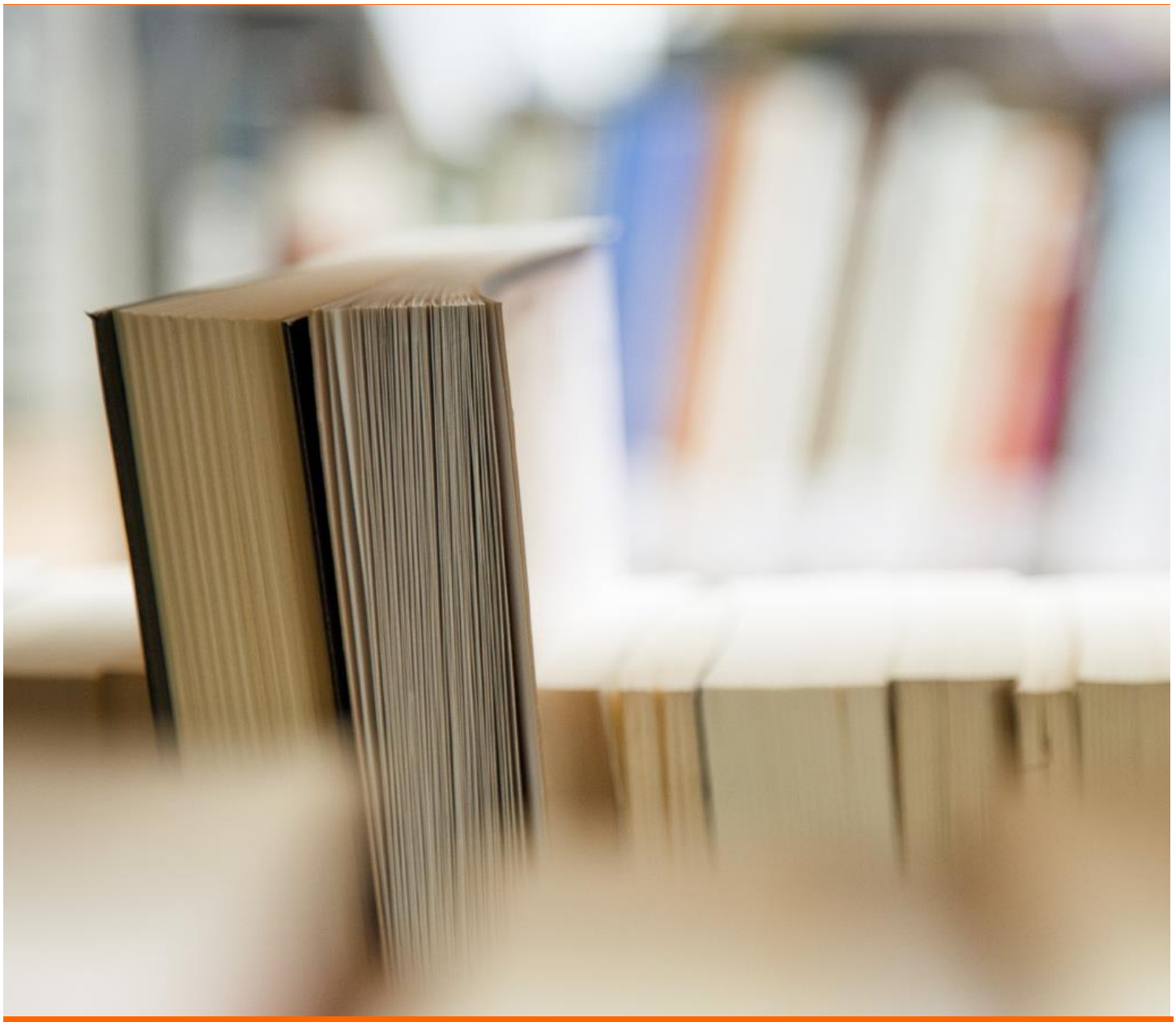


Chronic Care Workforce Initiative: Primary Health Workforce Capacity Building for Self-Management Support

Prepared by:
Leanne Cleeland
Integrated Care Coordinator, Central Hume Primary Care Partnership
for Victorian Department of Health and Human Services

Project Report 2017

Project Governance and Operations

Ovens Murray and Goulburn Chronic Care Steering Committee

Jane Judd	Alexandra District Health
Daniel Baxter	Albury Community Health
Lisa Pryor	Beechworth Health Service
Vicki Pitcher	Gateway Health
Craig Chadwick	Goulburn Valley Primary Care Partnership
Anna Hession	Indigo North Health
Sandra Saxton	Lower Hume Primary Care Partnership
David Kidd	Northeast Health Wangaratta
Richard McClelland	Murray Primary Health Network
Leigh Rhode	Goulburn Valley Health

Project Sponsors

Judith Scarfe	DHHS, East Division Health
Jackie Eckert	DHHS, East Division Health

Project Team

Jenny Ashby Project Manager	Central Hume Primary Care Partnership
Leanne Cleeland Project Officer	Central Hume Primary Care Partnership

Funding for this project was provided by the Victorian Department of Health and Human Services, East Division.

Acknowledgements

On behalf of the Project Steering Committee, Central Hume Primary Care Partnership wish to acknowledge the many people who supported this project. In particular we would like to thank the following people:

- Jaimie Poorter, Lower Hume Primary Care Partnership
- Dale-Maree Florence, Goulburn Valley Primary Care Partnership
- Brydie Donnelly, Upper Hume Primary Care Partnership
- Respondents to the training survey
- Participants in the West Hume Chronic Care Collaborative
- Participants in the Benalla Health Self-Management Peer Support Group

Finally, we would also like to thank our office support team, Hannah Symes and Lisa Guppy at Central Hume Primary Care Partnership, for enabling the project to run smoothly and to be delivered on time.

Table of Contents

Executive Summary

Over the past 40 years, the burden of disease in Australia has shifted away from infectious disease and injury, well suited to an episodic care model, towards chronic conditions requiring attention to prevention activities and coordinated care management.

The Chronic Care Model is recognised as a more appropriate framework for programs and services. However, it has been identified that many health professionals working with people with chronic conditions are not familiar with the essential component of the Chronic Care Model, Self-Management Support (Higgins, 2012).

The '*Primary Health Workforce Capacity Building for Self-management Support'* Project is a Chronic Care Workforce initiative. Its aim is to increase workforce confidence by building capability in self-management support.

The project surveyed 83 people across the Ovens Murray and Goulburn areas and identified fundamental skills gaps in self-management support capabilities.

The project subsequently funded training to address identified gaps in self-management support core capabilities.

The survey findings identified:

- the primary healthcare workers that have received *nil* training; and
- the primary healthcare workers that are *not confident* in behaviour change approach techniques, motivational interviewing skills, collaborative care planning, use of peer support groups and health promotion approaches.

Various training packages were examined for relevance. The training selected for delivery is the evidenced-based Australian Centre for Heart Health, online training '*Supporting Chronic Disease Self-Management'*. The training was delivered to 100 primary healthcare workers within the Ovens Murray and Goulburn areas of East Division, Department of Health and Human Services in Victoria.

The following recommendations are designed to create sustainability in workforce capability and competence in self-management support it is recommended:

Recommendation 1: Continuation of specific training to meet identified gaps in workforce capacity.

Recommendation 2: Increase awareness of the Regional Chronic Care Strategy and related projects that support strategy implementation.

Recommendation 3: Establish a Regional Self-Management Support 'Community of Practice' in Ovens Murray and Goulburn areas of DHHS, East Division.

Recommendation 4: Develop and implement a Regional Self-Management Support Framework to provide consistency and competency within the health system.

1. Background

Chronic conditions are the leading cause of illness, disability and death in Australia. Tackling chronic illness conditions and their causes is the biggest challenge facing Australia's health system. Along with our ageing population, the increasing consumer expectations and the ever-increasing rates of chronic conditions are putting unprecedented strains upon individuals, communities and the health system.

Over the past 40 years, the burden of disease in Australia has shifted away from infectious diseases and injury, well suited to an episodic care model, towards chronic conditions requiring attention to prevention activities and coordinated management. Chronic conditions are occurring earlier in life and Australians may live longer with complex care needs.

Traditionally, health education programs and services available in Australia to support patients with chronic disease have been developed within the 'bio-medical model'. More recently, the chronic disease self-management model has been recognised as a more appropriate framework for programs and services. The chronic disease self-management approach, with an emphasis on patient-centred care, optimises the likelihood of the delivery of collaborative care.

Two Australian audits have demonstrated that many health professionals working with patients with a chronic disease are not familiar with the essential components of Chronic Disease Self-Management (Higgins, 2012). They identified that many health professionals have little knowledge or understanding of the principles of chronic disease self-management. Also identified in the audits, was the lack of skills to support patient self-management and that health professionals are unsure of how to integrate self-management support into clinical practice. It is evident that health professionals working with people with chronic disease require training in Chronic Disease Self-Management and the integration of a Chronic Disease Self-Management approach into clinical practice.

The *Primary Health Workforce Capacity Building in Self-Management Support* Project is part of the implementation of the Ovens Murray and Goulburn Chronic Care Strategy. The project aims to increase workforce confidence by building capability in self-management support. A skilled primary health workforce is essential to enable effective chronic condition self-management support for people living with these conditions across their lifespan.

2. Methodology

Stage	Tasks
1	**Scoping and Desk Based Research** • Scope parameters of the Project • Develop a Project Implementation Plan • Research training relevant to this Project • Design Training Needs Analysis Survey and Focus Groups questions • Identify key contacts for project (PCPs, Community Health Services, etc.)
2	**Data Collection** • Distribute survey for Training Needs Analysis • Conduct Focus Groups (maximum 2) to establish a baseline of the workforce's Self-Management Support knowledge base • Collate Data
3	**Analysis** • Analyse data for themes • Produce a Needs Assessment and Gap Analysis Report inclusive of recommendations, ie. detailing identified solutions and training plan for implementation
4	**Training provision** • Source and organise delivery of Self-Management Support training in the Oven Murray and Goulburn areas based on evidence of specific training needs • training organised – training delivery method and format to be identified • training delivered and evaluated
5	**Framework and Documentation** • Draft and Final Report

3. Scoping and Desk Based Research

3.1 Self-Management

Chronic condition self-management is a process that involves a broad set of attitudes, behaviours and skills. It is directed toward managing the impact of the disease or condition on all aspects of living by the individual with a chronic condition. It includes, but is not limited to; self-care and it may also encompass prevention. The following are believed to contribute to this process:

- Having knowledge of their condition and/or its management
- Adopting a self-management care plan agreed and negotiated in partnership with health professionals, significant others and/or carers and other supporters
- Actively sharing in decision making with health professionals, significant others and/or carer's and other supporters
- Monitoring and managing signs and symptoms of the condition
- Managing the impact of the condition on physical, emotional, occupational and social functioning
- Adopting lifestyles that address risk factors and promote health by focusing on prevention and early intervention
- Having access to, and confidence in, the ability to use support services (*National Health Priority Action Council, 2006)*

3.2 Self-Management Support

Effective self-management support helps people and their families cope with the physical, social and psychological challenges of living with, and managing, a chronic condition.

The Guide for Community Health Programs '*Care for people with chronic conditions'* describes self-management support as the health services processes and practices for people with a chronic condition. In relation to self-management this includes:

- Assessing and documenting self-management needs as part of the standardised assessment process
- Collaborative goal setting and shared decision making as part of the care planning process, and giving the person a copy of their care plan
- Skilled practitioners who use evidenced-based approaches and practices to provide self-management support
- Accommodating individual preferences by offering a range of modalities such as groups, telephone and online programs
- Routinely linking people with condition-specific organisations and peer support. This is particularly important for young people, and people who have rare conditions, as these two groups often experience isolation from not having access to peers to share concerns/experiences
- Processes and training to support recruitment and involvement of peer support workers in self-management and education programs
- Giving people information in accordance with health literacy principles, including strategies to accommodate different learning styles. Minimum information requirements would include:
    - Information on health conditions, and consumer-friendly versions of condition-specific guidelines
    - Lifestyle activities that promote health and reduce risk of disease/complication
    - Actions to take if they experience acute changes in their condition
- Team members are sensitive to cultural beliefs, people with diverse needs and to people's social and economic circumstances
- Offering interpreter services to people who need them
- Taking an organisational approach to implement health literacy principles
- Supporting people to access
    - Credible online resources
    - Emerging technologies that provide self/remote-monitoring
    - Applications that support monitoring of conditions and motivation for lifestyle changes.

3.3 Capability vs Competency

Capability and Competency are two terms that pertain to human ability. They are often mentioned in many Human Resource-related materials as well as in career and job communications.

'Capability' is the term that describes the quality of being capable. A person with a capability has a potential to acquire a specific ability or skill that will be helpful in a task. The learned skill or ability adds to a person's knowledge bank or skill set. Capabilities also increase the functions of a person which can lead to more productivity. New skills and abilities make a person more capable to complete a certain task.

In time and practice, capabilities will develop into competence. It serves as the starting point of being able to do something and gradually becoming more adept in performing a task.

On the other hand, '**competence'** is the state or quality of an individual's work. A person and their work can be evaluated as competent if the performance is considered as "satisfactory". Competence can also be applied to the improvement or development of a one's abilities and skills for the benefit of the person and the group or institution that he or she represents.

Competence starts from a person's capabilities. In a sense, competence is the proven abilities and improved capabilities. Competence can include a combination of knowledge, basic requirements (capabilities), skills, abilities, behavior, and attitude.

3.4 Core Capabilities

For this project we are only identifying the core capabilities for individual health professionals, not organisational requirements. In 2007 a national project for the Australian Government Department of Health and Ageing was undertaken to investigate training needs and information options available to the primary health care workforce to support chronic conditions self-management.

The motivation to assess training needs arose from the Australian National Chronic Disease Strategy (2006), with recognition that significant workforce changes and specific skills development would be required to support the healthcare system shift towards greater chronic condition management.

A project in 2009 determined the core knowledge, attitudes and skills required for prevention and self-management support of chronic conditions. These capabilities are essential for effective chronic conditions self-management (Lawn S, 2009). The core capabilities are identified in Table 1 below.

Table 1 Core Skills for the Primary Health Care Workforce

Capability Type	Core Capabilities
General Patient-Centred	1. Health promotion approaches
	2. Assessment of health risk factors
	3. Communication skills
	4. Assessment of self-management capacity (understanding strengths & barriers)
	5. Collaborative care planning
	6. Use of peer support
	7. Cultural awareness
	8. Psychosocial assessment & support skills
Behaviour Change Capabilities	9. Models of health behaviour change
	10. Motivational interviewing
	11. Collaborative problem definition
	12. Goal setting & goal achievement
	13. Structured problem solving & action planning

3.5 Core Competencies

Competencies are the skills, abilities, knowledge, behaviours and attitudes that are instrumental in the delivery of desired results, and consequently, of job performance. Competencies "add further definition to any job by their focus on how work is done and what work is done" (Pan American Health Organisation, 2002).

The World Health Organisation identified five core competencies for caring for patients with chronic conditions (World Health Organisation, 2005). They were identified following a process that included a document review and international expert agreement. Determination of the competencies included a review of literature on educational reform for health care providers and health care for chronic conditions. These core competencies have the potential to shift current thinking about providing care for patients with ongoing health problems and in turn, to reform the training and preparation of the health care workforce. The WHO core competencies are listed in Table 2.

Table 2 World Health Organisation Core Competencies for Primary Health Care Workforce

Core Competencies	Skills & Knowledge
1. Patient-centred care	• Interviewing and communicating effectively • Assisting changes in health-related behaviours • Supporting self-management • Using a proactive approach
2. Partnering	• Partnering with patients • Partnering with other providers • Partnering with communities
3. Quality Improvement	• Measuring care delivery and outcomes • Learning and adapting to change • Translating evidence into practice
4. Information & communication technology	• Designing and using patient registries • Using computer technologies • Communicating with partners
5. Public health perspective	• Providing population-based care • Systems thinking • Working across the care continuum • Working in primary health care-led systems

3.6 Regional Example of Peer Support Networks

Both networks were attended by the Project Officer to discuss the project and to seek feedback on how the networks support their clinical practice with the participants. Both networks are well supported by the primary healthcare workforce. Both networks have been active for many years.

The Benalla Health Self-Management Peer Support Group is an organisational network that is coordinated by the Early Intervention in Chronic Disease Coordinator who has post graduate studies in Chronic Disease Management and is a skilled clinician in Self-Management Support (*Refer to Terms of Reference below).*

The West Hume Chronic Care Collaborative is a regional network and coordinated by the Lower Hume & Goulburn Valley PCP (*Refer to Terms of Reference overleaf).*

Benalla Health Self-Management Peer Support Group

Terms of Reference

Purpose

The Self-Management Peer Support Group aims to assist clinicians to embed self-management support principles and practices into usual care, as well as to improve the use of behaviour change methodology within clinical practice.

Objectives

- To increase clinicians' understanding of self-management support principles and practices
- Increase clinicians' understanding of how self-management support applies to discipline specific practice
- To enhance clinicians' skills to provide self-management support

Membership

Open to all Benalla Health clinicians' but it is anticipated that individuals will have completed Health Change Australia core training, Flinders Model, Stanford, Motivational Interviewing, 5As or similar.

Frequency of Meetings

- Frequency of Meetings: Monthly meetings
- Duration of meetings: 1hour

Performance Indicators

- One Case Study annually
- The Assessment of Primary Care Resources & Supports for Chronic Disease Self-Management (PCRS) survey
- Staff Satisfaction Survey

West Hume Chronic Care Collaborative

Terms of Reference

Purpose

The West Hume Chronic Care Collaborative provides a supportive and nurturing environment for staff working in the health and social services area. Key functions of the Collaborative include encouraging members to share experience, training and workplace implementation in the self-management arena.

Objectives

- To provide an opportunity for discussion, communication and networking, between group members who can represent their views and experiences in a safe, supportive environments
- To explore and exchange ideas and information regarding self-management and self-management support
- To report and review on current initiatives relating to chronic disease management at local, regional, state and National level and related issues identified by Department Health and Human Services Victoria.
- To provide information, support and training relevant to building West Hume workforce capacity across Goulburn Valley and Lower Hume Primary Care Partnership catchments.

Membership

Membership is voluntary and comprises any health professional, in particular those working in the area of chronic disease management, self-management support, and appropriate key member organisations staff within West Hume (Goulburn area).

