WORKABILITY
Building Tomorrow's NDIS Workforce

EXTENDING YOUR WORKFORCE

The Allied Health Assistants Good Practice Guide

An evidence-based guide for employers on introducing Allied Health Assistants to deliver quality NDIS services

Jobs Queensland

TERMS USED IN THIS REPORT

AHA	Allied Health Assistant
AHP	Allied Health Professional
APA	Australian Physiotherapy Association
CF	Calderdale Framework
MMM	Modified Monash Model
NDIS	National Disability Insurance Scheme
NDS	National Disability Service
OTA	Occupational Therapy Association
QPC	Queensland Productivity Commission
RTO	Registered Training Organisation
TEHS	Top End Health Service
VAWM	Victorian Assistant Workforce Model
VET	Vocational Education and Training

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For further information on the NDIS Workforce Research Project visit: https://jobsqueensland.qld.gov.au/projects/ndis-workforce/ or https://workabilityqld.org.au/

Introduction

This Guide gives you practical steps to successfully introduce Allied Health Assistants (AHAs) to deliver quality NDIS services.

Learn about the role AHAs can take in your workplace, and how they intersect with the more skilled Allied Health Professional (AHP).

UTILISING AHAs CAN BENEFIT YOUR BUSINESS BY:

- **Freeing up AHPs to focus on high-level therapeutic assessment and clinical services only they can deliver**
- **Providing greater value for money for clients – they get more service hours per dollar in their NDIS plan**
- **Helping reduce the current long waiting lists for some services.**

The information in this Guide includes case studies and research that underscores both the case for change and provides insights into how to introduce the role of AHAs to your workplace.

AS A SERVICE PROVIDER, YOU CAN USE THE KEY CONSIDERATIONS AND CASE STUDIES IN THIS GUIDE TO:

- **Develop a business case for introducing AHAs to your organisation**
- **Run a pilot project to guide the roll-out of AHAs specific to your workplace**
- **Create a full implementation plan that includes training, pricing, model of supervision for AHAs, and continuous education.**

The research used as a basis for this Guide includes findings from interviews with key stakeholders including allied health organisations, Australian AHPs and AHAs, NDIS employers, and higher education and VET training providers. The key themes emerging from those interviews reflect the findings from the literature review about the benefits and challenges in using AHAs in the disability sector.

Why clients, the sector, and your business need Allied Health Assistants (AHAs)

SOLVING THE SHORTAGE OF ALLIED HEALTH PROFESSIONALS

Research shows that providers – particularly in regional and remote areas – are struggling to meet demand for NDIS allied health supports due to shortages of Allied Health Professionals (AHPs).

We know from this research that increasing the use of AHAs in a para-professional role to support AHPs helps alleviate this shortage and provides other benefits to clients, providers, and the sector as a whole.

In their 2021 report, 'Shades of Grey Allied Health Assistants', Jessica Quilty and Vanessa Robinson of DCS Consulting write how employing AHAs to deliver services can provide value for money and reduce the current long waiting lists for some services. They also found that the inclusion of AHAs was welcomed by both the NDIA, and NDIS participants.

Most research to date has been drawn from the experiences of the aged care and health care sectors, but there is growing evidence AHAs are also a great fit for the disability sector.

BENEFITS OF AHAs

More hours of allied health – research shows more hours of allied health service delivery can be provided to NDIS participants while also freeing up the AHP to focus on high-level therapeutic assessment and clinical services that only they can deliver.

Telehealth supervision and regional/ remote service provision – they can deliver place-based services to NDIS participants in regional, remote, and very remote locations under the delegation and supervision of an AHP via telehealth, and telehealth can be cost and time-effective. The rate for AHAs is more attractive in locations classified as remote – or very remote – by the NDIA, based on the Modified Monash Model (MMM).

As other service capacity – AHAs can deliver therapy supports while the AHP provides services to other AHP participants, allowing your business to grow. Providers report that this model works best under the current NDIS pricing structure if AHAs are employed at NDIS Level 2 and can work without direct supervision.

Support for individuals and groups – AHAs can deliver ongoing therapy supports to groups of NDIS participants, as well as individuals – providing a sustainable income stream for AHAs and enabling them to build hours from casual to permanent full-time over time.

Paid research time – under the NDIS price guide, AHPs can charge for the time involved in researching the needs of an NDIS participant. This information can be shared in a supervision session with the AHA. In fact, a video resource to streamline communications could be developed for the AHA to provide effective assistance to the NDIS participant.

It's important to communicate clearly with NDIS participants about the role of an AHA and how they could benefit from working with them.

The next section of this Guide will take you through the key steps to developing a more sustainable workforce with AHAs.

PROMOTING MODELS OF GOOD PRACTICE

The review this Guide is based on identifies the benefits of using AHAs to address the shortage of AHPs – particularly in regional and remote locations – and opportunities to improve participant outcomes, satisfaction, and level of services.

The review also identifies several challenges in increasing the uptake of AHAs more widely in the sector, and how those challenges can be overcome. These challenges include a lack of understanding of the benefits of engaging AHAs for NDIS service delivery, and the perception of some providers that it is not profitable to supervise an AHA at current NDIS Level 1 and Level 2 AHA rates.

However, many providers and AHPs have identified the benefits for both employers and NDIS participants. They are making the model work by being strategic about the services delegated to AHAs and employing cost-effective strategies for supervision and management of AHAs.

Tip: *The case studies in this Guide (p13-24) include practical examples of good practice you can implement as part of your workforce strategy.*

Key considerations for introducing AHAs

Introducing AHAs to your workforce is easy. Below is the information and workforce planning steps and activities you need to make this crucial decision towards a more sustainable workforce.

Prepare your organisation for using AHAs effectively by answering the following questions.

Are AHAs right for your business?

What pricing model suits your business?

What is the model of AHA practice in your business?

Is there a role for remote supervision of AHAs?

What do you need to communicate to your workforce?

Where can you find the right candidates to fill AHA roles?

What support do AHPs and AHAs need?

1 A Therapy Assistant (Level 1) must work under the delegation and direct supervision of a therapist at all times.

2 A Therapy Assistant (Level 2) must work under the delegation and supervision of a therapist and can work independently without direct supervision if assessed by the therapist as able to work at that level of responsibility.

