

Queensland Strategy for Chronic Disease 2005–2015

# Framework for self-management 2008–2015

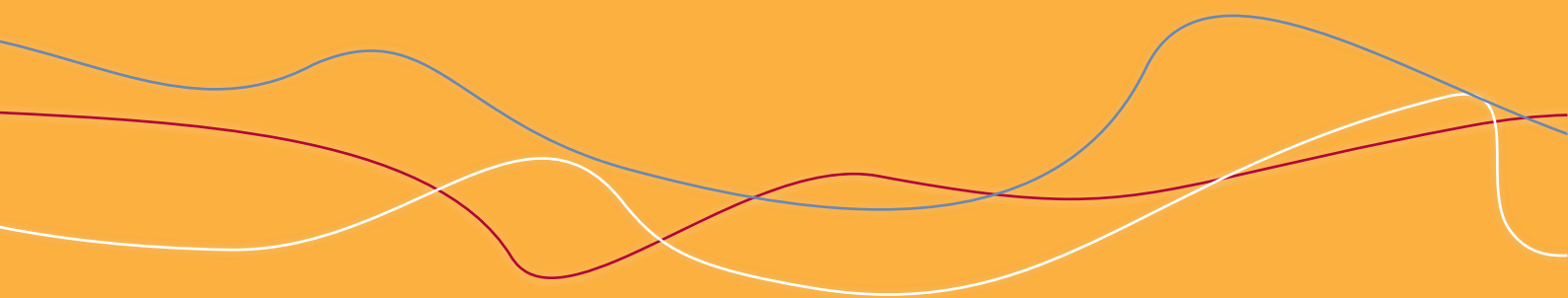
*working together*

health • care • people

Queensland Strategy  
for Chronic Disease  
2005–2015

# Framework for self-management

2008–2015



## Foreword

Improving health care and strengthening services to the community is an important priority in promoting a strong and healthy Queensland. This involves supporting an increased quality of life through disease prevention and health promotion, as well as improving the standard and accessibility of hospital and health services.

The Queensland Government, through the *Queensland Strategy for Chronic Disease 2005–2015*, identified the opportunity to improve the quality of life for people with chronic disease, reduce the incidence and prevalence of such conditions and address the current pressure on the acute hospital system by reducing avoidable hospitalisations.

The *Framework for Self-Management 2008–2015* provides direction to empower and prepare individuals to manage their health and health care through the development of a statewide self-management framework and the provision of training and support for self-management approaches. Of particular concern are people from Aboriginal and Torres Strait Islander communities, people from culturally and linguistically diverse backgrounds, and people living in rural and remote communities.

Encouraging active self-management in chronic disease is also included in the *Australian Better Health Initiative*, which was announced by the Council of Australian Governments (COAG) in February 2006.

The Framework for Self-Management forms part of the implementation of the *Queensland Strategy for Chronic Disease 2005–2015* and guides the Queensland Government's contribution to the *Australian Better Health Initiative: Self-Management*.

The purpose of the Framework is to guide the planning, development, implementation and evaluation of self-management approaches for people with, or at risk of developing chronic disease throughout Queensland. It is envisaged that the Framework will also contribute to the creation of a shared vision for self-management and the development of a common language across and within sectors.

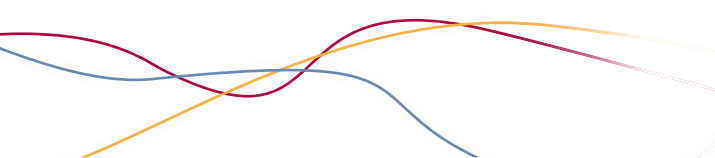
Aspects of the Framework's implementation will be evaluated as part of the evaluation process of the *Queensland Strategy for Chronic Disease 2005–2015*.

Dr Linda Selvey  
Senior Director  
Population Health Branch

Queensland Strategy  
for Chronic Disease  
2005–2015

# Framework for self-management

2008–2015



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### Acknowledgement

The Framework is based on consultation with key state and interstate stakeholders; best available evidence; and existing frameworks, specifically the South Australian *Chronic Condition Self-Management Framework*. Permission was sought and kindly provided by the Department of Human Services, Government of South Australia for this document to be used to guide the development of the Queensland Framework. The Chronic Disease Strategy Implementation Team has developed the Queensland Framework for Self-Management (the Framework) in consultation with the Queensland Self-Management Alliance.

## Background

In Australia, as in other countries throughout the world, chronic conditions contribute significantly to the burden of disease. Factors that have been identified as contributing to this increasing burden include:

- an ageing population
- increasing prevalence of lifestyle and behavioural risk factors
- improved survival from advances in treatment
- an increased prevalence of some chronic diseases.

Chronic diseases are of major concern both nationally and internationally because of the significant burden experienced by individuals, communities and health services.<sup>1,2</sup> Queensland has the highest rate of preventable deaths of all states in Australia with more than one-third of these deaths occurring as a result of a chronic disease. Aboriginal and Torres Strait Islander Queenslanders experience higher rates of chronic disease than any other group.<sup>3,4</sup>

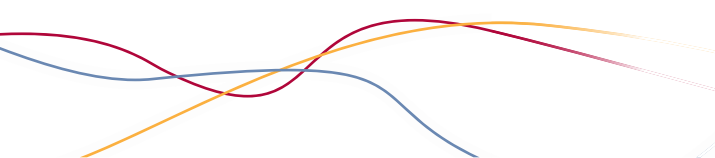
It is widely acknowledged that the growing demand on the health system created by chronic disease cannot be met by the health sector alone and will require collaboration among community, non-government and government sectors.<sup>5</sup>

Queensland Health in consultation with key partners has developed the *Queensland Strategy for Chronic Disease 2005–2015* with the aim of addressing the major factors that contribute to the rising occurrence of chronic disease throughout Queensland. The development of this framework will support consistent approaches to self-management and access to self-management initiatives for all Queenslanders with, or at risk of developing chronic disease.<sup>3</sup> It is a strategic direction that aligns with a number of other policy documents, detailed in Appendix 2, including the *Australian Better Health Initiative: National Implementation Plan 2006–2010*.

