Post Acute Care Program Review

Discussion Paper

Metropolitan Health and Aged Care Services Division
Department of Human Services

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Department of Human Services

Victoria
The Place To Be

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1. Introduction

The purpose of this paper is to provide an overview of the current role and activities of the Victorian Department of Human Services' (DHS) Post Acute Care (PAC) Program.

A survey has been developed, based on this paper, to seek the views of stakeholders on what are the key issues requiring further consideration. A copy of this survey can be found at the following website address http://www.health.vic.gov.au/pac/.

The results of this survey will inform further consultations with stakeholders with the aim of identifying opportunities to improve the way the PAC Program operates as a provider of post hospital recuperative supports.

This review has been initiated by the Continuing Care and Clinical Service Development Section, Programs Branch, Metropolitan Health and Aged Care Services Division of the Department of Human Services.

Further enquries about the review can be directed to Ms Carol Pyke on (03) 9616 1335 or via email at carol.pyke@dhs.vic.gov.au.

2. Background

The Post Acute Care (PAC) Program was introduced in 1995 at a time when there were a variety of pressures upon hospitals to reduce inpatient length of stay, and community resources were becoming increasingly constrained. In this environment concerns for patient welfare led to the introduction of the PAC Program[1].

The PAC Program was established with the following objectives:

- To support recuperation after a hospital episode by providing an appropriate package of community-based supports; and
- To facilitate safe and timely discharge.

To achieve these objectives, PAC services have the following features:

Care coordination: negotiating, purchasing and reviewing the provision of community-based supports to support recuperation after a hospital episode.

Rapid response: ability to respond to short time-frames for people being discharged from hospitals by purchasing services from public and/or private providers.

Flexibility: ability to arrange individually tailored packages of care and fill short-term gaps in the service system.

Interface: provision of a bridging/liaison service between the hospital sector and the community sector.

[1] Post Acute Care Program Health Outcomes and Cost Benefit Study, April 2001

3. Why review the Post Acute Care Program

The health system environment has significantly changed since the PAC Program was introduced in 1995. Issues that are prompting the review of the PAC Program include:

- The increasing complexity of the service system leading to concerns about access, administrative overheads, service system duplication/overlap and the subsequent push to try and reduce this complexity via program integration.

- Gaps/pressures in other parts of the service system resulting in PAC services providing recuperative supports that could be considered to be more appropriately provided by other programs such as therapy services.

- Improved working relationships between the acute and primary care sectors, through the work of the Hospital Admission Risk Program (HARP) and Primary Care Partnerships (PCPs). These policy initiatives provide scope to identify further opportunities to develop these relationships to improve health care service delivery across the care continuum.

- Maintaining the financial viability of providing post hospital recuperative supports in an environment of increasing demand and cost.

- Recognition that an increasing number of recipients of post hospital recuperative supports have on-going service needs and that their care is being fragmented through a range of different program arrangements resulting in:

    - multiple assessments;
    - changes in the people providing similar services as people move from one program to another; and
    - different levels of service provision between programs.

3.1 Increasing Demand Pressures

The issues that are driving the need to review the PAC Program are not unique and reflect of broader trends across the health system. A key issue that has been identified for the future of the health system is managing increasing demand for health services across all sectors. Factors that have been identified as having an impact on this increased demand include:

- Demographic changes including the ageing of the population, which is associated with increasing complexity of illness and the subsequent higher usage of health services in comparison to other age groups.

- New treatment options through advances in medical technology resulting in people living longer and having access to treatments that may not have previously been available.

- New clinical practices resulting in changes in the use of acute health services with an increase in the delivery of services in community settings.

- Consumer choice and preference, such as the desire to remain living in their own home for as long possible.

The pressure that the health system is under as a result of increasing service demand is also complicated by a range other issues including:

- Health workforce shortages – a global not just local problem.
- A reduction in the availability of General Practitioners (GPs) for home visits and after hours care.
- Shortage of residential aged care beds relative to demand.
- Demand for community-based supports exceeding availability.
- Societal changes that have led to a reduction in the capacity of the informal carer network in the community.

3.2 Policy Directions

The review of the PAC Program needs to be undertaken in the context of the broader policy work being conducted by DHS. Some of these major policy initiatives are described below.

The **Ambulatory Care Policy and Planning Framework** is being developed in recognition of the changes in clinical practice and patient choice, leading to a need to identify how this sector needs to be developed to meet these changing needs. Further details on the Ambulatory Care Policy and Planning Framework can be found at the following website: **http://www.health.vic.gov.au/ambulatorycare/**.

The **Sub-acute Ambulatory Care Services (SACS) Framework** is focusing on the development of an integrated service framework for the delivery of community-based rehabilitation and specialist assessment services. The development of improved intra and inter-service system relationships is a key aspect of this work to ensure that people receive access to an appropriate range of rehabilitation and sub-acute assessment services. More details on the SACS Framework can be found at: **http://www.health.vic.gov.au/subacute/sacs/index.htm.**

Community Health Services – creating a healthier Victoria provides a guide to developing Community Health Services and to expand their role as a platform for community-based health care. The policy supports integrated and effective primary health care to put Victoria in a better position to respond to growing pressures facing the health system. The policy paper can be found at :**http://www.health.vic.gov.au/communityhealth/publications/chs.htm.**

The strategic vision for rural health services, **Rural directions for a better state of health** articulates the Government's commitment to sustaining a contemporary health system in rural and regional areas, providing high quality and appropriate health services in the best setting, as close as possible to where people live.

The three key directions for the rural health system are:

- Direction 1: Promote the health and wellbeing of rural Victorians
- Direction 2: Foster a contemporary health system and models of care
- Direction 3: Strengthen and sustain rural health services

The detailed policy plus summary documentation is available at: **www.health.vic.gov.au/ruralhealth.**

The demographic issues of a growing and ageing population are reflected in the **Metropolitan Health Strategy (MHS)**. The MHS outlines specific infrastructure and service system changes to increase, redistribute and reconfigure capacity primarily for acute and sub-acute health services. Whilst the MHS has a major focus on health system fabric and infrastructure, it also recognises the importance of the need to identify service substitution and diversion options as well as to develop new service models to improve service efficiency and enhance continuity of care. The MHS is available at the following website **http://www.health.vic.gov.au/metrohealthstrategy/.**

Improving care for older people: a policy for Health Services has flagged opportunities to develop new service delivery models both within and between the acute, sub-acute, community and primary health sectors to ensure the delivery of the most appropriate care in the most effective and efficient manner.
The policy encourages Health Services to:

- adopt a strong person-centred approach to the provision of care and services;
- better understand the complexity of older people's health care needs; and
- improve integration between Health Service's community based programs and ongoing support services available in the broader community.

For further information, the policy paper is available from the following website: **http://www.health.vic.gov.au/older/.**

The **Hospital Demand Management Strategy** (HDMS) has identified and implemented a range of strategies in the areas of service substitution and diversion. The **Hospital Admission Risk Program (HARP)**, which was introduced in 2001-02 to prevent emergency department presentations/admissions, has focussed on preventative diversion activities by trialling, for example, new models of community-based care for people with ambulatory care sensitive conditions and for older people with complex and/or chronic health care needs. These strategies have the dual aim of ensuring that people get the most appropriate treatment as well as making the best use of the health system. More details on the HARP Program are available from the following website: **http://www.health.vic.gov.au/harp-cdm/.**

Primary Care Partnerships (PCP) strategic directions 2004 - 2006: Better health stronger communities focuses on building a stronger role for the PCP strategy as an effective means for strengthening the primary health care sector. The strategic directions outlined in the policy paper strengthen and broaden the strategy with the aim of delivering better health outcomes and stronger communities for all Victorians. The PCP policy document can be found at **http://www.health.vic.gov.au/pcps/index.htm.**

Health*SMART*, a strategy to facilitate the upgrade of health services information technology (IT) infrastructure, has identified the potential for improvements in quality and efficiency resulting in better health outcomes and better utilisation of the health workforce. Key opportunities will include the improved sharing of information between health care professionals. The **Health*SMART*** website can be found at the following address **http://www.health.vic.gov.au/healthsmart/.**

