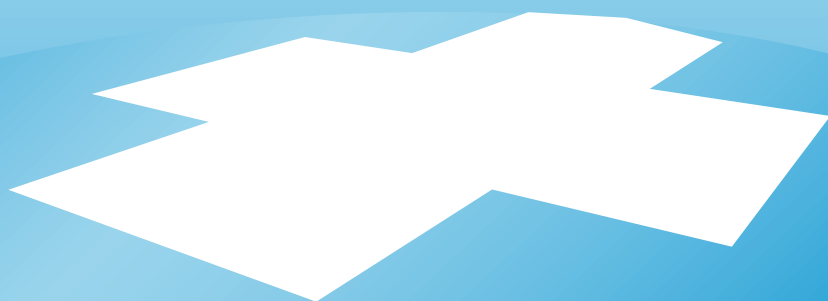


CONNECTING CARE

Chronic Disease Action
Framework for Tasmania

2009–2013



Consumer stories contained in this document reflect the views and experiences of individuals and do not necessarily represent the views of the Tasmanian Department of Health and Human Services.

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My story: Sessions ease pain

Fifteen years ago Annie Deverell was a healthy, active woman in her early 40s. But when her joints began to seize up and walking became a chore, her life was flipped upside down. At one stage the severe pain forced the Strahan woman to live on the couch, and at other times, left her in an ambulance.

After endless doctor visits the results came through – but the last thing she expected was arthritis. “I thought I was too young to have it – but then I didn’t realise young children get it,” she said.

Mrs Deverell was diagnosed with spondylitis arthritis – a spinal condition that affected her back nerves. “It was just a consistent bad back and not being able to walk,” she said. Pain management sessions and vitamins helped her cope with the condition, but what gave Mrs Deverell the motivation to get her life back to normal was a HealthWest seminar. “Maggie Johnson (the coordinator) was running a chronic disease management course in Queenstown and asked would I go.”

The weekly sessions helped shake Mrs Deverell out of the black hole that had caused her to put on weight and lose energy. “That’s one of the things that mucks everything up ... we have to stay active and keep fit.”

The Get the Most out of Life* sessions gave her an introduction to condition management and different options available for sufferers.

She found talking to others and relaying stories made dealing with the illness all the easier. “The group therapy was great ... people would sit down and tell me what they did for the week.”

Annie Deverell, Strahan

This is an edited version of a story that first appeared in the Advocate.

*“Get the Most Out of Life” is a structured group based self-management program for people with chronic disease and their carers or family. It is also known as the Stanford or Lorig Chronic Disease Self-Management Program. The program runs for 2.5 hours a week over six weeks. It includes topics such as managing symptoms, communicating with health providers, setting goals and problem solving, nutrition and physical activity. Get the Most Out of Life programs are run by various organisations across Tasmania. For more information call Population Health, DHHS – North (ph 6336 2405), North West (ph 6440 7134), South (ph 6222 7708).

Foreword

Together with *Tasmania's Health Plan and Strategic Directions 2009 - 2012*, *Connecting Care* charts the direction for a coordinated and strategic approach to improve the prevention, detection and management of chronic disease in Tasmania over the next four years. The Framework identifies a shared vision, principles, goals and action areas that can guide all individuals and groups working to improve the health and wellbeing of Tasmanians.

While Tasmanians enjoy an enviable quality of life, we fall below the national average in a number of important health and lifestyle measures and experience greater levels of disease and disability. There are also a number of disadvantaged population groups in Tasmania at increased risk of chronic conditions and who have fewer resources to cope when illness strikes.

The financial cost of chronic disease is often reported, but chronic disease also damages the quality of life of many individuals, their families and carers and impacts on their ability to participate fully in workforce, community and family life. It affects the broader community by reducing community participation and economic productivity and draws resources away from other parts of the health and human service system. Given that many chronic diseases are preventable, we can make potentially large improvements to our health and wellbeing through changes to lifestyle and other risk factors. We must also improve the way we detect and manage chronic disease because even with the very best health promotion efforts, many Tasmanians will continue to be affected by chronic disease into the future.

Most importantly, we need to recognise the importance of placing people accessing the health and human service system at the centre of all service delivery and planning activities.

My Department can only hope to achieve this with the collaboration of our many health and community service partners, in particular with the general practitioners and community sector organisations that support people affected by chronic disease. Government and health service providers at all levels need to work with the broader community if we are to succeed and I am grateful to the partnerships that have been established in putting this Framework together.

To put it simply: we need to do better. We need to create a health and wellbeing system for Tasmania that makes it easier for people to stay healthy, identifies disease early and eases the burden for those who are living with chronic disease. I believe this Framework is a significant step towards building that health and wellbeing system and I look forward to a healthier Tasmania in the future.



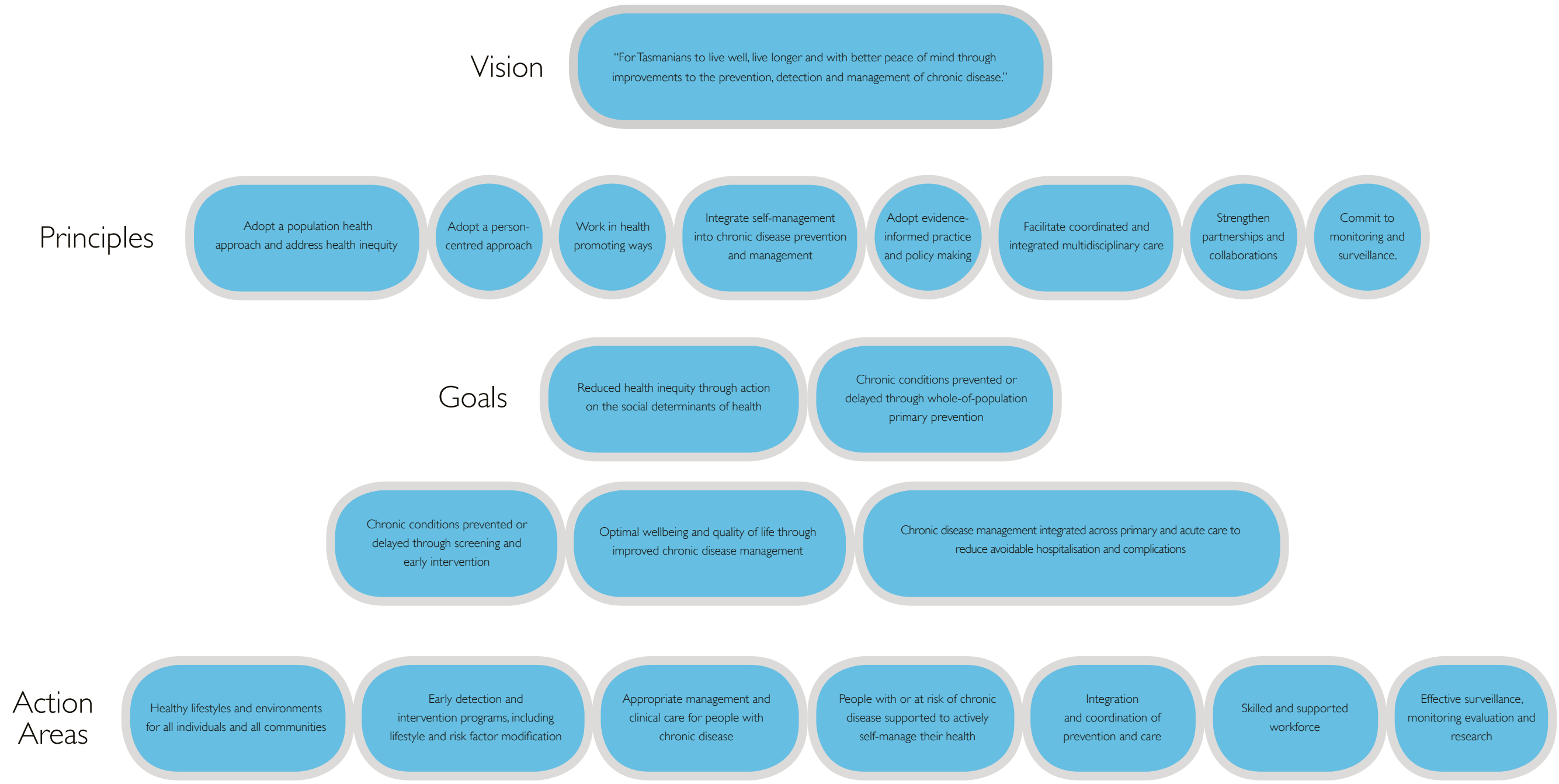
Lara Giddings
Minister for Health

Connecting Care at a glance

Connecting Care charts the direction for a coordinated and strategic approach to improve the prevention, detection and management of chronic disease in Tasmania over the next four years. It presents a shared vision, principles, goals and action areas that can guide all individuals and groups working to improve the health and wellbeing of Tasmanians.

Chronic diseases:

- Have complex and multiple causes
- Usually have a gradual onset, although they can have a sudden onset and acute stages
- Occur across the life cycle, although they become more prevalent with older age
- Can compromise quality of life through physical limitations, disability and psychological consequences
- Are usually long term and persistent, and may lead to a gradual deterioration of health
- While usually not immediately life threatening, they are the most common and leading cause of premature mortality.¹



¹ Adapted from: National Health Priority Action Council. *National Chronic Disease Strategy*. Canberra: Australian Government Department of Health and Ageing, 2006.

Acronyms

DALY	Disability Adjusted Life Year (see page 12)
DHHS	Department of Health and Human Services
DoE	Department of Education
DPAC	Department of Premier and Cabinet
NGO	Non Government Organisation
PPAC	Premier's Physical Activity Council
SNAPPs	Smoking, Nutrition, Alcohol, Physical Activity and Psycho-social factors (see page 18)

My Story:

Ailing system prolongs illness

Peter Willoughby's story is a hymn to why we need greater integration and smoother health pathways in Tasmania.

Peter is a social worker who has lived with chronic illness for over five years. At its worst, his chronic disease kept him out of the workforce for the better part of two years. Understandably, this hit him and his family hard financially.

But it might have been different.

Peter, who is back at work and getting better, faced a gruelling round of frustrating visits to more health professionals than necessary, which he says did nothing to improve his health. According to Peter, when depression strikes you need to see your GP immediately.

"To see your GP each time you need to make an appointment one or even two weeks ahead; this does not work well in my situation," Peter says. "When you're chronically unwell, the last thing you feel like doing is telling the same story to different GPs."

Peter says this is made worse because most GPs are under so much time pressure. "With a 15 minute time slot and running behind, most GPs just don't have time to listen. It was a major barrier," Peter says.

The next hurdle was finding the right psychiatrist. It took Peter three attempts. Initially, Peter was reluctant to take the medication road but found it a challenge to find a psychiatrist with more than one strategy.

While Peter concedes that medication did help, he also needed coping strategies and help working out daily and weekly life plans. Peter reflects that having different GPs and psychiatrists did not work well for him.

"The lack of continuity of process causes psychological distress and is a barrier to people getting well; it prolonged my illness. If I had stayed at work it would have been better – you get sicker outside of work. If I could have eased back into work earlier it would have improved my sense of worth and I would have focused less on myself. It would have eased the financial worries that led to greater distress. It was a downward spiral – normalcy helps."

Peter says people with chronic disease need a direct pathway. "People still need to have choices but should be able to opt for some direct approach, a chronic disease specialist service that quickly puts people in touch with those who can help you specifically."

Peter Willoughby, Hobart

Introduction

The need to significantly reform health and human service systems in response to the current and future challenge of chronic disease is increasingly recognised in Australia and overseas. Changes in healthcare needs and practices demand corresponding changes to the structure and nature of healthcare systems.

In the past, healthcare was designed to deal with acute illness and injury as it occurred, primarily in the acute, hospital-based setting. This reactive style of healthcare is now struggling to cope with the increasing numbers of people living with chronic disease who need ongoing contact with a range of services. Now and into the future, healthcare will aim to prevent or reduce the impact of chronic diseases and support people to live well in the community for as long as possible.

The vision of *Connecting Care* is, “for Tasmanians to live well, live longer and with better peace of mind through improvements to the prevention, detection and management of chronic disease.” To this end, the Framework identifies a vision, goals and principles that all individuals and groups can share in working to improve the health and wellbeing of Tasmanians. These have been identified with the expert advice of many health professionals and practitioners, significant research, and the collaborative input of consumers and their families.

