

■ Reflections from the NAHCC Executive Officer

Ian Woodruff completed his term as the NAHCC EO in June and was asked to reflect on the most commonly asked questions of Allied Health.

What exactly is Allied Health?

Most would respond with “I’m actually a Physiotherapist / Social Worker / Speech Pathologist (insert your own profession here), but we are part of the Allied Health Division”.

Allied Health has long struggled with its identity as a collective. Most frequently it is defined by exclusion – “the non-medical, non-nursing clinicians”. Various professions move in and out of the Allied Health “box” depending on the organisation, care setting and policy issue.

NAHCC Member Organisations

Full Members

- Audiological Society of Australia
- Dietitians Association of Australia
- Australian Association of Exercise and Sport Science
- Australian Music Therapy Association
- Occupational Therapy Australia
- Orthoptic Association of Australia
- Australian Orthotic & Prosthetic Association
- Society of Hospital Pharmacists of Australia
- Australian Physiotherapy Association
- Australasian Podiatry Council
- Australian Psychological Society
- Australian Association of Social Workers
- Speech Pathology Australia

Associate Member

- Health Professions Council of Australia

Health Professions Council of Australia Member Organisations

Full Members

- Audiological Society of Australia
- Dietitians Association of Australia
- Health Information Management Association of Australia
- Occupational Therapy Australia

- Optometrists Association Australia
- Orthoptic Association of Australia
- Australian Orthotic & Prosthetic Association
- Society of Hospital Pharmacists of Australia
- Australian Physiotherapy Association
- Australasian Podiatry Council
- Australian Psychological Society
- Australian Institute of Radiography
- Australian Association of Social Workers
- Speech Pathology Australia

Associate Member

- Australian Association of Hospital Interpreters

What does the “allied” mean?

For the past seven years I have had the privilege of occupying the role of NAHCC Executive Officer.

It has always impressed me that such a diverse group of health professionals successfully manages to remain cohesive and patient focussed – that to me is the “allied” part of the allied health label. At face value, social workers and orthoptists have as little (or as much) in common with each other as they do with an oncologist, yet the thirteen core professions in NAHCC have maintained a unified, inclusive approach to their contribution to the health care system.

Change is now a given in all sectors of health and Allied Health professionals have been packaged and then repackaged in numerous structural configurations in



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their respective organisations. The wisdom of some of the restructures is open to debate, but interestingly, even when they are widely dispersed across an organisation, Allied Health still retain a sense of cohesion and group identity.

In the acute hospital environment, Allied Health is relatively small in budgetary terms, which usually means that it has to work harder than “big budget” groups to gain attention. As the care acuity decreases, Allied Health seems to gain increasing power and “centrality”. The irony is that, in absolute numbers, most Allied Health professionals are in the acute sector.

What does Allied Health contribute to healthcare?

No one would deny the value of Allied Health in any sector of the health system, but with small numbers (and consequently limited resources), a comprehensive collection of evidence based outcome measures for an Allied Health service has not yet been achieved.

Individuals, Allied Health professional bodies and some research groups have worked hard to develop specific measures – for example, the imminent release of Australian Therapy Outcome Measures (AUSTOMs) by Latrobe University will be a strong contribution in the fields of Occupational Therapy, Physiotherapy and Speech Pathology – but there is, as yet, no nationally consistent evaluation framework across the range of professions and care settings.

What of the future?

Technology is driving rapid change in all aspects of daily life. Healthcare is no exception.

Telehealth

Linking rural patients with city specialists is now routine thanks to high quality video linkages. This helps to address the inequalities of access between metropolitan and remote Australians. However, it offers huge potential to all patients. Within a decade most households will be equipped with videophones projecting images onto large plasma screens. Care delivery in fields where physical manipulation is not routinely required is quite feasible via this technology.

