

# Transforming Allied Health

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## Abstract

*In 1995, the Division of Allied Health at the Women's and Children's Hospital Adelaide (WCH) began a process of critical review of its service delivery models and organisational structure in order better to meet the vision and values of the WCH and the needs of consumers. This paper describes the change management process. Barriers to and facilitators of change are highlighted. The outcomes of the change process are described, including the new multidisciplinary team and program-based organisational structure and culture.*

## Historical context

Tross and Cavanagh (1996) noted that health care organisations contemplate a critical choice: innovate and change, or run the risk of being replaced by organisations that do. The Division of Allied Health (AH) at the WCH was issued a challenge by the Hospital's Executive in late 1995. This challenge was to officially review its service delivery models and organisational structure in order that it might better meet the vision and values of the WCH and the needs of AH consumers.

The Division was formed in 1992. Its structure at that time was traditional: six departments based on the six professions of Occupational Therapy, Orthotics, Pharmacy, Physiotherapy, Social Work and Speech Pathology. In 1993 external consultants for the hospital undertook an organisational structure design study. One principle recommended by this study was the organisation of patient-focussed multidisciplinary units around patient types (not professional lines). The author was appointed to the position of Divisional Chief of AH with a clear mandate of leading the division through the organisational change process.

## Consumer Input

As a first step in the change process, the AH division sought input from its key consumers groups. This was due to the importance of having accurate insight into consumer needs, and a growing emphasis on consumer participation in health care and decision-making (O'Connor 1995; Roe 1995). Six internal and external consumer groups were identified: patients and families in receipt of AH services; most frequent Medical referrers; WCH medical and nursing staff working with AH staff in delivering patient care; AH Division Staff; Community Agencies and Public Hospitals referring/receiving patients to/from the Division; and WCH Executive and Board.

Qualitative research techniques including questionnaire, telephone interview, personal interview and focus groups were utilised to obtain consumer responses to three central questions: what did AH do well, what did AH not do well, and how can AH improve to meet consumer needs better?" The planning group identified themes from the responses. These included high patient/family satisfaction with an AH service when intervention from one professional group only was needed; extremely variable patient/family satisfaction when services were required from staff from multiple AH professions; a need for improved communication, co-ordination and teamwork; while interdisciplinary communication, teamwork and co-ordination of service delivery needed to improve, the strengths of each profession should be maintained; improvements were recommended in the areas of research, health promotion and community orientation in service provision;

location of staff and services needed to be improved to enhance patient/family access, and co-ordination of service provision.; and a clearer description and definition of Allied Health was needed.

## Strategy before Structure

Stace and Dunphy (1994) and Braithwaite (1993) emphasised the need for a strong relationship between an organisation's strategic planning and its organisational structure. Before any attempt is made to alter the structure of an organisation, a review of the strategic direction should be completed first (Braithwaite, 1993).

The themes obtained from WCH consumers, as well as information obtained from a literature review, were key influences at a strategic planning day. The participants in the strategic planning group included members of the planning group, a selection of support staff, and clinicians.

The planning session achieved the identification of a new strategy to redirect AH to better respond to the changing health care environment, and to better meet its consumers' needs. The strategy was based on a new vision and set of values centred on a new service delivery model. The model embraces collaboration, multidisciplinary teamwork, community orientation and product line or program based management. The session also achieved a commitment to the adoption of a multidisciplinary team organisational structure based on core service programs in order effectively to implement the new strategy.

