Transition 2 Sub-acute

Initiative Type

Service Improvement

Status

Deliver

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https://cnxp3cuvtvrn68yjaibaht5ywrxspj7m.clinicalexcellence.qld.gov.au/improvement-exchange/transition-2-sub-acute

Summary

A partnership has been established between a group of allied health professionals from across the central and north-west belt of Queensland to improve the patient’s sub-acute journey, particularly for those patients from rural and remote communities. The aim is to use a collaborative approach to provide a seamless and effective allied health sub-acute service and expedite care close to home.

Key dates

Jan 2018

Jun 2020

Implementation sites

Central West, Central Queensland, North West and Townsville HHSs

Partnerships

Central West, Central Queensland, North West and Townsville HHSs and North West Remote Health, Mt Isa Centre for Rural and Remote Health and Gidgee Healing Aboriginal Medical Service and Alliance Rehabilitation.

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Aim

To provide a seamless and effective allied health sub-acute service and expedite care close to home across central and north-west Queensland

Benefits

If successful we anticipate that:

- Patients will move to the right care quickly and home as soon as possible with the appropriate resources and infrastructure to support their care
- Patients and their family will be actively involved in care planning and have adequate health literacy to drive their journey.
- Care will transfer seamlessly between providers regardless of funding.

Background

An allied health sub-acute collaborative was established that includes allied health representation from Hospital and Health Services (HHS) and non-government partners across the central and north-west belt of Queensland. Process mapping using a retrospective chart audit followed patients who had presented into each partner organization with either a CVA or fractured neck of femur. On average, the audit found that a patient:

- spends 28 days in hospital
- has more than 80 individual handovers
- needs to be readmitted through the Emergency Department three times (from rural to regional and back to rural hospital/facility) and
- will have one day back at the rural facility prior to discharge

Queensland Health admitted patient data collection was also analysed to explore patterns of sub-acute care across the state using two tracer conditions: cerebrovascular accident and fractured neck of femur. (snapshot attached) The Transition 2 Sub-acute project was subsequently established to address identified process and practice issues.

Solutions Implemented

To date:

- An Allied health rural and remote sub-acute services framework has been developed and

endorsed by both the Statewide Rehabilitation Clinical Network and Rural and Remote Clinical Network. The framework describes key components of allied health sub-acute service capabilities in rural facilities and guides rural health services to develop high quality and sustainable sub-acute service models using partnerships, telehealth, delegation and skill sharing approaches.

- An allied health criteria-led transition tool and companion discharge planning process have been developed and piloted to provide a predictable, consistent and evidence-based transition from intake into sub-acute care at the regional site and step down from sub-acute to the rural services. (User guide attached)
- Sub-acute care services are currently being mapped – including referral pathways and processes, current practices and the capacity of allied health workforce in health and primary health care services.
- New and enhanced sub-acute service plans are being developed for implementation in facilities across the Collaborative

Evaluation and Results

Monitoring and evaluation framework has been developed and ethics approval gained to commence data collection.

Resources

Transition Planning Tool User guide

Snapshot cerebrovascular accident (CVA) and fractured neck of femur (NOF) data