

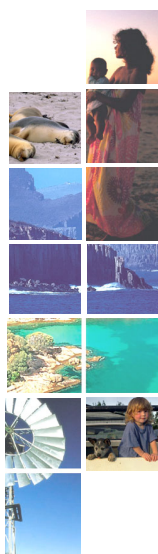
Allied Health Professional Enhancement Program ... improving the health of rural communities

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INTRODUCTION

It has been well documented that allied health professionals in rural and remote Australia face many challenges in delivering responsive services to communities. Many of these challenges are addressed through appropriate education, training and support programs. Generically these aim to improve the skills of the allied health workforce, and support clinicians in the day to day delivery of a service.

The Allied Health Professional Enhancement Program (AHPEP) has been developed in Queensland to respond to the education and support needs of rural and remote allied health professionals. This paper will present the implementation, observations, challenges and evaluation results to date of this program. AHPEP offers improved access to quality professional development that aims to improve health outcomes for remote, rural and provincial communities in Queensland. AHPEP also facilitates the development and maintenance of networks for allied health professionals beyond geographic boundaries.



BACKGROUND

AHPEP has been developed in response to recommendations made in the Director General's Allied Health Recruitment and Retention Taskforce (2000). An existing model of clinical education¹ was expanded to incorporate a wider range of clinical disciplines, and wider geographical coverage.

In 2000, AHPEP expanded to become a state-wide professional enhancement program for allied health professionals. Participating allied health professionals include audiologists, dietitians and nutritionists, occupational therapists, orthoptists, podiatrists, prosthetists and orthotists, pharmacists, physiotherapists, psychologists, radiographers, social workers and speech pathologists.

AHPEP is implemented as an ongoing program through the Queensland Health Rural Health Training Units, in conjunction with a co-ordinator based in a large tertiary hospital. The program is corporately funded and supported by Queensland Health.

¹ Royal Children's Hospital (RCH) Paediatric Allied Health Clinical Experience Program.



OBJECTIVES

Objectives of AHPEP include:

- To provide remote, rural and provincial allied health professionals with an opportunity to gain knowledge of, and experience in areas relevant to their Health Service District and Zonal priorities.
- To provide provincial and metropolitan allied health professionals with an opportunity to gain knowledge of, and experience in remote, rural and provincial services and in issues relevant to remote, rural and provincial service delivery.
- To provide an opportunity for remote, rural, provincial and metropolitan allied health professionals to share relevant knowledge and expertise.
- To develop and maintain networks between remote, rural, provincial and metropolitan allied health professionals, to enhance service co-ordination and continuity of care for those clients who access both services.

The planned outcomes include:

- a sustainable quality professional development program implemented on a state-wide basis
- improved access to professional development for allied health professionals
- improved job satisfaction for allied health professionals with a flow on effect to recruitment and retention of allied health professionals in Queensland Health
- improved service delivery due to enhanced clinical skills, networking and confidence.

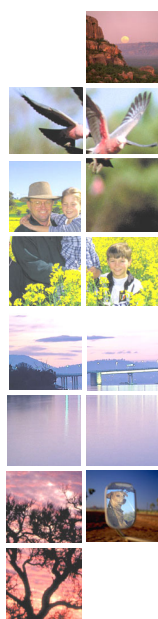
PROGRAM OVERVIEW

Program co-ordinators

To assist in the management of AHPEP, part time co-ordinators are employed at the three Rural Health Training Units, and the Royal Children's Hospital (RCH) in Brisbane.

AHPEP co-ordinators work collaboratively on all aspects of program development, implementation and evaluation and their role, which is pivotal to the program include:

- the development of guidelines in relation to the program
- marketing the program
- establishment and maintenance of relationships with key stakeholders
- ensuring that the necessary organisation is conducted for the individual and team placements including comprehensive pre-visit preparation of participants and the



host sites, approvals, developments of learning contracts and timetables and accommodation and travel arrangements

- co-ordinating videoconferences and workshops including sourcing and negotiating with presenters, advertising the activities, booking videoconference and workshop facilities, organising travel and accommodation for presenters and evaluating the activities
- co-ordination of any other innovative applications²
- monitoring the financial position of the project
- ensuring appropriate documentation and evaluation of the project.

