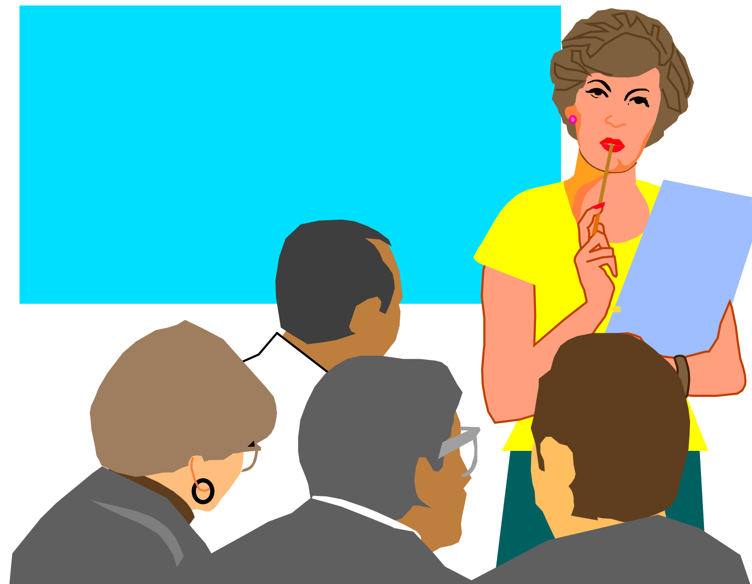
SUB-ACUTE SERVICES STRATEGIC DIRECTIONS VICTORIA

DISCUSSION PAPER



Sach & Associates
In association with:
Healthwise Consulting

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Project Brief

Overview of current sub-acute programs

1. Overview of sub-acute services in Victoria

This project is about building on the gains made in the provision of sub-acute care in Victoria and providing direction for future service development

The Victorian Sub-Acute Service System

Victoria has a well developed sub-acute service system, comparable to services nationally and internationally[1].

It has moved from institutional aged care and stand alone rehabilitation services towards models of specialist geriatric health services and enhanced community and home-based services to enable people, particularly older people, people with chronic illness, injury or disability to be supported in the most appropriate location.

The system of service delivery is unique in Australia. In particular, it includes a system of extended care and rehabilitation centres on separate campuses. These campuses have developed from public sector aged care residential, geriatric services and rehabilitation service providers into multi disciplinary sub-acute service centres many of which incorporate inpatient, ambulatory and outreach services.

Significant developments have occurred in the Victorian health system in recent years. However, further changes are needed to address the impact of population ageing and to ensure that the system can deliver quality care to all those who need it.

What is "sub-acute" care

Sub-acute care has many definitions, depending on the context in which it is considered.

At its simplest, sub-acute care is about time-limited intervention aimed at assessing and managing often complex conditions and maximising independence and quality of life for people with disabling conditions.

Most sub-acute services are used by older people. There are also other groups that need specialist sub-acute care including: children and adolescents, people with chronic illness of all ages and people with disabilities requiring post-operative rehabilitation or bursts of rehabilitation.

In some countries, this range of services is called "intermediate care", others call it "transition care" and others "sub-acute care". None of these terms are entirely satisfactory and some may limit the way we think about this form of service. The use of the term "sub-acute care", for example, implies that it is a service or intervention that follows "acute care", whereas these services are more related to a philosophy and method of care than a separate program.

Sub acute services encompass rehabilitation, geriatric evaluation and management, palliative care for all age and need groups.

[1] See Working Paper 2, *Sub-Acute Review Victoria, Literature Review* (May 2001)

2. Why are sub-acute services being examined?

The primary objective is to develop a more strategic context for the future planning of sub-acute services in Victoria to meet emerging challenges

What this project is about

This project is seeking to develop an improved framework for the future planning and delivery of sub-acute services in Victoria. The project will identify options and inform possible directions as a context for detailed policy development and planning by the Department of Human Services and Health Services.

This project is about:

- clarifying the role of the sub-acute service system
- clearly identifying how sub-acute services might be provided within a whole-of-system health perspective
- clarifying and enhancing the interface between sub-acute care and other elements of the health and community services system
- options for a more integrated system, particularly with acute services
- identifying service models that relate to the emerging future demand for rehabilitation, sub-acute aged care, ambulatory and in-home services
- setting a strategic framework to improve future service planning.

The project is set at a strategic level. It aims to set directions for sub-acute service provision for people of all ages, cultural backgrounds and people with specific needs.

Some key questions

- How can increasing demand be met?
- How do we improve access for people of all ages?
- How can we better manage the sub-acute components of the system?
- How could sub-acute services be better organised?
- What might be the optimum service balance between bed-based and community-based services?
- Should sub-acute beds be co-located with major acute hospitals?
- How could sub-acute services be best provided in non-metropolitan regions, particularly to people from smaller rural communities?
- What opportunities exist to better link components of the health system?

What will the project produce?

Directions for sub-acute service development will be identified for the short and medium term.

The major elements of the strategy will include:

- a strategic direction for better linking of sub-acute services into an integrated health system
- options for sub-acute service system development
- how the service system might better meet the sub-acute care needs of children, young people, adults and older people
- directions on how services might be organised for specialist, regional and sub regional service provision
- possible approaches for the equitable distribution of resources
- guidance on the specific issues, such as co-location of sub-acute services within acute hospital settings

3. How is this project being undertaken?

A consultant team is undertaking a four phase investigation, to be completed by mid September 2001

Project Team

Jack Sach	Project director	Sach & Associates
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Steering Committee

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The Sub-Acute Strategic Directions Project Steering Committee includes DHS, metropolitan/regional services, sub-acute service providers and a consumer representative.

