

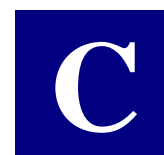
VICTORIAN DEPARTMENT OF HUMAN SERVICES

REVIEW OF MEDIHOTELS: FUTURE DIRECTIONS

SUMMARY REPORT



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INTRODUCTION

The Department of Human Services Victoria (DHS) engaged Health Outcomes International (HOI) Pty Ltd in March 2006, to:

“Review the models of care and performance of Medihotels and provide recommendations on ongoing management and funding”.

1.1 TERMS OF REFERENCE

The six (6) terms of reference for the review as set out in the contract for services between the Department and HOI were to:

- Document the models of Medihotels and clinical profile of patients;
- Identify areas that should be addressed to ensure optimal effectiveness of the Medihotels;
- Evaluate the cost-effectiveness of Medihotels;
- Provide analysis and recommendations about the future funding options of Medihotels for consideration by the Department;
- Identify any unexpected (positive or negative) outcomes resulting from the implementation of Medihotels; and
- Identify the major achievements of the individual Medihotels and evaluate how strategically the health service has managed the opportunities and barriers to achieving the stated aims.

1.2 POLICY CONTEXT

The DHS has been focused on rebuilding the capacity of the hospital system to treat more patients, faster and better. These initiatives have progressively reduced waiting lists and bypasses. The key policy initiatives that have been implemented include:

1. **Hospital Demand Management Strategy (HDMS).** The key elements include:
 - “Creating extra capacity through funding growth;
 - Relieving pressure on acute hospital beds and Emergency Departments (EDs) through diversion to alternative options for care where clinically appropriate e.g. Medihotels.
 - Working with clinicians to achieve better patient management practices through negotiation of a tailored response for each hospital;
 - Improving working conditions that will attract and retain nurses; and
 - Implementing a prevention strategy to reduce the demand pressures on hospitals (known as the Hospital Admission Risk Program or HARP)”.¹
2. **Other funded initiatives.** The Statewide Emergency and Elective Programs provide funding for initiatives that provide substitution of more appropriate care options for people who would be traditionally managed in acute beds. These substitution models of care have included short stay units, medical assessment and planning units, Medihotels, day of surgery admission and reduced length of stay.

¹ Emergency Demand Coordination Group. (2002). HDM Strategy Projects: Summary of Findings from Project Interim Reports

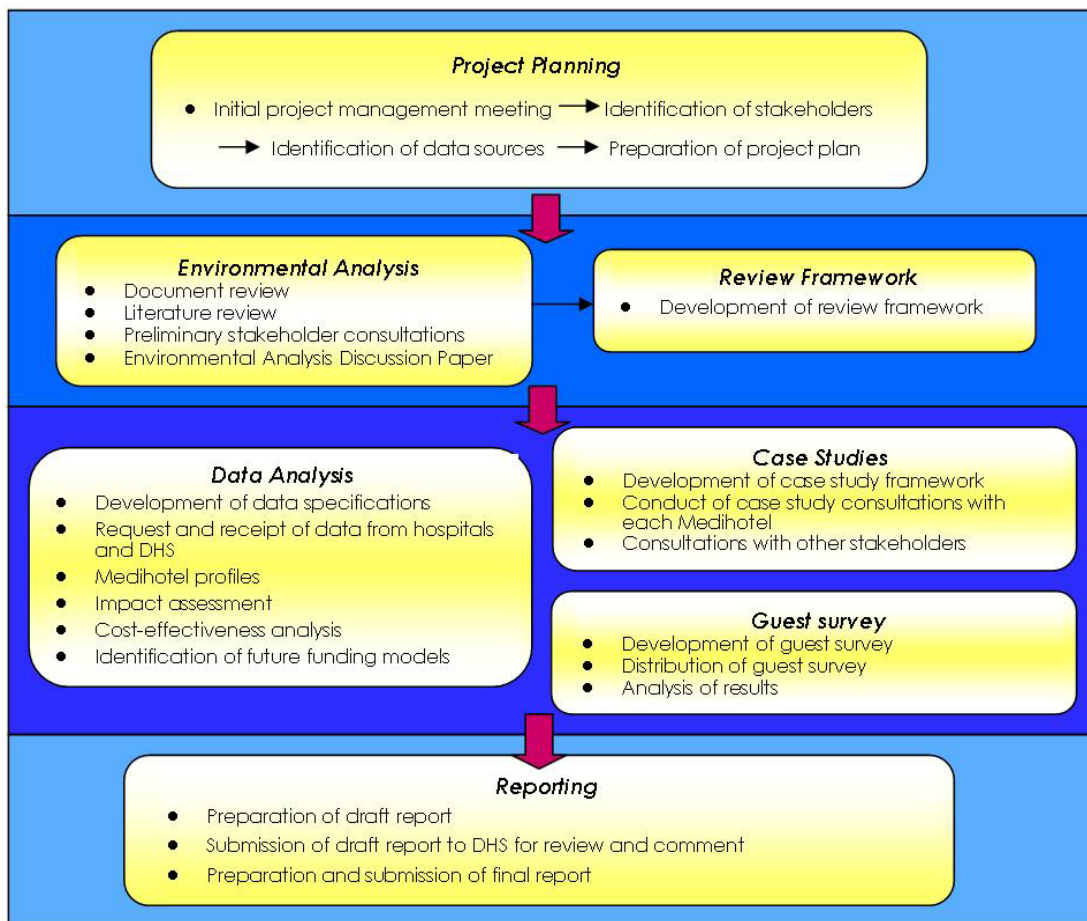
1.2.1 ESTABLISHMENT OF MEDIHOTELS

The first Medihotel was established in Victoria at The Alfred Hospital in August 2001. Since then, a total of nine (9) Medihotels have been funded by the DHS at The Alfred Hospital; Royal Melbourne Hospital; St Vincent’s Hospital Melbourne; Royal Victorian Eye and Ear Hospital; Box Hill Hospital; Monash Medical Centre; Austin Repatriation and Medical Centre; and Royal Children’s Hospital.

1.3 PROJECT METHODOLOGY

The methodology for this review comprised six (6) key stages which are identified in Figure 1.1

Figure 1.1: Review Methodology



2

OVERVIEW OF MEDIHOTEL MODELS

This chapter provides an overview of the Medihotels from the perspective of the business rules and operational arrangements associated with the eight (8) Medihotel models reviewed.

2.1 MEDIHOTELS MODEL

A Medihotel is an alternate model of care which provides accommodation for patients who do not need acute care but need to be on-site. The model is designed to indirectly create capacity to manage demand by freeing up multi-day beds.² Medihotels cater for self-caring patients who require overnight accommodation and may require access to acute care facilities. Some low level supervision is provided but not direct clinical care.

2.1.1 BUSINESS RULES FOR MEDIHOTELS

Generally, a patient who is a client at a Medihotel is considered to be on leave. However, for the purposes of VAED reporting, other guidelines include:

- Where a patient is resident in the Medihotel overnight, and during the day receives admitted patient care in a treatment area of the hospital, the patient must be admitted;
- Movement between ward accommodation and Medihotel accommodation is reported in the Status Segments within the same episode, except in situations where this is explicitly excluded;
- The use of the Medihotel must be recorded as leave where the patient receives two or more consecutive days of non-admitted services, with an intervening night in the Medihotel and receives admitted patient care both directly before and after this period;
- Where the patient receives no care for two to seven consecutive days, with intervening nights in the Medihotel, the use of the Medihotel must be recorded as leave;
- The use of the Medihotel must not be recorded as an 'admitted episode' where the patient is receiving only non-admitted or no services on the first day – the patient must be admitted on the day they first receive admitted services; and
- Where the patient is receiving only non-admitted services on the last day, the patient must be separated at the time they leave the admitted services area to go to the Medihotel.³

2.2 AN OVERVIEW OF THE MEDIHOTEL MODELS

This section provides an overview of the eight Medihotel models that were reviewed from the perspective of operational arrangements and referral patterns.

2.2.1 BAYSIDE HEALTH – THE ALFRED HOSPITAL

In 2001 Bayside Health, as part of the Hospital Demand Strategy, introduced a number of initiatives to improve waiting times in the Emergency Department and admission processes for people who

² Ibid

³ Department of Human Services Victoria (2005). *Section 4: Business rules, VAED manual*, 15th Edition <http://www.health.vic.gov.au/hdss/vaed/2005-06/manual/sect4.pdf#search=%22VAED%20MANUAL%2015%20edition%20business%20rules%22>

require hospitalisation, including the establishment of a 10 bed Medihotel. The Medihotel proposal was based on evidence from studies in the United Kingdom which showed that approximately 10% of inpatients admitted to hospital were suitable to be accommodated in a Medihotel. The Medihotel opened in August 2001 for 4 days per week. The objective of the Medihotel is to provide a cost-effective substitution to inpatient care for a range of clients.

OPERATIONAL ARRANGEMENTS

1. **Location, size and hours of operation.** The 15 bed Medihotel is situated in a refurbished ward in the main patient care block. The area has an additional 5 flexi beds used to meet hospital demand, either Medihotel or acute care. The Medihotel is currently co-located with the Medical Admission Day Unit (MADU) of 8 treatment chairs and 4 treatment trolleys. This arrangement will alter with the opening of the Alfred Centre which will have a separate 8 bed Medihotel and the relocated MADU. The Medihotel operates 24 hours 7 days per week.
2. **Management arrangements.** The combined units (MADU, Medihotel and Acute Bed overflow) have a Nurse Unit Manager with staff working across the three areas. The NUM reports to the Co-Director (Nursing), Neurosciences and Medicine. Prior to the opening of the Alfred Centre, responsibility for the Medihotel will be transferred to the Manager Patient Flow.
3. **Organisational linkages.** The Medihotel has linkages with each of the hospital clinical units, the investigative departments and the bed management staff. Medihotel and bed management staff cooperate closely to facilitate patient flow and to manage patient admissions. The NUM has good relationships with nursing and medical staff of the various clinical units to facilitate the admission process and to ensure continuity of care arrangements. The Medihotel purchases protected access to MRI and CT scans to the value of \$80,000 per year to facilitate early access of patients to investigations and diagnosis.

REFERRAL TO THE MEDIHOTEL

1. **Client eligibility criteria.** The admission criteria for the Medihotel require patients to be ambulant, self-caring, self-medicating, alert, oriented, accountable and to need minimal intervention. They must be medically admitted with a plan of care and medication chart. Self Medication Eligibility Criteria have been developed. An assessment form is completed by the patient with the Nurse, Doctor or Pharmacist prior to transfer to the Medihotel. Some patients who are unable to self-medicate may also be accepted.
2. **Referral processes.** Requests for transfer are made through the bed assignment area with the completion of a "Check List" by the referring clinical unit. The Nursing Unit Manager (NUM) uses this to screen the request and determine the patient's suitability. The final decision on patient suitability rests with the Medihotel staff. Where not all of the admission criteria are met, other options are canvassed with the referring unit.
3. **Clinical Unit referral patterns.** All clinical units refer to the Medihotel although to varying levels. The largest user of the Medihotel is the Neurology Unit which uses it primarily for patients admitted for investigation.