Bringing your team together for this process can give you fresh insights and a mutual understanding of the AHA role across the organisation.

1. ARE AHAs RIGHT FOR YOUR BUSINESS?

Before you establish and implement AHA roles, take the time to explore models of practice, potential benefits to your participants and business, and the approach that best suits your setting.

Tip
There are case studies later in this Guide to help make these decisions.

- AHPs can support more participants by delegating some services and supports
- NDIS participants can afford more hours of allied health supports through a mix of AHP and AHA
- AHPs can focus on more high-level therapeutic assessment and clinical services that only they can deliver
- You can support more NDIS participants in regional, remote and very remote locations by having local AHAs supervised by an AHP through telehealth.

2. WHAT PRICING MODEL SUITS YOUR BUSINESS?

You will need to consider the pricing model that will support your AHA roles.

- Will the AHA be appointed at a Therapy Assistant Level 1[1] or 2[1]?
- Is remote loading applicable? The rate for AHAs is higher in locations classified as remote or very remote by the NDIA based on the Modified Monash Model (MMM).
- What are the economies of scale for providing individual and/or group supports?

Once you have explored the roles of AHAs in your service delivery – and understand the benefits of using AHAs and the different pricing models – you may want to consider establishing a business case before moving on to piloting the model.

3. WHAT IS THE MODEL OF AHA PRACTICE IN YOUR BUSINESS?

You will need to develop a fit-for-purpose delegation and supervision framework for AHAs that provides:

- clarity around the roles and responsibilities of both the AHA and the supervising AHP
- an outline of the expectations and strategies for delegation and supervising AHAs.

Tool
Examples of AHA delegation frameworks are included in the Building your governance, delegation, and supervision framework section of this Guide (pg 8).

A good tip is to include a clinical practice competency checklist to guide AHPs when delegating tasks to AHAs. Being clear about the scope of practice and having a standard for assessing the level of AHA skill and experience can help you decide whether an AHA should be classified as a Level 1 or Level 2 therapy assistant.

Sharing good practice in delegation and supervision with AHP networks is helpful for your business and AHPs. This can include mentoring and collaboration amongst services, particularly in regional and remote locations.

4. IS THERE A ROLE FOR REMOTE SUPERVISION OF AHAs?

Telehealth services provide supports to participants in remote locations. For example, an AHA might deliver services in regional and remote locations under the supervision of an AHP based in a different location.

To replicate this option, you may have some extra considerations in recruiting, training, supporting remote AHAs, and telehealth technology and training.

5. WHAT DO YOU NEED TO COMMUNICATE TO YOUR WORKFORCE?

When establishing AHA roles it's important to communicate with your team, participants and their families about the new role and how it will work.You can promote the benefits of AHA roles to encourage greater uptake of AHAs in delivering NDIS supports. Sharing case studies and developing easy to understand promotional material are great ways to communicate with NDIS participants, staff, and other AHPs.

6. WHERE CAN YOU FIND THE RIGHT CANDIDATES TO FILL AHA ROLES?

A crucial step in implementing AHA roles involves attracting and recruiting suitable workers.

The research undertaken gives us several strategies for establishing AHA roles – including adding to their role or promoting suitable support workers, creating training pathways, and recruiting new workers who already have the right skills and experience.

This identifies a range of labour sources, including:

- experienced support workers
- AHA students and graduates (Certificate III, Certificate IV or Diploma in AHA)
- allied health higher education students (Undergraduate AHP Degree)
- students or graduates with Certificate/ Diploma or Associate Degree in AHA
- overseas-trained AHPs who are not AHPRA registered.

Draw on the case studies in this Guide for strategies to attract and recruit your future AHA workforce. These can be found on pages 13-24.

7. WHAT SUPPORT DO AHPs AND AHAs NEED?

Training AHPs to supervise – AHPs can be supported to implement AHA roles via training and development focussed on two key areas: delegating practice (based on an agreed delegation framework) and supervision skills. You should also provide support skills in telehealth for remote supervision.

Further AHA training – once appointed, AHAs should be supported to undertake further training. This includes AHAs appointed without relevant formal qualifications and AHAs progressing to higher-level qualifications while on the job.

In-house training – both AHAs and AHPs responsible for delegating and supervising AHAs need appropriate in-house training opportunities to complement their formal education. In-house training can be supported and enriched with relevant training videos and resources.

Peer networking – in addition to supporting AHAs with training opportunities, it is important that the supervising AHP provides regular opportunities for checking in on the AHA as a complement to more structured supervision sessions. Providers and AHPs can also explore ways AHAs can access peer support networks.

8. HOW DO YOU SUPPORT AND DEVELOP YOUR AHA RECRUITS?

Providing ongoing professional development opportunities is key to the all-important retention of AHAs. To do this you can provide:

- opportunities for AHAs to develop skills in a range of allied health disciplines
- avenues for AHAs to be promoted to more senior leadership roles in your organisation
- support for AHAs who wish to pursue a professional AHP pathway by undertaking AHP studies while working in the AHA role.

Building your governance, delegation and supervision framework

Occupational Therapy Australia defines an AHA as 'a person employed under the supervision of an allied health professional who is required to assist with therapeutic and program-related activities. Supervision may be direct, indirect or remote and must occur within organisational requirements.'

In Australia, there are Level 1 AHAs and Level 2 AHAs. Your delegation and supervision framework should call out the specific requirements for each level as well as the shared requirements. The two levels are described by providers as Level 1 (supervised tasks) to Level 2 (direct delivery of service under delegation of an AHP).

According to the NDIA:

- Level 1 AHAs work under the delegation and direct supervision of a therapist and must be covered by the professional indemnity insurance of the supervising therapist (or the therapist's employer's provider)
- Level 2 AHAs work under the delegation and supervision of a therapist, where the therapist is not satisfied that the AHA can always work independently without direct supervision. The AHA must be covered by the professional indemnity insurance of the supervising therapist (or the therapist's employer's provider) (NDIA, 2020).

There is no formal framework specifically for disability providers. Therefore supervision methods vary from one organisation or AHP to another. For example, one organisation may provide supervision on an informal basis while another might hold weekly meetings with AHAs to review if participants' needs have been met.

