National PHN Allied Health in Primary Care Engagement Framework

CASE STUDIES

November 2022

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These case studies are intended to assist PHNs in implementing the National PHN Allied Health in Primary Care Engagement Framework (the Framework). They represent a point in time and showcase a range of approaches to PHN engagement with Allied Health, offering practical examples of how the Framework can be applied across a variety of settings and key issue areas across Australia. The case studies included here have been selected from a larger set of available case studies, and a broader case study library is being developed.

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Case Study 1: WA Primary Health Alliance

Pharmacists in General Practice (Jan 2021 - June 2021)

Stakeholders: **Pharmaceutical Society of Australia, WA Primary Health Alliance (WAPHA)**

This case study relates to:

Integration, models of care and funding

✓

Workforce & Access to Allied Health Care

✓

Key contact and email: Dianne Bianchini (dianne.bianchini@wapha.org.au)

Challenge

There is a need for more pharmacists integrated into general practices, with the ability to tailor activities to specific needs of individual practices. The integration of a practice pharmacists into a general practice team works towards an overall goal of improving patient health outcomes and providing effective and efficient care through Quality use of Medicines (QUM) services.

Solution

The Pharmaceutical Society of Australia and Western Australia Primary Health Alliance (WAPHA) devised a program to deliver pharmacists into general practice settings to provide clinical pharmacy and education services through a coordinated, collaborative and integrated approach. The overall goal of the program was to improve patient health outcomes through Quality use of Medicines. The main roles of the GP Pharmacist were grouped into four broad categories:

- **Consumer focused activities and patient feedback**
- **Medication Management reviews (MMRS), medication reconciliation, managing medicines through transitions of care, counselling on both medications and lifestyle issues**
- **Practice focused activities for example accreditation, DUEs, research, education, medication information, team meetings**
- **System focused activities for example transitional care, liaison with hospitals and allied health, and sharing information between the GP, community pharmacy and patient**

Impact

During the reporting period a total of 11,954 activities were provided to 10 practices. As the Program progressed, the time taken for practices to embed and utilise their pharmacist improved significantly. Initially, it took four to six months to embed a pharmacist into the general practice which came down to within three to six weeks in the latter phases. Since implementation:

- **Ten practices were engaged in Perth South PHN, Perth North PHN and a country region during this period**
- **Retention of pharmacists within the practice has been successful with a 40% uptake from practices**
- **An additional 2 practices offered work to their pharmacist for commencement at a later date.**

The following outcomes were also observed:

- **Improved patient experience of care, and improved access to Quality Use of Medicines (QUM) services**
- **Increased understanding of patients towards their condition and medications along with active participation in their health care, and increased knowledge and confidence for patients**
- **Capacity building within the system, furthering instances of seeing the Pharmacist as an integral part of the practice team, and understanding the sustainability of the program**
- **Pharmacists are capable of and supported to deliver in the general practice Program.**

Case Study 2: Sydney North Health Network

Primary Care Frailty Initiative and Allied Health Engagement (2018- current)

Stakeholders: **Sydney North Health Network (SNHN) and North Sydney Local Health District (LHD)**

This case study relates to:

Data, quality and digital maturity ✓

Integration, models of care and funding ✓

Key contact and email: Deb Pallavicini (dpallavicini@snhn.org.au)

Challenge

It important to identify frailty early, and general practice is the ideal environment for screening. It is also important that general practices who identify a patient who is frail can then refer that patient to an appropriate treatment or intervention. There is an opportunity for general practice to play a larger role in identifying and providing care for patients with frailty.

Solution

The Northern Sydney Frailty Initiative commenced in 2018 as a partnership between SNHN and NSLHD to co-design and deliver an integrated model of care that addresses the reversible contributing factors of frailty for the ageing population of Northern Sydney, across the full patient journey. The project was delivered in both the inpatient setting and in primary care, and the primary care arm of the Initiative was approached in two phases. Phase one occurred throughout 2018-2019 and focused on building health professional knowledge, capacity, and the understanding of how to appropriately screen for frailty and the options for implementing preventive and reablement management plans to deliver good patient outcomes. Several workshops were held by the PHN and allied health professionals who had an interest or who specialised in older persons and frailty were invited to participate.

