

***Victoria—Public Hospitals and
Mental Health Services
Policy and Funding Guidelines
2002—2003***

June 2002

Acknowledgments

Victoria – Public Hospitals and Mental Health Services Policy and Funding Guidelines 2002-2003, Victorian Government Department of Human Services Melbourne Victoria

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Message from the Minister

The rebuilding of Victoria's public health system will continue in 2002-2003 with a \$960 million increase over four years to treat more patients, employ more nurses, reduce hospital waiting lists and improve mental health services, and upgrade hospital buildings and equipment.

The 2002-2003 State Budget has increased recurrent funding for public hospitals by 8.2 per cent while funding for mental health services has increased by 11.6 per cent over 2001-2002. The Budget builds on the successful Hospital Demand Management Strategy introduced last year that has more than halved ambulance bypass and reduced waiting lists.

Over the next four years the Hospital Demand Management Strategy will be enhanced by a further \$464 million. Medical equipment and hospital infrastructure will be significantly upgraded through additional funding of \$65 million and Victoria's medical research institutes will receive \$35 million to maintain their leading role in medical research. Hospitals will be assisted to fund superannuation and purchase medical supplies through additional funding of \$169 million. Community mental health services such as mobile support and treatment teams and supported housing services will receive additional funding of \$36 million, \$25 million (included in the Hospital Demand Management Strategy) will be provided to open more mental health hospital beds, and for new diversionary services.

Major capital works will be undertaken in metropolitan and rural and regional Victoria to continue the redevelopment and expansion of Victoria's health facilities, part of a \$900 million commitment to health capital works in the Bracks Government's first three budgets.

This Budget continues the turn around of Victoria's public hospital and mental health systems, with better facilities, new approaches and more health workers to give Victorians the highest possible quality of care.



Hon John Thwaites MP
Minister for Health

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The Government's Policy Framework

In November 2001, the Government released *Growing Victoria Together*, a statement about its priorities for the next ten years. This statement expresses the Government's broad vision for the future and balances economic, social and environmental goals.

Victoria 2010: A Vision for Victoria

The Government's vision for Victoria is that by 2010 we will be a State where innovation leads to thriving industries generating high quality jobs, protecting the environment for future generations is built into everything we do, we have caring, safe communities in which opportunities are fairly shared, and all Victorians have access to the highest quality health and education services all through their lives.

To make this vision a reality the Government has identified strategic issues that are important to Victorians, along with key priority actions needed to address them.

The issues and priority actions for health are:

- high quality, accessible health and community services
- sound financial management
- growing and linking Victoria
- building cohesive communities and reducing inequalities
- protecting the environment for future generations
- promoting rights and respecting diversity

For more information about *Growing Victoria Together* go to www.growingvictoria.vic.gov.au

Department of Human Services

The mission of the Department of Human Services is to protect and enhance the health and wellbeing of all Victorians, emphasising vulnerable groups and those most in need.

To assist the Department achieve its mission and to address the strategic issues identified by Government, six organisational objectives have been developed.

These are:

- achieving benchmark waiting times
- improving service quality
- building sustainable and efficient services
- building strong communities and primary services
- increasing the proportion of family or community based service responses
- reducing inequalities in health and wellbeing and improving access to services

This document provides an overview of the Government's overall policy for health including mental health services for 2002-2003. It details the Government's funding initiatives, programs and budget allocations to individual public hospitals, together with expected outputs and reporting requirements. This enables agencies to have a clear understanding of the Government's health policies and the detail of the Department's funding programs to enable them to formulate timely budgets and harness resources to implement the program.

Section A — Policy

1 Highlights of the 2002–2003 Policy

Funding

- The total funding to Victoria's hospitals and mental health services is \$5 billion in 2002-2003, an increase of \$398 million from 2001-2002, with \$202 million of additional funding allocated in this year's Budget. The additional funding will be allocated to the Hospital Demand Management Strategy (\$113 million), financial sustainability (\$60 million), upgrading biomedical equipment (\$20 million), and improving and expanding mental health services (\$15 million, of which \$6 million is included in the Hospital Demand Management Strategy).

Hospital Demand Management Strategy (\$113 million)

- The new approach to the management of hospital demand emphasising changes in clinical practices will continue in 2002-2003. The key elements are:
 - Funding growth with an additional 19,360 WIES for agreed hospital initiatives.
 - Extra funding of \$20 million for improved clinical practices that divert patients from acute to sub-acute, interim care, short stay, palliative care and community based options where appropriate.
 - Preventing admissions by improving the management of people with chronic conditions, the elderly and frequent users of emergency services, under the Hospital Admission Risk Program.
- This year elective surgery will be targeted with additional funding provided for initiatives to reduce elective surgery patient waiting times and waiting lists. Further clinical innovations will increase the rate of day surgery and day of surgery admissions (DOSAs) to free capacity to treat additional patients. A new model of referral for rural and metropolitan health services will be implemented with particular emphasis on ophthalmology, orthopaedic and plastic surgery patients.
- As a result of the Hospital Demand Management Strategy there will be 30,000 extra patients treated, an increase of 2.9 per cent.
- In 2002-2003 extra funding of \$6 million will be provided for strategies that improve patient management practices in emergency departments, taking into account best practice developments in overseas emergency care. These may include streamed emergency care, improved discharge practices (for example better access to allied health or a focus on weekend discharge) and fast track multidisciplinary triage.

Capital and Equipment

- A significant commitment has been made to continuing the renewal, expansion and refurbishment of the health services asset base of the State. Funding has been allocated to redevelopment of a number of major metropolitan hospitals to expand services, better manage emergency demand and ensure facilities meet current standards of operating and functional efficiency. The extensive program of refurbishment and redevelopment of rural health and aged care facilities will continue with a major funding injection in this budget.

Financial sustainability

- The Government will also support the ongoing viability of the public hospital system with funding of \$60 million in 2002-2003 to meet increased costs associated with medical and pharmaceutical supplies and consumables (\$12 million), and employer superannuation costs (\$48 million). The Department will undertake a targeted review

of four selected metropolitan health services. Target B has been eliminated and one full price WIES introduced with rural adjustments.

Mental Health

- The Budget provides new funding of \$15 million in 2002-2003 (\$6 million of which is included in the Hospital Demand Management Strategy) for growth in Mental Health Services including:
 - \$4 million to re-open approximately thirty acute inpatient psychiatric beds to address projected demand growth in 2002-2003.
 - An additional \$6.32 million is provided to expand elements of the non-acute mental health system. This will provide growth for adult clinical community services, aged clinical services and Psychiatric Disability Support Services.
 - \$2.76 million for pilot projects to trial models of sub-acute service provision in metropolitan areas. A total thirty short-stay sub-acute places will be involved in the pilot projects.
 - \$1.16 million to provide additional clinical and support services to fifty clients living in Office of Housing properties and to assist the implementation of the Supported Rooming House Project.
 - \$0.76 million for rural workforce initiatives and Dual Diagnosis services for young people with a drug abuse problem.

Rural and Regional Health Services

- Initiatives in 2002-2003 will include \$5 million in growth funds for rural and regional hospitals. Greater flexibility will be introduced in funding and purchasing for small rural hospitals and \$4.5 million will be allocated to enhance access of rural patients to elective surgery and for other rural initiatives.
- Services in rural and regional Victoria, employing innovative models of service delivery, will be funded to a total of \$3 million. New programs will include new clinical programs for asthma sufferers in Geelong, the establishment of a rural allied health team operating from Warrnambool, expanded community rehabilitation centres in Wodonga and Seymour and a new oncology service in Kilmore.

Breast Disease Strategy

- In 2002-2003, \$3 million will be provided for the continued implementation of the Breast Disease Service Redevelopment Strategy. The nine statewide breast care demonstration projects will continue to promote and implement best practice, with a focus on evaluation and sustainability. A consumer focused Breast Cancer Resource Centre will also be established.

Improving Quality

- Quality Framework funding will be provided to health services in anticipation of their participation and contribution to agreed quality activities, timely and accurate data provision and continuing support for performance indicator development and implementation.
- Working with health services to improve the safety and quality of care will continue to be a strong focus of the Department. The Victorian Quality Council has been established and a three year strategic plan has been developed. The Council will be working on six specific areas over the next year.
- Annual Quality of Care Reports will continue to provide consumers and community members with information about the quality activities and outcomes of the health service.

2 Strategic Directions and Policy Outcomes

2.1 Policy Outcomes

2002-2003 continues the commitment of funding to ensure access to high quality public hospitals and to better manage increased patient demand. The major policy outcomes will be:

- Managing emergency and elective demand;
- Financial sustainability of hospitals and funded agencies;
- Improving quality of services;
- Implementing the new Mental Health Strategy; and
- Nurse recruitment and retention.

2.1.1 Managing Emergency and Elective Demand

The Hospital Demand Management Strategy introduced in 2001-2002 has changed clinical practices in the assessment and treatment of patients admitted through emergency departments. The introduction of diversionary and prevention measures, such as greater use of sub-acute, interim care and community care options, have enhanced patient flows and prevented unnecessary admissions. The primary policy outcomes expected for 2002-2003 will build on this base and include:

- A target of no more than 1,800 ambulance bypasses system-wide
- 95 per cent of emergency patients requiring admission being admitted within 12 hours
- All triage Category 1 emergency patients seen immediately
- All Category 1 elective patients admitted within 30 days
- 5 per cent reduction in the percentage of Category 2 patients waiting more than 90 days
- 10 per cent reduction in the average waiting time of Category 2 patients
- The number of patients on the elective surgery waiting list to be at or below 40,000 by 30 June 2003
- The percentage of elective surgery admissions treated as same day as agreed with hospitals

For elective surgery, prioritisation techniques for selected specialties are being developed and a possible new four category system will be assessed this year.

The monthly targets set for each of these indicators, and the bonuses payable upon their achievement, are contained in the *Hospital Demand Management Strategy Business Rules 2002-2003*. In addition a range of key activity indicators will be monitored on a monthly basis and these, in conjunction with monthly performance indicators, will form the basis of regular monitoring and review meetings involving Metropolitan Health Services and the Department.

2.1.2 Financial Sustainability

Sound financial management is essential to the viability of hospitals and health services. In 2002-2003 the major initiatives in this priority area will be:

- Creation of a Financial Management and Review Unit to assist selected Metropolitan Health Services to improve their financial performance.

- Reduced use of agency nurses in conjunction with greater employment of full time and hospital “bank” staff.
- Centralised purchasing by Health Purchasing Victoria.
- The funding of WIES at full rates rather than rates based on marginal cost of additional throughput.
- Initiatives to encourage the maximum collection of revenue from private patients.
- Additional funding for superannuation and increased costs of medical and pharmaceutical supplies due to the low Australian dollar.
- Development of commonality in the definitions and use of the chart of accounts across hospitals in order to facilitate cost comparison and benchmarking across hospitals and to identify system-wide cost pressures.
- Continuation of clinical practice changes such as those implemented as part of the Hospital Demand Management Strategy.
- Optimum use of Commonwealth funding, including the joint pharmaceutical reform.

2.1.3 Quality

The Victorian Quality Council (VQC) was established in October 2001 to undertake a statewide role in fostering quality and safety in health services in Victoria. It aims to work with stakeholders to identify and act on opportunities for improvement.

Working Groups have been set up to review current strategies and provide advice on falls prevention, pressure wounds, infection control, appropriateness of care, blood and blood product safety and appropriateness, and medication safety.

The 2002-2003 Clinical Indicator Program will focus on progressing the work already undertaken by the Department, Professional Colleges and hospitals in developing and trialling clinical indicators to support a comprehensive system of quality monitoring, analysis and action. The Department will continue to collect clinical indicators to provide benchmarking opportunities and statewide comparisons for Metropolitan Health Services and public hospitals.

2.1.4 Mental Health

Hospital Demand Management Strategy funding for hospital-based mental health services includes \$6 million to meet the increased need for acute inpatient services for the mentally ill and to assist people being treated in the community through better diversion, prevention and early intervention programs. The release of a new Mental Health Strategy in mid 2002 will give further direction to new services and programs including increased collaboration between services to better treat people with complex needs.

2.1.5 Nurses

2002-2003 will see the full implementation of the Nurses (Victorian Health Services) Award 2000 improving nurse-patient ratios, wages and conditions for the nursing workforce. The Government’s recruitment and retention initiatives will result in a further seven hundred nurses and other health workers being employed in Victoria’s hospitals.

2.2 Activity Trends

Demand for public hospital services continues to grow, with an estimated 35,000 more admitted patients in 2001-2002 than in the previous year. Emergency admissions account for more than half the increase in patients in Victoria's public hospitals with an estimated increase of 5.3 per cent in 2001-2002. Emergency admissions to the major metropolitan hospitals grew by an estimated 8.4 per cent in 2001-2002 and account for 97 per cent of the total increase in emergency patients across the state. This concentration of demand requires specific initiatives to increase capacity and manage demand through innovative substitution and prevention programs. The Hospital Demand Management Strategy introduced in 2001-2002 is progressively implementing strategies to redesign patient processes and relieve emergency inpatient pressure.

Between 1999-2000 and 2000-2001 the total number of registered clients in the public mental health system rose by 6.6 per cent. The area of greatest growth has been in adult services where the numbers of registered clients rose by 9.3 per cent between 1999-2000 and 2000-2001. Similar increases in demand are reflected in the Psychiatric Disability Support Services, which also focus on adult clients.

Table 1: Activity Trends 1999-2000 to 2001-2002 (estimated) Victoria

	1999-2000	2000-2001	2001-2002 (estimated)
WIES Fundable Separations	977,527	1,002,932	1,037,978
Increase over previous year (no.)	41,879	25,405	35,046
Increase over previous year (%)	4.3%	2.5%	3.4%
Emergency Separations	320,092	341,633	360,855
Increase over previous year (no.)	12,534	21,541	19,222
Increase over previous year (%)	3.9%	6.3%	5.3%
WIES 9	769,089	768,507	785,972
Increase over previous year (no.)	19,087	-581	17,464
Increase over previous year (%)	2.5%	-0.1%	2.2%

Source: Victorian Admitted Episodes Dataset (VAED), Department of Human Services. Activity refers to WIES fundable separations only. Data for 2001-2002 based on annualisation of data to February 2002.

Note: This table excludes WIES equivalent activity in specialised inpatient services such as the Alfred Road Trauma Unit, AIDS units and healthstreams conversions. In 2000-2001, WIES numbers including WIES equivalent were 788,800.

Table 2: Activity Trends - Major metropolitan hospitals 1999-2000 to 2001-2002 (estimated)

	1999-2000	2000-2001	2001-2002 (estimated)
WIES Fundable Separations	500,054	516,275	546,747
Increase over previous year (no.)	23,837	16,221	30,472
Increase over previous year (%)	4.8%	3.1%	5.6%
Emergency Separations	189,421	204,549	223,221
Increase over previous year (no.)	12,504	15,128	18,672
Increase over previous year (%)	6.6%	7.4%	8.4%
WIES 9	420,484	419,400	436,794
Increase over previous year (no.)	14,782	-1,084	17,393
Increase over previous year (%)	3.5%	-0.3%	4.0%

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

Activity refers to WIES fundable separations only.

Data for 2001-2002 based on annualisation of data to February 2002.

The major metropolitan hospitals are: The Alfred, Angliss Health Services, Austin & Repatriation Medical Centre, Box Hill Hospital, Dandenong Hospital, Frankston Hospital, Maroondah Hospital, Monash Medical Centre, Northern Hospital, Royal Melbourne Hospital, St Vincent's Hospital, Sunshine Hospital, Western Hospital.

Table 3: Activity Trends Mental Health Services, 1999-2000 to 2001-2002 (estimated) Total Victoria

	1999-2000	2000-2001	2001-2002 (estimated)
Total Number of Registered Clients	50,154	53,443	56,600
Increase over previous year (no.)	2,002	3,289	3,157
Increase over previous year (%)	4.2%	6.6%	5.9%
Child & Adolescent	10,188	10,381	10,600
Increase over previous year (no.)	899	193	219
Increase over previous year (%)	9.7%	1.9%	2.1%
Adult	31,722	34,658	37,400
Increase over previous year (no.)	929	2,936	2,742
Increase over previous year (%)	3.0%	9.3%	7.9%
Aged	8,244	8,404	8,600
Increase over previous year (no.)	174	160	196
Increase over previous year (%)	2.2%	1.9%	2.3%
Number of PDSS clients	8,265	9,097	9,200
Increase over previous year (no.)	1,050	823	103
Increase over previous year (%)	14.5%	10.1%	1.1%

Data sources:

Prism Records Information System Manager (PRISM) 1999-2000

Redevelopment of Acute and Psychiatric Information Directions (RAPID) 2000-2002

Victorian Psychiatric Disability Support Services Minimum Dataset 1999-2000 to 2001-2002

2.3 Victorian Budget Details

In 2002-2003, the total operating budget for acute, sub-acute and mental health services has increased by \$398.3 million over the 2001-2002 budget, to a total of \$5,055.8 million. The budgets for acute, sub-acute and mental health services are given in Table 4.

Table 4: Victorian Budget Details

	2001-2002	2001-2002	2002-2003	Variation ^(b)	
	\$m Budget ^(a)	\$m Revised	\$m Budget	\$m	%
Acute Health Services (Including Sub-Acute Services)	4130.2	4249.6	4467.3	337.1	8.2
Mental Health	527.3	563.4	588.5	61.2	11.6
Total	4657.5	4813.0	5055.8	398.3	7.5

Source: Department of Treasury and Finance, Budget paper No. 3, p.61

^(a) 2001-2002 Output Budget incorporates changes to Output structure and organisational restructuring and therefore may differ from figures published in the 2001-2002 Budget.

