

# **Pathways To Independence Improving Access to Rehabilitation Intervention for Older People**

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**Government  
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SA Health

# Overview

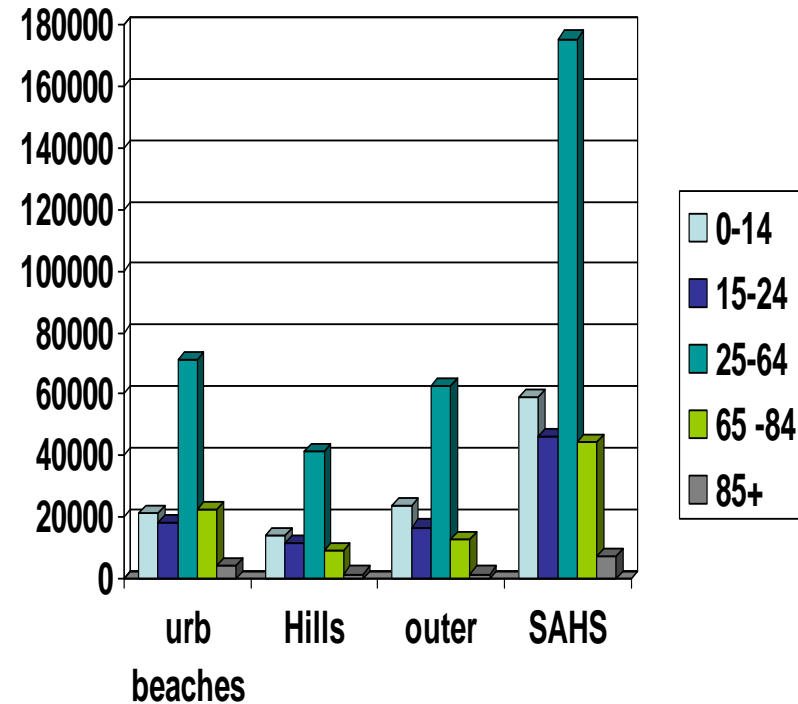
- > Health Service Integration
  - Who we are and what we do
  
- > Why “Pathways” to Rehabilitation Interventions
  
- > Pathways To Independence
  - Minimising Functional Decline Program
  
- > Key Learning's & Outcomes to date

# Health Service Integration

- > Primary health care team that works across the acute – community interface
  
- > Focus
  - avoiding hospital admissions
  - improving longer term health
  - building community capacity
  
- > Targets are to ↓ demand through:
  - avoiding presentations to ED
  - avoiding presentations becoming admissions
  - facilitating early discharges to ↓ OBD

# Southern Adelaide region

- > **Southern metropolitan Adelaide**
- > **1/5<sup>th</sup> of population of South Australia, 350,000**
- > **3 public hospitals, Private hospitals**
- > **2 EDs and 1 ARU**
- > **100 GP practices with approx 400 GPs**
- > **Community based health services – State, Cmmwth (NGO's) & private funded**



Source: Epidemiology Dept Southern Health

# Variances Service Architecture

- > In SA a majority of our community rehabilitation is provided by a range of NGO's – commonwealth funded providers
- > 1/3 of all Day Therapy Centre's in Aust are in SA
- > Other States have community rehab services under the State Govt., which we don't.