The Allied Health Professions' Office of Queensland recommends using a robust delegation and supervision framework to make the best use of AHAs in your organisation. The right training and development opportunities should be provided as part of this, in addition to supervision by a suitably qualified and experienced AHP.

Below we share some valuable pointers from providers who have developed their own frameworks.

WHAT TO INCLUDE IN YOUR SUPERVISION FRAMEWORK

Clear roles – Detail on the scope of practice for the AHA role in your setting is particularly important for large teams and across diverse settings. A lack of clear delineation of tasks and responsibilities could result in ineffective utilisation of AHAs, or AHAs being assigned inappropriate tasks that are outside their scope of practice.

Competent trained supervisors

Provide specific training to your more senior staff on supervising AHAs in delivering disability services. Include their specific responsibilities to provide an appropriate level of ongoing supervision to AHAs.

POINTERS FROM PROVIDERS USING AHAS

Here are some direct-from-provider ideas of what to include in your supervision framework:

- Develop all-staff training on delegation – and how to work with AHAs – including a process for feedback following AHA assessment and intervention
- Provide training to AHPs on employing, delegating, and supervising AHAs – including the benefits to both the participant and the AHP
- Give the AHA clear expectations, direction, and check-in points for when they will be involved in service delivery
- Use a basic competency checklist that is participant specific and can be further developed into a method to assess the competency of the AHA.

VALUABLE RESOURCES FOR CREATING SUPERVISION FRAMEWORKS

Activity

Use the following guides and reports to develop your own models of delegation and supervision.

The reports from Queensland Government and Health Victoria are not disability-specific, but offer valuable information that can be adapted for your purposes. The National Disability Services (NDS) guide includes resources for training clinical supervisors of AHPs, supervision and support, using technology to support remote supervision and training, mentoring and networks, and training for collaborative working relationships of AHPs and AHAs.

- NDS - Supervision and Support of Allied Health Professionals and Therapy Assistants working remotely in Disability Queensland Government - Allied Health Assistant Framework
- Health Victoria - Supervision and Delegation Framework for Allied Health Assistants.

The NDIA's review of therapy pricing arrangements (NDIA, 2019) identifies the need for a clear framework to govern the use of therapy assistants under the NDIS, with detailed descriptions of required qualifications and eligible activities for both a Level 1 and Level 2 AHA. Supervision training for senior staff could include knowledge of AHA qualifications and what they have learnt during their education.

CREATING A PROCESS OF CONTINUOUS TRAINING AND EDUCATION

The NDIA does not specify any formal qualifications for AHAs, nor minimum training requirements for the two levels of assistance covered in the pricing guide. However, the case studies in this Guide indicate the benefits of continuous education and training when it comes to retention and creating a workforce pipeline.

In their report, Shades of Grey: Allied Health Assistants research authors Jessica Quilty and Vanessa Robinson point out concerns about whether the current Certificate IV in AHA is fit-for-purpose in preparing AHAs to work in NDIS roles. They note that most delivery of these courses is health-focused and does not include the skills and knowledge required for AHAs to work independently in the community. They observe that while some NDIS providers are using allied health undergraduate students to deliver AHA services to NDIS participants, there is still some reluctance by AHPs to use AHAs in this way.

Tip

Use the case studies in this Guide to overcome these challenges and develop a defined system of understanding of the qualifications the AHA staff you employ, and how to develop their skills and knowledge into the future.

LESSONS LEARNED FROM THE RESEARCH

Qualitative research conducted by Professor Wood and Dr Simons found that many providers expect the AHAs they employ to obtain a relevant certificate qualification in AHA, complemented by in-house training.

Growth in Certificate IV AHA enrolments is moderate and relatively low compared to other NDIS-related Certificate qualifications despite the growing demand, particularly in the health and aged care sectors.

To maximise the potential of AHAs in providing much-needed allied health supports, we need greater promotion of the role and to increase the number of VET AHA graduates.

Our sector needs to create opportunities for AHAs to keep developing their individual skills through professional development opportunities. To do this, we can offer pathways within allied health services and on the Allied Health Assistant Network of Australia platform (AHANA). https://www.ahana.com.au

Interviews and focus groups with key NDIS providers suggest there are concerns that the NDIS does not have a specified minimum training requirement for AHAs. Providers acknowledged the importance of formal AHA training but highlighted the need for flexibility to employ based on their attributes as well. These attributes include communication skills, empathy, ability to work with people with disability, flexibility and a willingness to learn.

> AHAs require, ***'Really good people skills to better work with clients and build up a rapport with them. Yes, compassion and understanding for the clients as well'*** (AHA, SA).

An NDIS regional provider notes that while 'the training prepares them for the introduction into the role … there's another amount that has to be based in experience [on the job]' (Regional Provider).

Providers indicate they also deliver in-house training of specific skills related to an individual participant within the allied health discipline. However, findings from the research suggest there are inconsistencies in the level and type of training that AHAs receive in-house, as well as concerns about how well the Certificate IV in AHA prepares students for working in an AHA role in the NDIS sector.

> ***'The Certificate IV in Allied Health Assistance only requires assistants to undertake training in one specific discipline. Most workforces use a multidisciplinary approach to care which then takes the assistant time to develop skills and understanding to support other allied health disciplines'.*** (AHA, NSW).

Ensuring AHA VET students can undertake quality placements during their studies is also vital in preparing graduates. The following case study describes how a regional TAFE provider ensures appropriate placements for AHA students by building strong relationships with local employers.

SUMMARY OF KEY PRINCIPLES OF GOOD PRACTICE

What we know about good practice from providers, the literature review, and case studies is:

- Support workers can be encouraged to undertake AHA studies and develop AHA skills to further advance their careers
- Several providers say there is an opportunity to support staff retention and career progression by encouraging AHAs to progress with a higher education allied health qualification part-time, while working as an AHA. This strategy has proven to be effective in the longer-term recruitment of AHPs
- Providers suggested that AHAs who progress to a full AHP degree are more likely to graduate with the skills and understanding of how to make the most effective use of AHAs in their practice
- One provider suggested supporting AHAs in regional and remote locations to undertake AHP training may be an effective strategy for addressing AHP shortages in those locations.

