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Summary Report of the Evaluation of
the SGG Rehabilitation Program

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**For the Continuing Care and Clinical
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Acronyms

BI	Barthel Index
BSW	Barwon South Western
DHS	Department of Human Services
GP	General Practitioner
NARI	National Ageing Research Institute
OT	Occupational Therapist
PC-PART	Personal Care - Participation Assessment Resource Tool
PDHS	Portland District Health Service
ROAST	Rural Organisation of Acute Stroke Teams
SGG	Southern Grampians Glenelg
VAED	Victorian Admitted Episodes Dataset
VMO	Visiting Medical Officer
WDHS	Western District Health Service

Summary Report of the Evaluation of the SGG Rehabilitation Program

1. The need for a rehabilitation program in the Southern Grampians Glenelg (SGG) Region

A strategic planning review of sub-acute services in the SGG district, completed in 2002 examined a wide range of factors influencing effective and efficient service delivery (Sach & Associates, 2002)¹. Included in the project brief was the requirement to design a model of care that would respond to the needs of people in the Southern Grampians Glenelg district who required a continuum of rehabilitation. A model was developed through a consultative action planning process involving the five health services in the district at the time, Heywood, Portland, Coleraine, Casterton, and Western District (which included Hamilton and Penshurst)².

Rehabilitation Medicine has been defined by the Australasian Faculty of Rehabilitation Medicine as “that part of the science of medicine involved with the prevention and reduction of functional loss, activity limitation and participation restriction arising from impairments, the management of disability in physical, psychosocial and vocational dimensions, and improvement of function” (2005)³.

The proposed model aimed to address the difficulties for people living in rural communities where demand for rehabilitation is variable and widely distributed. It was based on existing infrastructures and allowed individual health service autonomy. Mechanisms were to be established to integrate use of inpatient, ambulatory and primary care services, to share workforce, develop training initiatives and integrate allied health workforce planning and recruitment across the five health services. Equitable access to this service was to be achieved through multi entry and exit points through the continuum of care and flexibility in the mode and the locality of service delivery across the six sites.

One of the key features of the model was that clients with rehabilitation conditions admitted to SGG hospitals would more routinely be assessed for rehabilitation and if it was required could access a client-centred coordinated program of inpatient rehabilitation within the SGG sub-region. Figure 1 illustrates the model by providing an example of a pathway of inpatient care for clients with planned orthopaedic surgery.

Service planning commenced in 2003 and the service commenced in July 2004. The Rehabilitation Program was developed and is overseen by a Planning Committee consisting of representatives of the SGG Health Services (Directors of Nursing and Chief Executive Officers/Hospital Managers), the Rehabilitation Project Leader, the

¹ Sach, J. & Associates. (2002). *The Southern Grampians/Glenelg Rehabilitation Program*. Melbourne: Healthwise Consulting Colcot Consulting.

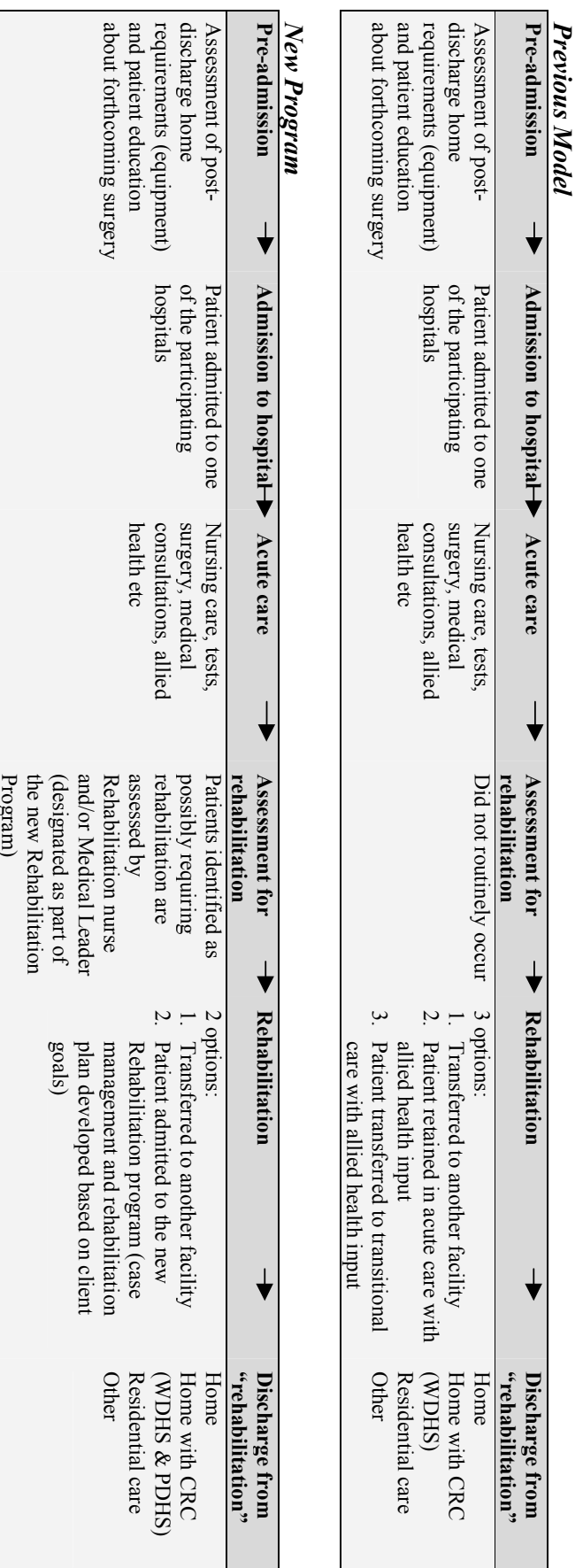
² Since commencement of the Rehabilitation Program, this changed to four Health Services with Coleraine becoming part of WDHS

³ Australasian Faculty of Rehabilitation Medicine (2005) *Standards 2005: Adult Rehabilitation Medicine Services in Public and Private Hospitals*. Sydney.