In phase two, the project will gain a deeper understanding of the screening process and identify service gaps to assist in developing a co-commissioning strategy. This involves developing a screening tool with PenCS using their TopBar application, that general practices could use to screen and identify patients for frailty. Practice staff receive a pop-up reminder to screen patients 75 and over when they attend the practice. The frailty score is recorded by the app and practices refer to the associated management suggestions and interventions. Patient diagnosis, referrals and interventions are recorded in the patient's medical record as necessary. Practices also record data on patient scores, diagnosis, and referral information in a provided template.

Impact

Allied health professionals and GPs were invited to be part of a frailty advisory group to discuss current barriers and develop solutions to accessing screening and early interventions in the community. They provide expert advice, relevant sector knowledge, guidance, and support for implementing and supporting a Frailty Screening and Management Program in primary care.

400 screens have been completed since the project started with several barriers identified, one being the onset of COVID-19 and older persons being socially isolated. One of the solutions have been allied health professionals being able to provide online tailored exercise programs and advice. The advisory group have also identified some strategies and resources that general practices can use to engage their patients and challenge perceived barriers and behaviours.

A search tool was also developed as a resource for GPs and lists allied health providers with an interest in frailty. These providers work within the PHN and includes pharmacists that can assist with polypharmacy review.

Case Study 3: Gippsland PHN

Enabling Access to Allied Health in Remote Areas – Far East Gippsland Allied Health Program

Stakeholders: Gippsland PHN

This case study relates to:

Workforce & Access to Allied Health Care

Key contact and email: Amanda Proposch (amanda.proposch@gphn.org.au)

Challenge

A remote region in Far East Gippsland has a limited range of health services, and health data information is limited for publication to avoid confidentiality issues. The region has access to one medical practice, the state operated ambulance service, a community health service, and a community pharmacy. The closest Emergency Department is two and a half hours away. There is a high need for quality allied health services in this region, with potential to commission more services in the area.

Solution

Following the identification of a high need for allied health services, Gippsland PHN commissioned the community health service to provide allied health services. A collaborative approach with the community health service was undertaken to investigate options to reduce the long travel time, which was an identified barrier for service provision by allied health clinicians. The approach to fly clinicians into the region was identified as a solution, allowing for a wide range of services to be delivered onsite in a face-to-face setting in response to need. Current allied health services being delivered include:

- **Dietetics;**
- **Counselling;**
- **Speech therapy;**
- **Speech pathology;**
- **Occupational therapy;**
- **Physiotherapy.**

Impact

Gippsland PHN collaborated with the community health service to regularly review and adapt the program to ensure access to Allied Health services for this isolated community. The commissioned service enables service flexibility when required. For example, the small planes are unable to operate due to bad weather, requiring contingency plans to reschedule and adjust the service delivery based on the availability of clinicians. The region was highly affected by the Black Summer bushfires closely followed by the COVID-19 pandemic. These events not only impacted members of the community, but also the service providers and their staff in terms of ongoing and cumulative trauma, and the challenges of recovery. The service showed resilience and the ability to reassess the best options to service the community.

Case Study 4: Nepean Blue Mountains PHN

Community Chronic Pain Management Program (CCPMP) (July 2019 – current)

Stakeholders: **Nepean Blue Mountains PHN**

This case study relates to:

Data, quality and digital maturity

Key contact and email: Tracy Kane-White (tracy.kane-white@nbmphn.com.au), Rebecca Padgett (rebecca.padgett@nbmphn.com.au)

Challenge

Chronic Pain has a significant burden of disease on the community with a prevalence of 1 in 5 people experiencing chronic or persistent pain. Current research supports small group education sessions for people suffering low to moderate distress and interference in quality of life, as an effective tool for management of persisting pain.

Solution

The allied health-led Community Chronic Pain Management Program (CCPMP) aims to help people in the Nepean Blue Mountains region who are living with chronic pain, to experience improved functional capacity through proven chronic pain self-management strategies. The CCPMP is based on an existing Agency for Clinical Innovation (ACI) model for patients with low to moderate severity chronic pain.

The CCPMP is an evidence-based, predominately non-pharmacological approach to pain management. The program collects data in the form of questionnaires at referral, end-of-program and 12-week post program follow up. This data is collected and collated by the electronic Persistent Pain Outcomes Collaboration (ePPOC), a program of the University of Wollongong, aimed at improving patient outcomes for people with chronic pain.

