

MIWATJ HEALTH ABORIGINAL CORPORATION  
CHRONIC DISEASE PREVENTION AND MANAGEMENT POLICY

PREAMBLE

*The available evidence suggests that Indigenous Australians continue to suffer a greater burden of ill health than the rest of the population. Overall, Indigenous Australians experience lower levels of access to health services than the general population, are more likely than non-Indigenous people to be hospitalised for most diseases and conditions, and are more likely to experience disability and reduced quality of life due to ill health, and to die at younger ages, than other Australians. Indigenous Australians also suffer a higher burden of emotional distress and possible mental illness than that experienced by the wider community<sup>1</sup>.*

*Most of the burden of illness for Australians is due to chronic disease and its prevalence is rising<sup>2</sup>. The Indigenous community bears a greater burden of chronic disease prevalent in the population. The rise in prevalence is relatively recent and it has only been within the 20<sup>th</sup> century that chronic disease has passed infectious disease and injuries as a dominant health concern. Cardiovascular disease and mental disorders are the leading causes of disease burden in the Australian Indigenous population accounting for 32% of the disease burden. Chronic respiratory disease, diabetes and cancers are the next three leading causes<sup>3</sup>.*

*Effective health care using an evidence based approach can prevent and reduce premature death and disability from chronic disease in spite of the broader social determinants of health such as poverty and unemployment. The prevention and management of chronic disease requires a systematic approach to health care moving from simple, episodic, technical solutions required for infectious diseases to one that requires the establishment of more complex systems of ongoing care, which require engagement with clients and other organisations as partners in a multidisciplinary team approach.*

*The evidence about chronic disease care and support systems strongly recommends using a Continuous Quality Improvement (CQI) approach to monitor and inform what is happening with regards to chronic disease and identify and address any systems issues that may be creating barriers to effective patient outcomes. The CQI approach to chronic disease management utilises a Plan Do Study Act approach and these principles are incorporated into the operational management of Miwatj Health Aboriginal Corporation (MHAC).*

*MHAC is part of a network of health services that deliver health care to Aboriginal people in the Miwatj region. The Miwatj region covers an Indigenous population of*

---

<sup>1</sup> [www.aihw.gov.au/indigenous/health/index.cfm](http://www.aihw.gov.au/indigenous/health/index.cfm) Jan 2007

<sup>2</sup> AHMAC National Chronic Disease Strategy 2005 pg 3

<sup>3</sup> Vos T, Barker B, Standley L, Lopez AD 2007, The burden of disease and injury in Aboriginal and Torres Strait Islander peoples, Summary report Brisbane: School of Population Health, The University of Queensland.

approximately 10,000 spread over many communities and homelands centres from Ramingining in the east to Groote Eylandt in the west, and from Yirrkala in the north to Numbulwar in the south. MHAC provides clinical services to Aboriginal people in on the Gove peninsula and at Galiwin'ku, and allied health and health promotion services to other communities in the Miwatj region as required and depending on resources. MHAC operates electronic patient information systems at Gove (Ferret./Medical Director) and at Galiwin'ku (Communicare) to support high quality patient care. The Indigenous population of the region is highly mobile and as such may access care at any one of a number of health services.

MHAC recognises that clients are the most important person involved in their primary health care delivery as well as being the expert on their own health and lives. MHAC also recognizes that their health professionals support their clients by lending their expertise as consultants, providing information about the disease process, supporting the client to set their own goals and helping them learn to manage and solve health problems themselves.

POLICY INTENT

The intent of this policy is to clearly explain the standard of practice expected by staff working at MHAC in relation to the planning, delivery and evaluation of chronic illness prevention and management. This includes adopting a systematic approach to the planning, delivery and evaluation of child health and maternal services as a key strategy for the prevention of chronic disease.

STANDARD REQUIRED

1. The health delivery systems of MHAC will adopt a holistic life course approach to chronic disease prevention and management including the promotion of a healthy life style. An overview of the types of interventions across the life continuum is outlined in the table below.