The strategic planning group selected a multidisciplinary team and program model based on literature evidence and WCH culture and philosophy. Literature evidence clearly indicated the benefits of such a model, as opposed to traditional profession oriented structures, in addressing weaknesses in AH service delivery as reported by consumers. The use of healthcare teams as a form of health workforce organisation for delivering services is well documented (Griffin, 1996). Multidisciplinary teamwork, interprofessional and interagency collaboration was noted by O'Connor (1995) to be instrumental in providing quality services for children. Roe (1995) and O'Connor (1995) stated that a single professional group cannot adequately serve the needs of all patient groups. Collaboration and effective multidisciplinary teamwork is a key factor in improving the health of communities, and enhancing the flexibility and quality of the provision of health service. Braithwaite (1993) reported that program or product line management structures are more strategically oriented, demonstrate a greater patient focus and facilitate the reduction of barriers between professional groups. Matrix organisations provide a better fit for a task and patient focussed culture, as opposed to traditional professional role cultures (Timpson 1996). In addition to the literature evidence, the strength of multidisciplinary teamwork as a key philosophy of WCH staff, patient care service delivery and organisational planning at the WCH was another factor that influenced staffs' decision to adopt a multidisciplinary model.

## Figure 1: steps in Allied Health Reorganisation Process

Executive mandate for organisational & service review	November 1995
Consumer input	March - September 1996
Appointment new AH chief	July 1996
Strategic planning day & commitment to multidisciplinary structure & service delivery model	October 1996
AH team identification	November - December 1996
WCH endorsement	January 1997
Job description determination	February - April 1997
'Leading change for AH' course	April - May 1997
Implementation new structure	July 1997
Funding achieved for AH facility upgrade	July 1997
Decision making workshop	December 1997
Facility design consultation	April - December 1997
Facility upgrade completed	September 1998
Merging of Acute Care/Rehabilitation & Development Programs to form Paediatrics program, and refinement of Women's and Babies Program to form Women's Health Program	July 1999

