Te Kāwanatanga o Aotearoa
New Zealand Government

MANATŪ HAUORA
MINISTRY OF HEALTH

Australia and New Zealand Summit on the Value of Allied Health Care

A virtual summit hosted by the Australian and New Zealand Chief Allied Health Profession Officers, Dr Anne-marie Boxall and Dr Martin Chadwick

25–26 August 2022

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AU/NZ ALLIED HEALTH SUMMIT 2022
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@ARTBYTUSS

He aha te mea nui o te ao?
Te tangata, te tangata, te tangata.

What is the most important thing in the world?
It is the people, it is the people, it is the people

Acknowledgements

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Summary of summit compiled by

Associate Professor Peter J Larmer and Edie Taylor

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Foreword

The Australia and New Zealand Summit on the Value of Allied Health Care created an opportunity to showcase innovative health initiatives from across the allied health professions. These initiatives have the potential to make a significant contribution to improving health care across our two countries.

The summit has been timely as the world has been learning to cope and think differently in the post COVID-19 era. COVID-19 had a significant and damaging effect across the world. Very few, if any, sectors of society were left unaffected by the pandemic. In many aspects, the health sector had the greatest need to respond. Dealing with the pandemic put enormous strain on health systems throughout the world. Many countries' health systems were already under significant stress. Lockdowns became a way of protecting populations and limiting large and increasing case numbers, however, they also resulted in major disruptions, particularly in the health sector. Providing continuity of care to those with health needs was difficult as the, until then, normal in-person consultations were restricted. Learning how to manage in this new environment created innovative working opportunities.

The summit provided an opportunity to highlight innovative thinking. While several presentations came about as a direct result of needing to manage the COVID-19 pandemic, other presentations have been developing and had already been trialled for a number of years. Some presentations were pilot projects that need further development to be considered for implementation. However, there were also presentations that while still being pilot projects and needing further research, are seriously suggested as worthy of funding as it is clear they are the 'right thing to do'.

The summit has provided the health authorities and decision makers in both Australia and New Zealand with evidence and solutions for new ways of working. Many of these initiatives have merit for our health systems, can demonstrate cost savings/avoidance and importantly improve health care services for patients and their community. We are at a time when there are increasing demands on the health system, critical workforce shortages and shrinking health funding. The summit provided examples of how we might address some of these issues by stepping outside our traditional models of health care delivery. We would be negligent if we failed to heed the famous words of Winston Churchill: 'Never let a good crisis go to waste'.

The lead organisers and opening presenters at the summit, Dr Anne-marie Boxall and Dr Martin Chadwick provided the setting, challenging delegates to do away with competition and 'patch protection' between the professions. It was identified that health workforce shortages were likely to increase, and the allied health workforce needed to work differently. However, providing value-based health care was paramount and being able to provide the evidence through rigorous research was critical in demonstrating this.

The keynote presentation from Mr George Leipnik and the panel presentation from Professor Sarah Dennis, Professor Carlo Marra and Associate Professor Faye McMillan further enhanced the opening challenge. The keynote presentation started with Mr Leipnik emphasising the need to move from our traditional model of health care delivery. He clearly defined and identified the need to prioritise value-based health care. The panel presenters

shared their experience and solutions for ensuring that the allied health professions engaged in evidence-based practices and were able to appropriately inform health policies. They were clear that research needed to be a normal part of clinical practice.

At the conclusion of the summit, Drs Boxall and Chadwick presented the challenge to the allied health professions to work collaboratively across the professions and with the communities they serve. Alongside this challenge was a clear message that the allied health professions must be able to provide the evidence, through research, that they are adding the best value to the communities they serve. There are many examples throughout the presentations that clearly demonstrate the allied health workforce is not only up for this challenge but also ready and able to achieve great things. As a collective, the allied health professions must question and challenge politicians, policy makers, funders and health managers as to why, when we have clear research backed evidence, many of these initiatives are not being implemented.

Associate Professor
Peter Larmer

Disclaimer
The following sections provide an overview of the keynote addresses along with a summary of each presentation and a commentary. The summaries are based on notes collected from the live presentations along with the supplementary slide presentation material. The commentary is an independent opinion. The referenced research is not exhaustive nor critiqued but is merely provided to add additional support to the proposed initiative.

Contents

Opening addresses

Value-based health care – Dr Anne-marie Boxall and Dr Martin Chadwick

As a profession, we need to think about how, collectively, we can begin to influence the system that we work within and utilise system-level thinking to highlight the benefits of allied health. This involves thinking about the complexity of health care and the scale of that complexity, including striving to achieve the best outcomes for individuals. We must consider that individuals are placed within a context and that their care is placed within a system.

New Zealand and Australia both have excellent health systems – safe and affordable. However, changing consumer expectations, demographics and technologies require us to develop new ways of doing things. System-level changes and investment in allied health improve patient outcomes.

The purpose of this summit is to bring together research and provide input into policy about what value allied health can add to improve health / health services in New Zealand and Australia.

Key messages

- A strength of allied health is the many professions that come together with shared skills and individual strengths. Once we have acknowledged and put aside the sense of competition there can be between professions, we can expand the care that we provide to our people in need and work together to multiply the benefits for those people.
- 'Utility' is an important concept to understand. We need to place ourselves in an economic context – particularly as there is always an urgency to get the most from every dollar invested in the health system. We need to showcase the utility that allied health services provide in these terms.
- Allied health is worthy of investment because as a group, we can deliver better outcomes for people – better for the individual and the health care system.
- The emphasis is on keeping people well by leading, convening, assessing and advising through all allied health services.
- Individuals can contribute collectively to system-level outcomes.

Allied health services are at the forefront in the shift to value-based health care. We need to highlight what our professionals need to do and promote the research

they are already doing to demonstrate how allied health services contribute to the value-based agenda.

Part of the challenge is that our professionals don't always share their research. We need to get better at sharing our research with decision and policy makers – that was essentially the stimulus for this summit. The summit brought together researchers to encourage them to share with each other, and ultimately governments and decision and policy makers, the work the allied health profession can do and is doing to improve value-based health care in both Australia and New Zealand.

Keynote presentation

What do we mean by value-based care? – George Leipnik

Why do we focus on value-based health care? And what opportunities and challenges are we presented with in responding to changes in population health status and chronic and complex conditions? We can list them as:

- rising health costs and new technologies
- increasing demand and complexity of delivering care
- changing needs and expectations of patients, carers, staff and communities
- more active involvement of patients in their health care and choices about what matters to them.

Globally, there are many definitions of value-based health care; 'value' is not a simple term to define. We can define it as meaning the best outcomes and experiences that matter most to those receiving and delivering health care relative to the cost of achieving those outcomes.

There are many dimensions and perspectives that need to be incorporated into a value-based health care approach. The common focus is on improving outcomes for patients and seeking a culture change and, to make this business as usual, encouraging everyone to consider value-based health care in all aspects of their work both at an individual and organisational level. Delivering at scale in complex health systems is challenging.

Human experience drives value-based health care – the interface between patient and staff experience which are inextricably linked.

What is distinct about value-based health care?

- Movement from outputs to outcomes
  - Traditional volume or activity-based funding models focusing on the number and mix of patients being treated within a service and measure throughput
- Value-based health care measurement of the impact of resources and activity on outcomes
  - Measuring what matters most to patients
- Systematic measurement of patient-reported outcomes to inform care planning, evaluate the impact of care and improve care delivery

  - Structuring care around people, not episodes of care
- Structuring care around the people receiving the care and improving outcomes across the care pathway.

While it is possible to have high-quality care that is not better value care, it is not possible to have better value care that is not high quality. Value refers not only to best-practice clinical care and clinical outcomes but is a higher-order concept that also considers the outcomes that matter to patients and the effectiveness and efficiency of the care from a system perspective. This shifts the focus from asking if the system is 'doing things right' to whether we are 'doing the right things.'