Occupational Therapist, the two Medical Leaders and staff from the Department of Human Services (DHS) Barwon South Western (BSW) Region.

A Rehabilitation Program Project Leader, located at the Portland District Health Service (PDHS) and the Western District Health Service (WDHS) in Hamilton, oversaw the Program. The Project Leader was responsible for assessing all rehabilitation clients on admission to the Program as well as case management for all clients. An Occupational Therapist was dedicated to the Program and worked across all sites, although this position was being modified when this report was completed. At all sites the Director of Nursing was responsible for Rehabilitation Program management at that site. Two Medical Leaders, one located at PDHS and one at WDHS, oversaw the medical care of rehabilitation clients. Three beds at WDHS were dedicated to rehabilitation and two beds at PDHS were allocated to rehabilitation clients as required. Allied health and inpatient nursing staff at each health service were responsible for the delivery of rehabilitation care. General Practitioners in the SGG district had Visiting Medical Officer (VMO) rights within the hospitals and were responsible for the medical management of their patients in the community, playing an important role in the rehabilitative process.

Figure 1: Inpatient Rehabilitation process prior to and post implementation of the SGG Rehabilitation Program (e.g. orthopaedic surgery)



2 Evaluation of the SGG Rehabilitation Program

An evaluation of the Rehabilitation Program was undertaken by the National Ageing Research Institute (NARI) for the Department of Human Services. The work undertaken by NARI was overseen by a Reference Group consisting of representatives from DHS (Barwon-South Western Region and Central Office), from the Rehabilitation Program and from organisations specialising in rehabilitation and geriatric medicine.

The overall aim of the evaluation was to determine whether this model of rehabilitation service provision has been successful in addressing the needs of rural health service users and to make recommendations about its adoption in other rural areas.

The evaluation comprised of three phases. The first phase of the evaluation, the formative evaluation, was conducted from January to June 2004, prior to the Rehabilitation Program's implementation in June 2004. The purpose of the formative evaluation was to determine the status of rehabilitation services in the SGG district, to identify possible weaknesses in the Program design, gauge key stakeholders' perceptions and expectations of the Program and their role within it, and to develop an evaluation framework and data measurement approaches. The "Report of Phase 1 of the Evaluation of the Southern Grampians and Glenelg Rehabilitation Program" (Dow & Nankervis, 2004) summarises the methods and findings from this phase. It is available on the National Ageing Research Institute's (NARI) website: http://www.nari.unimelb.edu.au/research/service_hcr.htm

The second phase, the process evaluation, was conducted from September 2004 to June 2005. This phase focused on monitoring and supporting the early implementation of the Rehabilitation Program by the five Health Services. An interactive, action research approach was adopted to support staff to share ideas, identify areas for improvement and to plan, implement and review actions to address these. A report of Phase 2 (Dow & Nankervis, 2005) has been completed and is also available on the NARI website.

The third and final phase of the evaluation was a summative evaluation with the main aim to determine whether the Program was implemented as planned and whether implementation resulted in the desired outcomes being achieved. This report will also be made available on the NARI website.

This report provides a summary of the key findings from all three phases of the evaluation.

2.1 Research Questions

The overall methodology of the SGG Rehabilitation Program Evaluation aimed to answer the following key evaluation questions:

1. What are the expectations of the key stakeholders (DHS, local health service providers, clients and carers) of the Rehabilitation Program?
2. Has the program been implemented as planned?

3. What elements of the program have been modified to achieve the intended outcomes?
4. What are the main barriers or other factors contributing to implementation of the program?
5. What are the critical success factors in the SGG Rehabilitation Program that lead to effective rehabilitative care?
6. What facilitates local linkages and cooperation in monitoring clients who have a progressive or chronic recurring condition that needs bursts of rehabilitation over a long period of time?
7. Are the participating health care services working in a collaborative way to provide effective, accessible rehabilitation to the targeted population?
8. Has this rehabilitation program improved the health status and quality of life of the clients and carers?
9. Are clients, carers and practitioners satisfied with the service?
10. Has the program resulted in improved consumer access to sub-acute rehabilitation services where they most need them?

The first phase of the evaluation, clarified expectations of the key stakeholders of the Rehabilitation Program (question 1) to identify and correct program design weaknesses, and to provide the framework for the second phase (process evaluation). The process evaluation focused primarily on questions 2-5 and 7. The final phase (summative evaluation) addressed questions 6, 8, 9 and 10. Section 4 of this report summarises the key findings in relation to each of the research questions.

The evaluation also aimed to support the implementation of the proposed redevelopment through clarification of the program model; identification of barriers; problem solving; and continuous feedback on the progress of the implementation with key stakeholders. Another major aim of the study was to make recommendations for other rural regions planning to implement a similar rehabilitation program.

3. Methodology

The evaluation involved a range of data collection strategies and consultation with a broad range of key stakeholders. Table 1 summarises the data sources and collection strategies in each phase. The evaluation has involved consultation with the Rehabilitation Program's Planning Committee, nursing and allied health staff involved in the Program, services/GPs who might refer clients to the Program, and potential or actual rehabilitation clients and their carers. Various Health Service and Rehabilitation Program data sources have also been utilised.

Some of the strategies were repeated to provide comparisons and measure changes over time. For example, Health Service data, such as type and number of admissions to the Rehabilitation Program were collected in Phase 2 (the early stages of the Program) and then again in Phase 3 to determine whether there had been any change in the admission patterns as the Program settled. Rehabilitation staff in the Planning Committee were interviewed in all three phases to monitor their perceptions and expectations of the Program before it commenced, after it first commenced, and then again after the Program settled.

