

2.1 Needs Analysis

Introduction

How do you determine the workforce training needs of a region that encompasses the range of health settings from acute care through to community and aged care?

After a review of the literature failed to identify an appropriate diabetes workforce needs analysis tool the workforce development (WD) team developed one.

The Workforce Development Skills Analysis Tool

The workforce development skills analysis tool (WDSAT) aimed to assist agencies across the Primary Care Partnerships (PCP) to assess both organisational and workforce capacity in order to implement best practice diabetes prevention and management.

Evidence Based

The WDSAT was developed through the identification and tailoring of best practice pointers from:

1. The Australian Diabetes Educators Association, National Standards for Diabetes Education Programs (2001)¹
2. American Diabetes Association, National Standards for Diabetes Self Management Education (2003)²
3. Department of Human Services (Victoria), Integrated Disease Management Interim Policy Directions and Guidelines (2001)³
4. Department of Human Services (Victoria), Health Promotion Skill Assessment Tool for Organisations (2001).⁴

The format of the tool was adapted from the Department of Human Services (Public Health) Health Promotion Skill Assessment Tool for Organisations, 2001.

Process for collaborative review of diabetes services

The WDSAT was designed for implementation within a facilitated workshop format with key diabetes service providers across a designated catchment.

¹ Australian Diabetes Educators Association. National Standards For Diabetes Education Programs. Canberra,:Australian Diabetes Educators Association; 2001.

² American Diabetes Association. National Standards for Diabetes Self Management Education. Diab Care 2003; 26:S149-S156.

³ Department of Human Services (Primary Care Partnerships). Integrated Disease Management Interim Policy Directions and Guidelines. Victoria 2001

⁴ Department of Human Services (Public Health). Health Promotion Skill Assessment Tool for Organisations. Victoria 2001

Participants worked through a process that:

1. Assisted agencies to reflect on the role they can play in promoting best practice within a community setting, and the corresponding skills and infrastructure required for best practice.
2. Reviewed the agency's current skills in diabetes prevention and management.
3. Established priorities for skill development.

Practical application

The WD team consulted with Local Diabetes Service Development (LDS) service providers and DHS Diabetes Prevention and Management Initiative (DPMI) personnel to ensure the tool was acceptable and appropriate.

Workshop participants indicated that the process had raised awareness of diabetes care and practices within their organisation.

Evaluations have indicated that LDS projects felt the needs analysis allowed for representation of key local diabetes service providers and agreement on priorities for workforce development.⁵

Included in Attachment 1

The following are included in attachment 1:

1. A guide for implementation of the Workforce Development Skills Analysis Tool (WDSAT)
2. The WDSAT tool template.

⁵ Program Evaluation Unit. School of Population Health. Summary Report on the Second Project Self-Assessment Evaluation of the Local Diabetes Service Development Program. Melbourne: The University of Melbourne ; 2004.

Diabetes Workforce Development Skills Analysis Tool

The Diabetes Prevention & Management Initiative - Local Diabetes Service Development Projects 2005

**Prepared by gill + willcox on behalf of the
DPMI Alfred Workforce Development Team**

Adapted from the Department of Human Services (Public Health).
Health Promotion Skill Assessment Tool for Organisations. Victoria
2001

The Diabetes Workforce Development Tool was produced for the Public Health Diabetes Prevention and Management Initiative by the Alfred Workforce Development Team incorporating The Alfred and gill + willcox. Permission to use this tool should be obtained from the Public Health Group of the Department of Human Services Victoria.

This manual is a general guide only to appropriate practice to be followed subject to the health professionals judgement. The tool is designed to provide information to assist decision making and is based on the best available information at the time of compilation.

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Introduction

This Diabetes Workforce Skills Analysis Tool (WDSAT) has been developed to assist the Local Diabetes Service Development (LDS) Projects funded by the Public Health Diabetes Prevention and Management Initiative (DPMI) to:

- Recognise the diabetes prevention and management skills and capacity across agencies within the Primary Care Partnerships (PCP).
- Identify opportunities and scope for further workforce development.

Aim of Tool

The tool outlines a number of indicators for best practice in diabetes prevention and management and steps the agencies through a process that will:

1. Assist agencies to reflect on the role they can play in promoting best practice within a community setting, and the corresponding skills and infrastructure required for best practice.
2. Review the agency's current skills in diabetes prevention and management.
3. Establish priorities for skill development.