The main program aims are to provide support with:

- **Self-management of Chronic Pain by the Patients**
- **Return to work**
- **Significant improvement in aspects of their mental health**
- **Opioids reliance reduced**

Impact

Measured outcomes include:

- **Improvement of pain self-management skills by participants**
- **Participants reporting improved quality of life at the end of program and at 4 and 12 week post program follow ups**

There are three providers of this program in the Nepean Blue Mountains area. It has been running in the Hawkesbury since July 2019, Lithgow since April 2021 and Penrith and the Blue Mountains since July 2021. These facilitators provide unique lifestyle-based management strategies that reduce reliance on medical and surgical interventions.

Participant feedback: "For me, it needed a "head shift" a change in thinking to happen before the "body shift" could occur. The exercise regime is slowly becoming embedded in my daily routine, but my attitude has changed. Until now, I hadn't realised how pain meds had eroded my confidence and caused an apathy, I am now working on regaining enthusiasm".

Case Study 5: Brisbane North PHN

Brisbane North Allied Health Collaborative (2016 – 2021)

Stakeholders: **Brisbane North Allied Health Collaborative**

This case study relates to:

Governance and culture ✓

Practice Engagement ✓

Integration, models of care and funding ✓

Key contact and email: Amanda Queen (Amanda.queen@brisbanenorthphn.org.au)

Challenge

In September and October 2015, Brisbane North PHN held a series of workshops for allied health professionals from across the Brisbane North region. These workshops were held to discuss the need for better collaboration between allied health professionals; and allied health professionals and primary and secondary healthcare providers. There is now an opportunity to create better collaboration between allied health professionals, primary and secondary healthcare providers.

Solution

Since 2016, Brisbane North PHN has been working in partnership with allied health providers from local private practice, community organisations and the Hospital and Health Service to develop a collaborative model that can be used to provide peer development support and improve communication and partnerships between acute, community and Allied Health providers. The Brisbane North Allied Health Collaborative aims to provide allied health direction and leadership for enhancement of client health and wellbeing through collaboration between private, public and non-
government organisations. The membership includes Allied health practitioners work across a variety of organisation types in the region, including the Metro North Hospital and Health Service (MNHHS), private hospitals, for-profit organisations, not for-profit organisations and private practice. The main goals of the collaborative are to:

- **Identify relevant local needs and issues in allied health**
- **Improve collaboration and partnerships for allied health professionals and organisations**
- **Provide strategic direction and leadership to allied health professionals and organisations**
- **Improve professional practice and knowledge**
- **Provide better access to allied health services and coordinated care for consumers**

The Brisbane North Allied Health Collaborative (AHC) was inactive in 2020-2021 due to impacts of COVID-19, limited staff capacity and absence of funding, but the AHC Steering Committee and Collaborative have been re-established in the last 6 months - although with limited scope within existing resources.

Impact

Impacts of the Collaborative thus far include:

- **Improved collaboration and partnerships between allied health professionals in the North Brisbane and Moreton Bay region**
- **Improved professional practice and knowledge for allied health professionals in the region**
- **Identification of relevant local needs and issues in allied health which helped inform the implementation of the Brisbane North Health Care Services Plan for Older People, 2018-2022.**

Case Study 6: Northern Queensland PHN

Northern Queensland Primary Health Network Workforce Enhancement and Optimisation Projects (2019 – current)

Stakeholders: **Northern Queensland Primary Health Network (NQ PHN), Health Workforce Queensland (HWQ)**

This case study relates to:

Workforce & Access to Allied Health Care

Key contact and email: Karin Barron (karin.barron@nqphn.com.au)

Challenge

Workforce recruitment deficits and retention of allied health professionals working in rural areas are persistent challenges. These challenges are exacerbated by financial barriers and limited access to sufficient supervision and support, driving early career allied health professionals to seek opportunities primarily in urban areas. There is a significant opportunity to increase allied health workforce capability and capacity in rural and regional areas.

