Rehabilitation Research Review™

Making Education Easy

Issue 6 - 2017

In this issue:

Abbreviations used in this issue:

AR = active rehabilitation
SCI = spinal cord injury
WHO = World Health Organisation
YLD = years lived with disability

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Welcome to the sixth issue of the Rehabilitation Research Review.

This issue has been inspired by the recent World Health Organisation "Rehabilitation 2030", a call for action to all countries to address the significant and ever-increasing need for rehabilitation services. Across the world, we are facing challenges associated with the ageing population and the rise of non-communicable diseases, like cerebrovascular disease, cancer, traumatic injuries, mental ill health and drug abuse. When this need is juxtaposed against historically underdeveloped and poorly coordinated rehabilitation systems in most countries, a significant gap is revealed. The growing need for rehabilitation has not been met in any country, and Australia is no exception. Rehabilitation 2030 encourages governments to strengthen, extend and enhance rehabilitation. In this issue, we seek to contribute to this challenge by exploring a range of workforce issues and novel approaches that can increase the capacity and scope of rehabilitation. My co-editor is Associate Professor Pim Kuipers who has been a constant source of innovation in rehabilitation over the last 25 years. Pim has worked across all contexts of rehabilitation and with all disciplines to develop creative new approaches that can be more effective and sustainable. He has a strong commitment to consumers and their engagement in the process of service design, but also to workforce redesign and ways in which professionals can be supported to deliver the best and most efficient services to the most people across complex environments. In this issue, we highlight three potentially promising workforce responses that can contribute to the scaling up of rehabilitation. There is no doubt that innovative strategies and policies will be needed to generate more efficient models and a more sustainable workforce for the future of rehabilitation. We hope this issue contributes to your thinking about how to achieve this in the future. If you are interested in the topic of scaling up rehabilitation in Australia, take the time to express your ideas on our Hopkins Hive (https://mindhive.org/issue/how-can-we-scale-up-rehabilitation-in-queensland) or join our network of rehabilitation researchers, practitioners, policy-makers and consumers (http://www.hopkinscentre.edu.au/). There are so many innovative practices that are not adequately documented and shared with the broader rehabilitation community so the more we can communicate, the more we can shape the future.

I hope you enjoy reading this issue of Rehabilitation Research Review and welcome your feedback.

Kind Regards,

Professor Elizabeth Kendall

elizabeth.kendall@researchreview.com.au

Rehabilitation 2030: The need to scale up rehabilitation

Authors: World Health Organisation

Summary: This report provides substantial evidence that the potential applications for rehabilitation in the next decades are vast. The global burden of disease study notes that 74% of the total number of "years living with disability" across the world's population is linked to health conditions for which rehabilitation is beneficial. Although the calculations in the report are speculative, they portray the vastness of the potential impact of rehabilitation in the future if we invest sufficiently in its development. To emphasise the potential of the scale-up challenge, the authors map out the extent of global unmet need and the obscene international disparities in the distribution of resources and trained staff. They conclude by noting that the sixty-sixth World Health Assembly endorsed a coordinated global action plan by all stakeholders to "strengthen and extend rehabilitation, habilitation, assistive technology, assistance and support services, and community-based rehabilitation".

Comment: It is clear from the "Rehabilitation 2030" agenda that the challenge facing global society is vast. The key issues and priorities facing global society over the next decades include the critical health and demographic trends of aging populations, the growing number of people living with chronic diseases or the long-term consequences of injury, and the rising prevalence of those with severely disabling conditions. Although none of these challenges are exactly new, they raise the importance of strong rehabilitation services and efficacious interventions that go beyond the traditional focus on physical restoration. There are some indications of what might be done to address this challenge, but there are no clear strategies. Some principles can be gleaned from this and other reports to indicate how energies can be invested. First, there is a clear need for more innovative and efficient models of rehabilitation services that can respond to multiple challenges in complex environments. Second, a key priority must be to develop and maintain a skilled and sustainable workforce for the delivery of interdisciplinary, innovative and timely rehabilitation services. Third, better data and targeted research are needed for service improvement and evidence-informed policy in the area of rehabilitation.

