

Strengthening allied health in rural Victoria: a strategic program to enhance interdisciplinary continuing professional education and capacity building

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SUMMARY

Building capacity in rural areas is paramount to ensuring sustainable professional education. Key themes to be discussed to enable capacity building in rural health services and community health centres include: information technology resources, access and training; communication processes and educational resources.

BACKGROUND

It is broadly acknowledged that education and workforce issues for allied health practitioners in rural areas have received scant attention relative to other professions. Provision of continuing professional education is recognised as one of the key factors affecting the recruitment and retention of allied health professionals in rural Victoria.

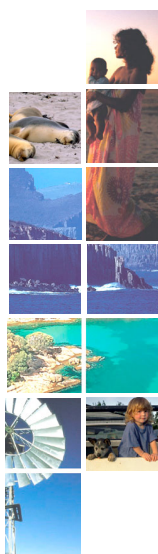
A joint project between the Victorian Healthcare Association (VHA) and the Allied Health Professions Alliance (AHPA) was established in November 2001 to develop multi-disciplinary continuing professional education (CPE) for rural allied health professionals. The project is funded by the Department of Human Services (DHS) and targets both private and public practitioners.

The key themes for the two-year project include:

- continuing professional education
- networking and capacity building
- promotion of allied health
- sustainable CPE models.

PROJECT AIM

To provide opportunities for continuing professional education, to build the capacity of the rural allied health sector in Victoria and promote the work of rural allied health professionals.



OBJECTIVES

- To enhance the opportunities for continuing professional education (CPE) for allied health professionals working in rural Victoria.
- To strengthen the potential for networking and capacity building for allied health professionals in rural Victoria.
- To promote the role of allied health in rural Victoria.

METHODOLOGY

A group interview schedule was developed in order to establish the key issues identified in the project brief. Five rural discussion groups were conducted to obtain issues unique to each DHS region as well as similarities across the state. As there are nine disciplines represented as part of the AHPA, representatives from each of the Associations were invited, including public and private practitioners.

The transcript notes from each discussion group were sent to participants for further input. A summary report was written for each and sent to an additional 225 allied health practitioners (45 in each region – five per discipline) for input.

In addition, allied health practitioners were invited to nominate themselves to provide input into the development of the content of the education sessions.

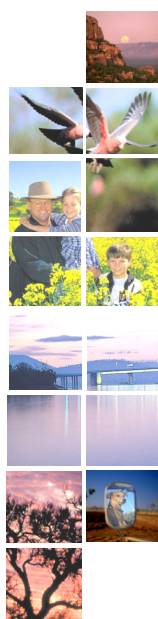
KEY CONSULTATION ISSUES

Travelling to the city for Continuing Professional Education (CPE) has not only proved time consuming, costly, and an increased burden on practitioner work load, it is often inaccessible due to the timing of sessions, travelling distance and various professional and personal commitments.

Priority areas for clinical and non-clinical multi-disciplinary CPE have varied slightly for each region, but the overwhelming state priorities are for education on **Information Technology** including the use of the Internet, email and videoconferencing, **Project Management** such as writing submissions, managing project delivery, health statistics and clinical research and **Clinical Management** including the development of business plans, budget monitoring, management of case loads and conflict resolution. **Diabetes** was at the top of the list for multi-disciplinary education of chronic conditions.

Recruitment and retention of the workforce and overbearing caseloads were reported as significant challenges faced by rural allied health practitioners. Professional isolation from peers and other health professionals was also a concern for many practitioners.

The establishment of networking opportunities was high on the agenda of allied health practitioners, with education sessions being a key forum in which networking opportunities could be developed. Practitioners wanted to network with their peers and to establish links between public and private allied health practitioners.



Establishing networking relationships with other health professionals, particularly general practitioners was also of high importance.

Allied health practitioners wanted professional education sessions to be open to any health professional forming part of the health care team and not limited to specific disciplines. Networking was considered to provide an opportunity to clarify and understand each other's role, and ensure more efficient communication processes and appropriate referrals.

A lack of awareness of the education sessions currently available to rural practitioners was a significant factor with a number of suggestions for a central electronic noticeboard of relevant education sessions.

A CPE MODEL

A project model for the continuing professional education of allied health practitioners working in country Victoria was developed (see end of paper).

The shaded areas reflect the key focus of this project.

Continuing professional education

Continuing professional education is the core to the project. It will include clinical and non-clinical topics that integrate allied health practitioners' knowledge and skills. Topics will have a rural context with local speakers providing that context wherever possible.

Promotion of allied health profession

Strategies will be identified and developed to promote allied health practitioners to the community, amongst their peers and with other health professionals.

