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Allied Health Professional Services Tasmanian Health Organisation-South

submission to

**One Health System Exposure Paper stakeholder
consultation process**

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A. Introduction

Allied Health Professionals (AHPs) within THO-S submitted a response to the One Health System Green Paper stakeholder consultation process. The response provided information on current service delivery and innovative models of care, and opportunities for best practice from the literature. With the full use of their scope of practice, and also an expansion of their scope of practice (where appropriate), AHPs could significantly affect the quality of community, emergency and elective surgery services.



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Allied health professionals are extremely keen to participate in the further analysis and planning that is required to formulate a Tasmanian framework for change. This includes solid strategies for AHPs to address the many major AHP service gaps that currently significantly affect client health outcomes and efficiencies.

Allied Health Professionals have provided excerpts of from their response to the Green Paper relevant to the topics within the Exposure Paper.

Numbers within the document relate to headings within the Exposure Paper.

1. Time for Change

Allied health professionals in the THO-South welcome the vision for the new Tasmanian Health Service, as they recognise that changes are required to the way healthcare services are delivered and by whom.

1.1 Tasmania's health status

Chronic Disease

- Real and effective investment in the prevention of chronic conditions such as diabetes, overweight, eating disorders and vascular disorders needs to be made to address these at the community and population level (not just with individuals) and also through promotion of physical activity and regulation of the food supply. There needs to be funding directed to prevention in the early years of life, rather than to surgery in later life.
- A core AHP function is chronic disease management. This is undertaken on an individual-basis as part of a treatment regime, or through primary health group programs.

Patient self-management of their conditions can be more successful in terms of the uptake of self-management skills, increased physical capacity and decreased hospitalisations, if programmes are tailored and flexible, use coaching or motivational interviewing and trans-theoretical models of change (Bonsaken et al., 2012). These are usually delivered by psychologists, social workers or occupational therapists.

When public funding is reduced, these group programs are frequently those reduced in favour of acute or more immediately required services. There are few chronic disease management group

programs provided by the private or non-government sectors. So, although there are Medicare schemes to fund general practitioners and private AHPs to provide these services, there are very few private AHPs in general to provide individual chronic disease management, e.g. occupational therapists or dietitians, or few private AHPs specialising in the delivery of group programs. This Medicare-funding model supports limited one-to-one AHP services primarily, and does little to support the provision of proven, evidence-based multidisciplinary chronic disease programs, e.g. for chronic obstructive pulmonary disease (Brooke, 2014), which require dietitians, nurses, occupational therapists, physicians, physiotherapists, psychologists and respiratory technicians.

Obesity

- Allied Health involved in multidisciplinary teams are able to provide alternative care to surgery for obese patients. Proposals have been put forward previously for a pilot program, modelled on interstate practice, that provides multidisciplinary care to a specific target group of morbidly obese patients in order to reduce the impact of their care on the acute health system. The team included medical lead, psychologist, dietitian, exercise physiologist, and social work.
- The proposed pilot included:
 - A multidisciplinary consultation service for Royal Hobart Hospital morbidly obese (bariatric) inpatients.
 - A multidisciplinary clinic service for THO South outpatients.
 - Development of clinical guidelines and assessments that are based on WHO obesity management strategies and that focus on behavioural management and support for prevention of weight gain, promotion of weight maintenance and management of obesity co-morbidities.
 - The longer term promotion of weight loss is proposed to occur through working collaboratively and in partnership with existing community health services.

1.2 Health system challenges

Aged Care

See Geriatric services below.

2. Designing a better health care system

Providing holistic, evidence-based health services that deliver the best patient outcomes at affordable costs

Allied Health Professional recognise their responsibility for using available resources to maximise consumer outcomes. The Allied Health Professionals Service (AHPS) within THO-S have a [Service Priorities Protocol](#) with operational principles that:

- guide equitable and well-governed access to comprehensive, consumer-centred and evidence-based affordable AHPS services across the continuum of care.
- ensure that consumers receive the right service, at the right time and in the right place to optimise their outcomes based on their current needs.
- enhance transparent multidisciplinary team communication regarding access to AHPS to facilitate the consumer's journey.
- align AHPS service delivery to THO-South strategic directions.

- ensure specific services are provided at times of short-term low staffing and/or higher than usual clinical demand to safely and appropriately address consumer needs, and to ensure staff workloads are safe and sustainable.

Throughout the response to the Green Paper, AHPs demonstrated how they can continue to contribute to:

- improving patient access to services, especially in emergency care and community services to avoid or provide an alternative to hospital admission.
- reducing waiting times in emergency departments and for specialist and surgical appointments.
- improving patient flow and reducing hospital and health system length of stay by using full and expanded scope of practice to deliver evidence-based models of care.

Role delineation framework

It is noted that allied health professionals are mentioned throughout the “One State, One Health System, Better Outcomes: Tasmanian Role Delineation Framework” document dated 30 March 2015. There is varying detail on with the Framework’s Core Clinical Services section in identifying specific disciplines and the skills and qualification / experience level required to provide services at each Service Level. Specific disciplines of AHPs welcome the opportunity to become more involved in the CAGs to further develop service delivery and innovative models of care that meet the principles of the One State, One Health System.

Examples of where allied health currently contribute to the various Core Clinical Services, and where there are opportunities to provide a better service to Tasmanians are included under Section 2.2 within this document.

Quality and safety of care

This is addressed throughout this document. Allied Health are cognisant of the requirement to provide quality and safe care to Tasmanians receiving their services. This is achieved through provision of services by appropriately skilled workforce, and provision of supervision and ongoing professional development.

Complex care in community

Community AHP services, which are provided from community health centres, integrated care centres, and in the client's home, focus on keeping clients living in their homes and well in the community. Further funding is recommended to help prevent expensive critical and acute care, repeat hospital presentations and longer-term services for clients.

- Within THO-S each Allied Health profession is integrated providing services across the acute, subacute and community settings. This enable these services to focus resources on the complete patient journey, rather than parts of it, and may be a model other health professions adopt.
- Mental health services a Help Line to assist people in the community to avoid RHH ED and ward admissions. The use of a similar service to access after-hours AHP advice and services could also help prevent admissions.

