

# AUSTRALIAN ALLIED HEALTH FORUM

## Australian Allied Health Forum response to the Advisory Group's Consultation on Primary Health Care established by the Australian Government

### Background

Overall Australia delivers a high quality health system. Like all other jurisdictions it faces the challenge of responding to the shift in burden of disease to chronic long term conditions.

The impact of this epidemiological shift is escalating costs, unmanageable demand, perceived and real shortages of workforce. The effectiveness and appropriateness of episodic care is challenged and internationally the funding of health care is in the process of evolving from reimbursing activity to an emphasis on value for population health outcomes. This signals the need to move away from a system that was developed to manage infectious disease and trauma on an episodic or one-off basis.

Nearly 35% of Australians aged 45 years and over have two or more lifestyle –related chronic conditions. Co-morbidity requires radically different approaches to alter both the cost and demand pressures on our health institutions **and** the implications of chronic ill health on individual's labour and social participation<sup>1</sup>.

The wide-ranging disciplines representing allied health constitute a large and rapidly growing healthcare workforce in Australia. Comprising around 25% of the health workforce, Australia has nearly 154,000 registered allied health practitioners, a figure that increases significantly when allied health practitioners from self-regulated professions are included.<sup>2</sup> AH together with medical and nursing constitutes the three pillars of the patient care workforce.

AH practice in an evidence-based paradigm, providing diagnostic capability, functional restoration and improvement in quality of life. This is focused on the need for effective ways of keeping people healthy in their homes and actively connected to family and community, returning them to work and other life functions, for better social and economic participation. These social determinants all have an impact on the individual's health status and population health outcomes. AH's contribution to health, well-being and wealth creation is made along the continuum of care and therefore, takes a whole of health view. This recognises the absolute need to expertly manage those with the highest needs, to help people maintain function and independence, and support those with early risk factors to prevent them becoming the future 'tip of the complexity triangle'<sup>3</sup>.

AH have tested and applied early intervention, cost-efficient workforce models and effective clinical and health pathways, which demonstrate significant effects on costs, demand pressures and supply of workforce. Examples are:

1. **reduced waiting times** for specialist surgical outpatient appointments for management of foot and ankle pathologies, avoiding costly and invasive procedures: triage to early podiatry conservative management from the non-urgent category of the waiting list resulted in a reduction across three hospitals of between 23% and 49.7%, increased timeliness and improved patient flows<sup>4</sup>
2. **minimising deterioration with lower cost, early interventions:** Exercise and strength training for knee OA are highly cost-effective interventions of (< \$5000/QALY), whereas OA interventions that have been shown to be ineffective (for example, arthroscopy) should be targets for redistribution of healthcare resources.<sup>5</sup>

<sup>1</sup> Rimmer, M. Balancing the health budget: chronic disease investment pays big dividends. The Conversation.

<https://theconversation.com/balancing-the-health-budget-chronic-disease-investment-pays-big-dividends> (accessed Aug 27 2015)

<sup>2</sup> AIHW Allied Health Workforce 2012. National health Workforce Series 5. Cat.no. HWL 51. Canberra : AIHW (accessed 4 May 2105)

<sup>3</sup> The Wellness / Illness Pyramid originally conceived by Kaiser Permanente: see page 50 Background Paper McKinsey and Co

<sup>4</sup> Homeming LyndonJ et al. 2012 **Orthopaedic podiatry triage: process outcomes of a skill mix initiative** *Australian Health Review*, 2012, 36, 457–46

<sup>5</sup> Segal, I. 2004. Can we reduce disease burden from osteoarthritis? An evidence-based priority-setting model. *MJA* 204; 180: S11-S17



# AUSTRALIAN ALLIED HEALTH FORUM

- Physiotherapy triage and conservative management for people with shoulder or knee injuries showed more than 75% of the patients referred by primary care physicians did not need to see the surgeon and were managed by an experienced orthopaedic physiotherapist with impact on unnecessary referrals<sup>6</sup>. About 70% of diabetic amputations are avoidable and podiatry plays a significant role in this prevention<sup>7</sup>.
- 3. reduced medications errors** providing potential large cost savings at health service level where approximately 28% of adverse drug events are preventable (Bates et al): The Alfred Pharmacy initial 12 month pilot of the Advanced Practice Pharmacists Partnered Pharmacist Medication Charting model among 549 patients demonstrated a very low error rate of 1.47 per 1000 medications charted compared to literature reported rates of 13.1 per cent where medications are brought into hospital with the patients and 25.5 per cent where no medications are brought in (MJA 2009, Austin Hospital). In particular there was a 76.5% reduction in medication errors reported in the ICU.
  - 4. reduced admissions:** the SA Chronic Disease Community Program 2005 – 2008 enrolled 689 older patients with two or more comorbidities into a multi-disciplinary and multi-model evidence-based service; for 289 there was a 59% reduction in the (frequent) readmission rates when compared pre and post intervention. This program also wrapped services around consumers to enhance the ‘plan in’ and ‘pull out’ of hospital capacity, reducing costs for services and consumers alike.
  - 5. prevention of risk factor impact:** the economic evaluation of the Intensive Lifestyle Change (nutrition and physical activity) to Prevent Diabetes showed that it performed “exceptionally well” and appeared cost-effective relative to societal norms<sup>8</sup>.

However, AH and these tested models are largely overlooked at the systems level and represents a major untapped resource, particularly in the primary health care arena.

Given the challenges faced by the primary health care system in managing chronic and complex care, and the principles of health reform<sup>9</sup>, the AH workforce must be able to function at its full scope and range of services.

Primary health care is typically delivered in the community and as a consumer’s first contact and main source of health care. It is a multidisciplinary and multi-modal system<sup>10</sup>.