Table 1: Consultation strategies in the three phases of the evaluation of the SGG Rehabilitation Program

Data source	Phase 1: Jan-Jun '04	Phase 2: Jun '04-Jun '05	Phase 3: Jul '05-Dec '06
Consultation with Planning Committee	<ul style="list-style-type: none"> • Interviews with Health Services' Staff • Ongoing reporting of evaluation progress 	<ul style="list-style-type: none"> • Interviews with Health Services' Staff • Teleconferences • Ongoing reporting of evaluation progress 	<ul style="list-style-type: none"> • Interviews with Health Services' Staff • Ongoing reporting of evaluation progress
Consultation with allied health and nursing staff involved in the Rehabilitation Program (including Project Leader)	<ul style="list-style-type: none"> • Survey • Provision of support and information to project leader as required 	<ul style="list-style-type: none"> • Survey • Action research groups 	<ul style="list-style-type: none"> • Survey
Consultation with clients and families	<ul style="list-style-type: none"> • Interviews with Health Service patients in SGG region with a condition responsive to rehabilitation 	<ul style="list-style-type: none"> • Satisfaction survey to Rehabilitation clients 	<ul style="list-style-type: none"> • Satisfaction survey to Rehabilitation clients • Interviews with Health Service patients in SGG region with a condition responsive to rehabilitation
Consultation with referring agencies/GPs	<ul style="list-style-type: none"> • Interviews 	<ul style="list-style-type: none"> • Interviews 	<ul style="list-style-type: none"> • Survey
Health Service data collection	<ul style="list-style-type: none"> • Victorian Admitted Episodes Dataset (VAED) 	<ul style="list-style-type: none"> • VAED • Program data 	<ul style="list-style-type: none"> • VAED • Program data

4. Key Findings

This summary of findings presents the key results of the three phases of the Program's evaluation according to the ten research questions. Refer to Phase 1, 2 and 3 reports for more detail.

Research Question 1: What were the expectations of the key stakeholders (DHS, local health service providers, clients and carers) of the Rehabilitation Program?

Prior to the commencement of the Rehabilitation Program, staff perceived that the new Program would:

- co-ordinate and formalise what was currently happening in inpatient settings (i.e. case management and protocols such as admission criteria would be established)
- introduce a rehabilitation culture within the hospitals
- improve integration between hospital and community services
- provide rehabilitation within the local region
- lead to development of data systems to track clients, client outcomes and services provided.

The new Program was seen as having the potential to benefit clients and their families by providing rehabilitation services closer to home, a more coordinated approach with a rehabilitation plan based on their goals, case management and continuity of care from hospital to home and better community access to rehabilitation. Perceived opportunities for staff included improved job satisfaction with greater follow-up of clients in the community, improved communication between hospital and community services and opportunities to improve rehabilitation skills.

Stakeholders also raised possible concerns and questions in relation to the establishment of the Rehabilitation Program including:

- lack of rehabilitation background and experience of staff
- concerns by GP that they might be excluded from care planning and medical management during the inpatient rehabilitation phase
- concerns by the smaller hospital Rehabilitation Managers that they would need consent from one of the two Medical Leaders at the larger sites to admit patients into their hospital for rehabilitation
- concerns from allied health staff about the additional demands on their time to implement the Program
- concerns from nurses about the lack of accepted nurse:patient ratio for rehabilitation and that they would have to take on more allied health tasks with patients in rehabilitation beds
- lack of a rehabilitation culture in hospitals and the community
- capacity of the new Program being too small to have a significant impact

- uncertainty about home based rehabilitation and whether there was adequate funding to support this.⁴
- how clients with chronic conditions would access the service
- what the consequences would be of the two Medical Leaders interpreting their roles differently⁵.

Research Question 2: Was the Program implemented as planned?

The second research question explored whether the Program was implemented as planned, in particular, to investigate whether the SGG Planning Committee completed the service redevelopment according to the revised Program plan developed in July 2004. Tables 2 and 3 summarise the ‘necessary ingredients’ and the ‘fundamental program activities’ as identified in the Figure 7 in the Phase 2 report, identifying key elements of the revised Program plan. Whether an ‘ingredient’ or ‘activity’ has been achieved and the data source used as evidence is reported in the two tables.

Table 2: Necessary Ingredients (all sites).

Necessary Ingredient	Achieved?	Comment	Evidence
Consistent management support.	Partially	Managers from all sites support the Program. Some staff reported limited support from middle management.	Managers from all sites participated in all 3 Phases of the evaluation. Allied Health and nursing staff also reported consistent management support.
Designated on-site Rehabilitation Managers.	✓	Each site has a designated rehabilitation manager.	Designated on-site Rehabilitation Managers from all sites participated in all Phases of the evaluation.

⁴ Stakeholders were unclear about what the home-based component of this Program would consist of (e.g. full substitution of rehabilitation into the home, home visits from nursing and allied health staff, Post Acute Care type services for rehabilitation clients, or clients based at home accessing hospital or centre based allied health and nursing services).

⁵ In WDHS the Medical Leader saw his role as having overall medical responsibility of inpatient Rehabilitation Program clients but having minimal involvement with community based clients. The PDHS Medical Leader saw his role as gatekeeper to accessing the Program as well as providing consultancy for both inpatient and community Rehabilitation Program clients.

Necessary Ingredient	Achieved?	Comment	Evidence
Project Leader to facilitate action.	✓	The Project Leader has been instrumental in promoting the program, getting various stakeholders involved, implementing protocols and practices and establishing a rehabilitation culture in the hospitals.	Planning committee interviews and allied health and nursing surveys.
People who have the enthusiasm and will to bring about change individually and collectively.	Partially	There has been a gradual shift towards a rehabilitation culture. Some staff are proactive but there is still some need for change in attitudes.	Planning committee interviews and allied health and nursing surveys.
Consistent Medical input.	✓	Medical Leaders have been proactive in the program and have good communication with referring GPs. Some evidence of a small number of GPs in the region not referring to the Program and facing obstacles when referring to program.	Allied health, nursing and GP surveys.
Availability of allied health staff.	✓	The program has assisted in recruiting, retaining, and thus increasing availability of allied health staff. There are still some disciplines needing to increase numbers.	Planning committee interviews, allied health, nursing and GP surveys, and action research meetings.
Continuing formal and informal education opportunities for staff.	✓	A broad range of formal and informal training has been conducted.	Planning committee interviews and action research meetings.
Dedicated separate unit for rehabilitation.	Partially	WDHS has a dedicated rehabilitation unit. PDHS has a flexible approach to allocating beds for rehabilitation.	Planning committee interviews, allied health and nursing surveys and action research meetings.

