknowledge and/or seek help for them) or another factor.
- However it is obviously a concern given the strong link between physical health and mental wellbeing - a link which was highlighted by a number of respondents.

Location of services:

- The vast majority of respondents were able to see all or most of their health professionals either in Moe, Morwell, Churchill, Traralgon or another Gippsland town. This again indicates the availability of a good range of locally available services and health professionals for people with these chronic conditions.
- However, a significant number of respondents did report going to the Melbourne/Metro area to see certain health professionals. The most common were some specialists (rheumatologists, cardiologists, endocrinologists), orthopaedic surgeons and physiotherapists. A number of COPD patients (13%) also reported travelling to the Melbourne/Metro area to see a respiratory nurse.
- Some people may obviously travel to Melbourne to see a particular health professional due to a personal preference or a recommendation from a family member, friend, colleague or other health professional. However, these findings, when considered together with comments made by some of the respondents regarding the effectiveness of current supports (see next section below), indicate that there are definitely service gaps in some areas.

Effectiveness of current supports:

- A significant proportion of the community members indicated that they were happy with their current services and managing their condition well (diabetes 58%, osteoporosis 52%, heart failure 45%, arthritis 42%, COPD 33%).
- This was reflected in a number of positive comments made by community members:

"I appreciate funding for the exercise group which I attend in Yinnar - to enable us to attend and have a cuppa afterwards."

"The staff at Latrobe Community Health Service Moe have been very supportive and have given me great assistance with dealing with diabetes."

"As my husband and I are in our 80,'s we have had quite a few medical events happen to us. We have constantly found that Gippsland Hospitals and Medical staff keep up with better standards and equipment."

"Thanks to the Chronic Pain Management clinics attended at both Moe Community Health and LRH 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."

"I got a beautiful home help who is helpful. We have had her for many years and she is just the best."

- For all conditions except diabetes, however, these figures also meant that between two thirds and one half were not happy and/or did not feel that they were managing well.
- Numerous comments and suggestions were made by community members regarding things that would make it easier for them to manage their chronic illness and/or areas where current supports were not working so well.
- 24 themes were identified from these comments, falling into five broad categories described below:

1. Shortage of GPs and specialists / difficulty getting appointments / continuity of care:

- More GPs / better access to GPs / shorter wait for GP appointments.
- Less GP turnover / better continuity of care.
- More time with GP.
- More specialists and specialist services (diabetes specialists / endocrinologists, cardiologists, rheumatologists, psychologists experienced in CDM, respiratory services).
- More after hours appointments.

"Due to shortage of doctors in the Valley, it is harder to make appointments to see your doctor or any doctor."

"Doctors are hard to get to see. GPs don't stay in this area very long."

"Doctors change - no continuity. Have to go through all details again."

"There needs to be continuity of care if a health professional leaves, especially for those people who have experienced trauma."

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

“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.”

“Most specialists come from Melbourne. Long waiting list. Can't do much for you.”

“We need endocrinologist (consultants) available in Gippsland.”

“Service delivery is very limited in Gippsland. Support for quarterly appointments at The Alfred would make life easier, particularly transport - over 3 hours each way, plus 5-6 hours at The Alfred make it a tough and tiring day.”

2. Communication with and between GPs, specialists, other health professionals and services:

- More compassion / interest from their GP or other health professional.
- Lack of communication b/w GPs and specialists.
- More GP support with referrals to other services / organisations.
- Better service provider responsiveness.
- Medication management issues.

“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 treating 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!”

“I'd like more attention and time from ALL providers – not enough information from health professionals which leaves me confused and afraid”.

“I don't feel listened to or acknowledged. I know they only have limited time to give me but I feel like a number and not a person. My most immediate need has NOT been addressed and I feel fobbed off, irrelevant and scared.”

“The hour long wait in the waiting room then 10 minute consultation with interruptions from the phone and the nurse and feeling no interest – this is from ALL providers.”

“My GP is not helpful in referring or telling me about resources or help. It is hard to find out these things yourself”.

3. Access to, cost or availability of support / services / equipment / transport:

- Access to and/or financial support for services.
- Access to and/or financial support for equipment.
- Financial support for medication (e.g. health care card).
- Better access to and/or assistance with transport.
- Support with home care and/or home maintenance.
- Better access to and/or more frequent exercise classes.
- Better access to hydrotherapy.
- Access to MEPACS / portable alarm.

“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."

"Make appointments and services cheaper."

"Sick & tired of waiting for a pain management appointment."

"(Specialists) charge like wounded bulls."

"It would have been a help if there was assistance available to help cover the cost of wound dressings and support stockings."

"I'm still driving so can get around. I don't know what I'll do when I can't drive anymore."

"Transport is always a problem because I depend on others and can't afford a taxi."

"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."

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

"Really need a hydrotherapy pool in the Moe area."

4. Need for more information and support / isolation and loneliness:

- More information about their condition.
- More information about services to help self-manage their condition.

"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."

"There are a lot of women who have lost partners and are in pain. They are often lonely and have no idea where to turn to when their bodies let them down."

"Loneliness is the biggest problem."

5. Need for more disability-friendly local infrastructure:

- Bus stop at Latrobe Regional Hospital (closer to the hospital entrance door).
- More disabled parking spots in towns / better monitoring of these spots.
- More seats in town.
- Footpaths and pedestrian crossings improved / more disability friendly.
- Public transport more disability friendly.

"If I have to go to LRH I have to use a bus. It is a long walk from the bus stop and very difficult for me."

"Not enough disabled parking bays or seats in town."

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

"We need our footpaths fixed, so dangerous in some streets."

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

"Getting on and off buses and trains, lower step seems too far from the platform."

"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."