^(b) Variation between 2001-2002 and 2002-2003 Budget.

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 \$36 million. Wage EBAs not yet agreed, such as the AMA and HSUA No.1 and No.5, are not included. The budget figures provided in Table 4 include all these items and represent the net outcome.

2.4 Funding Intensive Care

Subsequent to the publication of the 2001-2002 policy a new mechanical ventilation co-payment was introduced. All patients eligible for a mechanical ventilation co-payment received an additional “one time” payment of 0.6980 WIES to enable flexibility to respond to peak periods. This additional payment shall continue to apply in 2002-2003.

A review of mechanical ventilation co-payment arrangements undertaken in 2001–2002 found that while co-payment rates were adequate, small reductions were required to weights in DRGs with significant ICU costs to prevent double payment through the cost weights and the mechanical ventilation co-payment.

The Neonatal Intensive Care Unit (NICU) mechanical ventilation payments were introduced in 2001-2002 as a temporary measure until better measures of complexity among neonates were identified. Discussions during 2001-2002 indicated some support for the introduction of a CPAP (Continuous Positive Airways Pressure) based severity measure. CPAP hours will be introduced as a mandatory field in the VAED for major NICU hospitals in 2002-2003. This will allow the Department to model various funding options prior to the introduction of the 2003-2004 policy.

2.5 Quality of Care

Funding for a number of quality and safety programs has been incorporated into the Quality Framework in 2002-2003, which has been revised in light of the strategic focus on hospital demand and waiting list management. Improving quality of care will be furthered by reporting back to health services on their performance to enable benchmarking. There will also be a focus on disseminating information learnt through the quality improvement projects. Innovating service delivery will continue to be encouraged through supporting and extending proven initiatives and through Breakthrough Collaboratives.

2.6 Mental Health Services

The overall objectives of mental health services are to lessen the impact of mental illness on individuals and the community, to manage the growing demand for mental health services, to reduce relapse and readmission amongst people with mental illness, and to provide community based alternatives to inpatient services.

Initiatives funded in the 2002-2003 State Budget represent the first stage of implementing new directions for mental health services in metropolitan and rural Victoria and provide for:

- Growth in key aspects of the service system, including acute inpatient beds, community based services, specialised aged services and services for women.
- Additional support to mental health clinicians in rural areas.
- Development of lower cost bed-based and other service alternatives as substitutes for high cost inpatient beds. These services will incorporate improved models of care for people with complex conditions, aiming to prevent crisis/relapse and provide pathways out of acute inpatient care.
- Piloting of innovative early intervention and prevention services for young people who have both substance abuse and mental health problems.

2.7 Nursing Workforce

2.7.1 Nurse Recruitment and Retention

Funding has been provided for more than 3,300 additional EFT nursing positions in the public hospital system since July 2000. Growth funding will enable the employment of an additional seven hundred EFT nurses and other health workers in 2002-2003. A second advertising campaign began in March 2002. Nursing courses at both universities and TAFE colleges have been over-subscribed and a wide range of measures have been put in place to improve retention.

In 2002-2003 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 two hundred 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 nursing specialties;
- resources to support clinical placements of up to five weeks in rural hospitals for 400 undergraduate nursing students.

2.7.2 Funding outcomes of the Nurses (Victorian Health Services) Award 2000

The outcomes of the Nurses (Victorian Health Services) Award 2000 (and the additional funding for medical practitioners to achieve interstate parity) were funded in 2001-2002 on a line item basis. With the exception of funding for Directors of Nursing the remaining funding has for 2002-2003 been included in cost weights and prices. For 2002-2003, the effects of the award have been modelled as part of the cost weight calculations to ensure that the current costs are accurately recorded. This was necessary as the cost weight data are collected from the previous year. Comparisons were then undertaken between the actual daily nursing costs in 1999-2000 (prior to the nurses' EBA), the modelled nursing costs for 1999-2000 (actual rates + EBA adjustment) and the actual 2000-2001 daily nursing costs (EBA partly included). The results were incorporated into the 2002-2003 cost weights. The methodology is set out in Appendix 8.

The impact of this and other cost weight changes on individual hospitals (i.e. WIES9-WIES10) has been separately modelled and identified. An adjustment factor will be applied in 2002-2003 in order to smooth the impact of this change. Where the impact is less than \$100,000, negative amounts will be compensated fully but no adjustment will be made to positive changes. Where the impact is greater than \$100,000, hospitals other than major providers will receive 66 per cent compensation for negative changes and retain 66 per cent for positive changes. For major providers, hospitals will receive 33 per cent compensation for negative changes and forego 33 per cent of positive changes. The differential treatment between major providers and others reflects the greater contribution to WIES10 cost weights by major providers as well as the greater variability of impact of the nurses EBA on smaller providers. The NICU EBA nurse-patient ratio has been excluded and funded separately because of the higher increase in NICU nurses.

2.7.3 Nurse Agency Services

In March 2002 the Department directed public hospitals to restrict the price and volume of nurse agency services, with the intention of capping rapidly rising costs. The impact of this measure is

being monitored closely in all metropolitan health services and the three largest non-metropolitan health services.

In the second half of 2002 a major study of nurse supply and demand will be undertaken as part of an overall strategy to help ensure adequate numbers of nurses are available to meet community expectations about healthcare services.

2.8 Pharmaceutical Reform

Commonwealth and State Ministers agreed a variation to the Australian Health Care Agreement in October 2001. The variation allows participating hospitals to gain access to a list of subsidised chemotherapy pharmaceuticals for outpatients and day-admitted patients, and to the Pharmaceutical Benefits Scheme (PBS) for patients on discharge and for outpatients.

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 three elements:

- provision of thirty days' supply (or clinically appropriate quantity) of pharmaceuticals to patients on discharge and to outpatients. This includes PBS, RPBS and non-PBS items;
- listing of a number of cytotoxic chemotherapy and antiemetic drugs under Section 100, allowing public hospitals to be funded for the pharmaceuticals supplied to same-day patients and non-admitted patients; and
- implementation of the Australian Pharmaceutical Advisory Council's (APAC) guidelines on continuum of pharmaceutical care.

Seven hospitals began implementing the reforms during January and February 2002: The Geelong Hospital, Grace McKellar Centre, The Alfred Hospital, Monash Medical Centre Clayton, Monash Medical Centre Moorabbin, The Kingston Centre and Dandenong Hospital. The Mercy Hospital for Women will implement the reforms in April 2002. It is expected that other hospitals will participate in these reforms in 2002-2003.

During 2002-2003 at full operation, Victorian public hospitals will be able to access approximately \$20 million for chemotherapy pharmaceuticals and \$48 million for PBS pharmaceuticals, funded directly by the Commonwealth. Victoria is providing grants totalling \$4 million to enable hospital pharmacies to upgrade their software and hardware in preparation for the reforms.

2.9 Capital, Equipment and New Technology

A significant commitment has been made to continuing the renewal, expansion and refurbishment of the health services asset base of the State. Funding has been allocated to redevelopment of a number of major metropolitan hospitals to expand services, better manage emergency demand and ensure facilities meet current standards of operating and functional efficiency. The extensive program of refurbishment and redevelopment of rural health and aged care facilities will continue with a major funding injection in this budget.

2.9.1 Royal Melbourne Hospital Stage 3 Redevelopment – \$32 million

A major redevelopment has been funded to enable full commissioning of the integrated trauma services and provide new ward accommodation to replace existing inadequate and substandard accommodation. The redevelopment will enable the extension of the front entry building by replacement of ward accommodation on three new floors and fit out of two floors to provide 120 beds. A new high-speed patient lift to service the helipad will be installed. Construction of the new floors is planned to commence later in 2002.

2.9.2 Angliss Hospital Redevelopment Stage 2A – \$18.5 million

Funding has been allocated for the next stage of redevelopment of the Angliss Hospital and will enable an increase in the capacity of the hospital to deal with emergency demand and improve access to emergency services and acute care for the residents of outer eastern Melbourne. The redevelopment will provide a new and expanded Emergency Department with an increase of eleven treatment bays, a new eight-bed Short Stay Unit, a new Critical Care/High Dependency Unit and a new General X-Ray facility to support increased demand.

2.9.3 Dandenong Hospital Redevelopment Stage 2 - \$10 million

Initial funding has been allocated to commence the next stage of the Dandenong Hospital Redevelopment. This will involve the development of a new and expanded intensive care unit, additional sub-acute beds and support services.

2.9.4 Stawell District Hospital Stage 2 - \$3 million

The funding of Stage two works will complete the redevelopment of Stawell District Hospital, and ensure the facility meets required operating standards and is able to continue to deliver specialist services to the sub-region. This Stage of redevelopment provides for a combination of major refurbishment and new construction to provide an enhanced Operating Theatre/Sterile Supply suite, redeveloped Radiology Unit and new Accident and Emergency facilities. Construction of Stage two will commence in 2003 upon completion of Stage one works.

2.9.5 Lorne Community Hospital - \$3 million

Additional funding has been provided to enable redevelopment of the Lorne Community Hospital on the current hospital site. The redevelopment will provide a total of thirty acute and residential aged care beds and community health facilities. Construction of the hospital will commence early in 2003.

2.9.6 Redevelopment of Rural Health Facilities – Stage Three

This strategy will continue to address upgrade and redevelop works required to enable residential aged care facilities to meet Commonwealth accreditation and certification requirements, to address poor physical infrastructure and to undertake associated upgrade and redevelopment in linked rural health facilities.

Funding under Stage three will address:

- Stage two redevelopment of the Beechworth Hospital and Nursing Home constructing a new thirteen bed acute ward, accident and emergency services, allied health day procedures, food services, administrative support services and associated engineering works.
- Stage two redevelopment of the Omeo Multi Purpose Service including

redevelopment of four acute beds and a range of primary care, dialysis and district nursing services.

- Redevelopment of ten palliative care beds and other support services at the Grace McKellar Centre, Barwon Health Geelong.

Redevelopment of a forty-five bed high care aged care facility, medical imaging services and support services for Stage one of the redevelopment of the Maryborough Campus of the Maryborough District Health Service.

2.9.7 Biomedical Equipment - \$20 million

An additional \$20 million will be provided in 2002-2003 to allow the upgrade of biomedical equipment in a range of metropolitan and rural health facilities including acute hospitals.

2.9.8 New Technology: Clinical Practice Program

Funding is available for the New Technology/Clinical Practice Program for 2002-2003 at a similar level to that at 2001-2002. Submissions were sought in May 2002, and agencies will be notified of outcomes by September 2002. 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, 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). This funding is not applicable for items such as service enhancements, equipment, research, or pharmaceuticals covered by S100 arrangements.

2.9.9 Statewide infrastructure Renewal - \$20 million

Funding has been provided to continue the program of works addressing critical infrastructure investment requirements across health facilities. This program is targeted at ensuring the continuing operational viability of existing health facilities and ensuring compliance with current legislative and regulatory standards and requirements. The works are targeted at upgrading of infrastructure in ageing tertiary referral hospitals, ambulance services, regional community hospitals and rural sites with poor infrastructure.

2.9.10 Fire Risk Management Strategy - \$10 million

Continuation of the Fire Risk Management Strategy will address the upgrade of metropolitan, rural acute and aged care facilities to meet fire risk standards.

2.9.11 Hospital IT Systems Replacement - \$1million

Funding will be used to contribute to the replacement of core hospital patient management and financial systems. Funding will enable the planning and assessment phase for replacement of core information technology that manages patient activity and services in hospitals.

2.9.12 Preston Integrated Care Centre

The new Preston Integrated Care Centre will be operational in January 2003. The new Centre has been named the Panch Health Centre and will provide public dental services, renal dialysis, specialist outpatient clinics including general surgery, orthopaedics, urology, general medicine, antenatal clinics, cardiology, family planning and midwifery, and allied health services such as physiotherapy, podiatry and drug and alcohol services.

2.10 Metropolitan Health Strategy

The Department's Policy and Strategic Projects Division is developing the Metropolitan Health Strategy. The Strategy will provide a policy and planning framework for the provision of health care services in and across metropolitan Melbourne for the period 2002 to 2006. It is being developed using a system-wide health program approach and will encompass the full range of health services. The Strategy will cover both local and statewide services that are situated in the Melbourne metropolitan area. Interrelations and impacts on services beyond the metropolitan fringe will be considered as appropriate.

The Metropolitan Health Strategy will:

- Guide the future level, mix, distribution and quality of health services across metropolitan Melbourne.
- Provide a metropolitan-wide health-planning framework in which local planning and implementation can occur.
- Identify and promote emerging models of care for managing demand and improving health outcomes.

Initial work tasks are due for completion by October 2002 to comply with the Government's integrated management cycle. These initial projects include ambulatory care service provision, elective surgery and mental health services and reviews of particular acute specialties. These, and related Departmental projects, will help inform development of a forward capital plan. All projects will be strongly underpinned by detailed data work, including the scoping of current and projected demand for health services.

A range of consultation processes are being used to develop the Strategy. A Project Advisory Group is being convened to facilitate development of the Strategy and to advise the Department on key priorities and implementation of recommendations arising from the Metropolitan Health Strategy. In addition, workshops and individual meetings with the health services sector and health programs have helped to scope challenges and directions for the Strategy.

2.11 Rural Human Services Strategy

The Victorian Rural Human Services Strategy is being developed by the Department's Policy and Strategic Projects Division. The Strategy will provide a framework to plan the delivery of sustainable high quality human services in rural and regional Victoria from 2002–2007, reflecting the Government's ongoing commitment to investing in rural and regional communities.

To highlight the importance of the Strategy and to demonstrate commitment to integrated service delivery for rural and regional Victoria, a cross-portfolio approach has been adopted. An expert Project Advisory Board has been appointed to ensure detailed oversight of the Strategy. A number of papers will be released for public consultation commencing with an Issues Paper in 2002. A Stage Two Recommendations Paper for the next phase will be presented to the Minister for Health in October 2002.

2.12 Occupational Health & Safety Improvement Strategy for the Victorian Budget Sector

In 2001 the Economic Review Committee (ERC) of Cabinet introduced an Occupational Health and Safety improvement strategy for the Victorian Budget. Under the strategy a number of defined Work Cover performance indicators must be reduced by 20 per cent over three years. Departments have the flexibility to identify annual improvement targets to achieve the 20 per cent improvement over three years. Hospitals are included in the Department targets. The Victorian Work Cover Authority will use 2000-2001 performance data as the baseline for improvement targets.

Advice on the strategy and proformas for notifying targets, gap analysis and action plans were supplied to all hospitals in October 2001. For the purpose of providing a sector return, the Department has focused on the submissions from the fourteen major providers and fifteen large regional base hospitals. A mechanism has been established for hospitals to report at least quarterly against the initiatives set out in their action plans and results achieved against certain key performance indicators.

2.13 TAC Patients

New funding arrangements will be introduced in 2002-2003 for the admitted patient treatment of Transport Accident Commission (TAC) patients in public hospitals funded through WIES. Please see refer to *Circular No 13/2002* for further details.

TAC WIES throughput will be uncapped. The arrangements are detailed in the *Section B—Conditions of Funding*.

3 Managing Demand and Improving Access

3.1 Metropolitan Hospital Demand Management and Access

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 for emergency and elective patients.

The new approach to the management of hospital demand emphasising changes in clinical practices will continue in 2002-2003. The key elements are:

- Funding growth with an additional 19,360 WIES for agreed hospital initiatives
- Extra funding of \$20 million for improved clinical practices that divert patients from acute to sub-acute, interim care, short stay, palliative care and community based options where appropriate
- Preventing admissions by improving the management of people with chronic conditions, the elderly and frequent users of emergency services, under the Hospital Admission Risk Program

This year elective surgery will be targeted with additional funding provided for initiatives to reduce elective surgery patient waiting times and waiting lists. A new Elective Surgery Access Strategy will increase hospitals' capacity to respond to the increased demand for elective surgery. Further clinical innovations will increase the rate of day surgery and day of surgery admissions (DOSA) to free capacity to treat additional patients. A new model of referral for rural and metropolitan health services will be implemented with particular emphasis on ophthalmology, orthopaedic and plastic surgery patients.

As a result of the Hospital Demand Management Strategy there will be 30,000 extra patients treated, an increase of 2.9 per cent.

The Hospital Demand Management Strategy will be implemented in close collaboration with clinicians and hospital management. Hospitals will be provided with the capacity to improve access and the quality of care for emergency patients through an individually tailored package of capacity growth, substitution and emergency department initiatives funded under the Strategy.

Under the Hospital Admission Risk Program, funds will be allocated to specific projects that aim to improve the management of chronic conditions both in hospitals and in the community. Under HARP, Health Services will be encouraged to form closer collaborative working relationships with primary care and community providers in their local areas to ensure that where possible, people receive the appropriate care in the most appropriate place and avoid unnecessary hospital admissions.

3.1.1 Access to Emergency Services

Access to emergency services will be improved through funding extra capacity to treat 14,000 more emergency patients, substitution services to provide more appropriate care options for some people currently in acute beds and improvements to emergency department processes. Substitution services include post-acute care, short stay units, interim care, medical assessment

and planning units, mobile assessment teams, care coordination and home-based alternatives. Many of these services were funded in 2001-2002 and will be extended to more sites in 2002-2003.