Key Functions

The key functions include (but are not limited to):

- Colleague learning sessions
- Information sharing and networking between attendees
- Professional development; and
- External presentations when appropriate.

Frequency of Meetings

- Four times per year
- Duration – 1 hour

4. Training Needs Survey

4.1 Design

Survey Objectives

The survey was developed to identify the types of training that our regional Primary Healthcare Workforce have completed in regard to self-management support capability. It is also needed to identify barriers and enablers to putting capability training into practice. Most importantly, the survey asked the primary healthcare workforce to **self-assess** how confident they are in each core self-management support capability. (*Refer to Attachment A: Sample Survey for full content.)*

Core Content of Survey

- Introduction
- Demographic information
- Previous training
- Barriers and Enablers
- Chronic Disease Management local resources
- Supporting chronic condition self-management capabilities
    - Health Promotion approaches
    - Assessment of health risk factors
    - Communication skills
    - Assessment of self-management capacity
    - Collaborative care planning
    - Recommending peer support networks/groups
    - Cultural awareness and interpreter services
    - Conducting a psychosocial assessment
    - Behaviour change approach
    - Motivational interviewing
    - Collaborative problem solving
    - Goal setting and achievement
    - Structured problem solving and action planning

SurveyMonkey™ was utilized as the survey platform as it allows, via the Internet, flexibility to customize the survey questions, distributes the questionnaire and starts collecting responses in real time.

Once the online survey is completed, the survey tools turn the survey data into reports and actionable insights.

4.2 Distribution

The survey was distributed by the Project Officer via the 4 Primary Care Partnerships in the Ovens Murray and Goulburn areas for forwarding to their Member Agencies.

Primary Care Partnership	Member Agencies
Central Hume	Alpine Health
	Benalla Health
	Gateway Health Wangaratta
	Mansfield District Hospital
	Northeast Health Wangaratta
Goulburn Valley	Cobram District Health
	Goulburn Valley Health
	Nathalia District Hospital
	Numurkah District Health Services
	Primary Care Connect
	Yarrawonga Health
	Rumbalara Aboriginal Cooperative
Lower Hume	Alexandra District Hospital
	Kilmore and District Hospital
	Nexus Primary Health
	Yea & District Hospital
Upper Hume	Albury Wodonga Health
	Beechworth Health Service
	Gateway Health Wodonga
	Indigo North Health
	Tallangatta Health Service
	Upper Murray Health & Community Services
	Walwa Bush Nursing Centre
	Albury Wodonga Aboriginal Health Service
	Mungabareena Aboriginal Corporation

4.3 Survey: Data Analysis and Key Findings

Key findings from the self-assessment survey
(For full survey results refer to Attachment B Survey Results)

RESPONDENTS		**Total Ovens Murray Goulburn Areas**	**Number (n) = 83**
		Central Hume PCP	35% (n=29)
		Goulburn Valley PCP	25% (n=21)
		Upper Hume PCP	24% (n=20)
		Lower Hume PCP	16% (n=13)

STRENGTHS	More than 75% self-assessed as confident or very confident	
	Person-Centred Care Capabilities	Assessment of health risk factors
		Assessment of self-management capacity
		Communication skills
	Behaviour Change Capabilities	Collaborative problem solving
		Goal setting and achievement
		Structured problem solving and action

WEAKNESSES	25% and over self-assessed as low confidence	
	Person-Centred Care Capabilities	Health promotion approaches
		Collaborative care planning
		Use of peer support groups
		Cultural awareness &interpreter service utilisation
		Psychosocial assessment & support skills
	Behaviour Change Capabilities	Models of health behaviour change
		Motivational interviewing

OPPORTUNITIES	Identified areas	
	Team Support	69% of respondents identified team support as an enabler to translate new knowledge & skills into clinical practice
	Regional Chronic Care Strategy	50% of survey respondents had never heard of the Hume Region Chronic Care Strategy 2012-2022 (half of the relevant workforce surveyed).
	Regional Clearinghouse	87% of those surveyed had never heard of the OM&G Area Chronic Clearinghouse. The purpose of this site is to support regional quality improvement efforts in the prevention and management of chronic conditions in the Ovens Murray and Goulburn areas of East Division, DHHS in Victoria, Australia.
	Care for People with Chronic Conditions Guide	60% of those surveyed had never heard of the Care for People with Chronic Conditions – Guide for the Community Health Program. The guide details the planning and delivery of care for people with a chronic condition. It outlines the principles that underpin good practice in the delivery of care for people with chronic conditions and aims to ensure a consistent approach.

THREATS	Identified areas	
	Post Graduate Studies	Only 2.5% (n=83) surveyed have completed post graduate studies in Chronic Disease Management
	Nil Training Completed	25% surveyed identified that they have not completed any training in self-management support capabilities therefore ¼ of relevant workforce surveyed are untrained in chronic disease self-management.
	Peer Support Networks	Approximately two thirds of all survey respondents do not have access to a local peer support network to translate new knowledge & skills into clinical practice. Survey indicated 26% have difficulty applying new skills & knowledge with some client groups. Access to peer support networks would assist clinicians in dealing with some challenging clients/groups

4.4 Conclusion

Fundamental skills gaps appear to exist for the current primary healthcare workforce. Based on the survey results, it is recommended training for the primary healthcare workforce addresses 10 core capabilities. This will address the gap for primary healthcare workers that have received nil training and those that are not confident. Specifically it will upskill the workforce in behaviour change approach techniques, motivational interviewing skills, collaborative care planning, use of peer support groups and health promotion approaches.

5. Training Provision

Training was chosen based on survey findings and desk based research that met the identified training gaps. The training was also influenced by affordability, evidence-based & be able to be delivered within a specific timeframe.

Training that aligns with identified core capabilities

In 2009, the Heart Research Centre developed a training program addressing knowledge, attitudes and skills for self-management support. This program covered the development of patient centred communication skills and increasing participants' capacity to support clients in their behaviour change. The program teaches participants to apply strategies from motivational interviewing and cognitive behaviour therapy to support Chronic Condition Self-Management (CCSM) in clients. The content of the program covers all of the skills and knowledge in the unit of competency 'Support Client Self-Management' (CHCICS406A) as specified by the Commonwealth of Australia Community Services Training Package.

Ten Core Capabilities

Overall, the face to face training program developed addresses ten core CCSM capabilities identified by Battersby and Lawn (2009). 'General patient centered capabilities' covered in the course include health promotion approaches, communication skills, assessment of self-management capacity, collaborative care planning and use of peer support. In addition, the 'behaviour change capabilities' covered in the course include models of behaviour change, motivational interviewing, collaborative problem definition, goal setting and goal achievement, structured problem solving and action planning.

Rural Workforce

An evaluation of the training, undertaken by the Heart Research Centre in 2009, demonstrated the efficacy of the face-to-face training in terms of increased confidence and positive practice changes amongst health professionals. The findings of that evaluation were presented to the Commonwealth Department of Health and Ageing in October 2009 (Higgins & Murphy, 2009). However the evaluation also identified rural and remote health professionals are limited in their ability to access such face to face training. Therefore alternative delivery methods for training and skilling up rural health professionals are required.

Online Training

Online learning is gaining traction as a method of overcoming barriers to participation in training experienced by health professionals in a range of settings. Such training is acceptable to health professionals who appreciate the convenience of being able to access training in their own workplace. The translation of the Heart Research Centre's face to face CCSM training package into the 'Supporting chronic disease self-management' online training package was developed by Edmore, an organisation that specialises in online training of health professionals. This training now provides accessibility and affordability for rural and remote health professionals.

6. Training Delivery

The Project Officer, following research, identified the most relevant and suitable training for health professionals in the Ovens Murray Goulburn areas. The following information is sourced from the Australian Centre for Heart Health https://www.australianhearthealth.org.au/.

6.1 Online Modules: Content

Online Training 'Supporting Chronic Disease Self-Management'

This online course covers the basic principles, skills and strategies, including effective communication and behavioural goal setting, motivational interviewing and cognitive strategies, to assist health practitioners to support self-management and behaviour change in people with chronic disease.

Module 1: Understanding chronic disease self-management

In this introductory module you will learn about the importance of chronic disease self-management in everyday practice and the range of common emotional reactions to a chronic disease. You will be introduced to key methods to assist in a client's behaviour change.

By the end of the module you will:

- Understand the importance of chronic disease self-management in everyday practice
- Understand the range of common emotional reactions to a chronic disease
- Be introduced to key methods to assist in a client's behaviour change.
-

Module 2: Behavioural goal setting

This module explains the use of behavioural goal setting as an effective strategy for supporting client self-management.

You will learn about how to:

- Communicate and motivate to encourage client self-management;
- How to personalise client management discussions and address barriers for behaviour change;
- How too effectively help the client set goals using the BeSMART goal setting tools.

Module 3: Effective communication

This module will develop your capacity to effectively communicate with clients to support discussions around self-management.

You learn how to:

- Engage in effective questioning to encourage communication and self-management;
- How to engage in active listening to encourage effective communication and self-management;
- How to identify and overcome potential barriers to effective communication.

Module 4: Cognitive strategies

This module will further support the development of your skills to encourage behaviour change for effective chronic disease self-management.

In this module you will learn about:

- The link between thoughts, feelings and actions
- The difference between thoughts and feelings
- How unhelpful thinking can lead to poor lifestyle choices
- How helpful thinking can support lifestyle change
- How to support clients to address unhelpful thinking.

Module 5: Motivational interviewing

This module will further support the development of your skills to facilitate behaviour change and encourage effective chronic disease self-management.

In this module you will learn about:

- The principles of Motivational Interviewing in relation to stages of change
- How to apply the key principles and strategies of Motivational Interviewing to support chronic disease self-management
- How to strengthen client motivation to maximise adherence to behaviour change and success with their chronic disease self-management

6.2 Training: Eligibility and Registration

Training Eligibility

The eligible workforce would be the Primary Healthcare Workforce of the member agencies within the 4 Primary Care Partnership catchments in the Ovens, Murray and Goulburn areas that participate in the implementing of the Chronic Care Strategy.

Training Registrations

The project was able to fund 100 registrations for the online training. The invitation to participate in training was distributed via the same means as that of the Survey with the addition of Jodie Nolan, Project Officer, Rural Workforce, East Division Health, via her email distribution list. Within 5 working days, Central Hume Primary Care Partnership received more than 100 Expressions of Interest for the training. Training registrations were allocated on receipt of the Expressions of Interest 'first come, first served'.

All registrants are working with the clients that are within the continuum of care from early disease through to complex. Thirty nine registrations alone were from the Health Independence Teams which work with our clients that require intensive care coordination and self-management support. The balance of the registrants also works with clients that require self-management support from early stages of chronic disease to established chronic disease with complications.

Summary of Registrations by Primary Care Partnership area

REGISTRATIONS	Total Ovens Murray Goulburn Areas	Number (n) = 100
	Central Hume PCP	15% (n=15)
	Goulburn Valley PCP	39% (n=39)
	Upper Hume PCP	38% (n=38)
	Lower Hume PCP	8% (n=8)

Summary of Registrations by Organisation

Organisation	Team/Program Area	Number Registered
Albury Wodonga Health	Heath Independence Program	16
	Chronic Pain Management Program	6
Alpine Health	Early Intervention Team	3
Beechworth Health Service	Primary Health Team	7
Benalla Health	Health Independence Program	6
Cobram District Health	Community Services Team	3
Gateway Health Wangaratta	Allied Health Team	1
	District Nursing Service	2
Goulburn Valley Health	Physiotherapy Team	1
	Diabetes Centre Team	1
	Social Work Department	3
	Speech Pathology	3
	Hospital Admission Risk Program	12
	Community Rehab Centre	6
	Rural Allied Health Team	2
	Nutrition and Dietetics	3
Indigo North Health	Primary Care Team	9
Kilmore Hospital	District Nursing Service	3
Northeast Health Wangaratta	Community Services	3
Numurkah District Health Service	Primary Health	5
Seymour Health	Health Independence Program	5
Total Registered for Online Training		**100**

7. Project Findings

Implications of the data and suggested responses.

Identified gaps that require additional training requirements.

Capability Gaps	Potential Training	Possible Key Stakeholder
Cultural Awareness	Aboriginal Cultural Competency Training	Hume Region Aboriginal Health Steering Committee
Interpreter Service	Working with Interpreters	Department of Health and Human Services
Psychosocial assessment and support skills	Psychosocial assessment and support skills training	Hume Allied Health Education Group
Difficulty engaging challenging client groups	Bridges out of Poverty	*Integrated Health Promotion Coordinators for Ovens Murray Goulburn Region
Health Literacy	State-wide PCP Online Health Literacy Training (NB. this project has funded $8,000 towards development of the Online Health Literacy Training)	Ovens Murray & Goulburn Primary Care Partnerships will deliver training when authorised for release later this year.

*Bridges Out Of Poverty Training

The Ovens Murray Goulburn Integrated Health Promotion Coordinators have identified the need for delivery of the Bridges out of Poverty Training. This training will allow the health promotion and prevention workforce to also integrate and align self-management behaviour change approaches. The coordinators have developed costings and have no budget to support cost. A *high risk* has been identified regarding unmet costs and how funding shortfall would be funded if insufficient enrolments are obtained. The coordinators have approached their Primary Care Partnerships and only two are able to assist with funding.

The purpose of the *'Bridges out of Poverty'* workshop is to optimise community and economic sustainability, increase practitioner efficacy and enhance outcomes for people who can find themselves trapped in situations of disadvantage. It explores the impact of economic diversity in our country, considers the root causes of poverty and presents proven and realistic strategies and pathways to provide constructive and sustainable assistance to growing numbers of people caught in this cycle. The '*Bridges out of Poverty'* workshop will provide participants with the knowledge, understanding and tools to tackle sensitive issues in respectful and constructive ways. It offers solutions that are practical and strategic, addressing everyday interactions through to policy implications in every sector, from justice, health and housing, education and employment, through to transport and training.

Estimated Costing:

Bridges out of Poverty Costing		
One day workshop (75 participants)		
Item	**Cost (ext. Gst)**	**Cost (inc GST)**
Trainer	$7,500	$8,250
Travel	$950	$1,045
Venue	$500	$550.00
Catering ($20/p)		$1,500.00
Miscellaneous		$250
Workbooks ($15/p)		$1,125
Total		**$12,720**

Increase awareness of the Ovens Murray Goulburn Chronic Care Strategy, objectives, related projects and resources.

Recommended Communication Strategy			
Objective	**Strategy**	**Rationale**	**Action**
Shift communication from informal to formal channels	Create focused, timely, relevant and consistent communications	Facilitate formal communication to encourage clear and succinct communication of the Chronic Care Strategy	Six monthly newsletter distributed to Primary Health Workforce to update on Chronic Care Strategy objectives
Support the vision and priorities	Sharing of information	Sharing best practices and service improvements provides the opportunity to acquire knowledge, strategies & activities to improve effective interventions .	Six monthly request for best practice submissions to identify regional Chronic Care activities
Promote a sense of regional pride	Acknowledging regional successes	Formally recognising best practice and service improvements achievements that align with the Chronic Care Strategy at a team, organisational, and partnerships levels .	All service improvement initiatives aligning with the Chronic Care Strategy are uploaded onto the Clearinghouse website under a regional initiatives section.

Create a sustainable Self-Management Support workforce.

Regional Community of Practice Overview.

Goal: A Self-Management Support Community of Practice (CoP) would bring together healthcare professionals to sustain and advance self-management skills and techniques. A shared goal would be to increase/improve/integrate self-management skills and techniques through knowledge exchange, skill development and integration of self-management support within healthcare practices with the aim to best assist clients living with chronic conditions to self-manage with confidence and knowledge.

Aim: The CoP would work collaboratively to address the needs of our primary healthcare workforce to deliver best practice knowledge dissemination and implementation. The CoP would engage in hosting and facilitating in-person case studies and self-management skills and techniques, follow-up and/or practice sessions.

Delivery: A virtual network, using a web-based seminar approach. A webinar is a presentation, lecture, workshop or seminar that is transmitted over the Web using video conferencing software. A key feature of a Webinar is its interactive elements: the ability to give, receive and discuss information in real-time.

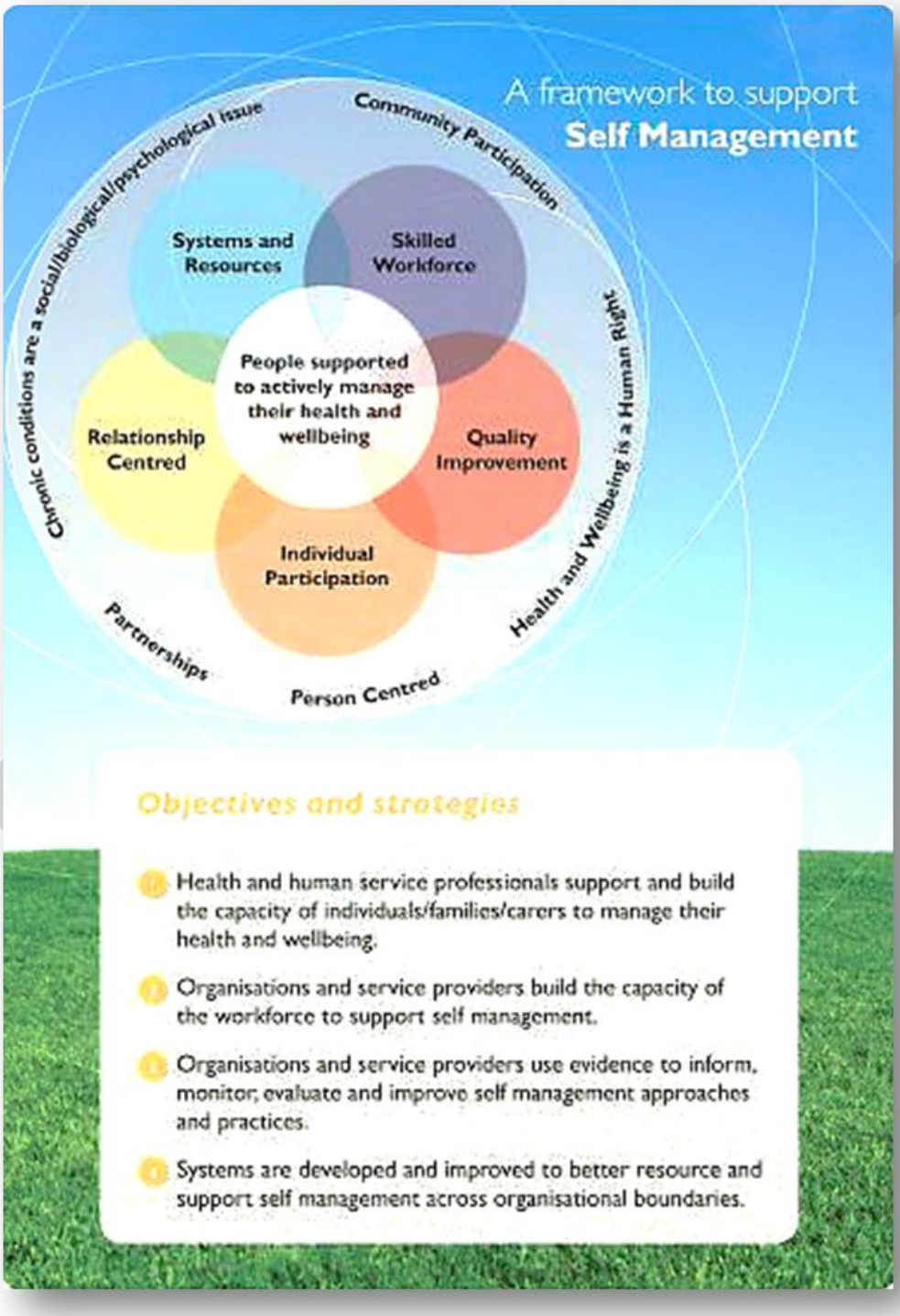
Using Webinar software participants can share audio, documents and applications with webinar attendees. This is useful when the webinar host is conducting an lecture or information session. While the presenter is speaking they can share desktop applications and documents. The webinar even has an option for recording.

