

*Victoria – Public Hospitals
Policy and Funding Guidelines
2001 – 2002*

Acute Health Division

June 2001

Acknowledgments

Victoria – Public Hospitals Policy and Funding Guidelines 2001-2002
Published by Acute Health Division,
Victorian Government Department of Human Services
Melbourne Victoria

June 2001

Available on the Acute Health Division website at: <http://www.dhs.vic.gov.au/ahs>

© Copyright State of Victoria 2001.

(0120501)

Message from the Ministers

This Government's health policy places the highest importance on the fundamental principle of access to quality health care in public hospitals for all Victorians. It has taken steps to ensure that public hospitals remain in public hands, and has introduced a range of initiatives to ensure community representation and responsible public accountability for hospital services.

This year a total of \$1.6 billion (\$1.1 billion operating and \$500 million capital) of additional funding has been committed for the next four years to ensure a vital and productive health sector.

This Government recognises that the problems facing hospitals cannot be fixed overnight. Years of bed closures, and budget and staff cuts, despite rising demand for urgent care, have led to the point where hospitals are not always meeting demand in a timely manner. These underlying problems have been made much worse for Victoria by the dramatic Commonwealth underfunding of nursing home places, causing the frail elderly to languish inappropriately in hospitals and worsening the bed shortage.

This Government has directed attention to these problems through attracting and retaining more than 1,300 extra nurses, through building capacity and through strategies to improve management of patients within hospitals. The Hospital Demand Management Strategy brings together the work of the Patient Management Taskforce and Emergency Demand Coordination Group to provide a range of innovative measures to alleviate emergency pressures, and to ensure that patients receive appropriate follow-up care after discharge.

In 2001-2002 systemic attention will again be given to quality issues, consolidating a number of initiatives that have occurred over the past years.

Changes will continue to be undertaken in an active and collaborative manner with the industry with the primary objective being the improved health and welfare of patients.

Victorian public hospitals are of world-class standard. The specific problems that need urgent attention will be a high priority for the Government in the coming years. This Government continues to seek to create a co-operative, highly effective health system for all Victorians in keeping with the Government's key policy pillars.



Hon John Thwaites MP
Minister for Health



Hon Bronwyn Pike MP
Minister for Housing & Aged Care

Table of Contents

Section A – Policy

- 1 Highlights of the 2001–2002 Policy 1**
- 2 Strategic Directions 5**
 - 2.1 Major Objectives5
 - 2.2 Activity Trends6
 - 2.3 Victorian Budget Details7
 - 2.4 Hospital Demand Management Strategy8
 - 2.5 Nurse Workforce10
 - 2.6 Funding Intensive Care11
 - 2.7 Capital Funding11
 - 2.8 Equipment, Infrastructure and New Technology Funding13
 - 2.9 Improving Patient Safety: Clinical Risk Management Funding14
 - 2.10 VicRehab14
 - 2.11 Quality Fund15
 - 2.12 Pharmaceutical Reform15
 - 2.13 DVA Patients16
- 3 Improving Services to Rural Communities 17**
 - 3.1 Nurturing and Sustaining Small and Medium Health Services17
 - 3.2 Targeting Service Gaps17
 - 3.3 Rebuilding the Rural Health Workforce17
 - 3.4 Building For the Future18
 - 3.5 Rural Patient Waiting List Initiatives18
 - 3.6 Rural Specialist Services Grants18
 - 3.7 Continuing Medical Education19
 - 3.8 Rural and Isolated Hospitals19
 - 3.9 Increased Flexibility for Small Rural Hospitals19
 - 3.10 Flexible Service Arrangements (Healthstreams)20
 - 3.11 Multi-Purpose Services (MPS)20
 - 3.12 Other Rural Initiatives21
- 4 Summary of 2001–2002 Payment Rates 23**
- 5 Hospital Activity and Throughput Targets 25**
 - 5.1 Hospital Activity Targets25
 - 5.2 Recall Adjustment26
 - 5.3 Metropolitan and Regional Inpatient Activity Targets27
 - 5.4 Same Day Caps28
 - 5.5 Published Rates29
 - 5.6 Service Agreements29
- 6 Improving Hospital Demand Management 31**
 - 6.1 Sub-Acute and Interim Care31
 - 6.2 Care Coordination and Change Management33
 - 6.3 Emergency Department Enhancement33
 - 6.4 Substitution34

6.5	Prevention.....	35
6.6	Monitoring and Review	35
7	Quality Improvement: A New Approach.....	37
7.1	The Quality Framework	38
7.2	Performance Monitoring and Reporting.....	38
7.3	Quality Indicators.....	39
7.4	Quality Fund – Metropolitan Health Services.....	39
7.5	Allocation of Quality Funds	40
7.6	Redistribution of Retained Quality Funds.....	40
7.7	Quality Funding – Regional and Rural Health Services.....	40
7.8	Same Day Incentives	41
8	Specific Quality Programs.....	43
8.1	Accreditation	43
8.2	Clinical Indicators.....	43
8.3	Improving Safety	45
8.4	Improving Effectiveness.....	48
8.5	Improving Continuity.....	50
9	Improving Rehabilitation and Sub-Acute Services.....	53
9.1	Service Profile.....	53
9.2	Funding of Sub-Acute Services: Inpatients.....	53
9.3	Funding of Sub-Acute Services: In Home and the Community	55
10	Health Services working with their Communities	57
10.1	Metropolitan Health Services Community Advisory Committees	57
10.2	Primary Care and Population Health Advisory Committees	57
10.3	Reporting to the Community on Quality of Care.....	57
10.4	Patient Experience	58
10.5	Provision of Consumer Information	58
11	Service Development	61
11.1	Trauma	61
11.2	Breast Care Redevelopment	62
12	Emergency Services and Non-Admitted Patients Funding.....	65
12.1	Non-Admitted Emergency Patient Funding	65
12.2	Outpatients – Victorian Ambulatory Classification System	66
12.3	Non-Admitted Patient Radiotherapy	66
13	Research/Training & Development.....	69
13.1	Research Funding.....	69
13.2	Training and Development.....	69
14	Major Initiatives in Information Technology.....	73
14.1	Replacement of Homer patient administration systems	73
14.2	I2T2 Strategy Funding	73
14.3	Growing Victoria – Information Infrastructure	73
14.4	Change Management Education and Training (CMET)	73
14.5	Clinicians Health Channel	73
14.6	Designing Care.....	74

15 Special Grants.....	75
15.1 Removal of Capped Block Grants	75
15.2 Higher Payment for Aboriginal & Torres Strait Islander Patients.....	76
15.3 Mechanical Ventilation Co-Payment	76
15.4 Thalesaemia	76
15.5 Cystic Fibrosis	77
15.6 Victorian Maintenance Dialysis Program (VMDP)	77
16 Development of the Cost Weights and WIES.....	79
16.1 AR-DRG Version 4.2	79
16.2 Development of Cost Weights	79
16.3 Calculation of Inlier Boundaries: Trim Points.....	79
16.4 Same Day DRGs.....	79
16.5 Calculation of Inlier Weights.....	80
16.6 High Outliers.....	81
16.7 Prostheses Adjustments	81
16.8 Private Patient Adjustments	82
16.9 Changes to Mechanical Ventilation Co-payments	82
16.10 Data Quality & the Victorian Admitted Episodes Dataset (VAED)	83

Modelled Budgets

Targets

Appendices

- Appendix 1 - Consultation and Liaison
- Appendix 2 - Activity Trends
- Appendix 3 - VicRehab: Weighted Units Specification
- Appendix 4 - Quality Fund
- Appendix 5 - Clinical Risk Management
- Appendix 6 - Identified Savings

Section B – Conditions of Funding: Acute Health

Section C – Supplementary Information

- Current Cost Weights – Inpatients
- Current Cost Weights – Victorian Ambulatory Classification and Funding System
- Current Cost Weights – VicRehab
- Calculation of WIES
- IES9 and Related Items Report
- Regional Contacts

Section A – Policy

1 Highlights of the 2001–2002 Policy

New Directions and Major Funding Commitments

- The 2001-2002 Budget provides a \$1.6 billion (\$1.1 billion operating and \$500 million capital) boost to hospital funding over the next four years, to relieve pressure from rising demand and maintain public hospital access. For the first time, outlays to hospitals for acute and sub-acute care will be more than \$4 billion.
- The 2001-2002 operating budget has increased by \$459 million to increase emergency and elective surgery capacity; to fund and treat extra patients; to open 300 new hospital beds; to employ 1,300 extra nurses and provide for CPI and wage increases.
- The Hospital Demand Management Strategy with additional funding of \$582 million over four years (\$125 million in 2001-2002) will increase emergency department, emergency inpatient and elective surgery capacity at major metropolitan and regional hospitals; expand access to sub-acute and interim care services; expand initiatives which divert or prevent the need for hospital admission; and improve patient care processes in partnership with clinicians and hospitals.
- \$469 million will be committed over four years (\$96 million in 2001-2002) to recruit 1,300 extra nurses to improve nurse-patient ratios and working conditions.
- Approximately \$9.5 million will be reallocated to boost funding for Neonatal Intensive Care Units in the four major NICU hospitals.

New Capital Funding

- \$500 million will be provided in capital funding for hospital redevelopment and construction, including \$310.7 million for the complete redevelopment of the Austin and Repatriation Hospital and relocation of the Mercy Hospital to Heidelberg.
- Funding is also provided to upgrade and expand services in a number of key metropolitan, regional and rural hospitals to better meet emergency demand and to ensure facilities are of a standard appropriate to current service requirements – Northern Hospital (\$12 million), Frankston Hospital (\$9 million), Outer East Service Expansion and Redevelopment - Maroondah and Angliss Hospitals (\$18.5 million), Grace McKellar Centre at Geelong (\$19 million), Ararat and Stawell Hospitals (\$10.5 million) and Kyneton Hospital (\$1.7 million).

New Equipment and Infrastructure Funding

- \$30 million (over 4 years) has been committed from the Connecting Victoria Fund to basic Information and Communication Technology (ICT) infrastructure to link metropolitan health services, regional and rural hospitals and primary care partnerships throughout Victoria. This will establish wide area and local area networks for hospitals and primary care partnerships across Victoria and consolidate data centres for metropolitan health services.

- \$28 million in 2001-2002 will be provided statewide as part of the on-going Fire Risk Management Strategy, for the upgrading of cooling towers to meet the requirements of the Legionella Strategy, and for urgent infrastructure upgrades.
- \$17.55 million will be allocated to purchase new and replacement items of major biomedical equipment required for public hospitals.
- \$12 million additional funding will be provided to meet the growing cost of imported equipment and medical and pharmaceutical supplies as a result of the depreciation of the Australian dollar.

Improving Services to Rural Communities

- A range of funding initiatives will continue be provided to rural services including differential WIES prices, rural specialist services grants, rural and isolated hospital grants and payments to assist with on-call arrangements with GPs. These rural premiums total \$37.5 million in 2001-2002.
- \$5 million of growth funds will be applied to specific initiatives to improve access to targeted specialties for rural patients in order to reduce waiting times for rural elective surgery and medical patients. This is in addition to growth funds, applied in the normal manner, which also fund these target areas.
- A new scheme will be established to enable small rural hospitals (Groups D & E) to transfer some of their inpatient funding (WIES) to other forms of health care in order to provide more appropriate health services to their communities.

Improving Quality

- Quality improvement processes are being consolidated. There will be a suite of indicators, helping health services to move towards a more integrated approach to quality improvement in patient care. Health services will build on the quality improvements already achieved in previous years.
- Funding for quality improvement initiatives and programs will no longer be provided to metropolitan health services on an individual program basis. A new consolidated Quality Fund totalling \$58.9 million (which aggregates quality improvement monies previously received by hospitals under individual initiatives and provides some new funding) will be introduced to assist health services and hospitals to improve patient care.
- \$4.8 million will be provided, subject to Commonwealth approval, for clinical risk management. The Clinical Risk Management strategy aims to improve patient safety by focussing on preventable adverse events.
- \$9.9 million will be provided statewide for infection control and cleaning to continue implementation of infection control strategic plans and cleaning standards. The Victorian Nosocomial Infections Surveillance Centre will be established. Funding will also commence for projects to manage the emergence of antibiotic resistant organisms.

- The Maternity Services Program will continue to improve antenatal and postnatal care provision and maternity services for women with special needs; promote care during pregnancy and childbirth that reflects best available evidence on effectiveness; and improve the provision and quality of information on care options. Funding of \$16.4 million statewide will be continued.
- In 2001-2002, \$3 million will be provided for the continuation of the Breast Disease Service Redevelopment Strategy, including demonstration projects to promote integrated and networked breast care services, with a focus on the implementation of best practice and improving quality, accessibility and coordination.
- All Aboriginal and Torres Strait Islander patients will continue to be funded at 10 per cent higher than the usual payment for WIES9.

Health Purchasing Victoria

- In response to the recommendation of the Ministerial Review of Health Care Networks that centralised purchasing arrangements be established for Victoria's public hospitals, Health Purchasing Victoria will commence operation on 1 July 2001. Health Purchasing Victoria will receive establishment funding of \$1 million per annum for two years. It will be governed by a Board of Management comprising hospital and health service representatives, and will establish clinical and other reference groups to inform strategic purchasing and priorities.

2 Strategic Directions

2001-2002 marks the introduction of committed funding for four years to better manage demand, especially emergency pressures, and to improve hospital patient care processes.

The Hospital Demand Management Strategy to be implemented from 2001-2002 brings together the work of the Patient Management Taskforce and the Emergency Demand Coordination Group. It addresses the growth in emergency admissions, and access blockages in the major metropolitan public hospitals. It involves a funding commitment of \$582 million over four years (\$125 million in 2001-2002) for extra capacity as well as innovative substitution and prevention programs which will improve the flow of patients through the range of hospital services. The strategy recognises that the current problems of capacity limitation, continuously increasing demand for emergency inpatient care, and inadequate numbers of (Commonwealth funded) nursing home beds, cannot be solved in one year. The strategy will progressively result in resolving emergency access problems and, over time, the lengthening waiting lists for elective surgery.

In addition, the Patient Management Taskforce has produced a series of discussion papers, which address ambulatory care, multi-day care, emergency services, post-acute care and collaborative processes across the Metropolitan Health Services. Recommendations for change include a range of measures to bring about a substantial shift from multi-day treatment to same-day care.

2.1 Major Objectives

The major policy and funding objectives for public acute health services in 2001-2002 are to:

- Improve patient management practices within and between acute hospitals; nursing homes and other community care;
- Introduce new short-stay, medical assessment and planning, post-acute and sub-acute services to relieve emergency inpatient pressure by substitution and to improve continuity of care;
- Commence new initiatives to identify practices which prevent hospital admissions, through care coordination and targeted interventions for people with chronic illness;
- Increase the number of inpatients treated by 2.8 per cent or 27,400 admissions;
- Improve the quality of hospital services through nurse recruitment and retention;
- Improve the monitoring, reporting and prevention of adverse events during treatment of patients in all Victorian hospitals;
- Undertake hospital building and redevelopment programs and associated capital works in defined areas of need;
- Encourage health services and health professionals to maintain high standards for infection control and hospital cleaning; and
- Improve access to specialist services in rural areas and improve linkages between metropolitan and rural areas.

The development of the proposals and processes outlined in this document has been undertaken with industry consultation. Industry groups have provided advice and support in the development of general policy initiatives, classification and implementation issues. Details of Committees are provided in Appendix 1.

Special visits were undertaken by Departmental officers to major hospitals during 2000-2001 and a mid-year review will be undertaken involving metropolitan and regional health services.

2.2 Activity Trends

Demand for public hospital services has grown due to a range of factors including the ageing population, improvements in treatment options and lack of alternative services. Admissions to Victoria's public hospitals grew by four per cent in 1999-2000 and are estimated to increase by a further two to three per cent in 2000-2001. These activity trends are shown in Tables 1 and 2 below and in Appendix 2. The area of greatest growth has been in emergency admissions in the twelve major metropolitan hospitals, which have increased by seven per cent over the last year. Emergency admission growth of this level has been consistent for the past several years. These twelve hospitals treat over 50 per cent of Victoria's patients and some 60 per cent of Victoria's emergency admissions. They account for 55 per cent of Victoria's total WIES.

Table 1: Activity Trends, 1998-1999 to 2000-2001 (estimated) Total Victoria

	1998-1999	1999-2000	2000-2001 (est)
WIES Fundable Separations	940,482	977,520	1,002,672
Increase over previous year (no.)	34,978	37,038	25,152
Increase over previous year (%)	3.8%	3.9%	2.6%
Emergency Separations	307,921	320,098	341,378
Increase over previous year (no.)	9,622	12,177	21,298
Increase over previous year (%)	3.2%	4.0%	6.6%
WIES 8	735,308	768,106	784,000
Increase over previous year (no.)	n/a	32,798	15,904
Increase over previous year (%)	n/a	4.3%	2.1%

Source Victorian Admitted Episode Dataset (VAED), Department of Human Services.

Activity funded through WIES payment system, excluding mental health and sub-acute.

Data for 2000-2001 based on data to December 2000.

Table 2: Activity Trends - Twelve major hospitals 1998-1999 to 2000-2001 (estimated)

	1998-1999	1999-2000	2000-2001 (est)
WIES Fundable Separations	480,504	500,062	512,930
Increase over previous year (no.)	20,349	19,558	12,868
Increase over previous year (%)	4.4%	4.1%	2.6%
Emergency Separations	177,062	189,421	203,036
Increase over previous year (no.)	10,280	12,359	13,615
Increase over previous year (%)	6.2%	7.0%	7.2%
WIES 8	396,697	421,903	428,613
Increase over previous year (no.)	n/a	25,205	6,053
Increase over previous year (%)	n/a	6.0%	1.4%

Source Victorian Admitted Episode Dataset (VAED), Department of Human Services.

Activity funded through WIES payment system, excluding mental health and sub-acute.

Data for 2000-2001 based on data to December 2000.

The twelve hospitals included in this table are: The Alfred, Angliss Health Services, Austin & Repatriation Medical Centre, Box Hill Hospital, Dandenong Hospital, Frankston Hospital, Maroondah Hospital, Monash Medical Centre (including Moorabbin), The Northern Hospital, Royal Melbourne Hospital, St Vincent's Hospital and Western Hospital.

The growth in demand for emergency services has been addressed through additional funding and specific initiatives outlined below in the Hospital Demand Management Strategy.

The Hospital Demand Management Strategy will enable Victorian public hospitals to meet unavoidable demands and improve patient flow through increased capacity and a range of innovative substitution and prevention programs. The Hospital Demand Management Strategy recognises that these problems will not be solved within one year but require a progressive resolution over the next four years.

Analysis of the data indicated that there is potential to reduce the growth in emergency demand by concentrating on preventable and manageable medical conditions that are common causes of hospital emergency admissions. For example, emergency admissions have grown from patients with injuries, abdominal pain, diabetes, and ear nose and throat conditions, but in all such cases there are opportunities to prevent some admissions with active management.

In any interpretation of activity trends, the number of patients treated, the length of stay and the WIES levels need to be taken into account in order to gauge the number of patients presenting and the level of resources used.

2.3 Victorian Budget Details

The budgets for acute health services for all hospitals for 2000–2001 and 2001–2002 are given in Table 3. A balanced result for 2000–2001 is the projected end of year position, based on April data. The outlay figures given are for the hospital entity excluding capital depreciation, and abnormal items.

Table 3: Victorian Public Hospitals

	2000–2001 (\$Million)	2001–2002 Budget (\$Million)
i) Total Acute Health Outlays	3,235	3,738
ii) Total Sub-Acute Health Outlays	320	346
iii) TOTAL	3,625	4,084
Increase over previous year	+242	+459

In 2001–2002, the total operating Budget for acute and sub-acute health has increased by \$459 million over the 2000–2001 budget, to a total of \$4,084 million. This increase includes \$125 million in 2001–2002 for the Hospital Demand Management Strategy, which includes \$96 million for extra capacity. There has been considerable collaboration with hospital management, clinicians and nurses in devising the particular growth programs for individual hospitals. An integral part of the growth package will be demonstrated improvements in key patient indicators.

