Facilitating sub-acute care 'closer to home' for rural and remote patients

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An innovative collaboration, between public allied health services and primary healthcare service providers, is supporting the implementation of a project to provide an integrated sub-acute service across agencies and geographical boundaries in central and north-west Queensland.

Background

An allied health sub-acute collaborative (the Collaborative) was established in November 2017 between allied health professionals from public health services and primary health care providers with the aim of improving a patient's sub-acute journey, particularly for those patients from rural and remote communities. The partner agencies include hospital and health services, an Aboriginal community-controlled health organisation, non-government organisations and a university department of rural health; working across the large expanse from Rockhampton and Townsville on the eastern seaboard, to the west and north west of Queensland. Providing sub-acute care across the health continuum is considered core business for allied health professionals.

The Collaborative was formed in response to a commitment from Queensland Health to provide equitable access to safe, quality healthcare for all consumers. It also supports a growing trend to transfer clients to smaller facilities in the sub-acute period, minimise displacement from home communities and support system efficiency in large regional and metropolitan hospitals (Dow et al 2010, NSW Health 2015).

Sub-acute care refers to the generally accepted interpretation and intent of the Australian National Sub-acute and Non-Acute Patient (AN-SNAP) definition and is consistent with the WHO definition of rehabilitation, where the overall aim is to improve, maintain or minimise the loss of function. (IHPA 2019, WHO 2017).

Providing care closer to home and the introduction of early supported discharge to the community has been shown to have a meaningful impact on clinical outcomes and recovery and meet health service imperatives (AIHW, 2013; Grigoryan & Javedan, 2014). However, results from a process mapping exercise found that, for those people from rural and remote communities who had sustained an acute episode that required rehabilitation, completing their sub-acute care close to home, or at home, was generally not an option. Patients invariably have multiple transitions and assessments throughout their acute and sub-acute journey and may stay longer in the regional centre, with only one or two days stay in their closest health facility prior to being discharged home

Anecdotally discharge planning is late in the sub-acute episode with little consideration for clients' home environments and the availability of services within their local community.

An analysis of the Queensland Hospital Admitted Data collection (July 2014-June 2017), using fractured neck of femur and stroke as sub-acute tracer conditions, suggests that people from rural and remote communities are less likely to have access to sub-acute care. For those clients that do have a sub-acute episode of care, they tend to complete their acute and sub-acute care away from home, often up to 200 Km and in a few isolated cases up to 1400 Km, from home.

The 'Transition 2 sub-acute' project places the client in the centre of the sub-acute journey, and aims to expedite return to home communities, or as close as clinically feasible, for sub-acute care. The service model aspires to provide a seamless sub-acute service regardless of service provider and reduce duplication and gaps in existing models.

A series of tools have been developed to improve processes and build capability and capacity across rural and regional sub-acute services:

- A framework has been developed that builds on the allied health rural generalist service model, including better use of assistants, telehealth, skill sharing and partnerships.
- A criteria-led decision-support tool and companion discharge communication process have also been developed to facilitate a predictive, inclusive and consistent transition between regional and rural hospitals, and between rural hospitals and primary health care services.

This paper describes the journey thus far in working as a partnership towards providing a seamless sub-acute service, particularly for those from rural and remote communities.

A two-year implementation phase commenced in mid-2018 with oversight from the Collaborative. The key activities currently underway include:

- Introducing and embedding the decision-support tool and early discharge planning across all sites
- Developing sub-acute service plans using the allied health rural and remote sub-acute framework (AHPOQ 2018)
- Undertaking a formal evaluation using a mixed-methods approach to explore the effectiveness of project activities on the provision of equitable, efficient and sustainable allied health sub-acute services over time

Findings

Introducing the criteria-led intake and step-down transition tool

A key objective of the 'Transition 2 Sub-acute' project is to develop a criteria-led decision-support tool that can be initiated by allied health clinicians to improve consistency and predictability of transitions across the acute to sub-acute and home continuum. It is intended to be used in collaboration with other members of the multi-disciplinary team at the treating and receiving sites, and the patient and their family, to ensure timely and shared decision-making.

