

**SOUTH AUSTRALIA – FINAL REPORT AGAINST SUBACUTE CARE  
IMPLEMENTATION PLAN NATIONAL PARTNERSHIP AGREEMENT ON  
HOSPITAL AND HEALTH WORKFORCE REFORM – SCHEDULE C**

**1<sup>st</sup> July 2012 – 30<sup>th</sup> June 2013**

**Summary of Progress**

South Australia's fourth annual report on the expansion of subacute care documents service delivery initiatives that have enhanced the patient journey from initial access to individual outcomes. These COAG funded initiatives are working along-side reform activity already underway in South Australia, underpinned by three state wide service plans:

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

The South Australian Government's response to the Stepping Up Report is also incorporated into the psychogeriatric component of the Country Health SA Local Health Network's health service expansion.

In addition to the current COAG funding which is being provided, South Australia is also contributing other State funds to further enhance the availability and expansion of subacute care service delivery initiatives that will enhance the patient journey from initial access to individual outcomes.

Some of the major themes that have influenced the design of service expansion have been:

- The delivery of services closer to where patients live
- Taking pressure off public hospitals
- Achieving consistency in evidence-based practice across all sites
- Reducing length of stay
- Increasing throughput.

Local Health Networks (LHNs), there are five LHNs in South Australia:

- Women's and Children's Health Network (WCHN)
  - Central Adelaide Local Health Network (CALHN)
  - Northern Adelaide Local Health Network (NALHN)
  - Southern Adelaide Local Health Network (SALHN)
- Country Health SA Local Health Network (CHSALHN).

## 2012 / 2013 Annual Overview of Achievements – COAG Subacute

Subacute Area	High Level Summary	FY 2012/13 Funding Allocation
<b>1. Rehabilitation:</b>		
WCHN	<p>In 2012/2013 the focus continued to be getting children out of hospital as quickly as possible, while still maintaining their intensive level of rehabilitation to allow for maximal improvement in functioning. There was also a focus on intensive rehabilitation for children and adolescents following acute medical or surgical interventions.</p> <p>Work has continued to find ways of providing intensive rehabilitation using assistive devices such as robotics and there are plans to establish a robotics gym to assist with rehabilitation in the future.</p> <p>Work has continued on the transition model as well as enhanced clinic models.</p>	\$582,000
CALHN	<p>Continuing COAG funded initiatives, included:</p> <p>Concussion Clinic- commenced in 2012 with multi – disciplinary (MD) team providing advice and education to people following a concussion. During this period, procedures have been further refined. People are provided with advice about managing their symptoms by telephone as soon as a referral is received and are then given a follow up appointment as necessary.</p> <p>Spinal Outreach Rehabilitation Team - established a multi-disciplinary ambulatory rehabilitation service as part of the state wide spinal cord injury services, providing discharge / transition support for people with newly acquired injury. Commenced a monthly Southern Metro outreach clinic at Noarlunga .GP Plus funded medical consultant resources. This service improves access for individuals in outer metro and rural areas who battle with transport barriers and medical issues, including fatigue, to access Hampstead-based follow-up services. The clinic has received positive feedback from patients and is fully booked each month.</p> <p>At this early stage, a meaningful analysis of clinical outcomes is not available, however early data is showing a positive change in independence scores and quality of life measures.</p> <p>Interdisciplinary Professional Assessment program - Inter - disciplinary clinician to complete initial assessment, undertake discharge planning role, increased group sessions to improve efficiencies for service provision which</p>	\$576,722

