Outcomes of a remote clinical supervision model for multidisciplinary allied health staff in regional South Australia

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A model of remote supervision was implemented for a new workforce of allied health clinicians involved in the Transitional Care Program (TCP) across regional South Australia. Six regionally based senior allied health clinicians are located in remote sites across the state and are brought together and supported through a clinical supervisor (Allied Health Leader – Aged Care) who provides clinical supervision, skills and knowledge training and accountability. The model includes elements of individual supervision and support, group based skills and knowledge training, development of resources and evaluation.

Background
Rural based practice for allied health clinicians has commonly involved clinicians having limited access to adequate clinical supervision. As a result there are diminished opportunities for ensuring that the services provided are high quality, are consistent and safe. The development of a structured clinical supervision model for clinicians working in Country Health SA has been high priority and has been able to be enacted over the last twelve months for two distinct groups of allied health through two main initiatives. Funding through the TCP program and the COAG (Commonwealth of Australian Governments) subacute allocations have strategically been used by Country Health SA, to create advanced clinical supervisor positions within these two programs. Today’s presentation will outline the application of the clinical supervision model within the TCP program and the outcomes achieved through that initiative.

Country Health SA are one of the main providers of the TCP in South Australia, and as such, are committed to ensuring that the service provided, is as optimal as possible. TCP is a commonwealth and state funded program that provides a short term package of care and services targeted towards enabling clients to be discharged as early as possible from acute care facilities. It is particularly appropriate for clients who require additional time to regain independence, additional support to manage at home, support to resume previous roles and time for carers and clients themselves to consider the optimal care arrangements. A key element of TCP is a case management model that engages the client in a goal orientated care plan that commonly involves a combination of the provision of additional care ie cleaning assistance, wound care or transport assistance, and a program of restorative based services aimed at improving the person’s ability to perform their identified activities. This, of course, is in the ideal world. In reality, when the provision of Country Health SA’s TCP was reviewed formally by RDNS (Royal District Nursing Service) in 2009, they found among other things, that the packages lacked a restorative focus, and this was primarily identified to be related to a lack of access to, or limited engagement of allied health clinicians.

Country Health SA (CHSA) had two significant initiatives which complimented each other to address this issue. The first was the review of TCP conducted by RDNS that explored the service delivery model. This work was considered by CHSA and the organisation committed to address the lack of restorative focused packages by the direct employment of dedicated allied health positions to the TCP. Six new senior allied health positions were created with five full time equivalent positions being aligned with the larger cluster based regions and a clinical supervisor position to provide expert supervision to enhance skills and knowledge in restorative based practice, and to support the integration of this workforce. The positions were advertised as either occupational therapy or
physiotherapy and were to support TCP service delivery across the cluster – commonly across 5-6 health units. (show map)

The second large piece of work that influenced this initiative was a significant project that looked at the issues around access to clinical supervision for rural based allied health staff (Country Health SA Allied Health Clinical Support Framework). CHSA had been concerned for some time about the need for staff to have access to clinical supervision and the initiative to be presented was one of the first attempts by the organisation to implement the findings and recommendations from that report.

As a result there were high levels of interest to track the outcomes for the allied health staff supervised in this model, whether it was possible to remotely supervise staff and to measure the outcomes that the additional supported allied health staff had on the overall TCP program.

The framework that was implemented in this initiative consisted of a matrix of support and supervision for the clinicians. Each clinician was based at the local health unit and were integrated with the existing TCP staff ie case manager, paramedical aides that were already there. They had line responsibility to the local team leader who provided direction around direct operational matters. The clinician then had a line of clinical supervision to the clinical supervisor.

The skill set of allied health clinicians employed into the roles relative to restorative practice, goal setting, design of therapy plans, restorative techniques, working with allied health assistants etc. was relatively low, but the majority of them had good levels of experience specific to rural based practice and had worked mainly in the acute hospital or community sector. Most of them had minimal experience in service development, quality improvement initiatives and change management. For the five positions there were five (two job share) occupational therapists and one physiotherapist. The clinical supervisor had an Occupational Therapy background.

The early emphasis on these new roles was on
- building their own skills and knowledge relative to an advanced restorative practice
- to consider the issues of integrating with an existing service model for TCP, how to understand the current service models, skills and knowledge of the case managers, AHA, other allied health staff. This proved to be really important and took some time to demonstrate a culture of valuing the current processes and to plan to improve them.
- mapping existing allied health service access for TCP clients, as each clinician was only adding capacity in one discipline and so had to understand the existing levels of access, to build additional paths of access or referral. This has been quite successful. The other aspect to this was to work on the type of service from each allied health professional and to understand restorative approaches across all disciplines
- achieving consistency of service delivery across the different regions
- promoting and coordinating the development of resources and systems by a group, as the resources needed to support restorative based services did not exist in the organisation
- ensuring accountability for the quality of service clinicians were providing clients

**Model of support established**
A planned approach was used within the three main stages of implementation.
Recruitment phase for each clinician
- the clinical supervisor to be on site at the health unit for the interview and again at orientation
- clinical supervisor to engage directly with the line manager and establish separation of supervision issues. Used CHSA AH clinical support framework document as a format to support this.
To complete a baseline assessment of skills and knowledge used to determine where clinicians were starting from, and to assist with the determination of training needs for individuals and for the group.

