

Pre-Conference Workshop: Allied Health – Selling our Value

Monday 5th August 2019 – Brisbane Convention and Exhibition Centre

Workshop Notes

1. Consumer speakers

The following speakers presented personal experiences of the health system

- *Carolyn Wharton, consumer*
- *Donna and Freya Toussaint, carer and consumer*

2. Nick Steele, Deputy Director General, Healthcare Purchasing and System Performance Division Department of Health

- How do we maximise the value in allied health? – deliver the outcomes that matter most to patients in the most efficient way:
 - Value can be increased by delivering the same (or better) outcomes at a lower cost
 - Delivering care in the least resource intensive care setting
 - Workforce models working to top of scope of practice
 - Addressing low benefit care, that is, care that provides little or no benefit, may cause harm, or yields marginal benefits at a disproportionately high cost – including clinically ineffective interventions, routine treatments not relevant for that patients, and screening as opposed to risk-based approach
- Key considerations to improve value:
 - Focus on alternative efficient and effective health pathways that reduce length of stay or avoid admission
 - Collaborative approach to care led by consumers and AHPs
 - Measure success (PROM/PREMs) and cost effectiveness. Accurate valid data for peer to peer conversations
 - Providing care where it matters – ‘closer to home’ – moving the interaction into the community. Engagement with GPs and primary care

3. Steve Williamson, Chief Executive, Central Queensland Hospital and Health Service

- AHP- led transformation inclusive of:
 - Leadership – Executive level involvement in strategy and transformation
 - Partnerships between metro, regional and rural areas to deliver services
 - Advanced scope of practice roles for AHPs
 - Delegation and new roles for allied health assistants – eg 7 day AHA led rehab

4. Peter Buttrum, Executive Director Allied Health Professions, Royal Brisbane and Women’s Hospital, Queensland

- Need to consider improving allied health’s current and broader value:
 - To assess current value, ask:

- Are we truly aligned to the organisational goals?
- Do we monitor/audit for current service efficiency?
- Are we culturally committed to continuous change and re-prioritisation of allied health services?
- Strategies to optimise current value:
 - A plan for change
 - Incentivising change, budgeting targets and re-prioritisation
 - Optimise partnerships in service delivery with NGOs, primary care and universities
 - Internal (rostered) reviews and external (peer) reviews
- To improve broader value, consider patient focus, patient satisfaction, alignment to service KPI, full scope, demonstrable service outcomes and cost effectiveness

Through facilitated discussion, participants identified priority areas for demonstrating the value of allied health, enablers and barriers to providing high value care, and low value activities that could be dis-invested in.

1. Priority areas:

- Executive advocacy and relationship building: up, across and outside of the system
- Intersectoral collaboration including health, disability and education dept and screening embedded in schools
- Interstate collaboration and leadership
- National standards and alignment to allied health course accreditation
- Marketing to consumers about WHAT WE DO and industrial advocacy
- Health funding mechanisms: Commonwealth and State funded services – Primary vs secondary and tertiary care. Allied Health ambulatory services should be provided in Primary Care.
- Development of funded primary care models
- Preventative approaches and early intervention to avoid hospitalisation including reallocation of workforce to hospital avoidance and early assessment and intervention models and Hospital in The Home models
- Embedding, sustaining and scaling proven models
- Training pathways to support the generalist allied health workforce and primary contact specialty areas
- Focus on Frailty: hospital acquired functional decline, #PJ paralysis
- Focus on chronic disease and bariatric care
- Focus on Child development, including childhood obesity
- Requirement for robust analysis of efficiency and cost effectiveness, including PREMS and PROMS
- Uptake of digital initiatives and utilisation of telehealth

2. Enablers to providing High Value care:

- Leadership roles – advocacy and advisory, Australian Allied Health Leadership Forum, Recognition of Allied Health having a seat at the executive table
- Knowledge sharing across jurisdictions

- Service agreements to identify service provision priorities with links to hospital KPIs: decrease LOS and decrease costs
- Health system support and recognition of value of allied health contribution, including medical and nursing acknowledgement
- Use of a common language and terminology
- Role substitution models of care (SOPD primary contact clinics and PT in the ED). Redirection of resources and enables follow up
- Co-design and Consumer engagement – integrated models of care. Allied Health providers of meet and exceed client expectations
- Primary care partnerships
- Digitisation including MYHealthRecord, iEMR, health record integration tools
- Interprofessional practice models
- Emerging tech savvy workforce, use of informatics and analysis of health data

3. Barriers to providing High Value care:

- Political influences and industrial drivers i.e. Nurse navigator positions. Why not Health navigators or Care co-ordinators?
- Funding mechanisms (Commonwealth and State)
- Governance of primary care
- Health literacy of the population
- Culture Change required to dis-invest and promote skill sharing and delegation
- Allied Health are risk averse
- Workforce factors within and outside of allied health teams i.e. rotational nature of early career professionals including medical nursing and allied health

4. Low value allied health activities

- Identification of low-value activities requires professional body identification and support i.e. Australian Physiotherapy Association promoting cessation of specific non-EBP activities
- Non- essential tasks – i.e. administrative and AHA roles and delegation
- Collecting data that never gets used
- Referral to ‘allied health’ mentality by medical and nursing staff – how to we educate our peers to refer specifically to most appropriate professional
- Specific low-value examples identified by workshop participants:
 - Physiotherapists solely responsible for plaster clinics – plaster techs responsible for applying cast based on delegation of cast type, however enable Physiotherapists to continue to apply in emergency or specialty casts
 - Pharmacists dispensing – Allied Health Assistant appropriate where trained and skilled
 - Physiotherapist exercise classes and cardiac rehab – Allied Health Assistant appropriate where trained and skilled
 - Dietitians doing menu modifications – Allied Health Assistant appropriate where trained and skilled
 - Outreach services should be substituted with Telehealth where possible
 - Repeat assessments without intervention – why assess if you are not going to treat?