South Australia – Final Report against Subacute Care Implementation Plan National Partnership Agreement on Hospital and Health Workforce Reform – Schedule C
(DoHA Template)

July 2009 – June 2010

Summary of Progress

This COAG funded initiative is working along-side reform activity already underway in South Australia, providing opportunities for health regions to maximise the design and delivery of expanded services. 3 Statewide Service Plans underpin ongoing reform relevant to COAG-funded Subacute Care:

- Statewide Rehabilitation Service Plan 2009-2017
- Palliative Care Services Plan 2009-2016
- Health Service Framework for Older People 2009 – 2016

Also, the SA Government response to the Stepping Up Report Recommendations informs the reform activity being undertaken in the Psychogeriatric sector.

Each South Australian health region has delivered implementation plans and activity has commenced in this first year of the initiative. Establishment phases are beginning to transition into consolidated reform efforts which are impacting on the patient journey in measurable ways:

- Access to subacute services (measured by number of episodes/occasions of service for hospital and community care)
- Patient outcomes and quality of care (measured through reduced waiting time for services, functional scores, and comprehensive care planning)

South Australia is investing in the expansion of ambulatory and day centre services to:
a) Improve the patient journey and deliver services closer to where patients live, and
b) Take pressure off public hospitals
Our inpatient focus has been on improving models of care to:
a) Achieve consistency in evidence based practice across all sites
b) Reduce length of stay, and
c) Increase throughput
This investment is funded by the co-allocation of State and Federal monies.

Throughout the report the following acronyms are used:
CNAHS – Central Northern Adelaide Health Service
SAHS – Southern Adelaide Health Service
CHSA – Country Health South Australia
CYWHS – Child Youth Women's Health Service

Key deliverables	Progress and timing	Allocation of NPA funding	Comments
1. Rehabilitation Strategies (a) Expand Ambulatory capacity in CNAHS, SAHS and CYWHS	Metropolitan FTE has increased across the 3 regions: SAHS – Medical Officer by 0.4, Nursing by 0.4 and Allied Health by 5.2. CNAHS - Medical Officer by 2.2, Nursing by 2.0 and Allied Health by 1.6. AHS focus has been on expanding Day and Home Based rehabilitation capability.	SAHS: $466,000 CNAHS $931,000	All regions have developed local implementation plans and are progressing from establishment to operation. The South Australian recruitable pool for Allied Health is limited and it has taken longer than planned to recruit to most teams.

	CYWHS ambulatory rehabilitation service multi-disciplinary FTE establishment has progressed to 0.1 Medical Officer and 5.7 Allied Health. CYWHS focus has been on expanding Day and Home Based rehabilitation capability.	CYWHS: $495,000	
(b) Expand subacute inpatient and ambulatory capacity at Whyalla Country General Hospital	Whyalla Country General Hospital has commenced its ambulatory rehabilitation service with a multi-disciplinary FTE establishment of 2.5 Nursing and 13 Allied Health.	CHSA: $1,500,000	Country patients are now able to return to their home towns for ongoing home-based therapy, rather than remain inpatients in metropolitan hospitals away from their families for long periods of time. Focus has been on the development of models of Rehabilitation care across CHSA, working in partnership with metropolitan-based Rehabilitation services, Specialists and local service providers, developing best practice clinical protocols, designing a smooth patient journey and supporting the implementation of training and development programs.
2. GEM Strategies (a) Establish community based specialist GEM	Metropolitan FTE has increased across its 2 regions: SAHS – Medical Officer by 0.6, Nursing by 1.2 and Allied Health by 7.6. FTE recruitment for community GEM service (1.7 Medical Officer, 1.9 Nursing and 4.3 Allied Health) has commenced. CNAHS - continuing to develop plans to create 2 Level 6 services to facilitate bringing together the separate teams currently located in different hospitals and services in the community to form regionalised services. Country Health SA has also increased its FTE: Nursing by 2.33 and Allied Health by 5.24.	SAHS: $467,000 CNAHS: $934,000	
(b) Establish	CHSA FTE establishment has	CHSA:	

specialist GEM services at Whyalla Country General Hospital (inpatient & ambulatory)	progressed to 3.3 Nursing and 5.8 Allied Health, to provide specialised assessment, management and care coordination for GEM patients, with the aim of preventing, reversing or minimizing the impact of functional decline.	$750,000	
3. Palliative Care Strategies (a) Expand capacity of specialist palliative care service teams to increase volume of patients able to be supported in the community (including paediatric services)	Patient Choices and End of Life Programs are in place in all regions. Metropolitan FTE has increased across both regions: SAHS: 1.0 Allied Health CNAHS: 1.0 Medical Officer, 2.0 Nursing, and 4.5 Allied Health. CYWHS has successfully recruited to its full FTE expansion of 0.5 Medical Officer, 0.8 Nursing and 1.5 Allied Health. CHSA has ongoing recruitment campaigns, and has commenced service delivery to enable Patient Choices and End of Life Programs. Current FTE establishment is 3.6 Nursing and 1.9 Allied Health.	SAHS: $558,000 CNAHS: $1,115,000 CYWHS: $236,300 CHSA: $750,000	Both regions have extensively modernised their palliative care bedside equipment and assessment aides to meet patient need and improve service delivery. The priority has been to implement coordination to enable the establishment and management of specialist Palliative Care services in the Adelaide Hills area. Partnership with local providers in community and inpatient settings, metropolitan-based Specialists, and the development of integrated services that improve functional capacity and quality of life are resulting. CHSA have received two awards in 09/10 from SA Health for Excellence in service delivery for their Respecting Patient Choices and End of Life Care programs.
4. Psychogeriatric Strategies (a) Expand service delivery in country regions (b) Redistribute metro service delivery	CHSA is progressing from establishment to operation with most of the multi-disciplinary FTE recruitment to expand existing teams complete.	CHSA: $600,000	The focus has been on ambulatory services and has involved investment in telemedicine. This provides more frequent more intensive more accessible services to psychogeriatric patients by enabling the link to metro based Psychiatrists. The technology is being shared

