Queensland **Strategy**

for

Chronic Disease

2005-2015

Summary

promoting a ***healthier*** Queensland

a partnership approach

Queensland
Government
Queensland Health

The Queensland Strategy for Chronic Disease 2005-2015 is being progressed under a partnership approach.

A partnership approach

Key partners represented on the steering committee include:

- Queensland Health
- Australian Government Department of Health and Ageing
- General Practice Alliance
- Queensland Divisions of General Practice
- Community Health Agency Group
- Centre for Primary Health Care, University of Queensland.

Key informants include:

- expert clinicians
- public and private health service managers
- the private health sector
- District Health Councils
- Divisions of General Practice
- Queensland Government agencies
- non-government organisations
- peak representative groups
- consumer groups
- universities
- health insurance organisations
- local councils.

Consultancy support has been provided by:

- Centre for Primary Health Care, University of Queensland
- The Cognitive Institute
- Australian Institute for Primary Care, La Trobe University.

Queensland Government
Queensland Health

Queensland Strategy for Chronic Disease 2005-2015

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Foreword

The Queensland Government has embarked on a major transformation of the public health system.

We have committed a record $6.367 billion in just over five years to 2010–11, including $4.431 billion of new money.

This funding will relieve immediate service pressures, provide more doctors, nurses and allied health staff, and identify smarter ways to deliver health services.

Our renewal program follows on from the Queensland Health Systems Review. Peter Forster, who headed the Review, identified the need to balance acute hospital care with a stronger focus on prevention and early management of chronic disease.

Our massive injection of funding will help Queensland Health to better promote healthy lifestyles to prevent or reduce illness, to identify disease earlier, and to better manage existing conditions.

In this context, the *Queensland Strategy for Chronic Disease 2005-2015* forms a critical component of the Queensland public health system's renewal.

It is no secret that Queensland has the highest rate of preventable deaths of any state in Australia. More than one-third of all deaths in Queensland are the result of a chronic disease — heart disease, heart failure, stroke, respiratory disease, diabetes and kidney disease — that could have been prevented.

An estimated seven in every 10 patients seen by a General Practitioner have at least one chronic disease.

To keep Queenslanders healthier and help reduce these deaths, the Queensland Government has developed the *Queensland Strategy for Chronic Disease 2005-2015*, in partnership with a broad range of service providers and other stakeholders.

This new Strategy helps prevent chronic disease by reducing risk factors like smoking, poor diet, lack of physical activity and alcohol misuse. For people with a chronic disease, the Strategy helps them identify and manage their disease earlier, and access services faster.

When a person's disease is not properly managed, it can lead to unnecessary complications and hospital admissions. This new statewide Strategy involves the full spectrum of services involved in patient care – from hospitals to General Practitioners, community health centres, and private and non-government health services.

The Strategy helps all Queenslanders, but particularly those people who live in rural and remote areas, Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, and people who are experiencing socio-economic disadvantage, who often have more risk factors and higher rates of chronic disease.

The reform of our health system offers a real opportunity to improve the health of all Queenslanders by preventing or better managing chronic disease, encouraging greater personal responsibility for health and building partnerships with the Australian Government, the private sector, non-government organisations, the community and individual consumers.

This is a first, but significant, step forward in helping to prevent and better manage chronic disease in Queensland.

Peter Beattie MP
Premier and Treasurer

Stephen Robertson MP
Minister for Health

Introduction

The *Queensland Strategy for Chronic Disease 2005-2015* (the 'Strategy') is being progressed in partnership with the Queensland Government and key partners. This statewide Strategy aims to engage all stakeholders involved in the prevention, intervention and management of chronic diseases at a system, service and individual level across the continuum of care. It identifies evidence-based approaches to prevent or reduce behavioural and lifestyle risk factors, and support better care for people with chronic disease and their carers/families. The Strategy aims to address barriers to quality chronic disease care, address the current pressure on the acute hospital system by reducing avoidable hospitalisations, and identify more systematic and sustainable approaches to the prevention and management of chronic disease across Queensland.

The Queensland Government, through the *Smart State: Health 2020 Directions Statement*,[1] has identified the prevention and management of chronic diseases as one of its major strategic priorities for the coming decade. In Queensland, cardiovascular disease (coronary heart disease, heart failure and stroke), chronic respiratory disease (chronic obstructive pulmonary disease (COPD) and asthma), type 2 diabetes mellitus, and renal disease account for a significant proportion of morbidity experienced by the population and for more than one-third of all deaths in the state. Depression as a co-morbidity to these chronic diseases also affects the functioning and quality of life of people with chronic disease. Poor nutrition, physical inactivity, tobacco smoking and alcohol misuse are four common underlying risk factors associated with these diseases.

The Strategy will manage the current and growing pressures on the health care system both now and in the future, and address the impact of chronic diseases and risk factors on individuals, families and communities in Queensland from 2005 to 2015. A significant priority is to better manage the care for people who already have chronic diseases and avoid hospitalisation wherever possible. Concurrent investment is also required around the strategies to achieve longer-term outcomes of reduced prevalence and incidence.

In parallel with the development of the Strategy is the development of three place-based initiatives in North Lakes and surrounds, Logan-Beaudesert, and Innisfail. These initiatives focus on producing integrated service delivery models at the local level across the continuum of care. The goal of the three place-based initiatives is to develop new ways of working which engage a range of public and private providers in partnership to address the health needs of local populations.

To fully achieve the goals of the Strategy and the place-based initiatives, a collaborative approach is required which needs to be supported by all partners in the Queensland health sector, including the Australian Government, other Queensland government departments, public and private health professionals, non-government and community organisations, consumer representatives and the academic sector.

[1] Queensland Health. *Smart State: Health 2020 Directions Statement*. Brisbane: Queensland Health, 2002.

The concept of partnership is fundamental to driving the implementation of the Strategy. In this context, partnerships are required at a number of levels. Reflecting the current Australian health system, these partnerships will operate at the government-to-government level (including federal, state and local levels), across government at the state level, and across service providers at the local level (testing of different approaches to partnership is occurring in the three place-based initiatives).

The health of a population is determined by a broad range of environmental, psychosocial and behavioural determinants. However, the Strategy focuses, in particular, on those gains that can be made in relation to chronic disease, through:

- improved prevention of risk factors (primary prevention)
- better integrated early detection and management of risk factors and disease markers (secondary prevention)
- effective management of existing disease and prevention of complications (tertiary prevention).

System enablers and evidence-based strategies at the individual and whole-of-population levels are being implemented to improve the prevention and management of chronic disease, particularly addressing the needs of various groups including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds and people from rural and remote areas.