It is envisaged that the CoP would utilise a web-based platform such as the Ovens Murray Goulburn Clearinghouse, which would centralise self-management support training videos, training notices, resources and discussion boards.

Team: The CoP would require leadership by someone competent in Chronic Disease Management specialised in Self-Management Support. The Integrated Care Coordinator, Central Hume Primary Care Partnership has a post graduate diploma in Chronic Disease Management and would be a potential coordinator for this Community of Practice. It would require a team to manage and ensure its success. It would require someone competent in providing administrative support as well as someone competent in IT using web based platforms and software. The opportunity to maintain sustainability would also require someone that would be willing to be mentored to continue and develop the CoP into the future.

Build self-management approaches and practices into planning, development, implementation and evaluation.

Conceptual Diagram from DHHS Tasmania



8. Recommendations

The following are recommendations for sustainability of ongoing self-management support capacity building in the Primary Healthcare Workforce for Ovens Murray Goulburn areas of East Division, Department of Health and Human Services of Victoria.

8.1 Recommendation 1.

Continuation of identified training needs. The Ovens Murray Goulburn Chronic Care Steering Committee to engage key stakeholders to support identification, development, and/or delivery of training. This will continue to support the additional identified gaps in capabilities that were not covered in the online training *'Supporting Chronic Disease Self-Management'.*

8.2 Recommendation 2.

The Ovens Murray and Goulburn Chronic Care Steering Committee to increase awareness within the primary health workforce of the Ovens Murray and Goulburn Chronic Care Strategy and related projects, resources and objectives by implementing a communication strategy.

8.3 Recommendation 3.

Establishment of a Regional Self-Management Support Community of Practice (CoP) will transition the primary health workforce from a skilled workforce into a competent workforce.

8.4 Recommendation 4.

Develop and implement a Self-Management Support Framework. A move to supporting self-management support as a region will require significant change and a strategic approach is recommended. Establishment of a Chronic Care Steering Committee sub-group called the Self-Management Support Framework Reference Group could be formed to develop and implement the Ovens Murray Goulburn Self-Management Support Framework.

References

Higgins, R. M. (2012). Supporting chronic disease self-management:translating policies and principles into clinical practice. *Australian Journal of Primary Health*, 80-87.

Lawn S, B. M. (2009). *Capabilities for Supporting prevention and Chronic Condition Self-Management: A Resource for Educators of Primary Health Care Professionals.* Flinders University, Adelaide: Department of Health and Ageing.

National Health Priority Action Council. (2006). *National chronic disease strategy.* Canberra: Australian Government Department of Health and Ageing. Retrieved from Australian Governement Department of Health and Ageing.

Pan American Health Organisation. (2002). Definition of competency. Washington DC.

World Health Organisation. (2005). Preparing a health care workforce for the 21st century. Geneva.

Appendix A. Sample Survey

Self-Management Support Training Needs Analysis

Introduction

The Victorian Department of Health and Human Services Eastern Division is funding the Primary Health Workforce Capacity Building for Self-Management Support project. Central Hume Primary Care Partnership is the project lead.

This project is part of the work associated in the implementation of the Ovens Murray and Goulburn Chronic Care Strategy and aims to increase workforce confidence by building capability in self-management support. This Training Needs Survey will help identify what training is required to build workforce capacity in self-management support.

This survey was developed by Leanne Cleeland, Integrated Care Coordinator, Central Hume Primary Care Partnership.

Information provided will be kept confidential and will only be used for the purposes of workforce development planning.

Self-Management Support Training Needs Analysis

Demographic Information

* 1. **Which Primary Care Partnership catchment do you work in? (refer to map below)**

Hume Region - Primary Care Partnerships

* 2. **Please tick your Organisation you are completing this survey for?**

- ◯ Albury Wodonga Aboriginal Health Service
- ◯ Albury Wodonga Health
- ◯ Alexandra District Hospital
- ◯ Alpine Health
- ◯ Beechworth Health Service
- ◯ Benalla Health
- ◯ Cobram District Health
- ◯ Gateway Health Wangaratta
- ◯ Gateway Health Wodonga
- ◯ Goulburn Valley Health
- ◯ Indigo North Health
- ◯ Kilmore & District Hospital
- ◯ Mansfield District Hospital
- ◯ Mungabareena Aboriginal Corporation
- ◯ Nathalia District Hospital
- ◯ Nexus Primary Health
- ◯ Northeast Health Wangaratta
- ◯ Numurkah District Health Services
- ◯ Primary Care Connect
- ◯ Rumbalara Aboriginal Cooperative
- ◯ Seymour Health
- ◯ Tallangatta Health Service
- ◯ Upper Murray Health & Community Services
- ◯ Walwa Bush Nursing Centre
- ◯ Yarrawonga Health
- ◯ Yea & District Hospital

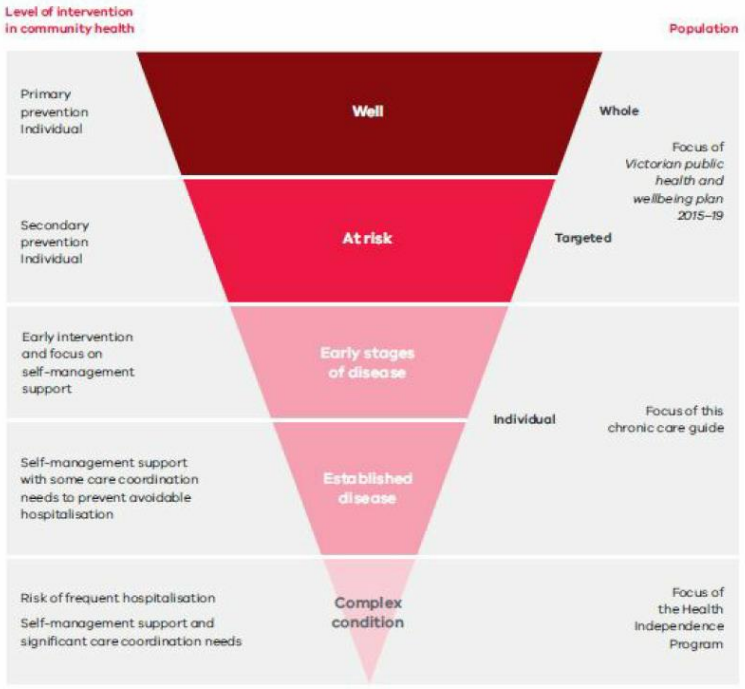
Other (please specify)

* 3. Which Department do you work in?

- ◯ Community Health
- ◯ Other (please specify)

* 4. What is your Clinical Discipline?

Figure 1: Continuum of care and intervention points for chronic conditions



Note: 'Self-management support' refers to all types of interventions offered by community health, including education, treatment, linking with peers and group programs, and social and psychological support.

* 5. Please select a population group that you primarily work with (refer to Figure 1. above)?

Self-Management Support Training Needs Analysis

Previous Training

* 6. **Please tick which training you have already done.**

- [ ] Cross Cultural awareness and communication
- [ ] Client Centred Care
- [ ] Working with interpreters and translators
- [ ] Health Change Australia Core Training Part 1 Workshop
- [ ] Health Change Australia Core Training Part 2 Workshop
- [ ] Health Change Australia Core Training for Managers
- [ ] Health Change Australia Peer Support Leader
- [ ] Health Change Australia Train the Trainer Program
- [ ] Health Change Australia Practice Leader Support Program
- [ ] Graduate Certificate in Chronic Condition Management
- [ ] Health Literacy
- [ ] Graduate Diploma in Chronic Condition Management
- [ ] Master of Public Health (Chronic Condition Management)
- [ ] Flinders Chronic Condition Management Program
- [ ] Flinders Accredited Trainer Program
- [ ] Flinders Closing the Gap Program
- [ ] Flinders Living Well, Smoke Free
- [ ] Consumer Directed Care and Goal Setting
- [ ] Motivational Interviewing
- [ ] Cognitive Behavioural Therapy
- [ ] Chronic Disease Self-Management Support Program
- [ ] QUIT Educator
- [ ] None of the above

Other (please specify)

Self-Management Support Training Needs Analysis

Barriers & Enablers for putting training into practice

* 7. **What has ENABLED you to translate new knowledge and skills learned in previous training in to your practice? Please tick all that apply**

- [ ] Nothing
- [ ] Clinical Supervision
- [ ] Team Support
- [ ] Local peer support network
- [ ] Systems in place
- [ ] Supportive organisation
- [ ] Follow up training sessions/support
- [ ] Resources/references (e.g. guidelines, education resources)
- [ ] Course materials/handouts
- [ ] Support from professional associations
- [ ] Support from regional peer networks
- [ ] Support from Primary Care Partnerships

Other (please specify)

* 8. **Have you experienced any BARRIERS in translating new knowledge and skills into your clinical practice following training? Please tick all that apply**

- [ ] No
- [ ] Lack of clinical supervision
- [ ] Lack of peer support network
- [ ] Lack of systems in place
- [ ] Lack of organisational or management support
- [ ] Lack of resources
- [ ] Lack of time
- [ ] Difficulty applying with some client groups
- [ ] Lack of follow-up training sessions/support

Other (please specify)

Self-Management Support Training Needs Analysis

Chronic Disease Management

* 9. **How aware are you with the following resources? Please click on the most relevant answer.**

	Never heard of it	Aware of it	Refer to it
Hume Region Chronic Care Strategy 2012-2022	○	○	○
Ovens, Murray & Goulburn Area Chronic Clearinghouse	○	○	○
Care for People with Chronic Conditions - Guide for the Community Health Program	○	○	○

Self-Management Support Training Needs Analysis

Supporting Chronic Condition Self-Management Capabilities

* 10. **How confident are you in delivering 'Health Promotion' approaches?**

What it is: Health Promotion is any work which actively and positively supports people, groups, communities or entire populations to be healthy. It does not focus on sickness, but on building capacity. It includes building health public policy, creating supportive environments, strengthening community action, developing personal skills and re-orientating health care services towards prevention of illness and promotion of health. It involves working with people and communities as they define their goals, mobilise resources and develop action plans for addressing problems they have collectively identified.

* 11. **How confident are you in conducting an assessment of health risk factors?**

What it is: Assessment of health risk factors is the identification of predisposing factors (smoking, nutrition, alcohol, physical activity, stress) that may lead to future health problems for the patient.

* 12. **How confident are you in your communication skills?**

What it is: Effective communication skills involves the ability to establish and develop mutual understanding, trust, respect and cooperation with your patient. It is the ability to express oneself clearly so the other person understands, and to listen and interpret effectively to understand what the other person is trying to express. In this context, it includes communication between patients and primary healthcare workers, as well as communication between staff in primary healthcare teams and with other service providers.

* 13. **How confident are you to conduct an assessment of self-management capacity?**

What it is: Is the assessment to identify patient's health beliefs, knowledge, attitudes, behaviours, strengths, barriers, readiness to change (motivation), confidence (self-efficacy) and the importance they place on their health (priority). It may also include an assessment of carers/family capacity to support self-management.

* 14. **How confident are you in collaborative care planning?**

What is it: Collaborative care planning is the process in which all those involved in the organising, provision and receipt of care are actively involved in the planning and decision-making surrounding that care.

* 15. **How confident are you in recommending the use of peer support networks/groups(within chronic disease self-management context)?**

What it is: Peer support is provided by people with a 'lived experience' of effectively self-managing chronic conditions who can therefore act as positive role models for others with chronic conditions.

* 16. **How confident are you in cultural awareness and interpreter service utilisation?**

What is it: Cultural awareness entails an understanding of how a patient's culture may inform their values, behaviour, beliefs, and basic assumptions. It involves understanding the local community and it needs, and specific communication skills that are culturally respectful. This may involve the effective use of interpreters to accurately relay and receive what is communicated between the worker and the patient and their carers/family.

* 17. **How confident are you in conducting a psychosocial assessment?**

What is it: The ability of health professionals to identify, build and sustain positive aspects of psychosocial health such as resilience, strengths and coping skills with the patient and their carers. Psychosocial support by health professional and others are interventions and methods that enhance the individuals ability to cope, and to achieve personal and social wellbeing; enabling them to experience love, protection, and support that allows them to have a sense of self-worth and belonging.

* 18. **How confident are you applying models of 'behaviour change approach' techniques?**

What is it: Health behaviour change techniques are models which help us to understand human behaviour and how to change it. This involves theoretical understanding of the mechanisms involved in the choices people make in their lives and how to engage them in the process of change.

Various models exist including:

- The Health Belief Model
- Theory of Reasoned Action & Theory of Planned Behaviour
- Social Learning Theory
- Transtheoretical (Stages of Change) Model
- Health Promotion Model
- The 5As Model
- Cognitive Behavioural Therapy

* 19. **How confident are you using motivational interviewing techniques?**

What is it: Motivational interviewing techniques is a process undertaken with a person to support their behaviour change. This process involves encouraging the person to talk, generate self-motivational statements, deal with resistance, develop readiness to change and negotiate a plan, developing determination and action. The 5 principles underlying the process are expressing empathy, developing discrepancy, avoiding arguing, rolling with resistance and supporting self-efficacy. Motivational Interviewing embodies cognitive change skills.

* 20. **How confident are you in providing collaborative problem solving?**

What is it: Having an open dialogue with the patient about what they see as their main problem, what happens because of the problem, and how the problem makes them feel.

* 21. **How confident are you in goal setting and achievement?**

What is it: Goal setting is the process of deciding what one wants, planning how to get it, and then working towards the objective of achieving it, usually by ensuring that it is a SMART (specific, measurable, achievable, realistic, and timely) goal. In the health context, goal setting can be done by the patient alone or with the support of others to help formulate the goal and help the patient to remain motivated to achieve it, i.e. involving collaboration goal setting, problem-solving and other goal attainment skills.

* 22. **How confident are you in structured problem solving and action planning?**

What is it: The ability to systemically assist a patient to learn the skill of problem solving i.e. identifying and analysing practical issues that arise in a certain situation and to determine options for a practical solution to overcome this.

Self-Management Support Training Needs Analysis

Next Step

This information will be compiled and analysed to identify the gaps in capability and identify appropriate training options.

Self-Management Support Training Needs Analysis

Thank you

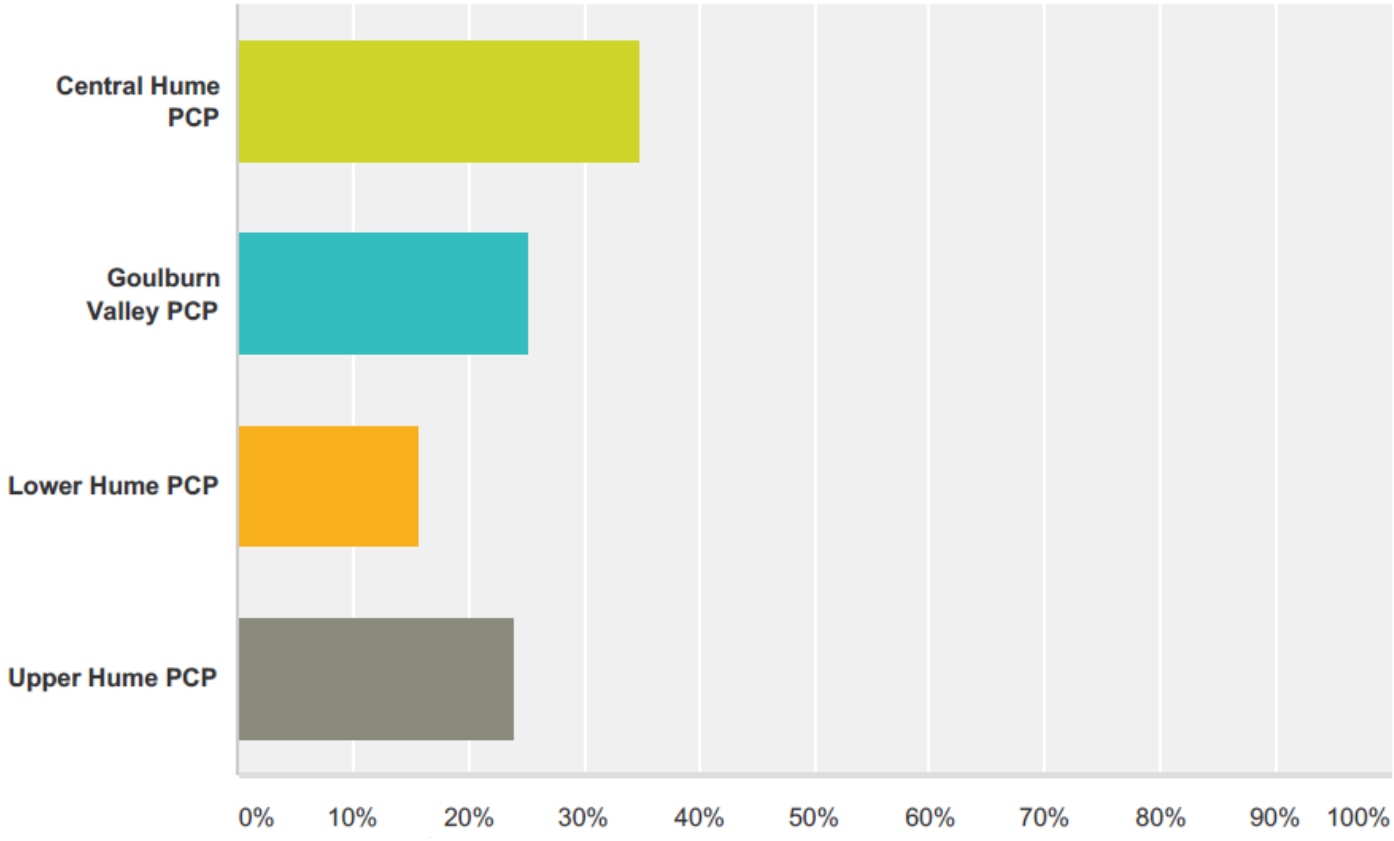
Thank you for your time and participation in this survey.

