Allied health rural and remote sub-acute services framework

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The Allied health rural and remote sub-acute services framework was developed in consultation with allied health professionals working in rural and remote parts of Queensland and has been endorsed by the Statewide Rehabilitation Clinical Network and Statewide Rural and Remote Clinical Network.

Background

Queensland Health is committed to improving equitable access to safe, quality healthcare for consumers across the state (Queensland Health, 2016c). Sub-acute care features strongly in the casemix of many small rural hospitals and multipurpose health centres (Saberi, 2015). There is a growing trend to transfer clients to smaller facilities in the sub-acute period to minimise displacement from home communities for clients and family, and to support system efficiency in large metropolitan hospitals. Along with medicine and nursing staff, allied health professionals have a central role in the delivery of sub-acute care. Therefore access to allied health is a key component in maximising the quality and efficiency of sub-acute care and is critical to sub-acute service capability in rural and remote facilities.

Sub-acute care described in this framework is based on the generally accepted interpretation and intent of the Australian National Sub-acute and Non-Acute Patient (AN-SNAP) definition and consistent with the WHO definition of rehabilitation:

"*Specialised multidisciplinary care in which the primary need for care is optimisation of the client's functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person, or the whole person in a social context, and to impairment of a body function or structure, activity limitation and/or participation restriction*" (IHPA 2017, WHO 2011).

Sub-acute care delivered in the rural and remote context can be considered as striving to achieve the following functional outcomes:

- prevent loss of function
- slow the rate of loss of function
- improve or restore function
- compensate for lost function
- maintain current function.

Scope and purpose

The Allied health rural and remote sub-acute services framework (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. The Framework will support:

- service and workforce planning in rural facilities
- inter-facility and inter-agency coordinated care pathways including transfer and discharge decision-making

- implementation of safe and appropriate service models that fully capitalise on the skills of allied health teams and on technology solutions to address the challenges of providing sub-acute care to small, geographically-dispersed populations.

The Framework has been developed to:

- promote and optimise the value allied health professionals can provide for rural and remote sub-acute services
- capitalise on the growth in allied health professional and range of assistant positions more broadly in select rural sites and clearly define the allied health assistant role and scope of practice in sub-acute care
- align to rural generalist service and workforce strategies.

Principles and assumptions

The Framework is underpinned by several principles and assumptions including:

- coordinated multidisciplinary care and inter-agency service integration are needed to deliver efficient, high quality and client-centred care in the sub-acute phase of recovery
- shared decision-making, informed self-management and client choice are the foundations of sub-acute service models
- accessing care closer to home may be the preferred option for the client and their family
- cultural awareness and safety underpins all aspects of sub-acute services
- Hospital and Health Service and partner agencies providing sub-acute care have robust clinical governance, patient safety and risk management processes established to implement the service delivery strategies described in the Framework i.e. delegation, skill sharing, and telehealth
- sub-acute service models aligned to the Framework will require support from all levels of the Hospital and Health Service including allied health, nursing and medical staff.

Sub-acute services

The functional outcomes, as previously described, will be achieved by providing sub-acute care in inpatient, outpatient, or community settings. The Framework will inform the development of resources with a focus on high frequency clinical presentations to rural allied health sub-acute services for adults and children such as a neurological event, post-arthroplasty, frail aged and falls. Resources may include clinical care protocols, and training and supporting resources.

Locations and facilities

The Framework has been developed for rural locations with facilities classified as *district, rural and community hospitals, multipurpose health services* and *community clinics* in the Queensland Rural and Remote Health Service Framework (Queensland Health, 2014). Facilities in urban locations, those classified as *regional hospitals* (except Mount Isa) and *specialist services*, and rural facilities with a narrow service

scope that does not include sub-acute care (e.g. mental health facilities) are not considered in this Framework.

Professions

It is acknowledged that a range of allied health professions contribute to the care of sub-acute clients in rural and remote facilities. For the purposes of this framework, the following professions will be considered, but should not be limited to:

- nutrition and dietetics
- occupational therapy
- physiotherapy
- podiatry
- psychology
- speech pathology
- social work.

Note: Medical imaging and pharmacy are described with greater specificity in the Clinical Services Capability Framework (CSCF) and Queensland Rural and Remote Health Service Framework than other allied health professions. These frameworks are more appropriate service planning resources for these two professions.