How do we frame the move to value-based health care?

- Long-term evolution, not a discrete project
- Maximising outcomes from the patient perspective
- Building on the good work already occurring, aligning the narrative
- Systematically measuring outcomes
- Reprioritising.

The journey to value-based health care is a long-term commitment. A continuing focus on experience and outcomes will be essential.

We can enable value-based health care at a system level through:

- patient and community engagement
- measurement and evaluation
- research and innovation
- delivery organisations
- people, culture, governance and capability
- digital health and analytics
- funding and purchasing
- clinical leadership and engagement.

Panel discussion

Getting evidence into policy – Professor Sarah Dennis, Professor Carlo Marra and Associate Professor Faye McMillan

How do we integrate evidence into policy?

- Promoting allied health research more and promoting the value so that allied health is seen as a valuable member of the health care team
- Doing research that is relevant in informing policy makers and translating findings in a way that is meaningful to policy makers
- Providing more support for continuing professional development and protecting time for evidence-based research in practice
- Considering how students can be brought in to improve uptake of evidence-based practices
- Having the courage to challenge the status quo.

What are the challenges and barriers to integrating evidence-based research into practice?

- A lack of time to implement, skills, authority to make change, understanding of the value of allied health
- Resistance to change
- Making the shift from an output to outcome focus
- Poor organisation of workflow
- No long-term pathway (though there is Health Research Council of New Zealand funding for one year).

What are the opportunities for integrating evidence-based research into practice?

- Changing how we do research – co-design, community focus
- Retaining the clinical-research-policy mix in employment
- Keeping research real to the communities, involving our community – looking at networks that exist for rural and remote communities
- Co-designing, co-developing and co-decision-making – what is the research and how can we inform how the decision-making is done?

- Developing innovative models of care and multidisciplinary teams
- Connecting through multidisciplinary teams
- Looking at employer models that allow people to work in practice, research, education and the community in multiple ways
- Protecting time: involving students in research and management support in dedicated research time
- Covering the issues that matter 'on the ground' and matter most to the people who will benefit – to maximise the benefits, communities need to see value in the research or intervention
- Seeking new opportunities for partnerships in research. This includes thinking about how we can bring innovation into the research agenda so that when it is being co-designed, the end-product is something usable in practice. It means thinking about what the research is for, who it is being driven by and how we can ensure community is part of the journey, and part of the research team.

Forging a pathway for clinicians to influence policymaking is important. This involves:

- measuring clinical practice
- reporting on the impact that allied health is having
- implementing outcome measures that are meaningful for policy makers
- clinicians seeing the value in being able to demonstrate change in their practice.

How do we get 'protected time' for clinicians to research?

- Get commitment from senior management – convince employers of the value of research, including how it will improve service delivery and health outcomes overall.
- Change the understanding of what research is and the settings that it can be undertaken.
- Incorporate research into professional development – evolving the way we define what research is and how we do it collectively.
- Involve students, whether that be in private practice or large health services, to support clinicians with research.
- Consider project-based placements across allied health services.

Broad-scale collection of data – how can data be used and prove value?

- Marry the data with bigger administrative datasets that have information on hospitalisations and treatments. Data is very powerful in terms of assessing clinical outcomes but also value propositions – when you get data on hospitalisations and how they are seen in the health care system, you can quickly assign costs and make economic arguments based on health outcomes.
- Shift thinking from individual gain to 'what will others gain?' from sharing research. In the current Western paradigm, research can be 'owned' by individuals or organisations and sometimes not shared back in the way it was originally intended.

- Bring forward a narrative of working together collectively and putting people back at the centre of the work that we want to do. While there are challenges around privacy and confidentiality, there are spheres where information has been able to be shared more freely to help the people who need it most.
- Research is a privileged space and a powerful resource; we need to acknowledge this and consider what we do with that privilege and how do we use it for the collective good.
- Connected data is very powerful. One of the current challenges is that useful data is stored in many places in many systems that do not speak to one another. If we could solve that with a united or common system, whether it be through private providers or public health services, consistency in the systems would allow linked data and measurement of outcomes.

Collaboration

- The collaborative process matters – not just the outcome but the process itself, and the process of collaborating with colleagues both within and beyond allied health services.
- Investing time and energy into how we collaborate will allow us to build multidisciplinary teams with a foundation of trust, making connections with communities and people, which are necessary to improve outcomes.

Funding

- Small upfront investment can deliver huge savings – we have the data to show it.
- Researchers need to include economic analyses or evaluation where possible.
- We need to show the need for funding reform to deliver best allied health services.

Data and research

- We need to make better use of existing data, for example, patient outcome data – some of this is at a service delivery level and some involves government policy and intervention.
- There is an abundance of great evidence out there already.
- We need to find a way to continue collaborative research to make it easier to find research that relates to policy and practice.

Promoting our value

- We have high-quality research. We need to get better at promoting it to other health professions and health services policy makers and decision makers.

Summaries and commentary

Session presentations

COVID Clinical Care in the Community: **Innovative Primary Care approach** – Sarah Alani, Prescriber Pharmacist, Coast to Coast Health Care

The aim of this programme was to enable high-quality primary health care; addressing the issues of access and equity through a centralised population-based approach to safely manage a large number of COVID-19 cases in the community. The group developed a comprehensive triage programme that involved screening for risk, particularly around anti-viral prescribing. Enablers to this programme were: good team communication and strong pharmacy input. The group are looking to expand the model to diabetes care.

Translation to practice

- Prescriber pharmacist versatile role
- Innovative approach – integration support and centralisation
- Working smarter
- Quality improvement
- Clinical governance and networking.

This presentation described a comprehensive triage screening programme that was quickly implemented to help deal with the COVID-19 crisis within a community. It showed how health professions stepped up their involvement to meet a challenge and how critical communication was to success. While the programme was within the traditional medical model, health professionals, particularly pharmacists, were able to work across a wider scope. The programme is a blueprint that could be expanded to involve more health disciplines – for example, including social support services could be beneficial. The programme would be relatively inexpensive to roll out as it does not greatly challenge the present health system (a cost-benefit analysis would show how much value it could add). There is potential to apply the programme to other conditions, beyond the specific COVID-19 pandemic example, and diabetes was suggested as a possible condition. There is evidence of similar models being used in other countries.[1, 2]

www.health.govt.nz/system/files/documents/pages/day_1_-_5.1_sarah_alani.pdf

ReCOVery: Designing an allied health model of care for post-acute (long) COVID-19 – Dr Joanne Wrench, Manager, Psychology, Leigh Seidel-Marks, ReCOVery Clinical Lead, Jessamae Pieters, Neuropsychologist & Brit Gordon, Chief Allied Health Officer, Austin Health

The ReCOVery model was developed to manage long COVID-19. It includes the concepts of access to multidisciplinary rehabilitation, goal setting and self-management strategies and intentions / supports to return to premorbid functioning. The model includes an initial triage and assessment through the telehealth ReCOVery triage tool. Triage involved collecting clinically relevant information, including patient expectations of the clinical service. This was followed by a goal-setting appointment to identify priority areas for therapy and to streamline referrals to appropriate disciplines for individualised care. Opportunities and next steps were identified as equity of access, evaluation and improvement research and sustainability.

The principles of the ReCOVery model

- Access to multidisciplinary allied health care
- Symptom management and functional improvement
- Scalability and automation
- Sustainability: self-management and telehealth
- Data and research aligned.

