Evaluation framework – In-reach rehabilitation

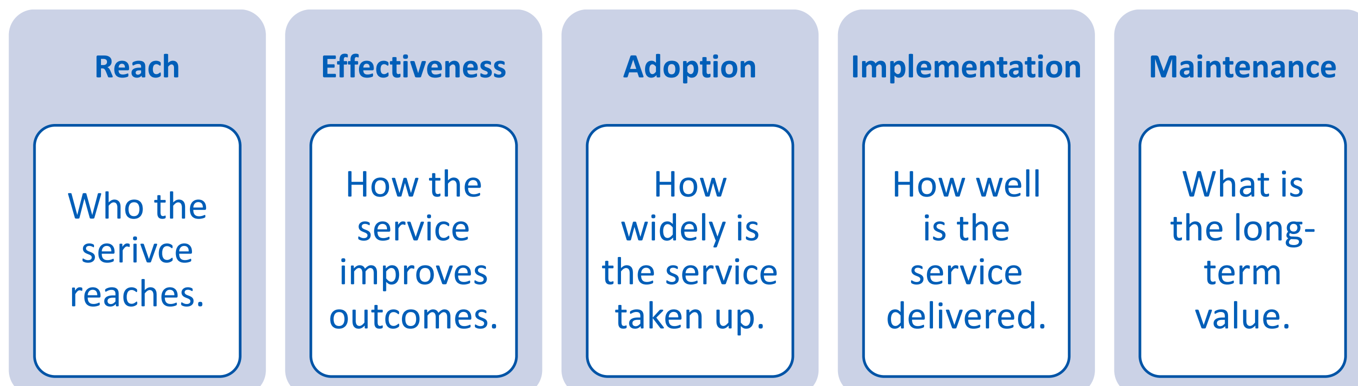
This document establishes a template evaluation framework to support new and redesigned services to embed evaluation procedures from inception. The purpose is to ensure that services are designed with clearly defined outcomes, performance measures, and data collection processes in place when designing the service, enabling progress to be monitored systematically over time. By integrating evaluation into early service design and implementation, the framework supports timely, accurate, and proportionate reporting to service sponsors and executive teams, reduces reliance on retrospective data collection, and strengthens the ability to demonstrate impact, value, and sustainability.

The framework applies across the full-service lifecycle and is intended to support consistent, credible, and decision ready evaluation outputs aligned with organisational governance and funding requirements. This document should be used jointly with other resources from the toolkit including the Model of Care for minimum data set expectations and the *Pre-implementation Reflection Tool* to consider key service priorities to inform decision making on data collection.

Evaluation questions & measures

The following evaluation processes may be adjusted based on the data sets determined by each individual service. The following is not prescriptive but a guideline of evaluation measures.

Evaluation can be modelled using a number of frameworks or models depending on the typical evaluation models within local Hospital and Health Services (HHS). A framework that can be utilised for service evaluation is the RE-AIM framework (Glasgow et al.,2019). How this may be applied for the evalution of an in-reach service is as follows:



R- Reach

Definition: Who the service reaches and whether access is equitable.

Evaluation questions:

- Who accessed the service?
- Who did not access the service?
- Are referral and acceptance rates appropriate?
- Does the service reach priority populations?

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Measures:

- Number of referrals, accepted patients, commencements
- Reasons for non-acceptance.
- Demographic profile of patients (age, gender, diagnosis/impairment code, ATSI status)
- Complexity data: Relevant to localised complexities e.g. Infection control patients, bariatric, non-english speaking background (NESB), non-Medicare/funded patients. Specific metrics will be dependent on the HHS.

E- Effectivness

Definition: The degree to which the service improves outcomes for consumers and the systems.

Evaluation questions:

- What changes did consumers experience?
- Are functional improvements clinically meaningful?
- Does the service improve patient flow and reduce LOS?
- Is the model cost-effective?

Measures - Consumer effects

- Patient experience: Patient Rated Experience Measure (PREM), structured questions + open text, collected during care or at discharge. Example version of PREM included in Appendix 1
- Patient outcomes: Admission/discharge Functional Independence Measure (FIM), goal-based outcomes (e.g. Goal Attainment Scale or Patient-Specific Functional Scale), additional discipline specific measures (e.g. De Morten Mobility Index, Canadian Occupational Performance Measure), Patient Reported Outcome Measures (PROM)
- Discharge destination

Measures - Clinical/system effects

- Length of stay (LOS) changes (acute, program, subacute)
- Sub-acute admissions avoided
- Readmissions
- Bed-day savings **
- Cost–benefit **

A- Adoption

Definition: Who adopts the model, how widely it is taken up, and how well do stakeholders participate.