The key principles identified through the research you can implement in your workforce planning include:

- Use a mix of AHP students and Certificate III and IV AHA graduates to create a more balanced workforce of specific knowledge and broader skills
- Provide support workers with the opportunity to undertake training and develop AHA skills to advance their careers
- Facilitate career progression of AHAs by encouraging and supporting them to undertake higher education qualifications in their chosen allied health field.

Encourage regional and remote AHAs to do their initial AHP studies in their local community before transferring the remainder of the degree to a metropolitan location will make them more likely to return to their communities when they graduate. This will help address the shortage of AHPs in regional and remote Australia.

RECRUITING YOUR AHA WORKFORCE

While providers say they prefer AHAs to have relevant AHA qualifications, they also tend to recruit based on the right fit within the organisation, values and attitudes, communication skills, and experience in the disability sector. In addition, they highly valued empathy, flexibility, cultural awareness, and willingness to learn.

Like several of the providers in the research, you may come up against challenges recruiting AHAs. One provider indicated that they only received a small number of applicants each time they advertised. Out of the applicants, most were not assessed as being a good fit and did not exhibit the personal attributes required, such as communicating well. This provider commented that it had been 'quite a challenge to get ones with the Certificate IV who are willing to come and do this'. [work] (Metro Provider).

One way to overcome this is to recruit AHP students as AHAs, thus 'providing them with the potential workforce pipeline … so that they can engage them create some loyalty to the business, train them up in the way that they want them to be trained, and so that they're ready to go as new grads to be recruited into AHP position'. (Training Provider, VIC).

Sources of new hires

As part of your recruitment process consider exploring a range of labour sources, for example:

- Experienced support workers
- AHA students and graduates (Certificate III, Certificate IV or Diploma in AHA)
- Allied health higher education students (Undergraduate AHP Degree)
- Students or graduates with Certificate/ Diploma or Associate Degree in AHA
- Overseas trained AHPs who are not AHPRA registered.

Recruitment lessons from providers

There are several key desirable attributes for AHAs working in the disability sector, as identified by providers. These include:

- Experience working with people with disability
- An understanding of the unique aspects of the person with disability
- An understanding of the difference between providing support and building capacity – doing it for people versus helping people do it for themselves – is also considered important.

Tip

Consider matching individual AHA skill sets with the specific needs of NDIS participants. Place-based and targeted recruitment is more effective in recruiting suitable people to the AHA workforce.

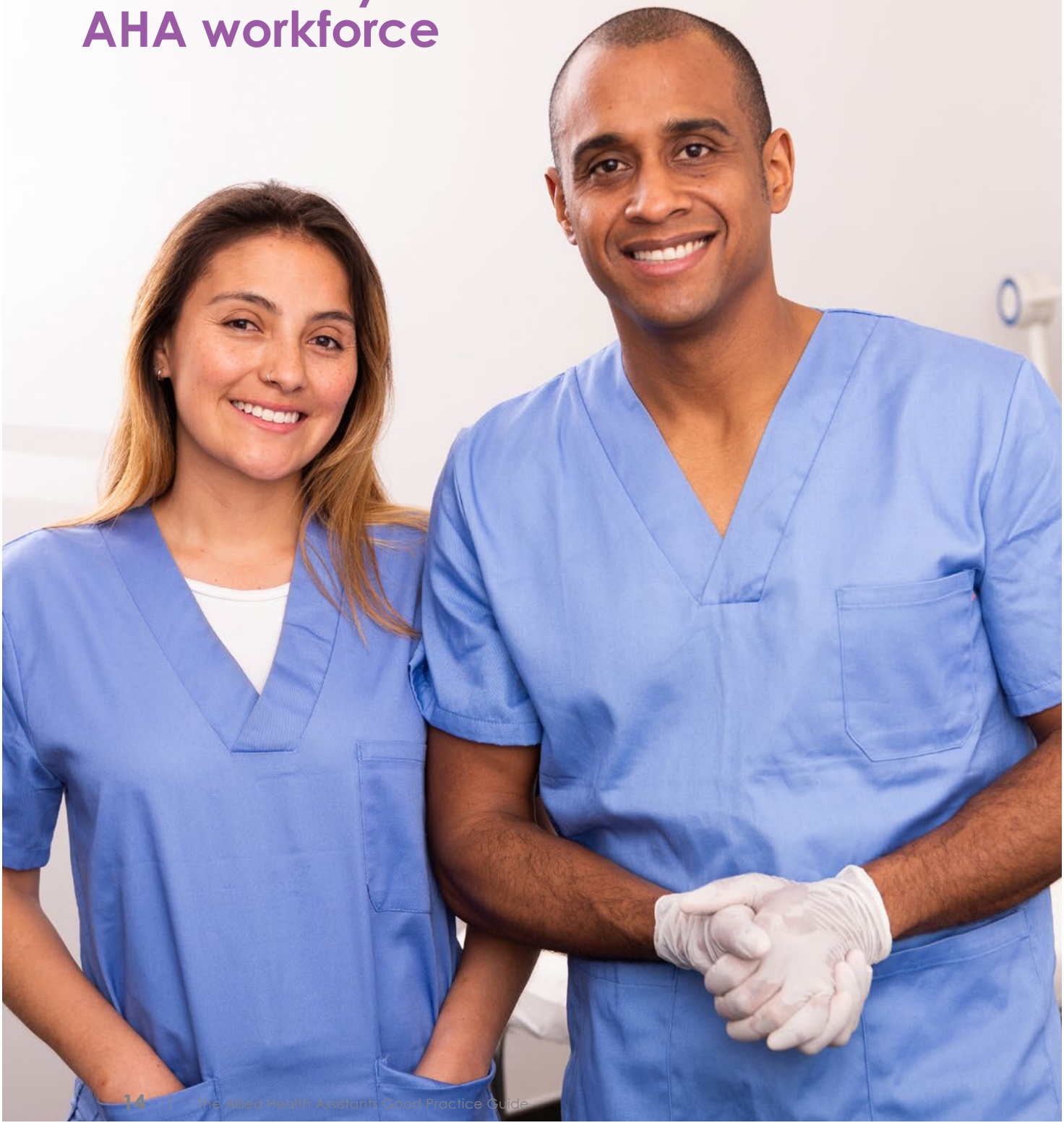
Principles of good practice in recruitment

The qualitative research and case studies reveal the following practices you may find beneficial in your recruitment process:

- Deliver school-based traineeships, new worker traineeships, and existing worker traineeships to build local AHA workforce capacity where these roles exist or are forecast to exist
- Target recruitment of AHAs to those who have the skillsets that match participant's needs and attributes
- Create pathways to employ local members of the community as AHAs
- Explore accessible and easy-to-use online platforms for hiring AHAs such as Community Services JobMatch
- Promote the value of AHAs to NDIS providers and AHPs.