Connecting Care sits within the context of a number of national and state initiatives designed to improve how we respond to chronic disease (see Figure 1). In particular, it is led by *Tasmania’s Health Plan, Strategic Directions 2009-12*, the *National Chronic Disease Strategy* and the Council of Australian Government’s (COAG) national health reform agenda. For a more detailed list of relevant national and state policy initiatives see Appendix 6.

The framework will also be complemented by DHHS’ strategic framework for health promotion: *Working in Health Promoting Ways* (see Appendix 5). Together these documents form a platform to guide a range of initiatives to improve the health and wellbeing of Tasmanians. This platform includes a chronic disease self-management framework, clinical networks, and the development of clinical service standards and guidelines. The other fundamental component to the successful implementation of the framework will be to align with the DHHS Policy for the Integration of Care and the Area Health Service integration plans bringing primary and acute health services together.

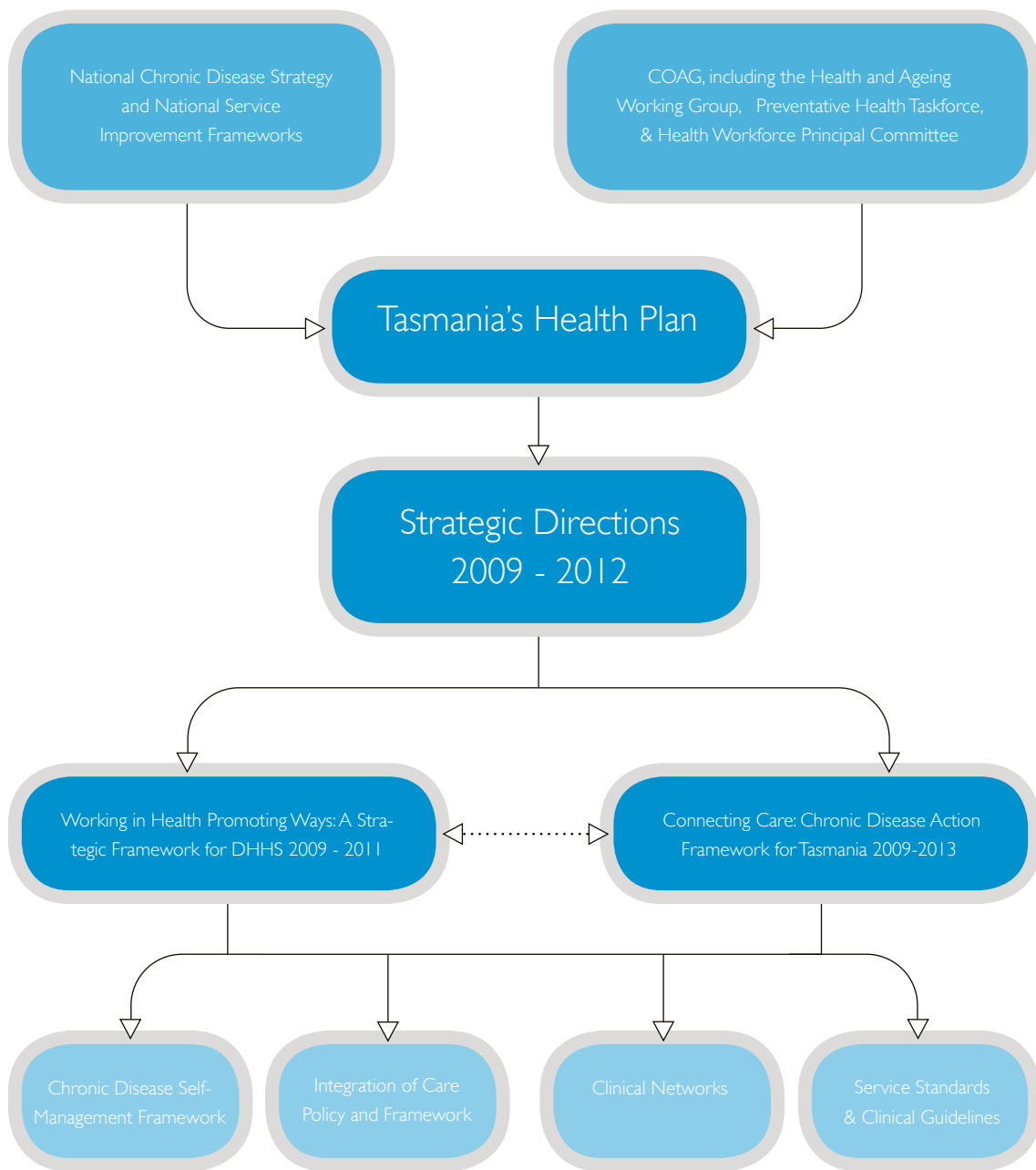


Figure 1. State and national chronic disease policy context

Why we need a chronic disease action framework

Having a chronic disease often has a significant and ongoing impact on a person's long term health and wellbeing. Chronic disease can reduce the ability of the person, and their family and carer, to actively participate in work, home and leisure roles, which in turn can lead to isolation, social exclusion and further complications to health and wellbeing.

Chronic disease also poses special challenges for the health system. People with chronic disease use health services and medicines frequently and for long periods. They often develop complex conditions with associated co-morbidities including mental health problems such as depression².

To reduce the impact that chronic disease places on individuals, families, carers, the health and human service system and the broader community, Tasmania needs a coordinated and strategic approach to guide the improved prevention, detection and management of chronic disease. This includes improvements to existing services as well as new and innovative ways to deliver services.

Chronic Disease in Tasmania

Chronic diseases account for a majority of the burden of disease in Australia. Burden of disease is a measure of the gap between the current health status in a population and an ideal situation where everyone lives into old age free from illness and disability³. It is commonly assessed using the disability adjusted life year (DALY), a measure of healthy years of life lost due to disability. The table below shows the 10 leading causes of DALYs by broad disease categories for Australia.

Table 1. % Total burden, detection and management of chronic disease.⁴

Cause of Burden (DALYs)	% of Total Burden, detection and management of chronic disease. ⁴
Cancers	19.0%
Cardiovascular disease	18.0%
Mental disorders	13.3%
Neurological & sense disorders	11.9%
Chronic respiratory diseases	7.1%
Diabetes mellitus (type 2)	5.5%
Unintentional injuries	4.8%
Musculoskeletal conditions (including arthritis)	4.0%
Genitourinary conditions	2.5%
Intentional injuries	2.2%

² National Health Priority Action Council. *National Chronic Disease Strategy*. Canberra: Australia Government Department of Health and Ageing, 2006.

³ Australian Institute of Health and Welfare (AIHW). *Australia's Health 2006*, AIHW Catalogue No AUS73. Canberra: AIHW, 2006.

⁴ Australian Institute of Health and Welfare (AIHW). *The Burden of Disease and Injury in Australia 2003*. Canberra: AIHW, 2007

The table below lists the 10 leading specific causes of burden of disease for Australia and summarises for Tasmania these causes in terms of rank order and percentage of total burden. The relative distribution of the total burden of disease among the 10 leading causes of disease in Tasmania is similar to the rest of Australia, with the exception of Chronic Obstructive Pulmonary Disease (COPD), which is greater in Tasmania than the rest of Australia.

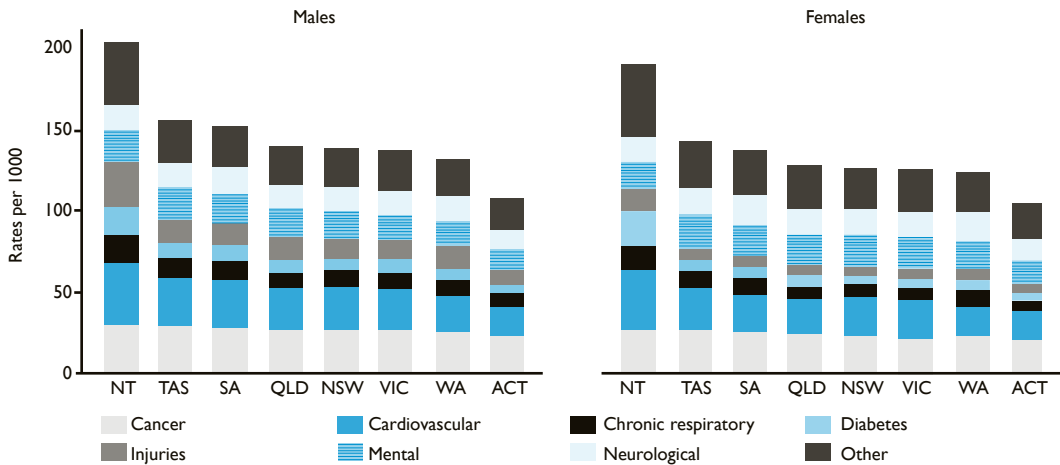
Table 2. Differentials in burden (DALYs) in Tasmania and Australia for the 10 leading specific causes of burden of disease, 2003⁵

Cause of burden (DALYs)	Rank		% Total burden Tasmania
	Tasmania	Australia	
Ischaemic heart disease	1	1	10.7
Anxiety and depression	2	2	7.3
Type 2 diabetes	3	3	5.0
Cerebrovascular accident	4	4	4.4
Dementia	8	5	2.5
Lung cancer	6	6	3.8
Chronic obstructive pulmonary disease (COPD)	5	7	4.0
Adult-onset hearing loss	9	8	2.4
Colorectal cancer	7	9	2.7
Asthma	10	10	2.4

⁵ Australian Institute of Health and Welfare (AIHW). *The Burden of Disease and Injury in Australia 2003*. Canberra: AIHW, 2007.

Due to a higher proportion of older and lower socioeconomic populations, Tasmania experiences a greater burden of disease as a result of chronic disease. Figure 2 shows the proportion of burden of disease and injury experienced by each state and territory as measured by DALYs across a number of chronic diseases. Age standardised rates show Tasmania has the second highest rates of burden of disease and injury after the Northern Territory.

Figure 2. Age standardised DALY rates by 1,000 by state/territory, broad cause group and sex⁶



While the facts and figures about chronic disease appear alarming, it is also important to remember that at a population health level the health of Tasmanians is the best it has ever been⁷. Comparatively speaking, Australians enjoy one of the highest levels of population health and access to health and human services of any country in the world. Of the 191 countries whose health status is monitored by the World Health Organization, Australia has the fifth highest life expectancy⁸, a strong indication of the overall good health of our population.

But while Australians enjoy relatively good health and access to high quality care, many chronic diseases are preventable; so we can and should do better⁹.

In addition, given the significant inequalities in health between population groups within Tasmania and between Tasmania and Australia as a whole, as well as Tasmania's poorer overall health status, ageing population and risk factor profile, it is critical we improve the prevention, detection and management of chronic disease.

⁶ Australian Institute of Health and Welfare (AIHW). *The Burden of Disease and Injury in Australia 2003*. Canberra: AIHW, 2007.

⁷ Department of Health and Human Services. *State of Public Health Report*. Hobart: Tasmanian Government, 2008.

⁸ Ibid

⁹ Ibid

My Story:

Time for health to get with IT

Bev Pinkett has seen Tasmania's health system up close and personal for a long time – so she's quite aware of the pitfalls.

Bev has lived with asthma for 24 years and then about 10 years ago she developed osteoarthritis and rheumatoid arthritis. More recently she has experienced mini strokes. Bev, who worked for the DHHS' Population Health Unit, is full of praise for Tasmania's GPs and acute services staff at the Royal Hobart Hospital.

"People working at the coalface in health are really good, with very few exceptions," Bev says. She is particularly impressed with pharmacists who, she says, never fail to ask if you've taken a particular medication and then carefully explain how it should be used. But Bev does echo one common complaint: it is often very difficult to get in to see GPs, allied health workers and specialists at short notice.

"Waiting 10 days to see your GP is quite common these days, which means the emergency medicine department is the best place to go when you're feeling really unwell," she says. "But even here you can wait a long time in an ambulance or a corridor before being admitted."

Bev is all for the introduction of electronic records. "People shouldn't have to keep repeating the same information to everyone over and over again. There have been times when I've had to go through all my medical details while desperately trying to breathe."

On another level, Bev says people with arthritis, for instance, may also have MS, diabetes or a mental illness at the same time.