4. The PAC Program

4.1 PAC services and their catchments

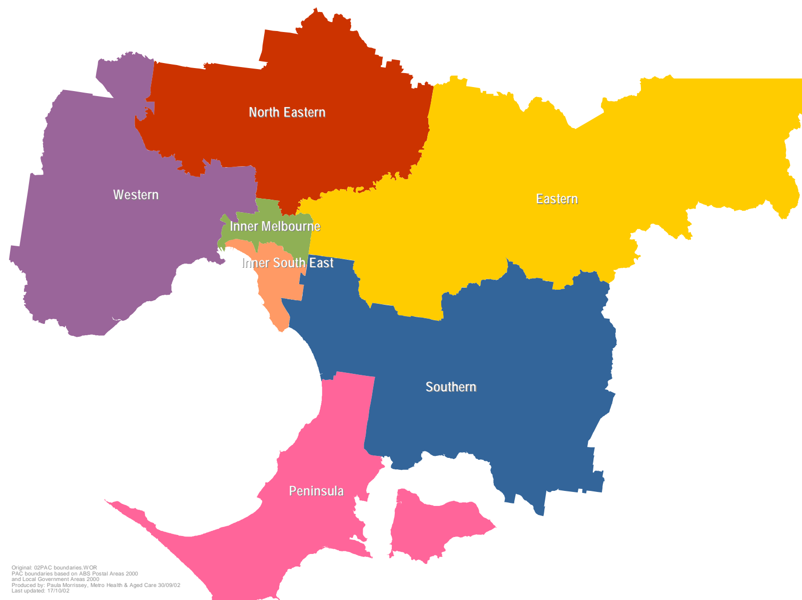
There are eighteen funded PAC services. Sixteen of these services are auspiced by Health Services[2] and two auspiced by Community Health Services (CHS). Seventeen of these services have specific catchments whilst the Royal Children's Hospital service provides a statewide service.

PAC catchment sizes are not uniform and can vary from a service that covers an entire DHS region to services that cover a few local government areas. The maps below show the catchments for PAC services. More details on PAC catchments can be found at Appendix 1.

Funding is also provided to three specialist hospitals (Peter MacCallum Cancer Institute, the Royal Victorian Eye and Ear Hospital and the Royal Women's Hospital) to facilitate the use of post acute care services. These services do not have brokerage funds to provide direct service provision but make referrals to other PAC services for clients discharged from their hospitals.

Figure one: Rural PAC catchments

Figure two: Metropolitan PAC catchments



[2] Western PAC service catchment is currently being reviewed and will result in the establishment of two services – one based around Western Health and one based around Melbourne Health.

4.2 PAC eligibility criteria

The key eligibility requirements for the PAC Program are:

- People discharged from a public hospital, including emergency departments, acute services and sub-acute services, and that

- These people have been assessed as requiring community-based supports to assist them to recuperate at home.

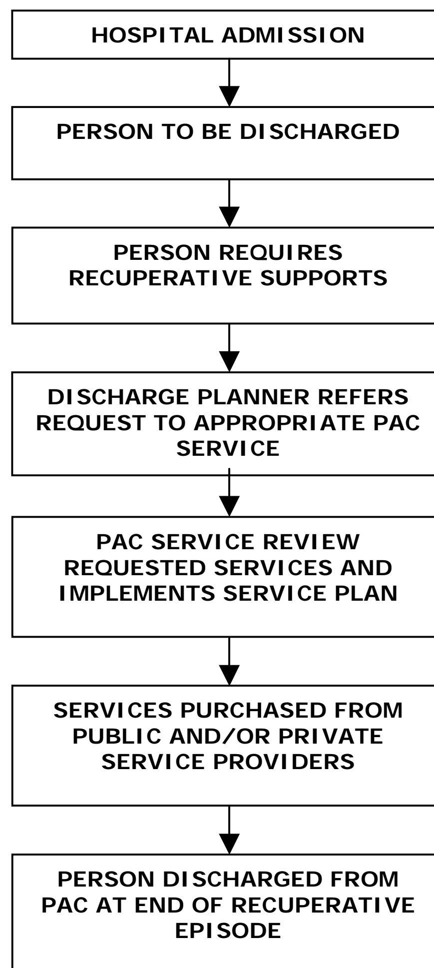
The main groups who are not eligible to access the PAC Program are people being discharged from a private hospital; people with a mental health primary diagnosis; and people being discharged to nursing homes.

Separate funding arrangements exist for Department of Veterans' Affairs (DVA) and Transport Access Commission (TAC) clients to enable them to access the PAC Program.

4.3 PAC service system model

The original conceptual model for the delivery of post acute care services is illustrated below:

Figure three: PAC service system model



Whilst this is the original conceptual framework, there is considerable variation amongst PAC services in how post hospital recuperative supports are delivered.

The key area of difference is in the identification of potential recipients for post hospital recuperative supports. The two main models are:

- Hospital staff (for example, nurse unit managers) are responsible for identifying potential PAC clients and referring to PAC; or

- PAC Care Coordinators identify potential clients in hospital (for example, via attendance at discharge planning meetings or ward rounds).

Another key variation amongst PAC services is that the service is either located on-site (ie located at a hospital site) or is located off-site with referrals being made by phone, fax and email.

Whilst all PAC services are delivering post-hospital recuperative supports, what has not been established is whether one model is more effective than another or if different models suit different hospital/community relationships. What is critical in any of the various models is the relationship of PAC services with hospitals to ensure that people who require post hospital recuperative supports are identified and appropriate services are arranged.

4.4 PAC services care coordination role

The primary work of PAC services in organising post hospital recuperative supports is care coordination. This work includes the following activities:

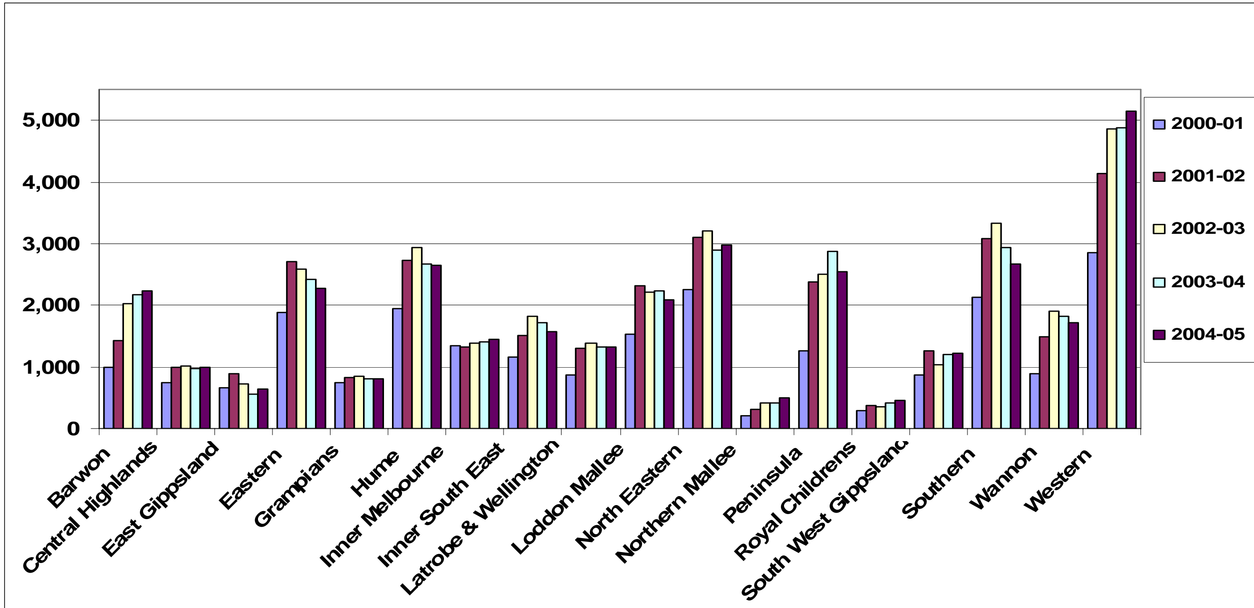
- Accepting referrals
- Screening and eligibility assessment
- Setting up care plans and monitoring service provision
- Liaising with hospital clinicians, service providers, clients and their carers/families
- Engaging clinical, home support and welfare services
- Reviewing and assessing service provision
- Liaising with community agencies to ensure a smooth transition to long term care
- Completing referrals to other agencies
- Advocating on behalf of the client as necessary

5. PAC Program demographics

5.1 Completed episodes of care

In 2004-05 PAC services provided approximately 33,300 episodes of post hospital recuperative supports. The number of episodes of care provided by each program since 2000 is illustrated in the graph below.