Evaluation questions:

- Are acute wards referring consistently?
- Are disciplines engaged as intended (physiotherapy/occupational therapy/speech pathology/social work/allied health assistants)?
- Are external stakeholders (e.g., sub-acute units) using the service's recommendations?
- Is staff turnover affecting adoption?

Measures:

- Referrer sources (which wards/teams generate referrals?)
- Percentage of eligible patients identified early
- Staff engagement (survey data)

- Induction and training uptake
- Use of care coordination pathways
- Alignment with sub-acute referral partners

I - Implementation

Definition: How well is the service delivered according to the model of care.

Evaluation questions:

- Is therapy dosage delivered as intended?
- Are processes reliable (data completeness, PREM/PROM capture)?
- How well does the Multidisciplinary Team (MDT) coordinate care?
- Is service delivery consistent across clinicians and wards?

Measures:

- Therapy minutes (direct + indirect)
- Productivity KPIs (caseload, sessions/day, time to assessment from referral)
- MDT communication and care coordination measures
- PREM/PROM completion rates
- Data quality audits

M - Maintenance

Definition: The sustainability and long-term value of the model.

Evaluation questions:

- Is the service meeting its intended outcomes over time?
- Has the model become embedded in standard care?
- Are cost savings stable year-on-year?
- How will the service continue if funding changes?

Measures:

- Multi-year trend analysis (referrals, LOS, bed-day savings)
- Staff retention and capability
- Integration into hospital flow governance
- Continued alignment with Australasian Rehabilitation Outcomes Centre (AROC) Pathway 2
- Longitudinal cost effectiveness **
- Updates to work unit instructions or standards of practice, training, and induction

** Financial Evaluation

Financial evaluation methods vary significantly across Hospital and Health Services (HHSs), and therefore cost benefit findings presented in this report should not be interpreted as directly comparable across services or settings. Each HHS applies its own approved financial methodologies, data sources, and cost models, which can substantially influence economic estimates.

The following methods of financial evaluation can be considered:

- Bed Days Saved: This approach evaluates the number of bed days in a sub-acute unit that are avoided through the in-reach service. This is calculated for all patients that were projected to require a sub-acute rehabilitation bed and were discharged home directly from the in-reach service. Using their demographic data in the AN-SNAP calculator to identify the projected length of stay, the difference to their true length of stay is then multiplied by the cost of a subacute bed to identify cost saved for the health service.
- Activity Based Funding: Some services routinely ensure all eligible patients have an episode of care change to “Rehabilitation” to capture Queensland Weighted Activity Units (QWAU) and the respective generated activity or Activity Based Funding (ABF). Given the shared care nature of the in-reach model of care, this generated activity is supported at a hospital level rather than identifying the individual contribution of the in-reach service. This is because the WAU value is calculated based on the intent and complexity of care, not which team or staff deliver it. This is also dependent on local procedures for SNAP accordance.

As such, cost-benefit results in this report reflect the methodology approved within this HHS only. They should not be used to compare performance across HHSs without adjusting for methodological differences. Results should be interpreted as indicative of local value, not as universal financial benchmarks.

Benchmarks

Each service is recommended to collect a minimum data set to maintain the statewide *In-reach Rehabilitation Model of Care.* All In-reach services are encouraged to report to AROC Data Pathway 2 – In-reach Rehab, to maintain benchmarking and consistency across the state. Refer to the In-reach Model of Care document for details on the minimum data set requirements.

AROC Pathway 2 Data Dictionary can also provide the exact details of data sets require or In-reach Rehabilitation Pathway 2. More details on reporting pathways area also available at AROC.

Data systems, quality and governance

Data collection processes will be unique to individual health services depending on typical electronic record however, the following systems can be considered.

- Excel spreadsheets to monitor patient demographics and key outcome measures. Note this is a low tech, accessible option though minimal functionality for complex data management or visualisation. Example versions have been established in the *In-reach Rehabilitation Toolkit*.
- Power BI: Microsoft suite option that can be integrated with Microsoft List/SharePoint, however, requires significant set-up, maintenance and monitoring. High-tech options with complex software though high functionality.
- Microsoft forms: Forms can be utilised to capture patient reported data including PREMs/PROMs and staff surveys. Data typically be exported into excel spreadsheet directly from Forms.

Roles and responsibilities of the individual team members in data collection will vary but could be completed as follows:

- Team lead or senior staff members: oversees design, delivery and reporting of evaluation including analysis and ensuring methodology and frameworks are applied consistently
- Clinicians: Complete or collect outcome measures to complete minimum data sets including administering any PROMs/PREMs
- Administrative staff: Manage oversight of data completeness.