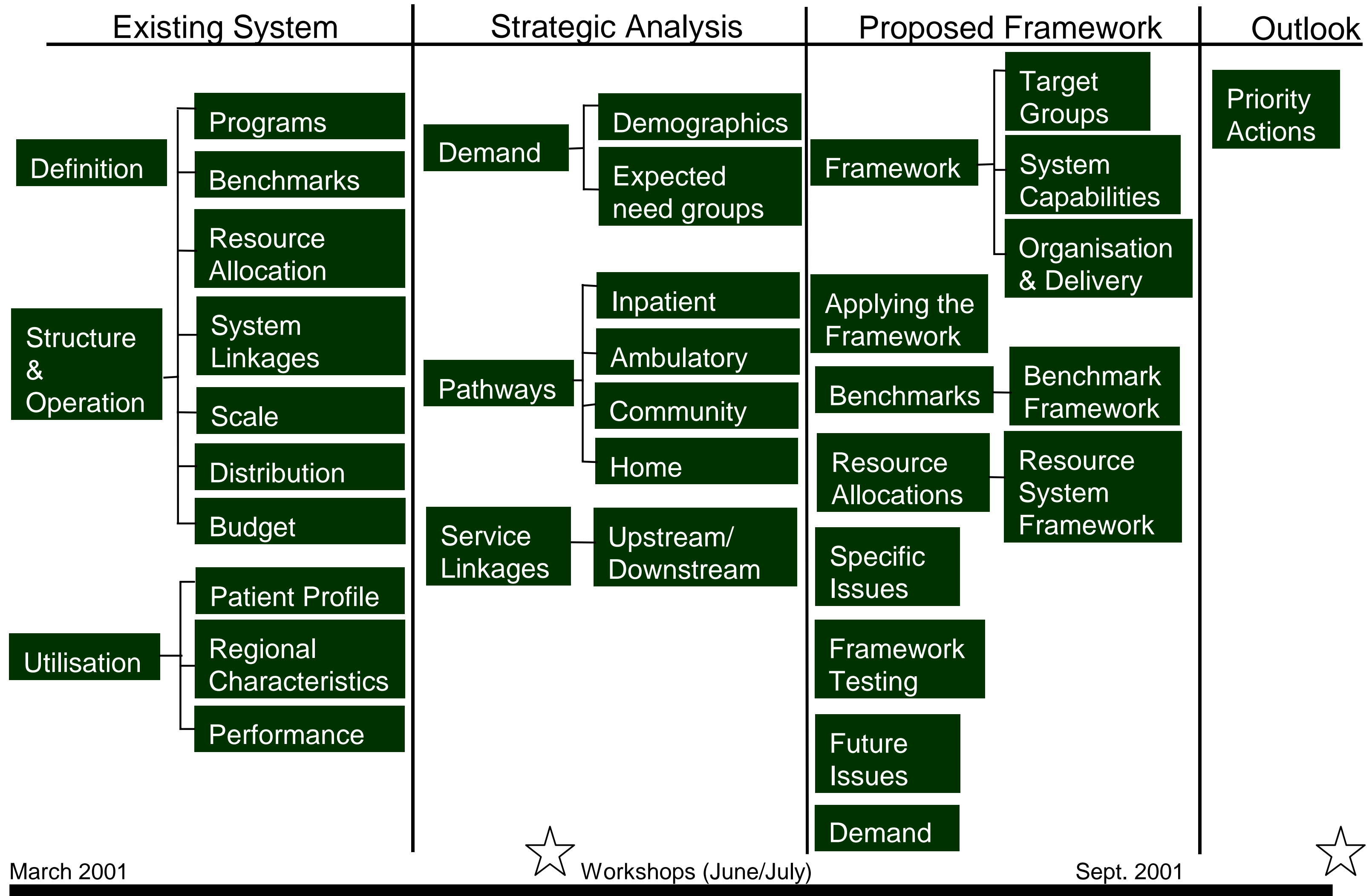
Project Map

The project commenced in March 2001 and is programmed for completion in mid September 2001.

It is being completed in four phases:

1. profile of the existing sub-acute system
2. strategic analysis
3. development of a strategic sub-acute framework
4. forward directions for the short and medium term.

Project Methodology Map



4. What is the relationship between sub-acute and other elements of the health service system?

Sub-acute health services support the continuum of care across a range of services

Health system interfaces

The interdependence of the whole health system needs to be managed. The challenge of this project is to ensure that those interfaces function efficiently and are configured to optimise continuity of care.

Sub-acute services represent only a small part of the total system. A *small* change to any part of the system over the next 5 to 10 years (such as an increase in people awaiting residential care beds) could have a *major* effect on the efficiency of sub-acute services and on capital planning.

Particular attention needs to be given to enhancement of the system to ensure that services function effectively at the following interfaces:

- sub-acute care and acute care
- sub-acute and post acute
- sub-acute care and residential care
- sub-acute care and primary care and community services sectors.

In addition, there are opportunities for sub-acute acute services to better integrate and function alongside other service sectors, bringing their expertise into the acute sector and community sectors.

Issues for consideration

The sub-acute service system is complex in its funding and service provision levels.

Examples of areas in gains might be achieved include:

- clarification of the operational links between Geriatric Evaluation & Management (GEM) and general rehabilitation in instances where they are dealing with the same patient group
- the development of clearer pathways for entry into the service system for some groups, such as children and adolescents
- the proportional allocation of the budget for sub-acute services provided in acute, sub-acute inpatient, ambulatory and in-home settings
- the future distribution of resources to optimise access for those needing a sub-acute level of care
- consideration of ways in which outpatient clinics, day rehabilitation clinics, specialist clinics and community rehabilitation clinics might be more effectively linked into a more consistent funding framework
- identification of how sub-acute services could be further developed and integrated into acute hospital settings
- clarification of the type of system that is needed for all patients to get access to treatment or support required, based on need.

5. What are the main dimensions of sub-acute service provision in Victoria?

The current services system provides a mix of inpatient beds, community and home based services.

- There are 25 designated rehabilitation providers across the State. These services provide a range of inpatient, community based and in some cases, home based services.
- They provide 949 Rehabilitation beds.
- There are 31 GEM providers across the State.
- They provide 762 GEM and Geriatric Respite beds.
- There are 52 palliative care providers across the State, including 29 inpatient units, 14 community based providers and 9 Statewide services.
- There are currently 244 palliative care beds.
- There are 43 Community Rehabilitation Centres (CRC).
- Outpatient rehabilitation provided on a "same-day" basis or as single occasions of service, is provided from a number of facilities, separate to CRC.
- Specialist clinics recognised within the sub-acute program include:
    - ♦ 15 Continence Clinics
    - ♦ 5 Falls and Mobility Clinics
    - ♦ 4 Pain Management Clinics[2]
    - ♦ Additional clinics exist funded through other sources.
- There are 14 Cognitive, Dementia and Memory Services (CDAMS) and 4 Gerodontic clinics funded within the Aged Community and Mental Health Program.

