PHN Allied Health Case Studies

2024

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

phn COOPERATIVE

An Australian Government Initiative

Introduction

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

Case studies are nominated under the 6 areas of opportunities listed in the National PHN Allied Health in Primary Care Engagement Framework, (excluding Nationally-led collaboration):



Integration, models of care and funding



Workforce & Access to Allied Health Care



Practice Engagement



Governance and culture



Data, quality and digital maturity

In addition to the subcategories of case studies listed above, in 2024, case studies are intended to be used to support the development of two PHN policy papers focused on the areas of progressing PHN workforce data and integration, models of care and funding.

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

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

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

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

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		LinkMyCare – COPD (funded under Collaborative Commissioning)	✓	✓			
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Case Study: Capital Health Network

Title: ACT Breathlessness Intervention Service

Stakeholders: Capital Health Network, Southside Physio, University of Technology Sydney (UTS) (co-design and program evaluation)

This case study relates to:



Integration, models of care and funding

Key contact name and email: Ros Kirk r.kirk@chnact.org.au	Year of commencement: 2023	PHN Funding Source/s: After Hours and Greater Choice for At Home Palliative Care.

The Challenge: Chronic illness is a leading cause of death in Australia. Breathlessness is one of the most distressing and disabling symptoms in advanced chronic disease. Despite optimal medical management, patients experience breathlessness everyday leading anxiety & panic, social isolation and reduced function. Internationally, growing research supports the use of non-pharmacological symptom-based care to lessen effects of breathlessness to improve quality of life, assist families/carers in distress and potentially reduce hospital admissions. Despite the research, there are few available services in Australia, including the ACT, that focus on the management of breathlessness.

The Solution: A pilot home breathlessness intervention service tailored for the ACT (ABIS) was co-designed with consumers and clinicians. UTS was engaged to lead the co-design and evaluate the pilot. Southside Physio Team were commissioned to deliver the home service. Patients are eligible if they have breathlessness from chronic disease rated as ≥2 on the modified Medical Research Council (mMRC) scale. Referrals were initially invited from general practice and one inpatient respiratory service. This has since broadened to all medical referrers across the ACT. The pilot runs from March 2023 – December 2024 and is based on the University of Cambridge Breathing Thinking Functioning (BTF) Model. Patients and carers receive an initial assessment by a physiotherapist at home, with up to 6 follow-up visits determined by need. A phone call follow up is carried out at 3- and 6-month mark. The BTF model is a non-pharmacological approach that focuses on 3 domains of breathlessness - breathing, thinking and functioning - which supports health professionals to provide personalised breathlessness management for their patients, providing education on non-pharmacological management, exercise and other lifestyle factors. The interventions empower patients to self-manage and improve their control of their breathlessness.
The aim of the ABIS pilot is to appraise its feasibility and impact on patient and carer outcomes. A quality improvement approach was taken using plan-do-study-act (PDSA) cycles. The project's SMART goal was 100 patients completing ABIS within 12-months, with at least 75% reporting clinically important benefits on one or more outcome: activities of daily living (ADL) selected by each patient, severity of worst breathlessness and breathlessness mastery. Self-reported ambulance avoidance and carer confidence were also measured. Semi-structured interviews were conducted with patients/carers via phone to canvass their perceptions of the service.

The Impact: From March 2023 to June 2024, 124 patients had been referred to ABIS and 70 had completed the program. Most patients discharged received 4-5 visits. Referrals have been received from GPs, respiratory, geriatric and renal teams. 80% of patients had lung disease and 17% heart disease. All patients completing ABIS achieved improvement on at least one outcome measure: 68 (97%) on ≥1 ADL, 48 (69%) on worst breathlessness, and 52 (74%) on mastery. 18 (24%) patients reported thinking about calling an ambulance on 32 occasions but self-managing instead. 48/58 (76%) carers reported improvements in confidence. Patients and carers have reported benefits to mental as well as physical health, especially praising the person-centred, coaching aspects of service delivery and its delivery in the community (home) rather than outpatient setting. Very few had received previous support for management of breathlessness, regardless of specialist involvement.

Implications for policy? This pre/post evaluation adds to evidence that Breathlessness Intervention Services improve patient and carer outcomes, including hospital avoidance. Public-private partnerships can enable home community-based access to support for people with chronic illness whose lives are substantially impacted by persistent breathlessness. Other considerations should include commissioning private allied health providers to provide a community-based BIS including the utilisation of existing MBS items; funding and formation of a BIS within ACT Health Community Care Program – AH Domiciliary Program.

Case Study: Capital Health Network

Title: Healthy Aging Early Intervention

Stakeholders: Capital Health Network, Interchange Health Co-operative, Allied Health providers (Endeavour Therapy Services; Southside Physio)

This case study relates to:



Integration, models of care and funding

Key contact name and email: Jessica Hewson - j.hewson@chnact.org.au	Year of commencement: 2023	PHN Funding Source/s: Department of Health – Aged Care Funding

The Challenge

Some older Australians are entering aged care earlier than they may otherwise need to due to a lack of support for healthy ageing or ability to manage their chronic conditions in the community.

The Solution

Over the last 12 months, CHN has commissioned 6 providers to deliver a Healthy Ageing, Early Intervention program. Community care providers undertake activities that support older persons to live at home longer. By aiming to promote healthy ageing, slow decline, and support the ongoing management of chronic conditions. The program also involves:

- Co-design and implementation of targeted interventions to prevent, identify and reduce chronic disease and health issues, avoid inappropriate hospital admissions and improve health outcomes for the elderly.
- Supporting collaborative approaches between multidisciplinary teams and primary care providers.
- Expanding existing healthy ageing programs where relevant.
- Educating primary health care providers on how to connect senior Australians with necessary psychosocial, health, social and welfare supports.
- Educating family members or carers on how to manage an older person's health.

One of the providers, Interchange Health Co-operative involved a multidisciplinary team led by a nurse coordinator with the aim to prevent chronic conditions and health issues to reduce hospitalisation. The program involves an Exercise Physiologist (Exercise programs), Occupational Therapist (Home Reviews), Pharmacist (Medication Reviews), Nurse (Healthy Ageing Assessment), Dietitian (Nutrition Review, Health Checks, Group Sessions), and a Social Worker (Group/Individual Sessions).

The Impact

The Interchange Health Co-operative has had a total of 149 participants involved in the program over the last year. With a total of 354 service occasions with each component of the program. Participants have reported that they have increased strength, endurance, balance and function after completing the program. Specific comments include reduced substance use, reduced pain, improved sleep, increased strength and endurance, and improved balance and function.

Implications for policy?

Funding models/policy change is needed to address several key barriers that were identified across the Healthy Ageing, Early Intervention program that reduced participation. Some recommended changes would be improving the accessibility to community programs - by subsidising or supporting transportation to the programs. Developing funding models to alleviate the financial barrier to participants can ensure that costs does not deter participation. By addressing these areas through targeted policy interventions, programs can be more inclusive for the ageing population.

Case Study: Adelaide PHN

Title: Early Intervention

Stakeholders: General Practices, General Practitioners, Allied Health providers, older persons

This case study relates to:



Integration, models of care and funding



Practice Engagement

Key contact name and email: **Krystle Meyers, kmeyers@adelaidephn.com.au**	Year of commencement: **2024**	PHN Funding Source/s:

The Challenge: In response to the Aged Care Royal Commission, the Australian Government announced investment in the 2021-22 budget to improve access to primary care for senior Australians. Adelaide PHN supported general practice in early monitoring and identification of health needs to support people to live at home for longer.

The Solution: ***"Early Intervention Initiatives to Support Healthy Ageing and Ongoing Management of Chronic Conditions for persons aged 40 to 70 years old in the Adelaide PHN region."***
10 dedicated General Practices undertook 3 x12 week sprints of activity to drive primary care quality improvement over 12 months which are led by General Practice quality improvement consultants. There was a focus on supporting individuals aged between 40-70 and who were at risk or recently diagnosed with a chronic condition, frailty and/or dementia. Local medical neighborhood activities were undertaken by the involved practices to support stronger relationships and coordinated care with common allied health and specialists which the practices refer to regularly. Activities included opportunities to meet and share information regarding services available, case conference planning and implementation and group education for patients. The General Practices and consultants developed a range of Early Intervention toolkits and tested their usage. The toolkits include clinical tools, quality improvement activities to follow, patient resources and business cases to support General Practice self-directed quality improvement activity. Practices were involved in several Community of Practices which allowed for networking, education and sharing of project activity. A project showcase event occurred which allowed for involved practices to present on their project experiences and launch the toolkits to broader primary care across the Adelaide PHN region. Project ECHO CPD opportunities were facilitated and allowed for virtual team-based learning and sharing of cases with a focus on dementia and frailty. General Practices across the Adelaide PHN region accessed these sessions. Flinders University led evaluation whereby project data will be analysed along with several interviews and focus groups for consumers and involved health practitioners

The Impact Across the project, activity focused on the importance of the local medical neighborhood activity and bringing together the care teams. Activity included case conferencing and networking opportunities with the General Practice teams and allied health professionals. Case conferencing training and implementation across the 10 involved General Practices and respective care teams was the primary focus. A total of 155 case conferences occurred in this sprint and in most cases the General Practice teams led this activity and invited allied health to contribute along with the involved patient. The involved practices added in brain health and frailty checks in to all forms of health assessments and chronic disease management planning which allowed for broader screening opportunities amongst a larger patient cohort and supported better preventative measures. General practices and key allied health contacts connected to each practice attended face-to-face education and networking sessions which allowed for shared learning as well as the ability to strengthen relationships with other practices. There was opportunity to work through case studies and agree on some common principles to enhance team care. Two ECHOs were coordinated over the project period, one with a focus on frailty and one with a focus on dementia. Both were well attended by primary care clinicians across the Adelaide PHN with positive feedback reported.

Implications for policy? Supporting older persons in Australia requires a comprehensive approach that addresses their unique needs and challenges. Some key policy considerations could include;
•**Strengthen Aged Care Services -** Increase funding for aged care services to improve quality, accessibility, and affordability. Invest in training and support for aged care workers to ensure high standards of care and address workforce shortages.
•**Enhance Primary and Preventive Care -** Integrated Care Models: Develop integrated care models that coordinate primary, specialty, and social services. Preventive Health Programs: Expand programs focused on preventive health to manage chronic conditions and promote healthy aging. This includes access to screenings, vaccinations, and wellness programs.
•**Improve Access to Healthcare -** Increase access to home-based medical services for older individuals who prefer or need to receive care in their own homes. Expand telehealth options to facilitate remote consultations and follow-up care, especially for those in rural or remote areas.
•**Aging in Place - p**romote policies that support aging in place, including modifications to homes to improve accessibility and safety for older adults.
•**Address Social Isolation -** Develop and fund community programs and activities that reduce social isolation and promote engagement among older individuals. Provide training and resources to improve digital literacy, helping older Australians stay connected and access online services.
•**Research and Data Collection -** Invest in research to better understand the needs and challenges of the aging population and use this data to inform policy. Improve data collection and monitoring systems to track the effectiveness of policies and programs aimed at supporting older Australians.

Case Study: Adelaide PHN

Title: Nurse Practitioners in Primary Care

Stakeholders: General Practices, General Practitioners, Allied Health providers, vulnerable populations

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Krystle Meyers, kmeyers@adelaidephn.com.au	**Year of commencement:** 2024	**PHN Funding Source/s:**

The Challenge

Demand for primary care services are expected to increase over the next 10 years due to the aging population, higher prevalence of chronic conditions, and greater emphasis on preventive care.
Availability of the primary care workforce is likely to be influenced by several key factors over this time, including but not limited to, growing demand, physician shortages, policy changes, technological advances, workforce development, geographic and demographic shifts and the expansion of roles for Nurse Practitioners and Physician Assistants.
Growing economic challenges across Australia have seen a downturn in bulk-billing practices leading to increased out of pocket expenses. Challenges such as inflation and changes in the economic landscape, affect both patient ability to pay and the financial viability of bulk billing practices, leading to a greater perveance of co-payments and out-of-pocket expenses, impacting on access to healthcare, particularly for those from vulnerable population groups.

The Solution

High quality primary care delivery depends more and more on health care teams, harnessing the strengths and skills of the diverse health workforce, including GPs, nurses, nurse practitioners and midwives, pharmacists, allied health professionals, Aboriginal and Torres Strait Islander health workers and others. Outcomes(*source, strengthening Medicare Taskforce Report, December 2022).
The Nurse Practitioner and Team Based Care Pilot (the Pilot) will fund Nurse Practitioners (NPs) until June 2025, who will work in collaboration with other health practitioners in primary care, to diagnose, treat, prescribe, and refer patients within their approved scope of practice. Services provided by the Nurse Practitioner will be provided free of charge, supporting access to healthcare for those who are most vulnerable in our communities.
Pilot recruitment utilized population health and workforce needs assessment data, targeting areas of high need, low access in the Adelaide PHN region, utilizing a place-based model of care while supporting health equity.
3 General Practices and 3 nurse practitioners (1 at .8FTE and 2 at .6FTE) have been recruited to the pilot project to date. General Practices are located across the PHN region in areas of high need and low access.

The Impact

In partnership with the South Australian Department for Health and Wellbeing, the Pilot aims to enhance the availability and accessibility of comprehensive primary care to the metropolitan Adelaide community, including supporting the delivery of care to vulnerable and underserviced populations and innovative models of care. The funding ensures the services offered through the Pilot are free to patients and in addition to existing services.
Further information on the impact of the pilot and formal evaluation will be made available at the end of the pilot in July 2025.

Implications for policy?

Funding and regulatory arrangements should support all parts of the primary care workforce to work to their full scope of practice and to collaborate across the health and other care systems, optimising the use of our most vital workforce resources, and supporting the delivery of person-centred care.
Addressing these challenges involves a multifaceted approach, including increasing support for primary care training programs, enhancing financial incentives, expanding the roles of nurse practitioners and physician assistants, and implementing policies to improve work-life balance and reduce burnout.
Efforts to improve the distribution of primary care providers and integrate technology effectively could also assist in addressing workforce challenges.

