Appendix C

Method for and Results of the Participant Feedback Questionnaire and IFI Support Officer Exit Interviews

Participant feedback questionnaire

Method. Following the completion of IFI coding all participants were invited to complete a feedback questionnaire about a number of aspects of their experience of allocating the IFI in their clinical work. This questionnaire included questions about training, issues around including a support person (where available), how the clinician gained access to the IFI code set in order to select a code, the process of IFI allocation, and the usefulness of the IFI codes. The paper version of the questionnaire can be found in Appendix A. The clinicians were offered the option of completing the feedback questionnaire on-line, where the data was immediately sent to a central database, or by hardcopy to be returned to the Project Officer. Feedback was in the form of both quantitative data as responses to specific questions and qualitative data in the form of written comments.

Participants. In total 114 clinicians responded to the feedback questionnaire. As a percentage of the number of clinicians who entered IFI data (341), the overall participation rate was 33.4%. The number of clinicians who completed the feedback questionnaire from the 12 sites, and the percentage of the total number of participants are shown in Table C1. Austin Health, the Royal Adelaide Hospital, and the Royal Children's Hospital each had between one and seven participants (see Table 2) in the overall pilot study and no responses were received on the feedback questionnaire from these sites.

Table C1

Feedback questionnaire participation by site

Hospital/Health Service	Number of Participants	% of total
Barwon Health	12	10.5
Canberra Hospital	20	17.5
Hunter New England	27	23.7
Lyell McEwin Hospital	4	3.5
Mater Allied Health Services	6	5.3
Royal Hobart Hospital	18	15.8
Royal Victorian Eye and Ear Hospital	11	9.6
Southern Health	14	12.3
Townsville Hospital	2	1.8
Total	**114**	**100**

The number of participants who completed the feedback questionnaire from each profession is shown in Table C2. The percentage of participants from each profession as a fraction of the total number of participants is also shown.

Table C2

Feedback questionnaire participation by profession

Profession	Number of Participants	% of total
Audiology	10	8.8
Dietetics	13	11.4
Exercise Physiology	1	.9
Occupational Therapy	20	17.5
Orthoptics	5	4.4
Physiotherapy	24	21.1
Podiatry	4	3.5
Prosthetics & Orthotics	2	1.8
Psychology	13	11.4
Social Work	10	8.8
Speech Pathology	11	9.6
Unidentified	1	.9
Total	**114**	**100**

IFI Support Officers Semi-Structured Exit Interviews

Method. The exit interview was divided in three sections. Section one contained questions about preparation and training for IFI coding. Section two referred to the IFI data collection process and section three to aspects of the Support Officer role and any general comments. The outline for this interview can be found in Appendix C.

Participants. IFI Support Officers were employed in eight of the twelve sites involved in the pilot study. At one site two Support Officers were employed over the pilot phase due to illness of the original Support Officer. Both of these Support Officers participated in the exit interview. One Support Officer could not be interviewed due to lack of availability during the interview period. Therefore eight Support Officers from seven sites participated in the interview process. Information provided by the Support Officers during the exit interviews is interspersed throughout the following summary of the IFI pilot results.

Preparation and Training

Reasons that the Support Officers applied for the position

The Support Officers were asked to indicate what prompted them to apply for the Support Officer position. Five of the eight Support Officers stated that they had been looking for non-clinical work, often to fit with part-time clinical work. Other responses indicated wanting to maintain a connection with allied health now that the individual had ceased work as a clinician, and wanting to gain a 'bigger picture' of allied health outside one-to-one clinical intervention. Three of the Support Officers were selected for the position and offered the position directly by supervisors or managers.

Prior familiarity with the IFI

Five Support Officers had not heard of an Indicator for Intervention prior to their involvement in the project. One had previously collected an IFI but this was diagnostic-based. Further, one participant had used the ICF code set as part of a Masters study and so was familiar with the code set.

Gaps in training to be a Support Officer

Most of the Support Officers were employed within the health service/hospital in which they worked as a clinician, and met with the IFI research team on the day of the group training workshops. Prior contact was restricted due to the geographic spread of sites throughout Australia and time-constraints. While most Support Officers felt that the group training was adequate to gain an understanding of the project, the majority would have preferred some face-to-face contact with the research team prior to the group training session to establish the parameters of their role and to discuss the IFI concept and coding process. Two of the Support Officers reported that they would have liked clearer definitions of the IFI concept on completion of their training.

General overview of the IFI Support Officer role

Organisational integration of the Support Officer role

The Support Officer role was integrated into the organisation in a variety of ways between sites including; the Support Officers being housed and managed in the department where they conducted their clinical work, having no particular location to work from, being located with and reporting to the Director for Allied Health, being located with a different clinical department to that in which they conduct their clinical work, or being located within a more research-based section of the service. The Support Officers generally agreed that the best

arrangement was to be located in a profession-neutral location and to be primarily managed by an allied health director or someone who is similarly ‘unaffiliated’ with any one profession. The Support Officers felt this was important to show an equal alliance with all allied health professions, so as not to get ‘side-tracked’ from their IFI work into clinical back-fill for other staff, and so that they were not perceived by other clinical staff as ‘not working’ if they were at a desk carrying out IFI tasks.

