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C O R P O R A T E A D V I S O R Y

REPORT TO

The Department of Human Services
Metropolitan Health and Aged Care Services Division
Post Acute Care Service Models



POST ACUTE CARE SERVICE MODELS EVALUATION

SUBMITTED BY

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TABLE OF CONTENTS

1.0	EXECUTIVE SUMMARY	5
	Introduction.....	5
	Methodology.....	6
	Key Findings.....	6
	Recommendations	8
2.0	BACKGROUND	12
	Establishment.....	12
	Current Issues.....	12
	Previous PAC review.....	13
	Previous PAC review - outcomes.....	13
	Future directions for the PAC Program - Principles	14
3.0	METHODOLOGY	15
4.0	INTERVIEWS – ANALYSIS AND KEY FINDINGS	18
	Governance arrangements.....	18
	Governance arrangements – key findings.....	21
	Consortia arrangements.....	22
	Consortia arrangements – key findings.....	23
	Service system relationships.....	23
	Service system relationships – key findings.....	24
	On-site presence	24
	On-site presence – key findings.....	25
	Linkages to discharge planning.....	25
	Linkages to discharge planning – key findings.....	26
	Accessibility.....	27
	Accessibility – key findings.....	28
	Program interaction	28
	Program interaction – key findings.....	30
	Guidelines	31
	Guidelines – key findings	32
	Measurement and reporting tools.....	32
	Measurement and reporting tools – key findings.....	33
	Efficiency	34
	Efficiency – key findings	35
	Brokerage agreements.....	36
	Brokerage agreements – key findings.....	37
	Future impacts and developments	37
5.0	SURVEY – ANALYSIS AND KEY FINDINGS	39
	Method	39
	Sample Characteristics	39
	Findings.....	40
	Governance arrangements.....	40
	Governance arrangements - key findings	47
	Consortia arrangements.....	47
	Consortia arrangements - key findings.....	48
	On-site presence.....	48
	On-site presence - key findings.....	49
	Linkages to discharge planning.....	49
	Linkages to discharge planning - key findings.....	51

	Accessibility	51
	Accessibility – key findings	53
	Program interaction	54
	Program interaction - key findings	56
	Guidelines	56
	Guidelines - key findings	59
	Measurement and reporting tools	59
	Measurement and reporting tools - key findings	59
	Efficiency	59
	Efficiency - key findings	61
	Brokerage agreements	61
	Brokerage agreements - key findings	61
	Future impacts and developments	62
6.0	WORKSHOP – ANALYSIS AND KEY FINDINGS	63
	Method	63
	Attendees	63
	Service model objectives	63
	Statements of options	65
	Consortia	65
	Dispute resolution	67
	Financial management	69
	Brokerage agreements	71
	Guidelines	73
	Integrated access	75
	InterPAC service delivery	77
	OH&S	79
	Ward presence	81
7.0	WORKING SESSIONS – OUTCOMES	83
	PAC issues identification	83
	Good governance in PAC	86
	Review and discussion of interview issues	88
8.0	RECOMMENDATIONS	89
	Results of analysis	89

APPENDIX A Interview questions

APPENDIX B Survey questions

APPENDIX C Workshop participants

APPENDIX D Working party members

Abbreviations used in this report

ACCV	Aged and Community Care Victoria
ANF	Australian Nursing Federation
AS	Australian Standard
CALD	Cultural and linguistic diversity
CHS	Community Health Service
CRC	Community Rehabilitation Centre
DHS	Department of Human Services
DMC	Dench McClean Carlson Corporate Advisory
ED	Emergency Department
GP	General Practitioner
GPDV	General Practice Divisions - Victoria
HACC	Home and Community Care
HARP-CDM	Hospital Admission Risk Program – Chronic Disease Management
HITH	Hospital in the Home
HR	Human Resources
IMPAC	Inner Melbourne Post Acute Care
IP	Inpatient
ISEPAC	Inner South East Post Acute Care
KPI	Key Performance Indicator
OECD	Organisation for Economic Co-operation and Development
OH&S	Occupational Health and Safety
OT	Occupational Therapist
PAC	Post Acute Care
PCP	Primary Care Partnership
PEG	Percutaneous Endoscopic Gastrostomy
PenPAC	Peninsula Post Acute Care
PT	Physiotherapist
RDNS	Royal District Nursing Service
RITH	Rehabilitation in the Home
SACS	Sub-acute Ambulatory Care Services
SCTT	Service Coordination Tool Templates
SPAC	Southern Post Acute Care
SPSS	Statistical Package for the Social Sciences
VINAH	Victorian Integrated Non-Admitted Health Minimum Dataset

1.0 EXECUTIVE SUMMARY

Introduction

- 1.1 Dench McClean Carlson Corporate Advisory (“DMC”) were appointed by the Department of Human Services (“DHS”) to undertake a review of the Post Acute Care (“PAC”) service models. DMC were assisted with specialist advice from Dr Peter Cameron of the Department of Epidemiology and Preventative Medicine, Monash University and data analysis assistance from Matthew Nichol of Compelling Economics. We also acknowledge the contribution from the Post Acute Care Service Model Review Working Party.
- 1.2 The review commenced in April 2007 and was completed in September 2007.
- 1.3 The review found that the PAC program is well regarded by all stakeholders. It is generally flexible and responsive and meets its aims of a safe referral home for patients while supporting efficient bed management in hospitals. It is mostly considered accessible and meets referrer and patient requirements.
- 1.4 The program currently consists of 20 services providing access to a range of post acute care clinical and community support services statewide, and one specialist service located at the Royal Children’s Hospital.
- 1.5 The background to PAC and the findings of previous reviews are provided in section 2.0 of this report
- 1.6 This current work was to undertake a review of a representative sample of PAC service models to determine their efficiency and effectiveness in meeting the objectives of the PAC program.
- 1.7 Key areas for investigation included:
 - the off-site versus on-site model for delivery of post-acute care
 - referral systems and relationships
 - current governance arrangements
 - consortia arrangements
- 1.8 The alignment/relationship of PAC service models with a range of other hospital-community interface programs such as the Hospital Admission Risk Program-Chronic Disease Management (“HARP-CDM”), and Sub-acute Ambulatory Care Services (“SACS”) was also to be considered.

Methodology

- 1.9 The key components of our methodology for the review included discussions with over 130 PAC service employees and stakeholders, working sessions with the PAC Working Party, a survey from 541 respondents, development of options, an options workshop, analysis and preparation of a final report. A full description of the methodology is provided at Section 3.0 and the instruments are provided in the Appendices.

Key Findings

- 1.10 As stated earlier the PAC program is generally well regarded. However there were a few situations identified where eligible clients had not been able to access PAC or were given less assistance than their referrers requested.
- 1.11 Most of the complaints in relation to these matters arose from interPAC referrals where the client was a patient from a metropolitan hospital seeking PAC services from another metropolitan hospital-based PAC.
- 1.12 Primary concerns in regional PACs relate to:
- Shortages of some services especially allied health
 - Unrealistic expectations from metropolitan based discharge planners
 - Too many co-ordination meetings for a range of programs eg PAC, Home and Community Care (“HACC”), HARP-CDM, SACS
 - Efficient co-ordination of visits for a number of programs eg nursing visit to a small town able to cover clients of different programs at the same time
- 1.13 The investigation was inconclusive regarding the value of the off-site versus on-site model. The conclusions reached were as follows:
- It is not possible to cover all discharge points in a large hospital even with on-site staff
 - Referrers value timely response to telephone calls, ease of administration and timely service arrangements
 - There are benefits where the staff of a number of programs are co-located eg PAC and HARP-CDM whether on-site or off-site
- 1.14 Referral systems and relationships are generally good, supported strongly at the operational level. However interactions with general practitioners (“GPs”) are limited and relationships at the PAC management level are not so strong.

- 1.15 Current governance arrangements need attention. The significant issues are:
- Lack of financial transparency for stakeholders
 - Accountability of decision making for interPAC referrals
 - Inconsistency in access and service provision
 - Lack of published quality of care and service standards
 - Multiple governance and management meetings for regional PACs involving extensive travel
 - Lack of a co-ordinated approach to risk management
 - Ad hoc approach to brokerage agreements
 - Absence of financial planning and forecasting
- 1.16 Consortia arrangements were mostly considered a carryover from establishment. Most stakeholders felt that the relationships were now matured and good collaboration existed. There was no strong support for continuance of formal consortia agreements. While input from members might be valuable in an advisory sense, there was no evidence they participated in governance. Their continued existence probably clouds accountabilities.
- 1.17 There is some support for a closer alignment with other programs such as HARP-CDM and SACS. We understand the DHS is currently developing an integrated model. However a number of survey respondents commented that integrated models have lead to loss of skill and knowledge, less responsiveness and more administrative overhead. Care must be taken in any integrated model to ensure that competency, responsiveness and flexibility for PAC is not lost.
- 1.18 There is insufficient data collected to provide robust monitoring and reporting to support decision making. We understand that the new Victorian Integrated Non-Admitted Health Minimum Dataset (“VINAH”) reporting system is expected to improve this situation.
- 1.19 Structurally the PAC program has high transaction costs. The assessment process it must go through to identify the service requirement and fill that requirement is as expensive as the process required to meet a much longer term need (such as a HACC service).
- 1.20 The ratio of value of services delivered to transaction costs for PAC will always indicate a less efficient service than longer term services, but for quality of care and occupational health and safety (“OH&S”) reasons, these assessment and service establishment costs will be required. Care should therefore be taken before any additional costs are incurred including costs of additional reporting.

Recommendations

- 1.21 We drew a series of recommendations from the analysis of data collection from interview and survey, Working Party sessions and workshop analysis. These recommendations are provided at **Section 8.0** in the categories identified in the data gathering framework.
- 1.22 We had a subsequent discussion with DHS to group these recommendations into a program format and to understand where existing work was already incorporating some of the changes we had suggested.
- 1.23 In the tables below we have provided the recommendations in the categories agreed with DHS.

<i>Equity of Access</i>
<p>That DHS consider development of an improved system-wide governance framework to ensure equitable treatment of patients with respect to eligibility and service provision.</p> <p>That PAC services consider the following improvements to accessibility:</p> <ul style="list-style-type: none"> • Midwifery patients need better consideration • Refusal of PAC should be kept to a minimum if the result of refusal is a longer hospital stay (especially interPAC referrals) • That private patients in public hospitals and their discharge planners be advised of their eligibility in PAC education materials • Review the impact on accessibility of the restriction on funds in some PAC catchments (mainly regional)
<i>Customer Service Standards</i>
<p>That PAC services develop and publish customer service standards for responsiveness and quality to all stakeholders.</p>
<i>InterPAC Arrangements</i>
<p>That DHS consider development of an improved system-wide governance process for interPAC referrals to ensure that metropolitan hospital-based PACs are not disadvantaging patients from other hospitals.</p> <p>That DHS immediately develop a monitoring program for interPAC referrals and require PACs to provide reason for any refusal of service. The monitoring should also require PAC services to identify and justify any additional administrative requirements they place on interPAC referrals.</p> <p>That DHS consider the adoption of a common form for all interPAC referrals.</p> <p>That DHS consider retaining the budget cover for interPACs and reimbursing interPAC service provision when provided to ensure that patients from hospitals outside a PAC catchment are not disadvantaged for financial reasons.</p>
<i>Dispute Resolution</i>
<p>That DHS require PAC services to immediately develop and publish dispute resolution and complaint handling processes. These processes must focus on urgent resolution given the impact on bed availability if PAC services are not supplied.</p>
<i>Fundholder</i>
<p>That DHS contract with one party only as the fundholder and that this party be held responsible for transparency and accountability of governance. Previous consortium</p>

members may meet or continue to meet as an advisory group if desirable.
<i>Service Model</i>
<p>That PAC services consider the most efficient use of staff time rather than focus on staff location. Face-to-face discussions are valuable in complex discharges and high bed pressure units, but electronic and telephonic referrals are more efficient for simpler discharges. For off-site services the development of a hospital liaison PAC role should be considered. There should be a focus on units where there is pressure on beds.</p> <p>That PAC services consider the following improvements to linkages to discharge planning:</p> <ul style="list-style-type: none"> • Continuing education to ward staff regarding PAC services and provision of contact details • Regular visits (at least monthly) to discharge points • Earlier discharge planning, commencing at admission for patients requiring PAC services • Greater weight to be given to clinical assessments • Streamlining of simple discharges requiring a simple service package eg. home help and meals on wheels • A focus on prompt response to telephone messages from discharge planners • A focus on relevant, accurate and appropriate information in referrals to service providers
<i>Integrated Model</i>
<p>That DHS continue the policy development for an integrated model for a range of programs including PAC but ensure that access to PAC services is still provided with a sense of urgency and that current knowledge and skills with respect to service networks is not lost. The process will need to be very efficient and not just add another layer of administration between clinicians and service delivers.</p> <p>That DHS develop a robust implementation plan for the integrated model that will reach clinicians, service providers and other stakeholders to ensure a smooth transition.</p>
<i>Guidelines</i>
<p>That DHS sponsor the preparation and publication of a consolidated list of programs, their eligibility requirements, access arrangements and the services provided.</p> <p>That DHS lead the development and publication of minimum core PAC guidelines covering the following issues:</p> <ul style="list-style-type: none"> • Eligibility • Minimum service packs (for simple and complex cases) • Pre-approvals for after hours discharges for minimum service levels eg one or two nursing visits <p>Guidelines to be reviewed at least annually with input from referrers, service providers and other stakeholders.</p> <p>That DHS and PACs consider aligning PAC service levels with HACC service levels where there is no clinical requirement for a difference.</p> <p>The guidelines should allow for flexibility in the initial service provider visits when unidentified issues become apparent eg OH&S issues.</p>
<i>General Practitioners</i>
That PAC services develop mechanisms to improve interactions with GPs.

<p><i>Brokerage Agreements</i></p> <p>That DHS lead the development of model brokerage agreements – at least two – one comprehensive for complex services (such as physiotherapy) and a simple version for simple services (such as nappy washing or dog walking).</p> <p>That DHS and PACs investigate the feasibility of non-exclusive agreements for the purchase of services in bulk from large suppliers such as the Royal District Nursing Service (“RDNS”).</p> <p>That DHS require all PACs to ensure their brokerage agreements are current and that they cover identified risk management processes such as OH&S risk management.</p>
<p><i>Standards and Risk Management</i></p> <p>That PAC services develop quality of care standards to ensure adequate risk management for patients and service providers including communication with GPs for ongoing care.</p> <p>That risk identification and risk mitigation frameworks within PAC services are identified at the governing group level and reported annually to DHS. These risks could include OH&S risks, clinical care risks and financial risks.</p>
<p><i>Workforce</i></p> <p>That DHS consider strategies for overcoming service shortages in allied health eg. discussions with health services on allocation of OT budgets for PAC or promoting the use of allied health assistants working under the supervision of senior staff. <i>Note: regional areas report shortages of OTs, physiotherapists (“PTs”), psychologists. The metropolitan shortages are mainly in OT departments.</i></p>
<p><i>Home and Community Care</i></p> <p>That DHS review the impact of HACC waiting lists on PAC service delivery and relationships.</p>
<p><i>Community Access</i></p> <p>That DHS consider expanding the PAC program parameters to pre-admission clients where a hospital admission may be avoided if PAC services are provided.</p>
<p><i>Efficiency</i></p> <p>That DHS and PACs consider the following opportunities for improvements in efficiency:</p> <ul style="list-style-type: none"> • Greater use of e-referrals • Continuity of care utilising the same service provider for different programs where possible • Direct employment of allied health staff where cost savings are clearly demonstrated • Streaming of simpler discharge cases into simple administration for assessment and case management rather than one size fits all • Sharing legal costs for brokerage agreements • Bulk purchasing of services (where quality of service is guaranteed to be maintained) • Creation of a single point of entry with other related programs (provided the urgency of assessment and service provision for PAC is not lost and no additional administration burden is imposed on referring clinicians) • Use of multiskilled staff who are co-located to handle PAC service requests • Improved referral information to be given to service providers

<i>Reporting</i>
That DHS consider improving the data collection from PAC services to support benchmarking and performance assessment (the introduction of VINAH may address this issue).
<i>Financial Reporting Framework</i>
That PAC services develop an annual financial reporting framework that ensures stakeholders (especially referring hospitals) receive accurate, comprehensive and comparative information that supports decision making in relation to usage of PAC services.
<i>Management and Reporting Tools</i>
<p>That DHS lead the development of standard reporting in consultation with PACs. As PAC transaction costs are already unavoidably high, the imposition of any additional administration requirements should be kept to a minimum. This means utilising information that is already collected or could be easily obtained eg from service providers.</p> <p>That DHS develop and publish rigorous definitions for the cost elements used in PAC reporting so that this data is more robust and can be used for benchmarking.</p> <p>That DHS and PACs consider efficient ways to report on the following matters:</p> <ul style="list-style-type: none"> • Maternity cases referred to PAC • Refusals of PAC services especially interPACs • The percentage of separations that receive PAC by hospital • Funds allocated and expended by hospital • Client satisfaction • Care outcomes • Reports on patients to GPs • Re-admissions related to the provision or lack of provision of PAC data
<i>Meetings</i>
That DHS reconsider the governance and management meetings required for regionally based programs and consider replacing multiple meetings with a meeting covering a range of programs.
<i>Future Planning</i>
That DHS lead an annual planning meeting of PACs (with input from stakeholders) to identify likely changes over a three year time frame to provide input into DHS policy making.

2.0 BACKGROUND

Establishment

- 2.1 The 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.
- 2.2 In this environment, concerns for patient welfare led to the introduction of the PAC Program (Post Acute Care Program Health Outcomes and Cost Benefit Study, April 2001).
- 2.3 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
 - To facilitate safe and timely discharge

Current Issues

- 2.4 The health system environment has significantly changed since the PAC Program was introduced in 1995. Issues that are prompting a 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 might 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 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
 - different levels of service provision between programs

Previous PAC review

- 2.5 The key areas explored in the previous program review included:
- The current role and functions of the PAC Program to ensure that it delivers person-centred health care
 - The current referral relationships to, from and between PAC services to identify opportunities to improve the linkage of people being discharged from hospital into community-based services, both short-term and long-term
 - The current relationships of the PAC Program with other programs that provide access to post-hospital and/or preventative supports, identifying opportunities for ensuring that the right care is being provided in the right place and at the right time
 - The current brokerage model of the PAC Program to identify potential to increase the purchasing power of the program
 - The current arrangements for administering the PAC Program to identify opportunities to increase expenditure on provision of services
 - The current funding, governance and data collection models to ensure alignment with supporting appropriate delivery of post acute care services

Previous PAC review - outcomes

- 2.6 The previous process identified six areas where improvements could be made in the delivery of post acute care services. They were:
- eligibility and equity of access to the program
 - referral models and relationships
 - service model (assessment, care coordination and discharge planning)
 - service provision
 - service integration and alignment
 - service management
- 2.7 The consultation also highlighted the variance between PAC services in how they operated to meet the program's objectives.
- 2.8 A significant contributing factor to this variance was believed to be the variety of service models for delivery of post acute care. There are five different service models.
- 2.9 A range of stakeholder feedback during the review reflected conflicting opinions on the optimum model for PAC services.