- A service model, which uses allied health assistants across four AHPs (occupational therapy, physiotherapy, speech pathology and podiatry) in THO-South assists AHP services to be more efficient. The four AHP services collaborate to coordinate the use of 1.8 FTE allied health assistants to service areas from Swansea to Dover to Maydena.
- There is strong-level evidence to support conservative physiotherapy interventions for suitable clients with intermittent claudication (leg pain and restricted mobility due to poor lower limb circulation) as being as effective as vascular surgery. Currently, some clients are referred for this cost effective treatment option, but there is the opportunity to expand the availability through community-based physiotherapy (Lane et al., 2014).
- Some AHP services, e.g. audiology, and occupational therapy and physiotherapy in burns routinely employ tele-health facilities to increase patient access to their services and service efficiencies.

There are great opportunities to expand its use, especially for rural and remote areas, where visiting AHP services have been reduced, e.g. attendance at pre-admission clinics to identify health issues and prepare clients for their health pathway (possibly for cardiac surgery and arthroplasty) as well as for case management.

Health workforce has appropriate skill mix and is supported to sustain clinical and professional competence.

- Many AHPs, because of their speciality and small numbers (or indeed sole-practitioner status in Tasmania) require:
 - professional supervision and mentoring outside Tasmania, e.g. neuropsychology and forensic psychology.
 - travel interstate to centres of excellence to up-skill.
- Due to undergraduate and postgraduate education for many AHP disciplines coming from interstate, partnerships with all mainland universities must be maintained to ensure recruitment, retention and up-skilling of the AHP workforce.
- See “Workforce – needs, availability, education and training, qualifications and ongoing professional development” below for further detail.

2.1 Strengthening our acute care system

Every clinical discipline will have a state-wide focus

THO-S has responsibility of provision of state-wide allied health services in the disciplines of audiology, and orthotics and prosthetics. A state-wide focus is achieved by managers of other disciplines, and Directors of Allied Health working together with colleagues across regions to provide state-wide consistency in practice and service delivery.

Access – patient experience including access and wait times

- A recent Podiatry Services audit of clients attending a Huon Valley community podiatry service over the period 2008-2011, found that lack of transport in that area, as well as no podiatry services in Geeveston, were significant deterrents to good foot health outcomes.

- Many allied health services are provided via a hub and spoke model to ensure that as many clients receive services as possible within clinic sessions, as travel reduced the time available for clinics. Transport is a necessity for clients to be able to access these clinics.

Workforce – needs, availability, education and training, qualifications and ongoing professional development

The Tasmanian Department of Health and Human Services (DHHS) employs staff from approximately 25 AHP disciplines. Of these, pharmacists, clinical psychologists, medical scientists and social workers can be educated through the University of Tasmania (UTAS); the first three, through the Faculty of Health. Social workers are educated through the Faculty of Arts. Medical radiation science has arrangements for partial education through the School of Health Sciences. Even with schools here, many from these disciplines are recruited from other states. All other AHP disciplines (possibly more than 20) are trained interstate.

The Tasmanian

Health Organisation-South employs university-qualified AHPs as clinicians, educators, researchers and managers, many of whom have specialty postgraduate qualifications.

As well, AHP support staff are employed, e.g. allied health assistants, cast technicians, orthotic/prosthetic technicians, play therapists, technicians and administrative officers.

However, Tasmania is behind the rest of the nation in the employment of AHPs in hospital and community health services. For example, the Health Workforce Australia Report 'Health Workforce by Numbers Issue 3' (2014) presents the following Tasmania AHP workforce statistics:

- The Tasmanian AHP workforce is lower than the Australian norm per 100,000 population; but the Tasmanian medical workforce equals the Australian norm and the Tasmanian nurse workforce is above the Australian norm.
- The audiology workforce in Tasmania is the lowest in Australia at 1.5 full-time equivalents (FTE). To meet Australian levels, DHHS would need to employ at least an additional 5 FTE audiologists (Audiology Australia, 2010).
- The dietetics workforce in Tasmania of 13.5 dietitians per 100,000 population is very low compared to the Australian norm of 20.1 per 100,000 (Dietitians Association of Australia, 2013).
- The occupational therapy workforce in Tasmania is the lowest in Australia at 32.9 FTEs per 100,000 population compared to the Australian norm of 44.9.
- The physiotherapy workforce in Tasmania is the second lowest in the country at 58.7 FTEs per 100,000 population, which is significantly lower than the highest state - ACT at 93.3 and the Australian norm at 79.7.
- The total psychology workforce is the second lowest in the country (68.2 FTEs per 100,000 population compared to the Australian norm of 84.7) and for psychologists working in community health services or hospital settings, once again are the second lowest in the country (17.8% compared to Australia 21%).

Queensland Health (2013) established a taskforce to investigate AHP roles and found that:

- AHPs are educated to competently undertake a greater range of tasks and responsibilities than are often used
- opportunities exist to extend the scope of practice of some AHPs in line with reforms in other Australian states and internationally to improve patient satisfaction, clinical outcomes and reduce waiting times
- the support workforce can be used more efficiently to enable AHPs to work to their full scope of practice
- many current hours of AHP operation do not align with the needs of patients and a number of barriers exist in realising the full capacity of this workforce.

Similar findings to these Queensland ones would be found in the Tasmanian AHP workforce.

Health Workforce Australia (March 2014) also published a number of workforce In Focus Reports for dietetics, optometry, pharmacy, physiotherapy, podiatry and psychology. Although these are national reports, they would be beneficial starting points for Tasmanian reviews of these workforces and the basis for more effective workforce planning for the AHP group.

- Over the last 20 years, various initiatives, primarily through the Partners in Health collaboration have explored the requirements and development of the Tasmanian AHP workforce. Many of these first-round initiatives have been instituted for some years, e.g. radiography. There is a considerable potential for the DHHS and the Faculty of Health to contribute to the identification and development of the workforce needs of possibly another 20 AHPs.
- Some AHPs within THO-South are not working to their full scope of practice, nor are they funded to keep up with contemporary, efficient models of care, e.g.
 - multidisciplinary clinics for surgical wait-list management, e.g. assessment/triage/management of orthopaedic, neurosurgical, gastric banding surgery etc.
 - advanced practice physiotherapy role in the emergency department (assessment, diagnosis and management of category 4 and 5 patients as primary contact/sole practitioner.
- The development of expanded scope of practice roles for AHPs in Tasmania is at an early stage. A 'Framework for Implementation of Expanded Scope of Practice for Allied Health Professions in the Tasmanian Health System' has been recently distributed for discussion.

The Framework states that 'the diversity of the AHP workforce and a tradition of training, which emphasises the relevance of varied intervention approaches selected on the basis of clinical assessment, render this workforce particularly well-suited to engaging with expanded scope of practice.'

