PHN Allied Health Case Studies

2023

Living Library of case studies: National PHN Allied Health in Primary Care Engagement Framework

phn COOPERATIVE

An Australian Government Initiative

Introduction

Curating and championing on an ongoing basis case studies to demonstrate the benefit of allied health models of care is part of the implementation of the *National PHN Allied Health in Primary Care Engagement Framework*. The aim of collating this annual 'living library' of case studies is to help demonstrate the value of allied health and share ideas among PHNs.

Case studies nominate which of the six areas under the National PHN Allied Health in Primary Care Engagement Frameworks, Area of Opportunity it relates to (excluding Nationally-led collaboration):

Integration, models of care and funding

Workforce & Access to Allied Health Care

Practice Engagement

Governance and culture

Data, quality and digital maturity

In addition, subcategories of case studies having a focus on Multidisciplinary Team Care, Rural Access, or Long COVID have been identified.

Each case study identifies the individual PHN name, stakeholders, a contact name and email, funding source, and describes The Challenge, The Solution and The Impact.

This collation of case studies is not extensive of all the PHN activities in allied health.

You can find out more about PHNs, including your local PHN via this link: Primary Health Networks | Australian Government Department of Health and Aged Care

The Secretariat coordinating the collation of case studies can be contacted by email: alliedhealth@thephn.com.au

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Case Study: Adelaide PHN

Title: Adelaide PHN Reconciliation in Action

Stakeholders: Aboriginal Community Advisory Council, Commissioned Services, Partners, Adelaide PHN staff, Aboriginal and Torres Strait Islander community

This case study relates to:

Governance and culture

Key contact name and email: Christine Bell [cbell@adelaidephn.com.au]	Year of commencement: 2020	PHN Funding Source: Core/Governance Focus on: Cultural Competency

The Challenge

Designing culturally safe and effective governance practices and structures

Committing to continuing to improve cultural safety within PHNs and in commissioned Allied Health services, in line with the PHN and ACCHO guiding principles.

The Solution

In 2022-2023, we continued our commitment to reconciliation, ensuring the voices of Aboriginal and/or Torres Strait Islander people are heard and considered in all the organisations decisions and actions. The Adelaide PHN has an Aboriginal Advisory Council that plays an active role in advising the organisation and Board, in particular around the organisation's Reconciliation Action Plan.

This year Adelaide PHN has been working on the development of our second Innovate Reconciliation Action Plan (RAP), with colleagues from across the organisation together with our Aboriginal Advisory Council to identify initiatives that will create real change in how we work towards improved health and wellbeing outcomes for Aboriginal and/or Torres Strait Islander people.

During the year, Adelaide PHN has improved engagement with Aboriginal and/or Torres Strait Islander organisations, with a greater emphasis on getting out and visiting them to better understand how we can improve the health outcomes of the community. We continue to create opportunities for staff to learn about Aboriginal and Torres Strait Islander cultures, the organisation is helping to foster an understanding that Aboriginal and Torres Strait Islander health is everybody's business at Adelaide PHN. Our next priorities are exploring how Adelaide PHN can increase employment opportunities of Aboriginal and Torres Strait Islander people.

The Impact

The Adelaide PHN now has an Aboriginal Health Lead that is a dedicated position.

With an Aboriginal Medical Service, we co funded an Aboriginal Internship Program where for the first time in Australia, 5 first-year doctors have undergone dedicated accredited Aboriginal health internship placements to gain a strong understanding of Aboriginal health and encourage future careers in this specialised area.

The Chair of the Aboriginal Advisory Council is now Board appointed from July 2023 and the Council is recognised in the Adelaide PHN Constitution.

Adelaide PHN Aboriginal Community Advisory Council member shared the story of 'Coming of the Light', a significant cultural event for Torres Strait Islander people, during NAIDOC week with staff.

Adelaide PHN held a health information stall at "Rec in the West"; a Reconciliation Week event held at Tauondi College.

Adelaide PHN were a proud sponsor of the Reconciliation SA Reconciliation Breakfast and Closing the Gap Day attended by 3,000 people

We increased the number of commercial relationships with Aboriginal and Torres Strait Islander businesses.

Staff attended a Kaurna Language Workshop, confidently learning the Acknowledgement of Country in Language.

Increased number of formal and informal partnerships with Aboriginal and/or Torres Strait Islander organisations.

Staff continue to engage in structured cultural learning programs.

Delivery of cultural awareness, and trauma informed grief and loss education for primary care providers supporting our Aboriginal and Torres Strait Islander communities.

Case Study: Adelaide PHN

Title: HealthPathways SA
Stakeholders: Allied Health and Pharmacy

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Veronica Hunter – Riviere, HealthPathways Lead [Vhunter-riviere@adelaidephn.com.au]	**Year of commencement:** 2017	**PHN Funding Source:** Core **Focus on:** Multidisciplinary Team Care

The Challenge

- The need to improve overall understanding of the value of Allied Health in integrated care models
- The need to engage with allied health end users, executives, and the rest of the of the health system so they take on the vision and increase use of HealthPathways.

The Solution

This is an ongoing activity across the Adelaide PHN Practice Support team, Integration Portfolio and HealthPathways SA, promoting the use of multi-disciplinary team approaches and the importance of team based care

- Educating and informing GPs on the value of Allied Health in integrated care models and informing referrals through HealthPathways. HealthPathways SA is an online portal for GPs and other Health Professionals
- The HealthPathways SA Team have focused efforts of engagement with executives and allied health clinical leaders from across the 3 metropolitan Local Health Networks. We have harnessed engagement with those who understand the benefits of HealthPathways and are strong advocates for its use across the health system. Dietitians and pharmacists are two focus professional groups for HealthPathways SA in enhancing relationships and engagement opportunities for 2022>2023.
- Actively engaging local allied health experts and peak bodies as Subject Matter Experts, collaborating on pathway development i.e Nutrition and Weight Management in Older Persons (*Nutrition Professionals Australia*); Polypharmacy and Deprescribing in Older Adults (*Drug and Therapeutics Information Service SA - DATIS*)
- Using HealthPathways to document and embed new or improved health system processes. i.e - Care Finder services within all older person's health/related clinical pathways; agreed new state-wide model of care of Muti-disciplinary referral pathways (physiotherapy, exercise physiology, psychology and cardiac nurse led services and community-based supports) for Cardiac Failure pathway (in development)
- Integration of HealthPathways SA with Medi-Map Pilot - Medication Management Portal for prescribers and pharmacy users (in development and testing phase)

The Impact

HealthPathways SA has seen a 54% increase in Allied health user sessions between June 2022 compared to June 2023*

- 53 x Adult, Older Persons and Paediatric Allied Health, Pharmacy and Muti-disciplinary care related referral pathways have been developed to date - this equates to 17% of localised pathways within the HealthPathways Portal *(53 of 322)*
- Care planning protocols / resource pages such as Chronic Disease Care Planning, Mental Health Treatment Plan, Medication Management Reviews and Aged Care Supports that enhance access to allied health services have been systematically included in all relevant clinical pathway.

** Google Analytic (2023) HealthPathways South Australia. Session Views by User typ*

Case Study: Adelaide PHN

Title: IAR-DST Adelaide PHN

Stakeholders: Allied Health employed within General Practice, Commissioned service providers and SA Health

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Tamira Pascoe [tpascoe@adelaidephn.com.au]	Year of commencement: 2023	PHN Funding Source: Focus on: Multidisciplinary Team Care

The Challenge

The challenge is to use the 'common language' of the IAR to meaningfully engage Allied Health professionals to systemically integrate a new practice, valuing the disciplined defined strengths, but also recognising the areas of clinical skills are with few exceptions common to all treating disciplines and sufficient to achieve satisfactory patient outcomes.

The Solution

The IAR with Commonwealth, State and Territories endorsement as a whole of service instrument, offers an almost optimal opportunity for partnership and integration with all stakeholders. Allied Health professionals are significant in number, occupy the full range in clinical and administrative hierarchy, and are instrumental in achieving positively valanced outcomes. IAR training sessions with participation of Allied Health professionals and other service providers, particularly GPs, is intrinsically integrating. It also provides an agency in cross disciplinary knowledge of skills- both those shared in common but also discipline specific. Functional emphasis in OT, and a strengths based paradigm in SW, examples of the discipline specific emphasis.

The Impact

The IAR training offered by APHN TSOs, has been completed for 320 GPs and 118 Allied Health practitioners. The IAR evaluation has two components. These are discussions with participants during training, and results of standardised surveys completed by trainees at the conclusion of training. Both have been extremely positive. Survey questions which number in excess of 3,000 have included only approximately 20 which are not 'strongly agree' or 'agree' on the value of training and the instrument itself. There is no apparent difference in results as a function of discipline. Indeed some of the strongest support for the use of the IAR has come from Allied Health practitioners. Meetings with senior staff, almost all from Allied Health backgrounds, to implement the IAR has been successful and many future such sessions are planned.

While it has not been a briefed requirement of training, further extension of the integration of Allied Health practitioners could easily be achieved by a promoted discussion of professional background and skills set appropriate to the Level of Care generated in scoring the IAR. The potential of this could be realised in greater awareness of and accessibility to Allied Health professionals with improvements in appropriate service provision.

Case Study: Adelaide PHN

Title: Opportunities for Joint Multidisciplinary Education

Stakeholders: Primary health care providers, including general practitioners, nurses, allied health professionals and community health workers

This case study relates to:

Practice Engagement ✓

Governance and culture ✓

Key contact name and email: Wendy Saunders, Integration Manager [wsaunders@adelaidephn.com.au]	Year of commencement: 2017	PHN Funding Source: Greater Choice in Palliative Care Program Focus on: Multidisciplinary Education

The Challenge: Embedding Allied Health across PHN structures and functions, including those linked to education, commissioning, and multidisciplinary team care

- Identifying opportunities for joint education and training, bringing together GPs, Allied Health, and other healthcare professionals
- Supporting multidisciplinary team care by providing education opportunities for all members of the care team.

The Solution

Adelaide PHN regularly consults Allied Health across all priority areas and where they have subject matter expertise. In education in particular, Adelaide PHN has commissioned interdisciplinary education since 2017 as a deliberate strategy to support, promote and embed the role of allied health in holistic person centred care. A calendar of topics are determined through a needs assessment that involve allied health and education sessions are then developed with a multidisciplinary team in mind, using a variety of clinicians to facilitate sessions, including allied health.

Adelaide PHN co-funded the Palliative Care ECHO (Extension for Community Health Outcomes) program to support primary care providers to manage complex presentations by sharing knowledge, disseminating best practices, supporting integrated care. ECHO is a virtual peer-group learning model for primary health care providers, including general practitioners, nurses, allied health professionals and community health workers. Through didactic presentation and case-based discussion, the ECHO program aims to build communities of practice to support primary healthcare providers gain knowledge and confidence to manage patients with complex conditions in their own local communities. The Palliative Care ECHO was run over six sessions between February and May 2023 and had great uptake from a range of clinicians from both primary and acute care, including allied health.

Adelaide PHN provides details of upcoming multidisciplinary education and training addressing key health priorities in the Adelaide region targeting primary care practitioners. This is promoted via our fortnightly and quarterly newsletter (Primary Links and Connect) and website. The provider commissioned to deliver the education program also used their extensive database to promote the training on offer via their newsletters and website.

The Impact

The statewide program had 150 people enrolled to participate, with two people withdrawing.
49% were from Rural/Regional locations and 51% were from Metropolitan SA.
29% were GPs/medical professionals, 44% are nurses, 10% pharmacists and 17% from other professions (OT, Paramedic, Social Worker, Speech Pathologist, Ambulance Officer, Physiotherapist, Palliative Care professional)
We had an average attendance of **40 participants per session** and **77 participants attended at least 1 session.**

As a result of the great response to this mode of education, future ECHOs have been confirmed for the coming year. Another Palliative Care ECHO is being planned for early 2024; a Frailty ECHO is already underway having commenced in August – December, with plans in place for a Dementia ECHO in the new year. All of these will have allied health involvement.

Case Study: Brisbane South PHN

Title: Pharmacists in general practice

Stakeholders: Brisbane South PHN, Griffith University, Pharmaceutical Society of Australia

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Practice Engagement ✓

Key contact name and email: Angela How [ahow@bsphn.org.au]	Year of commencement: 2021	PHN Funding Source: PHN Focus on: Multidisciplinary Team Care

The Challenge

Employment of non-dispensing pharmacists in Australian general practice remains limited. While relatively new in Australia, the role of practice pharmacists, where a non-dispensing pharmacist works within a general practice, is well established internationally. There is currently a lack of practical frameworks that map the potential roles of non-dispensing pharmacists and available funding sources across a range of practice funding models to support this integration. Furthermore, there are limited resources to support general practices with recruiting and embedding a pharmacist into their practice combined with a poor understanding of the scope and role of a general practice pharmacist.

Despite the robust evidence that practice pharmacists improve the safe and quality use of medicines in the community, integrating practice pharmacists in a practical sense is not straight forward and requires finding the 'right' pharmacist, clearly defining their role, and identifying sustainable funding.

The Solution

Brisbane South PHN (BSPHN) in collaboration with Griffith University aimed to build the practice pharmacist workforce in the Brisbane south region. Five practices expressed their interest in embedding a practice pharmacist. Each practice was provided $10,000 seed funding, to provide the practice with funds to account for any training or equipment costs and establish regular working hours within the practice. Four practices successfully recruited a practice pharmacist in the pilot phase. BSPHN provided the practice pharmacists with a mentor (practice pharmacist who has worked in general practice for several years), funded the pharmacists to undertake General Practice Pharmacist training by the Pharmaceutical Society of Australia (PSA), provided Information and Communication Technology (ICT) systems training and continue to host a monthly practice pharmacist forum to support this enhanced model of care. The pilot practices experienced varying levels of success with integrating the pharmacist with most practices reporting a lack of ongoing financial sustainability to support the position. BSPHN then undertook interviews with practice pharmacists, who had been sustained in their roles for several years to better understand how their role was financially sustained. Three main funding models were identified, resulting in the development of a practice pharmacist business case. Since introduction of the business case, we have grown our practice pharmacist workforce to 12 pharmacists across 9 practices, with every role being sustained without ongoing funding from the PHN.

Unlike other programs in Australia, Brisbane South PHN sought to show that a pharmacist role in general practice could be financially sustainable without a continued reliance on PHN funding.

The Impact

All general practice pharmacists that have been placed through this program have been retained by the general practices. General practices report an increased understanding of the scope of pharmacists within a general practice and value the pharmacist's contribution. Other outcomes of this project include:

- Improved acceptance of the pharmacist role in care as member of the multidisciplinary team (from consumers and practice staff)
- Improved patient knowledge and confidence to manage medications
- Improved revenue generated by pharmacist activities and increased HMR item numbers
- Increased job satisfaction and evolving career pathways for pharmacists
- Increased interprofessional respect and opportunities for team-based care

Practices realise that the value of integrating pharmacists into their practice team goes far beyond generating income.

Case Study: Brisbane South PHN

Title: Modelling the value of social workers in general practice

Stakeholders: Brisbane South PHN, The Community Services Industry Alliance (CSIA)

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Angela How [ahow@bsphn.org.au]	Year of commencement: 2023	PHN Funding Source: PHN Focus on: Multidisciplinary Team Care

The Challenge

Primary care workforce shortages, long waiting times for psychological support services and lack of time and expertise to address social determinants of health during general practice appointments are resulting in patients not having all their care needs met. There is a wide body of evidence that shows patient-centred care delivered by multidisciplinary teams leads to better health outcomes. Alongside that, general practitioners are increasingly spending time supporting patients with psychosocial issues, impacting on their appropriate focus on biomedical care, and adding to the pressures on general practice. Further evidence shows social health outcomes can be delivered by social workers that are working within a general practice.

The Solution

The initial project concept was to develop a model, financial tool and information sheet to support general practices to use the Medicare Benefits Schedule (MBS) to embed social workers in general practice. As the project progressed, both the context and the project concept iterated several times. Notably, the May 2023 federal Budget announced changes to team care and flexible funding which confirmed the challenges already surfacing through stakeholder engagement that relying solely on the MBS to fund an embedded social worker is not feasible. Similarly, the Budget flagged a potential change to PHN funding that might support direct commissioning of allied health or related services. This led to exploration and development of several service delivery and financial models to support the project goal.

The Impact

The project found that a social health model could be achieved in several ways, including through the effective embedding of social workers in general practice. The project identified three drivers for implementing social workers in general practice:

- Person centred care.
- Better health outcomes.
- A more sustainable primary care workforce where professions are enabled to make the best and highest value use of their scope of practice.

The evidence is clear that embedding social workers in general practice is of value, with benefits across a range of health and quality of life outcomes. However, the project found the structural constraints of the MBS, in its current form, does not support this kind of innovation in care. This project did not find a way to sustainably fund a social worker in general practice using only MBS.

Moving forward Brisbane South PHN will explore how a combination of commissioning approaches and other funding sources, including the MBS, could realise the desired benefits of embedding social health providers by using the expected increase in PHN purchasing power to test the operation of different models. This will enable the more effective integration of health and community services for patients affected by social determinants of health, ageing and societal changes within our communities.