Necessary Ingredient	Achieved?	Comment	Evidence
External facilitation of problem solving meetings to facilitate reflective practice and continuous improvement.	✓ (not ongoing)	Evaluation team from NARI facilitated action research meetings in Phase 2 to reflect on practice. This led to reintroducing regular staff meetings within the team, which is perhaps a more sustainable approach.	Planning committee interviews and action research meetings.

Table 3: Fundamental program activities.

Program activity	Achieved?	Comment	Evidence
Establish planning committee to oversee program implementation.	✓	The Planning committee continues to meet on a routine basis (every 2-3 months).	Project staff attended meetings and received minutes
Establish rehabilitation units in major hospitals.	Partially	WDHS has a dedicated rehabilitation unit. PDHS has a flexible approach to allocating beds for rehabilitation.	Planning committee interviews and allied health and nursing surveys.
Produce and disseminate written policies and procedures to key participants and referrers.	✓	Program Leader has been proactive in promoting the program and disseminating written policies and procedures.	Planning committee interviews and Phase 2 allied health and nursing survey.
Introduce common assessment instrument to measure functional gains.	✓	Barthel Index (BI) and Personal Care - Participation Assessment Resource Tool (PC-PART) introduced. Outcomes for BI reported in Program monitoring data.	Monitoring data in Phase 2 and 3
Train staff to work in rehabilitation program.	✓	A broad range of rehabilitation training has been conducted including 2-3 day programs as well as post-graduate level courses.	Planning committee interviews and allied health and nursing surveys.
Appoint Medical Leaders in large sites to manage medical care of rehabilitation clients.	✓	Medical Leaders engaged and involved in PDHS and WDHS.	Interviews with Medical Leaders all three phases.

Program activity	Achieved?	Comment	Evidence
Establish care planning and monitoring processes that are inclusive of clients and carers.	✓	Establishment of family meetings, development of careplans, more involvement of clients and families.	Planning committee interviews, allied health and nursing surveys, action research meetings and interviews with clients and carers.
Develop strategy for staff recruitment and retention for SGG district.	✓	Strategy developed and has helped recruit allied health staff, although this is an ongoing challenge and there are still some disciplines where additional staff/expertise is required.	Planning committee interviews.
Establish links with external networks/ individuals to ensure people with progressive conditions get ongoing access to rehabilitation over time.	Partially. Future direction	Information concerning the extent to which external networks have been established for progressive conditions is limited. However, clients reported satisfaction with chronic disease management programs provided and the Program Leader reported benefits of involvement in the Rural Organisation of Acute Stroke Teams (ROAST) program.	Planning committee interviews, allied health, nursing and GP surveys and interviews with clients and carers.
Develop pathways for community clients in need of rehabilitation.	✓	Issue raised in Phase 1 but by Phase 3 clients could access community rehabilitation services through various avenues through the community without requiring an SGG inpatient admission.	Allied health and nursing surveys and interviews with clients and carers.

Research Question 3: What elements of the Program were modified to achieve the intended outcomes?

The main elements that needed to be modified in order to achieve the intended outcomes included:

1. adapting the role of the Medical Leader according to local requirements
2. setting clear limits to the Program in order to alleviate staff anxiety about workloads
3. introducing and adapting the appointment of an Occupational Therapist (OT) dedicated to the Program who was able to visit each site on a regular basis. Although having the OT working across sites was considered highly valuable, the workload for one OT was too great. A trial has been commenced with more than one OT working across the Program.

Research Question 4: What were the main things that hindered and/or helped in the implementation of the Program?

Barriers to the implementation of the Program included:

- staff attitudes and lack of rehabilitation culture in the hospital and general community
- recruiting and retaining staff with appropriate skills
- uncertainty about funding
- unrealistic expectation to provide intensive rehabilitation at the same cost as acute care
- lack of equipment (eg, kitchen area, some physiotherapy and OT equipment, walking equipment, hydrotherapy pool)
- conflicting roles for nurses working on wards with combined acute and rehabilitation beds – they felt the need to prioritise acute patients first
- no allied health available to clients in their own home
- high demand for services at WDHS
- too great a workload for one OT to work across all sites
- smaller hospitals did not use assessment instruments on a frequent basis and therefore do not become adept at using them
- difficult to motivate staff to undertake training, particularly when there is a small staff base and many areas to specialise in
- some instances of limited support from middle management
- lack of longer term rehabilitation for older clients (80+ years old)
- disruptions due to ward closures and openings
- lack of transport for follow-up sessions.

Factors that facilitated implementation of the Program included:

- having a dedicated, enthusiastic and full time Program leader
- having a sub-regional Program leader and OT to improving consistency in protocols
- the active promotion of the Program in the community through multiple avenues

- organising steering committee meetings that promoted partnerships between sub-regional hospitals
- having supportive medical officers who communicated effectively with GPs in the region
- keeping key stakeholders involved and informed throughout the establishment and ongoing running of the Program
- involvement in the ROAST program
- involvement in the external evaluation
- employment of an allied health assistant, which was particularly useful for the coordination of the community Rehabilitation Program in PDHS
- having dedicated rehabilitation beds located within the hospital appears to be a major facilitator for acceptance of the Rehabilitation Program and culture, where staff can see the benefits of the Program on a regular basis
- training to increase confidence amongst staff (e.g. rehabilitation nursing training for nurses and transfer of allied health skills to nursing staff and allied health assistants as appropriate)
- having enthusiastic staff who are willing to change
- having management support for the Program
- having adequate numbers of allied health staff, especially a dedicated OT
- accessing peer support and visiting other sites with established rehabilitation programs.

