Health Sciences Australia

Australian Council of Pro Vice Chancellors and Deans of Health Sciences

ACPDHS response to the HWA Allied Health Professions Rural and Remote Generalist Project Closed Consultation

Domain 1: Health workforce reform for more effective, efficient and accessible service delivery

What do you think are the key components needed for the definition of rural and remote generalist?

A rural and remote generalist (or comprehensive allied health health worker) is someone who can work at full and expanded scope to provide a range of services relevant to their local community's/catchment area needs. A rural and remote generalist has skills outside of their original professional role/training, allowing expanded scope of practice. A rural and remote generalist needs to be adaptable and flexible, as the skills for practice may change depending on the community's evolving needs and the different needs between communities.

Domain 2: Health workforce capacity and skills development

What do you perceive as essential non-clinical skills for allied health professionals working in generalist roles in rural and remote settings?

- Service planning and evaluation skills: The ability to conduct needs analysis and evaluation of services is essential to prioritise caseloads of patients and ensure service delivery improves patient outcomes.
- Basic epidemiological skills: To inform data gathering and service planning.
- Networking and communication skills: The ability to liaise, train and learn from other professions and work in multidisciplinary teams is crucial.
- Cultural sensitivity: For working in culturally and socially diverse populations.
- Risk management skills: To identify, minimise and manage risks to the patient, staff and self.
- Problem solving and flexibility: Working in often difficult and under-resourced settings in full and expanded scope requires an allied health practitioner who can identify barriers and issues to service delivery and work flexibly to acquire the necessary skills to "get the job done".
- Financial acumen: Potentially some basic business management skills for managing service needs and budgets.

What do you identify as essential components of a clinical governance process/framework for each of the three types of generalist roles identified?

- Full scope/rural and remote competent

Clear supervision and support structures are required to ensure professional development and mentoring to achieve full scope in a rural and remote context. The ability to learn from others, reflect on practice and be up skilled by other professionals outside the local service may be necessary. New graduates in particular will require mentoring and support to ensure the development of key skills for practice (both clinical and non-clinical skill sets).

- Expanded depth of practice

Professional development with supervised practice will be required, potentially within a larger service where the expanded tasks/skills sets are utilised more regularly. Alternatively, it would be useful for a "city to bush" supervision strategy to be developed, where therapists from higher resourced settings travel to the rural setting to support and up skill the local rural remote generalist therapist. This would allow the training to be developed with some knowledge and awareness of local context and could partially negate the backlog of work that builds when the rural practitioner travels away for training and professional development.

- Expanded breadth practice

For this role, it is particularly important to identify the key training requirements for additional skill sets outside of the original professional role and how these are acquired and assessed for competence. Supervision of learning may be required by another profession or a previously trained generalist allied health practitioner. This may need to be done outside of the health service the professional is working in, if skilled supervisors are not available locally. It would be useful to consider whether formalised training (with or without accreditation) is necessary for expanded breadth of practice roles.

Domain 3: Leadership for the sustainability of the health system

How can we use Health LEADS Australia, the national health leadership framework, to better enable promotion and adoption of the rural and remote generalist model?

Include Health LEADS in entry level professional programs and ensure buy-in from the professional associations.

What do you identify as key leadership challenges facing the adoption, support and translation of a remote generalist role for allied health professions on a national scale?

The need for leadership to support culture change across the professions to embrace expanded scope of practice approaches is key to the success of this project. Bringing a group of professions along a path of expanded scope/generalism will be much more complex than a singular profession such as medicine.

Leadership will be required at the service, district and state health department levels to ensure service planning is clearly tied to community health needs and that workforce planning is overseen with clear patient referral systems, training and supervision processes in place. Professional recognition and award levels will need to be developed to support career progression and recognition for those with advanced skills who are working to full/expanded scope and expanded breadth of practice. It is important that leadership is developed in those doing generalist/comprehensive health worker roles, and that leadership is both recognised and harnessed.

