Developing transition planning frameworks to deliver sub-acute care closer to home

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About the project - Transition2Subacute

The *Transition2Subacute project* involves a partnership between allied health professionals from across the central and north-west belt of Queensland with the aim of improving the clients sub-acute journey, particularly those from rural and remote communities.
28 days in hospital
>80 clinical handovers
3 ED attendances  -(Rural – Regional – Rural)
3 days from injury to Sx
1 day IHT – Discharge home
About the project - Transition2Subacute

• Phase 1 “inception phase” – the following tools and resources were developed 1. *Allied Health Rural and Remote Sub-acute Framework*, which supports workforce and service planning 2. *Transition Planning Tool* with *User Guide* and *Communication Flow Chart*.

• Phase 2 (July 2018-June 2020) concentrates on developing and enhancing team capability to facilitate early allied health lead discharge planning and deliver subacute care closer to home, particularly for patients from rural and remote communities.
Rural Queenslanders’ Journeys

- Excessive waiting between transitions
- Delayed discharge planning
- Delayed communication between sites
- Decreased understanding of availability and capacity
- Volume of handovers & assessment at each transition
- Inconsistent service delivery models, skills and capacity in rural and remote sites
- Once patient returns to rural sites their goals are not always clear
  - Regularly discharged prior to Allied Health review
What will success look like?

• Patients will transition to the right care quickly and return closer to home as soon as possible with the appropriate resources and infrastructure to support care.

• Patients and 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.

• Care will be coordinated and facilitated through home-based or regionally-based care.
Transition Planning Tool

Facilitates a predictive, inclusive and consistent transition between regional and rural hospitals, and between rural hospitals and primary health care services.
Creation of the Transition Planning Tool

- Literature Scan

Highlighted the need for greater standardization of decision-making for referrals into rehabilitation and the process mechanisms (Poulos & New 2008, Kimmel 2017)

- Staff Surveys

- Focus Groups
Transition Planning Tool (TPT) – Communication Flowchart

1. **Patient admitted**
   - Notify rural allied health service & establish key contacts

2. **Handover from rural → region**
   - Treating team commences assessments
   - Teams liaise if V/C needed or ongoing phone communication required

3. **Use TPT to identify issues to be addressed & what services are currently available at rural location**
   - If patients needs have changed from the original transition plan
     - Identify patient’s ongoing sub acute goals and set review date for MDT VC
   - Is the patient’s progress consistent with estimated date of transition?
     - Review TPT with a proposed Telehandover
     - Key contact advises rural contact of the change in status

4. **If discharge plan delayed but unchanged**
   - Key contact advises rural contact of the change in status
   - Complete Telehandover

5. **Interhospital transfer/ transfer home with sub acute services**
   - Yes
   - No
Implementation

Rockhampton

Ayr

Mt Isa
### Transition Planning Tool

#### Clinical/Functional Factors

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Is the patient medically stable enough to be transferred to a rural service?</td>
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<td>Does the patient have presence of multi-resistant organisms? (e.g. MRSA, VRE)</td>
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<td>If yes, liaise with rural facility on need for patient’s own equipment &amp; bed management</td>
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<td>Does the patient have ongoing specialist health needs and/or specialist follow-up? (e.g. satellite dialysis, trachostomy, PEG, stoma)</td>
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#### Social/Emotional Factors

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<thead>
<tr>
<th>Question</th>
<th>Yes</th>
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<tr>
<td>Does the person have capacity?</td>
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<td>Is EPOA Invoked?</td>
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<td>Is a QCAT application completed or in progress</td>
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<td>Is carer training required? Will this take place in the regional or rural health facility?</td>
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<td>Has the patient received information/education regarding their health condition? (self-management)</td>
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<td>Is the patient continuing to demonstrate improvements in clinical outcome measures? (e.g. 10mWT, m3I, WAS, improvements on VFSS, meeting dietary requirements)</td>
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<td>Is the patient engaged/motivated in their inpatient rehabilitation currently?</td>
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<td>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?)</td>
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#### Environmental/Discharge Planning Factors

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<tr>
<th>Question</th>
<th>Yes</th>
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<td>Is the patient returning to their usual home address?</td>
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<td>Is a home visit required?</td>
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<td>Are home modifications required?</td>
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<tr>
<td>Corametry:</td>
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<tr>
<td>Is equipment required or anticipated to be required on discharge?</td>
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<td>Have the prescriptions been commenced?</td>
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<td>Are there options to hire in the interim?</td>
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<tr>
<td>What is the delivery timeframe? (Est. date of delivery):</td>
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#### Have outpatient services been explored

- Day Leave
- Rehabilitation at Home
- TCP/HITH
- Outpatient Therapy
- Other:
• Implementation of the TPT is proving that the process needs to be embedded and that allied health can be the lead for the transition of sub-acute patients

• Early transition planning and communication between regional and rural sites is critical to providing seamless and integrated sub-acute care that is closer to home
“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”
Enablers & Learnings
Conclusion

From this... starting and finishing rehabilitation further away from home...

To this... finishing rehabilitation closer to home.
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