## Definition of ‘self-management’

In the context of this framework, ‘self-management’ is defined as the engagement of individuals, in activities and practices that sustain and promote health and well-being by:

- making, and/or participating in decisions
- building and sustaining partnerships with others who are involved in their health
- having the capacity (knowledge, resources, confidence) to manage the impact of their health on functioning, emotions and interpersonal relationships
- monitoring and managing signs and symptoms of illness and chronic conditions.<sup>3,5,11</sup>



## Rationale

The ability to self-manage impacts on every aspect of peoples' lives and should, therefore, be a critical focus of the systems that affect people's health and well-being. Self-management differs from traditional medical and expert approaches to treatment. It means that people can take a more active role in decisions about their own treatment and about healthy lifestyle. Self-managing one's condition does not mean that medical treatment is no longer necessary, but it does mean that people retain as much control over their own lives as possible. Evidence suggests that assisting people to self-manage can result in significant gains in health status, increased symptom control, reduced use of general practitioners and reduced admissions to hospital.<sup>6,7</sup> This does not mean that self-management is the sole responsibility of the individual. It is a shared responsibility between the individual and service provider, in that service providers recognise the individual's role in managing their health and well-being. Furthermore, evidence suggests that to realise the long-term benefits of self-management, it is necessary to develop an ongoing collaborative relationship between patients and professionals.<sup>8</sup> It is necessary to ensure that the entire health system supports self-management in a consistent and meaningful manner.<sup>9</sup>

To adopt a self-management philosophy and embed self-management within current and future practice, it is necessary to make major shifts in cultures, attitudes, infrastructure, tools and practices.<sup>3</sup> Equally, it is important to note that self-management may differ across communities because of diverse cultural perspectives. For instance, some Aboriginal and Torres Strait Islander people view health and well-being as a product of family, community and societal factors rather than simply the actions of the individual. Therefore, diabetes, for example may be viewed as a product of genetics, community well-being and societal factors such as access to country, alienation and economic prosperity.<sup>10</sup>

## Purpose

The goal of the Framework is to empower and prepare individuals to manage their health and health care. The Framework is intended to guide the planning, development, implementation and evaluation of current and future self-management approaches for people with, or at risk of developing chronic disease throughout Queensland.

It is envisaged that the Framework will also contribute to the creation of a shared vision for self-management and the development of a common language across and within sectors. The Framework also contributes to the implementation of the *Queensland Strategy for Chronic Disease 2005–2015* and the *Australian Better Health Initiative*, which aim to improve the quality of life for people with chronic disease and reduce the burden experienced by individuals, the community and the health care system.

The Framework is designed to inform and guide service providers, peak bodies/ organisations and policy-makers across a range of sectors about how a self-management approach can be promoted and integrated into current and future service delivery. The Framework identifies seven key principles (three core principles and four enabling principles) that underpin service delivery. These principles are fundamental for the integration of self-management into services and practice.

The Framework will guide future investments under the *Queensland Strategy for Chronic Disease 2005–2015* and the *Australian Better Health Initiative 2006–2010* from 2008–09.

## Scope

**The Strategy identified specific areas for initial action, which are reflected in the Framework. Targeted chronic diseases include:**

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

Note that depression and anxiety are similarly targeted as they are recognised as prevalent co-morbid conditions that should be considered in all interventions targeting those at risk of, or who have a chronic disease.

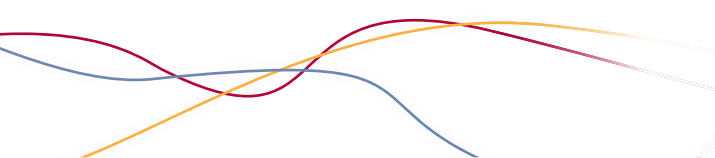
**Targeted underlying lifestyle and behavioural risk factors identified for initial action include:**

- poor nutrition
- physical inactivity
- alcohol misuse
- tobacco smoking
- lack of social supports and networks.

**Target populations identified for additional support include:**

- Aboriginal and Torres Strait Islander peoples
- people from culturally and linguistically diverse backgrounds
- people in low socio-economic circumstances
- people from rural and remote areas
- children and young people
- older Queenslanders.

It is important to note that Aboriginal and Torres Strait Islander Queenslanders have the highest rates of lifestyle and behavioural risk factors; have the lowest socio-economic circumstances; the highest proportion of the population living in remote and very remote communities; the lowest literacy levels in the state; and have a diverse range of cultures and languages.<sup>12</sup>



## Summary of the consultation process

The development of the Framework has been informed by a statewide consultation process undertaken by Queensland Health and the Queensland Self-Management Alliance (QSMA). The consultation process through 2007 and 2008 included eleven consultation forums; an electronic questionnaire; feedback on draft proposals, including progress reports to the Queensland Strategy for Chronic Disease Reference Group and Steering Committee; meetings with key stakeholders; and a post forum workshop.

Key stakeholder groups that participated in the consultation process included state and commonwealth government departments; non-government organisations; professional bodies; peak bodies; the private sector; consumer advocacy groups; health professionals; universities; and national and international expert representatives.

