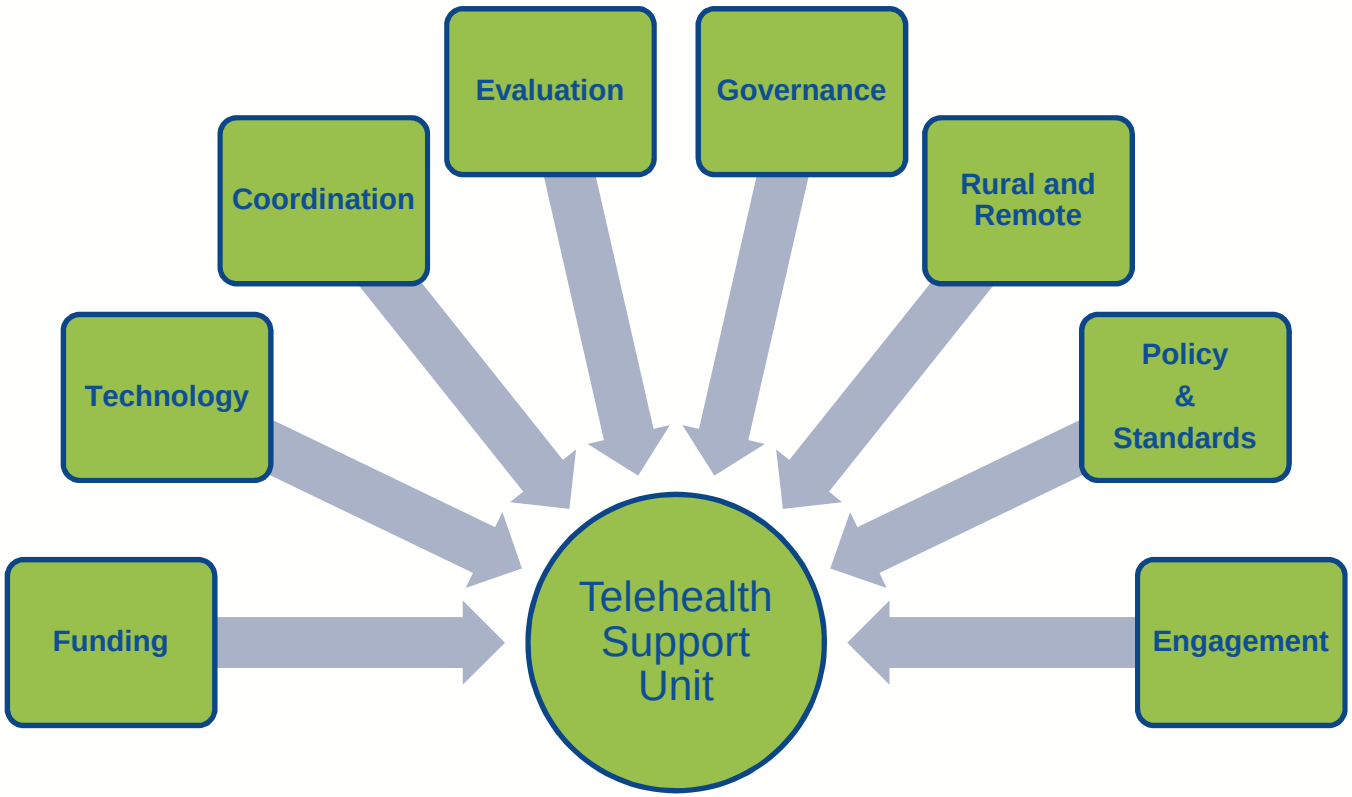
Queensland Health

Telehealth supported rural stroke units

Lessons from the pilot

Queensland Government

Functions


Evaluation
Governance
Coordination
Rural and Remote
Technology
Policy & Standards
Funding
Telehealth Support Unit
Engagement

Benefits of telehealth

- Equity of access to specialist care
- Partnership in management of patient at rural/regional sites
- Reduced burden of travel
- Up skilling of local teams in rural sites

Benefits of rural stroke units

- Remote thrombolysis (“clot busting”)
- Early assessment and transfer for clot retrieval
- Equity of access to specialist care & interventionist treatment
- Reduction in stroke mortality associated with admission to a stroke unit