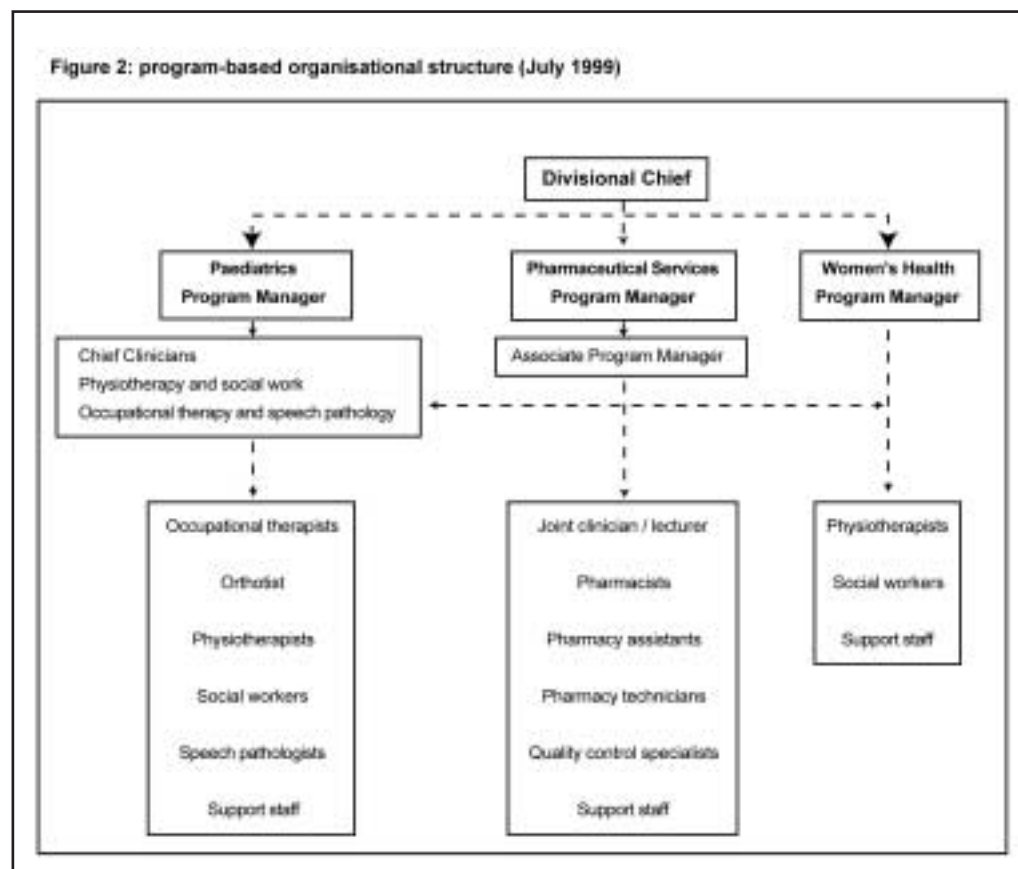
## Program and team identification

Following the strategic planning day a period of intensive staff consultation was undertaken to identify the program structure. Critical success factor information was gathered from several community agencies that had adopted a multidisciplinary team organisational structure. The planning group reviewed all AH services. Similar services and client groups were grouped together. AH's diversity of services complicated efforts to clarify team formation. The following AH service programs were determined to be provided by four multidisciplinary staff teams: Acute Care; Rehabilitation & Development; Pharmaceutical Services; and Women's & Babies' Services.

This process was not without its difficulties. The challenges in identifying Allied Health programs with consistent client groups and staff should not be underestimated. Further refinement of the teams in response to health care environment changes has occurred since.

## Management structure

Concurrent with the team determination process were discussions regarding the roles proposed by the management structure. The matrix structure reflected an attempt to balance multidisciplinary team management, service delivery, and profession development. The position of 'Program Manager' was identified as the role of most decision-making accountability within each team. The position included strategic, budgetary and human resource responsibilities. Clinical leadership positions were identified for each profession - "Chief Clinicians". The role identified was one of "profession-specific" clinical standard development and included a requirement for close liaison with the relevant universities. The Divisional Chief and Program Managers formed the AH senior decision making forum or "management team". Figure 2 illustrates the structure in July 1999.



## WCH endorsement

The Division's new service delivery model and organisational structure was presented to the WCH's senior decision making forum. It received unanimous endorsement, and encouragement for implementation. The presentation was useful to inform and seek approval of WCH's senior management of the division's activities. It conveyed a clear message to the hospital's senior managers that the division was taking responsibility for its own future. Decisions and new directions did not have to be imposed by the WCH Executive. It provided a message back to AH staff that "there was no turning back", and that there was now an expectation from the broader hospital of implementation of the new system. It completed the review of service delivery models within all WCH divisions.

## Human resource changes

The next phase was turbulent, generating anxiety for many staff members. Job description, salary and classification determination for the Program Manager and Chief Clinician positions were completed. At the same time the method of staff selection for these positions and administrative positions to each team was being negotiated with the union. The new organisational structure, including all human resource, strategic and financial responsibilities, came into effect July 1, 1997. The structure was subsequently refined in July 1999 - refer to Figure 2.

## Environment

Each multidisciplinary team formed its own project group to determine its required environment given the constraint of the current physical environment. The result of this process highlighted deficiencies in the current environment that would compromise patient and staff safety and patient care quality e.g. unavailability of oxygen and suction equipment for management of children with respiratory illness; excessive noise levels for family counselling and speech and language sessions.

An opportunity in other divisions of the WCH arose at this time to enable funding for physical changes to be possible. This included the collocation of the two AH paediatric teams (Acute Care and Rehabilitation & Development) on the same floor. This proposal presented a vast improvement of the existing environment on AH professionals, who were located in seven different areas of the WCH. The proposal responded to one of the strong themes of the consumer feedback: difficulty in access. It provided further opportunities for reduction in duplication in administrative activities, equipment and record keeping. Building works were completed in September 1998.

## Organisational Culture

Stace and Dunphy (1994) stated that organisational culture evokes a powerful influence over day to day operations, decision making and a group's ability to adjust to change. To create an innovative culture, consistency in structure, culture and strategic leadership is needed (Truss, 1996; Stace and Dunphy, 1994).