Research Question 5: What were the critical success factors in the SGG Rehabilitation Program that lead to effective rehabilitative care?

Refer to the enablers listed under Research Question 4.

Research Question 6: What facilitated local linkages and cooperation in monitoring clients who have a progressive or chronic recurring condition that needs bursts of rehabilitation over a long period of time?

Evidence concerning the extent to which external networks had been established for progressive conditions was limited. However, clients reported satisfaction with chronic disease management programs provided and the Program Leader reported benefits of involvement in the ROAST program. Rehabilitation Program managers also reported that chronic disease self-management was something that they were planning to develop further in the coming years.

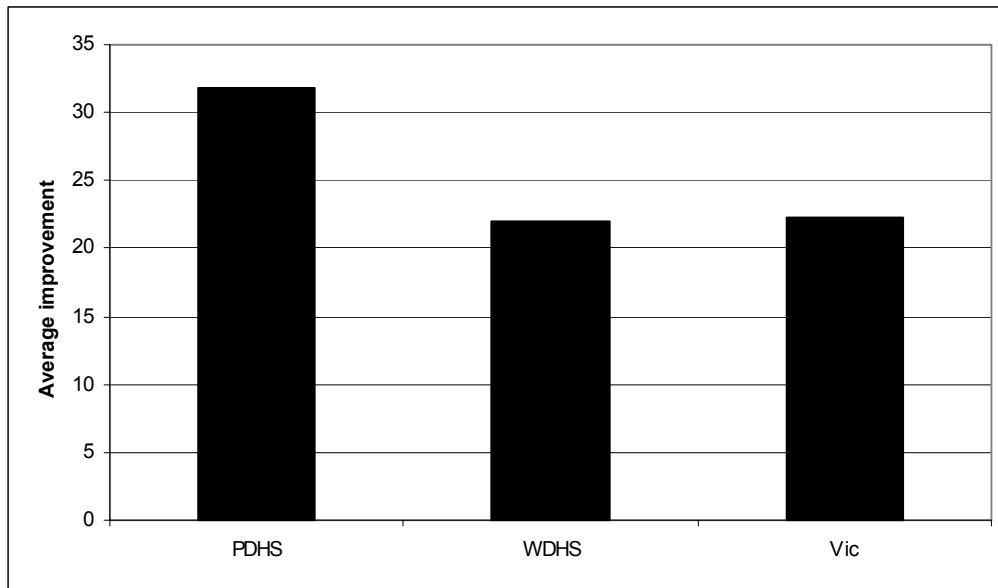
Research Question 7: Are the participating health care services working in a collaborative way to provide effective, accessible rehabilitation to the targeted population?

Possibly one of the biggest challenges that the Rehabilitation Program faced during its development was getting the participating Health Services working collaboratively, with consistent protocols and effective referral pathways. The smaller Health Services have had less demand for rehabilitation than the larger sites and therefore it has been difficult to establish streamlined and routine procedures for referral and admission to the Program. These problems were further exacerbated by the lack of allied health staff in the smaller towns. However, these obstacles are being worked through and there appears to be stronger partnerships developing between the Health Services. Feedback from allied health staff and management working on the Program indicated that the Program had improved links between hospitals and between departments, allied health and acute care.

Research Question 8: Has this Rehabilitation Program improved the health status and quality of life of the clients and carers?

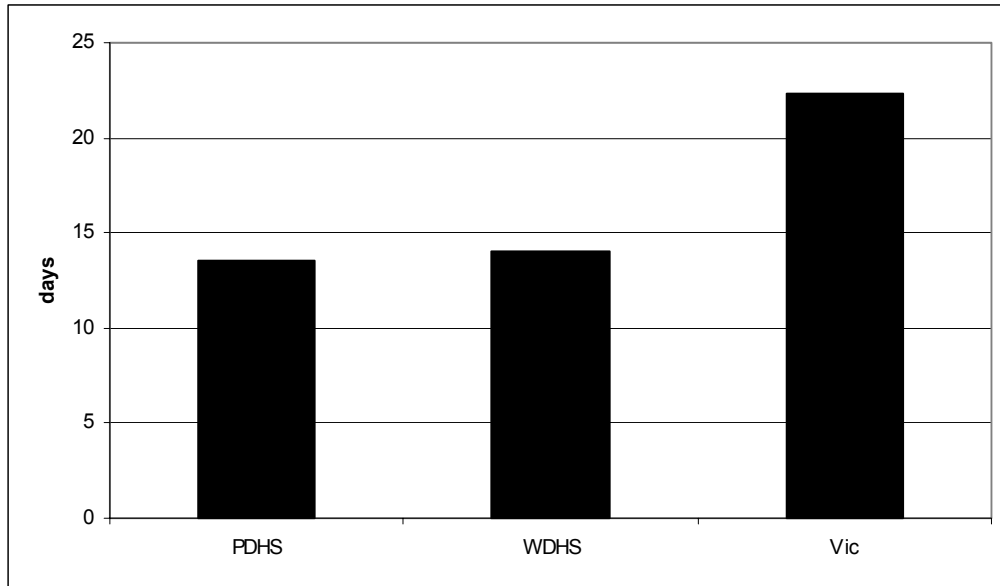
The introduction of assessment tools such as the BI and the PC-PART has assisted in monitoring functional outcomes for clients and developing client centred goal setting. Assessment of all Rehabilitation Program clients indicated a substantial improvement on the BI in both the first and second years of the Program. Figure 2 shows average improvement on the BI for the second year of the Program and compares this with the average improvement for level 2 rehabilitation clients across Victoria during this time. The higher improvement at PDHS may be explained by the different casemix of clients (refer to Figure 6).

