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# **Allied Health Professional Services Tasmanian Health Organisation-South**

**submission to**

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

**20 February 2015**

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## I Executive summary

Allied health professionals (AHPs), along with doctors and nurses, are an integral part of the Australian health system. 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. However, the Green paper has little information about current AHP services and contributions, the issues encountered, and possible AHP services redesign and initiatives. This AHP response to the Green Paper provides a brief summary of this missing information.

A separate response to the role delineation framework has been submitted from state-wide AHP structures.

The Tasmanian AHP workforce is significantly undersupplied and underdeveloped, and their competencies are underutilised when compared to AHP workforces interstate. 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.

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.

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.

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.

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.

# Introduction

## 1.1 Vision for the Tasmanian Health Organisation

Allied health professionals (AHPs) in the Tasmanian Health Organisation-South (THO-South) welcome the vision for the new Tasmanian Health Service. It provides opportunities for improved service quality (especially safety, effectiveness and efficiency) and linkages across Tasmanian primary, secondary and tertiary services and facilities.

Allied health professionals in the THO-South, as with the Australian Government's Productivity Commission 'Australia's Health Workforce Research Report' (2005) recognise that escalating demands on services, rising costs, an increasing prevalence of chronic diseases, and changing demographics are driving the need for changes to the way healthcare services are delivered and by whom.

## 1.2 Allied health professions

Along with nurses and doctors, AHPs are an integral part of the Australian health workforce (Health Workforce Australia, May 2014).

'Allied health professions are a distinct group of health professionals who apply their expertise to diagnose, treat and rehabilitate people of all ages and all specialties. Together with a range of technical and support staff they may deliver direct patient care, rehabilitation, treatment, diagnostics and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive and social functions' (International Chief Health Professions Officers Consensus Statement June 2012).

Of the approximately 25 allied health professions employed across THO-South, 10 of these are employed in Allied Health Professional Services:

Audiology	Orthotics/Prosthetics	Speech Pathology
Chaplaincy	Physiotherapy	Social Work
Nutrition and Dietetics	Podiatry	
Occupational Therapy	Psychology	

These services manage people with all health conditions—from acute and life-threatening to chronic and complex, and across the age continuum—from ante-natal to extreme old age and death.

Allied Health Professional Services recognise their responsibility for using available resources to maximise consumer outcomes. They 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 this response to the Green Paper, AHPs demonstrate 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.

## **2 Responses to Green Paper: Delivering safe and sustainable clinical services**

Allied health professionals (AHPs) welcome the understanding that health system changes are required so that the general health of Tasmanians improves well beyond the current poor status.

### **2.1 General comments**

#### **2.1.1 Shifting focus to primary and community care**

- The Green paper and supplements do not clearly differentiate between community and primary health care services in terms of delivery or sources of funding. For example, to AHPs, 'community' means publically funded services (whether delivered by the state, NGOs or other entities) outside hospitals; 'primary care' means the first point of contact in the community for health care that is not specialist care (this could be delivered by services, such as general practitioners, private AHPs or publically-funded community AHPs).
- Allied health professions are integral to clinical service delivery, but there is little mention of their services. The Green Paper and supplements mainly focus on doctors and nurses and this undervalues the AHP contribution.
- There is no discussion of the socio-economic determinants of health. For example, how low levels of education in Tasmania translate to low levels of health.

#### **2.1.2 Redesigning clinical services**

- Allied health professions support role delineation of services. They understand that the current dilution of clinical services across Tasmania is not only unsafe, but is very expensive and unsustainable.
- Allied health professions support the use of visiting specialists and tele-health technologies and improving linkages between local and specialist providers to extend best care across Tasmanian.
- The expansion of RHH specialty outpatient clinics to incorporate AHP services, making them truly multi-disciplinary and comprehensive is required.
- Clarification of the Launceston General Hospital's current and future provision of tertiary services (as page 26) is required.

#### **2.1.3 Changing governance and funding structures**

Allied health professions support a purchaser-provider model where central data analysis by the purchaser determines the services provided. Activity based funding is also supported, if

internal funds are transparently allocated to all services (specifically AHP services) involved in the care of specific patient groups.

## 2.2 Questions for clinicians

### **A. *How well does the proposed framework align with practice in your discipline?***

From an allied health professional (AHP) perspective, the Green Paper's proposed framework is vague, making it difficult to answer this question.

As well, lack of specifics limit specific responses from each of the 10 responding AHPs. Although some allied health professions may be few in numbers, their speciality needs consideration, as their efficiency may be more significantly impacted by proposed changes, than larger professions with more resources.