The Framework also states that 'At least one influential Australian report (Queensland Health, 2014) has identified powerful barriers to development of both extended scope of practice and full scope of practice by AHPs. This report found AHPs are not able to perform the full scope of tasks and duties they are trained and qualified to perform, even though these may be performed by their colleagues in the private sector. This is due to a range of existing legislative, administrative, funding, policy, custom and practice barriers. These barriers and those noted above for the national context also impact on the delivery of Tasmanian health services by allied health practitioners.'

- Although AHPs support the development of an allied health assistant workforce, quality services cannot be provided or sustained by replacing the professional workforce with assistants. There must be sufficient AHPs to ensure safety of delegated activities, as per the [DHHS Allied Health Assistant Supervision and Delegation Framework](#).
- Efficient, full-scope workforce utilisation also includes effective and sufficient utilisation of administrative staff.
- A number of training issues also affect the sustainability and suitability of the AHP workforce for the challenges of contemporary healthcare. In contrast to the medical and nursing workforces, AHP reliance on primarily interstate training, makes it particularly vulnerable to factors impacting tertiary institutions and employment in other jurisdictions. The development of partnerships to meet workforce/employer needs is complex with multiple Australian education providers. New course design interstate may have limited relationship with Tasmanian health system needs.
- Allied health professionals require a formal system to access interstate centres of excellence, as many are sole specialist in their area in Tasmania. This system is required to easily facilitate interstate site visits, work shadowing and staff exchanges for professional development.

Service capability – support services and equipment

- Opportunities exist to reduce clinical and litigations risks associated with meal mistakes by providing adequate investment in information technology to achieve efficiencies in production and distribution of patient meals across the state.
- Use of equipment to enable activities of daily living (ADLs) has been shown to be effective in reducing length of stay, facilitating discharge and preventing admissions (Davis & Rodd, 2014). The implementation of the state-wide TasEquip program will support more equitable access to equipment for those who require it.
- Custom seating and wheelchair services for clients with complex physical and often global impairments. The numbers are small but the service provides these clients and their family with solutions that greatly improve their quality of life by decreasing their pain, reducing their hospital admissions and increasing their mobility. Investment is required to reduce waiting periods of over 12 months. These long waiting times many clients experience significant negative consequences, occasionally leading to hospital admission.

2.2 Key service issues

2.2.1 Surgical services

- Allied health professions acknowledge that Tasmanian patient waiting times for elective surgery must be addressed. Some international and interstate AHP initiatives that could assist in Tasmania are: the use of alternate conservative AHP pathways and self-management strategies to avoid or delay surgery, the full participation of AHPs in pre-admission clinics to prepare clients and their homes for surgery, and comprehensive geriatric assessments to help prevent poor outcomes through failed rehabilitation due to inappropriate surgery.
- Elsewhere Psychologists work with patients/clients on elective surgical waiting lists with co-morbid conditions e.g. diabetes, heart disease, obesity, arthritis, etc.
- Prosthetic services for amputees. are essential for a small number of Tasmanians over the course of their lives. Technology has advanced, allowing amputees greater mobility and comfort

when using their prostheses. Standard technology, which is now more than 20 years old, is still difficult to fund for amputees, due to stagnant, inadequate budget allowances. The quality of life of some clients could be significantly enhanced by a modest increase in the funding of these services.

- Allied health professions are contributing and can further significantly contribute to improvements to elective surgery waiting times at a number of stages in the process.
- Alternative pathways to avoid surgery. Frequently patients are not referred by their general practitioner to primary-level AHPs for management or a trial of treatment for the condition—simply directly to a surgeon, whose strategy is to operate.

In particular, physiotherapists and podiatrists can assess and treat a patient's musculoskeletal condition, which is then reduced such that surgery is not required or is can be delayed.

For example, the RHH's Comprehensive Osteo-Arthritis Pathway, the Spinal Assessment Clinic and the Inflammatory Spinal Clinic have run since 2012 and are typical of well-established AHP services in mainland hospitals. These are multidisciplinary teams (orthopaedic, rheumatology, physiotherapy and nursing), whose model relies heavily on advanced practice physiotherapists to assess and triage musculoskeletal surgery and rheumatology patients to determine suitability for surgery, and identify, refer for and monitor conservative treatments (Victorian Government, 2006; Butterworth, 2014).

- comprehensive AHP participation in pre-admission clinics as a structured part of the client journey to prepare the client for their surgery and rehabilitation, and to assess their home and provide equipment and modifications. Currently AHP involvement is ad hoc, and dependant on the awareness of clinic doctors and nurses and this can lead to later delays in discharge from the RHH.
- promotion of self-management approaches. Disease self-management, when linked with early assessment and management by AHPs, can also stop or delay the requirement for surgery. The patient's functioning and quality of life can also be improved pending the surgery and post-surgery, if their fitness and function is maintained or increased while waiting for surgery (Davis and Dodd, 2014). There appears to be low awareness amongst general practitioners of these AHP possibilities.
- comprehensive geriatric assessments (including neuropsychology where clinically appropriate) prior to placing elderly patients on waiting lists. Baseline assessments would assist decision-making about the long-term benefits of surgery for high-risk patients, as well as an understanding of the impact of possible complications of the surgery would have for AHP services. For example, people older than 85 years who are contemplating total-knee joint replacement are frequently unable to participate in the post-operative rehabilitation required for a good outcome.
- an understanding that multi-disciplinary packages of care are required to ensure positive long-term outcomes for surgical patients. Frequently funding is provided for the surgery only and not for the pre-operative AHP services that are required for the patients and their homes to be prepared for the surgery—leading to increased hospital stays; or for the post-operative AHP services to complete the patients rehabilitation to maximum function. For example, increased funding for hand plastic surgery has not been extended to physiotherapists and occupational therapists to deliver the pre-and post-operative care and rehabilitation required for overall success.

Another example is when lap-banding funding has been allocated, there has been poor recognition of the need for AHP resourcing to enable the comprehensive management that is offered interstate, e.g. psychological and social work assessments and carer support; physiotherapy pre-operative fitness work-ups; dietitian education and preparation for surgery (low calorie diet) and post-surgery nutritional support, advice and monitoring to prevent dislodgement and distorted eating; and occupational therapy management and home environment modifications.

- the ability of AHPs with expanded scope of practice to run appropriate pre-operative and post-operative clinics. These clinics, e.g. for knee and hip replacement and neurological patients are well established in the rest of Australia, see Attachment A.

2.2.2 Integrated cancer services

- Recently, the Palliative Care Service has obtained Australian Government funding for AHP services to facilitate more comprehensive multi-disciplinary care, and to lessen the demand on state-funded community AHP services.