Networking and capacity building

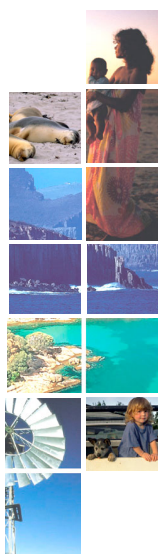
Networking opportunities will be created and strategies identified for capacity building amongst rural allied health practitioners.

Sustainable CPE

Practical models and strategies to ensure CPE continues in the future will be identified.

Mentoring

Whilst the project will not be focusing on mentoring, it is acknowledged that mentoring programs, formal and informal, will impact on CPE needs.



Workforce retention and recruitment

It is well documented that the availability of CPE impacts on the retention and recruitment of the workforce. Whilst related, workforce retention and recruitment issues are not a direct focus of this project.

The boxes relate to the delivery of the key themes identified.

Multi-disciplinary

This is an acknowledgment that the professional education sessions are focused on topics that are appropriate across a number of disciplines. The priorities and focus therefore will be different to the more clinical, or discipline specific sessions that allied health practitioner's need. Networking and promotional strategies will also ensure interdisciplinary activities.

Central/regional linkages

Central co-ordination is clearly necessary for this project to be effective, with close links with the regions to utilise the existing skills and experience of rural allied health practitioners.

Education delivery mode

A range of educational delivery modes is necessary to address the varying needs of the practitioners, dependent on the topic chosen. James and Beattie (1996) grouped educational delivery into four categories as outlined in the delivery mode component of the model. Face-to-face interaction will be a key method in the delivery of the sessions as it offers an opportunity for networking. However, with appropriate training and resources, some sessions are also relevant using video-conferencing technology.

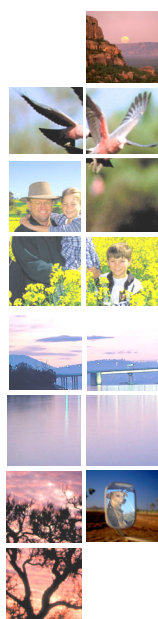
There is no doubt that other formal and informal methods of education that exist for allied health practitioners through their employer or Associations are also effective. The project will focus on establishing processes in which relevant resources are shared to increase access for rural allied health practitioners.

Integration and co-ordination

There will need to be adequate, timely and efficient integration and co-ordination of facilitators and participating organisations for good quality education sessions and outcomes.

Partnerships

Partnerships with key organisations will be investigated. Partnerships will enable the utilisation of existing skills and expertise and create opportunities for sustainable CPE models in the future.



PROGRAM DELIVERY

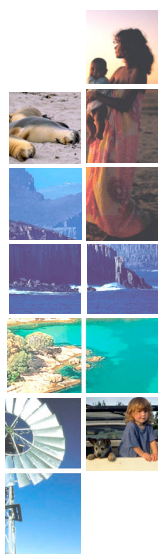
The education sessions developed as part of this project meet the quality standards outlined by CURHEV (1999) and meet any additional accreditation criteria of the Associations. The CURHEV report on quality standards of CPE recommended six standards:

- The proposed CPE activity must meet a need identified by rural allied health practitioners
- The proposed program must have content which is relevant to rural practise and reflect the individual health needs of the specific rural community
- The rural CPE activity must have clear learning outcomes
- The delivery method/s proposed should facilitate maximum access for, and participation by, rural practitioners
- The CPE activity must be facilitated by suitably qualified and experienced presenter/s, and
- The CPE activity must have appropriate and useful evaluation processes.

Articles to generate project awareness have been placed in the VHA Report, Allied Health Association newsletters and in the Herald Sun.

In response to the priority areas identified in discussion groups with over 50 rural allied health practitioners from nine disciplines, and additional consultation inviting contribution from 225 practitioners, the following multi-disciplinary activities have been delivered in Year One:

- 85 rural allied health practitioners attended network lunches with health promotion presentations in five country venues across the state
- 95 rural allied health practitioners participated in Information Technology sessions focusing on Internet and email training across eleven rural locations
- 190 rural practitioners participated in seven project management workshops that provided skills in writing funding submissions and sourcing funding
- 120 participated in a pain management education session delivered through video-conference across 21 rural sites, and
- 60 pain management videos distributed to the field
- 2 e-groups have been identified and will be developed in the areas of mental health and paediatrics in regional areas.



EVALUATION

Input, process and outcome evaluation measures have been utilised to measure the success of each education session. Overall, the sessions attended have been well received. A brief discussion of the results will be provided.