"If you see one medical professional about one chronic illness they often don't consider how it relates to another disease – there's little cross communication. And with multi diagnoses comes multi medication; so it's little wonder there are adverse reactions, some of which can be quite dangerous."

Bev is happy for health professionals to have access to her files so they know her health status and how she is treated.

However, Bev insists that medical information must be owned by the patient, who must decide who has access. She also acknowledges that not everyone trusts electronic record systems and that some will need to be convinced.

Now in retirement, Bev works as a volunteer with Arthritis Tasmania to help people better manage their illness through the Get the Most out of Life chronic disease self-management program. This helps participants develop self-management strategies and improve their health outcomes.

Bev Pinkett, Hobart

The underlying causes of chronic disease

To effectively address chronic conditions, we need to acknowledge and address the underlying causes. The determinants of health are those risk and protective factors known to influence the development, degree and duration of most chronic diseases.¹⁰

The social determinants of health

The social determinants of health are the conditions of daily living that determine a person's chances of achieving good health: the conditions in which people are born, grow, live, work and age.¹¹ A safe environment, adequate income, meaningful roles in society, secure housing, higher level of education and social support within communities are associated with better health and wellbeing.

The development of chronic disease later in life is strongly connected to childhood experiences. Preparation and support for parenting prior to birth and during childhood is vital, as is facilitating effective health promotion activities and interventions during childhood and adolescence.

Lower socioeconomic status, whether measured by income, educational attainment or occupation, is associated with poorer health, higher rates of chronic disease and their risk factors and higher use of health and human services.

Table 3 shows that in Australia people of a lower socioeconomic status experience a greater burden of chronic disease than people of a higher economic status.

Action to address the social determinants of health must take place at a whole-of-community level because many of these factors are beyond the control of the health and human service system alone. The World Health Organization recently called for whole-of-government, civil society, local community and business action to address the social determinants of health.¹²

Table 3. Burden of disease (DALYs) for socioeconomic quintiles by proportion of total population, Australia 2003¹³

Socioeconomic status	DALYs ('000)	% of total burden
Low	562.5	21.4
Moderately low	564.2	21.4
Average	523.6	19.9
Moderately high	507.7	19.3
High	474.8	18.0
Total	2,632.8	100.0

¹⁰ Department of Health and Human Services. *State of Public Health Report*. Hobart: Tasmanian Government, 2008.

¹¹ Commission on Social Determinants of Health. *Closing the Gap in a Generation*. Geneva: World Health Organization, 2008.

¹² Commission on Social Determinants of Health. *Closing the Gap in a Generation*. Geneva: World Health Organization, 2008.

¹³ Australian Institute of Health and Welfare (AIHW). *Burden of Disease and Injury in Australia 2003*. Canberra: AIHW, 2007.

Vulnerable population groups

People from vulnerable or at risk population groups have a greater risk of health inequity and the development of a chronic condition because of social and economic disadvantage.¹⁴

In Australia, population groups particularly vulnerable to chronic disease include Aboriginal people, people with disabilities, people with mental health issues, migrants and refugees, people held in the criminal justice system, young people from low socioeconomic or disadvantaged backgrounds and homeless people.

For example:

- Aboriginal people experience significant health inequities. They have poorer overall health status, lower life expectancy and higher infant mortality rates¹⁵
- People with developmental and intellectual disability have a higher risk of chronic disease than the average population and have more difficulty accessing services and self-managing their condition¹⁶
- 18% of Australians have a common mental disorder (depression, anxiety or substance misuse) and 43% of these people have a physical illness. There is consistent evidence that depression is a risk factor for heart disease, stroke and diabetes mellitus (type 2).¹⁷

Gender is also a strong determinant of health and can have a compounding effect on other inequities. Men and women experience particular types of chronic disease differently because of their biology. Gender can also have an impact on people's ability to manage their condition; for example, the impact of being the primary carer of children and other family members.

Families and carers of people living with chronic disease can be at increased risk of developing a chronic disease themselves. Carers are those people who provide unpaid care for family members or friends unable to live independently in the community because of disability or chronic illness. Carers need support in their own right because providing care can involve significant daily physical, emotional and mental demands that place them at increased risk of chronic disease, particularly depression.

¹⁴ Marmot, M., 'Social Determinants of Health Inequalities,' *Lancet*, (2005): 1099-1104.

¹⁵ Department of Health and Human Services. *Strengthening the Prevention and Management of Chronic Conditions*. Hobart: Tasmanian Government, 2005.

¹⁶ Lawrence D., Holman D. and Jablensky A. *Duty to Care: Preventable physical illness in people with mental illness*. Perth: The University of Western Australia, 2008.

¹⁷ Clarke, D. and Currie K., 'Depression, anxiety and their relationship with chronic diseases,' *Medical Journal of Australia* 7, (2009): 190.

Risk factors for chronic disease

The known risk factors for chronic disease include:

- Structural determinants or risk conditions such as poverty, discrimination, low socioeconomic status and dangerous work
- Psychosocial risk factors such as isolation, lack of social supports and networks and low self esteem
- Behavioural risk factors such smoking, poor nutrition, physical inactivity and substance abuse
- Physiological risk factors such as high blood pressure, high cholesterol and genetic factors.¹⁸

The behavioural risk factors are sometimes referred to as lifestyle risk factors or modifiable or preventable risk factors, as these are factors that can be changed to decrease the likelihood of developing many chronic diseases, and or reduce the complications or progression of chronic disease.

The behavioural risk factors for chronic disease are also commonly known as the SNAPPs factors: smoking, poor nutrition, alcohol misuse, physical inactivity and psycho-social conditions.

Epidemiological evidence indicates that four non-communicable diseases make the largest contribution to mortality in most low- and middle-income countries: cardiovascular disease, cancer, chronic respiratory disease and diabetes mellitus (type 2). These four diseases share the same underlying behavioural risk factors: tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol.¹⁹

In Australia, tobacco, high blood pressure, high body mass, physical inactivity and high cholesterol made the greatest contribution to Australia's burden of disease in 2003 (see Table 4).

Table 4. Burden of disease (DALYs) attributed to selected risk factors, Australia, 2003²⁰

Risk factor	% Attributed to total burden of disease
Tobacco	7.8
High blood pressure	7.6
High body mass (being overweight)	7.5
Physical inactivity	6.6
High blood cholesterol	6.2
Alcohol	2.3
Low fruit/vegetable consumption	2.1
Illicit drugs	2.0

¹⁸ Department of Human Services. *Integrated health promotion: A practice guide for service providers*. Melbourne: Victorian Government, 2003.

¹⁹ World Health Organization. www.who.org. Geneva: WHO, accessed 2 February 2009.

²⁰ Australian Institute of Health and Welfare (AIHW). *Burden of Disease and Injury in Australia 2003*. Canberra: AIHW, 2007.

Tasmanians have higher levels of some of the behavioural risk factors for chronic disease. Compared with the national average, they are more likely to be obese and to smoke.²¹ Table 5 below provides a comparison of selected risk factors for chronic disease in the Tasmanian population against national averages.

Table 5. Chronic disease risk factor prevalence, Tasmania and Australia, National Health Survey 2004/05²²

Risk factor	Indicator	Tasmania	Australia
Smoking	% of 18 years+ who are current daily/occasional smokers	25.4	23.2
Alcohol misuse	% of 18 years+ at risk of long-term alcohol-related harm	11.5	13.5
Physical inactivity	% of 15 years+ classified as sedentary	33.6	34.0
Overweight/ Obesity (BMI)	% of 18 years+ classified as overweight % of 18 years+ classified as obese	31.8 17.1	32.7 16.6

As elsewhere, in Tasmania risk factors associated with chronic disease are linked to socioeconomic status. People from low income households are more likely to smoke, be physically inactive and be overweight or obese. However, people from high income households are more likely to engage in risky alcohol consumption (see Table 6).

Table 6. Chronic disease risk factor prevalence by household income quintiles, NHS, Tasmania 2004/05²³

Risk factor	% within household income quintile				
	1 st (lowest income)	2 nd	3 rd	4 th	5 th (highest income)
Daily/occasional smoking ^a	32.1	29.4	24.9	23.9	15.6
Alcohol consumption levels at risky/high risk for long term harm ^a	9.4	9.6	9.9	15.6	17.0
Sedentary activity levels	41.9	41.9	33.8	27.4	17.8

^a >18 years; b >15 years; c >12 years

²¹ Department of Health and Human Services. *Primary Health Services Plan*. Hobart: Tasmanian Government, 2007.

²² Department of Health and Human Services. *Health Indicators Tasmania*. Hobart: Tasmanian Government, 2008.

²³ Australian Bureau of Statistics (ABS). *National Health Survey*. Canberra: ABS, CURF data 2004/05.

Ageing and chronic disease

Age is another factor linked to the increase in chronic disease. While ageing itself is not a risk factor for ill health – and many older people live healthy, productive lives – the prevalence of chronic disease and the need for associated services increases significantly within older age groups, particularly after the age of 65 years.²⁴ For example, over 60% of all cancers in Tasmania occur in people aged 65 years and over.²⁵ Tasmania is experiencing the effect of population ageing more than other states and territories and the gap is widening:

- Tasmania has the oldest population of all states and territories with the greatest proportion of people aged over 65 years²⁶
- The median age of Tasmanians is projected to reach 49.8 years by 2051, an increase of 11.4 years on current levels²⁷
- Based on these projections, over 30% of Tasmanians will be 65 years or over by 2040, which is double the current rate.²⁸

The projected increase in the age of Tasmania's population will have significant implications for health and human service delivery, particularly hospital services. Data from 2001-2005 shows that hospitalisation rates in Tasmania double between the 40-59 year-old age group and 60-79 year-old age group.²⁹

There are even further increases among those aged 80 years and over. If these hospitalisation rates remain stable, the future demand for hospital services in Tasmania will increase dramatically.³⁰

²⁴ Borowski et al. *Longevity and Social Change in Australia*. Sydney: NSW Press, 2007.

²⁵ Department of Health and Human Services. *State of Public Health Report*. Hobart: Tasmanian Government, 2008.

²⁶ Demographic Change Advisory Council of Tasmania. *Demographic Change in Tasmania: Challenges and Opportunities*. Hobart: Tasmanian Government, 2007.

²⁷ Australian Bureau of Statistics (ABS). *Population by Age and Sex, Australian States and Territories, June 2007*, Cat. No. 3201.0, Canberra: ABS, 2007.

²⁸ Department of Health and Human Services. *Health Indicators Tasmania*. Hobart: Tasmanian Government, 2008.

²⁹ Department of Health and Human Services. *State of Public Health Report*. Hobart: Tasmanian Government, 2008.

³⁰ Ibid.

My Story:

Tracey measures success in Tens

In training for the Burnie Ten, Tracey Klippel regularly breaks the pain barrier. But unlike most other competitors in Australia's premiere road race, Tracey is forced to live with pain day in, day out. That's because she has rheumatoid arthritis.

Tracey chose to compete in the Burnie Ten when asked to set a personal goal at a six-week self-management course she joined for people living with chronic disease in 2007.

Tracey was determined to find something that went beyond medication to improve her quality of life. One of the elements of the self-management course is developing strategies to reduce a participant's focus on their pain.

Tracey's strategy was to get physical.

As a result, in 2008 Tracey completed the Burnie Ten and has now challenged herself to complete the Burnie and Launceston Tens in 2009. Tracey says it has taken her a year to experience the full benefits, but she now takes less medication, is a lot calmer and can better handle life's ups and downs.

"These days my illness doesn't stress me as much as it once did and I communicate better with work colleagues when I'm well," Tracey says.

Some on her course felt it was a waste of time, but Tracey says she went in with an open mind because she wanted it to work.

"I've chosen to actively help myself because I don't want to lose my independence a day sooner than I must. I'm reasonably young and want to enjoy life; and while I have to live with this disease, I'm determined it's not going to control my life."

Tracey says when she feels better physically it naturally improves her mental wellbeing.

"It is easy to just get medication, but in my experience it's really worth thinking about attitude and taking some personal control."

As a result of her positive experiences and of giving a couple of presentations to health department staff, Tracey has approached Arthritis Tasmania to become a volunteer.

"I'm now really keen to help others, and I think volunteering will be good for me too," Tracey says.

Tracey Klippel, Launceston

Tasmania's conceptual framework for the prevention and management of chronic disease

Many countries have developed or are working toward new models for the prevention, detection and management of chronic disease. Known as conceptual frameworks, these models provide direction for organisations to plan and prioritise healthcare services.

