



Health
South Eastern Sydney
Local Health District

COAG Subacute Programme Report:

Rehabilitation

August

2012

This summary report has been designed to critically evaluate the effectiveness of Council of Australian Governments (COAG) funding enhancements to the Rehabilitative Medicine Unit at Calvary Healthcare for the period of 1 July 2009 to 30 June 2012. Recommendations of improvements for future service delivery and data reporting are provided.

Calvary
Healthcare

DRAFT

Council of Australian Governments (COAG) Subacute Allied Health and Clinical Data Project
Division of Primary and Ambulatory Healthcare
South Eastern Sydney Local Health District

Table of Contents

| | | |
|------------|---|-----------|
| 1.0 | EXECUTIVE SUMMARY | 4 |
| 2.0 | INTRODUCTION..... | 5 |
| 2.1 | SES LHD..... | 5 |
| 2.2 | NATURE OF COAG FUNDING..... | 5 |
| 2.3 | COAG KEY PERFORMANCE INDICATORS | 5 |
| 2.4 | ALIGNMENT TO SUBACUTE CARE SCHEDULE C OBJECTIVES | 7 |
| 3.0 | BACKGROUND TO CCH COAG REHABILITATION ENHANCEMENT..... | 8 |
| 3.1 | KEY PERFORMANCE INDICATORS | 8 |
| 3.2 | DESCRIPTION OF LOCAL REHABILITATION MODELS OF CARE | 8 |
| 4.0 | MODEL 1 : INTENSITY OF THERAPY PROGRAMME (ITP) | 9 |
| 4.1 | DESCRIPTION OF MODEL OF CARE | 9 |
| 4.2 | RECRUITMENT CONSIDERATIONS | 9 |
| 4.3 | SERVICE DEVELOPMENT | 10 |
| 5.0 | KEY PERFORMANCE INDICATORS | 12 |
| 5.1 | COAG KEY PERFORMANCE INDICATORS | 12 |
| 5.1.1 | <i>Increase subacute bed activity.....</i> | <i>12</i> |
| 5.2 | INTENSITY OF THERAPY (ITP) | 13 |
| 5.2.1 | <i>Average length of stay.....</i> | <i>13</i> |
| 5.2.2 | <i>Number of separations</i> | <i>15</i> |
| 5.2.3 | <i>Improvement in patient Functional Independence Measure (FIM) outcomes.....</i> | <i>16</i> |
| 5.2.4 | <i>Effectiveness of the rehabilitation service</i> | <i>18</i> |
| 5.2.5 | <i>Discharge destination</i> | <i>20</i> |
| 6.0 | RECOMMENDATIONS..... | 21 |
| 7.0 | TABLE OF ABBREVIATIONS..... | 22 |
| 8.0 | LIST OF FIGURES..... | 23 |
| 9.0 | LIST OF TABLES..... | 24 |

1.0 Executive summary

This is the first of a series of reports designed to detail the performance of Council of Australian Governments (COAG) subacute Allied Health funding enhancements in General Rehabilitation at Calvary Healthcare (CCH).

General Rehabilitation accepted the COAG enhancements in the form of the Intensity of Therapy (ITP) programme. The programme was introduced in March 2010, following consultation between the Director of Rehabilitation and Allied Health Heads of Department.

COAG determined that the formal key performance indicator (KPI) was to provide a 5% increase in subacute activity incrementally for four years from 2009/10 FY. This report outlines the programme-specific outcome measures that have been developed to provide a more detailed reflection of performance, including the contribution of Allied Health.

Overall, the COAG funded rehabilitation programmes at CCH have achieved:

- (i) CCH achieved 38% above their COAG total subacute bedday target
- (ii) CCH achieved 51% above their COAG rehabilitation bedday target
- (iii) Better utilisation of subacute General Rehabilitation beds through:
 - decreasing LoS (10% for 07/08 v 11/12, 31% for 08/09 v 09/10)
 - increasing number of separations (36% for 07/08 v 11/12)

Several recommendations are made for future actions, at a local health district, facility and discipline level.

2.0 Introduction

2.1 SES LHD

The demand for rehabilitation services continues to grow with the latest national data revealing a growth of 6.3% (2008), with further significant growth expected over the next two decades. Research also reveals that an increased length of stay in an acute setting directly relates to an increase in length of rehabilitation required (this group doubled between 2006 and 2008)¹

By 2022, SESLHD subacute inpatient activity is expected to increase to between 12,000 to 16,000 episodes of care and 146,000 bed days.

Of the 11, 579 subacute episodes of care recorded in SES LHD in 2009/10:

- 70% were for rehabilitation (accounting for 64% of all beddays)
- 74% were among people aged 70 years or older (46% among people aged 70-84 years old and 28% were older than 85 years)

Of the 8,115 rehabilitation episodes of care in SES LHD in 2009/10, 89% were for three clinical groups: orthopaedic, other disabling impairment and stroke.²

2.2 Nature of COAG funding

COAG funding was provided to the former SESIAHS in 2009/10 for the enhancement of sub acute services over the next 4 years. This funding is tied to an increase in subacute activity by 5% per year from 2009/10 across the subacute care types of:

- Rehabilitation
- Geriatric Evaluation and Management (GEM),
- Palliative Care
- Psychogeriatrics

2.3 COAG key performance indicators

COAG determined that the formal key performance indicator (KPI) was to provide a 5% increase in subacute bed activity incrementally for four years commencing 2009/10FY. The increased activity is collectively achieved across inpatient and non-admitted patient domains for the four subacute care type categories. Baseline figures were derived from subacute activity for 2007/08FY.

The achievement of the primary KPI can be made via any of the following mechanisms:

- (i) Inpatient domains:
 - Increase number of subacute beds
 - Increase the occupancy rate of the subacute bed base without increasing the number of subacute beds
 - Increase the occupancy rates of the subacute bed base and increase the number of subacute beds
- (ii) Non-admitted patient domains:
 - Increase subacute non-admitted patient occasions of service (NAPOOS)

¹ NSW Rehabilitation Redesign Project Report 2011

² SES LHD Subacute Inpatient Activity Factsheet (January 2011)

SESLHD subacute and rehabilitation performance

The progress to date across all subacute care types in SESLHD is shown in Figure 1. Although the COAG KPI is applied globally across all sub-acute categories, for comparison purposes the rehabilitation sub-acute category has also been shown with the 5% KPI applied in Figure 2.