2.2.2 MELBOURNE HEALTH – ROYAL MELBOURNE HOSPITAL

In 2001 the Royal Melbourne Hospital commenced using off-site hotels/ motels to accommodate ambulant inpatients who did not require nursing care. This service was not widely supported by medical and nursing staff. To improve their support, Melbourne Health began exclusively using Rydges Hotel to provide Medihotel services. In 2004 a pilot with a Registered Nurse on site was commenced and while this increased occupancy, it was discontinued on July 1, 2006 due to escalating accommodation and nursing costs.

The objectives of the Medihotel are to enhance patient access throughout Melbourne Health; provide a safe secure environment where patient care remains uppermost; maintain the continuum of care; provide highly skilled and competent staff; provide an environment conducive

to healing and recuperation; provide open communication between the acute hospital and the sub-acute area; and facilitate the effective and efficient use of hospital resources⁴.

OPERATIONAL ARRANGEMENTS

1. **Location, size and hours of operation.** The Medihotel occupied one floor comprising of 8 beds at the Rydges Hotel (500 metres from the hospital). The Medihotel services were available 24 hours a day, 7 days a week, with services provided by hotel staff.
2. **Management arrangements.** The Medihotel and HITH were jointly managed. The service was overseen by the Executive Directors for Medical Services and Nursing and the Divisional Director of Nursing in Ambulatory and Continuing Care. The Medihotel operated as a stand alone service.
3. **Organisational linkages.** The Medihotel had established linkages with all clinical units and investigative departments, the pre-admission clinic, allied health staff, peritoneal dialysis unit, neurology day treatment centre and HITH.

REFERRAL TO THE MEDIHOTEL

1. **Client eligibility criteria.** An 'eligibility assessment tool' is completed prior to Medihotel referral. Patients must be medically stable, independent with activities of daily living (ADLs), safe to ambulate within a hospital environment, responsible, alert and able to self-medicate.
2. **Referral processes.** Referrals are made through the Medihotel Manager. The referring clinical unit completes an eligibility criteria form. There is a requirement for all criteria to be met; where there are issues these are discussed with the referring unit Manger. If a referral is considered 'simple' (e.g. preoperative admission with no medication or other preparation required), hospital administrative assistants place a direct booking for the guest with the Rydges staff. Allied health staff and HITH staff (for HITH patients) are available to assess patient mobility and social skills if required.
3. **Clinical Unit referral patterns.** A range of clinical units use the Medihotel, however this has varied depending on the presence or absence of nursing staff in the unit.

2.2.3 ST VINCENT'S HEALTH – ST VINCENT'S HOSPITAL MELBOURNE

In 2002, St Vincent's Hospital Melbourne (SVHM) applied for funding through the Hospital Demand Management Strategy to establish a Medihotel and Day Treatment Centre 'to address surgical demand, to expedite surgical admissions, reduce hospital induced surgical cancellations and to enable the hospital to target day surgery'. In developing the service, visits were made to the Alfred and Royal Melbourne Medihotels and research conducted into models operating overseas. The Medihotel opened in September 2002 with the Day Treatment Centre. SVHM closed 10 acute beds when the Medihotel opened to ensure the Medihotel provided a substitution service. The purpose of the Medihotel is to provide supported accommodation to patients who require access to the hospital without the need for an acute inpatient bed.

OPERATIONAL ARRANGEMENTS

1. **Location, size and hours of operation.** The Medihotel is located in the main inpatient services building in a refurbished ward and has 10 beds. It is co-located with the Day Treatment Centre. It is operational from 1pm Sunday to 7pm Friday and closes over long weekends and during periods of planned low activity.
2. **Management arrangements.** The Manager of the combined unit reports through the Director Hospital Demand and Mental Health as the Medihotel forms part of the Inpatient Services Cluster of the HDMS and Mental Health Directorate.

⁴ Melbourne Health (2006). Medihotel policy and procedure manual: Purpose and scope.

3. **Organisational linkages.** The Medihotel has developed linkages with services within the same directorate, clinical units, investigative departments and demand management staff. Close links have been established with the Departments of Neurology, Neurosurgery, Endocrinology, Rheumatology and Gastroenterology, which are the primary users of the ambulatory treatment centre.

REFERRAL TO THE MEDIHOTEL

1. **Client eligibility criteria.** Guests are required to be independent, self-mobilising (with or without aids), self-medicating, self-caring, responsible, alert and oriented. They must have an agreed plan including a discharge time and date from the Medihotel and a list of all their medications. Post procedural patients must be discharged from the acute facility and have their discharge letter, medication and follow-up appointments. Broadly, the eligibility criteria assesses whether 'the patient could go home if there were different circumstances'. Clients may be accepted from all clinical units except the Mental Health and Drug & Alcohol units. If a patient does not meet the criteria but has a designated carer, the patient and carer are accepted into the Medihotel.
2. **Referral process.** All admission requests, including any after-hours, are made on a referral form through the Bed Coordinator for initial assessment. A more detailed assessment is made in the Medihotel and if there are concerns about patient suitability they are returned to the referring ward. Medihotel staff are responsible for determining patient suitability for admission to the Medihotel.
3. **Clinical unit referral patterns.** There are four (4) main groups of patients that utilise the Medihotel service that include: (1) pre-operative and pre-procedure patients who generally require pre-admission and other reviews and/or investigations prior to major surgery; (2) post-operative and post-procedural patients who may require observation; (3) patients in the last days of their admission once their acute episode has resolved and (4) patients admitted for a series of tests, investigations, infusions and consults that may take several days to complete. The Neurology Unit is a major user of the Medihotel.

2.2.4 ROYAL VICTORIAN EYE AND EAR HOSPITAL

The Royal Victorian Eye and Ear Hospital (RVEEH) is a state-wide referral centre for eye and ear conditions, where 90% of the hospital activity is same day surgery, and the remaining 10% is acute overnight care. Due to the hospital's casemix, Medihotel throughput is high. The RVEEH was approached by the Department in mid-2003 to establish a Medihotel which commenced operation in February 2004, with an acute ward being closed for this initiative. Occupancy of the Medihotel was initially poor, but progressively increased to approximately 80%. The primary objective of the RVEEH Medihotel facility is to reduce demand on the Hospital's acute care beds.

OPERATIONAL ARRANGEMENTS

1. **Location, size and hours of operation.** The Medihotel is located in the inpatient building. It comprises 10 beds (2 x 4 beds and 1 x 2 beds) with the flexibility to use up to 14 beds. No accommodation is available for relatives or carers.

Initially the business hours were from 3pm to 10am each day but longer opening hours were required to meet demand. The Medihotel currently operates from Monday evening to Saturday morning between 6pm and 10am each day. RVEEH has approached the Australian Nursing Federation regarding the possibility of permanently increasing to 18 the number of Medihotel beds.
2. **Management arrangements.** The Medihotel is staffed by one Division 1 Registered Nurse. The Clinical Care Co-ordinator and the After Hours Nursing Supervisor are jointly responsible for the management of the facility's resources. The Acute Care Ward Nursing Unit Manager manages the Medihotel Unit and nursing staff rotate between the acute care ward and the Medihotel. The emergency medical staff are responsible for following up any additional care requirements for Medihotel clients.

3. **Organisational linkages.** The Medihotel is recognised as an integral hospital service. The Medihotel Manager's involvement in the bed access strategies includes participation in regular bed management meetings and this has improved the referral of appropriate patients. The Dental Hospital has approached the RVEEH seeking access to the Medihotel. While an agreement has been reached between the parties, the Dental Hospital has made no use of the Medihotel to date.

REFERRAL TO THE MEDIHOTEL

1. **Client eligibility criteria.** The RVEEH has developed the following admission criteria to determine eligibility for referral to the Medihotel: clients can be accommodated in the Medihotel following surgery and/or prior to surgery or treatment booked for the following day; clients need to be self-caring and self-medicating; and clients are transferred to Emergency if they require medical attention. Nursing staff are available from 7.30am to 10am.
2. **Referral processes.** Booking forms have been distributed to doctors to facilitate assessment of the suitability of patients to stay in the Medihotel. Referral protocols are consistent regardless of whether referrals originate within RVEEH or from clinicians' private rooms. Private practice managers are able to refer appropriate patients to the Unit.
3. **Clinical unit referral patterns.** Clients referred to the Medihotel include those who need supervision rather than treatment after surgery, those who do not have a carer at home for the first night after an operation and patients from rural areas who need to be present at the Hospital the day after surgery for a follow up appointment or treatment. Patients are admitted prior to and after surgery.

2.2.5 BOX HILL HOSPITAL

The Medihotel at Box Hill Hospital commenced operations on 22 May 2006. Prior to implementing the hospital-based facility, hospital clients were accommodated at Chelsfield Residential Accommodation or a nearby hotel. The objective of the Medihotel is to provide suitable onsite accommodation for patients who have had or who are about to undergo an acute intervention. The aim of the Medihotel is to achieve appropriate bed substitution for inpatient beds. The Review noted that the hotel-model option did not provide a high level of clinical support and was subsequently discontinued.

OPERATIONAL ARRANGEMENTS

1. **Location, size and hours of operation.** The Medihotel is co-located with the Day Surgery Unit (8 beds) and newly opened 23-hour Admission Unit (8 beds). The Medihotel is open only overnight and utilises 4 Day Surgery beds (and up to 8 beds if necessary). On occasions the adjacent Midwifery Unit also uses 4 Day Surgery beds. The Medihotel is open from Sunday 2pm until Monday 7.30 am, and Monday to Thursday from 5pm to 7.30am (the Day Surgery Unit is open from 8.30am to 5pm).
2. **Management arrangements.** The Medihotel, 23-hour Admission Clinic and Day Surgery Unit are staffed as one. The Medihotel Manager reports to the Director of Ambulatory Care.
3. **Organisational linkages.** Linkages have been established with selected clinical units, but due to the recent implementation of the Medihotel these are expected to be extended over time.

REFERRAL TO THE MEDIHOTEL

1. **Client eligibility criteria.** Client eligibility criteria have recently been developed and circulated to medical staff and to wards to promote the Medihotel. The criteria are that the patient be ambulant, alert and oriented, self-caring with ADLs, responsible, understand their medication and are able to self-medicate and understand the Medihotel concept. At the request of the Australian Nursing Federation (ANF), a criterion for the presence of patient aggression was included in the patient eligibility criteria.

2. **Referral processes.** All client referrals to the Medihotel are undertaken through the Patient Access Manager who discusses the appropriateness of Medihotel referral with the Medihotel Manager.
3. **Clinical unit referral patterns.** Given that the hospital-based Medihotel model has only recently been implemented, no clear referral pattern was discernable.

2.2.6 SOUTHERN HEALTH – MONASH MEDICAL CENTRE

In 2005, Monash Medical Centre received funding through the Hospital Demand Management Strategy for the establishment of a Medihotel based on the models developed at the Alfred Hospital and St Vincent's Hospitals. In a 'snap' audit of inpatients during a single week in August 2005, an average of 8-10 patients were identified each day as being suitable for accommodation in a Medihotel. The Medihotel commenced operating in March 2006.

The objective of the Medihotel is to provide appropriate accommodation to patients undergoing subsidiary diagnostics or assessments who do not require 24-hour observation. The overall aim is to improve patient flow into and through the MMC and to release inpatient beds for other patients.