Reference: Geneva. World Health Organisation 2017

Abstract

Strengthening health systems to provide rehabilitation services

Authors: Krug E and Cieza A

Summary: In this commentary article, the directors of the WHO rehabilitation and disability services department signal the need for a major shift in rehabilitation. Krug and Cieza remind us that from a global statistical point of view, we are experiencing a dramatic increase in need, reflected in a statistical increase in absolute number of years lived with disability – YLDs across the world. This increase amounts to a current and emerging crisis that will necessitate massive growth and shift in the delivery of rehabilitation services. They rightly point out that the crisis goes beyond patient and population issues to include service issues such as inadequate workforce, limited skills, poor accessibility, transport barriers, high out-of-pocket expenses, and long waiting times. They importantly note that this context is set against a general lack of awareness of the importance of rehabilitation; what it is, what it does, and who it benefits. Krug and Cieza map out an agenda for rehabilitation into the future in which they argue that rehabilitation should be embedded in healthcare and health systems, a core part of universal health and social care. Further, rehabilitation requires a breadth of approaches. If the scope of rehabilitation is to grow as the authors predict, it will need to encompass diverse approaches to meet the diversity of emerging needs. This shift has considerable implications for workforce skills, interdisciplinary practices and training opportunities. Finally, they note that if rehabilitation is to scale-up there will be a profound need for better data, enhanced data systems, and substantially more research evidence to inform service design, delivery methods and practices.

Comment: Krug and Cieza lay out a broad agenda for rehabilitation that goes beyond our traditional focus on complex conditions that require intensive and highly specialised treatment and therapy. They remind us that rehabilitation acts to reduce disability more generally and optimise functioning for all individuals with health conditions or those at risk of deterioration. It enables people to better interact with their environments to produce better long-term outcomes. As such, rehabilitation is not restricted to a minority group of people with disabilities or significant long-term impairments. It also plays a vital role in maximising the impact of other health services for a range of populations—surgical interventions, trauma care and non-communicable diseases. The potential for significant cost savings associated with this more wide-scale implementation of rehabilitation is frequently misunderstood, overlooked or underestimated. For example, one key impact of rehabilitation is reducing length-of-stay in hospitals and decreasing readmissions, thus mitigating the negative social and health risks associated with prolonged hospitalisation. By improving a person's ability to participate more fully in everyday life, rehabilitation reduces the costs related to ongoing care, and may accelerate the ability to return to education or employment. More detailed understanding is needed in this area.

Reference: Ann Rehabil Med. 2017;41(2):169-70
Abstract

Randomised controlled trial of a transprofessional healthcare role intervention in an acute medical setting

Authors: Kaltner M et al.

Summary: This study reports on a workforce intervention using a newly developed trans-professional role in an acute setting. A single trained professional provided initial trans-professional assessment and intervention that incorporated elements of physiotherapy, occupational therapy, dietetics, speech pathology, podiatry, social work, and psychology, developed using the Calderdale Framework. The Calderdale framework enables managers and work units to identify skills and tasks that might appropriately and safely be shared among different health professions. This trained professional worked alongside medical and nursing colleagues to plan and manage patient care within the first 48-hours of admission to an area of high patient throughput, short lengths of stay and high rates of referral. Fifty-eight participants were randomly allocated to either standard care or the new model of care, and compared on a range of patient and service provision outcome measures. Patients who received the new model of care underwent more comprehensive and prompt assessments than those in standard care, and demonstrated more positive health and functional outcomes at 1-, 3- and 6-month follow-up.

Comment: This study demonstrated the effectiveness of a "skill-shared" allied health role in an acute care setting. Indeed, the outcomes from a professional skill-sharing model were better than from a conventional, uni-professional service. A particularly important aspect of the study is the randomised controlled design, seeking to be as objective as possible in measuring outcomes of complex skill-sharing interventions. The study shows that skill sharing and expanding scope of practice may hold considerable promise in the area of acute rehabilitation. A particular potential advantage of the Calderdale approach is that it seeks to reduce inefficiencies and remove redundancies. Using this approach addresses three main barriers to innovation, namely: overlap (many health professionals performing essentially the same task), narrow professional demarcations (professionals ensuring that only they can perform what in many cases are relatively simple generic tasks), and over-qualification (advanced professionals performing relatively routine tasks that could be easily performed by someone with less specialised skills). These are fundamental barriers to workforce capacity and limit the growth of rehabilitation.

