Queensland Health

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# Transition to Sub-Acute

## Transition Planning Tool User Guide
Updated 20 March 2019

Gidgee Healing

NWRH

Centre for Rural & Remote Health

James Cook University Australia

Alliance Rehabilitation

Improvement | Transparency | Patient Safety | Clinician Leadership | Innovation

Queensland Government

Transition Planning Tool User Guide
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# Purpose

The Transition Planning Tool (TPT) is a criteria-led tool to support predictive and consistent decision-making for sub-acute patients transitioning across phases of care, particularly for those patients transitioning between regional and rural health services and onto primary health care services.

The tool was originally developed as part of a suite of tools to support the work of the Sub-acute Collaborative and 'Transition 2 sub-acute' (T2SA) project.

This user guide is to be used with the TPT and companion flowchart (see appendix 1 and 2). It provides information on the tool, including the transition planning process, frequently asked questions and other information that may be useful to better understand the TPT.

# Transition Planning Process

A transition planning process flowchart (see appendix 2) has been developed as a companion document to describe the process for using the TPT.

The TPT commences once a patient from a rural or remote location has been admitted to a regional facility and has been identified as requiring ongoing rehabilitation. Once the person has had a classification change to a SNAP category (for the 'Transition 2 sub-acute' project this would include Rehab, GEM or maintenance), the rural site is contacted to notify the allied health team of their current admission.

Following completion of initial assessments, a videoconference (VC) between sites is scheduled to complete the TPT. Following this initial meeting, the two sites will identify any issues that need to be addressed prior to transfer and share their capacity and capability to provide care for the patient in the short to medium term.

The second meeting, or review of the TPT, will usually take place close to the scheduled inter-hospital transfer and therefore can assist in the provision of a tele-handover.

# Transition planning tool: Frequently asked questions

## Who is the key worker?

The team is required to determine their key worker prior to the multidisciplinary team (MDT) VC, when notifying the rural team of the patient's admission. There is no recommendation for a specific discipline to be the key contact person, as this will vary across sites. It would be suitable for a staff member who is highly involved in the patient's care to be a key contact, or if a certain team member already had contact details for a therapist in the rural site, as this will allow for increased ease of communication.

## Who are the TPT champions?

Following initial T2SA workshops, staff from each site nominated to become TPT champions; a clinician who will prompt for the tool to be completed and work with the MDT to ensure that the use of the TPT continues in the long-term, following conclusion of the T2SA project. The list of TPT champions is below.

**Table 1 TPT champions**

| Name | Facility | Role | Email Address |
|---|---|---|---|
| *CQHHS* | | | |
| Stuart Orr | Gladstone & Banana | AH network manager | stuart.orr@health.qld.gov.au |
| Sandra Greensill | Rockhampton | CNC SAGE | sandra.greensill@health.qld.gov.au |
| Kym Shearer | Rockhampton | NUM SAGE | kym.shearer@health.qld.gov.au |
| Robert Farquhar | Emerald | Allied Health Team Leader | Robert.farquhar@health.qld.gov.au |
| NWHHS | | | |

| Abbey Wroots | Gidgee Healing | Occupational Therapist | awroot@gidgeehealing.com |
|---|---|---|---|
| Katheryn Farry | Mt Isa/Cloncurry | Physiotherapist | katheryn.farry@health.qld.gov.au |
| Rahni Cotterill | NWRH | Integrated Allied Health manager | rahni.cotterill@nwrh.com.au |
| *CWHHS* | | | |
| Liz McDonald | Longreach | A/Allied Health Team Leader | liz.mcdonald@health.qld.gov.au |
| *THHS* | | | |
| Sandra Phillips | TTH- SACU | Allied health team leader | sandra.phillips3@health.qld.gov.au |
| Shannon Woods | TTH – SACU | Senior Physiotherapist | shannon.woods@health.qld.gov.au |
| Toni McCormack | TTH – Rehab | CNC | toni.mccormack@health.qld.gov.au |
| Rachel Pennisi | Ingham | Physiotherapist | rachel.pennisi@health.qld.gov.au |
| Elyse Papale | Ayr | Occupational Therapist | elyse.papale@health.qld.gov.au |
| Roxanne Milne | Charters Towers | Physiotherapist | roxanne.milne@health.qld.gov.au |

## How are the TPT meetings arranged?

Patients from rural or remote settings will be identified on admission to the relevant sub-acute unit or identified on the acute ward as a SNAP patient from a rural or remote community, and a discussion in case conference would be a suitable forum to select a team member to liaise with the rural site and arrange the initial TPT meeting.

