

# Aged Care Network

## Rehabilitation & Restorative Care Services Model of Care

For the Older Person in WA

1 July 2008



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# Table of Content

FOREWORD .....	6
EXECUTIVE SUMMARY .....	7
ACKNOWLEDGEMENTS .....	9
RECOMMENDATIONS.....	10
1. OVERVIEW OF THE MODEL OF CARE FOR REHABILITATION AND RESTORATIVE CARE SERVICES .....	12
2. OBJECTIVES: SERVICE DELIVERY MODEL OF CARE.....	14
2.1 Entering Older Age .....	14
2.2 Transitional Stage.....	14
2.3 Frail Aged.....	14
3. DRIVERS FOR CHANGE .....	15
3.1 Coverage issues .....	15
3.2 Access issues.....	15
3.3 Quality issues .....	15
3.4 Demographic Drivers .....	16
3.5 Frailty of the older aged population.....	16
3.6 Research Evidence .....	17
3.7 Community Expectations .....	17
4. FUTURE SERVICE DELIVERY MODEL OF CARE .....	18
5. FUTURE SERVICE DELIVERY MODEL OF CARE: CONFIGURATION OF SERVICES .....	20
6. CONTINUUM OF CARE APPROACH .....	28
6.1 Primary Care .....	28
6.2 Acute Care .....	28
6.2.1 Emergency Department Risk Assessment for older patients in triage categories three - five .....	29
6.2.1 Emergency Department Risk Assessment for older patients in triage categories three - five .....	30
6.2.2 Assessment for older patients in <i>triage categories one - two</i> .....	30
6.3 Sub - Acute Care .....	32
6.3.1 Aged Care Rehabilitation Units (ACRU's) .....	32
6.3.2 Transition Care Services.....	34
6.3.3 Well-Tel Rehabilitation Services .....	37
6.4 Ambulatory Care .....	38
6.5 Community Rehabilitation .....	39
6.5.1 Day Therapy Centres (Outpatient Day Hospitals) .....	39
6.5.2 Mobile Support Teams .....	40
6.5.3 Liaison officer attached to Day Therapy Centres .....	40



7.	SUPPORT SERVICES .....	42
8.	SUPPORT INFRASTRUCTURE.....	44
	GLOSSARY .....	47
	APPENDICES .....	49
	Appendix 1: Definition of Rehabilitation Services .....	49
	Appendix 2: Methodology .....	50
	Appendix 3: Current Service Delivery Model.....	52
	Appendix 4: Clinical Services Framework Configuration .....	62
	REFERENCES .....	65



# Index of Tables

Table 1.	Rehabilitation in-patient therapy episodes (including GEM) across the WA public hospital system .....	17
Table 2.	Service configuration.....	22
Table 3.	Service configuration matrix of rehabilitation and restorative care services.....	24
Table 4.	Northern TCS program .....	36
Table 5.	Southern TCS program .....	36

# Index of Figures

Figure 1.	Rehabilitation Cascade .....	29
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## FOREWORD

The *Service Delivery Model of Care for Rehabilitation and Restorative Care Services* builds upon the Statewide Rehabilitation Service Plan for Western Australia and reflects the WA Health Clinical Services Framework 2005-2015.

The presence of co-morbidities due to chronic and long term illnesses coupled with conditions associated with ageing, create unique challenges in responding to the need for rehabilitation and restorative care services.

It takes account of the challenges brought about by an increasingly ageing population and a population whose care needs are complex.

The model has sought to address these challenges through the application of geriatric expertise in the management of older people who require rehabilitation and restorative care services and a shift in focus from care in the acute setting to less intensive forms of care in the sub-acute care setting.

The delivery of rehabilitation and restorative care services should be viewed as continuum in terms of intensity and length of time for each type of rehabilitation service appropriate to a specific target group. It should be based on sound assessment practices that promote the movement of the older person along the continuum of care. Premature decision making and limited access to rehabilitation and restorative care options can consign elderly people to inappropriate care destinations.

Targeted strategies are required to address the care needs of an older population who require less intense levels of services over a longer period to recover to maximal functional independence that promotes return to the preferred place of residence and optimal quality of life.

Significant improvements to the delivery of rehabilitation and restorative care services in regional and rural areas have been identified. Hospitals in these areas may face less pressure on services in the emergency department setting and “access block” to inpatient beds than their metropolitan counterparts. However, rural and regional hospitals are also focussed on reducing lengths of hospital stay, reductions in re-presentations to the health system and reductions in overall costs.

The WA Health system also wishes to promote a system in which most older people can return safely to their own home with supports and services that assist both the older person and their carer. WA Health also aims to meet the objective of cost-effective care while in the acute care setting, reductions in lengths of stay, fewer inappropriate discharges and reductions in re-presentations to the hospital system.

The WA Health system wishes to promote a choice and equity of access for a range of rehabilitation and restorative care options in order that the older person is able to retain mobility and functional independence for the maximum period possible and in their preferred residential setting.



## EXECUTIVE SUMMARY

The Service Delivery Model of Care for Rehabilitation and Restorative Care Services for the Older Person in WA has sought to:

- outline the range of rehabilitation and restorative care therapy options appropriate in preventing functional decline for the older person
- indicate the appropriate location of such services with respect to the configuration of such services across the WA health system
- demonstrate appropriate care pathways for an older person based on clinical criteria
- incorporate the application of geriatric medicine assessment and management in the care of the older person as they move along the rehabilitation care pathway
- promote a multi-disciplinary approach to rehabilitation and restorative care
- emphasise community based physiotherapy options
- promote increased equity of access to rehabilitation and restorative care services across WA Country Health Services
- promote linkages between the North and South Metropolitan Area Health Services and WA Country Health Services through dedicated consulting geriatric medicine services
- emphasise the need for robust data collection processes that can lead to a benchmarking of services across the continuum of care
- emphasise the need for appropriate infrastructure support to assist in the implementation of the service delivery model of care
- indicate the need for continuous improvement through education and training initiatives
- increase recognition that rehabilitation is an investment in maintaining good health that enhances functional mobility and independence
- promote that importance of investment in services that support the maximisation of the benefits associated with the rehabilitation process when an older person is discharged from hospital.



The approach outlined in this model may seem to focus disproportionately on improvements in care across the acute and sub-acute care sectors. However, this focus should not be seen to overshadow or undervalue the role that ambulatory or community care support services play in supporting the desire of the older person and their carers to live in the community as independently as possible.

Without a commitment to the development and strengthening of such services, the desired outcome to remain in the community may not be fully realised.

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## ACKNOWLEDGEMENTS

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The members of the group were:

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Anne Riordan	Planning Officer, Aged Care Policy Directorate

Special thanks also goes to Hilary Johnston, who so willingly and efficiently was able to provide data to support the work of the sub-group.

The group also acknowledges the help and assistance of the Osborne Park Hospital Rehabilitation and Aged Care Liaison Service (RAILS) and Joanna Riches, Business Manager at Royal Perth Hospital.

The Aged Care Clinical Advisory Committee and the Executive of the Aged Care Network provided comment on the document. Jenny Stevens, Aged Care Director of WACHS also provided valuable comment.

Questionnaires relating to the model were distributed across the WA Health system to seek further input.

Feed back on the document was also sought at the Aged Care Network stakeholder Forum held on 9<sup>th</sup> April, 2008.



## RECOMMENDATIONS

### Range of services

1. In principle agreement to the range of appropriate rehabilitation and restorative care services should be reached amongst stakeholders
2. Priority establishment of Geriatric Evaluation and Management services (GEMS) in all Level 6 and designated Level 5 hospitals where there is an Emergency Department
3. Additional priority funding for Transition Care Service programs in metropolitan areas and further establishment in WACHs regional resource hospitals
4. Establishment of dedicated Aged Care Rehabilitation Units at Regional Resource Hospitals

### Assessment

5. Extension of risk screening identification processes through Care Coordination Teams in all metropolitan hospitals that have an Emergency Department to identify older patients at risk of functional decline
6. Strengthening of risk screening processes all WACHS Regional Resource Hospitals that have an Emergency Department through National Action Plan Coordinators

### Geriatrician services

7. Commitment to the strengthening of visiting geriatricians services in WACHS Regional Resource Hospitals with a view to the development of a formal agreement between WACHS and metropolitan Level 6 hospitals for these services
8. Geriatric consultation services on acute general wards, particularly for ortho-geriatricians and for those older patients assessed as being at risk of functional decline

### Ambulatory and Community Care

9. Day hospital expansion for outpatient based rehabilitation services
10. Expansion of ambulatory care services to enable services to be attached to Aged Care Rehabilitation Units and integrated clinical decision making in rehabilitation care planning for the older person
11. Aged Care Rehabilitation Units to have dedicated ambulatory care service capacity
12. Outpatient Day Hospital terminology to be changed to "Day Therapy Centres" to reflect the wellness approach
13. Post acute discharge support packages considered as an integral component of rehabilitation therapy for effective outcomes of care
14. Clinical targetting of older people who can be supported through early discharge programs for rehabilitation and restorative care
15. Establishment of outreach "rapid response teams" attached to Day
16. Therapy Centres
17. Establishment of Liaison Officers attached to Day Therapy Centres



18. A specific model of care be developed that focuses on the delivery of services from Day Therapy Centres
19. Expansion in rehabilitation programs that are based in the community

#### Infrastructure support

20. Agreement for appropriate bed numbers for metropolitan Aged Care Rehabilitation Units
21. Education and training of medical, nursing and allied health staff to increase awareness and sensitivity to need for comprehensive assessment and management of older people in hospital assessed as at risk of functional decline
22. Investment in information communication technology, workforce and transport services to support effective rehabilitation

#### System Improvements

23. 22. Revision and publication of Statewide Rehabilitation Services Plan for
24. WA
25. 23. Targetted research that focuses on in-patient substitution strategies that avoid iatrogenic harm associated with hospital admission for older people
26. 24. Revision of data collection processes for existing out-patient Day Hospital sites that promotes accessibility to the data, consistency in reporting and ability to monitor improvements to the health system and allow benchmarking of services across the continuum of care.

*Peter Goldswain*

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**CLINICAL LEAD  
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## 1. OVERVIEW OF THE MODEL OF CARE FOR REHABILITATION AND RESTORATIVE CARE SERVICES

The vision for the service delivery model for rehabilitation services is “a coordinated statewide rehabilitation service that offers a range of appropriate rehabilitation service options and promotes equity of access across the continuum of care.”<sup>1</sup>

The elements of the model are congruent with the strategic vision for the WA Health system presented in “A Healthy Future for Western Australians”<sup>2</sup> and reflected in the WA Health Clinical Services Framework 2005-2015<sup>3</sup>:

- State Rehabilitation Centre (SRC) for medical conditions requiring state-wide tertiary rehabilitation services
- metropolitan secondary rehabilitation services comprising Aged Care Rehabilitation sub-units (ACRU’s) and dedicated stroke rehabilitation sub-units
- provision of appropriate step-down sub-acute rehabilitation services
- rural rehabilitation and aged care inpatient units in nominated rural regions
- ambulatory care services that substitute hospital based rehabilitation in the home and support the individual to return to maximum functional independence
- community based rehabilitation services

The model of care for service delivery builds on this configuration by identifying appropriate rehabilitation service options within the framework in order to meet the varying care needs of people who require such services as they move along the continuum of care and links to geriatric medical services and ambulatory care services. The definition of rehabilitation and restorative care services is at Appendix One.<sup>4</sup>

The key features of the model are:

- a focus on health promotion and prevention campaigns targeting older people and lifestyle behaviours that are risk factors for diseases and conditions that produce the need for rehabilitation therapy
- strengthening of in-patient substitution strategies through risk screening at emergency departments and direct linkages to primary health and community support services
- demand amelioration strategies for acute inpatient rehabilitation services

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<sup>1</sup> Based on the vision encapsulated in the Executive Summary – Statewide Rehabilitation Service Plan for Western Australia. Unpublished Department of Health 2004.