Future directions for the PAC Program - Principles

- 2.10 The Post Acute Care Program Discussion paper also identified a range of principles that needed to be maintained when considering any changes to the current PAC Program. These principles focused upon:
- Provision of a rapid response service for patients discharged from hospital
 - Person centred care that was focused upon the needs of the whole person
 - Delivery of the right care, in the right place, at the right time
 - Ensuring equity of access to services for those in need
 - Promoting the seamless delivery of services across the continuum of care
 - Maximising service coordination between a range of different providers
 - The promotion of administrative efficiency
- 2.11 These objectives and principles have also informed the current work.
- 2.12 This current work is to undertake a review of a representative sample of PAC service models to determine their efficiency and effectiveness in meeting the objectives of the PAC program.
- 2.13 Key areas for investigation included:
- the off-site versus on-site model for delivery of post-acute care
 - referral systems and relationships
 - current governance arrangements
 - consortia arrangements
- 2.14 The alignment/relationship of PAC service models with a range of other hospital-community interface programs such as HARP-CDM, and SACS will also be considered.

3.0 METHODOLOGY

- 3.1 The PAC service models review commenced with a project establishment stage to discuss and agree methodology, timeline and project management.
- 3.2 During this stage the seven PAC services which would be subject to in-depth review were identified and the representatives to be interviewed from DHS and peak bodies were agreed.
- 3.3 Seven services were identified for in-depth review, representing the five different service models and included both metropolitan and regional services. These services were:
- Inner Melbourne (“IMPAC”)
 - Inner South East (“ISEPAC”)
 - Southern (“SPAC”)
 - Peninsula (“PenPAC”)
 - South West Gippsland PAC
 - Wannon PAC
 - Hume PAC
- 3.4 The peak bodies interviewed included:
- DHS
 - General Practice Divisions - Victoria (“GPDV”)
 - Australian Nursing Federation (“ANF”)
 - Carers Victoria
 - RDNS
 - Aged and Community Care Victoria (“ACCV”)
- 3.5 The primary research stage included the identification and interviewing of PAC service staff, key stakeholders and the peak bodies.
- 3.6 We were provided with the contact details for the PAC manager at each of the seven services identified. We contacted the managers and requested each provide us with a list of key contacts to be interviewed, including:
- PAC service staff
 - Referrers

- Service providers
 - Other stakeholders including Local Government
- 3.7 Face-to-face interviews (including individual and group interviews) were conducted with over 130 people representing the seven PAC services, key stakeholders and peak bodies.
- 3.8 The interviews were structured with a pre-determined format addressing key issues identified in discussions with DHS and the PAC working party. Each interviewee or interview group was sent a copy of the questions prior to their interview time in order to prepare additional information as required. See Appendix A.
- 3.9 An on-line survey was used to capture information across the rest of the PAC services. The survey was developed by incorporating issues raised during the interview process to further explore their impact and relevance across the PAC community.
- 3.10 The survey, incorporating 35 questions on governance, consortia arrangements and on-site presence, was reviewed by DHS and our statistical analyst prior to being released to the services. See Appendix B.
- 3.11 We distributed the survey link to the PAC managers across the state as well as to a distribution list supplied by DHS. The list contained key representatives across the Victorian acute and sub-acute health sectors and the email requested that the link be provided to any staff member or stakeholder who has dealings with PAC.
- 3.12 We received 541 responses with representation from PAC staff, service providers, referrers and other stakeholders across the state. This was considered a very strong response.
- 3.13 The data collected has been analysed both thematically as well as statistically using software including Statistical Package for the Social Sciences (“SPSS”) to determine significant relationships within the data.
- 3.14 The final component of the data collection phase was to hold a workshop for which we developed statements of options on the following topics:
- Consortia
 - Dispute resolution
 - Financial management
 - Brokerage agreements
 - Guidelines
 - Integrated access

- InterPAC service delivery
 - OH&S
 - Ward presence
- 3.15 Seventeen representatives of PAC services and stakeholders attended the workshop, developing key objectives for the PAC service model and considering the options sets proposed. See Appendix C for a full list of the workshop participants.
- 3.16 During the review process we met with the PAC Working Party on three occasions. A full list of the PAC Working Party members is provided in Appendix D. The Working Party meetings generated the following:
- Meeting 1 (27 April 2007) – PAC issues identification
 - Meeting 2 (13 June 2007) – Good governance in PAC
 - Meeting 3 (15 August 2007) – Review and discussion of interview issues
- 3.17 The output from these meetings was incorporated into question and questionnaire development, analysis and reporting.
- 3.18 In the analysis and reporting stage we brought together findings from the research and consultation stages to:
- Outline the major findings, addressing key terms of the review and linking findings with a variety of sources of evidence
 - Provide a series of recommendations to improve governance and management models together with the evidence supporting each recommendation
 - Provide recommendations on opportunities for improvement identified during the review

4.0 INTERVIEWS – ANALYSIS AND KEY FINDINGS

- 4.1 As discussed in Section 3.0 Methodology, the brief from DHS required us to conduct in-depth interviews with the staff and stakeholders of seven PAC services – four metropolitan and three regional. In addition we interviewed representatives from the six peak bodies listed in Section 3.0
- 4.2 The structured interview format that we followed is provided at Appendix A.
- 4.3 In this section we have provided a high level summary of the issues and concerns identified in our discussions with over 130 staff and stakeholders and have detailed our key findings from the interviews.
- 4.4 Feedback from interviewees is in plain text; DMC comment is in italics.
- 4.5 We have considered the issues under the following headings.
- Governance arrangements
 - Consortia arrangements
 - Service system relationships
 - On-site presence
 - Linkages to discharge planning
 - Accessibility
 - Program interaction
 - Guidelines
 - Measurement and reporting tools
 - Efficiency
 - Brokerage agreements
 - Future impacts and developments

Governance arrangements

- 4.6 There were a range of governance issues of concern.
- 4.7 In the metropolitan area, referrers who were interviewed did not believe that there were adequate measures to meet disclosure and transparency obligations. Hospitals had no understanding of the amount of PAC they accessed against any benchmarks. Generally they did not see financial reports from their PAC services and would have found them valuable if they were provided. Hospitals have no

way of measuring whether their use of PAC is about the expected average or substantially over or under.

- 4.8 This was different for the referrers in the regional PAC services we interviewed. One service centrally manages funds to ensure equitable allocation of funds and reviews the use of funds annually with referrers. The other two divide the PAC budget amongst members based on separations and use negotiation to manage funds across services to ensure patient needs are met.
- 4.9 There was perceived to be a lack of transparency in funding streams with interaction between HACC and hospital funding and resources and PAC funding. *DMC comment - The financial reporting to DHS does not provide a sufficient level of definition to provide the data to review these arrangements and set guidelines.*
- 4.10 Dispute resolution and complaint handling is generally a weakness, especially in metropolitan PACs. The complaints were focused mainly on interPAC referrals where hospital staff cited many unresolved instances of rudeness, inconsistency of service provision and eligibility, delaying and blocking behaviours such as inappropriately long questionnaires and documentation, refusal to assist and refusal to accept a referral. These complaints were generally confined to PACs based in metropolitan hospitals, whereas community health PACs and regional PACs were viewed as very supportive of patients needing assistance in the community and helpful to hospital staff in making referrals.
- 4.11 The end result of difficulties in making interPAC referrals is that patients stay longer in hospital beds costing the community significantly more than the value of the PAC services and potentially denying another patient the opportunity for a surgical procedure. *DMC comment: Bed availability is often a factor in managing the elective surgery access list.*
- 4.12 Uncertainty in eligibility and service provision means that referrers find it difficult to plan discharges. This is especially a problem for the larger metropolitan hospitals whose patients may be drawn from all over Victoria. PAC catchments are defined by the patient's home address so that hospitals such as St Vincent's Hospital and the Royal Women's Hospital will be discharging patients potentially into 18 different PAC services.
- 4.13 Metropolitan referrers have cited a large number of incidents where patients with similar clinical and community status get very different PAC service provision (or no service) depending on the local (unpublished) rules. They believe that service provision lacks transparency eg they are told a maximum of four allied health visits per month will be funded but then find that sometimes six will be allowed. They comment that PAC services seem to be service rationers rather than service providers.
- 4.14 *DMC comment: We note that PAC services are a public service and we believe the provision to public patients should be substantially the*

same regardless of residential location or who is approving the services.

- 4.15 There is a lack of engagement with service providers. *DMC comment: As a consequence there is little discussion on quality of service or PAC requirements and opportunities for ongoing improvement are probably missed.*
- 4.16 Risk assessment processes are regarded by a significant number of stakeholders as inadequate. There are two aspects to this risk assessment. The first is the risk to the patient of an unsafe referral home without PAC services or with inadequate PAC services. The second is the OH&S risk to service providers from the work environment. The work environment in this case includes the patient's home, the patient themselves (eg lifting heavy or obese patients) and other occupants or visitors (eg abusive or drug addicted family members, aggressive dogs).
- 4.17 Some PAC services when handling interPAC requests believe that hospital OTs should visit all patients at home for a comprehensive risk assessment. We are advised that this is not achievable.
- 4.18 *DMC comment: Full engagement with stakeholders including referrers and service providers would help to identify these risks and to develop approaches to mitigate them.* Currently there are limited mechanisms for feedback and accountability and information exchange is dependent on staff goodwill and communication skills. Regular discussions between PAC staff and stakeholders would be valuable.
- 4.19 General practitioners also comment that they get no communication from PAC services. They find it difficult to understand what services are being provided to their patients and comment that patients are often uncertain or confused about which program is providing the services they receive eg PAC, HARP-CDM, HACC. They comment that hospitals often do not identify the patient's GP on admission.
- 4.20 A small number of service providers perceive that there is unfair competition between public and private providers. They believe that the public providers do not include all costs in their pricing. This has implications for breach of the Victorian Government's competitive neutrality requirements when purchasing Government services.
- 4.21 Metropolitan clinicians comment that their assessments are not always accepted and are frustrated when their requests are refused. They are confused about what is allowed; a clinician described arranging directly with a provider for a nursing visit on Monday for a patient discharged on a weekend in the belief that this was acceptable as no PAC staff worked the weekend. The PAC staff refused to approve the Monday visit but agreed to arrange nursing services for Tuesday. Transparency of service provision is clearly an issue. In particular discharge from the emergency department ("ED") is problematic with no clear guidelines.

- 4.22 Regional PACs comment that metropolitan clinicians do not understand the limited availability of some services in regional areas and find that they need to adjust the service provision to what is available. However all referrers accepted that regional PACs provided good support to patients and were helpful even if not all requested services were able to be provided. In contrast hospital-based PACs in the metropolitan area were very often unhelpful to referring clinicians from a hospital other than their own.
- 4.23 There was general consensus in the interviews that while advisory groups would be beneficial for stakeholder communication, the existing consortia did not play a role in governance. There was a view that fewer governing members may lead to stronger governance. In some networks there were reports that PAC has unclear reporting structures. In larger metropolitan institutions governance of PAC suffered from a lack of focus, turf wars and management deals.
- 4.24 Regional PACs leverage off the hospital governance systems. They generally have clear budget guidelines.
- 4.25 In regional PACs concerns were expressed about the large number of meetings staff must attend for the different programs including PAC. Often staff must travel significant distances for program management meetings and there are multiple meetings. The regional interviewees would like to see co-location of meetings for the different programs (PAC, HARP etc) to improve efficiency.
- 4.26 Interviewees, especially those arranging interPACs, believe the program should be more uniform.
- 4.27 There was a view that DHS should identify more clearly the governance expectations for the program.
- 4.28 DHS interviewees advise that DHS is developing a model that would see a number of programs including PAC brought under one integrated access and management framework.

Governance arrangements – key findings

- 4.29 Financial transparency for stakeholders needs to be improved especially in metropolitan PACs. Concerns relate to understanding individual hospital allocations and usage, and interaction with other funding streams. There are no concerns regarding misuse of funds. Financial forecasting and planning is generally regarded as inadequate.
- 4.30 There is insufficient definition of the data provided to DHS to support benchmarking and the development of guidelines regarding interaction with other funding streams.
- 4.31 Dispute resolution and complaint handling needs to be improved. There needs to be a focus on urgent resolution given the impact on bed availability if PAC services are not supplied.

- 4.32 Management of interPACs need to be improved to ensure that metropolitan hospital-based PACs are not disadvantaging patients from other hospitals.
- 4.33 There is wide variability in eligibility and service provision. The program model should be more uniform.
- 4.34 Interaction and communication with stakeholders including service providers and GPs needs to be improved to maintain quality of care for the patient and ensure adequate risk management for patients and service providers.
- 4.35 Program guidelines are not clear to metropolitan referring clinicians and they find it difficult and time-consuming to make referrals especially interPACs. Staff from metropolitan hospital-based PACs are not always helpful when dealing with interPAC requests.
- 4.36 Multiple governance and management meetings for regionally based programs may be inefficient given the large distances to be travelled. Co-location of program meetings including PAC meetings would be more efficient.

Consortia arrangements

- 4.37 The general consensus was that accountability is poor though the consortia model of governance.
- 4.38 While at the establishment stage of the PAC program it was useful to have a number of organisations working together on matters such as policy development, it appears that the consortia arrangements in most instances are not now used as governing structures. Relationships are well matured and collaboration occurs as needed.
- 4.39 Not all consortia members are even aware that they are still members. Funding agreements have not been signed since 2004 and there was little evidence that consortia members exercised any influence over financial governance. There is confusion between the role of consortia member and fundholder. Stakeholders feel that funding arrangements are unclear and there are inappropriate charges in some cases.
- 4.40 Most interviewees felt that it would be better if one party with good governance structures was responsible for governance.
- 4.41 The main benefit of consortia arrangements was that they can expose the program to multiple inputs, so if a change were to be made it would be valuable to increase stakeholder communications to receive this input. It was felt that even in the existing model input from consortia membership was underutilised.
- 4.42 Some consortia had service providers as members; this could give rise to related party transactions and could bias service delivery selection. While input from service providers is very valuable in maintaining quality of care and in risk assessment and mitigation it

could cause concern regarding conflict of interest if they participate in governance.

- 4.43 It was felt that the consortia model of governance can lead to a weakness in staff governance and management.

Consortia arrangements – key findings

- 4.44 Consortia do not operate as a governing structure in most instances and, while technically members could be held accountable for financial governance, risk management, program guidelines and dispute resolution, in practice they have little influence over these matters.
- 4.45 Governance is most commonly exercised by the fundholder but transparency of governance and accountability is lacking.

Service system relationships

- 4.46 Interviewees identified shortages of OTs. The interaction with hospital OTs is problematic with insufficient capacity available to service the PAC home visits. Since this is a hospital responsibility consideration could be given to holding back money from the hospital budgets for OTs and allocating the money to PAC.
- 4.47 In regional environments apart from the shortage of OTs, there are also resource problems with PTs and psychologists. Regional guidelines allow for substitution to supply required services.
- 4.48 To overcome the workforce shortage with respect to OTs, stakeholders believe that a work model should be considered where senior OTs delegate appropriate work to lessor trained support staff.
- 4.49 Operational relationships (at case manager level) are seen as strong across PAC, but relationships between service providers and PAC management are not so strong. There is little feedback. Very few PAC services use two-way provider satisfaction surveys.
- 4.50 There are workforce shortages on a seasonal basis eg Christmas, Easter, and timeliness of service delivery is a problem at those times.
- 4.51 Service providers have requested that bulk funding rather than a contract approach be considered for PAC. It is believed that this would be more efficient and would help with lead times for arranging services across seasonal shortages. On a contract system, service providers cannot book staff until they have received the order.
- 4.52 Relationships are often based on personal skills rather than good consultation and feedback mechanisms.
- 4.53 In regional areas there are additional problems with transport issues, especially across the New South Wales-Victorian border. Transport outside main towns is not funded.

- 4.54 There are limited relationships with GPs as PAC is hospital driven. This limits the opportunities for patient-centred care and well supported continuing care.
- 4.55 There are some issues with the flexibility of local government services due to extensive OH&S guidelines in operation. Private service providers are used instead.
- 4.56 In most places there are extensive waiting lists for HACC services. This puts pressure on PAC to gap fund even though the acute event may be resolved.
- 4.57 Some stakeholders believe interactions would be better and faster with greater use of e-referrals. A few PACs have started to use e-referral systems.

Service system relationships – key findings

- 4.58 Generally local service systems relationships are good, supported mostly at the operational level. However there is limited interactions and communication with GPs and relationships are not so strong at PAC management level.
- 4.59 There are workforce shortages in OTs and hospitals have insufficient capacity to make timely OT home visits when required to support PAC services. In regional Victoria there are also shortages in PTs and psychologists. These problems are exacerbated at certain times eg Christmas, Easter
- 4.60 The existence of extensive waiting lists for HACC puts pressure on relationships and service delivery.

On-site presence

- 4.61 Stakeholders comment that if discharge planning is working well it doesn't matter where the PAC is located, but if there were only one on-site person this could cause a bottleneck in discharges.
- 4.62 PAC employees believe that they help improve the quality of discharges with their knowledge of the support services available in the community and that they help educate discharge staff. There is a belief that acute staff may not understand community matters.
- 4.63 Referrers comment that the model of a liaison person operating across a network is well regarded.
- 4.64 Service providers believe that they get better clinical information from a ward discharge than from a centralised referral system. This is particularly where referral information comes from a social worker rather than a discharge nurse.
- 4.65 Stakeholders believe that a face-to-face discussion between patient and PAC staff is advantageous for more complex cases but is not necessary for simpler discharges.