The transition planning tool (TPT) was developed, using best practice markers to support evidence informed decision making, after an initial scan of the literature and other jurisdictions confirmed

that such a tool was needed but did not exist. The tool is planned to be used at least twice after a patient has been classified using the SNAP classification; early in the sub-acute phase and then closer to the scheduled transfer date. During the initial videoconference between sites the TPT is completed, the two sites identify any issues that need to be addressed prior to transfer and share capacity and capability to provide care for the patient in the short to medium term. The final meeting will generally include the family and carers. Developing the tool was an iterative process and included trials with 25 patients in the two regional hubs of the Collaborative.

Feedback from sub-acute care staff who were involved in trials indicated that, in most cases, the tool was considered useful in assisting with discharge planning, improving communication and facilitating discharge closer to home sooner. Staff did highlight concerns about the time it took and issues around setting up the videoconference.

Feedback from patients and family were very positive. Comments from two sub-acute patients who returned to rural towns early using the TPT included:

> "I felt like I was in control of what was happening with my discharge plan to home" "It [the planning tool] has helped me mentally and physically (returning home) sooner rather than later"

The criteria-led intake and step-down transition tool and early discharge communication processes are now being rolled out for use across the project sites to transition patients between phases of care and services. This includes being introduced into acute wards where sub-acute patients could transition directly to a rural facility or home with support rather than progressing through the acute to sub-acute transition at the regional hospital prior to discharge.

None of this is without its challenges. There has been, and continues to be, some resistance from regional allied health clinicians to using the tool routinely for all sub-acute patients from rural and remote communities to transition patients closer to home. Whilst anecdotal at this stage, the main concerns seem to relate to: a) the level of care that the patient will receive if they transition to a rural service as opposed to if they stayed in the regional hospital longer; and b) a lack of recognition for the skillset of their rural colleagues. There has also been some indifference by the broader multi-disciplinary team, which will require considerable attention if the tool is to be embedded into practice.

Developing rural allied health sub-acute services

Considerable time has been spent mapping current services and models, understanding referral pathways and the current capacity and capability of rural allied health teams to provide sub-acute care.

We undertook a three-month audit of sub-acute activity for allied health services across Collaborative sites and services. What we found was that most sub-acute services (97%) are provided at the base location, 1% of services are provided through outreach and 2% of services are delivered by telehealth. Delegation and use of allied health assistants were reported in approximately 30% of episodes of care. What was surprising was the sheer number of sub-acute occasions of service being reported by allied health outside the regional sites.

Mapping sub-acute services offered no surprises. In most cases, sub-acute services are provided as part of an allied health generalist model in rural services and facilities. Consistent across sites were the perennial issues around the transient nature of the workforce and high numbers of early career clinicians, poorly defined or understood referral pathways, lack of clarity within and across services

about who will provide what services and inherent risks of duplication, coupled with the tyranny of distance. Access to telehealth capability was reported as available across all sites and all services, although connectivity outside the more populated towns remains an issue.

Modes of service delivery varied: several services are using delegation to a generic allied health assistant; there is infrequent use of telehealth, but almost exclusively for speech pathology for dysphagia screening; and skill-sharing is used informally.

Project sites within the Collaborative are now implementing key components of the allied health rural and remote sub-acute framework within their sub-acute services and building on results from the mapping process. Some services are more advanced than others but there is a genuine commitment and enthusiasm to create a sub-acute service that will deliver innovative workforce solutions and models of care.

The following examples demonstrate progress to date:

> One of the larger sub-acute project sites has undergone significant change. They have shifted from four quite disparate services, including a hospital that did not consider sub-acute care was core business, to a cohesive sub-acute partnership. They now have formalised a partnership between agencies, have established a single referral pathway and forged more transparent relationships with the regional referring hospital. Together they are now exploring options to better utilise partnerships and telehealth to provide more timely and equitable access to sub-acute care. A patient who recently transitioned from a regional hospital to home, where he is continuing his rehabilitation through a partnership between two of the agencies stated: “It’s good to be home.”
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> Several rural facilities are developing sub-acute service plans that demonstrate their readiness to manage sub-acute patients earlier in the continuum, including exploring options to deliver telehealth into the home as an alternative to resource-intense outreach service. One service is trialling skill-sharing between physiotherapy and occupational therapy. Within these facilities there is a strong desire to bring patients closer to home early and debunk myths suggesting the service is, in anyway, inferior to what they may receive at the regional facility. One patient from a rural town who remained in the regional facility rather than transitioning home earlier had this to say:
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> “Patients assume that a bigger facility with a large gym and more staff to help you is better, however little hospitals shouldn’t be different. Closer to home you will get more visitors, you will be happier and your family will be happier”