- **The top six most frequently occurring themes** identified across all of the chronic conditions (i.e. mentioned by an average of 10% or more respondents) were a need for:
 - More information about their condition (average 24%).
 - More compassion / interest from their GP or other health professional (average 21%).
 - More information about services to help self-manage their condition (average 19%).
 - Better access to and/or assistance with transport (average 19%).
 - More GPs / better access to GPs / shorter wait for GP appointments (average 12%).
 - Support with home care and/or home maintenance (average 10%).

Self-management of chronic illnesses:

- For all five of the chronic illnesses, respondents reported using a wide and diverse range of methods (usually in combination) to self-manage their condition and make life living with it easier.
- These strategies included:
 - Taking prescribed medications and/or supplements for their condition.
 - Seeing a therapist e.g. to do exercises to help with balance and muscle strength and/or having an occupational therapist come to their home to do an assessment.
 - General self-care / preventative health-care (e.g. taking other medication regularly, healthy diet, flu vaccination, not smoking/drinking, enough sleep, manage weight).
 - Social activities / inclusion (seeing friends, attending groups/clubs, hobbies).
 - Allied health (e.g. physiotherapy, Pilates, chiropractic).
 - Exercise / staying physically active (in groups or at home).
 - Complementary / alternative healthcare (e.g. relaxation/meditation/mindfulness, massage, osteopathy, Feldenkrais technique, acupuncture/dry needling, natural remedies, smoking marijuana).
 - Increasing their own knowledge / awareness of the condition.
- It is unclear whether some of these strategies were suggested by health professionals, learnt of through support/self-help groups, discussed within social/peer networks or discovered via the person's own research.
- However, it is clear from these results that most people are willing to try a variety of strategies to manage their condition.

Providing support to people with chronic illnesses:

- Most people indicated that they would prefer to receive information 'face-to face during an appointment' (average 60% across the 5 conditions) and/or via 'a newsletter in the mail' (average 51%).
- There was also some support for 'by telephone' (average 23%) and 'a newsletter by email' (average 18%).
- There was very little support for 'Facebook/Social Media' (average 6%), 'Phone Apps' (average 5.5%) or 'Skype/Telehealth/Face Time/Video Chat' (average 2.5%).
- These results may reflect the older demographic of the vast majority of the respondents (73% over 65 years and 15% 55-64 years).

Conclusion

With over 300 community members participating, the findings from the Latrobe Living Well Conversations, and the common themes identified, provide an excellent basis for local health professionals and service providers to inform their discussions around future actions and priorities to improve the experience of people living with chronic conditions and help them 'live well'. These findings are especially relevant for older members of the Latrobe Valley community who have been living with their condition for a long period of time.

Participants were candid both in their conversations with the Peer Facilitators and responses provided via the survey and very clear in the areas of concern they identified and their suggestions for improvements.

In summary:

- 1. GPs/Doctors** have a vital role not only in initial diagnosis but also clear, effective communication with the patient regarding treatment options, the ongoing management of their condition and referral to other health professionals and services. However, many respondents reported:
 - Issues accessing GPs locally: e.g. not enough GPs; difficulties getting appointments (especially with their usual/ preferred GP); limited clinic opening hours; not enough time with their GP during the appointment; high GP turnover leading to a lack of continuity of care.
 - Communication problems with their GP/Doctor: e.g. not feeling listened to, lack of compassion and/or interest; GP not providing adequate information about their condition or available treatments/resources; GP not helpful in providing/facilitating referrals to other health professionals or services; medication management issues.
- 2. Specialists** also play a central role in both diagnosis and ongoing care. However, a significant number of respondents reported:
 - Difficulty accessing specialists and specialist services locally e.g. diabetes specialists/ endocrinologists, cardiologists, rheumatologists, psychologists experienced in CDM and respiratory services.
 - Lack of communication between specialists and their GP/Doctor.
- 3. Other health services and health professionals.** People see a wide range of health services and professionals for their condition apart from their GP and various specialists. However, many respondents reported:
 - A lack of communication between their GP/Doctor and specialists involved in their care and/or other health services and professionals.
 - A lack of responsiveness from health services or professionals e.g. contacting services but nobody getting back to them.
- 4. Access to support, services, equipment and transport.**
 - Many respondents reported problems accessing services or supports to help them manage their condition due to cost; funding cuts/limited subsidies for services; lack of local facilities; transport.
 - Transport was highlighted by a large number of respondents, with several noting that they were fearful of how difficult things would become if they were not able to drive.

5. Information and support / isolation and loneliness

- Many respondents reported that they were not provided with adequate information about their condition or available services by their health professionals and/or had difficulty accessing that information themselves.
- A significant number mentioned mental health issues and the impact of loneliness and isolation on people living with a chronic illness. However, for 2 of the chronic conditions (COPD and osteoporosis), none of the respondents reported seeing a psychologist.

6. Disability-friendly infrastructure

- A general need for improved infrastructure for people with disabilities, limited mobility or other physical challenges was clearly identified.
- Specific suggestions included: a bus stop closer to the Latrobe Regional Hospital entrance door, more disabled parking spots and better monitoring of these spots, more/better footpaths, more seats in towns and disability friendly public transport.

7. Self-management of chronic illnesses

- People with chronic illnesses are willing to consider a wide range of strategies to manage their condition in order to 'live well'.
- GPs and other health professionals can play a central role in providing information about, and facilitating access to, these options. For many people, however, self-help/support groups and peer/social networks are a major method of sharing and discussing this type of information.

8. Providing support to people with chronic illnesses

- For older people, providing information and support face-to-face and/or via newsletters in the mail are the preferred options. Few people aged 55 and over indicated a preference to receive information about their condition electronically (email, social media, Skype/video chat etc.)

Despite the above-mentioned concerns, it is important to note that a large number of participants in the project (an average of 46% across the five chronic conditions) reported overall satisfaction with current services and a feeling that they were managing their condition well.