- 4.66 Some referrers prefer a telephone based referral system with ward visitation and believe PAC staff should target units where there is pressure on beds. EDs in particular need a process to identify potential PAC users.
- 4.67 *DMC comment: Whether the model is on-site or off-site, information on access points, phone numbers and names should be readily to hand, perhaps on stickers at the nurses' station.*
- 4.68 Some referrers believe better continuity of care can be offered if hospital staff can be used to deliver PAC services eg nursing staff making home visits. This would be assisted with an on-site model.
- 4.69 Development of e-referral systems in some PAC services was noted in both metropolitan and regional services. These systems provide fast links between the PAC co-ordinator, service providers and referring agencies.

On-site presence – key findings

- 4.70 There is no consensus concerning an on-site versus off-site presence for PAC staff. There are arguments for and against both models. What is important is that referrers have quick access to staff, who will help them define their service requirements in an accurate and efficient manner, and who can accurately deliver comprehensive clinical information to service providers.
- 4.71 There are many discharge points in the larger hospitals and a focus on units where there is pressure on beds would be advantageous.
- 4.72 The development of e-referral systems seems to offer opportunities for improvement with faster and better referrals.
- 4.73 Complex discharges probably benefit from a face-to-face discussion between the patient and PAC staff.

Linkages to discharge planning

- 4.74 Referrers believe it would be an inefficient use of staff to have a ward presence at every discharge point, especially in the larger hospitals. However in the larger hospitals there is high staff turnover and the message about PAC services is hard to get into the wards and maintain accurately. There is a constant need for information on PAC services to be provided to discharge planners. PAC staff should visit the discharge points at least once a month.
- 4.75 Clinicians believe clinical assessments should have precedence over community assessments and don't like to have their requirements modified. PAC staff believe that in some cases they are strengthening weak discharge practices. They comment that for a safe discharge home the right questions need to be asked and that community issues and OH&S issues need to be carefully considered.
- 4.76 Discharges linkages depend on the experience of the case manager and the ability to assess information.

- 4.77 Stakeholders comment that discharge planning and the potential for access to PAC services should be commenced at admission, however it appears that insufficient information is gathered at admission to commission PAC services.
- 4.78 HACC representatives comment that PAC staff need to triage their cases before they refer to HACC. They comment that PAC staff refer everything to HACC even clients who are not eligible. PAC staff should be educated in HACC eligibility requirements.
- 4.79 Referrers comment that it is sometimes difficult to contact PAC staff and they are slow to return calls.
- 4.80 Service providers comment that the process of providing contracts on a case by case basis is very slow.
- 4.81 Stakeholders comment that discharge planning from acute is better than from sub-acute, but that the time available for discharge planning is decreasing with less time available in acute settings.
- 4.82 Referrers comment that discharge options are increasingly complex. There are multiple programs and complex requirements both clinical and social.
- 4.83 Referring clinicians believe that there is too much information required for simple cases. They quote a resource requirement of three hours to make one referral for home help and meals on wheels.
- 4.84 Referrers find interPAC very time consuming and frustrating. They believe that PAC staff should do interPAC referrals – not clinicians.
- 4.85 Stakeholders quote some poor assessment practices eg a patient discharged with no PAC support with the husband at home recovering from coronary bypass surgery.

Linkages to discharge planning – key findings

- 4.86 Linkages to discharge planning are adequate in most cases; however there are improvements that could be made. They include:
- A constant flow of information regarding PAC services and contact details to the wards
 - Regular visits (monthly) by PAC staff to discharge points
 - Greater weight given to clinical assessments
 - Earlier discharge planning, commencing at admission for patients needing PAC services
 - Simple discharges requiring simple services should be streamlined
- 4.87 InterPACs present particular problems and are very time consuming for clinicians.

- 4.88 Some PAC services need to improve communication. In particular they need to respond promptly to telephone messages from discharge planners.

Accessibility

- 4.89 Stakeholders believe the target population for PAC should include pre-admission clients eg patients needing help with an indwelling catheter, Percutaneous Endoscopic Gastrostomy (“PEG”) tube feeds or cellulitis. These patients will be hospitalised for treatment but the provision of PAC services may prevent hospitalisation.
- 4.90 Stakeholders comment that the PAC population is not consistently defined and that some clients get missed. In particular midwifery patients are believed to miss out on PAC services in cases where they should be eligible.
- 4.91 We did receive reports of innovative PAC services provided to assist the homeless and specific cultural groups, although we are told that it is difficult to achieve flexibility with the rigid purchasing protocols that exist in some large hospitals.
- 4.92 Referrers report being forced into inefficient decision making because PAC services have been refused. This can result in a longer than necessary hospital stay.
- 4.93 Stakeholders commented that private patients in public hospitals are not eligible for PAC. However we were later informed by DHS that they are eligible. Clearly the guidelines on eligibility for PAC need to be published.
- 4.94 There is a shortage of providers in some areas especially on weekends. In addition in some local government areas the wait for home help is twelve months or more. We were given reports of one local government service where the wait for assessment is twelve months and the wait for service is three years.
- 4.95 HACC representatives suggested the PAC should consider similar service provision to HACC so that clients’ ongoing expectations are managed. HACC usually provides homecare once a fortnight but PAC often provides a weekly service.
- 4.96 Many referrers believe the Service Coordination Tool Templates (“SCTT”) information gathering proforma is too complex and time consuming for simple cases and we received reports that clinicians were advising patients to ring for home help and meals on wheels themselves when they get home. The clinicians believe that the patients get a faster response this way.
- 4.97 In the regions stakeholders believe that the recent growth in demand for services combined with the growth in workload means that accessibility is lessened.

- 4.98 Demand on PAC resources is greater in those regions that do not have access to the HARP-CDM program.
- 4.99 There is some confusion about Cardinia residents and which PAC catchment should service their needs.
- 4.100 PAC staff in the regions comment that they are reluctant to promote the service extensively and then be in a position of under delivering on services.
- 4.101 Regional PAC staff comment that clients who have been treated elsewhere eg Melbourne may not come to the attention of the local PAC referral process. These clients are often picked up by the local community services.

Accessibility – key findings

- 4.102 Accessibility is generally good with stakeholders believing most eligible patients are getting services.
- 4.103 There are a few areas where accessibility may need to be improved. They include:
 - Midwifery patients need better consideration
 - Refusal of PAC (identified mainly in interPAC) should be kept to a minimum if the result of refusal is longer hospital stays
 - Private patients and their discharge planners in public hospitals need to be advised of their eligibility
 - Some clients need HACC services following an acute episode and a lack of HACC services can delay a return to the community and may result in discharge to an institution
 - Restriction on funds may mean less accessibility in some PAC catchments
- 4.104 Consideration could be given to expanding PAC services to pre-admission clients where a hospital admission may be avoided if PAC services are provided.
- 4.105 There is not always consistency of access and service within a PAC service where individual staff can make idiosyncratic decisions.

Program interaction

- 4.106 The PAC program interacts with a range of programs including HARP-CDM, HACC, SACS, Hospital in the Home (“HITH”) and Rehabilitation in the Home (“RITH”). Referrers find the programs hard to navigate and are often uncertain which is the most suitable for their patients.
- 4.107 InterPACs were also discussed under this topic as they have elements of program interaction.

- 4.108 Stakeholders are attracted to a model that provides a single point of entry to all programs, but they want this without any diminution in the responsiveness of PAC services. *DMC comment: Most of the other programs do not face the same sense of urgency of assessment and service delivery as PAC which is expected to arrange services sometimes in a 24 hour timeframe.*
- 4.109 There are common service providers across a number of programs. This can be beneficial in providing continuity of care but can also give rise to issues of cost shifting that need to be managed. Service providers comment that there is a reluctance to engage private providers.
- 4.110 Referrers comment that there is an urgency around rehabilitation, both social and clinical but that they have poor access to home based rehabilitation. They comment that they can wait a week for an assessment, they are unable to refer patients from ED and there is a reluctance to take patients from the ward.
- 4.111 Regional stakeholders comment that it is a challenge to find local rehabilitation services.
- 4.112 All stakeholders both metropolitan and regional comment that HACC assessments and services are delayed or waitlisted and that HACC is severely under resourced in some areas. It is common for there to be a four week wait for assessment and another four week wait for service
- 4.113 Referrers find the SCTT information gathering proforma hard to use and very time consuming to complete but note that it is mandated for HACC referrals.
- 4.114 HACC does not fund case management whereas PAC and HARP-CDM will. This is problematic for some clients.
- 4.115 Some areas do not have access to the HARP-CDM program which puts additional load onto the PAC services.
- 4.116 Where HARP-CDM is available referrers comment that the interface is very complicated and others comment that they have very limited interaction.
- 4.117 The relationship with SACS programs is reported as patchy and historically it has been poor. Many stakeholders did not know what was in SACS. There appeared to be very limited referral from PAC to SACS.
- 4.118 HITH is not always available in regional areas and in general the relationship is not strong. PAC staff report that it is very difficult to move patients from PAC to HITH where this is necessary eg for extensive wound management.
- 4.119 There is a further complication with maternal and neonatal cases where the hospitals receive some funding for domiciliary visits. There

appears to be little or no co-ordination with PAC and HITH in these cases.

- 4.120 Interactions with other metropolitan hospital-based PAC services caused the greatest number of complaints. There were no problems identified with referrals to regional PACs or community-based PACs.
- 4.121 Referring clinicians identify the following problems:
- Multiplicity of forms and information requirements
 - Excessively long questionnaires to complete before referrals will be considered
 - Refusal to accept a referral after many hours have been spent in preparation of documentation
 - Inconsistency of eligibility
 - Inconsistency of service provision
 - Rude and unhelpful staff
 - Lack of assistance to patients
 - Longer than necessary hospital stays because PAC services are refused or subject to delays and blocking behaviour
- 4.122 Regional PACs report that metropolitan hospitals over promise on what services can be delivered. They comment that limited opportunities for discussion with clinicians are available once the patient has been discharged. It is not uncommon to have problems with PAC referrals from Melbourne.
- 4.123 Stakeholders comment that an e-referral system would be useful for improving service interaction. They comment that PAC and programs generally need better connectivity.
- 4.124 Some regional services have the same co-ordinator for PAC and RDNS; this greatly simplifies interaction.
- 4.125 In regional areas need good co-ordination between programs to ensure efficient use of service providers time eg co-ordinating district nursing service to ensure maximum value is obtained from visits to outlying towns.

Program interaction – key findings

- 4.126 There is value in a program model that has a single point of entry for a number of related DHS programs providing that access to PAC services is still provided with a sense of urgency and that current knowledge and skills with respect to service networks is not lost.

- 4.127 InterPAC referrals to metropolitan hospital based PACs cause significant problems. Clinicians find these referrals very frustrating and time consuming.
- 4.128 One form for interPAC referrals would be helpful.
- 4.129 Implementation of the SCTT has had limited success.
- 4.130 Program co-ordination in general is not strong. Access to rehabilitation is problematic, the HARP-CDM interface is very complicated, SACS services are not well known to PAC stakeholders and access to HITH from PAC is very difficult.
- 4.131 Shortage of HACC resources has the potential to delay hospital discharge and puts pressure on PAC services.

Guidelines

- 4.132 There was strong support for minimum core guidelines for eligibility and service provision on which all stakeholders especially referrers could rely. These guidelines should be widely published to improve transparency. There are some ambiguities about eligibility that need to be clarified eg access to private patients, access to patients who have another adult at home.
- 4.133 Stakeholders want any guidelines to be regularly reviewed to ensure they remain relevant.
- 4.134 Referrers would like some consistency in service packs eg personal care – three times a week, shopping – once a week, cleaning – once a fortnight.
- 4.135 HACC representatives believe PAC and HACC service provision guidelines should be consistent so that client expectations can be managed.
- 4.136 However all PAC stakeholders agree that flexibility and innovation are essential in meeting PAC's aims of a safe referral home and managing hospital bed availability.
- 4.137 Service providers comment that PAC services prefer controlled units of service eg 30 minutes so that costs are controlled, but they comment that the specific service needs to be determined by the provider on the initial visit. OH&S issues need to be assessed by the provider on site. Providers sometimes find situations not identified in referrals eg an industrial clean is needed before service can be provided, the patient is very large or obese and cannot be handled by one person.
- 4.138 Service providers comment that they are able to apply for additional time, say 15 minutes, for the initial visit but that it takes them another 15 minutes to complete the necessary paperwork.
- 4.139 Guidelines are needed for after hours referrals and referrers believe that some pre-approvals or standing approvals are necessary. There

are inconsistencies at the moment. Ward staff ring RDNS first to arrange a nursing visit. Some PACs are happy with this; others are not.

- 4.140 Some stakeholders reported that services such as home care is requested when there is another able bodied adult at home who will assist, but on other occasions no service is provided when there is an adult at home who is unable or unwilling to assist.
- 4.141 Flexibility and innovation are necessary to solve problems but some PACs are not sufficiently flexible especially those with rigid purchasing guidelines. There are often significant start up costs to service providers for PAC services.
- 4.142 Referrers would like some clarity regarding the need for multiple referrals eg PAC and HACC at the same time.
- 4.143 There is a need to free up clinical staff to focus on clinical issues and requirements, especially for complex cases. PAC shouldn't require clinicians to be heavily involved in administrative arrangements.
- 4.144 PAC guidelines should also consider other funding sources. Regional staff report that over time they have become more targeted with PAC services and that they make better use of other programs.

Guidelines – key findings

- 4.145 Minimum core guidelines would benefit all stakeholders but especially referrers and patients. The guidelines would need to cover eligibility, minimum service packs (for simple and complex cases) and pre-approvals for after hours referrals or minimum service levels eg one or two nursing visits. The guidelines would need to be reviewed regularly, at least annually, with input from referrers to ensure they remain relevant.
- 4.146 HACC representatives would like PAC service provisions guidelines to be consistent with HACC guidelines where there is no clinical reason for the difference eg shopping or home cleaning support to help manage client expectations.
- 4.147 Service providers would like guidelines that are more flexible for the initial visit when unexpected circumstances that impact on service provision become apparent.
- 4.148 Guidelines that described the interaction with other services would also be valuable.

Measurement and reporting tools

- 4.149 All stakeholders commented that minimal data is collected and there is little if any regular reporting to hospital and other stakeholders on allocation and expenditure of PAC funding and services. Referring hospitals do not know if they are receiving a fair share of the PAC money and they cannot form a view about whether they are under or over utilising PAC.

- 4.150 The situation is slightly better in regional Victoria where allocation of funding between hospitals appears to be more transparent, although reporting tools are not well developed.
- 4.151 *DMC comment: Minimum data is reported to DHS but the data elements are not well defined and it is difficult to know if like is being compared to like. Therefore that data is not very useful for benchmarking. At least one service found that matters were being incorrectly reported when they had a change of personnel.*
- 4.152 Most PAC services do ad hoc reporting to meet management needs but there is no co-ordinated reporting of any depth.
- 4.153 There is no data on re-admissions to form a view whether provision of PAC services would have prevented re-admission.
- 4.154 Most stakeholders felt that reporting was often anecdotal and commented that it would be good to see some statistics.
- 4.155 PAC services use a range of electronic programs to keep their records and there is no consistency or possibility of easy amalgamation.
- 4.156 One stakeholder commented that they would like to see the data on maternity cases referred to PAC as there is a belief that these cases have difficulty accessing PAC. This belief was also expressed by a number of referrers.
- 4.157 There is no widespread use of customer satisfaction surveys although accreditation processes drive some reporting and surveys.
- 4.158 GPs want reporting on their patients and this does not occur generally in PAC services, although one regional PAC interviewed reports regularly to patients' GPs.
- 4.159 Stakeholders comment that reports on care outcomes would be useful.
- 4.160 Some stakeholders believe that DHS incident reporting guidelines (eg for Category 1) should be followed by PAC services.
- 4.161 *DMC comment: There is little or no reporting on the number and type of PAC referrals that are declined. This is especially important for interPACs as they are a strong source of complaint from referrers when they are referring to metropolitan hospital-based PACs.*

Measurement and reporting tools – key findings

- 4.162 There are no robust measurement and reporting tools in the PAC environment and this will have consequences for performance monitoring and management decision making.
- 4.163 Reports on re-admissions related to the provision or lack of provision of PAC services would be valued by stakeholders.

- 4.164 Reports would also be useful on matters such as:
- Maternity cases referred to PAC
 - Refusals of PAC services especially interPACs
 - The percentage of separations that receive PAC by hospital
 - Client satisfaction
 - Care outcomes
 - Reports on patients to GPs
 - Funds allocated and expended by hospital
- 4.165 PAC services would also value robust benchmarking data. This would require hospitals to adopt common rigorous definitions on cost reporting elements.

Efficiency

- 4.166 Most PAC services are uncertain of their level of efficiency. They carefully ration services so that they do not exceed budget and mostly this aim is achieved.
- 4.167 *DMC comment: PAC services by the nature are structurally inefficient. They have high front end costs in assessments and service initiation and relatively low levels of ongoing services. In contrast with other long term services such as HACCC, PAC transaction costs represent a very large percentage of total costs.*
- 4.168 *DMC comment: This would appear to be an unavoidable consequence of delivering short term services. In order to properly manage the risks, assessments must be robust and hence incur significant costs.*
- 4.169 This structural inefficiency is true for service providers as well who must incur significant initiation costs in familiarising themselves with the patient and the work environment. Service providers tell us that often additional matters are identified in the first home visit that were not known at assessment. This commonly occurs because the patient's understanding of what constitutes a risk is different from the risk assessment of a health professional or because insufficient clinical information is provided when the referral is made.
- 4.170 If the service provider is only making two or three visits they do not always recoup their costs. Most service providers, especially the not-for-profit sector, see this as a community service. They also comment that the mix of services they deliver includes delivery for longer service programs and these programs to some extent subsidise their PAC clients. We did not attempt to quantify this in any way.

