



Orientation Participant Handbook

Part 1—Introduction/Chronic Disease

Name _____

Community _____

Site _____

Position _____

Date Completed _____





PaRROT Orientation Handbook, Part 1

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Welcome

Welcome to the Orientation Module of the Pathways to Rural and Remote Orientation and Training (PaRROT) program. This program is available as an e-learning program through www.health.qld.gov.au/parrot or as a workshop delivery mode. This handbook – which is the first of three, can be used as a guide for the e-learning program, or as a record for the workshop delivery program.

Documents associated with this program can also be accessed and completed electronically.



Checklists

Health Professional Checklist

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

Administration Officer Checklist

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



Orientation

Unit 1

Introduction to

PaRRROT





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















PaRROT Program







Introduction








health • care • people



<p>Slide 1 PaRROT Program</p>	 <h2>PaRROT Program</h2> <h3>Introduction</h3> <p>health • care • people </p>	<p>Notes:</p>
<p>Slide 2 Learning objectives</p>	 <h2>Learning objectives</h2> <p>Understand and be aware of:</p> <ul style="list-style-type: none"> 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. There is no assessment for this unit <p>health • care • people </p>	<p>Notes:</p> <p>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.</p>
<p>Slide 3 History</p>	 <h2>History</h2> <ul style="list-style-type: none"> 1999-2000: Initial research 2002 – Rural and remote strategy developed 2005 State strategy developed Evidence supporting the need for a systematic approach <p>health • care • people </p>	<p>Notes:</p> <p>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.</p> <ul style="list-style-type: none"> 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

<p>Slide 4 History</p>	 <h3>History</h3> <ul style="list-style-type: none"> ■ 2008 – Successful bid for People Plan funding ■ 2008 – Needs and SWOT analyses conducted ■ 2009 – Development of the chronic disease orientation and training framework ■ 2009 – Early development of the PaRROT orientation and training program <p>health • care • people </p>	<p>Notes:</p> <p>2008 – Successful bid for People Plan funding to develop the orientation and training program for chronic disease in rural and remote areas</p> <p>2008 – Needs and SWOT analyses conducted by Dr Felicity Croker, JCU as part of phase 1 of the orientation and training program</p> <p>2009 – Development of the chronic disease orientation and training framework.</p> <p>2009 – Early development of the PaRROT orientation and training program</p>
<p>Slide 5 Objectives</p>	 <h3>Objectives</h3> <ul style="list-style-type: none"> ■ Provide <ul style="list-style-type: none"> ■ Knowledge and skills ■ Training support ■ Sustainable training program ■ Accessible and appropriate resources ■ Improve the quality of clinical chronic disease care ■ Support the systematic approach to chronic disease care <p>health • care • people </p>	<p>Notes:</p> <p>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).</p>
<p>Slide 6 Principles</p>	 <h3>Principles</h3> <ul style="list-style-type: none"> ■ Create an environment to promote learning ■ Align learning priorities ■ Integrate best practice and standards ■ Provide and promote learning options ■ Lead and manage learning ■ Monitor and evaluate. <p>health • care • people </p>	<p>Notes:</p> <p>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.</p>

<p>Slide 7 Principles</p>	 <h2 style="text-align: center;">Principles</h2> <p>For the Learner it will be</p> <ul style="list-style-type: none"> ■ Sustainable ■ Supported ■ Affordable ■ Accessible ■ Appropriate ■ Acceptable and ■ Effective <p style="font-size: small;">health • care • people </p>	<p>Notes: For the Learner the PaRRROT program will provide orientation and training that is: Sustainable Supported Affordable Accessible Appropriate Acceptable and Effective</p>
<p>Slide 8 Expected Outcomes</p>	 <h2 style="text-align: center;">Expected Outcomes</h2> <ul style="list-style-type: none"> ■ Enhanced workforce ■ Standardised information ■ A systematic approach to chronic disease ■ Population health focus ■ Improved rural and remote health. <p style="font-size: small;">health • care • people </p>	<p>Notes: It is expected that universal completion of the PaRRROT 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.</p>
<p>Slide 9 Program Content</p>	 <h2 style="text-align: center;">Program Content</h2> <p>17 Units</p> <ul style="list-style-type: none"> •Core •Prevention •Early Detection •Management <p style="font-size: small;">health • care • people </p>	<p>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.</p>

<p>Slide 10 Delivery Modes</p>	 <h2 style="text-align: center;">Delivery Modes</h2> <p>Flexible modes delivery including:</p> <ul style="list-style-type: none"> ■ DVD – self directed learning ■ Web page – self directed learning ■ Workshop delivery mode <ul style="list-style-type: none"> ■ Facilitator training ■ Participants need to be taken off-line <p style="text-align: center;">Or any combination of the above</p>  	<p>Notes:</p> <p>The program has been developed to provide flexible modes of delivery including</p> <ul style="list-style-type: none"> 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 <p>Or any combination of the above</p>
<p>Slide 11 Stages</p>	 <h2 style="text-align: center;">Stages</h2> <ul style="list-style-type: none"> ■ Orientation ■ Induction ■ Professional Development ■ Additional  	<p>Notes:</p> <p>The training is delivered / accessed in various stages which include:</p> <ul style="list-style-type: none"> 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
<p>Slide 12 Introduction to PaRROT Learning Activity</p>		<p>Notes:</p>



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

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



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.
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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.sarahtraining.com.au/site/index.cfm>.



PaRRROT
Pathways to Rural and Remote Orientation and Training

a Primary Health Care approach to Chronic Disease

Orientation

Unit 2

Introduction to Chronic Disease



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.