Positive and negative aspects of the IFI Support Officer role

Almost all Support Officers enjoyed the face-to-face aspects of their support role. These aspects included meeting and training staff from allied health departments outside their own profession, trouble-shooting as problems arose, attending meetings with members of the NAHCC committee, the IFI research team and other IFI Support Officers, and providing feedback to managers and staff about the progress of the project. A number of Support Officers also referred to gaining a ‘bigger picture’ of allied health outside clinical work and of the workings of research, systems and representatives involved with improving public allied health systems.

The Support Officers in general did not enjoy following up with clinicians who were not completing regular IFI coding as they often felt they were ‘harassing’ or ‘nagging’ their colleagues. Despite this, they understood that this follow-up was a central part of their role and important to the project. One Support Officer was employed from outside of the health service and was initially cautious about ‘treading on toes’ by assuming an authority role when managers and staff were not familiar with them.

Structures and supports needed for the support position

The Support Officers stated they felt very supported by the IFI research team. In particular they appreciated being able to access support and fast responses to queries at any time. They generally felt that the team was approachable and that this helped to lessen the isolation of the role, as did regular feedback throughout the coding process. The Support Officers found teleconferences with other Support Officers very useful and all but one felt that attending face-to-face meetings with the NAHCC allied health representatives and representatives from the Department of Health and Ageing was invaluable for gaining the ‘big picture’ perspective of the project.

A number of Support Officers would have liked increased linkage between the Support Officers at the different sites and felt that this could have been facilitated more at the face-to-face meetings.

The Support Officers seemed generally positive about their experience with the IFI project, most often wanting to continue in other research roles. One Support Officer felt that she had acquired a greater understanding of allied health at a broader level which would assist in higher level positions throughout her career progression.

Participant feedback regarding the IFI Support Officers

Assistance from the Support Officer

Participants from sites where an on-site Officer was employed who completed a feedback questionnaire were asked to indicate how often they sought assistance from their Support Officer. The responses are illustrated in Figure C1. Columns represent percentages of the total and data above the columns shows the frequency of that response.

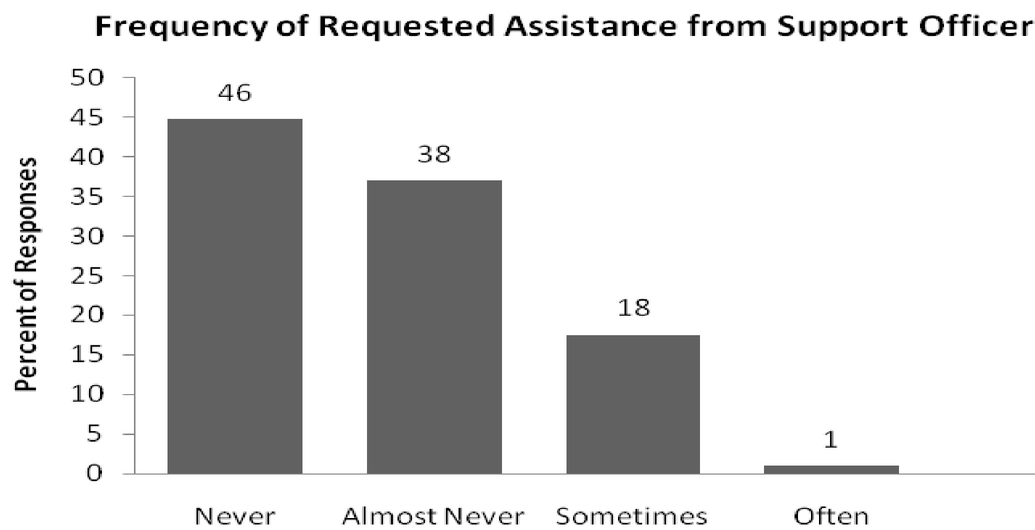


Figure C1. Frequency of requested assistance from the Support Officer

Usefulness of the IFI Support Officer role

Participants were asked to rate the usefulness of having a Support Officer employed on-site for the duration of the project. Despite close to half of respondents saying they had never sought assistance from the Support Officer, 74% of participants indicated they thought having a Support Officer was 'moderately', 'very' or 'extremely' useful. Participant responses to this question are shown in Figure 2.While they may not have sought assistance from the Support Officer, they may have received other assistance such as training, feedback and ongoing support from the Support Officer.