It is hoped that local health services and providers can build on the positive experiences to identify and implement actions which will ensure that all community members living with a chronic illness in the Latrobe Valley and surrounding areas are able to 'live well' with their condition.

References

1. Local Government Area Profiles Datasheet 2015, Department of Health and Human Services, Victoria, <https://www2.health.vic.gov.au/about/publications/data/gippsland-region-2015>
2. Gippsland Health and Demographic Snapshot, Gippsland Health Online, <http://www.health.vic.gov.au/regions/gippsland/gippslandhealthonline/index.htm#sp>
3. National Health Performance Authority, [http://www.health.gov.au/internet/main/publishing.nsf/Content/annual-report2015-16-cnt1/\\$File/department-of-health-annual-report-2015-16.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/annual-report2015-16-cnt1/$File/department-of-health-annual-report-2015-16.pdf)

Appendices

Appendix 1

Projects with Potential Intersections to the Latrobe Chronic Disease Community Consultation

Health Area	Existing Project Title	Lead / Participating Agencies	Project Summary
Asthma Management	'Scarfie' - Asthma prevention and awareness campaign	Latrobe Health Assembly	Scarfie - Asthma prevention and awareness campaign that is conducted through Latrobe City that educates the community on asthma treatment and asthma causes through a variety of different innovative methods.
	Asthma Education in Pharmacies	Latrobe Health Assembly Latrobe Community Health Service	Collaborative 4 staged asthma campaign project; stage 3 is currently underway. A month long Asthma Education campaign at Latrobe City Chemists' - Traralgon, Morwell, Moe and Churchill; where a respiratory nurse is made available to discuss and educate with the community about the correct use of asthma medication/preventions to control their conditions.
Chronic Disease Management	Guided Care Project	Latrobe Community Health Service	This project has a focus on self-management continuum across Complex, Supported, Collaborative and Self-Directed. The first phase of this project has been completed, with positive analysis in that with applied intervention client's ability to self-manage increased. Next step of the project will involve evaluating the intra operator reliability of category selection and expand this guided care model of care into cardiovascular work.
Chronic Disease Management / Mental Health	LRH and LCHS collaboration: Youth Physical Health Program	Latrobe Regional Hospital Latrobe Community Health Service	Youth Physical Health Program is a collaboration project with a focus of 16-25 year olds recently diagnosed or living with mental health and supporting the physical health. This project is currently on hold due to staffing however it is anticipated work will recommence in February 2019. The program has recent approval to approach Headspace to collaborate and the next step is to investigate the feasibility of LCHS staff attending the Clozapine Clinic at Washington Street, Traralgon.
Mental Health	Connect Call / Text Back Program	Supported by the Latrobe Health Innovation Zone Delivered by Lifeline Gippsland	The project funds Lifeline Gippsland to enable people living in Latrobe Valley experiencing a crisis to navigate the crisis by matching them to a trained Lifeline volunteer (Connect Partner) who will provide ongoing empathic support for a period of up to 12 weeks to assist the individual to build resilience, contain and alleviate emotional distress, and affirm self-efficacy.
	headspace	Gippsland PHN	Gippsland PHN is responsible for overseeing contract management of the existing headspace centre in Morwell and the newly established headspace centre in Bairnsdale.

Health Area	Existing Project Title	Lead / Participating Agencies	Project Summary
			headspace centres aim to improve mental health outcomes for young people aged 12-25 years with, or at risk of, mild to moderate mental illness. Headspace also services the 9 Gippsland Doctor-in-Schools programs.
Mental Health <i>(continued)</i>	Gippsland Mental Health Alliance	Wellways (fund holder for the Gippsland Mental Health Alliance) DHHS (Hazelwood Mine Fire Inquiry Implementation)	On 25 January 2019, DHHS requested that Wellways, as the fund holder for the Gippsland Mental Health Alliance, release funds of \$30,000 to complete the mapping of Mental Health activities (forums, training, awareness raising and projects) within the Latrobe Valley as part of Action Item 84 from the Hazelwood Mind Fire Inquiry Implementation plan. This work has already been started through the Mental Health Forum Working Group, but it needs further attention to complete thoroughly before the working group can reconvene and make a firm decision on what type of forum to progress with. (Completion is expected by the end of the 2018/19 calendar year).
	LIFESPAN	Gippsland PHN Department of Health and Human Services (DHHS)	LIFESPAN is a place-based approach to suicide prevention. LIFESPAN is being implemented in the Latrobe Valley and Bass Coast, working with the local community, including the wider population and health agencies, local governments, emergency services, schools and media outlets to contribute to the reduction of the suicide rates. Community advisory groups are providing guidance, information, advice, engagement and supporting regional coordination and reform. Groups consist of local representatives including government, non-government, health, business, education, media, community agencies, emergency services, and people with lived experience.
	Low Intensity Mental Health Calm Kid Central online program	Gippsland PHN <i>Developing Minds Psychology and Education</i> (contracted to deliver program)	<i>Developing Minds Psychology and Education</i> have been contracted to deliver Low Intensity Mental Health Calm Kid Central online program services for children, parents/caregivers and professionals throughout Gippsland.
	Men's Shed Field Officer	Latrobe Health Assembly	A field officer to work with the men at the Men's Sheds across the Latrobe City to connect them to organisations to access services to receive the support they need in relation to Mental Health issues.
	Mental Health Awareness Strategy	Supported by the Latrobe Health Assembly Delivered by Lifeline Gippsland	The project will look at developing the capacity of the Latrobe Valley community to recognise, understand and respond to the mental health needs of its population. These needs are to be determined by the community through a process of active engagement and consultation.
	Mental Health Nurse in Practice Program	Gippsland PHN	The Mental Health Nurse in Practice Program provides coordinated clinical care across four Gippsland locations (not including Latrobe) for people with serious or persistent