# Why “Pathways” to Rehabilitation Interventions

## 1. Evidence

### Physical:

Hill et al 2004, Close 1999, Campbell 1999, Wetherall 2004, Chang et al 2004

### Cognitive and Psychosocial:

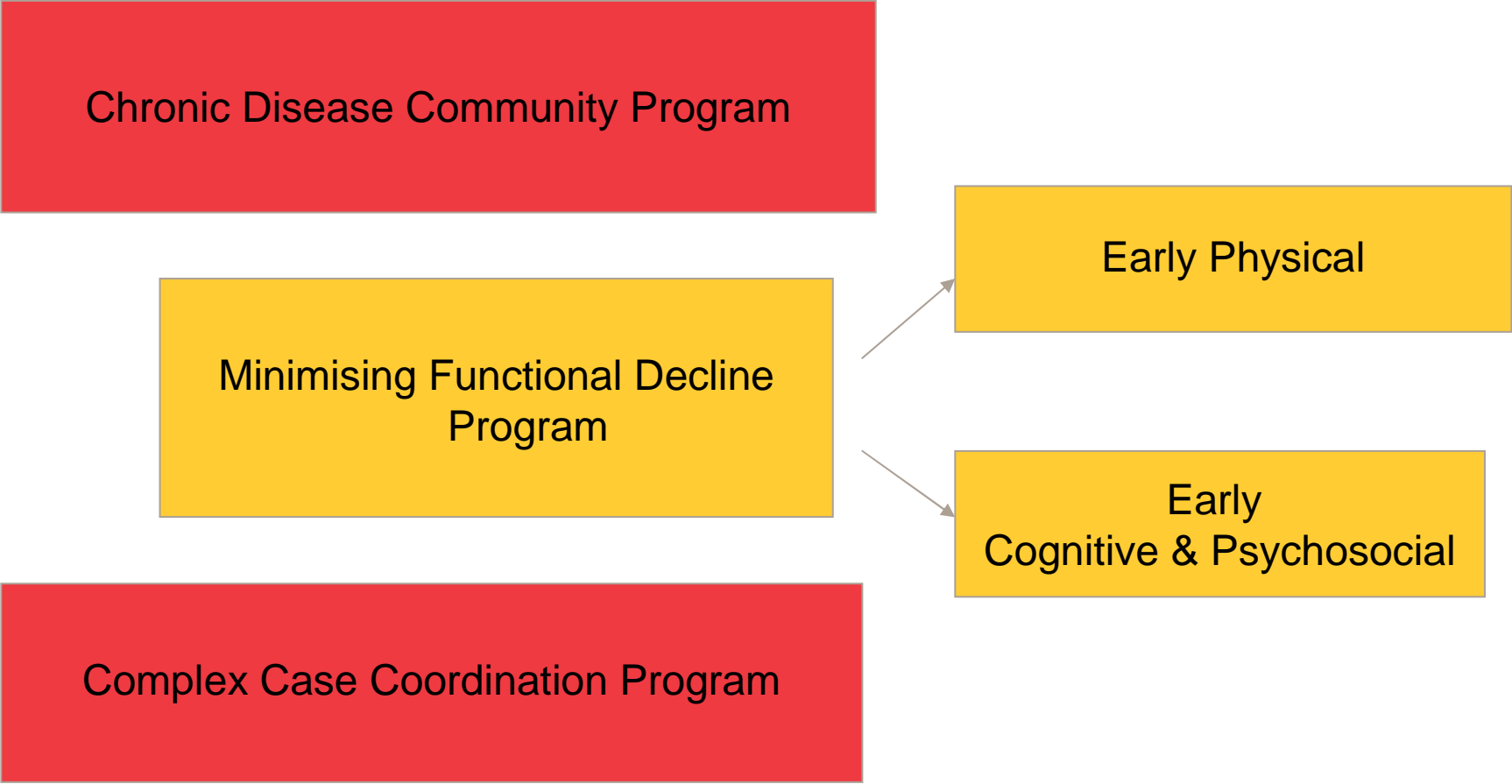
Philip NHS 2007, Lautenschlager et al 2008, ALSA 2005, McReynolds et al 2004



## 2. Low rehabilitation service uptake

- > Complex and fragmented
- > Older person experiences significant obstacles in transitions between services
- > Multiple services/funding streams/criteria