It's not hard to imagine scenarios where the clinician (located in a hospital) is counselling a patient in his or her own home. For example, the following are not too far into the future:

- A Dietitian providing nutrition counselling to a person with diabetes and even guiding the patient's shopping selection in real time with the aid of a videophone!
- An Occupational Therapist monitoring an elderly patient's progress with activities of daily living without leaving the hospital!
- A Social Worker following up a patient's recent nursing home admission by videoconferencing with the patient and her family.

Electronic health records

Augmenting the telehealth revolution will be universal patient records. With appropriate privacy safeguards, clinicians will be able to create, access and share relevant patient information simply by asking the patient to “log-in” with their smartcard.

Advanced diagnostic and treatment aids

Self-diagnosis and testing equipment is becoming increasingly more accessible to the lay-public. Blood glucose monitoring, blood pressure monitoring, urine analysis and body composition testing were all “clinician-only” activities as little as a decade ago – imagine what will be available to the public in the next decade!

Readily accessible diagnostic tools will substantially change the way that preventive health is practiced and promoted. Community pharmacies – already the primary health information point for much of the population – may become “self-testing” stations for a wide range of illness risk factors. Advances in prosthesis and nerve regeneration technologies will have profound impacts on trauma recovery – perhaps moving rehabilitation from the hospital to the home.

Globalisation

We have an increasingly mobile Allied Health workforce with Australian professionals gaining experience around the globe. This is likely to result in practice enhancement but may also exacerbate existing local shortages in various Allied Health professions. Is it too ridiculous to imagine health agencies “buying in” bereavement counselling services from New York? This approach is already pervasive in the “call centre” industry – why not health?

Allied Health professionals are creative and fast-adopters and will navigate the rapidly changing environment to continue delivering the best quality, evidence-based healthcare achievable with available resources.

The Challenges of being a chair!

- The challenges of a “National” Allied Health Organisation

contributed by Lauren Andrew, Chair, National Allied Health Casemix Committee

For 10 years National Allied Health Casemix Committee has breathed life into the measurement systems of Allied Health. The National Allied Health Casemix Committee (NAHCC) was established in 1993 to provide a collective “casemix voice” for Australia’s Allied Health professionals. There is a motley crew of who we represent from (alphabetically!) Audiology to Social Work.

Since 1995 funding has also been obtained from the Commonwealth Department of Health and Ageing for project work, and from 1997 a Secretariat was established at RMIT University in Melbourne.

Perhaps some of the challenges of being a Chair come from the aim of NAHCC which is: To provide the Australian healthcare industry with nationally consistent methods of classifying, measuring, evaluating and developing Allied Health services, contributing to better health outcomes.

The NAHCC outcomes have been:

- Development of a National identity and infrastructure
- Development of the Health Activity Hierarchy – believe it or not most of us have been affected by this!
- Minimum Data Set
- Indicators for Intervention (version 1)
- Allied Health sensitive ICD codes
- Convened 5 National Allied Health casemix conferences, and numerous presentations across the country to different Allied Health groups
- Published 28 editions of Talking Casemix
- Developed and maintained a fantastic resource in the NAHCC website
- Provided expert members to a range of National projects and peak bodies (NCCA, AIWH, CCCA, AusTOM, NHCDC and other acronyms!!!)
- Published a Strategic Plan for NAHCC

To be able to fulfill these aims and outcomes there are some key elements that need discussion:

1. The Allied Health services that we are trying to measure
2. National uptake of our tools to be implemented to contribute better health outcomes.

WHAT ARE THE ALLIED HEALTH SERVICES WE ARE TRYING TO MEASURE?

The tools that NAHCC have developed have gone a long way to help clinicians measure their activity, with the recognition that we need to develop this further. In the past, most of NAHCC’s products have been taken up by the acute/sub acute public health sector. We need to take this further, particularly into the realm of performance measures to support innovative practice in health.

What do we need to do to take our measurement systems further? We need engagement from a range of sectors in the Allied Health community. We need to target the areas which have the eye of the greater health agenda: ambulatory care, emergency, the transition points from acute to subacute to community. We need to determine what is it we need to measure to support or indeed dismiss our practice. We also need to continue to develop tools that are patient not discipline focussed.

