Australian Non-Admitted Care Classification Development

Submission by the

Australian Physiotherapy Association

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Executive Summary

The Australian Physiotherapy Association (APA) welcomes this opportunity to make a submission to the Independent Hospital Pricing Authority (IHPA) on the Australian Non-Admitted Care Classification (ANACC) on behalf of the physiotherapy profession.

We support a non-admitted care classification scheme that adopts a person-centred model of care.

Our profession, at the level of both individual physiotherapists and collectively, is focused on supporting people to achieve their goals and using interventions based on the best available evidence at the lowest cost, whilst maintaining quality of care.

Physiotherapy can improve the value of quality care to people, however some of the structures of the current system make that difficult to achieve.

We are concerned that people in the community, including those in non-admitted care, may not fully appreciate the quality care and beneficial functional outcomes that a physiotherapist can achieve, or the important role physiotherapists play in supporting and engaging people in the health care continuum.

We value to role physiotherapists play in non-admitted care, and want to ensure the classification system supports that reflects this value add.

We want to see improvements in the non-admitted care classification that reflect the complexity of care provided by physiotherapists, the dynamic scope of practice of physiotherapists and a system that is digitally agile and adaptable as practices change.

Through this submission we identify opportunities physiotherapy services can provide in non-admitted care, and potential ways to facilitate this.

We would welcome the opportunity to meet with the IHPA on behalf of the physiotherapy profession. We have provided a summary of our recommendations at the end of our submission.

1. Introduction

The Australian Physiotherapy Association (APA) welcomes this opportunity to make a submission to the Independent Hospital Pricing Authority (IHPA) on behalf of the physiotherapy profession.

Services provided by physiotherapists in non-admitted care make up an important component of the health care continuum.

We recognise that as the population of Australia ages and chronic disease rates rise, demand for non-admitted services will increase. It is important the Australian Non-Admitted Care Classification (ANACC) is designed to meet the changing demand, to ensure people are provided the most appropriate, and high quality care regardless of where they live.

We support the IHPA taking a person-centred approach to care and support. Taking this approach requires the IHPA to find and fund ways that assure the participation of people managing their own care. A number of the recommendations we make in our submission aim to ensure that the centrality of personal decision-making is enshrined, and appropriately balanced with a number of other legitimate issues, including the overall costs to the community.

2. Non-Admitted Physiotherapy care

Across Australia, non-admitted care physiotherapy services are delivered in both the acute hospitals, outpatient clinics, in the community and patients' homes. Physiotherapists have a role in improving the health of Australians with a wide range of conditions, particularly those which contribute substantially to the disease burden in Australia musculoskeletal conditions, cancer, and cardiovascular conditions. Physiotherapists treat people who have acute or recurrent and persistent pain. Physiotherapists provide care for people with respiratory conditions. Physiotherapists work closely with patients to educate and support patients back to physical health after stroke, head injury or other trauma. Physiotherapists provide care for people with arthritis or injury, joint replacement, developmental conditions and disability.

Physiotherapists provide care for people across the lifespan – from children, through people in their working life and older people.

In the community, physiotherapists improve the quality of life for hundreds of people every week – keeping them active, contributing to their families and communities and at work. Importantly, they keep these people in the community and out of hospital including the emergency department.

In hospitals, physiotherapists are an essential part of the multidisciplinary team who ensure that the hospitalisation is as valuable as possible and reduce hospital stay by optimising independence.

Because of the highly-skilled services physiotherapists provide in non-admitted care, it is important people have access to physiotherapy treatment when and how they need it.

We need to capture the value of physiotherapy provided to people in Non-Admitted Care

High-quality physiotherapy care provided to people in non-admitted care has the potential to improve a person's social, emotional and physical wellbeing.

Indeed, physiotherapists have the capability to undertake a significantly more valuable role in patient care than is currently used within our non-admitted care practice.

Australian physiotherapists are recognised diagnosticians with 'first contact' rights (i.e. patients do not require a doctor's referral to see a physiotherapist). In Australia and internationally, physiotherapists are being employed to undertake roles with components traditionally thought of as 'medical'. Advanced-practice physiotherapists are experts in their fields having undertaken additional training and having gained specialist experience. This allows them to deliver services to highly complex patients and achieve very high levels of patient satisfaction.[2]

As a profession, physiotherapists pursue what has come to be called 'value-based healthcare'.[3] At its core, value-based healthcare is about maximising value for patients: that is, achieving the best health and related outcomes at the lowest cost.[4]

The physiotherapy profession engages in a range of strategies to reduce the prevalence of low-value/low-quality care. Physiotherapy graduates are scientists with a very rich education in evidence-based practice. Commitment to achieving maximum value is evidenced by our participation in Choosing Wisely Australia.[5] In addition, we are involved in stewardship of a number of 'incremental fixes'[4], including implementing coordinated electronic health records, improving the uptake of clinical guidelines, reducing error and harm, and strengthening the skills of patients as 'consumers'.