Early phases in the positions

- An early face to face meeting between the clinicians was planned to build rapport between the group, primarily to facilitate the relationships that were then maintained through phone contact.
- To chair a weekly group teleconference, which ran with an action plan to support development of resources and tracking progress. The emphasis was on supporting individuals within the group to each take a lead on a project or topic, either chosen by themselves or from the list of issues/resources that arose from the group.
- Formed them into pairs to work jointly on projects, grouping different clinicians with each other to discuss issues.
- Weekly individual supervision sessions with each clinician. The clinician was made responsible for setting the agenda, sending through information ahead of time for review, and keeping minutes of the meeting. The sessions addressed a combination of service development issues, client issues and personal learning and mentoring.
- Face to face training sessions were held three times in the year to address group based learning topics. Topics included supporting change in practice in Allied Health Assistant’s, goal setting, motivational strategies, restorative versus maintenance program planning, clinical application of cultural awareness, and falls assessment and screening. Used a combination of clinical supervisor, clinician and invited speakers.
- Establishment of a shared directory for document management.

Current implementation has altered slightly to reduce the frequency of the meetings.

- Fortnightly schedule for group teleconference and fortnightly individual sessions.
- The group has significantly expanded by the addition of three more clinicians, to make a total of nine clinicians and one supervisor.

Evaluation

The outcomes of the initiative will be presented outlining issues of workforce design, the impact of clinical supervision on the individuals, and the overall impact on the TCP program.

Firstly, workforce design.

The model of allocation of one clinician to a provide services across a cluster of services was a relatively new and unique service allocation model for CHSA. There was interest in whether the choice of having a multi classed position ie OT or PT seemed to work. The initiative was the first example of clinical supervision framework being implemented by the organisation through a remote format, using a group based structure of support, and using a group based model for development of resources across disciplines.

On a very basic level, the multi classification of OT and PT supported recruitment from a wider range of clinicians into the positions and, as such, all positions were successfully filled. Clinical presentation of issues for clients were primarily related to the two professions and thus the choice of OT or PT appeared to be the indicated professions. Other professions were required for some clients, and often at significant levels, but not for all clients. The negative aspect was that the increased capacity was limited to only one profession and as the profile of allied health in TCP increased so did the referrals increase to the other professions.

Secondly, the impact of clinical supervision framework on the individuals was considered through an independent researcher running a focus group with the clinicians independently of the clinical supervisor. This focus group was conducted after six clinicians had been in their roles for 9 months. There were two clinicians who had only just started in the new roles and had been in place for one month.
The main points of feedback included:

**Strategies used**
- The combination of group and individual sessions were very useful

**Group sessions**
- Easier to develop networks once people had met face to face
- Themes from individual sessions brought to group for shared learning was beneficial
- Valued flexibility, could miss a group session if had clients booked, or could call supervisor in between sessions if needed
- Supervisor played a larger role initially then was able to pull back
- Group size works well, may be more difficult with larger group
- Group dynamics worked well as all started at the same time, and faced similar challenges
- Very cohesive group – similar mindsets / approaches meant it has worked well

**Remote supervision**
- If they were new graduate positions, it wouldn’t work, need certain level of autonomy and initiative
- Having positions under CHSA enabled feedback to higher levels

**Skill of facilitator / supervisor is critical**
- Pulls everyone together
- Divide tasks evenly
- Ability to pin point everyone’s issues
- Flexibility
- Facilitator was always challenging my own practice, useful for improving skills and knowledge

**Change in measurable skills and knowledge**
- Identified that these roles have been different to previous roles and improved clinical support through TCP
- Self assessment process useful, helped to identify what they didn’t know
  - Common themes led to group training
  - Admitted tendency to overestimate knowledge – “didn’t know what I didn’t know”

**Outcomes at an individual level**
- Discovered what liked about the professions – reignited passion for rehabilitation / client centred practice
- This level / mode of support should be what is provided to everyone (comparison to previous roles where very little clinical supervision/support)
- Culture of need for supervision needs to change in broader CHSA, it is not valued as much in previous roles – it is about safe practice and development of services – not to be viewed as something that is put in place because an individual has a weakness.
- “nudge to keep moving, developing those skills” – encouraged to submit conference papers
- Gave “permission” to spend time on collaborating and sharing the good achievements
- Raised confidence in own skills – reduced fear of exposure.
- Encouraged accountability for language and documentation – supported to have a more professional approach

**Outcomes at group level**
- Have been part of a change management process to improve quality of TCP delivery
- “huge” impact on health services, not just the larger sites, but also the smaller sites – linking them into the TCP world of CHSA
- Precipitated a change in service delivery for other services within the clusters – restorative approach in other settings
- Influence on acute sector – other options besides Nursing Homes
- Influence on uptake of TCPs – now a waiting list
- Development of resources and quality documents
- Assistance with recruitment and retention
“feel that I am going to really help these people, created passion”
“First time since I started work that I feel like I am being an OT”
Has created interest in metro regions

