Key Action Area 1 - Increase the focus on the Social Determinants of Health.

Key Action Area 2 - Increase the focus on primary prevention to prevent and reduce risk factors.

Key Action Area 3 - Early detection and secondary prevention.

Key Action Area 4 - Self management.

Key Action Area 5 - Care for people with chronic conditions.

Key Action Area 6 - Workforce planning and development.

Key Action Area 7 - Information, communication and disease management systems.

Key Action Area 8 - Continuous Quality Improvement.

References
What is the Strategy?

The Northern Territory Chronic Conditions Prevention and Management Strategy 2010-2020 (NT CCPMS) provides a framework and key evidence-based strategies for building and strengthening a system-wide approach to prevention and management of chronic conditions in the NT. The NT CCPMS can be found online at:


Who developed the Strategy?
The Northern Territory (NT) Department of Health and Families has worked with partners in the non-government, private and Aboriginal health sectors and consulted widely with other stakeholders to develop the Strategy.

What is the aim of the Strategy?
The NT CCPMS aims to improve the health and wellbeing of all Territorians by reducing the incidence and impact of chronic conditions.

What are the goals of the Strategy?

- Promote and support healthy lifestyles and well being in the community.
- Reduce the prevalence of risk factors in the population.
- Prevent or delay the onset of chronic conditions.
- Maximise the wellbeing of those living with chronic conditions.
- Reduce health disparities among different population groups with regard to the conditions and risk factors in the Framework.
- Reduce the gap in life expectancy associated with chronic conditions between Aboriginal and non-Aboriginal people.
- Increase self management.
- Improve collaboration and integration across all sectors.

Who is the Strategy for?
The Strategy provides key evidence-based strategies for building and strengthening a system-wide response to prevent and reduce the impact of chronic conditions for:

- all people in the NT
- across the continuum of care
- across the life-span.

What conditions are in the Strategy?

- Cardiovascular Disease
- Rheumatic Heart Disease
- Type 2 Diabetes
- Chronic Airways Disease
- Chronic Kidney Disease
- Chronic Mental Illness
- Cancers (associated with common risk factors for other chronic conditions)
What are the key elements of the Framework?

1. INDIVIDUAL, CARER, AND FAMILY CENTRED CARE
2. COMMUNITY CAPACITY
3. STRATEGIC SUPPORTS TO ENABLE INTERVENTIONS TO BE EFFECTIVELY IMPLEMENTED:
   - Positive policy environment
   - Investment and resources
   - Health system organisation
   - Delivery system design
   - Decision support
   - Information, communication and disease management systems
   - Workforce capacity
4. INTERVENTIONS ACROSS THE CARE CONTINUUM:
   - Primary prevention
   - Early detection and secondary prevention
   - Management and tertiary prevention
   - Multidisciplinary care planning and review
   - Care co-ordination
   - Evidence-based clinical management
   - Self management support
   - Psycho-social support
   - Ongoing monitoring
   - Rehabilitation
   - Palliative care

What are the key action areas?

1. ACTION ON SOCIAL DETERMINANTS OF HEALTH
2. PRIMARY PREVENTION
3. SECONDARY PREVENTION AND EARLY INTERVENTION
4. SELF MANAGEMENT SUPPORT
5. CARE FOR PEOPLE WITH CHRONIC CONDITIONS
6. WORKFORCE PLANNING AND DEVELOPMENT
7. INFORMATION, COMMUNICATION AND DISEASE MANAGEMENT SYSTEMS
8. QUALITY IMPROVEMENT

How will we know if we are achieving the goals?

The Strategy’s ten-year time frame reflects the long term approach required to reduce the incidence and impact of chronic conditions in the population. Ongoing monitoring and evaluation throughout this ten year period will reflect our success at achieving the goals.

What will we measure?

The NT CCPMS 2010-2020 Monitoring and Evaluation Plan outlines the goals, targets, and performance indicators that help measure progress and identify areas for improvement. A report against these measures will be produced annually and disseminated widely to stakeholders.


When will we review and update the Strategy and Implementation Plan?

<table>
<thead>
<tr>
<th>Financial year</th>
<th>09/10</th>
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<tr>
<td>Strategy 2010-2020</td>
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</tbody>
</table>
What is this Implementation Plan?
The Implementation Plan provides an outline of strategies and actions for chronic conditions prevention and management from 2010 to 2012 in government and non-government health organisations, workplaces and communities throughout the Northern Territory. The plan will be updated every three years throughout the life of the Strategy.

How can individuals and organisations use the Implementation Plan?
Individuals and organisations can use the Implementation Plan to develop local business plans and to identify opportunities to work collaboratively with others to implement the Strategy.

Who else is implementing the Strategy?
Everyone in the Northern Territory – from individuals to government departments – can take part in implementing the Strategy. The following groups are key and the role of each is identified by symbols, in this plan. They are indicated as follows:

- Researchers/Educators
- Communities/Schools/Workplaces
- Non-Governmental Services
- Other Government Departments (represents non-Health departments)
- Hospital Services and Other Acute Care Services
- Primary Health Care Services
- Policy Makers

* DECIDE WHICH GROUP/S YOU BELONG TO AND SEE WHAT THE RELEVANT ACTIONS ARE.
Key Action Area 1:

Increase the focus on the Social Determinants of Health.

OBJECTIVE:
Contribute to improving the Social Determinants of Health (SDOH) through improving living conditions, food security, education, employment and health literacy.

KEY REFERENCE DOCUMENTS:
Commission on SDOH 2008 Closing the Gap in a generation: Health equity through action on the Social Determinants of Health.1

How will we check progress?

YEAR 1
• Level of awareness among health professionals of the impact of SDOH on chronic conditions.
• Number of partnerships between the health sector and other government departments.
• Number and proportion of Aboriginal staff employed within DHF.