The Government’s budget process provides an allowance for CPI and wage increases agreed prior to the time of the budget, and requires an annual productivity saving of 1.5 per cent from all Government sectors including the hospital sector of \$34 million. In accordance with previously announced policy \$13 million has been deducted from funding for Embedded Tax Savings resulting from the full impact of the GST. The budget figures provided in Table 3 include all these items and represent the net outcome.

Funding of \$12 million in 2001-2002 has been allocated to assist hospitals in meeting the increased costs of imported medical supplies, pharmaceutical supplies, and equipment purchases, due to the deterioration in the Australian dollar.

2.4 Hospital Demand Management Strategy

Hospital systems around Australia are experiencing demand pressures, which when combined with a shortage of aged residential and community care options for people being discharged, place great pressure on hospitals' capacity to provide timely access to patients needing to be admitted from emergency departments or for elective surgery. Following extensive consultation with hospitals through the Patient Management Taskforce and the Emergency Demand Coordination Group, a new approach to the management of demand for hospital services will be introduced in 2001-2002. The major elements of this new Hospital Demand Management Strategy are presented below.

2.4.1 Creation of extra capacity

A total of \$96 million will be provided in this budget for 2.8 per cent growth in the capacity of hospital emergency departments, emergency inpatient wards, intensive care units (ICUs), elective surgery, inpatient mental health and radiotherapy services to treat extra patients. \$33 million is provided to treat an extra 14,000 emergency medical and surgical patients (11,500 WIES). \$30 million will be allocated to provide 11,800 additional elective medical and surgery admissions (9,700 WIES) and \$4 million to provide 1600 acute mental health admissions (1300 WIES equivalents). Funding also includes \$10 million for Emergency Departments for growth and to improve clinical practices, \$7 million for intensive care units, and \$5 million for renal services. \$5 million will be provided to meet increased costs and demand in specialised blood products and implement new regulatory standards to protect the blood supply and \$2 million will be provided for radiotherapy services to be opened at Ballarat and Bendigo in 2001-2002.

Funding allocated in 2000-2001 for the Winter Emergency Demand Strategy will continue, but will be focused on contributing to extra capacity where appropriate.

Growth funding for inpatient services will focus in particular in 2001-2002 on the expansion of the Sunshine Hospital and its emergency department, to take pressure off the other major metropolitan hospitals. Extra beds will also be provided as a priority to Frankston hospital.

2.4.2 Substitution and Diversion

Additional funding of \$48 million over four years (\$12 million in 2001-2002) will be provided for programs which involve substitution of more appropriate care options for some people currently in acute beds. These services include post-acute, short stay, and home-based alternatives. The additional funding to Victorian hospitals will help provide a range of specific initiatives to assist in providing a high quality continuum of care for people accessing acute hospital services. It will also include the establishment of interim care units to provide a transitional setting between hospital care and aged residential care, where appropriate. Initiatives and strategies to increase the flow of patients through acute settings include, ambulatory care services, measures to improve access to elective surgery (such as increasing same day surgery rates) and improvements to discharge practices (for example better access to allied health or a focus on weekend discharge will be part of this program). In determining specific allocations for Metropolitan Health Services and Barwon Health, consideration has been given to a package of programs and funding sources which best suits each service according to its own nominated

priorities. For example, extra sub-acute or interim care could be funded from the substitution or prevention funding pools or from WIES, either existing or additional, depending on the particular set of circumstances of the particular health service. Funding includes \$1 million to expand the Acquired Brain Injury Slow to Recover Program and \$1.0 million to enable 110 additional residential aged care services to open, as outlined in Table 4 below.

2.4.3 Prevention

Preventative programs, which improve management of chronic conditions and reduce readmissions, will receive additional funding of \$150 million over a four-year period, commencing with \$17 million in 2001-2002. These additional funds will be targeted to assist patients who require time and for whom a more holistic multi-disciplinary treatment approach may be preferable to acute care. Funds will be allocated to hospitals on the basis of negotiated strategies to reduce demand for hospital services. Potential measures will include an expansion of post-acute care services to support patients' return home and prevent readmission; intensive community support services to better help people manage chronic illness; expansion of falls prevention services; and improved chronic disease management through better care coordination and linkage with GP services. Clinical advisory groups will also be established to foster best practice in treatment and demand management.

While the majority of this funding will be individually negotiated, \$1 million will be provided for new and expanded falls prevention clinics as outlined in Table 4 below.

The funds for preventative programs increases progressively from \$17 million in 2001-2002 to \$34 million in 2002-2003 and to \$50 million in 2003-2004 and 2004-2005. This will support continuation and expansion of successful initiatives and is a clear sign of Government's commitment to this approach.

Table 4: Emergency Demand Strategy Allocations

HEALTH SERVICE	ADDITIONAL EMERGENCY DEPARTMENT (\$10M)		SUBSTITUTION (\$12M)		PREVENTION (\$17M)			TOTAL
	One-off (\$'000)	Recurrent (\$'000)	One-off (\$'000)	Recurrent (\$'000)	Falls Clinics (\$'000)	One-off (\$'000)	Recurrent (\$'000)	
ARMC	470.0	270.7	650.0	556.8			595.0	2,542.5
Barwon					62.9		470.9	533.8
Bayside	7.5	455.7	176.4	1,360.9	120.0		2,379.8	4,500.3
Eastern Health	265.0	891.3	53.0	620.0	83.0	40.0	1,363.0	3,315.3
Melbourne Health		282.7	398.0	1,148.5			729.0	2,558.2
Northern Health		500.0	47.8	1,318.9			704.5	2,571.2
Peninsula Health		710.1	150.0		100.0		658.2	1,618.3
Southern Health	194.0	1,459.0	374.0	2,556.0	120.0	95.0	847.0	5,645.0
St Vincents		841.7			85.0		450.0	1,376.7
Western Health	576.7	3,227.4		515.0	170.0	15.0	575.0	5,079.2
MHS & Major Indep Sub Total	1,513.2	8,638.6	1,849.2	8,076.1	740.9	150.0	8,772.4	29,740.4
Rural Services								
Ballarat Health Services					76.0			76.0
Goulburn Valley					90.0			90.0
Other Programs								
Statewide Acquired Brain Injury (Southern Health)				1,000.0				1,000.0
Top up of Commonwealth funding to open 110 public sector high care residential beds*				990.0				990.0
Change Management*							1,500.0	1,500.0
Community Based Falls Prevention*							500.0	500.0
To be allocated after further consultation							5,170.7	5,170.7
TOTAL	1,513.2	8,638.6	1,849.2	10,066.1	906.9	150.0	15,943.1	39,067.1
GRAND TOTAL		10,151.8		11,915.3			17,000.0	39,067.1

* To be allocated to agencies

2.4.4 Partnership with clinicians and hospitals

The funding boost for hospitals in the 2001-2002 budget will be implemented in partnership with clinicians and hospitals, to ensure that funding addresses specific issues for hospitals and enables local solutions to be developed. The Department will negotiate contracts with the major metropolitan hospitals with individual performance targets and strategies to address such issues as ambulance bypass and discharge blockage to aged residential care.

2.4.5 Post Acute Care Services

The recurrent Post Acute Care budget has increased from \$13 million to \$15.5 million in 2001-2002. Services can be provided to emergency department patients to prevent their admission to hospital and patients discharged from public acute and sub-acute hospitals.

The Patient Management Taskforce has recommended that hospitals utilise post-acute care in prevention of admission where appropriate. Community based services should be available to provide support to people after discharge from hospital to their home and, where clinically appropriate, avoid the need for admission to in-patient services.

2.5 Nurse Workforce

A total of \$469 million is to be allocated over four years (\$96 million in 2001-2002) to address shortages of nurses across the public health sector and improve the quality of health and aged care services provided to the community. The funding will allow for creation of 1300 additional nursing positions, together with a wide range of measures specifically designed to reduce workload, improve conditions of employment, and otherwise assist with the recruitment and retention of qualified nursing staff. The new strategies have been developed with input from the Victorian Nurse Recruitment and Retention Committee, which was chaired by Emeritus Professor Margaret Bennett.

In 2001-2002 funds will be provided to universities and hospitals to implement key strategies and to implement certain provisions of the Nurses (Victorian Health Services Award) 2000. Initiatives include:

- HECS scholarships for 200 university postgraduate courses;
- postgraduate specialist study assistance for 1,000 nurses;
- a postgraduate qualification allowance for nurses in recognition of the specialised study they have undertaken;
- refresher courses to assist nurses wishing to re-enter the workforce;
- funding to assist with the further development of the Division 2 nursing workforce;
- resources to support clinical placements of up to five weeks in rural hospitals for 400 undergraduate nursing students; and
- the introduction of senior positions to improve career structure, specifically to provide for the employment of 50 EFT Nurse Educators, 50 EFT Clinical Nurse consultants and 50 Assistant Directors of Nursing across the system.

2.6 Funding Intensive Care

Additional targeted funding has been allocated to intensive care, as this system continues to experience high demand pressure. Whilst the average number of beds open has increased somewhat in line with increasing demand, the number of beds available to receive critically ill patients has decreased. The Department has undertaken a review of intensive care services, which provides evidence of sustained system pressure. In recognition of this need, twelve additional intensive care beds will be funded. Eleven extra intensive care beds will be opened in metropolitan Melbourne, including four beds in a new unit at Sunshine Hospital. Geelong Hospital will be funded for one extra intensive care bed.

The allocation in the 1999-2000 financial year of an additional \$10 million (4000 WIES) in operational funding for clinical procedures containing ICU services was absorbed into the overall operating budgets of hospitals, with an expectation that hospitals would demonstrate increased activity, but without a mandated requirement to report specific ICU outputs or outcomes associated with this investment. This has proven to be unsatisfactory.

The funding for the opening/commissioning of additional ICU beds or additional activity in 2001-2002 will be made available through a specified allocation of additional WIES from the Department. Specific commitments will be required from hospitals receiving this funding.

Reporting requirements and service agreements will take cognisance of:

- Baseline levels of activity;
- Baseline bed availability;
- Agreed levels of average beds open;
- Targets for critical care inter hospital transfers;

Additional work will be undertaken in 2001-2002 to consider marginal activity and availability costs for unutilised capacity.

2.6.1 Neonatal Intensive Care

For 2001-2002 the WIES funding formula has been modified so that neonates in the four hospitals with neonatal intensive care units attract additional WIES depending upon the amount of time they undergo mechanical ventilation. This payment provides a significant increase in funding for the sickest and/or smallest neonates and replaces a number of previous specified grants designed to compensate these hospitals for the higher costs incurred in treating these babies. It is estimated that the net effect of introducing the co-payment, new cost weights based upon the most recent data and the removal of the previous specified grants will be an increase of approximately \$9.5 million in funding associated with sick and low birthweight neonates in the four major NICU hospitals.

2.7 Capital Funding

Significant funding has been approved for the acute health system including \$310.7 million of state funding for the redevelopment of the Austin and Repatriation Hospital and relocation of the Mercy Hospital to Heidelberg. Funding is also provided to expand and upgrade services in a number of key metropolitan, regional and rural hospitals to better meet emergency demand and to ensure facilities are of a standard appropriate to current service requirements. This includes \$39.5 million for other metropolitan hospitals, \$31.3 million for the regional and rural hospital

sector, \$17.55 million for equipment, \$6 million for urgent infrastructure upgrades, \$4 million for the implementation of new legislation on control of Legionella, and \$18 million for fire safety works.

2.7.1 Austin and Repatriation Medical Centre Redevelopment (A&RMC)

In August 2000 the Victorian Government announced the redevelopment of the A&RMC including the relocation of the Mercy Hospital for Women (MHW) from East Melbourne to the Austin campus. This is the largest public hospital project ever undertaken in Victoria.

The project will include for A&RMC a new emergency department, intensive care and critical care units, refurbished and new operating theatres, new wards, a new day surgery area and a purpose designed mental health facility. It will also incorporate a new Mercy Hospital for Women with 128 adult beds, 60 neonatal cots and 17 delivery suites and a new research precinct involving the University of Melbourne and research institutes affiliated with A&RMC. Construction will begin in September 2001. The main new facilities are expected to be completed in 2004 with the remaining redevelopment works to be completed in 2006.

2.7.2 Sunshine Hospital Development

The capital works at Sunshine Hospital, which will see the hospital develop from a women's and children's hospital to a major regional acute health service for the outer western metropolitan area, are nearing completion. Sunshine Hospital will be partly commissioned in early July 2001. With an additional 7,000 WIES, the hospital will open its new emergency department and 60 beds, including critical care beds. Additional beds will be opened in one or two stages throughout 2001-2002. Some WIES will be re-allocated within Western Health to support the new services.

2.7.3 Frankston Hospital Stage 1B Redevelopment Project

New Works funding of \$9 million has been provided for the Frankston Hospital Stage 1B redevelopment project, which comprises new integrated maternity facilities (delivery rooms, 25-bed ward and special care nursery) and a 17-bed paediatric unit. This project complements the \$12 million Stage 1A project, which was funded under the State Budget last year and is currently under construction.

2.7.4 Northern Hospital

Further funding of \$12 million has been committed to expand the Northern Hospital facilities. The investment will involve reconfiguration of existing facilities and the development of new services to provide two new operating theatres with enlarged recovery, set up and storage spaces, improved day surgery/day procedure facilities, new multipurpose ward accommodation (32 additional beds), and redevelopment of the central sterilising and supply department. This redevelopment will effectively double the current day surgery capacity.

2.7.5 Outer East Service Expansion and Development (Maroondah and Angliss Hospitals)

Funding of \$18.5 million has been provided for the first stage of redevelopments at Maroondah Hospital and the Angliss Health Service. At Maroondah Hospital, funding will be provided for the emergency department to be upgraded, a new 12-bed short-stay unit and a new acute inpatient ward. Redevelopment of the Angliss Health Service will involve a new geriatric evaluation and management service, an expanded rehabilitation service, and provision of temporary car parking spaces.

2.7.6 Grace McKellar Redevelopment

\$19 million has been provided for the first stage of the redevelopment of the Grace McKellar Centre in Geelong. This stage of the redevelopment will provide a new purpose built 90 sub-acute facility comprising 40 geriatric evaluation and management beds and 50 rehabilitation beds. The development of an off-site 30-bed aged residential care facility will allow the existing Geriatric Centre to be decommissioned and improve the geographical distribution of residential aged care.

2.7.7 Ararat Hospital

\$7.3 million has been provided for the redevelopment of the Ararat Hospital. Existing facilities will be refurbished and new construction will provide an acute medical/surgical ward at ground floor level, a dedicated day procedures unit, an operating theatre suite, accident and emergency unit, medical imaging facilities, a birthing and obstetrics suite and administration and medical records area.

2.7.8 Stawell Hospital

\$3.3 million has been allocated to commence the redevelopment and expansion of facilities at Stawell Hospital.

2.7.9 Kyneton – Additional funds

\$1.7 million has been allocated to complete the development of the new Kyneton Hospital.

2.8 Equipment, Infrastructure and New Technology Funding

Funding of \$17.55 million has been allocated to hospitals to assist in meeting their annual equipment funding needs for 2001-2002.

The targeted equipment program for the replacement, upgrading or acquisition of new major equipment items will be undertaken through a formal submission process. This will commence in the first quarter of 2001-2002.

As in previous years, funding support will also be provided for a number of specific purpose equipment programs. This includes \$1 million for infection control and \$2 million for renal dialysis.

The Department has also received a final report on its Review of Capital Equipment Funding Strategy for Victorian Public Hospitals. This Review will inform the development of the capital equipment funding program for the next several years. Details of the Review are available on the Department's website.

2.8.1 Infrastructure Maintenance Works

Specific purpose funding of \$6 million has been provided to assist in urgent remedial infrastructure maintenance work at metropolitan and rural health facilities in 2001-2002.

The provision of funding for priority infrastructure works is contingent upon the findings of the Victorian Public Hospitals Fabric Survey. Funding allocations will also be dependent upon consultations between the Department and the hospital sector. Based on the survey findings, it is

envisaged that funding will be sought on an ongoing basis for infrastructure maintenance and upgrade works.

2.8.2 Information and Communication Technology (ICT) Infrastructure

\$30 million (\$19 million in 2001-2002) has been committed to basic Information and Communication Technology (ICT) infrastructure to link metropolitan health services, regional and rural hospitals and primary care partnerships throughout Victoria. The improved connections should facilitate better continuity of care, improved clinical decision making and management of chronically ill, frail aged and disabled people in the community, through supporting local referral and care co-ordination networks.

2.8.3 New Technology: Clinical Practice Program

\$13.5 million will be available for the New Technology/Clinical Practice Program for 2001-2002. Submissions will be sought in July 2001. Submission criteria are set out in *Section B- Conditions of Funding*.

Examples of new technologies that have been funded over the previous years include prostheses (e.g. abdominal aortic stents), new surgical procedures (e.g. lung reduction surgery), diagnostic techniques (e.g. new test to detect viral load and drug susceptibility for HIV patients) and drugs (e.g. cardiac and oncology drugs). In 2001-2002 grants will be assessed and notified prior to 31 October.

2.9 Improving Patient Safety: Clinical Risk Management Funding

\$4.8 million will be provided, subject to Commonwealth approval, statewide to improve patient safety and to reduce the number of preventable adverse events in Victorian hospitals over time.

The aim is to identify the systemic issues involved. Each metropolitan hospital and regional base hospital will establish a clinical risk program including medical record review and incident reporting. Funding will also be provided to rural hospitals and their rural divisions of general practice to establish medical record review programs in each region.

The Department is also establishing a system whereby hospitals are required to systematically investigate and report on a set of specific important adverse events called Sentinel Events. An initial list of these events has been developed through consultation; this list will be refined and improved.

These funds have been provisionally included in the Quality Fund. Hospitals and health services will be separately advised once approved.

2.10 VicRehab

In 2001-2002 funding for rehabilitation in seventeen designated rehabilitation units (20 beds and over) will move from a historical bed-day system to payment on an inpatient episode basis.

Essentially this new model categorises patients into 16 clinical and functional status groups. Payments are provided for weighted units, short stay patients (less than 4 days), and same day patients. Details are provided in Chapter 9.

General rehabilitation services will continue to be funded through the AR-DRG casemix funding arrangements. Designated units with less than 20 beds will continue to receive the per diem based budget.

This model has been developed over a number of years and with industry input through the Monitoring and Review Committee.

2.11 Quality Fund

In recent years the Department has funded health services for quality improvements in specific program areas such as maternity services, infection control, hospital access, hospital in the home and effective discharge. The Review of Metropolitan Health Care Networks recommended the introduction of a suite of performance indicators to measure quality and the integration of small individual programs.

A consolidated approach to quality improvement will be introduced in 2001-2002. It incorporates a suite of indicators, helping health services to move towards a more integrated whole of service approach to quality improvement in patient care.

Consistent with the new approach, funding for quality improvement will no longer be provided to metropolitan health services on an individual program basis. A new consolidated Quality Fund totaling \$57.5 million (which aggregates quality improvement monies previously received by hospitals under individual initiatives and incorporates some new funding) is being introduced in 2001-2002 to assist metropolitan health services and hospitals to improve patient care. Regional rural hospitals will continue to receive specified funding for these initiatives.

2.12 Pharmaceutical Reform

Victoria expects to sign an agreement with the Commonwealth to implement pharmaceutical reform in 2001. It is expected that some hospitals will start accessing the reforms in October 2001, with another group starting in January 2002.

The aim of the reform is to provide a better continuum of care for patients moving from hospitals to the community setting. Essentially, there are four elements:

- Extension of the Pharmaceutical Benefits Scheme (PBS) to cover hospital initiated prescriptions for non-admitted patients and admitted patients on discharge;
- Provision of 30 days supply (or clinically appropriate) of pharmaceuticals on discharge and to outpatients. This includes both PBS and non-PBS items;
- Listing of some injectable cytotoxic chemotherapy drugs and antiemetics under Section 100, allowing funding for public hospital same-day patients and non-admitted patients; and
- Implementation of the Australian Pharmaceutical Advisory Committee's (APAC) guidelines on continuum of pharmaceutical care.

The Department has been meeting with stakeholders on a monthly basis since November 2000. The Pharmaceutical Reform Implementation Working Group consists of hospital pharmacists, doctors, CEOs, a discharge coordinator, and representatives from the Departments of Health and Aged Care, Veterans Affairs and Human Services. The group has provided input into issues ranging from chemotherapy budgets and growth rates to prescription forms.

