Australian Physiotherapy Association
Submission

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Sustainable Health Review

Government of Western Australia
Department of Health

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Authorised by:

Rahul Madan
President
WA Branch
Australian Physiotherapy Association
2/174 Hampden Road
Nedlands WA 6009
Phone: (08) 9389 9211
Fax: (08) 9389 9221
www.physiotherapy.asn.au

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Introduction

As a profession, Australian physiotherapists pursue what has come to be called 'value-based healthcare'.[1] At its core, value-based healthcare is about maximizing value for patients: that is, achieving the best health and related outcomes at the lowest cost.[2] Many of these 'fixes' improve technical efficiency.

We put our view into action by participating, for example, in Choosing Wisely Australia.[3] Additionally, our members in both the public and private sectors have participated in service innovation trials and have expressed an interest in participating in further trials as a way of testing the feasibility of reforms. For example, we are in discussion about partnering in a trial which will test 'bundled payments', in recognition that this is one mechanism that may assist to achieve the goal of improving value.

We take the view however, that a stronger focus is needed on mechanisms that, collectively, are more transformative – that create allocative efficiency (the allocation of resources to the places where value will be maximised) as well as technical efficiency.

As a professional peak body, we have begun a structured program through which we anticipate enhancing our member's skills and knowledge in this area.

We understand the desire to deliver coordinated and integrated care. We suggest that careful consideration of two dimensions of coordination/integration – firstly a critical appraisal of the operational domains that impair consistent and reliable care (e.g. information systems, funding rules, scope of the service); and secondly a determination of the point at which further integration will have diminishing returns (i.e. the degree or intensity of the integration).[4] We suggest that efforts to enhance coordination/integration need to focus on aspects of the health system where there is a clear operational opportunity to improve, and that the degree of integration needed to achieve the improvement results in a net 'return on investment'.

Leveraging existing investment in primary, secondary and tertiary healthcare, as well as new initiatives to improve patient centred service delivery, pathways and transition

It is our view that the sustainability of the WA health system will improve where there is continued reappraise of 'gate-keeping' / 'authorisation' mechanisms. We believe that a reappraising of these mechanisms can improve patient centred service delivery, 'smooth' the pathways of the patient in the system and reduce 'transaction costs'.

We suggest that targets for this reappraisal include:

- enhancing the ability of physiotherapists to play a role in optimising the use of medicines, and
- allowing for direct referral to diagnostic imaging.

For example, there was a 55% increase in emergency department (ED) presentations between 1999 and 2009. The population growth was only 19% over that period.[5] Approximately 10% of all ED presentations are appropriate to be seen by a Primary Contact Physiotherapist (PCP), and the third most common reason for delays in PCP managing their patients has been reported to be delays in gaining access to prescribing analgesia. There is a clinical trial of prescribing by physiotherapists in this environment.

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The Australian Physiotherapy Association is preparing a proposal to seek an endorsement for physiotherapists to prescribe within their scope of practice for the Physiotherapy Board of Australia. The WA government could amend its legislation to allow physiotherapists to prescribe where the practitioner's registration is endorsed under section 94 of the *Health Practitioner Regulation National Law* (as the South Australian law allows) and where the activity occurs within a clinical trial which has Human Research Ethics Committee (HREC) approval (as the Queensland law allows). This would allow WA to use any such endorsement to assist in sustaining its health system.

Physiotherapy pre-entry training provides a sound basis for direct referral for diagnostic imaging and later professional education and experience enhances the basic competencies. Rather than have patients be involved in 'circular referral' where reference back to a doctor is solely for the request for imaging, we take the view that the WA health system would be made more sustainable by credentialing physiotherapists and allowing direct referral to diagnostic imaging in a range of contexts.

One study from an orthopaedic outpatient department which ran a physiotherapy screening program showed that costs were reduced because physiotherapist 'were less likely to order radiographs and to refer patients for orthopaedic surgery than were the junior doctors'.[6] Another UK study found that that physiotherapists ordered no MR scans or x-rays without therapeutic value, compared to 21% of imaging ordered by doctors.[7] A third study found that physiotherapists did not refer excessively for investigations.[8]

The mix of services provided across the system, including gaps in service provision, sub-acute, step-down, community and other out-of-hospital services across WA to deliver care in the most appropriate setting and to maximise health outcomes and value to the public.

We see a small number of rapidly emerging challenges in the health arena.