The Health Promotion presentations were successful, although greater facilitation would be required for the networking component of the session to be more successful in the future. The IT – Internet and email training sessions were very successful. There were inadequate numbers for two of the sites, whilst enormous demand in other areas. The submission writing sessions were highly successful. The presentations for the pain management videoconference were rated favourably, yet due to the numerous technical difficulties that occurred, there was considerable delay in the commencement of the session, with many sites missing out altogether. However, there have been successful outcomes from this, such as the establishment of a pain management network.

CAPACITY BUILDING

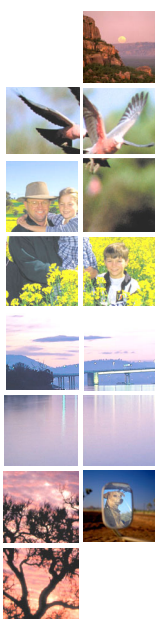
Whilst the delivery of education programs and the establishment of networks is a key aim of the project, building capacity in rural areas is paramount to ensuring sustainable professional education. Capacity building activities include:

- establishing adequate information technology resources
- ensuring video-conferencing facilities are accessible to all disciplines
- ensuring well resourced libraries
- delivering multi-disciplinary education programs for both public and private practitioners
- establishing a central co-ordinating body linked to local clinicians
- provision of locum support.

Information technology

Whilst knowledge of IT was considered a high priority, access to IT resources was considered a barrier with some practitioners having to share with 15 other health professionals in an allotted timeframe. Practitioners based in community centres or small hospitals were less likely to be able to access computers at work. As two practitioners stated, it is ...”meant to be bridging the gap, but it’s making the gap wider” as we don’t have access.

Many health services have video-conferencing facilities. However, barriers still exist as to their use. These include: the cost associated with using these facilities cannot often be covered by departmental budgets, lack of training on how to use the videoconferencing facilities, lack of awareness of their existence or access to the facilities when they are locked in rooms that people do not have access to. Historically, a number of videoconferencing facilities were placed in the psychiatry departments.



These departments have been reported by some as having priority over other practitioners in regard to access. Some allied health bookings remain tentative in case a mental health videoconference comes up.

Communication processes

Whilst the project's contact database is expanding, there will continue to be instances where practitioners are not aware of education sessions. In an effort to capture as many staff as possible for these and other events, information dissemination processes at the workplace and on public databases need to be reviewed.

Educational resources

Some practitioners raised concern regarding the lack of library resources; in particular, journals that are available for allied health disciplines.

Locum support

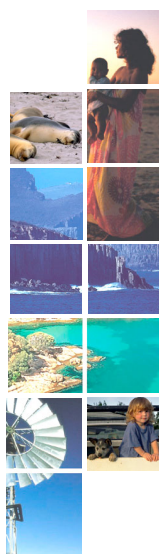
The use of locum services in the country is minimal. Public sector allied health do not use locum services, primarily because they are not available to rural allied health practitioners. Budget limitations were also a key factor as well as the time required to train locums. At times new graduates were available to locum at the start of the year, but were not available otherwise.

Most private practitioners could not access a locum either. Chiropractors and Optometrists were the only private practitioners that did use locum services that were accessed through their Association's database. However, it was noted that this service is not always easy to access. Participants reported that the locum arrangement is very lucrative as they are paid a percentage of the practice income "...you just have to run your practice at a loss ... to go on holidays". The locum arrangement often is that the locum staying in the practitioner's home and using their car while they are away.

Locum services were utilised for holidays and not to attend a 2-3 day education session.

RECOMMENDATIONS

- The development and delivery of programs that work to enhance service delivery and increase the number of allied health practitioners in rural areas need to be led by rural allied health practitioners.
- Funding needs to be dedicated to support capacity building.
- Increase access to educational resources such as video-conferencing by providing training and ensuring access by all practitioners.
- Resource pooling options to be considered to expand the number of allied health publications available to practitioners through their local health service library.



PRESENTER

Clare O'Reilly has worked in a project management, research and policy capacity for the past 15 years. Her role in the last 11 years has primarily been in the management and evaluation of education programs in the health sector, particularly with general practitioners. Clare is currently working on a joint initiative between the Victorian Healthcare Association and the Allied Health Professions Alliance with rural allied health practitioners.

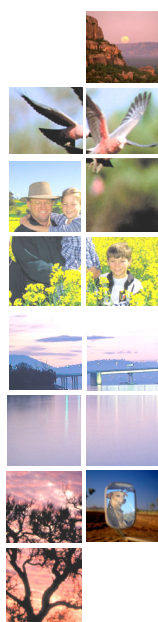


Figure 1 A model for the continuing professional education of allied health practitioners working in country Victoria