Training will be provided on-site by the HIC to ensure doctors and pharmacists are fully briefed on PBS prescribing.

Details will be provided directly to hospitals.

2.13 DVA Patients

The new funding arrangements introduced in 1999-2000 for the treatment of Department of Veterans' Affairs (DVA) patients in public hospitals will continue in 2001-2002.

The new agreement funds a majority of public hospital services on the basis of outputs and the price paid by the Department of Veterans' Affairs allows the Department to pay a premium for a range of services provided to veterans. Veteran throughput is uncapped. The arrangements are detailed in the *Section B – Conditions of Funding*.

Post-acute care services are also available to DVA patients in public hospitals through the Post Acute Care program.

3 Improving Services to Rural Communities

The key elements of rural and regional strategy will be:

- Nurturing and sustaining small and medium health services;
- Targeting service gaps;
- Rebuilding the rural health workforce; and
- Building for the future.

It is recognised that rural and regional Victoria is not one but many communities with many service elements. Furthermore, issues differ between large regional, medium sub-regional and smaller rural health services. One major difference is the importance of aged care in small and medium rural hospitals. This will continue to grow. The elements of this Rural and Regional Strategy are outlined below.

3.1 Nurturing and Sustaining Small and Medium Health Services

In 2002-2003, casemix funding for rural group C, D & E hospitals will be adjusted to offset annual 1.5 per cent productivity dividend (\$2.5 million benefit) and case weight changes. There will be a greater flexibility in use of funds by D & E hospitals. Information and Communications Technology strategy will link metropolitan health services, regional and rural hospitals and primary care partnerships throughout Victoria (\$30 million over three years). Voluntary alliances between groups of rural hospitals to improve services and enhance viability will be encouraged and supported.

3.2 Targeting Service Gaps

Rural hospitals will share in growth funds. \$12.5 million has been allocated in this year to rural agencies for growth in inpatient and non-admitted patient services. This includes \$5 million to target long-ignored service needs of rural Victorians (e.g. ophthalmology and orthopaedics). Hospitals in large regional centres with emergency demand pressures will also have access to a share of the emergency management funds and the \$100 million admission prevention funding over 4 years. This includes extending Falls and Balance Clinics to Gippsland, Hume and Grampians regions. Radiotherapy services will be operating at Bendigo and Ballarat next year and Traralgon radiotherapy is a high priority for capital funding in 2002-2003.

3.3 Rebuilding the Rural Health Workforce

Workforce needs of rural Victoria are being seriously addressed for the first time with new commitment of \$10 million over 3 years to establish rural clinical schools within universities. This will be of direct benefit for Shepparton, Bendigo, Ballarat, Horsham, Mildura, Traralgon, Sale, Bairnsdale, and the existing school involving Warrnambool and Portland. Rural and regional hospitals will benefit from \$469 million over 4 years to recruit 1300 new nurses and improve nurse-patient ratios. Over 900 extra Division 2 training places will also be funded through TAFE. This recognises the crucial role of Division 2 nurses in rural Victoria.

Negotiations are underway for other components of workforce rebuilding, especially allied health.

3.4 Building For the Future

The 2001-2002 budget focuses on redevelopment of Ararat and Stawell hospitals (\$10.5 million) and repair of neglected aged care infrastructure and services. This includes:

- \$25 million to upgrade aged care facilities in rural Victoria;
- \$28 million to undertake fire risk management works in rural hospital and nursing home facilities; and
- \$19 million for rebuilding of Grace McKellar Centre at Geelong.

Building infrastructure for the future must be needs-based and strategic:

- Adhoc investment is no basis on which to provide for special needs of rural and regional Victoria – development of the Rural Human Services Strategy to drive future capital investment is therefore a high priority for the Department;
- Strategic planning must be multi-year and based on collaboration with the sector – the opportunity and challenge is for the sector to work with the Government to get it right; and
- The Department will encourage alliances and sharing of physical, financial and people capacities and skills.

3.5 Rural Patient Waiting List Initiatives

Growth funds for rural Victoria include \$5 million, which in 2001-2002 will focus on improving access to targeted specialties for rural patients. These funds will be aimed at reducing waiting times for long waiting rural elective surgery patients and medical patients experiencing delays in receiving services.

Funding for the Rural Patients Waiting List Initiatives will be available through a funding round to be completed by the end of September 2001. Regions will be the key contact point for hospitals wishing to discuss and submit proposals. Final decisions will be made by the Director, Acute Health, on advice from Regions and Divisional staff on priority needs. Criteria are outlined in *Section B - Conditions of Funding*.

3.6 Rural Specialist Services Grants

The Rural Specialist Services Grant will continue to foster and maintain specific specialty services in rural regional and sub-regional hospitals. In 2001-2002 funding for each specialty will be up to \$70,000.

For the purposes of grant allocation, specialist services include general surgery, obstetrics and gynaecology, anaesthetics, and general medicine for sub regional and regional hospitals. For larger rural communities served by major regional hospitals additional specialist services of paediatrics, orthopaedic surgery, psychiatry, geriatrics and rehabilitation and emergency medicine and other specialist services may be supported through the Rural Specialist Services Grant. Criteria for rural specialist services grants are contained in *Section B-Conditions of Funding*.

Applications for these grants must be received by the Department prior to 15 September 2001. Applications should be addressed to the Regional Partnerships and Service Planning Manager.

3.7 Continuing Medical Education

In many rural communities general practitioners assume responsibility for delivering a greater range of services, particularly in the areas of obstetrics, anaesthetics, minor surgery and accident and emergency services. A Continuing Medical Education subsidy program for rural general practitioners commenced on 1 July 1996. The joint contribution to the costs of the program by the Department, hospitals and general practitioners will continue in 2001–2002. The Department's insurance policy will also continue to provide medical indemnity insurance at an attractive rate to a number of rural general practitioners – including rooms-based care and care in many Bush Nursing Hospitals. The grants will assist small hospitals to ensure that they have on-call general practitioners.

3.8 Rural and Isolated Hospitals

The Rural and Isolated Grant has been retained at 2000–2001 levels. This provides an additional \$3.2 million to qualifying hospitals.

3.9 Increased Flexibility for Small Rural Hospitals

In line with the Government's commitment to examine the suitability of casemix funding for small rural hospitals, considerable consultation has taken place with these hospitals on this issue. This has included a special consultancy commissioned to examine viability and funding issues in Group D & E hospitals. Consultation revealed generally strong support for the use of casemix funding for acute services as the funding mechanism is transparent and the model provides appropriate accountability. Nevertheless the support was qualified by indications that the effectiveness of funding could be increased by introducing an element of flexibility.

The new arrangement has two primary aims. The first is to release some acute funding (that was previously allocated for WIES-based services) and utilise these funds for the development of community-based activities/services that lead to a reduced need for in-hospital care (for example, community-based allied health, or education activities).

The second is to release funding for activities/expenditures which are not direct substitution but are necessary or desirable to provide services appropriate to the community needs. This will provide managers with the capacity to legitimately move funds to meet existing and emergency needs.

The new arrangement must be consistent with the provision of services within a rural area/region as part of an integrated health system. The rural relevant regional Director will therefore review all WIES conversions under this new scheme.

To give effect to this new arrangement, the following will apply in 2001-2002 for D & E hospitals:

- up to 10 per cent of WIES will be convertible to provide outputs which lead to a short or medium term substitution of, or reduced need for inpatient hospital care; and
- up to 5 per cent of WIES will be convertible to meet expenditure for activity appropriate to community need.

Expenditure on the above will be acquitted by the Department to the Department of Treasury and Finance as WIES equivalents. Reporting of the amounts converted for substitution will be similar to that provided in the Healthstreams model. Reporting for community expenditure will be the minimal necessary but must be accurate, timely and verifiable.

Detailed reporting requirements will be issued in July. The outcome of this new approach will be evaluated during the year.

3.10 Flexible Service Arrangements (Healthstreams)

The Rural Healthstreams Program enables smaller rural hospitals to participate in more flexible funding and purchasing arrangements. Healthstreams now has 12 agencies approved as participants in the Program with a further 10 agencies approved in principle. These agencies have received Implementation Grants totaling almost \$0.66 million to date. Considerable interest has been shown by other agencies in participating in this Program. A total of \$1.86 million in specified grants of reallocated funds was approved in the last financial year to enable facilities to provide services such as community health nursing and allied health services, palliative care and health education programs.

Flexible funding and purchasing should not shift acute throughput to other acute funded non-Healthstreams agencies unless this is warranted on a service basis. Management of Rural Healthstreams agencies must ensure that this does not occur and the Department is monitoring activities in this area.

3.11 Multi-Purpose Services (MPS)

The conversion of small hospitals to MPS agencies enables considerable and desirable flexibility to these agencies in choosing service delivery mechanisms appropriate to local circumstances. Monies provided previously for acute throughput have been converted to a net grant (i.e. net of private patient and other revenue). The MPS agencies will be subject to ongoing Acute Program policies in respect of further funding, and entitled to an appropriate share of additional growth and capital expenditure allocations. Similarly, the agencies will be subject to the same policy decisions as other small hospitals on private patient revenue and productivity requirement as smaller hospitals, which remain in the Acute Program. Monitoring arrangements will be implemented to ascertain whether acute throughput has been merely shifted from an MPS to another acute funded agency and if so an appropriate funding adjustment will be made.

3.12 Other Rural Initiatives

Rural capital works to be undertaken in 2001-2002 include Geelong, Ararat, Stawell and Kyneton Hospitals, details about which have been provided in Chapter 2.

Rural radiotherapy services will be improved through the establishment of single machine units at:

- St John of God Health Care in Ballarat, which is anticipated to commence operation in December 2001. St John of God, Ballarat Health Services and local community support have provided capital for the facility;
- Bendigo Health Care Group, anticipated to commence operation in late March/April 2002. Bendigo Health Care Group was allocated \$10 million in the 2000-2001 Budget for the construction of the SMU and purchase of the linear accelerator. The estimated cost of the project is \$14 million and costs exceeding \$10 million will be met by the Department's Acute Health Equipment Program;
- Latrobe Valley, detailed planning for which will commence in 2001-2002. It is anticipated that the unit at Latrobe Valley will commence services in 2003; and
- Recurrent funding for each facility will be provided by the Commonwealth and the State. This is established at \$3 - \$3.5 million per machine, per annum.

4 Summary of 2001–2002 Payment Rates

Table 5 Payment Rates, 2001-2002

Payment	All Hospitals	Major Providers	Rural Group B (large)	Rural Group B (small)	Rural Group C	Rural Group D & E
Inpatients						
• Target A per Public WIES 9		\$2,266	\$2,289	\$2,323	\$2,358	\$2,389
• Target A per Private WIES 9		\$1,854	\$1,874	\$1,907	\$1,936	\$1,965
• Target B per Public WIES 9	\$1,804					
• Target B per Private WIES 9	\$1,476					
• Rural/Isolated Hospital Payment per WIES 9 ²	\$15/\$37					
• Nursing Home Type Patient per Day	\$137					
• DVA per WIES 9		\$2,321	\$2,347	\$2,374	\$2,410	\$2,440
Sub-acute						
• CRAFT (episode)	\$9,121					
• Rehabilitation Level 1 (per diem rate)	\$419					
• Rehabilitation Level 2 (per diem rate)	\$348					
• Geriatric Evaluation & Management (per diem)	\$348					
• Interim Care Beds (per diem rate)	\$240					
Non-Admitted Patients						
• VACS Payment per Weighted Encounter ³	\$116					
• Allied Health per Occasion of Service ³	\$42					
• Emergency Services Grant	See Chapter 12					
• VACS Base Grant	See Chapter 12					
• VACS Teaching Grant	See Chapter 12					
Training and Development Grants						
• Training and Development Payments	See Chapter 13					
• Research Grants	See Chapter 13					
Specified Grants						
	See Chapter 15					
<ol style="list-style-type: none"> 1. Same day medical targets for specified DRGs have been defined for each hospital and same day medical throughput in excess of these targets will not be funded. 2. The rural and isolated hospital payment will apply to those hospitals designated in the funding guidelines. 3. Ballarat Health Services and Bendigo Health Care Group are the only Rural Group B hospitals funded through VACS. 4. Details on specific grants / payments are outlined in the Condition of Funding. 5. The above rates do not include savings required from embedded taxes/specific network savings/network supplies and consumable savings. They do not therefore represent the "published rates" as defined in contract arrangements with privately operated hospitals. The official published rate for metropolitan hospitals is \$16.80 per WIES less than the rates shown above and for non-metropolitan hospitals \$10.75 per WIES less than the rates shown above. 						

5 Hospital Activity and Throughput Targets

5.1 Hospital Activity Targets

This section describes the throughput targets for each metropolitan health service and each rural region. It also explains the strategies underlying the setting of these targets and their linkages to other hospital services, in particular sub-acute services and proposals under the Hospital Demand Management Strategy, including prevention and substitution activities. The smaller size of the Metropolitan Health Services has ensured greater transparency and consideration of local trends in emergency and elective demand. In 2001–2002, the unit of measure for casemix adjusted throughput will be known as WIES9 with the total number of WIES9 for hospitals in 2001–2002 being 785,425. Full details of WIES9 are given in *Section C – Calculation of WIES*.

5.1.1 Impact of New Grouper—AR-DRG Version 4.2

From 1 July 2001, a new grouper version (AR-DRG Version 4.2) will be used for casemix funding of Victorian public hospitals. DRG numbers and descriptions are unchanged from AR-DRG Version 4.1. There are a few changes as outlined in Chapter 15. The cost weight data was based on the 1999–2000 Cost Weight Study.

From 1 July 2000, all hospital admissions have been coded using ICD-10-AM, 2nd edition. For 2001–2002, no code mapping is required, as AR-DRG Version 4.2 has been designed to accept direct input of 2nd edition codes (for 2000–2001, diagnosis and procedure codes were mapped back to ICD-10-AM, 1st edition for input to AR-DRG Version 4.1).

The new grouper contains some changes in logic. It addresses a number of the anomalies identified in AR-DRG Version 4.1 and consequently a number of Victorian specific DRGs used in 2000–2001 (bilateral hip replacement and bilateral knee replacement; hook needle localisation of breast lesion; retained placenta and membranes without hemorrhage; paraurethral injection; care of lactating mother; and post natal depression) are no longer required in 2001–2002.

The Cost Weight Study was based on data from the 1999–2000 year. First edition codes were mapped forward to 2nd edition codes in order to derive AR-DRG Version 4.2 cost weights.

5.1.2 Target A and Target B

The simplification of WIES targets introduced in 2000–2001 has been retained. This simplified system has two types of WIES only - Target A and Target B, with Target B comprising 5 per cent of the total allocation for metropolitan health services and 3 per cent for rural hospitals. Target A rates will vary in accordance with the size and nature of the provider between \$2,266 and \$2,389. Target B WIES will be paid at a constant rate of \$1,804 to all providers.

Table 6: Components of Target A, 2001–2002

	Target A Standard Rate	Rural Adjustment	Target A Rurally Adjusted Rate
Major Providers	\$2,266	-	\$2,266
Rural Group B1	\$2,266	\$23	\$2,289
Rural Group B2	\$2,266	\$57	\$2,323
Rural Group C	\$2,266	\$123	\$2,358
Rural Group D and E	\$2,266	\$92	\$2,389

Prices per WIES will continue without separate fixed and variable components. It was recognized that these separate components in the past had led to inequalities, with the same types of agency doing the same types of work but with some being paid a significantly different price.

5.1.3 Price Adjustments

Prices for all providers have been adjusted to reflect agreed wage increases and an indexation factor of 2.5 per cent on non-wage costs. For major providers and Group B hospitals the price will also be adjusted to reflect the 1.5 per cent productivity savings requirement. WIES prices for Group C, D and E hospitals will not be adjusted for this requirement, however it should be noted that this is not an acknowledgment that further productivity gains within these hospitals are unachievable. Ongoing continuous improvement is expected and the benefits from improved efficiencies are expected to further improve their financial position. Admitted patient revenue targets have also been increased by 2.5 per cent. Hospitals will be advised shortly of revised bedday rates to be charged.

Additional funding from the Department for the cost of the 1,300 extra nurses employed by hospitals to meet the requirements of the nursing EBA is not included in the overall WIES price. Instead this is identified separately in hospitals’ detailed budget tables.

5.1.4 Under-utilisation of WIES

Hospitals are required to advise the Department by 10 February 2002 of any impending under-utilisation of their WIES target allocations. Rural hospitals should advise their relevant rural Regional Office and major providers should advise the Acute Division at the Department Head Office. New annual targets will be subsequently set, and any under-utilisation will be made available to other providers at a price agreed by agencies and the Acute Health Division. The price for WIES so identified will recognize some component of fixed cost to the hospital unable to undertake their target WIES. Otherwise the normal recall adjustment (below) will apply.

5.2 Recall Adjustment

Given the demand pressure on available inpatient services, it is the responsibility of hospital management to manage throughput to target levels. This year there will be the opportunity for revision in February 2002, so that hospitals’ ability to operate at target level is increased. Shortfalls will be recalled at a progressively increasing rate as outlined below.

Table 7: Recall Adjustment Rates, 2001–2002

Major Providers	Recall Adjustment
0 – 2 per cent below target	50 per cent of Target B Rate
2 – 3 per cent below target	80 per cent of Target B Rate
3 – 5 per cent below target	100 per cent of Target B Rate
5 per cent + below target	100 per cent of Target A Rate
Rural Group B Hospitals	Recall Adjustment
0 – 2 per cent below target	50 per cent of Target B Rate
2 – 3 per cent below target	80 per cent of Target B Rate
3 – 5 per cent below target	80 per cent of Target A Rate
5 per cent + below target	100 per cent of Target A Rate
Rural Group C/D/E Hospitals	Recall Adjustment
All recall	50 per cent Target B Rate

Throughput in excess of target of up to 2 per cent will be paid at 50 per cent of the Target B rate. This provides recognition of the difficulty of achieving absolute precision in demand management.

5.3 Metropolitan and Regional Inpatient Activity Targets

Table 8 sets out the targets for 2001–2002 for the new Metropolitan Health Services (MHS) and non-metropolitan regions. Detailed non-metropolitan hospital allocations are in *Section A – Targets*.

Table 8: Targets, 2001–2002

	Target A WIES9 (ex. DVA)	Target B WIES9 (ex. DVA)	DVA WIES9	Total WIES9
Austin & Repatriation Medical Centre	45,401	2,390	4,369	52,160
Bayside Health	55,014	2,895	1,836	59,745
Eastern Health	55,541	2,921	1,945	60,407
Melbourne Health	10,053	529	587	11,169
Northern Health	8,776	462	330	9,568
Peninsula Health	23,758	1,251	233	25,242
Peter MacCallum Cancer Institute	52,782	2,778	630	56,190
Royal Victorian Eye and Ear Hospital	51,132	2,691	1,164	54,987
Southern Health	82,908	4,363	1,042	88,313
Western Health	32,233	1,696	1,337	35,266
Women's & Children's Health	51,534	2,712	10	54,256
Barwon Health	33,780	1,778	1,308	36,866
Mercy	16,295	857	21	17,173
Werribee Mercy	9,362	290	195	9,847
St Vincent's	36,056	1,898	819	38,773
Total Major Providers	564,625	29,511	15,826	609,962
Barwon-South Western	23,750	732	1,904	26,386
Grampians	35,496	1,099	1,965	38,560
Loddon Mallee	41,973	1,298	3,137	46,408
Hume	40,927	1,267	2,533	44,727
Gippsland	39,128	1,208	2,266	42,602
Total Non-Metropolitan	181,274	5,604	11,805	198,683
Grand Total	745,899	35,115	27,631	808,645

5.3.1 Metropolitan Targets (including Barwon Health)

Throughput growth has been allocated according in the context of the Government's Hospital Demand Management Strategy announced as part of the Victorian budget. This approach recognises that each hospital's strategy will comprise a range of measures to meet particular demand pressures at individual hospitals. The package includes WIES growth, particularly to meet increases in emergency inpatient demand; substitution initiatives including growth in sub-acute and other services; and preventative initiatives. Detailed discussions have been held with senior management and clinicians at the major health services, and the WIES targets above are one part of each health service's overall package.

