

INFORMATION REGARDING FUNDING AND HEALTH SERVICE RESPONSIBILITIES UNDER THE VARIABLE MATERNITY SERVICES GRANT (VMSG)

1. INTRODUCTION

This information related to the Variable Maternity Services Grant (VMSG) for the provision of maternity domiciliary care across both rural and metropolitan areas, intends to clarify the funding, reporting and service responsibilities of health services. In particular, this information aims to ensure health services understand their responsibilities in circumstances where a referral (sub-contracting) to another health service (*hospital B*) for postnatal home visits is required or necessary.

One of the key objectives in developing this document is to ensure that appropriate consideration be given to actual costs incurred for provision of the service when determining sub-contracting costs. This is in recognition that it is not always feasible (nor desirable) for the hospital in which women give birth (*hereto referred as the **birth hospital** hospital A*) to directly provide postnatal home visits, particularly when women live a long distance or out of area from the birth hospital, or when women have been transferred between hospitals during birth or in the immediate postnatal period.

The information may be utilised as a basis for development of contractual arrangements and referral policies. This information does not address Victorian legislation and the issues of Privacy and confidentiality.

2. FUNDING OF POSTNATAL DOMICILIARY CARE

In 2008/09 health services are funded \$429 per public status birthing episode separation; this is based on the number of public birth episode separations in the calendar year 2007. This funding stream is known as the Variable Maternity Services Grant (VMSG) and is provided to cover postnatal domiciliary care to public maternity clients who give birth in Victorian hospitals. In addition \$120 per public status birthing episode separation where LOS is less than 24 hours is provided towards additional postnatal support for women with a short length of stay for the birthing episode, and for related breastfeeding, mother or newborn health issues. This once-off supplementary payment, which reflects the increase in early discharges, is intended to recognise the additional workload associated with the nature of postnatal support provided when women leave hospital shortly after birth. Approximately \$20.8 million has been distributed to individual health services in total. This funding is to be used exclusively for maternity services. Page 39 of the 2008-09 Policy and Funding Guidelines outlines further work to be undertaken in the course of the year to assess funding approaches for postnatal domiciliary care.
<http://www.health.vic.gov.au/pfg/pfg0809/pfg0809.pdf>.

In some circumstances, health services may determine that in the interests of providing continuity of care/carer, a proportion of the VMSG may be used to provide antenatal midwifery care. Where hospitals provide birthing services only i.e. a neighbouring hospital

provides the antenatal and/or postnatal services to women, negotiations between health services in determining fair pricing is left at the local level.

Under the funding conditions of the Maternity Services Program (MSP) grant (www.health.vic.gov/maternitycare/funding2.htm) health services are expected to ensure adequate postnatal care for women and their families according to clinical and psychosocial needs, this includes:

- an offer of at least one postnatal domiciliary visit to every woman giving birth and further visits for women according to their needs;
- at least two postnatal home visits or more if required for women with special needs, e.g. newly arrived migrants, single young mothers, women with disabilities, some first time mothers; and
- at least two or more postnatal home visits for women after a caesarean section, or with complications arising from the birth or immediate postnatal period
- improved arrangements for monitoring, review and improvement in the quality of care
- greater opportunities for consumers to make informed choices, participate in decision making and provide feedback for service improvement

In reference to continuity of care the funding conditions outline:

- care during pregnancy and childbirth that reflects best available evidence on effectiveness;
- increased continuity of care, with respect to hospital care and integration with the community provision of antenatal and postnatal care and support;
- improved responsiveness to women with special needs;

Funding of \$429 (2008-09) per public birth episode separation (the number of public clients who gave birth) in the previous calendar year is provided only to those services that provide birthing services. This calculation of funding does not apply to private clients who birth in a public hospital.

Where provision of a domiciliary visit by a non-birth / hospital B is contracted, funding of the service is expected to come from the birth hospital (hospital A) from their VMSP grant.

Where health services assess that a woman lives outside a feasible catchment area for provision of efficient service, sub-contracting of the service may be necessary. In many outer metropolitan fringe and rural areas, domiciliary visiting may encompass midwives travelling long distances (in some case up to 75-100 kilometres one way). This increases the cost of provision of the service and needs to be recognised in determining costs where sub-contracting services to other hospitals /services is required.

2.1 Privately insured clients

The Australian Health Care Agreements does not exclude public health services from charging private maternity patients for domiciliary services. A public hospital does have the option of charging the client a co-payment or charging for full-cost recovery for the service. If a public hospital charges the private patient/client for provision of a domiciliary service the public hospital should inform the patient of the anticipated out-of-pocket expenses prior to discharge. A public hospital may choose to provide the service to privately insured mothers free of charge.

Public patients cannot be charged for the domiciliary service.

3. SERVICE PROVISION

It is expected that a woman's needs will be one of the key factors in determining service provision. One of the main aims of postnatal domiciliary visiting is to ensure the mother is able to care for her infant and to assess the mother and baby's health following birth and discharge. It is expected that this assessment will be provided within a woman's own environment. Where possible all effort should be taken to provide this service in the woman's residence. Phone follow-up without a visit, or the woman returning to the hospital should be avoided.

Rural Victorian hospitals that are located in an area bordering on another state are expected to provide a domiciliary service or facilitate follow up to those public status women who **give birth in the Victorian hospital** – this includes women who live across the state border. This cross border service may be provided by the birth hospital or contracted to a service provider in the woman's local area, which may be interstate. This service, provided by the birth hospital or contracted out is funded from the birth hospital's VMSG.

