Engagement Summary: SARRAH and Aboriginal Community Controlled Health Organisations

ALLIED HEALTH LESSONS LEARNED DURING THE IMPLEMENTATION OF TAHRGETS AND BRAHAW

2023

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The purpose of this document is to outline SARRAH's approach to understanding the positioning of allied health professionals and allied health assistants within Aboriginal Community Controlled Health Organisations (ACCHOs) as they relate to the allied health rural generalist pathway and building the rural and remote allied health assistant workforce; and to summarise the feedback from ACCHOs regarding allied health and allied health assistants and these programs.

It should be noted that not all views expressed in the report are attributed to all ACCHOs.

ACKNOWLEDGEMENTS

The SARRAH team has been privileged to participate in many conversations to inform this paper. These conversations have been held on many First Nations lands across Australia, either in person visiting, or meeting via video or telephone conference.

SARRAH would like to acknowledge and pay our respects to the Elders of these many lands and thank them for their ongoing custodianship of the land, waters and skies where we live work and play.

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SARRAH	Services for Australian Rural and Remote Allied Health
ACCHO	Aboriginal Community Controlled Health Organisation
ACCO	Aboriginal Community Controlled Organisation
AHA	Allied health assistants
TAHRGETS	The allied health rural generalist education and training scheme
BRAHAW	Building the rural and remote allied health assistant workforce
AHRG	Allied health rural generalist
AH	Allied health
NACCHO	National Aboriginal Community controlled health organisation

EXECUTIVE SUMMARY

Services for Australian Rural and Remote Allied Health (SARRAH)is currently implementing two workforce development initiatives establishing supported training positions within allied health service providers across rural and remote Australia:

- Allied Health Rural Generalist (AHRG) training positions through The Allied Health Rural Generalist Education and Training Scheme (TAHRGETS) program; and
- Allied Health Assistant (AHA) training positions through Building the Allied Health Assistant Workforce (BRAHAW) program.

In alignment with performance indicators, each program has allocations for training positions within Aboriginal Community Controlled Health Organisations (ACCHOS).

As part of the activities against these performance indicators, SARRAH has undertaken an extensive engagement process with ACCHOs, ACCOs and relevant peaks across Australia. This engagement was undertaken with regards to organisations' interest and ability to participate in either workforce development pathway.

This engagement process has allowed SARRAH to build an understanding of allied health services in ACCHOs - their current service provision, and the supports necessary for this provision to thrive within ACCHOs; as well as the role that SARRAH's workforce programs play in the current context. Figure 1~~Figure 1~~, below, is based on feedback from this engagement process, and provides a summary of the identified barriers to a thriving allied health service within ACCHOs.

For one of the programs – Building the Rural and Remote Allied Health Assistant Workforce (BRAHAW) – this engagement process has resulted in the achievement of all allocated training positions.[1]

For the second program – The Allied Health Rural Generalist Education and Training Scheme (TAHRGETS) – this engagement process has resulted in an understanding of the barriers to successful achievement of these allocated training positions.

For SARRAH, the engagement process has not concluded, rather it has established a foundation for ongoing and future program delivery and advocacy, in close partnership with Indigenous Allied Health Australia (IAHA). The work has also confirmed SARRAH's focus on First Nations communities' access to allied health services for all rural and remote communities as part of ongoing advocacy and project work.

More broadly, the work has highlighted the need for a cohesive review of policy drivers and funding mechanisms with a view of enabling allied health service delivery by ACCHOs, and the opportunity for collaborative research in this area.

[1] At the time of writing, noting that numbers may fluctuate during the term of the program.