Solution

NQPHN, in response to persistent primary health workforce deficits, initiated a partnership with HWQ in late 2019 to pilot two innovative primary health workforce capacity and capability enhancement models. The Rural Allied Health Workforce Enhancement Project has been designed to specifically address persistent allied health shortages in rural communities through incentivisation. The focus of this program is to increase the number and priority type of permanent allied health professionals in the rural areas of the Mackay Hospital and Health Service area in North Queensland. The following phases play a key role in the project:

- **Implementing targeted recruitment campaigns**
- **Funding to support relocation and settlement, as well as upskilling programs provided by HWQ scholarships and bursaries to meet the needs of place-based care and career planning.**

The partnership also designed and implemented the Vocational Education and Training (VET) Workforce Optimisation Initiative. The aim of this initiative is to support regional, rural, and remote health personnel to access available funding for VET training. The initiative targeted existing primary health personnel and provided primary care providers opportunities to recruit new employees into a learning pathway. Qualifications were selected and offered, based on the rates of expressions of interest from previous campaigns and provider feedback during engagement activities. Providers were invited to submit an expression of interest for staff to undertake training and units of competency were packaged to meet the specific needs for primary care services.

Impact

The impact of the two pilot programs thus far includes:

- **Establishment of nine additional clinical personnel delivering services to rural and regional communities (Rural Allied Health Workforce Enhancement Project)**
- **Development of workforce partnership between HWQ, peak bodies, and training organisations (Rural Allied Health Workforce Enhancement Project)**
- **Improved relationship with and knowledge of challenges and barriers to recruiting and retaining primary care personnel into regional and rural areas (Rural Allied Health Workforce Enhancement Project)**
- **Provided 22 relocation packages to allied health professionals (Rural Allied Health Workforce Enhancement Project)**
- **Funding of VET training access for 97 primary care personnel across 17 Local Government Areas (LGAs) (VET Workforce Optimisation Initiative)**
- **Enhancement of NQPHN workforce intel through a consultation process to inform the NQPHN Health Needs Assessment (HNA) (VET Workforce Optimisation Initiative)**
- **Improved understanding of skills shortfalls and upskilling required across NQPHN region, and primary care providers with increased awareness of the value of VET to upskill both support and health professional workforce for business sustainability (VET Workforce Optimisation Initiative)**

Case Study 7: Tasmania PHN

North West Tasmania Exercise Treatment Program (2018-2022)

Stakeholders: **Primary Health Tasmania (Tas PHN)**

This case study relates to:

Integration, models of care and funding

✓

Workforce & Access to Allied Health Care

✓

Key contact and email: Mark Broxton (mbroxton@primaryhealthtas.com.au)

Challenge

Primary Health Tasmania's Needs Assessment Report noted that Tasmanians have the highest prevalence of chronic diseases and multi-morbidity in Australia, with 83% of Tasmanians having at least one chronic condition and 65% of these having two or more chronic conditions. In addition, 70% of Tasmanians report inadequate levels of muscle strengthening activity, with community health profiling across the Northwest of Tasmania indicating between 12 and 24 % of the population are getting insufficient moderate/vigorous activity (with variation between Local Government Areas)

Health outcomes, morbidity and mortality for sedentary Tasmanians who are older and who have multiple or mobility or exercise limiting chronic conditions are significantly worse than for the general population and those without chronic conditions. There are multiple barriers including motivation, safety, self consciousness and cost that inhibit active engagement of the elderly and chronically ill from participation through commercial gyms or more public facing programs. The ability for healthcare practitioners to actively refer patients in this cohort to a cost free, locally based, allied health supervised and supported treatment program has been shown to significantly increase mobility, core strength and psychosocial outcome for this population.

Solution

The Exercise Treatment Program is an exercise treatment initiative accessible to Tasmanians resident in the Northwest of the State, based upon the previously successfully evaluated Strength2Strength exercise treatment and conditioning program that ran for 4 years in Launceston. Delivered by Physiotherapists and Exercise Physiologists, it uses a 12 week supervised programmatic approach targeting the elderly, frail and aged, with weight or obesity issues or at risk of chronic disease or with other target chronic conditions. Patients assessed as suitable are referred by their GP into the program, where their pre, mid and post strength and conditioning measures are taken. Participants engage weekly under supervision in a range of core strength, flexibility and mobility and low intensity cardio exercises within the program and are given simple exercises and challenges to complete in their home environments in between supervised sessions.