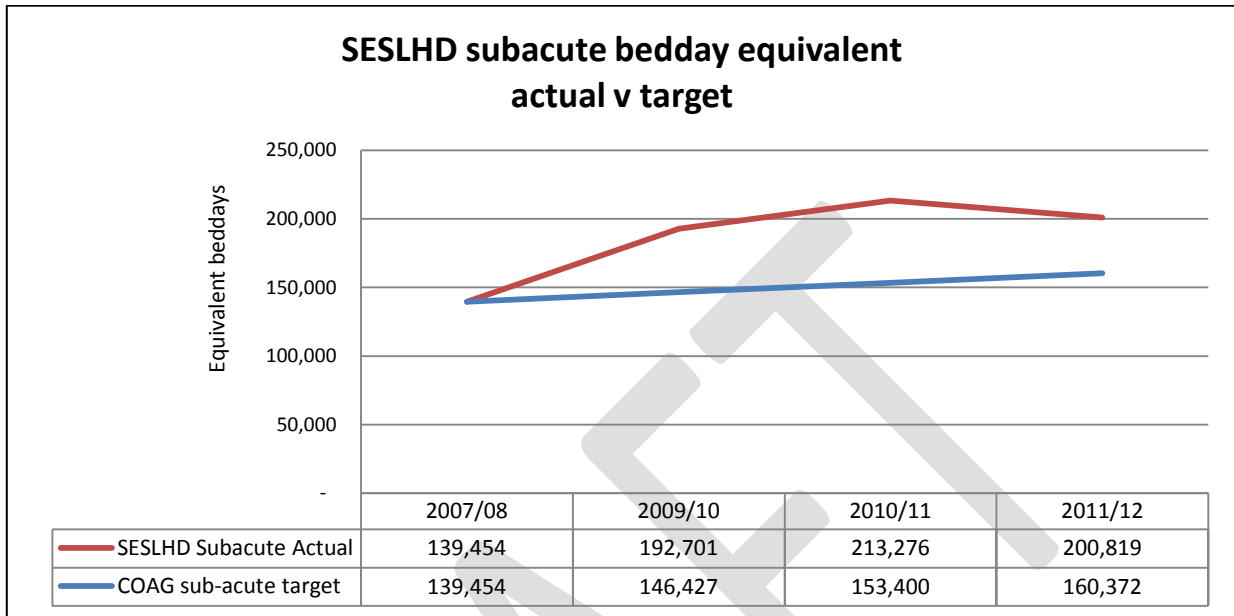


Figure 1: SESLHD subacute performance against COAG KPI target (source: SPaRC)

- 32% increase in total subacute bed activity above COAG target (606, 796 v 460, 199)

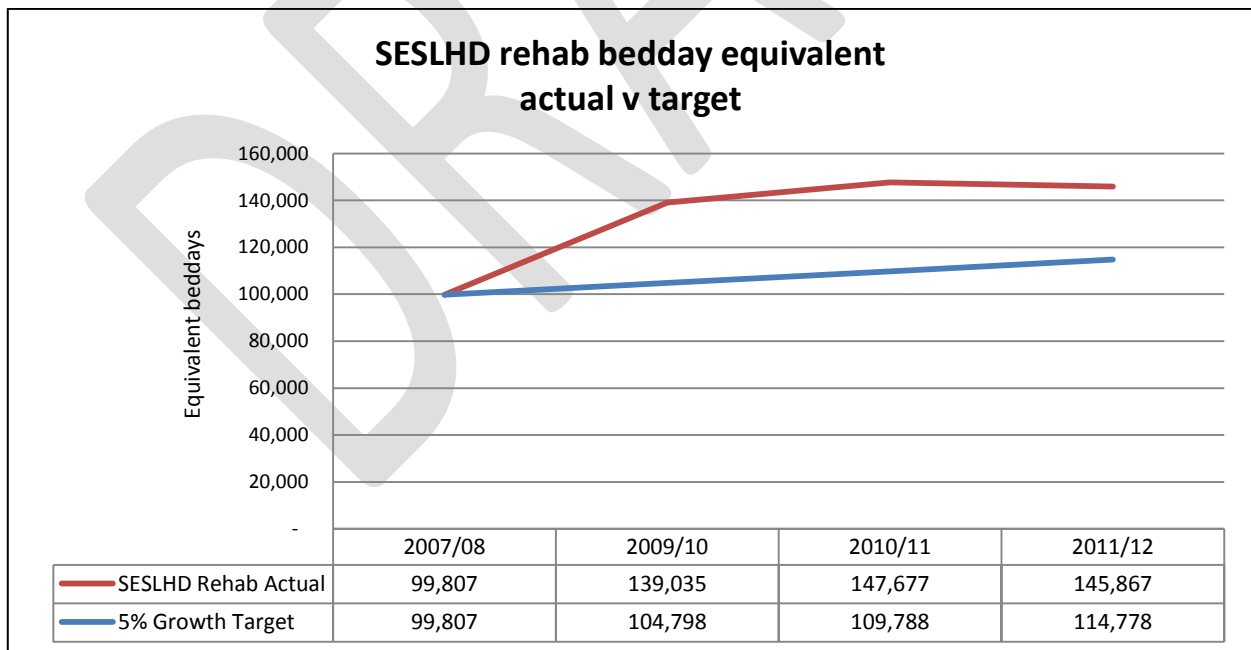


Figure 2: SESLHD rehabilitation performance against 5% growth target (source: SPaRC)

- 31% increase in rehabilitation subacute bed activity above COAG target (432, 579 v 329, 364)

2.4 Alignment to subacute care Schedule C objectives

Programme-specific key performance indicators were developed for rehabilitation programmes to align to Schedule C Performance and Benchmark Indicators

| Schedule C Performance Indicator | Programme | Key Performance Indicator |
|---|-----------------------------|---|
| C16 – Access to subacute care services | ALL ITP ART OP | Development of three new rehabilitation models of care Increased number of separations Increased number of patients receiving rehabilitation programmes in the acute setting Increased number of avoided admissions Increased number of non-admitted patient occasions of service Number of patients receiving outpatient programmes |
| C17 - Increased workforce capacity in subacute care | ALL | 25.33FTE employed across Allied Health and Medical disciplines |
| C18 – Patient outcomes | ITP ART | Improvement in Functional Independence Measure (FIM) outcomes – admission and discharge FIM, and discharge destination Avoided admissions |
| C20 – Timeliness of care | ART | Increased number of patients receiving rehabilitation programmes in the acute setting |
| C21 - Efficiency | ITP ART | Performance of the service against casemix adjusted relative means Improvement in Functional Independence Measure (FIM) outcomes –FIM improvement rates Avoided admissions |

3.0 Background to CCH COAG rehabilitation enhancement

Funding was provided to Calvary Healthcare progressively from March 2010. COAG funding was quarantined and allocated through a collaborative approach between Allied Health Heads of Department and Rehabilitation Physicians. Funding was invested in the form of:

- Workforce enhancements
- Investment in property, plant and equipment
- Consultancies covering business planning

The total FTE Enhancements across the programme is summarised in the table below.

Table 1: Summary of FTE distribution for CCH COAG rehabilitation programmes

| Position | FTE |
|-------------------------|-------------|
| Medical | 0.00 |
| Physiotherapy | 1.00 |
| Occupational Therapy | 0.60 |
| Social Work | 0.00 |
| Nutrition and Dietetics | 0.00 |
| Speech Pathology | 0.00 |
| Psychology | 0.00 |
| Allied Health Assistant | 1.20 |
| Total FTE | 2.80 |

3.1 Key performance indicators

There are considerations with regard to the performance of CCH rehabilitation programmes towards the KPI within the inpatient domain. Contribution can be made via:

- additional designated rehabilitation beds opened during the COAG period
- improved occupancy rates compared to baseline year

Programme-specific KPIs have been developed to better reflect the various rehabilitation models of care implemented as a result of COAG funding, with particular reference to the workforce enhancements afforded. Programme-specific KPIs have been designed as either a capacity or efficiency measure to align to Schedule C performance indicators.

3.2 Description of local rehabilitation models of care

COAG subacute enhancements were provided to General Rehabilitation, under the care of the Rehabilitation Medicine Unit, at Calvary Healthcare during this reporting period. Rehabilitation Medicine accepted funding enhancements in the form of the Intensity of Therapy (ITP) programme in the subacute inpatient setting in March 2010.