Case Study: Brisbane South PHN

Title: Shared Medical Appointments

Stakeholders: Brisbane South PHN, Inala Primary Care

This case study relates to:

Workforce & Access to Allied Health Care ✓

Practice Engagement ✓

Key contact name and email: Angela How [ahow@bsphn.org.au]	Year of commencement: 2022	PHN Funding Source: PHN Focus on: Multidisciplinary Team Care

The Challenge

Health and social inequality mean that lifestyle related chronic diseases are both more prevalent and more burdensome among populations of lower socioeconomic status. Lifestyle modification is an effective prevention tool for most chronic diseases and patients living with lifestyle-related chronic diseases often require support beyond what is available in one-on-one primary care consultations. People living with such conditions benefit from a coherent, multidisciplinary approach to care and management comprising of self-management education, lifestyle coaching and counselling, and behavioural change conversations. Shared Medical Appointments (SMAs) which typically involve 3 to 15 patients engaging with a general practitioner, a group facilitator and relevant allied health professionals are an opportunity to provide that support, potentially more efficiently and effectively. Originally trialled in small pilots in New South Wales since 2013, the model has yet to see wider adoption. This can be attributed to common barriers including lack of experience with operationalising such an appointment structure within the local clinic environment, uncertainty over the ability to appropriately bill Medicare for the SMA and additional administrative resources required to organise and sustain the groups on top of the usual GP clinic workloads.

The Solution

Brisbane South PHN has supported Inala Primary Care to pilot Shared Medical Appointments in their practice. The first phase of this project took place in 2022 and involved development and implementation of materials to support people with COPD and diabetes. Evaluation data provided further evidence to support SMAs for the benefit of both patients and providers. Year 2 built on the success of Year 1 through development of new workbooks specific to weight management and a toolkit to support other practices to adopt this model of care.

Delivery of the SMA sessions utilised a multidisciplinary team approach, involving staff most appropriate to deliver the education and care relevant to the session including nursing, pharmacists and other allied health professionals.

The Impact

Our work has found that the SMA model of care is acceptable for patients and providers. Patients reported valuing the peer support and not feeling alone in their journey, having more time to ask their doctor questions and learning from how others managed their condition. Health providers also reported satisfaction with SMAs as it reduced the need to repeat information and enabled patient uptake of the information when the patient group collectively agreed with it.

All patient survey respondents indicated they were satisfied with the SMAs. Reasons for liking the SMAs included:

- Good to hear about other people's journeys and knowing they are not alone (87.5%)
- Learnt new things from others (75%)
- I had more time to listen to information from the doctor (87.5%)
- It was also a social event which was enjoyable (75%)
- It felt good to share their own story (75%)

Case Study: Capital Health Network

Title: Social Workers in General Practice

Stakeholders: Capital Health Network, general practices and University of Canberra (program evaluation)

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Practice Engagement ✓

Key contact name and email: Mamta Porwal [M.Porwal@chnact.org.au]	Year of commencement: 2022	PHN Funding Source: Focus on: Multidisciplinary Team Care

The Challenge

Capital Health Networks (CHNs) 2021-2024 Needs Assessment identified the social determinants of health as a significant barrier in accessing health services, in particular the lack of support for people with complex social and health needs, in accessing, and navigating between appropriate services.

The Solution

Stakeholder consultations and extensive scoping of the literature supported the establishment of the Social Workers in General Practice Pilot Program. CHN has funded four general practices across the ACT to recruit and embed social workers into general practice, with the aim to integrate social workers in the general practice setting. CHN is the first PHN to initiate such a pilot.

The objectives of the pilot program align with the Primary Healthcare 10-year Plan 2022-2032 and the Quadruple Aim

- To increase the efficiency and effectiveness of services providing care to people at risk of poor health outcomes.
- To improve coordination of care to ensure patients receive the right care in the right place at the right time.

Following an Expressions of Interest process four successful general practices employed a social worker for a minimum of 19 hours per week. CHN engaged a social worker subject matter expert to provide monthly clinical supervision to all social workers. Monthly Community of Practice meetings assisted in establishing a network for social workers as well as facilitation of discussion and streamlining of referrals. The pilot program is envisaged to run for an estimated 18-month period allowing time for social workers to be fully integrated into the practices. University of Canberra will independently evaluate the pilot program through practice quantitative data collection and focus group qualitative studies. This pilot will add to the evidence base in the ACT as well as at an individual, health care professional and system level.

The Impact

Social worker activities in general practice include working with clinic staff on social workers scope of practice, educating patients during consultations, gaining knowledge about services available, eligibility and barriers, and sharing this information with GPs involvement in practice quality improvement and completing psychosocial reports for NDIS and other applications. Work activity tracking for administration, clinical, professional development and multi-disciplinary liaison is analysed.

Practices reported challenges with recruitment and retention of social workers, patients' initial uptake due to anxiety about enrolling in a new service , and coordination of patient referral and follow-up. However, having the social worker onsite has resulted in improved referral processes and communication across teams, spread the workload across the teams and contributing to more time for provision of clinical care .It has enabled development of stronger partnerships with social and community organisations and helped support patients while waiting for mental health care , improved continuity of care and reduced non-attendance at appointments.

Positive feedback received from patients includes receiving facilitated access to services and advocacy, education about services and early health interventions to avoid unnecessary hospitalisation.

Practice data: July 2022- December 2022 from four social worker sites
Number of referrals received: 195
Number of referrals seen by social workers: 184

Capital Health Network | For Health Professionals - Social Workers in General Practice Pilot Program

Case Study: Capital Health Network

Pharmacists in General Practice Program

Stakeholders: Capital Health Network, General Practices, Pharmacists and University of Canberra

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Mamta Porwal [M.Porwal@chnact.org.au]	Year of commencement: 2016	PHN Funding Source: Focus on: Multidisciplinary Team Care

The Challenge

The program addressed the need in ACT for innovative models that improve access to multidisciplinary team- based care, particularly for people living with multiple chronic conditions, support for shared care and improved health literacy around medications for older Australians.

The Solution

In 2016 CHN funded a two-year pilot program to support the employment of a pharmacist in a non-dispensing role for three general practices in ACT with the aim of building the experience and confidence of GPs to include a pharmacist into the health care team. Pharmacists were employed for 15 hours per week and CHN provided support via a local pharmacist mentor and regular meetings with stakeholders and evaluators during the pilot. Building on the success of the pilot, CHN extended the pharmacist model to another eight general practices across the course of 2018-2021.

The pharmacist's role developed over time based on practice needs and their skillset. This included identifying and supporting patients with specific conditions, antimicrobial stewardship, contributing to MBS claimable activities.

- 48% of their time completing medication reviews, particularly for patients with multiple medications and those with chronic diseases.
- Quality of practice activities (28%) comprised clinical audit, educating other general practice staff, antimicrobial stewardship and updating medical records with allergy/adverse drug reaction status.
- Collaboration with health professionals external to general practice (12% of time) for patients who had been recently discharged from hospital and in liaising with community pharmacists.
- Other patient contact activities (17% of time) included administering vaccines, point of care testing and conducting smoking cessation sessions.
- 23% of activities recorded initially were related to service development including education and training for new roles and liaising with other stakeholders.

The Impact

The pilot demonstrated successful outcomes in improving medication safety, compliance and health outcomes for patients and effectively demonstrated to practitioners and practices the benefit of embedding and sustaining the pharmacist role as part of the health care team. Clinical audit produced the following positive results:

- Identifying patients with atrial fibrillation: five patients were subsequently started on anticoagulant therapy which reduced their risk of a stroke.
- Proton pump inhibitors (PPIs): Deprescribing occurred for 140 patients (25%) at follow up at least 5 months after the initial audit which had identified 568 patients as suitable for a discussion with the GP
- Aboriginal and Torres Strait Islander children aged under 2 years old that were identified as having not received three meningococcal B vaccinations: By January 2021, 71 % of these children had received the full course or had scheduled their final vaccination.
- Dose monitoring, dose and therapy changes, referrals to other services, improving compliance, initiating therapy and deprescribing recommendations were made from medication reviews.

A cost benefit analysis completed by University of Canberra indicates that for every five hours that a pharmacist is employed, approximately one hour of time is saved for a GP to perform other activities.

Two of the general practices retained their pharmacist after CHN funds had been exhausted. Interprofessional collaboration, patient acceptance and satisfaction was high, demonstrating that the pharmacists became a valued and integral member of the team at these practices.

Capital Health Network | Workforce - Benefits of Pharmacists in general practice

Case Study: Capital Health Network

Pharmacists in Residential Aged Care Facilities (PiRACF) Study

Stakeholders: Capital Health Network, Residential Aged Care Facilities, Pharmacists and University of Canberra (program evaluation)

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Russelle Trinidad [r.trinidad@chnact.org.au]	**Year of commencement: 2016**	**PHN Funding Source:** **Focus on: Multidisciplinary Team Care**

The Challenge

95% of residents living in Residential Aged Care Facilities (RACFs) have medication related problems with >50% taking a potentially inappropriate medicine. 20% of RACF residents take antipsychotic medicines. 18% of unplanned hospitalisations are potentially due to inappropriate medication. The Royal Commission into Aged Care Quality and Safety has highlighted problems relating to medication management and has made several recommendations, including increasing access to allied health professionals, including pharmacists. In Australia, there is a growing recognition that a more integrated approach for pharmacists' involvement in RACF residents' medication management is required.

The Solution

CHN funded on-site pharmacists to be employed on a part-time basis by residential aged care facilities for 12 months to conduct a range of medication management activities including education, clinical audit, medication reviews, vaccinations, medication round optimisation and contributions to organisation policies and procedures. The pharmacists worked as part of the facilities' care teams, working and collaborating with residents, family members, carers, general practitioners and other prescribers (nurse practitioners, geriatricians, and other specialists), allied health professionals, and community and hospital pharmacists.
Capital Health Network commissioned the University of Canberra to undertake a program evaluation.

The Impact

Having an onsite pharmacist at RACFs:

- Reduced the proportion of residents taking potentially inappropriate medicines
- Reduced the anticholinergic drug burden of medicines prescribed for residents
- Reduced the dose of antipsychotic medicines prescribes for residents
- Established positive working relationships with staff, residents and families
- Successfully implemented and established as part of routine practice

As part of the program, resources have been developed to support integration of pharmacists in RACFs.
A range of recommendations to explore similar options and models of care to improve medication management in RACFs should be considered for national roll out.

Capital Health Network | For Health Professionals - Pharmacists in Residential Aged Care Facilities

Case Study: Early Intervention Speech Pathology – Central and Eastern Sydney PHN

Title:

Stakeholders:

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Brendan Goodger, General Manager, Primary Care Improvement b.goodger@cesphn.com.au	Year of commencement: 2017	PHN Funding Source: Core Focus on: Early Intervention Speech Pathology

The Challenge

In 2017, CESPHN identified a gap in services for vulnerable children who could benefit from early intervention speech pathology services.

Approximately 20% of children starting school in Australia have a speech, language, or communication impairment. The prevalence of language and communication impairment in young children is known to be much higher in socially disadvantaged populations. Any challenges in speech and language development can result in significant issues with school readiness and on life factors into adulthood including social participation, education attainment and employment. There is clear evidence that early intervention to address children's speech and language needs has benefits over their life course.

The Solution (Including who is the program delivered to, by which Allied health professions, and in which setting/s?)

The Early Intervention Speech Pathology program was developed in partnership between CESPHN and Sydney Local Health District (SLHD) in 2017. Following the early success of the SLHD model, CESPHN then commissioned South Eastern Sydney LHD (SESLHD) and Sydney Children Hospital Network (SCHN) in 2018.

The Program provides targeted, in-depth screening to vulnerable children aged 0-6 years to identify speech, language, and communication difficulties. The service delivered by SCHN is specifically targeted to Aboriginal and Torres Strait Islander children. Children identified as being at medium to high risk of communication difficulties are offered speech pathology assessment and intervention, while caregivers of children identified as low risk are provided information to support their child's development.

The service is delivered at early childhood education centres, as well as community health centres, community events and playgroups. The model involves close cooperation between speech pathologists, early childhood education centre staff, caregivers, as well as other health professionals such as GPs. The program also provides upskilling and capacity building for early childhood education centre staff to identify and support children with communication difficulties.

The Impact (Including any evaluation data available)

In 2022, CESPHN engaged a consultant to conduct an independent evaluation of the Early Intervention Speech Pathology program. The evaluation confirmed the program has successfully achieved its aims and objectives and has delivered substantive benefits to vulnerable children and their families in the CESPHN region. Since 2017, program highlights include:

- Screening more than 12,000 vulnerable children
- Offering speech pathology assessment to 100% of children identified as being at 'moderate' or 'high' risk of communication difficulties
- Improving access to diagnostic and therapeutic supports for children with speech and communication difficulties
- Improving access to speech pathology services for children from priority population group and increasing their likelihood of achieving developmental milestones
- Upskilling of staff from participating early childhood education centres

Qualitative feedback from early childhood education providers indicated that without the Program many children would have been 'left behind,' as many families within the targeted suburbs cannot afford private speech pathology services.

Case Study: Healthy Ageing Hubs, CESPHN

Title: Healthy Ageing Hubs

Stakeholders:

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email:	Year of commencement:	PHN Funding Source: Focus on: Multidisciplinary Team Care | Rural Access | Long COVID

The Challenge

The challenge of sharing information about the range of services on offer to older people and how to access them.

The objectives of the healthy ageing hub are to:

- Address health inequities and provide navigation to help older people resolve issues and connect with aged care and other services in their local area.
- Support healthy ageing through education that improves the knowledge and supports older people to maintain their health and stay socially connected.
- Support GPs and local primary healthcare providers by providing a place for them to refer their older patients who could benefit from the assistance of a social or welfare worker.

The Solution

Through the establishment of Healthy Ageing Hubs, we are aiming to provide more opportunities for older people to access and make the most of existing services in their local communities and help them to access quality health and aged care information. Funding has been provided to commission the establishment of two regional healthy ageing hubs set up within community neighbourhood centres. The hubs are administered through the employment of full time social worker/ welfare workers dedicated to supporting older people to live well in their local community and promoting healthy ageing within their region. The hubs provide a local and face-to-face drop-in service for older community members, the family and carers, where they can to receive practical assistance and advice on issues associated with ageing, tips on positive and healthy ageing, social connection, and assistance in navigating local services and programs to meet their needs.

The Impact

The early outcomes of this initiative are:

- Increased numbers of older people accessing aged care and social supports in their local community
- Increased numbers of older people accessing healthy ageing education programs in their local community.
- Improved integration between the health, aged care and social care systems.

The two hubs have assisted more than 300 older people in the first six months of operation, creating local linkage to aged care and other support services, and empowering older people, their families and carers, to more confidently manage their own health and wellbeing in the community. The program is proving worthy of helping the PHN advance community development and health promotion activities for older people, while also providing a much needed opportunity for older people to access low level individual face-to-face supports.

Case Study: COORDINARE, South Eastern NSW PHN

Title: Social prescribing in South Eastern NSW

Stakeholders: GPs, community services

This case study relates to:

Integration, models of care and funding ✓

Practice Engagement ✓

Key contact name and email: Simone Jones [sjones@coordinare.org.au]	Year of commencement: July 2021	PHN Funding Source: Core Flexible Focus on: Multidisciplinary Team Care

The Challenge

Many factors that affect our health can't be treated by medicine alone. Unemployment, housing and economic stress, relationship issues, loneliness and social isolation can have an impact on our physical and mental health. On a background of an ageing population with rising loneliness and social isolation, the drought, bushfires and COVID-19 and the rising cost of living have severely impacted communities in South Eastern NSW.

The Solution

Social prescribing is an innovative approach to healthcare that allows GPs and other healthcare professionals to refer patients to local community organisations and other services in order to improve their health and wellbeing. That is, to 'prescribe' non-medical treatments to assist their patients.

In July 2021, COORDINARE funded the non-profit organisation Primary and Community Care Services (PCCS) to establish a social prescribing service, called Social Rx, for the Illawarra Shoalhaven region. In July 2022, this project was expanded to cover the entire South Eastern NSW region. Using a unique and innovative model of care, the Social Rx project on average involves a 12-week intensive program of 45 minutes contact each week with a 'link worker' who is a trained social worker. The Social Rx program is unique in that the link worker spends significant time coaching the client before referring them on to community supports that could include art or yoga classes, book clubs, walking groups, cooking groups or other health and lifestyle programs. The link worker also assists with practical issues such as assisting clients to obtain social services (NDIS, My Aged Care, Centrelink), housing support, food security (Meals on Wheels, food banks etc) and other practical needs.

The service currently employs 6 link workers, who are supported by a database of over 2,800 local community and wellbeing activities.

The Impact

In the year from April 2022 – April 2023, Social Rx saw 489 clients and commenced 910 social prescriptions. Clients were referred from GPs (45.1%%) and other health/community service professionals (54.9%).
Approximately 69% of clients were of working age (18-65), with 31% over 65 years of age. The majority of clients were recorded as female (65.2%). Nearly 6.75% of clients identified as Aboriginal.
Most clients were either unemployed (48.6%), or not in the workforce/ retired (41.3%). Only 4.7% of clients were in the workforce.
Of people referred to the program, 82.6% choose to participate.

The top areas for prescription were for physical health (29.3%), social wellbeing (21%), and emotional wellbeing (16.8%).

Approximately 26% of clients have so far recorded their level of satisfaction with Social Rx using a bespoke survey tool; giving an average satisfaction score of 8.4 /10.
Clients who were asked to rate their general health from 0 to 100 (using the EQ-VAS tool), reported a 39% improvement in self-care and a 55% improvement in anxiety and depression.

Case Study: COORDINARE, South Eastern NSW PHN

Title: Opioid deprescribing by practice-based pharmacists

Stakeholders: GPs, pharmacists

This case study relates to:

Workforce & Access to Allied Health Care ✓

Practice Engagement ✓

Key contact name and email: Kaleena Webbe [kwebbe@coordinare.org.au]	Year of commencement: 2019	PHN Funding Source: Core Flexible Focus on: Multidisciplinary Team Care

The Challenge

The increase in pharmaceutical opioid use has become a major public health concern due to clear evidence of potential harm, such as misuse, dependence and death. Studies have demonstrated that opioids are of limited benefit when used long term for chronic non-cancer pain, and so clinical guidelines have been reassessed.[1]

Opioid deprescribing has been demonstrated to improve patient safety, reduce the risk of opioid misuse, and improve overall healthcare outcomes; although this process can be challenging for medical practitioners.[2]

The Solution

Evidence demonstrates that having a consulting, non-dispensing pharmacist working closely with a general practice team can reduce medication-related misadventure for patients.