<sup>2</sup> A Healthy Future for Western Australians. Report of the Health Reform Committee. Department of Health. March 2004. Recommendations 26, 28, and page 73 relating to reductions in lengths of stay.

<sup>3</sup> Page 11b, WA Health Clinical Services Framework 2005 -2015. Department of Health. 2005

<sup>4</sup> Technical Bulletin 3/7; Operational Instruction 1947/05. Rehabilitation Program – All Public Hospitals in Western Australia. Department of Health <http://www.intranet.health.wa.gov./circulars>



- a strengthening of cost effective outcomes for the WA health system through the substitution of acute care models with sub-acute, ambulatory and community based rehabilitation services, particularly in rural areas
- recognition of the complexity of the ageing process, impact of co-morbidities in the recovery process and resulting recovery time, particularly as a person becomes increasingly frail
- inclusion of the carer as a partner in the health care team
- interdisciplinary care model that considers the holistic care needs of the older person
- recognition that rehabilitation should be seen as an investment in maintaining good health rather than a cost to the health system



## 2. OBJECTIVES: SERVICE DELIVERY MODEL OF CARE

### 2.1 Entering Older Age

#### Objectives

- adherence to healthy lifestyle practices including regular exercise, healthy eating, management of cholesterol, blood pressure and normal BMI ranges coupled with an annual General Practitioner check-up under the Enhanced Primary Care Medicare item.
- screening for cognitive impairment and falls risk in primary care
- improved adherence with management plans to manage health conditions (including prescribed medications)

### 2.2 Transitional Stage

#### Objectives

- provision of support services including transport and aids and equipment that promotes independent living in the community
- promotion of self-management behaviours by the General Practitioner and primary care clinics to delay the onset of ill-health
- screening assessments for falls, continence and memory to become part of the primary care preventative treatment strategy
- ambulatory and community care provision of rehabilitation services through targetted strategies for people identified as at risk of functional decline.

### 2.3 Frail Aged

#### Objectives

- provision of flexible services that support independent living in the community
- availability of comprehensive assessment services in the hospital setting, commencing at the emergency department
- interdisciplinary care including geriatric evaluation and management expertise at ward level, dedicated ortho-geriatrician services, range of rehabilitation services and psycho-geriatrician services
- access to sub-acute rehabilitation care services
- ambulatory and community care provision of rehabilitation services through targetted strategies for people assessed as at risk of functional decline.
- adequate access to a range of “downstream” bed types such as Transition Care Services (TCS) including places in regional areas and Australian Government funded residential aged care places.
- major regional hospitals to provide visiting geriatrician services, geriatric and evaluation and management model with access to rehabilitation and access to downstream TCS beds.



### 3. DRIVERS FOR CHANGE

The current rehabilitation service delivery model is characterised by the following:

#### 3.1 Coverage issues

- Geriatric Evaluation and Management Units linked to hospitals with Emergency Departments
- dedicated access to transition care rehabilitation places from Level 6 hospitals
- dedicated rehabilitation beds at sub-acute Aged Care Rehabilitation Units at the secondary level metropolitan hospitals
- dedicated rehabilitation beds at sub-acute Aged Care Rehabilitation Units at the major regional hospitals
- transitional care services linked to the sub-acute Aged Care Rehabilitation Units at the secondary level metropolitan hospitals
- community based rehabilitation services based in the primary care sector and linked to Day Therapy Centres for older people who live in metropolitan and regional areas
- ambulatory care rehabilitation services (RITH) for people who live in metropolitan and regional areas
- support services that assist the older person and carer to recover from illness and participate in rehabilitation programs including provision of transport services and aids and equipment, particularly in regional areas
- Australian Government funded residential aged care packages that support older people to live as independently as possible in their own home with the assistance of rehabilitation services, such as CACP's and EACH packages.
- rehabilitation therapy services in Australian Government funded residential aged care facilities

#### 3.2 Access issues

- consultative geriatrician services in regional areas
- transitional care rehabilitation services in regional areas
- outpatient and home based rehabilitation services in the major regional centres
- Chronic Disease Management Programs in regional areas

#### 3.3 Quality issues

- poor referral linkages between General Practitioners to primary care outpatient/community based rehabilitation services
- poor referral linkages between the acute sector and community care sector support services that promote recovery and independent living in the community



- discharge planning from hospital and effective transition to place of residence
- duplications in assessments by multiple agencies that complicate the transition to place of residence
- inappropriate assessment for residential aged care placement due to lack of suitable rehabilitation therapy options that would assist in recovery

### 3.4 Demographic Drivers

According to ABS projections, the total number of people aged 65 years and over is projected to grow around 277,700 people or 12.5% of the total population by 2011 and by 2051 to almost 25% of the total population in Western Australia.<sup>5</sup>

A key feature of the ageing of the population in Australia will be the increased numbers of people aged over 80, with the proportion of very old (aged 85 and over) expected to treble between 2007 and 2047 from 1.7% to 5.6%.<sup>6</sup>

Based on data in the 2006 Census, the number of people aged over 80 as a proportion of the 65+ age group is projected to rise to 26% by 2011.<sup>7</sup>

### 3.5 Frailty of the older aged population

Frail aged people take longer periods of time to rehabilitate to levels of functional independence where they can be discharged safely. In this context, an appropriate range of rehabilitation and restorative care services at the sub-acute level is required. While older people do require less intensive levels of service, they require more time to recover from the presenting acute condition.

The implication for the WA Health system is the increasing proportion of the frail aged requiring acute and sub-acute rehabilitation and restorative care services.

The greatest overall demand for inpatient rehabilitation services comes from patients in the older age groups as demonstrated by the following table.

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<sup>5</sup> page 10, *ibid.* Discussion Paper <sup>5</sup> Appendix Three :Model of Care for the Older Person in Western Australia. Aged Care Network. Department of Health. 2007.

<http://www.healthnetworks.health.wa.gov.au/aedcare/publications.cfm>

<sup>6</sup> page 10, *ibid.*

<sup>7</sup> page 11, *ibid.*



**Table 1. Rehabilitation in-patient therapy episodes (including GEM) across the WA public hospital system<sup>8</sup>**

	2001-2002	% of total	2005-2006	% of total
Age range				
0-66	968	24.6%	1541	22.6%
66-80	1331	33.8%	2341	34.3%
81+	1637	41.8%	2931	43%
Total	3936	100%	6813	100%

### 3.6 Research Evidence

A body of research evidence is now emerging that demonstrates the viability and clinical safety of an increasing range of therapy options in the residential and community setting that can assist in promoting functional mobility and independence.

This is particularly so in terms of ambulatory care initiatives which focus on hospital substitution strategies according to appropriate clinical referral criteria. Research evidence to support these conclusions is contained in the Reference section of the document.

### 3.7 Community Expectations

It is reasonable to assume that in the context of the “baby-boomer generation” there will be increasing expectations in the community for care to be provided locally. Demand for less intensive forms of sub-acute rehabilitation and restorative care services in a home-based setting or in institutional settings “closer to home” will form part of these expectations.

This is particularly so for the ATSI indigenous population who prefer to remain in the local area.

The increasing frailty of the older population will require therapy options closer to home as their means of independent transport to access geographically dispersed services becomes more limited.

Expectations of care “closer to home” present unique challenges for the delivery of rehabilitation and restorative care services in regional areas of WA.

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<sup>8</sup> These are raw recorded episodes. Interruptions due to dialysis, pin removal, etc split some episodes into 2 or more which increases numbers. Transferring a patient from one hospital to another during a rehabilitation episode will also lead to two episodes being recorded. Estimates are that these factors increase the numbers by 10%.

Data provided by the Epidemiological Branch of WA Health, June 2007 and sourced from the WA Health morbidity system. Peel, Joondalup and Mercy Hospitals are not included.



## 4. FUTURE SERVICE DELIVERY MODEL OF CARE

### Preface

The service delivery model:

- incorporates the foundation framework provided by the SRSP - WA 2004<sup>9</sup> with respect to configuration of services
- provides an understanding of the range of rehabilitation and restorative care needs of an aged person with complex conditions and co-morbidities
- presents an outline of the cascading nature of rehabilitation and restorative care services appropriate to the changing care needs of the older person over time
- reflects the comprehensive nature of rehabilitation and restorative care services that span the entire continuum of care ranging from initial assessment in ED to primary care interventions in the community
- reflects the constantly evolving care needs and in that respect is partly evidenced by quantitative data and partly evidenced by qualitative data gathered during the consultation phase from allied health staff and geriatricians that requires further substantiation and
- requires more analytical statistical research to define specific quantitative service configurations that will be determined at the local implementation level and documented in the Statewide Rehabilitation Service Plan for Western Australia.
- implementation at the local health service level will need to reflect indigenous care needs

The generic service model mainly targets older patients, who in addition to co-morbidities relating to chronic disease, have geriatric syndromes or a partial resolution of an acute illness.

Through a risk screening process, older patients who have been identified as having reversible functional impairments, will access rehabilitation and restorative care therapies that assist in returning a person to levels of mobility and self-care that promote functional independence.

While the target groups of patients who have suffered a stroke, limb amputations, and ortho-geriatric patients who require rehabilitation and restorative care services have been considered in further models of care completed by the Aged Care Network, they will access services described in this model as they move along the continuum of care.

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<sup>9</sup> Statewide Rehabilitation Service Plan for Western Australia. Unpublished Department of Health 2004.



## Principles of a quality rehabilitation service

- competence - ability to deliver program objectives and monitor progress;
- respect for patients - recognition of psychological and spiritual needs;
- choice - customer based options including home and community services;
- accessibility - physical access and eligibility for services; and
- responsiveness - flexibility of services to meet changing needs of patients.<sup>10</sup>

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<sup>10</sup> Statewide Rehabilitation Service Plan for Western Australia. Unpublished Department of Health 2004.



## 5. FUTURE SERVICE DELIVERY MODEL OF CARE: CONFIGURATION OF SERVICES

The future model of care for the delivery of rehabilitation and restorative care services can be characterised as a “hub and spoke model” with a statewide specialist centre linked to metropolitan secondary and regional resource hospitals that have aged care rehabilitation units and providing an extended range of sub-acute care services. Community based rehabilitation services will support this configuration.<sup>11</sup>

Configuration at the local area health service level will be informed by population planning projections for the ATSI group of 45+ and the non-ATSI 65+ age groups.

