Expanded Scope of Practice and Aged Care Workforce Reform Progress Report
Contents

Why workforce innovation and reform? 4
Workforce innovation and reform methodology 5
Current projects 6
  1. Expanded Scope of Practice in focus 7
  2. Aged Care Workforce Reform in focus 18
Diffusion of workforce models 27
Why workforce innovation and reform?

Health Workforce Australia’s (HWA) national workforce innovation and reform program is driving change across the health and aged care sectors to create a more productive, sustainable and consumer-centred system for the future. Evidence is increasing on what service and workforce reforms work, why they are successful and how they might be implemented nationally.

Large-scale change across the health system is possible when it is based on the evidence and expertise of locally driven innovation and reform initiatives. It is enabled where consumers and organisations come together to design and invest in sustainable service models with redesigned workforce roles to deliver them.

This report demonstrates the scale and pace of reform being delivered across Australia by those on the frontline of service delivery. They are striving to deliver a consumer-focused service that is innovative, improved and provided within existing constraints. In many cases, participation in HWA’s health and aged care workforce projects has enabled a local acceleration in reform that has the potential to be replicated nationally.

The evidence developed through the local and national evaluations of the 52 projects outlined in this report will allow for the further uptake of good ideas and disinvestment in what has proven not to work. The formal evaluation reports that are scheduled for completion in September 2014 will assist with the development of policy advice to government, the diffusion of successful workforce models and implementation support for future adoption sites.

HWA’s investment in workforce reform is already creating energy for change, which is being supported and promoted through the health and aged care sectors. Across 99 project sites, roles have been redesigned for over 2,200 members of the health and aged care workforce. Consumer and carer satisfaction rates are high with many stating the services delivered by the redesigned workforce are more responsive and better suited to their needs.

HWA’s workforce innovation and reform program has partnered with a wide range of jurisdictional and organisational partners to provide tangible and timely responses to many of the workforce challenges facing the Australian health and aged care sectors.

It demonstrates how new and redesigned roles can be introduced to more effectively and efficiently meet the growing demands of an ageing population that has more complex health needs, in an environment where expenditure pressures need to be closely managed.
Workforce innovation and reform methodology

HWA’s program builds on the evaluations and evidence developed at the local level and structures innovation and reform projects to test the scalability and applicability of reform nationally. Through research in action, HWA ensures lessons learned are identified and valued to inform further change. Partnerships and resources created for one purpose can be further developed for use at the national level. By sharing with the sector evidence of what works elsewhere and supporting the uptake nationally, HWA is able to accelerate the change across the health and aged care system.

The following key principles underpin the workforce innovation and reform methodology:

- Innovations must lead to a productivity gain.
- Innovations must be consumer-focused and ensure the quality and safety of care delivered is maintained or improved.
- Reforms should be based on evidence of what works from either national or international sources.
- Reform initiatives should be co-designed with and have co-investments by implementation partners.
- Local and national evaluation partners should be engaged in the design phase to optimise the research questions and expected evidence and outcomes.
- System change leadership capacity must be developed and maintained across the whole of the workforce to deliver large-scale change.
- Initiatives must build capability and explore roles based on a better balanced skill mix to meet community need rather than traditional professional demarcations.
- A whole of workforce approach to reform should be used to ensure change is scalable, sustainable and replicable.
- Reforms must span boundaries, geographical, jurisdictional, organisational and/or professional.
- Sustainability must be planned for at the beginning and throughout the reform.
Current project sites

Key
- Expanded Scope of Practice project sites
- Aged Care Workforce Reform project sites
1. Expanded Scope of Practice in focus

The Expanded Scopes of Practice program is delivering four large-scale, innovative health workforce reform initiatives that focus on role redesign and expanding the scope of existing health professionals in acute and primary care settings.

The role redesigns have the potential to improve the patient journey, reduce waiting times and ease pressure in areas of high demand, such as emergency departments, by equipping health professionals with the skills and experience to undertake expanded roles. There is a need to implement and evaluate these models systematically, to assess whether they are suitable for wider (national) roll-out and to determine the conditions where they are most likely to succeed.
Advanced Practice in Endoscopy Nursing

This project responds to the national trend of increasing demand for endoscopic procedures. There is a resulting need to enhance the capacity and capability of the workforce to cope with this demand.