4.0 Model 1 : Intensity of therapy programme (ITP)

4.1 Description of model of care

Definition

This care setting is defined by an increased intensity of multidisciplinary rehabilitation therapy to a targeted cohort of patients within the subacute inpatient rehabilitation setting. This model of care aligns to the second rehabilitation care setting, “subacute inpatient”, as described in the NSW Rehabilitation Models of Care³.

Objectives

The primary objective of this model of care is to accelerate patient functional recovery in a subacute inpatient rehabilitation setting through enhanced intensity of therapy, with the overarching goal of decreasing rehabilitation length of stay.

This model of care aims to:

- improve access to multidisciplinary rehabilitation services
- increase throughput of the subacute inpatient rehabilitation setting by decreasing patient overall average length of stay
- improve patient Functional Independence Measure (FIM) outcomes. FIM is the current measure of complexity for subacute rehabilitation services.

Contribution towards COAG KPI

This programme directly contributes to the primary KPI (inpatient activity portion only). Additional contribution is made by:

- additional 12 designated rehabilitation beds that were procured through separate funding in May 2010
- additional 4 beds were procured through private funding in May 2012
- increased occupancy rates

COAG funding was initially quarantined for 12 out of the 40 beds within the Rehabilitation Unit at CCH.

4.2 Recruitment considerations

COAG funding for the ITP programme was allocated over four years commencing 2009/10 FY. The distribution of staffing is demonstrated in the table below.

Table 2: Staffing in CCH subacute inpatient unit – 1 South and 1 West

| Position | Enhanced FTE | Commenced | Additional FTE | Total FTE |
|-------------------------|--------------|------------|----------------|--------------|
| Physiotherapy | 1.00 | March 2010 | 2.00 | 7.00 |
| Occupational Therapy | 0.60 | March 2010 | 2.00 | 6.60 |
| Social Work | 0.00 | - | 1.10 | 4.10 |
| Nutrition and Dietetics | 0.00 | - | 0.00 | 0.20 |
| Speech Pathology | 0.00 | - | 0.00 | 0.11 |
| Psychology | 0.00 | - | 0.00 | 0.00 |
| Allied Health Assistant | 1.20 | March 2010 | 0.80 | 3.00 |
| Total FTE | 2.80 | | 5.90 | 21.01 |

³ NSW Rehabilitation Redesign 2011, pp. 49

Summary of key issues regarding recruitment

- Funding was made available from September 2009
- Positions commenced in March 2010 due to recruitment delays
- Additional Physiotherapy, Occupational Therapy, Social Work and Allied Health Assistant FTE commenced in May 2010 and May 2012 through separate funding
- A study funded through Department of Veterans Affairs (DVA) in 2011 provided additional FTE in Nutrition and Dietetics for a six (6) month period. This has not been accounted for in FTE figures.
- 1.0FTE vacancy in Physiotherapy for periods November and December 2010, February and April 2011

Further information is available in Appendix 1

4.3 Service development

This section provides information regarding the impact of COAG funding on Allied Health services in the subacute inpatient rehabilitation setting in relation to:

- workforce profile, including comparison to AFRM recommended staffing levels as per Appendix 1
- delivery of rehabilitation modalities, including improvements and limitations

According to AFRM (2011), “the ultimate determinant of the appropriateness of the staff establishment of the rehabilitation medicine service will be the amount and type of therapy and care that patients admitted to the service actually receivethe ultimate aim must be the delivery of appropriate rehabilitative therapy”⁴
 The contribution of COAG enhancement toward AFRM guidelines is shown in Table 3.

Table 3: Comparison of FTE to AFRM adjusted recommended levels based on casemix for the period prior to and following COAG enhancements

| Position | Pre-COAG | | Post-COAG | | Additional Funding | | % AFRM Diff |
|-------------------------|--------------|------------------|--------------|------------------|--------------------|------------------|-------------|
| | FTE | (% AFRM Recomm.) | FTE | (% AFRM Recomm.) | FTE | (% AFRM Recomm.) | |
| Physiotherapy | 4.00 | 60% | 5.00 | 72% | 7.00 | 72% | +12% |
| Occupational Therapy | 4.00 | 74% | 4.60 | 86% | 6.60 | 89% | +15% |
| Social Work | 3.00 | 75% | 3.00 | 77% | 4.10 | 77% | +2% |
| Nutrition and Dietetics | 0.20 | 8% | 0.20 | 8% | 0.20 | 6% | -2% |
| Speech Pathology | 0.11 | 13% | 0.11 | 12% | 0.11 | 9% | -4% |
| Psychology | 0.00 | 0% | 0.00 | 0% | 0.00 | 0% | 0% |
| Allied Health Assistant | 1.00 | 38% | 2.20 | 83% | 3.00 | 80% | +42% |
| Total | 12.31 | 52% | 15.11 | 64% | 21.01 | 63% | +11% |

Patient selection

Patient selection for recruitment into the programme is based upon those patients who fulfil all of the following inclusion criteria:

- predicted to benefit from additional therapy to improve functional independence and outcomes; and
- likely to progress through to discharge in shorter time frames with additional therapy; and
- capable of engaging and participating in the rehabilitation process; and
- demonstrate continued achievement of identified rehabilitation goals

⁴ AFRM 2011 section 2.1.18

Patients were excluded from recruitment to the programme if they fulfil any of the following criteria:

- awaiting residential aged care placement; or
- waiting home modifications with limited or nil further functional improvement expected; or
- acutely unwell for 48 hours; or
- on maintenance management; or
- experiencing complex psychosocial issues that limit estimated date of discharge

Summary of key changes in service development:

- Improved staffing levels towards AFRM adjusted recommendations by 11% following COAG and separate funding
- Enhanced weekday intensity of therapy in Physiotherapy and Occupational Therapy in both face-to-face and group settings, including the development of new group therapy sessions
- Expansion of the Physiotherapy service from five (5) to six (6) days per week
- A study funded through DVA in 2011 afforded a period of intense Nutrition and Dietetics intervention, which improved nutritional outcomes for patients.
- Development of the role of the Allied Health Assistant to increase patient therapy time

Further information is available in Appendix 2.

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5.0 Key performance indicators

5.1 COAG key performance indicators

5.1.1 Increase subacute bed activity

The COAG KPI is determined by a 5% increase in subacute bed activity annually for four years commencing 2009/10FY. Baseline figures are derived from 2007/08FY. Achievement of the KPI is measured by combining inpatient and non-admitted patient bedday equivalents across all SES LHD facilities. For the purpose of this report, performance against COAG KPI is also shown on a site basis (see Figure 3).