This presentation provided an excellent example of a well-functioning multidisciplinary team (MDT). The summit has identified a challenge in the form of health disciplines needing to work collaboratively, and this programme demonstrates the potential for meeting this challenge. There are obvious indications that the programme could be expanded to cover more health conditions than just COVID-19. It links to overseas guidelines that are also being developed in similar areas. Further evaluation is needed as the programme is at the early stage of implementation, however, early findings indicate that the programmed achieved a speedy return to work for participants. This clearly has significant economic benefit. The programme could add further value by incorporating an equity lens across its roll-out and adding social support around housing, employment and social care. Overseas research and guideline development suggest the programme could be implemented relatively quickly.[3–5]

www.health.govt.nz/system/files/documents/pages/day_1_-_5.2_jo_wrench_et_al.pdf

Allied Health Welfare: Responding to the waves – Jolene Hunter, Clinical Coordinator, Canterbury Hauora Coordination Hub, Te Whatu Ora | Health New Zealand

The Allied Health Welfare Team was created within the Canterbury Hauora Coordination Hub to respond to the COVID-19 Omicron outbreak.

- Within a framework of the '5 Cs' (see below), the Canterbury Hauora Coordination Hub responded to the Omicron wave in a multidisciplinary way.
- The response was set up with an equity lens, focusing on complex situations and the unenrolled population.

Working in an across-government collaboration (particularly with the Ministry of Social Development), the Canterbury Hauora Coordination Hub created a safety net in the form of an advocacy, referral and escalation centre for anyone requiring support. This involved making connections across the health system to ensure patients' basic needs were met and, if needed, assessing and coordinating alternative accommodation options for people isolating.

The hub was a resource for the highly vulnerable (for example, the unenrolled population), who were at risk of falling through the gaps. It involved allied health assistants working virtually and was centred around isolation for COVID-19. Social workers and allied health assistants applied the '5 Cs' model of care, working with **complexity** and utilising the skills of **communication** and **coordination** with a goal of **connecting** people to supports and resources and a focus on identifying cultural and other support needs.

Implementation / translation to practice

- Mixed workforce + working virtually = high output and wide reach
- Meeting basic needs + emotional/mental health and health support = improvements in wellbeing

Successful coordination requirements

- Relationships
- Co-Location
- Collaboration.

Next steps – Allied health supporting wider systems

- Unenrolled population health and welfare care
- Avoiding admissions
- Complex discharge support.

This presentation highlighted the success of not only a MDT approach using social workers and allied health assistants but also a cross-government approach involving the ministries of Health and Social Development. The initiative had a strong equity lens, focusing particularly on the highly vulnerable populations that do not typically engage with the health sector and would normally fall through the cracks only to re-present with more serious problems. The programme was delivered virtually, demonstrating new possibilities for ways of working. While the initiative requires further evaluation, it showed significant potential for MDTs working at the top of their scope, and importantly with transference across disciplines and in a virtual environment. At this stage, there is limited international literature to support this concept,[6] however, the programme showed health professionals adapting to a changing environment and, importantly, addressing aspects of unmet need in the community.

www.health.govt.nz/system/files/documents/pages/day_1_-_5.3_jolene_hunter.pdf

Allied Health COVID Community Navigator Service – Kate Palmer, COVID Community Navigator, The Royal Melbourne Hospital

The Royal Melbourne Hospital is a designated COVID-19 'streaming hospital'. The COVID Community Navigator (CCN) service commenced September 2021. The service utilised allied health professionals to meet the changing needs and associated challenges of a large number of COVID-19 patients across the hospital. It included triage criteria to identify level of risk and therefore level of monitoring and follow-up required.

The CCN service role includes:

- discharge planning
- education
- food
- COVID-19 home monitoring
- end-of-life care.

Addressing health inequities

Social

- Written education pack
- Translated information
- Facilitating social work and mental health support contacts

Economic

- Essential health care equipment and masks
- Avoiding unnecessary hospital admissions
- Food and transport vouchers

- Emergency food supplies
- Access to government crisis payment

Environmental

- COVID Home Monitoring programme
- Supporting safe isolation at home
- Quarantine in emergency accommodation

Outcomes

Total CNN Referrals	**1539**
Social Work Virtual Clinic Referrals	>400
Food Packages/Meals Provided	228
Patients Discharged Home with COVID Home Monitoring	2119
Peak Number of Referrals in 1 Month	437 (Jan 2022)
Average Number of Transports Per Day	4.5
Peak Number of Transports Per Day	13
Average Age of Patients Referred	53.3 years

This presentation followed a similar theme to the previous presentation in that it had a strong focus on both health and social aspects of COVID-affected patients. However, it was led by a 'community navigator' that facilitated early discharge from hospital of COVID-affected patients. The navigator was able to take a broad cross-disciplinary perspective to ensure both health and social aspects were considered. The initiative highlighted the need for a strong home-based support network. An economic impact evaluation has not been undertaken, however, the impact is likely to be significant due to reduced length of hospital stay. There is some early research supporting some aspects of this initiative.[7, 8]

www.health.govt.nz/system/files/documents/pages/day_1_-_5.4_kate_palmer.pdf

GLA:D to provide high value care for people with osteoarthritis – A/Prof Christian Barton, La Trobe University

Good Life with osteoArthritis in Denmark (GLA:D) is an education and exercise programme for people with knee or hip osteoarthritis developed by researchers in Denmark. Its aims are to accelerate implementation of the national clinical guidelines into clinical practice, to ensure all people with osteoarthritis have equal access to evidence-based treatment irrespective of place of residence or financial situation and to ensure surgery is considered only when non-surgical treatment measures have failed.

The three core elements of GLA:D are:

- physiotherapist education, training and support
- GLA:D intervention delivery
- data collection of patient outcomes.

The study found that real-world improvements in pain and quality of life following GLA:D are consistent or better than what is found in controlled clinical trials evaluating exercise therapy for osteoarthritis. Three in four people reported clinically meaningful improvement in pain or quality of life at 12-month follow-up. Three in four people desiring surgery before GLA:D have not had surgery and no longer desire surgery at 12-month follow-up.

- GLA:D provides an effective and cost-effective first-line care programme.
- Although GLA:D is available in all states and territories in Australia, publicly funded offerings of the programme remain limited.
- Improved health system funding (Medicare Benefits Schedule, MBS; primary health network, PHN; private health) to provide the programme in the community at low or no cost would improve equity of access.

The GLA:D presentation showcased a treatment protocol that has been offered for nearly 20 years and has strong international links. It has been well researched and provides clear evidence of the benefits of exercise therapy for osteoarthritis across a number of measures including: economic impact, quality of life, pain, and return to work. Note: This programme is 'franchised', that is, clinicians need to sign up to the GLA:D programme, and there is an associated cost of 'buying' the programme. This cost obviously needs to be recouped from the patients unless funding comes from elsewhere. This is one example of a number of similar exercise-based programmes that can be delivered for osteoarthritis. The programme is very physiotherapy-centric and does not necessarily involve other health disciplines. However, it is a programme that can easily be scaled up and rolled out immediately and has the evidence to support its success.[9–12]

www.health.govt.nz/system/files/documents/pages/day_1_-_5.5_christian_barton.pdf

Telepharmacy & the value of integrating clinical pharmacists in general practice – Katrina Azer, Digital clinical pharmacist in general practice

Clinical pharmacy is a growing field in pharmacy practice; it is the branch of pharmacy that focuses on optimising medicine-related outcomes through comprehensive management of medicines, which not only enhances health outcomes but also reduces the economic burden of medicines and morbidity, specifically for patients with long-term conditions. Although evidence exists for clinical pharmacist integration into general practice and its effect on enhancing patient health outcomes, the effectiveness of this

integration virtually (in light of the shortage of qualified clinical pharmacists and funding constraints) has not been explored.

An innovative approach was adopted to integrate a clinical pharmacist in general practice remotely, providing pharmacist-led telehealth services to patients and advice to clinicians in a multidisciplinary collaborative environment to enhance health outcomes for patients. A clinical pharmacist undertook virtual medicines optimisation activities, such as medication reviews, medicines reconciliation post discharge, medicines counselling, clinical education to clinicians and responding to clinical questions. An analysis of the feedback received from practitioners and patient follow-up strongly supports the case for embedding a clinical pharmacist in general practice virtually.