Funding from COORDINARE enabled a consultant pharmacist to be embedded in Woonona Medical Practice, a general practice located in the Northern Illawarra, in 2019-2020. A particular focus for the project was the management of patients who had been prescribed opioids, a recognised area of need at the practice.

The pharmacist developed an opioid policy and protocol that were endorsed by all GPs at the practice. These included details on legislative requirements, best practice guidelines and clinical governance advice. The GPs identified patients who had recently commenced opiate medication and those who were long-term users, with a view to tapering or reducing doses. With consent, patients were referred to the consultant pharmacist for opioid review which included medication reconciliation, counselling and tapering plans if appropriate.

The Impact

In total, 110 patients were referred to the consultant pharmacist for review. Of these, 10 patients did not proceed to review (exclusion criteria included prior cessation of opioids, relocation from the practice, requirement for palliative care, and patient choice). Therefore, over 90% of patients referred participated in an opioid review with the pharmacist.

At Wonoona Medical Practice, the pharmacist and medical team successfully adopted a practice-wide approach to opioid tapering, with the result that 39 patients out of 100 (39%) of patients who were reviewed and counselled by the pharmacist had complete cessation of opioid use. In total, 82% of patients referred to the pharmacist for review either had their doses tapered or ceased opioid medication. At the end of the opioid review project (at 9 months), the oral Morphine Equivalent Daily Dose (oMEDD) had significantly decreased from a mean of 44.5 mg to 7 mg among all the participating patients. Only 18 people (18%) had no significant change in their oMEDD.

This intervention demonstrated the powerful impact of allied health working with general practice to establish safer prescribing practices and improved patient outcomes.

1. Therapeutic Goods Administration (Updated 22 June 2021). Prescription opioids: Information for health professionals. www.tga.gov.au/resources/resource/guidance/prescription-opioids-information-health-professionals

2. Langford, A.V. et al. (2023) Clinical practice guideline for deprescribing opioid analgesics: summary of recommendations. Med J Aust doi: 10.5694/mja2.52002. www.mja.com.au/journal/2023/219/2/clinical-practice-guideline-deprescribing-opioid-analgesics-summary

Case Study: Darling Downs West Moreton PHN

Title: Allied Health Development Grants

Stakeholders: Darling Downs West Moreton PHN

This case study relates to:

Workforce & Access to Allied Health Care

Key contact name and email: Rebecca Cerqui [Rebecca.Cerqui@ddwmphn.com.au]	Year of commencement: 2023	PHN Funding Source: Core Funding Schedule Focus on: Multidisciplinary Team Care | Rural Access |

The Challenge

Key challenges faced by the allied health sector in the Darling Downs and West Moreton Region have been identified through extensive primary care consultation and research, alongside local health intelligence, interrogation of local health data and health needs assessments, review of industry literature and reference to evidence-based research. Several themes emerged from this consultation including workforce challenges, issues with service access and availability, and sustainability. Themes that emerged from this consultation included shortage of new graduates, retention issues - particularly in rural settings, the impacts of NDIS on workforce and demands, and a lack of networking and professional development opportunities.

The Solution

In response to the significant demand for services being experienced by local health professionals due to workforce shortages and the unsustainable patient volumes, the Darling Downs and West Moreton PHN have provided a capped number of Development Grants for eligible Allied Health Providers. These grants have been provided to assist health professionals to build workforce capacity within the primary health care sector to:

- Improve health outcomes for community members, particularly in regional and remote areas;
- Enhance sustainability of the allied health workforce;
- Provide opportunities for collaboration between health professionals involved in patient care, including with General Practitioners;
- Support alternative models of service delivery.

The Impact

In June 2023, 21 Allied health Organisations received a grant, ranging from $5,000 to $20,000 supporting many allied health disciplines. Examples of grant funding programs that are currently being implemented include, but not limited to:

- Running a multidisciplinary clinic in a rural school, targeting at-risk children of developmental issues
- Upskilling Allied Health Assistants and establishing allied health assistant led clinics
- Establishing outreach clinics to rural areas
- Developing organisation's profile as an employer of choice
- Providing relocation assistance to new health professionals in rural areas
- Implementing a new graduate support program
- Establishing a local Health Professional Community of Practice in regional community.

More details will be available regarding the evaluation of this grant program, following the implementation of activities.

Case Study: Darling Downs West Moreton PHN

Title: Chronic Conditions

Stakeholders: Darling Downs West Moreton PHN

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Ruqaiyah Buksh [Ruqaiyah.buksh@ddwmphn.com.au]	Year of commencement: 2023	PHN Funding Source: Focus on: Multidisciplinary Team Care | Rural Access

The Challenge

The increasing prevalence of chronic conditions, combined with their long-term and persistent nature and their impact on quality of life and overall health, is placing unprecedented pressure on individuals, families, our communities, and the health system. Chronic conditions impact all Australians, but some populations are disproportionally affected due to a complex interaction between the physical environment, social and cultural determinants, and biomedical and behavioural risk factors. This is demonstrated by a higher prevalence of chronic conditions and a greater burden of disease in these populations, resulting in inequitable health outcomes. Due to the disparity in health outcomes, equal focus is not sufficient: greater investment and sustained efforts are required to positively advantage priority populations and overcome current inequities in health outcomes.

The Solution

In alignment with the National Strategic Framework for Chronic Conditions, the PHN has redesigned the Chronic conditions program to move away from a disease-specific approach and support coordinated care across the health sector. The revised program now focuses on prevention for a healthier Australia, provides efficient, effective, and appropriate care to support people with chronic conditions to optimise quality of life and targets priority populations. As such, the PHN has importantly identified and targeted rising risk patients as a population health strategy to address sustainability of health care provision and increasing the commission of allied health and nursing services to supplement general practice teams in underserved and financially disadvantaged communities.

Somerset, Southern Downs, Western Downs, and Goondiwindi were identified as four regions with among the highest rates of ‘rising risk’ population, along with lower availability of suitable services. The PHN selected these regions based on our comprehensive Commissioning Framework process. This process included consideration analysis of existing service availability, local, state and federal health data and engagement with local providers and community members. Utilising the quintuple aims of health care as a framework, several multidisciplinary organisations providing allied health services have subsequently been commissioned by the DDWM PHN to provide the following services to target populations in the region between 2023-2025:

Podiatry

- Diabetes Education
- Physiotherapy
- Exercise Physiology
- Dietetics

The Impact

Given the recent change, it is not possible to provide any comments on the impact of program re-design at this stage.

Case Study: Gippsland PHN

Title: Bush Nursing Centre Outreach

Stakeholders:

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Cassie Mayman [cassie.mayman@gphn.org.au]	Year of commencement: 2021	PHN Funding Source: Commonwealth – MH Support for Bushfire affected Australians Focus on: Rural Access

The Challenge

The 2019/20 bushfires, followed by COVID-19, compounded the incidence of ill health in East Gippsland. There were many community members living remotely feeling particularly isolated and vulnerable. With almost 30% of the population 65 years or older, this cohort was likely to experience social isolation and many face deterioration of their ability to drive.

The Solution

Gippsland PHN commissioned Bush Nursing Centre's in late 2021 to 30 June 2022 to increase the delivery of non-clinical supports in their regions to those over the age of 65. The purpose of the Community Wellbeing and Participation funding stream was to increase the delivery of non-clinical supports in fire-affected communities based on the needs of the local region.

Specific items identified as within scope for this funding were:

- Additional allied health social workers
- Support for community events (virtual or online)
- Allied health Mental Health professional attendance and engagement at community events
- Activities designed to enhance mental health literacy
- Activities to engage vulnerable population groups less likely to seek out traditional mental health services
- An expansion of low intensity psychological interventions

Six Bush Nursing Centre's took part in this program with primarily Registered Nurses running the program however many allied health links were made in the course or service delivery (social workers, psychologists, optometrists, podiatrists, audiology, physiotherapy). For example, one provider engaged a Podiatrist to attend the Centre once every six weeks to assist with foot care for the elderly.

The Impact

The increase to service delivery allowed the Bush Nursing Centres to support people over the age of 65. Supports received were telehealth coordination, medication coordination, home care package management/application, optometrist screening, counselling and general medical care. On occasion this did include COVID-19 supports.

Referrals out to allied health occurred on a regular basis including hearing screen appointments, physiotherapy, podiatrists and psychologists.

This program delivered over 2,300 occasions of service.

Case Study: Gippsland PHN

Title: Bushfire Program

Stakeholders:

This case study relates to:

Workforce & Access to Allied Health Care

Key contact name and email: Cassie Mayman [cassie.mayman@gphn.org.au]	Year of commencement: 2021	PHN Funding Source: Commonwealth – MH Support for Bushfire affected Australians Focus on: Rural Access

The Challenge

The Black Summer Bushfires of 2019-2020 devastated East Gippsland, burning over 1.5 million hectares of land, and causing extensive damage to homes, businesses, and natural environments. The fires had a profound impact on the mental health and wellbeing of the affected communities, with many individuals experiencing significant distress. Challenges in delivering mental health services in East Gippsland were:

- **Providing support to those living in remote areas proved challenging due to the region's diverse geography**. One significant barrier is the distance to service providers, as many of these communities are located in remote areas that can be difficult to access. This can be compounded by a lack of public transport options and poor road infrastructure, making it challenging for people to attend appointments in person.
- **Stigma associated with seeking mental health support, which can be particularly prevalent in rural and regional areas**. This may make individuals hesitant to seek help or disclose their mental health concerns, leading to delays in accessing services or not seeking help at all.
- **People working in agriculture may face unique challenges related to the nature of their work,** such as long hours, financial pressures, and the unpredictability of weather and market conditions. This can impact their mental health and wellbeing and may require tailored support that takes these factors into account.
- **Cultural barriers to accessing services, particularly for individuals from Indigenous or CALD communities**. This may include a lack of culturally appropriate services or language barriers, which can make it challenging to communicate and access appropriate support.
- **COVID-19 presented an extra barrier** with many services needing to move to online services and on occasion communities needed to go into lockdown.

The Solution

To address the mental health needs of East Gippsland's communities affected by the bushfires, the Australian government provided significant funding for mental health support and recovery programs. Gippsland Primary Health Network (PHN) commissioned one service provider to deliver outreach care services, with availability of both face-to-face and telehealth throughout the region, even in remote areas. The provision of outreach care services in non-clinical settings, including local parks, removed the barrier of distance to accessing services and enabled individuals to seek support in a less confrontational manner. The outreach workers consist of psychologists and counsellors. Gippsland PHN also commissioned two service providers to provide trauma counselling provided by psychologists. The service providers were encouraged to establish partnerships to enhance service delivery by working together to address challenges and reduce duplication of services.

The Impact

The provision of clinical and non-clinical services by allied health psychologists, including trauma counselling and outreach care, has played a crucial role in ensuring access to support for all affected communities. The outreach service was easy to access with no barriers, this allowed a soft entry into the wellbeing and mental health space, with a number of individuals supported to access clinical mental health services. Additionally, partnerships were established between service providers, resulting in more efficient service delivery. Successful partnerships included access to a central bushfire referral line and co-location of office space. In summary, the provision of both clinical and non-clinical services has allowed communities in East Gippsland to access vital support, build relationships with service providers, and facilitate effective service delivery.

The Outreach program had a total of 313 wellbeing consultations occur in 2021/2022 not including wellbeing activities and stakeholder engagements, and this program is continuing to June 2024 through a local funding mechanism.

Case Study: Gippsland PHN

Title: Early Intervention initiatives to support healthy ageing

Stakeholders: PHN - Gippsland PHN

This case study relates to:

Workforce & Access to Allied Health Care ✓

Practice Engagement ✓

Key contact name and email: Cass Morrell [cassandra.morrell@gphn.org.au]	Year of commencement: 2023	PHN Funding Source: Aged Care Focus on: Multidisciplinary team care

The Challenge

Gippsland PHN received funding to commissioning early intervention initiatives to support healthy ageing and ongoing management of chronic conditions for Gippsland seniors, living in their own homes. This initiative was exciting, although Gippsland PHN did not have strong established relationships connections with community based allied health service providers delivering community based services prior to establishment of the services.

The Solution

Gippsland PHN conducted an extensive literature review to identify areas of needs associated with chronic disease management. This guided the tender approach and ensured our tender specifications were reflective of need within the senior community. To ensure the tender campaign reached a broad representation of service providers, Gippsland PHN created a engagement strategy which captured a detailed marketing campaign to ensure this tender opportunity reached all key stakeholders. This campaign involved direct emails to CEO's, emails to allied health peak bodies, extensive promotion on the Gippsland PHN website, a comprehensive tender briefing and tender application support.

The result of this extensive tender campaign resulted in a broad representation of the community care sector and private Allied health organisations lodging tenders to deliver early intervention services. Seven service providers have subsequently been commissioned to deliver services and include:

A Cardiac Clinic – outreach to Aboriginal and/or Torres Strait Islander people, delivered by Bairnsdale Regional Health Service

- A Chronic Disease Clinic in Far East Gippsland to support rural and remote communities, delivered by Omeo District Health
- Positive Ageing and Advocacy service, delivered by South Gippsland Hospital
- Healthy Ageing webinar series across Gippsland, delivered by Geriatric Care Australia,
- Falls, Strength and Balance exercise programs, delivered by My Physio Inc
- Healthy Ageing exercise and balance program, delivered by Healthlink Gippsland
- Healthy Lifestyle Management program delivered by Bass Coast Health Service

Three of these commissioned services are new providers for Gippsland PHN and two are private Allied Health practices' thus demonstrating the extensive reach and effectiveness of our marketing campaign.

The Impact

These programs have been delivering early intervention supports to senior members of the Gippsland community for 6 months and already the intervention is resulting in improved and sustained outcomes for all of participants measured against the RAND SF-36 assessment scale. The programs offered are contemporary, evidence based and extremely effective. As these programs are offered by accredited Allied Health practitioners, the uptake and effectiveness of the program is very high. Gippsland PHN is pleased this initiative is directly resulting in observed improvements in the quality of life for our Gippsland senior community through the contribution of allied health services.

Case Study: Gold Coast PHN

Title: Chronic Disease Service: Persistent Pain, Gold Coast PHN

Stakeholders: Gold Coast PHN, PainWise and local Allied Health Professionals

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Chantelle Howse [ChantelleH@gcphn.com.au]	Year of commencement: 2014	PHN Funding Source: Core Flex Focus on: Multidisciplinary Team Care | Rural Access

The Challenge

The main goal of this program is to help vulnerable people in the community who suffer from chronic pain to learn more about their condition whilst maximising their functional ability/s. The program aims to improve the way people use primary healthcare services and to provide them with ongoing support and guidance. By working closely with GPs and allied health professionals, the program ensures that people in chronic pain receive the best possible care based on current evidence and guidelines. The design of the program addresses the challenge that vulnerable people face in accessing affordable, professional and multidisciplinary care in the community to address their chronic pain needs. The program is designed to maximise functional outcomes for participants and create a positive and lasting impact on their quality of life and well-being.

The Solution

The program offers a comprehensive and personalised pain management plan designed and implemented by various allied health professionals including pharmacists, occupational therapists, psychologists, physiotherapists, and exercise physiologists. The individual program design for clients can include individual and group education, peer support groups, case coordination, and access to fully funded allied health services. The program offers medium term support to maximise functional activity outcomes, whilst also enhancing the capacity of participants to self-manage their condition over the medium to long term. The program is community-based and does not involve any pain specialist procedures or surgeries. Patients who are actively engaged in the program can also benefit from an additional 4 extra Chronic Disease Management (CDM) Services . These are on top of the 5 CDM services that are allocated by Medicare through the GP Management Plan. The aim of these extra services is to give patients the opportunity to explore new allied health treatment options that they may not have access to otherwise and/or enhance their current treatment outcomes. Allied Health providers can complete a referral form and provide this to the patient to take to their GP or discuss the proposed referral directly with the GP. GPs will then authorise the referral and send through to the program to initiate the initial referral.

The Impact

This pain program achieved excellent results in the following ways:

- Improved capacity for vulnerable people to access relevant professional care to support assessment and management of their chronic pain condition.
- Improved client medication management, self-efficacy, and hospitalisations.
- Improved client medication management in alignment with clinical pain medication guidelines.
- Improved client harm reduction through better medication management, which has focussed on reducing interactions and duplications of antidepressant and pain medications.
- Reduced opioid use.
- Improved client ability to self-manage their condition and better cope with their chronic pain presentation.
- Improved functional outcomes for clients including improved walking ability, improved ability for self-care, capacity to perform activities of daily living, and capacity to participate in employment.
- Reduced presentations to hospital leading to reduced hospital costs and waitlists – evaluation of the program reported 78% drop in hospitalisations (Ref: Pain Medicine, 20(5), 2019, 925–933 doi: 10.1093/pm/pny241 Advance Access Publication Date: 12 December 2018)

Case Study: Healthy North Coast

Title: Engaging Allied Health through a clinical society model

Stakeholders: Healthy North Coast

This case study relates to:

Workforce & Access to Allied Health Care

Practice Engagement

Key contact name and email: Monika Wheeler, CEO, Healthy North Coast, [mwheeler@hnc.org.au]	Year of commencement: 2021	PHN Funding Source: Health Systems Improvement - Workforce Focus on: Multidisciplinary Team Care

The Challenge

Allied Health is an integral component of Healthy North Coast's primary care workforce. In a time of General Practice workforce decline, the allied health workforce is instrumental in collaborating with GP services and supporting immediate and ongoing care. In 2021 Healthy North Coast undertook consultation with the primary care workforce to better understand their continuous professional development needs. A key finding of this consultation and co-design was the need for networking to build local knowledge and referral pathways with other disciplines identified as a priority need for health services; quoted as the most impactful element of CPD for many clinicians. It was also found that some regions/disciplines have no relevant face-to-face CPD within a reasonable drive from their geographical area, with many allied health clinicians preferring evening sessions.