# Pathways To Independence Framework



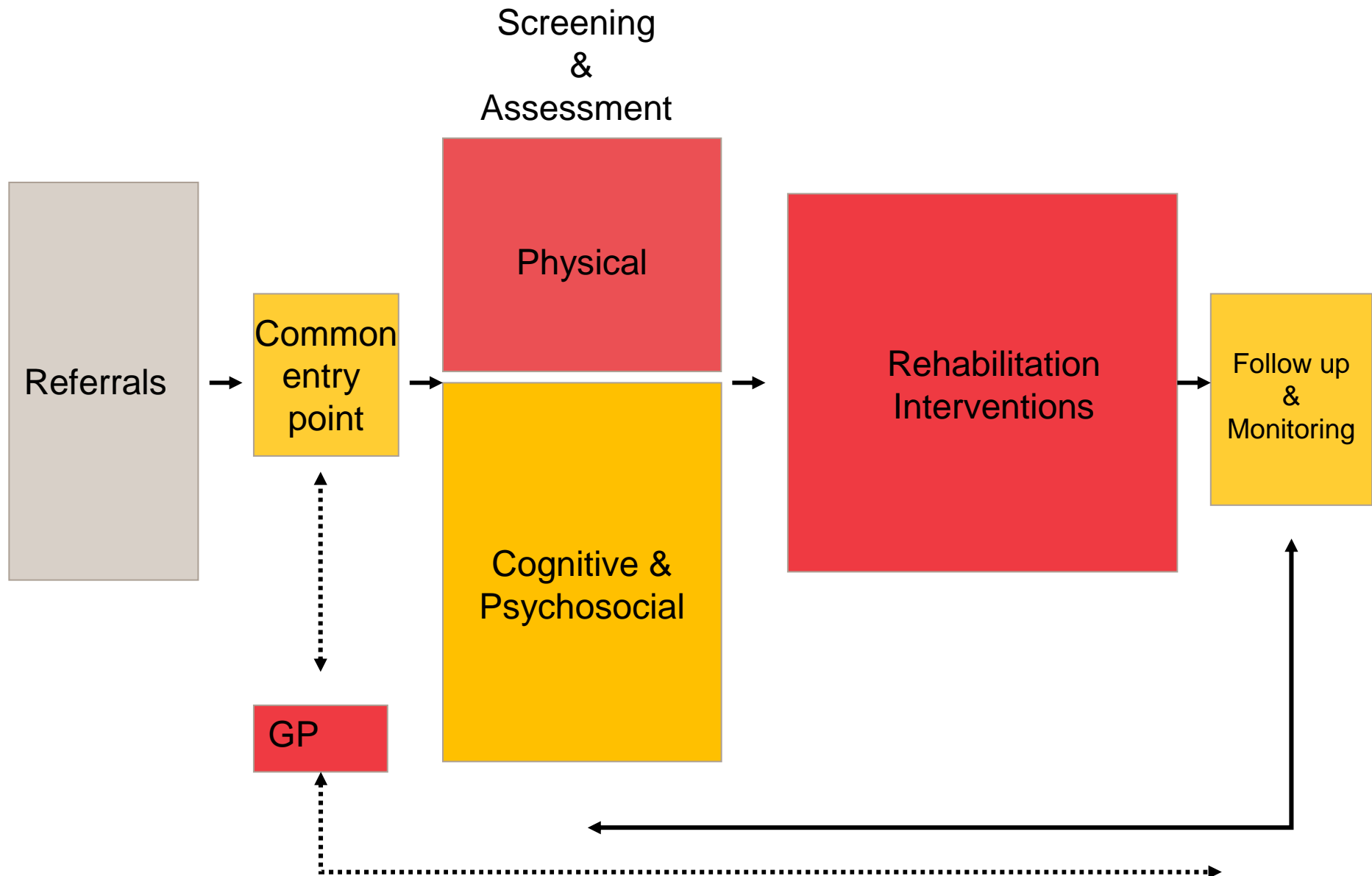
# Design of the Programs - systems, content & form

- > **State Govt. funded with partner services**
- > **Services based on agreed clinical guidelines & pathways**
- > **Service reform & systems approach was required to support this response**
  - active screening process & pull rather than push or opportunistic referral
  - coordination
  - consistency
