Care setting 1: Inreach to acute

Overview of scope of services

- Early intervention - potential to maintain and improve function
- Integrated medical and rehabilitation multidisciplinary team
- Comprehensive assessment
- Shared care model between medical specialist groups
- Can treat acute illness and provide rehabilitation services in parallel

Outcomes for the rehabilitation patient journey

- Enables early discharge planning
- Patient independence and an enablement model of care in the acute setting
- Prevention of functional decline during acute hospitalisation
- Integrated assessment of patients in an interdiscipliary environment
- Enhanced effectiveness in the patient journey as measured by: reduction in re-admissions, decrease in average length of stay, decrease in patients requiring a sub-acute inpatient stay, reduction in nursing home placement waiting times,
- Reduction is discharge delays due to early assessment and discharge planning

Implications for implementation

- Admission and discharge criteria will be required to describe eligible patients in the acute sector who require and will benefit from inreach rehabilitation services
- Inreach services will need to be set up in a manner that prevents acute beds turning into sub-acute beds
- Protocols regarding adequate workforce provision to rehabilitation services will assist to ensure patient care and intensity of therapy aligns with best practice
- Good communication, collaboration and team work between the rehabilitation service and the acute care service will need to be developed
- Evolving a new model of rehabilitation will require that acute services (including health administrators) are educated in the role of Rehabilitation Services, and the importance of appropriate and early recognition of relevant patients. The concept of informing/educating/liaising with acute services must be one of the earliest steps taken. There is a high degree of dependence on the acute services to identifying patients who are relevant for rehabilitation
• Integration and communication across NGO, State government, Federal government and private services to support continuity of care, for example through interdepartmental /agency policies and programs

• The implementation of inreach services will involve collaboration and liaison with acute medical and nursing staff and the provision of information and education for the acute care staff to enable the successful integration of an inreach service

The case studies below provide examples of how inreach models of rehabilitation care have been implemented.

Case study 1: Acute care Rehabilitation Team

The Acute care Rehabilitation Team (ART) at Wollongong Hospital aims to provide early rehabilitation to appropriate patient while they remain in the acute setting. The ART is a standalone team providing multidisciplinary rehabilitation input on a consultation liaison basis with ART patients in addition to standard therapy offered to patients on an acute ward. The program supports the philosophy that rehabilitation should be viewed as a continuum that commences in acute care to prevent deconditioning that often results from bed rest and inactivity inherent in the acute hospital environment. The objective being that improving the functional status of patients in the acute setting will lead to discharge directly from acute care where possible avoiding the need for a rehabilitation admission or leading to a shorter rehabilitation length of stay.

Case study 2: The Acute Care of the Elderly (ACE) Model

The Acute Care of the Elderly (ACE) Model is an aged care initiative undertaken by Hornsby Ku-Ring-Gai hospital. ACE is a shared care arrangement between the admitting Physician and a Geriatric Specialist, for patients aged 65 years and over who are admitted to ED. The model of care is based on the admitting physician working alongside the ACE team (which includes a geriatrician and a multi-disciplinary team) from day one of admission developing a comprehensive care plan. The patient has one episode of care (ie the patient is admitted from ED to the ACE ward and preferable discharged from this ward) which improves continuum of care, reduces patient confusion and usually reduces the average length of stay. The focus is on maintaining function, encouraging activity and independence through the acute phase of their illness.

Evaluation of the ACE Model has shown improved patient outcomes:

• Decreased re-admissions within 28 days for ACE patients reduced from 12.4% - 3%. Average cost saving for 10 ACE patients NOT re 3%.

• Less numbers of patients require a stay within a rehabilitation facility from the ACE ward, prior to discharge

• However, if an ACE patient does require rehab, the ALOS = 11 days compared to a Non ACE patient ALOS = 21 days.
Case study 3: Specialist Management with Acute Rehabilitation Treatment (SMART)

Early commencement of rehabilitation in the acute phase. Care with a joint focus on acute care and active rehabilitation. Westmead is in the process of commissioning a new rehabilitation model of care and a SMART ward model – which involves early intervention into orthopaedics, neurosurgery and trauma (the pilot is for 8 beds fully staffed with allied health in the surgery ward). A risk stratification tool will be utilised to identify patients on admission who are at risk of loss of function whilst in hospital, have 3 or more co-morbidities and would benefit from a rehabilitation approach. Patients enrolled in the pilot will commence rehabilitation while under the management of their specialist surgical team in the surgical ward. It is proposed to build into the project an evaluation of the SMART service to establish its potential impact on other hospitals and clinical specialties other than surgery. An evaluation plan will be developed in the first two months of project operation.

Case study 4: Comprehensive Geriatric Medicine Service

Through the provision of a Comprehensive Geriatric Medicine Service at Westmead Hospital the above inreach programs are obviated by having such capacity inbuilt into the operational structure of the geriatric medicine services. The duality of inputs is replaced by having the attending physician skilled in both acute care and rehabilitation. The patient is admitted under the care of a geriatrician and associated interdisciplinary team. The patient undergoes a comprehensive assessment of their physical, psychosocial and functional needs. Care is focused on accurate diagnosis, optimising physiological and physical function and development of comprehensive care plan under the auspices of the service. There is a continuum of care provision through the acute, subacute and non-inpatient settings as required.