In particular, the following have been taken into account:

- the level of increased emergency demand predicted for that health service;
- the capacity of the health service to meet that demand;
- whether the health service is using its existing resources (including WIES) to best effect;
- whether existing resources should be reapplied to diversion and substitution projects before additional WIES are considered; and
- other factors such as the need for service rationalization and restructure.

A further number of additional WIES has been allocated to hospitals with intensive care pressure or where patients have incurred significantly longer than average waiting times related to historical unmet demand. Hospitals receiving additional WIES for specified purposes will be closely monitored in their delivery of that activity. Under-performance, for example in the level of intensive care provided, may result in fund withdrawal and reallocation.

Quarterly targets at the Metropolitan Health Service (MHS) and campus level will be nominated by each Metropolitan Health Service no later than 31 July 2001, and be included in the Health Service Agreement (HSA). Significant departures from these targets (greater than 2.5 per cent) after consultation with the hospital, may result in financial penalties. Campus level activity will be monitored and any significant departure from the agreed service plans or indicative levels will be assessed by the Department. Same day caps will operate within overall WIES9 targets. Non-admitted patients will have a budget ceiling for each hospital campus.

5.3.2 Rural Targets

Some limited growth in inpatient targets has been allocated to large regional hospitals to meet significant increases in demand pressures, particularly increases in emergency demand. The approach is consistent with the criteria noted above for metropolitan health services in that individual demand pressures have been assessed. Additional activity to be undertaken through the Rural Specialties package has yet to be allocated to individual hospitals.

It should be noted that where agencies have performed under target in 2000-2001 and entered into sub-contracts, their targets including any allocated growth are notional only. Full discussions must be held with the rural Regional Director regarding the appropriateness of the WIES level.

Smaller rural hospitals have not faced the same increase in demand - particularly emergency demand - as other hospitals, and there has been no general increase in inpatient activity to those hospitals. Instead the smaller Group D and E hospitals have been given increased flexibility to provide a range of services appropriate to smaller rural communities.

Quarterly targets will be nominated by each rural hospital by 31 July 2001 and included in the relevant Health Service Agreement. This will assist monitoring of throughput and scheduling of cash flows. Significant departures from these targets (greater than 2.5 per cent) after consultation with the hospital and the Regional Office may result in financial penalties. Same day caps will operate within the overall WIES9 targets.

5.4 Same Day Caps

Some of the growth in same day cases has been the direct result of improved hospital practices involving the substitution of multi-day stays with same day care. However, the number of

patients admitted for medical conditions on a same day basis has also increased significantly, with an increase in admissions through emergency departments and for investigative procedures.

In 1995-1996 the Department introduced caps and these currently apply at the aggregate level for metropolitan hospitals and the hospital level for rural hospitals. During 2000-2001 the same day cap was at the level of 6.5 per cent of total WIES.

Some of the growth in same day cases has been as a direct result of substitution of multi-day stays with same day care. Under the Hospital Demand Management Strategy, a number of hospitals are establishing short stay/observation units and/or medical ambulatory care centres. These will be WIES, funded from existing under-utilised WIES, or from growth.

During 2001-2002 there will be ongoing evaluation of the impact of such initiatives funded under the Hospital Demand Management Strategy on same day caps. Penalties will not be applied automatically if it can be demonstrated at a mid-year review that same day changes have occurred in accordance with improved practices.

5.5 Published Rates

The rates presented in this document and its attachments, including modelled budgets, do not include ongoing savings required from embedded taxes, specific network savings or network supplies and consumable savings. These identified savings are listed in Appendix 6. The amounts remain identical to those in 2001-2002. These rates do not reflect the "published rates" as referred to in contract arrangements with the privately operated Mildura hospital. The official published rate for services reflects adjustments for the above items.

The official published rate for non-metropolitan hospitals is:

- a) For WIES9: \$10.75 less than the rates per unit described in *Chapter 4*.
- b) For other items including sub-acute bed day rates; CRC funding rates; emergency services categorisation; radiation oncology units; training and development grant payments; dialysis program payment rates; VACS unit rate; DVA sub-acute rates: 0.5 of one per cent less than the rates described in *Chapter 4*.

The official published rate for metropolitan hospitals is:

- a) For WIES9: \$16.80 less than the rates per unit described in *Chapter 4*.
- b) For other items including sub-acute bed day rates; CRC funding rates; emergency services categorisation; radiation oncology units; training and development grant payments; dialysis program payment rates; VACS unit rate; DVA sub-acute rates: 0.77 of one per cent less than the rates described in *Chapter 4*.

5.6 Service Agreements

Service Agreements with the Department are to be signed as soon as possible in the financial year. In particular, the Acute Schedule to the Service Agreement must be concluded by 30 September 2001. The Acute Health Division will provide assistance to resolve any outstanding issues in that period. However, agencies who do not sign the Acute Schedule will not be eligible to receive bonus payments under the Quality Improvement Fund.

6 Improving Hospital Demand Management

This chapter covers services for patients entering hospital, including emergency demand management initiatives. It covers services on discharge or substitution services for hospital-based care, such as the effective discharge strategy and hospital in the home (HITH). It also deals with post-acute care (PAC) and the development of new models to cater for patients awaiting placement in aged residential care or supported community settings (interim care).

Additional funding for hospital demand management involves the development and implementation of carefully targeted strategies to tackle the problems of access to emergency care in the major metropolitan hospitals with emergency departments and Barwon Health. Individual metropolitan health services (and Barwon Health) submitted proposals that were assessed by the Department to determine the most appropriate mix of initiatives to meet local demand pressures. Specific agreements will be negotiated for the allocation and use of these funds and the high-level performance measures that will be monitored to assess progress.

These funds demonstrate the Department's commitment to supporting the directions set out by the Patient Management Taskforce and provide real incentives for hospitals to implement the patient care process improvements and streamlined service models which the Taskforce has identified. The budget strategy is also informed by the work of the Emergency Demand Coordination Group and associated inter-sectoral projects.

In 2001-2002, funds are provided in the following categories:

- Sub-acute and interim care (\$12.9 million)
- Care Coordination and Change Management (\$5.9 million)
- Intensive Care Unit (ICU) enhancement (\$7 million)
- Emergency Department Enhancement (\$10 million)
- Substitution (\$12 million)
- Prevention (\$17 million)

In order to foster clinician involvement in the development and implementation of emergency demand management initiatives, clinical advisory groups will be established in the coming months. Made up of senior expert clinicians (nurses, doctors and other health care professionals), the groups will advise on strategies most likely to have a substantial impact in practice improvement. In the first instance, they will be asked to provide advice on priorities for the allocation of a proportion of the prevention fund particularly focusing on reducing unneeded admissions by better coordination of care and support. (In order to ensure that the full allocation is committed and spent wisely on worthwhile service enhancements during 2001-2002, the Department is committing a proportion of these funds as part of the packages agreed to with metropolitan health services. Further allocations will be made on the basis of submissions from health services assessed by the clinical advisory groups.)

6.1 Sub-Acute and Interim Care

These funds will be allocated in 2001-2002 to a mix of service initiatives and enhancements designed to improve care for older people and people with more complex care needs, especially those awaiting placement in residential care. Services to be funded include additional GEM beds, establishment of a limited number of pilot interim care models, and expansion of rehabilitation in the home.

6.1.1 Development of Pilot Interim Care Models

The Department will support a small number of proposals from metropolitan health services to develop interim care on a trial basis to test their effectiveness. The target group for these projects are people who:

- Have completed their acute or sub-acute episode of care;
- Have been assessed by an ACAS and recommended for high or low level aged residential care; and
- Are suitable for immediate placement in a residential care facility if a place were available.

While the details of the service model may vary between the trial projects, all people participating in an interim care project should have access to an appropriate mix of nursing and allied health care to maintain function to the extent possible. Projects are expected to include access to additional social work services to assist people to move to more appropriate long-term care. The focus of activity for the units will be on providing additional time and assistance for families/carers to arrange longer-term placements for each person. Consideration can also be given to flexible funding (see below).

Initial funding rates for these new projects will be set at \$240 per bed day. As these units will be configured and staffed for a particular target group, implementation experience and evaluation may result in a revision of these rates beyond 2001-2002.

Specific program guidelines and costings (based on practice) will be developed as soon as possible. An evaluation framework will also be developed to determine the effectiveness of the pilot projects.

6.1.2 Interim Care – Flexible funding opportunities

Flexible funding may also form part of pilot programs. This will provide the capacity for participating health services to enable people waiting for residential care to be managed either as an inpatient, or through appropriate care and accommodation services, or, in cases where it is appropriate, providing extra support services in a person's home. Effective assessment to determine which patients may benefit from a trial at home; which patients could be safely managed at home for a limited period with more significant support resources; and which would need to have 24-hour support as an inpatient or through other accommodation and care services would be an essential feature of this project.

The purpose of any flexible funding component will be to provide a person who has completed their acute and/or sub-acute inpatient care, and who has been assessed as needing residential care, with appropriate support while they wait for a residential place. It is expected that people will access the program funding for a limited period of time and there will be a flow of patients to either the community or to residential care. Where a person is able to continue to manage in the community on a longer-term basis, transfer to community services within 90 days would be expected.

The capacity for flexible funding will be provided on the basis of an agreed plan, which indicates the flow process to alternative care arrangements.

6.2 Care Coordination and Change Management

The care coordination funding provided under the Winter Emergency Demand Strategy of 2002-2001 has proven to be effective in better managing patients presenting to the emergency department by assisting them to return home earlier with appropriate support or move more quickly to another setting better suited to their care needs. This is an important response to the increasing number of patients with complex problems presenting at emergency departments, particularly older patients and those with psychiatric and substance abuse problems. Staff employed vary from hospital to hospital according to their patient mix and particular demand pressures, however they include gerontic nurses, psychiatric nurses, social workers and other allied health staff.

\$4.4 million of these ongoing funds will enable hospitals to continue to provide care coordination at the levels provided in 2000-2001. Additional funding will be provided for care coordination in some metropolitan hospitals and Barwon Health.

In addition, an amount of \$1.5 million will be distributed to some participating health services for the purposes of fostering change management processes and care models. This investment is expected to form a base for system wide best practice and innovative models of admission prevention will continue into future years.

6.3 Emergency Department Enhancement

These funds are available to provide both one-off and recurrent payments to enhance emergency department functioning. Typically, funds may be allocated as:

- A contribution to establishment costs of new services
- An incentive over and above the normal WIES payment
- Recognition of the costs of extra intensive allied health, senior medical and nursing input
- A contribution to the costs of service/process design/re-engineering and change management

A range of innovative models have been trialled in Victoria, and elsewhere, intended to streamline episodes of care for people in the emergency department or admitted from the emergency department. Various named, these include short stay units, rapid assessment teams and medical triage.

6.3.1 Short stay units

These units involve a new patient management model in which small numbers of beds are attached to emergency departments to enable the fast tracking of patients who, with proper assessment and treatment, can be discharged within 24 hours. Without these units patients are either admitted to a hospital ward with a subsequent longer than necessary length of stay or remain in the emergency department reducing access for new patients.

Operating these beds produces efficiencies for the hospital as a whole by avoiding admissions to ward beds and relieving pressure on emergency departments.

6.3.2 Rapid Assessment Teams

Like short stay units these teams assist in fast tracking patients in the emergency department. They are made up of senior staff within the emergency department who can deal more efficiently and effectively with less urgent (typically triage category 4) patients. These patients require the services of the emergency department but wait for treatment for significantly longer than the time recommended by the Australian College of Emergency Medicine. Rapid assessment improves the quality and the timeliness of care for these patients and also frees up resources for more urgent patients.

6.3.3 Medical Triage

Medical assessment and planning units (MAPUs), while not co-located in the emergency department, facilitate admission of medical patients from emergency departments as well as reducing length of stay of medical inpatients.

As the patients treated in short stay units and MAPUs already attract a WIES payment, the Department will not separately fund the operation of these units. However, to encourage their implementation in hospitals where they are likely to be effective in improving access, the Department will make an incentive payment to reflect the higher costs of running these units. It may also make a payment in recognition of the additional resources required to run rapid assessment teams or their equivalents. These models (and the payments associated with them) will be evaluated prior to the conclusion of the financial year in order to assess the need for any ongoing payments in future years.

The funds allocated to enhance emergency departments will also cover the agreed costs of the new emergency department at Sunshine Hospital.

6.4 Substitution

Substitution funding will be distributed for a range of initiatives, including establishment and incentive funding for a limited number of well-defined ambulatory care services. There are real opportunities for hospitals to improve access to emergency services by diverting patients elsewhere in the system. For example, by increasing day of surgery admission (DOSA) rates and substituting same day for multi-day care, additional beds can be made available for emergency patients when required. Similarly, pre-admission clinics are an essential element in improving inpatient flows.

This fund includes specific allocations for services to people with acquired brain injury. While these funds will be allocated to a statewide program, the enhanced program should assist acute and sub-acute facilities by making services available to people awaiting slow stream rehabilitation. It will also meet the costs of topping up Commonwealth payments for recently opened public sector operated nursing home beds. These beds will relieve pressure on the public hospital system.

This fund will also cover the costs of providing care coordination at Sunshine Hospital and Barwon Health.

6.5 Prevention

The budget allocation of \$17 million has been subdivided so that \$1.5 million is allocated to care coordination and change management and the remaining \$15.5 million goes to prevention strategies. A key element of the emergency demand management strategy is a strong focus on reducing pressure for future hospital presentations/admissions, especially from frequent users, by diverting potential demand through better coordinated community and home based services.

Whilst a substantial part of the prevention fund will be allocated to hospitals during the course of the financial year after the Department has received advice from clinical advisory groups, an initial allocation will be made as part of the package of measures currently being negotiated with health services.

One of the initiatives to be funded in this first “round” will include acute-primary care liaison – an example is carefully targeted strategies to increase utilisation of hospital in the home in conjunction with GPs to avoid the need for in-hospital care. This will be subject to close monitoring and evaluation to ensure that there is a genuine diversionary effect and that real hospital admissions are avoided.

Other programs to be funded include specific chronic disease management (such as for congestive cardiac failure and chronic obstructive pulmonary disease (COPD) and programs for older patients with multiple problems) where the patients are known to the hospital and are or are likely to be frequent users; and initiatives that provide immediate/timely access to community services to avoid presentations and/or prevent hospital admissions. The aim is not necessarily to absolutely avoid admissions, however, there is good evidence that a combination of better community based care and planned admissions, for example for patients with COPD, can reduce unplanned admissions with a net benefit in total time in hospital, and reduction in the cost of care at the same time as improving quality.

This fund will also support a range of falls services including specialist falls clinics funded by the Acute Health Division and community falls prevention programs through the Aged Community and Mental Health Division.

6.6 Monitoring and Review

The funds allocated under the emergency demand management strategy will be subject to specific individually negotiated targets with each health service. The high-level performance indicators are to be monitored. They are closely linked to the at-risk indicators that form part of the Quality Fund (refer Chapter 7 for details). Monthly comparative performance information will be supplied to all participating health services and will be the subject of regular meetings with the Department.

In addition, over the next four years a small percentage of the allocations for emergency departments, substitution and prevention will be set aside for evaluation of, and dissemination of information about, the effectiveness of the various initiatives implemented.

7 Quality Improvement: A New Approach

In recent years the Department has developed a strong focus on quality of care. New programs have been funded in a range of areas to promote safety and improve access, care and outcomes for consumers using Victoria's acute and sub-acute health services. Health services have received additional funds through multi million dollar programs in specific areas such as maternity services; infection control; hospital access; hospital in the home; and effective discharge. The development of a systemic, strategic approach to quality improvement has been guided by the principles articulated by the Taskforce on Quality in Australian Health Care and the key action areas identified by the National Expert Advisory Group on Safety and Quality in Australian Health Care. The Department now contributes substantial funds to the Australian Council for Safety and Quality in Health Care to help develop a national approach to strengthening consumer involvement; fostering clinical best practice and enhancing innovation; strengthening accreditation; measuring quality and outcomes; and promoting accountability for quality.

At a local level there has been a strong focus on improving state wide systems for effective delivery of quality care; developing performance indicators for measuring health care quality; improving information available to consumers and the general public; and encouraging the use of health care practices that are known to improve outcomes. Boards of metropolitan health services now have specific responsibilities to ensure that effective and accountable systems are in place to monitor and improve the quality and effectiveness of health services. Additional resources have been allocated to provide infrastructure support for a range of special purpose groups that will work to improve safety and quality in specific areas such as the new infection control co-ordinating centre, and Consultative Councils established to examine preventable causes of mortality and morbidity. The new Statewide Quality Committee will review information from across the system relating to quality of care, identify system wide issues and advise on whether appropriate actions are being taken by hospital management and Boards. The Committee will liaise closely with the national Australian Council for Safety and Quality in Health Care to ensure that state actions are consistent with national approaches.

To assist Government in evaluating health service performance with respect to quality, a Quality Framework is being introduced. This is consistent with that developed by the National Health Performance Committee to report to Australian Health Ministers. The Quality Framework is designed to provide a structure to approach and appraise health service performance. Performance indicators previously in use or currently in development are now placed under the various dimensions of care quality within the framework. Health services will be required to measure and monitor their performance in delivering quality health care according to this framework. There will be a focus on working to ensure indicators in each of the dimensions are consistently gathered and reported so that services will be able to compare their performance with similar organizations. In areas where quantitative indicators are currently unavailable or inappropriate, regular reporting of progress in quality improvement will occur.

While there will continue to be a focus on statewide programs aimed at improving specific aspects of care quality, for metropolitan health services, the funds previously received for a range of quality improvement initiatives will form part of a general quality fund that also incorporates additional funding for developing good systems of clinical risk management. For the 2001–2002 financial year, regional and rural health services will continue to receive separately identified funding for these initiatives, although reporting on progress against these initiatives will be consolidated as for metropolitan health services.

7.1 The Quality Framework

The quality dimensions included in the framework incorporate the following areas:

Access – the ability of people to obtain health care at the right place and right time; includes performance monitoring and quality improvement action to improve in key areas such as emergency services, elective surgery, critical care, neonatal and sub-acute services.

Appropriateness – health care provided is relevant to the patient’s needs and based on established standards. This includes performance monitoring and quality improvement action taken in areas such as disease specific and maternity services clinical indicators, sub-acute patient management and timeliness of emergency and elective treatment.

Effectiveness – health care achieves its desired outcome. This includes performance monitoring and quality improvement action taken in areas including maternity services.

Safety – the potential risks of an intervention or the environment are identified and avoided or minimised. This includes performance monitoring and quality improvement action taken in areas such as clinical indicators, clinical review, general adverse event monitoring, relevant coroner’s recommendations, infection control and prevention, and cleaning standards.

Acceptability – health care which provides respect for and is orientated to the needs and wishes of patients and their carers. This includes performance monitoring and quality improvement action taken in areas such as patient satisfaction.

Continuity of care – the ability to provide continuous, coordinated care across programs, practitioners and organisations over time. This includes performance monitoring and quality improvement action taken in areas such as discharge effectiveness and links with community service providers.

Organisation of systems for quality improvement – a health care organisation’s capacity to provide infrastructure such as workforce, facilities and equipment and be innovative and respond to emerging needs. This includes performance monitoring and quality improvement action taken in areas such as hospital accreditation and implementing innovative or recognised good practice in patient management.

7.2 Performance Monitoring and Reporting

The Department and the sector need to work jointly to improve the quality of health care. Performance in this area will be an integral component of all forums and other mechanisms for monitoring and analysing health service performance. Forums also need to provide opportunities for information sharing across health services to improve patient management.

Metropolitan health services funded under the Hospital Demand Management Strategy will be having regular monthly meetings with the Department. On a quarterly basis these meetings will also be the forum for a more general performance review with the Department where health services can report formally on performance in all relevant programs, assess their progress against quality indicators and targets, and their performance against like health services. Rural regions will hold similar discussions with their agencies.

More comprehensive public reporting on the quality of health care is important both for accountability and to increase community understanding of the factors influencing health care

delivery. A number of formal mechanisms for reporting quality of care to both health services and the public will be in place. To enable hospitals to benchmark their own performance against their peers the Department will report comparative quality performance data to hospitals. Performance against a number of indicators will be reported publicly, as currently occurs through the Hospital Services Report. Health service reports to their communities on quality of care will also commence during 2001-2002.