It is recognised that AH as actors on their own, as with all other disciplines, are unable to achieve the comprehensiveness demanded by the very nature of complexity and chronicity. AH professions can play an indispensable role in development of collaborative models. As many AH are also private practitioners, a greater level of cooperation or collaboration will be needed across primary and secondary settings to achieve change.

Given the right enablers and a commitment to fully harness AH, this workforce have the tested capability to enhance the four following areas and be used (together with their nursing and medical counterparts) as a greater strategic resource in the effective management of chronic and complex care<sup>11</sup>:

- 1. Improving quality of care**
- 2. Improving consumers’ experience of primary health care**
- 3. Improve access to primary health care**
- 4. Reducing the rate of health care expenditure**

<sup>6</sup> Napier et al. 2013 A Physiotherapy Triage Service for Orthopaedic Surgery: An Effective Strategy for Reducing Wait Times. Physiotherapy Canada 65 (4) 358-363

<sup>7</sup> See Diabetic Amputations in Australia Infographic [https://www.facebook.com/permalink.php?story\\_fbid=534681449934601&id=155549374514479](https://www.facebook.com/permalink.php?story_fbid=534681449934601&id=155549374514479)

<sup>8</sup> Dalziel K and Siegal L 2007. Time to give nutrition interventions a higher profile: cost-effectiveness of 10 nutrition interventions Health Promotion International, Vol. 22 No. 4

<sup>9</sup> Health reform principles agreed by COAG: Communique 17 April 2015

<sup>10</sup> How can Australia Improve its primary health care system to better deal with chronic disease. McKinsey & Company 2015

<sup>11</sup> Philip K 2015. Allied Health : untapped potential in the Australian health systems. AHR 39, 244-47



# AUSTRALIAN ALLIED HEALTH FORUM

Current reforms and AH are focused on system improvements to provide best care for the people with multiple and/or complex chronic conditions by strengthening primary health care to prevent avoidable deterioration at any point of care and unnecessary hospitalisations.

The broad principles used in this paper by AH are aimed at driving the best possible outcomes, health status and community participation for people with chronic conditions. They include:

- care at the right point and time
- efficiently targeting health system resources which stratifies risk, but importantly manages both 'ends of the risk spectrum', focusing on wellbeing as well as illness management
- delivering value for money and eliminates waste;
- preventing avoidable deterioration and unnecessary hospitalisations through early intervention
- promoting alignment of incentives with health outcomes
- coherent team-based approaches to avoid repeating the consequences of deconstruction (fragmentation and specialisation) as with the current response to complexity
- optimising scopes of practice, supported by clear multi-disciplinary roles and meso-level structures<sup>12</sup>
- predictable and consistently applied evidence based care in local pathways
- harnessing the workforce capacity through partnerships and linkages
- enabling consumers to exercise choice in managing their health outcomes better<sup>13</sup>.

Better outcomes critically rely upon on service providers aligning their goals and working together supported by financial flows, which incentivise coordination and different behaviours<sup>14</sup>.

## Improving quality of care

**Key issues: reducing clinical variation; providing evidence-based care at the right time to improve peoples' quality of life through full AH engagement and spectrum of care; and multidisciplinary care.**

### a. Reducing clinical variation

AH work in an evidence-based, problem solving paradigm<sup>15</sup> and should be fully harnessed as a key contributor to the application of evidence and continuous practice improvement processes of a genuinely multidisciplinary primary health care team.

The development and application of clinical pathways by AH improve health outcomes and reduce variations in care. This methodology is the key to effectively harnessing the full impact of AH and the comprehensive range of those disciplines.

The evidence base for management of Diabetes is for early intervention services to prevent harm and deterioration. The following example of clinical application of evidence were provided in 2007 and yet this AH intervention is still not be viewed as mainstream care in primary health care.

The use of Intensive Lifestyle Change (nutrition and physical activity) to Prevent Diabetes, The economic evaluation of this amongst 9 other nutritional programs showed that it performed "exceptionally well". All interventions subject to economic evaluation appeared cost-effective relative to societal norms.

<sup>12</sup> Nelson S, Turnbull J, Bainbridge L, Caulfield T, Hudon G, Kendel D, Mowat D, Nasmith L, Postl B, Shamian J, Sketris I. (2014) Optimising Scopes of practice. New Models of Care For a New Health Care System: Report of the Expert Panel appointed by the Canadian Academy of Health Sciences:

<http://www.caahs-acss.ca/optimizing-scopes-of-practice-new-models-of-care-for-a-new-health-care-system/>

<sup>13</sup> Excerpts from 17 April 2015 COAG Communique and Federation White paper Discussion paper

<sup>14</sup> One person, One team, One System: Report of the Independent Commission on Whole Person Care . Feb 2014 <http://www.yourbritain.org.uk> (accessed 7/3/14)

<sup>15</sup> Allied Health Professionals Australia (AHPA). Definition of Allied health, 2015.



# AUSTRALIAN ALLIED HEALTH FORUM

Nutrition interventions can constitute a highly efficient component of a strategy to reduce the growing disease burden linked to over/poor nutrition<sup>16</sup>.

There is an increasing body of published cost-utility analyses of health interventions. It would seem for any given condition, modality or setting there are likely to be examples of Interventions, which are cost effective and cost ineffective. It will be important for AH and the PHC system to (fund) and continue to develop evidence of economic value of interventions (discarding those practices that are not cost effective) so that decision makers do not have to rely on broad generalisations<sup>17</sup>.

## b. Harnessing the full spectrum of AH primary health care services

Other health referrer or user groups generally have a poor understanding of AH.

In 2013 the Australian Medicare Local Alliance identified a need to publish a guide for members so that " the unique depth and breadth of skills, knowledge and roles of Allied Health professions are understood, valued and appropriately utilised within the development and delivery of primary care"<sup>18</sup>. In 2014 PHCRIS focused an entire research round -up to understand the role and contribution of AH, creating better visibility for the primary health care system<sup>19</sup>.

