Business case – SBAR application

This document is provided as a general guide to assist services in preparing a business case for an In-reach rehabilitation service. It is particularly suited for urgent or short turnaround applications where a structured approach is required. The content and format are not prescriptive and may be adapted as necessary to meet local requirements, organisational priorities, and available data. Services are encouraged to tailor the information to reflect their specific context, resources, and strategic objectives. Note that formal submission of any applications should be done so in line with the templating and formatting expectations of the local HHS with this acting as a generalised SBAR reference point that may be adapted, as necessary.

1. Situation

- Describe the current problem affecting patient flow, bed capacity and activity funding.
- Explain how patients awaiting transfer to inpatient rehabilitation are remaining in acute beds, leading to longer lengths of stay and unfunded bed-days.
- State the immediate opportunity to commence rehabilitation on acute wards and the decision you are seeking e.g. approval for a pilot vs ongoing funding.

Example:

[HHS / Hospital] is experiencing pressure on acute bed capacity with patients awaiting transfer to inpatient rehabilitation. These patients remain in acute wards for [insert number] days after acceptance, contributing to unfunded bed days and delaying functional recovery. Delayed access to rehabilitation and increased time on acute wards can increase risk of hospital acquired complications, worsen deconditioning and impact utilisations of key neuroplasticity periods that require timely input.

Current activity data indicate [insert WAU shortfall or other relevant metric]. The immediate opportunity is to commence multidisciplinary rehabilitation care on acute wards under the oversight of a Rehabilitation Physician, enabling [insert funding mechanism, e.g., SNAP Episode of Care change or Activity Based Funding (ABF) optimisation], improving patient flow and ensuring patients have access to rehab at the time that they are ready for it rather than when a bed is available.

Approval is sought for [insert duration] pilot of an in-reach rehabilitation team to address these issues and evaluate a model for business-as-usual adoption.

2. Background

- Provide the organisational context, including demand growth and constraints on the inpatient rehabilitation bed base.
- Outline the requirements for changing a SNAP Episode of Care to Rehabilitation Care Type (multidisciplinary care led by a rehabilitation physician, weekly case conferencing, and functional measurement such as FIM).
- Summarise relevant benchmarking or prior experience and cite alignment to strategic priorities. Note this is available in the toolkit resource with the following key resources:
  - Current state analysis includes details of benchmarking data, literature evidence and impact of in-reach services to date
  - National Safety and Quality Health Service (NSQHS) Standards alignment resource and Department of Health Strategic Plan 2025-2029 alignment resource available for insights into in-reach services alignment with key Queensland Health strategic priorities.

Example: *[HHS/Hospital] serves a growing population (note the key demographics can be identified for the specific HHS at: https://www.choreport.health.qld.gov.au/our-people/demography), with demand for both acute and inpatient rehabilitation beds increasing and no commensurate expansion of the rehabilitation bed base. Existing in-reach services have demonstrated considerable impacts on their local patient cohorts. Existing in-reach services have demonstrated the following patient outcomes:*

- *Insert metric e.g. FIM efficiency/change or LoS*

In addition to the impacts for both patients and patient flow, services have demonstrated return on investment through the following metrics:

- *[Insert metric, e.g., bed days saved],*
- *[Insert metric, e.g., Activity Based Funding gains].*

Similar models implemented in other health services have demonstrated substantial benefits, including increased funded activity and avoidance of inpatient rehabilitation admission for a significant proportion of referred patients. The proposed model aligns with organisational priorities such as [insert strategic priorities].

*Note: The choice of what metric or health service's data should be chosen based on the priorities of the local HHS, which should be determined using the *pre-implementation reflection tool*. Noting there is some consideration required for inclusion of existing in-reach service's data given challenges of applying outcomes of other services with different locations, sizes and patient cohorts. Application of any of the existing data should include a caveat to interpret and apply results with caution and consideration for applicability to local HHS.

