PaRROT

Pathways to Rural and Remote Orientation and Training

a Primary Health Care approach to Chronic Disease

Orientation Facilitator Handbook

Part 1—Introduction/Chronic Disease

Name _____

Community _____

Site _____

Position _____

Date Completed _____

PaRROT Orientation Handbook, Part 1

Table of Contents

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Introduction to PaRROT

Welcome

Welcome to the PaRROT program and thank you for agreeing to facilitate training workshops.

PaRROT has been developed as a multi-disciplinary, multiple-modality program for primary health care professionals working in rural and remote areas. The multiple delivery modes were developed in an effort to meet the training needs of the rural and remote workforce because people have different ways of learning, there are wide ranges in computer literacy and access to functional technology is varied.

The program is available in eLearning format and can be found at www.health.qld.gov.au\parrot. You can also download and print facilitator and participant documents from this site.

PaRROT can be completed through eLearning, workshops via video-conference or face to face or by a combination of the three. The decision on access modes is made by the participant, a health team or a district – with each style having identical content but with some minor changes to activities and quizzes.

This manual has been developed for facilitators and is separated into units which can be used as stand alone topics for professional development. The choice to do the topics as stand alone is up to the learner, the health service or the district but we do recommend completion of the full module. The manual includes printed versions of all of the content on the eLearning site as well as session plans for each unit, suggestions for group activities and information on adult learning and teaching that you may find useful.

Comments on the content are welcome and recommendations for changes can be made by contacting the PaRROT team at parrot@health.qld.gov.au. Comments and recommendations for content change are discussed and endorsed by the PaRROT steering committee in order to ensure the content is kept current and relevant to the target audience.

Facilitator Notes

Content	Descriptor
Session Plan	The session plan provides step by step guidance for the unit. It can be used as a prompt for facilitation, but does not have to be followed if you are more comfortable adlibbing. It identifies the learning goals, provides notes for each part of the session and provides guidance for the activity.
Ice breaker	The ice breaker can be used at the start of the session as a fun way to get to know the participants. You can use this one, choose one from the examples included in this package or use your own. Icebreakers do not have to be included in a session, but they are a great tool for setting the scene and getting to know each other.
Checklists	The checklists are to be given to the participants – they provide a list of the recommended units and information on the time each unit should take. Participants can mark of the units they have completed and keep the checklist as a record for professional development purposes.
Session 1	Session 1 provides the introductory information for the unit. It can be delivered in what ever way you choose. We recommend you read the information prior to commencing the unit, but deliver it in your own words.
Presentation	The presentation is provided as a word document in this manual – this is for your information and is also included in the participant manual for the learners. You can download the presentation from the DVD as a power point show and use the word document to assist with narration, or you can choose to run the audio version also on the DVD and follow the narration using the word document.
Activity	The activity in this unit is a questionnaire used to determine a person's learning style – explanations for each style are included in the activity and more information is in session 2. Once everyone has identified their learning style it would be useful to do a brainstorming session or small group discussion on what their learning styles are and how they could maximise their learning eg a visual learner would benefit from watching videos, looking at diagrams etc, an audio learner would benefit from listening to lectures and a kinaesthetic learner by applying to knowledge to situations they are familiar with.
Session 2	This session summarises the unit and provides information on application of learning styles. Again, it would be useful if you read the notes and present the information in your own words.

Checklists

Health Professional Checklist

	Topic / Unit	20	PaRROT Unit		OCNO Unit		SARRAH		Time
Core									
01	**Introduction**	1 hr	Introduction to PaRROT	☐					
02	**Chronic Disease**	4 hr	Introduction to Chronic Disease	☐	Chronic disease	☐			
03			Queensland Strategy for Chronic Disease	☐	Chronic disease	☐			Week 1
04			Chronic Disease Strategy - Rural and Remote	☐					
05	**Clinical Support**	4 hr	Evidence based guidelines	☐	Essential Guides: supporting clinical practice	☐			Week 2
06			Clinical information systems	☐	Essential Guides: Supporting clinical practice	☐			
07			Patient information recall system	☐					
08			Medicare - Rural and Remote Medical Benefits Scheme	☐					
09	**Team Work**	3 hr	Looking after yourself	☐	Self Care, Support and Staying Sane	☐	Self Care	☐	Week 3
10			Team Work	☐					
11	**Cultural Issues**	3 hr	Multicultural health	☐			Cultural Safety	☐	
12			Working with A & TSI communities	☐					
13	**Quality and Safety**	1 hr	Patient safety	☐					Week 4
Prevention									
14	**Primary Health Care**	3 hrs	Aboriginal and Torres Strait Islander Health	☐					Week 4
15			Comprehensive primary health care	☐			Primary Health Care	☐	
16			Selective primary health care	☐					
Early Detection									
17	**Health Checks**	1 hr	Introduction to health checks	☐					Week 4

Administration Officer Checklist

	Topic / Unit	10 hrs	PaRROT Unit		OCNO Unit		SARRAH		Time
Core									
01	**Introduction**	1 hr	Introduction to PaRROT	☐					Week 1
06	**Clinical Support**	3 hr	Clinical information systems	☐	Essential Guides: Supporting clinical practice	☐			
07			Patient information recall system	☐					
08			Medicare - Rural and Remote Medical Benefits Scheme	☐					
14	**Quality and Safety**	1 hr	Patient safety	☐					
09	**Team Work**	2 hr	Looking after yourself	☐	Self Care, Support and Staying Sane	☐	Self Care	☐	Week 2
10			Team Work	☐					
11	**Cultural Issues**	3 hr	Multicultural health	☐			Cultural Safety	☐	
12			Working with A & TSI communities	☐					
				☐					

PaRROT

Pathways to Rural and Remote Orientation and Training

a Primary Health Care approach to Chronic Disease

Orientation

Unit 1

Introduction to PaRROT

Session Plan

Session 1: Introduction to PaRROT Program

Location

Overall Session Time: **1 Hour**

Synopsis knowledge required for understanding of the PaRROT Program

Learning outcomes Understanding and knowledge of the history, objectives, principles, expected outcomes, content, delivery modes and stages of the PaRROT program. Understand and apply learning styles.

Time allocated	How will session run	Delivery method & resources equipment	Assessment
5 minutes	**Housekeeping** Slide 2	Presentation	
10 minutes	**Ice Breaker (see detailed notes)** Slide 3	Verbal instructions Activity sheet	
15 minutes	**Content (See detailed notes)** Slides 4 to 15	Presentation and Session 1 notes	
5 minutes	**Summation** Slide 16	Presentation and session 2 notes.	
15 minutes	**Activity and Questions** Slides 17	Presentation Written and discussion VAK Learning Styles Activity sheet White board or butchers paper and pens.	
	Close		

Detailed Session Notes		
Slide	**Slide Title**	**Notes**
1	**Session title**	Introduction to PaRROT Program.
2	**House keeping** • Emergency • Toilets • Mobile Phones • ***Respect***	Point out exits and evacuation plans Point out where toilets are Ask to switch off or if need to take calls to do outside ***Ask group to respect each other's differences and get group to brainstorm their rules of respect and write up on whiteboard – leave up for entire program if possible.***
3	**Interest** (Create Interest) **Ice Breaker** **Need** (Explain why they need to know)	Ask the group if they were a bird what type of bird would they be, and why they would like to be that type of bird. Need to understand the program for it to be applicable and make sense to them when working through it.
4 plus Session 1 notes.	**Introduction:** **Topic** (What the session is about) **Range** (What will be covered)	Use session 1 notes to introduce the training. Ensure participants are aware this session will include: • An overview of the PaRROT training program which is important in helping them understand where it has come from and its intentions. • An introduction to the training program and its content • An activity that looks at learning style and an opportunity
5	**Learning Objectives** **Outcomes** (What they will achieve) **Assessment** (How they will be assessed)	To understand and be aware of:- • History, objectives and principles of PaRROT • Expected outcomes, program content, delivery modes and stages • Learning styles and application. • There is no assessment in this unit.
6	**History**	The rural and remote Chronic Disease Strategy and the Enhanced Model of Primary Health Care identified the need for robust orientation, education and training of staff in remote areas **In 2005** the State-wide *Queensland Strategy for Chronic Disease 200-2015* (QSCD/the Strategy) – further identified the need for orientation, education and training. Evidence also supports the need for a systematic approach with a number of documents and papers developed as a result of research by different people.
7	**History**	**2008** – Successful bid for People Plan funding to develop the orientation and training program for chronic disease in rural and remote areas **2008** – Needs and SWOT analyses conducted by Dr Felicity Croker, JCU as part of phase 1 of the orientation and training program **2009** – Development of the chronic disease orientation and training framework – endorsement currently being sought from stakeholders **2009** – Early development of the PaRROT program

Slide	Slide Title	Notes
8	**Objectives of the program**	Provide knowledge and skills to the primary health care workforce to deliver chronic disease care Provide training support through the life of employment of people working in rural and remote areas Provide a sustainable training program that is constantly reviewed and updated Provide accessible and appropriate resources for staff working in rural and remote areas Improve the quality of clinical chronic disease care by boosting the capacity of the primary health care workforce Support the systematic approach to chronic disease care (prevention, early detection, management).
9	**Principles of the program**	• Create a supportive, sustainable environment to promote learning • Align learning priorities across all levels • Integrate best practice concepts and standards into practice • Provide and promote appropriate and innovative learning options • Lead and manage learning effectively and efficiently • Monitor and evaluate.
10	**Principles for the learner**	The program needs to be • Sustainable • Supported • Affordable • Accessible • Appropriate • Acceptable and • Effective •
11	**Expected Outcomes**	• Competent confident primary health care workers • Stable rural and remote workforce • Decreased problems with recruitment and retention in rural and remote areas • Standardised information about comprehensive primary health care and chronic disease care • A systematic approach to chronic disease prevention, early detection and management • Ongoing focus on the population approach to health care • Improved rural and remote health. • More affordable health services as a result of a decreased burden of chronic disease
12 and 13	**Program Content**	Show the slide and draw the learners attention to the red headings ie core, prevention, early detection and management. Point out some of the units under each heading and discuss very briefly what the unit is about.

Slide	Slide Title	Notes
14	**Delivery Modes**	**Flexible** modes delivery offered. Needs to be decision about delivery mode that is supported at District / Organisation management level. Can be delivered via: **DVD** – self directed learning **Web** page – self directed learning **Workshop** delivery mode • Facilitator training • Participants need to be taken off-line Or any combination of the above
15	**Stages**	Orientation • Some modules within first week of commencement • Some modules with a 4 week time frame Induction • Within 12 weeks of commencement Annual Review • Annual on relevant topics • In line with changes to guidelines and research Professional Development • For those wanting to specialise • Some topics will be on PaRROT • Access to information on training provided outside of PaRROT program
16 and session 2 notes.	**Summation**	Participants should all now understand and be aware of: • The background of the PaRROT program • Some of the details of the program. • Strategies they can use to ensure they get the most out of this training.
17	**Activity**	VAK Learning styles. Hand this out to the participants and ask them to complete the questionnaire including adding up their results. (Give at least 10 minutes to do this). Some instruction on filling it in may be required. Once completed bring the group back together, ask them to identify their style by raising their hands. Explain to them that each person has a distinct learning style, and it is useful for them to be aware of theirs when they do the training. Take note of the preferred styles of the group and ensure you cater to each style through out the workshop. Ask the group to then think about the best way for them to approach the training. If time permits strategies can be written up on whiteboard or butchers paper and learners can get ideas from there. Once done ask them to write their strategies in the journal which will be submitted at the end of the training program. Observe for understanding and preparedness to be involved. The group should be encouraged to hold onto their VAK for future reference.

Ice Breaker

Introduction to PaRROT

Ask participants to state their name, position and area they work and to then consider if they were a bird what type of bird they would be and why they have chosen this bird.

The object of this exercise is to have the group introduce themselves and get them to know each other in a fun way.

For the facilitator it is an opportunity to learn the names of the participants and observe them for confidence and ability to contribute to the group. Take note of anyone who is embarrassed or unwilling to share. They may need to be drawn out slowly over the training – be aware of not isolating them in any way.

Also take note of the participants who may try to over talk or take some control of the group. They also need to be observed – harness their leadership skills but be careful to not let them dominate the training.

Session 1

Hello and welcome to the Pathways to Rural and Remote Orientation and Training (PaRROT) introductory unit.

The PaRROT program has been developed following years of work into the rising burden of chronic disease in rural and remote areas. Research has identified a number of gaps, including training as contributing factors to this rising problem.

This has been supported by the development of The Queensland Strategy for Chronic Disease which clearly identifies the need for education and training to ensure chronic disease prevention, early detection and management is implemented. It also identifies the need "***To support the continued development of the health workforce to achieve and sustain the implementation of chronic disease prevention and management".***

Findings from local research added to the body evidence including:

a) The outcomes of a work shop run by the Clinical Support Direct in the former Northern Area Health Service (NAHS) on education and training needs in rural and remote areas.

b) Research using the Audit and Best Practice for Chronic Disease (ABCD) quality program which supports the findings from the workshop, with evidence collected from practitioners clearly identifying the same current training and education needs.

c) The findings from the "Evaluation of the Queensland Strategy for Chronic Disease 2005 – 2015 – Baseline Report - Key Informant Interviews with Clinicians" which was funded by the Chronic Disease Strategy Unit, Queensland Health which identified what the clinicians believed were the main needs in education and training [1] .

d) Work done by Janie Dade-Smith Smith et al in 2006 and Peter D'Abbs et al in 2005 and 2008 also supported the need for training and recommended topics that should be covered [2-5]

Both the Office of the Chief Nursing Officer (OCNO) [6] and Services for Australian Rural and Remote Allied Health (S-A-R-R-A-H) [7] have developed online training programs, which complement the PaRROT program. You are welcome to complete some of those units instead of the PaRROT units which may have similar content, or you could do both – the check list which you downloaded identifies them – please indicate which ones you have completed.

The Allied Health program can be found at

http://www.sarrahtraining.com.au/site/index.cfm

And the Nursing program (Queensland Health Staff only) at

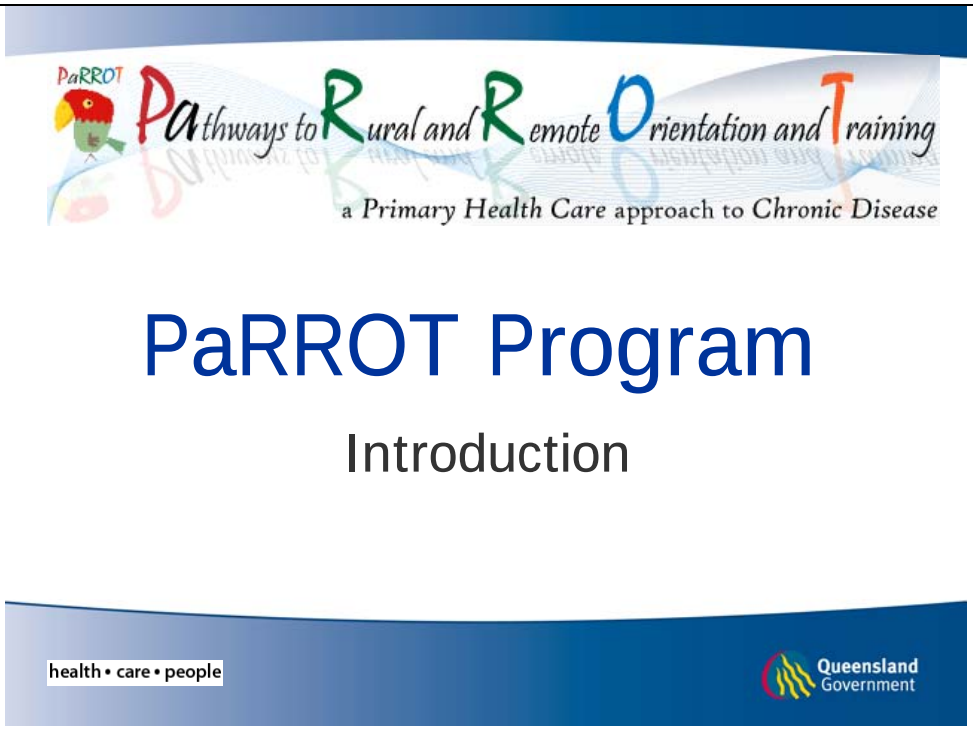
http://cdes.learning.medeserv.com.au/portal/index_qldhealth_cdp.cfm

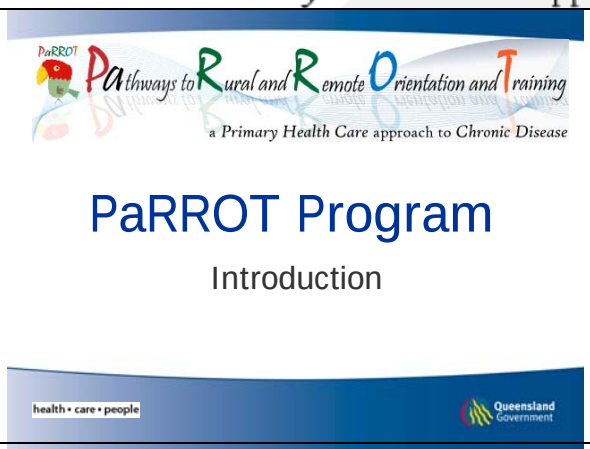
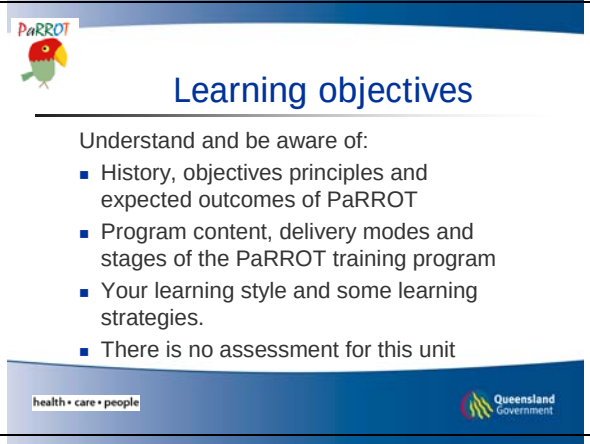
This portal is only available to Queensland Health staff and requires an employee name and password to access.

