Transcript

Department of Health and Aged Care  
Ministry of Health

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

Day 2

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**mc:**

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[*Opening visual of slide with text saying ‘Manatū Hauora’, ‘Ministry of Health’, ‘Australian Government with Crest (logo)’, ‘Department of Health and Aged Care’, ‘Australia/New Zealand Summit on the Value of Allied Health Care’, ‘Day 2: Friday 26 August 2022’*]

[The visuals during this webinar are of each speaker presenting in turn via video, with reference to a PowerPoint presentation being played on screen]

**Dr Martin Chadwick:**

(Speaking Māori language)

So welcome back everyone to day two of our inaugural Australia/New Zealand Summit on the Value of Allied Health Care. For those of you who are able to see the slide I just want to acknowledge the colours and recognising that we have the great Australian gold and the New Zealand black. We did have a lot of discourse as to which colour needed to go on top or not but that was put together by our Australian colleagues so we’ll just go with it for now.

But really do want to welcome you back for day two. We had a fantastic day yesterday. We had a great number of presentations that I thought were very challenging that really put forward the value that does sit within allied health care. We started with a real sense of what is value within care and then a lot of very good examples focusing the first group around COVID predominantly but then the second group gave us some really high powered work that I think we can all chew on a little bit as to what we need to do and how we can start to integrate it more fully into our everyday.

So welcome, welcome, welcome and really pleased to have you all on board. And I’m going to hand over to my good colleague Dr Anne-Marie Boxall to go through a little bit of housekeeping. So over to you please Anne-Marie.

**Dr Anne-Marie Boxall:**

Thank you Martin. And before we go on any further I would like to acknowledge the traditional owners of all the lands on which we are meeting today across Australia and New Zealand and to pay my respects to Elders past, present and emerging and for me on Ngunnawal land here in Canberra to particularly pay my respects to the Ngunnawal people. And also would like to welcome any Aboriginal and Torres Strait Islander people or Māori or Pacific Islander people that are joining us today.

So thank you to everyone who is joining us today. As Martin said we had a great session yesterday and we’re looking forward to a fantastic session again today. There is a little bit of housekeeping with all of these kind of things particularly since we’re working across two countries and via Zoom. We are using the webinar format for this which means the audience has been muted. But that does not mean we want you to stay muted. We want you to participate but we want you to do that by using the Q&A function which is at the bottom of the screen not the chat function. You can use the chat function but we won’t be monitoring that for questions. We are looking for questions for our panellists and our presenters today through the Q&A function. So please use that and we will be monitoring that.

You can also upvote a question. If you’re interested in something somebody else has asked click the little I think it’s a thumbs up button and that will raise it up higher and that will make it easier for us to see. So I encourage you to participate actively by using that function.

Just for your awareness we are recording the Summit so that it is made available to people who weren’t able to attend today. We also will be asking some polling questions to you and they will come up during the breaks. They’re actually really useful information for us so if you can participate – make your cup of tea of course but do participate in the polling questions – that would be really wonderful. And we’ll use the same polling at the end of the session so we can get some feedback on this session and what you think we should do with a session and how we should sort of change it if we do it again. As Martin said this is the first time we’ve done it so we’d be really happy to hear what your thoughts are about it.

Just some other things. We do have a writer who will be producing a summary of our two day Summit which will be really valuable for us. We will have a collection of research that has been conducted on the value of allied health care and we will be able to use that to inform policy making and a lot of other products I guess that we can then distribute as well highlighting how valuable allied healthcare is. We also have James Nicholls who is an illustrator. His screen is on there and you can see he’s started scribbling away of pictures of Martin and I and Martin and I have both made some suggestions about how he can improve our look. But he will be doing a visual summary of the Summit. So just check in on what James is doing throughout the day as well. It’s quite fun to see.

Okay. With all of that again welcome. We’re looking forward to our session today and I’ll hand back to Martin. Over to you Martin.

**Dr Martin Chadwick:**

[*Visual of slide with text saying ‘Getting evidence-based research into policy’, ‘Panel Discussion’, ‘Prof. Sarah Dennis’, ‘Professor of Allied Health, University of Sydney’, ‘Prof. Carlo Marra’, ‘Dean and Professor, School of Pharmacy, University of Otago’, ‘A/Prof. Faye McMillan’, ‘UNSW & Deputy National Rural Health Commissioner’, ‘Australian Government with Crest (logo)’, ‘Department of Health and Aged Care’, ‘Manatū Hauora’, ‘Ministry of Health’*]

Thanks Anne-Marie. So we’d like to bring us into our first panel session today. And very, very pleased to be able to have three very distinguished members on the panel that we’re going to spend a bit of time doing a bit of a Q&A with them. So I’d like to introduce first up Professor Sarah Dennis who’s a Professor of Allied Health at the University of Sydney. Secondly would like to introduce Professor Carlo Marra who’s the Dean and Professor at the School of Pharmacy at the University of Otago, and also Associate Professor Faye McMillan who works at the University of New South Wales and is also one of the Australian Government Deputy National Rural Health Commissioners.

So a very warm kia ora and welcome to all of you and really looking forward to spending some time with you. We do have some questions which are prepared but then really do encourage people listening in to submit their questions as well. So I’ll hand back to Anne-Marie and she can kind of run through how we’re going to run this panel session. But to our panellists welcome. Get yourselves comfortable because we want to get every bit of information we can out of you. So get ready. Over to you Anne-Marie.

**Dr Anne-Marie Boxall:**

Thanks Martin. So what we’re going to do is we’re going to ask two questions to each of our panellists in succession. So we’ll start with Sarah and then we’ll go to Carlo and then to Faye. So that will give you some time to think of the questions that you would like to ask to our panellists as well. We’ve got a fair amount of time for this session which is great. So we’ll get the conversation started but we do really encourage you to ask your questions to our panellists. Please signal who you are asking that question to in particular if it is to one of our panellists or if it's to all of them just say all and then we can go from there.

So Sarah you’re the lucky first. So I’ve got two questions for you first of all. The first one is what barriers have you faced getting evidence-based research into practice and how did you overcome it? And then the second question, how can we overcome that we’ve got really kind of rigid or set patterns of service delivery even though there’s evidence in contrast to that? So I guess it’s that resistance to change despite the evidence.

**Professor Sarah Dennis:**

Thank you. Thank you Anne-Marie and thank you for inviting me to be part of this panel. So in my role as Professor of Allied Health I’m based at the University of Sydney and I’m also embedded in South West Sydney Health District. So I thought I’d give a couple of examples of some of the barriers from the Health District.

So there was a study. Anne Moseley and Alison Harmer and colleagues did a study where they surveyed physios in south west Sydney and then they ran a series of education sessions around evidence-based practice, how to understand the evidence and then strategies for implementing it into practice. And really I just thought I’d highlight some of the main sort of things. People talked about not having enough time to implement new ideas, the usual not enough time to read the research, reported sort of lack of skills around understanding research and then how to get that into practice. And then interestingly after they ran the education program some of those things improved but then one of the things they reported was not having the authority to make change which I thought was quite interesting about how do we then empower clinicians especially more junior clinicians to actually make change.

And some of the recommendations that came out of that were obviously more support for continuing professional development and protected time for evidence-based practice in practice. And that also then made me think of private providers who are running a sole business, how it’s even more difficult in those settings without the team around you and without that sort of protected time. So those were some of the sorts of challenges that we found. So hopefully that’s answered that question.

In terms of improving that – maybe this will come up later. We’ve looked at how we can bring students into that to improve uptake of evidence-based practice so I can talk more about that later. In terms of your second question it’s such a tricky one isn’t it because I see it all the time, that we are set in certain patterns and that it takes a long time to sort of disinvest from particular types of behaviour. And I thought Christian Barton’s presentation yesterday highlighted some of that really clearly.

I think some of it is about having the courage to challenge it. And you’ve been doing some of that work Anne-Marie with the residential aged care facilities and how that is now starting to change and bring in evidence-based practice. But I think the other thing is increasing the value or promoting allied health research more and promoting that value so that we are seen as a much more valuable member of the healthcare team and that our services are funded adequately instead of only half funded which seems to be the normal pattern.

**Dr Martin Chadwick:**

Great. Thanks Sarah. So just going to keep you in the spotlight for a little bit further. I’ve got a follow up question with you. And given your background just wondering what advice you would give to researchers or clinicians or policy makers in how we can incorporate more research into policy and practice?

**Professor Sarah Dennis:**

I think coming from an academic background my advice is more for academics but we need to be doing research that actually makes a difference to the health system. I think for a long time some of us have been doing research which is important and interesting but might be about how many more degrees flexion can we get in a knee or how many more metres of a six minute walk distance can we get, which is all very interesting but it doesn’t tell us what’s the best way to implement this particular approach, how can we support or encourage other health professionals to refer to us. If no one refers to us then no one’s going to get an extra however many centimetres in a six minute walk distance.

So I think it’s about for us thinking more about what policy makers and health service managers and PHNs and whatever need in terms of doing research that’s more relevant really and translating those findings in a way that’s meaningful to policy makers instead of sometimes of our dense academic papers.

**Dr Anne-Marie Boxall:**

Thanks Sarah. I might come back to you with a follow up question later on that but I will go now to Carlo. And just want to ask you the same questions Carlo. So what barriers have you faced getting evidence-based research into practice and how did you overcome it? And thoughts you have on overcoming very rigid set patterns of service delivery despite evidence which says it should be done otherwise?

**Professor Carlo Marra:**

Yeah. Thank you very much and thank you for inviting me for being here. So my context is sort of the same but slightly different than Sarah’s. So I’ve been associated with pharmacy throughout my career and I’ve done a variety of different health services type research and also my perspectives are that of someone who takes a view of health economics on the evaluation side of things. So often the arguments that we make are sort of health economic arguments overall.

So in terms of barriers and getting evidence-based research into practice Sarah’s points – we encounter those points all the time in pharmacy-based situations or where initiatives start in pharmacies and may involve other healthcare providers. But it’s really the lack of time, re‑organising workflow, re-organising set patterns, lack of funding. And all these are general barriers. And I think what Sarah said also is that people don’t necessarily feel empowered especially in the professional pharmacy sometimes where you have practitioners who are working in a pharmacy, in a community pharmacy, whereas they’re an employee but they’re also an independent practitioner which I think creates some conflict there as well about what they should be doing and what the bottom line for the pharmacy is. And often sadly pharmacists are paid to dispense medication rather than to do clinical services even though there are proven clinical services with lots of research to back them. Hypertension strikes me as being one of the ones that pharmacists – there’s more than 50 randomised controlled trials that show that a service that involves pharmacists with other healthcare providers is superior to one that doesn’t involve pharmacists. But you can’t really go into a pharmacy and get your hypertension treatment initiated and monitored even though there’s this huge amount of research that supports it. And a lot of these are barriers that we’ve discussed and the key is how do you overcome those barriers and how do you actually shift that mindset to provide these types of proven services overall.

**Dr Martin Chadwick:**

Great. Thanks Carlo. And just to keep you in the spotlight there, so what advice would you give to the researchers, clinicians or policy makers to look at incorporating more research into policy and/or practice?

**Professor Carlo Marra:**

I think there’s a few things. I think initially it’s really important to come up with the sort of irrefutable evidence. So if you’re going to do the research it has to be done in a format where it’s really systematic and really high quality in such a way that it’s irrefutable. This is really good evidence that this makes a difference and actually impacts on end points that are translatable to improvement in health outcomes.

But the other thing that we really have to make a case for I think, which unfortunately I think necessarily the non-allied side of health don’t have to make, but we have to make a really good value for money argument. We have to show that our services result not only in improved health outcomes but they do it at a reasonable cost or even cost avoidance sometimes. And I think they are the key messages that we need to impart to promote allied health research into practice and to take that going forward.

**Dr Martin Chadwick:**

Great. Thank you.

**Dr Anne-Marie Boxall:**

Yeah. Fantastic. Some great points there and again I think they’re probably starting to stimulate some discussion. So just a reminder to put your questions for our panellists in the Q&A function. But before we go to your questions, Faye hello. Welcome. And I probably don’t need to repeat the first questions to you again. You’ve heard them twice now. So your thoughts on the barriers of getting evidence into practice?

**Acting Professor Faye McMillan:**

Firstly yamma dummarung and kia ora. So I’d like to acknowledge that I’m coming from the lands of the Wiradjuri peoples, my nation, and pay my respects to all first peoples across the globe that are really working in the spaces to try and elevate research and community driven activities. And I think for me it is the opportunity to bring I suppose what would be seen as disparate parts but it’s taken 30 years for me to be able to be an academic work within the policy space and continue to practice as a practitioner, as a community pharmacist and for that to actually be seen. And so the challenge is how younger early career professionals that want to be in multiple spaces are given the opportunity and particularly in research and how that then translates into policy agenda as well as the actual implementation of those policies in real life becomes the challenge.

And for many people in rural and remote, and that’s where I speak from because that’s my experience which I’ve actively pursued to stay a rural clinician, but it is about bringing communities together and looking at how research becomes defined and who is defining the research. They’re parts of the challenges. But how we overcome them is through collective design and looking at innovative ways for people to be able to be measured against the metrics that they see as successful. And so when we talk about putting in research agendas, being sure that the people that we are wanting to work with are reflected in that, but how they do that when they’re not ‘Tell me your top five research publications’ or ‘Tell me your top five research grant applications’. When we want to involve the people that really are (a) the end users and (b) that are going to actually drive these agendas then we have to find ways that allow them to be in the research design. So for many first peoples we talk about research that is co-designed and co-developed. We now want part of that co-decision making too around what is the research and how are we going to inform the decisions that are done.

And it’s through innovative models of care. It’s part of that multidisciplinary team. I’ve heard both Carlo and Sarah both say we need to elevate the value and the value proposition of the allied health workforce to the health outcomes for all people across many nations and the opportunity to see that both in the public and private sector and the ability for people to be able to work to the scope of practice that they get trained in and then become pigeon holed once they’re beyond their academic training. And so we have an early career workforce that’s really excited about doing this because they’ve seen examples through their educational pathways that then become challenged once they get out and become practitioners. So it’s how do we do that, what is the value of multidisciplinary teams. And it is through the connections and it’s as I said being able to look for what are the one employer model type of scenarios that allow people to work in research, education, practice and community in multiple ways that I think is one of the opportunities that I’ve started to see become realised over the last little while.

**Dr Martin Chadwick:**

That’s great Faye. And I just reflect that we’ve had pharmacy and physiotherapy students that have joined us in the Ministry and I think that’s been a great eye opener for them in understanding that there is a real breadth that they can be involved in.

So similar follow up questions to you, is that sense of what advice would you give researchers or clinicians and policy makers looking to incorporate more research into policy or practice?

**Associate Professor Faye McMillan:**

So if I don’t put my academic hat on, which is the public or perish type of activity that’s required within institutions, it is about being brave and looking at who are the new partners in research that we want to be working with rather than just usual suspects I suppose for want of a better word. But it’s really saying how do we bring innovation into the research agenda so that when it is being codesigned that the end is also being something that is actually useable. So it is about saying what do we do and looking at the networks that exist as I said for rural and remote and regional that we’re covering the issues that matter to the people that are there, not the issues that the academic institutions think are sexy or we would like to have more information on this. Because communities won’t take it up if they can’t see value. And so for me that would be the advice, is start to be a bit brave. Again that’s really nice for me to sit in a really privileged position as not an early career researcher anymore but to push back on some of that agenda of what’s the research for, who’s it being driven by and how can we ensure that we bring community and whichever way community looks like on this journey and be part of that team of researchers.

**Dr Martin Chadwick:**

Great. Thank you. So Anne-Marie do you want to kick off on the questions that we’ve got there?

**Dr Anne-Marie Boxall:**

Yes. I’m just getting myself off mute. Sorry.

Okay. So we’ve got a lot of questions which is fantastic. So please continue to enter them and I will get to the top of the list. So a question for you Sarah.

*Q: How do you encourage multidisciplinary research rather than individual profession specific research?*

**Professor Sarah Dennis:**

Yep. Good question. So certainly in my role within the Health District we’re looking at research across teams. And I am under a flight path and a plane’s just about to come over so apologies for that. So looking at that across teams. And also I think because we all know that research is easier when you do do it as part of a team but bringing in those different perspectives and the different sort of clinical backgrounds. So I’m thinking about we have a large communication project underway in our district and with western New South Wales at the moment and that’s bringing together speech pathologists, people from a disability support background and there are other allied health, social work, physios, OTs all involved in that project, and everyone is bringing different parts to that team.