In 2002-2003 extra funding of \$6 million will be provided for strategies that improve patient management practices in emergency departments, taking into account best practice developments in overseas emergency care. These may include streamed emergency care, improved discharge practices (for example better access to allied health or a focus on weekend discharge) and fast track multidisciplinary triage. This is the second year special project funding has been provided. It should be noted that emergency department services are funded by the non-admitted patient availability grant, WIES payments and Training and Development payments. Project funds will be consolidated after two years.

In determining specific allocations for Metropolitan Health Services, consideration has been given to a package of programs and funding sources which best suits each service according to its own nominated priorities. As in 2001-2002, the negotiated package of initiatives will be the subject of agreements between the Minister for Health and Chairs of the Metropolitan Health Service Boards and between CEOs of Metropolitan Health Services and the Secretary of the Department. These agreements identify key performance indicators and associated targets and milestones. Funding allocated to date is provided in the following table:

Table 5: Hospital Demand Management Strategy – Budget 2002-2003 (excluding growth funds)

Health Service	Diversion	ED	Prevention
	\$ (a)	\$	\$ (b)
ARMC	1,040,373	581,934	1,188,683
Barwon	300,000	14,593	640,981
Bayside	1,006,375	288,000	1,526,890
Eastern Health	2,835,272	791,430	1,466,204
Melbourne Health	824,781	11,319	1,166,987
Northern Health	1,200,837	524,690	1,706,494
Peninsula Health	2,640,636	793,083	833,780
Southern Health	1,223,492		1,262,313
St Vincent's	726,428		1,864,766
Western Health	1,031,738		418,217
MHS & Major Indep Sub Total	12,829,932	3,005,048	12,075,315
Ballarat Health Service			254,494
Bendigo Health Care Group			133,980
Latrobe Regional Hospital			350,953
Other Agencies			1,222,714
Statewide Projects and ED funding adjustments		2,994,952	3,006,374
Palliative Care	4,000,000		
Primary and Aged Care	4,000,000		
TOTAL	20,829,932	6,000,000	17,150,000

(a) Total funds include \$20 million budget allocation and an additional \$0.83 million carried over from 2001-2002.

(b) Total funds include \$16 million budget allocation and an additional \$1.15 million carried over from 2001-2002.

3.1.2 Elective Surgery Access Strategy

An Elective Surgery Access Strategy will commence in 2002-2003, building on hospital demand management initiatives commenced in recent years. The aim of this strategy is to improve waiting times for elective surgery, stabilise waiting lists and to enhance the experience of elective surgery patients.

Key features of the strategy will be:

- Reducing average waiting times for Category 2 patients;
- Reducing the total waiting list number;

- Improving the management of patient episodes of care;
- Improving the management of patients on the waiting list; and
- Developing and validating referral and management guidelines for high volume and low priority conditions.

This strategy presents a package of initiatives which will improve the elective surgery experience for patients. In many cases these initiatives will target high volume procedures, for example, cataracts and hip and knee joint replacements.

- **Reducing Average and Maximum Waiting Times**

Whilst the majority of patients are admitted within desirable waiting times, some patients wait for lengthy periods prior to being admitted from the waiting list.

An Elective Surgery Access Service (ESAS) will be piloted in 2002-2003 to coordinate access for semi urgent Category 2 patients in selected specialties. These patients will be treated at designated elective surgery centres at Western Hospital (general surgery), St Vincent's Hospital (orthopaedics, general and plastic surgery) and Southern Health (ophthalmology).

Elective surgery targets will focus on the reduction of average waiting times for Category 2 patients. Maximum waiting times will be monitored and work will commence to introduce the concept for 2003-2004 for certain conditions, for example, hip and knee replacement and cataract patients.

The introduction of maximum waiting times will be trialled in six health services through the implementation of *Checklist*, a waiting list management tool which assists health services to better understand the characteristics of the queue for elective surgery. *Checklist* is being evaluated in 2002-2003 to gauge its ability to ensure patients on the list are equitably treated and to reduce waiting times.

- **Reducing the Total Waiting List Number**

Waiting list targets have been set for individual health services/hospitals to ensure the reduction in waiting list numbers experienced in 2001-2002 is replicated in 2002-2003 across the system.

- **Management of Elective Episodes of Care**

The Department will continue to focus on improving the efficient management of patient episodes of care through improving day of surgery admission (DOSA) and same day surgery rates.

The aim of the same day surgery indicator is to encourage health services/hospitals to treat more multi-day patients as same day, where opportunities exist to do so without compromising quality of care. Same day surgery targets are set to encourage long-term practice change in the way procedures are performed and patients are managed. Health service/hospital targets will apply to an overall 'basket' of procedures, which have wide variation in same day rates across the sector and significant same day throughput at the majority of hospitals. The basket of procedures will be tailored for specialist hospitals.

Admission on the day of surgery improves bed utilisation and therefore access to inpatient treatment, with evidence showing that it does not delay discharge or increase morbidity or mortality for selected groups of patients. DOSA targets are set at

specialty level in order to identify where practice change is required. Targets for 2002-2003 are either 85 per cent or 95 per cent dependent on the specialty.

DOSA and same day surgery targets are set as six-monthly targets to ensure that any natural variation in the mix of patients within health services/hospitals is able to be accommodated.

- **Hospital Initiated Postponements**

Attention continues on reducing the number of hospital-initiated postponements for patients waiting for elective surgery, particularly in rural areas. Benchmarks have been set and hospitals improving their performance in this area will attract bonus payments in 2002-2003.

- **Management of Waiting List Patients**

Whilst improvements in waiting times for patients are expected, issues related to the management of patients whilst on waiting lists will also be targeted for improvement. Patients can be more actively managed whilst waiting for surgery, and areas such as pain relief and exercise to increase fitness for surgery have been highlighted as areas for improvement. In addition, there are patients on waiting lists who may benefit from being offered medical alternatives to surgery.

A total of \$400,000 will be allocated and submissions sought in September 2002 for one-off projects which demonstrate best practice in managing patients whilst on waiting lists for surgery.

- **Categorisation of Elective Surgery Patients**

Clearer guidelines for the assignment of priority to patients on elective surgery waiting lists need to be developed. Prioritisation tools have been developed in other countries and for some specialties. With the support of clinicians, Victoria is currently assessing the value and feasibility of introducing categorisation tools for hip and knee replacement surgery and prostatectomy. Cataract prioritisation tools already available will be assessed for their validity in Victoria. Surgical sub-specialty groups will be asked to contribute to the process by developing specialty-specific prioritisation guidelines for common conditions.

The present three-category system of categorisation for elective surgery is being reviewed. It has been proposed that a four category system would allow clinicians to better discriminate between the urgency of patients. Revised definitions for all categories will be the subject of consultation and the Elective Surgery Information System will be modified to give effect to the change for 2003-2004.

- **Referral and Management Guidelines**

Intervention rates for surgery and thresholds for treatment vary between health services in Victoria and internationally. The development of referral and management guidelines for high volume surgical procedures, such as cataract surgery, varicose vein ligation and stripping and hysterectomy will assist general practitioners, health services and surgeons to ensure treatment is provided to those who will most benefit from it, and in managing waiting list patients.

New Zealand has developed expertise in the field of prioritisation and the development of referral and management guidelines. In 2002-2003, the New Zealand approach to guideline development will be further examined and trialled to determine applicability to the Victorian system.

- **Elective Surgery Indicators and Targets**

Table 6 outlines system wide targets for the range of elective surgery indicators in 2002-2003. The targets for the total waiting list, the percentage of Category 2 patients waiting more than ninety days and the average waiting time of Category 2 patients on the waiting list are expressed as a system-wide expectation. Individual health service/hospital targets will be based on the latest ESIS data. Targets will take into account any growth funds received for elective surgery in 2002-2003 and the growth trend being experienced at different health services/hospitals in 2001-2002. Further detail is provided in the *Hospital Demand Management Strategy Business Rules 2002-2003*.

Table 6: Targets for Elective Surgery Indicators 2002-2003

Indicator	Assessment	Target
Percentage of Category 1 patients admitted within 30 days.	Quarterly	100%
Percentage of Category 2 patients waiting more than 90 days.	Quarterly	A 5% reduction in the percentage of Category 2 patients waiting more than 90 days as at 30 June 2002.
Average waiting time of Category 2 patients on the waiting list	Quarterly	A 10% reduction in the average waiting time of Category 2 patients as at 30 June 2002.
The number of hospital-initiated postponements (HiPS) per 100 waiting list admissions	Quarterly	Targeted reduction or maintenance of performance based on 2001-2002 benchmark set for hospital groupings.
The percentage of planned overnight elective surgery admissions on the day of surgery (DOSA)	Six-monthly	95% for ear, nose and throat, ophthalmology, orthopaedics, plastic surgery and urology. 85% for cardiothoracic, general, gynaecology, neurosurgery and vascular.
The percentage of elective surgery admissions treated as same day	Six-monthly	Tailored for specialist hospitals; 80% for selected procedures for non-specialist hospitals.
The number of patients on the elective surgery waiting list	Quarterly	At or below 40,000 patients by 30 June 2003.

3.2 Prevention and Continuity of Care

3.2.1 Hospital Admission Risk Program (HARP)

The Hospital Admission Risk Program (HARP) includes those programs funded in 2001-2002 that focused on developing models of care to prevent the need for emergency presentations or hospital admission/readmission. In 2002-2003, an additional \$16 million will be allocated under HARP to further develop new models of care in this area. \$7 million was also allocated last year for prevention.

A HARP Reference Group has been established that brings together a range of stakeholders with an interest and relevant expertise in the area. The Reference Group provides strategic advice and monitor the implementation and evaluation of HARP. It is chaired by Professor John Funder.

New initiatives funded under HARP in 2002-2003 have been selected on the basis of a competitive selection process overseen by the HARP Reference Group. Hospitals and primary

care agencies were invited to submit Expressions of Interest for funding; successful EoIs were then asked to submit full proposals before the final selection was made. Selection panels comprised Reference Group members and other co-opted experts. Where funding for successful HARP submission is to be paid to Health Services, these strategies will be incorporated into the HDM agreements between Health Services and the Department.

3.2.2 Post Acute Care

The objectives of the Post Acute Care (PAC) program are to:

- provide additional home-based services to assist individuals to recuperate after hospitalisation;
- improve 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, where appropriate; and
- assist hospitals and sub-acute services to maximise use of beds for patients who require hospital services.

The Post Acute Care Program will continue to be funded as a separate program throughout Victoria. The budget for the program has increased from \$15.5 million to \$19.5 million in 2002-2003. All eligible patients discharged from acute public hospitals and sub-acute services across the state can gain access to the service. In addition, services can be provided to patients presenting to emergency departments to prevent their admission to hospital.

All PAC Services are required to have an Advisory Committee with representatives of major referring hospitals and community providers.

As in 2001-2002, additional funds will be available for PAC Services for DVA clients. Details are available in *Section B - Conditions of Funding*. Further negotiations will be undertaken with TAC and WorkCover for coverage of their clients.

3.2.3 Hospital In The Home (HITH)

Hospital In The Home (HITH) is provided to patients in their own home, whether that be a private residence, a community residential unit, a nursing home or supported residential service. Since its introduction into Victorian public hospitals, demand has grown and there are now 43 acute hospitals with HITH programs. The Department will continue to encourage the use of HITH by hospitals and quality improvement in HITH services.

In 2002-2003 casemix payments for patients treated in HITH will continue. Extra funding for HITH has also been incorporated in the Quality Framework.

In 2002-2003, the following recommendations from the Patient Management Taskforce will be implemented:

- Establishment of performance benchmarks for commonly treated conditions in HITH; and
- Support for the development of direct referral from emergency departments where appropriate.

Funds will continue to be made available for the Victorian Centre for Ambulatory Care Innovation in 2002-2003 for the development and dissemination of information to facilitate good practice and innovation in HITH services.

For further information refer to *Section B - Conditions of Funding* and the *Quality Framework Business Rules 2002-2003*.

3.2.4 Patient Flow

The Effective Discharge Strategy commenced in 1998-1999 for health services (acute hospitals, sub-acute services and Multi Purpose Services).

Health services are expected to report on their performance against the four performance indicators using the database supplied by the Department. An audit will be conducted in July 2002-2003. A random sample will be drawn for each health service from the VAED for this purpose. Health services will be provided with both individual and comparative results. It is expected that health services will use these indicators on an ongoing basis for internal reporting.

To improve links between health services and general practitioners and coordination of care, four demonstration projects commenced in 2001-2002 and completed in October 2003. Findings will be disseminated via a final report and a good practice guide. It will bring together existing knowledge in good practice in patient flow with examples in a range of settings and patient groups, to assist hospitals in improving practices.

4 Major Rural and Regional Initiatives

This section highlights those special initiatives for rural and regional hospitals (The total document sets out the policy and funding conditions for public hospitals in metropolitan, regional and rural areas and this section must be viewed in that context). Key initiatives include:

- \$5 million in growth funds for rural and regional hospitals
- Greater flexibility in funding and purchasing for small rural hospitals
- \$4.5 million to enhance access to elective surgery and for other rural initiatives

4.1 A Strengthened Policy Focus

The creation of the Rural and Regional Health Services Division in December 2001 brings a renewed focus on health provision in rural and regional Victoria. The Rural and Regional Health Services Division will provide advice across the range of programs with the aim of achieving:

- accessible, quality, effective health services for all rural Victorians;
- greater understanding and consideration of rural health issues in policy formulation and decision making; and
- a stable, viable rural health service system that supports and encourages flexible health services models.

During 2002-2003, the Rural and Regional Health Services Branch of the Division will:

- establish revised agency financial monitoring systems;
- commission a new board of management development program;
- develop and disseminate a new service planning framework;
- develop new funding and accountability requirements for small rural health services; and
- undertake specific service development initiatives.

For further information about the role of the Rural and Regional Health and Aged Care Services Division, please refer to <http://www.dhs.vic.gov.au/rrhacs/>

In addition, the Victorian Rural Human Services Strategy is being developed as a flagship project under the Policy and Strategic Projects Division within the Department (see *Section 2.13*).

4.2 Self-Sufficient, Sustainable Services

4.2.1 Growth

In 2002-2003 \$5 million has been allocated for growth in inpatient services at rural and regional hospitals (equivalent to 2000 WIES). Growth funds will target areas where significant levels of unmet demand for hospital services have been demonstrated.

Table 7: Individual hospital allocations for growth funds 2002-2003

Hospital	No. of WIES
Barwon South Western Region	
Barwon Health	1,000
Loddon-Mallee Region	
Bendigo Health Care Group	250
Echuca Regional Health	50
Maryborough District Health Service	20
Swan Hill District Hospital	50
Grampians Region	
Djerriwarrh Health Service	100
East Grampians Health Service	60
Stawell Regional Health	20
Hume Region	
Wangaratta District Base Hospital	150
Wodonga Regional Health Service	70
Benalla and District Memorial Hospital	30
Gippsland Region	
West Gippsland Health Care Group	100
Gippsland Southern	50
Wonthaggi and District Hospital	50
TOTAL	2,000

4.2.2 Rural Grant

The Rural Grant comprises two previously separated streams. The first is a consolidation of special purpose funding previously distributed through a range of funds, totalling \$37.5 million. These special funding arrangements have accumulated over a period of years and include:

- Rural Specialty Core Services
- AMA Rural Enhancement Package
- Conversion Stabilisation reserve
- Rural Isolated Grant
- Rural Public Target A premiums
- Price Maintenance Grant

The variety of allocation methodologies has led to wide variations between similar agencies in the individual total amounts received. The Rural Grant simplifies these grants and distributes monies on a more equitable basis.

In 2002-2003, Rural grant amounts payable to each hospital have been adjusted to ensure that each hospital's Rural Grant is greater than or equal to the sum of the amounts allocated through these sources in 2001-2002.

In addition to the above the Rural Grant provides \$2 million for maternity services funding, and has been consolidated with other grant funds.

The Rural Grant will be paid according to the number of WIES generated by each hospital (in the year 2000-2001), according to the following rates:

Table 8: Rural Grant Rates 2002-2003

Total Annual WIES Generated (2001-2002)	Rural Grant Rate (per WIES)
Rural Group B Greater than 13,000 WIES	\$114
Rural Group B 7,500 – 13,000 WIES	\$192
Rural Group B 5,000 – 7,500 WIES	\$258
Rural Group B Less than 5,000 WIES	\$273
Rural Group C	\$110
Rural Group D and E	\$144

4.2.3 Rural Initiatives Pool

In 2001-2002 an amount of \$4.5 million was made available for targeted reduction of rural waiting lists. Fourteen regional and two metropolitan health services were funded to treat patients under the initiative. Similar amounts will be available in 2002-2003, for waiting list reductions and other rural initiatives.

Funding allocations for these hospitals, as listed in modelled budgets for 2002-2003, are based on 2001-2002 activity, are notional and subject to change.

Further information on unspent funds will be given to hospitals in 2002-2003 (see *Section B – Conditions of Funding*).

4.2.4 Support for the Rural and Regional Workforce

The Continuing Medical Education (CME) Program for General Practitioners was established in 1996 as a targeted educational activity to improve the quality of medical practice in rural locations. A long term objective of the program was to ensure that GPs appointed to undertake practice in designated rural clinical areas were supported in undertaking regular CME appropriate to the area of practice. A review of the program is underway and will be finalised over the next few months. Subsidies will continue to be provided as per current guidelines until that time.

