Keeping up with the Joneses while at home with the Smiths

Janelle Amos, Miriam Gerber
Hope Therapy

Introduction

With the introduction of the Australian Health Practitioner Registration Authority many allied health disciplines have had significant changes to their registration standards, including some states and disciplines that have never had stateside registration requirements previously. This has been a significant transition for the whole workforce but one group particularly affected by the changes are "stay at home (SAH)" care givers. The issues facing this group of people are further compounded by living in rural and remote locations. This paper aims to explore the issues and possibilities for better supporting SAH care givers to maintain their registration whilst living in rural and remote locations.

Background

Rural and remote health

The ongoing challenges of recruitment and retention to the rural and remote workforce are well documented. It is also nationally accepted that the health status of those living in rural and remote geographical locations have poorer health then their urban counterparts. Given this crisis there has been increased effort in targeting health practitioners and encouraging and supporting them to 'try' rural and remote health. With this in mind, it is our experience that there is one group of clinicians that are not only willing to live in a rural and remote environment but are there already, integrated in the community, because it is 'home', yet are struggling to maintain registration and find appropriate work – stay at home caregivers.

Australian Health Practitioner Regulation Agency (AHPRA)

The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia. AHPRA works with 14 National Health Practitioner Boards in implementing the National Registration and Accreditation Scheme. AHPRA and the National Boards regularly consult with advisory groups to gather feedback, information and advice on a wide range of issues.

Continuing Professional Development (CPD) & Recency of Practice

The Physiotherapy Board of Australia states that continuing professional development is "the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives."[1(p1)]

Each National Professional Registration Board stipulates its own professional development requirements that need to be met yearly in order to maintain registration through AHPRA and therefore legally work within Australia. As a rough guideline, the table below[3-7] illustrates the number of hours or points that must be accrued with evidence to support completion of the required number of points within a given registration period.

Profession	Numbers of hours/points
OT	30
Physio	20
Podiatry	20
Psychology	30
Optometry	40

In addition to continuing professional development requirements, all practitioners must have undertaken a certain number of hours of practice within their health profession, as specified by their National Board, within preceding years of registration.[2] This is known as 'Recency of Practice'.

Demographic information

Non-practicing but registered allied health professionals

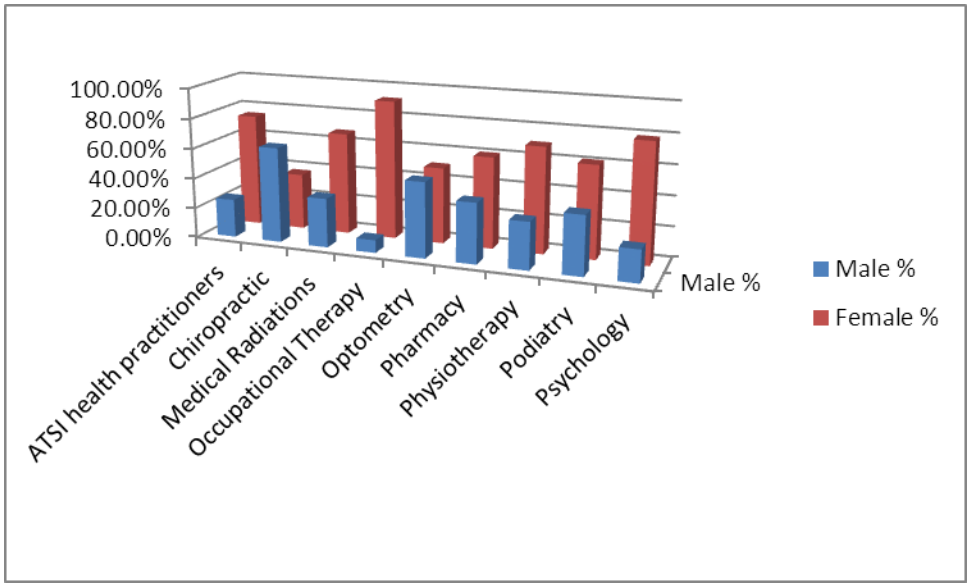
The information below has been obtained from the Occupational Therapy Board of Australia[8,9] who commenced collection of data of registered OTs in 2012. The table compares demographic information regarding numbers of **registered** OTs who were **not practicing** at the time of data collection. Data on previously registered OTs who have relinquished their registration voluntarily was unable to be obtained but would be also provide valuable information.