What we have heard

implementing allied health workforce development initiatives in ACCHOS

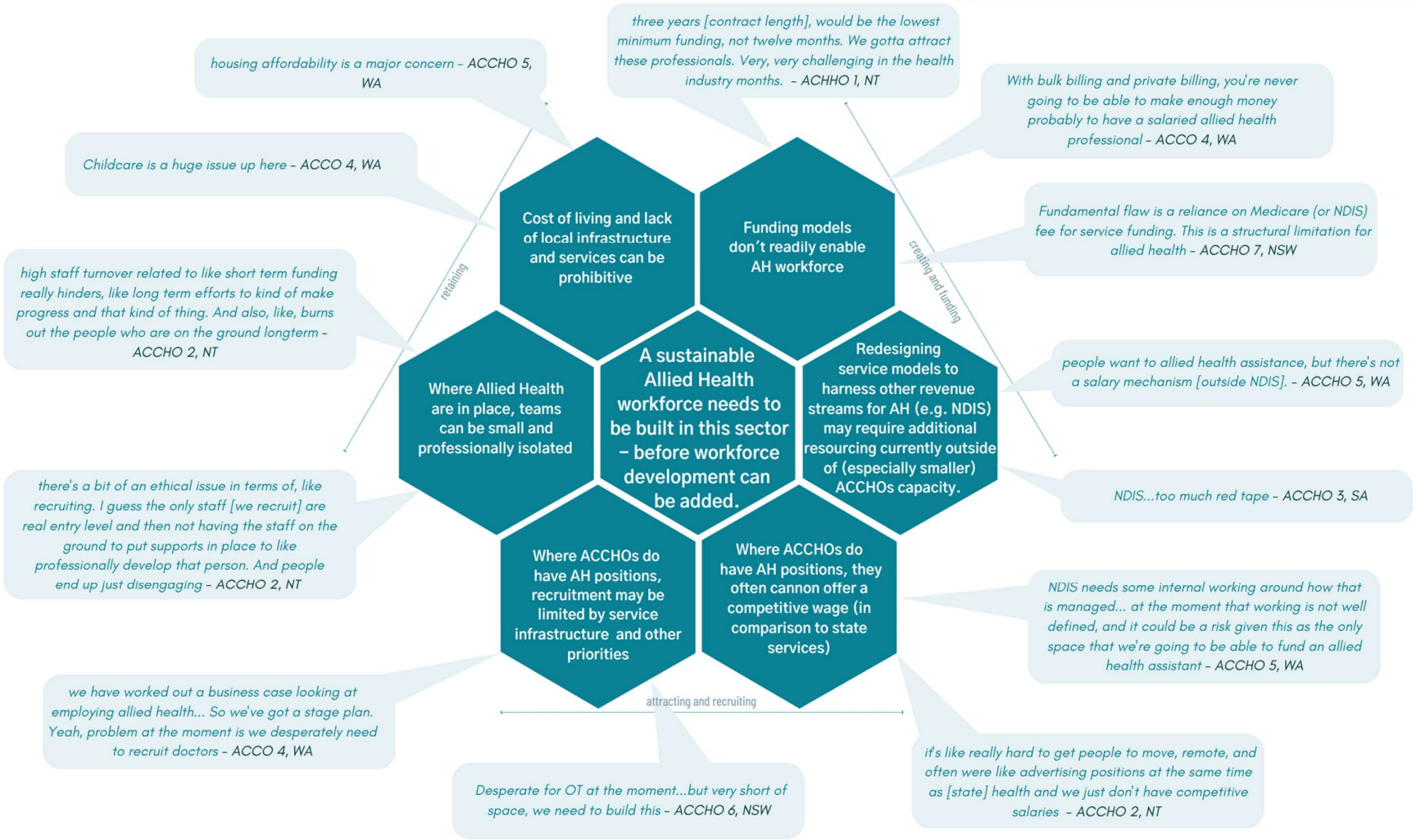

Figure 1: Overview of engagement

1 INTRODUCTION

1.1 Background of project

Services for Australian Rural and Remote Allied Health (SARRAH) has received funding from the Commonwealth Department of Health to deliver two (three-year) workforce development initiatives focussing on the rural and remote allied health workforce. Funding for these programs represents the first new Commonwealth investment specifically for the rural and remote allied health workforce in many years. The programs received three years' funding, with funding to be expended or fully committed by September 2024

1. *The Allied Health Rural Generalist Education and Training Scheme (TAHRGETS)* (Allied Health Rural Generalist Pathway - 4-GCRQIYP) focuses on the further development of the qualified Allied Health Professional.
2. *Building the Rural and Remote Allied Health Assistant Workforce (BRAHAW)* (Allied Health Assistant Workforce Package - 4-GCRQJ18) focuses on the development of a rural and remote Allied Health Assistant (AHA) workforce.

In both programs, a training position must be created by the employing organisation. This training position may be a newly established position that the organisation wishes to recruit to, or to place an existing member of the workforce. SARRAH provides education funding for the trainee, workplace training grants for the organisation, and support, capacity building, and resources to all participants.