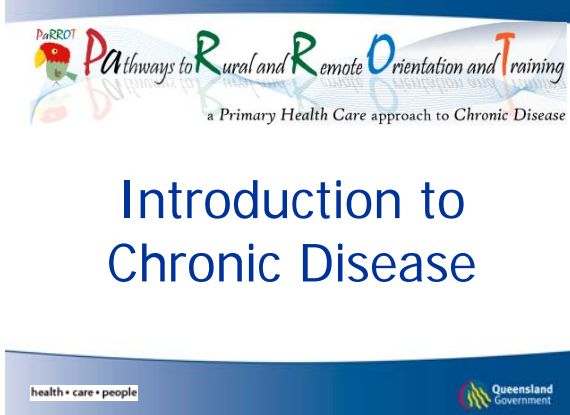
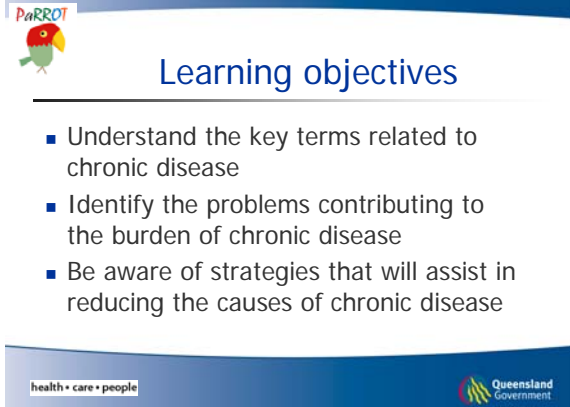

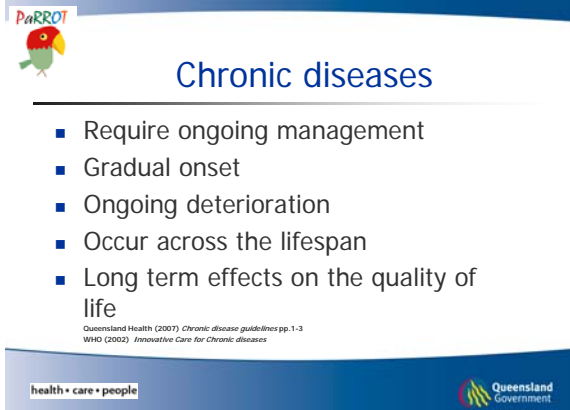
Presentation

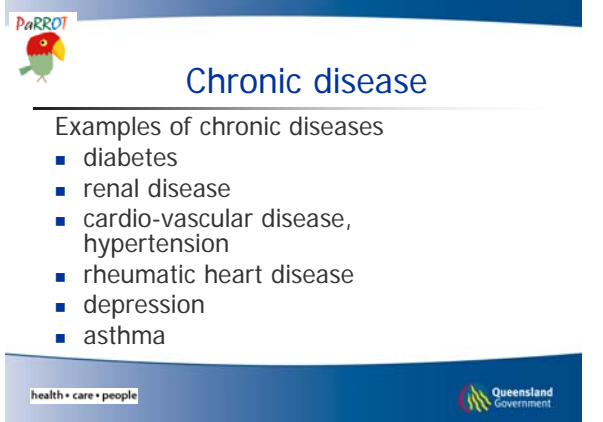

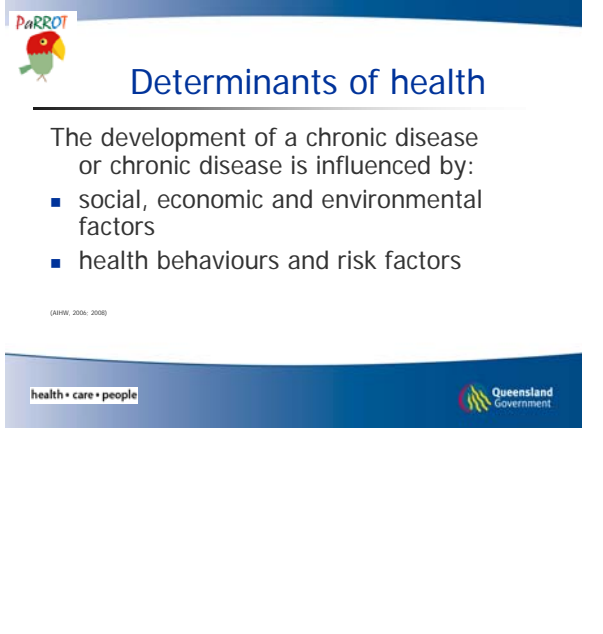









Introduction to Chronic Disease







health • care • people









<p>Slide 1 Introduction to Chronic Disease</p>	 <p>health • care • people</p> <p>Queensland Government</p>	<p>Notes:</p>
<p>Slide 2 Learning objectives</p>	 <p>health • care • people</p> <p>Queensland Government</p>	<p>Notes:</p>
<p>Slide 3 Key concepts</p>	 <p>health • care • people</p> <p>Queensland Government</p>	<p>Notes:</p> <p>The key concepts associated with chronic disease will be explored in detail in this unit.</p>
<p>Slide 4 Chronic diseases</p>	 <p>health • care • people</p> <p>Queensland Government</p>	<p>Notes:</p> <p>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</p>

		<p>including physical limitations disability and social and emotional well being.</p>
<p>Slide 5 Chronic disease</p>	 <p>Chronic disease</p> <p>Examples of chronic diseases</p> <ul style="list-style-type: none"> ■ diabetes ■ renal disease ■ cardio-vascular disease, hypertension ■ rheumatic heart disease ■ depression ■ asthma <p>health + care + people </p>	<p>Notes: Chronic diseases are caused by multiple complex inter-relating causes and the determinants of health</p>
<p>Slide 6 Determinants of health</p>	 <p>Determinants of health</p> <p>The development of a chronic disease or chronic disease is influenced by:</p> <ul style="list-style-type: none"> ■ social, economic and environmental factors ■ health behaviours and risk factors <p>health + care + people </p>	<p>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</p>

