



Ensuring Workforce Competency in Effective Chronic Disease Management Forum

August 4 2008

Forum presented by Whitehorse Community Health Service in conjunction with Box Hill Institute of TAFE & Department of Human Services
Report provided by Whitehorse Community Health Service



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2 Executive Summary

This report outlines the content and discussions covered in the forum 'Ensuring workforce competency in effective chronic disease management'. It was designed to bring together community health and education providers to enable a discussion of effective approaches to the management of chronic diseases, to explore the workforce skill needs in delivering effective chronic disease management ('CDM') and requirements for education and training. This report provides an overview of the broad themes and key issues that were raised and key directions.

A number of common themes came out of the presentations and workshop sessions, with many shared views among senior managers, practitioners and trainers. These included: the effectiveness of CDM approaches; broadening employee roles and managing change; specifying skill needs; developing appropriate training; creating provider partnerships; and active engagement with education and training providers. Partnering was seen as a way of securing the necessary resources for continued improvement within CDM, in addition to enabling the development of education and training programs necessary to ensure a workforce that is effective in their delivery.

The seminar considered a number of key headings in addressing the delivery of effective of CDM and the requirements that new models create for workforce development at all levels:

Population Context

Demand is increasing:

- An ageing population and population health issues mean a major increase in the demand for health services and the cost of provision.
- There is an increased incidence of chronic diseases such as diabetes, cardiovascular, respiratory and musculoskeletal conditions.
- Many health consumers currently utilising community health services have multiple problems covering physical, mental and emotional health, social isolation, environmental and economic issues.

CDM Models [underpinned by organisational change]

Models have been developed and programs implemented

- Models have been developed for managing chronic disease (eg Flinders Model), with programs being applied at the local level.
- These models of care and management require cooperation between disciplines (clinical and social) and collaboration between organisations (including the need for a shared philosophical approach)
- The models are evidence based and put the client/patient at the centre. They recognise the *journey* that a chronic disease sufferer experiences.
- There is a need to understand the health consumer and their individual needs, if effective programs are going to be developed.
- In developing programs, lessons can be learned from other fields, including drug and alcohol and family services.
- CDM needs to be underpinned by effective systems including information, management and reporting.

Roles

Roles change with CDM

- Major changes in professional roles and ways of working are often integral to effective CDM approaches. This includes broadened roles, capacity for flexible responses to client needs and working within multi-disciplinary teams. There is a need for well managed change processes to support this significant change for clinical staff; including breaking down existing silos between practicing professions.

Skills and Training

Competent staffing is fundamental to the effective delivery of programs

- Education and training is important and requires national frameworks, which can be applied to tailored delivery at the local level.
- Required skills have to be defined by the industry, and be based on both the experience of implementing quality CDM within organisations and in response to current research findings.
- Skills development needs to target the existing and future workforce, including clinical and management staffing. It needs to be flexible and involve a range of strategies such as formal training programs; organisationally based initiatives; peer training; mentoring.
- Ongoing support, advice, skill development and mentoring are needed to support persons delivering programs.
- Orientation to and ensuring an understanding of, CDM approaches need to be undertaken with new entrants into the community health sector.
- Effective inclusion of approaches to CDM within undergraduate curriculum (across health professionals)
- The potential of training para-professionals remains untapped.

Partnerships

Partnerships are seen as critical

- Education providers need strong partnerships with health providers to enable practical, responsive training programs to be developed.
- Community health services need effective partnerships with general practice and other health providers to ensure consumers get an integrated service.
- Partnerships between community health services can contribute to improvements in the consistency and quality of CDM, as well as the greater sharing of resources and learning.
- These partnerships can also create the scale needed to secure funding for: sector wide research programs; program development and improvement; and training programs.

Research

Research needs to be ongoing

- Ongoing research is important for improving practice and programs. Translating new evidence into practice is challenging and needs to be supported.
- Evaluations are required to measure outcomes and the effectiveness of programs.
- Flinders University has led the research in Australia, through several workforce related projects. It is also working with several services on program evaluation.
- There is a need to better disseminate research findings to the field.

Funding

Application of funding is important for the future.

- Internal: funding for program development and delivery; and adequate training budgets to develop skills.
- Government funding for: research projects; development of CDM approaches; and for the development of training programs and resources.

There is significant interest in developing, improving and sharing success in chronic disease management. This is evidenced by the level of interest in participating within this forum, the active generation of ideas and issues on the day, and in the interest of those not attending to be involved in subsequent forums. The initiation and progression of dialogue between the Community Health Sector and the Higher Education/TAFE/VET sector in relation to workforce development specific to the requirements of chronic disease management was considered extremely positive. This report presents a number of key issues for consideration to DHS; with the recognition that successful progression of these, within and across sectors, is reliant upon effective working partnerships.

3 Introduction

This report outlines the content and discussions covered in the forum 'Ensuring workforce competency in effective chronic disease management'. It was designed to bring together community health and education providers to enable a discussion of effective approaches to the management of chronic diseases, to explore the workforce skill needs in CDM and requirements for education and training. This report provides an overview of the broad themes and common issues that were raised and key directions.

The 'Ensuring workforce competency in effective chronic disease management' forum was organised by Whitehorse Community Health Service (WCHS), in conjunction with Box Hill Institute (BHI) of TAFE and the Department of Human Services (DHS), Service and Workforce Planning Branch.

The forum was held on August 4, 2008 at BHI TAFE, and attracted a total of 108 participants from a range of organisations, including community health services, divisions of general practice, acute & sub-acute care, government departments, universities, TAFE institutes, other education providers and affiliated associations. Participants included senior managers, clinicians, educators and persons involved in the delivery of client services.

We were privileged to have expert key note speakers who shaped the issues for the day and the community health providers, who were able to relate their on the ground experience in implementing CDM programs and systems. These local examples set the ground work for an active discussion of issues during the afternoon workshop sessions. Active participation by all in attendance resulted in the generation of a wealth of issues and ideas.

Finally, it is emphasised that the information presented in this report represents a summary of a wide range of issues that were raised and discussed during the day. The views expressed are not attributable in full or part to any specific individual or organisation (other than those outlined in the summary of a speaker presentation).

While directions were identified and discussed in the workshop sessions, specific recommendations were not formulated and put to the forum. Therefore not all participants may necessarily be in agreement with the key areas for consideration that are contained in this report.

4 Objectives

The concept for the forum was developed in consultation with the Department of Human Services - Workforce Branch. It was designed to bring together community health and education providers to enable a discussion of effective approaches to the management of chronic diseases, to explore the workforce skill needs in CDM and requirements for education and training.

The forum had a number of key objectives:

- (a) To explore effective chronic disease management approaches and the role of education and training providers in preparing/supporting a workforce that is competent in their delivery.
- (b) To identify gaps in education and training in meeting the current and future needs of the industry in supporting their workforce
- (c) To provide to DHS a summary of the day's outcomes, including any recommendations on education and training programs and delivery methods which can be developed and implemented in order to further support chronic disease management in the workplace.
- (d) To promote best practice and generate discussion between providers and across sectors.
- (e) To contribute to the development of the Victorian submission aiming to secure appropriate placement numbers for TAFE health students, via the new federal VET funding.

The forum, with its mix of participants, was successful in meeting a number of these objectives. It facilitated information sharing and a dialogue across the community health and higher education and VET sectors on chronic disease and effective CDM approaches; as well as initial discussion of the skill needs of persons involved in service/program delivering and requirements for education and training. Further exploration of the key workforce skill requirements/competencies and the potential for flexible educational and training responses at both the local and state level will be essential in progressing this work.

5 Chronic Disease Management and Workforce Skills

5.1 Overview

In opening the forum, Jim Killeen (CEO of WCHS) set the scene from a health provider's perspective. He identified the challenges that chronic disease management presents for community health services and their employees in delivering service to clients. This included:

- The need for flexibility and adaptability in working in interdisciplinary teams to meet client support needs.
- A need to develop the capability and skills of employees who are working with persons with chronic diseases, in particular in use of self management support approaches.
- A need to share experiences among health providers and to shape best practice approaches through partnerships.
- A need to involve education and training providers, from the higher education sector and from TAFE/VET, in the process of developing best practice and adopting a flexible approach in the development and provision of appropriate training programs.

Many of these themes were developed by the keynote speakers who covered the DHS perspective, the national industry skills perspective and the higher education perspective.

5.2 The DHS Perspective

Kim Sykes, Director, Service and Workforce Planning from the Department of Human Services, set the overall context in terms of a rising incidence of chronic disease; a need for different ways of working, including interdisciplinary teams and organisational systems that support a chronic care model; and the need for a coordinated health workforce response, which is also geared to local needs.

The population health context is being set by a number of factors:

- An ageing population, with greater life expectancy.
- An increased incidence of chronic diseases such as diabetes, cardiovascular, respiratory and musculoskeletal conditions.

These are contributing to an increased burden on the healthcare system with a growing demand for services. At the same time this demand is being exacerbated by an ageing health workforce, along with emerging skills gaps and skill shortages. These are placing pressures on the capacity of current services to meet these increased health needs.

New approaches are needed to compete with the often multi-dimensional problems experienced by people with chronic disease. A combination of health and psychosocial issues, create the need for involvement of health professionals across disciplines. This includes the need for a range of strategies: a combination of prevention and self management approaches; improved education and awareness; a move from a discipline approach to a client focused approach; and a shift from episodic to long term care models of service.