Health Area	Existing Project Title	Lead / Participating Agencies	Project Summary
			<p>mental illness. Mental Health Nurses employed by Gippsland PHN work closely with Psychiatrists and/or General Practitioners to assist with assessment and care planning, monitoring mental state, managing medication and improving links to other health professionals.</p>
Mental Health <i>(continued)</i>	National Psychosocial Support Measure	Gippsland PHN <i>Within Australia</i> (contracted to deliver program)	Caters to the needs of people with severe mental health conditions who require psychosocial supports on a group basis and one-to-one. The National Psychosocial Support Measure is designed to be short term and provide support for non-NDIS participants. <i>Within Australia</i> has been contracted to deliver the program Gippsland-wide, including Latrobe.
	Partners in Recovery	Gippsland PHN	Partners in Recovery aims to support people experiencing severe and persistent mental illness and is also designed to assist their carers and families. The program aims to ensure that services required are working together to enable recovery. <i>Program funding is completing in June 2019 and services are transitioning to be captured under the National Disability Insurance Scheme (NDIS). Partners in Recovery was Gippsland wide, including Latrobe.</i>
	Psychological Therapies for Underserved Groups program	Commonwealth Department of Health Gippsland PHN	The Psychological Therapies for Underserved Groups program is a free, confidential psychology program funded by the Commonwealth Department of Health. The program provides access to effective, low cost treatment for people with a mental illness who may not otherwise be able to access services. Psychological Therapies is a key component within the stepped model of care within Gippsland, particularly supporting those experiencing mild to moderate mental illness. Service providers exist across Gippsland except Latrobe at present.
	Youth Mental Health and Eating program	Gippsland PHN Butterfly Foundation (contracted to deliver program)	Gippsland PHN has contracted the Butterfly Foundation to deliver the Youth Mental Health and Eating program, delivering Recovery and Carer Support Services that are community-based support for people affected by eating disorders. The goal of the Butterfly Support Services is to support the person with an eating disorder, and their carers, in their journey towards recovery.

Latrobe Chronic Illness Community Consultation Processes and Procedures

Introduction

Thanks for committing to be a volunteer Peer Facilitator with the Latrobe Chronic Illness Community Consultation Project. We value your time and effort as a volunteer and have developed the following processes to assist you to undertake the Peer Facilitator role in a manner which is effective, (hopefully fun /meaningful) and safe for volunteers and community members.

This document consists of 4 sections:

1. Information relevant prior to attendance at events, groups etc.
2. Information relating to during the conversation with community members
3. Information relating to follow up after your conversation with community members
4. Administrative information

The staff at CWGPCP are here to support you.

CWGPCP Office hours are 9am – 5pm Monday – Thursday

Ph. 03 5127 9156

Central Email: cwgpcp@gmail.com

We are located at Latrobe Community Health Service:
42 – 44 Fowler St, Moe 3825

Additional contact information:

The three CWGPCP project support staff are:

- **Pat Lovelock:** Email: Pat.Lovelock@lchs.com.au; Phone: 0439 498 817
Pat will be overseeing the project and will be the contact for submission of Sign In Sheets, debriefing, and will be the primary contact for this project.
(Please note Pat will be unavailable 23 August - 22 September: alternate contacts are below)
- **Leonie Riddle:** contact via CWGPCP Office details above
Leonie will be providing administrative support; and will be the contact for scheduling of events, sending materials, reimbursement of expenses and fuel vouchers.
(Leonie will be unavailable 14 June - 22 July: however, the Central Office will be attended to).
- **Liz Meggetto:** Email: liz.meggetto@lchs.com.au; Phone 0419 390 046
Liz is the Executive Officer at CWGPCP and is the secondary after hours contact (if you can't reach Pat).
(Liz will be unavailable 28 June - 29 July: please contact Pat or the Central Office during this period)

1. Prior to the event / consultation

1.1 Volunteer attendance at community events

Central West Gippsland Primary Care Partnership (CWGPCP) will identify appropriate community events in the following communities:

- Traralgon
- Moe
- Morwell
- Churchill.

Volunteers will be notified of community events via email and can nominate to attend an event by emailing cwgpcp@gmail.com

CWGPCP will keep a calendar of events with the name and contact details of the volunteers attending the events.

Prior to the event, CWGPCP will arrange for the volunteers' preferred method of capturing conversations (e.g. paper, ipad/tablet, voice recorder) to be delivered to / accessed by the volunteer.

The following material should be taken to the event / group:

- Volunteer ID badge
- Laminated Information Sheet on Common Chronic Illnesses
- Community Consultation banner (this can be collected from the CWGPCP office in Moe, or arranged with CWGPCP)
- A supply of:
 - Conversation Guides (the hardcopy of the surveys)
 - Copies of the Survey Monkey survey to distribute to community members to complete and send back via reply paid envelope
 - Reply paid envelopes
 - Printed postcards
 - Peak body information flyers on common chronic illnesses

1.2 Volunteer attendance at groups / meetings

If a volunteer has contacts with specific community groups, they can contact the group to advise them of the project and see if they would like a volunteer to speak to their group. If the group are willing to have a volunteer speak at their group meeting, the volunteer can directly arrange a suitable time with the group and advise the CWGPCP Central Office of the details.

It is important to ensure we are providing consistent information to the community, so please use the following information as a guide when talking about the project and/or approaching a group:

Name of the project: 'Living Well with Chronic Illness' (Latrobe Chronic Disease Community Consultation)

Chronic Illnesses we are focussing on: Arthritis, COPD, Diabetes, Heart Failure, Osteoporosis

Aims: The aims of the project are to conduct community consultation and engagement with people living with chronic illness and their carers to:

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

Timelines: To have community consultations between May and the end of September 2019, with reporting to the funding bodies by December 2019.

Ways community members can participate: Either by talking with a volunteer or completing an online survey.