<p>Slide 7 The data</p>	 <h3>The data</h3> <p>Chronic disease in Australia 2007:</p> <ul style="list-style-type: none"> ■ chronic care consumes 70% of the health budget <p>2030:</p> <ul style="list-style-type: none"> ■ entire state budgets will be consumed by chronic diseases <p>health • care • people </p>	<p>Notes:</p> <p>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)</p> <p>There is a belief that the children of today will have a shorter lifespan than their parents if factors leading to the development of chronic diseases are not addressed now.</p>
<p>Slide 8 What is the problem?</p>	 <h3>What is the problem?</h3> <p>In QLD there is significant morbidity and mortality from:</p> <ul style="list-style-type: none"> ■ cardiovascular disease ■ type 2 diabetes mellitus ■ renal disease ■ chronic respiratory disease <p>health • care • people </p>	<p>Notes:</p> <p>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.</p>
<p>Slide 9 Inequalities in health</p>	 <h3>Inequalities in health</h3> <ul style="list-style-type: none"> ■ Inequalities in health are evident in disadvantaged and under-served groups ■ The health of Aboriginal and Torres Strait Islander Australians has not improved ■ 90% presentations to rural and remote health centres are caused by chronic ongoing illness (AIHW 2008, Australia's health 2008) <p>health • care • people </p>	<p>Notes:</p> <p>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</p> <p>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.</p>

<p>Slide 10 Risk factors</p>	 <h3>Risk factors</h3> <ul style="list-style-type: none"> ■ Chronic disease is largely preventable. ■ There are 4 major health damaging behaviours (SNAP) <ul style="list-style-type: none"> ■ tobacco smoking ■ poor nutrition ■ alcohol misuse & ■ physical inactivity + Poor emotional health (SNAPE) <p>health • care • people </p>	<p>Notes:</p>
<p>Slide 11 Biomedical approaches</p>	 <h3>Biomedical approaches</h3> <ul style="list-style-type: none"> ■ Focus of care and the health budget has been on acute medical needs of the patients ■ Rather than preventative strategies <p>health • care • people </p>	<p>Notes:</p> <p>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 interventions 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.</p> <p>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</p>
<p>Slide 12 Acute model of care</p>	 <h3>Acute model of care</h3> <p>Sick people come to hospital Provided treatment and discharged</p> <p style="text-align: center;">↓</p> <p>Chronic diseases aren't 'curable' with a 'quick fix'. A different approach is needed.</p> <p>health • care • people </p>	<p>Notes:</p>

<p>Slide 13 What can we do?</p>	 <h3>What can we do?</h3> <ul style="list-style-type: none"> ■ Refocus from acute episodic care to: <ul style="list-style-type: none"> ■ ■ ■ Management ■ Reducing the burden of disease will occur by addressing the <p>health • care • people </p>	<p>Notes:</p> <p>In order to reduce the incidence of chronic disease, the focus of care should be widened 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.</p>
<p>Slide 14 A thought ...</p>	 <h3>A thought ...</h3> <p>“The mark of a good primary health care service is not only how it cares for those who seek them out... <i>but how it cares for those who don't.</i>”</p> <p>World Health Organisation</p> <p>health • care • people </p>	<p>Notes:</p>
<p>Slide 15 Learning Activity</p>	<p>PROPERTIES</p> <p>On passing, 'Finish' button: On failing, 'Finish' button: Allow user to leave quiz: User may view slides after quiz: User may attempt quiz:</p> <p>Close Window Close Window After user has completed quiz At any time Unlimited times</p> <p> Properties...  Edit in Quizmaker</p>	<p>Notes:</p>



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 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
<input type="checkbox"/>	Cardio-vascular disease
<input type="checkbox"/>	liver disease
<input type="checkbox"/>	Type 2 Diabetes Mellitus
<input type="checkbox"/>	mental illness
<input type="checkbox"/>	Renal disease
<input type="checkbox"/>	chronic respiratory disease
<input type="checkbox"/>	cancer
<input type="checkbox"/>	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/pg-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





Orientation

Unit 3

Queensland Strategy for Chronic Disease





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.

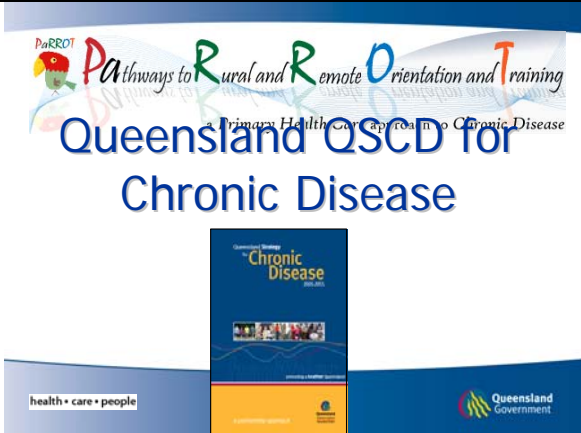
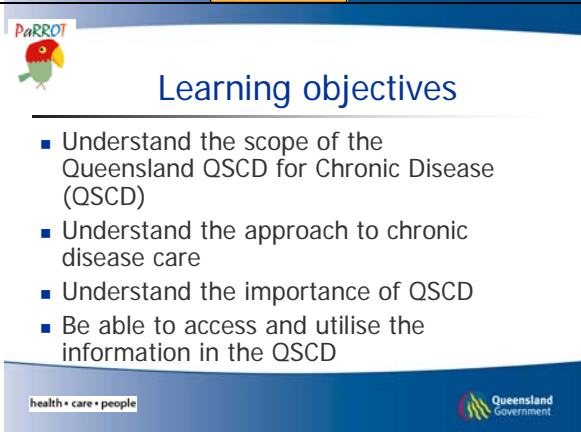
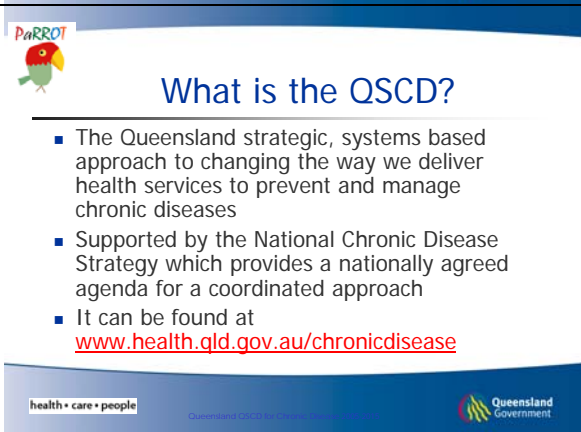
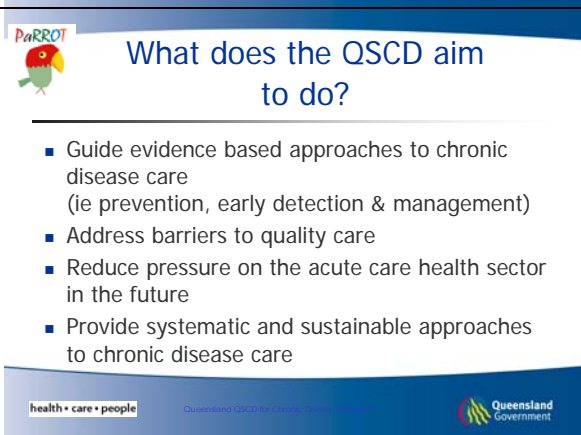
This unit will introduce you to the QSCD and explain the link between it, comprehensive primary health care and the work you will be doing in rural and remote areas in Australia. It will also look at the way the strategy has been implemented in rural and remote Queensland and alert you to any differences 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.



















