Workforce Innovation Grant Program 2013-14

health

Final project report

Expanding community workforce capacity to deliver multidisciplinary non-surgical management of back pain in community-based settings

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Executive summary

As part of its reform-ready agenda, Merri Community Health Services (MCHS) identified workforce and service model redesign as critical elements in delivering better outcomes for clients. In an increasingly complex environment, providing advanced practice roles in community health improves the ability to offer innovative services to more complex clients, to increase referral by the acute sector and general practitioners to community health, and also to create a clinical career structure to improve workforce satisfaction and retention.

As a result, MCHS and Melbourne Health partnered to develop solutions to the sub-optimal management of low back pain for clients in their shared catchment area, setting up services in the community for the assessment and management of back pain, by developing their respective workforce capability.

The partnership was an ideal platform to combine tackling each of the identified problems in the individual organisations to maximise impact.

The drivers for both organisations were:

- to optimise the use of evidence-based practice for the non-surgical management of back pain
- optimal use of workforce expertise
- the need to improve access to a range of services in the community.

Melbourne Health had the added drivers of improving throughput and reducing waitlists, having experienced long waiting times for specialist outpatient appointments, the limited role of surgery and low conversion rates to surgery.

MCHS and Melbourne Health were funded separately from the Victorian Department of Health Workforce Innovation Grant Program 2013-14. The program's aim was to explore, identify and trial innovations that improve the utility, productivity and sustainability of the workforce, while improving access and quality of services, and consumer and worker satisfaction.

Along with the program funding, MCHS contributed substantial in-kind program management costs, enabling the pilot project to deliver:

- new models of care, including one-to-one interventions and multidisciplinary group programs
- referral pathways and communication mechanisms between the acute and community sectors
- 225 occasions of advanced practice physiotherapy one-to-one interventions to 79 new clients referred from the back pain assessment clinic, with a utilisation of 99.85 per cent at one day per week
- credentialing of a Grade 3 physiotherapist
- increased capability of the community health workforce to provide management to more complex clients
- embedding the use of clinical outcome measures and data analysis.

MCHS is now seeing clients with increasing complexity, including more than 70 per cent who are experiencing moderate to severe levels of pain, and more than 60 per cent who are experiencing moderate to severe levels of disability or stress.

All clients surveyed so far expressed an overall net positive response to the program, saying it allowed them to manage their condition better and do more things that they enjoy doing. Clients were very happy to receive services in the local community, rather than in a hospital.

The collaboration between the MCHS management clinic and Melbourne Health's back pain assessment clinic provided opportunities for shared professional development, mentoring and credentialing of MCHS's Grade 3 physiotherapist. The advanced practice roles have helped to build clinical expertise in community health, increase workforce capacity and create career pathways for allied health staff, thereby increasing clinical staff satisfaction.

Learnings accrued during the process of development and set up focused on information sharing, defined roles and responsibilities, project coordination, inclusive decision making and clear documentation. The close collaboration between MCHS and Melbourne Health has built trust and confidence.

The new model of care has provided clients with access to appropriate expert clinical assessment and management in a timely manner and at a convenient location in their community. This demonstrates that advanced practice roles in community health, combined with genuine collaborative relationships with acute partners, can make a positive difference for clients by improving access to services, developing expertise in community health and utilising the workforce optimally.

This model has the potential to be replicated with other partnerships at other sites and for other chronic conditions.

Background and context

Merri Community Health Services (MCHS) is an independent, not-for-profit community health service that provides a range of primary care services for people living in the Northern Melbourne metropolitan area. MCHS provides a suite of allied health, nursing, social work, case management, mental health and carer support services.

In late 2013, MCHS undertook a reform-ready review and identified that there was scope for further development of its workforce roles and business development. There was also a commitment to build capacity within the community health service system to keep people out of hospital. Anecdotally, feedback from some general practitioners and the acute sector indicated that a lack of specialist skills is one of the barriers to referring complex clients on to community health settings. MCHS recognised the limited opportunities (outside of clinical supervision components or taking on a line management role) for clinical career progression in community health. A MCHS all-staff climate survey in 2014 suggested that only 31 per cent of staff in the primary health team considered that 'MCHS provides good development and career opportunities', as compared to the industry average of 48 per cent.[1] MCHS considered that advanced practice roles could offer these opportunities and would likely increase workforce satisfaction and retention.

Since 2013, MCHS, Melbourne Health, cohealth and the Melbourne Primary Care Network have been actively working together to deliver collaborative projects and programs to improve client care, outcomes and pathways for their shared community. A model for improving the management of back pain and related disorders within the community was identified as a shared priority for the organisations.

Back pain is a very common condition, with estimates that 70 to 90 per cent of people suffer from back pain in some form at some point in their lives, having a significant impact on the client and community, and consuming considerable health resources. Currently, a client with back pain referred to Melbourne Health may wait up to 18 months for an initial consult with a neurosurgeon or orthopaedic surgeon as the first point of assessment and triage.

A recent audit conducted at Melbourne Health examining the neurosurgery outpatient waiting list (1,500 patients) indicated that 68 per cent of all 'non-urgent' waitlisted patients (1,020) were referred for back pain and related disorders. However, the majority of clients assessed did not require surgery, suggesting non-surgical management may be a more appropriate option. The extended delay for the client can lead to deterioration and development of chronic symptoms, and poorer health outcomes, resulting in additional health resources being required. This enormous waitlist pressure also prolongs waiting times for those who do require surgery.

Back pain presently places considerable demand on specialist outpatient clinics and this problem is not unique to Melbourne Health. In Victoria, specialist clinics operate in the secondary and tertiary hospital setting for which very lengthy waiting lists exist and during which time avoidable deterioration can occur. However, it is widely accepted that the management of back pain is best first managed in primary care. Specialist interface clinics successfully operate in the UK and Canada in the primary care setting.[2] [3]

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[1] Best Practice Australia, 2014 *MCHS Employee engagement survey* (internal document)

[2] Desmeules F, Toliopoulos P, Roy J, et al. 2013 'Validation of an advanced practice physiotherapy model of care in an orthopaedic outpatient clinic' *BMC Musculoskeletal Disorders,* vol. 14, p. 162 http://www.biomedcentral.com/1471-2474/14/162

[3] Durrell S, 1996 'Expanding the scope of physiotherapy: clinical physiotherapy specialist in consultants' clinics', *Manual Therapy*, vol. 1, pp. 210-213.

Melbourne Health and MCHS discussed how best to improve management of back pain and related disorders for our shared community and the funding opportunity provided a platform to identify priorities in a combined way to maximise impact. Although the impetus for a project on the management of back pain initiated from a distinct problem identified by Melbourne Health, MCHS recognised that a collaborative partnership with a combined solution would progress the development of advanced practice roles and services in community health that could be offered to clients.

Under the leadership of the Health Workforce Reform Implementation Taskforce, the Department of Health Victoria established the Workforce Innovation Grant Program 2013-14 to explore, identify and trial innovations that improve the utility, productivity and sustainability of the workforce, while improving access and quality of services, and client and worker satisfaction.

MCHS was successful in attaining a workforce innovation grant to establish a service model and evaluation framework for community-based programs in which back pain was used as a case study.

The resulting MCHS multidisciplinary community-based model for non-surgical management of back pain integrated with the back pain assessment clinic piloted by Melbourne Health, which was the result of a separate but linked workforce innovation grant.

It was anticipated that the two projects would collectively address the drivers for both organisations which were:

- to optimise the use of evidence-based practice for the non-surgical management of back pain
- the optimal use of workforce expertise
- the need to improve access to a range of services in the community.

Melbourne Health also had the added drivers of improving throughput and reducing waitlists.

The project involved reconfiguring, broadening and redesigning the current workforce skill base at MCHS to establish advanced scope of practice roles that would deliver the required best practice programs for the management of back pain under the supervision of a Grade 3 physiotherapist.

In preparation for the project, MCHS provided in-kind contribution to employ a Grade 3 physiotherapist with postgraduate musculoskeletal physiotherapy qualifications to lead the back pain management clinic. A Grade 3 exercise physiologist was also recruited and MCHS drew on its existing clinicians (including occupational therapists and allied health assistants) to support the multidisciplinary clinic.

This report details the activities and outcomes from the development of the MCHS model of care and the evaluation framework, and reports against the project objectives and indicators. Data is provided on the outputs of the new MCHS back pain management service. However, final analysis of outcome measures from the management clinic are not included, as six-month follow-up measures are being used as part of the evaluation framework and will not be available until late 2016.

Aims and objectives

The overall aim of the project was to 'establish a physiotherapy-led community clinic for the management of back pain at MCHS'. The objectives and indicators in Table 1 outline the desired effect of the project. A program logic was also developed, outlining key activities and anticipated outcomes (see Appendix 1).

The reasons for the overall aim and objectives were that MCHS:

- recognised that Melbourne Health had long waiting lists and that they could develop additional services to divert people from Melbourne Health to community-based management options
- had insufficient workforce capability to respond to clients with complex clinical presentations
- could increase quality client outcomes for people on Melbourne Health waitlists
- needed to strengthen their focus on clinical outcome measures in community health settings
- needed to improve the range of services offered.

Table 1. MCHS project objectives and indicators

Overarching objectives	Indicators
Safety and quality of care Improve quality of care to clients through the articulation of a community-based model of care for back pain management in a community health setting	New models of care established
	Time in direct contact with Grade 3 clinicians
Identify the implications of providing acute/subacute back pain assessment services in a community-based setting	Time and cost of providing administration support
	Time required to develop processes – meetings
	Tools developed to facilitate services
	In-kind support provided
Safety and quality of care and access Improve access through a range of services for back pain management in the community	Increase in range of services in the community
	Increase in occasions of service
	Reduce time from referral to assessment clinic through to conservative management
	Number of referrals from Melbourne Health assessment clinic to MCHS management clinic
Integrated workforce Increase collaboration between the acute and community sector organisations in the management of back pain	Peer education framework
	Number of in-services attended at Melbourne Health Number of structured meetings between clinicians of different grading
	Number of meetings between agencies to develop and deliver extra services
	Tools produced collaboratively to administer the extra services
	Participation in multidisciplinary case conferencing
	Peer education framework
	Number of in-services attended at Melbourne Health Number of structured meetings between clinicians of different grading
	Number of meetings between agencies to develop and

	deliver extra services
Workforce satisfaction Enhance scope of practice and learning opportunities for Grade 3 physiotherapy in a community health setting for back pain management and assessment	Scope of practice documents Position descriptions Peer education framework
Client satisfaction Ensure client satisfaction with the new back pain management	Customer satisfaction in-service provided

Scope

The scope of the project was to use back pain as a case study, and pilot a community-based multidisciplinary model of care and an evaluation framework for the management of back pain that would integrate with Melbourne Health's back pain assessment clinic. Workforce roles were expanded to support advanced scope of practice and multidisciplinary care arrangements to manage clients with increased complexity.

The focus of the model of care development and evaluation for MCHS was to extend the capability of community health services to manage a broader range of clients referred for non-surgical management of back pain, and to improve workforce satisfaction with career paths available to community allied health practitioners.