In TARHGETS, the training position is allocated to an already qualified Allied Health Professional[2], and the trainee must undertake the Allied Health Rural Generalist (AHRG) pathway[3] with the support of their employing organisation.

In BRAHAW, the training position is for an Allied Health Assistant. Through the program, the organisation follows a roadmap to the development of an AHA service. The trainee undertakes training (with or without certification) to deliver, under supervision, the AHA service delivery model, and the organisation undertakes the establishment of the required governance; and the workplace training and supervision and support of the AHA[4].

Under the grant agreements, both programs have a fixed number of training positions allocated to Aboriginal Community Controlled Organisations (ACCHOs). For TAHRGETS, 30 of the 90 packages are allocated to training positions within ACCHOs. For BRAHAW, 15 of the 30 packages are allocated to training positions within ACCHOs. The aim of these targeted allocations is an increase in access to allied health services for First Nations people (note, these are not allocations specifically for increasing Indigenous allied health workforce).

Achieving these allocations are identified as key performance indicators for the grants.

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[2] Current eligible allied health professions: Dietetics, Occupational Therapy, Pharmacy, Physiotherapy, Podiatry, Radiography, Speech Pathology, Psychology, Social Work

[3] The Allied Health Rural Generalist Pathway is an innovative workforce development strategy to increase access to a highly skilled allied health workforce for rural and remote Australian communities. This innovation is enacted through the use of three trusted mechanisms: formal education, structured supervision and support, service model development. For more information see https://sarrah.org.au/ahrgp

[4] For more information on BRAHAW, see https://sarrah.org.au/brahaw

SARRAH's approach to implementing the ACCHO training positions and engagement of the ACCHO sector has been developed following advice and guidance from the TAHRGETS and BRAHAW advisory committees, SARRAH's close partner, the Indigenous Allied Health Association (IAHA), and NACCHO. These activities have resulted in the development of strong relationships with many ACCHOs across the country and contributed to a depth of understanding of the enablers and barriers to implementation.

1.1.1 TAHRGETS

As of June 2023, SARRAH had received a total of six applications for TARHGETS training positions (6/30) from ACCHOs. Two applications received were for existing Allied Health Professionals within an ACCHO. Four applications established new training positions with the organisation intending to recruit to these positions. Of the two existing allied health positions – one withdrew to return to her home in Sydney. Of the four recruitment positions, all have failed to recruit. One AHRG ACCHO trainee remains (1/30).

1.1.2 BRAHAW

As of June 2023, SARRAH is oversubscribed with 20 of 15 training positions for AHA allocated within ACCHOs.

The BRAHAW program has received significantly more applications from ACCHOs than has TAHRGETS. Additionally, BRAHAW has had interest from mainstream organisations wishing to employ locally based First Nations Allied Health Assistants.

1.2 Purpose of stakeholder engagement

To successfully implement training positions within the TAHRGETS program, SARRAH sought to identify ACCHOS satisfying the following requirements:

- are rural and remote
- have an organisational priority to deliver allied health services
- have Allied Health Professionals employed.

To successfully implement training positions within the BRAHAW programs SARRAH needed to identify ACCHOS satisfying the following requirements:

- are rural and remote
- have an organisational priority to deliver allied health services
- have Allied Health Professionals who are either employed or externally contracted, to delegate to and providing training and supervision to an AHA
- already fund, or are able to fund, AHA positions within their current business.

Furthermore, SARRAH needed to ascertain whether individuals within these organisations had the interest and capacity to participate in the workforce development pathways.

The identification process has been illustrated below, in Figure 2.

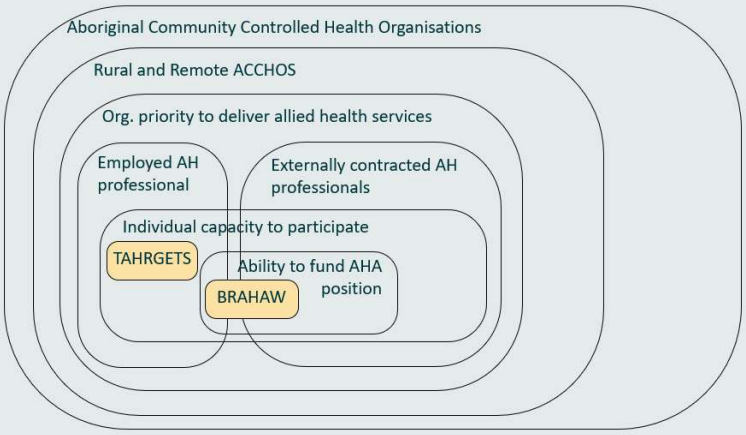

Figure 2: Identifying ACCHOs and individuals to target during the engagement process.