YEAR 2
• Evidence of local community involvement in setting priorities and strategic directions for health care services.
• Evidence of evaluation of sharing health information initiatives e.g. recording on QIPPS.
• Number of targeted chronic conditions training and mentoring programs for Aboriginal people.

YEAR 3
• Health literacy included in service planning.
### 1.1 Raise Awareness of the Impact of the Social Determinants of Health on Chronic Conditions and Increase Capacity to Take Action

<table>
<thead>
<tr>
<th>Why Are We Doing It?</th>
<th>How Will We Do It?</th>
<th>Who?</th>
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<tbody>
<tr>
<td>• Evidence shows that the greatest risk factor for chronic conditions in the NT is low socio-economic status.</td>
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<tr>
<td>• Addressing the Social Determinants of Health (SDOH) will impact on the prevention of chronic conditions.</td>
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<tr>
<td>• Responsibility for many of the factors that impact on the SDOH lie outside the health sector. Increasing awareness and collaboration between health and other sectors is needed to address these factors.</td>
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<tr>
<td>• Disseminate information about the SDOH and key action areas, to health professionals, policy makers, planners and service managers.</td>
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<tr>
<td>• Partner with local education providers to include information about the SDOH and skills for collaboration into health professional education.</td>
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<td>• Disseminate information and promote discussion about the SDOH to communities.</td>
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<tr>
<td>• Develop partnerships with research/educational institutions to promote inclusion of SDOH in health research relevant to chronic conditions.</td>
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</table>

### 1.2 Provide Leadership to Strengthen Intersectoral Collaboration in Relation to Chronic Conditions

<table>
<thead>
<tr>
<th>Why Are We Doing It?</th>
<th>How Will We Do It?</th>
<th>Who?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Effectively addressing the SDOH and improving the daily living conditions, requires action across a range of government departments, in particular housing, education and employment.</td>
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<tr>
<td>• Identify and strengthen existing – and develop new – partnerships between government and non-government organisations.</td>
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<tr>
<td>• Contribute to intersectoral collaboration to reduce the impact of SDOH on chronic conditions and promote the inclusion of health impact assessments in all policies.</td>
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<tr>
<td>• Promote intersectoral collaboration to improve daily living conditions for people in remote communities.</td>
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</tbody>
</table>

Researchers/Educators  Non-Governmental Services  Hospital Services and Other Acute Care Services  Policy Makers  Communities/Schools/Workplaces  Other Government Departments  Primary Health Care Services
### 1.3 IMPROVE ACCESS TO HEALTH SERVICES FOR ALL TERRITORIANS

<table>
<thead>
<tr>
<th>WHY ARE WE DOING IT?</th>
<th>HOW WILL WE DO IT?</th>
<th>WHO?</th>
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<tbody>
<tr>
<td>• Many people have difficulty in accessing health services. Barriers include: health literacy, cultural security, language, distance. vii</td>
<td>• Support initiatives to increase access to comprehensive PHC for prevention and management of chronic conditions.</td>
<td></td>
</tr>
<tr>
<td>• Community control of Primary Health Care (PHC) services will enhance effective service delivery. viii</td>
<td>• Support initiatives to increase the number of Aboriginal Community Controlled Health Services providing comprehensive PHC.</td>
<td></td>
</tr>
<tr>
<td>• Culture and related social behaviours influence Aboriginal people’s decisions about: • when and where they should seek services, • their acceptance or rejection of treatment, • likelihood of accepting recommendations and follow-up, • likely success of health prevention and health promotion strategies, • client’s assessment of the quality of care, • their views about the facility and staff providing the care. ix This also applies to other vulnerable populations, e.g. culturally and linguistically diverse populations.</td>
<td>• Promote involvement of local communities in decision-making processes that impact on chronic conditions prevention and management.</td>
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<tr>
<td>• Community engagement has the potential to improve the quality of services supplied, and to improve the opportunities and capability of those who rely on services, which lessens their need for them. x</td>
<td>• Promote initiatives to improve health literacy in the community, e.g. consumer feedback, consumer groups, sharing health information, with particular emphasis on disadvantaged populations.</td>
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<tr>
<td>• Evaluation is a key to effective practice and ongoing practice improvement.</td>
<td>• Partner with educational organisations to include health information into numeracy and literacy programs.</td>
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<td></td>
<td>• Partner with other key stakeholders to identify and/or develop resources about chronic conditions prevention and management.</td>
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<td></td>
<td>• Support reorientation of health services to promote cultural security.</td>
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<td></td>
<td>• Evaluate effectiveness of sharing health information initiatives.</td>
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Researchers/Educators  Non-Governmental Services  Hospital Services and Other Acute Care Services  Policy Makers  Communities/Schools/Workplaces  Other Government Departments  Primary Health Care Services
### 1.4 INCREASE ABORIGINAL EMPLOYMENT IN THE HEALTH SECTOR

<table>
<thead>
<tr>
<th>WHY ARE WE DOING IT?</th>
<th>HOW WILL WE DO IT?</th>
<th>WHO?</th>
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</table>
| • Employment is a major factor in improving the SDOH. The health sector has a broad range of roles that can provide economic opportunity and employment.  
• Employment of Aboriginal people provides experience at a different level than that of health professionals.  
• Health services provided by Aboriginal people enhance cultural security. | • Develop employment opportunities in chronic conditions programs and link with targeted training and mentoring programs in all health sectors with focus on PHC and acute care settings.  
• Promote the use of accredited chronic conditions professional development activities that articulate with higher level education.  
• Promote active participation by Aboriginal employees in planning and evaluation of all chronic conditions services.  
• Promote opportunities for community members to be employed in the health sector e.g. carers, administration, educators.  
• Identify opportunities and support Aboriginal people in policy and management positions related to chronic conditions. | Researchers/Educators  
Non-Governmental Services  
Hospital Services and Other Acute Care Services  
Policy Makers  
Communities/Schools/Workplaces  
Other Government Departments  
Primary Health Care Services |
Key Action Area 2:

Increase the focus on primary prevention to prevent and reduce risk factors.