Figure four: PAC services: Completed episodes 2000-2005

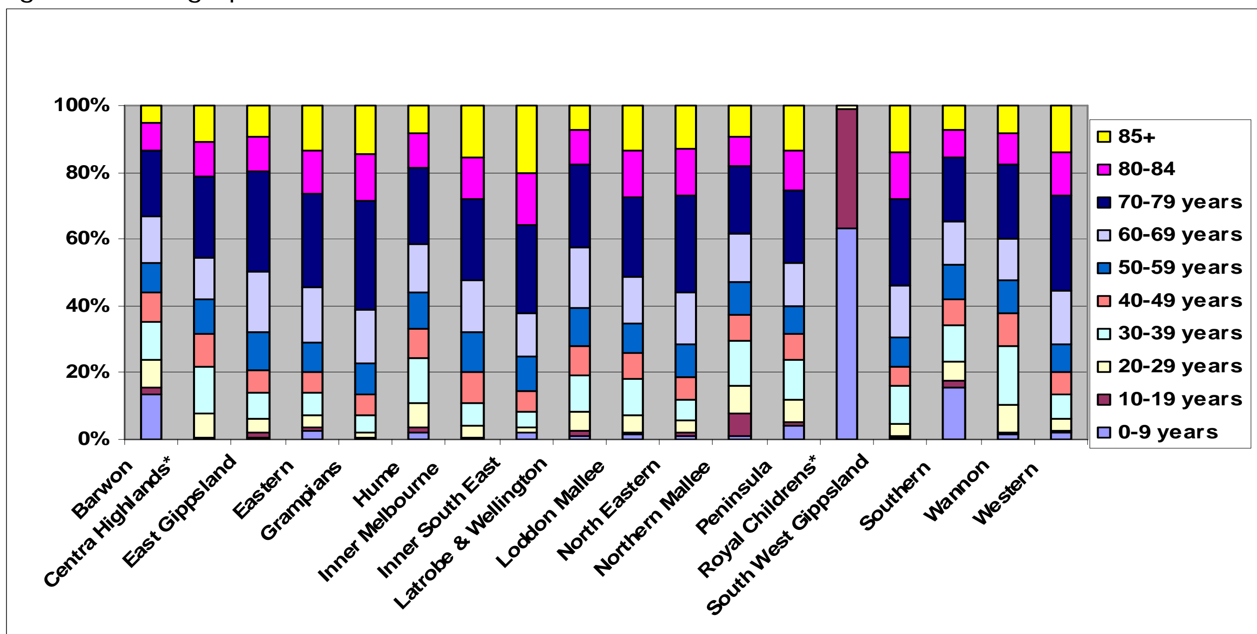


The number of completed episodes for the majority of PAC services has declined in the preceding two years. This decline has been attributed to no new funding being allocated to the program over this period as well as increasing costs of services provision.

5.2 Client age profile

The age profile of PAC clients for each PAC service is illustrated below.

Figure five: Age profile of PAC clients 2004-05



*2003-04 data

Those aged 70 years and over comprised 48% of the total number of recipients of post acute care. Just under half of all the recipients of post acute care were people aged 65 or less.

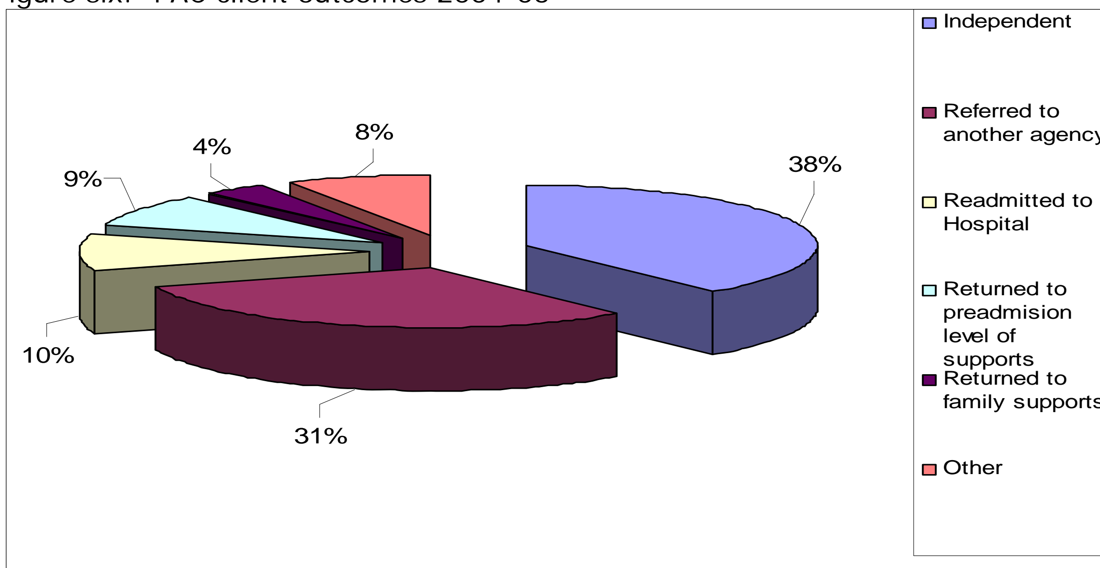
5.3 PAC client profile

There is no information available to identify what types of people are likely to require post-hospital care nor the mix of services that are typically required. The factors that can contribute to need and mix of services includes not only health factors such as the need for wound dressings but may also include psycho-social factors such as the person having no resident carer or carer stress and burden.

5.4 PAC client outcomes

Outcomes for PAC clients in 2004-05 indicate that 38% of clients returned to total independence. A significant percentage of the recipients of post acute care had care needs beyond their immediate post hospital episode. Approximately 40% of all clients discharged from PAC continued to receive some community-based care. No details on the nature of these on-going services are available. The graph below illustrates the main client outcomes for PAC services in 2004-05.

Figure six: PAC client outcomes 2004-05

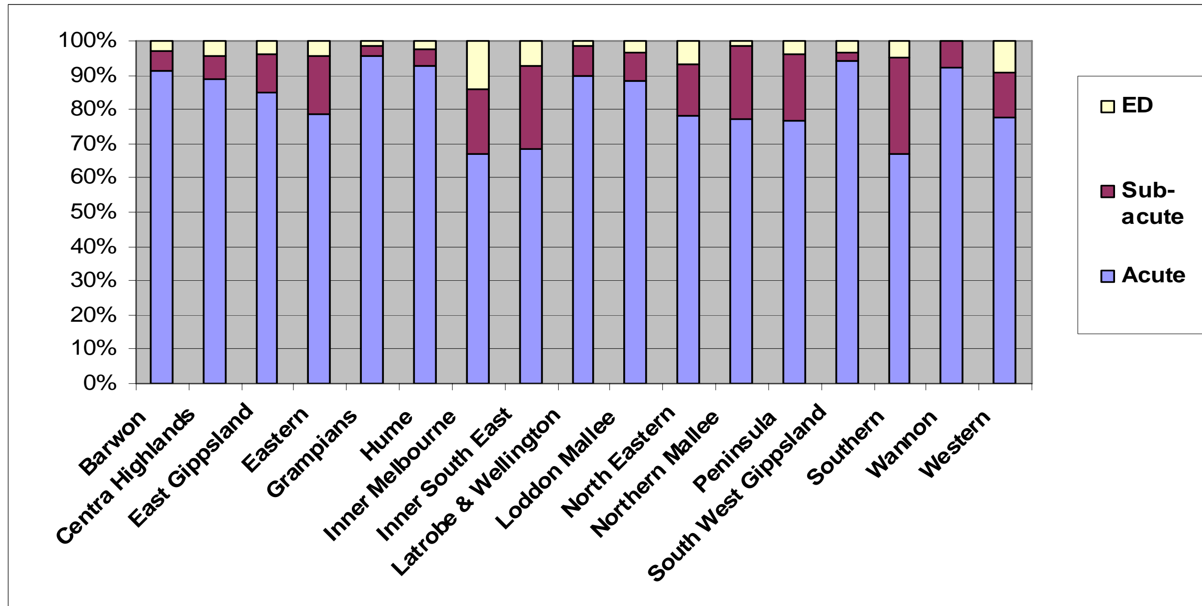


Other outcomes include refused further services, were admitted to a rehabilitation program or died.

