Leap tall buildings with a single bound? Not a problem (provided you've got a building!)

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INTRODUCTION OR DESIGNING THE BUILDING

The North West Queensland Allied Health Service (NWQAHS) is an innovation of the Northern Queensland Rural Division of General Practice (NQRDGP), funded by the Commonwealth Government under the Regional Health Strategy.

The outreach allied health service is based in Mt Isa and provides a multi-disciplinary allied health service to eleven culturally diverse (Indigenous, non-Indigenous and mixed) remote communities, spread over 373 000 km², utilising a hub and spoke model. The service operates within a primary health care framework, and operates across the continuum of health promotion, preventive care, illness treatment and rehabilitation. Early intervention, primary and secondary prevention are focal to the service.

The key steps in the development of the model are described by Battye and McTaggart (2002), and included:

- development of a planning matrix
- environmental scan — mapping of existing services and gap analysis with respect to demographics, morbidity and mortality
- community consultation to inform the gap analysis and also provide information on the context in which services should be delivered
- review of recruitment and retention strategies for health professionals in rural and remote areas.

Following the development of the planning matrix, the research to develop the model occurred over a 5 month period.

The key features of the model include allied health professionals (AHPs) operating and travelling in functional teams, under a calendar established for a 6 month period. Each team visits its target communities on a 6 weekly rotation, working for 2-3 days in the community dependent on size. The teams travel by charter aircraft to most communities, and a centralised booking number is used to make appointments where culturally feasible. The model includes the development of therapy assistant positions in each community to provide follow-up to clients between visits by the allied health professionals. Collaboration with the resident health professionals and other agencies, carers and families is seen as core business to promote co-ordinated care and client self-management.
The recruitment package for the allied health professionals sought to address issues raised in recent research into the retention of allied health professionals (Director General’s Allied Health Recruitment and Retention Taskforce 2000, Fitzgerald et al., 2001), and specifically addressed line management and supervision, access to professional development and clinical mentoring, orientation to remote practice, travel time, and incentives to address remote locations ie annual leave allowance, accommodation subsidy, salary commensurate with solo practice.

BUILDING THE BUILDING

The consultant responsible for the development of the model was retained by the NQRDGP to assist the CEO and later the Manager, in the establishment of the service.

Floor 1. Recruitment of the manager

Poor management practices were identified as a major factor in the retention of allied health professionals in rural and remote areas (Director General’s Allied Health Recruitment and Retention Taskforce, 2000). Therefore the NQRDGP sought to employ an allied health professional, experienced in rural and remote practice.

Key selection criteria were

- possession of a relevant degree in an allied health professional discipline, registration for some professions, and a current driver’s licence are essential requirements
- demonstrated ability to manage and lead a multi-disciplinary team
- high level of written and oral communication skills
- experience in rural practice and the planning of holistic patient/client services within a variety of clinical areas
- knowledge of alternative allied health service delivery methods and organisational structures pertinent to non metropolitan areas
- skill in record keeping, data collation, and evaluation procedures
- demonstrated ability in resource development and the education of others
- sound knowledge of contemporary human resource management issues including workplace health and safety issues, equal employment opportunity and anti-discrimination.

Recruitment strategies included advertising widely in national newspapers, and promotion of the service and the concept at an International Rural and Remote Allied Health Conference held in Cairns late in 2001.

Applications were received from allied health professionals in several States and overseas, and the successful applicant started work in Mount Isa in the middle of January, 2002.
Floor 2. Recruitment of allied health professionals

The recruitment of allied health professionals commenced in December 2001, with two advertisements placed in national newspapers calling for expressions of interest across the six disciplines of physiotherapy, dietetics, podiatry, speech pathology, occupational therapy and psychology.