Currently the role of the occupational therapist is being established and expanded and it is seen that there is scope for earlier interventions. At present, the nursing and medical focus is on end-stage palliative care. Earlier AHP intervention would enable people with palliative conditions to remain more active and engaged in their palliative year/s and more able to self-manage their health routines (Keesing & Rosenwax, 2011).

- The NHMRC 'Clinical practice guidelines for the psychosocial care of adults with cancer' (2003) clearly articulate the impact of psychological problems that are associated with patients who have cancer, and the need for appropriate input to address these issues. At this time, most people in Tasmania who have cancer are unable to access psychological services when receiving treatment in secondary or tertiary health services.
- In recognition of the growing need for cancer services, Speech Pathology THO-South have redirected resources from a general community position to create a Senior Speech Pathologist, Oncology. This role has enabled team-based work within the cancer service and is focussed on timely, evidence-based intervention for people with head and neck cancer. This includes early intervention to prevent the development facial contractures, reducing the risk of dysphagia and loss of speech.

2.2.5 Subacute care services

- Within THO-S there is input across the inpatient, and ambulatory care sectors of subacute care services. Aged care clients also receive subacute community care through the Transition Care Programs.
- Further enhancement of programs could occur through rehabilitation in the home. A pilot project has been scoped within the rehabilitation review, but has not received funding. This model of care occurs in other jurisdictions with good outcomes for patients and carers, as well as reducing length of stay.
- Currently a review of rehabilitation model of care is being undertaken in THO-S with the move of the acute rehabilitation unit (ARU) to the Repat site. The review encompasses establishment of

an in-reach multidisciplinary team, admission criteria for the offsite ARU, ambulatory services, and possible home based programs.

- Neuropsychology is not Medicare-funded. As such, for most Tasmanians if they are not seen whilst an inpatient and are not MAIB covered, they will not be able to access neuropsychological assessment; this includes individuals with stroke, brain tumour, traumatic brain injury (not motor vehicle) and neurodegenerative disorders where an understanding of their cognitive skills is essential to returning to home, work, family roles and community engagement. The cost to the community of not providing these services is immense.

2.2.7 Burns services

- Psychology services are available to patients with burns in most mainland Australia hospitals. However, currently there is no publicly funded psychology service for patients who sustain burns in Tasmania. If these are required, individuals must have a Mental Health Care Plan developed by their general practitioner to access a small amount of private psychology services in the community; these have no links to the burns services provided at the tertiary level.

Other services from Tasmanian Role Delineation Framework (March 2015)

ENT services

- Enhancement of services can be provided through opportunities offered with further investment in audiology services.
 - Provision of diagnostic audiological services in the North or North West of the state.
 - Diagnostic services at the RHH is offered only for children and for adults attending a RHH clinic. The current wait for a paediatric audiology appointment is nearly 12 months.
 - Adults with hearing loss who are not eligible for the Commonwealth Office of Hearing Service must see a private provider. This is problematic for some due to charges.
 - Currently a limited service is available to patients attending RHH Ear Nose and Throat Clinics. This increases waiting times for an initial appointment as well as increases the number of medical appointments patients with ear and hearing-related disorders require.

A recent National Partnership Agreement funded project found that over 50% of patients referred to RHH Ear Nose and Throat Clinics for ear and hearing related disorders were incorrectly triaged due to lack of audiological assessment. It was also found that at least 10% of these patients did not need ear nose and throat management, but rather could be appropriately managed by the audiologist only.

- Speech Pathologists in THO-S are currently undergoing Fibre optic endoscopic evaluation of swallowing (FEES) training, supported through ENT, with the intention of establishing a speech pathology led FEES clinic. We are at the stage of independently running FEES assessments with ENT on call.
 - Adults and children receiving cochlear implants are required to receive assessment and initial rehabilitation services interstate. These services could be provided in each region for less than the cost of sending these patients to Melbourne. A submission was made to the Green paper on this proposal.



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Paediatric services

- Extension of dietetic services to see children who require access to insulin pump training by a dietitian, as demand is much higher than the ten currently seen.
- Extension of the paediatric allergy dietitian clinic to reduce waiting times.
- There is no dietitian in the DHHS-funded St Giles service that manages children with growth failure and conditions requiring permanent tube feeds.
- Paediatric neuropsychology. There is no dedicated psychology position for children who require cognitive assessment, e.g. following a traumatic brain injury, or if they have a brain tumour or an acquired brain injury. Assessment of cognition in this population is essential; most children and adolescents are simply discharged home and return to formal education.
- Paediatric clinical psychology. The 'Children and Adolescents Guidelines for Care in Acute Care Settings' (NSW, 2010) and the 'Standards for the Care of Children and Adolescents in Health Services' (Royal Australasian College of Physicians, 2008) both highlight the psychological impact of hospitalisation and illness on children and adolescents, and the importance of having staff trained to address the psychological needs and distress in this population. Currently there are no dedicated clinical psychology services for children in the THO-South.
- Clinical psychology services to paediatric diabetes, which has the potential to reduce the health burden and improve health outcomes of this population over the course of their lifetime;

Mental Health services

- Provision of an adult eating disorder team, with dietitian involvement in the paediatric and adolescent eating disorder team.
- Specialised psychological services in Mental Health Statewide Services, such as alcohol-related brain injury assessments, Alcohol and Drug Services inpatient therapeutic interventions.

Endocrine services

- Increased presence of Podiatry services in the inpatient setting that considers the high needs of people with diabetes complications affecting their lower limbs. In addition, the well-documented increased rate of diabetes should be met with greater coverage from community health centres across southern Tasmania, where presently there is a reduction in podiatry services. More podiatrists and footcare therapists (allied health assistants) are required for the ongoing care of people with foot pathologies and diabetes.

Geriatric services

- Several psychologists consult to areas that service the older adult population, however, there are no neuropsychologists working in memory and dementia assessment clinics in THO-South. The 'Cognitive Dementia and Memory Service Best Practice Guidelines' (Victoria Department of Health, 2013) stipulate employment of a neuropsychologist, and the use of neuropsychology assessment 'when a diagnosis cannot be made, is borderline or the client's presentation is unusual or complex'.

2.4 Strengthening our primary care system and linkages

2.4.2 The importance of primary care in delivering better health outcomes for the community

- Expansion of the publically-funded nutrition services offered are three clinics per week at Clarence and Kingston community centres to other areas across the state.
- Coordinated planning, coordination and communication between these Tasmanian Medicare Local and non-government organisations and THO-South for the provision of community/primary care dietitian services.