- 4.171 Stakeholders commented that electronic referral would make PACs more efficient and would also improve the quality of the referrals.
- 4.172 Many stakeholders believe it would be more efficient to have continuity of care across PAC and HACC. This is probably the case where the same service provider can be easily accessed for both, but a significant number of PAC cases will not require or be eligible for HACC services. The focus needs to be on keeping the transaction costs for PAC as low as is commensurate with safety and quality of care.
- 4.173 Some referrers believe private providers are costly compared with in house resources eg \$70 per hour for nursing. *DMC comment; Care must be taken to properly consider all costs of in house services. In particular all on costs must be considered.*
- 4.174 Some PACs have directly employed their own physiotherapists and believe that has improved efficiency.
- 4.175 Stakeholders comment that case management is really only necessary for complex discharges. Simpler cases need administration only. To manage more efficiently it could be valuable to stream cases when they are first identified into complex or simple.
- 4.176 There are opportunities to develop shared efficiencies. Currently all PACs develop their own brokerage agreements and each pay their own legal costs. Sharing legal costs would be more efficient.
- 4.177 Service providers suggest a bulk arrangement for purchasing would be more efficient. This is discussed later in the section on brokerage.
- 4.178 The program model with a single point of entry also has the potential to improve efficiency. The use of multiskilled staff to cover PAC and other programs may give better coverage and require less use of casual staff to provide coverage for holidays and other absences.

Efficiency – key findings

- 4.179 Most PACs do not have appropriate monitoring and reporting measures in place to accurately assess their efficiency.
- 4.180 However there are a number of opportunities identified to improve efficiency. They include:
- Greater use of e-referrals
 - Continuity of care utilising the same service provider for different programs where possible
 - Direct employment of allied health staff where cost savings are clearly demonstrated
 - Streaming of simpler discharge cases into simple administration for assessment and case management rather than one size fits all

- Sharing legal costs for brokerage agreements
- Bulk purchasing of services (where quality of service is guaranteed to be maintained)
- Creation of a single point of entry with other related programs (provided the urgency of assessment and service provision for PAC is not lost and no additional administration burden is imposed on referring clinicians)
- Use of multiskilled staff who are co-located to handle PAC service requests

Brokerage agreements

- 4.181 Brokerage agreements offer flexibility and responsiveness that is particularly important for the PAC program. Staff comment that they could not achieve the same level of responsiveness if they had to rely entirely on in house services.
- 4.182 However in metropolitan PACs, contractual arrangements are generally considered problematic. While some PACs review brokerage agreements annually, others have agreements that are expired and have not been replaced.
- 4.183 PACs believed it would be helpful if DHS led the development of generic contracts that all services could use. Services need at least two contract forms - one comprehensive version for complex services such as nursing and allied health and a short and simple version to suit smaller contractors eg for shopping or dog walking.
- 4.184 Providers consider PAC services are difficult to manage. Service provision for short periods is structurally inefficient and they are not always able to cover costs.
- 4.185 Providers comment that PACs do not do forward planning for seasonal fluctuations eg Christmas and Easter and this can make service provision in these times difficult.
- 4.186 One large provider has suggested that a bulk agreement for services would result in cost savings and in better planning for service availability. While PACs do not want to be captive of one provider as they believe customer service may suffer, they are attracted to the idea of bulk purchasing with regular reporting.
- 4.187 There is a strong focus on breaking service provision down into incremental costs.
- 4.188 Both PACs and service providers comment that the new OH&S legislation is impacting on their operations. It appears that the PAC services and the service providers are both trying to manage the same OH&S risks. There was a general agreement that the brokerage contracts need better quality and risk management provisions.

- 4.189 PACs identify problems in getting some services. Childcare was cited as an example.
- 4.190 Service provider rates are different for HACC and PAC suggesting there may be some opportunities for cost savings if there were common brokerage agreements between services.
- 4.191 Stakeholders of the South West Gippsland model comment that it enables minimum cost for administration as it is a centralised model. However another regional service finds centralised brokerage limiting as suppliers are different across the region.

Brokerage agreements – key findings

- 4.192 Currently each PAC service develops its own brokerage agreements and there is strong support for the development of model agreements accessible to all PACs.
- 4.193 There will be synergies and savings in legal fees possible by using common agreements across a number of related services.
- 4.194 Bulk agreements with large providers could lessen administration costs. However any bulk agreements should not be exclusive as PACs are wary of bulk providers losing customer service focus.

Future impacts and developments

- 4.195 Most stakeholders believed that the need for PAC services would grow in the next five years. The few that expressed the opposite view believed that the need for PAC services would not grow only because other health programs would be offered in the future that would pick up a number of clients who would otherwise need PAC.
- 4.196 The reasons given for growth in the need for PAC services included:
- More frail aged living alone
 - A growing need to prevent hospital admissions
 - Increased presentation of mental health patients who will become PAC clients
 - Increasing burden of diseases such as diabetes
 - Increase in day procedures and short stay procedures
 - Shorter stays for maternity cases eg six hours
 - Greater requirement for rehabilitation
 - Increasing complexity of cases
 - The impact of private patients
 - Population growth

- Constant innovation in treatments and procedures
 - Movement into retirement villages that don't offer care arrangements
 - Better techniques for young patients leading to earlier discharge
 - Increased maternity requirements in some areas
- 4.197 Most stakeholders believed that substantial matters other than growth would also impact on PAC. These matters included:
- Increased provider OH&S requirements
 - Labour force shortages and changing focus eg GPs may not do home visits, shortage of OTs, PTs and psychologists especially in regional areas
 - More money needed for community based support
 - Concerns regarding reduced access to HACC funding and possibilities of re-admission if no HACC funding
 - Increasing CALD patients especially ageing patients
 - Need for more educated and aware service provider staff
 - In regional communities the impact of self-funded retirees especially the sea-change group

5.0 SURVEY – ANALYSIS AND KEY FINDINGS

Method

- 5.1 The on-line survey was developed to provide a feedback forum for all PAC services and their stakeholders, including the thirteen who were not involved in the in-depth consultation process.
- 5.2 The survey was developed by incorporating issues raised during the interview process to further explore their impact and relevance across the PAC community. The survey, incorporating 35 questions on governance, consortia arrangements and on-site presence, was reviewed by DHS and our statistical analyst prior to being implemented.
- 5.3 We distributed the survey link via email to PAC managers as well as a list of key acute and sub-acute contacts supplied by DHS, encouraging distribution to all PAC staff and stakeholders. The distribution list included 620 contact points.
- 5.4 The survey was available on-line for three weeks in July and August 2007 on a secure website.

Sample Characteristics

- 5.5 We received responses from 541 people incorporating 202 referrers, 175 service providers, 95 PAC employees and 69 other related stakeholders. The group defined as other included respondents comprising HARP-CDM staff, managers, community health staff and various clinicians.
- 5.6 All of the 20 PAC services are represented by the responses received with both regional and metropolitan stakeholders providing input. The dominant category of responder, however, is from the acute sector (48%).
- 5.7 The following table presents the response count for the PAC service that the respondent is most familiar with. As each respondent could enter more than one PAC, the total number of responses exceeds the number of respondents.

Table 5.1 PAC service most familiar with

PAC Service	Response Count
Austin	82
Eastern (Metro)	75
Southern (Metro)	73
Northern (Metro)	61
Melbourne (Metro)	54
Grampians	49
Inner Melbourne (Nth Richmond)	47

PAC Service	Response Count
Hume	45
Peninsula (Metro)	37
Western (Metro)	37
Inner South East (Bayside)	35
Loddon Mallee (Bendigo)	35
South West Gippsland	28
Wannon (Warrnambool)	27
Barwon	23
Latrobe & Wellington	16
Central Highlands	13
East Gippsland	13
Royal Children's Hospital	11
Northern Mallee (Mildura)	8
TOTAL:	769

Findings

5.8 Findings from the on-line survey are presented in this section and are included under the following headings:

- Governance arrangements
- Consortia arrangements
- Service system relationships
- On-site presence
- Linkages to discharge planning
- Accessibility
- Program interaction
- Guidelines
- Efficiency
- Brokerage agreements
- Future impacts and developments

Governance arrangements

5.9 Good governance is perceived as an important component of PAC by the respondents. The results of the data analysis, while not confirming causation, suggest a perception that good governance

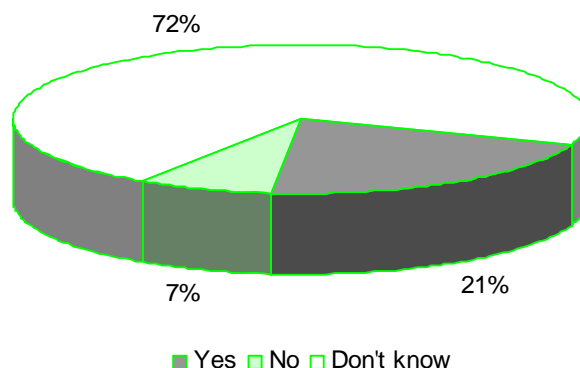
leads to good service. However care must be taken in valuing this perception as less than 20% of respondents felt able to comment on this question.

- 5.10 High ratings for the question, "Please rate the effectiveness of the consortia arrangements in providing governance.", are significantly correlated with:
- Accountability of management (Q10) (SIG. 0.01)
 - Transparency of management (Q10) (SIG. 0.01)
 - Efficiency of PAC service eligibility assessment process (Q22) (SIG. 0.01)
 - Consistency of PAC service eligibility assessment process (Q22) (SIG. 0.01)
 - Consistency of PAC service provision in relation to PAC most familiar with (Q23) (SIG. 0.01)
 - PAC service(s) linkages to the discharge planning processes (Q24) (SIG. 0.01)
 - Adequacy of the procedures to assess risk to clients during the PAC service provision period (Q31) (SIG. 0.01)
 - Information given to service providers on client requirements (Q34) (SIG. 0.01)
 - Brokerage agreements that PAC services have with providers (Q36) (SIG. 0.05)
- 5.11 This correlation results from analysis of the 98 responses to the governance question and subsequent responses to the questions listed. Significance levels are shown in brackets for each of the correlations above. Where significant correlations have been flagged the responses to the two relevant questions have revealed a similar pattern in terms of strength and direction. 'Excellent' responses to one question are associated with 'Excellent' responses to the second question, and 'Poor' with 'Poor'. If the level of significance is 0.01 then we are 99 percent confident that the responses to the two respective questions are correlated, as opposed to being random with no apparent relationship.
- 5.12 Accountability of management is ranked as excellent or more than adequate by 79% of respondents. When separated by PAC employees and by referrers the results are similar, 80% and 76% respectively.
- 5.13 Transparency of management is ranked as excellent or more than adequate by 73% of respondents. When separated by PAC employees (86%) and by stakeholders (66-75%), the result suggests that external transparency of PAC management is not as robust as internal transparency.

- 5.14 Forecasting and planning is reported as adequate by only 21% of respondents.

Figure 5.1 Group response

Adequate forecasting & planning?

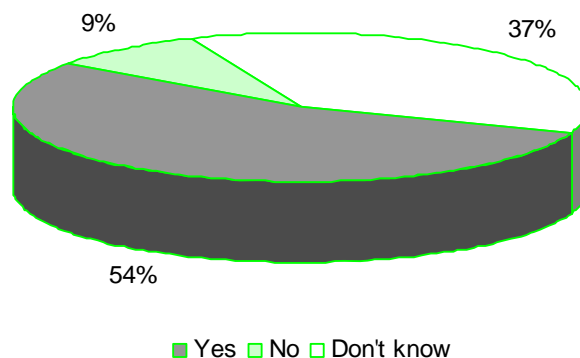


	Yes	No	Don't Know	Total
Response Count	87	31	296	414

- 5.15 When analysed by PAC service employees, the result is 54% which suggests some forecasting and planning is done internally but it is still not adequate.

Figure 5.2 PAC employee only response

Adequate forecasting & planning?



	Yes	No	Don't Know	Total
Response Count	37	6	25	68

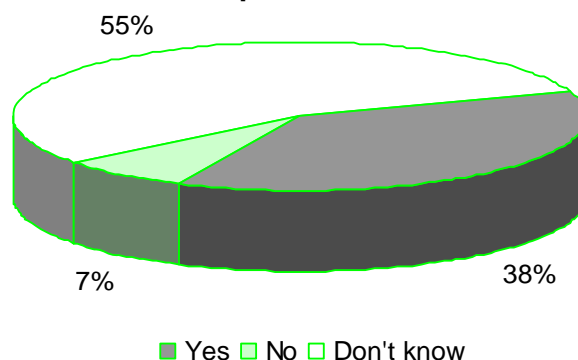
- 5.16 The group result suggests that the stakeholders perceive the level of forecasting and planning from PAC services as inadequate. *DMC comment: The stakeholders and the PAC services need to be able to plan collaboratively to provide an efficient and responsive service.*
- 5.17 PAC service financial reporting is available according to 18% of respondents. Analysis by referrers shows only 6% report receiving financial reports from their PAC service. *DMC comment: This result*

shows that referrers are unaware of the value and use of their PAC dollar and reinforces the perception of low external transparency.

- 5.18 When a report is provided, however, it is rated as excellent or more than adequate by 92% of respondents. When analysed by referrers, the rating is lower (80%) but still indicates that the quality of the reports that are provided is high. It must be noted that the number of respondents rating the adequacy of financial reports is only 75.
- 5.19 The presence of an identified dispute resolution and complaint handling process is reported for only 38% of services.

Figure 5.3 Group response

Dispute resolution and complaint handling service provided?



	Yes	No	Don't Know	Total
Response Count	155	30	227	412

- 5.20 The higher percentage of “Yes” responses to this question came from the regional services.

Table 5.2 “Yes” response to PAC service having an identified dispute resolution and complaint handling service as percentage of total responses excluding PAC staff

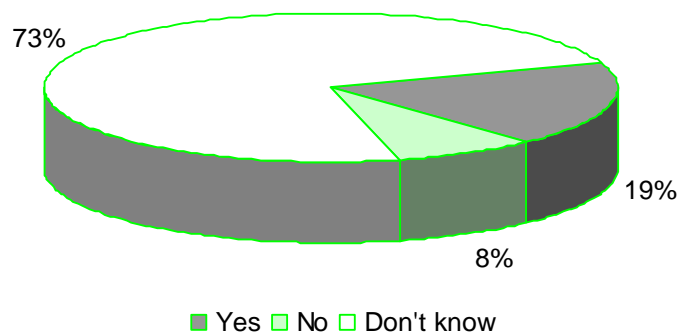
PAC Service	Yes
Loddon Mallee (Bendigo)	36.7%
Grampians	36.6%
Central Highlands	33.3%
South West Gippsland	33.3%
Hume	32.4%
Royal Children’s Hospital	30.0%
Barwon	29.4%
Northern Mallee (Mildura)	28.6%
Latrobe & Wellington	26.7%
Wannon (Warrnambool)	25.0%

PAC Service	Yes
Peninsula (Metro)	25.0%
Inner South East (Bayside)	25.0%
Western (Metro)	20.0%
East Gippsland	18.2%
Eastern (Metro)	14.3%
Melbourne (Metro)	13.3%
Southern (Metro)	12.9%
Austin	11.6%
Inner Melbourne (Nth Richmond)	10.5%
Northern (Metro)	9.6%

- 5.21 Analysis by referrers shows that only 19% believe there is an identified dispute resolution and complaint handling process.

Figure 5.4 Referrer only response

Dispute resolution and complaint handling service provided?



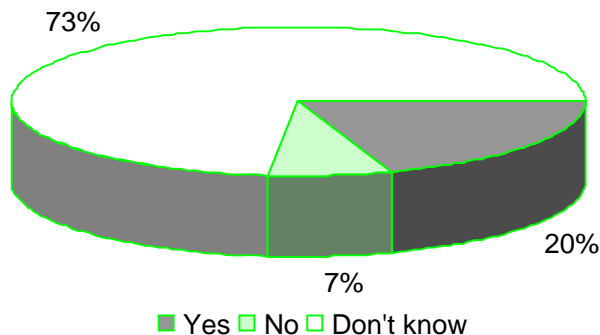
	Yes	No	Don't Know	Total
Response Count	30	13	119	162

- 5.22 When analysed by service providers, an identified dispute resolution and complaint handling process is reported by 36%. Other stakeholders reported 48% were aware of an identified process which may reflect the views of the manager component of this group.
- 5.23 The result of 36% for service providers is particularly low as brokerage agreements between the service provider and the PAC service should outline this process.
- 5.24 Analysis by PAC employees shows that 78% believe there is an identified dispute resolution and complaint handling process. The implication of this result is that PAC staff are unaware of the lack of an identified dispute resolution and complaint handling process for their stakeholders.

- 5.25 From the 38% of all respondents who reported awareness of an identified process, most rated it to be excellent or more than adequate (94%). This group consisted of 141 respondents.

Figure 5.5 Group excluding PAC employee response

Are customer service standards for responsiveness & quality published?

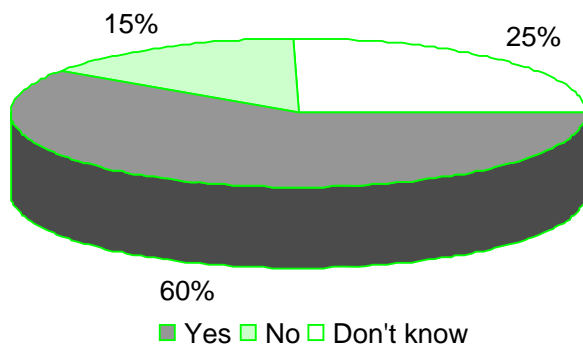


	Yes	No	Don't Know	Total
Response Count	67	23	249	339

- 5.26 Published customer service standards for responsiveness and quality are reported to be available by only 26% of respondents.
- 5.27 Analysis of the responses excluding PAC employees shows only 20% of respondents report the availability of published customer service standards with 73% not knowing if they are available.
- 5.28 PAC employees report a much higher level of availability of published customer service standards (60%) compared to the total respondents group. The implication of this result is that the method of publication of available standards is inadequate.

Figure 5.6 PAC employee only response

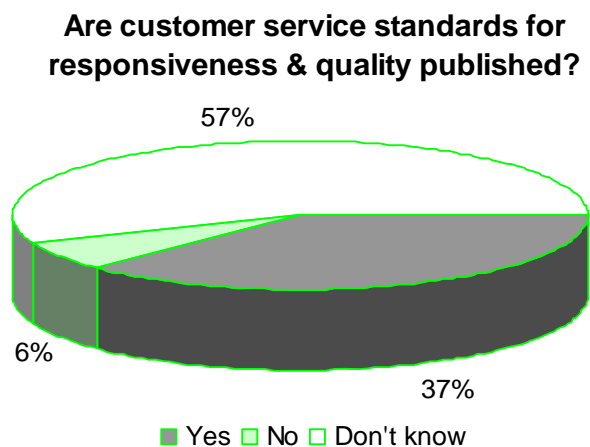
Are customer service standards for responsiveness & quality published?