7.3 Quality Indicators

The 2001–2002 suite of indicators are formed by existing and recently developed indicators in the Acute Health Division’s quality programs, along with additional indicators that have emerged through other processes such as the Patient Management Taskforce. A selected group of high level indicators drawn from the framework will form part of the Health Service Agreement performance indicators and targets.

Not all indicators are applicable to every health service or hospital for a number of reasons. The particular service to which they relate may not be provided or patient numbers may be too small for meaningful performance measurement. The framework allows for negotiated institution-specific indicators where this is considered desirable. Targets against indicators will be set where appropriate. In some cases these will be statewide targets and in others they will be individually negotiated. Non-indicator based reporting has also been included in the framework under the relevant dimensions of care.

The indicator set has been based on indicators currently collected and specific areas where indicators have been developed within existing quality programs. It is not yet comprehensive and balanced across care dimensions. However it provides an initial point to work towards a comprehensive suite of quality indicators, as recommended by the Review of Metropolitan Health Care Networks and accepted by Government. This set will be further developed over time and in consultation with health services and appropriate clinical groups. It is also important to note that the indicators reported to the Department are not intended to be exhaustive and Boards and health services need to develop their own performance indicators for monitoring which take into account their particular local operating environments. Further, information on general clinical indicators is provided in *Section 8.2*.

7.4 Quality Fund – Metropolitan Health Services

Consistent with the new approach, funding for quality improvement will no longer be provided to metropolitan health services on an individual program basis. A new consolidated Quality Fund totaling \$58.9 million (which aggregates specific program funds and quality improvement monies previously received by hospitals under individual initiatives and provides some additional funding) is being introduced in 2001-2002. The current funding streams being aggregated into the Quality Fund are: hospital access program; effective discharge strategy; infection control; cleaning, hospital in the home incentive funding; funding for programs for people from non English speaking backgrounds; maternity services; enhancement of health promotion in emergency departments; and accreditation bonuses. Thus 9 individual programs will be consolidated, with a significant reduction in bureaucratic burden for metropolitan health services.

A sizeable proportion of the Quality Fund will be dependent on performance against specified high level performance indicators and targets. These will be a combination of statewide and hospital specific indicators focused on patient access and management. The indicators, targets and associated monies at risk are detailed in *Appendix 4*. The significant additional funds being made available through the Hospital Demand Management Strategy are clearly also intended to ensure improved performance against key indicators.

For the purpose of calculating the bonus component of the quality fund, maternity services funding has been deducted from the total health service quality fund allocation, if applicable, in anticipation of the mainstreaming of this funding in the 2002-2003 financial year. For health services and hospitals which do not report against emergency, elective or critical care indicators the bonus component of the quality fund has been set at 25 per cent. For all others it has been set at 65 per cent.

Five per cent of performance funding will be attached to data quality and timeliness of reporting in key areas. These include reporting *via* the Elective Surgery Information System and the Victorian Emergency Minimum Dataset as well as reporting on other specific indicators. Further details are provided in the *Quality Fund Business Rules* to be forwarded to hospitals separately.

The remaining funding will be cash flowed to health services to support quality service provision in existing and new areas. This continues the prior practice in many individual programs whereby a proportion of health services' quality funding is not dependent on specific performance requirements, but is available to enhance quality and in some cases to provide additional services. A continuing focus is expected on quality of health care provision in areas previously highlighted for improvement through separate funding programs and performance in these areas will be the subject of review with senior health service staff through the mechanisms noted above.

7.5 Allocation of Quality Funds

For the 2001-2002 financial year funding will be allocated to health services in accordance with allocation methods that existed in 2000-2001 under the individual programs that have been aggregated to form the fund. The level and allocation mechanism of the quality fund for metropolitan health services will be reviewed prior to the 2002-2003 financial year.

7.6 Redistribution of Retained Quality Funds

To maximise quality funding made available to the system, any bonus funds available to metropolitan health services, but retained by the Department because performance targets have not been met, will be distributed to metropolitan health services that have performed well and have met reporting requirements across the care dimensions.

7.7 Quality Funding – Regional and Rural Health Services

Regional and rural health services will continue to receive separately identified funding totaling \$16.8 million for relevant programs and quality initiatives in 2001-2002. This has been allocated to health services in accordance with allocation methods that existed in 2000-2001. Where

relevant, the quality performance and accountability requirements for rural hospitals will be the same as for metropolitan health services. However, funding for quality improvement for rural hospitals and bonuses for achieving targets will continue to be on a program basis. Bonus funds retained by the Department because performance targets are not met, will be distributed to services that have performed well and have met reporting requirements across the care dimensions.

7.8 Same Day Incentives

In 1999-2000, 61 per cent of medical separations and 31 per cent of procedural (including surgical) separations in Melbourne's major metropolitan hospitals were same day. However there remains clear scope for further improvement. Information gathered by the Patient Management Taskforce identified that in the USA in 1996, 45 per cent of all surgical procedures were carried out on an ambulatory (same day) basis. For 'community' (short-term) hospitals, which account for 94 per cent of all inpatient admissions, this proportion was 60 per cent. While it is recognised that there are system and definitional differences between Australia and the US that make close comparisons unreliable, the direction and scale of the variation in these data are indicative of a significant difference in patient management practices.

The Taskforce reviewed data from the Victorian Admitted Episodes Dataset to identify differences among hospitals in the proportion of inpatient episodes that are completed on the same day as the admission. It also took account of recent international experience. The goal was to identify a sample of DRGs where there is variability in the extent of same-day treatment, in order to set targets for operational improvement based on this analysis. The Taskforce has suggested targets for specific types of same day care and for Day of Surgery admission.

An indicator measuring same day admissions is being introduced through the new quality indicator framework. Targets for this indicator and associated bonuses will be set for the second half of 2001-2002. Additional funds have been provided for health services in the Quality Fund and for Ballarat Health Service and Bendigo Health Care Group to implement this approach.

In line with this approach hospitals will be asked to develop a program to improve their percentage of same day care, in consultation with the Department. Because there is such variability in performance across hospitals, targets for different specialties/procedures will be negotiated with each hospital. These will need to be tailored to the specific circumstances at the individual health service level, including such factors as work practices, skill mix, information technology and equipment.

8 Specific Quality Programs

This section describes strategic directions and statewide issues for a number of quality programs focused on improving care. For metropolitan health services, the funding for many of these programs has been consolidated into the Quality Fund. Reporting by hospitals and health services on their progress in these areas has also been consolidated. For metropolitan health services review of progress in these programs will form part of the quarterly performance reviews undertaken in association with the Hospital Demand Management Strategy. For regional and rural hospitals review of progress will be undertaken as part of the regular meetings held with rural regions.

8.1 Accreditation

Accreditation is now regarded as a minimum standard for all public providers of acute care and sub-acute services.

Health services may be accredited through the Australian Council on Healthcare Standards Evaluation and Quality Improvement Program (ACHS-EQuIP); the ISO 9000 Quality Management System; the Quality Improvement Council's Quality Improvement and Community Services Accreditation (QICSA); or other equivalent programs.

For metropolitan health services accreditation funding has been included in the general Quality Fund. Regional and rural hospitals will receive specified funds, as in previous years. Reporting on any relevant accreditation outcomes will be included as part of the consolidated reporting on quality initiatives.

8.2 Clinical Indicators

Over the past five years, the Department has worked in consultation with the field to develop a number of general clinical performance indicators that can form part of the overall set of quality indicators. These indicators fall into the areas of the quality framework that are concerned with appropriateness, effectiveness and safety of care. Clinical indicator development has also occurred in some specific specialty areas such as maternity services.

In August 1998, the Department commissioned the Australian Council on Health Care Standards (ACHS) and Monash University's Department of Epidemiology and Preventive Medicine to identify an appropriate set of general clinical quality of care indicators suitable for statewide monitoring. Selection of the final set of recommended indicators was carried out by a comprehensive review of existing national and international programs and indicator topics and reviewed by three expert clinical working groups from the disciplines of medicine, surgery and obstetrics and gynaecology. The Final Report of this project (the Acute Health Clinical Indicator Project) was published on the Internet at www.dhs.vic.gov.au/ahs.quality/clinical.htm in 2000-2001 and identifies a total of fifteen clinical indicators for this purpose.

The Department is mindful of the administrative burden involved in collecting performance data against all of these, especially given that routine data systems for their collection have not been universally established to date. Until more advanced health information infrastructure systems are established to support reporting against clinical indicators the Department must balance the

need to minimise administrative burden with the need to obtain information that is relevant to the 'core' clinical business of the majority of Victorian public hospitals. It is important to note that the inadequacy of existing data systems to support quality monitoring is being recognised internationally and the dilemmas cited above are not unique to Victoria. In fact, there is a growing consensus that meaningful, comprehensive quality reporting will require the development and implementation of electronic clinical data systems that are integrated with the care delivery process.

Therefore, in the first instance only four of the clinical indicators recommended by the ACHS/Monash consortium will be trialed. The choice of these indicators has been influenced both by the frequency with which the relevant clinical procedures are performed and their clinical significance to the community. In addition, ICD-10-AM coding can be used as an initial screen to determine occurrence of these clinical events, thereby reducing collection and reporting burden.

Metropolitan Health Services and public hospitals should refer to the Quality Fund Business Rules document for detailed indicator definitions and reporting requirements. The Department will also issue an additional, more detailed document to all metropolitan health services and public hospitals setting out the background to, and rationale for, these indicators. This will also contain guidance to hospitals on how to evaluate and respond to their own performance against the clinical indicators.

The four clinical indicators to be trialed in 2001-2002 consist of three that focus on complications or adverse events and one that focuses on appropriateness of care and are as follows:

1. The number of patients having a colonoscopy which results in perforation of the colon, as a proportion of the total number of patients having a colonoscopy, during the time period under study.
2. The number of patients having a large bowel resection and anastomosis for cancer of the colon, with anastomotic breakdown, as a proportion of the total number of patients having a large bowel resection and anastomosis for cancer of the colon, during the time period under study.
3. The number of patients having a laparoscopic cholecystectomy with a bile duct injury requiring operative intervention, as a proportion of the total number of patients having a laparoscopic cholecystectomy, during the time period under study.
4. The number of patients with acute myocardial infarction who receive thrombolytic therapy within one hour of presentation to the hospital, as a proportion of the total number of patients with acute myocardial infarction requiring thrombolysis who receive thrombolytic therapy during the time period under study.

There is a degree of overlap between some of the clinical indicators designed for trialing and some of the sentinel events that are the subject of mandatory reporting to the Department. For example, perforation of the colon following colonoscopy represents a case of perforation of a viscus during an endoscopic procedure. Similarly, bile duct injury during laparoscopic cholecystectomy may have arisen as a result of perforation of the bile duct during the procedure.

However, the Department has decided to focus specifically on colonoscopy and laparoscopic cholecystectomy not only because they were recommended by the Final Report of the Acute Health Clinical Indicator Project, but also because historical analysis of the Victorian Admitted Episode Dataset (VAED) indicates that these procedures are performed with reasonably high levels of frequency across most hospital groupings throughout Victoria and as a result represent 'core' clinical business for a large number of acute care providers.

Given the relatively high service volumes for these procedures, it is reasonable to expect that a high level of technical competence can and should be achieved and that unintended procedural

complications of the sort described should trigger further investigation to identify potential improvements in the process of care.

The Department will carefully monitor the progress of the clinical indicator trial by organising consultations with key stakeholders to address any issues associated with the collection and reporting of the clinical indicators and their use in quality improvement. A forum will be convened to discuss and resolve important issues encountered during the first quarter of data collection. The Department recognises that the trial clinical indicator set identified above will require careful review and evaluation. Work will also start in 2001-2002, in consultation with key stakeholders from the sector, to put in train a process for the continued development and improvement of clinical indicators gathered as part of the appropriateness, safety and effectiveness dimensions of the Quality Framework.

8.3 Improving Safety

8.3.1 Clinical Risk Management (CRM)

Adverse events and errors in health care have been recognised as important public health issues, at a national and international level.

A major study in this area *Improving Patient Safety in Victorian Hospitals* report was commissioned by the Department and produced by the Department of Epidemiology & Preventive Medicine, Monash Medical School Monash University. The report was released in October 2000 and is available at: www.dhs.vic.gov.au/ahs/quality/clinrisk.htm The CRM strategy is based on this report's recommendations.

Given the complexity of the health care system, preventing adverse events and improving patient safety requires a multifaceted approach. The Government is committed to improving patient safety in Victorian hospitals, but this requires a collaborative effort with hospitals and clinicians in order to achieve tangible results. Clinical risk management (CRM) should be an integral part of routine hospital functioning so that adverse events are managed and prevented. Additional funding will be provided to health services and hospitals throughout the State to help implement CRM programs. For metropolitan health services this funding has been provisionally included in the general Quality Fund. Large regional hospitals will receive specified funds. CRM programs for small rural hospitals will be coordinated through rural Divisions of General Practice. Reporting on implementation of these programs will be included as part of the consolidated reporting on quality initiatives. Details are provided in *Appendix 5*. Funding details will be provided, once approved.

The CRM strategy for 2001-2002 will target preventable adverse events and encourage a systems approach in examining contributory factors leading to these events. This strategy marks a shift in the traditional approach of adverse event management from one that in general focuses on individuals, to one that focuses on the conditions under which adverse events occur, and where the investigation of these events is seen as an opportunity to improve practice and patient safety.

Metropolitan health services and regional base hospitals are expected to make patient safety a priority and establish local hospital based CRM programs, or develop existing CRM programs, to ensure that this activity becomes an integral part of the functioning of the hospital. To ensure success of local hospital based CRM programs the commitment of senior management, clinical and nursing staff is required.

CRM for small rural hospitals will be coordinated through rural Divisions of General Practice. The Department is currently working with the West Vic Division of General Practice to develop an appropriate model. It is anticipated that the establishment of CRM in small rural hospitals will occur throughout 2001-2002.

The Department will also establish a statewide system for reporting against a subset of adverse events called Sentinel Events. Sentinel Events are specific important adverse events that should be systematically investigated to determine any improvements that could be made in hospital systems and processes. The establishment of this system is justified by the need to accumulate as much information as possible to assist in collective preventive efforts; by the need for hospitals to closely examine current practice in particular areas; and critically assess processes/systems currently in place. The Department will provide education for hospital personnel in the principles of a systems approach to CRM; and training to undertake root cause analysis.

8.3.2 Infection Control Initiatives

The effective prevention, monitoring and control of infection is the responsibility of managers and all health care workers and is an integral part of the day-to-day quality and safety operations of any health service. It is the responsibility of all health services and hospitals to ensure appropriate development and maintenance of infection control programs and infrastructure in their facilities.

The Government's 5-Point Infection Control Strategy has as its main objectives to:

- develop a coordinated and strategic management approach to infection control in Victorian hospitals;
- improve adherence to staff infection control guidelines;
- establish a Victorian Nosocomial Infection Surveillance System;
- monitor and reduce the emergence of antibiotic resistant organisms and vaccine preventable diseases; and
- improve environmental surveillance.

8.3.3 Infection Control Strategic Management Plans and Equipment Funding

Funding will be provided to Victorian health services and hospitals for the implementation of their Infection Control Strategic Management Plans; for infection control infrastructure and equipment to ensure compliance with key Australian Standards and Infection Control Guidelines; and for operational support. For metropolitan health services this funding has been included in the general Quality Fund. Regional and rural hospitals will receive specified funds for these initiatives through the region, as in previous years. Guidelines for the development of the Strategic Management Plans have been distributed. Health services and hospitals will be required to submit a progress implementation report to be included in their consolidated reporting on quality initiatives. This report should cover each of the 5 key priority areas contained in the Strategic Management Plan: management commitment, leadership and accountability; monitoring infection control and reducing infection rates; prevention of adverse events; protecting health care workers and visitors; and surveillance.

8.3.4 Infection Control Re-Survey

The Department will undertake a re-survey of infection control and sterilisation practices using a new instrument developed in conjunction with infection control and sterilisation experts and experts in survey and research design. The re-survey will start in August 2001. The aim is to evaluate the effectiveness of current infection control programs, policies and procedures in all

acute Victorian public hospitals (and multipurpose centres), and to allow comparisons with key findings of the initial survey conducted in 1996-1997. The re-survey will focus on key areas such as infection control policies and procedures; management roles and responsibilities; cleaning; disinfection and sterilisation of medical and surgical instruments and equipment; surveillance of hospital-acquired infections; staff health and immunisation including adherence to the Immunisation Guidelines; education and training; risk management programs for infection control; maintenance of equipment and facilities; and prevention programs for anti-microbial resistant microorganisms. The instrument will also be made available to agencies so that they can conduct their own evaluation of their infection control programs, policies and practices.

During 2001-2002, there will be consultation with the sector to enable this approach to be extended to sub-acute services.

8.3.5 Prudent Use of Antibiotics

Strategies to address anti-microbial resistance through the promotion of appropriate anti-microbial drug use are an important component of the Government's Infection Control Strategy. Under the 2001 Quality Improvement and Best Practice Funding Round, the Department is funding multi-site collaborative proposals, which aim to improve the prescribing of antibiotics, and the monitoring of their use.

Details can be found on www.dhs.vic.gov.au/ahs/quality/qualfund.htm

Under the 1999-2000 Round the Department funded a three year program to develop a computer assisted decision support system for antibiotic use, which links to National antibiotic guidelines. The program aims to test the system initially in a small, well-defined environment (ICU), with the longer-term aim that the system will be applicable in any hospital and other clinical areas.

8.3.6 Victorian Advisory Committee on Infection Control (VACIC)

The Victorian Advisory Committee on Infection Control held its first meeting in February 2001. This committee replaces the previous Standing Committee on Infection Control (SCIC). VACIC is made up of members from various professional associations and groups, and membership has been broadened from the Standing Committee on Infection Control (SCIC), to include hospital management and consumer representation. The role of VACIC is to provide professional advice and support to the Department on a range of issues involving infection control and prevention in Victoria. Four VACIC sub-committees have been established to work on priority areas, such as surveillance, and infection control education and training.

8.3.7 Victorian Nosocomial Infection Surveillance Centre

In 2001 the Department will launch a Coordinating Centre to provide advice and support for the Victorian Nosocomial Infection Surveillance System (VICNISS). The Centre will eventually receive data and report on public hospital infection rates for all hospitals with more than 100 beds. The system will initially be piloted in ten hospitals. Benchmarked, risk adjusted, aggregated data (for all hospitals with more than 100 beds) will be available within 2 years of the Centre's inception. This will provide the first reliable and meaningful information about Victorian hospital infection rates. A surveillance system for smaller hospitals will be developed and piloted during the initial two years of the Centre's operation.

8.3.8 Improved Cleaning Standards

The *Cleaning Standards for Victorian Public Hospitals* have been distributed to all hospitals and will be reviewed in 2001. \$3 million will continue to be distributed to health services and hospitals

across the State for ongoing monitoring of cleaning standards. For metropolitan health services this funding has been included in the general Quality Fund. Regional and rural hospitals will receive specified funds for these initiatives through the region, as in previous years. Health services and hospitals are required to undertake regular audits of cleaning standards outcomes. Results of the external, random cleaning audit program, which includes audits of all acute Metropolitan public hospitals and a sample of rural hospitals, will be publicly released in 2001.

8.4 Improving Effectiveness

8.4.1 Quality Improvement and Best Practice Initiatives

In 2001-2002, projects funded under the Quality Improvement and Best Practice Program will be in their start-up phases. Projects will run from one to three years in duration, and aim to improve the quality and safety of practices in hospitals and sub-acute facilities through the application of research evidence into systems and practice change.

The program of funding brought together a number of previously discrete quality improvement initiatives in services development, maternity services, sub-acute services, and infection control. All had the underlying aims of reducing adverse events and applying research evidence to improve patient outcomes.

The projects now underway were either identified by health services themselves, or were funded in targeted areas of interest. Projects identified by health services cover a range of topics, focusing on disease management (particularly for COPD and respiratory diseases); clinical care pathways and implementing clinical guidelines; better management of complex medical patients; improving the integration of clinical pharmacy services; and evidence based decision support systems.