APPLICATION PROCESS

Participants access the program via one of the following:

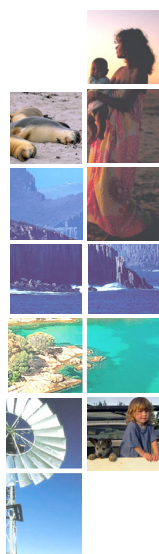
- individual placement of up to one week in an another health service – within or across zones
- team placement of another health service within or across zones
- videoconferencing for specific case discussion and/or clinical consultation
- innovative applications for alternative professional development activities, such as workshops and development of training kits.

Selection process

Applicants are selected with consideration of the following criteria:

- employment location/level of remoteness (rural and remote have priority)
- participant identification of zonal/district/service priorities
- congruence with referral patterns
- sole practitioner status
- degree of cross fertilisation between metropolitan and rural practice (metropolitan applications are encouraged to have a rural and remote focus)
- support of line manager
- participants and host sites ability to meet objectives/goals of the program.

² An innovative application demonstrates the use of alternative methods and processes to access clinical education and support, and provides information for Queensland Health on the value of progressive alternatives.



PROGRAM EVALUATION

Data collection

Data was collected on a number of factors including:

- number of participants: remote, rural, provincial, metropolitan
- number of participants: sole practitioners, new graduates
- disciplines participating in program
- numbers of males/females participating in program.

AHPEP uses the Geographical Area Classification sourced from the Director General's Allied Health Recruitment and Retention Taskforce Report (2000) to classify districts as metropolitan/ provincial/rural/remote. Table 1 indicates the Health Service Districts within Queensland Health, and their geographical classification.

Table 1 Geographical classification of health service districts

Metropolitan	Provincial	Rural	Remote
Bayside	Bundaberg	Banana	Cape York
Gold Coast	Cairns	Bowen	Central West
Logan–Beaudesert	Fraser Coast	Central Highlands	Charleville
Mater Hospital	Gladstone	Charters Towers	Mt Isa
Princess Alexandra Hospital	Mackay	Gympie	Torres Strait and
Redcliffe–Caboolture	Rockhampton	Innisfail	Northern Peninsula
Royal Brisbane and Royal	Toowoomba	Moranbah	
Women's Hospitals	Townsville	North Burnett	
Royal Children's Hospital		Northern Downs	
Sunshine Coast		Roma	
The Prince Charles Hospital		South Burnett	
Queen Elizabeth II Hospital		Southern Downs	
West Morton		Tablelands	

Table 2 summarises the types of activities undertaken by applicants in 2000–01. 56 participants attended Individual placements, including 11 from remote locations, 23 from rural locations, 18 from provincial and 4 from metropolitan locations. Videoconference requests were received from three applicants. These applications consequentially benefited 59 other allied health professionals. Innovative applications were received from rural, provincial and metropolitan locations. These included 5 workshops, which benefited 74 other allied health professionals, and the development of two directories that were sent to over 125 Queensland Health and non-Queensland Health clinicians.

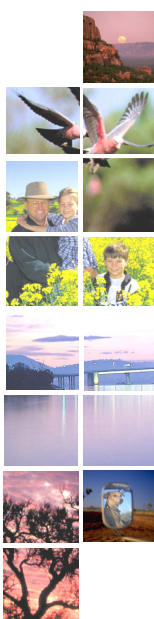


Table 2 Type of activity by originating location

Activity	Originating location				Total
	Remote	Rural	Provincial	Metropolitan	
Individual placement	11	23	18	4	56
Team					0
Videoconference		2		1	3
Innovative		1	3	3	7

Table 3 demonstrates the geographic location of where activities were undertaken, according to the originating location of the application. One participant undertook an activity in a remote location, three participants undertook an activity in a rural location, 27 participants visited provincial locations with 31 attending metropolitan locations. The majority of activities occurred in a metropolitan location. This may be due to the consolidation of large teaching and clinical facilities within Brisbane.

