Victoria – Progress against Subacute Care Implementation Plan
National Partnership Agreement on Hospital and Health Workforce Reform – Schedule C

July 2009 – June 2010

Summary of Progress

As outlined in the 2008-09 report and the July-December 2009 report, in December 2008 the Victorian State Government provided funding to sub-acute services as a part of the 'Victorian Bed Strategy'. This included an additional full year effect of $36 million encompassing 170 new sub-acute beds across rehabilitation, geriatric evaluation and management (GEM), palliative care and restorative care, $2.5 million for Rehabilitation in the home (RITH), $2.5 million for Residential Aged Care Clinical In-reach programs and $1 million one-off funding for capital improvements. In 2009-10 recurrent funding of $35 million was allocated to sustain the Bed Strategy. This will result in expenditure of greater than $140 million (when including capital and indexation) over the life of the Subacute NPA which is in excess of Victoria's allocation of $125 million. With this funding an additional 95 GEM, 8 rehabilitation, 10 palliative care beds and 57 restorative care places have been opened across the state, with 139 beds in the metropolitan and 31 in the rural regions (refer to Appendix A).

Victoria continues to implement the Sub-acute NPA as outlined in the agreed Implementation Plan. As a function of the Bed Strategy the additional services that were funded in July 2009 and which are outlined in Appendix A are now fully operational.

Subacute service activity and growth 2009/10

Victoria's overall actual subacute service activity and growth for 2009/10 is 12.35 percent compared to Victoria's target of 11.5 percent from the 2007/08 baseline year. Across the settings of care a 10.43 percent increase has been achieved for hospital based care (inpatient beds days) and a 15.81 percent increase in occasions of services (centre and home based care). This is an encouraging result and reflects the work being undertaken in Victoria to improve the mix of subacute service models to better met the care needs of older people with complex care requirements in more appropriate settings. Please see Appendix C for details of the subacute care annual service activity and growth report.

An improvement in service mix is being developed via the implementation of strategies such as the Sub-acute Services Planning Framework, Health Independence Program guidelines, palliative care outcome measures and clinical indicators and embedding of improved workforce models.

Key deliverables	Progress and timing	Allocation of NPA funding	Comments
Implementation of the Sub-acute Services Planning Framework (SSPF) • The SSPF was used as a guide for allocation of resources and services with funding from the 'Victorian Bed Strategy' and state funded initiatives.	Continued establishment of services funded through the Victorian Bed Strategy.	See Bed Strategy spreadsheet (appendix A)	An interim report for the SSPF has been completed and is available at www.health.vic.gov.au/subacute There has been an increase in GEM and non-admitted rehabilitation service mix in line with growth received through the Bed Strategy. Capital builds and infrastructure capacity were also considered in resource allocation and present limitations to the full implementation against the SSPF. Access to specialist medical staff, especially in rural regions, may also limit implementing the SSPF. Health services will work together through workforce strategies; consultation and liaison and shared care arrangements to improve access to an appropriately skilled workforce. This will inform future resource allocation in the regions.
• Development of metropolitan and rural and regional implementation plans that map current service provision against the SSPF (service capability criteria and access benchmarks) and to identify gaps.	August 2009	State funded	Each rural region has been funded to map current service provision against the service capability criteria and develop a subacute implementation plan. Three of the regions have completed draft reports and identified short term, medium and longer term priorities for the development of subacute services. Finalising approval through regional alliances of health services set up through this work is occurring. The regional plans will inform broader statewide service planning and capital investment. A Metropolitan health services will undertake a similar process of self assessment and map current sub-acute service provision against the SSPF.

Key deliverables	Progress and timing	Allocation of NPA funding	Comments

Health Independence Program Implementation
 	
• Health services completed self assessment against each of the HIP guidelines
• Health services completed implementation plans for 4 key priority areas:
  o Access
  o Initial needs identification
  o Appropriate setting
  o Corporate Governance
• Health services commencing implementation against the HIP implementation plans
	July 2009
	
	First quarter 2009-10
		State Funded
		
		State Funded
			Implementation plans have been completed and are being actioned by health services.