NATIONAL UPTAKE OF OUR TOOLS

As mentioned in the previous point, we need engagement from the Allied Health community to guide the development of our tools and then to appropriately implement and report on them.

In the past five years the advancement of Allied Health in public health has been incredible. Most major health services now employ Directors of Allied Health. In addition, the health services are demanding that we work with an Allied Health focus, rather than our individual disciplines. We need a national peak body that represents Allied Health, not a collection of disciplines. The work of NAHCC is complementary to this final point. We need to develop tools that advance Allied Health measurement and hence engage with the Allied Health community. Unless we become less

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'I wish I knew then, what I know now'

- Contributed by Annette Byron, Dietetics representative to NAHCC

The answers to the questions of what does an allied health manager need to know, and what does an allied health junior clinician need to know, are rather dependent on the environment in which the department is placed.

Generally speaking however, the manager will need to know enough about the external environment and their own department in order to effectively and efficiently plan, organise, direct, staff, coordinate, report and budget ⁽¹⁾ in relation to departmental activities. The junior clinician on the other hand, will at least need to know enough to comply with departmental and organisational guidelines.

For the manager, information about departmental activities may be gained through the collection of statistics within the department alone, or in combination with other organisational clinical information management systems. The manager needs to know what classifications are available, for example ICD-10-AM ⁽²⁾, Indicators for Intervention ⁽³⁾, HAH Version 1 ⁽⁴⁾ to support data collection and identify which classifications will be most useful in their health care setting. They will need to know enough about these to implement a system independently or, as a group of allied health disciplines within one organisation to ensure that useful data is collected without an excessive burden. More importantly, the manager should know how to analyse the data collected so that they can advocate for their service to other disciplines and administrators.

In more specific terms, having information about the indicators for intervention enables the manager to discuss with other disciplines and administrators in the organisation as to why their particular discipline is needed as part of the health care team. When combined with other information such as time and intervention, a better understanding of the profile of care provided can be achieved, particularly when this exercise is undertaken on a multidisciplinary basis. Perhaps in the future we will have better defined outcomes for each IFI and related interventions to enhance this further. Having time as a measure of resource use, rather than occasion of service, facilitates better allocation of resources to particular inpatient and outpatient areas. It can also inform the development of group programs rather than individual service provision and demonstrate the efficiency of departments.

Defining all departmental activities in terms of the HAH will enable comparison of activities between organisations of like dimensions. It will also enable tracking of important activities such as teaching and training, which are coming increasingly under scrutiny as more students are placed with limited resources to support their training experience. Managers are thus able to have discussions with their organisation and universities about the resources employed in training and the productivity of students and staff while this is happening.

In returning to the issue of what junior clinicians need to know, they need to be able to follow the direction set by their strategically thinking and information wise manager. Empirically however, it can be argued that some knowledge of the reasons behind the direction will enhance the understanding of the junior clinician and promote a commitment to the entry of accurate data into clinical management information management systems. This is probably best achieved by consulting all clinicians when new systems are being implemented and upgraded, and by occasional updates. Hopefully, this will keep junior clinicians in the picture and prepare them for potential roles in the future as managers.

- (1) Barthol, K., Martin, D., Tein, M. & Matthews, G. (2nd Edition) *Management: a Pacific Rim Focus*, McGraw Hill
- (2) National Centre for Classification in Health <http://www2.fhs.usyd.edu.au/nch/>
- (3) Report on the Development of Allied Health Indicators for Intervention (IFI) and Performance Indicators (PI) and Revision of Allied Health-sensitive ICD-10-AM codes for inclusion in ICD-10-AM Edition 2, National Allied Health Casemix Committee <http://www.dlsweb.rmit.edu.au/bus/nahcc/hierarchy.htm>
- (4) Health Activity Hierarchy V1, National Allied Health Casemix Committee <http://www.dlsweb.rmit.edu.au/bus/nahcc/>

Australian Therapy Outcome Measures Update

The Australian Therapy Outcome Measures (AusTOMs) project is now nearing completion. As you may recall, the AusTOMs project is a Commonwealth-funded initiative, aiming to develop a valid and reliable measure of therapy outcomes for the physiotherapy, speech pathology, and occupational therapy professions. The project has been run from La Trobe University, Melbourne, with key investigators from the Schools of Human Communication Sciences, Physiotherapy, Occupational Therapy and Public Health. Representatives from the National Allied Health Casemix Committee (NAHCC) have contributed to the reference group overseeing this project. The reference group has met every six months to disseminate and discuss issues arising from the project.