	<p>positively impact on LOS. The program provides a contact after hours (AH) consultancy for potential and complex clients to ensure right service right time right place.</p> <p>A Data Reporting and Analysis project position was established to develop, review and monitor data management systems and reports to ensure efficient and effective activity reporting and ensure that service delivery models are based on financial modelling. The role works closely with service managers to ensure the provision and development of quality services and client outcomes.</p> <p>In line with the National Stroke Foundation Guidelines The Stroke Follow up Clinic provides assessment and review within 3 months, then again at 6 and 12 months post discharge of clients who have experienced a stroke and been discharged from the Hampstead Rehabilitation Centre (HRC) inpatient Stroke Rehabilitation Unit. In addition clients receive secondary prevention screening, review of discharge rehabilitation goals, community integration and identification of new issues and goals. The overall impact aims at decreasing re-admission due to exacerbation.</p>	
NALHN	<p>2012/13 saw the development of a new rehabilitation service in the Northern Adelaide Local Health Network. From July 2012, new Rehabilitation In The Home (RITH) came on line providing in home rehabilitation to eligible NALHN residents. The service operates on average at 15 ambulatory places each day.</p> <p>In August 2012, 8 inpatient rehabilitation beds opened in Modbury Hospital and have remained at capacity since opening. Two new outpatients clinics are now also operational; prosthetics and musculoskeletal – running from GP Plus Elizabeth and GP Plus Super Clinic Modbury respectively.</p> <p>This activity has consolidated Modbury as the hub for aged care, rehabilitation and palliative care in NALHN.</p>	\$576,722
SALHN	<p>The 4<sup>th</sup> Generation Ambulatory Rehabilitation Clinic opened in April 2013. Integrating COAG funded services, research and teaching into a modern clinical facility. It incorporates a range of specific rehabilitation programs, clinics and services. These include treatment and rehabilitation of persons in the community with complex neurological conditions such as cerebral palsy in adults, brain tumours, brain injury and stroke. Other day rehabilitation streams include falls, fracture, fragility and amputee. These services continue to experience high levels of demand from the community.</p> <p>Rehabilitation In the Home (RITHOM) continues to provide the equivalent of 20 inpatient rehabilitation beds, allowing patients to reduce length of stay/ increase in- patient</p>	\$571,445

	<p>throughput, and deliver rehabilitation services within a patient's environment.</p> <p>Realignment of the Rehabilitation inpatient wards, creating a 40 bed stroke/ neurological specialised rehabilitation unit/ 7 day week service has meant that patients have an earlier admission/ transition from acute (Flinders Medical Centre), and that severe/ complex stroke patients are considered for a coordinated program. Evidence demonstrates reduced dependency and increased quality of life.</p>	
CHSALHN	<p>The services continue to experience most demand in the ambulatory settings.</p> <p>Four new telehealth units were purchased for the Country General Hospital sites and were delivered late in the financial year. This will support an expansion of telehealth services linking the rehabilitation teams with metropolitan based specialists.</p> <p>Ongoing service improvement activities were supported through the state wide clinical leads.</p> <p>Teams transitioned from AROC version 3 to AROC version 4 data collection.</p>	\$2,000,000

Subacute Area	High Level Summary	FY 2012/13 Funding Allocation
<b>2. GEM:</b>		
CALHN	<p>Community GEM – MAST</p> <p>The split of the Community GEM service split occurred between CALHN and NALHN on July 1, 2012. As a result, there was a reduction in the number of FTE for the service. While this caused challenges for the service, the client services grew.</p> <p>A new initiative which saw the integration of Integrated Complex Care Older People with Community GEM allowed the service to meet increased service demands.</p> <p>TQEH GEM Unit was established in 2009. There was no additional funding in 2012/2013 to the GEM Unit and so, the focus was on service improvement with a focus on safety and quality and building future capacity through teaching and training.</p> <p>1) Average Length of Stay (ALOS): The majority of patients in the GEM Unit are aged 80 years and older and the unit has contributed positively to the overall reduction in ALOS seen in the Queen Elizabeth Hospital- 2012 7.03 days vs. 2008 8.42 days for patients aged 80 years and older.</p> <p>2) Achieving or Contributing To Evidence Based Practice:</p>	\$578,722