There is a recognised need for different approaches. The same systems utilised in acute disease intervention cannot be used in the management of chronic diseases. A service model

that is founded on partnerships and employing a comprehensive integrated approach to quality care is required. Such an approach would involve new service delivery models and be:

- focused on prevention, effective care coordination and increased self management support; and
- “client-centric” with tailored care programs that cater for diverse client problems.

These new approaches have implications for the way professionals work together, with greater convergence of interdisciplinary teams. This requires a more flexible and multi-skilled workforce capable of working across traditional boundaries and an acknowledgement of non-clinical roles in working with people with CD.

There is a need to develop the workforce so that they can deliver care in this way. This includes ensuring local delivery and satisfying community expectations concerning the quality of care. The Department’s response is focused on ensuring quality and cost effective care provision, including skills development for the existing workforce and for new entrants (through VET and university pathways).

The Victorian approach uses national training frameworks for skills. These need to be combined with local collaboration and partnerships, between community health service providers and education and training providers in the VET and university sectors, to deliver programs that meet the needs of the workforce involved with new delivery models.

5.3 National Industry Skills Perspective

Di Lawson, CEO of Community Services and Health Industry Skills Council (CSHISC), focused on the work that the Council had undertaken in CDM and workforce skills. This work has shaped competencies within the training packages for health and community services.

The CSHISC plays a key role in shaping national training to meet current and future training needs and innovation in workforce practices. This is based on an annual environmental scan and continual interaction with industry. While VET is integral to skilling the workforce, “workplace competence” is reflected in practices and delivery models and the way skills are applied.

The Skills Council had taken a structured approach to Chronic Disease Self Management (CDSM). It examined the principles of CDSM and mapped those against competencies covered by existing industry qualifications. They then identified the gaps and considered the training that would best articulate these principles. In September 2007 the CSHISC released the *Incorporating Chronic Disease Self-Management Principles in Training Packages (CHC02 & HLT07) - Research Report*.

The report highlighted a number of principles of CDSM, and these, along with key elements of practice have been incorporated into units of competency in the national training packages. CSHISC relies on government and private employers, industry unions, and other Health and Community Services workforce representatives to provide feedback on training package and workforce development issues.

National standards deliver major benefits to industry including: units of competency which are industry required standards of practice at a work place level; increased ability to address skill shortages; validation of work roles and practices of existing staff in these functions; potential development of a nationally recognised qualification in CDM; national packages and skill sets which allow lateral movements between jobs roles and national portability.

There is ongoing need to identify training needs for CDM and in developing skills. CSHISC and local Industry Training Advisory Boards continue to consider how to best support effective local partnerships in health and community services to develop workforce strategies.

In summary, the key issues were: the need for national standards; development of practical competencies based on best practice models; continued industry involvement in shaping national frameworks; and a need for active partnerships between health and community service providers and education and training providers.

5.4 Higher Education Perspective

Associate Professor Malcolm Battersby of the Flinders Human Behaviour and Health Research Unit, Flinders University, concluded the morning session with an overview of the Higher Education sector's activities aimed at skilling the primary care workforce in Self-Management Support (SMS).

Two major national Chronic Condition Self Management (CCSM) Education Projects, which are being conducted over the 2006-2008 period, were highlighted:

- Project 1: An audit and curriculum framework for Chronic Condition Self-Management Support (CCSMS) for undergraduate or professional entry nursing, medical and allied health courses across Australia.
- Project 2: An audit and skills needs analysis and recommendations on skills for the primary care workforce involved in prevention and self managed support for chronic conditions.

Both projects are funded by the Commonwealth Department of Health and Ageing, and are run in conjunction with other higher education and health sector partners. These projects included extensive consultation with educational and healthcare professionals, as well as with groups representing health consumers.

The two audits revealed a number of issues in relation to the teaching of CCSMS, the understanding of self management and self management support; and skill requirements.

- While some general CCSMS skills were being taught through the Higher Education system (and there were some innovative things happening in some isolated areas of curriculum), much of it was implicit and there was no evidence of explicit theoretical and clinical teaching of CCSMS skills, and little explicit assessment of CCSMS knowledge or skills.
- In the case of the current workforce, there was limited understanding of self management and support and limited explicit use of CCSMS support skills. [the Flinders team has developed a definition of self-management support, refer Appendix C]
- Moreover, although it was verified that the skills required for supporting prevention are the same as those needed for supporting self management of chronic conditions, primary care health professionals did not feel that their responsibilities included assistance with prevention.

In addition, they identified what consumers want and the resultant benefits of involving the person in their own care [refer Appendix C].

The need to move from an acute care to a chronic (planned) care system was identified.

From an acute care to a chronic (planned) care system PHC professionals need to think of management and self-management as a continuum of necessary adjustments to change; one that considers the whole journey for the person and their significant others, not just the here and now and in isolation from the person's psychosocial circumstances and environment

There are a number of core principles that underlie the implementation of effective CCSMS practices.

- All health professional graduates will be competent in supporting people to self-manage their chronic disease or condition(s).
- Health professional education will ensure that graduates are equipped to:
 - Conduct their practice so that the person with the chronic disease or condition and their carers are central to the process of care, ensuring they feel understood, valued and involved in efforts to support their self-management
 - Work in inter-professional teams that support self-management
 - Understand and base their self-management support on the bio-psychosocial, cultural and economic context of the person and their carers

To support these core principles a number of operational principles are required, which underpin service delivery and education and training.

- Consumers are involved in the design, conduct and evaluation of self-management support education.
- The agreed national self-management definitions and terms are used.
- Students are exposed to a range of self-management models of consumer education.
- Students understand the influence of the health care system on self-management.
- Self-management support education incorporates inter-professional learning.
- Students learn self-management support in inter-professional practice settings.
- There are identified individuals competent in self-management support to champion development and delivery of self-management support education.
- Self-management support education is integrated across all years of the curriculum.
- Self-management support competencies are explicitly assessed.
- The effectiveness of the self-management support education is explicitly evaluated.

There are a set of core skills for chronic care and self-management support, which cover:

- Person centred skills – health promotion, assessment, communication, collaborative care planning, cultural awareness, psychosocial assessment, use of peer support;
- Behaviour change skills – knowledge of behavioural change models, motivational interviewing, collaborative problem definition, problem solving and action planning; and;
- Organisational/systems skills – working in multidisciplinary teams / Inter-professional learning and practice, information, assessment and communication management systems, organisational change techniques, evidence based knowledge, conducting practice based research/ quality improvement framework, and awareness of community resources.

In summary, Assoc Prof Battersby provided a clear model for service delivery based on extensive research on consumers' needs, practice approaches and skill needs. The skills required by practitioners for the development and implementation of programs for effective chronic disease management have been outlined, and these need to be incorporated into education programs for new health workers and in training for existing employees.

6 Local Perspectives

6.1 Overview

The second session comprised a series of short presentations on local responses from a number of community health service (CHS) providers that have implemented Early Intervention in Chronic Disease (EICD) program and a Primary Care Partnership involved in a regional system improvement project. These focused on programs being implemented, outcomes and lessons.

The five presenters were:

- Whitehorse Community Health Service – WCHS with Susie Summons (Team Leader and Project Manager);
- Knox Community Health Service (KCHS) with Anne Parkes (Program Manager, Active Health Programs);
- Darebin Community Health with Carolyn Hines (Chronic and Complex Care Program Manager);
- Monash Link with Linda Fiddes (Dietician & Team Leader, Healthy Ageing); and
- Inner East Primary Care Partnership with Cheryl Wood (Executive Officer).

While a range of models, that have been developed and applied in local settings were discussed, there were number of common themes and elements.

- There is a need for broad organisational support for the new approaches and practices. In particular with regard to resources; the principle of inter-disciplinary and inter-organisational collaboration; and organisational structure.
- Programs within these community health services are based on the Wagner Chronic Care Model; many staff had undertaken training in Flinders University Self-Management, Lorig Better Health Self-Management Course, Motivational Interviewing and Health Coaching.
- Providers each acknowledge the necessity to recognise the journey of the client with chronic disease.
- Programs are client focused and goal focused.
- Effective programs were time intensive, requiring substantial time in assessing consumers and developing individual plans.
- The Flinders Model has been important in shaping approaches to service delivery.
- The programs that have been developed and trialled have all contributed to the learning experience and there is a concerted effort to integrate such practices more broadly across organisations.
- There is a need to ensure that staff has the appropriate skills through: training in undergraduate training; postgraduate programs; and through specialised training for existing staff.
- Psychosocial factors are major issues, affecting the physical health of many clients and their capacity to undertaken behavioural change.
- Clients may not fit defined boxes.

- Measurable positive results have been delivered for clients.
- There is a need for peer group learning and for communities of practice that involve a range of health services.
- Active engagement with GPs is fundamental to program effectiveness.

6.2 Whitehorse Community Health Service

WCHS one of the initially funded Early Intervention in Chronic Disease (EICD) initiatives. The Whitehorse Good Life Club (ECID Program name) was implemented with significant organisational change in order to underpin its approach to CDM.

A key lesson from the WCHS program was the need to structure the provision of services in a way that ensured the consumer being central to and actively participating in their own health care. The need for a very clear understanding of the individual and their over all health needs, both at initial assessment and as an ongoing function of the intervention process was considered the basis for this to occur. In this regard, the *health coach* role was introduced to work specifically with clients to assist with service linking, self management, goal setting and behaviour change. This position has a specific and additional role to that of the key worker.