Each of these elements incrementally contributes to maximising the value that physiotherapists offer the healthcare system, for the benefit of consumers.

Physiotherapy can provide substantial value to non-admitted care, through all levels of disease and disability prevention.

Physiotherapy offers substantial opportunity to tackle some low-value areas across the continuum of care, as well as improve patient safety and quality of care.

3. Our response to IHPA Consultation Considerations

We support the IHPA to reform the current 'Tier 2' non-admitted care classification model into a modern, agile and technologically advanced system. As previously discussed, care provided in the non-admitted care scheme is dynamic and evolving and requires a funding and classification system to reflect changing service delivery needs.

The ANACC needs to be responsive to changes in technology, the type of non-admitted care delivered and patient complexity. Physiotherapy, like many other health services, has undergone continuous innovation and development, allowing services previously provided in hospitals, to be safely provided in community settings.

In considering the ANACC, we want to emphasise the importance of safe, high quality care available to patients, while avoiding burdensome administration. We are also strongly supportive of a funding model that minimises inappropriate rewards and perverse incentives, and inversely, encourage high quality care.

We are largely supportive of many of the IHPA's consultation considerations, and subsequently, the following section only responds to questions raised by IHPA where we feel there is opportunity for further consideration and improvement.

Should the new classification for non-admitted care support the delivery of integrated care between health care settings? If yes, how?

Physiotherapists provide care to people in outpatient settings, community care and a number of other settings. As such, we are supportive of a new classification system that assists the delivery of integrated care between health care settings.

It is important that, regardless of where physiotherapy services are delivered, the non-admitted care classification can be applied. Integration and consistency across settings will encourage consistency in quality care, and ease of information sharing.

In developing an integrated system, it is important that there is no duplication in administration demands and the benefits and system efficiencies of interoperability outweigh any potential negative outcomes.

A digital health platform that is agile, and adaptable to different health settings will encourage the delivery of integrated care.

Further detail of a proposed technology to support integrated care will be discussed in the following section.

Should the new classification for non-admitted care services account for and adapt to newer models of care and technology? If yes, how?

Digital innovation

We believe that it is imperative the ANACC accounts for changes in technology.

In mid-2017, we began a digital discovery project. The findings of this project reflect the substance of the discussion in the stakeholder discussion paper.

Broadly, our digital discovery suggests the following domains of work:

- refining models of digitally-supported physiotherapy care in the context of digital innovation
- developing a fit-for-purpose information and communications architecture for physiotherapy
- exploring 'peripherals' – the devices, apps and capabilities that can be added, updated, modified, and deleted over time as requirements change and new capabilities develop – wearables, home-monitoring, robotics, 3-D printing, video overlay, augmented reality and virtual reality
- defining the roles that organisations play in data analytics and developing the capabilities for advanced analytics
- addressing the facilitators – the payment models, training systems, regulation, and infrastructure (e.g. broadband capability) needed to scale digitally-supported physiotherapy
- supporting the professions adoption and diffusion of digital innovation, including the culture change involved.

Our work suggests, for example, that there are fundamental challenges to the existing models that:

- involve the patient and their physiotherapist being collocated for each interaction

- fail to fully fund the professional expertise required to design and undertake 'light touch' models that use synchronous and asynchronous communication between patients and their physiotherapists
- fail to fund the require equipment and infrastructure that facilitates these models of care; and
- fails to understand that safety and quality improvement activity that must be funded as a part of these models.

Recommendation 1:

We recommend that the IHPA engage with physiotherapists who are digital innovators as one means of ensuring that implications of the complete (non-hospital and hospital) trajectory of digitally supported physiotherapy (and broader patient care) is considered in IHPA's development of new models.

We would be happy to brief IHPA on our digital discovery work, and its implications.