2.4.3 Alternatives to hospital

Many presentations to Tasmanian emergency departments and hospitals are avoidable. Allied health professionals appreciate the opportunity to participate in an analysis of this data, and in services that maybe developed to target specific client conditions.

- Services such as occupational therapy, physiotherapy, psychology and social work at a minimum and (depending on the type of patient presentation) also, chaplaincy, dietetics, orthotics/prosthetics, podiatry and speech pathology can assist in patient flow through the emergency departments. For consumers presenting due to a range of medical, functional or socioeconomic reasons, AHP services can facilitate return home from the emergency department or commence early intervention to enable timely discharge if admitted. Specific examples are:
 - physiotherapy triage for musculoskeletal conditions, which has the potential to improve access to appropriate care (Joseph et al., 2014) and outpatient services.
 - social work and occupational therapy interventions to address the social determinants causing people to present to the emergency department. There is evidence to show that addressing these reduces admissions (Jiwa et al., 2002).
 - people presenting to emergency departments who have difficulties with activities of daily living (ADL) have an increased likelihood of admission (Considine et al., 2011). Occupational therapy intervention is effective in reducing ADL dysfunction (Carlill et al., 2003; Considine et al., 2011; Xu et al., 2012).
- The focus should be on services that keep clients living in their homes and well in the community. Short-term input and costs in the community greatly outweigh expenditure on possible later critical and acute care, repeat presentations and longer-term services. Allied health professionals have a major value-adding role in maintaining and improving client function in the community.

Allied health professionals currently prevent client presentations and re-presentations to the Royal Hobart Hospital Emergency Department by providing services in the community, and in the Royal Hobart Hospital specialist outpatient clinics, Emergency Department and wards. An expansion of AHP services to provide a rapid response AHP service to the community, a trial an

after-hours community AHP service, a centralised number for emergency AHP advice and interventions, and the inclusions of other AHP services, such as psychology in the Royal Hobart Hospital Emergency Medical Assessment Team would further assist in preventing inappropriate hospital presentations.

Senior AHPs (occupational therapists, physiotherapists and social workers) and nurses are employed in the Emergency Medical Assessment Team in the RHH ED to assess patients admitted to the RHH ED.

The Emergency Medical Assessment Team aims to:

- avoid 'inappropriate' hospital admissions by providing immediate AHP services (e.g. interventions in ED and home visits) and the coordination of community services, including ongoing AHP services.
- improve links/interface between the RHH and community services to ensure optimum care and support for patients and their families.
- increase carers' confidence when taking a patient back home, through the provision of education, information and the coordination of community services for ongoing care.
- organise early referrals to AHPs on the RHH wards, thereby facilitating timely inpatient discharge.
- recognise and advise on un-safe or unsustainable discharges from ED to enable a hospital admission and later effective discharge from the ward.

The Emergency Medical Assessment Team is highly successful in achieving its aims.

- There are instances where the Emergency Medical Assessment Team could prevent an ED presentation, if the Team was to be able to be contacted directly by the general practitioner, client, carer or community services for advice and immediate care in the community. For example, frequently Ambulance Tasmania is called to assist people who fall in the community. If there was a centralised telephone number and an increased level of AHPs in the Emergency Medical Assessment Team, an ED AHP rapid response team could travel out into the community to assess and coordinate care, thereby preventing an ED presentation.
- The RHH ED performance targets are currently met for triage categories 1, 2 and 3, but not for categories 4 and 5, i.e. non-urgent categories.

Frequently AHPs are the most appropriate clinicians to assess and manage these non-urgent clients, e.g. those with no safe community housing, acute musculoskeletal injuries, or chronic obstructive pulmonary disease (Brooke, 2013). Current funding for Emergency Medical Assessment Team limits their core work to the more dependent/complex patients requiring significant AHP input for discharge from the ED.

Less complex patients, e.g. those with musculoskeletal injuries often are not managed by the Emergency Medical Assessment Team, but evidence suggests physiotherapy can provide timely and comprehensive management and discharge of these patients. Recently, a three-year National Partnership Agreement funded project, Senior Physiotherapist-ED has commenced at the RHH and aims to provide seven-day-a-week primary and secondary-contact physiotherapy service. The service specifically focuses on preventing hospital admissions for lower category ED presentations, increasing capacity to provide a primary

role service and further enhancing the vital Emergency Medical Assessment Team role. At this time, the role is not 'advanced practice'.

The utility of the Emergency Medical Assessment Team would be boosted by:

- the expansion of community services, such as home help, personal carers and access to food (especially on weekends and after-hours) to support patient discharge from ED back to the community.
 - a centralised telephone number for emergency advice to general practitioners, client, and carers.
 - increasing funding to enable the Team to manage all client groups presenting to ED, e.g. those with psychosocial needs (social workers and psychologists), high-risk diabetic patients (podiatrists), hand injuries (occupational therapists and physiotherapists), and swallowing issues (speech pathologists and nutrition issues (dietitians).
 - an expanded scope of practice for physiotherapists to manage acute musculoskeletal and respiratory presentations.
 - a rapid response social work, physiotherapy, occupational therapy and nursing team with capacity to provide home visits (with medical support).
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- As there are approximately 10% of emergency department presentations are for primary mental health needs (Queensland Health, 2014), employment of specialised AHPs in the mental health services in the RHH ED would enhance the current PEN nurse, or EMAT service.
 - Expansion of the current 0.6 FTE Social Work Services allocated to the Emergency Medical Assessment Team (which has a specific client focus of those over 65 years of age, and those with complex disabilities) will assist with the prevention of social admissions and decrease Emergency Department and RHH length of stay for other general client groups.
 - There is no rapid response AHP team that can go from the RHH or community centres on general practitioner or family request, to manage community clients and prevent their need for ambulance, emergency department or inpatient services.
 - Development of full range of AHP services in multi-disciplinary teams at community centres would aim to prevent ED presentations. Some community AHP services, e.g. physiotherapy, psychology and social work should also be provided for limited times outside Monday to Friday office hours to manage clients who cannot access acute private AHP services. Enhancement of current Podiatry services to support community nurses to manage community clients with leg ulcers and prevent hospitalisation.
 - A multi-disciplinary gastrostomy and stoma outreach service needs to be established to manage accidental tube removal and stoma issues when they occur.