We are concerned that people with disability will 'fall through the gaps' as the National Disability Insurance Scheme (NDIS) finishes its national consolidation and state-based models are superseded. We are beginning to hear disturbing examples of 'boundary guarding' (i.e. "That's the responsibility of the Health Department.", or "That's a NDIS obligation.").

We are concerned that older people, especially those in residential aged care facilities are at risk of de-conditioning because the incentives are such that it is easier to transport them to hospital for assessment, rather than actively intervene at home / on-site.

Thus, a key element of the Sustainable Health Review might be to work on the intersections with the federally funded components of whole-person care for vulnerable groups. One illustration of this would be to review legislation, regulation and program arrangements for the provision of aides, equipment and assistive technologies and ensure that program boundaries do not result in problems with the provision of a comprehensive package of care.

We are also concerned that people with mental health issues are at risk of missing out on access to health professionals who can assist them with physical health issues. People with mental health issues are known to have poor physical health and without access to services will be further disadvantaged.[9] Employing professionals such as physiotherapists will alleviate some of these issues. These professionals need to be supported by structural and systemic

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adjustments, so that the system overcomes biases like diagnostic over-shadowing and other risks to whole-person care.

Ways to encourage and drive digital innovation, the use of new technology, research and data to support patient centred care and improved performance.

The physiotherapy profession has signaled its determination to participate fully in the digital health environment. As a result, in 2017 the APA embarked on a substantial digital health strategy, and is nearing the end of the initial discovery phase. We believe that we are the only allied health profession to be making such a significant investment in digital health.

The report on our discovery phase is not yet in the public domain. Despite that, we would be happy to discuss the findings of this work with the Department.

We outline some of the key issues below.

A key way to encourage and drive digital innovation will be to cultivate a 'digital-ready' and 'digital-eager culture'. The transition to a digitally-enabled approach is likely to require services to give up legacy systems and processes they have relied on and change the fundamental workflow and administration already established.[10] To achieve this level of effectiveness, frontline staff may need to change how they work in order to incorporate these insights and act on them at the point of care.[11] This means that we will need to create organisational cultures that make the uptake of innovation more likely.[12] [13] Recruitment is likely to need to shift to ensure that new team members have the appropriate cultural fit.

Another key mechanisms will be "trial-ability" – the ability to try out an innovation without total commitment and with minimal investment improves the prospects for adoption and diffusion. In this context, we believe that secure messaging will need to be supported in both the public and private sector – to create the connections desired by all.

Synchronous audio-visual communication where the parties are not collocated needs to cultivated as a norm – both for clinical services, but also for routine contact which would previously have occurred by telephone. Our members are taking up 'telehealth'; but are consistently confronted by the challenge that this is not 'the norm'.

A recent systematic review found that telerehabilitation is effective in the improvement of physical function, whilst being slightly more favourable than the control cohort following intervention. Sub-group analyses reveals that telerehabilitation in addition to usual care, is more favourable than usual care alone; whilst treatment delivered solely via telerehabilitation is equivalent to face-to-face intervention for the improvement of physical function. The improvement of pain was also seen to be comparable between cohorts following intervention.[14] (Figure 2 from paper follows).

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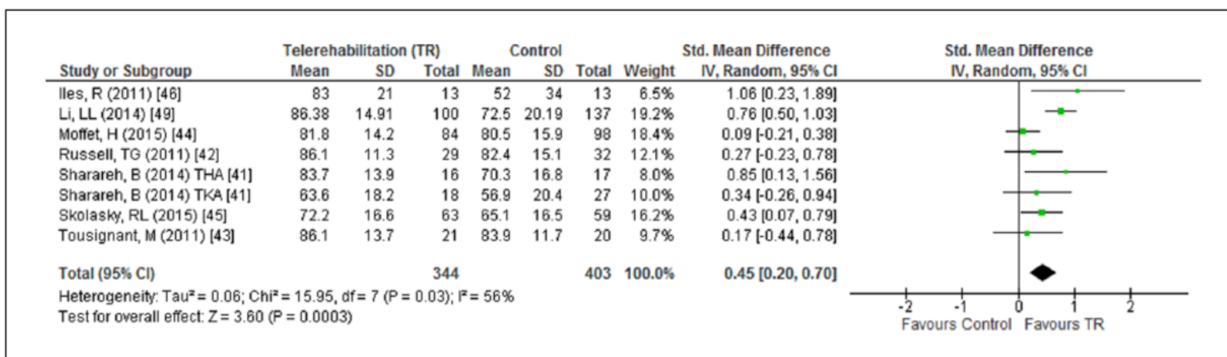