Leveraging advanced scope practice

It is important the ANACC acknowledges the changing boundaries of care delivered in non-admitted and primary care. Throughout Australia and the world, physiotherapists are reducing the burden on medical colleagues by providing specialist triage and management in orthopaedics, neurosurgery, geriatrics, rheumatology, paediatrics, critical care and respiratory care. These practitioners are recognised for their advanced skills.

In all Australian jurisdictions advanced* scope models of physiotherapy have emerged. These include physiotherapy care in the emergency department, in the management of orthopaedics (and orthopaedic wait-list review) and paediatrics.[2, 7]

Within the emergency department, physiotherapists are primary contact practitioners for acute musculoskeletal injuries. Enhancement of this role was identified around autonomous management of simple fractures and independent interpretation of x-rays and relocation of simple fractures and small joint dislocation. This innovation was introduced in response to increasingly heavy workloads which had placed significant stresses on medical staff to meet the National Emergency Access Targets (NEAT). The results, which were published in the peer reviewed literature in 2015, showed that the advanced-scope physiotherapist achieved results which were superior to their nursing and medical peers in terms of both access and length of stay in the emergency department resulting in significant service improvements.[2]

Advanced practice physiotherapy is an accepted role in Australia and other countries. For example, in delivering both primary and secondary care for musculoskeletal services including back care, orthopaedic and rheumatology. This role can include case management, medication management, ordering and interpreting diagnostic tests (such as scans, x-rays and blood tests), administering certain injections, and directly listing patients for surgery.

In other Australian jurisdictions physiotherapists perform triage for back pain patients and also spinal surgical follow-up assessments freeing up surgical time and reducing waiting lists. This is also the case for orthopaedics, with physiotherapists assessing and following up joint replacement patients. Expert respiratory physiotherapists perform bronchoscopies and lung

* Also called 'extended' scope practitioners

ultrasound examinations in intensive care and lead community-based respiratory and cardiac care services to prevent acute admissions.

It is worth noting that advanced-scope physiotherapists in the UK are now performing minor surgery such as meniscectomy and tendon releases in response to increasing pressure on the health system.

There is substantial scope to expand the use of advanced-scope physiotherapists to achieve better and timelier care for patients and also a cost-effective strategy for tackling waiting times. There is scope for these models to be used outside the hospital context.

Recommendation 2:

We recommend that the IHPA develop pathways in the ANACC for new models of health care, including the introduction of expanded/extended-scope physiotherapists in both primary and secondary care in areas including musculoskeletal, critical care, respiratory care, neurology and neurosurgery, and geriatrics in order to provide increased patient service and value within the health system.

As the types of care delivered in admitted, non-admitted and primary care are challenged, how can the future ANACC system account for these changes?

In terms of a classification system for non-admitted care, we take the view that the setting for the care (admitted or not) is increasingly outdated as a descriptive or determining factor for the type of care.

In this context, the focus of the classification system needs to be focused on patient condition and intervention characteristics, rather than the place at which the care is provided, or the status of the patient with respect to admission.

Later in this submission we outline a number of advances in the scope of physiotherapy which have challenged traditional approaches to who should provide the care and where the care should be provided.

A useful illustration of the challenges is the field of robotics in physiotherapy. The use of advanced robotics is allowing care to be provided in the homes of patients or in outpatient settings when this care would previously have been provided only as inpatient care.

This dynamism is likely to create pressure for more consistent review of the ANACC system, and a more consistent focus on the 'ingredients' of the service (e.g. the complexity of the patient and the complexity of the intervention provided), rather than on location of the service provision.

The classification principles have been designed to guide and support the development of the future classification, do you agree with these and/or are there other principles that should be considered in developing ANACC?

We support IHPA in developing a classification system built on patient needs, clinical reasoning and is simple and transparent in its utilisation.

We believe the ANACC should minimise susceptibility to gaming and perverse incentives, and conversely, it should encourage high quality care.

Although we support models that move away from occasion-based, 'fee-for-service', episode based models can also create perverse incentives.[1]

We believe that in the Australian health system, it is important to be overt about a commitment to safety and quality and strongly support the references to the consideration of safety amongst the principles that will inform the development of the ANACC system.

Recommendation 3:

We recommend that the IHPA be informed by experts on the potential perverse incentives of funding approaches that move away from a fee-for-service' based classification model.

Should IHPA continue to use service event as the ANACC unit of count? If yes, do you agree with the proposed revised definition of a service event? How could it be improved?

The challenge of capturing digitally-enabled interactions as service events

We understand that importance of defining service events in ways that will be useful to the system.