Impact

A focus on confidentiality, peer interaction and supported motivation and encouragement under the supervision of appropriately skilled allied health providers creates a supportively motivating and easily achievable set of personal goals for each participant. Outcomes delivered from this program includes a measurable increase in physical activity with greater than 70% of participants having increased their physical activity with >50% of these recorded as meeting national physical activity guidelines. Qualitatively it was also noted that self-reported confidence to participate in physical activity remained high at 3 months post program.

Case Study 8: Sydney North Health Network

Dedicated Allied Health Governance Representation on PHN Board (2021)

Stakeholders: **Sydney North Health Network (SNHN)**

This case study relates to:

Governance and culture

Key contact and email: Ros Knight (rknight@snhn.org.au)

Challenge

When the Sydney North Health Network (SNHN) was formed, the decision was made to have one allied health member listed in the constitution as a Board requirement, in addition to 3 GP members, together comprising four of the elected positions on the Board. Since then, as the remit of the PHNs has expanded to include significant mental health and aging well funding, the need to again broaden the skills base of the Board to include further allied health (AH) perspectives was noted.

Solution

In 2021, the Board acknowledged the increasing breadth of skills base needed to assure due diligence and meet its legal obligations. Strategically acknowledging that primary care requires the input of all consumers, carers and practitioners meant the Board needed to ensure a breadth of experience and skills among elected practitioner members. Therefore a second allied health practitioner member was added to the Constitution at last year's Annual Governance Meeting (AGM).

The SNHN Board is a skills-based Board of 10 members, with up to six elected from the membership of practitioners at the AGM. There is a skills matrix, and nominees must endorse they have at least one of the required skills. Board composition requires a minimum of three GPs and minimum of two allied health professionals (AHPs). Directors of the same profession must not make up 50% or more of the Board. The other four positions are appointed to fill gaps. Current AH representation includes AHPs from the Occupational Therapy and Psychology professions. These AH members contribute to the Board and lead councils such as Clinical Governance and Clinical Council, in line with their strengths and value proposition.

Impact

Thus far, this governance structure has enabled and led to:

- **Strengthened Clinical Governance;**
- **Increased workforce understanding and strategic planning;**
- **With the majority of commissioned funding going to Mental Health, having a psychologist on the Board helps with identifying risks;**
- **Development of the SNHN Allied Health Strategic Plan in 2021.**

Case Study 9: Hunter New England and Central Coast PHN

Hunter New England and Central Coast PHN Governance and Practice Engagement (2020 - current)

Stakeholders: **Hunter New England and Central Coast PHN (HNECC PHN)**

This case study relates to:

Practice Engagement

Governance and culture

Key contact and email: Jo Coutts (alliedhealth@thephn.com.au)

Challenge

Limited and incomplete data on allied health providers limits reach and knowledge around the best kinds of activities to implement, making it challenging to respond to the need for increased support to local allied health professionals. While the Hunter New England and Central Coast PHN (The PHN) has a growing relationship with allied health providers and services, there is a significant opportunity to build on existing engagement to develop more targeted local support for allied health professionals.

Solution

The PHN's Allied Health Strategy was developed in 2020, following survey and consultation with allied health services and providers. Implementation of the Strategy is guided by a multi-disciplinary Allied Health Reference Group (AHRG). The AHRG provides valuable context and input on the implementation of key workstreams: Health Information & Data, Telehealth, Education and Advocacy. Monthly allied health focussed education topics are developed and delivered by The PHN's education team and the experience of the inter-disciplinary AHRG members is used to scope the delivery of education and interactive, tailored and business webinars focussing on business support for the sector.

A hybrid face-to-face and online Allied Health Conference was delivered by The PHN in May 2022 to support sharing of knowledge, integration, inclusive care, and demonstrate accelerated behaviour change through digital innovation. The conference was attended by 151 people – 49 being online attendees. Other opportunities for allied health engagement have been made available through the provision of 60, $5,000 Digital Health Supplementary Grants, which are complemented by information sessions on what makes a quality video consultation and how to register for My Health Record.