The following conceptual model for Tasmania has been adapted from many of these ideas. Importantly, the framework also illustrates how the health and human service system can achieve the vision:

"For Tasmanians to live well, live longer and with better peace of mind through improvements to the prevention, detection and management of chronic disease"

In Tasmania, the DHHS has endorsed and works within the context of Wagner's Chronic Care Model (see Appendix 4), a conceptual framework for the prevention and management of chronic disease. The DHHS has also developed *Working in Health Promoting Ways*, a strategic framework to guide the direction of its health promotion work (see Appendix 5). *Connecting Care* acknowledges these models and presents Tasmania's Conceptual Framework for the prevention and management of chronic disease as a model to guide all stakeholders (see Figure 4).

The conceptual framework is based on the National Public Health Partnership's comprehensive model of chronic disease prevention and control,³¹ which was endorsed by all Australian governments in 2006. It also contains elements of the Queensland Government's conceptual frameworks for chronic disease³² and the Kaiser Permanente Triangle.³³

The conceptual framework for Tasmania shows the different levels of care across the prevention and management continuum. The aim is to support and enable people to stay as well as possible for as long as possible, including the well population and regardless of their chronic condition. The focus is to provide the optimal care at the right place and the right time, encouraging continuity and integration of care, and engaging all stakeholder organisations, practitioners and people as partners in managing their health and wellbeing.

³¹ National Public Health Partnership. *The Language of Prevention*. Melbourne: Australian Government, 2006.

³² Queensland Health. *Queensland Strategy for Chronic Disease 2005 – 2015*. Brisbane: Queensland Government, 2005.

³³ See www.kaiserpermanente.org

My Story: Helping to help yourself

Natasha Street has lived with chronic illness since birth and continues to surprise everyone with the level of her mobility. Everyone that is, except herself.

Medicos marvel at Natasha's determination to maintain her quality of life, but for Natasha taking responsibility and managing her wellbeing is an article of faith.

"I believe a modern health system should encourage wellness and actively help people to take responsibility for and maintain their own health and wellbeing," Natasha says. "Prevention is definitely better than a cure, but if that isn't possible then preventing further complications is a win-win for those with chronic conditions and the health system as a whole," she says. "Quality of life for those with existing chronic disease is very important."

However Natasha says that those with chronic conditions who try to stay as healthy as possible are often penalised by the existing system and have to battle to get any support. Yet these people if supported will in many cases end up saving valuable health system dollars and will be in a better position to contribute to and participate in society.

Natasha supports the Chronic Disease Strategy. She says it is a step forward, but warns it will need adequate funding.

"People will also need to accept that the preventative approach will take a long time to show results. It's not a cheap, quick fix. I hope the strategy works because it is often too late when people present at the acute end."

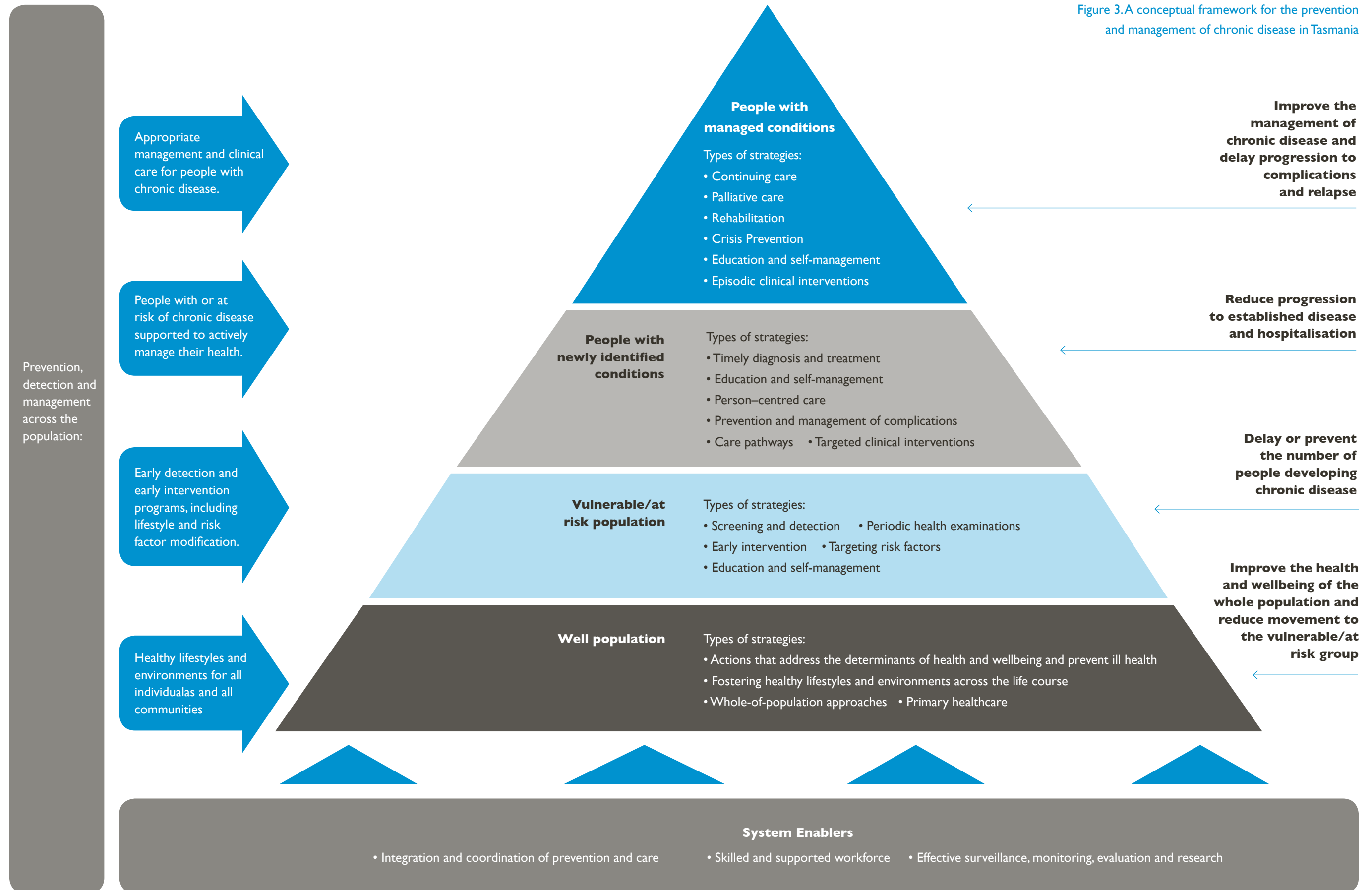
On the preventative side of the equation, Natasha says hospitals and health professionals must start setting an example.

"Hospitals have to lead the way by providing a greater range of healthy food options for patients, staff and visitors to choose from. More allied health professionals including dietitians, physiotherapists, exercise physiologists and orthotists are also needed in the system to support people to manage their health and wellbeing. Hospitals also need to provide healthy lifestyle programs for their staff so they can model healthy lifestyles."

Health professionals, Natasha says, will also have to start speaking more candidly to encourage their patients to adopt healthier lifestyle choices and then provide them with the support to do so.

Natasha Street, Launceston

Figure 3.A conceptual framework for the prevention and management of chronic disease in Tasmania



Guiding principles

The following principles guide the goals and strategies outlined in Connecting Care. They are drawn primarily from the National Chronic Disease Strategy and reflect contemporary approaches to chronic disease prevention and management. They complement and are consistent with the health planning principles identified in *Tasmania's Health Plan*.³⁵ These principles provide a strong foundation for guiding future actions and directions for the prevention, detection and management of chronic disease.

1. Adopt a population health approach and address health inequity³⁶

A population health approach aims to improve the health and wellbeing of the whole population and reduce health inequities among population groups.

It acknowledges the wide range of social, economic and environmental factors that influence the development and progression of chronic disease as well as the behavioural risk factors that affect health. The needs of all Tasmania's population groups and communities must be recognised and addressed.

Special challenges must be confronted to meet the needs of population groups disproportionately affected by chronic conditions such as Aboriginal people, older people, people from lower socioeconomic backgrounds and people with mental illness, or physical or intellectual disabilities.

Chronic disease prevention and management must be responsive to the needs of people:

- from all cultural and linguistic backgrounds,
- of all ages (including children, young people and older adults),
- of all socioeconomic and educational backgrounds, and
- living in all types of settings, including rural and remote communities.

2. Adopt a person-centred approach³⁷

A person-centred approach puts the person at the centre of their health and wellbeing.

It means the patient journey, comprising a person's whole experience of the health system – for each episode of care, across all healthcare settings and across the lifespan – is seamless and makes a positive difference as determined by the patient.

A person-centred approach drives healthcare services with outcomes relevant to the person living with chronic disease, their family and carers.

3. Work in health promoting ways³⁸

Many chronic diseases are preventable, which means we must prioritise health promotion and risk reduction for people at all stages of chronic disease: those without disease, those at risk of disease and those with chronic disease of varying complexity.

³⁵ Department of Health and Human Services. *Tasmanian Health Plan*. Hobart: Tasmanian Government, 2007.

³⁶ National Health Priority Action Council. *National Chronic Disease Strategy*. Canberra: Australian Government, 2006.

³⁷ Ibid.

³⁸ Ibid.

Health promotion represents a comprehensive social and political process. It not only embraces actions directed at strengthening the skills and capabilities of individuals but also actions directed at changing social, environmental and economic conditions to alleviate their impact on public and environmental health. Factors such as income, employment, education and social inclusion are a critical focus for promoting health and reducing risk, and require collaborative and concerted whole-of-government and whole-of-community action.^{39 40}

Working in Health Promoting Ways: A Strategic Framework (see Appendix 5) identifies eight principles of practice required to address health promotion priorities in an effective and sustainable way. These principles have their foundations in the Ottawa Charter, the Jakarta Declaration and the Bangkok Charter. They are: evidence-informed practice, addressing the social determinants of health, equity, partnerships, action across the continuum, cultural change, supportive settings and community participation.

4. Integrate self-management into chronic disease prevention and management

Self-management is the active participation by people in managing their own health. Self-management incorporates health promotion and risk reduction, informed decision-making, care planning, medication management and working effectively with healthcare providers to attain the best possible care and to effectively negotiate the often complex health system.⁴¹

Self-management requires collaboration between health workers and the person living with a chronic disease. It is part of an integrated healthcare system and an important element of delivering high quality chronic care.

While self-management is a central element of an evidence-informed approach to chronic disease management, not all diseases can be self-managed in the same way and people vary in their readiness, willingness and ability to self-manage.

5. Adopt evidence-informed practice and policy making

Evidence-informed practice and policy making integrate evidence from high quality research, clinical experience and patient values into service delivery practices and policy making. They encourage health practitioners and policy makers to access research evidence to inform specific decisions.

Evidence-informed practice and policy making is assisted by a translational research approach where practice and policy inform research, and research informs practice and policy. Translational research involves new research tools and methodologies as well as collaborations for developing service delivery practices and policy.

³⁹ National Health Priority Action Council. *National Chronic Disease Strategy*. Canberra: Australian Government, 2006.

⁴⁰ Wilkinson, R. and Marmot, M.E. *Social determinants of health: the solid facts, 2nd edition*. Edited by World Health Organisation (WHO). Geneva: WHO, 2003.

⁴¹ National Health Priority Action Council. *National Chronic Disease Strategy*. Canberra: Australian Government, 2006.

6. Facilitate coordinated and integrated multidisciplinary care

Management and support for people with chronic disease generally involves multiple healthcare providers in many settings including general practice, community health, hospitals, private providers, and community and non government organisations.

Chronic disease care may also draw on community and disability support as well as support from family and carers.

Integration of chronic disease prevention and management requires a flexible health system that can coordinate care planning across services, settings, sectors and over time. This demands commitment from a range of services and sectors, and their ability to work together to achieve shared goals.⁴²

Multidisciplinary care is provided by teams of health professionals made up of a mix of several relevant disciplines. The different disciplines within the team pool their expertise to make team-based treatment decisions based on the client's identified needs.⁴³

Multidisciplinary teams include the person with chronic disease and their family as a joint decision-maker in goal setting, assessment, care planning and delivery. Care is integrated into the natural environment and daily living of the person with chronic disease.