### **B. *Where are the areas of service duplication in your discipline?***

- Although community and RHH AHP services have no overlaps in service delivery, the current integration of these services will facilitate easier movement of resources across these sectors to match client demands.
- Duplication in clinical procedures outside AHP services greatly affects the efficiency, effectiveness, morale and overall quality of these services. For example, if AHPs were able to work to their full scope of practice, they could accept direct referrals, rather than referrals through a general practitioner; or they could complete services, rather than passing the patient onto another profession. Examples are the surgery follow-up clinics operated by AHPs Supplement 5 and in Attachment A.
- There is duplication in administration procedures for AHP clinicians, e.g. multiple referral systems, low technology paging systems. Poor access and lack of information technology in the community at the point of care, and no access to the digital medical record necessitates double-handling (hard and later electronic copy) of client information. This reduces clinician efficiency in small services that are already struggling to match client demands, as there are few administration and clerical staff to support them to do this.
- Double and triple handling of paperwork by AHP managers, particularly in the human resource area, means that the health system is not receiving value for money, and as well, managers are diverted from their very important role of quality improvement.
- There is duplication of ambulatory rehabilitation services in THO-South.
- There is professional governance duplication, as AHPs in the Community Rehabilitation Services are not linked to Allied Health Professional Services' professional governance structures.

### **C. Where are the gaps?**

- See also responses to individual Supplements 2, 3, 4, and 5.
- The number of AHPs per population in Tasmania is significantly lower than other Australian jurisdictions, e.g. audiology, dietetics, occupational therapy, physiotherapy and psychology (Health Workforce Australia, May 2014).
- There are no exercise physiologists employed within Tasmanian health services. This profession can significantly contribute to the management of chronic diseases.
- There are no AHP management structures that cross all departments within the DHHS to enable a complete overview to improve access to AHP services and the flow of patients/clients from one department to another, e.g. across THO-South, Disability, Housing and Community Services and Children and Youth Services. A global perspective would also assist with the development of partnerships with private and non-government services.
- 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.
- Currently there are very limited psycho-geriatric AHP services across THO-South.
- Patients in interim care beds and in rural hospitals have limited access to visiting AHP services, which is not optimum comprehensive care.
- Bariatric services are not multi-disciplinary as recommended by clinical practice guidelines (Mechanick et al., 2013). Hence, the ongoing dietetic, occupational therapy, physiotherapy, psychological and social work services to sustain weight loss and health are not provided.
- There are gaps in rehabilitation services for medically stable inpatients. For example, interstate health services provide step-down rehabilitation and rehabilitation-in-the home for people who do not need medical and nursing care in hospital, and can resume more of their independent function; a much less expensive model. Internationally, AHPs have taken a leading role in provision of these services (e.g. post-acute neuro-rehabilitation in the United Kingdom).
- There are specific gaps in each AHP. However, a few of the major gaps are:
  - in audiology services,
    - there are no diagnostic audiological services in the North or North West of the state.
    - diagnostic services are only available at the RHH for children and for adults attending a RHH clinic. The current wait for a paediatric audiology appointment is nearly 12 months.



- the lack of audiology services means that adults with hearing loss who are not eligible for the Commonwealth Office of Hearing Service must see a private provider.
- only 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.

- 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.

○ in dietetic and nutrition services,

- the only community publically-funded nutrition services offered are three clinics per week at Clarence and Kingston community centres.
- other community/primary care dietitian services are offered by Tasmanian Medicare Local and non-government organisations, but there is no overall planning, coordination and communication between these organisations and THO-South.
- there is a limit of ten children per year who can access insulin pump training by a dietitian, with demand being much higher.
- there is no adult eating disorder team, and no dietitian involvement in the paediatric and adolescent eating disorder team.
- there is no adult food allergy service and the paediatric allergy dietitian has a three -month waiting list.
- there is no dietitian in the DHHS-funded St Giles service that manages children with growth failure and conditions requiring permanent tube feeds.
- 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.

- in podiatry services,
  - there is a very low RHH inpatient coverage, considering 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.
- In psychology services,
  - Burns clinic. 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.
  - Older adults/dementia. 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'.
  - Oncology. 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.
  - 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.

- 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.
- In addition, there are several services provided by psychology where staffing is either unfunded (and therefore not sustainable) or underfunded. These include paediatric diabetes, which has the potential to reduce the health burden and improve health outcomes of this population over the course of their lifetime; specialised psychological services in Mental Health Statewide Services, such as alcohol-related brain injury assessments, Alcohol and Drug Services inpatient therapeutic interventions; and psychologists working with patients/clients on elective surgical waiting lists with co-morbid conditions e.g. diabetes, heart disease, obesity, arthritis, etc.
  - in social work, there are significant gaps in the provision of services in the Emergency Department. This is the frontline for service delivery in the RHH and Social Work Services currently have only 0.6 full-time equivalent (FTE) social worker 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). There is no broader permanent social work allocation to the Emergency Department, which has the potential to prevent social admissions and decrease Emergency Department and RHH length of stay for other general client groups.
- 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). There is insufficient funding for ADL equipment to support consumers to remain living in their community environment and to facilitate effective and timely discharges from hospital.
- 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. Due to lack of

investment over the past 20 years, waiting periods are now longer than 12 months, during which time many clients experience significant negative consequences, occasionally leading to hospital admission.

- Prosthetic services for amputees. These services 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.
- There are gaps in staff to support AHPs, especially administration and clerical staff. This results in huge inefficiencies and reduced services to clients from specialist clinicians. This strategy of reducing administration staff to reduce costs is one of those, which actually increases health system costs through the diversion of clinicians away from the delivery of client services (Kaplan & Derek, 2014).
- 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.