Prescribers reported a reduction in administrative tasks, nurses reported a reduction in time spent answering medicine-related patient queries and medicines reconciliation and patients reported a better relationship with their provider and increased medicines understanding and adherence. Moreover, they subjectively had improvements in biomarkers (for example, HbA1c, BP). There are also significant health system benefits to integrating pharmacists in general practice virtually as well as in person. These include: cost savings for the health system, sustainability for health workforce, increased patient access and better patient outcomes.

Addressing health inequities

- This model of care allows equitable access to clinical pharmacist services to remote Māori and Pacific populations, which would not otherwise be possible physically due to the limitations highlighted in the abstract.
- This equity in access means that clinical pharmacists can optimise medicines and health outcomes in Māori and Pacific populations with long-term conditions anywhere in the country.
- It allows integration between providers, which is not limited by the physical presence (in this scenario the pharmacist was physically situated in Christchurch but integrated in a medical practice in Auckland). It is a novel and sustainable model of care that leverages the scope and potential of all health practitioners working together to enable better health outcomes for patients.

Implementation / translation to practice

Policy or practice implications

- Clinical pharmacists are significantly underutilised; they can significantly reduce the burden of chronic conditions through their expertise on the quality use of medicines and save health spending.
- Virtual, remote integration of clinical pharmacists providing pharmacist-led digital health services is a sustainable strategy.
- More providers can collaborate digitally; their physical presence in the same space should not be a barrier for collaboration!

What levers would support this change?

- Clinical pharmacists should be funded in general practice and in terms of education.

- Medication safety needs to become a priority with data gathering about quality use of medicines – need a public policy on quality use of medicines. For example, Australia has a national medicines policy led by the Royal Commission, with the integration of pharmacists in ARC being a recent investment.

This presentation identified the benefits of engaging an underutilised and skilled workforce (pharmacists) to ease pressure on aspects of primary health care and improve medication safety. The programme was able to address health inequities and support the integration of culturally appropriate services. The use of telehealth demonstrated optimum service uptake and was able to provide national coverage. There is good evidence of the effectiveness in providing this type of service.[13–15]

www.health.govt.nz/system/files/documents/pages/day_1_-_7.1_katrina_azer.pdf

Training health workers with advanced technology to assess and triage diabetes-related foot disease in Aboriginal and Torres Strait Islander people – Hannah Snelling, Joseph Agius, Cathy Loughry, Ancret Szpak & Zygmunt Szpak, Central Adelaide Local Health Network

A culturally appropriate MDT service for high-risk diabetic foot care was developed. The aim was to use allied health technology to improve care for Aboriginal and Torres Strait Islander people who have poorer health outcomes compared with non-Aboriginal Australians. Scientists developed a virtual reality (VR) education package to train local and Aboriginal health workers to assess and triage Aboriginal people with diabetes-related foot disease (DRFD) near their home communities. This VR education allows for immersive and interactive training in a culturally safe environment. Based on initial assessment and feedback, the training programme engages users with useful and culturally appropriate skills for helping manage DRFD in Aboriginal people.

Translation to practice

- Communities already engaging with their local telehealth service will use the training to upskill and provide feedback. The implementation study will place the device/software in the hands of Aboriginal health workers at key sites in South Australia.

This innovative programme demonstrated effective integration of a culturally appropriate service that addressed a serious community concern using an MDT approach. Early intervention to prevent diabetic foot problems has a significant downstream effect. This programme utilised VR to train local ethnic health workers. While the programme is currently being researched, there is already good evidence to support a roll-out, particularly to rural and deprived communities.[16–21] This is a

programme that should be supported to address a serious health issue, particularly for the indigenous population.

www.health.govt.nz/system/files/documents/pages/day_1_-_7.2_hannah_snelling.pdf

Dietitian-led GDM telehealth pathway – Liz Love, Diabetes Dietitian, Te Whatu Ora | Health New Zealand

At Christchurch Women's Hospital, every pregnant woman patient diagnosed with gestational diabetes mellitus (GDM) now has access to a dietitian throughout their pregnancy – virtually, face to face or via telehealth. The aim is to reduce pressure on service and inequities. Implementation involved developing a resource guide and monitoring by dieticians. There is no need for face-to-face appointments due to telehealth. Benefits from diet-controlled intervention were observed. There was a reduction in needing hospital appointments and specialists, and the programme had positive patient feedback. Evidence of allied health involvement in change included physicians, nursing staff and midwives working collaboratively, an increased use of telehealth resources and reduced hospital activity (which allows more consultant resources for more complex patients).

Translation to practice

- In future, dietitians may prescribe and resources may be translated (into seven languages).
- 3-month email – lifestyle management
- 6-month email – including introducing solids
- 12-month email – lifestyle management
- Increasing rates of post-prandial HbA1c
- Permanent dietitian FTE funding.

This GDM presentation was another telehealth initiative that demonstrated that virtual consultations were effective and resulted in reduced inequities, better workforce utilisation and reduced need for hospital-based appointments. The programme developed a resource booklet and identified benefits from diet-control interventions. The reduction in routine and unnecessary hospital appointments resulted in better access for those who needed face-to-face specialist consultations. There is strong evidence as to the effectiveness of this type of intervention.[22–24]

www.health.govt.nz/system/files/documents/pages/day_1_-_7.3_liz_love.pdf

Are primary and community care programmes for osteoarthritis cost-effective? A modelling study using data from the Mobility Action Programme – Prof. Haxby Abbott and Dr Ross Wilson, Centre for Musculoskeletal Outcomes Research, University of Otago Medical School

In 2015, the New Zealand Government initiated a pragmatic pilot programme to investigate the potential benefits of delivering early-intervention, community-based programmes for people with musculoskeletal health conditions: The Mobility Action Programme (MAP). From observed data, simulation modelling was used to a 15-year horizon to conduct an economic evaluation of the MAP for people with osteoarthritis (OA). The incremental health and economic impacts of the MAP programme added to usual medical care for people with OA were estimated using the previously validated New Zealand Management of Osteoarthritis (NZ-MOA) computer simulation model. The MAP demonstrates that national implementation of such programmes is highly cost effective and can decrease inequities of access and outcomes.

Features associated with MAP effectiveness included incorporating an equity focus into the programme and implementing specific strategies to target priority groups and meet their specific health, social and cultural needs. The MAP participant survey results show that respondents who identified as Māori were:

- 1.9 times more likely to report learning how to manage their weight than non-Māori respondents
- 3.6 times more likely to report health improvements than non-Māori respondents
- 3 times more likely to report an improved ability to seek or return to working following MAP than non-Māori respondents.

This presentation is further validation of the effectiveness of interventions for OA. It described two New Zealand-based interventions: the NZ-MOA study and the MAP programme, a government initiative. Based on the NZ-MOA study, the economic data modelling analysis of the MAP demonstrated long-term benefit particularly for Māori and Pacific peoples. The MAP programme utilised an MDT approach and had a strong equity focus. This presentation further strengthens the already significant evidence for an early non-surgical approach to osteoarthritis.[9, 25–29]

Preventing pneumonia after surgery: Preoperative physiotherapy providing BANG for buck – Dr Ianthe Boden, Cardiorespiratory Specialist Physiotherapist, Launceston General Hospital, and Senior Lecturer, University of Tasmania College of Health and Medicine

This study compared preoperative education with post-operative education to determine the value of preoperative physiotherapy. Results showed that preventing pneumonia is important to patients and that they found the physiotherapy education meaningful. Patients preferred face-to-face information delivery rather than by a booklet.