Study or Subgroup	Telerehabilitation (TR) Mean	SD	Total	Control Mean	SD	Total	Weight	Std. Mean Difference IV, Random, 95% CI
Iles, R (2011) [46]	83	21	13	52	34	13	6.5%	1.06 [0.23, 1.89]
Li, LL (2014) [49]	86.38	14.91	100	72.5	20.19	137	19.2%	0.76 [0.50, 1.03]
Moffet, H (2015) [44]	81.8	14.2	84	80.5	15.9	98	18.4%	0.09 [-0.21, 0.38]
Russell, TG (2011) [42]	86.1	11.3	29	82.4	15.1	32	12.1%	0.27 [-0.23, 0.78]
Sharareh, B (2014) THA [41]	83.7	13.9	16	70.3	16.8	17	8.0%	0.85 [0.13, 1.56]
Sharareh, B (2014) TKA [41]	63.6	18.2	18	56.9	20.4	27	10.0%	0.34 [-0.26, 0.94]
Skolasky, RL (2015) [45]	72.2	16.6	63	65.1	16.5	59	16.2%	0.43 [0.07, 0.79]
Tousignant, M (2011) [43]	86.1	13.7	21	83.9	11.7	20	9.7%	0.17 [-0.44, 0.78]
Total (95% CI)			344			403	100.0%	0.45 [0.20, 0.70]

Heterogeneity: $Tau^2 = 0.06$; $Chi^2 = 15.95$, df = 7 (P = 0.03); $I^2 = 56\%$
Test for overall effect: Z = 3.60 (P = 0.0003)

Figure 2. Meta-analysis comparing the effect of telerehabilitation on physical function and disability following intervention for all conditions.

The research, and our members, support the use of 'telehealth' as a part of a structured approach to services, rather than an ad hoc approach.

Greater sustainability in the WA health system could be achieved by supporting private practice and public system use of telehealth, with a focus on ensuring continuity of care. In this context, the physiotherapists who are involved in patient care prior to hospitalisation could be funded to provide follow up care through telehealth mechanisms, as a complement to telehealth outreach by hospitals,

We understand that the focus of the Review is on the resources managed by the Health Department. However, other Western Australian agencies have the ability to create incentives that would assist with service integration. For example, both WorkCover WA and the Insurance Commission of WA could play roles by providing incentives for physiotherapists to adopt contemporary electronic health records.

Opportunities to drive partnerships across sectors and all levels of government to reduce duplication and to deliver integrated and coordinated care

The WA system has the opportunity to lead Australia by complementing the 'traditional' ways of commissioning services (which have generally been within the publicly-managed sector) with commissioning services from the private sector.

In particular, the 'public system' needs the authority and mechanisms to purchase from the 'private system' (e.g. for patients who hold no private health insurance), and thus prevent them (sometimes literally) attending comparatively high cost service sites such as hospitals. This model is particularly valuable in a dispersed context such as Western Australia, where the establishment of community health infrastructures and the maintenance of private practice services are likely to be mutually incompatible for cost and workforce reasons.

For example, referral to community-based physiotherapy from an ED currently uses three options – that the referral is to another state-funded service (e.g. community health), that the referral is to a physiotherapy private practice and the patient relies on their private health insurance, or that the referral is to a private practice and the patient pays the entire fee. Our WA members believe that a mechanism to allow for referral to specialised services provided in the private sector, but having these services funded by the state, would be a valuable complement to the existing models. We believe that, in appropriate circumstances, this will facilitate prompt

care, shift the model from being one which involves return to the hospital site and leverage the expertise in the private sector.

A number of emerging 'interface' problems are occurring. Generally, these are at the interface between the state-managed 'health' system and private health insurance or the National Disability Insurance Scheme (NDIS); and between hospital and community health services.

Our members are also aware of circumstances in which patients would be happy to fund services under their private health insurance, however constraints on those products with respect to aide and garment provision result in a choice to have the entire service provided by the state-funded system as an outpatient.

We believe that there are mechanisms, especially through the use of smart technologies and changes in funding rules, to better coordinate service provision, which is funded under two insurance schemes.