Workforce planning is usually predicated on large volume workforce groups to ensure the efficacy of the modelling. AH have received less attention because of the relatively small numbers of the component disciplines. This affects workforce planning and visibility for AH and it is critical that being a "small number" does not mean there is a lack of recognition that AH roles are essential links in the health care chain

AH service outputs and points of care explicitly cover the need to be responsive to both high end users (comorbidity and frequent users of hospital care) and those early at risk requiring a higher investment to prevent onset or minimise risk and maintain health for as long as possible and compress morbidity<sup>20</sup>. AH's *whole system view* is provide through a comprehensive range of services and across their disciplines often as co-workers for the 3 major transition points in chronic and complex care (see Figure 1).

<sup>16</sup> Dalziel K and Segal L 2007. Time to give nutrition interventions a higher profile: cost-effectiveness of 10 nutrition interventions Health Promotion International, Vol. 22 No. 4

<sup>17</sup> Dalziel K et al. 2008. **Review of Australian health economic evaluation – 245 interventions: what can we say about cost effectiveness?**

<sup>18</sup> Australian Medicare Local Alliance. (2013). *Guide to Allied Health in the Primary Care Setting*. AML Alliance: Canberra. [http://www.actml.com.au/programs/allied-health/amla-guide-to-ah-professions-in-the-primary-care-setting\\_20140102133953.pdf](http://www.actml.com.au/programs/allied-health/amla-guide-to-ah-professions-in-the-primary-care-setting_20140102133953.pdf)

<sup>19</sup> Raven M. (2014). Allied health practitioners in Australian primary health care. RESEARCH ROUNDup Issue 38. Adelaide: Primary Health Care Research & Information Service <http://www.phcris.org.au/publications/researchroundup/issues/38.php>

<sup>20</sup> Fries James F et al. 2011 Compression of Morbidity 1980–2011: A Focused Review of Paradigms and Progress Journal of Aging Research Volume 2011 (2011), Article D 261702

<sup>16</sup> Vale MJ, Jelinek MV & Best JD. Impact of Coaching Patients on Coronary Risk Factors: Lessons from The COACH Program. Disease Management and Health Outcomes 2005; 13(4): 225-244 (review).



# AUSTRALIAN ALLIED HEALTH FORUM

Figure 1: Allied Health services across the wellness/ illness pyramid

Stage of Chronicity	Example of AH Interventions
At risk - early identification and intervention, lifestyle changes/ coaching	Self-management: Stanford Lorig or Flinders Partners in Health (collaborative goal setting, working with your health professional, exercise, nutrition, relaxation, fatigue management) Health Coaching Peer Support programs eg SA mental health peer support program (FU) Early detection of risk factors through first point of care (PT/ exercise, Dietetics, Podiatry, Aboriginal Health Workers, community care workers & AH assistants)
Diagnosed Chronic disease - functional restitution, harm minimisation, long term monitoring, education and motivation	AH provide a range of bio-medical, physical and functional tolerance, nutrition, and psycho-social programs to restore and maintain health and well-being and decrease bio-medical factors whilst living with a chronic condition. Multidisciplinary Podiatric Clinic for high risk feet (Prince Charles Hospital Queensland) Connecting Care - NSW Integrated – hospital avoidance BAC Victoria – AH conservative management and review in the community as alternative to lengthy specialist WL MNHHS Brisbane AH service models as <i>first point of contact care</i> on 6 surgical specialty waiting lists Victorian Advanced Musculoskeletal Physio- telehealth program Barwon Health – telehealth program Chronic Disease Community program (CDCP) (SA) coordination and evidence based service organisation for people with 2 or more CD – hospital avoidance Telephone Coaching in risk factor self-management (adapted for CDCP – AH and Nursing <sup>21</sup> ) and Tele-Rehabilitation (Qld) Silver Chain WA – comprehensive coordination of care
People with comorbidities high risk, high cost frequent users – specific interventions; care coordination or case management	AH contribution to plan in / pull out and post discharge subacute care eg Victorian project on HACC and AHA discharge coordination Collaborative OA Chronic Care program multidisciplinary teams led by musculoskeletal coordinators (PTs) <sup>22</sup> Silver Chain WA , AH led Home Independence Programs Care Coordination and Supplementary Services (CCSS) program for Aboriginal and Torres Strait Islanders WA Musculoskeletal Health Network : 4 MoC – Inflammatory Arthritis Model of Care ; spinal pain; osteoporosis; elective joint replacement

## c. AH participation in Multidisciplinary Care

The effectiveness of a multidisciplinary team will require both meso - level (governance, CQI processes and technological enablers) and micro- level structural changes ( team and professional cultures communication and infrastructure) to ensure the 3 pillars of the workforce, and indeed the consumers, are a party to reducing clinical variation and ultimately reducing avoidable hospital admissions.

These enablers include:

1. AH should be integral to the outcomes of a Primary Health Care ‘health home and enrolment’ or GP Practice, as opposed to a referred service via GP Team Care Plan.

Levels of AH participation may be cooperation or linkage, or collaboration, or full integration (a combination of processes, methods and tools)<sup>23</sup> and will depend on the risk stratification or “consumer segmentation” of the population health region

Care coordination, considered more fully in section 2 , will be a quality improvement strategy as well as

<sup>22</sup> PHCRIS. 2014. AH integration: collab care for arthritis and other mskc conditions. 2014 pg 19

<sup>23</sup> Goodwin N and Smith J. 2011. The evidence Base for Integration .The Kings Fund and Nuffield Trust



# AUSTRALIAN ALLIED HEALTH FORUM

one that may reduce costs long term

2. Better targeting of the financial incentives (for example PIP) more explicitly linked to demonstrable quality improvements gained from the whole-of-workforce contribution, where Medical, Nursing and AH are consistently required to contribute to outcomes.
3. Transparent and shared access to patient and service data to:
  - enable team cooperation/ collaboration to participate in continuous practice improvement and comparison of outcomes, and
  - model risk stratification and responses.