As a part of our digital discovery work, we found that, for some stakeholders, the notion of a service was constrained to one mode of interaction. In medicine that mode has been described as:

> "a video conference where the patient sits down in from of a PC, connects with a doctor, and then sticks out a tongue and says 'ahhhh' to the web camera." [2]

However, in physiotherapy, activities that might be described as 'service events' can take many different forms. Depending on the context, they may involve:

- *synchronous* communication where the parties are not collocated on either a one-to-one or group basis, through:
    - audio-visual contact (e.g. video-conferences for treatment including education)
    - audio contact (e.g. telephone coaching and models of assertive outreach)
    - visual, non-auditory contact (e.g. text such as 'instant messaging')
- *asynchronous* communication where the parties are not collocated on either a one-to-one or group basis through:
    - text (e.g. use of email, including messaging through 'patient portals' in EHRs; patient-held diaries, questionnaires and other scale)
    - image collection and transmission of information such as x-rays and photographs
    - data (e.g. telemetry /remote monitoring or test scores).

Models of asynchronous communication have in common a so-called 'store-and-forward' approach. Data (whether held as data or a text file, audio file, image or audio-visual file) is recorded/stored and later forwarded). The origin of the data can be the client or the physiotherapist. The point of the transfer is for the other party (client or physiotherapist) to *interpret and use* the data in the furtherance of clinical objectives.

Telemetry / remote monitoring might focus on:

- physiological signals (e.g. pulse rate, oxygen saturation, electrocardiograms [ECG], range of joint movement) through specially designed equipment or off-the-shelf consumer devices, using software programs including apps
- function (e.g. falls) through sensor technologies
- web-based diaries (to record exercise and provide feedback, for example

- capture of client information through forms, questionnaires and photos (rather than through direct interaction with a physiotherapist)
- use of apps as a part of a program (e.g. data transfer from the app, monitoring and feedback from the physiotherapist to the client and vice versa).

The increasing intelligence and reach of devices supported by the IoT and sensor technology will open up new possibilities for better resource management, client self-care and improved prevention.[3]

In addition to video-based consultations with clients, physiotherapy services supported by digital technologies includes professional services such as secure messaging in which the contact is with another member of the care team or a person involved in the third-party funding of the service.

We are already seeing the emergence of 'guided self-monitoring' where clients use wearable and hand-held devices to capture data and share this with their health professional on a structured basis.[4]

Digitally enabled physiotherapy services are also likely to lead to self-managed programs such as those occurring through gamification.

Education programs (e.g. using internet platforms that provide automated goal setting and feedback) are used. One such initiative occurred in conjunction with a pedometer for patients with non-specific low back pain).[5]

There is an emergence of the use of augmented reality (AR) and robotics, amongst other technologies. A systematic review of the modality in published in 2013 reported that AR applications for rehabilitation in a physical context were still in the early stages of development; that evidence for effectiveness in rehabilitation is limited and that the encouraging results support further research.[6]

A combination of modalities is often used

'Traditional' physiotherapy may involve a single activity or may involve a range of activities.

The authors of two recent systematic reviews[7] [8] report that all of the studies involved complex interventions with multiple components. No single self-management component was found to be consistently effective, or consistently ineffective. The interventions differed in many respects (e.g. intervention goals, number and extent of intervention components, duration and intensity, and mode of delivery). Reporting of the details of the components of the interventions was highly variable.

The interrelationship between the provision of clinical interactions in which the client and professional are collocated, video consultations, telephone interactions, secure messaging, client use of 'apps' which transfer information to the physiotherapist and other activities is unclear.[9] [10] This may be because of limitations within the research, the variable needs of clients, or the ongoing introduction of new technologies.

In addition to better understanding the components of a program that is digitally-mediated, it is also likely to be important to understand the sequence needed to optimise the positive impact of the program, including the way in which it is combined with other strategies.[11]

This suggests that it will be useful to look at 'episodes'.

We would be concerned about the use of a time-based model as this may not be the best way to delineate the bundles/episodes. In particular, for people who have chronic conditions, time-based episodes might be long.

Should an episode be considered as a unit of count in the new ANACC? If not for all conditions, then for which specific conditions?

We understand the utility of using an episode as the unit of count in the new ANACC.

We consider that it may be useful to begin with episodes for which there is a strong evidence-base for delineating an episode – for example, post-joint replacement rehabilitation.