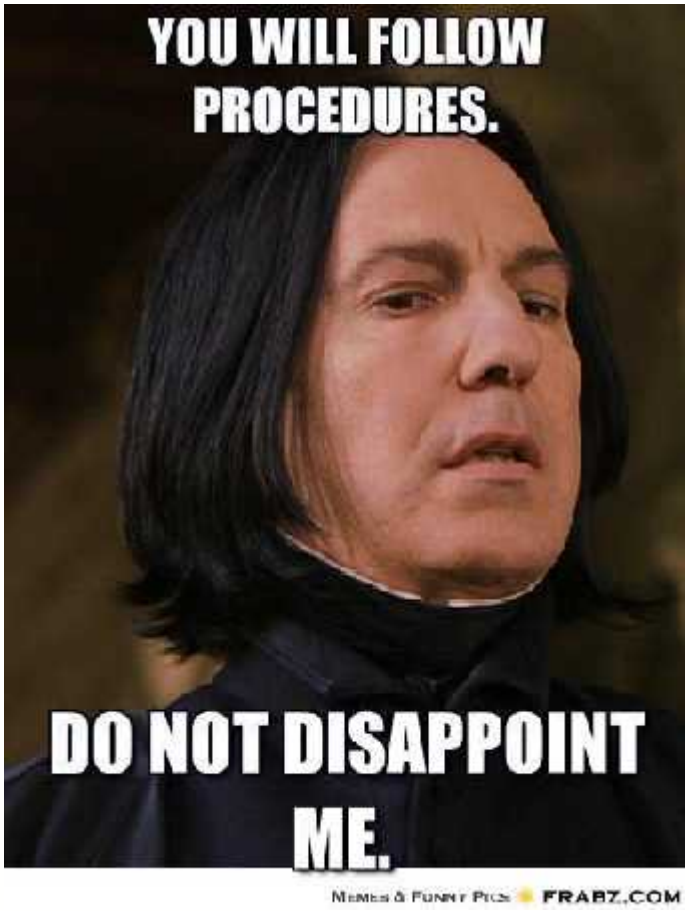
We formed a committee

- Statewide Stroke Clinical Network
- Providing Stroke Specialist
- Providing Stroke Coordinator
- Recipient Executive Team
- Recipient Clinicians
- Telehealth Support Unit

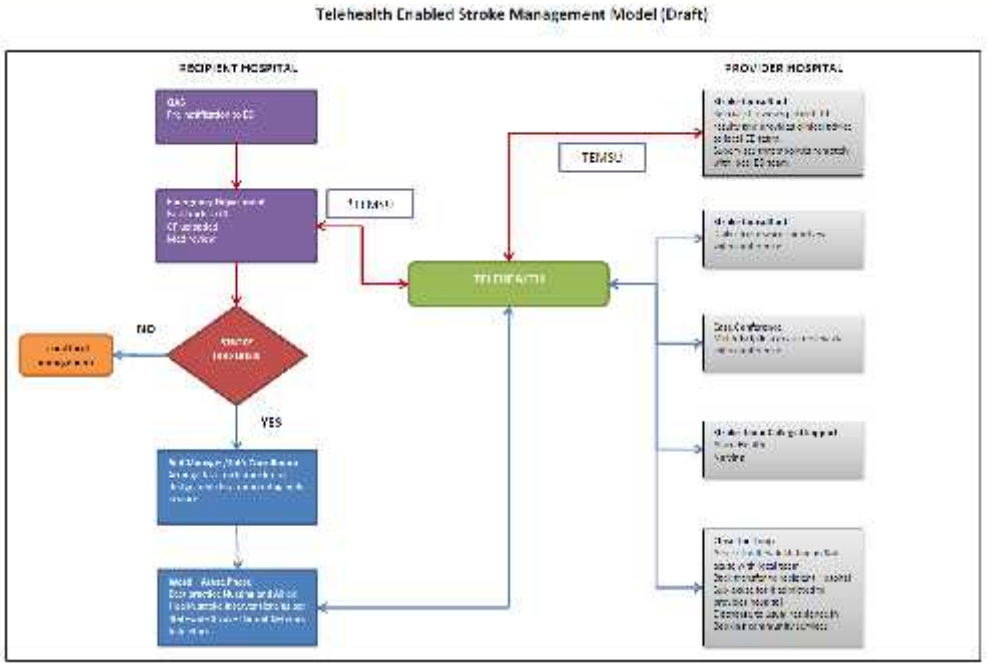
We planned intensively…

- 2 x site visits to rural site
- Comprehensive engagement at all levels
- Developed a communication plan
- Identified the gaps
- Identified the solutions
- Set milestone dates