	Yes	No	Don't Know	Total
Response Count	40	10	17	67

5.29 Regional services are more likely to have published customer service standards for responsiveness and quality than metropolitan PAC services, however this is still a low response.

Figure 5.7 Regional response



	Yes	No	Don't Know	Total
Response Count	52	9	78	139

5.30 Less than half (47%) of all respondents report the availability of channels for PAC services to seek feedback from stakeholders. Analysis by stakeholders only shows 42% have channels for the PAC services to seek feedback.

5.31 This low score represents a lack of communication channels between PAC services and their stakeholders.

5.32 Where channels are available, adequacy is reported as excellent or more than adequate by approximately 80% of respondents. The majority of the respondents reporting an excellent rating are from regional areas.

5.33 Procedures to assess risk to clients during the PAC service provision period are rated as excellent or more than adequate by 77% of the group of respondents. The regional services are more likely to score higher for this question.

5.34 Risk management procedures for service providers are rated as excellent or more than adequate by 80% of the group of respondents. Again, the regional services are more likely to score higher for this question

5.35 Identified risks are reported to be well managed during the PAC service provision period by 56% of the group of respondents. The response of "don't know" was also high (40%) for this question.

Governance arrangements - key findings

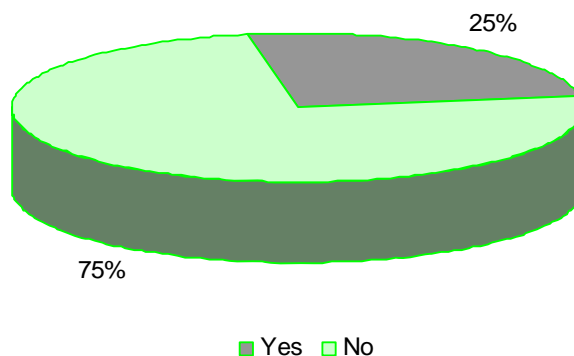
- 5.36 Respondents to the survey believe that good governance is required for a good service to be delivered, but less than 20% of respondents felt able to comment on this question.
- 5.37 Forecasting and planning by PAC services is inadequate and as a result it is difficult for referrers and service providers to plan their response to PAC demand.
- 5.38 Financial reporting is inadequate and as a result stakeholders are unaware of the value/use of their PAC dollar.
- 5.39 Poor communication channels exist between PAC services and their stakeholders for stakeholders to provide feedback.
- 5.40 Dispute resolution and complaint handling processes are important for effective governance and the low percentage of available processes suggests this is an area that needs to be addressed.
- 5.41 The majority of stakeholders are not aware of published customer service standards for responsiveness and quality which are an important component of good governance. The absence of these standards means that stakeholders do not have a benchmark against which to consider the performance of their PAC services.
- 5.42 Whilst risk identification is seen to be good, the process for managing identified risks is not as robust.

Consortia arrangements

- 5.43 Whilst the majority of the PAC services operate under a consortia arrangement, only 25% of respondents are aware of the consortia arrangements for their most familiar PAC service.

Figure 5.8 Group response

Aware of consortia arrangements for your PAC?



	Yes	No	Total
Response Count	108	317	425

- 5.44 Of those that are aware of the consortia arrangements, the rating for adequacy is excellent or more than adequate for 85% of respondents. When analysed by role, the ratings range between 79% and 90% for referrers and PAC employees respectively.
- 5.45 PAC employees rate the consortia arrangements more highly than any stakeholders, however this result is based on less than 30 responses for each of the groups.

Consortia arrangements - key findings

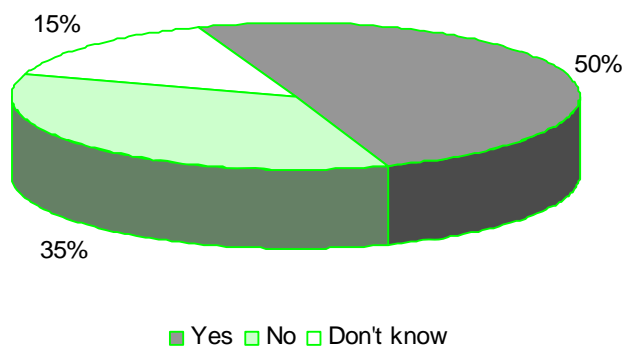
- 5.46 Most of the respondents are not aware of the consortia arrangements for PAC services.
- 5.47 Respondents who are aware of the consortia arrangements rate them as adequate.

On-site presence

- 5.48 About 50% of referrers think it is necessary to have PAC staff on wards.

Figure 5.9 Referrers response

Necessary to have PAC staff on wards?

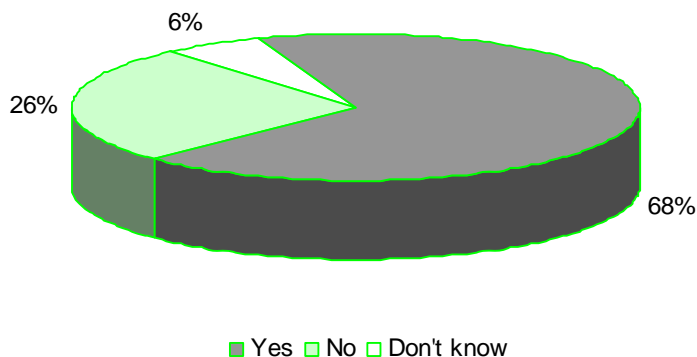


	Yes	No	Don't Know	Total
Response Count	83	58	24	165

- 5.49 In contrast, 68% of PAC staff believe a ward presence is necessary.

Figure 5.10 PAC employee response

Necessary to have PAC staff on wards?



	Yes	No	Don't Know	Total
Response Count	47	18	4	69

- 5.50 *DMC comment: The data above shows that the referrers do not see the same benefit of a ward presence as the PAC staff.*
- 5.51 The free text comments generally stated that whilst there may be some benefits, PAC referrals should be a part of the standard discharge planning process and therefore may not justify the resource allocation involved in having PAC staff on the ward.
- 5.52 Free text comments include the alternative suggestion of increasing the level of education to referring staff about discharge processes and options.
- 5.53 It was also raised that benefit may be seen in having PAC staff available to discuss and plan with referrers for complex cases.

On-site presence - key findings

- 5.54 Only 50% of referrers believe it is necessary to have PAC staff on the wards.
- 5.55 Having access to PAC staff when required is seen as beneficial and a suggested example of good practice is the use of a PAC liaison position, especially for planning discharge in complex cases.

Linkages to discharge planning

- 5.56 PAC service linkages to the discharge planning processes are well regarded by the respondents. The linkages to the discharge planning processes are rated excellent or more than adequate by 79% of total respondents.
- 5.57 A summary of the free text comments for this question raised the following points:

- The discharge planning linkages are strong where discharge planning education has been implemented or where PAC staff are involved in the process
 - Lack of communication and education result in poor linkages to PAC services during the discharge planning process
 - Early assessment and referral allows for the appropriate service to be implemented at the appropriate time
 - Referrals need to contain relevant and appropriate information
- 5.58 Lack of communication and education is also raised as a barrier to the discharge planning processes for interPAC referrals.
- 5.59 The highest response of excellent is from the regional respondents.

Table 5.4 ‘Excellent’ responses to PAC’s linkages to the discharge planning processes as percent of total responses by PAC Service

PAC Service	Excellent
Central Highlands	53.8%
Grampians	38.8%
Northern Mallee (Mildura)	37.5%
Loddon Mallee (Bendigo)	34.3%
Wannon (Warrnambool)	29.6%
Latrobe & Wellington	25.0%
South West Gippsland	25.0%
Northern (Metro)	19.7%
Austin	18.3%
Hume	17.8%
Inner Melbourne (Nth Richmond)	17.0%
East Gippsland	15.4%
Melbourne (Metro)	14.8%
Peninsula (Metro)	13.5%
Western (Metro)	13.5%
Eastern (Metro)	13.3%
Inner South East (Bayside)	11.4%
Royal Children’s Hospital	9.1%
Barwon	8.7%
Southern (Metro)	4.1%

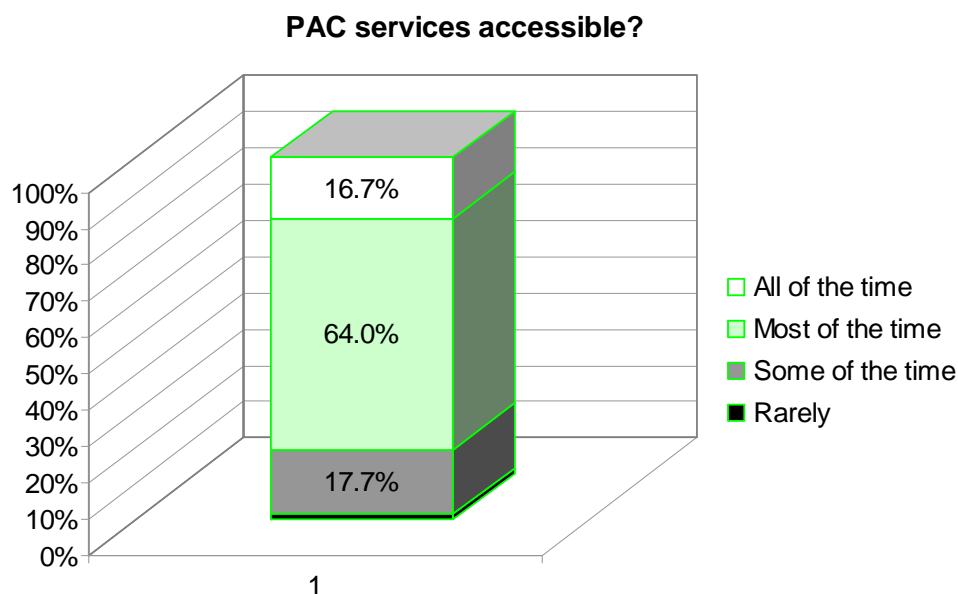
Linkages to discharge planning - key findings

- 5.60 Communication with and education of referrers is seen as the key to having good linkages between the PAC services and the referrers.
- 5.61 Absence of communication and education creates barriers to the discharge planning process.

Accessibility

- 5.62 Respondents were asked to rank the assessment process for PAC eligibility according to efficiency and consistency. The overall ranking for efficiency is high, with efficiency ranked as excellent or more than adequate by 86%.
- 5.63 There are no significant differences between regional and metropolitan services in the ranking of the assessment process.
- 5.64 Accessibility of PAC services to eligible clients was ranked as all of the time or most of the time by 81% of the group of respondents.

Figure 5.11 Group response

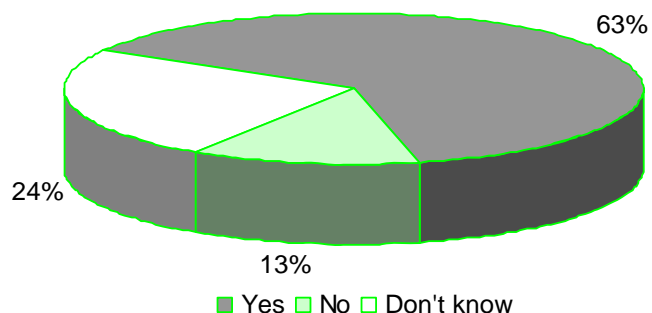


	All of the time	Most of the time	Some of the time	Rarely	Total
Response Count	63	242	67	6	378

- 5.65 The consistency of the services available for eligible clients with similar clinical and personal care needs was assessed within PAC services as well as across PAC services.
- 5.66 When the data is analysed excluding PAC employees, the result shows that only 63% believe the service is consistent for patients with similar clinical and personal care needs.

Figure 5.12 PAC staff excluded response

Provision of services within a PAC consistent?



	Yes	No	Don't Know	Total
Response Count	204	42	78	324

5.67 A summary of the free text comments qualified the response with the following points:

- Consistency of practice is limited by the uniqueness of each patient's situation
- Service provider availability can influence services available and therefore consistency of services
- Budget restrictions may influence consistency especially at the end of the budget period

5.68 Regional PAC services are more likely to report higher results of consistency for service provision to eligible clients with similar clinical and personal care needs than metropolitan PAC services.

Table 5.5 'Yes' responses to consistent service provision within a PAC as percent of total responses by stakeholders (without PAC staff)

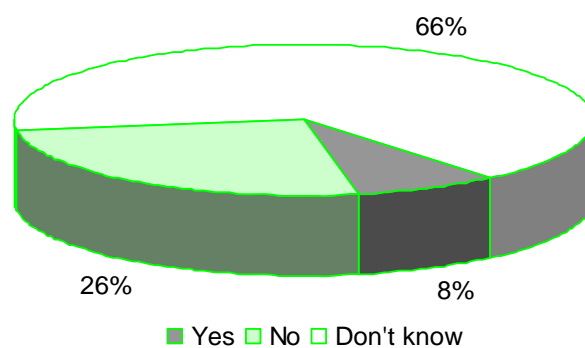
PAC Service	Yes
South West Gippsland	62.5%
Grampians	61.0%
Loddon Mallee (Bendigo)	56.7%
Central Highlands	55.6%
Hume	54.1%
Latrobe & Wellington	53.3%
Wannon (Warrnambool)	50.0%
Western (Metro)	50.0%
Barwon	47.1%

PAC Service	Yes
Eastern (Metro)	46.0%
Peninsula (Metro)	45.0%
Austin	43.5%
Northern Mallee (Mildura)	42.9%
Royal Children's Hospital	40.0%
Northern (Metro)	38.5%
Melbourne (Metro)	37.8%
East Gippsland	36.4%
Inner Melbourne (Nth Richmond)	34.2%
Southern (Metro)	32.3%
Inner South East (Bayside)	31.3%

- 5.69 The response to the question regarding service consistency across the state was dominated (65%) by respondents not knowing the level of consistency of service.
- 5.70 The referrers response shows that the majority of referrers either do not know or do not believe there is consistency of services across the state for eligible clients with similar clinical and personal care needs
- 5.71 The free text comments implied there is very little consistency across the state for many different reasons including staffing levels, eligibility criteria and demand on services.

Figure 5.13 Referrers response

Provision of services across PACs consistent?



	Yes	No	Don't Know	Total
Response Count	12	39	100	151

Accessibility – key findings

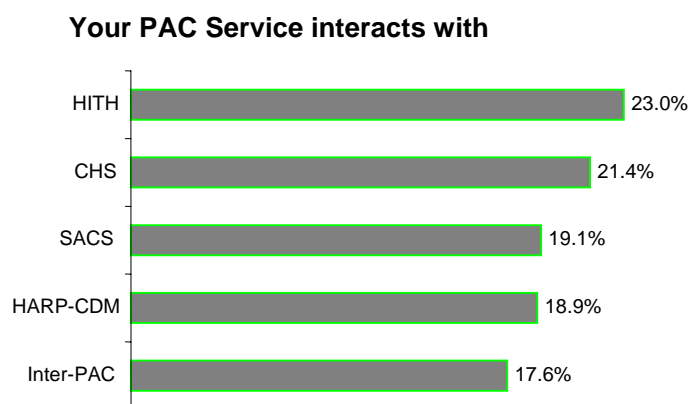
- 5.72 The assessment process for eligibility for PAC services appears to be efficient and consistent.

- 5.73 The level of consistency of services available for eligible clients with similar clinical and personal care needs within a PAC service is not highly rated by the survey respondents, however they note that it is difficult to be consistent due to the uniqueness of each patient.
- 5.74 Consistency of service provision for eligible clients with similar clinical and personal care needs between PAC services across the state is unknown by the majority of the respondents. *DMC comment: The low response for consistency highlights that effective referrals are difficult to make if the available resources are unknown.*

Program interaction

- 5.75 PAC is one of a number of programs available to referrers when considering the discharge planning for their clients. The various programs will therefore need to interact as clients move between them during their post-acute phase of service.
- 5.76 The PAC services are shown to interact with all of the services we listed, however the interaction with HITH and community health services (“CHS”) is slightly higher than the rest.

Figure 5.14 Group response

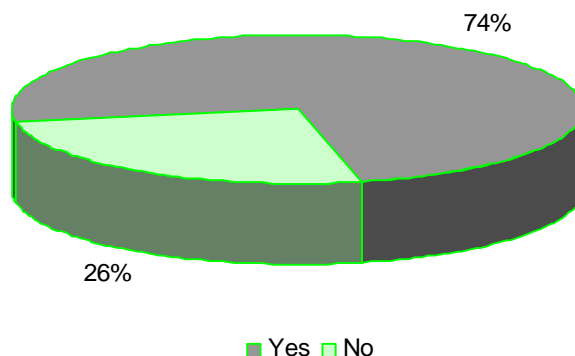


	SACS	HARP-CDM	CHS	HITH	Inter-PAC	Total
Response Count	197	195	221	237	181	1031

- 5.77 Differences emerged when analysed by PAC employee and service provider. PAC employees are more likely to report interaction with interPAC where as referrers are more likely to report interaction with HITH and CHS.
- 5.78 Having a single referral point for all sub-acute/community based programs is being trialed at some centres and has been suggested as a method of increasing the efficiency of the referral process.
- 5.79 The single referral point is supported by 74% of all respondents as being beneficial.

Figure 5.15 Group response

One referral point for all care programs beneficial?

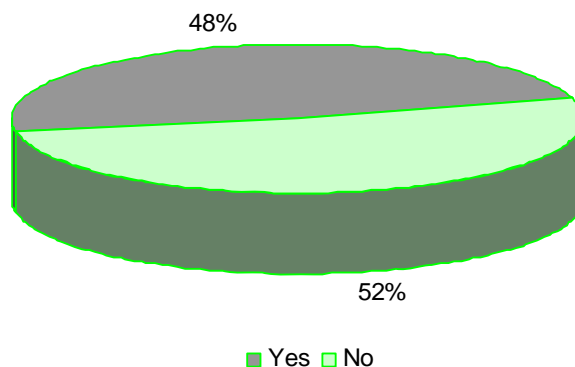


	Yes	No	Total
Response Count	254	89	343

5.80 This response reflected the opinions of PAC stakeholders when analysed separately, however, the PAC staff are much less supportive of a single referral point (48%).

Figure 5.16 PAC staff only response

One referral point for all care programs beneficial?