***D. Are there any services being inappropriately provided, or planned, at your facility?***

- The location of AHP services in the Telstra Building across from the main RHH campus and the need for clinicians to cross multiple times per day, reduces the output of all of these services, possibly by a minimum of 15% each day. There is no obvious plan for the relocation of these services back into the main RHH campus.
- There are allied health assistants working with no supervision in some areas of THO-South. This is not only potentially very unsafe, but also this lack of appropriate direction is wasteful of these resources.
- Adults and children receiving cochlear implants have assessment and initial rehabilitation interstate. These services could be provided in each region for less than the cost of sending these patients to Melbourne.
- Paediatric bariatric services are planned without a comprehensive multi-disciplinary team, including all the AHPs required to support the children and their family.
- Many psychologists across Tasmania are working in isolation from their discipline, due to low numbers and distance. There is evidence that this increases the likelihood of misconduct and difficulties maintaining professional boundaries (Grenyer & Lewis, 2012); a more cohesive, state-wide psychology service would alleviate some of this isolation.

**E. *How do we promote and maintain safe primary and community care to consumers and communities such that they seek out these services rather than attend Emergency Departments when their conditions are more advanced?***

- See responses to Supplement 3: Community Care and Supplement 4: Emergency care.
- There needs to be clarification of what is meant by 'community' and 'primary' services.
- 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.
- There needs to be the full range of AHP services in multi-disciplinary teams at community centres 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. Only limited podiatry services are available 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.

**F. *How do we determine which services to focus on to expand the role of primary and community care?***

- 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.
- 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.

**G. What services do not have sufficient volume or activity in Tasmania to maintain a safe, high quality service?**

Traumatic spinal injury and some complex spinal surgery services should continue to be obtained from interstate centres. Allied health professionals must continue to maintain and develop relationships with the interstate providers to be able to provide the follow-up management required in Tasmania.

**H. What additional areas should we be considering for interstate partnerships in order to improve service within Tasmania?**

- 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.
- Allied health professionals have research partnerships with many mainland universities, as there is no local dedicated AHP professorial research unit or assistance.

**I. What services, despite comparatively low volumes, should we continue or invest in in Tasmania, and what interstate supports may be required to maintain them?**

As AHPs participate in The Health Roundtable, they can identify through benchmarking which client groups require more THO-South AHP services than the Health Roundtable norm. Generally, these are complex, multi-trauma cases, which might require long periods of intubation in intensive care or ongoing behavioural management for severe head injuries. The management of these 'one-off' cases is usually appropriate in THO-South utilising senior and specialising local AHPs. If required, further specialist advice is sought from colleagues in appropriate interstate centres of excellence, e.g. Royal Children's Hospital, the Austin Health.

### **3 Response to working draft: Tasmanian role delineation framework**

See separate response from the Tasmanian Directors of Allied Health.

## **4 Responses to Green Paper issues papers**

### **4.1 Supplement 1: Sustainability and the Tasmanian health system**

Allied Health Professional Services are committed to a sustainable Tasmanian health service and already prioritise their clinical caseloads with objectives to:

- balance the clinical needs of consumers, available staff and the needs of the referring service
- allocate allied health professional (AHP) resources to areas of greatest impact on health outcomes. Most services are only funded in regular hours, Monday to Friday
- operate within the World Health Organisation's (2002) bio-psycho-social model, which recognises the dynamic interaction between a person's health condition, environmental factors and personal factors.

Allied health professional interventions in the THO-South are prioritized to:

- avoid hospital admissions (RHH Emergency Medical Assessment Team, community AHP services and RHH specialist AHP outpatient clinics)
- provide alternatives to hospital presentation (RHH Emergency Medical Assessment Team, community AHP services and RHH specialist AHP outpatient clinics)
- substitute hospitalisation (community AHP services and RHH specialist AHP outpatient clinics)
- decrease hospital length of stay and facilitate safe discharge to prevent hospital readmission (RHH AHP inpatient services)
- optimise the use of health system resources through the appropriate and timely involvement of AHPs (community AHP services and RHH specialist AHP outpatient clinics). This includes health promotion and disease prevention, and chronic disease management.

As can be seen, AHPs benefit clients and the health system across the continuum of the RHH, community and outpatient services.

Allied health professional interventions are mainly delivered through people, rather than technology. Hence, little AHP technological waste has been identified, as discussed in the Supplement 1 page 5.

In addition, there are no duplications of AHP services within the Tasmanian Health Organisation-South or from it across Tasmania, as discussed in Supplement 1 page 6. Rather, many service gaps have been identified by AHPs, see specific clinical questions earlier.



## 4.2 Supplement 2: Tasmania's health workforce

### 4.2.1 General overview

Allied Health Professional Services support the strategies outlined in the Tasmanian DHHS 'Strategic Framework for Health Workforce 2013-2018', particularly:

- 'Grow the workforce in line with forecasted services need, including developing a planning structure for small but critical sections of the health workforce.'
- 'Work with key stakeholders to ensure education and training pathways reflect the needs of the health system workforce and desired population health outcomes.'
- 'Identify and progress initiatives that extend the scope of practice of health professionals.'