The identified **purpose** of the engagement process was to:

- identify appropriate ACCHOs;
- increase ACCHO understanding of workforce development pathways; and
- secure ACCHO participation in the workforce development pathways.

To ascertain eligibility, SARRAH has asked the following questions:

1. What does allied health service delivery look like in your organisation? (Status of allied health within ACCHOs)
2. Under what conditions would allied health service delivery thrive in your organisation? (Enablers and Barriers to allied health within ACCHOs)
3. Would SARRAH's workforce development initiatives help to optimise these conditions? (Reception of the TAHRGETS and BRAHAW programs)

1.3 Scope and limitations of report

This report is focused on the engagement with, and feedback from, the Aboriginal and Community Controlled Sectors with regards to their interest and ability to participate in either the TAHRGETS or BRAHAW workforce development pathways.

2 METHODOLOGY

2.1 Stakeholder engagement

Engagement with stakeholders has been led by SARRAH's engagement strategy. This strategy, illustrated in Figure 3Figure 3 below, has been an evolving and iterative strategy over the course of the TAHRGETS and BRAHAW planning and implementation phases.

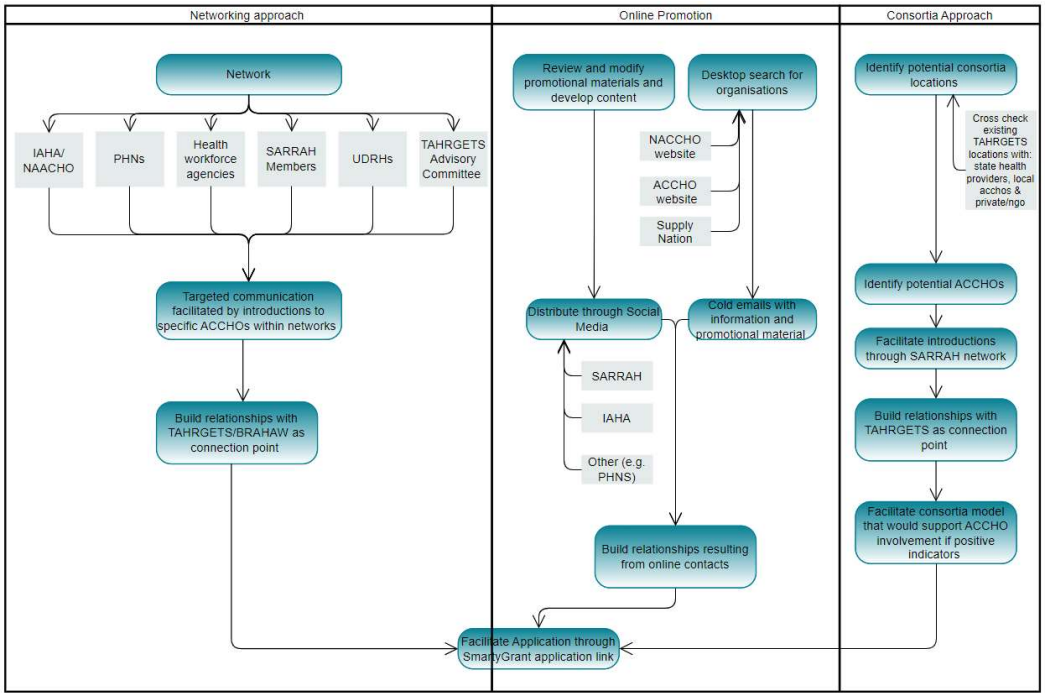

Figure 3: SARRAHs engagement strategy: identifying ACCHOs and individuals to target during implementation.

Figure 4, below, further explores the networking approach outlined in the engagement strategy.