The Solution

From 2021**,** local clinical societies were set up in eight different areas of the North Coast: Tweed Valley, Ballina-Byron, Lismore-Kyogle-Casino, Clarence Valley, Coffs Harbour-Bellingen, Nambucca-Macskville, Kempsey-Macleay and Port Macquarie-Hastings. This allowed for health professionals to come together each quarter for education, dinner and networking with the common aim of integrating services and systems and improving experience and outcomes for patients in their community. In addition to this, each area was comprised of clinical champions; a small committee that helped develop localised topics and speakers. This was largely represented by allied health and some general practice staff.

The focus of each clinical society has been to:

- Build strong collaborative partnerships between primary healthcare providers
- Feel supported within your clinical community
- Enhance knowledge of local services and referral pathways.

The Impact

The past 18 months has seen a strong growth in allied health clinical society membership. This can be partly attributed to a renewed need for connection after a devastating impact on the region due to the Northern Rivers floods. In light of this, Healthy North Coast was able to consult with each clinical society provide education such as Mental Health & Alcohol and other Drugs, Post Traumatic Stress Disorder, Vaping in Adolescents and Eating Disorders. Allied Health were highly represented at Clinical Societies, particularly in the past 18 months at 34.5% of the 2113 members (as at 30/6/23). Evaluation data indicates overall satisfaction ratings for events sit within the 90% range, indicative of speakers, content and venue. Ongoing consultation with the HNC Education Advisory Group and North Coast Allied Health Association allows for Clinical Societies to ensure that content is well aligned to Allied Health audiences.

Case Study: Healthy North Coast

Title: North Coast (NSW) Allied Health Association

Stakeholders: Allied Health professional voice on the North Coast (2014-2023)

This case study relates to:

Integration, models of care and funding	*Workforce & Access to Allied Health Care*	*Practice Engagement*	*Governance and culture*	*Data, quality and digital maturity*
✓	✓	✓	✓	✓

Key contact name and email: Monika Wheeler, CEO, Healthy North Coast [mwheeleer@hnc.org.au]	Year of commencement: 2014	PHN Funding Source: Health Systems Improvement Focus on: Multidisciplinary Team Care

The Challenge

There has long been need for a collective and coordinated voice for the allied health professions in representing the issues of allied health service provision on the North Coast NSW. There are significant gaps in allied health services in the region, difficulty in accessing allied health professionals for certain sections of the community, and consequently high rates of avoidable emergency department consultations and hospitalisations and unnecessary hardship for affected community members and carers.

The Solution

In 2014 the North Coast Allied Health Association (NCAHA) was formed by a group of concerned allied health professionals with the support of the then North Coast Medicare Local. The primary intention was to link local AHPs into collective action to improve allied health service provision in the region. A further goal was to facilitate communication between the Medicare Local and the allied health sector to enhance opportunities for better integration of services in primary care.

Since its inception, NCAHA has continued to develop as an advocate for AHP services and meeting needs on the North Coast. The NCAHA has the following features:

- An Australian company limited by guarantee
- A Board of Directors
- Individual membership with practising AHPs as the principal members
- A member organisation of Healthy North Coast (North Coast PHN)
- A small operational budget derived from an annual grant from HNC

The principal activities of the NCAHA includes: Close engagement with HNC on allied health issues relevant to primary care provision; representation for allied health on relevant forums, consultations, projects in the region; monthly newsletters for members and interested stakeholders; regular CPD events including webinars and face-to-face forums on priority topics for allied health in the region; commentary on reforms and policies.

The Impact

NCAHA has become a respected voice for allied health on the North Coast. It has a committed membership of AHPs and supporters from a broad range of professions and from every district within the region. It provides this membership with regular news, accessible CPD events, and opportunities for networking and information-sharing. The future ambitions of the NCAHA are to establish closer collaborations with Healthy North Coast, the Local NSW Health Districts, and the private and not -for-profit health sectors to enhance the integration and coordination of healthcare built around the issues and needs of North Coast residents and communities. NCAHA is currently involved in developing the Allied Health stream for the Healthy North Coast Clinical Societies regarding chronic disease, to be held in Port Macquarie and Lismore in November 2023 which is a first for the region and will provide an opportunity for interdisciplinary collaboration and the opportunity to highlight issues and develop solutions for allied health.

Case Study: Hunter New England and Central Coast PHN

Title: Digital Health Maturity Assessment for Allied Health

Stakeholders: Hunter New England and Central Coast PHN, Semantic Consulting

This case study relates to:

Data, quality and digital maturity

Key contact name and email: Joanna Coutts [jcoutts@thephn.com.au]	Year of commencement: 2023	PHN Funding Source: Core Flexible Focus on: MDT

The Challenge

To understand the spectrum of digital health maturity across allied health practices in order to support a differentiated approach to digital health change and adoption based upon digital maturity.

The Solution

Semantic Consulting had previously undertaken digital maturity assessment for General Practice and RACF's, therefore they were engaged to co-design an allied health focused survey and to be delivered to allied health private practices across our region. The survey designed, completion and analysis was managed in Kaleidoscope software which is owned by the consultant and the PHN has 12 months of access to the available data on completion of the data collection phase of the project.

The survey was named the Health-e Together Digital Care Survey and was promoted to targeted private allied health practices within the Hunter, New England and Central Coast region via social media, direct mail out, webinars, newsletters and face to face events. An incentive of entering into a draw to win a $1000 voucher for Brennan IT technical support specialists was made available for allied health practices to encourage completion. The PHN provided an allied health email contact list and the survey were distributed by the consultant and remained opened for one month.

The Impact

A total of 80 allied health practices completed the survey from a variety of professions with Dietetics, Exercise Physiology, Occupational Therapy, Physiotherapy, Speech Pathology and Psychology being the most dominate. The data output can be viewed by all participants or drilled down by profession, or specific practices or regions enabling detailed analysis of needs.

The data shows us that

- Allied Health digital health maturity (59.2) is lower than general practice (71.4), but slightly higher than RACFs (54.1)
- Work remains to drive the meaningful use of digital health solutions, for example in My Health Record and Secure Messaging.
- Digital literacy amongst allied health providers needs improving. As many survey responders are likely to be more digitally mature, digital literacy is likely to be more of an issue than acknowledged in the survey.
- Patient safety; 57% of practices use a fax machine, 66% 'frequently' or 'occasionally' send patient information via email and 21% still use paper or cards for medical recording keeping
- Only 21% of practices surveyed used health featured and security compliant telehealth software.

We can view practices maturity level status such as foundational, intermediate and advanced and can therefore tailor our support appropriately to ensure it is relevant to individual practice needs. This survey also provides a baseline, if we re-run the survey in future years, we can compare the results and measure the change and hopefully progress that has been made in our region in digital health usage.

Case Study: Hunter New England and Central Coast PHN

Title: Business Skills Workshops for Allied Health

Stakeholders: HNECC PHN and Momentum Business Improvement Specialists

This case study relates to:

Workforce & Access to Allied Health Care ✓

Practice Engagement ✓

Key contact name and email: Joanna Coutts [jcoutts@thephn.com.au]	Year of commencement: 2023	PHN Funding Source: Core Flexible Focus on:

The Challenge

Business skills training was identified as a need area by the Hunter New England Central Coast PHN's Allied Health Reference Group (AHRG) members. Clinician feedback indicated often their training as a clinician failed to provide education on how to navigate a business as a sole trader or small business owner in primary health care and therefore business knowledge and skill was lacking.

The Solution

The HNECCPHN distributed an Expression of Interest to business coaching and training providers to develop a proposal for a full day allied health focused business skills workshop and then deliver the workshop in 4 locations across our region. The target audience was small to medium size allied health practices focusing on practice owners, managers, administration staff or allied health professionals with an interest in learning business skills. The session were run face to face in small groups in an interactive workshop with a maximum of 25 attendees per session. Applicants were required to complete a series of questions to demonstrate their experience and explain how the workshop would be run In addition reference checks were conducted on the shortlisted submissions.

The learning outcomes were to provide participants with an understanding of;

- how to develop a high-level business plan for their practice
- steps to implement a business plan
- business measures to monitor performance and support quality improvement
- business soft skills required to run an effective practice.

The PHN's role was to establish a panel including AHRG members to assess the EOI submissions and select a preferred supplier, promote the workshops, source participants, coordinate communications, manage registrations and evaluations and organise and fund the venues and catering.

The Impact

A total of 82 participants attended across the 4 locations with 92% completing the evaluation survey. The evaluation results are outstanding with an average rating of 100% for presenter effectiveness in delivery, organisation and overall session rating. The workshops were professional, engaging and exceeded expectations on delivering the learning outcomes. The impact on the allied health participants is clear from the evaluation comments a few in the following.

"Thank you so much! As someone who has only clinical skills (not business) I feel a lot less overwhelmed and know where to go with a booming business.", "Life changing!", "..feel inspired to do something differently."

Business Skills Workshops for Allied Health professionals a huge success. - Primary Health Network (thephn.com.au)

Case Study: Hunter New England and Central Coast PHN

Title: Digital Health Grants Evaluation

Stakeholders: Hunter New England and Central Coast PHN

This case study relates to:

Practice Engagement ✓

Data, quality and digital maturity ✓

Key contact name and email: Joanna Coutts [jcoutts@thephn.com.au]	Year of commencement: 2022	PHN Funding Source: Core Flexible Focus on: Rural Access

The Challenge

In Australia, Allied Health Professionals make up the largest clinical workforce in Primary Care. They also have the lowest rates of digital health integration. There are many recognised barriers which impact Allied Health Professionals including the diverse professions within their body and the wide range of workplaces, including rural and remote areas in which they deliver healthcare. COVID expeditated the necessity for many to change the way in which they delivered healthcare. Consultation with Allied Health professionals highlighted an appetite within the region to increase their digital capabilities. The challenge was how to assist them to continue to increase their digital maturity further, to build capacity to provide safe, secure, efficient and user-friendly health services for both clinician and client.

The Solution

In April 2022, The Hunter New England and Central Coast Primary Health Network (The PHN) released Digital Health grants worth $5000 each. 60 grants were awarded. The grants were to support Allied Health Professionals in the implementation of initiatives of digital platforms and equipment to enhance digital, clinically appropriate health capabilities across a variety of platforms within Allied Health practices. Suggestions given by The PHN to recipients included ways to increase digital capabilities such as implementing secure messaging, onboarding of SeNT eReferrals (HNE region only), purchasing of clinically appropriate video consulting systems, upgrade of website to include online bookings, My Health Record, ePrescriptions and eRequests for pathology and imaging.

The PHN held several educational webinars on methods of increasing digital maturity and Q & A sessions which were well attended. The PHN Digital Health Team supported Allied Health Professionals with one-on-one support to access and register for digital platforms such as My Health Record and SeNT eReferrals.

The Impact

The desire for Allied Health clinicians to provide safe and efficient care is reflected in grants being overprescribed. Over 50% of grant recipients responded to the post grant evaluation. Most grant funds were devoted to improving infrastructure across two categories; telehealth and practice management software. Firstly, use of funds towards improving and enhancing the quality of delivery of telehealth consultations was high. Post pandemic, many wished to continue offering telehealth consults with enhanced delivery.

The second leading use of funds was purchasing digital health platforms such as practice management software that is My Health Record conformant, updating websites or adding applications such as patient online booking systems. Many grant recipients linked purchasing of conformant software in with the purchase of new hardware.

The purchase of practice management software, compliant with national safety and quality standards, helps maturing practices implement consistent clinical governance, streamlining and enhancing healthcare delivery. Feedback concludes that supporting Allied Health Professionals with funding to improve their systems enhances streamlined, secure, and integrated care delivery. In addition, enhanced websites, online booking systems, conformant practice management software, and telehealth delivery make Allied Health Professionals more visible and accessible, thus ensuring their essential role in the primary care sector.

FUNDING GIVES TAMWORTH PHYSIO A BOOST IN TECH | NBN News

Case Study: Murray PHN

Title: General Practice Services – Care Coordination

Stakeholders:

This case study relates to:

Workforce & Access to Allied Health Care ✓

Practice Engagement ✓

Key contact name and email:	Year of commencement:	PHN Funding Source: Focus on: Multidisciplinary Team Care | Rural Access | Long COVID

The Challenge

Serious medication-related problems can lead to a range of life-threatening issues such as haemorrhage, exacerbation of heart failure, renal failure or acute asthma, causing unplanned hospitalisations, serious and costly health complications or death. In Australia, 250,000 hospital admissions and 400,000 emergency presentations were due to potentially preventable medication-related hospitalisations, at a cost of $1.4 billion per year. Northeast General Practice Services was experiencing the below challenges:

- Workforce Shortages impacting on General Practitioners (GP) ability to complete Chorionic Disease Management (CDM) Medicare Items in a timely manner
- Pharmacists working in General Practice with no defined role or ways for remuneration
- Low numbers of Domiciliary Medication Management Reviews (DMMR) being completed – few community pharmacists to refer to with long waiting lists for reviews to be completed

The Solution

PHN care coordination funding utilised to embed community Pharmacist into the General Practice setting to complete medication reviews, CDM assessments (Pharmacist trained to do these), give advice on safe use of medications and devices, refer back to GP or community services where appropriate. Priority to underserviced populations (Contract July 2022 – June 2023)

- Pharmacist immuniser for opportunistic catch up of vaccinations
- Establishment of a Pharmacist Community of Practice (CoP) to support pharmacists working in the GP setting – to develop terms of reference, share learnings and lobby for pharmacist specific MBS item numbers in the GP setting
- Development of health literacy material related to safe use of medicines (displayed on practice website)

The Impact

- 228 patients seen to date
- 155 GPMP or TCAs completed (to date)
- 50 GPMP reviews completed (to date)
- 40 TCA reviews completed (to date)
- 66 age based health assessments completed (to date)
- 7 CALD or ATSI clients
- Referral sources – 126 from GPs, 73 from other sources (such as Nurses, Pharmacist, self referral)
- 142 referrals to nurses
- Sustainable model now achieved post funding period

Case Study: Murray PHN

Title: Medical Clinic – Care Coordination

Stakeholders:

This case study relates to:

Integration, models of care and funding

Practice Engagement

Key contact name and email:	Year of commencement:	PHN Funding Source: Focus on: Multidisciplinary Team Care | Rural Access | Long COVID

The Challenge

Exercise physiologists develop fitness and exercise programs that help patients recover from chronic diseases and improve cardiovascular function, body composition, and flexibility. Medical Clinic was experiencing the below challenges:

- Funding a Wellness program for patients with chronic and complex condition(s) which seeks to improve coordination of a multidisciplinary approach to patient- centred care.
- limited availability of Allied Health Practitioners caused challenges limiting the number and variety of education delivered throughout the program.

The Solution

Medical Clinic was funded to deliver a wellness program for patients with chronic and complex condition(s) which seeks to improve coordination of a multidisciplinary approach to patient- centred care. The program was based on Wagners Chronic Disease Model of care. The program included health and physical assessments, 2 exercise sessions each week plus access to interactive workshops with and Exercise Physiologist (EP) and other appropriate Allied Health Professionals relating to patients conditions. The provider worked collaboratively with patients, supporting them in reaching goals that are meaningful to them, reduce risk of hospitalisation and improve quality of life. For those unable to commit to program, individual consultations with EP were available. A Falls & Balance class was also available at the clinic for patients who have balance concerns or may lack confidence on their feet. Throughout the pilot in partnership with the PHN the patient intake and flow was analysed and adjusted to ensure MBS utilisation was captured for sustainability.

The Impact

Total of 905 occasions of service delivered over the contract period. 131 group sessions (across exercise and education) delivered over the contract period. Put a Spring in Your Step wellness program 40 clients completed initial assessment and accessed services over the program. Falls and Balance clinic and individual EP consultations were accessible to additional patients. Sustainable model developed post finding period

Benefits for the patients

- Improved cardiovascular fitness and walking capacity
- Improved muscular strength and bone density
- Improved balance and confidence, reduced falls risk
- Improved socialisation and interaction, development of social connection and peer support
- Improved health education and literacy
- Improved physical, social and emotional wellbeing

Benefits for staff (clinical and non-clinical)

- Ability to provide additional service & care for patients, building rapport and trust.
- Opportunities to develop knowledge, skills and relationships with other clinicals and patients.
- Source of employment for program staff

Benefits for the health sectors (primary care, community health and acute health services)

- Improved health at primary care and community level via GP referral to program
- Program available to all patients, not just those at one specific clinic
- Improve health literacy and reduce risk and rate of hospitalisation.

Case Study: Murrumbidgee PHN

Title: Vitality Passport in Community

Stakeholders: Murrumbidgee PHN, Back on Track Physiotherapy

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Janelle Dufty [janelle.dufty@mphn.org.au], Christina Eastall [christina.eastall@mphn.org.au]	**Year of commencement: 2016**	**PHN Funding Source: Core Flex and Healthy Ageing** **Focus on: Rural Access**

The Challenge

The Murrumbidgee region has an ageing population with higher proportions (over 4% higher) of people over the age of 65 years compared with NSW and Australia. There is also a higher proportion of adults who report having a long-term health condition and less people report having excellent, very good or good health compared Nationally. The Murrumbidgee region also had the second highest rate of fall-related injury hospitalisations in New South Wales for the 65+ age group.