Overview of the Tool

Purpose

The tool has been developed for use by LDS projects to assist agencies across the PCP to assess both organisational and workforce capacity to implement best practice diabetes prevention and management.

The Tool has **not** been designed to review the skills of individuals, but rather to reflect on the collective diabetes prevention and management skills/ activities and services of member agencies.

The term ' Agency' has been used to refer to the diverse range of groups that have a role in delivering an integrated diabetes program or service.

Process

The tool has been designed to be implemented within a facilitated workshop format where key individuals from agencies across the PCP can discuss and clarify issues around best practice,

develop a common understanding of existing skills/capacity and identify opportunities and scope for further development of skills and capacity across the PCP.

Outcome

The information obtained from the implementation of the tool will provide the basis for scoping of workforce development activities which have been planned and resourced as part of the LDSD DPPI projects. The LDSDs have been resourced with a dedicated workforce development team.

An outline of the Tool

The tool has three sections:

1. Agency capacity and resources

Section 1 reviews agency capacity and resources to provide diabetes prevention and management, according to best practice recommendations.

2. Provision of planned care based on best practice guidelines

Section two reviews the process of diabetes prevention and management: is it planned delivered and evaluated according to best practice guidelines. This section is based on diabetes education standards and principles of integrated disease management.

3. Planning and provision of diabetes services including health promotion and early intervention programs

Section three looks at the capacity of the agency to assess, plan and implement diabetes services, health promotion and early intervention programs for people with diabetes or at risk of developing diabetes.

The three sections of the tool identify best practice pointers, which have been adapted from:

1. The Australian Diabetes Educators Association, National Standards for Diabetes Education Programs (2001)⁶
2. American Diabetes Association, National Standards for Diabetes Self Management Education (2003)⁷

⁶ Australian Diabetes Educators Association. National Standards For Diabetes Education Programs. Canberra, Australian Diabetes Educators Association; 2001.

⁷ American Diabetes Association. National Standards for Diabetes Self Management Education. Diab Care 2003; 26:S149-S156.

3. Department of Human Services (Victoria), Integrated Disease Management Interim Policy Directions and Guidelines (2001)⁸
4. Department of Human Services (Victoria), Health Promotion Skill Assessment Tool for Organisations (2001).⁹

The format of the tool was adapted from the Department of Human Services (Public Health) Health Promotion Skill Assessment Tool for Organisations, 2001.

Completing the tool

Review the tool before the workshop and discuss it within your organisation. You will have the opportunity to discuss each of the questions at the workshop and clarify issues but it would be worthwhile working through the tool informally in your agency prior to the workshop to ensure there is agreement on capacity and skills within your organisation.

The rating system

Working through each of the skill components and their questions at the workshop, participants will establish current skill level in their agency and identify areas for further skill development.

Within the group participants will be going through the following process:

1. Under each section there are a number of questions that identify the different aspects of that skill/capacity. Pointers for best practice are provided under each question to stimulate the discussion and thinking.
2. Opportunity will be given to consider all the best practice pointers as a group and discuss examples to illustrate the presence of the skill in individual agencies. If needed, highlight the boxes next to the best practice pointers that need particular attention for your agency.
3. Allocate a rating for each best practice pointer (or yes/no) and a overall rating for each of the questions in each section, for your agency using the rating system below.

⁸ Department of Human Services (Primary Care Partnerships). Integrated Disease Management Interim Policy Directions and Guidelines. Victoria 2001

⁹ Department of Human Services (Public Health). Health Promotion Skill Assessment Tool for Organisations. Victoria 2001

Rating System

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|------------|---|
| A = | The agency meets the criteria of best practice, and has leading edge expertise that others could learn from. |
| B = | The agency's approach has been considered. There is some intention to improve the performance of the organisation in relation to this skill. |
| C = | The agency has yet to consider this approach |
| D = | Not applicable to our agency |

4. Where it is identified that some groups/individual practitioners within the agency have the desired skills, and others may not this should be documented in the comments section.

There will be an opportunity at the end of workshop to discuss priorities for areas of skill/capacity development across the catchment

The responses for each agency will be collated at the end of the workshop by the LDSD projects and the workforce development team and used to plan workforce development activities to support the project over the next 2 years.