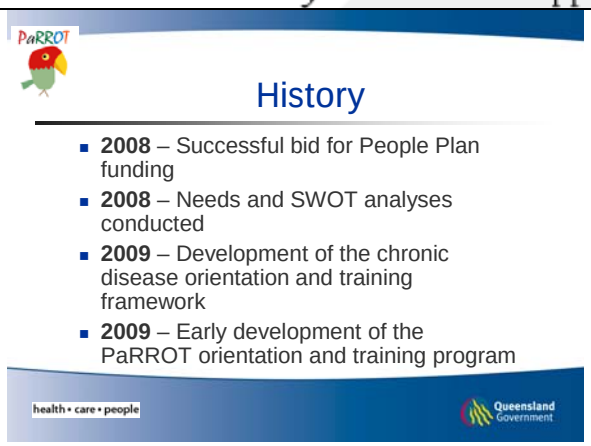
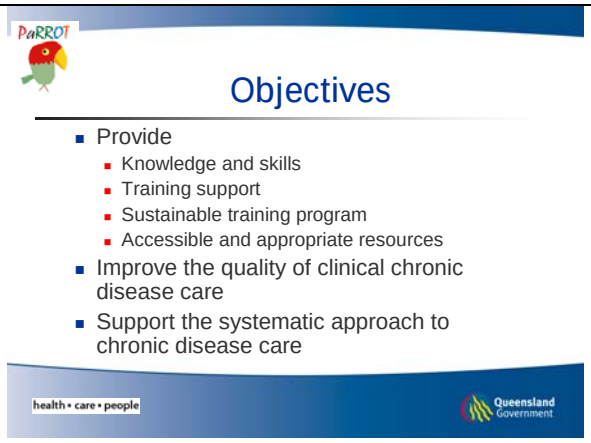
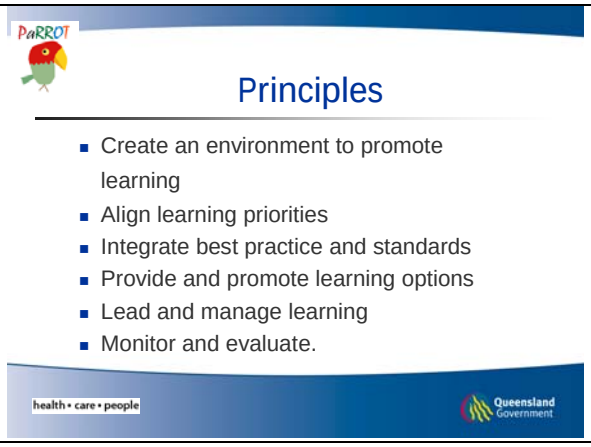
This unit will provide information on the PaRROT training program from its history through to its current status. You will be able to identify your learning style and think about the best way to approach this training.

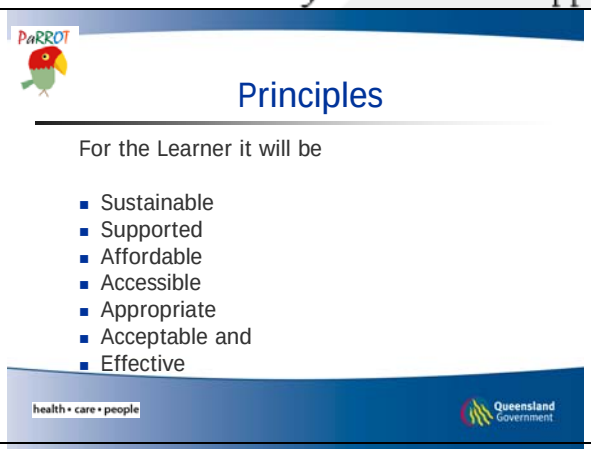
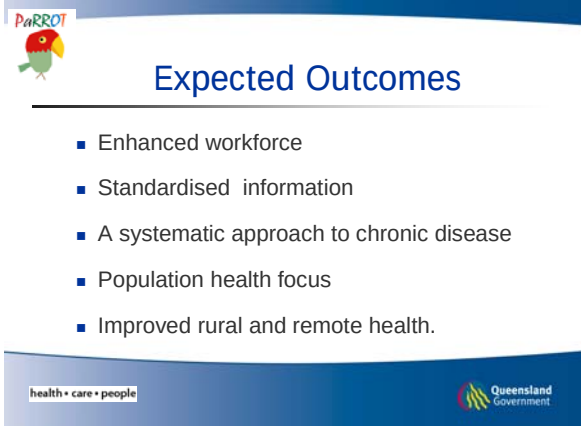
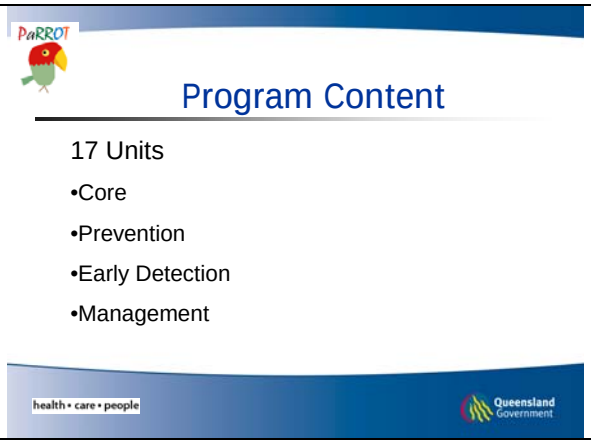
There is no assessment attached to this unit, but we would like you to reflect on your learning style and note down some strategies you can use – examples of these strategies includes listening to the presentations rather than reading them if your style is auditory, taking notes and recording thoughts in a journal if your style is visual and so on.

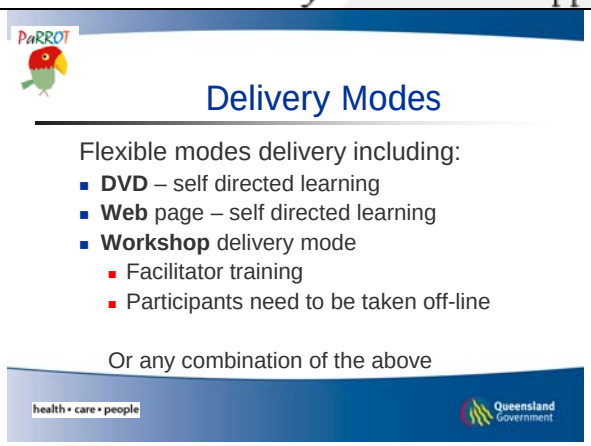
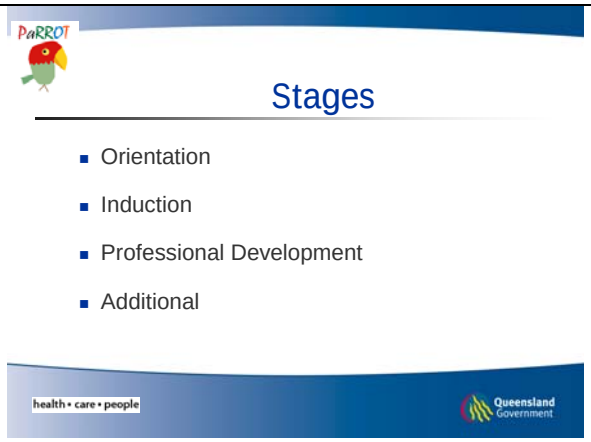
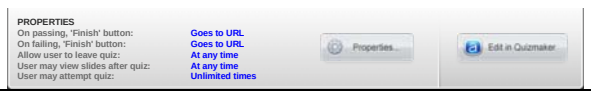
Presentation



Slide 1 **PaRROT Program**		Notes:
Slide 2 **Learning objectives**		Notes: Understand and be aware of: History, objectives principles and expected outcomes of PaRROT Program content, delivery modes and stages of the PaRROT training program Your learning style and some learning strategies you could adopt to ensure you get as much from this training as you can.
Slide 3 **History**		Notes: The Chronic Disease Strategy – Rural and Remote and the Enhanced Model of Primary Health Care identified the need for robust orientation, education and training of staff in remote areas In 2005 the Statewide Queensland Strategy for Chronic Disease 2002-2015 (QSCD/the Strategy) – further identified the need for orientation, education and training. Evidence also supports the need for a systematic approach with a number of documents and papers developed as a result of research by different people including. •Curriculum Document by Janie Dade- Smith et al - 2006 •Evaluation Baseline Report by Orlandi, Thorpe and Donald – 2007 (University of Queensland) •[former] NAHS Chronic Disease Workshop – 2008 •ABCD audit findings 2008 - 2009

Slide 4 **History**		Notes: 2008 – Successful bid for People Plan funding to develop the orientation and training program for chronic disease in rural and remote areas 2008 – Needs and SWOT analyses conducted by Dr Felicity Croker, JCU as part of phase 1 of the orientation and training program 2009 – Development of the chronic disease orientation and training framework. 2009 – Early development of the PaRROT orientation and training program
Slide 5 **Objectives**		Notes: The objective of the PaRROT program is to provide knowledge and skills to the primary health care workforce to deliver chronic disease care, including training support through the life of employment of people working in rural and remote areas. The intent is to provide a sustainable training program that is constantly reviewed and updated, and is accessible and appropriate the workforce working in rural and remote areas. There is also a need to improve the quality of clinical chronic disease care by boosting the capacity of the primary health care workforce and to support the systematic approach to chronic disease care (prevention, early detection, management).
Slide 6 **Principles**		Notes: The principles of the program are to create a supportive, sustainable environment to promote learning and align learning priorities across all levels. There is also intent to integrate best practice concepts and standards into practice, provide and promote appropriate and innovative learning options. Lead and manage learning effectively and efficiently and to monitor and evaluate orientation and training across rural and remote areas.

Slide 7 **Principles**		Notes: For the Learner the PaRROT program will provide orientation and training that is: Sustainable Supported Affordable Accessible Appropriate Acceptable and Effective
Slide 8 **Expected Outcomes**		Notes: It is expected that universal completion of the PaRROT program will ultimately result in a Competent, confident and stable rural and remote workforce Decreased problems with recruitment and retention in rural and remote areas Standardised information about comprehensive primary health care and chronic disease care A systematic approach to chronic disease prevention, early detection and management and an ongoing focus on the population approach to health care.
Slide 9 **Program Content**		Notes: There are 17 units in the orientation module. Some are grouped under topics such as team work and cultural competence and some stand alone, for example patient safety. They are also grouped under the domains of the strategy.

Slide 10 **Delivery Modes**		Notes: The program has been developed to provide flexible modes of delivery including Interactive self directed e-learning Workshop delivery mode which includes facilitator training and will require participants to be taken off-line and DVD – self directed learning with links to web pages Or any combination of the above
Slide 11 **Stages**		Notes: The training is delivered / accessed in various stages which include: Orientation with some modules to be completed within first week of commencement and some with a 4 week time frame Induction to be completed within 12 weeks of commencement Professional Development on relevant topics and in line with changes to guidelines and research and Additional - for those wanting extra. Some topics will be developed by PaRROT but there will also be access to information on training provided outside of PaRROT program
Slide 12 **Introduction to PaRROT Learning Activity**		Notes:

Learning Activity

VAK Learning Style

Tick the answer that most represents how you generally behave

Statement	
1. When I operate new equipment I generally:	
a. read the instructions first	☐
b. listen to an explanation from someone who has used it before	☐
c. go ahead and have a go, I can figure it out as I use it	☐
2. When I need directions for travelling I usually:	
a. look at a map	☐
b. ask for spoken directions	☐
c. follow my nose and maybe use a compass	☐
3. When I cook a new dish, I like to:	
a. follow a written recipe	☐
b. call a friend for an explanation	☐
c. Follow my instincts, testing as I cook	☐
4. If I am teaching someone something new, I tend to:	
a. write instructions down for them	☐
b. give them a verbal explanation	☐
c. demonstrate first and then let them have a go	☐
5. I tend to say:	
a. watch how I do it	☐
b. listen to me explain	☐
c. you have a go	☐
6. During my free time I most enjoy:	
a. going to museums and galleries	☐
b. listening to music and talking to my friends	☐
c. playing sport or doing DIY	☐
7. When I go shopping for clothes, I tend to:	
a. imagine what they would look like on	☐
b. discuss them with the shop staff	☐
c. try them on and test them out	☐
8. When I am choosing a holiday I usually:	
a. read lots of brochures	☐
b. listen to recommendations from friends	☐
c. imagine what it would be like to be there	☐
9. If I was buying a new car, I would:	
a. read reviews in newspapers and magazines	☐
b. discuss what I need with my friends	☐
c. test drive lots of different types	☐

Statement	
10. When I am learning a new skill, I am most comfortable:	
a. watching what the teacher is doing	☐
b. talking through with the teacher exactly what I'm supposed to do	☐
c. giving it a try myself and work it out as I go	☐
11. If I am choosing food off a menu, I tend to:	
a. imagine what the food will look like	☐
b. talk through the options in my head or with my partner	☐
c. imagine what the food will taste like	☐
12. When I listen to a band, I can't help:	
a. watching the band members and other people in the audience	☐
b. listening to the lyrics and the beats	☐
c. moving in time with the music	☐
13. When I concentrate, I most often:	
a. focus on the words or the pictures in front of me	☐
b. discuss the problem and the possible solutions in my head	☐
c. move around a lot, fiddle with pens and pencils and touch things	☐
14. I choose household furnishings because I like:	
a. their colours and how they look	☐
b. the descriptions the sales-people give me	☐
c. their textures and what it feels like to touch them	☐
15. My first memory is of:	
a. looking at something	☐
b. being spoken to	☐
c. doing something	☐
16. When I am anxious, I:	
a. visualise the worst-case scenarios	☐
b. talk over in my head what worries me most	☐
c. can't sit still, fiddle and move around constantly	☐
17. I feel especially connected to other people because of:	
a. how they look	☐
b. what they say to me	☐
c. how they make me feel	☐
18. When I have to revise for an exam, I generally:	
a. write lots of revision notes and diagrams	☐
b. talk over my notes, alone or with other people	☐
c. imagine making the movement or creating the formula	☐
19. If I am explaining to someone I tend to:	
a. show them what I mean	☐
b. explain to them in different ways until they understand	☐
c. encourage them to try and talk them through my idea as they do it	☐
20. I really love:	
a. watching films, photography, looking at art or people watching	☐
b. listening to music, the radio or talking to friends	☐
c. taking part in sporting activities, eating fine foods and wines or dancing	☐

Total A	Total B	Total C

If you chose mostly A's you have a **VISUAL** learning style.
If you chose mostly B's you have an **AUDITORY** learning style.
If you chose mostly C's you have a **KINAESTHETIC** learning style.

Some people find that their learning style may be a blend of two or three styles, in this case read about the styles that apply to you in the explanation below.

When you have identified your learning style(s), read the learning styles explanations and consider how this might help you to identify learning and development that best meets your preference(s).