The Strategy incorporates a range of approaches that contribute to preventing disease and promoting health for all Queenslanders, by:

- including both population-wide and at-risk group approaches
- involving sectors working together at national, state and local levels
- focusing on and addressing key risk and protective factors
- addressing lifestyle and behavioural risk factors
- addressing equity issues in relation to people in low socioeconomic circumstances, Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds and people from rural and remote areas
- taking a life-course perspective.

The implementation of the Strategy will support better access to primary health care, improve and support an integrated and coordinated approach to preventing common risk factors and provide more efficient and targeted use of health resources across the health continuum.

Further information can be found on the Queensland Health website at:
http://www.health.qld.gov.au/publications/corporate/chronstrat2005/default.asp

Scope

The Strategy guides the approach and direction taken at a system level in Queensland to prevent and manage chronic disease. The following chronic diseases have been identified as the focus for initial action:

- cardiovascular disease (coronary heart disease, heart failure and stroke)
- type 2 diabetes mellitus
- renal disease
- chronic respiratory disease (chronic obstructive pulmonary disease (COPD) and asthma).

It is envisaged that increased coordination and integration across services and sectors, and the implementation of evidence-based management programs, will yield better health outcomes for a much broader range of chronic diseases.

Mental health problems, particularly depression, often co-occur with chronic disease. Depression, as a co-morbidity of these chronic diseases, is considered within the Strategy and a number of guiding principles have been developed to improve the psychological wellbeing of people with chronic disease.

The immediate underlying lifestyle and behavioural risk factors for the chronic diseases being addressed through the Strategy are:

- poor nutrition
- physical inactivity
- alcohol misuse
- tobacco smoking.

Goals

By 2008:

- demonstrate that the implementation of evidence-based strategies is on track as per endorsed resourced plans
- improve the quality of life for people with the chronic diseases in scope
- demonstrate a reduction in the number of avoidable admissions to hospital.

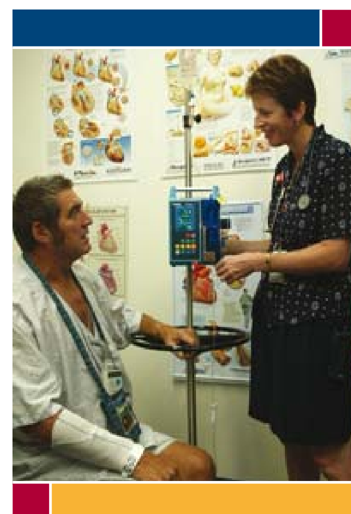
By 2015:

- reduce the age-standardised incidence and prevalence rates of the chronic diseases in scope, and their immediate underlying lifestyle and behavioural risk factors
- improve the quality of life for people with the chronic diseases in scope.

Principles

The *Queensland Strategy for Chronic Disease 2005-2015* provides an overarching framework at the statewide level to outline key directions for building and strengthening a system-wide response to the prevention and management of chronic disease. Within this overarching framework, the following guiding principles have been identified that underpin the development and delivery of all components within the Strategy, and provide an impetus for effective chronic disease prevention and management activities across the continuum:

- **Achieving respectful and committed person-centred care and optimal self-care** positions people at the centre of care (as an expert on his or her own experience of illness), and ensures their interaction and experience with the health system is valued as an integral part of the process of care.
- **Encompassing prevention across the continuum of care** promotes the integration of appropriate prevention activities across all stages of the total continuum of chronic disease prevention and management and has potential to prevent or delay progression of chronic disease and associated complications and co-morbidities and result in improved quality of life and better health outcomes.
- **Providing the most effective interventions** across the care continuum promotes the achievement of desired outcomes and has the capacity to delay the progression of disease, and the onset of complications and disabilities including co-morbidities, reduce hospitalisations, improve quality of life, and maintain functional capacity and independence.
- **Addressing the needs of disadvantaged groups,** such as Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, people living in rural and remote areas, people from socioeconomically disadvantaged backgrounds, frail older people, people with a psychological or mental health disorder and people with a disability, is required to reduce health inequalities.
- **Promoting integrated multidisciplinary care** recognises both the total care and support needs of people with, or at risk of developing chronic disease, including consideration of care planning, psychosocial issues, and co-morbidities.
- **Working together in partnership and collaboration** requires the establishment of partnerships on a number of levels and includes partnering with people with chronic disease, their families and carers, their communities and other service providers involved in their care.[2]
- **Building on current best practice models** promotes practical evidence-based approaches to prevention and management of chronic disease, and ensures innovative and new approaches are supported through relevant health outcomes research.



[2] World Health Organization. *Preparing a Health Care Workforce for the 21st Century. The Challenge of Chronic Conditions.* Geneva: WHO, 2005.

Together with these guiding principles, consideration to improve the psychological wellbeing of people with chronic disease is highlighted as a key component within the Strategy. The development of a chronic disease is recognised as a challenge to the psychological and social wellbeing of the individual and their family and it is considered important to appreciate that the meaning of illness and the personal experience of illness can differ between people, even though they might have the same physical condition.

Depression is a common experience associated with chronic disease, and can be either pre-existent to, or a consequence of, the presence of a chronic disease. Depression itself is a risk factor for some chronic diseases, and can affect adherence to medical regimes, the effectiveness of care, the potential speed of recovery and increase the risk of poor outcomes.

Effective and high quality care for people with chronic disease must incorporate assessment of psychological and social health status and appropriate responses where these are adversely affected. Training for staff in providing care for people with chronic disease must incorporate recognition of, and appropriate skills development in responding to, psychological distress.

The *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013: Framework for Action by Governments* highlights nine principles required when planning and delivering services to Aboriginal and Torres Strait Islander peoples and they will be applied consistently as part of the implementation of the *Queensland Strategy for Chronic Disease 2005-2015*.

Contemporary models of health care for preventing and managing chronic disease

The health care system in Queensland has historically comprised acute care/hospital services delivered by Queensland Health and private organisations, a small community health sector, and a general practice focused primary health care sector.

The effective management of chronic diseases requires long-term care using the "full spectrum of health care services, from primary (health) care to acute care and health maintenance".[3] This changing model of health service delivery requires greater emphasis on primary prevention, an increased focus on community- or home-based services, and the strengthening of partnerships between the community, primary health care providers and the acute care sector.[4]

Long-term sustainability of the health system can be achieved by sharing responsibility among government, private providers, non-government agencies and consumers. A greater focus needs to be placed on the care needs of groups including older people, Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds and people from rural and remote areas with chronic disease. To ensure the sustainable delivery of quality health care services, better coordination is required across the acute and primary health care sectors and across the continuum of care.