Priority areas to progress self-management were identified during the consultation process. These will be used to inform future investments from 2008–09.

## Framework principles

This framework consists of two tiers:

- core principles
- enabling principles.

The core principles form the foundation of all self-management approaches to service delivery, whereas the components comprising the enabling principles support the operationalisation of the self-management process.

These core and enabling principles should underpin and be reflected in the development and implementation of new and existing services.

The following three core principles are vital to ensuring that self-management is promoted in the future. They recognise that an individual's ability to self-manage can be influenced by a range of factors including for example, social supports, readiness for change, the way in which services are delivered and by the unique expertise of the individual, carers/family and service providers across all sectors involved in self-management.<sup>13,14</sup>

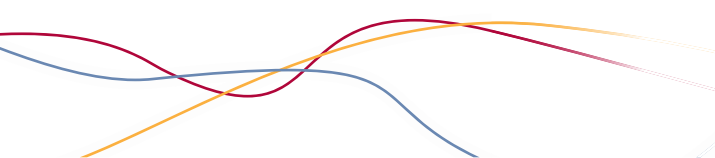
The three core self-management principles are:

### 1) A person-centred approach:

- places the person at the centre of all services they are receiving
- respects choice and autonomy and supports individuals to determine their own goals
- encourages and supports individuals to actively participate in preventing and managing their chronic disease, whilst recognising that the desire to undertake self-management will differ across individuals
- involves collaboration and negotiation between all sectors, the individual and/or family/significant other
- views the individual holistically and as an expert on his/her experience and as having a valuable understanding of their health and well-being
- recognises that individuals need access to clinical expertise and best available evidence to inform their decision-making about their health and well-being and that this information should be delivered in an appropriate and meaningful manner
- respects the diverse and unique cultural/social context of each individual.

### 2) Promoting health and well-being:

- encourages and supports individuals to develop the knowledge, confidence and skills to change risk behaviour/s and sustain a healthy lifestyle
- promotes health across the whole of life continuum and across the various stages of treatment
- engages health promotion strategies irrespective of the treatment or setting
- acknowledges the differing health issues that emerge across the whole of life continuum, within different environments, for example, rural and remote and across diverse cultures.



### 3) A capacity building approach:

- engages local communities in health activities that build on existing services and supports
- acknowledges that the circumstances of service providers and individuals/families in rural and remote communities may differ from those in urban communities
- develops strategies based on local need, knowledge and expertise
- increases the capacity of the health system to support self-management through education and training
- promotes integration and collaboration across services and sectors to ensure that all services are promoting self-management
- supports the provision of resources, policies, infrastructure and educational programs that are responsive to the changing needs of the community.

It is recognised that self-management may be more attainable in a context where services are effectively delivered, accessible and coordinated. To promote self-management, it is necessary for services to maintain a quality improvement orientation; be equitably accessible across the population; and to be integrated and coordinated within a sustainable and supportive system.

**The following four enabling principles support the operationalisation of self-management processes.**

#### 1) A quality improvement orientation:

- initiatives or services are based on best available evidence and knowledge about self-management
- appropriate education, training and resources are identified to enable access to and delivery of effective interventions to Aboriginal and Torres Strait Islander and culturally and linguistically diverse peoples as well as people living in rural and remote areas
- appropriate screening processes are used to identify psychosocial issues and co-morbidities that could impact on self-management
- initiatives are evaluated and reviewed from the perspective of the consumer, to demonstrate that desired self-management outcomes have been met
- research and training in self-management is promoted
- monitoring is supported to allow progress and trends to be tracked over time.

#### 2) A focus on equity and access:

- services are provided on the basis of need, regardless of age, gender, culture, ethnicity, socio-economic group, or geographic location
- services are flexible and provided at a time, venue and in a manner that meets the needs of participants and enables them to adopt and maintain self-management
- social, cultural, biological and emotional factors are considered in service delivery and design.

### 3) Integration and coordination through partnerships:

- the support provided by family and/or informal carers is recognised
- services across all sectors work together in a seamless and coordinated way to minimise confusion and maximise continuity
- individuals, carers, families and key stakeholders are engaged at the local, regional and state-wide levels to establish communication pathways to promote active participation and collaboration between sectors
- multi-disciplinary team work/joint case management is promoted to support a coordinated and integrated approach to care
- individuals, target populations and key stakeholders are actively engaged across all sectors in planning, implementing and evaluating self-management initiatives.

### 4) A sustainable and supportive system:

- networks relevant to chronic disease management and primary health care are utilised
- information technology to facilitate transfer of information and knowledge is utilised
- consistent use of evidence-based practice and meeting minimum standards of practice is promoted
- existing evidence-based self-management initiatives are supported.

## Objectives and strategies

It is widely acknowledged that self-management approaches need to be responsive to the unique needs of individuals, communities and specific target population groups. *It is important to recognise that simply providing self-management information and/or resources alone will not ensure that people can or will access and use them.*<sup>5</sup> The precursor to successful implementation is the education and engagement of the whole of the community, including service providers, community champions and consumers, to ensure understanding and participation by all stakeholders. Another important element to the successful integration of self-management is the promotion of a supportive and responsive community, which can adapt to the community's ever changing needs and cultural competency.