Useful examples of risk stratification and responses are the UK: South Devon and Torbay Virtual Wards and predictive models<sup>24</sup>, and the Victorian Hospital Admission Risk program.

Therefore, AH must be integrally involved in collaborative processes to develop and use escalation and de-escalation triggers, critical in long term condition management. An effective vehicle is the use of the Australian Primary Care Collaborative processes (for example Diabetes Management), which in the past have been supported by The Divisions of GP and Medicare Locals, but remains entirely a GP focus and not universally adopted across all practices.

## Improving consumers' experience of primary health care

**Key issues: Allied health participation in care coordination, team based care and local patient pathways; moving to client centred care**

Chronic condition care needs are different to other health needs. They are complex and long term. They require multiple professional interactions moving away from disease specific approaches, recognising the importance of shared health determinants and risk factors. They are also characterised by the need for intensive periods of intervention as well as monitoring and education over time.

Successful management not only requires active engagement of all the three pillars of workforce but also the increased role of the private health insurers, technology, and multidisciplinary models of care. Given the range of disciplines, the spectrum of their services and skills in implementing complex service interventions, AH roles very often depend on interfaces across care teams and across sectors of care, and they are highly skilled in this domain.

As such, "integrated care" would seem to be a strong platform for AH. The challenge is to ensure that there is coherence. Whilst there is relatively good information on public sector AH and registered professions in Australia, there is less focus on ensuring private sector AH can optimise their contribution to be an equal part of the integrated solution in primary health care. There is also less rural and remote 'proofing' of policies, which are meant to incentivise AH presence (in the bush) or provide meaningful workforce data to address inequities in access and the ability to improve the consumer's health experience.

Both integrated and coordinated care is a strong platform for optimising allied health workforce contribution to the primary health care management of chronic and complex care.

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<sup>24</sup> Goodwin, N et al. 2013. Co-ordinated care for people with complex chronic conditions. The Kings Fund



# AUSTRALIAN ALLIED HEALTH FORUM

The capacity of the primary health sector to manage a more complex health population depends on:

- optimally using all the workforce resources
- engaging with the continuum of care from the high cost end where most pressure is felt by acute services to early identification of risk or deterioration and intervention at any 'point of care', and
- institution of self-management and health literacy

Care coordination and care-coordinator roles are not a one-size-fits-all model.

AH skills and expertise noted previously should be used to optimise outcomes for people that:

- frequently move between primary and specialist care settings
- that have a diagnosed long term condition but are a targeted population experiencing greater health inequity
- with a specific chronic condition, but have risk factor for multiple long term conditions
- may have difficulty navigating the health system due to social and/or cultural determinants, thereby limiting access.

**Care coordinator roles** are not discipline specific, nor a registered discipline. These roles encompass an understanding that:

- many chronic conditions share common risk factors and are often risk factors for each other; these factors are demographic, behavioural, biomedical and social determinants
- the need to address a broad range of conditions and move away from the disease specific approach , recognising the importance of shared health determinants and risk factors
- increasing prevalence of multiple comorbidities with need for multidisciplinary models, self-management tools , and skills in minimising duplication and encouraging cohesiveness on behalf of the consumer
- require more time than an individual treatment and
- the need to address cultural and language barriers to gain consumer confidence
- Care coordination places the client at the centre of care, linking together a myriad of services required to meet the complex care needs of an individual with chronic condition/s.
- A care coordinator may be located either regionally or within a primary healthcare home, or indeed work across multiple GPs, depending on population health profile of communities/regions and the available health workforce.

The roles require advanced problem solving skills and relationships, with a broad knowledge of the conditions and factors that are common to all chronic and complex care, and belief and skills in person centred care, person-centred goal setting and self-efficacy.

**Coordination** is everyone's business, but enacted at different levels of competence and expertise. The community front line workers (care worker or allied health assistants) should be up-skilled to be equally cognisant of risk factors and needs of coordination to make timely detection and referrals, but will not function at the expertise of a health professional and/ or Care Coordinator in delivering care.

The need for integration is recognised as relevant for all people with chronic and complex care needs, and most critically for Aboriginal and Torres Strait Islander consumers - "Providing comprehensive primary health care and a core set of services is not always possible within a single service setting. Primary health care that is comprehensive and spans a lifetime will call upon a range of services, including allied health services and other social support networks. The capacity of comprehensive primary care to reduce the health gap faced by the



# AUSTRALIAN ALLIED HEALTH FORUM

Aboriginal and Torres Strait Islander population depends crucially on these necessary services being available, culturally accessible and coordinated<sup>25</sup>”.

**Clinical and local team pathways** will be an essential feature of delivering better health outcomes using a combination of service and workforce models. To enable integrated care changes must occur at the:

- Macro level systems: structures, processes and techniques to reduce fragmentation and to fit with the health needs of populations across the continuum of care
- Meso level organisational integration: coordination of care for particular groups of patients and population via organised provider networks, pooling of skills across boundaries, with standardised referral procedures, service agreements, joint training, and shared information systems
- Micro level management of individuals: through case-managed multidisciplinary team care, with a single point of contact and coordinated care packages<sup>26</sup>.

## **Case study 1: AH and PHC integration for a consumer with co-morbidities.**

“Integrated care has dramatically improved the health of a 64-year-old man in Western NSW with a history of poorly controlled diabetes, hypertension, coronary artery disease and depression. He was attending a hospital ambulatory clinic for dressings following the amputation of a toe on his left foot due to complications from diabetes. The nurse recognised he was having difficulty managing at home. After six weeks of care coordination the patient’s foot healed and he said the various health services and providers involved in his care *“have not only helped me achieve a happier, healthier life, I can honestly say the psychologist has probably helped save my life by referring me to the self-management support group”*.<sup>27</sup>

If the **evidence based clinical pathway** for Diabetes had been applied as an early intervention and as integrated care, it would have provided podiatry management to prevent the catastrophic deterioration in his feet, eye checks, dietetic advice to control his diabetes, psychology for depression and exercise tolerance to maintain cardiac fitness. Each of these disciplines would have recognised and collaboratively managed the common risk factors related to all four conditions.