A targeted Health Information project, BEAP (Best Practice, Equity, Analysis Pilot) was developed and implemented with five engaged allied health practices, each with a focus profession (Exercise Physiology, Physiotherapy, Dietitian, Diabetes Educator, Podiatrist). The project tests the concept that software technology can improve allied health clinician experience in data input and in sharing of that information to other healthcare providers. Longer term, this may lead to the development of and access to evidence-based reporting and data sets, to demonstrate the impact of allied health interventions, and support Quality Improvement opportunities for those treating people living with chronic diseases.

Impact

The PHN has worked to build its relationship with allied health providers and professionals focussing on provision of education, events, and support for improvements in data collection and digital health service provision. Continuation of this multipronged approach to engagement has enabled The PHN to build on its knowledge and understanding of the needs of the allied health sector. It has provided more accurate insights into the areas The PHN can provide further focussed support and advocacy for allied health professionals, which will ultimately support patients to gain access to high quality primary health care.

Case Study 10: Western Queensland PHN

North West Queensland Inter-Agency Allied Health Workforce Strategy (2019-2022)

Stakeholders: **Western Queensland Primary Health Network (WQPHN), Health Workforce Queensland (HWQ), University Department of Rural Health (UDRH), and Allied Health Professions' Office of Queensland (AHPOQ)**

This case study relates to:

Workforce & Access to Allied Health Care

Key contact and email: Chris Mitchell (cmitchell@healthworkforce.com.au)

Challenge

Rural and remote allied health workforce challenges are well known within the region. Consistent with many rural and remote areas, health services in north west Queensland report difficulties with recruitment (particularly of experienced practitioners) and retention of allied health professionals. Difficulties providing supervision and work-based training for early career practitioners and releasing staff for professional development, and flat workforce structures also contribute to challenges with workforce sustainability. There is a significant opportunity to build a multi-professional workforce that has the capacity to deliver the breadth and depth of services needed by the community.

Solution

Allied Health service providers and commissioners in north west Queensland met in Mount Isa in November 2019, where they agreed on the endorsement of a scoping project to develop a strategy enabling a regional approach to allied health workforce development in north west Queensland. It was designed to bring key stakeholders together to develop, implement and evaluate an inter-agency, collaborative, regional approach to allied health workforce development. This included recruitment, retention, and capacity building for the allied health workforce in north west Queensland.

The scoping project was conducted between March and June 2020, and ultimately produced a strategy that provides guidance for partner organisations regarding opportunities, enablers, risks and resources required for implementation. The strategy focuses on attraction, development and support of the early career workforce using the Allied Health Rural Generalist (AHRG) Pathway, and aims to see the development of designated rural generalist training positions in multiple health services. WQPHN played a key role as a funder and commissioner of primary services, with this commissioning support a critical enabler of primary care sector participation.

A two year implementation plan (2020-2022) is currently underway to implement and evaluate the strategy, deliverables of which include designated rural generalist training positions in partner organisations, implementation of allied health rural generalist training, and an evaluation report. The strategy leverages funding from HWQ, AHPOQ, the Centre for Rural and Remote Health (CRRH) and Services for Australian Rural and Remote Allied Health (SARRAH).

Impact

This initiative aims to provide direction for the development of an 'own-grown' allied health workforce model suitable for rural and remote health services with a number of multi-professional teams, ultimately developing and strengthening the rural allied health workforce pipeline. Other intended benefits include a common workforce strategy and increased cross-agency collaboration, as well as a platform to promote workforce attraction and build service capacity across the region. By using the AHRG Pathway as a foundation of the workforce development strategy, the initiative aims to provide intensive development of clinical and non-clinical skills for the early career workforce as well as education outputs (eg. activities and assessments) that can be tailored to service needs.

Case Study 11: Central Eastern Sydney PHN

Development of Allied Health Engagement Strategy (2022-2025)

Stakeholders: **Central and Eastern Sydney PHN (CESPHN) and Central and Eastern Sydney Allied Health Network (CESAHN)**

This case study relates to:

Integration, models of care and funding

Data, quality and digital maturity

Key contact and email: Dr Brendan Goodger (b.goodger@cesphn.com.au)

Challenge

Allied health professionals (AHPs) play a critical role in driving person centred integrated care models and meeting the health needs of our community. At national, state and local levels, AHPs have become central to discussions and feature significantly in the consultation draft of Australia's 2022-2032 Primary Health Care 10 Year Plan and in the CESPHN Strategic Plan 2022-2025. To date, AHPs have not been given much support to become digitally enabled, and unsurprisingly have not fully utilised digital tools such as My Health Record and secure messaging. As a result, many AHPs have felt disconnected from other healthcare providers with their skills not fully utlilised as part of the primary care team.