OPERATIONAL ARRANGEMENTS

1. **Location, size and hours of operation.** The Medihotel has 8 beds and is located on site in a refurbished ward (54N). The available funding determined the site developed for the Medihotel. The Unit operates 24 hours 7 days per week.
2. **Management arrangements.** The Medihotel is a stand alone unit with a Nursing Unit Manger who reports directly to the Director of Nursing. Protocols have been developed for any medical emergency in the Medihotel. Patient feedback forms are provided to each guest.
3. **Organisational linkages.** The Medihotel has links with each of the clinical units to identify potential patient types that may be suitable for accommodating in the Medihotel. Allied Health services, including social work, physiotherapy, dietetics and discharge equipment are available to clients on referral from the Medihotel. The Medihotel Manager attends the daily Bed Meeting with the aim of generating referrals to maximise patient throughput for the day. The Patient Manager and the NUM liaise to facilitate the transfer or admission of a guest to the Medihotel.

REFERRAL TO THE MEDIHOTEL

1. **Client eligibility criteria.** Patients are required to be alert and oriented, self-caring, ambulant, and self-medicating. A limit of 2 nursing interventions per night is placed on admissions. Medihotel patients are discharged prior to their transfer to the Medihotel where they are considered a 'guest'. They are recorded on the local Homer System (Patient Master Index).
2. **Referral processes.** The treating clinical unit completes the Medihotel Referral form, including the reason for referral. The Access Manager receives the request which the Medihotel Manager assesses. If there are multiple patients suitable for transfer beyond the capacity of the Medihotel, admission decisions are made with the Access Manager in order to maximise access for the hospital. Pre-booked patients for the Medihotel are managed by the Access Manager.
3. **Clinical Unit referral patterns.** Referrals are made from a range of clinical units. Country patients scheduled for early morning surgery may be admitted to the Medihotel if no bed is available in the hospital's Wright Street flat. Other patients include those having a raft of tests over several consecutive days and those requiring an MRI prior to discharge.

2.2.7 AUSTIN HEALTH – AUSTIN REPATRIATION AND MEDICAL CENTRE

A Medihotel service based at a nearby motel was initially established by the Austin Repatriation and Medical Centre (ARMC) in 2001. This service was described as unsuccessful as there was

insufficient clinician support. As part of the planned response to the Hospital Demand Management Strategy, in 2002-03 the ARMC submitted a proposal for funding to establish a 16 bed Medihotel to 'provide some facilities for substitution of multi-day inpatient stays but also to provide overnight accommodation for some country patients'. A new purpose built Medihotel was constructed at the Hospital using the ground floor area of a residence for students and an additional new wing. This unit commenced operating in August 2004.

The objective of the Medihotel is to provide appropriate accommodation to patients undergoing subsidiary diagnostics or assessments who do not require 24-hour observation. The overall aim is to improve patient flow into and through the MMC and to release access to inpatient beds.

OPERATIONAL ARRANGEMENTS

1. **Location, size and hours of operation.** The Medihotel is located on the hospital site in a building that is separate from the main hospital ward areas in the Tower block. The Unit has 14 Medihotel beds plus beds for 7 carers to stay overnight. Carers are charged an accommodation fee based on their income ranging from \$7 to \$30 per night. The Medihotel operates 7 days per week but is staffed only overnight. During the day reception and cleaning staff are present in the unit and the Ambulatory Care Nurse Unit Manager is on call by pager for any patient requirements in the Medihotel.
2. **Management arrangements.** The Medihotel is part of the Home and Ambulatory Services area and shares a Nurse Unit Manager with the Ambulatory Care Centre (Day Treatment Centre) Elective Admissions Transit Lounge. The Manager of the Home and Ambulatory Care Services reports to the Executive Director, Ambulatory and Nursing Services. The Unit is managed by the Nurse Unit Manager Ambulatory Care and is staffed by one Registered Nurse for the evening shift from 6.30pm and another Registered Nurse for the night shift from 10.30pm to 8.30am. Emergency care is provided through the Emergency Department.
3. **Organisational linkages.** The Manager of Home and Ambulatory Care Services has promoted the Medihotel concept in the hospital for the last 2 years, developing linkages with medical, nursing and management areas of the hospital. Linkages have also been developed with the patient access area. The Medihotel Manager is a member of the care co-ordination team which facilitates patient flow through the hospital and into the community including HITH, early discharge, and post acute care. The Patient Flow meeting of senior staff members including the Executive monitors and promotes the Medihotel strategy.

REFERRAL TO THE MEDIHOTEL

1. **Client eligibility criteria.** Clients must meet the criteria of being self-caring in Activities of Daily Living, in accessing meals and for medication.
2. **Referral processes.** Referrals are managed by the Medihotel Nurse Manager, the single point of control for beds in the hospital, in consultation with the Bed Manager. A screening tool is used for all Medihotel referrals to assess suitability for the Unit. The Bed Manager has twice daily discussions with the hospital Nurse Unit Manager to discuss planned admissions and to identify discharges and potential Medihotel patients.
3. **Clinical Unit referral patterns.** All clinical units with the exception of the General Medical Unit and the Cardiology Unit refer patients to the Medihotel. The reason for physicians not referring to the Medihotel is that nursing care is not provided in the Unit. For instance, the Cardiology Unit considers cardiac patients to be at too high a risk to be accommodated in the Medihotel.

2.2.8 ROYAL CHILDREN'S HOSPITAL

The Royal Children's Hospital (RCH) Medihotel (known as the Supported Care Centre) was opened in August 2004 as a three-bed unit. Due to the nature of the patient population at the hospital (children and their families) the RCH Medihotel service must be able to accommodate one parent with the child in the Medihotel, and the parent must be able to meet the care requirements of the

child. Continuity of care through extensive care planning is a key focus of the hospital, thus the benefit of transferring patients to new wards with new staffing must be weighed up against the requirement for continuity of care. In 2007, the hospital is being re-built at a new site which will create further change for the Medihotel model.

The objective of the Medihotel is to improve patient access through the provision of a cost-effective alternative to acute beds for less dependent patients and families.

OPERATIONAL ARRANGEMENTS

1. **Location, size and hours of operation.** Medihotel is open 7 days a week and is co-located with parent accommodation (8 beds) and the Post-natal Mothers' Unit (2 beds). During the winter of 2006 parent accommodation services have been temporarily purchased through Rydges Hotel Carlton and the Medihotel bed capacity has been increased to 11. When the hospital redevelopment is complete, it is planned that the Post-natal Mothers' Unit will be relocated to the Neonatal Unit and the Medihotel will take over these beds. This will result in a 5-bed Medihotel.
2. **Management arrangements.** The Medihotel is managed jointly with the Parent Accommodation and Post-natal Mothers' Units as these three facilities are co-located. The facility is staffed during the day by a Registered Nurse (1 FTE) and overnight the Medihotel is overseen by the Short Stay Unit (located in another area of the hospital).
3. **Organisational linkages.** The RCH Medihotel has developed a relationship with the Rehabilitation Unit, which frequently refers patients to facility. Approximately 25% of Rehabilitation patients transition through the Medihotel which has enabled increased access to Rehabilitation Unit beds.

REFERRAL TO THE MEDIHOTEL

1. **Client eligibility criteria.** The set eligibility criteria for admission to Medihotel are as follows:
 - The patient must be medically stable and at minimal risk of sudden deterioration;
 - Nursing care required is limited to intermittent intervention only;
 - There must be a parent accompanying the child who is competent in providing the child's core requirements;
 - The parent must have the ability to understand and follow simple emergency procedures;
 - The child must have a defined care plan that has been commenced;
 - The 'home unit' is aware of the child's transfer and has accepted responsibility for care coordination;
 - The 'home unit' has discussed booking and care requirements with the Medihotel manager or Short Stay Unit (after hours); and
 - Independent adolescents will be considered on an individual basis in consultation with the adolescent unit (and must be self-caring).
2. **Referral processes.** Referrals are made to the Medihotel by Nurse Managers and guidelines relating to use of the Medihotel are available on the hospital's intranet. Bed management meetings are held twice daily and are utilised to identify potential Medihotel patients.
3. **Clinical unit referral patterns.** The Rehabilitation Unit's frequent use of the Medihotel has evolved due to the bed pressures in the Rehabilitation Unit and was facilitated by the Unit Director who understood the model and the capacity it provided the inpatient unit. The Review noted that the pattern of referral to the Medihotel differed at the RCH relative to other facilities with the Medihotel being utilised more than once by a rehabilitation patient during an episode of care. For example, the patient may stay in the Medihotel for 1 week whilst undergoing rehabilitation at the hospital, return home for 1 week to continue the rehabilitation at home, and then return to the Medihotel to continue the rehabilitation program.

2.3 SUMMARY OF CLIENT ACTIVITY

Table 2.1 provides a summary of the key operational features of the Medihotel models. The findings demonstrate that there has been a varied approach to implementing these initiatives, with different service delivery roles and functions across the various models.

Whilst a “one size fits all” approach is not advocated we believe there is an opportunity to provide a more coordinated approach to Medihotel operations through the development of standardised protocols and guidelines.

Table 2.1: Summary of Medihotel Model Features

Model Features	TAH	RMH	SVHM	RVEEH	BH	MMC	ARMC	RCH
Implementation date	2001	2001	2002	2004	2006	2006	2004	2004
Location	Hospital – in ward area	Hotel	Hospital – in ward area	Hospital – in ward area	Hospital – in ward area	Hospital – in ward area	Hospital – separate building	
Number of Beds	15 + 5 'flexi' beds	8	10	10	8	8	14 + 7 carer beds	3 Temporary increase to 11 beds – winter strategy.
Hours of operation	24 hours / 7 days per week	24 hours / 7 days per week	1pm Sunday to 7pm Friday	Monday to Saturday from 6pm to 10am each day	2pm Sunday to Thursday	24 hours / 7 days per week	Sunday pm to Friday pm	7 days per week
Management arrangements	Manager – combined unit NUM. Report through Nursing – to change to Manager Patient Flow. Own staff.	Manager – shares with HITH. Part of Ambulatory Care & Continuing Care Management Division.	Manager – combined Unit Manager Part of Hospital Demand and Mental Health Directorate. Own staff	Manager – Acute Ward NUM. Clinical Care Coord and A/H Nursing Supervisor manage resources. Staff rotate from acute ward.	Co-located with Admission & Day Surgery Units. Medihotel Manager reports to Director Ambulatory services	Stand alone unit with NUM. Reports directly to Director of Nursing.	Shares a NUM with the Ambulatory Care Centre. Reports through the Manager Home & Ambulatory Care Services.	Managed jointly with the Parent Accom. & Post-natal Mother's Unit by a midwife.
Staffing	1 Div 1 nurse	Nil	1 Div 1 nurse	1 Div 1 nurse	1 Div 1 nurse	1 Div 1 nurse	1 Div 1 nurse	1 midwife
Organisational linkages	MADU; Clinical units; Investigative Departments; Hospital Demand Management	Clinical units; Investigative Departments; pre-admission clinic, allied health, HITH, Neurology Day Treatment Ctre	Treatment Ctre Accom Service Clinical units; investigative Departments; Hospital Demand Management	Integral part of hospital service. Agreement with Dental Hospital for access.	Selected clinical units.	Clinical units; Hospital Demand Management.	Clinical units; Hospital Demand Management.	Rehabilitation Unit

MEDIHOTELS CLIENT PROFILE

This chapter presents a comparative analysis of the clients referred to Medihotels with respect to:

- Number of clients and average length of stay in a Medihotel;
- Clients' area of residence;
- Clinical Unit referrals to Medihotels;
- Reasons for admission; and
- Adverse events.