For more information: they can contact Pat Lovelock at the Central West Gippsland Primary Care Partnership: Email: Pat.Lovelock@lchs.com.au; Phone: 0439 498 817

CWGPCP will provide a written acknowledgement to the community group as well record details of the meeting in the calendar of events.

If the arrangements are made between CWGPCP and a community group, CWGPCP will liaise with the volunteer, providing contact details to enable the volunteer to have direct communication with the community group key contact.

1.3 Volunteer attendance at Pharmacy / GP clinic

CWGPCP will liaise with the pharmacy / GP clinic to arrange a time for the volunteer to attend the pharmacy / clinic and liaise with the volunteers to arrange for them to attend the pharmacy / clinic.

Ideally, the pharmacy / GP clinic will allow the positioning of the banner, and an allocated space with a small table (if not a consultation room) for the volunteer to set up and utilize.

Ideally, pharmacy customers / GP patients will be attracted to the stand and can be engaged in a conversation whilst they wait for their appointment / script etc.

1.4 One on One conversations

To ensure the safety of the volunteer, one on one conversations will not be conducted in individuals' homes. If a community member would like to meet one on one with a volunteer to go through the survey questions (as opposed to doing so at a community event or group), the volunteer can arrange to meet the community member in a public place at a time that is mutually convenient. This may include the local library, café (ensuring privacy concerns are addressed), community house etc.

Alternatively, a phone conversation can be arranged. Volunteers can contact the CWGPCP Office if they would like to utilize a PCP office desk and landline phone.

1.5 Volunteering schedule

CWGPCP will keep a calendar of community events and groups that volunteers are attending. If a volunteer arranges a meeting with a community member/s, they shall notify CWGPCP (who will be diarize to ensure follow up as required).

2. During the event / conversations

2.1 Ethical considerations

1. Wear your CWGPCP Identification tag so people know the organisation you represent.
2. Peer Facilitators (the person guiding the conversation) and participants (the person telling their story) have to be happy with the location of the conversation. The participant should be offered an alternative time or location to have the conversation, at a time that suits them. Conversations should not be conducted in a participants' home.
3. The facilitator should be aware of issues involving his/her own safety when undertaking a conversation.
4. Confidentiality is an important concern. Participant details (name, phone number, email etc.) should only be documented with their consent (verbal) if necessary (e.g. to contact them to arrange a different time / location for the conversation, or if they would like to be involved in the video. (Note: CWGPCP will undertake the follow up with consumers who have indicated they would like to be involved in a video; and will coordinate the additional formal consent requirements).
5. Participants will not normally be named in the recording of data (unless their permission has been explicitly sought, and this should only be done where the participant is involved in the video).
6. Any recorded contribution, in written form, on tape etc., or in notes taken from the conversation by the facilitator, should be used in accordance with the wishes of the participant. Facilitators must tell the participants what their information will be used for, and that it will be de-identified (outlined in the conversation preamble) and seek verbal consent to continue the conversation.
7. Where notes of the conversation are taken on paper, copies of all written information will be forwarded to the CWGPCP Office for shredding once details have been entered into the data base.

2.2 Conversations with community members

When you first talk with the potential participant:

1. Go through the conversation preamble with the potential participant to explain who you are, why you want to talk to them, and what you wish to find out. Explain about the possibility of recording the conversation (if the volunteer prefers this rather than taking notes) and follow the procedures for this accordingly. If the participant does not wish to be recorded, you can
2. Ask the participant if they have any questions before you begin.

Preparation for the conversation:

1. **Move to a space or choose a setting with little distraction.** Avoid loud noises, ensure the participant is comfortable to speak with you at that location (e.g. community event, group etc).
2. **Explain the purpose of the conversation.**
3. **Explain the format of the conversation.** Explain the nature of the conversation and let the participant know they can ask questions along the way.
4. **Indicate how long the conversation usually takes.** (approximately 10 minutes)
5. **Ask them if they have any questions** before you both get started with the conversation.
6. **Don't count on your memory to recall their answers.** Ask for permission to write notes or if there is another Peer Facilitator present, ask them to take notes.

Wording of questions

1. **Follow the wording on the conversation guide, ensuring questions are open ended.** Respondents should be able to choose their own terms when answering questions.

2. **Questions should be as neutral as possible.** Avoid wording that might influence answers, e.g., evocative, judgmental wording.
3. **Questions should be worded clearly.** This includes knowing any terms particular to the participants' culture.
4. **Ensure participants have the opportunity to add any additional information** and their impressions of the conversation.

Conducting the conversation

1. **Ask one question at a time.**
2. If the participant doesn't respond right away to a question, wait. **Give them time**, while you add to your notes.
3. **Use prompts** but don't lead the person: ask the person to tell you more, to give more details.
4. **Attempt to remain as neutral as possible.** That is, don't show strong emotional reactions to their responses. Act as if "you've heard it all before."
5. **Encourage responses** with occasional nods of the head, "uh huh"s, etc. Don't put words in the participants' mouths, let them choose their own vocabulary and phrasing when responding.
6. **Be careful about the appearance when note taking.** That is, if you jump to take a note, it may appear as if you're surprised or very pleased about an answer, which may influence answers to future questions.
7. **Provide transition between major topics**, e.g., "we've been talking about (some topic) and now I'd like to move on to (another topic)."
8. **Don't lose control of the conversation.** This can occur when participants stray to another topic, take so long to answer a question that time begins to run out, or even begin asking questions to the facilitator.
9. After you have asked all your questions, **give the person time to ask you any questions they have about the project.** Provide the participant with a postcard identifying who they can contact if they have further questions.
10. **Thank the person and acknowledge** their contribution to the project and helping to identify how to improve services for people with a chronic illness living in Latrobe.
11. **Provide the person with a postcard** detailing who they can contact for further information, and relevant chronic illness fact sheet/s.