5.5 PAC referral sources

The primary source of referrals' to Post Acute Care services is acute hospitals; they accounted for 81% of all referrals. The breakdown of referral sources for PAC services in 2004-05 is illustrated below.

Figure seven: PAC referral sources 2004-05



Referral source data for 2004-05 for Royal Children's Hospital is not available.

There has been feedback that PAC services and some HARP projects may overlap in their targeting of people presenting at Emergency Departments as both have a role in providing community-based supports to facilitate return to the community.

5.6 Referring Health Services

There is no uniform data available about which Health Services refer to which PAC services although it is reported that PAC services tend to receive the majority of their referrals from health services located in their area. For rural and regional health services, on average 90% of people discharged from hospitals live in the "local area" making referrals to the local PAC service relatively straightforward.

Metropolitan Health Services also tend to have a primary relationship with one PAC service but a greater number of people leaving the hospital will be "out of area". This is particularly the case for the major metropolitan hospitals and those hospitals that provide a statewide service. Some metropolitan/rural fringe Health Services tend to have regular referral relationships with more than one PAC service, depending on where the person being discharged resides.

5.7 Expenditure

There are three major components to expenditure for PAC services:

- Infrastructure: This can include
    - administrative/management staff recruitment, salaries, on-costs and training
    - office administration expenses (eg. stationery, printing and postage)
    - office equipment including computer system maintenance
    - motor vehicle expenses
    - travel expenses
    - repairs and maintenance
    - office rental
    - administration fees to auspice agency

  - depreciation of fixed assets.

- Care Coordination: This includes care coordinators recruitment, salaries, on-costs and training.

- Purchased services: Costs attributed against this includes purchased client services, purchased care coordination and travel (provider/care coordinator).

When the PAC Program was established there was a notional split of 50% of expenditure for service provision with the remaining 50% to be expended on care coordination and infrastructure.

In 2004-05 the breakdown of expenditure for the PAC Program was:

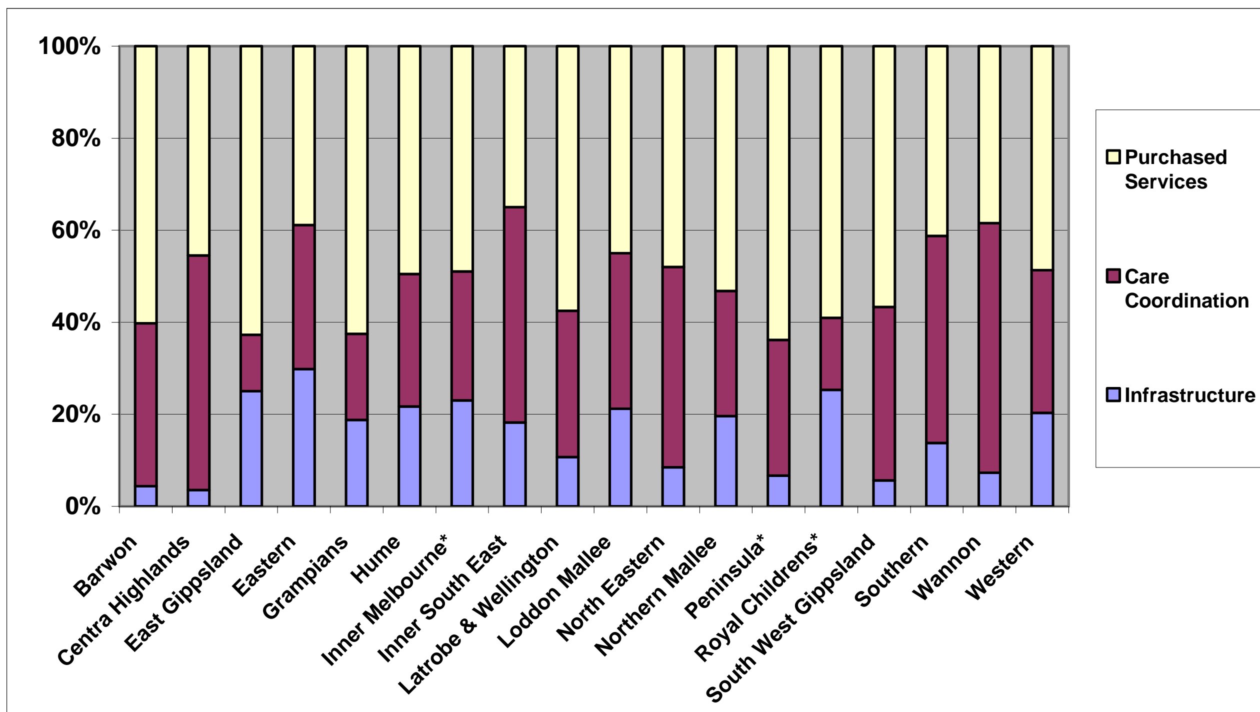
- Infrastructure 16% ($3.1 million)

- Care Coordination 37% ($6.7 million)

- Purchased Services 47% ($9.3 million)

In 2004-05, expenditure on infrastructure and care coordination accounted for 53% of the cost of the Program. Whilst this reflects the total Program expenditure, there is also considerable variation between PAC services in their expenditure against these items as illustrated in the following graph.

Figure eight: PAC services expenditure: 2004-05



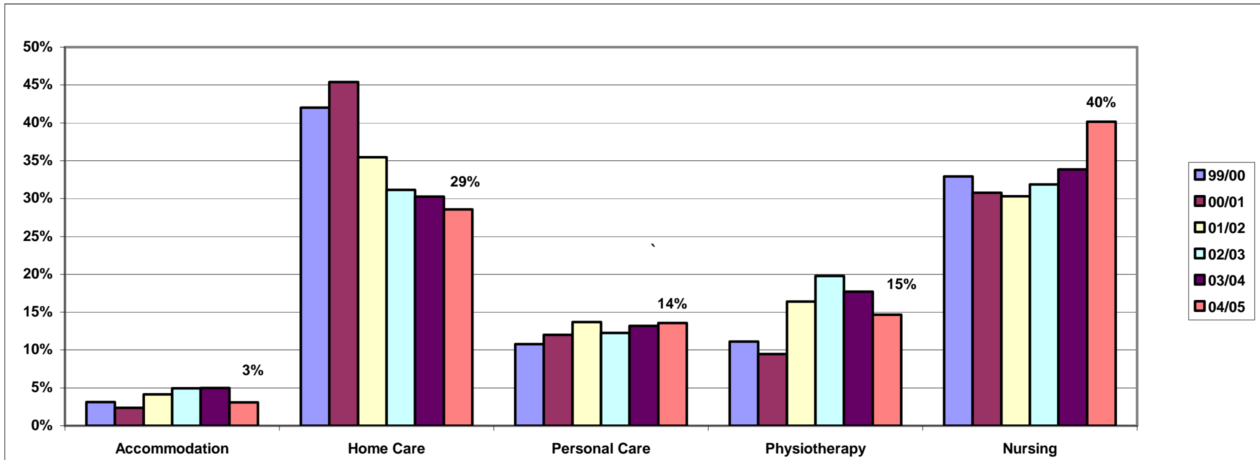
*2003-04 data

Some of the variations in expenditure can be attributed to variations in service models. For example, one PAC service purchases its care coordination and this expenditure is recorded under purchased services rather than against care coordination. Other reasons for the variance between PAC services need to be explored.

5.8 Purchased Services

The main community-based services purchased by all PAC services are community nursing[3], home care and personal care. Physiotherapy is also a significant item of expenditure but primarily for metropolitan PAC services. Accommodation has also been a significant item of expenditure in one metropolitan PAC service. In 2004-05 these five items accounted for 87% of total PAC purchased service expenditure. The historical purchasing levels for these five types of services are illustrated in the graph below.