To determine the effect of a single preoperative physiotherapy education and deep breathing and coughing (DB&C) training session on the incidence of respiratory complications following major upper abdominal surgery (UAS), researchers conducted a multicentre, binational, placebo-controlled, double-blind (assessor and patient), parallel-group randomised control trial with concealed allocation and intention to treat analysis. The study found that preoperative physiotherapy halved pneumonia rates after UAS. They found a reduction in mortality risk in those with an experienced physiotherapy subgroup when adjusted for age, respiratory disease and surgical category. Preoperative physiotherapy was also found to reduce prescription of antibiotics. In regard to cost effectiveness, preoperative physiotherapy saved the hospital approximately NZ$460 per patient in downstream hospital costs. Preoperative physiotherapy improved quality adjusted life years (QALYs) at an overall cost saving for the hospital but only if the physiotherapy was provided by an experienced physiotherapist.

This presentation discussed an intervention that has been implemented for several years. The trial findings showed that preoperative physiotherapy is effective in reducing post-operative complications following UAS. While there were significant upfront costs to establish the intervention, downstream savings were notable. The intervention was very specific to the physiotherapy profession and relied on experienced physiotherapists conducting face-to-face consultations. Given the workforce shortage of experienced cardiothoracic physiotherapists, the programme may be difficult to implement in all hospitals. There is evidence of this and similar type interventions being effective.[30–35]

www.health.govt.nz/system/files/documents/pages/day_1_-_7.5_ianthe_boden.pdf

Māori community based solutions to addressing inequities in pain management – Dr Hemakumar Devan, University of Otago & Cheryl Davies, Tū Kotahi Māori Asthma & Research Trust

Chronic pain disproportionately affects Māori and disabled people in New Zealand. This study partnered with Māori on a co-design experiences journey that involved whakawhanaungatanga (process of establishing relationships) and meaningful engagement. It unpacked how the unequal burden of pain in Māori is dealt with silently; Māori are underrepresented in tertiary pain services and present with more severe symptoms than non-Māori; they have low self-efficacy and high unmet need.

Outcomes and impact

- Marae-based pain clinic (June 2021 – ongoing)
- Capacity building of kōkiri (lead) nurses and kaimahi (health workers)
- Development and delivery of a pain management programme focused on whānau (family and significant others) (July–August 2021)
- Pilot test initial version of the pain management programme focused on whānau
- Evaluate the clinical and process outcomes.

Reflections from this journey

- Whakawhanaungatanga is critical for whānau and community engagement.
- Research centred on Māori and embedded with the co-design method empowers the community voice in health service delivery.
- Metaphors are powerful in communicating health concepts.

Implementation / translation to practice

- Whānau valued the strengths-based approach focusing on whānau wellbeing as a collective.
- Stepped care could be offered as a generic pain education programme in the community led by a kaiāwhina (health assistant).
- Mix skills by upskilling kaiāwhina and including rongoā Māori (traditional Māori health practitioners) to provide community-level pain management.

This programme was based on delivering pain management in an innovative way that had a strong cultural focus. It had a clear emphasis on addressing ethnic inequalities and delivering interventions that were culturally appropriate. The programme followed an MDT approach, utilising community health workers. It was based on the marae and valued kanohi ki te kanohi (face-to-face) interactions. The programme was designed with a tikanga (strong traditional values) focus, and relevant written material reflected this. The programme incorporated these values to reflect that the focus was on the wider whānau rather than the individual. This model could be adapted and scaled up

to include other health conditions. However, to be successfully implemented, it will require a significant shift in thinking from the current model of health. Research both nationally and internationally has highlighted the inequality issues and reinforces the need for the health system to work differently.[38, 40–43]

www.health.govt.nz/system/files/documents/pages/day_2_-_3.1_hem_devan_and_cheryl_davies.pdf

A 'Community of Practice': Weaving a responsive safety net for veterans in Aotearoa, New Zealand – Robin Kerr, President Acupuncture New Zealand

This pilot study, funded by the Royal New Zealand Returned and Services Association (RSA), trialed acupuncture and mindfulness practices in a peer support group for six weeks. The aim was to improve health outcomes (including mental health) for veterans and whānau. There was a reported reduction in pain and subsequent increase in physical activity.

Outcomes / translation to practice

- Increased activity improves mental health.
- Veterans identified the programme was less confronting for their stoic military mindset.
- They found it to be a comfortable side-step entry into a treatment pathway.
- It was cost-effective: treatment within a peer-support context.
- The pilot study continues, identifying subgroup of veterans and models of cooperation with other health professionals.

The poor mental health of veterans is a well-established fact. This presentation was an initiative approach between a service organisation (RSA) and health professionals that provided acupuncture and mindfulness as an intervention. The programme identified that there was a gap in support for veterans once they returned to civilian life. Many veterans experienced long-term mental health issues. The intervention was able to demonstrate that participants reported reduced pain and an increase in physical activity as a result of participating in the study. This is a pilot study and what is not clear is if the effect of acupuncture or mindfulness or the combination of both resulted in the change. Studies involving veterans and acupuncture in the United States of America were inconclusive[44–47] and a systematic review[48] indicated further research was needed in this area.

www.health.govt.nz/system/files/documents/pages/day_2_-_3.2_robin_kerr.pdf

Retrospective ClinPharm Review of MET Calls – James Lucic, Advanced Clinical Pharmacist, Te Whatu Ora | Health New Zealand

This research involved a retrospective medical emergency team (MET) call audit. The team used an electronic whiteboard to refer MET calls to the ward pharmacist, who then reviewed the MET call and any other medicines-related contributing issues. The majority (67%) of MET call referrals received an intervention related to a medicine, with the most common medicine types being cardiac, manipulation/alteration of regular medicine, neurological and analgesia. In all, 82.6% had a response time within 24 hours and 10.9% within 48 hours. The review allowed for identification of high acuity and at risk of acute deterioration patients. By category, 58% of interventions were category 3 (significant) and 42% were category 4 (somewhat significant). Just over half (59%) of referrals seen had an additional clinical pharmacist intervention, with the most common being medicines advice, reconciliation and therapeutic drug monitoring. Not all wards in the hospital receive a clinical pharmacist service, and this audit demonstrated the value of the clinical pharmacist role in identifying high acuity, at risk of deterioration patients and intervening as appropriate.

This presentation described exploratory work involving clinical pharmacy and MET call-outs. Typically, in New Zealand, there is little in the way of clinical pharmacy involvement in MET calls. There are examples in the United States of America and some Australian hospitals where the clinical pharmacist is involved. While the presentation was able to identify that 59% of MET call-outs required additional clinical pharmacy input, it did clearly identify what the exact impact of early clinical pharmacy involvement has for MET. However, having a clinical pharmacist involved early is likely to reduce prescribing error. There is supporting international research in this area.[49–54]

www.health.govt.nz/system/files/documents/pages/day_2_-_3.3_james_lucic.pdf

Escalated Care Pathway (ECP): Implementing a South Island IDT care pathway for back, knee and shoulder injuries – Mark Shirley, Physiotherapist Habit Health

The Escalated Care Pathway (ECP) was an outcomes-based programme based around where the patient wanted to receive care and leveraging the provider network. The aim was to address the fragmented management of treatment and rehabilitation that impacts client experience and outcomes for back, knee and shoulders (high cost). It involved low-friction delivery of rehabilitation, return to work, allied health and surgical services. Wrap-around services were delivered collaboratively and were monitored. Standardised outcome measures were used along the patient's journey to monitor progress. Functional assessment on discharge helped determine when a patient had recovered enough to exit the ECP service.

Implementation

- Pre-determined referral by industry.
- E-triage by the clinical team (physiotherapy and specialist/GP) to determine if the patient meets the entry criteria.

An interdisciplinary team establishes:

- the best clinical pathway (surgical or non-surgical) (pre-approved surgical codes)
- the appropriate mix of services to facilitate the best outcome for the patient (non-transactional care)
- further investigation as required (before first specialist assessment)
- the appropriate funding bundle (based on complexity).