The Sub-acute Collaborative

Contrary to the way that many collaboratives are established, this multi-agency, multi -site collaboration grew organically from a shared view amongst partner agencies that they could provide a more integrated approach to care if they worked more closely together. Consistent with recent research, the underlying assumption is that the Collaborative will learn faster, be more motivated to do things differently and be more effective at implementing and spreading innovative ideas by collaborating and comparing practice rather than working as a single entity (de Silva 2014, Wells et al 2017).

The Collaborative meet regularly to review progress and address identified issues, and as a result have established strong inter-agency and rural-urban partnerships that are changing the approach to sub-acute care in the region.

The overall health and usefulness of the partnership is being assessed and monitored using the Vic Health Partnership Tool (Vic Health 2016). This tool is a way of reflecting on the partnership; how it is working to motivate for change, develop necessary supports to introduce change and manage the process.

Feedback from the first time the tool was used, six months into the implementation phase of the project, suggests that the Collaborative is working as intended but requires ongoing monitoring and investment to continue to add value to the work of each partner. Overcoming differences in organisational priorities and language, ensuring that all member voices are heard and being able to share information easily were identified as issues that require further attention if the partnership is to continue to meet member expectations.

Lessons learnt and conclusion

The 'Transition 2 Sub-acute project' still has a long way to go to meet its ambitious outcome of providing equitable access to sub-acute care across the central and north-west belt of Queensland. Three significant lessons we have learnt so far include:

- Resistance to change often comes from within. As identified in earlier publications exploring allied health scope of practice (Department of Health, Queensland 2014), allied health professions often assume that nursing and medicine create the greatest barriers to introducing new ways of working, but it is frequently the allied health professionals themselves that create the greatest resistance to change. There needs to be a shift in thinking about what is in the best interest of the patient and their family and being open to the range of proven ways in which sub-acute services can be delivered.

- Permission to lead continues to impede allied health professionals to feel confident to lead change.

- Current tension between the 'push and pull' dynamics along a patient's referral pathway can limit the ability to provide a truly patient centred and seamless sub-acute services. Best practice would suggest that services need to be able to 'pull' patients from the acute and rehabilitation beds as soon as is safe and appropriate to do so, but equally there needs to be available services at the receiving end of the continuum to meet demand (Ontario Stroke Network 2012). The current model is more a 'push' model from the regional acute and rehabilitation service than a pull model from rural services. The balance needs to shift to create a stronger and supported 'pull' model.

- Using a collaborative approach appears to be working positively to achieve agreed strategies but requires ongoing effort to nurture the group, keep on task and maintain ongoing commitment, particularly as each partner agency has many other competing priorities.

Co-design of sub-acute services across agencies, sectors and regional-rural teams presents opportunities to enhance service outcomes and the patient experience but requires attention to address the challenges and roadblocks along the way.

This partnership has the potential to fully capitalise on the scarce allied health resources in rural and remote communities. We anticipate that if this project is successful in delivering innovative allied health models and workforce solutions that improve access to seamless sub-acute care, particularly into rural and remote communities, we will also be successful in improving the overall delivery of allied health services.

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Presenter

Jenny Finch is a physiotherapist by background with a diverse range of clinical and health management experiences both in Australia and internationally, in less industrialised countries. She has an extensive background in health service development and workforce reform. Currently Jenny is working within the Queensland Department of Health Allied Health Professions' Office and is supporting work related to the allied health expanded scope of practice workforce reform. In previous positions she has been responsible for leading strategy development for the allied health professionals at a health service and statewide level.