OBJECTIVE:
To reduce the impact of behavioural and lifestyle factors and create supportive environments for healthy behaviours.

KEY REFERENCE DOCUMENTS:
Australia: The Healthiest Country by 2020 National Preventative Health Strategy – the road map for action.xiv
Primary Health Care Reform in Australia Report to Support Australia’s First National Primary Health Care Strategy.xv

How will we check progress?

YEAR 1
• Number of education opportunities for health professionals to increase knowledge, understanding and skills about health promotion and prevention.
• Number and proportion of PHC services that provide antenatal, early childhood, school age and adolescent programs.
• Number of community education/health promotion/social marketing activities to promote quitting and smoke-free environments.

YEAR 2
• Number of programs that provide Aboriginal people with skills and understanding of preventative health behaviours.
• Evidence of partnership between agencies that support the creation of healthy environments.
• Evidence of the implementation of healthy workplace policies.
• Number of health services who use health promotion CQI tools.

YEAR 3
• Evidence of the use of health impact assessment in government planning processes.
### 2.1 INCREASE COMMUNITY AWARENESS ABOUT RISK FACTORS AND PROMOTE CONSISTENT MESSAGES

#### WHY ARE WE DOING IT?
- Many chronic conditions can be prevented or delayed through intervention, effective management and lifestyle change. Making informed choices is essential for behaviour change.
- Health promotion plays an important role in reducing risk factors at population level.
- Health promotion interventions from across the continuum are more likely to make a difference if they are focused on settings as well as on individuals.
- Health education is more effective when consistent messages are delivered by a wide range of service providers and as part of a broader campaign or program.
- Targeted public awareness campaigns are an effective part of health promotion.

#### HOW WILL WE DO IT?
- Develop complementary approaches, and extend the reach of national social marketing campaigns that promote consistent messages about smoking, nutrition, alcohol, physical activity.
- Participate in the development of national social marketing campaigns that target Aboriginal people.
- Implement campaigns that target specific population groups.
- Develop campaign-specific information and resources.
- Support the development of a broad range of interventions in partnership with NGOs.

#### WHO?

<table>
<thead>
<tr>
<th>Researchers/Educators</th>
<th>Non-Governmental Services</th>
<th>Hospital Services and Other Acute Care Services</th>
<th>Policy Makers</th>
<th>Communities/Schools/Workplaces</th>
<th>Other Government Departments</th>
<th>Primary Health Care Services</th>
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</table>

### 2.2 ENCOURAGE BEHAVIOURS THAT PROMOTE HEALTH AND WELL BEING

#### WHY ARE WE DOING IT?
- Lack of access to affordable, appropriate and evidence-based chronic conditions risk reduction programs, is a barrier to good health outcomes.
- Ongoing personalised support is needed to encourage self management of lifestyle risk factors and to prevent chronic conditions.
- Evaluation of interventions is needed to create evidence of what is effective and what is not effective.

#### HOW WILL WE DO IT?
- Develop referral pathways and systems to refer clients for lifestyle and behavioural risk factor modification.
- Support the implementation of the NT Nutrition and Physical Activity Action Plan and the NT Tobacco Action Plan.
- Support the implementation of effective evidence-based healthy lifestyle interventions.
- Evaluate the impact of healthy lifestyle interventions.
### 2.3 SUPPORT COMMUNITIES TO CREATE HEALTHY ENVIRONMENTS

**WHY ARE WE DOING IT?**
- Environments are important factors in behaviour choice.\[^vii\]
- Collaboration between agencies is effective in creating healthy environments.
- Health impact assessment is a tool that can inform development of policy by providing evidence of intended and unintended consequences of policy decisions on the health of a population.\[^viii\]

**HOW WILL WE DO IT?**
- Partner with other government and non-government agencies to promote town planning that supports healthy and safe behaviours.
- Promote the use of health impact assessment in government planning processes, to especially consider chronic conditions risk factors.

**WHO?**

### 2.4 INCREASE THE FOCUS ON THE EARLY YEARS OF LIFE, CHILDREN AND YOUNG PEOPLE

**WHY ARE WE DOING IT?**
- Evidence shows that the early years of life influence lifelong health and development. A focus on those early years including antenatal, early childhood and adolescence is essential.\[^ix-\]^\[^x\]
- Unhealthy choices in early life have life-long consequences. Parents and families influence choices individuals make.
- Focusing on groups rather than individuals, is more effective in creating settings that support individual health choices and behaviour.

**HOW WILL WE DO IT?**
- Support maternal, child and youth health strategies.
- Provide information and support to parents in relation to smoking, poor nutrition, physical inactivity and harmful alcohol consumption.
- Focus on the whole-of-life in healthy lifestyle programs.
- Promote good health in adolescence and early presentation in pregnancy.
- Promote improved access to well babies services e.g. Healthy Under 5’s program, immunisation.