2.3 Immediately after conversation

1. **Make notes on your written notes.** For example, your name and if there was another person present; who took notes; place of the conversation; date; start and finishing times; was the person interested in the videoing?
2. **Write down any observations made during the conversation.** For example, clarify if the participant could not / chose not to answer a question, ensure pages are numbered, fill out any notes that don't make sense, etc.

Keep documentation in a secure, private location to ensure confidentiality.

ADAPTED FROM: Health Issues Centre resource,

Carter McNamara, MBA, PhD, Authenticity Consulting, LLC. Copyright 1997-2006.

Lynch Associates. Conversationing Principles. Reprinted From: Copyright, Lynch Associates, 1996

http://www.casaforchildren.org/site/c.mtJSJ7MPisE/b.5468199/k.7352/Conversationing_Principles.htm

3. After the event / conversation

3.1 Volunteer safety and support

1. Text Pat Lovelock on 0439 498 817 at the end of an event, group presentation or one on one conversation to advise CWGPCP that you are safe.
2. If you would like debriefing / follow up, contact Pat on 0439 498 817. If you do not receive a response from Pat and it is during business hours, contact on the CWGPCP Office on 03 5127 9156. If it is in business hours or after hours and you do not receive a response from Pat, contact Liz Meggetto on 0419 390 046.

3.2 Document the person's story

1. If you have completed a paper based survey, volunteers can chose to enter the data online into 'Survey Monkey'.

<https://www.surveymonkey.com/r/latrobe>

Document on the hard copy that the data has been entered into Survey Monkey.

Alternatively, volunteers can post or scan and email the hardcopy surveys to the CWGPCP office for Leonie to enter the data.

2. Post the hard copy surveys to CWGPCP for secure destruction (using supply of reply-paid envelopes) or deliver to:
CWGPCP
42 – 44 Fowler St
Moe 3825

4. Administration

4.1 Transport

Volunteers will typically use their own vehicle to attend groups / events and will be reimbursed with fuel cards. Leonie Riddle will distribute fuel cards as required.

4.2 Reimbursement of expenses.

Should a volunteer meet a community member at a local café, the volunteer may choose to pay for a beverage for the community member and themselves and seek reimbursement from the CWGPCP. The volunteer must obtain a tax invoice for the purchases and forward this to Leonie Riddle at CWGPCP for reimbursement.

4.3 Sign in sheets

Sign in sheets must be completed and forwarded each fortnight to Pat Lovelock at the CWGPCP either via email Pat.Lovelock@lchs.com.au or posted in a reply paid envelope. Sign in sheets are due on Sundays, on the following dates:

- 26th May
- 9th June
- 23rd June,
- 7th July
- 21st July
- 4th August
- 18th August,
- 1st September (*note: please email to cwgpcp@gmail.com during this period*)
- 15th September (*please email to cwgpcp@gmail.com during this period*)
- 29th September

Overview of Common Chronic Illnesses

‘Arthritis’ is a name for a group of conditions affecting the joints. These conditions cause damage to the joints, usually resulting in pain and stiffness. Arthritis can affect many different parts of the joint and nearly every joint in the body.

More information: <https://arthritisaustralia.com.au/>

Chronic Obstructive Pulmonary Disease (COPD) is a term for a group of progressive lung conditions including:

- Emphysema
- Chronic bronchitis
- Chronic asthma (note – we are not including asthma in this project)

The condition causes narrowing of the bronchial tubes in the lungs (sometimes called bronchi or airways) and this makes it difficult to breathe. With the right diagnosis and treatment there are many things people can do to manage their condition and breathe better. People can live for many years with COPD and still enjoy a good quality of life.

More information: <https://lungfoundation.com.au>

Diabetes is a serious complex condition which can affect the entire body. Diabetes requires daily self care. While there is currently no cure for diabetes, you can live an enjoyable life by learning about the condition and effectively managing it.

There are different types of diabetes; all types are complex and serious. The three main types of diabetes are type 1, type 2 and gestational diabetes.

More information: <https://www.diabetesaustralia.com.au/managing-type-2>

Heart failure happens when your heart muscle gets damaged, then becomes weak and doesn't pump properly. The damage can be caused by a heart attack, or long-term health problems like high blood pressure, diabetes or heart disease. It can also be caused by cardiomyopathy, affecting the heart muscle.

More information: <https://www.heartfoundation.org.au>

Osteoporosis is a disease makes bones become brittle leading to a higher risk of breaks than in normal bone. Osteoporosis occurs when bones lose minerals, such as calcium, more quickly than the body can replace them, causing a loss of bone thickness (bone density or mass).

More information: <https://www.osteoporosis.org.au/>

Latrobe Chronic Illness Community Consultation Volunteer Conversation Guide

Preamble.

I am a volunteer with the Central West Gippsland Primary Care Partnership. We are hoping to find out from people in Latrobe Valley about how they manage their health and living with arthritis, Chronic Obstructive Pulmonary Disease (COPD), diabetes, heart failure or osteoporosis.

The questions won't take too long (about 10 minutes) and are based around how you manage to stay well, and what, if any, health services you go to.

We will not tell anyone your name or any other identifying information about you. What you tell us will be combined with the information we get from all the people we talk with.

We will then use the information to make recommendations on how health services could do things differently. As well as any suggestions you have on what services or supports could be helpful to you.

There is the opportunity for you to be included in a video to tell your story if you would like to. If you are interested, please provide your contact details at the end of the survey.

Is it OK to talk with you about this? So I can make sure I get everything you tell me, is it OK for me to take notes?

1. Which town do you live in?

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Churchill | <input type="checkbox"/> Traralgon |
| <input type="checkbox"/> Moe | <input type="checkbox"/> Other town in Latrobe City |
| <input type="checkbox"/> Morwell | <input type="checkbox"/> Outside of Latrobe City |

2. What is your gender

- Female
- Male
- Other
- Prefer not to say

3. What is your age group?

- Under 18
- 18-54
- 55-64
- 65+
- Prefer not to say

4. Are you Aboriginal or Torres Strait Islander?

- Yes
- No
- Prefer not to say

5. Type of condition

If community member has more than one of these conditions, please complete 1 survey for each condition and staple them together so the data can be entered electronically as one survey.