Health Coaching is the practice of health education and health promotion by trained health professionals with the aim of enhancing health and wellness. It embraces the idea that people can learn new skills and access their own inner resources to change behaviours that get in the way of health and wellbeing. (Health Coaching Australia)

Susie Summons, WCHS

The experience of the WCHS Good Life Club, and use of specific health coaching positions, provides some valuable lessons for extending chronic disease management practices and these were highlighted in the presentation. These included:

- A need for management support. In addition, the need for managers and team leaders to undertake training to support teams in implementing practice changes, particularly around process mapping, Plan Do Study Act (PDSA) cycles, needs identification and model development, and evaluation.
- A need for clearly developed role descriptions for key workers and health coaches and a team commitment to systems/processes to support their functions.
- An extensive roll out of internal training. Recognising that training alone does not result in practice change. Staff need ongoing access to secondary consults, peer learning circles etc. and structure to underpin this way of working, such as appropriate screening processes, and systems for evaluation.
- Confidence in this new way of working is crucial for key workers and health coaches in providing self management support in a flexible way. Building this confidence requires ongoing support and training, different people have different capacity to work from a self management perspective, and require differing levels of support.
- Psychosocial issues are the most significant contributing factors impacting on physical health conditions. The benefit of working from the self management perspective is that room is given to address these broader issues/ health determinants
- Working from a self management perspective has provided positive outcomes for WGLC clients

6.3 Knox Community Health Service

The model incorporated the following range of service elements.

Insulin Initiation	Home Medication Review Procedures
Diabetes Self-Management Program	DAFNE (Dose Adjustment for Normal Eating)
Osteoarthritis	Better Health Self-Management
Health Psychology	GP Consultancy and Liaison
Tobacco Free Clinic	Next Step – Beyond Rehab

A number of key lessons were gained from these programs, particularly the importance of clearly defining the competencies required and training staff accordingly. This in turn required the availability of adequate systems to support ongoing practice change.

Some of the major challenges faced included:

- Difficulties in recruiting staff to the public health sector, let alone developing their capabilities with current staff turnover rates;
- A need for workforce flexibility and for staff to broaden their skills capabilities, which is made more difficult due to the perception that it could threaten their specialist status;
- The need to clearly define certain roles, such as that of the Allied Health Assistants; and
- Developing longer-term strategies for workforce re-design.

A notable challenge is in reforming attitudes that are in part affected by confusion in relation to the individual's scope of responsibilities.

6.4 Darebin Community Health

Darebin's Health Wise Program targets people with chronic disease, specifically diabetics, heart failure patients, and people with chronic lung disease such as COPD and Asthma. It has a focus on the management of the peoples' lifestyle risk factors such as smoking, nutrition, physical activity (inactivity), and weight control.

The Health Wise Program is underpinned by the Flinders model, complemented by Health Coaching for ongoing SMS. The client attends a 90 minute appointment with the "Key Worker" who assesses their condition, devises a tailored Healthy Living Care Plan, provides SMS, as well as co-ordinate the services required by each client, and serves as their key contact for future reviews and follow-ups. The role of key worker is undertaken by a range of allied health, nursing and Aboriginal health nursing staff; all key workers have to work across this role and than of a clinical role, at times proving to be very challenging.

Management had made a commitment to CDM and SMS, effectively making them organisational priorities to be considered in shaping any internal restructuring. In recognition of the significant change in practice for clinicians, Team Leaders and key workers were involved in all program planning stages. This included defining their respective roles, ensuring clarity of the scope of responsibilities and ultimately encouraging ownership by staff.

6.5 Monash Link

The Early Intervention in Chronic Disease (EICD) Program is targeted toward people with chronic diseases in particular diabetes, cardiovascular, respiratory and musculoskeletal conditions.

The program operates under “Best Practice” principles that were outlined in the presentation. It focuses on ensuring effective leadership and management, availability of the appropriate systems and structures for administering and evaluating CDM, and providing adequate training and professional development to the staff involved.

Difficulties were experienced in promoting change and integrating skills into normal practice. Candidates for Key Worker opportunities exhibited varying levels of readiness to take on role. Other issues were identified in the reporting structure, which required senior management and leadership support. Client recruitment barriers, specifically cultural ones, were also identified. Finally, workforce recruitment and development was a focal issue with the need to build and sustain capacity overtime. This was made more difficult with constant staff turnover.

Staff recruitment and retention was an issue that was tied to education and training. Staff needed to have their responsibilities clearly defined, and could be encouraged if the value of their roles are recognised. There were opportunities for introducing more flexible training modules, with implementation requiring assistance from education and training providers to lay down the necessary systems needed to ensure quality and evaluate competencies.

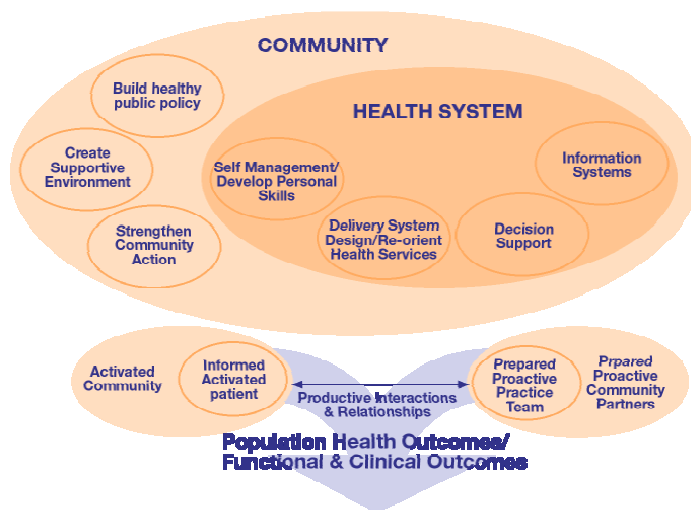
6.6 Inner East PCP

“Improving the Journey” is a collaborative project undertaken by Primary Care Partnerships (PCPs) across the Inner East and Outer East regions of Victoria. The project focused on improving the health and wellbeing of people suffering from, or who are at risk of, preventable chronic disease. The program was developed to target Type-II Diabetes specifically, with the stated goal:

To improve the health and wellbeing of people with, or at risk of, Type-II diabetes through the development of a regional systems approach.

Cheryl Wood, Inner East PCP

In developing the program, clinicians and centre managers were called upon to provide their expertise, in addition to consultation with the healthcare consumers for input on their needs. It was built from the consumer perspective, based on an expanded chronic care model illustrated below:



Source: “A Regional Approach to Partnerships for Integrated Chronic Disease Management and Prevention”, Cheryl Wood, Inner East PCP – Presentation to the “Ensuring Workforce Competency in Effective Chronic Disease Management Forum”; August 4, 2008

Clients are identified and following a risk assessment are allocated to receive the appropriate package of care as indicated in the following table:

	Low risk	Medium risk	High risk
Diabetes Education	◆	◆	◆
General Practice - Annual Cycle of Care	◆	◆	◆
National Diabetes Services Scheme	◆	◆	◆
Self management assessment and support	◆	◆	◆
Smoking cessation	◆	◆	◆
Fitness to Drive Assessment	◆	◆	◆
Complications screen	-	◆	◆
Medication review	-	◆	◆
Support group and/or counselling	-	◆	◆
Complications management and prevention	-	◆	◆
Urgent GP medical review	-	-	◆
Short term (intensive) care coordination	-	-	◆
Interagency care plan	-	-	◆
Wait time for services	14-56 days	14-28 days	1-14 days
Recall and review	6 months	3 months	Monthly for 6/12, then 3/12 minimum

Source: “A Regional Approach to Partnerships for Integrated Chronic Disease Management and Prevention”, Cheryl Wood, Inner East PCP – Presentation to the “Ensuring Workforce Competency in Effective Chronic Disease Management Forum”; August 4, 2008.

The program was reviewed at a forum held late 2007. It produced a number of recommendations for change: a need to develop and endorse specific packages of care; a need for accurate identification of chronic disease risk factors; recall and reminder systems to be built-in; appropriate information systems for efficient information sharing, communication, care planning and coordination; and a major requirement to address the workforce needs and skill shortages.

The challenges that were identified did not differ from those experienced elsewhere, but a key to making any progress is appreciating that whole of system change is incremental. Effective collaboration benefits from good communication, but also the willingness to negotiate and make compromises. Developing good partnerships requires time as well as trust.

7 Discussion of Issues

A panel session was held which involved Di Lawson, Anne Parkes and Malcolm Battersby. This allowed for questions and discussion of issues raised in the presentations.

Issues raised include:

- The relationship between GP care plans and the chronic disease management plans. There were concerns that many plans are filed and are not part of an active health management approach. GPs are limited in their capacity to manage care plans and provide the more detailed interventions that are required to affect behaviour and allow for self management. A/Prof. Battersby was of the view that care planning would not materialise in General Practice until it aligns with the systems and operational principles outlined for self management of chronic disease. Major progress would require the widespread development of the practice nurse approach, with these nurses taking on the CDM role for patients of a general practice.
- A concern was raised about the cost-benefit implications and sustainability of some of the managed care programs for CD sufferers in terms of the time/resources required to support programs. The Darebin program that was used as an example and was based on developing care plans over two 45 minute consultations, some of them engaging more than one practitioner (buddy system). It was clarified that early intervention programs required time to implement. While a significant proportion of clients attending the clinic present with some chronic condition, those who end up being referred into the EICD program are matched against specific selection criteria to establish need and determine suitability. In this respect, the model took account of limits in resources and prioritised their allocation.
- Another response on the cost/benefit issue was that while interventions required significant resources, there were major costs on the overall health systems, if self management programs and behaviour modification programs were not adopted.
- From a client perspective, some people with chronic disease conditions had complex problems, which required a holistic multi-disciplinary teamwork approach in resolving them. It was acknowledged that there was a need to ensure the sustainability of the model of care, but it was highlighted that a major objective of these programs is to reduce the reliance and pressure on high cost hospital services.
- In response to a question on potential barriers to CDSM, Di Lawson cited system wide inadequate resources in social psychology, and the need to ration services based on specific criteria to cope with rising demand. She emphasised the necessity to invest significantly in population health and primary care to take the pressure off tertiary care.
- There was a need to develop the industry and workforce and provide competencies for case management work. Effective case management required a range of conceptual and assessment skills. These skills have been developed in Drug and Alcohol services for both professionals and volunteers. Some of the lessons learned could be taken into the management of chronic disease. Targeted training programs can be used to develop these skills in the existing workforce. While education and training providers have a responsibility for ensuring skills are being provided for new professionals and health workers entering the system.