Session 2

VAK Learning Styles Explanation

The VAK learning styles model suggests that most people can be divided into one of three preferred styles of learning. These three styles are as follows, (and there is no right or wrong learning style):

Someone with a **Visual** learning style has a preference for seen or observed things, including pictures, diagrams, demonstrations, displays, handouts, films, flip-chart, etc. These people will use phrases such as 'show me', 'let's have a look at that' and will be best able to perform a new task after reading the instructions or watching someone else do it first. These are the people who will work from lists and written directions and instructions.

Someone with an **Auditory** learning style has a preference for the transfer of information through listening: to the spoken word, of self or others, of sounds and noises. These people will use phrases such as 'tell me', 'let's talk it over' and will be best able to perform a new task after listening to instructions from an expert. These are the people who are happy being given spoken instructions over the telephone, and can remember all the words to songs that they hear!

Someone with a **Kinaesthetic** learning style has a preference for physical experience - touching, feeling, holding, doing, and practical hands-on experiences. These people will use phrases such as 'let me try', 'how do you feel?' and will be best able to perform a new task by going ahead and trying it out, learning as they go. These are the people who like to experiment, hands-on, and never look at the instructions first!

People commonly have a main preferred learning style, but this will be part of a blend of all three. Some people have a very strong preference; other people have a more even mixture of two or less commonly, three styles.

When you know your preferred learning style(s) you understand the type of learning that best suits you. This enables you to choose the types of learning that work best for you. There is no right or wrong learning style. The point is that there are types of learning that are right for your own preferred learning style.

You should also have understanding about your preferred learning style, and some strategies you could adopt to ensure you get the most out of this training.

Bibliography

1. Orlandi A, Thorpe M, and Donald M, *Evaluation of the Queensland Strategy for Chronic disease 2005 – 2015. Baseline Report - Key Informant Interviews with Clinicians*. 2007, University of Queensland: Brisbane.
2. D'Abbs P, *Evaluation framework for Northern Territory Preventable Chronic Disease Strategy and North Queensland Indigenous Chronic Disease Strategy*. 2005, James Cook University: Cairns.
3. D'Abbs P, et al., *Implementing a chronic disease strategy in two remote Indigenous Australian settings: A multi-method pilot evaluation.* Australian Journal of Rural and Remote Health, 2008. **16**: p. 67-74.
4. Smith J, *Educating to improve population health outcomes in chronic disease: A curriculum package to integrate to integrate a population health approach for the prevention, early detection and management of chronic disease when educating primary health care workforce in remote and rural northern Australia*. 2006, Menzies School of Health Research: Darwin.
5. Smith J, et al. (2006) *Report on educating to improve population health outcomes in chronic disease: an innovative workforce initiative across remote, rural and Indigenous communities in northern Australia*. Electronic Journal of Rural and Remote Health, Research, Education, Practice and Policy **Volume**,
6. Office of the Chief Nursing Officer. MedEServ. *From Burbs to the Bush. Orientation for Rural and Remote Nurses*. 2009 [cited 2009 26/08/2009]; Available from: http://www.health.qld.gov.au/cpic/default.asp.
7. S-A-R-R-A-H Services for Australian Rural and Remote Health. *Rural and Remote Transition Toolkit*. 2009 [cited 2009 27/08/2009]; Available from: http://www.sarrahtraining.com.au/site/index.cfm.

PaRROT

Pathways to Rural and Remote Orientation and Training

a Primary Health Care approach to Chronic Disease

Orientation

Unit 2

Introduction to Chronic Disease

Session Plan

Session: Introduction to Chronic Disease

Location

Overall Session Time: **1 Hour**

Synopsis Performance outcomes, skills and knowledge required to understand

Learning outcomes

Understand the key terms related to chronic disease
Identify the problems contributing to the burden of chronic disease
Be aware of strategies that will assist in reducing the incidence of chronic disease

Time allocated	How will session run	Delivery method & resources equipment	Assessment
10 minutes	**Introduction** 1. INTROA 2. Learning Objectives	Session 1 notes Presentation	
25 minutes	**Content (See detailed notes)**	Presentation	
10 minutes	**Activity Brainstorm**	Activity sheet	
5 minutes	**Wrap up**	Session 2 notes	
10 minutes	**Assessment** Complete quiz – self mark using answer sheet.	Quiz	Quiz – self mark
	Close		

Detailed Session Notes		
Slide	**Slide Title**	**Notes**
1	**Session title**	Introduction to Chronic Disease
Session 1 notes	**Interest** (Create Interest) **Need** (Explain why they need to know)	The burden of chronic disease on our health care system is burgeoning into unmanageable levels and is resulting in high levels of morbidity and premature mortality in our community. We need to be aware of the reasons for this increase and to have some strategies in place, as health care professionals, to help stem the tide.
Session 1 notes	**Introduction:** **Topic** (What the session is about) **Range** (What will be covered)	This unit introduces chronic disease and defines what chronic disease s are. It looks at the costs associated with managing chronic disease and explores ways in which we, as primary health care practitioners can help stem the tide. The next unit looks specifically at chronic disease and the Aboriginal and Torres Strait Islander communities, which, as cited above, are one of the groups carrying an uneven burden of chronic disease.
2	**Learning Objectives** **Outcomes** (What they will achieve) **Assessment** (How they will be assessed)	Understand the key terms related to chronic disease Identify the problems contributing to the burden of chronic disease Be aware of strategies that will assist in reducing the incidence of chronic disease Brainstorming activity and a quiz to be submitted with the learning journal.
3	**Key concepts**	The key concepts associated with chronic disease will be explored in detail in this unit.
4	**Chronic Diseases**	**Chronic diseases are:** • Diseases that require ongoing management over a period of years or decades. They have a gradual onset with ongoing deterioration • Chronic diseases occur across the lifespan, so are more prevalent in older age. Age is the greatest risk for chronic disease. • Chronic diseases have long term effects on quality of life including physical limitations disability and social and emotional well being.
5	**Chronic Disease**	Chronic diseases are caused by multiple complex inter-relating causes and the determinants of health
6	**Determinants of Health**	Determinants of health include: Social, economic & environmental factors e.g. living diseases, working environments, education, income, food quality, water & air quality, social support, age, geographic location, Aboriginal and Torres Strait Islander & ethnic status Health behaviours and risk factors - unhealthy lifestyles e.g. smoking, risky alcohol drinking, poor nutrition, lack of physical activity, unsafe sex, poor social & emotional health, early childhood development

Detailed Session Notes		
Slide	**Slide Title**	**Notes**
7	**The data**	The burden of Chronic disease in Australia is becoming unmanageable. In 2007 2.5 million Australians had a chronic disease which is the leading cause of hospital admissions and preventable deaths. Chronic disease care consumes 70% of the health budget. By 2016 it is projected that 3.5 million Australians will have a chronic disease and by 2030 entire state budgets will be consumed by chronic diseases. Children of today may have a shorter lifespan then their parents if factors leading to the development of chronic diseases are not addressed now.
8	**What is the problem?**	In Queensland there is significant morbidity and mortality from chronic diseases. This means large numbers of Queenslanders are battling poor health which is impacting on their ability to work, earn a living, and live a fulfilling lifestyle. This is also costing the government huge amounts of money, and impacting on the ability to provide a sustainable, preventative health service.
9	**Inequalities in health**	Although the burden of chronic disease in Queensland is great, Aboriginal and Torres Strait Islander people carry an even greater burden. Their life expectancy is on average 10 years less than non-Aboriginal and Torres Strait Islander people and 90% of presentations to rural and remote health services are the related to chronic disease.
10	**Risk factors**	Tobacco smoking, poor nutrition, alcohol misuse, physical inactivity and poor emotional health the major causes of ill health in Queensland. Research shows that intervention that supports the reduction in health damaging behaviours decreases the chance of chronic disease development. The following statistics demonstrate the level of risk behaviours in Queensland: **Smoking** • 20.6% are daily smokers, with more men smoking than women • smoking rates were higher (by > 10%) in Mt Isa, Torres & NPA and Cape York Health Service Districts **Nutrition** • 52.5% eat at least two serves of fruit per day • prevalence of sufficient fruit and vegetable intake was lower (> 10%) in Mt Isa, Torres & NPA and Cape York Health Service District • one in eight adults (11.9%) eat five or more serves of vegetables as day. **Alcohol** • one in eight drink alcohol at risky levels • risky alcohol consumption is considerably higher (>30%) in south West, Mt Isa, Central West, Torres & NPA and Cape York Districts **Physical activity** • almost half (47.5%) of adults do sufficient physical activity for health benefit • prevalence of sufficient physical activity was lower (>10%) in South West and Central West Districts **Overweight and obesity** • half (49.9%) of adults report overweight or obese • prevalence was higher (>10%) than average in south West, Central West and Mt Isa Districts Ref: Queensland Health: S Begg, M Bright, C Harper. Smoking, nutrition, alcohol, physical activity an overweight (SNAPO) indicators for Health Service Districts (208 Districts). Queensland Health. Brisbane 2008

Detailed Session Notes		
Slide	**Slide Title**	**Notes**
11	**Biomedical Approaches**	Focus of care and the health budget has been on acute medical needs of the patients which in many cases is expensive and does little to fix the cause of the disease for example iinterventions and treatments such as dialysis, coronary and bypass surgery of those with an existing chronic disease. There is also the added out of pocket costs to the patient, such as travel and medications, along with inconvenience. Rather than on preventative strategies, which in the long term are more cost effective, eg health promotion and early detection in the well or at risk population
12	**Acute Model of Care**	Added to the problem of high costs associated with secondary and tertiary levels of care, is the way in which chronic disease care has been managed in the past. A person suffering from a chronic disease may present to a hospital with an acute exacerbation of that disease. They will receive potentially expensive short term treatment for the presentation, and be discharged when they are stabilised with little being done to ensure the disease is better managed over a longer term. A different approach is needed – health services should be identifying and responding to risk factors long before chronic disease develops and once developed, it needs to work with the clients to manage their disease and ensure they remain as healthy as possible for as long as possible.
13	**What can we do?**	In order to reduce the incidence of chronic disease, the focus of care should be widen to ensure it is not just acute care that is being provided. Chronic disease care should be approached across the domains of prevention, early detection – including management of risk factors, and ongoing management once a chronic disease has developed. The focus needs to be on the causes of illness not just on illness management.
14	**A Thought …**	"The mark of a good primary health care service is not only how it cares for those who seek them out… *but how it cares for those who don't."*
Activity Sheet	**Brainstorming strategies**	Learners are asked to identify the most prevalent chronic diseases in their community and how they could respond under the domains of promotion, prevention, detection and management. Write answers on activity sheet.
Session 2 notes	**Wrap up**	This unit has looked at the causes of chronic diseases, reviewed the issues associated with managing the increasing burden and identified the need for some major changes in the way in which we deliver health care, in order to stem the tide of growth in chronic conditions in our community. If every health professional working in primary health care is able to incorporate preventative and systematic strategies into practice, then we will go a very long way in assisting with the reduction of the burden of chronic disease.
Quiz	**Complete and self mark**	Give learners 10 minutes to complete the quiz for this unit. Learners can self mark, or swap with another learner, make corrections and hand the quiz in for data collection.

Session 1

The Queensland Strategy for Chronic Disease very clearly identifies the issues surrounding our increasing burden of chronic disease. It states

"In Australia ,…, chronic disease is a major contributor to the burden of disease. Factors contributing to this increasing burden of disease include an ageing population, increasing prevalence of lifestyle and behavioural risk factors, improved survival from advances in treatment and an increased prevalence of some chronic diseases.

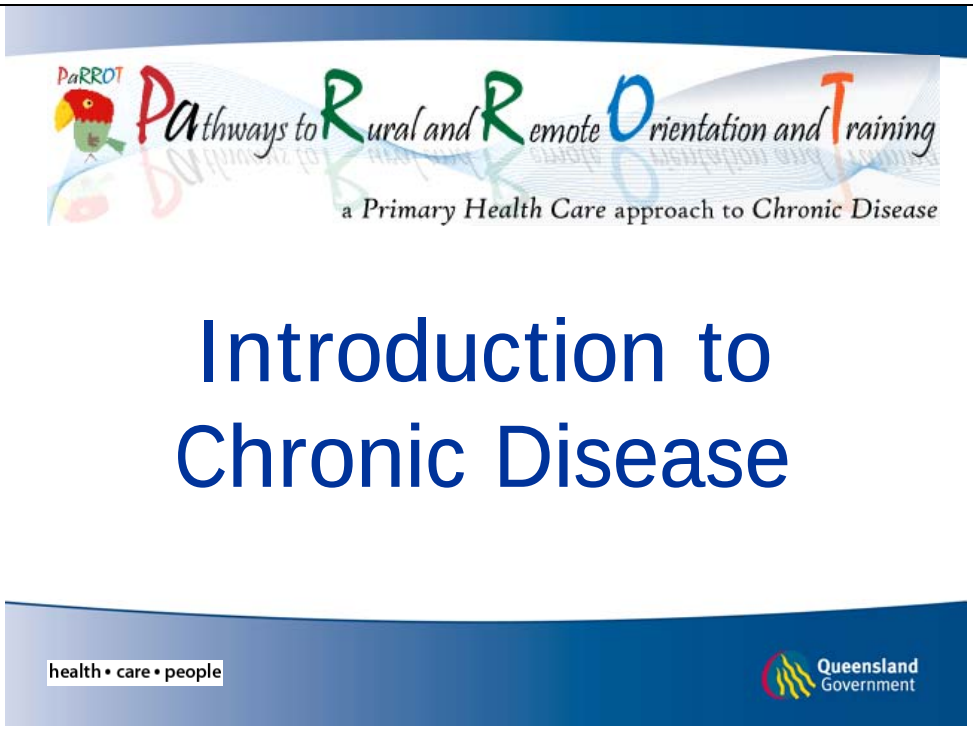
The burden of chronic disease is shared unequally across the population. People in low socioeconomic circumstances, Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds and people from rural and remote areas have higher levels of disability, morbidity and mortality from chronic disease, compared to the rest of the population.

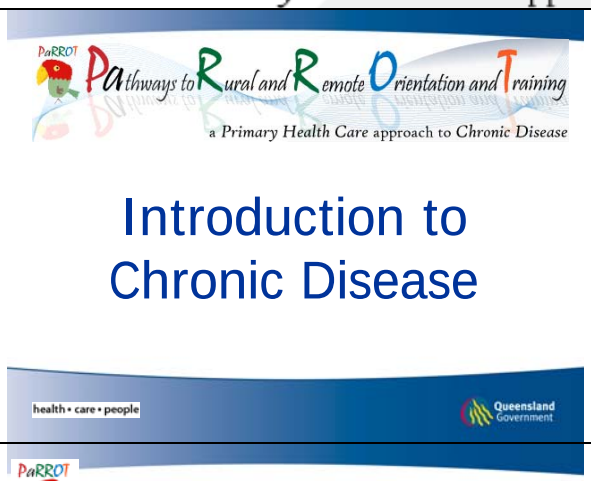
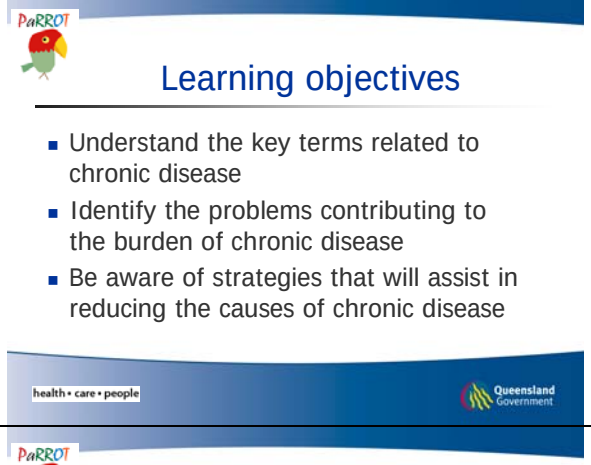
In Queensland, cardiovascular disease, chronic respiratory disease, type 2 diabetes mellitus and renal disease account for a significant proportion of morbidity experienced by the Queensland population, and more than one-third of all deaths in the state.