Appendix B. Survey Results

Self-Management Support Training Needs Analysis

Q1 Which Primary Care Partnership catchment do you work in? (refer to map below)

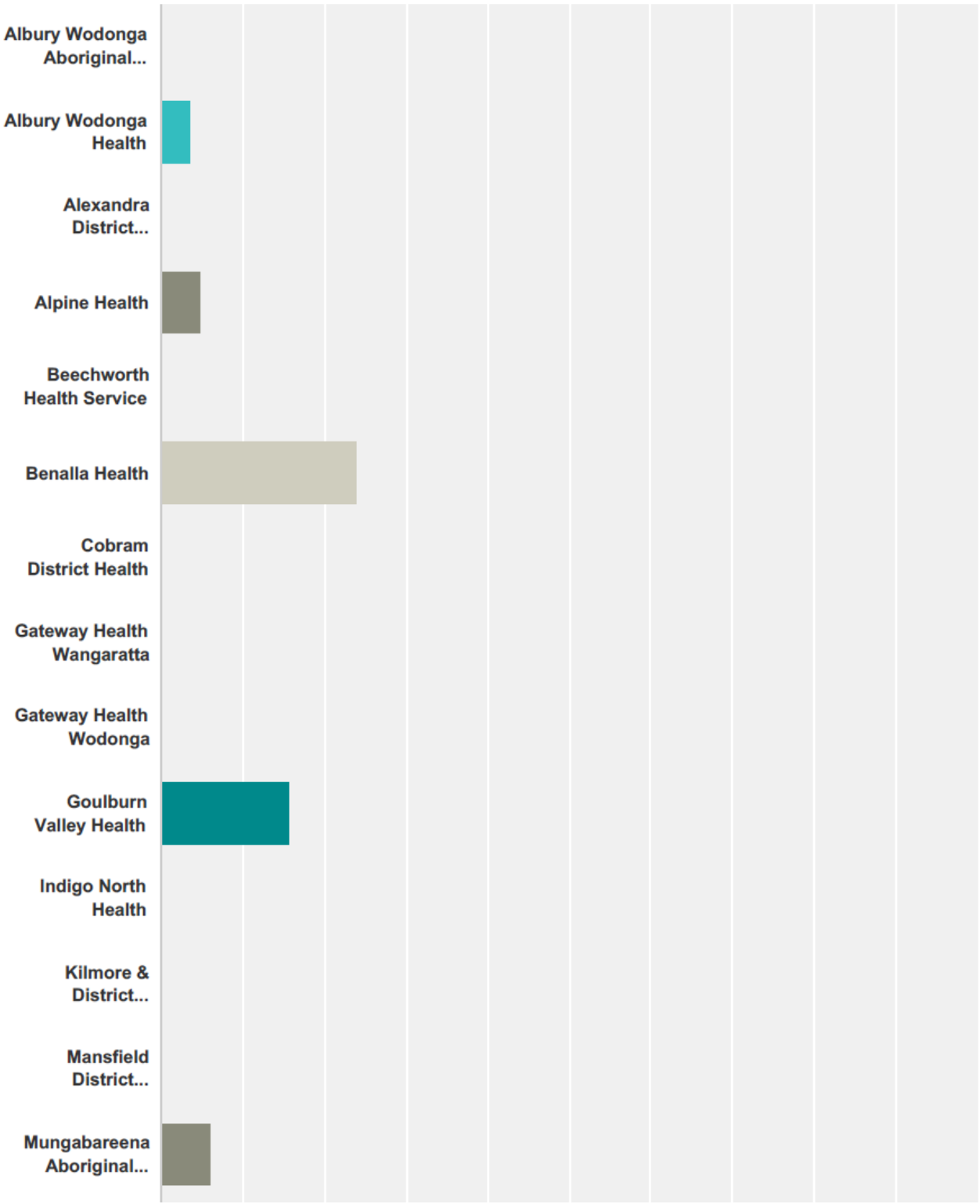
Answered: 83 Skipped: 0

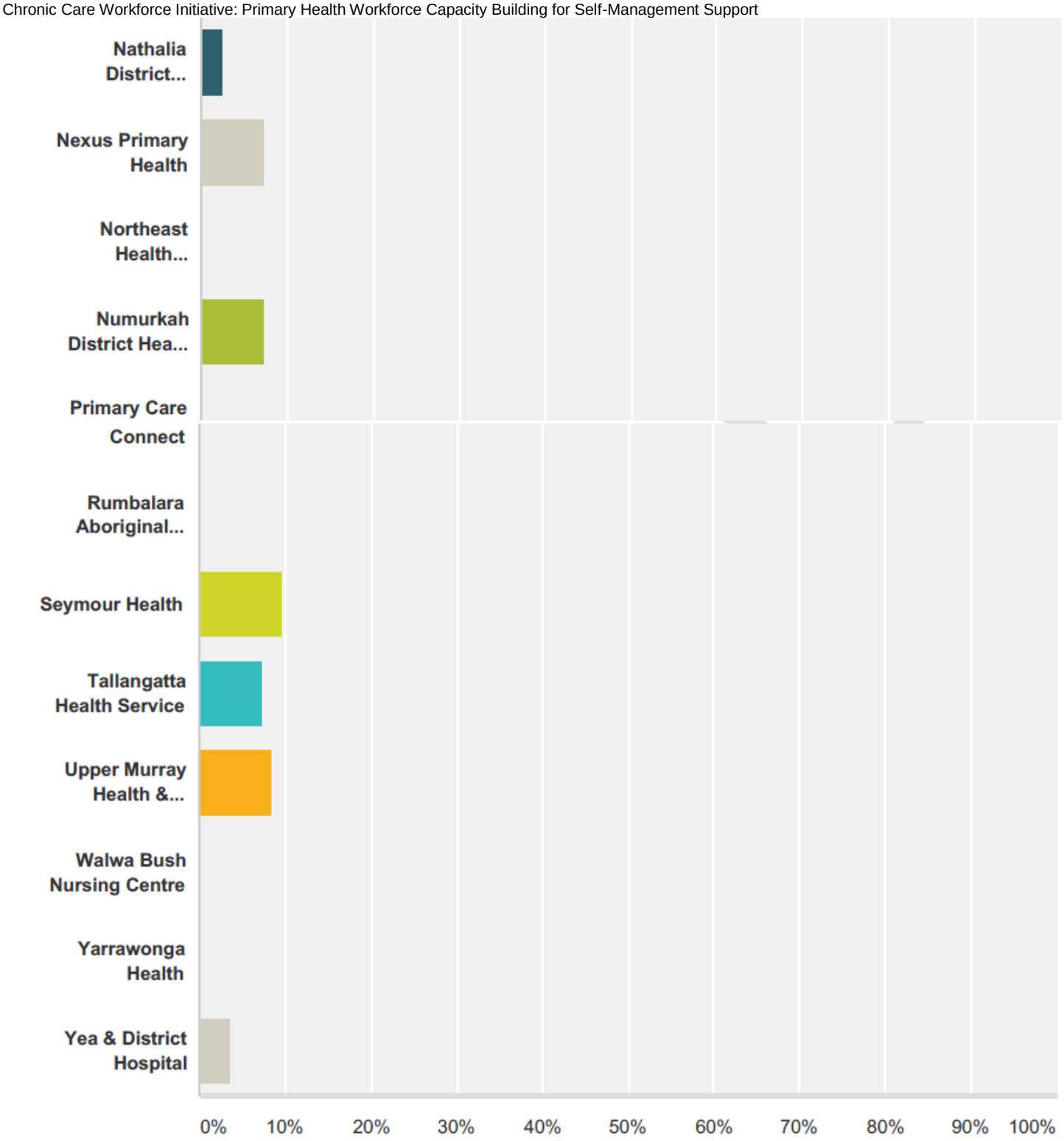


Answer Choices	Responses	
Central Hume PCP	34.94%	29
Goulburn Valley PCP	25.30%	21
Lower Hume PCP	15.66%	13
Upper Hume PCP	24.10%	20
Total		83

Q2 Please tick your Organisation you are completing this survey for?

Answered: 83 Skipped: 0

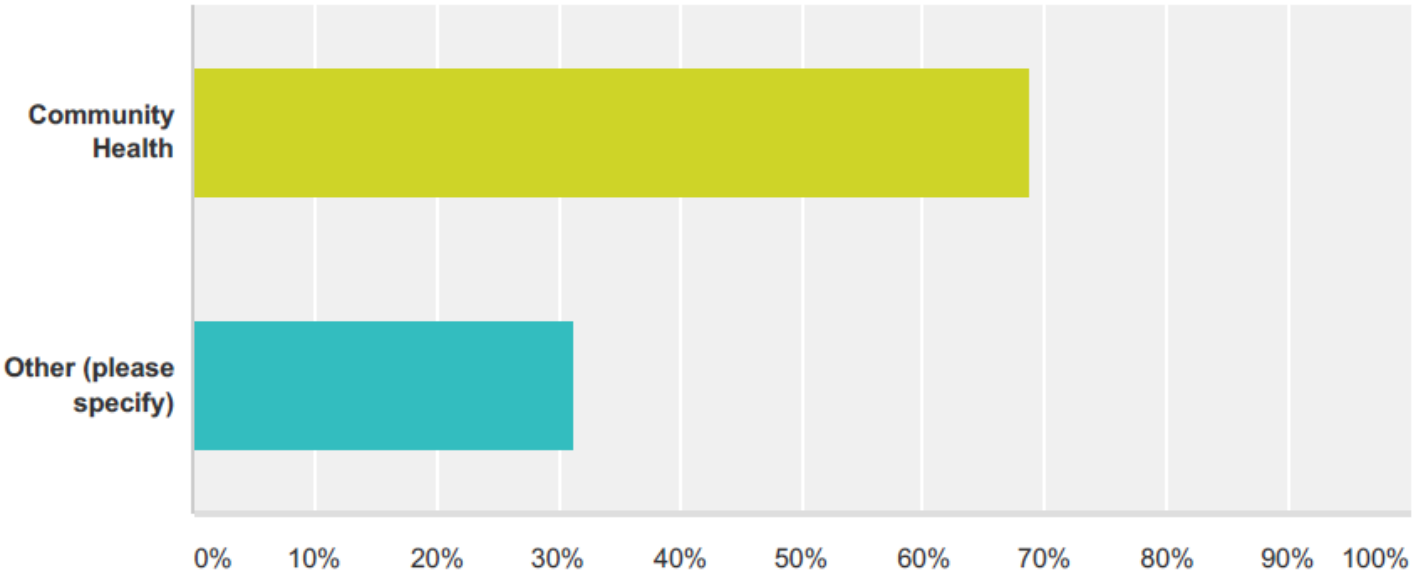



Nathalia District...
Nexus Primary Health
Northeast Health...
Numurkah District Hea...
Primary Care Connect
Rumbalara Aboriginal...
Seymour Health
Tallangatta Health Service
Upper Murray Health &...
Walwa Bush Nursing Centre
Yarrawonga Health
Yea & District Hospital
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

Answer Choices	Responses	
Albury Wodonga Aboriginal Health Service	**0.00%**	0
Albury Wodonga Health	**3.61%**	3
Alexandra District Hospital	**0.00%**	0
Alpine Health	**4.82%**	4
Beechworth Health Service	**0.00%**	0
Benalla Health	**24.10%**	20
Cobram District Health	**0.00%**	0
Gateway Health Wangaratta	**0.00%**	0
Gateway Health Wodonga	**0.00%**	0
Goulburn Valley Health	**15.66%**	13
Indigo North Health	**0.00%**	0
Kilmore & District Hospital	**0.00%**	0
Mansfield District Hospital	**0.00%**	0
Mungabareena Aboriginal Corporation	**6.02%**	5
Nathalia District Hospital	**2.41%**	2
Nexus Primary Health	**7.23%**	6
Northeast Health Wangaratta	**0.00%**	0
Numurkah District HealthServices	**7.23%**	6
Primary Care Connect	0.00%	0
Rumbalara Aboriginal Cooperative	0.00%	0
Seymour Health	9.64%	8
Tallangatta Health Service	7.23%	6
Upper Murray Health & Community Services	8.43%	7
Walwa Bush Nursing Centre	0.00%	0
Yarrawonga Health	0.00%	0
Yea & District Hospital	3.61%	3
Total		83

Q3 Which Department do you work in?

Answered: 83 Skipped: 0



Answer Choices	Responses	
Community Health	68.67%	57
Other (please specify)	31.33%	26
Total		83

#	Other (Please Specify)	Date
1	aged care nursing	4/17/2017 6:01 PM
2	Medical Centre, Corryong	4/13/2017 11:48 AM
3	General Practice	4/12/2017 1:01 PM
4	regional assessment	4/11/2017 2:18 PM
5	Education	4/10/2017 3:02 PM
6	District Nursing	4/6/2017 3:26 PM
7	Education	4/5/2017 5:21 PM
8	Education	4/5/2017 5:01 PM
9	Health Independence Programs	4/4/2017 5:31 PM
10	Ambulatory Care Centre	4/4/2017 11:54 AM
11	Urgent Care	4/4/2017 10:20 AM
12	Ambulatory Care Centre	4/4/2017 9:43 AM
13	Acute and Aged Care	4/4/2017 12:20 AM
14	Home and Community Care, Commonwealth Home Support Program, ECIS, Slow to Recover Programme.	4/3/2017 4:32 PM
15	Ambulatory Care- Health Independence Program	4/3/2017 3:51 PM
16	HARP from Seymour Hospital	4/3/2017 3:28 PM
17	Aboriginal Corporation	4/3/2017 10:09 AM
18	Aboriginal corporation	4/3/2017 9:42 AM
19	Nursing Admin	4/1/2017 9:35 PM
20	Acute ward, Urgent Care, Community Health	4/1/2017 2:34 AM
21	Midwifery	3/30/2017 8:14 PM
22	Medical Clinic	3/30/2017 2:30 PM
23	Early Intervention Team - Health Promotion	3/30/2017 10:37 AM
24	Clinical Services	3/30/2017 10:15 AM
25	Age Care	3/30/2017 12:43 AM
26	Physiotherapy	3/29/2017 4:50 PM

Q4 What is your Clinical Discipline?

Answered: 83 Skipped: 0

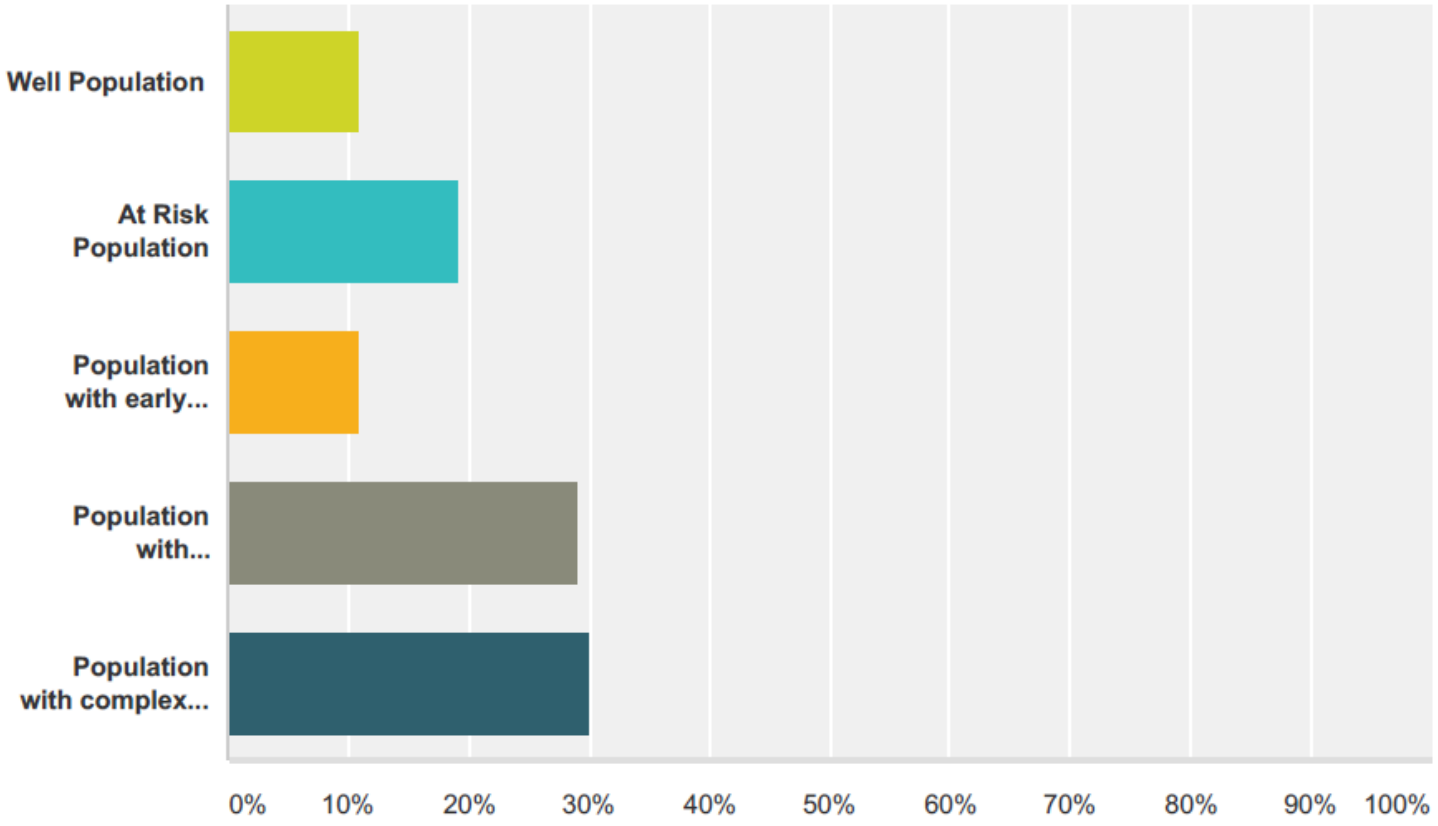
#	Other (Please Specify)	Date
1	Registered Nurse	4/18/2017 10:30 AM
2	Enrolled endorsed nurse	4/17/2017 6:01 PM
3	district nursing	4/13/2017 3:20 PM
4	Medical Imaging	4/13/2017 1:59 PM
5	Nursing - Credentialed Diabetes Educator	4/13/2017 11:48 AM
6	Dietitian	4/12/2017 4:27 PM
7	Practice Manager	4/12/2017 1:01 PM
8	Occupational Therapy	4/12/2017 11:49 AM
9	NURSING	4/12/2017 9:25 AM
10	Home Care	4/11/2017 5:00 PM
11	Social Work	4/11/2017 3:03 PM
12	Allied Health Assistant	4/11/2017 2:50 PM
13	OT	4/11/2017 2:28 PM
14	regional assessmemt officer	4/11/2017 2:18 PM
15	Community nursing	4/11/2017 12:33 PM
16	AHA	4/11/2017 11:48 AM
17	OT	4/10/2017 3:07 PM
18	Perioperative	4/10/2017 3:02 PM
19	Diabetes Education	4/7/2017 4:13 PM
20	AHA	4/7/2017 9:35 AM
21	None	4/6/2017 5:47 PM
22	Nursing	4/6/2017 3:26 PM
23	PATHOLOGY	4/6/2017 2:43 PM
24	Diabetes	4/6/2017 10:49 AM
25	Health Coach	4/6/2017 10:15 AM
26	Key Worker	4/6/2017 9:31 AM
27	AOD Counsellor	4/6/2017 9:08 AM

