Applying the evidence—recruiting and retaining allied health professionals in a remote area

Elaine Ashworth, Community and Allied Health Services, Riverland Regional Health Service, Berri,
Dr Kristine Battye, Consultant, Kristine Battye Consulting, Townsville, Joanne Symons, North West Queensland Allied Health Service, Mount Isa

Background

The North West Queensland Allied Health Service (NWQAHS) was an innovation of the Northern Queensland Rural Division of General Practice (NQRDGP), which is now part of North and West Queensland Primary Health Care (NWQPHC).

NWQAHS resulted from a planning process undertaken in 2000, funded by the Commonwealth Government under the Regional Health Services (RHS) program. This program is designed to help small rural communities expand their local primary health care services.

The planning process is described by Battye and McTaggart1, and included a review of recruitment and retention strategies for health professionals in rural and remote areas as it was identified that recruitment and retention would be an important factor in providing sustainable, appropriate services to the target communities.

The service model

NWQAHS is based in Mount Isa, which is a mining community of around 20 000 people about 900 km west of Townsville in North Queensland. The service initially provided a multi-disciplinary Allied Health service to eleven culturally diverse (Indigenous, non-Indigenous and mixed) remote communities in North West Queensland and additional funding was obtained in 2004 to add services to an additional 5 communities in the west and south west of the state. The communities vary in size from about 200 to about 4000 and have local health services that vary from clinics staffed by one Registered Nurse and one Indigenous Health Worker to hospitals with 10 or more beds. All of the communities have schools, and several have aged care facilities. Few have any resident Allied Health Professionals (AHPs).

The area covered is now over 590 000 km²—more than twice the size of Victoria—yet has a population (excluding Mount Isa itself) of between 13 500 and 17 500 people depending on the source used. Regional Health Service funding is only available to communities of less than 5000 people, so Mount Isa is not covered. There is however, very limited access to Allied Health services in Mount Isa and to assist in addressing this gap, a cost recovery service has been developed in Mount Isa.

The service operates under a hub and spoke model, and within a primary health care framework. Services are provided across the continuum of health promotion, preventative care, illness treatment and rehabilitation, with access being a major factor—as it is sometimes problematic to
be identified with a particular service in a small community, the team operates from a range of locations. Collaboration with the resident health professionals and other agencies, carers and community members to facilitate early identification of health issues and to promote co-ordinated care and client self-management is also a key factor.

This service model means that AHPs are required to operate in ways which might be quite different to those they have been trained for or previously experienced.

Some key features of the service which impact on the professional demands on the team include:

- **Regular and reliable service.** An itinerary is published six months in advance. Teams are away from base from between 2 to 5 days depending on the community/communities visited, and travel by charter aircraft and 4WD. Usually 3 team members travel together, spending large amounts of time together which can place considerable demands on tolerance!

- **Community participation.** Team members work closely with a community panel which includes representation from most of the communities visited, plus key local service providers. There are also other strategies in place to engage with communities and groups within communities who are not well represented by the community panel, and the team members’ relationships with community members play a key role in this.

- **Building and strengthening existing services and programs operating in the region.** Team members and management put considerable effort into developing links with the myriad of other organisations providing health (in the broadest sense) and education services in the area.

- **Primary Health Care Model.** This is not usually a concept that has been explored at undergraduate level, or that many professionals have had experience in.

- **Generalist Specialist Role.** “Birth to Death” eligibility criteria.

- **Cost Recovery Practice.** The services provided by this part of the model in Mt Isa are quite different in concept to the more holistic services provided in the communities.

### Recruitment and retention

It was anticipated that recruitment of AHPs to a remote area like Mount Isa would be difficult, and considerable thought was put into the package offered and the recruitment process. The recruitment package and team structure was based on (at that time) recent research into the retention of allied health professionals²,³ and attempted to address the issues identified in these reports.

This research indicated that the main contributing factors to the poor recruitment and retention of allied health professionals related to management. The issues identified included

- lack of advocacy

- inappropriate line supervision ie by non-allied health professionals or non-clinical people

- lack of clinical and professional support (particularly in solo positions)
difficulties in accessing professional development due to geographic isolation, cost, and lack of information technology access

lack of orientation

unrealistic expectations and pressure on allied health professionals for large caseloads including excessive travel

failure to backfill or delay in recruiting vacant positions, lead to loss of esteem for the allied health positions and a backlog of work.