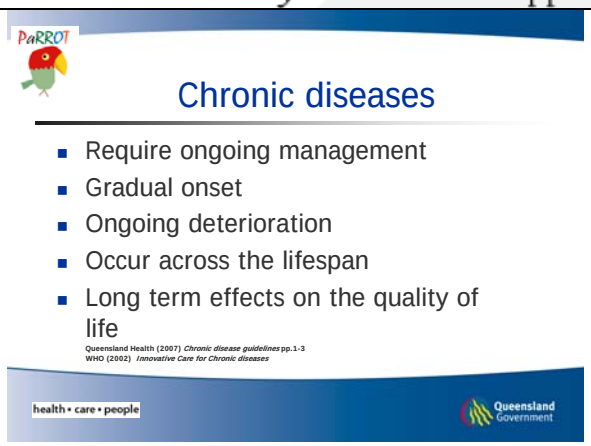
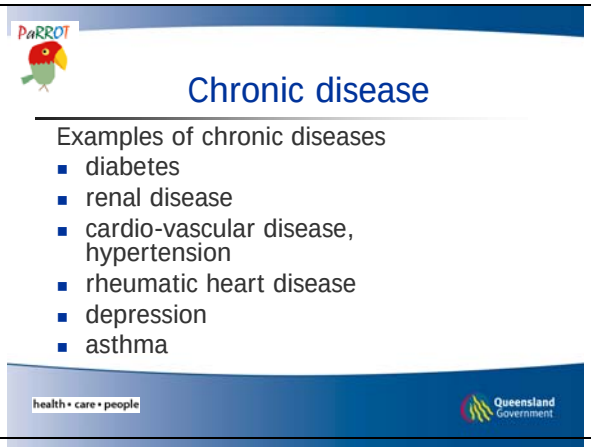
Many factors determine and influence health. It is now understood that health status results from a complex interaction of social, economic, environmental, behavioural and genetic factors. Health determinants are those factors that have either a positive or a negative influence on health at the individual or population level. Health determinants can be broadly divided into upstream determinants (education, employment, and income, living and working conditions), midstream determinants (health behaviours, supportive environments and psychosocial factors) and downstream determinants (physiological and biological factors)." [1].

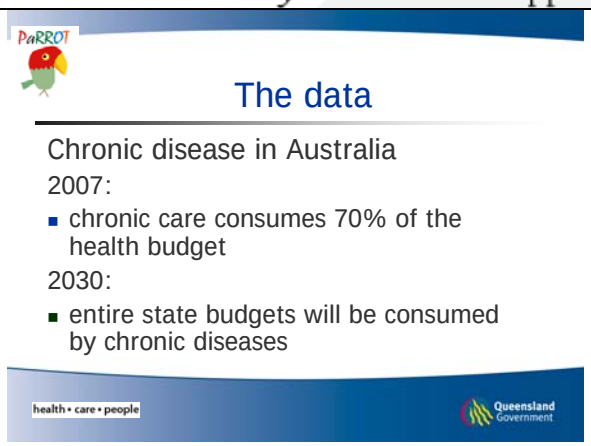
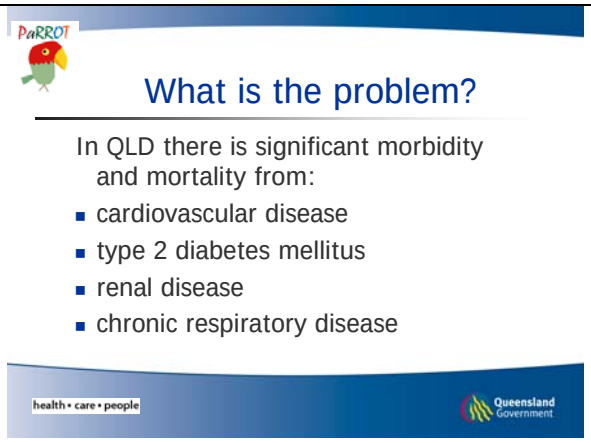
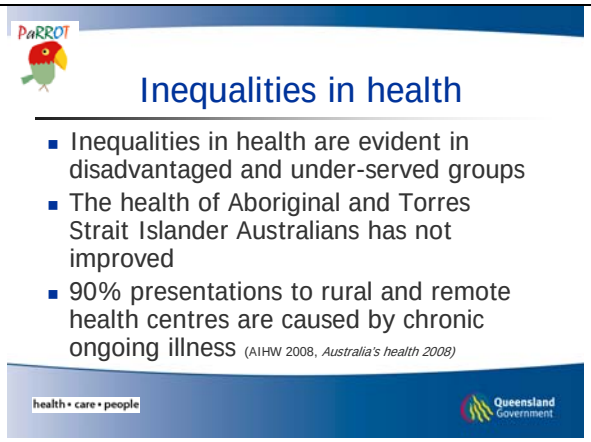
This unit introduces chronic disease and defines what chronic conditions are. It looks at the costs associated with managing chronic disease and explores ways in which we, as primary health care practitioners can help stem the tide. The next unit looks specifically at chronic disease and the Aboriginal and Torres Strait Islander communities, which, as cited above, are one of the groups carrying an uneven burden of chronic disease.

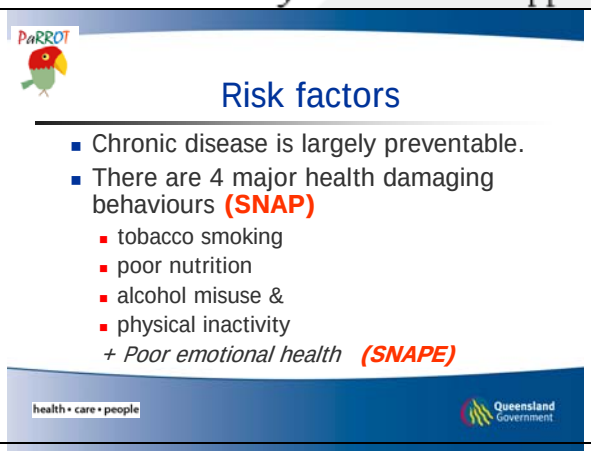
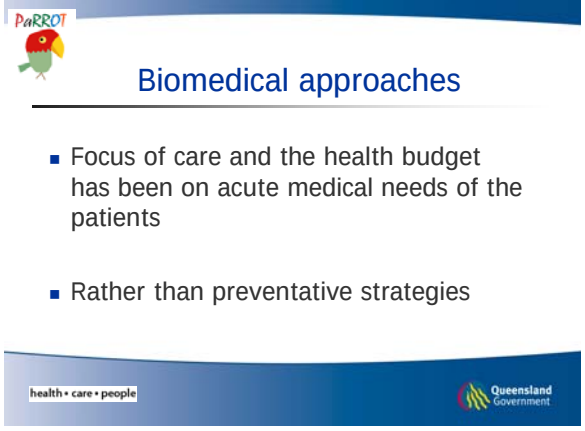
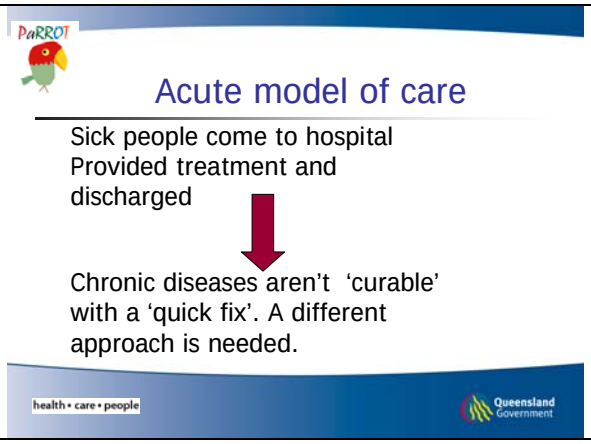
Presentation

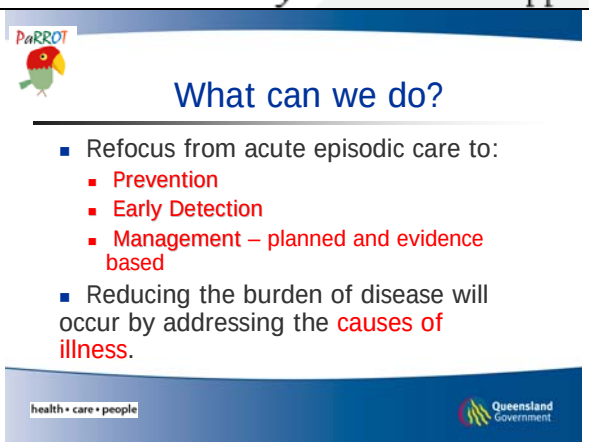
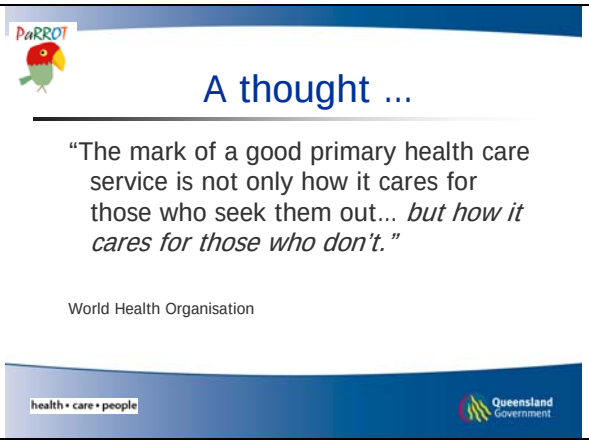
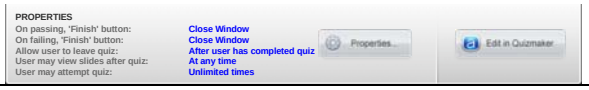


Slide 1 **Introduction to Chronic Disease**		Notes:
Slide 2 **Learning objectives**		Notes:
Slide 3 **Key concepts**		Notes: The key concepts associated with chronic disease will be explored in detail in this unit.

Slide 4 **Chronic diseases**		Notes: Chronic diseases are: Diseases that require ongoing management over a period of years or decades. They have a gradual onset with ongoing deterioration Chronic diseases occur across the lifespan, so are more prevalent in older age. Age is the greatest risk for chronic disease. Chronic diseases have long term effects on quality of life including physical limitations disability and social and emotional well being.
Slide 5 **Chronic disease**		Notes: Chronic diseases are caused by multiple complex inter-relating causes and the determinants of health
Slide 6 **Determinants of health**		Notes: Determinants of health include: Social, economic & environmental factors e.g. living diseases, working environments, education, income, food quality, water & air quality, social support, age, geographic location, Aboriginal and Torres Strait Islander & ethnic status Health behaviours and risk factors - unhealthy lifestyles e.g. smoking, risky alcohol drinking, poor nutrition, lack of physical activity, unsafe sex, poor social & emotional health, early childhood development

Slide 7 **The data**		Notes: The burden of Chronic disease in Australia is becoming unmanageable. In 2007 2.5 million Australians had a chronic disease which is the leading cause of hospital admissions and preventable deaths. Chronic disease care consumes 70% of the health budget. By 2016 it is projected that 3.5 million Australians will have a chronic disease and by 2030 entire state budgets will be consumed by chronic diseases (Battersby, 2008) There is a belief that the children of today will have a shorter lifespan then their parents if factors leading to the development of chronic diseases are not addressed now.
Slide 8 **What is the problem?**		Notes: In Queensland there is significant morbidity and mortality from chronic disease. This means large numbers of Queenslanders are battling poor health which is impacting on their ability to work, earn a living, and live a fulfilling lifestyle. This is also costing the government significant amounts of money, and impacting on the ability to provide a sustainable, preventative health service.
Slide 9 **Inequalities in health**		Notes: Although the burden of chronic disease in Queensland is great, Aboriginal and Torres Strait Islander people carry an even greater burden. Their life expectancy is on average 10 years less than non-Aboriginal and Torres Strait Islander people Those living in rural and remote settings also experience a greater burden, with 90% of presentation to rural and remote health services being related to chronic disease.

Slide 10 **Risk factors**		Notes:
Slide 11 **Biomedical approaches**		Notes: Focus of care and the health budget has been on acute medical needs of the patients which in many cases is expensive and does little to fix the cause of the disease for example iinterventions and treatments such as dialysis, coronary and bypass surgery of those with an existing chronic disease. There is also the added out of pocket costs to the patient, such as travel and medications, along with inconvenience. Rather than on preventative strategies, which in the long term are more cost effective, for example health promotion and early detection in the well or at risk population
Slide 12 **Acute model of care**		Notes:

Slide 13 **What can we do?**		Notes: In order to reduce the incidence of chronic disease, the focus of care should be widen to ensure it is not just acute care that is being provided. Chronic disease care should be approached across the domains of prevention, early detection – including management of risk factors, and ongoing management once a chronic disease has developed. The focus needs to be on the causes of illness not just on illness management.
Slide 14 **A thought …**		Notes:
Slide 15 **Learning Activity**		Notes:

Learning Activity - Facilitator

Information for facilitators

This activity can be conducted as a brainstorming. Participants can either complete this activity prior to or after the brainstorming. Please copy, scan and email it to parrot@health.qld.gov.au or fax it to 4033 3040 and keep a copy for your records.

Questions

1. What are the main chronic diseases or risk factors in your community?
(Short answer Question)

Feedback:
These answers will depend on the community in question. It is expected a number of communities will have high numbers of patients with diabetes, renal disease, cardiac disease and respiratory disease. Risk factors are likely to include smoking, alcohol and substance use, overweight and obesity, poor nutritional status, poor dental health, hypertension, asthma etc.

2. How can you or your profession contribute to?
1) Promoting wellness? *(Short answer Question)*

Feedback:
Answers here might include health promotion programs which may include involvement in community education, development and distribution of information pamphlets, etc. immunisation programs, sexual and reproductive health promotion.

2) Preventing illness *(Short answer Question)*
Feedback:
Targeted health promotion programs like Smoke Check, Nutrition, dental or environmental health programs, nose blowing and ear care programs.

3) Early detection? *(Short answer Question)*
Feedback:
Screening programs like health checks, sexual health, breast, cervical cancer, bowel and child health screening

4) Chronic disease management? *(Short answer Question)*
Feedback: Self-management programs, falls prevent, rehabilitation, cardiac rehabilitation etc

Learning Activity Participant

Information for Participants

This activity will be conducted as a brainstorming which will be led by your facilitator. Your facilitator may get you to complete this activity prior to the brainstorming or you can complete it after the brainstorming. Please submit a copy of this to your facilitator who will scan and email it to parrot@health.qld.gov.au or fax it to 4033 3040 and keep a copy for your records.

Questions

1. What are the main chronic diseases or risk factors in your community?
(Short answer Question)

2. How can you or your profession contribute to?

1) Promoting wellness? *(Short answer Question)*

2) Preventing illness *(Short answer Question)*

3) Early detection? *(Short answer Question)*

4) Chronic disease management? *(Short answer Question)*

Session 2

This unit has looked at the causes of chronic diseases, reviewed the issues associated with managing the increasing burden and identified the need for some major changes in the way in which we deliver health care, in order to stem the tide of growth in chronic conditions in our community.

The Queensland Strategy for Chronic Disease clearly identifies the issues, and has included a number of strategies which need to be implemented in order to reduce the incidence of chronic disease. As primary health care practitioners there are a number of things we can do, they include:

- Maintaining continuity of care using evidence based guidelines, policies and primary health information systems.
- Adopting a comprehensive primary health care approach to practice.
- Working collaboratively in multidisciplinary teams
- Providing programs that promote and maintain wellness, detect and prevent ill health and manage chronic conditions.
- Working in partnership with community and clients to develop the capacity of individuals and the community.
- Contributing to the monitoring and evaluation of primary health inputs, outputs and outcomes using quality processes including the ABCD Project (Menzies School Population Health) and
- Ensuring knowledge and practice is current and evidence based.

If every health professional working in primary health care is able to incorporate the entire list into practice, then we will go a very long way in assisting with the reduction of the burden of chronic disease.

Quiz - Facilitator

Property	Setting
Passing Score	50% or 19/38
Total Number of Questions	4
Total Number of Questions to Ask	All

Information for Facilitators

Give the participant version of this quiz to participants at the end of the unit. Allow them 10 to 15 minutes to complete. Information on the questions can be found in the session notes and presentation story board. They can do the quiz individually or in pairs. Once the quiz has been completed, hand out the answer sheet and get the participants to self mark.

Please scan and email the answer sheets to parrot@health.qld.gov.au or copy and fax to 40333040. You can choose to keep a copy for yourself and give the original to the participants for their records.

Questions

1. How is chronic disease defined? *(Essay Question, 10 points)*

Feedback:
Chronic diseases are conditions that require ongoing management over a period of years or decades (2 points). They have a gradual onset (2 points) with ongoing deterioration (2 points). They occur across the lifespan (2 points), so are more prevalent in older age (2 points). There is a saying that age is the greatest risk for chronic disease and has long term effects on the quality of life including physical limitations and disability.