Table 1. 2000-2001 estimated public sub-acute bed provision by DHS region
(as at Jan 2001)

Region	Palliative Care Beds	Rehabilitation Beds	GEM / Other Beds	Total
Barwon South Western	16	60	18	94
Grampians	13	30	35	78
Loddon Mallee	10	77	36	123
Hume	7	45	20	72
Gippsland	11	30	34	75
Western Metropolitan	20	105	140	265
Northern Metropolitan	40	121	113	274
Eastern Metropolitan	58	189	141	388
Southern Metropolitan	70	292	225	587
Victorian total	**244**	**949**	**762**	**1,955**

(Funding is based on bed days and not beds. Therefore, bed numbers may vary.)

Beds distribution approximates to the distribution of the over 70 years age group.

[2] Department of Human Services, *Victoria- Public Hospitals Policy and Funding Guidelines 2000-2001* p60

6. Who uses sub-acute services?

Services tend to be focused on older people. However, current service use, in part use reflects service availability and service type.

Inpatient services

- 62% of sub-acute patient separations were aged 70 years or older. However, this varies from 36% in Rehabilitation Level 1, 50% for Rehabilitation Level 2, 60% for Palliative Care and 86% for GEM.
- 75% of bed days were used by people aged 70 years and older.

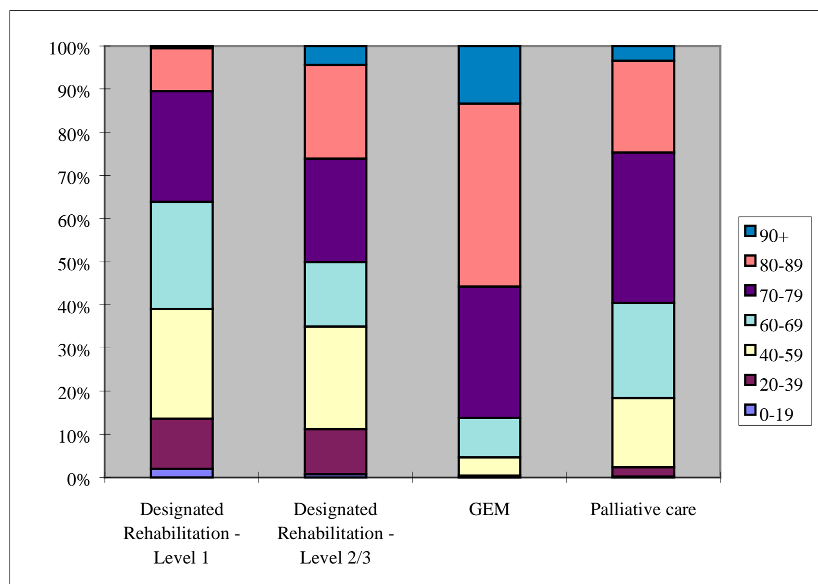


Figure 1. 1999-2000 public sub-acute patient separations by age group and care type

- 71% are referred from either another hospital or acute care at the treating hospital.
- 72% of rehabilitation patients are discharged home, 50% of GEM patients, 29% of palliative care patients and 20% of nursing home type.
- 14% are discharged to residential care services.

Private hospital sub-acute patients receiving rehabilitation:

- 60% female
- median age 76 years
- 81% transferred from another hospital
- 86% discharged home.

The sample is influenced by funding and admission policies to the private sector.

Community Rehabilitation Services

Limited data was available on CRC use as not all agencies are currently reporting. However, from the available data:

- 61% were aged 70 years or older
- 60% of CRC clients are female (2000-2001 March YTD)
- 34% were referred by a GP, 30% from hospital inpatient units
- 20% of clients attended for orthopaedics, 17% for pain and 9% stroke.

Data on community based palliative care was not available for inclusion in this report and data on other sub-acute ambulatory services is incomplete.

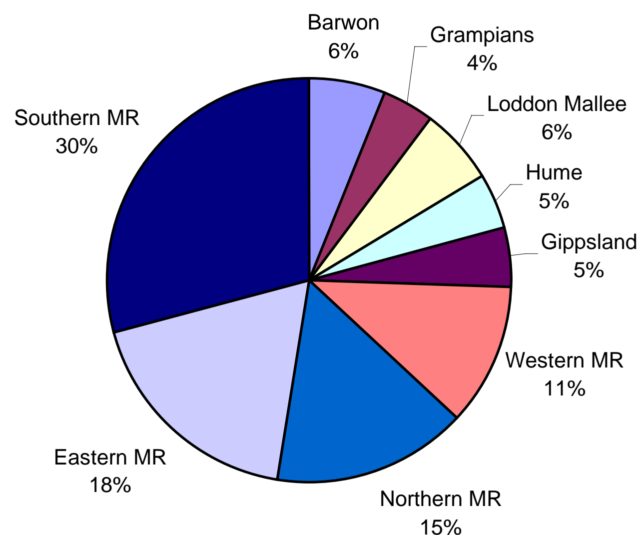


Figure 2. 1999-2000 patient separations by region of residence.

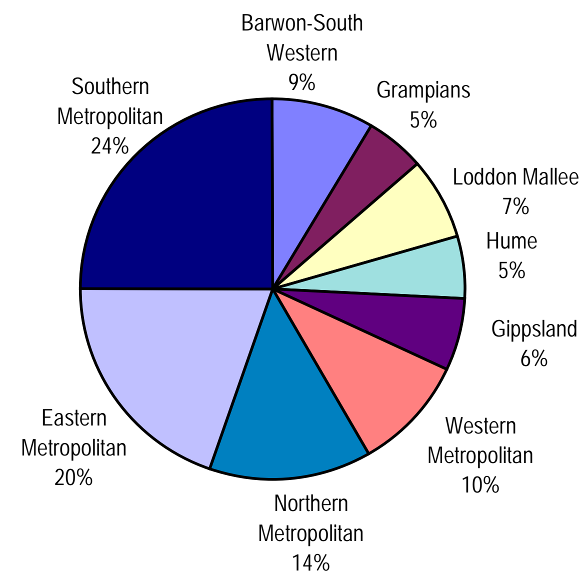


Figure 3. 1999-2000 population aged 70 plus by region of residence.

Distribution of sub-acute inpatients

- 74% of inpatient separations are resident in the metropolitan area (Fig 2)
- 68% of the population aged 70 plus are resident in the metropolitan area (Fig 3)
- 73% of bed days are provided to residents in the metropolitan area
- Nearly half (48%) of all sub-acute inpatients live in the Southern and Eastern Metropolitan Regions.