**WHO?**

Researchers/Educators  Non-Governmental Services  Hospital Services and Other Acute Care Services  Policy Makers  Communities/Schools/Workplaces  Other Government Departments  Primary Health Care Services
### 2.5 INCREASE WORKFORCE CAPACITY FOR ACTION TO REDUCE POPULATION RISK FACTOR LEVELS

<table>
<thead>
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<th>WHY ARE WE DOING IT?</th>
<th>HOW WILL WE DO IT?</th>
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</table>
| • Upskilling the workforce increases its capacity to implement effective interventions, and support behaviour change.  
• Healthy workplaces demonstrate healthy behaviours and increase the capacity of the workforce to support interventions.\(^{251}\) | • Work with education organisations to provide learning that increases knowledge and skills relating to prevention, including skills in health promotion, community development, planning and evaluation.  
• Support the development of healthy workplaces within the health sector. | ![Image](Researchers/Educators) ![Image](Non-Governmental Services) ![Image](Hospital Services and Other Acute Care Services) ![Image](Policy Makers) ![Image](Communities/Schools/Workplaces) ![Image](Other Government Departments) ![Image](Primary Health Care Services) |

### 2.6 ENSURE HEALTH SECTOR REFORMS ARE RESPONSIVE TO THE NEED FOR PRIMARY PREVENTION

<table>
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<th>WHY ARE WE DOING IT?</th>
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</table>
| • The health system continues to focus on management of established disease, however recent reforms strengthen the focus on prevention.\(^{251}\)  
• Comprehensive primary health care results in improved and sustained health outcomes.  
• Evidence shows that a multidisciplinary approach to prevention results in better health outcomes.  
• Primary prevention continues to have a low priority in budget allocations. Focus needs to move from individual to population strategies. | • Promote health sector reforms based on recognised health promotion frameworks and principles e.g. Alma Ata, Ottawa charter.  
• Promote the integration of primary prevention across multiple professional groups throughout the health sector.  
• Support the allocation of appropriate funding and resources to promote population-based prevention strategies. | ![Image](Researchers/Educators) ![Image](Non-Governmental Services) ![Image](Hospital Services and Other Acute Care Services) ![Image](Policy Makers) ![Image](Communities/Schools/Workplaces) ![Image](Other Government Departments) ![Image](Primary Health Care Services) |

### 2.7 INCREASE MONITORING AND SURVEILLANCE, EVALUATION AND INTERVENTION RESEARCH

<table>
<thead>
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<th>WHY ARE WE DOING IT?</th>
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| • Monitoring and evaluation is critical to the development of a robust evidence base that informs policy and practice, resulting in more cost effective interventions and better health outcomes. | • Support risk factor monitoring and surveillance.  
• Use data from monitoring and surveillance to inform program and policy development. | ![Image](Researchers/Educators) ![Image](Non-Governmental Services) ![Image](Hospital Services and Other Acute Care Services) ![Image](Policy Makers) ![Image](Communities/Schools/Workplaces) ![Image](Other Government Departments) ![Image](Primary Health Care Services) |
Key Action Area 3:
Early detection and secondary prevention.

OBJECTIVE:
Increase the early detection and management of disease markers in the ‘at risk’ population to delay or halt the progression of chronic conditions.

How will we check progress?

YEAR 1
• Description of strategies to improve recording of risk factor status in health records, in different settings.
• Number and proportion of Aboriginal people aged 15-54 years who have had a full adult health check.
• Number and proportion of Aboriginal people aged 55 years and over who have had a full adult health check in the past 12 months.
• Number of non-Aboriginal people aged 40-45 years who have had a health check.

YEAR 2
• Description of educational opportunities for health professionals to increase knowledge, understanding and action on early detection and risk factors.
• Description of a systematic approach to early detection and management of disease markers in different settings.
• Evidence of inclusion of risk factor profiles in health service planning.
### 3.1 Enhance Primary Health Care Capacity to Implement a Co-Ordinated, Systematic Approach to Early Detection and Management of Disease Markers that Target Vulnerable / ‘At Risk’ Populations

#### Why Are We Doing It?
- The early detection and early management of risk factors and disease markers, reduces the likelihood of progression from wellness, to an established chronic condition.
- Screening should focus on those risk factors and disease markers for which there is evidence that screening is both effective and ethical.
- Evidence shows that a systematic approach to follow-up for people with identified risk factors or early disease markers, for assessment referral for the presence and severity of disease, and for management of disease, results in better outcomes.

#### How Will We Do It?
- Increase workforce capacity to identify population risk profiles and to implement risk factor reduction strategies.
- Improve access to evidence-based information about risk factor reduction.
- Encourage all health service providers to include profiles of the risk characteristics of the service population, in health service planning.
- Disseminate information about evidence-based systems that target ‘at risk’ populations.

#### Who?
- Researchers/Educators
- Non-Governmental Services
- Hospital Services and Other Acute Care Services
- Policy Makers
- Communities/Schools/Workplaces
- Other Government Departments
- Primary Health Care Services

### 3.2 Develop, Implement and Evaluate Flexible Approaches to Early Detection and Follow-Up of Disease Markers in a Range of Settings, Based on Local Needs of ‘At-Risk’ Populations

#### Why Are We Doing It?
- Evidence shows that systematic approaches to early detection and follow-up of disease markers, results in better health outcomes for individuals and populations.
- Specific targeting of vulnerable populations increases uptake of early detection and follow-up.

#### How Will We Do It?
- Increase focus on screening, brief intervention and early intervention in primary health care settings.
- Develop and implement evidence-based approaches to early detection including recall systems.
- Promote the use of decision support tools e.g. cardiovascular risk assessment tool.
- Identify variations in access to screening, and implement strategies to increase screening in under-screened populations.

#### Who?
- Researchers/Educators
- Non-Governmental Services
- Hospital Services and Other Acute Care Services
- Policy Makers
- Communities/Schools/Workplaces
- Other Government Departments
- Primary Health Care Services
Key Action Area 4:

Self management.

OBJECTIVE:
Implement a Territory-wide approach to self management.

How will we check progress?

YEAR 1
• Development of an NT Framework for chronic conditions self management.
• Description of opportunities for community members to access information about chronic conditions.

YEAR 2
• Description of educational opportunities for health professionals to develop skills in supporting/promoting self management.
• Number of opportunities for individuals/carers to participate in self management training.