7. Strengthen partnerships and collaborations

Chronic conditions need to be dealt with by all levels of government, individuals, community groups, community sector organisations, private enterprise/business and across sectors.

Each of us must consider our role in the system and what we can do to improve the way we care for people at risk of, or living with, chronic disease.

Networks that link primary, acute and specialist care within a broader network of allied health and community support services are needed to provide patients who have complex needs with integrated, continuous care. This capacity must be enhanced.⁴⁴

8. Commit to surveillance, monitoring, evaluation and research

Ongoing surveillance, monitoring, evaluation and research are vital to enable the collection of reliable, timely and accurate information to inform decision-making, policy and practice.

In Tasmania, improved surveillance and monitoring will allow for better reporting on trends, stronger evidence of the extent of chronic disease, assessment of the effectiveness of interventions and help to forecast future healthcare needs.

⁴² National Health Priority Action Council. *National Chronic Disease Strategy*. Canberra: Australian Government, 2006.

⁴³ Department of Health and Human Services. *HARP Chronic Disease Management Guidelines*. Melbourne: Victorian Government, 2005.

⁴⁴ National Health Priority Action Council. *National Chronic Disease Strategy*. Canberra: Australian Government 2006.

My Story: Get the most out of life

Kim Robinson is a very busy woman. She lives and works on the family farm, is a mother, runs her own sports events and marketing business and is marketing manager for the Devonport Chamber of Commerce and Industry. Despite living with diabetes for many years, nothing much slowed Kim down.

That is until she developed fibromyalgia, a chronic disorder that causes widespread musculoskeletal pain, fatigue and weakness in the extremities. Suddenly, Kim was in so much pain and so tired that she became almost entirely reliant on her husband. "The symptoms of the disease put incredible pressure on my family, and my business suffered," she says.

Kim had lived with back pain for many years and severe sciatica, which sent searing pain down her leg. She twice had spinal surgery, which relieved the back pain she had before contracting fibromyalgia. At the time Kim had an obesity problem that she admits didn't help. "I didn't sleep well and then comfort ate to compensate."

Kim also suffered depression and took anti-depressants for a time. After her fibromyalgia diagnosis, Kim took steroids and a range of prescription drugs for about eight months. To make things worse, Kim developed further back problems and ongoing sciatica pain following lap-band surgery. "I was unhealthy and the pain was debilitating; it was a vicious circle," Kim says.

With such a high level of pain, Kim became concerned that she might get hooked on painkillers. "I was taking 10 Nurofen Plus a day to manage the pain; and while it was easy to function, I didn't feel 100 per cent normal. The fibromyalgia experience was a real awakening; a dress rehearsal for old age!"

So Kim decided to win back some measure of control and made health her number one priority. About 12 months ago she joined the Get the Most out of Life course. It proved a revelation. "Within a couple of months I began to feel a real benefit and now I'm off all painkillers and able to undertake mild exercise most days. Getting on top of the pain has been simply amazing."

Kim says having positive people around her at the course was a big help. "Sharing with others means you don't feel so alone; the group helped put things in perspective for me."

Kim learned how to do things differently, like using her arms and elbows to turn taps. "The course also taught me that I can't do things as I did before. Now if I get tired I stop what I'm doing and take a rest; I know I'll feel better for it the next day. I also recognise that feeling good doesn't mean being better – you have to pace yourself," Kim says.

Kim Robinson, Devonport

Chronic Disease Action Framework for Tasmania 2009–2013

Connecting Care provides the direction for a coordinated and strategic approach to build and strengthen the prevention, detection and management of chronic disease. The following vision, scope, goals and action areas will provide the guidance and momentum for action.

Vision

For Tasmanians to live well, live longer and with better peace of mind through improvements to the prevention, detection and management of chronic disease.

Definition and scope

Chronic disease can occur across the whole spectrum of illnesses and conditions. These include non-communicable diseases such as diabetes, cardiovascular disease, asthma, chronic obstructive pulmonary disease, cancer, arthritis and chronic kidney disease. They also include communicable diseases like Hepatitis B and C and HIV/AIDS; neurological conditions including dementia, multiple sclerosis and Parkinson's disease; chronic disability arising from injuries; and social and mental health conditions such as homelessness, social exclusion and depression.

Prevention programs aim to prevent chronic disease, and management programs treat and delay the onset of complications of chronic disease while reducing unplanned and avoidable hospital admissions.

While many chronic diseases can be prevented or their onset delayed, there are other chronic diseases that cannot be prevented but their progression can be slowed and often associated complications can be better managed, slowed and/or reduced. Examples include diabetes type 1, cystic fibrosis, rheumatoid arthritis (juvenile and adult) and congenital neuro-muscular conditions.⁴⁵

Chronic diseases and conditions differ in complexity and have differing levels of healthcare needs ranging from self-management support, to disease care and management. There are some highly complex chronic conditions that need specific health professional expertise and specific interventions in addition to care, management and self-management support.⁴⁶

While there is often disagreement on what constitutes chronic disease – and views differ on whether the term chronic disease or chronic condition should be used – for the purpose of this Strategy, the National *Chronic Disease Strategy's* broad definition of chronic disease is adopted.⁴⁷

⁴⁵National Health Priority Action Council, *National Chronic Disease Strategy*. Canberra: Australian Government, 2006.

⁴⁶*ibid.*

⁴⁷*ibid* (adapted).

Chronic diseases:

- *Have complex and multiple causes*
- *Usually have a gradual onset, although they can have a sudden onset and acute stages*
- *Occur across the life cycle, although they become more prevalent with older age*
- *Can compromise quality of life through physical limitations, disability and psychological consequences*
- *Are usually long term and persistent, and may lead to a gradual deterioration of health*
- *While usually not immediately life threatening, they are the most common and leading cause of premature mortality.*

Goals

The goals of *Connecting Care* are:

1. Reduced health inequity through action on the social determinants of health
2. Chronic conditions prevented or delayed through whole-of-population primary prevention
3. Chronic conditions prevented or delayed through screening and early intervention
4. Optimal wellbeing and quality of life through improved chronic disease management
5. Chronic disease management integrated across primary and acute care to reduce avoidable hospitalisations and complications.

Action areas

Connecting Care identifies seven action areas that offer potentially large gains through improvements to the health and human service system.

These action areas align with the directions set out in the *National Strategy for Chronic Disease* and reflect the issues raised by stakeholders during the development of the Strategy. They support the overarching vision, goals and principles of the Framework.

1. Healthy lifestyles and environments for all individuals and communities
2. Early detection and early intervention programs, including lifestyle and risk factor modification
3. Appropriate management and clinical care for people with chronic disease
4. People with or at risk of chronic disease supported to actively self-manage their health
5. Integration and coordination of prevention and care
6. Skilled and supported workforce
7. Effective surveillance, monitoring, evaluation and research.

Action area I: healthy lifestyles and environments for all individuals and communities

Rationale

Health is not merely determined by behavioural, biological and genetic factors, but also by a range of economic, environmental and social determinants.

Addressing broad structural determinants of health such as poverty, education, employment and transport, and improving social supports, community capacity and family functioning are important for better outcomes in health and wellbeing. These broader determinants of health require collaboration and action across many settings and involve multiple agencies.

Creating healthy communities and preventing ill health and chronic disease require the development of environments that support people to make healthy lifestyle choices and to live healthier lives.

Establishing good health and wellbeing early on in life through good parenting and positive early childhood experiences can also create lasting benefits.

The settings and circumstances in which people are born, grow, live, work and age are known to greatly impact on a person's chances of achieving good health. This makes schools, workplaces and neighbourhoods valuable places to promote health and wellbeing and address health inequity.

Health promotion should occur in these settings throughout life – from early childhood through to old age – and from the well population to those managing chronic disease. A whole-of-community approach involving multiple agencies across all relevant sectors is necessary if we are to succeed.

Strategies

- 1.1 Invest in strategies that promote health and wellbeing and reorient the health system to increasingly support prevention and health promotion.
- 1.2 Create healthy and supportive environments to improve health and wellbeing and decrease risk factors for chronic disease.
- 1.3 Support lifestyle interventions starting early in life and continuing across the life span.
- 1.4 Promote health and wellbeing in key settings such as childcare, schools, communities and workplaces.
- 1.5 Raise community awareness about the impacts and influences on health and encourage action to strengthen community support for good health.
- 1.6 Focus on reducing health inequities and addressing social determinants of health.
- 1.7 Use all appropriate healthcare interactions as an opportunity to promote and support actions that enhance health and wellbeing.

Case study: Family Food Patch

Family Food Patch improves parents' skills and knowledge about child and infant nutrition and physical activity by training peer educators, known as Family Food Educators, in their local communities. Educators are then supported to promote good nutrition and physical activity to other parents, relatives and groups. Of over 200 educators trained since 2001 in 23 Tasmanian communities, more than 150 remain active.

The project is delivered by the Child Health Association in partnership with the DHHS Community Nutrition Unit, who provide training and develop resources. The Family Food Patch steering committee includes representatives from the Child Health Association, Eat Well Tasmania, Playgroup Tasmania and the DHHS.

For further information call the Family Food Patch project officer on 6224 9198 or email familyfoodpatch@iprimus.com.au.

Case study: Move Well Eat Well

The Move Well Eat Well program provides positive, easy messages that promote healthy eating and physical activity for school communities. Since 2004, the program has worked to engage schools in sustainable health promoting strategies. It was substantially revised in 2007 along the lines of the Victorian Kids – *Go for your life* initiative.

Move Well Eat Well provides schools with recognition, support and a simple guide to create healthier environments. It uses the World Health Organization health promoting schools concept and enables engagement with families and the wider community.

The statewide program is funded under the Australian Better Health Initiative and managed by the DHHS and Tasmanian Department of Education.

For further information call the Move Well Eat Well project manager on (03) 6222 7328 or email movewelleatwell@dhhs.tas.gov.au.

Case study: Healthy By Design

The Heart Foundation has developed *Healthy by Design: A planner's guide to environments for active living in Tasmania* to help improve the health and wellbeing of Tasmanians.

A collaborative project between the Premier's Physical Activity Council and the Heart Foundation, *Healthy by Design* addresses issues around people's health and the built environment.

To be launched in 2009, the resource was originally developed by the Heart Foundation, Victoria in 2004, in response to local government requests for practical guidance in designing walkable and more liveable, neighbourhoods.

The Tasmanian edition, developed in consultation with the Local Government Association of Tasmania, provides information for planners, urban designers and engineers on how to incorporate healthy urban planning and design into neighbourhoods.

The resource includes design considerations to promote walking, cycling and public transport. It focuses on making changes to existing developed areas by providing or improving facilities, links and environments for active living.

For further information call the Heart Foundation's Tasmanian branch on (03) 6224 2722.

Case study: Active Launceston

Active Launceston aims to improve the health and wellbeing of Launceston's 120,000 residents through greater participation in physical activity.

The community-driven project is led by the University of Tasmania (UTAS) with support from Launceston City Council (LCC), the Tasmanian Department of Education, the *Examiner* and the Trim and Fitness International Sport for All Association. Since launching in 2008, Active Launceston has added value to local events, identified and developed resources that support and monitor physical activity and helped individuals overcome barriers to exercise.

UTAS has won the support of its faculties, schools and students, while LCC has moved from simply providing physical activity settings to offering services and programs.

It is funded by the Australian Department of Health and Ageing and the Tasmanian Department of Economic Development.

The DHHS (Women's Health North), Southern Cross Television and Hawthorn Football Club are among several supporters.

For further information call the Active Launceston project manager on 6324 4047 or visit: www.activelaunceston.com.au.

My Story: Peter distinguishes between treatment and care

Peter Weir shrugged off a three-generation tradition when he turned his back on a career in pharmacy, but couldn't shake something else running in the family – diabetes type 2.

Like many others with chronic disease, Peter has had more than one brush with serious illness. Not only has he had diabetes type 2 for more than a decade but last year he was diagnosed with lung cancer. Fortunately, the cancer was caught in its early stages and was removed without the need for chemotherapy. Since surgery three tests have shown him clear of the disease.

Peter, who works part time as a medical receptionist and surgery attendant, says his work and health concerns have given him some insight into health system issues and he offers a couple of possible remedies.

Firstly, he says it is essential that medicos show they care. "People must be made to feel that medical professionals care for them," Peter says. "In my experience there are two types of doctor: those who treat and those who care," he says.

