Grey, Christine W (DHHS)

From: Hollings, Cindy (DHHS)
Sent: Monday, 18 May 2015 4:57 PM
To: One Health System (DHHS)
Subject: FW: Allied Health Srevices THO-North response to exposure paper
Attachments: Delivering Safe and Sustainable Clinical Services White Paper Exposure Draft ~ AHS Key Points_Analysis_Evidence (3).pptx

Dear Onehealthsystem email receivers.

I have been informed that a slight extension of time has been granted for responses from Allied Health (Lee McGovern).

Unfortunately my response is far from complete, has not been correctly referenced, and is quite bizarrely via power-point, but I hope it will be received as a draft, to be upgraded if required.

Although in draft, I hope to impress that Allied Health has the will and skill to contribute extensively to the health care of our population, no matter where services are provided, and have provided evidence to back my claims.
I understand that this evidence is better placed at the CAG level where models & service design could be robustly debated amongst a range of professional providers, if structure of the CAGs allows this. I note an interesting paper from SARRAH which I hope has also been submitted, showing a range of evidence supporting allied health's value in the system.

I send this as additional to the submissions made by other allied health such as THO-South, and AHPEC, rather than in contradiction to these

Thankyou for your consideration
Yours sincerely
Cindy Hollings

Cindy Hollings
Acting Director Allied Health

Internal contacts- please browse the THO-N Preventing Falls and Harm from Falls Intranet page

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Tasmanian Health Organisation – North
Allied Health Services

Delivering Safe and Sustainable Clinical Services White Paper – Exposure Draft March 2015

Response/Evidence: unreferenced version

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TASMANIAN HEALTH ORGANISATION NORTH

2.	Designing a better health care system	17
2.1	Strengthening our acute care system Allied health support any system reforms which result in higher quality, more safe, efficient and effective health care for Tasmanians. Some suggestions: • Naming-up the acute system clearly as "Health Care" rather than "Health" will provide definition of core service, boundaries & community expectation. • Transparent outcome measures, relevant to the patient's experience, can be clearly determined, stated & measured in order to measure the success of the health care system rather than process measures. Example: hip & knee pain/osteoarthritis treatment aims to improve mobility and decrease pain; there are many ways of treating the patient to achieve these outcomes including surgery as dependent on many variables. Current KPIs are based on surgery and waiting lists, not patient experience or outcomes. • Patient centred care, both as a value and an outcome measure, should be built in to the KPIs for services. • The Acute Care system's strength is provided by it's staff, management, facilities and common goals or stated purpose. • Allied Health should be provided at benchmark numbers, with state wide equity dependent on service level, with leave relief built in to the numbers, and be accessible on a 7 day per week basis where evidence exists, to enable the system to work at an optimum level- this requires adequate (increased) staffing funding. • Evidence exists to show that Tasmania consistently rates in the lower or lowest numbers of allied health per head of population, even though Tasmania has high needs in terms of health outcomes and social disadvantage. • To enable strong health outcomes, allied health numbers should be increased across the board to enable a shift of care to less costly and better positioned services. • Services need to be broadly aimed at the most common & preventable diseases existing in Tasmania, at all levels and departments of government including education & local , with coordination across primary health, secondary & tertiary providers, both public & private: in musculo-skeletal, cardio-respiratory, obesity, diabetes and stroke. • Health interacts with other areas of government and outcomes are cross sectorial: for example, early	

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- Allied Health has valuable expertise in both the treatment of surgical patients, and in alternatives to surgery in some cases, both as independent practitioners and as members of a multidisciplinary team working in close consultation with Surgeons.
- This expertise should be engaged at the high levels of planning and advising, and systems informed by current evidence (evidence takes somewhere between 8-14 years on average to be implemented into practice within medicine broadly).
- Strong evidence exists that allied health practitioners can improve patient outcomes, reduce complications, decrease length of stay, and contribute to pre-op work ups and triaging, for musculo-skeletal disorders, vascular disorders , and for prevention of chest infections post abdominal surgery.
- Strong evidence also exists to show that allied health practitioners can reduce the need for surgery, as first contact independent practitioners or within a surgical multi-disciplinary team.
- Examples of allied health intervention possibilities for Tasmania:

Research performed in Australia shows physiotherapy is an effective and risk-free treatment, which should be recommended as a first-line approach for women with stress urinary incontinence (SUI) before consideration of surgery. A groundbreaking study shows up to 84 per cent of women with SUI can be dry with continence physiotherapy, and cure rates equal to surgery for these women (Neumann et al 2005a). A further study, found that physiotherapy management of female stress urinary incontinence costs on average $302.40, while surgical management costs between $4668 and $6124 (Neumann et al 2005b).
According to data obtained from Medicare Australia there were more than 4500 surgical procedures for SUI performed in 2007. At an average cost of $5000 per procedure, this equates to a total outlay in excess of $23 million. The cost of successfully treating 84 per cent of those women with conservative physiotherapy would

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- Allied health practitioners provide support, maintenance & rehabilitation for patients undergoing assessment and treatment, often requiring intervention close to the patients home rather than place of treatment. This needs to be considered when designing support services around cancer services. Allied Health contribute to patients functioning and their quality of life, often for a long term post treatment- eg head & neck cancer & ongoing larengectomy care, lymphoedema treatment etc, and have been shown to prevent ongoing complications & avoid hospital presentations (dysphagia/pneumonia)
- Survivorship is an emerging field of intervention within cancer treatment which is heavily reliant on allied health and strong secondary & primary services. Physiotherapy led exercise groups have ben found to promote significant changes in Quality of Life, decreased fatigue and increased fitness in patients with newly diagnosed cancer diagnosis, which has flow on cost benefit to society.