	<p>Quality improvement initiatives undertaken in the 2012/2013 year:</p> <p>Medications: The GEM clinical pharmacist audited prescribing practices at discharge from the TQEH Geriatric Evaluation and Management Unit between 2008 and 2012 using the Screening Tool of Older Person's Prescription (STOPP) and noted a significant reduction in the prescribing of inappropriate medications contributing to falls risk- i.e. neuroleptics and sedatives.</p> <p>Falls Prevention: An audit of update and display of 'bedside posters' to facilitate clinical handover as part of best practice in terms of falls prevention in the TQEH Geriatric Evaluation and Management Unit revealed poor adherence as a result of challenges arising from the current complex paper and sticker system. In collaboration with engineering researchers, a handheld information tool (HIT) has been developed and action research to evaluate the implementation of the HIT tool supported process will be undertaken over the next 12 months. Also, clinicians and patients from the unit have also been participating in research to develop an innovative movement sensor alarm system to prevent falls in collaboration with University of Adelaide researchers.</p> <p>3) Supporting Teaching and Training: Building Capacity For The Future.</p> <p>Undergraduate students: The unit hosts undergraduate medical, nursing, allied health and pharmacy student and provides them with exposure to gerontology.</p> <p>Postgraduate students: PhD students (1 completed in 2013) in the areas of nutrition, oral health, technology &amp; falls prevention and medication optimisation 2 Masters students in the area of technology and falls prevention.</p> <p>Postgraduate training: An in-service program is in place for all clinical staff. The principle being that expert clinicians support the training of rotational staff who in turn take their skills elsewhere through the hospital improving the care older patients receive.</p> <p>4) Engaging With Consumers: The unit has had effective engagement with and support from consumers and volunteers.</p>	
NALHN	<p>In August 2012 the NALHN team collocated with the GEM service and other subacute services at Modbury Hospital. The community team consolidated previous functions under the Community GEM banner and commenced providing both outreach and clinic services for older people within</p>	\$578,722

	<p>NALHN.</p> <p>Falls services had in excess of 500 referrals during the 2012/13 year – with over 220 people seen within multi-disciplinary Falls Clinics (geriatrician, nurse, OT and Physio) and a further 140 being referred to Day Therapy and other community services.</p> <p>The Community GEM service provided support for over 200 people during the year – providing multidisciplinary nursing, social work, physio, OT and geriatrician services for complex older people living at home.</p> <p>The move to Modbury has seen opportunities to plan services across the sub-acute area and develop better pathways and service systems.</p>	
SALHN	<p>The 4<sup>th</sup> Generation Ambulatory Rehabilitation Clinic opened in April 2013, integrating COAG funded services, research and teaching into a modern clinical facility. It incorporates a range of specific aged care programs, clinics and services. These include assessment and treatment of persons in the community with :</p> <ul style="list-style-type: none"> <li>• neuro-generative disorders such as dementia</li> <li>• cognitive / memory disorders</li> <li>• syncope (recurrent unconscious collapse or vertigo)</li> </ul> <p>These services continue to experience high levels of demand from the community.</p> <p>The Community Geriatrics Outreach team is a multidisciplinary team which includes a Geriatrician. They have become well established providing a community service which is an essential component of assessment and management/ hospital avoidance of older persons in the community.</p>	\$ 573 444
CHSALHN	<p>Services have continued to operate as they have in previous years.</p> <p>All multi-disciplinary teams continue with a visiting geriatrician service supplemented by video case conferencing.</p> <p>A major focus has been on continuing to consolidate the services.</p> <p>Teams transitioned from AROC version 3 to AROC version 4 data collection.</p> <p>Uncertainty in funding towards the end of the financial year has impacted on teams.</p>	\$1,000,000