The scope of practice focused on non-surgical physiotherapy management (such as therapeutic exercise, stretching, soft tissue massage, joint mobilisation and other manual therapy, , and use of modalities), and included components of group therapy and multidisciplinary management. Interventional back pain management (specialist invasive procedures) was not in scope.

Back pain has been used as the case example to illustrate the model of care development. There are components identified through this process, however, which have the potential to be extrapolated (replicated) within other programs, services and clinics. The underlying theme for these models of care is that they provide responsive services within the community setting for clients with complex needs, through incorporating expanded workforce roles, advanced scope of practice and multidisciplinary care arrangements.

Methodology

Model of care and evaluation framework

MCHS contracted Aspex Consulting to assist in compiling an appropriate model of care and evaluation framework to examine the design, implementation and impact of the newly established multidisciplinary clinic for community-based non-surgical management of back pain.

Developing the model of care required articulating and documenting opportunities to:

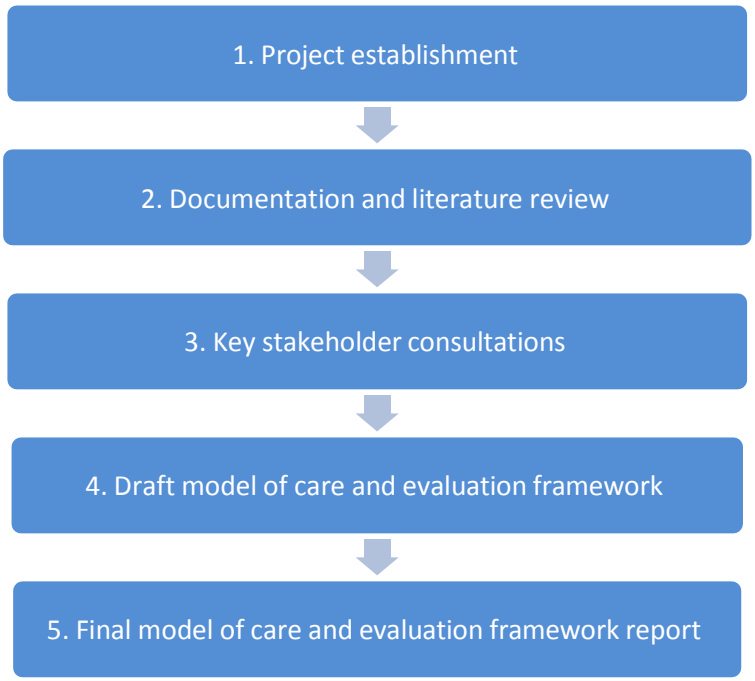
- support multidisciplinary practice and advanced scope of practice
- identify expanded workforce roles
- ascertain referral and care pathways to enhance service coordination
- support strategies for clinical governance and clinical supervision mechanisms.

The model was also used to inform redesign for the allied health resources at MCHS and will be used for future service redesign.

In a broader context, the model of care was to operate in partnership between the acute sector and community health services. It was anticipated that this would confer a range of system-level benefits for clients, clinicians and health services. The purpose of commissioning the development of the evaluation framework was to provide a rigorous structure for MCHS to use to evaluate this pilot project (and potentially other similar services), identify and assess the impact of changes on the community sector, and provide evidence that may subsequently contribute to the broader system-level outcomes.

The approach used by Aspex Consulting to developing the model of care and evaluation framework for MCHS is summarised in Diagram 1.

Diagram 1. Project methodology framework



A high-level literature review was undertaken, focusing on relevant documentation and peer-reviewed scientific publications that examined community-based models of care for back pain management. Typical outcome measures used to assess patient severity and treatment outcomes were reviewed, and the role of physiotherapist-led assessment clinics was also examined. The purpose of the literature review was to inform the proposed model of care components relevant to the optimal configuration of the MCHS back pain management clinic and to support the development of the evaluation framework.

Consultations were undertaken with 20 primary stakeholders prior to and following the drafting of the model of care and evaluation framework. Stakeholders were identified from:

- MCHS
- Melbourne Health
- Department of Health and Human Services
- Local general practitioners
- Other community health services.

Initial face-to-face meetings were held with all stakeholders, with follow up conducted via email or phone to seek clarification, additional information and feedback.

Key components of a community-based model of care for the non-surgical management of back pain were identified based on the findings of the literature review, key stakeholder consultations, and documentation outlining current (or planned) models of service delivery at MCHS and Melbourne Health. Using information obtained from the review of background documents, and taking into account the Victorian Innovation and Reform Impact Assessment Framework, key elements of the evaluation framework were drafted.

Both the draft model of care and evaluation framework were provided to MCHS and other stakeholders for subsequent discussion, consideration and feedback. The detailed final report of the multidisciplinary back pain model of care and evaluation framework was completed and sent to all stakeholders in May 2015.

Development and delivery of the back pain clinics

MCHS and Melbourne Health worked together to set up services in the community for the assessment and management of back pain as a case study in action. It was vital that the two project teams worked closely, as many aspects of each project, from development to operation and evaluation, were contingent on the other. The collaboration was also critical to ensure development of the most effective program delivery and potential best outcomes for shared clients who attended both services.

The project managers from each organisation met initially to share information about the projects and to determine the best way to develop strategies and solutions for the smooth operation of the clinics. This was vital for the project, as Melbourne Health was operating a clinic on a MCHS site and MCHS was receiving referrals and clinical mentoring from Melbourne Health. The project managers were the principal drivers of progress and information sharing, and throughout the project maintained close contact either in person, via telephone or email.

A project working group was set up to help guide the smooth implementation of the new clinics by developing the clinical and administrative structure, detail and logistics for the interface of the clinics at setup and for monitoring progress. The project working group also provided guidance on implementing systems for collecting data and evaluation measures, reporting back to other groups and championing the project within each of their respective organisations.

Initially, the group met fortnightly (and at times more frequently) and then monthly for the duration of the project. A *Licence to Occupy and Provision of Services Agreement* with legal input was developed to address governance, liability, and quality and risk issues. An extensive task and action list was drawn up to identify all actions necessary for the setup of the clinics, the timeframes required and the lead person responsible for the action.

Apart from the interaction with clinical areas, the intricacies of the project also included the interface with several departments from both organisations. At Melbourne Health, the departments involved were Legal, IT, Health Information Services and the Direct Access Unit. At MCHS, the program areas involved were the Reception Team, Service Access, Facilities, Human Resources and IT.

As clinicians from Melbourne Health were conducting clinics at MCHS, an orientation session was conducted for them including:

- a general tour and introductions
- access – ID badges and security pass
- general MCHS policies and procedure (for example, occupational health and safety, security, emergency procedures and the Code of Conduct)
- introduction to rooms, equipment and telephone systems
- computer systems, and appointment and clinical software training.

A key administration contact from MCHS was assigned to the Melbourne Health back pain assessment clinic to provide support for the clinic and clinicians, and to troubleshoot operational issues. A back pain assessment clinic support procedure manual was also developed to detail all the processes involved in the operation of the clinic.

Additionally, the Melbourne Health advanced practice physiotherapists worked collaboratively with community health physiotherapists to provide training and education to facilitate knowledge transfer and enhance community workforce skill mix.

From the outset, the projects were approached collaboratively. The close working relationships and constant information sharing helped to build trust among the two project teams. Without this collaborative relationship, it would have been very difficult to offer streamlined clinical services to clients, and the clinical mentoring and credentialing of the community health physiotherapist would not have been possible.

Regional Reference Group

At the same time as the consultants were developing the model of care and evaluation framework, a Regional Reference Group was established to help guide its development, implementation and evaluation.

Membership of the group comprised:

- MCHS (Chair and resource meetings)
- Melbourne Health
- Northern Health
- surrounding community health services – Dianella Community Health, Plenty Valley Community Health, Darebin Community Health and cohealth.

Engaging with this broader key stakeholder group was important for:

- providing advice on opportunities and challenges to develop and implement the model in a community health setting
- providing advice on opportunities and challenges to support replication of the model at other community health settings across metropolitan Melbourne, and to explore similar models of care delivery in the primary care setting that addresses traditional demand pressures in the acute setting
- promoting opportunities to discuss expanded workforce roles in community health settings to support advanced scope of practice, expanded roles and multidisciplinary care arrangements to manage clients with increased complexity.

Workforce

A baseline staff survey was undertaken in October 2014 to understand the effects the workforce redesign may have on the current community health workforce, both for those clinicians having a

Grade 3 clinician introduced into their discipline, as well as for other health professionals involved through the multidisciplinary models of care being implemented for clients with back pain.

Project governance and management

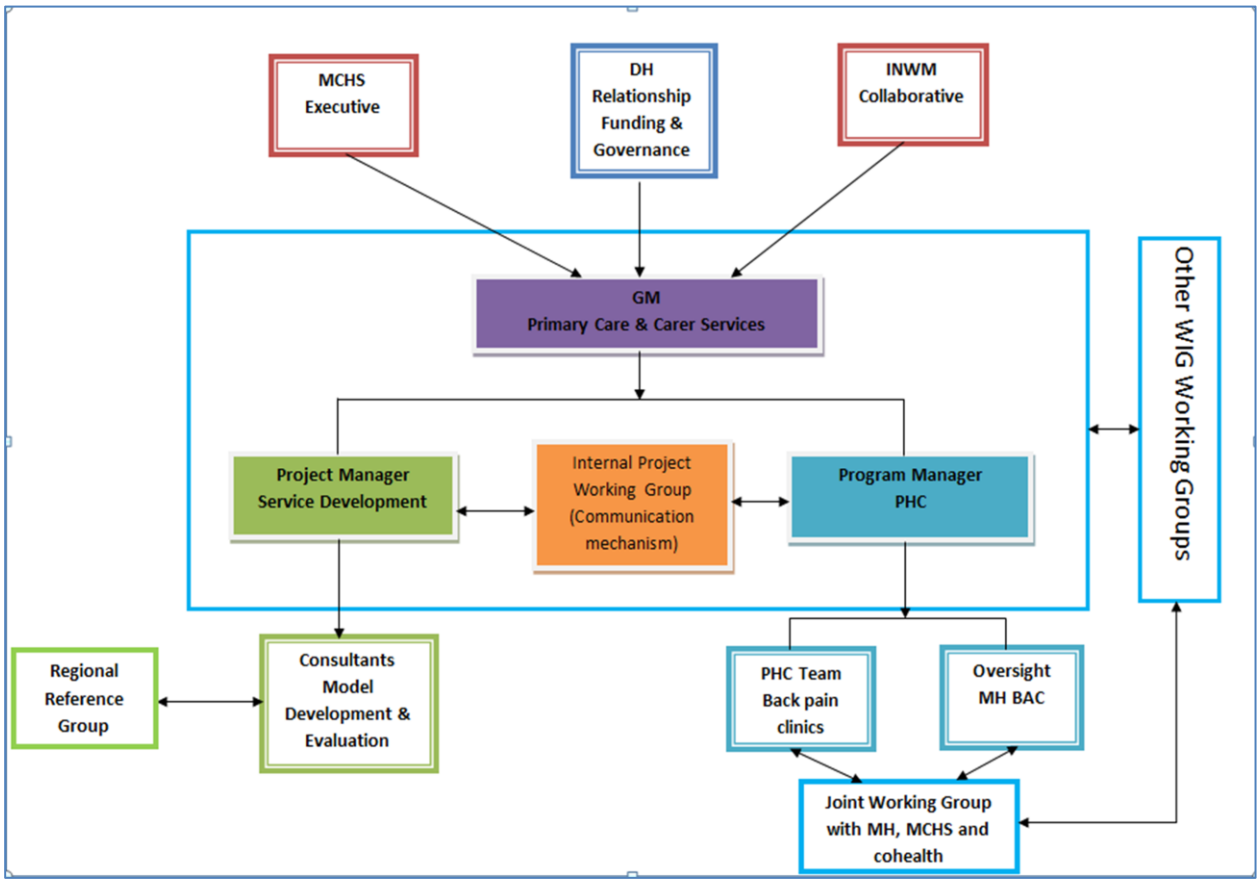
This project started as a venture resulting from the Inner North West Melbourne Collaborative between MCHS, Melbourne Health, cohealth and the Melbourne Primary Care Network. The collaborative has existing governance structures that supported the implementation of the project. Additional structures were put in place to support project deliverables and are outlined in Diagram 2.