#	Other (Please Specify)	Date
28	Endorsed Enrolled Nurse	4/6/2017 8:56 AM
29	Clinical Support Nurse	4/5/2017 5:21 PM
30	Nursing	4/5/2017 5:01 PM
31	occupational therapist - paediatric	4/4/2017 5:56 PM
32	Nursing	4/4/2017 5:31 PM
33	Psychology	4/4/2017 2:41 PM
34	Welfare	4/4/2017 11:54 AM
35	Case Management	4/4/2017 11:46 AM
36	Emergency Nursing	4/4/2017 10:20 AM
37	Registered Nurse -Palliative Care and District Nurse	4/4/2017 10:13 AM
38	Physiotherapy	4/4/2017 9:43 AM
39	Allied Health Assistant	4/4/2017 9:40 AM
40	Nurse	4/4/2017 9:38 AM
41	Registered Nurse	4/4/2017 12:20 AM
42	Occupational Therapist	4/3/2017 5:37 PM
43	allied health	4/3/2017 5:01 PM
44	physio	4/3/2017 4:58 PM
45	Speech Pathology	4/3/2017 4:32 PM
46	Occupational Therapist	4/3/2017 3:51 PM
47	Physiotherapist	4/3/2017 3:28 PM
48	Exercise Physiologist	4/3/2017 3:21 PM
49	Diabetes Education	4/3/2017 1:59 PM
50	Nursing	4/3/2017 1:18 PM
51	Podiatry	4/3/2017 1:14 PM
52	Physiotherapy	4/3/2017 12:42 PM
53	Nursing	4/3/2017 11:58 AM
54	Nursing	4/3/2017 11:13 AM
55	OT	4/3/2017 10:41 AM
56	Preventative	4/3/2017 10:23 AM

#	Other (Please Specify)	Date
57	prevention	4/3/2017 10:09 AM
58	Preventative	4/3/2017 10:06 AM
59	Preventative	4/3/2017 9:54 AM
60	speech pathology	4/3/2017 9:45 AM
61	Preventative	4/3/2017 9:42 AM
62	Primary Health	4/2/2017 3:22 PM
63	Nursing	4/1/2017 9:35 PM
64	Registered Nurse	4/1/2017 4:21 PM
65	Nursing/Midwifery	4/1/2017 2:34 AM
66	activity assistant	3/31/2017 3:52 PM
67	Nurse/Midwife	3/30/2017 8:14 PM
68	Clinic Manager	3/30/2017 2:30 PM
69	Speech Pathologist	3/30/2017 1:24 PM
70	Registered Nurse	3/30/2017 1:16 PM
71	Physiotherapy	3/30/2017 11:22 AM
72	Health Promotion	3/30/2017 10:37 AM
73	Social Worker	3/30/2017 10:34 AM
74	Health Promotion	3/30/2017 10:15 AM
75	Nursing	3/30/2017 10:15 AM
76	Physiotherapy	3/30/2017 10:10 AM
77	psychology	3/30/2017 9:48 AM
78	Div 2 Mern	3/30/2017 12:43 AM
79	Registered Nurse	3/29/2017 4:57 PM
80	AHA	3/29/2017 4:50 PM
81	Diabetes Education	3/29/2017 2:54 PM
82	Speech Pathology	3/29/2017 2:34 PM
83	Dietitian	3/29/2017 2:30 PM

Q5 Please select a population group that you primarily work with (refer to Figure 1. above)?

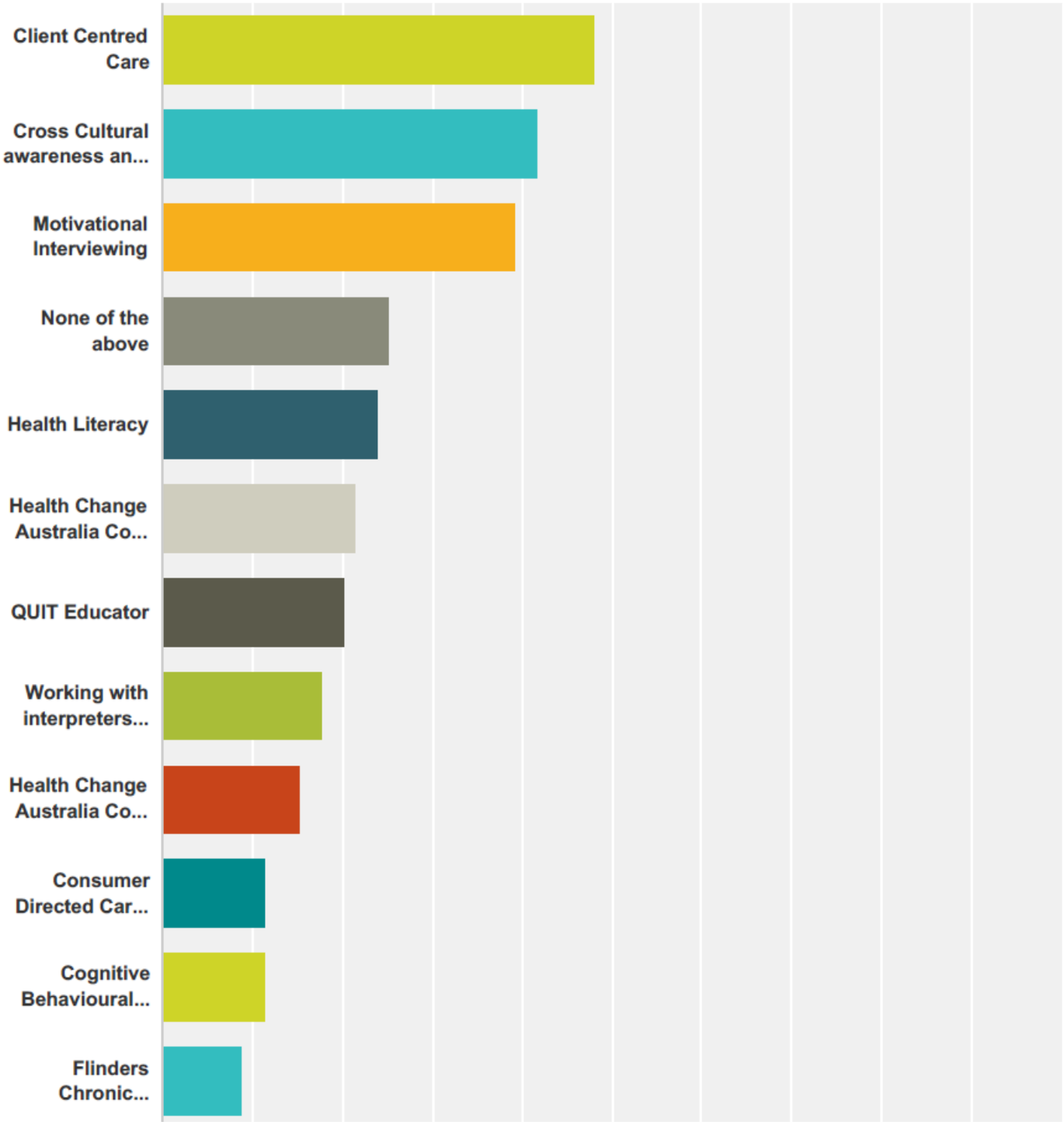
Answered: 83 Skipped: 0

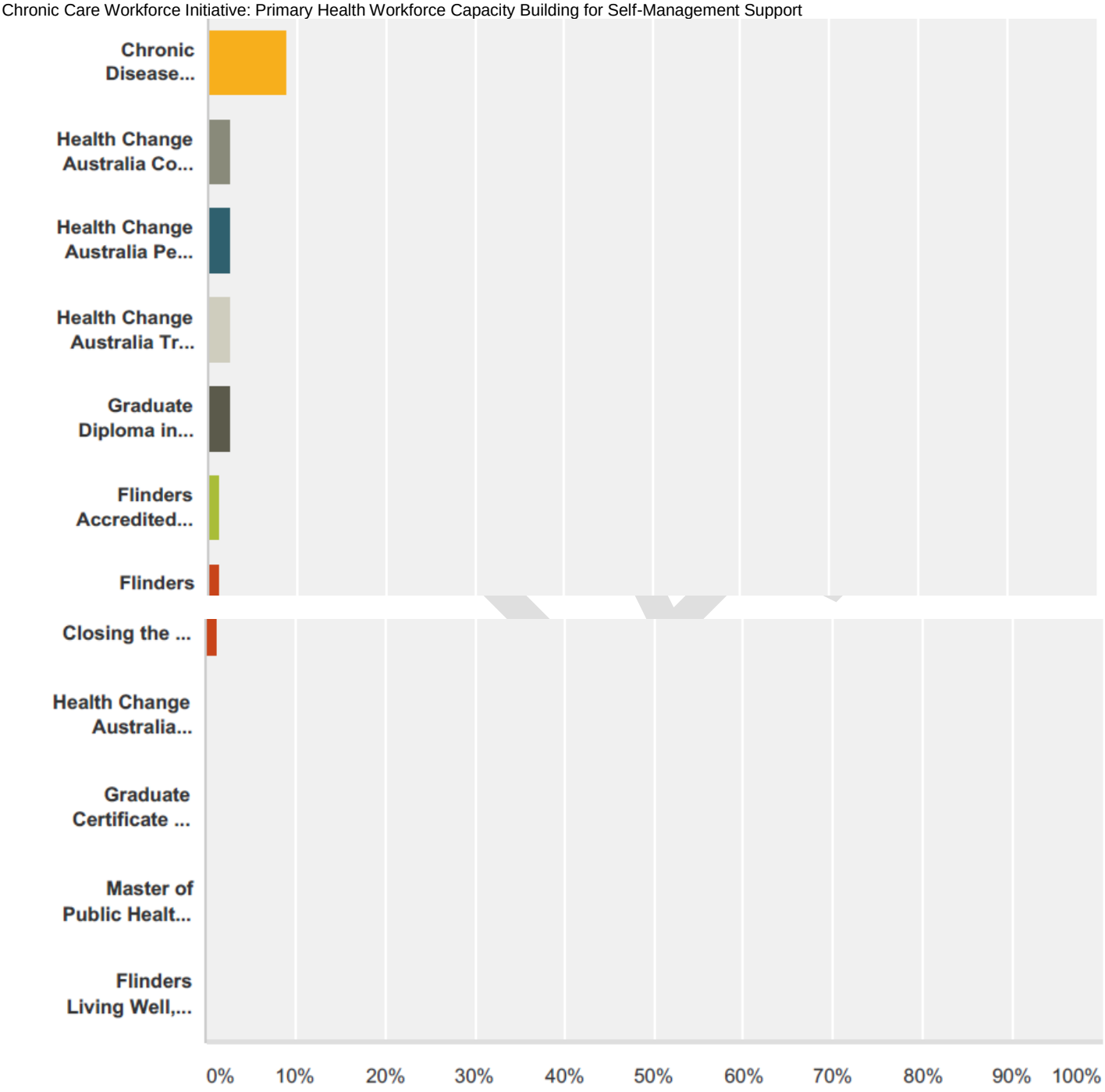


Answer Choices	Responses	
Well Population	10.84%	9
At Risk Population	19.28%	16
Population with early stages of disease	10.84%	9
Population with established disease	28.92%	24
Population with complex conditions	30.12%	25
Total		83

Q6 Please tick which training you have already done.

Answered: 79 Skipped: 4



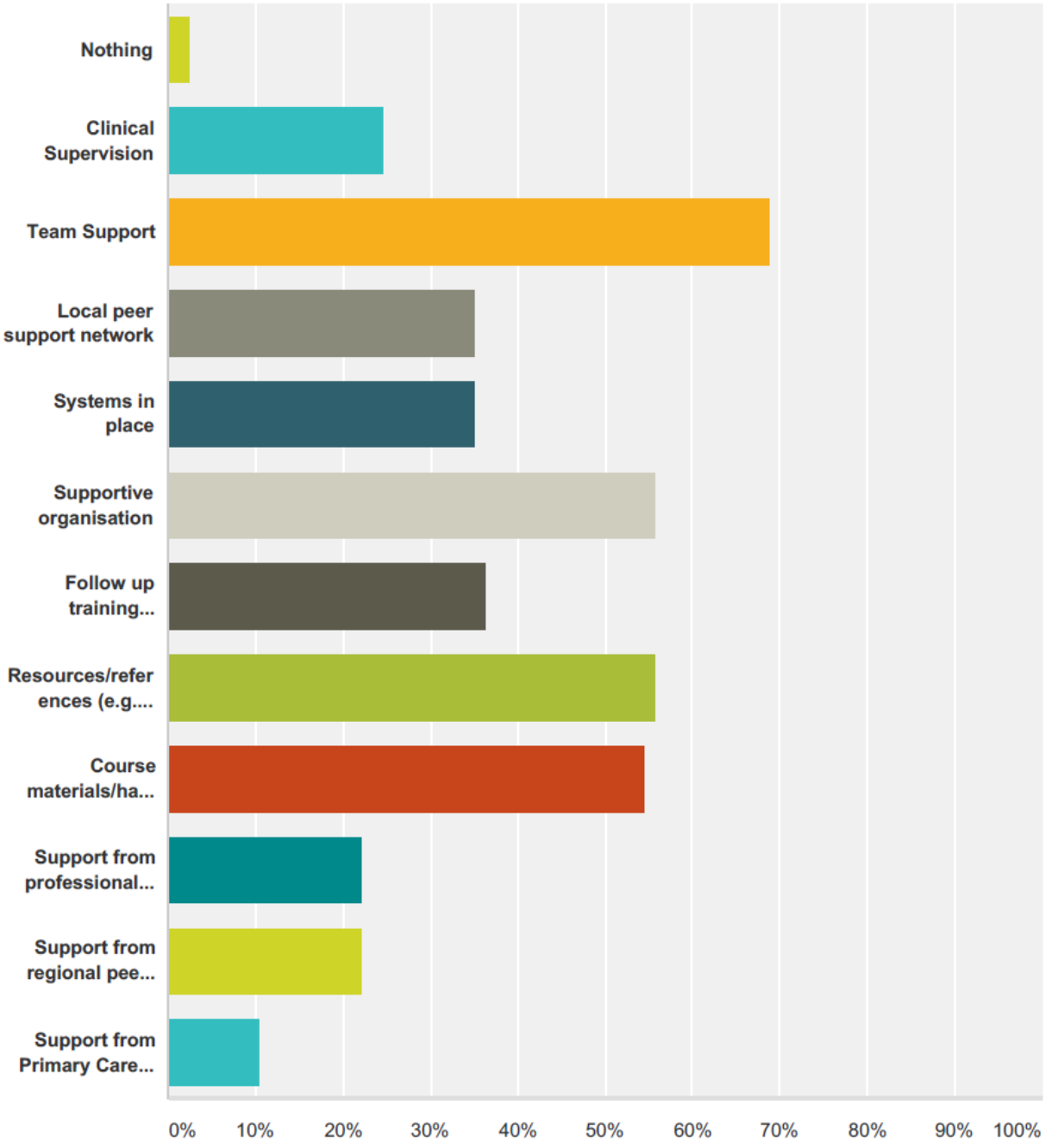

Chronic Disease...
Health Change Australia Co...
Health Change Australia Pe...
Health Change Australia Tr...
Graduate Diploma in...
Flinders Accredited...
Flinders
Closing the ...
Health Change Australia...
Graduate Certificate ...
Master of Public Healt...
Flinders Living Well,...
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

Answer Choices	Responses	
Client Centred Care	**48.10%**	38
Cross Cultural awareness and communication	**41.77%**	33
Motivational Interviewing	**39.24%**	31
None of the above	**25.32%**	20
Health Literacy	**24.05%**	19
Health Change Australia Core Training Part 1 Workshop	**21.52%**	17
QUIT Educator	**20.25%**	16
Working with interpreters and translators	**17.72%**	14
Health Change Australia Core Training Part 2 Workshop	**15.19%**	12
Consumer Directed Care and Goal Setting	**11.39%**	9
Cognitive Behavioural Therapy	**11.39%**	9
Flinders Chronic Condition Management Program	**8.86%**	7
Chronic Disease Self-Management Support Program	**8.86%**	7
Health Change Australia Core Training for Managers	**2.53%**	2
Health Change Australia Peer Support Leader	**2.53%**	2
Health Change Australia Train the Trainer Program	**2.53%**	2
Graduate Diploma in Chronic Condition Management	**2.53%**	2
Flinders Accredited Trainer Program	**1.27%**	1
Flinders Closing the Gap Program	**1.27%**	1
Health Change Australia Practice Leader Support Program	**0.00%**	0
Graduate Certificate in Chronic Condition Management	**0.00%**	0
Master of Public Health (Chronic Condition Management)	**0.00%**	0
Flinders Living Well, Smoke Free	**0.00%**	0
Total Responses		79