Key selection criteria were

- possession of a degree or equivalent qualification from an approved course recognised by the appropriate professional association. For psychology, physiotherapy, podiatry, occupational therapy and speech pathology, current registration with the appropriate Registration Board of Queensland. Eligibility for membership of the appropriate professional association

- demonstrated ability to provide high quality discipline specific assessment, treatment and intervention to achieve maximal outcomes for a broad range of clients and conditions

- demonstrated ability to work effectively as part of a multi-disciplinary team, including a willingness to impart appropriate skills to other team members, local service providers and consumers

- awareness of Indigenous health issues and an ability to work in a culturally sensitive environment

- demonstrated high level communication skills

- demonstrated knowledge or the ability to gain knowledge of the issues and organisations involved in the delivery and support of health services in rural and remote communities

- ability to undertake work in communities distant from Mount Isa, travelling both by road and by air, including absence from the base for up to a week at a time and possibly some work after hours

- current driver’s licence.

Over 40 expressions of interest were received, with 6 staff eventually being recruited from these expressions of interest. Three additional staff were recruited through targeted advertising and using links with other organisations to target professionals who may be interested in this type of work. All applicants were interviewed using the same questions. The focus of the interviews was to rate the applicants according to two evenly weighted criteria, which were professional quality (ie their demonstrated ability/knowledge/experience in their discipline) and suitability for the service (as a proxy for their likely sustainability/longevity).

The service chose not to fill all positions from the initial pool due to an explicit strategy to identify the most suitable staff for the type of work to be undertaken, rather than simply fill the positions

Of the 9 staff appointed in the first round, six were born and brought up in rural and remote Australia, two in North Queensland, one in Southern Queensland and one
each in the Northern Territory, Victoria and South Australia. Of the three brought up in urban environments, one hails from Melbourne, one from Brisbane and one from Nottingham in the United Kingdom.

Significantly, six of the nine AHPs had personal or family links to the north-west Queensland area. One was living and working in Mt Isa at the time of application; one was moving to Mt Isa with a spouse who had been relocated to the region with work, two had family in Mt Isa itself, while two others had family in the region. Those with family links to the area identified this as a very strong positive reason for applying to the service.

One AHP qualified in the UK, while the rest all graduated from Australian universities, most attending institutions close to their home base. The postgraduate experience of the AHPs ranged from nine years down to one new graduate, with the remainder having between two and five years clinical practice.

Most of the AHPs had experience limited to the Australian public health system, with only one having undertaken significant private practice and only one of the Australian graduates having worked overseas. The level of rural experience varied enormously although the majority (five) had previously worked in larger rural centres including Mt Isa, Roma, Mackay, Alice Springs and Armidale. Two AHPs had only urban practice experience while two had extensive experience in remote and Indigenous communities (one as a registered nurse prior to allied health training).

One AHP was ‘headhunted’ for the position through the service’s strong links with the RFDS, and two found out about the positions through ‘word of mouth’. The other six responded to advertisements, one in a specialist speech pathology journal, one each in the Townsville Bulletin and Cairns Post and three responded to the advertisement in the Australia newspaper.

Preliminary evaluation of the recruitment and retention strategies identified several successful factors which contributed to the successful recruitment of the AHPs. These included:

- the salary package, in particular the remuneration (which is the same as Queensland’s PO3 level, ie one level up from base grade)
- rent assistance
- postgraduate opportunities (all staff are funded and supported to undertake the Graduate Certificate in Remote Health Practice through the Alice Springs Centre for Rural and Remote Health)
- annual flight home
- provision of six weeks annual leave
- offer of relocation costs
- type of work involved
- newness/innovative elements of the service
• an experienced AHP as the service manager
• location (for people with family ties to the area)
• working in an allied health team
• advertisement which focused on the innovative aspects of the project.

The evaluation identified that the structure of the package and the obvious thought that had gone into meeting the needs of the AHPs was much more important than the individual benefits or overall financial package provided.

It is interesting that one of the planks of the retention package not mentioned in this early evaluation is the provision of paid professional mentorship for each AHP. Most staff are now having regular telephone and email mentoring from experienced AHPs scattered across the country, and are finding it invaluable. The service manager believes that this is one of the most important retention strategies in the package — the ability for individuals to access support from clinicians with the specialist skills required to understand the type of work and the environment in which they are providing services, and to discuss issues and challenges with someone outside of the team may well prove to be a key strategy in the long-term survival of staff.