### Statewide Rehabilitation Centre (SRC)<sup>12</sup> - tertiary level

The SRC will:

- act as specialist rehabilitation centre for amputees who are generally younger requiring rehabilitation and prosthetic services, people with spinal injuries, neurological conditions, post cardio-thoracic conditions, people who have acquired brain injuries (ABI), rheumatology therapies and a generic group of patients who require specialist rehabilitation thereby providing equity of access for such services to all patients across the state
- provision of interdisciplinary services led by neurologists and rehabilitation physicians with access to geriatric expertise where appropriate
- act as centre of excellence for evidenced - based best practice rehabilitation and research
- provide advice and conducts training and education programs
- provide an interface with metropolitan and rural health and community centres
- provide sub-acute Well-tel services for people who require a longer period to rehabilitate and for WACHS and outer metropolitan patients
- the Centre will continue to operate at RPH - Shenton Park Campus until relocated to the Southern Tertiary Campus at Fiona Stanley Hospital in the future.

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<sup>11</sup> page 5, ibid.

<sup>12</sup> page 5, ibid.



The Rehabilitation Technology Unit<sup>13</sup> will be co-located with the SRC and will:

- act as the major coordinating centre for training, education and research.
- promote and support research into rehabilitation and innovative use of technology to further the rehabilitation process
- act as a specialised resource and training centre for rehabilitation technology services in WA
- onsite prosthetic services will be located at the Technology Unit linked to the State Rehabilitation Centre
- provide tertiary - level specialised and complex rehabilitation services
- encourage metropolitan and rural rehabilitation services to support the operation of secondary equipment services at the local hospital and service level.

#### Level 6 tertiary level metropolitan hospitals

- The matrix at Table Three (pages 17-19) delineates the services to be provided by the tertiary hospitals.
- A key focus of services provided will be the early identification of older people at risk of functional decline, early intervention and prevention of further complications emanating from declines in functional mobility and deconditioning.<sup>14</sup>
- The risk screening process is based on “A guide for assessing older people in hospitals”.<sup>15</sup> Respective hospitals will develop risk screening tools based on the domains in the guide. This process has commenced with the use of the tools by Care Coordination Teams (CCT’s) and the Council of Australian Governments (COAG) initiative for Older Persons.

#### Aged Care Rehabilitation Units (ACRU’s) - metropolitan sub-acute rehabilitation services at Level 5 and Level 4 hospitals<sup>16</sup>

- The ACRU’s will be linked to the Level 6 tertiary metropolitan hospitals according to North and South Metropolitan Area Health Service catchment areas as defined in the WA Health CSF 2005-2015. Table Two delineates these linkages.

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<sup>13</sup> page 21, *ibid*.

<sup>14</sup> This will be effected through the use of the following guidelines; “A guide for assessing older people in hospitals”. Developed by the Centre for Applied Gerontology, Bundoora Extended Care Centre. Northern Health. Commissioned on behalf of the Australian Health Minister’s Advisory Committee. Care of the Older Australian Working Group. (COAWG). September 2004.

<sup>15</sup> As above.

<sup>16</sup> page 12, Statewide Rehabilitation Service Plan for Western Australia. Unpublished Department of Health 2004.



**Table 2. Service configuration**

2008-2013		Post 2013	
Region	ACRU linkage	Region	ACRU linkage
North Metro L6		North Metro L6	
RPH In the transition phase	- Mercy Hospital - Swan Districts Hospital	Sir Charles Gardiner Hospital	- Mercy Hospital - Swan Districts Hospital - Joondalup Hospital - Osborne Park Hospital
Sir Charles Gairdner Hospital	- Joondalup Regional Hospital - Osborne Park Hospital		
South Metro L6		South Metro L6	
Fremantle Hospital	- Armadale/Kelmscott Hospital  - Rockingham/Kwinana District Hospital	Fiona Stanley Hospital	- Fremantle Hospital - Armadale/Kelmscott Hospital - Rockingham/Kwinana Hospital - Bentley Hospital - Peel Health Campus
RPH	- Bentley Hospital		

- The Level 5 and Level 4 hospitals will also focus on early identification of older people at risk of functional decline, early intervention and prevention of further complications emanating from declines in functional mobility and deconditioning.
- The ACRU's will focus on providing services to older people that have been referred from a Level 6 hospital and have been assessed as having the potential to return to previous levels of functional mobility but require less intensive services in a sub-acute environment, and thereby providing a more cost-effective alternative.
- The ACRU's will be based at hospitals where there are existing rehabilitation and aged care units.
- At some sites, services will also include aged care rehabilitation stroke rehabilitation sub-units. Older amputee patients who have been assessed as medically unstable to receive an interim prosthesis will also receive follow up rehabilitation and restorative care services at the ACRU closest to where they live.<sup>17</sup>

<sup>17</sup> Aged Care Network - Amputee Services and Rehabilitation Model of Care for Older People.



- The relocation of funded rehabilitation beds at RPH - SPC currently utilised by fractured hip patients and distributed to aged care rehabilitation sub-units will assist in the strengthening of services offered at ACRU's.<sup>18</sup>
- Where appropriate, the ACRU's would initiate or complete rehabilitation for patients with other medical conditions referred from regional areas where rehabilitation services are not available.
- Based on the extensive consultation undertaken for the preparation of the SRSP-WA 2004 and subsequent consultations relating to the WA Health CSF 2005-2015 it is anticipated that there will be an overall adjustment of bed numbers in aged care rehabilitation sub-units.
- It is recommended that adjustments in bed numbers will be clarified as the service delivery model of care begins to be implemented at the local area health service level and informed by target population projections.

### WACHS Regional Resource Hospitals

The WACHS Regional Resource Hospital will:

- perform the combined roles of early identification of older people at risk of functional decline, early intervention and prevention of further complications emanating from declines in functional mobility and deconditioning and the provision of less intensive services in a sub-acute environment.
- the Regional Aged Care Rehabilitation Units will be established at Albany, Geraldton, Kalgoorlie, PH, Broome and Northam and in the South West Area Health Service. These centres will act as "hubs" for each region.
- formal support relationship with a metropolitan area ACRU would form the basis of specialist advice and referral pathways for rural patients who require rehabilitation and restorative care services in the metropolitan area
- rehabilitation services for stroke, amputation and orthopaedic conditions would also be available
- patients would either be transferred to rural rehabilitation and aged care inpatient units after receiving initial rehabilitation in the metropolitan area or remain in the rural area for acute management, and then transferred to a rural rehabilitation and care inpatient unit.
- dedicated areas for care at regional and district hospital sites will be identified
- constraints in terms of workforce requirements will necessitate training across the medical, nursing and allied health staff.
- Tele-health services may be able to form a useful support to the provision of consultation and training services to the WACHs sites.

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<sup>18</sup> page 5, Statewide Rehabilitation Service Plan for Western Australia. Unpublished. Department of Health 2004.  
Aged Care Network - Ortho-geriatric Model of Care.



**Table 3. Service configuration matrix of rehabilitation and restorative care services**

	Level Six Metropolitan Tertiary Hospital	Level 4 and 5 hospital with ACRU's	WACHS Regional resource hospitals
<u>Rehabilitation discipline specific services</u>			
Risk screening assessment for positive rehabilitation therapy indicators through Coordination Care Teams (CCT's) and Elder Care Pathway COAG initiative within Emergency Departments <sup>19</sup>	YES	where there is an Emergency Department	where there is an Emergency Department
GEM units where Emergency Departments occur with a geriatrician led multi-disciplinary therapy team	YES	where there is an Emergency Department  comprehensive geriatric assessment/management	where there is an Emergency Department  comprehensive geriatric assessment/management principles
Geriatrician led multi-disciplinary therapy team that is available to provide comprehensive geriatric assessment on acute general medical inpatient wards for older patients identified as at risk of functional decline <sup>20</sup> due to the acute condition or presence of a geriatric related condition or co-morbidity	YES	YES	Where a resident geriatrician is not available, purchasing of services through an agreement by WACHS with partnership metropolitan hospitals is required.

<sup>19</sup> A further extension of this model is the OPERA model provided by geriatric service with conventional service ability and discussed in the Aged Care Network Emergency Department Model of Care.

<sup>20</sup> Identified through risk screening



	Level Six Metropolitan Tertiary Hospital	Level 4 and 5 hospital with ACRU's	WACHS Regional resource hospitals
Visiting geriatrician service			YES
Dedicated ortho-geriatrician on surgical ward or alternatively, early referral to a geriatrician	YES	Access to geriatrician services	Purchasing of geriatrician services through an agreement by WACHS with partnership metropolitan hospitals is required.
Access to psycho-geriatrician services with access to dedicated beds both in the acute inpatient setting and sub-acute rehabilitation setting	YES	YES	YES
Step-down rehabilitation and restorative care services	NO	YES	YES
Inpatient rehabilitation beds	NO	YES	YES
Transitional care services to further progress slow stream rehabilitation requirements	NO	YES	YES



<u>Ambulatory care services</u>	Level Six Metropolitan Tertiary Hospital	Level 4 and 5 hospital with ACRU's	WACHS Regional resource hospitals
RITH, HITH, Post acute care discharge packages	YES	YES outreach Aged Care Service rapid response team (RRT) services to identify and implement strategies that prevent inappropriate hospital admissions	YES outreach Aged Care Service rapid response team (RRT) services to identify and implement strategies that prevent inappropriate hospital admissions
<u>Assessment services</u>			
Aged Care Assessment services that provide for assessment for appropriate Australian Government funded residential aged care options and community care services.	YES	YES	YES
<u>Outpatient Day Therapy Centres</u>			
<ul style="list-style-type: none"> <li>- Community based day outpatient day therapy centres for Parkinson's Disease, Falls, Continence, Memory</li> <li>- Liaison Officer attached to Day Therapy Centres to receive community based referrals</li> <li>- Outreach mobile teams, rapid response teams</li> </ul>	NO	YES	YES



<u>Community based rehabilitation physiotherapy services</u>	Level Six Metropolitan Tertiary Hospital	Level 4 and 5 hospital with ACRU's	WACHS Regional resource hospitals
	YES - referral and access to community service	YES - referral and access to community service	IF POSSIBLE



## 6. CONTINUUM OF CARE APPROACH

### 6.1 Primary Care

- Health promotion and intervention campaigns that specifically target the older population
  - exercise campaigns
  - healthy lifestyle promotion campaigns that focus on ageing well and healthily
  - falls prevention programs such as SOYFWA®
  - Population Health Units to conduct campaigns to raise awareness of chronic diseases
- Targeted intervention programs
  - Chronic disease management programs
  - Diabetes management programs with access to dietician and podiatrist
  - Metabolic syndrome management programs
  - Community physiotherapy services
- General Practitioner care team
  - Annual screening through Enhanced Primary Care initiatives to monitor blood pressure, cholesterol, weight gain, glucose levels, falls risk, continence, cognition, depression
  - referral linkages to Outpatient based Day Therapy Centres
  - referral linkages to Community based physiotherapy services
- Community Care Services
  - adequate resourcing of services that support the older person to maintain functional independence in the community
  - adequate resourcing of transport services , aids and equipment
  - promotion of wellness approach across the Home and Community Care Program that encourages functional independency