The vision and values of the AH division resulting from the change process emphasised collaboration, multidisciplinary teamwork, consumer and community orientation, respect for one another's profession and skills, constant learning, situational leadership committed to shared decentralised decision-making, and courage to take risks in adopting new ways of doing tasks in creating a new future. Some staff readily embraced this culture and encouraged it in others. Other staff gradually "tested the waters" in the new team environment. Progressively more of these staff became change agents themselves, quietly supporting the more overt champions of change. Others have retreated to their comfort zone of what they know - that is, profession-based work operations.

Several activities have acted as catalysts in nurturing the new culture and commitment to the new structure. The "Leading Change for Allied Health" staff development course was acknowledged by staff as being extremely beneficial for their own professional development as well as the organisational change process. Not only did it stimulate new ideas and a structured plan for the next phase of the change process; it also brought out for open discussion barriers to the change process. The course enabled reflection and focus on the framework presented by Armstrong and Rotem (1986) for developing effective health care teams. The workshop participants utilised this framework in creating a change plan.

Table 1: framework for developing effective teams

Environmental Context	What the funding body expects of us, broad policy environment, adequacy of resource base, degree of support from senior levels of management, characteristics and needs of patients, families and communities, our role in relationship to other teams and organisations
Goals	Our vision, what we are here to achieve, with and for whom
Roles	The jobs each team member does to enable achievement of goals
Structures, systems and procedures	The way we are organised and the way we do things to support members to fulfil their roles
Relationships	How we get on together and how recognised/valued each member feels

A workshop dedicated to staff determination of a process of decision making for the division was described by staff as facilitating the new culture. Outcomes included a decision making tool which recognises situational leadership, WCH and AH vision and values, and the need for priority setting. There was also an explicit commitment for Chief Clinician involvement for decisions on profession specific clinical issues. Alternatively issues not related to one profession but applicable to one or more teams, would be decided at the division's management team level. There was staff recognition of the constraints that minimal time has on the consultation process, and an agreed two-way communication method.

One element of the change plan determined at the Leading Change course was a request by staff for feedback. The CEO gave this feedback. Positive reinforcement on the division's new direction and input regarding likely changes in the external health care environment was conveyed. Other division-wide activities including social, education and planning sessions have all contributed to the development of a cohesive sense of "Allied Health".

The Division's management team has adopted a shared approach to financial devolution. Rather than having a narrow program-only orientation to budgetary management, collaboration as opposed to competition has resulted in satisfactory end of financial year status since the reorganisation.

Ownership of the new culture was stimulated through the communication of the Division's changes externally to patients and families, referrers and the broader WCH staff community.

Several AH multidisciplinary workgroups completed projects. These projects included revision of patient intake and co-ordination of services, referral system improvements and quality improvement project planning. In addition, benefits of learning about group members' professions, work methods and teamwork skills assisted the development of the new culture.

## Experiences of barriers to change and recommendations for future change processes

### Professional Territorialism

Organisational change is reported to be difficult to achieve in a health care organisation as the strategy of individuals or professional groups can be different from the organisation's strategy. Professionals have a large degree of control, autonomy and discretion over their work and are usually highly trained and skilled (Tross and Cavanagh, 1996; Braithwaite, 1993). Reorganising structures to a patient focussed, product line model poses difficulties in environments in which clinical knowledge, technology, professional power and roles have been the norm for decades. To change to a product line management model requires persistence and skill by managers and clinicians alike. The experience of change at the WCH supports these comments.

Particularly initially in the division's change process, professional territorialism proved to be a significant factor. However, some professional groups within the Division embraced the new culture. In an environment in which few staff have worked within a multidisciplinary team structure and service delivery model, it was not surprising

that staff preferred to work in an environment that they knew. Leaders of change must also be ready to reflect on the reasons why people may cling to their professional groups and not necessarily assume that this is an example of resistance to change. In any change process, it should be remembered that resistance to change is neither good or bad but must be a signal that more attention is needed to explain either the process or the management of the changes (Timpson, 1996). Conversely staff must be challenged to think beyond their professional boundaries when issues are not confined in relevance to one profession.