The Austin Hospital in Melbourne is a lead site and is part of the ‘Austin Consortium’, which includes Victorian implementation sites at Austin Health, Western Health, Southern Health and Alfred Health.

The Logan and Beaudesert Hospital, Queensland is both a lead and implementation site. This hospital is based on two campuses, one at Logan and one at Beaudesert.

The project has provided training to six nurse endoscopist trainees and created guidance and structure for future training through the development of a draft Nurse Endoscopy Training Framework.

Key achievements

• Between January 2013 and January 2014 the nurse endoscopist trainees completed 1,259 colonoscopies.
• Building on the HWA project, both Victorian and Queensland governments have allocated funding to develop initiatives to train more nurse endoscopists.
• Development of a draft Nurse Endoscopy Training Framework with key stakeholders.
• A high level of support of a new model of care from clinicians at implementation sites.

Monash Health case study

A nurse endoscopy model implemented at Victoria’s Monash Health has reduced its seven year waiting list for routine endoscopic procedures to a maximum of 40 days.

Before nurse endoscopy procedures were introduced in February 2013 as part of the HWA program, there were a total of 400 people on the hospital’s routine or category 3 waiting list.

These included consumers who had not been screened for bowel cancer but were concerned about various symptoms.

“Our endoscopy unit had not seen a category 3 consumer in four years,” Nerissa Horne, the Project Manager, said. But a dedicated nurse endoscopist and a proactive approach to waiting list managements has successfully reduced this waiting list.

“For some consumers we have required urgent intervention and treatment for removal of polyps and bowel resections,” Ms Horne said.

“The increased capacity to address these consumers has certainly changed lives – intervening before polyps become cancerous, treating consumers and enabling them to leave here with some peace of mind,” she said.
Expanded Scope of Practice Physiotherapists in the Emergency Department

This project responds to the increasing number of presentations to emergency departments (EDs) and the pressures on local systems resulting from the four hour National Emergency Access Target (NEAT).

The two lead organisations Alfred Health, Melbourne and the Canberra Hospital, ACT Health also support nine other implementation sites.

The workforce changes implemented involve experienced musculoskeletal physiotherapists undertaking a primary contact role for suitable consumers with musculoskeletal injuries. The highly trained physiotherapists have increased competency and autonomy in areas such as simple fracture management, interpretation of imaging, and referral to specialist services.

There have been consistent positive responses to the introduction of the service by consumers, ED staff and key stakeholders across all sites.

Preliminary findings

While it is not yet possible to provide consolidated evaluation results across all sites, selected examples of results from two implementation sites are provided below.

Alfred Health reported overall length of stay for all Triage Category 4 and 5 consumers decreased by 20.3 minutes when compared to the same period pre-implementation.

• The average wait time for consumers in Triage Category 4 and 5 was 23.5 minutes less than similar consumers treated by medical team.
• The length of stay for consumers treated by the physiotherapist was 71 minutes less than the same category consumers treated by the medical team.
• Of the Triage Category 3, 4 and 5 consumers with musculoskeletal issues, 96.3 per cent were treated and discharged by the physiotherapist within four hours.
• There was a 65 per cent increase in the number of consumers seen with a 40 per cent increase in hours of service delivered by the physiotherapist.

St Vincent’s Hospital, Melbourne, reported that in the specific category of treatment of ‘low back pain’ results for the primary contact physiotherapist revealed:

• Shorter ED length of stay.
• Reduced hospital admission rates.
• Reduced unnecessary radiological investigations relative to other clinicians.
Feedback from staff at Ballarat Health Service

The Primary Contact Physiotherapist service at the Ballarat Health Service ED in Victoria has received positive feedback for this service delivered under the Expanded Scope of Practice project.

“We had dedicated physiotherapists in the ED during the weekend, treating consumers with musculoskeletal injuries, caused mainly by sporting activities,” Leonie Lewis, a physiotherapist at Ballarat Health Service, said.

“We treated a lot of junior netball and football players, who came to us with soft tissue sports injuries. The treatment they received from our physios ensured they were back at school on the Monday.

“We treated a self-employed consumer with chronic knee pain. He was treated by our physiotherapists and able to return to work that week.