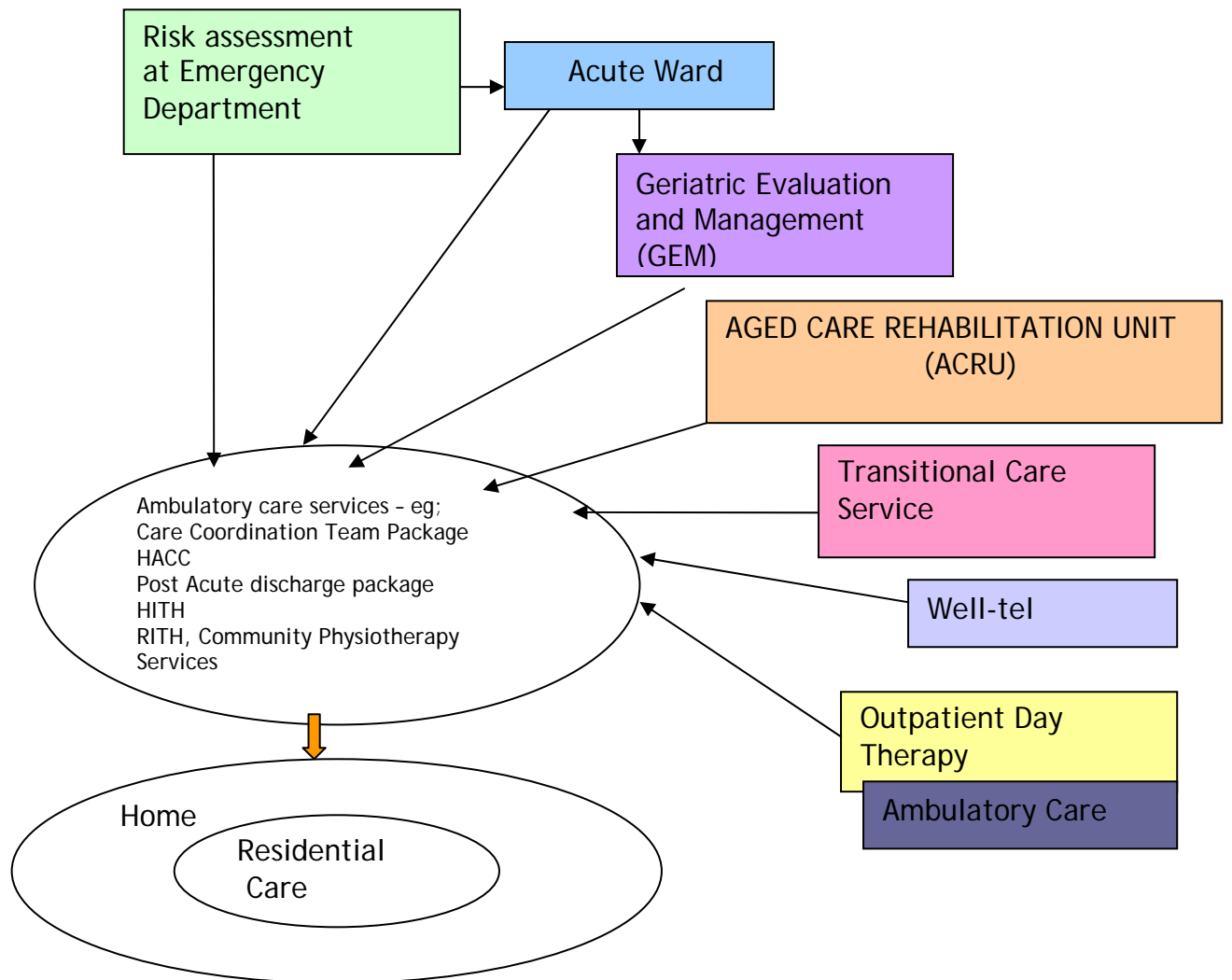
### 6.2 Acute Care

Rehabilitation and restorative care for patients that enter the acute system should be understood as a cascading level of services that commences with risk assessment, and can vary with intensity and length of time depending on the care needs of the particular individual.

Figure One depicts the cascading nature of such services.



Figure 1. Rehabilitation Cascade





### 6.2.1 Emergency Department Risk Assessment for older patients in triage categories three - five

The clinical pathway for the identification of older people at risk of functional decline and the need for rehabilitation and restorative care services commences in the Emergency Department. This will be for people aged 65+, or 70+ as determined by the respective hospital.

- The Elder Care Pathway risk screening assessment undertaken by Care Coordination Teams in Emergency Departments to screen early for risk factors<sup>21</sup> across the following domains:
  - Mobility, Delirium, Cognition, Continence, Social Isolation, Medical health
- When a risk is identified, further assessment by the relevant clinician or allied health profession is undertaken using appropriate tools for the particular domain. Where appropriate, there are a number of options available to avoid an unnecessary acute hospital admission.
- The older person in ED can be:
  - referred for a Care Coordination Team discharge community care package
  - Referred to a Day Therapy Centre for rehabilitation therapy in an outpatient setting,
  - provided with a RITH service and discharged to home,
  - provided with a PEP package provided by Silver Chain Nursing Association or
  - referred to a Home and Community Care service provider and discharged home
  - referred to a relevant medical specialist (for example to a Parkinson's Disease specialist).
- Alternatively, the older person can be referred to a GEM unit, an ACRU or a Transition Care Service (TCS), community care package, depending on the level of rehabilitation and restorative care needs the person may have.

### 6.2.2 Assessment for older patients in *triage categories one - two*

Patients who have been triaged as category one and two will be followed up post stabilisation of the acute presenting condition.

They will be identified through a specific box inserted on the patient's medical record that will flag the need for a consultation with a geriatric consulting service to perform a comprehensive assessment for identification of risk factors for functional decline and possible readmission to hospital following stabilisation.

### Geriatric Evaluation and Management (GEM) Unit

Comprehensive geriatric evaluation is a technique that aims to uncover the multi-dimensional problems of an "at risk" frail elderly patient with the

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<sup>21</sup> A guide for assessing older people in hospitals. Care of the Older Australian Working Group. (COAWG). AHMAC. September 2004.



purpose of planning and/or implementing coordinated medical, psychosocial and rehabilitative care tailored to the patient's specific needs and designed to rehabilitate the patient to a level of functional independence where they are able to maximise functional mobility and live independently in the community. The term GEM is appropriate when the assessment process is combined with some form of rehabilitative therapy.

The seminal study by Rubenstein<sup>22</sup> demonstrating the benefits of inpatient GEM interventions and "usual medical care," has been further confirmed by studies that report benefits to patient functional status, decrease in nursing home admission rates and decrease in acute care hospital readmission rates associated with GEM interventions compared with usual hospital care.<sup>23</sup>

Further on-going rehabilitation therapy may be required<sup>24</sup> to return to optimum levels of functional independence, but this is more appropriately provided in a sub-acute setting.

A specific service delivery model of care for GEM has been developed by the Aged Care Network and has been recommended to be established at appropriate level hospitals where there is an emergency department.

### WACHS Regional Resource Hospitals

At regional resource hospitals, the establishment of such a unit may not be feasible due to workforce constraints. However, the principles of comprehensive geriatric evaluation should be embedded into care standards across medical, nursing and allied health staff as a measure of the adoption of best practice for the care of older people.

#### ■ Inpatient General Medical Wards

The incorporation of direct geriatric consultation and liaison input is recommended in the model of care for elderly patients who have been streamed to acute inpatient general medical wards and who require rehabilitation and restorative care services. The effectiveness of this approach is best demonstrated in research findings relating to the care of elderly people with hip fractures and the incorporation of ortho-geriatric services at the pre-, peri, and post operative care stages for the shared management of such patients.<sup>25 26 27 28</sup>

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<sup>22</sup> Rubenstein LZ, Stuck AE, Siu EL, Wieland D 1991, Impacts of geriatric evaluation and management programs on defined outcomes: overview of the evidence, *Journal American Geriatric Society* 39:8S-16S; discussion 17S-18S.

<sup>23</sup> page 44, NSW Health. Framework for integrated support and management of older people in the NSW health care system 2004-2006.

<sup>24</sup> The establishment of GEM at RPH has demonstrated that over the period 2002/03 - 2005/06, approximately 51% of patients were recorded as being discharged directly to home. (GEM Model of Care - Aged Care Network).

<sup>25</sup> Kenne DC, Reid J, Richardson IR, Kiamari AA, Kelt C 1988, Effectiveness of geriatric rehabilitative care after fractures of the proximal femur in elderly women, a randomised clinical trial, *BMJ* 297:1083-6.

<sup>26</sup> Elliot JR, Wilkinson TJ, Hanger HC, Gilchrist NL, Sainsbury R, Shamy S, Rothwell A 1996, The added effectiveness of early geriatrician involvement on acute orthopaedic wards to ortho-geriatric rehabilitation, *N Z Medical Journal* 109:72-3.

<sup>27</sup> Murphy PJ, Rai GS, Lowy M, Bielawska C 1987, The beneficial effects of joint ortho-geriatric rehabilitation, *Age Ageing* 16:273-8.

<sup>28</sup> Sainsbury R, Gillespie WJ, Armour PC, Newman EF 2000, An orthopaedic geriatric rehabilitation unit: the first two years experience, *New Zealand Journal* 99:583-5.



Compared with usual (orthopaedic) care, ortho-geriatric liaison services result in shorter hospital lengths of stay (up to 46% less), greater functional independence with “consequently higher rates of home discharge and lower nursing home placement (approximately 69% less)”.<sup>29</sup>

It is also recommended that the geriatrician has primary responsibility to implement management recommendations relating to the rehabilitation and restorative care needs. The research evidence demonstrates that without such a mandate, there is “little impact on in-hospital complication rates, lengths of stay, mortality and subsequent re-admission rates”.<sup>30 31 32 33 34</sup>

It is recommended that education and training in the principles of geriatric evaluation and management occur across allied health staff, medical and nursing workforces. The aim is to increase sensitivity to geriatric care, the relationship to management of older people and recognition and understanding of the ability to reverse conditions of functional impairment through rehabilitation and restorative care.

This standard of practice should occur across metropolitan and regional hospitals.

### 6.3 Sub - Acute Care

#### 6.3.1 Aged Care Rehabilitation Units (ACRU's)

Older patients who have a combination of slowly resolving or changing medical problems and ongoing functional impairment, require rehabilitation and restorative care services at a less intensive level, but over a longer period of time. The provision of such services in a sub-acute setting is a cost effective solution to this clinical requirement.

Research evidence demonstrates the benefits of such care in terms of cost-effectiveness, reduced hospital lengths of stay, improved quality of life, and improved mortality and morbidity rates.<sup>35</sup>

This sub-group includes patients that may continue to require 24 hour nursing care but have been assessed as having the potential to return home after a process of enablement and rehabilitation.