3.1 NUMBER OF CLIENTS AND LENGTH OF STAY IN MEDIHOTELS

Table 3.1 presents a comparative analysis of Medihotel activity in terms of number of clients and average length of stay for the 2004-05 financial year.

Table 3.1: Summary of Medihotel Activity – 2004-2005

Medihotel	No. Clients	Total Days	ALOS
The Alfred Hospital	1,906	3983	2.09
Royal Melbourne Hospital	827	1342	1.62
St Vincent's Hospital Melbourne	1,522	1841	1.21
Royal Victorian Eye and Ear Hospital	1,443	1144	0.79
Box Hill Hospital ⁽¹⁾	21	N/A	N/A
Monash Medical Centre	153	497	3.25
Austin Hospital	693	981	1.42
Royal Children's Hospital ⁽²⁾	220	N/A	N/A
Total	6,785	9,788	1.44

(1) Box Hill client activity does not reflect a full year of operations.

(2) Royal Children's Hospital does not reflect a full year of operations.

Table 3.1 shows that:

- The total number of clients admitted to Medihotels in 2004-2005 was 6,785 and the average length of stay was 1.44 days.
- The number of clients receiving Medihotel services ranged from 1,906 at The Alfred Hospital to 21 at Box Hill Hospital (the latter figure does not reflect a full year of operations).
- The Medihotel average length of stay varied from 3.25 days at Monash Medical Centre to approximately 1 day at the Royal Victorian Eye and Ear Hospital.

The differing levels of client activity illustrated in Table 3.1 can in the main attributed to the years of operation of each Medihotel, increasing periods of operation enabling the establishment of more effective referral patterns.

3.2 CLIENTS' AREA OF RESIDENCE

Table 3.2 shows the proportion of Medihotel clients who resided in metropolitan and rural areas during 2004-05.

Table 3.2: Client's Area of Residence – 2004-05

Area	ARMC	MMC	RCH	RMH	RVEEH	SVH	TAH	Total
Metropolitan	38%	59%	73%	31%	82%	89%	61%	67%
Rural	62%	41%	27%	69%	18%	11%	39%	33%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total clients	632	153	197	773	1,426	1,477	1,794	6,452

Note: This analysis is based on a subset of data as not all Medihotel sites collected this information.

Table 3.2 above shows that:

- Of the total of 6,452 clients that utilised Medihotel services in Victoria during 2004-05 financial year 67% resided in metropolitan areas and 33% in rural areas.
- The proportions of rural clients attending the ARMC and RMH (62% and 69% respectively) were significantly higher than the proportions at other Medihotels.

3.3 CLINICAL SPECIALTY UNIT REFERRALS

A comparative analysis of the proportion of client referrals from clinical specialty units during the 2004-05 financial year is provided in Table 3.3 below.

Table 3.3: Comparative analysis of clinical specialty Unit Referrals – 2004-05

Clinical Specialty	ARMC	MMC	RCH	RMH	RVEEH	SVH	TAH	Total
Ophthalmology	3.5%	0.0%	0.5%	8.2%	96.3%	0.0%	1.6%	24.2%
Neurosurgery	4.6%	18.9%	0.5%	17.4%	0.0%	17.1%	6.2%	8.3%
Gastroenterology	6.9%	15.4%	34.4%	9.7%	0.0%	11.0%	4.1%	6.9%
Thoracic Surgery	3.6%	7.0%	4.8%	0.0%	0.0%	18.6%	5.4%	6.2%
Vascular	4.8%	2.1%	0.0%	4.3%	0.0%	10.0%	6.9%	5.1%
Neurology	3.6%	10.5%	2.4%	3.0%	0.0%	10.3%	6.2%	5.0%
ENT/Head & Neck	0.6%	0.0%	0.0%	5.6%	3.7%	7.9%	3.2%	4.1%
Plastic/Oral/Faciomax	3.0%	0.0%	13.9%	6.3%	0.0%	2.8%	6.4%	3.8%
Cardiology	9.4%	6.3%	1.9%	1.7%	0.0%	4.4%	4.7%	3.7%
General Surgery	7.6%	2.1%	11.0%	0.0%	0.0%	0.0%	8.3%	3.5%
Endocrinology	0.4%	1.4%	7.7%	6.8%	0.0%	2.5%	6.9%	3.5%
Urology	5.9%	1.4%	0.0%	3.2%	0.0%	6.5%	3.6%	3.4%
Emergency Medicine	0.3%	0.0%	0.0%	1.4%	0.0%	0.0%	9.1%	2.7%
Renal	4.8%	2.8%	0.0%	0.0%	0.0%	2.8%	4.7%	2.5%
Orthopaedics	3.9%	1.4%	6.2%	8.4%	0.0%	2.6%	0.9%	2.4%
Haematology	3.2%	2.1%	0.5%	3.9%	0.0%	2.2%	4.0%	2.4%
Liver Transplant Unit	14.1%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	1.6%
Oncology	7.9%	2.1%	1.0%	3.5%	0.0%	0.0%	1.0%	1.6%
General Medicine	4.0%	0.0%	8.6%	0.6%	0.0%	0.1%	2.5%	1.5%

Clinical Specialty	ARMC	MMC	RCH	RMH	RVEEH	SVH	TAH	Total
Nephrology	0.0%	11.2%	0.5%	10.4%	0.0%	0.0%	0.0%	1.4%
Resp & Sleep Med	0.9%	0.7%	0.0%	0.1%	0.0%	0.1%	3.1%	1.0%
Rheumatology	1.0%	1.4%	0.0%	0.4%	0.0%	1.0%	2.0%	1.0%
Radiation Oncology	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	2.9%	0.9%
Dermatology	0.0%	5.6%	0.5%	0.1%	0.0%	0.1%	2.2%	0.8%
Infectious Diseases	0.1%	0.0%	0.0%	0.7%	0.0%	0.0%	2.2%	0.7%
Cardiac Surgery	2.7%	0.0%	0.0%	1.7%	0.0%	0.0%	0.0%	0.5%
Stroke	0.1%	1.4%	0.0%	0.3%	0.0%	0.0%	1.1%	0.4%
Radiology	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%	0.3%
Renal Dialysis	0.1%	0.0%	0.0%	1.9%	0.0%	0.0%	0.0%	0.2%
Dental	0.0%	0.0%	5.7%	0.0%	0.0%	0.0%	0.0%	0.2%
Obstetrics	0.0%	5.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
Gynaecology	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
Geriatric Medicine	0.1%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Nuclear Medicine	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 3.3 shows that:

- That the highest proportion of client referrals (approximately 24% of all Medihotel clients) came from Ophthalmology Units. This result is slightly skewed due to the large volume of clients from the RVEEH which specialises in same day eye and ear procedures.
- Neurosurgery, Gastroenterology, Thoracic Surgery and Vascular Units contributed between 5% and 8% of total client referrals.

These findings indicate that there is scope to increase client referral rates to Medihotels at many of the sites.

3.4 REASON FOR ADMISSION

Due to data limitations a comparative analysis of the reasons for admission to a Medihotel was only possible for the Monash Medical Centre, Royal Melbourne Hospital and the Royal Victorian Eye and Ear Hospital. This analysis is presented in Table 3.4 below.

Table 3.4: Reason for Admission to Medihotels – 2004-05

Reason for Admission	MMC	RMH	RVEEH	SVH	Total
Pre-op Patient	26.1%	0.0%	0.0%	66.2%	26.6%
Other/Not Coded	0.0%	0.0%	34.2%	8.0%	15.6%
Country Patient	0.0%	53.3%	8.4%	0.0%	14.2%
Awaiting Home Services	0.7%	11.2%	29.8%	0.0%	13.2%
Observations & Dressings	13.7%	11.4%	25.7%	0.4%	12.5%
Awaiting Diagnostic Tests	15.7%	5.8%	0.0%	15.7%	7.9%
Awaiting R/V, transport, tests, results, appointments	19.6%	15.9%	1.9%	0.0%	4.8%
Post-op Observations	3.3%	0.0%	0.0%	7.7%	3.1%
Administration of IV/SC medication	8.5%	0.0%	0.0%	2.0%	1.1%
PD Training	2.6%	1.3%	0.0%	0.0%	0.4%
Refuge (abusive/aggressive partner)	0.7%	1.0%	0.0%	0.0%	0.2%
Ante-natal Patient	5.2%	0.0%	0.0%	0.0%	0.2%
Baby in NICU	2.6%	0.0%	0.0%	0.0%	0.1%
Diabetic education, monitor blood sugar levels	1.3%	0.0%	0.0%	0.0%	0.1%
	100.0%	100.0%	100.0%	100.0%	100.0%

The data presented in Table 3.4 indicate that:

- Pre-operative patients comprised the highest proportion of clients (26%) admitted to this sub-set of Medihotels.
- No identified reason for admission to the Medihotel was given for a significant proportion of clients (approximately 16%).
- Just over 14% of those admitted to these Medihotels were country patients.

There is a need to improve the accuracy of data collection and reporting of activity relating to Medihotel operations in the future.

3.5 ADVERSE EVENTS

Hospitals providing services have a duty of care to monitor adverse events so that action can be taken when appropriate. Medihotels provided the Review with a tabulated summary of all of the adverse events occurring during 2004-05. A summary of the numbers of patients and the types of events are presented in Table 3.5 below.

Table 3.5: Summary of Medihotel Adverse Events – 2004-05

Medihotel	No. Adverse Events	Nature of Event
The Alfred Hospital	0	
Royal Melbourne Hospital	0	
St Vincent's Hospital Melbourne	0	
Royal Victorian Eye and Ear Hospital	3	<ul style="list-style-type: none"> • Loss of property • Incorrect Medihotel procedure • Incorrect Medihotel procedure

Medihotel	No. Adverse Events	Nature of Event
Box Hill Hospital	0	
Monash Medical Centre	0	
Austin Hospital	0	
Royal Children's Hospital	1	<ul style="list-style-type: none">• Treatment for seizure
Total	4	

As shown in Table 3.5 above, there were a total of four adverse events reported by Medihotels in two hospitals which represents .06% of total clients referred during 2004-05. Based on this analysis the Review is able to conclude that Medihotel services present a low clinical risk and do not put clients at risk of harm.

The Review support the continuing monitoring and analysis of adverse events which will enable redesign and improvement processes to be developed for reducing or removing the potential for similar events in the future.


 4

MEDIHOTEL CLIENT SURVEY

This chapter provides a summary of the analysis of the Medihotel client survey which was conducted during the course of the review.

4.1 SUMMARY OF SURVEY FINDINGS

Whilst survey forms were distributed to all Medihotels involved in the review responses were not received from all facilities. There was a total of 84 survey respondents as detailed in Table 4.1 below.

Table 4.1: Medihotel Client Survey Sample

Medihotel	Total Respondents
The Alfred Hospital	14
Royal Melbourne Hospital	11
St Vincent's Hospital Melbourne	11
Royal Victorian Eye and Ear Hospital	14
Monash Medical Centre	16
Austin Repatriation and Medical Centre	12
Medihotel not known	6
<i>Total Survey Sample</i>	<i>84</i>

Analysis of the survey responses indicates that the majority of clients are satisfied with the Medihotel services that they receive. The majority of respondents commented that the facilities were very pleasant and that Medihotel staff were very supportive and caring. The key survey findings are that:

- There is a reasonable level of satisfaction (78%) with the information provided regarding Medihotel services but that there is room for improvement;
- There is a high level of satisfaction (94%) with the level of nursing support provided by the Medihotels although some respondents considered nursing resources to be stretched and as a result staff are too busy to provide support to clients;
- There is a higher level of consumer satisfaction with the physical facilities provided in the hotel-based model relative to the hospital-based model, particularly from the perspective of :
 - Privacy (private rooms are available in hotel model whilst clients are required to share accommodation in the hospital model);
 - Security (the hotel model provides a 24 hour reception service whilst the hospital model does not have a similar service);
 - Functionality of bathroom facilities and electrical appliances; and
 - Ready access to telephone services.