There is a strong community desire for people to live in their home in the community for as long as possible. However, this does come with an increased risk of falls and injury to older people living in their homes by themselves, without regular community support and networks.

The Solution

The Vitality Passport in Community program commenced in early 2016 and is a lifestyle program aimed at improving the quality of life of older people (65+ and 55+ for Aboriginal and Torres Strait Islander people). The program aims to reduce or halt the progression of frailty in older people through improved nutrition, physical activity, social interaction and cognitive functioning. The Vitality Program is delivered via a range of allied health therapies including dietetics, occupational therapy and physiotherapy. Participants progress is measured using the Edmonton Frailty Score upon commencement of the program and at 6 months for each participant.

The program develops an individualised plan for each participant with components of exercise, nutrition and cognition activities. The program actively promotes a positive behaviour change delivering evidence-based interventions aimed at improving participant capacity to age well and improve physical, cognitive and nutritional areas of their life. Participants have access to 3 x individual face to face nutritional assessment and advice consultations, 3 x individual cognitive training sessions, 1 x individual session of low intensity mental health support, 8 x group sessions and 1 x reunion/sustainability group session.

The program expanded in 2019 to include people living in residential aged care facilities.

The Impact

The Vitality Passport in Community program continues to grow and expand each year with improvements in participants extending far beyond frailty, helping them to also stay socially connected through group led activities. An evaluation conducted in 2018 by University of Notre Dame showed that between 75-90% of participants agreed that their quality of life and overall health had improved, with better physical function, ease of socialising and less fear of falling as a result of the program.

In 2022-23, the program supported 275 clients with 80% of participants reporting halted or reversed frailty scores. The program continues to receive exceptional feedback from participants and remains a highly valued program being run in communities across the Murrumbidgee region.

Case Study: Murrumbidgee PHN

Title: WARATAH – Murrumbidgee Wellness and Resilience Achieved Through Allied Health

Stakeholders: Murrumbidgee PHN, Marathon Health

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: **Janelle Dufty [janelle.dufty@mphn.org.au], Joel Irlam [joel.Irlam@mphn.org.au]**	**Year of commencement: 2019**	**PHN Funding Source: Core Flex** **Focus on: Rural Access**

The Challenge

Allied health services play a significant role in the prevention, early intervention and management of chronic disease and ensuring people achieve independence and wellness. There are ongoing challenges in rural and remote regions in ensuring access to allied health services, as well as efficiently integrating and coordinating such services in ways that promote optimal outcomes for patients. In rural areas, the limited health workforce and geographic spread of populations, as well as high demand on available services, makes accessing services even more challenging.

The Solution

In 2018/19 MPHN codesigned the Wellness and Resilience Model of Care to provide the basis for commissioning allied health services across the region. The vision of the Model of Care is to improve the overall wellbeing of at risk or vulnerable residents of Murrumbidgee communities and create greater resilience towards the multitude of factors which may impact upon health status. The WARATAH program was commissioned in late 2019 with the lead contractor engaging a number of local allied health service providers to deliver services. The program also includes Health Linker roles as part of the model which help clients link with the community services needed to support them to achieve their wellness goals.

The Lead Contractor is also responsible for facilitating a community of practice for allied health providers, working with GPs to ensure engagement with the program and working with MPHN and other key stakeholders to develop roles such as the health linkers and allied health assistants.

The WARATAH program is delivered across three community networks – Border, Riverina and Western/Wagga Wagga and includes a range of allied health disciplines including diabetes education, dietetics, podiatry and physiotherapy. Services are delivered in a range of different settings including within local general practices, community health facilities and private rooms.

The Impact (Including any evaluation data available)

In 2022-23, the WARATAH program has delivered 6,347 services across the three community networks as follows:

- Border – 3,541
- Riverina – 1,394
- Western/Wagga Wagga – 1,403

Two Health Linkers are also currently employed as part of this program, supporting patients to recognise and set goals, access and engage in developing community networks and improving self-care and sustainable behaviour change in relation to increased confidence, resilience and healthier lifestyle choices.

Services are delivered from 33 different locations across the region with 30 of these being within local general practices and 3 community health settings. When surveyed, 100% of respondents reported a high level of satisfaction in relation to the WARATAH service. All respondents felt that other areas, apart from their health, were also considered as part of their care and 98% felt that their health and wellbeing had improved since working with the WARATAH allied health services.

Case Study: Murrumbidgee PHN

Title: WARATAH for Kids

Stakeholders: Murrumbidgee PHN, Marathon Health

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: **Janelle Dufty [janelle.dufty@mphn.org.au], Karly Pollard [Karly.pollard@mphn.org.au]**	**Year of commencement: 2022**	**PHN Funding Source: Core Flex** **Focus on: Rural Access**

The Challenge

MPHN needs assessment identified disparities and issues within maternal and child health across the region. To improve the accessibility and appropriateness of health care services within the Murrumbidgee that support women, their families and children a Maternal and Child Health Strategy was developed (see https://mphn.org.au/frameworks-and-strategies). This strategy is an agreed regional approach to improving maternal and child health outcomes and it proposes a number of priorities over the next three years. One of these priorities is to increase the uptake of maternal and child health early intervention screening and assessment for developmental and behavioral issues in the first 2000 days of life.

The Enhancing Paediatrics in Primary Care (EPiPC) model was then developed as a result of the need for improved screening and assessment in primary care, including the engagement of a Community Paediatrician to work with general practice to improve capacity and capability. Evidence indicates that there is a lack of paediatric speech therapy and occupational therapists within rural and remote areas. Appropriate access to speech and occupational therapy for assessment and early intervention is required to support the EPiPC model of care.

The Solution

To meet the demands for allied health services in regional and rural areas, MPHN codesigned and commissioned the WARATAH (Wellness and Resilience Achieved Through Allied Health) program in 2019 to enable people living with a chronic illness to have access to allied health services. It was determined that this model would be utilised as the basis for the WARATAH for Kids pilot. MPHN requested a proposal from the existing provider of the WARATAH model to pilot the development and implementation of an integrated approach to the delivery of paediatric allied health services to support the Enhancing Paediatrics in Primary Care Program (EPiPC). This would build on the existing WARATAH service model and will be a pilot for 18 months. The pilot program will have three phases – codesign, development/implementation and evaluation.

Allied Health Practitioners will work with GPs participating in the program through case conferencing, assessment and management of children aged up to 7 years of age with developmental and behavioural concerns. WARATAH for Kids will be delivered in identified locations of need including Wagga Wagga, Hay, Gundagai and Deniliquin.

The Impact

A codesign process took place in the latter part of 2022 with relevant GPs and allied health professionals. The service model was then approved in January 2023 and a multidisciplinary team clinic workflow was mapped, including GP referral, initial intake, prioritisation and clinic coordination processes. It is anticipated that a clinic will be held one day per month in each location and clinics should run for a minimum of eight months. Each clinic will be attended by a speech pathologist, occupational therapist and/or other key clinicians as required. Children aged 0-7 are assessed at the clinic and an appropriate referral pathway is determined.

Clinics began in late April – early May 2023 and to date, 20 children have been assessed. 8 families have provided feedback via the provider's consumer voice platform and 100% of respondents indicated that they understood the next steps for their child, felt heard regarding their child's needs and concerns, and felt they were communicated to with empathy and understanding. Whilst still in the pilot phase, the early results of this program appear promising in providing a service that meets an identified local need.

Case Study: South Western Sydney PHN

Title: My Care Partners
Stakeholders: South Western Sydney PHN, South Western Sydney Local Health District . General Practice, Allied Health

This case study relates to:

Integration, models of care and funding ✓

Data, quality and digital maturity ✓

Key contact name and email: Abhai Dhillon [Abhai.Dhillon@swsphn.com.au]	Year of commencement:2017	PHN Funding Source: Core Focus on: PCMH, Multidisciplinary Team Care

The Challenge

Patients who have complex health needs typically suffer from multiple chronic health conditions, functional limitations and unmet social needs[1]. These individuals often experience a fragmented care pathway characterised by clinicians working in isolation from each other rather than as a team. As a result, effective communication between the health 'team' can be challenging and inconsistent, which leads to concern regarding the quality and safety of patient care[2]. Furthermore, these patients often account for a disproportionate share of health care spending[1].

The Solution

The My Care Partners Program adopts a 'medical neighbourhood' model of care, co-designed by South Western Sydney Primary Health Network (SWSPHN), South Western Sydney Local Health District (SWSLHD) and members of the community (general practices, allied health, local NGOs). The goal of My Care Partners is to Improve coordination between the patients' medical home, primary and community services and acute care, Improve outcomes for patients with complex and chronic conditions who are at risk of potentially preventable hospitalisations and Improve patient and provider experience by encouraging continuity of care and team-based care to reduce the risk of omission or duplication of services. My Care Partners practices receive ongoing support to transform into a patient-centered medical home (PCMH). Practices are supported to complete models for improvement to improve key areas within the PCMH model; patient-centered care, coordinated care, comprehensive care, accessible care and safe, high-quality care. Practices also receive ongoing support from SWSPHN to implement My Care Partners into their workflow processes. Patients enrolled in My Care Partners receive care coordinator support and care enabling services to access 3 months of intervention via SWSLHD care coordination or care navigation followed by 9 months of GP monitoring and all supported by a SWSPHN Care Enabler. During the 12 months of enrolment, allied health providers identified as part of the patient care team via a Team Care Arrangement are invited to participate in case conferencing and actively participate in aligning patient care. Further supplementary services funding is accessible to patients with an identified need. GPs liaise with LHD care coordinators to coordinate services that may have previously been a barrier to patient needs. This may include allied health services and support equipment.

The Impact

Currently in formal evaluation phase of implementation. The impacts are expected to include

- Increase in team-based care and case conferencing/clinical huddles
- Allied health information to be included at point of care during case conferencing
- Allied health participation in neighbourhood communities of practice
- Increase in general practice, nursing and allied health working to top of scope
- Better alignment of care to patient and carer needs
- Reduced Potentially Preventable Hospitalisations (PPH) and readmissions
- Reduced duplication of services
- Potential decreased total health spending

References

1. McCarthy D, Ryan J, Klein S. 2015 "Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis" Issue Brief vol.31, pub.1843, Commonwealth Fund
2. Primary Health Care Advisory Group 2015 "Better Outcomes for People with Chronic and Complex Health conditions through Primary Health Care Discussion Paper"; August 2015, Department of Health, Canberra

Case Study: South Western Sydney PHN

Title: Metabolic Team Care Program

Stakeholders: SWSPHN, General Practice, Allied Health, Patient Cohort

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Mele Lokotui [mele.lokotui@swsphn.com.au]	Year of commencement: 2023	PHN Funding Source: Core (Prevention) Focus on: Multidisciplinary Team Care | Rural Access | Long COVID

The Challenge

- GPs don't have time to support patients aiming to improve their weight and fitness and ECPs are insufficient and only apply once the patient has a chronic disease.
- Allied Health can't participate in case conferences unless there is a diagnosed chronic disease
- Modifiable risk factors such as obesity, physical inactivity and poor nutrition can have a marked effect on the prevalence of conditions such as CVD and type 2 diabetes and are contributing factors to Metabolic Syndrome.
- The number of residents with CVD in SWS is projected to increase by 38% by 2031 rising from 160,710 people in 2016 to 221,197 people in 2031. The highest increase is expected in Camden and Liverpool LGAs (56% and 38.5% respectively).

The Solution

The National HEAL (Healthy Eating Activity and Lifestyle) program is conducted by SWSPHN in association with ESSA (Exercise and Sports Science Australia). Under the Healthy Communities initiative, the program aims to identify and treat patients at risk of developing Metabolic Syndrome using case conferencing and patient participating in HEAL.

- 5 practices nominating 20 patients each. Each patient will have a case conference between GP, Exercise Physiologist and Dietitian.
- Patients (in groups of 10) then complete the HEAL program over 8 weeks with the EP and dietitian including 1 hour of group based physical activity and 1 hour of group based healthy lifestyle education each week.
- At 5 months and 12 months, participants will have a follow up consultation with the Exercise Physiologist and Dietician.
- At the 6 month mark, there is a follow up case-conference.
- PHN subsidises allied health for the case conferences and pays them per patient who completes the HEAL program.

The Impact

Pilot program has not yet been completed; data currently unavailable.

Case Study: Sydney North | SNHN

Title: SNHN Allied Health Primary Care Grants Program

Stakeholders: Allied health providers and community

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Alex Jaksetic [alliedhealth@snhn.org.au]	Year of commencement: 2022	PHN Funding Source: Core/Flexible

The Challenge

Allied health practices in the region have faced the same challenges as general practice over the past couple of years with the impact of the COVID pandemic on continuity of care and patient health and wellbeing.
The Sydney North Health Network (SNHN) Allied Heath Grants were intended to recognise innovation and contributions of allied health professionals in response to emergencies and natural disasters, or in enhancing primary health services that promote community connection across the region.

The Solution

Allied health professionals working in primary care in Northern Sydney were invited to provide innovative and creative approaches to delivering allied health services through a 'Request for Proposal' procurement process. Eligible activities in scope for an Allied Health Grant included evidence-based allied health services or therapies, such as improving health literacy in vaccine hesitant populations; maintaining COVID safe planning, winter preparedness and infection control; enhancing continuity of care during emergencies and natural disasters; building digital health capabilities (e.g. clinical information systems, telehealth video consultations); enabling connected care with general practice and/or other primary healthcare providers; interventions that address prevention or management of chronic disease; new models of collaborative, multidisciplinary, team-based care (e.g. management of long COVID); or linking social prescribing to community-led activities.

The Impact

A total of 21 small grants were offered, supporting delivery of a range of activities (commencing July 2022 and concluding June 2023). The grants helped support delivery of a range of activities aimed at:

- Increasing vaccinations
- Managing the symptoms of prolonged COVID
- Screening and providing management strategies for older people at risk of frailty and falls
- Preventing and managing chronic conditions
- Enhancing mental health and wellbeing
- Improving access to allied health services for vulnerable groups
- Building skills and capacity of the health workforce
- Enabling connected care with general practice and other primary healthcare providers

Case Study: Sydney North | SNHN

Title: Frailty and Fall Prevention | In-Home Exercise Program | Allied Health Primary Care Grants Program

Stakeholders: Older population

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Alex Jaksetic [alliedhealth@snhn.org.au]	Year of commencement: 2022	PHN Funding Source: Flexible

The Challenge

Northern Sydney has an ageing population with increasing presentations of frailty and falls. Some people are unable to access group-based programs due to limited mobility or are not eligible for other funded programs.

The Solution

Proposed grant activity: To provide a 10-week home exercise intervention to individuals that have been identified as requiring further supports as they are at risk of falls or have been assessed to be frail. The program aimed to improve functional movement, lower limb strength and balance of individuals. As well as assist with identifying any further falls risk factors around the home. This service aimed to provide up to 10 home exercise consultations with an Accredited Exercise Physiologist to deliver tailored exercise therapy for the older population. This service aimed to help individuals at risk of declining function until the time they are approved for more ongoing services under a Home Support Program level 3 or 4 package.

The Impact

- 22 Referrals in 4 weeks – 14 included in program
- 8 excluded – out of SNHN area, declined service, previously engaged with Activempowerment
- 5 of 8 excluded seen via EPC referral or paid privately
- 18 Referrals - Ryde and Hornsby hospitals, 1 - GP practice, 3 – Aged Care Service providers
- 14 Participants – 10 covered by funding and 4 covered in-kind
- Timed Up and Go: 20% average increase
- Sit to Stand: 35% average increase
- 10 out of 14 participants achieved significant improvement in balance
- 7 participants have continued engaging with our service via Home Care Package since completing program in December 2022

“Mum really likes how exercises can be modified when she’s not feeling the best, so she can always feel positive about doing something. She is so much more confident walking in the community now.” (Participant’s daughter)

“Thank you for your help, and your knowledge. I appreciated your consideration at all times, especially with the appointments.” (Participant)

Case Study: Sydney North | SNHN

Title: Frailty and Fall Prevention | Frailty Screening Program | Allied Health Primary Care Grants Program

Stakeholders: Older population

This case study relates to:

Integration, models of care and funding ✓	***Workforce & Access to Allied Health Care*** ✓	*Practice Engagement* ✓	*Governance and culture* ✓	*Data, quality and digital maturity* ✓

Key contact name and email: Alex Jaksetic [alliedhealth@snhn.org.au]	**Year of commencement: 2022**	**PHN Funding Source: Flexible**

The Challenge

Northern Sydney has an ageing population with increasing presentations of decline in physical function, frailty and fall risk. Based on recent epidemiological studies of Australian adults aged 65 or older, it is estimated that up to 21% are frail and another 48% are prefrail (Thompson, 2018). There is strong evidence for the role of physical activity to impact health outcomes in this population (Merchant, 2021); however, many barriers remain to its implementation. One barrier is the lack of awareness of the prevalence of frailty, how it is defined and potential management strategies. Another perceived barrier is the lack of time for screening in general practice, which is currently the most likely environment for screening to take place.