Case Study: Brisbane South PHN

Title: ACTMed - Activating pharmacists to reduce medication related problems: The ACTMed stepped wedge randomised controlled trial

Stakeholders: Brisbane South PHN, The University of Queensland, The University of Melbourne, Australian Digital Health Agency, Future Health Today, National Aboriginal Community Controlled Health Organisation, Pharmaceutical Society of Australia, Pharmacy Guild of Australia

This case study relates to:



Integration, models of care and funding



Data, quality and digital maturity

Key contacts: Nicolette Ellis (nellis@bsphn.org.au), Nicole Forrester (nforrester@bsphn.org.au)	Year of commencement:2022	PHN Funding Source/s: MRFF Grant

The Challenge

Serious medication-related problems (MRPs) can lead to a range of life-threatening issues such as hemorrhage, exacerbation of heart failure, renal failure or acute asthma, causing unplanned hospitalisations, serious and costly health complications or death. In Australia, it is estimated that 250,000 hospital admissions and 400,000 emergency presentations were due to potentially preventable medication-related hospitalisations, at a cost of $1.4 billion per year. MRPs occur for a range of systemic reasons including: i) consulting time constraints of doctors and pharmacists; ii) the involvement of multiple prescribers and dispensers in consumer care; iii) increased reliance on medications to manage chronic illness (increased complexity of care); iv) weaknesses in the recording and presentation of the necessary information in clinical records; and v) lack of economic incentives to proactively identify and address MRPs. Medication reviews are the only funded service currently operating in Australia focused on identifying MRPs in a structured way. However, previous studies have found little or no effect of medication review services in reducing the most serious outcomes of medication safety. Streamlined systems are required that identify and deliver targeted medicines safety interventions when they are required to the people who need them most.

The Solution

ACTMed provides an evidence-based solution. ACTMed builds upon the existing evidence base by incorporating Australian clinical indictors that have been adapted to be inclusive of Aboriginal and Torres Strait Island health. ACTMed uses innovative IT solutions and an actionable dashboard combined with economic incentives to activate the pharmacy workforce to work with general practitioners (GPs) working in either ‘mainstream’ practices and/or Aboriginal Community Controlled Health Organisations (ACCHOs) and reduce a consumer’s risk of harm and costs to the health care system. This stepped wedge randomised controlled trial (RCT) will examine whether ACTMed can significantly reduce serious MRPs, prevent medication-related hospitalisations, reduce costs and improve health. The ACTMed Service includes:

- An innovative ICT system called Future Health Today which identifies patients at risk of medicines harm
- A practice pharmacist to support team-based care of patients at risk of medicine harms
- 6 months of continuous quality improvement (QI) (Plan, Do, Study, Act) to drive patient safety

The Impact

- Full trial findings to be disseminated late 2024. 40 sites across Queensland participated in the ACTMed research trial. **All 40 sites** demonstrated data improvements, collectively processing **over 6700** individual medication safety recommendations, during the live trial phase. Anticipated benefits to patients may include a reduction in hospitalisations, improved knowledge of medicines and improved management of chronic conditions.
- 39 Sites submitted a total of **73 Plan-Do-Study-Act (PDSA) cycles** outlining changes that were tested. Successful ideas for change included streamlining communication methods, use of micro-huddles, trialing point-of-care prompts, incorporating medicines safety recommendations into chronic disease management plans, patient, and practice staff education initiatives, and trialing systems for case conferencing.
- QI coaching sessions have seen an improvement in QI knowledge for participating pharmacists and an enhanced capability to apply these principles in a practical setting. Pharmacists have reported feeling more confident to engage with future onsite QI projects.

Implications for policy?

The ACTMed trial demonstrated that there is a strong appetite for onsite general practice pharmacists. Of the 40 participating sites, more than half have continued a professional relationship with the ACTMed trial pharmacist, with almost all sites expressing an intent to do so if provided a sustainable funding stream.

Case Study: Brisbane South PHN

Title: The Aunty Joan Hendricks Bursary

Stakeholders: Brisbane South PHN, Institute for Urban Indigenous Health (IUIH)

This case study relates to:



Integration, models of care and funding



Governance and culture

Key contact name and email: Luke Booth (firstnations@bsphn.org.au)	Year of commencement: 2022	PHN Funding Source/s: PHN Funded

The Challenge

The low employment rate of First Nations peoples contributes to economic deprivation and a range of social problems. Increasing employment rates is key to reducing disadvantages for First Nations people and central to the Closing the Gap targets. Paid employment can provide the economic independence and autonomy that allow First Nations people to explore their own aspirations. TARGET 7- in the National Agreement on Closing the Gap identifies that youth are engaged in employment or education. The Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2026 recognises the significant importance of developing and supporting a First Nations workforce to enhance the cultural capability and safety of health care services provided throughout the state. This Strategic Framework identifies a number of priorities for action, including:

- Increasing the numbers of First Nations peoples entering and remaining within the health workforce
- Culturally-tailored and appropriate recruitment and retention processes
- Development and sustainment of partnerships to enhance professional development for ongoing learning opportunities
- Provision of leadership and planning development opportunities

The Solution

The Institute for Urban Indigenous Health (IUIH), has established an Academy which is a partnership between IUIH and IAHA (Indigenous Allied Health Australia) which aims to offer a supported school engagement opportunity to provide Cert III in Allied health assisting qualification thereby creating an appropriate pathway into employment and/or further study. There is a focus on wraparound support including practical assistance, transport, learning support and mentoring/pastoral care. Brisbane South PHN (BSPHN) have established the Aunty Joan Hendricks bursary to honour Aunty Joan Hendriks legacy working within the health sector and acknowledging her passion for lifelong learning. Brisbane South PHN are providing bursary scholarships in partnership with IUIH to provide school-based traineeships, in certificate III in Allied Health Assistance.

The Impact

In 2022 we commenced with 2 school-based trainees studying Certificate III in Allied Health Assistance and completing a rotation with BSPHN as part of work placement. This arrangement has been highly successful from IUIH's perspective providing opportunity for trainees to see beyond the Community Controlled Health Sector and connecting with local Aboriginal and Torres Strait Islander students within the North Stradbroke Island and surrounding areas. The program has now been extended to 5 recipients and trainees have been assisting in podiatry, Deadly Choices, oral health, exercise physiology and a community pharmacy.

Implications for policy?

- Employment is essential for achieving the Closing the Gap targets, particularly in increasing participation in the mainstream economy.
- Paid employment supports economic independence and gives First Nations people the autonomy to pursue their own goals.
- Policies should focus on creating job opportunities that respect the cultural values and aspirations of First Nations communities, promoting broader social and economic inclusion.

Case Study: Brisbane South PHN

Title: Allied Health Roundtable

Stakeholders: 25 PHNs, Department of Health & Aged Care, Queensland Health, Australian Healthcare and Hospitals Association, Allied Health Professions Australia, Indigenous Allied Health Australia, Pharmaceutical Society of Australia, Services for Australian Rural and Remote Allied Health.

This case study relates to:



Workforce & Access to Allied Health Care



Governance and culture

Key contact name and email: Nicolette Ellis (nellis@bsphn.org.au)	Year of commencement: 2024	PHN Funding Source/s: PHN Funded

The Challenge

An identified need to get the right mix of allied health and PHN stakeholders in a room for a day to share, collaborate and define policy and advocacy priorities across PHNs and allied health and pharmacy peak bodies. There had been recent endorsement from PHN CEOs to develop a National policy paper – focused on the potential role that PHNs can play in integration, evidence of MDT models and allied health workforce solutions in primary care.

The desire to expand on the collaborative relationship built over the past 7 years between a growing number of PHNs and the Pharmaceutical Society of Australia through activity to deliver pharmacist in general practice Programs. This was set amongst the backdrop of the known 'big issues' including:

- Funding issues
- Regulatory barriers
- Sustainability of models
- Workforce supply issues
- No clear picture of the number of allied health professionals working in primary care

The Solution

To convene a national allied health roundtable event with stakeholders from a range of organisations committed to enhancing collaborative allied health engagement in primary care. Presentations from the Pharmaceutical Society of Australia, Allied Health Professions Australia and Services for Australian Rural and Remote Allied Health set the scene for some interesting table discussions focused around how PHNs can leverage successes, overcome barriers and advocate for policy changes and funding to support sustainability and growth of allied health models.

The Impact

- Sharing of what has worked well and opportunities for learning among PHNs and other organisations
- Identification of the opportunities for collaborative action including applying value-based commissioning principles, advocacy and addressing data gaps.
- Commitments from the attendees to move forward and progress the work
- ***Key recommendations report provided to the PHN Cooperative Implementation Framework Group (IFG) for Allied Health***
- ***Brisbane South PHN is tabling the establishment of a Medicines Safety Working Group at the CEOs national meeting***

Implications for policy?

Scope of practice review recommendations:

- We need a nationally accepted definition of allied health and a national register of allied health professionals
- Every community has allied health professionals with different scope and skill mix – place-based service design is critical. Models of care should be designed to use the desired skills, not necessarily the specific profession.
- **Provide key recommendation to PSA regarding the Strategic Agreement and other policy and regulatory areas to improve integration of pharmacists in general practice**

Case Study: Brisbane South PHN

Title: Thriving and On Track (ToTs)

Stakeholders: Brisbane South PHN, Children's Health Qld, Department of Education, Logan Together

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Tennille Burkitt (tburkitt@bsphn.org.au)	Year of commencement: 2020	PHN Funding Source/s: PHN Funded

The Challenge

Childhood is an important time for healthy development, learning, and establishing the foundations for future wellbeing. Most Australian children are healthy, safe, and doing well. However, childhood is also a time of vulnerability and a child's outcomes can vary depending on circumstances. AEDC data for Logan and Inala indicates up to 40% of children are presenting to school with developmental vulnerability in one or more domains, compared with the Qld average of 24.7%. Many families experiencing vulnerability are not engaging with traditional health system supports (only 10% of families supported by the Thriving on track (ToTs) Initiative have had contact with the Child Health Service in the past 12 months).

The Solution

ToTs is a cross-sector collaborative initiative that has been co-developed over the last 4 years to improve access to health screening, early intervention services and family support services for young children in target locations. The program was developed in response to existing service gaps in ensuring children aged 1 to 4 years are meeting their developmental milestones .The ToTs initiative employs a place-based approach that targets specific geographical locations and population groups that face increased developmental vulnerability. The initiative is delivered in community hubs and early childhood education centres (ECEC) with transdisciplinary clinicians that:

1. assist children and families to access developmental support by providing developmental screening and allied health support and intervention in these environments
2. build the capacity of families and early childhood educators to support and promote children's development, including a tailored service to support and build the capacity of educators at each ECEC within the given service region

The Impact

There are encouraging results to date, including over 2700 children completing developmental screening, over 1000 children completing secondary developmental assessments with a Child Health Nurse and over 500 children accessing early allied health support. FY24 ToTs outcomes:

- 340 early childhood educators supported to understand and respond to the developmental presentations of children in their classroom
- 85% of surveyed educators strongly agreed the support increased their confidence in supporting children in their class
- 97 children and their families provided with culturally safe and appropriate allied health support in community hubs
- 40 children and their families provided with 1:1 intervention in early childhood education centres

Implications for policy?

- Clarity of state and federal funding responsibilities, in addition to adequate funding to provide foundational supports at a population level and more targeted supports for those who need them
- Place-based solutions to promote accessibility for vulnerable families
- Integrated, early intervention for children and families with a stepped care model delivered in community with a focus on building the capacity of those in the environment to promote children's development

Case Study: Central and Eastern Sydney PHN

Title: First Nations Early Intervention Speech Pathology Program

Stakeholders: South Eastern Sydney Local Health District, Sydney Children's Hospital, First Nations communities.

This case study relates to:

Integration, models of care and funding

Workforce & Access to Allied Health Care

Key contact name and email: Brendan Goodger. General Manager, Primary Care Improvement b.goodger@cesphn.com.au	**Year of commencement: 2018**	**PHN Funding Source/s: Flexible** **Focus on: Early Intervention Speech Pathology**

The Challenge

In 2017, CESPHN identified a significant gap in services for vulnerable children, identifying the need for early intervention speech pathology services to enhance long-term health outcomes.
In Australia, approximately 20% of children start school with a speech, language, or communication impairment, with higher rates in socially disadvantaged and Aboriginal populations. The early years (0-6) are critical for language acquisition, laying the foundation for learning, social interaction, and emotional development. Early screening and intervention are crucial for preventing long-term issues that can impact academic performance, social relationships, and future employment. There is clear evidence that addressing children's speech and language needs early results in lasting benefits throughout their lives.

The Solution

The First Nations Early Intervention Speech Pathology program, established in 2018 by CESPHN and Sydney Children's Hospital Network (SCHN), and in collaboration with South Eastern Sydney LHD (SESLHD) since 2024, provides culturally appropriate services to Aboriginal and Torres Strait Islander children and their families. The program focuses on early intervention for developmental and communication challenges for First Nations children. It provides targeted speech pathology assessments and interventions for children identified at medium to high risk, and developmental support for low-risk children. The program also includes capacity building for early childhood staff to better support children with communication challenges. The program was developed in partnership with the local First Nations community and is supported by an Aboriginal Health Worker. The approach involves close collaboration among speech pathologists, early childhood staff, caregivers, First Nations community and other health professionals. Services are delivered at early childhood education centres, community health centres, events, and playgroups.

The Impact

Since the program's inception in 2018, over 6,500 Aboriginal children have been screened for developmental and communication challenges, with approximately 1,200 receiving targeted speech pathology interventions. The capacity building component for early childhood staff has notably improved educator confidence and proficiency in key areas such as vocabulary, language, phonological awareness, print concepts, and play techniques.

During FY23/24 the program expanded to include support for children transitioning to school by enhancing their vocabulary, attention, listening skills, and use of complex sentences. The Speech Pathology team successfully partnered with Gujaga Preschool, an Aboriginal-run preschool in La Perouse, to implement a language and pre-literacy program. The program, co-facilitated with Gujaga staff, also focused on capacity building and promoting in-language skills. Additionally, the La Perouse School Starters Group, which ran for two weeks in January 2024, assisted 22 Aboriginal children preparing for school. The program aims to expand its reach by collaborating with local kindergarten orientations for tailored transition support.

The program's success in addressing developmental and communication challenges early through targeted interventions and comprehensive support, highlights its critical role in improving outcomes for First Nations children. Its culturally tailored approach and collaborative model ensure effective service delivery and meaningful community engagement. Qualitative feedback from early childhood education providers indicates that without the program many children would have been 'left behind,' as many families cannot afford private speech pathology services. Given its proven benefits and the ongoing need for such support, it is essential to maintain and strengthen the program to continue enhancing the well-being and development of at-risk First Nations children.

Case Study: Central and Eastern Sydney PHN

Title: Healthy Ageing - Primary Care Workforce

Stakeholders: Local community councils and service groups, general practices and allied health.

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Brendan Goodger, General Manager, Primary Care Improvement b.goodger@cesphn.com.au	**Year of commencement: December 2022**	**PHN Funding Source: Flexible Focus on: Integration – Healthy Ageing – Primary Care Workforce**

The Challenge

GPs often lack the time to support social prescribing and service navigation which links older people to non-medical supports addressing the social determinants of health and activity in the community to improve mental and physical health and well-being. The Healthy ageing hubs initiative aims to provide an important conduit between general practice and the additional health and social care needs often required by older people in order to manage their health, independence and well-being.