The postnatal domiciliary program that is funded through the VMSG is designed to facilitate care provided to the mother post birth and is not aimed at neonatal visiting. The VMSG is not a funding stream for neonatal visiting/HITH for purposes of assessing neonatal health of a baby who has been an inpatient of a neonatal nursery, other than that as part of routine mother / baby dyad assessment for purposes of determining adjustment and 'family health'. It is expected that health services will ensure a domiciliary visit/s after discharge of a baby from a neonatal unit/nursery is provided to assess adjustment of the mother/family to the new infant not to primarily assess the infant's wellbeing following discharge from the nursery. If required, this visit may be funded through the VMSG.

One of the key aims of domiciliary visiting is the provision of continuity of care for women across the full continuum from the antenatal period to 'handover' to the Maternal and Child Health service. Continuity with local services reaching into childhood also needs to be considered. Where this is not possible due to a woman birthing at a hospital outside her local area, liaison between services/ health services is paramount to ensure informed care and a key contact at the birth hospital and hospital B/service needs to be identified when sub-contracting. Where possible provision of a domiciliary visit by a known midwife is preferable. In circumstances where a woman has had antenatal care in her own local community, with the resultant opportunity to 'know' the midwife/s, and gives birth outside this community referral back to her local community for domiciliary care should be considered.

4. AIMS REPORTING AND FUNDING

The Admitted Information Management System (AIMS) reporting framework outlines reporting on postnatal domiciliary service utilisations. This reporting framework does not relate to funding responsibilities. In some cases responsibility for reporting of domiciliary occasions of service and funding of those services rest with different service providers. Health services need to be aware of their reporting responsibilities to ensure accurate reporting and planning of domiciliary referral and service.

Examples of differing reporting and funding responsibilities

1. Where a non-birth hospital (hospital B) provides the domiciliary service for a woman discharged from a birth hospital (hospital A) it is the responsibility of hospital A to complete the AIMS report regarding the domiciliary service. Hospital A is also responsible for funding the service provision by Hospital B through their VMSG.

2. Where a mother and baby are transferred from the birth hospital (hospital A) for ongoing inpatient care at hospital B, hospital B is responsible for the AIMS reporting of domiciliary occasions of service as the service would be provided following discharge from an inpatient episode of care. Hospital A is responsible for funding of the domiciliary service as the birth occurred at Hospital A thus attracting VMSG funding. It would be expected that Hospital B would provide a summary of discharge and domiciliary visits to hospital A as a condition of funding.
3. A woman is discharged home from the birth hospital (hospital A) back to her local community but her baby remains in hospital A; after a period of time the baby is transferred back to the woman's local hospital (hospital B) for step down care. Hospital A is responsible for:
 - ensuring that the woman receives a domiciliary visit (either through their own services or through a contracted arrangement with a local provider or hospital B). There is no defined period in which this can occur as it is provided according to a woman's needs; this may occur after the baby has been discharged from hospital B.
 - reporting of the domiciliary occasion/s of service through AIMS
 - funding of the service from hospital A VMSG.
 Hospital B would be responsible for providing a summary of domiciliary care to hospital A.

5. REFERRAL

Under the funding arrangements the following responsibilities for the provision of domiciliary care apply:

5.1 Birth hospital (Hospital A)

Responsible for:

- Arrangement/facilitation of domiciliary visiting for all women giving birth at the hospital; this can be through:
 - Provision of visit by birth hospital
 - Sub-contracting of domiciliary service to other health service or District Nursing service
- Payment for domiciliary visiting from VMSG funding, based on realistic costs of service – midwife salary, transport, infrastructure and resources required, through:
 - Internal (where visit is conducted by birth hospital)
 - Payment of invoice from hospital B/service
 - Payment of previously agreed/contracted fee
- Quality referral, including a summary of the birth and postnatal episode of care should be provided to the receiving organisation should the domiciliary visiting be conducted by another service.
- Where the infant remains or is transferred to a neonatal unit, the birth hospital is responsible for ensuring that the mother receives a domiciliary visit following discharge, or in cases where this is not provided until the infant returns home, after the discharge of the infant.
- Obtaining consent, providing contact details and informing the woman about arrangements, as part of quality referral for domiciliary visiting.

5.2 Hospital B/service

Responsible for:

- Provision of domiciliary visit/s according to the woman's needs where this has been requested by hospital A; this should be balanced against costs of service provision
- Notification to birth hospital of inability to accept referral or conduct visit

- Provision of a summary of the domiciliary visit to birth hospital (hospital A) in the interests of quality and safety, and closure of the episode of care.

5.3 Joint responsibilities

- Financial arrangements (invoice or contract) taking into consideration costs incurred for salaries, transport, resources and infrastructure
- Determination of contractual arrangements between health services
- Development of an appropriate policy that outlines funding and referral arrangements in the interests of quality and safety.

6. Other Issues

- The neonatal unit/nursery hospital is not responsible for the maternal domiciliary visit following discharge of the infant but may be responsible for the infant home visit following discharge – this is not funded under VMSG. Funding for this service may be provided through HITH or other domiciliary funding stream
- Where hospitals provide birthing services only i.e. antenatal and / or postnatal care is provided by a neighbouring/hospital B, negotiations between health services in determining fair pricing is left at the local level. DHS has no mandate to mediate or fix pricing in this situation.
- A suggested tiered costing system could be considered when health services negotiate service provision costs with external agencies / health services. A different fee for visits undertaken could be applied for:
 - Visits <25kms
 - Visits 25-50kms
 - Visits >50kms
 - Visits to defined geographically isolated areas eg. Alpine resorts

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