This is clear evidence where primary health care with AH as a critical element would have been a cost effective approach for the consumer and the system.

**Case study 2: In rural and remote health integration** may mean Shared Care – a team approach to care, with both primary and secondary care practitioners contributing to elements of a patient’s overall package, communicating effectively and working together to make that patient’s pathway through the system as smooth as possible. The Mental Health program is an example which facilitates shared care arrangements between PHC providers (including GPs, Psychologists, Mental Health Nurses and other Mental Health Workers) and specialist services<sup>28</sup>.

**Case study 3:** The WA Musculoskeletal Health Network pathways for 4 models of care exposed the underutilisation of AHP and the multidisciplinary medical, nursing, AH team recommended that at least a physiotherapist, occupational therapist, nurse specialists and social worker should be involved.

<sup>25</sup> 2010-11 AMA Indigenous Health Report Card - “Best Practice in Primary Health Care for Aboriginal Peoples and Torres Strait Islanders”

<sup>26</sup> Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary health care. Pim P Valentijn, Sanneke M Schepman, Wilfrid Opheij, Marc A Bruijnzeels Int J Integr Care. 2013 Jan-Mar; 13: e010.

<sup>27</sup> <http://www.health.nsw.gov.au/integratedcare/Documents/integrated-care-info-summary.pdf>

<sup>28</sup> SARRAH. 2009. Models of Primary Healthcare Services . November 2009



# AUSTRALIAN ALLIED HEALTH FORUM

The following examples demonstrate where AH are key contributors and 'fit for purpose', as part of the integrated, coordinated care team in primary health care.

## Example 1:

Care Point: a partnership between WA Department of Health, Medibank and HBF.

A 2 year trial commencing in 2014 using a mix of dedicated coordinators, care navigators, health coaches, home and community care and nurse triage, aimed at supporting General Practice to plan and facilitate the care of people with chronic and complex needs. A similar Care Point Trial is underway in Victoria.

## Example 2:

The [Care Coordination and Supplementary Services \(CCSS\) Program](#) exists to assist Aboriginal and Torres Strait Islander people with chronic conditions and complex care needs who have a GP Management Plan and are enrolled with a GP under the Practice Incentives Program Indigenous Health Incentive.

Significant points of risk in a person's journey through the health care system arise at times when care is transferred – in particular, at hospital entry and discharge, and in transit from primary care in and out of outpatient specialist and allied health services, rehabilitation, mental health, and other specialised services. The Institute for Urban Indigenous Health 'IUIH CONNECT' assists the patient, patient's family and referring providers to link up care no matter where it is provided.

Working closely with Queensland Health, the Metro North Brisbane Medicare Local, Aboriginal Community Controlled Health clinics on the north side, mainstream general practices and community-based social health and other support services, IUIH CONNECT is a "virtual" program without boundaries. It ensures accessing a care coordinator if a person:

- is at significant risk of experiencing otherwise avoidable hospital admissions
- and not using community based services appropriately
- requires more intensive care coordination than is currently able to be provided by general practice/Indigenous Health Service staff.

The aim of the CCSS program is to provide better access to coordinated and multidisciplinary care in

- provision of appropriate clinical care
- arranging services
- assisting patients to attend appointments
- ensuring medical records are complete and current
- ensuring regular reviews are undertaken by the patient's health care team.

A Supplementary Services flexible funding pool is available to Care Coordinators when access to urgent and essential allied health, specialist or other support services is required.

Hear some of patients yarn about their stories and experiences with the Care Coordination team, including how the program has helped them with their chronic and complex care needs, visit [Aunty Davina Wickham Daylight](#) and [Aunty Colleen Costello](#).



# AUSTRALIAN ALLIED HEALTH FORUM

## **Example 3: Adelaide Health Service- South – Virtual Interagency Network and Complexity manager- 2011<sup>29</sup>.**

The Virtual Teams supported by a virtual interagency network (all sectors and public, NGO and private services, statewide services eg ambulance, disability, aged care and community services) actively working together for the best interests of the clients rather than being a collection of individuals from disparate organisations. The program specifically identified the existence of the many coordinator roles from each organisation / sector and explicitly worked towards an agreed position on distinct roles and pathways to avoid consumer confusion. Core elements of the coordination role ('complexity manager') were the personal abilities/attitudes and skills as opposed to advanced clinical skills.

Essential:

- Skills in advocacy and persistence,
- Ability to foster team work and work collaboratively with key stakeholders

Core elements:

- Advanced communication skills
- Ability to analyse and problem solve complex issues,
- Develop and pursue innovative and practical, strategic and holistic solutions
- Possess a breadth of clinical knowledge across conditions (not a high level of one specific condition) to facilitate interdisciplinary care including impacts of mental health and chronic conditions

Both AH/ Social workers and Nurses were equally effective – and allocated depending on what were the main focus elements (clinical, functional or social) of a person's complex needs.

## **Example 4**

**NSW – Chronic Disease Management Program** also focused on consumers with complex needs and high risk of hospitalisation and exhibited similar features to the SA example.

## **Example 5: Health Care Homes**

Enrolment with 'health care homes' already exists for Aboriginal and Torres Strait Islander peoples and is incentivised by the Practice Incentive Payment (PIP) Indigenous Health Incentive. This aims to support general practices and Indigenous health services to provide better health care for Aboriginal and Torres Strait Islander patients, including best practice management of chronic disease. More information can be found here [Indigenous Health Incentive guidelines](#).