“The local netball and football club and self-employed consumer sent us letters of thanks for the care they received from our physiotherapists,” Ms Lewis said.
Expanded Scope of Practice Nurses in the Emergency Department

The project responds to the increasing number of presentations to ED and the pressures resulting from the four hour National Emergency Access Target (NEAT). Across the 13 project sites, expanded scope of practice has been introduced to nursing roles to support medical practitioners and nurse practitioners to manage consumers in urgent triage categories.

The project sites have implemented diverse models of care to suit the specific needs of their service and included a focus on paediatric and mental health consumers, and rural and remote settings. Examples drawn from the implementation sites and preliminary finding are outlined below.

The Royal Children’s Hospital Melbourne implemented a criteria led discharge (CLD) model, which enabled highly trained and experienced ED nurses to discharge paediatric consumers using a care plan and treatment pathway specific to the consumer’s diagnosis.

Preliminary findings for the Royal Children’s Hospital, Melbourne

- The project improved service efficiency by redistributing medical resources and improved the quality of care.
- Consumers utilising the CLD model with the diagnosis of asthma, croup and gastroenteritis were more likely to be treated and discharged within four hours than non-CLD consumers.
- Ninety-six per cent of parent/carers were very satisfied/satisfied with their experience of being cared for by the Expanded Scope ED Nurse.
- The model of care is transferable to other organisations and can be used as a framework to develop target diagnosis and pathways that follow local policy and procedures.

Eastern Health developed a mental health model that builds upon the skills of the existing Nurse Practitioner role and expands the scope to include the ability to undertake a physical assessment, order pathology, prescribe selected medications in accordance with hospital guidelines and order direct referrals to other specialists.

Preliminary findings for Eastern Health

- The project provides a single point of care for consumers rather than multiple clinicians providing treatment.
- The capacity of the mental health workforce has increased as the nurse practitioners have developed skills and knowledge beyond their traditional role in the ED.
- The model of care has received positive feedback from the psychiatric triage staff regarding the expertise of the mental health nurse practitioner/clinician (MHNP/C).
- The project reports that the mental health assessments provided solely by the MHNP/C achieved 94 per cent NEAT rate.
Consumer feedback

A final evaluation report from the Royal Children’s Hospital Melbourne contains the following consumer quotes about the CLD model:

“Very sensible and time effective.”

“I have attended the ED for the same problem before and after the implementation of this system, this new role allows us to leave sooner.”
The Expanded Scope of Practice project in the Murrumbidgee Local Health District provided additional education and training to registered nurses at five rural EDs to enable them to autonomously assess, manage and discharge consumers through the use of designed clinical pathways.

**Preliminary findings for Murrumbidgee Local Health District**

- Consumers received timely, safe and appropriate care. Seventy per cent of responses from consumers or relatives of consumers who were treated by an expanded scope of practice nurse considered the overall experience to be outstanding.
- The need for a visiting medical officer was reduced. For instance, 63 per cent of consumers did not require an assessment by the visiting medical officer as appropriate care was provided by the registered nursing staff.
- Consumers received their total episode of care at the single site, rather than having to incur the cost of private or ambulance transport to an alternative ED or health service.

This model has the potential for national transferability, particularly in hospital EDs where medical officers are difficult to recruit and/or retain.
Extending the Role of Paramedics

This project supports the implementation of key success elements from an existing metropolitan Extended Care Paramedic (ECP) model developed by the South Australian Ambulance Service. Five sites in South Australia, Tasmania, Northern Territory and Australian Capital Territory, have customised the model to meet local needs and conditions. This is particularly important because ambulance services are structured differently in most states and territories.

The objectives of the project are:

- To deliver more appropriate healthcare within the consumer’s usual place of residence, thereby minimising disruptions to both consumers and carers.
- To reduce costs to the broader health system by decreasing admissions to hospital, inter-hospital transfers and early entry into residential aged care facilities.
- To expand the competencies and skills of paramedics to provide an alternative career pathway and thereby improve staff retention.