Based on the results of the client survey, there is evidence to suggest that the hospital-based facilities (housed in refurbished hospital wards) do not quite make the grade for comfort and

privacy that may be expected by some “hotel” guests. However, a compensatory factor in favour of the hospital-model is that these sites are able to provide more timely nursing and medical care to clients when required. Whilst clients utilising hotel-based facilities may be more comfortable, clinical staff have highlighted that access to acute care facilities from hotel-based facilities is more problematic. This presents a challenge to Medihotel operations as refurbishment of hospital-based Medihotels to a standard comparable with hotel-based services will ultimately have space, cost and funding implications.

5

ACHIEVEMENTS, BARRIERS AND OPPORTUNITIES

This chapter provides a summary of the findings with respect to the achievements, barriers and opportunities for improving the delivery of Medihotel services.

5.1 MEDIHOTEL ACHIEVEMENTS

The findings demonstrate a range of achievements that have been attributed to the implementation of Medihotels. These include:

- A high level of client satisfaction with Medihotel services;
- Different approaches have been implemented with respect to service delivery roles and functions across the models;
- Each model has evolved over time in response to local hospital priorities;
- The more established Medihotels have achieved increased DOSA rates;
- The more established Medihotels have been able to achieve high referral rates resulting in increased occupancy rates whilst other facilities have acknowledged a need to implement strategies to increase referrals to the service; and
- The implementation of Medihotels in some hospitals has resulted in hospital-wide clinical practice improvements being introduced to support efficient bed management.

5.2 BARRIERS AND CHALLENGES

The review has identified a number of barriers and challenges impacting on Medihotel operations, including:

- A number of Medihotels need to develop strategies to establish effective linkages with clinical units in order to increase the level of referrals, and this requires clinician acceptance of the facility;
- Limitations relating to existing bed capacity, which result in waiting lists, is a barrier to increasing the operations of a number of Medihotels;
- A high level of cooperation is required between the hospital Bed Managers and Medihotel Managers in the referral process to ensure that only suitable patients are referred;
- There is concern regarding continuity of Medihotel nursing staff and potential deskilling due to the relative low acuity of patients referred to the facilities. A closer alignment of Medihotels with acute care wards (e.g. surgical wards) would enable staff to maintain their nursing competencies;
- A number of industrial relations issues relating to the implementation of the Medihotels were identified. These include:
 - Nursing staff working in isolation;
 - Classification of nursing staff working in a low-care environment; and
 - Change of working hours for staff due to different shift requirements.
- Medihotels do not currently have access to an integrated management information system which has meant that client referral processes are not streamlined and are often difficult. In addition, the collection of data regarding Medihotel operations is not standardised across all Medihotels.

5.3 OPPORTUNITIES FOR IMPROVEMENT

The review identified a number of opportunities for improving Medihotel services in order to meet the strategic objective of providing substitute care models for people who would traditionally be managed in acute beds. These include:

- A range of service improvement opportunities can be achieved through the establishment of clearer lines of communication and stronger relationships with clinicians;
- There is considerable scope to improve the number of referrals to Medihotels through the implementation of a focused marketing strategy to promote greater acceptance of Medihotel services among clinicians;
- There is scope to increase referrals of patients undergoing same day procedures (e.g. same day angioplasty);
- There will be opportunities for expansion of Medihotel services as advances in radiology and pharmacology, which are reported as resulting in less intrusive surgery, are implemented in Australia.
- There is an opportunity to include the option for transfer to a Medihotel in clinical pathways once defined criteria are met. This would ensure that the option for transfer to a Medihotel would be considered at a particular point in the care plan.
- Whilst it is important that each Medihotel model respond to individual hospital needs, there is also a need to ensure a level of consensus and consistency in the operations of all Medihotels. This requires the development of a standardised approach with respect to:
 - Patient and management information systems and interfaces with hospital based systems;
 - Development of clinical standards and guidelines;
 - Reducing the level of duplication across units with respect to developing operational guidelines and processes common across units;
 - Benchmarking of operations to improve operational efficiency; and
 - Information sharing.
- There is the potential to expand the services provided some Medihotels by increasing bed capacity, but this would be conditional on the availability of space and additional capital funding.
- The delivery of Medihotel services has the potential to create secondary demand for hospital services if Medihotel services are used in lieu of "hotel/motel type" accommodation. This would limit the ability of Medihotels to provide services to clients who would be more appropriately supported in these facilities. For example, there is a potential for Medihotels to provide services to clients, for instance pre-surgery country clients, who could otherwise be accommodated in other facilities. In order to ensure that the type of accommodation provided is clinically appropriate and reflects individual client needs it may be necessary to explore further modelling options. For example, the literature review identified a number of Medihotel model options that have been implemented overseas and these could be further examined in order to develop local models that effectively manage secondary hospital demand.

6

ECONOMIC ANALYSIS OF MEDIHOTELS

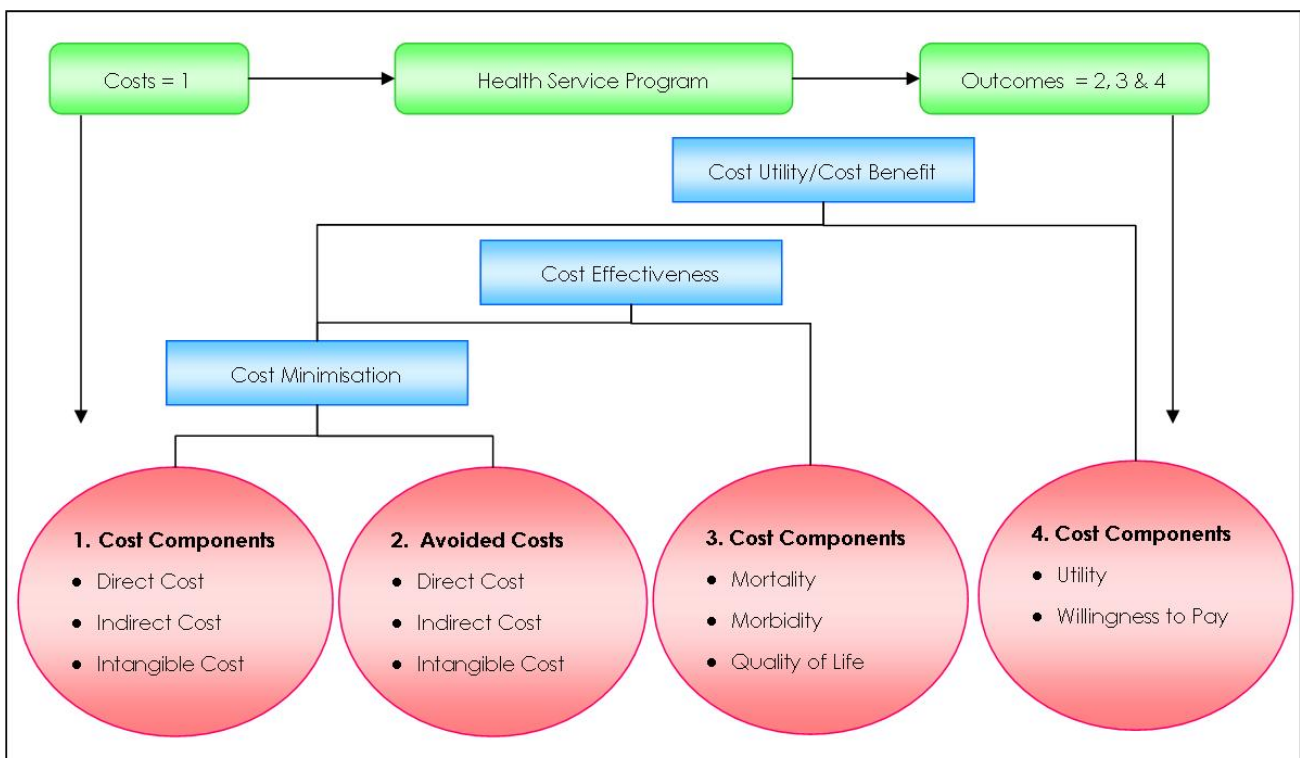
This chapter provides a summary of the evaluation of the cost effectiveness of Medihotels with respect to:

- An overview of economic evaluation techniques used to assess the impact of health program implementation;
- The applied economic evaluation methodology that was used for the purposes of determining the cost effectiveness of these initiatives; and
- A summary of the review findings.

6.1 ECONOMIC EVALUATION TECHNIQUES

This section outlines the different types of economic evaluation methodologies that have been used in the decision making process to assess the impact of the implementation of health programs. There are four main techniques that have been utilised in the health sector which are illustrated in Figure 6.1 below.

Figure 6.1: Techniques of Economic Evaluation



In summary, in a full economic evaluation both costs and benefits are measured. The most frequently used method is cost effectiveness analysis in which benefits are measured in terms of clinical outcomes. Cost minimisation analysis is sometimes described as a partial economic analysis as only costs are measured and benefits are not considered. This form of analysis is appropriate when the outcomes of the program being evaluated have been demonstrated to be better than or as good as the alternative.

6.2 APPLIED ECONOMIC EVALUATION METHOD

Given the relevance of alternative approaches to the context of the Medihotel program, the review considered that cost minimisation analysis (CMA) was the most appropriate approach to the economic analysis. This assumes that:

- The primary intended outcome from the Medihotel Program is to provide for an equivalent clinical outcome at a lower cost;
- There is no evidence to demonstrate that the Medihotels model has resulted in a reduced clinical outcome (for example as might be reflected in a higher re-admission rate for participants); and
- Data are available (or can be derived) that enable a comparison of costs on a common platform.

The aim of the CMA was to compare the costs of providing Medihotel services to clients relative to the costs of providing services in the acute care sector.

6.2.1 DATA INPUTS

The CMA requires data on the costs of the Medihotels to be compared with the comparable costs for an inpatient stay for the same patient group.

We have assumed that the clinical intervention and associated services (such as pharmacy, theatre, ICU etc.) are the same for both the Medihotels and inpatient models. Therefore the area where costs are expected to differ relates to the per diem costs associated with the hospital wards or nursing costs (under the inpatient model) and Medihotel accommodation and nursing costs.

6.2.2 CALCULATION OF INPATIENT NURSING COSTS

The Department provided 2004-2005 inpatient data from the Victorian Admitted Episodes Dataset (VAED) comprising component costs by DRG for each hospital with a Medihotel facility. Using these data we were able to determine the total nursing cost component for each hospital and for each DRG to enable comparison with the per day costs of providing Medihotel accommodation. The nursing cost component included both direct and indirect costs which encompass the actual nursing salary costs and the ward services cost of a patient occupying a bed in hospital.