Allied health rural sub-acute services framework

The Framework outlines how rural generalist services can enable sub-acute care closer to home for local clients including expedited transfer from a regional/tertiary hospital to a rural facility or discharged directly home with follow-up care as an outpatient or in the community. Care is delivered through a combination of outreach, protocol-driven delegation, skill sharing, shared care and collaborative practice between professions, and telehealth.

Care plans guide the coordination and safe implementation of the service strategies. Support workers (including but not limited to allied health assistants) provide a significant component of the clinical engagement with the client, particularly in smaller centres. This is supported by competency-based task training, established delegation procedures, and telehealth-supported task monitoring and progress reviews by the delegating health professional.

Strong local collaboration with medical and nursing staff will be essential to support the safety and effectiveness of the service model.

Key components of the Framework

1. Client care plan

The client-centred care plan will be developed and monitored by the members of the multidisciplinary team, the client and their family. The care plan is central to effective multidisciplinary care and shared goal-setting with clients and families. The care plan will include functional goals that guide the allied health clinical interventions delivered by the team that is likely to include nursing, enrolled nurses and other support workers in delegated roles. The plan will be used as a key component of the allied health rural sub-acute service model, including the implementation of rural generalist service strategies.

2. Rural generalist service delivery strategies

The term “allied health rural generalist” refers to a service, or to a position or practitioner delivering the service, that responds to the broad range of healthcare needs of a rural or remote community (SARRAH 2017). This includes delivering services for people:

- with a wide range of clinical presentations
- across the age spectrum
- in a variety of clinical settings e.g. inpatient, ambulatory care, community.

The primary aim of generalist service models is to deliver high quality, safe, effective and efficient services as close to the client’s community as possible. To meet this aim, teams and individual health professionals need to implement strategies that maximise local service access and quality. The primary strategies are:

- telehealth
- delegation to support workers e.g. allied health assistants
- extended scope of practice including skill sharing e.g. trans-professional practice

- partnerships supporting the implementation of a ‘generalist scope’ for complex or low frequency clinical presentations.

Delegation to support workers

A support worker implements clinical services under the delegated authority of a health professional (Queensland Health, 2016a). Historically allied health professionals delegate to an allied heath assistant or similar position e.g. physiotherapy assistant, dietetics assistant, therapy assistant. The *Rural and Remote Health Workforce Strategy for Queensland* (Queensland Health, 2017) identified that a multi-professional support worker who can accept delegated tasks from nursing and allied health professions is a strategic priority for the system. For the purposes of this Framework the term “allied health assistant” will be used but this does not exclude the use of other delegated workers.

The client care plan will include profession-specific functional goals that describe the clinical and therapy tasks to be implemented by the allied health assistant in partnership with the client, working towards agreed goals. This includes criteria for implementing specific protocol-driven progressions to clinical tasks as performance improves, and indicators that performance is failing to progress at an expected rate, plateauing or declining e.g. observed performance, objective measures, timeframes for expected progression.

Telehealth and/or outreach allied health professional reviews will also be scheduled in the plan, and aligned to expected progression points, or to provide clinical tasks that sit outside the scope of the delegation model.

The composition of a training process for a specific allied health assistant role will be driven by the service requirements and may include training from the Certificate IV in Allied Health Assistance, other formal training programs, and workplace-based training implemented using Clinical Task Instructions and local procedures. For efficiency of training, and the safety and effectiveness of the model, this is most applicable to client groups and clinical presentations with relatively predictable therapy progression.

Skill sharing

Skill sharing or trans-professional practice, involves two or more health professionals sharing knowledge, skills and responsibilities across professional boundaries in assessment, diagnosis, planning and/or intervention (Queensland Health, 2013: p.20). Informal skill sharing, implemented with a limited mix of training, competency assessment and governance processes, has been found to be common in rural and remote areas. It arises through a need to support care continuity and service frequency in teams using an outreach model (GNARTN, 2013). Queensland Health is developing resources as part of work on the allied health rural generalist pathway that include clinical task instructions and training to improve the rigour, quality and safety of skill sharing.