Reference: J Interprof Care 2017;31(2):190-98
Abstract

Skill-sharing between allied health professionals in a community setting: a randomised controlled trial

Authors: Pighills AC et al.

Summary: This study was a randomised controlled trial of a model of professional skill-sharing known as the Calderdale Framework. The study involved 153 community-dwelling older people aged 65 years and over, who experienced some functional decline. Roughly equal numbers of participants were randomised to either professional care based on a skill-sharing intervention (using the Calderdale framework), or traditional single professional occupational therapy and/or physiotherapy care (control). They measured level of disability, mobility, independence in activities of daily living and quality of life using an independent assessor who was blinded to the participants' condition. No statistically significant differences were found between the groups on any of the outcome measures at either 1 or 4 months.

Comment: Even in the complex community setting, an appropriately trained single allied health professional achieved comparable outcomes to multiple professionals on specific tasks. The Calderdale Framework is a highly structured, carefully planned, task-oriented skill-sharing model. Certain cross-professional skills are delivered by appropriately trained professionals or assistants, but not necessarily the professionals who have traditionally carried out these tasks. This study, and the previous study, indicate that appropriately expanding scope of practice can maintain quality of care and be effective and efficient across a range of contexts. The emphasis in this approach is on regulating or formalising tasks and capabilities, not professions. If we are to scale up rehabilitation, we must ensure that rehabilitation professionals of the future have the skills they need to perform the tasks required to optimally meet individual need in the environment in which those skills are required. This suggests that our thinking about rehabilitation needs to be more context-specific and task-specific in the future.

Reference: Int J Ther Rehab. 2015;22(11):524-34
Abstract

Implementation and maintenance of patient navigation programs linking primary care with community-based health and social services: a scoping literature review

Authors: Valaitis RK et al.

Summary: This article analysed 34 papers on the topic of 'patient' navigation gathered through a systematic review of the literature. The authors found that navigation programs were linked with numerous positive outcomes, and concluded that the navigator function is a potentially constructive adjunct to rehabilitation. The goals of navigation include improving the delivery of health and social services for specific populations or needs, and improving the quality of life and wellbeing of patients. Although they cautioned that the review comprised mostly descriptive studies, they found general improvements in quality of life and some specific outcomes including greater consistency, integration and coordination of care, timeliness of follow-up, cultural appropriateness, reduced emergency use and prevention of institutionalisation, better health monitoring and screening, better treatment adherence and reduced co-morbidities, greater satisfaction, mental health, self-efficacy and empowerment, and reduced stress and caregiver strain.

Comment: Patient navigation programs were originally developed to promote access in cancer care, but have since expanded internationally and in scope. They have considerable potential application in the area of rehabilitation. Patient navigation programs use an external person (a volunteer lay person, peer or trained professional) to link patients and families to primary care services, specialist care, community health, and social services. While there is considerable variation in the detail of patient navigation approaches, all use an external person in a collegial navigator role to work alongside the patient and their family to facilitate more holistic patient-centred care, to identify emerging concerns, and to resolve patient barriers to care. Despite the fact that many of the reviewed studies were descriptive, this review identifies positive outcomes from patient navigation. It provides a useful foundation for further exploration of this potentially effective method of addressing a small part of the rehabilitation workforce challenge. It would appear that if patient navigation were implemented within routine service delivery, in such a way as to be sustainable, it would require some reconsideration of traditional versus non-traditional roles in rehabilitation. Having identified the potential of non-professionals to address at least a part of the rehabilitation workforce challenge, this review suggests the need for substantial discussion as to what this would require. How might we ensure quality and consistency of intervention in a non-professional workforce? How might we convey and ensure rehabilitation "thinking", that which is at the core of rehabilitation interventions, to people who are not trained as rehabilitation professionals?