2. The four conditions causing significant morbidity and mortality in Queensland are:
(Multiple Response Question, 8 points – 2 per each correct answer)

Correct	Choice
✓	Cardio-vascular disease
✓	Type 2 Diabetes Mellitus
✓	Renal disease
✓	chronic respiratory disease
	liver disease
	cancer
	mental illness
	arthritis

3. Name the five lifestyle behaviours that are the main determinants of chronic disease?
(Fill in the Blank Question, 10 points- 2 per correct answer)

Correct answers
Tobacco smoking
Smoking
Poor nutrition
Bad nutrition
Alcohol use
Alcohol misuse
Physical inactivity
Lack of exercise
Poor emotional health
Mental illness

4. Why is it important we start reducing the incidence of chronic disease now?
(Essay Question, 10 points)

Feedback:
The incidence of chronic conditions is growing with the costs of managing the conditions becoming unmanageable (2 points). By 2030 at the rate of growth today, it is estimated the entire health budgets will be taken up with the costs for chronic disease care (2 points). The growth is also putting a burden on the health system (2 points) and the increased incidence of morbidity and premature mortality (2 points) associated with chronic disease care is impacting greatly on lifestyles and ability to work and earn a living(2 points) .

Quiz Participant

Property	Setting
Passing Score	50% or 19/38
Total Number of Questions	4
Total Number of Questions to Ask	All

Information for Participants

Please complete the following quiz individually or in pairs. The scores for each question are indicated in the question. Information for your answers can be found in the session notes and or the presentation story board which are included in your participant package. Once the quiz has been completed, your facilitator will provide and answer sheet for you to self mark. The quiz should take 10 to 15 minutes to complete.

Your facilitator will scan and email the answer sheets to parrot@health.qld.gov.au or copy and fax to 40333040. They may keep a copy for themselves for their records and give the original copy to you for your records.

Questions

1. How is chronic disease defined?

(Essay Question, 10 points)

2. The four conditions causing significant morbidity and mortality in Queensland are:

Please tick the correct answers 8 points

Correct	Choice
☐	Cardio-vascular disease
☐	liver disease
☐	Type 2 Diabetes Mellitus
☐	mental illness
☐	Renal disease
☐	chronic respiratory disease
☐	cancer
☐	arthritis

3. Name the five lifestyle behaviours that are the main determinants of chronic disease?

(10 points- 2 per correct answer)

4. Why is it important we start reducing the incidence of chronic disease now?

(Essay Question, 10 points)

Bibliography

Australian Institute of Health & Welfare (2008). *Australia's health 2008* (Chap. 4. Determinants – keys to prevention) http://www.aihw.gov.au/publications/aus/ah08/ah08-c04.pdf

Chronic diseases & associated risk factors in Australia (2006)
http://www.aihw.gov.au/publications/index.cfm/title/10319 National Chronic Disease Strategy

CDS & National Service Improvement Frameworks
http://www.aodgp.gov.au/internet/main/publishing.nsf/Content/pq-ncds-strat

QLD Strategy for Chronic Disease 2005-2015
http://www.health.qld.gov.au/publications/corporate/chronstrat2005/default.asp

Smith, J.D. (2007). *Australia's rural and remote health: A social justice perspective*. (2nd ed.). Croydon, Vic: Tertiary Press.

Queensland Health and the Royal Flying Doctor Service (Queensland Section)(2007). *Chronic Disease Guidelines* 2nd Edition. Cairns

World Health Organisation report, *Preventing Chronic Diseases a vital investment*. 2006

PaRROT Pathways to Rural and Remote Orientation and Training

a Primary Health Care approach to Chronic Disease

Orientation

Unit 3

Queensland Strategy for Chronic Disease

Session Plan

Session 1 — Queensland Strategy for Chronic Disease

Location

Synopsis: Performance outcomes, skills and knowledge required to understand the Queensland Strategy for Chronic Disease.

Learning outcomes

Understand the Scope of the Queensland Strategy for Chronic Disease

Understand the approach to Chronic Disease Care

Understand the importance of the Strategy

Be able to access and utilise the information in the strategy document

Time allocated	How will session run	Delivery method & resources equipment	Assessment
10 minutes	**Introduction** 3. INTROA 4. Learning Objectives	Session 1 notes Presentation	
25 minutes	**Content (See detailed notes)**	Presentation	
10 minutes	**Activity** Brainstorming 3 questions. Journal entry	Activity sheet	Journal
5 minutes	**Wrap up**	Session 2 notes	
10 minutes	**Assessment** Complete quiz – self mark using answer sheet.	Quiz	Quiz – self mark
	Close		

Detailed Session Notes

Slide	Slide Title	Notes
1	**Session title**	Queensland Strategy for Chronic Disease
Session 1 notes and slide 2	**Introduction** **Interest** (Create Interest) **Need** (Explain why they need to know) **Topic** (What the session is about) **Range** (What will be covered) Introduction to topic	Session 1 notes introduces the unit – use this as the basis of the introduction. • Information on the Queensland Strategy for Chronic Disease which provides the context for the PaRROT training program. • A learning activity asking you to reflect on the document and its application in your daily work • A Journal entry which will be submitted at the end of the orientation module • Quiz for self marking
2	**Learning Objectives** **Outcomes** (What they will achieve) **Assessment** (How they will be assessed)	• Understand the Scope of the Queensland Strategy for Chronic Disease • Understand the approach to Chronic Disease Care • Understand the importance of the Strategy • Be able to access and utilise the information in the strategy document • Complete the quiz to demonstrate understanding of the unit.
3	**What is the QSCD?**	The QSCD was endorsed in Queensland in 2005. It is A strategic, systems-based approach to changing the way we deliver health services to prevent and manage chronic diseases.
4	**What does the QSCD aim to do?**	The QSCD is a plan of action designed to address the growing levels of chronic diseases in the population through prevention, early detection and management of disease. Standardised evidence based guidelines, such as the 'Chronic Disease Guidelines' are supported within the QSCD. The QCDS focus is on the whole populations, not just those who already have a chronic disease.
5	**Approach**	The QSCD has a three pronged population based approach incorporating: Primary Prevention - aims to prevent and reduce risk factors by: • raising community awareness and promoting consistent messages • encouraging behaviour change that promotes health and well being • increasing workforce capacity to reduce population risk factors • creating healthy environments • focusing on the early years of life, children and younger people • monitoring and surveillance, evaluation and intervention research Secondary Prevention - early detection and management of disease markers • age and risk appropriate screening • health checks • management of risk factors, e.g. smoking, blood pressure, hypercholesterolemia Management and tertiary prevention – management of existing conditions • acute primary health care interface • ongoing management of condition e.g. care plan and recall palliative care and rehabilitation

Slide	Slide Title	Notes
6	**Population approach**	The population approach to chronic disease includes programs such as immunisation, addressing risk factors at community level and community based screening.
7	**A population approach**	This slide shows a series of pictures of clients receiving care. Point out the different levels of care demonstrated in the pictures. Note the ages of the clients and the various levels of interaction they are receiving.
8	**Conceptual framework (i)**	This part of the conceptual framework identifies chronic disease **interventions** that are aimed at the whole population at various stages across the health continuum, from wellness (known as primary prevention) to those "at risk" (known as secondary prevention), through to management of chronic conditions (also known as tertiary prevention).
9	**QSCD Conceptual Framework (ii)**	This part of the conceptual framework was adapted from the World Health Organisation (WHO) Innovative Care for Chronic Conditions framework. It identifies the support systems (known as enablers) for the delivery of chronic disease prevention, early detection and management across the life and acuity continuum.
10	Learning Activity	Split the group into 4 and give each smaller group some butchers paper and a copy of the QSCD. Ask each group to complete 1 question. Bring the groups back together and discuss the answers – ask participants to copy the answers onto their answer sheet. Please copy, scan and email it to parrot@health.qld.gov.au or fax it to 4033 3040 and keep a copy for your records.
Session 2 notes	**Wrap up**	Use session 2 notes to wrap up.
	Quiz	Ask participants to complete the quiz – they have 10 minutes now and if not finished come back to it later. Get them to swap with the person next to them and mark their answers. Quizzes should be collected and photocopied and the originals returned to the participants.
	Questions	

Session 1

Welcome to the PaRROT Queensland Strategy for Chronic Disease (QSCD) unit.

The QSCD was developed in response to the increasing burden of preventable chronic diseases on health services. It is being progressed through partnerships, and strives to involve all stakeholders working in prevention, early detection and management of chronic disease [1].

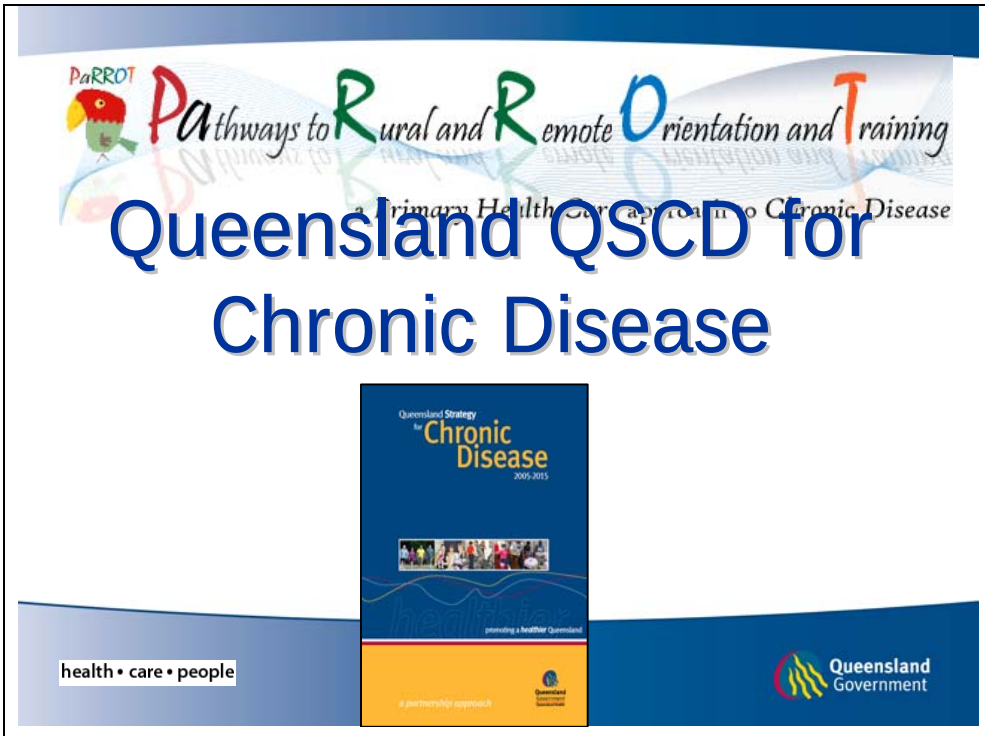
In rural and remote areas these processes are further supported by system enablers including:

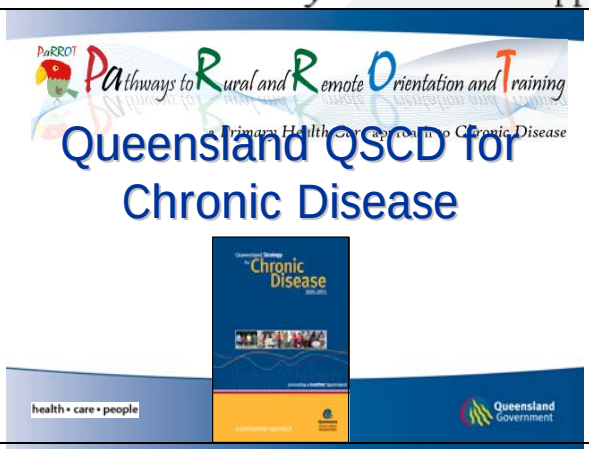
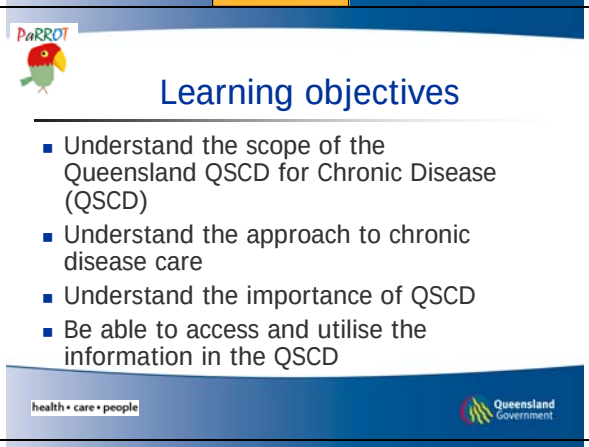
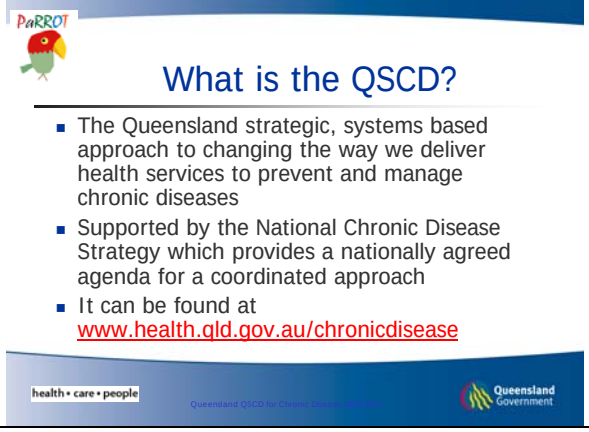
- Evidence based clinical guidelines
- Quality improvement processes
- Workforce capacity
- Partnerships and
- Electronic support.

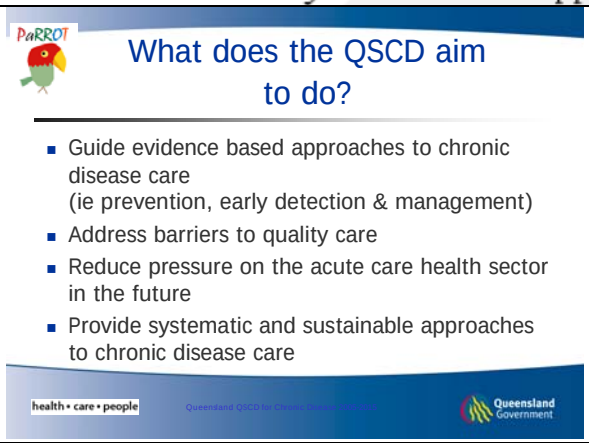
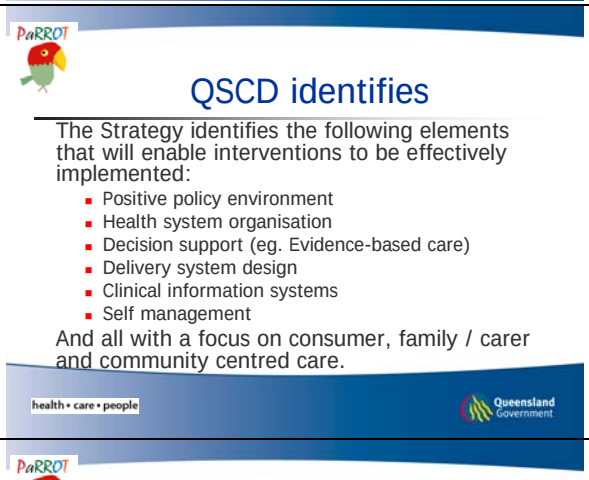
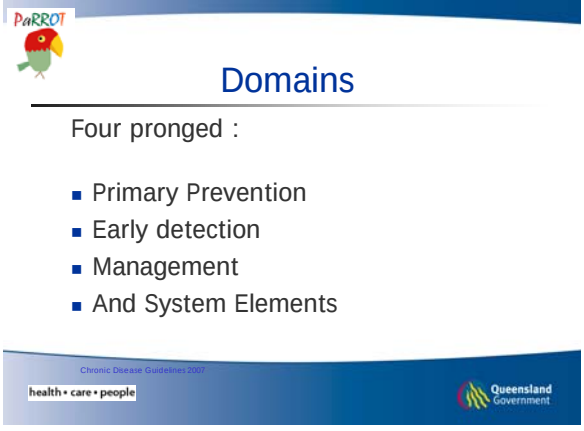
In order to implement and ensure chronic disease prevention and management is the focus of service delivery, it was recognised that health professionals working in the area needed to re focus on delivering population based comprehensive primary health care over both the life and acuity continuum. It was also recognised that health professionals working in rural and remote areas required systematic and population based training instead of the traditional focus on acute and episodic care.

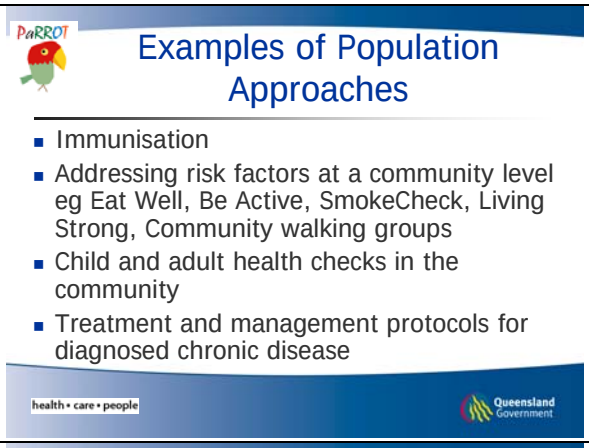
This unit will introduce you to the QSCD and explain the link between it, comprehensive primary health care and the work you will be doing in rural and remote areas in Australia. It will also look at the way the strategy has been implemented in rural and remote Queensland and alert you to any differences between the two. You aren't expected to remember the QSCD in detail, just to be aware of it, and understand how it all links together.