Although Supplement 2 states that 'We need a range of health professionals working together to deliver our services', it focuses mainly on the medical and nurse workforce. It is suggested that terminology such as 'clinician' is broadened beyond doctors to include allied health professionals (AHPs); and that 'discipline' is broadened beyond that of a medical sub-speciality to include other professions in general, such as AHPs.

Workforce models for AHPs cited as 'new' in the document' are only such in the Tasmanian context; they are now routine practice in mainland Australia. Allied health professionals support the realignment of the Tasmanian medicine, nursing and AHP workforces to implement 'new' models of care that provide more efficient and effective delivery of care for both the clients and the state, see examples in Attachment A.

The Productivity Commission's 'Australia's Health Workforce Research Report' (2005) states that simply expanding the health workforce would not be an adequate response to these challenges. The report identifies the importance of achieving improvements in the efficiency and effectiveness of health workforce arrangements, including utilising the AHP workforce to their full capacity, and also including a broader scope of practice for these professions.

Other Australian jurisdictions have taken on these recommendations and have since begun to explore options for utilising the AHP workforce and broadening the scope of this group of highly trained professionals. For example, 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.

#### **4.2.2 Current allied health professional workforce**

The Tasmanian Department of Health and Human Services (DHHS) employs staff from approximately 25 AHP disciplines. Of these, pharmacists, 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 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%).

### 4.2.3 Issues

- Health Workforce Australia has released the 'Health Workforce 2025 Report' (2012), which focuses on workforce issues of doctors, and nurses and midwives and medical sub-specialities. Key issues from these reports are described in Supplement 2 page 4.

However, Health Workforce Australia (March 2014) also published a number of workforce In Focus Reports for dietetics, optometry, pharmacy, physiotherapy, podiatry and psychology. These were not discussed in Supplement 2. 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. The trend in THO-South has been to eliminate these positions, putting the burden of performing the necessary customer service duties on AHPs or assistant staff, significantly reducing clinical capacity (Kaplan, 2014).
- A number of training issues also affect the sustainability and suitability of the AHP workforce for the challenges of contemporary healthcare. These are not mentioned in the Green Paper. 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.

#### **4.2.4 Allied health professional workforce initiatives**

- The DHHS, in collaboration with a registered training organisation and the Australian Government, is supporting vocational education for allied health assistants in order to standardize their competencies so that they can support AHPs where the activities are routine and less complex.
- A recent DHHS review of the expanded scope of practice of AHPs has been undertaken. A framework for health service providers wishing to develop an expanded scope of practice role for an AHP, has been drafted. This proactive strategy will support consistency when determining the need, planning, implementation and evaluation of expanded scope of practice for AHP roles.
- Allied health professionals have benefited from access to DHHS scholarships for postgraduate study through the University of Tasmania, especially the School of

Medicine. Staff from the Faculty of Health and AHPs are currently developing a UTAS unit on supervision to assist clinicians with student and peer-supervision.

## 4.3 Supplement 3: Building a stronger community care system

### 4.3.1 General overview

- The Green paper and supplements do not clearly differentiate between community and primary health care services in terms of delivery or sources of funding. For example, to allied health professionals (AHPs) 'community' means publically funded services (whether delivered by the state, NGOs or other entities) outside hospitals; 'primary care' means the first point of contact in the community for health care that is not specialist care (this could be delivered by services, such as general practitioners, private AHPs or publically-funded community AHPs).
- In addition, the document completely omits description of community services provided by AHPs in the public (dietetic, occupational therapy, orthotics/prosthetics, physiotherapy, psychology, podiatry, social work, speech pathology services ), private and non-government sectors.
- Some additional AHP community services, service issues and initiatives are described in the response to Supplement 4: Emergency care.

### 4.3.2 Current allied health professional services

Similar to community nursing services, AHP services are provided outside the Royal Hobart Hospital, see the functions in Supplement 4.

Allied health professions are represented on the Tasmanian Medicare Local's Clinical Working Groups as key stakeholders in developing Tasmanian Health Pathways, and on some Clinical Advisory Groups.

### 4.3.3 Issues

- The Supplement states that 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).
- 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.

- The well-established service models cited in Supplement 3, such as the Victorian Hospital Admission Risk Program (HARP) and the Queensland Community Assessment and Referral Service (CARS) provided the basis for the establishment in 2003 of the Emergency Medical Assessment Team in the RHH ED, as described in Supplement 4.
- Other hospital avoidance models, e.g. hospital-in-the-home or rehabilitation-in-the-home, involving AHPs have been trialled. However, dis-economies of scale, especially in tight fiscal environments have significantly affected their ability to be continued/developed or expanded.
- Limited community AHP services are provided to rural health and multi-purpose centres. These services are ideal to increase access to health care for rural communities,

which are often those with significantly reduced health outcomes. These AHP services are frequently the first services to be ceased or decreased with funding cuts.

