Victoria – Report against Subacute Care Implementation Plan

Six Monthly Report: July – December 2009

Summary of Progress

As outlined in the 2008-09 report and the September-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 1).

Victoria continues to implement the Sub-acute NPA as outlined in the agreed Implementation Plan. As a function of the Bed Strategy additional services have now commenced at:

- Austin Health (GEM) – new 24 bed acute aged care ward
- 12 health services funded to improve elective orthopaedic pathways
- 12 Residential Aged Care Clinical In-reach services implemented (7 recurrently through the Bed Strategy)
- Melbourne Health (Palliative Care) – new 9-10 bed service

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.

Victoria actively contributes to the work of the Sub-acute Care Working Group and in the development of measures for the Performance Indicators stipulated in the Sub-acute NPA.

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 1)	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. These are 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	To facilitate regional implementation of the SSPF each rural region has been individually funded so as to map current service provision against the service capability criteria, identifying gaps and developing an implementation plan for sub-acute services in their respective regions. Metropolitan health services will also be asked to complete a self assessment and map their current sub-acute service provision which can then inform future service planning.

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	First quarter 2009	$2.5 million recurrent (refer to appendix 1)	12 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 anecdotally

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• reduce the variation in clinical pathways and timelines across health services • increase acute inpatient capacity for elective joint replacement patients			significant reductions in acute length of stay where patients are discharged at day 3 or 4 post surgery (where clinically safe) to home with RITH. One health service has reported an estimated total bed-day saving of 265 days from June to December 2009.
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 1	The refurbishment of the ward at Austin Health was commissioned in August 2009 and commenced service delivery in September 2009. This ward allows for admission directly from the Emergency Department (ED) and diversion from the General Medical and other acute units. An evaluation of this new model of care has been commenced and will be compared to 2 similar Victorian models.
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	Commenced July 2009	$2.5 million recurrent (refer to appendix 1) 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 evaluation noted that for the period 1/7/2008 to 7/5/2009, 4,070 episodes of care were recorded over the 10 original pilot sites. • Of the 3,995 episodes where data were collected,

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unnecessary presentation to emergency departments but also to manage people in a more appropriate care setting.			55.2% (2,206) were resolved without the need for ED input or admission. • A further 19.1% (764) were resolved in ED with input from the Residential In-reach teams, and patients were transferred back to their Residential Aged Care Services without the need for a ward admission. • A reduction in ambulance use for this client group was also noted. 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.
Palliative care *Admitted* Provision of an additional 9-10 (3,285) palliative care beddays at Melbourne Health.	Implementation commenced July 2009	State funded	Victoria's implementation plan projected a growth in palliative care beddays against the 2011-12 service growth targets. The establishment of this new palliative care service has been brought forward to the 2009-10 financial year and commenced service delivery in July 2009.

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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	Four new measures for community palliative care introduced: • Phase of care definitions adopted from Palliative Care Outcomes Collaborative • Preferred place of death and preferred setting of care monitored for Victoria's Cancer Action Plan targets. Clinical Advisory Groups established and subcommittees of each of the eight regional palliative care consortia
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	Interim service delivery framework completed and available on website Regional palliative care consortia undertaking regional self assessment against service capability levels. Terms of reference and call for expressions of interest developed for Palliative Care Clinical Network.

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Psychogeriatics Exploration of a definition of psychogeriatric care.	July-December 2010	State funded	Aged Person's Mental Health and GEM policy areas working in partnership to define detailed plan for implementing improved coordination and integration of services for 'psychogeriatric' patients.
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 2009	State funded State funded	2007-08 baseline data reviewed and finalised Replacement of Modified Barthel with FIM planned for July 2010 for all rehabilitation admitted episodes and in 2011 for GEM. From July to December 2009, 222 new FIM users and 20 new FIM facility trainers have been trained. An additional 180 new users and 20 facility trainers will be trained in the next 6 months.

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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

Growth in subacute care services, July – December 2009					
Year	Patient type	Admitted	Non-admitted	Combined	Additional Comments
	Unit of measure for services	*Patient days*	*OOS*	*Bed-day equivalents*[2]	• 2007-08 baseline data have been revised to include all subacute services based on unit price so that each service (every type of admitted and non admitted) has a ratio applied. • Psycho-geriatric revised 2007-08 baseline data uses Psycho-geriatric 2008-09 actuals as this is considered the first year when all definitional clarifications issued in late 2006 were adopted. • Baseline data may continue to be updated as improvements in data quality, transmission and compliance against the Victorian Integrated Non Admitted Health minimum dataset (VINAH) are achieved.
2007-08	Baseline data[1]	506,575 bedday equivalents	708,333 OOS equivalents	786,770 subacute bedday equivalents	
2009-10	Targeted growth for 2009-10[3]	31,416	17,500	40,165	
	Growth in 2008-09 (actual activity)	24,020	79,137		
	Growth in July-Dec 2009 (planned activity)	15,351	12,386		
	Growth in 2008-09 (Subacute WBEs)	19,753	69,088	47,082	
	Growth in July-Dec 2009 (subacute WBEs)	2,999	12,386	14,927	
	Growth calculations (Subacute WBE)	2,999 + 19,753	12,386 + 69,088	14,927 + 47,082	
	Total Growth (Subacute WBE)	22,752	81,474	62,009	
	Growth on baseline (Subacute WBE)	4.5%	11.5%	7.9%	

(1) Based on 2007-08 data for the 6 month report.
(2) Please specify the basis of comparison/conversion of admitted and non-admitted services if this method of counting is used – a detailed description of the comparison/conversion methodology is outlined in Appendix 2.
(3) As specified in the implementation plan for each State and Territory.

Appendix 1 ***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					

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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%**