Telehealth

Allied health professionals can provide assessments and interventions directly to the client in a Queensland Health facility or the client's home using telehealth. Telehealth is often used in a dual clinician service model to support delegation, skill sharing and shared care/collaborative practice. For these models, telehealth enables the local clinician to source knowledge and expertise from a hub site in order to assess, review or progress the care plan. This includes allied health assistant-initiated telehealth reviews between the allied health assistant and client at the recipient site and delegating health professional at the hub site. This can support changes to the prescribed program including progression and revision of goals. Dual clinician telehealth models can also support collaboration models between rural generalist clinicians and clinical experts (Queensland Health, 2015a).

Most allied health services implement synchronous telehealth (video-conference) using standard telehealth equipment including desktop/MOVI and tablet devices. Some clinical applications require peripheral devices such as medical camera systems or lapel microphones, or specific rehabilitation software or applications. Store and forward technology and bandwidth augmentation are also used for some clinical tasks that require high resolution still or video images respectively.

Partnerships, shared care and collaborative practice

Partnerships between service providers in rural areas are common, including rural-urban, cross-agency and cross-sectoral partnerships that use shared care or collaborative practice models. This service strategy supports care integration and continuity between service settings such as transitioning a client from inpatient care in an Hospital and Health Service facility to community care delivered by a community-controlled heath service or other primary health care provider.

The Framework supports clinical teams working collaboratively and being able to differentiate and respect the various expertise that each health professional brings to the team, including recognising scope of practice overlap.

Collaborative outreach models between health professionals in different organisations could also maximise service continuity and increase service frequency for clients. However, cross-agency service responsibilities are uncommon due to funding, coordination and policy barriers.

Partnerships also include consultation and collaborative practice between the rural generalist clinician and clinical experts, usually in specialised units in urban facilities (Queensland Health, 2015b). These partnerships are particularly valuable for clients with complex ongoing needs.

3. Supporting resources for rural sub-acute service models

Understanding the high frequency presentations to rural sub-acute services allows standardisation of some resources; including care pathways, clinical task instructions, forms etc. This can support clinical governance, quality of services and the efficiency of service model development.

Rural services designing service models using the Framework will develop and share, or access, a range of resources to support implementation, as appropriate and available. Rural services will map the service pathway for high frequency presentations

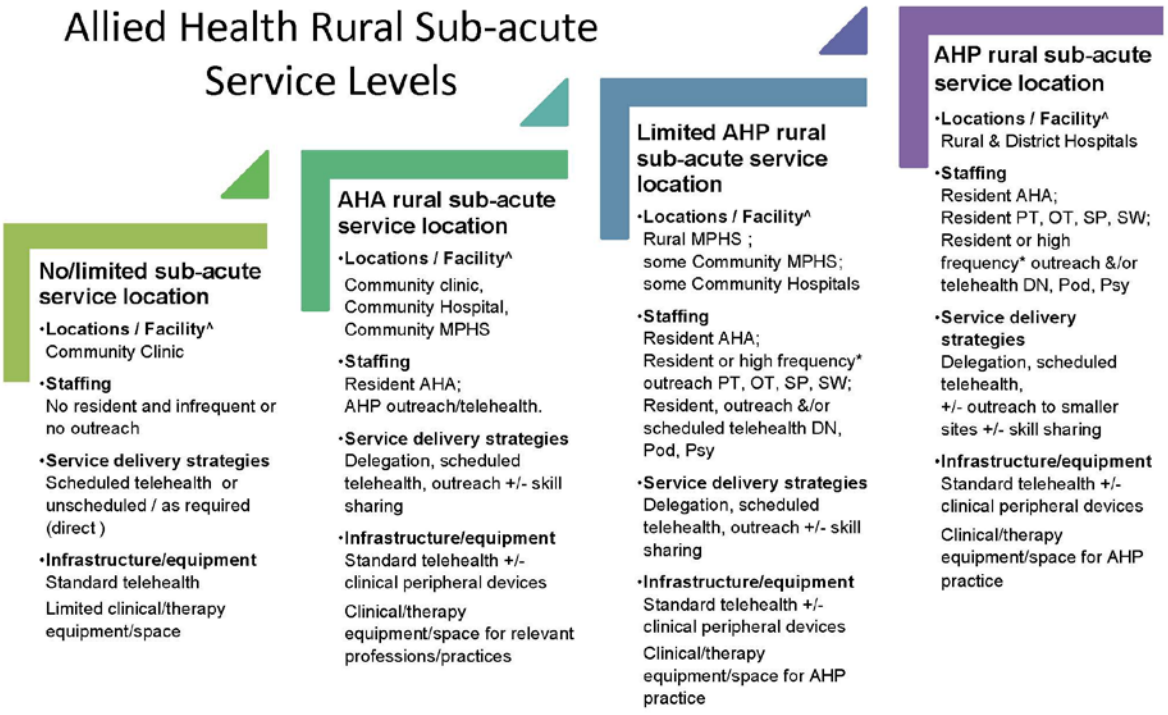
to identify key supporting resource requirements for the sub-acute pathway, see Figure 2 Sub-acute service pathways.