Secondly, Peter says people must take more responsibility for their health. "It is very important that people take an interest in their health; but to do this they must be made aware of the issues."

Peter says that today there are too many people on too many pills. "Because pills make them feel better some people mistake this for good health. People have to do something about the causes of their illness; they have to be mindful of their health. But today it seems that too many people don't have time for this; they're too busy dancing with shadows."

Peter says he supports the Chronic Disease Strategy's aims to create a health and wellbeing system that makes it easier for people to stay healthy and helps those living with chronic disease to better manage their health. "Threatening people with future illness simply doesn't work," Peter says.

Following a series of "heart-to-hearts" with his own caring medico, Peter has taken a much more serious approach to his own health over the past 12 months. He now walks a lot and watches what he eats.

Peter Weir, Hobart

Action area 2: early detection and intervention programs, including lifestyle and risk factor modification

Rationale

The early detection of chronic disease and its risk factors through primary health services and population-based screening programs is a key strategy for preventing vulnerable or at risk population groups from developing chronic disease.

In many cases, early detection can reduce premature death, delay the progression of chronic disease and its complications, improve a person's quality of life and ability to self-manage, and may avoid unnecessary hospital admissions and the cost of complex care.

Early detection can even halt or reverse the development of chronic disease for some people. Supporting people to modify their lifestyle and reduce risks to their health is another key strategy to prevent or slow the progression of chronic disease and reduce the likelihood of premature death.

Even brief interventions, such as talking to people about their health and lifestyle during healthcare delivery, followed by appropriate referral and support, can have significant outcomes.

Strategies

- 2.1 Promote targeted screening programs for the early detection of chronic disease in people and populations identified as high risk.
- 2.2 Invest in strategies that raise the awareness of the principles of lifestyle and risk factor modification among health professionals and consumers.
- 2.3 Develop plans to ensure brief interventions are established by health and community professionals for key groups and populations who are vulnerable because of age, circumstance – such as schools, childcare settings or custodial system – Aboriginal people, and people with chronic and enduring mental illness.
- 2.4 Develop and formalise partnerships and collaborations with pharmacists, pharmacies, the General Practice Tasmania Network, General Practitioners and practice staff and community sector organisations to establish new opportunities such as lifestyle and risk factor modification.
- 2.5 Promote consistent health messages tailored to reach and promote behaviour change in targeted populations.

Case study: Get Active Program

The Get Active Program (GAP) aims to improve health and wellbeing through greater involvement in physical activity and by developing healthy eating habits.

Participants take part in a 10-week series that covers motivation, stress management, self-esteem and healthy eating. Fun physical activities are chosen by the group itself.

The GAP specifically seeks to engage people of all ages who are not physically active and who may have experienced barriers to physical activity such as lack of confidence and motivation, negative body image and personal safety concerns. It also engages with those who may lack knowledge about the benefits of healthy eating.

Groups are usually male or female-specific, but can be mixed if appropriate.

The GAP was introduced in Tasmania in 2005 by Womensport and Recreation Tasmania. The program is adaptable for men and women of all ages and from a diversity of backgrounds. Programs will soon run for people with diabetes and cancer.

For further information call the GAP coordinator on 6222 7401 or email gap@wsrt.org.au.

Case study: Smoking cessation gets breath of fresh air

The Department of Health and Human Services has set up a new smoking cessation delivery model and hired four new staff to implement it around Tasmania.

Part of the DHHS Smoking Cessation Project, the Smoking Cessation Service will promote the delivery of a brief smoking cessation intervention to all health professionals in Tasmania.

The intervention uses the ABC framework (Ask, Brief Intervention and Cessation) developed and used in New Zealand. This is a simple aid for health professionals to remember and, therefore, is more likely to be used.

New Zealand recently launched an ABC E-learning package for health professionals. Tasmania has been given permission to adapt this training package to a face-to-face training format suitable for a Tasmanian audience and implementation will start in mid-2009 in the acute care sector.

The four new staff comprises a statewide cessation coordinator and three regional cessation coordinators in the north, north west and south.

DHHS consulted members of the Tobacco Coalition on the use of the ABC model and its implementation.

For more information call the DHHS Senior Advisor Tobacco Policy and Programs on 6222 7728 or email marinabrkc@dhs.tas.gov.au.

Action area 3: appropriate management and clinical care for people with chronic disease

Rationale

People living with a chronic condition need appropriate management and clinical care to reduce the progression of their disease, its symptoms and complications, to maximise their quality of life and to reduce unnecessary hospital admissions and acute care.

The focus of chronic disease management should be on providing appropriate care at the appropriate time and in the appropriate setting for those living with chronic disease.

It is important that the person living with chronic disease be involved in decision-making in goal setting, assessment, care planning and service delivery.

Family members and care givers should also be involved where desired by the individual, and healthcare providers need to acknowledge and meet these needs.

Adherence to evidence-informed service standards and clinical guidelines are key strategies to improve the management and clinical care of people with chronic disease.

Strategies

- 3.1 Develop sustainable and accessible chronic disease services and deliver timely, evidence-informed care that meets the needs of people with chronic conditions.
- 3.2 Improve the integrated delivery of evidence-informed chronic disease management across services, including the non-government sector, to maximise client health outcomes.
- 3.3 Improve the skills of Tasmania's clinical workforce for chronic disease management.
- 3.4 Enhance the capacity and flexibility of clinical services to manage the growing disease burden.



Many countries and other parts of Australia have taken, or are working towards, actions that help prevent, detect and manage chronic disease.

We are using their experiences to ensure we adopt the best outcomes for Tasmanians.

Action area 4: people with or at risk of chronic disease supported to actively self-manage their health

Rationale

Supporting people with chronic disease to self-manage their condition is a key element of an evidence-informed approach to the management of chronic disease.

Self-management approaches place the person at the centre of their care planning and support them to take greater control of their health and wellbeing.

Self-management should not occur in isolation, but rather form an integral part of the broader care planning and management process.

If self-management is to become an integrated part of the health and human service system, it is important that there is a systems approach to implementation and that health professionals, people living with a chronic condition and their families and carers, have appropriate skills and support.

Strategies:

- 4.1 Support the implementation of consistent and evidence-informed approaches to self-management as part of integrated chronic care management.
- 4.2 Build self-management strategies and principles into routine care and service delivery.
- 4.3 Improve the capacity of the health and community sector to support self-management.
- 4.4 Build partnerships with key stakeholders including general practice, the community sector, University of Tasmania and other training providers.
- 4.5 Increase access to self-management support, programs and practices for people with chronic disease and in particular for people in high risk groups.

Case Study: Aussie Heart Guide

Heart attack patients who live over 50km from a centre-based cardiac rehabilitation program can miss out on measures to help them return to an active life and prevent further heart problems. This led the Australian Cardiovascular Health & Rehabilitation Association (ACRA), in consultation with Professor Bob Lewin and Multi-Ed Medical Australia, to produce the Aussie Heart Guide, a mentor-supported, home-based cardiac rehabilitation program. The Guide has now been trialed in Tasmania and ACRA is monitoring outcomes of the pilot study through pre- and post-intervention questionnaires and scales.

Professor Lewin trained cardiac rehabilitation nurses from each major hospital in Tasmania as mentors.

Patients are given a two-part manual (and one for the family), an interactive CD, a relaxation CD and a personal diary at a face-to-face meeting with their mentor. The mentor then conducts regular phone interviews and supports patients to become active self-managers of their health through action planning, goal-setting and modifying behaviour and lifestyle risk factors.

Patients set an exercise goal each week and use the relaxation tape everyday. They keep a daily diary of these and other activities, which are reviewed in follow-up phone meetings with their mentor. The program runs for at least six but up to 12 weeks. Patients with other cardiac diagnoses (post surgery, stenting, heart failure, multiple risk factors) may soon have access to the Guide.

Contact Sue Sanderson on 6222 6815 sue.sanderson@dhhs.tas.gov.au.
or Terry Frohmader on 6348 7222 terry.frohmader@dhhs.tas.gov.au.

Action area 5: integration and coordination of prevention and care

Rationale

Integration and continuity of care are essential to ensure that patients receive all the services they need in a timely manner to maximise their health outcomes and smooth their journey.⁴⁸

People living with a chronic condition have particular needs for integrated care because they must often maintain ongoing and long-term contact with many parts of the healthcare system.

For the client, care is integrated when services received in the primary, community and secondary care sectors appear as if they are provided by the one continuous and organised service.

Services should be targeted so clients receive the right care at the right time and in the right setting. This type of service delivery requires a partnership approach and greater communication and collaboration across all service providers and sectors.

Strategies

- 5.1 Improve collaboration between and across clinical services in the private, public and non government sector for the better prevention, detection and management of chronic disease.
- 5.2 Develop models of care that work within and across primary and acute care services to coordinate and integrate care and better manage avoidable hospital admissions.
- 5.3 Develop improved links between community and health services at the local level, sharing evidence-informed practice for improving integrated models of service delivery in the prevention and management of chronic disease.
- 5.4 Develop consistent standardised procedures for referral, pre-admission, discharge and other transfer arrangements that support continuity of care between services and sectors.

⁴⁸ National Health Priority Action Council. *National Chronic Disease Strategy*. Canberra: Australian Government, 2006.

Action area 6: skilled and supported workforce

Rationale

The reorientation of our health and human service system to improve prevention and management of chronic disease will require significant changes to a range of existing practices and activities.

This will only succeed by adequately equipping the health and human services workforce to deal with current and future challenges.

In addition, people, and their families and carers, living with and managing their condition, must receive support to manage the everyday reality of living with chronic disease.

Providing optimum prevention and care for people with or at risk of chronic conditions requires the involvement of a wide range of professions and practitioners and requires strong inter-professional and inter-sectoral collaboration and cooperation.

Strategies

- 6.1 Develop innovative workforce models, supported by healthcare education and research approaches that meet the needs of people with chronic disease.
- 6.2 Establish and invest in strategies to support and facilitate inter-professional learning for healthcare professionals.
- 6.3 Support the health workforce in developing and maintaining the skills and knowledge for chronic disease prevention and care (including lifestyle and risk factor modification and self-management approaches).
- 6.4 Develop partnerships with the tertiary education sector to develop education and training opportunities to better manage the growing burden of chronic disease.
- 6.5 Develop strategies to recruit and retain healthcare professionals who will provide services that match the needs of people with complex chronic conditions.
- 6.6 Support and develop opportunities for greater intersectoral collaboration to facilitate and enhance staff learning.

Case study: HACC Nutrition Service

The Home and Community Care (HACC) Nutrition Service is a team of dietitians who guide and support Tasmanian HACC-funded service providers in food and nutrition.

HACC service providers support older people living in the community, enhance their independence and avoid premature admission to long term residential care.

Started in January 2008, the HACC Nutrition Service helps day respite centres, in-home care support workers and others make quality improvements to food and nutrition service delivery, and increase their capacity to support good nutrition for their older clients.

Strategies that services implement lead to more awareness, better management of nutritional risk and improved quality and variety of foods for clients.

Key quality improvement activities services undertake include nutrition training for staff and volunteers, help with meal planning and menu development, and malnutrition risk screening and management.

As well as helping services with quality improvement activities, the HACC Nutrition Service also reviews, updates and distributes the *Appetite for Life* nutrition education manual for older people.

The HACC Nutrition Service is funded by HACC Tasmania and run by the DHHS Community Nutrition Unit.

For further information call the HACC Nutrition Service project team in the DHHS Community Nutrition Unit on 6222 7222.

Action area 7: effective surveillance, monitoring, evaluation and research

Rationale

Recent qualitative and quantitative research makes it clear that the prevention and management of chronic disease needs to be improved.

More research, evaluation and a state-based approach to surveillance and monitoring will contribute to evidence-informed practice and ensure the most appropriate strategies are developed.

In Tasmania, improved surveillance and monitoring mechanisms are needed to better measure the overall health of our population and risk factors for chronic disease.

Without adequate surveillance, monitoring and evaluation, we cannot know whether current health and human service delivery directions are having a positive impact or whether an alternative path is needed.

Strategies

- 7.1 Develop systems for integrated chronic disease monitoring and surveillance.
- 7.2 Develop better infrastructure and information technology for more integrated chronic disease prevention and care, including electronic patient information systems.
- 7.3 Develop chronic disease research capacity and funding infrastructure.
- 7.4 Systematically translate research evidence into practice.