Figure 2: Average improvement on the Barthel Index for inpatient rehabilitation clients 2005-06 financial year.



Comparisons with the average length of stay for Victorian level 2 rehabilitation clients and improvements on the BI indicate that the SGG Rehabilitation Program was able to achieve greater improvements in function with a shorter length of stay (see Figure 3 for average length of stay in inpatient rehabilitation). However, it was not possible to compare the casemix of clients in the statewide data and therefore to determine whether the SGG Rehabilitation Program had a larger proportion of conditions more responsive to rehabilitation in a shorter timeframe.

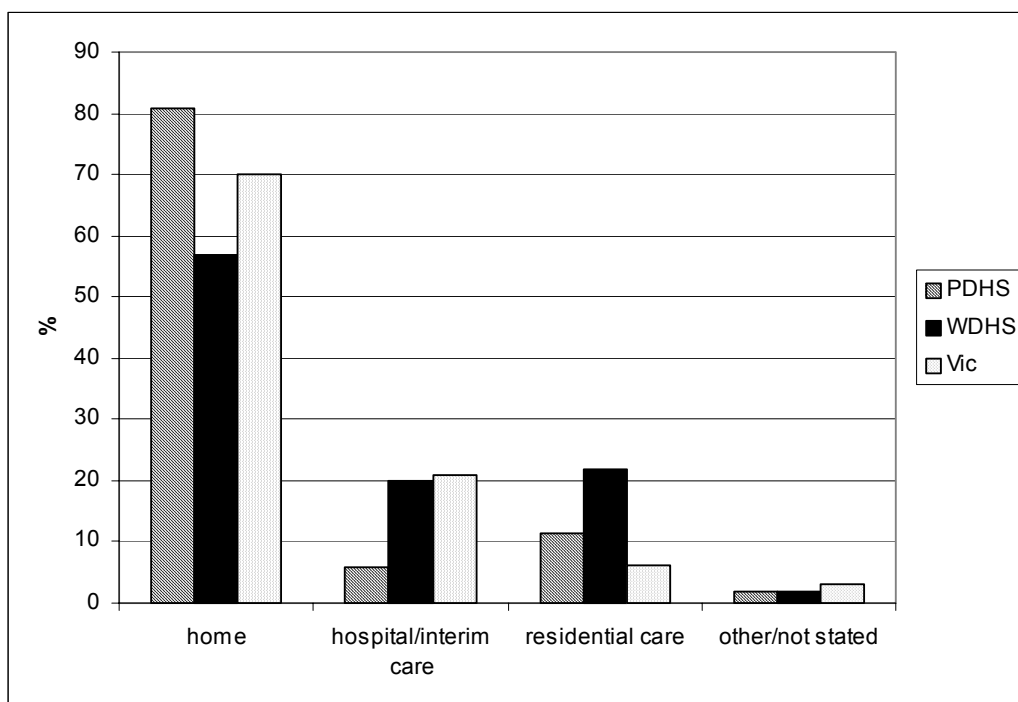
Figure 3: Average length of stay in inpatient rehabilitation 2005-06 financial year.



Clients and carers reported benefits of having access to rehabilitation closer to home, such as reduced travel time for carers and having closer contact with friends and family. The provision of community-based rehabilitation in the region was reported to be of particular significance to a number of clients.

Figure 4 indicates that the majority of SGG Rehabilitation clients were discharged home. There were, however, a larger proportion of clients from the WDHS discharged to residential aged care compared to level 2 rehabilitation clients across Victoria generally. This finding warrants further investigation.

Figure 4: Discharge destinations for rehabilitation clients 2005-06 financial year.

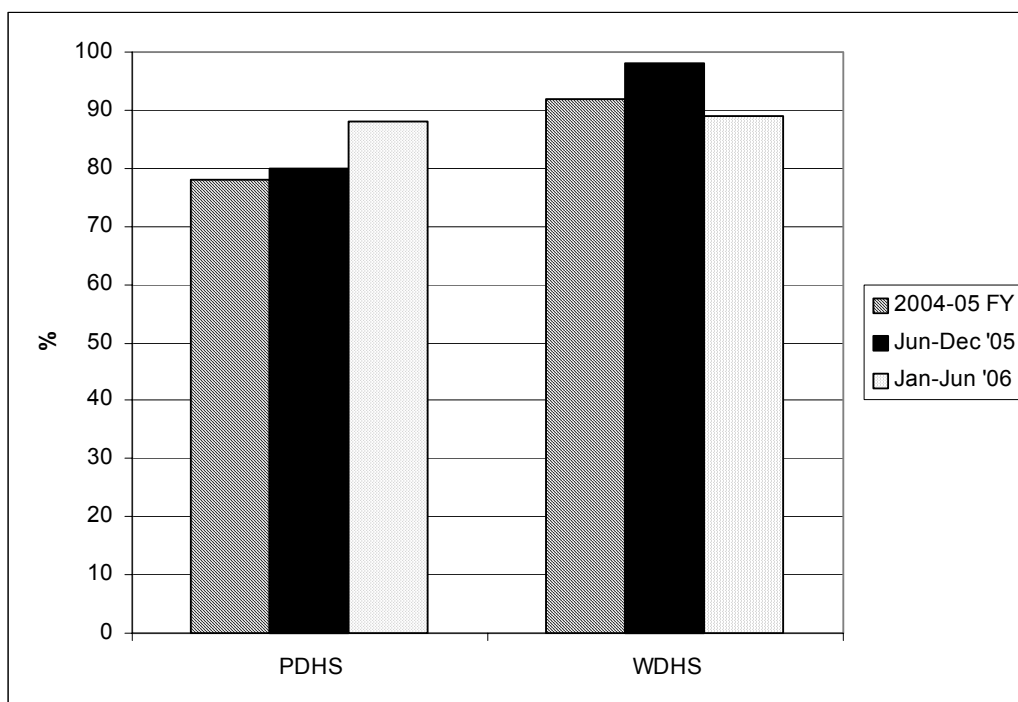


Staff and Program leaders reported numerous benefits for clients that would assist in improving health outcomes for clients including; better coordination of care, case management, more client centred goal setting, improved discharge planning and reduced unplanned readmissions.