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- Integration with Tas ambulance and reinstatement of the extended scope ambulance officers could enable allied health and nursing intervention for minor trauma, and falls prevention, which has potential to save admissions, bed days and morbidity & mortality for patients.

Evidence suggests:

Falls are one of the leading causes for emergency department (ED) presentations in older people.

In the 6 months following an index fall ED presentation, up to 52% of cases experience subsequent falls,2 3 49% are re- hospitalised and many experience functional decline.

There is conflicting evidence surrounding the effect of programmes designed to reduce secondary falls in older people presenting to the ED with a fall. Eight studies have reported programmes that had no effect on new falls, fall injuries or ED presentations, while three reported programmes reduced secondary falls. The characteristics that appear to differentiate successful programmes from others include delivery of the intervention within 1 month of the index fall and greater intensity of the interventions.

Strong evidence exists to support the efficacy of experienced Physiotherapist and Occupational Therapist intervention in reducing the rates of falls in high risk groups.

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Strong evidence supports Allied Health intervention and an early rehabilitation model of care within critical care services. For example: with early ICU Physiotherapy directed rehabilitation:

At least half of all ICU patients get severe muscle wasting, weakness, and significant long-term functional deficits.

ICU acquired muscle weakness is independently associated with poorer patient outcome, increased morbidity & mortality, longer LOS, and increased hospital costs.

ICU based early Physiotherapy reduces ICU muscle weakness and improves function

The following outcomes have been shown in large blinded randomised controlled trials comparing a control group to Physio directed early rehabilitation in ICU.

2.5 days less days on ventilator

2 days less delirium

1.5 days shorter ICU LOS

Better functional status at time of hospital discharge

3 days shorter overall hospital LOS

Overall, Physiotherapy directed early rehabilitation in ICU improves patient outcome and reduces ICU and hospital LOS following an ICU admission. There is a large and significant cost benefit to the health system.

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- Rehabilitation needs to be provided as close to patients homes as practicable.
- Levels of rehab need be defined, commencing in the acute phase of treatment (prevention of functional decline), and provided along the continuum into the community, with opportunity for community dwelling people to access preventative rehabilitation as required. In this regard, the north & North west community requires access to an equivalent to the southern Community Rehabilitation service.
- Some degree of rehabilitation could be provided in district facilities, provided staff are up-skilled, access to appropriate support staff exists at the sites, access to allied health supervision is factored into the establishment at major centres, sufficient & appropriate technology, and allied health have a role in decision making for the patient journey.
- Patients with chronic pain are a significant burden to the health care system. This is particularly the case in Northern Tasmania, with limited support often shifting the burden of care to emergency departments.
- Allied Health provide a small chronic pain service in Launceston which provides outreach.
- Although this team provides a strong allied health focus, the North of the state lacks a Medical pain specialist and associated specialised pharmacy input, as per best practice evidence . This is a significant key service gap for the North, and may also be evident in the North -West

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2.2.6	Maternity and neonatal services	35

- Neonatal services at various role delineation levels require Allied Health practitioners with expertise, however these neonates often require lengthy if not ongoing Allied Health care, which occurs in the local community, so needs to be funded as such, and not necessarily limited to the acute delineation location.

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- Medium and longer term follow-up is provided by Allied Health in the patient's local area, regardless of where the acute treatment occurs.

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- Cancer services, diabetes, infectious diseases (migrant & refugee health), neurology, respiratory, rheumatology & pain management, surgical services, neonatology, mental health & geriatric services all require allied health, in the acute, sub-acute and community phases. Effective patient outcomes from these services requires robust allied health investment, both in the North and the North-West. Increase in the role level of the LGH will require additional allied health input in order to assist flow through the system to free up beds, as well as expert intervention in the various clinical areas.

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- This is irrefutable. Health literacy consists of language/ literacy as well as social and environmental components, which are expertise areas of allied health.

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2.	Designing a better health care system	17
2.4	Strengthening our primary care system and linkages	52
2.4.2	The importance of primary care in delivering better health outcomes for the community 53 Evidence suggest that advanced scope of practice Physiotherapy care may be as (or more) beneficial than usual care by physicians for patients with musculoskeletal disorders, in terms of diagnostic accuracy, treatment effectiveness, use of healthcare resources, economic costs and patient satisfaction. The role of a strong allied health presence in primary care is currently limited by funding models, however could be supplemented by Health to keep people from presenting to ED or sitting on lengthy waiting lists.	