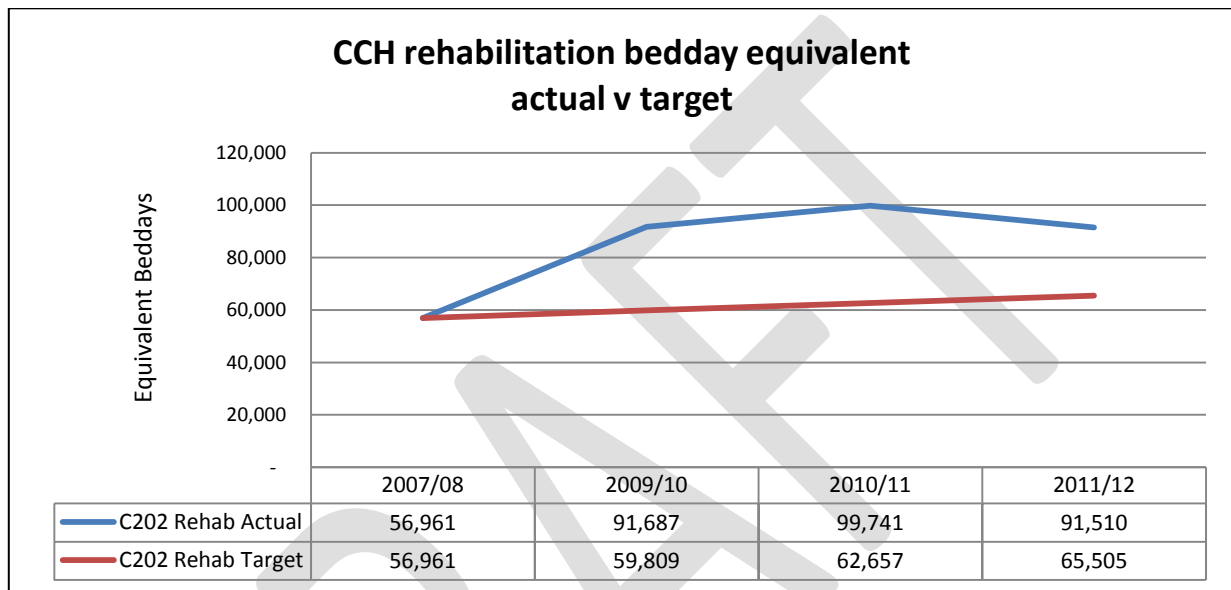


Figure 3: CCH rehabilitation subacute rehabilitation beddays actual v 5% growth (source: SPaRC)⁵

Key findings:

- CCH achieved between 1 July 2009 – 30 June 2012:
 - 38% increase (327, 337 v 237, 317) in total subacute bed activity above COAG target
 - 51% increase (282, 938 v 187, 971) in rehabilitation activity above target
- It is noted the 16 additional rehabilitation beds opened through private funding during the COAG period do not contribute towards the COAG KPI, based on the Ministry of Health NSW methodology.
- The crude occupancy rates for CCH SNAP designated wards increased from 82% (07/08FY) to an average of 83% from 09/10FY onwards

Summary:

- CCH achieved 38% above the COAG KPI this reporting period.

⁵ It should be noted that COAG 5% increased activity targets are applied broadly to all care types across SES LHD. 5% KPI is only illustrated here for comparative purposes.

5.2 Intensity of therapy (ITP)

5.2.1 Average length of stay

Increased efficiency and effectiveness of a rehabilitation service is demonstrated by decreasing average length of stay to increase throughput.

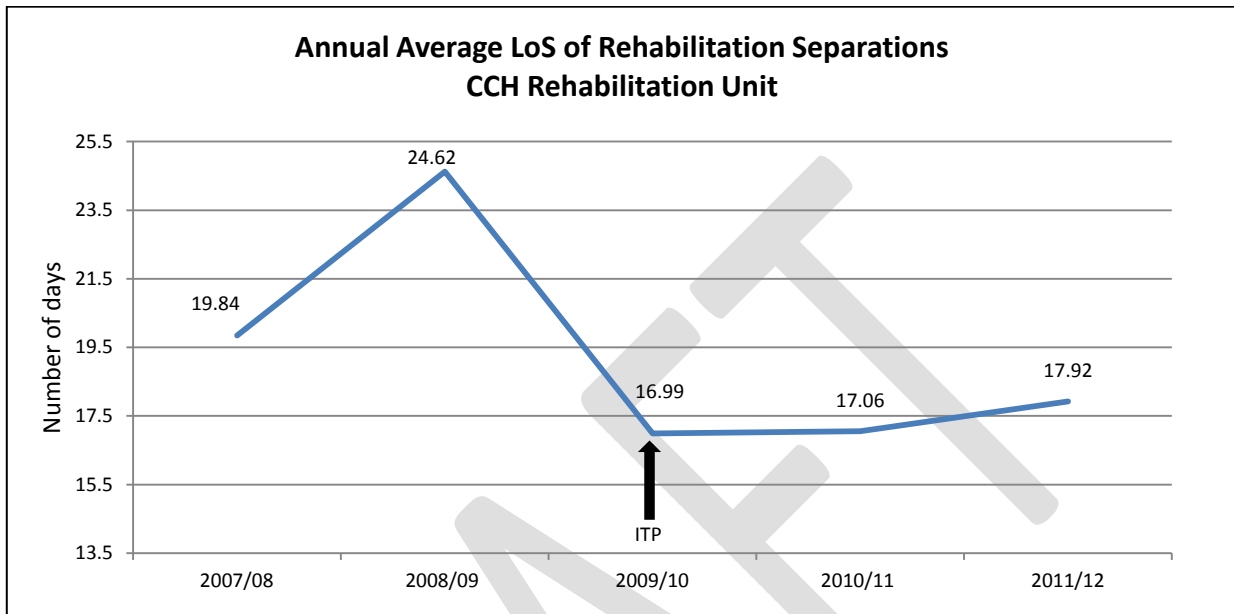


Figure 4: Annual average length of stay of rehabilitation care type in CCH General Rehabilitation (source: PAS, Synpatix)

Key findings:

- 10% (1.92 days) decrease for 07/08FY v 11/12FY
- 31% (7.63 days) decrease for 08/09FY v 09/10FY following ITP

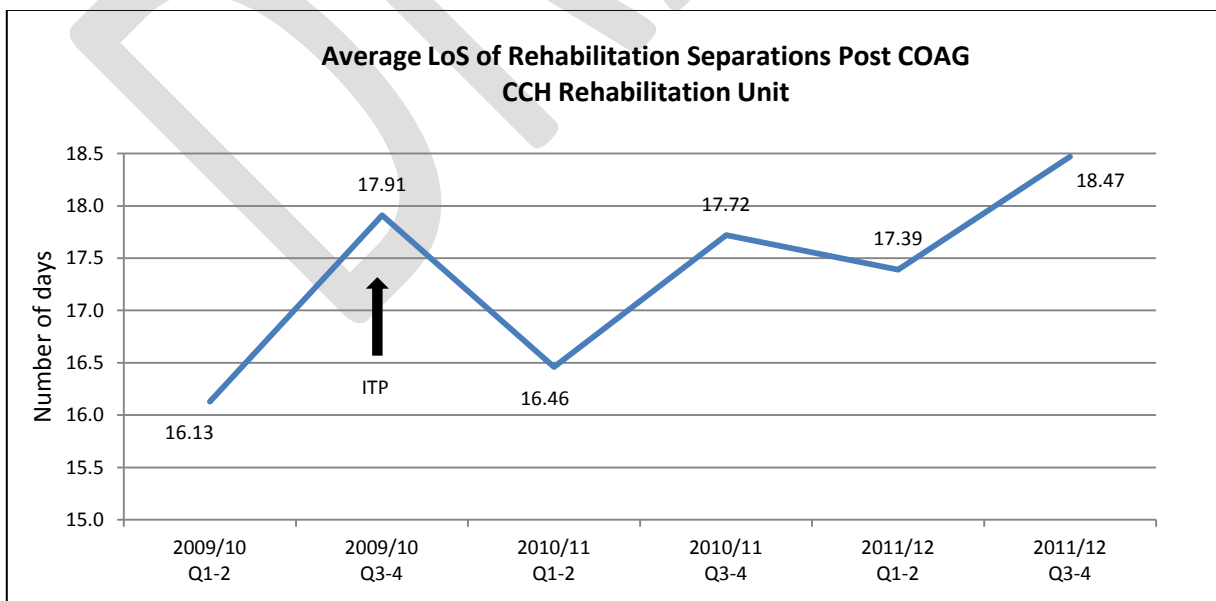


Figure 5: Bi-annual average LoS of rehabilitation care type in CCH General Rehabilitation for the period following COAG (source: Synpatix)