It will be important to involve allied health professionals who are already experienced rural and remote practitioners and leaders in their own right. The three roles described in the project relate clearly to many roles that are already being done in practice (even if not formally acknowledged). Leadership will be needed to bring new people into rural and remote generalist practice, whilst supporting and acknowledging those who have spent years doing under resourced and unrecognised generalist practice. Many are likely to be sceptical about the capacity of HWA to deliver on the ground changes in terms of professional development, support and identified award structures that acknowledge expanded scope and breadth of practice.

Training will need to be considered both for those who are new to expanded roles and those more experienced in practice. Leadership will be required in the tertiary training environment to embed a skill sharing culture and the clinical and non-clinical skills sets within entry to practice training and, potentially, in post graduate specialised courses. Training will need to be harmonised with those services being provided with the health system, requiring leadership in both the health and education sectors.

Domain 4: Health workforce planning

Is there any additional data available to assist with this project related to workforce planning capacity?

There are a number of research projects that have recently investigated skill sharing and expanded scope of practice for the allied health workforce in Australia. Whilst these are often focused on allied health workforce in a particular region, they offer great value in providing evidence of the allied health roles and tasks currently being implemented across rural and regional Australia, their impact on client/patient care and outcomes and the therapist experience of transitioning to a skills sharing model. Of particular relevance to the HWA project are the following studies:

Rural and Remote Generalist Allied Health Project Report (GNARTN) December 2013

This project identified the tasks and roles of allied health professionals (OT, physio, dietetics and nutrition, speech pathology, social work and podiatry) across five sites in northern Queensland. Teams were then asked to conduct a risk assessment of skills sharing or delegation of clinical tasks. The key findings of this project were:

- Significant skill sharing was already occurring across the profession. 45% of clinical tasks in the services were already delivered by more than one profession.
- 127 of the 337 tasks being conducted in the service were identified as appropriate for skills sharing between two or more allied health professions.
- The project identified 13 clusters of workload tasks appropriate for skills sharing: activities of daily living and function, mobility and transfers, prevention of foot morbidity in high risk groups, children's development, cognition and perception, communication, psycho-social, fatigue/sleep/energy conservation, pressure care/skin and wounds, diet and nutrition, neuro-musculoskeletal and pain, cardiovascular fitness and exercise tolerance and continence.
- There was also evidence for further development of an allied health assistant workforce.

An RCT on Professional Skill Sharing, led by Alison Pighills and Michelle Bradford of Mackay Hospital and Health Service (see attached document for reference)

This RCT investigated the question: "Is professional skill sharing as clinically effective as usual uni-professional OT/PT care in enhancing functional independence in community dwelling older people"? The key findings were:

- There were no differences in patient outcomes between the conventional uni-professional interventions and those that were skill shared.

A Study into Implementing Skill Sharing Practices: Barriers and Enablers, led by Alison Pighills and Michelle Bradford of Mackay Hospital and Health Service (see attached document for reference)

Focus groups with allied health professionals who had been involved in a skill sharing initiative within a northern Australian health service were asked to reflect on their experiences of skill sharing in practice. The key findings were:

- Professionals were initially anxious around the transition to skill sharing. Key concerns were that the model would diminish specialist knowledge in allied health disciplines and would dilute the quality of patient care.
- However, post skill sharing, the clinicians believed there was increased appreciation of the allied health disciplines, greater efficiencies in service provision, improved cross disciplinary relationships and greater clinician satisfaction and career development.

A study on Patient Experiences of Health Care Services Provided by Allied Health Professionals using Skill Sharing, led by Alison Pighills and Michelle Bradford of Mackay Hospital and Health Service (see attached document for reference)

Patients were asked for their views and impressions of the care they received from the allied health skill-sharing practitioners. The key findings were:

- The vast majority of participants were oblivious to the traditional demarcation of treatment activities between allied health disciplines, and expressed greater interest in reflecting on the value of the treatment received and the quality of their interactions with the skill-sharing practitioner.