The recruitment/retention package was designed to address these issues, and included

- **Line management by an allied health professional** with experience of rural and remote service delivery, personnel and service management.

- **Salary.** The service did not wish to ‘steal’ local staff, however did want to provide a salary commensurate with the demands of the positions, so the salary range was set at the Queensland Health PO3 level, which was equivalent to that paid to the Queensland Health outreach AHPs.

- **Time at base.** Although it was identified that excessive travel and the amount of time that was spent ‘away from home’ were critical contributors to ‘burn-out’ of outreach allied health professionals, at the time of the development of the proposal there was very little information available to identify the amount of time required back at base to follow-up outreach visits. The service delivery schedule and identification of staffing requirements was developed on the basis that allied health professionals would not be working in communities more than 50% of the time, which was based on the best information available at the time.

- **Professional development.** This included attendance at a minimum two conferences per year with a budget of $1500 per conference, access to quality library resources through the Mount Isa Centre for Rural and Remote Health (MICRRH) and Queensland Health Mount Isa facilities and access to other workshops/training both locally and using available technology.

- **Orientation to remote and Indigenous practice.** This was provided largely through the Graduate Certificate in Health (Remote Health Practice) offered through the Centre for Remote Health in Alice Springs, by Flinders University but also including local orientation to Indigenous culture.

- **Professional mentoring.** Funding was designated to pay mentors to address the need for discipline specific support.

- **Annual leave.** Six weeks annual leave was provided in recognition of the distance from ‘home’ for most employees and the dislocation involved in undertaking outreach work on a regular basis.

- **Annual airfare home.** Designed to compensate for the financial difficulty staff may experience in getting ‘home’ for holidays.

- **Housing subsidy.** In recognition of the relatively expensive rental market in Mount Isa. The amount provided was equivalent to that paid by Queensland Health, but more flexibly applied.
Relocation costs, with costs to be repaid on a pro-rata basis should the employee not complete their contract.

Assistance with spouse/partner employment if required

Childcare subsidy if required

Retention payments. To be paid after 2 years service, but with no amount specified either in the funding submission, or the staff contracts.

The recruitment process

The initial recruitment strategy involved placing advertisements within regional and national newspapers, with a single advertisement calling for Expressions of Interest for all disciplines (Physiotherapy, Dietetics, Podiatry, Speech Pathology, Occupational Therapy and Psychology) to emphasise the “allied health professional team” approach. The style of the advertisement emphasised the innovative elements of the service and presented the key features of the employment package.

Over 40 expressions of interest were received, with six staff recruited from this pool. Not all positions were filled 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. Subsequently 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. Most applicants were interviewed, and the same questions were used for all disciplines in this initial process. The focus of the interviews was to rate the applicants according to two evenly weighted criteria:

- professional quality (ie their demonstrated ability/knowledge/experience in their discipline), with a particular focus on their ability to handle complex client situations and to work in multi-disciplinary teams
- suitability for the service, especially ability to handle conflict and appreciation of rural/remote lifestyle issues. It was hoped that this focus would assist in identifying people who were more likely to remain longer in this remote area.

By 1 July 2003, all 9 of the initial clinical staff were in place, consisting of a Podiatrist, a Dietitian, a Physiotherapist, 2 Occupational Therapists, 2 Psychologists and 2 Speech Pathologists.

There have subsequently been several more recruitment processes undertaken, with 8 additional staff employed.

All of these recruitment processes have resulted in the immediate appointment of the required staff, with the exception of the Podiatrist appointed in February 2004—this position had been vacant for 5 months. Several applicants had been interviewed prior to the successful applicant, but only one was identified as suitable for the position and unfortunately for personal reasons that applicant withdrew.

Of the 12 staff appointed at the time of formal evaluation of the service, nine were born and brought up in rural and remote Australia, and four of these in North Queensland. Of the others, 2 were born overseas, with one completing her training in the UK. All the other staff employed to that date were trained in Australia.
Significantly, six of the first nine AHPs had personal or family links to the north-west Queensland area. One was living and working in Mount Isa at the time of application; one was moving to Mount Isa with a spouse who had been relocated to the region with work, two had family in Mount Isa itself, while two others had family in the region. In the initial evaluation of the recruitment strategy, those with family links to the area identified this as a very strong positive reason for applying to the service.

The postgraduate experience of the AHPs ranged from 20+ years down to one new graduate (who was a mature age Psychology graduate with considerable experience as a remote area nurse), with the remainder having between two and nine years clinical practice.