YEAR 3
• Evidence of improved linkages that encourage and support self management between sectors and organisations.
### 4.1 Develop and Implement a Framework for Self Management to Support Consistent Approaches for People with Chronic Conditions Across the NT

**Why Are We Doing It?**

- Evidence shows that self management by people with chronic conditions improves health outcomes. xxii
- Patients with chronic conditions access services across a range of providers, and a consistent approach to self management will enable people to participate more effectively.
- Current models of self management have not been effectively implemented in many NT communities. The development of a model that meets the needs of the community is required.

**How Will We Do It?**

- Collaborate with health sector organisations and communities to identify a consistent self management framework, for use across the NT and adapt to specific populations and settings e.g. Aboriginal populations, rural and remote settings.
- Identify barriers that prevent services working collaboratively, and implement strategies and systems that promote integration and collaboration.

**Who?**

- Researchers/Educators
- Non-Governmental Services
- Hospital Services and Other Acute Care Services
- Policy Makers
- Communities/Schools/Workplaces
- Other Government Departments
- Primary Health Care Services

### 4.2 Empower and Support Individuals/Carers to Be Active Participants in Monitoring and Managing of Their Chronic Condition

**Why Are We Doing It?**

- Individuals, carers and families are the central players in the self management approach. xxv
- Self management courses can improve self efficacy and confidence of people with chronic conditions. xxv

**How Will We Do It?**

- Implement training and toolkits that support individual, carer and families to participate in self management.
- Identify or develop strategies that support the needs of vulnerable populations.
- Promote the development of effective systems to support individuals/carers to participate in self management activities.

**Who?**

- Researchers/Educators
- Non-Governmental Services
- Hospital Services and Other Acute Care Services
- Policy Makers
- Communities/Schools/Workplaces
- Other Government Departments
- Primary Health Care Services
### 4.3 DEVELOP A SKILLED WORKFORCE TO SUPPORT INDIVIDUALS/CARERS/FAMILIES TO MANAGE THEIR HEALTH AND HEALTH CARE

<table>
<thead>
<tr>
<th>WHY ARE WE DOING IT?</th>
<th>HOW WILL WE DO IT?</th>
<th>WHO?</th>
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</table>
| • Health professionals and other members of the health workforce need to develop new skills to enhance partnerships with individuals, families and carers managing chronic conditions.  
• Systems that link health services and individuals, families, carers with other support mechanisms will support self management. | • Work with education providers to develop knowledge and skills that enable and encourage health professionals to provide self management support.  
• Promote systems for linking individuals with services and resources to support self management including participation in care planning and chronic conditions management.  
• Facilitate self management by supporting the development of effective information systems across the NT. | Researchers/Educators  
Non-Governmental Services  
Hospital Services and Other Acute Care Services  
Policy Makers  
Communities/Schools/Workplaces  
Other Government Departments  
Primary Health Care Services |
Key Action Area 5:

Care for people with chronic conditions.

OBJECTIVE:
Ensure clients with chronic conditions receive high quality clinical care and co-ordinated and integrated multidisciplinary care across services, settings and time.

How will we check progress?

YEAR 1

- Number and proportion of clients in Aboriginal PHC service aged 15 years and over with Type 2 Diabetes and/or Coronary Heart Disease who have a chronic disease management plan. (AHKPI 1.7)
- Number and proportion of resident clients aged 15 years and over with Type 2 Diabetes who have had an HbA1c test in the last 6 months. (AHKPI 1.8)
- Number and proportion of Diabetic patients with albuminuria who are on ACE inhibitor and/or ARB. (AHKPI 1.9)
- Description of care co-ordination process for people with complex chronic conditions.
- Improved linkages between mental health and AOD services and PHC services.

YEAR 2

- Number and reach of outreach medical specialist services provided for people with chronic conditions.
- Strategies to increase allied health professionals in chronic conditions programs.
- Description of increased access to co-ordinated multidisciplinary care for people with chronic conditions.
- Number of education opportunities for health professionals that include co-morbidity of chronic mental illness and other chronic conditions.
- Improved recording of emotional and social wellbeing in risk factor assessment.
- Strategies to improve access to rehabilitation for people with chronic conditions.
- Number of people with chronic conditions who are referred for palliative care.

YEAR 3

- Number of health services providing access to cardiac and pulmonary rehabilitation programs.
### 5.1 IMPROVE COMMUNICATION AND EDUCATION ABOUT CHRONIC CONDITIONS FOR INDIVIDUALS, CARERS AND FAMILIES

**WHY ARE WE DOING IT?**
- Access to information is a key factor in supporting people with chronic conditions to self manage.
- People in disadvantaged populations require targeted strategies to provide access to information.

**HOW WILL WE DO IT?**
- Identify information resources for use across the NT.
- Support the enhancement and implementation of a resource database that community members can access.
- Partner with research organisations to develop specific strategies for Aboriginal people and others in vulnerable populations.
- Promote ‘sharing of health information’ in all health professional education.

**WHO?**
- Researchers/Educators
- Non-Governmental Services
- Hospital Services and Other Acute Care Services
- Policy Makers
- Communities/Schools/Workplaces
- Other Government Departments
- Primary Health Care Services

### 5.2 PROVIDE ACCESS TO HIGH QUALITY EVIDENCE-BASED CLINICAL CARE

**WHY ARE WE DOING IT?**
- Access to evidence-based care promotes the use of effective interventions and helps health care providers improve decision-making process and care delivery.
- Ongoing evaluation of clinical care and best practice models through the Continuous Quality Improvement (CQI) process, improves standards of care and inform the evidence base.