Reforming Care Pathways *Elective Orthopaedic Pathway* The project's aims are to: • improve the understanding of elective orthopaedic patient pathways across Victorian public hospitals • decrease patients' acute inpatient length of stay • improve the linkage between acute and rehabilitation services (inpatient and ambulatory) • decrease the number of patients referred to inpatient rehabilitation and increase the referral to RITH services • reduce the variation in clinical pathways and timelines across	First quarter 2009	$2.5 million recurrent (refer to appendix A)	11 health services have been funded through the Bed Strategy to develop service models aimed at targeting people on the elective surgery waiting list for total hip replacement and total knee replacement. Most health services participating in the initiative enhanced existing or developed new orthopaedic RITH services with admission to this service being organised at the preadmission clinic. All projects are using the same risk assessment tool, the Risk Assessment Prediction Tool (RAPT) at preadmission Outcomes to date are reports of improved systems and patient flow. Health services report significant reductions in acute length of stay where patients are discharged at day 3 or 4 post surgery (where

Key deliverables	Progress and timing	Allocation of NPA funding	Comments
health services • increase acute inpatient capacity for elective joint replacement patients			clinically safe) to home with RITH. In 2009-10, the acute average length of stay decreased approximately 1.2 bed days for hips and 0.9 bed days for knee for those sites with orthopaedic RITH services. This is a reduction of approximately 3500 acute bed days for Victoria. There was also a 8% reduction in referral rates for clients post hip replacement to subacute inpatients.
Reforming Care Pathways *Geriatric medicine pathway:* Austin Health has opened a new 24 bed acute aged care ward on their sub-acute campus as a part of an innovative model of care funded by the Bed Strategy	September 2009	Refer to appendix A	Funding for the refurbishment of a ward at Heidelberg Repatriation Hospital (Austin Health) to allow for the delivery of an acute care GEM model of care. This ward allows for direct admission from the Emergency Department (ED) or early transfer from acute care to a more appropriate subacute care setting with the aim of reducing functional decline in at risk older people and reducing unnecessary long length of stay. The unit commenced service delivery in September 2009. An evaluation of this new model of care was undertaken (May 2010) comparing it to 2 similar models being delivered in Victoria. It found that this model was very effective with good outcomes and considerably reduced lengths of stay as long as the care setting promoted independence and the care planning approach was multidisciplinary and involved senior clinicians and there was support from acute medicine and access to diagnostics. Average length of stay in the unit was found to be around 8-9 days as opposed to an ALOS of 25 days in more conventional GEM units.

Key deliverables	Progress and timing	Allocation of NPA funding	Comments
Reforming Care Pathways *Residential Aged Care Clinical In-reach Program* Mainstreaming commenced for eight programs post evaluation of pilot. The aim of this initiative is to provide services to residents of aged care facilities with access to treatment within their care setting. The intention is to both prevent unnecessary presentation to emergency departments but also to manage people in a more appropriate care setting.	Commenced July 2009	$2.5 million recurrent (refer to appendix A) plus additional state funding	An independent evaluation completed in July 2009 found that the Residential In-reach pilots were well regarded, accessible and met referrer and hospital requirements. The key findings of the evaluation were that: • the Residential In-reach pilots met their main objective of avoiding unnecessary ED presentations for older patients; • they provided good quality of care under the clinical governance standards and protocols of the health services, and • the pilots should be expanded. As of July 2010, thirteen Victorian metropolitan and regional health services have been allocated recurrent funding to provide Residential In-reach services, including one new service.
Palliative care *Admitted* Provision of an additional 3,285 palliative care beddays at Melbourne Health.	Commenced July 2009	State funded	The new palliative care service commenced service delivery in July 2009. The beddays are being utilised and are funded recurrently. These bed days have been increased to recurrently fund 3,650 in 2010/11.

Key deliverables	Progress and timing	Allocation of NPA funding	Comments
Palliative Care: **Outcome measures/clinical indicators** Introduction of four new measures for community palliative care: • Phase of care at patient contact • Model of care • Patient preferred place to die • Patient preferred setting of care Clinical Advisory Groups established in each regional palliative care consortia	From 1 July 2009	State funded	The four new measures for community palliative care are being collected by all community palliative care services. Clinical Advisory Groups and subcommittees of each of the eight regional palliative care consortia meet regularly.
Palliative care **Consultation liaison/shared care model:** Progression of proposed minimum data set developed and business case submitted for inclusion in hospital data collection for 1 July 2010. Service delivery framework to be further developed. Statewide Palliative Care Clinical Network to be further developed.	Throughout 2009-10	State funded	Collection of minimum data set commencement deferred to 1 January 2011. Regional palliative care consortia undertaking regional self assessment against service capability levels. Palliative Care Clinical Network established and four projects have commenced: • Palliative care clinical tools and outcome measures • Palliative care clinical indicators for pain • Victorian bereavement framework and clinical guidelines • End of life care pathways in Victoria.