Evaluation of the recruitment and retention strategies conducted 3 to 6 months following recruitment of the first cohort identified several factors which contributed to the successful recruitment of the AHPs. These included:

- the salary package, in particular the remuneration
- rent assistance
- postgraduate opportunities
- 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 initial 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.

In contrast to many larger organisations, an explicit policy of active contact with potential employees was and continues to be a key strategy in recruitment, and considerable information about the service provided prior to application. Evaluation identified that the staff felt that the information provided gave them a very clear understanding of the background of the service and the expectation of their role within it.

One commented that this gave them the opportunity to really decide whether they were the right person for the role as opposed to traditional job application/interview processes, where that decision is made mainly by the prospective employer. The emphasis was that there was a full disclosure of information on the part of both prospective employer and employee and that this was unusual and very satisfying. This transparency of management process was also noted to be a
significant ongoing positive factor for the allied health professionals and may well prove a key factor in retention of staff over the duration of the program.\textsuperscript{4}

Retention of staff, while not perfect, has certainly been better than in many other remote areas. Of the original cohort of staff, 2 resigned after about 18 months with the service. Of interest is the fact that these were the 2 staff members who had previous experience providing outreach services, and that both initially remained in Mount Isa. One changed careers entirely and the other temporarily filled a previously never filled position with Housing Queensland, which has less travel and a narrower clinical focus. Four more of the original cohort have recently resigned, but these staff stayed until the end of their original contract (corresponding to the end of the original RHS funding period) ie more than 2 years.

Evaluation of the retention strategies undertaken in September 2003 (ie 12 months after the initial evaluation) identified the following

- **Salary levels:** It was felt that scale in use was imposing an unnecessary limitation on the capacity of the service to offer higher salaries to high calibre applicants and to reward existing staff for attainment of high levels of performance.

- **Workload:** It became evident early in the life of the service that the amount of time available to staff for the work required was inadequate, and despite ongoing attempts by management to alleviate this, it remains an issue.

- **Professional development:** The workload issue has impacted on the ability of the staff to access the amount of professional development available to them. In addition, the flexibility to release staff to attend postgraduate course intensives has proven difficult for a number of reasons. Some staff found the identified course of great benefit, while others were not as positive.

- **Mentoring:** It was identified that a more formal mentoring process would be valuable.

- **Relocation support:** As important as the financial support offered in meeting relocation expenses was the practical support with accommodation, transport and orientation to the community provided on arrival in Mount Isa.

- **Annual airfare ‘home’:** This element of the package has been universally popular.

- **Housing subsidy:** This subsidy “effectively boosts the salary by nearly $4000 per annum and adds to the frequently reported sense that staff are “looked after” by the service.”\textsuperscript{4}

- **Childcare subsidy:** Whilst only used by one staff member during the evaluation period, this strategy was seen as valuable.

- **Spouse employment assistance:** This assistance was practical rather then financial, and although not widely utilised, was found to be helpful.\textsuperscript{4}

**Lessons learnt**

**Recruitment:** The service evaluation identified that:

When comparison is made between the recruitment and selection process used by NWOPHC/NWQAHS and international human resource management practices, it appears that the NWQAHS has executed a number of these.
The recruitment and retention strategy demonstrates that NWQPHC through the NWQAHS had made provision for training, career planning, compensation, family assistance (availability of childcare subsidy and spousal assistance) and repatriation support through the annual trip ‘home’. Furthermore the successful applicants exhibit some of the traits of those seeking international assignments as the majority are single, some had previous experience working in rural and remote areas (and several in Indigenous communities), and given their relative youth or stage of life have a strong career focus.4

The evaluation identified that the following factors assist in successful international assignments:

- cultural adaptability including cross-cultural fluidity, previous overseas experience, cultural sensitivity
- tolerance of ambiguity
- maturity
- stability and ability to adapt behavioural style
- identification of needs of the family, and involving the spouse/family in the selection process from the start
- technical ability.4

The service management concurs with these factors when considering the attributes desirable in staff working in NWQAHS.