8 Workshop Issues

8.1 Format of Sessions

The afternoon session involved all forum participants in two workshop sessions. These sessions involved structured discussions in groups of 10, with a facilitator for each group.¹

- The first session focused on major challenges from an organisational perspective (management, practitioner and health worker). Break Out session 1: What needs to happen at an organisational and management level?
- The second session focused on practical solutions, including education and training requirements. Break Out session 2: What is needed in practice? What is needed in training?

The discussions also included the benefits of partnerships and the challenges associated with structuring them. The discussions at each table were highly productive and the major themes that were considered and issues raised are summarised in the following tables.

In addition, many of the ideas and strategies put forward within the participant feedback forms (returned at the end of the day) aligned with issues highlighted within the workshops and have therefore been included at Appendix D. [Appendix E of this report details additional elements of participant feedback.]

8.2 Senior Management Perspectives

A number of issues were identified from a senior management perspective. It was noted that CDM has to be formally built into strategic planning, with realistic timetables being established. Program development and implementation needs to be evidence based, client focused, supported by adequate systems and requires all staff to understand CDM. Education and training is important here and needs to be driven by the sector. Senior managers need to engage with the training system while also recognising that research and evaluation are important and need to be funded. Partnerships are important and need to include health service providers and the education and training sector.

Initiating change will require an understanding of organisational readiness and engagement with Team Leaders and staff in a process to support change. CDM requires new approaches to working and will entail changes in structures and specification of work roles. Staff skills will need to be adapted to reflect these changes to enable staff to perform their duties within new and changed work roles and environments. Change management becomes important for implementation and requires greater emphasis on provision of information/support/training for managers in leading and supporting these practice changes.

8.3 Middle Management/Team Leader Perspectives

Middle managers/team leaders form a critical link between staff and senior management. During the discussions, it was noted that, for success, the organisational culture needs to be client centred and built on information sharing, flexibility and cooperation in multi-discipline approaches. Commitment of middle managers to CDM approaches is important.

¹ Discussion guides and topics were prepared for each facilitator.

With this in mind, participants identified a need to develop new best practice models of service delivery and to ensure that staff has adequate program knowledge. Middle management also has a role in ensuring that there is good communication between the disciplines within their organisations and should clarify the definitions of work roles, including the key worker role. A team work approach is needed, with all staff having knowledge of CDM approaches.

Education and training will support staff in adapting to change and needs to be led by the industry, with practitioners involved in shaping content. Different levels of training are needed to meet the differing needs and levels of expertise amongst staff. This may include content from higher education programs and/or tailored local programs. Training opportunities should be combined with practical experience and ongoing mentorship programs for employees.

Local networks are also important to exchange information, research and learning. PCPs can play a key role in this process.

8.4 Practitioner Perspectives

Practitioners at the forum were keen to develop structured programs for CDM, which are documented, have systems and include research and evaluation processes. They identified a number of issues around the consistency of work role definitions and skill requirements across health services which need to be addressed to ensure the efficacy of such programs. Practitioners highlighted a need for clarity regarding key worker roles and competencies, noting that standardised national/state definitions/guidelines would assist in the development of consistent strategies at the organisational level and across sectors.

Practitioners were open to new workforce models and recognised a need to explore generic worker roles, broaden existing work roles (eg. allied health, Div 2 Nurses and administrative assistants) and expand thought around the use of peer workers and volunteers. Active teams should be formed but with clarity of roles and responsibilities.

Mandatory skill requirements were deemed important to ensure that people had the skills to implement effective CDM programs. There was a focus on VET and people being provided with practical skills. To get this practical dimension, practitioners identified a need for health workers to be involved in the development of skills programs. Ongoing internal programs and support were also required. It was noted that DHS will play a key role in driving training programs in terms of a continued role in gathering data relating to CDM workforce competencies and communicating these to VET/Higher Education institutions.

There is a need for strong communication (internal and between agencies) to enable a sharing of experiences and research findings. Practitioners noted that DHS has a role in the continued facilitation of opportunities to share knowledge within the health sector regarding training course development and delivery that ensues.

8.5 Trainer Perspectives

Like the practitioners, training providers recognised the importance of developing strong training programs with a focus on practical skills training. There was a recognised need for formal processes to identify skill needs and training requirements. These processes should focus on developing practical skills for all staff within health services that are aligned with a person's role in CDM. Trainers shared the view that training needs to be industry relevant, and wanted partnerships with health providers to develop these programs. Accredited training should be the priority.

Trainers were concerned about the accessibility of training programs and agreed that there needs to be stronger marketing of the available training programs. It was argued that funding should also be sought from the Commonwealth and the State Government to develop and enhance new and existing training programs.

Trainers noted the geographic constraints that may hamper practitioners' participation in education and training programs. They identified a need to ensure that education and training programs are accessible to staff in metropolitan and regional areas and viewed flexible learning programs with a mentoring component as a way of meeting these requirements. In house follow up programs were seen as important for ongoing skills development.

Finally, the trainers also noted that there is a role for Registered Training Organisations (RTOs) to actively seek more opportunities for sharing of training needs.

8.6 Partnerships

Partnerships were examined from a senior management, practitioner and trainer perspectives.

There were some similarities: health provider partnerships are important, community health services engaging with GPs, other health providers and member agencies within their PCP. In the case of across sector partnerships, there was a need for clarity in expectations about outcomes and the form of cooperation and acknowledgment that many concepts indicate need for engagement of government and funding bodies in broad health system change.

For managers, practitioners and trainers partnerships were seen vehicles for research and dissemination of findings; for developing new shared models for CDM; and for identifying future skill needs. Partnerships also play a role in securing funding for the development of care models and special education and training programs within health services.

Managers, practitioners and trainers acknowledged the importance of regional partnerships and noted the key role of PCPs in stimulating local discussion and information sharing. GP partnerships were noted as important for referrals and for ensuring that clients were receiving an integrated service. Education partnerships were seen as being based around research, education and training; and may participate in the development and delivery of training programs.

Managers, practitioners and trainers identified a role for DHS in progressing relationships with localised RTOs and supporting agencies locally to explore opportunities for partnering. This includes expanding the knowledge and understanding of local training providers within health services; facilitating the sharing of 'best practice partnership models' that may already exist; and ensuring metro-regional support.

For practitioners and trainers, partnerships were also seen as a way of influencing the policy agenda and program funding. This included examining overseas models in USA and UK and having CDM included in health policy agendas at state and national levels. Partnerships were seen as a way of creating critical mass and creating opportunities to seek funding for joint programs (service delivery and education and training).

9 From Ideas to Practical Reform: Implementing CDM Approaches

The morning presentations and discussions at the forum identified challenges to service delivery in Victoria and explored innovative measures that have already been adopted by health services to address these issues. The afternoon sessions shifted the focus towards planning an approach for the future, and asked stakeholders to consider existing arrangements within their own health services and any measures which may improve and enhance the quality of care within their organisations. As indicated in section 8, the afternoon discussions identified clear strategic planning at a senior management level as important for facilitating organisational change, which should then be matched by practical supports for ground-level staff, such as greater availability of education and training opportunities for practitioners. The findings of these discussions form a strong strategic basis from which to explore next steps for the continued improvement and implementation of CDM approaches within health services.

9.1 Characteristics of an Ideal Model of Care

There is no single model of care that can be universally applied to all health services. Each organisation is unique in its clientele, workforce profile and service delivery needs. There are, however, a number of key features which can be implemented to address the shifting demands on healthcare services and to deliver flexible, responsive and efficient care to clients.

The Department of Human Services' Primary Health Branch has endorsed the Wagner Model for Improving Chronic Care as the model to inform and guide the service system redesign required to support people with chronic disease.² The Wagner Model framework outlines six elements which should be included in CDM approaches to improve the quality of chronic care. They are:

- Community – resources and activities that provide ongoing support for people with chronic disease/s.
- Health Systems – support prepared and proactive practice teams.
- Self-management support – empowers and prepares clients to manage their health and health care.
- Delivery System Design – assists care teams to deliver systematic, effective, efficient clinical care and self-management support.
- Decision Support – including design, systems and tools to ensure clinical care is consistent with evidence based guidelines.
- Clinical Information Systems – including data systems that provide information about the client population, reminders for review and recall, and monitor the performance of care teams.

As part of good practice in ongoing service quality improvement, the Primary Health Branch encourages funded health services to regularly monitor their provision of chronic care services using accredited audit tools such as the Assessment of Chronic Illness Care (ACIC) tool developed by the McColl Institute for Healthcare Innovation (Seattle).

