

Skills escalator in allied health: a time for reflection and refocus

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Abstract: It is abundantly clear that the health workforce of tomorrow will meet a number of unique challenges. There are a number of drivers for this, including the changing demographics of patients and health professionals, changing working patterns and mobility of the health workforce, evolving models of care, emerging evidence base, altering funding models, and the need to underpin health care service delivery with safety, effectiveness, patient centeredness, efficiency, equity, and timeliness. It is in this time of change that role extension within health disciplines is seen as an important tool to meet some of these challenges. Role extension is viewed as a skills escalator, where practitioners move up the skills escalator within the scope of their discipline, to advance it and then, with training, extend it. Within allied health, in some disciplines, advanced and extended scope of practice initiatives have mushroomed. Often these initiatives have been ad hoc, and opportunistically created in response to local needs and requirements. As these initiatives are local and context-dependent, to date there is very little uniformity or congruency between these initiatives. This has led to variability in implementation, lack of rigorous evaluations and, ultimately, poor long-term sustainability. In this paper, we reflect on a number of key issues, drawing on our own experiences in undertaking such initiatives, which need to be taken into account when considering advanced and extended scope of practice for allied health.

Keywords: allied health, skill escalation, extended scope of practice, advanced scope of practice

Introduction

Future health workforce modeling appears to indicate that role extension across most health disciplines will become a reality sooner rather than later. Some of these extensions are already in place and well established, for instance, nurse practitioners and physician assistants.¹ Role extension is viewed as a skills escalator, where practitioners move up the skills escalator within the scope of their discipline, to advance it and then, with training, extend it (which often means adopting roles usually undertaken by other health professionals).^{2,3} Discussions have occurred around Australia regarding the potential for extending the scope of a number of allied health disciplines as a means of addressing workforce shortages and patient demand. A number of pilot projects have subsequently been conducted to operationalize extension of scope in allied health disciplines.⁴⁻⁶ In some instances, scope extension in allied health has even become accepted practice, albeit without appropriate processes or evaluation. While role extension is relatively new in allied health, the skills escalator provides current new allied health graduates with opportunities to advance and extend their scope of practice and build on their core competencies.

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Recognizing the opportunities presented by role extension, the Australian Capital Territory (ACT) Government Health Directorate, an organization that provides a range of coordinated health and community health care services to the people of ACT in Australia, has committed to extending the scope of practice in several allied health disciplines by undertaking a series of staged investigations and pilot projects.⁷ All of the projects on skills escalation have been underpinned by current best available evidence from the literature. This has been in the form of extensive and structured reviews of the literature, eg, systematic and rapid reviews.⁸ Many lessons have been learnt from the current evidence base, including the many evidence gaps. What has been clear from these reviews is not only the lack of rigorous evaluation of clinical outcomes, but also the lack of detailed descriptions of processes undertaken as part of these initiatives or descriptions of the many elements that need to be considered before implementing an advanced or extended scope role on allied health. Advanced scope of practice can be termed as a role that is within currently recognized scope of practice for that profession, but that through custom and practice has been performed by other professions. The advanced role would require additional training, competency development as well as significant clinical experience, and formal peer recognition.⁹ This role describes the depth of practice. Extended scope of practice can be termed as a role that is outside the currently recognized scope of practice and requires legislative change. Extended scope of practice requires some method of credentialing following additional training, competency development, and significant clinical experience. Examples include prescribing, injecting, and surgery. This role describes the breadth of practice. Our experiences in the ACT Government Health Directorate have led us to develop questions which need to be answered before considering introducing role extension in any allied health discipline.

This paper outlines these questions, in no particular order, and offers a blue print (checklist) for key stakeholders in allied health (eg, health professionals, managers, administrators, and workforce policy makers) to ensure that when allied health extended roles are considered, they are likely to be sustainable and successful in the long term.

Is there a need for a new role?

Role extension discussions should be underpinned by clear patient need, for instance, extensive waiting lists, which cannot be addressed using the traditional workforce. Our work at ACT Government Health Directorate, especially in the area of extended scope physiotherapy, to date has shown

that the intervention of an extended scope physiotherapist has significantly impacted on waiting times for outpatient orthopedic appointments and has improved access to appropriate care for patients who would otherwise have remained untreated for some years.⁸ Extending the scope of practice simply to offer a career path for health professionals, rather than to address patient need or workforce shortage, is unlikely to be successful because it may well impact on other health professionals' within scope roles.^{2,10}

What is the impact on other health professionals by introducing the new role?

Extending the skills of any allied health discipline is likely to cross into other health discipline areas (for instance, extended scope physiotherapists prescribing or injecting). Thus, there is the distinct possibility of "turf wars".² It is imperative to consider what impact the introduction of a new (extended scope) role may have on other health professionals. Where there is a workforce shortage, the role extension may be welcomed; however, where there is no obvious workforce driver and where there is no clearly demonstrable patient need (eg, extensive waiting lists) there may be little point in investing effort in the role extension, which may very quickly adversely impact on currently successful interdisciplinary working relationships.²

Have appropriate rationale and networks been established?