- Arthritis
- COPD
- Diabetes
- Heart disease
- Osteoporosis

6. How did you find out about your (condition)? (Tick all that apply)

<input type="checkbox"/> GP / Doctor
<input type="checkbox"/> Hospital admission
<input type="checkbox"/> Specialist appointment
<input type="checkbox"/> Other (please specify): _____

7. When were you diagnosed with your condition?

<input type="checkbox"/> Less than 12 months	<input type="checkbox"/> 5 – 10 years
<input type="checkbox"/> 1 – 5 years	<input type="checkbox"/> > 10 years

8. Which health professionals do you see?

Health Professional	Town you see them at	How often
<input type="checkbox"/> Cardiologist		
<input type="checkbox"/> Diabetes educator		
<input type="checkbox"/> Dietician		
<input type="checkbox"/> Doctor / GP		
<input type="checkbox"/> Exercise physiologist		
<input type="checkbox"/> Occupational Therapist		
<input type="checkbox"/> Orthopaedic surgeon		
<input type="checkbox"/> Pharmacist		
<input type="checkbox"/> Physiotherapist		
<input type="checkbox"/> Podiatrist		
<input type="checkbox"/> Psychologist		
<input type="checkbox"/> Respiratory nurse		
<input type="checkbox"/> Rheumatology nurse		

Health Professional	Town you see them at	How often
<input type="checkbox"/> Rheumatologist <input type="checkbox"/> Other (please specify): _____		

9. How well do the current supports work for you and why? For instance, is there anything that makes it harder for you to manage? (e.g. transport, time, family commitments, knowledge, lack of response from service providers (no one got back to you), opening hours, bad experience, etc.?).

10. What are you currently doing to make life easier? (Tick all that apply)

<input type="checkbox"/> Take medication regularly <input type="checkbox"/> Quit smoking (if previously a smoker) <input type="checkbox"/> Stayed within a healthy weight range (manage weight) <input type="checkbox"/> Eat a healthy diet <input type="checkbox"/> Stay physically active (e.g. walking group, gym, exercise group) <input type="checkbox"/> Developed an alcohol action plan (for safer drinking) <input type="checkbox"/> Make sure to get enough sleep <input type="checkbox"/> See friends and/or do hobbies. <input type="checkbox"/> Practise relaxation / meditation <input type="checkbox"/> Get the flu shot / other vaccinations <input type="checkbox"/> Other (please specify): _____

11. What do you do to manage your condition?

Arthritis (tick all that apply)

- Attend a pain management program
- Exercise (including walking / gentle movement)
- Use heat and cold packs on painful spots
- Do activities in a way to save energy / look after your joints
- Massage
- TENS machine (transcutaneous electrical nerve stimulation)
- Relaxation / Mindfulness
- Hand therapy
- Other (please specify): _____

COPD (tick all that apply)

- Go to pulmonary rehabilitation program?
- Go to an exercise group (e.g. Lungs in Action)
- Take medication each day as prescribed by the doctor, even if you feel well
- Take reliever medication (for quick relief if you get breathless)
- Take maintenance medications to help control symptoms and prevent flare ups
- Take flare up medication short term to manage a flare up of your symptoms
- Have oxygen therapy
- Have a lung function test regularly
- Other (please specify): _____

Diabetes (tick all that apply)

- Take medication each day that the doctor prescribed (e.g. tablets, insulin)
- Monitor Blood Glucose Level (BGL) at home? If so, how often per day? _____
- Stick to a diabetic diet as advised
- Other (please specify): _____

Heart Failure (tick all that apply)

- Go to cardiac / heart failure rehabilitation classes?
- See a doctor regularly and have blood pressure monitored? If so, how often? _____
- Other (please specify): _____

Osteoporosis (tick all that apply)

- See a therapist to do exercises to help with balance / muscle strength
- Had an occupational therapist come to your home and do a safety assessment
- Take vitamins / supplements for osteoporosis (e.g. Vitamin D, Calcium)
- Take medication for osteoporosis
- Other (please specify): _____

12. What would make it easier for you to manage your condition? (Volunteer prompts *only* if required: *for example, access to after-hours services, home-based services, increased appointment availability, etc.*)

13. What is the best way for health services to provide support to you? (Tick all that apply)

- Newsletter in the mail
- Newsletter by email
- Video chat / Telehealth / Skype / Face Time
- Facebook / social media
- Face to face (e.g. during an appointment)
- Telephone
- Phone Apps
- Other: _____

Thank you, that's the end of our questions...

Is there anything else you would like to tell us?

We are hoping to capture people's stories, like yours, on a video which will be shown to the funding body and the health services.

Would you be interested to be contacted regarding this?

Yes **No**

If yes, please provide your contact details:

Name: _____

Phone: _____

Email: _____

If you have other questions when you get home, here is a card with some further information on the consultation project.

Hand the person the post card.

Thanks so much for your time.

<u>Facilitator Use Only</u>	
Name of interviewer: _____	Location: _____
Date: _____	Time taken: _____
Other comments: _____	

Entered onto database: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: / /	

Latrobe Living Well Conversations

Do you have arthritis, COPD, diabetes, heart failure or osteoporosis?

We are hoping to find out from people in Latrobe Valley about how they manage their health and living with arthritis, Chronic Obstructive Pulmonary Disease (COPD), diabetes, heart failure or osteoporosis.

The questions won't take too long (about 10 minutes) and are based around how you manage to stay well and what, if any, health services you go to.

We will not tell anyone your name or any other identifying information about you.