The ACRU's form the “backbone” of rehabilitation services for older people. The services provide a sustained and concentrated program of rehabilitation therapy services to promote functional mobility and a return to independent living the community.

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<sup>29</sup> page 45, NSW Health Framework for integrated support and management of older people in the NSW health care system 2004-2005.

<sup>30</sup> Page 45, *ibid*.

<sup>31</sup> Becker PM et al. 1987. Hospital acquired complications in a randomised controlled clinical trial of a geriatric consultation team. *JAMA* 257:2313-7.

<sup>32</sup> Allen CM et al. 1986. A randomised, controlled clinical trial of a geriatric consultation team, compliance with recommendations. *JAMA* 255:2617-21.

<sup>33</sup> Saltz CC et al. 1988 Impact of geriatric consultation team on discharge placement and repeat hospitalisation, *Gerontologist*. *Gerontologist*, 28:344-50.

<sup>34</sup> Rueben DB et al. 1995. A randomised control trial of comprehensive geriatric assessment in the care of hospitalised patients, *New England Medical Journal* 332:1345-50.

<sup>35</sup> NSW Branch of Australian Society for Geriatric Medicine. Discussion Paper: Transitional Geriatric Care.



The Australasian Faculty of Rehabilitation Medicine in the faculty publication "The Standards 2005-Adult Rehabilitation Medicine Services in Public and Private Hospitals"<sup>36</sup> outlines the best practice standards for the provision of comprehensive quality care for rehabilitation services.

The ACRU's will comprise a multi-disciplinary care team that includes geriatrician consultation services, access to psycho-geriatrician consultation services, nursing, physiotherapy, occupational therapy, dietetics, podiatry and social work services as well as a counselling service for carers and the patient.

In addition, access to ortho-geriatrician services are also required in recognition of the proposed relocation of NOFs from RPH - SPC to ACRU's and the improved rehabilitation outcomes where this service is available.<sup>37</sup>

The ACRU's will also provide rehabilitation therapy services to various sub-groups that require therapy such as orthopaedic patients, amputees and Parkinson's disease patients. A close link will be developed with Specialist Stroke Units to enable "cross fertilisation" of skills in similar areas such as neurology. All Stroke Units are expected to formally incorporate geriatric services as part of the multi-disciplinary model.

Patients who experience the early onset of biological diseases associated with ageing and who require rehabilitation therapy services should have equity of access to services provided through ACRU's.

In determining staffing ratios for ACRU units, reference should be made to the Standards 2005 - Adult Rehabilitation Medicine Services in Public and Private Hospitals.<sup>38</sup>

Equity of access to the distribution of rehabilitation beds will be based on demographic planning principles with reference to population growth projections across health service geographic catchment areas.

A national survey of inpatient geriatric services and supply of beds indicated that "in relation to the aged population, the greatest supply of beds was in Western Australia"<sup>39</sup> with 3.98 beds per 1000 people aged 70+.

While WA may have the highest ratio of beds per 1000 people aged 70+, this should not be considered a measure of reaching a suitable planning target. The survey indicated that on a national basis, "the most striking finding is the wide variation in availability at hospital, regional and state levels, which is not fully explained by demographic differences".<sup>40</sup>

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<sup>36</sup> Standards 2005 - Adult Rehabilitation Medicine Services in Public and Private Hospitals. Australasian Faculty of Rehabilitation Medicine (AFRM).

<sup>37</sup> Elliot JR, Wilkinson TJ, Hanger HC, Gilchrist NL, Sainsbury R, Shamy S, Rothwell A. 1996. The added effectiveness of early geriatrician involvement on acute orthopaedic wards to ortho-geriatric rehabilitation, N Z Medical Journal 109:72-3.

<sup>38</sup> Standards 2005 - Adult Rehabilitation Medicine Services in Public and Private Hospitals. Australasian Faculty of Rehabilitation Medicine (AFRM).

<sup>39</sup> page 272, Gray L, Moore K, Smith R, Dorevitch M. 2001. Supply of inpatient geriatric medical services in Australia. Internal Medicine Journal 37 (2007) 270-273.

<sup>40</sup> page 272, *ibid*.



The survey stated that this variation was “in stark contrast to the clearly articulated provision arrangements for residential care places that were established in 1986”.<sup>41</sup>

The promotion of integrated clinical care associated with discharge will be achieved with access to ambulatory care services such as RITH. The allocation of a dedicated service for RITH will support this process for the ACRU.

The ACR Units will have good linkages with GEM units and access to Transitional Care places to promote the appropriate placement of patients according to appropriate assessment protocols.

The ACR Units will have strong linkages to downstream referral options such as Day Therapy Centres where patients can access out-patient rehabilitation and clinic services. Linkages to ACAT’s are also necessary in order that patients are appropriately referred for community care services such as those offered by the HACC program.

The strengthening of these services at the established sites will be required as the impact of the ageing population is felt on the WA Health system.

#### WACHS Regional Resource Hospitals

Establishment of dedicated ACRU’s in the regional areas is also required to address the care needs of the older population and promote best practice across the system, although workforce constraints will limit the range of services available.

The minimum level should be:

- Visiting geriatrician supported by tele-health services
- GEM care principles
- Components of an allied health team

It is recommended that partnerships are negotiated and established between the metropolitan level 6 hospitals and WACHS to provide visiting geriatric consultation services to all Regional Resource Hospitals in WA on a sustainable basis in recognition of the lack of equity of access to such services in rural and regional areas of WA.

#### 6.3.2 Transition Care Services

The development of additional transitional geriatric services with a focus on rehabilitation and restorative care over a longer time frame, is an opportunity to close a major gap within the current WA Health care system although it will not replace the need for acute geriatric and rehabilitation services.

Transition Care Services (TCS) are an opportunity to transfer a patient between hospital and home whilst still continuing to receive appropriate care.

The program focuses on “short-term interventions to assist older people who, at the end of their stay in hospital, or when they experience a change

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<sup>41</sup> page 272, *ibid.*



in circumstances or care needs, require more time and support in a non-hospital environment to improve their capacity for independent living".<sup>42</sup> The research evidence demonstrates the positive outcomes associated with this approach.<sup>43</sup>

A service has been operating in Western Australia since 2002 It is a jointly funded program between the State and Australian Governments. The initial pilot commenced in 2005 in the North Metropolitan Area Health Service Region through a contracted private provider based at a residential aged facility.

The objectives of the program are to:

- prevent avoidable rehabilitative related re-admissions to hospital following an acute episode
- improve the transition of patients back to the community or lower levels of care
- increase patients' level of functioning
- achieve appropriate discharge of older people in hospital
- establish sustainable models of care for the provision of rehabilitation to patients following an acute admission or following admission to rehabilitation
- prevent avoidable admissions to long term or permanent residential or community care

The results of the initial pilot are in Appendix Three, Table Four. Of note were the discharge rate back to home (54%) and changes in physical functionality and marked differences in costs per episode of care. On the basis of the strong results from the pilot the program was extended.

The following tables<sup>44</sup> demonstrates the outcomes for the mainstream programs now operating and demonstrates positive results from the program, particularly for orthopaedic patients who can improve and maximise their independence over a longer period of time in a sub-acute setting at a lower level of intensity of rehabilitation.

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<sup>42</sup> page one, Western Australia Intermittent Care Service February 2005 - 30 June report. 2006. Department of Health.

<sup>43</sup> Young J, Forster A, Green J, Bogle S. Post-acute transfer, older people to intermediate care services: the sooner the better? *Age and Ageing* 2007. 36; 589-592.

<sup>44</sup> Unpublished data, Aged Care Policy Directorate. October 2007.



**Table 4. Northern TCS program**

<b>1 January 2006- 30 September 2007</b>	
Discharge destination	
Hospital	21.4%
home with or without support	49.6%
Residential care facility	16.5%
Other	12.5%
Average length of stay	55 days
	59.5% (219) clients had an orthopaedic related diagnosis
Estimated beds saved	62 beds (22,712 bed- days saved)

**Table 5. Southern TCS program**

<b>1 July 2006 - 30 September 2007</b>	
Discharge destination	
Hospital	20.8%
home with or without support	40.5%
Residential care facility	34.5%
other	4.5%
Average length of stay	48 days
	48% (170) clients had an orthopaedic related diagnosis
Estimated beds saved	47 beds (17,316 bed days saved)
TOTAL beds saved while program in operation January 2006- July 2007	109 beds

As a practice model, the TCS program is clearly beneficial to the older patient in terms of restoration of functional independence through rehabilitation over a longer time frame.

As a funding model, it is also clearly beneficial to WA Health, as not only does it promote more effective use of beds within the hospital setting, but the funding is shared between the Australian Government and WA Health. In comparison with an average bed-day cost of approximately \$700-\$1,000 in



the hospital setting, an average cost per place of approximately \$200 per day for the TCS program is beneficial to WA health.

Waiting lists occur for this service. Over a nine month period from March to November 2007, an average of 8 patients per week in the metropolitan area were waiting for a TCS place.<sup>45</sup>

Qualitative evidence from the Rehabilitation Aged Care Network sub-group indicates that this type of service option is necessary for a sustainable framework for rehabilitation services. It was also stated that, in the absence of TCS options, patients remain in the acute system or are placed in less optimal forms of care, including residential care.

The sub-group indicated that waiting lists for the service were now consistent. This has happened as the service has matured, the acute sector has begun to appreciate the benefits of the service and the type of patients suitable for TCS, particularly ortho-geriatric patients who are non-weight bearing.

Equity of access to Transition Care Services should be established at WACHS Regional Resource Hospitals in order to promote rehabilitation care “closer to home” for and reduce the activity that metropolitan hospitals provide for patients from regional and rural areas.

### 6.3.3 Well-Tel Rehabilitation Services

Services through a Well-tel rehabilitation program are designed for a specific group of patients who need further rehabilitation but are in the following circumstances:

- their home is unsuitable
- intermittent rehabilitation in another location would reverse outcomes already achieved
- a carer is not available
- limited access to rehabilitation for people who live in rural and remote locations of WA or in outer metropolitan areas where transport is an issue

Patients need to be:

- independent and self-caring
- are able to get own meals and
- self-medicating

The only Well-tel service operates at the Shenton Park Campus of RPH. A limit is placed on LOS of 10-14 days.<sup>46</sup> The average length of stay since commencement of the service in April 2006 is 11 days. It is only available to patients who are located at RPH or RPH - SPC.

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<sup>45</sup> Unpublished data, Aged Care Policy Directorate. October 2007. This trend has continued with an average of 8 patients per week waiting for a place in the north metropolitan area from January - June 2008.

<sup>46</sup> Unpublished data, Business Management Unit Royal Perth Hospital. October 2007.



The program has 18 beds in a 10 room facility and costs approximately \$70-\$100/day per patient depending upon occupancy levels.

The program is set up with minimal staffing requirements <sup>47</sup> An enrolled nurse is available from 7 am – 9pm daily with a personal alarm system for back-up. The patient is treated as an outpatient with medical supervision by a GP locum.