So I think within services often you’re focusing on particular conditions or particular patient populations that it is much easier to bring that team approach. I think one of the other things that we’re trying to encourage as well is – we’re collecting all this data as teams anyway as part of routine clinical practice – is also trying to look at how we can actually use that better. If we collect that in a way that we can access it and pull it out then we’ve got a readymade system where if we make changes to whatever it is that the team does, change in approach or whatever, we’ve got data collection happening routinely as part of service delivery so we can just continuously evaluate as we go along. And that’s another approach that we’ve been trying to take.

**Dr Martin Chadwick:**

That’s great. Thank you. A question here for Faye.

*Q: Has any work been done to try to quarantine any Australian Government research funds for research led by rural health academics focused on rural healthcare?*

You’re muted there Faye.

**Associate Professor Faye McMillan:**

Sorry. I was just saying thanks Leanne and thank you for also putting the nation in which you are sitting, again that acknowledgment of contribution. Yes and no. There is always conversations around the uniqueness of what rural, regional and remote environments look like across all of the countries that we are speaking with and how do we ensure that the way that research is funded is reflected across them and where the funding then goes. So yes there has been. There are specific calls at times. So GrantConnect – I’m sure New Zealand has their own version of grant systems and things like that. But it’s actually time consuming. Unless you put in specific search words and things like that you do actually have to spend a bit of time trying to find research that might be applicable or research opportunities where there is funding applicable specifically to rural, regional and remote as well as specifically to allied health. And it is that investment in spending some of that time and when you’re already a busy clinician or a busy individual that can be hard.

But certainly I know that the Australian Government is looking at different ways in which innovation can be applied and there are as I said specific grant rounds that do look at some research opportunities for regional, rural and remote and particularly multidisciplinary.

**Dr Martin Chadwick:**

And just a follow up question there Faye was:

*Q: Any thoughts on how research funds could be specifically quarantined for allied health research?*

I have to say I feel so weird saying quarantined because I think it’s taken on such a different context over the last couple of years. Ring fenced. I don’t know. Let’s think of another term. But how can we have funds that are specific to allied health? Let’s go with that.

**Associate Professor Faye McMillan:**

And I think it goes back to the conversation that the other panellists have already raised which is the value of allied health and where allied health is seen in the value proposition of the health and wellness of all of our communities. I think as we start to get more positions such as Chief Allied Health Officers and other positions within Governments that do recognise that the allied health workforce actually does provide significant cost effective measures both across the private and the public sector – and so when we start to look at that across the long term then I do see that corralling of specific funding to sit that would allow specifically allied health and also that multidisciplinary allied health. And so it is acknowledging that particularly in regional, rural and remote areas that it is a collective – whilst you might be a solo practitioner, you do do it as part of a collective approach to how a service is delivered.

So I do see that there are opportunities to have corralling of specific funding as we move forward and as we start to create the evidence in the allied health space that allows a level of comfort in the investment and then back into research for allied health.

**Dr Anne-Marie Boxall:**

Fantastic. Thank you. We’ve got lots of questions and lots of upticks, upvoting. So the next question I think is for Carlo. It’s New Zealand specific but it is actually relevant in Australia as well. So I’ll provide the context and Carlo if you can take this one on. It says:

*Q: Health Research Council New Zealand came up with a new stream of funding, Health Delivery Career Development Fellowship which gives clinicians funded time to do health research and vice versa. Unfortunately after a year there is no existing allied health career pathways as a clinician researcher in New Zealand. It’s well established for non‑allied health colleagues so how do we develop this allied health clinician researcher workforce career pathway?*

And it is absolutely relevant in Australia too. So any thoughts on that Carlo?

**Professor Carlo Marra:**

Yeah. I think it is a tricky one because there is that funding that does exist and then it sort of dries up and you’re kind of left on your lonesome after that. But I think from this point of view that there are opportunities to build upon our workforce in this regard where we do want people who are obviously on the frontline being clinicians but also have skills in research. And I think compared to – I’m a North American. We used to have a lot of cross appointments in our schools of pharmacy and physiotherapy that they served both as strong clinicians and they brought that to the research world. So in terms of their jobs when they were out being clinicians that was a research laboratory and then they contributed through the research space in that regard.

So I think it’s just a change in mindset about universities and how we hire people and how we define research and how we actually empower people to go down that career pathway and cross appoint them to university posts or places where they can effectively use their advantage of being at the frontline and being a clinician but also draw upon their research expertise that they have acquired to answer really relevant policy questions in that regard.

**Dr Anne-Marie Boxall:**

Yeah. Thank you. And I know I’m meant to be asking the questions not answering them but I’ll just make a comment about clinician policy makers as well. Because in Australia here in the Federal Government we don’t have a lot of clinicians. My Chief Allied Health Officer is stacked full of clinicians which is unusual. But trying to forge that pathway that clinicians can influence policy making is also really important. And I might ask Sarah later on about her experiences. Sarah did a secondment here in the Department for a very brief period of time. So she’s a Professor and she came and worked in the Department and I might ask Sarah for her reflections on being a clinician researcher/policy maker as we get further along in the panel.

But for now we do have – it’s not my turn. It’s Martin’s turn. Over to you Martin.

**Dr Martin Chadwick:**

And I’m not going to let this opportunity slip by but maybe Carlo we can put a bit of a challenge out to the universities in New Zealand as to who’s going to be the first to have a professorship for allied health. Maybe put that one out there just as a little bit of a teaser.

So Sarah I’m going to come back to you and around the point that clinicians are keen to innovate but are not often supported to do so. Now one of the presenters yesterday George spoke about the need to shift funding models from output focused to outcome focused. So what do you see as the steps between these two ends of the spectra? And I think that kind of got referenced a little bit. It’s not about degrees of motion so much more, but it’s about trying to get to those outcomes. So any thoughts there?

**Professor Sarah Dennis:**

Yeah. This is an interesting one and a challenging one. I think some of the roles that we have – so there’s a number of us now in these Professors of Allied Health roles around Australia based in different types of health services with university appointments, and I think some of the work that we do around supporting clinicians to think about how they can embed research in their practice, how they can look at measuring outcomes as opposed to just measuring occasions of service or throughput which often has been the approach that has been taken, is starting to gather momentum. Certainly amongst my colleagues who are in these roles we’re starting to see that happening much more in health services where clinicians are looking at outcomes rather than – and I’ve gone off topic now – but looking at those sorts of outcomes and how they can measure that.

And it comes back to some of that stuff around what we measure. Again if we’re not measuring this stuff in our clinical practice then we’re not able to report on the impact that we’re having. So it’s really sort of trying to encourage that. I mean we had an interesting conversation with some clinicians about implementing some outcome measures that they wanted to measure and getting sort of pushback from clinicians sort of saying ‘Well we probably don’t need to measure that because we just know. We just know that patients get better and we just know that this happens’. And there was quite a bit of resistance. And so that’s been an interesting journey in terms of – it’s back to the value of allied health and of clinicians seeing the value in being able to demonstrate change in their practice. I think I’ve sort of waffled a bit and not really answered your question.

**Dr Anne-Marie Boxall:**

Sorry. I’m trying to get off mute again. Sarah I might just do a bit of a rapid fire one to all panellists because there’s a couple of questions here that are similar that I think sort of builds on the conversation we’re having. And it goes to this issue of clinicians are busy. They work in sort of activity-based funded or fee for service based systems a lot of the time. And we want especially junior clinicians to get on that research journey. So how do we get protected time for clinicians who want to start that research journey? So I’ll go to a couple of thoughts from you first Sarah and then Carlo and then Faye.

**Professor Sarah Dennis:**

So I think a big one is getting commitment from senior management certainly in big health services. So that’s been a journey to demonstrate the value and to get that commitment from higher up to let clinicians have that time. One of the other things that we have been doing as well is it’s the value add of students. So how can we involve students whether it’s in private practice or in large health services to support clinicians with research? So we’ve had a number of examples now where we have lots of project based placements across allied health and often the students involved in those project based placements are adding value to the service and are able to do work with the clinicians to actually get them started on research. So senior management and the value add of students in services.

**Dr Anne-Marie Boxall:**

Yeah. Fantastic. Good points. Carlo your thoughts? How do we get clinicians to start research in fee for service systems, giving them some dedicated protected time to do it?

**Professor Carlo Marra:**

Yeah. I think getting the dedicated protected time, I think Sarah really nailed the answers there in terms of convincing the employers of the value proposition of why this is important and how this will actually improve service delivery and health outcomes overall and that this is actually an important thing to do. So I think that is a really necessary thing to do, to actually have a value proposition around the research that supports the value proposition in doing the clinical interventions so to speak. I think that is really worthwhile.

Convincing busy clinicians to do research or getting involved in research is a trickier aspect. In some of the bigger sort of pharmacy-based multidisciplinary clinical trials we’ve done we had the rule of tens. So you would put an ad out to get people involved in doing the research. There might be 100 people who actually volunteered to do it. About half of those people will actually show up and do the training and get involved and know what the protocol is about, and then out of all those people about ten people will actually enrol participants and do the appropriate – so it’s challenging. It’s been tricky. But those ten people who do deliver deliver a lot and their capacity and their contributions are massive.

But again it’s those people who really see value in what you’re doing and can see where it’s going to lead and how it translates into improvement in clinical outcomes and patient care and also for better service delivery I think is the key of making that statement really strong.

**Dr Anne-Marie Boxall:**

Yeah. Thanks. Good points. And I think too that the more clinicians see their research being used by decision makers is a bit of a motivating factor as well. I mean we heard some fantastic research yesterday and it is relevant to policy making. So at some point when we can put that into practice and then go back to the clinicians and say ‘Hey thanks for doing that research. This is what we used it for’ is pretty motivating I think.

And Faye to you. Protected time for clinicians to do research.

**Associate Professor Faye McMillan:**

I’ve had the joy of actually being able to listen to the other two panellists and potentially coming at this from a different perspective. I think we also need to work with the people that we’re going to want to do research with and talk to them about what research is. For many people they think research is done in a lab, it’s often invasive or it’s right at the other spectrum where you get stopped in the car park and get asked what sort of car you drive. So the understanding of what research is and the value of research to the everyday individual isn’t well thought. It isn’t part of what they do. So I think there’s some opportunities for education in that space that then would allow that value proposition that we’ve all spoken about of research and where research can really make a difference.

Coming from a person who has only ever worked in small individual owned pharmacies it is hard to talk about research when that isn’t your job. But when we talk about investment it’s allowing people to see that that investment in themselves as clinicians is also really valuable and that if we actually want to have a sustained workforce that allows people to have aspirations across multiple spaces in their profession that we need to look at that investment and talk to that investment very differently. Incorporating it in professional development is one way of saying well research forms part of your professional development. Whether you are actively applying for grants to do research or whether you’re actually ‘I don’t need to do research because I know that’ well how did you know that? You’ve actually been doing research. You’ve just not thought of it from that research paradigm. So it’s trying to get us to potentially evolve the way we think of what is research and how do we do research collectively.

**Dr Martin Chadwick:**

That’s great. Thanks Faye. Now I’m going to pick up on your point there. I’m going to mix it up with regards to order to keep you all on your toes. So I’ve got an absolute ripper of a question here and it’s along the lines of broad scale collection of data in allied health. An example that’s given is that independently owned clinics and practices hold an extraordinary amount of information which could be used and prove value. So any thoughts on how we can get access to or how we can start to pull those datasets in? I know you’re all nervous. Who’s going to go first? I’m going to go Carlo, Faye and then Sarah.

**Professor Carlo Marra:**

Well I think there is a lot of data out there both in individual practices around the data that’s collected but I think the real strength with some of that data or those data is to marry that data together with bigger administrative datasets that actually have data on hospitalisations, treatments. And that’s when the real power comes in because you have it at sort of the microlevel when patients come in and see clinicians but you also get the data on the harder outcomes like hospitalisations and deaths and things like that, the ones that really, really matter.

So it’s never easy. There’s always privacy issues and there’s issues around linking those datasets together. But once you manage to circumvent those things they become very powerful in terms of being able to assess not only the clinical outcomes but also the value propositions. Because when you get the data on hospitalisations and how they are seen in the healthcare system you can very quickly assign costs and you can make economic arguments based upon the health outcomes quite easily in that regard.

So I didn’t really answer the question about how can we do this because it’s very, very tricky how to do this, but it’s really important that we do this. And it’s worth the effort but not easy. I’ll let the other two come up with how we do this.

**Dr Martin Chadwick:**

Go for it Faye.

**Associate Professor Faye McMillan:**

I think again it’s language. As a Wiradjuri woman sometimes it’s challenging for me to think in the western paradigm of how research can be owned by individuals or organisations and not really shared back in the way that it was originally intended. We almost force at some point this process of I have to own this, this is mine and if I share it then I will lose. Part of it is not what will I lose. It’s what will others gain and trying to change the way we talk about sharing. Rather than saying ‘I’m going to access your data. How do I get access to something? I want to access your back yard,’ those sorts of things, it’s trying to bring forward a narrative of let’s collectively work together. Let’s put people back at the centre of the work that we want to do. And yes there are some challenges as Carlo pointed out around privacy and confidentiality and things like that but I think there’s been demonstrations in other spheres where they’ve been able to share material quite freely for ensuring that the humans in which we work with are the ones that are going to benefit the most.

So I think we just have to work towards changing that because research has always been seen as a very privileged space. To be a researcher really is a privileged space. It mightn’t feel like it when we’re in there trying to write grants and do all of those things but it’s something that we need to acknowledge of what do we do with that privilege and how do we use it for – it sounds a bit like [0:47:48] – but the collective good.

**Dr Martin Chadwick:**

All right. And final word Sarah?

**Professor Sarah Dennis:**

This is something that I’m so passionate about because if we had connected data then we could just do so much with it. I mean I think one of the challenges – I mean obviously there’s all the privacy issues and the value to the community and demonstrating the value of having this connected data. One of the big things for allied health is that it’s just stored all over the place in a complete shemozzle of systems that don’t speak to one another. And if we could solve that that would be fantastic. If there was some united or common system whether it’s private providers or even within public health services, to have some consistency in the systems so that we can then link data and look at outcomes would just be fantastic if we can manage to achieve that. I don’t quite know where responsibility sits with that, whether that’s with you Martin and Anne-Marie, but if we can solve that problem then the value of that is excellent.

I mean if you look at some of the examples internationally, if you look at the health system in Utah, every encounter that you have with the health system can be tracked until you leave – you have to leave the state. As soon as you leave the state it’s not tracked anymore. But it means that they’ve got such a huge, powerful, linked dataset and they can interrogate that dataset to look at long term outcomes. And it’s just such a powerful resource. It would be fantastic if we could achieve that.

**Dr Martin Chadwick:**

Yeah. I was kind of chuckling there Sarah. You’re not supposed to chuck the ball back at us but point well made. And yeah was very privileged to spend some time at Intermountain to have a look at what they have there so quite remarkable.

All right team. I have us bang on the dot at 11:50. So well done. And I have to give an incredibly huge apology to the 19 odd questions which are sitting there. So maybe if I can just extend a huge vote of thanks to our panellists. If you have an ability to hang around panellists and maybe just type away and answer some of those questions that would be greatly appreciated because I think that just demonstrates that there was some real interest in that. So really, really pleased with the kōrero, with the conversation that we just had. I think there was some great pointers there. I think it really highlights the challenge that we have, that we do have to bust down some of those barriers be they real or perceived between research and clinical practice, how we get them much more integrated and see researchers and clinical practice and then clinicians and research. And so I think it’s one of those that the answers are there but I also hear that it takes a little bit of bravery to go ahead and do that as well.

So thank you for your time. Please hang around if you can and please answer some of those questions that are sitting out there as well.

So what I’d like to do now is to hand back to our ever fantastic Nick Andreopoulos. And so what he’s going to be doing is he’s going to be working through the next session if you will. And so there’s going to be a series of ten minute presentations showcasing research papers and case studies that demonstrate the value of allied health. We are being very stringent for those who listened in yesterday with regards to our ten minutes time limit because we’re just wanting to make sure that we get everybody through. Nick will be just giving people a one minute warning when we do get there.

And so what we’re going to have is five presentations and that will be followed by around about ten minutes of Q&A time. And again please feel free to post your questions into the Zoom Q&A section, not into the chat section and upvote if you like them so we can make sure that we’re getting the most relevant ones.

So with that Nick if I could hand back over to you please.