The Solution

Proposed grant activity: To provide physiotherapy-led frailty screening assessments with primary objective of promoting awareness of frailty in the community and championing prevention strategies. Program consisted of:

- Assessment of key physical domains of frailty: strength, gait speed, balance
- Completion of FRAIL Scale questionnaire and the Short Physical Performance Battery; both of which have been validated as reliable screening tools in the community-dwelling population (Boreskie, 2022).
- Discussion and education regarding frailty and management
- Written report of findings to participant and general practitioner including norms comparison

The Impact

- 18/60 screening assessments completed as of June 2023 and continuing
- Development of norms-based assessment toolkit and education resources

"I think the most important thing I learned from the Test was how important it is to do those small, ordinary movements regularly in order to keep mobile. We all need that necessity reinforced as we get older before our systems seize up!" (participant)

"I found the Positive Aging Screen very helpful. The report could have included more details but was sufficient to gauge overall fitness. My General Practitioner appreciated receiving the report of my health." (participant)

"I'm now doing more lower body strengthening." (participant)

Case Study: Sydney North | SNHN

Title: Prevention and Management of Chronic Conditions | Managing Symptoms of Prolonged COVID | Allied Health Primary Care Grants Program

Stakeholders: People presenting with long-COVID

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Alex Jaksetic [alliedhealth@snhn.org.au]	Year of commencement: 2022	PHN Funding Source: Flexible

The Challenge

Most people with COVID-19 recover completely within a few weeks of their first symptoms. However, some people may experience longer-term effects from their infection. Multidisciplinary, team-based management of prolonged symptoms of COVID was and still is an emerging area. Limited access to long-COVID clinics in our region, coupled with lockdowns and other restrictions, further compounded the barriers to accessing timely care for people presenting with prolonged symptoms of COVID. The role of community-based allied health providers in the management of long-COVID was also evolving.

The Solution

Proposed grant activity: To deliver a wholistic education and support program for people experiencing prolonged symptoms of COVID. The program aimed to equip participants with knowledge and skills to safely manage symptoms, paced and tailored to their individual needs. A team of exercise physiologists, dietitians and occupational therapists developed a 12-week program, delivered via telehealth to enhance accessibility and participation. Features of the program included a modifiable physical activity and gentle exercise program to accommodate varying level of condition, function and progression rate, and educational resources/platform for clients regarding symptom management and pacing strategies. Each session was also recorded.

The Impact

- Fifteen people registered for program (with capacity for up to 20)
- Of those completing program: WHO Disability Assessment Schedule scores improved from 29/60 to 22/60; and sit-to-stand scores improved from 9 to 14
- Drop-out rate was high, partly due to participants recovering, and partly due to poor adherence
- Lessons learned and contribution to a growing body of evidence on rehabilitative approaches to long-COVID in primary care settings

“Thought it was real innovation – loved being involved”

“I like that this is preventative and will minimise the strain on public health. Would be beneficial to have it run in more places as family members have taken an interest.” (Participant)

“I feel better compared to a couple months ago and compared to when I signed up to the program. Now I feel more energetic but still have ups and downs.” (Participant)

“Great program overall and super beneficial for participants to gain support from exercise physiology, dietetics and occupational therapy – a very holistic approach.” (Provider)

Case Study: Sydney North | SNHN

Title: Prevention and Management of Chronic Conditions | Community Chronic Pain Program | Allied Health Primary Care Grants Program

Stakeholders: Individuals with chronic pain

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Alex Jaksetic [alliedhealth@snhn.org.au]	Year of commencement: 2022	PHN Funding Source: Flexible

The Challenge

Musculoskeletal (MSK) pain is the number one cause for global disability and this burden is expected to rise with an aging population, with 1 in 5 Australians experiencing chronic MSK pain.(Ferreira et al., 2023),(Blyth et al., 2001) Clinical guidelines consistently recommend integrated physical and psychological care for chronic MSK pain.(Hartvigsen et, al., 2018) However, this is not always readily available in primary care.(Hogg et al, 2021)

The Solution

Proposed grant activity: To develop and implement a model of care for chronic MSK pain which was community based, evidenced based, and integrated physical and psychological care specific to chronic MSK pain. The program was developed and delivered by a chiropractor and aimed to provide community based chronic pain education, counselling and exercise therapy. The goals of the program were to improve functional capacity through education and exercise, and assist individuals to identify goals, barriers, and boundaries, and to develop crisis management strategies and self-help routines. A 1-hour face-to-face education, counselling and exercise session once a week that ran over 5 consecutive weeks, with a small group size – max 10 participants.

The Impact

Participants were provided with a workbook which includes goal charts, exercise charts, suitable exercises. In addition, participants are provided a list of resources including websites for further information relating to self-management of chronic pain, relaxation techniques, and assistance with setting up self-help routines at home. The key success of the program was the consistent and positive experience shared among the participants. All participants enjoyed the program and found the information beneficial to their pain experience. This was further highlighted in improvements in pain and related psychological outcomes, and program satisfaction. From a practice perspective, staff are now equipped with the experience and manuals to deliver future programs to patients.

"You have done me a great favour. I learned that the way I was managing my pain was actually making it worse in the longer term, and my plan of avoiding pain was wasting my muscle mass and causing further immobility. I enjoyed the educational aspects of your course most of all." (Participant)

"Use of the phone app for the exercises is good, when you have brain fog and in pain, I can easily access the exercises and it reminds me what to do. The program has reinforced the importance of a holistic approach to my chronic pain." (Participant)

"I thoroughly enjoyed developing and delivering this program. The program aligns with my clinical and research expertise and is a great opportunity to translate evidence-based treatments to people with chronic pain, within my community. I found the program fun to deliver and noticed positive improvements in the participants' chronic pain." (Provider)

Case Study: Sydney North | SNHN

Title: Improving Access to Allied Health Services for Vulnerable Groups | Psychoeducation Program for Aged Care Residents | Allied Health Primary Care Grants Program

Stakeholders: Elderly population

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Alex Jaksetic [alliedhealth@snhn.org.au]	Year of commencement: 2022	PHN Funding Source: Flexible

The Challenge

Willandra Village is a retirement village and a home to over 160 elders operated by BaptistCare. The organisation offers 136 independent living units as well as three residential aged care facilities within the same complex in Macquarie Park, NSW. In May 2022, the residents of Willandra Village were informed that the village will close in 2025, due to redevelopment for a period of up to two years. All residents to vacate premises permanently, no promise for accommodation post refurbishment. Apart from the personal impact on the residents, staff are also facing redundancies and new employment opportunities will arise once development is completed.

Most of the residents of Willandra are elderly and retired members of our community aged in their 80s and 90s. Many residents receive home care support, meal delivery and allied health services. No on-site counselling available. Research into wellbeing in late life indicates that older adults are the least likely age group to seek mental health support, face ageism, are at risk of suicide and yet respond well to short-term evidence-based treatment. The impact of COVID-19, prolonged isolation and the impending move are impacting the wellbeing of Willandra residents who are highly vulnerable members of our community.

The Solution

Proposed grant activity: To deliver a preventive group based “Wellness Adventure” program (reduce isolation, loneliness, improve adjustment, boost resilience, build new skills, form friendships and identity residents at –risk), with individual pre and post program screening and support. A clinical psychologist developed and delivered the 8-week program.

The Impact

- Pre-post administered Geriatric Depression Scale (GDS) showed a reduction in scores (screening tool not diagnostic tool)
- High retention of participants across the 8-week program (n=16)
- Residents self-referred themselves to the program, “bring a friend” was also welcomed, several couples joined the sessions
- Qualitative feedback reflected themes of improved coping skills, opportunities to tackle problem solving in a more structured way, mastering new skills and introducing mindfulness and self-care strategies

“The Wellness group provided many strategies of coping with problems in my life and able to share with other group members which as a group we helped each other. It was a wonderful time of fellowship”. (Female resident)”

“I’ve had people tell me that I’m more confident since I did the Wellness group.” (Female resident)

“The whole exercise of the Wellness group was extremely helpful – everyone was comfortable in sharing and from that I was able to get to know the group. The discussions were friendly and humorous, we were able to laugh and perhaps a few tears and to understand each other. I learnt a lot – I am not alone, people do care.” (Male resident)

“This was a wonderful opportunity to support Willandra residents who were facing a big challenge with their impending relocation. The program allowed the residents to learn better coping strategies, connect with one another in a safe environment and for the facilitator to learn more in depth the challenges faced by this population.” (Provider)

Case Study: Sydney North | SNHN

Title: Allied Health Networking Breakfasts | Allied Health Practice Engagement

Stakeholders: Allied health professionals working in primary care

This case study relates to:

Workforce & Access to Allied Health Care ✓

Practice Engagement ✓

Key contact name and email: Alex Jaksetic [alliedhealth@snhn.org.au]	Year of commencement: 2022	PHN Funding Source: Flexible and sponsored

The Challenge

SNHN has an estimated 2,500 allied health practices and over 3,000 allied health professionals working in the private primary care setting. Key priorities in our allied health engagement strategy include engaging allied health professionals in decision making; building relationships; supporting digital connectivity and facilitating collaboration, yet many allied health practices remain unfamiliar with the Primary Health Network. The SNHN Allied Health Reference Group members suggested some networking events to increase practice engagement and awareness of the role and work of the PHN.

The Solution (Including who is the program delivered to, by which Allied health professions, and in which setting/s?)

SNHN is piloting a series of multidisciplinary allied health networking breakfast meetings in different part of the region with the aim of building relationships, increasing engagement with the PHN, fostering local collaboration, and identifying other opportunities for working alongside and supporting allied health professionals in our region.

The Impact (Including any evaluation data available)

Three breakfasts held to date. Response to these breakfasts has been very positive, with attendees expressing their interest in meeting and collaborating with other allied health professionals in the local area. Participant benefits have included:

- Opportunity to meet other local allied health professionals
- Being able to expand referral networks
- Learning more about the PHN and supports available to allied health practices

"Just wanted to say thank you for hosting the Allied Health practitioners breakfast this morning. It was lovely to meet yourself and other local health professionals - face to face".
(Physiotherapist, Hornsby Local Government Area)

"I just wanted to thank you for the beautiful breakfast this morning. It was great to connect with other health professionals and get to know who is in the community. Much appreciated".
(Clinical Psychologist, Northern Beaches Local Government Area)

"It was a wonderful networking breakfast. I think it is easy to forget how helpful and enlivening it can be to chat with colleagues beyond our own workplace".
(Occupational Therapist, Willoughby Local Government Area)

Case Study: WA Primary Health Alliance

Title: Social Work in General Practice

Stakeholders: Complex Needs Coordination Team (CoNeCT South Metro Health Service) and eight General practices

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Dianne Bianchini [dianne.Bianchini@wapha.org.au]	Year of commencement: 2019	PHN Funding Source: Core Flex Focus on: Multidisciplinary Team Care

The Challenge

Codesign workshops with practices identified that GPs were spending increasing amounts of time addressing social determinants of health for large numbers of patients and their carers. They recognized they did not have the expertise or time to address the issues**.**

The Solution

Social workers, as part of the care team, worked directly with patients and their carers to address social determinants of health and complex psychosocial issues. This was to enable general practitioners and clinicians in participating practices to work to the top of their scope and provide team based care. The program used measures across the Quadruple Aim.

The Impact

Positive patient experience -needs being met and improvement in sense of well-being – 94% Highly Satisfied;' 94% Improves care; 96% would use the service gain. Patient Reported Outcomes Measures consistent improvement over eight domains – Lifestyle, Looking After Yourself, Managing Symptoms, Work and Activities, Money, Where you live, Family and Friends, Feeling positive. Increased linkage to community services by 250%
Positive practice staff experience – 83% staff reported SW service positively impacted on team based care; 75% reported the holistic needs of the patients were supported including MDT care planning and case conferences; 90% of practice staff reported increased confidence dealing with patients with complex psychosocial needs; 85% reported increased capacity of the practice to manage the healthcare of complex patients; 68% reported a positive effect on GP staff emotional wellbeing and less emotional energy expended with 'heart sink' patients with more time reported to deliver medical and nursing care
Learnings – financial sustainability of the model to employ SW without subsidisation was difficult but three practices maintained the SW service for a time; Employing Mental Health Accredited SW would have assisted financial sustainability; high levels of clinical lead engagement impacted positively on average patient outcomes and practice staff satisfaction; reduction in presentations to ED not observed as with hospital patients of the CoNeCT service (more complex cohort)

Link to references

https://outcomesstar.com.au/ - PROMs tool used
https://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=80160&qt=ItemID Mental Health Accredited Social Workers and MBS

Case Study: WA Primary Health Alliance

Title: Nurse Practitioner and Team Based Care Pilot – commencing Sept 2023

Stakeholders: WA Department of Health, WAPHA, General Practitioners, ACHHOs, Nurse Practitioners

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Dianne Bianchini [dianne.Bianchini@wapha.org.au]	Year of commencement:2023	PHN Funding Source: Focus on: Multidisciplinary Team Care

The Challenge

Address workforce challenges by assisting the development of team based care by providing funding for employment of nurse practitioners and undertake this program in partnership with WA Department of Health. The Australian Government has committed $100 million nationally to pilot new ways to enhance primary care. WA will receive $11.7 million to encourage primary care to offer more comprehensive, team-based services utilising the clinical skills of nurse practitioners working within primary care services

The Solution

An Expressions of Interest was sent out to Nurse Practitioners advising of the opportunity to work in primary care settings and requesting EOIs.

EOIs were then sent to general practices and Aboriginal Health Community Controlled Services. Requesting their identification of vulnerable populations, how they could implement Team Based Care utilising a Nurse Practitioner.

The EOI is currently open and the program has not yet commenced. Matching of the two EOIs will be finalised in Sept 2023.

The Impact

Funding allows for approx. 20 FTE Nurse practitioners to be employed in this pilot. Evaluation will occur in partnership with the Dept of Health and Aged Care

Link to references

The Nurse Practitioner Pilot has been developed in collaboration with the Australian Department of Health and Aged Care and the Department of Health Western Australia, in alignment with key recommendations of the:

WA Nurse Practitioner Workforce Innovation Strategy (2023-2028)

Commonwealth Strengthening Medicare Taskforce Report, 2023 (external site)

WA Sustainable Health Review Report (2019-2029)

Commonwealth Nurse Practitioner Workforce Plan, 2023 (external site)

Case Study: WA Primary Health Alliance

Title: Non Dispensing Pharmacists in General Practice

Stakeholders: General Practices, Pharmaceutical Society of Australia

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Dianne Bianchini [dianne.bianchini@WAPHA.org.au]	Year of commencement: Commencing Sept 2023	PHN Funding Source: Early Intervention Older Adult funding Focus on: Multidisciplinary Team Care |

The Challenge

Keeping older adults well in the community by providing team based care, focusing on quality use of medications and linkages to community supports

The Solution

The program, commencing Sept 2023, will be delivered to older adults in general practices in areas of high needs and large older adult populations. Non Dispensing Pharmacists will be employed by the Pharmaceutical Society of Australia and will work at least two days a week within the practice as part of the MDT.

The Impact

Evaluation of the program will include achievement of the Quintuple Aim as well as using the EQ-5D-5-DL measure.

Link to references

Quality use of Medications

https://www.safetyandquality.gov.au/our-work/medication-safety/quality-use-medicines

Medicine Safety: Take Care and Medicine Safety: Aged Care

https://www.psa.org.au/advocacy/working-for-our-profession/medicine-safety/

Case Study: Wentworth Healthcare Limited/Nepean Blue Mountains PHN

Title: Intergenerational Programs

Stakeholders: Music Therapy service in Penrith and Hawkesbury LGAs, local early education care centres and local independent living homes

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Ella Ibbitson [ella.Ibbitson@nbmphn.com.au]	Year of commencement: 2023	PHN Funding Source: Early Intervention Funding Focus on: Multidisciplinary Team Care

The Challenge

An emerging issue in NSW is the premature placement of older people into residential aged care homes (RACHs) and a lack of appropriate aged-based care initiatives to support independent living at home. The Nepean Blue Mountains (NBM) region has 29 RACHs with capacity for just over 2,600 residents. If ageing projections are fulfilled, there will be significant challenges in our region to support the needs of the ageing population with the existing workforce. To reduce the pressure on RACHs and local health services, programs that support older adults to live at home for longer need to be developed and prioritised.

The Solution

Intergenerational programs aim to support older adults to live at home for longer by improving their social, emotional, and physical wellbeing through participation in group-based activities. These activities will promote healthy ageing by providing mutual learning opportunities and improving social connectedness. Wentworth Healthcare Limited (WHL) has commissioned a local Music Therapy service to deliver three x 10-week intergenerational music programs between July 2023 and June 2024, targeting older adults aged 65 years and over (or aged 55 years and over for Aboriginal and Torres Strait Islander people). These programs bring together older adults from the community and residents of independent living, and children aged between 3 and 5 years, for group-based activities and music therapy sessions. The activities may range from play-based interactions, leisure activities and/or purposeful learning experiences. Music therapy is delivered by qualified and registered music therapists, who have undergone an accredited university course in music therapy, and are registered with the Australian Music Therapy Association. The programs will be delivered onsite, at the aged care independent living locations.

The Impact

Intergenerational programs have been shown to improve health outcomes for older adults and children including improvements in physical and mental health, cognitive abilities and communication skills (Skropeta et al., 2014). Connecting older adults with the younger generation through purposeful intergenerational activities benefits both cohorts by building meaningful connections that foster deeper communication. WHL's intergenerational programs will utilise various qualitative and quantitative tools to evaluate the programs and determine if program objectives have been achieved.

Skropeta CM, Colvin A, Sladen S. An evaluative study of the benefits of participating in intergenerational playgroups in aged care for older people. BMC Geriatr. 2014 Oct 8;14:109. doi: 10.1186/1471-2318-14-109. PMID: 25292218; PMCID: PMC4197292.

Case Study: Wentworth Healthcare Limited/Nepean Blue Mountains PHN

Title: Mobile Occupational Therapist Service

Stakeholders: Local service providers, General Practices and Regional Assessment Teams.