The data collected since commencement has demonstrated good outcomes for amputee stroke patients who require additional time in a home like environment to complete the rehabilitation process in order that they can return home to live as independently as possible.

It is recommended that this service continue to be provided at the Southern Tertiary Campus Fiona Stanley Hospital once completed and linked to the State Rehabilitation Centre as a facility in which equity of access to such a service is available for all suitable patients across WA.

Referral pathways will promote equity of access to this service on a statewide basis.

#### 6.4 Ambulatory Care

Reductions in average lengths of stay and re-admission rates to hospital are only achievable if appropriate levels of community, home and other non-inpatient services are available. A sustained commitment to providing ambulatory and community care in the context of rehabilitation and restorative care is required.<sup>48</sup>

The research evidence demonstrates the effectiveness of “rehabilitation in the home” models of care in the context of rehabilitation and restorative care. <sup>49</sup> This area of service provision is where the greatest impact can be made in terms of moving care from the sub-acute setting to the community home based setting.

The effectiveness of such models is based on:

- appropriate clinical referral criteria
- availability of a carer
- adequate post acute support services
- effective and early discharge planning process
- adequate provision of aids and equipment
- appropriately qualified and experience therapists

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<sup>47</sup> Enrolled Nurse 7am-9pm(daily), PT0.5, OT 0.5, SW 6Hrs/wk, SP 6Hrs/wk  
Cleaner 4hrs/day.

<sup>48</sup> The “Reid Review” advocates that reductions in Length of Stay, “in cases identified as requiring rehabilitation ALOS should be reduced by three days where usual LOS is 14-28 days and by 10 days where the usual LOS is 29 days. This will be achieved through the introduction /expansion of community based rehabilitation and post acute care discharge. (page 73, Reid Review).

<sup>49</sup> See Reference section.



The provision of RITH services has commenced in the Perth Metropolitan area.<sup>50</sup>

It is recommended that strategies are commenced to develop clinical criteria in order to target older patients who are suitable for RITH and early supported discharge programs.

Factors such as the availability of a carer, additional co-morbidities and cognitive decline need to be taken into account during the assessment process.

It is recommended that Departments of Geriatric Medicine/Aged Care Services, and the ACRU's have access to dedicated "RITH" services in order that integrated clinical care in a timely manner is promoted.

In order to achieve cost-effectiveness, service delivery will need to increase in order to increase RITH to a level that achieves economies of scale.

## 6.5 Community Rehabilitation

### 6.5.1 Day Therapy Centres (Outpatient Day Hospitals)

Older patients will be referred to Day Therapy Centres from an admitted inpatient referral source or Emergency Department screening processes or from the primary care sector.

Targeted strategies should be developed to identify older patients at risk of functional decline, during the risk screening process carried out by Care Coordination Teams and their referral initiated to the Day Therapy Centres, thereby by-passing the admitted inpatient pathway for those patients where it is identified that an increase in community services will be beneficial but also require some medical intervention.

Day Therapy Centres to include:

- Falls Clinic
- Parkinson's Disease
- Stroke
- Continence
- Memory
- Amputee therapy
- Generic conditions associated with the de-conditioning process

In addition to therapy services a key function will be regular review of the patient's progress, including the provision of community care support services to maintain the client and carer to live independently in the community.

It is recommended that the current terminology of Day Hospital Clinics should be altered to "Day Therapy Centres" to increase the focus on moving

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<sup>50</sup> RITH episodes of care for Royal Perth Hospital and QEII for April 2004/2005 were 1,175 and in April 2005/2006 the number of referrals was 1,831 indicating an increase of 56%. At Fremantle Hospital this service commenced in July 2005 and in April 2006 there were 383 patients.<sup>50</sup>



care away from hospitals and a focus on overall wellness approach to healthcare.

Expansions in community based and ambulatory care services will be contingent on expansions in allied health workforce capacity, dedicated programs and services and infrastructure requirements.

It is recommended that a commitment is made to the establishment of multi-disciplinary teams (MDT's) that are attached to Day Therapy Centres with the ability to provide targetted outreach services rehabilitation services in the community. Commitment to the associated infrastructure is required to support this approach.

It is recommended that a specific model of care be developed that focuses on the delivery of services from Day Therapy Centres.

#### 6.5.2 Mobile Support Teams

Community and ambulatory care rehabilitation therapy services will be supported by mobile allied health teams that provide such services. Infrastructure support will accompany these teams.

This component of the model should be modelled on the Rehabilitation Aged Care Intervention and Liaison Service (RAILS) initiative at Osborne Park Day Hospital. RAILS has developed specific strategies that target older people over 65 years of age who live in the community.

The strategies aim to:

- prevent unnecessary admissions to an emergency department through a rapid response team that acts on urgent community referrals and provision of MDT services
- decrease in length of stay on ACRU ward through coordinated discharge planning and provision of RITH services
- prevention of readmissions through post discharge support of at risk patients including RITH and Saturday nursing follow-up
- same day contact for elderly person upon referral from the community

Financial savings have been made since the establishment of the program, with an estimated 393 bed days saved over the 2006-2007 financial year.<sup>51</sup>

It is recommended that mobile outreach services should target older people at risk of re-presenting to hospital through integrated "rapid response teams" (RRT's) within a mobile outreach service and be attached to Day Therapy Centres to promote effective integration.

#### 6.5.3 Liaison officer attached to Day Therapy Centres

Liaison officers attached to Day Therapy Centres that focus on clients living in the community should be able to receive, manage and coordinate requests from the care team at a general practice for assessment and management of specific acute and gerontological problems that are amenable to rehabilitation therapy and are able to be managed on an

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<sup>51</sup> Unpublished data. Osborne Park Hospital, RAILS program. November 2007.



outpatient basis in the community, thereby avoiding unnecessary presentations to an acute hospital.<sup>52</sup>

Liaison officers should also provide linkage and coordination roles to mobile outreach teams (including integrated rapid response teams), existing community care service providers and community based outreach rehabilitation therapy services. They should exist as a minimum at metropolitan Level 6 hospitals.

### **WACHS Regional Resource Hospitals**

Tele-health services may support clinicians and allied health professionals in the delivery of community based rehabilitation services in regional and rural areas.

Visiting geriatrician consultancy services established through an agreement between the tertiary hospitals and WACHs will support allied health professionals in follow-up case management.

Rural hospitals should seek to extend their ability to provide slow-stream and step-down rehabilitation therapy services as part of a regional “hub and spoke” model of service delivery.

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<sup>52</sup> This component of the model should be modelled on the service provided at Osborne Park Day Hospital.



## 7. SUPPORT SERVICES

### Role of effective discharge planning and provision of support services

Effective patient outcomes for the older person in the context of rehabilitation and restorative care is dependent on an appropriate range of support services that assist the older person and their carer to live independently in the community. The services are:

- Care Coordination Team Discharge Packages linked to ED discharge
- Post Acute Care Community Support packages
- Personal Enablement Packages (PEP)
- Hospital In The Home (HITH)
- Post Discharge Support Services
- RITH
- Community based physiotherapy services
- Medication Reviews by Community Pharmacists
- Rapid Response Teams
- Aids and equipment services
- Referral to HACC services

These services should be considered as integral components of rehabilitation and restorative care therapy.

Programs such as community based physiotherapy services based in the community with referral linkages from hospital at discharge, Chronic Disease Management Teams, Aged Care Departments of public hospitals, HITH, RITH, General Practitioners and non-government organisations provide opportunities for clients to self-manage their rehabilitation program and on-going maintenance in the community. The provision of such services aligns with the “wellness” approach to the maintenance of functional mobility and the ability to live independently in the community.

These services also serve to support the older person and the carer both psychologically and physically, while recovering from an illness or reversible condition that has caused functional impairment.

### Role of Assessment Services

The timely provision of assessment services through the Aged Care Assessment Teams is instrumental in providing access to community care services through the HACC program or TCS service.

A standardised assessment instrument at entry for risk screening identification, and documentation across sites will promote consistency of care and outcomes.

### Role of effective linkages and referral mechanisms

The facilitation of a co-ordinated, smooth journey through the various clinical pathways will be supported by effective communication processes and a single electronic patient record that will accompany the patient as they transfer from one care sector to another.



Effective linkages will also occur between the metropolitan Level 6 hospitals, ACRU's and regional resource hospitals to promote care coordination. Tele-health support services will support clinicians and allied health professionals at regional resource hospitals.



## 8. SUPPORT INFRASTRUCTURE

The following considerations apply to an effective model of care at the service delivery level:

### Workforce

- adequate FTE allocation for access to rehabilitation provision, with due consideration to travel time for community/ambulatory based services.
- interdisciplinary rehabilitation teams with full compliment of disciplines
- based locally for local service provision
- recognition of need for full integration of Aboriginal Liaison Officers and Health Care workers in the Rehabilitation Care Team.
- recruitment and retention strategies including a focus on allied health staff

### Infrastructure

- mobile teams attached to Day Therapy Centres will require appropriate resources to support provision of mobile services including vehicles and appropriate information and technology equipment
- services that support “care closer to home” will require office and treatment space within appropriate community setting and telecommunication linkages with other health service providers
- assessment and treatment areas may need to be multipurpose designed to cater for Multi-Disciplinary Team working.
- security for tracking home visiting workers

### Education and training

- inter-professional learning at a tertiary level
- workforce appropriately trained and supported within Aged Care and Rehabilitation care Teams/Units
- future direction of professional training to consider practitioners, clinical specialists, support workers and therapy assistants to be multi-disciplinary with common general skills
- training on indicators for rehabilitation and restorative care through comprehensive assessment processes
- ongoing research into multi-disciplinary team approaches to support practice improvement and training on effective delivery of ambulatory care services for rehabilitation
- primary care education for General practitioners on availability of rehabilitation services and referral pathways

### Information and communication technology

- single patient electronic record
- use of Tele-health - video and tele-conferencing particularly for rural and remote areas
- consistent data collection processes and collection platforms



### WACHS Specific Issues

- additional FTE funding to support gaps in workforce
- expansion of Tele-health services
- visiting geriatrician consultancy services established through an agreement between the tertiary hospitals and WACHs to support clinicians and allied health professionals in follow-up case management.
- training in the delivery or rehabilitation models of care, particularly ambulatory and community based models.
- adequate provision of rehabilitation equipment supported by CAEP funding



## Patient Journey Ambulatory Care Pathway

An elderly man lives at home with his wife in the community.

He has diabetes and osteo-arthritis. He has recently had increasing difficulty mobilising around his home and completing his Activities of Daily Living (ADL's). He now requires help from his wife.

The man attends his GP with his wife. The GP accesses his patient electronic record with information about past health care contact within WA.

The GP uses a standardised documentation/assessment process and identifies patients need best addressed by ambulatory care MDT.

The GP contacts local ambulatory care service and refers patient for MDT assessment and management.

An appropriate member of the Ambulatory Care team will be designated as patient's care coordinator and act as liaison between team, patient and other services.

The MDT Ambulatory Care Service accesses patient electronic record with all relevant information and attends patient and his wife at their home.