2.4.4 Rural primary health services

- Occupational therapy, physiotherapy, podiatry, social work and speech pathology services are employed by THO-South to manage clients in the community.
- As part of multi-disciplinary teams, these AHPs work in and from community centres, in RHH specialised outpatient clinics (Hands Clinic, Persistent Pain Management Unit, Cystic Fibrosis, Lymphoedema, Paediatric Continence, Neonatal), integrated care centres (ICCs), multipurpose health centres, and/or visit clients in their homes.

- These community services, although described as primary (i.e. not secondary or tertiary) health care, are funded by the DHHS, not through Medicare arrangements.

The AHP services:

- prevent urgent and non-urgent ED presentations by monitoring, maintaining and improving clients in their local area.
- facilitate client discharge from the RHH ED and wards by providing linked AHP services in the community to support post-acute recovery. Research shows that discharging people back to the community with new unmet activities of daily living (ADL) needs, increases the risk of readmission (DePalma et al., 2013) and that post-discharge services were effective in reducing ADL, socioeconomic and environmental risks for readmission (Arbaje et al., 2008; Roberts and Robinson, 2014).
- maximise client function and prevent RHH representations, through specialised AHP care in the community, e.g. chronic disease management and self-management.
- reduce the risk of harm for clients and their carers when the client returns home through assessments of the home situation and education, and referral to other appropriate services.
- improve short and long-term client health and well-being.
- As a strategy to prevent inappropriate ED/RHH admissions, walk-in/hot clinics have been trialled by physiotherapy services in the Clarence and Glenorchy ICCs for people with acute back pain. These walk-in clinics have been used by appropriate clients, but there is capacity for increased use. This model of care requires ongoing promotion to general practitioners, medical specialists and the community, and development, as it provides timely and appropriate access and prevents costly hospital admissions and long waits for specialist clinics when the condition becomes chronic. There is the opportunity to expand the model to non-urgent acute musculoskeletal injuries and work alongside general practitioners, where the general public do not access walk-in clinics independently.
- Community social workers also provide 'walk ins' services at each community centre as urgency dictates and availability allows.
- About 300 people in southern Tasmania access subsidised nutrition products for home use through the Tasmanian Home Nutrition Program. This service prevents nutritional deterioration in vulnerable people that could result in hospitalisation for tissue breakdown, chronic diarrhoea, major loss of weight and severe malnutrition. A more appropriately resourced service (offered from community bases) could facilitate: more timely assessment and review, patient discharge when they no longer require nutrition support, and escalation of interventions when patient deterioration is evident.

Initiatives to improve the services

- The trial funding of limited after-hours emergency social work and physiotherapy services (with expanded scope of practice) in the RHH ED, a community setting, or urgent care centre (if established) would be a valuable to evaluate this service model.
- Evidence supports the need to address activities of daily living (ADL) in the home environment to prevent admission and enable effective discharge (Considine et al., 2011; Hall et al., 2012;

Siebans et al., 2000; Zu et al., 2012). It would be valuable to fund a trial of increased community occupational therapy intervention to provide:

- a rapid response service for consumers at risk of imminent hospital admission due to ADL dysfunction or crisis.
- self-management, environmental modification and activity modification interventions to people with increasing ADL dysfunction due to chronic or progressive disorders.
- restorative interventions to enable successful discharge post-acute admission.

3.4 Clinical advisory groups

There is currently limited involvement / representation of allied health professionals within CAGs. AHPs welcome the opportunity to become more involved in the CAGs to further develop service delivery and innovative models of care that meet the principles of the One State, One Health System. Due to the diversity of disciplines (over 20 are recognised with DHHS as being Allied Health Professions) it would be preferable to target those disciplines that have the most input into each clinical area.

4.1 Workforce: planning, education and training

This has been covered throughout the document, particularly in 2.1.

4.2 Innovation

Examples have been provided throughout the document. Attachment A provides further examples, detail and references.

4.3 Research

- Allied health professionals have research partnerships with many mainland universities, or Menzies.
- AHP research within THO-S has a strong governance model. It could be enhanced further with the joint employment (with UTAs) of a AH Professorial Unit, similar to those established in other jurisdictions.

4.4 Technology

Allied Health currently use a number of technologies to support patient care – for example telehealth, iPads, and screening in audiology. Patient care and staff workload is captured occurs across allied health professional services, and within multidisciplinary teams. This data is used within Benchmarking with other jurisdictions. There has been inadequate investment in information technology to achieve efficiencies in production and distribution of patient meals in the RHH and to reduce clinical and litigation risks associated with meal mistakes.

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Attachment A: Scope of practice examples

Summary of examples of allied health professional (AHP) expanded scope of practice and common practice (Queensland Health, June 2014)

Attachment A: Summary of examples of allied health professional (AHP) expanded scope of practice and common practice (Queensland Health, June 2014)

Acute hospital examples				
Initiative details	Approach	Outcome/s	Extended scope	Priority area
<p>Initiative: AHP acute medical clinical leader established in the Medical Assessment and Planning Unit (MAPU)</p> <p>Location: Toowoomba Hospital, Darling Downs Hospital Health Services, QLD</p> <p>Workforce: multidisciplinary</p> <p>Model: single-centre study</p> <p>Reference: www.health.qld.gov.au</p>	<ul style="list-style-type: none"> An AHP clinical leader role was established to provide assessment and intervention as the first point of contact for patients in the MAPU A framework of skill-sharing was introduced across physiotherapy, occupational therapy, podiatry, speech pathology, nutrition and dietetics, psychology and social work 	<ul style="list-style-type: none"> Patients are discharged 82 hours earlier than those seen by standard care AHPs Initial AHP assessment provided 11 hours earlier than the standard care service At one month follow-up, patients demonstrated superior outcomes for balance and mobility and self-reported quality of life Reduced emergency department re-presentation (10% compared to 24% at 1 month) 		Improve patient flow
<p>Initiative: Dieticians and speech pathologists in stroke management</p> <p>Location: UK, USA, Canada</p> <p>Workforce: nutrition & dietetics, speech pathology</p> <p>Model: established practice</p>	<p>For stroke patients, dieticians screen for and manage dysphagia while speech pathologists screen for and manage malnutrition</p>	<ul style="list-style-type: none"> Patients assessed and treated more quickly Earlier intervention through more timely and accurate referrals can improve nutritional status and overall health in patients with dysphagia 	X	Improve patient flow