Professional Improvement Assistance Fund Scholarships will also continue to be available to assist those involved in rural health in Victoria to participate in conferences of relevance to the development and provision of rural health services in 2002-2003. The scholarship budget was increased to \$75,000 per annum in 2001-2002.

4.3 Supporting Service Innovation

4.3.1 Flexible Funding Models

The Healthstreams program enables smaller rural hospitals to participate in more flexible funding arrangements. The program follows an extensive evaluation, conducted by KPMG Consulting during 2002 that found that the program had been of benefit to participating agencies.

To date, Healthstream agencies have received Implementation Grants totalling almost \$0.66 million. Approximately \$1.8 million was provided in 2001-2002 in specified grants of reallocated funds to provide services such as community health nursing and allied health services, palliative care and health education programs.

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.

As with Healthstreams, monies provided previously for hospital patient services have been converted to a net grant (i.e. net of private patient and other revenue). Commonwealth aged care funding has also been cashed out in the MPS model.

The opportunity to make these service and viability improvements will be provided to all Group D & E hospitals (and some group C hospitals) from 2002-2003. These hospitals will be encouraged to ensure that service provision meets local requirements and is delivered in accordance with local planning processes. Although total Acute Program allocations for these hospitals will reflect historical casemix-based funding there will be no cap on the extent to which WIES or other health and aged care program funding can be converted. Conversions will be subject to the approval of the Department Regional Director in consultation with the Director, Rural and Regional Health Services. Reporting requirements are unchanged.

Further work will be carried out during 2002-2003 to develop appropriate alternative funding models for small rural agencies. These models will replace the use of casemix for Group D and E hospitals in 2003-2004, and will inform future directions of the Healthstreams program.

The Healthstreams and MPS agencies (as well as other Group D and E hospitals that choose to convert State health and aged care program funds) will continue to be subject to Acute Program policies in respect of further funding, and entitled to an appropriate share of additional growth and capital expenditure allocation. Similarly, the agencies will be subject to the same policy decisions regarding private patient revenue and productivity requirements as other hospitals, which remain in the Acute Program. Monitoring will be continued to ascertain whether acute throughput has been shifted from a flexible funded agency to another hospital and if so an appropriate funding adjustment may be made.

4.3.2 Innovative Service Delivery

The development of innovative service delivery models is further supported through the expenditure of \$0.6 million to fund new services in regional and rural Victoria. Projects funded in 2002-2003 are:

- New clinical programs for asthma sufferers in the Barwon-South Western Region (\$200,000)
- Rural allied health team operating from Warrnambool (\$100,000)
- Expanded community rehabilitation in Wodonga and Seymour, (\$100,000)
- New patient oncology service in Kilmore, (\$130,000)
- New ED care co-ordination service at the Latrobe Regional Hospital (\$100,000)

Innovative service delivery models will also be developed and funded under the auspices of the Victorian Rural Human Services Strategy. Relevant projects include the Integrated Service Delivery Project and the Rural Health Innovative Practice Fund, which has been established to improve support, education, training and research opportunities in rural and remote Victoria through innovative models of practice.

4.4 Filling Service Gaps

Ongoing development of health services in rural and regional areas continues through the expansion of other health services. Additional services to rural hospitals are described in other sections. Highlights include:

- \$1 million have been allocated to expand Community Rehabilitation Centres in fifteen rural locations:

Table 9: Community Rehabilitation Centres Funding Allocation 2002-2003

Regional Agency	Total Additional Funding 2002-2003
Colac Community Health Services CRC	34,569
South West Health Services – Warrnambool CRC	64,614
Wimmera Base Hospital CRC	95,880
Echuca Regional Health CRC	85,656
Mt Alexander Hospital CRC	51,937
Swan Hill District Hospital CRC	59,474
Ramsay Health Care Mildura CRC	58,194
Goulburn Valley Health CRC	78,176
Wangaratta District Base Hospital CRC	45,840
Wodonga District Hospitals CRC	22,206
Bairnsdale Regional Health Service CRC	84,663
Wonthaggi District Hospital CRC	75,696
Yarram & District Health Service CRC	79,000
West Gippsland Health Care CRC	79,112
Latrobe Regional Hospital CRC	84,688
Total	999,978

- \$865,000 has been provided for additional palliative care services at eleven rural locations.
- \$850,000 has been provided for community-based palliative care at eleven rural locations.
- An additional \$2.75 million recurrent funding has been provided for radiotherapy services in Ballarat and Bendigo.
- \$0.4 million has been allocated for the Rural Workforce Initiative, aimed at enhancing professional support to clinical staff in rural mental health services. This initiative will not only help retain valuable qualified staff, but also enhance the quality of services available to those in regional Victoria (see *Section 7*).
- Sub-acute mental health services for people requiring pre-crisis post-acute treatment and support will be piloted in a regional centre.
- New ambulance stations at Mildura and Shepparton will be established to be operational by 2003-2004. \$0.7 million has also been provided to commence the training of paramedics to staff these new stations.
- \$1.4 million will be provided to co-locate ambulance stations and Hopetoun, Ararat, Colac and Kyneton will be rebuilt as part of the redevelopment of other health services.

5 Summary of 2002 – 2003 Public Hospital Payment Rates

Table 10: Payment Rates, 2002-2003

Payment	All Hospitals	Major Providers	Rural Group B >13000 WIES	Rural Group B 7500-13000 WIES	Rural Group B 5000-7500	Rural Group B <5000	Rural Group C	Rural Group D & E
Inpatients								
• Public WIES 10		\$2,515	\$2,629	\$2,707	\$2,773	\$2,788	\$2,625	\$2,659
• Private WIES 10		\$2,058	\$2,151	\$2,215	\$2,270	\$2,282	\$2,155	\$2,187
• Rural/Isolated Hospital Payment per WIES 10	\$17/\$42							
• Nursing Home Type Patient per Day	\$154							
• DVA per WIES 10		\$2,603	\$2,632 ⁴	\$2,662 ⁵			\$2,702	\$2,736
Sub-acute								
• CRAFT (episode)	\$10,226							
• Rehabilitation Level 1 (per diem rate)	\$470							
• Rehabilitation Level 2 (per diem rate)	\$390							
• Geriatric Evaluation & Management (per diem)	\$390							
• Interim Care Beds (per diem rate)	\$269							
Non-Admitted Patients								
• VACS Payment per Weighted Encounter	\$125							
• Allied Health per Occasion of Service	\$45							
• Emergency Services Grant	See Ch.11							
• VACS Base Grant	See Ch.11							
• VACS Teaching Grant	See Ch.11							
Training and Development Grants								
• Training and Development Payments	See Ch.12							
• Research Grants	See Ch.12							
Specified Grants								

1. The rural and isolated hospital payment will apply to those hospitals as designated.
 2. Ballarat Health Services and Bendigo Health Care Group are the only Rural Group B hospitals funded through VACS.
 3. The above rates do not include savings required from embedded taxes and network review savings.
 4. Rural Group B over 10,000 WIES.
 5. Rural Group B under 10,000 WIES.

6 Hospital Activity and Throughput Targets

6.1 Hospital Activity Targets

This section describes the throughput targets for each metropolitan health service and each rural region. In 2002–2003, the unit of measure for casemix adjusted throughput will be known as WIES10 with the total number of WIES10 for hospitals in 2002-2003 being 835,160. Full details of WIES10 are given in *Section C—Calculation of WIES*.

6.1.1 Cost Weight Study - Grouper

The Cost Weight Study was based on data from the 2000-2001 year modified for the impact of the Australian Nursing Federation Enterprise Bargaining Agreement. All hospital admissions have been coded using ICD-10-AM, 2nd edition and grouper according to AR-DRG Version 4.2.

6.1.2 Targets

In 2002-2003 WIES targets will be one full price. The public WIES rate will vary in accordance with the size and nature of the provider between \$2,515 and \$2,788.

Table 11: Components of Target, 2002–2003

	Standard Rate	Rural Grant	Rurally Adjusted Rate
Major Providers	\$2,515	-	\$2,515
Rural Group B > 13,000 WIES	\$2,515	\$114	\$2,629
Rural Group B 7,500-13,000 WIES	\$2,515	\$192	\$2,707
Rural Group B 5,000-7,500 WIES	\$2,515	\$258	\$2,773
Rural Group B < 5,000 WIES	\$2,515	\$273	\$2,788
Rural Group C	\$2,515	\$110	\$2,625
Rural Group D and E	\$2,515	\$144	\$2,659

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.

6.1.3 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 and/or increase the range of services provided. 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.

6.1.4 Under-utilisation of WIES

Hospitals are required to advise the Department by 15 January 2003 of any impending under-utilisation of their WIES target allocations. Rural hospitals should advise their relevant rural Regional Office. Metropolitan hospitals and the Rural Health and Aged Care Division should

advise the Metropolitan Health and Aged Care 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 relevant DHS 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.

6.2 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 2003, so that hospitals' ability to operate at target level is increased. Shortfalls will be recalled at a progressively increasing rate as outlined below.

Table 12: Recall Adjustment Rates, 2002-2003

Metropolitan Health Services and Rural Group B Hospitals	Recall Adjustment
0 — 2 per cent below target	\$1,000 per WIES
2 — 3 per cent below target	\$1,600 per WIES
3 — 5 per cent below target	\$2,100 per WIES
5 per cent + below target	Full WIES rate
Rural Group C/D/E Hospitals	Recall Adjustment
All recall	\$1,000 per WIES

Throughput in excess of target of up to 2 per cent will be paid at \$1,000 per WIES. This provides recognition of the difficulty of achieving absolute precision in demand management.

6.3 Metropolitan and Rural Inpatient Activity Targets

Table 13 sets out the targets for 2002-2003 for the Metropolitan Health Services (MHS) and the rural regions. Detailed rural hospital allocations are in *Section A - Targets*.

Table 13: Targets, 2002–2003

	Target WIES10 (ex. DVA)	DVA WIES10	TAC	Total WIES10
Austin & Repatriation Medical Centre	47,435	4,266	1,349	53,050
Bayside Health	60,675	2,010	5,314	67,999
Eastern Health	61,495	2,141	645	64,281
Melbourne Health	55,297	752	862	56,911
Northern Health	25,094	280	512	25,886
Peninsula Health	36,945	1,601	350	38,896
Peter MacCallum Cancer Institute	11,204	714	-	11,918
Royal Victorian Eye and Ear Hospital	8,906	366	11	9,283
Southern Health	86,870	1,251	1,626	89,747
Western Health	55,420	1,178	694	57,292
Women's & Children's Health	52,950	-	492	53,442
Mercy	17,326	25	1	17,352
Werribee Mercy	9,542	232	14	9,788
St Vincent's	39,354	852	420	40,626
Total Metropolitan	568,513	15,668	12,290	596,471
Barwon-South Western	60,861	3,509	559	64,929
Grampians	36,275	2,064	386	38,725
Loddon Mallee	43,431	3,252	366	47,049
Hume	42,081	2,744	339	45,164
Gippsland	40,150	2,361	313	42,824
Total Non-Metropolitan	222,798	13,930	1,963	238,691
Grand Total	791,311	29,598	14,253	835,162

6.3.1 Metropolitan Targets

Priority has been given for growth funding to meet emergency demand of an estimated additional 14,000 patients admitted from emergency departments and an increase of 10,000 elective surgery patients. 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 to meet increases in emergency inpatient demand and to decrease waiting lists in a targeted manner. 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.

Quarterly targets at the Metropolitan Health Service (MHS) and campus level will be nominated by each Metropolitan Health Service no later than 31 July 2002, 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 WIES10 targets. Non-admitted patients will have a budget ceiling for each hospital campus.

6.3.2 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 Waiting List reduction package has been notionally allocated to individual hospitals.

It should be noted that where agencies have performed under target in 2001-2002 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 2002 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 WIES10 targets.

6.4 Same Day Caps

Same day caps currently apply at the aggregate level for metropolitan hospitals and the hospital level for rural hospitals as a disincentive for unnecessary statistical inpatient admissions. During 2001-2002 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 have established short stay/observation units and/or medical ambulatory care centres. These are WIES funded.

During 2002-2003 there will be continuing evaluation of the impact of 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 practices that improve emergency patient flow.

6.5 Published Rates

The rates presented in this document and its attachments, including modelled budgets, do not include ongoing savings required from embedded taxes, or network review savings as listed in Appendix 3. The savings 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, as outlined in *Section B - Conditions of Funding*.

6.6 Service Agreements

Service Agreements with the Department are to be signed as soon as possible in the financial year. In particular, the Acute, Sub-Acute and Mental Health Schedules to the Service Agreement must be concluded by 30 September 2002. The Metropolitan and Rural Health and Aged Care Divisions will provide assistance to resolve any outstanding issues in that period. However, agencies that do not sign the Schedules will not be eligible to receive bonus payments under the Quality Improvement Fund.

7 Mental Health Services

7.1 Mental Health Policy and Planning

Between 1999-2000 and 2000-2001, the total number of registered mental health clients in the public system rose by 3,290 clients (6.6 per cent). Demand for adult services rose by 2,940 clients (9.3 per cent) between 1999-2000 and 2000-2001.

Service developments for specialist mental health services in 2002-2003 emphasise the need to reduce relapse and readmission amongst people with mental illness. These developments will also begin to address the increased demand for mental health services, including:

- Increasing prevalence of co-existing mental illness and problematic substance use.
- Increasing numbers of people who have severe and complex psychological and social problems.
- The growth in an ageing population and corresponding increase in age related psychiatric disorders.

7.1.1 The Mental Health Service System

Mental Health Services in Victoria are provided on an area basis. All clinical area services have been mainstreamed with general hospitals and each area provides a range of services.

Service delivery within Area Mental Health Services across Victoria includes:

- twenty-one Adult Mental Health Services, which assess and treat adults (aged sixteen to sixty-four) with serious mental illness.
- seventeen Aged Persons Mental Health Services, which assess and treat older people (aged sixty-five and over).
- thirteen Child and Adolescent Mental Health Services, which assess and treat children and adolescents (up to eighteen years of age) who have a serious mental disturbance or who are known to be at risk of such disturbance.

All areas have access to a range of inpatient, community residential and ambulatory services. Service providers also have access to a range of specialist and statewide services such as mother and baby units, eating disorder units and neuropsychiatry services.

In addition, forensic mental health services are provided for people who have both a mental disorder and a history of criminal offending or who present a serious risk of such behavior. Inpatient forensic services are now consolidated at the Thomas Embling Hospital in Fairfield and managed by a statutory authority, the Victorian Institute of Forensic Mental Health. Forensic mental health services are also provided by VIFMH at the Melbourne Assessment Prison and in community programs for the assessment and treatment of offenders with a serious mental illness.

Complementing clinical services are a range of psychiatric disability support services delivered by non-Government organisations. These services provide support and rehabilitation services to people who have a disability resulting from mental illness.

7.1.2 Growth and New Initiative Funding in the 2002-2003 State Budget

New funding in the 2002-2003 State Budget will provide:

- Growth in key aspects of the service system, including acute inpatient beds, community based services, specialised aged and women's services.
- Additional support to mental health clinicians in rural areas.
- Development of lower cost bed-based and service alternatives as substitutes for high cost inpatient beds. These services will incorporate improved models of care for people with complex conditions, aiming to prevent crises and relapse and provide pathways out of acute inpatient care.
- Piloting of innovative services for young people who have both substance abuse and mental health problems.

Specific funding commitments for 2002-2003 are:

- **Re-opening of Acute Inpatient Beds – \$4 million**

Despite population increases and the growing number of admissions into the public mental health system, the overall number of general adult acute inpatient beds has remained relatively constant since 1996-1997.

Funding has been provided for re-opening approximately thirty acute inpatient psychiatric beds that were closed in previous years. This initiative aims to relieve the considerable pressure on inpatient services and the consequent effect on the general hospital system. This will occur within existing capital infrastructure and mainly in metropolitan areas with some provision for regional centres where pressure on inpatient services is also significant. Beds are targeted to be opened at St Vincent's, The Alfred, Royal Melbourne and Frankston Hospitals and the Broadmeadows Health Service. Further locations will be determined during the first quarter of 2002-2003.

There will be further examination of inpatient bed distribution, and ways of managing demand for inpatient services, during 2002-2003.

- **Community Mental Health Growth – \$6.32 Million**

New funding has been provided for expansion of aged and adult clinical community services and adult Psychiatric Disability Support Services (PDSS) in response to growing waiting lists for PDSS and increasing client registrations to clinical community services.

Growth in Adult Clinical Community Services

Funding will provide forty additional mobile intensive treatment and support staff and crisis assessment and treatment staff. This will include intensive home-based clinical treatment and enhanced residential rehabilitation services for people with co-existing substance abuse. It will also provide fourteen additional continuing care positions.

Funding will also be provided for forums and awards to recognise initiatives to prevent sexual abuse of women in inpatient services.

Growth in Aged Clinical Community Services

This funding will provide fifteen additional psychogeriatric assessment and treatment staff to provide clinical services to older people living at home or in residential aged care.

Growth in Adult Psychiatric Disability Support Services (PDSS)

This funding will provide fourteen additional psychiatric disability support staff for day programs, home-based outreach services, including home-based support services for women with a mental illness living with dependent children, and enhanced residential rehabilitation for people with co-existing substance abuse.