	September 2012		December 2015	
Age group	Non-practicing	Total registered OTs	Non-practicing	Total registered OTs
21-25	2	1832		
U-25			26	1780
26-30	25	3063		
25-29			149	3817
31-35	18	2406		
30-34			152	3295
36-40	17	1817		
35-39			99	2373
41-45	12	1453		
40-44			44	1849
TOTAL:	96	10571	563	13114
% of non practicing OTs	0.91%		4.30%	

Gender

The majority of the allied health workforce in Australia is female (with the exception of chiropractors which is a male dominated profession and optometry which is equally distributed). This distribution has a significant affect due to the percentage of the workforce that are likely to have a period of 'leave' from active work due to pursuing a family. According to information obtained from the APRHA website[8,10-17], at December 2014, the ratio of females to males in a range of allied health professions is represented below.

Profession	Male %	Female %
ATSI health practitioners	25.27%	74.73%
Chiropractic	62.87%	37.13%
Medical Radiations	32.39%	67.61%
Occupational Therapy	8.36%	91.64%
Optometry	49.65%	50.35%
Pharmacy	39.65%	60.35%
Physiotherapy	31.04%	69.96%
Podiatry	38.76%	61.24%
Psychology	21.18%	78.82%



Stay At Home (SAH) care givers

For the purpose of this paper, the term “stay at-home care-giver” refers to a person who either chooses, or out of necessity, leaves the workforce to stay home to care for children or other family members. It is our experience that from the implementation of these standards, that SAH caregivers have been particularly affected for the following reasons.

- SAH care givers are not practicing or work very part-time or intermittently
- SAH care givers often do not have time, finances, or access to professional development opportunities and therefore are at risk of leaving the professional due to an inability to maintain registration requirements
- The difficulties facing SAH care givers are compounded by professional challenges of living in a rural or remote location

As SAH caregivers ourselves, it is our experience that the seeming enormity of meeting the CPD and Recency of Practice requirements inevitably leads to the dilemma of whether or not to relinquish our professional registrations and leave the profession.

Why are SAH Care Givers in rural and remote locations valuable to allied health professions?

- We have often chosen to make these rural and remote locations our “home” and are likely to stay. We also have an invested interest and passion for the community as well as local knowledge, respect and contacts.
- We are often clinicians with many years of experience behind us, and in senior clinical roles.
- Retention of health professionals affects health of communities[18]

The issue for SAH caregivers

Barriers to staying registered

Some of the barriers that we have identified and experienced as SAH caregivers are listed below. The list is not extensive but is reflective of our experiences and of those whom we have talked with.

- Recency of practice standards
- Ongoing continuing professional development requirements.

- Financial Pressures. Reduced income (as not working) to invest in CPD activities such as conferences which require not only large conference fees but also extensive travel and accommodation costs but also often costs in providing care for children still at home. While working there is often an allocation of professional development money available to be used but when you are not actively employed this is often not available.

- Time constraints. When you are working the workplace often accommodates CPD activities by allowing the clinician to participate in 'worktime'. As a SAH care giver not only is the burden of financial requirements solely the responsibility of the individual but so is the time to complete the activities. In addition, as a SAH Care Giver anytime that you are away from the home you are required to provide alternate care for your children / family member. Finding time when others can be at home and provide the care required can often be a real juggle and at times very expensive undertaking.

- Disconnected. When the SAH Care giver is isolated from the work place due to extended leave, they also get disconnected from their colleagues (who have often left before they get back and there are all new faces) and disconnected from the profession. It has been this disconnection that has been one of the biggest struggles in our experience. When the burden of juggling family commitments and registration requirements conflict, it is then that you need the support of 'like-minded' colleagues and friends to support you through the crisis and give you ideas on how to meet the requirements of both.

Possibilities for the SAH caregiver

How can we stay at home and remain registered so I can work or re-enter the workforce?

The Occupational Therapy Guidelines on Continuing Professional Development recognises that attaining CPD points is more difficult for clinicians residing in rural and remote areas.[3] The use of online and distance learning is highlighted as option for remote clinicians however does not reflect the reality of the challenges faced by the remote allied health workforce who wish to "stay at home with the Smiths". Therefore in the following paragraphs we will explore options to address each of the listed barriers and hopefully provide some concrete suggestions for individual clinicians to take away as well as recommendations to professional bodies to better support the needs of this increasing professional demographic.