The position of Project Manager Service Development was utilised for 0.7 EFT to:

- coordinate the project
- liaise with consultants
- provide secretariat to the groups
- present monthly reports to the collaborative senior managers
- provide status reports to the Department of Health and Human Services at the required times.

The project ran from July 2014 to June 2015, with status reports and risk reports provided to the department in November 2014 and March 2015.

Diagram 2. MCHS governance and information flow



The position of General Manager Primary Care and Carer Services reported on the activities of the project to the:

- MCHS Executive team on a regular basis
- Collaborative Senior Managers Group monthly
- Collaborative Chief Executives every three months.

The MCHS Internal Project Working Group met on a regular basis to drive and monitor project deliverables and to ensure appropriate internal communication on project milestones. The Regional Reference Group met three times during the project and the Workforce Innovation Grant Joint Working Group met every two weeks as the clinics were being set up (or more regularly as required) and then monthly for the remainder of the project.

Budget acquittal

The budget acquittal and additional in-kind costs are presented in Table 2.

Table 2. Project costs

Salaries and wages - project officer (with admin support)	$	75,763.00
Impact assessment, model development and evaluation framework	$	49,237.00
	$	125,000.00
Use of clinical space for Melbourne Health clinicians - 3 rooms x 1 session per week	$	3,600.00
Salaries and wages - Grade 3 physiotherapist clinical and acute community collaboration	$	31,000.00
Salaries and wages - Grade 3 physiotherapist credentialling	$	6,500.00
Workshop for crendentialing	$	600.00
Multidisciplinary group program development	$	15,000.00
Multidisciplinary group program implementation	$	5,000.00
Data input	$	3,300.00
Statistical data analysis - cost to be determined		
	$	65,000.00
Total	$	190,000.00

The workforce innovation grant enabled MCHS to develop the evidence-based model of care and evaluation framework, as well as to set up the processes for development of the management clinic and the relationship with the Melbourne Health back pain assessment clinic.

The funding from the Department of Health and the in-kind resources from MCHS, plus in-kind program management, enabled the pilot project to deliver:

- new models of care, including one-to-one interventions and multidisciplinary group programs
- referral pathways and communication mechanisms between the acute and community sectors
- 225 occasions of advanced practice physiotherapy one-to-one interventions to 79 new clients referred from the back pain assessment clinic with a clinic utilisation of 99.85 per cent at one day per week
- credentialing of the Grade 3 physiotherapist
- increased capability of the community health workforce to provide management to more complex clients
- the instigation of clinical outcome measures.

In-kind contributions were applied to the costs for ongoing implementation of this program. Utilising existing facilities and equipment, the costs include:

- salary and wages of the Grade 3 physiotherapist:
    - direct service provision to clients of the back pain management clinic (approximately one day per week)
    - direct service provision to clients undertaking the eight-week modified pain management program
    - undertaking activities within the credentialing framework (approximately nine hours per month over nine to 12 months)
    - development of other services with the multidisciplinary team

- salary and wages of the Grade 3 exercise physiologist and other clinicians in developing and delivering the multidisciplinary modified pain management program
- data collection and data entry (data analysis needs to be added, which for MCHS will be outsourced).

Data from the pilot project to inform ongoing implementation costs indicate that:

- on average, five appointments of one-to-one management with the Grade 3 physiotherapy is $500 per client
- the multidisciplinary eight-week group program of three contact hours per week with a physiotherapist, exercise physiologist, occupational therapist and allied health assistant is approximately $450 per client.

Limitations and solutions

The complexities of this project centred on the nature of the two separate but linked projects involving multiple organisations, multiple sites and multiple disciplines. Having robust governance structures, clear project plans and project managers from both organisations facilitating the working groups was fundamental in mitigating risk and keeping the project on track.

A risk assessment was developed at the commencement of the project to identify and manage priority risks. Appendix 2 provides detail of the risk assessment status report provided to the Department of Health and Human Services. However, throughout the project, other factors emerged that challenged the teams and required collaborative solutions.

Operational issues

Hosting a tertiary clinic in a community setting presented many logistical problems in terms of space, information technology, clinical records and administration. It was necessary for MCHS to move some existing clinicians to other days and locations in order to provide space for the Melbourne Health clinicians, and it was essential to provide extra administrative support for the smooth operation of the clinic.

The amount of administration support that was required should not be underestimated. The disparate client information systems between the two organisations resulted in paper client records being couriered each week to the community clinic and duplication of recording. Although inefficiencies in some processes were acknowledged, compromises needed to be made to ensure clinical safety and compliance with the clinical governance frameworks of both organisations.

Clinical governance

It was originally anticipated that the Grade 3 physiotherapist would be involved at project commencement, conducting assessments in the back pain assessment clinic. However, there was initial reluctance from both organisations due to issues of capacity and clinical governance in community health, with questions from tertiary partners relating to the level of clinical expertise in the community setting. As a result, an arrangement was negotiated to set up a credentialing process for the physiotherapist so that on completion, they will be able to perform assessments in the back pain assessment clinic.

The model of care identified that a psychologist is an important part of a multidisciplinary team managing clients with chronic pain conditions. MCHS was not able to resource this position during the pilot phase. Subsequently, strict eligibility criteria were developed for the modified pain

management program to ensure that clients who attend gain the most benefit from the program, given the mix of allied health skills available. For example, clients with high levels of stress or depression associated with their pain are unlikely to be adequately supported and would require referral to other services.

Evaluation

The evaluation framework was based on the Victorian Innovation and Reform Assessment Framework and then adapted in the *Multidisciplinary back pain model of care and evaluation framework final report April 2015* developed by Aspex Consulting (pp. 58-76). This lead to the identification of a comprehensive design and evaluation options menu. However, it posed a genuine challenge for MCHS to implement the total evaluation framework, given the resource intensity required to undertake all options.

The framework recommended collecting several clinical measures in addition to what was currently being collected by the Melbourne Health back pain assessment clinic and the MCHS clinic. The required critical data, the resource implications and the evaluation measures were all considered in making decisions about how to implement the evaluation framework.

In this context, the time required to administer all the recommended tools for the client, as well as to score and enter the data, were not commensurate with the value gained for MCHS clients. As a result, MCHS agreed on the elements of the framework that were most applicable to implement. Additional administrative support for data entry and follow up was then allocated by MCHS. Appendix 3 outlines the proposed elements of the evaluation framework and indicates which elements were instituted throughout the pilot project.

MCHS recognises that it does not have the dedicated staff resources or software packages to undertake statistical analysis of clinical outcome data. Strategies have been put in place to collect the measures, although the statistical analysis will be outsourced to incorporate analysis of the baseline and discharge data, as well as six-monthly follow-up data. The cost for this will be met by MCHS as an in-kind contribution.

The evaluation framework also recommended that a comparison group be used for the evaluation to test the assumptions that:

- MCHS is likely to be taking more complex clients
- because of the complexity of clients and the new model of care, it may possibly demonstrate better outcomes
- usual community healthcare may achieve similar outcomes or some improvement.

MCHS was unable to recruit a comparison site as the community health services approached did not have the time or operational and resource requirements to administer the evaluation tools. While it would have strengthened the evaluation analysis to have longitudinal comparisons with another community health service, the evaluation framework being utilised still allows MCHS to identify changes in key outcomes and activities of the model of care, regarding referrals, patient profiles, services delivered and clinical outcomes (see Appendix 3).

Replicability and scalability

The literature review and consultation process highlighted some important considerations that are likely to influence replicability and sustainability. The key issues are outlined below and a detailed discussion is contained in the *Multidisciplinary back pain model of care and evaluation framework final report, April 2015* by Aspex Consulting (pp. 80-85).

Likely influencers on sustainability

1. *Timely access to the right care in the right location*
2. *Strengthen continuum of care from hospital to community*
3. *Earlier access to specialist medical assessment*
4. *Workforce capability enhanced through multidisciplinary teams*
5. *Training, development and career pathways promoted through partnerships*
6. *Comprehensive client assessment*
7. *Improved monitoring of client outcomes*
8. *Evaluation of service delivery*

Main issues for replicability

1. *Inter-agency collaboration*
2. *Shared clinical governance*
3. *Credentialing and scope of practice*
4. *Appropriate triage and diversion of clients*
5. *Ability to demonstrate good outcomes in a community setting*
6. *Demonstrating return on investment*

Key deliverables

Two of the key deliverables of the project were:

- to develop a model of care that could be reproduced by other community health providers to reduce avoidable back pain presentations to hospitals by strengthening management in the community setting
- a documented evaluation framework.

Model of care

The model of care components are outlined below. A detailed description of the components can be found within the *Multidisciplinary back pain model of care and evaluation framework final report April 2015* by Aspex Consulting (pp. 39-57).

Model of care components

1. *Pathway for client referral and treatment*
2. *Establish a clinical policy and procedure manual*
3. *Multidisciplinary team composition*
4. *Client eligibility and referral protocols*
5. *Multidisciplinary assessment and treatment planning*
6. *Program streams according to client needs*
7. *Outcome measures for client assessment and monitoring*
8. *Clinical interventions provided by the treating team*
9. *Communication protocols with referring providers*
10. *Ongoing client self-management planning*

11. Clinical governance and upskilling arrangements
12. *Program monitoring, evaluation and ongoing improvement*

Evaluation framework

A key requirement of the Workforce Innovation Grant Program was that funded projects utilise the Victorian Innovation and Reform Assessment Framework to understand and measure the local impacts of the change in relation to efficiency, effectiveness and sustainability.

For this project, the purpose of developing the evaluation framework as an adjunct to the Victorian Innovation and Reform Assessment Framework was to identify the data requirements to determine and assess the impact of changes associated with community-based multidisciplinary team management of clients with back pain, which may subsequently contribute to improved health and wellbeing, and broader system-level outcomes.

The key components of the evaluation framework are outlined below. A detailed description of the key data to be collected for efficiency, effectiveness and sustainability is contained in the *Multidisciplinary back pain model of care and evaluation framework final report April 2015* by Aspex Consulting (pp. 58-85).