- **Sub-Acute Service Pilots – \$2.76 million**

In 2002-2003, the Mental Health Branch will develop and trial sub-acute service models in metropolitan areas of Victoria and one regional centre. The pilots will offer approximately thirty new sub-acute places which include bed based services and, if needed, home support. The pilots will aim to manage demand for inpatient services by providing:

- treatment and support to people experiencing a crisis that, if unmanaged, may lead to an inpatient admission;
- post-acute treatment and support for clients recovering from an acute phase of illness but not yet ready to return to their usual accommodation; and
- short-term flexible funding packages for clients requiring support on return to home.

Each service will be assisted and managed by the Crisis Assessment and Treatment Service of the area mental health service/s where the places are located. However, access to bed based services may be shared across areas. Staffing includes nurses, psychiatrists, allied health professionals and support staff.

- **Supported Housing Services – \$1.16 million**

Closure of large mental health institutions during the 1990s and declining availability of low cost housing, including Supported Residential Services, has increased the need for supported housing for clients with ongoing mental health problems and associated disabilities. There is evidence that stable and supported housing reduces relapse and readmission rates for people with chronic mental illness.

In 2002-2003 funding is provided for intensive treatment and support services to an additional fifty clients with high needs prioritised for placement in Office of Housing properties and to assist the implementation of the Supported Rooming House Project, including:

- ten additional psychiatric disability staff to provide intensive home-based support in collaboration with other clinical services,
- thirty flexible funding packages (\$5,000 each) for the purchase of required practical supports and services.
- Intensive clinical support

- **Youth Dual Diagnosis Services – \$360,000**

Funding has been provided for two pilot 'dual diagnosis' services for young people. The pilot projects will extend two existing dual diagnosis services currently providing services to metropolitan and rural areas by providing two additional staff and sessional psychiatry for each pilot to:

- Strengthen the capacity of local Child and Adolescent Mental Health Services (CAMHS) to work in partnership with youth drug treatment services.
- Provide support and resources to existing youth substance abuse services and

CAMHS in the selected areas.

- Provide consultation and training to staff of CAMHS and youth drug treatment services, as well as some direct service provision to young clients.
- **Rural Clinical Workforce Development – \$400,000**

Service demand pressures are exacerbated by a declining skilled and aging mental health workforce, particularly in rural areas.

New funding will be provided for the provision of expert clinical opinion and supervision by metropolitan services to the eight rural area mental health services (AMHS). This support will be provided through teleconferencing and other media, and will focus particularly on aged and child/adolescent issues. The initiative will target medical and allied health staff to complement the nursing workforce initiatives implemented in 2001.

7.2 Funding and Budget Overview

7.2.1 Mental Health Output Streams

For budget and reporting purposes, there are four mental health output streams:

- Clinical Inpatient Care, which includes hospital inpatient treatment programs for people with serious mental illness.
- Clinical Community Care, which provide initial screening and consultancy for people requesting public mental health services, as well as assessment, treatment, continuing care, clinical case management and support and residential care for people with serious mental illness.
- Psychiatric Disability Support Services which provide support and rehabilitation services to people who have a disability resulting from mental illness.
- Service System Capacity Development, covering activities such as research, training and education.

Appendix 4 provides information about funded activities that contribute to each of these outputs

7.2.2 Mental Health Budget

The table below provides an overview of the mental health budget in 2002-2003. Further details are in *Section A – Modelled Budgets*.

Table 14: Mental Health Budget Allocations, 2002-2003

Budget Item	2002-2003 Budget Allocation (\$ Million)	% Total Allocation
Adult	263.8	56.5
Aged	63.5	13.6
Child and Adolescent	40.5	8.7
Psychiatric Disability Support Services (PDSS)	47.6	10.2
Mental Health Service System Development & Resourcing	13.1	2.8
Specialist	38.1	8.2
Total Mental Health Budget	466.7	100

These figures provided are correct as at June 2002. However, there may be some minor changes to the budget allocation during the financial year.

7.2.3 Funding and Prices

In 2002-2003 the Mental Health Branch has distributed funds among the Department regions using a weighted population formula, numbers of registered clients and other statistical information. The weighted population formula uses population weightings to estimate morbidity levels in mental health service areas and to account for the higher service costs of some consumers due to their geographic location or particular circumstances. This formula has been recently updated to incorporate new population and demographic data. In addition, specific initiatives may be funded according to local (rather than statewide) demand or an assessment of existing infrastructure and capacity.

Mental health services are funded through four main mechanisms: block funding/historical allocations, bedday rates—EFT, and submissions. There will be a pricing review undertaken during 2002-2003 to examine current pricing arrangements. The current bedday rates of the clinical mental health output streams are as follows:

Table 15: Bedday Rates Applicable to Clinical Bed Based Services*

Output	Service element	Funded unit	2002-2003	2002-2003
			Metro unit price	Rural unit price
Clinical Inpatient Care	Adult Acute	Available Bed Day	\$372	\$375
	Aged Acute	Available Bed Day	\$372	\$375
	CAMHS Acute	Available Bed Day	\$441	\$444
	Acute Specialist	Available Bed Day	\$489	\$492
	Extended Care Adult	Available Bed Day	\$356	\$359
Clinical Community Care	Community Care Unit	Available Bed Day	\$244	\$247
	Psychogeriatric Nursing Home Supplement	Available Bed Day	\$63	\$63
	Psychogeriatric Hostel Supplement	Available Bed Day	\$56	\$56

Inpatient services are funded at the prevailing benchmark daily bed rates, less a revenue target in adult and psychogeriatric units. The bedday rates are based on 100 per cent availability of the funded beds, regardless of actual occupancy.

** EFT prices for clinical ambulatory and PDSS services outputs vary depending on historical funding allocations adjusted for consumer price index and award increases. Unit prices for these outputs will be clarified in the pricing review. The Service System Capacity Development output will continue to be funded through historical funding allocation and submissions pending the outcome of the pricing review.*

Area Mental Health Services are required to allocate a minimum of 55 per cent of their budget to community based services and are encouraged to increase this allocation by redirecting any budget savings, under-utilized inpatient resources and revenue from resident fees and Commonwealth nursing home funding to community based services.

7.3 Future Directions

7.3.1 Future Service Development

The continued development of an accessible, integrated range of mental health services remains a high priority. With a strong policy commitment to support people to live in the normal community environment wherever possible, there is ongoing planning to increase the range of services that facilitate movement of people out of inpatient beds and help prevent crisis and relapse.

Alternatives to inpatient care including new sub acute services and intensive supported accommodation services introduced in 2002-2003 will be evaluated and further developed based on the outcome of the evaluations. Simultaneously, there will be a renewed emphasis on the quality and effectiveness of inpatient services for people who need this level of care.

Mental Health in the Community

Public specialist mental health services are – and will remain – targeted to people who are seriously affected by mental illness. However, the future development of these and related services must take into account the mental health needs of the wider community.

A focus on mental health prevention and early intervention is necessary to address the increasing incidence of some forms of mental illness (such as depression) and reduce future demand on mental health and other community services.

To prevent escalating problems in people with serious mental illness it is planned to build the capacity of existing community based services, including the expansion of primary mental health, clinical and disability support services, and other relevant services through training and consultation.

Another priority area is the development of improved responses to early signs of mental illness, such as early psychosis in young people.

Service Linkages

In 2002-2003, the Department will begin to examine ways of improving linkages between Area Mental Health Services as a basis for more co-operative approaches to the use of local resources, particularly inpatient beds and new sub-acute services. In this context an examination of the size and purpose of catchments, including the application of boundaries, will be undertaken to identify ways to improve client access and enable better service management.

7.3.2 Quality, Performance Management and Accountability

A comprehensive performance management framework will be developed to underpin a stronger role for the Mental Health Branch in monitoring and evaluating mental health services. This will be based on existing national and departmental quality frameworks, supporting a system of performance measurement, accreditation, and regular reviews and audits.

Key performance indicators and performance benchmarks are being developed during 2002-2003 to enhance performance management. As part of this work, comparative data on agency performance will be published, in line with the public hospital system data.

Concurrently, further development and implementation of client outcome measurement will occur over 2002-2003.

7.3.3 Technology and Infrastructure

A capital asset investment strategy and management plan for mental health services, including IT infrastructure, will be initiated in 2002-2003. The aim of this work is to align the availability and functional design of buildings and technological systems with information about future service requirements.

The developments described in this section will be undertaken during 2003-2003 with some developments continuing over a number of years. These service and infrastructure initiatives will contribute to the creation of a more robust and responsive mental health system for all Victorians.

8 Quality of Care

8.1 Quality Framework

2001-2002 Quality funding of \$75.5 million has been restructured to better focus on hospital access and quality improvement. In 2002-2003 Quality Framework funding will total \$43.8 million and \$31.6 million will be subject to health services access performance as Hospital Demand Management bonus funding which is outlined in 2.1.1. The Quality Framework has been revised to focus on clinical governance, performance indicators, extending and maintaining best practice initiatives, and improving consumer involvement and information.

The Quality Framework includes a number of quality and safety programs and initiatives: accreditation; infection control; cleaning, clinical risk management, effective discharge and funding for programs for people from non-English speaking backgrounds.

Collaboration with health services will underpin the Quality Framework in 2002-2003. Funding will be provided to health services participating in quality initiatives and quality improvement activities as measured by performance in relation to targets and benchmarks. Funding will also be dependent on timely and accurate provision of data to enable health service performance monitoring and reporting of performance indicators as outlined in the *Quality Framework Business Rules 2002-2003*.

There will continue to be an expectation that health services will actively utilise quality performance data, maintain and implement internal clinical monitoring and review processes and implement evidence based health care across the continuum of patient care. Hospitals are also expected to achieve and maintain accreditation.

8.2 Clinical Governance

Health Services and Hospital Boards are responsible for having systems within their institutions to assure and improve quality and to address any quality problems in a timely manner. The system of internal reporting to the Board needs to provide members with the information necessary to monitor performance and undertake action as necessary. Boards are responsible for ensuring that effective and accountable systems are in place to provide accurate data for external performance monitoring and reporting, both to the Department and to the community.

In 2002–2003 all Victorian hospitals and Metropolitan Health Services are required to:

- Report regularly to their Board on safety and quality of care delivered and to take action to improve quality;
- Report to the public on quality of care by means of an annual Quality of Care Report;
- Report regularly to the Department on specified performance indicators as outlined in the *Quality Framework Business Rules 2002–2003*.

It is expected that health services will have in place clear mechanisms for reviewing quality data, in particular, all sentinel events and associated root cause analysis findings and actions, and routinely reported clinical indicators.

8.2.1 Victorian Quality Council

The Victorian Quality Council (VQC) was established in October 2001 to undertake a statewide role in fostering quality and safety in health services in Victoria. It aims to work with stakeholders to identify and act on opportunities for improvement.

Its Terms of Reference are available on the website <http://qualitycouncil.health.vic.gov.au>.

The VQC has undertaken a planning process, and developed a strategic plan which is available on its website. Working Groups have been set up to review current strategies and provide advice on falls prevention, pressure wounds, infection control, appropriateness of care, blood and blood product safety and appropriateness, and medication safety.

8.2.2 Consultative Councils

The Surgical Consultative Council was established in November 2001 to systematically review safety and quality issues in surgical care, in particular preventable morbidity and mortality. It is based on the successes of the Consultative Council on Anaesthetic Mortality and Morbidity (CCAMM), and the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) which have reviewed cases for over twenty-five years, and provided reports to the system. A Physicians' Consultative Council will be established in 2002-2003.

8.3 Performance Reporting

During 2001-2002 a sentinel event reporting program was implemented by the Department as part of the Clinical Risk Management Strategy. A group of clinical indicators was reported by health services and a number of databases established. This program has been reviewed and refined to improve outcomes.

8.3.1 Sentinel Events

The 2001-2002 sentinel events list has been refined to comply with the agreed national set. It is expected that all hospitals and health services will report all such events, undertake a root cause analysis (RCA), which will be considered by the appropriate health service/hospital Quality Committee, and signed off by executive prior to submission to the Department. In addition to the national list, an "others" category has been included to encourage reporting and RCA for rare events as a result of system failure. A summary of the event and health service recommendations will be forwarded to the relevant Consultative Council who will advise both the health service of the outcome, and the Department.

8.3.2 Consultative Council Reporting

The establishment of the Surgical Consultative Council in 2001-2002, and the plans for the Physicians' Consultative Council in 2002-2003 will enhance the vehicles for hospitals/health services and individual clinicians to report adverse events and complications to a group of expert peers. For example it is expected that the following events will be reported to the relevant Council:

- Unexpected/unexplained serious neurological damage which is likely to be permanent following spinal procedures (anaesthetic/surgical/medical); and
- Hypoxic brain damage, which may be attributable to anaesthesia, airway

management or ventilation techniques.

8.3.3 Clinical Indicators

The 2002-2003 Clinical Indicator Program will focus on progressing the work already undertaken by the Department, Professional Colleges and hospitals in developing and trialling clinical indicators to support a comprehensive system of quality monitoring, analysis and action. The Department will continue to collect clinical indicators to provide benchmarking opportunities and statewide comparisons for Metropolitan Health Services and public hospitals. In addition, it is expected that hospitals will routinely review their own clinical indicators for data trends that may require action. Clinical indicators collected by the Department will also be reported to the Victorian Quality Council on a six monthly basis for trend analysis and review.

In 2002-2003 the Department will consult with clinicians and hospital personnel for advice and assistance in the selection, development and piloting of new indicators in key clinical areas.

Work will be undertaken to develop further indicators relevant to the rural sector and to build on the data being sourced from databases in Intensive Care, Vascular Surgery and cardiothoracic surgery.

A protected web site will be established allowing hospitals to enter the clinical indicator data required by the Department. This website will also provide information and reporting proformas on the indicator program, and will be progressively improved to develop a common platform for collecting and reporting clinical indicators.

It is expected that health services will report indicators to their appropriate Quality Committee and report to the Victorian Quality Council on a six monthly basis (definitions and details of reporting are in the *Quality Framework Business Rules 2002-2003*).

8.3.4 Clinical Risk Management Strategy

The Clinical Risk Management Program aims to reduce the incidence and impact of adverse patient events through a series of measures aimed at identifying system errors which contribute to adverse events, enhancing structures and processes that support treatment and care of patients, and improving communication with patients and families when unexpected events occur.

The components of the Clinical Risk Management Program are:

- Limited Adverse Occurrence Screening (LAOS) and incident reporting (see *Quality Framework Business Rules 2002-2003* for reporting requirements).
- Sentinel event reporting and root cause analysis (see Appendix 5 for details). As a result of the first year of collection, changes have been made to the list of sentinel events to reflect a more precise focus, and to be consistent with the national list agreed by the Australian Council for Quality and Safety in Health Care.
- Responding to the Coroner's findings and recommendations in relation to deaths occurring in hospitals.
- Improving communication with patients and families following adverse patient events, in accordance with national standards being developed by the Australian Council for Safety and Quality in Health Care and which will be circulated to all Victorian Health Services when available.

In May 2002 the Department of Epidemiology & Preventive Medicine, Monash University, commenced an education program in a systems approach to the management of preventable adverse patient events.

Funding will continue to be provided to health services, hospitals and rural divisions of general practice throughout the State to implement, and further consolidate existing clinical risk management programs.

8.4 Best Practice

8.4.1 Evidence-Based Practice

Support will continue to be provided in 2002-2003 to centres to assist health services to implement evidence into clinical and hospital practices. These centres include:

- Clinical Epidemiology and Health Service Evaluation Unit: www.mh.org.au/clinicalepidemiology/
- Centre for Clinical Effectiveness: <http://www.med.monash.edu.au/healthservices/cce>
- Cochrane Collaboration Consumer and Communication Review Group based at La Trobe University: <http://www.cochrane.org>
- Victorian Centre for Ambulatory Care Innovation (VCACI): <http://vcaci.health.vic.gov.au/>
- National Ageing Research Institute (NARI): <http://www.nari.unimelb.edu.au/>

8.4.2 Quality Improvement Funding Program

In 2002-2003, \$2.2 million will be allocated through the Quality Improvement Funding Program for projects approved in previous funding rounds for periods of one to three years' duration. The projects 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.

Of the forty-three currently funded projects, the majority address the six priority areas of the Victorian Quality Council.

During 2002-2003, the Quality Improvement Funding (QIF) program will focus on activities that will inform future policy development in improving healthcare practices in health services and sub-acute facilities across the whole of the state:

- An evaluation of the overall QIF program & individual projects funded under QIF. This review will provide direction for policy development and inform possible dissemination of successful healthcare guidelines and practices across the state.
- A series of workshops will be organised for project members and other interested parties that will encourage and facilitate sharing knowledge across health services and facilities. Projects will be expected to contribute to these workshops.
- A conference to be held in 2003 to showcase and promote the QIF projects, and to celebrate the achievements of the individual project teams involved. The conference will provide health services and sub-acute facilities with a forum to network and promote successes and positive outcomes.

8.4.3 Breakthrough Projects

Victoria is leading Australia in adapting the Institute for Healthcare Improvement (IHI) Breakthrough Collaborative methodology to improve the systematic approach to delivery of health care services. The Breakthrough methodology brings clinical teams together to work on common aims and to adapt and implement existing knowledge to improve patient care.

The Victorian Emergency Department Breakthrough Collaborative undertaken in 2000-2001 was a first in Australia. The success of this Collaborative succeeded in reducing clinical cycle times, operational cycle times and improving patient satisfaction. The National Institute of Clinical Studies has extended this project to fifty-one emergency departments across Australia.