The model involves the consumer’s usual general practitioner (GP) and is designed to deliver more appropriate care in situ wherever possible. Each site works under the guidance of a medical mentor and seeks to fill gaps in service delivery that might traditionally be filled by the consumer’s own GP or the local emergency department under traditional arrangements. There is particular interest in the impact of the ECP role in the delivery of in home care and how they could be better used as part of an integrated primary healthcare team.

The benefits of ECP role become obvious when the ECP is not available. One recent case reported that a consumer requiring wound closure presented when an ECP was not available. The case was attended by a single ambulance officer and then required response backup by a clinical station officer. The consumer had to be transported to hospital for treatment and was then transported back to the residential aged care facility by the consumer transport service. An ECP could have safely closed the wound for the consumer in the aged care facility with a referral to community nursing for follow up the next day.

Key achievements

- Consumers are being managed by ECPs in their own home with follow up and referrals into the primary healthcare system.
- Clinical practice guidelines and scope of practice have been tailored to be relevant to local contexts and ensure the quality of care delivered.
- GPs, aged care facilities, palliative care teams and community nursing are supportive of the initiative and appreciative of the quality and timeliness of the service offered.
- Referral pathways to appropriate follow up care in the community have been established.
Preliminary findings

- ECPs are treating consumers in situ and avoiding transport to an emergency department in around 70 per cent of cases.
- High levels of consumer satisfaction have been recorded.
- The quality of care delivered has been high with strong GP support and referrals coming back into the service from the primary healthcare sector.
- Savings to the broader healthcare system are substantial but without shifts in funding streams to the ambulance service, the model is unlikely to be financially viable in the long term.
- System change is required to ensure that funding streams can be identified to ensure ECPs can be used as part of an integrated primary healthcare team in the future.
- The role is able to liaise with general practice to fill gaps in primary healthcare delivery, especially in rural and regional settings.
- The role provides an alternate career pathway for paramedics.
- The ECP training is the equivalent of the Australian Qualifications Framework level 9 and can articulate four units towards a masters degree in paramedicine.

Tasmanian ECP case study

A residential care facility in Tasmania had a breakout of gastroenteritis. ECPs were able to provide in-home treatment and support to the residents and staff resulting in hospital avoidance for several residents and minimum disruption to both residents and staff.

South Australian ECP case study

Palliative care is a keen focus for many of the ECP teams. The prevention of hospital admission for those who wish to stay at home or to die at home had a profound impact on the ECP team. In rural Australia, out-of-hours care is limited or non-existent. To be able to put in place a pain relief plan for the weekend, or to be able to put in place an end of life plan which allows the patient to be supported and the family to cope in those final days are very rewarding.

A 42-year-old mother-of-three had advanced breast cancer with metastasis and was discharged from hospital. But she had a narcotic overdose while at home. We attended and was able to put in place a simple plan to reduce her overdose initially. We then started her back on her background pain relief and her break through pain relief when required, which still allowed her to function within her young family. This required significant time with her family, including supporting the mother with her baby so that her husband could collect the other children from school. Our support assisted the husband, who was distraught, to have a plain English plan put in place that he could cope with. The lady was able to stay at home and interact with her family, in line with her wishes.

Although she died within a few days we were able to avoid hospital admission. Without the ECP role in place she would have most likely spent a minimum of two days in hospital. The time she was able to have with her family prior to her death at home was surely worthwhile. Without the support of two ECPs that day this would have never been achieved.
Consumer feedback

As part of the evaluation of this project, consumers were asked to provide feedback on their experiences of being treated by ECPs. Feedback includes:

“The ECP that attended to me was thorough. They explained what they were doing and gave me excellent advice. I found the idea of being treated at home for something not life threatening a brilliant idea. Also like the idea of follow-up by the ECP. Thanks! Great job.”

“The response was good – 15 minutes. Knowledgeable ECP who had a calming and confident manner.”

“The ECP was effective and efficient. He was both professional and friendly. I was relieved to know that the consumer did not need to be taken to the hospital after the treatment. Thank you.”

“The ECP officer was extremely thorough who answered all questions, provided plenty of information on care for wound, gave advice on what to do for follow up care and made arrangements to follow up the next day.”

“Great initiative. It makes good sense for a triage approach to the management and distribution of ambulances in a resource stretched environment. My son is better for this service. I received a follow up phone call from the paramedic a couple of days after to check up, a nice touch.