It is important to recognise that, for most of the time, a person at risk of developing or living with a chronic disease is managing their health on a daily basis without the involvement of health care providers. Consequently, these individuals and their carers require the knowledge, skills, ability and tools to manage their own health. A growing body of evidence supports the development of effective 'self-management' programs.

Self-management frameworks will incorporate the need to foster resiliency, one aspect of which is development of self-efficacy, and recognise that psychological and social wellbeing also involves family and community.

To effectively manage chronic disease, practitioners need a high sensitivity to the potential presence of depression and anxiety. Routine assessment of all people with chronic disease should include a psychological assessment to ascertain strengths and vulnerabilities, and referral to appropriate available services where indicated.

[3] Queensland Health *Smart State: Health 2020 Directions Statement*. Brisbane: Queensland Health, 2002.

[4] Queensland Health. *Queensland Health Strategic Plan 2004-10*. Brisbane: Queensland Health, 2004.

Strategies supporting activity across the health continuum

System enablers

Positive policy environment and community capacity

Objective: *To achieve effective and efficient implementation of the Strategy through appropriate governance structures, partnerships and change-management processes*

Strategies:

1. Enhance positive policy environment and community capacity through governance arrangements and partnerships with key stakeholders

1.1 Identify the range of local stakeholders and existing partnerships and, where required, augment or develop local partnerships to progress chronic disease prevention and management strategies.

1.2 Identify the range of federal, state and regional stakeholders and existing partnerships and, where required, augment or develop partnerships at these levels, to progress chronic disease prevention and management strategies.

1.3 Support mechanisms to enhance linkages between new and existing federal, state, regional and local partnerships.

1.4 Develop models and tools to support partnership development, including governance options, identification of barriers, critical success factors and change-management processes.

1.5 Progress bilateral negotiations between Queensland Health and the Australian Government in relation to funding reform and service delivery models to enhance chronic disease prevention and management strategies.

1.6 Resource ongoing statewide implementation mechanisms to manage change, and to coordinate and implement chronic disease prevention and management strategies.

Health system organisation: quality health care services

Objective: *To establish chronic care services delivered to an agreed standard consistently across Queensland*

Strategies:

2. Create mechanisms that promote safe, high quality care

2.1 Develop and support multidisciplinary primary health care collaboratives.

2.2 Develop and enhance existing quality improvement mechanisms for the prevention and management of chronic disease.

2.3 Develop data sources and linkages to support quality improvement activities across the continuum.

2.4 Identify and support priority chronic disease research and innovation initiatives, including the translation of research into policy and practice.

2.5 Support relevant health outcomes research through partnerships between academics and health service providers.

Self-management

Objective: ***To have a Queensland approach to self-management implemented across the state***

Strategies:

3. Empower and prepare individuals to manage their health and health care

3.1 Develop, resource and implement a framework for self-management to support consistent approaches and access for all Queenslanders with, or at risk of developing, chronic disease.

3.2 Identify or, where required, develop models that support the needs of specific population groups including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds and people from rural and remote areas.

3.3 Identify appropriate models and develop toolkits to support the delivery of self-management programs including ongoing support for individuals to increase self-efficacy and coping strategies.

3.4 Develop and implement awareness-raising and training programs for health professionals and peer leaders around self-management.

Information systems and decision support

Objective: ***To leverage existing and emerging standardised information management (IM) and information communications technology (ICT) initiatives to provide connectivity, sharing of useful information, access to accurate, timely and reliable information and access to appropriate services to support chronic disease prevention and management***

Strategies:

4. Organise information systems and decision support to facilitate efficient and effective care

4.1 Engage with existing IM and ICT projects (such as the Clinical Informatics Program, HealthConnect, Health Contact Centre, Telehealth and general practice systems) to influence their development, achieve quality and connectivity of clinical information and determine health system performance in the prevention and management of chronic disease.

4.2 Support continuity of care initiatives aimed at providing efficient and effective transfer of health information across the care continuum (e.g. the *Continuity of Care Planning Framework for Queensland*) to improve health outcomes for people with, or at risk of developing, chronic disease.

4.3 Develop and maintain an agreed list of chronic disease prevention and management requirements for incorporation into IM and ICT projects, to meet the needs of service providers and people with, or at risk of developing, chronic disease.

4.4 Continue to develop and support the interface between Queensland Health and key partners to ensure that the chronic disease needs are considered in IM and ICT solutions.

4.5 Support processes that improve the validity, reliability and continuity across settings of clinical information about people with, or at risk of developing, chronic disease.

Delivery system design: workforce

Objective: *To support the continued development of the health workforce to achieve and sustain the implementation of chronic disease prevention and management*

Strategies:

5. **Recruit, develop and retain an appropriately skilled workforce**

   5.1 Encourage and support partnerships between the education and health sectors at federal and state levels to ensure an adequate supply of skilled workers and an equitable workforce distribution across Queensland.

   5.2 Ensure that workforce orientation and ongoing training underpins the development of integrated, multidisciplinary care, with training provided in a variety of locations, using a range of modalities.

   5.3 Develop flexible human resource practices including cross-organisation agreements, incentives and specific initiatives for Aboriginal and Torres Strait Islander peoples, to facilitate workforce recruitment and retention.

   5.4 Realign existing health workforce roles, create new health workforce roles, and consider the role of community and peer leaders in provision of effective and efficient chronic disease prevention and management.

   5.5 Support the implementation of the *Queensland Health Workforce Strategy 2005-2010* and the *Queensland Health Indigenous Workforce Management Strategy*, as they apply to the prevention and management of chronic disease.

   5.6 Monitor and evaluate the implementation and effectiveness of workforce strategies.

Strategies supporting activity at stages in the health continuum

Primary prevention: preventing and reducing risk factors

Objectives:

- *Reduce smoking prevalence and exposure to passive smoking*
- *Reduce the prevalence of high-risk consumption and dependence on alcohol*
- *Improve nutritional status of the population*
- *Increase physical activity*
- *Improve identification and management of lifestyle and behavioural risk factors*

Raise community awareness and promote consistent messages

Strategies:

6. Implement and evaluate social marketing campaigns

6.1 Implement anti-smoking mass media campaigns targeted at specific population groups.

6.2 Implement campaigns for specific population groups to sustain key messages about risky and high-risk drinking.

6.3 Implement and evaluate social marketing activities to promote healthy eating and physical activity including implementation of a social marketing campaign to promote the consumption of fruit and vegetables: *Go for 2 Fruit and 5 Veg.*

6.4 Develop campaign-specific information and resources.

6.5 Support the development of federal, state, regional and local interventions as an important component of social marketing (e.g. Health Promoting Schools and parenting education) and engagement with non-government and private sector organisations.