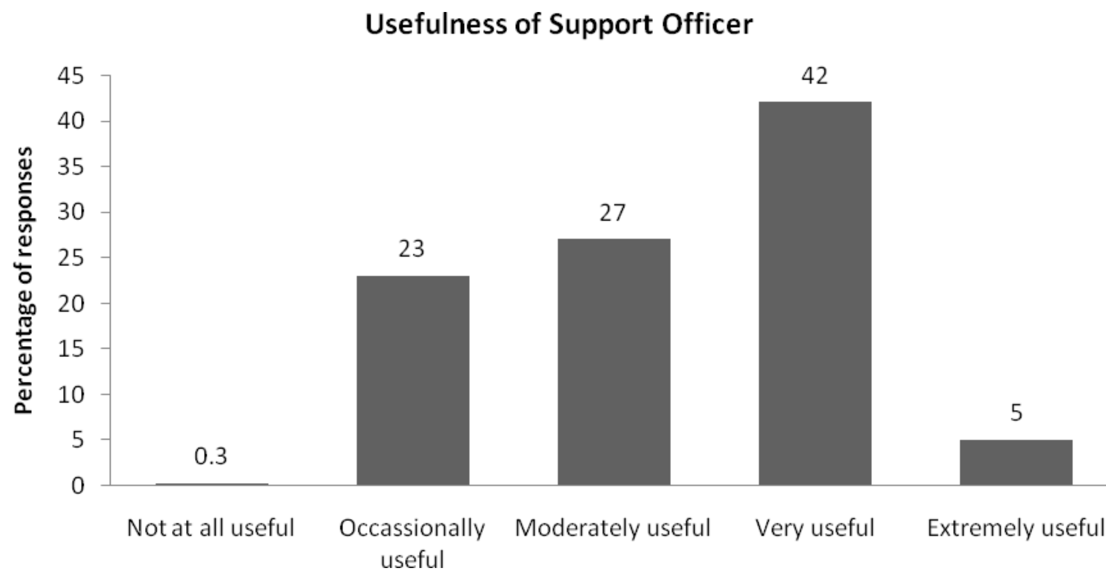


Figure C2. Usefulness of the on-site Support Officer role

Participant and Support Officer feedback about IFI training

Participants completing the feedback questionnaire (N=114) and the eight Support Officers interviewed provided feedback about the IFI training.

Method of training

The majority of participants providing feedback (59.6%) indicated they had been trained in group training by the IFI research team. Of the remainder of participants 18.4% had been trained individually by the IFI Support Officer and 19.3% had been trained in a group by the IFI Support Officer. The remaining 2.6% had been trained either by the manager of their department or a colleague who had attended a formal training session.

The Support Officers were asked if they encountered any difficulties in training individuals or groups of clinicians. While they found training initially challenging, most Support Officers reported gaining confidence in teaching other staff about IFI coding over time. The Support Officers were provided with the training package used by the IFI research team and stated that they found this very useful. This package was then adapted for individual clinicians and for individual time constraints. Two Support Officers maintained some uncertainty about the IFI concept, stating that they felt the concept was ‘a bit grey’ and that further clarification would have assisted them in their training role.

Adequacy of training

Participants completing the feedback questionnaire were asked to indicate how adequate they believed their training was in preparing them to allocate the IFI in their clinical work. Figure C3 shows participant responses to this question. Approximately 85% of participants indicated they thought their training was either ‘totally’ or ‘mostly’ adequate.

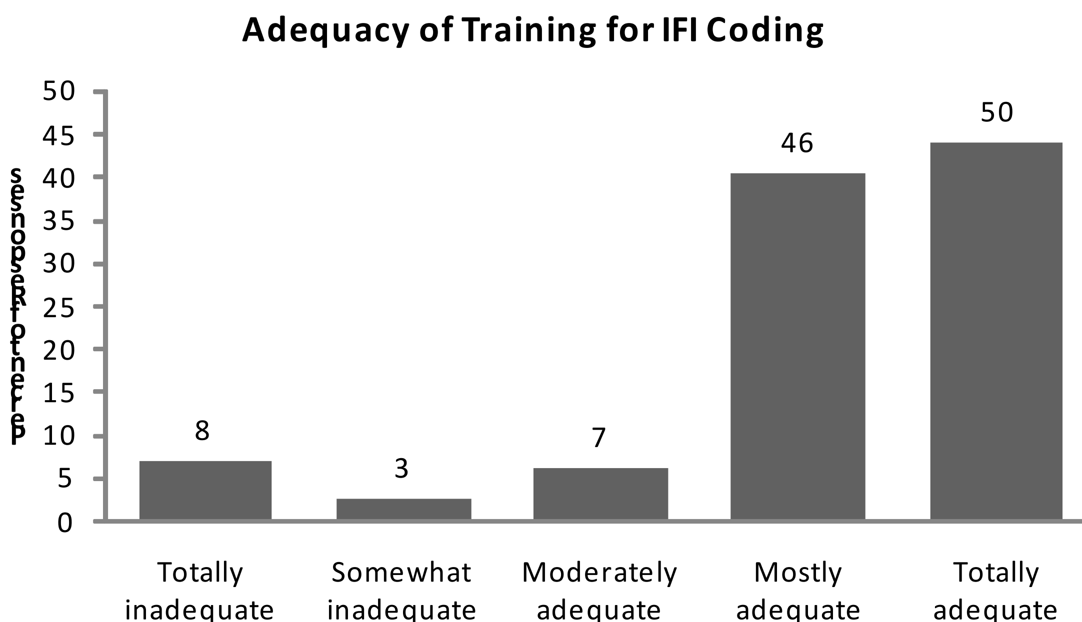


Figure C3. Adequacy of training for IFI coding

Participants were also requested to specify any aspects of the IFI coding process that were not covered in the training that may have been useful to include. Thirty-one participants specified some aspect of the training they thought could have been improved. A thematic analysis of these responses revealed five major themes.

