Editorial

INDIVIDUALS ARE LIVING longer than ever before, with a propensity to acquire debilitating conditions, often with comorbidities. This necessitates care delivered from many sectors of the service system. This issue's featured Models of Care article, "Integrated care facilitation for older patients with complex health care needs reduces hospital demand" on *page 451* describes a model of care which aimed to coordinate health care services for older adults. One of the successes of this model was the employment of personal care facilitators, who assisted the patients in understanding their health condition, which promoted self-management in accessing required services.

There are many models of care for older adults that include an individual, such as the personal care facilitator identified in our featured paper, to coordinate care. However, coordination of care is an imprecise term with many applications in medical, social or other types of care. Embedded in this elusiveness are the multiple professional groups, such as medical specialists, general practitioners, nurses and allied health professionals involved with various elements of care and the coordination of that care.

As health professional education is the theme of this issue of *AHR*, it is an opportunity to reflect on the education, competencies and skills of those health care professionals who assist in coordinating care for patients with chronic illnesses or conditions. To date, there is no agreed curriculum or set of skills for this role.[1] There is a growing debate over whether the professionals, whose purpose is to coordinate the various elements of care delivery, need specialised education or whether they have the skills through their professional degree, on-the-job learning, or ongoing professional education.

Internationally, the World Health Organization provides a set of competencies for the health care workforce who care for those with chronic conditions.[2] In the United States there are a range of certifications available, ensuring professionals in case management roles have relevant skills. For instance, there is a Commission for Case Manager Certification which exists for the sole purpose of certifying case managers. At present, nurses are the primary professional group that receives this certification.[3]

Another common model of care practised in the US, disease management, focuses on a range of skills for those in disease management roles. Medical professionals have been the primary professional group for this role. One hypertension disease management study involved resident physicians acquiring skills in at least three of the six core competencies defined by the Accreditation Council for Graduate Medical Education.[4]

In Australia, specific care coordination competencies have been mentioned in a range of policy papers and reports;[5,6] however, with health care workforce shortages, many public and private sector groups have fallen short of committing adequate investment in training and education as well as compensation for these specialised roles. There are a range of professional bodies, institutions and affiliated groups which have a vested interest in the extent of education and training for those in care coordination roles.

Regardless, professionals who advocate and assist clients in navigating the service system should have adequate education, training and experience. One factor to be considered is the extent of care management that the health professional is meant to influence. As the care requirements become more complex and the breadth and depth of coordination need increase, the professional should possess a broader range of skills. Likewise, the investment in these roles can be wasted if positive outcomes are not realised for the client and cost effective for the broader system. It will be

interesting to see how the Australian system addresses this issue to ensure standards of care coordination for varying levels of need.

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1 Cooper BJ, Yarmo Roberts D. National Case Management Standards in Australia — purpose, process and potential impact. *Aust Health Rev* 2006; 30(1): 12-16. Available at: http://www.aushealthreview.com.au/publications/articles/issues/ahr_30_1_0206/ahr_30_1_012.asp (accessed Jun 2007).

2 World Health Organization. Preparing health care workforce for the 21st century. The challenge of chronic conditions. Geneva: WHO, 2005.

3 Tahan HA. Certification helps CMs meet today's challenges. Skills, knowledge, competency enhanced. *Hospital Case Management* 2005; 13(2): 22, 31-2.

4 Gorman RS, Edwards F, Frey K. Designing a disease management program: a collaboration. *Managed Care Interface* 2002; 15(5): 68-72, 75.

5 National Health Priority Action Council. National Chronic Disease Strategy. [Endorsed by the Australian Health Ministers' Conference.] Canberra: Australian Government Department of Health and Ageing, 2005. Available at: http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pq-ncds-strat (accessed Jun 2007).

6 Australian Government Department of Health and Ageing. A new strategy for community care: the way forward. Canberra: Commonwealth of Australia, 2004. Available at: http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-research-commcare-wayf.htm/$FILE/wayforward.pdf (accessed Jun 2007). □