#### **4.3.4 Allied health professional initiatives that could assist community care**

- As well as the initiatives for community services recommended in Supplement 4, there are currently three AHP services (occupational therapy, physiotherapy and social work) that each have had separate community and Royal Hobart Hospital (RHH) organisational structures. These have been or are in the process of integration to enable easier service redesign and transfer of AHPs between the two sectors. These amalgamations will also 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, as described in Supplement 4.
- Recently, the Palliative Care Service has obtained Australian Government funding for limited AHP services to facilitate more comprehensive multi-disciplinary care, and to lessen the demand on regular community AHP services. However, it has not been possible to recruit to the physiotherapy position, so for this profession, the old model of care continues with referral from the Palliative Care Service to community or primary-based physiotherapy services. This results in fragmented care.

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).

- A service model, which uses allied health assistants across four AHPs (occupational therapy, physiotherapy, speech pathology and podiatry) in the 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. Whilst this service is extremely limited, it is an opportunity to trial the benefits.
- 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.

Allied health professions also utilise tele-health facilities for state-wide and interstate staff development and journal clubs.

## 4.4 Supplement 4: Emergency care

### 4.4.1 General overview

The Supplement does not provide information about allied health professionals (AHP) in emergency care teams within the RHH Emergency Department (ED), in community and rural centres and services, or in specialist outpatient clinics. In addition, it does not describe opportunities (including service redesign and new services) where the AHP workforce could contribute to improved emergency care, or the needs of the AHP workforce in providing emergency care. This information is now supplied below.

### 4.4.2 Royal Hobart Hospital ED: Emergency Medical Assessment Team

#### 4.4.2.1 Current allied health professional services provided

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. However, there is no mention of the team, which has been in operation since 2003, in Supplement 4.

#### 4.4.2.2 Issues encountered

- The Team assists with ED throughput and output, but is limited by:
  - support
    - from other RHH-based AHP services to assist in immediate assessments and decision-making in ED, e.g. speech pathology to assess a person's swallowing (currently speech pathologists provide a very limited

consultancy service from the RHH wards), and dietetics to advise on diets that can reduce the risk of further presentation (e. g. constipation, diarrhoea, malnutrition, food allergy, compromised swallow, poorly tolerated tube feeds).

- for ED discharge, from a range of community services, especially after-hours (out of 9.00 am-5.00 pm, Monday to Friday), e.g. respite care, community housing and community nursing. People have to be admitted to the RHH as there is no other care available.
- the decreasing ability (because of reduced funding) of RHH inpatient AHP services to address quickly the needs of new patients admitted to wards.
- unpredictability of demands on a small specialist team.
- their capacity (time) to respond to out-of-hours referrals from the ED, or the capacity for community based AHP services to follow up out-of-hour referrals within 24 hours. A funded out-of-hours AHP referral service would enable doctors to discharge people from ED with a certainty of follow-up within 24 hours to address risk of representation/admission.
- 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 Emergency Medical Assessment Team occupational therapist and social worker have very limited capacity to attend to all ED presentations appropriate for their services. A six-month study in an Australian ED demonstrated that of the consumers referred to occupational therapy or social work, 81.3% were discharged home from ED following intervention. Of the total referrals, it was predicted that 48% would have been admitted without direct intervention from occupational therapy or social worker (Carlill et al.,2002).

- The recently established RHH ED Fast Track service includes doctors and nurses but no AHPs. Again, many of the client presentations could be managed by AHPs whose core competencies appropriately match client requirements. Supplement 4 outlines an expanded role for nurses, but not AHPs. Expanding the scope of practice of physiotherapists in ED would enable them to directly assess, refer for diagnostic and specialist assessments and treat patients with acute musculoskeletal injuries and respiratory conditions. Not only would this be more effective, it would be more efficient by freeing up nurses and doctors to attend higher category patients. This model of care is well established in many other jurisdictions across Australia (e.g. ACT Health, VIC Health), see Attachment A: emergency service examples.

#### **4.4.2.3 Initiatives to improve the service**

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).

#### **4.4.3 Royal Hobart Hospital ED: Mental health services**

Although approximately 10% of emergency department presentations are for primary mental health needs (Queensland Health, 2014), currently there are no AHPs employed in the mental health services in the RHH ED.

#### **4.4.4 Royal Hobart Hospital ED: Short stay**

Patients in RHH short stay units, e.g. Emergency Medical Unit (EMU) and the Assessment Planning Unit (APU) receive similar AHP treatment to patients in other wards. This includes

assessment, advice/recommendations and family/carer education, and depending on the length of stay in the unit, some patients may receive initial therapy. However, these AHP services are supplied from RHH AHP ward services and there is limited capacity to assist a timely discharge from the short stay units.

#### **4.4.5 Community and rural services**

##### **4.4.5.1 Current allied health professional services provided**

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.

#### **4.4.5.2 Issues encountered**

- There are waiting lists for people to access community AHP services, and this affects their health outcomes, e.g. a sprain can become a chronic by the time the person attends an appointment; lymphoedema and incontinence (NICE, 2013) can become a significant, long-term chronic disease burdens in terms of quality of life and health care cost, if not treated early.
- Many multi-disciplinary community teams do not have the full range of AHPs and care can be delayed or extended waiting for an AHP assessment (Mayhew, 2009; Jiwa et al., 2002; Batty, 2010), e.g. the waiting list for RHH dietitian appointments for children with growth failure is three months.
- Community services do not fund after-hours AHP services. This means that there are no emergency social work, physiotherapy or psychology services available in the community; people are forced to present to the RHH ED, which also has very limited out-of-hours AHP services.