An example at the WCH includes an analysis of staff education needs completed by an AH multidisciplinary task group. Initial responses by staff were of predominantly profession oriented staff education programs. There was facilitation of open and detailed discussion of the education needs of all staff. In addition, staff recognised the feasibility and benefits of an integrated system of in-service activities suitable for staff from multiple professions as well as profession specific clinical in-service sessions. The process challenged historical staff education systems and brought about a greater focus on the support of multidisciplinary as well as profession-specific staff education needs. Additional outcomes of this process included a reduction in total staff time spent in education sessions, while access to a greater variety of sessions was increased.

## **Identity**

A health care team's function is influenced by the way it develops as a small group, including its norms and values, goals, role expectations, leadership, communication and decision making processes (Griffin, 1996). Three of AH's four teams developed their own sense of identity and goals stemming from this sense of cohesion. Clinical improvement processes were initiated readily. One team found it more difficult to develop a "feel" for its own identity because of the vast array of client groups it services and less frequent interactions of team members in patient care provision. Consequently team functioning was slower to develop for this program. With the subsequent merging of the Acute Care, and Rehabilitation & Development Program's to form one "Paediatrics" program, team identity and shared goals were greatly enhanced.

## **Environment**

The problem of focussing on environment and location prematurely in the team development process has been described previously.

## **Workload**

Change leaders must be aware of workload pressures to ensure that energy for change planning, decision making and implementation is maintained. Tross and Cavanagh (1996) noted that a clinician's primary focus is on patient care. Clinicians have a tendency to resent changes that take them away from clinical work. Relaxing the emphasis on change during times of extreme workload was essential to avoid burnout. Periods of consolidation were identified by the AH management team as being necessary for the success of the change process.

## **Inconsistent communication**

The division's methods of communication should have been addressed at the beginning. Communication methods had included written memoranda, newsletters and verbal communication at staff meetings. Initially staff reported inconsistency of content and timing of communication. Unnecessary frustration for staff, the planning group, and the change leaders alike could have been minimised had investment in clear communication been completed far earlier.

## **Experiences of facilitators of change and recommendations for future change processes**

### **Catalysts**

A catalyst can act to stimulate an organisation to change (Braithwaite, 1993). The challenge extended from the Hospital Executive in late 1995 was clear in its intent. AH staff responded to the opportunity of designing their future rather than having changes being imposed.

### **Vision**

Any structural, strategic, clinical and managerial performance changes should stem from a vision (Stace and Dunphy, 1994). The development of the new vision and strategic direction with AH staff completed a key role in the division's change process. It served as a platform upon which to develop the new organisational structure and culture.

### **Staff participation**

Managers will experience more success in their roles if their staff are skilled implementers of new ideas (Tross and Cavanagh, 1996). Timpson (1996) emphasised the need to recognise and respect peoples' needs and feelings in any organisational change process. The experience at the WCH supports this.

### **Sustaining the momentum**

"Change fatigue" was discussed by some AH staff as a barrier to change. Supporting change agents and developing new competencies through such staff development courses as "Leading Change for Allied Health" were extremely beneficial in overcoming this.

### **Champions**

Champions of change must be identified in order to sustain the momentum and to bring about change in others. In a division with more than 120 staff, without several change agents, effective implementation would have been extremely difficult, and taxing of energy on the leader(s). Being perceptive about the staff needs and identifying the less overt champions assisted the process.

### **Conflict can be an opportunity**

An expectation of little or no conflict during a change process of the magnitude of the change process at the WCH is unrealistic. In an environment of redefinition of roles, power and autonomy, the use of both negotiation and managerial rationality skills, while being sensitive to staffs' needs is imperative (Tross and Cavanagh, 1996). Tackling conflict as an opportunity for learning and positive change can bring about creative solutions (Roe, 1995).

### **Open management style**

Establishing and reinforcing credibility in management through honesty, openness and directness in leadership style was highlighted by Tross and Cavanaugh, (1996). The pursuit of this by the AH Division in achieving a staff endorsed decision making model facilitated the change process.