Allied Health Assistant Case studies

Strategies to attract and recruit your future AHA workforce



Case Study One:

On-the-job support

This case study was from one Queensland AHA and AHP student who talked about the value of the in-house workplace support.

They emphasised the importance of building rapport and communicating respectfully with participants while under the supervision of an AHP. The AHA said they appreciated the value of regular meetings and catch-up sessions with other AHAs and AHPs, and being able to message the AHP with questions and/or concerns.

The AHA also said they benefitted from being trained in various disabilities to build the skills required to interact with participants from diverse backgrounds.

This student also benefitted from being employed as an AHA while completing their AHP studies, which allowed them to earn an income in a relevant field while building an AHP career pathway.

Benefits

AHAs can work in their chosen discipline, earn money, and learn on the job while studying. Students are 'building and improving skills on the job'. (AHP student). AHP students have a good knowledge of different disabilities and are taught to work effectively with a diverse group of participants as 'the right fit is important'. (AHP Student).

Challenges

The AHA felt they had the skills and knowledge to work effectively as an AHA and therefore did not mention any challenges. (This may not be the case with all AHP students given the diversity of higher education providers and AHP qualifications.)

Strategies for success

- Clear two-way communication between AHPs and AHAs with regular meetings and catch-up sessions
- Further development of AHAs ability to build rapport and communicate effectively and respectfully with all participants.

AHP provided in-house training in specialised skills that AHAs could use with participants.

Key principles of good practice

- Foster clear two-way communication between AHAs and AHPs
- Use AHP students as AHAs to gain real workplace experience as they complete their degree and gain valuable on-the-job training.

Case Study Two:

Finding a balance

This case study was of a regional TAFE Victoria campus that delivered a Certificate III and Certificate IV in AHA. They considered Certificate III an introduction into health, and the Certificate IV preparation for an AHA role. Based on industry needs, the program focused on occupational therapy and physiotherapy. Thirty enrolment places were offered annually for the mixed-mode course, which had students attend campus two days a week, plus one day online. After the theory component was completed students chose from one of three placement blocks offered by the TAFE.

Benefits

Students who gained a Certificate IV in AHA had a broad knowledge base in working as an AHA. The high-level communication and observation skills they learned were transferrable to working with any AHP. Enrolling a limited number of students ensured adequate progress supervision and the provision of placements with the possibility of future employment.

Challenges

This TAFE found it challenging to find enough quality placements for the students in their regional area. Students often came into the program with very clear ideas on what they wanted to do as an AHA.

'Most of them talk about the fact that they want to help people. Although we don't always think that they have had a good understanding of what that actually could involve'. (TAFE Coordinator).

Strategies for success

- The TAFE worked to provide quality placements by fostering close positive relationships with local employers – who reciprocated with enough places for every student each year.
- The TAFE provided flexible mixed-mode study and timed its placements to accommodate students' other commitments, offer the best chance of students' success, and ensure the quality and availability of placements.
- Students underwent a selection process before being accepted into the program. After being given an overview of the program – including information that could have triggered an emotional response – followed by a group interview where they worked together on three tasks to see how they interacted with people they had just met. They then completed an individual ten-minute interview where they were asked questions such as why they wanted to become an AHA and how they would balance their study commitments. Finally, the students discussed their suitability for AHA studies with the program coordinator.

Key principles of good practice

- Created ongoing positive relationships with industry to secure ongoing placements for AHA students
- Capped AHA student numbers to ensure quality education
- Ensured student suitability for the AHA career pathway
- Provided flexible course delivery.

Case Study Three:

Classroom versus on-the-job training and skills building

Although this AHA developed a broad range of skills from a Certificate IV in AHA, they found the on-the-job training and supervision by an AHP more beneficial than the course.

'When I finished the course, I got a job in a hospital, so I learnt a very broad range of skills in the hospital.' (Queensland AHA). This assistant noted that people skills were essential for AHAs to work with a broad range of participants with disability – as well as their family members, carers, and service providers.

The AHA worked independently under different AHPs, from different disciplines, within the same organisation. The AHA explained generic AHA skills were relatively transferrable across disciplinary areas. However, they needed the supervising AHP to assist them in developing more specialised discipline-specific skills. This AHA worked as a permanent full-time employee in the NDIS and regularly liaised with AHPs via email, phone calls and videoconferencing.

Benefits

Certificate IV trained AHAs were broadly trained – and with further specialised in-house training – could work under the delegation of AHPs with a wide range of AH disciplines. As a result, these AHAs were more likely to make a career as an AHA in disability and could build on their skills.

Challenges

This AHA had not experienced any challenges as the AHPs were readily available for support and training.

Strategies for success

- The AHPs provided in-house training for the AHAs to deliver therapy plans in discipline-specific skills.
- The AHPs delegated to the AHA who was best aligned with the participant, and they were readily available to support the AHA.

Key principles of good practice

- The Certificate IV in AHA prepared the graduate to work under the delegation of an AHP across NDIS-relevant AHP disciplinary areas.
- The Certificate IV provided a good foundation for an AHA career pathway.
- The AHP-provided supervision and professional development furthered the training of the AHA and fostered the development of the AHA's written and oral communication skills.

Educating future Allied Health Professionals

Providers identify the need for AHP graduates to have the knowledge and skills to delegate services and supervise AHAs, including remote supervision via telehealth.

Providers and AHPs say that most AHP graduates have not had the opportunity to develop these skills during their undergraduate studies.