#	Other (Please Specify)	Date
1	Associate Diploma in Human Nutrition and Graduate Certificate in Diabetes Education	4/13/2017 11:50 AM
2	Associate Diploma in Human Nutrition and Graduate Certificate in Diabetes Education	4/12/2017 9:27 AM
3	Graduate Diploma in Community Health	4/11/2017 5:01 PM
4	Family Therapy, Depression In Older Adults, Self Care, Mental Health Specific	4/11/2017 3:04 PM
5	Certificate IV In Allied Health Assistance	4/11/2017 2:52 PM
6	My Health My Life group program training	4/6/2017 9:32 AM
7	Graduate Certificate in Continence Promotion and Management	4/6/2017 8:57 AM
8	Wesley Lifeforce Suicide Prevention; Mental Health First Aid; other courses in dementia/Mental health/e-CBT/Chronic cardiac and respiratory courses	4/4/2017 5:37 PM
9	Respecting Patients choices (Advanced Care Planning)	4/4/2017 10:14 AM
10	Strength based training. Family Partnership training. Bridges out of Poverty	4/3/2017 3:36 PM
11	Stanford Self-Management	4/3/2017 11:14 AM
12	certificate 3 in Aboriginal Primary Care	4/3/2017 10:10 AM

Q7 What has ENABLED you to translate new knowledge and skills learned in previous training in to your practice? Please tick all that apply

Answered: 77 Skipped: 6

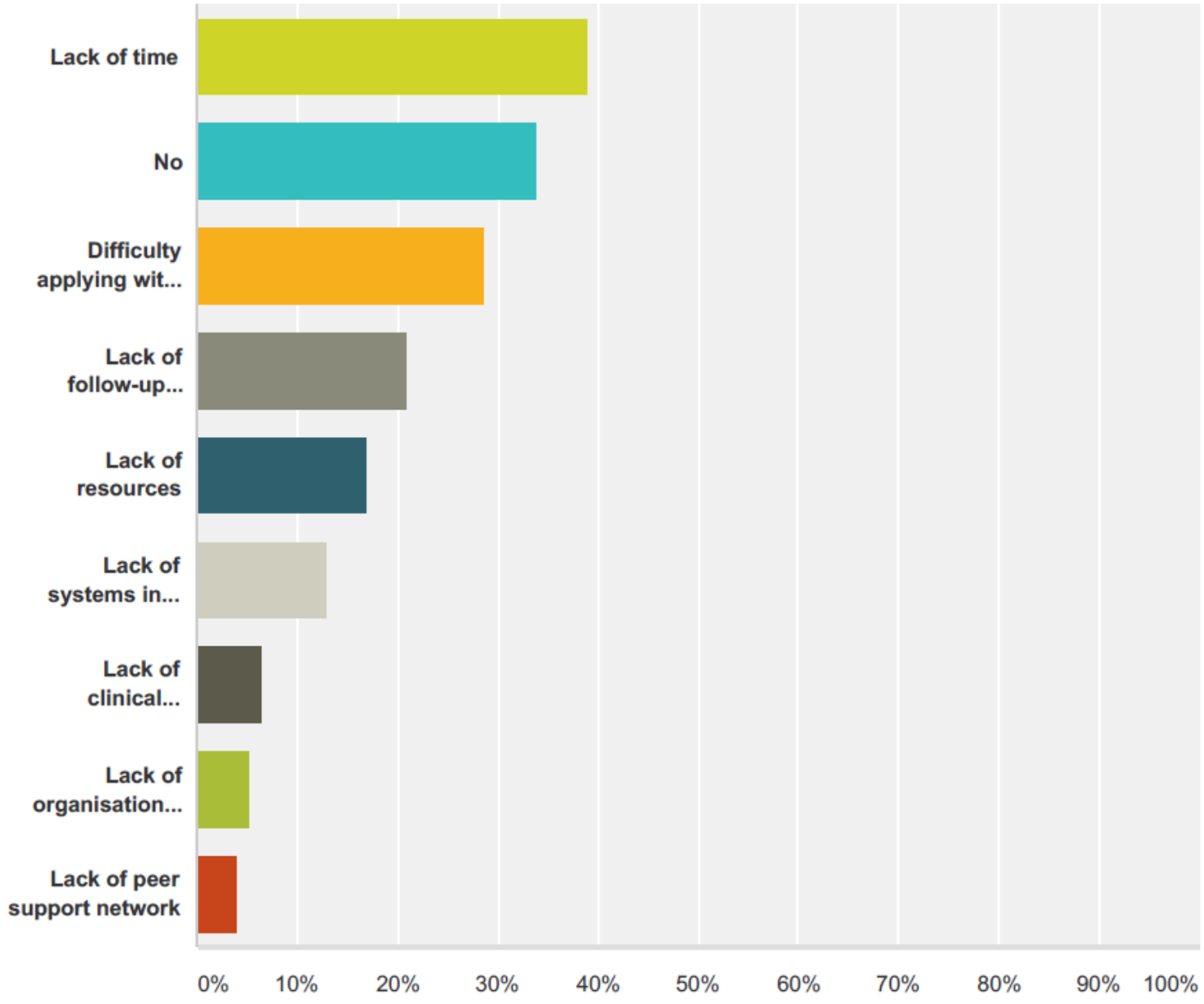


Answer Choices	Responses	
Nothing	2.60%	2
Clinical Supervision	24.68%	19
Team Support	68.83%	53
Local peer support network	35.06%	27
Systems in place	35.06%	27
Supportive organisation	55.84%	43
Follow up training sessions/support	36.36%	28
Resources/references (e.g. guidelines, education resources)	55.84%	43
Course materials/handouts	54.55%	42
Support from professional associations	22.08%	17
Support from regional peer networks	22.08%	17
Support from Primary Care Partnerships	10.39%	8
Total Respondents: 77		

#	Other (Please Specify)	Date
1	I have listed these above, if they were available, sometimes they are, and other times no.	4/11/2017 3:07 PM
2	grants to financially support	4/11/2017 2:30 PM
3	practice	4/6/2017 9:33 AM
4	My Health My Life	3/29/2017 2:56 PM

Q8 Have you experienced any BARRIERS in translating new knowledge and skills into your clinical practice following training? Please tick all that apply

Answered: 77 Skipped: 6

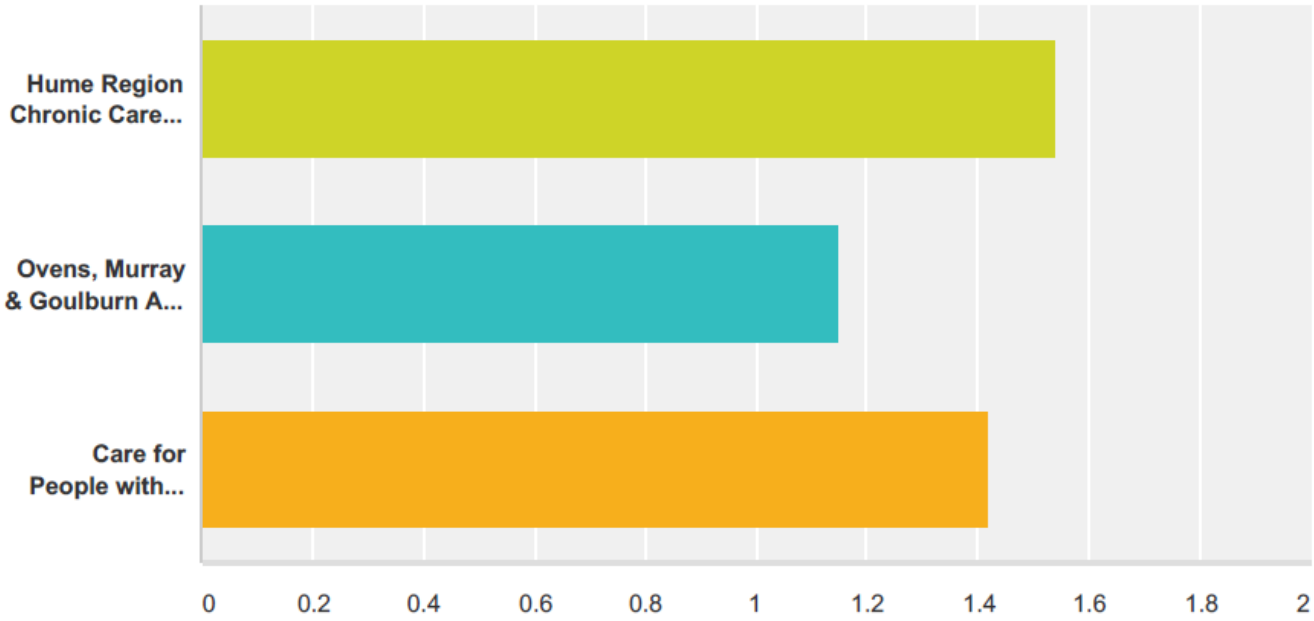


Answer Choices	Responses	
Lack of time	38.96%	30
No	33.77%	26
Difficulty applying with some client groups	28.57%	22
Lack of follow-up training sessions/support	20.78%	16
Lack of resources	16.88%	13
Lack of systems in place	12.99%	10
Lack of clinical supervision	6.49%	5
Lack of organisational or management support	5.19%	4
Lack of peer support network	3.90%	3
Total Respondents: 77		

#	Other (Please Specify)	Date
1	culture within the workplace	4/12/2017 11:51 AM
2	finance	4/11/2017 2:30 PM
3	The local Peer support network meets on a day when I work in a different workplace	4/3/2017 11:15 AM

Q9 How aware are you with the following resources? Please click on the most relevant answer.

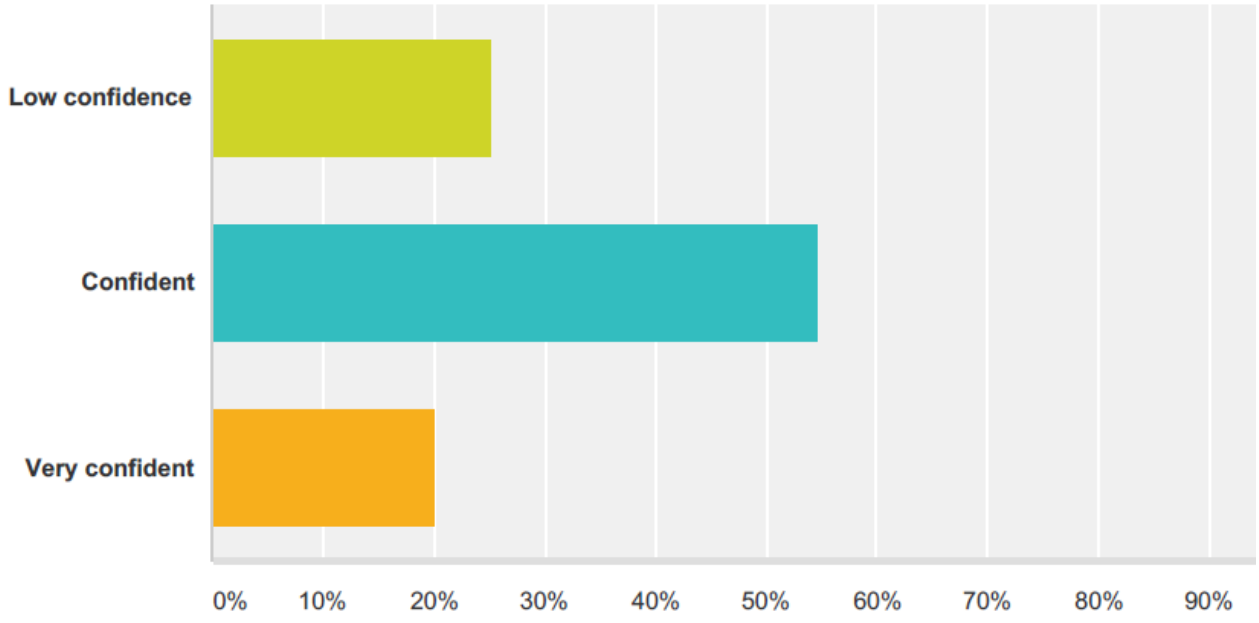
Answered: 77 Skipped: 6



	Never heard of it	Aware of it	Refer to it	Total	Weighted Average
Hume Region Chronic Care Strategy 2012-2022	**50.00%** 38	**46.05%** 35	**3.95%** 3	76	1.54
Ovens, Murray & Goulburn Area Chronic Clearinghouse	**86.67%** 65	**12.00%** 9	**1.33%** 1	75	1.15
Care for People with Chronic Conditions - Guide for the Community Health Program	**59.74%** 46	**38.96%** 30	**1.30%** 1	77	1.42

Q10 How confident are you in delivering 'Health Promotion' approaches?What it is: Health Promotion is any work which actively and positively supports people, groups, communities or entire populations to be healthy. It does not focus on sickness, but on building capacity. It includes building health public policy, creating supportive environments, strengthening community action, developing personal skills and re-orientating health care services towards prevention of illness and promotion of health. It involves working with people and communities as they define their goals, mobilise resources and develop action plans for addressing problems they have collectively identified.

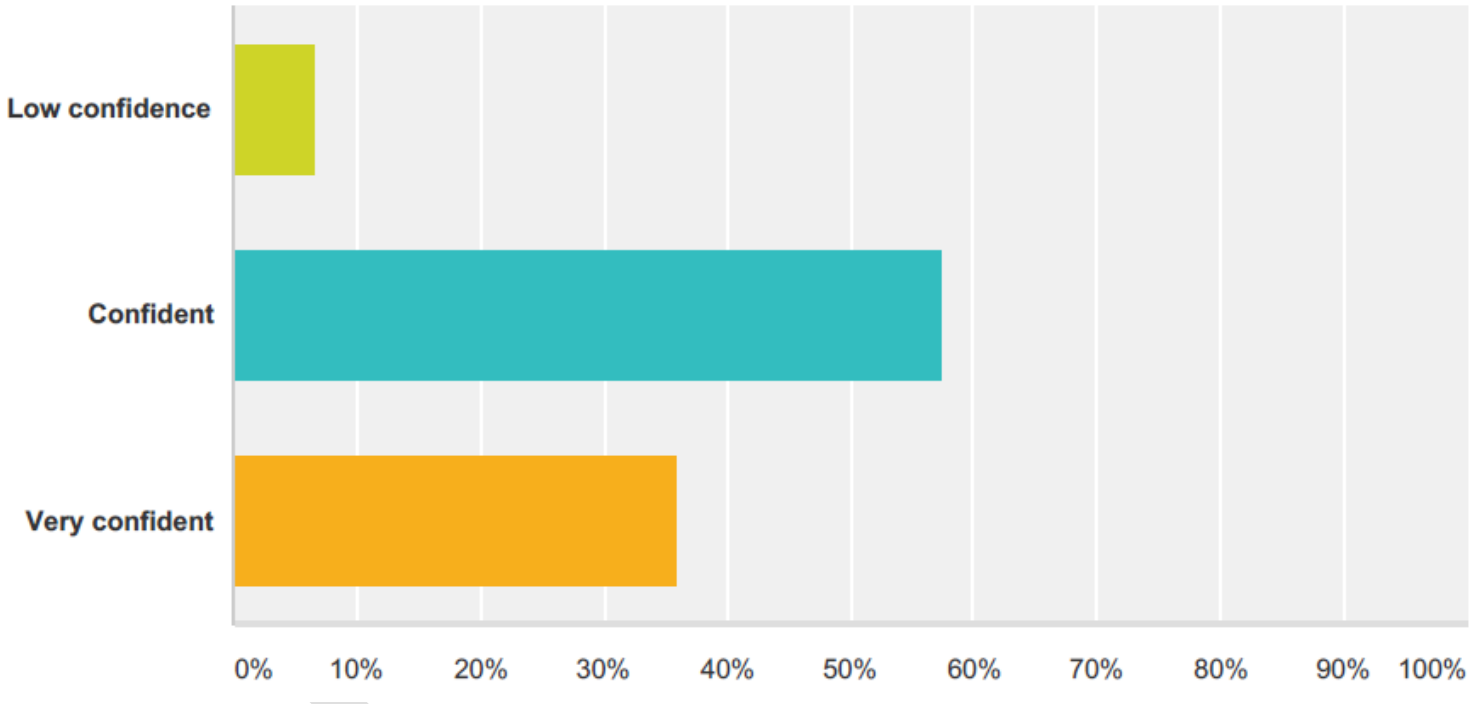
Answered: 75 Skipped: 8



Answer Choices	Responses	
Low confidence	25.33%	19
Confident	54.67%	41
Very confident	20.00%	15
Total		75

Q11 How confident are you in conducting an assessment of health risk factors? What it is: Assessment of health risk factors is the identification of predisposing factors (smoking, nutrition, alcohol, physical activity, stress) that may lead to future health problems for the patient.