The total nursing cost for each hospital was calculated by taking the mean cost of nursing as provided by the Department and multiplying this by the number of separations for each DRG. This data was then aggregated to derive a total nursing cost per hospital. This resultant figure was divided by the total length of stay for the hospital to arrive at a per diem cost for the nursing for an inpatient episode. Table 6.1 presents the per diem cost of nursing for inpatient episodes for 2004-05.

Table 6.1: Per Diem cost of nursing for inpatient episodes - 2004/2005

Site	Per Diem Cost
The Alfred Hospital	\$369.06
Royal Melbourne Hospital	\$366.96
St Vincent's Hospital Melbourne	\$310.70
Royal Victorian E&E Hospital	\$297.86
Box Hill Hospital	\$296.60
Monash Medical Centre	\$354.38
Austin Repatriation and Medical Centre	\$411.09
Royal Children's Hospital	\$442.91
Total Average	\$356.20

Table 6.1 shows that the per diem nursing costs for inpatient episodes (adjusted for casemix) ranges from \$442.91 for the Royal Children's Hospital to \$296.60 for Box Hill Hospital. Our analysis has shown that the RVEEH has a lower than average per diem cost for nursing, however this Hospital's casemix is distinctly different from the other hospitals due to a specialisation in ambulatory and elective surgery. Conversely, the Royal Children's Hospital has a higher than average per diem cost which reflects the additional time and effort required to provide nursing services to children.

6.2.3 CALCULATION OF MEDIHOTEL NURSING COSTS

The per diem nursing costs for Medihotel facilities were derived by dividing the total expenditure for each Unit by the total length of stay for all clients. Where possible data for the 2004-05 financial year was used, however these data were not available in all instances. Table 6.2 provides a summary of the data elements that were used to undertake this analysis.

Table 6.2: Data available for Medihotel per diem calculations

Medihotel	Budget/Expenditure Data	Year	Quality
The Alfred	Budget	2004-2005	Estimate only
Royal Melbourne Hospital	Expenditure	2004-2005	Very comprehensive expenditure report, may include costs that others don't
St Vincent's Hospital Melbourne	Expenditure	2005-2006	Extrapolated estimate only
Royal Victorian Eye & Ear Hospital	Expenditure	2004-2005	No breakdown provided
Box Hill Hospital	N/A	N/A	Data not available
Monash Medical Centre	Expenditure	2005-2006	Year to date only
Austin Hospital	Budget	2004-2005	Recurrent cost estimate provided
Royal Children's Hospital	N/A	N/A	Data not available

Given the data limitations highlighted above, the per diem costs calculated for each site should be viewed as indicative cost estimates only, although they do provide a basis for comparison to inpatient costs.

Table 6.3 presents the estimated per diem costs for Medihotel services.

Table 6.3: Estimated per diem costs for Medihotel services

Site	Per Diem Cost
The Alfred Hospital	\$70.29
Royal Melbourne Hospital	\$441.69
St Vincent's Hospital Melbourne	\$203.62
Royal Victorian E&E Hospital	\$240.71
Box Hill Hospital	N/A
Monash Medical Centre	\$275.47
Austin Repatriation and Medical Centre	\$275.49
Royal Children's Hospital	N/A
Total Average	\$251.21

Table 6.3 shows that:

1. Based on the available data, the estimated per diem cost for Medihotel services ranges from \$441.69 at the Royal Melbourne Hospital to \$70.29 at The Alfred Hospital. This analysis indicates that the cost structures for four of the Medihotel sites are similar.
2. In the case of the Royal Melbourne Hospital, Medihotel services are provided through a commercial hotel nearby and this has contributed to the relatively high accommodation costs in comparison with the other models that are hospital based. Additionally, the expenditure report for this site was very comprehensive and included all overheads costs for the running of the Medihotel which may have also contributed to the high per diem cost. As previously discussed in Chapter 2, the Royal Melbourne Hospital has since completely changed the model of the Medihotel facility and as such has significantly reduced the costs for providing this service.
3. The Alfred Hospital's Medihotel per diem cost of \$70 on face value appears to be understated relative to the other Medihotels that have been reviewed. However, The Alfred Hospital has been able to progressively create significant efficiencies by sharing resources with the Day Treatment Centre through co-location, which could be an explanation for the significantly lower cost.

6.2.4 COMPARATIVE ANALYSIS OF INPATIENT AND MEDIHOTEL PER DIEM COSTS

A comparative analysis of the per diem cost of inpatient episodes and associated costs in the Medihotel Units to derive an estimated per diem cost saving was undertaken. Table 6.4 presents the results of that analysis.

Table 6.4: Comparison of Inpatient and Medihotel per diem costs

Hospital	Inpatient \$	Medihotel \$	Estimated per day Saving
The Alfred Hospital	\$369	\$70	\$298.77
Royal Melbourne Hospital	\$367	\$442	-\$74.73
St Vincent's Hospital Melbourne	\$311	\$204	\$107.08
Royal Victorian E&E Hospital	\$298	\$241	\$57.15
Box Hill Hospital	N/A	N/A	N/A
Monash Medical Centre	\$354	\$275	\$78.91
Austin Repatriation and Medical Centre	\$411	\$275	\$135.60
Royal Children's Hospital	N/A	N/A	N/A

Table 6.4 above illustrates that most sites demonstrate a reasonable cost saving on a per diem basis ranging from approximately \$299 for The Alfred to \$57 for the RVEE, whilst the Royal Melbourne Hospital incurred an additional per diem cost of approximately \$75.

6.2.5 NOTIONAL IMPUTED COST SAVING

Table 6.5 presents the notional imputed cost saving for the 2004-05 year based on the estimated per diem savings shown in Table 6.4 above.

Table 6.5: Imputed cost saving by hospital for 2004-2005

Hospital	Bed Days Medihotel Clients	Bed Day Variance \$	Estimated Saving \$
The Alfred Hospital	3,983	\$298.77	\$1,190,000
Royal Melbourne Hospital	1,342	-\$74.73	-\$100,288
St Vincent's Hospital Melbourne	1,841	\$107.08	\$197,134
Royal Victorian E&E Hospital	1,144	\$57.15	\$65,380
Box Hill Hospital	N/A	N/A	N/A
Monash Medical Centre ⁽¹⁾	497	\$78.91	\$39,218
Austin Repatriation and Medical Centre	981	\$135.60	\$133,024
Royal Children's Hospital	N/A	N/A	N/A
Total Estimated Cost Saving	9,788		\$1,524,460

(1) Monash Medical Centre Medihotel not in operation in 2004-05, bed days are 2005-06 year to date.

Table 6.5 shows that:

- The estimated total cost savings that could be attributed to the provision of substitutable services by Medihotels was approximately \$1.5 million.
- The Alfred Hospital Medihotel generated the highest cost saving (approximately \$1.2 million) as a result of having significantly higher activity (approximately 41% of total Medihotel bed days) and the lowest unit bed day cost of \$70.
- The Royal Melbourne hotel-based Medihotel incurred a total additional cost of \$100,288 relative to the costs of providing these services in the acute area.

6.3 SUMMARY OF REVIEW FINDINGS

In summary the review has demonstrated that:

1. **Medihotel services are cost effective.** The results of the retrospective economic analysis demonstrate that the provision of Medihotel services is a cheaper alternative to inpatient care for hospital-based models. However, the results also indicate that hotel-based models are more expensive.
2. **Medihotels provide a viable alternative service.** The review has provided evidence that early discharge programs such as that provided by the Medihotel model for patients recovering from elective surgery (multi day and same day) and for elderly patients with a medical condition are viable alternatives to providing similar services in acute care, providing the specific needs of patients are taken into account.
3. **Data limitations exist.** One of the challenges encountered by the Review Team in undertaking the Cost Minimisation Analysis was the collection of consistent data for Medihotel activity and associated costs. Due to these data limitations we were required to make a number of cost imputations. As a result of these estimations, we have emphasised that the results of the Cost Minimisation Analysis presented in this chapter should be regarded as indicative.
4. **Standardised definitions and reporting protocols are necessary.** It is important for the purposes of the future management and funding of Medihotels, particularly with respect to benchmarking analyses, that hospital-based information systems develop the capacity to accurately report activity and financial data relating to the operations of Medihotels. This will require the development of standardised definitions for data collection and reporting protocols.



MEDIHOTELS FUNDING MODEL OPTIONS

This chapter provides a discussion of funding model options for Medihotels and recommendations for future funding options for Medihotels.

7.1 MEDIHOTEL FUNDING ARRANGEMENTS

The total grant funding allocation to hospitals to provide Medihotel services for the two year period 2004-05 and 2005-06 is presented in Table 7.1 below.

Table 7.1: DHS Grant Funding Allocation to Hospitals for Medihotels 2004-05 to 2005-06

Medihotel	2004-05		2005-06		Total	
	\$'000	%	\$'000	%	\$'000	%
The Alfred Hospital	\$288,818	20.79%	\$299,538	15.57%	\$588,356	17.76%
Royal Melbourne Hospital	\$349,000	25.12%	\$361,955	18.81%	\$710,955	21.46%
St Vincent's Hospital Melbourne	\$127,238	9.16%	\$131,961	6.86%	\$259,199	7.82%
Royal Victorian E&E Hospital	\$247,428	17.81%	\$256,614	13.34%	\$504,042	15.21%
Box Hill Hospital	\$0	0.00%	\$350,000	18.19%	\$350,000	10.56%
Monash Medical Centre	\$0	0.00%	\$133,000	6.91%	\$133,000	4.01%
Austin Repatriation and Medical Centre	\$246,707	17.76%	\$255,865	13.30%	\$502,572	15.17%
Royal Children's Hospital	\$130,000	9.36%	\$134,827	7.01%	\$264,827	7.99%
Total	\$1,389,191	100.00%	\$1,923,760	100.00%	\$3,312,951	100.00%

Total DHS grant funding allocated to hospitals for the provision of Medihotel services increased approximately 38% over the two financial years from approximately \$1.4 million in 2004-05 to approximately \$1.9 million the subsequent year. Funding levels varied among the hospitals in 2005-06.

7.1.1 STRENGTHS AND WEAKNESSES OF CURRENT FUNDING ARRANGEMENTS

Table 7.2 provides a summary of the strengths of weaknesses of the current Medihotel grant funding arrangements.

Table 7.2: Strengths and Weakness of Current Funding Arrangements

Strengths	Weaknesses
Grant funding for Medihotel services is included as part of the mainstream hospital funding and is not tied to activity.	Level of grant funding is insufficient for some hospitals to cover Medihotel operating costs and does not take account of increased activity or service demand.
Provision of a specified grant provides a defined budget for Medihotel services.	Hospitals are required to provide addition funds to support the delivery of Medihotel services from casemix funded allocations.
	Some hospitals have been required to reduce the level of nursing support to the Medihotels as a result of insufficient funding which limits the type of clients referred to the facility. Increased funding is required to sustain appropriate staffing levels.
	Some hospitals have been required to limit the hours of operation (over weekends) of Medihotels due to funding constraints. Increased funding is required to enable increased activity levels.

7.2 SUMMARY OF REVIEW FINDINGS

A key weakness of the current grant funding arrangements, identified by all of the Medihotels that have been in operation for over 12 months, relates to the cost pressures associated with increasing activity levels and higher patient acuity levels that require appropriate levels of nursing to be provided to clients admitted to these units. The review found that for the most part, the current level of grant funding is sufficient based on existing activity levels. However the review also identified there is scope to increase the level of Medihotel services which would result further benefits being achieved with respect to increased access to acute care beds. This would require consideration of a funding mechanism that takes account of increases in activity levels to provide funding equity.

