

GUIDE

# Sub-Acute Care Type Policy Guidance

Aged Health, Palliative Care and Rehabilitation Networks



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## 1. Introduction

This advice provides guidance to Local Health Districts (LHDs) and Specialty Health Networks (SHNs) regarding implementation of the Care Type Policy for Acute, Sub-Acute and Non-Acute Patient Care (PD2016\_039) to support the use of consistent definitions and terminology across the state for sub-acute and non-acute care types.

## 2. Purpose

Good clinical care is the core business of clinicians and NSW Health. Within an Activity Based Funding environment, care must be appropriately classified into the relevant care type to allow funding to support that care.

The majority of care provided in NSW is acute care, with a small but significant proportion being subacute care. This guidance document is intended to clarify the core components of care that are required to meet national definitions of subacute care. It is not intended to define good clinical practice.

This advice provides guidance to Local Health Districts (LHDs) and Specialty Health Networks (SHNs) regarding implementation of the Care Type Policy for Acute, Sub-Acute and Non-Acute Patient Care (PD2016\_039/PD2014\_010) to support the use of consistent definitions and terminology across the state for sub-acute and non-acute care types. It will assist in ensuring that application of the policy is consistent; in particular that the assignment and change to care type occur in conjunction with the provision of appropriate care and are supported by the appropriate evidence.

Specifically, this document provides guidance to LHDs to comply with national definitions of sub-acute classifications by:

- defining “clinicians with specialist expertise”,
- defining “multidisciplinary team”, and
- providing key features for inclusion in a multidisciplinary management plan.

It aims to provide a level of consistency in the provision and documentation of subacute care across NSW. It is not intended to define the clinical care provided.

Definitions of the subacute care types are found in Appendix 1.

## 3. Background

### Care Type Assignment

NSW Health released the revised Care Type Policy for Acute, Sub-Acute and Non-Acute Admitted Patient Care (PD2016\_039) in September 2016. The policy provided the opportunity for Local Health Districts (LHDs) and Specialty Health Networks (SHNs) to ensure appropriate and uniformly consistent classification of activity types, with a focus on data quality.

LHDs are required to implement the policy in a planned way to ensure uniform application across their District. For sub-acute care types, this will involve consideration of models of care, staff education on assessment tools and care/management planning for Rehabilitation, Palliative Care,

Geriatric Evaluation and Management (GEM), Maintenance and Psychogeriatric care types, as well as rolling out the SNAP data collection via SYNAPTIX.

NSW Health services have an obligation to count and classify activity in a meaningful and consistent manner. This Policy **Directive (PD2016\_039)** subsequently referred to as The Policy) provides a framework to ensure assignment to, and changes in, care type occur appropriately and correctly. Accurate care type assignment will ensure that LHDs and SHNs provide appropriate sub-acute clinical services and are funded appropriately under Activity Based Funding (ABF) for the clinical services provided. Sub and Non-Acute care is classified using the Australian National Subacute and Non-acute (AN-SNAP) Classification.

### Care Type

“Care Type” refers to the overall nature of a clinical service provided to an admitted patient during an episode of admitted patient care. Correct assignment of care type will ensure that each episode is classified appropriately for ABF. Services must ensure that episodes of patient care are classified using the care type that best reflects the primary clinical purpose or treatment goal of the care provided, rather than the care that the patient is intended to receive. When the clinical purpose or treatment goal changes so must the care type. The care type to which the episode is allocated must always be evidenced by documentation within the patient health record. Type changing is not anticipatory in nature and should only occur when the patient commences receiving the required subacute care type.

For the sub-acute care types – Rehabilitation, Palliative Care, Geriatric Evaluation and Management, and Psychogeriatric care, the patient’s medical record must show evidence that:

- Care has been delivered under the management of, or informed by a clinician with specialised expertise
- An individualised multi-disciplinary management plan has been developed and is documented in the patient’s medical record.

The Policy does not provide definitions of a clinician with specialised expertise, or the composition of the multidisciplinary team, leading to the risk of services adopting widely varying response to how the policy is implemented.

At the request of clinician and service managers, the Agency for Clinical Innovation (ACI) has progressed the development of this guidance resource to support implementation of the policy. The sub-acute care type definitions are provided at Appendix 1.

## 4. Process

In order to support Local Health Districts and Specialty Health Networks to progress the implementation of the Policy, the sub-acute care networks at ACI met to develop advice to support implementation of the policy. An inter-network group of co-chairs and executive members from the Rehabilitation, Aged Health, Older Peoples Mental Health and Palliative Care networks, as well as a representative from the ABF taskforce met to develop this response.

The group agreed to develop guidance relating to the following definitions and/or evidence:

1. Clinician with specialised expertise
2. Multidisciplinary team (MDT)
3. Multidisciplinary team management plan.

Implementation of the Policy remains the responsibility of each Local Health District and Specialty Health Network, and consultation with subacute service providers is recommended to ensure that definitions are locally agreed and consistently applied across services.