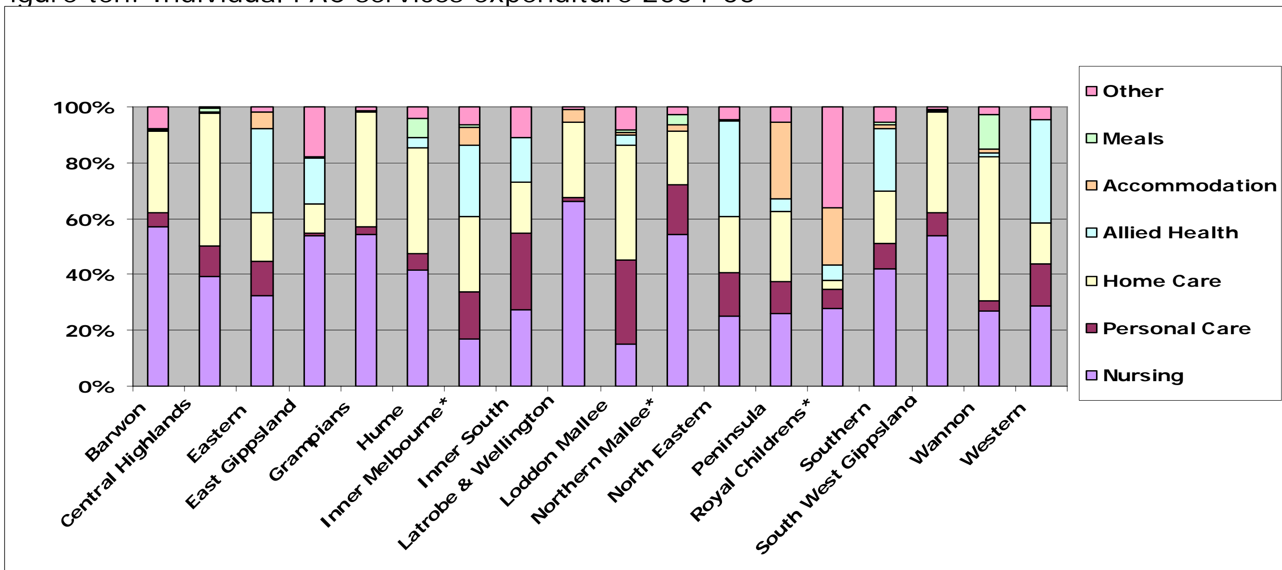
Figure nine: Expenditure on main purchased service types: 1999-2005



The increase in nursing expenditure has been attributed to increases in unit prices and, in metropolitan Melbourne at least, clarification of the funding responsibilities for post-acute nursing between PAC Services and Royal District Nursing Services (RDNS). Provision of post-acute nursing is also seen as a priority area of service provision for PAC services in terms of its' benefit to assist recuperation after a hospital episode.

As noted in relation to overall expenditure, there is also considerable variation in patterns of service expenditure by individual PAC services as illustrated in the graph below.

Figure ten: Individual PAC services expenditure 2004-05



*2003-04 data

[3] This data represents the percentage of total expenditure on services. Services such as nursing and physiotherapy have a higher unit cost than for personal care and home care, so the actual units of service are significantly higher for these latter groups.

The lower expenditure on allied health services by rural PAC services has in part been attributed to poorer access to allied health services in rural and regional areas. Expenditure on allied health services, primarily physiotherapy, in metropolitan Melbourne has been partly attributed to lack of timely access to Sub-acute Ambulatory Care Services (SACS) in some areas.

5.9 PAC referral relationships

PAC services are an interface program between hospital-based and community-based services. As noted previously, the primary source of referrals to PAC services are acute health services and this service system relationship will continue to be integral to any future model for service delivery.

PAC also has a role as a referrer/purchaser of community-based services under its brokerage model of service provision. PAC services purchase recuperative supports from both the public and private sector. Factors that can influence these purchasing decisions for PAC services include timeliness of response, service quality and cost-effectiveness. Factors that can compound these purchasing decisions particularly for HACC funded agencies are lack of clarity around program boundaries, different eligibility and assessment processes and lack of timely notification of an existing client being admitted to hospital and returning to the community. The level of demand for HACC services is acknowledged to be greater than their capacity to respond which can create a tension in dealing with requests from brokerage programs such as PAC to provide services even when funded.

PAC has a referral role to ongoing community-based service providers for approximately 31% of their clients (Refer figure six). The transition of people from the PAC Program to other community-based support programs also needs to be considered.

6. Rural PAC services

There are ten rural PAC services. The majority of referrals for post acute care to rural PAC services come from the hospitals located in the PAC service's catchment area. Rural PAC services tend to have reasonably well defined relationships with their referring hospitals, local government agencies and other HACC funded agencies.

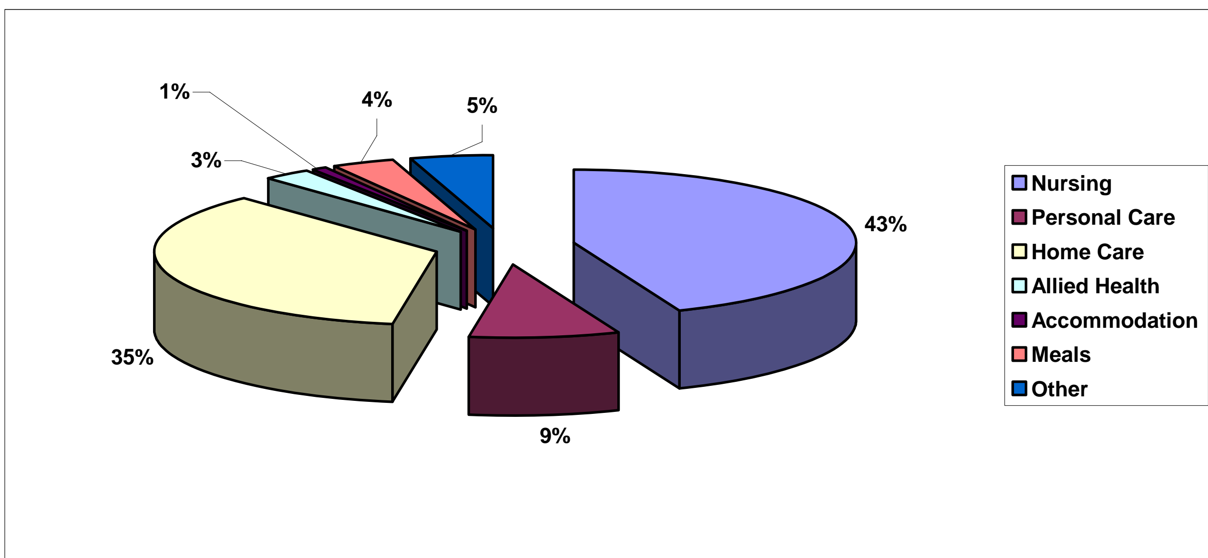
Rural PAC services, by comparison to metropolitan PAC services, have a larger number of hospitals, albeit of smaller size, to support (Refer Appendix 1). Rural PAC services also tend to have strong organisational alignments with their rural hospitals. All rural PAC services have a Health Service as their lead agency and almost all are physically located on hospital sites. In general, rural PAC services are more actively engaged in discharge planning at their respective hospitals. In some instances, because of workforce logistics, the discharge planner and the PAC coordinator are the same health professional.

Rural PAC services are becoming increasingly involved in activities to assist hospitals to manage bed demand such as assisting with identifying residential care places and/or care packages.

6.1 Rural PAC service provision

The main types of services purchased by rural PAC services are nursing and home care as illustrated below.

Figure eleven: Rural PAC service provision 2004-05



Nursing and home care account for 78% of all rural PAC service expenditure.

The main providers of these services in 2004-05 were:

- Community Nursing ($1.82 million)
  - HACC funded/not-for profit organisations 99.2%
  - Private providers 0.8%

- Home Care ($1.47 million)
  - Private providers 50.5%
  - HACC funded/not-for profit organisations 49.5%

- Personal Care $0.36 million)
  - Private Providers 51.9%
  - HACC funded/not-for profit organisations 48.1%

- Meals ($0.15 million)
  - HACC funded/not-for profit organisations 82.1%
  - Private providers 17.9%

6.2 Rural PAC services and community nursing

Nursing services are in the main purchased from hospitals[4]; these are often the providers of community-based nursing services for other programs such as HACC. In comparison to metropolitan PAC Services, rural PAC services appear to be reasonably significant purchasers of community nursing services from Community Health Services (CHS) and this may reflect that in some rural areas, CHS' are the funded providers of community nursing services for other programs such as HACC.