<p>Reference: Wright, L. et al. (2009). Dysphagia and nutrition: an extended scope of practice. Proceedings of the Nutrition Society 68, (OCE1): E59</p>				
<p>Initiative: Fibre optic endoscopic evaluation of swallowing (FEES) clinics</p> <p>Location: Princess Alexandra Hospital, Royal Brisbane and Women’s Hospital, the Townsville Hospital, Gold Coast Hospital, QLD.</p> <p>Workforce: speech pathology</p> <p>Model: established practice</p> <p>Reference: www.health.qld.gov.au</p>	<ul style="list-style-type: none"> • Four regular and established FEES clinics across QLD • Development and implementation of a FEES competency training programs – introductory and advanced levels. • Patients requiring dysphagia assessment with FEES can be managed by a speech pathologist without need for referral to an ENT surgeon, or can be removed from an ENT waiting list • Not dependent on access to radiology suite/ENT • Can be repeated flexibly as required. 	<ul style="list-style-type: none"> • Reduced waiting time for instrumental dysphagia examinations • Reduction of 24-48 hours for urgent referrals • Timely commencement of patient diet/fluid recommendations • Reduced duplication for attendance for dysphagia assessment and ENT assessment • Reduced referral to radiology for video fluoroscopy by 25% 	<p>X</p>	<p>Improve patient flow</p> <p>Reduce outpatient department waiting time</p>
<p>Initiative: Placement of feeding tubes by dietitians</p> <p>Location: Baylor University Medical Centre, USA</p> <p>Workforce: Nutrition and dietetics</p> <p>Model: established practice</p> <p>Reference: Tynan, C. et al. (2008). Placement of small bowel feeding tubes by advanced practice dietitians:</p>	<ul style="list-style-type: none"> • Dietitian and nurse teams in intensive care unit trained to insert small bowel feeding tubes using electromagnetic tube placement device technology • Initial pilot of 101 small bowel feeding tube placements showed higher success rates compared to traditional methods 	<p>Initial pilot of 101 small bowel feeding tube placements showed:</p> <ul style="list-style-type: none"> • lower radiography costs • reduced time to initiation of feeding compared to traditional methods 	<p>X</p>	<p>Improve patient flow</p>

common practice? Support Line, August: 12-20				
<p>Initiative: Podiatric high-risk foot coordinator</p> <p>Location: Great Western Hospital, Swindon, UK</p> <p>Workforce: Podiatry</p> <p>Reference: Cichero, M et al. Reducing length of stay for acute diabetic foot episodes using an extended scope of practice podiatric high-risk foot coordinator in an acute foundation trust hospital</p>	<p>Introduction of a podiatric high-risk foot coordinator to focus on more efficient and timely management of people with complex diabetic foot disease</p>	<ul style="list-style-type: none"> • Average length of stay for patients with complex diabetic foot disease reduced by 10 days • No statistically significant difference in readmission rates 		<p>Improve patient flow</p>
<p>Initiative: Transdisciplinary screening and intervention in nutrition, cognition, communication and swallowing</p> <p>Location: Eastern Health, Victoria</p> <p>Workforce: speech pathology, nutrition and dietetics</p> <p>Model: single-centre study</p> <p>Reference: Porter, J, et al. (2012). Transdisciplinary screening and intervention – an opportunity to extend dietetic practice. Nutrition and Dietetics, 69 (suppl. 1): 30</p>	<ul style="list-style-type: none"> • Early screening and intervention for nutrition, cognition communication and swallowing deficits were provided for medical admissions in a large metropolitan hospital with no weekend dietetic or speech pathology service • Using validated tools, dieticians placed patients on 'nil by mouth' if sub-optimal results were demonstrated on a speech pathology screen; speech pathologists commenced patients on high energy diets if they were identified with malnutrition 	<p>As a result of successful implementation of education and training to appropriately skilled speech pathologists and dietitians, screening across both clinical practice areas was implemented to better meet patient's needs, particularly out of regular business hours</p>	X	<p>Improve patient flow</p>
Emergency service examples				
Initiative details	Approach	Outcome/s	Extended scope	Priority area

<p>Initiative: AHP in the emergency department</p> <p>Location: Mackay Hospital, Mackay Hospital and Health Service, QLD</p> <p>Workforce: occupational therapy, physiotherapy</p> <p>Model: single-centre study</p> <p>Reference: www.health.qld.gov.au</p>	<p>The Calderdale framework was used as a workforce redesign tool to train occupational therapists and physiotherapists to skill-share each other's clinical tasks for non-complex clients (older people with functional decline) and additionally trained in social work, speech pathology, dietetics and podiatry tasks</p>	<ul style="list-style-type: none"> Professional skill sharing between occupational therapists and physiotherapists was equivalent in outcome to uni-professional intervention, in a cohort of community dwelling older people experiencing functional decline Patients preferred a model where care was provided by one, as opposed to multiple, AHP clinicians 	<p>X</p>	<p>Improve patient flow</p> <p>National Emergency Access Target</p>
<p>Initiative: Physiotherapy in the emergency department</p> <p>Location: Cairns Hospital, Cairns and Hinterland Hospital and Health Service and Robina Hospital, Gold Coast Hospital and Health Service, QLD</p> <p>Workforce: physiotherapy</p> <p>Model: multi-centre study</p> <p>Reference: Physiotherapy Department, Cairns Base Hospital and Gold Coast Hospital, QLD</p>	<ul style="list-style-type: none"> As part of the HWA 'Expanding the role of physiotherapists in Emergency Departments', category 3-5 patients presenting with an appropriate musculoskeletal injury/disorder are assessed, treated and discharged directly by the physiotherapist from triage Tasks include fracture diagnosis, simple fracture management, joint relocation, sick certification, plastering, radiology referral and interpretation The addition to the role of ordering of radiology, injecting of local anaesthetic and limited prescribing of analgesia is being explored 	<p>Expected outcomes:</p> <ul style="list-style-type: none"> Reduced time in Emergency Department Released capacity/availability of medical officer and nursing resources for higher acuity patients (especially category 1-3). 	<p>X</p>	<p>National Emergency Access Target</p>
<p>Initiative: Primary contact musculoskeletal physiotherapist in the emergency department.</p>	<p>Physiotherapists who completed training in radiology, pharmacology and specific tasks (e.g. plastering) managed patients allocated to fast-track in the emergency</p>	<ul style="list-style-type: none"> Consistent improvement in 4-hour waiting time for non-admitted patients Patients with back pain seen by physiotherapists were 	<p>X</p>	<p>National Emergency Access Target</p>