MDT services may include OT, PT, SW, Nursing (or for others, Dietetics, Podiatry)

The elderly man receives appropriate input including equipment provision and short term home service support while receiving rehabilitation input at home. Standardised documentation with the single patient record identification is used.

The elderly man regains previous functional ability according to standardised assessment tools. The Ambulatory Care team refers the patient to a maintenance HACC program within his community that also provides transport support.

The GP is notified electronically of the progress and discharge outcomes via the single patient record.

The single-patient record system will include a flagging-type system for recall/review of patient as appropriate.

*NB: this case example does not reflect the chronic aspect of some of the conditions that patients receive treatment for in the acute and sub-acute sector. It is important to consider this within 'the system', in the context of management of patients with chronic and/or degenerative conditions*



## GLOSSARY

(in serial order)

SRC	State Rehabilitation Centre
ACRU	Aged Care Rehabilitation Unit
TCS	Transitional Care Service
CAP	Care Awaiting Placement
RITH	Rehabilitation in the home
CACP	Community Aged Care Package
EACH	Extended Aged Care at Home
ABS	Australian Bureau of Statistics
GEM	Geriatric Evaluation and Management
SRSP - WA	Statewide Rehabilitation Services Plan - WA
ED	Emergency Department
WACHS	WA Country Health Services
CCT	Care Coordination Team
COAG	Council of the Australian Government
CSF	Clinical Services Framework
ACRU	Aged Care Rehabilitation Unit
RPH - SPC	Royal Perth Hospital Shenton Park Campus
HITH	Hospital in the Home
GP	General Practitioner
SOYFWA	Stay On Your Feet WA
HIP	Home Independence Program
SCNA	Silver Chain Nursing Association



NOF	-
ACAT	Aged Care Assessment Team
HACC	Home and Community Care
MDT	Multi-disciplinary Team
RAILS	Rehabilitation and Aged Care Intervention and Liaison Service
PEP	Personal Enablement Package
RRT	Rapid Response Team
FTE	Full time equivalent
CAEP	Community Aids and Equipment Program
CVA	Coronary Vascular Attack
ATSI	Aboriginal and Torres Strait Islander
RPH	Royal Perth Hospital
RN	Registered Nurse
SP	Speech Pathologist
SRN	Senior Registered Nurse
PT	Physiotherapist
OT	Occupational Therapist
ED	Emergency Department
ICAM	Information and Collection and Management (Branch)



## APPENDICES

### Appendix 1: Definition of Rehabilitation Services

Rehabilitation and or/restorative care services are provided to patients who have completed their acute surgical or general medical care and have experienced a decline in their overall physical health condition while this has taken place. For example, patients who have experienced a fracture or a stroke, or present with conditions such as Parkinson's disease, benefit from such services.

A person with a disability participates in a multi-disciplinary program aimed at improvement in functional capacity, retraining in lost skills and/or changes in psychosocial adaption including people with complex, multi-dimensional medical problems associated with disabilities and /or psychosocial problems, usually but not always, an older person.

The primary treatment goal is the improvement in functional status and optimising living arrangements evidenced by:

- An individualised and documented initial periodic assessment of functional ability, psychosocial needs and complex medical problems by use of a recognised functional assessment measure.
- A multi-disciplinary rehabilitation plan working towards negotiated rehabilitation goals and including time-frames
- Regular review of current management plan and rehabilitation goals<sup>53</sup>

Rehabilitation services can be delivered in a designated specialised rehabilitation unit under the care of a rehabilitation physician or an aged care rehabilitation unit under the care of a geriatrician where the principle intent is the improvement in functional terms and organisation of living arrangements to accommodate the functional status of the person.

The chief long term aims are to:

- maximise independence and quality of life for people with a disabling medical condition, and maximise the likelihood that they will remain or become active and productive members of the community; and
- minimise the long-term health care needs and community support needs of these people, and so bring about considerable cost savings both in acute health care and in long-term social security, community care and supported accommodation.

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<sup>53</sup> Technical Bulletin 3/7; Operational Instruction 1947/05  
Rehabilitation Program - All Public Hospitals in Western Australia  
Department of Health <http://www.intranet.health.wa.gov.au/circulars>



## Appendix 2: Methodology

### Stage One

The model of care has benefited from the extensive and inclusive consultations that took place across the WA Health system for the development of the SRSP - WA 2005. The recommendations regarding the broad service configurations were subsequently reflected in the WA Health Clinical Services Framework 2005-2015.

It was therefore thought inappropriate to commence such extensive consultations once again, particularly as the ACRU's have already commenced with secondary hospital level rehabilitation services.

### Stage Two

A targetted approach to developing the model of care was therefore adopted in the context of the Aged Care Network Rehabilitation sub-group.

The key objectives of the group were to:

- confirm the establishment of the proposed model that has already been partially adopted and
- investigate the types of specific service models appropriate to the varying rehabilitation and restorative care needs of the specific subsets of the target population that require such services.

The following steps were adopted:

1. The Rehabilitation Network Sub-group was established comprising the following representation:
  - Clinical Lead of the Aged Care Network/Geriatrician
  - Geriatric medicine physicians from the North and South Metropolitan Area Health Services
  - Senior allied health staff from the North and South Metropolitan Health Services
  - Silver Chain Nursing Association - Community Care services
  - WACHS - Ambulatory care services
2. A template was used as a guide to gather baseline data and distributed to all sub-group members.
3. Data research from the Information, Collection and Management Branch of WA Health was incorporated.
4. A literature search, including reference to past departmental reviews, international guidelines and reviews informed the development the model of care.
5. Consultation with Carers WA and WACHS was undertaken.



Busy work schedules and participation on other network sub-groups limited the number of “face to face” meetings. A large part of the communication and consultation process was conducted electronically, in recognition of the benefits of operating as a “virtual” network sub-group.

Further feedback on the document was sought at the Aged Care Network held on 9th April, 2008.

Questionnaires relating to the model were distributed across the WA Health system to seek further input.



### Appendix 3: Current Service Delivery Model

The characteristics of the current service delivery environment are the predominance of rehabilitation services in the inpatient setting. Tertiary and secondary hospital settings currently provide the bulk of rehabilitative and restorative care.

#### Volume of services

An analysis of the number of rehabilitation inpatient therapy episodes for the 65+ age group indicates the following trends:

- the number of episodes of care increased substantially between 2001 - 2002 and 2005-2006.
- the number of episodes of care increases with age

Rehabilitation therapy episodes can also take a considerable time to complete with length of stays lasting up to 3-4 months.

**Table 1: Rehabilitation therapy episodes (including GEM) across the WA public hospital system<sup>54</sup>**

	2001-2002	2005-2006
Age range		
0-66	968	1541
66-80	1331	2341
81+	1637	2931
Total	3936	6813

#### Activity

##### Inpatient activity

Tables Two and Three describe the rehabilitation activity that occurs across the WA health system.

The activity is characterised by very little GEM activity in the major level 6 hospitals with the exception of RPH and a disproportionate amount of rehabilitation in the acute level 6 hospitals Fremantle and Sir Charles Gardiner (where there are links to level 5 sub-acute ACRU's).

The number of episodes almost remained the same across the metropolitan region between 2005/06 and 2006/07, but the total length of stay decreased by approximately 5000 days or the equivalent of 13 beds.

<sup>54</sup> These are raw recorded episodes. Interruptions due to dialysis, pin removal, etc split some episodes into 2 or more which increases numbers. Transferring a patient from one hospital to another during a rehabilitation episode will also lead to two episodes being recorded. Estimates are that these factors increase the numbers by 10%.

Data provided by the Epidemiological Branch of WA Health, June 2007 and sourced from the WA Health morbidity system. Peel, Joondalup and Mercy Hospitals are not included.



**Table 2: Inpatient Rehabilitation Activity - WA Health System**

HEALTH REGION	HEALTH SERVICES IN THE REGION	SUB ACUTE ADMITTED (Inpatient) 2005-2006				SUB ACUTE ADMITTED (Inpatient) 2006-2007			
		Rehabilitation		GEM		Rehabilitation		GEM	
		Episodes	LOS	Episodes	LOS	Episodes	LOS	Episodes	LOS
NORTH METRO	Joondalup Health Campus	302	5358			294	5030		
	Kalamunda District Community Hospital	26	408			19	399		
	Mercy Hospital	271	7894			245	6522		
	Osborne Park Hospital	968	19879			904	19217		
	Royal Perth Hospital	398	3973	602	5508	403	4182	623	5696
	Royal Perth Hospital Shenton Park Camp	631	14496			636	12866		
	Selby Authorised Lodge (Mhs)	1	189						
	Sir Charles Gairdner Hospital	829	7492	1	2	923	8398	1	6
	Swan District Hospital	225	6851	8	116	240	7057	5	167
	<b>Total</b>	<b>3651</b>	<b>66540</b>	<b>611</b>	<b>5626</b>	<b>3664</b>	<b>63671</b>	<b>629</b>	<b>5869</b>
SOUTH METRO									
	Armadale/Kelmscott District Memorial Hospital	269	7644			247	6807		
	Bentley Hospital	444	11860			420	11816		



	Fremantle Hospital	764	20756	4	72	782	15696	12	222
	Kaleeya Hospital	7	134			25	334	2	4
	Murray District Hospital [Pinjarra]					5	93		
	Peel Health Campus	134	3465			159	3371		
	Rockingham - Kwinana District Hospital	2	48			12	197		
TOTAL		1620	43907			1650	38314	14	226



**Table 3: Rehabilitation activity in the regional and rural areas of WA Health system**

Health Region	WA COUNTRY HEALTH SERVICES	SUB ACUTE ADMITTED (Inpatient) 2005-2006				SUB ACUTE ADMITTED (Inpatient) 2006-2007			
		Rehabilitation		GEM		Rehabilitation		GEM	
		Episodes	LOS	Episodes	LOS	Episodes	LOS	Episodes	LOS
GREAT SOUTHERN	Albany Regional Hospital	14	37			19	356		
	Denmark District Hospital	2	24			2	19		
	Katanning District Hospital	7	71			6	59		
	Kojunup District Hospital					2	40		
	Kondinin District Hospital	1	6			2	138		
	Narrogin District Hospital	5	74			10	145		
	Plantaganet District Hospital	2	49			6	125		
	Corrigin District Hospital					1	47		
	Pingelly District Hospital					3	18		
	Wagin District Hospital					1	32		
SOUTH WEST	Augusta District Hospital	6	145			7	100		
	Bridgetown District Hospital	2	82			6	113		
	Bunbury Regional Hospital	12	239			22	314		
	Busselton District Hospital	17	180			37	670		



	Collie District Hospital	6	119			16	273		
	Donnybrook District Hospital	5	86			8	107		
	Gnowangerup District Hospital	1	25						
	Harvey District Hospital	6	137			8	140		
	Yarloop District Hospital	1	48						
	Margaret River District Hospital	2	33			3	102		
	Warren District District Hospital					5	77		