The Solution

Staffed by social workers, healthy ageing hubs assist older people to know what programs, services and groups are available in the community to help them maintain their health and well-being and how to access them. They provide practical navigation support and help older people resolve practical issues associated with ageing. The hubs offer in person or phone-based support tailored to meet individual needs. This includes assistance connecting with;

- Local programs, services, groups and activities of interest
- My Aged Care services
- Healthy eating, strength and movement programs
- Mental health and wellbeing programs
- End of life planning support, and
- Legal, housing and financial assistance services

The healthy ageing hubs;

- Form a back-drop to social prescribing for our GPs and other primary health care workers lacking the time to assist older people to access the non-medical care and social support services they need
- Empower consumers to take the lead in the provision of their own health by seeking out information on health and social services available to them close to where they live

The Impact

In the last year the healthy ageing hubs have:

- Provided individual support to over 1000 older people covering a wide variety of health topics such as diet and exercise, navigating local health services, aged care support services, and end of life planning
- Delivered over 100 community education sessions, attended by more than 3000 older people in the Sutherland and Inner West regions
- Taken regular referrals from over 50 GP practices in the Sutherland and Inner West regions of Sydney
- Collaborated with local councils, hospital workers and local community service providers in multi-agency awareness raising health promotion activities, to bridge the gap between health and community services

Case Study: COORDINARE Limited (SENSWPHN)

Title: LinkMyCare – COPD (funded under Collaborative Commissioning)

Stakeholders: Commissioning of Pulmonary Rehabilitation providers by the PHN

This case study relates to:

Integration, models of care and funding

Workforce & Access to Allied Health Care

Key contact name and email: James Linden – jlinden@coordinare.org.au	Year of commencement: 2024	PHN Funding Source/s: NSW Ministry of Health

The Challenge

There are many barriers facing COPD patients after an exacerbation in obtaining timely Pulmonary Rehabilitation (PR) services. The waiting time for the delivery of PR in a hospital setting can be up to 6 months, and the long travel distances for those in rural and regional areas are major barriers. Research shows that patients are at high risk of re-exacerbation and re-admission in the early recovery phase. Research shows a ***significant reduction in hospital admissions*** in patients enrolled in PR programs following an exacerbation. The challenge was how to provide PR services to patients in rural and remote areas, in close proximity to the LinkMyCare – COPD commissioned practices where the core interventions (cycle of care) will be delivered.

The Solution

Through the LinkMyCare – COPD program, COORDINARE plan to make Pulmonary Rehabilitation more accessible to those patients in rural and remote areas, and to reduce waiting times. COORDINARE, with the support of the Physio Australia Association, will commission allied health providers, experienced in the delivery of rehabilitation services and with an interest in the delivery of pulmonary rehabilitation. The commissioned allied health providers will be located in close proximity to the commissioned practices, removing the travel barrier, and will be provided training in the delivery of PR. Referrals will be made from either the hospital setting or a commissioned practice to the closest commissioned PR provider. It will be up to the commissioned allied health provider to decide if they will run the PR service out of their own business premises or to work with a local general practice to enable the service to be delivered within their premises. Contract arrangements will cover the training and cost of the delivery of the PR program, ensuring no out-of-pocket costs for the patients.

The Impact

The patients' referred to the allied health PR services will be monitored to ascertain if there is a reduction in exacerbations and re-admissions post exacerbation, when compared to patients who did not receive the intervention. Patient wellbeing surveys, as well as the St George's Respiratory Questionnaire for COPD patients, will be completed pre and post intervention to measure any improvements in the patients' overall health.

Implications for policy?

Evaluation will demonstrate the impact of PR access on outcomes for COPD patients and should support a case for change to MBS items to include the delivery of PR by allied health providers in the community.

Case Study: COORDINARE Limited (SENSWPHN)

Title: LinkMyCare – COPD (funded under Collaborative Commissioning)

Stakeholders: Lungs in Action Programs within the Community

This case study relates to:

Integration, models of care and funding

Workforce & Access to Allied Health Care

Key contact name and email: James Linden – jlinden@coordinare.org.au	Year of commencement: 2024	PHN Funding Source/s: NSW Ministry of Health

The Challenge

Presently there are only two Lungs in Action programs in the SENSWPHN region. One in Wollongong and the other in Goulburn. COPD patients outside of those catchment areas have no further pathway for group exercise programs delivered specifically for COPD patients.

The Solution

Through the LinkMyCare – COPD program, and in conjunction with the Lung Foundation, COORDINARE plan to fund the set up of additional Lungs in Action groups, managed by an exercise physiologist (EP), within close proximity to practices enrolled in the program. This will enable COPD patients, who have completed a PR program, to continue to get exercise support in a supportive environment. COORDINARE will train and commission EPs to deliver the program utilising approved NSW Health collaborative commissioning funding.

The Impact

The patients' who have completed a PR program after an exacerbation, and transitioned into a Lungs in Action group, will be able to build on what they achieved through the PR service. Research shows that continuing to exercise regularly after participation in PR helps to maintain the benefits achieved. It also improves symptoms of breathlessness, making daily activities such as cooking or doing the washing easier, increasing the patients' independence. Due to the group setting of Lungs in Action attendance on a regular basis also decreases social isolation and provides the opportunity to meet and socialise with people who have a lived experience of lung disease, enhancing community connectedness and belonging.

Case Study: Darling Downs & West Moreton PHN

Title: Indigenous Wellness Connect

Stakeholders: Allied health professionals, General Practice, Aboriginal and Torres Strait Islander people

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Project Coordinator Melissa Lansbury melissa.Lansbury@ddwmphn.com.au	Year of commencement: 2024	PHN Funding Source/s: IMOC (Innovative Model of Care) Commonwealth Government Grant

The Challenge

Toomelah and Boggabilla are towns on the border of NSW and QLD with a predominantly Indigenous population and limited onsite attendance from primary care providers and unreliable telecommunications connectivity. Access to the closest General Practice and range of Allied Health services is in the township of Goondiwindi in Queensland, with the closest specialist care in Toowoomba. Within the Boggabilla and Toomelah Health Clinic patients, there are a high prevalence of chronic conditions including mental health, cardiovascular disease and diabetes.

The Solution

The Indigenous Wellness Connect model was developed as a solution to the access issues experienced by the Toomelah, Boggabilla and Goondiwindi areas. The model will improve equity of access for Aboriginal and Torres Strait Islander people based in rural and remote Australia. It will also support the non-Indigenous population for management of chronic health conditions.

The model will introduce a Telehealth Hub co-located at the local Medical Centre. A health professional will be recruited as a Telehealth Hub Care Coordinator and Aboriginal Health Worker and will be embedded within the local General Practice in Goondiwindi. The Hub Care Coordinator will work closely with eligible patients and the Multidisciplinary Team (MDT) to facilitate access to care. The role includes triaging patients/assessments; receiving and monitoring device outputs (via a Telehealth cart); booking and coordinating appointments; coordinating transport; patient communication and advocacy; and support with health literacy. The Allied Health Professional will facilitate an initial MDT assessment. This will identify goals, coordinate services, self-management, shared care-planning case conferencing, and transition supports (e.g. discharge processes), ensuring culturally safe services are delivered. Care will be delivered through a connected network of primary care services to the closest primary care hub and beyond to support underserviced rural communities with Indigenous populations. The care model will include the use of a sophisticated telehealth cart system with diagnostic peripheral tools, enhanced digital satellite connectivity, and remote support from a multidisciplinary team of General Practitioners, Allied Health and Specialists.

The Impact

This pilot project will commence in August 2024, and as such, it is not possible to provide any evaluation to date. However, successful execution of this program will result in patients receiving ongoing MDT care and continuous improvement to culturally safe primary care services. Success will be evaluated through ongoing patient and provider reported outcome measures.

Implications for policy?

To improve continuity of care across the Queensland and NSW Health jurisdictions, a model of patient consent and data sharing between hospitals, rural health clinics, ACHOs and GPs will be established. Reduce the barriers impacting the Cross-border communities to access the most suitable health care locally when required.

Case Study: Gold Coast PHN

Title: Early Intervention initiatives to support healthy ageing

Stakeholders: Gold Coast PHN, commissioned service providers, consumers, general practitioners and general practice staff in the region.

This case study relates to:



Integration, models of care and funding



Practice Engagement

Key contact name and email: Ella Baitieri [EllaB@gcphn.com.au]	**Year of commencement: 2023**	**PHN Funding Source/s:** Primary Health Networks – Aged Care Funding – Commissioning early intervention initiatives to support healthy ageing

The Challenge Approximately one-quarter of people over the age of 70 on the Gold Coast are considered frail. This means they often feel tired, weak, and may struggle with walking 300 metres or climbing ten stairs without assistance. Many also face serious health issues such as cancer, heart disease, or diabetes. It is crucial for those who are/or at risk of becoming frail, to have access to high-quality programs that enhance limb strength, functional movement, and balance. With one of the highest rates of older people nationally, the GCPHN region has a strong need for older Australians to be supported to manage frailty and chronic conditions in the community.

The Solution

GCPHN implemented an innovative agile project approach through multi pronged program streams, in order to achieve the program outcomes, set by the Department of Health and Aged Care. Three commissioned services were established; Frailty Care in the Community, the BUnyAH Interprofessional Healthy Lifestyle Program, and the Mungulli Yarn and Walk Program. These services have been specifically designed to manage frailty and positively impact participants' mobility and overall quality of life. These programs empower individuals to reduce their risk of falls and loss of independence by working with multidisciplinary teams comprising exercise physios, occupational therapists, pharmacists and other allied health, to improve physical strength, nutrition, cognition, mental health, and social support. They also enhance access to community health services, reduce isolation, foster social participation, and provide ongoing support after the programs have finished. By providing fully funded, professional, and multidisciplinary care within the community, treatment can be tailored to address the unique needs of each participant. This activity is supported by a dedicated health promotion campaign, *I am not frail*, as well as facilitated general practice quality improvement (QI) activities.

The Impact

Health promotion:

- Following extensive consumer consultation, the *I am not frail* campaign launched in January 2024 utilising a combination of Facebook, digital display and digital out of home advertising, cinema advertising and good news stories, all of which far exceeded media targets and benchmarks.
- In total, the campaign achieved 1,059,411 impressions (the total number of times ads were seen by the audience), and more than 7,700 clicks to the *I am not frail* GCPHN website landing page (which was the top viewed page for 2023-24).

- Commissioned services: Early provider results indicate a high level of client satisfaction with the program, as well as enhanced multidisciplinary collaboration. Significant increase in program uptake since launch of health promotion campaign, with programs building referral base as awareness grows. Participants reporting improved confidence, mobility, and strong satisfaction with both education and exercise program components.
  - *"It's all very social working with the instructors and doing the group circuit work with likeminded people just wanting to stay fit and healthy. The big thing I found was if you lose your balance, you can get it back, it doesn't have to go forever"* – Giulia, Frailty Care in the Community participant.
  - *"With ageing, you need to get out of bed and have something to do, and this gave me that thing"* – John, BUnyAH Interprofessional Healthy Lifestyle Program participant.
- General Practice QI Activity: Improvement was noted in 6 of 7 data measures. Of those, 5 measures showed the level of improvement was higher in QI/clinical audit participating practices, compared to non-participating practices. Screening for (and diagnosing frailty) was a key component of the QI activity to proactively provide early intervention.

Implications for policy?

Without ongoing funding, services will not be able to continue in the community. This is due to vulnerability and affordability limitations of the target population accessing these programs, often being pensioners over the age of 65 (55 for Aboriginal and Torres Strait Islander people).

Case Study: Hunter New England Central Coast PHN

Title: Allied Health Engagement

Stakeholders: HNECC PHN - Integrated Care team & Marketing and Communications team

This case study relates to:



Workforce & Access to Allied Health Care



Data, quality and digital maturity

Key contact name and email: Jo Dean jdean@thephn.com.au	Year of commencement: 2024	PHN Funding Source/s: Core Flex

The Challenge

Allied Health did not initially have strong engagement with the PHN and there are limited PHN resources available to support such a large number of allied health practices in our region.
As a result, we face significant challenges with maintaining up-to-date and effective data base for Allied health practices .The transient nature of the sectors clinicians along with frequent changes in practices opening and closing can make it difficult to track effectively. There are still many allied health in our region that we are not connecting with and have no understanding of the supports our PHN can offer allied health.

The Solution

The PHN Integrated Care Team in collaboration with the Marketing, Engagement and Communications team developed a comprehensive engagement plan for the 2023-2024 fiscal year. The primary objective of this plan was to enhance engagement between Allied Health professionals and the PHN through a series of networking, educational, and promotional initiatives. The high- level areas of focus were set out as follows;

- Allied Health Conference held in May 2024, focusing on connection, technology and multidisciplinary team care
- Education sessions: at least four targeted allied health educations sessions
- Face to Face engagement & Networking events: to gather information on allied health needs by attending conferences, site visits and hosting allied health breakfasts
- Allied health initiatives and group coaching: offering access to training in business skills, wellness for clinicians and pride membership training (to enhance equity of access)
- Workforce connections: by engaging with Universities and workforce agencies attending university Careers Expo, partnered with local universities to deliver a Mental Health Innovation Challenge
- Increase social media presence: developing news articles sharing good news stories and interviewing local clinicians and writing articles on key industry professions days
- Database: set a target to increase the number of new practices added and data quality.

The Impact

By increasing our face –to- face engagement we reached over 300 allied health clinicians which has helped us to build stronger connections with the allied health sector and increased our two-way engagement. Our allied health conference sold out attracting 127 delegates face to face and 100 joining the live stream option. As a result, we are looking at extending the capacity for our future conferences. The networking events enabled our PHN team to gain valuable insights into local needs providing valuable input into planning our future initiatives. By engaging with Universities and workforce agencies our PHN is creating awareness of our organisation and the supports we offer for our future workforce. We also increased our database numbers by 15% which will assist with improving targeted communications moving forward. Whilst we know our engagement has increased, we do not have a good understanding of the percentage of total allied health in our region working in primary care we have reached, due to a lack of workforce data available to PHNs.

Implications for policy? Capturing local PHN allied workforce is a manual, heavy human resource process. Access to quality primary care allied health workforce data would better assist PHNs to determine community needs and service requirements through inclusion in core needs assessments, provide support the existing and future workforce and measure the impact of engagement strategies.

Case Study: Hunter New England Central Coast PHN

Title: Allied Health Outreach

Stakeholders: HNECC PHN, Recovery Station and multiple rural service providers

This case study relates to:

Integration, models of care and funding

Workforce & Access to Allied Health Care

Key contact name and email: Joanna Coutts jcoutts@thephn.com.au Jo Dean jdean@thephn.com.au	Year of commencement: 2023 - 24	PHN Funding Source/s: COVID-19 funding

The Challenge

Many community members in our rural towns face barriers to accessing allied health services, including long wait times, out of pocket costs, distance to travel to services and access to sub-specialty allied health services. With reduced access to services due to COVID-19 consequently, many people did not receive the necessary, timely, equitable access to care.