There have been three main stages to this project, reported in previous *Talking Casemix* newsletters:

1. *Scale development*: This involved focus groups of Victorian clinicians in all three professions to determine appropriate scale headings and terminology. The draft scales were then sent to clinicians in each profession, using the NAHCC membership, for further refining, and to determine consensus agreement on the scales.
2. *Training and reliability testing*: Various health settings across Victoria were recruited for participation in the study, and clinicians within these settings were trained in the use of the AusTOMs scales. The reliability of the scales was assessed using written case studies.
3. *Data collection and validation of the scales*: Trained clinicians from participating health settings were then asked to collect data on prospective clients from October 2002 to March 2003. Clinicians made ratings of patient status at admission and discharge using the relevant AusTOM scale. These data will now be used to investigate the validity of the AusTOMs scales for measuring patient outcomes.

The team received a total of 1068 responses for the validation phase of the AusTOM, across the three professions (264 speech pathology, 289 physiotherapy, and 515 occupational therapy responses). We are still in the process of analysing these results to answer questions about the validity of the AusTOMs. However, some interesting points within our data so far, include:

- *Swallowing* was by far the most frequently selected scale for speech pathologists, indicating that patients with dysphagia (swallowing disorders) make up a large proportion of speech pathology work within these settings. It was also a 'high priority' disorder — the majority of responses indicated that swallowing was the first priority for treatment, even where the client had other disorders such as language or speech.
- *Musculoskeletal* was the most common scale selected for physiotherapy, indicating that a lot of physiotherapy work in these settings is concentrated on this area. Musculoskeletal disorders seen by physiotherapy clinicians included those related to aetiologies such as fractures, arthritis and back pain.
- Occupational therapists most often selected the '*Upper limb use*' scale to rate the outcomes of their patients in these settings, followed closely by the '*Functional Walking and Mobility*' and '*Self-care*' scales, which were also commonly used. Our data indicates that occupational therapists often concentrated on more than one aspect of client functioning during the same 'episode of care', frequently selecting up to three AusTOMs scales (reflecting three areas of therapeutic focus).

The results of the AusTOMs study, including information on the validity and reliability of the scales, were presented at the Allied Health Outcomes Conference, on 8th August, 2003. This conference was held in Melbourne, at the Hotel Sofitel. We were pleased to have Professor Pam Enderby and Dr Alex John (co-creators of the Therapy Outcome Measures or TOMs from the UK) as guest speakers at the conference.

Pam and Alex spoke about the latest developments of their UK-TOM, and how these scales have been applied and used in managing caseloads across the National Health Service (NHS) in Britain.

Best Practice Benchmarking for Allied Health

- Contributed by Debbie Law

Were you an Allied Health representative from a state or peak body, attending the Benchmarking Workshop in November 2001?

The "Standards for Benchmarking of Allied Health Services" has been finalised by a national working party with the assistance of the Commonwealth Department of Health and Ageing, following industry consultation. It is now available on the NAHCC website located at www.dlswb.rmit.edu.au/bus/nahcc/ or, from your state representative to NAHCC.

The genesis of this collaborative project was based on issues raised with the NAHCC Executive by Allied Health managers, who had experienced the application of inconsistent methods and inappropriate staffing and funding formulae by external consultants benchmarking their services. The workshop was used to develop both a better understanding of the issues and to establish the standards and key data elements of a desired process.