Clinical Supervisor outcomes
The remote model of supervision was also a new skill for the clinical supervisor but it was possible to support change of practice by reviewing documentation that had been sent through, by discussing client care plans and design of programs, etc. All of the actions and outcomes that are undertaken as an onsite clinical supervisor were able to be achieved, apart from workshadowing someone with a client. And even this may have been possible via videoconferencing.
The matrix of line reporting was challenging to ensure that each manager was conscious of the need for open and regular communication and this outcome varied somewhat across the positions.
It has been really exciting to offer support to clinicians and to establish an expert group who now support each other and are recognised within the organisation as high achieving staff.

Overall impacts on the Transitional Care program
One area of interest was related to whether the structured and supported allied health involvement made a difference in the range of clients accepted onto the program. Either through assisting with the identification of potential clients who would benefit from a TCP, through assisting the pathway into TCP with discharge planning or from general education of the acute/ACAT staff regarding the extent of TCP outcomes that can be achieved.
Almost immediately the profile of clients accepted into the program expanded to include greater numbers of clients with complex presentations, rather than what was typically seen on the program ie those clients with clear rehab potential ie post fall, post orthopaedic surgery. Complex clients entering the program included those with primary mental health presentations, aboriginal clients whose main goals were around re-engaging with community rather than functional gains, packages directed to couples who both required input etc. This was achieved through individual training and discussion regarding the restorative potential for different clients and case presentations.
Another primary outcome was to track the increase in allied health input into the programs. The allied health initiative started during September 2009 and to date there has been an increase in allied health time from 8.2% to 23.5%. This involved an increase in the number of hours offered, an increase in the range of professions engaged, and related to improved data capture generally. There is still under-reporting to an extent, but even this gain has been exciting to see.
There was interest in measuring whether the additional involvement of allied health and the increasing skill development of the case managers were evident in the range, number and style of goals that were documented for the clients. On admission to the program the case manager drafts a care plan that lists goals that the client identifies and these are grouped into domains such as personal care, mobility, community. A review was completed at the 6 months point to compare the care plans developed prior to the initiative and then since the initiative was implemented. The overall results showed insignificant changes in the total number of goals set, a 6 percent increase in goals achieved and a 17% increase in percentage of measurable goals set. Documentation of goals and the tracking of achievement of goals continues to be an area for improvement and is a challenging method of outcome measurement.

**Recommendations** for other health regions will be presented

Learnings from the initiative
- as the supervisor, set up consistent and regular times for supervision sessions and for the group teleconferences and commit to them, try not to alter the sessions especially early on.
- establish this routine immediately upon appointment
- be flexible accounting for the different individual’s styles of working. Some were more formal in their approach, some were collegiate in style, certainly different topics were addressed in the individual sessions as this was lead by the person themselves.
- Put the individual clinician in the centre of the supervision arrangement, support them to plan for the session, to come prepared and to set the agenda for discussion
- strive to keep the structure of the support really flat, don’t put yourself up as the only ‘expert’, encourage them to support each other, sharing learnings and group them together for quality improvement activities
- to keep in regular contact with the line supervisor
- the combination of individual sessions, group teleconferences and 2-3 in person training sessions per year worked really well

Challenges
- the complexity of the matrix of dual reporting for the individual clinician
- issues of trying to impact on an existing system and processes through the group remotely, needs careful integration at the local site and adaption to the local situation
- cross discipline supervision. Be conscious of the need to delineate between general restorative supervision and profession specific issues – need to align with a specific professional supervisor when appropriate

Clinician feedback regarding anything that could be modified in future recommended
- New people need weekly face to face meetings
- Wherever possible facilitate face to face meetings with the group before starting on the teleconference
- Formalising the supervision agreement – documentation
- Improved relationship between line supervisor and clinical supervisor

Clinician feedback on the applicability to other disciplines / clinical areas
- New graduates would need extra support and possibly wouldn’t work with this remote supervision model.
- If it is a small group – could just translate
- If a larger group it would need to look different
  o Could be broken up into areas with a representative at a larger meeting
- It worked because it was a containable group in a containable program
- Need to have skilled and expert supervisors.
- Need commitment of Line managers and Directors of sites (time, training, documentation, supervision)
- No ownership at cluster level allowed for service development, QI and ability to support more remote areas

Conclusions
The outcomes of this initiative demonstrated that clinical supervision for allied health staff was able to be offered remotely. As a result, the allied health input for TCP clients is of a higher quality, is consistent across the state. Rigorous quality improvement activities have resulted in specific restorative resources that are now available to the wider groups of staff. TCP service to clients has been significantly transformed with increased restorative programs, and the range of services expanded. Allied health clinicians who were supervised, report being challenged, extended in their practice and proud of the difference that they have made to clients and to the program.