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Ella Ibbitson [ella.Ibbitson@nbmphn.com.au]	Year of commencement: 2023	PHN Funding Source: Early Intervention Funding Focus on: Multidisciplinary Team Care

The Challenge

To prevent early admission into residential aged care, there is a need to support older people to better manage their chronic conditions at home. For the purposes of understanding the unique needs and priorities of the older community in the Nepean Blue Mountains (NBM) region, a consultation process was undertaken with key stakeholders. Through this approach, a number of themes were uncovered, including:

- Overwhelming need to access timely allied health, such as Occupational Therapists to conduct early and holistic assessments of older people's functional abilities to remain living independently at home
- Greater access to specialised allied health
- Preventative support to reduce falls, maintain mobility and functional independence, and prevent unnecessary functional decline
- Targeted assessments and referrals that enable older people to continue to participate in activities they enjoy
- Service gaps identified in the Lithgow region

The Solution

Wentworth Healthcare's Mobile Occupational Therapy (OT) service provides in-home assessments for older adults aged 65 years and over (or aged 55 years and over for Aboriginal and Torres Strait Islander people) residing at home, in Lithgow and surrounding areas, including the upper Blue Mountains and outer Hawkesbury. The 'Early Intervention Consultation and Commissioning Recommendations Report' by Eliza Pross (2022) identified that physical deconditioning, falls, and social isolation are the most impactful and modifiable contributors to functional decline in older adults. Occupational Therapists (OTs) are best placed to assist older adults with physical reconditioning and coordinating care for people who are managing chronic conditions at home. OTs can also provide support to improve cognitive function, diet, social connectivity and assist older adults to reduce their falls risk at home by providing in-home OT assessments and making referrals for home modifications and equipment.

The Impact

OTs can provide support to improve cognitive function, diet, social connectivity and assist older adults to reduce their falls risk at home by providing in-home OT assessments and making referrals for home modifications and equipment. The Edmonton Frailty Scale will be used as the key measure of frailty and quality of life for the Mobile OT outcome reporting.

Case Study: Wentworth Healthcare Limited/Nepean Blue Mountains PHN

Title: Speech Pathology Service in Lithgow and Portland Area

Stakeholders: Lithgow Allied Health Service, Multiple schools and preschools in Lithgow and Portland area

This case study relates to: Speech Pathology services in Lithgow LGA

Workforce & Access to Allied Health Care

Key contact name and email: Rakesh Patel, Workforce Program Officer, NBMPHN	**Year of commencement:** 2015	**PHN Funding Source:** HEBHBL funding from NSW Rural Doctors Network **Focus on:** Multidisciplinary Team Care

The Challenge

Lithgow is significantly disadvantaged area in Nepean Blue Mountains region. It is located 160km west of Sydney and ranked 20 out of 153 for most disadvantaged LGAs in NSW (SEIFA). It has a small rural hospital which is staffed by GPs and VMOs. It is extremely difficult to recruit doctors, nurses and allied health professionals to this area. There was significant service gaps identified in 2015, mostly for specialist paediatric and allied health services. Families were unable to get to the hospital for appointments or do regular speech and language practice at home. Increasing number of children identified with developmental speech and language issues at an older age and could not be accepted at hospital due to long wait lists and age restrictions. There was a need for speech pathology assessments in Lithgow area. Due to issues with accessibility and wait lists, a service was needed which could directly support children.

The Solution

Weekly speech pathology service commenced in 2015. A speech pathologist from Lithgow Allied Health Service provides in school assessment of children, plus intensive therapy and appropriate referrals. Children are screened and assessed for receptive and expressive language, speech sound disorder, phonological awareness etc. Group therapy is also being organised for children with hearing, speech and language difficulties. Speech pathologists regularly organise upskilling sessions for teachers and student learning support officers. This service started at one particular school and now expanded to include total 6 schools and 6 pre-schools in the Lithgow and Portland arear.

This service is a joint program between the NBMPHN and Lithgow Allied Health Service with funding from the NSW Rural Doctors Network.

The Impact

During 2015-22, an average of 198 hours of clinical speech pathology services were organised in Lithgow and Portland area. A total of 298 occasions of speech pathology services were provided per year. Approximately 32% of occasions of service are with Aboriginal children.

Case Study: Wentworth Healthcare Limited/Nepean Blue Mountains PHN

Title: Diabetes Educator services in Hawkesbury

Stakeholders: Diabetes Educator, two General Practices in Hawkesbury area

This case study relates to: Diabetes educator services in Hawkesbury LGA

Workforce & Access to Allied Health Care

Key contact name and email: Rakesh Patel, Workforce Program Officer, NBMPHN	**Year of commencement:** 2018	**PHN Funding Source:** MOICDP funding from NSW Rural Doctors Network **Focus on:** Multidisciplinary Team Care

The Challenges

In 2016, NBMPHN needs assessment identifies that rates of diabetes in the region were higher than the state average, and the prevalence was growing exponentially each year. Additionally, NSW comparison of Aboriginal and non-Aboriginal populations showed that Aboriginal people had a high proportion of risk factors that result in chronic conditions. There was 3 to 4 months waiting list to see public diabetes service at that time. There was no Aboriginal Medical Service in the region at that time and it was a big challenge for First Nations people to access culturally safe diabetes education services in the local area. Windsor is a semi-rural centre on the outskirts of Sydney, but is geographically isolated by poor roads, poor public transport and natural geographical boundaries (Nepean River and National Parks).

The Solution

A multi-disciplinary diabetes clinic was established within a busy general practice in Hawkesbury LGA. This general practice had a high proportion of Aboriginal patients. Clinic was started on a half day fortnightly basis with a Credentialled Diabetes Educator and an Endocrinologist. Over the following year the clinic expanded to another large general practice in the same area which is still continuing. These clinics are open to all diabetes patients in Hawkesbury area with priority access to First Nations people in our community. All GPs in the local area can refer their patients with diabetes to this clinic.

This service is a joint program between the Nepean Blue Mountains PHN and two local General Practices with funding from the NSW Rural Doctors Network.

The Impact

Total 890 diabetes education consultations provided since the clinic started in 2018. Total 152 half day clinics are organised in this period. Multiple sessions of education events organised for staff and GP at an Aboriginal Medical Service to upskill them regarding diabetes education.

Case Study: Western NSW PHN

Title: COVID-19 Vaccinations in the RACH's

Stakeholders: Western NSW PHN, Life Pharmacies, RACHs

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email:	Year of commencement: 2023	PHN Funding Source: Vulnerable populations Focus on: Multidisciplinary Team Care | Rural Access

The Challenge

Following the approval of the 5th booster vaccination for COVID-19, there was an urgent push for primary care to administer vaccinations to Residential Aged Care Homes (RACHs). However, in the far western regions of New South Wales, a significant challenge was posed due to the shortage of General Practitioners (GPs) and pharmacies with sufficient time and staff to handle these vaccinations. The region's geography, with its widespread and remote locations, added a layer of complexity to an already challenging task.

The Solution

To address the challenge of vaccine distribution in far western NSW, particularly in Remote Aged Care Homes (RACHs), an approach was devised involving a group of pharmacies operating across multiple towns within the region. This program catered to the requirements of RACHs in remote areas where access to General Practitioners (GPs) or pharmacies was restricted due to geographical or staffing limitations.

Key players in this solution were a group of qualified pharmacists, who were contracted for their ability to cover a large geographical area and administer vaccines effectively. One unique aspect of this program was the involvement of a pharmacist who was a pilot and owned an airplane. This allowed the program to extend its reach to even the most isolated sites that were otherwise difficult to access.

The pharmacists were responsible for administering the 5th booster COVID-19 vaccinations to residents of RACHs. Vaccinations were carried out in the RACHs themselves, to ensure that elderly residents did not have to travel, reducing potential stress or health risks. This solution effectively overcame the shortage of available GPs and pharmacies in the region, ensuring that vulnerable individuals in remote areas were not left behind in the vaccination rollout.

The Impact

The introduction of this innovative solution resulted in several outcomes:

- Pharmacies became critical assets in vaccine administration, providing essential relief to the overwhelmed GP workforce.
- Vaccinations were successfully delivered within the timeframe, thus ensuring timely immunity against the virus across the RACHs
- The initiative also boosted the capacity of rural pharmacies and demonstrated the potential of pharmacies in expanding the healthcare reach in rural settings.
- It brought about enhanced inter-professional collaboration, with the unique contribution of pharmacies being recognised and utilised for the larger public health benefit.
- For the residents in remote regions, this was an assurance that their health and safety were given priority, and all possible measures were undertaken to ensure they received necessary medical interventions.
- The Pharmacies' hard work was acknowledged with a written letter of thanks from Anna Peatt, the Acting First Assistant Secretary of the Department of Health and Aged Care (DoHAC).

This novel strategy illustrates the potential of cross-disciplinary collaboration and innovative thinking in addressing public health challenges, especially in geographically challenging areas. It demonstrates the potential versatility and adaptability of the healthcare system in times of need.

Case Study: Pharmacy in General Practice (PiGP) Western NSW PHN

Title: Pharmacy in General Practice (PiGP)

Stakeholders: Pharmacy; General Practice & ACCHS

This case study relates to:

Integration, models of care and funding	*Workforce & Access to Allied Health Care*	*Practice Engagement*	*Governance and culture*
✓	✓	✓	✓

Key contact name and email: Sonya Berryman **Sonya.berryman@wnswphn.org.au**	**Year of commencement: 2020-2022**	**PHN Funding Source: Innovation funds** **Focus on: Multidisciplinary Team Care | Rural Access**

The Challenge

Pharmacists are a key part of the patient healthcare journey. However, in many respects, specialist general practitioners (GPs) and pharmacists deliver care through models that are isolated from one another.
Exploring the potential model for a PiGP role offers an alternative to delivering medication services by integrating pharmacists into primary healthcare teams.
Numerous studies indicate that having an integrated pharmacist in a general practice has many clinician, patient, and cost benefits.

The Solution

To develop and enhance the use of non-dispensing pharmacists in general practice. To learn how pharmacists can work collaboratively with the practice team in our diverse region. To enhance the management of medication use and access to medication advice and review services across our rural and remote communities. Real and meaningful clinical engagement in joint planning to improve system integration and commissioning. Provide primary health care with a representative link and brokerage across groups of clinicians and practices for the PHN as well as work alongside Hospital clinicians to understand Local Health District (LHD) linkage for various LHD services/departments.
This program was designed to look at the role of PiGP in the variety of GP settings. This included AMS/ACCHO and general practices that vary in size and locations and potentially even the role of outreach to communities with no pharmacists. The project involved embedding 11 pharmacists in practices in Broken Hill, Coonamble, Dubbo, Forbes, Grenfell, and Orange These part-time pharmacy project positions commenced over May/June 2021, through to the end of October 2021. Renumeration was provided. A PIGP advisory group was formed. A training program for the teams was formalized. Project was evaluated (against the quadruple aim)

The Impact

The 2020-21 COVID-19 impact in NSW negatively affected the project for more than one third of the implementation phase.
Based on the semi-structured evaluation interviews of the project pharmacists, provider satisfaction was generally high. Among activities such as medication reviews, GP liaison, and health care consumer and provider education provided by pharmacists, descriptions were also given of pharmacist interventions demonstrating how useful the role might be for consumer health.

It appeared that the size of the town, the familiarity of the pharmacist with the local health care providers, the understanding of the role among other health care service providers, and the embeddedness of the pharmacist in the local community all work to determine the success of the project role and the provider satisfaction that followed. The minority of pharmacists who did not have a positive alignment of these factors felt somewhat isolated and frustrated. Most of these issues have appeared to some extent in the literature. While no sharp conclusions can be drawn here based on evidence for the evaluation, there are suggestive positives, and the role seems worth pursuing in a carefully planned way. Among those who provided feedback on the pilot, there was unanimity that the project needed to run for longer – perhaps two or three years – for all parties to make a reasonable assessment of the role. It was universally recognized in feedback that funding the role as an ongoing component of a practice's services was very difficult, if not impossible, but that there was merit in pursuing funding solutions, including those that might be attached to the MBS. Of those participant-pharmacists who provided feedback, there was unanimity regarding enthusiasm for the role, with the right supports and funding in place, and that it would likely be a role providing greater pharmacist professional satisfaction than either hospital or community pharmacy practice. Integrating pharmacists into general practice provides both an opportunity to enhance the collaboration between general practice and community pharmacy, and an opportunity to expand the scope of practice for pharmacists to better support people with chronic health conditions, particularly in regions in which there are GP shortages.

Case Study: Western Sydney Primary Health Network

Title: Tiny Tots Talking

Stakeholders: Early Childhood Education Centres, Allied Health including speech pathologists, audiologists, occupational therapists, physiotherapists, and counsellors, and parents

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Dr Michael Fasher (Michael.Fasher@wentwest.com.au)	**Year of commencement: 2018**	**PHN Funding Source: Core Flexi** **Focus on: multidisciplinary care and access**

The Challenge

Doonside is an area of high cultural and linguistic diversity with 51.9% of the population born overseas and 52.4% speaking a non-English language at home. The top five most spoken languages in Doonside are Tagalog (6.6%), Arabic (4%), Hindi (3.7%), Punjabi (3.2%) and Filipino (3.0%). 4.7% of Doonside's population are Aboriginal and Torres Strait Islander peoples. Doonside is considered a region of high socio-economic disadvantage with an unemployment rate of 7.6% and median personal weekly incomes 20% lower than the NSW average. Many children in the area have the potential to be exposed to adverse childhood experiences (ACEs) or miss out on high-quality early childhood education. Many staff working in Early Childhood Education Centres (ECEC) do not have qualifications in early childhood development, yet Centres are crucial to raising the life chances of these children, becoming proactive in addressing developmental delays and supporting appropriate interventions. Parents are also crucial to addressing these needs but need support to implement positive parenting styles. A myriad of studies underscore the potential 'buffering' role of ECEC against the pitfalls of socioeconomic disadvantage, with attendance at ECEC linked to improved child health, wellbeing and development – provided the staff have the necessary skills.

The Solution (Including who is the program delivered to, by which Allied health professions, and in which setting/s?)

Tiny Tots Talking commenced in 2018 and is designed to improve the quality of three participating council-run Early Childhood Education Centres (ECECs); gathering the evidence to rollout to more locations, given that 1 in 5 (17,000) Western Sydney children under 5 years are developmentally vulnerable. The intervention is focused on improving the educational pedagogy and practices designed to support the development and adjustment of vulnerable children, with a specific focus on language development and social-emotional competence. The intervention includes in-service face-to-face and online professional development for ECEC educators and directors. In-centre mentoring and support is provided by a Speech Pathologist, who is embedded in each centre one to two days per week. The Speech Pathologist also provides screening, interventions and referrals for children requiring higher levels of support, and engagement of families in this process. All parents are provided with a consent form for their child to be screened as part of the program and they are invited to attend sessions to learn how to implement language learning activities at home.

The speech pathologist works closely with ECEC staff to help them learn more about the importance of language development, how to encourage conversations and interactions, how to develop robust action plans, and how to build in time for book reading, creative writing and playing with words in the classroom.

The Impact (Including any evaluation data available)

For five years, Speech Pathologists have delivered professional development training to all three ECECs which has proven to increase their capacity to stimulate language, respond to children's needs and self-reflect on pedagogical practice (disrupted by pandemic restrictions & lockdowns). Using the speech pathologist's advice, ECEC facilitators have improved their lesson planning and the availability of printed materials and resources that accommodate different learning styles. 482 children have been screened by a Speech Pathologist throughout the program, and 57% were identified with a delay or disorder, including 9% eligible for NDIS/ECEI pathway, reinforcing the level of need in this area of Western Sydney. This has meant that 276 children have received additional support at their ECEC, with many also referred to other services including hearing services, counselling and speech therapy groups for parents. There is substantial evidence to suggest that the Tiny Tots Talking program is meeting its objectives to increase opportunities for children to develop language and social-emotional skills for school readiness A key part in supporting this outcome is a high level of communication and trust building between the therapist, parent and ECEC staff regarding the child, their needs and how best to support them. Program Evaluation is ongoing and informs ongoing improvement.

"Following a routine screening the speech pathologist was the first person to identify concerns for a 2-year-old's overall development and share this with the family. This family had limited prior engagement with health. The speech pathologist was able to link this family with nursing, audiology and occupational therapy. The combined findings of all the health professionals resulted in the child being referred for a comprehensive multidisciplinary assessment. The family requested the speech pathologist's support during the assessment to help them advocate for their child. The speech pathologist presented observations and paperwork requirements to apply for KU inclusion support funding to the wider multidisciplinary team. The child's educators have been filming their interactions with the child and seeking mentoring from the speech pathologist."

References: ABS (2021), 2021 Census, 'Doonside', https://abs.gov.au/census/find-census-data/quickstats/2021/SAL11277

Case Study: Western Sydney PHN

Title: CALD Community Mental Health (MH) Projects

Stakeholders: WentWest, Community Health Provider

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Sara Tejani (Sara.Tejani@wentwest.com.au)	Year of commencement: 2020	PHN Funding Source: After Hours and Mental Health Focus on: Wellbeing & Prevention, Outcome-based Commissioning

The Challenge

In the 2021 Census, 52.6% of Western Sydney residents stated that they were born outside of Australia, and 58.2% used a non-English language at home[1]. Both statistics are higher than the NSW average of 34.6% and 32.4%, respectively.

More than one in five Australian adults will suffer from mental health problems each year[2]. However, compared to the mainstream population, a large proportion of culturally and linguistically diverse (CALD) community members who experience mental health challenges do not seek support. This puts Western Sydney in a unique position, and it is essential to ensure that our diverse population has access to culturally appropriate care. Many communities do not have terminology or cultural acceptance around MH. We also know there are trust issues as well as a lack of MH awareness which can make it hard for people with complex trauma to seek help. We know that complex trauma is notoriously difficult to address, but many participants don't need higher Stepped Care levels or clinical interventions. Doing it right at Levels 1 and 2 reduces escalation of need.