Research Question 9: Are clients, carers and practitioners satisfied with the service?

Clients and carers reported high levels of satisfaction in both satisfaction surveys and face-to-face interviews. Clients appreciated pre-admission assessments and home modifications for orthopaedic surgery as well as support services offered on discharge. Having rehabilitation available close to home was appreciated, particularly for community-based rehabilitation where travel was required for each session and which was usually for a longer period of time. Lower satisfaction with follow-up from the Program reported in the satisfaction survey by clients at PDHS warrants investigation. Figure 5 shows that overall satisfaction with the Program over the first two years of its operation was around 80-90%.

Figure 5: Client satisfaction with the SGG Rehabilitation Program



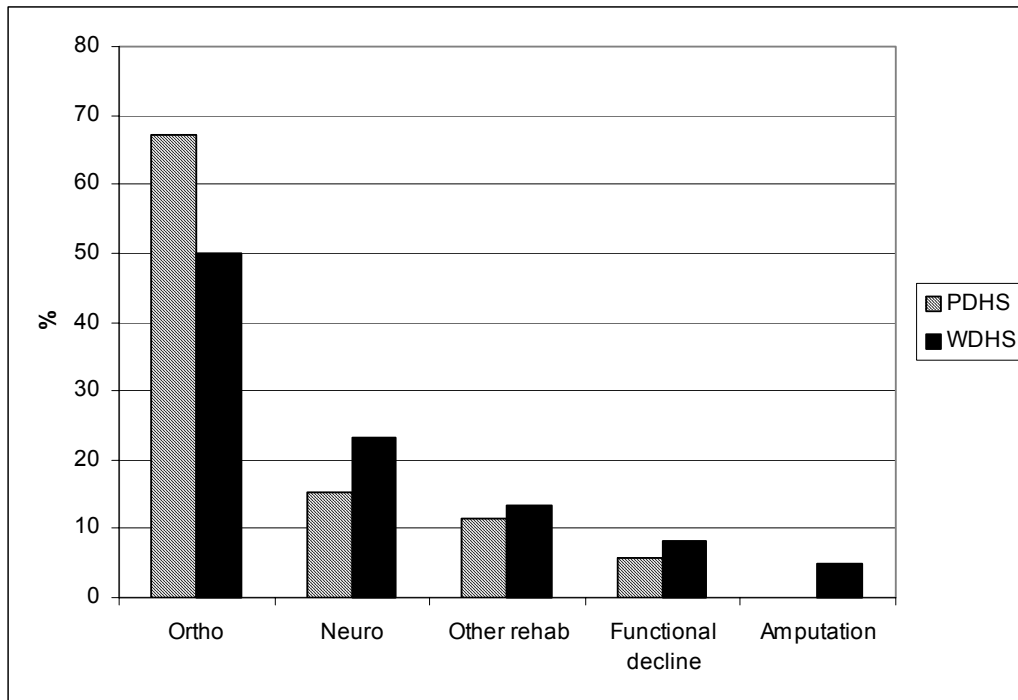
Establishment of the Rehabilitation Program has increased diversity for staff in their work, which has also assisted in recruitment and retention of staff to the Program. Staff have had increased opportunities for training, developing skills, and for accessing mentors. Staff reported the most satisfaction with improved teamwork and communication. Managers also reported satisfaction with the Program as it has improved partnerships with other hospitals and has provided opportunities to share resources, expertise and protocols, for example payroll and workforce recruitment strategies.

There were a small number of examples of GPs not referring to the Program or having access difficulties due to their remote location. These issues suggest that ongoing liaison and involvement with GPs in the sub-region is required to ensure that their concerns and barriers are being acknowledged and addressed.

Research Question 10: Has the Program resulted in improved consumer access to sub-acute rehabilitation services where they most need them?

The establishment of the Rehabilitation Program in the region means that clients now have more accessible sub-acute rehabilitation. A total of 257 clients have been admitted to the Rehabilitation Program during the first two years of its operation. The majority of clients had an orthopaedic diagnosis and the second largest number of clients had a neurological diagnosis, see Figure 6 for primary diagnosis of inpatient Rehabilitation clients during the second year of the SGG Rehabilitation Program.

Figure 6: Primary diagnosis of SGG inpatient Rehabilitation Program clients 2005-06 financial year.



Data from VAED indicates an increase in the proportion of clients staying in the SGG hospital they were admitted to, and fewer clients being transferred to other hospitals since commencement of the Rehabilitation Program. In addition, there was a trend for SGG clients admitted to out of area hospitals to be more likely to be transferred to another hospital after the Program started. This may indicate that the client was transferred to a hospital in the SGG region for rehabilitation but it is not possible to decipher this from the data provided.

There were limited data available regarding community rehabilitation in the region, which was reported by Program staff to have had a significant impact on the availability and provision of rehabilitation in the region, particularly in Portland. Access to more complete data on community-based rehabilitation warrants attention in the future development of the Program.

Recommendations for other rural areas

Recommendations made for other rural areas planning to implement a similar program included:

- set aside 4-6 months to establish policies, protocols, and guidelines training before commencing the program
- involve all stakeholders in the planning stages of the program
- have a champion/driver in each hospital as well as support from all levels of management
- develop a flexible model that adapts to the different needs and cultures within each hospital

- provide extensive and ongoing promotion of the program to all stakeholders, including GPs, nursing and allied health staff, local community care services such as ACAT and local government. This not only includes informing people about the program but also involving them in the planning of the program
- secure funding for 3-4 years. One to two years is insufficient time to get the program running and to provide evidence of effectiveness for ongoing funding
- establish regular rehabilitation team meetings to enhance communication
- have a full time, sub regional coordinator
- ensure adequate staff levels to provide intensive rehabilitation
- have staff experienced in rehabilitation, supplemented with training of existing staff at various levels. For example, post-graduate education for rehabilitation staff, as well as general training for non-rehabilitation staff regarding the role of the rehabilitation program, the importance of a rehabilitation culture and referral processes to the program
- establish peer support and ongoing mentoring from other hospitals. For example, site visits to established rehabilitation programs and meeting with experienced rehabilitation staff
- formalise the referral system and ensure it ties in with existing systems
- undertake an external evaluation to provide an alternative perspective and encourage staff to reflect on the program.