#### **4.4.5.3 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.
- 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.

## 4.5 Supplement 5: Elective surgery

Allied health professions (AHPs) acknowledge that Tasmanian patient waiting times for elective surgery must be addressed. However, although Supplement 5 states that systemic changes must be implemented, redesigned or new services models are not presented.

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.

### 4.5.1 Issues and initiatives

The current surgery service models do not encompass:

- 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.

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## 6 List of respondents

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## 7 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><b>Initiative:</b> AHP acute medical clinical leader established in the Medical Assessment and Planning Unit (MAPU)</p> <p><b>Location:</b> Toowoomba Hospital, Darling Downs Hospital Health Services, QLD</p> <p><b>Workforce:</b> multidisciplinary</p> <p><b>Model:</b> single-centre study</p> <p><b>Reference:</b> <a href="http://www.health.qld.gov.au">www.health.qld.gov.au</a></p>	<ul style="list-style-type: none"> <li>An AHP clinical leader role was established to provide assessment and intervention as the first point of contact for patients in the MAPU</li> <li>A framework of skill-sharing was introduced across physiotherapy, occupational therapy, podiatry, speech pathology, nutrition and dietetics, psychology and social work</li> </ul>	<ul style="list-style-type: none"> <li>Patients are discharged 82 hours earlier than those seen by standard care AHPs</li> <li>Initial AHP assessment provided 11 hours earlier than the standard care service</li> <li>At one month follow-up, patients demonstrated superior outcomes for balance and mobility and self-reported quality of life</li> <li>Reduced emergency department re-presentation (10% compared to 24% at 1 month)</li> </ul>		Improve patient flow
<p><b>Initiative:</b> Dieticians and speech pathologists in stroke management</p> <p><b>Location:</b> UK, USA, Canada</p> <p><b>Workforce:</b> nutrition &amp; dietetics, speech pathology</p> <p><b>Model:</b> established practice</p> <p><b>Reference:</b> Wright, L. et al. (2009). Dysphagia and nutrition: an extended scope of practice. Proceedings of the Nutrition Society 68, (OCE1): E59</p>	For stroke patients, dieticians screen for and manage dysphagia while speech pathologists screen for and manage malnutrition	<ul style="list-style-type: none"> <li>Patients assessed and treated more quickly</li> <li>Earlier intervention through more timely and accurate referrals can improve nutritional status and overall health in patients with dysphagia</li> </ul>	X	Improve patient flow
<p><b>Initiative:</b> Fibre optic endoscopic evaluation of swallowing (FEES) clinics</p> <p><b>Location:</b> Princess Alexandra Hospital, Royal Brisbane and Women's Hospital, the</p>	<ul style="list-style-type: none"> <li>Four regular and established FEES clinics across QLD</li> <li>Development and implementation of a FEES competency training programs – introductory and advanced levels.</li> </ul>	<ul style="list-style-type: none"> <li>Reduced waiting time for instrumental dysphagia examinations</li> <li>Reduction of 24-48 hours for urgent referrals</li> <li>Timely commencement</li> </ul>	X	<p>Improve patient flow</p> <p>Reduce outpatient department waiting time</p>

<p>Townsville Hospital, Gold Coast Hospital, QLD.</p> <p><b>Workforce:</b> speech pathology</p> <p><b>Model:</b> established practice</p> <p><b>Reference:</b> <a href="http://www.health.qld.gov.au">www.health.qld.gov.au</a></p>	<ul style="list-style-type: none"> <li>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</li> <li>Not dependent on access to radiology suite/ENT</li> <li>Can be repeated flexibly as required.</li> </ul>	<p>of patient diet/fluid recommendations</p> <ul style="list-style-type: none"> <li>Reduced duplication for attendance for dysphagia assessment and ENT assessment</li> <li>Reduced referral to radiology for video fluoroscopy by 25%</li> </ul>		
<p><b>Initiative:</b> Placement of feeding tubes by dietitians</p> <p><b>Location:</b> Baylor University Medical Centre, USA</p> <p><b>Workforce:</b> Nutrition and dietetics</p> <p><b>Model:</b> established practice</p> <p><b>Reference:</b> Tynan, C. et al. (2008). Placement of small bowel feeding tubes by advanced practice dietitians: common practice? Support Line, August: 12-20</p>	<ul style="list-style-type: none"> <li>Dietitian and nurse teams in intensive care unit trained to insert small bowel feeding tubes using electromagnetic tube placement device technology</li> <li>Initial pilot of 101 small bowel feeding tube placements showed higher success rates compared to traditional methods</li> </ul>	<p>Initial pilot of 101 small bowel feeding tube placements showed:</p> <ul style="list-style-type: none"> <li>lower radiography costs</li> <li>reduced time to initiation of feeding compared to traditional methods</li> </ul>	X	Improve patient flow
<p><b>Initiative:</b> Podiatric high-risk foot coordinator</p> <p><b>Location:</b> Great Western Hospital, Swindon, UK</p> <p><b>Workforce:</b> Podiatry</p> <p><b>Reference:</b> 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"> <li>Average length of stay for patients with complex diabetic foot disease reduced by 10 days</li> <li>No statistically significant difference in readmission rates</li> </ul>		Improve patient flow
<p><b>Initiative:</b> Transdisciplinary screening and intervention in nutrition, cognition, communication and swallowing</p> <p><b>Location:</b> Eastern Health, Victoria</p> <p><b>Workforce:</b> speech pathology, nutrition and dietetics</p> <p><b>Model:</b> single-centre study</p> <p><b>Reference:</b> Porter, J, et al.</p>	<ul style="list-style-type: none"> <li>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</li> <li>Using validated tools, dietitians placed patients on 'nil by mouth' if sub-optimal results were demonstrated on a speech pathology screen;</li> </ul>	<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	Improve patient flow