## Who attends the meeting?

For the **initial meeting**, it is sufficient for **allied health only** to attend this meeting. This is to discuss allied health specific issues and obstacles to be addressed prior to transition or step-down. Any other issues raised in this initial meeting can be fed back to the most appropriate clinician. For the **final meeting** which is likely to be a **tele-handover**, it is recommended that all members of the multidisciplinary team are present to handover the patient's care in one meeting, rather than doing so via multiple individual handovers.

It is encouraged for as many members of each MDT to attend the meeting as possible – this allows for more detailed planning and information sharing between teams. The allied health assistants (AHA) does not need to attend the meeting, although comments about their frequency of service provision would be provided by their colleagues (e.g. if physiotherapy visits a region once per week but AHA completes the program prescribed by the PT, the frequency of the AHA availability is documented).

## Who completes the tool?

Whilst both sites will use the tool to discuss the patient's care and needs, the referring site is responsible for completing the tool. There is no requirement for a specific team member or discipline to complete the tool for every occasion. If the patient is present with the MDT discussion then TEMSU may complete additional documentation, as this takes the form of a tele-handover.

## Do we fill it out in advance?

The tool is completed during the meeting, providing an opportunity for the accepting site to ask questions and allow for discussion about (and with) the patient, rather than the referring site providing a report. The referring site is encouraged to answer relevant questions asked on the tool, which may require some preparation (i.e. investigate home set-up etc).

## What do the colours mean?

The tool is designed to assist with decision making and planning of a patient's transition. The red, amber and green boxes in the right panel are to help clearly identify where there may be particular barriers or obstacles prior to transition. When completing the tool, if a specific area is marked in red, this does not necessarily mean the transition needs to be ceased; what is does flag is the need to explore other options to better meet patients' needs or their rehabilitation service requirements e.g. telehealth. The amber colour flags that there are potential barriers that may push out the expected transition date and these needs to be addressed before a definitive transition can occur e.g. commencing home visit. Green indicates that there is no perceived barrier in the given area and transition is indicated.

Do all sites have generic allied health email addresses?

**No.** A number of sites have such accounts, see below for a table of the addresses. Please note some sites' email accounts may be managed by administration staff, therefore ensure to clearly identify in the subject heading that the purpose is to transition a patient and not to make an outpatient appointment.

**Table 2 Generic emails**

| HHS | Facility | Email Address |
|---|---|---|
| *CQHHS* | Emerald/Springsure/Blackwater | emeraldalliedhealth@health.qld.gov.au |
| | Biloela/Moura/Baralaba/Theodore | biloelaalliedhealth@health.qld.gov.au |
| | Rockhampton Rehabilitation | garsrockhampton@health.qld.gov.au |
| | Gladstone | gladstonealliedhealth@health.qld.gov.au |
| *NWHHS* | Mt Isa Base Hospital/Cloncurry | Mt_Isa_Allied_Health_Services@health.qld.gov.au |
| *CWHHS* | Longreach/Winton/Blackall/Barcaldine/ Alpha | cwalliedhealth@health.qld.gov.au |
| *THHS* | Charters Towers Hospital/Hughenden | CTAlliedReferrals@health.qld.gov.au |
| | Ingham Hospital | TSV-Ingham-CommReception@health.qld.gov.au |

## Does this replace family meetings?

Family meetings are still essential to support the patient and their family to have adequate knowledge to make informed decisions about their ongoing care and to manage complex family situations, however if the overall aim of a family meeting is to facilitate discharge planning to rural areas, then the use of the TPT should be considered.

Literature suggests that it is important for MDT to meet prior to family meetings to clarify current status, goals of care and explore options for ongoing treatment/discharge planning. The TPT is an effective way to engage MDT teams from both regional and rural to establish the above information which then can be utilised in future family meetings as required.