Solution

As a recognised priority for the 14,000 AHPs within the region, CESPHN has developed an Allied Health Engagement Strategy 2022-2025 in collaboration with the Central and Eastern Sydney Allied Health Network (CESAHN) to act on opportunities to increase AHP participation and improve practice in allied health. This works alongside CESPHNs Strategic Plan 2022-2024 and CESPHNs Digital Health Strategic Plan 2022-2025.

There are significant opportunities for CESPHN to create greater professional connections between AHPs and other local primary health providers such as general practice and increase the uptake and use of digital health technologies. Our three year allied health engagement strategy (2022-2025) focuses on:

- **Improving the quality of data on allied health, understanding the make-up of providers, where and how they practice and the tools they are using**
- **Targeted and personalised CPD events and webinars for AHPs**
- **Normalising digital health technologies and workflows with allied health for a more connected system**
- **Linking allied health disciplines to existing HealthPathways for GPs**
- **Advocating for the use of quality improvement frameworks**
- **Increasing the use of patient reported measures.**

Impact

The impact of our engagement since the strategy was launched in May 2022 includes:

- **The employment of a dedicated Allied Health Integration Officer**
- **Improved data quality on allied health and increased identification of AHPs in the region**
- **Conducted four CPD webinars targeting AHPs**
- **Supported 18 AHPs to connect to digital health technologies, which have included telehealth, My Health Record and secure messaging**
- **Recognition of allied health in digital adoption through the CESPHNs inaugural Primary Health Awards**

Case Study 12: WentWest, the Western Sydney PHN

Primary Centred Medical Home (2014 - current)

Stakeholders: **WentWest (Western Sydney Primary Health Network), general practice, allied health, Western Sydney Local Health District**

This case study relates to:

Integration, models of care and funding

Data, quality and digital maturity

Key contact and email: Maria Pipicella (Maria.Pipicella@wentwest.com.au)

Challenge

For the years 2012-2014, dedicated funding was available for an Allied Health Program delivered by two full-time Medicare Local staff. The team offered practice visits, educational workshops, role and scope of allied health introductory videos, business model development and accreditation support. The program facilitated access to Healthlink secure messaging and the PenCat platform, national services directory registration support, shared care planning tool implementation, and My Health Record (MHR) support for 348 Allied Health practices and 178 Pharmacies across the region. This provided support to Allied Health practices which was similar to the ongoing support offered to General Practices. Without dedicated funding, capacity to provide this kind of support to Allied Health practices has been constrained.

Solution

WentWest partners with general practices, applying the 10 Building Blocks of High Performing Primary Care framework under the Patient Centred Medical Home (PCMH) model. PCMH focuses on the first four Foundational Building Blocks (Engaged Leadership, Data Driven Improvements, Patient Registration and Team Based Care). In 2019 we began designing the healthcare neighbourhood (general practices, allied health, local NGOs, specialists and hospitals) to take forward more effective, integrated health and eventually, social care delivery. The participating 24 General Practices have access to a range of tools, including CareMonitor, an electronic shared care planning tool to enable coordinated integrated team based care with other care providers. This electronic shared care planning tool supports communication across the neighbourhood partnerships, including Allied Health, for shared care planning and reviews, patient self-management apps, and telehealth. Through the PCMH model, the Western Sydney Local Health District contributes a designated Care Coordinator to a practice to support their patients into tertiary care when required. With the right support, there is an opportunity to incorporate the more diverse digital needs of Allied Health in this journey and move towards a similar model of funded support as established for general practice.

Impact

Health system benefits include:

- **Increase in team-based care and shared case conferencing**
- **Increase in general practice, nursing and allied health working at top of scope**
- **Better alignment of care to patient and family needs**
- **Increase in allied health information included in My Health Record, to inform GP-patient decisions**
- **Opportunity to incorporate allied health digital information into secondary data whole-of-pathway evaluation**
- **Reduced emergency department visits, hospitalisations and readmissions**
- **Reduced duplication of services**
- **Decreased total health spending**


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