The Solution

A multidisciplinary allied health provider from within the HNECC PHN metropolitan region received a PHN Allied Health reconnection grant to provide a multidisciplinary approach to re-engage people with their health post COVID. Allied Health Professionals including physiotherapists, psychologists, occupational therapists and speech pathologists, travelled quarterly to areas of need to provide face to face consultations, with telehealth support offered in between visits. A training package was developed to upskill Allied Health Assistants (AHA) and the client support team, enabling ongoing clinical support between allied health professional visits. This program not only provided services to remote vulnerable groups but also built local capacity by partnering with multiple stakeholders, including referral partners, families, care staff, and GPs. One Speech Pathologist secured funding for specialist equipment to improve clinical delivery. The program was flexible, adjusting delivery sites based on referral numbers.

The Impact

The multidisciplinary team visited four regional areas, including Tamworth, Muswellbrook, Taree & Gosford, delivering over 288 hours of service through quarterly face-to-face visits. Two allied health professionals attended each visit based on clinical need, increasing allied health in primary health care delivery to priority groups such as aged, disabled, and chronically ill patients. The upskilling of the client support team improved healthcare delivery even when allied health professionals were not available in person through telehealth for patients, and ongoing support and advice between service providers. The telehealth component reduced costs of service delivery. This work also strengthen connections and networks between multidisciplinary care teams and multiple stakeholder partners.

Implications for policy? The program's strengths lie in its integrated model of care, providing tailored services to identified regions and individual community members and in building capacity of rural health care providers by liaison with senior and sub-specialty allied health providers from metropolitan areas. The multidisciplinary approach, including GPs, allied health, and NDIS providers, offers a robust, patient-centered care model in accessing health care. The model offers opportunity for ongoing capacity building for rural allied health providers, and the assistance workforce in areas of thin markets.

Case Study: Hunter New England Central Coast PHN

Title: Coffee on Country Podcasts

Stakeholders: HNECC PHN and interviewees

This case study relates to:

Workforce & Access to Allied Health Care

Data, quality and digital maturity

Key contact name and email: Kristy Lee Priestly, kleepriestly@thephn.com.au	Year of commencement: 2024	PHN Funding Source/s: ITC

The Challenge

First Nations people often underutilise health services including allied health services compared to non-First Nations people, contributing to a significant gap in life expectancy and health outcomes between these groups. This underutilisation is frequently rooted in historical events and a general mistrust of healthcare providers among First Nations communities.

The Solution

The PHN developed a series of Podcasts. *Coffee on Country - Community Yarns* aims to give voice to those who wish to be heard and identifying problems that the community faces. Coffee on Country explores solutions to the barriers that impede access to primary health services and to gain a broader understanding of the challenges faced by First Nations communities. Annual data report | Closing the Gap Information Repository - Productivity Commission (pc.gov.au)

The podcasts feature yarns conducted by the PHN's First Nations team members who lead conversations in identified communities. These conversations gather community voices and stories, share key messages about relevant health issues, provide information on available services, and normalise discussions with healthcare providers. Each podcast episode is tailored to the specific needs of the community and includes discussions on 'Closing the Gap' targets, with interviews conducted both in larger community settings and individually if participants are comfortable. The content is developed by the First Nations team and edited before being uploaded to the Spotify platform. The podcast is disseminated through email distribution lists and promoted on PHN social media platforms, with stakeholders encouraged to share within their local networks. All information gathered from the yarns is being compiled into a comprehensive report detailing community needs, contributing to the PHN's core needs assessment report. A community report will be shared internally and externally with the community to help identify opportunities for the PHN to influence and fund services in these areas. Additionally, we will explore ways to advocate for the community by sharing de-identified themes with the yarn participants and key organisations across the region to assist with increasing workforce capacity to respond culturally to community needs.

The Impact

The Coffee on Country – Community Yarns are expected to improve connections between First Nations people and the PHN, as well as with commissioned service providers some that provide allied health services across the HNECC footprint. This initiative aims to increase service utilisation and aligns with the mission of the Primary Health Network to enhance the health and well-being of First Nations communities. While community engagement and podcasting might seem like modest components, their significance lies in their potential to address key strategic objectives. The podcasts will support the development and recognition of a diverse healthcare workforce. Additionally, the engagement activities and podcasts foster cultural understanding and competence among healthcare professionals.

Implications for policy?

Podcasts address some of the systemic barriers that First Nations communities face in accessing healthcare services by enhancing culturally safe allied health practice. The approach also offers a mechanism for effective engagement with First Nations populations enabling development of culturally appropriate and responsive services. Scaling up the impact of the podcast and community engagement can be achieved with formal partnerships with local health services including allied health services. Further incorporating participatory approaches in service planning and delivery of primary health care will help to increase health equity.

Case Study: Hunter New England Central Coast PHN

Title: Spring Ridge Health Hub, Small Town Engagement Model

Stakeholders: Boyd Health & Spring Ridge Pharmacy (Spring Ridge Health Hub), HNECCPHN

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Annabelle Williams awilliams@thephn.com.au	Year of commencement: 2023 - ongoing	PHN Funding Source/s: PHN Core Flex to support establishment, MBS, Private

The Challenge

Around one in four Australians live in rural and regional areas, with a life expectancy that is 10 -15 years less than the population living in metropolitan Australia and less again for First Nations peoples. In rural communities' healthcare is often fragmented and siloed with patients having less access to services than their urban counterparts.

The Solution

In July 2023, the Spring Ridge Health Hub, on the Liverpool Plains, NSW, was created by two courageous health professionals, who were prepared to pilot a multi-disciplinary team care approach for a small rural town to increase the equity of access for primary health care services for rural communities. The solution was to create a space for Boyd Health to operate a hybrid general practice model in the pharmacy / general store / post office. The patients' book their appointments online and either see the GP face to face or via telehealth. The utilisation of the hybrid model enables the rural community continuity of quality health care with the same GP and an ability to access Dr Boyd via telehealth from the farm gate. This saves the patient travel time and improves the timeliness of access of GP care. Dr Boyd transmits e-scripts directly to the pharmacy, providing the patient with holistic and timely medication dispensing and support through the onsite pharmacy. These scripts are often put on the mail run for the farming communities to ensure timeliness of their medication. The initiative was born out of the PHNs Better Health for the Bush Framework, Small Town Engagement Model. https://hneccphn.imgix.net/assets/src/uploads/images/Better-Health-for-the-Bush-Framework-and-Model-of-Care-Revised.pdf

The Impact

To date Dr Boyd has seen a total of 105 new patients in the Liverpool Plains LGA region and has provided telehealth consults to over 400 patients in the region, who wouldn't have timely access to General Practitioner services. It has been reported that the middle-aged male cohort, have engaged well with Dr Boyd and because of this service's early detection of cardiovascular risk factors, such as high blood pressure has been detected and interventions have been able to be made, potentially saving the lives of many young rural males who wouldn't have seen the GP. In the short time of working together, the pharmacist has reported a significant increase in the number of scripts processed through the pharmacy. Dr Boyd has (12.6%) of all scripts compared to other local GPs in the region at (6%). This model featured at the 3rd Asia Pacific Conference, 2023 by the Deputy Rural Health Commissioner as a positive example of a community solution.

Implications for policy?

The GP bills a combination of mixed billings utilising the MBS payment scheme. On 1 November 2023, these MBS rates did change for rural based GP, for concessional card holders and under 16 years of age, however Boyd Health is not eligible for the Practice Incentive Payments. If a rural practicing GP working in a hybrid structure, was eligible for some of the practice incentive payments for the delivery of GP services to these small rural towns, this model becomes more viable and sustainable to Boyd Health and to the community, providing a solution to the rural workforce crisis. The PHNs Better Health for the Bush Small Town Engagement Model could be replicated and localised for implementation in other rural communities with populations less than 5,000 residents to improve equity of access to primary care services.

Case Study: Hunter New England Central Coast PHN

Title: Virtual Psychologist for Postnatal Wellness Pilot

Stakeholders: HNECC PHN, Virtual Psychologist and Local Health Districts (CCLHD and HNELHD), Community.

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care



Data, quality and digital maturity

Key contact name and email: Tom Synnott, tsynnott@thephn.com.au	Year of commencement: 2024	PHN Funding Source/s: Core Flex

The Challenge

There is a clear need for enhanced mental health services in regional and rural settings. Feedback from Central Coast Local Health District (CCLHD) and Hunter New England Local Health District (HNELHD) highlighted a significant gap in accessible, immediate mental health support, particularly in remote areas where traditional services are limited. Many existing services require GP referrals, creating a barrier to access, especially for new mothers, who have given birth within the last 12 months in Narrabi, Gunnedah and Moree who may not regularly visit their GP. This service addresses that gap by being self-referred, directly targeting vulnerable communities.

The Solution

The Virtual Psychologist Pilot introduced a digital mental health service providing on-demand access to qualified psychologists through text, chat, and other digital means. Unlike traditional services that often require a GP referral, this program is self-referred, allowing individuals to access support directly when needed. This model improves accessibility and reaches a broader pool of individuals, who can refer themselves or be referred by others within their community, effectively targeting those most in need. The pilot offers support to new mothers experiencing symptoms of postnatal depression without requiring a formal diagnosis of postnatal depression and GP referral to access these services. The service has been praised for its convenience, cultural safety, and the ability to provide immediate support to those who might not seek traditional avenues.

The Impact

The pilot received positive feedback, showing increased engagement from individuals in regional and rural communities who previously had limited access to mental health support. Metrics indicate that 83.3% of rural mothers would not have sought out mental wellbeing support if this service was not available, highlighting the critical role it plays in these communities. Furthermore, 94.4% of rural mothers preferred digital-based counselling due to its convenience, and 100% would use the same counsellor again, underscoring the program's effectiveness and acceptance among users. By removing the GP referral requirement, the service has been able to connect with those who may not have engaged with traditional pathways, providing an accessible and culturally safe environment for support. However, the absence of sustainable funding streams threatens the program's continuity, highlighting the critical need for secure funding to maintain and expand such services.

Implications for policy?

The Virtual Psychologist model is an innovative digital solution to accessing mental health care, particularly in underserved locations for a vulnerable population. The pilot demonstrates early success in self-referral services in reaching hard-to-access populations and serves as a model for other mental health services looking to improve accessibility and impact in rural settings.

Case Study: Murray PHN

Title: Commissioning Primary Mental Health Care in rural settings

Stakeholders: Primary Health Networks, Victorian funded rural health service

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Jovie Ingram jingram@murrayphn.org.au	Year of commencement: 01/07/2023 – 31/07/2024	PHN Funding Source/s: Primary Mental Health Services (2023-2024)

The Challenge

Lack of accessible mental health supports for rural communities in rural/sub-regional areas of Victoria. The client, a 55-year-old female living alone in rental accommodation in rural Victoria has complex mental health challenges stemming from a history of trauma, family violence, substance abuse, unstable relationships, anxiety, and post-traumatic stress. The person was unable to engage with local mental health services, complicating her recovery and ability to manage daily living activities. Primary Mental Health Care has traditionally only been available from support services located in nearby regional centres over 100km away. The client's journey has been non-linear with constant setbacks which has negatively impacted her mental health and substance use.

The Solution

Primary Mental Health Services were commissioned to the Victorian funded health service in the small rural community. Due to the size of the community, the Victorian health service hosts primary care as well as hospital-based acute health services. By funding the rural health service, Murray PHN integrated primary mental health care alongside General Practitioners and allied health programs hosted by the service. By commissioning primary mental health, the allied health mental health clinician (psychologist) was able to provide care as part of a multidisciplinary team at the rural health service. These supports could then be provided alongside additional community supports from disability employment services, financial counselling, Food Bank and the Salvation Army.

The Impact

Commissioning services in this way has meant that mental health service delivery has been consistent, allowing regular access to mental health care. The flexible and responsive mental health services has been crucial to individuals maintaining connection to the service and to mental health care. While activity targets declined in the early stages of program implementation, the number of service contacts steadily increased over time.

Implications for policy?

Commissioning new mental health programs in thin markets requires gradual expectations regarding service performance. The case study also illustrates the necessity for integrated care in rural settings, allowing individuals to receive care in multi-disciplinary settings that are sustainable for the allied health workforce. This integration is crucial for a holistic approach to care. Aligning funding with rurally based health services is key to ensuring that service activity is conducted in rural areas, rather than just in regional settings with larger populations near the rural communities. Funding models need to consider the complexity of human needs, where long-term, flexible support is required.

Case Study: Murray PHN

Title: Using Non-dispensing Pharmacists in Chronic Disease Management - General Practice Investment Strategy

Stakeholders: General Practitioners, Non-dispensing Pharmacists

This case study relates to:



Workforce & Access to Allied Health Care



Practice Engagement

Key contact name and email: Kim Harlock kharlock@murrayphn.org.au	Year of commencement: 2021	PHN Funding Source/s: Core funding

The Challenge

As chronic disease management places increasing pressure of the healthcare system, greater collaboration between GPs and other healthcare professionals is required to provide adequate care that meets the demands. Non-dispensing pharmacists (NDPs) can contribute to the care team by delivering a range of clinical services, to both the patient and other healthcare professionals, to optimise medical therapy, provide medical management services, promote medication safety initiatives, improve health literacy and educate and empower patients to employ effective medication self-management.

The Solution

Between June of 2021 and July of 2023 General Practice Investment Strategy funds were used to deliver care coordination for patients with chronic and complex conditions utilising an integrated NDP model of care. These funds were part of the Core Funding - Flexible Funding Schedule.
A 0.4 FTE NDP was funded with the purpose of improving chronic disease management, quality use of medicines, optimised prescribing and improved health and medication literacy. They were also to develop and embed education activities and systems and policies to support other General Practice staff.

The Impact

Initially funded for 12 months, this project was extended for a further 12 months to enable proper and sustainable establishment within the General Practice. Since funding ceased in July 2023, the service has continued and is now fully funded by the practice. Over the course of the funded program, the NDP delivered over 2,000 consultations, 174 Home Medicines Reviews, over 100 patient education sessions and over 600 clinical staff education sessions/interventions on optimal medication usage. These services increased primary healthcare services to the community, as the activities performed by the NDP were timesaving for the GP and freed up appointment time for more acute and urgent matters.

Implications for policy?

After the initial 12 months of funding, the practice owners where this project was implemented decided that the NDP position was not viable without PHN funding support. It took another 12 months of funded support for the ongoing viability to be proven. This was largely driven by the NDP and required a lot of unfunded time put into making a case for viability and change management support for practice staff. For this activity to be viable and extrapolated into other practices, funding and change management support would likely be required to allow establishment and to prove viability to owners.