Key deliverables	Progress and timing	Allocation of NPA funding	Comments
Psychogeriatics Exploration of a definition of psychogeriatric care.	July-December 2010	State funded	Victoria has begun to progress specific elements of the Mental Health Reform Strategy and set the groundwork for a more comprehensive plan for Older Persons Mental Health across acute, subacute, community and nursing home settings to be a key part of the second phase of strategy implementation. Working within the service and policy context including aged residential care and community aged care (national and state), GP aged care initiatives, and broader population ageing policy. This will provide a framework for further development of a definition of "psychogeriatric care"
Improving service mix Further explore and trial new models of care that: • promote the redirection of services from admitted to non-admitted settings • reduce the use of acute health care for services that can be met in an admitted or non-admitted sub-acute care setting	Throughout 2009-10	State funded.	This is a key strategic direction within the Subacute NPA in Victoria. Examples of current funded initiatives include: • elective orthopaedic pathway • geriatric medicine pathway • residential aged care clinical in-reach program
Standardised reporting Finalise the 2007-08 baseline data Replacement of Modified Barthel with FIM progressed by: • Conducting a Forum with key stakeholders in the sector • Implementing training for health service staff in FIM in both rehabilitation and GEM settings.	September 2009 September 2009 October–December	State funded State funded	2007-08 baseline data reviewed and finalised From July 2010 all rehabilitation services are expected to collect and report FIM into the VAED for admitted episodes. From January 2011 GEM admitted episodes will be able to report FIM with all services reporting it from July 2011.

Key deliverables	Progress and timing	Allocation of NPA funding	Comments
	2009		From October 2009 to September 2010 the department has supported all metropolitan and rural health services with subacute beds to train and accredit staff in the use of FIM. In addition all larger health services have trained facility trainers to manage ongoing training needs. Over 400 new users and 40 facility trainers have been accredited in Victoria through this process.
National Benchmarking Actively contribute to the development of national benchmarks that are required within the Sub-acute NPA.	Throughout 2009-10		To date this work has encompassed work: • Reviewing and/or developing data definitions and descriptions • Drafting of measures against the Sub-acute Care NPA performance indicators • Participating on the Benchmarking Reference Group for the Commonwealth led Benchmarking study

Appendix A ***Victorian Bed Strategy 2009-10***

2009-10	Rehab Admitted (beds)	GEM Admitted (beds)	Restorative Care Admitted and No-admitted (Places)	Pall Care Admitted (Beds)		Resi In-Reach Non-admitted (Funding)	RITH Non-admitted (Funding)
Metro							
Alfred		16	6			$ 400,000	
Austin		24	1			$ 400,000	$ 250,000
Eastern			6	4			
Melbourne			11			$ 400,000	$ 250,000
Mercy							
Northern			8			$ 400,000	$ 200,000
Peninsula			4				$ 200,000
PMCC							
Royal Children's							
RVEEH							
Royal Women's							
Southern		24	4				$ 275,000
St Vincent's	4	4	4				$ 275,000
Western		16				$ 400,000	$ 200,000
Calvary				3			
Metro Total Beds	4	84	44	7			
GEM complexity grant		$963,600					
Metro total Funding	$762,120	$16,004,520	$5,813,720	$1,359,260		$2,000,000	$1,650,000
Regional							
Barwon			5	3			$ 275,000
Ballarat		5					$ 150,000
Bendigo		5	4			$ 400,000	$ 275,000
Goulburn Valley			4			$ 100,000	$ 150,000
Latrobe	4	1					
Regional Total Beds	4	11	13	3			
Regional Total Funding	$762,120	$2,095,830	$1,717,690	$586,920		$ 500,000	$ 850,000
Total Beds	***8***	***95***	***57***	***10***			
Total Funding	***$1,524,240***	***$18,100,350***	***$7,531,410***	***$1,946,180***		***$2,500,000***	***$2,500,000***
	Beds	**Funding**					
Metropolitan	139	$28,553,220					
Regional	31	$6,512,560					
State	170	$35,065,780					

Appendix B: 6 Monthly Report-Footnote 2 Page 9

Basis of comparison/conversion of admitted and non-admitted services

Calculating care type Weighted Bedday Equivalents (Rehab, GEM, Palliative care and Psycho-geriatric care)

All data was extracted for the various care types into the different services and associated cost for each service (e.g. for Rehab this includes: Admitted Level 1 Rehab, Admitted Level 2 Rehab and Non-admitted Rehab).