1. Eight responses alluded to the need for *more specific examples* to be included in the training. The case examples used in the training were multidisciplinary and therefore contained quite general information for each of the professions. Examples of participant responses reflecting this theme are “*more specific examples of disease states and the codes to use”,* and *“more therapy specific/individual training would be better in future to ensure awareness/understanding of the codes”.*

2. Often related to the need for more specific examples, seven clinicians specified a preference for some profession-specific training or at minimum some profession-specific ‘back-up’ to clarify certain issues (note that this was available at all times throughout the pilot study through the profession representatives from NAHCC).

Examples of responses expressing a need for profession specific training are "*examples of profession specific coding dilemmas"* and *"I would have found a discipline-specific training more relevant".*

3. Four responses referred to coding difficulties either in general, or by giving specific coding difficulties from their practice that may need to be clarified in future training. For example one response indicated the need to know what to do when *"there might be many codes and none of them fit your intervention"*. More specific responses include; *"difficult scenarios where* (there are) *mobility issues from body function or activities for environment"* and *"code for developmental assessment needs for children, lacking codes for paediatric assessment for infants"*.

4. Three responses related to the need for more background and contextual information. That is, the need for more understanding of the purpose of the codes or of the background to the general study. One response was *"more about the purpose of the coding system so that we fully understand the implications of coding a patient a particular way".*

5. Two responses focussed on the need for the training to further emphasise that there will be *more than one 'correct' IFI code* for any case. Individual responses also underlined the need for training to *differentiate between similar codes*, *choosing the correct 'clinical setting*' in the demographic information about the patient, and how much *weight to give to the secondary IFI code* when allocated.

Support Officers were generally supportive of the group IFI training. There was some discrepancy in their views however about the depth of background needed in regard to the IFI project. A detailed description of the development of the IFI concept and the need for this data item was provided during the training. Some Support Officers felt this was imperative in gaining the participation of the clinicians stating that clinicians "*had good internal motivation because they could see the purpose of it because of the background information provided in the training".* Others disagreed; "*the training was perhaps too in-depth for the participants"* and *"clinicians often wanted a brief snap-shot of the 'how-to' and the training needed more on this rather than background information".* One Support Officer stated that the desire for more or less background information varied between clinicians. The Support Officers also stated that other aspects of IFI coding that needed to be clarified in training were; whether primary and secondary IFI codes should be weighted in importance and how to differentiate between similar codes.

IFI Data Entry

Facilitators and barriers to IFI data entry

Support Officers were asked to identify facilitators and barriers to clinicians' ongoing IFI data entry. These are listed below.

Facilitators

- Having managers that were interested in the project, providing encouragement, support and 'downward pressure'

- Being provided with specific feedback on coding progress both individually and as a participating site compared to other sites

- Encouraging 'friendly' competition between professions to enter more data than other professions. This requires profession-specific tallies and feedback,
- Understanding the purpose of the study by providing background (internal motivation)

- Face-to-face contact with the Support Officer ("rubbing shoulders with colleagues"). This was evident in that the department in which the Support Officer worked generally entered the most data at that site)

Barriers

In addition to the lack of the facilitators listed above, the other barriers to data entry included:

- Heavy workload, particularly following holidays and trying to catch up, and
- Little access to computers, especially between patients.

Accessing the IFI code set

Participants in the feedback questionnaire were asked various questions to identify the primary means they used to access the IFI code set for coding.

The IFI coding manual

Participants indicated whether they thought the IFI coding manual was a useful tool to assist IFI coding by selecting from a set of statements. Reponses to this question are shown in Figure C4. Almost one-third of participants indicated they thought the manual was 'very useful'. Of all respondents 70.2% indicated that the manual was either 'moderately', 'very' or 'extremely' useful. Figures above the columns show the number of participants indicating that response while the columns represent the percentage of all responses in that category as a fraction of all responses.