In 2002, the Department is supporting two further Breakthrough Collaboratives, in adult intensive care and in the flow of patients from acute to sub-acute care.

The Intensive Care Breakthrough Collaborative involves fifteen Victorian and three South Australian intensive care teams aiming to improve the timely delivery of appropriate, safe patient care whilst increasing family and staff satisfaction.

The Acute to Sub-Acute Patient Flow Breakthrough Collaborative involves twenty-eight health service teams aiming to improve the transfer of care from acute hospitals to sub acute care facilities.

A Collaborative to improve the safe and appropriate use of blood and blood products is planned for 2003.

8.4.4 Designing Care

Launched in March 2001, Designing Care is an eighteen month innovative program aiming to improve health care delivery and continually improve patient's experience of the Victorian health care system. It is the first Victorian program to target health and ambulance services' process redesign, and to actively involve multi-disciplinary teams and consumers in improving processes across the whole health system. The program has funded fifty-three process redesign projects in twenty-nine health and ambulance services across the Victorian health care system. The projects include improving the process of care for older patients, improving access to care and improving the safety of patient care. The program has provided training for project teams to increase the capability in health services to continually improve health care processes.

For further information see: <http://designingcare.health.vic.gov.au>

8.4.5 Infection Control Initiatives

Effective prevention, monitoring and control of infection are an integral part of the day-to-day quality and safety operations of any health service.

Funding of \$6 million will continue to 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, rural and regional health services, this funding has been included in the Quality Framework funding.

Health services and hospitals will be required to submit a progress implementation report as detailed in the *Quality Framework Business Rules 2002-2003*. This report should cover each of the five 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.

Infection Control Re-Survey

The Department will report on the 2001 Infection Control Re-Survey in September 2002. The aim of the re-survey 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. Individual health service survey reports will inform health services of specific strategies that will allow continuous improvement of their programs.

During 2002-2003, there will be consultation with the sector to enable this approach to be extended to sub-acute services.

Victorian Nosocomial Infection Surveillance Centre

In 2001-2002 the Department established a Coordinating Centre to provide advice and support for the Victorian Nosocomial Infection Surveillance System (VICNISS). The Centre will receive data and report on public hospital infection rates for all hospitals with more than one hundred beds. The system will initially be piloted in ten hospitals commencing in August 2002, using NISS definitions. Benchmarked, risk adjusted, aggregated data (for all hospitals with more than one hundred beds) will be available within two years of the Centre's inception and be released within three years. 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 first two years of the Centre's operation.

Improved Cleaning Standards

The *Cleaning Standards for Victorian Public Hospitals* have been distributed to all hospitals and will be reviewed in 2002. These are mandatory for public hospitals. \$3 million will continue to be distributed to health services and hospitals across the State for ongoing monitoring of cleaning standards. For metropolitan, rural and regional health services this funding has been included in the Quality Framework funding. All acute and sub-acute health services and hospitals are required to undertake regular audits of cleaning standards outcomes. This includes external audits as outlined in the *Cleaning Standards for Victorian Public Hospitals*. All acute and sub-acute health services and hospitals will be required to submit cleaning standards performance indicator data as detailed in the *Quality Framework Business Rules 2002-2003*.

8.5 Consumer Involvement and Information

8.5.1 Reporting to the Community on Quality of Care

Health Service and Hospital Boards are required to report annually to their communities on the quality of care delivered within their institutions. The annual Quality of Care Report for the 2002-2003 year should be available to the Department in draft form for rural health services submitting reports for the first time, by 31 August 2002 for awards assessment and must be published by October 2002, although it is expected that metropolitan health services, regional and rural hospitals will aim to publish these reports earlier in the year to coincide with publication of their general annual report.

The reports should provide 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 three categories based on the size of the organisation. The groups will be: metropolitan and large regional health services and B and C rural hospitals.

Guidelines are available at <http://www.dhs.vic.gov.au/ahs/quality/effect.htm> and mandatory areas for reporting will be notified in January 2003.

8.5.2 Patient Experience

The Patient Satisfaction Monitor will continue in 2002-2003.

Each hospital participating in the survey will receive reports that provide survey results for their hospital benchmarked against other hospitals in the same category. All data is risk adjusted for age, overnight/same day status and public/private status. Category A/B/C hospitals will receive reports 6 monthly and Category D/E/F and MPS annually.

Hospitals will be required to report annually on what action has been taken in response to the results of the Monitor, in particular, whether the result enabled hospitals to identify trends in particular areas of service provision and to implement strategies to improve the quality of care and services provided in their hospital.

8.5.3 Patient Charter

The Public Hospital Patient Charter launched by the Minister in June 2002, provides a clear set of principles on the rights and responsibilities of patients in public hospitals. The principles of the Charter seek to promote a partnership between the patient and health service staff.

All hospitals are expected to promote patients' rights and responsibilities, inclusive of the statewide principles. Health Services and public hospitals are required to adopt the principles of the Charter, where appropriate, into their own patient information and documentation as part of the Board's clinical governance framework.

An extensive range of resources are available to hospitals to assist with the implementation of the Charter including a poster, a pamphlet in English, fact sheets in English and sixteen community languages and a comprehensive web site.

The Public Hospital Patient Charter and all the resources are available on the patient charter website: <http://patientcharter.health.vic.gov.au/>

8.5.4 Metropolitan Health Services Community Advisory Committees

Health services are required to continue to work with their Community Advisory Committees to ensure that consumer and community participation is integrated in service development and quality improvement planning and activities at all levels of their health service and in strategic planning and priority setting for the future.

In 2002-2003, Metropolitan Health Services Boards will need to revise their strategic Community Participation Plans. These plans should outline the role of the Community Advisory Committee, Health Service Board and Executive Management in ensuring that consumers and community members are involved in service development and quality improvement within the health service. It should 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. The plans should include some form of measurement of whether policies, processes and actions that have been identified as necessary for effective participation are in place and useful. Metropolitan Health Services Boards should also consider how to integrate and support the work of Community Advisory Committees, both financially and administratively.

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 2001-2002 Report.

Ongoing training and support for Health Services and Community Advisory Committees will be 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. The form that this training and support will take will be decided in consultation with Health Services.

8.5.5 Services for people from non-English speaking backgrounds

The Victorian Government recognises the importance of ensuring that Victorians from culturally and linguistically diverse backgrounds have full and fair access to health services. This requires the provision of quality interpreting services and greater sensitivity to the specific needs in the delivery of services.

In 2002-2003, a total of \$4 million will be provided to health services through Quality Framework funding to assist provision of culturally and linguistically diverse services.

The Department has provided funding to the Centre for Ethnicity and Health (CEH) for a two-year period, which is undertaking a review, on behalf of the Department, on the provision of culturally appropriate services in hospitals. It will develop and recommend strategies to improve the capacity and infrastructure of services to cultural and linguistically diverse patients in the acute health sector.

A review of the way funding is provided to hospitals for culturally and linguistically diverse services will be conducted during 2002-2003, in consultation with hospitals, CEH, and other Departmental Divisions. In addition, work will be undertaken to develop a minimum data set to be used by all hospitals to collect data about culturally and linguistically diverse consumer needs and services. Once this data set is established, Metropolitan Health Services and public hospitals will be required to report annually to the Department.

Health services should continue to report on their language services and culturally appropriate service provision in their Quality of Care reports.

8.5.6 Primary Care and Population Health Advisory Committees

In 2002-2003 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.

To achieve this, the Primary Care and Population Health Advisory Committees should support initiatives occurring to improve the primary care – acute care interface and have a key role in facilitating the coordination of these initiatives to build on each other.

Metropolitan Health Services Boards should be informed by the work of the Primary Care and Population Health Advisory Committee in developing their Health Services Strategic Plan and should report on the work of the committee in this plan.

The Department will 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.

8.5.7 Patient Complaints

Complaints made by consumers of health services are an important source of information that, with continued monitoring and evaluation, can yield information not otherwise available.

A project to develop and implement best practice guidelines for complaint handling in hospitals and promote effective complaints management processes and reporting by hospitals will be funded in 2002-2003. The project is auspiced by the Health Services Review Council and will undertake an extensive consultative process with relevant hospital personnel.

Regulations are being developed pursuant to the *Health Services (Conciliation & Review) Amendment Act 2001*. The Regulations, to be implemented by late 2002-2003, will require all public hospitals to report a minimum dataset of complaint information to the Health Services Commissions on a regular basis.

8.5.8 Provision of Consumer Information

Informing consumers and involving them in decisions about their care is integral to good quality health care, and should be a high priority for all health services. Policies promoting patient involvement in treatment decision making need to be flexible enough to ensure that they are appropriate across the range of contexts in which health care decisions are made and acceptable to people with diverse preferences and abilities. During 2002-2003 the Department will fund work, building on the assessing the quality of consumer Information Project undertaken in 2000-2001, to identify structures and processes that support the timely and effective provision of quality health information for consumers.

9 Service Development

9.1 Breast Care

The *Breast Disease Service Redevelopment Strategy* (Victorian Government in 1999) was developed by the Department and the Breast Care Implementation Advisory Committee to provide a framework to improve breast care services in Victoria.

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.

9.1.1 Breast Services Enhancement Program

The Breast Services Enhancement Program (BSEP) is a quality improvement initiative that funds nine demonstration models to develop, trial and evaluate best practice models of service provision. The Program commenced in 1999 and is currently funded until December 2003. 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 has 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.

In 2002-2003 an evaluation will be undertaken of best practice initiatives and the development of ways in which the Department and local services can work collaboratively to ensure the long-term sustainability of current achievements.

In 2002-2003 an additional \$1.5 million will be allocated to continuing the Breast Services Enhancement Program, and to implementing a range of projects, including:

- service development to inform the statewide performance indicator project, particularly in the areas of protocol development, information provision and linkages with general practitioners;
- piloting performance indicators and associated quality improvement mechanisms;
- evaluating multidisciplinary care strategies, and developing protocols and criteria for assessment;
- further development of the Breast Care Nurse role, in both community and acute settings;
- development and evaluation of strategies to address psychosocial issues, including clinical depression;

- development of an information and support service for women diagnosed with benign breast disease; and
- trialling successful initiatives in other areas and consolidating initiatives common to a number of BSEP areas.

9.1.2 Strengthening Support for Women with Breast Cancer

BreastCare Victoria is working collaboratively with the Commonwealth Government 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. Victoria has been funded \$530, 000 over a period of four years (until 2004), and is implementing a program with a primary focus on e-health. Initiatives developed for the SSWBC program build on current strategies being implemented in rural and regional Victoria through the Breast Services Enhancement Program.

9.2 Trauma

The Victorian state trauma system covers three Major Trauma Services (MTSs) – these are the Alfred Hospital, the Royal Melbourne Hospital and the Royal Children’s Hospital - and is supported by two levels of trauma and injury treatment services in metropolitan Melbourne and three levels in regional Victoria.

It is overseen by the State Trauma Committee (STC) which reports to the Ministerial Emergency and Critical Care Committee.

Five Regional Consultative Committees on Emergency and Critical Care Services, each supported by a Regional Trauma Coordinator, manage the development of the emergency, critical care and trauma systems in regional Victoria.

9.2.1 Funding Initiatives

WIES utilised in the treatment of Transport Accident Commission (TAC) patients is uncapped.

Separate payment arrangements will be made with the three MTSs following negotiations with the TAC regarding the composition of the funding streams for the financial year. Further guidelines for Trauma Appropriateness Payments will be issued during the year.

9.2.2 Service Initiatives

A dedicated trauma telephone service has been established for the provision of clinical advice, transfer and referral assistance.

The Department and the STC will continue during 2002-2003 to enhance work already undertaken in monitoring and evaluation of the trauma system, the coordination of targeted trauma education and trauma system development in regional Victoria.

9.3 Maternity Services

9.3.1 Provision of Maternity Services

Safe, effective, consumer-focused maternity care continues to be a high priority of the Government. The momentum will be maintained with selected initiatives, with the current method of distribution of the recurrent component of the funding maintained for a further twelve months, while additional costing and modelling work is undertaken on an episode of care, extended DRG funding model.

The 2002-2003 maternity services funding will total \$14.3 million, of which \$0.55 million will be allocated to specific statewide initiatives.

9.3.2 Statewide Initiatives for 2002-2003

During 2002-2003:

- Consultation and development work will commence on a statewide maternity care record incorporating the best features of existing records and linked to the Three Centres Consensus Antenatal Guidelines. The record will facilitate better integration of primary and acute services, rural, regional and tertiary health services, and assist consumers in decisions regarding their own care.
- Support for implementation of evidence-based consensus antenatal guidelines beyond the three teaching hospitals will enable level 2 and level 1 hospitals to consider local implementation in collaboration with general practitioners, obstetricians and community midwives.
- There will be further development and improvement of performance monitoring and maternity services information systems.
- The *Having A Baby in Victoria* Website (<http://maternity.health.vic.gov.au>), which provides definitions and locations of models of care, will be developed. Work will continue to develop consumer information and decision tools, including small scale specific improvements for women without proficiency in English, with or without literacy skills in their own language.
- Funding for the Koori Maternity Services Strategy will be extended to respond to the expanding needs in metropolitan and rural areas. Health services are expected to ensure that maternity care for Koori women is provided in collaboration with their community based carers in a manner that is sensitive and appropriate.
- The second set of Maternity Services Performance Indicators, piloted in 2001-2002, will be included in reporting requirements as outlined in the *Quality Framework Business Rules 2002-2003*. Measuring Maternity Care II: A trial of Performance Indicators (Royal Women's Hospital, 2002) will be launched early in 2002-2003.

10 Sub-Acute Services

10.1 Service Profile

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

Sub-acute care provides goal oriented (and in most instances, time-limited) interventions aimed at assessing and managing often complex conditions to maximise independence.

Timely access to high quality sub-acute care plays a critical role in the optimal flow of patients through the health system.

Sub-acute inpatient services include rehabilitation; geriatric evaluation and management (GEM); and palliative care. Non-acute/nursing home type care may also be delivered to patients who are awaiting longer-term placement either in residential care or home base settings. To optimise the appropriate use of limited sub-acute beds, Health Services need to ensure that good management and communication processes are in place across their entire system. Good internal processes and discharge planning and the use of programs such as Post Acute Care minimise the proportion of inpatient services being utilised by people who have already completed their acute and/or sub-acute episode of care. Another key element in facilitating appropriate patient care and resource management is working with general practitioners and community services in care planning.

Sub-acute ambulatory care services, which include specialist clinics, community rehabilitation centres, and some home-based therapy services, extend and complement the inpatient services. Specialist ambulatory services include forty-six community rehabilitation centres and specialist clinics for continence; falls and mobility; cognitive, dementia and memory; and pain management. A significant proportion of palliative care services are provided outside inpatient settings.

10.1.1 Policy Directions for Service Planning

During 2001-2002 the Department commissioned the "Sub-Acute Services Strategic Directions, Victoria" project to review the sub-acute system in Victoria and make recommendations for future service system development. The Department is considering these recommendations and will recommend a new policy directions framework. The key recommendations revolve around the central aim of increasing the responsiveness of the sub-acute service system to benefit patients and for anticipated growth in service demand.

10.1.2 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.

While older people are significant users of sub-acute acute services, sub-acute services - in particular rehabilitation and palliative care - need to be accessible to people of all ages.

10.2 Funding of Sub-Acute Services: Inpatients

Over recent years the funding of sub-acute services has been moving towards output based funding where appropriate. This work will continue in 2002-2003 with:

- a feasibility study to scope capacity to determine existing costs for GEM inpatients
- the costing component of the interim care evaluation

Progress in sub-acute ambulatory funding model development work will continue in 2002-2003 with the further development of a new funding model for Community Rehabilitation Centres.

In 2001-2002 the new VicRehab funding model was fully implemented. Data to date shows that this model has been successful in all agencies and will continue in 2002-2003. An evaluation report will be provided in 2002-2003.

10.2.1 Rehabilitation Funding – Vic Rehab

In 2002-2003 funding for specialised designated sub-acute VicRehab units with twenty or more beds will continue on an inpatient episode basis in the following hospitals:

- 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.

This model categorises Level 2 rehabilitation patients into sixteen groups according to clinical and functional levels (CRAFT). Categories cover the major clinical groupings in rehabilitation services (stroke/neurological, orthopaedic, cardiopulmonary, amputee, major head injury, spinal, burns and other rehabilitation). Given the statistical variability in episode length, amputee, major head injury, spinal and burns patients, these categories (Special Level 2) are funded on a per diem basis. For all other categories, payments are provided for weighted units, short stay patients (overnight stays from one to three days), and same day patients. Payments are also provided for Level 1 services (first post-acute rehabilitation episode for spinal, amputee and major head injury patients) on a per diem basis.

To minimise provider risk for smaller units, funding for designated sub-acute rehabilitation units with less than twenty beds is on a per diem basis. The Department provides a spreadsheet for use in calculating CRAFT Rehabilitation Weighted Units at <http://casemix.health.vic.gov.au>

Details of budgets and targets at the agency level are provided in *Section A* and in *Section B – Conditions of Funding*.