Case Study: Nepean Blue Mountains PHN

Title: Mobile OT

Stakeholders: Local services providers and GPs

This case study relates to:

Integration, models of care and funding

Workforce & Access to Allied Health Care

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

The Challenge

In NSW, older people are entering aged care earlier than they may otherwise need to due to a lack of support for healthy ageing or ability to manage their chronic conditions at home. For the purposes of understanding the unique needs and priorities of the older community in the Nepean Blue Mountains region, a number of discussions and stakeholder interviews were conducted. Through this approach, a number of themes were uncovered, including:

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

The Solution

Wentworth Healthcare's Mobile Occupational Therapy (OT) service provides in-home assessments for older adults aged 65 years and over (or aged 55 years and over for Aboriginal and Torres Strait Islander people) residing at home, in Lithgow and surrounding areas, including the upper Blue Mountains and outer Hawkesbury. The 'Early Intervention Consultation and Commissioning Recommendations Report' by Eliza Pross (2022) identified that physical deconditioning, falls, and social isolation are the most impactful and modifiable contributors to functional decline in older adults. Occupational Therapists (OTs) are best placed to assist older adults with physical reconditioning and coordinating care for people who are managing chronic conditions at home. OTs can also provide support to improve cognitive function, diet, social connectivity and assist older adults to reduce their falls risk at home by providing in-home OT assessments and making referrals for home modifications and equipment. The mobile OT service can provide up to 8 hours of support per client.

The Impact

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

Implications for policy?

There is a shortage of Occupational Therapists across the region.

Case Study: Nepean Blue Mountains PHN

Title: Perinatal education program for Aboriginal and Torres Strait Islander pregnant women and lactating mothers by registered Aboriginal midwife in Hawkesbury area

Stakeholders: Merana Aboriginal Community Association for the Hawkesbury, Registered Midwife, Aboriginal and Torres Strait Islander pregnant women and lactating mothers in Hawkesbury area

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Rakesh Patel, Program Development Officer, NBMPHN (Rakeshbhai.Patel@nbmphn.com.au)	Year of commencement:2023-24	PHN Funding Source/s: Medical Outreach Indigenous Chronic Diseases Program (MOICDP) – by NSW Rural Doctors Network (RDN)

The Challenge

Research highlights the critical need for perinatal education programs led by midwives for Aboriginal pregnant women. Community-led antenatal care has significantly improved health outcomes, as demonstrated by Waminda's (an Aboriginal women health facility on the south coast) success in achieving higher rates of vaginal births, full-term pregnancies, better average birth weights, and increased antenatal and postnatal care attendance compared to government facilities. The Australian Institute of Health and Welfare emphasises that early antenatal care can mitigate adverse pregnancy and birth factors by providing timely information and identifying medical risks such as pre-existing diabetes and chronic hypertension, which can prevent labor complications. Lack of antenatal care is associated with increased rates of pre-term births, perinatal deaths, low birth weight, and higher NICU admissions, while adequate care improves maternal health and child health outcomes. There was a need for culturally sensitive education programs for Aboriginal and Torres Strait Islander pregnant women and lactating mothers by a registered midwife in the Hawkesbury area.

The Solution

10 weeks structured education program was designed and delivered for Aboriginal and Torres Strait Islander women and their partners or support persons at Merana Aboriginal Community Association located in Hawkesbury LGA. The program was developed by a local registered midwife and also reviewed and improved by an antenatal shared care GP. The program included various topics such as introduction to pregnancy and antenatal care, nutrition, preparing for labour and childbirth, breastfeeding and the post natal care.

The Impact

A total 6 women and their partners/support persons attended the program for 10 weeks. All participants remained committed to the program, with strong attendance continuing through Thursday night sessions even after giving birth. This ongoing participation underscores the program's effectiveness in fostering a supportive community. The final feedback was overwhelmingly positive, reflecting a high level of satisfaction with the program:

- Exceeded Expectations: 100%
- Would Recommend the Program: 100%
- Would like to program to continue 100%

The Pregnancy Program at Merana has reached a successful conclusion, demonstrating its effectiveness in providing essential support and education to expectant mothers. The comprehensive curriculum, which included topics such as labour and birth, breastfeeding, newborn care, and the postnatal period, was well-received by the participants. In summary, the Pregnancy Program at Merana not only achieved its educational goals but also succeeded in creating a nurturing and connected community. The positive feedback from participants and their continued commitment to the group highlight the program's success and its vital role in supporting expectant and new mothers.

Implications for policy?

Culturally sensitive local perinatal education is very important for Indigenous pregnant women and their partners for achieving safe and uncomplicated delivery and infant care. This type of service can be expanded across local Aboriginal organisations as they are the first point of contact for pregnant women and lactating mothers.

Case Study: Nepean Blue Mountains PHN

Title: Speech pathology service for children attending crisis accommodation in Lithgow region

Stakeholders: Lithgow Community Projects, Direct Focus Solutions, Children (and families) attending crisis accommodation in Lithgow region

This case study relates to:

Integration, models of care and funding

Workforce & Access to Allied Health Care

Key contact name and email: Penny Wood and Rakesh Patel, Program Development Officers, NBMPHN (Rakeshbhai.Patel@nbmphn.com.au & penny.wood@nbmphn.com.au)	Year of commencement:2023-24	PHN Funding Source/s: Rural Health Outreach Fund (RHOF) – NSW Rural Doctors Network (RDN)

The Challenge

Lithgow is significantly disadvantaged area in Nepean Blue Mountains region. It is located 160km west of Sydney and ranked 20 out of 153 for most disadvantaged LGAs in NSW (SEIFA). It has a small rural hospital which is staffed by GPs and VMOs. It is extremely difficult to recruit doctors, nurses and allied health professionals to this area. There are significant service gaps identified in Lithgow, mostly for specialist paediatric and allied health services. Many women and children experiencing domestic abuse choose to reside in crisis accommodation, often losing access to established community and health supports. This urgent need for safety can lead to overlooked health services like speech development in children exposed to trauma. Speech Pathology Australia highlights the critical role of speech pathologists in addressing trauma-related developmental difficulties. Speech pathology is a specialised therapy that helps children learn to communication skills such as expressing themselves, understanding instructions, pronunciation, or stuttering. There was a need for speech pathology services to affected children in the crisis accommodation facility (e.g. Lithgow Community Projects)

The Solution

Lithgow Community Projects and Direct Focus Solutions (DFS) are currently working in partnership to provide access to Speech Pathology services to identified individuals accessing crisis accommodation in the Lithgow region. This project is facilitated by Nepean Blue Mountains Primary Health Network through the Rural Doctors Network (NSWRDN) funding stream to support local community members to access Speech Pathology services. An important part of this initiative involves engaging clients on how to access this service as in some cases, this has been a first for a client, having never sought out speech therapy before. This involved the development of an intake process which included a risk mitigation plan and identifies who the key contacts are, availability of transport, legal obligations, work/school obligations. The information collated by the therapist provides valuable information on what programs may be required to help facilitate ongoing services as part of Speech Pathology.

The Impact

Providing a speech therapist at the Lithgow Community Projects has enabled early detection and intervention for speech, language, and communication issues, mitigating long-term effects of domestic violence. 9 days of speech pathology service was provided to many children accessing the Lithgow Community Focus facility during 2023-24 and program received additional year of funding from NSWRDN to continue delivering this service in 2024-25. A detailed report is being provided to NSWRDN and also relevant referrals are made in case a child needs further interventions with other allied health professionals or specialists such as Paediatricians.

Implications for policy?

Speech therapy builds a child's confidence to communicate effectively. (https://www.actforkids.com.au/the-issue/how-speech-pathology-helps-kids-to-heal-from-trauma/). Children impacted by any form of trauma can affect that child's development including, types of communication. This could lead to problems understanding what people say, how to express themselves and learning to read. Speech therapy helps children with communication, language and speech skills. There is a need for local speech pathology services in rural areas such as Lithgow at a location which is safe for children impacted by domestic and family violence and abuse.

Case Study: North Western Melbourne PHN

Title: Chronic Pain Service – Northern Region

Stakeholders: Merri Community Health Service

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Sarah O'Leary, sarah.oleary@nwmphn.org.au	**Year of commencement:** 2020	**PHN Funding Source/s:** Core Flex Chronic Conditions

The Challenge A 2019 NWMPHN chronic pain needs assessment identified 825,800 people living with chronic pain in Victoria, a limited number of available pain management services and a high prevalence of associated indicators of chronic pain, including reported back problems, arthritis and opioid medication dispensation. In a qualitative engagement activity conducted by the PHN, consumers and providers expressed frustration about long service wait times and limited referral options. Unaddressed chronic pain is associated with potentially preventable hospital admissions, reliance on high medication use, maladaptive coping mechanisms and a decrease in mental wellbeing, as summarised in the National Strategic Action Plan for Pain Management (the Plan). The Plan also identified the need to educate clinicians and consumers about contemporary evidence on the neuroscience of pain. In 2020, a community health provider was commissioned to enable consumers to self-manage their pain in the community.

The Solution The Chronic Pain Service (CPS) is delivered to adults, referred by a GP or tertiary service, who have chronic pain and who reside in the LGAs of Hume, Darebin, Merri-bek, Moonee Valley or Macedon Ranges. This program specialises in, but is not limited to, clients who experience nociplastic pain. The key multidisciplinary team members consists of pain-specialised roles in physiotherapy, psychology and physician. Supporting disciplines are occupational therapy, allied health assistant and care coordinator roles. Client individual and/or group sessions are delivered in a hybrid of community health setting and telehealth, depending on client preferences and need. The program uses a Psycho-Neuro-Endocrine-Immunology (P.N.E.I) approach to shift the lens of chronic pain away from a biomedical perspective towards that of a biopsychosocial paradigm. The intervention combines pain education, mindfulness, physiotherapy, cognitive reframing techniques and movement. Allied health workforce is upskilled to pain-specific approaches with supervision, training and conferences. In addition, GP education webinars are delivered to streamline appropriate referrals into the community-based program instead of towards hospitals, emphasising the value of community allied health in an integrated chronic pain model. For tertiary settings, referral linkages have been developed, with an especially strong link with the Royal Melbourne Hospital.

The Impact The program team's interdisciplinary approach allows for tailored client treatment, for example, the senior pain physiotherapist uses pain neurophysiology education and embodied movement approaches, complemented with Acceptance and Commitment Therapy, to help clients navigate the workings of their pain. The program's continued upskilling of staff in interdisciplinary approaches is an essential program component due to the nature of this region's cohort complexity: 71% of program clients reported a mental health condition, compared to 46% in all other pain services reporting to the electronic Persistent Pain Outcomes Collaboration (ePPOC). This holistic pain approach has proven impacts: in 2023, 95.5% of clients successfully discharged from the CPS reported some overall improvement in their health, which includes achievement of their wellbeing goals. Other 2023 ePPOC outcomes include reduced pain interference, frequency and catastrophising and decreased severity in mental health conditions. To date, 231 people have commenced the program. Regarding strengthened linkages between different levels of the health system, it has been identified that a more targeted approach is needed for GP education in select LGAs where there is a dearth of GP program referrals and where there are strong indicators of local population need. In addition, there has been ongoing discussions between the provider and an asylum and refugee seeker health organisation to develop potential referral pathways and/or train/upskill bicultural workers in identifying those who present with chronic pain and may benefit from such a program. A program evaluation is in progress.

Implications for policy There are opportunities for pooled funding to scale the program across PHN regions –this might involve strengthening collaborations across different service providers and PHNs. Different funding approaches include pooled funding from hospitals, as referrals are being successfully diverted into the program where appropriate from GPs, and ongoing work with tertiary referrals into this program is in progress. The program has delivered education to staff in hospital settings about the benefits of this community allied health program. MBS items might also be used to sustainably support allied health in the delivery of self-management pain programs.

Case Study: North Western Melbourne PHN

Title: Integrating non-dispensing pharmacists in general practice

Stakeholders: Pharmaceutical Society of Australia (PSA)

This case study relates to:



Integration, models of care and funding

Key contact name and email: Lyanna Yamsuan; Lyanna.Yamsuan@nwmphn.org.au	Year of commencement: 2017	PHN Funding Source/s: Single source funding under Chronic Conditions

The Challenge

While new in Australia, the role of practice pharmacists, where a non-dispensing pharmacist works within a general practice, is well established internationally. (1, 2) The costs to the health system and patient population associated with over prescribing/under prescribing, medication misuse, non-compliance, adverse drug events and preventable hospital admissions are significant.(3) In Australia 250,000 hospital admissions and 400,000 Emergency Department presentations per year are medication-related, costing AUD$1.4 billion annually. 50% of these admissions are potentially preventable. (3)

The Solution

Non-dispensing pharmacists practising at full scope within multidisciplinary teams in General Practice play a significant role in medicine optimisation and patient safety. Their integration into primary care teams is crucial to addressing the increasing barriers that patients face in accessing General Practitioner services, leading to delayed diagnoses and subsequent advanced disease progression, and fundamentally increased costs to the healthcare system. Since 2017, NWMPHN has commissioned the PSA to deliver a program integrating clinical non-dispensing pharmacists into general practices in central, north and western Melbourne. These general practice pharmacists enhance quality use of medicines by delivering activities which support patients, General Practitioners, practice nurses and other practice staff. The current phase of the program involves 6 pharmacists working at 6 general practices for 14 hours per week.

The Impact

In FY23-24, our data shows us:

- The six 0.35 FTE pharmacists in the program contributed to 2,404 MBS and practice-focused activities, including transition of care, team-based collaboration, and education and training.
- Between 97% and 100% of patients needing intervention have had their medication lists updated, received medication reconciliation, and had their allergies confirmed in the electronic medical record.
- The program has consistently received positive feedback from both patients and practice staff, along with favourable patient reported outcomes.

Implications for policy?

The primary obstacle to implementing a GP-led multidisciplinary team is the current Medicare funding model, which is based on fee-for-service GP-patient consultations (either face-to-face or telehealth) and provides incentives for practice nurses or allied health professionals. There is a need to promote to GP businesses the valuable role that other workforce, including, pharmacists can play using the incentive program. The Primary Health Care 10-year plan highlights a shift towards team-based primary healthcare services and blended funding models that offer a balanced approach to incentivizing high-quality, person-centered, integrated care. (4) Although GPs cannot currently bill Medicare directly for their services, pharmacists can contribute to clinic revenue generation in various ways. These include participation in the Practice Incentives Program, providing indirect financial benefits through involvement in care plans (such as GP Management Plans and Team Care Arrangements), conducting medication management reviews, and participating in case conferences. Additionally, pharmacists can support practice nurses by assisting with health assessments and immunizations, which may help reduce the need for locums and minimise appointment cancellations.

Case Study: North Western Melbourne PHN

Title: NWMPHN Allied Health in Residential Aged Care Homes (RACHs) Program

Stakeholders: NWMPHN, RACHs, Local Allied Health (Physical Therapy) providers

This case study relates to:

Integration, models of care and funding

Workforce & Access to Allied Health Care

Key contact name and email: Juliet Fieldew, juliet.fieldew@nwmphn.org.au	Year of commencement: 2021	PHN Funding Source/s: COVID Allied Health Package 2021-22, After Hours funding 2022-23, Core Flex funding 2024.