Section 1: Agency capacity and resources

| Key Question Section 1 Agency capacity and resources | Grading/comment |
|---|-----------------|
| 1.1 Is there agency support for best practice diabetes prevention and management? ⁹ | |
| <p>Best Practice would mean:</p> <ul style="list-style-type: none"> ▪ An overall agency vision has been developed via a collaborative effort within the agency and the vision is explicitly supported in agency policies and plans ▪ Workplans are developed and implemented collaboratively with clear objectives, agreed timeframes and specified team member roles ▪ Appropriate resources and time are allocated to the provision of diabetes prevention and management ▪ There is support for team members involved in diabetes services to participate in diabetes related committees, working parties and professional activities. | |
| 1.2 The agency has suitably qualified staff to oversee the planning, implementation, and evaluation of diabetes services. ⁹ | |
| <p>Best Practice would mean:</p> <ul style="list-style-type: none"> ▪ The diabetes services have a project coordinator with academic and/or experiential preparation in program management and expertise in diabetes and the care of individuals with chronic disease. ▪ The agency ensures that the skill level of health professionals involved in diabetes services is appropriate. ▪ In an integrated diabetes service staff, work to co-ordinate their roles with others in the team to ensure quality of practice is maintained. | |
| 1.3 The agency develops co-operative working relationships with other agencies? ⁹ | |
| <p>Best Practice would mean:</p> <ul style="list-style-type: none"> ▪ The agency involves key partners in the development of new services and or products. ▪ The agency explores options for problem solving and works towards reaching an agreement with partner agency's to solve problems. ▪ The agency supports the formation of joint planning working parties involving interdisciplinary representation of health professionals & consumers to develop implementation agreements. | |

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| A = Meets the criteria of best practice | B = Need to improve the performance of the agency in relation to this skill |
| C = The agency has yet to consider this approach | D = Not applicable to our agency |

| <p>Key Question Section 1 cont.</p> <p>Agency capacity and resources</p> | <p>Grading/comment</p> |
|---|-------------------------------|
| <p>1.4 The agency has suitably qualified staff to provide diabetes prevention and management services⁶</p> | |
| <p>Best Practice would mean:</p> <ul style="list-style-type: none"> ▪ Diabetes prevention and management is provided according to best practice standards incorporating current knowledge and research findings. ▪ Core diabetes prevention and management team consists of a registered nurse, dietitian and podiatrist these team members are credentialed (or working towards) diabetes educators or have recent experience and knowledge in diabetes management and would be competent to education in the following areas. <ul style="list-style-type: none"> 1. Describing the <i>diabetes disease process</i> and treatment options 2. Incorporating appropriate <i>nutritional management</i> 3. Incorporating <i>physical activity</i> into lifestyle 4. Utilizing <i>medications</i> (if applicable) for therapeutic effectiveness 5. <i>Monitoring</i> blood glucose, urine ketones (when appropriate), and using the results to improve control 6. Preventing, detecting, and treating <i>acute complications</i> eg. <i>hypoglycaemia/hyerglycaemia</i> 7. Preventing (through <i>risk reduction</i> behaviour), detecting, and treating chronic complications 8. <i>Goal setting</i> to promote health, and <i>problem solving</i> for daily living 9. Integrating <i>psychosocial adjustment</i> to daily life 10. Promoting <i>preconception care</i>, management 11. during <i>pregnancy</i>, and <i>gestational diabetes management</i> (if applicable). ▪ Other health workers involved in service provision that may not be diabetes specific but has people with diabetes involved have knowledge in the areas above sufficient to provide safe care to people with diabetes. | |

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Section 2: Provision of planned care based on best practice guidelines