The Solution (Including who is the program delivered to, by which Allied health professions, and in which setting/s?)

WSPHN commissioned a not-for--profit organisation, providing culturally appropriate psychological treatment, support and community interventions to implement culturally and linguistically diverse (CALD) mental health literacy and suicide prevention programs for refugees, asylum seekers and other diverse communities in Western Sydney. The organisation has shown time and again that for many people non-clinical solutions work best. They do this without traditional formal 1:1 psychology sessions. The organisation addresses these issues by offering soft entry points. All initiatives look like social activities. They look like community connections. They look like a place to belong, to feel welcome, to feel understood. They are always groups, usually run by Peer Leaders, and services are grounded in trauma-informed approaches underpinned by:

Provision of support in a social context, then using recovery-focused care to support clients to feel trust and be ready for the next steps, using **social prescribing, community building,** and **lifestyle interventions** to build trust and connection Building a **holistic approach, non-clinical space** to safely introduce MH topics, **avoiding the use of the term "mental health"**, and using less clinical language e.g., 'social and emotional wellbeing', 'feeling connected', creating a **sustainable support network** – building community groups that go beyond the scope of the MH program, t**rained staff and peer leaders** – united by language, culture, experiences, purpose, e**ncouraging community-based initiatives –** supporting community-driven ideas, tapping into existing capacity, linking into brokerage, r**ecording lessons learned** and building up skills with other programs.

The Impact (Including any evaluation data available)

The organisation captures **qualitative and quantitative** responses through M&E reporting. They are using **culturally-appropriate outcome measures** e.g. WHO-5 in lieu of K10. On average, for this organisation, the WHO-5 scores increase 10-15 points (scale 0-25) from pre to post-engagement scores. One group saw the WHO-5 scores increase from an average pre-score of 4.25 to post engagement score of 20.75. They are considering **impact beyond service delivery** e.g. building sustainable community networks that continue without a formal facilitator or lead. They are using o**utcome-based measures** to evaluate the *social* impact of programs, cultural competency and integrating this into our procurement processes (scope & evaluation). They have **demonstrated innovation, initiative, and agility –** developing methods to capture new, non-clinical, evidence-based applications of ideas outside traditional mental health interventions.

We believe many of our services meet the definition of social prescribing and we remain excited by the growing evidence base for social prescribing interventions, including how they can be incorporated into multi-disciplinary teams based in general practice, noting also that: This model of care is **applicable beyond multicultural** communities. Many of our **First Nations providers** are already applying a similar model of holistic care. **Social prescribing** and **community-based support** are designed as Level 1 and Level 2 stepped care approaches, they can be more acceptable first steps for someone to recognise their MH needs and access additional services. **Holistic initiatives** that create community groups that prevent isolation, promote a sense of belonging, encourage exercise, and share health information are valid approaches to addressing mental health. This may be enough to prevent a person's intervention needs escalating to stepped care Level 3-5. We have **embedded cultural competency when commissioning** services – in the scope of service description, capability and experience of providers, and in M&E.

Case Study: Western Sydney PHN

Title: The COVID Rehabilitation and Recovery Program

Stakeholders: GPs and Allied Health

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Rachel Barker (Rachel.Barker@wentwest.com.au)	Year of commencement: 2023	PHN Funding Source:: Living with COVID Program Focus on: Multidisciplinary Team Care | Long COVID

The Challenge

For people of all ages, living with an ongoing condition such as Long COVID can strain individuals in numerous ways, including physical, mental, emotional, financial, social and spiritual. Given that the condition has an enduring nature, there can be a sense of not being able to move forward with life or feeling stuck in fatigue, mental distress and feeling of poor physical health, and for many, this is exceptionally debilitating. The COVID-19 experience was a painful one in particular for residents of Western Sydney, many of whom are from CALD backgrounds and who would have struggled through long lockdown periods with poor availability of tailored supports. This has left some communities isolated and led to potential dormant mental health needs going unchecked and untreated. Co-morbidity between mental and physical health is well established, so it stands to reason that a person still feeling the effects of Long COVID faces issues emotionally and physically and ideally requires services that a specific setup to treat their full spectrum of needs.

The Solution (Including who is the program delivered to, by which Allied health professions, and in which setting/s?)

In early 2023, WSPHN engaged with a local health care provider on a unique and innovative project: COVID Rehabilitation & Recovery Program. It has been set up to support the rehabilitation and recovery of patients experiencing symptoms of Long COVID including both physical and mental health challenges. The service provider has a unique offering of highly trained psychologists and allied health workers who can work together to tailor physical and mental health approaches to people affected by Long COVID who have co-morbid and complex health issues. The program provides access to a workforce that is bilingual and has superior cultural knowledge and awareness, meaning that many people who may not have sought support for COVID-related health issues, due to an inadequate and hard-to-access service system, can now receive a multidisciplinary service to meet their needs within a culturally appropriate context. The program is set to support 100-200 people through its pilot period of 12 months and will offer allied health services, particularly within the fields of physiotherapy, exercise physiology, dietary advice, and psychological support. In keeping with quality, team-based care, access will be via GP referral.

Founded in 2005, the provider is well-respected as a mental health and multidisciplinary health provider based across Western and South Western Sydney. They offer culturally informed and culturally tailored psychological services for adults, children and adolescents, plus NDIS psychosocial care coordination, support work and behaviour support.

The Impact (Including any evaluation data available)

In its pilot phase, the COVID Rehabilitation & Recovery Program seeks to increase access to services for people from CALD backgrounds, with a streamlined referral pathway from GPs, and tailored multidisciplinary intervention.

Case Study: Western Sydney PHN

Title: National Symposium for Pharmacists in General Practice

Stakeholders: WentWest, Pharmacists, Allied Health

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Practice Engagement ✓

Key contact name and email: Timothy Perry tim.perry@wentwest.com.au	Year of commencement: 2022	PHN Funding Source: PHN Core Focus on: Multidisciplinary Team Care

The Challenge

Western Sydney PHN has run a Pharmacist in General Practice (PIGP) program continuously since 2016. The Pharmaceutical Society of Australia (PSA) has published guidelines around the PIGP role, but there has been little dialogue among pharmacists working in this innovative role and even less communication with the broader pharmacist community. Increasing communication between pharmacists working in this space and outward to other pharmacists is needed to demonstrate the value of the role, support calls for expanded funding and to attract new pharmacists into the role.

The Solution (Including who the program is delivered to, by which Allied health professions, and in which setting/s?)

The first-ever National Symposium for Pharmacists in General Practice was organised in 2022 and held at WentWest's head office on the last weekend of October 2022. Over 110 people attended the all-day event, both virtually and in person. Sessions highlighted some of the unique work carried out in Western Sydney and showcased other PIGPs in action from across Australia. All states were represented. The PSA provided assistance including continuing education points for attendees. The WentWest presentations featured a local psychologist who offered techniques (Acceptance Commitment Theory) that help people make and sustain behaviour changes as well as our Consultant Pharmacist Audit Tool and a self-audit process - both were devised to build a consistent framework around patient interviews while maintaining flexibility.

The Impact (Including any evaluation data available)

Among our online attendees was a South Australian group who chose to collect at one venue in Adelaide, so they could recreate the "live" event within their own locality. The Acceptance Commitment Theory workshop received positively by attendees as a practical and powerful strategy to help people build their self-efficacy. There were high levels of engagement and networking among attendees, and attendee feedback included requests for a repeat Symposium in 2023. One attendee flew in from central Victoria, knowing no one at all working in this space. She arrived with plans to start working in General Practice in the next few years but left the Symposium with plans to take action straight away. She immediately contacted her PHN, reached out to a local Medical Centre and organised an interview with them the same week of the Symposium!

Case Study: Western Victoria Primary Health Network (WVPHN)

Title: The key to integrated and equitable health care – Inclusive Practice

Stakeholders: All health care services, inclusive of allied health professionals, and the interface with other sectors

This case study relates to:

Workforce & Access to Allied Health Care

Key contact name and email: Kerry Robinson & Nicole Radford, Project Managers – Supporting People with an Intellectual Disability to Access Health (SPIDAH) Project spidah@westvicphn.com.au	**Year of commencement:** 2021-2024	**PHN Funding Source: Department of Health and Aged Care (Cth)** **Focus on: Multidisciplinary Team Care**

The Challenge: The current barriers to accessing timely healthcare for people with an intellectual disability is revealed in the National Roadmap for Improving the Health of People with Intellectual Disability.[1] Current statistics indicates that people with an intellectual disability die 27 years earlier than the general population.[2] The Supporting People with an Intellectual Disability to Access Health (SPIDAH) project team conducted a co-design with key stakeholders inclusive of people with lived experience an intellectual disability, their supporters, health professionals, community members and others. The key themes established aligned with the National Roadmap's findings that more needs to be done to improve access to timely, affordable and accessible health care for people with disability and other priority populations. The challenges stem from the person and their supporter's inability to adequately describe clear indicators of their health concerns to primary health care professionals. Further to this, most health professionals have minimal training in intellectual disability health care.[3]
The introduction of the Comprehensive Health Assessment Program (CHAP) (annual health assessment) provides a pathway that is fundamental in the development of shifting focus to a shared vision that is preventative in nature and wellbeing-focused, inclusive of the role that allied health professional's play in providing high-quality health care.

The Solution: The approach of the SPIDAH project team consists of a three-pronged approach:

- By developing health literacy resources targeting people with lived experience of disability and their supporters.
- By facilitating the upskilling of health professionals in how to apply reasonable adjustments, inclusive of how to build their own easy English tools and resources; and
- By delivering face-to-face and online training called 'Inclusive and Best Practice in Healthcare for People with an Intellectual Disability' targeting all health professionals.

The training is aligned with the United Nations Convention on the Rights of Persons with Disability, particularly Article 9 (Accessibility) & Article 25 (Health) - Persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. This training session is further strengthened by the use of subject matter experts. While the main facilitator brings a personal family lens and over 30 years experience in working in the disability and health sectors, the co-facilitator Aunty Jane, brings a unique experience from her lens of being person with lived experience of an intellectual disability, a strong self-advocate, identifying as a First Nations woman from Yorta Yorta Country, represented Australia at the Special Olympics, and recipient of the Tony Fitzgerald Memorial Award at the Australian Human Rights Awards.

While the initial training sessions started off by targeting reception and administration staff within primary health care clinics, the sessions were further enhanced by moving to a training model of inclusive practice and reasonable adjustments to provide access to integrated equitable and high-quality healthcare outcomes. The session targets all touchpoints from a patient perspective, inclusive of connecting and communicating directly with the patient tailored to their individual's needs. While the training emphasises the integral role of supporters, it also highlights the importance of the partnership between the patient and the identified treating health professionals that cover all aspects of the patient's health journey (history, preventive health care, early intervention and future health and wellbeing needs).

The Impact

This approach not only addresses the health needs of people with an intellectual disability, but many priority populations inclusive of but not limited to people with low health literacy, English as a second language, people with dementia, people from culturally linguistically diverse background and others. This training promotes an integrated model of care for a shared leadership approach for both primary health care and allied health professionals to provide inclusive practice and support their knowledge, capacity and confidence to work more effectively with people with an intellectual disability.

- Feedback from multiple resources inclusive of emergency services, allied health professionals and others are that the training needs to be mandatory.

Link to references

[1] National Roadmap for Improving the Health of People with Intellectual Disability | Australian Government Department of Health and Aged Care
[2] Trollor J, Srasuebkul P, Xu H, et al. Cause of death and potentially avoidable deaths in Australian adults with intellectual disability using retrospective linked data. *BMJ Open* 2017;7:e013489. doi: 10.1136/bmjopen-2016-013489
[3] Primary Care Enhancement Program for people with intellectual disability | Australian Government Department of Health and Aged Care

Case Study: Step Thru Care, Western Victoria PHN

Title: Step Thru Care, Regional Care Partnerships Mental Health and AOD

Stakeholders:

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Practice Engagement

Governance and culture

Data, quality and digital maturity

Key contact name and email: Monica Murnane – Monica.Murnane@westvicphn.com.au Natalie Haugh – Natalie.Haugh@westvicphn.com.au	**Year of commencement:** 2023	**PHN Funding Source:** AOD (NIAS and AOD Core) Mental Health **Focus on:** Multidisciplinary Team Care

The Challenge

The Royal Commission into Victoria's mental health system and literature reviews identified there many people experience co-occurring mental health and AOD support needs. A review was undertaken of WVPHN's commissioned mental health and AOD programs and emerging research which identified that service users with co-occurring mental health and AOD needs reported better outcomes when they received integrated treatment, care and support. The review also showed that separately funded AOD and mental health services had the potential to be siloed leading to inefficient service delivery that could be isolating to consumers and their natural supporters.

The Solution

WVPHN undertook codesign and market sounding with service providers, community members and lived experience members which led to the development of a blended mental health and AOD service model delivered through partnerships across four sub regions of the WVPHN. The new program Step Thru Care delivers four key services – AOD, low intensity mental health, structured psychological therapy and high intensity mental health treatment and coordination. Each partnership brings together mental health and AOD agencies to deliver these services via an appropriately credentialled allied health workforce to step up and down levels of care without the need for clients to re-tell their story or return to their referrer to access a different service.

The core elements that are incorporated into the service model to ensure a seamless care experience through warm transfer and care coordination are; streamlined screening, assessment and referrals through use of the IAR (Initial Assessment and Referral tool), integrated, coordinated care and partnerships, person centered & outcomes focused service delivery, inclusive and culturally safe services, building workforce capacity, targeted funding model that enables flexible allocation of funds. The Service Delivery Model also identifies a range of priority groups for access to the program with scope for providers to identify further potential cohorts throughout the course of the program.

Service delivery for Step Thru Care covers the entire WVPHN catchment through the delivery of outreach services and can flexibly respond to identified and emerging needs in specific regions, demonstrating a place based approach to care that reduces service duplication and fragmentation, whilst meeting the AOD and mental health support needs of the western Victoria community. Delivery of the Step Thru Care program commenced on 1 July 2023 and is contracted for three years until June 2026.

The Impact

Step Thru Care is in its infancy, with service delivery commencing on 1 July 2023. WVPHN is working with an external provider to undertake a comprehensive evaluation of the program during its first three years. The evaluation is outcomes focussed and aligned to the quintuple aim of health care with patient experience, outcome, cost, clinician wellbeing and health equity shaping the evaluation framework. Outcome measures will include MH and AOD specific tools as well as measured to assess quality of life, consumer experience of care and provider experience. Performance metrics and KPIs focus on outcomes and impact and are expected to extend beyond the required Minimum Data Sets (MDS). Impact focused metrics will enable WVPHN to clearly identify what impact, if any, commissioned services are having upon the people of a specific place. Measurement will also extend to including measuring the success and strength of partnerships, as well as the level and effectiveness of service integration.

Case Study: Early Intervention Speech Pathology – Central and Eastern Sydney PHN

Title:

Stakeholders:

This case study relates to:

Integration, models of care and funding ✓

Workforce & Access to Allied Health Care ✓

Key contact name and email: Brendan Goodger, General Manager, Primary Care Improvement b.goodger@cesphn.com.au	Year of commencement: 2017	PHN Funding Source: Core Focus on: Early Intervention Speech Pathology

The Challenge

In 2017, CESPHN identified a gap in services for vulnerable children who could benefit from early intervention speech pathology services.

Approximately 20% of children starting school in Australia have a speech, language, or communication impairment. The prevalence of language and communication impairment in young children is known to be much higher in socially disadvantaged populations. Any challenges in speech and language development can result in significant issues with school readiness and on life factors into adulthood including social participation, education attainment and employment. There is clear evidence that early intervention to address children's speech and language needs has benefits over their life course.

The Solution The Early Intervention Speech Pathology program was developed in partnership between CESPHN and Sydney Local Health District (SLHD) in 2017. Following the early success of the SLHD model, CESPHN then commissioned South Eastern Sydney LHD (SESLHD) and Sydney Children Hospital Network (SCHN) in 2018.

The Program provides targeted, in-depth screening to vulnerable children aged 0-6 years to identify speech, language, and communication difficulties. The service delivered by SCHN is specifically targeted to Aboriginal and Torres Strait Islander children. Children identified as being at medium to high risk of communication difficulties are offered speech pathology assessment and intervention, while caregivers of children identified as low risk are provided information to support their child's development.

The service is delivered at early childhood education centres, as well as community health centres, community events and playgroups. The model involves close cooperation between speech pathologists, early childhood education centre staff, caregivers, as well as other health professionals such as GPs. The program also provides upskilling and capacity building for early childhood education centre staff to identify and support children with communication difficulties.

The Impact In 2022, CESPHN engaged a consultant to conduct an independent evaluation of the Early Intervention Speech Pathology program. The evaluation confirmed the program has successfully achieved its aims and objectives and has delivered substantive benefits to vulnerable children and their families in the CESPHN region. Since 2017, program highlights include:

- Screening more than 12,000 vulnerable children
- Offering speech pathology assessment to 100% of children identified as being at 'moderate' or 'high' risk of communication difficulties
- Improving access to diagnostic and therapeutic supports for children with speech and communication difficulties
- Improving access to speech pathology services for children from priority population group and increasing their likelihood of achieving developmental milestones
- Upskilling of staff from participating early childhood education centres

Qualitative feedback from early childhood education providers indicated that without the Program many children would have been 'left behind,' as many families within the targeted suburbs cannot afford private speech pathology services.


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