9.2 Towards a Broader Implementation of CDM Approaches

There are a number of workforce requirements that are congruent with the Wagner principles. The Wagner Model necessitates a shift towards a wellness model of care in which proactive, client centred approaches are key. Workforce structures and roles, along with organisational

² DHS Primary Health Branch, *Revised Chronic Disease Management Guidelines for Primary Care Partnerships and Primary Health Care Services*, available at <http://www.health.vic.gov.au/communityhealth/cdm/index.htm>.

cultures, will need to be reconsidered to ensure that these aims are met. For example, greater interdisciplinary teamwork may help to improve staff flexibility and efficiency to meet the criteria for effective Delivery System Design. Client self-management support mechanisms may be improved by a increasing the focus on health coaching, either through the work of existing staff or via designated health coach staff.

Workshop participants identified a number of changes which could assist in the broader implementation of CDM approaches within their own health services and others. Participants noted that change needs to occur at three levels within health services: senior management, middle management and at the health practitioner level. Some of the key reforms identified by participants at each level are as follows:

Change at Organisational/Senior Management Level

- Realistic, evidence-based strategic planning (including timelines)
- Consideration of consumer perspectives within strategic planning
- Make funding available to implement CDM approaches within health services
- Implementation of reporting and feedback mechanisms to evaluate the success of new approaches.

Change at Middle Management/Team Leader Level

- Introduction of best-practice within delivery models
- Facilitation of partnerships between health services and training providers
- Clarification of work roles and identification of training needs to assist staff to manage change and work according to new models
- Facilitation of cultural change within organisations by breaking down internal silos and encouraging interdisciplinary teamwork, building CDM approaches into position descriptions and sourcing necessary staff to support shifts in service delivery.

Change at Health Practitioner/Staff Level

- Recognition that new CDM approaches represent a significant shift in work methodologies
- Improve familiarity with CDM tools and others' roles and skill sets
- Access appropriate education and training to prepare for change and adapt work practices to support new CDM models.

The service delivery reforms identified by forum participants are practical measures with potential for broad application across health services. The ongoing improvement of CDM approaches in Victoria will depend upon continued commitment to innovation and health care reform across government and the healthcare industry. To provide clarity and direction to reform processes, the Primary Health Branch has developed an ICDM workforce development strategy as part of the Early Intervention in Chronic Disease (EliCD) initiative.

9.3 ICDM Workforce Development Strategy

The recent expansion of the EliCD initiative to another 18 local government areas has provided an opportunity to address some workforce need. The expansion includes the development and implementation of an ICDM workforce development strategy to ensure an appropriately skilled workforce is available to support the implementation of the EliCD initiative and to progress integrated chronic disease management now and into future.

The strategy seeks to develop sustainable workforce programs that build upon and maximise efficient use of current workforce initiatives. It recognises that professional learning is integral to building and maintaining a quality workforce to improve outcomes for clients with chronic disease. The strategy also acknowledges that workplaces should be supported as learning communities that share and value knowledge, skills, diversity and innovation in clinical practice.

The strategy focuses upon facilitating and supporting an authorising environment for systems change in agencies funded for ELiCD. This will contribute to increased employee skill levels and will support sector capacity to deliver evidenced based services to people with chronic disease. This includes the development of a workforce with capacity to coordinate care so that clients receive an integrated response.

The workforce development strategy provides a strong policy to guide the further integration of chronic disease management approaches in health services across Victoria. It is anticipated that the strategy will assist health services to implement those priority reforms identified by forum participants within their organisations. Implementing evidence-based changes across the primary healthcare sector in accordance with the strategy will ensure that the sector is well-equipped to meet the increasing burden of chronic disease into the future and can continue to deliver high quality healthcare to all Victorians.

10 The Way Forward

Issues and ideas generated during the forum, in particular within the afternoon workshop sessions and via participant feedback, present an overall picture of opportunity for development of positive partnership work between community health services, the broader health sector, TAFE/VET and the higher education sectors.

Many of the concepts discussed clearly require the need for engagement of one or more government departments and to be considered within the potential changes to the broader health system. In addition, participants agreed that support and guidance from DHS across a range of associated issues will be pivotal to successful response to the ever growing demand for CDM. This includes the initiation, development and support of the necessary partnerships between health services and the TAFE/VET/higher education sector. It is only via partnership that the current workforce development needs (in delivery of effective CDM) can be addressed and done so in a manner that capitalises on available resources.

The Department of Human Services will be working with health services and training providers to ensure that its workforce development strategy responds to these challenges as part of rolling out the EliCD initiative.

Strategic Direction - Key areas for the partners to consider:	
Leadership and support	Suggested Role for the Following Partner(s)
<ul style="list-style-type: none"> - <i>Clear workforce development strategy required, with input across departmental branches</i> - <i>Continued need for DHS to drive organisational uptake of the 'fundamentals' required for effective CDM – for instance service coordination</i> - <i>Communication to organisations regarding the importance of, and expectation for, CDM to be written into strategic plans</i> 	<p>Government (key leading role)</p> <p>Health Services (active participation)</p>
Clarity regarding key competencies / research & evaluation	Suggested Role for the Following Partner(s)
<ul style="list-style-type: none"> - <i>Key competencies need to be outlined within scope of practice for both clinical and management staff working within CDM. Agencies need guidance to ensure clarity about the educational requirements, skills, experience – 'who' and 'how' to employ.</i> - <i>Development and direction relating to clinical and/or performance indicators for CDM – how to measure a 'good service'</i> - <i>Facilitation of a 'clearing house' for resources / learnings; facilitation of locally based opportunities for workshops and forums on a regular and well marketed basis</i> - <i>Provision of 'alerts' to the sector regarding current resource availability/development; recent research</i> 	<p>Government (key leading role; key role in communication within health sector and across sectors; * this may include liaison with VHA where work relating to scope of practice is taking place currently)</p> <p>Health Services (key role to ensuring current practice / experience inform the process)</p> <p>Education (key role to ensuring research outcomes inform the process)</p>

<i>findings; new implementation guidelines and the like – the primary care bulletin a potential vehicle</i>	
Training and skills development	Suggested Role for the Following Partner(s)
<ul style="list-style-type: none"> - CDM requires new approaches to working, with subsequent changes in structures and specification of roles. Addressing the training needs of organisations needs to therefore include the provision of training directed to managers and senior staff. This includes areas such as change management, leadership and project management. - The exploration of the role for 'non-professional' or para-professional staff within CDM is clearly important. Whilst this is an obvious opportunity in terms of workforce development and increasing the sector's capacity to respond to CDM demands, significant questions and concerns are evident. Facilitation to describe these potential roles and support their uptake is required. This includes an understanding of the role for consumers in peer training and support and developing the sector's capacity to progress this effectively. - Continued role in communication with the CSHISC relating to industry involvement in the development and review of relevant training packages. This includes more effective marketing / provision of information back to the CHS sector relating to training package availability and access. A clear desire for accredited training exists. 	<p>Government (key leading role; key role in communication within health sector and across sectors)</p> <p>Health Services (key role to ensuring current practice / experience inform the process)</p> <p>Education (key role to ensuring research outcomes inform the process; and in developing responsive training options)</p>
Partnership development	Suggested Role for the Following Partner(s)
<ul style="list-style-type: none"> - A potential role exists in relating to partnering development with key professional bodies, in particular with reference to the above potential for role development of para-professionals with CDM - Identification of 'partnering success' models (in particular involving health and TAFE/VET providers) and dissemination within the sector - Consideration of the potential for development of the current partnering platform, ie. PCPs, in regard to promoting inclusion of RTOs and developing these partnerships at a local level - Consideration of the potential for development of the current partnering platform, ie. PCPs, in regard to exploring a range of support and training/skill development suggestions put forward within the forum, for example peer learning, case presentation forums, mentoring – a sub-regional or regional approach may be 	<p>Government (key role in developing models / guidelines and disseminating information)</p> <p>Health Services & Education (need to be active partners at the PCP (or alternative) forum to 'champion' relationships)</p>

<p>the most effective means of fulfilling this ongoing support/development need.</p> <ul style="list-style-type: none"> - Incentives are suggested for inclusion within the system to ensure 'working partnerships' are rewarded - KPIs for CEOs (eg. Inclusion of reference/steering group action to operationalise strategic plans); a method of ensuring outcome measures for partnerships is in place, not just clinically driven targets (eg. Demonstration/description of service model outcomes) 	
Organisational readiness for change and review	Suggested Role for the Following Partner(s)
<ul style="list-style-type: none"> - Providing information and guidance relating to the need for organisational change – several participants clearly expressed the need for a review of their organisation's current capacity to undertake effective CDM - Communication relating to the expectation that CDM be integral to strategic plans of organisations and what this actually means; including, partnering requirements, training (at both the management & clinical levels), and the embedding of training to ensure practice change is achieved. Again, this requires organisational performance measures of 'what is a good service' 	<p>Government (key role in leading, communicating, 'expecting')</p> <p>Health Services (active participation; responsiveness)</p>