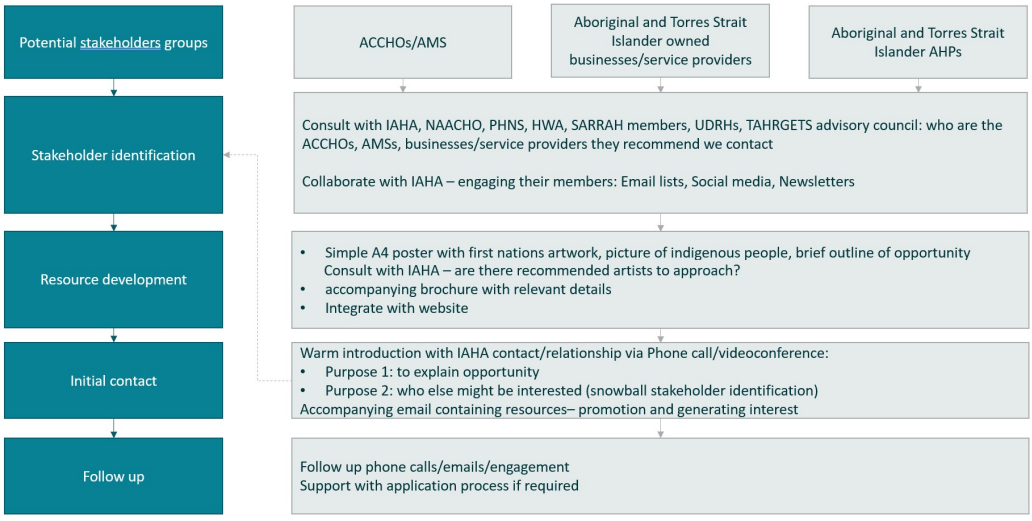

Figure 4: SARRAH Identifying ACCHOs and individuals to target during the engagement process.

Communication with stakeholders was distributed across the SARRAH team, with all members of the TAHRGETS and BRAHAW implementation team as well as the SARRAH CEO and Policy and Advocacy Director contributing to these activities. The decision of who engaged with stakeholders was made based on the level and type of engagement, and where existing relationships already lay. A summary of communications can be found below in Table 1.

Party engaged	New engagement[1]	What/how did engaged group contribute? [2]	Outcomes? [3]
Indigenous Allied Health Australia	N	Provided advice and guidance, distribution of promotional material through networks and membership, warm introductions to ACCHOs potentially interested in the project	Relationship ongoing Increased profile of TAHRGETS/BRAHAW increased SARRAHs network of ACCHOs
National Aboriginal Community Controlled Health Organisation	N	Provided advice and guidance. Facilitated relationships with ACCHOs with program interest	Relationship ongoing Increased profile of TAHRGETS/BRAHAW increased SARRAHs network of ACCHOs
Aboriginal Community Controlled Health Organisations	Y, N	Considering program applicability in their setting, Snowball identification of other potentially interested ACCHOs.	Some ACCHOs not interested – relationships not ongoing at this time. Some ACCHOs interested but not capacity/interested individuals – relationships ongoing. Some ACCHOs applications received for training positions – relationships ongoing
Primary Health Networks - Rural PHN group - Individual rural PHNs	N	Provided advice and guidance, distribution of promotional material through networks	Relationships ongoing Increased profile of TAHRGETS/BRAHAW
Health workforce agencies	N	Provided advice and guidance, distribution of promotional material through networks and membership, warm introductions to ACCHOs potentially interested in the project	Relationship ongoing Increased profile of TAHRGETS/BRAHAW increased SARRAHs network of ACCHOs
University departments of rural health	N		Relationships ongoing Increased profile of TAHRGETS/BRAHAW
TAHRGETS Advisory Committee	N	Provided advice and guidance, distribution of promotional material through networks and membership, warm introductions to ACCHOs potentially interested in the project	Ongoing, continue to provide guidance and advice in the implementation of TAHRGETS
SARRAH members	N	Asked to consider program and distribute to networks	Ongoing

1 New engagement as part of this project consultation

2 Contribution of engaged group: Classify the contribution according to which stage in your research project the engagement has occurred. For example: Design; Implementation/fieldwork; report writing; review. Consideration of findings/recommendations; Communication / dissemination

3 Change: Outcomes in terms of changes in engagement – relationships / structures, networks including creation of new networks; formalizing relationships e.g., through MoU's.