The Challenge During the first few years of the COVID-19 pandemic, RACH lockdowns led to residents being confined to their rooms for several weeks at a time. This confinement and reduction in physical activity led to physical deconditioning of residents, leaving them more at risk of falls, injury and subsequent hospitalisation. In 2020, 7% of all COVID-19 cases in Australia and 75% of all deaths were in people living in residential aged care.[1] To combat this growing issue, the Commonwealth Department of Health funded NWMPHN to commission allied health providers to deliver a group-based physical therapy program for 53 eligible RACHs that experienced COVID-19 outbreaks up to 23 October 2020. The NWM region was one of the hardest hit by COVID-19 in 2021, and as a result, many more RACHs continued to be impacted by COVID-19 lockdowns and restrictions after this cut-off date. This led to NWMPHN choosing to recommission the program, broadening it to other impacted RACHs in 2022.

The Solution In the Allied Health in RACHs program, physical therapy providers (physiotherapists, occupational therapists and exercise physiologists) facilitate group-based exercise therapy to groups of up to 4 RACH residents. Residents are assessed at outset and, where possible, placed in groups with others of similar ability. Exercise sessions occur for 1 hour, twice a week and are conducted in the common living areas in RACHs. The program is based on the SUNBEAM program, which has been proven to be effective in preventing falls in older adults.[2] Where possible, NWMPHN purposefully commissioned the local incumbent physical therapy provider at each RACH, to equip providers and RACHs with both the physical equipment (weights, bands, etc.) and the framework to continue to provide a similar program after the cessation of funding. Initially the program was structured to run for 26 weeks, however this was shortened to 13 weeks after Round 2 to enable more RACHs the opportunity to participate in the program. The program has continued to 2024 and has now run in 123 RACHs (96%) in the North-Western Melbourne region. 4,776 residents have completed the program* (*approximately 3,000-3,500 individuals – some have participated twice). Many residents, RACH staff and family members have reported positive outcomes, including improved mobility, increased socialisation, reduced falls, greater confidence in completing activities of daily living and improved mood.

The Impact During this time, aged care was going through a period of transition from ACFI to AN-ACC funding frameworks. Under the prior ACFI funding model, physiotherapists were predominantly funded in aged care settings to provide massage for residents with chronic pain, which represents a disease-treatment focus rather than the focus on prevention championed in the National PHN Allied Health in Primary Care Engagement Framework. The AN-ACC funding model shares the aim of broadening allied health scope of practice in aged care. This program occurred at an ideal time for the allied health providers to demonstrate a new way for physiotherapists, occupational therapists and exercise physiologists to work to the top of their scope in an evidence-based proactive & preventative model of care. As a result of their participation in the program, some of the physiotherapy providers have now incorporated a similar program offering into their portfolio, while several RACHs have implemented wellness programs for their most at-risk residents. They report that these wellness programs often lead to increased occupancy, which reinforces sustainability.

Implications for Policy This program has demonstrated that there is a positive role for physical therapy providers to work to the top of their scope to provide group exercise therapy to residents of aged care homes in Australia. There is a strong case for using the program as a short-term capacity-building strategy for residents who are particularly frail. RACHs could use their regular resident mobility assessments to identify those who are most in need of support and focus their efforts there, improving frail residents' strength and balance and reducing risk of falls and hospitalisation.

[1] https://www.aihw.gov.au/reports/burden-of-disease/the-first-year-of-covid-19-in-australia/summary

[2] Hewitt, J. et.al. (2019) Progressive Resistance and Balance Training for Falls Prevention in Long-Term Residential Aged Care: A Cluster Randomized Trial of the Sunbeam Program. Available at https://pubmed.ncbi.nlm.nih.gov/29402651/

Case Study: Northen Territory PHN

Title: Supplementary Allied Health Services (SAHS)

Stakeholders:

This case study relates to:



Integration, models of care and funding



Practice Engagement

Key contact name and email: Lily Trinh lily.trinh@ntphn.org.au	Year of commencement: 2008	PHN Funding Source/s: Rural Primary Health Services

The Challenge

The Rural Primary Health Services (RPHS) Program commenced in 2008. The aim of the RPHS Program is to improve and promote the health and wellbeing of people in rural and remote Northern Territory through access to a range of community-based health services including promotion, preventative health, clinical and allied health programs.

The Solution

The Supplementary Allied Health Services (SAHS) Program was in place for over ten years in Alice Springs, with commissioned providers in podiatry, exercise physiology and physiotherapy services. In the last few years, the SAHS program slowly scaled back to podiatry and physiotherapy services. The program enabled general practitioners (GP's) to refer eligible Alice Springs residents with sub-acute conditions for a series of consultations with contracted allied health providers, at no charge to the resident. To access the SAHS Program, clients must meet the following eligibility criteria:

- Hold a current health care card;
- Live in Alice Springs or the surrounding area;
- Have an acute condition (not ongoing for more than six months) and would benefit from allied health care. This may be a specific event or an acute exacerbation of a chronic condition; and
- Be referred to a participating allied health practice through a GP practice.

The Impact

In its initial years, the SAHS Program experienced heavy utilization, reflecting the high demand for accessible allied health services in Alice Springs. Though referral rates have remained steady, the program has been scaled back due to funding availability. The demand highlighted the program's role in filling a gap for Alice Springs residents, as there are few subsidised services available within the town. While many of the services commissioned through other programs are focused on remote Indigenous communities, the SAHS Program provided Alice Springs access to allied health where access to other subsidised health services were lacking.

NT PHN decommissioned the program as of 31st August 2024.

Implications for policy?

The program sustainability was a challenge. The lack of funding for allied health services via MBS continues to present issues to system enablement of evidence based multidisciplinary care. Though PHNs can provide access to localised solutions where funding allows, this is a structural issue that requires a system approach. One of the local allied health providers issued the following statement which is also accurate for non-Indigenous, low- and middle-income community members in the context of a cost-of-living crisis:

"*The current funding mechanisms that support multidisciplinary team care within primary health care are not conducive to growing services to address community needs. The limitations of Medicare funding for allied health have created a barrier to provide a sustainable bulk-billed physiotherapy service. Consequently, physiotherapists can only respond to referrals by primary health care practitioners for clients who are eligible for either CHSP (aged 50 and over) or NDIS (a permanent and significant disability).Therefore, there are currently no physiotherapy services for people under 50 years of age who are not NDIS eligible. This creates confusion for clients and referrers, exacerbating barriers to accessible and timely care for Aboriginal people*".

Case Study: Sydney North Health Network (SNHN)

Title: Engaging Allied Health in Decision Making - Allied Health Reference Group

Stakeholders: Allied health providers

This case study relates to:

Practice Engagement

Governance and culture

Key contact name and email: **Alex Jaksetic** ajaksetic@snhn.org.au	Year of commencement: 2022	PHN Funding Source/s: SNHN Funding

The Challenge

One of the pillars of the SNHN Allied Health Engagement Strategy is to engage allied health professionals in decision making. With allied health representation on the SNHN Board, Clinical Council and the Education Advisory Committee, the need to provide a forum for representatives of a range of allied health professions and areas of clinical practice was recognised.

The Solution

Expressions of interest were sought from allied health professionals to join an Allied Health Reference Group, with a small group established. The purpose of the group is to provide multidisciplinary input to help guide implementation of the SNHN Allied Health Engagement Strategy, and to promote networking and collaboration among allied health professionals working in primary care across Northern Sydney. Recognising the diversity of allied health professionals across the region, collectively, group members represent a range of disciplines and offer a mix of skills, clinical experience expertise and experience. The group meets quarterly, with group members also invited to review or offer insights on relevant activities or local community issues.

The Impact

Allied health professionals are recognised for their expertise in understanding the needs of our community and are more embedded in decision-making processes. The Allied Health Reference Group has created an additional mechanism to build local allied health relationships and for them to provide input and for multidisciplinary collaboration.

"As you know, when you invited me to assist on this committee, I was a little pessimistic. I have to say that what you've been able to come up with and deliver has been so wonderful for the allied health community in our region". (Physiotherapist, SNHN Allied Health Reference Group, May 2024)

Case Study: Sydney North Health Network (SNHN)

Title: Recognising and Supporting Provider Wellbeing - Allied Health Wellbeing Retreat

Stakeholders: Allied health providers

This case study relates to:

Workforce & Access to Allied Health Care *Practice Engagement*

Key contact name and email: Alex Jaksetic ajaksetic@snhn.org.au	**Year of commencement: 2024**	**PHN Funding Source/s: SNHN Funding**

The Challenge

Provider or care team wellbeing is a well-established element of the Quintuple Aim for healthcare improvement. Healthcare providers are passionate about improving the health and wellbeing of their patients and clients; however, it is not always easy for providers to schedule time to focus on their own health and self-care. Healthcare providers have expressed feelings of burnout and at higher levels over recent years.

The Solution

An inaugural Allied Health Wellbeing Retreat was held in May 2024. Recognising the importance of provider wellbeing and facilitated and presented by a multidisciplinary team of local health professionals, the program offered a unique opportunity for allied health providers to come together for a day – to reconnect, reflect and rejuvenate. The program for the day included a Walk on Country and Ochre Ceremony; a facilitated session on peer connectedness; a practical session on provider wellness and creating a self-care plan; a mindful bushwalking activity; an art for wellbeing activity; and a facilitated discussion on recognising the signs and developing a preventive plan for managing the symptoms of burnout. The day was promoted to allied health professionals across the region and fully subscribed within 24 hours.

The Impact

Attendees evaluated the day, rating the:

- overall quality of the Wellbeing Day as excellent (83%) or good (17%)
- opportunity to connect with other allied health professionals as excellent (89%) or good (11%)
- peer connectedness session presented and facilitated by a local clinical psychologist as excellent (78%) or good (22%)
- provider wellness session presented and facilitated by a local occupational therapist as excellent (78%) or good (22%)
- art for wellbeing session facilitated by a local art therapist as (78%) or good (22%)
- mindful bushwalking session facilitated by a local registered psychologist as excellent (83%) or good (17%), and
- burnout preparedness session facilitated by a local GP as excellent (78%) or good (22%)

"It was an amazing experience that recharged my battery and gave me tools to assist me into the future. The setting and the way in which the presenters interacted with us allowed us to really get to know each other, connect with each other and offer and receive support". (Allied Health Professional, May 24)

Case Study: Sydney North Health Network (SNHN)

Title: Strengthening Workforce Capacity - Allied Health Business Skills Workshops

Stakeholders: Allied health providers

This case study relates to:

Workforce & Access to Allied Health Care

Practice Engagement

Key contact name and email: Alex Jaksetic ajaksetic@snhn.org.au	**Year of commencement: 2023**	**PHN Funding Source/s: SNHN Funding**

The Challenge

While allied health professionals in our region can access continuing professional development within their specific discipline or area of clinical practice, as well as multidisciplinary education opportunities on areas of identified health needs, developing business skills to establish and sustain a thriving allied health practice was identified as a learning gap.

The Solution

As part of a broader SNHN Allied Health Engagement Strategy and following consultation with neighbouring PHNs and the SHNH Allied Health Reference Group, the solution was to pilot the delivery of an allied health business skills program. Facilitated by a local allied health professional and director of a large multidisciplinary allied health business in the region, a series of Allied Health Grow Your Clinic business skills webinars and workshops for allied health professionals was offered over a 12-month period. Presented in partnership with Clinic Mastery, the program included a 4-part webinar series run over 4 consecutive months between the months of August to November 2023. Three half-day face to face business skills workshops were run in the first half of 2024. The program was promoted to all allied health professions, with attendees working in a mix of practice/clinic sizes and areas of clinical specialty, and predominately from the disciplines of chiropractic, dietetics, exercise physiology, occupational therapy, physiotherapy, podiatry, nursing, psychology, and speech pathology.

The Impact

The Allied Health Grow Your Clinic webinars and workshops have explored and equipped participants with skills in building and nurturing a thriving team culture; recruiting and retaining new team members; engaging new clients; elevating client experience and health outcomes; and establishing sound business and financial foundations for growing and sustaining their practices. Workbooks and planning templates were provided. To date, over 150 allied health attendees have accessed the business skills webinars and workshops, with plans to offer additional sessions and one-to-one coaching/mentoring sessions in the last quarter of 2024.

Case Study: Tasmania PHN

Title: Allied Health Engagement

Stakeholders: Primary Health Tasmania (Tas PHN) and allied health professionals.

This case study relates to:



Workforce & Access to Allied Health Care

Key contact name and email: spowell@primaryhealthtas.com.au	Year of commencement: 2023	PHN Funding Source/s:

The Challenge

Primary Health Tasmania (PHT) identified a need to strengthen engagement with the allied health sector to enhance collaboration, integration and workforce sustainability across the Tasmanian primary healthcare system. Tasmania's geographic and demographic challenges, including an ageing population and high rates of chronic illness, exacerbate the need for effective collaboration across the primary healthcare system. Allied health professionals, particularly in rural and remote areas, often face barriers to effective communication, coordination and inclusion in governance structures. Greater integration of allied health professionals into decision-making processes was identified as essential to ensuring their contributions are fully valued and utilised to address the state's growing healthcare needs.

The Solution

Primary Health Tasmania developed the Allied Health Engagement Strategy to better engage and support allied health professionals across the state. This strategy, aligned with the National PHN Allied Health in Primary Care Engagement Framework, was developed in consultation with representatives from 25 allied health peak bodies, ensuring a diverse range of perspectives and needs were considered. The strategy outlines four key priority areas for engagement and support:

- embedding allied health in decision making
- enhancing connectivity
- supporting workforce initiatives; and
- fostering awareness of allied health's role within the healthcare system.

Primary Health Tasmania are developing a road map to classify these priorities and identify appropriate stakeholders and timelines.

The Impact

Whilst in the preliminary stages of implementation, the Allied Health Engagement Strategy has already begun to influence the way Primary Health Tasmania engages with allied health professionals and think about how we integrate allied health into Tasmania's primary healthcare system.

The development of the Allied Health Engagement Strategy marks a significant step toward improving communication and collaboration between allied health professionals and Primary Health Tasmania.

Key proposed outcomes of the strategy include:

- Refined Governance Structures
- Multidisciplinary Education and Training
- Workforce Resilience and Accessibility
- Enhanced Digital Integration

Case Study: Tasmania PHN

Title: Healthy Aging - Exercise Treatment Program (2023-2025)

Stakeholders: Primary Health Tasmania (Tas PHN), allied health professionals and patients.

This case study relates to:

Integration, models of care and funding

Workforce & Access to Allied Health Care

Key contact name and email: spowell@primaryhealthtas.com.au	Year of commencement: 2023	PHN Funding Source/s:

The Challenge

Tasmania faces significant health challenges stemming from an ageing population and high rates of chronic disease. With one-third of Tasmanians failing to meet physical activity guidelines in 2022, the prevalence of cardiovascular diseases, musculoskeletal disorders, diabetes, and dementia continues to rise, particularly among people aged 65 and over. These conditions contribute to premature deaths, many of which could be prevented through lifestyle changes and better management of risk factors. Aboriginal populations also face disproportionately shorter life expectancies compared non-Aboriginal populations, further highlighting the need for targeted health interventions.