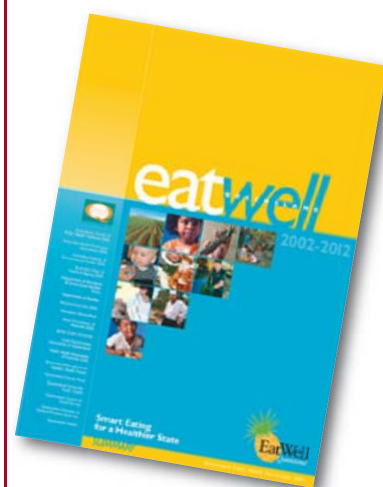
7. Disseminate and promote evidence-based guidelines for targeted population groups

7.1 Promote and disseminate the *Dietary Guidelines for Children and Adolescents in Australia, Dietary Guidelines for Australian Adults* and *Dietary Guidelines for Older Australians.*

7.2 Disseminate and promote physical activity guidelines for targeted population groups (e.g. children, young people, adults, older adults).

7.3 Promote and disseminate the National Health and Medical Research Council's *Australian Alcohol Guidelines: Health Risks and Benefits.*

7.4 Develop and disseminate quit smoking brief intervention guidelines to assist health professionals to deliver opportunistic quit smoking advice and support.



Encourage behaviour change that promotes health and wellbeing

8. Enhance effective quit smoking strategies

8.1 Increase Quitline capacity to provide improved assessment of nicotine dependence, quit smoking brief intervention, call-back counselling, and dissemination of self-help materials.

8.2 Provide additional support to Quitline for social marketing campaigns including staff and campaign-specific information and resources.

8.3 Increase the workforce to undertake quit smoking interventions.

9. Implement Aboriginal and Torres Strait Islander anti-smoking strategies

9.1 Provide and evaluate training and support for health professionals to enable them to implement effective quit smoking brief interventions such as *SmokeCheck* for Aboriginal and Torres Strait Islander peoples.

9.2 Provide and evaluate community-based sponsorship programs to promote culturally effective anti-smoking messages such as the *Event Support Program*.

10. Expand the reach of effective alcohol harm reduction programs

10.1 Develop and implement statewide, regional and local harm reduction programs that involve collaboration within and/or across government, non-government and private sectors to address alcohol related issues such as high-risk drinking.

10.2 Improve government department program and campaign coordination, effectiveness and efficiency through communication and mutual support, such as that provided by the Alcohol Strategic Management Group.

10.3 Provide a 24-hour telephone information and counselling service.

11. Increase the availability of group-based, behaviour change, healthy lifestyle interventions

11.1 Increase the availability of healthy lifestyle programs such as *Lighten Up to a Healthy Lifestyle* and *The Healthy Weight Program* (for Aboriginal and Torres Strait Islander groups) – through increasing the number of trained facilitators, establishing positions to coordinate referral/access to the programs and increasing availability of resources.

12. Extend the availability and sustainability of evidence-based physical activity and nutrition programs and interventions across identified priority settings and target population groups

12.1 Implement and evaluate strategies to enhance nutrition and increase physical activity in Aboriginal and Torres Strait Islander communities.

12.2 Extend the reach of existing programs and strategies to increase physical activity and/or improve nutrition such as *10,000 Steps*, active transport programs, community-led walking groups and *Active-Ate* (in schools).

12.3 Promote the development, evaluation and implementation of evidence-based strategies and approaches to increase physical activity and/or nutrition.

Increase workforce capacity and infrastructure for action to reduce population risk factor levels

13. Increase the workforce to undertake campaign support and prevention activities in relation to alcohol and tobacco

13.1 Develop partnerships with government, non-government and private sector organisations to support federal, state, regional and local interventions (e.g. Health Promoting Schools, activities to prevent under-age drinking, and parent education).

13.2 Increase the availability and capacity of Aboriginal and Torres Strait Islander staff to work with Aboriginal and Torres Strait Islander communities to undertake prevention activities.

14. Enhance alcohol treatment capacity

14.1 Increase the availability and capacity of Aboriginal and Torres Strait Islander staff to work with Aboriginal and Torres Strait Islander communities to undertake alcohol treatment interventions.

14.2 Increase the skilled workforce to address the management of co-occurring alcohol and mental health issues, commonly known as 'dual diagnosis'.

15. Extend geographic reach and dose of evidence-based primary prevention nutrition and physical activity interventions

15.1 Increase the number and capacity of community and public health nutritionists in Health Service Districts and Public Health Unit Networks, and reorient services provided by dietetic and generalist staff in primary health care services.

15.2 Increase the number and capacity of health promotion staff, including Aboriginal and Torres Strait Islander specific physical activity staff, in Public Health Unit Networks and reorient services provided by generalist and some dietetic staff in primary health care services.

15.3 Increase the availability and capacity of Aboriginal and Torres Strait Islander staff to work with Aboriginal and Torres Strait Islander communities to implement nutrition and physical activity programs.

16. Disseminate and promote evidence-based practice and strategies to the workforce

16.1 Improve the focus on alcohol harm reduction programs that are based on evidence as outlined in the Ministerial Council on Drug Strategy's *The prevention of substance use, risk and harm in Australia: a review of the evidence.*

16.2 Increase and continue to develop knowledge and skills of the nutrition and physical activity workforce and the capacity of health service providers to deliver consistent evidence-based nutrition and physical activity advice and interventions.

16.3 Develop and implement a Queensland physical activity plan for the health sector, in response to *Be Active Australia: A Health Sector Framework for Action 2005-2010* that builds on existing relevant regional and local plans and strategies or those under development.

16.4 Disseminate and promote: *Eat Well Queensland 2002-2012: Smart Eating for a Healthier State*, *Eat Well Australia 2000-2010*, the *National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000-2010*, and *Be Active Australia: A Health Sector Framework for Action 2005-2010.*

17. Enhance primary health care capacity to provide lifestyle and behavioural risk factor advice and support

17.1 Increase focus on screening, brief intervention and early intervention in primary health care settings.

17.2 Increase the available clinical workforce in primary care settings to provide lifestyle and behavioural risk factor advice and support.

17.3 Develop referral pathways and systems to triage, prioritise and refer clients for lifestyle and behavioural risk factor modification.