Implementation

Implementation of *Connecting Care* cannot be achieved by the DHHS working in isolation. Successful implementation will require cooperation across the whole community, including all levels of government, private and non government healthcare providers and general practice. The DHHS has well established working relationships with members of the General Practice Tasmania Network and the Tasmanian Chronic Disease Prevention Alliance. These can be further strengthened and developed for the benefit of consumers and the broader community.

Specific areas of the DHHS will take a key role in implementation. For example, Population Health will coordinate the implementation of the Health Promotion Strategic Framework – *Working Together in Health Promoting Ways*, develop the Chronic Disease Self-Management Framework and coordinate the continued roll out of self-management education and training across the State.

A new suite of performance indicators are required under the *National Healthcare Agreement 2009–2012* (previously the *Australian Health Care Agreement*) which sets out the conditions under which the Tasmanian Government receives Australian Government funding for hospital services. Several of the new performance indicators specifically relate to chronic disease management across DHHS and will be drivers for change within the new Area Health Services in the North West, North and South, and with other service improvement initiatives in Mental Health, Alcohol and Drug Services, in Oral Health Services, and across the Human Services portfolio of housing and disability, child, youth and family services. See Appendix 7 for a summary of these performance indicators.

Another important task is to establish consistent service standards and clinical guidelines for chronic disease, which will likely flow from each of the clinical networks.

While each of the strategies listed under the action areas will involve their own discrete implementation processes, an overarching process for coordination of priority setting, planning and monitoring will be established to facilitate implementation of the Strategy across the broader community – Tasmania's Chronic Disease Clinical Network.

The DHHS will coordinate the implementation of the Framework using the structure of the Chronic Disease Clinical Network to provide the clinical leadership required both inside and outside of government to affect change. This will be supported through the organisational leadership of the Office of the Deputy Secretary Care Reform, and will link strongly with Population Health, the offices of the Chief Health Officer and the Chief Nurse and Allied Health Advisor, and through the operational management for each of the Area Health Services, the Statewide Specialist Health Services and with Human Services.

Evaluation

Evaluation of *Connecting Care* will be carried out using the Tasmanian health and human service system's existing monitoring and surveillance mechanisms (e.g. *Tasmania Together* indicators, *State of Public Health Report* data, *National Healthcare Agreement* indicators).

Our capacity to evaluate the Framework will be greatly assisted by any future improvements to these systems, either as a result of this Framework or through reforms underway at a national level through the Council of Australian Governments and Australian Health Minister's Conference. In particular, Tasmania needs improved population health measurements rather than simple service output measures.

At a national level work is progressing towards improved surveillance of chronic disease and risk factors through better integration of existing surveys and the compilation of state statistics for national comparison. This will help lay the foundations for ongoing monitoring of trends in chronic disease and its determinants and contribute to national reporting of key health risk factors that impact chronic disease.

At a state level this surveillance will help us evaluate the effectiveness of our investment in chronic disease prevention and management; but further work is needed if we are to monitor at regional or more local levels.

Many of the specific activities that will be guided by *Connecting Care* will have discrete evaluation plans. For example, the Primary Health Chronic Disease Demonstration Service and Integrated Care Centres will feature comprehensive evaluation strategies carried out in partnership with the University of Tasmania. Evaluation of the Framework will take the findings of these studies into account, as well as the evaluation of the state's broader health reform agenda set out in *Tasmania's Health Plan and Strategic Directions 2009 - 2012*.

In addition, the introduction of performance monitoring for some Health Promotion Framework activities will help us evaluate how we are progressing as a system, particularly in the management of the determinants of health.

Appendix I: Acknowledging our partners

The DHHS acknowledges our many partners working across the community to improve the health and wellbeing of the people of Tasmania. The General Practice Tasmania Network, public and private service providers, community sector organisations, community groups, educational and research facilities, professional groups, peak bodies and the Australian and local governments all play an important role in keeping Tasmanians healthy and supporting people living with chronic disease. Many of the dedicated staff and members of these organisations have helped develop *Connecting Care*. The DHHS thanks them for shaping the policy direction and helping us create a Framework that accurately reflects the needs of the Tasmanian community.

Steering Committee membership:

Ms Mary Bent, Deputy Secretary, Statewide System Development, DHHS

Ms Catherine Katz, Deputy Secretary, Strategy Planning and Performance, DHHS

Ms Siobhan Harpur, Director, Statewide System Development, DHHS

Dr Roscoe Taylor, Director, Population Health, DHHS

Ms Wendy Quinn, Director, Aged Care and Rehabilitation, DHHS

Ms Fiona Stoker, Chief Nursing and Allied Health Advisor, DHHS

Mr Kieran McDonald, Manager, Strategy Planning and Performance, DHHS

Ms Amanda Daly, Policy Analyst, Statewide System Development, DHHS

Ms Caroline Wells, Chief Executive Officer, Diabetes Tasmania and Chair, Tasmanian Chronic Disease Prevention Alliance

Ms Alice Burchill, Deputy Secretary, Care Reform, DHHS

Dr Craig White, Chief Health Officer DHHS

Virtual Network membership and participants in stakeholder workshops:

Clinicians and health professionals from across the public and private sector: nurses, medical specialists, GPs, diabetes educators, podiatrists, dietitians, physiotherapists, occupational therapists, practice nurses, social workers and health promotion officers.

Service managers and administrative staff from across DHHS

Representatives of community sector organisations and community groups

Consumers

Staff and board members of the General Practice Tasmania Network

Peak body members of the Tasmanian Chronic Disease Prevention Alliance and Tasmanian Self-Management Alliance

Australian and local government representatives

Representatives of Tasmanian Government agencies

Researchers and academics

Advice and expertise:

Associate Professor Maarten Kamp, Clinical Practice Improvement Centre, Queensland Health

Ms Narelle Smith, State Coordinator Chronic Conditions Prevention and Management, Population Health, DHHS

Appendix 2: Development of the framework

Significant research and community consultation has guided the development of *Connecting Care*.

Activities that have informed the direction of the Framework include:

- Policy oversight from a high level steering committee comprising senior DHHS managers and the chair of the Tasmanian Chronic Disease Prevention Alliance.
- Input and advice from a virtual network of more than 150 stakeholders from a diverse range of professions, organisations and locations throughout the state. These included clinicians, general practitioners, private service providers, peak bodies, community sector organisations, researchers and consumers.
- A literature review of contemporary Australian and international chronic disease policy and models of care.
- A state wide regional mapping exercise to identify the range of stakeholders, services, activities and resources in place for chronic disease prevention and management as well as to identify current and future needs.
- Expert consultancy and advice from Queensland Health's Clinical Practice Improvement Centre, which works at the clinician and strategic level to improve the quality and safety of patient care in Queensland.
- A series of workshops with various groups and at different locations throughout the state where participants identified issues and made suggestions about chronic disease prevention, detection and management.
- Calls for written submissions at various stages of development against the draft Strategy.

Comments received during consultation for Connecting Care

“The pharmacy profession can play a much wider role in areas such as preventative health, chronic disease management and other initiatives involving the appropriate use and management of medicines.”⁴⁹

“[It’s] great to be fostering useful relationships with Community sector organisations as they have a lot to share, often a great passion for the condition in question and many useful resources and networks.”⁵⁰

“I would like to see training in participant-centred care and self-management support part of regular staff development and competencies, both at community and acute sector levels.”⁵¹

⁴⁹ Submission by the Pharmaceutical Society of Australia (Tasmania Branch), 19 November 2008

⁵⁰ Comments from Dr Michelle Towle, DHHS Health Promotion Coordinator – Hellyer Region, 7 November 2008

⁵¹ Comments from Mrs Helen Cameron-Tucker, Physiotherapist Royal Hobart Hospital, 28 August 2008



Appendix 3: Definitions

Ambulatory care sensitive conditions (ACSCs) – Chronic conditions for which hospitalisation is avoidable within the application of public health interventions and early disease management, usually delivered in an ambulatory setting such as primary care. High rates of hospital admissions for ACSCs may provide indirect evidence of problems with patient access to primary healthcare, inadequate skills and resources, or disconnection with specialist services.⁵²

Burden of disease – The physical, emotional, social and economic impact that disease, injury or disability places on the individual, the community and the nation.⁵³ Burden of disease is measured by the gap between the current health status in a population and an ideal situation where all citizens live into old age free from illness and disability. This is most commonly expressed in disability adjusted life years (DALYs), a measure of healthy years of life lost because of disability.⁵⁴

Care planning – A process to outline how the issues identified in an assessment or review of the client's needs are best managed. This may involve linking into a range of existing services, determining how self-management is provided and setting up communication between the GP and other people involved in the client's care. Care planning involves balancing competing needs and helping consumers come to decisions appropriate to their needs and circumstances.⁵⁵

Chronic disease management – Refers in a generic sense to care for people with chronic disease. It usually involves many healthcare providers in multiple settings. Care should be provided within an integrated system.⁵⁶

Clinical guidelines – Guide the individual clinician through the decision-making process. Clinical guidelines are based on scientific and systematic reviews of evidence to help health professionals and people with specific conditions make care decisions. They are usually developed by professional or research bodies such as the National Health and Medical Research Council.

Coordinated care – Care is coordinated when services across the primary, community and secondary healthcare sectors appear to be provided by one organised service. Coordinated care relies on effective communication, liaison and integration between services provided in the different sectors.⁵⁷

E-health – Healthcare using electronic health records, TeleHealth and online services, personal communication systems and decision support tools. Activities range from providing services and treatment for individuals, to monitoring and managing the health status of communities and populations. These are used by health organisations, health professionals, patients and the general community.⁵⁸

⁵² Department of Human Services. *The Victorian Ambulatory Care Sensitive Conditions Study*. Melbourne: Victorian Government, 2003.

⁵³ Menzies School of Research, et al. *Educating to Improve Population Health Outcomes in Chronic Disease*. Darwin: Menzies School of Research, 2005.

⁵⁴ Australian Institute of Health and Welfare (AIHW). *Australia's Health 2006*, AIHW Cat. No. AUS73. Canberra: AIHW, 2006.

⁵⁵ Department of Health and Human Services. *HARP Chronic Disease Management Guidelines*. Melbourne: Victorian Government, 2005.

⁵⁶ Department of Health and Human Services. *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services*. Melbourne: Victorian Government, 2006.

⁵⁷ National Health Priority Action Council. *National Service Improvement Framework for Diabetes*. Canberra: Australian Government, 2006.

⁵⁸ Liaw, S.T. and Kilpatrick, S. (Eds). *A Textbook of Australian Rural Health*, Canberra: Australian Rural Health Education, 2009.

Evidence-informed practice – Professionals use the best evidence integrated with professional expertise to make decisions about patient care. This demands that practitioners seek the best evidence from a variety of sources, critically appraise that evidence, decide the desired outcome, apply that evidence in professional practice and evaluate the outcome. Consultation with the client is implicit in the process.⁵⁹

Health inequity – Unnecessary, avoidable or unjust differences in the health status of different population groups. Health inequity is known to occur by gender, race or ethnicity, education, income, disability, geographic location and sexual orientation, and includes differences in access to services and information, treatment and health and well being outcomes.

Health promotion – A process that lets people increase control over and improve their health. This incorporates an individual's actions and also aims to create supportive environments, strengthen community action, develop personal skills, reorient health services and build healthy public policy.⁶⁰

Incidence – The number of new cases of a disease that occur during a specified time period in an at risk population. Incidence is usually expressed as the number of cases per 1,000 people. The incidence rate is calculated by taking the number of new cases over a specified time period and expressing this as a proportion of the population.⁶¹

Integration - Integration links, by various means, two or more service providers and/or agencies that coordinate the individual's or family's comprehensive preventive, treatment, maintenance and support needs.

Integrated care – Care provided to a client that is coordinated and connected across the continuum of services and among providers in all sectors and levels.⁶² Integrated care is about designing services so patients get seamless care when moving between healthcare professionals such as general practitioners, nurses, allied health professionals and specialists – and between facilities such as hospitals and community health centres.

Integrated Care Centre - As part of the program of reforms outlined in Tasmania's Health Plan, DHHS is developing Integrated Care Centres to provide an interface between the primary and acute care systems, and to better manage the impact of chronic disease on the health and wellbeing of the population. Integrated Care Centres:

- accommodate a range of health services across primary and acute care
- provide efficient, coordinated care regardless of who funds, owns or provides each service
- are less interventional and more oriented towards care in the community rather than in hospitals.

