Allied Health students contributing to high quality patient care: findings from a multi-site study

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Abstract

Demonstrating value of AH care is challenging in an increasingly over stretched healthcare system where limited AH resources impact negatively on impact and reach

Need to invest in graduating more AH professionals to enable better care – but need to juggle delivery of care alongside offering rich placement learning experiences for students

Our goal: To create strong ***health–education partnerships*** demonstrating value and utility of allied health care

Our research question

Is it possible to demonstrate positive impact of AH and simultaneously invest in development of the future workforce through re-designing clinical services that authentically integrate AH students into care delivery?'

Our approach

Co-design principles; case study design; Physio & OT; six different hospital settings

Outcomes

- Positive patient experiences:

  "I had more help this stay in hospital then before" (Patient)

  "She's been referred to the program four times and has never actually come. And then she turned up for the first session because she knew I was going to be there". (student)

- Improved health outcomes:

  "I went from being not mobile to now reasonably mobile". (Patient)

  "[we've] been able to pull it [discharge] a bit further forward, because he's progressed so nicely and quickly with it". (Educator)

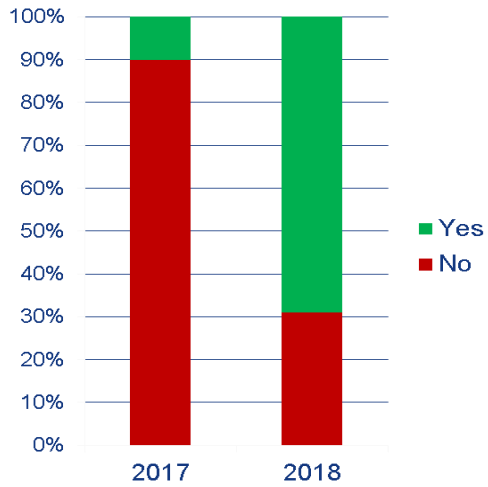
- Enhanced service efficiencies:

  "they're [physios] never able to cover everybody all of the time whereas now, . . .[rehab ward] has a line drawn through it, the word written "covered" which is unheard of". (Manager)

- Feasible educational models

  "For us, I would never believe that you could convince an educator that they would rather have 4 students compared with 2". (Manager).

Example outcome from one study setting



A patient with a Hip Fracture should mobilise at least once a day, everyday, after surgery (ACSQHC 2016)

Addressing Health Inequities

Through re-designing clinical services that authentically integrate students into care delivery, we addressed:

Service availability inequities → Increased services such as:
- Rehab whilst inpt in a renal ward
- Health promotion education in a general medical ward
- Daily upper limb group therapy post stroke

Wait times inequities → Outpt pulmonary rehab waitlist reduced by 3/7 for priority 1 pts, 17 weeks for all other patients

Service delivery prioritisation → Greater flexibility to re-distribute staff resources to other priority areas within the service.
- winter months flu admissions surge

Implementation/Translation to Practice

Key learnings:

- Re-frame the education - practice narrative to partnerships of mutual benefit:
  - **First**, identify the service gap and opportunities for subsequent service re-design from ***the perspective of the health service provider***.
  - Clearly articulate ***what patient outcomes*** the service wants to influence.
  - ***Co-design service re-designs*** that attend to patient, student and service outcomes where students are central to delivery of care.
  - Co-design placements to take into account ***local context coupled with sound educational practices***.

- Re-framing provides opportunities for future and current workforce development:
  - Requires **policy *and* practice commitment** and engagement at all levels within health and education

Next Steps

- Test principles developed on a larger scale across different contexts, health priority areas
- Engage service users in co-design – patients/clients, students