**Workload:** One of the major challenges the service has faced has been the need to quantify workload. The original submission calculated that 7.75 FTE would be required to provide the outreach services, and this included one day ‘back at base’ for every day on the road. This amount was to include professional development, conference leave, (which is considerable), annual leave, sick leave and cover for colleagues while they are absent doing any or all of the above. The number of relatively inexperienced staff employed has exacerbated this issue—it has been identified that for Occupational Therapists at least, recent graduates may take longer to complete tasks and perceive higher caseload demands than more experienced clinicians.5

Examination of time use for 2002/2003 has identified that while the largest proportion of staff time is spent in individual client consultation (24%) followed not surprisingly by travel (21.9%), resource preparation (11%), client scheduling (10.4%), service liaison (8.7%), non contact documentation (7.4%) and health promotion (7%), which are critical to the primary health care focus of the service, absorb a considerable amount of time.

Adjustments of travel days and expectations of time available at base for cost recovery work have evolved over the life of the service, with one full day at base now being allocated per travel day, plus additional time allocated for study leave and annual leave.

In recognition of the difficulties the service has faced in quantifying workload expectations, the Australian Government has provided one-off funding under the RHS program for a ‘Benchmarking project’, to build upon the work done by Robyn Adams in NSW and Rob Curry in the Northern Territory, and use the experiences of the NWQAHS and the Katherine RHS project, to develop a process to assist funders and managers to identify reasonable staffing levels for the specified Allied Health disciplines in different service contexts. This project is currently under way and it is hoped that the results will allow more accurate planning of services in the future.
Support of staff has been another of the major challenges facing the service. Even with an explicit strategy to provide support, it is not easy. NWQAHS staff receive (relatively speaking) a lot of support, including orientation, funded mentoring, monthly supervision with the team leader or manager, access to considerable amounts of professional development, the benefits of working (usually) with at least one other member of the same discipline in the team (although due to travel commitments they seldom have the opportunity to spend much time together) and the benefits of travelling in a team. Plus the more tangible rewards listed previously.

However NWQAHS still faces lots of challenges, especially in supporting younger staff with less experience. The different expectations and support needs of the “Generation X” age group is an area that the service did not anticipate—this group seeks clear goals and quick, specific feedback on performance which is difficult to achieve in the flexible model of service provision required to meet the needs of communities. However NWQAHS has constantly adapted strategies to better meet the needs of this group, and of individuals. Appropriate line management was identified in the Queensland Health taskforce report as a critical component of a successful recruitment and retention model. At the end of 2002 it was identified that additional management time was required to provide appropriate levels of staff support whilst dealing with the complexities of developing a new Primary Health Care Service in this region and a 0.5 Full time equivalent (FTE) Team Leader position and 0.75 FTE Administration Manager were created.

It may be that recruiting more experienced staff might overcome this difficulty, but the reality is that it is mostly young, single people who are ready for the challenge of such a job. There is a need to try to strike a balance between the requirement for structure felt by some staff, and the necessary flexibility to effectively meet the needs of such a diverse group of communities and service types.

Other suggested retention strategies recommended by the evaluation include:

- the need to review the salary scale with possible progression to equivalent of the Queensland Health PO4 level on the basis of clinical expertise, with progression through increments being performance based, and opportunities for extra increments earned through completion of the Graduate Certificate in Remote Health Practice or another approved course, or taking on professional supervision/mentorship of a recently graduated staff member. It is hoped that these factors may be able to be addressed in the new contracts

- a more flexible approach to study, allowing enrolment in alternative appropriate courses according to individual need.

Conclusion

The first two years of the NWQAHS was a time of rapid development. In that time it was 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.

But where to from here?

A number of the ‘lessons learnt’ have already been implemented, but the sustainability of the service and the ability to continue with this implementation are challenged by, as always, funding issues.
Although there has been a commitment to funding this service for four more years, the level of funding has not been adjusted to allow for the identified need for a more robust management structure which has delayed the implementation of the auspicing organisation’s preferred management model, with an interim model in place for the last 6 months meaning limited time is available for support of staff. It is also proving difficult to meet realistic workload requirements under the existing funding.

An additional issue has arisen with the announcement in June 2004 that due to Ministerial delays, RHS services would not receive their ongoing four year contracts for several months, although the commitment of funds was assured. A four month contract has been given, with the corresponding problems that this presents in not being able to offer new contracts to staff incorporating some of the ‘lessons learnt’, leasing arrangements etc. The likelihood of an election being called in the next few months, which would then put the government into caretaker mode, adds to the uncertainty for staff and management.

It is hoped that these uncertainties are overcome rapidly, to allow this innovative and effective service to continue to break new ground in providing appropriate, effective services to remote residents of North and West Queensland.

References