Non-admitted patients often present with multiple co-morbidities, and may be treated under a chronic disease model. Should the future ANACC system have a separate path for classifying chronic disease patients.

The burden of comorbidities and chronic conditions is one which threatens to overwhelm our healthcare system.

The root of the problem lies in a lack of coordinated resources to prevent individuals from sliding into a state of poor health or worsening chronic conditions.

It is accepted that physical activity is a key driver of health and wellbeing. However, there is little to be gained by making physical activity opportunities available to people who are fearful of exercise or are in pain. Physiotherapists are highly effective at working in partnership with people to help them break down barriers to physical activity by reducing pain and increasing their confidence and capacity to return to full physically active lives. An example is provided in a case study presented in *Appendix 1*. Therefore, physiotherapy is an important element in sustainable healthcare for the future, particularly in preventing chronic conditions and supporting patients with comorbidities.

Current funding models appear to be limiting the public physiotherapy workforce capacity to deliver preventive care to reduce the burden on comorbidities.

The careful design of the ANACC which takes into account patient complexity will allow for better care management. Further discussion on including patient complexity is discussed later in the submission.

One of the challenges with establishing a separate path for classifying chronic diseases is to ensure that there is rigorous data capture. Another is to determine, when both an acute and chronic condition are evident, how that situation is classified.

What implementation timeframe is required for jurisdictions to transition to a patient-based non-admitted care classification system?

We support a gradual transition to new funding models, including the ANACC. A phased approach will allow both smaller and larger organisations time to transition to a new funding model when they have the available staff and resource capacity. Small providers may need additional time to manage the administrative burden. A six to twelve month transition time by jurisdiction may be appropriate.

Change management and education for providers will be necessary to support the transition. A phased approach will provide time for changes to be clearly communication to relevant

stakeholders. Taking a proactive approach, may reduce the likelihood of any panic or excessive stress to providers or significant disruption to services.

Communication of changes needs to include clear, consistent messaging and content needs to be presented in an accessible format – taking into consideration the needs to culturally and linguistically diverse communities, Aboriginal and Torres Strait Islanders and other minority groups. Using appropriate technology and multimedia will be pertinent to reach people in rural and remote communities.

As the ANACC model is implemented, it is important there is opportunity for regular feedback to provide monitoring and evaluation and incremental improvements as required. The transition requires effective communication to relevant stakeholders, including allied health providers. A grass roots approach to change will be necessary to encourage sustainable and effective change.

We appreciate that the mandate for the IHPA is in the publicly-managed health sector. However, many of the propositions and outcomes of IHPA's work have implications for physiotherapists in the private sector. In the context of a well-coordinated, less fragmented health system which is person-centric, IHPA's approach to care coordination, digital transformation, coding, units of count, and complexity all have implications for the physiotherapy services provided in private settings.

As a result, it will be useful for the implementation strategy to include ways in which important decisions, and their impacts in the private sector are communicated.

Recommendation 4:

We recommend a gradual transition to the ANACC classification system, allowing jurisdictions time to implement and adapt to the change, adjusting to any issues as they arise.

Recommendation 5:

We recommend that consideration be given to a communications and engagement strategy that addresses the need for private practitioners to know about, and to make adjustments resulting from IHPA decisions.

Do you agree with the list of complexity variables presented in Section 5.3? What other variables should be considered for the new ANACC system?

We appreciate that the ANACC needs to better describe patient complexity and more accurately reflect the costs of non-admitted care.

We support the inclusion of the variables proposed by IHPA, however some of these variables would need to be carefully described to minimise the risk of perverse impacts in their use.

For example, consider the issue of multi-disciplinary care. Will the variable pertain the *provision* of multi-disciplinary care, or to the *need for* multi-disciplinary care? If it is a person-centred model, then, arguably, the variance relates to need. In many settings with constraints on access to appropriate physiotherapy, if the variance depends on the actual provision, it is likely to have a perverse impact.

Another example is the notion of new and repeat visits. This distinction is at odds with the contemporary approach in physiotherapy. Although some initial visits are more complex than

the visits which follow, this is not always the case. Physiotherapists are concerned about the disincentives to substantially re-assess clients who have chronic and complex conditions (for example). In the eighteen month initiative that led to the revision of our National Physiotherapy Service Descriptors (NPSDs)[12], physiotherapists took a consistent view that some follow up visits where complex and needed to have a resource relativity assigned to them that acknowledged this. Although there may be merit in distinguish a 'new' episode; the notion that a repeat visit is routinely 'cheaper' is substantially at odds with the views in the physiotherapy profession.