**HOW WILL WE DO IT?**
- Promote and support the implementation of the National Service Improvement Frameworks for Asthma, Cancer, Diabetes, Heart, Stroke and Vascular Disease.
- Promote the use of the Central Australian Remote Practitioners Association (CARPA) guidelines for chronic conditions in PHC and acute care services.
- Support clinicians to promote proactive care by improving feedback and reminder systems within and across organisations.
- Support the implementation of outreach medical specialist services.
- Support the implementation of clinical CQI programs in the acute and primary health care sectors.

**WHO?**
- Researchers/Educators
- Non-Governmental Services
- Hospital Services and Other Acute Care Services
- Policy Makers
- Communities/Schools/Workplaces
- Other Government Departments
- Primary Health Care Services
### 5.3 PROVIDE ACCESS TO QUALITY, CO-ORDINATED AND INTEGRATED MULTIDISCIPLINARY CARE

**WHY ARE WE DOING IT?**

- Evidence shows that care co-ordination utilising a multidisciplinary approach for people with complex chronic conditions, ensures that services are used in a timely and appropriate way resulting in improved patient outcomes.

**HOW WILL WE DO IT?**

- Support implementation of multidisciplinary models of care, focusing on improvements in communication and links between and within all sectors.
- Collaborate with acute and PHC providers to implement care co-ordination for people with complex chronic conditions, including multidisciplinary care planning and review.
- Partner with NGOs and private providers to implement outreach multidisciplinary allied health teams in PHC.
- Build workforce capacity to work effectively in multidisciplinary teams.

**WHO?**

- **Researchers/Educators**
- **Non-Governmental Services**
- **Hospital Services and Other Acute Care Services**
- **Policy Makers**
- **Communities/Schools/Workplaces**
- **Other Government Departments**
- **Primary Health Care Services**

### 5.4 RAISE AWARENESS OF CO-MORBIDITY OF CHRONIC MENTAL ILLNESS WITH OTHER CHRONIC CONDITIONS, AND ENHANCE EARLY DETECTION AND CARE FOR THESE PEOPLE

**WHY ARE WE DOING IT?**

- Mental health conditions contribute to 17% of the total burden of disease in the NT.
- There is strong evidence of high levels of co-morbidity of chronic mental illness and other chronic conditions.
- Managing chronic mental illness enables better management of other chronic conditions, and enhances the capacity for self management.

**HOW WILL WE DO IT?**

- Disseminate information to individuals, carers, families and communities about chronic mental illness and the link with chronic conditions.
- Build workforce capacity and increase the focus on prevention and early detection of chronic mental illness through health professional education.
- Improve screening and the capacity of health professionals to identify common mental illnesses.
- Improve referral pathways and access to specialist support.
- Promote integration of mental health services and alcohol and other drug services within primary health care.
- Improve links between primary health care and specialist mental health services.
- Improving links with other organisations providing care and support for people with mental illness.

**WHO?**

- **Researchers/Educators**
- **Non-Governmental Services**
- **Hospital Services and Other Acute Care Services**
- **Policy Makers**
- **Communities/Schools/Workplaces**
- **Other Government Departments**
- **Primary Health Care Services**
### 5.5 Improve Rehabilitation Services for People with Chronic Conditions in Order to Maximise Function, Improve Quality of Life and Reduce the Risk of Further Complications

<table>
<thead>
<tr>
<th>WHY ARE WE DOING IT?</th>
<th>HOW WILL WE DO IT?</th>
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</table>
| • Evidence shows that people who have participated in cardiac or pulmonary rehabilitation have better outcomes, including improved quality of life.⁴⁴⁸¹ | • Raise awareness of the benefits of rehabilitation for people with chronic conditions.  
• Implement agreed cardiac and pulmonary rehabilitation programs across the NT.  
• Collaborate with providers to provide access to ongoing stroke rehabilitation in remote communities.  
• Increase integration across services, including private and non-government sectors.  
• Develop or increase the capacity to deliver evidence-based multidisciplinary rehabilitation services for people with chronic conditions within primary health care services.  
• Develop and implement rehabilitation models that increase access to culturally appropriate services for people in rural, regional and remote areas. | ![Researchers/Educators](image1) ![Non-Governmental Services](image2) ![Hospital Services and Other Acute Care Services](image3) ![Policy Makers](image4) ![Communities/Schools/Workplaces](image5) ![Other Government Departments](image6) ![Primary Health Care Services](image7) |

### 5.6 Provide Access to High Quality Evidence-Based Clinical Care

<table>
<thead>
<tr>
<th>WHY ARE WE DOING IT?</th>
<th>HOW WILL WE DO IT?</th>
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</thead>
</table>
| • Evidence shows that people with chronic kidney disease benefit from a palliative care approach in the end stages of life.  
• This approach can be applied to other chronic conditions to maximise quality of life, at the end of life. | • Support the implementation of the NT Palliative Care Strategy.  
• Increase the recognition and identification of people with end-of-life chronic conditions who will benefit from palliative care.  
• Increase the number of people with life threatening illness who develop an advanced care plan with their health care team and family/carers.  
• Increase the capacity of primary health care services to provide palliative care, and give access to specialist support for people with chronic conditions. | ![Researchers/Educators](image1) ![Non-Governmental Services](image2) ![Hospital Services and Other Acute Care Services](image3) ![Policy Makers](image4) ![Communities/Schools/Workplaces](image5) ![Other Government Departments](image6) ![Primary Health Care Services](image7) |
Key Action Area 6:

Workforce planning and development.

OBJECTIVE:
Recruit, develop and retain an appropriately skilled workforce.

KEY REFERENCE DOCUMENTS:
Educating to Improve Population Health Outcomes in Chronic Disease.\textsuperscript{xxxii}

How will we check progress?

YEAR 1

• Evidence of collaboration with education providers, to promote educational opportunities across disciplines and settings.