Despite improvements in life expectancy, the state still ranks poorly in many health indicators when compared to other regions in Australia. Low physical activity levels among adults, particularly older adults, exacerbate these health risks.

The Solution

Primary Health Tasmania has launched an exercise treatment program to address the challenges faced by Tasmania's ageing population, particularly in rural and remote areas, where elderly residents with chronic conditions face barriers to health care access. The 14-week exercise treatment program includes individual assessments, exercise sessions, and educational components, focusing on promoting physical activity to improve health outcomes and quality of life for older adults. The program is delivered by exercise physiologists and accredited exercise scientists.

Targeting seniors aged 60 and above, or 45 and above for Aboriginal and Torres Strait Islander people, the program is designed for those at risk of chronic conditions such as cardiovascular disease, pulmonary conditions, diabetes, depression, and musculoskeletal issues. With flexible referral pathways, including self-referrals, the program promotes strength training and other exercises with the objective of helping seniors remain in their communities and out of aged care facilities.

The Impact

The impact of the program is still being evaluated as it has been operational for less than 12 months, but feedback is positive with 100% of participants indicating they would recommend the program to friends and family, highlighting its perceived value. Additionally, 73% of participants have self-referred, showing strong community interest in the initiative. Preliminary Patient Reported Experience Measure (PREM) data shows 80% of respondents rated the program as 'excellent' and 20% as 'very good'. Early data reflects improvements in health status:

- participants maintained or achieved weight loss
- participants had a decreased systolic blood pressure post program completion
- participants maintained or decreased overall waist circumference
- participants decreased seconds score in 'timed up and go' testing
- participants decreased seconds score in 'sit to stand' testing
- participants increased ability to walk further in (meters) pre v post 'six-minute walk' testing.

Case Study: Western Australia Primary Health Alliance

Title: Endometriosis and pelvic pain clinics- Collaboration in supporting patients

Stakeholders: General practice, Endometriosis patients, WA Primary Health Alliance

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Fionnuala O'Mahoney (Fionnuala.OMahoney@wapha.org.au)	**Year of commencement: September 2023**	**PHN Funding Source/s: Australian Government is funding endometriosis and pelvic pain clinics**

The Challenge

Endometriosis affects one in nine Australian women, the Australian Government has funded 20 endometriosis and pelvic pain clinics across Australia, including two in WA, to build the capacity of primary care to manage this condition and improve access to expert, multidisciplinary services.

The Solution

There are two clinics in WA in general practice, one in Country PHN and one in Perth Metro South.

The program in Metro South, the Garden pelvic pain clinic, has a holistic model, including an on-site pelvic pain physiotherapist who provides non-medicinal treatment for patients. The clinic has also started running pelvic pain specific Pilates classes, facilitating peer support and connection and allowing patients to exercise in a supportive environment. Clinicians are focussed on the impact pain is having on a patient's life and are led by treatment goals identified by patients, including improving quality of life, effective pain management, and improved daily functioning.

The Impact

The Garden Pelvic Pain Clinic offer services across WA through general practice, nurse and pelvic physiotherapist appointments via telehealth (video or phone).

Since accepting patients in September 2023, 184 women have visited the clinic with an average of 2.88 interventions per patient.

Staff at the clinic have undertaken 14 education sessions around endometriosis and pelvic pain. These were run by allied health or specialist providers in endometriosis and chronic pelvic pain.

Implications for policy?

Patient feedback stated they appreciate being listened to (often for the first time about their pelvic pain) and being given time through longer appointments to holistically engage with their often-complex issues.

Staff have stated this model of care is the future of primary care for chronic conditions, due to the speed of the process, accuracy of treatment, and access to a valuable multidisciplinary team. The team will be visiting Broome and Fitzroy Crossing to connect with local GPs and find out more about the needs of Aboriginal women suffering from endometriosis and pelvic pain in these communities.

Links to References

Endometriosis and pelvic pain clinics

Case Study: Western Australia Primary Health Alliance

Title: Non-Dispensing Pharmacists in General Practice

Stakeholders: General practices, Pharmaceutical Society of Australia

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Fionnuala O'Mahoney (Fionnuala.OMahoney@wapha.org.au)	**Year of commencement: September 2023 to June 2024**	**PHN Funding Source/s:** Early intervention Older Adult Funding **Focus on**: Multidisciplinary Team Care

The Challenge

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

The Solution

The program commenced in September 2023, will be delivered to older adults in general practices in areas of high needs and large older adult populations.
Non dispensing pharmacists (NDP) will be employed by the Pharmaceutical Society of Australia and will work at least two days a week within the practice as part of the MDT.

The Impact

During the reporting period a total 12,414 activities were undertaken by NDP's in 19 practices across metropolitan and country locations of WA.
2659 patient consultations were conducted, 2089 medication management reviews, 2148 multidisciplinary team consultations and 110 information sessions were provided by the NDP.

100% of patients surveyed found it beneficial to talk to the NDP about their medications. Feedback indicates increased understanding by patients of their condition, medications and confidence for active participation in their health care. One of the NDP's has been awarded WA Early Career Pharmacist of the year, being recognised for their work as a non-dispensing pharmacist at Mead Medical.

Implications for policy?

The program has continued to add practices since commencement demonstrating scalability and use in other sites, goal is 20 practices.

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

Enablers of program success has been identified as early integration and defined scope discussions within the practice; formal mentoring sessions facilitated by an experienced NDP and allowing at least 6 months for NDPs to be integrated into the practices.

Links to references
Quality use of Medications
Medicine Safety: Take Care and Medicine Safety: Aged Care

Case Study: Western Australia Primary Health Alliance

Title: Non-Dispensing Pharmacists in General Practice

Stakeholders: General practices, Pharmaceutical Society of Australia

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Fionnuala O'Mahoney (Fionnuala.OMahoney@wapha.org.au)	**Year of commencement: January 2023 – June 2024**	**PHN Funding Source/s: NDP in General practice 20866** **Focus on**: Multidisciplinary Team Care

The 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.

The Solution

The Pharmaceutical Society of Australia and Western Australia Primary Health Alliance (WAPHA) devised a program to deliver non dispensing pharmacists (NDP) 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 were:

• 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

The Impact

During the reporting period a total 3855 activities were undertaken by NDP's in 12 practices, five in Perth PHN, four Perth South PHN and three Country PHN.

The report indicates 1570 patient consultations, and 1320 multidisciplinary team consultations were completed, and 32 information sessions were provided by the NDP.

Medication reconciliation is a clinical activity that does not always take priority in the general practice environment, NDP has integrated this into their Street Doctor's workflow, which has led to improvements in medication compliance, health literacy around their patients' chronic conditions, and confidence with self-management.

Enablers of program success has been identified as early integration and defined scope discussion; formal mentoring sessions facilitated by an experienced NDP, and the program allowing at least 6 months for NDPs to be integrated.

Outcomes/ Implications for policy? Evaluation of the program will include achievement of the Quintuple Aim as well as using the EQ-5D-5-DL measure.

Link to references:

Quality use of Medications

Medicine Safety: Take Care and Medicine Safety: Aged Care

Case Study: Western Australia Primary Health Alliance

Title: Nurse Practitioner and Team Based Care Pilot

Stakeholders: WA Department of Health, WA Primary Health Alliance, General practitioners, Aboriginal Community Controlled Health Services, Nurse practitioners

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Fionnuala O'Mahoney (Fionnuala.OMahoney@wapha.org.au)	**Year of commencement: September 2023**	**PHN Funding Source/s: Nurse practitioner pilot program**

The Challenge

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

The Solution

Placements began in March 2024 and continue to be rolled out, as further opportunities are identified. Ongoing evaluation will inform the 18-month pilot as well as being used to inform future primary care policy.
The Pilot aims to enhance the availability and accessibility of comprehensive primary care to the Western Australian communities, including supporting the delivery of care to vulnerable and underserved populations.

The Impact

The nurse practitioner Pilot is funded for up to 20 nurse practitioners over 18 months, to work with other health practitioners at selected locations to diagnose and treat a wide range of health conditions at no cost to patients, while collecting data to inform future primary care policy.

The Pilot model has been co-developed by the Australian and Western Australian governments and was announced by the Federal Minister for Health and Aged Care in February 2023.

Placements commenced in March 2024 and there are currently 16 Nurse Practitioners employed with a primary care service across metropolitan and country locations of WA.

Implications for policy?

Evaluation will occur in partnership with the Australian Government Department of Health and Aged Care for the pilot and identify scalability of the program.

Link to references

WA Sustainable Health Review Report (2019-2029)
Commonwealth Nurse practitioner workforce Plan, 2023
Commonwealth Strengthening Medicare Taskforce Report, 2023 (external site)
WA Nurse Practitioner Workforce Innovation Strategy (2023-2028)

Case Study: Western Australia Primary Health Alliance

Title: Support and educate vulnerable and culturally and linguistically diverse patients

Stakeholders: General Practices, WA Primary Health Alliance

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Fionnuala O'Mahoney (Fionnuala.OMahoney@wapha.org.au)	**Year of commencement: 2023**	**PHN Funding Source/s: WAPHA** **Focus on**: Multidisciplinary Team Care

The Challenge

There is an ongoing need for improved engagement with culturally and linguistically diverse (CALD) patients regarding their health and increasing their health literacy in primary health care settings.

The Solution

The Willetton Family Practice and the Pramana Medical Centre in Gosnells collaborated with WA Primary Health Alliance (WAPHA) to support and educate vulnerable and culturally and linguistically diverse patients regarding vaccinations and a variety of other health concerns.

The two clinics worked together to provide vulnerable and CALD patients with home visits from a nurse and multilingual counsellor, plus they held clinics for weekly in-house education sessions that were conducted in various languages with culturally appropriate catering.

The Impact

77 of their patients received home visits and in addition to being vaccinated for COVID-19 and other diseases, they also received concurrent health checks that resulted in referrals to allied health or specialists on the spot through telehealth consultations with the patient's primary GP.

Feedback from staff indicated the patients were more comfortable and accepting to receive a vaccination in their own home after some conversation with the counsellor. The conversation also included other general health and wellbeing concerns.

Implications for policy?

Feedback from the patients was extremely positive. There has been an increase in family and community members coming to the clinic or contacting the clinic for information about getting vaccinated for communicable diseases, after their family member seen at home spoke to them about their vaccine history. The GPs thought the service was very valuable in developing bonds with patients who were reluctant to attend the clinic. The GPs also found having a counsellor a useful dynamic to support health navigation and education in a culturally appropriate way, which we are hopeful to continue into 2024.

Case Study: Western Australia Primary Health Alliance

Title: Telehealth Carts in Residential Aged Care Homes

Stakeholders: General Practices, WA Primary Health Alliance, Residential Aged Care Homes

This case study relates to:

Integration, models of care and funding

Workforce & Access to Allied Health Care

Key contact name and email: Fionnuala O'Mahoney (Fionnuala.OMahoney@wapha.org.au)	**Year of commencement: 2023**	**PHN Funding Source/s: WAPHA** Digital Team **Focus on**: Multidisciplinary Team Care in residential aged care homes

The Challenge

Reduce unnecessary hospital admissions for residents in aged care homes by improving access to multidisciplinary care teams through video conferencing.

The Solution

By providing Residential Aged Care Homes (RACHs) with the technology and required training to access virtual care services, residents have improved access to the multi-disciplinary team care required to prevent unnecessary hospital admissions.

Connected healthcare supports aged care homes and allows residents to receive better continuity of care. The use of telehealth and My Health Record add value to the way providers coordinate their services and ensure continuity of care while enhancing clinical governance. WA Primary Health Alliance (WAPHA) digital health team are continuing to work closely with stakeholders and recently travelled to the Great Southern to support the setup and use of telehealth and My Health Record. In June 2024 WAPHA announced it had placed telehealth carts in 180 residential aged care homes (RACH's).

The Impact

WAPHA provided telehealth carts equipped with cameras, screens and peripherals including blood pressure monitors and digital stethoscopes to RACHs alongside training sessions.

Multiple face-to-face support sessions were provided by WAPHA's digital team staff, this included support in the use of clinical telehealth devices that could communicate live patient readings to a GP during a telehealth consult. Participating clinicians highlighted the potential use of the telehealth equipment to support the review of RACH residents and improve access to primary care.

The team provided face to face sessions where possible at the RACH's with staff to learn about their new telehealth equipment. It also provided an overview session on telehealth and My Health Record as critical enablers of enhanced multidisciplinary care.

Implications for policy?

The telehealth cart increases access for aged care residents to primary health care professionals and will offer more options for older persons to be assessed onsite by their treating team and specialists.

Link to references

Residential aged care (digitalhealth.gov.au)

Case Study: Western Qld PHN

Title: WQPHN Service Delivery Data Improvements

Stakeholders: Allied Health Providers, WQPHN community members, other commissioned Health providers

This case study relates to:

Integration, models of care and funding

Data, quality and digital maturity

Key contact name and email: Jennie Sealy (jennie@wqphn.com.au)	Year of commencement: 2024	PHN Funding Source/s: Core/Flex; CPSP

The Challenge

The Western Queensland (WQ) Health Data Improvement Project aims to enhance the efficiency and effectiveness of data collection practices among commissioned health professionals including Allied Health Providers. This project focuses on streamlining data collection processes to reflect social prescribing/holistic practices, support inclusive methods, and capture innovative community engagement programs. By improving data collection, the project seeks to map rural community engagement, knowledge of services, holistic care, and access to health services, ultimately guiding informed decision-making for future health care planning.

The Solution

- Design and implement data collection tools that capture a broader range of wellbeing indicators, including those related to holistic care. These tools will be adaptable to various program types and services.
- Develop methodologies and tools specifically tailored for capturing community engagement data to enhance the ability to collect accurate and relevant community data, improving the understanding of community needs and program effectiveness as well as the social prescribing practices of health professionals.

The Impact

- **Enhanced Program Evaluation-** Collecting comprehensive holistic and wellbeing data will enable more thorough evaluation of health programs, ensuring they meet the diverse needs of rural communities.
- **Informed Decision-Making -**With better data on community engagement and health service access, WQPHN will be better equipped to make informed decisions regarding future health care planning and resource allocation.
- **Increased Community Impact-** Improved data collection will allow for a more accurate assessment of community needs and the effectiveness of non-mainstream and non-commissioned programs, leading to more tailored and impactful health interventions.

Implications for policy?

- Policy Adaptation - Policies governing data collection and reporting may need to be updated to accommodate new systems and methodologies. This includes ensuring that privacy and data protection standards are maintained in new data collection tools.
- Resource Allocation - The adoption of new data management solutions may require initial investments in technology and training. Policymakers will need to consider the allocation of resources to support these changes.
- Evaluation and Accountability - Policies should be developed to ensure ongoing evaluation of the new data collection practices and their impact on program outcomes. Accountability measures will be necessary to monitor the effectiveness of the implemented solutions.
- Stakeholder Engagement - Effective implementation of the project will require collaboration with stakeholders, including health professionals, community members, and policymakers. Policies should promote active stakeholder engagement and feedback mechanisms to ensure successful outcomes.

