	Consultant's Recommendation	DHS Response
1	*That DHS accepts the principles and strategic objectives identified in this report as the agreed basis for reform of the VACS funding and classification model.*	Agreed.
2	*That DHS implements an Enhanced VACS model as the basis for funding and classification of outpatient services.*	DHS agrees that the enhancement of the existing VACS funding and classification system represents the best approach to maximising the value and appropriateness of output based funding for outpatient services in the absence of a true patient-level clinical classification system.
3	*That DHS considers more fundamental reform of outpatient funding over the longer-term, including the possible establishment of a single funding framework across all ambulatory services, and the option of bundling the outpatient episode with other related services conditional on other developments including the introduction of patient-level data for outpatient services.*	In the longer term, DHS anticipates undertaking further work in the area of episode of care funding and aggregation of similar funding streams within a common framework.
4	*That the Enhanced VACS model be based largely on the continued use of clinical specialties as the organising dimension.*	In the absence of high quality, detailed patient level data that includes diagnoses, procedures, and treatment modalities, a clinic-based approach is considered the next best proxy.
5	*That DHS set a single target across all VACS variable activity for each health service. VACS variable activity will include medical/surgical, allied health, multidisciplinary care, care plan conferencing, and early assessment and linkage services.*	The establishment of single targets combining medical/surgical, allied health, and new service categories would facilitate substitution and would further devolve clinical management decisions to health service executives. DHS agrees to further explore this proposal subject to impact assessment and appropriate transition arrangements.
6	*That DHS allow health services flexibility regarding the locations in which they use their VACS funding, subject to DHS and health services jointly considering the service planning implications of any significant changes to the proposed use of VACS funding by individual health services. Locational flexibility includes other public hospital campuses and non-public hospital settings.*	Setting single targets at a health service, rather than campus, level would promote greater flexibility in location of services to maximise use of facilities and economies of scale.
7	*That DHS proceed to introduce weights for individual and relevant group allied health services, noting that:* ➢ *Further work will be required to improve costing data with estimation or modelling of weights in the short term; and;* ➢ *Definitions of 'group' encounters for allied health services will need to be developed, together with business rules to ensure appropriate counting of group and individual allied health sessions.*	While some preliminary cost data exists, it is not representative of all health services. Due to the high volume of allied health services, any sudden change to funding through allocation of cost weights may have a significant impact within and between health services – more work is required to model this impact and move progressively from static to variable weights. The delivery of allied health services within a group context can be both efficient and effective, though these may be intermixed with concurrent individual treatment programs and may only be applicable to certain allied health disciplines. In general, DHS acknowledges the additional staffing effort often expended in a group setting and will work to identify appropriate funding levels and business rules.
8	*That the VACS Clinical Panel review whether there are distinct patient cohorts within oncology, neurosurgery and cardiothoracic to determine possible splitting of these VACS categories. Splitting of VACS categories should reflect clinical grounds, rather than simply variations in the costs of services.*	Although the review has identified a number of potential VACS splits on the basis of inputs (diagnostic procedures) and costs, the clinical determinant has not been identified. Further, current cost differences arising from high cost diagnostics may be ameliorated through the increased use of private services. The VACS Panel (or similar clinically based review process) would seem to be an appropriate mechanism for review of VACS splitting proposals where health services would need to identify and describe particular clinical patient cohorts and demonstrate a clear cost relationship for consideration of establishing new VACS categories and appropriate cost weights. New categories would need to be defined in clinical terms that can be assessed at patient presentation, and not in terms of subsequent inputs.
9	*That health services are encouraged to present submissions to the VACS Clinical Panel for consideration of the creation of additional VACS categories for clinics with separate patient cohorts and costs outside the existing VACS categories. As the development of weights requires data from multiple health services, submissions to the VACS Clinical Panel for new categories should ideally be jointly prepared by all health services*	See above.

	involved in providing the clinics that are the subject of the potential new VACS categories.	
10	*That DHS proceed with excluding the costs of Section 100 and PBS pharmaceuticals in the development of outpatient cost weights, but retain the funding within the overall funding pool.*	Agreed. This approach will be retained until such time as DHS is confident that all pharmaceutical costs are properly allocated within health service costing systems.