7. What will drive future demand for sub-acute services?

Research indicates that the ageing of the population will exert an increasing pressure on the service system. The planning and service structure should have the capacity to adapt to a major structural shift in demand particularly after 2011.

The next 10 years

It is well understood that future demand will be driven by demographics - there will be more older people. However, the issue is more complex.

The main demand drivers for sub-acute services include:

- population ageing: The number of people over 70 years in Victoria is expected to increase by 77,171 between 2001 and 2011. There will be 519,734 people over 70 years in Victoria by 2011[3].
- the distribution of older people: two thirds of the 70+ population will be in metropolitan regions.
- incidence/prevalence of disease
- changing community expectations
- access to private services
- access to residential care
- reduced carer availability
- increased responsiveness to people with a disability and people of cultural and linguistic diversity.

Changes within the health and aged care system are creating specific challenges for the health system. Reduced acute length of stay and service demands are producing higher patient throughput and this is having a flow-on effect. Similarly, the availability of community services and residential care places impacts on the sub-acute service system. Consideration will need to be given to the most effective strategic role within the sub-acute sector to support patient care. Attention internationally is being given to a wide range of possible approaches including GEM units, community-based services, sub-acute service delivery, ambulatory service development, disease self management and other approaches. The Victorian health system already includes many of these elements and is well positioned to make further advances.

Looking beyond 10 years.

It can be expected that sub-acute services will become more significant within a future health system.

Although this Review is about the next 5 to 10 years, there is a need for system development to also take account of the next decades. Whereas in 2000/01 the aged population (over 65 years) accounted for 12% of the national total, by 2030/31 it will represent 22%. Another perspective may be obtained from the aged dependency ratio (the proportion of the aged population to the non-aged population) which is expected to increase from 18% today to 36% by 2030/31. These are very major changes. Any significant future policy changes could also impact on service demand.

[3] Department of Infrastructure *Victoria in Future,* 2000

8. To what extent do we meet the sub-acute health needs of all groups?

Whilst older people consume the most acute and sub-acute services it is important that the future sub-acute strategic framework recognises all groups requiring this level of care.

Need groups

The future sub-acute service system should support the needs of all age groups, disability groups, ethnic communities and indigenous people.

A sub-acute service system should have the capacity to respond to the following (overlapping) need groups:

- people of all ages with specific conditions who would benefit from rehabilitation
- children and adolescents with congenital, acquired or long term conditions
- people with severe deconditioning/disability following prolonged hospitalisation or critical illness
- adults (non-aged) with chronic, recurring conditions who would benefit from periodic rehabilitation
- older people with chronic or interrelated conditions
- people who are dying, with active, progressive and far advanced disease and little or no prospect of cure.

The needs of carers and family also need to be incorporated as part of the service response.

Service types

Currently, the main services are:

- **Assessment and management**

Assessment and management provides episodes of care for (usually older) people with complex and unstable, multi-dimensional medical problems, often associated with disabilities and psychosocial problems, for whom the primary treatment goal is maximising health status and or optimising living arrangements. Functional gain may be a by-product, but is not the primary goal. [4]

- **Rehabilitation**

Rehabilitation is an episode of care for a person with a disability for whom there is a reasonable expectation of functional gain and for whom the primary treatment goal is improvement in functional status.

Rehabilitation seeks to meet the needs of people following an acute episode or catastrophic event and people with a progressive or chronic recurring condition who need bursts of rehabilitation over a long period.

- **Palliative care**

Palliative care is provided when the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary approach that considers the physical, psychological, emotional and spiritual needs of the patient; and grief and bereavement support service for the patient and their carers or family.

- **Related needs**

There is also a set of services that are complementary to the sub-acute services which may benefit from co-location. These services include care whilst waiting placement and respite care.

[4] Prof Peter Disler Professor of Rehabilitation University of Melbourne

9. What should be the capabilities of the sub-acute system?

The sub-acute service system combines a range of skills to deal with the complexities of managing the care of sub-acute patients

Delivering the care

A sub-acute service system should provide a range of skills to address the needs of people with chronic illness, terminal illness and disability.

The capabilities of a sub-acute system might include:

- Services to achieve functional gain, restorative care and management of complex medical conditions
- Integrated inpatient, community and home-based care
- Geriatric medicine
- Specialist rehabilitation assessment and treatment
- Time limited and goal oriented care planning
- Specialised nursing care and allied heath therapeutic interventions
- Review and management of patient medications
- Complex discharge planning and follow up
- Terminal care
- Culturally sensitive policy and practice
- Research, teaching and training
- Consultation and liaison service to acute, community services, general practitioners and residential care services
- Information, education and prevention programs for patients, families and carers
- A multidisciplinary care model.

Many of these capabilities currently exist. There is a need to ensure that they are adequately reflected in all services and further developed where there are service gaps.

Some forward directions

Not all of the potential of the sub-acute service system is currently realised. This reflects a traditional focus on bed based services and innovation through the development of ‘one off’ programs that are not well generalised through the system or supported by a broader policy context. Current expenditure is largely focused on bed based services.

The ageing of the population and increasing consumer expectations will increase demand for sub-acute services. Sufficient capacity needs to be available in the sub-acute system to enable rehabilitation to be provided to enhance quality of life, even when the outcome may be residential care.

Further, the capabilities which exist in the sub-acute sector are extremely valuable. These capabilities could be further developed and harnessed to work with acute care and community based service providers to reduce hospitalisation, better manage people with chronic illness and disability within the community and reduce the acute and sub-acute length of stay in hospital for those requiring an admission. Better coordination between all services is increasingly important. This is being pursued through initiatives such as Primary Care Partnerships, Multi-Purpose Services and other innovations.

10. How might we achieve an optimal mix of services?

Finding the right balance in service delivery is critical in promoting access to services, responding to community preferences and making the best use of available funds.

Sub-acute service modalities

Sub-acute services can operate across a range of modalities:

- collaborative health promotion, injury prevention and early intervention
- consultation and liaison
- ambulatory care
- home based care, and
- inpatient care, either in the acute or an extended care setting.