**Nick Andreopoulos:**

[*Visual of slide with text saying ‘The value of allied health care’, ‘Session three’, ‘Please submit your questions via the Zoom Q&A’, ‘Australian Government with Crest (logo)’, ‘Department of Health and Aged Care’, ‘Manatū Hauora’, ‘Ministry of Health’*]

No worries. Thank you Martin. Just a reminder to all the attendees who would like to ask questions of our presenters please make sure you include the presenter’s name. Obviously there are five presentations to one part of question time so make sure that you include the name of the presenter or the presentation for whom your question is designed. And with that I’m going to pass on to Dr Hemakumar Devan and Cheryl Davies to talk about the first presentation. Over to you both.

**Dr Hemakumar Devan:**

[*Visual of slide with text saying ‘Māori community based solutions to addressing inequities in pain management’, ‘Cheryl Davies, Manager, Tū Kotahi Māori Asthma & Research Trust’, ‘Dr Hemakumar Devan, Lecturer, University of Otago, Wellington’, ‘Team: A/Prof Lisa Te Morenga, Dagmar Hempel, Susan Reid’, Advisors: Bernadette Jones, A/Prof Tristram Ingham, Barbara Saipe, A/Prof Meredith Perry, Prof Rebecca Grainger, Prof Leigh Hale’*]

Tēnā koutou katoa. [0:52:49]. I’m a lecturer at the Rehab Teaching and Research Unit in Otago University in Wellington and extreme pleasure to join our Māori community partner Cheryl.

Can’t hear you Cheryl.

**Cheryl Davies:**

Kia ora koutou katoa. Ko Cheryl Davies toku ingoa. I hale from Ngati Raukawa, Ngati Mutunga and I manage the services for the TūKotahi Māori Asthma & Research Trust. And it’s great to be here today. Kia ora.

**Dr Hemakumar Devan:**

Next slide please.

Yeah. Chronic non-cancer pain affects one in five New Zealanders and I believe it would be the same in Australia as well. But prevalence is quite disproportionate for our tangata whenua, for Māori, as you can see in the graph and also for people living in areas of high deprivation and people with disability. Next slide please.

**Cheryl Davies:**

TūKotahi Māori Asthma Trust are part of a large whanau order collective comprising eight Māori health social service, education and justice services in the Hutt Valley and it was really important for us when Hem initially came out to meet with us that that was face to face, kanohi ki te kanohi and that really started the strengthening and establishment of our relationship.

Next slide please.

**Dr Hemakumar Devan:**

Yeah. This was one of the first hui or the focus groups we had with the whanau for Māori women, wahine. They often prioritised their whanau responsibilities and community responsibilities on top of their pain and therefore they were silent suffering with pain. And for Māori men, the tāne, pain was perceived as a sign of weakness and therefore pain expression and help seeking was a challenge. Next slide please.

And this is an audit from across all tertiary pain services in New Zealand. As you can see Māori are under-represented and when they do come to us they present with very severe symptoms. And this picture as you would have seen at yesterday’s presentation as well, the current way of working is not currently working for Māori whanau with pain and we see this new health system reform in Aotearoa as that kind of third picture, as something that would work for everyone. Next slide please.

And that’s where this co-design journey with the whanau started and we really acknowledged whanau as their own experts of pain. And we were thinking an online could be a good medium because it can enhance access for pain management. Next slide please.

So here’s a little visual summary of what we heard from the whanau in the focus group. I really want to highlight the centre part next to the ‘Our wish list,’ something called kanohi ki te kanohi. So whanau were very clear that they wanted something face to face or in person and they were already doing quite a few things to manage their pain in terms of natural remedies like rongoā which is a Māori traditional treatment and also being connected to the nature and also connecting and being the support of other whanau living with pain as well. Next slide please.

Yeah. Cheryl.

**Cheryl Davies:**

So this was a follow up session that we had a little while later and I think the great thing about having whanau support throughout our project was that they really keep you grounded. So right in the middle there there’s a note that says ‘Can we do this now? Get a pain support service for whanau now’. So they really pushed us to make sure that we actioned some of the findings from our earlier focus groups and studies.

**Dr Hemakumar Devan:**

Yeah. So the feedback that we got was can we have a pain specialist come to a Marae and run a monthly clinic? Can we have a support group which is actually run by whanau in the community? And in fact that was a tricky point in the journey because we only had funding to ask what they wanted and not necessarily implement what they wanted. But luckily – next slide please.

We had the funding which was the HRC Health Development Fellowship last year and we were able to implement those initiatives which whanau suggested. We have this monthly pain clinic ongoing and we also have some of the community health workers, the Kaiawhina from Kokiri visit us at the Wellington Pain Service to understand how the referral processes work and the assessment and treatment work. And we ran a whanau pain program last year which we’ll talk about in the next few minutes. Next slide please.

So the program is essentially focused on the whanau and not necessarily on the individual and that’s what the current western way of treating would look like. So that is something that whanau were very clear. It has to be a collective focus. We had also more focused on the existing strengths of what already whanau know. And these were two objectives and the sessions were led by Cheryl and myself, a physio, and it was run in a community setting with eight whanau and we had six sessions all up. Next slide please.

So here is a brief overview of the tikanga that we followed during the six week program. And we’re going to highlight some of the key aspects that we did in the program. Next slide please.

**Cheryl Davies:**

The Mauri stone was an important part of our session. So really the Mauri stone was a way for us to establish relationships at the beginning. So it’s a stone that’s passed around and held by everyone in the group including both Hem and myself. So it’s a great way to start our programs just to hear how whanau have faired during the week prior to our session. And also at the end we passed the Mauri stone around again and whanau are able to give us an evaluation and tell us how they found the session. We believe the Mauri stone holds the essence of everybody in that group so while it’s being passed around the Mauri from each person holding that stone is passed through the group as well.

Next slide please.

**Dr Hemakumar Devan:**

And we’ve also gifted this tohu or this symbol on the right hand side which is a Ngata, a snail, and it’s used as a traditional treatment as part of the Rongoa for some respiratory illnesses. And on the left hand side for those of you who don’t know it’s a Māori health model which is actually a balance of all of these four elements. And we use this in our program in a way that whanau can go within their shell if they are living with long term pain but the idea of the program is to help them to come out of the shell and still live well with pain. Next slide please.

And we kind of transformed this Ngata. We’re working with another Māori artist. As you can see in the shell part we asked whanau to write about things that hold them back and whanau wrote about the whakama or the stigma of being in pain or asking for help and the disconnectedness that comes with living with long term pain, and previous unhelpful experiences like historical racism, all as things that hold them back. And also we asked them to write things that actually help them in the snail part in terms of coming out of their shell. And as you can see we used this as a reflective exercise at the beginning and at the end of the six week program. Next slide please.

**Nick Andreopoulos:**

You’ve got about a minute left guys.

**Dr Hemakumar Devan:**

Thank you. And we used some animations that was created for another research project and also we brought in Lorimer Moseley and Russ Harris to the community program as well. Next slide please.

**Cheryl Davies:**

The Rongoa session was a really important session for us looking back at our traditional Māori medicines and incorporating that as part of our six week session. Next slide please.

**Dr Hemakumar Devan:**

And we also had a workbook which kind of reinforced some of the key messages from the program. And as you can see the cover image of the Ngata. Even though the pain still remained but the other aspects have tended to move along. Next slide please.

These are some of our reflections. The power of relationships and acknowledging whanau as their own experts in pain management and the power of metaphors.

Next slide please.

And we also asked whanau who took part in the program in terms of what their feedback are. So here are some excerpts and we have a short video and I’ll post that in the chat section soon. Next slide please.

Final word Cheryl?

**Cheryl Davies:**

So just whanau really valued our strengths-based approach and focusing on the wellbeing as a collective and not as an individual. A stepped care approach could be offered as a generic pain education program in our communities led by our own Kaiawhina and supported by an allied health professional. And just skill mix. Capacity building is really important for community providers. So offering those opportunities and including our own Māori knowledge for example Rongoa Māori.

**Dr Hemakumar Devan:**

Last slide please.

Yeah. Really want to acknowledge our research team and the advisory team on the left and the clinical team from Wellington on the right. Kia ora everyone.

**Nick Andreopoulos:**

Thank you very much.

All right. And we’ll move on to our second presentation, to Robin Kerr who’s talking about a community of practice, weaving a responsive safety net for veterans in Aotearoa, New Zealand. Over to you Robin.

**Robin Kerr:**

[*Visual of slide with text saying ‘RSA NZ’, ‘Returned and Services Association’, ‘Te Area TeaTea Whare Hauora’, ‘Acupuncture NZ’, ‘The Acupuncture and Chinese Medicine Professionals’, ‘E hara taku toa I te toa takitahi ‘engari he toa taku tini’, ‘My strength is not from myself alone, but from the strength of the group’*]

Kia ora. What a wonderful presentation to follow. Ko Robin Kerr from Whakaraupo Lyttelton from Acupuncture New Zealand. [1:05:03] to begin with which is what you finished with which is beautiful. E hara taku toa I te toa takitahi ‘engari he toa taku tini. My strength is not from myself alone but from the strength of the group. Next slide please.

This is a ground up initiative that began with practitioners of Acupuncture New Zealand treating several veterans in Wellington in 2021. They became aware of the difficulties veterans faced when transitioning from military life to civilian life. Together they began to discuss developing a community of care to meet the needs of veterans and their whanau. Acupuncture New Zealand, a leading professional organisation, joined to support this kaupapa with the purpose to support not only a community of care but also a community of practice, engaging with other service providers and organisations to begin to develop a culturally aware safety net for veterans and families.

We set out to identify gaps and practitioner awareness in practice and to developing resources to support the ability to deliver culturally safe care and importantly to improve access to veterans and their whanau to a broader range of services. This initiative was a pre-empt to the policy documents that came out of Veterans Affairs.

As both a project and a model that aims to reduce health inequities – sorry next slide.

As both a project and model that aims to reduce health inequities of access and outcomes New Zealand veterans are identified as a vulnerable group at risk for mental health and wellbeing issues as they transition to civilian life. 17.2% of the New Zealand Defence Force are Māori, 5.6% Pacifica and just under 3% Asian. Adverse social determinants of health are compounded by the challenge to accessing care for those with military service. Veterans have identified that there is a gap of appropriate understanding.

Sorry. Mine’s flicking on. That there’s a gap in appropriate understanding and care in primary health which leads to social isolation and poorer outcomes. So the next slide please.

With support veterans transition well into civilian life however approximately 25% are identified as suffering mental health challenges including substance abuse, self-harm, head injuries, grief and anger issues and suicide. This is impacting families, whanau and society. Trauma, moral injury, loss of identity and chronic pain are complicated by the military culture and value of stoicism.

And the complexity of accessing appropriate support and care. Veterans have found talking therapies and pills don’t quite resonate with the mindset for them and they’ve shown preference for alternative and complementary therapies. Next slide please.

A small pilot study funded by the Royal New Zealand Return Service Association trialled acupuncture and mindfulness practices in a peer group for six weeks. Outcome measures demonstrated a reduction in pain that resulted in a reported increase in physical activity. With increased physical exercise their mental health indicators improved. Veterans identified it was less confronting and that it provided an oblique side step into a willingness to undertake further treatment. So this is seen as a gateway. Providing treatment with the context of a peer support group is cost effective and provides added value of reducing isolation and increasing access to their support network. Partners of these veterans reinforced the positive impacts reported by veterans citing the improvement in their mental health, moods, ability to relax and most importantly the ability to engage. Next slide please.

Other veterans throughout networks began to engage. We worked to develop a joint certification process between the Royal New Zealand Soldiers Association and Acupuncture New Zealand. Registered traditional Chinese medicine practitioners undertook online training and development with veteran advocates drawing on the resources from America in absence of local and further develop specific acupuncture training webinars aiming to develop a community of care identifiable to veterans through their networks, an IT registry and reinforced visibly by the availability of RSA resource pamphlets and materials.

Research from Professor David McBride of Otago University regarding veterans suffering from chronic pain and distress identified that Māori veterans demonstrated higher distress and pain scores. Acupuncture New Zealand sought to partner with the organisation Te Whare Hauora to support culturally appropriate care. Rongoa Māori practitioners are well positioned to recognise the impacts that intergenerational trauma has for whanau and the generations to come. With both of our organisations having practitioners based throughout the country we recognise that we could also partner to bring strength and support to those and we could share the burden and grow as practitioners. So there was a cumulative effect of our going together. Next slide please.

Further lockdown provided a good opportunity to work on a joint submission with Professor McBride to apply for a lotteries grant to undertake a formal study trial through Otago University titled ‘Alternative and Complementary medicine as a pathway to care for military veterans experiencing pain and distress’. Currently this is under review with the ethics committee. Concurrently a second phase to the Wellington acupuncture peer group was approved by the RSA. Next one please.

Initial IT developments included creating a landing page for veterans on our Acupuncture New Zealand website. We upgraded a Find a Practitioner search facility to include the ability to isolate veteran certified practitioners throughout the country. We developed the online training resources. We envisaged that with appropriate support an online community of practice database for veterans could be developed and made available for GPs and veteran and Defence Force organisations. Next slide please.

Policy and practice implications. So Acupuncture New Zealand supports the Veteran, Family, Whanau Policy Framework specifically in the areas of professional and service development and this only came out in July 2022. As identified in this there is a need to reduce the gap in awareness and skill in the health workforce regarding the vulnerabilities and needs of veterans and their families, the need to develop training modules and resources for practitioners and organisations specific to developing a competent workforce to form an identifiable network of veteran aware educated and supportive organisations and practitioners, effectively a community of practice.

An action you can take away today is to include military service in your assessment and provider records. That question is a key engagement one. Also developing further opportunities for veteran peer group engagement with mental health and wellness services and providers. Next slide please.

In conclusion this joint veteran ready certification process between the Royal New Zealand Returned Services Association and Acupuncture New Zealand is believed to be one of its first kind in New Zealand. Together we’re working to reduce stigma and other barriers to accessing care for a significant subpopulation and by providing treatment and support options that are more appealing or cognisant of their unique culture. We’re developing a model of cooperation and collaboration to develop innovative combinations of interdisciplinary care across the health sector developing a community of practice in which the whole is greater than the sum of the parts. Next slide please.

Included here is a link to the Veterans Family and Whanau Mental Health and Wellness Policy Framework which was released as I said in July 2022 by Veterans Affairs, a link to Acupuncture New Zealand and the contact details for Mark Compain, our community of practice facilitator. Thank you so much.

[*Visual of slide with text saying ‘Contacts and Reference’, ‘Acupuncture New Zealand’, ‘www.acupuncture.org.nz’, ‘Royal New Zealand Returned Service Association’, ‘Contact: Mark Compain: markcompain@hotmail.com’, ‘The-Veteran-Family-and-Whanu-Mental-Health-and-Wellbeing-Policy-Framework.PDF (veteransaffairs.mil.nz)’, ‘RSA NZ’, ‘Returned and Services Association’, ‘Te Area TeaTea Whare Hauora’, ‘Acupuncture NZ’, ‘The Acupuncture and Chinese Medicine Professionals’*]

**Nick Andreopoulos:**

Thank you Robin.

We’re now going to move on to James Lucic doing a presentation on the retrospective clinical pharmacist review of MET calls. James if you’re around if you could put your camera on.

Sorry James. I’ll give you another 10/20 seconds to work it out.

**James Lucic:**

Perfect. So just waiting on my slides.

[*Visual of slide with text saying ‘Te Whatu Ora’, ‘Health New Zealand’, ‘Capital, Coast and Hutt Valley’, ‘Retrospective ClinPharm review of Met Calls’, ‘James Lucic’, ‘Advanced Clinical Pharmacist’*]

Fantastic.

Shall I begin?

**Nick Andreopoulos:**

Yes. If you want to turn on your video James. It’s up to you. We can’t see you at the moment.

**James Lucic:**

That’s okay. I’m in an ugly room so I’ll leave it off.

**Nick Andreopoulos:**

No worries. Go for it then.

**James Lucic:**

Excellent. Right. Kia ora koutou katoa. My name is James Lucic and I’m an advanced clinical pharmacist here at Wellington Hospital in New Zealand. My recent background has mainly been focused on intensive care and paediatrics however I’m about to switch into the emergency department to work and to start establishing a clinical pharmacy service there. Today I’ll be talking to you about a service I designed and implemented here which was the retrospective clinical pharmacist review of MET calls. Next slide.