  - communication & referral pathways across sectors – building a virtual team
  - increased capacity within community – skills & access
  - evidence based practice in action
  - underpinned with self management approach

# Community , Acute & GP sector engagement

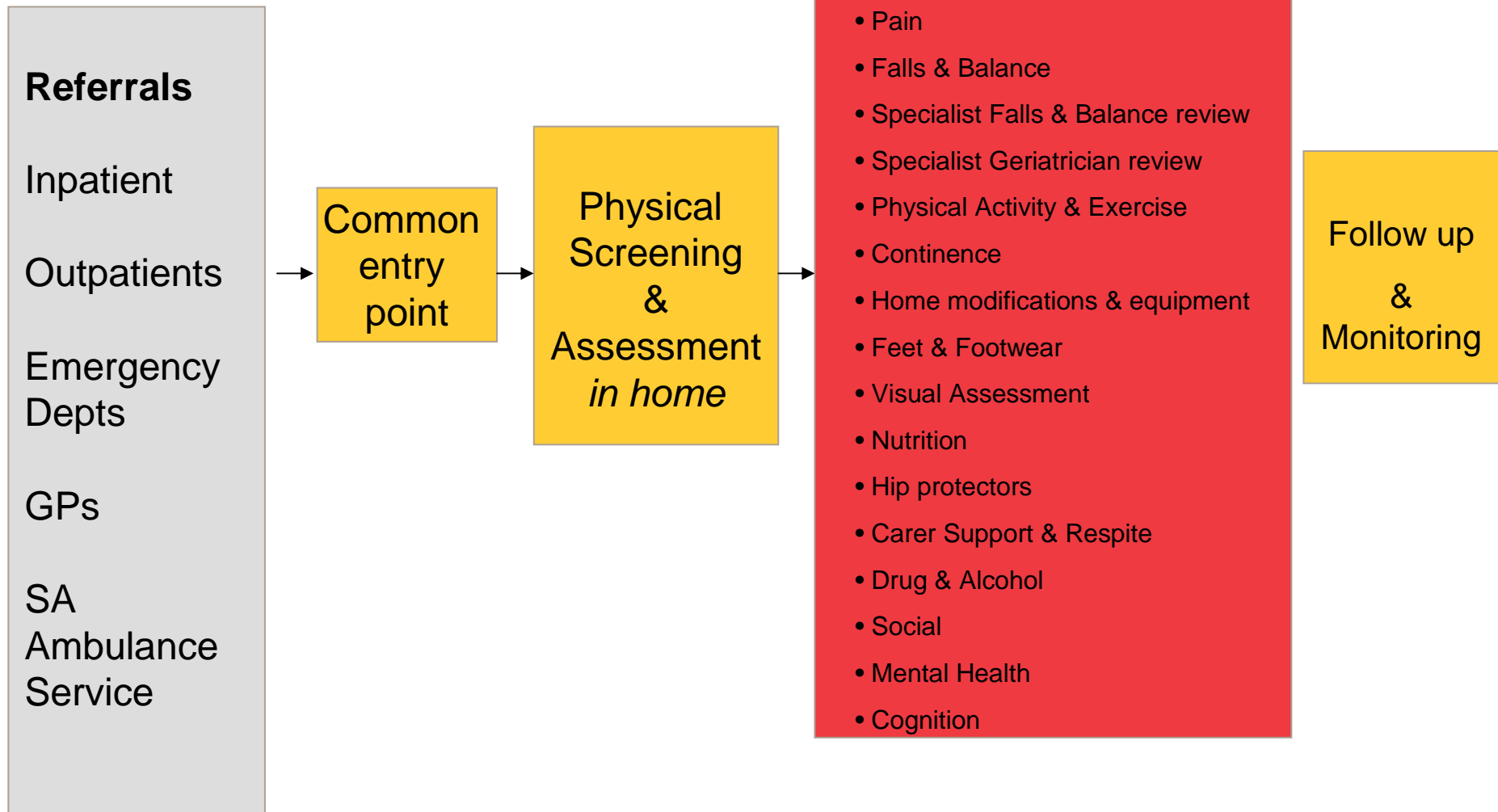
- > early involvement
- > addressing their issues
- > working with diversity but gaining consistency
- > utilising known systems
- > making it the easiest choice
- > closing the communication loop