Care plans and pathways are being funded to facilitate care across sectors and by different providers. Models that promote multidisciplinary and integrated care are preferred for funding.

Targeted projects were funded under the following areas:

- Prevention of adverse events in older persons in sub-acute facilities
- Improving handwashing practices
- Preventing Adverse Events in Intrapartum Care
- Prudent use of antibiotics
- Preventing transmission of Vancomycin Resistant Enterococci
- Psychosocial support and referral for vulnerable families during antenatal care
- Preventing adverse events in intrapartum care
- Best practice in clinical care plans and pathways
- Using better consumer information to improve patient outcomes

There are clear synergies between the Quality Improvement and Best Practice Program and the Designing Care Program (also launched in 2000-2001). While both programs have different emphases (the Quality Improvement and Best Practice Program emphasises the implementation of research evidence into clinical practice, for instance) both programs have the aims of fostering learning and capacity in the health system to improve practices, processes and quality through applying research evidence and best practice process redesign techniques to the health care system. The Department will be offering joint training and networking opportunities throughout

the year to support collaboration and shared learning between health services involved in both programs, and skills development in critical appraisal, process redesign and project management.

Boards, CEOs and other clinical decision makers may need to consider the synergies between projects funded under the Quality Improvement and Best Practice program and the Department's Designing Care program, and should seek to learn from the experiences of projects funded under both programs. Information about both programs and the projects funded under them will be made available directly and via the Internet.

Boards and CEOs may also need to consider strategies to sustain the outcomes of projects funded under the Quality Improvement and Best Practice Funding Program and to transfer the experiences from their projects to other relevant parts of their organisation.

8.4.2 Maternity Services Program

The Maternity Services Program enters its fourth and final year in 2001-2002. The many positive benefits resulting from the increased focus on maternity services have been confirmed by the recent Review of Maternity Services Enhancement Plans conducted by the Centre for Development and Innovation in Health. It was particularly pleasing to note that service provision has improved for women with special needs and that there has been rapid growth in the provision of postnatal services especially for lactation and domiciliary care. It is now a community expectation that all women receive appropriate post natal domiciliary visits.

In 2001-2002 health services and hospitals will be expected to continue implementing their Maternity Services Enhancement Plans and to actively promote multi-disciplinary collaboration and consultation across maternity services. By the end of 2001-2002 each metropolitan health service and rural region should have in place at least one major model of maternity care that promotes continuity of care. Health services and hospitals should include progress reports as part of their consolidated reporting on quality initiatives.

Strategic initiatives for 2001-2002 include:

- development of options for mainstreaming of Maternity Services Program funding;
- implementation of performance indicators for public maternity services;
- dissemination and publication of the key results of the Survey of Recent Mothers 2000;
- implementation of the collaborative project conducted by the three teaching maternity providers to develop consensus evidence based guidelines for the provision of antenatal care; and
- development of improved consumer information

8.4.3 Services for Koori Women

In partnership with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), recurrent funding of \$0.6 million is provided to support and evaluate a program to enhance existing community based Koori health services in providing additional and culturally appropriate support to Koori women during pregnancy, birth and the postnatal period.

8.4.4 Services for people from non-English speaking backgrounds

The Victorian Government recognises the importance of ensuring that Victorians from migrant and non-English speaking backgrounds have full and fair access to health services. This requires the provision of quality interpreter services and greater sensitivity to linguistic and cultural diversity in the delivery of services, particularly for women and older people.

In 2001–2002, NESB funding will be provided to metropolitan health services through the Quality Fund and to rural services as a specified program grant. The approach to calculating NESB allocations will remain unchanged from the approach adopted for 2001–2002. The calculation is based on data provided via the Victorian Admitted Episodes Dataset (VAED) and regional average proficiency in English (ABS). Work will progress in 2001–2002 to develop a suitable performance indicator for access to services for people from culturally and linguistically diverse backgrounds.

Two new and one renamed ethnicity identifier ('First Language Spoken', 'Proficiency in Spoken English' and 'Birthplace of Person') were to be included on the VAED as of July 2001. This follows rigorous developmental work involving the Australian Bureau of Statistics, the Council of Ministers of Immigration and Multicultural Affairs. While it is recommended that all national and state administrative data collections which require information of cultural and linguistic diversity adopt a combination of three data items, the implementation timetable has been delayed at the national level. Further advice will be given on a new timetable for implementation. The aim is to measure and monitor service needs (access and equity requirements), and to provide a measure of cultural diversity in its broader sense. In the longer term it will enable funding to be allocated more appropriately to reflect service needs.

Hospitals have recently provided information on their language services and culturally appropriate service provision and need to consider reporting on these issues in their Quality of Care reports.

8.5 Improving Continuity

8.5.1 Hospital in the Home (HITH)

Since its introduction into Victorian public hospitals, demand for HITH continues to grow with service expansion treating more patients and new conditions. Patients who meet the eligibility criteria can access HITH from 43 acute hospitals around the state. The Department will continue to encourage the use of HITH by hospitals and quality improvement for HITH services. Casemix payments for patients treated in HITH will continue. For metropolitan health services incentive funding for HITH has been included in the general Quality Fund. Regional and rural hospitals will receive specified program funds as in previous years. Allocations will be based on 2000–2001 inpatient days, excluding same days but including chemotherapy. Additional allocations will be made to health services and hospitals exceeding the average substitution rate for the Program, which is 4.9 per cent for the period July 2000 to February 2001. Further details are in *Section B - Conditions of Funding*.

Across the State \$1 million will be made available for:

- quality improvement grants that were funded for an 18 month period in 2000–2001;
- specific rural regional grants to enable rural HITH providers to address common issues collaboratively; and
- the Victorian Centre for Ambulatory Care Innovation.

The Department will consider ways to assist hospitals implement the recommendations of the Patient Management Taskforce and support the development of guidelines for HITH in emergency services, the use of new technology, and will establish performance benchmarks for commonly treated conditions in HITH.

8.5.2 Effective Discharge Strategy

The Effective Discharge Strategy began in 1998-1999. Every acute hospital, sub-acute service and Multi Purpose Service was provided with funds to develop and implement a three year discharge improvement plan. Two patient record audits were conducted to assess documented evidence of discharge activities and hospitals that performed well received performance bonuses. A General Practitioner Register developed by General Practice Divisions Victoria was completed and piloted with funding from the Commonwealth Department of Health and Aged Care and Victorian Department of Human Services.

In 2001-2002, \$8 million statewide will be distributed to health services, according to their number of separations, for discharge process improvement and measurement of performance. For metropolitan health services this funding has been included in the general Quality Fund. Regional and rural hospitals will receive specified funds for this initiative, as in previous years.

1. Discharge Process Improvement

Health services, hospitals, sub-acute services and MPS are expected to develop a discharge improvement plan for the last two years of the strategy, with particular emphasis on ensuring that improvements made over the life of the Strategy are sustainable. Emphasis should also be on collection and reporting of data for the performance indicators and working collaboratively with GPs and other community providers, and patients and their carers.

2. Measuring Performance

Performance of health services, hospitals, sub-acute services and MPS will be measured in relation to four performance indicators of effective discharge. Health services will be required to report by July 2002 on measurement of these indicators in a sample of patient records. The sample will be drawn by the Department and provided to health services. As this will be the first year of implementation of the indicators, funding will not be tied to performance against these indicators. However, all hospitals will be provided with information on their own performance and comparative information on the performance of other hospitals.

3. Statewide Initiatives

During 2001-2002, various activities with a statewide application will begin, including:

- evaluation of the strategy;
- demonstration projects for use of the Enhanced Primary Care MBS items to involve GPs in discharge planning;
- cost benefit analysis of follow-up of patients post discharge;

Further details are in *Section B - Conditions of Funding*.

8.5.3 Post Acute Care (PAC)

The Post Acute Care Program continues to be funded as a separate program throughout the State. Post acute care funds will not form part of the metropolitan health services Quality Fund. The Acute Health Division and the Aged Community and Mental Health Division jointly fund the PAC program. The budget for the program in 2001-2002 is \$15.5 million. The program has statewide coverage and all eligible patients discharged from acute public hospitals and sub-acute services are eligible for the service. In addition, PAC services can be provided to patients presenting to Emergency Departments to prevent their admission to hospital.

The objectives of the PAC program are to:

- provide additional post acute services for individuals to assist those who recuperate;
- improve care planning and continuity of care for patients following their discharge from hospital;
- work collaboratively with hospitals to provide support to patients as an alternative to inpatient admission from the emergency department; and
- assist hospitals and sub-acute services to maximise use of beds for patients who require hospital services.

The PAC program provides short-term interventions designed to meet the needs of patients. As such there is no defined length of stay in PAC, nor maximum cost per patient, nor set unit costs. For sub-acute patients, PAC may be provided in the interim period until ongoing continuity services can be provided.

All PAC Services are required to have an Advisory Committee with representatives of major referring hospitals and community providers. This will ensure that a range of interests are represented, not just those of the auspice body.

As in 2000-2001, additional funds will be available for PAC Services for DVA clients. Details are available in the *Section B - Conditions of Funding*. Further negotiations will be undertaken with TAC and WorkCover for coverage of their clients.

9 Improving Rehabilitation and Sub-Acute Services

9.1 Service Profile

Victoria's sub-acute service system has both an inpatient and community focus on rehabilitation, restorative care and community support. Sub-acute services comprise inpatient care in Extended Care Centres and in dedicated sub-acute units within acute hospitals, together with a range of specialist ambulatory care services, and home based care.

Sub-acute inpatient services include rehabilitation; geriatric evaluation and management (GEM); geriatric respite; and non-acute care/nursing home type services.

In 2001-2002 funds will be made available on a pilot basis to develop and evaluate a small number of discrete interim/transitional care units. Work will occur during 2001-2002 to consider the effectiveness of the new interim/transitional care units and examine their costings. Depending on the extent of longer term growth and resource equalisation in the Commonwealth residential aged care program, it is possible that the need for interim/transitional care may lessen over a 3-5 year period.

Sub-acute ambulatory care services, known as specialist clinics, extend and complement the inpatient services. Specialist ambulatory clinic services include 45 community rehabilitation clinics and specialist clinics for continence; falls and mobility and pain management.

9.1.1 Interaction of Acute and Sub-acute services for Older People

There is a strong correlation between age and demand for medical and hospital services. Currently 55 per cent of public hospital beddays are utilised by older people. The expansion of the sub-acute service system has enabled older people to be admitted directly to sub-acute care, or to be transferred to sub-acute care from either emergency departments or inpatient acute settings. Increasingly, the provision of sub-acute care is also instrumental in deferring entry to residential care for older people with chronic illness or severe disability.

9.1.2 Service Planning

Planning aims to ensure that sub-acute services are made available across Victoria, with a focus on equity of access and choice in range of services. The current Review of Sub-Acute Services in Victoria will consider the ongoing relevance of the existing planning benchmarks as well as the current environment of increasing numbers of people waiting in acute hospitals or sub-acute services for residential care.

9.2 Funding of Sub-Acute Services: Inpatients

The Department has spent a time over recent years working with the field to move the funding of sub-acute services progressively towards output based funding. This work will continue in 2001-2002 with:

- The full implementation of the VicRehab funding model for "designated" specialised rehabilitation services with 20 beds or more;
- The development of a new CRC funding model prior to partial implementation (via a shadow budget) in 2002-2003;

- Consultation with the field on the development of alternative funding models for GEM;
- An evaluation and costing study for interim/transitional care.

9.2.1 Rehabilitation Funding—VicRehab

In 2001-2002 funding for designated units will move from a historically based bed-day system to payment on an inpatient episode basis. General rehabilitation services will continue to be funded through the AR-DRG casemix funding arrangements. Specialised rehabilitation services funded through the VicRehab funding model include:

- Austin and Repatriation Medical Centre
- Ballarat Health Services-Queen Elizabeth Centre
- Barwon Health-Grace McKellar
- Bendigo Health Care Group-Anne Caudle Campus
- Bundoora Extended Care Centre
- Caulfield General Medical Centre
- Goulburn Valley Health
- Kingston Centre, including Hampton Rehabilitation Hospital
- Latrobe Regional Hospital
- Mount Eliza Aged Care & R.S
- Melbourne Extended Care & Rehabilitation Service
- Peter James Centre
- Royal Talbot Rehabilitation Centre
- St George's Health Service
- St Vincent's Hospital
- Sunshine Hospital.

Essentially this new model categorises patients into 17 groups according to clinical and functional levels (CRAFT). Payments are provided for weighted units, short stay patients (overnight stay from 1-3 days), and same day patients. The new system provides incentives to management to assess and review lengths of stay and encourages the adoption of the average or industry standard. The introduction of a patient based and financially targeted system will improve equity in funding and efficiencies in patient management. It is also likely to improve patient coding and reporting. For rehabilitation episodes the expected or inlier range has been set at plus or minus 4 days from the mean. As with DRG payments, stays shorter and longer than the inlier time, will be funded according to outlier policies. Budgets have been shadow modelled for the past two years and targets have been set in consultation with the agencies. Details are provided in *Appendix 3* and in *Section B - Conditions of Funding*. The early development of the system is outlined in *VicRehab - Rehabilitation Classification and Funding Systems: Options Paper* circulated to the industry in 1998.

Payments are also based on the level of the rehabilitation service provided.

- Level 1 services (for example, spinal, amputation and head injury).
- Level 2 services (for example, stroke, orthopaedic, neurological).

Designated units with less than 20 beds will continue to receive the per diem based budget.

Section A - Modelled Budgets outlines the budgets for the 17 designated units and for each Metropolitan Health Services and rural region. Targets include weighted units, beddays for specified grants and veterans' targets. These targets, with the exception of veterans', are capped for the next year at Metropolitan Health Services and rural regional level. The targets are given in *Section A - Targets*. Details relating to DVA patients are outlined in *Section B - Conditions of Funding*.

9.2.2 Sub-Acute Bedday Rates (non-CRAFT)

The bedday per diem rates for 2001–2002 are:

Table 9: Sub-Acute Bedday Rates, 2001–2002

Stream of Care	Per Diem rate 2001-2002
Rehabilitation Level 1	\$419
Rehabilitation Level 2	\$348
Geriatric Evaluation & Management	\$348
Geriatric Respite / Nursing Home Type	\$137
Interim/Transitional Care	\$240

Bedday targets for 2001–2002 have been established for each stream of care and the summary is provided in Chapter 19. Targets are established for both DVA (estimates) and non-DVA services capped for the year.

The Rehabilitation bedday rates outlined above apply to those hospitals (i.e. less than 20 rehabilitation beds) that are not covered by the new VicRehab funding system. These bedday rates will be reviewed and the possibility of change towards an episode-based payment will be considered.

9.3 Funding of Sub-Acute Services: In Home and the Community

Sub-acute services must be responsive to the needs of patients, carers and family, so a number of flexible funding arrangements have been established. These arrangements support continuity of care between the hospital and community and allow for substitution of inpatient services with home or community based care, where this is clinically and socially appropriate. The Acute Health Division must approve funding under the following programs.

The Division will work with the field during 2001-2002 to streamline the number of separate community and home-based sub-acute-in-the-home programs and develop consistent funding and accountability measures:

9.3.1 Geriatric Evaluation and Management (GEM) patients only

- a) Unassigned Bed Funds are available for geriatric evaluation and management services only to allow agencies the flexibility to purchase additional professional short term support services for patients who would otherwise need admission to acute or sub-acute care; and to those who could be discharged earlier from sub-acute care provided that inpatient level care can be continued for a time limited period in the community.

Services are limited to a 28 day provision and will be interventionist or directed to the provision of active support and direct services rather than ongoing care and maintenance.

Patients treated with unassigned funds are not included as admitted patients, nor are beddays included in either targets or reported actuals.

- b) Continuum of Care: two sub-acute services have converted a limited number of beddays to be considered as Continuum of Care services. This provides another form of flexibility by allowing hospitals to cash-in geriatric evaluation and management beddays for community services.

The community services are counted on a 1:3 ratio, meaning three occasions of service provided in the community, including the patient's home, equate to one bedday for funding purposes where these services are provided by staff of the hospital.

Patients treated under a Continuum of Care program are not to be included as admitted patients. Services are to be reported through the Agency Information Management System (AIMS).

9.3.2 Community Rehabilitation Clinics

The 2001–2002 budgets for Community Rehabilitation Clinics (\$27.8 million) have been determined based on the 2000–2001 budget. Service activity targets for 2001–2002 are measured by 'CRC place'. A place is considered to represent a full day place or a full day of treatment. A full day place may be utilised by more than one individual, depending on the operating style of the centre.

CRC places are calculated on the assumption that one full day client utilises one full day place, two sessional clients utilise one full day place and six single therapy clients utilise one full day place. For the first time, for 2001–2002 the Division has developed throughput targets for DVA clients of CRCs.

The department is currently reviewing the designation of CRCs to ensure all services are provided at the appropriate level.

9.3.3 Specialist Clinics

Sub-acute specialist clinics comprise: continence clinics, falls and mobility clinics and pain management clinics. They are funded by a block funding grant determined at the commencement of each year (see *Section B - Conditions of Funding*).

10 Health Services working with their Communities

10.1 Metropolitan Health Services Community Advisory Committees

In 2001-2002, Metropolitan Health Services Boards will be working with their Community Advisory Committees to develop strategic Community Participation Plans. These plans will provide information on how the Metropolitan Health Services will communicate with and integrate the views of their consumers and communities into all levels of governance, planning and service delivery in their health services. They should be informed by audits of current community participation activities, and suggest strategies to progress work into further areas.

Ongoing training and support for Health Services and Community Advisory Committees will be provided through the Health Issues Centre, which has been funded by the Department to assist with the implementation of Community Advisory Committees, in accordance with the non-statutory guidelines published by the Department in November 2000.

Metropolitan Health Services Boards should seek the views of their Community Advisory Committees when compiling their Annual Quality of Care Reports, and when designing their dissemination strategy, and evaluating the 2000-2001 Report.

They should also consider how to integrate and support the work of Community Advisory Committees, both financially and administratively.

10.2 Primary Care and Population Health Advisory Committees

In 2001-2002 Primary Care and Population Health Advisory Committees to Metropolitan Health Services Boards will be working to enhance hospital integration with the primary care service system and to support hospital engagement in population health initiatives. The aim is to improve the experiences of consumers using acute and primary care services, as well as improving the health and wellbeing of the broader community.

The Department will continue to work with Metropolitan Health Services to review the need for and nature of guidelines for these committees as well as defining their links with Community Advisory Committees.

10.3 Reporting to the Community on Quality of Care

Health Service and Hospital Boards are now required to report annually to their communities on the quality of care delivered within their institutions. The first reports covering activities in the 2000-2001 year are due in September for metropolitan health services and in October for regional hospitals. The Annual Quality of Care Report for the 2001-2002 year must be published by October 2002 at the latest, although it is expected that metropolitan health services and regional hospitals will aim to publish these reports earlier in the year to coincide with publication of their general annual report. For rural hospitals, this will be their first report.

Emphasis in the reports should be on the results and outcomes of quality monitoring and quality improvement initiatives. Relevant performance indicators and other information on each of the

key areas within the Quality Framework should be included. All performance indicators should be accompanied by a commentary, understandable to a lay reader, which explains what the indicator measures, how any figures should be interpreted, and how the indicator is used by the health service. Information must be published in a form that protects patient confidentiality. Clinicians, consumers and community groups should be involved in the process of developing appropriate content and presentation of information within the reports. In late 2002, the Minister will again present Public Reporting Awards for the best annual report in each of the following three categories: metropolitan health service, regional, and rural.

10.4 Patient Experience

Patient perceptions of their hospital care have been surveyed in Victoria, using 'one-off' or 'point-in time' surveys since the introduction of casemix funding in 1993. Use of the Patient Satisfaction Monitor to continuously survey patient experiences of care began in Victorian acute care hospitals in September 2000. The Monitor will provide regular, ongoing monitoring and reporting of patient satisfaction in key areas of service delivery in Victoria. Hospitals will have information that can inform their quality improvement initiatives and will also have data that compares their performance against other like hospitals.

The Monitor is conducted by way of a mail-out self-completion questionnaire. The key indices of care to be reported on are access/admission; general information; treatment information; physical environment; complaints management; and discharge/follow up. There are 27 questions within these indices that are all weighted equally.