(2012). Transdisciplinary screening and intervention – an opportunity to extend dietetic practice. Nutrition and Dietetics, 69 (suppl. 1): 30	speech pathologists commenced patients on high energy diets if they were identified with malnutrition			
Emergency service examples				
Initiative details	Approach	Outcome/s	Extended scope	Priority area
<p><b>Initiative:</b> AHP in the emergency department</p> <p><b>Location:</b> Mackay Hospital, Mackay Hospital and Health Service, QLD</p> <p><b>Workforce:</b> occupational therapy, physiotherapy</p> <p>Model: single-centre study</p> <p><b>Reference:</b> <a href="http://www.health.qld.gov.au">www.health.qld.gov.au</a></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	<ul style="list-style-type: none"> <li>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</li> <li>Patients preferred a model where care was provided by one, as opposed to multiple, AHP clinicians</li> </ul>	X	<p>Improve patient flow</p> <p>National Emergency Access Target</p>
<p><b>Initiative:</b> Physiotherapy in the emergency department</p> <p><b>Location:</b> Cairns Hospital, Cairns and Hinterland Hospital and Health Service and Robina Hospital, Gold Coast Hospital and Health Service, QLD</p> <p><b>Workforce:</b> physiotherapy</p> <p><b>Model:</b> multi-centre study</p> <p><b>Reference:</b> Physiotherapy Department, Cairns Base Hospital and Gold Coast Hospital, QLD</p>	<ul style="list-style-type: none"> <li>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</li> <li>Tasks include fracture diagnosis, simple fracture management, joint relocation, sick certification, plastering, radiology referral and interpretation</li> <li>The addition to the role of ordering of radiology, injecting of local anaesthetic and limited prescribing of analgesia is being explored</li> </ul>	<p>Expected outcomes:</p> <ul style="list-style-type: none"> <li>Reduced time in Emergency Department</li> <li>Released capacity/availability of medical officer and nursing resources for higher acuity patients (especially category 1-3).</li> </ul>	X	National Emergency Access Target
<p><b>Initiative:</b> Primary contact musculoskeletal physiotherapist in the emergency department.</p> <p><b>Location:</b> Alfred Hospital, Victoria</p> <p><b>Workforce:</b> physiotherapy</p> <p><b>Model:</b> single-centre study</p>	Physiotherapists who completed training in radiology, pharmacology and specific tasks (e.g. plastering) managed patients allocated to fast-track in the emergency department.	<ul style="list-style-type: none"> <li>Consistent improvement in 4-hour waiting time for non-admitted patients</li> <li>Patients with back pain seen by physiotherapists were 14.5 times less likely to be admitted</li> <li>Released capacity of</li> </ul>	X	National Emergency Access Target

<b>Reference:</b> <a href="http://www.hwainventory.net.au">www.hwainventory.net.au</a>		medical staff to manage other patients		
<b>Initiative:</b> Soft tissue injury management by physiotherapists in emergency department  <b>Location:</b> University Hospitals Bristol NHS Foundation Trust, UK  <b>Workforce:</b> physiotherapists  <b>Model:</b> single-centre study  <b>Reference:</b> McClellan, C et al. (2012). A randomised trial comparing the clinical effectiveness of different emergency department healthcare professionals in soft tissue injury management. BMJ Open, 2: e001092	<ul style="list-style-type: none"> <li>Adults presenting to the emergency department with peripheral soft tissue injury were randomly assigned to and managed by physiotherapist, emergency nurse practitioner or doctor</li> <li>Measure taken: upper and lower limb functional scores, quality of life, days off work</li> </ul>	All three groups had clinically equivalent outcomes		Improve patient flow  National Emergency Access Target
<b>Outpatient clinic examples</b>				
<b>Initiative details</b>	<b>Approach</b>	<b>Outcome/s</b>	<b>Extended scope</b>	<b>Priority area</b>
<b>Initiative:</b> AHP in pain management  <b>Location:</b> Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service, QLD <b>Workforce:</b> Psychology, occupational therapy, physiotherapy  <b>Model:</b> single-centre study  <b>Reference:</b> <a href="http://www.health.qld.gov.au">www.health.qld.gov.au</a>	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	Outcome to date: <ul style="list-style-type: none"> <li>Reduced assessment replication</li> </ul> Expected outcome: <ul style="list-style-type: none"> <li>Reduced outpatient waiting time</li> </ul>		Improve patient flow  Reduce outpatient department waiting time
<b>Initiative:</b> Physiotherapist assessment of spinal pain using Telehealth  <b>Location:</b> Sir Charles Gardiner Hospital, WA <b>Workforce:</b> physiotherapy <b>Model:</b> established practice  <b>Reference:</b> <a href="http://www.hwainventory.net.au">www.hwainventory.net.au</a>	<ul style="list-style-type: none"> <li>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</li> <li>Patients come to Perth and see the surgeon the same day as their imaging is performed</li> <li>Sustained for the past three years</li> </ul>	<ul style="list-style-type: none"> <li>Reduced costs for travel</li> <li>Reduced patient stress</li> </ul>		Improve health services for regional, rural and remote communities.  Improve patient flow
<b>Initiative:</b> Audiologist led triage clinic	An audiology team reviewed patients on the waiting list for ENT	<ul style="list-style-type: none"> <li>Initial findings suggest that 75% of referrals</li> </ul>		Reduce outpatient