6.3 Rural PAC services and home care

Purchasing of home care is almost equally split between private providers and agencies funded to provide HACC services. All rural PAC services purchase home support services from private providers.

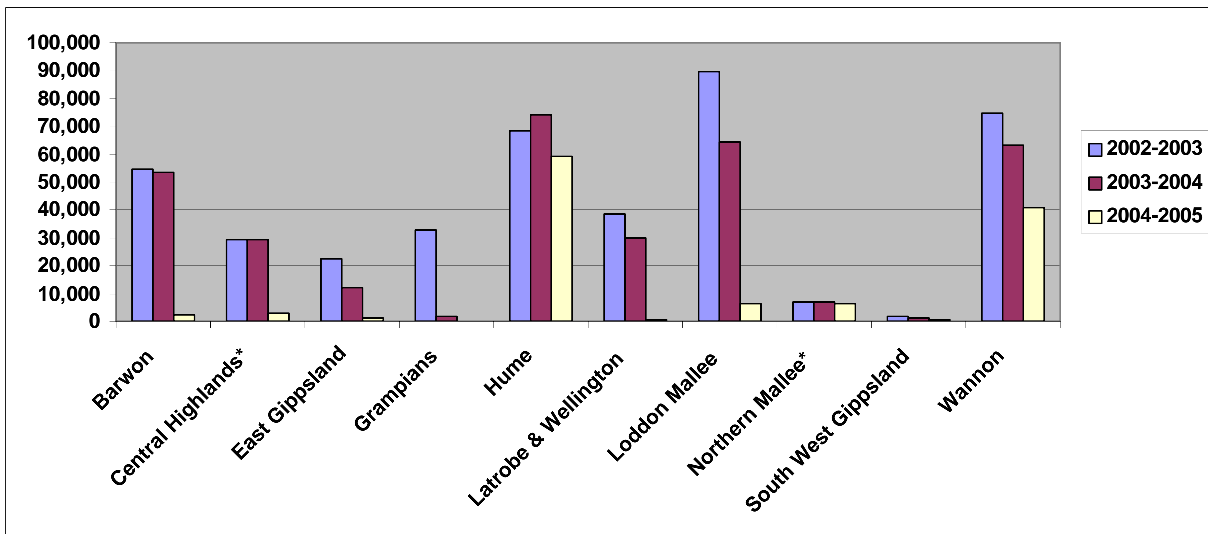
6.4 Rural PAC services and personal care

The profile of personal care purchasing is very similar to that for home care with just over half of all services being purchased from private providers.

6.5 Rural PAC services and meals

Meals are predominantly purchased from agencies funded to provide HACC meals services, including local government authorities and hospitals. The purchase of meals by all PAC services was reviewed in 2003-04 as it was considered that provision of meals was not a common requirement to support recuperation after a hospital episode. As a result of this review, expenditure on meals by rural PAC services has declined significantly. The graph below illustrates the shift in expenditure by rural PAC services on meals.

Figure twelve: Rural PAC services meal expenditure



* 2002-03 data estimated

[4] Ballarat has a stand alone District Nursing Service similar to the Royal District Nursing Service model.

7. Metropolitan PAC services

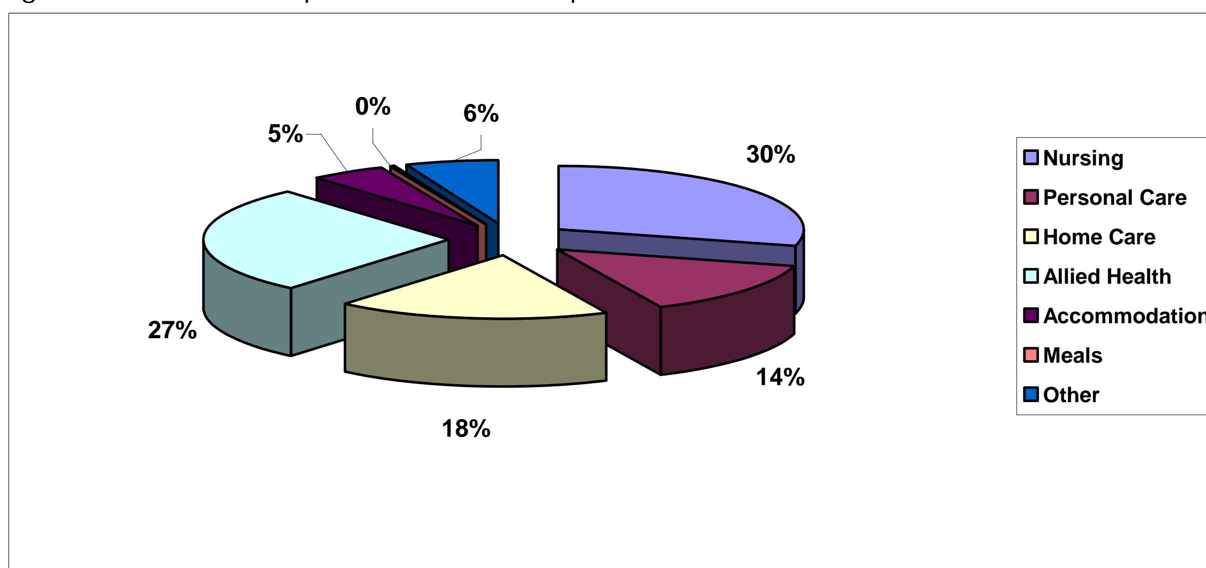
There are seven metropolitan PAC Services (excluding the state-wide service operated from the Royal Children's Hospital). There is greater diversity of operating arrangements for metropolitan PAC Services when compared with rural PAC Services. Five of the seven are auspiced by metropolitan Health Services and two are auspiced by CHS (Inner Melbourne and Inner South East). Five of the seven PAC services have care coordinators located on hospital campuses whilst two accept referrals via phone/fax (Inner Melbourne and Western).

All of the metropolitan hospitals also have HARP funding and as previously noted there is potentially an overlap in the target groups of patients for people presenting at Emergency Departments who may be eligible for both programs.

7.1 Metropolitan PAC service provision

The main types of services purchased by metropolitan PAC services are nursing, physiotherapy (included in allied health), and home care.

Figure thirteen: Metropolitan PAC service provision 2004-05



The main types of organisations that metropolitan PAC services purchased these services from in 2004-05 were:

- Community Nursing ($1.5 million)
  - HACC funded/not-for profit organisations 77.5%
  - Private providers 22.5%
- Allied Health (primarily physiotherapy) ($1.4 million)
  - Private providers 72.8%
  - HACC funded/not-for profit organisations 27.2%
- Home Care ($0.9 million)
  - Private providers 90.7%
  - HACC funded/not-for profit organisations 9.3%
- Personal Care ($0.7 Million)
  - Private providers 79.9%
  - HACC funded/not-for profit organisations 20.1%
- Accommodation ($0.3 million)

7.2 Metropolitan PAC services and community nursing

The majority (75%) of community nursing is purchased from the Royal District Nursing Service, its private arm Rally Healthcare and not-for profit nursing providers.

7.3 Metropolitan PAC services and physiotherapy

Of the total volume of allied health service expenditure by metropolitan PAC services, 24% is directed towards the purchasing of physiotherapy. The remaining 3% is expended on a range of other allied health services including occupational therapy, social work, speech pathology and podiatry. Physiotherapy services are primarily purchased from the private sector (73 % of all physiotherapy expenditure). Frequently patients are referred to PAC for therapy services because other therapy services, such as Sub-acute Ambulatory Care Services (SACS), have waiting lists. This becomes an issue as the patient's continuum of care is broken and generally there is duplication of effort in assessment processes and delays in achievement of therapy goals.

As part of the review of SACS, models of care will be developed for a number of broad groups of people including people who have had a hospital admission who may need therapy or community services for a limited time while they recover or rehabilitate following an acute or sub-acute episode. Part of this work, will encompass reviewing the role of PAC services in the provision of physiotherapy with a view to ensuring that people are able to access the most appropriate therapy service to meet their rehabilitation needs.

7.4 Metropolitan PAC services and home care

The majority of home care services are purchased from the private sector (91%). As with rural PAC Services, the low level of these types of services purchased from metropolitan HACC funded agencies suggests that these agencies do not have the workforce capacity to respond within the time frames required and/or meet the level of need of PAC services for home support services.