Table 1: Engagement of external individual/groups/networks

Table 2, below, lists the resources developed by the implementation team to support ACCHO stakeholder engagement and communication.

Resource	TAHRGETS	BRAHAW
Program guidelines	✓	✓
Posters	✓	✓
Social media tiles and contents	✓	✓
Short videos	✓	✓

Table 2: Resources developed.

A summary of communication methods used in the stakeholder engagement, can be found below in, Table 3.

Communication method	Audience Reached	Response
Cold call emails SARRAH undertook a desktop screen of rural and remote ACCHOS regarding allied health service provision. Those with obvious allied health services listed on their website were sent emails that introduced SARRAH and provided preliminary information about the TAHRGETS and BRAHAW programs and invited further conversations.	ACCHOS identified in desktop search	No meaningful ongoing engagement using this method
Third party introductions SARRAH was introduced to ACCHOS via a third party from within SARRAHs extensive stakeholder network. Once an introduction was made, SARRAH followed up via email providing more information about the TAHRGETS and BRAHAW funding and inviting further conversations	ACCHOs who SARRAH did not yet have relationships with.	Resulted in meaningful engagement with ACCHOs
The conversations Through face-to-face visits, videoconferencing, telephone calls and emails SARRAH has had conversations with ACCHOs about allied health, professionals and AHAs. These conversations have included discussions with organisations CEOs, Clinical Directors, Executives, Clinical Managers, Allied Health Professionals and Aboriginal Health Workers.	ACCHOs that SARRAH had pre-existing relationships with, or that SARRAH had been introduced to.	Deepened relationships, increased understandings of workforce development initiatives.

Table 3: Methods of Communication

2.2 Ongoing engagement activities

Engagement activities remain ongoing. SARRAH continues to work with partners to further build relationships with ACCHOs, as well as deepen understanding of workforce development initiatives.

3 ENGAGEMENT FINDINGS

To date, SARRAH has engaged with 18 ACCHOs (17 regional, rural and remote, 1 metropolitan based), four ACCOs, and two peaks (Indigenous Allied Health Australia and National Aboriginal Community Controlled Health Organisation). These rich, ongoing conversations have provided SARRAH with an understanding of what allied health service delivery looks like in ACCHOs; enablers and barriers for thriving allied health service delivery within ACCHOs, and the current role and relevance of SARRAH's workforce development initiatives.

Findings are reported against the three focus questions used in the engagement.

1. What does allied health service delivery look like in your organisation? (Status of allied health within ACCHOs)
2. Under what conditions would allied health service delivery thrive in your organisation? (Enablers and Barriers to allied health within ACCHOs)
3. Would SARRAH's workforce development initiatives help to optimise these conditions? (Reception of the TAHRGETS and BRAHAW programs)

3.1 Status of allied health within ACCHOs

Findings indicated that allied health service delivery differs across ACCHOs due to variations in employment structures and services provided.

3.1.1 VARIATIONS IN EMPLOYMENT STRUCTURES

Only one of the ACCHOs employs an entire allied health team, the remainder range from relying entirely on externally contracted Allied Health Professionals to provide services; to those ACCHOs who have a mix of some internally employed and some externally contracted Allied Health Professionals

3.1.2 VARIATIONS IN SERVICES PROVIDED

The reported allied health services provided also varied. Most ACCHOs provided social and emotional wellbeing services (program funding) and some accessed Medicare billing for psychology services under a mental health treatment plan. Most ACCHOs also had funding for the provision of primary allied health services related to chronic disease management through programmatic funding (short term grant agreements). Few ACCHOs reported Medicare being a primary source of allied health revenue. Some of the ACCHOs are registered NDIS providers with growing disability allied health service provision. Contributing factors for this large variation can be grouped into the themes listed here and discussed in the following Enablers and Barriers section.

- Creating and funding allied health positions
- Attracting and recruiting allied health professionals
- Retaining allied health professionals

3.2 Enablers and Barriers to allied health within ACCHOs.

3.2.1 CREATING AND FUNDING ALLIED HEALTH POSITIONS.

Within ACCHOs, funding of allied health services fall predominantly into one of the three categories, as summarised below:

1. Program/Block funding.

Program block funding is normally tied to specific health outcome areas. Allied health positions may be created as part-time or full-time positions for the duration of the program contract (often only one to two years long, sometimes three).