10.2.2 Sub-Acute Bedday Rates (non-CRAFT)

The bedday per diem rates for 2002-2003 are:

Table 16: Sub-Acute Bedday Rates, 2002-2003

Stream of Care	Per Diem Rate 2002-2003
Rehabilitation Level 1	\$470
Rehabilitation Level 2	\$390
Geriatric Evaluation & Management	\$390
Geriatric Respite/Nursing Home Type	\$154
Inpatient Palliative Care - Metro	\$390
Inpatient Palliative Care - Rural	\$393
CRAFT Rehabilitation Weighted Unit	\$10,226

Bedday targets for 2002-2003 have been established for each stream of care and the summary is provided in *Section B - Conditions of Funding*. Targets are established for both DVA (estimates) and non-DVA services. Funding for DVA activity is uncapped while non-DVA activity is capped and cannot be substituted. Further details are provided in *Section B - Conditions of Funding*.

The rehabilitation bed day rates outlined above apply to those hospitals (i.e. less than twenty rehabilitation beds) that are not covered by the VicRehab CRAFT Funding system.

General rehabilitation services in acute hospitals continue to be funded through the DRG casemix funding arrangements.

10.3 Funding of Sub-Acute Services: In Home and Community

Sub-acute services must be responsive to needs of patients, carers and family, so a number of flexible funding arrangements have been established to meet needs in the community or at home.

The sub-acute ambulatory programs that are available in all regions include:

- community rehabilitation centres; and
- specialist sub-acute clinics (Falls and Mobility, continence, and CDAMS)

There are also a small number of specialist sub-acute pain management clinics.

In addition to these established programs, there are currently a number of smaller services and flexible funding arrangements that have developed in recent years. These include – unassigned GEM, continuum of care and various rehabilitation in the home or therapy in the home programs. During 2002-2003 these programs will be reviewed in consultation with the field as part of a new sub-acute ambulatory care service framework. Reporting arrangements for unassigned GEM, continuum of care and therapy in the home programs remain unchanged for 2002-2003.

Until the framework is in place, the Sub-Acute unit in the Metropolitan Health and Aged Care Services Division must be consulted about and approve any proposals to establish new sub-acute ambulatory services or convert inpatient services to ambulatory services.

10.3.1 Community Rehabilitation Clinics

The 2002–2003 budgets for Community Rehabilitation Centres (CRC) have been determined based on the 2001–2002 budget. Additional funds were made available to some metropolitan and rural CRC in the Hospital Demand Management Strategy. Service activity targets for 2002–2003 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.

Throughput targets for DVA clients of CRCs were initially developed in 2001-2002 and have been reviewed for 2002-2003.

The Department is currently developing an episode based funding model for Ambulatory Rehabilitation that will be piloted for CRC's. This needs to be supported by further collaborative work with the field to better define service practice in certain areas and establish costings.

10.3.2 Specialist Clinics

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

10.4 Palliative Care Services

The primary objectives of the palliative care program in Victoria are to meet the needs of the individuals requiring palliation during the terminal phase of illness, and to provide support to the clients' family members and carers while care is being provided and following death.

The palliative care services include inpatient services located in a health service or hospice environment, community-based palliative care services and a number of statewide services that provide specialised consultancy and other services. The consultancy services provide specialised advice related to palliative care in the areas of motor neurone disease, paediatrics and HIV/AIDS.

In 2002-2003, additional funding of \$4 million will be allocated to palliative care, providing a total budget of \$49 million. This will allow the expansion and improvement in palliative care services.

\$17.75 million will be allocated for community based palliative care services in 2002-2003 including an additional \$2.25 million.

\$28.75 million will be allocated for inpatient services, including an additional \$1.25 million (for 3,125 beddays) for health services where there are demand pressures. Allocations are based on expected beddays and health services or hospices will have funds recalled if significantly under used.

\$2.9 million will be allocated to statewide services and activities, which include an increase of \$0.25 million in 2002-2003.

There is also the facility to optimize flexibility through unassigned bed funds. See *Section B – Conditions of Funding* for details.

10.4.1 Range of Services

Inpatient palliative care services provide services within a hospital based or hospice environment to patients who are in the terminal phase of illness. Generally this is when active treatment for the patient's diagnosed illness ceases.

Community based palliative care services provide a range of services to clients in their home and may include nursing, liaison with medical practitioners, counselling for the client and their family, other allied health services, complementary therapies such as massage, and co-ordination with other services. Services are also required to provide palliative care support to clients 24 hours a day, seven days a week.

Community based services are required to meet the Standards for Palliative Care Provision, Palliative Care Australia October 1999.

10.4.2 Data Collection and Reporting Requirements

As a requirement of the service agreements signed with the Department, all services are required to provide data to the Department during specific periods.

Inpatient services are required to provide data through the Victorian Admitted Episodes Dataset.

Community based palliative care services are required to provide data to the Department through the VicPCRS on a quarterly basis. Details are in *Section B – Condition of Funding*.

10.4.3 Future Directions

The Department will be reviewing various aspects of the program in 2002-2003. The focus will be on strengthening the relationships between the various components of the palliative care network, to provide services with a strong client focus in particular, the distribution and funding of services. To achieve this, the Department will work with palliative care services and other relevant stakeholders.

10.5 Interim Care

During 2001-2002 the Department supported pilot interim care projects in five Metropolitan Health Services. The target group for these projects are people who:

- have completed their acute or sub-acute episode of care;
- have been recently assessed by an Aged Care Assessment Service (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 most people separating from interim care pilots are placed in long-term residential care, a proportion are ultimately able to be supported at home by other existing programs such as Commonwealth Community Care Packages or HACC Linkages.

These projects will continue in 2002-2003 with funding rates set at \$269 per bed day. A formal evaluation of the Interim Care pilots is scheduled for completion in October 2002.

While the details of the service models utilised by the five metropolitan health services differ, all people participating in the interim care projects must have access to an appropriate mix of nursing, personal care and allied health care to maintain function to the extent possible.

Consideration can also be given to flexible use of available funding 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, by providing extra support services in a person's home.

It is expected that people will access the flexible program funding for a limited period of time and that there is a flow of patients to either community or residential care.

11 Emergency Services and Non-Admitted Patients Funding

11.1 Non-Admitted Emergency Patient Funding

11.1.1 Non-Admitted Patient Emergency Services Grant

Funding for the non-admitted component of emergency departments has been provided on a block grant basis in recognition of the importance of availability of emergency services. Funding for these services overall 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 specific purpose grants.

During 2001-2002 work was undertaken to gain a better understanding of the factors that influence emergency department cost structures and to develop a new funding model. The results of the costing studies will be published in September 2002. The Emergency Services Categorisation and Funding Taskforce has considered various funding models in terms of their capacity to provide acceptable measures of emergency department availability and workload. It has been recognised that:

- Availability operates at hospital and ED level. Hospital availability comprises services provided by the hospital but not necessarily by the Emergency Department (ED) that must be available to the ED on-call regardless of the actual level of activity. At the ED level, availability comprises the minimum level of staff and resources required to be able to treat complex emergency cases whether they arrive or not.
- While 'availability' serves both admitted and non-admitted patients, the activity associated with admitted patients is costed and recompensed through WIES payments, based on cost weights, in which the actual costs of receiving and treating admitted patients through 24-hour emergency departments are diluted. This extra-cost component has been extremely difficult to isolate, as data quality issues and widely varying costing practices across hospitals present considerable barriers to costing emergency services accurately.

The Taskforce will continue its investigation into measures of activity and availability (including role delineation) in 2002-2003. Over the next five years it is also likely that work will progress on a national patient classification for patients in emergency departments.

As an interim step, the Taskforce has agreed that the funding formula for the non-admitted emergency services grant should be changed to more explicitly recognise actual workloads associated with non-admitted patients and the additional costs of a hospital providing a 24-hour ED service that are not provided in the WIES payment. The non-admitted patient component will be provided on the basis of non-admitted patient attendances weighted by triage category. The availability component will be distributed on the basis of each hospital's share of the total number of multi-day WIES admitted through emergency departments. While it is accepted that this measure is only a proxy for availability, it is considered the best available indicator of a hospital's ability to receive complex cases through its emergency department.

The interim model will be introduced over two years. In 2002-2003 compensatory grants will be paid and adjustments made to ameliorate the difference between the modelled distribution and the amount actually paid in 2001-2002 to each hospital for its non-admitted emergency services.

Funding will be a block grant based on general activity categories. Additional activity within the year will not lead to additional funding.

Appendix 6 sets out the 2001-2002 allocation and the allocation based on the interim funding model for each hospital which will total \$132 million in 2002-2003. The former categorisation of E1 to E7 for emergency services no longer applies, as each service will be funded on an individual basis. In most cases the new model provides higher levels of funding to the former E2 hospitals.

11.2 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. The total number of unweighted medical and surgical encounters for the calendar year was 1,022,704 (excluding DVA) plus 488,292 (excluding DVA) allied health occasions of service. In 2002-2003 the total outpatient budget for Victoria (excluding DVA) will be \$423 million.

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 2002-2003, 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 2002-2003 are outlined in *Chapter 5 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 2001-2002. Hospital specific clinic schedules for 2002-2003 have been set and hospitals will be advised of changes to their individual clinic schedule by August 2002. The current process of notification of clinic changes will continue during 2002-2003. The closing date for notification of clinic changes, to be considered for the 2003-2004 funding year, is 26 March 2003. In 2002-2003, aspects of VACS will be reviewed. It is also anticipated that an audit will commence in the later part of the year.

11.3 Non-Admitted Patient Radiotherapy

Early in 2002 the Industry Finance Committee Radiotherapy Funding Working Group was established to address a number of funding matters, raised by the industry, around the funding of non-admitted patient radiotherapy services in Victoria. The first outcome of the review is a change in the funding model in a move towards achieving funding equality across providers. Unequal funding per unit of activity has existed due to historical arrangements by which some hospitals attracted additional payments from the Commonwealth. This has been corrected in 2002-2003 to provide the equity sought by the industry.

The funding model has been modified in two ways.

1. Agencies will retain 30 per cent of their total estimated private revenue, as provided during the review process. Previously, the targets were fixed at low historic levels that were not reflective of actual revenue, contributing to inequality of income.
2. Activity growth, up to a maximum target will be funded for all account types.

The Non-Admitted Patient Radiotherapy funding model will comprise:

- a) A variable payment per WAU;
- b) An associated department cost payment
- c) A DVA premium (where applicable)
- d) A specified grant (for SXRT, DXRT, Brachytherapy, Stereotactic Radiosurgery and IMRT)
- e) A growth payment on targets set for each patient account type. This is to be funded at the full variable rate.

The prices per WAU and the Specified Grants are adjusted for CPI, awards and productivity savings.

Base targets for each provider have been set at the estimated 2002-2003 full year activity level. This has amounted to a 10 per cent increase in base targets. In addition, growth of up to 4 per cent for public and private patients will be funded. Data collection requirements are outlined in *Section B - Conditions of Funding*.

11.3.1 National Radiotherapy Single Machine Unit Trial

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. Until now, there have been no Radiotherapy services available locally in these areas.

The Bendigo Single Machine Unit, located at Bendigo hospital and operated by the Peter MacCallum Cancer Institute, commenced operating on 2 April 2002.

The Ballarat Single Machine Unit is located at the St John of God Hospital (Ballarat) site, and will be operated by the Austin & Repatriation Medical Centre. The unit commenced operating on 1 June 2002.

It is anticipated that the third Trial site at Latrobe Hospital will come into operation in 2003-2004.

11.3.2 Ballarat and Bendigo Radiotherapy

New recurrent funding has been provided for radiotherapy treatment at Bendigo Hospital (\$1.4 million) and at Ballarat Hospital (\$1.6 million).

12 Research/Training & Development

12.1 Research Funding

Victoria has the largest concentration of leading health and medical research institutes in Australia. Victoria's universities and health and medical research institutes win 40 per cent of the national competitive medical research grants annually.

To consolidate Victoria's position at the forefront of international medical research the Government is providing additional funding of \$35 million over the next four years for operational infrastructure support for Victoria's medical research institutes. Funding for 2002-2003 will increase to \$17 million and by 2005-2006 operational infrastructure funding support for institutes will reach \$25 million, double the allocation for 2001-2002.

Further recurrent funding in excess of \$2 million 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. This payment is part of \$30 million allocated to the Consortium over ten years, commencing in 1997. The infrastructure funding to research institutes, the Breast Cancer Consortium and public health and health service research are administered by the Biomedical Health Research Section, Disease Control and Research Branch of the Department.

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.

Research infrastructure grants are also provided to the major teaching hospitals as part of the Training and Development Grants and in excess of \$15 million will be allocated in 2002-2003.

12.2 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 Training and Development Grant commenced in February 2001. Appendix 7 outlines the issues and the major findings of the Review draft report. The identification of costs associated with patient complexity, clinical training and research is a long-standing, theoretical problem due to its interrelationship with patient care, and further consideration of the proposed complexity measure will be required. The formal conclusion of the Review will be considered by the Reference Group later this year for implementation in 2002-2003.

The Training and Development Grant funding provided to hospitals for 2002-2003 will see increases in both subsidised staff numbers and in some rates. The increased numbers of subsidised staff are in the following categories – graduate and postgraduate nurses, medical Postgraduate Year 1, medical radiation trainees, and medical laboratory scientists and entry level

allied health graduates in rural areas. The increases are being applied to staff categories currently receiving the lowest percentage subsidy.

Following finalisation of the Review, the Department will provide advice regarding the future directions for the Grant. As occurred in 2001-2002, funding will also be directed to a number of strategically significant workforce initiatives. These initiatives include: the Rural Clinical Schools, the Postgraduate Medical Council of Victoria, the Victorian Universities Rural Health Consortium, an expanded program of support for medical specialist trainees in rural areas, continuing education and mentoring for allied health professionals, support for overseas trained doctors working in the public hospital system who are in the process of completing the Australian Medical Council examination and nursing projects.

For 2002-2003, 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 17: Training and Development Grant Payments, 2002-2003

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	\$ 7,600
Postgraduate Diploma Nurses	\$15,300
Postgraduate Midwifery Nurses	\$15,300
Midwifery Nurses	\$ 3,000
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
OT, SP & PT Grade 1, Year 3 (entry level, rural)	\$14,700
Medical Laboratory Scientists	\$11,900

12.2.1 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 2001-2002. 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, but additional positions have also been created to allow some other appointments including interstate graduates.

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 2002-2003 will be distributed to positions included in the computer matching process and based on 2001-2002 numbers.

12.2.2 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 2002 academic year.

In 2003, funding rates for Postgraduate training will differentiate between Postgraduate diplomas and Postgraduate certificates.

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.

12.2.3 Allied Health

The Grant currently subsidises, to varying degrees depending on the professional group, positions filled by entry level 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. The total amount allocated will remain unchanged from 2001-2002.

13 Special Grants

In 2002–2003 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 2002–2003:

- 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.

13.1 Continuous Positive Airways Pressure, Home Enteral Nutrition and the Victorian Artificial Limbs Programs

As in 2001-2002 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.

In 2001-2002 the previous agency budgets for the Victorian Artificial Limbs program were rolled into and added to individual agencies budgets. The effect of this policy change, which will be continued in 2002-2003, is 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*.

13.2 Higher Payments for Aboriginal & Torres Strait Islander Patients

In 2002–2003, the WIES10 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 2001-2002, the number of ATSI patients comprised 0.75 per cent of total hospital admissions compared with 0.5 per cent in 2000-2001 and 0.64 per cent in 1998-1999.

13.3 Mechanical Ventilation Co-Payment

The mechanical ventilation co-payment was first introduced in 1996-1997 as a sound and clinically valid surrogate for patient severity. Payments were made based upon the number of days ventilated, provided that at least six hours of continuous ventilation were provided.

Mechanical ventilation co-payments were further extended in 2001-2002 to include a one-off payment of 0.6980 WIES10 to all patients eligible for a per diem payment. This additional payment was made to allow hospitals to run intensive care units at slightly lower occupancy levels than in 2000-2001, but was conditional on hospitals opening ICU beds.

The 2001-2002 mechanical ventilation co-payments will continue to apply for 2002-2003. There are:

- 0.6980 WIES10 per patient, plus
- 0.7729 WIES10 per eligible day

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

- have been ventilated for more than 6 hours (or 96 hours for DRG A06Z);
- be admitted to a hospital with a recognised intensive care unit (ICU) for non-neonates or a recognised neonatal intensive care unit (NICU) for neonates; and
- be allocated to a DRG which is eligible for the co-payment.

During 2001-2002 the co-payment rates were reviewed and found to be appropriate when compared to the daily ICU costs. However, given the extension of mechanical ventilation co-payments it was necessary to slightly reduce the weights of ICU DRGs to prevent double payment in the DRG weight and in the co-payment.

13.4 Colonoscopy Co-payment

It is becoming routine practice in some instances for patients to undergo both a gastroscopy and an endoscopy during the same theatre session. Such patients typically group to gastroscopy DRGs. However, uncomplicated gastroscopy DRGs undertaking an additional colonoscopy, represent a significant additional cost. As a consequence, in 2002-2003 such patients will receive a WIES co-payment of 0.1765 WIES10 per episode.

13.5 Aortic Abdominal Aneurism (AAA) Stent Co-payment

In recent years the Department has provided additional assistance to hospitals for the provision of AAA stents through new technology grants. It is expected that these procedures are now regularly reported and costs allocated to patients.

Given the high costs of AAA stents and their relative frequency within two DRGs a co-payment of 3.1421 WIES10 will be made to patients with a ICD10 procedure code of 33116.00.