7.5 Metropolitan PAC services and personal care

As for home care services, the majority of personal care services are purchased from the private sector (80%). Again, the low level of these types of services purchased from metropolitan HACC funded agencies suggests that these agencies do not have the workforce capacity to respond within the time frames required and/or meet the level of need of PAC Services for home support services.

7.6 Metropolitan PAC services and accommodation

Accommodation services are used to provide non-home based respite. The majority of metropolitan PAC services spend 5% or less of their total services budget on accommodation, however there is some variation between PAC services that needs to be explored.

8. PAC Funding

Since the PAC Program's introduction the budget has grown from $2.5 million to $20.3 million per annum. This growth in funding can largely be attributed to expanding the Program to ensure the provision of post hospital recuperative supports across the state of Victoria as well as expansions to cover patients following discharge from sub-acute services and Emergency Departments (2000-01).

The 2005-06 budgets and targets for all PAC services are listed:

Figure fourteen: PAC budgets and targets: 2005-06

PAC Service	Target Episodes	Budget
Barwon	1,741	$1,051,167
Central Highlands	953	$575,588
East Gippsland	627	$378,551
Eastern	2,968	$1,791,869
Grampians	1,066	$643,489
Hume	2,798	$1,689,254
Inner Melbourne	1,347	$813,596
Inner South East	1,639	$989,688
Latrobe & Wellington	1,241	$749,120
Loddon Mallee	2,133	$1,287,911
North Eastern	2,662	$1,607,324
Northern Mallee (Mildura)	584	$352,388
Peninsula	1,765	$1,064,561
Royal Children's	342	$364,258
South West Gippsland	1,033	$623,529
Southern	3,581	$2,272,550
Wannon	1,329	$802,329
Western	5,165	$3,118,698
Total	**32,974**	**$20,329,564**

Initially, PAC funds were allocated on a project-by-project basis. As the Program became established there was seen to be a need to establish an equity-based funding model. In 2001-02 the Post Acute Care Resource Allocation Model (PACRAM) was introduced as the basis for allocating funds to PAC services. Consumer Price Indexation (CPI) and Enterprise Bargaining Agreements (EBA) increases were applied to the PAC Program budget commencing in 2004-05.

The PACRAM uses the following parameters for funds allocation between services:

Proxy target population:

- public hospital separations (previous 12 months and adjusted)

Needs weightings:

- age (65 plus as a percentage of separations) – double weighting,
- socio-economic status – double weighting,
- isolation – single weighting
- single parent status – single weighting; and
- cultural and linguistic diversity – single weighting.

The PACRAM funding formula is applied to seventeen of the existing eighteen PAC Services. PACRAM is not applied to the allocation of funding to the Royal Children's Hospital.

Three hospitals – Peter MacCallum Cancer Institute, the Royal Victorian Eye and Ear Hospital and the Royal Women's Hospital receive a fixed amount per year to support post acute care. These services do not receive brokerage funds but refer clients to existing PAC services based on the area where the person is returning to after hospital.

A current limitation of PACRAM is that with no new funding, it reallocates the existing funds amongst the seventeen services, with the major factor affecting this redistribution being hospital separations. As metropolitan hospital separations are tending to grow at a greater rate than regional and particularly rural areas, the impact has been to draw funds away from these services to the larger metropolitan PAC services. This is despite the needs weightings tending to "advantage" rural PAC services. PACRAM has not been used to allocate funds for the previous two years as there has been no new funding and the ongoing impact of applying it would be a continuing reduction in the viability of the smaller rural PAC services.

9. Current issues in the work and role of PAC services

There are a number of issues that have been noted in relation to the work and role of PAC services:

- There is still a need for a rapid response service to provide short-term recuperative supports to people leaving hospital when they require them.

- PAC episodes equate to approximately 10% of all hospital multi-day stays, suggesting a significant level of need for the type of services that the Program provides.

- A significant percentage of the PAC client group are older people who often have ongoing care needs at the conclusion of their PAC episode, highlighting the importance of ensuring that people are linked in with long-term community support services.

- An important constituency for PAC services are younger people who are unlikely to have access to any other community-based program such as HACC.

- The key post hospital recuperative support services provided are nursing and home support services (personal care and home care).

- PAC services have multiple relationships with both hospitals and community service providers that are often complex and reflective of the local service system mix.

- The provision of therapy by PAC particularly in relation to the development of the SACS Framework requires review.

- The method of delivering and arranging post hospital recuperative supports varies significantly amongst PAC services.

9.1 PAC and the delivery of post hospital recuperative supports

The PAC Program was established within a framework of hospitals having responsibility for discharge or transition planning.

A significant investment has been made to improve transition planning practices in hospitals. The Effective Discharge Strategy (EDS) was introduced in 1998-99 and was funded to a total of $42 million over the course of five years and aimed to support hospitals to improve their transition planning practices. Some of the main initiatives of this strategy were the funding of dedicated project officer positions to work on improving transition planning processes supported by audits of these processes. However, with the cessation of the strategy, many of the dedicated project officer positions were withdrawn and audits of practice ceased.

Under this framework, PAC services are not considered to be responsible for identifying a person's needs for post hospital care, although as previously noted, some PAC services do perform this role.

However, variance in transition planning and referral processes has been identified as an issue during the development of this discussion paper. Issues raised for people being discharged from hospital and their families and carers include:

- Assessment of their needs program by program rather than an assessment of their total needs.
- Multiple referrals including inappropriate and unrealistic referrals.
- Completion of multiple referral forms and assessments often collecting the same or similar information.
- Involvement of multiple services and/or agencies in supporting the person's transition from hospital to the community including multiple service providers and/or care coordinators in the community setting.

This variance also has service system implications including:

- "Out of area" referral processes that place the onus on referring Health Services to have a state-wide knowledge of service providers and agencies.
- Variance in "business rules" on what recuperative supports PAC services will provide under what circumstances, resulting in inequity of access to recuperative supports.
- Some PAC Services reporting that they undertake the transition planning function in their Health Services.

9.2 PAC and the brokerage model of service provision

PAC Services were established as a brokerage model of service provision; they have a pool of flexible funding to enable them to buy the services that are required, usually within the short time-frames that are required to assist with hospital discharge.

Whilst the brokerage model of service provision has been pivotal in ensuring that people receive the services they need in the time frames required, there are also limitations for both service recipients and service providers.

From the service recipient's perspective this can include:

- Lack of continuity of service providers as people move from one funded program to another (for example, from PAC to HACC).

- Not being considered or referred on to long-term service providers because longer term needs were not considered as part of transition planning.

- People being reassessed as they move from one funded program to another.

- Receiving different levels of services from different providers when there is more than one funded program involved (for example, HACC and PAC).

- Having a range of service providers whose visits are uncoordinated when there is more than one funded program involved.

- Having different fee contribution requirements for the same types of services when there is more than one program involved.

- People with complex, chronic health care needs may potentially have multiple service providers involved in their care coordination/case management or have no one taking responsibility for supporting their ongoing care needs in the community.

From the service provider perspective these can include:

- PAC Services purchasing services that are more appropriately delivered by other programs because of real or perceived difficulties in accessing these services within the required time frames. For example, the high level of provision of physiotherapy by metropolitan PAC Services has been largely attributed to difficulties in timely access to community-based physiotherapy services through SACS or a lack of awareness of the work of SACS.

- PAC Services spending considerable time and resources in negotiating "funding demarcations" with other funded agencies.

- PAC Services spending considerable time in negotiating access to ongoing services such as HACC and providers of care packages.

- The administrative workload for both service purchasers and service providers in arranging and billing for services.

10. Future directions for the PAC Program - Principles

The following principles need to be maintained when considering any changes to the current PAC Program:

10.1 Rapid Response Service

The model for delivering post hospital recuperative supports needs to ensure that a rapid response service is maintained to facilitate safe and timely discharge from hospital.

10.2 Person Centred

The model for delivering post hospital recuperative supports needs to put the person at the centre of care and consider their total needs with a minimum of duplication of assessment. This also includes considering the needs of their family and carers.

10.3 Right Care

The model for delivering post hospital recuperative supports needs to ensure that people are linked into the most appropriate service providers to ensure that both their short-term and long-term care needs are met.