There is a need to have an appropriate supply and balance between all components of the system in every region. The absence of any component or their incorrect sizing has an effect on effective patient flow and is a contributor to bed blockages and sub-optimal care planning. However, it is recognised that bed blockages are also influenced by the availability of both community and residential care services.

Principles to guide service development

Some of the principles which might guide the development of sub-acute care within an integrated health system framework include:

- **Prevention**: disease management, health promotion and early intervention.
- **Equity of access**: availability of services to all those needing sub-acute care.
- **Service mix**: a mix of inpatient, ambulatory and home-based services in all regions to address local priorities. A range of service intensities is required across all settings to promote care in the environment most appropriate for the patient and family. Inpatient beds are just one option in the continuum of care.
- **System linkage**: the development of systems to optimise patient management and flow.
- **Service quality**: the establishment of a quality framework and appropriate performance indicators to measure quality, monitor service performance, accessibility and value for money.
- **Appropriateness:** the provision of services which are culturally appropriate and respond to consumer preferences and needs.
- **Streamlined funding and reporting:** program funding which provides like funding for like services across agencies. An integrated client management system which streamlines reporting and promotes accountability.

11. Are there some services that should be provided on a supra-regional or statewide basis?

State level services can provide a high quality service for complex, low volume client groups. However, they need effective links to local providers.

Need for some supra regional or statewide sub-acute services

There are some sub-acute services that are highly specialised and meet the needs of small numbers of people. These are currently recognised within the Victorian sub-acute system as Level 1 services and include amputee, head injury and spinal rehabilitation services. Regional population-based benchmarks are an inappropriate mechanism for planning such services. There is a need to identify these service types and establish an appropriate method of service provision.

Benefits of specialised services

State level/supra regional, sub-acute services have the following benefits:

- a critical mass of expertise to provide high quality care to high complexity, low volume patient groups
- teaching, training and research focus
- an identified base for Professorial positions
- consultation and liaison support to regional providers.

Limitations

A statewide or supra-regional service model may have limitations:

- all areas may not have the same access
- non-metropolitan regions may receive limited support.

Main issues for strategic planning

- There is a trade-off between specialist sub-acute expertise and local access for all people needing the service.
- Consideration needs to be given to the identification of specialist sub-acute services and the number required in each category.
- There is a need to establish and resource a system to enable a consultation and liaison service to work effectively, including the use of technology, such as e-health.

Are the current arrangements satisfactory, or is there a better way?

12. What are core regional sub-acute services?

There is need for a clear, equitable, integrated set of sub-acute service arrangements in every region.

Current configuration

Geriatric and Evaluation Services are provided from 31 services throughout Victoria, many of which also provide rehabilitation services.

There are 25 designated rehabilitation services in Victoria providing Level 1 (spinal, amputee, head injury) or Level 2 (other rehabilitation) services.

There is also a variable range and distribution of community rehabilitation centres, clinic programs, bed substitution programs, community and home based sub-acute services.

Extended care centres have developed as significant sub-acute service sites and include a combination of inpatient, ambulatory and community-based services, with well developed links to Aged Care Assessment Services, Community Aged Care Package (CACP) providers, Linkages Programs, HACC services and others. Traditionally, they also included significant public sector residential care services. In metropolitan areas and some major regional centres, nearly all sub-acute services are provided from these sites.

Key questions

- Which sub-acute services are best provided on separate sites?
- Which sub-acute services would best operate by clustering?
- Should sub-acute services be co-located with acute?
- Should residential aged care facilities be co-located with sub-acute inpatient services?
- How can access to sub-acute services on extended care centre sites be improved for all groups?
- What else needs to change?

Key functional relationships

There may be benefits in clustering related sub-acute services on single sites (including co-location on acute hospital sites) to facilitate continuity of care and to take advantage of various service synergies:

- *specialist rehabilitation/general rehabilitation*. General and specialist rehabilitation services require access to the same range of consultant and allied health professional services, and may share rehabilitation facilities (eg hydrotherapy).

- *people requiring complex medical care*. People with multiple pathologies may benefit from services provided by either geriatric medicine or rehabilitation medicine. Services can be designed in a coordinated manner to meet the needs of these groups.

- *ambulatory and home based sub-acute services.* Better access to ambulatory services and improved continuity of care could be facilitated by integrated management of inpatient, community and home based sub-acute services.

- *older people requiring secure services.* Acute psychogeriatric and GEM for people with challenging behaviours are services that may benefit from clustering.

- *hospices.* Hospices are compatible with other sub-acute services and could benefit from the range of services available on a sub-acute site.

- *critical mass.* Sufficient services need to be available to promote economies of scale and teaching, training and research activities.

Potential role of regional sub-acute providers

General themes:

1. *Change of image.* Most extended care centres have an aged care heritage. Consideration will need to be given to improved access for all age groups to all significant sub-acute service centres.

2. *Integration.* There is a need to plan for sub-acute service provision in a range of locations to facilitate improved continuity of care across the health system. Extended care centres could be recognised as significant but not exclusive sub-acute service provider sites.

3. *Sub-acute site differences.* A generic model for a sub-acute service mix on a single site is likely to be inappropriate due to existing infrastructure investment, local needs, existing service regimes and flexible service provision.

4. *Residential care.* There appears to be no *functional reason* for residential aged care to be located with sub-acute centres. Ideally, residential aged care services should be provided in a community setting. However, residential aged care for people with complex conditions may be compatible with sub-acute services, given that the Commonwealth Residential Care Program does not promote specialisation.

Sub-acute service arrangements

One option might be to build on existing arrangements by developing a sub-acute service framework that has certain key components.

The system might recognise three service levels:

1. *State level or multi-regional sub-acute services:* The identification of key services that provide a State level or multi-regional liaison and consultancy role. These services could be co-located with other general sub-acute services.

2. *Regional clusters:* A full range of key sub-acute services including inpatient and community delivery methods to all those requiring sub-acute care. These could be co-located with acute services or on stand alone sites according to key service relationship needs.

3. *Sub regional clusters:* Fully integrated sub-acute services which might include small numbers of sub-acute beds (GEM, rehabilitation, palliative care) and ambulatory sub-acute services in a rural setting. Home-based services could be provided for nearby locations and brokered for more distant locations. A single set of allied health services support all levels of care. Example: Multi-Purpose Service (MPS) providers.

Are there other basic frameworks that might be used to guide the development of a clear, equitable set of sub-acute service arrangements?