17.4 Improve consumer access to appropriate and timely information.

17.5 Support the implementation of the *Smoking, Nutrition, Alcohol and Physical Activity (SNAP) Framework for General Practice.*

Create healthy environments

18. Encourage acceptance and compliance with legislation relating to the sale and use of tobacco products and increase enforcement capacity

18.1 Commence implementation of tobacco legislative changes to restrict smoking in indoor and outdoor areas, and severely restrict tobacco product displays in retail outlets.

18.2 Increase the available workforce to undertake education and enforcement of tobacco legislation.

18.3 Implement public and industry education campaigns about tobacco legislation.

18.4 Maintain a telephone service to provide information and mandatory signage to industry, and to process reports of possible breaches.

18.5 Develop partnerships with non-government organisations around education and enforcement initiatives.

19. Implement the Queensland Health Smoking Management Policy

19.1 Develop policy, marketing strategy and support materials.

19.2 Implement a Queensland Health Staff Quit Smoking Program.

19.3 Provide nicotine replacement therapy to inpatients to address nicotine withdrawal.

20. Encourage acceptance and compliance with legislation relating to the sale and use of alcohol

21. Improve access to, and availability of, healthy foods throughout Queensland, particularly in rural and remote areas, by implementing initiatives under the food supply priority action area of Eat Well Queensland 2000-2012: Smart Eating for a Healthier State and supporting the national food supply in remote areas project

22. Implement coordinated cross-sectoral approaches to address physical activity at the state, regional and local levels

22.1 Develop and implement plans that influence physical activity across settings (e.g. community health plans, local physical activity area plans, sport and recreation strategies, infrastructure plans).

22.2 Advocate for and facilitate urban planning processes that promote physical environments for active living.

22.3 Consider impacts on physical activity in the review of relevant Queensland policy and legislation (e.g. urban planning processes, cycling and pedestrian plans).

Focus on the early years of life, children and young people

23. Provide information and support to parents in relation to smoking, poor nutrition, physical inactivity and excessive alcohol consumption

23.1 Provide information to parents about the harms, such as Sudden Infant Death Syndrome (SIDS) and asthma, of exposing children to passive smoking.

23.2 Offer effective smoking cessation interventions for pregnant women, and women who are breastfeeding, through antenatal care providers.

23.3 Collaborate nationally on the development and implementation of guidelines for women in the antenatal period in relation to smoking, alcohol and nutrition.

23.4 Support dissemination and promotion of physical activity resources to parents such as those developed as part of Sport and Recreation Queensland's *Get Active Queensland Children and Young People Strategy*.

24. Improve the nutritional health of mothers, infants and children

24.1 Expand growth assessment and early life interventions for Aboriginal and Torres Strait Islander communities.

24.2 Support implementation of *Queensland Health Optimal Infant Nutrition: Evidence-Based Guidelines 2003-2008*.

24.3 Support exclusive breastfeeding to six months and continued breastfeeding up to at least 12 months in partnership with community breastfeeding organisations, general practice and Aboriginal and Torres Strait Islander communities.

24.4 Disseminate, promote and update relevant physical activity and nutrition resources to childcare and outside school hours centres/services.

24.5 Work with Education Queensland to implement the healthy weight component of the Joint Work Plan, particularly the *Healthy Food and Drink Supply Strategy for Queensland Schools*, addressing issues in schools such as: food and drink supply including tuckshops and vending machines; enhancing the nutrition and physical activity components of the health and physical education curriculum; teacher professional development; and access to evidence-based nutrition and physical activity resources and programs.

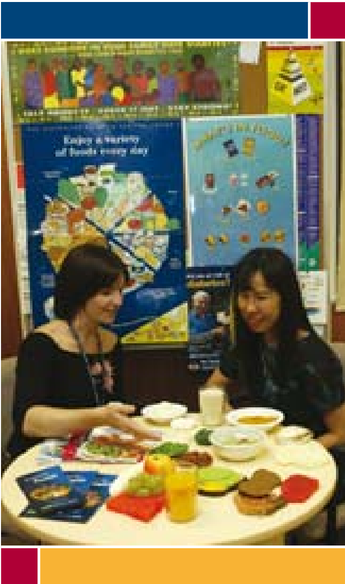
25. Coordinate implementation and evaluation of the Smart State Healthy Weight in Children and Young People Action Plan: Eat Well, Be Active – Healthy Kids for Life

26. Implement strategies to prevent young people from smoking

26.1 Enforce legislation prohibiting the sale of tobacco products to minors, restricting tobacco product displays in retail outlets and restricting smoking in indoor and outdoor areas.

26.2 Support education sectors to address smoking issues for students and wider school communities such as the Health Promoting Schools anti-smoking resource.

26.3 Contribute to the implementation of the national multi-strategy youth smoking prevention campaign.



Monitoring and surveillance, evaluation and intervention research

27. Advocate for, implement and enhance risk factor monitoring and surveillance

27.1 Collaborate with, and support implementation of, three-yearly *National Drug Strategy* survey series in Queensland.

27.2 Implement nutrition and physical activity surveys for children in Queensland every five years.

27.3 Collaborate in support of a national framework for coordinated, systematic monitoring and surveillance of nutrition and physical activity.

27.4 Regularly include and report on questions about risk factors and their determinants in Queensland Health Omnibus Survey and other relevant surveys.

28. Implement evaluation and intervention research findings from the three place-based initiatives and three demonstration projects for healthy weight.

Secondary prevention

Early detection and early management of disease markers

Objective: *Increase the early detection and management of early disease markers in the vulnerable/at-risk population to delay or halt the development of chronic disease, including:*

- *high blood pressure*
- *high cholesterol*
- *glucose intolerance*
- *protein in the urine/glomerular filtration rate*
- *increased body mass index/waist-hip ratio*
- *impaired lung function*

Strategies:

29. Enhance primary health care capacity to implement a coordinated, systematic approach to opportunistic early detection and management of disease markers that targets vulnerable/at-risk populations

29.1 Develop, implement and evaluate common approaches to early detection and management (including systems of triage, call and recall systems, referral pathways, decision support tools, evidence-based protocols and programs and follow-up/review procedures).

29.2 Improve access to early detection and management through implementing flexible approaches in a range of settings based on the needs of local vulnerable/at-risk population groups.

Management and tertiary prevention

Management and the acute-primary health care interface

Objective: *To ensure clients with chronic disease receive quality, co-ordinated and integrated multidisciplinary care across services, settings and time, to optimise quality of life for individuals living with chronic disease and their families and carers*

Strategies:

30. Support improvements in acute management and care coordination within and across services

30.1 Establish multidisciplinary chronic disease teams in the community (including Aboriginal and Torres Strait Islander health workers and/or culturally and linguistically diverse health workers where appropriate), to work collaboratively with general practice and medical specialists.