Evaluation framework

1. *Indicators required to measure implementation:*
   - *outputs relating to model of care development*
   - *outputs relating to service delivery*
2. *Indicators required to measure outcomes:*
   - *outcomes to be evaluated in the short term*
   - *outcomes to be evaluated in the medium term*
   - *outcomes to be evaluated in the longer term*
3. *Methods of attributing cause and consequence*
4. *Monitoring ongoing implementation and impact*
5. *Governance arrangements for evaluation*
6. *Data collection tools*
7. *Sampling parameters*
8. *Evaluation reporting*

For this pilot project, MCHS collected data on outputs relating to the model of care development (see Table 4), outputs relating to service delivery and outcomes to be evaluated in the short term (see Appendix 3).

The outcome measures selected for assessing and monitoring client progress were the:

- Brief Pain Inventory (BPI) to measure pain severity and the impact of pain on daily functions
- Neck Disability Index (NDI) to measure the impact of neck pain on activities of daily living
- Oswestry Low Back Disability Index (OLBDI) for measuring the degree of disability and the impact of lower back pain on activities of daily living
- Keele Start Back Screening Tool (SBST) to measure psychosocial associated with back pain
- SF-36 to measure health-related quality of life and enable comparison with community-based norms for the Australian population.

The outputs from the physiotherapy-led back pain management clinic at MCHS are reported below. Due to the close interaction of the Melbourne Health back pain assessment clinic in the community

and the MCHS management clinic, some outputs from the collaborative relationship and the interaction between the services are also reported.

Outputs from the management clinic

This data includes all clients who had an initial appointment from the start of the clinic in August 2014 up until June 30th 2015. The data is not complete or ready for full outcome analysis, as some clients are still receiving a course of management and have not yet been discharged.

Table 3. MCHS management clinic data

Date range	* No. of referrals to MCHS	No. of appts attended	No. of new clients	No. of review clients	DNAs	Time from BAC referral to appt (wks)	No. discharged	Other comments
September 14	6	**4**	**4**		0	1.5		
October 14	16	9	6	3	0	2.0	0	Physio 1 week leave
November 14	8	32	13	19	1	1.5	1	
December 14	13	25	5	20	5	2.5	1	MCHS Xmas closure 10 days
January 15	5	34	10	24	3	2.5	3	
February 15	6	37	8	29	2	1.5	8	
March 15	16	23	5	18	11	1.5	2	
April 15	16	15	7	8	7	2.0	3	
May 15	9	15	9	6	6	3.0	0	Physio 1 week leave
June 15	6	31	12	19	10	2.5	8	
Cumulative totals	101	225	79	146	45	2.1	26	
** Unable to contact four clients*								

Outputs from the modified pain management program included:

- The first pilot group April to June 2015
- 10 participants
- 24 hours in direct contact with Grade 3 clinicians.

Outputs from acupuncture and dry needling included twenty five occasions of service that were provided to six clients across the broader community health primary care program.

Outputs from the community gym group included seven clients who are now attending the gym group.

The implications of providing an acute/sub-acute back pain assessment service in a community based setting are described in Table 4.

Table 4: Implications for acute community interface

Theme	Participants	Activity
Time required to develop processes, including: • governance and accountability • human resources • client information and appointment systems • consent • operational requirements • administration processes • data collection and monitoring • staff training.	Representatives from the four collaborative partners and nominated clinicians	• 19 meetings from May 2014 to June 2015 • Total meeting time = 29 hours • Plus additional time to resource the meetings

Theme	Participants	Activity
Time and cost of providing administration support to the back pain assessment clinic, which was vital for managing the operational interface of the two organisations and their services.	Designated MCHS administration officer with management support allocated to the back pain assessment clinic	• Initial training (4.5 hrs) was provided by the MCHS project manager • The cost for the weekly support was funded by Melbourne Health ($18,000 per annum) • 15.2 hrs/week from Aug to Dec 2014 • 7.6 hrs/week from Jan to June 2015
Tools developed to facilitate services included: • administrative • operational • legal • professional development • workforce	Project managers from Melbourne Health and MCHS with input from clinicians and others as required (for example, legal department	The list of tools, resources and documents is provided in Appendix 7

Key findings

Melbourne Health reported that at the time clients were first seen at the back pain assessment clinic, those referred to neurosurgery clinics had been waiting an average of 101 weeks, and clients referred to orthopaedic clinics had been waiting an average of 71 weeks. Only 1.8 per cent of those clients were referred back to a surgical unit[4].

These findings illustrate the importance of the clinics working in collaboration and demonstrate that the 'whole' adds much more value than the sum of the parts. The broader outcomes that MCHS has achieved through the project are both exciting and sustainable, and include:

- developing a valued and trusting relationship between primary and community partners
- credentialing a Grade 3 physiotherapist in community health
- embedding a multidisciplinary approach into services for back pain and incorporating an exercise physiologist (which is not traditional in community health).

Safety, quality of care and access

As a result of this project, MCHS was able to offer new clinical services that included:

- a Grade 3 musculoskeletal physiotherapy-led back pain management clinic (commenced August 2014) – a Grade 3 musculoskeletal physiotherapist was employed to provide expert clinical assessment and non-surgical management for clients referred from the Melbourne Health back pain assessment clinic. As a clinical leader, the physiotherapist shares knowledge and expertise with the physiotherapy workforce at MCHS, including developing, mentoring and upskilling Grade 2 physiotherapists, and supervising physiotherapy students. Position descriptions and scope of practice documents were developed to identify the professional roles, activities, practice settings and guiding frameworks covered by the position to preserve safety and quality of care (see Appendices 4 and 5)

[4] Landgren F, Liew D, August 2015 *Back pain Assessment Clinic (BAC) Evaluation Report*

- a modified pain management program (launched in April 2015) – an eight-week multidisciplinary program directed at helping clients with persistent pain to improve their ability to manage activities of daily living and engage in regular physical activity,
- acupuncture and dry needling treatments (commenced March 2015) (see Appendix 6)
- community-based gym groups (commenced February 2015).

Due to the close collaboration with the back pain assessment clinic and subsequent referral of clients to the management clinic, community health is now seeing clients with increasing complexity, with more than 70 per cent experiencing moderate to severe levels of pain, and more than 60 per cent experiencing moderate to severe levels of disability or stress.

MCHS is able to assure the safety and quality of care of these clients through the advanced skills of the Grade 3 physiotherapist and the increased clinical expertise that the Grade 2 physiotherapists gained throughout the project.

Integrated workforce
An integrated workforce was achieved through the increased interaction and collaboration between the acute and community sector clinicians and organisations in the assessment and management of back pain.

This was evidenced by;
- tools produced or agreed on collaboratively to deliver the services and measure outcomes, such as referral pathways, scope of practice and clinical outcome measures
- the development and implementation of a credentialing framework for the MCHS Grade 3 physiotherapist (see Appendices 8 and 9)
- the MCHS Grade 3 physiotherapist engaging in peer supervision, co-consults, case discussions and client reviews with the acute sector clinicians. Activities included:
    - attending peer review (in-service sessions) at Melbourne Health – 6 x 1 hours
    - attending specialist clinics at Royal Melbourne Hospital – 3 x 3.5 hours
    - participating in supervision, shadow clinics and case reviews – 8 x 2 hours
    - Self-directed learning – 13 x 3 hours (average) and a two-day workshop.

Workforce collaboration within MCHS also occurred with the development of the modified pain management program, involving the physiotherapist, exercise physiologist, occupational therapist and dietitian.

Additional progress towards an integrated and coordinated workforce included the involvement of the hospital rheumatologist, Grade 4 physiotherapists and the Grade 3 community physiotherapist in the development of the *Back Pain Health Pathways*. This is an online manual to assist general practitioners to assess, manage and refer their clients to secondary, tertiary, and community services.

Workforce satisfaction
The introduction of a Grade 3 physiotherapist to MCHS, and their involvement with both the assessment and management clinics, will strengthen the workforce landscape in community health services, as it has introduced additional clinical expertise with advanced skills to offer new or enhanced services.

The Grade 3 physiotherapist position description and scope of practice documents (see Appendices 4 and 5) describe the additional roles in service development, service provision, quality research and

clinical service improvement. The credentialing framework has added to workforce development, as well as helping to improve the tertiary sector's faith in the capabilities of community health clinicians.

The Grade 3 physiotherapist has contributed to the development and workplace satisfaction of other clinicians within MCHS through mentoring and professional development activities provided regularly to other MCHS clinicians.

This is evident through responses to a baseline survey of relevant staff in October 2014, in which:

- 44 per cent agreed and 50 per cent strongly agreed to the statement 'I think that Grade 3 clinicians are an important resource for staff members to learn from'
- 50 per cent agreed and 50 per cent strongly agreed to the statement 'I think the development of Grade 3 roles in the Primary Health Care Program is a positive step for MCHS'.

A repeat survey with MCHS clinicians in August 2015 has shown that now almost 60 per cent strongly agree that Grade 3 clinicians are an important resource for staff members to learn from and almost 60 per cent strongly agree that the development of Grade 3 roles in the Primary Health Care Program is a positive step for MCHS

The addition of a Grade 3-level role has now created a career pathway and structure in community health that did not exist before. The baseline staff survey indicated that only 11 per cent of MCHS clinicians were satisfied with the career structure available to allied health clinicians in community health services. The follow-up survey in August 2015 saw this increase to 31 per cent of MCHS clinicians who recorded that they were satisfied with the career structure, indicating positive progress as a result of the workforce redesign.

Client experience

A client experience survey was provided to all clients who were seen in the back pain assessment clinic at the time of their discharge from the clinic and/or group sessions. The survey had an emphasis on self-management and lifestyle change (see Appendix 10). At the time of writing this report, 30 clients had been discharged from the service and 23 had completed a client experience survey.

Overall, a net positive response was recorded to all questions, with analysis of the date showing that:

- 87 per cent of participants either agreed or strongly agreed with the statement that 'after participating in this program, l am now able to do more things that l enjoy doing'. Only one participant disagreed
- 96 per cent of participants either agreed or strongly agreed with the statement that 'I think this program has helped me to manage my condition better'
- 87 per cent of participants either agreed or strongly agreed with the statement that 'l feel happy that l received specialist services for my condition within my local community rather than in a hospital'
- 96 per cent of participants either agreed or strongly agreed with the statement that 'if a friend or family member were in need of similar help, l would recommend this program to them'
- 87 per cent of participants either agreed or strongly agreed with the statement that 'overall, l feel satisfied with the services l received as part of this program'
- 91 per cent of participants either agreed or strongly agreed with the statement that 'l think that participating in this program has been a positive step toward a healthy lifestyle'.

Client story

Stuart is a 49-year-old male who presented with approximately a 10-year history of lower back pain going into his legs and also causing numbness. He had three CT scans of his lumbar spine (between November 2013 and February 2015), which mainly showed right L5 and left S1 nerve root compression. His doctor referred him to the neurosurgery unit at Royal Melbourne Hospital in February 2015. This referral was triaged and diverted to the back pain assessment clinic at MCHS where he was assessed in May 2015.

Assessment at MCHS

Based on assessment, Stuart appeared to have a clinical presentation of persistent mechanical low back pain with intermittent sciatica. He was referred for physiotherapy with a focus on pain education and active exercise program.

