State Spinal Cord Injury Service (SSCIS): Past, Present & Future
Objectives

- Promote and strengthen network through interactions and shared planning activity
- Discuss what network is, where has come from and where should be going now
- Collectively identify current core strengths to build on, as well as key issues, future challenges and opportunities for redesign
- Develop a shared vision!
Overview

- SSCIS Directorate established in 2002 as a network of the Agency for Clinical Innovation (previously of GMCT) to facilitate networking and co-ordination of spinal cord injury services within NSW

- Encompasses traumatic and non-traumatic injuries, which are acquired and non-progressive, requiring specialised SCI services
Enhancement funding (GMCT)

- SSCIS Directorate
- Staffing enhancements in each SCI unit
- Additional spinal beds (4 beds at POWH, 2 acute beds at RNSH and 2 beds at Royal Rehab)
- Spinal Plastics Outpatient Services (POWH/RNSH)
- Spinal Seating Services (POWH and NSLHD, latter offering rural outreach services)
- Spinal Cord Injury Database
- Spinal Outreach Service & Rural SCI Service
2010 Spinal Plan Recommendations

- ‘...define referral pathways, criteria for admission and readmission to adult…’
- ‘...develop more formal linkages between the adult and paediatric SCI services, to provide consultative support & assist the transition from paediatric to adult services.’
- ‘...an integrated service model for state-wide non-inpatient, outreach and hospital support…’
- ‘...transition model of care for adults with spinal cord injury, in partnership with other agencies…’
- ‘...work with ADHC and Housing NSW, in the Department of Human Services NSW, regarding positive measures to expedite funding approval…’
- Other (Data Mgt, VDT, NDIS, ABF)
Current SSCIS Priorities

- Working to implement Plan recommendations
  ▲ Progress a transition model of care (not just accommodation), in partnership other agencies
  ▲ Establish Interagency Working Group

- Developing implementation strategy for the *Acute Spinal Cord Injury Transfer Guidelines*

- Implementing *PIPM MoCare for SCI and SB*

- Update of all *Education Factsheets*

- Review of *Data Collection/Management*
Data Management

- Urgent need to upgrade SCID, and related SOS & RSCIS databases - outdated platform, requiring development of a web based format / platform
- Data items - need to harmonise with / incorporate international standard datasets for benchmarking
- Collaboration between ‘Access to Care’ project and VSCS / Melbourne Univ. eResearch team.
- Web-based data portal, latest security-oriented e-Infrastructures, anonymised/encrypted data hosted on secure virtual machines, allowing cross-jurisdictional data collection / analysis.
Research

- Right Care, Right Time, Right Place - Access to Acute Care (*NHMRC*)
- Psychosocial Care – Best practice assessment & intervention (*LTCSA*)
- Develop Community of Practice for Knowledge Translation & Practice Improvement (*NSW Health*)
- Chronic Pain in SCI (*LTCSA*)
National Disability Insurance Scheme / National Disability Insurance Scheme

Links between hospital services, primary & community care

Funding models & incentives (ABF)

Care Pathways, Guidelines & Protocols

Data & Outcomes monitoring

IT and other infrastructure

Workforce

Enablers

Clinical Practice Innovations

Education

MoC for the Prevention and Integrated Management of Pressure Injuries in People with a SCI or Spina Bifida

State Spinal Cord Injury Service Psychosocial Strategy / Peer Support Services

Spinal Seating Professional Development Program and Resources

MoC for the Prevention and Integrated Management of Pressure Injuries in People with a SCI or Spina Bifida

InVoc Program

Early Access to Care / ATGs / Surgical decompression & fusion

Prevention of secondary complications

Fragmented, episodic, inefficient care, segregated by organisational boundaries, gaps in service, lack of access, inequity

ACI NSW Agency for Clinical Innovation

ParaQuad and SCIA programs & Community services

Spinal Outreach & Rural SCI Services

LTCSS
Addressing Health System Problems

- Fragmented care (working in silos)
- Episodic focus
- Inefficient use of financial/human resources
- Growing pressures on health system

**Integrated Care** to provide person-centred, seamless, effective and efficient care

**Collective impact** through common agenda, networks / partnerships, shared data & outcomes, mutually reinforcing activities, continuous communication, supporting infrastructure
Collective Impact