	Yes	No	Total
Response Count	29	31	60

5.81 The free text comments from this question raised the following points supporting a single referral point:

- This model may streamline and simplify the referral process
- Increased efficiency would be gained with this model
- This model may be more time efficient

5.82 The free text comments from this question raised the following points to be considered before implementing a single referral point:

- PAC has a responsiveness requirement that is not required in other programs and may be diminished with this model
 - Staff in a centralised referral centre would require extensive amounts of knowledge about a number of complex programs
 - The centralized referral point would need to be very efficient
 - A single referral point adds another layer of administration and slows the referral process down
- 5.83 The free text comments cautioning the implementation of a single referral point were mainly provided by those that have had experience of a single referral point. *DMC comment: Careful attention needs to be paid to the issues raised as barriers to achieving the PAC program objectives before implementing a single referral point.*
- 5.84 The presence of an appropriate system for referring to a PAC service outside the referrer's catchment area is reported by 52% of respondents. Analysis by referrers only shows that 56% believe the system is appropriate.
- 5.85 The interPAC referral system is regarded as appropriate by just over half respondents. This combined with the free text comments reflects that the current system is inadequate and presents as a barrier to referral/discharge in some cases.

Program interaction - key findings

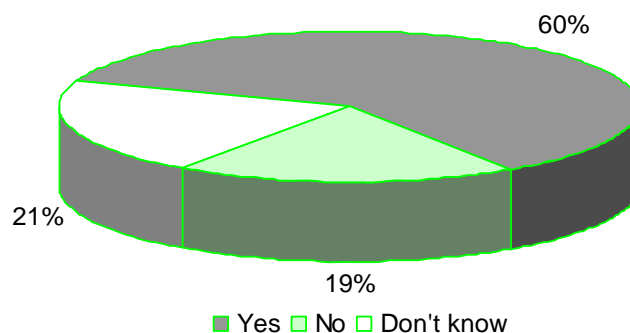
- 5.86 Having a single referral point for all sub-acute/community based programs is well supported by the survey respondents, however PAC staff have reservations due to the potential impact on responsiveness.
- 5.87 A single referral point would also require the staff to have a large amount of knowledge about many programs if they are to be more efficient than the current system.
- 5.88 Respondents who have had experience dealing with a single referral point raised a number of issues that need to be considered before incorporating PAC into a single referral point.
- 5.89 The current system for interPAC referrals is inadequate and needs to be addressed as it can be a barrier to referral/discharge.

Guidelines

- 5.90 When questioned about PAC services providing guidelines, 60% of referrers report that they believe guidelines about the provision of services to clients are clear. *DMC comment: This lack of clarity makes it difficult for referrers to provide efficient referrals as they are not aware of the service provision guidelines and therefore unable to accurately predict what services they should request.*

Figure 5.17 Referrer only response

Are guidelines on provision of services clear?

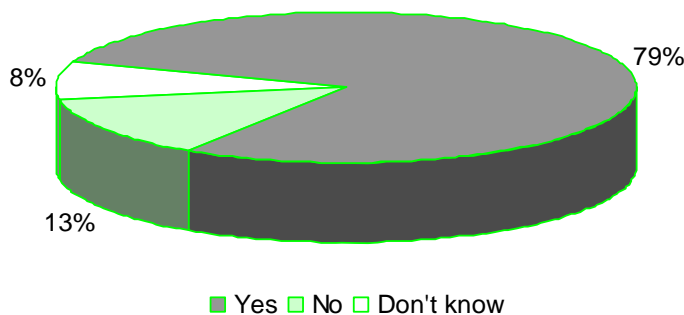


	Yes	No	Don't Know	Total
Response Count	84	27	29	140

5.91 Analysis by service provider shows a higher score for clarity of guidelines.

Figure 5.18 Service provider only response

Are guidelines on provision of services clear?



	Yes	No	Don't Know	Total
Response Count	96	16	10	122

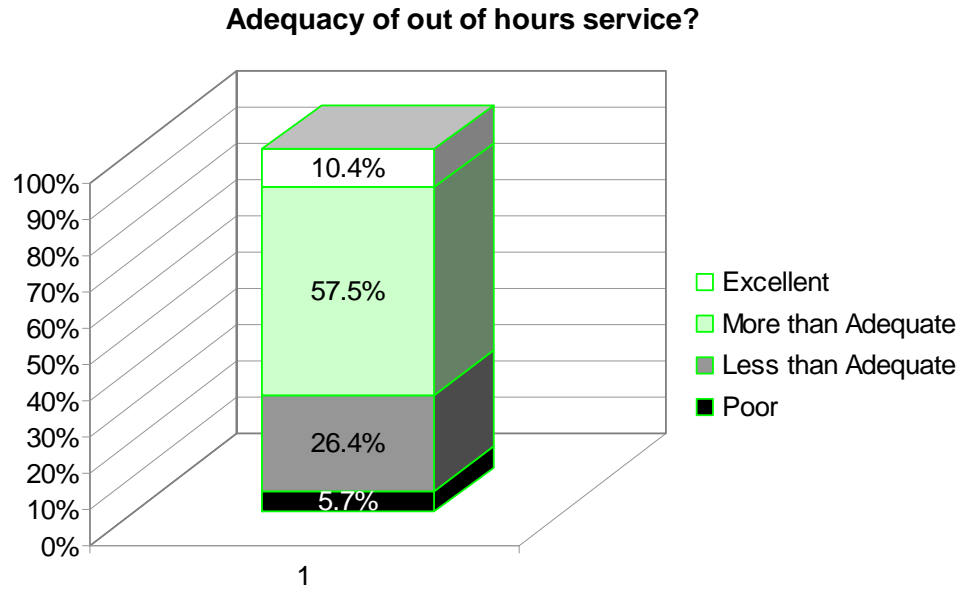
5.92 Out-of-hours arrangements for accessing PAC services are reported to be excellent or more than adequate by only 58% of all respondents. When analysed by referrers, the result was even lower (52%).

5.93 *DMC comment: As the acute hospital system operates seven days each week, the low provision of out-of-hours services is of concern.*

5.94 Regional services are rated as having better out-of-hours services than metropolitan services.

5.95 Regional services are rated 68% excellent or more than adequate for out-of-hours services.

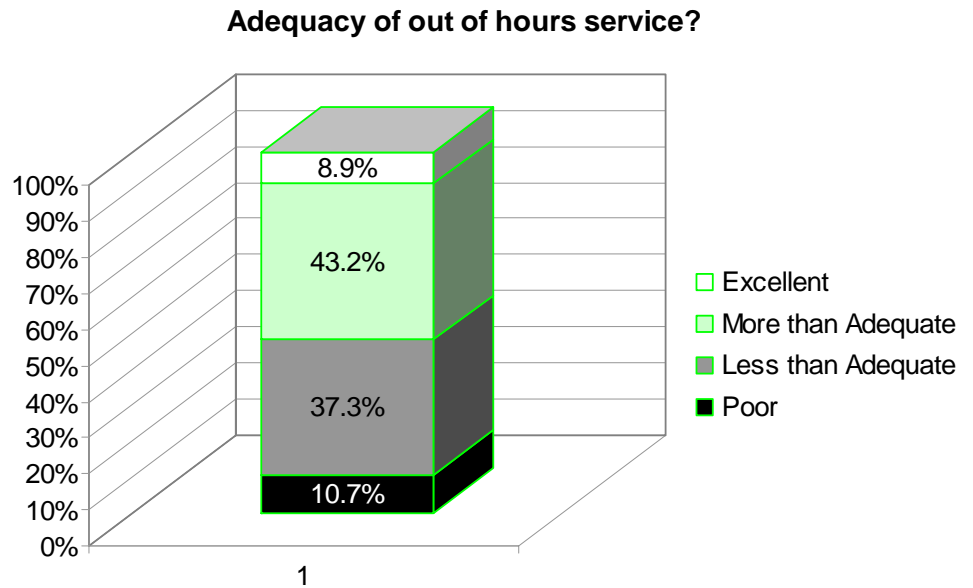
Figure 5.19 Regional response



	Excellent	More than Adequate	Less than Adequate	Poor	Total
Response Count	11	61	28	6	106

5.96 Metropolitan services are rated 52% excellent or more than adequate for out-of-hours services.

Figure 5.20 Metropolitan response



	Excellent	More than Adequate	Less than Adequate	Poor	Total
Response Count	15	73	63	18	169

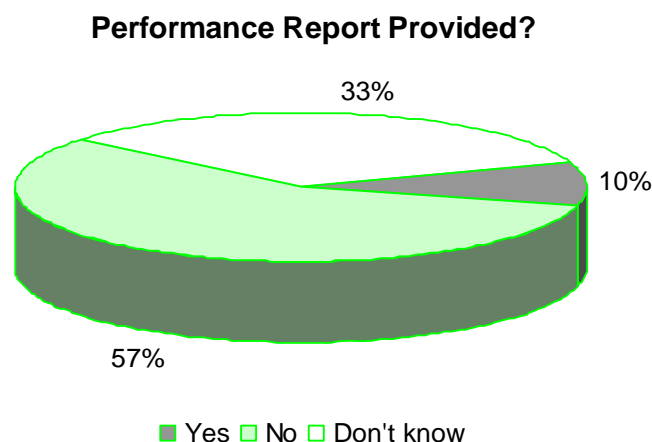
Guidelines - key findings

- 5.97 Guidelines for service provision is reported to be clear by service providers, however referrers report the clarity of guidelines as much lower. *DMC comment: This makes it difficult for referrers to provide efficient and accurate referrals as they are not clear on the services available.*
- 5.98 Out-of-hours arrangements for service provision or referrals are inadequate at present, however the regional areas have more adequate arrangements in place than the metropolitan services. *DMC comment: It is possible that regional responses are more favorable due to lower expectations or a relative lack of comparative information.*

Measurement and reporting tools

- 5.99 The level of performance reporting is low according to the service providers with 57% reporting there is no performance reporting from the PAC services and 33% not knowing if there is any performance reporting from the PAC services.

Figure 5.21 Service provider response



	Yes	No	Don't Know	Total
Response Count	12	72	42	126

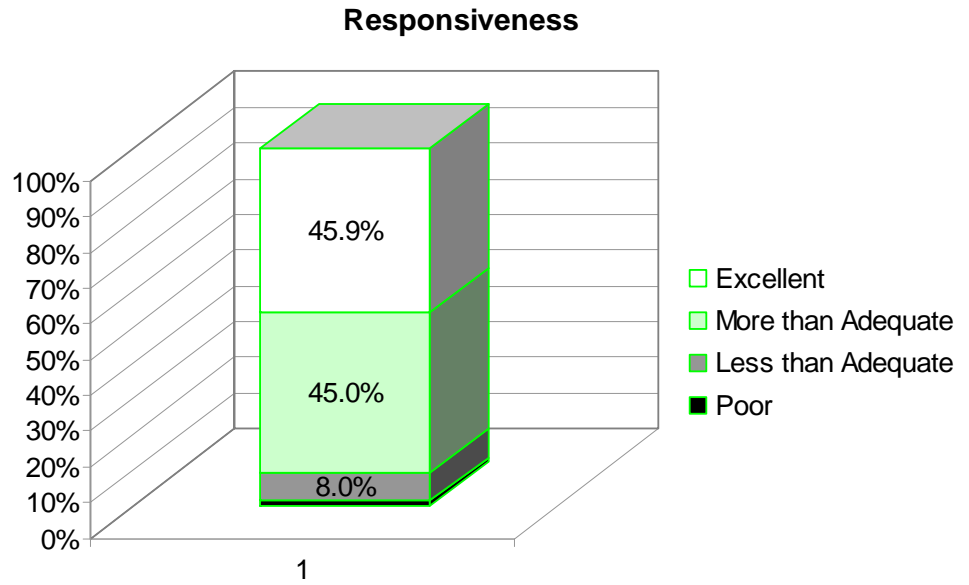
Measurement and reporting tools - key findings

- 5.100 Formal key performance indicator (“KPI”) reporting is not provided by PAC services consistently to its service providers.

Efficiency

- 5.101 Responsiveness of PAC services is very well regarded with 91% of respondents rating responsiveness as excellent or more than adequate. When analysed excluding PAC employees, the response remained at 89%.

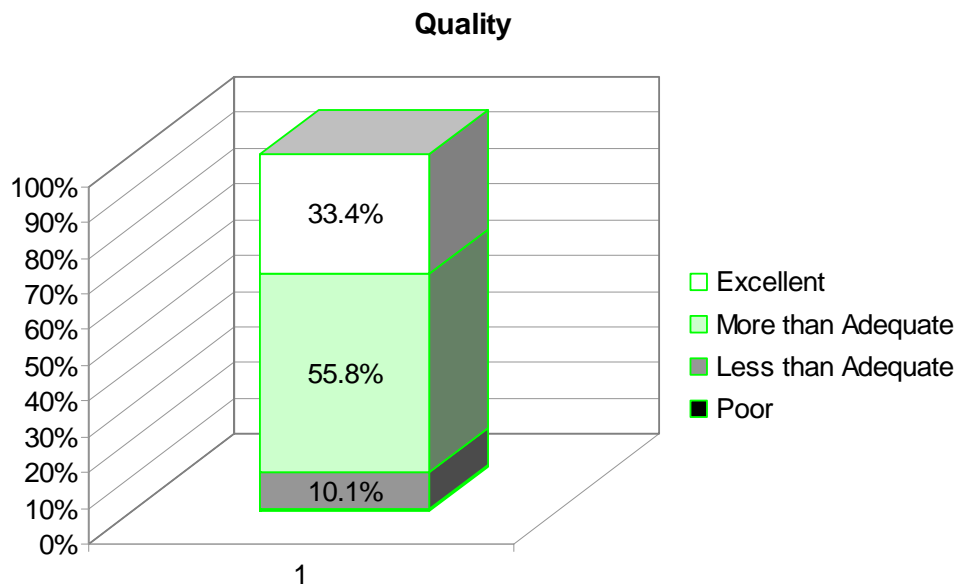
Figure 5.22 Group response



	Excellent	More than Adequate	Less than Adequate	Poor	Total
Response Count	155	152	27	4	338

5.102 Quality of service provided by PAC services is also well regarded with 89% of respondents rating quality as excellent or more than adequate. When analysed excluding PAC employees, the response remained at 87%.

Figure 5.23 Group response



	Excellent	More than Adequate	Less than Adequate	Poor	Total
Response Count	103	172	31	2	308

- 5.103 *DMC comment: The general impression of respondents is that PAC provides a good service with very few responding negatively.*
- 5.104 Readmissions due to inadequate provision of PAC services are not high, with only 11% of respondents saying they were aware of occurrences. Service providers reported a slightly higher level (16%).
- 5.105 Service providers do not rate the information provided to them on client requirements as highly as PAC employees and referrers, with 71% excellent or more than adequate. The information provided is rated as excellent or more than adequate by PAC employees and referrers as 94% and 85% respectively. *DMC comment: This result reinforces the requirement for comprehensive clinical and community information to be provided to service providers.*

Efficiency - key findings

- 5.106 The PAC services are regarded as efficient, providing responsive and high quality service.
- 5.107 The information provided to service providers regarding client requirements is currently adequate, however there is room for improvement in this area.

Brokerage agreements

- 5.108 Brokerage agreements are rated as excellent or more than adequate by 89% of service providers. This result, however, is based on the response of only 54% of the service providers who completed the survey.
- 5.109 Regional respondents are more likely to rate the brokerage agreements highly than the metropolitan respondents.
- 5.110 One free text comment for this question raised the point that brokerage agreements allow the PAC services to be more responsive and therefore facilitate discharge.

Brokerage agreements - key findings

- 5.111 Current brokerage agreements appear to be adequate, however this question was only answered by 46% of respondents and only 54% of service providers.

Future impacts and developments

5.112 Expectation that demand for PAC services will increase over the next five years is supported by 98% of respondents. Free text comments were entered by 72% of respondents and a summary of the thoughts includes:

- Ageing population will increase demand
- Increasing acuity and complexity of discharged clients
- Increasing levels of mental illness in society
- Increasing pressure to clear hospital beds

6.0 WORKSHOP – ANALYSIS AND KEY FINDINGS

Method

- 6.1 Part of the data analysis phase was to hold a workshop to discuss the options for change that we had generated following the data gathering phase. For the workshop we developed statements of options on the following topics:
- Consortia
 - Dispute resolution
 - Financial management
 - Brokerage agreements
 - Guidelines
 - Integrated access
 - InterPAC service delivery
 - OH&S
 - Ward presence
- 6.2 Seventeen representatives of PAC services and stakeholders attended the workshop, developing key objectives for the PAC service model and considering the options sets proposed.

Attendees

- 6.3 Potential attendees for the workshop were invited by DHS to attend a workshop for the PAC service models evaluation facilitated by DMC on September 11, 2007.
- 6.4 DHS nominated the composition of the group and a full list of attendees with their current role is included in Appendix C.
- 6.5 Attendees represented regional and metropolitan PAC services, DHS and RDNS.

Service model objectives

- 6.6 The first task of the workshop was to develop key objectives for the PAC service model. A total of 20 objectives were developed during group discussion.
- 6.7 The 20 options were then scored and ranked to identify the priority of each objective. The following table shows the options and their score and ranking.

Table 6.1 Key PAC service model objectives ranked

Rank	Objective	Score
1	Accountability	49
2	Person centred service model – a continuum of care	48
3	Easily accessible program – minimise barriers (simple, easy and quick)	48
4	To maintain flexibility of service	47
5	Timely and responsive and avoid duplication of assessment (incl. across different services)	46
6	Clear market focus, competitors and partners - improving coordination across programs, understanding role of the various program options	44
7	Improve consistency of eligibility and service	43
8	Financial accountability and financial efficiency	43
9	Relationships with stakeholders	42
10	InterPAC processes and methods standardised across state	41
11	Region wide service system approach	41
12	Provide for assessment coordination for longer term needs	38
13	Measurable outcomes with evaluation review processes	36
14	Consistent data	36
15	Service agreements with providers and stakeholders to achieve quality management and risk management and OH&S, etc	35
16	Onsite presence in acute hospitals for better targeting of resources and promotion of access	33
17	Catchment area definitions and alignment	33
18	Provide opportunities for stakeholder feedback	32
19	Reporting transparency	32
20	Targeted services within a quality framework and dispute resolution framework	30

6.8 The scoring was based on each objective being ranked high, medium or low by the workshop members and the weighted total then calculated.