AHAs are entering the workforce through several pathways including upskilled support workers, school traineeships, Certificate III or IV in AHA, AHPs who have trained overseas, and AHP students.

The following case study highlights the benefits of ensuring future AHPs are suited for the profession through sub-bachelor pathways such as via an AHA undergraduate Certificate, and working as an AHA while studying towards an AHP qualification.

Case Study Four:

A pathway to higher qualifications

This case study is from a higher education provider that offered AHP degrees, and a newly approved undergraduate Certificate in AHA that will articulate to the AHP degrees. The Certificate allowed this provider to have conversations with students about AHP career pathways and assess individual students' capacity to continue into an AHP degree program. It is an effective way for students to determine their suitability for working in allied health, and build their confidence to continue to a degree. Students are using this as a stepping-stone into AHP.

‘it's a great confidence booster, and the other side is that it means that they've got a qualification that they can present to an employer to work as an AHA while they're doing their degree in OT’ (OT, Senior Lecturer, regional Queensland university).

Students are taught about working within the NDIS throughout the AHP degree. This is integrated into their course assessment; for example, ‘students write reports that are specifically an NDIS assessment’. (OT, Senior Lecturer, regional Queensland university).

Benefits

Students who obtained a Certificate in AHA could work in the field as they studied. On completion, they could continue in any of the fields covered in this course, ‘so it’s a great way to see the breadth of allied health professions’ (OT, Senior Lecturer, regional Queensland university).

Alternately, they can be employed as an AHA and deliver programs to participants. This suggests the possibility of a stackable degree, or an intermediate qualification, whereby students enrol in an AHP degree and gain an AHA undergraduate Certificate, then a diploma, and then the degree – without having to enrol separately in each component.

Challenges

Students have often entered courses with their own, sometimes inaccurate, views of how the profession worked. Although this provider has always included telehealth as part of their courses, students often saw it as unimportant and something they would not use in their practice. The COVID-19 pandemic changed this perception – students now understood the importance of utilising technology for service delivery, and why they needed to learn how to use it effectively. Telehealth has become a part of most allied health professional practices during the pandemic and it is expected this will continue in the future.

Case Study Four:
A pathway to higher qualifications

Strategies for success

- To prepare students for the workforce they needed to understand the NDIS and its processes. In recognition of this, the provider integrated NDIS information throughout the OT course and assessment.
- As the undergraduate Certificate in AHA articulated into an AHP degree, the provider recognised the potential of the stackable degree. This created a flexible learning environment where students could gain progressive sub-Bachelor qualifications, giving them the option to work in a field directly related to their course while studying, or defer study to work.
- Suitability and capacity to become an AHP was determined while students were completing the undergraduate Certificate course. It is noted that delegation skills need to be included in all AHP courses to better prepare future graduates to utilise AHAs in service delivery.

Key principles of good practice

- The capacity and suitability of students for AHP degrees was assessed prior to them entering, via sub-degree pathways (including Certificate IV in AHA and undergraduate Certificate in AHA from the university).
- The skills needed for future AHPs to supervise AHAs – understanding the role of AHAs, and how to delegate and supervise AHAs delivering NDIS service – was embedded in the AHP curriculum.
- AHP students' skills in telehealth were developed so they could be utilised to competently deliver services, as well as provide delegation and supervision to AHAs in regional and remote locations, via telehealth technologies.

Case Study Five:

A provider's recruitment strategy

This case study showed the importance of matching an AHA's individual skillset with the participant, and how to create pathways to employ AHAs from the local community.

This Queensland allied health provider worked entirely within the NDIS and employed physiotherapists, occupational therapists and speech and language therapists. The provider employed 75 people, 12 of whom were AHAs. The AHAs were comprised of Certificate IV trained, AHP students, and people from other backgrounds and educations.

The NDIS participants the provider supported had requested AHAs because they were less expensive than therapists and worked with them in the community – which meant they got more therapy sessions in their NDIS plans.

The provider explored the candidate types that would allow them to counter the difficulty they had in recruiting enough AHAs. First, AHAs were employed casually, and then if they were a good fit, they were moved onto permanent part-time and then permanent full-time work as they built a caseload. AHP students were employed casually due to study commitments.

Benefits

AHAs were utilised for ongoing lower-level therapy to help participants' NDIS plan funds go further. This increased the number of therapy sessions the NDIS participant could afford in their plan.

AHP students were hired as AHAs. They provided discipline-specific knowledge and an understanding of disability and received on-the-job training under the delegation of an AHP. This gave the provider the option of employing the AHP students on completion of their degree and integrating them into their AHP workforce.

Challenges

This provider found it difficult to source AHAs as there were not enough available. When advertising positions the response rate was lower than required, and often occupational therapy students would apply, but few physiotherapy students.

Case Study Five:
A provider's recruitment strategy

Strategies for success

This provider employed a range of strategies for sourcing and managing AHA recruits which included:

- Used a mix of AHP students and Certificate IV trained AHAs to create a more balanced workforce. Certificate IV trained AHAs could work in a range of AH disciplines and were more likely to continue in the AHA role, while AHP students were employed as AHAs in their specific discipline.
- Employed early recruitment of AHP students, which proved a successful workforce strategy. The provider sought direction from local universities as to what point in the courses they could recruit AHP students to work as AHAs under the delegation of an AHP.
- This provider advertised and used word-of-mouth to recruit AHAs who were then engaged based on the employer's needs.
- Scheduled regular face-to-face professional development meetings to counteract the fact that many staff worked remotely. This included AHPs running two-hour breakout sessions with the AHAs on discipline-specific skills.
- They were developing a delegation framework for AHPs and recommended that an understanding of how to delegate effectively should be included in all AHP qualifications.

Key principles of good practice

- Promoted the benefits of AHAs to NDIS participants who appreciated receiving more therapy sessions in their plan.
- Developed a delegation framework for AHPs so that AHAs could be supported in developing the skills to move from Level 1 (supervised tasks) to Level 2 (direct delivery of service under delegation of an AHP) and eventually to more advanced levels of clinical service delivery under the delegation of the AHP.
- Used a mix of AHA students and Certificate IV AHA graduates to create a more balanced workforce of specific knowledge and broader skills – while also providing opportunities for development of skills of both AHP students and certificate IV trained AHAs.
- Provided on-the-job training for AHAs to complement their formal training.
- Employed AHAs casually at first, and then if they were a good fit with the organisation, moved them into permanent part-time and permanent full-time.