So for those who aren’t familiar the MET call or rapid response system is designed to identify and address deteriorating patients to provide early intervention to prevent poor outcomes based off the patient’s vital signs or a practitioner’s concern for the patient. The Patient at Risk team or PAR team are a team of nurses and doctors who respond to the calls. We have approximately 2,500 MET calls per year in Wellington and previously there was no clinical pharmacist involvement in these MET calls and no communication between the clinical pharmacist and the PAR team services. Next slide.

So in the US it is often standard practice to have a clinical pharmacist directly involved in the rapid response team and at Middlemore Hospital here in New Zealand there is an ICU pharmacist who retrospectively reviews MET calls as well as being able to utilise their prescribing scope. Next slide.

So we designed and implemented a systematic clinical pharmacist review of patients who received a MET call. This involved utilising the hospital’s current electronic whiteboard system to refer the patient to the clinical pharmacy service by the MET team after the MET call had occurred. Pharmacists received education on a systematic approach to deteriorating patients. This allowed us to review patients who received MET calls as soon as we could within our current resources. Next slide.

So the average age of our patients who received a pharmacist review after a MET call was 67 and there was a very even gender split. The majority of MET calls occurred on our general surgery and orthopaedic wards. Next slide.

The ethnic diversity of referrals reflected what we would have suspected for the region that our hospital serves.

Next slide.

We reviewed 71% of total MET calls that were referred to clinical pharmacy. We were able to respond to the MET calls and provide a patient review within 24 hours 82.6% of the time. There was a small percentage that were reviewed within the 72 hour mark which was associated with Friday afternoon referrals as we don’t provide a weekend service.

Next slide.

So cardiac causes were the predominant reason for triggering a MET call followed by rhythm disturbances which I have further categorised as atrial fibrillation and supraventricular tachycardia. This was closely followed by respiratory and neurological causes.

Next slide.

So during MET calls 67% of patients received an intervention that was related to a medicine. Cardiac medicines were the most common point of intervention followed by alteration of a patient’s regular medicines.

Next slide.

From the referrals that were seen by a clinical pharmacist additional interventions were made in 59% of those patients that were referred. The majority of pharmacist interventions made was advice on medicines and the addition of medicines reconciliation. Other interventions included therapeutic drug monitoring advice and dose guidance, organ function monitoring and medicines administration advice.

Next slide.

In order to characterise the impact of the pharmacist’s intervention I used the Overhage analytics method. A lot of intervention grading tools focus on harm prevention as opposed to the beneficence where the Overhage and Lukes method focuses on beneficence of the intervention and this was more applicable to this service. The method is split into six categories. Category one being extremely significant or life or death interventions, category two being very significant, preventing organ disfunction, category three being significant and improving quality of life, category four being somewhat significant, involving information and recommendations, category five being of no significance and category six being an inappropriate recommendation or causing adverse outcomes.

So 58% of the pharmacist’s interventions were category three, significant, and 42% were category four, somewhat significant. And this is consistent with what I would have expected when providing a retrospective clinical review. There are many other outcomes that I wanted to measure however due to IT and database limitations this was not possible at current.

Next slide.

So this service meant that clinical pharmacists were highlighted acute, deteriorating patients from all areas of the hospital. Due to resource constraints from staff sickness, vacancies and that we don’t have a dedicated pharmacist for every single ward in the hospital, this referral and review system allowed us to give deteriorating patients from all areas in the hospital equal access to a clinical pharmacist review.

Next slide.

So I’d just like to acknowledge the following practitioners for their support and guidance for making this service possible. Next slide.

And that concludes my presentation. Thank you.

**Nick Andreopoulos:**

Thanks James.

We’re going to move on now to Mark Shirley. Mark if you can turn your camera on. There you are. On an Escalated Care Pathway (ECP) implementing a South Island IDT Care Pathway for Back, Knee and Shoulder Injuries. Take it away Mark.

**Mark Shirley:**

[*Visual of slide with text saying ‘Escalated Care Pathway (ECP)’, ‘Implementing a South Island IDT Care Pathway for Back, Knee and Shoulder Injuries’, ‘Mark Shirley’, ‘Habit Health’*]

Thanks Nick. So kia ora everybody. My name’s Mark Shirley. I live in Dunedin on the South Island of New Zealand. I’m a physiotherapist by trade and work at Habit Health which is a community-based health rehabilitation business across New Zealand. And just for context we employ just over 750 staff directly across 100 sites and we have around about 1,000 health partners that essentially sub-contract to us to provide care in the community that our patients live in. We have four main bits to our organisation. Rehabilitation, occupational health, EAP and we run a couple of health and fitness clubs. My role is heading up clinical innovation and today talking about the Escalated Care Pathway which is a pathway for back, knee and shoulder injuries in the South Island of New Zealand for people that can’t be managed in primary care alone. Next slide please.

So in 2018 ACC which is our main insurer in New Zealand challenged the industry to come up with innovative ways of solving the issue that they described as fragmented management of treatment and rehabilitation that impacts client experience and outcomes. They were focused on back, knee and shoulder injuries as they found that they were causing ACC the most cost. Historically ACC knew what they paid for these conditions but they didn’t really know what they achieved. They wanted to understand the outcomes that their patients or the people that were receiving these treatments were getting as opposed to just how much they were paying for the inputs.

So we leveraged our provider network to achieve a South Island care pathway and implement a number of other initiatives as we went along the way. The first one was negotiating bundled healthcare funding. So previously if you were working alongside a patient and you needed some additional input you’d have to apply for those separately. A little bit of occupational therapy, maybe some vocational rehab, some pain rehab. They were all applied for separately and you’d have to wait to get that approved. What we were managing to do is based on clinical complexity get a bundle of funding that we could then apply when it was needed as it was needed as part of an interdisciplinary team.

We employed a number of health navigators. They came from a range of backgrounds, allied health and case management, to be the single point of contact for all communications because we had a lot of health partners and internal staff working with these patients so they became a central point of communication. We worked with our surgical colleagues to really understand what they needed to make their decisions at that first surgical assessment so that if patients were to go to a first surgical assessment that the surgeons had all the information they needed to make a decision at that appointment. We also worked alongside ACC who looked at a number of surgical codes that they were using and found that over 95% to 96% of the time they were approving them. So they removed the administrative burden out of that and said depending on if they met the criteria the surgeon could have that approval on the day and go to book the patient in if that was appropriate.

And finally we worked really hard to remove the huge amount of administrative burden that often comes with working alongside ACC. We’d spend a lot of time justifying what we wanted to do and after we’d done it. So we said we’d rather spend that time with the patients and that’s what we managed to achieve with a really tight entry criteria, less intervention by the funder about what we were doing but a lot of intervention at the end to see what we’d achieved. So at a really high level the pathways there. Where people enter on to the pathway they can either self-refer, be referred by their employer, their GP or an allied health person. They will be e-triaged within 24 hours as soon as we get that referral to see whether they meet the entry criteria. If they do we put them in one of our interdisciplinary teams which was led by a senior physiotherapist and supported by an orthopaedic surgeon or an MSK doctor or a GP with some extra training. That can be done at the same time. It could be done at different times. It could be done a little bit virtually depending on which location the patient was at and the resources that were available in the local industry for that patient.

Regardless of how that happened what happens at the end of it is the patient had a really clear rehab pathway with a number of goals that the team agreed to and they could go on to the pathway, they’d be assigned a health navigator and they’d either move along an operative pathway or a non-operative pathway where the interdisciplinary team would deliver what was needed at the time based on the bundle of funding that we got. And then at the end we would provide a number of functional tests as well as PREMs and PROMs and report that back to the funder every month. Next slide please.

So the difference for us around this pathway was the referral was determined by industry. So previously we’d have to wait either for a referral or we would have to justify why we thought the patient needed some input. What happened in this pathway is that we could take a referral either from industry, GP or allied health or from an employer or from an individual and as long as they met the entry criteria we could get on and get going with the treatment. We had the e-triage team to decide whether or not they’d meet the criteria and then the interdisciplinary team at the start to decide on the best clinical pathway for that patient. Because we were delivering it as a bundle of funding it meant that we can deliver low friction rehab without having to continually wait on approval of funding.

In using standardised outcome measures – as an example we used a patient specific functional score to determine whether that patient is making improvements so at a scaled level we can see if they’re making improvement as we would expect and the patient’s happy and the clinicians are happy, then there’s not a lot of extra stuff that needs to happen. If the patient isn’t getting better or we’ve got some other digital engagement tools if they’re not accessing the care that we think they need, we can lean in or give some prompts to health navigator to understand what kind of barriers it may be promoting or becoming a barrier to continuing their rehab journey.

So the other big thing is that there isn’t any referral or case management from ACC. We internally manage it from a kind of client journey. What we can do is we can lean on the experience of ACC if there becomes a legislative decision. Next slide please.

So we’ve been going since the start of 2020. We’ve had 2,000 people through the pathway to date of which 1,000 of those have recovered and been discharged. We’ve had a big increase in referrals especially in the last three months which is why it’s a little bit unbalanced there in terms of patients in and patients out. Our referrals, 73% of those are from our allied health network and 25% of those from GPs or specialists. What’s also happened in the last three months is that ACC’s seen the benefit of the pathway and they’ve started to look across their system to understand if patients aren’t engaged in the health system how could they refer into the pathway as well. You can see that on the pathway we’ve got 30% shoulders, about 30% spines and 40% knees and most of those are on a non-surgical pathway.

The other bit that we’ve been really interested in is this concept of surgical conversion. So what was happening prior to the Escalated Care Pathway only about 20% of people that were having a first surgical assessment were actually going on to having surgery. We’ve managed to change that to about one in two or 50% of people with a shoulder or spine injury that see an orthopaedic surgeon for that first surgical assessment will have surgery and up to 60% in knees. So it just means that the specialists are seeing more appropriate patients. Next slide please.

Some of the outcomes or is it better. The graph three down which looks at the historical ACC surgical recovery pathway was information that ACC gave us prior to Escalated Care Pathway starting which said that on average for people that needed surgery that had a back, knee or shoulder injury they were taking 90 weeks to recover. The one in the middle is our results and at the moment we’re averaging about 39 weeks. So a huge reduction in time to recovery which is obviously of real interest to funders. The main savings there I think if we look at that time to first surgical assessment and also time from there to surgery, a lot of that at the moment is really in that reduction of administration or waiting for a surgical approval from a funder and then obviously some of that really focused rehabilitation reducing that from 322 down to 175 days.

The other bit is our conservative pathway up the top. Around about 19 weeks to recovery and we think that that’s about right. These are generally quite kind of complex musculoskeletal conditions that otherwise wouldn’t be recovering in primary care. And 40 days into entry means that those people that otherwise would have recovered in just normal basic primary care had that opportunity to do so. The other bits down the bottom are some of our PREMs and PROMs. We’ve got a nine out of ten patient satisfaction score. A four using the GRoC which measures from minus five to plus five, and a 69% reduction in disability is measured by the WHODAS. Next slide please.

**Nick Andreopoulos:**

You’ve got about 30 seconds.

**Mark Shirley:**

Cool. Next slide. So some of the health inequalities that we’ve been looking at is a simple entry criteria. We’ve made sure that it’s nice and simple for our referrers. And multiple entry points removing some of those barriers. And the other bit is that it’s fully funded so there’s no co‑payment which removes another barrier. Last slide please.

Finally some of the challenges in implementation. Going from one referral a month up to 240 has been quite a scaled kind of journey. What we know is that we’re proving that allied health led MSK works. It’s cost and time effective. We’ve had to work really hard with our orthopaedic colleagues to walk alongside that change process with them but what they’re finding now is that the patients that they’re seeing, they’re getting better quality referrals and improved outcomes.

There’s still the ongoing issue of kind of moving medical information around because we’re doing it at such large scale and some of that stuff is still being done manually unfortunately. Policy or process changes that we’re really interested in doing is we know that it works for an injury related population. Really keen to see whether it works for a non-injury related population as well. And then finally this concept of healthcare delivery in silos that when it’s funded in a siloed manner it tends to be delivered in a siloed manner. So just a real challenge for us to keep thinking about delivering or purchasing healthcare as an outcome-based concept as opposed to an intervention‑based concept. Thank you.

**Nick Andreopoulos:**

Excellent Mark. Thank you very much.

Last but not least we’ll move on to Luke Phelan. Luke if you can turn your video on and unmute yourself. On an efficient and efficacious model of care for equitable access to chronic pain clinics in regional areas. Now that is a mouthful. Luke over to you mate.

**Luke Phelan:**

[*Visual of slide with text saying ‘An efficient and efficacious model of care for equitable access to Chronic Pain Clinics in regional areas’, ‘Swan Hill District Health’, ‘Luke Phelan’, ‘Swan Hill District Health’, ‘Pain Clinic Coordinator’, ‘Exercise Physiologist’, ‘B. Ex Sci and M. Ex Phys (AES, AEP, ESSAM)’*]

Perfect. Thank you very much. So yeah the title is a bit of a mouthful. It’s hard to fit all that you want to speak about into a short and catchy sentence but I’ve done my best. So next slide please.

Perfect. So just before I begin I think it’s important with my presentation to acknowledge the work of others that’s been done both in university and pain management research institutes because what I’m presenting is certainly not new but what it does show is that there’s real world feasibility to some of the models of care that are done in more metropolitan centres also done in a modified way in a regional area and that’s what my presentation is about.

So just moving through. So in 2019 Swan Hill District Health which is where I work received some funding from the Victorian Department of Health to establish a chronic pain clinic. It was one of five regional areas to receive this funding and the aim of the funding was to provide access to specialist care sooner and closer to home and to increase regional self-sufficiency. And so with this support our organisation developed a model of care and established a local chronic pain service which we previously didn’t have. And the way the model of care has been developed is to leverage an interdisciplinary team of allied health professionals with virtual support from a pain medicine specialist to provide a comprehensive service. And our findings so far show that this model of care is feasible, efficacious and provides better access for those living in regional areas. Next slide please.

So as mentioned we had an interdisciplinary team of allied health professionals with an interest in chronic pain that were already working at the hospital but we recruited these allied health professionals to develop a bit of a working party and we also recruited a project officer with experience in pain for a three month period to help us develop this model of care as well. And the aim of that working party was to develop a model of care that would be suitable to the resources we have in a regional area and overcome some of the barriers that are faced in regional areas generally speaking.

And so the team that we developed had exercise physiology, physiotherapy, psychology and occupational therapy. And we conducted a gap analysis as part of this working party and we did a research and development phase and we eventually came up with what we consider to be a stepped model of care with reference to the guidelines that we were given from the Department of Health. Next slide please.

So this is our model of care which looks about as confusing as the title of my presentation as well. But basically what happens is we get a referral, we make contact with the client, we discuss their history of their presenting complaint in the setting of their chronic pain. And all of these clients if they meet the criteria that are pre-set by the Department of Health will get invited to attend a pre-education session. And in this pre-education session we do some brief chronic pain education and we discuss the services that we offer within our pain clinic. And then once informed the client can choose whether or not they want to be a part of the service or not, which one ensures that informed consent component and also ensures that we’re providing client‑centred care.

From there we have an initial needs assessment with the pain clinic coordinator which is myself and from that initial assessment we decide what services might help. That includes assessment from the other allied health team members, so physio, occupational therapy, exercise physiology and psychology. And essentially we case conference all of these new referrals and decide what services may be of help to them. And part of the efficiency of this model of care comes from using the allied health team members within the model of care but also looking at external services either within the community or already provided by the hospital. And pivotal to this whole process is having this multidisciplinary case conference where all of these allied health members and the pain nurse and specialist discuss new referrals and decide what services might benefit them and also decide whether or not it would be beneficial to have an appointment or a referral to the pain medicine specialist themselves. And the benefit of that is we’re not overloading the pain specialist. We’re not ensuring a pharmaceutical first approach. It’s very much that holistic approach and it’s eradicated a waitlist for pain medicine services. Next slide please.

So this stepped model of care typically speaking it offers the least resource intensive interventions first before offering more exhaustive or more expensive interventions to help overcome some of those regional barriers. And the level of care that we offer is dependant on several factors including the complexity of the client’s presentation and their medical history, the outcome measures that are taken after their pre-education session, factors for consideration following assessments from each allied health member and their engagement with the program to date, and obviously their goals as well. But it’s pretty important for me to emphasise here that it's not a fixed model of care so they don’t have to go from the least intensive to the most resource intensive interventions first, but generally that’s the way things happen to go. Next slide please.