3. Assessment

- Present the analysis of the current state supported by local data.
- Can include the number of internal rehabilitation referrals, average delay from acceptance to transfer, current WAU shortfall, and estimated opportunity to increase SNAP Rehabilitation activity. Noting that choice of barriers/challenges should be relevant to local procedures and executive priorities.
- Discuss clinical and operational benefits of commencing rehabilitation in acute wards, including faster functional gains, reduced complications, and earlier progression of discharge planning and equipment/NDIS applications.
- Identify key risks (e.g., resource constraints, referral volumes exceeding capacity) and mitigation strategies (e.g., phased implementation, collaboration with ward teams, clear referral criteria).

Example

In the preceding [insert time period], [HHS/Hospital] received [insert number] internal referrals for inpatient rehabilitation, and the average delay from acceptance to transfer to a rehabilitation bed was approximately [insert number] days. Commencing rehabilitation while patients remain on acute wards is expected to accelerate functional improvement, reduce hospital-acquired complications, and enable earlier progression of discharge planning, equipment provision, and NDIS applications.

Financially, initiating rehabilitation care in acute wards would [apply appropriate funding metric e.g. increase funded activity through SNAP or ABF or reduce cost via sub-acute bed days saved] and reduce unfunded bed-days. Modelling for the remainder of the [insert financial year or pilot period] indicates the potential for approximately [insert estimated WAU or bed-days saved] through in-reach rehabilitation, alongside measurable reductions in acute bed occupancy.

Risks include the scope of change within a constrained timeframe and the possibility of referral volumes exceeding capacity; these can be mitigated through a phased cohort-based implementation, collaboration with ward clinicians, and clear governance and referral criteria.

4. Recommendation

- Set out the proposed model of care and the decision requested. Describe the multidisciplinary team composition and governance (led by a rehabilitation physician), the pilot duration, and the implementation approach.
- Provide the investment required including:
    - Labour costs: Workforce should be considered based on the *In-reach Model of Care* recommendations for disciplines, ratios and seniority. Consider impact of leave on workforce budgeting.
    - Non-labour costs: Staff equipment (laptops, phone/vocera, IT licences, desk space etc., stationary), patient equipment (therapy equipment, consumables, ADL equipment, storage space).
- Include the expected financial and patient-centred outcomes (FIM change/efficiency, LoS, sub-acute admission avoidance, estimated WAU uplift, reduced acute bed occupancy).
- Include a timeline, reporting arrangements, and key performance indicators to track pilot outcomes and inform business-as-usual adoption. These can be identified in the *pre-implementation reflection tool* and the *Evaluation framework* within the *In-reach Rehabilitation Toolkit*.
- Consider implication of return on investment. This is typically evaluated and reported on through consideration of financial gain, either via ABF/WAU or bed-days saved, subtracted by the cost of the service.
- Reference can be made for ongoing monitoring/evaluation in quality cycle process. You can utilise the *Evaluation framework* to reference the planned reporting measures and evaluation processes including contribution to AROC Pathway 2 to support sustainability of evaluation, service outcomes and benchmarking.

Example

Establish and fund a multidisciplinary Rehabilitation Response Team to deliver in-reach rehabilitation care on acute wards for [insert duration] pilot or substantive funding period/recurrent funding. The team would be led by a rehabilitation physician and include [insert roles, e.g., physiotherapist, occupational therapist, social worker, clinical assistant], supported by ward administration and allied health leadership.

The estimated investment is [insert cost] over [insert duration], inclusive of labour, nonlabour, and corporate overheads. Expected outcomes include an uplift in funded activity (via [insert funding mechanism, e.g., SNAP, ABF or bed-days saved]), reduced acute bed occupancy through shorter or avoided inpatient rehabilitation stays, and improved patient outcomes and staff satisfaction.

The pilot will report through [insert governance pathway], track key performance indicators (e.g., WAU uplift, bed days saved, avoided admissions, functional outcomes), and provide recommendations for embedding the model into business as usual based on measured benefits and return on investment.