Palliative care – An approach that improves the quality of life of individuals and their families facing problems associated with life-threatening illnesses. It promotes the prevention and relief of suffering by early identification, assessment, and treatment of pain and physical, psychosocial and spiritual issues.⁶³

⁵⁹ National Health Priority Action Council. *National Chronic Disease Strategy*. Canberra: Australian Government, 2006.

⁶⁰ Ibid.

⁶¹ Liaw, S.T. and Kilpatrick, S. (Eds). *A Textbook of Australian Rural Health*, Canberra: Australian Rural Health Education, 2009.

⁶² Department of Health and Human Services. *HARP Chronic Disease Management Guidelines*. Melbourne: Victorian Government, 2005.

⁶³ Mungabareena Aboriginal Corporation. *Providing Culturally Appropriate Palliative Care to Indigenous Australians: Resource Kit*. Canberra: Government of Australia, 2004.

Person-centred care – Person-centred care is where people share the management of their illness with health professionals. The three elements that define person-centred care are communication, partnerships and a focus beyond the specific condition to health promotion, healthy lifestyles and quality of life.⁶⁴

Population health – Aims to maintain and improve the health and wellbeing of the entire population and to reduce inequities in health status among population groups. This takes into account the entire range of factors and conditions (determinants of health) and actions that influence health over the life course.⁶⁵

Primary healthcare - The first level of contact that most individuals, the family and community have with the national health system. It brings healthcare as close as possible to where people live and work, and is the first element of a continuing healthcare process.⁶⁶

Primary health partnerships - Primary health partnerships strengthen the links between local service providers from general practice, community sector organisations and state and local government, as well as community representation. This concept is intended to foster greater coordination of services within each area, develop clinical links between local services in order to enhance the quality and safety of services, support workforce sustainability and achieve greater efficiency in resource use.⁶⁷

Prevalence – The number of cases of disease that exists in a defined population at a particular point in time. The prevalence rate is determined by taking a cross-sectional count of disease (point of prevalence) and expressing it as a proportion of the total population at that time.⁶⁸

Prevention – In population health the following definitions apply to the stages at which prevention is undertaken across the continuum of disease:

- Primary prevention – seeks to limit the incidence of disease and disability in the population by measures that eliminate or reduce causes or determinants of departures from good health, control exposure to risk and promote factors that protect good health
- Secondary prevention – aims to reduce progression of the disease through early detection, usually by screening at an asymptomatic stage, and early intervention
- Tertiary prevention – seeks to improve function and includes minimisation of the impact of established disease, prevention of complications and the establishment of chronic conditions through effective management and rehabilitation.⁶⁹

Self-management – Self-management is the active participation by people in managing their own health. Self management incorporates health promotion and risk reduction, informed decision making, care planning, medication management and working effectively with healthcare providers to attain the best possible care and to effectively negotiate the often complex health system.⁷⁰

Self-management support – is defined by the National Health Priority Action Council (NHPAC) as what health professionals, carers and the healthcare system do to assist the patient to manage their condition.⁷¹

⁶⁴ National Health Priority Action Council. National Service Improvement Framework for Diabetes. Canberra: Australian Government, 2006.

⁶⁵ Australian Health Minister's Conference. National Chronic Disease Strategy. Canberra: Australian Government, 2006.

⁶⁶ World Health Organization (WHO). Declaration of Alma-Ata 1978, http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf Geneva: WHO, accessed 20 November, 2008.

⁶⁷ Department of Health and Human Services. Primary Health Services Plan. Hobart: Tasmanian Government, 2007.

⁶⁸ Liaw, S.T. and Kilpatrick, S. (Eds). A Textbook of Australian Rural Health., Canberra: Australian Rural Health Education, 2009.

⁶⁹ Australian Health Minister's Conference. *National Chronic Disease Strategy*. Canberra: Australian Government, 2006.

⁷⁰ National Health Priority Action Council. *National Chronic Disease Strategy*. Canberra: Australian Government, 2006.

⁷¹ *ibid.*

Service standards – Service standards set broad service delivery targets and are often based on the needs and expectations of clients. They are also generally targeted at specific diseases, for example, the minimal requirements for the treatment of a patient with skin cancer. In Australia, the National Service Improvement Frameworks for Chronic Disease set out basic standards needed to achieve optimal care.

SNAPPs – The behavioural risk factors for chronic disease most commonly identified are known as the SNAPPs factors: smoking, poor nutrition, alcohol misuse, physical inactivity and psycho-social conditions.

Socioeconomic status – Is a relative position in the community as determined by occupation, income and level of education.⁷²

TeleHealth – The delivery of healthcare using interactive audio, visual and data communications to provide diagnoses, consultation, treatment, education and transfer of medical data.⁷³

Translational research – Evidence-informed practice and policy making is assisted by a translational research approach where practice and policy inform research and research informs practice and policy. Translational research involves new research tools and methodologies, as well as collaborations for developing service delivery practices and policy.

⁷² National Health Priority Action Council. *National Chronic Disease Strategy*. Canberra: Australian Government, 2006.

⁷³ Ibid.

Appendix 4: Wagner's Chronic Care Model

Since the late 1990s a number of specific models of care have emerged that aim to address the rising prevalence of chronic disease. These models provide a conceptual framework from which governments and policy makers can plan and prioritise health service delivery. The first and most often adopted is Wagner's Chronic Care Model,⁷⁴ which was developed in the United States in 1998 (see Figure 4).

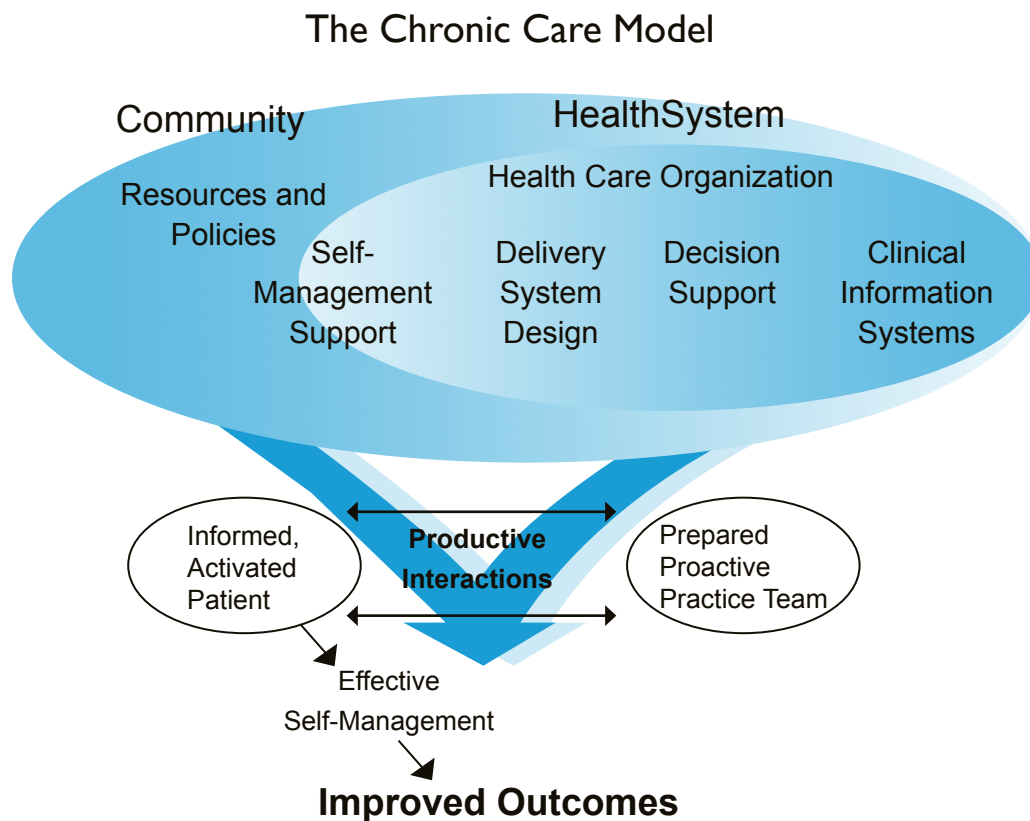


Figure 4. Wagner's Chronic Care Model⁷⁵

The key elements of Wagner's Chronic Care Model include:

- A strong emphasis on communication and multi-disciplinary team work to help people with chronic conditions navigate their regular contacts with the health system and place the patient's concerns at the centre of care
- A strong focus on health promotion and illness prevention (including the population health approach)
- Practice based on the best evidence
- Self-management to help those with chronic conditions maximise their health and wellbeing.

⁷⁴Wagner, E.H. 'Chronic Disease Management: what will it take to improve care for chronic illness?' *Effective Clinical Practice* August/September: (1998): 2-4.

⁷⁵Ibid.

Appendix 5: Working in Health Promoting Ways: A Strategic Framework for DHHS

Working in Health Promoting Ways: a Strategic Framework for DHHS establishes the DHHS' commitment to promoting safe, healthy individuals, workplaces and communities.

The Framework identifies seven health promotion priorities that will be the focus for 2009-2011 and eight principles of practice required to address these priorities in an effective and sustainable way.

The priorities have been identified based on their impact on the health of Tasmanians and issues that can be effectively addressed through a range of strategies. The eight principles have their foundations in the Ottawa Charter, Jakarta Declaration and the Bangkok Charter.

The priorities and principles are represented by the Health Promotion Framework conceptual diagram below:

Working in Health Promoting Ways



Figure 5. Conceptual diagram of Working in Health Promoting Ways: a Strategic Framework for the DHHS

Appendix 6: National and state chronic disease initiatives

Policy initiatives that will support the implementation of Connecting Care are listed below:

National

- *The National Preventative Health Strategy*
- *The National Primary Health Care Strategy* (in development)
- *The National Partnership Agreement on Improving Outcomes for People with Chronic Conditions*
- *Eat Well Australia 2000-2010*

State

- *Tasmania Together*
- *A Social Inclusion Strategy for Tasmania*
- *The Tasmanian Physical Activity Plan 2005-2010*
- *The Tasmania Government's Disability Framework for Action 2005-2010*
- *Tasmania Tomorrow*
- *Tasmanian Food and Nutrition Policy 2004*
- *Premier's Physical Activity Council*

DHHS

- *Tasmania's Health Plan*
- *Strategic Directions 2009 - 2012*
- *People Working in Partnership: Office for the Community Sector Strategic Plan 2008-2010*
- *Health Services Operating Framework 2008-09*
- *Integrated Care Policy and Planning Framework* (in development)
- *The Tasmanian Rehabilitation Plan* (in development)
- *Mental Health Services Strategic Plan*
- *Clinical Networks Policy and Planning Framework* (in development)
- *Working in Health Promoting Ways: a Strategic Framework for DHHS* (see Appendix 5)
- *Your Care, Your Say: Consumer and Community Engagement Strategy* (in development)
- *Tasmanian Diabetes Action Plan 2007*
- *Tasmanian Tobacco Action Plan 2006-2010*
- *Tasmanian Renal Plan*
- *Banscott Review of Patient Transport and Accommodation Services 2008*

Appendix 7: Performance indicators from the National Healthcare Agreement

The new *National Healthcare Agreement* replaced the *Australian Health Care Agreement* on 1 July 2009.

The following list is extracted from the suite of performance indicators which are included in the new agreement. It is not clear yet how the reporting against these indicators will be achieved.

- Prevalence of end-stage renal disease
- Incidence of mostly avoidable cancers (lung, bowel, breast, cervical and skin)
- Risk factor prevalence:
 - Proportion of persons obese
 - Proportion of adults who are daily smokers
 - Proportion of adults at risk of long-term harm from alcohol
 - Proportion of men reporting unprotected anal intercourse with casual male partners
- Cancer screening rates (breast, cervical, bowel)
- Proportion of children with fourth year developmental health check
- Proportion of diabetics with HbA1c below seven per cent
- Life expectancy (including the gap between Indigenous and non-Indigenous)
- Potentially avoidable deaths
- Treated prevalence rates for mental illness
- Selected potentially preventable hospitalisations
- Selected potentially avoidable general practitioner-type presentations to emergency departments
- Survival of people diagnosed with cancer (five-year relative rate)
- Differential access to hospital procedures
- Nationally comparative information that indicates levels of patient satisfaction around key aspects of care they received
- Age-standardised mortality
- Number of accredited/filled clinical training positions.

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