Statements of options

- 6.9 Each of the following option statements was presented to the workshop. The attendees worked in two groups to address each option statement and then reported back to the workshop. The groups were asked to consider the options in the following manner:
- Maintain the status quo
 - Support a preferred option or combination of options
 - Suggest a new option
- 6.10 The results of the workshop deliberations are provided at the end of each table in a cell headed Workshop outcome.

Consortia

<p>Option 1 – Status quo</p> <p>PACs by and large appear to have stayed with the consortia arrangements made when the program was initiated. There is little evidence that the consortia function as a governance group and some PACs are now governed by the fundholder only.</p>	
<p>Advantages</p>	<p>Disadvantages</p>
<ul style="list-style-type: none"> • Consortia members may provide feedback on service quality and appropriateness • Was probably valuable at start up 	<ul style="list-style-type: none"> • Consortia members may be accepting financial responsibility without any say in governance • Consortia membership by service providers may present a conflict of interest
<p>Option 2 – DHS move to develop funding agreements with fundholders only</p> <p>In this option responsibility for financial management and governance would rest with the fundholders only. Fundholders would develop and publish service standards for referrers and other stakeholders.</p>	
<ul style="list-style-type: none"> • Governance and financial management responsibilities are clear 	<ul style="list-style-type: none"> • Some consortia members may be unhappy with changing arrangements
<p>Option 3 – Fundholders be encouraged to develop an advisory group</p> <p>In this option DHS would lead the development of a role statement for an advisory group and fundholders would be encouraged to develop a local advisory group to ensure they receive feedback on their service quality and effectiveness.</p>	
<ul style="list-style-type: none"> • Will retain some of the benefits of the original consortia model including helping to ensure that the PAC service meets community expectations 	<ul style="list-style-type: none"> • Will require a time commitment by members • Stakeholders already comment that they have too many DHS sponsored meetings to attend – may especially

	be a problem for regional stakeholders
<p>Option 4 – Fundholders be encouraged to survey stakeholders for feedback</p> <p>In this option DHS would lead the development of a questionnaire that would seek feedback from stakeholders at least annually. This would provide former consortia members with an opportunity to raise issues of concern.</p>	
<ul style="list-style-type: none"> • Will provide a mechanism for collecting feedback from former consortia members without a big impost on their time 	<ul style="list-style-type: none"> • Only provides a limited opportunity for input
<p>Workshop outcome</p> <p><i>Maintaining the status quo was unanimously rejected by the workshop participants.</i></p> <p><i>The preferred outcome is to adopt Option 2 with components of Options 3 and 4 as listed below:</i></p> <ul style="list-style-type: none"> • <i>Local advisory group reporting to fundholder</i> • <i>Survey of stakeholders tied to mid-year review to go DHS</i> • <i>Primary Care Partnerships (“PCP”) would be too busy to take on extra work therefore not suitable for this purpose</i> • <i>Integrate with other programs eg. HARP and SACS</i> 	

Dispute resolution

<p>Option 1 – Status quo</p> <p>Dispute resolution is generally a weakness. There do not appear to be published processes for stakeholders to utilise and at interview a significant number of complaints concerning rudeness and refusal to accept referrals were described.</p>	
<p>Advantages</p>	<p>Disadvantages</p>
<ul style="list-style-type: none"> • None identified 	<ul style="list-style-type: none"> • Failure to meet program aims as referrers report clients remaining in hospital for three or four additional days due to failure to access PAC services • Results in inconsistent delivery of services to clients entitled to receive services • Wastes clinician resources as they try to negotiate with PAC staff with poor communication skills and unhelpful attitudes
<p>Option 2 – DHS led development of dispute resolution process for PAC</p> <p>In this option DHS would lead a small group of PAC staff and referrers to develop a complaint handling and dispute resolution process. It may be based on an existing process if a suitable model can be identified. All PACs to adopt and publish a process by end 2007.</p> <p>The process will need to ensure immediate resolution of complaints ie. same day resolution in keeping with the aims of the program.</p> <p>DHS will require all PACs to report on complaints and their resolution every six months.</p>	
<ul style="list-style-type: none"> • Provides a better opportunity to meet program aims in freeing hospital beds • Should improve consistency of service delivery • Will provide referrers with the opportunity to by pass unhelpful staff • Will provide PAC management with feedback from stakeholders 	<ul style="list-style-type: none"> • Will take time and resources to develop • Will require resources for reporting
<p>Option 3 – Incorporation of dispute resolution processes in all brokerage agreements</p> <p>In this option DHS will advise PACs that all brokerage agreements should contain a dispute resolution clause. DHS will provide a model clause for consideration by</p>	

PACs and their legal advisors.	
<ul style="list-style-type: none"> • May improve relations between providers and PACs • Demonstrates good governance and contract management 	<ul style="list-style-type: none"> • None identified
<p>Workshop outcome</p> <p><i>None of the options listed were fully accepted by the workshop participants. They formed a further option as described below.</i></p> <p><i>Where there are existing unutilised processes within health services they should be tailored for PAC and publicised rather than developing new processes. Where there are no existing processes one should be adopted. The processes would need to include:</i></p> <ul style="list-style-type: none"> • <i>Customer service (staff to staff)</i> • <i>Transparency of decisions</i> • <i>Transparency of guidelines regarding minimum service levels</i> • <i>Continuity with HACC unless clinical reason for difference</i> <p><i>It is acknowledged that there is difficulty in regional areas where other services (eg HACC) may be available straight away (which has a cost to client) and therefore the client may be disadvantaged. However PAC is a support for existing systems therefore it should not be accessed if it is not necessary.</i></p> <p><i>DHS would act in a referee capacity in this model.</i></p>	

Financial management

<p>Option 1 – Status quo</p> <p>PACs manage finances by rationing towards the end of the year.</p> <p>Little evidence of financial planning; few hospitals provided with financial reports; hospitals are unable to assess whether they are accessing a proportionate share of PAC dollars.</p> <p>DHS has no forecasting data from PACs to determine whether needs are adequately covered.</p>	
Advantages	Disadvantages
<ul style="list-style-type: none"> PACs manage within a budget, no concerns regarding over-expenditure were identified 	<ul style="list-style-type: none"> In many cases neither hospitals or PACs know whether funds are allocated proportionally across hospitals Underutilisation of PAC by a hospital may mean less than optimal bed management
<p>Option 2 – DHS led development of standard financial report to be made available at least annually to hospitals</p> <p>In this option DHS would work with a small group of PAC staff and hospital managers to develop a standard report framework for PACs to provide to hospitals concerning hospital specific expenditure of funds.</p> <p>PACs should report to DHS and hospitals when rationing services at the end of the year.</p> <p>PACs should report to DHS on expectations for the year ahead.</p>	
<ul style="list-style-type: none"> PACs would still manage within a budget but would report when rationing starts DHS may have the option to release additional funds if the rationing is likely to impact on bed availability Hospitals would understand whether their % separations receiving PAC support were according to averages and expectations 	<ul style="list-style-type: none"> Resources required to prepare reports
<p>Option 3 – DHS to consider withholding some PAC budget to meet unexpected needs.</p>	
<ul style="list-style-type: none"> If PACs have a larger than anticipated call on funds during the year, they would be able to apply for additional funds in place of some 	<ul style="list-style-type: none"> The pool of funds allocated at the start of the year may be less

rationing	
<p>Option 4 – PACs to provide a forecast of expected PAC service requirements annually for the next financial year giving reasons for any variations from current year expenditure.</p> <p>In this option PACS would be expected to consult with referrers to understand any likely changes in PAC service requirements in the budget year ahead and prepare a brief forecast for DHS.</p>	
<ul style="list-style-type: none"> DHS will have information on likely requirements for future years and information on any implications for hospital bed management 	<ul style="list-style-type: none"> Resources required from PACs and referrers to complete the forecasts
<p>Workshop outcome</p> <p><i>The workshop group do not support maintaining the status quo and also believe Option 3 would be too difficult to manage.</i></p> <p><i>The preferred option is Option 2 with components of Option 4 including:</i></p> <ul style="list-style-type: none"> <i>Regular forecasting</i> <i>Establish dialogues around rationing</i> 	

Brokerage agreements

<p>Option 1 – Status quo</p> <p>Each PAC service enters into its own brokerage agreements with service providers. Agreements can be significant and extensive for large purchases such as nursing, or simple for small purchases such as dog walkers.</p> <p>Some services are purchased in house where this is seen as cheaper and more effective eg physiotherapists employed directly by PACs and providing clinical services to clients.</p> <p>There is no bulk provision of services across PACs.</p>	
Advantages	Disadvantages
<ul style="list-style-type: none"> • Each PAC has agreements tailored to its special requirements • In house services are capable of delivering better value for money 	<ul style="list-style-type: none"> • Legal costs are incurred many times over as each PAC develops its own agreements • The mix of in house and brokered services is not transparent to funders
<p>Option 2 – Development of model agreements</p> <p>In this option DHS would lead the development of a set of standard agreements for brokered services from complex to simple.</p> <p>This could utilise a working group from PACs and be based on good practice agreements identified by the PAC employees or service providers.</p> <p>Each PAC could adopt the agreements in their entirety or modify them to meet particular service provider or organisational needs.</p>	
<ul style="list-style-type: none"> • Legal costs will be minimised • Good practice arrangements will be available to all PACs • Any modifications required eg for OH&S need only be completed once 	<ul style="list-style-type: none"> • Will be implementation work
<p>Option 3 – Development of protocols for in house services</p> <p>In this option DHS would provide some guidance on in house models including ratios for in house against brokered services and arrangements for financial reporting.</p>	
<ul style="list-style-type: none"> • Would provide some certainty for PACs who are uncertain about the DHS view on this 	<ul style="list-style-type: none"> • Implementation work for DHS
<p>Option 4 – Investigation of opportunities for bulk agreements</p> <p>In this option DHS would lead the investigation of opportunities for bulk agreements with service providers. This could be by way of an open tender. PACs would need</p>	

to have input into the development of service standards and reporting expectations.

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| <ul style="list-style-type: none">• Reduces transaction costs as it avoids raising an invoice for each service episode | <ul style="list-style-type: none">• May not meet the needs of all PACs• Service responsiveness may drop off |
|--|--|

Workshop outcome

The preferred option for brokerage agreements is Option 2 with Option 4.

The inclusion of Option 4 was noted to be with reservations.

An additional requirement from the group is the inclusion of OH&S requirements within the brokerage agreements.

Guidelines

<p>Option 1 – Status quo</p> <p>Each PAC service has its own set of informal guidelines.</p> <p>Referrers comment that acceptable service packages vary greatly between PACs and sometimes even between different staff at the one PAC.</p> <p>There is some confusion about eligibility – eg some referrers have been told no PAC service will be provided if there is an able bodied adult in the home.</p>	
Advantages	Disadvantages
<ul style="list-style-type: none"> Flexibility and ability to respond to different situations 	<ul style="list-style-type: none"> Uncertainty from referrers about what can be provided – especially difficult when requesting interPAC services Can result in clients with the same clinical and community status receiving very different PAC support
<p>Option 2 – Develop guidelines setting a minimum service package</p> <p>In this option a minimum service package would be agreed by PACs.</p> <p>There may need to be different packages agreed for metropolitan and regional PACs given regional workforce constraints.</p> <p>Eligibility guidelines would be agreed by all PACs.</p> <p>The proposed service packages would be discussed with HACC to harmonise with HACC service provision where possible.</p>	
<ul style="list-style-type: none"> Provides some certainty for referrers and clients regarding what services will be supplied If harmonised with HACC will better manage client expectations post PAC Relatively easy to develop and implement 	<ul style="list-style-type: none"> May reduce flexibility
<p>Option 3 – Develop guidelines covering all situations</p> <p>In this option standard services packages would be agreed by all PACs for all circumstances.</p> <p>There would probably need to be different standard packages agreed for metropolitan and regional PACs given regional workforce constraints.</p> <p>Eligibility guidelines would be agreed by all PACs.</p> <p>The proposed service packages would be discussed with HACC to harmonise with</p>	

HACC service provision where possible.	
<ul style="list-style-type: none">• Provides some certainty for referrers and clients regarding what services will be supplied• If harmonised with HACC will better manage client expectations post PAC	<ul style="list-style-type: none">• Will reduce flexibility in dealing with difficult and complex cases• Will be difficult to develop and implement
Workshop outcome <i>The preferred option for guidelines is Option 2 with a change of wording from “service package” to “principles”. The principles will guide what services will be delivered.</i>	

Integrated access

<p>Option 1 – Status quo</p> <p>Discharge planners are often confused over the range of different support programs available post discharge eg HARP, HITH, RITH, CHS, SACS, HACC.</p> <p>There is no one point of reference and information about the programs does not seem readily available to referrers.</p>	
Advantages	Disadvantages
<ul style="list-style-type: none"> • Direct access to PAC means that in most cases there is no delay in arranging services when they are agreed 	<ul style="list-style-type: none"> • It is not clear that referrers always choose the most appropriate service – PAC is often considered the gap filler
<p>Option 2 – Centralised referral point then triaged to appropriate program</p>	
<ul style="list-style-type: none"> • Will assist referrers who do not know which program to access for their clients 	<ul style="list-style-type: none"> • All referrals need to be assessed individually for the programs they are referred to; centralised referral may just add another layer • May impact adversely on responsiveness and flexibility • Difficulties in mixing acute with sub-acute
<p>Option 3 – DHS led development of program summary covering all the likely post-discharge services</p> <p>In this option DHS would lead the development of a summary document that would identify the eligibility requirements and program aim and scope for each of the identified post discharge programs.</p> <p>The document would be published and circulated to all discharge planners in both acute and sub-acute environments</p>	
<ul style="list-style-type: none"> • Brings together all the eligibility and coverage programs in the one place 	<ul style="list-style-type: none"> • Implementation work • Maybe some difficulties with maintaining currency
<p>Option 4 – Hospitals encouraged to have internal brokers</p> <p>In this option hospitals would be encouraged to nominate internal brokers (especially in high volume units) to develop expertise across each of the identified post discharge programs.</p>	
<ul style="list-style-type: none"> • Has worked well in some places eg the Trauma Coordinator at The Alfred • Gives clinicians a local point of contact and may improve efficiency 	<ul style="list-style-type: none"> • Hospital resources required to train staff

Workshop outcome

Support is for a blend of Option 2 with Option 4 (as some services already have centralised intake).

The development and regular updating of a program summary (Option 3) is also well supported. The method of publication and distribution will need to be addressed and it is suggested that these issues could be included in PAC service guidelines.

InterPAC service delivery

<p>Option 1 – Status quo</p> <p>Currently this would appear to be the worst performing aspect of PAC from the referrers' viewpoint. Problems identified include extensive and varying documentation requirements, lack of assistance in trying to arrange service, reluctance to take clients not in the PACs hospital, poor attitude, lack of professional courtesy and greater requirements put on remote referrers than are required of local clinicians.</p> <p>These problems were identified mainly for metropolitan PAC services. Regional PACs and the Community Health PACs in the metropolitan areas were not the subject of these complaints.</p> <p>It may be that PACs attached to health services in metropolitan areas see their resources as hospital resources and are reluctant to take a client discharged from a remote hospital.</p>	
Advantages	Disadvantages
<ul style="list-style-type: none"> • Works well for regional PACS and metropolitan community health PACs who are reported as having a strong client focus 	<ul style="list-style-type: none"> • Works poorly in metropolitan areas where the PACs based in health services appear more focused on their hospitals and are not supportive of clients discharged from other hospitals • Wasteful of clinicians' time as the process for arranging interPACs is very time consuming and frustrating • Patients remain in hospital longer than is necessary because PAC is too difficult to organise
<p>Option 2 – DHS led development of a common form for interPACS that all PACs must agree to accept</p> <p>In this option a small group of PAC managers and referrers would agree a common form and protocol, and instructions for referrers to use when making an interPAC referral.</p> <p>The rollout of the form should include briefings to all referrers so that they understand what to expect. The information gathering should be kept to what is necessary and be as brief as is compatible with a safe referral home. It should not assume clinicians can visit the home of the client.</p> <p>It may be useful to consider a variation in the form for regional referrals where workforce limitations may be an issue.</p>	
<ul style="list-style-type: none"> • Will greatly assist referrers • Will help ensuring similar eligibility criteria are used for all Victorians 	<ul style="list-style-type: none"> • Individual PAC services may have to compromise on some of their requirements

Option 3 – Financial resources for interPACs are held by DHS and made available as required

In this option financial resources for interPACs are held back from the budgets in areas mostly commonly receiving interPAC referrals and are released by DHS against specific PAC service delivery as required. Consider also providing a financial incentive for interPAC referrals.