Who should use the Standards? It is hoped that all participants in the complex task of benchmarking will use it. It represents a product which should inform the development of best practice clinical models, assist health administrators and government officials to take an appropriate and valued view of Allied Health

services and resource utilisation, and build capacity within Allied Health to work with and steer consultants and actively contribute to benchmarking processes.

Benchmarking may serve several purposes and the Standards help identify cooperative, correct, precise and transparently purposeful processes for enhanced Allied Health performance. Most of all, it's about having a framework from which to reach an agreement on the method that makes it a meaningful project. However, underpinning this is a clear message to all managers and staff of Allied Health services that standardised data collections and methods of analysis are crucial to achieving the right outcomes.

Our next steps are to have this published as an official publication of Standards Australia to engage our State and Territory Departments of Health or Human Services and later produce an article for publication.

The working party recommends this publication to you and further assistance or information can be sought via the NAHCC.

Jo Bothroyd, Carolyn Broadfield, Annette Byron, Debbie Law, Helen McCathie, Ibolya Nyulasi, David Rhodes, Stephen Tucker, Ingrid Vogelzang, Ian Woodruff.

Meeting of the National Hospitals Cost Data Collection Reference Group — June 3, 2003 in Canberra

- Annette Byron, Chief Clinical Dietitian, Royal Adelaide Hospital

The main topic of discussion for the day was the creation of AR-DRG Version 5.0 service weights by late 2004 for Round 8 (2004-2005) of the National Hospital Cost Data Collection. Participants in the meeting came from the various State/Territory jurisdictions and clinical areas. Eight categories require review including nursing, operating rooms, pharmacy, prostheses, critical care, pathology, imaging and medical and surgical supplies. The current application of existing service weights in the public and private sector was considered, their initial development

and subsequent revisions, and potential methodology for Version 5.0 service weights. It was acknowledged that where possible, the methodology should be robust and sustainable. In some areas such as nursing, it was agreed that definition of a minimum data set would be useful and that clarification of cost buckets should be undertaken. More background work will be done following the June 3 meeting before tenders covering methodology, data collection, analysis and development of the service weights can be let, after which, consultants will have tight timelines to meet the 2004 deadline.

The Future Of Allied Health In The Australian Health System

- contributed by David Stokes, Psychology Representative and Executive Member of NAHCC

Any planning for the future of allied health services in the Australian community needs to keep clearly in mind the small proportion of expenditure, and therefore importance, allied health professionals can command. We never will be major players while ever there is the dominance by the medical profession that we currently experience in Australia. The significant role that the medical profession plays in practice and in policy formulation ensures that GPs, specialists and closely related services will dominate health settings for years to come.

That should not stop allied health continuing to promote its interests and calling for a fairer deal. Particularly, it should not inhibit its pursuit of evidence-based practice and associated efforts to demonstrate not only the efficacy of allied health interventions, but also its cost-effectiveness and capacity to make savings in the specialist services area (\$4 or \$5 billion annually) and to drug costs.

In looking ahead, it seems reasonable to assume that the current Commonwealth health initiatives and priority areas reflect future trends in health services management. Although there is a focus on specific community disorders (diabetes, asthma, obesity, breast cancer and illicit drugs), there is an underlying agenda of a shift of focus away from acute and even community health services towards population health issues and prevention. There is also a great emphasis on primary care and initiatives that provide funding for primary care programs with the divisions of general practice as the fund holders. This is best exemplified in the Better Outcomes in Mental Health Care, the Practice Nurses program, MAHS and the Aged Care initiatives.

It may well be that the future of health services and funding in Australia in years to come will centre on state funded acute hospitals and commonwealth funded medical services. If such a trend continues, the major focus of allied health services may well move to being primary care providers emphasising education, prevention and cost-effective interventions. Those in the acute

setting will continue to have a major role in brief assessment interventions and case planning but may play a secondary role to the community-based primary care services funded by the Commonwealth.

This is, of course, speculative but would have major impacts on professional practice, professional education and training and the relationships between health-care providers. Its most significant influence may be a shift from the dominance of the acute care sector in allied health and the emerging pre-eminence of the primary and community care based services.