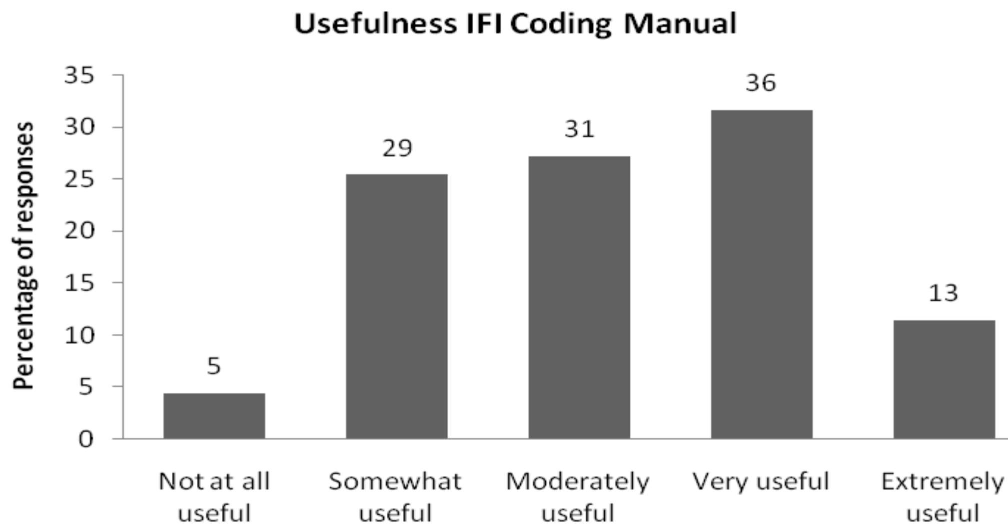


Figure C4. Usefulness of the IFI Coding Manual

Means of accessing the IFI code set

Participants were then asked to indicate which means of accessing the IFI codes they had used throughout their data collection. The results of this question are shown in Figure C5. As participants could indicate more than one means of accessing the code set the total is more than 100%.

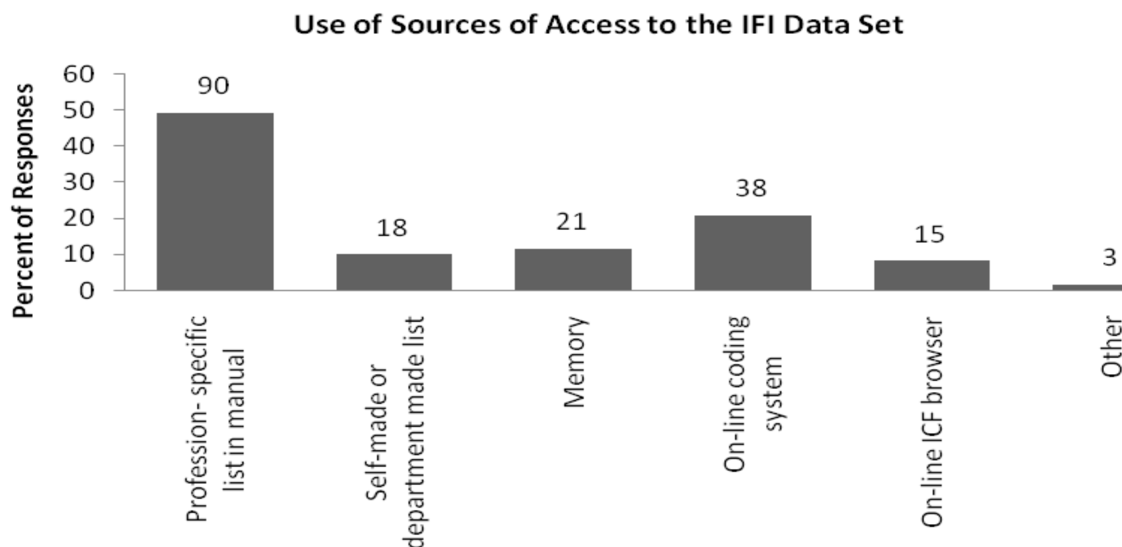


Figure C5. Means of Accessing the IFI Code Set

‘Other’ means of accessing the codes were *“discussion with other colleagues”, “discussion with others”, and “other professional lists”* (this refers to accessing other profession-specific lists from the manual).

Primary means of accessing the IFI codes

Participants were asked to indicate the *primary* means of accessing the IFI codes that they used throughout the coding period. The profession-relevant lists in the IFI Coding Manual were by far the most frequently used means of accessing the codes with 52.6% of participants indicating this was their primary means of access. Figure C6 shows the percentage of use of all other means.

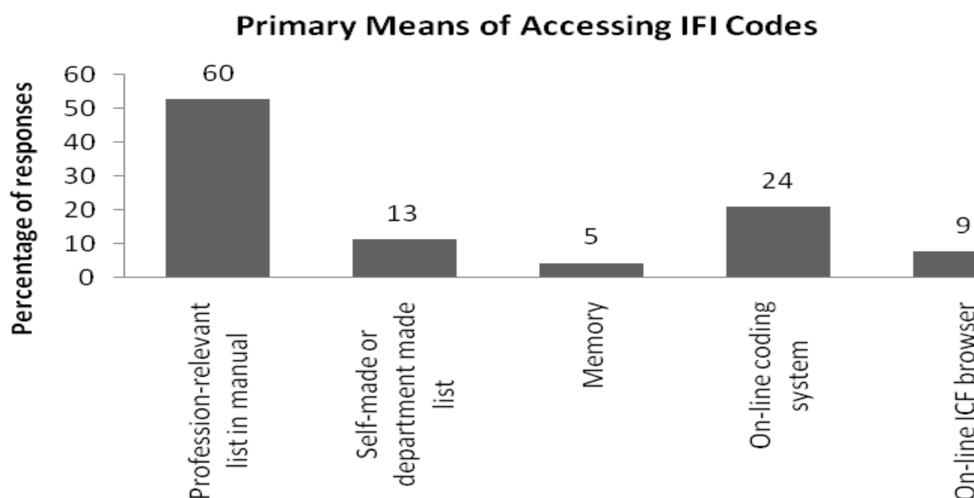


Figure C6. Primary Means of Accessing the IFI Code Set

Time taken to enter IFI data

Of the 114 participants who completed the feedback, 113 participants estimated approximately how long it took to select and enter each IFI data entry. This estimate was an average of the time taken, and clinicians completing the IFI coding could have been using any method of data collection. These included collecting hard copy data and entering it on-line, entering the IFI selected directly, or just using the hard copy sheet and having someone else enter the data. Using any of these methods 85% of participants indicated the IFI coding process took less than two minutes. The results of this question are illustrated in Figure C7.