The incentive provides a start-up payment; a registration payment; and an outcomes payment. Registered patients with chronic disease identifying as Aboriginal can then receive:

- care coordination (eg, arranging services required by the patient);
- support to attend appointments (eg, by providing transport);
- supported access to specialist and allied health services;
- lifestyle modification and chronic disease self-management advice; and
- co-payment relief for medicines on the Schedule of Pharmaceutical Benefits.

<sup>29</sup> Final Report : HWA Workforce Innovation and Reform: Caring for Older People Program . **Adelaide Health Service - South** June 2011  
Appendix 23: Key Knowledge Areas and Attitudes Mapped to Roles for Working in the Midst of Complexity



# AUSTRALIAN ALLIED HEALTH FORUM

## Example 6: WA Silver Chain

Provides comprehensive care coordination for older people at home, focusing on health needs, wellness and everyday home and community connection needs. This is complemented by the AH led Home Independence Program (restorative health care) and Personal Enablement for those leaving hospital, delivered by a mix of assistants and professionals.

### The enhancement of Care Coordination and AH participation will require the following enablers in the care of those with chronic conditions and complex care needs:

- Expanding MBS to be more flexible and tailored to a multidisciplinary course of care, and including group work, rather than the current individual consultations,
  - to be at minimum more than 5 visits per year across all AH and not only as a consequence of a GP Team Care Arrangement; those with more complex needs will need in excess of this
  - to include telehealth reimbursement and case conferencing for AH interventions;
  - CW Interpreter services for private AH;
- Those with poorly managed chronic and complex needs, multiple co-morbidities, will require greater and more tailored investment;
- Potential enrolment to a 'primary health care home' to get full value of all health professional services and joint accountability;
- Streamlining and bundling payments to enable innovative and flexible multi-disciplinary services around high need groups and to support the benefits and processes of team care;
- Local care pathways for clear roles and responsibilities around evidence-based practice and management across sectors for example AH 'plan in' and 'pull out' from hospitalisations; and improving referral protocols to ensure patients receive more intensive coordination and support when needed;
- Modifying the PIP Indigenous Health Incentive practice improvement incentives so that they are more explicitly linked to demonstrable quality and practice improvement outcomes;
- Acknowledgement in future incentive programs that primary health care team-based care (inclusive of AH) is central to primary health care<sup>30</sup>;
- Understanding the capacity constraints of Care Coordinators, many of whom currently have high caseloads and need to participate in continuous improvement activities of a team model;
- Ensuring organisational buy in to the use of self-management models of care and the ability to be applied in everyday practice.

<sup>30</sup> PHCRIS. May 2014. Quality improvement financial incentives for general practitioners. Policy Issues Review. <http://www.phcris.org.au> (accessed 23/5/14)



# AUSTRALIAN ALLIED HEALTH FORUM

## Improve access to Allied Health in primary health care

**Key issues: improving gateways to the full Allied Health workforce scope and range of Allied health services; Allied Health use of e-health enablers.**

### Access

Whilst special needs are identified for culturally diverse people including Aboriginal and Torres Strait Islanders, other vulnerable populations (refugee/ homeless), and rural and remote locations, the key access issues may also be relevant to metropolitan services. They are:

- Physical access
- Geographical access
- Economic access
- Discipline access (to AH)
- Cultural access
- Social access (health literacy and social determinants)
- Data access

However, these access issues disproportionately determine whether Aboriginal peoples and Torres Strait Islander people use allied health services.

### Increasing the availability of AH in primary health care

AH is an essential element of the evidence-based practice related to the nature and needs of chronic and complex care to contain costs and improve health outcomes. Increasing the AH availability encompasses:

- Ensuring genuine connectedness of AH to other health care members (more than a referral for a team care plan)
- Full and working understanding by other team members of AH contributions, roles and expectations to ensure client gets right, care, right place, right time and continuity of care
- Addressing culture preferences of GPs such as for nurses as coordinators when they are already a predicted shortfall resource; largely not using pharmacists for HMR and RRMRs; and a lack of engagement in using Enhanced Primary Care items<sup>31</sup>. This may be a culture of traditional ownership and a lack of introduction to outcomes based team work
- Agreed processes to target AH and team efforts. This requires an understanding of the expected outputs of programs ; for example
  - once older persons fall into chronic ill health they tend to stay there with low labour (and subsequently social) participation<sup>32</sup>
  - allocating resources for both high end users and early at risk consumers , which will be applied long term but will not be at the same intensity throughout
- Acknowledgement that harnessing private AH will require local pathways and access to funding (for example CW interpreter scheme) to enable them to work across sectors.

### Structural Support for AH: E Health

The ability for both public and private AH to integrate their function into an evidence-based, integrated team model of primary health care will rely on access to e - health to achieve sufficient scale of input and the anticipated system efficiencies. This will be deployed in:

- Team-based, coordinated care, with integration between primary and secondary care providers, requiring a fully functional digital support platform as an enabler.

<sup>31</sup> PHCRIS. Aug 2014 Allied health integration: Collaborative care for arthritis and other musculoskeletal conditions, pg 27

<sup>32</sup> Rimmer , M. 2015 Balancing the health budget: chronic disease investment pays big dividends. The Conversation 26 Aug 2015.



# AUSTRALIAN ALLIED HEALTH FORUM

AH professionals require full, read and write access to digital records – integrated electronic health record (EHR), shared care plans and clinical decision support tools; and the funding to support full use of digital infrastructure.

The connected team may use e-health for similar functions as the UK ‘virtual ward’ experiences in progress case conferencing and daily targeting of input.

- Video conference technology to support therapy assistants and clients in intervals between services in rural and remote areas.
- Infrastructure and targeted funding for use of telehealth with patients
  - Evidence -based and timed condition reviews
  - Home risk factor monitoring and management
  - Tele-rehabilitation units to enable clients from remote areas access to rehabilitation services to undertake assessment and treatment via portable videoconference facilities with software calibrated to assist with accurate assessment measures<sup>33</sup>.
- Funding of E health participation  
Currently there is funding available under the MBS items and Video Consultation but only if AH personally attends the patient<sup>34</sup> or is part of an initiated GP–specialist telehealth conference.