Clinical indicators

Quality of sleep (subjective), lumbar spine range of movements (objective) and a nine-point Keele Start Back Tool were used as the clinical outcome measures.

Outcomes

Within a few weeks of attending the community-based physiotherapy clinic, Stuart's back and leg pain improved. He noticed improvement, not just in his health and fitness but, also in his emotional wellbeing. In a physiotherapy review in July 2015, he reported that he was sleeping well through the night and his lumbar spine range of movements were also normal on examination. He also showed some improvement with the Keele Start Back total score (Initial score was 6/9, score two months later was 5/9). Keele Start Back helps to measure psychosocial distress associated with back pain. It is a nine-point self-scoring tool – the lower the score, the lower the psychosocial distress due to back pain.

This is what Stuart said about his experience:

> *'I am extremely happy with the services I received at Merri. My back and leg pain is much better. I am not taking any pain medications now, which I never liked to take as I am already on lots of medications for my other medical problems. I understand now what was causing my pain and more importantly, I know now what I can do to prevent it from occurring in future.'*

Conclusion

The results of this project demonstrate that the multidisciplinary back pain model of care can successfully deliver evidence-based early intervention for a growing population of people with complex back pain, thereby reducing the burden of ill health. Correspondingly, working in a collaborative acute and community health partnership can reduce the increasing pressure on hospitals.

The project set out to establish a physiotherapy-led community clinic for the management of back pain at MCHS, utilising advanced practice roles in order to improve community workforce capability to offer services to clients with increasing complexity and to increase the range of services offered; thereby demonstrating the role that the community health platform can play in reducing demand on acute services.

Initial effort was focused on the hospital internal systems and processes. MCHS recognised the need to demonstrate its value proposition, which required a focus on increasing community health capacity through workforce capability and increasing the range of existing services.

The close collaboration between multiple disciplines, and hospital and community health partners, has been integral to the success of the project, providing a value add for both organisations and for clients.

The results of the program demonstrate the capability of the community health platform to effectively divert clients to community-based management services with no adverse incidents, high levels of client, staff and referrer satisfaction, and an increased focus on research capability.

Safety and quality in healthcare has been achieved through service and workforce redesign, providing improved client access to timely expert assessment and management, and streamlined referral and care pathways.

The introduction of advanced practice Grade 3 clinical roles is unique in community health in Australia, and is an example of workforce innovation made possible by collaboration. The credentialing process for the MCHS physiotherapist has built community health workforce capacity. This has resulted in new models of care and clinical services being offered to our community, with a renewed focus on evidence-based clinical care and evaluation, implementation of professional development, career pathways and peer support for physiotherapy and other allied health staff.

The level of productive activity and tangible positive outcomes generated from the project resources has demonstrated the value add that the community health platform can provide in diverting appropriate clients off hospital waitlists.

The project has been able to demonstrate short-term outcomes for the partner organisations. Evaluation of major outcomes in the medium term (12 months of implementation) and longer-term data (three years or longer) will provide further evidence to evaluate efficiency and effectiveness. Data collected through any replication sites will also add to this body of evidence.

This model has the potential to be replicated for other chronic and subacute conditions, and at other sites, demonstrating that advanced practice roles in community health, and relationships with tertiary partners built on trust and confidence, can make a positive difference.

Future directions

MCHS will continue its commitment to the provision of innovative and evidence-based models of care to address chronic care in its catchment area. It recognises the importance of inter-organisational collaboration with hospitals and general practitioners to tackle unnecessary hospital presentations and to strengthen capacity within the primary care setting. It will continue to promote workforce innovation and redesign opportunities to support new models of care.

Data is still being collected from the back pain assessment clinic, including six-month follow-up outcome measures, which will be analysed in April to June 2016. The eight-week modified pain management program will continue to be offered and evaluated with improvements made incorporating client feedback. Our new services will be marketed to general practitioners and direct referral into our programs will be encouraged.

Involvement in the Health Pathways project has been a positive step in notifying general practitioners of appropriate referral pathways. However, challenges remain in changing referral patterns and promoting non-surgical community-based care as an appropriate, safe and effective first step for many clients.

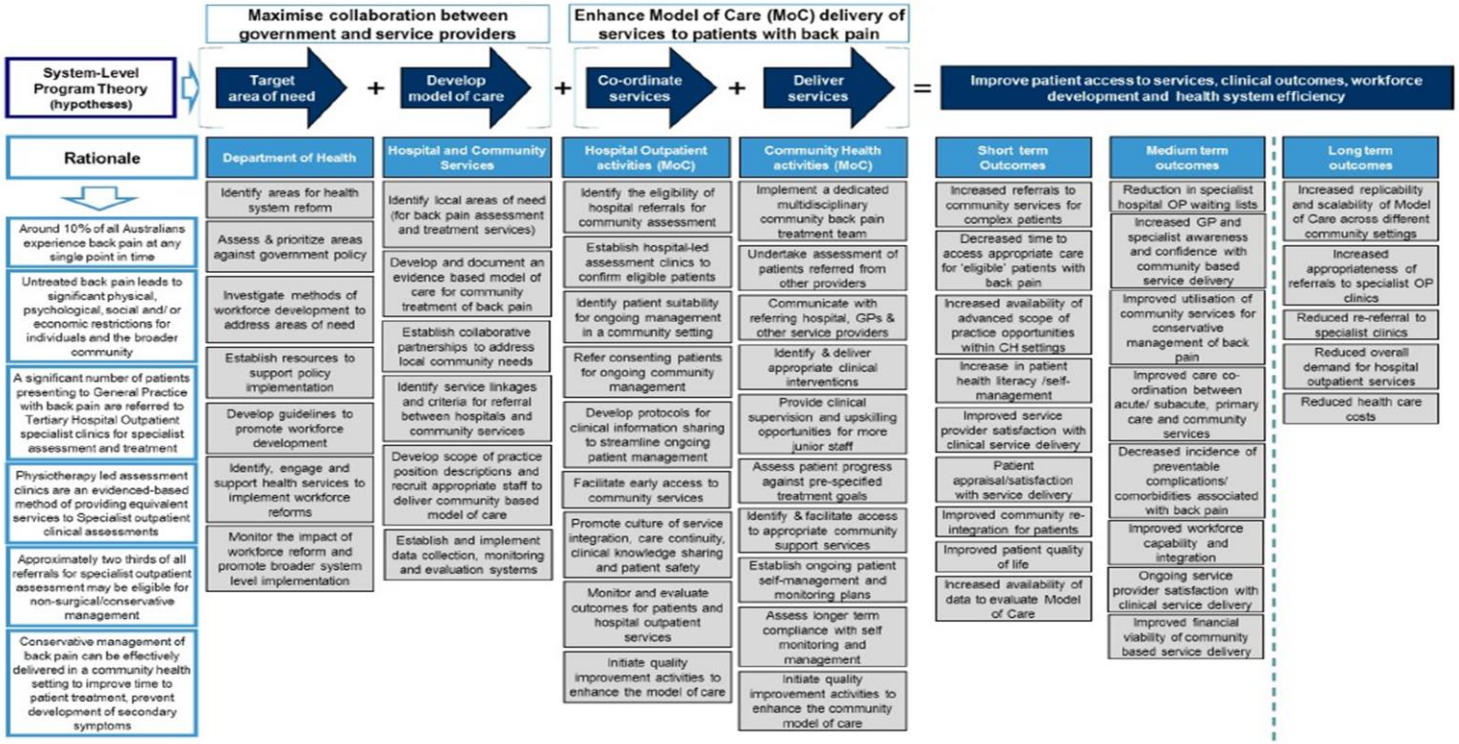
The community health Grade 3 physiotherapist has completed all credentialing elements and is at the assessment phase. They have been appointed to an honorary position at Melbourne Health, which will enable them to work in the back pain assessment clinic, conducting medical assessments of referred clients. Although the future of the clinic is not yet guaranteed, MCHS hopes this collaborative arrangement will continue to further boost advanced scope of practice roles in community health, and build on the trust and confidence between the two sectors.

MCHS and Melbourne Health, as members of the Inner North West Melbourne Collaborative, will continue to work with the Primary Health Network and community health partners to promote the model of care and to identify further opportunities for replicability and scalability. The Chief Executives of the collaborative have agreed to jointly fund an economic impact analysis of collaborative projects, in order to advocate on the need for government to establish suitable funding mechanisms to support better integration and redesign between hospital and primary healthcare. The economic impact analysis is expected to be available in early 2016.

As a result of further funding received from the Department of Health and Human Services, MCHS will work with Melbourne Health on replication of the model in other health services in a mentorship role. The data collected from this project and the replication sites will add to the body of evidence for sustainability of the model.

Appendix 1. Model of care and evaluation framework program logic

Figure 5-1: An overall program logic outlining key activities and anticipated outcomes associated with community based multidisciplinary team management of patients with back pain



Appendix 2. Risk assessment status report

Risk assessment status report Number 2: March 2015

Event		Degree of risk	Likelihood of risk	Consequences	Possible treatments	March 2015 Status
1	Scope of Grade 3 Physiotherapist in the community setting poorly defined and/or not maximised, leading to a workforce model that does not address current client management practice issues across the sector	Could affect quality of project and its outcomes	Very unlikely	High consequence	Active Monitoring Expertise will be drawn from MCHS's existing clinical governance framework, consultant's feedback and associated quality and accreditation resources.	Scope of practice document created and role well defined with both a clinical and leadership component.
2	Lack of appropriate clinical supervision structure for Grade 3 Physiotherapists.	Could affect quality of project and its outcomes	Very unlikely	High consequence	Active Monitoring Expertise will be drawn from MCHS's existing clinical governance framework and associated quality and accreditation resources.	Professional development and clinical supervision framework developed. The process will work toward having a fully credentialed community physiotherapist at MCHS to undertake specialist assessments by June 2015.

3	Limited data and lack of clarity from MH on client type and volume	Affects establishment and design of Grade 3 role in the community and potential use of and recruitment to other MCHS Allied Health roles. Data reporting adherence may be affected if client age and functional status make them ineligible for HACC services	Possible or Likely	High consequence	Proactive Management Requires close collaboration with MH to match demand and clinic capacity. Dependent on demand from MH will approach Northern Health & GPs to directly refer into Clinic/s. Investigate predicted cohort of clients requiring pain management service and how the Community Therapy Service at Parkville is integrated into the model Mixed funding for employment of expanded scope Grade 3 staff in community health to allow for all client groups.	Monthly data monitoring across clinics and agreement to share de-identified data Establishing a MCHS Spinal Rehabilitation Service is in progress.

4	Delay in establishing agreed triage protocols at MH Back Pain Interface Clinic	Will impact on timelines and subsequently all aspects of the project	Possible	High consequence	Proactive Management Collaboration required from commencement of project. Need to identify and align collaborative key tasks and timelines	Protocols developed
5	Lack of engagement of MH specialists	Will impact on all aspects of the project	Possible	High consequence	Proactive Management Collaboration required from commencement of project. MH Project Manager and lead specialist also need to champion the cause of community Physiotherapy-led clinics and the timely patient access to specialist assessment and management this will provide. MCHS presence at MH Steering Committee will assist with communicating MCHS engagement and commitment to project.	Good engagement with MH - consultation is through the MH lead specialist (Dr John Moi) and Physiotherapy Project Manager.