# Minimising Functional Decline Program



# Minimising Functional Decline

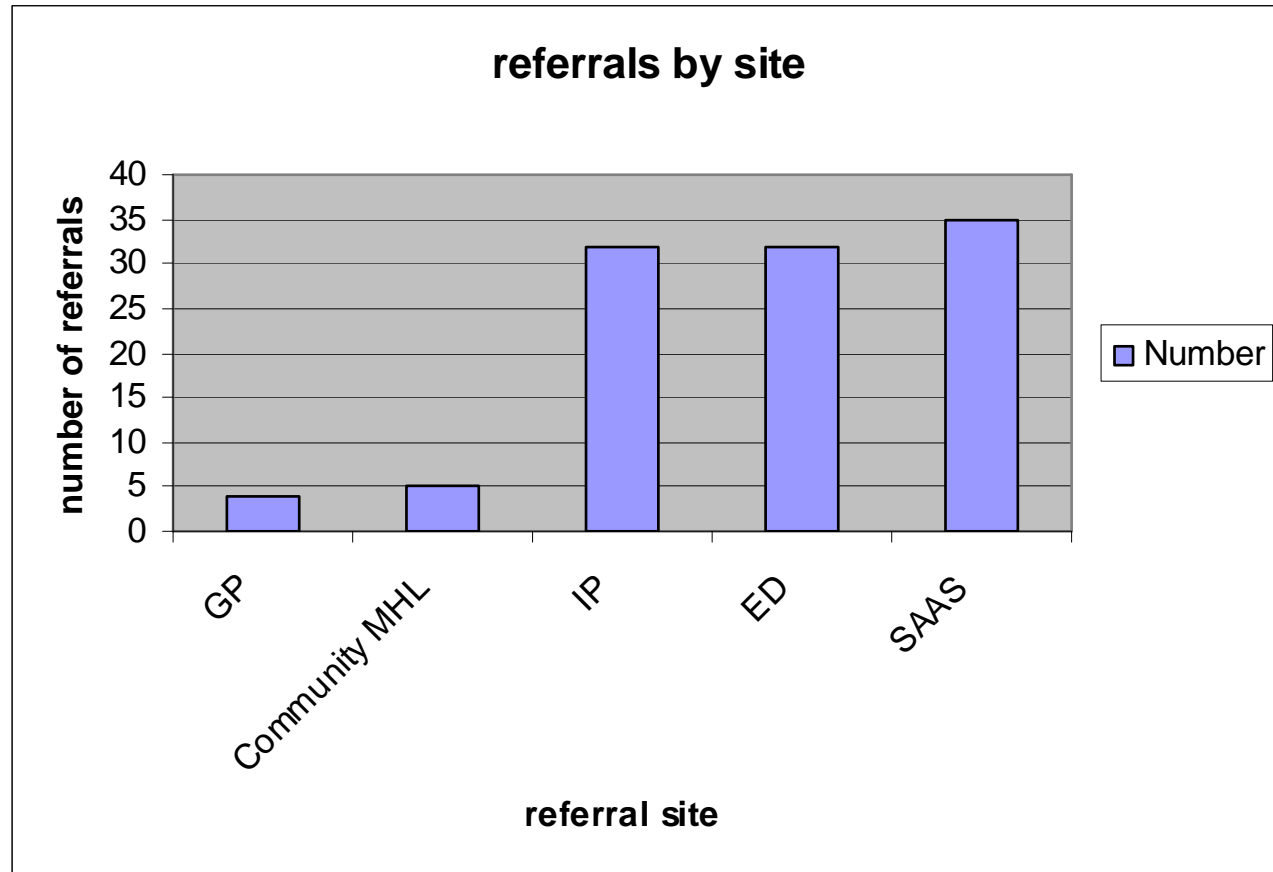
Early physical decline



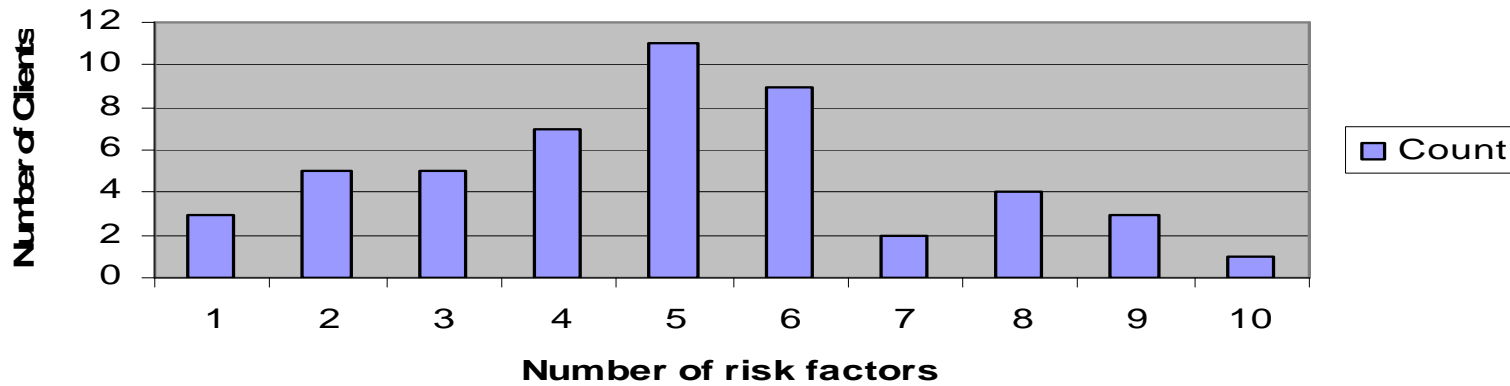
# MFDP - Early Physical Outcomes

- > 1 year – part of which was the pilot
  
- > 278 referrals
  - Initially 3-4 referrals per week
  - Now 15- 20 referrals per week
  
- > Measures 6/52, 6/12, 12/12 incl:
  - Readmissions rates pre and post
  - Risk factors- no. & type
  - Uptake of recommendations/interventions
  - Reduction modifiable falls risk factors