What you tell us will be combined with the information we get from all the people we talk with.

We will then use the information to make recommendations on how health services could do things differently. As well as any suggestions you have on what services or supports could be helpful to you.

There is the opportunity for you to be included in a video to tell your story if you would like to. If you are interested, please provide your contact details at the end of the survey.

Conversation Feedback closes 30 September 2019.

Please complete this survey and post it back to us in the reply paid envelope attached.

14. Which town do you live in?

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Churchill | <input type="checkbox"/> Traralgon |
| <input type="checkbox"/> Moe | <input type="checkbox"/> Other town in Latrobe City |
| <input type="checkbox"/> Morwell | <input type="checkbox"/> Outside of Latrobe City |

15. What is your gender?

- Female
- Male
- Other
- Prefer not to say

16. What is your age group?

- Under 18
- 18-54
- 55-64
- 65+
- Prefer not to say

17. Are you Aboriginal or Torres Strait Islander?

- Yes
- No
- Prefer not to say

18. Do you have any of the following conditions? Please select only ONE condition to talk about for this survey.

If you would like to tell us your experience of living with more than one of these conditions, please complete a separate survey for each condition.

- Arthritis
- COPD – Chronic Obstructive Pulmonary Disease
- Diabetes
- Heart disease
- Osteoporosis

19. How did you find out about your condition? (tick all that apply)

<input type="checkbox"/> GP / Doctor
<input type="checkbox"/> Hospital admission
<input type="checkbox"/> Specialist appointment
<input type="checkbox"/> Other (please specify): _____

20. When were you diagnosed with your condition?

<input type="checkbox"/> Less than 12 months	<input type="checkbox"/> 5 – 10 years
<input type="checkbox"/> 1 – 5 years	<input type="checkbox"/> > 10 years

21. Which health professionals do you see for your condition? (tick all that apply)

Health Professional	Town you see them at	How often
<input type="checkbox"/> Cardiologist		
<input type="checkbox"/> Diabetes educator		
<input type="checkbox"/> Dietician		
<input type="checkbox"/> Doctor / GP		
<input type="checkbox"/> Exercise physiologist		
<input type="checkbox"/> Occupational Therapist		
<input type="checkbox"/> Orthopaedic surgeon		
<input type="checkbox"/> Pharmacist		
<input type="checkbox"/> Physiotherapist		
<input type="checkbox"/> Podiatrist		
<input type="checkbox"/> Psychologist		

Health Professional	Town you see them at	How often
<input type="checkbox"/> Respiratory Nurse <input type="checkbox"/> Rheumatology nurse <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Other _____ _____ _____		

22. How well do the current supports work for you and why?

For instance, is there anything that makes it harder for you to manage? (e.g. transport, time, family commitments, knowledge, lack of response from service providers (no one got back to you), opening hours, bad experience, etc.?).

23. What are you currently doing to make life easier? (tick all that apply)

- Take medication regularly
- Quit smoking (if previously a smoker)
- Stay within a healthy weight range (manage my weight)
- Eat a healthy diet
- Stay physically active (e.g. walking group, gym, exercise group)
- Developed an alcohol plan for safe drinking
- Make sure to get enough sleep
- See friends and/or do hobbies
- Practice relaxation / meditation
- Get the flu shot / other vaccinations
- Other (please specify) _____

24. What do you do to manage your condition?

If you have Arthritis - how do you manage your arthritis? (tick all that apply)

- Go to a pain management program
- Exercise (including walking / gentle movement)
- Use heat and cold packs on painful spots
- Do activities in a way to save energy / look after my joints
- Massage
- TENS machine (transcutaneous electrical nerve stimulation)
- Relaxation / Mindfulness
- Hand therapy
- Other (please specify): _____

If you have COPD - how do you manage your COPD? (tick all that apply)

- Go to pulmonary rehabilitation program
- Go to an exercise group (e.g. Lungs in Action)
- Take medicines each day as prescribed by the doctor, even if I feel well.
- Take reliever medication (for quick relief if I get breathless)
- Take maintenance medication to help control my symptoms and prevent flare ups
- Take flare up medication short term to manage a flare up of my symptoms
- Have oxygen therapy
- Have a lung function test regularly
- Other (please specify): _____

If you have Diabetes – how do you manage your diabetes? (tick all that apply)

- Take medication each day that the doctor prescribed (e.g. tablets, insulin)
- Monitor my Blood Glucose Level (BGL) at home. If so, how often per day? _____
- Stick to a diabetic diet as advised
- Other (please specify): _____

If you have Heart Failure – how do you manage your heart failure? (tick all that apply)

- Go to cardiac / heart failure rehabilitation classes
- See a doctor regularly and have blood pressure monitored. If so, how often? _____
- Other (please specify): _____

If you have Osteoporosis – how do you manage your osteoporosis? (tick all that apply)

- See a therapist to do exercises to help with balance / muscle strength
- Had an Occupational Therapist come to my home and do a safety assessment
- Take vitamins / supplements for osteoporosis (e.g. Vitamin D, Calcium)
- Take medication for osteoporosis
- Other (please specify): _____

25. What would make it easier for you to manage your condition?

26. What is the best way to provide support to you? (tick all that apply)

- Newsletter in the mail
- Newsletter by email
- Video chat / Telehealth / Skype / Face Time
- Facebook / social media
- Face to face (e.g. during an appointment)
- Telephone
- Phone Apps
- Other (please specify) _____

27. Is there anything else you would like to tell us?

28. We are hoping to capture people's stories, like yours, on a video which will be shown to the funding body and the health services.

Are you interested in being contacted about this?

Yes **No**

If yes, please provide your contact details and someone may call you to discuss it:

Name: _____

Phone: _____

Email: _____

Thank you for your time.

Central West Gippsland Primary Care Partnership, in collaboration with the Latrobe Health Assembly.