Suggestions to meet recency of practice

Within each of the Allied Health disciplines the requirements for recency of practice are different, hence we will not discuss the criteria itself rather look at means of completing the stipulated recency of practice requirements. Generally recency of practice requires a certain number of hours of work within the profession within a given time frame, for example 6 months full time equivalent in the last 5 years. This can be particularly difficult if SAH care givers have had multiple children. Some suggestions are listed below.

- Part-time work within previous role

- Complete contracts for clinicians within your area (eg. Back fill for holiday leave)

- When going to family for school holidays etc, try and line up some back-fill work during that time when family can assist with children.

- Approach service providers within your region to assist you in maintaining your registration by employing you for small number of hours each week. Service providers may be Medicare Locals / Primary Health Care Networks; Aboriginal Health Services; Government; Non-Government Organisations such as Home and Community Care service providers, Blue Care/Domiciliary Care, Frontier Services etc.

- Approach private service providers such as General Practitioners for opportunities to provide services such as Enhanced Primary Care (EPC) under Medicare etc.

- Commence your own sole-trader business in order to provide, EPC Medicare services, Department of Veterans Affairs (DVA) services, workers compensation authorities and motor vehicle accident insurers.[19] This can be a bit daunting for some but there are a number of organisations that help you establish a small business and the outlay need not be great. The benefit of this is you have control over your own hours allowing you to book work when it suits family commitments. Although Merritt, Perkins and Boreland[19] do highlight a number of difficulties with providing a private occupational therapy practice in rural and remote locations, other allied health professions may not have the same limitations and it may be a viable and sustainable option. Doing some work-shadowing with another small business somewhere is a great place to start and will provide you with an insight into small business.

- Work in large hospitals of a week or two a year as backfill (often Hospitals and Health Services have causal positions for backfill)

- Volunteering within your professional capacity at a local level (note you must consider insurance cover)

Suggestions for accruing CPD points/hours

- Use of Information Technology - "In a survey of Western Australian occupational therapists' use of ICT [information and communication technologies], Taylor and Lee (2005) found ICT use to be high, with 62.3% of non-metropolitan based respondents using ICT as a method for maintaining professional development and 90.8% using ICT as a means of communicating with peers and health professionals".[20(p337)]

- Workshadowing (even when you go on holidays somewhere line up a day or two at the hospital etc)

- Reading journals

- Participating in case conferencing. This can be more difficult when care givers are not connected with a local workplace.

- Presenting papers

- Further post-graduate study. There are many external opportunities for post graduate study. Consideration does need to be given to the number and location of intensives as they can be very costly and time demanding. There are scholarships available to support rural and remote staff in completing activities such post graduate study.

- Conferences. Additional CPD can be earned by completing papers or poster presentations when attending conferences. Speaker rates are also generally reduced cost.

- Webinars have facilitated more opportunities for rural and remote clinicians provided they have access to good internet (which at times can be a problem). Webinars are streamed live over the internet and are generally reasonably priced. They are similar to 'videoconferencing' but do not require specific equipment aside from a good internet connection, a computer and a web camera. Another benefit of webinars is that in our experience they are generally in the evenings. They are also often recorded and you are able to access them at a convenient time.

- Access international OT associations links to online education (eg. Webinars)

- Mentoring others or being mentored yourself is another great way of accruing CPD points that has very limited financial or time requirements.

- Communities of Practice – online discussion forum where professional issues can be discussed with other practitioners who have an interest and expertise in that particular clinical area. (eg. Aged care, paediatrics, stroke rehabilitation etc). Within occupational therapy, in order to access the communities of practice, one is required to be logged in to OT Australia to post questions, check conversations and to contribute in any way. In 2011, a small study[20] was conducted which looked at the use and effectiveness of this type of forum which highlighted the perceived strengths and limitations of such an arrangement.

  Strengths

  – the ability to interact with other therapists

  – an ongoing history of items discussed

  – more interactive

  – the ability to be used when convenient

  – a time efficient and readily accessible means of obtaining information and resources, developing networks and overcoming professional isolation, receiving responses to questions ⁄comments and mentoring opportunities

  Limitations:

  – lack of awareness of the CoP

  – technical issues with access

  – listservs are more regularly and easily accessed via email than the CoP, which requires users to log on

  – listservs meet their informational needs whereas the CoP information is 'sometimes limited and often out of date due to limited use by therapists

  – because of the lack of active participation in the CoPs, there was a perceived, loss of discussion momentum, limited discussions and resources, and loss of motivation to habitually check and contribute to the CoP.