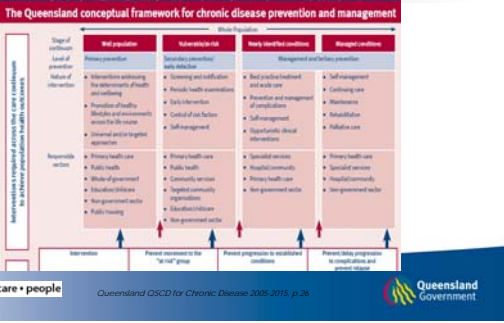





Presentation

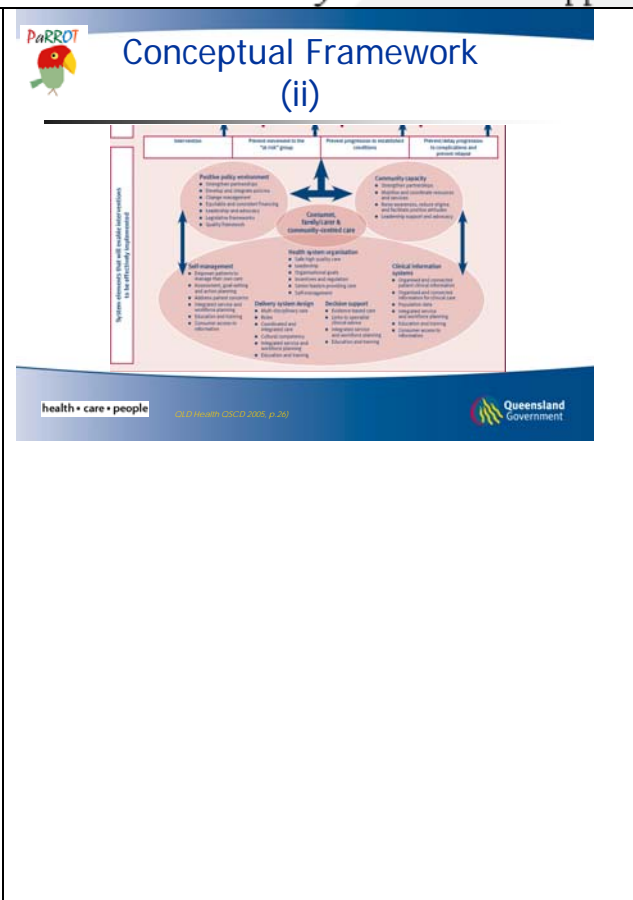
The slide content is framed within a blue border. At the top, it repeats the PaRROT logo and title. Below this, the main title 'Queensland QSCD for Chronic Disease' is displayed in a large, bold, blue font. Underneath the title is a central image of the cover of the 'Queensland Strategy for Chronic Disease 2009-2015' document. The cover is blue and yellow, featuring a group photo of people and the text 'presenting a Healthier Queensland'. To the left of the cover is a blue box with the text 'health • care • people'. To the right is a blue box with the Queensland Government logo and the text 'Queensland Government'. At the bottom of the cover image, there is a small logo and the text 'a partnership approach'.

<p>Slide 1 Queensland QSCD for Chronic Disease</p>		<p>Notes:</p>
<p>Slide 2 Learning objectives</p>	 <ul style="list-style-type: none"> ■ Understand the scope of the Queensland QSCD for Chronic Disease (QSCD) ■ Understand the approach to chronic disease care ■ Understand the importance of QSCD ■ Be able to access and utilise the information in the QSCD 	<p>Notes:</p>
<p>Slide 3 What is the QSCD?</p>	 <ul style="list-style-type: none"> ■ The Queensland strategic, systems based approach to changing the way we deliver health services to prevent and manage chronic diseases ■ Supported by the National Chronic Disease Strategy which provides a nationally agreed agenda for a coordinated approach ■ It can be found at www.health.qld.gov.au/chronicdisease 	<p>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.</p>
<p>Slide 4 What does the QSCD aim to do?</p>	 <ul style="list-style-type: none"> ■ Guide evidence based approaches to chronic disease care (ie prevention, early detection & management) ■ Address barriers to quality care ■ Reduce pressure on the acute care health sector in the future ■ Provide systematic and sustainable approaches to chronic disease care 	<p>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.</p>

<p>Slide 5 QSCD identifies</p>	 <h3>QSCD identifies</h3> <p>The Strategy identifies the following elements that will enable interventions to be effectively implemented:</p> <ul style="list-style-type: none"> ■ Positive policy environment ■ Health system organisation ■ Decision support (eg. Evidence-based care) ■ Delivery system design ■ Clinical information systems ■ Self management <p>And all with a focus on consumer, family / carer and community centred care.</p>  	<p>Notes:</p>
<p>Slide 6 Domains</p>	 <h3>Domains</h3> <p>Four pronged :</p> <ul style="list-style-type: none"> ■ Primary Prevention ■ Early detection ■ Management ■ And System Elements   	<p>Notes:</p> <p>The QSCD has a four pronged population based approach incorporating:</p> <p>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</p> <p>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</p> <p>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</p> <p>System Elements</p>