## 5. Agreed Definitions

### **Clinician with Specialised Expertise**

The subacute care types of Rehabilitation, Palliative Care, Geriatric Evaluation and Management, and Psychogeriatric care all share a requirement in the Policy that care is 'Delivered under the management of or informed by a clinician with specialised expertise' in the care type being provided.

A clinician with specialised expertise can be a medical, nursing or allied health professional who possesses recognised clinical skills in the subacute care type being provided. This can include formal specialist qualification, evidence of advanced training, relevant/extensive clinical experience, and/or recognition of possessing expertise by peers within the subacute care specialty.

In addition, the clinician with specialised expertise should be able to:

- lead a team that is capable and skilled in the relevant collection of outcome measures/data collection;
- direct the development and implementation of a multidisciplinary team (MDT) Management Plan
- monitor the progress of the MDT Management Plan
- progress planning for transfer of care
- determine the appropriate composition of multidisciplinary team based on individual patient requirements and
- possess knowledge and skills in negotiating goals, determining appropriate timeframes.

The Policy recognises that the clinician responsible for the management of care may not necessarily be located in the same facility as the patient, for example in a hub and spoke model of care, and that in these circumstances, the expertise of the clinician at the patient's location does not affect the assignment of care type. The use of telehealth may facilitate the continuation of care across sites.

If a medical officer with recognised expertise in the relevant subacute care type is available on campus, they should be involved in the delivery of that subacute care type. This does not imply that the specialist physician has to actively assess and manage every patient; rather that their involvement may be reflected through the provision of sub-acute programs or pathways that are relevant to the patient's needs. In the absence of a specialist medical officer on campus, there must be formalised links in place to access to a service that has that expertise (either within or outside the organisation).

### **Multidisciplinary Team (MDT)**

Medical, nursing and allied health clinicians appropriate to the care needs of the patient should be involved in a formal assessment of bio-psychosocial functional ability which will lead to the development of the multidisciplinary management plan based on patient centred goals. Each LHD is responsible for providing the appropriate health professional resources and to ensure that staff are appropriately trained in use of tools required for the care type being provided. The MDT

should consist of the appropriate mix of medical, nursing and allied health clinicians to provide the care required for the patient to meet their goals. This will vary according to patient need and type of care required.

Each sub-acute care type has specific data collection requirements to enable care to be classified using the Australian National Subacute and Non-Acute Classification (AN-SNAP) and staff require training and in some cases accreditation, to be able to administer the required tools. For Rehabilitation and Geriatric Evaluation and Management (GEM) care, staff require training and accreditation in the use of the Functional Independence Measure (FIM), for Palliative and non-acute care the Resource Utilisation Groups – Activities of Daily Living (RUG-ADL) is the required tool and for psychogeriatric care the Health of the Nation Outcomes Scales (HoNOS).

### **MDT Management Plan**

The Policy requires the care type to which the episode is allocated be evidenced by documentation in the patient health record. Evidence supporting the provision of subacute care includes an individualised multidisciplinary management plan.

The MDT management plan comprises 'a series of documented and agreed initiatives or treatments specifying program goals, actions and timeframes which have been established through multidisciplinary consultation and consultation with the patient and carers.' The management plan may be evidenced through a variety of mechanisms including a standard management plan template, case conference record form or planning meeting document.

However, individual, discipline specific plans documented throughout the medical record without evidence of a consolidated, coordinated team approach to the management plan is not sufficient to meet the intent of the policy statement.

The management plan should include process elements, as well as care components. Any documented multidisciplinary management plan should include the following process elements and a majority of these care components:

PROCESS ELEMENTS	CARE COMPONENTS
Negotiated goals Timeframes Formal assessment of functional ability	Physical Psychological and Behavioural Cognitive Emotional Social Spiritual Advance care planning Education for patient Carer education and support

The relevant clinical network may provide guidance regarding the appropriateness of any management plan template developed for use by a particular service.

## 6. References and Related Policies

1. AIHW 2013. Development of nationally consistent subacute and non-acute admitted patient care data definitions and guidelines. Cat. No. HSE 135. Canberra: AIHW.
2. Australasian Rehabilitation Outcomes Centre <http://ahsri.uow.edu.au/aroc/index.html>
3. Australian National Subacute and Non-Acute Patient (AN-SNAP) classification Version 3 <http://ahsri.uow.edu.au/chsd/ansnap/index.html>
4. Health System Information and Performance Reporting Branch (20164), PD2016\_039PD2014\_010 Care Type
5. Policy for Acute, Sub-Acute and Non-Acute Patient Care, NSW Health.
6. Inter-Government and Funding Strategies Branch (2008), PD2008\_025 SNAP Data Collection – Australian National Sub-Acute and Non-Acute Patient (AN-SNAP) Classification, NSW Health.
7. Palliative Care Outcomes Collaboration <http://www.pcoc.org.au/>



## 7. Appendices

### APPENDIX 1

#### NATIONAL CARE TYPE DEFINITIONS FOR SUB ACUTE CARE

##### 1. Rehabilitation Care

Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with impairment, activity limitation or participation restriction due to a health condition.

The patient will be capable of actively participating.

Rehabilitation is always:

- Delivered under the management of or informed by a clinician with specialised expertise in rehabilitation, and
- Evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that includes negotiated goals within specified timeframes and formal assessment of functional ability.

##### 'Rehabilitation Care' Guidelines

When an acute patient is waiting for Rehabilitation, but Rehabilitation care has not yet commenced, a care type change to Rehabilitation cannot occur. The patient must remain in an acute care type until rehabilitation care begins. In some instances a care type change to maintenance may be warranted.

If Rehabilitation is occurring on an acute ward, the Rehabilitation care type should be used, as care type is independent of patient location.

The period of recovery at the end of an acute episode prior to separation (for example, the final 1-2 days after a joint replacement) is not necessarily a separate episode and should not trigger a care type change to rehabilitation. Even though the care has lower resource intensity and the patient may receive some allied health involvement, unless the definition of Rehabilitation (as stated above) is met, the care type remains acute.

A multidisciplinary management plan comprises a series of documented and agreed initiatives or treatments (specifying program goals, actions and timeframes) which have been established through multidisciplinary consultation and consultation with the patient and/or carers.

Patients who receive acute same day interventions, such as dialysis, during the course of a Rehabilitation episode of care do not change care type. Instead, procedure codes for the acute same day intervention(s) and an additional diagnosis (if relevant) should be added to the record of the Rehabilitation episode of care.

##### 2. Palliative Care

Palliative care is care in which the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs.

Palliative care is always:

- Delivered under the management of, or informed by a clinician with specialised expertise in palliative care, and
- Evidenced by an individualised multidisciplinary assessment and management plan, which is documented in the patient's medical record, which covers the physical, psychological, emotional, social and spiritual needs of the patient and negotiated goals.

### **'Palliative Care' Guidelines**

Interventions such as radiotherapy, chemotherapy, and surgery are considered part of the palliative episode if they are undertaken specifically to provide symptom relief.

Patients referred to the Emergency Department by a clinician for palliative care should have a care type of Palliative Care assigned from the ED time of admission.

### **3. Maintenance Care**

Maintenance (or non-acute) care is care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition.

Following assessment or treatment, the patient does not require further complex assessment or stabilisation. Patients with a care type of 'maintenance care' often require care over an indefinite period.

### **'Maintenance Care' Guidelines**

Maintenance Care includes:

- Care provided to a patient, who would normally not require hospital treatment and would be more appropriately treated in another setting, which is unavailable in the short term, or where there are factors in the home environment making it inappropriate to discharge the patient in the short term.

For example:

- A patient requires home modifications in order to be safely discharged home.
- The modifications are not yet complete and therefore, although ready for discharge the patient cannot safely return home.
- A patient requires nursing home placement and although ready for discharge a place is not yet available. The patient has a current acute care certificate.
- Nursing Home Type patients for whom there is no acute care certificate.
- Patients in receipt of care where the primary reason for admission is respite.

### **4. Geriatric Evaluation and Management (GEM)**

Geriatric Evaluation and Management care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with multi-dimensional needs associated with medical conditions related to ageing, such as a tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems.

Geriatric Evaluation and Management is always:

- Delivered under the management of, or informed by a clinician with specialised expertise in geriatric evaluation and management, and

- Evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative timeframes and formal assessment of functional ability.

### **'GEM' Guidelines**

When an acute patient is waiting for GEM, but GEM care has not yet commenced, a care type change to GEM cannot occur. The patient must remain in an acute care type until GEM care begins. In some instances a care type change to maintenance may be warranted.

If GEM is occurring on an acute ward, the GEM care type should be used, as the care type is independent of patient location.

The period of recovery at the end of an acute episode prior to separation (for example the final 1-2 days after a joint replacement), is not necessarily a separate episode and should not trigger a care type change to GEM. Even though the care has lower resource intensity and the patient may receive some allied health involvement, unless the definition of 'GEM' (as stated above) is met, the care type remains acute.

A multidisciplinary management plan comprises a series of documented and agreed initiatives or treatments (specifying program goals, actions and timeframes) which have been established through multidisciplinary consultation and consultation with the patient and/or carers.

Patients who receive acute same day intervention(s) during the course of a GEM episode of care do not change care type. Instead, procedure codes for the acute same day intervention(s) and an additional diagnosis (if relevant) should be added to the record of the GEM episode of care.

## **5. Psycho-geriatric**

Psycho-geriatric care is care in which the primary clinical purpose or treatment goal is improvement in the functional status, behaviour and/or quality of life for an older patient with significant psychiatric or behavioural disturbance, caused by mental illness, an age-related brain impairment or a physical condition.

Psycho-geriatric care is always:

- Delivered under the management of or informed by a clinician with specialised expertise in psychogeriatric care, and evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative timeframes and formal assessment of functional ability.

Psycho-geriatric care is not applicable if the primary focus of care is acute symptom control.

Where psycho-geriatric care is provided within a designated mental health unit, mental health care type should be assigned instead of psychogeriatric care type.