The model of care I think clearly reflects that we’ve got that interdisciplinary client-centred approach and it’s delivered within a biopsychosocial framework. So there’s that opt in/opt out process after they hear what we have to offer. There is the wide range of allied health services to provide support and there’s those referral pathways to other community or hospital services as well and these include things like alcohol and drug withdrawal, dietetics, podiatry, diabetes educator, social work and so on. And the goals of our therapy within the pain clinic is directed by the client goals but we really are putting an emphasis on improved quality of life rather than eradication of the pain altogether. Next slide please.

So in terms of the way we access our pain medicine specialist, he works at St Vincent’s Hospital Barbara Walker Centre for Pain Management and after we discuss a new referral together with the interdisciplinary allied health team and then the pain medicine specialist at our fortnightly case conference we might say this person’s suitable or not for pain specialist input. If they are suitable essentially I’ll develop a referral with the help from the interdisciplinary allied health team. We send that through to the pain medicine specialist and we do essentially what’s called assisted telehealth where I’m in the room with the client and we telehealth the pain medicine specialist in Melbourne which is four hours away from where our service is and I can provide any assistance with the assessment aspect via webcam. And following that the pain medicine specialist can dictate a letter which I sight and send on to the client’s GP outlining any recommendations for both the pain service itself and also in terms of any medication prescription changes. Next slide please.

So the outcomes from our model of care so far. It was a little bit held up with COVID interruptions to service provision initially but now we’ve had a good run at it and we’ve done some trials. So preliminary findings following implementation of our model of care show that one pain clinics in regional areas are sustainable and they’re feasible given the well documented inequalities of healthcare resources in regional areas. And that’s things like recruitment. So we’ve had issues recruiting all of allied health over the years but we’re using existing allied health workers at the hospital and just providing extra EFT to those roles to provide pain clinic services. We also provided funding for extra chronic pain training for those allied health professionals as well.

The service increased accessibility to persistent pain services in a regional area. So as mentioned we previously didn’t have one but with this funding we were able to develop one that is currently so far running smoothly. And that is closing the gap between metro and regional areas. Again existing allied health services are being leveraged to ensure that the model of care is sustainable in the long term and most importantly it leads to meaningful improvements in the consumers who engage with the services provided. Which brings me to my next slide please.

So these are outcomes from the initial cohort of clients, so the first 15 clients that came through our pain service, and we used a brief pain inventory, a 21 point depression, anxiety and stress scale, pain self-efficacy questionnaire and pain catastrophising scale scores and we can see that there is reasonably meaningful improvements across all of those outcomes for the consumers that have engaged with the service. Next slide please.

We also did a gap analysis before we developed the model of care and that estimated that there was 6,000 people in our region living with persistent pain. And just for background our region, the catchment of our hospital service is about 25,000 people. So that’s going off that one in four, one in five people living with persistent pain that we know from the national data. Considering there was that many people in our region living with persistent pain that was estimated there was no access to a patient-centred best practice pain management program in the region and healthcare consumers were previously being referred to Melbourne from their GP which is a 700 kilometre round trip to access the service of not only interdisciplinary pain services but also pain medicine specialist support. And we found that this was pretty shocking considering goal four of the 2018 National Strategic Action Plan that was supported by the Australian Government highlighted the need for timely access to patient-centred care in all areas of the country. Next slide please.

So we’ve obviously made or we feel like we’ve made significant progress to goal four of that National Action Plan for Pain Management and we made a concerted effort to educate health professionals in the region about our service and also about best practice pain care. And we saw a very large increase to referrals to the newly established chronic pain service during the first 12 months versus the previous 12 months for chronic pain services in our hospital. So that brings me to my next slide please.

So this is just a little bit of data. So we looked at 12 months of referrals to our previous services for chronic pain reasons and we saw that there was 27 total referrals and only five of them coming from general practitioners. And after a little bit of advocacy and education that increased to 133 total referrals and 75 referrals from GPs reflecting that there’s a clear need for these services in regional areas. Next slide please.

**Nick Andreopoulos:**

You’ve got about 30 seconds.

**Luke Phelan:**

Perfect. Thank you.

So translating this into practice. Again in summary we’re showing that this model is quite feasible in a regional setting and that that allied health led first approach can be translated really well in a chronic pain setting but I also think it has good potential to be implemented into other models of care such as orthopaedic surgery and so on. And we’ve since provided assistance and shared this model of care with a number of other services in the region. Next slide please. I think I’m coming to an end.

Perfect. That’s it. Thank you.

**Nick Andreopoulos:**

Beautiful. Thanks Luke.

Right. If I could ask all presenters to turn their cameras back on. I will stop sharing so we can all see you in a gallery view. And we’ll just take some questions. So I’ll just pass back to Anne-Marie and Martin.

**Dr Anne-Marie Boxall:**

Sorry. A bit of confusion about who was going to start there. So looks like me. So again thank you for some fantastic presentations. We are sort of coming up to our break time but I think what we will do – there’s some great questions so we’ll ask one question to each speaker and then see how we’re going for time. So the first question I think is for Luke and the comment is:

*Q: Great model. Have you done an economic assessment of the service compared to specialist led services?*

**Nick Andreopoulos:**

You’re on mute Luke.

**Luke Phelan:**

Sorry. I just said great question and certainly not something we’ve done so far but it is probably something that would be worthwhile looking into. And I think unfortunately again with the time we have allocated to providing the service it would be fairly time intensive to look into that but it would certainly be something that’s worthwhile. And if we ever run into issues with funding it’s certainly something we could look into. So great question but sorry I don’t have an answer for that.

**Dr Anne-Marie Boxall:**

It’s always good to have another research project lined up.

**Luke Phelan:**

That’s right. Good idea. Thanks.

**Dr Anne-Marie Boxall:**

Martin.

You’re on mute Martin or we can’t hear you.

Try again.

**Dr Martin Chadwick:**

How’s that if I bring my boom down. There we go. All right. Robin it’s good to see you again. A question is around the work there and just asking the question around:

*Q: Is there any loop back or connection to the veterans GP? How’s that loop managed?*

**Robin Kerr:**

Okay. So there’s various parts of our project and the Otago study is one and that certainly has that built into it. From adverse reactions through it’s built to loop to the GPs. But we’ve been discussing this and this is an invitation for other allied health and primary health to be coming into that collaboration. And the aim is to develop an easily accessible database that can go through health navigator. And we are discussing things, bringing it to the College of GPs as well. So that whole integration is absolutely pivotal in our model.

**Dr Anne-Marie Boxall:**

Thank you. And so over to me. And so this is to Hemakumar and Cheryl. I have to say as an Australian listening to your presentation I was fascinated because it’s obviously a very different culture and very different symbols and community to what I am part of. So I’m just intrigued about how much time and sort of preparation I guess was put in to working with the community and understanding community and understanding their values and the way they understood pain. Because to me that looked – I mean it’s clearly very effective but it also takes a lot of time and investment in resources in those relationships. So can you give me a little bit more information about how much sort of lead up there was I guess until you were able to engage effectively with community?

**Dr Hemakumar Devan:**

So I can go Cheryl. Because I think this whole journey started five or six years ago for another research project where we were thinking of again an online option for whanau but then we were clearly told in that journey that online may not work and then we have to start again. And then I think none of this would have happened without the support from the community led by Cheryl. So Cheryl has the mana of the community and she has been the manager for Tu Kotahi for the last 30 years. And it was that relationship and trust built with Cheryl and through Cheryl we built and gained the community’s trust. Your thoughts Cheryl?

**Cheryl Davies:**

Yeah. It seems like it’s been quite a journey for us but actually every part of it was really important and I think just the whole process ensured that the whanau voice was valued.

**Dr Hemakumar Devan:**

Yeah. One of the key learnings for us was it’s the process that matters and the process is the key outcome as opposed to the outcome per se. So if you do the process right, if it’s meaningful you will get the outcome that will work for everyone.

**Dr Anne-Marie Boxall:**

Yeah. It’s a really good lesson I think isn’t it, about you can’t skate over those parts and expect to get the outcome you want. They are essential. And I think often the process is not valued or seen as an important part of healthcare. So yeah it’s a really good lesson. Thank you. Martin to you.

**Dr Martin Chadwick:**

Great. So I’m going to ask the next question of Mark and just really interested just to dive into the comment that you made around needing to negotiate with ACC as the insurer around making sure that you’re getting more time for clinical interaction. So just wondering if you can give us a little bit of insight as to what you had to do to be able to shift the perspective of ACC on that one?

**Mark Shirley:**

We spent nine months repeating our story over and over again is probably the first thing Martin. But it really came down to kind of value of what we as allied health providers could deliver. So when we started to say to them we’re spending hours writing reports and these kind of weekly updates that no one is actually doing anything with what’s the point in us doing it, it became a self‑serving argument in that they could see that they’d be better off putting that money into more of a trusting relationship to understand that we are going to do what is needed and to let us do the clinical care as opposed to do something and then report on it and then ask for something else and then do it and then report on it. So it wasn’t difficult once we started to explain it both from a cost and also a value perspective and then bringing the patient voice in to say actually the people that we work with are telling us they want to spend time with people as opposed to us writing reports and emailing or sending them off to an insurer to kind of provide justification of what we’ve done.

**Dr Martin Chadwick:**

Great. Thank you.

**Dr Anne-Marie Boxall:**

And final question for this session is to James. It’s a bit of a two-parter James. One it’s picking up on something that someone has asked in general to the whole panel but it’s this issue – again listening to your research clearly what you’re doing is saving lives but you mentioned that the clinical pharmacists are not embedded on each ward. And so I’m interested in why you think that the research then hasn’t been translated into practice but also is the service provided Monday to Friday or seven days a week?

**James Lucic:**

That’s a thing that we always will struggle with and I don’t know how to change that as that goes into the kind of upper management realms of things that I’m sure other allied health also struggle with. But we’re a Monday through Friday service, 8:00 to 4:30 at current. So it’s very difficult to have full continuity of service or innovation and provide that to all patients at any given time. I know around the world, like in the US and I know Australia as well have seven day services and I know in the US they have 24/7 services but it’s something we really struggle with here and I don’t know how we bridge that gap because obviously the amount of funding that would require would be probably astronomical.

**Dr Anne-Marie Boxall:**

Yeah. I mean that sort of comes back to one of the themes of our conference so far is trying to communicate to policy makers the yes it’s an investment but it delivers significant savings and the same or better outcomes. And it’s essentially what we’re trying to do with allied health. But yes it’s a tough one isn’t it?

**James Lucic:**

And I think from the clinical pharmacist perspective is that our service has changed so much over the last probably 20, 30, 40 years is that we’ve shifted from being practitioners who supplied medicines to now where we’re more focused on a clinical service but all the funding models are all based on the old method of practice, and how we make those changes and demonstrate our kind of new practice and new value to have those adjustments made.

**Dr Anne-Marie Boxall:**

Absolutely. And again I think that’s another emerging theme is the funding models are not keeping pace with the service delivery and the reforms and the innovations. So great.

Okay. Well look with that as I said we’re running a little bit behind but I do want to take the opportunity to again thank all of our fantastic presenters not just for their presentations today and their willingness to share their research but for doing it in the first place and for doing it in a robust way and communicating it to us in such a clear way. So thank you for your participation. And I will definitely be reaching out to some of you on topics that are very relevant to work that we are doing here in Australia so be aware for an email coming.

So what we’re going to do now is we are going to have a ten minute break. I will hand over to Nick just to talk through the Poll EV question. But we will have the full ten minutes and we’ll take off a little bit of time at the end of the day. So I’ll hand to Nick and we’ll come back at ten past 11:00 Australian time and ten past 1:00 New Zealand time. So Nick.

**Nick Andreopoulos:**

Great. Thanks Anne-Marie. So I’m going to have a few questions that I’m going to put in the chat and they are going to come through right now. There’s two questions that are visual questions and that will be the shared screen during the tea break so we’ll be able to see them as they get live updated. At the moment we’re in a bit of a competition with New Zealand. You’ll see what I mean when they pop up. There’s also an open ended question which is more about the Summit itself and how allied health can best demonstrate its value. That’s an open ended question and any good responses we will probably come back to towards the end of the day if we have time otherwise we’ll be collating them and using them for our works coming up as well. So take ten and I’ll share my screen so you can see your results. And please respond to the questions. Thanks guys.

**Dr Anne-Marie-Boxall:**

Thanks everyone. See you soon.

All right everybody. Welcome back to our session for today which is our final session of presentations. As we have done with all of the others we will allow each speaker to have ten minutes to present their research. I encourage you all to post questions for your speakers as you go so you don’t forget. But if speakers could hold off answering those questions we’ll do it publicly at the end so everyone can hear the answer. So with that I will hand over to Nick our compere.

**Nick Andreopoulos:**

[*Visual of slide with text saying ‘The value of allied health care’, ‘Session four, ‘Please submit your questions via the Zoom Q&A’, ‘Australian Government with Crest (logo)’, ‘Department of Health and Aged Care’, ‘Manatū Hauora’, ‘Ministry of Health’*]

Anne-Marie you got me at a bad time. I’m just chomping on a snack. Sorry guys. Just give me one second.

Okay. So just a reminder, just like the previous ones, our presenters when you are presenting please put your video and unmute yourself. When you’re not presenting just stay on the line with your video off and muted and we’ll get you all to turn your videos back on during the panel discussion.

The first presentation that we have this afternoon is Melanie Lai doing an Orthoptic-led Clinics – Seeing the Value presentation. Melanie if you can turn your screen on. There you are. Great. And over to you.

We can’t hear you Melanie.

**Melanie Lai:**

[*Visual of slide with text saying ‘Exceptional Care, Healthier Lives’, ‘Orthoptic-led clinics’, ‘Seeing the value’, ‘Melanie Lai’, ‘Orthoptic Department Head, Sydney Eye Hospital’, ‘Orthoptic Advisor, South Eastern Sydney Local Health District’, ‘NSW Government with Crest (logo)’, ‘Health’, ‘South Eastern Sydney Local Health District’*]

Can you hear me now? Yep. Fantastic. Thanks Nick for that introduction and good morning from Australia to everybody and afternoon in New Zealand. As Nick mentioned I’ll be presenting today on the value add that orthoptic-led clinics have had here at Sydney Eye Hospital.

So next slide please.

So the orthoptic-led clinics at Sydney/Sydney Eye. The Sydney Eye outpatient department provides over 60,000 occasions of service each year and the orthoptic department provides approximately 18,000 of these. On average there’s a 5% growth in activity annually that we’ve been seeing over time. To address the increasing burden of chronic eye disease, health inequities and finite resources, both workforce and physical space, we’ve adopted new models of care to support patients to receive timely and appropriate care.

Over the past five years at Sydney Eye Hospital we’ve implemented five new models of care for patients with uncomplicated cataract, glaucoma and diabetic and retinal eye disease where orthoptists are working collaboratively with the other members of the multidisciplinary eye team. Four of the five models involve a virtual care component and since the COVID-19 pandemic we’ve seen these grow significantly.

So today I’ll be focusing on the Stable Glaucoma Monitoring Service which I’ll refer to as the SMS clinic or SMS model of care moving forward. So glaucoma in most cases is a chronic eye disease where raised intraocular pressure causes irreversible damage to the optic nerve and permanent vision loss. It’s known as the silent thief of sight with over 300,000 Australians estimated to have glaucoma and 50% of these patients are unaware that they even have the condition. For effective management of the disease and to prevent permanent vision loss early detection and ongoing review to monitor for disease progression are essential.

In the traditional model of care for glaucoma it’s an ophthalmology-led model of care which involves face to face assessments with an orthoptist and ophthalmologist for the patient and the ophthalmologist will then develop a care plan. The SMS model of care which was implemented at the Sydney Eye Hospital in 2018 is an orthoptic-led clinic that provides care to patients with low risk and stable glaucoma. Next slide please.

Sorry I’ve probably told you to step forward too quickly there Nick. But you can leave it on that screen. That’s fine. So the Sydney Eye Hospital glaucoma service has a number of clinics both face to face and virtual. The Stable Monitoring Service is provided to patients that are for follow up only. So before COVID-19 hit the eye hospital was providing 7,500 occasions of service within the overall glaucoma service and 91% of these were for follow up or review. In the context of an ageing population there is an increased incidence and prevalence of glaucoma and we needed to review how we could sustainably manage the increasing demand for services moving forward.