<p>Slide 7 Examples of Population Approaches</p>	 <h3>Examples of Population Approaches</h3> <ul style="list-style-type: none"> ■ Immunisation ■ Addressing risk factors at a community level eg Eat Well, Be Active, SmokeCheck, Living Strong, Community walking groups ■ Child and adult health checks in the community ■ Treatment and management protocols for diagnosed chronic disease  	<p>Notes: The population approach to chronic disease includes programs such as immunisation, addressing risk factors at community level and community based screening.</p> <p>Also, providing protocols that enable evidence-based, standardised care will address the population of people with diagnosed chronic disease.</p>
<p>Slide 8 A population approach</p>	 <h3>A population approach</h3>    	<p>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.</p>
<p>Slide 9 Conceptual Framework (i)</p>	 <h3>Conceptual Framework (i)</h3>    	<p>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).</p>

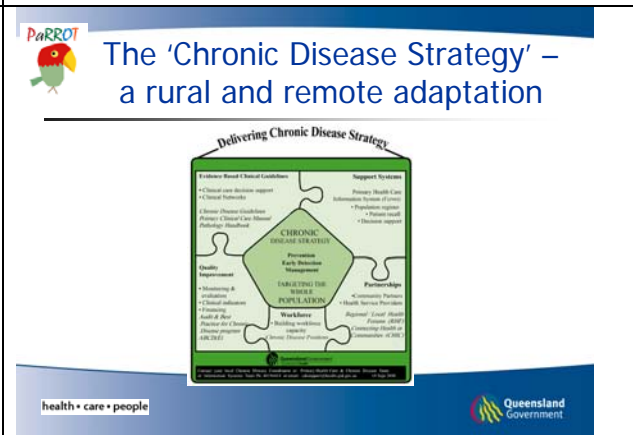
Slide 10
Conceptual Framework
(ii)



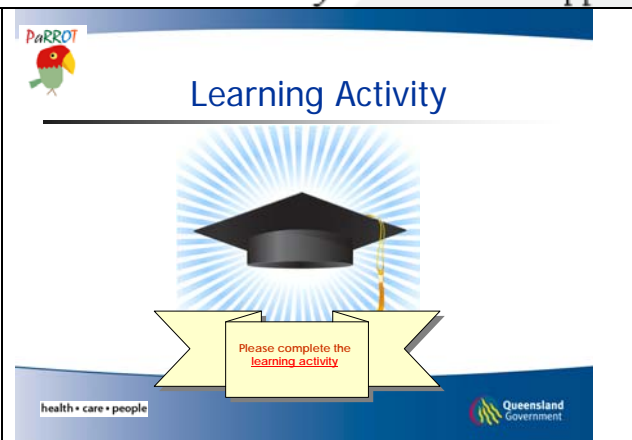
Notes:
 This part of the conceptual framework was adapted from the World Health Organisation (WHO) Innovative Care for Chronic Conditions framework. It identifies the support systems (known as enablers) for the delivery of chronic disease prevention, early detection and management across the life and 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.

<p>Slide 12 Learning Activity</p>	 <p>PaRROT</p> <h3>Learning Activity</h3> <p>Please complete the learning activity</p> <p>health • care • people</p> <p>Queensland Government</p>	<p>Notes:</p>
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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 - 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 an 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

Questions

1. What 4 diseases have been identified as the focus for initial action for the Queensland Strategy for Chronic Disease? *(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? *(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	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
	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



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.

Orientation

Unit 4

Chronic Disease Strategy—Rural and Remote



Session 1

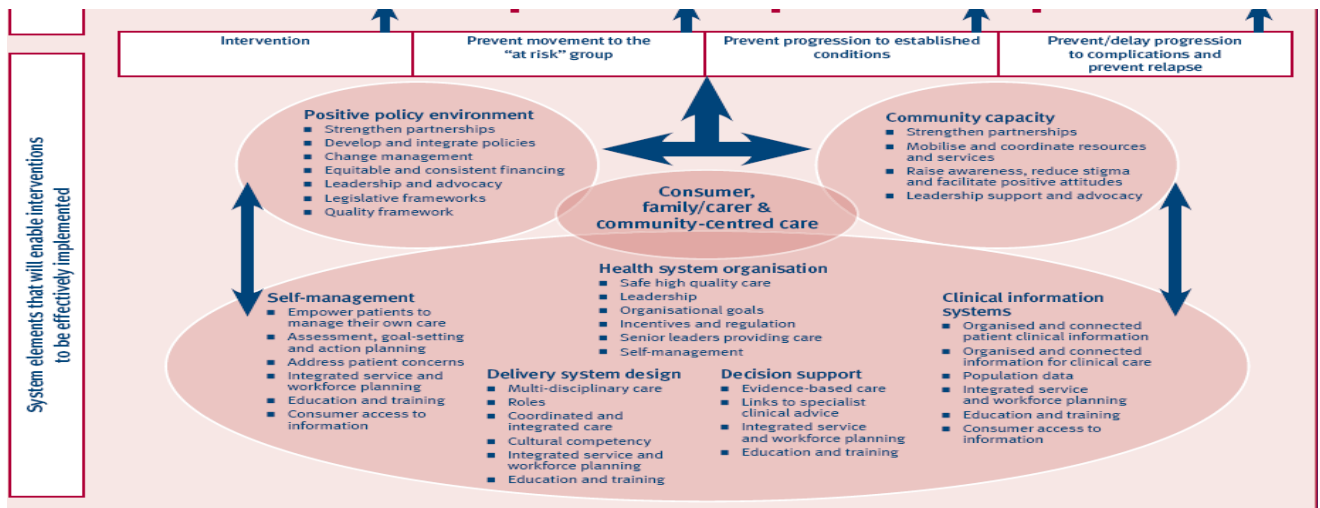
Effective delivery of primary health care services requires a systematic and supported approach to service delivery [1-3]. The components of the service delivery model need to link with each other to ensure effective and efficient of the service. Both the Queensland Strategy for Chronic Disease (QSCD)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

PaRROT



Conceptual Framework



(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.