## What is tele-handover and TEMSU?

Tele-handover is a patient-centred process of completing clinical handovers via videoconference. Tele-handover is integrated into current patient transfer processes, and particularly useful for complex, non-critical rehabilitation patients requiring ongoing care. For more information, see the Tele-handover website. If the tele-handover process is not familiar to your HHS, please contact your local telehealth coordinator, or the Telehealth Principal Project Officer for more information and guidance.

TEMSU stands for Telehealth Emergency Support Unit. It provides support, not only for emergency management, but can also provide support with scheduled videoconferencing and complete clinical documentation for the meeting. In order to access the TEMSU funding criteria, the tele-handover meeting using the TPT must have the patient present, and both referring and accepting MDTs.

For more information, see the TEMSU website.

## How Do We Arrange the Videoconference?

### Between two sites (Point to Point)

You do **NOT** need to book this via the Multipoint Booking Portal – it is just like making a phone call. Simply book your local videoconference room and request the other party book their videoconference room.

Determine who will initiate the call on the day of the scheduled meeting.

If you are unsure how to dial another site for a Point to Point call or are not sure what information is required for another site to dial into your system, then please call Statewide Telehealth Services on **1800 066 888** for assistance. Please provide the Asset Number of your system which is the white sticker that can be found on the camera.

More information and resources can be found on the Statewide Telehealth Services website and information on how to use the equipment is located in the Training section.

## Who sets the goals?

The patient may identify specific goals with specific disciplines, although this meeting provides an opportunity for the patient to discuss and set goals with MDT presence, where team members in both referring and accepting sites may claim responsibility for attainment of aspects of the goal.

Remember your goal setting may address both short-term goals to get the patient to the rural site as well as more long-term discharge goals. For example: the service goal may be to return the patient to their home environment with independent use of a wheelchair inside the home, which requires the accepting team to complete an environmental home visit to ensure the wheelchair will fit inside the home, whilst the referring team will complete wheelchair prescription and wheelchair mobility training +/- outdoor wheelchair mobility training to attain any community access goals.

Below is an example goal submitted by a stroke survivor to the Enable Me website

| **Goal:** | Return to the bush |
|---|---|
| **Best Outcome:** | Being able to go to the bush independently whenever I want. |
| **Timeframe:** | Long term (more than a year) |
| **Steps (i.e. sub-goals):** | Being able to walk on rough terrain.<br>Carry items i.e. fishing rod |
| **Obstacles (i.e. problems):** | Decreased balance<br>Getting lost<br>Currently don't have AFO's |

Based on this goal and obstacles, the MDT can determine their specific roles in achieving this. For example:

- Physiotherapy (PT) and Occupational Therapy (OT) input will support the patient to be independent in their self-care and mobility, if they are planning on returning to an isolated location and functioning independently.
- The patient's goal of carrying items will be addressed by PT and OT, with orthotics input for AFO prescription.
- The OT, and possibly a neuropsychologist if available, will assist in addressing concerns about getting lost, to ensure cognition is adequate to perform the whole goal.
- PT and orthotics will assist in improving balance.

The regional and rural sites can determine their capabilities to support the patient to meet their goals, such as rural providers suggesting completion of outdoor mobility and community access following transition to rural facility, to provide context to the goal.

## What education needs to be provided?

All CVA patients receive My Stroke Journey on admission to an acute stroke unit, and some Aboriginal and Torres Strait Islander stroke survivors may receive the Journey After Stroke booklet as a component of their education. Family meetings, education regarding hip precautions or general self-management strategies (including medication management) are also included in this description.

If any written education has been provided to the patient, a copy may be provided to the rural team, or notification that this has been provided will be noted on the TPT.

## Why is presence of MROs important to allied health?

If a patient requires their own equipment as a result of multi-resistant organisms (i.e. MRSA, VRE, C. Diff, ESBL, CRAB etc), the accepting site may not be able to guarantee exclusive access to certain items as it may need to be shared with other patients.

As a result, the patient may be required to hire equipment to use upon their return (if prescribed for the longer term), or the accepting site may require some notice to prepare for the arrival of this patient, to ensure they have sufficient resources for the patient's needs.