<p><b>Location:</b> Royal national Throat, Nose and Ear Hospital, UK</p> <p><b>Workforce:</b> Audiology</p> <p><b>Model:</b> single-centre study</p> <p><b>Reference:</b> NHS improvement. (2010). Pushing the boundaries – evidence to support the development and implementation of good practice in audiology 2010. <a href="http://www.improvement.nhs.uk/audiology">www.improvement.nhs.uk/audiology</a></p>	<p>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>	<p>did not meet 'red flag criteria' and could potentially be managed by the diagnostic audiology service in a direct access service</p> <ul style="list-style-type: none"> <li>• New model would potentially release approximately 45 outpatient appointments with ENT per week</li> <li>• In 95% of cases, audiologists and ENT doctor were in agreement as to the referral pathway to audiovestibular medicine or ENT</li> </ul>		department waiting time
<p><b>Initiative:</b> Community forensic mental health outreach service</p> <p><b>Location:</b> Multiple sites across QLD Hospital and Health Services</p> <p><b>Workforce:</b> psychology and social work</p> <p><b>Model:</b> established practice</p> <p><b>Reference:</b> <a href="http://www.health.qld.gov.au/forensicmentalhealth/">www.health.qld.gov.au/forensicmentalhealth/</a></p>	<ul style="list-style-type: none"> <li>• 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)</li> <li>• This community-based service is delivered by clinicians within the clients mental health treating team</li> <li>• 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</li> </ul>	<p>Increased access for targeted client groups</p>		Support recovery from mental illness
<p><b>Initiative:</b> General paediatrics AHP screening advice</p> <p><b>Location:</b> Royal Children's Hospital Children's Health, QLD</p> <p><b>Workforce:</b> psychology, speech pathology, occupational therapy, physiotherapy</p> <p><b>Model:</b> established practice</p> <p><b>Reference:</b> <a href="http://www.health.qld.gov.au">www.health.qld.gov.au</a></p>	<ul style="list-style-type: none"> <li>• 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</li> <li>• Phone triage was used to gather information and refer to the most appropriate service, including back to general paediatrics</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced duplication of service</li> <li>• Timely access to more targeted services</li> <li>• Released medical specialists time to see more complex cases</li> </ul>		<p>Reduce outpatients department waiting time</p> <p>Improve patient flow</p>
<p><b>Initiative:</b> Psychologists as first contact for general paediatric</p>	<ul style="list-style-type: none"> <li>• The psychologists provided the first point of contact</li> </ul>	<ul style="list-style-type: none"> <li>• Significant reduction in wait time</li> </ul>		Reduce outpatient

<p>referrals.</p> <p><b>Location:</b> Ipswich Hospital, West Moreton Hospital and Health Service, QLD</p> <p><b>Workforce:</b> psychology</p> <p><b>Model:</b> single-centre study</p> <p><b>Reference:</b> Psychology Department, Ipswich Hospital</p>	<p>following triage for 60% of category 2 and 3 referrals to general paediatric clinics</p> <ul style="list-style-type: none"> <li>Where required, the psychologist referred directly to the paediatrician</li> </ul>	<ul style="list-style-type: none"> <li>25% of patients seen by psychologist required referral on to paediatrician</li> </ul>		<p>department waiting time</p>
<p><b>Initiative:</b> Podiatrist led musculoskeletal clinic</p> <p><b>Location:</b> The Northern Hospital, Victoria</p> <p><b>Workforce:</b> podiatry</p> <p><b>Model:</b> single-centre study</p> <p><b>Reference:</b> <a href="http://www.hwainventory.net.au">www.hwainventory.net.au</a></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"> <li>Reduced waitlist for orthopaedics</li> <li>Quicker access to appropriate care</li> <li>Improved outcomes through timely conservative management</li> </ul>		<p>Reduce outpatient department waiting time</p> <p>Improve patient flow</p>