13. What might an integrated sub-acute ambulatory care service include?

A prominent sub-acute ambulatory care service is strategic to overall system efficiency and effectiveness.

Ambulatory sub-acute

Ambulatory sub-acute care may be defined as the provision of targeted rehabilitation or aged care management of patients on a non-inpatient basis for a limited duration.

Current configuration

Sub-acute ambulatory services are currently variable in distribution and quantity.

They are provided by:

- outpatient clinics
- same day rehabilitation services
- community rehabilitation centres
- "specialist clinics": clinics recognised by the DHS sub-acute program: continence, falls and mobility and pain. ACMH Division funded clinics: CDAMS (cognitive, dementia and memory services) and gerodontic.

Home-based sub-acute services have also developed in recent years. These are currently highly individualised and small in number.

They are provided through a range of approaches:

- Unassigned GEM (block funded value of 12 beds worth of funding)
- GEM/Rehabilitation Continuum of Care (inpatient staff provide care at home)
- Rehabilitation and GEM in the Home (cashed out bed days program)
- Post-Acute Care Program – brokered home based services and supports (recently extended to sub-acute patients, April 2001).

How should community and home-based sub-acute services be made more accessible? What is the potential of such programs within a sub-acute service framework for the future?

Sub-acute ambulatory service capacities

Some elements that could be considered as part of an ambulatory service include:

- specialist diagnosis and care planning
- outpatient care
- short term treatment programs eg defined pain management programs
- longer term follow up and review
- bursts of treatment for people with chronic or recurring conditions
- direct linkage to the main service interfaces, especially acute and community services.

The target groups for such a service could include people of all ages and conditions who would benefit from ambulatory rehabilitation.

The service setting could be centre-based and/or home-based depending on client needs.

14. How might we better serve rural communities?

Rural communities should be an acknowledged part of a sub-acute service system based on appropriate service arrangements

Smaller communities may have limited access to sub-acute services such as specialist medical services and allied health services.

This is mainly due to:

- low demand to support viable specialist medical services
- allied health, medical and nursing workforce limitations.

A common strategy is to:

- provide sub-acute services in district or sub-regional centres and clients travel to the service. Whilst practical, this approach has limitations such as transport constraints, higher inpatient care than is required by the presenting condition and social dislocation
- support people in their home and local communities through community nursing and home-based services.

Some ideas for discussion

1. Plan the delivery of all health services together

System limitations in local areas appears to occur when services are individually funded. This often results in funding for part EFT positions. In contrast, integrated approaches illustrate how allied health services can support acute, sub-acute and community care needs.

2. Base planning at a sub-regional level

Integrated sub-acute service planning needs to extend down to the sub-regional district level.

3. Provide the right balance of services

An imbalance in the range of services can impact on total health service performance. For instance, an inadequately resourced service may produce care plans that lead to residential care, which is limited in supply, which then impacts on the use of acute beds.

4. Improve access to regional sub-acute services

Regional service consultations may be more effective if low cost self supported accommodation is provided to enable the patient to remain on-site over several days.

5. Extend program funding down to the sub regional level

The incorporation of defined baseline sub-acute funding to sub-regional providers can underpin rural service responsiveness.

6. Increase local service ownership of services

Local communities are often provided with outreach services which may be variable. Ways of linking funding to existing local services warrant discussion.

7. Learn from successful approaches to integrated care

Multi-Purpose Services (MPSs), Rural Health Streams and related programs are illustrating the benefits of flexible, cashed-out approaches to service provision.

Overview:

Existing innovations indicate that it is possible to provide an effective general sub-acute service to rural communities, if funding streams allow for high levels of local service flexibility and services are integrated. However, there is a need to balance local access with the provision of good quality services which are often difficult to deliver directly to smaller communities.

15. Where are sub-acute service funds spent and are planning benchmarks met?

There is an emphasis on bed-based sub-acute services, with community-based services being relatively undeveloped in some areas.

The sub-acute service budget for each program stream is built up from a combination of fixed grants and measures of output such as bed days, occasions of services or episode funding. In 2000-01, the sub-acute services budget equates to $275 million (including some specialist clinics and palliative care funded through ACMH).

- 78% of funding is budgeted for inpatient services (Fig 4).

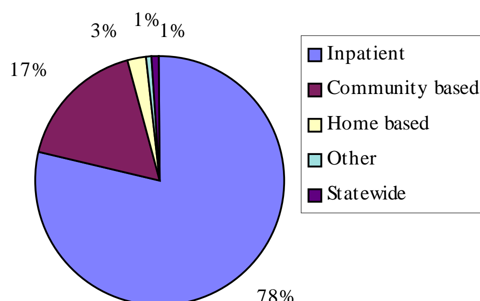


Figure 4. 2000-01 Sub-acute service funding by mode of delivery

- 49% of funding is budgeted for rehabilitation services that are provided from a range of facilities (Fig 5).

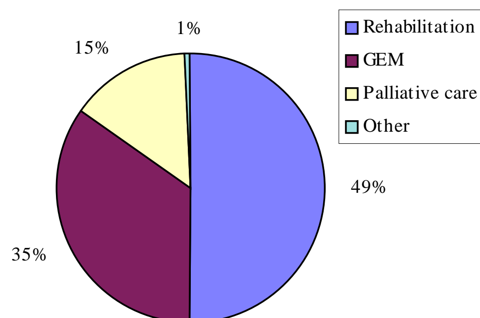


Figure 5. 2000-01 Sub-acute funding by program type

- 28% of the Victorian population currently live in rural regions (2001).
- 32% of the population aged 70 years plus live in rural regions
- 26% of funding is budgeted for rural and regional services (Fig 6).

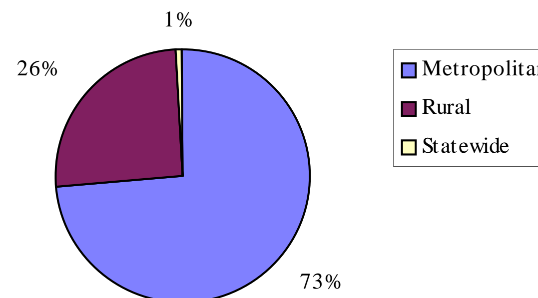


Figure 6. 2000-01 Sub-acute service funding by rural and metropolitan regions.