Reference: BMC Health Serv Res. 2017;17(1):116
Abstract

Promising workforce responses – peer approaches

Active Rehabilitation-a community peer-based approach for persons with spinal cord injury: international utilisation of key elements

Authors: Divanoglou A et al.

Summary: This study documents an approach that was originally developed in Sweden in 1976 known as Active Rehabilitation (AR). This approach has been adopted in practice in many places internationally, but has not been well researched, and is not part of mainstream rehabilitation. AR is a community peer-based approach to Spinal Cord Injury (SCI) rehabilitation in which peer mentors make early contact with newly injured persons to provide support and mentoring. Training camps are conducted to provide intensive, goal-oriented, intentional, group-based, customised training and peer-support opportunities. Follow-up is coordinated to provide ongoing support, and community awareness and educational activities are also conducted. In this study, the authors conducted an online survey of 22 organisations from 21 countries across Europe, Asia and Africa who had reported using components of the AR approach over the past 10 years. The goal of the study was to describe the profile of the organisations that use components of the AR approach, and to explore the characteristics and the international variations of the approach.

Comment: There is compelling evidence that newly injured individuals feel unprepared physically and psychologically to make the transition to home, no matter how comprehensive the rehabilitation they receive. Peer mentors play a key and ongoing role in this transition and are critical to expanding the capacity of rehabilitation interventions. Peer mentors are experienced and trained individuals with SCI who provide real-life examples of the SCI experience and what can be achieved. The training camps cover activities of daily living, wheelchair skills, sports and recreation as well as formal training focused on SCI, wheelchair use, health and hygiene, sexuality and fertility. The grounded peer-focused approach involves training in real-life learning environments and has a strong goal setting dimension. Disappointingly, this study does not provide any information on outcomes. However, it documents the vast number of repeat implementations, the provision of ongoing funding for the model and the global spread of the approach. This non-professional approach might be easily integrated with, or provided alongside the traditional rehabilitation model. This raises a number of questions, including: How do we develop a rehabilitation system with the optimal balance of "therapy" and "learning"? How do we find the optimal balance between professional, family and peer interventions? How do we find the optimal balance between group-based and individually oriented approaches? How do we better integrate formal and informal organisations in the rehabilitation system?

Reference: Spinal Cord 2017;55(6):545-52
Abstract

Human resources for health (and rehabilitation): Six rehab-workforce challenges for the century

Authors: Jesus TS et al.

Summary: This study sought to "map out" some key challenges that might guide rehabilitation workforce-related research and policy in the future. The authors conducted a detailed critical review of the rehabilitation workforce literature, and then performed a SWOT analysis of the concepts they identified. As expected, they found multiple examples of undersupply and inequitable distribution, but few exemplary innovations that might help reduce supply-side shortages. Their discussion noted 'six rehabilitation workforce challenges': (1) improving monitoring and accounting for rehabilitation needs and demand; (2) for better specificity and breadth of workforce data; (3) ensuring the study of a whole rehabilitation workforce (i.e. not focused on single professions); (4) enhancing staffing by innovations in education, attractiveness and teleservices; (5) adapting policy options to different contexts; and (6) developing more international solutions.

Comment: Rehabilitation has been criticised because it sometimes fails to deliver optimal outcomes – this is largely due to the undersupply and inequitable distribution of the rehabilitation workforce and expertise. Jesus et al. define the poorly documented issues that can contribute to this problem. We need a more specific and detailed understanding of "need" and "demand" in rehabilitation. To inform the collection of better data, we require better definitions, global standardisation and consistent minimum data sets for meaningful international comparisons. In this review, the authors challenge us to think more broadly about the composition of the rehabilitation workforce. They note that rehabilitation can exist within many sectors (education, social and health systems), many locations (inpatient, outpatient, home, school), and can take place at many points along a continuum (acute, long term, community). They argue that community health workers, athletic trainers, special education teachers and others have a meaningful role to play in rehabilitation services and should be integrated into workforce considerations. They also remind us about some of the more practical aspects of scaling up the rehabilitation workforce, underscoring the need for broad and creative staff training and clinical education. Within this broader vision of what might constitute the rehabilitation workforce of the future, they argue that we need to think creatively about incentives, support, training, coaching and mentoring. Importantly, these authors emphasise that effective rehabilitation for the future will require nimble, context-responsive policy that can facilitate new ways of funding (such as value-based reimbursement), and new ways of working (such as task-shifting).