Table 3 Geographic location of activity by originating location

Geographical location	Originating Location				Total
	Remote	Rural	Provincial	Metropolitan	
Remote activity			1		1
Rural activity		1	1	1	3
Provincial activity	7	14	3	3	27
Metropolitan activity	4	8	15	4	31

Table 4 details the allied health professions who participated in the program in the initial year. Physiotherapists used the program most often with the majority of this group originating from rural locations. Podiatrists were the group who accessed the program the least with one podiatrist each originating from a provincial, rural and remote location. The Director General's Summary of the Taskforce Report (2000) indicates that podiatry along with audiologists, prosthetics and orthotists constitutes one percent of the allied health workforce.

Table 4 Allied health discipline by originating location

Discipline	Originating location				Total
	Remote	Rural	Provincial	Metropolitan	
Audiologists					0
Dietitians/nutritionists	3	2	4	1	10
Occupational therapists		4	4	2	10
Orthotists and prosthetists					0
Orthoptists					0
Pharmacists					0
Physiotherapists	3	9	3	2	17
Podiatrists	1	1	1		3
Psychologists	1	2	3		6
Radiographers					0
Social workers	2	1	2	3	8
Speech pathologists	1	6	5		12

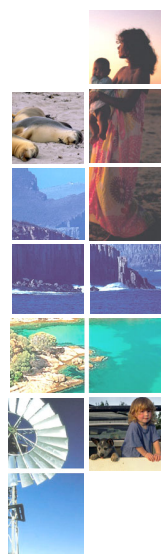


Table 5 summarises the numbers of male and female participants, sole practitioners and new graduates who participated and their originating locations. A number of the sole practitioners were also new graduates. The two sole practitioners originating from a metropolitan location offer outreach services. The number of female versus male participants is consistent with the Director General's Allied Health Recruitment and Retention Taskforce Report, which states that approximately 85% of the allied health workforce are female.

Table 5 Participant demographics

Participant demographic marker	Originating location				Total
	Remote	Rural	Provincial	Metropolitan	
Sole practitioner	7	25	9	2	43
New graduate	2	7	5	0	14
Male	2	2	1	1	6
Female	7	39	7	7	60

Evaluation tools

AHPEP utilised a range of evaluation tools. They consist of seven components:

Participant pre-activity questionnaire

This questionnaire sought information on anticipated benefits of the program, perceived barriers to the implementation of skills acquired on the program, current energy levels and job satisfaction and information on the inservice option chosen to present during the placement and on return to their district.

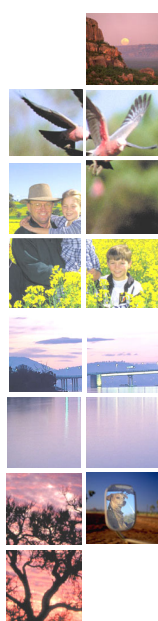
Line manager pre-activity questionnaire

This questionnaire sought information on anticipated benefits of the program, perceived barriers to the implementation of skills that the participant would acquire on the program and room for any further comments.

Participant post-activity questionnaire

Two post-activity questionnaires were administered one at 4–6 weeks and one at 4–6 months. These questionnaires sought information on:

- change in job satisfaction as a result of the program
- relevance of the program to clinical priorities/practice
- change/validation of work practices as a result of the program
- barriers to implementation of skills on return to the workplace
- networking and improvement of service co-ordination and continuity as a result of the program
- organisational aspects of the program.



Line manager post-activity questionnaire

A post-activity questionnaire was sent to Line Managers at 4–6 weeks and 4–6 months after the activity. These questionnaires sought information on:

- relevance of the program to clinical priorities/practice
- change/validation of work practices as a result of the program
- any other comments.