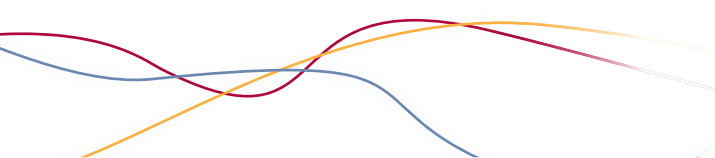
Four broad objectives and a range of supporting strategies that promote self-management across a variety of settings have been developed to assist in meeting the Framework's aim of empowering and preparing individuals to manage their health and health care. These objectives and strategies are detailed in diagram 1 and table 1. These can be used by individual service providers, peak bodies/ organisations and policy-makers to implement the strategies at a local or strategic level, or collaboratively facilitate broader regional and/or statewide implementation with other key stakeholders to achieve the proposed objectives.

**Objective 1:** Provide individuals with opportunities to manage their well-being and health care

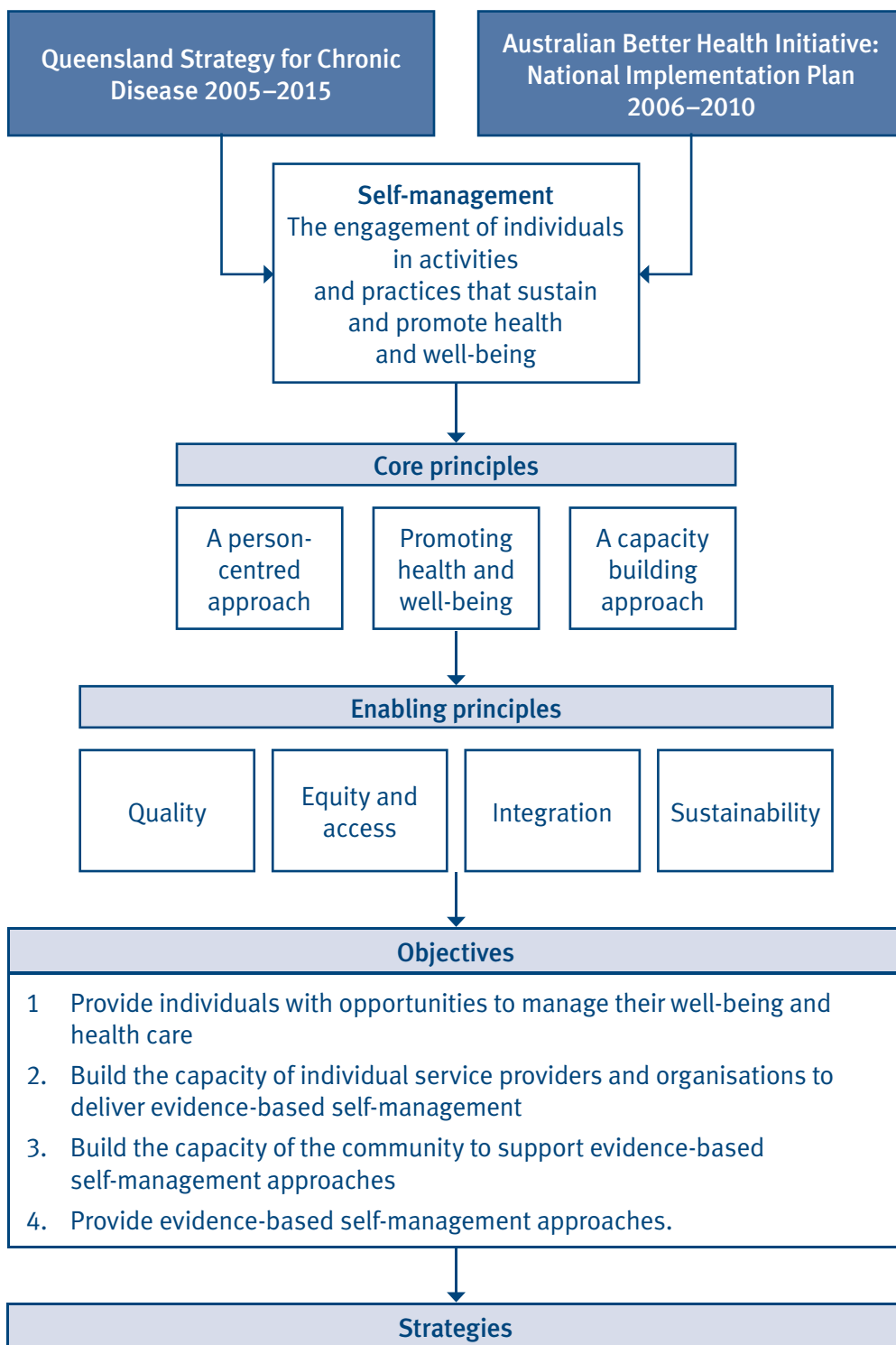
**Objective 2:** Build the capacity of individual service providers and organisations to deliver evidence-based self-management

**Objective 3:** Build the capacity of the community to support evidence-based self-management approaches

**Objective 4:** Provide evidence-based self-management approaches.



**Diagram 1: Flowchart of key principles and broad objectives**



**Table 1: Objectives and strategies**

Goal: To empower and prepare individuals to manage their health and health care

Objective	Strategies
<p><b>1: Provide individuals with opportunities to manage their well-being and health care.</b></p>	<p>1.1 Provide and promote quality, accessible and culturally appropriate information, education and training to individuals and family/ carers to manage and make decisions regarding their health and health care.</p> <p>1.2 Assist people to share in the planning of their care to a level of their comfort/choice where appropriate.</p> <p>1.3 Provide information to assist individuals to access available services.</p> <p>1.4 Promote the concept that self-management is a continuous process that occurs across the lifespan, and that a range of services may be required.</p> <p>1.5 Support individuals, family/carers to apply self-management strategies.</p>
Objective	Strategies
<p><b>2: Build the capacity of individual service providers and organisations to deliver evidence-based self-management.</b></p>	<p>2.1 Work with professional bodies, academic institutions and individual service providers to develop or improve standards, policies and procedures of practice in the area of self-management.</p> <p>2.2 Foster attitudes and cultures supportive of self-management amongst individual service providers and organisations in contact with people experiencing or at risk of chronic disease.</p> <p>2.3 Strengthen service provider knowledge and skills to deliver culturally appropriate evidence-based self-management approaches through training and development opportunities.</p> <p>2.4 Promote the inclusion of self-management approaches for people in the care of individuals with, or at risk of developing a chronic disease.</p> <p>2.5 Support systems to enable service providers to monitor the impact and outcomes of their practice in terms of self-management.</p> <p>2.6 Encourage service providers to contribute to the evidence-base for self-management.</p>