6	Delay in establishing agreed protocols between MCHS and MH on client flows/referrals and clinical governance arrangements	Would impact on timelines and ability to meet service targets	Possible	High consequence	Proactive Monitoring Collaboration required from commencement of project. Need to identify and align collaborative key tasks and timelines. Some adjustment may be required	Protocols developed and clinical governance arrangements agreed
7	Inadequate protocols and/or professional competency developed in community health to flag clients for specialist outpatient clinic management following failure to improve with conservative management.	Could affect quality of project and its outcomes Could reduce trust for ongoing referrals between acute, sub acute and community	Possible	High consequence	Proactive Monitoring Collaboration required from commencement of project Formal service arrangements in place for joint consultations and feedback between RMH G4 Physiotherapists and MCHS G3 Physiotherapist.	Protocols developed and joint consultations and secondary consultations are occurring as required. License and Service Agreement between MCHS & MH executed and credentialing framework which includes supervision arrangements agreed upon.

8	Staff mix at MCHS with some staff not keen to work with clients with chronic pain	Could affect quality of project and its outcomes and staff satisfaction	Possible	Low	Enable flexible approach to assessment and conservative management; staff mix and skills development to maximise clinician engagement in the project.	Staff perception survey indicated that 64% of staff were confident in managing clients with back pain;> 80% were interested in further professional development and > 90% considered a Grade 3 as an important resource for staff to learn form
9	Inability to demonstrate diversion of clients from hospital to community health setting and/or clinical impact.	Could affect quality of project outcomes – lack of data may weaken evaluation of program effectiveness	Possible	Low	Work with MH to identify best available data collection methods pre and post project and develop routine collection procedures. Clinical outcome measures and client satisfaction rating tools need to be investigated and agreed upon	Evaluation framework includes clinical outcome measures Longer term data collection is required to demonstrate diversion

Appendix 3. Evaluation framework elements

Evaluation framework elements – data labels

Data labels for MCHS back pain management clinic data entry	
Merri Health Unit Record Number	√
Name of patient's GP	√
Name of doctor making the latest referral	
Age of patient	√
Patient's current living arrangements	√
Current community services received by patient	
Clinical indications of cognitive impairment	
Interpreter required	√
Date of initial MCHS physio appointment	√
Total number of individual sessions to date	√
Total number of group sessions to date	√
Date of initial referral to RMH	√
Date of other referral	
Date of patient BAC assessment	√
Date of intake service access	√
Date of multi-disciplinary team assessment	√
Any red flags identified at assessment	√
Any yellow flags identified at assessment	√
Date of first to fifth team meeting where patient was discussed	
Date of patient referral to another service	√
Type of service referred	√
Date of reassessment	
Date of referral to other practitioner on patient discharge	
Type of practitioner referred to on discharge	
Date of referral to other community service on patient discharge	
Type of community service referred to on discharge	
Date patient self-management plan completed	
Date of patient discharge	√
Date of first to fifth follow up after discharge	
Date that six-month follow up occurred	
Any ongoing services patient is receiving	
Is patient undertaking ongoing self-management activities as per plan?	
Has patient experienced any clinical deterioration?	
Has patient received any further intervention?	
Date of patient representation for assessment	√

The √ indicates the measures that were collected during the pilot project.

Evaluation framework elements – outcome measures

Proposed outcome measures to be collected					
Measure	**Pre-screening**	**Intake screening**	**Initial team assessment**	**Community discharge**	**Six-month follow up**
SF-36	* √			* √	* √
SCTT		* √			
DASS			*	*	
SBST			* √	* √	
BPI			* √	* √	
NDI/ODI			* √	* √	

Explanatory notes

*The * indicates the proposed measures and suggested collection points*

The √ indicates the measures that were collected throughout the pilot project

SF-36 – Short Form 36 (implemented January to June 2015)

SCTT – Service Coordination Tool templates

DASS – Depression Anxiety and Stress Scale

SBST – Keele Start Back Screening Tool (implemented from August 2014- January 2015 and then replaced by SF-36)

BPI – Brief Pain Inventory (collected by MH clinicians in BAC)

NDI/ODI – Neck Disability Index/Oswestry Disability Index (collected by MH clinicians in BAC)

Appendix 4. Musculoskeletal physiotherapist position description

Merri Community Health Services

Position Description

Position Details	**Position Title**	Musculoskeletal Physiotherapist
	Position Number	
	Probationary Period	3 Months
	ISR Review Period	Annual
	Location	Bell St, Coburg
	Reporting To	Team Leader, Independent Living Team
	Number of Direct Reports	Nil
	Effective Date	May 2014
Position Summary		The Grade 3 Physiotherapist is responsible for providing expert clinical assessment and conservative management for clients referred by primary, secondary and tertiary providers to MCHS' Specialist Community Transition Clinic for Back Pain and wider physiotherapy service. In accordance with the Active Service Model, physiotherapy management aims to maximise clients' functional independence and their ability to participate fully in the community. As a clinical leader the Grade 3 Physiotherapist will share their knowledge and expertise with the physiotherapy workforce at MCHS, including developing, mentoring and up-skilling Grade 2 Physiotherapists and supervising physiotherapy students. In order to maintain currency of professional knowledge and advanced clinical skills, the Grade 3 participates in on-going professional development including secondary consultation and clinical supervision with a Grade 4 Physiotherapist. The Grade 3 physiotherapist is experienced in service development, quality and research and applies their understanding of wider organisational and public health challenges – particularly the interfaces between tertiary, secondary and primary care settings – to a leading role in ongoing clinical service improvement.
Organisational Accountabilities		Merri Community Health Services (MCHS) provides a range of services including dental, allied health disciplines, generalist and specialist counselling programs, aged and disability services, case management, family support, carer support programs, and social support programs for people with a mental illness as well as health promotion programs. A detailed description services offered by MCHS is provided on the web site www.mchs.org.au
Key Accountabilities	**General**	• Work successfully with internal and external stakeholders to facilitate the development of a collaborative service model to improve the management of back pain clients in the community, including but not limited to the development of triage processes, referral/care pathways and scope of practice. • Facilitate the smooth transition of clients through the health care system, liaising with relevant staff and community agencies to ensure continuity of care for individual patients/clients and their families, collaborating to refer clients to other services as necessary. • Actively contribute to the development of specialist physiotherapy

1

		clinics and multidisciplinary team approaches that are part of the MCHS Community Transition Program. • Demonstrate expertise in a range of clinical work that is guided by evidence based practice and in which outcomes are monitored. Modifications to clinical service are proposed, planned and initiated using a quality improvement methodology aimed at promoting cost-effective, safe, efficient and client-centred services. • Manage time and prioritise competing demands so that clinically appropriate care is delivered in a timely fashion, and non-clinical deadlines and responsibilities are met. • Work with Team Leaders, the Primary Health Care Program Manager and Physiotherapy Clinical Support person in developing a positive culture within the physiotherapy department and model active participation within the multidisciplinary team. • Develop effective and productive professional relationships with external and internal stakeholders, demonstrating highly developed communication, negotiation and conflict resolution skills. • Promote MCHS services to external parties and contribute to the ongoing growth of MCHS' referral base. • Model professional leadership and act as a mentor/supervisor within physiotherapy and across disciplines and programs.
	Clinical	• Deliver independent, high level Physiotherapy clinical services for back pain presentations utilizing evidence based practice to guide clinical decision making. • Provide high quality education and information to patients about the management of their musculoskeletal disorders, involving clients and carers in decision making and negotiating agreed plans and arranging appropriate medical and allied health follow up where required. • Actively contribute to the development of professional and clinical standards, clinical practices, and work unit guidelines. • Demonstrate detailed knowledge of relevant community resources, information and referral processes, and utilizes this knowledge in clinical practice. • Provide high level clinical advice to professional and operational supervisors, relevant managers and other stakeholders regarding service delivery, and monitor and report on clinical service issues and outcomes. • Utilize high level communication and negotiation skills with patients and their families, other health professionals, referrers, and students to facilitate cooperation, positive relationships and effective service delivery. • Lead and participate in developing and implementing quality and service improvement activities that enhance the delivery of physiotherapy services, and undertake clinical service development responsibilities as delegated. • Actively participate in professional development, supervision and mentoring of clinicians and students to ensure the maintenance of professional clinical standards and general up skilling of staff in the conservative management of back pain in the community. • Have evidence of regular continuing education in musculoskeletal physiotherapy and back pain management. • Record appropriate information and outcomes (e.g. in medical histories) in an accurate and timely manner and be aware of and adhere required standards. • Foster and model a detailed understanding of culturally and linguistically diverse communities (CALD).
Key Performance Measures	**General**	• Achieve targets set by funding agreement. • Initial clinical assessment of client documented in Merri within 24 hours. • Care plan commenced within 2 business days of initial

		assessment. • Care plan finalised prior to discharge of client. • 80% client satisfaction with services reflected by the client satisfaction survey. • Knowledge of agreement with University to ensure timely delivery of relevant, tailored supervision and teaching of students. • Contribute to student reports. • Satisfactory rating regarding compliance to MCHS policy and procedure for client file audit. • Knowledge of and compliance with OHS policies and procedures. • Actively participate in the strategic planning process and complete individual Workplan in line with organisation timeframes and requirements. • 70% attendance of and participation in team and A.H Meetings. • 100% attendance and participation in operational and clinical supervision. • IPR completed and submitted to Team Leader within set timeframe.
	Clinical skills and Service Development	• A set of key performance measures for the clinical and service development aspects of this position will be developed in parallel with the evaluation framework for the Community Transition Clinic for Back Pain. The evaluation will be designed in accordance with the Victorian Innovation and Reform Assessment Framework.
Key Selection Criteria	**Essential**	• More than 5 years post graduate clinical experience; • At least 3 years musculoskeletal experiencing including a primary contact component; • Demonstrated high level of clinical competence and expertise in musculoskeletal physiotherapy; • Demonstrated knowledge and experience in planning, implementation and evaluation of service models and novel models of care; • Demonstrated high level interpersonal and communication skills both written and verbal (including conflict resolution and negotiation); • Demonstrated ability to impart knowledge to staff at all levels and across services, as well as members of the wider community; • Demonstrated ability and experience working as part of a multidisciplinary team; • Demonstrate leadership skills and initiative in developing and promoting evidence-based clinical care; • Dynamic and innovative problem-solving skills; • High level organisational skills and computer literacy; • Understanding of health structures and health service interfaces; • Demonstrated commitment to MCHS values and philosophy, and capacity to engage in the enhancement of MCHS culture in meeting organisational objectives;
	Desirable	• Knowledge and experience of the Active Service Model and client-centred self-management principles; • Research skills; • Involvement in professional groups associated with musculoskeletal physiotherapy; • Possess knowledge and understanding of the cultural diversity of the community.
Training, Qualifications and Registrations		• Degree qualified in Physiotherapy; • Current registration as a Physiotherapist with the Australian Health Practitioner Regulation Agency; • Relevant postgraduate qualifications (Clinical Master of Physiotherapy or equivalent) or progression toward these, with a commitment to completion; • Current Victorian Drivers Licence