Subacute Area	High Level Summary	FY 2012/13 Funding Allocation
<b>3. Palliative Care:</b>		
WCHN	<p>Research Project assessing Home Medicines Reviews was completed. End of life Care (EOLC) network policy developed, Resuscitation and EOLC Plan for paediatrics redeveloped. Establishment of perinatal palliative care services.</p> <p>Commencement of liaison with South Australia Ambulance Service (SAAS) regarding response and management of paediatric clients with resuscitation limitations. Project to develop on line resources for bereaved families commenced.</p>	\$278,000
CALHN	<p>Central Adelaide Palliative Care Service (CAPCS) is now running on the single service multisite model, delivering services at the Royal Adelaide Hospital, Mary Potter Hospice, Philip Kennedy Centre, Queen Elizabeth Hospital and in the community.</p> <p>As a part of developing as a Level 6 service, the main service and administrative base of the service is Queen Elizabeth hospital, where all of the community nurses are now based. Limited service arrangements are in place with our Level 4 partners - Adelaide Hills, Port Lincoln, Port Augusta and Whyalla.</p> <p>The following strategies have been implemented:</p> <p>1. Workforce development to increase community based services. This has been through the creation of positions for:</p> <ul style="list-style-type: none"> <li>• Advanced Practice Pharmacist</li> <li>• Advanced Practice Occupational Therapist</li> <li>• Advanced Practice Physiotherapist (currently vacant)</li> <li>• Psychologist</li> <li>• Nurse Practitioner Candidates (2 FTE).</li> <li>• Additional Social Worker positions (1.8FTE)</li> <li>• Community Registrar (0.5FTE).</li> </ul> <p>All of these positions provide services in the community, and provide an additional resource.</p> <p>2. Infrastructure development to support community services. The development of CAPCS as a regional service, and one with a stronger community base, has required some infrastructure support in the form of regional leadership roles, some administrative capacity and additional vehicles.</p> <p>3. Bringing together the RAH and TQEH services into one</p>	\$691,723

	<p>regional team, CAPCS, is assisting with the streamlining of clinical practice and protocols, e.g. assessment and referral. CAPCS has developed a bed management strategy which will ensure that all patients who require care in a hospice/hospital setting have the best possible chance of being placed appropriately and in a timely way. This is another strategy in reducing hospital stays, and developing community options.</p>	
NALHN	<p>Service Manager appointed in September 2012 to enable the merging of Modbury and Lyell McEwin Community Services.</p> <p>Lyell McEwin Palliative Service relocated to Modbury in 2013 and now functioning as the Northern Adelaide Palliative Service.</p> <p>Psycho Social Lead appointed in December 2012.</p> <p>All recruited multi-disciplinary team members remain employed; in line with the Palliative care Services Plan.</p> <p>Nurse Practitioner Candidates are continuing with their studies with the completion of one candidate at the end of 2013.</p> <p>The development of a palliative care bereavement service model continues to be supported within NALHN.</p> <p>Hospice beds continue to be utilised across NALHN with a continued increase in inter hospital transfers between Lyell McEwin and Modbury Palliative Care Unit.</p> <p>New governance structures established under a dedicated LHN wide sub-acute division. The Aged Care, Rehabilitation and Palliative Care Division will bring together all sub-acute areas and aim to improve service delivery across the NALHN.</p>	\$691,723
SALHN	<p>Services have continued to operate as they have for the previous year. All positions appointed continue to provide ongoing support to community patients.</p> <p>Outreach services increased by 39% in the 2012/13 financial year from the previous financial year, some of this is due to increased activity; however there has also been a concerted effort by the service to impress upon staff to record all activity.</p> <p>The percentage of patients that have been contacted within 48 hours from referral has increased from previous year. 51% are now contacted within 48 hours compared to 23% in 2011-12.</p>	\$686,445



CHSALHN	Continued provision of at-home palliative care through End of Life Care Packages as well as continuing to provide services by multi-disciplinary teams that work in admitted and non-admitted settings.	\$1,000,000
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<b>Subacute Area</b>	<b>High Level Summary</b>	<b>FY 2012/13 Funding Allocation</b>
<b>4. Psychogeriatric Care:</b>		
CHSALHN	<p>All mental health teams have had full staffing establishment throughout most of 2012/13.</p> <p>In addition to the support provided from mental health teams, support through visiting psycho-geriatrician services and specialist services through Digital Tele-health Network continued to be provided within country South Australia (SA).</p> <p>An evaluation of the older person mental health service was undertaken by Flinders University, which concluded at the first half of 2013. In summary, the service was viewed to have met previously unmet needs and viewed as a positive adjunct to service delivery for older people with mental health issues living in rural South Australia.</p> <p>In 2012/13, a set of online training modules were developed, these will be launched at the later part 2013. Hosting platform is being investigated.</p>	\$800,000

## Subacute Care Annual Service Activity and Growth Report:

The COAG Subacute report template uses methodology that measures growth in bed days. As stated on previous occasions 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 bed days.