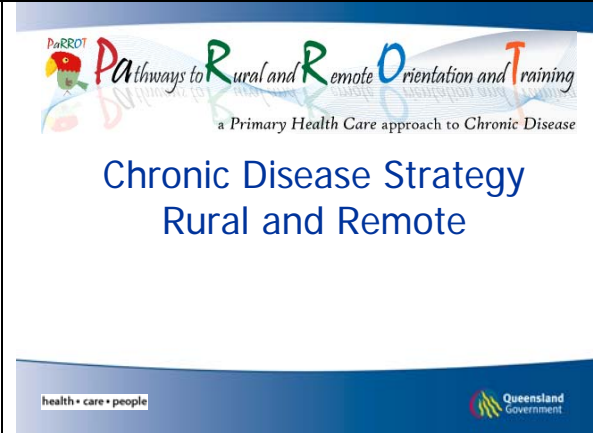
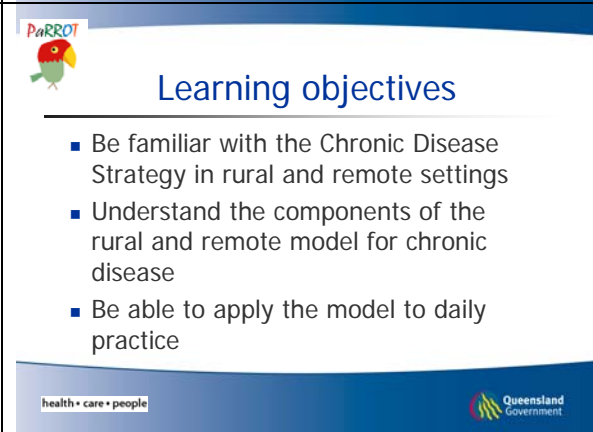
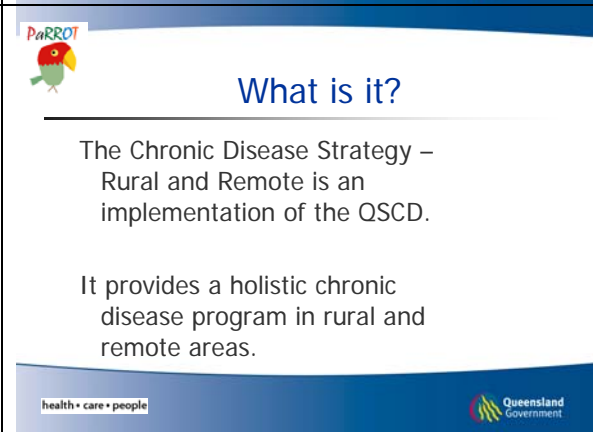
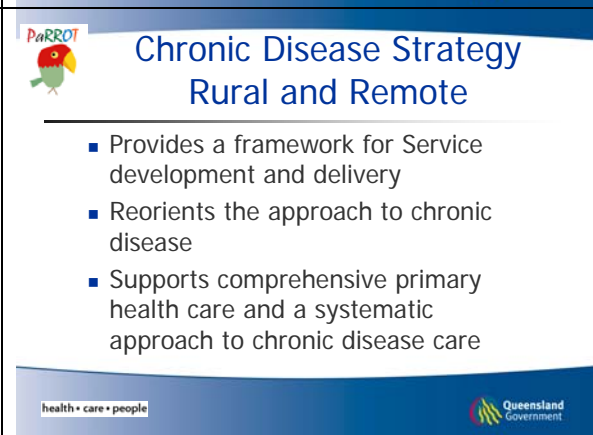
Presentation



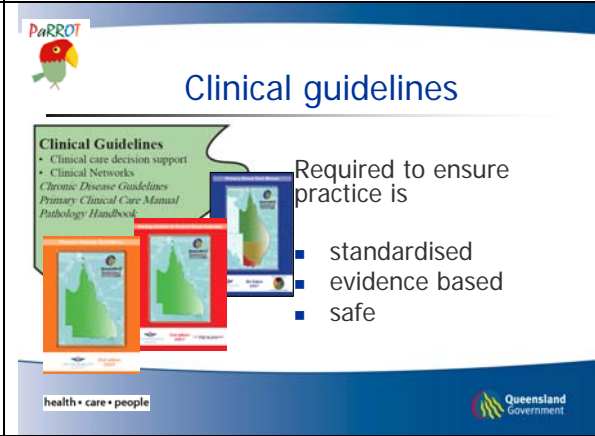
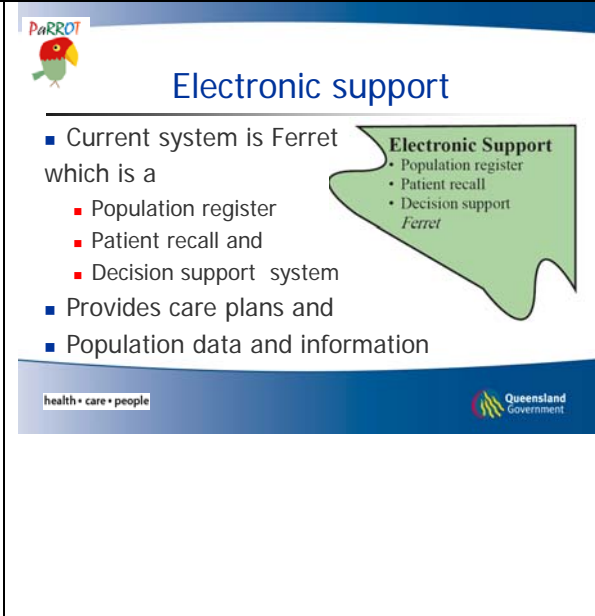
Chronic Disease Strategy Rural and Remote