Case Study: Western Qld PHN

Title: WQPHN Targeted Allied Health Services to address Thin Markets in Rural and Remote Areas

Stakeholders: Allied Heath Providers, WQPHN community members

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Jennie Sealy (jennie@wqphn.com.au)	Year of commencement: 2024	PHN Funding Source/s: Core/Flex

The Challenge

The objective of the project is to assist Western Queensland PHN (WQPHN) with improved planning, co-ordination, and support for allied health care services in the Western Queensland region, in relation to people who are experiencing barriers to allied health due to thin markets and workforce shortage with current commissioned providers.

The Solution

Allied Health Assistants (AHAs) are vital for ensuring access to allied health services in rural and remote areas, especially when supervised by Allied Health Professionals (AHPs). Many AHPs start their careers in these settings and require location-specific guidance from seasoned AHPs to effectively delegate tasks to AHAs. However, there are notable skill gaps among AHAs in rural communities, exacerbated by shortages of AHPs.

To bridge these service delivery gaps, it is crucial to evaluate client needs across rural areas and assess current professional development opportunities for AHAs. Enabling AHAs to attend targeted professional development courses could help them deliver innovative services that address unmet community needs. Two initiatives have been undertaken by one of WQPHN commissioned Allied Health providers. These initiatives have been launched to improve AHP training in delegation and to create service delivery models aligned with both AHA capabilities and community needs: Project 1: Develop an internal professional development course. Project 2: Facilitate AHA participation in targeted professional development courses to enhance their ability to deliver innovative services.

The Impact

The evaluation of these projects will provide insights into the role of AHAs in rural and remote areas and aid in developing a scalable model of care throughout the WQPHN region. Metrics for assessing impact include:

- Data from the refeRHEALTH reporting tool.
- Reduction in Did Not Attend (DNA) rates.
- Consumer feedback and evaluation.
- Provider commitment demonstrated through the establishment of private practices, outreach services, or alternative funding sources like Medicare.
- Increased community awareness about service availability and access.

Implications for policy?

Policy changes are needed to address access barriers and enhance service delivery in rural and remote areas. To achieve scalability, the project's outputs will demonstrate how access barriers have been mitigated through:

- Reflections in data reporting tools.
- Lower DNA rates.
- Positive consumer feedback.
- Provider commitment to targeted areas through various funding and service models.
- Improved community understanding of service access.

These outcomes will support the case for policy adjustments and broader implementation of successful models.

Case Study: Western Sydney PHN

Title: Flourish Australia: Primary Care – Psychiatric Liaison Service (PCPLS)

Stakeholders: Primary Care, local allied health providers and Community

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Kieran Mahony (Kieran.Mahony@wentwest.com.au)	Year of commencement: 2019	PHN Funding Source/s: Mental Health (Severe and Complex)

The Challenge

Western Sydney is a highly diverse population of 1,080,820 with 56,382 people in the region reporting they have a mental health condition (including anxiety and depression). The rapidly growing population has led to a challenge for patients in accessing psychiatric care, with long wait times for consultations. This in turn places pressure on GPs to meet the mental health support needs of patients. Often GPs report that they require a level of guidance in supporting patients, particularly in terms of diagnosis and prescribing, which a psychiatric liaison service can provide. Other common challenges include the often-complex psychosocial support needs of psychiatric patients, and the lack of coordinated multidisciplinary care.

The Solution

The Primary Care Psychiatric Liaison Service (PCPLS) program is provided by Flourish Australia across Western Sydney with funding provided by Western Sydney Primary Health Network (WentWest). The PCPLS program brings holistic care into GP Practices and offers access to a community psychiatrist (bulk-billed) and psychosocial support. The program works with nominated general practices in the Western Sydney region. Access to the PCPLS program is via referral from a GP within the nominated general practice.

Services are delivered jointly by Flourish Australia's community psychiatrist and psychosocial team in collaboration with the GPs and other associated allied health professionals associated with the practice. Case conferences are attended by the GP, community psychiatrist, the patient, and another health professional which may include the practice's nurse, dietitian, psychologist, physiotherapist, or a member of Flourish Australia's psychosocial team.

The Impact

The model is cost effective and sustainable due to the program's structure which allows a single psychiatrist to deliver support across 10 different practices in Western Sydney. This approach maximises impact in terms of the number of patients who can benefit, and the number of practitioners upskilled to be able to enhance the quality of mental health services for future patients. On average around 20-25 appointments/case conferences are delivered per week across the 10 participating practices.

Implications for policy?

This model has scope for expansion in its current form, and based on results to date should be considered for scalability. No policy change is required for this happen.

References: Australian Bureau of Statistics (2021), Combined 2021 Census data for Blacktown, Cumberland, Parramatta and The Hills LGA's. Accessed by: Search Census data | Australian Bureau of Statistics (abs.gov.au)

Case Study: Western Sydney PHN

Title: Marrin Weejali Alcohol and Other Drugs & Mental Health Services: Healing Minds Healing Spirits

Stakeholders: Allied health, Community

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Kieran Mahony (Kieran.Mahony@wentwest.com.au)	Year of commencement: 2017	PHN Funding Source/s: AOD Enhanced Rehabilitation, NIAS funding & ATSI Mental Health Services.

The Challenge

Western Sydney is home to over 20,537 Aboriginal and Torres Strait Islander peoples, one of Australia's largest urban Aboriginal and Torres Strait Islander populations. Unfortunately, a significant number of Aboriginal and Torres Strait Islander individuals encounter challenges regarding alcohol and other drug (AOD) concerns and/or mental health. These challenges include a disconnect between available services and their cultural practices, the effects of historical trauma and difficulties in accessing care due to geographic barriers. Additionally, there is a shortage of culturally-appropriate services and professionals, which is intensified by stigma, mistrust of mainstream services, and the complexities of managing co-occurring mental health and AOD challenges.

The Solution

Healing Minds, Healing Spirits, by Marrin Weejali is an Aboriginal community-controlled organisation providing culturally appropriate AOD treatment and case management model which supports adult Aboriginal and Torres Strait Islander men and women with families experiencing the harmful effects of alcohol and illicit substances to achieve physical, social and emotional wellbeing. Services and programs are kept accessible, relevant and targeted to the needs of Aboriginal and Torres Strait Islander people.

The service employs both AOD and mental health workers to support clients with substance abuse issues, with or without co-morbidity, and their families, through their treatment and wellness journey. Both internal services and referral pathways/linkages such as legal, employment, medical, child and family care and housing are available through the service.

The Impact

Over the past three years *Healing Minds, Healing Spirits*, have supported over 1,800 clients. The culturally-appropriate treatment models have seen clients connected to the organisation for a long time to achieve a therapeutic outcome.

Implications for policy?

Policy change is needed to ensure that the focus is on supporting and expanding community-led programs which have proven to be successful. Developing and scaling integrated care models that combine mental health and AOD services with other supports such as housing and social services, ensures a holistic approach to care.

References: Australian Bureau of Statistics (2021), Data by Region. Accessed by: dbr.abs.gov.au/

Case Study: Western Sydney PHN

Title: Place-Based Care Delivery – Cumberland Healthcare Neighbourhood

Stakeholders: Allied Health, Pharmacy, General Practice, Council, Residential Aged Care Homes, Commissioned Service Providers and Community

This case study relates to:

Practice Engagement

Data, quality and digital maturity

Key contact name and email: Scott Walters (Scott.Walters@wentwest.com.au)	Year of commencement: 2024	PHN Funding Source/s: PHN Core

The Challenge

In the 2021 census, the Cumberland LGA had a reported population of over 235,000 residents, with 60.3% of residents born outside of Australia and 73.9% of households using a non-English language as their primary language. As a largely culturally and linguistically diverse (CALD) community which was also heavily impacted by the COVID-19 pandemic, it was identified that the traditional siloed-approach to health and social care was failing to adequately meet patient needs. Whilst a significant amount of quality, supportive work is occurring in our local communities, connectivity and access to available services is fragmented.

The Solution

In early 2024, WSPHN hosted the first Cumberland Healthcare Neighbourhood Networking event to enhance collaboration, partnership and a holistic approach to patient-centred care between health care providers within the region. Attendees present included local council members, acute and primary care services, allied health providers, pharmacists, commissioned providers and aged care support pathways. The success of the initial event has led to additional events, and a further rollout of this approach into other Western Sydney LGAs.

This heavily-researched strategy has been in discussion in Western Sydney since 2010, and by the Commonwealth in 2012 (as evidenced below). Place-based care enables regionally specific solutions to be delivered to local communities. Stakeholders present are untied through a healthcare neighbourhood which encourages networking, relationship bridging and building, with examples presented of pilot place-based initiatives (including the Aged GP Night Service available in the Cumberland region). The approach taken leads to a key group forming a healthcare association to drive reform, demonstrate multi-disciplinary models of care and test initiatives such as social prescribing programs in the future.

The Impact

The impact of place-based organisations within local community settings enhances the continuity of care established through local relationships between providers, increasing the uptake and understanding of local commissioned services. Networking leads to the sharing of locally relevant and available services and resources connected to community.

The importance of placed-based organisations within community is highlighted in Practical place-based initiatives: a better practice guide (2012). This approach is further supported by the success of the Wellbeing Project, an additional place-based organisation in Western Sydney.

Implications for policy?

The change in policy is needed to ensure that the focus is on building systems, not just programs within community. Achieving a collaborative approach requires governance to be established between existing pillars of care providers. Incentive for these pillars to coordinate activity will aid in the success of the model an equitable approach across all community areas such as health and education, with a focus on ensuring that systems are funded, not just funding programs. The funding and approach need to differ based on regional needs and local data, ensuring that diverse communities are adequately connected to available services.

References: Australian Bureau of Statistics (2021), *Cumberland 2021 Census Community Profiles*. Accessed by: 2021 Cumberland, Census Community Profiles | Australian Bureau of Statistics (abs.gov.au)

Case Study: Western Sydney PHN

Title: Place-Based Care Success: North West Community Services: The Wellbeing Project

Stakeholders: Allied Health including therapists, Community

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Kieran Mahony (Kieran.Mahony@wentwest.com.au)	Year of commencement: 2023	PHN Funding Source/s: Mental Health Flexible

The Challenge

The impact of natural disasters and the growing challenges associated with the rising cost of living means that there has been an increase in people experiencing crisis and vulnerability, along with complex individual and family needs. Community members within the Blacktown and Hills LGA, areas of immense growth and diversity, are experiencing challenges with the limited supply of affordable housing, rentals and mortgage stress, increasing health care costs and growing mental health issues. These areas are home to a diverse population of over 588,652 people.

The Solution

The program prioritised the community of Blacktown and Hills LGA's who were impacted by the Hawkesbury-Nepean floodplain with aim to expand community wellbeing and therapeutic programs with counsellors. The program organised free events and festivals such as Spring Fairs in South Maroota and Riverstone to enhance the connection between local communities. In addition, the Wellbeing Project offered therapeutic support in a school-based setting at Cattai Primary School, with nearly half of the students engaging with this additional support, with positive feedback being received from both school staff and students.

The Impact

Information on the impact of The Wellbeing Project's initiatives was sourced from clients who engaged with the project, as well as North West Community Services staff members who delivered the initiatives. Feedback was sourced via client feedback to staff. NWCS staff sharing during a focus group discussion with members of the WESTIR research team.

Independent report: https://www.westir.org.au/publication/the-importance-of-place-based-community-organisations-in-disasters-reflections-from-the-well-being-project/

Implications for policy?

No policy change is required, however more long-term support and recognition for place-based community centres is required as they act as intermediaries between their communities and external organisations. Placed-based community organisations also fill in the gaps in disaster recovery by providing informal support. Their local knowledge, relationship with community, their experiences in disaster responses, and their capacity to adapt to the needs and care of their communities not only provides awareness, but also encourage access to health services.

References: Australian Bureau of Statistics (2021), Combined 2021 Census data for Blacktown, Cumberland, Parramatta and The Hills LGA's. Accessed by: Search Census data | Australian Bureau of Statistics (abs.gov.au)

Case Study: Western Victoria Primary Health Network (WVPHN)

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

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

This case study relates to:



Workforce & Access to Allied Health Care

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

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

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

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

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

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

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

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

Link to references

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

Case Study: Western Victoria Primary Health Network (WVPHN)

Title: Your Care Path (YCP), Regional Care Partnerships Chronic Conditions

Stakeholders: Rural Health Services, Allied Health Clinicians

This case study relates to:



Integration, models of care and funding



Workforce & Access to Allied Health Care

Key contact name and email: Sara Thomas – sara.thomas@westvicphn.com.au	Year of commencement: 2024	PHN Funding Source/s: Core Flexible

The Challenge

Allied health services play a significant role in the early intervention and ongoing management of chronic conditions to support consumers to self-manage symptoms to promote independence and wellness. There are ongoing challenges in rural regions in ensuring access to allied health services including limited allied health workforce and high demand on available services.

The Solution

Throughout 2022-2023, WVPHN undertook a process to recommission core flexible funding to better support the delivery of services for people with chronic conditions that supports thin markets to overcome allied health workforce shortages to increase service access for people in rural regions. A comprehensive service redesign process involving codesign and market sounding with service providers, community members and people with lived experience led to the development of an enhanced chronic condition service model, known as Your Care Path (YCP), that is delivered through regional partnerships across the four WVPHN subregions. Each partnership includes one lead agency that represent formal partnerships with relevant organisations (12 rural health services and one general practice collectively) required to deliver YCP across all rural areas within the subregion. YCP includes a broad range of treatment interventions delivered by qualified allied health clinicians to support the needs and preferences of consumers with chronic conditions.

The inclusion of regional partnerships as a core element of the YCP service model has supported service access and integration through the implementation of shared workforce models across multiple regional partnerships that are supported by appropriate clinical governance. These include:

- reallocation of 1.0 (allied health) FTE, associated funding and activity targets from a lead agency across multiple partner agencies to manage capacity and support service demand.
- sharing employment of an occupational therapist across three partnering organisations (one lead agency and two partner agencies) to increase access to service.
- multiple allied health clinicians (employed by a lead agency) providing services within two partner agencies to increase access to services.

The Impact

YCP is in its infancy, with service delivery commencing on 1 January 2024. WVPHN is working with an external consultant to undertake a comprehensive evaluation of the program during its first three years. The evaluation is outcomes focussed and aligned to the quintuple aim of health care with patient experience, population health, reducing costs, clinician wellbeing and health equity shaping the evaluation framework. Outcome measures will also include measuring the success and strength of partnerships, as well as the level and effectiveness of service integration.

Implications for policy?

WVPHN supports policies that enable partnership approaches to overcome allied health workforce challenges in rural areas, including flexible funding models to support the development and maintenance of partnerships and implementation of associated business models (i.e. shared workforce models) to increase access to services.


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