11	*That further work be undertaken with health services to identify the costs associated with non-PBS pharmaceuticals to ensure that these costs (and funding) are retained in the cost weights.*	This review has highlighted issues surrounding the need for full and accurate cost allocation processes, and these matters will be further emphasised through the CCSAA and future costing projects
12	*That DHS consider options to address the costs of 'unmatched' pharmaceuticals that are outside the 30 day window or do not relate to a funded VACS encounter. One option might be the establishment of a medication review category within VACS.*	The issue of 'unmatched' pharmaceutical costs will be referred to the CCSAA user group for further consideration. Medication review should be undertaken through normal VACS or MBS clinic attendance.
13	*That DHS proceed with the proposal to allow substitution of nurse practitioners in the VACS medical/surgical categories.*	Agreed subject to registration of updated clinic schedules with the VACS Clinical Panel. This is a natural extension of existing arrangements where Midwifes are eligible to claim medical VACS for obstetric consultations.
14	*That DHS consider removing the requirement for involvement of a medical specialist in the existing medical/surgical VACS categories and recognise the concept of enhanced scope of practice for allied, nursing and other health professional staff,* ***subject to****:* ➢ *Development of a framework by DHS, with input from the health sector, within which enhanced scope of practice can be sanctioned and implemented that supports substitution of defined aspects of care or treatment currently being performed by medical specialists;* ➢ *Provision for data capture and regular reporting of outpatient services provided under an enhanced scope of practice model; and* ➢ *Development of an evaluation framework to monitor and evaluate the outcomes of implementing enhanced scope of practice for outpatient services.*	DHS has some reservations about extending the medical VACS eligibility generally across non-specialist staff as this may have serious downward cost pressures that may disadvantage those health services not able to adapt to this change through workforce or case complexity issues. Establishment of weighted Allied Health categories may also be an appropriate alternative and, together with the option of allocating Nurse led clinics to a separate category, would allow future review and monitoring.
15	*That DHS implement a system to monitor and evaluate the impact of 'standard' and 'substitution' for each clinical grouping to track changes over time in role substitution in the delivery of outpatient services.*	It is anticipated that profiles of service profession within VACS categories will become available through modification and roll-out of VINAH and the outpatient MDS. It is also anticipated that trialling of EAL clinics would be accompanied by reporting of referral, diversion, and substitution statistics. Longitudinal activity and cost comparison would further inform uptake and impact assessment.
16	*That DHS consider amending the current limitation that prohibits funding for outpatient consultations not involving the physical presence of the patient and extend payment for consultations involving telephone and/or videoconferencing, subject to resolution of the following issues:* ➢ *Guidelines that describe the core elements of a VACS funded encounter. This could include reference to the involvement of health professional staff in providing* ***clinical*** *advice and assessment to* ***individual*** *patients. Excluded from scope for payment would be telephone or other communications that are of an administrative or non-clinical nature;* ➢ *The ability to capture the activity and costs of these encounters has not yet been demonstrated and DHS would need to have further discussions with health services on whether to separately identify and report these types of encounters; and* ➢ *There would need to be further discussion of payment*	While the presence of patients for initial assessment is highly desirable, DHS acknowledges that some of this work can be undertaken in their absence through EAL clinics. Additionally, the increasing use of care plan conferencing (with or without the patient being present) for complex cases is also recognised by DHS and supported by the Commonwealth through the establishment of new MBS items. The development of guidelines will be paramount to the effective and appropriate use of funded non-participatory services. Ideally, telephone contacts (whether of a clinical or administrative nature) should be captured as part of the underlying bundled VACS encounter. The department may consider providing project funds to assist in the trialling of these new service delivery models.

	options including equivalent VACS payments (to encourage these types of consultations) or discounted payments (in recognition of likely reduced diagnostics/consumables in consultations not physically involving the patient).	
17	*That DHS proceed with the introduction of multidisciplinary care services and care plan conferencing categories within VACS, with these payments only being available for public patient services. All health services would be eligible to provide MDC and CPC services, but these services would be included within the fixed target of each health service.*	Agreed in principle for public patient services. Much work remains to be done to establish appropriate funding weights, business rules, reporting, and evaluation mechanisms.