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| <ul style="list-style-type: none"> • Will ensure interPACs are not disadvantaged by PACs in health services giving priority (especially financial priority) to patients discharged from their own hospitals | <ul style="list-style-type: none"> • Will require administrative resources |
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Workshop outcome

Option 2 is the preferred option for interPAC service delivery. The workshop participants added the following information:

- *Possibly separate part of the funding for interPAC based on separation history and reconcile periodically*
- *A standardised referral tool (SCTT) has already been developed and can be developed/adapted for interPAC as long as there is appropriate education provided to users*
 - *All service providers must agree to accept the form (eg RDNS)*
- *PAC services to do interPAC referrals as long as the cost of the workload is addressed*

OH&S

<p>Option 1 – Status quo</p> <p>Currently the responsibility for the OH&S of the service providers is unclear. Some PACs believe the hospital based clinicians should establish the home based risks. It is unlikely that hospital based clinicians can visit all homes. The first contact able to assess the home is the service provider.</p> <p>There is some concern expressed that the process of carrying out an OH&S assessment as well as completing a clinical assessment and treatment takes longer than the time allocated for the initial visit.</p>	
Advantages	Disadvantages
<ul style="list-style-type: none"> • Generally the final home based OH&S assessment is completed by first service provider (commonly a nurse) • Strategies are discussed and implemented if OH&S risk factors are present eg industrial clean • OH&S requirements can be formalised in brokerage agreements 	<ul style="list-style-type: none"> • Some PACs expect hospital based clinicians to complete the home based OH&S assessment
<p>Option 2 – OH&S trained service provider conducts first visit.</p> <p>In this option a mandatory OH&S assessment would be conducted by a trained service provider on the first visit. This may require training of key PAC service provider staff and allocation of appropriate time for the first visit.</p> <p>All service providers to be signed up to the process within twelve months.</p>	
<ul style="list-style-type: none"> • Thorough assessment and action plan developed for clients providing for a safe working environment for service providers 	<ul style="list-style-type: none"> • Increased cost of first visit as extra time allocation required
<p>Option 3 – Standardised OH&S checklist and protocols</p> <p>DHS led development of a standardised OH&S checklist that must be completed by first contact service provider. Standardised protocols should also be developed to protect staff eg. phone contact pre and post visit to dedicated contact point.</p> <p>Inclusion of this checklist and protocol in brokerage agreement unless service providers have their own protocols. Service providers to be required to report any adverse OH&S assessment to PAC immediately after visit for transmission to other service providers.</p>	
<ul style="list-style-type: none"> • Increased power to service providers to make OH&S based decisions in order to maintain a safe working environment 	<ul style="list-style-type: none"> • Increased cost of first visit as extra time allocation required

Workshop outcome

Option 3 is the preferred option with the group including the following comments:

- *When negotiating service agreements, include OH&S processes and requirements*
- *Consider utilising systems already in existence in another PAC or another service eg. site assessment tool (RDNS)*

Ward presence

<p>Option 1 – Status quo</p> <p>Mixed model currently with some PACs having a ward presence and others with PAC staff located remotely from hospitals.</p> <p>There is no clear evidence that one model works better than another.</p>	
<p>Comments</p>	
<ul style="list-style-type: none"> About 2/3 of PAC staff think a ward presence is valuable 	<ul style="list-style-type: none"> Only about 1/2 of referrers see benefit in an onsite presence If discharge planning is working well it doesn't matter where PAC is located Liaison person across a network rather than at one site was well regarded Telephone based service with ward visits preferred by some E-referral system development in regional
<p>Ward presence</p>	
<p>Advantages</p>	<p>Disadvantages</p>
<ul style="list-style-type: none"> May provide good education to discharge staff Better clinical information comes from the ward discharge Face-to-face is necessary for complex cases, not for simpler cases Acute staff may not understand community matters as well as PAC staff 	<ul style="list-style-type: none"> One onsite person can bottleneck discharges PAC staff may be gap filling for poor discharge practices Large costs to resource all discharge points – not practical in some cases
<p>PAC staff located together at a central place – not at a hospital</p>	
<ul style="list-style-type: none"> Able to access staff more readily Multiple staff available to answer telephones or deal with electronic requests May help to ensure equitable treatment for all referrers when not location dependent 	<ul style="list-style-type: none"> Constant need for information re PAC to discharge planners

Workshop outcome

The workshop participants developed an alternate option as follows:

- *Rename the option as “Hospital Presence”*
- *Develop a set of KPIs and minimum standards for PAC services*
- *Ensure the appropriate systems are in place*
- *PAC liaison role would be beneficial*
 - *Assists to increase efficiency of referral and frees up clinicians to do clinical work*
 - *Especially beneficial for interPACs*
- *Suggested using the “As long as it works” principle*

7.0 WORKING SESSIONS – OUTCOMES

- 7.1 During the review process we met with the PAC working party on three occasions. A full list of the PAC Working Party members is provided in Appendix D. The Working Party meetings generated the following:
- Meeting 1 (27 April 2007) – PAC issues identification
 - Meeting 2 (13 June 2007) – Good governance in PAC
 - Meeting 3 (15 August 2007) – Review and discussion of interview issues
- 7.2 The output from these meetings was incorporated into question and questionnaire development, analysis and reporting.

PAC issues identification

- 7.3 The first meeting of the working party was used to brainstorm an issues list for the PAC service models review. The group were asked to identify any issue they thought to be relevant in light of the impending review. The list generated was used as a starting point for the development of interview questions.

Table 7.1 Working party generated issues list

Relationship between community based services and health services
Eligibility criteria - those who can't navigate the system fall through the cracks
Governance and effect on accountability
Need robust guidelines - not well developed compared with HARP and SACS
Policy and funding guidelines more prescriptive in past – now very relaxed
Identification of those in hospital who may require PAC post discharge <ul style="list-style-type: none"> ○ Referrals dependant on the experience of the referring staff ○ Issue for discharge from metro hospital to regional area ○ Inter-PAC referral process not working ○ Different models of inter-PAC referral depending on service ○ Effect of inter-HARP and inter-SACS referrals
Need or resistance to change within the teams <ul style="list-style-type: none"> ○ Increased awareness of what core business is

<ul style="list-style-type: none"> ○ When to refer to other services ○ Ability to provide a more flexible service
<p>Acute staffing lack of understanding of community services</p> <ul style="list-style-type: none"> ○ Acute staff too busy and specialised to focus on transition to community ○ Lack of discharge planners within acute sector ○ Pressure of bed management within acute ○ Definition of discharge is different between acute and community sectors ○ Determine a way to educate acute sector as to consequences of poor discharge planning (readmission)
<p>Interaction with outpatients – outpatients currently under review by DHS</p>
<p>Shorter stay as inpatient (“IP”) decreases opportunity for referral to services</p>
<p>Cancellation of surgery</p>
<p>Inconsistent treatment by PAC for clients with similar eligibility</p>
<p>Person centred practice vs budget management</p>
<p>Referral between different services</p> <ul style="list-style-type: none"> ○ Not efficient ○ Different practices ○ Different catchment ○ Not utilising range of services available
<p>Service coordination vs care coordination</p>
<p>Measurement (outcome measures)</p> <ul style="list-style-type: none"> ○ Are we meeting the need ○ How do we measure it? ○ Efficient use of funds? ○ Outcome from client perspective?
<p>Alignment of PAC with other programs</p>
<p>Power of brokerage to assist to get people discharge support</p> <ul style="list-style-type: none"> ○ Creative use of the resource alongside other services

<ul style="list-style-type: none"> ○ Fill gaps
Quality of service and follow-up as part of the package (real time follow-up)
Ensure benefits of PAC aren't lost with integration
Measure effectiveness of preventing readmission (value of care coordination)
Reporting variations - definition standardisation
Process variability - difficult for referrers to know how to access different programs
Metro vs rural/regional for catchment - not as many service gaps regionally
Is the use of PAC to gap fill HACC eligible clients the correct use - there needs to be a service to cater for this group and allow for lead times
Risk of using guidelines and decreasing flexibility
Look at the funding source with option of reimbursement if eligibility lies elsewhere
<p>Gap fill utilises different provider to the longer term HACC providers</p> <ul style="list-style-type: none"> ○ Influenced by HACC waiting lists ○ No availability of service or service providers ○ Perhaps use the HACC providers to solve this issue utilising PAC funds
Consultation with the client about key outcomes and referrals and service providers
Self care planning with budget allocation may be a future direction
Good client consultation and involvement in the planning process will smooth the process for the client even in the environment of disjointed services
Brokerage purchasing patterns - issues with duplication of existing services
<p>Brokerage agreements</p> <ul style="list-style-type: none"> ○ What is included ○ Risk management

<p>When there isn't a ward service, is there equity of access (particularly in the rural setting)</p> <ul style="list-style-type: none"> ○ Is there a decreased service to those who live further from the location of the service ○ Is decentralised better than centralised? ○ Is this the same as metro ward presence vs no presence
<p>OH&S</p> <ul style="list-style-type: none"> ○ Referral to private provider rather than council due to OH&S issues that would limit the council staff ○ OH&S assessment required prior to HACC services ○ Risk is on the brokering agency

Good governance in PAC

7.4 Members of the working party were stepped through the objectives of good governance adapted from Australian Standard (“AS”) 8000-2003 Good Governance Principles.

7.5 The AS good governance principles loosely follow the Organisation for Economic Co-operation and development (“OECD”) Principles of Corporate Governance and cover five areas. These areas are:

- The role, powers and responsibilities of the board/governing body
- Disclosure and transparency obligations
- The rights and equitable treatment of shareholders (and funders)
- The responsibilities of shareholders (and funders)
- The role of stakeholders in corporate governance

7.6 The group identified issues relevant to PAC services under each of these areas and the results are presented in the following table.

Table 7.2 Working party generated good governance issues

Good Governance Principles	Stakeholder identified relevance to PAC services
The role, powers and responsibilities of the board/governing body	<p>Good clinical governance structures including clinical audits</p> <p>Credentialing staff service provision including subcontractor governance</p>

Good Governance Principles	Stakeholder identified relevance to PAC services
	<p>Brokerage agreements and contract management</p> <p>OH&S policy</p> <p>Clear management delegations and line management</p> <p>Contract management principles</p> <p>Good understanding of DHS contract and expectations</p> <p>Financial management protocols</p> <p>Human resources (“HR”) management protocols</p> <p>Reporting structures and meeting funder KPIs</p> <p>Risk identification and management protocol</p> <p>Strategic planning process</p>
<p>Disclosure and transparency obligations</p>	<p>Budget reporting and acquittal processes – internal and external</p> <p>Quality of care reporting</p> <p>Referral data and outcome measures</p> <p>Consumer participation and feedback</p> <p>Complaint measurement and reporting</p> <p>Accreditation reporting</p> <p>Subcontractor performance reporting including complaints</p> <p>Guidelines – established protocols for service provision, referral protocols, equitable access provisions</p> <p>General performance indicators</p> <p>Recording keeping protocols</p> <p>Privacy protocols</p>
<p>The rights and equitable treatment of shareholders and funders</p>	<p>Service co-ordination and care planning to meet funders’ expectations</p> <p>Assessment structures and reporting to funders</p> <p>Responsibility for catchment area with available</p>

Good Governance Principles	Stakeholder identified relevance to PAC services
	<p>funds</p> <p>Eligibility criteria</p> <p>Clear guidelines between different system funds</p> <p>Financial systems and reporting to be accountable for funds reaching intended programs</p>
The responsibilities of shareholders and funders	<p>Reasonable oversight protocols</p> <p>Reporting requirements</p> <p>Monitoring standards</p> <p>Service agreements including risk identification and minimisation</p> <p>Program guidelines</p> <p>KPIs</p> <p>Quality improvement framework</p> <p>Guideline development</p> <p>Policy framework</p>
The role of stakeholders in corporate governance	<p>Governance review structures at program and clinical level</p> <p>Feedback on achievements, opportunities for improvements,</p> <p>Participation in review processes</p> <p>Regular consultation between stakeholders and services – but consider conflicts of interests</p> <p>PAC services need to be willing to listen to stakeholders</p> <p>Risk identification and may be mitigation</p>

Review and discussion of interview issues

- 7.7 We presented the initial findings from the in-depth interview process to the members of the working party in the form of an issues list.
- 7.8 The group discussion was directed at clarifying and exploring commonalities and differences between the issues identified as well as identifying any areas that appear to be lacking coverage.

8.0 RECOMMENDATIONS

Results of analysis

- 8.1 We analysed the key findings from the extensive interviews (130 stakeholders), the survey (541 responses), the Working Party sessions and the workshop.
- 8.2 From this analysis we developed the recommendations below:

Recommendations – Governance arrangements

That DHS require PAC services to immediately develop and publish dispute resolution and complaint handling processes. These processes must focus on urgent resolution given the impact on bed availability if PAC services are not supplied.

That PAC services develop and publish customer service standards for responsiveness and quality to all stakeholders.

That risk identification and risk mitigation frameworks within PAC services are identified and reported annually to DHS.

That PAC services develop an annual financial reporting framework that ensures stakeholders (especially referring hospitals) receive accurate, comprehensive and comparative information that supports decision making in relation to usage of PAC services.

That DHS consider improving the data collection from PAC services to support benchmarking and performance assessment (the introduction of VINAH may address this issue).

That DHS consider development of an improved system-wide governance process for interPAC referrals to ensure that metropolitan hospital-based PACs are not disadvantaging patients from other hospitals.

That DHS consider development of an improved system-wide governance framework to ensure equitable treatment of patients with respect to eligibility and service provision.

That PAC services develop quality of care standards to ensure adequate risk management for patients and service providers including communication with GPs for ongoing care.

That DHS reconsider the governance and management meetings required for regionally based programs and consider replacing multiple meetings with a meeting covering a range of programs.

Reference key findings paragraphs 4.29-4.36, 5.36-5.42 and chapters 6 and 7

Recommendations – Consortia arrangements

That DHS contract with one party only as the fundholder and that this party be held responsible for transparency and accountability of governance. Previous consortium members may meet or continue to meet as an advisory group if desirable.

Reference key findings paragraphs 4.44-4.45, 5.46-5.47 and chapter 6

Recommendations – Service system relationships

That PAC services develop mechanisms to improve interactions with GPs.

That DHS consider strategies for overcoming service shortages in allied health eg. discussions with health services on allocation of OT budgets for PAC or promoting the use of allied health assistants working under the supervision of senior staff. *Note: regional areas report shortages of OTs, PTs, psychologists. The metropolitan shortages are mainly in OT departments.*

That DHS review the impact of HACC waiting lists on PAC service delivery and relationships.

Reference key findings paragraphs 4.58-4.60

Recommendations – On-site presence

That PAC services consider the most efficient use of staff time rather than focus on staff location. Face-to-face discussions are valuable in complex discharges and high bed pressure units, but electronic and telephonic referrals are more efficient for simpler discharges. For off-site services the development of a hospital liaison PAC role should be considered. There should be a focus on units where there is pressure on beds.

Reference key findings paragraphs 4.70-4.73, 5.54-5.55 and chapter 6

Recommendations – Discharge planning

That PAC services consider the following improvements to linkages to discharge planning:

- Continuing education to ward staff regarding PAC services and provision of contact details
- Regular visits (at least monthly) to discharge points
- Earlier discharge planning, commencing at admission for patients requiring PAC services
- Greater weight to be given to clinical assessments
- Streamlining of simple discharges requiring a simple service package eg. home help and meals on wheels
- A focus on prompt response to telephone messages from discharge planners
- A focus on relevant, accurate and appropriate information in referrals to service providers

Reference key findings paragraphs 4.86-4.88, 5.60-5.61

Recommendations - Accessibility

That PAC services consider the following improvements to accessibility:

- Midwifery patients need better consideration
- Refusal of PAC should be kept to a minimum if the result of refusal is a longer hospital stay (especially interPAC referrals)
- That private patients in public hospitals and their discharge planners be advised of their eligibility in PAC education materials
- Review the impact on accessibility of the restriction on funds in some PAC catchments (mainly regional)

That DHS consider expanding the PAC program parameters to pre-admission clients where a hospital admission may be avoided if PAC services are provided.

Reference key findings paragraphs 4.102-4.105, 5.72-5.74

Recommendations – Program interaction

That DHS immediately develop a monitoring program for interPAC referrals and require PACs to provide reason for any refusal of service. The monitoring should also require PAC services to identify and justify any additional administrative requirements they place on interPAC referrals.

That DHS consider the adoption of a common form for all interPACs.

That DHS consider retaining the budget cover for interPACs and reimbursing interPAC service provision when provided to ensure that patients from hospitals

outside a PAC catchment are not disadvantaged for financial reasons.

That DHS continue the policy development for an integrated model for a range of programs including PAC but ensure that access to PAC services is still provided with a sense of urgency and that current knowledge and skills with respect to service networks is not lost. The process will need to be very efficient and not just add another layer of administration between clinicians and service delivers.

That DHS develop a robust implementation plan for the integrated model that will reach clinicians, service providers and other stakeholders to ensure a smooth transition.

That DHS sponsor the preparation and publication of a consolidated list of programs, their eligibility requirements, access arrangements and the services provided.

Reference key findings paragraphs 4.126-4.131, 5.86-5.89 and chapter 6

Recommendations – Guidelines

That DHS lead the development and publication of minimum core PAC guidelines covering the following issues:

- Eligibility
- Minimum service packs (for simple and complex cases)
- Pre-approvals for after hours discharges for minimum service levels eg one or two nursing visits

Guidelines to be reviewed at least annually with input from referrers, service providers and other stakeholders.

That DHS and PACs consider aligning PAC service levels with HACC service levels where there is no clinical requirement for a difference.

The guidelines should allow for flexibility in the initial service provider visits when unidentified issues become apparent eg OH&S issues.

Reference key findings paragraphs 4.145-4.148, 5.97-5.98 and chapter 6

Recommendations – Measurement and reporting tools

That DHS lead the development of standard reporting in consultation with PACs. As PAC transaction costs are already unavoidably high, the imposition of any additional administration requirements should be kept to a minimum. This means utilising information that is already collected or could be easily obtained eg from service providers.

That DHS develop and publish rigorous definitions for the cost elements used in PAC reporting so that this data is more robust and can be used for benchmarking.

That DHS and PACs consider efficient ways to report on the following matters:

- Maternity cases referred to PAC
- Refusals of PAC services especially interPACs
- The percentage of separations that receive PAC by hospital
- Funds allocated and expended by hospital
- Client satisfaction
- Care outcomes
- Reports on patients to GPs
- Re-admissions related to the provision or lack of provision of PAC data

Reference key findings paragraphs 4.162-4.165, 5.100

Recommendations – Efficiency

That DHS and PACs consider the following opportunities for improvements in efficiency:

- Greater use of e-referrals
- Continuity of care utilising the same service provider for different programs where possible
- Direct employment of allied health staff where cost savings are clearly demonstrated
- Streaming of simpler discharge cases into simple administration for assessment and case management rather than one size fits all
- Sharing legal costs for brokerage agreements
- Bulk purchasing of services (where quality of service is guaranteed to be maintained)
- Creation of a single point of entry with other related programs (provided the urgency of assessment and service provision for PAC is not lost and no additional administration burden is imposed on referring clinicians)
- Use of multiskilled staff who are co-located to handle PAC service requests
- Improved referral information to be given to service providers

Reference key findings paragraphs 4.179-4.180, 5.106-5.107

Recommendations – Brokerage agreements

That DHS lead the development of model brokerage agreements – at least two – one comprehensive for complex services (such as physiotherapy) and a simple version for simple services (such as nappy washing or dog walking).

That DHS and PACs investigate the feasibility of non-exclusive agreements for the purchase of services in bulk from large suppliers such as RDNS.

That DHS require all PACs to ensure their brokerage agreements are current and that they cover identified risk management processes such as OH&S risk management.

Reference key findings paragraphs 4.192-4.194, 5.111 and chapter 6

Recommendations – Future planning

That DHS lead an annual planning meeting of PACs (with input from stakeholders) to identify likely changes over a three year time frame to provide input into DHS policy making.

Reference key findings paragraphs 4.195-4.197