11 Appendix A: Forum Program

8.30 – 9.00	Registration
9.00 – 9.05	Overview – Michael Connell, Convener
9.05 – 9.10	Welcome – Jim Killeen, CEO – WCHS
9.10 – 9.30	Presentation – Department of Human Services Perspective Kim Sykes, Director, Service and Workforce planning – Department of Human Services
9.30 – 10.00	Keynote speech – National Industry Skills Perspective Di Lawson, CEO – Community Services & Health Industry Skills Council
10.00 – 10.30	Keynote speech – Higher Education Perspective A/Prof. Malcolm Battersby, Director of Flinders Human Behaviour & Health Research Unit – Flinders University
10.30 – 10.50	<i>Break</i>
10.50 – 12.00	Presentations <ul style="list-style-type: none"> - Implementing Health Coaching into Practice Susie Summons, Team Leader & Project Manager – Whitehorse Good Life Club, WCHS - Ensuring Workforce Competency in Effective Chronic Disease Management Anne Parkes, Program Manager, Active Health Programs – Knox CHS - Early Intervention in Chronic Disease – Health Wise Program Carolyn Hines, Chronic and Complex Care Program Manager – Darebin CHS - Early Intervention in Chronic Disease (EICD) Program Linda Fiddes, Dietician & Team Leader, Healthy Ageing – Monash Link CHS - A Regional Approach to Partnerships for Integrated CDM and Prevention Cheryl Wood, Executive Officer – Inner East Primary Care Partnership
12.00 – 13.00	<i>Lunch</i>
13.00 – 13.15	Panel Q&A <ul style="list-style-type: none"> - Anne Parkes, Di Lawson, Malcolm Battersby and Kim Sykes.
13.15 – 13.45	Breakout Groups 1. A focus on challenges at the Organisational & Management levels
13.45 – 14.15	Breakout Groups 2. A focus on practical solutions: What is needed in practice? What is needed in training?
14.15 – 15.00	<i>Break</i>
15.00 – 15.40	Feedback & summary <ul style="list-style-type: none"> - Michael Connell, Naomi Kubina (Healthy Active Partners) and Malcolm Battersby.
15.40 – 15.45	Close

12 Appendix B : Keynote Speakers

Jim Killeen, CEO, WCHS

Jim Killeen is CEO of Whitehorse Community Health Service and his organisation put together this Forum.

Jim's has a long experience in community health and his career includes both clinical and senior management positions in the Victorian community health and community care sectors.

As a senior manager, Jim has held Program Management and Deputy CEO roles in a number of community health services, and Regional Management positions at Anglicare Victoria before joining WCHS as the CEO in 2004.

Jim has been a Director – Northern Health since 2003, and is currently Deputy Chairperson of that organisation and Chairperson of the Inner East Primary Care Partnership.

Kim Sykes Director, Service and Workforce Planning, Department of Human Services.

Kim Sykes is Director, Service and Workforce Planning at the Department of Human Services. Kim is responsible for policy and program development to ensure the Victorian health workforce meets current and future community needs.

Kim joined the Department in May 2004 as Victoria's Principal Nurse Advisor and Director Nurse Policy branch. She then worked as the Senior Workforce Consultant with the department's aged care branch prior to taking up her current role in August 2007.

Kim has a diverse career within health services including positions with responsibility for service-wide delivery of medicine, aged care, rehabilitation services and mental health services. She has held senior positions in Southern Psychiatric and Chemical Dependency Services, Monash Medical Centre, and Southern Health.

She brings a practical perspective to her work in workforce planning, and will provide the Victorian Governments perspective on these important skills and workforce training issues.

Di Lawson, CEO, Community Services & Health Industry Skills Council

Di Lawson has held the position of CEO of the Community Services and Health Industry Skills Council for over 5 years.

Di has held national leadership roles in learning and business development for over 15 years in Finance, Business and Health and she presently sits on a number of national workforce committees.

She has also undertaken a wide range of research and consulting projects on national workforce development, competency and training.

Di is well know to most of you for her work on skills in community services and health and will give us a national perspective on skill issues.

Assoc Professor Malcolm Battersby, Director of Flinders Human Behaviour & Health Research Unit, Flinders University

Malcolm Battersby is Director of the Flinders Human Behaviour and Health Research Unit and Course Leader of the Mental Health Science programs at Flinders University. He is Director of the Centre of Anxiety & Related Disorders, Department of Psychiatry, Flinders Medical Centre and Associate Professor in Psychiatry at Flinders University.

Malcolm is a recognised expert on chronic illness care.

Prof Battersby is responsible for the development of what has become known as "The Flinders model" of chronic condition self-management support, a generic, clinician provided method of care planning which aims to incorporate self-management support as part of routine clinical practice.

Local Presentations

A number of short presentations describing on the ground EICD/PCP initiatives were delivered by persons from four ECID [Early Intervention in Chronic Disease] programs and also a PCP [Primary Care Partnership].

The five presenters were:

- Whitehorse Community Health Service (WCHS) with Susie Summons (Team Leader and Project Manager);
- Knox Community Health Service (KCHS) with Anne Parkes (Program Manager, Active Health Programs);
- Darebin Community Health Service with Carolyn Hines (Chronic and Complex Care Program Manager);
- Monash Link Community Health Service with Linda Fiddes (Dietician & Team Leader, Healthy Ageing); and
- Inner East Primary Care Partnership with Cheryl Wood (Executive Officer).

13 Appendix C : Keynote Speaker Presentation Information

Additional Information – 54 Higher Education Perspective

The Flinders team has developed a definition of self-management support:

CCPSM support is what health professionals, carers and the health system do to assist the person to manage their disease or condition, in order to promote health and prevent illness, detect, treat and manage early signs of disease, and minimise the disabling impact of existing conditions and complications'

The ideal service from a consumer's perspective was scoped and this embraced a higher level of care through:

- more frequent (3 monthly) recalls for review and monitoring of chronic condition care plans;
- automated processes to flag recalls and provide population-specific data to a practice that could facilitate the identification of high needs groups and enable better targeting of services;
- longer consultations;
- effective use of practice nurses across broader range of activities; and
- health workers with more training in basic person-centred approaches such as in interviewing skills, assessment of patient needs, communication skills, collaboration over self-management role, and raising issues with consumers.

The benefits of involving the person in their own care were highlighted and include:

- enhancing the patient's understanding of their condition and its underlying causes;
- developing a better appreciation of the factors that influence their health;
- enhancing their capacity to monitor symptoms, and improving their capability to self-manage minor conditions;
- enabling the patient to select the most appropriate form of treatment for acute conditions in partnership with health professionals, which is most suited to their needs and self-management capabilities;
- encouraging patients to adopt preventative attitudes to managing their chronic conditions; and
- empowering patients to provide feedback on the quality and appropriateness of healthcare services.

Additional Information – 6.4 Darebin Community Health Service



Source: "Early Intervention in Chronic Disease Health Wise Program", Carolyn Hines, Darebin Community Health – Presentation to the "Ensuring Workforce Competency in Effective Chronic Disease Management Forum"; August 4, 2008

14 Appendix D: Workshop Outcomes

The following tables summarise discussions undertaken within the afternoon workshop sessions and are arranged according to the participants' work roles: senior management staff, middle management/team leaders, practitioners and trainers. In addition, ideas and strategies, provided via end of day feedback, that aligned with the issues raised with workshops discussions have been included here. General feedback from participants can be found at Appendix E.

Senior Management Perspectives	
Strategic Planning	Structure
<p>Key Elements in Plans</p> <ul style="list-style-type: none"> - Consider health consumer perspective in strategic planning - Include CDM as part of strategies – embed it in the strategic plan - Embed partnerships in the strategic plan (build cooperation) - Incorporate service improvement measures in strategic plan <p>Timetables</p> <ul style="list-style-type: none"> - Set realistic time-frames and have realistic expectations - Allow time for programs to mature 	<p>New Approaches/Structures</p> <ul style="list-style-type: none"> - Support change in structures to facilitate multidisciplinary approaches - Break down the internal silos <p>Facilitating Change</p> <ul style="list-style-type: none"> - Begin change process from a point of 'knowledge of the current' – organisational audits; training plans; strategic plan. - Involve staff in implementation of changes and change management - Senior management to be champions of change
Program Development and Implementation	Staff Roles
<p>Evidence Based Approach</p> <ul style="list-style-type: none"> - Take an evidence based approach to developing CDM - Use evidence from other sectors and providers to support program design <p>Time for Development</p> <ul style="list-style-type: none"> - Allow time for program development <p>Systems</p> <ul style="list-style-type: none"> - Develop appropriate systems for reporting and feedback - Evaluate effectiveness - Develop systems for revision of processes and procedures <p>Client Focus</p> <ul style="list-style-type: none"> - Build customer consultation into systems - Build understanding of CDM among clients <p>Develop Understanding of CDM</p> <ul style="list-style-type: none"> - Recognise key worker role in delivery and servicing of clients - Develop CDM awareness across the organisation - Hold regular think tanks at a local level 	<p>Develop Capacity</p> <ul style="list-style-type: none"> - Key challenges are building CDM and SMS capacity in health services. - Need to scope the responsibilities of the “key-worker” roles - Build CDM approaches into position descriptions <p>Implement Change</p> <ul style="list-style-type: none"> - Build stronger team approaches - Encourage behavioural change among staff - Process to identify 'champions for change' within organisations and support these staff

Research and Evaluation	Education and Training
Research is Important	Shape Education and Training
<ul style="list-style-type: none"> - Ensure funding is available for research programs - Utilise research findings in program design - Measure outcomes and communicate results - Establish structured monitoring and evaluation processes 	<ul style="list-style-type: none"> - Take a leadership role in influencing VET - Active commentary on training packages - Building relationships with training providers. - Strengthen relationship between tertiary institutions and Centres of Excellence
	Invest in Training
	<ul style="list-style-type: none"> - Coordinated training to overcome skilled staff shortages - Invest in staff (continual) training / development and secure budgets - Encourage secondments between DHS and service providers to transfer skills
Funding	Strategic Partnerships
Adequate Funding Needed	Provider Partnerships
<ul style="list-style-type: none"> - Ensure that funding is available to enable CDM to be implemented - Require funding to be supported by research and needs evaluation analysis. - Partner with other organisations in securing government support for programs and initiatives. 	<ul style="list-style-type: none"> - Develop partnerships between health care providers and networks - Develops strong links between CHS, Divisions of GPs and other PCP member agencies - Collaborate with other organisations
	Education Partnerships
	<ul style="list-style-type: none"> - Lead the development of education partnerships - Develop skills in managing partnerships