- Engage all sectors for policy change to promote health and wellbeing for people with SCI
- Parties have a common agenda with a shared understanding of the problem and solutions
- Consistent data collection / outcome measures for alignment and accountability
- A plan of action that outlines and coordinates mutually reinforcing activities for each party
- Open, continuous communication builds trust, assures mutual objectives, motivates system
- Organisational framework / infrastructure coordinates participating organisations / agencies
Key Challenges to Care Integration

- **SCI Services / Resources** - long-term funding/resources to maintain adequate multi-disciplinary staffing in specialist, rural and community services; *care is fragmented and unequal*; lack of OPD/ambulatory services; limited access to specialist services post-discharge; limited rural services;

- **Equity** - lack of consistency across services; ensuring equitable, lifelong access to specialist care;

- **Poor Communication** - inpatient to community; disengagement of community/primary care; between all stakeholders; within teams and to external stakeholders; lack of integration & communication across services
Key Challenges to Care Integration

- **Transition** - understand issues impeding transition, lack of transitional accommodation (esp. >60s, non-compensable), rush to discharge results in more work & support required in community, lack of community based support for bed rest; paediatric to adult services;

- **Equipment** - lack of funding; **delayed access** to once in the community; **difficult access** in rural and remote; fair and equitable access.

- **Other agencies** - need for **better coordination** across agencies, **delays** in getting housing, home mods, care, advocate for **greater community based support**

  ▲ **Care:** need for educated professional carers;
  ▲ **Home mods:** lack of funding; delays
Key Challenges to Care Integration

- **NDIS** - impact on service provision; shrinking community support; need for greater collaboration & working groups across agencies

- **Non spinal specialist services** - need for greater understanding of the needs of SCI people; lack of funding and care options; lack of understanding of how/where to access specialist services

- **Nursing Homes/over 60-65yrs** - lack of funding; lack of personal care

- **Rural** - lack of transport options; resources
Opportunities & Innovations

- **Improve Communication** - inpatient and community; rapid access to specialist advice by non-specialist clinicians; support local / rural staff to participate in discharge planning meetings; improve collaboration (within teams, within NSW, cross-border); inter-departmental approach to collaborative discharge planning; greater liaison with external agencies.

- **Expand Specialist Services reach** - statewide approach; guidelines re: role of specialist services vs GP/community in SCI care; better access to OPD / ambulatory services in metro area; continue support for rural services;

- **Education** - need for specialist & non-specialist education; education to local, regional, rural and nursing home staff; client education to promote realistic expectations.
Opportunities & Innovations

- **Other services** - support primary care services, approving exercise rehabilitation, lobby Health to be a provider for complex care needs

- **Technology** - to support rural clients/services, specialist staff to follow up rural clients via telehealth

- **Paediatrics** - greater links, greater education

- **Model of care** - transition
Key Issues to address in 6-24mths

- **Transition** (accommodation x7, equipment x2, services, rehab); also **Paediatric to Adult Transition**
- Extra **SCI-specific Outpatient services**
- **Interagency/Coordinated Govt Approach** to Service Provision (eg. Housing/EnableNSW to resolve delays)
- **Integration across Continuum / Patient Journey**
- **Equity** (viz. non-compensable, NTSCI, paediatrics)
- **Telehealth/Greater use of technology** (PI, rural clients, clinical services & virtual follow up)
- **PI Prevention & Management MoC x3**
- **Nursing Home clients** (advocacy staff/better care, equipment) support older SCI persons
Key Issues to address in 6-24mths

- **Data / Outcomes** (clinical, process & service outputs) – suitable instruments
- **Ongoing Education** (for clinicians) / Carer Training
- **Accessible client information/media, care pathways**
- **Psychosocial resources/support** for self management, staff, NDIS/LTCSS
- **Research** (PI post-surgery, service delivery/outcomes)
- **National Strategy** x3 (tied to NDIS, Housing, Health)
  ▲ Shared by all stakeholders, success defined by outcomes for SCI
- **NDIS/NIIS** x6 (lessons learnt NTSCI & older SCI, future impact on funding & services)
Any Questions?
What Future Services Look Like

- Person-centred
- Integrated and connected
- Right care in the right place at the right time
- Streamlined - access, flow and efficiency
- Interagency collaboration to facilitate timely discharge (and prevent exit block)
- Strong partnerships
- Innovative practices
- Financially sustainable
Our Future Services

- Improving access, continuity and responsiveness of health care services
- Developing collaborative, innovative models of care
- Systems in place for consultation, referral and transfer to higher levels of care
- Improve connectivity and access to health care services through technology
- Workforce / health infrastructure
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