Integrated therapy assistants and video-conferencing

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This paper will briefly overview the geographical, service provision model and recruitment issues that contributed to the decision to pilot the use of video-conferencing in supporting our established integrated therapy assistant program. The paper will then explore in more detail, the use of this technology in this support.

The Midwest Health Service is located within the Midwest and Murchison Health Region in Western Australia. It is made up of 6 main communities of Kalbarri and Northampton to the North, Mullewa, Yalgoo and Morawa to the East and Three Springs and Dongara to the south of the regional centre of Geraldton. Geraldton is approximately 420kms north of Perth. Geraldton and its population however are not part of the Midwest Health service area.

The Midwest Health Service covers 470 000sq km with a total population of approximately 14 000. The towns within the Midwest range from 100 to 2000 people and cover a diverse range of industry from tourism, fishing, broad acre farming, pastoral and mining. As you can appreciate, the communities of the Midwest are scattered and diverse presenting some challenges to the delivery of allied health services. The Indigenous population percentage ranges form 2–36% within our communities.

It is these challenges that provided the opportunity for the Midwest Health Service to explore the use of video-conferencing as just one strategy to enhance and support our service models while also addressing the management and HR needs of a small team of allied health professionals.

The Midwest Health Service endorsed and supports a primary health philosophy and attempts to apply the principles of primary health care (Ottawa Charter, 1978) through all aspects of our services. The allied health team is comprised of; 2 Speech Pathologists, 1 Occupational Therapist, 1 Physiotherapist, 1 Dietitian, 2 Social workers, 0.2 audiologist. We are also ably supported by an asthma educator and telehealth co-ordinator. This team is located in Geraldton as part of the corporate office, even though Geraldton population is not serviced by it. The choice of location of Geraldton was made for 3 reasons;

• the corporate office had already been established to provide support to the local health services

• Geraldton as a regional centre on the coast was more attractive for recruitment and retention

• Geraldton is central to service all the communities of the Midwest on an outreach model.
A small team and reasonably large distances to travel obviously restricts the frequency and time available in each of the Midwest communities by each of the disciplines. In general, each of the communities is visited monthly, with this requiring the staff to be travelling 3 days per week. This type of access immediately impacts on the type and level of services able to be provided. The introduction of Integrated Therapy Assistants in 1999 was one of the strategies implemented by the Midwest team to address this service frequency issue and has been very successful with us now having expanded the program from the original 5 ITA positions to now have nine Integrated Therapy Assistants in place, with these TAs being from 50 to 250 km away from the therapists in Geraldton.

Video-conferencing was introduced to the Midwest Health Service in November 2001 following a successful submission to the State Department of Health for funding of 5 clinical, 1 staff development and 1 management project using this technology. Within a short time of the commencement of the projects, the allied health clinicians embraced the many opportunities that this technology offered in “increasing” the face to face contact with clients, integrated therapy assistants and other staff to enhance their existing services.

It was also at this stage that there was a developing focus on therapy assistants in Western Australia. We had an intersectoral state working party that the Midwest was playing an integral part in, due to our use of integrated therapy assistants and the development of a competency-based training package. Staff changes and a review of our program began to raise questions about the appropriate level of supervision and support by the therapist of the TA.

This need to address more time with the assistants was a concern, especially when clinicians were saying that it was impossible to make more time available during regular monthly site visits. We were also 2 years into our integrated therapy assistant program so were seeing the staff turnover and introduction of new positions, so for the first time within this program we were experiencing differing levels of learning and abilities between the 8 integrated therapy assistants.

Video-conferencing presented an opportunity to explore options of supporting the monthly site visits by allied health clinicians to better develop, monitor and progress the work being undertaken by integrated therapy assistants on behalf of the therapists. It was hypothesised that the use of video-conferencing with the assistants would ensure an improved level of support, increase the responsiveness to changing client needs, enforce therapist accountability and promote the allied health services by increased exposure to them for the client, parents, carers and local service providers.

In planning how video-conferencing could be used to support the assistants, we considered the following scenarios:

- model program options in absence of client
- supervise assistant conducting a session (individual or group)
- assistant observing the therapist assessing a client (client could be with either therapist or assistant depending on type of assessment)
- assistant observing therapist conduct session (individual or group)
- general discussion and education related to client or client group.
Since this consideration to use video-conferencing with assistants we have:

- introduced guidelines where a video-conferenced session must be scheduled between the primary therapist and the assistant every 2 weeks (or midway between site visits). This is for all assistants, however the use of the session can vary depending on the assessed needs of the assistant from their development perspective and their current caseload.

- conducted a 3 month trial due to a staffing vacancy, where we contracted a private occupational therapist to provide fortnightly video-conference support to all assistants with current occupational therapy programs in progress.