<i>LIFE COURSE APPROACH TO CHRONIC DISEASE PREVENTION AND MANAGEMENT</i>				
<i>Age</i>	<i>0-4</i>	<i>5-14</i>	<i>15-54yrs</i>	<i>55+ yrs</i>
<i>Prevention</i>	<i>Immunisation</i>			
	<i>Health Education, Promotion and Advocacy</i>			
	<i>Antenatal/Postnatal care</i>			
<i>Early Detection</i>	<i>Health Check</i> <i>0-4</i>	<i>Health Check</i> <i>5-14</i>	<i>Health check</i> <i>15-54</i>	<i>Health check</i> <i>55+</i>
	<i>Men's and Women's Health</i>			
	<i>Social and Emotional well being</i>			
<i>Management</i>	<i>Treatment, ongoing management including self management</i>			
<i>Effective Health Information System – Ferret</i>				

- 2. The organisation supports the use of child health checks, adult health checks and over 55 health checks as a proactive strategy to identify individual health issues or problems early, and as a means to provide education and information to clients to prevent and manage risk factors for chronic disease. All staff are expected to commit to the organisations approach to the prevention of chronic disease. Staff will be supported to undertake training in order to meet their defined roles and responsibilities.*
  
- 2. Miwatj Health Services aspires to deliver best practice management strategies to support chronic disease prevention and management including:*
  - Taking a holistic approach to patient assessment and care.*
  - Evidence based treatment guidelines to inform patient management,*
  - The use of recall and reminder systems,*
  - The promotion of self management using a goal oriented care planning, multidisciplinary approach,*
  - A regularly updated electronic patient information system,*
  - Regular monitoring and evaluation within a quality improvement framework,*
  - Coordinating access to secondary and tertiary care required for best practice chronic disease management including allied health services, and*
  - Supporting community development activities and community based health promotion programs to target risk factors including smoking, nutrition and alcohol to increase community knowledge and access to services.*
  
- 3. The target population for completing child health checks, adult health checks, 55+ health check and chronic disease care planning by the MHAC team based in Nhulunbuy is Aboriginal people living in Nhulunbuy, Bitjimirri, Gungyangara and Galupa, while the target population of the Ngakanbuy team based in Galiwin'ku is Aboriginal people residing as Galiwin'ku. Medicare guidelines require that these services are delivered by the usual health practitioner.*
  
- 4. All staff are required to use the standard CARPA chronic disease care guidelines that define the minimum standard of care for people with chronic disease. Recalls for these health checks are incorporated into Ferret/MD and Commuicare to facilitate continuity of care and follow up of clients. All new staff employed by the organisation should be made aware of the CARPA chronic disease guidelines.*
  
- 5. The organisation supports clinical best practice with regards to antenatal and chronic disease care and encourages the development of care plans for all clients with chronic disease who regularly use the service to facilitate access to the range of services required to prevent further complications from chronic disease developing.*
  
- 6. Adult health checks will be completed in conjunction with the preparation of chronic disease care plans if an adult health check has not been completed in the last 12 months.*
  
- 7. Training will be provided through an orientation program and regular inservice education programs to ensure that staff have the skills required to support the standard of service delivery required.*

8. *All staff are required to support, educate and guide clients to take greater control over their chronic illness and to enable them to enter into partnerships with health care providers to promote more effective self management and improved quality of life.*
9. *All members of the clinic team are expected to routinely check Ferret/MD and Communicare for outstanding care needs and deliver health checks and brief intervention for overdue recalls when people attend the clinic opportunistically or for specific chronic disease care appointments.*
10. *MHAC will work in partnership with other agencies to advocate for more supportive environments and healthy public policy to address some key social determinants of chronic disease including alcohol misuse, lack of education at all levels, community infrastructure and unemployment.*