Recruitment into these positions is generally limited to a cohort of allied health professionals who are already local, or who are prepared to move rural and/or remote for a short period of time with no guarantee of ongoing employment. The ability to employ Allied Health Assistants within these models may be limited by grant funding agreements.

> *three years [contract length], would be the lowest minimum funding, not twelve months. We gotta attract these professionals. Very, very challenging in the health industry months.*
> *- ACHHO 1, NT*

> *With bulk billing and private billing, you're never going to be able to make enough money probably to have a salaried allied health professional - ACCO 4, WA*
> *Fundamental flaw is a reliance on Medicare (or NDIS) fee for service funding. This is a structural limitation for allied health - ACCHO 7, NSW*

2. Medicare funding

The limitations of funding allied health services through Medicare are well documented. At this time, Medicare is not a sustainable mechanism for fully funding Allied Health Professional positions, and there are no existing mechanisms for funding Allied Health Assistant positions through Medicare. Further subsidising through out-of-pocket expenses or top up block funding is required for a viable workforce model.

3. NDIS funding

NDIS provides the most likely mechanism for creating and delivering sustainable allied health services, providing funding mechanisms for employing both Allied Health Professionals and Allied Health Assistants. However, through this engagement, ACCHOS have reported varying opinions of, and willingness to engage with NDIS. Some ACCHOs consulted are NDIS providers and are building in this space. Some have been NDIS providers but do not see the benefit and are letting their status lapse, others are not providers and are considering it, and others are not providers and have no short-term plans of becoming providers.

> *NDIS...too much red tape - ACCHO 3, SA*

3.2.1 ATTRACTING AND RECRUITING ALLIED HEALTH PROFESSIONALS

Where ACCHOs have established Allied Health Professional positions, there are often barriers in attracting and recruiting to roles.

In the absence of viable funding mechanisms that enable creation of and recruitment to ongoing allied health positions, there is often a reliance on fixed term contracts. Recruitment to fixed term contracts in rural and remote Australia comes with additional difficulties of:

- attracting Allied Health Professionals to move to rural and remote areas.
- having available medium-term accommodation available at an affordable rate
- having an allied health network large and consistent enough to create a supportive professional environment.

Furthermore, ACCHOs may not be able to provide competitive salaries when compared to other service providers (e.g., state health jurisdictions)

> *it's like really hard to get people to move, remote, and often were like advertising positions at the same time as [state] health and we just don't have competitive salaries - ACCHO 2, NT*

Some ACCHOs have been able to create positions, but the physical infrastructure has not been sufficient for additional staff, or finite resources are redirected to other priorities.

> *Desperate for OT at the moment...but very short of space, we need to build this - ACCHO 6, NSW*
>
> *we have worked out a business case looking at employing allied health... So we've got a stage plan. Yeah, problem at the moment is we desperately need to recruit doctors - ACCO 4, WA*

Consequently, many ACCHOs, when not able to employ Allied Health Professionals locally, provide services through contracting external Allied Health Professionals. These may be local or fly-in-fly-out providers.

3.2.2 RETAINING ALLIED HEALTH PROFESSIONALS

Some of the factors mentioned above in the ability to attract Allied Health Professionals also affect retention. For ACCHOs these can include community factors such as liveability as well as professional factors. The cost of living and lack of local infrastructure and services can be prohibitive to both attraction and retention.

> *housing affordability is a major concern - ACCHO 5, WA*
>
> *Childcare is a huge issue up here - ACCO 4, WA*

When employed in ACCHOs Allied Health Professionals may be the only Allied Health Professional or may be employed in a small team. In the conversations SARRAH heard that there is a risk for Allied Health Professionals feeling professionally isolated, contributing to high turnover.

> *there's a bit of an ethical issue in terms of, like recruiting. I guess the only staff [we recruit] are real entry level and then not having the staff on the ground to put supports in place to like professionally develop that person. And people end up just disengaging - ACCHO 2, NT*
>
> *high staff turnover related to like short term funding really hinders, like long term efforts to kind of make progress and that kind of thing. And also, like, burns out the people who are on the ground long term - ACCHO 2, NT*

3.2.3 UNDER WHAT CONDITIONS WOULD ALLIED HEALTH SERVICE DELIVERY THRIVE IN YOUR ORGANISATIONS

Through the engagement process, the most consistent messaging heard from ACCHOs was the need for a sustainable funding mechanism for salaried Allied Health Professional positions; that this mechanism facilitates ongoing or long-term employment contracts that are competitive with state health jurisdictions.