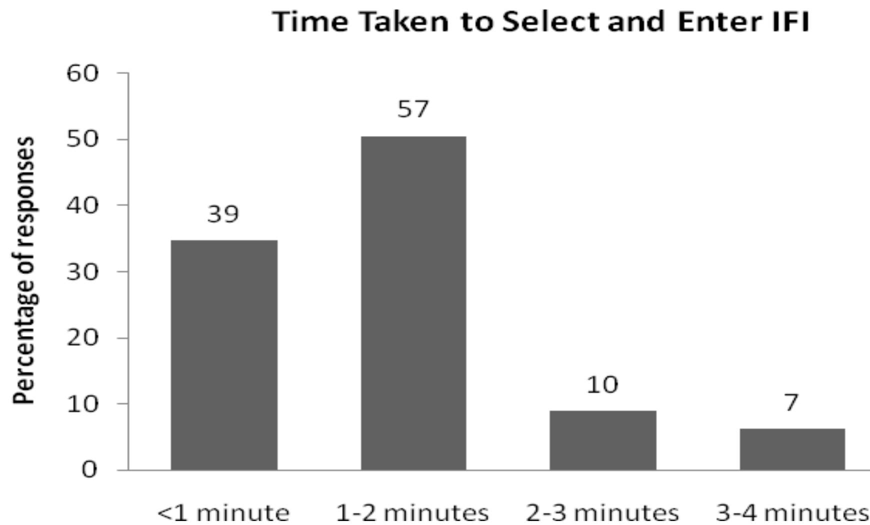
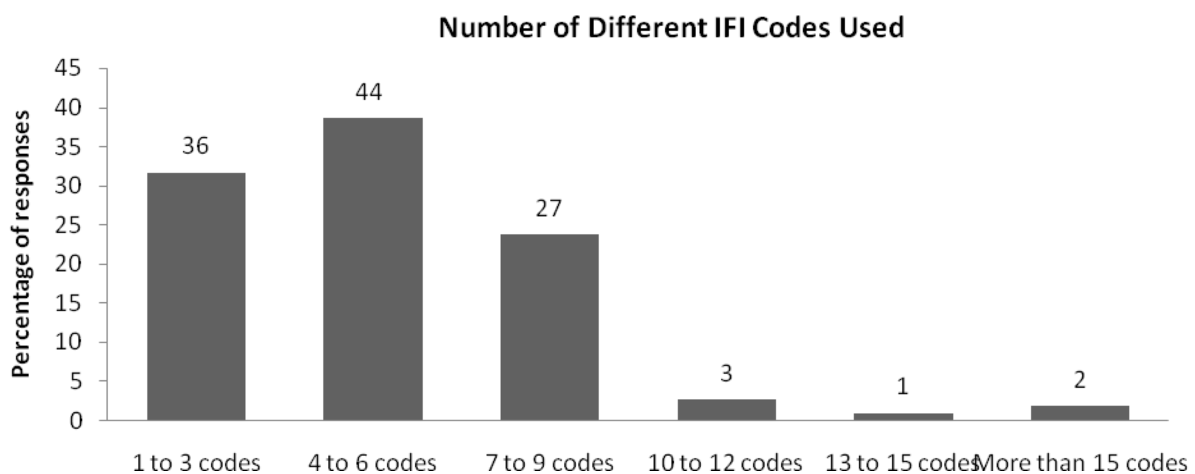


Figure C7. Time taken to select and enter IFI data

Use of the IFI codes

Number of IFI codes used by individuals

Clinicians participating in the feedback study indicated the total number of different IFI codes they thought they would have allocated throughout the coding period. Of all respondents 93.9% indicated they used less than nine codes in total. Figure C8 shows the pattern of results for this question.



FigureC8. Total number of different IFI codes used by individuals

Confidence in the accuracy of IFI coding

Participants in the feedback questionnaire indicated their level of confidence in the accuracy of their IFI coding. Approximately half of participants (50.9%) indicated they were 'moderately confident'. The percentage of participants who indicated being either 'moderately', 'very' or 'extremely' confident was 79%. The percentage who stated they were either 'somewhat' or 'not at all' confident was 19.3%. Responses to this question are shown in Figure C9.