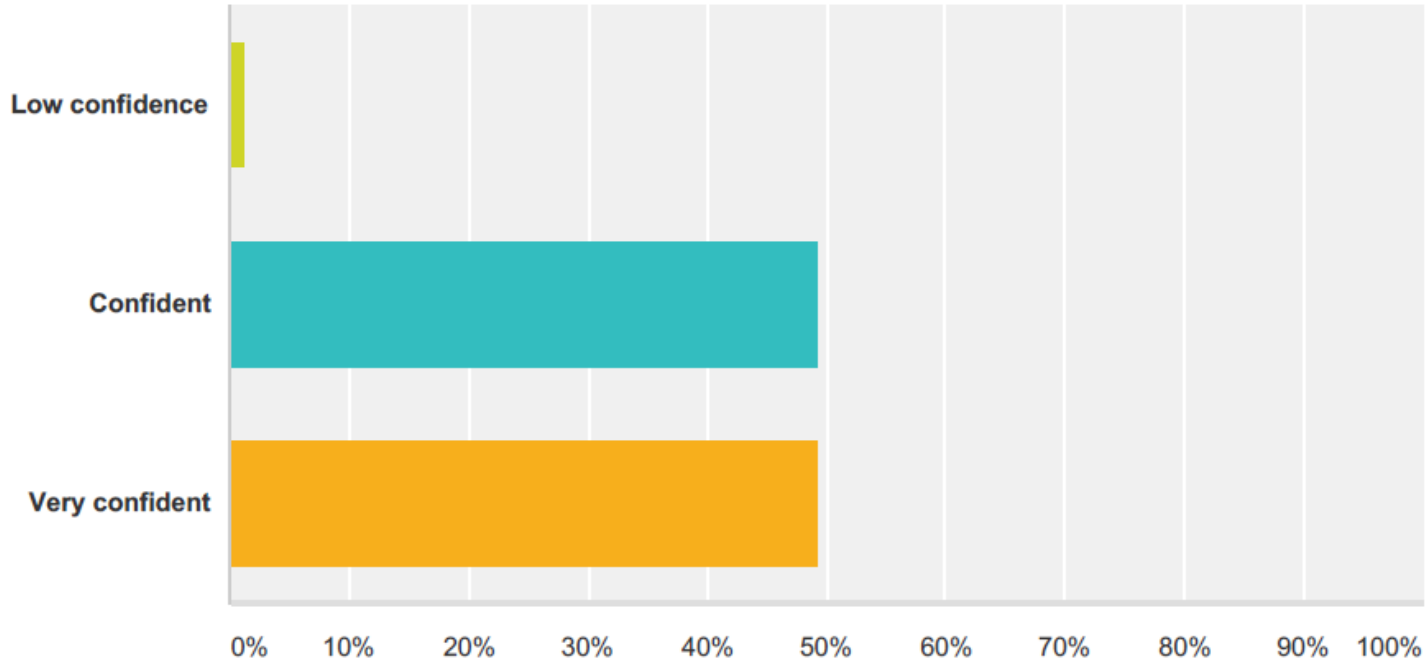
Answered: 75 Skipped: 8



Answer Choices	Responses	
Low confidence	6.67%	5
Confident	57.33%	43
Very confident	36.00%	27
Total		75

Q12 How confident are you in your communication skills? What it is: Effective communication skills involves the ability to establish and develop mutual understanding, trust, respect and cooperation with your patient. It is the ability to express oneself clearly so the other person understands, and to listen and interpret effectively to understand what the other person is trying to express. In this context, it includes communication between patients and primary healthcare workers, as well as communication between staff in primary healthcare teams and with other service providers.

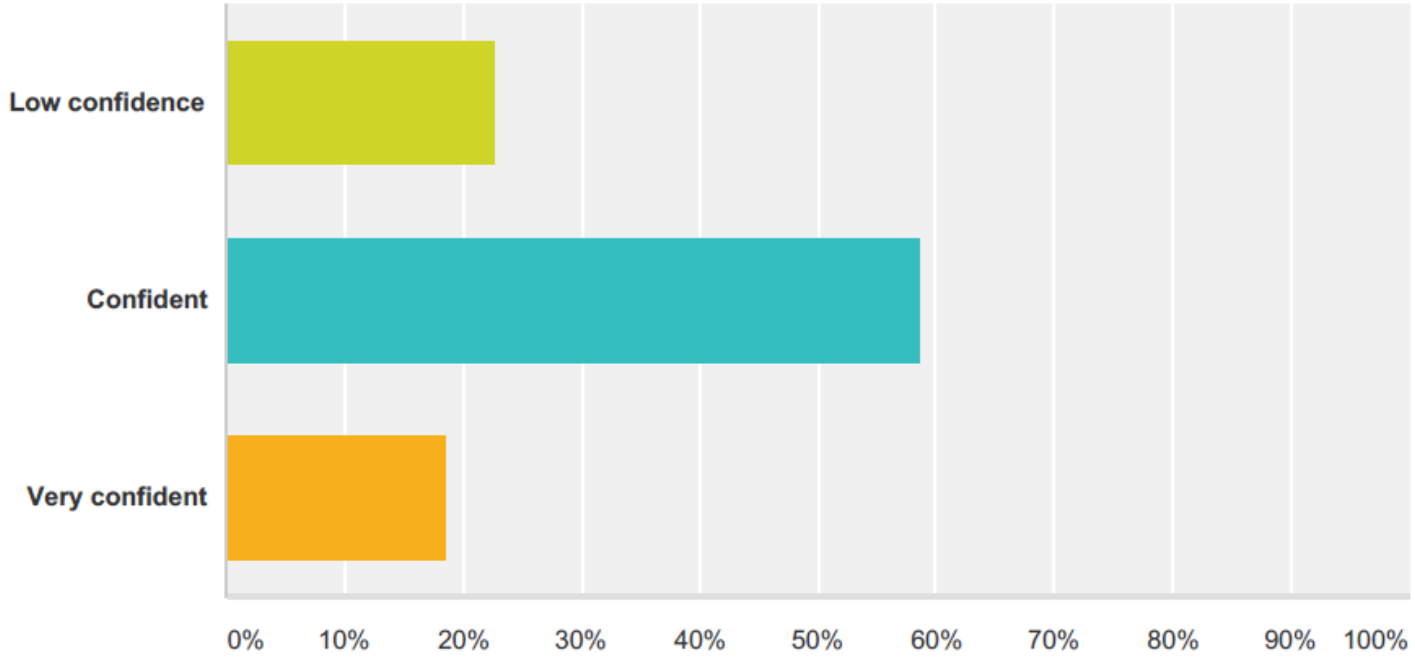
Answered: 75 Skipped: 8



Answer Choices	Responses	
Low confidence	1.33%	1
Confident	49.33%	37
Very confident	49.33%	37
Total		75

Q13 How confident are you to conduct an assessment of self-management capacity? What it is: Is the assessment to identify patient's health beliefs, knowledge, attitudes, behaviours, strengths, barriers, readiness to change (motivation), confidence (self-efficacy) and the importance they place on their health (priority). It may also include an assessment of carers/family capacity to support self-management.

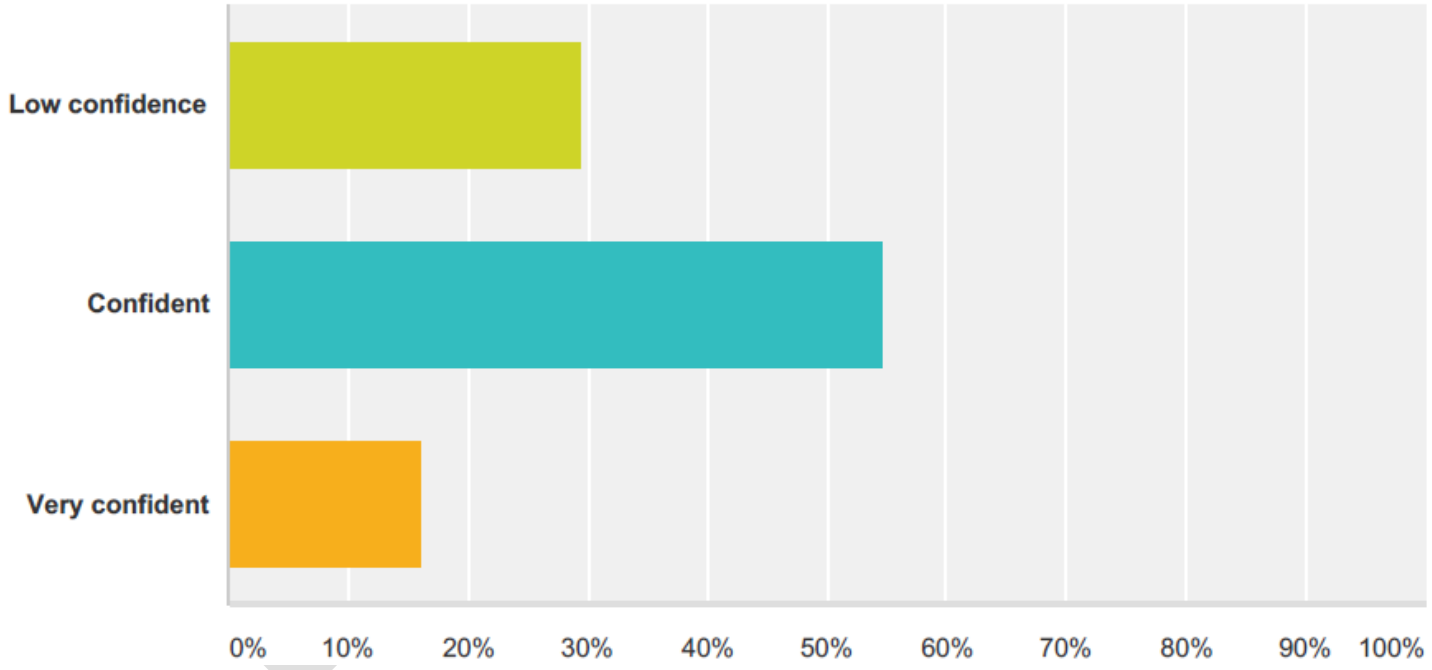
Answered: 75 Skipped: 8



Answer Choices	Responses	
Low confidence	22.67%	17
Confident	58.67%	44
Very confident	18.67%	14
Total		75

Q14 How confident are you in collaborative care planning? What is it: Collaborative care planning is the process in which all those involved in the organising, provision and receipt of care are actively involved in the planning and decision-making surrounding that care.

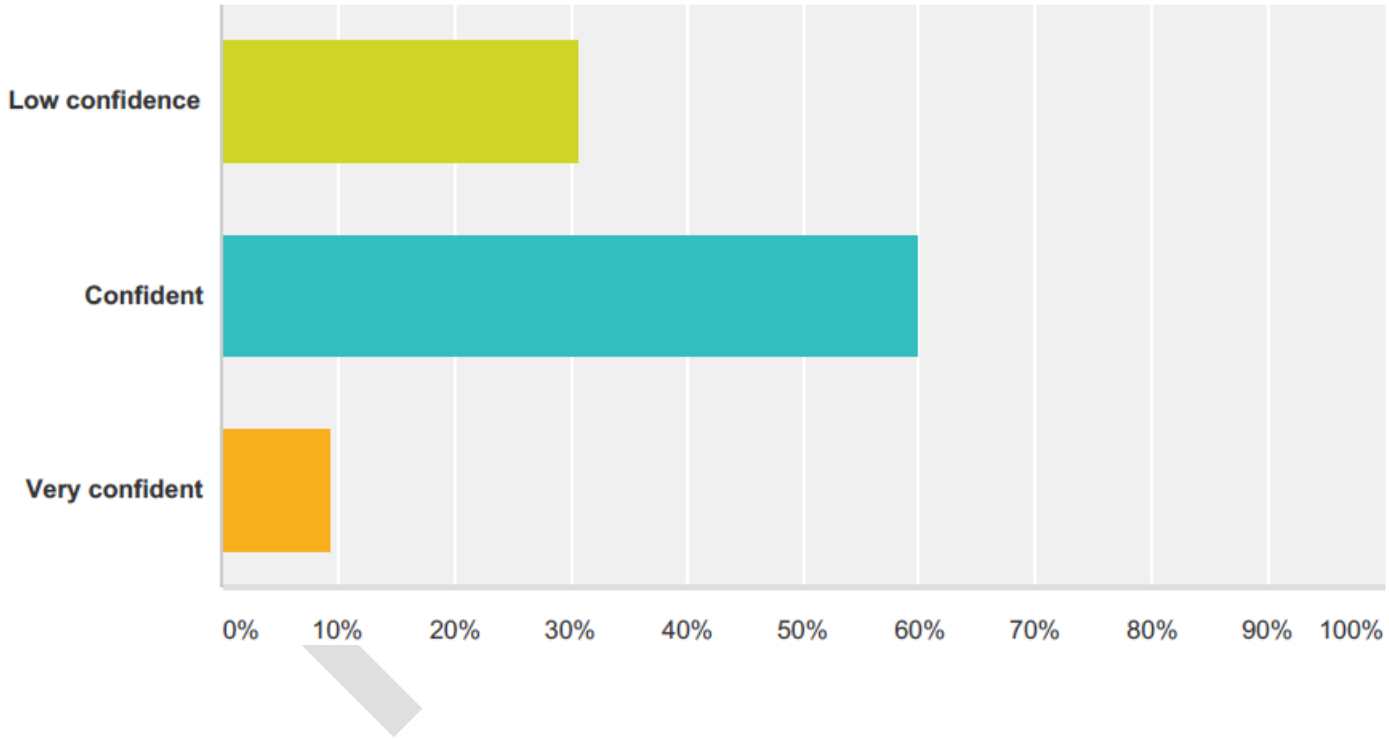
Answered: 75 Skipped: 8



Answer Choices	Responses	
Low confidence	29.33%	22
Confident	54.67%	41
Very confident	16.00%	12
Total		75

Q15 How confident are you in recommending the use of peer support networks/groups(within chronic disease self-management context)?What it is: Peer support is provided by people with a 'lived experience' of effectively self-managing chronic conditions who can therefore act as positive role models for others with chronic conditions.

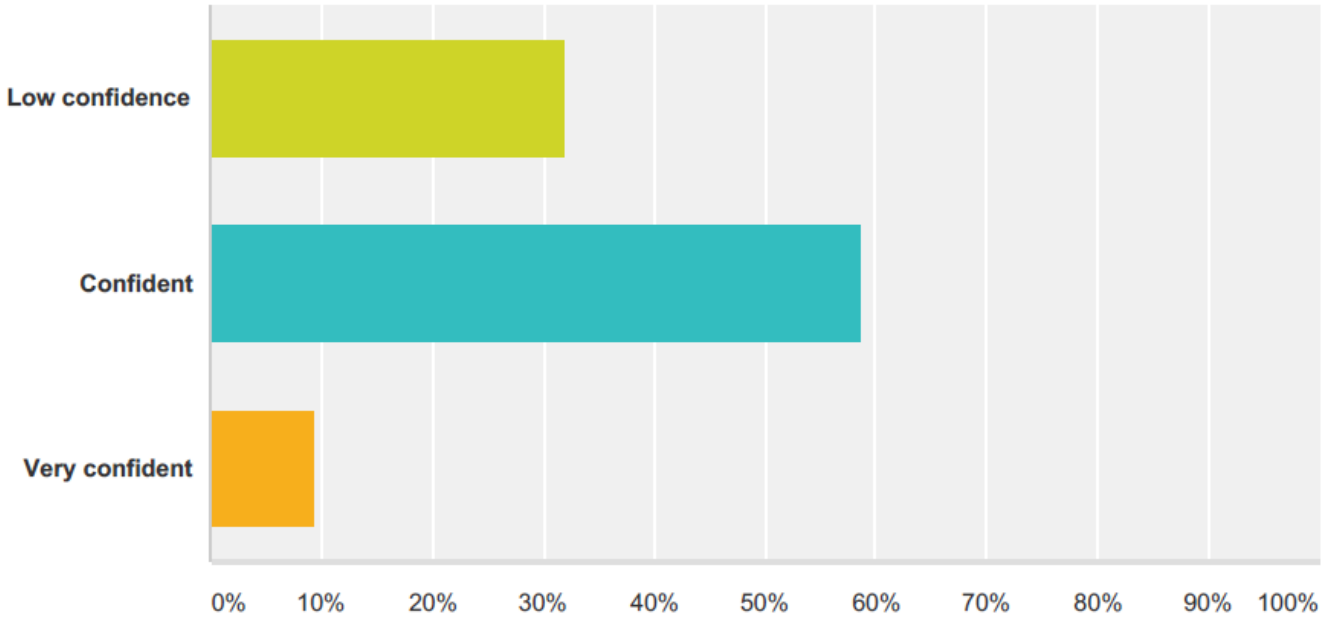
Answered: 75 Skipped: 8



Answer Choices	Responses	
Low confidence	30.67%	23
Confident	60.00%	45
Very confident	9.33%	7
Total		75

Q16 How confident are you in cultural awareness and interpreter service utilisation? What is it: Cultural awareness entails an understanding of how a patient's culture may inform their values, behaviour, beliefs, and basic assumptions. It involves understanding the local community and it needs, and specific communication skills that are culturally respectful. This may involve the effective use of interpreters to accurately relay and receive what is communicated between the worker and the patient and their carers/family.

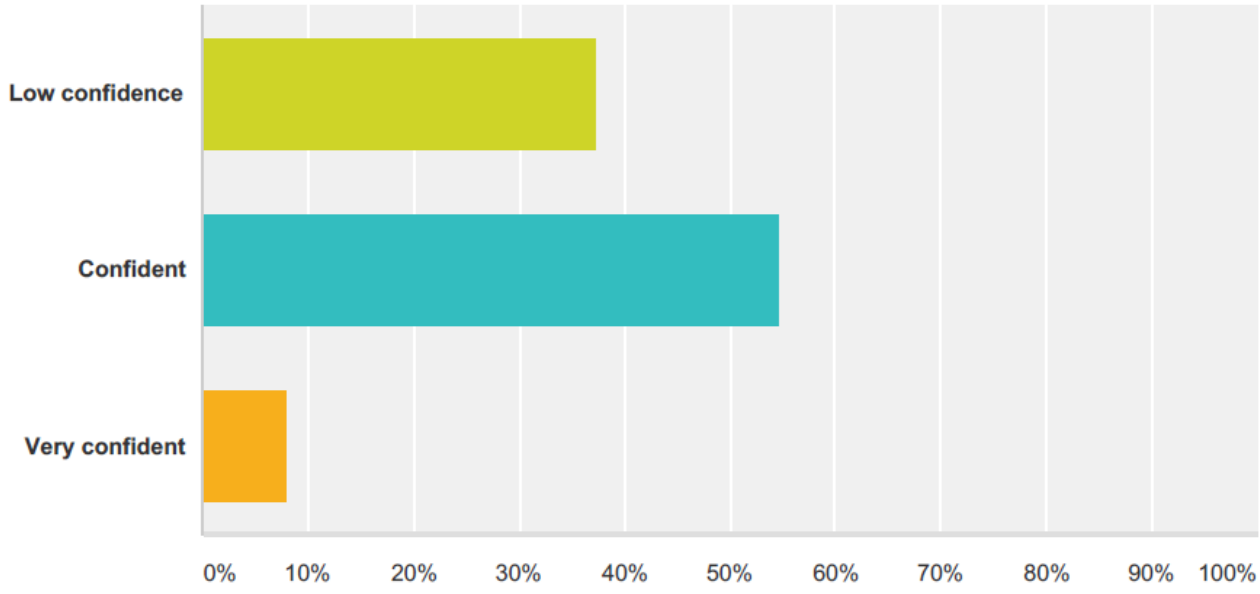
Answered: 75 Skipped: 8



Answer Choices	Responses	
Low confidence	32.00%	24
Confident	58.67%	44
Very confident	9.33%	7
Total		75

Q17 How confident are you in conducting a psychosocial assessment?What is it: The ability of health professionals to identify, build and sustain positive aspects of psychosocial health such as resilience, strengths and coping skills with the patient and their carers. Psychosocial support by health professional and others are interventions and methods that enhance the individuals ability to cope, and to achieve personal and social wellbeing; enabling them to experience love, protection, and support that allows them to have a sense of self-worth and belonging.