Participant learning contract

A learning contract was developed with each participant to assist in determining learning needs, and to evaluate the program. The goals of the activity were discussed and noted prior to the placement. This ensured that activities were developed to meet specific needs of the participant in consultation with the host supervisor. Line Managers were also encouraged to be involved in the identification of goals for the activity. At the end of the activity the participant was asked to complete the contract advising if goals had been fully, partially or not met and factors that impacted on this.

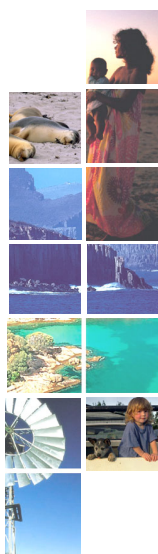
Supervisor post placement questionnaire

The questionnaire was sent 4–6 weeks after the placement and sought information on:

- organisational aspects of the program
- change/confirmation of perceptions regarding rural allied health practice
- costs/benefits to the host site due to involvement in the program
- networking and improvement of service co-ordination and continuity as a result of the program
- relevance of the program on improving health outcomes in rural and remote areas
- participants achievement of goals and related issues
- willingness to be involved in the program in the future
- any other comments.

Innovative applications – videoconference and workshop evaluations

Workshop and videoconference questionnaires were utilised for innovative applications. The workshop/videoconference questionnaires were administered to all participants who attended these activities. The applicant was required to complete the pre and post questionnaires although these tools were not always useful in assessing the innovative applications.



Evaluation results

The program has been successful in meeting its objectives, demonstrated through evaluation by participants, Line Managers and host sites.

The program met the 75% of the goals and expectations, as indicated from feedback from participants undertaking individual placements. These participants reported that factors that facilitated the learning process and meeting goals included:

- supervisor skills, knowledge and enthusiasm
- supportive environments that are willing to share
- access to and sharing of resources
- enhanced networking with ongoing contact via phone, email and videoconference
- the fact that clear goals and a program was established prior to the placement
- The flexibility of the host site to accommodate the participant.

80% of the participants reported enhanced and/or validated work practices, enhanced professional skills, confidence and competence and networking with benefits to local service, clients and community. The face to face contact, observation of experienced allied health professionals and the chance to gain feedback from observation of the participants' skills was cited as a major benefit of this type of activity. Participants indicated that networks were strengthened by face to face contact with peers.

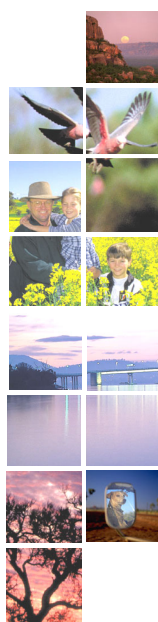
For metropolitan participants and host sites, a major benefit was increased awareness of non-metropolitan practice including:

- service delivery models, challenges and caseloads
- availability of resources
- working environments.

In fact one metropolitan participant decided to relocate to a rural area as a result of her AHPEP activity. The establishment of this understanding and networks contributed to improved clinical practice and service co-ordination for clients accessing both rural and metropolitan allied health services.

In the 4-6 month follow up questionnaires, 60% of participants continued to report that the program had enhanced their work practices. Increased networking had been maintained over the 4-6 month period.

Line Managers also gave positive feedback about the personal and professional gain that participants had received from involvement in the program. The gains most commonly expressed were in enhanced work practices, professional networking and increased confidence. Other factors contributing to positive uptake of this program were the provision of costs for accommodation, travel and locum cover. Line Managers regardless of geographic location, agreed that the program should be continued.



Factors reported by participants that impeded the learning process and attainment of goals included:

- limited supervisor and staff availability because of time restraints
- unforeseen circumstances (eg. sickness, funeral etc)
- models of service and resources available very different to participants base site
- availability of appropriate clients
- goals too broad
- not enough time to cover all that was requested.

Other limitations noted by rural and remote participants, centred around the generalisation of acquired skills within their local work environment. Barriers included lack of specialist services, lack of appropriate referrals due to lack of knowledge about allied health services, funding for resources and time. Line Managers also noted that finances and resources might be a barrier to implementing skills developed by the program.