There’s been success in the NHS with collaborative care clinics to manage low risk glaucoma. And so at Sydney Eye we undertook an audit of the glaucoma service as a whole using an international glaucoma risk stratification tool and we found that 11% of our patients had low risk glaucoma. And so we decided to pilot the same model of care here at the hospital. And the aim of the pilot project was to improve service efficiency and value-based care by using orthoptists working at an advanced scope of practice to ensure that patients received the right care at the right time whilst also improving access to care in glaucoma specialist clinics for patients who had complex care needs as well as looking to improve the patient’s experience overall.

Patients who were suitable for the SMS clinic were referred from a consultant clinic and the orthoptist would still provide a comprehensive glaucoma assessment. After the assessment if there were no red flags or incidental findings the patient would be sent home and the orthoptist would analyse the results more closely to develop a care plan based on the clinical findings. Within a week a glaucoma specialist would review the orthoptist’s recommendations and either validate or amend the plan that the orthoptist came up with. And then patients were either scheduled a follow up appointment in the SMS clinic for ongoing monitoring or referred back to a specialist clinic for appropriate review and management of the patient’s glaucoma.

Correspondence is then sent back to the patient with the outcomes of their appointment as well as a letter for their future appointment details. And this contrasts to the traditional model of care where both an orthoptist and ophthalmologist sees the patient face to face whereas in the SMS model the orthoptist component remains face to face and the ophthalmologist component occurs without the patient present.

So since 2018 we’ve provided over 600 occasions of service in the SMS clinic. 60% of these are new patients to the service and the remainder are patients for ongoing monitoring. In the past 12 months we’ve found that 83% of patients were stable with no disease progression and they remained in that same SMS service for monitoring. The remaining 17% that showed disease progression were referred back to consultant clinics for appropriate management and review.

The agreement rate of care plans between orthoptists and the glaucoma specialist was 76% and 24% of the discrepancies were arising from orthoptists being over-cautious in their care planning whether it be timeframe being too soon or sending the patient back to the specialist was not warranted.

In addition to reporting on patient outcomes our next steps are also to embed reporting on patient experience measures, so PREMs, as part of our business as usual reporting. Anecdotally we’ve had some very positive feedback from patients in the SMS clinics because they no longer need to wait up to four hours in a clinic for their total appointment time which is what was happening in the traditional model. And in some cases patients would often have to attend on two separate days to see the orthoptist and the ophthalmologist. So with the SMS model now they can attend on a single day for their assessment.

The implementation of the SMS model of care has also improved access to care in glaucoma specialist clinics for those with complex disease and on average there’s an additional 235 appointments that have become available in specialist clinics. And since the SMS clinic started in 2018 a total of 590 appointments in the specialist service for glaucoma have been made available. The model of care also presents a cost benefit where approximately $9,000 of employee related cost savings are realised each year compared to the traditional model of care. If we consider it from an activity-based funding context the SMS clinic is $1,860 less to run per clinic compared to the traditional glaucoma clinics which is orthoptist plus ophthalmologist face to face.

And so following the success of the SMS clinic unit’s first year back in 2018 it’s now implemented now as part of our business as usual clinics. There’s been significant growth in demand for the service particularly following the COVID-19 pandemic with the rapid adoption of more virtual models of care. So we’re currently operating at 216% capacity and quickly reviewing how we can sustainably manage this demand moving forward. Next slide please.

So in addition to the outcomes I just mentioned the SMS clinic is also working towards addressing health inequities. We know that the social determinants of health are largely responsible for the health inequities that we see in our communities. And with age there’s also an increased incidence of glaucoma along with people that have certain medical conditions such as diabetes and heart disease also being at higher risk of developing glaucoma and therefore being vulnerable to the impacts of permanent vision impairment.

There are also racial and ethnic disparities for the condition where those of Asian, African American and Hispanic background are at higher risk of developing glaucoma but also higher risk of disease progression.

In our local geographic primary health network which is the Central and Eastern Primary Health Network people in our community including those who are over 60 with certain medical conditions and of certain ethnic backgrounds are vulnerable to the impacts of the social determinants of health. And the network has also observed the needs for some of these groups requiring high levels of psychosocial support, reduced engagement with preventative health measures and there’s also in general a higher rate of homelessness.

So the SMS clinic is working towards addressing some of these inequities particularly those experienced by patients with glaucoma by not only increasing the ease of access to care and ongoing monitoring but also to provide a culturally sensitive service. Next slide please.

**Nick Andreopoulos:**

You’ve got one minute Melanie.

**Melanie Lai:**

Excellent. Thank you. So the SMS clinic has had significant benefits not only to patients but also system wide and translation or expansion of this model of care beyond Sydney/Sydney Eye will help to further drive the spread of sustainable models of care to manage the increasing burden of chronic eye disease. We also hope to support this widespread translation of the model of care by developing some endorsed postgraduate advanced practice modules in partnership with our key stakeholders and this is an initiative that’s already being commenced with orthoptists over in the NHS.

We also need to consider how we can establish some really clear pathways and partnerships with our primary care stakeholders which in this case include optometrists and GPs so that we can reduce the health inequities for patients with glaucoma.

And so in summary the SMS clinic demonstrates the value add that allied health-led clinics particularly orthoptics in this case provides not only to patient outcomes but also system wide and patient experience. Thank you.

So the next slide’s just got my contact details if anybody does want to reach out. Actually no. Sorry. I’ve got a different slide on my screen so don’t worry about that. But happy to provide my contact details if anybody wants to reach out at all. Thank you.

**Nick Andreopoulos:**

No worries. Thanks Melanie.

All right. Moving on to our second presentation. We’ve got Lara Kimmel and Melissa Webb on increased intensity allied health therapy following trauma. So over to you both. Melissa I can see – I think that might be a ceiling or a floor but I can’t see you.

**Melissa Webb:**

Yes. That is my ceiling and I’m just working out how to turn it around on this device. Sorry about that.

**Nick Andreopoulos:**

That’s fine.

**Melissa Webb:**

Yeah it is the back wall. There we go.

I’m really sorry.

**Nick Andreopoulos:**

That’s okay.

**Melissa Webb:**

You might be looking at my ceiling for the entire show. Sorry about that.

**Nick Andreopoulos:**

That’s fine. It’s a nice ceiling. You can get started if you want.

**Melissa Webb:**

Excellent. Thank you.

[*Visual of slide with text saying ‘Increased intensity Allied Health therapy following trauma’, ‘Melissa Webb – Allied Health Team Leader’, ‘Lara Kimmel – Allied Health Team Leader’, ‘Doug McCaskie – Director Allied Health’*]

So my name’s Mel Webb and I’m presenting on behalf of my co-presenters Lara Kimmel and Doug McCaskie. And although I’m the face or the wall of it today I’m definitely standing on the shoulders of giants. So thank you to them. And I’d like to present our project increased intensity of allied health therapy following trauma. Next slide please.

So there’s been some emerging evidence that shows that intensive allied health therapy models in an acute setting can certainly improve hospital outcomes. So if we go through some of these studies within a general med and acute medical population a length of stay reduction was shown with increasing allied health services. The intensive physiotherapy program comparing three times a day physio to standard care in trauma patients performed here at The Alfred Hospital by Sarah Calthorpe and her group showed a ten day reduction in length of stay across acute and sub‑acute. And again that intensive physiotherapy service in fracture patients in HIP4Hips showed the same length of stay reductions in acute and sub-acute of ten days. And the HIP4Hips has now progressed on under Lara Kimmel’s stewardship to a randomised controlled trial across multiple centres.

So we have this increasing evidence about allied health therapy and what it can contribute to improving patient outcomes in the acute care setting. Next slide please.

So using that as a background and a foundation the Transport Accident Commission here in Victoria and Alfred Health joined together in a partnership in July 2018 to work on modernising the allied health trauma workforce and also the trauma ward environment. So the workforce was redesigned to develop a new multidisciplinary workforce and you can see the EFT and resources that were available down in the bottom there. So this included very standard disciplines available to trauma physio, occupational therapy, nutrition, orthotics and social work but it also included new disciplines that we hadn’t had before in our trauma unit such as neuro psych and clinical psychology. And that model was supported by an allied health team leader as well as nearly five EFT of allied health assistants to provide a seven day service and to really aim to grow that therapy from 2.2 hours a day to 3.5 hours a day per patient.

Next slide please.

In terms of evaluation we had two evaluations. The first one was an internal Alfred Hospital evaluation which looked at baseline demographics, length of stay for specific diagnostic groups, length of stay overall, discharge destination, specifically comparing home and inpatient rehab, and objective measures of progress during the admission such as the SMAF score from the OT and the [2:26:10] from physiotherapy. We also looked at hospital readmission rates within 28 days and readmission to ICU because a reduction in length of stay is probably only of value if you don’t increase your readmission rate.

There was also an external evaluation conducted by Monash University requested by TAC and really that was to evaluate the patient related outcomes and the hospital related outcomes at discharge and also at six months for major trauma patients only. So this was a group of very severely injured patients whereas the Alfred evaluation looked at allcomers to the trauma ward to really try and look at organisational related KPIs and discipline specific measures that we could tweak our model of care with. Next slide please.

So in terms of our outcomes the key findings were an increase in bed capacity by that reduction in acute and sub-acute length of stay. We had a reduced inpatient rehab conversion rate. So 14% reduction in the older patients and 12% reduction in patients who have had an ICU stay. There was a reduction in patients being discharged to private hospitals. There was no increase in ICU readmissions or hospital readmissions. We had more patients discharged pre-10:00am which is an important KPI for our organisation to improve access and bed flow. There was a reduced risk of hospital acquired complications and in that major trauma cohort, so the evaluation through Monash Uni, showed a cost reduction whilst in hospital and for the first six months following discharge. And if you have a look at that little diagram on your right hand side you can see the majority of the data points are falling in that bottom right hand quadrant which is showing improved patient outcomes at a reduced cost. And that’s the holy grail of cost benefit analysis so we’re really pleased about that. Next slide please.

In terms of addressing the health inequities we think this study demonstrated that improving allied health access and intervention in the acute setting can really improve patient flow and that allows greater access to hospital not only for patients in an emergency setting waiting in the emergency department but also including those elective surgery patients who need to come in now particularly after COVID and trying to increase demand.

In terms of increasing the patient numbers who are discharged directly home we thought that was really important because it allowed access to inpatient rehab for those people who desperately need that service. And when we looked at our Alfred internal evaluation we could identify that there were specific trauma cohorts that really benefited from increased allied health therapy such as those with high levels of anxiety for psychosocial support as well as the older patient cohort and those discharged from ICU.

So we think it’s important that this model of care is expanded to all trauma patients not only at The Alfred Hospital but across all hospitals which will reduce the inequity of patients who don’t arrive on a trauma ward or those who don’t arrive at a major trauma service. Next slide please.

So in terms of implementation and translation to practice because that’s what it’s all about in the end, our intensive allied health therapy was very successful and on the trauma ward at The Alfred Hospital this is now considered business as usual. This is our standard of practice and it’s what we provide to our trauma patients who are on our trauma ward at The Alfred Hospital. And we’re looking at further discussions around business cases to expand the model for all trauma patients at The Alfred because they don’t all arrive on our trauma ward unfortunately. There are some outliers. So we’d love to expand our model of care to those patients as well.

In terms of future endeavours we’d really like to test the model in other patient cohorts. We think our model of care has demonstrated some significant gains and we think that could be applicable across general medicine as well as surgery. We think it would be helpful to explore allied health in that outpatient space which is something that probably is a big black hole at the moment, that space of once the patient’s discharged from hospital improving allied health in that capacity might help to improve their outcomes and reduce their readmissions. And that’s in things like virtual non‑admitted care environments such as fracture clinic or trauma outreach.

And through forums like this we’re keen to share our outcomes with other institutions to allow for their patients to benefit from an increased intensity of therapy. Next slide please.

So in terms of an overview the intensive therapy patients received early and intensive allied health therapy. There was a reduction in ward and rehab length of stay, a reduction in hospital acquired complications. There was a $15 million reduction in acute hospital costs across the entire inpatient admissions and there was a $4.1 million reduction in discharge costs for major trauma patients only after discharge and up to six months. So we certainly think this project has demonstrated the value of allied health and we think it’s important that we get this out there to not only trauma patients but potentially explore it in other patient populations as well. Thank you.

**Nick Andreopoulos:**

Thanks Melissa. You’ve got a bit of time to work out your camera now if you want.

**Melissa Webb:**

I’ll try and do that now.

**Nick Andreopoulos:**

Right. We’ll move on to our third presentation. We’ve got Mamta Porwal and Claudine Tule on behalf of Stacey Levers presenting embedding non-dispensing pharmacists in general practice. Over to you both.

**Claudine Tule:**

[*Visual of slide with text saying ‘Imagine Better’, ‘Embedding non-dispensing pharmacists in General Practice’, ‘Presentation to the Australian New Zealand Allied Health Virtual Summit, August 2022’, ‘Mamta Porwal’, ‘Senior Manager Quality Improvement’, ‘Claudine Tule’, ‘General Manager, Health Systems Improvement’, ‘PHN ACT’, ‘An Australian Government Initiative’, ‘Capital Health Network’, ‘Partnering for better health’*]

Kia ora. Good morning.

(Speaking Māori language)

And Canberra in Ngunnawal language means meeting place. So Yuma. Good morning and good afternoon. Thank you for the opportunity to be here and present on behalf of our colleague and sharing our learnings from the pharmacy and GP practices initiative by Capital Health Network which is a primary health network or PHN. So there are 31 PHNs across Australia which work quite closely with the state and territory local hospital networks. So currently we’re also implementing other allied health models as well into GP practices and primary care.

So on that note I will hand over to my esteemed colleague Mamta Porwal, Senior Manager of Quality Improvement. Thanks Mamta.

**Mamta Porwal:**

Thank you Claudine and thank you Nick. Kia ora everyone. So I would like to begin by acknowledging the traditional custodians of the land from which I am joining you all today from Sydney, the Gadigal land of the Eora nation, and pay my respects to Elders past, present and emerging and extend that respect to any First Nations people joining us today. Next slide please.

So the Pharmacists in General Practice Program was supported by funding from the Australian Capital Territory, the ACT’s primary health network through the Australian Government initiative. So in 2016 we conducted a two year pilot program to support employment of a pharmacist in three GP practices. So the program was evaluated independently by the University of Canberra and demonstrated successful outcomes in improving medication safety, compliance and health outcomes for patients. The evaluation showcased the pilot had effectively demonstrated to practitioners as well as the practices the benefit of embedding a pharmacist as part of their healthcare team.

So building on from the key findings and success of this pilot we extended the pharmacist model to another eight GP practices across the course of 2018 to 2021 within the ACT. Next slide please.

So how did embedding pharmacists in general practice add value to patients’ journey and address the needs that were identified in the general practice? The project contributed to addressing a range of population health needs identified in the Capital Health Network’s needs assessment and in the interest of time I will only talk about one of the needs.

So our needs assessment identified there was a need for improving health literacy around medications for older Australians. So embedding the pharmacist into the general practice resulted in reduction in medication burden, the cost of medication from a patient’s perspective and advice on the importance of medication interactions and provision of dosing aids like Webster packs to assist in accurate dosing of the medication. So overall 48% of the pharmacist’s time was spent doing medication reviews when they were embedded in the GP practices. And I think it was Katrina’s presentation yesterday that also touched on the importance of medication compliance particularly in older populations. Next slide please.

So the evaluation demonstrated outcomes for practices which included improvement in medication safety, compliance and health outcomes for patients. The evaluation showed 78% of the pharmacist’s recommendations were accepted and implemented by the general practitioners. The patient acceptance for overall project was nine out of ten people saying they would recommend the service of a general practice pharmacist to other patients. And overall there was improvement in general practice workforce satisfaction.

And I’m not sure if you can read the quotes there on the slide so I’d like to read one of the quotes that one of the GPs mentioned during our evaluation. And it says ‘Pharmacy I think is a natural part of the team with the incredible complexity of the medications we are dealing with, everyone’s living longer and all diseases we can cure like hepatitis. So you can’t possibly have that knowledge in your head and having that person in the role of a pharmacist is absolutely critical as part of our team’. Next slide please.

So in terms of addressing the health equity the Pharmacist in General Practice model addresses health equity by offering a free, flexible and adaptive service that complements the usual primary care services and supports health literacy. The model is highly adaptable to meet the patient population needs of general practice including private, bulk billing, corporate or independently owned GP practices. The specialist GP practices focus on primary care for people with co‑occurring alcohol and other drug use and/or experiencing social disadvantage.