7.2.1 RESOURCE ALLOCATION ISSUES

A number of issues directly relevant to the funding options for the mainstreaming of Medihotel services funding warrant consideration. These include:

- The lack of transparency in resource allocation processes for some Medihotels;
- Budgetary and expenditure information related to the operations of the Medihotels is not readily available; and
- Resource allocation does not currently take account of variations in activity levels, therefore hospitals supplement resource shortfalls.

7.2.2 SERVICE COSTING ISSUES

The identification of the costs associated with the provision of Medihotel services is a challenge for many hospitals, particularly where services are co-located. Reporting the costs of Medihotel operations in a separate cost centre would assist in the process of management, decision making and future benchmarking. This reporting strategy is integral to the determination of resource allocation prices and budget setting processes at both DHS and hospital levels.

7.3 FUNDING MODEL OPTIONS FRAMEWORK

In considering potential funding options for Medihotels two issues were considered, namely the level of funding to be provided and the method of resource allocation.

7.3.1 DETERMINATION OF LEVEL OF FUNDING

It is recognised that the level of recurrent funding will always be finite and will be set within the limits of the budget allocations to health. There is a need to develop a policy framework together

with relevant service agreements that specify the services to be provided, the level of funding, and the key performance indicators that need to be reported to ensure accountability for the funding provided.

7.3.2 RESOURCE ALLOCATION

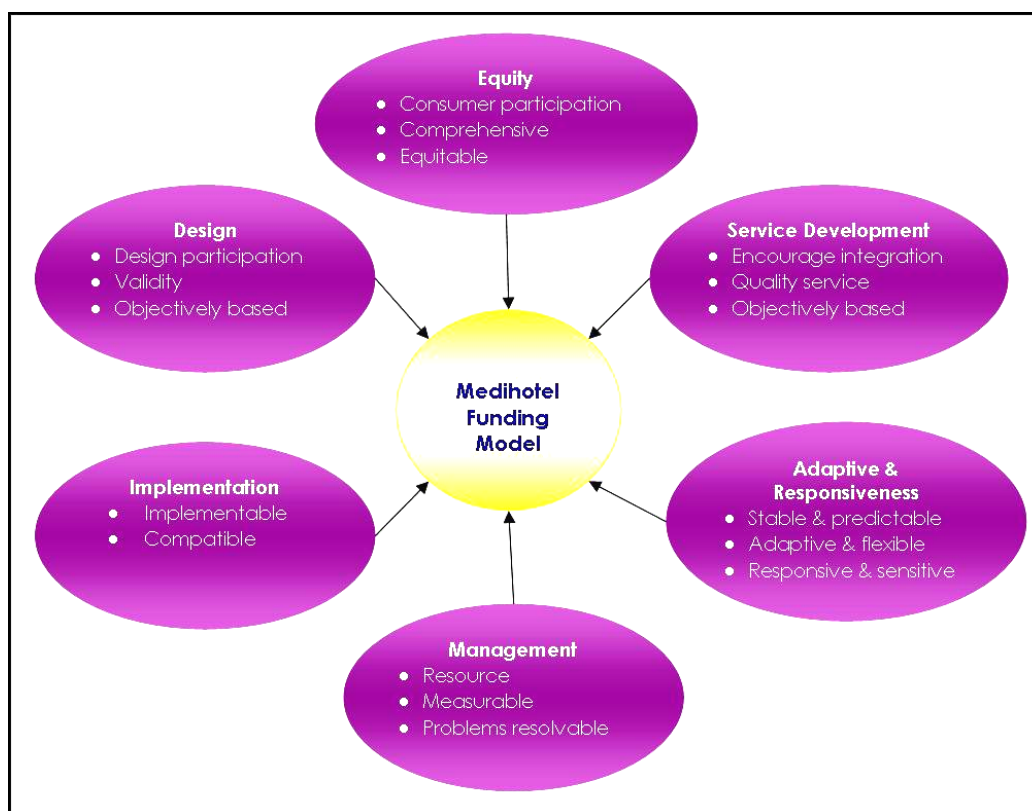
The evidence base indicates that the resource allocation formula should be consistent with the strategic direction of the DHS priorities with respect to improving access to acute care services. In addition, the allocation of resources to service providers must be equitable to facilitate cost comparisons and benchmarking.

Given that determining a funding policy is not within the scope of this Review, we have formulated a number of resource allocation model options, which are discussed below.

7.4 ELEMENTS OF A FUNDING MODEL FOR MEDIHOTEL SERVICES

Figure 7.1 is a diagrammatic illustration of the core elements that need to be considered in the evaluation of candidate funding model options for Medihotel services in Victoria.

Figure 7.1: Elements of Medihotel Service Funding Model



7.4.1 EVALUATION FRAMEWORK

The key features of the desired recurrent funding allocation model should:

1. Define a clear accountability structure in relation to expenditure between the DHS and hospitals providing Medihotel services.
 - Provide transparency for resource allocation decisions in terms of:
 - ~ ensuring that the basis of resource allocation model is understood; and
 - ~ flexibility that allows the model to be responsive to changes; and
 - ~ promoting opportunities for expanding Medihotel services.
2. Be reflective of fairness and equity for Medihotel service providers in terms of:

- promoting financial sustainability;
 - promoting efficiency in service delivery; and
 - ensuring a safe and effective level of care.
3. Be reflective of the strategic directions of the DHS.
 4. Be capable of reporting and acquitting against agreed frameworks of outcomes and outputs.
 5. Have the capacity to provide an understanding of the cost of service delivery.
 6. Facilitate benchmarking to improve the effectiveness and efficiency of service delivery.
 7. Be consistent with evidence based best practice.

To evaluate the resource allocation model options, we have considered each option against the specified requirements to determine the preferred model for implementation (see below).

7.5 MEDIHOTEL RESOURCE ALLOCATION MODEL OPTIONS

This section provides an overview of the five (5) resource allocation model options that were considered for Medihotel services funding.

OPTION 1: NO CHANGE TO THE EXISTING FUNDING ARRANGEMENTS

This option requires no change to the current grant funding arrangements.

OPTION 2: PER DIEM FUNDING MODEL

This model provides for the payment of Medihotel services on the basis of bed days utilised. Per diem payment approaches are generally applied when there are significant differences in resource utilisation and patient acuity (such as in Intensive Care Units and designated rehabilitation and mental health units).

One of the key weaknesses of a fixed payment per day of stay relates to the issues of economic efficiency. This approach provides no incentives to hospitals, doctors or patients to economise on length of stay.

OPTION 3: CASEMIX BASED CO-PAYMENT RESOURCE ALLOCATION MODEL (INCENTIVE PAYMENT MODEL)

This model is an extension of the existing Victorian Casemix Funding Model. It is essentially an "add on" payment to the existing casemix funding arrangements. For example, the Victorian Casemix Funding Model provides for four types of co-payments: Mechanical ventilation, Thalassaemia, Atrial septal defect closure and Abdominal Aortic Aneurysm Stents⁵.

OPTION 4: WIES PLUS PROPORTION OF HIGH OUTLIER PAYMENT

This model proposes funding Medihotel days of stay on the basis of a per diem outlier payment, similar to that used to fund Hospital in the Home (HITH). From a funding perspective, HITH services are considered as equivalent to inpatient care and patients treated in the HITH program are funded through WIES. HITH patients are identified through changes in accommodation type and the high outlier payment for HITH patients is reduced (to 80%) to better approximate costs⁶.

This funding approach will require:

- A methodology to determine the proportion of the high outlier payment that will be applied;

⁵ Department of Human Services, " Policy Funding Guidelines 2006-07 Technical Paper" <http://www.health.vic.gov.au/pfg/pfg0607/pfg0607.pdf>

⁶ Ibid

- Development of classification of service types and definitions;
- Development of activity collection and reporting frameworks to be used in the VAED; and
- A methodology for deriving costs.

OPTION 5: TARGET ACTIVITY VOLUME WITH BONUS PAYMENTS

This funding model is based on specified Medihotel Target Volumes, which will be outlined in the Health Service Agreements. Essentially the model will include WIES payments plus access to the bonus funding pool once targets have been achieved. The DHS currently operates a bonus funding framework which provides bonus funding to health services on a quarterly basis based on performance against statewide benchmark levels. The number of Medihotel clients could be included as one of the key performance indicators that are subject to bonus funding. This funding approach will require:

- A methodology to determine agreed target volumes and bonus payments;
- Development of classification of service types and definitions;
- Development of activity collection and reporting frameworks to be used in the VAED; and
- A methodology for deriving costs.

7.6 EVALUATION OF RESOURCE ALLOCATION MODEL OPTIONS

Table 7.3 provides an assessment of the recurrent resource allocation model options against the evaluation criteria.

Table 7.3: Evaluation of Resource Allocation Options for Medihotel Services

Evaluation Criteria	Option 1: No Change	Option 2: Per diem Payment Model	Option 3: Casemix Co-payment Model	Option 4: WIES + % high outlier payment	Option 5: Target Activity with Bonus Payment
1. Accountable between funding partners	Spasmodic accountability, depending on terms of current service agreements.	Provides accountability between the DHS and Medihotel service providers.	Provides accountability between the DHS and Medihotel service providers.	Provides accountability between the DHS and Medihotel service providers.	Provides accountability between the DHS and Medihotel service providers.
2. Transparency of resource allocation decisions	Creates uncertainty and confusion and not responsive to changes in outputs.	Understood by the DHS and service providers. Implementation requires the accurate reporting of Medihotel days of stay.	Understood by the DHS and service providers. Implementation requires minimum additional effort to determine co-payment methodology.	Understood by the DHS and service providers. Implementation requires some additional effort to determine a methodology for the % of outlier payment.	Understood by the DHS and service providers. Implementation requires minimum additional effort.
3. Reflects fairness and equity	Does not encourage financial sustainability.	Provides a level of financial sustainability.	Provides a level of financial sustainability.	Provides a level of financial sustainability.	Provides a level of financial sustainability.
4. Reflects strategic direction of the DHS	Does not reflect government strategic direction.	May reflect strategic direction of the DHS.	Reflects strategic direction of the DHS. Similar to existing DHS casemix co-payment arrangements.	Reflects strategic direction of the DHS. Similar to existing DHS HITH payment arrangements.	Reflects strategic direction of the DHS. Hospitals achieving specified targets would be eligible to access existing bonus pools.

Evaluation Criteria	Option 1: No Change	Option 2: Per diem Payment Model	Option 3: Casemix Co-payment Model	Option 4: WIES + % high outlier payment	Option 5: Target Activity with Bonus Payment
5. Able to report and acquit against agreed frameworks	Limited.	Requires relatively detailed level of data which can be reported and acquitted against.	Requires detailed level of data which can be used for reporting and acquitting against.	Requires detailed level of data which can be used for reporting and acquitting against.	Requires detailed level of data which can be used for reporting and acquitting against.
6. Able to understand cost of service delivery	Limited.	Provides understanding cost of services.	Provides understanding of the costs of service delivery.	Provides understanding of the costs of service delivery.	Provides understanding of the costs of service delivery.
7. Facilitates benchmarking	Limited.	Permits benchmarking.	Permits benchmarking at all levels for service outputs.	Permits benchmarking at all levels for service outputs.	Permits benchmarking at all levels for service outputs.
8. Consistent with evidenced based best practice	Does not recognise funding requirement of the DHS.	Does not provide incentives for improved efficiency.	Recognises the funding requirements of the DHS.	Recognises the funding requirements of the DHS.	Recognises the funding requirements of the DHS.