Middle Management / Team Leader Perspectives	
Self-Management Program Delivery	Organisational Culture
<p>New Models</p> <ul style="list-style-type: none"> - Move to a “wellness” model from illness thinking - Must introduce and embed best-practice in delivery models - Need to understand client expectations and their needs - Need to secure staff support for new systems including the health coach model - Provide ongoing support and health coaching to clients (mentor programs) <p>Communication</p> <ul style="list-style-type: none"> - Need to promote self management to clients and community - Implement effective communication procedures among managers, team-leaders and other staff to clarify CDM processes and outcomes <p>Program Knowledge</p> <ul style="list-style-type: none"> - Need to build understanding to secure buy in to change of practices - Everyone needs to be trained in basic principles, with specialised skills developed for each discipline 	<p>Internal Culture</p> <ul style="list-style-type: none"> - Client centred approaches - Positive problem solving - Team work - Information sharing - Flexibility - Multi –discipline approaches <p>Quality</p> <ul style="list-style-type: none"> - Need to also have a culture that is focused on continuous quality improvement <p>Commitment</p> <ul style="list-style-type: none"> - Commitment of middle managers is required for success in implementation
Employee Roles	Education and Training
<p>Define Roles</p> <ul style="list-style-type: none"> - Need to define role of key worker and to develop the key competencies - Restructure work roles to allow time for implementation of CDM - Incorporate CDM roles in job descriptions - Need for clarity of delivery and management roles, - Focus in effective team work - Need to recruit the right people for key worker roles <p>Act on Concerns</p> <ul style="list-style-type: none"> - Need to deal with concerns about role dilution - Clarify roles and responsibilities to ensure effective teamwork - Need clarity regarding risk <p>Knowledge</p> <ul style="list-style-type: none"> - Staff need knowledge of other disciplines - Ensure information sharing between disciplines internally 	<p>Industry Lead on Training Approaches</p> <ul style="list-style-type: none"> - Research needed to identify training needs & suitable training models - Practitioners need to be involved in shaping education and training - Training need to reflect current practice and have “roles and responsibilities” in mind <p>Levels of Training</p> <ul style="list-style-type: none"> - CDM approaches included in higher education and VET programs - Need to develop CDM awareness programs and workshops - PD programs for practitioners - Need tailored programs delivered by good accredited trainers – agencies need support to identify ‘good training options’ <p>Internal Skills Development</p> <ul style="list-style-type: none"> - Internal mentors; exploration of train the trainer models - Workshops - Case models and client session participation/observation <p>Training Combined with Practice</p> <ul style="list-style-type: none"> - Training is not enough – need to ensure that people are prepared for training and can implement what they learn <p>Explore Innovation in Training</p> <ul style="list-style-type: none"> - Online resources

- DHS support for a virtual training unit
- Support for the development of training programs

Mentoring	Networks
Develop Programs	Develop Active Networks
<ul style="list-style-type: none"> - Mentoring of employees is important - Develop mentoring roles internally and at regional level through PCPs - Mentoring needed and a change champion - Use can be made of the buddy role 	<ul style="list-style-type: none"> - Cultivate good local networks - PCPs to facilitate information exchange and learning around CDM - Participate in networks
Funding	
Funding for Development	
Funding required for strategy, program and systems development not just service delivery	

Practitioner Perspectives	
Developing Programs and Systems	Operational Issues
<p>Developing Structured Programs</p> <ul style="list-style-type: none"> - Need to recognise the CDM programs are a fundamental shift and a new way of working and are not a process for a single discipline - Need a good understanding of CDM tools, to recognise what works and what does not work - Engage professionals and experienced workers in formulating programs - There is a need to document programs and processes - Formal evaluation process are needed 	<p>Research Dissemination</p> <ul style="list-style-type: none"> - There is a need to ensure that new research/evaluations are distributed through the health system to ensure programs are evidence based and can be continually improved. <p>Consumer Consultation</p> <ul style="list-style-type: none"> - Programs require more consultation with consumers. <p>Communication</p> <ul style="list-style-type: none"> - Good intra-agency & inter-agency communication is required. <p>Information and Monitoring</p> <ul style="list-style-type: none"> - Need good quality client monitoring systems - Better IT systems are required
<p>Roles of Employees</p> <p>Clarity of roles:</p> <ul style="list-style-type: none"> - With CDM approaches, people are working across different territories and with different disciplines. - Staff need to understanding roles of others in teams - Roles need to be clear in delivery and reporting – including language used to describe roles across sectors - Staff need to understand the tools and the processes - Ensure people understand each others roles and skill sets <p>Broaden roles:</p> <ul style="list-style-type: none"> - Scope of responsibilities are broadening and people need some generic skills - Expand the role of the nurse practitioner in service delivery - Increase use of Allied Health and Div 2 nurses to support workers - Broaden the role of administrative assistants - Use volunteers to support programs <p>Team Approaches</p> <ul style="list-style-type: none"> - Effective team approach is required; with trust built among disciplines - Avoid creating silos by incorporating skills CDM skills across the professions - Careful management of multi-skilling is needed to avoid making staff feel overwhelmed by taking on board additional skill sets and responsibilities <p>Recruitment</p> <ul style="list-style-type: none"> - Need to look laterally beyond the health industry for staffing (eg. the fitness industry) 	<p>Skills and Training Needs</p> <p>Skills Required</p> <ul style="list-style-type: none"> - Need to have case work skills - Opportunities to utilise existing skills more effectively rather than re-skilling the entire workforce - Building in CDM & SM concepts & skills development within training across the board <p>Education Links</p> <ul style="list-style-type: none"> - Need for stronger links with higher education providers - Need for more integration between education and health providers in developing training <p>Type of Training</p> <ul style="list-style-type: none"> - Establish mandatory training requirements to ensure quality of programs - Need for greater focus on VET programs - practical training <p>Engagement</p> <ul style="list-style-type: none"> - Need for engagement with education and training providers and unions on future skills - There is a need to get peak health bodies involved to expand training and the scope of CDM practices <p>Internal Training</p> <ul style="list-style-type: none"> - Case discussions and workshops should be used to develop skill internally - Staff need to be enabled to implement training in the work environment <p>Support</p> <ul style="list-style-type: none"> - Internal support is need through mentoring and buddy systems

Trainer Perspectives	
Skills Requirements & Training needs	Course Development
<p>Identifying Needs</p> <ul style="list-style-type: none"> - Local, formal training needs analysis needs to be conducted - A spectrum of training is required from CDM awareness to induction and to advanced specialists - Prepare to be flexible in approach - There is a need to match skills and training to the CDM model being used <p>Focus on Practical Skills</p> <ul style="list-style-type: none"> - Skills training is needed for practitioners and managers - CDM understanding and implementation skills - Need to enhance understanding of working in teams - Need training for practice managers in change management, leaderships skills, and team development skills - Train the trainer programs are required - Focus on skills needed – counselling, active listening , communication - Risk management a major issue 	<p>Industry Relevance</p> <ul style="list-style-type: none"> - Need to ensure industry relevance of training - Have RTOs working in partnership with organisations to develop training programs - Trainers need knowledge of processes - Need to work with agencies to develop industry relevant courses - Education system needs better links and be more responsive - Hard to get trainers with industry experience because of wage disparities between teacher/ trainers and practitioners. <p>Program Development</p> <ul style="list-style-type: none"> - Develop teams involving educators and people from industry - Should have health consumer input on training development <p>Accredited Training</p> <ul style="list-style-type: none"> - Use accredited trainers only - Need validation of non-accredited courses <p>Develop New Programs</p> <ul style="list-style-type: none"> - Need to develop new programs - Establish cooperative programs – eg a regional champion and mentor to work with a group of services - Seek DHS and Commonwealth support for programs development
Course Delivery	Marketing
<p>Formats</p> <ul style="list-style-type: none"> - Competency-based training is required based on modules - There is a need to individualise training - This need to be followed with support and coaching after training is completed - There is limited application of SMS learning into practice for some people. A possible solution is using role playing and case study approaches - More flexible learning approaches are needed and this may combine e-learning programs with a mentoring program - e learning program has been developed by Sunraysia TAFE/ Mildura Hospital and La Trobe University - Need for more funding of places <p>Access</p> <ul style="list-style-type: none"> - Timing and locations of training are an issue - Need to ensure regional services have access to training 	<ul style="list-style-type: none"> - Need to build an awareness of education and training that is available - Promote training through DHS and through other sector and regional partnerships

Follow up

- Health services need to provide support and coaching/mentoring as people put their training into practice
- Need for ongoing professional development programs

The tables below outline workshop discussion around partnership agreements. The information in the tables is clustered according to work roles: those in managerial roles, practitioners and trainers.