<p>Location: Alfred Hospital, Victoria</p> <p>Workforce: physiotherapy</p> <p>Model: single-centre study</p> <p>Reference: www.hwainventory.net.au</p>	<p>department.</p>	<p>14.5 times less likely to be admitted</p> <ul style="list-style-type: none"> Released capacity of medical staff to manage other patients 		
<p>Initiative: Soft tissue injury management by physiotherapists in emergency department</p> <p>Location: University Hospitals Bristol NHS Foundation Trust, UK</p> <p>Workforce: physiotherapists</p> <p>Model: single-centre study</p> <p>Reference: McClellan, C et al. (2012). A randomised trial comparing the clinical effectiveness of different emergency department healthcare professionals in soft tissue injury management. <i>BMJ Open</i>, 2: e001092</p>	<ul style="list-style-type: none"> Adults presenting to the emergency department with peripheral soft tissue injury were randomly assigned to and managed by physiotherapist, emergency nurse practitioner or doctor Measure taken: upper and lower limb functional scores, quality of life, days off work 	<p>All three groups had clinically equivalent outcomes</p>		<p>Improve patient flow</p> <p>National Emergency Access Target</p>
<p>Outpatient clinic examples</p>				
<p>Initiative details</p>	<p>Approach</p>	<p>Outcome/s</p>	<p>Extended scope</p>	<p>Priority area</p>
<p>Initiative: AHP in pain management</p> <p>Location: Royal Brisbane and Women’s Hospital, Metro</p>	<p>AHPs were involved in triage, initial assessment, case coordination, care planning and providing self-management education for category 2 and 3 adults presenting persistent non-malignant pain</p>	<p>Outcome to date:</p> <ul style="list-style-type: none"> Reduced assessment replication <p>Expected outcome:</p>		<p>Improve patient flow</p> <p>Reduce</p>

<p>North Hospital and Health Service, QLD</p> <p>Workforce: Psychology, occupational therapy, physiotherapy</p> <p>Model: single-centre study</p> <p>Reference: www.health.qld.gov.au</p>		<ul style="list-style-type: none"> • Reduced outpatient waiting time 	<p>outpatient department waiting time</p>
<p>Initiative: Physiotherapist assessment of spinal pain using Telehealth</p> <p>Location: Sir Charles Gardiner Hospital, WA</p> <p>Workforce: physiotherapy</p> <p>Model: established practice</p> <p>Reference: www.hwainventory.net.au</p>	<ul style="list-style-type: none"> • Initial assessment of patients in regional areas referred to neurosurgery clinic with spinal pain is done by Telehealth, with assistance from a regional physiotherapist performing the examination in real time • Patients come to Perth and see the surgeon the same day as their imaging is performed • Sustained for the past three years 	<ul style="list-style-type: none"> • Reduced costs for travel • Reduced patient stress 	<p>Improve health services for regional, rural and remote communities.</p> <p>Improve patient flow</p>
<p>Initiative: Audiologist led triage clinic</p> <p>Location: Royal national Throat, Nose and Ear Hospital, UK</p> <p>Workforce: Audiology</p> <p>Model: single-centre study</p> <p>Reference: NHS improvement. (2010). Pushing the boundaries</p>	<p>An audiology team reviewed patients on the waiting list for ENT to determine the number of suitable referrals (i.e. did not meet any 'red flag criteria' indicating referral to ENT), and made decisions regarding appropriate management</p>	<ul style="list-style-type: none"> • Initial findings suggest that 75% of referrals did not meet 'red flag criteria' and could potentially be managed by the diagnostic audiology service in a direct access service • New model would potentially release approximately 45 outpatient appointments with ENT per week • In 95% of cases, audiologists and ENT doctor were in agreement as to the referral pathway to audiovestibular medicine or ENT 	<p>Reduce outpatient department waiting time</p>

<p>– evidence to support the development and implementation of good practice in audiology 2010. www.improvement.nhs.uk/audiology</p>				
<p>Initiative: Community forensic mental health outreach service</p> <p>Location: Multiple sites across QLD Hospital and Health Services</p> <p>Workforce: psychology and social work</p> <p>Model: established practice</p> <p>Reference: www.health.qld.gov.au/forensicmentalhealth/</p>	<ul style="list-style-type: none"> Psychologists and social workers (together with psychiatrists and nurses) provide targeted interventions to address problem behaviours identified in prior forensic assessment to reduce risk (e.g. sexual offending, stalking and violence) This community-based service is delivered by clinicians within the clients mental health treating team The program has great potential to assist hospital and health services to better address both the criminogenic and mental health treatment needs of people with mental illness who offend or who are at risk of offending 	<p>Increased access for targeted client groups</p>		<p>Support recovery from mental illness</p>
<p>Initiative: General paediatrics AHP screening advice</p> <p>Location: Royal Children’s Hospital Children’s Health, QLD</p> <p>Workforce: psychology, speech pathology, occupational therapy, physiotherapy</p> <p>Model: established practice</p> <p>Reference: www.health.qld.gov.au</p>	<ul style="list-style-type: none"> During a trial of AHP screening and brief intervention services to decrease waiting list in general paediatrics, 247 referrals were triaged out of general paediatrics into an AHP service Phone triage was used to gather information and refer to the most appropriate service, including back to general paediatrics 	<ul style="list-style-type: none"> Reduced duplication of service Timely access to more targeted services Released medical specialists time to see more complex cases 		<p>Reduce outpatients department waiting time</p> <p>Improve patient flow</p>
<p>Initiative: Psychologists as first contact for general paediatric referrals.</p>	<ul style="list-style-type: none"> The psychologists provided the first point of contact following triage for 60% of category 2 and 3 referrals to general paediatric clinics 	<ul style="list-style-type: none"> Significant reduction in wait time 25% of patients seen by psychologist required referral on to 		<p>Reduce outpatient department waiting time</p>

<p>Location: Ipswich Hospital, West Moreton Hospital and Health Service, QLD</p> <p>Workforce: psychology</p> <p>Model: single-centre study</p> <p>Reference: Psychology Department, Ipswich Hospital</p>	<ul style="list-style-type: none"> Where required, the psychologist referred directly to the paediatrician 	<p>paediatrician</p>		
<p>Initiative: Podiatrist led musculoskeletal clinic</p> <p>Location: The Northern Hospital, Victoria</p> <p>Workforce: podiatry</p> <p>Model: single-centre study</p> <p>Reference: www.hwainventory.net.au</p>	<p>Podiatrist-led clinic assessed patients (of low priority for foot surgery) to determine benefits of conservative management versus surgery</p>	<ul style="list-style-type: none"> Reduced waitlist for orthopaedics Quicker access to appropriate care Improved outcomes through timely conservative management 		<p>Reduce outpatient department waiting time</p> <p>Improve patient flow</p>