Current benchmarks

- Planning benchmarks for inpatient sub-acute are[5]:
  - Rehabilitation: 3 beds per 1000 persons 70 years and over
  - GEM: 2.5 beds per 1000 persons 70 years and over
  - Palliative care: 50 beds per 1 million persons
- Based on current benchmarks and 2001 population estimates, Victoria is 379 GEM and 344 rehabilitation beds short. Palliative care beds approximately meet benchmarks.
- 70% of Level 1 and 50% of Level 2 patients are under 70 years and this raises questions about age-based benchmarks.
- Current CRC benchmarks show a deficit of 247 full year places in the metropolitan area and 189 in rural regions.
- There is a need to examine whether bed-based or similar benchmarks are an appropriate method for determining need and whether such measures are sensitive enough to reflect differences between regions.

[5] Acute Health Division *Victoria - Public Hospitals Policy and Funding Guidelines 2000-2001* June 2000 p57

16. How might we introduce a better planning framework?

The future is about providing a logical regional service framework, which promotes equitable access, continuity of care across the entire episode of care, balances beds and community services and ensures that all people needing time-limited support services can get the level of care they need.

Equitable access

Current age based benchmarks for sub-acute services fail to recognise regional variations in morbidity, the differing demands of the old and very old or access to private rehabilitation services.

No evidence was identified in the academic literature of benchmarks being applied to sub-acute services.

The framework will need to determine an appropriate level of service delivery required to ensure access to:

- high and low intensity ambulatory care for community based and post inpatient care
- home based care, when appropriate
- specialist and general rehabilitation, evaluation and management and hospice beds.

Questions for further consideration include:

- Are benchmarks which focus on the population, particularly people aged 70 years plus, appropriate?
- What is the best way to equitably allocate resources in the future?
- Should benchmarks include private service provision?
- Are there better alternatives to the current benchmark approach?
- Should sub-acute services be planned in isolation or should there be a link to other services, such as acute? For example, should all community level hospitals have sub-acute beds? Should all acute stroke units have access to on-site rehabilitation units?
- At present sub-acute is tied to separate beds. Is it a specialist service to be retained in its own beds and services or is it a service which should access any hospital beds?

Resourcing

Resources need to be flexible to accommodate fluctuations in demand, seasonality and increasing moves towards ambulatory and home based care.

One possible strategy is for each service component to be weighted to enable flexible service provision, such as sub-acute WIES. Such a system might enable service substitution between inpatient, ambulatory and inpatient care.

It would also be possible for output funding to be developed to incorporate services provided in the outpatient setting, multidisciplinary clinics, various levels of intensity of community based rehabilitation, home based care and inpatient care. One approach would be for each sub-acute service provider to have a budget which recognises each element of care, but with funding able to move across settings, within agreed targets to promote flexible service provision. Relative value units could be developed over time to support system flexibility and accountability.

"Program Guidelines" could be developed to give providers flexibility to configure services according to their community's needs, whilst providing accountability for funds.

There is a need to further develop mechanisms to track process and outcome indicators, accountability, cost efficacy and to justify resource allocation.

What other approaches should be considered?

17. Where to from here?

Participation is invited through workshop forums and written submissions.

Workshop Forums

Three workshop forums to choose from:

- **Bendigo**:
  Friday 29 June 10am to 1pm Salvation Army Gravel Hill Community Arts Centre
- **Central Melbourne**:
  Wednesday 4 July 10am to 1pm Melbourne University, Union Building, Grand Buffet Hall
- **Southern Region:**
  Tuesday 10 July 10am to 1pm Ashley Ricketson Centre, Caulfield General Medical Centre.

Submission welcomed

Email: subacute.data@dhs.vic.gov.au
Please, respond to the issues listed on the Worksheets, or, make your own submission.
If you wish to download the worksheets, these can be obtained from: www.dhs.vic.gov.au/ahs/quality/subacute.htm

Closing date: Friday 20th July 2001

Sub-Acute Strategy
WORKSHEET 1: CURRENT SUB-ACUTE SYSTEM LIMITATIONS?

Main question:
What are the main issues with existing service provision?

1. List sub-acute service issues that require reform

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2. Nominate your top four issues in priority order

1.
2.
3.
4.

Some discussion prompts:
- Balance between bed-based and community based sub-acute services
- Bed blocking
- Boundary issues between acute, sub-acute, community, home care services
- Access to residential care
- Public/private sector roles
- Rehabilitation/GEM overlap
- Understanding the system
- Meeting the needs of all people
- Funding issues

Sub-Acute Strategy
WORKSHEET 2: SYSTEM ACCESS

Main question:
Whose needs are not well served under the current arrangements?

List (in column 1) groups of people who currently have difficulty in accessing time-limited rehabilitation services and identify what they need from the system (column 2).

GROUPS	SUB-ACUTE NEEDS

Sub-Acute Strategy
WORKSHEET 3: SPECIALIST, REGIONAL AND RURAL SERVICES

Main question:
What needs to change to provide a better sub-acute service to people of regional and rural Victoria?
How should statewide services support regional and rural services?

1. ***List service provision issues for regional and rural communities***

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2. ***Identify how the main shortcomings might be addressed***

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Sub-Acute Strategy
WORKSHEET 4: DESIGNING THE FUTURE SERVICE FRAMEWORK

Main question:
What would a good sub-acute system contain?

1. What are the priorities for action?

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Some discussion prompts:

- *Service capabilities*: What should the system be capable of delivering?
- *Services components*: Consider: inpatient, ambulatory, home-based services
- *Service balance:* Balance of inpatient and community/home services?
- *Links*: Links between acute, community and residential sectors?

2. Priority changes

Nominate two or three changes that should be made for each time period

Immediate

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Within the next 2 to 3 years

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-

Within 3 to 5 years

-
-
-

Appendix: Project Brief

The objective of the project is to provide a clear strategic and service planning framework, which identifies the type, amount and position of sub-acute services needed to meet the growing demand expected over the next 5-10 years.

Therefore, the primary objective of the project is:

- **development of a sub-acute service plan strategy that provides a framework for future planning of sub-acute services.**

Additionally, using a review of current literature and system monitoring data, and following thorough consultation with professional organisations, health services, hospitals, DHS and consumers, the contractors shall provide advice to DHS on a capital and service planning framework for sub-acute care services in Victoria and produce a report which:

- Publishes a review of the literature on sub-acute service provision relevant to the issues covered in this project;

- Clearly defines the characteristics of current service provision of inpatient and ambulatory sub-acute services (including programs delivered in the home and people awaiting nursing home placement) and specialist clinics within the Victorian public hospital system with particular reference to the clinical and demographic characteristics of the clients utilising sub-acute services, local catchment area profiles and any change in these characteristics that are apparent;

- Analyse the current sub-acute service utilisation and describe the trends and patterns of service provision across the State.