SA Health is undertaking a number of reforms that will result in a decreasing ALOS. SA Health seeks to operate services at full capacity over seven (7) days, so that patients receive therapy and can be admitted, discharged and transferred every day of the week. SA Health seeks to provide more intensive services in fewer days of therapy so as to prepare the patient to receive ongoing therapy from a community based provider, with services provided mostly in the client's home.

In order to measure growth appropriately, in the context of reform, SA Health has agreed with the Australian Government on a method for measuring growth in Rehabilitation, GEM and Palliative Care services. SA Health will use the reference year (2007/08) ALOS in the formula to calculate bed days in each of the years 2009/10, 2010/11, 2011/12 and 2012/13 (Table A). It is expected that ALOS will continue to decline over the forthcoming years. By using the reference year ALOS, the increasing bed days SA Health expects to see will reflect growth in patient separations.

In order to measure growth appropriately, in the context of reform, SA Health has agreed with the Australian Government on a method for measuring growth in Psychogeriatric Care. SA Health will use the benchmarked LOS of 25 days in the formula to calculate bed days in each of the years 2009/10, 2010/11, 2011/12 and 2012/13 (Table A). It is expected that LOS will continue to decline over the forthcoming years. By using the benchmarked LOS, the increasing bed days SA Health expects to see will reflect growth in patient separations.

It should be noted that reports C16a and b Admitted Beds days per 1,000 population and non-admitted occasions of service per 1,000 population clearly show the effect of SA reforms which have focussed on increasing ambulatory services to enable more people to receive care at home. The outcome for Psychogeriatric services reflects the transition of some of these patients from State run institutional long stay accommodation to community based NGO operated (state funded) accommodation.

**Table A:**

<b>Episode of Care Type (admitted)</b>	<b>Methodology</b>
Rehabilitation	Separations x reference year ALOS
GEM	Separations x reference year ALOS
Palliative Care	Separations x reference year ALOS
Psychogeriatric	Separations x benchmark LOS 25

**Table 1: Separations and Occasions of Service by Episode of Care Type for FY 2012/13** (Separations are calculated using the methodology in Table A).

State/Territory:

**South Australia**

Period:

2012/13

Rehabilitation	Palliative	GEM	Psycho-geriatric	Totals
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**Separations (patients)**

**Admitted**

Hospital based	3,369	1,524	1,481	310	6,684
Hospital-in-the-Home (HITH)	566	0	0	0	566
Combined hospital based and HITH	6,313	0	0	0	6,313
Other (public-funded private beds)	0	127	0	0	127
<i>Total admitted separations</i>	10,248	1,651	1,481	310	13,690
Benchmark Average Length of Stay	13.3	15.3	10.1	25.0	
<i>Total Bed Day Equivalents</i>	136,317	25,237	14,965	57,673	234,191

**Occasions of Service (volumes)**

**Non-admitted**

Centre based	1,137	42,077	21,526	9,143	73,883
Home based	19,231	2,473	9,781	0	31,485
Combined centre and home based	20,149	0	0	0	20,149
Other (please specify)					0
<i>Total occasions of service</i>	40,517	44,550	31,307	9,143	125,517
<i>Weighted Bed Day Equivalents</i>					62,759

**Table 2: Growth percentages for FY 2012/13** (In this table all four care types are totalled to one separations figure and growth is measured as a total for the State).

**Table 2: Growth percentages (2012/13)**

	Separations (BDEs)	Occasions of Service (WBDEs) Ratio 2:1	Total BDEs
<b>Growth percentages (2011-12)</b>			
Baseline 2007-08	174,826	22,757	197,583
Services in 2011-12	226,827	69,777	296,604
<b>Services in 2012-13</b>	<b>234,191</b>	<b>62,759</b>	<b>296,950</b>
Increase from 2007-08	59,365	40,002	99,367
Increase from 2011-12	7,364	-7,018	346
Targeted % increase	20.0%	20.0%	20.0%
% increase from 2007-08	34.0%	175.8%	50.3%
% increase from 2011-12	3.2%	-10.1%	0.1%

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