Overview of scope of services

- Hub and Spoke model between regional and tertiary hospitals or regional and smaller neighbouring rural hospitals
- The outreach model may be a Consultative Model (where the hub site provides advice and support to neighbouring hospitals as required) or a Collaborative Model (where the hub site and neighbouring hospitals work together to provide a rehabilitation program for patients). Both models may run simultaneously or separately
- Outreach coordinator and rehabilitation team collaborate with neighbouring hospital to facilitate ongoing rehabilitation and goal attainment
- Ongoing education from the hub site to spoke hospital staff (via various mechanisms including telephone, or onsite at either hospital)
- Collaborative rehabilitation care approach between the hub hospital and the neighbouring hospitals
- Involvement of the GP as a key coordination link for the client who is undertaking a rehabilitation program where there is limited access to Rehabilitation and Aged Care physicians.

Outcomes for the rehabilitation patient journey

- Enhanced access to rehabilitation services (including goals and rehabilitation plan) closer to patients home.
- Greater likelihood of family/carer involvement in rehabilitation care

Implications for implementation

- Good communication, collaboration and linkages between the hub and spoke hospitals will need to be developed
- Service planning for resources (staffing and equipment) at neighbouring hospitals to enable rehabilitation service provision
- Admission and discharge criteria will be required to describe eligible patients
- Education and liaison with neighbouring hospitals, local GPs and local specialists regarding the service and referral of appropriate rehabilitation patients

The case studies below provide examples and evidence supporting outreach models of care.
Case study 1: Outreach Case Study

Orange Hospital has an outreach rehabilitation services. The “Hub Site” at Orange Base Hospital identifies patient goals by the sub-acute multidisciplinary team. If a patient requires intensive or specialised inpatient rehabilitation that will be transferred to a rehabilitation unit at Orange, Dubbo or Bathurst. If the patient goals are identified as suitable for management at a neighbouring hospital (ie less complicated patients, requiring fewer disciplines for treatment). The patient will be transferred to a neighbouring hospital (‘spoke site’) within Orange Health Service Area. An Allied Health Assistant (AHA) will assist with therapy and the goal orientated progress will be monitored, case conferenced and reviewed by local staff in collaboration with the rehabilitation outreach coordinator and / or “Hub team” staff.

If patients at neighbouring hospitals are identified by staff as potential rehabilitation candidates, the rehabilitation outreach coordinator acts as a liaison point between the Hub/Spoke site staff to provide advice, intervention or admission to a rehabilitation unit.

Case study 2: South Eastern Australia Case Study

Evaluation of a innovative ‘outreach’ rehabilitation model in rural South Eastern Australia was effective in meeting the needs of a sparsely populated area covering five health services. The rehabilitation program aimed to strengthen the link between inpatient (acute) care and community rehabilitation. With the new program, protocols were established including community staff attendance at inpatient rehabilitation case discussion meetings and communication of the client's inpatient rehabilitation goals. Clients admitted to the program improved functionally at least as well as the Victorian State average for similar client groups (BI change 26.5 compared with 22.3 points), with a shorter LOS (13.8 compared with 22.3 days) but more were discharged to residential aged care (16.1% compared with 6%).

Key enablers to the success of the program included: collaboration between hospitals; a skilled and enthusiastic leader; recruitment of allied health staff; consistent medical leadership; access to training and support from a major regional rehabilitation centre; and access to funding to enable the program to establish itself and demonstrate outcomes for clients.
Case study 3: Cootamundra Hospital

Cootamundra Hospital has allied health staff who work across the continuum of care. An allied health assistant has been trained to carry out rehabilitation programs in patient's homes and in the outpatient setting and to undertake home visits to assess specific home requirements. The assistant has clear directions from the therapist as to the therapy requirements which are reviewed by the therapist at regular intervals. This model allows the slim resource of the therapist to treat more patients and patients to return to their local communities from the inpatient rehabilitation centres, for example, from Wagga Wagga in a timely manner. The allied health staff at the hospital work closely with the local GPs and are looking forward to a “Health One” site further enhancing this relationship.