30.2 Develop or enhance statewide multidisciplinary models that work across the acute-primary health care interface to coordinate and integrate care, and to better manage avoidable hospital admissions and inappropriate lengths of stay (e.g. models based on the community hospital interface program – CHIP and CHIP+[5]).

30.3 Develop or enhance multidisciplinary teams, with outreach capacity, to deliver evidence-based management programs and support for people with chronic disease and their carers (with an initial focus on outreach programs for heart failure and COPD).

30.4 Work with acute and primary health care providers (including general practitioners, diagnostic services and specialist health care providers) to develop or consolidate triage and referral pathways and develop or adopt standardised evidence-based guidelines and care plans for the management of chronic disease.

30.5 Develop or enhance ambulatory care programs, such as Hospital in the Home/Nursing Home and early discharge programs, to provide flexible alternatives for the management and support of people with chronic disease and their carers.

30.6 Enhance statewide capacity for stroke management through cooperative arrangements and formal agreements between public and private health providers and other services (particularly for imaging and protocols for thrombolysis).

30.7 Develop and strengthen statewide networks of multidisciplinary units that establish universal triage and referral pathways and clinical protocols to improve access to diagnostic and treatment services for all Queenslanders, particularly those living in regional, rural and remote areas (with an initial focus on stroke and renal disease).

[5] Queensland Health. *CHIP Community Hospital Interface Program – Resource Manual*. Brisbane: Queensland Health, 2005. http://qe2-irc.sth.health.qld.gov.au/irc/Community/community_access_integ/CHIP/CHIP_resource_manual_home.htm (accessed 14 June 2005).

Palliative care

Objective: ***To ensure people with chronic disease have appropriate access to quality, integrated palliative care services, to optimise quality of life for individuals, their families and carers***

Strategies:

31. Support the development and implementation of a statewide, integrated framework for palliative care

31.1 Review Queensland Health's *Strategic Directions for Palliative Care Services 2000-2005.*

31.2 Support the development and/or implementation of standard protocols for the appropriate referral, access and treatment of people with chronic disease requiring palliative care.

31.3 Formalise existing networks of services and providers through improved integration across relevant agencies.

31.4 Increase the capacity to provide palliative care services, including provision of culturally appropriate training for providers working with Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds.

31.5 Develop or increase the capacity to provide palliative care services in-home or in other culturally appropriate settings.

31.6 Support public awareness initiatives, aimed at both the wider community and health care workers, to increase understanding, acceptance and use of palliative care services for all chronic diseases, beyond cancer.

Rehabilitation

Objective: ***To maximise function, improve quality of life and reduce the risk of further complications for people with chronic disease, especially those who have had a stroke or a heart attack and people with COPD***

32. Increase the capacity of the rehabilitation sector to provide timely, coordinated and integrated cardiac, stroke and pulmonary rehabilitation services

32.1 Increase integration across service providers, including greater public-private sector collaboration.

32.2 Develop or increase the capacity to deliver evidence-based, multidisciplinary cardiac rehabilitation services across Queensland.

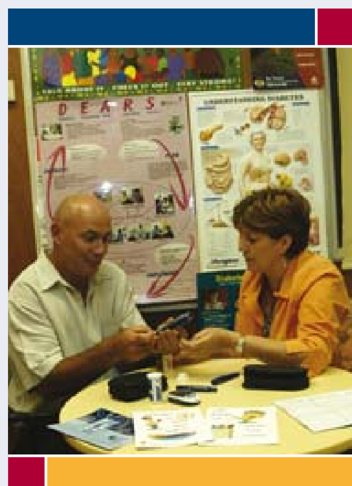
32.3 Develop or increase the capacity to deliver evidence-based, multidisciplinary pulmonary rehabilitation services across Queensland.

32.4 Develop or increase the capacity to deliver evidence-based, multidisciplinary stroke rehabilitation services across Queensland.

32.5 Develop or increase the capacity to provide healthy lifestyle programs to reduce key behavioural risk factors for people with established chronic disease.

32.6 Develop or increase access to evidence-based, multidisciplinary rehabilitation services for people from rural and remote areas, including alternative service delivery models.

32.7 Develop or increase provision of culturally appropriate rehabilitation services, particularly for Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds.



Implementation of the Strategy

Implementation of the *Queensland Strategy for Chronic Disease 2005-2015* requires significant reform of current practice by all partners, support for change-management and new investment. The development of the Strategy and the extensive consultation undertaken during this process have enabled new relationships between partners to be established, providing a firm foundation for implementing new strategies and doing business in different ways.

Queensland Health recognises the need for a mechanism to provide ongoing coordination and the driving force necessary to maintain momentum for implementation of the Strategy. Resources have been identified for this function in the budget from 2005-06. A governance mechanism representative of key partners will also be established to provide guidance and accountability for implementation of the Strategy.

The Queensland Government has a four-year budget cycle. Funding of $155 million has been allocated towards the implementation of the *Queensland Strategy for Chronic Disease 2005-2015* for the period 2005-2009. In addition, components of the budget for Aboriginal and Torres Strait Islander Peoples' health ($27.8 million), the cancer budget (tobacco component) ($18 million) and the budget for cardiac services ($11 million) will support implementation. The major areas for investment in chronic disease prevention and management identified in the Queensland Health budget for 2005-2009 are outlined in the table below.

Implementation Component	2005-06	2006-09
Place-based initiatives (Innisfail, North Lakes and surrounds, and Logan-Beaudesert)	$4.8 million	$37 million
Primary prevention (whole-of-population)	$9.7 million	$61.9 million
Screening and management of lifestyle and behavioural risk factors	N/A	$8.5 million
System strategies (i.e. partnerships, self-management, change-management)	$1 million	$10.9 million
Chronic care multidisciplinary teams in the community for early detection of disease markers, chronic care coordination and support packages	$1.4 million	$31.6 million
Acute management and tertiary prevention (CHIP, heart failure, COPD teams)	$4.14 million	$23.1 million
Rehabilitation (cardiac, pulmonary and stroke)	$0.85 million	$16.6 million

A number of areas such as quality improvement, workforce development and information management systems will require support and influence from the chronic disease prevention and management workforce to ensure that systems developed are geared to enable implementation of the Strategy.

An evaluation framework will be applied to assess progress and identify areas for change and refinement during implementation. The Centre for Primary Health Care, University of Queensland, has been resourced to coordinate the evaluation. The need for development of new data sources including the cohort study has been identified.