Ways to drive improvements in safety and quality for patients, value and financial sustainability, including cost drivers, allocative and technical efficiencies

There is a wide range of advanced physiotherapy services that can bring high value to the WA community. These services include, but are not limited to:

- primary contact physiotherapy services in Emergency Departments (EDs)
- physiotherapy-led orthopaedic, neurosurgical and rheumatology outpatient screening clinics
- physiotherapist led pelvic health clinics to manage patients referred to gynaecological, colorectal and urological specialist outpatient services
- osteoarthritis hip and knee services – including assertive outreach models for conservative management in the community, through to post arthroplasty rehabilitation and review clinics
- screening, on presentation to the ED, of all presentations from aged care facilities as well as older people from the community who are identified as frail
- back pain assessment clinics
- paediatric screening clinics.

Despite the high quality, safe and cost-effective treatment provided, at present, physiotherapy-led clinics are classified according to "the type of clinician providing the service", rather than "the nature of the service provided". The '20-series' classification needs to be applied to these clinics in recognition of the value of the service offered, rather than what appears to be a focus on inputs alone.

For example, an Australian study has shown that patients treated by Primary Contact Physiotherapists (PCP) waited on average 31 minutes less than those treated by other practitioners and had an average treatment time of 108 minutes compared with 148 minutes. Overall, 93% of patients treated by primary contact physiotherapists were discharged from the emergency department within a 4-hour time period compared to 75% of patients discharged when treated by other practitioners[15].

Physiotherapy-led specialist orthopaedic screening clinics have also been shown to bring high value to the health system.[16] [17] [18]

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We also take the view that the system needs to enhance web-based scheduling systems, which have been shown to have benefits such as enhanced patient satisfaction, reduced 'no-shows', and reduced time on waiting lists.[19] Contemporary models allow for a push-pull process that would allow reminders to ensure that tasks to be undertaken by the health service (e.g. completion of pathology and diagnostic imaging reporting) are complete, and reminders to patients also occur (e.g. to bring a medicines list to the appointment).

We also suggest that the Review consider what appears to be an emerging problem with multiple accreditation. Outside the hospital sector, our members are beginning to see calls for accreditation to meet standards in the primary health care area (from the Australian Commission on Safety and Quality in Health Care), in the disability area (from National Disability Insurance Australia [NDIA] / the National Disability Insurance Service [NDIS]) and the aged care sector. Our profession has a strong commitment to safety, and is concerned that the regulatory costs will outweigh benefits to the community (and thus be unsustainable).

The key enablers of new efficiencies and change, including research, productivity, teaching and training, culture, leadership development, procurement and improved performance monitoring

Our profession believes that the visible presence of leaders in the profession plays a key role in enabling improvement. In this context, the re-classification of the Chief Health Professions Officer position sends a message, which is in contrast to the Review's desire to identify key enablers for change and improvement.

In this context, we would suggest that the Review consider the way in which professional leaders such as the Chief Health Professions Officer are positioned in the structure of the Department going forwards, and

One of the key enablers for value creation must be a more sophisticated view of 'benefit sharing'.

We use the term 'benefit sharing' to describe the ways in which benefits from service innovation are distributed in the complex Australian healthcare environment, where the mechanism for improved value (e.g. in the primary care sector) is misaligned to where the 'saving' occurs (e.g. in the hospital sector). To date, there is a perception that prices based on marginal costs can be paid for services outside the publicly funded system when this will undermine sustainability of the service model.

Thus, should the WA Primary Health Alliance operate a program in the community setting which results in greater value in the hospital sector; it will be important for professionals in the community setting to share the benefit.

Any further opportunities concerning patient centred service delivery and the sustainability of the WA health system.

We are in discussion with universities (including Notre Dame in Fremantle) and the National Aboriginal Community Controlled Health Organisation (NACCHO) about strengthening the capacity of Aboriginal Community Controlled Health Organisations (ACCHOs) to host physiotherapy student placements. It is our view that such placements would have a number of short-term benefits (e.g. enhancement of access to physiotherapy for the Aboriginal community); but importantly would provide a sustained benefit (e.g. enhanced cultural safety

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skills for non-Indigenous physiotherapy students and the ability for Aboriginal students to develop their professional skills in their own community).

We believe that there is interest and capability for such a model to be tested in the WA context and would commend this model to the Review.

About the APA

The APA vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing.

The APA is the peak body representing the interests of Australian physiotherapists and their patients. It is a national organisation with state and territory branches and specialty subgroups. The APA represents more than 23,000 members who conduct more than 23 million consultations each year.

The APA corporate structure is one of a company limited by guarantee. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

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