**Floor 3. Leasing a building**

The process of seeking a building to lease in Mt Isa commenced during the development of the submission, and continued over the next 10 months. The building needed to accommodate at least 12 staff as well as provision for the establishment of a private practice facility. This proved to be one of the major challenges in setting up the service, with great difficulty finding a suitable building that could be leased for the relatively short time the service could commit to due to the funding contract (3 years). A building was identified after the relocation of the Service Manager to Mt Isa.

The building had considerable potential, but had been vacant for a number of years and had been vandalised. The service had to

• convince the owners to lease rather than sell the building (as was their preference)
• arrange rezoning and change of classification of the building — a complex and time consuming process
• arrange and supervise the refurbishment of the building.

This process took, in total, more than 6 months, although the team was able to commence some occupation of the building after about 4 months. Landscaping of the block is still to take place.

In the interim, the service commenced in the manager’s house, then in a building that had previously been a two-doctor practice. During this period staffing grew from 3 people to 10, causing considerable pressure on the individuals involved.
Floor 4. Service agreement with Queensland Health

The NWQAHS did not seek to duplicate the services provided by Queensland Health, or poach staff from the Districts. During the development of the model and subsequent submission, negotiations commenced between the Division and the District Managers to facilitate the establishment of a service that would value add to those currently provided by Queensland Health. The key components of the service agreements included:

- defined operational goals for the delivery of allied health services to the target communities

- opportunity to pool personnel to facilitate regular, reliable and consistent services to the identified communities/precincts

- develop a schedule of services on a 6 monthly basis to allow planning for visits at a local level, identifying the communities/precincts that will be serviced by personnel from each organisations

- co-ordination of transport of AHPs employed by the NWQAHS and the Mt Isa Health Service District. Responsibility of each organisation to meet travel allowance costs for its employees

- the allied health professionals will work within a primary health care framework, and position descriptions and practice of employees of both organisations will reflect this ethos

- Mt Isa Health Service District to allow access to community health, hospital and/or clinic facilities and records by the NQRDGP allied health personnel for patient treatment

- the allied health professionals employed by NQRDGP will deliver scheduled training and inservices to QUEENSLAND HEALTH employed health professionals and Indigenous health workers during visits to each community

- the NQRDGP and Mt Isa Health Service District will work collaboratively to identify and train personnel to work as therapy assistants

- the NQRDGP will make available to the Mt Isa Health Service personnel professional development opportunities developed and delivered at a local level

- the NQRDGP and Mt Isa Health Service District will promote and support ongoing evaluation of the delivery of outreach allied health services, and collaboratively develop strategies to implement recommendations of such evaluation.

Some of these strategies have proven easier to achieve than others, with access to Queensland Health facilities and records working extremely well, and inservices being provided to Queensland Health and other health and community staff in the target communities. Some other strategies are slower to implement, and at this stage the Queensland Health allied health outreach staff are not operating as part of the staffing pool of the NWQAHS. Travel is managed separately by each service, with the RFDS assisting in the development of the NWQAHS travel protocols in the first 6-month
period. In addition, although some Queensland Health allied health staff operate under a primary health care framework, this is not the case for all disciplines at this stage.

The therapy assistant part of the model is yet to develop and will be a priority for the next calendar year.

Strong collegiate relationships have developed between many of the NWQAHS staff and their Queensland Health counterparts, however vacant positions in the District Health Service have made this difficult in some areas.

**Floor 5. Developing a calendar of service**

The NWQAHS developed its first six month calendar in May 2002, which co-ordinates with travel undertaken by RFDS, and as far as possible with the Mt Isa Health Service District and Charters Towers Health Service District outreach services. However, as much of this travel is not scheduled in advance, or subject to change, this is difficult to ensure. The appointment of a community health co-ordinator in one District has facilitated co-ordination between the services and minimised potential for overloading of communities. The second calendar, covering January to June 2003 has just been finalised. Both the NWQAHS and the Mt Isa District Outreach Co-ordinator have found that co-ordination with the myriad of non-health visitors to communities is also required, although more of a challenge!!

**Floor 6. Formation of community panel**

An interim community panel was formed during the development of the model and submission, drawing on representatives from communities identified during the consultation process. Following the funding of the Regional Health Service, the community panel was re-convened, using a more formal process to seek community representation. Each local government and the Doomadgee Aboriginal Community Council were asked to nominate two representatives, one a community member and one an employee of the shire/council. Representation was also sought from aboriginal corporations, the two District Health Services, RFDS and the Mt Isa Centre for Rural and Remote Health.