David L Stokes
NAHCC Executive and Psychology
Representative

Interim contact arrangements for NAHCC

The NAHCC Secretariat service was completed in June 2003 when RMIT University completed its 3-year agreement with the Commonwealth Department of Health and Ageing to provide a secretariat for NAHCC. Ian Woodruff and Karin Illenberger (Executive Officer and Administration Manager respectively) would like to thank the readers of *Talking Casemix* for their support and contribution over this time. It has been a rich and rewarding experience. We wish NAHCC well with its future endeavours.

Interim contact arrangements for NAHCC are as follows:



Email: you can email any of the Executive Members as identified with an * on the back page contact listing.



Telephone: you can contact any of the Executive Members as identified with an * on the back page contact listing.



Mail: Ms Lauren Andrew, Chair, NAHCC, c/- Physiotherapy Department, Royal Melbourne Hospital Post Office VIC 3050

Dietetics Update



- Annette Byron (Royal Adelaide Hospital) is the Dietetics representative to NAHCC.

The DAA Casemix Working Party has recently undertaken a project recently to investigate the use of the ICD-10-AM intervention codes related to nutrition care. The aims of the survey were to inform changes to the nutrition intervention codes in readiness for future editions of the ICD-10-AM; to identify areas for education of dietitians into the proper use of the codes and to investigate the current and potential applications of the codes in settings other than acute care. Survey forms were emailed to dietetic managers in all States and Territories working in a variety of health care settings. 48 responses have been received in reply to the 82 survey forms distributed and the results are now being analysed.

It is still too early to provide a complete report but it is possible to make some preliminary observations as follows:

- 25% of respondents use ICD-10-AM intervention codes in their departmental clinical information management systems, and another 8% were using ICD-9-CM codes.
- A number of respondents indicated this data

was not collected at a departmental level because of the burden of collection or because they saw no value in collecting this data.

- Most respondents said their hospital codes only used the general discipline level of coding for nutrition intervention.
- Opinions were evenly divided on the need for a separate code for preventative education/ counselling as opposed to education/ counselling.
- Opinions were also evenly divided on whether oral nutrition support and therapeutic nutrition support codes could be reduced to one code.

Education in the use of the codes was supported by a number of respondents and it was clear from many of the responses that there is still confusion between the concepts of interventions and indicators for interventions.

The full results of the survey and recommendations arising from this work are being submitted as a poster abstract to the International Congress of Dietetics in Chicago in 2004.

Exercise and Sport Science Update



Bob Barnard (Centre for Physical Activity in Ageing, Hampstead Rehabilitation Centre, Adelaide) is the Exercise and Sport Science representative to NAHCC.

Developments in Exercise Science continue to occur across Australia. The most topical issues are the current community focus on the high numbers of Australians who are overweight or obese (7 million adults) and the percentage of the population who have low activity levels or are essentially inactive. Exercise Scientists as well as other Allied Health professionals continually deal with the poorer health outcomes associated with these conditions.

Exercise Science, through its professional body, the Australian Association of Exercise and Sports Science is currently developing a relevant model for evidence based practice (EBP) and plans to release the document at the Sports Medicine Australia, National Conference later this year. This will be a significant moment for the Exercise Physiology profession because although we all work with techniques and methodology firmly based on scientific evidence, our clinical practices have often just followed those directions.

Clinicians and academics in the field await the launch.



Jill Feltham (Austin Health, Melbourne) is the Social Work representative to NAHCC.

Casemix is a national committee of the Australian Association of Social Workers, known as the AASW National Casemix Network. This longstanding AASW committee originally had representatives from all states and territories. More recent national AASW rationalisation of AASW committee membership has restricted membership numbers and therefore precluded full state and territory membership which has restricted participation of all states/territories in national teleconferences. Subsequently, full national communication and participation of all states and territories is achieved via a broader system of corresponding members and email information dissemination/consultation which includes all states and territories.