YEAR 2

• Reform initiatives to address the need for an increasing workforce, to prevent and manage chronic conditions.
• Number of people taking up new roles related to chronic conditions.
• Increase in the number of Aboriginal people employed in chronic conditions area.
### 6.1 PROVIDE EDUCATION, TRAINING AND PROFESSIONAL DEVELOPMENT OPPORTUNITIES THAT ENCOMPASS ALL ASPECTS OF THE CHRONIC CONDITIONS PREVENTION AND MANAGEMENT STRATEGY

**WHY ARE WE DOING IT?**

- A skilled workforce is essential to implementing this strategy. This is particularly critical in light of the increased focus on prevention, and with increasing numbers of people with chronic conditions. These factors are clearly cause for a greater and more skilled workforce. xxxiv
- Workforce issues are exacerbated by the global shortage of health professionals and the challenges associated with attracting a workforce to the NT.
- This situation requires some innovative actions, to attract and retain skilled health professionals, and to recruit community members to take on roles to support the implementation of the strategy. xxxv

**HOW WILL WE DO IT?**

- Identify and disseminate core competencies required to develop an effective workforce.
- Collaborate with education organisations to incorporate chronic conditions prevention and management, in tertiary education for health professionals.
- Collaborate with key stakeholders to map and co-ordinate professional development and ongoing education opportunities across the health sector.
- Ensure workforce orientation and ongoing training in a variety of locations, using a range of modalities to support the development of: • integrated, multidisciplinary care • a broad range of skills in health promotion and prevention • skills to work in partnership with other health professionals, individuals, carers and family • health impact assessment • awareness of available resources and supports.

**WHO?**

- Researchers/Educators
- Non-Governmental Services
- Hospital Services and Other Acute Care Services
- Policy Makers
- Communities/Schools/Workplaces
- Other Government Departments
- Primary Health Care Services

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### 6.2 BUILD WORKFORCE CAPACITY TO MEET FUTURE POPULATION NEEDS THROUGH RESEARCH AND INNOVATION INITIATIVES

**WHY ARE WE DOING IT?**

- Given the diminishing number of health professionals available, it is essential that current roles are realigned and innovative new workforce roles are identified and supported, to undertake prevention and management of chronic conditions. xxxvi
- Evidence shows that community and peer leaders can undertake roles effectively, if provided with training and ongoing support.
- The ageing of the health workforce will further limit the capacity to implement the Strategy.

**HOW WILL WE DO IT?**

- Participate in primary health care reform initiatives to realign existing health workforce roles and create new ones, including the role of community and peer leaders in provision of chronic conditions prevention and management.
- Market a chronic conditions prevention and management career as a positive choice for health professionals and community workers.

**WHO?**

- Researchers/Educators
- Non-Governmental Services
- Hospital Services and Other Acute Care Services
- Policy Makers
- Communities/Schools/Workplaces
- Other Government Departments
- Primary Health Care Services
## 6.3 DEVELOP AND SUPPORT EMPLOYMENT OF ABORIGINAL PEOPLE IN MANAGEMENT, POLICY AND OPERATIONAL AREAS OF CHRONIC CONDITIONS

<table>
<thead>
<tr>
<th>WHY ARE WE DOING IT?</th>
<th>HOW WILL WE DO IT?</th>
<th>WHO?</th>
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</thead>
<tbody>
<tr>
<td>• Evidence shows that services better meet the needs of Aboriginal people when they are managed and provided by Aboriginal people.</td>
<td>• Collaborate with education agencies to provide education, training and professional development opportunities that specifically target Aboriginal people.</td>
<td></td>
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<tr>
<td></td>
<td>• Support flexible human resource practices for Aboriginal people to facilitate workforce recruitment and retention.</td>
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<td></td>
<td>• Increase workforce capacity to effectively mentor with Aboriginal people.</td>
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<td></td>
<td>• Support the development and employment of a community workforce, to work in partnership with health professionals.</td>
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</table>
Key Action Area 7:
Information, communication and disease management systems.

OBJECTIVE:
To improve connectivity, sharing of useful information and access to appropriate services to support chronic conditions prevention and management.

How will we check progress?

YEAR 1
- Number of health services with electronic care planning and recall systems.
- Report on the activities of the NT CDN.
- Evidence of collaboration with IM and ICT areas to incorporate needs of chronic conditions prevention and management strategies into systems.

YEAR 2
- Number of health service IT systems that communicate effectively with other services and sectors.

YEAR 3
- Utilisation of decision support tools by health professionals.
### 7.1 Utilise Existing and Emerging Information Management (IM) and Information Communication Technology (ICT) to Facilitate Efficient and Effective Chronic Conditions Prevention and Management

<table>
<thead>
<tr>
<th>WHY ARE WE DOING IT?</th>
<th>HOW WILL WE DO IT?</th>
<th>WHO?</th>
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</thead>
<tbody>
<tr>
<td>• Organising and communicating information for quality clinical care improves</td>
<td>• Engage with existing IM and ICT projects to influence their development,</td>
<td>Researchers/Educators, Non-Governmental Services, Hospital Services and Other Acute Care Services, Policy Makers, Communities/Schools/Workplaces, Other Government Departments, Primary Health Care Services</td>
</tr>
<tr>
<td>efficiency and quality of services provided.</td>
<td>achieve quality and connectivity of clinical information and determine health</td>
<td></td>
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<tr>
<td></td>
<td>system performance in the prevention and management of chronic conditions.</td>
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<tr>
<td></td>
<td>• Develop and maintain an agreed list of chronic condition prevention and</td>
<td></td>
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<td></td>
<td>management requirements for incorporation into IM and ICT projects.</td>
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<tr>
<td></td>
<td>• Support the development of systems to identify and monitor risk factors,</td>
<td></td>
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<tr>
<td></td>
<td>chronic conditions and their progression.</td>
<td></td>
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<tr>
<td></td>
<td>• Promote the development of care planning initiatives and support training of</td>
<td></td>
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<td></td>
<td>health professionals to ensure efficient and effective care planning.</td>
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</table>

