Care setting 2: Sub-acute inpatient

Overview of scope of services

- Access to a core multidisciplinary care team (medical, nursing and therapist) and access to other specialised services as required in an inpatient setting
- Intensive multidisciplinary inpatient program for patients that require and can tolerate an intense rehabilitation program or who require the structured environment for safety reasons
- Provision of one-on-one therapy, group therapy and client self management / family involvement in the therapy program
- Dependant on the capacity and capability of the unit the following may be characteristics of the sub-acute care setting:
  - Streaming of care, where patients are grouped according to impairment type
  - Integrated care types for example: acute care and rehabilitation care (i.e. inreach teams and SMART beds); rehabilitation care and aged care (i.e. parallel care for orthogeriatrics).

Outcomes for the rehabilitation patient journey

- Intensive multidisciplinary care leading to functional ability to be transferred to ambulatory care settings
- Streaming of care leads to specialisation and education of staff
- Integrated care promotes care coordination and improved flow of patients across the continuum of care.

Implications for implementation

- Admission and discharge criteria will be required to describe eligible patients in the acute sector who require and will benefit from inpatient subacute rehabilitation services

a) Standalone sub-acute facilities

- Clear processes need to be defined for the management and admission of patients requiring a higher level of care back to the inpatient acute wards or facilities
- Availability of 24 hour (on-call or onsite) medical coverage
- Access to clinical services (eg X-ray, pathology, specialist appointments) not available on site.
b) Colocated sub-acute facilities

- Protocols regarding adequate workforce provision to rehabilitation services will assist to ensure patient care and intensity of therapy aligns with best practice.
- It will be possible to transfer patients directly to acute wards if required.

The case studies below provide examples of integrated model of care and the implementation of case managers.

**Case study 1: Orthogeriatrics and rehabilitation**

There is evidence that inpatient rehabilitation specifically designed for geriatric patients compared with usual care results in improved functional status, decreased admission to nursing homes and decreased mortality. Orthogeriatric services have provided the model on which the ACE, ART and SMART are based. Orthogeriatric services operate on the principle of comprehensive geriatric assessment and an interdisciplinary approach that encompasses the totality of the patient’s medical, psychosocial and functional needs. For example, the orthogeriatric model is appropriate whilst patients are requiring the operative management of orthopaedic conditions. In this example a patient’s medical and rehabilitation requirements are attended to by geriatric medicine. Such programs are common in larger teaching hospitals and rollout to district hospitals strongly supported by the ACI and NSW Health.

**Case study 2: Case managers**

Case Managers/ Care Coordinators have been implemented in other patient groups such as cancer and chronic disease to improve the patient journey, in particular to facilitate the continuum of care, coordination of care, discharge planning/transfer of care, case management, integration of services and seamless care for patients.

Case Managers for rehabilitation have been implemented in a number of sub-acute facilities in NSW one example being Orange Hospital. The goals of case management at Orange Hospital include:

- To enhance and foster client-centred therapy where the patient and their family are included and central in the goal setting and discharge planning processes
- To improve the transition from acute care to rehabilitation to discharge destination. (Successful discharge should be well planned, timely, and coordinated).
- To increase and improve communication and information sharing between the treating team and the client and their family.

Orange Hospital seeks to allocate a case manager to patients within 48 hours of admission. The case manager is a member of the nursing staff and meets with the client at least once a week and the family is provided with the case manager’s contact details. The case manager is the first point of contact for clients, families and other health
professionals or service providers. The case manager is responsible for providing information, dealing with issues and assisting with transfer of care processes. The case manager also completes the goal planning sheet and discharge checklist.