<b>Table 1: Objectives and strategies</b>	
<b>Goal: To empower and prepare individuals to manage their health and health care</b>	
<b>Objective</b>	<b>Strategies</b>
<b>3:</b> Build the capacity of the community to support evidence-based self-management approaches.	<p>3.1 Work in partnership with government, non-government, professional bodies, universities and other key stakeholders to enhance self management approaches in Queensland to optimise efficient use of resources and avoid duplication.</p> <p>3.2 Encourage the involvement of consumers and the community in planning, implementing and evaluating culturally appropriate self-management initiatives.</p> <p>3.3 Identify and respond to infrastructure/models of care required to support evidence-based self-management approaches.</p> <p>3.4 Promote self-management within communities to raise awareness and increase up-take of available services.</p>
<b>Objective</b>	<b>Strategies</b>
<b>4:</b> Provide evidence-based self-management approaches.	<p>4.1 Focus service provision on prevention and health promotion across the continuum of care, shifting (where necessary) from an acute/episodic focus to a continuous, holistic approach.</p> <p>4.2 Provide and promote evidence-based self-management approaches that are coordinated, integrated, accessible, and appropriate to the needs of participants, specifically for Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds and people from rural and remote areas.</p> <p>4.3 Develop/modify and maintain referral pathways, protocols and guidelines that promote the uptake of evidence-based, culturally appropriate self-management approaches.</p> <p>4.4 Design/modify and maintain processes involved in service provision to people experiencing or at risk of chronic disease to enable appropriate and optimal participation in the management of their health and health care.</p> <p>4.5 Evaluate self-management initiatives and resources as part of a quality approach to service delivery.</p> <p>4.6 Provide consistent, quality health messages within and across services, systems and information sources.</p>

## Implementation and evaluation

The *Queensland Framework for Self-Management 2008–2015* (the Framework) provides both a strategic and operational direction to inform and guide service providers, peak bodies/organisations and policy-makers across a range of sectors about how self-management approaches can be promoted and integrated into current and future service delivery throughout Queensland. The Framework aims to provide a consistent approach and shared vision to self-management that will assist to empower and prepare individuals to better manage their health and health care.

The Framework aligns with the *Queensland Strategy for Chronic Disease 2005–2015* (the Strategy) and the *Australian Better Health Initiative: National Implementation Plan 2006–2010*. It will be facilitated by a range of new and existing local, regional and national initiatives across a range of sectors and service delivery contexts. New resources may be allocated to target specific priorities in the initial implementation period.

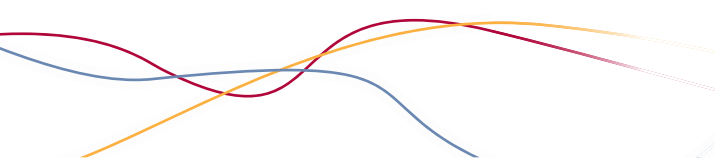
A number of key broad services were identified as priorities for future investment, as part of the consultation process undertaken during the development of the Framework, including:

- development and implementation of self-management models for Aboriginal and Torres Strait Islander, culturally and linguistically diverse, and rural and remote people
- education and training for service providers, such as the development of minimum standards of practice
- self-management and chronic disease education for individuals, carers and/or family/significant other
- social marketing campaign to raise awareness of self-management
- implementation of evidence-based self-management programs
- capacity building in communities to support self-management at the local level
- exploration and implementation of a consumer personal health record
- evaluation and monitoring of self-management initiatives.

The Strategy highlights that a move to self-management will require significant change.<sup>3</sup> Implementation of the Strategy, including the self-management component, is a dynamic process that will occur in different ways across Queensland over time, within a dynamic and resource-constrained health service environment. Implementation of the Framework will need to consider the opportunities and challenges arising within a complex and changing health environment.

The Framework will remain current for the life of the Strategy but will be reviewed and updated periodically, including the strategies. Ongoing scanning of changes in the health service environment both nationally and internationally, identification of community needs and performance review within Queensland Health will allow emerging opportunities to be identified and considered.

Evaluation of the Framework is encompassed in the evaluation of the *Queensland Strategy for Chronic Disease 2005–2015*. The University of Queensland, in consultation with key stakeholders, has developed an evaluation approach for the Strategy. The evaluation will track changes across time in key outcome areas, including self-management.