## Chronic Disease Management Funding

Currently the main form of funding for AH delivering chronic condition care in the community is the Medicare Benefit Scheme CDM items (10950-10970). This reimburses up to 5 AH visits per year and only as a consequence of a GP instigating a Team Care Arrangement. Other criteria are that the AHP is in private practice and it is an individual service (not as a group). Indigenous patients may also be eligible for a further 5 follow up AH services.

These criteria act as gatekeeper to AH care; and are also set a too low a level to be effective for this specific population. As a consequence patients are unable to meaningfully access the necessary number, range and type of AH services (public or private).

Complex needs require more coherent and agile funding than one of the current four types:

- Fee for service
- Capitated payments
- Salaried HP models
- Pay for performance ( only includes the GP and has discrete accountability measures)

As funding determines access and behaviours, other modes should be considered such as pooling of funding, which should be auspiced by PHN and co-accountable with LHN (reflecting the patient transitions), or blended funding to achieve:

1. Outcomes/ health status improvements + patient reported outcome measures (PROMS) and patient reported experience measures (PERMS)
  - and so provide financial incentives for team innovation and continuing practice improvement
2. Incentives to avoid unnecessary admissions
3. Incentives to provide care at all 3 levels of risk stratification.

<sup>33</sup> SARRAH. 2009. Models of Primary Healthcare Services . November 2009 . <http://www.uq.edu.au/tele-rehabilitation/index.html>

<sup>34</sup> PHCRIS. Aug 2014 Allied health integration: Collaborative care for arthritis and other musculoskeletal conditions,



# AUSTRALIAN ALLIED HEALTH FORUM

These considerations should ensure that the right workforce and pathway components exist predictably and consistently, not just reliant on the preferences or local knowledge of the GP.

There is a need for funding and workforce models that are 'localisable' and flexible to meet the needs of specific populations such as Aboriginal and Torres Strait Islander communities and particular problems for AH in rural and remote:

- in Central Australia private AH practitioners were contracted by the Division of GPs to deliver services under the MAHS program. The program is oversubscribed with some duplication of services that would previously have been provided by the Alice Springs Hospital. AH vacancies at the hospital lead to shortages in services with private practitioners attempting to fill the shortfalls
- Fly in/Fly out have focused on GP services only, but may be applicable for AH professionals in private practice. There is a potential to create salaried positions with the pooling of funding to increase access to PHC services [MAHS, RHS, MBS, HACC, Primary Health Care Access Program (PHCAP)<sup>35</sup>].
- SARRAH's position paper (2015) Rural and Remote Access to Medicare and Related Allied Health Services highlights many of the specific access problems in chronic condition management and acknowledges that a MBS Review Panel has been established.

## Reducing the rate of health care expenditure

**Key Issues: innovative AH models that support lower cost care, system efficiencies, and reduce avoidable hospitalisations.**

AH have or continue to build a range of innovative models focused on the efficiency of care, tested across continuum of chronic and complex care needs. These include:

- Shifting the care to the community (see example 1)
- Offering early and lower cost alternatives to the current main option for care – access to specialists , with concomitant lengthy wait lists (see example 2 and 3)
- Demonstrating capability for improved cost efficiencies and effectiveness through new workforce models (see example 4)

As with medical and nursing counterparts it is often difficult to assess and evaluate overall cost effectiveness as a single contributor, where the changes:

- are often not embedded in a wider whole-of-workforce reform. This piecemeal approach prevents full exploitation of the substitution and supplementation effects across all roles delivering care to consumers
- are hindered by the concern of other staff around potential erosion of their roles

This highlights the need in the primary health care sector for adequate culture change and incentives to act as genuine whole-of-workforce multi-disciplinary teams.

The broad categorisation of the range of alternative AH workforce models or expanded scopes of practice in primary health care, which provide early intervention to reduce avoidable deterioration and hospitalisations and connectivity with secondary care at a lower cost to the system, are:

- Podiatric surgery early and in the community for high risk feet , avoiding costly end stage amputations

<sup>35</sup> SARRAH. 2009. Models of Primary Healthcare Services . November 2009



# AUSTRALIAN ALLIED HEALTH FORUM

- Osteoarthritis hip and knee pathways, which provide pre-surgical preparation enabling better and quicker post-surgical restoration **or** maintenance and conservative management without recourse to surgery
- Prevention or secondary management of obesity through dietetic interventions and exercise
- Improved medication management / reduction of medication errors for chronic conditions through early input and review from pharmacists (often the most accessible workforce in rural and remote) in collaboration with GPs
- Maintenance of function in the home and connectedness to other services through AH Assistants, avoiding deterioration and readmissions; or, use of AHA for a low cost quality and higher volume service freeing AHP to focus on more complex cared .

The following evaluated examples of the efficiency mechanisms and models relevant to primary health care have been tested for a specific cohort and will potentially be replicated for other conditions and groups.

**Example 1:** Via a multi-disciplinary podiatry clinic care is escalated for patients with acute foot ulceration or those at risk of ulceration to specialist clinics or emergency departments. These high risk foot services have led to reductions of up to one third in the number of diabetes related amputations occurring within the Metro North Hospital and Health Service. (Allied Health Professions' Office of Queensland Ministerial Taskforce on health practitioner expanded scope of practice: final report. 2014)

**Example 2: Back pain assessment and management clinics (BAC) in the community (Victoria)**

Collaborative structure and principles to underpin service models and meet local health targets, A cohort of patients with low back pain (LBP) typically are referred by GPs to a surgical specialist (neurosurgery and orthopaedic). LBP has high prevalence, high impact on overall health and high economic burden. There is variable quality of care for LBP provided in primary care and long waiting times for specialist OP appointments (> 2 years). Extended delays lead to the development of chronic symptoms, unrealistic expectations, costly and unnecessary tests and poorer health outcomes, low conversion rates (3%) for surgery, inadequate trials of evidence-based non-surgical management.