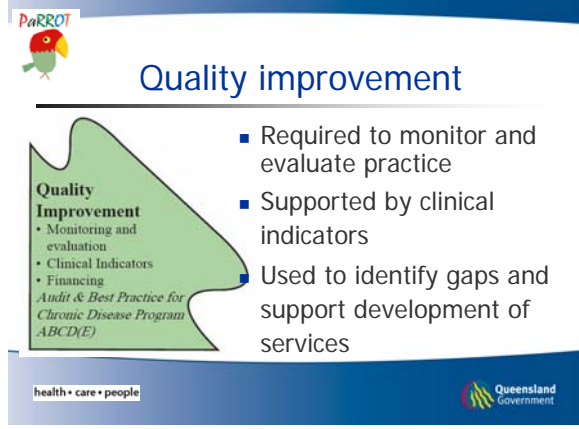

health • care • people

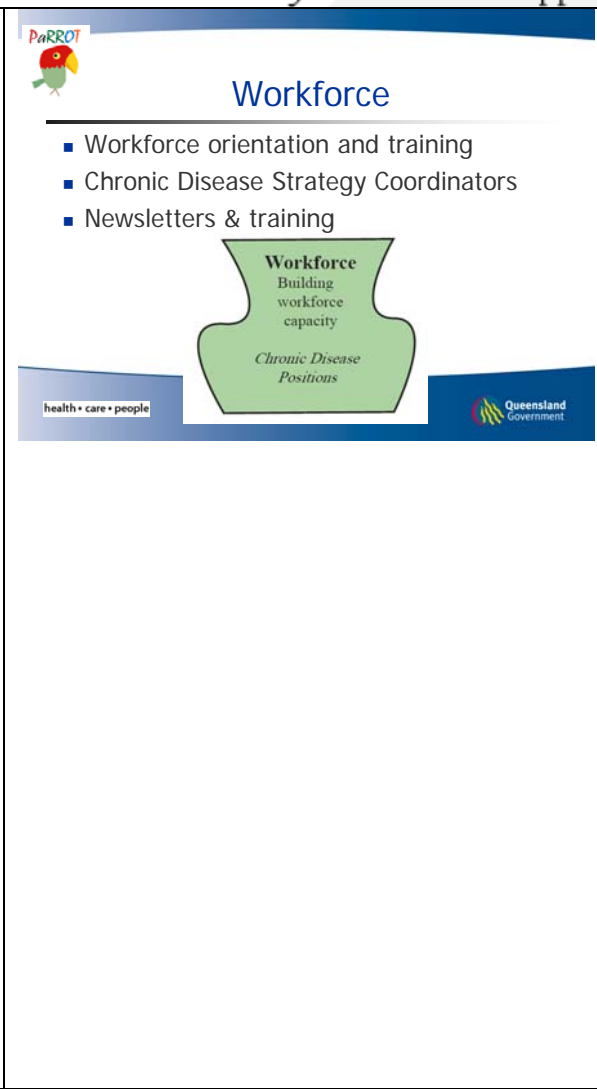
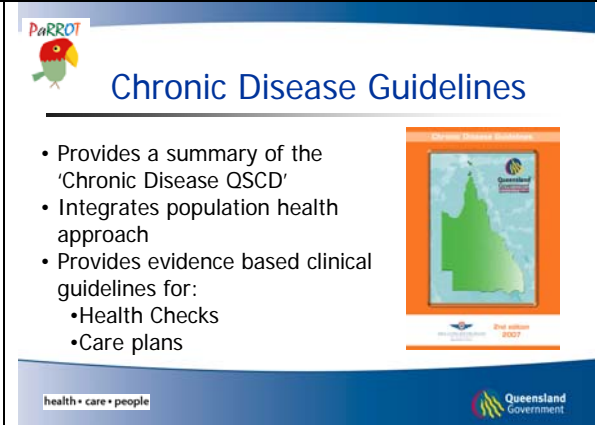


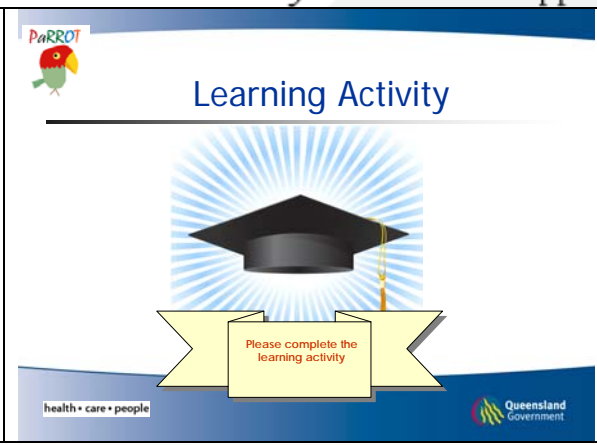
<p>Slide 1 Chronic Disease Strategy Rural and Remote</p>	 <p>Chronic Disease Strategy Rural and Remote</p>	<p>Notes:</p>
<p>Slide 2 Learning objectives</p>	 <p>Learning objectives</p> <ul style="list-style-type: none"> ■ Be familiar with the Chronic Disease Strategy in rural and remote settings ■ Understand the components of the rural and remote model for chronic disease ■ Be able to apply the model to daily practice 	<p>Notes:</p>
<p>Slide 3 What is it?</p>	 <p>What is it?</p> <p>The Chronic Disease Strategy – Rural and Remote is an implementation of the QSCD.</p> <p>It provides a holistic chronic disease program in rural and remote areas.</p>	<p>Notes:</p>
<p>Slide 4 Chronic Disease Strategy Rural and Remote</p>	 <p>Chronic Disease Strategy Rural and Remote</p> <ul style="list-style-type: none"> ■ Provides a framework for Service development and delivery ■ Reorients the approach to chronic disease ■ Supports comprehensive primary health care and a systematic approach to chronic disease care 	<p>Notes:</p> <p>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.</p>