National AASW Casemix Network representatives are linked into state/territory Social Work networks to facilitate information dissemination, consultation and input. As national AASW representative to the NAHCC, Jill Feltham is available for information, consultation and member input in relation to any project, product or tool which has been developed or supported by the NAHCC eg Health Activity Hierarchy, Indicators for Intervention, procedure/intervention codes and associated National Centre for Classification in Health co-ordinated revisions of the national ICD-10-AM data classification coding set.

Contact details for Jill are:
Phone: (03) 9496 5560
Email: jill.feltham@austin.org.au

Social Work has also participated in the Australian Community Health Terminology Project, a project co-ordinated by the National Centre for Classification in Health to develop/refine terms used in the Australian Community Health Terminology classification.

Casemix issues are also being pursued by Social Workers via postgraduate degree thesis focus, quality improvement initiatives, research proposals and journal/book publications. Recent publications include:

- Pockett R, Lord B, Dennis J (2001) *The Development of an Australian National Classification System for Social Work Practice in Health Care Social Work in Health care Vol 34 Numbers 1/2 & 3/4* Hawarth: NewYork
- Pocket R, Lord B, Dennis J (2002) *The Development of an Australian National Classification System for Social Work Practice in Health Care in "Social Work Health and Mental Health Practice, Research and Programs"* Jackson, Alun C & Segal, Steven P (Eds) Hawarth Social Work Practice Press: New York
- Cleak,H. (2002), *A Model of Social Work Classification in Health Care Australian Social Work*, 55,1,38-49.

Current members of the AASW National Casemix Network are:

Mary Haire	National Committee Convenor and Qld representative
Rosalie Pockett	NSW representative
Mary Lee Sinclair-Vogt	ACT representative
Lesley Mineall	SA representative
Sue Jordan	WA representative
Helen Murray	NT representative
Jill Feltham	VIC representative

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discipline focussed and more collective, the advances that we can make not for ourselves but ultimately for the community will be limited. At present we do not have this vision. What we have is a discipline focus within an Allied Health framework. Our challenge is to flip this to having an Allied Health focus.

Being the Chair of a National group will be a pleasure in that future!



The Queensland Council of Allied Health Professions (QCAHP) provides Queensland's state representation to NAHCC. QCAHP is a constituted body with membership of nine allied health professions: Audiology, Dietetics, Occupational Therapy, Orthoptics, Prosthetics and Orthotics, Physiotherapy, Psychology, Social Work, and Speech Pathology. Council representatives work in hospital and community settings, private and public healthcare, Education Queensland and university departments from North and Southeast Queensland. QCAHP strives for high quality healthcare through the combined efforts of allied health professions and promotes best professional practice and workforce conditions for allied health professionals.

One of the major achievements of the Council was to secure the position of Principal Allied Health Adviser in Queensland Health, which was attained in 1996. Amongst the many achievements of Paula Bowman in that role is the commencement last year of a conditional clinical advancement scheme which allows allied health staff to progress to the higher levels on the basis of outstanding clinical practice, educational or research expertise and performance. This provides the opportunity for advancement of staff and their retention in clinical positions, rather than the only opportunities for promotion occurring through management work.

Casemix issues are included in the Information Management portfolio of the Council and are regular agenda items at QCAHP meetings. When required, a casemix sub-committee has been convened and has provided representation and input to Qld Health's casemix policy work and funding models as well as facilitation of work with the NAHCC.

One of the important goals of QCAHP is to provide timely and relevant professional development. Several casemix and best practice seminars have been organised from 1995 onwards. Last year a seminar entitled "Outcome Measures for the Allied Health Professions" was successful in updating us on cotemporary

outcomes research, with informative and knowledgeable presenters such as Alison Perry and David Rhodes, and Margaret Tweeddale leading us in workshoping outcome measures.