Influences of LoS:

- (i) Implementation of ITP
 - accelerated patient functional outcomes, thereby, reduced LoS
- (ii) Establishment of a Day Rehabilitation Hospital (DRU) at Calvary in 2009
- (iii) Patient clinical complexity
 - Comparison of Figures 5 and 6 illustrates a direct relationship between LoS and cost weight for the period following implementation of COAG:
 - As cost weight increased (indicating a higher casemix complexity), the average LoS increased in a similar pattern. As cost weight decreased (indicating a lower casemix complexity), the average LoS reduced in a similar pattern.
 - This demonstrates that patients of higher clinical complexity attracted a longer LoS, and vice versa.

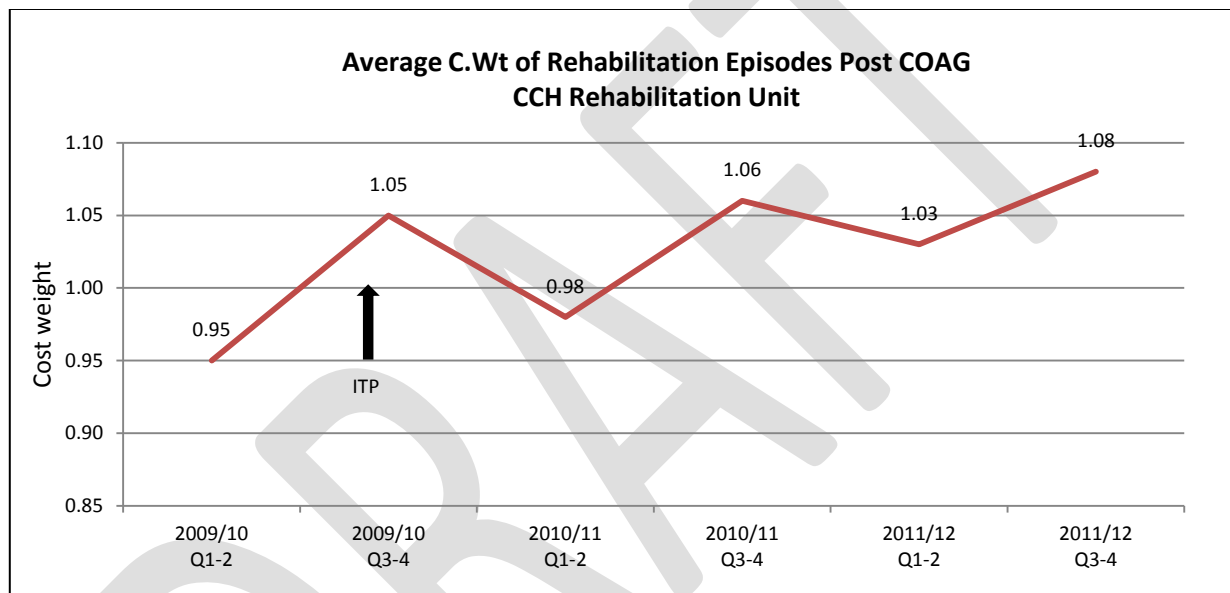


Figure 6: Bi-annual average cost weight of rehabilitation care type in CCH General Rehabilitation for the period following COAG (source: Synpatix)

- (iv) Staffing vacancies, delayed recruitment, and limited access to some Allied Health services

Summary:

- ITP had a direct effect in improving average LoS
- ITP provided efficiencies in accelerating functional gains to hasten discharge, as evidenced by decreases in LoS
- This effect was influenced in part by other factors, such as fluctuations in patient clinical complexity.

5.2.2 Number of separations

Increased efficiency and effectiveness of a rehabilitation service is demonstrated by increasing the number of separations as a result of reducing length of stay, increasing the subacute bed space, or a combination of both. This provides an increased capacity for rehabilitation services.

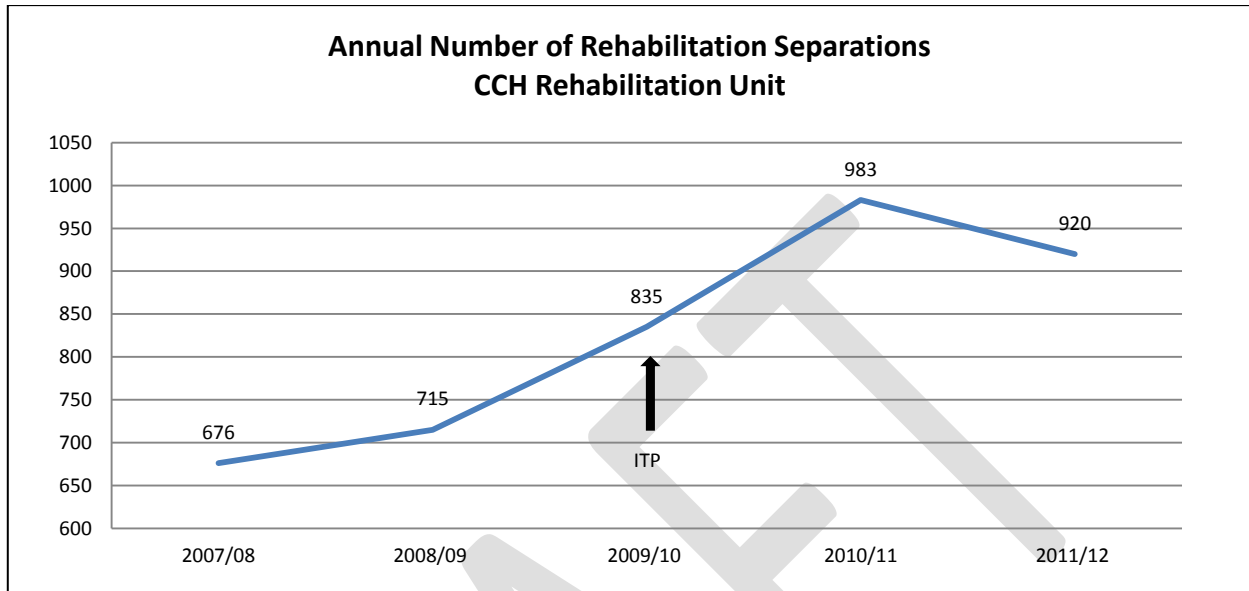


Figure 7: Number of rehabilitation separations in CCH Rehabilitation (source: PAS, Synpatix)

Key findings:

- 45% increase in separation for 10/11FY v 07/08FY
- 36% increase in separations for 11/12FY v 07/08FY