### **Profession-based development**

While promoting a multidisciplinary team structure and collaborative culture, maintaining profession-specific development activities such as education sessions was crucial. This demonstrated to staff a commitment to retaining the strengths of each profession in the new design; ensuring that profession specific "technical" skills continued to be of a high standard; and facilitating confidence in each clinician's role in a team environment.

Clinicians with greater role confidence and clarity will perform more comfortably in a team, than those lacking confidence (Griffin, 1996). Given the frequency of changes of Allied Health staff in teams as a result of roster systems (commonly the case with Physiotherapists), profession specific training was a key element in the development of effective multidisciplinary teamwork.

## **Communication**

Communication is key to successful implementation of any change (Cutcliffe and Bassett, 1997). In leading organisations, sound two way communication systems exist from leaders to the workforce about strategy, decisions, service areas, consumer needs and preferences (Stace and Dunphy, 1996).

## **Ongoing evaluation**

The adoption of a quality improvement approach was of assistance. Staff were looking for “the single solution”. Acknowledgement that the new model was probably not perfect and in need of ongoing improvement seemed to facilitate more staff ownership.

## **“Non-negotiables”**

Identification and communication of the “non-negotiables” was of benefit. Staff knew when their creativity and input was being sought, as well as when a situation was a “given”.

## **External facilitators**

The benefits of external facilitators should be factored in to the costs of any reorganisation process. They played a key role in working with AH staff to find a way forward beyond hurdles.

## **Acknowledgement of AH profession differences**

Acknowledgement of the differences that exist between the AH professions was positive to the change process. AH professions have arisen as a result of special areas of client need. Client needs must remain the focus throughout the process. It is all too easy to presuppose that one AH professional is the same and can provide the same client service as the next. This is not the case. Any restructuring of AH needs to embrace both the similarities and the differences between each of the health care disciplines. However, it should be noted that AH professionals at the WCH needed to be facilitated to recognise the similarities between the disciplines.

## **Outcomes Achieved**

With a multitude of concurrent changes including information system, finance and senior manager roles, it is difficult to isolate a specific group of performance indicators that directly equate to the change program (Braithwaite, 1993). A variety of outcomes have been achieved since the new structure was introduced at the WCH.

The new organisation structure was implemented in July 1997, and refined in July 1999. In January 1999 AH staff reported an emerging organisational culture based on respectful collaboration and interdisciplinary interaction. New facilities for the Division's paediatric services have been completed. The reorganisation served as the foundation for this development work. Features including offices shared by multidisciplinary staff; varying sized and equipped patient care areas for use by any one of any profession; divisional facilities such as meeting rooms and staff rooms; improved formal and informal communication; and easier access for patients. Substantial savings have been achieved. No redundancies occurred during the reorganisation. Administrative staff positions were reduced by 2.5 FTE. Improved consistency of role definition and classification of positions across the division has been achieved. Staff from all professions now have a consistent and enhanced career path. The creation of Program Manager roles included a divisional portfolio each of research, community liaison and health promotion. Enhanced linkages with the University are demonstrated through the creation of three joint university/WCH positions. Several health promotion projects from our Women's and Babies' team, and Paediatric team members have been implemented. Enhanced interactions with the community and community



agencies have occurred through some staff exchanges with community health team members. Involvement of community agency staff in planning of service co-ordination and communication activities is underway. Undergraduate students from the professions of Occupational Therapy, Physiotherapy, Speech Pathology and Social Work, now share the same multidisciplinary office area. This interdisciplinary environment is a step towards fostering a multidisciplinary approach at undergraduate level, in preparation for work environments upon graduation. It has created a further opportunity to breakdown interdisciplinary barriers and develop interdisciplinary team based competencies of collaboration (Betz et al, 1998; Balestrieire et al, 1996). A reduction of total hours that staff spend in regular meetings was achieved. Recognition (by the broader hospital community and health professionals external to the organisation) was received that Allied Health professionals can successfully lead and implement change when challenged to do so.