		Note: Appointment to this position is subject to passing a National Police Check
Credential		
Working Relationships	**Internal**	• General Manager, Clinical and Carer Services • Manager, Primary Health Care • Primary Health Care Team Leaders • Physiotherapy Clinical support • Physiotherapy Team • Other Primary Health Care staff • Other Merri CHS staff
	External	• Other physiotherapy services (public and private) • Medical specialists • Tertiary Institutions • Referring Agencies and Associations supporting clients • Case Managers and other client support services
Award Coverage		Health Professionals
Delegation of Authority	**Link to document**	

Appendix 5. Grade 3 musculoskeletal physiotherapist scope of practice

Merri Community Health Services

Scope of Practice

Position Title:	Grade 3 MusculO<SkeletalPhysiotherapist
Program Area:	Primary Health Care Program
Team Name (if applicable):	Independent Living Team
Target Population (and any exclusions):	All HACC and CH eligible dients living in northern metropditan Melbourne able to attend centre-based appointments atthe MCHS Coburg site_ All clents underthe age of 18 must be accompanied by a parent/guardan_
Service Delivery Model:(one on one or group wol'X)	Individualphysiotherapy assessment and treatment,and Group Programs
Service Location (Ilome visit, outreach and centre based):	Centre based services oly
Elements of Service Provision (e.g. Asessment, treatment, advocacy, health education,community development)	• Physiotherapy assessment and diagnosis • Physiotherapy treatment including manualtherapy,soft tissue techniques,education about health condition,therapeutic exercise prescription and progression,referralto otherallied health practitioners. • Service development includingidentifying opportunities for service growth through unmet need within the communityidentifying gaps in current service provision and how this could be improved, fostering an approach of continuous quality improvement driven by evidence based practicewithin the PHCP Physiotherapy team_ • Peer supervision and development of the Physiotherapy team including upskilling in musculoskeletal techniques and ongoing peer education about evidence based practice in musculoskeletalphysiotherapy_ • Developing and sustaining partnerships wh internaland external providers (Le. GPs, community groups) to improve continuity and coordhation of services as outlnedh the MCHS Person Centre Care and Service Coordination Policy & Procedure_
Scope of Practice – core (diagnosis or presenting issues managed by all):	General physiotherapy assessment,diagnosis and treatment of common musculoskeletal conditions routinely encountered in an out-patient or community setting, includig but not limited to: • Spinaland peripheraljoint pain and/or stiffness; • Postjoint replacement or surgery; • Soft tissue injuries; • Muscleweakness; • Uncommon muse conditions suclh as cervicogenic headache and TMJ disorders. features of assessment which are commonly conducted are outlined below_ It is expected that physiotherapists are able to modify positioning for assessment and treatment, partcularlly for clients whose movements are restricted by pain, stiffness, balance or

other issues.

Subjective assessment of presenting compliant including:

- History
- Mechanism of injury
- 24 hour behaviour
- Screening for red and yellow flags
- Aggravating and easing factors
- Limitation to functional/physical activity and client goals

Objective assessolent:

- Observation of posture, symmetry/landmarks and gait (if applicable);
- Observation of tissue status including swelling, redness, scars, skin breakdown as applicable;
- Observation of protective movements and neuromuscular control during active movement;
- Soft tissue palpation;
- Joint range of motion - active/passive/ with or without overpressure at end of range including the use of common measuring tools such as goniometers;
- Muscle strength testing including use of designated equipment (eg. grip strength dynamometer, Pressure Biofeedback Units);
- Muscle length tests;
- Neural provocation tests and neural length tests;
- Neural examination - sensory, reflex and motor;
- Joint palpation, physiological and accessory movements;
- The use of special tests to differentiate alternative diagnoses.

Treatment modalities:

As part of routine practice the decision to use any treatment modality should be based on clinical reasoning and the current evidence base and should be followed by re-assessment to determine if that treatment has been successful in managing the patient's condition, including use of outcome measures. Commonly used treatments are outlined below:

- Therapeutic soft tissue massage and stretches.
- Grades I to IV accessory and/or physiological joint mobilisations.
- Prescription and progression of therapeutic exercise to improve neuromuscular control, strength and length. This may include both land-based and water-based (hydrotherapy) exercise and the use of special equipment (eg. shoulder pulley, balance board, fit ball etc).
- Patient education regarding their condition and likely course (natural history and prognosis), strategies to manage pain and modify activity, rationale for treatment choice.
- Use of heat, ice or electrotherapeutic modalities (wherever indicative) including:
  - knowledge of equipment and appropriate dosage;
  - screening for contraindications and precautions;
  - conducting appropriate testing for sensation;

	○ observing for adverse treatment effects. • Taping techniques including: ○ screening for reactions to adhesives; ○ monitoring skin condition; and ○ education about precautions, duration of wear and removal technique • Referrals to other allied health practitioners if a multidisciplinary approach is required.
Scope of practice – specialists (include in scope for particular position under certain circumstances)	• Independently assess and treat complex musculoskeletal clinical presentations with good proficiency and with clear understanding of clinical indicators for urgent intervention or escalation of treatment. • Advanced understanding of mechanisms contributing to the development of musculoskeletal pain and progression towards chronicity, including the importance of psychosocial factors in its aetiology and evidence-based multidisciplinary management and education for clients with musculoskeletal pain. • Extensive knowledge of the current evidence base for patient self management and client-centred education, and well developed skills in delivering such education to clients of diverse cultural backgrounds and those with low health literacy. • The ability to communicate as a peer and with common language when dealing with all members of the multidisciplinary team to ensure a coordinated approach to patient management. This is with particular reference to communicating with: • General Practitioners for further investigation, medication management and recommendations; • Emergency Department, Neurosurgical, Orthopaedic and Rheumatological specialists in the event of clear red flags, clinical emergency or failure of appropriate conservative management. • Skilled in interpretation and analysis of clinical and non clinical information to form an accurate assessment and prognosis and to recommend the best course of intervention(s). • Specific advanced clinical skills including: ○ Expert knowledge of the pathophysiology of musculoskeletal conditions and ability to apply this in determining differential diagnoses for complex presentations; ○ Advanced understanding and ability to interpret a range of musculoskeletal radiological investigations (including but not limited to CT, MRI, plain radiographs); ○ Sound understanding of the range of pharmacological agents used to manage common and complex pain presentations including drug classes and purpose of prescription (eg. management of neuropathic pain); ○ Advanced skills in the assessment and management of spinal pain, including progression towards credentialing to conduct medical assessment of patients presenting with spinal pain; ○ Advanced manual therapy and complementary clinical skills (such as Grade

	V/high velocity manipulations, dry needling and acupuncture and Mulligan techniques) and therapeutic exercise prescription for complex musculoskeletal conditions. o Active participation in professional development including maintenance of a continuous professional development (CPD) portfolio and evidence of ongoing peer review. o Demonstrated reflective practice with advance clinical reasoning and decision making skills for routine as well as complex case presentations. • Advanced scope of practice skills - non-clinical o Act as a clinical lead in musculoskeletal physiotherapy and actively contribute to the existing knowledge base through the provision of specialized musculoskeletal clinical supervision and advice to other physiotherapists, including secondary consultation and case discussions. o Experience and/or willingness to participate in research programmes. o Participation in service development, including the ability to identify research opportunities to raise the profile and improve the quality of musculoskeletal physiotherapy services and the ability to build relationships with research partners such as universities and other health care providers. o Based on clinical expertise the ability to critically appraise service activity and quality through the use of audit and other quality improvement tools.
Qualifications and Relevant Experience:	• Completion (or working towards) a post-graduate Masters-level qualification in Musculoskeletal Physiotherapy or equivalent. • Continuous registration as a physiotherapist with the Australian Health Practitioners Regulation Agency (AHPRA) and affiliation with the Australian Physiotherapy Association (APA) Musculoskeletal Specialist Interest Group. • Experience as a clinical educator for undergraduate physiotherapy and post-graduate Master of Physiotherapy students as appropriate. • Minimum of 5 years clinical experience in a senior musculoskeletal physiotherapy role (Grade 2 minimum or equivalent for overseas trained therapists). • Evidence of ongoing professional development in the field of musculoskeletal physiotherapy which meets or exceeds the CPD requirements for AHPRA registration. • Note that a key goal for the Grade 3 advanced scope role is to increase the confidence of General Practitioners and other stakeholders to refer to Merri Community Health Service for assessment and management of spinal pain as a matter of first course, thereby reducing inappropriate referrals to hospital-based medical specialists and improving access to timely care for clients with spinal pain. In working towards this goal, the Grade 3 Musculoskeletal Physiotherapist seeks opportunities to maintain and build on their advance practice role through the pursuit of additional professional development. This will include preparing for a credentialing process to conduct medical assessment of clients with spinal pain in a community based setting, as an adjunct to comprehensive physiotherapy assessment.

Merri Community Health Services

Scope of Practice

- As part of the collaborative agreement between Melbourne Health (MH) and Merri Community Health Services, MH Grade 4 Physiotherapists will provide the following professional development and clinical supervision opportunities for the MCHS Grade 3 Musculoskeletal Physiotherapist:
  - over an initial six week period, fortnightly sessions of two hours duration to observe assessments at the Melbourne Health Back Pain Assessment Clinic conducted by the Rheumatologist, and both Grade 4 Physiotherapists (three sessions in total).
    A designated half hour clinical mentoring session alternating between the MH Grade 4 Physiotherapists on a fortnightly basis.
  - Secondary consultations for clinically challenging MCHS Back Pain Clinic clients, to be booked during MH BACC clinic time on an as-needed basis.
  - Attendance at relevant monthly Royal Melbourne Hospital (RMH) City campus Physiotherapy Department peer review case presentation sessions on Thursdays from 1.15pm – 2.15pm. The MCHS Grade 3 Physiotherapist will also have the opportunity to present at these sessions.
  - Observe the RMH Neurosurgery and Orthopaedic Spinal outpatient clinics with the Grade 4 Physiotherapists and/or consultant.

References

Victorian Healthcare Association How to guide for credentialing and Scope of Practice in Community Health. Accessed online 15 September 2014 at http//www.google.com.au/url?sa=t&rct=j&q=&esrc=s&fnm= &source=web&cd= &ved= OCB8QfjAA&url=http%3M%2F%2Fwww.healthcaregovernance.org.au%2Fdocs%2Fhow-to-guide-for-credentialing-and-scope-of-practice.pdf&e=SV4fVNjVHNfd8AWOioDgBQ&usg=AFQjCNG3Y·wvrc88_RWWabEYatDrtJDdg&bvm=bv.75775273 ,d.dGc

Appendix 6. Modified pain management program

BACK REHAB PROGRAM - SYNOP'SIS

The modified pan management program at: Merni Community Health SeJVices Sell St sitE is a multidisciplinary program directed at helping dents with persistent pain improve their ability to m.3n3ge activities ofdaily living and engage in regular physicalactivty.

Clients can b-e referr•ed to the group program by any alled health professional but must meet a numberof critE ria fore lgibility. These conditions are intended toensure that dient:s who attend 3re likEly to gain the most benefit from the program given the mix of allied heatbh skills available [eg. t:here is no Psychalagist: attaiched to the progr.3m so dient:s with high levels of stress or depression associated with their pain are unlikEly to be adequately supported land the program's go3ls. All cilent:s have a pre-group assessment with t:he Physothe1-.3pist or Exercise Phys dogist to complere physicaloutcome me3Suresand identifv dient-centred go3ls.