- When the specifics of the skill-sharing treatment received were pointed out to participants, they expressed satisfaction and support.

A study into Student Skill Sharing in a Community Setting, led by Alison Pighills of Mackay Hospital and Health Service (see attached document for reference)

This study investigated the outcomes of training 3rd year occupational therapy and physiotherapy students in skill shared tasks from the occupational therapy, physiotherapy, speech pathology and dietetics professions, in a community based aged care team. The key findings of this project were:

- Teaching skill sharing to students can be difficult when there is minimal experience of skill sharing within the clinical teams.
- Success depends on the attributes of the students (personal skills, prior clinical experience and timing of placement in study).
- Students require a solid understanding of the foundations of their own professions before successfully transitioning into a skill sharing role.
- There is more work to be done around models of supervision and training for students in skill sharing across the professions.

Is there any additional information other than data to assist with this project related to workforce planning capacity?

Key documents would include the QLD Health Allied Health Advanced Clinical Practice Framework (see attached document) and the work done internationally on the Calderdale Framework (prior to the trials in Australia) (see attached documents). Also of potential use could be the Health Professionals Rural Student Clinical Placement Project, led by Tanya Lehman and Kelly Schulze, for the Government of South Australia (see attached document for reference). Whilst the final details of this project have not been released, a report of early recommendations has been developed, some of which would relate to the clinical training for the future allied health generalist/comprehensive health worker workforce.

Expanded scope is also useful to consider in terms of pathway of care models. There are a number of areas where allied health professionals could have expanded scope of practice to increase outcomes and efficiencies of care. In tracheostomy weaning and decannulation, physiotherapist, nurse practitioners and speech pathologists trained in weaning and decannulation have reduced waiting times. Evidence has also been supportive of physio and nursing weaning from mechanical ventilation. Physios have also been involved in non-invasive ventilation in WA. In addition, the APA has called for MBS to include physiotherapist to be involved in diagnostic imaging to reduce waiting times and circular referrals.

In regards to physiotherapy there are a number of areas of possible extended scope. These include bronchoscopies (being done by physio in UK), ultrasound in intensive care (ie: for determining need for insertion of intercostal catheter – already done in the UK) and suturing. Also, physiotherapy could play a role in the areas of respiratory, cardiac and renal health which have been traditionally been completed by nurses only (ie: respiratory care nurses in community, oncology/ breast care

nurses). Increased scope of practice for occupational therapists in complex care roles in community settings has been evidenced to have significant impact on reducing hospital admissions, reducing carer burden and increasing health and quality of life outcomes.

In Queensland (and other States) we have seen the dedicated health promotion workforce reduced to a very small number of metropolitan based staff. This loss of dedicated health promotion positions opens up opportunities for all health disciplines to consider how health promotion and prevention can be incorporated into their current roles (i.e. health promotion and prevention become everyone's business).

Whilst there are obviously unique aspects to generalist practice for the allied health workforce, lessons could be learned from what has occurred previously in medicine, with acknowledgment that expanded scope of practice is very different to implement across professions compared to within a profession.

Domain 5: Health workforce policy, funding and regulation

What are the regulatory, policy or funding barriers to achieving a recognised pathway and role for Allied Health Professionals working as rural and remote generalists?

Key to successful implementation of advanced and extended scope are awards that recognise and effectively renumerate the advanced skills, training and responsibilities of expanded scope of practice. Retention is an ongoing issue in allied health professions. Having the opportunity to extend scope of practice and work in advanced scope of practice (expanded depth of practice) may be one strategy to retain staff, through opportunities to expand skill sets and work in a diversity of practice. Award structures need to reflect the advanced and extended nature of workload. This, in turn, may assist with retention of allied health professionals who often experience a lack of opportunities for career advancement and move onto other careers at a time they are most skilled to contribute to the health workforce.

Interstate recognition of award levels and qualifications is a likely challenge. There is a potential for state by state differences in the health system awards. Ideally, expanded scope descriptors and awards should be portable between state borders to assist with retention of allied health generalists, even between borders. Continuing professional development should be demonstrated for continuation of appointment at an advanced level for those working in expanded or advanced scope of practice.