A further example is 'providers'. The correlation between specific health care providers and corresponding diagnoses can arise from poor workforce deployment/access and/or outmoded models of care. Thus the inclusion of this variable would need to be carefully described.

We are very conscious of the challenges and potential disadvantages to a model that is multi-factorial, especially where the routine collection of valid and reliable data needed for the model is low.

In this context, the work on our NPSDs suggests that a number of other variables might need to be considered (or made explicit within those already considered). Our work looked at a number of domains that increased complexity, including factors associated with the individual patient, with their condition and with the environment.

With respect to the individual, physiotherapists asked to included factors such as whether or not the person spoke English at home, whether or not they had an existing disability (rather than medical condition), and whether or not they lived alone. This is not an exhaustive list, as physiotherapists indicated that they wanted a model of complexity built on principles, rather than prescriptive criteria.

With respect to the patient's condition, physiotherapists wanted the definition to encompass variations in the complexity and severity of conditions, such as extensive burns, neurological conditions, and some paediatric conditions – each of which as a range of complexity.

With respect to the environment, physiotherapists were concerned that factors such as the relative demand for human resources, equipment and capital, and incremental costs such as professional indemnity insurance be considered in the funding scheme, as they reflect the real costs of safe, sustainable and high quality care.

In particular, we would want the inclusion of provider type have flexibility in its application. Rather than classifying the complexity based on "the type of clinician providing the service", we support "the nature of the service provided" to be implemented. This is because, as discussed previously, some physiotherapists practice in an advanced scope.

The actions performed by physiotherapists in these settings, can have the same patient outcomes as other service providers, and as such, the service provided should be reimbursed consistently across health professionals.

Recommendation 6:

We recommend that the new ANACC system reconsider a differentiation of visits based on 'new' and 'repeat', and consider the underlying factors that create higher resource demand.

Recommendation 7:

We recommend that the new ANACC system include variables such as the existence of an existing disability and the speaking on a language other than English at home as variables considered when complexity is assessed.

4. Conclusion

We are committed to ensuring people who seek non-admitted physiotherapy services in Australia have access to high quality care, when and where it is needed.

The ANACC needs to be fit for purpose and support the provision of safe, high-value care.

We appreciate the active discussion occurring about the ANACC. We support both 'incremental fixes' along with this more extensive review, of how the non-admitted care funding model can be shaped to maximise patient outcomes.

The ANACC model needs to support physiotherapists to provide comprehensive and detailed consultations, allowing the physiotherapist time to engage fully with the patient, and where relevant, the family and people that support them. A model that supports a thorough and detailed consultation such as this, will afford the patient the opportunity to fully experience the benefits of physiotherapy services.

We believe it would be very cost effective for the actions provided by physiotherapists to reflect the value and benefit the treatment provides to the wider community. Effective treatment and care given by highly trained physiotherapists has the capacity to significantly reduce health care expenses and improve the health and wellbeing of Australians.

We would welcome the opportunity to further engage with IHPA on the changes to the non-admitted care classification, and the subsequent pricing models that emerge.

Australian Physiotherapy Association

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

The APA is the peak body representing the interests of Australian physiotherapists and their patients. It is a national organisation with state and territory branches and specialty subgroups. The APA represents more than 25,000 members who conduct more than 23 million consultations each year. To find a physiotherapist in your area, visit www.choose.physio

Appendix One

Example of how treatment for pain activity enablement in patient with severe chronic conditions

A 38 year old woman with shoulder pain was referred to physiotherapy from the Exercise Physiology Department. Her co-morbidities included obesity and Type 2 Diabetes. She was seeing the exercise physiologist to help with her diabetes but the exercise program caused too much shoulder pain.

On assessment she had

- poor posture - upper thoracic kyphosis and protracted scapulae
- tight pectoral muscles
- weak lower trapezius muscles
- weak tight posterior cuff
- forward sitting head of humerus bilaterally contributing to her pain.

The exercise physiologist could not diagnose this issue or treat it, but could see that needed to be treated by physiotherapy in order to return the patient to her management program.

This lady was very motivated to improve her pain and get back to her weight and diabetes management program.

She was compliant with hands on physiotherapy and a muscle retraining program, her pain settled.

It took 3 months of physiotherapy over 5 visits and a home program to achieve a return to her exercise physiology program.

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