Management Perspectives	
Establishing Partnerships	Regional & Provider Partnerships
<p style="text-align: center;">Development</p> <ul style="list-style-type: none"> - Develop models for cooperation - Establish models for collaboration and secure cooperation between training and service provider organisations - Establish clear and unified goals and understanding of objectives - Establish Memoranda of Understanding (MOUs) for cooperation. <p style="text-align: center;">Implementation</p> <ul style="list-style-type: none"> - Need to invest time and resources in partnerships - Secure leadership "buy-in" and cooperation - Securing commitment at senior management and organisational levels - MOUs and other agreements could be incorporated in strategic plans for action - Need to build trust - Commit adequate time and resources to enable practitioners/clinicians to be involved <p style="text-align: center;">Types of Activities</p> <ul style="list-style-type: none"> - Exchange of information - Develop single model of care involving all partners - Improved sharing of resources - Identify skill needs and contract training <p style="text-align: center;">Assessing partnerships</p> <ul style="list-style-type: none"> - Implement assessment procedures to evaluate how partners align with original models 	<p style="text-align: center;">Regional</p> <ul style="list-style-type: none"> - Regional collaboration needed to disseminate research findings via networks and partnerships. - Create working parties at a regional level to focus on workforce development <p style="text-align: center;">Providers</p> <ul style="list-style-type: none"> - Establish good local networks and promote cooperation – i.e. eliminate competition between providers - Need to partner with GP Divisions to get referrals - Need to have strong partnerships with local GPs
Funding	Education Partnerships
<p style="text-align: center;">Cooperation</p> <ul style="list-style-type: none"> - Need to secure appropriate funding for projects to be delivered in partnership – DHS, providers, education <p style="text-align: center;">Funding Structures</p> <ul style="list-style-type: none"> - Need for new funding structures - There are silos and competition for funding from providers - DHS funding is fragmented – by funding separate programs. - There is a need to move away from fragmented funding approaches <p style="text-align: center;">Secure Program Funding</p> <ul style="list-style-type: none"> - Partner with GPs in arrangements to secure funding - Replicate successful funding models – eg. Bendigo, where curriculum and training resources were developed with local industry, and piloted within local CHS centres - Secure funding to develop CDM - for program development, delivery, evaluation and training 	<p style="text-align: center;">Research</p> <ul style="list-style-type: none"> - Partnering with Higher Education institutions in conducting evidence-based research to drive process and to distribute results. - Undertaking collective training needs analysis to clarify particular skills needs relating to CDM <p style="text-align: center;">Training</p> <ul style="list-style-type: none"> - Collaboration on program design between service providers and education links to ensure it is suitable for local conditions, not just off the shelf (customise) - Work on clarifying the core competencies and skills required for achieving competence in CDM - Involve practitioners in sessional training at both TAFE/VET and Higher Education levels

Practitioner /Trainer Perspectives	
Delivery Partnerships	Education Partnerships
<p style="text-align: center;">Program Delivery</p> <ul style="list-style-type: none"> - Active partnerships needed in delivering CDM. - Partnerships with GPs are fundamental for effective delivery of CDM - There is a need to share records to develop linked care plans <p style="text-align: center;">Funding of Services</p> <ul style="list-style-type: none"> - There is a need to work out funding for service delivery (eg access to Medicare numbers) <p style="text-align: center;">Coordination of Services</p> <ul style="list-style-type: none"> - Services need to be better coordinated. - Clinicians and others need to speak the same language, so that the clients receive consistent messages - There is a key role for PCPs in delivery partnerships 	<p style="text-align: center;">Development</p> <ul style="list-style-type: none"> - Establish networks between health providers and education providers - Define functions, objectives and outcomes sought - Have a shared Vision between partners <p style="text-align: center;">Relationships</p> <ul style="list-style-type: none"> - There is a need to be active in relationship building - Better engagement by higher education and TAFE with the health sector is needed - Include partnerships with education in the CHS strategic plan <p style="text-align: center;">Develop champions</p> <ul style="list-style-type: none"> - Each partnership needs a champion to drive activities <p style="text-align: center;">Education System Partnerships</p> <ul style="list-style-type: none"> - Need cooperation between education providers - Active involvement with Skills Councils and ITABs to shape training programs - Pathways – need to develop seamless pathways through articulation <p style="text-align: center;">Program Development</p> <ul style="list-style-type: none"> - Embrace CDM approaches in education and training programs (build awareness and understanding) - Identify skills required and then develop them - Need to develop training programs for the degree professionals (clinicians) - Create an online forum - Trainers need knowledge of the service model - Need links to GPs and acute care - Use clinicians in TAFE to develop content
Funding for CDM Approaches	
<p style="text-align: center;">Secure Funding</p> <ul style="list-style-type: none"> - Need to develop clear strategies for CDM and fund them - There is the opportunity to draw on overseas models in USA and UK. - There is a need to have CDM included in health policy agendas at state and national levels - Partnerships offer opportunities to seek funding for joint programs (service delivery and education and training) 	

15 Appendix E: General Feedback from Participants

A total of 62 feedback forms were received from participants after the forum, representing a 57% response rate. Many points raised within these forms echoed discussions undertaken within the afternoon workshop section of the forum. This section provides additional elements of feedback with comments outlined with a précis of language used and described under identified themes. Where the same comment presented on multiple forms, the number of these has not been indicated. Information collected in the first section of feedback regarding venue and forum structure etc will inform future forum organisation, however, other than description within some of the general comments, is not reported on below.

15.1 General Comments

As a whole, comments received were very positive. They are represented below in 3 main themes:

Overview of EICD:

- multiple sector representation made it difficult for some to interpret relevance of EICD information as it was particularly new to them
- opened thinking around the possibilities for effective CDM
- great overview of EICD
- confirmed the need for a long term client focus

Opportunity to network/connect:

- table discussions really useful
- great to be able to support TAFE & the partnering training institutions (via venue use)
- have linked with RTO whilst here which has been very encouraging
- great for networking

Content:

- not enough discussion regarding training and steps involved in workforce restructure / development
- lots of good & stimulating information
- not enough discussion and Q & A time, needed one less presentation
- another forum would be good to bring forward and 'nut-out' these issues more
- excellent opportunity - learned a lot

15.2 Feedback regarding what was of most interest to participants

Quality of speakers & information provided:

- guest speakers; range of speakers; good variety of information presented
- hearing a community service perspective
- description of challenges within community based programs
- Flinders research results

Networking / general information sharing opportunity:

- access to colleague discussions; access to different stakeholders for discussion
- ability to share frustrations, challenges that cross community health management & CD

- links to RTOs that could potentially occur – new opportunity to explore common agendas
- hearing the diversity of views from the audience
- hearing how others have implemented CCSM model; especially issues related to management

Information specific to competencies:

- need for national/state competencies
- confirmed that BRIT is on the right track in terms of training content – highlighted need to continue with developments in consultation with the local industry

Generation of further questions:

- Raised more questions & issues regarding how to reorient service delivery & training

15.3 Feedback relating to potential plans / support strategies going forward that will assist organisations progress this work

Several feedback forms indicated the importance participants see in having a clear strategy and for DHS in leading work in regard to CDM, training and the associated partnering across sectors:

- Is there a potential role for DHS consider employment of trainers across regions/state in relation to CDM?
- DHS funds acute training needs, why not provide in house support to primary care around these training needs?
- Continued development of ‘non-silo’ support from within DHS; with coordination within DHS for linked areas to assist at the operational level
- Clear frameworks and service provision via RTOs across the state
- Guidance regarding ‘supervision’ of staff competencies with CDM skills – external/internal supervision, peer support, mentoring etc.
- A new approach to funding for CCSM project managers, evaluations, needs assessments etc. At the moment it is all integrated into current management & service provider roles
- Integrated and consistent best practice models will only rollout, broadly if part of FASAs
- How to market to consumers
- Need ongoing support/guidance to assist with effective program evaluation

15.4 Information relating to what participants plan to do next within their individual organisations

Many participants indicated work in the area of *partnerships* as their main issue:

- develop localised links with the relevant RTO/health service and initiate discussion around partnerships and collaborative opportunities
- identify if agencies within the PCP use RTO for upskilling staff
- consider coordinated approach to mentoring across the PCP
- use current partnership forums to advocate consistency of practice at the state-wide & catchment levels

Education / training were also an issue identified by a number of participants as main issue:

- Little knowledge of VET/TAFE within acute system – need to begin education relating to this
- Company training; discussion with management about training needs
- (from RTO) explore potential educational modules / packages that could be accessed / recommended to local professionals
- Consider options to pilot training with local industry

The other significant area identified as the next step for participants, related to *organisational change / review*:

- Review of how budgets are structured; funding; especially to enable focus away from core business delivery
- Encouragement of AH staff to incorporate SM practice; health care across the continuum, that is, these issues are relevant to acute health too
- Workforce empowerment
- Being open to new & flexible ways of thinking and working – how to progress this within the agency

15.5 Other comments from participants

Workforce issues:

Other comments listed by participants all related to workforce. In particular, issues concerning specific competencies required for the delivery of CDM, concerns and/or further questions relating to 'professional' vs 'non-professional' staffing profiles, and the need for an improved shared understanding of workforce issues.

- “SM should not be used as a key to address the problems /issues affecting the health care system. Service coordination and workforce issues have to be address independently from SM.”
- Exploration of streamlined approaches to recruitment
- “Need to recognise organisations require a mix of vocational/tertiary & programmatic experience – some workers won’t need higher qualifications to perform roles & higher qual. Graduates will not necessarily need service delivery roles”; legal issues?
- issues with some professional bodies in terms of maintain registration if not working in ‘clinical role’
- need for consistent (ie. Across the professions) and integrated training re CCSM principles in clinical undergraduate courses, including placements clear understanding of CDM & SM still varied across the sector – need to continue work re understanding of these concepts to underpin the development of workforce competencies