7.6.1 TARGET ACTIVITY VOLUME AND BONUS PAYMENT MODEL REPORTING REQUIREMENTS

For the purposes of mainstreaming the proposed Medihotel Funding Model, it is recommended that a service agreement be developed between the DHS and each hospital providing Medihotel services. The service agreement between the Department and each hospital should specify the following information:

- Product Definition.** The service agreement should provide a definition of all Medihotel service products including:
 - Pre-admission Medihotel services (including a description of service components); and
 - Post-discharge Medihotel services (including a description of service components).
- Specification of target activity.** Projected target activity should be specified. Data relating to the projected activity should be identified as part of the business planning and service agreement process. This will require Medihotel service activity to be collected and reported in a consistent manner in accordance with agreed product definitions.
- Performance Indicators.** In addition to standard reporting requirements, key performance indicators should be specified, including service utilisation measures.
- Access to bonus pool.** Guidelines outlining the criteria for access to the bonus funding pool should be developed by the Department and promulgated to hospitals in the Victorian Public Hospitals and Mental Health Services Policy and Funding Guidelines. These arrangements should also be specified in the service agreements.

8

CONCLUSIONS AND RECOMMENDATIONS

This Chapter provides a summary of the overall findings of the Review and associated recommendations. We have focused on the terms of reference as well as identifying opportunities for improvement and suggestions for future directions with respect of streamlining the implementation of Medihotel services.

8.1 OPPORTUNITIES TO IMPROVE SERVICE DELIVERY MODEL

The Review has highlighted that a common feature of the Medihotel service delivery models is the provision of an alternative service delivery model for people who would be traditionally managed in acute beds. From this perspective, the Medihotel service delivery model has been tailored to take account of individual hospital priorities. The greatest risk of the current model relates to the increasing client numbers being referred to the more established Medihotels and the limited physical capacity of these Units. In addition the Review found that clients were being referred with increasing more complex needs requiring higher levels of nursing support.

The opportunities to improve the current service delivery model include:

1. **Establishment of a Medihotels Reference Group.** The Review has identified a need to establish a Medihotels Reference Group comprising of nominated representatives of the Medihotels to facilitate sharing best practice and have an involvement in the development of a policy framework to support the further development of the Medihotel model across Victoria.
2. **Development of policy framework.** There is a need for the DHS to develop a policy framework to include guidelines, funding mechanisms to support the further development of the Medihotel model across Victoria. The Review has highlighted that benefits would be gained by Medihotels from a more standardised approach with respect to:
 - Consistent approach to classifying clients utilising Medihotel services;
 - Consistent approach to incident monitoring and reporting;
 - Implementation of a common Medihotel management system which is interfaced with hospital-based patient management systems;
 - Consistent approach to the development of Medihotel protocols, standards and guidelines, modified where necessary to reflect local hospital requirements; and
 - Agreed indicators to measure Medihotel performance.
3. **Medihotel Business Plan.** To support future Medihotel service development at the local hospital level, a Business Plan that maximises Medihotel utilisation and inpatient bed substitution. This Business Plan would provide Medihotels with the framework to systematically focus on service improvement quality and safety.
4. **Develop Medihotel protocols for referral and risk management.** The Review considers that hospitals implementing Medihotels should develop protocols for clinical unit referrals to the service and risk management strategies. The objective being to maximise the utilisation of Medihotels and ensuring quality and safe services are provided.
5. **Service Agreement.** The Review considers that the DHS should develop a service agreement for the provision of Medihotel services to provide hospitals with relevant information on process, reporting and accountability requirements. The Service

Agreement would outline the terms and conditions of service provision and funding including:

- Service level information, performance reporting and other requirements;
- Funding and scheduled payment information; and
- Financial accountability reporting.

Given that the Department enters into to Service Agreements with Hospitals, the inclusion of Medihotel services into these agreements would require minimal effort.

6. **Workforce service delivery innovation.** One of the key findings of the Review related to the challenges for maintaining nursing competencies for Medihotel staff. Consistent with the Department's policy to examine opportunities for workforce innovation, the Review considers there are benefits to be achieved by the DHS exploring more innovative workforce models to support Medihotel service provision in collaboration with hospitals.

It is recommended that:

R1 The DHS support the establishment of a Medihotel Reference Group to develop standardised protocols and guidelines for Medihotel operations, which would facilitate a more coordinated approach to a range of service improvement initiatives.

R2 A Business Plan be developed by hospitals implementing Medihotels identifying proposed service improvement initiatives to be undertaken.

R3 Hospitals providing Medihotel services develop local protocols for clinical unit referrals and risk management and quality improvement strategies.

R4 The DHS and the Medihotel Reference Group examine potential innovative workforce configurations to support the operations of Medihotels.

R5 The DHS develop a Service Agreement with hospitals providing Medihotel services which would include service level information, performance reporting, funding and financial accountability reporting.

8.2 OPPORTUNITIES TO IMPROVE MEDIHOTEL OPERATIONS

The Review has highlighted there are a number of opportunities to improve effectiveness and efficiency of the management of Medihotels with respect to achieving greater consistency regarding the operations of these units. We consider that the Medihotel Reference Group consider a range of initiatives aimed at standardising a range of operational issues including:

- Implementation of patient and management information systems and interfaces with hospital based systems;
- Development of Medihotel clinical standards and guidelines;
- Reducing unnecessary duplication across Medihotel units;
- Development of Medihotel data collection definitions and reporting guidelines to meet the requirements of the hospitals and DHS; and
- Benchmarking of operations to improve operational efficiency; and
- Information sharing.

R6 Hospitals providing Medihotel services develop strategies to improve the effectiveness and efficiency of Medihotel operations including mechanisms to monitor Medihotel operations.

8.3 OPPORTUNITIES TO IMPROVE SERVICE INTEGRATION

The Review has identified there are opportunities to improve integration of Medihotel services with other clinical services provided by hospitals. For example, the referral process to Medihotels would be improved by including Medihotel services as a referral option (where appropriate) into the preparation of clinical pathways. This would assist in further integrating Medihotel services with clinical services and would ensure that at a particular point of the care plan, the option for transfer to the Medihotel would be considered systematically.

It is recommended that:

R7 Medihotels develop strategies aimed at integrating these services with mainstream acute care services including referral options in clinical pathways. These strategies should also be included in the Business Plan.

8.4 OPPORTUNITIES FOR MAINTAINING NURSING SKILL COMPETENCIES

The Review has highlighted that in some Medihotels, nursing staff feel isolated and there is a concern that nursing staff are being progressively deskilled which impacts on staff continuity. In order to address this issue there is a need to develop strategies that would enable the nursing workforce assigned to the Medihotel to maintain current clinical skills and knowledge and foster professional development and clinical expertise.

We believe it is important from both staff development and quality of care perspectives that strategies are developed to ensure Medihotel staff maintain their technical and clinical skills so as to be able to efficiently and effectively respond to health service needs to achieve the best outcome for clients. This could be achieved by implementing flexible rostering to ensure that:

- Client care and organisation needs (e.g. continuity of care, coordination and accountability of care) are met;
- An appropriate skill mix of nurses is provided to meet anticipated clinical requirements;
- Nursing staff are allocated to the Medihotel according to known (or predicted) fluctuations in demand;
- A balance between patient care, employee and organisational needs is provided;
- Equity for all staff and core competencies are maintained;
- All industrial award provisions are met; and
- Organisational requirements are accommodated.

It is recommended that:

R8 Hospitals implementing Medihotels explore mechanisms to address the gap in nursing skill competency as a result of the lower level of nursing support required for Medihotel clients such as flexible nurse rostering which would facilitate skills retention.

8.5 OPPORTUNITIES FOR SERVICE EXTENSION

One of the key findings of the Review has been there are a number of Medihotels that are under utilised and there is capacity for services to be expanded, resulting in increased cost efficiencies. This would also provide additional support to Hospitals in meeting the demand for acute care beds. Opportunities for service extension have been highlighted in a number of areas including:

1. **Same day procedures.** As a result of increasing numbers of same day procedures being undertaken in Hospitals there is scope for Medihotel services to be provided to those patients requiring post procedure observation.
2. **Long stay patients.** Another option to expand Medihotel services relates to long stay patients (>30days) prior to transfer home. This would provide an opportunity for the Medihotel staff to work with the family to facilitate an effective transition process to home.

3. **Radiology and pharmacology.** Advances in radiology and pharmacology have resulted in less intrusive surgery being undertaken. This will present opportunities for expanding Medihotel services.
4. **Rehabilitation.** Opportunities exist to provide Medihotel services to patients from Rehabilitation Units provided they were ambulant, self-caring and did not require extensive supports such as wheelchairs or low beds.
5. **Increased emphasis on the marketing of Medihotel services.** It has been identified that benefits would be gained from increasing the awareness of clinicians of the availability of Medihotel services through focused marketing activities which would increase the utilisation of the Medihotel facilities.
6. **Mainstreaming implementation of Medihotel services.** Based on the results of our economic analysis in Chapter 6, the Review has demonstrated that the implementation of Medihotels has been a cost effective initiative that has resulted in increased access to hospital beds for emergency and elective patients. The Review considers there is significant potential to increase these benefits by mainstreaming these services in nominated hospitals across the state.
7. **Management of secondary demand.** As previously discussed the Review has identified the potential to create secondary demand for hospital services due to Medihotels providing services to clients who would be more appropriately accommodated in other facilities. The management of secondary demand in this instance would require a clear definition of Medihotel services, admission criteria and the outcomes to be achieved. In this context we believe it is important that the DHS and the Medihotel Reference Group:
 - Define the Medihotel services to be provided and the outcomes to be achieved;
 - Consider the range of accommodation options and develop strategies to implement the preferred options; and
 - Develop a secondary demand management strategy for the future operations of Medihotels which is aligned to the strategic business priorities of hospitals.

It is recommended that:

R9 The DHS mainstream the implementation of Medihotel services in nominated hospitals across the state with appropriate recurrent funding.

R10 Hospitals providing Medihotel services to develop strategies aimed at maximising Medihotel utilisation and inpatient bed substitution.

R11 Hospitals providing Medihotel services develop a secondary demand management strategy which is aligned with hospital strategic business priorities.

8.6 RECURRENT FUNDING MODEL

The Review has identified that there is a need to consider a more equitable funding approach for Medihotel services as the current historical grants funding arrangement does not adequately fund the cost of service delivery. The main reason for this is that the funding levels in the main do not reflect activity levels requiring Hospitals to supplement funding from existing budget allocations. In addition the existing grant funding arrangements do not allow consideration of expansion of services to meet unmet need. We believe this situation is not sustainable in the long term and will not enable the Hospitals to expand the level and quality of Medihotel services into the future.

The review considers that the DHS should move towards a system of mainstream funding for Medihotel services.

8.7 CAPITAL FUNDING

The Review has noted there is an opportunity to increase the capacity and physical facilities of a number of Medihotels which would result in increased access to acute care beds and savings to the cost of service delivery. In order to realise these benefits this would require an additional investment of capital funding.

It is recommended that:

R12	The DHS consider the future need for expanding Medihotel services and the submission of business cases from hospitals seeking capital funding.
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