So it addresses the health literacy values through co-location and integration. So consumers were offered this value adding service as part of an integrated part of their usual care without them having to navigate separate services, providing the education and information to patients around medication management as well as there were a few other topics that pharmacists once embedded in the practice did cover including smoking cessation and diabetes education. Next slide please.

So the translation to practice. This program offers three main considerations for broader translation to practice. Firstly improved patient outcomes. Secondly the financial saving through appropriate de-prescribing, because we know the number of medications that older populations particularly are on at any given point of time. Saved time for general practitioners to focus on providing clinical care.

So our evaluation, a clinical audit of one of the pharmacists resulted in an estimated healthcare cost saving of approximately 125,000 Australian dollars over three years and $183,000 for over five years.

So the program has helped to build a business case for sustainability of a pharmacist into a general practice. It is a successful example of outcomes-based commissioning as well with a shared set of outcomes and measures. The flexibility of the service allowed practices to identify specific population needs. And based on the success of this pilot and the value it provided to the patients and healthcare professionals we have extended to test this integrated care model into other allied health practitioners. And we’ve established a social workers in general practice program that commenced earlier this month which will be co-designed with all key stakeholders and independently evaluated.

Next slide please.

So a full report on the pilot and the final evaluation can be found on our website and happy to share the reports as well. And I would also like to acknowledge all PHN staff and general practices for their contributions to this program outcome. Thank you.

**Nick Andreopoulos:**

Thank you Mumta and thank you Claudine for that beautiful introduction as well.

Moving on to our fourth presentation. We have Zoe Gulliver and Tara Brady presenting on behalf of Sue Fitzpatrick and Kate Andersen on Quick Access Response Team, essentials for establishing a transdisciplinary allied health team. Take it away.

**Zoe Gulliver:**

[*Visual of slide with text saying ‘Quick Access Response Team (QuART): Essentials for establishing a transdisciplinary allied health team’, ‘Zoe Gulliver, Team Leader, QuART and Tara Brady, A/Allied Health Performance and Strategy Lead’, ‘for’, ‘Sue Fitzpatrick, Executive Director Allied Health and Disability Lead, and Kate Andersen, Occupational Therapy Head of Discipline’, ‘NSW Government with Crest (logo)’, ‘Health’, ‘Illawarra Shoalhaven Local Health District’*]

Hi. Thank you for the opportunity to present today on our Quick Access Response Team and what we would consider essentials for establishing this kind of transdisciplinary allied health team. Tara and I are presenting today on behalf of Dr Sue Fitzpatrick, our Executive Director of Allied Health and Disability and Kate Andersen, Occupational Therapy Head of Discipline. And we would like to acknowledge the traditional custodians of the lands we’re meeting on today, the Dharawal people, and pay respects to Elders past, present and emerging. Next slide.

So an increase in global demand on emergency departments is mirrored locally. Attendances have increased over 6% compared to the previous year. Growing use of healthcare by older people is also a common and important trend. The proportion of patients aged over 75 account for more than 15% of local admissions and this demand places stress on the health service and drives changes in practice to ensure patient safety.

An unacceptable proportion of hospital admissions are also associated with hospital acquired complications. Elderly patients commonly experience these as falls, delirium, pressure injuries and malnutrition. And there’s an opportunity to avoid these complications by avoiding unfamiliar hospital environments and maintaining activity and routine in the home environment.

The Quick Access Response Team or QuART as we will refer to it during the presentation was piloted in August 2020 to March 2021 to provide coordinated, at home allied health support so patients can avoid an admission and/or be discharged as early as possible. The pilot was a success and the team is now permanently established. Next slide.

So our model for QuART includes that we accept patients over 18 years of age who have been medically cleared but require allied health input for the safe discharge home from ED or within 72 hours from the wards. QuART provides an intensive two week interdisciplinary program within people’s homes or via telehealth as required and incorporates physiotherapy, occupational therapy, dietetics and speech pathology and we previously also had social work and exercise physiology. We have teams based at two tertiary hospital sites within the local health district and all team members have undergone interdisciplinary skill building to build capacity to provide more comprehensive care delivery.

Staff provide a case management approach with one clinician taking the lead and engaging other staff as required. This allows improved monitoring of the client and reduced need for clinical handover. It also reduces confusion for patients minimising the number of clinicians attending their home. And the main differentiating factor between QuART and a usual outpatient service is that these patients would have otherwise been admitted so therefore they’re more acute and requiring a high level of care. So for this reason they require the service to be delivered to them at home and the intervention time is slightly longer and more frequent in order to keep them safe. Next slide and I’ll hand over to Tara.

**Tara Brady:**

And so since QuART’s inception there’s been a planned, considered approach to how we can measure the allied health impact for the patient, the service as well as the experience for the allied health clinicians who are new to working in a transdisciplinary way. On the left of this slide there’s a snapshot of some of the data elements related to the service for both the pilot and the most recent financial year. So you can see the number of patients who were able to avoid a hospital admission, an ED presentation or have a decreased length of stay because of their ability to access the service.

We can also see here that we have calculated an estimation of savings in terms of cost avoidance and bed days by the support that the service can provide and that was calculated by calculating the number of patients for whom an admission was avoided and calculate by the average length of stay for each of the sites.

On the right our outcomes are related to the clinician experience. So we now have core competencies and training that were developed and now available for the team members. And that was obviously implemented initially when the pilot went live but as the team has evolved further topics have been added and included in that training.

One other key learning that came out of a qualitative study that was completed in parallel to the QuART’s development was related to I guess that concern that people often have when working in a transdisciplinary team. ‘I went to uni to be a speech pathologist not to just be a generic allied health professional’. And so the qualitative study that was completed as I said alongside QuART’s development actually showed that team members working with the team were working at the higher end of their scope and so could really address that as a concern not being true within the team. And so they found that they were working at the higher end of scope because they were able to delegate some of the less specialised skills to the other team members so that when they were required to do work within their discipline it was for those complex tasks they really needed their discipline specific skillset for.

The team has also worked really hard to embed in the local health district. So initially that was some of the predictable sitting in ED departments, talking to NUMs and doctors during rounds, to really highlight how allied health could support, what would be appropriate referrals for the service and more recently has moved into chatting to outpatient community services around if there’s any ways we can see people to prevent them having to present to ED, as well as trying to access people that may be on the acute wards and trying to get them home safely sooner. Next slide please.

This slide briefly – so I’m not going to go into a lot of detail around this slide but it does highlight the strategies that QuART are using to address the health inequalities. And so as Zoe mentioned we have teams at two sites, at our major hospital sites, and they service the northern and southern regions of our local health district. And we have a real focus on providing a service that is flexible and independent of what the patient needs or independent to what obviously their needs are, are determined by their needs, and whether that is allied health visits, whether that is support to link into GP and outpatient telehealth sessions or whether that’s really linking in to the social and community supports like liaising with My Aged Care or whether that’s the local Men’s Shed or supporting groups. Next slide please.

Finally we wanted to just highlight what we saw as some of the key aspects or essentials for the service. And so the QuART model was planned to be and has found to be transferable and scalable. So in our LHD it has operated out of two sites which obviously have their own contexts and nuances to how things work every day on the ground. But the fact that it has worked across the sites is helping to make a case for us establishing another site, another team within the LHD. The model has continued to evolve I guess potentially in large part that it was established during COVID times but always looking for newer ways or alternative ways of working as we keep trying to meet the unprecedented demand. And so some examples of that recently is a closer collaboration with our virtually enhanced community care service to help manage patients in the community using a virtual model.

Finally a really important element to describe the impact of QuART has been careful and consistent data capture. And as part of that we really needed to think about in the future how we can capture the activities that we do in that transdisciplinary way. Because I think historically our data capture has been within a single discipline so that’s I guess another thing to be thinking about.

So transferring clinical skill and knowledge between our team members, breaking new ground and adapting as required and carefully planning and measuring QuART through its pilot and in permanent phases has been really integral to its successes. Obviously a large part being played by our fabulous clinicians as well. Work continues on revising the team’s composition, introducing QuART to new sites within our LHD and further developing relationships to identify additional patient cohorts who could be supported to avoid an emergency or hospital admission and hopefully get home safely sooner.

So as with the other fantastic presentations we’ve seen as part of this Summit we believe QuART is another example of how allied health can add value for the patient and the overall system. Thank you.

**Nick Andreopoulos:**

Thank you both.

Right. And our very last presentation is Wendy Thiele on optimising clinical intake for children with developmental delay. Over to you Wendy.

**Wendy Thiele:**

[*Visual of slide with text saying ‘Optimising clinical intake for children with developmental delay’, ‘Wendy Thiele’, ‘ACL Early Childhood (RSS)’, ‘Manager Aboriginal Family Birthing Program (EFNLHN)’, ‘ACDHS’*]

Hi. Thanks. Thank you very much. So hi everyone. So my role in South Australia is as the Clinical Lead for our early childhood services, allied health services for children up to seven years of age, and it covers everything that’s not Adelaide metro services. So it’s a fairly big area. I’m an OT by background and the primary part of my role is really to support our 12 multi-d allied health teams with service improvement and innovation. And those teams do service both our regional and our remote, very remote communities including our Aboriginal communities. So they’ve got a big task. We get about 3,500 to 4,000 referrals a year and provide about 20,000 occasions of service across those sites. So it’s a fairly big need.

When I came into this role in 2013 we were just about to transition over into the NDIS, so the National Disability Insurance Scheme, and have all of our disability children transition over there. And what we were finding when I came on board the teams were saying that we had really long wait times. They were worried about these kids. Some of these kids were waiting over 50% of their lives to actually even see a clinician and that just doesn’t happen in an adult service. And the concerns were for these children that once they were referred we didn’t always have good referral data so once they actually saw these children we found that they actually had quite significant issues that should have been seen earlier. So if you’re waiting two years for a service that’s a fairly long time.

So in 2014/2015 we developed as a team, the allied health team, a different way and different approach of trying to see our children much earlier. So if you could put on to the next slide please.

Okay. We know that if we can get to children earlier it’s going to make a big difference to these children. Their needs aren’t going to be compounded and won’t be problematic over their life course. Next slide please.

So what we did as a team was look at what are the key things we want to know from our families. Rather than having a big long list of questions that we asked we wanted to know what were the key themes and what were the things that the families themselves or the parents themselves were finding the main reasons for their key concerns. This is a bit of a busy slide but we came up with a pneumonic called IREWARDS and really this was our first appointment. We aimed to see children – we’ve got a system for those that have got fairly high needs, clinically high needs, so children with swallowing issues. We’ll get them in within 24 hours to 48 hours. But most of our referrals are not high needs urgent referrals. So we aim to see these children within five weeks of their referral. Most we see within three.

It’s a conversation. We decided we want to just have a conversation with parents so that we actually understood what the parents’ concerns were. It wasn’t a clinician-led thing. It’s a parent‑led understanding of the child’s needs. So we wanted to hear from the parents about what their child was like and what their concerns were, what the challenges were, what were the big ticket items for the parents first up. Then we applied clinical judgment. So this first up appointment can be undertaken by any clinician on the team. So that’s speech, OT, physio, social work, dietetics even. We trained our staff up to be able to undertake these appointments and they would apply clinical judgment to assess whether there was a really high risk or sort of an issue that needed to be seen, a red flag across the developmental domains and any health needs. So we also provide services for health needs children.

And then in terms of that appointment with the family we then sort of talked and gave them a clinical response by the clinician. So if it was a clinician that had the information we would give the families some handouts to take away to start the process while they were waiting for ongoing services. We would make referrals through to for example the NDIS or through to a paediatrician if they needed that. We had a physio refer on to a podiatrist for podiatric surgery whilst the child was waiting for ongoing therapy.

So we were able to capture all of the needs of the child and the family and the concerns very first up and what were the priority needs for the family. And we did this in partnership with the University of South Australia who helped us develop and design this whole new process. Next slide please.

Okay. So what were our outcomes? So our main outcomes were really improved timeliness to our allied health services across all of our sites and that was no mean feat. So we reduced the first clinical response time. We had a 57% improvement in terms of how quickly we saw our children. The maximum wait time as you can see is just awful, 551 days. So that’s a 64% improvement in terms of how long the longest child was waiting to see an allied health therapist. And then we looked at where are we actually documenting what the parents’ and caregiver concerns were and that really improved afterwards as well to bring in that client-centred practice. So next slide please.

All right. So the main aim of getting children in early was to really understand and get those referrals happening so they didn’t have to wait long term. If they needed an assessment with a paediatrician for example for autism assessment that could happen sooner with support. Our families were supported. Once they had had this first appointment our families are supported by that clinician or that team. They can ring in if things get worse and they know they’ve got support there so they’re not just left waiting and hanging. And we do try to actively engage them in community support services as well including the NDIS.

And we know that by having this timely identification and early intervention really makes a significant impact on children’s outcomes. Next slide please.

So as you can imagine working in very remote areas there’s quite a lot of complex healthcare challenges that require innovative thinking and this was a big, big change for our clinicians. It’s been embedded now in practice. The clinicians were very much a part of the development and implementation and testing and gave us feedback all the way along. We undertook an audit at the 12 month mark which really we provided feedback to teams and they really took that on board. And then we have been able to – whilst we haven’t necessarily reduced the impact and burden of savings what we have done is made sure these children are on a better trajectory in terms of their long term health outcomes.

Where we’re at at the moment is we have just completed a review of this whole process with really good feedback from clinicians who are now very engaged and it’s very much embedded in practice. So that’s a real bonus. We are starting to look at how we can roll this out for Aboriginal communities to make this more user friendly with the assistance of an Aboriginal person who is trained to undertake some assessments for us and with us. We’ve embedded this in all of our data systems and our collection reporting. We have a KPI now that’s set up that we report on each quarter about how well we’re doing and we’re continuing to do that ongoing evaluation and improvement of our system.

So some of the anecdotal outcomes from families have been really very, very helpful and have really appreciated being able to at least settle their anxieties and understand what their child needs and how they can support their child. We have moved to now doing some of these online during COVID. So we try to get families in for these appointments or see them face to face but we’re also now doing them via video calls. Next slide. I think this is the last one. So that’s it from me.

**Nick Andreopoulos:**

Great. Thank you. I love that you timed yourself as well. I heard that.

**Wendy Thiele:**

Yeah.

**Nick Andreopoulos:**

Great. That’s all the presentations done. Thank you to everyone. That went probably as smoothly as we could have expected which is great. I’m going to throw back to Anne-Marie and Martin. If presenters can all put their videos back on, I’ll stop sharing my screen so we can see you all in a gallery view.

**Dr Anne-Marie Boxall:**

Excellent. Thanks. Thanks Nick and again thanks to all our presenters for their fabulous work and their commitment to trying to stay on time. So we will have ten minutes of questions now. So if you do have questions now is the time to put them in the Q&A or upvote ones that you can already see there. But whilst you’re also thinking about questions I’d also just point you again to the Poll EV questions that we are asking because Nick is going to do a little bit of a summary of some of the responses that are coming through of those Poll EV results in our wrap up session. So if you have thoughts on those please start entering them now.

Okay. So the first question I had has now disappeared and it is for Wendy. First of all there’s someone reaching out to you Wendy who wants to have a chat. So if you’d have a look in the chat there there’s an email and contact provided to you. But the question for you Wendy is:

*Q: Are you doing developmental assessment for diagnosis?*

**Wendy Thiele:**

Yes we are but that happens after this first appointment. So what we found was we’d often have a child come in for an appointment, for their first up appointment, do a full developmental assessment with three or four clinicians in the room and often we couldn’t provide therapy straight after so they would just be put on a waitlist. So we decided that it was actually better to see if we could get some therapy happening very soon and then see whether that settled and then we do a full developmental assessment for diagnosis and generally that’s we would refer to a paediatrician and do that with the paediatrician as well. So we do that after they’ve started therapy generally.

**Dr Anne-Marie Boxall:**

Okay. Great. Excellent. Thank you. Over to you Martin.

**Dr Martin Chadwick:**

Great. Thanks Anne-Marie. A little bit of a blast of the past. G’day Sarah. Good to see you online there. So a question from Sarah to the QuART team, so Zoe and Tara.

*Q: So the program sounds incredible on preventing older adults spending unnecessary time in hospitals.*

Sarah’s curious as to how it works alongside the existing transition care program and also the short term restorative care model.