Health Region	WA Country Health Service	SUB ACUTE ADMITTED (Inpatient) 2005-2006				SUB ACUTE ADMITTED (Inpatient) 2006-2007			
		Rehabilitation		GEM		Rehabilitation		GEM	
		Episodes	LOS	Episodes	LOS	Episodes	LOS	Episodes	LOS
CENTRAL WHEATBELT	Beverly District Hospital	2	136			2	19		
	Bruce Rock Memorial	4	75			1	10		
	Dalwallinu District Hospital	1	61						
	Kununoppin District Hospital	5	103						
	Northam Regional Hospital	39	747			38	690		
	Merredin District Hospital					7	193		
	Moora District Hospital					2	18		
	Narrembeen District Hospital					1	17		
	Quaraiding District Hospital	4	27			4	113		
	Wongan Hills District Hospital	2	19			1	41		
	Wyalkatchem - Koorda District Hospital					1	4		
York District Hospital	3	44			3	60			



		SUB ACUTE ADMITTED (Inpatient) 2005-2006				SUB ACUTE ADMITTED (Inpatient) 2006-2007			
		Rehabilitation		GEM		Rehabilitation		GEM	
		Episodes	LOS	Episodes	LOS	Episodes	LOS	Episodes	LOS
KIMBERLY	Broome District Hospital	9	147			9	219		
	Derby Regional Hospital	5	175			6	126		
	Fitzroy Crossing District	1	2						
	Kununurra District Hospital	3	28			6	90		
GASCOYNE	Carnarvon District Hospital	2	43						
	Kalbarri Health Service	1	5						
	Carnarvon District Hospital	2	43						
GOLDFIELDS	Kalgoorlie Regional Hospital	23	487			5	97		
	Esperance District Hospital	4	54			9	146		
	Norseman District Hospital					3	63		
MIDWEST	Geraldton Regional Hospital	13	247			40	760		
	Meekatharra District Hospital	1	6						
PILBARA	Port Hedland Regional Hospital	8	80			6	165		
	Nickol Bay District Hospital	1	6			2	37		
	Roebourne Dist Hosp.	3	30			2	31		
TOTAL		223	4187			312	5774		



## Day Hospital service levels

Day Hospital services are provided to a specific catchment area. Referrals are received for patients initially managed in the community, requesting assessment and management for specific acute and chronic gerontological problems such as Parkinson’s disease, Stroke and Falls. Day Hospital Services provide treatment to those who are community dwelling.

Waiting times for services vary between catchment areas. Access to service can vary according to patient transport needs and variability between transport assistance available/provided.

Conclusions regarding efficacy and cost effectiveness of out-patient non-admitted activity across the WA Health system are difficult to make. Different electronic recording systems, a lack of consistent data definitions and dedicated support for collection and recording has contributed to a situation where access to data is time consuming, varies in quality and is site specific. This makes it difficult to make informed statements about system capacity and development of outpatient non-admitted services.

## Transition Care Program

Table Three outlines the distribution of the service.

Table 4: Transition Care Program.

Transition Care Program	Flexible Places
South Metro	30 residential places
	20 community places
North Metro	20 residential places
	30 community places
Total	100 flexible care places
Rural	
Midwest	20 community places
Lower Great Southern	20 community places
South-West	20 community places
Total	60 places

## Initial Pilot Results

- Of all clients (199) a total of 109 (54.8%) were able to return home
- Of those clients who were ACAT assessed for high care, 35.8% returned home while for those clients who were ACAT assessed for low care, 62.3% returned home;
- a positive general improvement in physical function as measured by the overall average admission MBI of 72.0 at admission and 83.7 at discharge
- the average daily cost of residential-based services was \$337 with the associated average episodic costs being in the order of \$14,626; and



- the average daily cost of community-based services was \$66 with the associated average episodic costs being in the order of \$4,416.<sup>55</sup>

On the basis of the strong results from the pilot the program has been mainstreamed as an aged care program with recurrent funding from the Australian and State Governments.

TCS became operational in the South West from September 2007, and services in the Midwest and Lower Great Southern began in January 2008 and May 2008 respectively. Residential TCS is not available in rural or remote areas. However, the South West has a 5 virtual bed TCS model successfully operating. The TCS model in the Great Southern and Midwest also provides this virtual bed option.

Demand for TCS residential currently outstrips the supply, especially in the north metropolitan area, where waiting lists for residential services exist. Qualitative information from the sub group and from transition care service providers indicate that there is potential for a greater number of referrals to the service if patients could be accommodated more quickly. Delays in access result in some older patients needing to stay longer in hospital. Increasing TCS residential places in the metropolitan area would enable a more appropriate and timely discharge of older patients from hospital.

As TCS is a jointly State and Commonwealth funded program, expansion is dependent on an offer of places from the Australian Government. Additional places should be pursued to expand the program and to secure Australian Government funding.

### **Rural Rehabilitation and Aged Care**

The small proportion of the older population<sup>56</sup> that live outside the metropolitan area (26%) combined with the geographic spread of the rural population and no rural centre with a population of more than 30,000 compounds the difficulty of providing a comprehensive and responsive rehabilitation service in regional areas of WA.

Very few inpatient rehabilitation beds are located in rural areas; Albany Hospital has 2 beds exclusively for stroke rehabilitation (located in an acute ward) and there are 6 beds located within the Geraldton Regional Hospital. However, lack of appropriate staff has not allowed these beds to become operational.

Data sourced from WACHS indicates the paucity of rehabilitation services provided across the rural and remote regions of WA. As a care type, rehabilitation does not feature in the top 10 reasons for admission for the 65+ age group for each of the WACHS regions, with the only exception of the Pilbara Region where there were only 10 admissions for rehabilitation.<sup>57</sup>

The implication of this situation is that significant numbers of patients with conditions requiring rehabilitation are transferred to metropolitan tertiary

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<sup>55</sup> page 59-60. Evaluation of the WA Transitional Care Pilot - Final Report. Department of Health and Ageing. 2006.

<sup>56</sup> 65+ and the ATSI 45+ population cohort

<sup>57</sup> Unpublished HMDS data. WA Health. October 2007.



hospitals. While patients may be returned to their local rural hospital to complete rehabilitation, more often they are rehabilitated at Shenton Park Campus of RPH, or in an aged care rehabilitation unit in the metropolitan area. They may also remain on an acute orthopaedic ward until discharged home.

Complex cases for example, stroke and fractures, receive acute care in a metropolitan hospital area and may return to a regional or rural hospital for aftercare in either a sub-acute or community setting.

In a limited number of cases, where complex care is not required, they are managed by the local general practitioner and/or services of a private allied health professional.

The provision of allied health services in rural areas is limited due to shortages in the workforce. The efficacy of discharge planning and liaison is an important issue when a patient is transferred from the metropolitan to rural hospital.

A sub-acute care service (Transition Care) has recently commenced in the South-West (Bunbury) and Great Southern (Albany) through a contracted private provider.

The lack of rehabilitation/geriatric medicine physicians is a problem for rural areas, with considerable equity of access issues across the state. Suitable visiting arrangements for publicly funded visiting physicians in rural areas have not been established between WACHS and the metropolitan hospitals. There is also a reported lack of private physicians in rural and regional centres.

There are also special problems associated with the ATSI population relating to language, and lack of engagement with rehabilitation programs.

### **Rehabilitation Technology Unit**

The primary statewide unit providing rehabilitation technology and equipment services operates from RPH - Shenton Park Campus.

Rehabilitation Technology Unit - services both the SRC and rehabilitation patients throughout the state and provides the following services:

- comprehensive rehabilitation engineering, prosthetic, orthotic and assistive device
- unit based and outreach services across the state
- service delivered through the central RTU, satellite service units, metropolitan and rural outreach services and tele-health support

### **Equipment Services**

- equipment services are also provided by occupational therapy, speech pathology, physiotherapy and other departments in a number of major hospitals and health services.
- they are a mix of hospital funded and CAEP services
- there are different criteria with respect to the issue of equipment
- provision ranges from temporary loans to permanent issue



#### Appendix 4: Clinical Services Framework Configuration

MEDICAL SERVICES	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
<u>GERIATRIC</u>	Care is carried out by GP's (potentially visiting) with or without assistance of RN's depending on the type of patient care needed	As for Level 1 plus: - inpatient and outpatient care - visiting GP and possible visiting general physician - 24 hour cover by RN and by GP	As for Level 2 plus: - inpatient and outpatient care - resident GP and visiting general physician - 24 hour cover by RN and GP - respite care and limited rehabilitation services	As for Level 3 plus: - access to consultant physician specialising in geriatric medicine - active assessment and rehabilitation services for inpatient and outpatient hospitals	As for Level 4 plus: - inpatient care by resident specialist - registrar/RMO - link with inpatient rehabilitation unit - inpatient assessment unit and domiciliary consultant services - access to specialist SRN -some undergraduate teaching - links with geriatric psychiatry services	As for Level 5 plus: - resident geriatrician - postgraduate and undergraduate and teaching role - statewide referral role



REHABILITATION SERVICES	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
<i>REHABILITATION</i>	<ul style="list-style-type: none"> <li>- Visiting consultative services provided on request</li> </ul>		<ul style="list-style-type: none"> <li>As for Level 1 plus:</li> <li>- regular visiting provided by district/regional allied health staff</li> <li>- limited level allied health staff availability</li> </ul>	<ul style="list-style-type: none"> <li>As for Level 3 plus:</li> <li>- full time salaried physiotherapy, Occupational therapy</li> <li>- speech and social work services</li> <li>- district referral role</li> <li>- limited day hospital program</li> </ul>	<ul style="list-style-type: none"> <li>As for Level 4 plus:</li> <li>- rehab program for both in/outpatient</li> <li>- linkages between regions and designated metropolitan hospitals</li> </ul> <p>Day Hospital:</p> <ul style="list-style-type: none"> <li>- Memory clinic</li> <li>- Falls clinic</li> <li>- Continence clinic</li> <li>- A GEM unit if ED services collocated</li> <li>- Part time geriatrician services</li> <li>- Rehabilitation specialist with experienced RN/PT/OT/SP/Dietician</li> <li>- Collocated Psychogeriatric services</li> </ul>	<ul style="list-style-type: none"> <li>As for Level 5 plus:</li> <li>- GEM unit</li> <li>- access to acute care</li> <li>- full time rehab specialist</li> <li>- full time geriatrician</li> <li>- tertiary level rehab services (Statewide Rehab Centre) only in one level 6 hospital with full time clinical director</li> </ul>



AMBULATORY CARE SERVICES	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
<u>REHABILITATION</u>	- GP only	As for Level 1 plus:  - GP and specialist outpatient clinic at discharge hospital - limited access to generalist domiciliary nursing	As for Level 2 plus:  - visiting specialist - some hospital avoidance/hospital substitution - some early discharge services - access to generalist domiciliary nursing and some allied health	As for Level 3 plus  - increasing range and complexity of hospital substitution/avoidance/early discharge - chronic disease programs - resident/ visiting medical specialist - good access to generalist/allied health/nursing staff	As for Level 4 plus:  - specialist medical/nursing/allied health staff - increased range and complexity - HACC integration - enhanced diagnostics - teaching and training role	As for Level 5 plus:  - research role - fully integrated ambulatory care services Fully integrated diagnostics - includes regional subacute centre/service



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