## Appendix 1: Strategic influences

The overarching principles and key elements proposed within this Framework align with the following national and state strategic policy documents:

- *Queensland Strategy for Chronic Disease 2005–2015*<sup>3</sup>
- *National Chronic Disease Strategy*<sup>5</sup>
- *Council of Australian Governments Australian Better Health Initiative*<sup>7</sup>
- *Queensland Drug Strategy 2006–2010*<sup>15</sup>
- *Queensland Health Strategic Plan 2007–2012*<sup>16</sup>
- *Queensland Statewide Health Services Plan 2007–2012*<sup>17</sup>
- *Queensland Health Population Health Plan 2007–2012*<sup>18</sup>
- *Smart State: Health 2020*<sup>19</sup>

National and international strategic documents have also been reviewed in the development of the Framework. These include:

- *Preventing Chronic Diseases: A Vital Investment*<sup>2</sup>
- *Appendix 2: Chronic Condition Self-Management Framework*<sup>14</sup>
- *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013*<sup>20</sup>

## Appendix 2: Resources and initiatives

### ***13HEALTH (13 43 25 84)***

Provides qualified health advice to Queenslanders 24 hours a day, 7 days a week for the cost of a local call. It is not a diagnostic service, nor does it replace a medical consultation or dialling 000 in an emergency situation. For further information visit: [www.health.qld.gov.au/13health/default.asp](http://www.health.qld.gov.au/13health/default.asp)

### ***AMQuIP – Arthritis Musculoskeletal Quality Improvement Program***

AMQuIP is a program funded by the Department of Health and Ageing. The program includes arthritis self-management for patients and consumers, using computer software to manage progress and providing accurate information direct to the patient. For further information visit: [www.amquip.org.au](http://www.amquip.org.au)

### ***Climate***

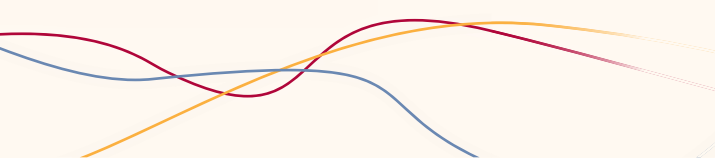
Climate is a web based health education system that has been developed to assist people with chronic diseases. It provides information to assist individuals to help manage their disorder and reduce the risk of illness. The site includes recovery courses for individuals with diabetes, asthma, depression, heart failure, arthritis, cancer, anxiety and incontinence, as well as continuing professional education courses for clinicians. Climate is a not-for-profit initiative of St Vincent's Hospital, Sydney in conjunction with the University of New South Wales and relevant peak bodies. For further information visit: [www.climate.tv](http://www.climate.tv)

### ***Connecting Healthcare in Communities Initiative (CHIC)***

Connecting Healthcare in Communities Initiative represents a new approach to establishing partnerships with local general practitioners and other primary health care providers in communities to build the capacity of the health system over the next five years. Partnership Councils will consist of partners such as Divisions of General Practice, community nursing services, relevant community and hospital services and consumer representatives. The focus of Partnership Councils will be on improving access to prevention and primary health care services for all Queenslanders, and relieving the pressure on our public hospitals to the benefit of patients and providers. Indications are that Partnership Councils will help reduce avoidable admissions to hospital, emergency department referrals and inappropriate outpatient servicing. For further information visit: [www.chicpartnerships.com.au](http://www.chicpartnerships.com.au)

### ***Community Hospital Interface Program (CHIP & CHIP+)***

The Community Hospital Interface Program focuses on enhancing the transition between hospital and the community, ensuring a safe continuum of care for the client on discharge. The underlying principle of CHIP is early identification of, and intervention among at risk clients who present or are admitted to the acute hospital setting using validated risk screening and assessment tools<sup>21</sup>. The Identification of Seniors at Risk<sup>22</sup> screening tool is one example of a tool to identify clients aged more than 65 years.



### ***Consumer Medicine Information Guide***

This guide is about consumer medicine information and how it can be used by consumers and health professionals to build better relationships and achieve the quality use of medicines. For further information visit: [www.health.gov.au/internet/wcms/publishing.nsf/Content/nmp-consumers-cmi.htm-copy](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/nmp-consumers-cmi.htm-copy)

### ***Eat Well Be Active***

This Queensland Government website contains a range of information about healthy food choices and physical activity, including menu plans, tips on physical activity, facts on obesity and national guidelines. For further information visit: [www.your30.qld.gov.au](http://www.your30.qld.gov.au)

### ***GPAC Continuity of Care Planning Framework:***

The Continuity of Care Planning Framework has been developed by the General Practice Advisory Council (GPAC) and outlines best practice in the continuity of care planning process. The framework is intended to guide recommended practice for all service providers involved in admission and discharge planning across the hospital/community interface. Privacy guidelines have been developed to support the framework. For further information visit: [www.gpac.net.au](http://www.gpac.net.au)

### ***HealthInsite***

This site provides a wide range of up-to-date and quality assessed information on important health topics such as diabetes and asthma. For further information visit: [www.healthinsite.gov.au](http://www.healthinsite.gov.au)

### ***Living Life to the Full***

This site is a new life skills resource. The course content has been designed to help people develop key life skills to help tackle common problems. The modules are supported by a range of structured and clearly written self-help materials. Joining and using the site is free. For further information visit: [www.livinglifetothefull.com](http://www.livinglifetothefull.com)

### ***Mungabareena Aboriginal Corporation***

Providing Culturally Appropriate Palliative Care to Indigenous Australians: Resource Kit<sup>23</sup>. For more information visit: [www.health.gov.au/internet/wcms/publishing.nsf/Content/palliativecare-pubs-indig-resource.htm](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/palliativecare-pubs-indig-resource.htm)

### ***Nutrition Australia***

Nutrition Australia is a community based organisation that aims to provide scientifically based nutrition information to encourage healthy eating habits for people of all ages. For further information visit: [www.nutritionaustralia.org](http://www.nutritionaustralia.org)

### ***Place-based Initiatives***

As part of the *Queensland Strategy for Chronic Disease 2005–2015*, Queensland Health is testing different approaches to partnership in three sites across Queensland (North Lakes and surrounds, Logan-Beaudesert and Innisfail). These three sites have a focus on producing integrated service delivery models at the local level across the continuum of care. The goal of the three place-based initiatives is to develop new ways of working, which engage a range of public and private providers in partnership to address the health needs of local populations.