Addressing health inequities

Designed to lower the barriers to access and involving:

- simple entry criteria
- multiple entry points – including self-referral and by the Accident Compensation Corporation (ACC) directly
- wrap-around care with health navigators walking alongside the patient and their family/whānau to access care and support
- full funded so there is no co-payment
- no purchasing of rehabilitation components in isolation so true interdisciplinary team funded in the right way
- multiple health partners coordinated 'under one roof'.

Outcomes / implementation to practice

- Can we manage injury and non-injury-related musculoskeletal (MSK) dysfunction the same way?
- When health care is purchased as a package, it can be delivered as a package. When it's purchased in silos, it will be delivered in silos.
- **But there are commercial, political, geographical and personal challenges to this approach!**
- Interdisciplinary team work with outcome measures.
- The programme identified appropriate patients for surgery.
- Time to recovery improved.

The ECP is a development between ACC and clinicians to address the fragmented management of treatment. There was evidence of lengthy delays in diagnosis and time to treatment/surgery for back, knee and shoulder conditions. This pathway project demonstrated several significant benefits to ACC, clinicians and, importantly, the patient. The project was also able to illustrate that having a health navigator involved in the patient's journey helped in providing wrap-around support. In addition, having an MDT involved and having the care delivered as a comprehensive package led to better outcomes. It was also shown that funding being provided specifically for the patients' needs rather than going to siloed professionals was beneficial. There were other important lessons learned, such as having simple and multiple entry points that reduced waiting times. This successful pathway

implementation answered some of the questions that have been hampering health delivery. Patients were seeing the 'right person' at the 'right time' with the 'right treatment'. With recovery time improved, return to work is likely to be enhanced, adding to the economic benefit. This fragmented management is not confined to New Zealand, and there are similar international examples of changing delivery of care models.[55–57]

www.health.govt.nz/system/files/documents/pages/day_2_-_3.4_mark_shirley.pdf

An Efficient and Efficacious Model of Care for Equitable Access to Chronic Pain Clinics in Regional Areas – Luke Phelan, Exercise Physiologist, Victoria, Australia

In 2019, the Victoria State Government's Department of Health made a funding commitment to deliver chronic pain services in regional areas. Swan Hill District Health was one of five regional areas to receive this funding. The aim of the funding was to provide access to specialist care sooner and closer to home and to increase regional self-sufficiency. With this support, Swan Hill District Health developed a model of care and established a local chronic pain service to support locals living with persistent pain. The service leverages an interdisciplinary team of allied health professionals, with virtual support from a pain medicine specialist, to provide comprehensive services. Early findings show that this model of care is feasible and successful and provides equitable access for people living with chronic pain in regional areas.

An interdisciplinary team of allied health professionals with an interest in chronic pain were recruited internally to develop a sustainable model of care that transcends the inequalities and barriers usually faced in regional health care settings. This team included exercise physiology, physiotherapy, psychology, and occupational therapy. After a gap analysis and research and development phase were completed, a 'stepped' model of care was developed with reference to Health Independence Program (HIP) guidelines from the Department of Health.

Outcomes

- The programme increased patients' accessibility to persistent pain services in a regional area and reduced the gap between the services available to patients living in regional areas and those in metropolitan areas.
- Existing allied health services can be leveraged to ensure sustainable models of care for regional areas and to provide specialist input.
- Most importantly, the programme results in meaningful improvements for patients who engage with the services provided.
- The significant increase in referrals reflects improved awareness and access and reduces inequitable access that is typical in regional areas.

Implementation / translation to practice

- This model of care is feasible and successful despite the barriers faced by regional health care settings.
- The service reflects the importance of interdisciplinary allied health teams in providing best-practice care. The stepped model of care may reduce the burden on specialist services and provide better access to care in regional areas.
- The interdisciplinary allied health-led approach used in this model of care could be translated to other areas of health care, including orthopaedics.
- The service was greatly praised by the pain medicine specialist, who was externally recruited to provide specialist input.
- The specialist has provided more assistance since and shared this model of care with other health services in regional areas to establish similar programmes.

This innovative MDT model of care for chronic pain was developed after a gap analysis identified rural patients having to travel long distances for consultations. The programme provided a stepped model of care transitioning from the simple to more complex conditions. The programme utilised an MDT approach, with specialist involvement when necessary. Even the specialist involvement was via telehealth, negating the need for face-to-face consults unless medically necessary. Importantly, the programme utilised existing services by reorganising the current workforce and having the team working to the top of their scope. It resulted in an increase in referrals. This is likely to lead to a negative economic effect, however, it is likely that the increase in referrals is due to identifying unmet need in the rural community. Identifying any economic benefits will take time and should consider the effect on those patients who previously had no opportunity to engage as well as the reduced burden on specialist time. This is a model of care that could be transferred easily into other rural areas and other health services. There is international and national evidence to support this type of programme, with additional suggestions for how it could be adapted.[36–39]

Orthoptic-led Clinics: Seeing the value – Melanie Lai, Orthoptic Department head, Sydney Eye Hospital and Orthoptic Advisor, South Eastern Sydney Local Health District

The orthoptic department at Sydney Eye Hospital established several orthoptic-led and multidisciplinary clinics to enable patients to access timely and appropriate care for chronic eye disease. One of these clinics is the glaucoma Stable Monitoring Service (SMS), where orthoptists work at an advanced scope of practice to assess and develop care plans for patients with low-risk glaucoma based on patient outcomes. In the traditional model of care for patients with glaucoma, patients are assessed by an orthoptist, followed by an assessment with an ophthalmologist who then determines the appropriate management plan.

Patient outcome measures

- 17% of patients progressed and were redirected back to consultant clinics for review.
- 83% of patients were stable, without disease progression, as diagnosed by the orthoptist and remained under surveillance in the orthoptic-led clinic.

Patient-reported experience measures

- Next steps are to commence collecting patient-reported experience measures for the SMS clinic.

Improved access

- The SMS clinic has improved access to care in specialty consultant-led glaucoma clinics for patients with complex glaucoma.
- Approximately 235 appointments have become available annually in consultant-led glaucoma clinics (590 appointments since the inception of the SMS clinic in 2018).

Cost benefits

There have been:

- employee-related cost savings of AU$9,000 per year
- non-admitted activity-based funding savings of AU$1,860 per clinic.

Addressing health inequities

- Social determinants of health are largely responsible for health inequities according to the World Health Organization (WHO).
- Glaucoma is a condition that can cause irreversible vision impairment. Certain ethnicities are known to have higher risk of developing glaucoma and therefore vulnerability to permanent vision impairment, including those of Asian, African American and Hispanic background.
- The older population (over 65 years) and people with diabetes are also at higher risk of developing glaucoma.
- Often these groups are impacted by social determinants of health as defined by WHO, including health care access and utilisation, education, economic stability and social and community contexts.
- The SMS clinic facilitates ongoing monitoring of patients with glaucoma to ensure early detection of any disease progression in these vulnerable populations to minimise the impacts of permanent vision impairment (costs to both the patient and health system).

Implementation / translation to practice

- Demonstrating the breadth of patient to system-wide benefits will support translation of this model of care beyond Sydney Eye Hospital.
- To support consistent and widespread translation of this model of care into practice, the orthoptic department is working with key stakeholders to develop endorsed post-graduate advanced practice modules.

- Establishing clear pathways, models of care and key partnerships to support integration between primary eye care professionals (that is, optometrists), orthoptists and ophthalmologists will be integral to reducing health inequities that exist with glaucoma.