Reference: Hum Resour Health 2017;15(1):8
Abstract

RESEARCH REVIEW - The Australian Perspective Since 2007

Promoting good policy for leadership and governance of health related rehabilitation: a realist synthesis

Authors: McVeigh J et al.

Summary: This exploratory study sought to establish the evidence-based principles of good policy for health-related rehabilitation services. The authors used an innovative two-phase design comprising: (1) a systematic search of the literature using a "realist synthesis" approach, resulting in 36 key publications for review, and (2) a Delphi-style survey of 18 expert stakeholders to refine and triangulate findings from the realist synthesis. They identified four key principles. Although the study has a broad focus on global health systems, including those in developing countries, these principles have considerable resonance with rehabilitation-related concerns in Australia, particularly those associated with leadership and governance.

Comment: The authors of this review acknowledged the vast contextual diversity and complexity across rehabilitation and disability settings globally. As such, they have provided broad policy guidelines, rather than a narrow focus that might not apply to all contexts.

The first principle is that the participation of people with disabilities in policy processes and research is vital. Participation improves the responsiveness, efficiency, effectiveness, and sustainability of rehabilitation. A culture of participation strengthens the self-determination and satisfaction of service-users. Unfortunately, to date, participation and consultation is not a core feature of Australian rehabilitation.

The second principle is the need to collect meaningful and disaggregated data about people with disabilities. In contemporary health and disability systems, it is only through comprehensive and appropriately presented data that we are able to influence policymakers. Situational analyses of disability based on data are vital for evaluation, accountability, and equitable allocation of resources. Although data is collected systematically, it is not always used in meaningful ways.

The third principle is that diverse policies and actions may interact adversely, so careful planning is warranted. There are so many policies and actions that impact on people with disabilities and amplify their vulnerabilities or limit access to services. It is rare for policy-makers to examine the impact of each new approach on other aspects of people's complex lives. There is a clear need for rigorous attempts to evaluate the potentially adverse impact of any interventions or policies. Unintended consequences and perverse outcomes need to be included as measureable variables in any research or implementation studies in the future.

Finally, the fourth principle is that there needs to be a coherent mandate for disability and rehabilitation programmes across government departments. Inter-sectoral coordination is necessary for the provision of meaningful rehabilitation services. Rehabilitation and disability services should become core aspects of healthcare to be sustainable and effective. Appropriate workforce innovations will be core to that mandate because reflective and thoughtful professionals are key to bridging the artificial boundaries that divide rehabilitation.

Reference: Global Health 2016;12(1):49
Abstract

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Independent commentary by Professor Elizabeth Kendall.

Elizabeth Kendall is a Research Professor at the Menzies Health Institute Queensland, Griffith University which is home to an extensive collaborative of multi-disciplinary and cross-sectoral researchers focusing on disability, resilience, recovery, and rehabilitation. The research collaborative includes partners from Queensland Health and Department of Communities along with large non-government organisations, private companies and local authorities. She completed her PhD in 1997 on the topic of adjustment following traumatic brain injury, for which she won the Dean's Commendation for Outstanding PhD Thesis at the University of Queensland. She has attracted over $40 million in research grants and consultancies and has over 200 publications. She has been an active advocate in the field of disability for her entire working life.

Independent commentary by Associate Professor Pim Kuipers.

Pim Kuipers is Associate Professor and holds a joint Principal Research Fellowship between Menzies Health Institute Queensland and Metro South Health. He is a member of the Hopkins Centre and the Centre for functioning and health and has interests in community based rehabilitation and disability services, allied health service provision, qualitative research and rehabilitation services in developing countries. In 2018 he will work as as Global Policy Advisor for the International Federation of Anti-leprosy Associations (ILEP).