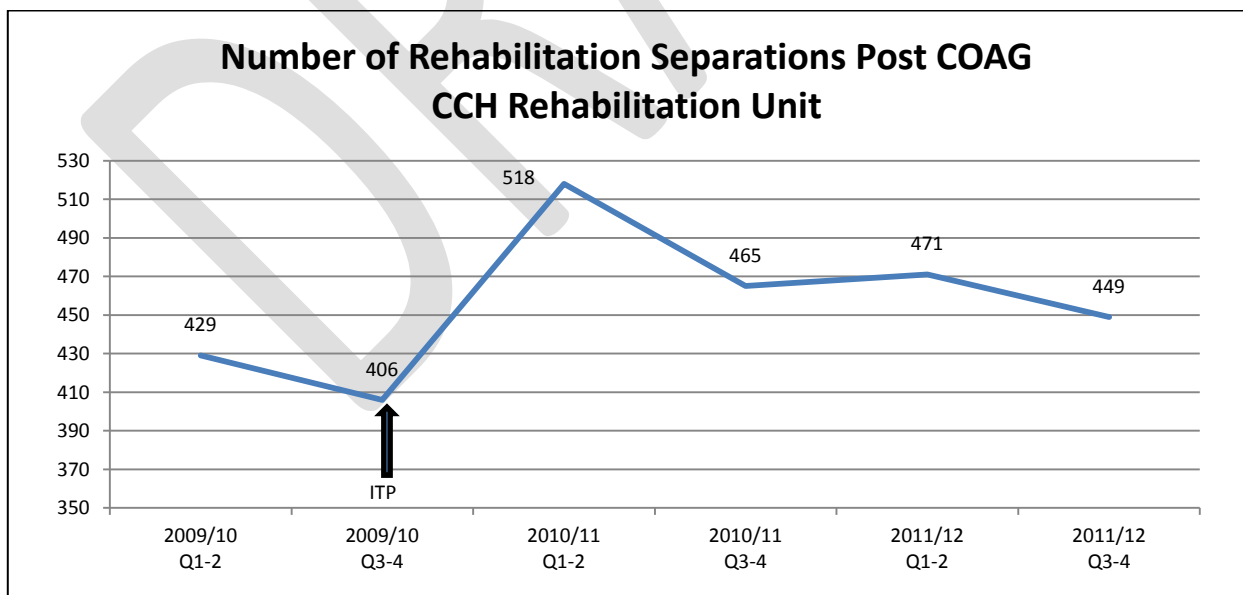


Figure 8: Bi-annual number of separations of rehabilitation care type in CCH General Rehabilitation for the period following COAG (source: Synpatix)

Key findings:

- Number of separations demonstrated a sustained increase post COAG:
- Fluctuations are in keeping with LoS changes, whereby decreases in LoS yield increases in separations
- Annual separations continued to increase despite minor increases in LoS due to additional rehabilitation beds opened
- Additional rehabilitation beds procured through private funding increased the capacity of the subacute bed space:
- 12 additional beds allocated in May 2010 (30% increase capacity cf. 07/08FY)
- 4 additional allocated in May 2012 (8% increase capacity cf. 10/11FY)

Summary:

- ITP had a direct effect in:
 - 36% increase in separations for 11/12FY v 07/08FY
 - sustained increase in number of separations post COAG
- Increases in LoS did not cause a decrease in number of separations due to addition rehabilitation beds opened in May 2010 and May 2012

5.2.3 Improvement in patient Functional Independence Measure (FIM) outcomes

FIM scores are indicative of a patient's level of impairment, with lower scores indicating of a higher degree of impairment and higher scores indicating a higher level of functional independence.

AROC data trends between 2006 and 2011 are illustrated in the graph below. It is noted the recruitment for ITP was finalised by March 2010.

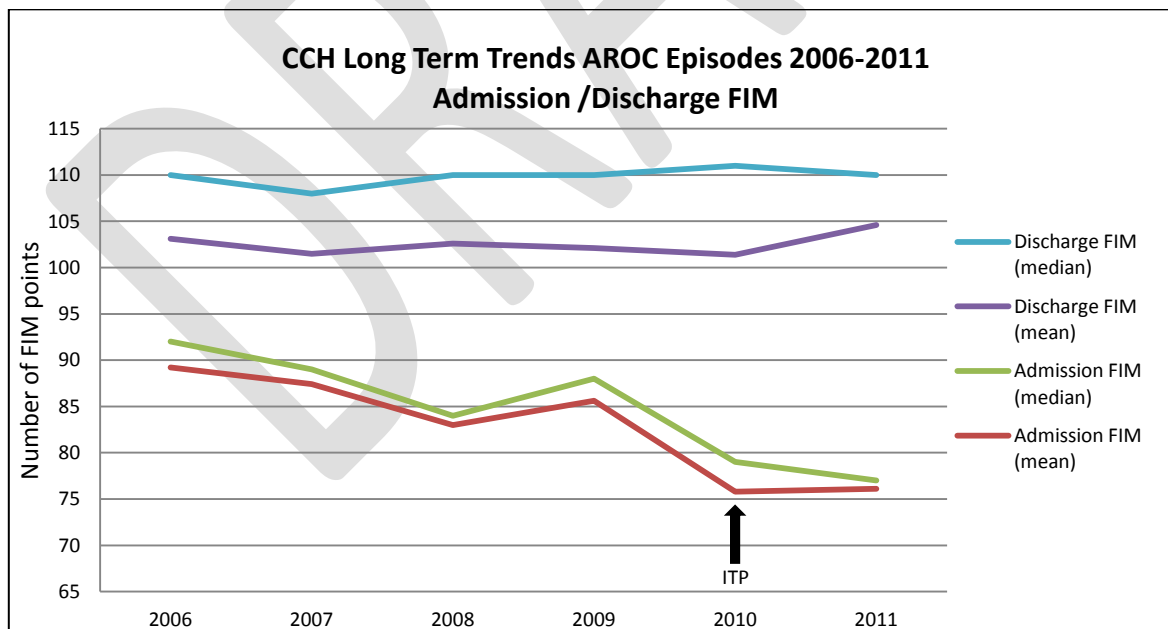


Figure 9: CCH long term trends of AROC episodes : admission and discharge FIM 2006 – 2011 (source: AROC CCH Rehabilitation Unit Calendar Year Reports)

Key findings prior to COAG ITP:

- AROC reporting parameters did not include patients with a rehabilitation LoS ≥ 90 days⁶. This does not appear to have had a significant impact on interpretation of trends for AROC reporting prior to and including 2009. This reporting change did have an impact at other facilities in SES LHD.
- Admission FIM scores:
 - fluctuations in mean (83-89.2) and median (84-92) scores
- Discharge FIM scores:
 - relatively stable mean (101.5 – 103.1) and median (108-110) scores

Key findings following implementation of COAG (2009 v 2011):

- Admission FIM scores:
 - 11.1% (9.5 points) decrease in mean scores and 12.5% (11 points) decrease in median scores
 - indicative of a higher level of impairment and patient acuity on admission
 - potentially due the decrease in average LoS facilitating an increase in bed throughput and decreased waiting time for admission
- Discharge FIM scores:
 - relatively stable mean (102.1-104.6) and median scores
 - indicative of patients achieving similar functional independence levels on discharge regardless of the decreasing average LoS (as per section 4.2.1)

Summary:

- ITP has enabled continued improvements in patient functional outcome measures during their rehabilitation admission
 - Patients are admitted to rehabilitation with higher levels of impairment, potentially due the decrease in average LoS facilitating an increase in bed throughput and decreased waiting time for admission
 - Patients are discharged from rehabilitation with similar levels of independence compared to prior to COAG
 - Ability of the subacute unit to accommodate an increased patient complexity whilst maintaining high levels of functional independence on discharge, evidenced by the combination of lower admission FIM scores; stable discharge FIM scores; and decreasing LoS

⁶ AROC Glossary 2009 Calendar Year Report

5.2.4 Effectiveness of the rehabilitation service

Effectiveness of a rehabilitation services is demonstrated by several measures, including:

- a patient’s functional improvement as a result of rehabilitation;
- comparison to benchmark groups;
- return to a level of accommodation that promotes independence

5.2.4.1 FIM gain during admission

FIM gain indicates the degree of functional improvement a patient achieved during a rehabilitation admission, contributing towards the effectiveness of the rehabilitation delivered.