Reporting standards and templates

Reporting guidelines vary between HHSs dependent on local templates and procedures. The following inclusions are recommended:

- Executive summary with key metrics and cost/value headline
- Sections: Introduction, Methodology; Process; Impact; Outcomes; Cost Effectiveness; Limitations; Appendices.
- Visual Standards: consistent colours, legends, annotation; define data period on each chart.

The following could be included as a template example for reporting documents:

- Executive summary
- Introduction & funding context – Model of care, goals, logic model.
- Methodology – Period, data sources, analytics, equity lens (RE-AIM rationale).
- REACH – Referrals, commencements, representativeness & equity.
- EFFECTIVENESS – PREMs, PROMs, pathways, LOS, readmissions, bed-day savings, cost–benefit.
- ADOPTION – Settings/wards, disciplines, partner engagement.
- IMPLEMENTATION – Dosage, productivity, fidelity, adaptations, data quality, delivery costs/time.
- MAINTENANCE – Year-on-year trends; embedding; sustainability actions.
- Limitations & future Work – Data gaps, next steps.
- Appendices – Minimum dataset, glossary, risk register, PREM, SOP extracts.

Risks & mitigations

Risk	Mitigation
Inconsistent data capture	Mandatory fields, spot audits, feedback loops.
Outcome measures not collected at discharge	Automated prompts and discharge checklists. Colour coding to identify missing data.
Benchmark unavailable	Use internal baseline and document assumptions.
Staff turnover	Cross-training and simple work unit instructions for data capture. Standardised staff induction procedures to support onboarding for data collection/

Ethics, privacy & consent

Given evaluation activities typically qualify as quality improvement, they do not usually require ethics review however it is beneficial to confirm local policy. Ensure collection of PREMs/PROMs aligns with privacy legislation and organisational policy. Use anonymised reporting and small-number suppression as required.

References

Glasgow, R. E., Harden, S. M., Gaglio, B., Rabin, B., Smith, M. L., Porter, G. C., Ory, M. G., & Estabrooks, P. A. (2019). RE-AIM Planning and Evaluation Framework: Adapting to New Science and Practice With a 20-Year Review. *FRONTIERS IN PUBLIC HEALTH*, *7*, 64. https://doi.org/10.3389/fpubh.2019.00064

Appendix 1 – Example Patient Reported Experience Measure (PREM)-Reported Experience Measure (PREM)

Purpose

This Patient-Reported Experience Measure (PREM) is designed to capture consumer experience of early rehabilitation delivered within acute care settings. Responses are de-identified and used for service evaluation, quality improvement, and reporting to service sponsors and executive teams.

Patients may receive assistance to complete the survey where required; however, responses should reflect the patient's own views and experiences. There are no right or wrong answers.

Please indicate **one response** that best reflects your experience with the In-Reach Rehabilitation Service. If a question does not apply to you, please select **Not applicable**.

Response scale for Questions 1–13:

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Not applicable

Section A: Therapy Delivery and Coordination

1. I am satisfied with the intensity of rehabilitation therapy I received.
2. Scheduling between my acute treating team and the In-Reach Rehabilitation team worked well.
3. I had adequate time for rest and sleep during my rehabilitation.
4. The In-Reach staff involved me and considered my individual needs when planning my care.
5. I feel the In-Reach Rehabilitation team helped me work towards and achieve my early rehabilitation goals.

Section B: Respect, Communication, and Emotional Support

6. I was treated with dignity and respect by the In-Reach Rehabilitation team.
7. I felt comfortable expressing my feelings, and my emotional needs (such as worries, fears, or anxieties) were recognised and taken seriously.
8. Members of my In-Reach team (therapists, nurse, key worker, doctors) appeared to work well together and were aligned in my care.
9. The In-Reach team and my acute treating team communicated effectively and worked consistently towards my goals.

Section C: Information, Coordination, and Discharge Preparation

10. I received information when I needed it.
11. My In-Reach Rehabilitation key worker helped to coordinate my care and answer my questions.
12. My family or friends were given the support and information they needed by the In-Reach staff

(where applicable).

13. I was given adequate information to prepare me for discharge from the In-Reach Rehabilitation Service (for example, information about community supports or sub-acute rehabilitation).

Section D: Open-Ended Feedback

14. Is there anything you feel the In-Reach Rehabilitation Service did particularly well?
(Free-text response)
15. Is there anything you feel the In-Reach Rehabilitation team could improve?
(Free-text response)
16. Do you have any additional feedback about your experience with the In-Reach Rehabilitation Service?
(Free-text response)