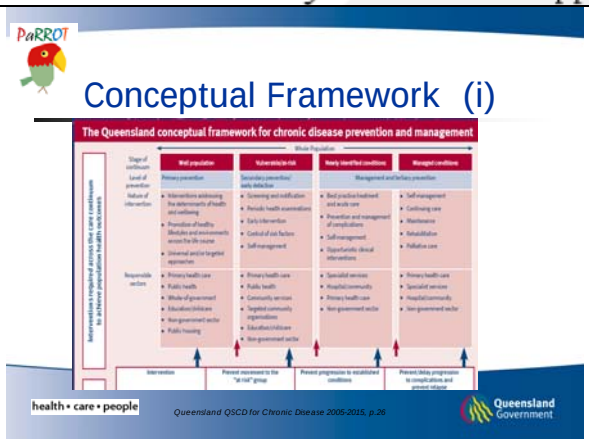
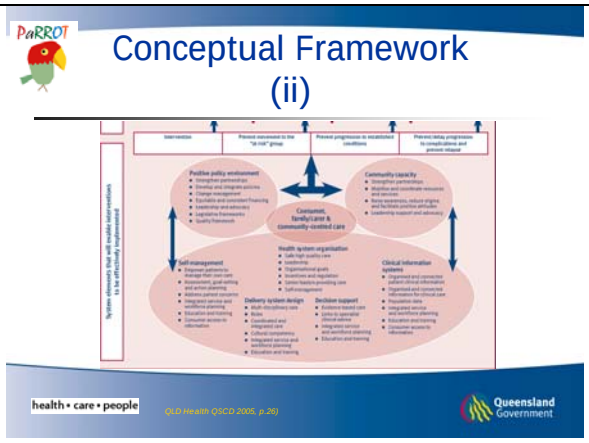
Presentation

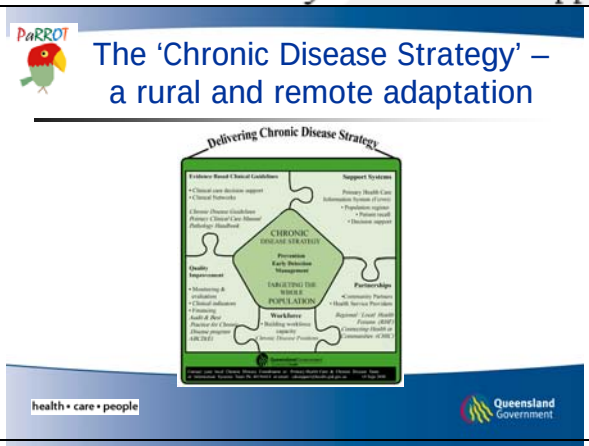
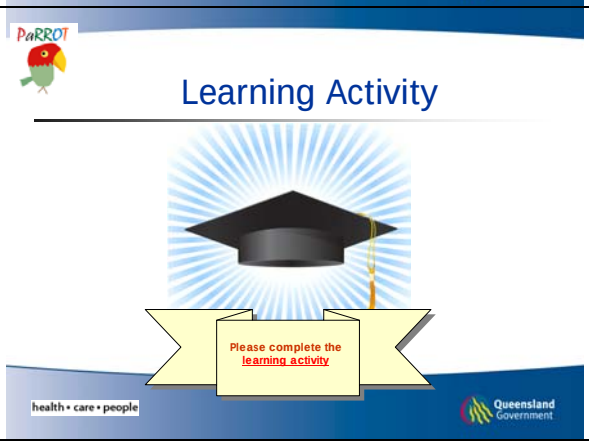


Slide 1 **Queensland QSCD for Chronic Disease**		Notes:
Slide 2 **Learning objectives**		Notes:
Slide 3 **What is the QSCD?**		Notes: The QSCD was endorsed in Queensland in 2005. It is a strategic, systems-based approach to changing the way we deliver health services to prevent and manage chronic diseases.

Slide 4 **What does the QSCD aim to do?**		Notes: The QSCD is a plan of action designed to address the growing levels of chronic diseases in the population through prevention, early detection and management of disease. The QSCD focus is on the whole population, not just those who already have a chronic disease.
Slide 5 **QSCD identifies**		Notes:
Slide 6 **Domains**		Notes: The QSCD has a four pronged population based approach incorporating: Primary Prevention - aims to prevent and reduce risk factors by: raising community awareness and promoting consistent messages encouraging behaviour change that promotes health and well being increasing workforce capacity to reduce population risk factors creating healthy environments focusing on the early years of life, children and younger people monitoring and surveillance, evaluation and intervention research Secondary Prevention - early detection and management of disease markers age and risk appropriate

		screening health checks management of risk factors, e.g. smoking, blood pressure, hypercholesterolemia Management and tertiary prevention – management of existing conditions acute primary health care interface ongoing management of condition e.g. careplan and recall palliative care and rehabilitation System Elements
Slide 7 **Examples of Population Approaches**		Notes: The population approach to chronic disease includes programs such as immunisation, addressing risk factors at community level and community based screening. Also, providing protocols that enable evidence-based, standardised care will address the population of people with diagnosed chronic disease.
Slide 8 **A population approach**		Notes: This slide shows examples of the various approaches to chronic disease in the community. Note the ages of the clients and the various levels of interaction they are receiving.

Slide 9 **Conceptual Framework (i)**		Notes: This part of the conceptual framework identifies chronic disease interventions that are aimed at the whole population at various stages across the health continuum, from wellness (known as primary prevention) to those "at risk" (known as secondary prevention), through to management of chronic conditions (also known as tertiary prevention).
Slide 10 **Conceptual Framework (ii)**		Notes: This part of the conceptual framework was adapted from the World Health Organisation (WHO) Innovative Care for Chronic Conditions framework. It identifies the support systems (known as enablers) for the delivery of chronic disease prevention, early detection and management across the life and acuity continuum. The Strategy identifies the following elements that will enable interventions to be effectively implemented: Positive policy environment Health system organisation Decision support (eg. Evidence-based care) Delivery system design Clinical information systems Self management And all with a focus on consumer, family / carer and community centred care.

Slide 11 **The 'Chronic Disease Strategy' – a rural and remote adaptation**		Notes: This framework was developed for rural and remote Queensland and is known as the 'Chronic Disease Strategy'. It is a local adaptation of the WHO Innovative Care for Chronic Conditions Framework and QSCD. It has been endorsed by the Office of Rural and Remote Health as the preferred model for the local adaptation of the QSCD.
Slide 12 **Learning Activity**		Notes:

Learning Activity - Facilitator

Information for facilitators

Split the group into 4 and give each smaller group some butchers paper and a copy of the QSCD. Ask each group to complete 1 question. Bring the groups back together and discuss the answers – ask participants to copy the answers onto their answer sheet. Please copy, scan and email it to parrot@health.qld.gov.au or fax it to 4033 3040 and keep a copy for your records.

Quiz Settings

Property	Setting
Total Number of Questions	4
Total Number of Questions to Ask	All

1. Now that you have viewed the presentation, could you take a few minutes to think about how the QSCD applies to the work you will be doing in rural and remote Australia.

Feedback:
Responses to this will depend on your experiences with primary health care and the type of services you are providing. Most of you, however, will have experience working in prevention, early detection and management programs which form the basis of the QSCD.

2. How does the QSCD relate to primary health care?

Feedback:
The approach to preventing and managing chronic disease is in line with comprehensive primary health care. It supports a collaborative, cross sector approach which addresses the social determinants of health, acknowledges the impact of the environment on health and takes an individual, family, community and population view on prevention, early detection and management of chronic disease.

3. How will the conceptual framework on page 26 help with clinical service planning?
Feedback:
It provides the domains which form the basis for the development of services. By matching services to the domains, it becomes easier to group activities, identify gaps and provide direction for current and future services.

4. How will knowledge and understanding of the QSCD benefit you?
Feedback:
Knowledge of the framework will put primary health care and chronic disease into perspective. Knowing and understanding the intent of the strategy will help raise awareness of the different domains associated with chronic disease care, and may

influence local service clinical activities, the approach to care, program development and utilisation of information technology. It will also provide guidance in the reorientation of an individual's and team's approach to care, from acute and reactive to preventative and management.

Learning Activity - Participant

Information for participants

Your facilitator will split the group will be split into 4 smaller groups and given butchers paper and a copy of the QSCD. Each smaller group will be asked to answer 1 question, once this is done the groups will be brought back together and discuss the answers – you will be asked to copy the answers onto your answer sheet. Please copy, scan and email it to parrot@health.qld.gov.au or fax it to 4033 3040 and keep a copy for your records.

Quiz Settings

1. Now that you have viewed the presentation, think about how the QSCD applies to the work you will be doing in rural and remote Australia.

2. How does the QSCD relate to primary health care?

3. How will the conceptual framework on page 26 of the QSCD help with clinical service planning?

4. How will knowledge and understanding of the QSCD benefit you?

Session 2

The QSCD is for health professionals working in rural and remote areas to be aware of as it

- Provides a framework for Service development and delivery
- Reorientates our approach to chronic disease care from management to prevention
- Supports a Comprehensive Primary Health and systematic approach to chronic disease care including prevention, early detection and management.

Our practice in rural and remote areas needs to be developed using the QSCD as a guide to ensure consumer, family and community-centred care is being delivered. The Chronic Disease Strategy is an example of this.

Now that you have viewed the presentation on the QSCD and completed the reflection activity, you should be more aware of the document and its application to your role in health care. Please complete the quiz using the following link. The correct answers can be accessed once you have answered all the questions.

For more information specific to nurses please complete the Chronic Disease Modules in the Rural and Remote Nurses orientation program.

More information can also be found in the Chronic Disease Guidelines [1]

Quiz - Facilitator

Information for Facilitators

Give the participant version of this quiz to participants at the end of the unit. Allow them 10 to 15 minutes to complete. Information on the questions can be found in the session notes and presentation story board. They can do the quiz individually or in pairs. Once the quiz has been completed, hand out the answer sheet and get the participants to self mark.

Please scan and email the answer sheets to parrot@health.qld.gov.au or copy and fax to 40333040. You can choose to keep a copy for yourself and give the original to the participants for their records.

Property	Setting
Passing Score	50% or 17/34
Total Number of Questions	7
Total Number of Questions to Ask	All

Questions

1. What 4 diseases have been identified as the focus for initial action for the Queensland Strategy for Chronic Disease? *(Multiple Response Question, 8 points, 2 for each correct answer)*

Correct	Disease
✓	Type 2 Diabetes Mellitus
	Cancer
✓	Cardio-vascular disease
	Skin disease
✓	Renal Disease
✓	Chronic respiratory disease
	Liver disease
	Arthritis

2. What underlying risk factors are being addressed through the Queensland Strategy for Chronic Disease? *(Multiple Response Question, 8 points, 2 for each correct answer)*

Correct	Risk factor
	Sun exposure
✓	Poor nutrition
✓	Alcohol misuse
	Illicit drug use
✓	Physical inactivity
	Mental illness
✓	Tobacco smoking
	Prescription drug misuse

3. Match the domain of intervention with the activity *(6 points, 2 per each correct answer)*

Domain	Correct answer
Prevention	Health promotion
Early detection	Screening and notification
Management	Preventing and managing complications

4. Which choice is an example of a decision support tool? *(2 points)*

Correct	Example
	On line learning program
✓	Evidence based guidelines
	Primary health information system
	Medicare

5. Which of the following are examples of community capacity building?
(Multiple Response Question, 6 points – 2 per correct answer)

Correct	Choice
✓	Health Action Groups
✓	Community forums
	Staff training
✓	Healthy lifestyle groups
	Provision of clinics
	Environment Health assessments

6. Training programs for the workforce are an example of delivery system design?
(True/False Question, 2 points)

Correct	Choice
✓	True
	False

7. Which choice is an example of a clinical information system?
(2 points,)

Correct	Choice
	Walking group
✓	Primary health information system
	Primary Clinical Care Manual
	On line training program

Quiz - Participants

Information for Participants

Please complete the following quiz individually or in pairs. The scores for each question are indicated in the question. Information for your answers can be found in the session notes and or the presentation story board which are included in your participant package. Once the quiz has been completed, your facilitator will provide and answer sheet for you to self mark. The quiz should take 10 to 15 minutes to complete.

Your facilitator will scan and email the answer sheets to parrot@health.qld.gov.au or copy and fax to 40333040. They may keep a copy for themselves for their records and give the original copy to you for your records.

Property	Setting
Passing Score	50% or 17/34
Total Number of Questions	7
Total Number of Questions to Ask	All

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	Illicit drug use
	Physical inactivity
	Mental illness
	Tobacco smoking
	Prescription drug misuse

3. Match the domain of intervention with the activity *(6 points, 2 per each correct answer)*

Domain	Correct answer
Prevention	Managing chronic conditions
Early detection	Health promotion
Management	Screening and notification

4. Which choice is an example of a decision support tool? *(2 points)*

Correct	Example
	On line learning program
	Evidence based guidelines
	Primary health information system
	Medicare

5. Which of the following are examples of community capacity building?
(6 points – 2 per correct answer)

Correct	Choice
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(True/False Question, 2 points)

Correct	Choice
	True
	False

7. Which choice is an example of a clinical information system?
(2 points,)

Correct	Choice
	Walking group
	Primary health information system
	Primary Clinical Care Manual
	On line training program

Bibliography

1. Queensland Health. (2005). *Queensland Strategy for Chronic Disease 2005-2015*. Retrieved. from http://www.health.qld.gov.au/chronicdisease/documents/strat2005to15_full.pdf

2. Queensland Health and the Royal Flying Doctor Service (Queensland Section). (2007). *Chronic Disease Guidelines* (2nd ed.). Cairns.

PaRROT Pathways to Rural and Remote Orientation and Training

a Primary Health Care approach to Chronic Disease

Orientation

Unit 4

Chronic Disease Strategy—Rural and Remote

Session Plan

Session: Chronic disease strategy – rural and remote

Location

Overall Session Time: **1 Hour**

Synopsis Performance outcomes, skills and knowledge required to understand the system supports or enablers required to develop and deliver effective chronic disease programs

Learning outcomes Be familiar with the Chronic Disease Strategy – Rural and Remote
Understand each component of the strategy
Be able to apply the strategy to daily practice.