This new model of orthoptic-led clinics described clinicians working at an extended scope to manage complex cases. The impact of COVID-19 and increasing glaucoma numbers led to the project's development. Low-risk patients were seen as well as appropriate complex cases, freeing up specialists' time. The model demonstrated cost benefit and improved access for patients. Inequities were identified that will be important to address in future developments. Reported examples of similar models for orthoptic care were not identified. Publishing these results would be useful to help support future development in this area.

www.health.govt.nz/system/files/documents/pages/day_2_-_5.1_melanie_lai.pdf

Increased Intensity Allied Health Therapy Following Trauma – Melissa Webb, Allied Health Team Leader, Lara Kimmel, Allied Health Leader and Doug McCaskie, Director Allied Health, Alfred Health

Evidence suggests that early and intensive interdisciplinary allied health therapy may help improve hospital-based outcomes. In 2018, there was a partnership between the Transport Accident Commission (TAC) and Alfred Health to modernise the Alfred Allied Health Trauma workforce (evidence based) and the trauma ward environment. The aim was to enable early and intense therapy to commence in the acute environment to help improve recovery outcomes for trauma patients on 5 West through design of a new MDT workforce with a seven-day extended-coverage service. Early and intensive allied health therapy was shown to reduce health service utilisation, increase bed capacity and improve the patient recovery trajectory.

System outcomes

- Decreased ward and rehabilitation length of stay
- Decreased hospital-acquired complications (HACs)
- Decreased acute hospital costs across entire inpatient admissions (major trauma patients only) by AU$15 million
- Decreased post-discharge costs (major trauma patients only / six months) by AU$4.1 million.

Patient outcomes

- Patients home sooner
- More patients discharged home
- Similar six-month patient outcomes

- Favourable qualitative results
- High patient-reported satisfaction with therapy provision.

Addressing health inequities

- Improves patient flow to allow greater access to hospital for those who need it, including elective surgery patients
- Increases number of patients discharged directly home to improve access to inpatient rehabilitation for those who need it
- Targets specific trauma cohorts to receive increased allied health therapy, such as those with high levels of anxiety and those requiring psychological support, as well as the older patient cohort.

Future work

- Expanding this model of care to all trauma patients in all hospitals will reduce the inequity of those patients who do not arrive on a trauma ward or at a major trauma centre.

This presentation focused on early and intensive allied health therapy, demonstrating significant beneficial outcomes for patients and the health service. It showed that moving away from the traditional five-day-a-week allied health intervention service to a seven-day-a-week extended coverage produced a substantial economic benefit. This work further supports Ianthe Boden's earlier presentation on early intervention from allied health professionals. It strengthens the call for allied health professionals to be working at the top of their scope and in extended roles. There is growing evidence to support allied health services working differently.[32, 58–60]

Embedding non-dispensing pharmacists in general practice – Mamta Porwal, Senior Manager Quality Improvement and Claudine Tule, General Manager Health Systems Improvement on behalf of Stacy Leavens, General Manager Primary Care Programs, Capital Health Network, Canberra

The aim of this programme was to assess pharmacists in general practice (PIGP) contributions to addressing a range of population health needs identified in the Capital Health Network's needs assessment. Primary health care professionals are supported to participate in team-based and shared care by improving health literacy around medications for older Australians by follow-up post hospital admission. The Capital Health Network funded the PIGP two-year pilot programme to support the employment of a pharmacist across three general practices.

PIGP contribution to addressing the need identified

- Sharing the knowledge and expertise of the pharmacist to empower the general practice team and improve the quality of their prescribing
- Providing a coordinated approach to medication management
- Contributing to practices' Medicare Benefits Schedule (MBS) items, including health assessments for those over 75 years old, general practitioner management plans, team care arrangements and case conferences
- Reducing the medication burden thus reducing patients' costs for medications
- Advising on medication interactions
- Providing dosing aids to help patients in accurate dosing of medications
- Ensuring drug allergy and adverse drug reactions are accurate on medical records.

The PIGP was evaluated by the University of Canberra and showed success in improving medication safety, compliance and health outcomes for patients. The evaluation showcased that the pilot had effectively demonstrated to practitioners and practices the benefit of embedding and sustaining the pharmacist role as part of the health care team. PIGP is a successful example of outcomes-based commissioning. With a shared set of outcomes and measures, the flexibility of the service allowed practices to identify and meet the specific needs of their patient populations. The collaborative care model trialled through PIGP could be extended to test integrating other allied health professionals and could be adapted to other allied health interventions.

The results of this pilot study showed that the integration of a pharmacist into a general practice had a number of sustainable outcomes: health literacy was improved and there was high patient acceptance, improved health outcomes, a freeing up of general practitioners' time and an economic benefit through more targeted and accurate prescribing. This pilot model could be extended to include other allied health interventions, such as musculoskeletal physiotherapy, and improve links with mental health practitioners. There is a growing amount of evidence to support this type of allied health interaction.[61–70]

www.health.govt.nz/system/files/documents/pages/day_2_-_5.3_mamta_porwal_and_claudine_tule.pdf

Quick Access Response Team (QuART): Essentials for establishing a transdisciplinary allied health team – Zoe Gulliver, Team Leader QuART and Tara Brady, A/Allied Health Performance and Strategy Lead on behalf of Sue Fitzpatrick, Executive Director Allied Health and Disability Lead and Kate Andersen, Occupational Therapy Head of Discipline, Illawarra Shoalhaven Local Health District, NSW Health

The aim of the Quick Access Response Team (QuART) programme is to avoid unnecessary admission of elderly into the emergency department. QuART was developed to provide coordinated, at-home allied health support and intervention so patients could avoid hospital admissions and/or be discharged as early as possible. The model involves an intensive two-week interdisciplinary programme within people's homes (or via telehealth as required) and incorporates physiotherapy, occupational therapy, dietetics and speech pathology (previously also social work and exercise physiology). The focus is on being flexible to meet patient needs and on providing appropriate social services. Teams are based at two tertiary hospital sites within the local health district (Wollongong and Shoalhaven). Positive outcomes related to admission avoidance, utilisation, costings and positive patient experience during the pilot (conducted from August 2020 to March 2021). QuART is now a well-established and utilised permanent service.

Addressing health inequities

- Extending the geographical coverage: Anyone living within the local health district boundaries is eligible
- Linking vulnerable patients to ongoing services and social supports
- Providing variable service delivery (frequency, modality including home visits and telehealth) determined by patient need
- Initially focused on the aged population (over 65 years), now expanded to all ages.

Implementation / translation to practice

- The QuART model is transferable and scalable – currently looking to establish a new site within the local health district.
- The model is continually evolving to meet demand – revising team composition, locations and weekend services.
- The model's referral criteria was recently expanded, and the workload increased subsequently – now QuART is better known, the team has been called on to support recent district initiatives, for example, access and flow and developing an appropriate winter strategy.

- The model requires a planned and consistent data capture – patient/activity/service data has been really important in demonstrating impact. Activity data collection strategies seek to encompass interdisciplinary activities.

The innovative QuART model is further evidence that early intervention can reduce or prevent hospital admissions for the elderly. This presentation showed that an MDT approach is effective and supports allied health services to work to the top of their scope. The services need to be patient focused and comprehensive, with strong links to social services. An important point was made that 'within service' education (for example, emergency departments, etc) is necessary to ensure the QuART is activated appropriately. The QuART model is still undergoing evaluation and data collection, but there is a significant body of international research to build upon.[71–76]

www.health.govt.nz/system/files/documents/pages/day_2_-_5.4_zoe_gulliver_and_tara_brady.pdf

Optimising clinical intake for children with developmental delay – Wendy Thiele, ACL Early Childhood (RSS), Manager Aboriginal Family Birthing Program (EFNLHN)

The foundation for achieving outcomes for children with developmental delay begins by identifying needs early, establishing clinical partnerships with the child and parent/caregiver and delivering clinical services as early as possible following receipt of a referral. Expertise is brought together through a partnership approach between allied health clinicians, parents and families, and researchers to identify what the parent/child needs, with a parent-led understanding of needs. Any therapist can do the first appointment through this model, which leads to timely identification and commencement of clinical services for children with developmental delay. Translation to practise involves addressing health inequities – improving timely access to children with developmental delay and their families/communities.