The surveying process is underway. All participating hospitals are required to:

- Have in place a process to distribute a *Patient Information Sheet* and *Refusal to Participate Form* to all inpatients during the surveying period;
- Ensure any ineligible patients are excluded from the sample data;
- Provide the sample data to the consultant (Category A/B hospitals quarterly sampling and category C/D/E and MPS monthly).

Each hospital participating will receive reports on the results of the survey. All data will be risk adjusted for age, overnight/same day status and public/private status. Category A/B/C hospitals will receive reports 6 monthly & category D/E/F & MPS annually.

Training workshops will be held following the release of the first annual hospital reports to assist quality managers interpret and use the results of the survey.

10.5 Provision of Consumer Information

Provision of good quality information for consumers, allowing them to make decisions about their health care based on the best available knowledge of effectiveness and safety, should be a high priority for all health services. During 2000-2001, a project titled Assessing the Quality of Consumer Information was funded to assess the quality and relevance of information provided by Victorian public hospitals to consumers in six health conditions. This produced a series of publications on Communicating with Consumers. These are available on the Department

website (www.dhs.vic.gov.au/ahs/quality/effect.htm). In 2001-2002 the Department will continue to support initiatives to improve the availability of quality evidenced-based information.

11 Service Development

11.1 Trauma

The Victorian state trauma system covers three Major Trauma Services (The Alfred, the Royal Melbourne Hospital and the Royal Children's Hospital) and is supported by two levels of trauma and injury management services in metropolitan Melbourne and three levels in regional Victoria. It is overseen by the Ministerial Emergency and Critical Care Committee, and its subcommittee, the State Trauma Committee.

There are five Regional Consultative Committees on Emergency and Critical Care Services each with a Regional Trauma Coordinator, to manage the development and implementation of regional trauma plans, the monitoring of regional trauma data and the provision of trauma education.

In addition, the Victorian Trauma Foundation provides advice to the Transport Accident Commission (TAC).

11.1.1 Funding initiatives

WIES utilised in the treatment of TAC patients is uncapped. For all hospitals, with the exception of the three Major Trauma Services, the baseline WIES payment from the Department and the associated revenue paid to the hospital by TAC is included in private patient revenue targets.

Separate payment terms will be arranged with the three Major Trauma Services.

A trauma appropriateness payment of \$2,000 per patient will be paid to a metropolitan referring hospital (\$3,000 for rural hospitals) for each trauma patient appropriately referred to a Major Trauma Service, for both TAC and non-TAC trauma patients.

11.1.2 Service Initiatives

In 2001-2002 the Department in conjunction with the State Trauma Committee and key stakeholders will enhance work already undertaken in the areas of:

- Establishing and maintaining a comprehensive monitoring system to support quality improvement processes, peer review, system monitoring and evaluation;
- Targeted educational strategies for trauma and emergency staff;
- Communications systems enabling rapid referral and transfer advice to anywhere in the state from the Major Trauma Services;
- Trauma System implementation and development in rural and regional Victoria;
- Dedicated trauma research.

11.2 Breast Care Redevelopment

The Breast Disease Service Redevelopment Strategy 1999–2003 was developed by the Department and the Breast Care Implementation Advisory Committee to provide a framework to improve breast care services in Victoria over five years.

The Strategy aims to achieve a sustainable integrated statewide system, which delivers equity of access to the highest quality breast services for all Victorians, and which meets the needs of women with breast cancer and benign disease at all stages of their care. The overall direction involves recognition of breast disease as an area requiring a level of specialisation, implementation of best practice, improving access to services, particularly in rural areas, and facilitating a coordinated approach to service delivery.

A dedicated unit, the BreastCare Victoria Coordination Unit, oversees the implementation, monitoring and evaluation of the Strategy.

11.2.1 Breast Services Enhancement Program

The Breast Services Enhancement Program is a quality improvement initiative, which fund nine demonstration models to develop, trial and evaluate best practice models of service provision. The Program commenced in 1998-1999. Four consortia of public and private providers in metropolitan areas, and a regionally coordinated collaboration of service providers in each of the five rural regions are participating in the program.

A broad range of strategies have been successfully implemented, including the establishment of new multi-disciplinary review processes in both metropolitan and rural settings; the piloting of breast care nurse coordinators; the development of clinical pathways and treatment protocols; and the development of mechanisms to enhance information, communication and continuity of care.

The BreastCare Unit has also funded the development and evaluation of a number of local projects to improve clinical practice and consumer outcomes. These initiatives arose from the consultation processes of the respective models. Many of these initiatives are being evaluated for their potential to be extended and implemented on a statewide basis.

In 2001–2002, \$1.4 million will be allocated to special projects including:

- Further development of a database to enhance breast care nurse practice;
- Enhancement and evaluation of lymphoedema services, including early intervention initiatives;
- Developing evidence-based education programs for GPs and cancer nurses;
- Facilitation of consumer involvement in breast service development;
- Information packages for consumers and practitioners, including web-based directories;
- Further development and evaluation of multidisciplinary care strategies;
- Further development of the Breast Care Nurse role in metropolitan and rural settings; and
- Developing strategies to address the psychosocial needs of women with advanced breast cancer.

11.2.2 Strengthening support for women with breast cancer

In addition to the Breast Services Enhancement Program, the Victorian Government, through BreastCare Victoria, is working collaboratively with the Commonwealth to improve supportive care for rural and remote women diagnosed with breast cancer. The Strengthening Support for Women with Breast Cancer (SSWBC) Program has an emphasis on developing sustainable improvements for women living in rural and remote areas. BreastCare Victoria has opted to develop an integrated program with a primary focus on e-health.

11.2.3 Statewide priorities for breast care

A further \$1.6 million will be allocated to developing and implementing a range of statewide priority initiatives, some of which commenced over the last two years. These include:

- Developing a statewide data management program for breast care services to facilitate monitoring and accountability for patient management and service delivery;
- Working collaboratively with the National Breast Cancer Centre to facilitate the implementation of evidence-based clinical practice guidelines and research into practice;
- Implementing strategies to enhance information and support to patients, particularly in the area of Ductal Carcinoma In Situ;
- Evaluation of the Breast Services Enhancement Program as a mechanism for achieving system-wide change;
- Developing strategies to facilitate continuity of care across acute and community health settings; and
- Implementing the recommendations of studies on breast prostheses and the Breast Care Nurse workforce.

In summary, key strengths of the Breast Disease Service Redevelopment Strategy include a strong focus on evidence-based practice, the extent of consumer involvement at all levels, the development of services in rural Victoria and the collaborative nature of the program.

12 Emergency Services and Non-Admitted Patients Funding

12.1 Non-Admitted Emergency Patient Funding

Non-admitted patients are seen in the emergency department of hospitals and in outpatient clinics. Funding for the non-admitted component of emergency departments is provided through a special grant. This grant is based on staffing and activity data to reflect the “availability” component of emergency services. Funding for emergency services is provided through a variety of sources including multi-day and same day WIES; the Training and Development Grant; the Hospital Demand Management Strategy; bonus funding in the Quality Fund; and specified grants to specific hospitals. This grant is only one component of emergency services funding.

An Emergency Services Categorisation and Funding Taskforce, which comprises departmental, industry and independent experts reviews staffing and activity data and categorises hospitals annually for the purposes of establishing funding levels. A major review of the scope of the non-admitted emergency services grant and the method of calculation commenced in 2000-2001.

A forum attended by experts from the field was held in November 2000, as the first stage of the review. The major issues discussed at the forum included the extent to which role delineation should be introduced; the need for the funding model to respond to changes in emergency service practice; the data requirements and data quality issues; and the balance between availability and output components.

Subsequently, a study has been commissioned of the overall costs at emergency departments at individual hospitals; how costs are attributed by individual hospitals, and the availability costs of particular ancillary services, e.g. on-call radiography. The study commenced in April 2001 and the results will be considered for possible introduction in 2002-2003.

12.1.1 Funding for 2001-2002

In view of the timelines associated with the review of the non-admitted emergency services grant, hospital emergency services will be funded as for 2000-2001 with an additional \$10 million for hospitals nominated as part of the Hospital Demand Management Strategy. The results of the Review and possible changes will be provided to hospitals in 2001-2002. Implementation of any changes will not occur until 1 July 2002.

Table 10: Non-Admitted Emergency Services Categorisation & Notional Funding Levels, 2001-2002

Categorisation	Funding (\$'000s)	Hospitals
E1	\$9,036.6	Alfred, Austin and Repatriation Medical Centre, Monash Medical Centre, Royal Melbourne
E2	\$5,625.2	Box Hill, Dandenong, Frankston, Geelong, Northern, St Vincent's, Western (Footscray)
E3	\$3,930.9	Ballarat, Bendigo, Maroondah
E4	\$2,259.0	Angliss, Goulburn Valley, Latrobe Regional
E5	\$1,694.4	Mildura, Wangaratta, Warrnambool
E6	\$1,129.6	Central Gippsland, Hamilton, Sandringham, Swan Hill, West Gippsland, Williamstown, Wimmera, Wodonga
E7	\$564.8	Echuca, Bairnsdale
E9	(Specialist)	Royal Children's (\$4,518.2), Sunshine (\$3,162.9), Royal Victorian Eye & Ear (\$2,259.0), Royal Women's (\$1,129.6), Mercy – East Melbourne (\$790.9)

12.2 Outpatients – Victorian Ambulatory Classification System

General and specialist services in outpatient and emergency departments play a key role in the health care system and represent a vital service and interface between inpatient and community care. The Victorian Ambulatory Classification System (VACS) covers all Group A hospitals, and Ballarat Health Services and the Bendigo Health Care Group. In 2001-2002 the total outpatient budget for Victoria (excluding DVA) will be \$413 million. The total number of medical and surgical encounters for the calendar year was 1,100,268 plus 468,820 (excluding DVA) allied health occasions of service.

VACS targets including DVA targets and reporting details are given in *Section A - Targets*. Budgets are capped as outlined in *Section A - Modelled Budgets*. For 2001-2002, the VACS cost weights have again been determined on the basis of a 'four year rolling average cost', smoothing fluctuations in average cost, which have been noted in some VACS categories, and ensuring greater stability in the system.

The components of the non-admitted patient grant for 2001-2002 are outlined in *Chapter 4 Summary of 2001-2002 Payment Rates*. Further details on the development of VACS, the definition of the 'encounter' and the ambulatory funding model, including the base grant and teaching component, are outlined in the publication *Victorian Ambulatory Classification and Funding System – VACS, September 1998* (<http://www.dhs.vic.gov.au/ahs/vacs/index.htm>).

The VACS Clinical Panel has evaluated all new and reviewed clinics notified by hospitals to the Department during 2000-2001. Hospital specific clinic schedules for 2001-2002 have been set and hospitals will be advised of changes to their individual clinic schedule by August 2001. The current process of notification of clinic changes will continue during 2001-2002. The closing date for notification of clinic changes, to be considered for the 2002-2003 funding year, is 28 February 2002.

12.3 Non-Admitted Patient Radiotherapy

Non-admitted patient radiotherapy services will continue to be funded under the existing model, which is comprised of

- a) A variable payment per Weighted Activity Unit (WAU) up to a target number at each provider;
- b) A payment for associated department costs per Weighted Activity Unit (for allied health services, patient transport, patient accommodation and staff education);
- c) A specified grant (for SXRT, DXRT, Brachytherapy and Stereotactic Radiosurgery); and
- d) A growth payment for public patient services.

Each provider's overall WAU target for 2001-2002 will be composed of-

- A **private** Weighted Activity Units (WAU) target that will be capped at the 2000-2001 target level; and
- A **public** WAU target that will continue at the 2000-2001 level or increase by four per cent where the 2000-2001 actual WAU level is greater than target.

The variable payment total per WAU (including payment for associated department costs) has been increased to \$160 per WAU for 2001-2002. The specified grants paid to providers for specialist services will be indexed.

Based on available data, the WAU level has increased by 2 per cent in 2000-2001. A decline in private and DVA services has been offset by an increase in public patient services.

Payments will continue to be made subject to a transmission of a data report (AIMS Form 111-S8) from each centre.

The National Radiotherapy Single Machine Unit Trial, that was agreed to by the Commonwealth Department of Health & Family Services and the Department during 1999-2000, aims to assess whether Single Machine Units can improve access to, and utilisation of radiotherapy services for Victorian rural patients, whilst maintaining standards of care which are clinically and socially acceptable. It is recognised that there are currently no radiotherapy services available locally in these areas.

Both the Ballarat and Bendigo sites are expected to commence services in early 2002.

13 Research/Training & Development

13.1 Research Funding

Victoria is recognised as a leader in the field of medical research in Australia. Research infrastructure grants are provided to the major teaching hospitals as part of the Training and Development Grants and \$15 million will be allocated in 2001–2002. The review of the Training and Development Grant undertaken during 2000–2001 is likely to recommend that the research infrastructure component be funded separately in future. This recommendation will be the subject of consultation during 2001–2002.

In September 1998, additional funding of \$10 million per annum over five years was negotiated through the Australian Health Care Agreement to further support medical research and teaching in all Victorian public hospitals. These funds will be continued and allocated as a specified grant, calculated on the same basis as for 2000–2001.

A greater emphasis is being placed on accountability and the manner in which hospital based research funding is spent. This is consistent with the strategic directions for medical and public health research and development in Victoria outlined in *Investing in Health*.

The Bio-Medical Research Support Program, administered by the Public Health Division of the Department currently provides over \$12 million in operational infrastructure funding support for medical research institutes. These funds are allocated on a performance basis according to the amount of competitive, peer-reviewed program or project grant income received by each institute from recognised sources. Eligibility for access to Departmental operational infrastructure support will be aligned with the modernised policy recommended by the Strategic Health Research Investment Committee.

Further recurrent funding in excess of \$2 million, managed by the Public Health Division, continues to be provided for Public Health and Health Services Research initiatives. In addition, \$3 million per annum is provided for the Victorian Breast Cancer Research Consortium. Capital funding for medical research institutes will continue to be considered on an annual basis as part of the Department's overall capital program, in the context of the Government's Science, Technology and Innovation initiative.

13.2 Training and Development

Training and Development Grants are paid to hospitals to recognise the additional costs of hospitals which conduct teaching, training and research activities. Training and research activities are linked inextricably to clinical hospital services. The funding program also represents a compensatory payment for the greater case complexity of teaching hospitals.

A review of the Grant commenced in February 2001 and is due for completion in July 2001. Pending the outcomes of the Review, the Training and Development Grant funding provided to hospitals for 2001–2002 will in aggregate remain at 2000–2001 levels. Individual payment rates have been adjusted to allow for increased numbers of some categories of subsidised staff (e.g. graduate nurses) and to allow key initiatives.

The Review is examining the structure of the Grant and has identified three principal components to the current funding arrangements that need to be addressed - early graduate training; workforce policy initiatives; and the level to which the grants provide compensation for increased case complexity. Research infrastructure support, which is currently provided under the umbrella of the existing grant arrangements, is likely to be funded separately in future. Consideration is being given to the funding and administrative arrangements surrounding each of the three principal components.

Following completion of the Review, the Department will provide advice regarding the future directions for the Grant. In the interim, cognisant of the need to address some significant workforce issues, a component of the Grant will be directed to a number of strategically significant initiatives. These initiatives will include: the newly established Rural Clinical Schools, the Postgraduate Medical Council of Victoria, the Victorian Universities Rural Health Consortium, additional training opportunities for nurses and an expanded program of support for medical specialist trainees in rural areas and a continuing education project for allied health professionals. In order to provide funding needed to support these initiatives, rounding of rates for all positions will be introduced, a new funding rate will be established for Postgraduate certificates in nursing that will reflect their difference from Postgraduate diplomas (to commence in 2002) and small adjustments will be made to the subsidies for registrar positions.

For 2001–2002, payments will continue to be made only for positions and staffing approved or otherwise recognised by the Department. Detailed definitions of the payment conditions for Training and Development Grants are included in *Section B – Conditions of Funding*.

Table 11: Training and Development Grant Payments, 2001–2002

Training and Development Grant	Rate per EFT
Medical Postgraduate Years 1, 2 and 3	\$34,500
Accredited Registrars	\$34,500
Clinical Academic Staff	\$40,200
Grade 1 Registered Nurses	\$12,600
Postgraduate Certificate Nurses	\$ 5,700 (a)
Postgraduate Diploma Nurses	\$11,500 (a)
Postgraduate Midwifery Nurses	\$ 5,000
Pharmacy Trainees	\$24,700
Medical Radiation Interns	\$24,400
Medical Biophysics Trainees	\$13,800
Physiotherapists Grade 1, Year 2	\$14,400
Occupational Therapists Grade 1, Year 2	\$14,400
Speech Pathologists Grade 1, Year 2	\$14,400
Medical Laboratory Scientists	\$11,700

(a) This rate may vary depending on the number of places to be made available next calendar year.

13.2.1 Medical

The Grant provides subsidisation for pre-vocational positions for Postgraduate Years 1, 2 and 3, Registrar positions and Clinical Academic staff. Pending the outcomes of the Review, the number and distribution of positions funded under the Grant will generally remain the same as in 2000–2001. The number of Intern (Postgraduate Year 1) positions funded will continue to be based on the number of Victorian medical graduates seeking places in Victorian hospitals and included in the computer matching process administered by the Postgraduate Medical Council of Victoria.

Pending the Review's recommendations regarding the degree of importance of linkages between the funding, accreditation and processes for allocation of Postgraduate Year 2 (PGY2) positions, funding for the PGY2 positions in 2002 will be distributed to positions included in the computer matching process and based on 2000-2001 numbers.

13.2.2 Nursing

This component of the Training and Development Grant covers Graduate Nurse Programs, Postgraduate Nurse Programs, Student Midwives, continuing nurse education and rural supplements. For Graduate Nurse Programs, Student Midwife and Postgraduate Programs, approval must be sought from the Department for any increase in numbers over and above approved numbers submitted at the start of the 2001 academic year.

In 2002, funding rates for Postgraduate training will differentiate between Postgraduate diplomas and Postgraduate certificates. The rate will reflect levels of demand for these programs and advice will be provided to hospitals by the end of 2001 on the exact rates.

The pool of funds available for the continuing nurse education initiative will be reduced in the 2002 academic year in order to assist in funding the large increase in the numbers of graduate and Postgraduate nurses. Hospitals will be notified of the funding levels prior to the commencement of the 2002 academic year, which will be dependent on the recommendations of the review. Funding identified to support the Rural Midwifery Upskilling Program will be unchanged.

A supplement of \$250 per nurse is available upon application to rural hospitals that offer specialist nursing courses in collaboration with a university to support costs incurred by nurses who must undertake a clinical placement a significant distance from the hospital where they are employed. Due to consistently low uptake the provision of this supplement is under review by the Nurse Policy Branch.

13.2.3 Allied Health

The Grant currently subsidises, to varying degrees depending on the professional group, positions filled by first year allied health graduates, as well as providing a small amount of support for undergraduate placements. Undergraduate placements supported include audiology, dietetics, health information management, orthoptics, occupational therapy, pharmacy, physiotherapy, podiatry, prosthetics, radiation science, social work and speech pathology. The industry based learning scheme which encompasses medical biophysics and medical laboratory sciences, continues as in previous years and is not included within the allied health undergraduate component.

Pending the outcome of the review of the Training and Development Grant, funding for first year graduate positions will remain as for 2000-2001. The undergraduate allied health component of the Grant will be allocated through the same process as previous years, with 10 per cent of the existing undergraduate allowance (\$1 million) allocated to allied health undergraduate teaching and supervision.

14 Major Initiatives in Information Technology

14.1 Replacement of Homer patient administration systems

The key challenge for the health system will be managing the tactical replacement of the Homer Patient Administration Systems, which has been necessitated by product withdrawal from the market, effective December 2002. Replacement of these systems will affect 22 sites across Victorian public hospitals, including 6 teaching hospitals. Replacement of the finance module of Homer will also impact on many hospitals. At present there are no standardised financial systems in hospitals, nor resource planning and scheduling systems. The Department will take a lead role in this process of replacement.

14.2 I2T2 Strategy Funding

2000-2001 was the last of the original four years of I2T2 Strategy Funding. Supplementary funding has been approved in 2001-2002 and 2002-2003 in recompense for the impact of Y2K on the strategic planning and investment in information technology across the state.