Clinical improvements are varied and are ongoing. Multidisciplinary client intake sessions have facilitated improved co-ordination of multidisciplinary services for Rehabilitation and Development program clients. Initiation of joint Physiotherapy and Occupational Therapy sessions for pre-school children with development delay has led to better co-ordination of services and increased access to services for this client group. Utilisation of transdisciplinary teamwork skills has been achieved by an Occupational Therapist, Physiotherapist and Speech Pathologists of the Rehabilitation and Development Team for infants with, or at risk of, developmental delay. This has resulted in a more family orientated and integrated service with fewer appointments needed by each family. The provision of multidisciplinary group programs for school age children with minimal motor dysfunction in the community, has supported access for this client group closer to their area of residence. Implementation of a teenage pregnancy support service by The Women's & Babies' Physiotherapists and Social Workers in community locations, has increased the health care options for this high health risk group. Implementation of home program services for children with Cystic Fibrosis by Physiotherapists, Social Worker and Pharmacy staff has occurred. Preliminary reports indicate outcomes to date include less disruption to these families' lives and improved quality of life. Contribution by an occupational therapist, physiotherapist and speech pathologist to a Primary Health Care project. This has improved co-ordination of services within the WCH and in the community for families with children with a disability or developmental delay who have eating or drinking difficulties. Achievements have included improved efficiency and quality of communication reported by clinicians within WCH and community agencies regarding care management and availability of services.

Reported activity levels have increased by as much as 30% in some areas since the reorganisation. Part of this is attributed to better accuracy in reporting techniques as a result of multidisciplinary project work to ensure accuracy and consistency of activity data set definitions and data entry. Productivity improvements have also been a contributor.

## Conclusion

Each Allied Health group must intelligently analyse its own approach to strategy and structuring according to its own health care environment. Transformational Change processes as utilised at the WCH can be utilised successfully when radical repositioning is required for survival. The experiences at the WCH have demonstrated that Allied Health can lead and re-create itself to become change-seeking, collaborative, and multidisciplinary teams equipped to be leaders of healthcare provision and planning.

## References

- Armstrong H and Rotem A 1986, *'Developing Effective Health Teams'*, Continuing Education Support Unit, University of New South Wales.
- Balestrieire J, Burdick W, Caplan D, et al 1997, 'The Pennsylvania Local Interdisciplinary Team: journey into collaborative learning and community health improvement', *Joint Commission Journal on Quality Improvement*, vol 22, pp171-7.
- Betz C, Raynor O and Turman J 1998, 'Use of an interdisciplinary team for clinical instruction', *Nurse Educator*, vol 23, pp 32-7.

- Braithwaite J 1993, 'Strategic management and organisational structure: transformational processes at work in hospitals', *Australian Health Review*, vol 16, pp383-404.
- Cutcliffe J 1997, 'Introducing change in nursing: the case for research', *Journal of Nursing Management*, vol 5, pp 241-7
- Griffin S 1996, 'Occupational therapists as health care team members: a review of the literature', *Australian Occupational Therapy Journal*, vol 43, pp 83-94
- Marriott A 1997, 'Using the core values of occupational therapy in management', *British Journal of Occupational Therapy*, vol 60, pp 169-73
- O'Connor B 1995, 'Challenges of interagency collaboration: serving a young child with disabilities', *Physical and Occupational Therapy in Pediatrics*, vol 15, pp 89-109
- Roe M 1995, *Working together to improve health; a team handbook*, Queensland Primary Health Care Reference Centre, University of Queensland
- Stace D and Dunphy D 1994, *Beyond the Boundaries*, McGraw-Hill Book Company Australia Pty Ltd
- Timpson J 1996, 'Towards an understanding of the human resource in the context of change in the NHS: economic sense versus cultural sensibilities? A critical analysis', *Journal of Nursing Management*, vol 4, pp 315-24
- Tross G and Cavanagh S 1996, 'Innovation in nursing management professional, management and methodological considerations', *Journal of Nursing Management*, vol 4, pp 143-9.