Service model design factors

1. Allied health rural sub-acute service levels

In addition to the components of the Framework described above, health services will need to consider the level of service capability appropriate to the facility when designing an allied health rural sub-acute service model. Figure 1 provides an example of how rural sub-acute services can be conceptualised as a staged hierarchy of service capabilities based on the resources available in the facility, primarily workforce resources but also physical space and equipment.

Figure 1 Allied health rural sub-acute service levels



Notes:
^ Facility type is not definitive and are presented for context only.
* 'High frequency' means intervention approximates resident workforce service
Abbreviations:
AHA: Allied Health Assistant; AHP: Allied Health Professional
PT: physiotherapy; OT: occupational therapy; SP: speech pathology;
SW: social work; DN: dietetics & nutrition; Pod: podiatry; Psy: psychology.

The relationship between allied health service capability and the Clinical Services Capability Framework (CSCF), including the rehabilitation module and the Queensland Rural and Remote Health Service Framework, is not well articulated. Although higher classification facilities such as district hospitals will, on average, have a larger allocation of allied health full time equivalent staff (FTE) and service hours there is a wide variation between sites. These classifications, primarily based on medical and emergency services, are a relatively poor indicator of allied health sub-acute service capability (Queensland Health, 2016b).

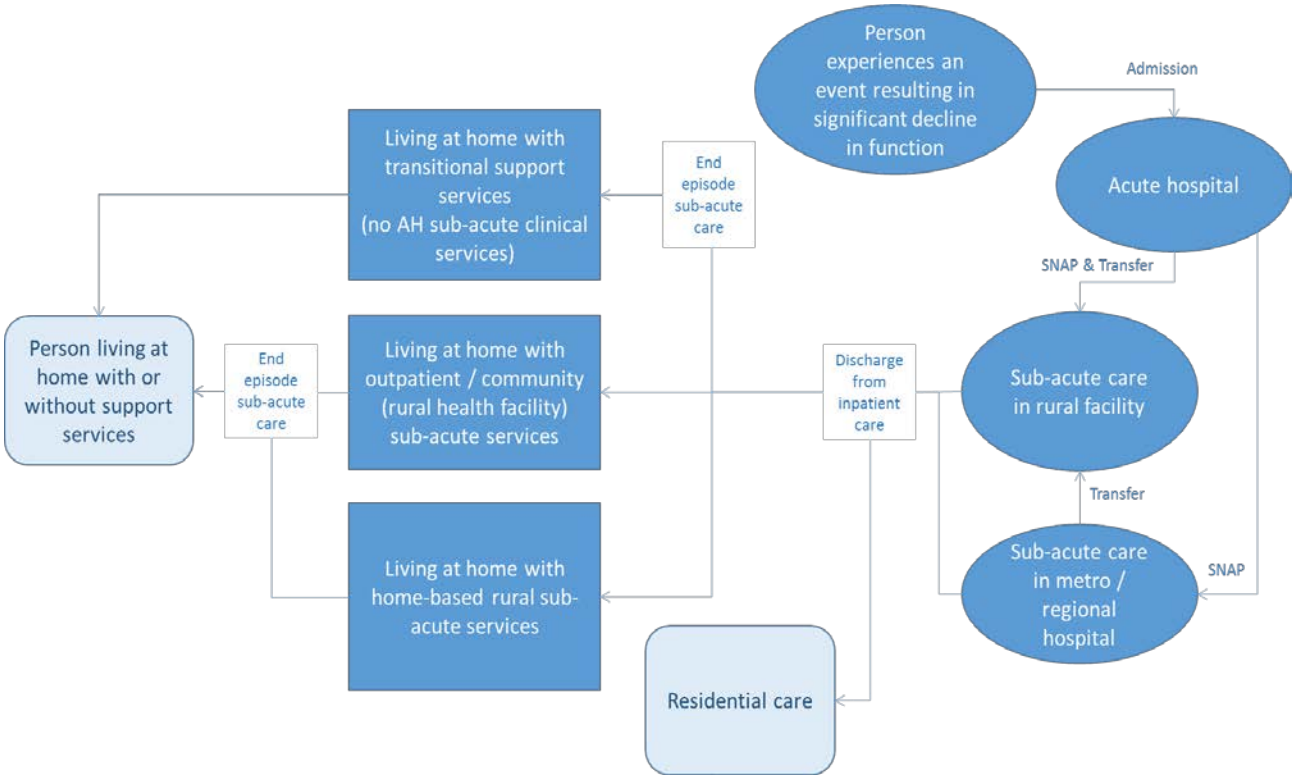
The CSCF concept of workforce, infrastructure and equipment hurdle requirements for discrete increments of service capability can be applied to allied health rural sub-acute services. The defining service indicator is whether there is a resident or visiting (outreach) service. This has been identified as a potentially suitable indicator of service capacity (Thomas, Wakerman and Humphreys, 2015). Like the CSCF, this framework does not describe FTE or specific skill sets, or other staffing groups including administration. These are local decisions based on activity, organisational structure and a range of other factors.