### ***Sharing Health Care Initiative***

Through a series of demonstration projects, The Australian Government's Sharing Health Care Initiative tested a range of chronic conditions self-management models that could be suitable for embedding within the Australian health care system<sup>24</sup>. Supporting the demonstration projects is a range of education and training materials for consumers and health providers and a national evaluation. For more information visit: [www.health.gov.au/internet/main/publishing.nsf/Content/chronicdisease-sharing.htm](http://www.health.gov.au/internet/main/publishing.nsf/Content/chronicdisease-sharing.htm)

### ***SNAP Framework***

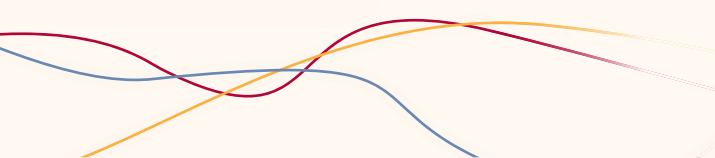
The Smoking, Nutrition Alcohol and Physical Activity Risk Factor Framework<sup>25</sup> for general practice is an initiative of the Joint Advisory Group on General Practice and Population Health. The SNAP Framework guides the implementation of integrated approaches to behavioural risk factor modification in general practice, focusing on smoking, nutrition, alcohol and physical activity. The SNAP Framework develops a system-wide approach to supporting general practice in the management of these behavioural risk factors with patients. For further information visit: [www.racgp.org.au/guidelines/snap](http://www.racgp.org.au/guidelines/snap)

### ***The Lifescripts Initiative***

Lifescrpts is a resource package to support lifestyle risk management (smoking, nutrition, alcohol, physical activity & weight management) in general practice. Introduced by the Australian Government in 2003, this initiative provides tools to help general practices support patients in making healthier lifestyle choices. For further information visit: [www.agpn.com.au](http://www.agpn.com.au)

### ***The MoodGym***

An innovative, interactive web program designed to prevent and decrease depressive symptoms. For further information visit: [www.moodgym.anu.edu.au](http://www.moodgym.anu.edu.au)



## Appendix 3: Glossary of terms

**Acute care:** health care in which an individual is treated for an acute (immediate or severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma, or during recovery from surgery.

**Ambulatory care:** health care provided without the individual being admitted, or requiring overnight admission. May include care provided in hospital emergency departments, outpatient departments, doctors' surgeries, community health services and home care.

**Best practice:** the benchmark against which programs can be evaluated. Best practice guidelines are statements based on the careful identification and synthesis of the best available evidence in a particular field. They are intended to assist people in that field, including both practitioners and consumers, to make the best use of the available evidence.

**Burden of disease:** loss of health, disability and premature mortality at the population level. The burden of disease is generally measured through Disability Adjusted Life Years (DALYs) for a disease or health condition. The Chief Health Officer's report defines burden of disease as: the gap between the current health status and the ideal situation where everyone lives into old age free of disease and disability. It is the total impact of health conditions judged by years of life lost due to disability and premature mortality. The population burden of disease can be measured, where one DALY is one year of 'healthy' life lost by either premature death or disability.

**Capacity building:** the development of structures (organisational and physical) within the community that contribute to the overall health and well-being of that community.

**Chronic disease:** diseases which have one or more of the following characteristics: (1) are permanent, leave residual disability; (2) are caused by non-reversible pathological alteration; (3) require special training of the individual for rehabilitation, and/or may be expected to require a long period of supervision, observation, or care.

**Chronic disease management:** aims to improve the health of people who already have one or more chronic disease. Chronic disease management is care that is specific to the disease and other measures to encourage self-care, to promote health, to prevent loss of function and to maintain quality of life. It includes strategies designed to:

- improve health-related quality of life for people with chronic disease, particularly those with more than one condition
- improve the use of the health care system by people with chronic disease
- enhance communication between health professionals, family, carers and people with chronic disease.

**Co-morbidity:** the co-occurrence of two or more health conditions, such as a heart disease with depression.

**Cultural competency:** the integration and transformation of knowledge about individuals, families and communities into specific standards, policies, practices and attitudes to improve the quality of service, thereby producing better outcomes.<sup>26</sup>

**Evidence-based decision making:** decision-making based on all available evidence on the benefits and harms of health care interventions compared with alternative methods of care.

**Health determinants:** those factors that have either a positive or a negative influence on health at the individual or population level. Health determinants can be broadly divided into upstream determinants (education, employment, income, living and working conditions), midstream determinants (health behaviours, supportive environments and psychological factors) and downstream determinants (physiological and biological factors).

**Health promotion:** the process of enabling people to increase control over, and to improve, their health. This incorporates actions not only at the level of the individual, but also aimed at building health public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services.

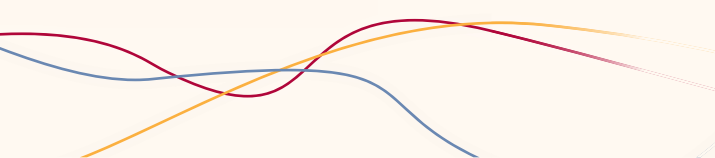
**Health system:** all services and initiatives of the health sector across the health continuum – health protection, health promotion, prevention, screening, early intervention, treatment, rehabilitation, palliative care and continuing care.