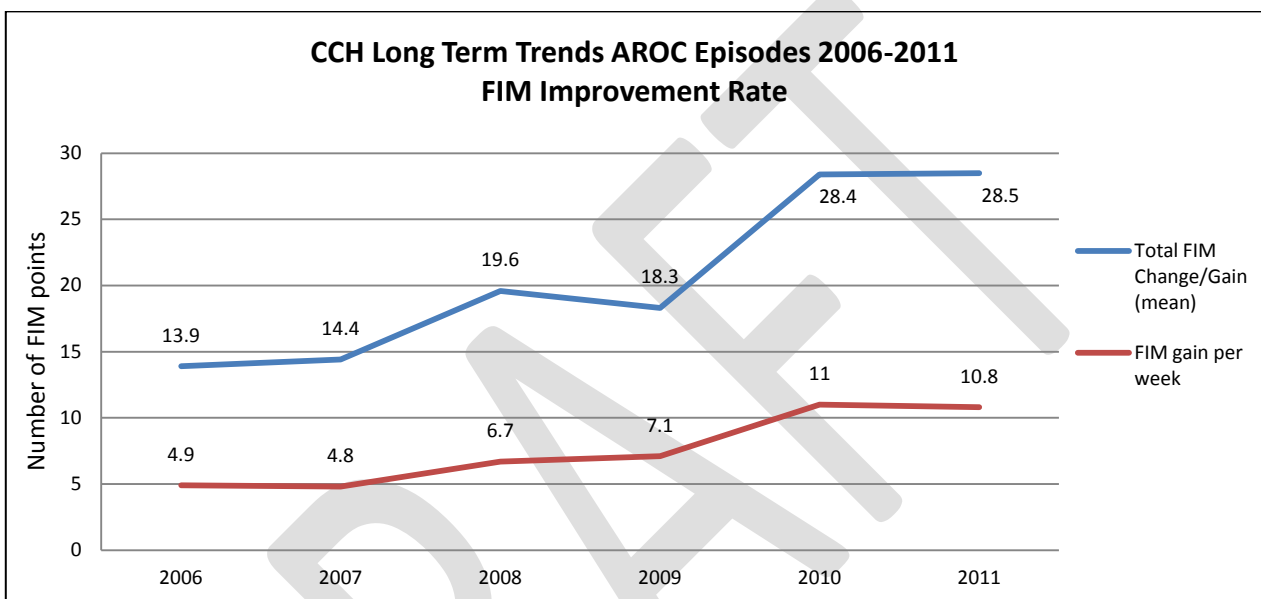


Figure 10: CCH long term trends of AROC episodes: FIM improvement rates 2006 – 2011 (source: AROC CCH Rehabilitation Unit Calendar Year Reports)

Key findings:

- FIM change increased 55.2% (10.1 points) between 2009 and 2011, which is likely due to lower admission FIM scores creating an increased scope for FIM improvement
- FIM gain per week increased 52.1% (3.7 points) between 2009 and 2011, indicating patients are achieving functional targets earlier

Summary:

- ITP has resulted in significant improvements in the scope and rate of FIM change in comparison to the period prior to enhancements.
- This supports an increased effectiveness of the rehabilitation service.

5.2.4.2 FIM gain and length of stay in comparison to benchmark groups

Casemix adjusted measures allow for direct comparison of public hospital subacute inpatient rehabilitation units in Australia with similar patient clinical complexity (ie. casemix). This enables benchmarking with peer hospitals to demonstrate the effectiveness of the rehabilitation service.

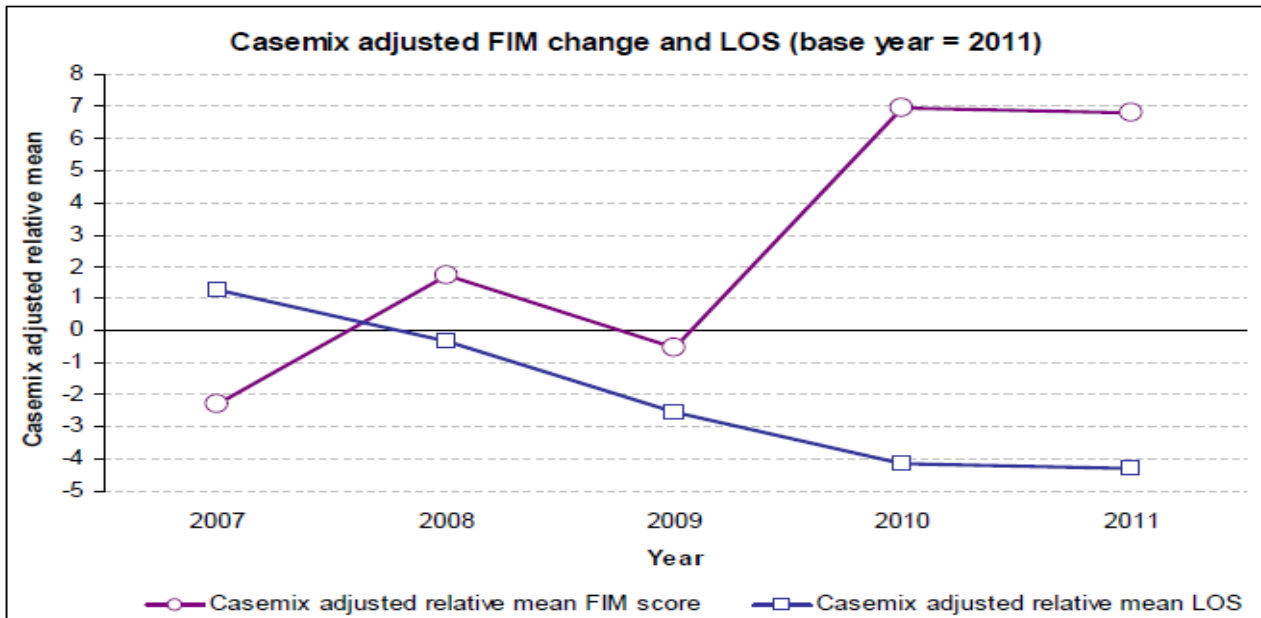


Figure 11: Casemix adjusted FIM change and LOS (source: AROC CCH Rehabilitation Unit Calendar Year Report 2011 pp. 26)

Key findings:

- Prior to ITP, patients exhibited shorter LoS and similar FIM change in comparison to benchmark groups
- In 2010, immediately following implementation of ITP:
 - LoS decreased, with patient LoS four (4) days less than benchmark
 - FIM change increased, with patients achieving seven (7) points higher than benchmark
 - Impairments with the largest volume (AROC episodes):
 - Orthopaedic (47%)
 - Reconditioning / restorative (19%)
- In 2011:
 - LoS and FIM change improvements were sustained
 - Impairments with the largest volume (AROC episodes):
 - Orthopaedic (50%)
 - Reconditioning / restorative (23%)

Summary:

- ITP had a direct effect in improving LoS and FIM change in comparison to benchmark, supporting an effective rehabilitation service as patients achieved greater functional gains in shorter periods
- Patients classed as orthopaedic and reconditioning/restorative appear to benefit from COAG enhancements for both LoS and FIM change

5.2.5 Discharge destination

The effectiveness of a rehabilitation service is demonstrated by a patient’s discharge destination following a rehabilitation admission. The Australian Clinical Healthcare Standards (ACHS) rehabilitation medicine clinical indicator six (6) describe an effective rehabilitation service enables a patient to “returns to their pre-impairment form of accommodation or a form of accommodation that allows greater independence”⁷ This is measured against the benchmark group.