- Interest Groups – coordinated through the OT association but the main communication between members of the interest groups is via email communication.

- Regional Groups – Virtual or face to face meetings and communication between professional members in a similar geographical location (eg. North west Queensland)

- Allied Health Interest Group - Professional body such as SARRAH look at capacity to host a SAH allied health 'interest group' that can meet as a webinar to look at case conferences etc, share ideas, etc for non-practicing remote allied health professionals.

Suggestions for reduced income

- Participate in as many local activities as possible such as local association groups or mentoring other clinicians.

- Complete as many hours as allocated through journal readings and such.

- Utilise the times when you are away at larger centres even for one day work-shadowing you are able to claim 8 hours of CPD.

- Investigate possibilities for scholarships such as “Nursing and Allied Health Scholarship and Support Scheme”

Suggestions for reduced time

- Complete home based options as much as possible
- Do a job share and child share arrangement with another local working person. They don’t need to be in your profession or workplace just someone for whom you can look after their children one day while they work and then they do the same for you.
- Try doing things in blocks rather than every week. For example 2 x2wk contracts or 4x 1wk in a year often mean that your requirements for recency of practice are complete within those blocks.

Suggestions for disconnection

- Maintain a relationship with your workplace wherever possible. Including asking them to send emails to your home address so you can remain aware of what is happening and be involved in any relevant CPD activities including case conferencing.
- Connect with other health professionals, working or not, even socially in order to discuss professional issues and share about barriers and possible strategies.
- Become an active member of an association such as your discipline specific national association or other associations such as SARRAH or NRHA.

Recommendations

The following recommendations are derived from our experiences and areas of need that we have identified that we believe would help quantify the reality of SAH care givers experiences and greatly support SAH care givers to maintain their registration.

- That a body such as SARRAH (Services for Australian Rural and Remote Allied Health) consider facilitating a group specifically for those stay at home caregivers. This group could use technology to keep in touch, complete case conferences together, book or journal reviews, or other activities that are related to support. By building this network SAH caregivers may feel more supported in their roles and would build a network of like-circumstance people who can share ideas and resources. It potentially could also provide opportunities for people to visit other people for workshadowing etc cutting down on accommodation and other associated costs.
- AHPRA have some way of identifying by postcode those practitioners whom are not re-registering or have asked for a waiver of their CPD so these clinicians could be identified and contacted to further discuss barriers to maintaining registration and offered ongoing support.
- In-depth research to formally investigate the issues around registration requirements and there impact on people maintaining registration. Particularly of interest would be the SAH Care giver in rural and remote areas.

Summary

This paper has addressed the demographic of health practitioners whom are still registered and are considering letting their registration lapse due to the difficulty of meeting their professional development and recency of practice requirements. It has identified barriers to maintaining registration and suggestions on how to address these barriers. It has been the experience of the authors, both of whom are SAH Care givers, that there is great conflict between the desire to SAH with infants and children and also remain current and professional within their chosen health career. Support, financial assistance, workplace understanding and connectedness with other likeminded people all contribute to ones ability to maintain their registration.

In addition to this group of people, it must be recognised that there are another group whom have made the decision to de-register for a period and are then trying to negotiate the requirements of getting re-registered. In our investigation of the requirements of re-registration and re-entry to the profession it is a very difficult to impossible task for those living in rural and remote environments. Considering this we believe that it is even more imperative that resources be allocated to clinicians in order to support them to maintain their registration during the years that they want to be at home rather than let it lapse and try to re-register at a later date. We also want to note that we are not condemning those whom wish to let their registration lapse due to not wanting to practice any longer, rather we are addressing this paper to those whom would like to maintain their registration, because they enjoy their profession, but are finding that the desire to be a SAH caregiver and maintain current registration is not compatible and are therefore considering the relinquishment of their registration.

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Presenter

Janelle Amos is an occupational therapist, with a Masters in Remote Health Practice, who has worked in a number of rural and remote communities across Queensland and north-west New South Wales. She has always had a love for rural and remote health with a particular interest in innovative service delivery models within the not-for-profit and private sector. In more recent years Janelle has been a busy stay at home mother to four young children. Through this experience she has developed a passion to support health professionals located in rural and remote enviroments through the competing demands of maintaining registration, while choosing to stay at home with their young children.