**Multidisciplinary teams:** teams that may contain general practitioners, nurses, nurse practitioners, Indigenous health workers, counsellors, physiotherapists, mental health workers, social workers and other practitioners working together to deliver integrated care.

**Palliative care:** an approach that improves the quality of life of individuals and their families facing the problems associated with life-threatening illness, promoting the prevention and relief of suffering by means of early identification and appropriate assessment and treatment of pain and other physical, psychosocial and spiritual issues.

**Population health:** aims to maintain and improve the health and well-being 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 their actions that have been shown to influence health over the life course.

**Prevalence:** the proportion of disease cases that exist within a population at a specific point in time, relative to the number of individuals within that population at the same point in time.



**Prevention:** in population health the following definitions apply to the stages at which prevention is undertaken across the continuum of disease. **Primary prevention** – aims 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 are protective of 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** – aims 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.

**Primary health care:** Derived from the Declaration of Alma Ata<sup>27</sup>, the Australian Primary Health Care Research Institute's definition of primary care relates to the process of promoting health; preventing illness; caring for the sick (curative, rehabilitative and palliative care); advocacy (for patients and families in and beyond the health sector); and community development.<sup>28</sup> It states that “primary health care should:

- reflect the economic, social and political characteristics of communities
- be universally accessible to individuals and families in their communities
- give priority to those most in need (equitable distribution of resources)
- involve collaboration with other related sectors such as education and housing
- maximise community and individual self-reliance and participation
- be based on scientifically sound and socially acceptable methods and technology”.<sup>28</sup>

**Primary care:** health care provided by a health professional which is a client's first point of entry into the health system. Primary care is practised widely in allied health and nursing, but predominantly in general practice. The Australian Primary Health Care Research Institute suggests that “the primary care workforce should:

- rely on health workers including general practitioners, nurses, midwives, pharmacists, dentists, allied health workers and community workers, as well as traditional practitioners as needed, who are:
  - suitably trained, socially and technically, to work as a health team
  - the first level of contact of individuals, families and communities with the health system
  - sustained by integrated, functional and mutually-supportive referral systems”.<sup>28</sup>

**Primary care networks:** networks of providers of primary health care for a region or geographical area.

**Public health:** collective actions by society to assure the conditions in which people can be healthy. This includes organised community efforts to prevent, identify, pre-empt, and counter threats to the public's health and to promote physical, social and cultural environments conducive to health.

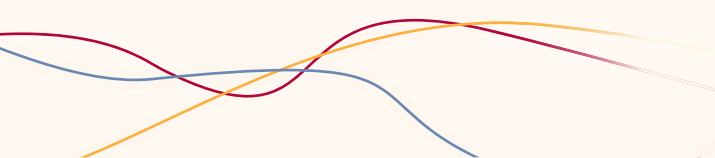
**Self-efficacy:** the confidence that one can carry out behaviour necessary to reach a desired goal.

**Self-management:** defined as the engagement of individuals, in activities and practices that sustain and promote health and well-being by:

- making, and/or participating in informed decisions
- building and sustaining partnerships with others who are involved in their health
- having the capacity to manage the impact of their health on functioning, emotions and interpersonal relationships
- monitoring and managing signs and symptoms of illness and chronic conditions.

**Self-management support:** the process of making and refining multilevel changes in health care systems (and the community) to facilitate self-management.<sup>29</sup>

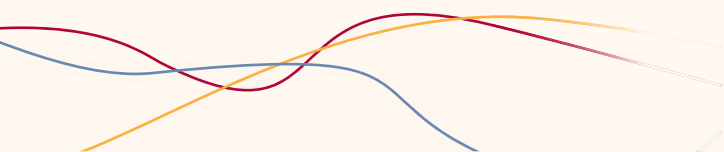
**Self care:** involves individuals taking responsibility for their own health and well-being. This includes: maintaining a healthy lifestyle, both physically and mentally; taking action to prevent illness and accidents; safe storage and use of medications; treatment of minor ailments and better care of long-term conditions.

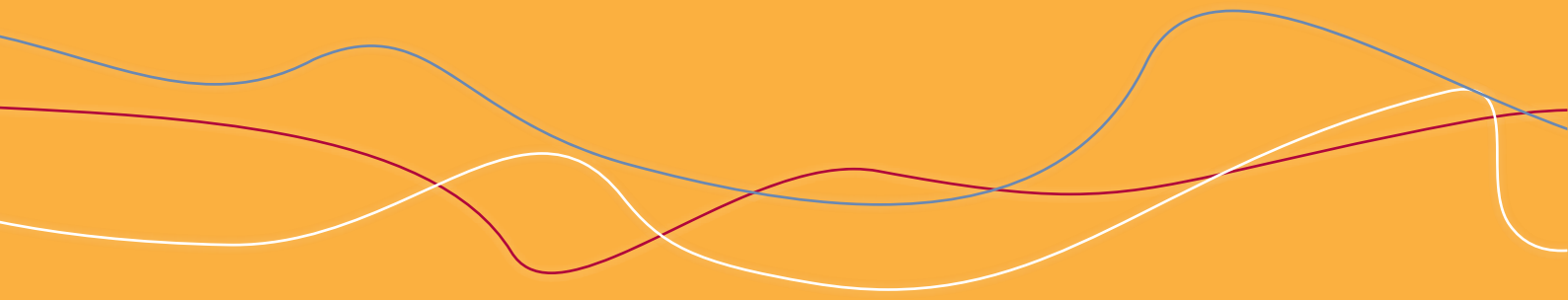


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