Case Study Six:

Providing a pathway to AHP roles

This Queensland-based NDIS provider employed AHPs and AHAs to deliver NDIS supports Australia-wide. Over the past year, they started recruiting fourth year AHP students as AHAs, primarily in support roles rather than clinical roles. They work one-on-one with AHPs to provide support by following up on quotes for services, looking for assistive technologies, doing joint therapy interventions, and developing resources and writing reports.

They recently recruited six AHAs to work directly with clinicians to go out into the community to deliver the intervention services for participants under the delegation of an AHP. Good practice involved providing the NDIS participant with sufficient information to make an informed choice about whether to have some of their approved services delivered by an AHA under the delegation of an AHP. This was communicated in language that was easily understood by the participant.

This provider also developed a basic clinical practice AHA competency checklist to be used on a case-by-case basis to ensure quality of service. The provider's future goal was to bring this approach into a broader framework. This would include check-in points to ensure consistency in the approach to delivery of allied health services by both AHPs and delegated to AHAs.

Benefits

The benefit to participants for using AHAs was that their funding went further. This increased the number of support sessions due to the lower hourly rate for an AHA.

'They get to build rapport with more than one person … introducing more than one person to a participant's journey.' (CEO, NDIS Provider).

The AHA's on-the-job learning was directly related to their future career, and directly linked to their study. This helps them to 'understand what it's really like to work with people in the community in their everyday environments'. (CEO, NDIS Provider).

Case Study Six:
Providing a pathway to AHP roles

Challenges

For this provider, the main challenge of taking on AHAs was how to ensure their competency. They were assessing AHA competency on a client-to-client basis whereby the AHP assessed the competency of the AHA to deliver a specific intervention with a participant. However, this approach was very labour intensive, so they were developing a systematic model to replace this method. There was also a barrier in getting AHPs to understand how to maximise the use of an AHA when they had not worked with one before – such as how to delegate – when to delegate – and when not to delegate physiotherapy students.

Strategies for success

This organisation integrated AHAs into their workplace by establishing a range of practices, including:

- A check-in process that covered each stage, including initial assessment, plan development and delivery of supports. (The process specified the number of sessions an AHA should deliver before checking in with AHP, setting markers so that the participant's care was consistent and of high quality.)
- The introduction of an option to use AHAs in the initial quotes for service by clearly communicating to participants why they used an AHA and their benefits.
- Recruitment of AHP students as AHAs so they could transition into the organisation when they had completed their qualification. This also provided the student with work directly related to their course and possible future employment.

Key principles of good practice

- Recruit AHP students as AHAs with the intention of recruiting them to the AHP workforce when they have completed their qualification
- Provide clear processes for NDIS participants and AHAs
- Create a competency checklist to be used on a case-by-case basis
- Have check-in points for when the AHP will be involved in service delivery
- Utilised AHAs for administrative support tasks and service delivery
- Educate AHPs on how to employ and delegate to AHAs
- Develop a systematic method to assess AHA competency.

Case Study Seven:

A rural provider builds capability

This rural provider focussed on building local capacity to deliver therapeutic supports in rural and remote locations. AHAs lived locally and had their own individual specialised skill sets which were then carefully matched with the NDIS participant. The provider recruited AHAs from various backgrounds, such as teachers, artists, and music therapists. The organisation also provided in-house training.

Benefits

Rural NDIS participants often preferred to work with people from their own town, so recruiting AHAs from the local population who had local knowledge and were accessible to participants was effective. This also benefitted communication and relationships between the AHAs and the participants, and reduced travel time for workers.

Challenges

The major challenge was in developing an AHAs' 'understanding of space and connection within a capacity-building role'. (Rural provider). Traditionally, supporting people with disability had been more about doing things for them, rather than building the participant's capacity to be able to do things for themselves. It has sometimes been difficult finding enough community members interested in becoming an AHA. In addition, rural and remote AHP students have found it hard to be away from their home base for the time taken to complete a degree.

Strategies for success

- Used a stepping-stone model whereby they gradually introduced new experiences and skills to the participant – thus building capacity one step at a time
- Provided in-house delegation training for AHPs entering the workforce
- Provided in-house training for AHAs with client-specific training to specific allied health plans
- A future strategy is to link up with the local TAFE to train the AHAs that they have employed in the Certificate IV in Allied Health Assistance. This is a preferred option rather than completing online courses offered by metropolitan RTOs. Another suggested future strategy was for students to study for a diploma or associate degree locally, accounting for one or two years of an allied health degree. This would mean they did not have to leave home for the full degree. And they would have gained confidence and knowledge before leaving their community to complete their degree in a metropolitan area.

Key principles of good practice

- Matched individual AHA skillsets with the participant needs and attributes
- Created pathways to employ local members of the community as AHAs
- Provided in-house delegation training provided for AHPs entering the workforce
- Provided AHAs with client-specific training to deliver AHP plans under the delegation of an AHP
- Facilitated career progression by supporting AHAs to complete their initial AHP studies in their local rural or remote community before transferring to complete the degree in a metropolitan location.

Case Study Eight:

Indigenous AHAs traineeship program

This case study looked at the recruitment of Aboriginal and Torres Strait Islander AHAs by creating a career pathway for Aboriginal and Torres Strait Islander people in the local community. This was achieved by establishing a traineeship program, creating a strong relationship between industry and school, and providing an appropriate level of support plus flexibility to ensure student success.

This case study comes from a Queensland regional Registered Training Organisation (RTO) that offered a Certificate III in AHA as a school-based traineeship. It was offered in response to industry feedback about the need for more local Indigenous AHAs who could communicate effectively with Aboriginal and Torres Strait Islander people with disability in metropolitan, rural, and remote settings. The traineeship program also helped to build the local Indigenous workforce.