“I was able to relax in my own home without the trauma of moving to a foreign environment, a lot less stress for me. I have nothing but praise for the ECP program.”
2. Aged Care Workforce Reform in focus

Australia’s ageing population affects both the supply of workforce and its ability to meet older Australian’s health needs. Funding was provided for 26 projects across Australia in four priority areas (or streams as shown below) with the aim of improving the capacity and capability of the workforce as a whole without compromising the quality and safety of care to older people.

Stream 1: Building Workforce Capacity for Safe Medications Management
- 3 projects
- 10 sites

Stream 2: Building Workforce Capacity and Capability in Residential Aged Care Facilities
- 10 projects
- 23 sites

Stream 3: Building Workforce Capacity for Early Intervention in Functional Decline
- 8 projects
- 14 sites

Stream 4: Building Workforce Capacity for Complex Care Coordination
- 5 projects
- 15 sites
The 26 projects across the four streams represent a diverse range of rural, urban, public, private and non-government healthcare settings across Australia with a significant project reach to 62 implementation sites in total.

HWA also invested in workforce innovation groups created across the four streams. These groups were led by a Lead Organisation to build leadership, facilitate collaborative approaches for change and innovation, enhance project performance and produce coherent reform at stream level. Active participation of all projects with the Lead Organisations resulted in a number of outputs including training, tools and resources that proved critical to implementation for many projects.

Implementation activities

Data from the mid-term evaluation, 1 January 2013 to 31 May 2013, provided a range of information concerning the implementation activities undertaken with each project. Particular issues to highlight from this analysis included that, as part of the implementation of the new workforce model:

- Across projects, there were 2,153 positions for which there was a role/position change that occurred as a result of the implementation of the new workforce model. Most positions impacted by these changes are positions related to care workers (53 per cent of positions), followed by nursing positions (18 per cent) and volunteers (15 per cent).
- Changes to roles/positions were implemented through changes to the position descriptions for around 20 per cent of positions, through revised policies and procedures for 43 per cent of positions and through staff development activities for 91% of positions.
- Over 70 per cent of participants were involved in development activities where over 80 per cent of participants had a positive reaction, and 25 per cent of participants were involved in development activities where 60 to 80 per cent of participants had a positive reaction.
- The workforce design activities for most projects involved the specification of new competencies (20 projects), design and implementation of new internal reporting processes (20), workflow mapping (19), consumer journey mapping (18), implementation of new consumer assessment processes (18), the specification of new position roles (14).

All 26 projects provided final data and a local evaluation report in January 2014. A final national evaluation report will be published in September 2014. The findings of the national evaluation will provide the sector with a clear understanding of the scalability and replicability of the new workforce models that have been implemented across the four streams.

The following provides an overview of the key achievements to date and preliminary findings across the four streams.
Stream 1: Building Workforce Capacity for Safe Medications Management

There are an increasing number of older people living in the community who are using medication, with a limited workforce to support the need to use those medications safely. Prevention of avoidable medication-related adverse events was a key objective of the three projects in this stream.

**Key achievements**

Each project implemented a model that would build the skills and capacity of existing staff to work in partnership with, and support consumers to safely self-manage their medications at home for as long as possible.

The projects collectively developed the following resources through their workforce innovation group:

- Glossary of terms related to supporting safe medicines use in the home – to address variability and confusion with how terms related to supporting safe medicines use are currently used within the community aged care workforce.
- Capability framework: identifying medication/medicines specific knowledge and skills required by the community aged care workforce.

**Preliminary findings**

- Improved workforce efficiencies and cost savings, and a movement of tasks between roles, with less dependence on nursing roles for safe medication use in the community.
- Improved quality of care, as evidenced by results of medication audits, staff feedback and reduction in the number of medication incidents.
- Development of technology to support workforce competency in safe medication use. For example the development of iNotice – a free app designed for care workers and caregivers working to a care plan that supports a person to stay safely in a home environment.
- Greater uptake by consumers of a range of devices and gadgets, supporting self-management and enabling a greater number of consumers to regain/maintain independence in relation to their medicines.
- Consumers continuing to be satisfied with the medication services.