Time allocated	How will session run	Delivery method & resources equipment	Assessment
10 minutes	**Introduction** 5. INTROA 6. Learning Objectives	Session 1 notes Presentation	
25 minutes	**Content (See detailed notes)**	Presentation	
10 minutes	**Activity** Application of model	Activity sheet	
5 minutes	**Wrap up**	Session 2 notes	
10 minutes	**Assessment** Complete quiz – self mark using answer sheet.	Quiz	Quiz – self mark
	Close		

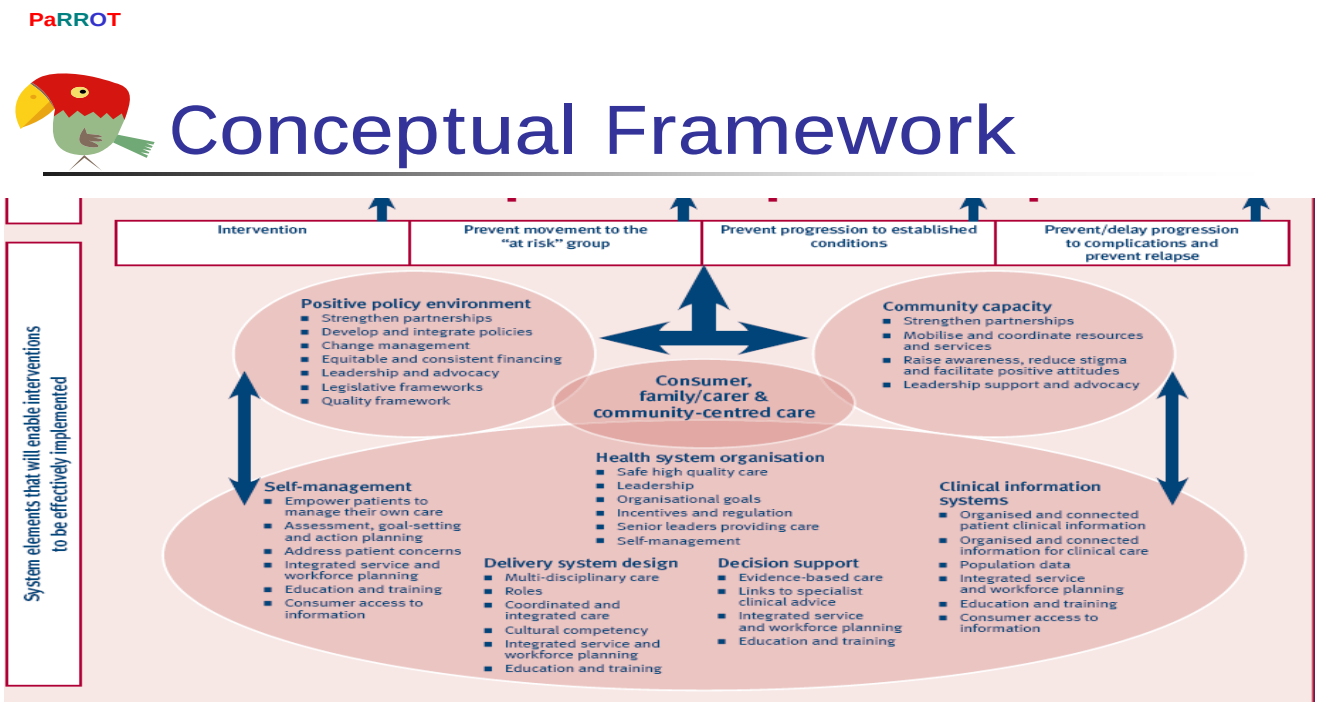
Detailed Session Notes		
Slide	**Slide Title**	**Notes**
1	**Session title**	Chronic Disease Strategy – Rural and Remote
Session 1 notes	**Interest** (Create Interest) **Need** (Explain why they need to know)	Effective delivery of primary health care services requires a systematic and supported approach to service delivery. The components of the support system need to link with each other in order for the service to be delivered effectively and efficiently. In order to develop and deliver effective primary health and chronic disease programs a basic understanding of the support systems is required.
Session 1 notes	**Introduction:** **Topic** (What the session is about) **Range** (What will be covered)	This unit will look at the support systems incorporated in both the Queensland Strategy for Chronic Disease and the Chronic Disease Guidelines and discuss in detail the components of the Chronic Disease Guidelines systems enablers
2	**Learning Objectives** **Outcomes** (What they will achieve) **Assessment** (How they will be assessed)	Be familiar with the Chronic Disease Strategy in rural and remote settings Understand the components of the rural and remote model for chronic disease Be able to apply the model to daily practice Learning activity and self-marking quiz
3	**What is it?**	The Chronic Disease Strategy – Rural and Remote is an implementation of the QSCD. It provides a holistic chronic disease program in rural and remote areas.
4	**Chronic Disease Strategy Rural and Remote**	The 'chronic Disease strategy' provides a model for service development and delivery. It reorientates the approach to chronic disease from management along t the inclusion of preventive approaches. It supports a comprehensive and systematic approach to chronic disease care including prevention, early detection and management.
5	**Life Continuum**	The Chronic Disease Strategy can be viewed across two continuums. • Acuity continuum - action at the prevention, early detection and management levels, and • Life continuum - strategies across the life span At each level, certain activities are recommended to ensure that prevention, early detection and management is happening uniformly
6	**Model for Rural and Remote Areas**	The model for rural and remote areas identifies the support system or enablers that are required to ensure the development and implementation of supported primary health care and chronic disease programs in rural and remote areas.
7	**Levels of Intervention**	In the centre of the model the levels or domains of intervention are identified. • Prevention includes health promotion health education, immunisation and environmental health • Early detection includes screening and brief interventions and • Management includes management of chronic diseases using protocols, care plan development and implementation and self management. Primary health care must be provided to the individuals taking into consideration their families and communities.
8	**Clinical guidelines**	Clinical guidelines are required to ensure practice is standardised, evidence based, safe and in line with agreed protocols, policy and legislative guidelines

Detailed Session Notes		
Slide	**Slide Title**	**Notes**
9	**Electronic support**	The current electronic support system is Ferret. It includes both a population register and patient recall system, but also supports decision making by providing information on what needs to be followed up, by whom and how in the form of a care plan. Care plans on Ferret are updated in line with the updates to the Primary Clinical Care Manual and Chronic Disease Guidelines. Population data can be retrieved from Ferret and used for community profiles and for planning purposes for scheduling visiting services and planned screening activities.
10	**Quality improvement**	Quality improvement using the ABCD program is: • Required to monitor and evaluate practice by regularly auditing practice at service delivery sites. • Supported by clinical indicators which have been developed at federal, state and local levels in line with the health Indicators of Queensland. • Used to identify gaps and support development of services
11	**Partnerships**	The development of partnerships ensures there is a collaborative approach to services. The partnerships need to include as many agencies working in health, as possible. This ensures the services are owned by the community and are therefore likely to be more sustainable. There have been a number of successful partnerships, such as the Regional Health Forums and the CHIC (Connecting Health Care in Communities). These partnerships improved service coordination, upstream health promotion, shared referral pathways and limit duplication in service provision. Regional and local health forums and community health action groups are also supporting community control of health care.
12	**Workforce**	One of the greatest challenges in rural and remote areas is recruitment and retention of the workforce. A number of projects have commenced to ensure both recruitment and retention of a quality trained workforce. Some of the projects are: • PaRROT orientation and training project • Office of Chief Nursing Officer (OCNO) rural and remote Nurses Orientation Program • Services for Australian Rural and Remote Allied Health (SARRAH). In order to ensure chronic disease prevention, early detection and management remains a priority, a number of Chronic Care Coordinator positions have been funded for the Districts. These positions are supported and receive some training from the Office of Rural and Remote Health. Further information and support is provided to Districts through regular newsletters and other chronic disease and primary health care training.
13	**Chronic Disease Guidelines**	The chronic disease guidelines contain an outline of the policy framework and system enablers for the Chronic Disease QSCD, along with evidence based protocols for screening, early detection and management of chronic disease.
Act Sheet	**Application of strategy**	Identify how work areas are utilising each component of the chronic disease strategy.
Session 2 notes	**Wrap up**	This unit has looked at the CDSRR and how they fit under the domains of prevention; early detection and management are supported at the development.
Quiz	**Complete and self mark**	Give learners 10 minutes to complete the quiz for this unit. Learners can self mark, or swap with another learner, make corrections and hand the quiz in for data collection.

Session 1

Effective delivery of primary health care services requires a systematic and supported approach to service delivery [1-3]. The components of the service delivery model need to link with each other to ensure effective and efficient of the service. Both the Queensland Strategy for Chronic Disease (QSCD) and the rural and remote model have incorporated conceptual frameworks as a basis for service development.

The first image is a part of the Queensland Strategy for Chronic Disease conceptual framework which was adapted from the World Health Organisation (WHO) innovative Care for Chronic conditions Framework and looks at the links which allow interventions to occur. These support the delivery of chronic disease prevention, early detection and management across the life and acuity continuum.

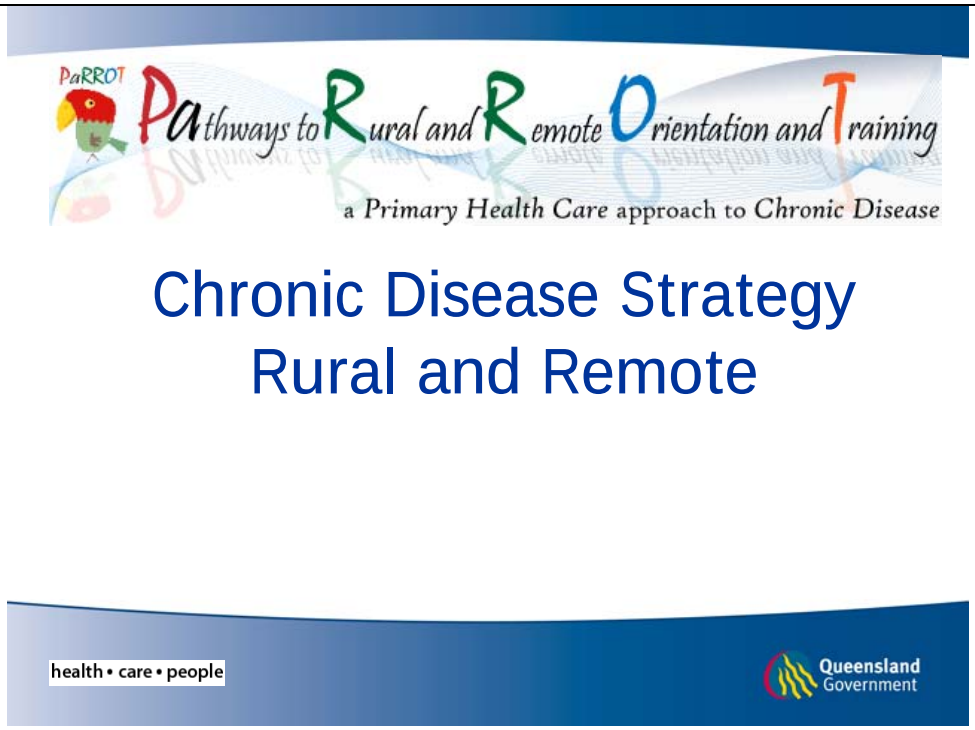


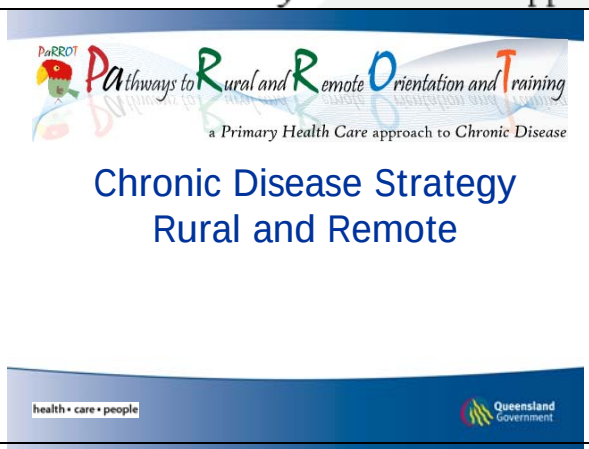
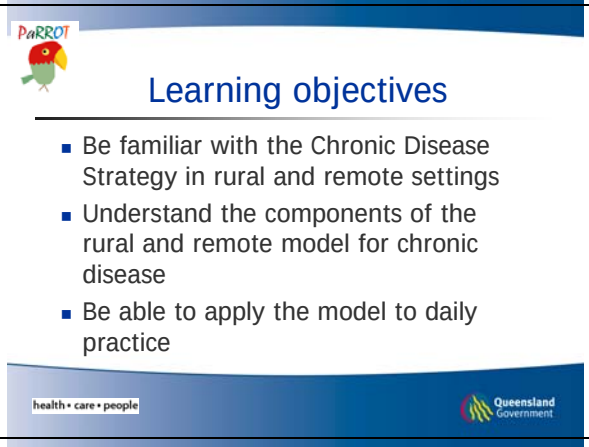
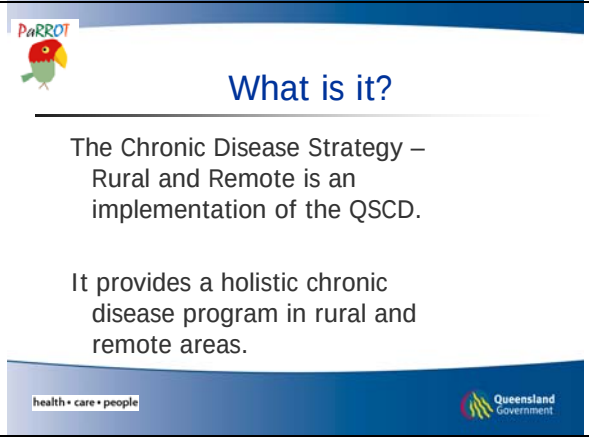
(QLD Health Strategy 2005, p.26)

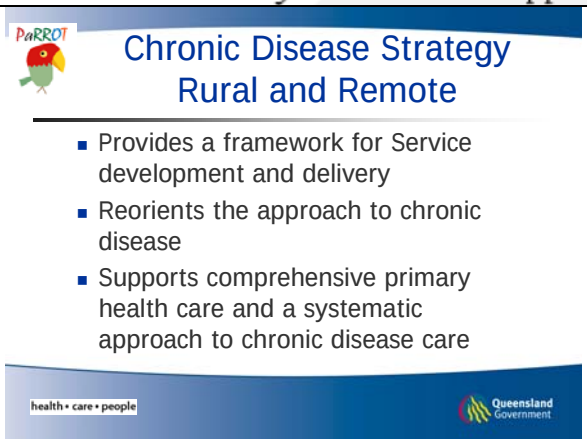
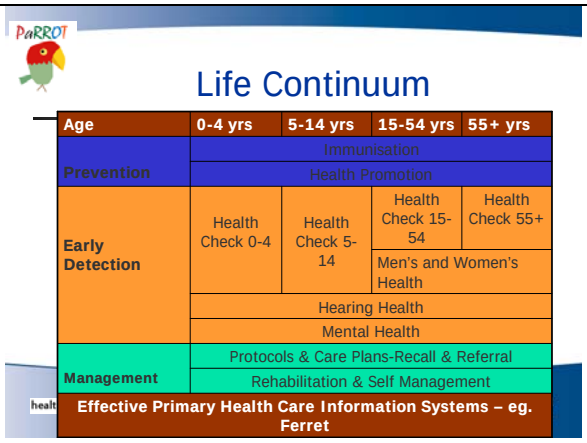
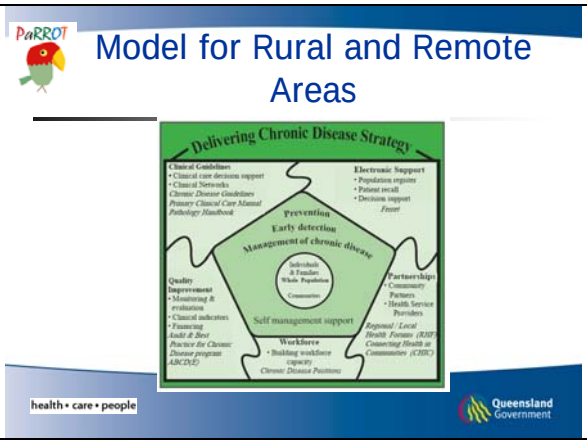
[3]

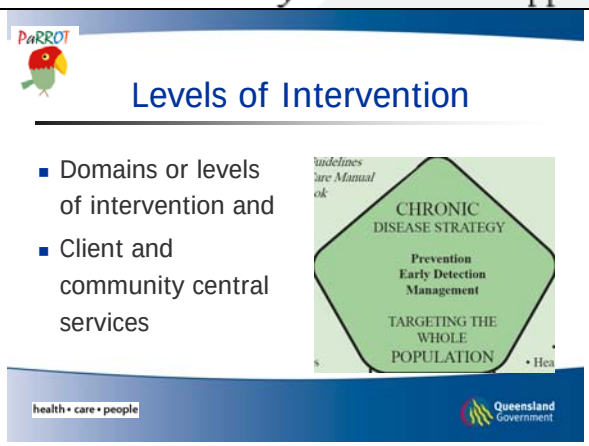
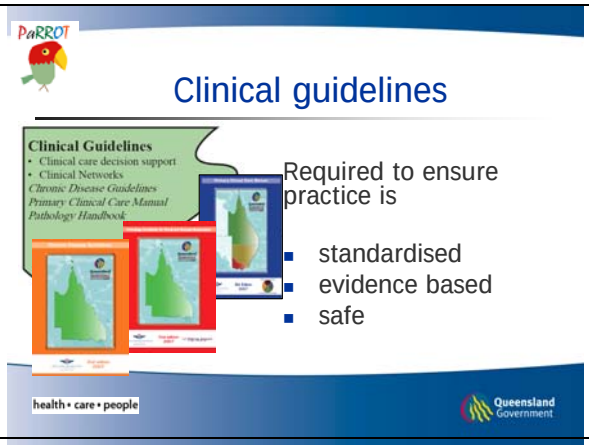
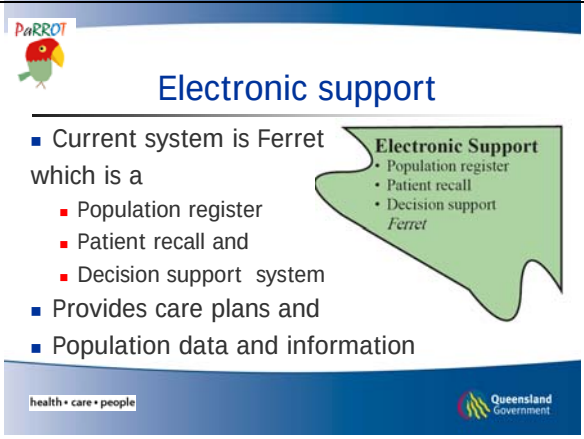
The Chronic Disease Strategy – Rural and Remote model was also adapted from the WHO innovative Care for Chronic conditions. The model, pictured below, identifies the support systems that are required to ensure the development of supported, holistic chronic disease programs, in rural and remote areas. This unit looks at the rural and remote model and defines the "puzzle" pieces within this framework.