Further to this, ACCHOs reported that there is a recognised need for an economy of scale of allied health services that would allow the formation of supportive teams, and the efficiencies to sustain the 'back-of-house' structures that enable allied health service delivery.

> *…certainty…you need some scale… you need some team capacity*
> *- ACCHO 1, NT*
> *structures and supports in place within the team to set that up to really thrive - ACCHO 2, NT*

3.3 Reception of the TAHRGETS and BRAHAW programs

3.3.1 TAHRGETS

The reception of the TARHGETS workforce packages by ACCHOs has been mixed. Many ACCHOs had little understanding of the AHRG pathway. This is consistent with the evaluation of the Allied Health Rural Generalist Workforce and Education Scheme (AHRGWES), the pilot preceding the TAHRGETS program. This lack of understanding was more apparent in organisations such as ACCHOs/AMSs for whom allied health service provision has not to date been seen as core business. Through SARRAH's engagement, knowledge and understanding of the pathway is growing. While most ACCHOs engaged with have been supportive of and interested in developing their allied health workforce, their interest is focussed on how to secure a stable allied health workforce, an acknowledgeable first step before workforce development initiatives can be applied.

For those ACCHOs who employed Allied Health Professionals, there were still some concerns regarding the applicability of the pathway for their current context. The Level 2 AHRG Pathway has a two-year (minimum) timeframe. Allied Health Professionals, employing ACCHOs and SARRAH need some assurance that the Allied Health Professional is likely to be employed for at least the two years the pathway would take to complete. This was problematic for ACCHOs where contracts of one or two years were the norm.

For those ACCHOs who relied on externally contracted service providers, the pathway offered no perceived direct benefit, as the workplace training grants and supports would go to the employing organisation. Furthermore, some employing organisations would not be eligible if they are offering fly-in-fly-out services from metropolitan areas[5].

The feedback and contextual information gathered through this process is essential to understanding why the implementation of AHRG training positions within ACCHOs has not worked at this time.

3.3.2 BRAHAW

The reception of the BRAHAW packages by ACCHOs is very positive. Given this workforce development initiative focuses on local workforce and there is not a requirement for the supervising and delegating Allied Health Professionals to be employed internally, there is scope to accommodate flexible and innovative approaches to developing this workforce.

This positive response is evident in the oversubscription of available BRAHAW training positions.

SARRAH understands that organisations who have limited experience delivering allied health services may require additional assistance to understand and support the essential relationship between the supervising and delegating Allied Health Professionals, and how this will function if the Allied Health Professional is employed externally.

[5] SARRAH does not currently consider applications from metropolitan based allied health services providing fly in fly out services. This decision was based on a priority at the time to develop a rural and remote workforce.

4 IMPLICATIONS NEXT STEPS

This engagement process has been essential to shaping SARRAH's role in increasing access to allied health services for First Nations communities.

4.1 Implications for SARRAH

This report informs three key action area for SARRAH:

1. Ensure that SARRAH's program delivery continues to promote increased access to allied health services for First Nations communities. Programs should prioritise service providers with proven track records of working with First Nations communities (including ACCOs and mainstream organisations)

2. Ensure that SARRAH continues to work closely with IAHA so that programs wherever possible promote the growth of an Indigenous health workforce, and that this workforce is distributed within rural and remote Australia.

   This should include reimagining how the pathway could be used for Indigenous Allied Health Professionals, to increase their skills, knowledge and exposure to rural and remote practice and increase their likelihood of moving into rural and remote practice.

3. Ensure that SARRAH continues to work closely with IAHA and NACCHO to communicate the unique issues raised by ACCHO and ACCO stakeholders to policy and decision makers.

4.2 Broader recommendations

1. That policy drivers and funding mechanisms are reviewed with the view of making changes that promote and enable ACCHOs to deliver sustainable allied health services to better manage the health needs of First Nations communities.

2. Undertake collaborative research into allied health service delivery by ACCHOs.
   This report summarises a small consultation process directly related to workforce development initiatives currently implemented by SARRAH. This report offers some preliminary recommendations to support collaborative research into allied health service delivery by ACCHOs.