For each project, the workforce model and associated processes will continue to be rolled out across their organisations, sustaining the workforce changes and project outcomes.
Resthaven consumer feedback:

A consumer had daily visits for medication prompting and reminding from support workers. Following a discussion about supporting independence, the consumer and their family opted to trial a medication storage container that sounds an alarm when the medicine is due to be taken and rotates to open a compartment of tablets. Family members agreed to pack the device and maintain the supply of medicines. The successful use of the device enabled the consumer to manage their own medicine, with assistance from family. This freed-up the support worker staff to undertake tasks with other consumers.
Stream 2: Building Workforce Capacity and Capability in Residential Aged Care Facilities: Case Study

The growing complexity of resident care is driving change across residential aged care facilities. The ten projects in this stream aimed to improve ways in which the current workforce is able to work together and to the full scope of their practice in order to deliver residents timely access to quality healthcare.

Key achievements

• Common core competencies were developed typically working in multidisciplinary teams, communication, leadership and health literacy.
• Staff training increased the type and level of clinical care provided to residents. This ensured greater continuity of care and a more productive and coordinated primary care team approach.
• Different delivery systems for training were developed to improve access and imbed the new competencies into practice. For example e-learning, toolbox talks and team coaches.
• Early warning tools were used, particularly the stop and watch tool, for all staff to flag, document and assess when residents appeared to be unwell.
• Guidelines and pathways were established to provide evidence based decision support for clinical care staff when assessing an unwell resident or calling external providers, including GPs and ambulance services.
• New roles were implemented to support resident needs related to restoring and maintaining function. For example lifecare assistants and rehabilitation therapists.

Preliminary findings

• Improvements in workforce capacity, capability, employee satisfaction and professionalism, and standards of resident care delivery.
• Reduced levels of absenteeism, agency use and costs.
• Hospital avoidance and associated costs.
• Reduced length of hospital stays and associated costs.
• Enhanced resident choice in care, quality of care for the unwell resident and end of life care.

Many project sites are continuing implementation of their new workforce models across their organisation. Interest to implement particular models has also been received from organisations including in-reach services, Medicare Locals and other aged care providers.
Feedback from staff at Catholic Homes

Catholic Homes in Victoria implemented the Raise the Bar workforce model, which introduced new processes to reduce the number of unnecessary transfers to hospital for unwell residents. A local evaluation report from Catholic Homes contains the following staff feedback:

“I think the obvious benefits were the lack of transfers out of the facility, the increased level of care that we can provide, the increased confidence that residents and families have in the staff. We can now provide the services and the care that is required right up to the end stage of life without having to transfer residents to a hospital facility, which can be quite traumatic for a resident.”

“A lot of nurses come to aged care bringing their clinical skills but because of the culture of aged care you’re encouraged not to use them. If someone’s unwell you send them off, so you very quickly lose your skills and you very quickly receive the message that you’re here in aged care but you’re not really practicing as a nurse. So by bringing in ‘Raise the Bar’ project, it’s giving the nurses permission to use their clinical skills.”
Stream 3: Building Workforce Capacity for Early Intervention in Functional Decline

This stream of eight projects developed new workforce models to facilitate earlier interventions and allow older people to remain well in their homes in the community rather than requiring more costly residential and/or hospital services.

Key achievements

• Expansion of the skills and knowledge of support workers, volunteers and carers in the five domains of functional decline, which are cognition and emotional health, mobility, vigour and self-care, continence, nutrition and skin integrity.

• Training to expand staff skills and knowledge in the use of functional decline tools and technology to support care plans.

• The introduction of new roles to improve staff retention, satisfaction and create new career pathways for support workers.

• The use of technology to facilitate real-time access to care plans and reporting of changes in the health status of consumers.

As a workforce innovation group, the projects also developed, implemented and evaluated the prevent tool. It was designed as a health literacy tool for older people to increase awareness of functional decline and provide information about how to maintain and enhance function. It also supported the early identification of risk alerts related to functional decline and early response to any identified changes.

Preliminary findings

• Improved productivity with support workers working to their full scope of practice and in some cases appropriate task shifting to volunteers.

• Improved motivation, performance and job satisfaction leading to increases in staff retention.

• An alternative use of home and community care allocation acceptable to both consumers and workers.