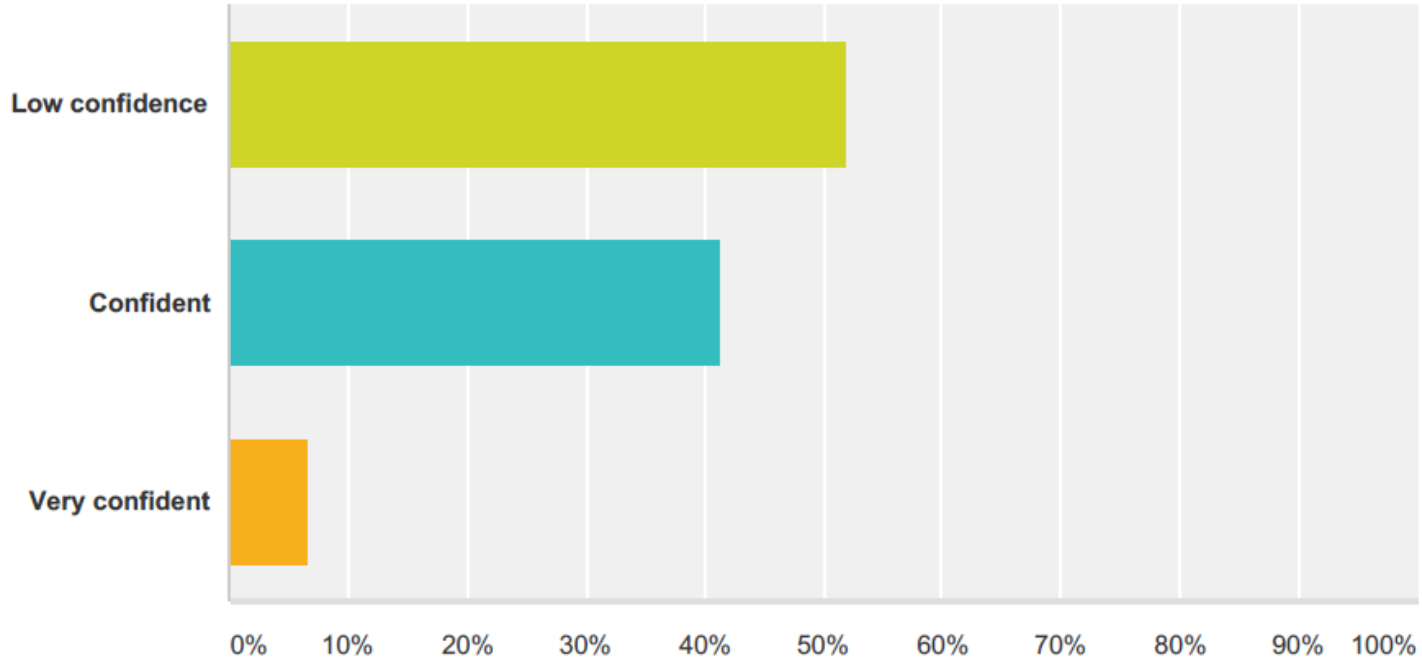
Answered: 75 Skipped: 8



Answer Choices	Responses	
Low confidence	37.33%	28
Confident	54.67%	41
Very confident	8.00%	6
Total		75

Q18 How confident are you applying models of 'behaviour change approach' techniques?What is it: Health behaviour change techniques are models which help us to understand human behaviour and how to change it. This involves theoretical understanding of the mechanisms involved in the choices people make in their lives and how to engage them in the process of change. Various models exist including: The Health Belief Model Theory of Reasoned Action & Theory of Planned Behaviour Social Learning Theory Transtheoretical (Stages of Change) Model Health Promotion Model The 5As Model Cognitive Behavioural Therapy

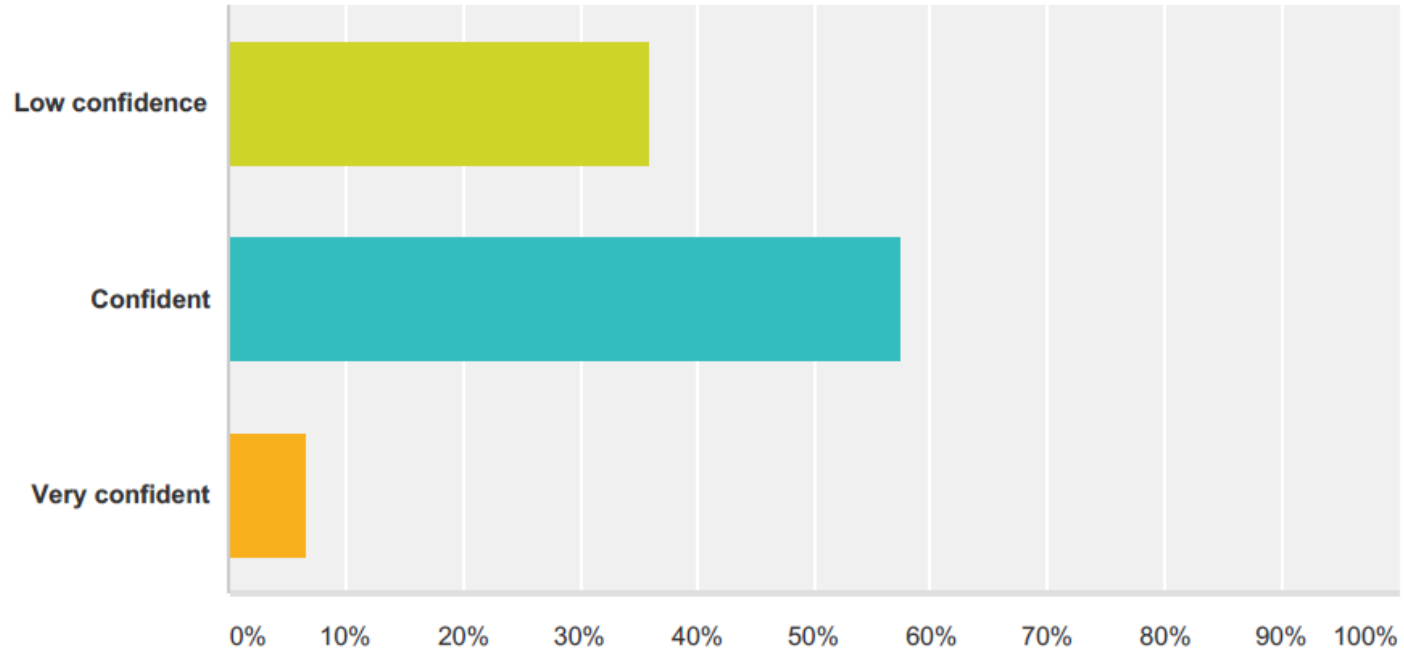
Answered: 75 Skipped: 8



Answer Choices	Responses	
Low confidence	52.00%	39
Confident	41.33%	31
Very confident	6.67%	5
Total		75

Q19 How confident are you using motivational interviewing techniques?What is it: Motivational interviewing techniques is a process undertaken with a person to support their behaviour change. This process involves encouraging the person to talk, generate self-motivational statements, deal with resistance, develop readiness to change and negotiate a plan, developing determination and action. The 5 principles underlying the process are expressing empathy, developing discrepancy, avoiding arguing, rolling with resistance and supporting self-efficacy. Motivational Interviewing embodies cognitive change skills.

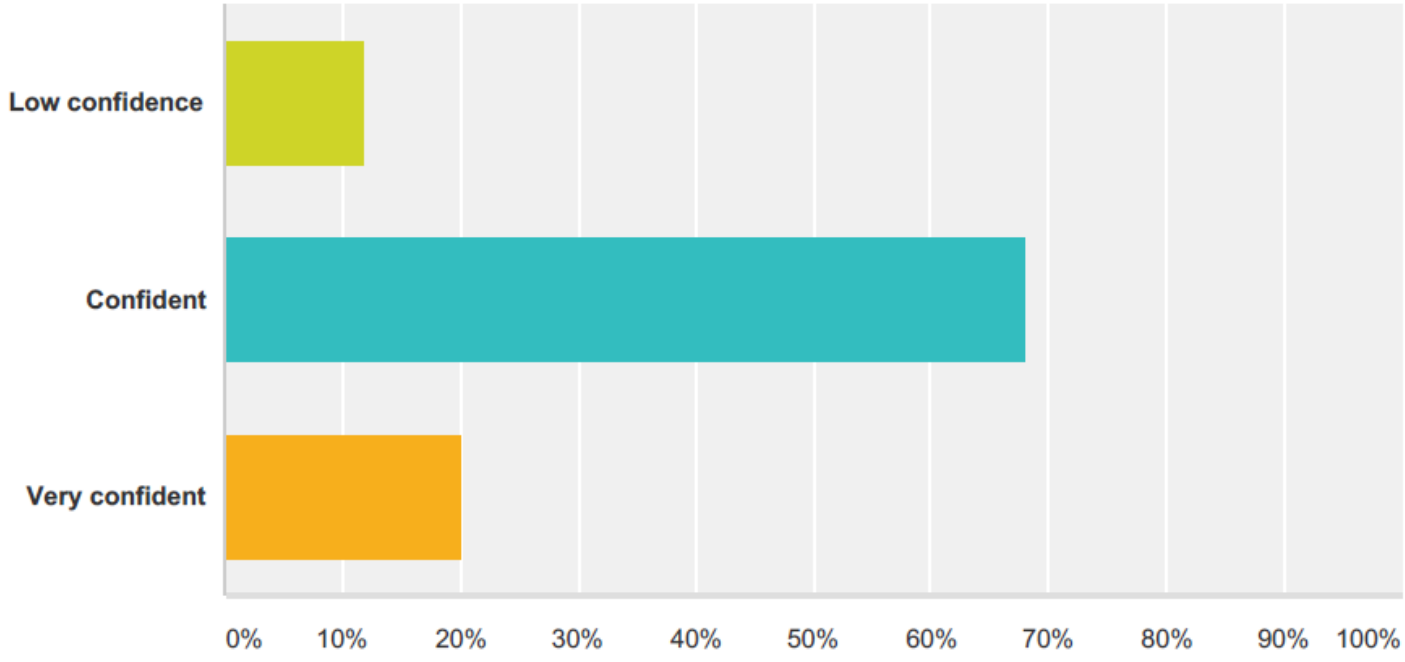
Answered: 75 Skipped: 8



Answer Choices	Responses	
Low confidence	36.00%	27
Confident	57.33%	43
Very confident	6.67%	5
Total		75

Q20 How confident are you in providing collaborative problem solving? What is it: Having an open dialogue with the patient about what they see as their main problem, what happens because of the problem, and how the problem makes them feel.

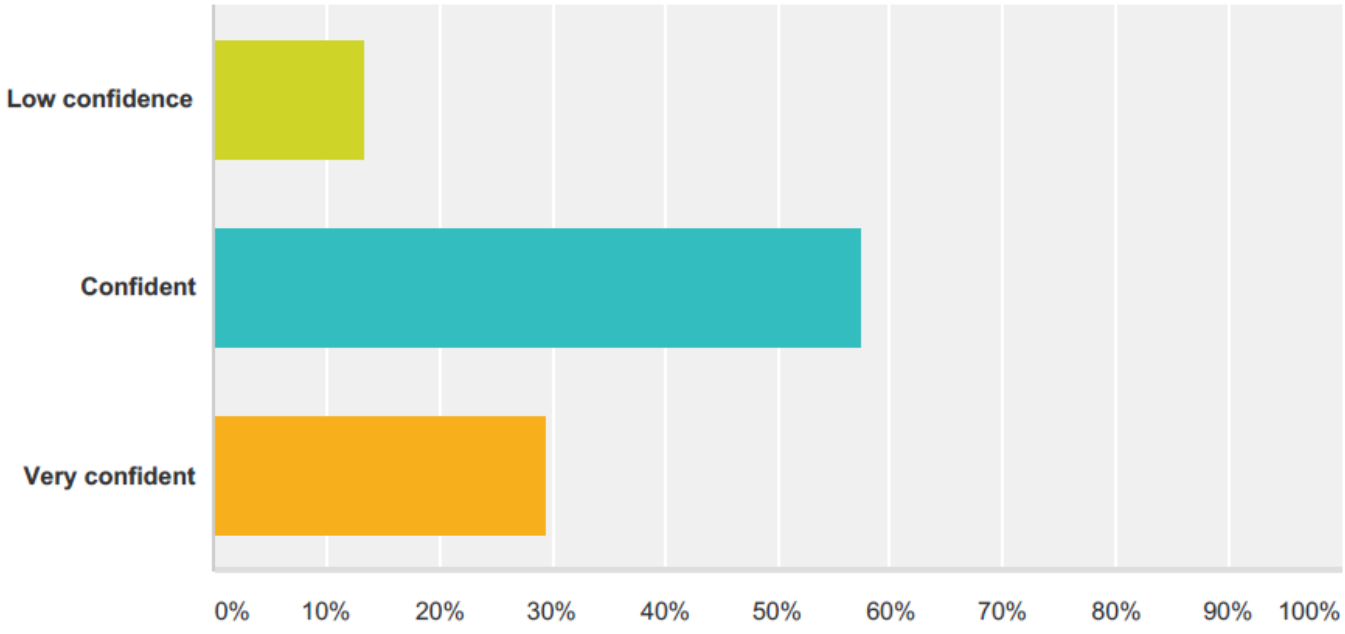
Answered: 75 Skipped: 8



Answer Choices	Responses	
Low confidence	12.00%	9
Confident	68.00%	51
Very confident	20.00%	15
Total		75

Q21 How confident are you in goal setting and achievement?What is it: Goal setting is the process of deciding what one wants, planning how to get it, and then working towards the objective of achieving it, usually by ensuring that it is a SMART (specific, measurable, achievable, realistic, and timely) goal. In the health context, goal setting can be done by the patient alone or with the support of others to help formulate the goal and help the patient to remain motivated to achieve it, i.e. involving collaboration goal setting, problem-solving and other goal attainment skills.

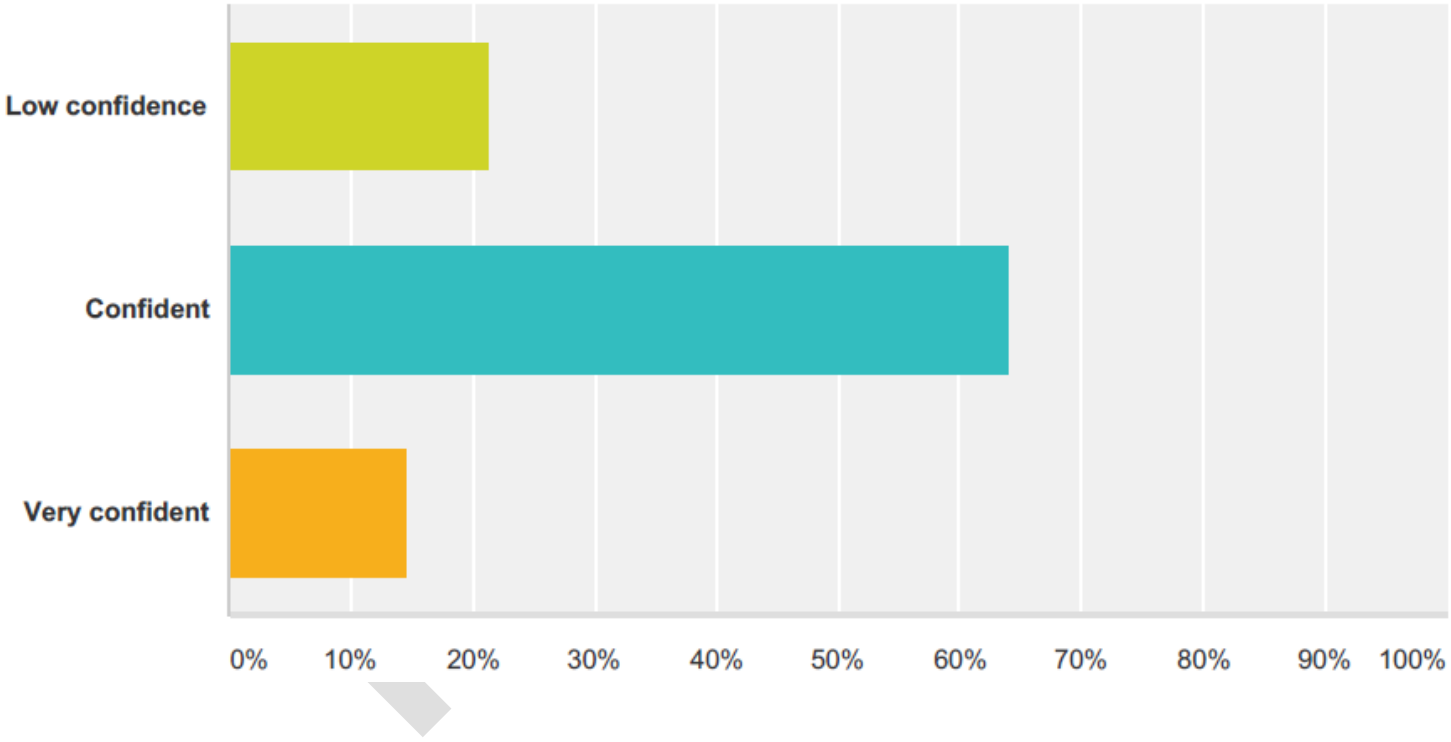
Answered: 75 Skipped: 8



Answer Choices	Responses	
Low confidence	13.33%	10
Confident	57.33%	43
Very confident	29.33%	22
Total		75

Q22 How confident are you in structured problem solving and action planning? What is it: The ability to systemically assist a patient to learn the skill of problem solving i.e. identifying and analysing practical issues that arise in a certain situation and to determine options for a practical solution to overcome this.

Answered: 75 Skipped: 8



Answer Choices	Responses	
Low confidence	21.33%	16
Confident	64.00%	48
Very confident	14.67%	11
Total		75