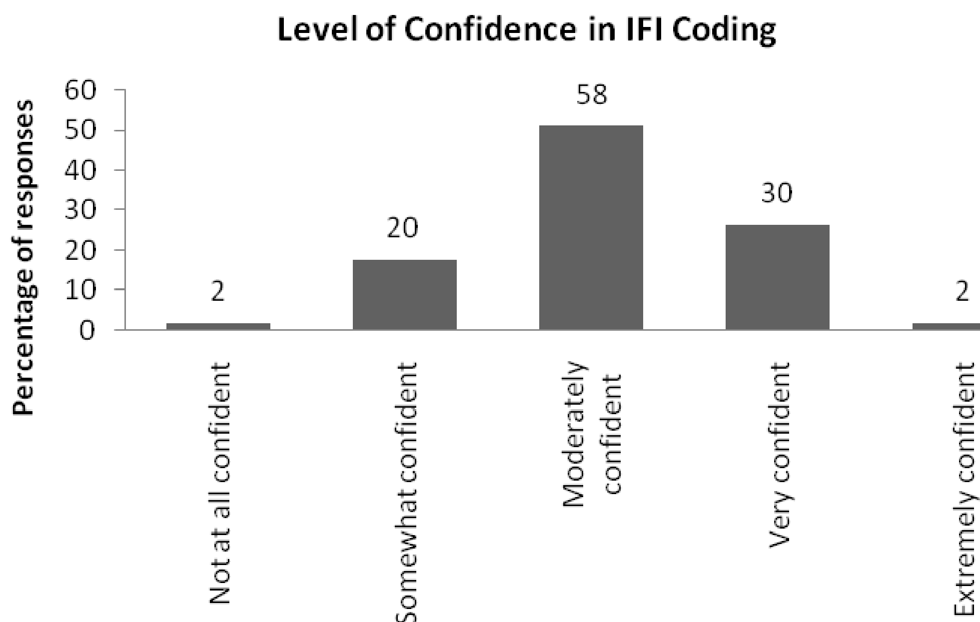


Figure C9. Confidence in the accuracy of IFI coding

Difficulty of allocating the IFI Codes

Feedback questionnaire responses to the question *"how would you rate the general difficulty of allocating the IFI in your clinical work?"* elicited a range of responses. These responses are shown in Figure C10.

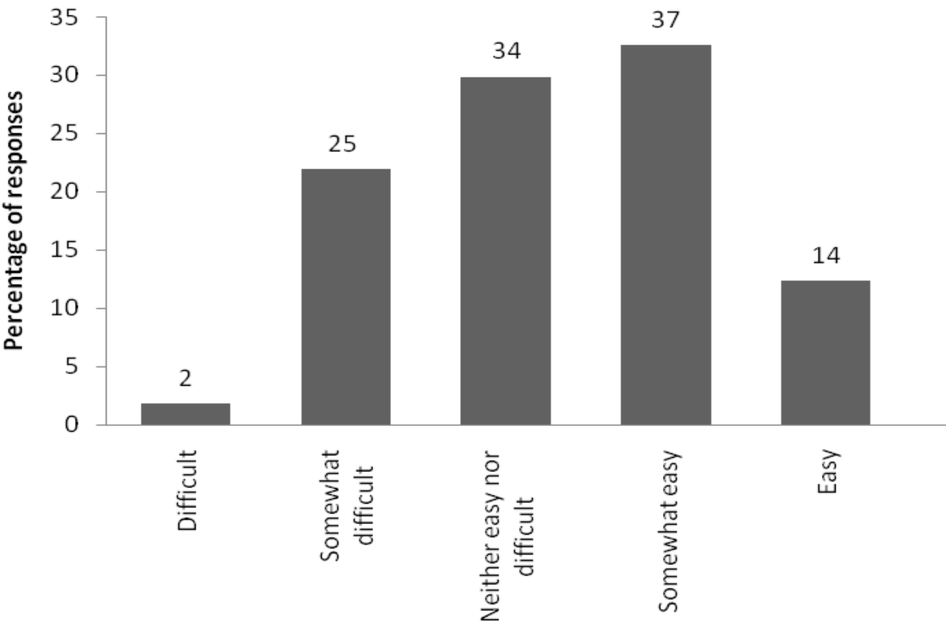


Figure C10. Difficulty of allocating the IFI codes

Usefulness of the IFI as standard Allied Health Care data

The final categorical question in the feedback questionnaire asked clinicians to choose the statement that reflected how useful they thought the IFI was as a standard item in allied health data collection. The responses to this question are shown in Figure C11. Of all respondents 74.1% indicated that they thought the IFI was between moderately and extremely useful to collect as an allied health care data item.