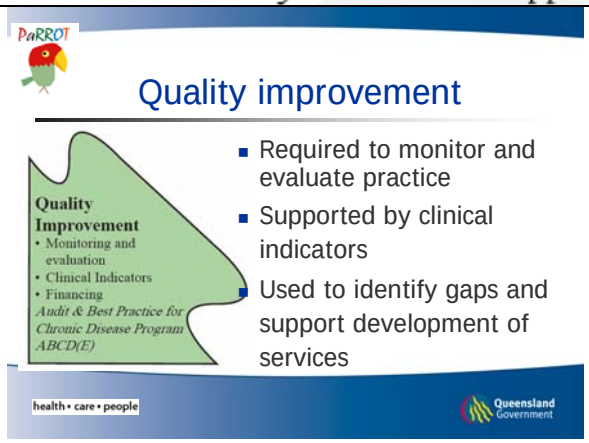
Presentation

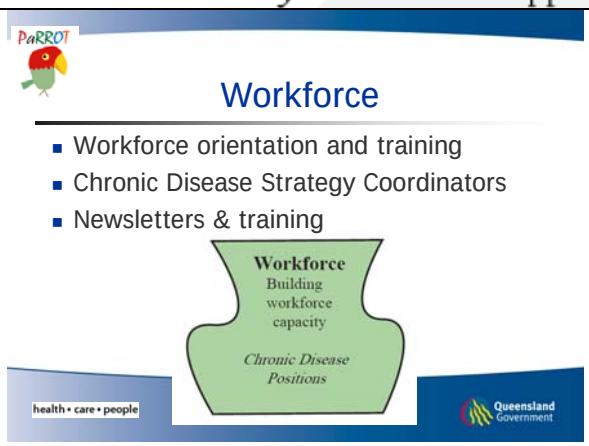
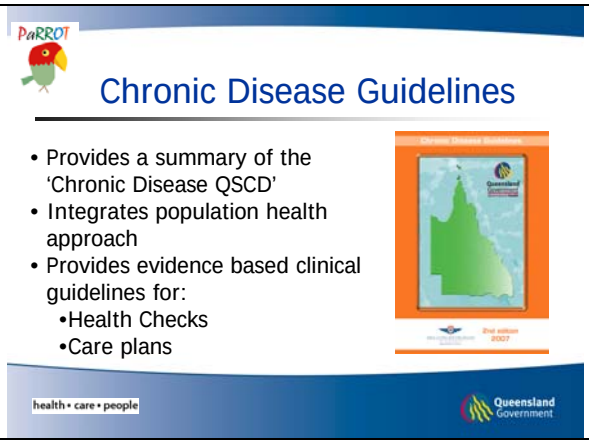


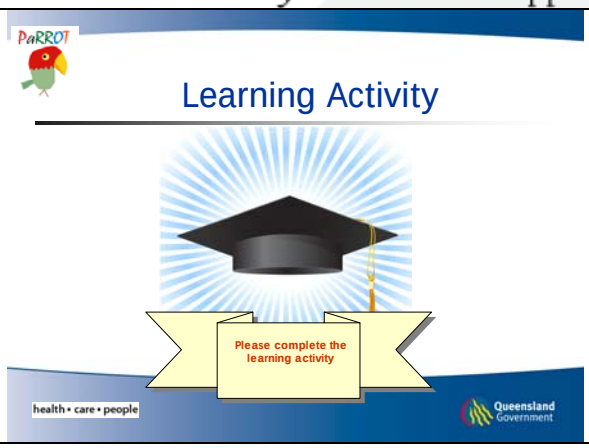
Slide 1 **Chronic Disease Strategy Rural and Remote**		Notes:
Slide 2 **Learning objectives**		Notes:
Slide 3 **What is it?**		Notes:

Slide 4 **Chronic Disease Strategy Rural and Remote**		Notes: The 'chronic Disease strategy' provides a model for service development and delivery. It reorientates the approach to chronic disease from management along t the inclusion of preventive approaches. It supports a comprehensive and systematic approach to chronic disease care including prevention, early detection and management.
Slide 5 **Life Continuum**		Notes: The Chronic Disease Strategy can be viewed across two continuums. Acuity continuum - action at the prevention, early detection and management levels, and Life continuum - strategies across the life span At each level, certain activities are recommended to ensure that prevention, early detection and management is happening uniformly
Slide 6 **Model for Rural and Remote Areas**		Notes: The model for rural and remote areas identifies the support system or enablers that are required to ensure the development and implementation of supported primary health care and chronic disease programs in rural and remote areas.

Slide 7 **Levels of Intervention**		Notes: In the centre of the model the levels or domains of intervention are identified. Prevention includes health promotion health education, immunisation and environmental health Early detection includes screening and brief interventions and Management includes management of chronic diseases using protocols , care plan development and implementation and self management. Primary health care must be provided to the individuals taking into consideration their families and communities.
Slide 8 **Clinical guidelines**		Notes: Clinical guidelines are required to ensure practice is standardised, evidence based, safe and in line with agreed protocols, policy and legislative guidelines
Slide 9 **Electronic support**		Notes: The current electronic support system is Ferret. It includes both a population register and patient recall system, but also supports decision making by providing information on what needs to be followed up, by whom and how in the form of a care plan. Care plans on Ferret are updated in line with the updates to the Primary Clinical Care Manual and Chronic Disease Guidelines. Population data can be retrieved from Ferret and used for community profiles and for planning purposes for scheduling visiting services and planned screening activities.

Slide 10 **Quality improvement**		Notes: Quality improvement using the ABCD program is: Required to monitor and evaluate practice by regularly auditing practice at service delivery sites. Supported by clinical indicators which have been developed at federal, state and local levels in line with the health Indicators of Queensland. Used to identify gaps and support development of services
Slide 11 **Partnerships**		Notes: The development of partnerships ensures there is a collaborative approach to services. The partnerships need to include as many agencies working in health, as possible. This ensures the services are owned by the community and are therefore likely to be more sustainable. There have been a number of successful partnerships, such as the Regional Health Forums and the CHIC (Connecting Health Care in Communities). These partnerships improved service coordination, upstream health promotion, shared referral pathways and limit duplication in service provision. Regional and local health forums and community health action groups are also supporting community control of health care.

Slide 12 **Workforce**		Notes: One of the greatest challenges in rural and remote areas is recruitment and retention of the workforce. A number of projects have commenced to ensure both recruitment and retention of a quality trained workforce. Some of the projects are: PaRROT orientation and training project Office of Chief Nursing Officer (OCNO) rural and remote Nurses Orientation Program Services for Australian Rural and Remote Allied Health (SARRAH) Supporting the Transition of Allied Health Professionals to Remote and Rural Practice project. In order to ensure chronic disease prevention, early detection and management remains a priority, a number of Chronic Care Coordinator positions have been funded for the Districts. These positions are supported and receive some training from the Office of Rural and Remote Health. Further information and support is provided to Districts through regular newsletters and other chronic disease and primary health care training.
Slide 13 **Chronic Disease Guidelines**		Notes: The chronic disease guidelines contain an outline of the policy framework and system enablers for the Chronic Disease QSCD, along with evidence based protocols for screening, early detection and management of chronic disease.

Slide 14 **Learning Activity**		Notes:

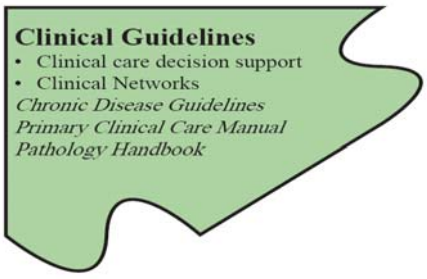
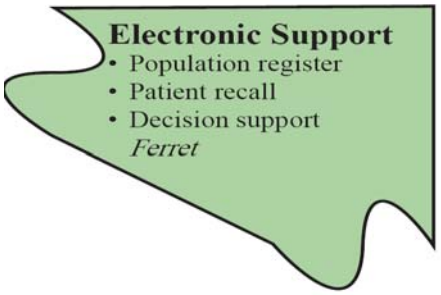
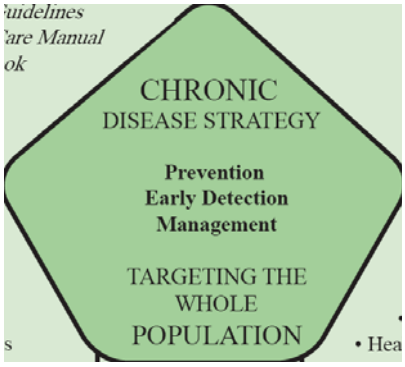
Learning Activity - Facilitator

Information for facilitators

This activity can be conducted in small groups. Please ask participants to record their answers on their activity sheet, then copy, scan and email it to parrot@health.qld.gov.au or fax it to 4033 3040 and keep a copy for your records.

Participants are asked to look at the model for the Chronic Disease Strategy – Rural and Remote on the second page of this document, and indicate what their service or district is doing to meet each part of the model.

Questions

<table>
<tr><td> 
</td><td> 
</td></tr>
<tr><td>Personal copies of the Chronic Disease Guidelines
Primary Clinical Care Manual in clinic
Pathology handbook in treatment room.</td><td>Use of Ferret, or Communi Care or Medical Director</td></tr>
<tr><td>Prevention
Immunisation programs
Health promotion programs
Parent groups
School based health education or promotion programs</td><td rowspan="2"> 
</td><td>Early Detection
Well Child Health Check Program
Adult Health Check Program
Baby clinics

Management
Self Management program
Eat well be active
Coach
Flinders self-management program</td></tr>
<tr><td> 
</td><td> 
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</td></tr>
<tr><td>Program evaluation plans
EQUIP
ACHS
ABCD</td><td>Chronic disease positions
Support for orientation and training to chronic disease care
Chronic disease programs</td><td>Health Council
Health Action Group
Health Action Teams
Collaborative steering or reference groups
CHIC partnerships council</td></tr>
</table>

Learning Activity - Participant

Information for participants

This activity can be conducted in small groups. Please record your answers on your activity sheet, and submit to your facilitator who will copy, scan and email it to parrot@health.qld.gov.au or fax it to 4033 3040 and keep a copy for your records.

Questions

Please look at the model for the Chronic Disease Strategy – Rural and Remote on the second page of this document, and indicate what your service or district is doing to meet each part of the model.

Clinical Guidelines
- Clinical care decision support
- Clinical Networks

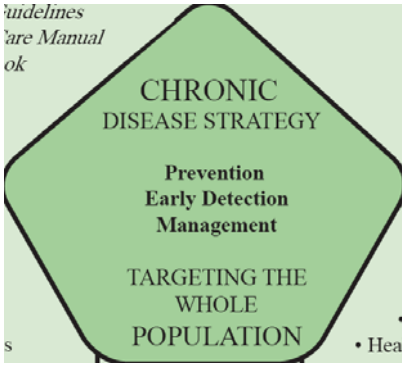
Chronic Disease Guidelines
Primary Clinical Care Manual
Pathology Handbook

Electronic Support
- Population register
- Patient recall
- Decision support

Ferret

Prevention

Early Detection



Management

Quality Improvement
- Monitoring and evaluation
- Clinical Indicators
- Financing

Audit & Best Practice for Chronic Disease Program
ABCD(E)

Workforce
Building workforce capacity

Chronic Disease Positions

Partnerships
- Community partners
- Health service providers

Regional / Local Health Forums (RHF)
Connecting Health in Communitites (CHIC)

Session 2

This unit has provided information on the Chronic Disease Strategy model for rural and remote areas. This model provides a framework for the support systems or enablers which are required to ensure primary health and chronic disease programs under the domains of prevention, early detection and management are supported at the development and delivery stages of the program.

Resources and systems have been developed to support this, and include:

1. The ongoing review and updating of evidence based guidelines such as the Primary Clinical Care Manual and the Chronic Disease Guidelines
2. The ongoing development and review of a primary health information system (currently Ferret)
3. Support for partnerships such as the Connecting Health in Communities (CHIC) and Regional or local health forums
4. Quality improvement processes including ABCD, EQUIP and ACHS
5. Workforce development strategies including:
    - Funding for chronic disease eg district based Chronic Disease Strategy coordinators
    - Funding for workforce development such as orientation and training programs such as PaRROT and the nurses rural and remote orientation program.

At the district and local community levels

- partnerships should be supported
- adequate resources for primary health information systems provided
- quality improvement should be used where available and
- workforce development initiatives included as part of core business

This local level of support is not only dependent on Districts or organisations but on the workers themselves who need to ensure they are participating in activities and utilising resources appropriately. Understanding what these support systems are and why they exist is an important first step in ensuring effective chronic disease programs are being developed and delivered.

Quiz - Facilitator

Information for Facilitators

Give the participant version of this quiz to participants at the end of the unit. Allow them 10 to 15 minutes to complete. Information on the questions can be found in the session notes and presentation story board. They can do the quiz individually or in pairs. Once the quiz has been completed, hand out the answer sheet and get the participants to self mark.

Please scan and email the answer sheets to parrot@health.qld.gov.au or copy and fax to 40333040. You can choose to keep a copy for yourself and give the original to the participants for their records.

Quiz Settings

Property	Setting
Passing Score	50% or 11/22
Total Number of Questions	3
Total Number of Questions to Ask	All

Questions

1. Why is a model for chronic disease - rural and remote required? *(2 points)*

Feedback: So that primary health care can be delivered in a systematic and supported way. The Chronic Disease Strategy is a basis for service development and delivery.

2. The five components required ensuring chronic disease prevention, early detection and management are supported in service delivery is: *(Multiple Response Question, 10 points, 2 points per correct answer)*

Correct	Choice
✓	Evidence based guidelines
✓	Clinical support systems
✓	Partnerships
✓	Workforce
✓	Quality improvement
	A, B and C only
	A, B and D only
	C, D and E only

3. Match the component of the chronic disease strategy - rural and remote with an example of that component *(Matching Drag and Drop Question, 10 points, 2 points per correct answer)*

Strategy component	Choice
Evidence based guidelines	Pathology Hand Book
Clinical support system	Primary health information system
Partnerships	Regional Health Forum
Workforce	Orientation program
Quality improvement	ABCD

Quiz - Participant

Information for Participants

Please complete the following quiz individually or in pairs. The scores for each question are indicated in the question. Information for your answers can be found in the session notes and or the presentation story board which are included in your participant package. Once the quiz has been completed, your facilitator will provide and answer sheet for you to self mark. The quiz should take 10 to 15 minutes to complete.

Your facilitator will scan and email the answer sheets to parrot@health.qld.gov.au or copy and fax to 40333040. They may keep a copy for themselves for their records and give the original copy to you for your records.

Quiz Settings

Property	Setting
Passing Score	50% or 11/22
Total Number of Questions	3
Total Number of Questions to Ask	All

Questions

1. Why is a model for chronic disease - rural and remote required?
(2 points)

2. The five components required ensuring chronic disease prevention, early detection and management are supported in service delivery is: *10 points, 2 points per correct answer)*

Correct	Choice
	Evidence based guidelines
	Clinical support systems
	Partnerships
	Workforce
	Quality improvement
	A, B and C only
	A, B and D only
	C, D and E only

3. Match the component of the chronic disease strategy - rural and remote with an example of that component *(10 points, 2 points per correct answer)*

Strategy component	Choice
Clinical Support System	Pathology Hand Book
Evidence Based Guidelines	Primary health information system
Quality Improvement	Regional Health Forum
Partnerships	Orientation program
Workforce	ABCD

Bibliography

1. Queensland Health and the Royal Flying Doctor Service (Queensland Section), *Chronic Disease Guidelines*. 2nd ed. 2007, Cairns.

2. D'Abbs P, et al., *Implementing a chronic disease strategy in two remote Indigenous Australian settings: A multi-method pilot evaluation.* Australian Journal of Rural and Remote Health, 2008. 16: p. 67-74.

3. Queensland Health, *Queensland Strategy for Chronic Disease 2005-2015*. 2005, Queensland Health.