## How often do we complete this tool?

The TPT is to be completed within two weeks of admission, and once again when approaching the inter-hospital transfer or transfer to a community-based provider, which will take the form of a tele-handover, to avoid excessive meetings with overlapping information. Following initial completion of the TPT, a number of items may be "flagged" (either red or orange check boxes) to be addressed prior to the patient being able to transfer to the accepting facility.

If the initial plan is progressing as expected and all items have been addressed prior to the second meeting date, the patient can be prepared for transfer back to the accepting hospital or into the community at the TPT review meeting, which takes the form of a tele-handover.

If the patient's circumstances change from the original plan (e.g. altered discharge destination/carer support, change in clinical status), the team is required to either suggest a delay in the transfer date, or schedule a review meeting to discuss the new issues and collaborate on an alternative management plan.

## When an Indigenous patient is involved?

When completing a TPT for an indigenous patient, it is important to consider setting up the process to be culturally sensitive. Indigenous patients are encouraged to have a support person or family member present during the TPT meeting to assist in the efficacy of TPT and facilitate and clarify any questions or understanding. The environment may be culturally sensitised by displaying Aboriginal and/or Torres Strait Islander symbols.

Further considerations that English may be a second or third language for some Aboriginal and/or Torres Strait Islander people increases the need for support during the process. Communication skills must remain central to creating a trusting and open environment. Staff should be aware of local Aboriginal and/or Torres Strait Islander work colleagues (internal and external) that can provide assistance with communication and relationship building. Local Aboriginal and Torres Strait Islander Liaison Officers are an excellent source and it is encouraged they be involved in the preparation and execution of the TPT.

## FIM & SNAP

SNAP is the classification used in Australia for sub-acute patients. AN-SNAP stands for Australian National Subacute and Non-Acute Patients. Timely classification to one of the SNAP categories, that includes rehabilitation, palliative care, geriatric psychiatry, nursing home type maintenance care and Geriatric Evaluation & Management (GEM) is important for Activity Based Funding, reporting clinical activity and understanding sub-acute services, as well as submitting accurate information to AROC and

Health Round Tables for participating sites.

Functional Independence Measure (FIM) is a clinical outcome measure. When changing a patient's care classification to either rehabilitation or GEM, a Functional Independence Measure (FIM) score is required.

## AROC

AROC is Australasian Rehabilitation Outcomes Centre which collects information from rehabilitation facilities from the commencement of rehabilitation. For more information on AROC data, see the AROC website.

In order to increase the reliability of the FIM completion, formal training is required.

## AN-SNAP Calculator

The AROC AN-SNAP calculator uses benchmark data submitted to AROC (Australasian Rehabilitation Outcomes Centre) to generate estimate length of stay (LOS) and estimated FIM change based on impairment code and admission FIM. These benchmarks provide an estimate only, and may be used to guide the estimated discharge date (EDD) for the facility, or the estimated inter-hospital transfer date for the patients. This calculator, as well as impairment codes and FIM information is available at the AROC website.

## Clinical Services Capability Framework

The clinical services capability framework (CSCF) describes the clinical and support services of a health facility by allocating a service capability level, ranging from 1-6. It is designed to guide an integrated approach to service delivery in Queensland hospitals, and acts as a patient safety tool.

The CSCF describes services, service requirements, workforce requirements and specific considerations for services for each "module", i.e. rehabilitation.

For more details, see the online resource for the CSCF Rehab Services Module.