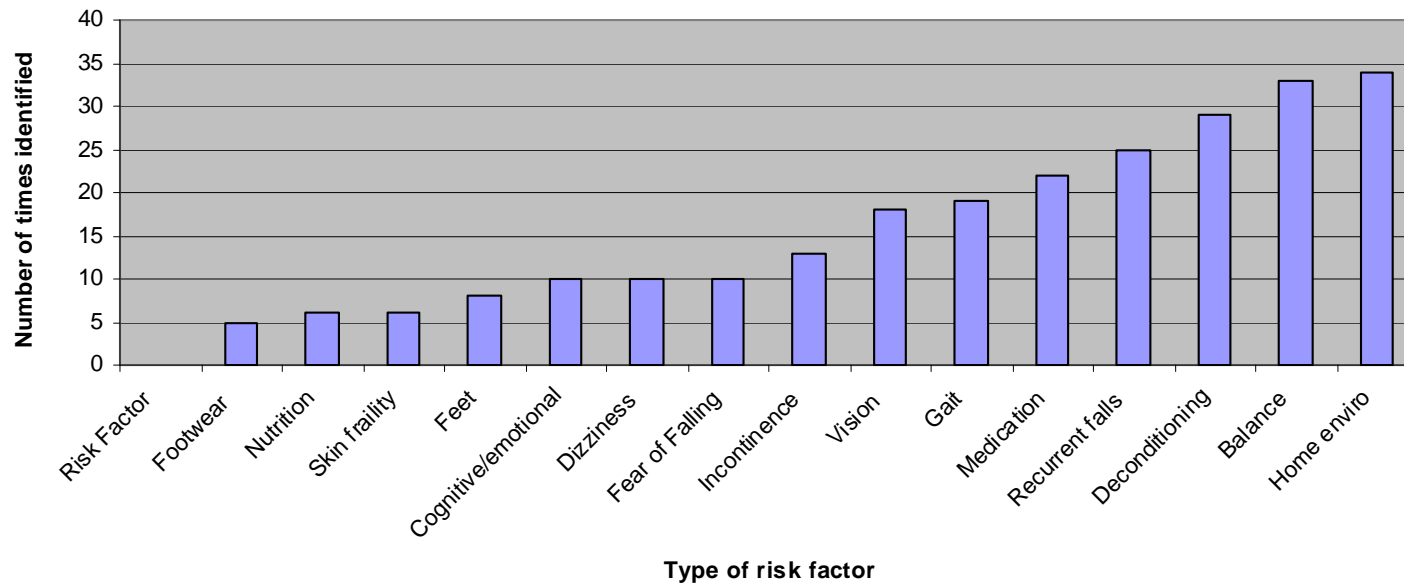
# Minimising Functional Decline activity