MCHS B:ack Rehab ?rogram -elgibility criterfa

- Willing & able to attend alle-Oucaticm/exerci.se sessions
- Appropriate level offunctional ability to particpate
- Notcure-focu.seil- mu.st be acceptingofchronic nature•of pain
- Cognitively sound and behaviorok for group environment
- Not expecting hand.s-on treatment
- Ace eptsa restorative/rehabilitative approach- active participation isexpected
- Commitsto fullduration of program
- Expectation that there will be no individualtherapy during or after program -the idea isto disc.hargetocommunity/ongoingself-management

This is an S week pragram which runs once weekly on Fidays 3nd can aommodate up to 12 c.lients. The session is 2.5 hours long and inoludes education, exercise and relaxati on. Educat on sessions assist dient:s to understand the difference between acute and i>ersistent pain and how commo n challenges such as pacing 3ct 'Jity and d3ily stress *can* impact on their ability to manage t'heir pain. The diffe rent. education sessions 3re delivered by a Physiothe rapist, Exercise Physiologist. and O:cup3t1onal The rapist,and a Dietitian will .also be conducting a session with the next iterat:ion ofthe program. The session topics are summar'i: ed below.

MCHS Back Rehab Program- Educationsessiontopics

- Intro to program and pain physiology
- Relaxationand:st:re:ssmanC1gement
- Boom and bust b-ehaviours
- Pacing and energy conservation
- Posture,ergonomics and activity modification PRACTICALSESSION
- Bringing it alltogether
- Community Gym visitwith Exercise Ph'\(Siologi:st:
- Future session1 with dietitian on wei ht, healthy eatirg, mood to be induded in program

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Education sessions *are* followed by a graded exercise program which is circuit-based and indudes some indi\'idual exercises tailored to each dent's needs as \Vell as general exercises that *are* designed to transition \Vell to a home or gym environment for ongoing self-management. These sessions *are* supervised by the Physiotherapist and Exercise Phy9ologist with the support of an Aled Health Assistant. Relaxation sessions complete the daifs program aid *are* intended to help dents develop an understandingof theInk between anxiety,stress and pan and strate§es to help menage thison adaily basis.

At the end of the 8 week program dents' outcome measures and goals *are* re-assessed to pro\'ide feedback on progress and to facltae quaty improvement and evaluaion. Depending on their goals,dents may be linked in with other programs a their local gym,community based exercise groupsorother servicesoffered by MCHS such as Planned Activity Groups.

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Appendix 7. Tools, resources and documents developed

Administrative:
Partnership template in portrait and landscape layout
Template coversheet referral to BAC at MCHS
Template MH referral outcomes
Template request for hard copy files from MH for BAC at MCHS Coburg
Template next available appointment data collection
BAC information sheet for clients
BAC reception script
BAC Support Procedure Manual
BAC letter to clients – unable to contact
BAC letter to clients – did not attend
BAC clinic information sheet for doctors

Operational:
BAC inclusion exclusion criteria
BAC Brief Pain Inventory
BAC Low Back Index
BAC Neck Index
MCHS suite of services
Back Rehabilitation Program synopsis
MCHS outcome measures spreadsheet
MCHS Spinal Pain Management Service Client Flow
MCHS Client Satisfaction Survey

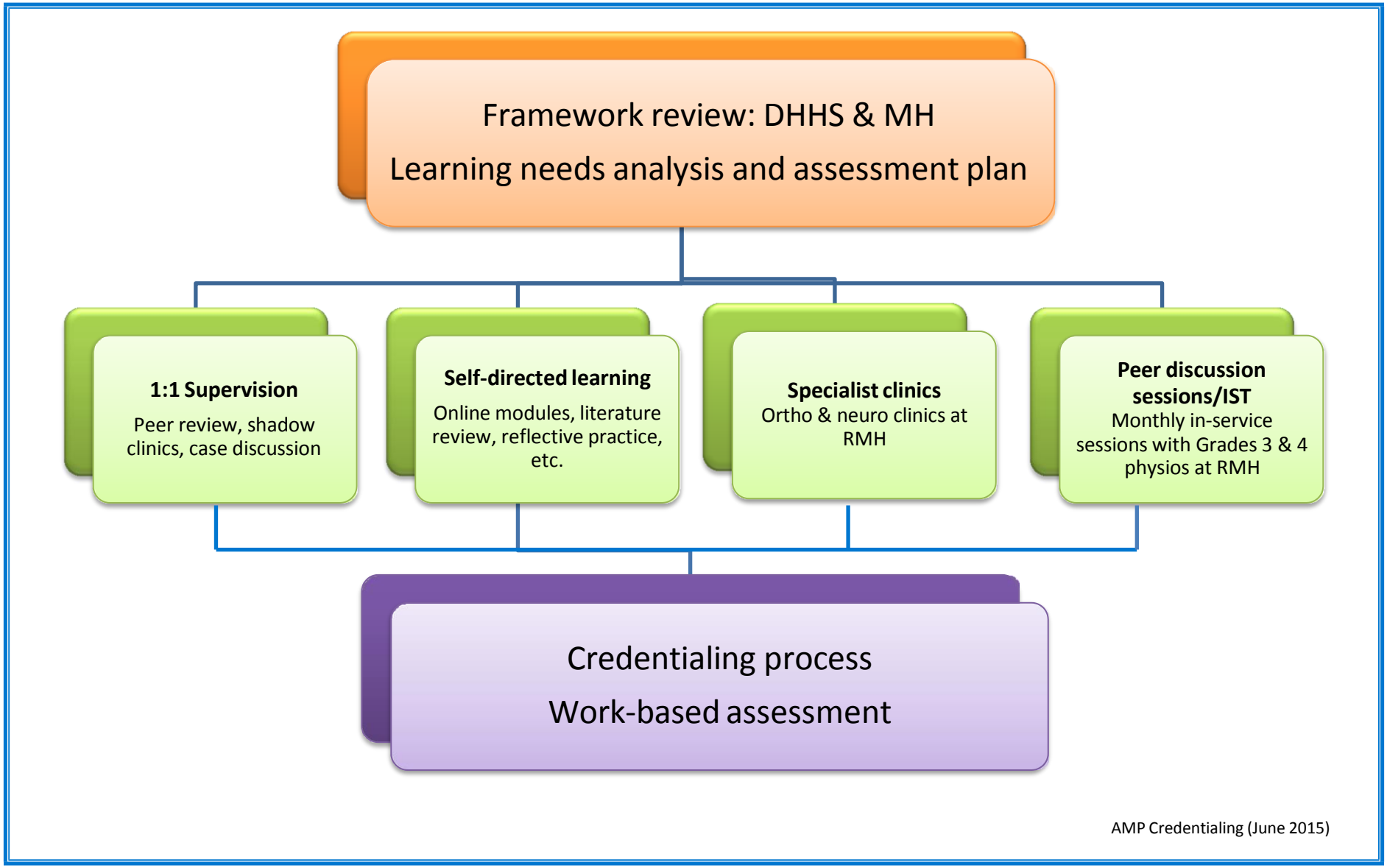
Legal:
License and Service Agreement
Memorandum of Understanding – Quality Improvement Project

Professional development/guidelines:
BAC clinical practice guidelines
Physiotherapy spinal treatment guidelines
Scope of Practice Grade 3 Musculoskeletal Physiotherapist
Credentialing program

Workforce/other:
MCHS Staff Perception Survey
MCHS Scope of Practice Grade 3 Musculoskeletal Physiotherapist
MCHS Scope of Practice Grade 2 Generalist CH Physiotherapist
MCHS Practitioner Comparison Table – Grade 2 exercise physiologist v Grade 3 exercise physiologist
MCHS Comparison Table – Grade 2 musculoskeletal physiotherapist v Grade 3 musculoskeletal physiotherapist

Appendix 8. Credentialing framework

Grade 3 Advanced Musculoskeletal Practice: Clinical Education Framework



Appendix 9. Credentialing framework professional development activities

9.1 Peer review (in-service) sessions at RMH

Date	Duration (hrs)
09/10/2014	1
13/11/2014	1
10/12/2014	1
11/03/2015	1
13/05/2015	1
10/06/2015	1

9.2 Consultant's clinic at RMH – O* = orthosurgery, N^ = neurosurgery

Date	Duration (hrs)
29/04/2015 (O*)	3.5
11/05/2015 (N^)	3.5
18/05/2015 (N^)	3.5

9.3 Supervision/shadow clinics/case reviews at MCHS Coburg

Date	Duration (hrs)
14/10/2014	2
25/11/2014	2
02/12/2014	2
10/12/2014	2
20/01/2015	2
27/01/2015	2
03/03/2015	2
31/03/2015	2

9.4 4 MCHS Grade 3 physiotherapist self-directed learning

Date	Duration (hrs)
29/11/2014	7.5
30/11/2014	7.5
05/03/2015	3.5
25/03/2015	3.5
30/03/2015	3.5
08/04/2015	3.5
16/04/2015	2.0
21/04/2015	3.5
30/04/2015	3.5
15/05/2015	2
21/05/2015	3.5
28/05/2015	3.5
04/06/2015	1.5
11/06/2015	1.5
25/06/2015	2.5

Appendix 10. Client experience survey

Merri Community Health Services

Client Experience Survey

Kindly hie lp us to improve our program by answering a few questions on the services you received. Wevalue your honest opi11ion,whether positiveor negative. W e also welcome any comments a.nd suggestions you may have.

Pleasecompletethisformandreturnittooneofourstaff

PLEASECIRCLEYOUR ANSWER

1. After participati in t his pmgram, I am now able t odo morethi sthat I enjoy doing

Strongly Dis:3gree | Disagree | N:ith:J Agree OOJ Dis:3gree | Agree | Strongly Agree

2. I think this program has helped meto manage myoondit ion better

Strdi\gly Dis"3gree | Disagree | N ith:r Agree *ooi* Dis:3gree | Agree | Strongly Agree

3. I feel ha,ppy that I reoeived specialist servicesfor my oond it ionwithin my local com m u nity rather than in a hospital

stro :r'Jy Dis:3gree | Disagree | N:ithsr Agree *nor* Dis:agree | Agree | Strongly Agree

4. If a friend/family member\vere in need of similar help,I \Vould recommend thisprogram tothem

O G Q Q Q

Strongty Dis. gr | Disagree | Ntitf\&r A.gr nor Dis. gr | Agree | Strongly Agree

5. Overall,I feelsatisfied \Vith theservicesI received aspart of thisprogram

O G Q Q Q

Strongty Dis. gr | Disagree | Ntittie,r A.gr nor Dis. gr | Agree | Strongly Agree

6.I think participating in thisprogram hasbeen a positivestep tO\vards a healthy lifest';le

Strongly Disagree | Disagree | Ntittie,r A.gr nor Dis. gr | Agree | Strongly Agree

AnY G!!ILJJJents otsuggest ons?

Name(optona)_____ Date:__£_ _ /_ _ _ _

Thank you fo r toking the time to complete this survey