13.6 Atrial Septal Defect (ASD) Closure Devices Co-payment

In recent years the Department has provided additional assistance to hospitals for the provision of ASD closure devices through new technology grants. It is expected that these procedures are now regularly reported and costs allocated to patients.

Given the high costs of ASDs and their relative infrequency within the DRG a co-payment of 2.4713 WIES10 will be made to patients with a ICD10 procedure code of 38742.00.

13.7 Thalassaemia

Costing data has shown that thalassaemia cases require more resources than other patients within relevant DRGs. For 2002–2003 each thalassaemia case in DRGs Q61A, Q61B and Q61C will continue to receive a co-payment of 0.2648 WIES.

13.8 Victorian Maintenance Dialysis Program

During 2001-2002 the average number of patients receiving maintenance dialysis treatment in Victoria is estimated to have grown by nearly 7 per cent. Satellite dialysis patient numbers grew significantly more than In-Centre dialysis and Home Haemodialysis remained constant. Continuous Ambulatory Peritoneal Dialysis also grew, while Intermittent Peritoneal Dialysis fell slightly. Consideration will be given in the 2002-2003 to removing the latter treatment modality as it nears obsolescence.

Victorian maintenance dialysis services will continue to be funded under the two-tier payment model – comprising a WIES Payment for In-Centre and Satellite patients and a Program Grant for all treatment modalities.

The policy of funding In-centre and Satellite dialysis WIES to actual, introduced in 2001-2002, will be continued in 2002-2003. The policy removes WIES constraints enabling the funding to follow the patients so they may undertake ongoing dialysis treatments within reasonable distances from their home or workplace. Industry feedback indicates that this policy is achieving its objective.

Targets for each parent (and its satellite network) have been based on the number of patients last reported to the Agency Information Management System plus 4 per cent growth in average

number of patients. The impact is a 6 per cent increase in targets and an 8 per cent increase in the dialysis budget. All providers' budgets will increase.

Section B – Conditions of Funding lists the per patient annual Program Grant amounts for each treatment modality and approximate WIES payments for In-centre and Satellite Patients.

Parents and satellites will continue to report to the Victorian Admitted Episodes Dataset (VAED) for In-Centre and Satellite services. Parent hospital report patient numbers in all modalities to the Agency Information Management System (AIMS).

13.9 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 2002–2003. Payments will continue to be made on the basis of outpatient allied health activity levels and subject to the submission of quarterly activity reports.

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

14 Development of the Cost Weights and WIES

14.1 AR-DRG Version 4.2

The AR-DRG Version 4.2, the latest national grouper, will continue to be used in 2002-2003. However, during 2002-2003 Victoria will move to collecting hospital data using ICD10 Version 3. Cost weights have been calculated using Version 4.2 DRGs with data collected under ICD10 Version 2 standards. Consequently data collected in 2002-2003 will require mapping back to ICD10 Version 2 prior to grouping and WIES10 allocation.

14.2 Development of Cost Weights

The 2001-2002 cost study used for developing the 2002-2003 funding policy was conducted internally by the Department, rather than by external consultants, resulting in a much greater level of consultation with hospitals. Cost information relating to 2000-2001 was collected for inpatients, outpatients and rehabilitation patients. Data were predominately from large hospitals with clinical costing capabilities, although for the first time cost modelled data from ten small rural hospitals were also used to develop the 2002-2003 cost weights. During 2002-2003 the Department will continue to work with small hospitals that are undertaking costing studies. As the amount of information available from small hospitals increases the Department will examine the effect of hospital size DRGs.

Detailed costing information was made available to participating hospitals, members of the Victorian Advisory Committee on Casemix Data Integrity and Victorian (VACCDI) members of the Clinical Costing Standards Association of Australia (CCSAA) prior to the completion of the study. Comments based upon this information and results from an extensive statistical review of all DRGs resulted in a number of adjustments to the data supplied by hospitals, and in some cases re-supply of all data from individual hospitals. Draft weights were submitted to the Victorian Clinical Casemix Committee.

In order to facilitate increased clinical consultation and to allow for increased modelling of policy changes it is proposed that the 2002-2003 cost study will be conducted between September 2002 and November 2002, allowing an additional five months for consultation and analysis.

14.3 Calculation of Inlier Boundaries: Trim Points

To reduce the level of variation between WIES versions, WIES10 inlier boundaries were set at the 2001-2002 values (WIES9). This means that inlier boundaries have been largely unchanged since WIES8. The method of calculating inlier boundaries is described in *Section C—Supplementary Information*.

14.4 Calculation of Inlier Boundaries: Impact on costs

For most DRGs inlier boundaries are set at one third the average length of stay (low boundary) and three times the average length of stay (high boundary). However, for some complex DRGs boundaries are set at two thirds (low boundary) and one and a half times the average length of stay (high boundary). These revised boundaries enable high outlier payments to apply earlier in the hospital stay of long stay patients, thereby reducing the financial risk to hospitals associated with these patients. However, the revised boundaries can result in a much higher proportion of outliers, particularly high outliers. In such DRGs long stay, possibly high cost cases are excluded. This can reduce the weights so that the resulting loss in WIES is greater than the increased WIES through high outlier payments. To prevent this from occurring WIES were first calculated for all DRGs using inlier boundaries set at one third and three times the ALOS, and for specific DRGs, weights were adjusted, where boundary policy was found to inappropriately reduce WIES.

14.5 Same Day DRGs

DRGs that were categorised as same day DRGs last year will continue. Statistical review of the 2001-2002 cost data suggested that for a small number of DRGs the proportion of same day cases was a major source of variation in average inlier costs. Consequently the following DRGs are reclassified as same day DRGs for 2002-2003:

- G08Z Abdominal, Umbilical & Oth Hernia Procs>0
- K60B Diabetes W/O Catastrophic or Severe CC
- K62C Misc Metabolic Dis W/O Cat/Sev CC < 75
- L60B Renal Failure W Sev CC or >69 W/O Sev CC
- L60C Renal Failure <70 W/O Catast/Severe CC
- O61Z Postpartum & Post Abortion W/O O.R. Proc
- P66D Neo 2000-2499G W/O Sign ORP W/O Problem
- P67D Neonate>2499G W/O Sign ORP W/O Problem

Statistical analysis also suggested that G09Z Inguinal & Femoral Hernia Procedures >0 be made a same day DRG. However, the Victorian Clinical Casemix Committee advised that G09Z should not be change to a same day DRG as this could discourage the move to same day care.

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*.

14.6 Calculation of Inlier Weights

As in previous years, the weights were calculated from the average costs of inliers. 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. In the few instances where there were no cases in AR-DRG4.2 within the 2001-2002 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 list of DRGs for which prosthesis adjustments are made was expanded to include all DRGs with a significant prosthesis contribution. Adjustments for prostheses are necessary because not all participating hospitals are able to allocate prostheses costs appropriately, resulting in an underweighting of DRG where prostheses are commonly used and an overweighting of other DRGs. Prosthesis adjustments were made available to the Victorian Clinical Casemix Committee and participating hospitals prior to setting of the 2002-2003 weights. Prosthesis costs were based upon either:
 - a) Last year's assumed price (eg cardiology where problems in the feeder systems for prosthesis in one hospital resulted in reductions in average prosthesis costs), or
 - b) The greater of either the average cost for patients with a non-zero prosthesis cost or the median average hospital cost for non-zero cases and
 - c) The estimated proportion of patients requiring a prosthesis.

Last year's policy of inflating prosthesis costs by 10 per cent to adjust for falls in the Australian dollar was continued for a second year.

- 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 small number of DRGs three years data were used to calculate average costs.
- Weights were adjusted to half the effect for adjacent DRGs: WIES10 differed by more than 10 per cent from WIES9 and where that difference represented at least \$1 million (using WIES9 price); or where WIES10 differed by more than 20 per cent from WIES9 (and that difference represents at least \$0.5 million (using WIES9 price).
- For complicated craniotomy (DRGs B02A, B02B) the average cost from the 2000-2001 Cost Weight Study was increased by 20 per cent.
- Six DRGs attracting specific co-payments were adjusted to prevent double payment (A06Z, F08A, F08B, F19Z, G42A, G42B).
- A review of chemotherapy costs in the Cost Weight Study data demonstrated major inter-hospital variations in average costs. In consultation with the hospitals concerned the preference was to base a weight on minimum drug and staffing costs in specific hospitals and conduct a more extensive review during 2002-2003. The Department adopted this approach and calculated chemotherapy assuming minimum costs for drugs and medical care in each hospital.
- All weights were subjected to rebasing to maintain statewide WIES equivalence between WIES versions. This was done by calculating both WIES9 and WIES10 on the same twelve months' VAED dataset and then scaling all WIES10 weights by the ratio of total WIES9 to total WIES10. Agreed target WIES9 levels were adjusted by similar hospital specific indices to derive WIES10 targets.
- In 2001-2002 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. This was not done for 2002-2003, where costs represented only about 50 per cent of heart or lung transplants, similar to length of

stay. Funding for A02Z will be reviewed during 2002-2003.

14.7 High Outliers

As the costs associated with prostheses, theatre and procedural room costs 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. Details of the calculation of high outlier per diems are given in *Section C—Supplementary Information*.

With the exception of dialysis, DRGs paid under contractual arrangements and error DRGs high outlier were set with a minimum cost weight of 0.0949 WIES and a maximum of 0.3648 WIES.

14.8 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.

For 2002-2003 the methodology used to adjust prosthesis cost was similar to that used in 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. The number of patients requiring a prostheses was typically estimated using the higher of:

- the proportion of patients with non-zero prosthesis costs in the cost study data, or
- the proportion of patients with a non-zero prosthesis cost of the median hospital.

Similarly the average prosthesis cost was calculated using the maximum of the average prosthesis cost for patients with a non-zero prosthesis cost or the results for the median hospital.

Exceptions to the general rules included:

- AICD and Cochlear Implants where an assumed price was used
- A number of cardiology DRGs where last year's price was used, due to potential data anomalies in this year's 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. VACCDI members supplied the Department with document evidence of prostheses manufacture's 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 and continued this policy in 2002-2003.

14.9 Private Patient Adjustments

The Department assessed the average costs of the DRGs for public patients only not public and private patients. Where there was reliable evidence (as statistically defined by 85 per cent confidence levels) private patients would reduce the average DRG cost, the weight was based on public patients only.

15 Hospital Activity Data Standards and Quality

15.1 PRS2 and related monitoring systems

The core element of the hospital funding and activity monitoring systems are the data reporting and analysis functions of the hospitals and department. Since the 1980s a system known as the Patient Reporting System (PRS2) has been used to deliver the Victorian Admitted Episodes Dataset (VAED). These data contain the core set of clinical, demographic, administrative and financial data about every admitted patient episode occurring in Victorian hospitals. The accuracy of the VAED is critical as it is used for:

- DRG classification and WIES construction;
- Monitoring of hospital activity and funding against performance targets;
- Service planning and coordination;
- Epidemiology and clinical research; and
- Performance benchmarking and evaluation.

Other data collections that are critical to hospital funding and monitoring of the system performance are the Victorian Emergency Minimum Dataset (VEMD) Elective Surgery Information System (ESIS) and the Victorian Ambulatory Classification System (VACS).

The annual reporting cycle for these collections is aimed at ensuring that they are kept relevant to monitoring performance against current operational priorities as well as providing up to date indicators of ongoing clinical activity trends.

Coding standards are applied by qualified health information managers in accordance with the relevant edition of the Australian Coding Standards. Reporting and coding staff are regularly updated on coding instructions produced by the Department and the National Centre for Classification in Health. Coding practices are subjected to regular internal audit and data quality software products developed by the National Centre for Classification in Health are utilised. To assist with this, the Department has purchased Statewide licences for both the Performance Indicators for Coding Quality (PICQ) and Australian Coding Benchmark Audit (ACBA) products.

Data quality is ensured by a series of edits and formal checks. Data are corrected by the hospital before transmission to Allegiance Systems and after data have been processed. Hospitals reconcile their data against reports produced by PRS/2. Hospitals correct and re-transmit records that have been rejected to ensure quality and integrity of the information on which their funding and activity monitoring is based. Transmission of monthly reports in accordance with the timelines specified in *Section B - Conditions of Funding* ensures that funding accurately reflects the activity of the hospital and variations from predicted activity levels and patterns is apparent while appropriate management responses can be taken.

To ensure currency, an annual review is conducted of definitions, codesets and input edits for PRS/2, detailed in the PRS/2 Manual. PRS/2 edits provide a backup to any edits that may exist in a hospital's individual patient information system.

New hospitals or hospitals changing their software supplier are assisted in meeting data transmission standards by a special testing process before commencing or resuming live transmission to PRS/2. Edits are also conducted on aggregate data to identify data quality

issues and the results are fed back to the hospitals involved for explanation, confirmation and correction. If necessary input edits are newly specified or amended and further guidance on data policies and standards is provided.

The Victorian Advisory Committee on Casemix Data Integrity (VACCDI), which comprises representatives of hospitals, networks, Regional Offices, the Department, and the Victorian Healthcare Association, is responsible for reviewing and making recommendations regarding casemix data quality issues. VACCDI oversees the VAED audits which have been conducted on separations in Victorian public hospitals for 1993-1994 and 1995-1996 and annually from 1998-1999 onwards.

The Victorian ICD Coding Committee comprises expert coders and is responsible for answering coding queries. It liaises with hospitals, health information managers, clinical coders and VACCDI to provide advice on specific coding issues. The Committee works with the National Centre for Classification in Health in the ongoing development of the Australian coding system and standards.

A quarterly *ICD Coding Newsletter* provides information on clinical coding and data quality issues and coding advice to Victorian clinical coders. The *HDSS Bulletin*, provides advice on PRS2 data quality issues to agencies that contribute to the VAED (and also reports on other data quality issues that arise in collections). Much of the input for these reports come from issues raised by hospitals with the VAED helpdesk service, which operates by telephone and email.

15.2 Activity monitoring and standard reporting

Each month hospitals receive reconciliation statement from the PRS2 system that reports hospital throughput by month for admitted patients. This allows hospitals to quickly check their activity measures against their agreed WIES targets as registered by the Department's monitoring systems.

Monthly reports provided to particular program areas assist in the monitoring of special areas of concern. These include quality framework indicators, emergency department activity, elective surgery access levels and various public health issues.

The PRS2 system also provides extracts of activity by episode for Department of Veterans Affairs and Transport Accident Commission so that funding from those sources can be acquitted on a regular basis according to the actual activity of hospitals.

Statistics and data on service utilisation by patients from other States and Territories are produced on a regular basis so that interstate-funding adjustments can be accessed as close as possible to the time services are provided. Analyses and consolidated activity data are also provided to a range of national data collections and research institutes on an annual and year to date basis.

These data collection systems and reporting functions form the basis for development of a more integrated and automated information and reporting system as the systems infrastructure capability is improved. In 2002/2003, hospitals will have the opportunity to further automate their reporting systems as the capability of the PRS2 and related systems is upgraded to receive generic messaging to standards such as HL7.

15.3 Victorian Admitted Episodes Dataset (VAED) Audit

The success and fairness of casemix funding is based on accurate and honest reporting of clinical information. Earlier VAED Audits (previously called Coding Audits) were conducted on 1993-1994, 1995-1996, 1998-1999 and 1999-2000 data.

The 2000-2001 VAED Audit, divided into random, follow-up and supplementary components, involved re-coding by external auditors of clinical, administrative and demographic data items from just over 10,000 records selected from 65 hospitals. Results for the random component showed that 90.2 per cent of the audited episodes were allocated to the same AR-DRGs and that overall, hospitals' original WIES8 values were about 0.9 per cent lower than the level achieved with the audited codes.

Most of the WIES8 differences are due to differences in AR-DRG. However differences in WIES8 can also occur because of differences in dates, mechanical ventilation hours and indigenous status. Importantly, assessment of those episodes resulting in a different WIES8 value indicated that they were evenly balanced between 'overcodes' (4.9 per cent) and 'undercodes' (5.9 per cent). These results compare more than favourably with the outcomes of previous Victorian studies, and recent audits conducted in other States, and substantiate the Department's very positive view of the validity of coding in Victorian public hospitals.

Follow-up and supplementary audits were conducted in addition to the annual random audit. Follow-up audits were conducted where the 1999-2000 audit identified possible coding anomalies, that is where the hospital's change in WIES8 exceeded plus or minus 2 per cent and/or the change in AR-DRGs exceeded 15 per cent. Supplementary audits were 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 was borne by the hospital.

The follow-up component of the 2000-2001 audit re-examined 1,830 separations from 4 sites, and the supplementary audit 700 separations from 7 sites. Results for the follow-up component showed that 84.0 per cent of the audited episodes were allocated to the same AR-DRGs and that overall, hospitals' original WIES8 values were about 0.9 per cent higher than the level achieved with the audited codes.

Results for the supplementary component showed that 88.9 per cent of the audited episodes were allocated to the same AR-DRGs and that overall, hospitals' original WIES8 values were about 0.7 per cent lower than the level achieved with the audited codes. Significantly the results for majority of hospitals participating in follow-up and supplementary audits indicated substantial improvement in coding accuracy, although a small number continue to be of concern.

The Department has commenced planning for the next round of VAED audits. Whilst in the first year there will be an emphasis on admitted episode issues (short stay admissions, care type changes, hospital in the home, mechanical ventilation, etc.), the audit will still contain random, follow-up and supplementary coding elements. It is planned to obtain statewide coding accuracy measures every second year.