In 2001-2002 the Department will allocate \$10 million to hospitals, to be primarily targeted at tactical replacement of systems or continuation of local strategies. This amount will reduce and finish at \$5-6 million in 2002-2003.

14.3 Growing Victoria – Information Infrastructure

Capital funding of \$30 million over a 3-year period has been approved for telecommunications and technology infrastructure for the health sector. Acute and ACMH Divisions will jointly manage funding of targeted and agreed infrastructure projects to support integrated care between public hospitals and Primary Care Partnerships, and within Primary Care Partnerships.

14.4 Change Management Education and Training (CMET)

The statewide CMET forum will continue monthly to exchange information on successful and unsuccessful change management experiences and projects. The rotation of venues will continue to ensure that all members have opportunity to visit sites and meet participants in local projects. In 2001-2002, hospitals will be asked to submit projects for the fourth round of CMET program funding. Funding of \$1 million will again be available and broadly allocated according to relative activity and size of organisation.

14.5 Clinicians Health Channel

Through the National Health Development Fund, the Department will continue to fund development and implementation of the Clinicians Health Channel. The final year of funding for the \$10 million 5 year program is 2002-2003.

14.6 Designing Care

The National Health Development Fund has provided \$5 million over an 18-month period for a structured and supported program of process improvement projects, using the Designing Care framework and methodology. The Designing Care program finishes in June 2002.

15 Special Grants

In 2001–2002 specified grants will continue to be paid to compensate hospitals for services which do not fall neatly into inpatient or outpatient service arrangements, and for classes of hospital care which DRGs do not measure well. The following specified grants will be retained with some modifications in 2001–2002:

- Heart and Liver Transplants;
- Neonatal Intensive Care Unit (NICU);
- Spinal Injuries;
- Neonatal Cardiac Surgery;
- Paediatric Cardiac Investigations;
- Paediatric Weights;
- Intensive Care Complexity (DRG A06Z); and
- Cystic Fibrosis.

For many small hospitals annual variations in casemix and cost weights resulted in significant fluctuations in WIES Targets. This is an effect that a relatively small number of patients can have on hospitals with very low WIES numbers. Budgets for Group D and E hospitals will be adjusted where necessary through the provision of specified grants to address this variation.

The Ministerial Review of Health Care Networks recommended that the Acute Health Division should review and minimise the list of specified grants requiring separate control and acquittal to minimise acquittal requirements and funding adjustments. This has been done for selected grants such as Continuous Positive Airways Pressure and Home Enteral Nutrition and several grants administered under the Quality program.

15.1 Removal of Capped Block Grants

15.1.1 Continuous Positive Airways Pressure and Home Enteral Nutrition

In 2000-2001 funding for each of the Home Enteral Nutrition and Continuous Positive Airways Pressure programs will be provided as part of the VACS base grant which has been adjusted accordingly.

15.1.2 Victorian Artificial Limbs Program

The capping of budgets for specific treatments is contrary to the general principle aligned to WIES based funding wherein clinicians make allocative decisions based on clinical priorities. In 2001-2002 the previous agency budgets for these programs have been rolled into and added to the individual agency's budgets.

The effect of this policy change will be to eliminate the caps on expenditure, enable the payment to be competitive to providers and to ensure that treatment priorities are determined at the clinical level.

Further details are given in *Section B - Conditions of Funding*.

15.2 Higher Payment for Aboriginal & Torres Strait Islander Patients

In 2001–2002, the WIES9 formula will continue to provide an additional payment for Aboriginal and Torres Strait Islander (ATSI) patients. All ATSI patients will be funded at 10 per cent higher than the usual WIES9 payment.

The introduction of additional funding provides an added incentive for hospitals to provide appropriate, high quality care and to ensure that these patients are identified in reporting to the VAED. The Department is committed to improving the recording of Aboriginality in its health data collections. In accordance with this commitment, the Department will monitor the accuracy of recording Aboriginality in the VAED and any increases in the reporting of Aboriginal and Torres Strait Islander admissions following the provision of increased funding.

In 2000–2001, the number of ATSI patients comprised 0.50 per cent of total hospital admissions compared with 0.64 per cent in 1998–1999 and 0.70 per cent in 1997–1998.

15.3 Mechanical Ventilation Co-Payment

The mechanical ventilation co-payment was introduced in 1996–1997 as a sound and clinically valid surrogate for patient severity. In some DRGs, mechanical ventilation is inherent to the episode of care and therefore only selected DRGs attract the additional payment. These arrangements continue for 2001–2002. All DRGs, including DRG A06Z, attracting the co-payment are listed in *Section C – Supplementary Information*.

The WIES9 mechanical ventilation co-payments are:

- 0.7729 WIES9 per eligible day on mechanical ventilation; or
- 3.1323 WIES9 per eligible neonate episode on mechanical ventilation.

To be eligible for the co-payment the patient must:

- Have been ventilated for at least six hours (or 96 hours for DRG A06Z);
- Be admitted to a hospital with a recognised intensive care unit (ICU); and
- Be allocated to a DRG which is eligible for the co-payment.

Analysis shows that the move to AR-DRG Version 4.1 DRGs and the new cost weights increase funding to ICU patients by about 2 per cent (\$5 million). Specific additional WIES have also been allocated to a number of hospitals to allow for growth in ICU bed numbers. Funding for intensive care has been extensively assessed over the past few years. Future work will stress the necessity of improving underlying hospital-wide costing systems rather than limited marginal cost analysis.

15.4 Thalesaemia

Thalesaemia cases were demonstrated by costing data to require more resources than other patients within relevant DRGs. For 2001–2002 each thalesaemia case in DRGs Q61A, Q61B and Q61C will continue to receive a co-payment of 0.2648 WIES. These WIES will be part of the hospital's WIES target and general funding arrangements.

15.5 Cystic Fibrosis

Cystic Fibrosis (CF) is a lifelong chronic illness that requires high levels of individual care on an outpatient and inpatient basis. There are three specialist providers of care in Victoria: Royal Children's Hospital; Alfred Hospital; and Monash Medical Centre. The additional specified grant for allied health services at the Alfred, Royal Children's Hospital and Monash Medical Centre which was introduced for the 1999-2000 financial year will be continued in 2001-2002. Payments will continue to be made on the basis of outpatient allied health activity levels and subject to the submission of quarterly activity reports.

The Department established a CF Expert Advisory Committee mechanism to enhance quality of care for a period of one year, and this will be superseded by a self managing statewide coordinating group.

Details are provided in *Section B – Conditions of Funding*.

15.6 Victorian Maintenance Dialysis Program (VMDP)

During 2000-2001 the average number of patients receiving maintenance dialysis treatment in Victoria grew by about 6 per cent. The treatment modality experiencing the highest growth was Continuous Ambulatory Peritoneal Dialysis (CAPD). In-Centre dialysis grew slightly faster than satellite dialysis. Home haemodialysis was the only treatment modality to experience a decrease.

Victorian maintenance dialysis services will continue to be funded under the two-tier payment model, comprising a case payment and a program grant.

For 2001-2002 WIES targets have been set for maintenance dialysis, which are included in the global WIES targets of each provider. Advice will be forwarded to each provider stating these. All maintenance dialysis WIES will be funded to actual. The rationale for this change is to ensure that dialysis funding 'follows the patient' by removing WIES constraints to patients undertaking long term dialysis treatments within reasonable distances from their home or workplace.

Unutilised dialysis WIES are not substitutable for other services and a revision will be made of the targets.

The variable payment and capitation payment rates for 2001-2002, adjusted for award increases (exclusive of ANF and AMA 2000-2001 EBAs), CPI and productivity savings are outlined in the table in *Section B – Conditions of Funding*.

The VMDP budget has been increased by 8 per cent. Subsequent to discussions in past years and the more recent consultation with providers for the purpose of informing the (in-process) Review of Maintenance Dialysis Services in Victoria, improved arrangements between parent and satellite services have been reported. Principled negotiations between parent and satellite providers continue to be required, in order to achieve/maintain fair, documented and transparent arrangements in relation to the program grant administered by parent providers. Whilst these matters are raised in the Review and it is anticipated that these will be addressed jointly with the Renal Reference Group, the Department can be invited to mediate where parent and/or satellites request this.

All reporting will continue to occur through the Victorian Admitted Episodes Dataset (VAED) and the Agency Information Management System (AIMS) and it is intended to commence a coding audit of maintenance dialysis in late 2001-2002.

16 Development of the Cost Weights and WIES

16.1 AR-DRG Version 4.2

2001–2002 sees the introduction of AR-DRG Version 4.2; the latest national grouper. Version 4.2 corrects a number of anomalies identified in Version 4.1 and is based upon ICD10-AM Version 2 coding standards. This means that for the first time in several years clinical details do not require ICD mapping and can be put directly into the grouper software.

16.2 Development of Cost Weights

The Department engaged KPMG to conduct the 2000–2001 Victorian Cost Weights Study of 1999–2000 inpatient, outpatient and rehabilitation activity. A review of all average costs was undertaken and the proposed areas of change were considered both through the Cost Weights Study itself and through formal Departmental consultations. A full list of weights is given in *Section C – Supplementary Information* and a full explanation of WIES9 is given in *Section C – Calculation of WIES*. The scope of the 2000–2001 cost study was increased from the previous year to include three additional hospitals and data for the entire year for all hospitals.

While the number of rehabilitation hospitals supplying data to the 2000–2001 cost study increased, clinical costing systems that provide accurate and reliable patient costing are yet to be fully implemented for rehabilitation care in most services. Some rehabilitation cost data have been collected from a small number of acute hospital rehabilitation units. These data have been used in developing CRAFT cost weights.

16.3 Calculation of Inlier Boundaries: Trim Points

To reduce the level of variation between WIES8 and WIES9, inlier boundaries were set at the 2000–2001 values (WIES8). The exception to this rule was for those DRGs where the move from AR-DRG Version 4.1 to AR-DRG Version 4.2 resulted in a change in the average length of stay for the DRG of more than 0.5 days. In these cases inlier boundaries were recalculated based upon the 2000–2001 cost study data, using the WIES8 algorithm but with a revised average length of stay.

16.4 Same Day DRGs

Version 4.1 DRGs that were classed as same day DRGs in 2000–2001 have been treated as same day Version 4.2 DRGs. In addition, a small number of additional DRGs were classed as same day DRGs, based on recommendations arising from KPMG's analysis of the 2000–2001 cost study data.

The Victorian Clinical Casemix Committee expressed concern that differential same day payment rates could lead to perverse incentives to keep patients in hospital overnight. However, they recognised that it is often inappropriate to pay same day patients at the full inlier rate; consequently, differential same day rates were necessary within the payment schedule. The

Committee indicated that same day policy and the setting of same day payment rates should be reviewed during 2001-2002.

For designated same day DRGs the same day weight is based on the actual average cost of same day patients rather than costs modelled from the inlier weight. The same day and one day DRGs are listed in *Section C – Supplementary Information*.

16.5 Calculation of Inlier Weights

As in previous years, the weights were calculated from the average costs of inliers but based upon the new inlier boundaries. Trimming was undertaken according to the criteria used for the 2000–2001 Victorian Cost Weights Study. In calculating weights, the following additional adjustments were made:

- The Victorian Cost Weight Study provided data for patients receiving acute care. Where there were no cases in AR-DRG4.2 within the 2000-2001 cost study, the weights were based on the costs reported for patients with similar DRGs, for example the weight for V61A was set based on V61B;
- The average costs of some DRGs were increased to adjust for prosthetic costs. The 2000–2001 policy of reducing the average cost of key intensive care DRGs to fund ICU related specified grants by 1.38 per cent has continued for 2000–2001;
- As in earlier years a number of strategies were undertaken to increase the statistical reliability of the weights and to reduce the impact of unexplained cost variations. These included using multiple years data to calculate average costs and/or average lengths of stay for inlier boundary calculations and also increasing or decreasing specific DRG weights based on financial modelling;
- Two years data were used to calculate average costs for the purposes of weight calculations where there were fewer than 150 inliers and the average inlier cost for 1999–2000 differed by more than 20 per cent from the 1998–1999 average cost. For a number of DRGs using two years data still resulted in significant variation between years. Three years data were not routinely used to calculate average costs in variable DRGs because data from three years ago were collected in ICD9-CM and required mapping to ICD10 for allocation to Version 4.2 DRGs. The appropriateness of the mapping algorithm for low volume DRGs was uncertain. Further, the current applicability of data from three years ago was also questioned. However, three years data were used where it was recommended by either the Victorian Clinical Casemix Committee or the KPMG Cost Study Consultants and where the move to Version 4.2 did not result in significant numbers of patients changing DRGs;
- Two years data were also used to calculate weights where there were more than 150 inliers, or where the consultants undertaking the 2000-2001 Cost Weight Study or the Casemix Clinical Committee suggested that multiple years data be used;
- Weights were scaled where financial modelling showed that for adjacent DRGs: WIES9 differed by more than 10 per cent from WIES8 and where that difference represented at least 500 WIES9; or where WIES9 differed by more than 20 per cent from WIES8 and that difference represents at least 200 WIES. Exceptions included:
 - Multiple organ transplants were scaled up by 1.80 to maintain funding equivalence with other organ transplant DRGs as recommended by the Victorian Casemix Clinical Committee;
 - In order to provide additional funding for high cost ICU cases the weight for DRG A06Z was reduced by 10 per cent to compensate for the mechanical ventilation co-

payment rather than 20 per cent required to fully fund the co-payment for this DRG;

- For complicated craniotomy (DRGs B02A, B02B) the average cost from the 2000-2001 Cost Weight Study was increased by 20 per cent.
- All weights were subjected to rebasing to maintain statewide WIES equivalence between WIES versions. This was done by calculating both WIES8 and WIES9 on the same twelve months' VAED dataset and then scaling all WIES9 weights by the ratio of total WIES8 to total WIES9. Agreed target WIES8 levels were adjusted by similar hospital specific indices to derive WIES9 targets.

16.6 High Outliers

High outlier weights have been adjusted to ensure that, when using Metropolitan Health Services payment rates, variable payments for high outlier days are at least \$213 per day and no more than \$819 per day. High outlier weights were calculated using the relevant specific high outlier adjustment factor. In general surgical DRGs were allocated a high outlier factor of 0.7, medical and other DRGs were allocated a high outlier factor of 0.8. Some specialist DRGs were allocated a high outlier factor of 1.0 or even higher to recognise the high cost of the patient concerned.

As the costs associated with prostheses and theatre are usually incurred early in a patient's stay, these costs are excluded when calculating high outlier WIES for DRGs with significant theatre and prosthesis costs.

During 2000-2001 the Department reviewed the appropriateness of the high outlier factors used in deriving the high outlier per diem rates. Regression analysis suggested that in general medical patients were under weighted and surgical patients were over weighted. However, budget modelling suggested that the overall impact of changing the high outlier payments would be minimal. Further, both the Victorian Casemix Clinical Committee and the Victorian Advisory Committee on Casemix Data Integrity questioned the appropriateness of increasing payments for long stay medical patients and recommended high outlier factors be retained at last year's value pending further analysis.

16.7 Prostheses Adjustments

Historically, prostheses costs have been poorly allocated to patients within hospital information systems. In many cases, costs associated with prosthetic devices are recorded and allocated across all DRGs as operating room costs. Consequently, since WIES4, adjustments have been made to increase the reported average price for a number of DRGs where prosthesis costs were known to be significant. Data collected from the National Costing Study, Service Weight Study and data from two Victorian Hospitals were used as a basis for making these adjustments. Extra costs were partly balanced by reducing theatre costs across most surgical DRGs.

The methodology in 2000-2001 used to adjust DRGs with low prostheses costs was again applied for 2001-2002. This methodology is based on an estimate of the proportion of patients receiving a prosthesis and the average prosthesis cost for public patients with reported prosthesis costs in hospitals with appropriate prosthesis costing modules. This year the Department used data from hospitals that had significant prostheses costs for high cost prosthesis. Hospitals with a reported prostheses expenditure of less than sixty per cent of their expected expenditure based cost study

average results were excluded when calculating average prostheses costs. Average costs from individual hospitals were compared to ensure that large numbers of atypical prostheses cases from individual hospitals did not significantly bias results.

During 2000-2001 hospitals had raised issues relating to the rapid increase in prostheses costs, in part due to large movements in the value Australian dollar. The Victorian Advisory Committee on Casemix Data Integrity (VACCDI) supported the concept of adjusting prostheses costs within the cost study data in line with the most recent prices movements. VACCDI members supplied the Department with document evidence of prostheses manufactures increasing prices by between five and twenty per cent. Consequently, the Department inflated prostheses costs by 10 per cent prior to calculating the 2001-2002 cost weights.

16.8 Private Patient Adjustments

During 2000-2001 concern was raised by a number of hospitals about the potential for private patients to inappropriately lower the cost weights for specific DRGs. This would occur because many of the costs of caring for private patients are not borne by the hospital but by other agencies (Medicare, Private Health Insurance etc). Where the medical, diagnostic/imaging and pathology costs were lower for private patients than for public patients and resulted in lowering the overall mean by more than 0.5 per cent, DRG average costs were increased to adjust for these lower costs prior to calculating weights.

The Department considered the option of excluding all private patients from the data used to calculate weights. This approach was rejected because basing the weight purely on public patients assumes no legitimate differences occur in the costs of treating public and private patients within a DRG. This assumption is unlikely to be valid given the observed demographic differences between private and public patients.

16.9 Changes to Mechanical Ventilation Co-payments

Over the past several years the Department has focused on improving the funding formula to more appropriately fund the most severely ill patients by increasing the scope of mechanical ventilation payments to adults. In developing WIES9, the Department examined ways to more precisely fund for the most severely ill neonates.

When the mechanical ventilation severity co-payment was first introduced for older children and adults, the Department was advised that mechanical ventilation was not a good proxy for severity amongst neonates. Industry comment has suggested that since that time, CPAP (Continuous Positive Airways Pressure) has become increasingly used within neonatology and mechanical ventilation has become increasingly restricted to the most severely ill neonates. Further, analysis demonstrated that major (Level 3) neonate hospitals are more likely to ventilate neonates with highest costs of care. Consequently, for 2001-2002 the mechanical ventilation co-payment has been extended to all neonates admitted to designated Level 3 neonate hospitals.

This initiative replaces the previous co-payments for DRGs P06A and P06B. In addition some specified grants associated with high outlier neonates have been subsumed into the WIES formula. Despite these changes the overall impact of this change is to significantly increase funding to neonates.

16.10 Data Quality & the Victorian Admitted Episodes Dataset (VAED)

The success and fairness of casemix funding is based on accurate and valid reporting of clinical information. Earlier VAED Audits (previously called Coding Audits) were conducted on 1993-1994, 1995-1996 and 1998-1999 data.

The 1999-2000 VAED Audit, divided into random and follow-up components, involved re-coding by external auditors of clinical, administrative and demographic data items from nearly 9,000 records selected from 55 hospitals. Results for the random component showed that 90 per cent of the audited episodes were allocated to the same AR-DRGs and that overall, hospitals' original WIES7 values were about 0.3 per cent lower than the level achieved with the audited codes. Importantly, assessment of those episodes resulting in a different WIES7 value indicated that they were evenly balanced between 'overcodes' (4.8 per cent) and 'undercodes' (5.4 per cent). These results are not 'statewide' results, because not all hospital groups were covered, however they compare more than favourably with the outcomes of previous Victorian studies, and recent audits conducted in other States, and substantiate the Department's strongly positive view of the validity of coding in Victorian public hospitals.

For 2000-2001 VAED data, follow-up and supplementary audits will be conducted in addition to the annual random audit. Follow-up audits are being conducted where the 1999-2000 audit identified possible coding anomalies, that is where the hospital's change in WIES7 exceeded plus or minus 2 per cent and/or the change in AR-DRGs exceeded 15 per cent. Supplementary audits are being conducted where both the hospital's 1998-1999 random and 1999-2000 follow-up audit results were outside the accepted parameters. The cost of supplementary audits, VAED data correction and WIES adjustment will be borne by the hospital.

The random component of the 2000-2001 audit will re-examine 7,700 separations from 56 sites, the follow-up audit 1830 separations from 4 sites, and the supplementary audit 700 separations from 7 sites.