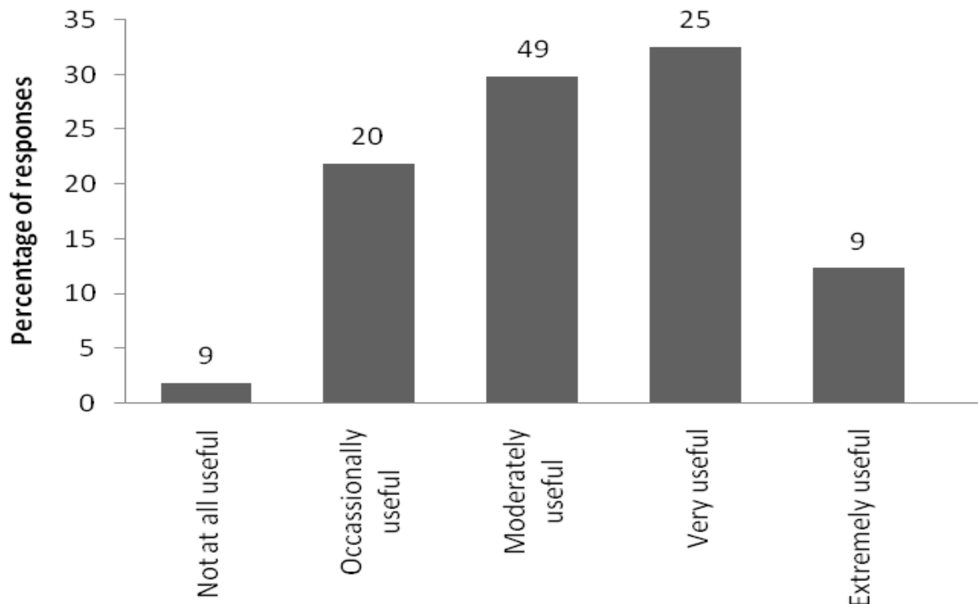


Figure C11. Usefulness of the IFI as a standard Allied Health data Item

'Gaps' in the IFI codes

In the participant feedback study close to half of participants (49.1%) indicated that they felt there were 'gaps' in the IFI codes which made it difficult to suitably allocate an IFI code to particular areas of their clinical practice. The remaining 50.9% indicated that they found no gaps.

Participants were able to specify what gaps they had found in the IFI codes that made it difficult to code aspects of their practice. There were 53 responses to this question. Thematic analysis of these comments identified five issues that were referred to by more than one individual.

1. The most common coding difficulty identified by nine participants related to allocating an IFI code when a patient had been referred for some sort of general, or *standard assessment*, for a 'blanket referral' or 'routine' assessment. Some of the comments in this regard include:

    - *"assessment of mental state"* (Neuropsychology),
    - *"general psychosocial assessment"* (Psychology),
    - *"home and safety assessments"* (Occupational Therapy),

- *“routine checks for anything… the patient doesn’t know why their doctor has referred them”*,
- “*assessments of foot health to determine if the person is high or low risk”* (Podiatry), and
- *“a range of possible deficits following injury”* (Neuropsychology).

This was also a common issue that was raised both in the training sessions and throughout the duration of coding. Another similar coding issue raised through the Support Officers was related to coding assessments for premature babies. These babies undergo a standard assessment to identify their level of functioning following their birth. This is a standard assessment process and clinicians found it difficult to allocate an IFI code as it is a screening procedure with no particular indicators leading to it other than the baby is premature (for which there is no specific IFI).

2. The second most commonly referenced theme in the feedback was that participating clinicians found the use of the *three-digit level of codes* (e.g. d230) *too general*. Clinicians often referred to the codes as ‘*vague*’, ‘*overlapping*’ or ‘*not specific enough*’. These perceived characteristics of the IFI codes led to confusion about which would be the most appropriate code and frustration because clinicians did not feel their workload, time spent and clinical role were adequately represented by a number of codes at the three-digit level. For example, dietitians, both in this feedback questionnaire and in feedback through the Support Officers, were frustrated by using the code *b530 – Weight maintenance* for a variety of their patients. These patients may have been underweight, overweight, or needing to maintain their weight. The dietitians felt misrepresented and that each of these issues was linked to very different interventions and treatment demands.

3. Another commonly identified area of concern was the clinicians’ difficulty in allocating appropriate IFI codes when there were *multiple presenting problems of equal importance*. This difficulty may have arisen either because participants could allocate a maximum of just two codes, or because the more general IFI codes did not encompass the presenting issues adequately. Five responses indicated this to be the primary concern. Examples of comments falling under this theme include *“difficult to prioritise IFIs sometimes when many options were present that could have been accurate”* and *“some gaps in multiple interventions – may work on strength, endurance, balance…”.*

4. Five participants outlined *psychosocial issues* that were particularly problematic in their coding. These psychosocial issues were *“palliative care”, “grief, loss, death/dying”, “psychosomatic/conversion”, “termination of pregnancy counselling, under aged child having consensual relationship with an older man, complex*

relationship counselling couple sessions….", and "*problems that seemed to relate to borderline personality disorders that also have a physical function component".* The identification of these types of issues may highlight either/or the need for more intensive training for clinicians intervening in these types of issues, review of the IFI codes to identify whether such complex issues can be adequately coded with this data set, or review of the ICF code set.

5. Another specific issue identified by three participants as being problematic for coding relate to issues around child development and paediatric interventions. For example *"paediatric language disorders"* and *"developmental needs of children, particularly for infants/toddlers".* This particular issue may be overcome by access to the recently released ICF data set for children.

Other specific issues which clinicians had difficulty coding, each cited by two clinicians were: *"lymphodaema", "diabetes", "tracheostomy",* issues related to *"falls and falls prevention",* and with the code "*s760 – Trunk used to cover both thoracic and lumbar spine"*.