### 7.2 Support and Develop Continuity of Care Initiatives That Support Health Professionals and Services, Working Together in an Integrated, Seamless, and Co-Ordinated Way, Enhancing the Interface Between Health and Other Sectors

<table>
<thead>
<tr>
<th>WHY ARE WE DOING IT?</th>
<th>HOW WILL WE DO IT?</th>
<th>WHO?</th>
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</thead>
<tbody>
<tr>
<td>• Efficient and effective transfer of health information across the care</td>
<td>• Engage with key partners across the health sector to support continuity of</td>
<td>Researchers/Educators, Non-Governmental Services, Hospital Services and Other Acute Care Services, Policy Makers, Communities/Schools/Workplaces, Other Government Departments, Primary Health Care Services</td>
</tr>
<tr>
<td>continuum is essential to provide integrated and co-ordinated care that has</td>
<td>care initiatives, aimed at providing efficient and effective transfer of health</td>
<td></td>
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<tr>
<td>been shown to improve patient outcomes.</td>
<td>information across the care continuum.</td>
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<tr>
<td></td>
<td>• Support processes that improve the validity, reliability and continuity across</td>
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<tr>
<td></td>
<td>settings of clinical information about people with, or at risk of developing, a</td>
<td></td>
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<tr>
<td></td>
<td>chronic condition.</td>
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</table>
### 7.3 UTILISE CURRENT INFORMATION TECHNOLOGY TO SHARE INFORMATION ABOUT CHRONIC CONDITIONS PREVENTION AND MANAGEMENT, WITH HEALTH PROFESSIONALS AND COMMUNITY MEMBERS

<table>
<thead>
<tr>
<th>WHY ARE WE DOING IT?</th>
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<tbody>
<tr>
<td>• Sharing of health information through ICT is efficient, accessible, prevents duplication of resources and provides organised access to quality and up-to-date information.</td>
<td>• Support the enhancement and implementation of a resource database that is accessible to all health professionals and community members.</td>
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</table>

### 7.4 IMPLEMENT STRATEGIES TO SHARE INFORMATION ACROSS THE NT

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<tr>
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<tbody>
<tr>
<td>• Sharing of information between both governmental and non-governmental organisations through existing networks promotes communication, collaboration and co-ordination in control of chronic conditions.</td>
<td>• Support ongoing development and innovation of the NT Chronic Disease Network and other partners.</td>
<td></td>
</tr>
</tbody>
</table>
Key Action Area 8:
Continuous Quality Improvement.

OBJECTIVE:
Improve chronic conditions prevention and management through CQI activities.

How will we check progress?

- Evidence of CQI approach in PHC services.
- Evidence of collaborative research and innovation initiatives between the health sector and researchers to improve and extend CQI.
### 8.1 Increase Community Awareness About Risk Factors and Promote Consistent Messages

<table>
<thead>
<tr>
<th>WHY ARE WE DOING IT?</th>
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<tr>
<td>• There is clear evidence that CQI results in improved outcomes for people with</td>
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<tr>
<td>chronic conditions.</td>
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<tr>
<th>HOW WILL WE DO IT?</th>
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<tbody>
<tr>
<td>• Support and promote CQI activities across all health services, including the</td>
</tr>
<tr>
<td>private and non-government sectors.</td>
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<tr>
<td>• Support the Continuous Quality Improvement Strategy for the Aboriginal</td>
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<tr>
<td>Primary Health Care sector in the NT.</td>
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<table>
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<tr>
<th>WHO?</th>
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<tbody>
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<td>Primary Health Care Services</td>
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### 8.2 Improve Service Delivery Through Research and Innovation Initiatives

<table>
<thead>
<tr>
<th>WHY ARE WE DOING IT?</th>
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<tbody>
<tr>
<td>• Access to evidence-based information will enable the capacity of health service</td>
</tr>
<tr>
<td>providers to implement interventions that achieve the desired outcomes.</td>
</tr>
<tr>
<td>• The evidence-base for disadvantaged populations that is applicable to a range</td>
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<tr>
<td>of settings is limited and requires strengthening.</td>
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<thead>
<tr>
<th>HOW WILL WE DO IT?</th>
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<tbody>
<tr>
<td>• Identify priority chronic conditions research and initiatives.</td>
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<tr>
<td>• Support relevant health outcomes research, including the translation of research,</td>
</tr>
<tr>
<td>into policy and practice through partnerships between academia and health</td>
</tr>
<tr>
<td>organisations.</td>
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<tr>
<td>• Disseminate outcomes of initiatives to a broad range of stakeholders to enable</td>
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<tr>
<td>service improvements.</td>
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<tr>
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<td>Other Government Departments</td>
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<tr>
<td>Primary Health Care Services</td>
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</tbody>
</table>
References


5. Ibid


10. Pathways to Community Control op cit.

11. Commission on Social Determinants of Health op cit.

12. Pathways to Community Control op cit.


20. Bellew, B. Primary prevention of chronic disease in Australia through interventions in the workplace setting: An Evidence Check rapid review brokered by the Sax Institute [http://www.saxinstitute.org.au/contentUploadedByEWeb/Files/PCCD%20200808%Epdf


The Northern Territory Chronic Conditions Prevention and Management Strategy 2010-2020 was launched in November 2009 by the Northern Territory Minister for Health, Kon Vatskalis. The Northern Territory Department of Health and Families worked with partners in the non-government, private and Aboriginal health sectors, and consulted widely with other stakeholders to develop the Strategy.

Copies of the NT Chronic Conditions Prevention and Management Strategy 2010-2020 and the Implementation Plan 2010-2012 can be downloaded from the following website: