ABF Information Series No. 6

Subacute care

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April 2010

As outlined in ABF Information Paper Number 1, the Council of Australian Governments (COAG) recognises five different types of patient care activities to be funded under Activity Based Funding (ABF):

- Acute inpatient admissions such as surgery, medical admissions, maternity and paediatrics
- Emergency department services
- Subacute care (both inpatient and outpatient) such as rehabilitation and palliative care
- Outpatient services
- Hospital-auspiced community health services such as home nursing and post acute care.

The focus of this paper is on subacute care and the difference between acute, subacute and non-acute care.

Acute care

We noted in ABF Paper Number 1 that, of the five care types above, only one – acute inpatient care – has a nationally adopted classification that can currently be used to define the 'activity' to be counted in an ABF model. This classification is the Australian-Refined Diagnosis Related Group (AR-DRG) classification.

In acute care, the treatment that the patient needs (and the cost of that treatment) can be largely predicted by the patient's principal medical diagnosis. So, for example, a patient with a hip fracture needs surgery and a patient with an infection needs antibiotics. The DRG system works well for acute care because it classifies patients into groups based on their diagnosis-related needs.

Acute care patients typically stay in hospital for a few days and represent about 97% of patients treated in Australian public hospitals. However, for reasons outlined below, acute care represents only about 82% of public hospital bed days. Patients receiving either sub-acute care or non-acute care occupy the other 18% of hospital beds.

Subacute care

As with acute care, subacute care is provided to patients who need care provided by hospitals and related health services. But the care that the patient needs is not primarily determined by their principal medical diagnosis. For this reason, a diagnosis-related classification like DRGs is not appropriate for this type of care.

In subacute care, the patient's treatment is driven primarily by their functional abilities (the physical and mental abilities that

Rehabilitation

Mrs Walker, who is 70 years old, is admitted to hospital after having a stroke. She receives acute stroke care and goes home the following week.

Mrs Frame, who is also 70 years old, has a stroke on the same day and is admitted to the same hospital. She also receives acute care. Ten days later, she still has no movement in her left side and her speech is very impaired. She can't manage the tasks of everyday living such as feeding herself or going to the toilet. Instead of going home, Mrs Frame is transferred to the rehabilitation unit.

Both patients have the same diagnosis. But the factor that determines which patient will need rehabilitation is not the diagnosis. Mrs Frame needs rehabilitation because she can't function independently. It is the patient's *functional ability* to manage everyday activities of daily living (ADLs) that predicts who needs rehabilitation and how much that rehabilitation will cost.

everyone needs to live independently) and by the goals they want to achieve, rather than the underlying medical diagnosis.

Two examples of subacute care are provided in the boxes. In addition to rehabilitation and palliative care, subacute care also includes Geriatric Evaluation and Management (GEM) and Aged Mental Health. GEM is care for frail older patients who have multiple health and related problems rather than a clear principal medical diagnosis. Aged Mental Health is the care of patients who have both physical and psychiatric illnesses.

Palliative Care

Mr Holmes has cancer. He has had treatment but his cancer can't be cured. He is now in palliative care.

Mr Watson has kidney failure and is also in palliative care.

These patients have different diagnoses. However, they happen to need the same type and amount of palliative care.

The need for palliative care is not determined by the patient's diagnosis. Rather, the need for palliative care (and the cost of that palliative care) is determined by the phase of the patient's illness, the patient's ability to manage everyday activities of daily living (ADLs), the pain and other symptoms that the patient is experiencing and the amount of support that the family needs.

In subacute care, therapy is the main intervention and it is provided to maximise the patient's functional abilities and to improve their quality of life. The goal of subacute care is to help patients (and their carers) to live well and to be as independent as possible for as long as possible.

By its nature, subacute care is care provided by a team of clinical disciplines. This team typically includes (but is not limited to) doctors, nurses, physiotherapists, occupational therapists, speech pathologists, psychologists, social workers and pastoral care workers.

Patients receiving subacute care generally require much longer stays in hospital than patients receiving acute care. For example, rehabilitation patients typically stay in hospital for two to three weeks or longer. For this reason, subacute patients (who represent just 2.5% of patients) occupy 13% of Australian public hospital beds.

It is sometimes assumed that subacute care is low cost. This is not correct. The cost of a day of subacute care for many patients is no different to the cost of a day of acute medical care and, in some cases, subacute care can be more expensive. This is necessary in order to achieve optimal outcomes and to minimise longer-term health costs.

But the mix of services that subacute patients receive is different to the mix of services that acute care patients receive. While subacute patients need fewer diagnostic tests, and don't have surgery, they need more allied health therapy (eg, physiotherapy and counselling) than acute care patients, often for several hours each day, and staff typically spend more time working with the patient's family. As well, many subacute care patients who go home require ongoing care and therapy after discharge. Coordination between hospital and home is thus a key element of subacute care. These services are essential in ensuring that the patient is as independent as possible for as long as possible.

Non-acute care

The words 'subacute' and 'non-acute' are sometimes used interchangeably. This is not correct.

Non-acute care is care for a patient (typically, but not always, a frail older person) who does not actually need to be in hospital but could, instead, be cared for at home or in a residential aged care home. Non-acute care is usually provided in a hospital while patients are waiting for placement in residential care, waiting for their homes to be modified or the services that they will need at home to be organised or when their carer needs a break (respite care).

Fewer than 1% of patients in Australian public hospitals are non-acute but these patients occupy 5% of Australian public hospital beds. Because non-acute patients do not require active treatment or intensive therapy, non-acute care is usually much less expensive than either acute or subacute care.