2. Service pathways

The sub-acute service pathways (see Figure 2) represent the general patient flow options from the time a person sustains an event, leading to a significant functional decline, acute hospital admission, through to discharge back into the community. Initial sub-acute care can take place in a dedicated sub-acute service within a metropolitan or regional hospital, or entry to sub-acute care may coincide with transfer to a rural facility. The next transition is when the patient is either discharged home with or without continuing sub-acute services, or to longer term residential care. The patient is discharged from sub-acute services when they have reached the agreed functional goals.

The rural allied health sub-acute service pathways can be used as a foundation for developing resources and local processes that address service needs for specific client groups in the rural sub-acute service model.

Figure 2 Sub-acute service pathways



3. Interagency workforce and service models' integration

Designing an effective and sustainable sub-acute model in a rural setting requires integration of key system enablers across agencies as well as across different Hospital and Health Services. This includes:

- workforce models, particularly rural generalist roles and allied health assistants
- training resources and pathways
- credentialing standards
- service agreements
- care pathways.

It also relies on well established relationships between rural and remote allied health staff and allied health professionals at Hospital and Health Service hub sites who are likely to be providing support and may also be providing some mentorship.

Implementation

What do we already have?

Elements of the Framework already exist in some health services. There are also a range of resources available at a state-wide level or that are in use in rural health services. To progress the development of the Framework, including the trial of local service models, existing resources and proven processes and systems will need to be drawn together.

What do we require?

Successful implementation of service models aligned to the allied health rural sub-acute services framework will require:

1. collaboration amongst key stakeholders that include Queensland Health, Primary Health Networks, General practice, non-government organisations, Aged Care Assessment Teams, National Disability Insurance Scheme and other community service providers
2. agreed referral pathway processes from regional/tertiary hospital to receiving health service including adherence to inter-hospital transfer procedures
3. agreed clinical pathways for core clinical presentations e.g. post orthopaedic surgery, fractured neck of femur, post neurological event, general frail and aged
4. protocols for treatment i.e. progression pathways for clinical tasks, indicators of delayed progression or decline
5. standardised, statewide templates for the rehabilitation plan/goal setting and client/allied health professional/allied health assistant roles
6. review of training resources to ensure a fit with rural settings and an allied health assistant delivering the service through protocol-driven and telehealth-supported delegation model (rather than onsite model in metropolitan and regional services)
7. telehealth access and internet capability.

Next steps

A collaborative project approach is underway to refine the Framework and develop service models aligned to the Framework. This project aims to engage clinicians and clinical networks, develop pathways and processes, establish allied health assistant protocols and training resources and to monitor and evaluate progress and outcomes.

Collaboration between all sites will be critical to bring the key stakeholders together, collate existing and develop new resources and guide framework development, based upon project learnings and outcomes.

Key bodies of work currently in progress include:

- collation of existing resources and development of new resources to support implementation of service models that align with the Framework
- development of an allied health criteria-led transition tool and discharge planning processes to expedite step down and early discharge planning with patients, their families and all relevant service providers
- development of enhanced rural and remote sub-acute models of care using the Framework
- evaluation of the implementation of the Framework
- dissemination of outcomes.

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