- Investigates the suitability or otherwise of co-location of sub-acute facilities with acute health facilities and with residential care facilities.
- Makes recommendations on the optimal role and functions of services to foster a continuum of care for people with chronic health needs.

- Makes recommendations on the ideal make up, size and positioning of services.

- Makes recommendations on one or more benchmarks for provision of Sub-Acute inpatient services including rehabilitation beds, geriatric evaluation and management beds, community rehabilitation clinics and specialist clinics or whether this is the best approach for determining appropriate levels of service provision over time. If the contractor makes recommendations on an alternative framework for planning for sub-acute services, this should be fully documented;

Makes recommendations on the optimum, maximum and minimum size of sub-acute services including Sub-Acute inpatient facilities, number and distribution of rehabilitation beds, geriatric evaluation and management beds, interim care beds, community based ambulatory and services in the home within Victoria to adequately service the aged community in Victoria. Particular attention should be made to the appropriate mix of inpatient, community and ambulatory services; possible future modes of service delivery; and projected future demand and supply of services including substitution of ambulatory, domiciliary and outpatient services for inpatient services where appropriate.

Department of Human Services

APPENDIX: Overview of Current Sub-Acute Programs

Sub-acute service	Description	Current benchmark
Inpatient services		
Rehabilitation care	Care in which the clinical intent or treatment goal is to improve the functional status of a person with an impairment, disability or handicap. It is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames that are evaluated by periodic assessment using a recognised functional assessment measure. The **primary treatment goal is improvement in functional status.** Designated Rehabilitation providers provide rehabilitation services.	3 beds per 1,000 population aged 70 years plus
Geriatric Evaluation and Management (GEM)	Geriatric Evaluation and Management is an episode of care provided for a (usually older) person with complex and unstable multi-dimensional medical problems often associated with disabilities and psychosocial problems for whom the primary treatment goal is maximising health status and/or optimising living arrangements. **Functional gain may be a by-product but is not the primary goal.** Designated GEM providers provide GEM services.	**Geriatric Evaluation and Management** and **Respite** beds combined: 2.5 beds per 1,000 population aged 70 plus.
Geriatric respite	Admission for care and support of a person with a stable, pre-assessed condition requiring accommodation, clinical and nursing care to provide relief for carers. Geriatric respite includes both planned and unplanned respite: • Planned geriatric respite care is provided for a planned or booked admission of a person in order to provide relief for carers • Unplanned respite provides accommodation and care when an emergency or crisis has occurred, including an episode of ill health for the carer. In both cases, the patient does not require assessment of clinical care over and above that which would normally have been provided in the usual place of residence.	As above.
Non-acute	This care stream seeks to maintain the function of people awaiting residential care placement who no longer require acute care. Often these patients are classified as Nursing Home Type (NHT) and most remain in the acute setting.	Benchmarks not applicable. Most in acute beds.
Palliative care	Care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and grief and bereavement support service for the patient and their carers/family.	50 beds per 1 million population.
Ambulatory care		
Community Rehabilitation Centres	Community Rehabilitation Centres (CRC) provide community based access to diagnostic and treatment programs that have an emphasis on rehabilitation. They are commonly linked to Extended Care Centres, rehabilitation hospitals or acute public hospitals. CRC are defined as providing a multi-disciplinary rehabilitation service to enable clients who are disabled frail, chronically ill or recovering from traumatic injury to achieve and retain optimal functional independence.	Metropolitan: 1.5 CRC places per 1,000 population aged 70 plus. Rural: 3.5 places per 1,000 population aged 70 plus.
Outpatient services	Outpatient services are currently provided by some services following an inpatient admission. Services include medical review and follow up allied health services. Some outpatient services are currently provided as "same day" admissions.	No benchmarks currently available.

Sub-acute service	Description	Current benchmark
Specialised sub-acute clinics	There are five recognised specialist sub-acute clinics: **Continence Clinics** provide: • an accessible, multidisciplinary clinical service specialising in incontinence and other bladder and/or bowel function difficulties; providing assessment, diagnosis, management, education and support to improve continence for clients. The service will also provide consultancy, education and support to carers, relatives and professional service providers. **Falls and Mobility Clinics** provide: • specialist multidisciplinary services, which focus on the assessment and management of clients with falls, mobility and balance problems. Clinics commonly provide time limited, specialist intervention to the client and advice and referral to mainstream services for ongoing management. They provide education and training to clients, to carers and to health professionals. **Pain Management Clinics** for older people provide: • specialised referral services, mainly for older clients who continue to be troubled by chronic non-malignant pain despite usual medical and community care. Multi-disciplinary services arr provided to address the medical, physical and psychosocial aspects of pain. Management strategies are developed to assist clients. PMC services usually have a self management and predominantly non-vocational and non-procedural focus. **Cognitive dementia and memory services (CDAMS)** provide: • early diagnosis, appropriate preventive treatment and advice, support and referral to appropriate services for people with cognitive difficulties causing confusion, memory loss or thinking problems, and their carers • consultancy, education and support to carers and professional service providers throughout the various stages of a person's cognitive impairment and deterioration • general information and advice to any person or service in contact a person with a cognitive impairment. **Gerodontic clinics** provide**:** • an accessible interdisciplinary service that aims to promote oral health, prevent and manage oral disease, relieve symptoms and restore and maintain function by assessment and management of less complex oral health needs through both clinic based and outreach services • consultancy, referral, education and support to clients, carers and professional service providers.	No benchmarks currently available.
Home based care	A variety of home based services exist across agencies. These are funded through a variety of sources including: Rehabilitation in the Home, Therapy in the Home, Post Acute Care, Unassigned GEM and Continuum of Care. These services generally seek to substitute home based care for inpatient bed days through a reduction in average LOS or through the prevention of a hospital admission.	No specific benchmarks are available. However, given that the funds are generally cashed out bed days, these services will fall within the current bed ratios.
Related services	A number of services are related to sub-acute care. These include: ABI Slow to Recover, psychogeriatric services and others	