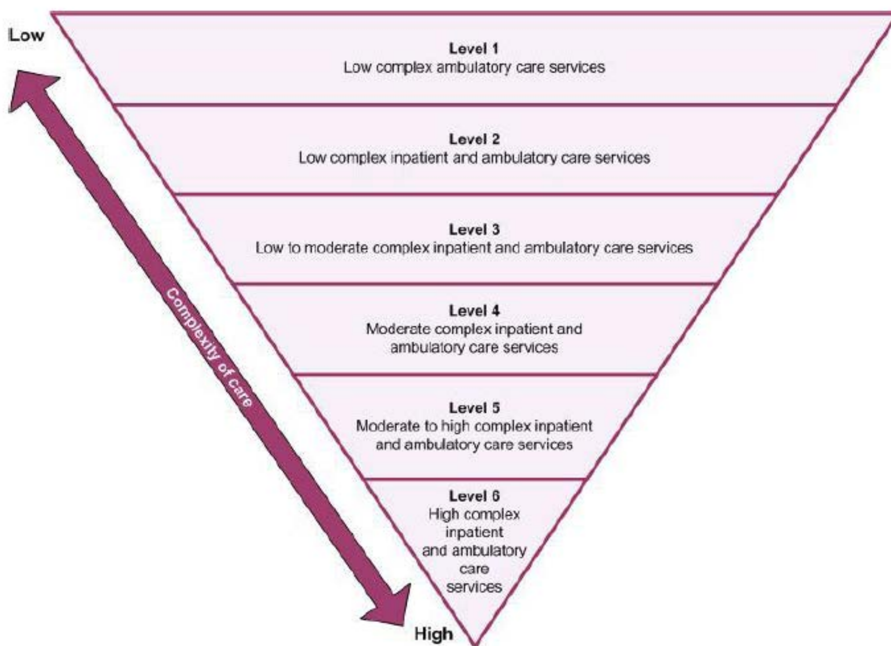
## Rehabilitation CSCF levels in participating T2SA facilities

**Table 3 CSCF Rehabilitation levels in T2SA facilities**

| HHS | Facility | CSCF Rehabilitation |
|---|---|---|
| **THHS** | TTH | 6 |
| | Ingham Hospital | 3 |
| | Charters Towers Hospital | 3 |
| | Ayr Hospital | 3 |
| | Home Hill Hospital | 2 |
| | Richmond Hospital | 2 |
| | Hughenden Hospital & MPHS | 2 |

| | | |
|---|---|---|
| **NWHHS** | Mount Isa Base Hospital | 3 |
| **CWHHS** | Longreach Hospital | 3 |
| | Barcaldine Hospital | 3 |
| | Blackall | 3 |
| | Alpha | 2 |
| **CQHHS** | Rockhampton Hospital | 4 |
| | Gladstone Hospital | 3 |
| | Mount Morgan | 2 |
| | Baralaba | 2 |
| | Woorabinda | 2 |
| | Emerald Hospital | 2 |

**Figure 1 CFS levels**




## Prognostic Indicators

Evidence regarding the use of prognostic indicators to predict outcome and discharge destination was briefly reviewed when completing research for this project. The intent is to use these clinical measures to inform practice, rather than to provide rules that reduce the influence of a clinician's clinical reasoning. The indicators were removed from the tool itself, but are provided below as a reference tool if the clinician requires some further information or guidance.

## Prognostic Indicators: CVA

**Table 4 CVA prognostic indicators**

| Indicator | Prognosis |
|---|---|
| Co-morbidities | More = poorer prognosis |
| Poor premorbid function (dependence in mobility/ADLs) | Poorer prognosis |
| mBarthel index at Wk1/D5 post-stroke) | >60 good; 80-100 excellent |
| SAFE test | Day 2/3:Excellent outcome if >/=8 and over 80yo, or if <80yo and SAFE >/=5 |
| Trunk Control Test at Wk 1 | >40 = likely walking at 6weeks post stroke |
| NIHSS* | Mild:1-5; Mod 6-14; Severe: 15-24; Very Severe: >25 |
| Age | No specific age of poor prediction – but as age increases, prognosis worsens |
| **Increased chance of return home post-CVA** | **Decreased chance of return home post-CVA** |
| Admitted to a teaching hospital | Higher severity of stroke (NIHSS) |
| Higher scores on Barthel Index | Higher score on Charlson Comorbidity Index |
| Higher premorbid level of function | Low current mobility level (MAAS) |
| Higher scores on cognitive screening test | Statin withdrawal in-hospital |
| Pre-stroke statin use | High BMI |
| | Alcohol abuse |
| | 60-80 years old (worsens with age) |
| | Presence of:<br>Dementia, rheumatological disease, peptic ulcer, liver disease, renal disease, diabetes |
| | Female gender |

## Prognostic Indicators: Fractured Neck of femur (#NOF)

**Table 5 #NOF prognostic indicators**

| Indicator | Prognosis |
|---|---|
| Admission Nottingham Hip Fracture Score | Poor prognosis if >/= 4 |
| Presence of mood disturbance (depression/anxiety) | Poorer prognosis |

| | |
|---|---|
| Cognitive status (delirium, MMSE) | Poorer prognosis if either presence, worse if both |
| Poor premorbid function | Poorer prognosis |
| Double incontinence | Poorer prognosis |
| Co-morbidities | More = poorer prognosis |