<p>Slide 5 Life Continuum</p>	<table border="1"> <thead> <tr> <th>Age</th> <th>0-4 yrs</th> <th>5-14 yrs</th> <th>15-54 yrs</th> <th>55+ yrs</th> </tr> </thead> <tbody> <tr> <td rowspan="2">Prevention</td> <td colspan="4">Immunisation</td> </tr> <tr> <td colspan="4">Health Promotion</td> </tr> <tr> <td rowspan="4">Early Detection</td> <td>Health Check 0-4</td> <td>Health Check 5-14</td> <td>Health Check 15-54</td> <td>Health Check 55+</td> </tr> <tr> <td colspan="4">Men's and Women's Health</td> </tr> <tr> <td colspan="4">Hearing Health</td> </tr> <tr> <td colspan="4">Mental Health</td> </tr> <tr> <td rowspan="2">Management</td> <td colspan="4">Protocols & Care Plans-Recall & Referral</td> </tr> <tr> <td colspan="4">Rehabilitation & Self Management</td> </tr> <tr> <td>health</td> <td colspan="4">Effective Primary Health Care Information Systems – eg. Ferret</td> </tr> </tbody> </table>	Age	0-4 yrs	5-14 yrs	15-54 yrs	55+ yrs	Prevention	Immunisation				Health Promotion				Early Detection	Health Check 0-4	Health Check 5-14	Health Check 15-54	Health Check 55+	Men's and Women's Health				Hearing Health				Mental Health				Management	Protocols & Care Plans-Recall & Referral				Rehabilitation & Self Management				health	Effective Primary Health Care Information Systems – eg. Ferret				<p>Notes: The Chronic Disease Strategy can be viewed across two continuums.</p> <p>Acuity continuum - action at the prevention, early detection and management levels, and Life continuum - strategies across the life span</p> <p>At each level, certain activities are recommended to ensure that prevention, early detection and management is happening uniformly</p>
Age	0-4 yrs	5-14 yrs	15-54 yrs	55+ yrs																																											
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<p>Slide 6 Model for Rural and Remote Areas</p>	<p>Delivering Chronic Disease Strategy</p> <ul style="list-style-type: none"> Clinical Guidelines: Clinical case decision support, Clinical Networks, Chronic Disease Guidelines, Primary Clinical Care Manual, Pathology Handbook Electronic Support: Population registers, Patient recall, Decision support, Ferret Quality Improvement: Monitoring & evaluation, Clinical indicators, Funding, Audit & Peer Practice for Chronic Disease program (ABCDS) Partnerships: Community, Factors, Health Service Providers Regional/Local: Health Forums (R2R), Connecting Health in Communities (CHIC) Workforce: Building workforce capacity, Chronic Disease Positions Management of chronic disease: Individual & Family, Whole Population, Communities Self management support: (Central to the model) 	<p>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.</p>																																													
<p>Slide 7 Levels of Intervention</p>	<p>Levels of Intervention</p> <ul style="list-style-type: none"> Domains or levels of intervention and Client and community central services <p>CHRONIC DISEASE STRATEGY</p> <p>Prevention Early Detection Management</p> <p>TARGETING THE WHOLE POPULATION</p> <p><i>Guidelines are Manual ok</i></p>	<p>Notes: In the centre of the model the levels or domains of intervention are identified.</p> <p>Prevention includes health promotion health education, immunisation and environmental health</p> <p>Early detection includes screening and brief interventions and</p> <p>Management includes management of chronic diseases using protocols , care plan</p>																																													

		<p>development and implementation and self management.</p> <p>Primary health care must be provided to the individuals taking into consideration their families and communities.</p>
<p>Slide 8 Clinical guidelines</p>		<p>Notes: Clinical guidelines are required to ensure practice is standardised, evidence based, safe and in line with agreed protocols, policy and legislative guidelines</p>
<p>Slide 9 Electronic support</p>		<p>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.</p>

<p>Slide 10 Quality improvement</p>		<p>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</p>
<p>Slide 11 Partnerships</p>		<p>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.</p>

<p>Slide 12 Workforce</p>	 <p>Workforce</p> <ul style="list-style-type: none"> ■ Workforce orientation and training ■ Chronic Disease Strategy Coordinators ■ Newsletters & training <p>Workforce Building workforce capacity Chronic Disease Positions</p> <p>health • care • people Queensland Government</p>	<p>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.</p>
<p>Slide 13 Chronic Disease Guidelines</p>	 <p>Chronic Disease Guidelines</p> <ul style="list-style-type: none"> • Provides a summary of the 'Chronic Disease QSCD' • Integrates population health approach • Provides evidence based clinical guidelines for: <ul style="list-style-type: none"> • Health Checks • Care plans <p>Chronic Disease Queensland Clinical Guidelines</p> <p>health • care • people Queensland Government</p>	<p>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.</p>

<p>Slide 14 Learning Activity</p>	 <p>PaRRROT</p> <h3>Learning Activity</h3> <p>Please complete the learning activity</p> <p>health • care • people</p> <p>Queensland Government</p>	<p>Notes:</p>
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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.

<div style="border: 1px solid black; background-color: #d4edda; padding: 10px; margin-bottom: 10px;"> <p>Clinical Guidelines</p> <ul style="list-style-type: none"> • Clinical care decision support • Clinical Networks <p><i>Chronic Disease Guidelines Primary Clinical Care Manual Pathology Handbook</i></p> </div>	<div style="border: 1px solid black; background-color: #d4edda; padding: 10px; margin-bottom: 10px;"> <p>Electronic Support</p> <ul style="list-style-type: none"> • Population register • Patient recall • Decision support <p><i>Ferret</i></p> </div>	
<p style="color: red; font-weight: bold;">Prevention</p>	<p style="color: red; font-weight: bold;">Early Detection</p>	
<div style="border: 1px solid black; background-color: #d4edda; padding: 20px; margin: 0 auto; width: 80%;"> <p style="text-align: center;">CHRONIC DISEASE STRATEGY</p> <p style="text-align: center;">Prevention Early Detection Management</p> <p style="text-align: center;">TARGETING THE WHOLE POPULATION</p> </div>		
<p style="color: red; font-weight: bold;">Management</p>		
<div style="border: 1px solid black; background-color: #d4edda; padding: 10px; margin-bottom: 10px;"> <p>Quality Improvement</p> <ul style="list-style-type: none"> • Monitoring and evaluation • Clinical Indicators • Financing <p><i>Audit & Best Practice for Chronic Disease Program ABCD(E)</i></p> </div>	<div style="border: 1px solid black; background-color: #d4edda; padding: 10px; margin-bottom: 10px;"> <p>Workforce</p> <p>Building workforce capacity</p> <p style="text-align: center;"><i>Chronic Disease Positions</i></p> </div>	<div style="border: 1px solid black; background-color: #d4edda; padding: 10px; margin-bottom: 10px;"> <p>Partnerships</p> <ul style="list-style-type: none"> • Community partners • Health service providers <p><i>Regional / Local Health Forums (RHF) Connecting Health in Communities (CHIC)</i></p> </div>



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 - 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 an 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)

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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.