Any role extension, even if it is indicated by workforce or service delivery gaps, will impact on the tasks undertaken by other health professionals, and therefore consultation is required.¹¹ This may be welcomed in the absence of sufficient workforce or it may be vigorously resisted and will be counterproductive to the notion of professional advancement, and interprofessional care. Prior to any concerted effort to extend scope of practice in any one discipline, there appears to be a need for several things:

- A transparent and comprehensive literature review, preferably undertaken by an independent body, to describe what has been done elsewhere, how it has been evaluated, and what outcomes have been achieved (identifying the evidence base).
- Discussions held with key stakeholders (anyone who is in a position to facilitate or block the initiative) in order to understand local contexts and to outline clearly the steps that will need to be undertaken to ensure a smooth passage of the extended scope initiative, if it is indeed required (setting the scene).

- The outcomes from a new role extension must be clearly defined and discussed with all stakeholders before anything is done to establish a new role. The literature on extended scope is sparse in term of measures of effectiveness (patient health outcomes), cost savings, and role substitution. Less tangible and measurable outcomes may be the result (improved access, decreased waiting time). However, it is difficult to put a value on these (the end point).
- Conflicts of interest need to be declared early, and throughout the process (open and honest communication).

Has a business framework been put forward?

A business case needs to be established prior to commencing discussions on role substitution (even in the pilot phase).^{10,12} It is unlikely that any organization will have the capacity to absorb the costs of new activities such as role extension, without looking for tradeoffs. For example if a staff member moves into a new role, others may need to backfill the previous role. Thus not only is a business case required to demonstrate tangible outcomes from this investment of resources, but the allied health staff compliment in a department needs to be in agreement with the initiative, in both the short and long term.

What, if any, training has been undertaken?

Much of the extended scope literature for allied health originates from the United Kingdom and the United States, where training for skills outside scope appears to have been provided mostly on an ad hoc bases, ie, by a specialist for an allied health provider working in a particular institution.¹³ While this may address local contextual issues, such as local needs and requirements, this has resulted in a poorly defined and recognized workforce which has restricted both the value of the extended scope role and the capacity of an individual to move from one institution to another, and be recognized for their expertise, and continue the same work.

For role extension in allied health to be a valid and continuing workforce option in Australia, formal accredited training programs are required.^{11,13,14} For instance, it would be efficient and visionary if allied health disciplines, which are interested in extending scope of practice, worked together with accredited tertiary educational institutions to provide core courses with which to underpin skill acquisition. These could include limited prescribing, invasive procedures such as injecting or inserting catheters, and ordering and reading imaging.

The notion of the professional doctorate has been poorly pursued by allied health training institutions, especially in Australia, and this pathway of study could well be linked with formal training to extend scope of practice.

Have roles and responsibilities been adequately clarified?

Australian graduates in allied health disciplines are assumed to have core competencies.¹⁵ For some allied health disciplines these are recognized by national or local state-based registration and for others the competencies are specified by professional bodies (which have no regulation capacity).¹⁶ Countries such as Hong Kong have developed clear remunerated career paths for allied health clinicians in the public sector, involving accumulated competencies, years of practice, and areas of interest. Australia does not have this approach, although acquisition of continuing education is an expectation (albeit rarely monitored). Clinical postgraduate specialty programs are generally undertaken by students on the understanding that there will be increased remuneration, particularly in the private sector.¹⁷ However, neither longevity in an allied health profession, nor additional training, necessarily mean higher level skills. Furthermore, the notion of maintenance of core competencies, specialization, and advanced scope of practice are poorly defined and variable with, and between, allied health disciplines and work places.

The literature on extended scope of practice often blurs the boundaries between advanced roles and extended roles. It appears that much ground could be gained by firstly defining scope, then advancing it by demonstrating professional excellence and improved health and cost outcomes. These steps are required prior to initiating discussions on extending the scope of practice. Based on our experience to date, in Australia at least, there is the current situation where physiotherapists working within scope, but in a specialist role, may use the title “specialist” practitioner.¹⁸

Commensurate with the skills escalation model is an increasing focus on allied health assistants. In recent years, these roles have become more formalized and the notion abounds that assistants will take on tasks that historically have been within the scope of allied health practitioners.¹⁹ The allied health assistant is presumably cheaper and no less safe than the allied health professional, who can then pursue advanced or extended scope activities. However, the skills escalation model would also infer that allied health professionals working in advanced or extended scope roles may well be seen by other health professionals as working in assistant roles in different areas. For instance, what is the

difference between a physiotherapist working in extended scope, an advanced nurse practitioner, and a physician assistant? If there is a sound business case for role extension and blurring of professional boundaries, then it may be reasonable to proceed with training in extended scope in one discipline. However, without such a case, role confusion and professional barriers may result.

Have the waters been tested?

Once the decision is made to move forward with a role extension, it is imperative that a formal pilot project should first be conducted. This has three clear elements.