			with other Episode of Care types, to ensure scales of economy.

Subacute Care annual service activity and growth report:

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These reforms seek to improve throughput in inpatient services and build capacity in ambulatory settings. Examples of specific focus areas in inpatient services include:

- Operating services at full capacity over 7 days, so that patients receive therapy and can be admitted, discharged and transferred every day of the week;
- Provision of more intensive services in fewer days of therapy prepares the patient to receive ongoing therapy within the community, with services provided mostly in the client's home; and
- Decreasing ALOS.

In relation to reform of the Psychogeriatric services, SA still needs to complete the deinstitutionalisation of older patients who have been resident in standalone psychiatric facilities for many years. Reform plans see the planned gradual closure of state funded residential beds on these sites with reallocation of resources to specialist teams supporting these individuals in aged residential care places.

In order to ensure growth in service delivery is adequately measured within this reform context SA Health determined a methodology for Rehabilitation, GEM and Palliative Care this methodology was included in the implementation plan agreed by the Commonwealth.

South Australia converted separations to bedday equivalents by applying a benchmark average length of stay based on 2007/08 data for rehabilitation, geriatric evaluation and management and palliative care.

For psychogeriatric care, the 2007/08 ALOS was recorded as 200 days. This was clearly inappropriate to use as a benchmark to be applied across four years, therefore a benchmark ALOS of 25 days was used to calculate growth in psychogeriatric bedday equivalents.

Two non-admitted occasions of service were calculated to be equivalent to 1 admitted bedday equivalent.

Growth is measured through the number of patients managed (separations) which are then converted to beddays using ALOS.

Refer Table A for methodology for each care type.

Table A:

Episode of Care Type (admitted)	Methodology
Rehabilitation	Current year separations x baseline year ALOS
GEM	Current year separations x baseline year ALOS
Palliative Care	Current year separations x baseline year ALOS
Psychogeriatric	Baseline year actual beddays + ((current year separations – baseline year separation) x benchmark ALOS 25)

Non-admitted activity and Performance Indicators are measured as per the methodology provided by the Commonwealth.

Admitted and non-admitted activity reports (tables 1 and 2), and Performance Indicator reports (tables 3-7) follow.

The COAG Subacute report template uses methodology that measures growth in beddays. SA Health is concerned that this measure will not reveal growth in patient throughput, because of SA Health's commitment to ongoing decreases in ALOS. That is, as ALOS decreases and patient throughput increases, the actual growth in activity may not be apparent by measuring beddays.

Table 1: Separations and occasions of service by Episode of Care type for FY2009-10. Separations are calculated using the methodology in table A

State/Territory:	South Australia				
Period:	2009-10				
	Rehabilitation	Palliative	GEM	Psycho - geriatric	Totals
Separations (patients)					
Hospital based	2,181	1,658	1,326	277	5,442
Hospital-in-the-home	210	1			211
Combined Hospital based & HITH	4,033	150			4,183
Other (public-funded private beds)		150			150
Total admitted separations	6,424	1,959	1,326	277	9,986
Benchmark Average length of stay	13.302	15.286	10.104	25.0	
Total Bed Day Equivalents	85,451	29,945	13,398	56,848^^	185,642
Occasions of service (volumes)			***Non-admitted***		
Centre based	12,370	1,553	5,040		18,963
Home based	4,634	844	86	28,512	34,076
Combined Centre & Home based	1,244				1,244
Other (please specify)					0
Total occasions of service	18,248	2,397	5,126	28,512	54,283
Weighted Bed Day Equivalents					27,142

^^Psychogeriatric methodology	Baseline year actual beddays + (current year separations – baseline year separations x benchmark LOS 25)	57048 + ((277 – 285) x 25)

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Table 2: Growth percentages for FY2009-10 In this table all 4 care types are totalled to one Separations figure; growth is measured as a total for the state.

				WBDE Ratios	
Growth percentages (2009-10)	Separations (BDEs)	Occasions of service (WBDEs)	Total BDEs		Ratio
Baseline	174,826	22,757	197,583	Rehabilitation	2.0
Services in 2009-10	185,642	27,142	212,783	Palliative care	2.0
Increase in 2009-10	10,816	4,385	15,200	GEM	2.0
% increase	6.2%	19.3%	7.7%	Psychogeriatric	2.0

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