| Key Question Section 2: Provision of planned care based on best practice guidelines. | Grading/comment |
|---|-----------------|
| 2.1 How well does your service provide planned diabetes prevention and management when a person with diabetes contacts your agency? ⁸ Error! Bookmark not defined. | |
| <p>Best Practice would mean:</p> <p>The service has clear protocols for Initial Contact/Initial Needs Identification: i.e. when people with diabetes contact your agency staff collect appropriate information to:</p> <ul style="list-style-type: none"> ▪ Determine eligibility for the service ▪ Identify individuals at high risk i.e. foot problems, newly diagnosed, pregnancy, poorly controlled diabetes ▪ Ensure those at high risk are referred and care prioritised appropriately within the service ▪ Individuals not eligible for the service are referred to appropriate resources ▪ Referrals from other agencies are acknowledged (receipt of referral) and informed of progress of referral. | |
| 2.2 How well do health professional in your service, assess the needs of individuals with diabetes? ⁸ | |
| <p>Best Practice would mean:</p> <p>The diabetes service has a clear and documented process for comprehensive assessment of individuals attending the service including:</p> <ul style="list-style-type: none"> ▪ Information about medical, physical, social and psychological needs, from a range of sources, to reflect a comprehensive picture of consumer/family/carer strengths, resources and problems ▪ Assessment is based on the participation of the individuals(s) with diabetes, their support systems(s) and interdisciplinary team members ▪ The assessment incorporates appropriate risk assessment for diabetes complications and other co-morbidities associated with diabetes. | |

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| 2.3 How well do health professionals plan care for people with diabetes?⁸ | |
| <p>Best Practice would mean:</p> <p>Following a comprehensive assessment individuals within your diabetes service have a documented care plan that:</p> <ul style="list-style-type: none"> ▪ Is developed collaboratively with individuals(s) with diabetes, their support systems(s) and interdisciplinary team members ▪ Identifies issues/problems, risk profile and develops appropriate strategies to address these. ▪ Includes appropriate treatment regime and education interventions according to best practice guidelines. ▪ Encourages and supports self-care strategies. ▪ Identifies appropriate follow up and review ▪ Has recall mechanisms in place including protocols for early identification and treatment of diabetes complications. ▪ Documents individual's progress, including goals and achievement of them. ▪ Referral to other providers is documented and appropriate information supplied ▪ Privacy and confidentiality procedures are adhered to. | |
| 2.4 How well do health professionals involved in your service support individuals to understand how diabetes mellitus affects their body and the implications of healthy living?⁶ | |
| <p>Best Practice would mean:</p> <ul style="list-style-type: none"> ▪ The diabetes service provides comprehensive information/ education for people with diabetes including information on: <ul style="list-style-type: none"> ○ Factors involved in the development of diabetes ○ Basic components of the treatment appropriate to the type of diabetes ○ The relationship between diabetes and other conditions ○ How to prevent, recognise and treat short term complications eg. hypoglycaemia and long term complications ○ The interrelationship between nutrition, exercise, stress, smoking, medications, and healthy living with diabetes. ▪ Education is provided in a variety of formats ▪ Information is provided in appropriate languages ▪ Individuals are provided with consumer friendly versions of best practice guidelines ▪ Individuals are informed of other services for people with diabetes such as Diabetes Australia, National Diabetes Services Scheme. | |

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| <p>Key Question Section 2:</p> <p>Provision of planned care based on best practice guidelines.</p> | <p>Grading/comment</p> |
| <p>2.5 How well do health professionals in your service support individuals to be actively involved in their own care and change behaviour?</p> | |
| <p>Best Practice would mean</p> <ul style="list-style-type: none"> ▪ Staff employ a range educational strategies that gain attention, influence beliefs and values and lead to a better understanding of the root causes (determinants of health) of their life situation. These may include: <ul style="list-style-type: none"> ▪ Use of a credible source to persuade individuals ▪ The provision of information in various forms ▪ Structure the learning experiences to suit different learning styles ▪ Staff teach skills needed to provide support for intentions and decision-making ▪ Appropriate group facilitation strategies are applied to promote a collective identification of the problem, enhance peer learning and skill development ▪ Staff understand and apply the principles underlying effective behaviour change ▪ Referral pathways exist and staff refer clients to complimentary activities to support maintenance of lifestyle changes ▪ Staff are sensitive to cultural beliefs and the social and economic circumstances of individuals. | |