10.4 Equity of Access

The model for delivering post hospital recuperative supports needs to ensure equity of access regardless of where a person lives.

10.5 Continuum of Care

The model for delivering post hospital recuperative supports needs to ensure that people move as smoothly as possible between their need for short-term and long-term care.

10.6 Service Coordination

The model for delivering post hospital recuperative supports, needs to incorporate implementation of the service coordination principles and practices enunciated in "Primary Care Partnerships strategic directions 2004-2006".

10.7 Administrative Efficiency

The model for delivering post hospital recuperative supports needs to be administratively cost-effective.

Appendix 1 PAC services catchments and relationships

Rural PAC services catchments and relationships

PAC Service	Hospitals[5]	Principal Catchments (LGAs) *Indicates shared LGAs	PCPs *Indicates shared PCPs
Barwon	Barwon Health (Geelong) Colac Hesse (Winchelsea) Lorne Otway (Apollo Bay)	Colac-Otway Golden Plains* Greater Geelong Moorabool* Queenscliff Surfcoast	Barwon Colac-Otway Greater Geelong Queenscliffe Surf Coast
Central Highlands	Ballarat Djerriwarrh (Bacchus Marsh) Hepburn Health Services (Creswick & Daylesford)	Ballarat Golden Plains* Hepburn Moorabool*	Central Highlands Ballarat Golden Plains Hepburn Moorabool
East Gippsland	Bairnsdale Omeo Orbost	East Gippsland	East Gippsland
Grampians Grampians cont	Stawell Regional Health East Grampians (Ararat) Beaufort & Skipton Beaufort Skipton Dunmunkle (Rupanyup) Edenhope Rural North West Warracknabeal Hopetoun Wimmera Horsham Dimboola West Wimmera Nhill Jeparit Kaniva Rainbow East Wimmera Health St Arnaud Donald Charlton Birchip Wycheproof	Ararat Buloke* Corangamite* Golden Plains* Hindmarsh Horsham Northern Grampians Pyrenees West Wimmera Yarriambiack	Southern Mallee Grampians Pyrenees Ararat Northern Grampians Pyrenees Wimmera Hindmarsh Horsham West Wimmera Yarriambiack
Hume	NorthEast Health (Wangaratta) Seymour Goulburn Valley (Shepparton) - HARP Wodonga Alpine Health Benalla Mansfield Cobram Nathalia Numurkah Yarrawonga	Alpine Benalla Greater Shepparton Indigo Mansfield Mitchell Moira Murrindindi Strathbogie Towong Wangaratta Wodonga	Central Hume Alpine Benalla Mansfield Wangaratta Upper Hume Indigo Towong Wodonga Lower Hume Mitchell Murrindindi Goulburn Valley

[5] PAC catchments are not based on health service catchments but on where people reside. However, this column reflects the major sources of clients for PAC Services. PAC Services are expected to provide services for people discharged from other hospitals who live in their catchment area.

PAC Service	Hospitals[5]	Principal Catchments (LGAs) *Indicates shared LGAs	PCPs *Indicates shared PCPs
Hume cont.	Beechworth Upper Murray (Corryong) Tallangatta Kilmore Alexandra Yea		Shepparton Moira Strathbogie
Latrobe & Wellington	Latrobe (Traralgon) - Central Gippsland (Sale) Yarram	Latrobe City Wellington	Central West* Baw Baw Latrobe Wellington
Loddon Mallee	Bendigo Boort Cohuna Echuca Inglewood Kerang Kyabram Kyneton Maldon Manangatang McIvor (Heathcote) Maryborough Mt Alexander (Castlemaine) Rochester & Elmore Swan Hill	Buloke* Campaspe Central Goldfields* Gannawarra Greater Bendigo Loddon Macedon Ranges Mount Alexander Swan Hill (excl Robinvale SLA)	Bendigo-Loddon Bendigo Loddon Campaspe Central Victorian Central Goldfields Macedon Ranges Mt Alexander Swan Hill-Ganawarra-Buloke (excl Robinvale SLA)
Northern Mallee	Mildura Patchewollock Robinvale Mallee Track (Ouyen)	Mildura (Robinvale SLA from Swan Hill)	Mildura (incl Robinvale SLA)
South West Gippsland	Wonthaggi South Gippsland Gippsland Southern West Gippsland	Bass Coast Baw Baw South Gippsland	South Coast Bass Coast South Gippsland Central West* Baw Baw Latrobe
Wannon	South West Health Care (Warrnambool & Camperdown) Portland Western District (Hamilton) Timboon Moyne (Port Fairy) Terang & Mortlake Heywood Casterton Coleraine Penshurst	Corangamite Glenelg Moyne Southern Grampians Warrnambool	South West Corangamite Moyne Warrnambool Southern Grampians – Glenelg

Metropolitan PAC services catchment and relationships

PAC Service	Hospitals[6]	Principal Catchments (LGAs) *Indicates shared LGA	PCP Catchments *Indicates shared PCP
Eastern	The Angliss Healesville Maroondah Box Hill Peter James Yarra Ranges	Knox Maroondah Manningham Whitehorse Yarra Ranges	Central East* Manningham Monash Whitehorse Outer East Knox Maroondah Yarra Ranges
Inner Melbourne	St Georges St Vincents	Boroondara Darebin* Melbourne Yarra	Boroondara North Central* Darebin Whittlesea Yarra Melbourne-Moonee Valley
Inner South East	The Alfred Caulfield Sandringham	Bayside Glen Eira Port Phillip Stonnington	Inner South East Glen Eira Port Phillip Stonnington Kingston-Bayside
North Eastern	Austin Hospital Repatriation Hospital Royal Talbot Broadmeadows Bundoora Extended Care The Northern Hospital Mercy	Banyule Darebin* Hume* Nillumbik Whittlesea	Banyule-Nillumbik Hume-Moreland* North Central* Darebin Whittlesea Yarra
Peninsula	Frankston Rosebud Mount Eliza	Frankston Mornington Peninsula	Frankston & Peninsula
Southern	Casey Dandenong Kooweerup Monash (Clayton) Monash (Moorabbin) Sandringham	Cardinia Casey Greater Dandenong Kingston Monash	Central East* Monash Manningham Whitehorse South East Cardinia Casey Greater Dandenong
Western	Royal Melbourne Royal Melbourne –Royal Park Western Hospital Mercy (Werribee) Sunshine Williamstown	Brimbank Hobsons Bay Hume* Maribyrnong Melton Moonee Valley Moreland Wyndham	Brimbank-Melton Hume-Moreland* Moonee Valley-Melbourne West Bay Hobsons Bay Maribyrnong Wyndham

[6] PAC catchments are not based on health service catchments but where people live. However, this column reflects the major sources of clients for PAC Services. PAC Services are expected to provide services for people discharged from other hospitals who live in their PAC catchment area.

Appendix 2 Glossary of Terms

Ambulatory care
Care that takes place as a day attendance at a health care facility or at the consumer's home. The umbrella term incorporates primary, secondary and tertiary level services; services provided to individuals or populations; services provided on a same day basis and acute episodic or longitudinal care.

Brokerage funds
Funds specifically allocated for the purchase of services for clients referred to Post Acute Care.

Carer
Someone (usually a family member) who provides support to children or adults who have a disability, mental illness, chronic condition or who are frail aged. Carers can be parents, partners, sons, daughters, brothers, sisters or friends of any age.

Care coordination
Coordination of the services required by the person so they are delivered in the most efficient and effective way to meet the person's needs.

Home and Community Care (HACC)
HACC is a joint Australian Government/State Government program that provides services to support frail older people, younger people with disabilities and carers. HACC funds a range of basic support services that enable people to stay in the community and live as independently as possible. HACC services are provided by local governments, Royal District Nursing Service, community health services, public hospital, community and voluntary agencies.

Person centred
Delivery of health care configured around the needs of the person.

Recuperative supports
An individually tailored package of community based supports to assist a person to return to health after a hospital episode.

Sub-acute care
Goal orientated, time-limited interventions, generally provided in a multidisciplinary environment to people who require evaluation, treatment and management for post-acute or chronic conditions.

Transition Planning
Transition planning is considered to be the process whereby hospitals, health services, general practitioners and other community service providers coordinate a person's care to ensure they can safely return to the community after a hospital episode. (Effective Discharge Strategy).