Once data is extracted to get a "Care type" Weighted Bedday Equivalent (WBE) the highest price service in each care type is used for generating a ratio. This is in line with the ratios previously submitted to the Commonwealth (outlined below). All ratios are calculated on price. There were changes to the non-admitted palliative care ratio as the original ratio calculation included indirect contacts and to be consistent, it should only include direct contacts. The non-admitted Psycho-geriatric care ratio needed to be revised to ensure consistency with other care type ratios

Rehabilitation example:

- The ratio for level 1 to Level 2 is 1:1.21 ($632 bed day rate/ $532 bed day rate=1.21)
- The ratio Level 1 to non admitted is 1:2.53 ($632/$250)
- The methodology for calculating Rehab care type WBE is:
    - Level 1 rehab bed day activity + (level 2 rehab bed day activity/1.21) + (Non-admitted rehab Occasions of Service (OOS)/2.53).
- The same methodology is used for GEM, Palliative care and for Psycho-geriatric care.

Care type Weighted Bedday Equivalents (WBEs)

Care Type Ratio	WBEs
Rehabilitation	
Level 1 rehabilitation bedday	1
Level 2 rehabilitation bedday	1.21
Non-admitted rehabilitation OOS	2.53
Geriatric Evaluation & Management	
GEM bedday	1
Restorative care bedday	1.44
Non-admitted GEM OOS	2.09
Palliative care	
Rural admitted bedday	1
Metropolitan admitted bedday	1.01
Non-admitted palliative care OOS	3.34
Psycho-geriatric care	
Psycho-geriatric admitted bedday	1
Psycho-geriatric Non-admitted OOS	1.55

Converting care type WBE into total subacute WBEs

The various care type equivalents can then be converted to a total subacute WBE using the same methodology. Therefore Rehabilitation WBE ($632) is used to calculate ratios for the other care type equivalents as shown in the table below (rounded to two decimal places).

Care Type	WBE $ Rate	Subacute WBE Ratio
Rehab	632	1.00
GEM	522	1.21
Palliative Care	536	1.19
Psycho-geriatric	496	1.27

The methodology for calculating subacute WBEs is:

- Rehab WBE + (GEM WBE/1.21) + (Pall Care WBE/1.19) + (Psycho-geriatric/1.32)

For example – 2007-08 baseline year

- Rehab WBE of 391,526 + (GEM WBE of 293,747/1.21) + (Pall Care WBE of 124,890/1.19) + (Psycho-geriatric WBE of 59,510/1.27) = 391,526+242620+105920+46704 = 786,770 Subacute WBE

The table below shows the initial baseline, the revised baseline using the initial methodology (with improved consistent data extraction) and data when the new methodology is used for calculating admitted WBEs, non-admitted weighted OOS equivalents and subacute WBEs.

Admitted	**2007-08**	**2008-09**	**July-Dec 2009**	**2009-10 FYE Target**
Initial baseline beddays	493,634			
Total beddays	605,780	629,800	330,251	660,502
Bedday growth for period		24,020	15,351	30,702
% Total bedday growth		4.0%	2.5%	5.1%
%Bedday growth cumulative		4.0%	6.5%	9.0%
Admitted WBEs (using ratios)	506,575	526,328	266,163	532,326
Admitted WBE growth for period		19,753	2,999	5,999
% WBEs growth		3.9%	0.6%	1.2%
WBEs growth cumulative		19,753	22,752	25,752
% WBEs growth cumulative		3.9%	**4.5%**	5.1%
Non-admitted	**2007-08**	**2008-09**	**July-Dec 2009**	**2009-10 FYE Target**
Initial baseline OOS	769,440			
Total OOS	748,355	827,492	426,132	852,263
OOS growth for period		79,137	12,386	24,771
% OOS growth		10.6%	1.7%	3.3%
% OOS growth cumulative		10.6%	12.2%	13.9%
Non-admitted weighted OOS equivalents (using ratios)	708,333	777,421	401,096	802,192
Non-admitted weighted OOS equivalents growth for period		69,088	12,386	24,771
% Weighted OOS equivalents growth		9.8%	1.7%	3.5%
Weighted OOS equivalents growth cumulative		69,088	81,473	93,859
% Weighted OOS equivalents growth cumulative		9.8%	**11.5%**	13.3%
Admitted and Non-admitted	**2007-08**	**2008-09**	**July-Dec 2009**	**2009-10 FYE Target**
Initial baseline (using 1:2 ratio)	878,354			
Total WBE using 1:2 ratio	979,958	1,043,546	543,317	1,086,634
Total OOS growth for period using 1:2 ratio		63,589	21,544	43,088
% OOS growth using 1:2 ratio		6.5%	2.2%	4.4%
% OOS growth cumulative using 1:2 ratio		6.5%	8.7%	10.9%
Subacute WBE (using ratios)	786,770	833,852	431,853	863,705
Subacute WBE growth for period		47,082	14,927	29,854
% Subacute WBE growth		6.0%	1.9%	3.8%
Subacute WBE growth cumulative		47,082	62,009	76,936
% Subacute WBE equivalents growth		**6.0%**	**7.9%**	**9.8%**