Advanced scope of practice for physiotherapy and multidisciplinary care with a rheumatologist in the community provides a single point of access, triaging referrals for assessment and appropriate management of back and neck pain supported by an integrated referral pathway, protocols, credentialing and data sharing.

After 12 months of operation:

- 250 patients were taken from the wait list from approximately 1500
- Patients are seen in the BAC within 6 weeks of referral with > 85% attendance rate
- 50% referred for non-surgical management to community health partners; seen within 2 weeks.
- Only 23% referred for further investigations: indicating a potential cost saving in reduced ordering of unnecessary investigations
- Increasing capacity > 50% clients were experiencing moderate – severe levels of pain and moderate – severe levels of disability
- Clients receive about 5 visits of 1:1 physiotherapy and referral to group care.

Similar potential cost effectiveness has been projected from the NSW OA chronic care program around reductions in bed days, hospital separations and overall costs (Agency for Clinical Innovation 2013).



# AUSTRALIAN ALLIED HEALTH FORUM

## **Example 2: Multidisciplinary AMP and AMP Telehealth (Victoria)**

Expanded scope of practice where advanced practice physiotherapists screen, review and manage in selected joint replacement and orthopaedic cohorts in clinics and ED.

This has been evaluated as a more accessible, efficient and cost effective service delivery model with real savings in time and lower cost professional input

Consultant's time is freed to focus on the more complex cases, or on patients who may require additional surgical intervention.

Access: Waiting times for clinics reduced, with further flow-on benefits to the hospital and community.

**Telehealth** has now been introduced to enable AMPs to perform reviews for consumers in their local regional or rural setting. This trial is indicating both time and cost savings for the consumer and for the AMP in acute care, as well as increasing the competency and capability of local community workforce.

**Example 3: Metro North Hospital and Health Service (MNHHS) models of AH First Point of Contact Care** to screen and manage patients with a variety of conditions in several specialty areas. Functioning since 2014 the key measures have been focused on changes in throughput and waiting times, clinical outcomes and patient experiences, service utilisation and safety and quality of discharge outcomes.

## **Example 4:**

36.4% of the primary health care budget is expended on medications. Together with the acute care budget on medications and the impact of medication error rates, this is a key focus for workforce change to deliver cost reduction.

**Alfred Pharmacy Model (Vic Health funded)** of medication screening, review and prescription at point of admission to acute care to overcome high levels of medication errors and poor quality outcomes experienced by consumers. The pharmacist is the first point of contact and works in collaboration with medical and nursing staff. The initial 12 month pilot of the Advanced Practice Pharmacists Partnered Pharmacist Medication Charting model among 549 patients demonstrated a very low error rate of 1.47 per 1000 medications charted compared to literature reported rates of 13.1 per cent where medications are brought into hospital with the patients and 25.5 per cent where no medications are brought in (MJA 2009, Austin Hospital)<sup>36</sup>.

**The Austin / Monash / RDNS project (2014) Safe Medicines Management in the Community (HWA funded)** trialled interdisciplinary communication and teamwork, involving general practitioners, nurses and pharmacists to improve medicines management for older people who require support with medicine-taking at home. This was achieved by community pharmacists and pharmacy assistants playing a greater role in monitoring medicine, using e-health assisted access to medicines reviews and case conferences. Recommendations included improved access to medicines review and case conferencing by pharmacist shared electronic medicines record and medication chart for community care.

These will provide important learning for GP practices, rural communities and PHNs in delivering evaluated outcomes of:

- lower cost workforce
- earlier application of evidence-based practice

<sup>36</sup> Erica Y. Tong, Erica Y et al Partnered medication review and charting between the pharmacist and medical officer in the Emergency Short Stay and General Medicine Unit. Australasian Emergency Nursing, Vol. 18, Issue 3



# AUSTRALIAN ALLIED HEALTH FORUM

- supported by protocols, technology and agreed local pathways where pharmacists work with medical colleagues but as a primary component of the service delivery.

## Example 5: Low cost, higher volume service provision

**Advanced Allied Health Assistant in management of diabetes and renal disease** in the Townsville Health Service Districts (THSD) and supported sites Using a foot screening protocol (with 98% correlation with screening by the Podiatrist) detected high risk feet (16% peripheral arterial disease, 42% peripheral neuropathy, 71% foot deformity, 18% lower limb amputations, 29% poor foot care practices) and resulted in 33% increase in referral uptake for clients with chronic disease.

Resources to support competency acquisition and assessment included evidence based protocols and engagement in group and one-on-one interventions, nutrition self-management group clinic, and the multidisciplinary intake screening clinic<sup>37</sup>.

## Conclusion

This paper has been written by the **Australian Allied Health Forum** as an addendum to its on line survey responses to the PHCAG.

It has focused on four key platforms where the tested capability and capacity of Allied Health to deliver enhanced primary health care for people with chronic and complex needs should be used as an integral part of the system

1. Improving quality of care
2. Improving consumers' experience of primary health care
3. Improve access to primary health care
4. Reducing the rate of health care expenditure

It has provided evidence and supporting examples and case studies of the efficacy of AH provision in primary health care people with chronic and complex needs and the rationale for mainstreaming this workforce in primary health care.

It has highlighted a number of constraints and the enablers to the optimal and integral participation of Allied Health in the primary health care system, which is commissioned with the response of Australia's health care system to a shift in burden of disease.

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<sup>37</sup> Queensland Government. 2014 Innovations in Models of care for the Health Practitioner Workforce in Queensland Health pg 33



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Services for Aboriginal,  
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Health Australia