QCAHP is excited that it is now able to enhance its mission to promote research across the allied health professions by providing modest seeding funds to support research where assistance is less likely to be available from other sources. The inaugural seeding funds will be offered, on a competitive basis, to allied health professionals who are current members of professional associations which are in membership with QCAHP (please see list above). The purpose is to foster collaborative allied health research and applicants must represent at least two professions. For Queensland allied health professionals who are interested, please contact Nancy Low Choy, Dept of Physiotherapy, University of Queensland. n.lowchoy@shrs.uq.edu.au). Closing date for applications is 31 July 2003.

QCAHP has appreciated the close association with the NAHCC Executive and members over the years, not the least through partnership in the professional development seminars. Chris Wilson, Cathy Nall, David Rhodes, Ian Woodruff and David Stokes have all provided valuable contributions to educational activities in both Southeast and North Queensland.

We have enjoyed the important project work and strategic planning sponsored by NAHCC, in which Queensland allied health professionals have enthusiastically engaged over many years, and hope that the opportunity to continue this work will be there beyond June 2003.

Mary Haire
QCAHP representative to NAHCC
Email: mary_haire@health.qld.gov.au

NAHCC REPRESENTATIVES – STATE / TERRITORY CASEMIX GROUPS

		<i>Telephone</i>	<i>Fax</i>	<i>E-mail</i>
ACT	MaryLee Sinclair-Vogt	02 6244 2152	02 6244 2346	mary.sinclair-vogt@act.gov.au
NSW	David Rhodes *	02 4924 6341	02 4924 6428	drhodes@doh.health.nsw.gov.au
NT	Rebecca Orr	08 8922 7074	08 8922 7304	rebecca.orr@nt.gov.au
QLD	Mary Haire	07 3350 8424	07 3212 5147	mary_haire@health.qld.gov.au
SA	Geoff Bloor	08 8276 9666	08 8277 9401	geoff.bloor@rgh.sa.gov.au
TAS	Fred Howard *	03 6222 8601	03 6234 5568	fred.howard@dchs.tas.gov.au
VIC	Helen Cleak	03 9479 2411	03 9479 3590	H.Cleak@latrobe.edu.au
WA	Jeff Ewen *	08 9346 2337	08 9346 3037	jeff.ewen@health.wa.gov.au

NAHCC REPRESENTATIVES – PROFESSIONAL ASSOCIATIONS

		<i>Telephone</i>	<i>Fax</i>	<i>E-mail</i>
Audiology	Jan Pollard	03 9345 5550	03 9345 5514	pollardj@cryptic.rch.unimelb.edu.au
Dietetics	Annette Byron	08 8222 5223	08 8222 5135	abyron@mail.rah.sa.gov.au
Exercise & Sport Science	Bob Barnard	08 8222 1889	08 8222 1828	rbarnard@hampstead.rah.sa.gov.au
Hospital Pharmacy	Naomi Burgess	08 8222 4951	08 8222 5881	nburgess@mail.rah.sa.gov.au
HPCA	Lin Oke	03 9416 1021	03 9416 1421	hpca@ausot.com.au
Music Therapy	Jacinta Calabro	03 9594 4300	03 9594 6910	jacinta_c@yahoo.com
Occupational Therapy	Jan Erven	02 4223 8250	02 4276 4111	ervenj@iahs.nsw.gov.au
Orthoptics	Kerri Martin	03 9616 7870	03 9616 8010	kerri.martin@dhs.vic.gov.au
Orthoptics & Prosthetics	Natalie Sullivan	03 9881 1811	03 9853 0950	natalie.sullivan@peterjames.org.au
Physiotherapy	Lauren Andrew *	03 9342 7440	03 9342 8440	lauren.andrew@mh.org.au
Podiatry	Stephen Tucker *	03 9288 3493	03 9288 3808	tuckersm@svhm.org.au
Psychology	David Stokes *	03 8662 3324	03 9663 6177	d.stokes@psychsociety.com.au
Social Work	Jill Feltham	03 9496 4591	03 9496 4589	jill.feltham@armc.org.au
Speech Pathology	Robin Branchi *	08 9346 2044	08 9346 3458	robin.branchi@health.wa.gov.au

To contact NAHCC please telephone or email one of the NAHCC Executive members (as indicated with an * above)