Students initially completed a Certificate II in Health Support Services, which gave them the background health knowledge and relevant skills to undertake the traineeship. Training was delivered in a blended mode with students undertaking the traineeship at school, working one day a week, and attending training blocks during the school holidays. The traineeship provided pathways to employment in local communities. Industry feedback identified the need to introduce the more specialised Certificate IV in AHA, as this was becoming the minimum qualification for AHAs.

Benefits

Students could complete the Certificate II in Health Support Services at their own pace, then a Certificate III in AHA through a traineeship whilst still attending school. This created a pathway for Aboriginal and Torres Strait Islander students to enter the workforce or continue and qualify as a health professional such as a nurse or an AHP.

The traineeship also allowed them to give back to their community and be role models for other Indigenous youth. This program reduced cultural barriers, thereby allowing clearer communication with providers so they could understand their needs.

Challenges

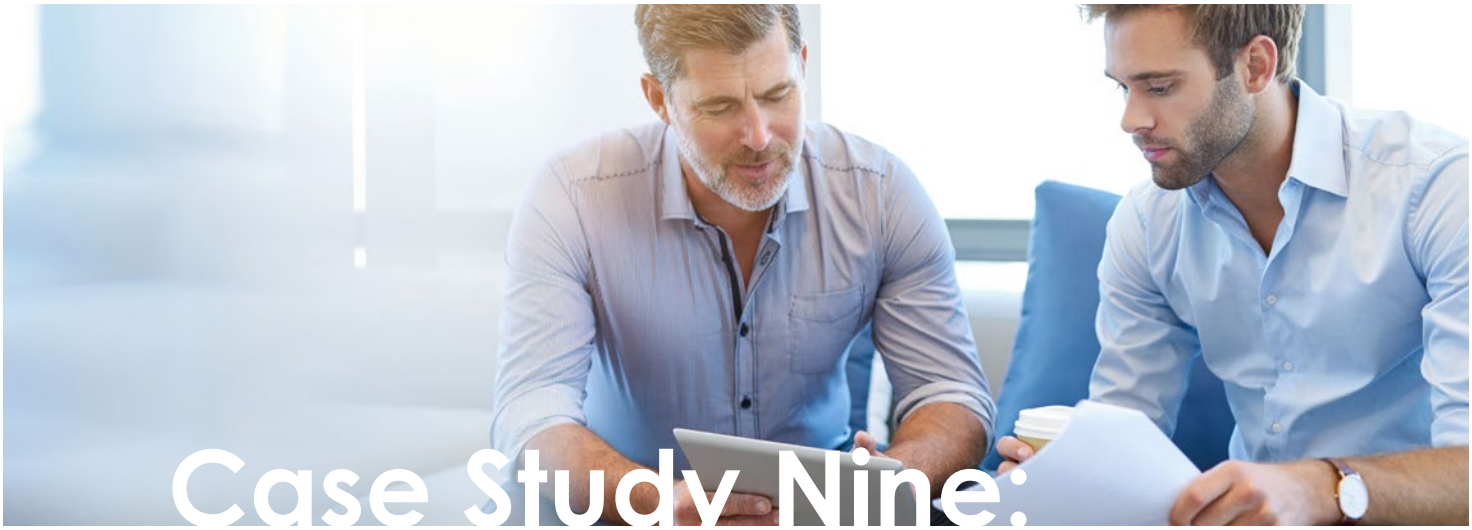
The number of students entering the traineeship dropped this year, even though the program was flexible to accommodate student needs.

Strategies for success

The RTO worked towards introducing the Certificate IV in AHA so students could be upskilled and job-ready as this level of qualification was becoming an industry requirement to work as an AHA. They provided regular and consistent student support via workplace visits and meetings on Microsoft teams to ensure as many completions as possible. In addition, they created stronger links between schools, communities, and the RTO to increase enrolments.

Key principles of good practice

- Creating positive working relationships with local schools supporting the traineeship program
- Targeted enrolment to recruit local Indigenous students to undertake the traineeship and develop the skills to deliver AHA services to the local community
- Providing a progressive pathway by first preparing students through training in the Certificate II in Health Support Services, which gives them the background health knowledge and relevant skills to undertake the traineeship and Certificate IV in Allied Health Assistance
- Providing regular support to students throughout the traineeship
- Using mixed-mode delivery to facilitate flexible learning options for students.



Case Study Nine:

Developing a recruitment platform

This case study looked at an online recruitment platform matching employers with suitable AHAs.

This Victorian-based organisation operated an online AHA recruitment and employment service for Victoria, Sydney, Brisbane, and Adelaide with the intention of covering all capital cities by the end of 2021.

The organisation worked by collecting the relevant qualifications, and conducting the NDIS-required screening checks and phone interviews to determine the AHA applicant's suitability for delivery of NDIS Level 2 AHA services. The organisation matched AHAs with both NDIS participants and AHPs who applied for AHA support via the platform.

To ensure a good fit, free meet and greet sessions were set up between the AHA and the participant or AHP. If both parties agreed to proceed, a handover was set up and the AHA was employed casually.

Benefits

The major benefit was in having a centralised online platform to hire AHAs. The platform did all of the recruitment work and gave participants choice and control over whom they shared their information.

The founders identified that AHP students with the right skills to be employed as AHAs were under-utilised and brought them into the workforce. This benefitted the employers and the students who were paid working in an area directly related to their study.

Challenges

The platform predominately hired AHP students. They found Certificate IV trained AHAs lacked the level of skill, knowledge or experience of AHP students. Consequently, they were not as well rounded and struggled with writing session notes and communicating professionally with participants.

Each State or Territory has different supervision and delegation expectations; no national framework existed to a national platform.

Many AHPs did not know the benefits of using AHAs, or how to delegate to them. The provider also found inconsistencies in the information obtained from Government departments and the NDIA.

Strategies for success

The platform developers were in the process of developing a training program on supervision and delegation for AHPs. This includes educating clients on the benefits of using AHAs, such as reducing wait times for new participants and increasing the amount of therapy they receive.

The developers recommended the development of a national delegation and supervision framework.

Key principles of good practice

- Delivered an online platform for hiring AHAs that is accessible and easy to use.
- Developed a training package on delegation and the benefits of using AHAs for new platform users, including NDIS providers and AHPs around.

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