*Q: Are there any plans to bring in RNs around wound care management and medical management?*

**Zoe Gulliver:**

Okay. So in terms of working alongside the transition care program and the short term restorative care model we sort of work at the other end of a patient’s journey. We’re trying to prevent them going into hospital where they would traditionally be evaluated for the transition care program and have that on their discharge. We’re trying to get them before they’ve really been in hospital for very long and probably their acuity is slightly lower than somebody that’s needed to be in hospital for a period of time.

In terms of the short term restorative care model we often refer to that. So we’re getting patients that have had no involvement with My Aged Care, that have had no ACAT, and we’re identifying that and referring them on to continue on with those services once we’ve had our two weeks. So we’re more of a care coordination and providing some allied health in that time and then referring on for that continuation of service.

In terms of RNs around wound care and medical management it would be amazing. At the moment we’re just traditionally allied health. It would be an amazing evolution to have that. At the moment we rely on community health to provide that nursing support.

**Dr Anne-Marie Boxall:**

Thank you. So I’ll ask the next question. I just have to find it because they keep moving. So the question was for Melanie. There’s kind of two parts to this. First is about the role of optometrists. So you did mention it at the end of your talk but if you could give a little bit more information about the role of optometrists in your pathway and then there is another question about the role of specialists which I’ll find while you’re answering that one. So if you could start on the role of optometrists Melanie that would be great.

**Nick Andreopoulos:**

You’re on mute I think Melanie again.

**Melanie Lai:**

Sorry. I’ve unmuted the screen but not on my headphones. Yeah. So optometrists in our pathway are the main source of referrals for new patients into the service. Due to the increasing demand and requirement to monitor these patients on an ongoing basis we have now started to shift to try and discharge patients from the SMS model of care into our primary healthcare partners which are optometrists. So the aim is to send more of these patients in the SMS clinic across to optometrists to see and instead now shifting the in-hospital model to be managing the more moderate complexity patients with glaucoma. I think one of the concerns was the challenge of having the patients from the community referred back into the service because we are so busy and so we’re also trying to set up some individualised criteria for each patient so optometrists feel confident to know when to send a patient back in and when they can remain under their care being monitored in the community.

**Dr Anne-Marie Boxall:**

Yeah. Great. Okay. And the question at the other end, the medical specialists. So in Australia specialist doctors are funded either under Medicare or perhaps as a salary at a clinic but how do you pay for them if the patient isn’t actually seeing them? Because often the payment depends on the patient being present so how are specialists funded?

**Melanie Lai:**

Yeah. So with the SMS model of care the specialist isn’t truly funded to actually provide that service. They’re sort of doing it from – they’re working in another clinic and with outpatient clinics. So they’re on the salary for that but they’re not getting any Medicare billing for the virtual aspect of reviewing the patient’s results and the orthoptic care plans that are developed. So I guess in short they are on a salary. If they do have rights to private practice and licence to occupy when they do see the patient face to face they can be billed, otherwise they’re not billed in the SMS model at all.

**Dr Anne-Marie Boxall:**

Yeah. Okay. Great. Interesting. Thank you. Martin to you.

**Dr Martin Chadwick:**

Great. Good stuff. So going to go to Melissa. And I really perked up at I think your comment around the holy grail. And so when we start to look at dosage intensity I think there’s a big understanding about understanding that if you get the dosage intensity right that you’re going to get the right outcomes. And I heard around about five hours is what you were working towards. And so the question which has come up is:

*Q: Have you considered integration of students into the service delivery model to increase your reach?*

**Melissa Webb:**

Yeah. Thanks Martin. Excellent question. Because 3.5 hours was our target and we absolutely acknowledge that one the patient couldn’t have 3.5 hours of every discipline every day and the therapist couldn’t provide 3.5 hours of therapy, with an actual AHP for 3.5 hours every day. So we integrated the AHAs. So we’ve got allied health assistants on our team and they formed a really important part of delivering that therapy alongside the nursing staff, the daily sort of care planning and integrating our therapy into the actual daily routine for the patients on the ward. So in terms of students we probably didn’t specifically have students. They work alongside our AHP. But the AHAs were definitely part of building that intensity for the patient and that was really important.

**Dr Martin Chadwick:**

Great. And I may have missed it – I don’t know where I got the five from – but the 3.5 hours, so did you obtain that in the end of your piece?

**Melissa Webb:**

I’ve just got Lara sitting next to me so I’ll just be very clear about the data before I say yes or no. I don’t think we have that detail yet and obviously that would be a combination of many different disciplines and measuring that is actually quite difficult. But in terms of the patients that we did actually specifically look at cohorts like chest trauma, spinal trauma, we did achieve the intensity of therapy that we were aiming for. In the overall group I can’t make that assumption for everyone but in the specific cohorts where disciplines were looking specifically at their input we did achieve that.

**Dr Martin Chadwick:**

Great. Well done.

**Lara Kimmel:**

I was just going to say don’t forget some patients do still just get seen and discharged. We’re not going to provide intensive therapy for somebody with an ankle fracture who just needs to be given a set of crutches and go home. So it was really about achieving that for the targeted groups that Mel mentioned. So we had a number of targeted groups that we are looking at auditing them as individuals rather than the entire group to show that sort of increase in intensity.

**Dr Martin Chadwick:**

Great. Thank you. All right Anne-Marie. Back to you.

**Dr Anne-Marie Boxall:**

Thank you. So this is a question for Mamta and Claudine. So first of all we’ve heard a few presentations over the last two days about allied health being sort of embedded in medical settings and some of them have reflected on the fact that it took a bit of time to sort of overcome initial resistance and to be sort of fully integrated in the team. Just wondering if you can reflect on how your pharmacists experienced working in general practice and whether they experienced any resistance and whether that changed over time.

**Mamta Porwal:**

Yeah sure. It definitely was challenging and it took about eight to nine months literally to kind of have them settled in and get them going within the practice. And we had to come up with lots of strategies in terms of having a chat with the GP during lunch time for example where you’re seen as a part of the team versus here it is, here’s a new person, you have to work with the person. So I guess it was also around the pharmacist communicating their value and how they do that value add within the practice too including doing some QA activities and going through some MBS, PBS item numbers and seeing how up to date are some of those records, how can they generate some income for the smaller practices as well. So yes it took a while to embed them. But I guess once we got that pilot going with the initial three general practices we could further expand that with the eight practices and apply those learnings there.

**Dr Anne-Marie Boxall:**

Yeah. That’s great. Thank you. Martin to you.

**Dr Martin Chadwick:**

I’m just seeing how we’re doing Anne-Marie because we’re at 13 past. Do you want to carry on or start to wrap it up at this point?

**Dr Anne-Marie Boxall:**

I’ve got one more question that’s got quite a lot of upticks or upvotes that I wouldn’t mind asking. So maybe we could make this the final question? Yep. So it’s a question for Zoe and Tara and it’s about:

*Q: How did you approach identifying skills that were transdisciplinary and also have the results of your study been published?*

**Zoe Gulliver:**

So the identification of skills that were transdisciplinary was something that happened between our Executive Director of Allied Health and the heads of department of allied health. I can’t comment if there was a framework used but it was around looking at the key core skills and core issues for our population group and then setting out a list of competencies that the clinicians on the team were able to then upskill the rest of the team. So for instance in dietetics that was around looking at a nutrition screening tool that was appropriate for the population which at the time was over 65s and then also identifying flags for malnutrition. That has evolved over the duration of the team and we sort of are continuing to undergo our interdisciplinary upskilling every six to 12 months based on the areas that we’re identifying as a team that we need to keep increasing our skills in.

**Dr Anne-Marie Boxall:**

Fantastic. Thank you very much. And I live in Wollongong so I hope if I need your services you’ll still be operating.

All right. Well look that wraps up yet another fantastic session of presentations on research. So again a huge thanks to our presenters for doing a wonderful job in presenting some fascinating research on allied health that demonstrates its value. So again a real contribution to our Summit and our work program going forward.

So we do have 15 minutes left and we just did want to do a couple of things to wrap up. First of all we’re going to hear from Nick about the thoughts that you’ve presented about what you’re taking away from this event to inform your work and what action you’d like to see following this event as well. So they’re really important for us to make sure that it doesn’t end here. And then Martin and I will just give a few sort of closing remarks and reflections. So over to you Nick.

**Nick Andreopoulos:**

Great. Thanks Anne-Marie. So we’ve got some really, really good responses and I think it’s great that the main responses that we’ve got were kind of the exact goals we had for the Summit I think. The top comment is working together collaboratively to better the health for all rather than profession specific. So when we all went through all of the applications I think one of the key criteria was to make sure that it wasn’t just profession specific, it was multidisciplinary. And that was a key term that we used in a lot of our criteria in ensuring that we can get some presentations that we can see that there are multiple different professions involved, not just a doctor and a podiatrist, that there’s more than two, there’s several different allied health professionals involved.

The second comment is ‘I agree with the many comments made during the Summit that we need to perform research that links allied health input to reduce health burden in dollar values. The more robust the research the more impact on policy makers’. I think that’s a really good point that we saw in several of the presentations about the millions of dollars that can be saved when we do prioritise allied health in primary care and other settings. So another good point when we have examples of someone like Sarah Dennis who is a researcher who’s come in to a policy area to try and make sure that we can have some of that research into the policy decisions we make at a Government level.

The next three points are all quite similar about I guess inviting non-allied health professionals to events such as this because I think as allied health professionals we know how valuable our work is. Perhaps it might be the medical profession that maybe don’t acknowledge this. Not my words. The person’s words. That they need to speak loudly and advocate for our work, grab opportunities to make the wider health community aware of our value. And I think that’s something that we all know. And again with this comment, ‘Using our voice, sharing our stories and successes, showing our value as loudly as what other more visible health professionals do’. And again another similar comment on ‘The value of allied health in terms of the return on investment not just clinical outcomes’. Again I remember Sarah saying something like a lot of the research is kind of how many more degrees of flexion can we get in the knee when we kind of already know a lot of that stuff and maybe a lot of the research needs to be more focused on return on investment to make sure that we can embed more of these things in policy.

I think they’re the main ones Anne-Marie and Martin. I’m happy to keep going down a few more. Otherwise we can just make some comments on how green New Zealand is. I knew it was green Martin but it looks very green which is great. And we’ve got a couple of people in the middle of the Tasman which is nice too, and a good spread around Australia and a really good spread in all the different sectors that all of our attendees work in. So I’m happy to pass back to you guys if that’s great.

**Dr Martin Chadwick:**

Yeah. Thanks Nick. I was just trying to figure out where Norfolk Island is. I’m just wondering if those two green ones in the middle there are somewhat close. But anyway good luck to whoever they are that are sitting there.

**Nick Andreopoulos:**

Big swim.

**Dr Martin Chadwick:**

Yeah. Big swim. So look Anne-Marie are you okay if I have an initial stab and then I’ll hand over to you? So look I think if I just try to reflect on the last couple of days this has had the theme of value as I listened and it’s really affirming to me to think that we’ve got presentations that are being quite explicit in talking about what is the dominant strategy, eg that which is lower cost and delivers better outcomes, that we are seeing pieces of research that are very definitively beginning to show that from an allied health perspective. And I think even more so rather than just saying that it’s the dominant strategy to be really clear about what it is that is then provided to get to that dominant strategy. And then the other thing which started to come through today for me is that key thing around how much. How much do we need to do of something in order to deliver that? Because if you start to think about a lot of what goes on it’s how we build that argument in saying that we deliver better outcomes, we deliver better value, and it is because we deliver better outcomes for a lesser dollar value. And this is what we know needs to be invested in and this is how much of that investment needs to occur in order to deliver that. So it’s a shape which is really beginning to take some good form there.

And then to be really able to quantify that around what are the costs avoided in doing that but then probably as or if not more importantly what are the downstream costs that we’re also able to avoid that when we are working with people in the now it’s the costs that are going to be avoided one, two, five, ten years from now. But then the other key thing which started to come through quite clearly for me today is about how we do all of this with the person, with the patient and within their context. And I always find it very humbling. It is humbling when you hear we’re as clinicians really going to people and sitting with people and understanding what their perspectives are and how we can work with them in their context to deliver these types of outcomes.

So if I was to sum it up it is how we’ve focused on the value, really getting that dominant strategy, understanding the what and the how much, what the benefit will be, all of this focusing on the person and the context in which they’re living in. So jolly good job. I don’t know how else to do it politely. But over to you Anne-Marie.

**Dr Anne-Marie Boxall:**

Thanks Martin. And I’m pleased I get the final word. That’s great. So I was very interested in the Poll EV results actually because they do align with what I had put down as my sort of three key messages. So that’s very affirming. So the first key message I think coming out of this for me is the process of collaboration matters. And I think that we’ve seen that in a number of presentations. It’s about the process of collaborating with community. It’s not just the outcome. The process really matters. It’s also the process of collaborating with our health professional colleagues both within allied health but outside of allied health as well in medicine, in nursing.

And I think investing the time and energy into thinking about how we collaborate we will build multidisciplinary teams that have a foundation of trust and we will build connections with community and people that are a necessary part of improving health outcomes. So for me that’s come out really strongly and I thank everyone for their contributions in helping me realise that. It’s been great.

The second key message for me is really about funding. And I think there’s been a lot of presentations in this session that have shown that a small upfront investment can actually deliver huge savings and we’ve got data to show it. I think that’s fantastic. There’s also a challenge in there for researchers to try and include economic analyses or evaluations where possible. And I know that is hard when you’re doing research on a shoestring. So my sort of call to action to you is try and find some health economists and make best friends with them because that will really help our cause. The other comment on funding is again it shows the clear need for funding reform in order to deliver these allied health services. And my role in the Commonwealth Government is largely advocating for that funding reform. So that has come through really clearly as well.

And then the final message for me is about data and research. We’ve had a few comments about better using existing data. So allied health professionals regardless of setting collect a huge amount of patient outcome data and so we need to find ways of better using what exists. Some of that you can do at a service delivery level. Some of that requires Government policy and intervention. So we take up the call to action on that one as well. But the other thing that I found really interesting is there’s so much great evidence already out there and the value of this collaboration for me has been able to very easily find some fantastic research that already exists that I had no idea about and to be frank have no capacity to find. So it’s come to me which is fantastic and I would really like to find some way of continuing this collaboration so that we can find research that is relevant to policy in practice easily and we can promote it.

And then the final message for me is about promoting our value. So we do have research that shows that we are valuable. We need to get better at promoting that to other health professions, to policy makers and decision makers in health services. And again that’s something that myself and Martin and I’m sure many of the other Chief Allied Health Officers in our country would be really keen to help you with.

So a huge thank you to you all for such a wonderful, wonderful Summit, for your contributions in research and practice and how you’re improving outcomes for patients and also our health system. There’s a couple of other thank yous that I really do need to make and that is to our teams that are working behind the scenes that have all their cameras off but they have been working both in Australia and New Zealand for many weeks to make this happen. It’s not easy to run an online seminar across two countries. But it has been a joy working with our New Zealand colleagues. It has been a real collaboration that’s built some really strong relationships and trust among us and I’m sure that’s a foundation for us for doing things together in the future. The teams have worked incredibly hard to make this happen so a huge round of applause to the teams that work with both Martin and I.

There was a final thing. There’s been a number of requests about sharing slides. And again I’m really keen to have a look at some of the slides again as well. So we will seek permission from presenters whether their slides can be made available to you and shared with you and we will make those available for all those that agree. So we will definitely be sharing a large majority if not all of them.

So with that I would like to officially say thank you for your participation and we will look forward to communicating with you via email. And of course very happy for you to contact us with any suggestions about future events should you be interested. So Martin do you want to say a final thanks?

**Dr Martin Chadwick:**

Final final. Thank you for doing the thank yous. And I think the one down side of doing it virtually we all can’t go for a beer or a wine afterwards because I think there’s a little bit of that collective sigh. But I think what I would leave you is a whakatauki that was given to me recently and I think it’s a really – so a whakatauki is basically a proverb or a saying that was given to me that I think is very pertinent and it goes like this.

(Speaking Māori language)

And so basically it translates to my courage is inherited. And so I think about what we have here today. It’s the courage to just keep pushing forward what we’ve inherited from those that have presented today and those that have gone before us that have allowed us to put this show on over the last couple of days. So someone mentioned earlier that we stand on the shoulders of giants and I think the work we’re doing here is because of those that have gone before us. So a big thank you. And I just do want to note that. So James you’ve been doing an amazing job and we look forward to getting out that final graphic there. It’s been amazing to watch it develop. So kia kaha. So go well everyone.

**Dr Anne-Marie Boxall:**

Thanks everyone. Bye bye.

[End of Transcript]