Firstly, the right person needs to be in place in the extended scope role. The pilot practitioner has far more responsibility than merely working in role extension. Prior to any new role development, it may be necessary that the core skills of the discipline are promoted widely to other health practitioners (within and outside the institution), administrative and clerical support workers, and patients. It is important to liaise with health professionals outside the institution because an extended scope practice role within a hospital may impact on acute care, outpatient clinics, and the community sector. General medical practitioners and representatives of the community health sectors are important to include in stakeholder representation during the consultative phase.¹¹

The pilot extended scope practitioner must also actively and transparently seek training for new skills and responsibilities, and must be comfortable in the role of professional leader. Validation of the new skills of the extended scope practitioner is essential, and will come from one or more of the following:

- Completion of formal, accredited training programs to support the new skills
- Observation by senior health practitioners in relevant disciplines to ensure that new skills can be undertaken safely, appropriately, and effectively
- Mentorship by senior health practitioners
- Credentialing using formal processes such as case studies, work books, presentations at grand rounds, and structured learning and assessment opportunities.

The pilot practitioner should be supported by appropriate permits or licenses related to extended scope tasks and responsibilities. He/she should be provided with requisite training and mentorship (within and outside the discipline) so that new tasks can be undertaken with safety and effectiveness.

The extended scope practitioner must also promote the new role, within and outside the profession, and become the “face” of the new role.¹⁴ Responsibilities of the new role include:

- Educating other health professionals about the new scope of practice
- Troubleshooting and identifying and dealing with unforeseen barriers within and outside the profession
- Promoting the new role in workplace and academic forums
- Promoting the new role to the public
- Separating the role itself from the role evaluation, in terms of ethics, data collection, quality improvement, performance measures, and research
- Being prepared to lead the way for others to follow.

The pilot project should be conducted under formal research principles. Formal ethical approval should be sought, the research should build on the business case, the time period of the pilot project should be limited, and there should be clear process, health and cost outcomes expected, and measured.

The results of the pilot study should be formally reported, preferably in the peer-reviewed literature. Whilst there is a wealth of literature available on role advancement and extension in allied health, much of this evidence lies within gray literature. Moreover, the research designs underpinning research into extension of scope are largely of low hierarchy because of the often uncontrolled biases in the research designs. Institutions wishing to implement extended scope roles would currently have little guidance in operationalizing the role and little confidence in whether the role is likely to be effective, on the basis of the current literature base.

Have governance issues been considered?

Any pilot project should be supported by appropriate governance.^{2,20} A steering committee which is committed to the project is essential. The committee should comprise stakeholder representatives who have two responsibilities in addition to assisting the pilot role. One is to communicate to their peers about the pilot role and to advocate for it, and the other is to bring the concerns and suggestions of their peers to the committee for consideration. It is our experience that many of those pilot projects which have failed to proceed to new long-term initiatives, or have achieved less than desired outcomes, have not had the right governance structures in place.

What about legislation and registration requirements?

Allied health role extension may require legislative changes to registration acts in the short term and long term.¹¹ Unless these are considered as part of any pilot study, the allied health extended practitioner may not be appropriately protected from public or professional litigation.²¹ Prior to implementing any pilot project, steering committees should be mindful of the need to seek support from appropriate licensing bodies and to be aware of the processes and time periods required to make long-term changes to the legislation. Tertiary training institutions which provide basic allied health training and advanced training (in the form of clinical postgraduate qualifications) also have a role to play in extending the scope of practice. What is role extension now, may well become

core competencies over time, and therefore, skills escalation, or the potential for it, should be a consideration in training programs.

Have clear outcomes, taking into account multiple stakeholders perspectives, been captured and reported?

Role extension has been promoted as a way of saving money by having less expensive staff to do tasks currently undertaken by health practitioners who could be freed up to do more complex work.²² However, there is little evidence to support this in the literature. At best, role extension in allied health may impact on health service quality in terms of improved



Figure 1 Checklist to assist in determining the need for extension of scope in allied health.

access to care, improved efficiencies, and reduced morbidity.¹¹ Extended scope practice may impact on role substitution in the absence of the traditional provider of care (for example, in rural and remote health situations where a full complement of health care providers may not be available). Thus, the outcomes proposed from any new extended scope role in allied health should be considered from the perspective of all stakeholders and not just in terms of cost savings.¹³

Conclusion

Advancing and extending the scope of allied health roles has the potential to assist in improving health care delivery in Australia. These initiatives thus are a viable part of the future Australian health care workforce as it faces several challenges in the coming decades. While such drivers exist, so do key evidence gaps on the effectiveness and sustainability of these initiatives. In order to ensure that the best value is made of advanced and extended scope allied health practitioners, we suggest that a concerted approach is taken to conceptualizing and implementing new roles.

The following series of questions, in the form of a checklist (Figure 1), is provided as a way of conceptualizing extended roles initiatives, streamlining efforts and avoiding potential pitfalls. This checklist is developed based on our experiences of, and lessons learnt from, piloting initiatives on advanced and extended scope of practice. These personal insights have been layered with evidence from the literature, where available, regarding advanced and extended scope of practice. On completion of this checklist it may be clearer about the need and support for a new, extended role, and where this is not currently available, interim steps would be to promote what tasks are undertaken by a discipline (within the scope of practice), what outcomes are achieved and how this discipline adds to the outputs of the institution.

Disclosure

The authors report no conflicts of interest in this work.

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