• Increases in consumer functionality, health literacy and satisfaction with services.

Hobart District Nursing Services case study

To improve a consumer’s appetite and nutritional status, a support worker, who had provided domestic care, now prepares, cooks and freezes meals alongside the consumer. This has contributed to the consumer’s critical weight gain of 3 kg, amounting to nearly ten per cent bodyweight in this case. The consumer is very proud of achieving a weight of 40 kg, stating she is not only eating more and better, but can “fancy” and “enjoy” these meals, and looks forward to them. This intervention has reduced the overall risk of functional decline for this consumer increasing the likelihood of her remaining independent at home.
**Stream 4: Building Workforce Capacity for Complex Care Coordination**

Older people with multiple and complex care needs are increasing and are high users of health and social services. To meet the needs of this consumer group, generalist and specialist care coordination roles have both grown rapidly but workforce structures have not kept pace with this new and emerging workforce. The five projects in this stream implemented workforce redesign to improve the workforce response to these consumers.

**Key achievements**

- Consumer involvement in workforce redesign, providing a consistent approach across care coordination services.
- Supporting clinicians to work to their full scope of practice to increase care coordination workforce productivity and efficiency.
- Workforce integration and partnership across local health systems to reduce fragmentation and duplication of care.

To support implementation, the projects commissioned the following:

- The use of an evidence-based instrument that helps support workers identify and report early decline in consumers with complex care.
- A capability resource for complex care coordination in the community.
- Skills for collaboration, behaviour change and managing complexity training workshops and a training resource.
- A simulation scenario and curriculum suite of tools for complex care coordination in the community.

**Preliminary findings**

- Positive impact on workforce productivity in terms of the number and cost of episodes of care.
- Increases in the number of high priority consumers seen within the target wait period.
- Increases in consumer/carer self-management, early identification of risk and the number of consumers who reported their care was more coordinated.
- Core case coordination capabilities embedded into competencies, position descriptions, professional development, recruitment and retention processes across workforce levels.
- An increase in care coordinator’s knowledge of available competencies, but a further need identified to support knowledge acquisition and confidence to apply skills in practice.
- The introduction of new roles and a shift in understanding of the roles and expertise within care coordination services with increased respect, communication, collaboration and improved knowledge management between teams and services.
- Demonstrated successful partnerships through local system collaboration and information sharing.

Project sites identify that the challenges of this growing consumer group and the emerging care coordination workforce will require a continued investment in, and commitment to, system-level partnerships.
Western Health case study

A 64-year-old man with multiple chronic, complex conditions had a number of admissions to hospital despite numerous community providers being involved in his care. Two of the admissions were over 300 days in duration. The man’s choice was to remain living at home in the community. A Community Service Consultant led care planning with key regional services to give the man an opportunity to stay in his own home and maintain his health. Regular reviews of his health status and care plan were undertaken. He had one unplanned re-admission and two planned readmissions. The patient was happy with his care plan and as a result, he has been supported to remain at home.
Diffusion of workforce models

Taken as a whole, the 52 health and aged care projects have demonstrated that it is possible to develop local workforce innovation and reform models that have national applicability. Lessons have been learned and documented to ensure future adoption partners can build on the strengths and better avoid the barriers to reform.

The program shows that using our current workforce more effectively, allowing each member of the workforce to work to the top of their scope of practice and by introducing assistant and support roles across the system, the productivity shifts we are seeking can be achieved and our workforce can feel more valued and inspired to make a difference.

The commitment and enthusiasm from the consumers and staff impacted by the reform, the project teams, their executive sponsors and the local partner organisations have created the cultural shift required locally to sustain and build further momentum for change. Many organisations are recognising that change is now a constant and understand the critical need to continue to build their workforce capacity and capability for change.

A significant number of project organisations are now actively sharing their learnings and the tools and resources that have been developed to enhance the capability of their workforce. They are now the leaders of workforce reform across the Australian health and aged care system.

This large-scale change program demonstrates that a whole of workforce approach to innovation and reform provides a robust platform on which to build momentum and create sustainable and scalable change. By creating local change capacity and knowledge we can influence and inform the national change agenda and develop policy advice that should bring about system change across the system.

The final national evaluation reports are due for completion in September 2014.