WA Spinal Cord Injury Services (WASCIS)
Background: Existing service status in WA

Fragmented services for people with SCI:

- Gaps in continuity of specialist clinical services after discharge from hospital, following injury
- Disability Services Commission (DSC) funding models limit option for people with SCI
- A lack of funded personal supports and accommodation for the person to return to community after injury

Result:

- Some people with SCI have to move to the Quadriplegic Centre temporarily or permanently
- Some people are discharged home with minimal personal supports, leading to multiple complications requiring re-admissions
Background: Existing Model of Care

- Hospital-based model of care (Quad Centre), is not considered a contemporary disability service model, as it does not enable independence
- WA does not have a specialist multidisciplinary community program for specialist care, unlike other states

Result: Delays in people with SCI resuming normal life after their injury, limiting their quality of life. Sometimes people get secondary infections and complications and have to be re-admitted in hospital
New Funding sources now available

- Reform in disability funding, ie NDIS
- No-fault Catastrophic Injury Compulsory Third Party insurance

Result:
- More options to fund people with SCI returning to community directly from hospital
- Quad Centre will not continue as an alternative care and accommodation option
New Model of Care

1. The specialist service: Spinal Outreach Service
   • Phase 1: a short term rehabilitation program, to assist the person adjust to living in the community, following discharge from hospital
   • Phase 2: long term monitoring and education (for person, carers and providers) to assist the person maintain their independance in the community

2. Integrated Discharge Planning- Disability Services Health and Housing Authority working together to plan and organise the NDIS funded supports that is required for the person to return to community from the hospital.

3. Peer Support Program- a volunteer based program to complement and work with the specialist services in supporting people with SCI reintegrate into community
Model for new governance of WA Spinal Cord Injury Service recommended by the 2015 Qld review
The new Model of Care aims to

• Be community based, not hospital based
• Enable independence, not foster reliance
• Support person centred approach, not be specialist driven
• Focus on linking with providers and services in the community
Community Rehabilitation Program (transition from hospital)

- First phase of the Spinal Outreach Service
- Provide rehabilitation in the person’s home as a continuation of the hospital rehabilitation program.
- Unlike the inpatient program, rehabilitation in the community includes the team making appointments to see the person at home usually once to twice per week.
- Opportunities for the person to practice the skills taught in the inpatient setting and develop new skills, with the involvement of family/friends/carers, as desired by the patient.
- This phase of the program is time-limited, with the duration of the program defined by the goals set for the program.
- Since this is a short term program, the focus is on the goals for the transition period immediately after discharge. Some of the patient’s longer term community goals may be worked on beyond the duration of this program, linking with local providers.
Community Rehabilitation Program aims

Nurse and therapists from the State Rehabilitation Service work with the person to

• identify and assist the person overcome barriers (physical or otherwise) and support the person’s resumption of community living

• build person’s confidence when they go back home and resume living/working in the community

• Ensure that the home modifications and prescribed equipment are fit for purpose and meet the needs of the person

• Promote participation in the person’s community by supporting the establishment of linkages with local care providers for clinical care, personal care, equipment services, vocational, leisure and other services as required. Local care providers include the GP, home visiting services, local therapists, NDIS providers, DSC local Co-ordinator and vocational rehabilitation providers
Community Rehabilitation Program- Regional patients

- For people living outside the Perth metropolitan area, accommodation can be provided in accessible community houses, for the duration of the program.
- The community houses will be in the Perth metropolitan area and patients can live in these houses with their families/carers while participating in the program.
- For people from regional areas who do not wish to continue their rehabilitation in Perth, the Outreach team will support to the sub-acute teams in the regional centres, to provide the program.
## Phase 2: Consultation and education

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<td>Following discharge/CRP, the patient is contacted regularly by the Outreach team for 12 months. The contact is usually via phone/email and the frequency of contact is planned in conjunction with the patient.</td>
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<td>During the phone call, the patient/carer is asked to identify issues that could be affecting their progress towards their goals after discharge. This can include in areas such as skin care, bowel and bladder management, equipment, activities of daily living, posture and seating etc.</td>
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<td>The Outreach team provides customised advice and/or education based on the patient’s needs, with the focus on maintaining independence.</td>
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<td>Where direct clinical services are required (eg: equipment to be repaired, wound to be dressed), Outreach links the person to the local service providers (nursing, allied health, GP etc.) and provides specialist support/education to the local provider, if required. Support can be provided via phone/email or videoconferencing depending on the issue.</td>
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<td>Based on the issue, the Outreach team plans frequency of further monitoring and intervention, working closely with the local provider or the Local Area Coordinator. The patient/carer/provider can contact the Outreach team as required, regardless of the planned contacts.</td>
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<td>In some instances, for ongoing clinical issues that cannot be managed in the community, the person may require an appointment at the Outpatient Services at SRS (eg: specialist medical review) and/or an inpatient admission at SRS.</td>
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Role of Advisory Group in the implementation of the new Model of Care

• Provide a ‘sense check’ as the model is developed- is this program going to benefit the consumer
• Engage with the wider SCI community on the MoC
• Canvas opinions of different sections, to gain breadth of opinions
Project Plan over 3 years

- Stage 1: Implementation of the new Model of Care
- Stage 2: Building new housing for the long term residents of the Quad Centre
- Stage 3: Transitioning the current Quad Centre residents to community living, with concurrent transition of Quad Centre workforce and decommissioning of the Quad Centre
We ask for your feedback on the Model of Care

• What do you like about the proposed Model? What do you think will make it work well for people with SCI in the community?

• What are the gaps in the proposed service from your perspective?
  - when a person first leaves hospital
  - when there is a change in health status (eg: pressure ulcer) or a change in functional status (eg: vocation/recreation)

• Any other comments/questions
Where to send your feedback

- Email: NMHS.RedevelopmentAdmin@health.wa.gov.au
- If you would like to provide your response over the phone please call 6457 1594 to leave your details for Elizabeth Ring to phone you back