### Complexity: number of risk factors per patient



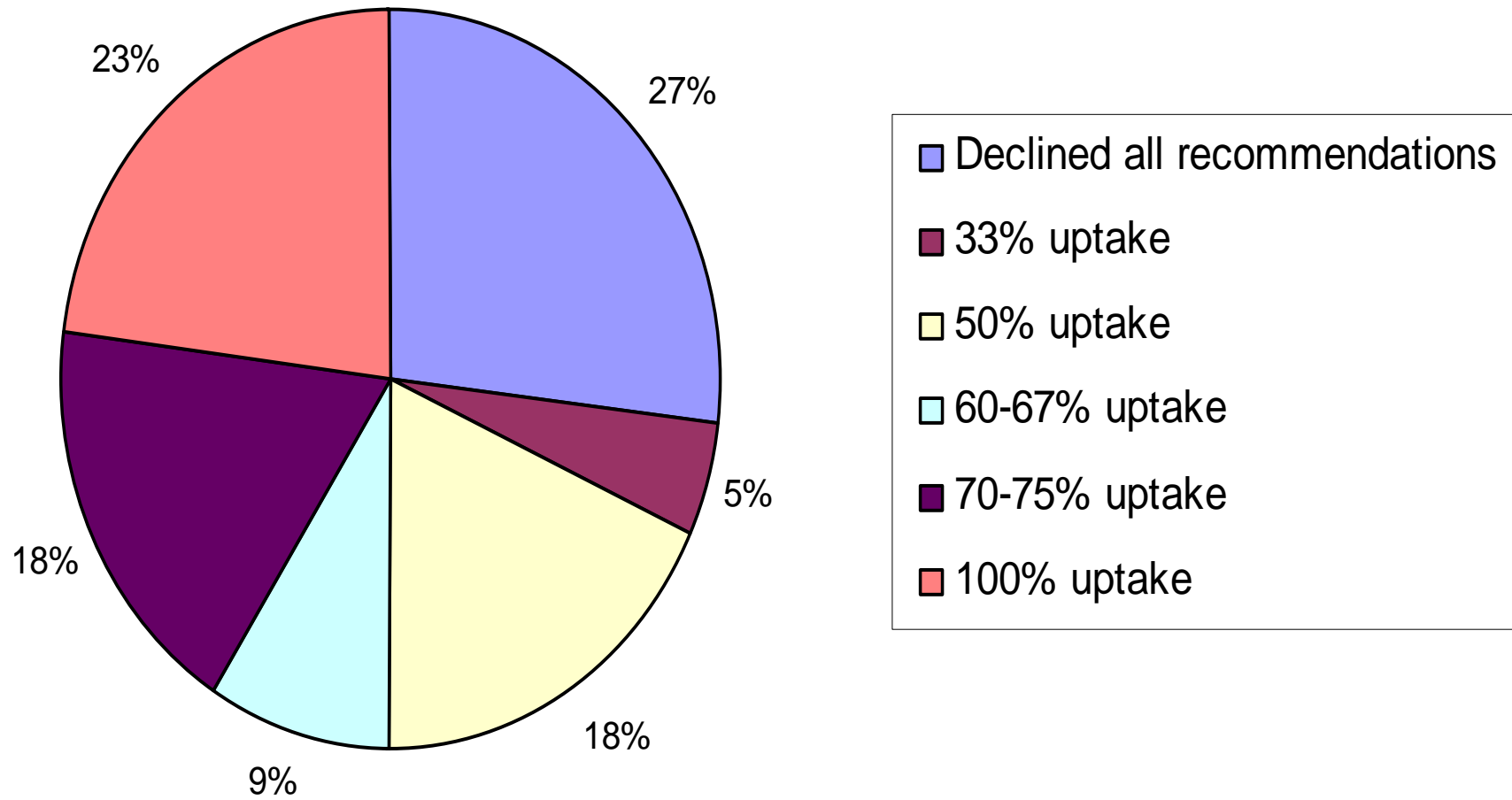
### Most common risk factors



# Uptake of Recommendations

- > Nearly  $\frac{3}{4}$  of the clients took up some to all of the recommendations
- > Why some are not taking up recommendations is an area of ongoing investigation for us - through our follow up & monitoring process

## Uptake of recommendations from assessment



# ***Minimising Functional Decline***

## Early Cognitive and Psychosocial

### **Screening**

#### **Cognition**

MMSE

RUDAS

Frontal Assessment Battery

#### **Mental Health**

K10

#### **Carer**

Carer Strain Index

#### **Social health & function**

Quality of Life

#### **Drug & Alcohol**

Audit Tool

#### **Advanced Care Directives**

### **Risk Factors**

Early cognitive decline

Reduced insight

Depression and anxiety

Carer fatigue/strain

Abuse

Social function decline

Transport finance etc.