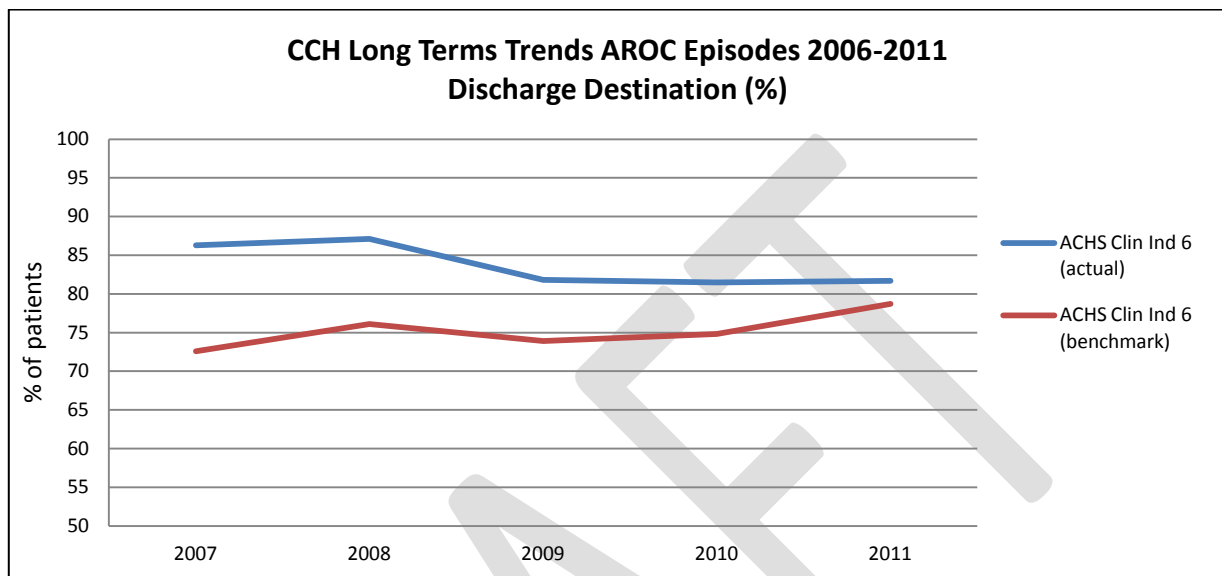


Figure 12: CCH long term trends of AROC Episodes: discharge destination 2006 – 2011 (source: AROC CCH Rehabilitation Unit Calendar Year Reports pp. 82)

Prior to 2009, AROC reporting parameters did not include patients with a rehabilitation LoS ≥ 90 days⁸, which has an unknown impact on interpretation of trends for reporting for this period. A correlation between longer lengths of stay and discharge destination cannot be conclusively determined.

Key findings:

- Prior to ITP, discharge destination was better than the benchmark group, contributing towards an effective rehabilitation service.
- Following implementation of COAG, CCH discharge destination continued to perform above the benchmark group.

Summary:

- Performance against the ACHS clinical indicator demonstrates patients continue to be discharged to pre-impairment accommodation or a form of accommodation that allows greater independence, in comparison to benchmark. This margin has decreased in recent years.
- This supports an effective rehabilitation service.

⁷ ACHS Clinical Indicator 6 (Discharge Destination), AROC Calendar Year Reports pp. 82

⁸ AROC Glossary 2009 Calendar Year Report

6.0 Recommendations

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7.0 Table of abbreviations

| | |
|---------|--|
| ACHS | Australian Clinical Healthcare Standards |
| AFRM | Australasian Faculty of Rehabilitation Medicine |
| AN-SNAP | Australian National Sub-Acute and Non-Acute Patient classification |
| AROC | Australasian Rehabilitation Outcomes Centre |
| ART | Acute Rehabilitation Therapy programme |
| CCH | Calvary Healthcare |
| COAG | Council of Australian Governments |
| FIM | Functional Independence Measure |
| FTE | Full time equivalent |
| GEM | Geriatric Evaluation and Management |
| ITP | Intensity of Therapy programme |
| KPI | Key performance indicator |
| LHD | Local Health District |
| LoS | Length of stay |
| NAPOOS | Non-admitted patient occasion of service |
| NPA | National Partnership Agreement |
| OP | Outpatients programme |
| POWH | Prince of Wales Hospital |
| SES | South Eastern Sydney |
| SESAHS | South Eastern Sydney Illawarra Area Health Service |
| SGH | St George Hospital |
| TSH | The Sutherland Hospital |
| WMH | War Memorial Hospital |

8.0 List of Figures

| | |
|---|----|
| Figure 1: SESLHD subacute performance against COAG KPI target (source: SPaRC) | 6 |
| Figure 2: SESLHD rehabilitation performance against 5% growth target (source: SPaRC) | 6 |
| Figure 3: CCH rehabilitation subacute rehabilitation beddays actual v 5% growth (source: SPaRC)..... | 12 |
| Figure 4: Annual average length of stay of rehabilitation care type in CCH General Rehabilitation (source: PAS, Synpatix) | 13 |
| Figure 5: Bi-annual average LoS of rehabilitation care type in CCH General Rehabilitation for the period following COAG (source: Synpatix)..... | 13 |
| Figure 6: Bi-annual average cost weight of rehabilitation care type in CCH General Rehabilitation for the period following COAG (source: Synpatix) | 14 |
| Figure 7: Number of rehabilitation separations in CCH Rehabilitation (source: PAS, Synpatix)..... | 15 |
| Figure 8: Bi-annual number of separations of rehabilitation care type in CCH General Rehabilitation for the period following COAG (source: Synpatix) | 15 |
| Figure 9: CCH long term trends of AROC episodes : admission and discharge FIM 2006 – 2011 (source: AROC CCH Rehabilitation Unit Calendar Year Reports)..... | 16 |
| Figure 10: CCH long term trends of AROC episodes: FIM improvement rates 2006 – 2011 (source: AROC CCH Rehabilitation Unit Calendar Year Reports) | 18 |
| Figure 11: Casemix adjusted FIM change and LOS (source: AROC CCH Rehabilitation Unit Calendar Year Report 2011 pp. 26) | 19 |
| Figure 12: CCH long term trends of AROC Episodes: discharge destination 2006 – 2011 (source: AROC CCH Rehabilitation Unit Calendar Year Reports pp. 82)..... | 20 |

9.0 List of tables

| | |
|--|----|
| Table 1: Summary of FTE distribution for CCH COAG rehabilitation programmes | 8 |
| Table 2: Staffing in CCH subacute inpatient unit – 1 South and 1 West | 9 |
| Table 3: Comparison of FTE to AFRM adjusted recommended levels based on casemix for the period prior to and following COAG enhancements | 10 |

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