The federal budget for 2005-2009 identified funding for continuation of existing programs around diabetes and asthma. From July 2005, there will also be new Medicare chronic disease management items to replace the existing Enhanced Primary Care (EPC) multidisciplinary care planning items. The *Healthy for Life* program has allocated $102 million nationally over four years to improve the health of Aboriginal and Torres Strait Islander babies and children. It will focus on improving the quality of maternal health care services and the early detection and management of chronic disease.

An action plan will guide implementation of the Strategy and will be available from early 2006 on the Queensland Health website at:
http://www.health.qld.gov.au/publications/corporate/chronstrat2005/default.asp

The action plan will be updated periodically to reflect further investment in later years by partners, and changes in implementation indicated through the evaluation program.

Evaluation of the Strategy

The development and application of an evaluation framework is considered critical to measure effectiveness, efficiency and outcomes throughout the 10-year implementation of the Strategy. The Centre for Primary Health Care, University of Queensland, in consultation with a multi-stakeholder working group, has developed the evaluation framework that will be used to evaluate the performance of the Strategy. The evaluation framework comprises six key components:

- implementation process
- health system responsiveness and supportive environments for healthy behaviour
- intermediate-term impact
- longer-term outcome
- place-based initiatives
- economic evaluation.

The evaluation will track change across time in key outcome areas and will allow comparison within the state between place-based initiative communities and other communities (which will be at different stages of implementation). In addition, there will be scope to compare data from communities outside Queensland and undertake whole-of-state comparisons. These evaluated changes will be mapped to data on changes in services and clinical practice through measures of change in individuals' behaviour, care received and perceptions of quality and responsiveness of care.

Implementation of the Strategy is a dynamic process that will occur in different ways across Queensland over time. Moreover, the Strategy is both complex in scope, and not occurring in isolation from other changes in the health and social welfare system. Attribution of specific changes in outcome measures will require a detailed understanding of what has changed, how it has changed and how it has affected the prevention and management of chronic disease in Queensland.

The evaluation of the Strategy will use existing state and national data sources wherever available. However, in addition to this, seven new surveys/studies/interview processes will be used to evaluate the implementation and effects of the Strategy in Queensland:

1) an annual survey of key stakeholders (representative of key partners)
2) interviews with key Aboriginal and Torres Strait Islander informants (every three years)
3) a computer-assisted telephone interview (CATI) survey of people with an in-scope chronic disease (every two years)
4) a CATI survey of the general population (every two years)
5) key informant interviews with clinicians (every two years)
6) a random survey of service providers (every two years)
7) a cohort study of people with chronic disease (annual data collection).

Each of the studies is independent and complementary to the others. However, collectively, these studies will track and monitor the effect of the Strategy from various perspectives. Throughout the implementation process new data may become available (e.g. from general practice, as part of the National Indicator Framework) that will further complement the evaluation components.

The selection of indicators for evaluation has been informed by the *National Health Performance Framework*. More detailed information on the evaluation methodology, including data collection and indicators, is available on the Queensland Health website at: http://www.health.qld.gov.au/publications/corporate/chronstrat2005/default.asp

Evaluation framework for the Queensland Strategy for Chronic Disease 2005–2015

Key components	Indicator	Data source	Frequency of data analysis *
Implementation process	1. Strategies implemented	1) Annual survey of key stakeholders 2) Existing Queensland Health reporting requirements (primarily ISAP)	1,2) Baseline (2005-06) and annually
	2. Strategies implemented in Aboriginal and Torres Strait Islander communities	1) Interviews with key informants	1) Baseline (2005-06) and three yearly

Key components	Indicator	Data source	Frequency of data analysis *
Health system responsiveness and supportive environments for healthy behaviour	3. Health system responsiveness	1) CATI survey (people with chronic disease) 2) Key informant interviews with clinicians	1,2) Baseline (2005-06) and two yearly
	4. Service providers' knowledge, understanding and practice in the prevention and management of chronic disease	1) Survey of service providers	1) Baseline (2005-06) and two yearly
	5. Behavioural risk factors and supportive environments for healthy behaviour ■ Tobacco use ■ Alcohol misuse	1) CATI survey (people with chronic disease) 2) CATI survey (general population) 3) Cohort study 4) National Drug Household Survey 5) National Health Survey 6) National Indigenous Health Survey 7) Burden of Disease Study	1,2) Baseline (2005-06) and two yearly 3) Baseline and annually 4-7) Baseline and two years (2007/2008)
	■ Poor nutrition ■ Prevalence of overweight/ obesity ■ Physical inactivity	1) CATI survey (people with chronic disease) 2) CATI survey (general population) 3) Cohort study 4) Measured BMI of participants in the Queensland module of the National Oral Health Survey 5) National Health Survey 6) National Indigenous Health Survey 7) Burden of Disease Study 8) Queensland Health Omnibus Survey	1,2) Baseline (2005-06) and two yearly 3) Baseline and annually 4-8) Baseline and three years (2008)

* Frequency of data analysis is indicative of intended timelines only, and is dependent on availability of data from sources.

Key components	Indicator	Data source	Frequency of data analysis *
Intermediate-term impact	**6. Health service utilisation** ■ **GP utilisation**	1) Cohort study 2) HIC 3) MBS	1) Baseline (2005-06) and annually 2,3) Baseline and three years (2008)
	■ **Hospitalisations (including in-scope avoidable admissions)**	1) Cohort study 2) Queensland Health admitted patient data 3) Baseline – Queensland Health Hospitalisations Avoidable by Ambulatory Care Project final report Nov 2004 4) Follow-up – r epeat of above study	1) Baseline (2005-06) and annually 2-4) Baseline and three years (2008)
	■ **Community health services**	1) Cohort study 2) CHIME 3) Ferret	1) Baseline (2005-06) and two yearly 2,3) Baseline and three years (2008)
	7. Quality of care ■ **Patient satisfaction**	1) CATI survey (people with chronic disease) 2) Queensland Health patient satisfaction survey/study (from a stratified random sample that will provide information at a District level) 3) Queensland Health Balanced Scorecard™ Patient Survey	1) Baseline (2005-06) and two yearly 2,3) Baseline and three years (2008)
	■ **Care received in relation to best practice**	1) CATI survey (people with chronic disease) 2) Queensland Health Balanced Scorecard™ Patient Survey 3) The Collaboratives for Healthcare Improvement (Cardiac, Stroke and Renal) (Diabetes and Respiratory when developed).	1) Baseline (2005-06) and two yearly 2,3) Baseline and three years (2008)
	8. Quality of life	1) Cohort study 2) CATI survey (people with chronic disease) 3) Queensland Health 2006 CATI management surveys 4) Queensland Health Omnibus Survey	1) Baseline (2005-06) and annually 2) Baseline and two yearly 3,4) Baseline and three years (2008)
	9. Uptake of prevention interventions	1) Cohort study 2) CATI survey (general population) 3) CATI survey (people with chronic disease) 4) Queensland Health Balanced Scorecard™ Patient Survey	1) Baseline (2005-2006) and annually 2,3) Baseline and two yearly 4) Baseline and three years (2008)
	10. Uptake of management interventions	1) Cohort study 2) CATI survey (people with chronic disease) 3) Queensland Health Balanced Scorecard™ Patient Survey	1) Baseline (2005-06) and annually 2) Baseline and two yearly 3) Baseline and three years (2008)
	11. Changes in self-management	1) Cohort study 2) Queensland Health Balanced Scorecard™ Patient Survey	1) Baseline (2005-06) and annually 2) Baseline and three years (2008)
	12. Behavioural risk factors and supportive environments for healthy behaviour	Refer to 5 above	CATI survey and cohort study as per 5 above Existing state and national data sources – baseline (2005-06) and three years (2008)