- implemented an early intervention speech and language group where the assistant was with the group and the therapist in an alternate location. During the group, the therapist monitored, demonstrated and supported the assistant to run the session. At the conclusion of each group session, the therapist reviewed the group progress and demonstrated activities and strategies for the next session.

Experience although fairly short has provided anecdotal evidence to date and it is planned that this will be evaluated as the program continues. Therapist and assistant feedback indicates:

- time and cost efficiencies through increasing contact without need to travel.

- improved responsiveness to changing client need and assistant development. This means that programs can be updated during or immediately after the session, with relevant instruction provided to the assistant for implementation of these changes.

- measurable evidence of increased contact between therapist and assistant.

- flexibility in use of the technology. There are options for the client to be included or not, for documents to be shown and demonstrated, for 3D items to be shown and demonstrated, for videos to be shown to support training and development.

- more comfortable environment.

As with all pilots or new programs, some issues are raised that require further consideration and even resolution and this was also the case with the use of video-conferencing to support the assistants.

We found that if the client was to be part of this link, then guidelines and procedures were needed to ensure clear understanding and application of these. An example being that if a school aged child was the client, then consent was required to transport the child from the school to the health service where the video-conference equipment is located. In this example, it also becomes clear that there is an immediate impact on the time to both organise this and to actually achieve the transport. Additionally, there was need to focus on the environment and the appropriate setup for the type of session being conducted. This was all part of the normal planning process however we had already become aware of the need to ensure that when using video-conferencing—whether for clinical or non-clinical reasons, planning and preparation was absolutely imperative for a successful session.
As we have progressed, we have had to explore options to use other video-conference facilities such as those available through Telecentres and the education department. This impacts on costs, as negotiations for rental need to be undertaken when accessing some of these services. Confidentiality, space and room set-up are other considerations when using equipment that is rented, as the flexibility and set-up may not be as easy to control as health service equipment. Familiarity, preparation and good rapport with the external provider all limit any issues in this area. For the therapists and assistants, the more this technology is used, confidence and ability to troubleshoot issues is developed.

Through the pilot and therefore exposure to this technology, the staff, clients and community have embraced this opportunity to enhance what was the traditional service delivery. Although formal evaluation has not been completed at this stage, our clients are satisfied. Additionally, it would appear that clinical goals are achieved more quickly with an impact on caseload throughput.

The fear of the unknown has been passed, with new opportunities now being looked for to extend the way this technology is used to enhance and further develop consistent and sustainable services in our rural communities.

Into the future, the Midwest Health Service is looking to extend our very willing group of volunteer support carers into a client advocate role where they can support new clients accessing video-conferenced appointments. Education and support remain imperative to sustain the viability of this service, however it is equally important to recognise that this is a service enhancement model and does not remove the need for continued face to face contacts within local communities by allied health clinicians.

So in summary, the Midwest Health Service recognised a need to improve the support and direction of therapy assistants and elected to use the video-conferencing option for this increased support. This required the following process:

- determine clear outcomes
- develop guidelines and procedures
- market/consult with assistants, consumers and other users of video-conferencing
- develop and implement training for assistants, therapists and local contact people
- implement as a pilot
- review each session, integrating feedback into guidelines/procedures where appropriate
- BE PREPARED.

Out of this, the key success factors have been;

- PREPARATION — for the pilot and for EACH session
- training in use of equipment, room set-up and organisation for the session
- willingness and commitment of staff and consumers
- clear outcome — again for the pilot and each session.
In particular I would like to emphasise the preparation and to reinforce for all therapists that the assistant is their responsibility and does require regular direction and support. It is the therapist that has the accountability for any program that the assistant is undertaking. The video-conferencing contact can provide opportunities for the therapist to engineer situations that allows the assistant to demonstrate competencies and areas of development. By increasing the level of contact between therapist and assistant, up-skilling in identified areas can become continuous and relevant at the time the assistant requires it for the programs that they are running. Open and honest communication is also imperative, with this being used from a development framework at all times.

In conclusion, The Midwest Health Service would be keen for the Alliance to ensure that video-conferencing is included as one of the strategies in the support of clinical services into the future, from both the specific area of therapist support for assistants, but also broader identification of what services could be supported though this technology for the rural sector. This will require promotion and marketing at allied health professional body level and further research on the existing pilot programs to provide the required evidence.

The Midwest Health Service and our consumers have benefited from this pilot and other pilots that we have initiated in the last 18 months. We always strive to have services on site, however I believe that our Therapy Assistant pilot has demonstrated how video-conferencing can still enhance services at times when staff establishments are not full. The Midwest Health Service has had a win/win for staff and consumers and we look forward to continuing this progress.