## Nottingham Hip Fracture Score

**Table 6 Hip fracture score**

| | Value | Score |
|---|---|---|
| Age | 66-85 | 3 |
| | >85 | 4 |
| Sex | Male | 1 |
| Admission Hb | <100 | 1 |
| Mini-mental test score (N.B. NOT an MMSE) | </=6/10 | 1 |
| Living in an institution | Yes | 1 |
| No of co-morbidities | >/=2 | 1 |
| Malignancy | Yes | 1 |

# Appendices

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# Transition Planning Tool

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Date completed:
Patient/ family consent (tick if yes) ☐
Information can be shared ☐

| Under 65? NDIS: (Registered/Plan made etc) | Over 65? MAC: (Referred/Not required/Package type/available) |
|---|---|

*Comment:*

| Home HHS: | Step-down service: | CSCF level: |
|---|---|---|
| **Current care need** | | |
| Mobility: | pADLs: | Diet/Fluids: |

Total FIM: Motor Cognitive

EDD with AN-SNAP calculator:

WB status: (If not WBAT, plan EDD for when WBAT)

CSCF required:

Other options closer to home? (e.g. CSCF 2/3)

Special equipment requirements? (eg bariatric, hoist, mobility/ADL aids); Est duration of these needs
*Comment:*

| **Organising the transition** | **Yes** | **No** |
|---|---|---|
| **Can the patient's allied health requirements be provided/accessed at the rural service?** e.g. speech pathology, AHA support, days of visiting services<br>Comments: | | |

**Who is the key contact person in the rural site?**
Name & details:

| **SMART goals** | | Service (S) Patient (P) | Therapist responsible? | Regional/ Rural | Estimated date |
|---|---|---|---|---|---|
| Discharge goals | | | | | |
| | | | | | |
| Transition goals | | | | | |
| | | | | | |
| | | | | | |

| **Clinical/Functional Factors** | **Yes** | **No** |
|---|---|---|
| Is the patient medically stable enough to be transferred to a rural service? | | |
| Does the patient have presence of multi-resistant organisms? (e.g. MRSA, VRE) | | |

➡ **If yes, liaise with rural facility re: need for patient's own equipment & bed management**

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# Transition Planning Tool

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

| Does the patient have ongoing specialist health needs and/or specialist follow-up? (e.g. satellite dialysis, tracheostomy, PEG, stoma) | | |
|---|---|---|
| **Social/ Emotional Factors** | **Yes** | **No** |
| Does this person have capacity? | | |
| Is EPOA invoked? | | |
| Is a QCAT application in completed or in progress? | | |
| Is carer training required? Will this take place in the regional or rural health facility? | | |
| Has the patient received information/education regarding their health condition? (Self-management) | | |
| Is the patient continuing to demonstrate improvements in clinical outcome measures? (i.e. 10mWT, mBI, WAB, improvements on VFSS, meeting dietary requirements) | | |
| Is the patient engaged/motivated in their inpatient rehabilitation currently? | | |
| Who, and where, are the patient's family and friends and/or supports? (Does the person have family relocated to the regional facility to support them +/- PTSS?) | | |
| **Environmental/ Discharge Planning Factors** | **Yes** | **No** |
| Is the patient returning to their usual home address?<br>Is a home visit required? | | |
| Are home modifications required?<br>*Comment:* | | |
| Is equipment required or anticipated to be required on discharge? | | |
| • Have the prescriptions been commenced? | | |
| • Are there options to hire in the interim? | | |
| • What is the delivery timeframe? (Est. date of delivery) | | |
| **Have outpatient services been explored** | | |
| Community rehab at home ☐ Hospital Outpatients ☐ NGO ☐ Other ☐ | | |
| Summary/Plan: | | |
| **Date of next meeting with Transition Planning Tool to prepare for transition:** | | |
| **Facility Estimated Date of Discharge:** | | |

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# Transition Planning Tool

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

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# Transition Planning Tool (TPT)– Communication Flowchart