Drug and alcohol issues

Increased care needs

Psychosocial issues

Advanced care planning

### **Service Coordination**

#### **Carer Support and Education**

Dementia Services

Services Navigation

Drug & Alcohol Counselling and Services

Social Support and Community Linking

Counselling – Grief and Loss, Anxiety, etc

Lifestyle Rehabilitation

#### **Working with GP:**

Specialist Geriatrician review

Memory Support

Mental Health Services

#### **Information:**

Finances

Respite

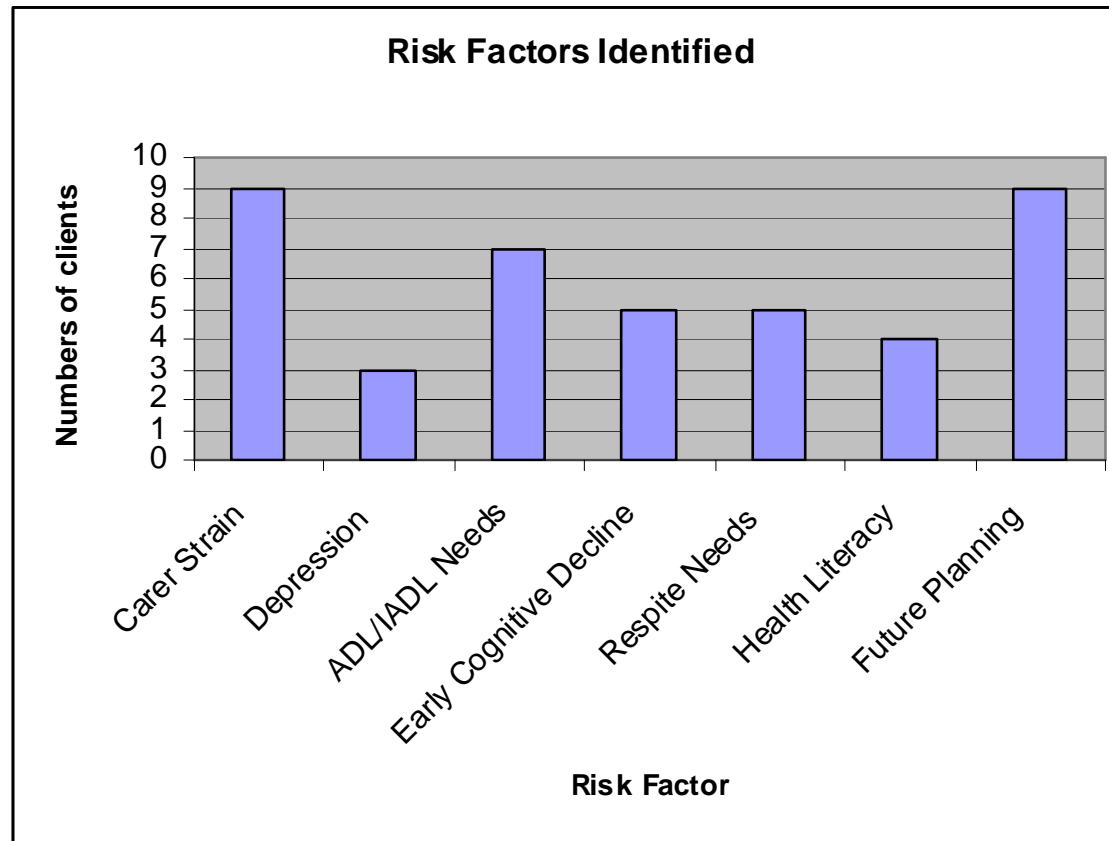
Transport

Home Safety

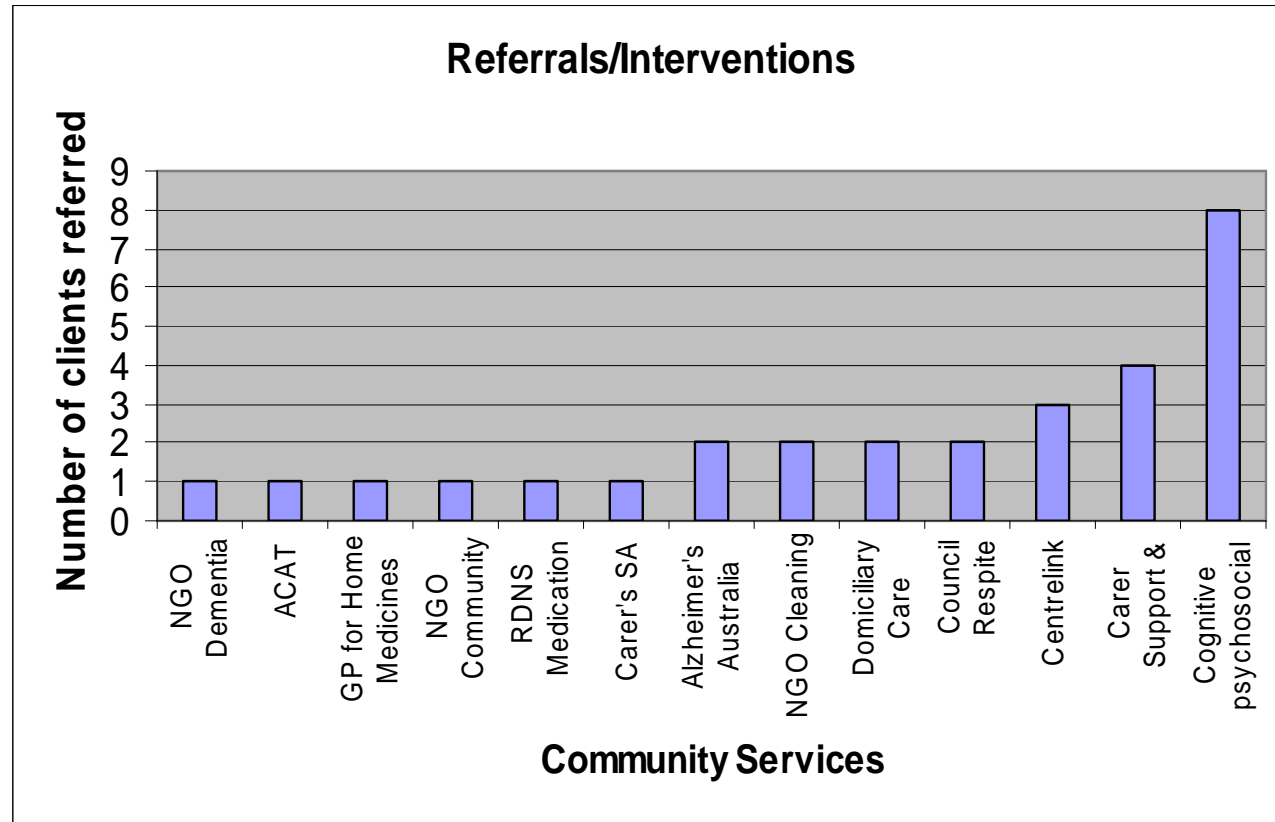
Enduring Power of Attorney

Enduring Power of Guardianship

# Cog/psychosocial Risk Factors



# Service Coordination



# Best Care, Best Place, Best Time across the Health & Aged care continuum

For all our target groups / programs ensure :

- > Pathways across community services/ GPs & acute - roles , responsibilities, EBP consistency
- > New programs build on established paths & platforms - ↓ silos ↑ visibility/ uptake
- > Piggy back onto other funding / common agendas/ shared resp/ benefits
- > Clear KPIs –resonate with other groups
- > Build workforce capacity – accredited panels of providers; new roles
- > Support change – vision, evidence, training, tracking, partnership, client input
- > Functional relationships

## Questions

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# **Government of South Australia**

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