* Frequency of data analysis is indicative of intended timelines only, and is dependent on availability of data from sources.

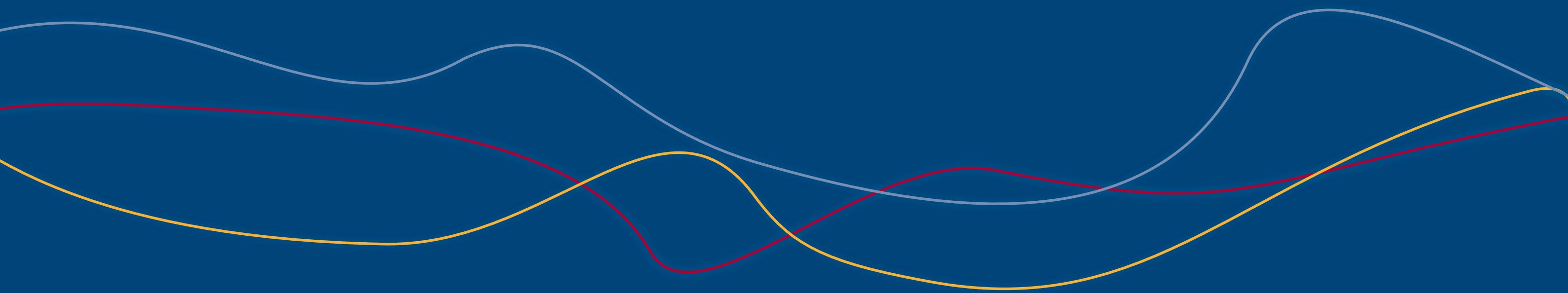
Key components	Indicator	Data source	Frequency of data analysis *
Longer-term outcome	13. a) Prevalence/incidence of in-scope chronic diseases ■ Cardiovascular disease (coronary heart disease, heart failure, and stroke)	1) CATI survey (general population) 2) Queensland Health CATI Survey 3) National Health Survey 4) National Indigenous Health Survey	1) Baseline (2005-06) and two yearly 2-4) Baseline, three years (2008), six years (2011) and ten years (2015)
	■ Renal	1) National Health Survey 2) National Indigenous Health Survey 3) AusDiab 4) National end-stage renal disease registry	1-3) Baseline (2005-06) three years (2008), six years (2011) and ten years (2015)
	■ Diabetes	1) CATI survey (general population) 2) National Health Survey 3) National Indigenous Health Survey 4) AusDiab 5) Queensland Health CATI Survey	1) Baseline (2005-06) and two yearly 2-5) Baseline, three years (2008), six years (2011) and ten years (2015)
	■ Asthma	1) CATI survey (general population) 2) National Health Survey 3) National Indigenous Health Survey 4) Queensland Health CATI Survey	1) Baseline (2005-06) and two yearly 2-4) Baseline, three years (2008), six years (2011) and ten years (2015)
	13. b) Incidence of one or more in-scope chronic diseases as a co-morbidity (including depression) in people with an in-scope chronic disease	1) CATI survey (people with chronic disease)	1) Baseline (2005-06) and two yearly
	14. Mortality from in-scope chronic diseases ■ Cardiovascular disease (coronary heart disease, heart failure, and stroke) ■ Renal disease ■ Diabetes ■ Chronic Respiratory Disease (COPD and Asthma)	1) Australian Bureau of Statistics	1) Baseline (2005-06), three years (2008), six years (2011) and ten years (2015)
	15. Quality of life	Refer to 8 above	Cohort study – baseline (2005-06) and annually CATI survey – baseline and two yearly All other data sources – baseline, three years (2008), six years (2011) and ten years (2015)
	16. Behavioural risk factors and supportive environments for healthy behaviour	Refer to 5 above	Cohort study – baseline (2005-06) and annually CATI survey – baseline and two yearly All other data sources – baseline, three years (2008), six years (2011) and ten years (2015)
	17. Health status	1) CATI survey (people with chronic disease) 2) Current state/national data sets	1) Baseline (2005-06) and two yearly 2) Baseline, three years (2008), six years (2011) and ten years (2015)
	18. Aboriginal and Torres Strait Islander health status	1) Interviews with key community and clinical informants 2) Current state/national data sets	1) Baseline (2005-06) and three yearly 2) Baseline, three years (2008), six years (2011) and ten years (2015)

* Frequency of data analysis is indicative of intended timelines only, and is dependent on availability of data from sources.

Key components	Indicator	Data source	Frequency of data analysis *
Place-based initiatives	**Innisfail** **Logan-Beaudesert** **North Lakes and surrounds**	1) Cohort study 2) CATI survey (people with chronic disease) 3) CATI survey (general population) 4) State/national data sets collected for all of the previously outlined evaluation indicators that report on place-based initiatives	1) Baseline (2005-06) and annually 2-3) Baseline and two yearly 4) As available and collected for previous indicators

Key components	Indicator	Data source	Frequency of data analysis *
Economic evaluation	**Total health services resource use**	1) CATI survey (people with chronic disease) 2) Cohort study 3) Queensland Health data for hospital admissions	1-3) Three years (2008) Ten years (2015) Other as appropriate
	Total costs	1) Queensland unit cost sources	1) Three years (2008) Ten years (2015) Other as appropriate

* Frequency of data analysis is indicative of intended timelines only, and is dependent on availability of data from sources.



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