Appendix C: December 2010 Update

Subacute care annual service activity and growth report

State/Territory: Victoria

Period: 2009/10

Table 1: Activity by care type

* To calculate growth percentages (Table 2), use EITHER Patient days (volumes) OR Separations (patients)

	Rehabilitation	Palliative	GEM[1]	Psycho - geriatric	Totals	
Patient days (volumes)			*Admitted*			
Hospital based	276,049	83,500	317,554		677,103	
Hospital in the Home						
Combined Hospital based & HITH						
Other (please specify)						
Total admitted patient days	276,049	83,500	317,554	-	677,103	(a)
or Separations (patients)						
Hospital based	13,233	5,854	12,946		32,033	
Hospital-in-the-home						
Combined Hospital based & HITH						
Other (please specify)						
Total admitted separations	13,233	5,854	12,946	-	32,033	
Average length of stay	20.9	14.3	24.5	-	21.1	
Total Bed Day Equivalents					559,271.0	(b)
Occasions of service (volumes)			*Non-admitted*			
Centre based	337,687	50,628	57,714	39,142	485,171	
Home based	158,912	160,522	11,821	47,164	378,419	
Combined Centre & Home based					-	
Other (please specify)				6686	6,686	
Total occasions of service	496,599	211,150	69,535	92,992	870,276	
Weighted Bed Day Equivalents					324,499	C
Episodes[2] (patients)						
Centre based				707	707	
Home based				2,025	2,025	
Combined Centre & Home based	47,363	4,283	16,747		68,393	
Other (please specify)				273	273	
Total episodes	47,363	4,283	16,747	3,005	71,398	
Total group sessions	19,097	11,096	131	3306	33,631	

[1] Geriatric Evaluation and Management

[2] Episode data is for information only, and not a factor for calculating growth in service delivery.

Table 2: Growth percentages (2009-10)

Growth percentages (2009-10)	Patient days	Separations (BDEs)	Occasions of service (WBDEs)	Total BDEs
Baseline	605633	506453	280,195	786,648
Targeted % increase				11.5%
Services in 2009-10	677,103	559,271	324499	883,770
Increase in 2009-10	71,470	52,818	44,304	97,122
% increase	11.80%	10.43%	15.81%	12.35%

WBDE Ratios

	Ratio
Rehabilitation	ndix
Palliative care	
GEM	
Psychogeriatric	

Definitions

Subacute care

Rehabilitation, palliative care, geriatric evaluation and management and psychogeriatric care, as defined in the most recent version

Admitted Care

Patient days – the total number of days for all patients who were admitted for an episode of care and who separated during a specified reference period (METeOR 270045).

Separation – the process by which an episode of care for an admitted patient ceases. A separation may be formal or statistical (METeOR 327268).

Hospital-in-the-home (HITH) – provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary (METeOR 327308).

Hospital based – admitted subacute care services provided in acute, non-acute and subacute hospitals or same-day establishments or through Hospital-in-the-home (HITH) care.

Non-admitted Care

Occasions of service (OOS) – the number of occasions of examination, consultation, treatment or other service provided to a patient (METeOR 291061)

Group sessions – care or assistance simultaneously being provided to more than one person (METeOR 294406), either as an occasion of service or episode.

Centre based – subacute care services provided in non-admitted settings including hospital outpatient clinics and hospital outreach and hospital auspiced community health facilities.

Home based – subacute care services provided to non-admitted patients in their place of residence through a hospital outpatient, hospital outreach or hospital-auspiced community health program.

Episode of care - A period of health care with a defined start and end date (METeOR 268978).

Weighted Bed Day Equivalents (WBE)

The WBE is the ratio of the admitted bed day cost to the non-admitted count cost.

Example:

If the admitted bed day cost is $1000 and non-admitted count cost is $250, then WBE = 1:4 ($1000/$250 = 4)

Appendix E
Summary of Victorian performance indicators data explanations and caveats

PI	PI description	Data source	Explanations and caveats
Growth	Activity growth against agreed baseline		1. Non-admitted Rehab & GEM episode numbers are based on 70% VINAH compliance and unable to be split into home/centre/mixed, therefore all are placed under combined centre and home based 2. Psycho geriatric: Other includes Inpatient Setting or Public Hospital non-MH ward 3. Palliative care non-admitted data is inferred from 2008/09 data. 4. Group sessions are occasions of service delivered in group setting