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| Key Question Section 2: Provision of planned care based on best practice guidelines. | Grading/comment |
|--|------------------------|
| 2.6 How well does your agency evaluate the effectiveness of its diabetes service? | |
| <p>Best practice would mean your service collects and documents appropriate client data and is able to demonstrate that:</p> <ul style="list-style-type: none"> ▪ Individuals attending diabetes services report or demonstrate increased ability to accomplish goals for health living with diabetes that are important or meaningful to them and consistent with their desired quality of life ▪ Individuals with diabetes report or demonstrate increased confidence in managing their diabetes. ▪ There is improved physiological control of diabetes as demonstrated by: <ul style="list-style-type: none"> ○ Blood glucose ○ Glycated haemoglobin ○ Serum lipids ○ Body mass index (BMI) and waist circumference ○ Emergency visits and/or hospital admissions for direct diabetes -related reasons are minimised. ▪ Referral and follow-up records indicate that: <ul style="list-style-type: none"> ○ Early detection of risk factors for diabetes complications occurs ○ Individuals with diabetes use resources to prevent complications ○ Emergency and other hospital admissions related to preventable complications are minimised ○ Length of hospital stays related to diabetes complications is minimised. ▪ That the services and care provided are appropriately matched to the client base of the service. ▪ The needs of "at risk" groups have been identified and addressed. ▪ Care planning and service coordination protocols are being adhered to. | |

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Section 3: Planning and provision of diabetes services including health promotion and early intervention programs

| Key Question Section 3: Planning and provision of diabetes services including <u>health promotion</u> and <u>early intervention</u> programs | Grading/comment |
|--|------------------------|
| 3.1 How well does your agency establish a relationship and consult with key community members/groups?⁹ | |
| Best Practice would mean: <ul style="list-style-type: none"> ▪ Clients/ stakeholders and/or client groups have been defined and staff are familiar with local community networks and leaders ▪ Needs of specific cultural and other minority groups are valued and participation by these groups is actively promoted ▪ Mechanism and systems are in place to ensure community participation and input into diabetes program planning ▪ The appropriateness of specifically targeted programs is checked with consumers. | |
| 3.2 How well do people in your agency assess the needs of diabetes community as whole?⁹ | |
| Best Practice would mean: <ul style="list-style-type: none"> ▪ Clients/ stakeholders and/or client groups have been defined and staff are familiar with local community networks and leaders. ▪ Needs of specific cultural and other minority groups are valued and participation by these groups is actively promoted. ▪ Mechanism and systems are in place to ensure community participation and input into diabetes program planning. | |
| 3.3 How well do people in your agency plan social marketing activities?⁹ | |
| Best Practice would mean: <ul style="list-style-type: none"> ▪ Target audience attributes are identified and segmented to create messages specifically for each segment. ▪ The appropriate locations and channels are selected to position the health message for effective audience reach. ▪ An established health behaviour model is used as the basis of the program. ▪ All the products, promotion materials and services developed for the program are pre-tested with the target audience. | |

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| <p>Key Question Section 3:</p> <p>Planning and provision of diabetes services including <u>health promotion</u> and <u>early intervention</u> programs</p> | <p>Grading/comment</p> |
| <p>3.4 How well do people in your agency undertake social marketing? ⁹</p> | |
| <p>Best Practice for this would mean:</p> <ul style="list-style-type: none"> ▪ Connections are established with key people, and networks built with community, media and other relevant stakeholders who may be able to complement the program. ▪ A variety of mass media or limited reach approaches are used and creatively executed. ▪ The effectiveness of the social marketing strategies are recorded and monitored and activity is adjusted accordingly. | |
| <p>3.5 How well do people in your agency plan risk factor screening activities for health promotion/early intervention?⁹</p> | |
| <p>Best Practice would mean:</p> <ul style="list-style-type: none"> ▪ Screening programs take into account community sensitivities and issues such as cultural factors, access to transport and follow-up medical attention. ▪ The screening programs are supported by complimentary health promotion interventions aimed at creating agency and social changes to support individual access to resources ▪ Specific high-risk populations are reached via planned strategies to access these groups. ▪ Key referral pathways exist to local GPs and other relevant agencies for diagnosis and on going counselling, support and management. | |
| <p>3.6 How well do people in your agency implement risk factor screening programs?⁹</p> | |
| <p>Best Practice would mean:</p> <ul style="list-style-type: none"> ▪ Staff ensure individuals are screened with privacy and sensitivity. ▪ Best practice use of screening tools and quality control is maintained and monitored to ensure the accuracy and validity of risk factor measurements. ▪ Pre-screening information and post-screening counselling/discussion is provided to all individuals screened. ▪ Clients are assisted to identify their own needs and rights to determine appropriate action. | |

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