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- Strength of the health care system is promoted by the wider system that acute care fits in as a small but expensive phase.
- Acute care can only function strongly within a fully functioning primary and community health and support system, aimed at promoting and maintaining health & well being, providing treatment in the community, aiming at hospital avoidance and substitution, and providing support and care post discharge or during functional decline.
- Allied Health have a unique capability of working across the continuum of care, including in the community, primary health, secondary & tertiary care, mainly due to the focus on human function rather than body structure. This provides great flexibility and responsiveness in the Allied Health workforce.
- Complex Care in the community is an area to be invested in- avoidance of hospitalisation and the potential resultant secondary issues is paramount in vulnerable groups.
- Allied Health intervention can provide alternative care models, both stand-alone and within Multi-disciplinary teams, as an alternative to hospital and as a preventative to reaching this level of impairment.

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2.4.4	Rural primary health services	55

- Allied Health Practitioners have capability of working across and within primary, secondary and tertiary settings.
- Rural Primary Health has variable levels of Allied Health input.
- Potential for strengthening these linkages and interventions is great, especially with goal setting and coordination at a high level to ensure coordination occurs across the range of public & independent providers.
- At present, we are aware of the poor health outcomes and are making efforts on an individual and community level in some areas, for example, cardiac & pulmonary rehabilitation in Flinders Island.
- To be more successful, planning to combat the community health issues needs to be transparent, involve the community, provide leadership, and enable all people to identify their particular role in the achievement of these goals, and all be working to a common purpose.
- Value for money needs to be demonstrated, tackling the serious health problems: it is doubtful whether the community alone or small groups of health providers currently have sufficient skills or knowledge to undertake this successfully.

2.	Designing a better health care system	17
2.5	Working with partners to effect change across the system	55

- Partnering with external providers and agencies will require a clear big-picture goal and service plan which is accessible and meaningful and translatable at all levels, from planners to providers to consumers.
- Previously health plans have existed, but have not been easily translated into individual practice, let alone providing guidance for the community.
- The role of the TH-S Executive could be strong in this area if they are both tasked to work in partnership rather than competition and provided the capacity to do so.
- UTas and other mainland tertiary institutions could have greater engagement in both the education of allied health professionals and in research: Tasmania has a unique 'captive' population which could provide valuable evidence for other states in terms of chronic disease management and ageing issues. Wit Tasmania's unenviable leadership in the ageing stakes, why aren't we a state of excellence and leadership in this area?
- The data coming from AROC (Australian Rehabilitation Outcomes Centre) shows that the population accessing rehabilitation in the north have higher comorbidity, less social support and are older than other comparable centres.
- When planning for services and benchmarking , these social and health factors must be taken into consideration.
- This data alone is sufficient evidence that a planned approach across sectors is required in order to achieve change in acute/subacute tertiary health settings.

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2.6	Strengthening our transport and accommodation support systems	56

- This will require IT systems support in order to be able to make co-ordinated appointments, and assessment processes and easily accessible information on accommodation options for patients.
- A particular accommodation issue arises for people under the age of 65 who suffer major functional impairment: these people can often occupy an acute care bed for 2 years whilst waiting for suitable accommodation options to become available. This is unacceptable for both the organisational and the individual. The wider system seems unable to accommodate such wide variations from the norm. Allied Health would welcome the re-formation of a decision making group for this cohort (Previously the board of Exceptional Needs)

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- The purchaser provider split between DHHS and THS needs to be clear, with measurable achievable KPIs that are within the capacity of the THS to achieve.
- THS executive need to be able to function in an autonomous environment, free from administrative overburden from Government, in order to achieve and effect truly remarkable change within the system .
- Allied Health welcomes the opportunity to be a partner at Executive level to assist the system to achieve the change required to meet its target of the healthiest population in 10 years time.

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3.	Governing the health system of the future	59
3.2	Statewide clinical governance framework	61

- Clinical panning and governance does not equate with staff management and should not be confused with operational activities required in each site.
- Planned service provision across this small population of Tasmania should be achievable with clarity of purpose and outcome measures.
- This will be challenging coming out of a fairly competitive individualised structure of the THOs.
- Allied Health have collaborated at both an executive and operational level prior to and during THOs, and look forward to greater planning and collaboration at the service level.
- State-wide clinical governance policy is already in place within Allied Health
- Allied Health are well positioned to operate within a state-wide framework, as patient and population functioning is our outcome measure which bypasses potential conflict around resource and status.

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3.	Governing the health system of the future	59
3.4	Clinical advisory groups	62

- To function transparently and effectively, these need to have a place within the governance structure and be fairly & democratically representative.
- Allied Health would welcome transparent, planned and equitable representation within the CAGs.

4.	64
4.4	Technology 67 • Many systems, both patient management and administrative, need to be upgraded and integrated, such as payroll, EDIS, PAS, and at worst actually implemented, such as true electronic medical records. • Poor information systems present safety risks to patients, disables system/process reforms, and wastes considerable amounts of valuable clinical time and energy.

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