Expanded prescription could be completed by many professions in line with the HWA Health Professional Prescribing Pathways (HPPP) project. A key issue in expanded prescription is preventing a conflict of interest between pharmaceutical companies and health professionals – an issue medicine has had a long history of ethical issues in regards to. Structures need to be in place to prevent the misuse of market power (ie: sponsorship of conferences/research etc), creating a conflict of interest between pharmaceutical companies and health practitioners. Considered guidelines for ethical prescription will be required for expanded prescribing practices. Variations in legislative environments (ie drugs and poisons acts) also limits transferability of practice between states.

What do you identify as the key drivers required to promote, implement and embed rural and remote generalist models of care in the current service system?

- Considered health service planning within districts to identify key areas of maldistribution of services where expanded scope of practice could have maximum benefit.
- Considered and resourced training and supervision models, in both face to face and online formats.
- Health system records which allow for data collection regarding patient outcomes, in order to drive service development and culture change.
- Clear and appropriate award structures that identify and encourage career development pathways and leadership in expanded scope of practice roles as well as rural incentives programs.
- Capital investment in telehealth initiatives beyond medicine and into allied health practice, particularly in rural and remote settings.
- Alignment with HWA HPPP to encourage expanded prescribing practices.

Effective sub-acute care requires the contribution of allied health practitioners in a strong and comprehensive primary health care model. Many of the current examples of expanded scope focus on allied health in the tertiary health (hospital) setting. Having allied health professionals in community settings to provide comprehensive services for the National Health Priority Areas is potentially cheaper and more accessible than those situated in tertiary health care settings.

Additional to interdisciplinary professional barriers is trust between professionals, sometimes in the same discipline. Multiple replications of assessment between community - hospital - discharge - outpatient care can at times be unnecessary, inefficient and burdensome to patients. This requires a systemic consideration of best practice and clear communication and health records between the different areas of the health system (would be supported by an efficient e-health records system).

Please make any further comments that will assist in the development of the project.

It is useful to consider that expanded scope of practice for allied health professionals is also applicable to urban areas where maldistribution of health services also occurs. Skill sharing between disciplines (for example a comprehensive or generalist allied health professional with OT, speech and physio generalist skills) could reduce the burden of multiple visits to health professionals for the patient. Keeping people healthy and active in their homes is a key focus of many allied health interventions and a comprehensive or generalist allied health professional model for community services may assist access for clients who would otherwise have to see multiple professionals (creating multiple barriers for access). However, expanded scope is likely to be easier to trial in areas where there have been minimal or no existing services than in areas with already established services.

There may also be some opportunity to develop expanded breadth of practice for particular areas of clinical need, rather than the demographic focus on rural practice. For example, an allied health generalist who specialises in diabetes management, neurological conditions or aged care.

The GNARTN project findings (which identified 13 clusters of workload tasks that were appropriate for skill sharing) indicate that there may be areas of practice where skills sharing could benefit allied health practice broadly. Delegation of tasks, to allied health assistants or nurses in community, could also be explored in greater depth.

Expanded prescription could be also completed by many professions in line with the HWA Health Professional Prescribing Pathways (HPPP) project. Trained and accredited clinical pharmacists with supplementary or independent prescribing rights are currently not utilised. Supplementary or Independent prescribers working in collaboration with medical staff could help to significantly reduce admission and discharge times in general medical and surgical settings. Specialised pharmacists in specialist centres (such as oncology, renal medicine, mental health etc) working as supplementary prescribers within agreed protocols could significantly reduce medical workloads in the prescribing of routine therapies within these units or clinics. Another major area in which pharmacists could have greater impact is in the area of antibiotic stewardship, where pharmacists have shown proven benefits in reducing unnecessary or inappropriate antibiotic prescribing. This in turn reduces costs but also the development of antibiotic resistance and the spread of resistant organisms.