In comparison metropolitan participants did not feel that there were barriers in their environment to utilise skills acquired during the placement.

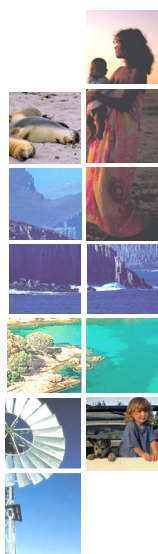
Feedback from the workshop and videoconference questionnaires indicated that workshops were positively received. Participants indicated that content was relevant and pitched at the right level, and that there was appropriate practical components within workshops. More time for practice, case studies and questions was the most regular comment in terms of changes to the workshops.

Feedback about the structure and organisation of the program were very positive. Program co-ordination including the development of the learning contract and visit timetable tailored to the individuals learning needs was reported as a factor that contributed to the success of the program. All of the participants said they would participate in the program again and would recommend it to others.

Several elements contributed to the success of this program, and as such are essential to maintain. These include:

- state-wide co-ordination of the program remains a priority to ensure that consistent guidelines are implemented
- placements to host sites are co-ordinated state-wide to avoid over-burdening certain sites, and to ensure that a variety of sites and resources are investigated and utilised.

The program is now in the second year of implementation with a high demand for places. Continued marketing, development and evaluation of AHPEP will ensure the program continues to meet the support and professional development needs of allied health professionals employed by Queensland Health. It is anticipated that longer-term data collection and evaluation of the program will provide details of the effect of AHPEP on staff morale/satisfaction and recruitment and retention.



CHALLENGES/RECOMMENDATIONS

The challenges and recommendations that have emerged from the implementation and evaluation of AHPEP program include the need to:

- seek recurrent funding to ensure that appropriate resources are available
- develop guidelines to ensure consistent state-wide co-ordination of the program
- redirect the promotion of AHPEP to professional groups not making optimal use of the program
- review and refine the evaluation tools
- use evaluation data to continuously improve the responsiveness of the program.

CONCLUSION

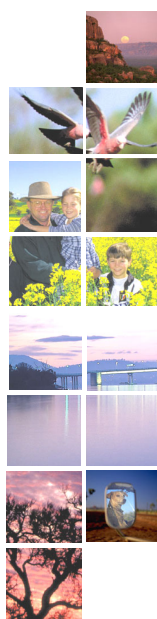
AHPEP has evolved from a small, discretely targeted professional support program, to a state-wide solution to education and support needs for fourteen allied health professions. Fifty eight allied health professionals from remote, rural and provincial areas as well as eight from metropolitan locations have participated in the Allied Health Professional Enhancement Program throughout Queensland during 2000–01.

Current data demonstrates that the program has positively influenced the sense of isolation that rural and remote clinicians experience. Additionally, the program has structured a mechanism that clinicians can establish and maintain networks more effectively and to have their work validated by peers. A broader acceptance and acknowledgment of the rewards of rural practice have also been an intangible outcome of this program.

Continued marketing, development and evaluation of AHPEP will ensure the program continues to meet the support and professional development needs of allied health professionals employed by Queensland Health. Long term evaluation is required to demonstrate the impact that this program may have on recruitment and retention metrics, and ultimately health outcomes in rural communities.

REFERENCE

Queensland Health (2001). *Director-General's Allied Health Recruitment and Retention Taskforce 1999–2000, Summary Report*, Queensland Health, Brisbane.



PRESENTER

LuJuana Abernathy is a Speech Pathologist by background. LuJuana started working at the Cunningham Centre in November 1999 as the Allied Health Program Officer. In her role as Program Officer LuJuana co-ordinates two programs, the Allied Health Professional Enhancement Program and Rural Connect. Both programs provide support and education to allied health professionals in the Southern Zone, Queensland. The Cunningham Centre is one of three rural health training units funded by Queensland Health to provide education, training and support to Southern Zone health professionals in rural and remote Queensland.