5. Summary and Conclusion

This report has provided an overview of the three phases of the Southern Grampians Glenelg Rehabilitation Evaluation. A brief summary of the key findings of the key findings is provided in Table 4 below.

Table 4: Summary of outcomes

		2004/05	2005/06	
Patient outcomes	Number admitted	129 inpatients 49 community	128 inpatients 41 community	
	BI change	>30 (13*)	22.0 (WDHS) 31.8 (PDHS) (22.3*)	
	LOS	10-12 (22.9*)	13.5-14 (22.3*)	
	Satisfaction		76-92	88-89
			Increased involvement in care planning/goal setting	
			Rehabilitation close to home	
			Better coordinated care	
	Improved discharge planning			
Staff outcomes		High satisfaction with Program		
		Improved training opportunities (Courses and visits to McKellar Centre)		
		Access to mentors		
		Improved recruitment		
		Improved teamwork/support and learning from each other and medical leader		
	Improved model of care			
Management/ organisation outcomes		Trial of a sub-regional approach – provided opportunities for sharing of resources, expertise and protocols		
		Development of a “rehabilitation culture”		
		Improved recruitment		
		Reduction in unplanned readmission		
Regional outcomes		Overall reduction in admissions and LOS for people with conditions considered responsive to rehabilitation		
		Increase in within hospital transfers within SGG hospitals		
		Increase in transfers to other hospitals for non-SGG hospitals (?back to SGG hospitals)		
		No reduction in out of area admissions		

*State averages

Ongoing challenges

Some of the future challenges for the SGG Rehabilitation Program include:

- securing ongoing funding
- developing strategies to enhance engagement of smaller hospitals
- further developing community rehabilitation services across the region
- meeting future increased community needs for rehabilitation and establishing Geriatric Evaluation and Management beds in the SGG sub-region

- developing adequate inpatient rehabilitation facilities and increasing availability of equipment
- investigating higher discharge to residential care in Hamilton
- recruiting and maintaining adequate numbers of allied health and medical staff
- ongoing mentoring and development opportunities for staff working in the Rehabilitation Program.

Conclusion

The commencement of the SGG Rehabilitation Program has been a major undertaking involving extensive commitment from staff and stakeholders across the SGG sub-region. Findings from all three phases of the evaluation have identified a range of positive outcomes for the region, including positive functional and quality of life outcomes for clients with conditions conducive to rehabilitation and a more coordinated and client centred approach to care, as well as areas for further development.

Prior to the commencement of the SGG Rehabilitation Program, patients within the participating health services did receive allied health support post surgery or stroke or other adverse events. However, there was no formal rehabilitation program. For clients, this meant that there was no consistent approach to determining eligibility for allied health support, no team care planning, no case management, no consistent medical management for rehabilitation clients and no access to public allied health support unless they had been admitted to hospital. For staff, there was little impetus to pursue training in rehabilitation and little opportunity to develop skills in rehabilitation.

In the two years of its operation the SGG Rehabilitation Program has established two inpatient rehabilitation facilities with a coordinated team approach to rehabilitation that is inclusive of the client and carer. There are pathways for access to this service from all participating health services and from the community (access to rehabilitation is now possible without a hospital admission). There is also a small-scale community rehabilitation facility at PDHS where both inpatients and community-based clients can access therapy. There is evidence of improved outcomes for clients participating in the Program and high levels of satisfaction. This has been achieved with a client group who are admitted at a lower level of function than the State average for level 2 Rehabilitation and within a shorter length of stay than the State average for level 2 Rehabilitation. The Program has supported staff development and appears to have increased staff satisfaction, recruitment and retention. These are major achievements and mean that almost all of the objectives set at the commencement of the Program have been achieved.

As with any major organisational change, implementation of the Program has involved a major shift in practice and organisational culture and has been faced with a number of attitudinal and resource obstacles. The Program was established in a sub-region that previously had minimal expertise in rehabilitative medicine. Having no model to build on, either from within or external to the sub-region, created a challenge to implementation of the Program. The ongoing dedication and consistency of the Program Leader appears to have assisted in the successful change management process. Barriers to implementation of the Program have been acknowledged and

well managed. Future challenges for the Program include meeting increased population demands, maintaining adequate levels of allied health and medical staff to support the Program, improving rehabilitation facilities and equipment and extending community based rehabilitation.

Findings from this evaluation provide some valuable insights for other rural regions aiming to implement a sub-regional rehabilitation program. Other rural regions will have the benefit of having an established model to build on and can learn from the experiences of those in the SGG sub-region. Findings from the evaluation suggest that trying to introduce an extensive Rehabilitation Program including building rehabilitation expertise and implementing inpatient, community and home-based rehabilitation may be overly ambitious to undertake at the commencement of a program. Perhaps the first phase is to develop rehabilitation expertise and inpatient beds in one or two of the larger sites in the region. This first phase may take around two years to entrench in the culture of the larger sites. Phase 2 could extend rehabilitation to community centres and also focus on promoting referral pathways between larger and smaller sites. A final phase could examine the feasibility of establishing home-based rehabilitation in the region.

In conclusion, the SGG Program appears to be viable and of benefit to the population of the SGG sub-region. It is therefore recommended that it be provided with the resources required to enable it to continue and that similar models be trialed in other rural regions of Victoria where there is a need for rehabilitation.