The community panel has established its own terms of reference and acts in an advisory capacity. However, the panel has direct input into operational decisions regarding the service and these have included:

- where the service should operate from within communities
- referral processes
- privacy information
- development of policy relating to the loan of equipment
- development of community mentors
- scheduling changes
- operational issues within communities (eg locating suitable garaging for a vehicle).
This is proving a valuable mechanism of gaining meaningful participation for some groups in some communities, although the service is still grappling with the difficulty of engaging some of the communities, and some of the groups within communities. A number of strategies are being tried and this also will be a major focus in the next year.

**Floor 7. Development of the purchaser/provider model**

Part of the model of service delivery envisaged for the NWQAHS was to develop a purchaser/provider service in Mount Isa city (which is not covered by the RHS funding) to assist in meeting unmet allied health needs in that community.

This is progressing slowly, and the appointment of a Business Manager will speed the development of systems to support this service. The purchaser/provider model includes contracting physiotherapy hours to the local private physiotherapy practice and Education Queensland, providing services funded under the More Allied Health Services program within Mt Isa, private services to individuals and also through third party providers such as mining companies, insurance companies.

The purchaser/provider model not only means that needs can be met both within Mt Isa and in the target communities, but is expected to assist in the retention of AHPs by decreasing the amount of travel undertaken by individual clinicians. A third occupational therapist has recently been recruited as the first ‘extra’ staff member to meet these needs.

**Floor 8. Evaluation, identification and rectification of building design faults**

The evaluation of the North West Queensland Allied Health Service is complex as there are a number of components to the service that inter-relate to underpin sustainability. The evaluation is both formative and summative, to ensure that the service is accessible to all groups within the target communities, and integrates with local and visiting service providers.

The primary domains of the evaluation include operational management, recruitment and retention of AHPs, service delivery, community participation, and integration. The secondary domains of the evaluation focus on client outcomes, health promotion, community development, access, mentoring, establishment and utilisation of therapy assistants.

Two recommendations have arisen from the preliminary evaluation.

1. Recent research identified key areas impacting on the recruitment and retention of allied health professionals in rural and remote areas (Fitzgerald et al., 2001; Director General’s Allied Health Recruitment and Retention Taskforce Report, 2000). The development of strategies by the NWQAHS that addressed these issues indicates that the best evidence available for successful recruitment of AHPs to remote areas is valid, and the authors recommend that services wishing to recruit in this context take note of the evidence with respect to management and support of AHPs.
2. The development of a new service of this size and complexity requires consideration of the time involved in sourcing infrastructure, recruitment and orientation of staff, and establishment of a sub-management structure to support the development and implementation of innovative components of the service.

Floor 9. Conclusion—the sky is the limit!!

The first full year of the NWQAHS has been a time of rapid development. It has shown that it is not only possible to recruit allied health professionals to remote areas, but to recruit high quality AHPs with the skills required to provide a quality service in a demanding environment.

Strategies are in place to support these people, but time will tell how successful these retention strategies are. The service has been very well received by communities, with positive feedback coming from a wide range of communities and individuals.

Long-term monitoring is required to determine the impact of this service on the health of the eleven target communities. However, there is now a raft of allied health services provided to the people of these communities, where previously only limited service existed. Not all aspects of the model have yet been developed ie. therapy assistants, community mentors, but like everything undertaken so far — it will happen!

REFERENCES


Director General’s Allied Health Recruitment and Retention Taskforce Report (2000), Health Advisory Unit, Queensland Health


PRESENTERS

Elaine Ashworth has a background is in physiotherapy and she has worked in metropolitan, rural and remote settings in three states and the Northern Territory, as well as the obligatory spell in the UK. After 10 years as a Physiotherapist and an Allied Health Manager with Queensland Health, working in the Wide Bay and Darling Downs areas, she is currently working for North and West Queensland Primary Health Care (the Northern Queensland Rural Division of General Practice), managing the North West Queensland Allied Health Service which is based in Mount Isa and provides services across 373 000 square kilometres of north-west Queensland.