Learnings

- Improved wait times and parent input – a lack of timely identification and early intervention can have ongoing impact
- Improved timeliness of access to allied health services across the regional local health network in SA Health
- Complex health care challenges require innovative thinking, and allied health can be at the forefront of innovation
- Importance of a partnership approach – collaborate with the Aboriginal community.

This presentation showed that early identification and intervention can be pivotal in lessening the impact of children's developmental delays. This allied health-led initiative focused on the understanding and needs of the child and parent rather than that of the clinicians. The importance of clinical partnerships was emphasised along with access to services and treatment at an early stage. Barriers were avoided by allowing any therapist to initiate and undertake a first assessment and then refer on directly; greatly improving access and decreasing wait times. The programme identified that more work was required in addressing inequities, particularly for the Aboriginal communities. It was difficult to identify evidence of similar initiatives, however, there is good evidence to support the early identification and interventions for these populations.[77, 78]

www.health.govt.nz/system/files/documents/pages/day_2_-_5.5_wendy_thiele.pdf

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Appendix 1: Agenda for the summit 25–26 August 2022

Australia/New Zealand Summit on the Value of Allied Health Care

Agenda 25-26 August

Day One – Thursday 25 August

Time		Item		Lead
AEST	**NZST**			
9:00am – 9:05am	11:00am – 11:05am	1	**Welcome, housekeeping and introductions**	Dr Martin Chadwick, Chief Allied Health Professions Officer, New Zealand Ministry of Health Dr Anne-marie Boxall, Chief Allied Health Officer, Australian Government Department of Health and Aged Care 5 minutes
9:05am – 9:25am	11:05am – 11:25am	2	**Welcome to Country & Mihi Whakatau**	Aunty Serena Williams, Ngunnawal Elder Australia John Whaanga, Deputy Director-General, Māori Health, New Zealand Ministry of Health 20 minutes
9:25am – 9:45am	11:25am – 11:45am	3	**Opening Addresses**	
		3.1	New Zealand opening address	Dr Martin Chadwick 10 minutes
		3.2	Australia opening address	Dr Anne-marie Boxall 10 minutes
9:45am – 10:00am	11:45am – 12pm	4	What do we mean by value-based care?	Mr George Leipnik, Director, Strategy and System Priorities, Strategic Reform Branch, NSW Health 15 minutes
10:00am – 11:00am	12:00pm – 1:00pm	5	**Presentations - session one**	
		5.1	COVID Clinical Care in the Community: Innovative Primary Care approach **Sarah Alani, Coast to Coast Health Care**	10 minutes

Time		Item		Lead
AEST	**NZST**			
		5.2	ReCOVery: Designing an allied health led model of care for post-acute (long) COVID-19 **Dr Joanne Wrench, Leigh Seidel-Marks, Jessamae Pieters, and Brit Gordon, Austin Health**	10 minutes
		5.3	Allied Health Welfare – Responding to the Waves **Jolene Hunter, Te Whatu Ora | Health New Zealand**	10 minutes
		5.4	Allied Health COVID Community Navigator Service **Kate Palmer, The Royal Melbourne Hospital (RMH)**	10 minutes
		5.5	GLA:D to provide high value care for people with osteoarthritis **A/Prof. Christian Barton, La Trobe University**	10 minutes
		5.6	Question Time	10 minutes All
11:00am – 11:10am	1:00pm – 1:10pm	6	Tea break & PollEV interactive questions. - *Interactive map – where do you work?* **http://bitly.ws/ti7W** - *Pie chart – what sector do you work in?* **http://bitly.ws/ti7X**	10 minutes All
11:10am – 12:10pm	1:10pm – 2:10pm	7	**Presentations - session two**	
		7.1	Telepharmacy & the value of integrating clinical pharmacists in general practice **Katrina Azer, Digital Clinical Pharmacist**	10 minutes
		7.2	Improving telemedicine delivery for Aboriginal people with diabetes-related foot complications using Virtual Reality **Hannah Snelling, Central Adelaide Local Health Network**	10 minutes
		7.3	Dietitian-led GDM telehealth pathway **Liz Love, Te Whatu Ora | Health New Zealand**	10 minutes
		7.4	Are primary and community care programmes for osteoarthritis cost-effective? A modelling study using data from the Mobility Action Programme **Prof. Haxby Abbott, and Dr Ross Wilson, University of Otago Medical School**	10 minutes
		7.5	Preoperative physiotherapy prevents pneumonia after major abdominal surgery and is cost effective: a multicentre randomised controlled trial **Dr Ianthe Boden, University of Tasmania**	10 minutes
		7.6	Question Time	10 minutes All
12:10pm – 12:30pm	2:10pm – 2:30pm	*8*	**Close of Day One** Discuss PollEV results and summary of the day	20 minutes Dr Anne-marie Boxall, Dr Martin Chadwick

Day Two – Friday 26 August

Time		Item		Lead
AEST	**NZST**			
9:00am – 9:05am	11:00am – 11:05am	1	**Welcome, and Acknowledgement of Country**	Dr Martin Chadwick, Dr Anne-marie Boxall 5 minutes
9:05am – 9:50am	11:05am – 11:50am	2	**Panel discussion – getting evidence-based research into policy**	Prof. Sarah Dennis, Professor of Allied Health, University of Sydney Prof. Carlo Marra, Dean and Professor, School of Pharmacy, University of Otago A/Prof. Faye McMillan, A/Prof, UNSW & Deputy National Rural Health Commissioner 45 minutes
9:50am - 10:50am	11:50am – 12:50pm	3	**Presentations - session three**	
		3.1	Māori community based solutions to addressing inequities in pain management **Dr Hemakumar Devan, University of Otago and Cheryl Davies (Ngati Raukawa, Ngāti Mutunga ki Te Wharekauri), Tū Kotahi Māori Asthma & Research Trust**	10 minutes
		3.2	A 'Community of Practice': weaving a responsive safety net for veterans in Aotearoa, New Zealand **Robin Kerr, Acupuncture New Zealand**	10 minutes
		3.3	Retrospective ClinPharm Review of MET calls **James Lucic, Te Whatu Ora | Health New Zealand**	10 minutes
		3.4	Escalated Care Pathway (ECP): Implementing a South Island IDT Care Pathway for Back, Knee and Shoulder Injuries **Mark Shirley, Habit Health**	10 minutes
		3.5	An efficient and efficacious model of care for equitable access to Chronic Pain Clinics in regional areas **Luke Phelan, Swan Hill District Health**	10 minutes
		3.6	Question Time	10 minutes All
10:50am - 11:00am	12:50pm – 1:00pm	4	Tea break: Poll EV interactive question - *How do you think allied health can best demonstrate its value?* Respond at **PollEv.com/nicka992**	10 minutes All
11:00am - 12:00pm	1:00pm – 2:00pm	5	**Presentations - session four**	
		5.1	Orthoptic-led Clinics - Seeing the Value **Melanie Lai, NSW Health**	10 minutes
		5.2	Increased intensity Allied Health therapy following trauma **Melissa Webb, Lara Kimmel, and Doug McCaskie, Alfred Health**	10 minutes
		5.3	Embedding non-dispensing pharmacists in General Practice **Mamta Porwal and Claudine Tule, Capital Health Network**	10 minutes

Time		Item		Lead
AEST	**NZST**			
		5.4	Quick Access Response Team (QuART): Essentials for establishing a transdisciplinary allied health team **Zoe Gulliver and Tara Brady, NSW Health**	10 minutes
		5.5	Optimising clinical intake for children with developmental delay **Wendy Thiele, SA Health**	10 minutes
		5.6	Question Time	10 minutes All
12:00pm-12:30pm	2:00pm – 2:30pm	6	**Close of Day Two and Summit** **a. Zoom Q&A to inform closing statement** - *What are you taking away from this event to inform your work?* - *What action would you like to see happen following this event?* **b. Wrap up discussion**	Dr Martin Chadwick, Dr Anne-marie Boxall 30 minutes