We developed a pathway



We developed a procedure and model of care



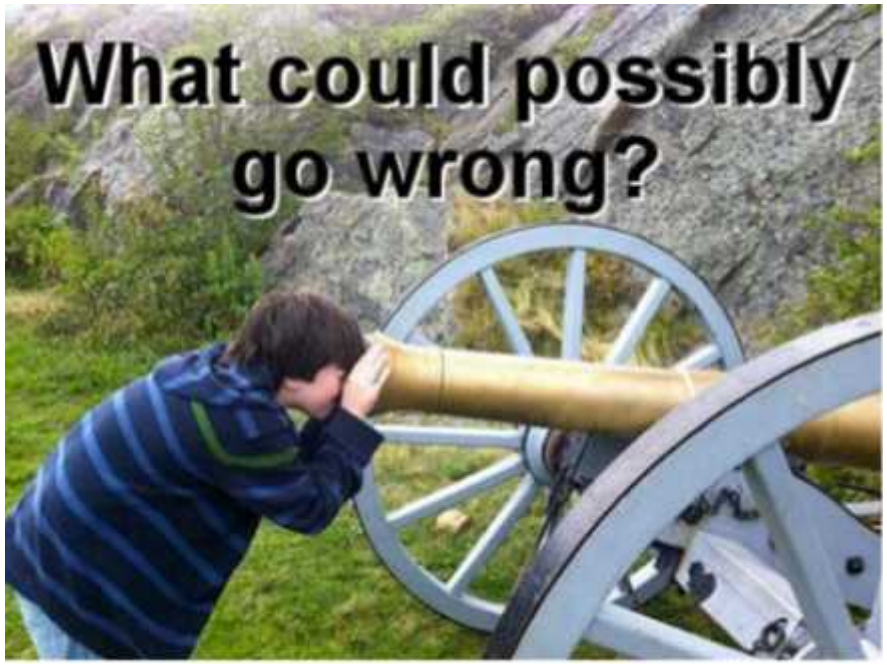
..and mapped the process

We set a date for kick off

Checklist

- Engagement
- Consultation
- Gap analysis
- Planning
- Communication
- Model of care
- Procedure
- Pathway
- Go live date
- Consensus

Right?



Shaving my head
EXPECTATION
REALITY

We had few stroke admissions after “go live”

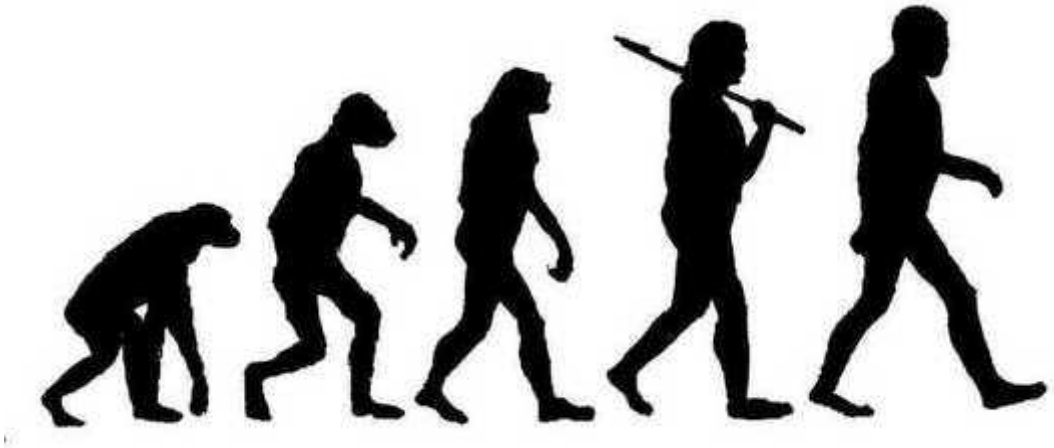
No stroke presentations were candidates for remote thrombolysis

Our model was dependent on the hub site providing telehealth support with an already over-committed workload, complicated by:

- Single specialist provider
- Cross HHS border care
- Ad-hoc ward reviews
- Palliation vs. transfer

Our primary medical lead and enthusiastic clinical champion at the rural site retired

The model was an informal pilot and changed over time



The “go live” date was a public holiday…

Despite intensive training and education, the procedure was frequently not followed

Other challenges were a result of cross HHS jurisdiction and determining the responsibilities of each site

So…what did we learn?

1. Expect the unexpected.
2. The pilot MUST be formal.
3. No matter how keen you are, DON’T start your pilot on a public holiday.
4. If you build it they WON’T always come.
5. Use it or LOSE it.
6. Everyone has good will and wants it to work.

Finally…

- This is the beginning.
- We learnt valuable lessons that will inform the next steps.
- The participating sites remain engaged and continue to collaborate in stroke management via telehealth.
- We have the basic building blocks and template of a rural stroke unit.
- Onward and upward.