18	*That the exact composition of MDC categories be further developed in business rules between DHS and health services, with some suggested parameters comprising:* ➢ *The lower limit for an MDC team be set at a minimum of 3 health professionals, at least one of whom is required to be a medical specialist or nurse practitioner;* ➢ *That GPs are able to be counted as part of the 3 health professionals in the MDC team, noting that an MDC team would still require a medical specialist in addition to the GP;* ➢ *That registrars and interns would not be directly counted in MDC services, but the consultant supervising the registrar would be included as a team member;* ➢ *That staff counted towards MDCs can include staff from outside the health service, including staff who are not physically present but participating through other modalities such as telephone or videoconferencing (this also applies to staff from within the health service); and* ➢ *There will need to be clarification regarding the counting of midwives, nurse practitioners, allied health assistants and Division 2 nursing staff.*	Agreed. The parameters described would be reviewed and expanded in consultation with the health services. Subject to satisfactory documentary evidence, the involvement of external care participants would not be prohibited but only a single payment to the primary health service would apply; health services would need to negotiate their own transfer pricing arrangements. DHS is unclear as to the role of GPs within an outpatient MDC context, whereas their involvement in care plan conferencing would seem more relevant.
19	*That the preference is for fewer MDC categories (rather than categories that are closely tied to the exact number and levels of staff) and that the key objective is to adequately reward the costs of high-end multidisciplinary care. On this basis, it may be desirable to establish only 1 or 2 MDC categories that are targeted at high-end multidisciplinary care.*	Agreed. A trial involving a single high-end MDC category would be most beneficial in assessing the relevance, cost, and impact of operating this type of service.
20	*That DHS develop business rules identifying what constitutes an MDC service, including clarifying the counting of services that may be organised sequentially.*	Agreed – see responses 18 and 19. The potential for the outpatient MDS to consolidate sequential services will be explored together with the development of appropriate business rules.
21	*That DHS clarify that for services that do not meet the definition of an MDC service, that health services are able to count and capture these costs in standard VACS encounters (medical/surgical/allied health).*	Agreed.
22	*That in introducing care plan conferencing, consideration be given to the option of structuring payments on the basis of time sessions (rather than patient-based payments). If sessional payments are used, there would only be 1 care plan conferencing category.*	To be further investigated.
23	*That business rules be developed relating to the staffing composition and core elements of what constitutes a care plan conferencing session.*	Agreed.
24	*That pending the collection of accurate data on the real costs of MDC and CPC services, that weights be developed for these categories on an estimated or modelled basis in early years.*	Agreed. In all cases involving the establishment of new clinics or treatment modalities a degree of modelling and rebasing will be required.
25	*That DHS proceed with the establishment of a single category for EAL clinics.*	Agreed in principle. See response 15.

26	*That the implementation of the EAL category by DHS would need to resolve the following issues:* ➢ *Defining the core elements of what constitutes an EAL service (including a valid referral) and the associated business rules for health services;* ➢ *The extent to which a weighted output-based payment approach is offset by the administrative burden of data collection and verification;* ➢ *How EALs relate to other services including MBS clinics, pre-admission clinics and existing outpatient clinics;* ➢ *Clarifying that EALs involve the health service assuming clinical responsibility and that accordingly these services would need to be provided by appropriately qualified clinical staff (not administrative or clerical staff);* ➢ *Development of other tools (guidelines, maximum referral periods, target numbers of review visits) so that there is a multi-faceted strategy in place around the timely and appropriate discharge of outpatients; and* ➢ *Development of validation and auditing processes to support a robust approach to the counting and funding of all new clinic types, with rules relating to funding adjustments for inappropriate counting.*	Agreed. To be further developed in consultation with health services and the VACS clinical panel. Work is currently proceeding to establish outpatient key performance indicators that are likely to include measures of diversion, substitution, referral, and discharge.
27	*That DHS recognise the importance of evaluating the implementation of all the proposed new clinic types (MDCs, CPCs and EALs), with up-front specification of the performance and other measures that will be required to assess the impact of the proposed changes.*	Agreed. Health services would be expected to specify the objectives, outcomes, and measures associated with any proposal to implement EAL clinics. MDC and CPC utilisation may be subject to targeted audit and review.
28	*That DHS proceed with the discontinuation of the VACS base grant, with the implementation comprising the following tasks:* ➢ *Undertake modelling to identify the quantum of base grant relative to outpatient activity at each health service to understand the potential size of any redistributional impacts;* ➢ *Transfer/continue funding for specific programs (TPN, HEN and CPAP) that are currently included in the base grant for particular health services; and* ➢ *Modelling of the impact of redistribution of the base grant across variable grants (price and volume) and the Reform and Innovation grant needs to balance financial sustainability, stability in funding for individual health services and support for new clinic types.*	Agreed in principle. DHS is currently modelling the impact at the health service level of rolling the Base Grant into variable funding. Specific program funding will be retained where appropriate.
29	*That DHS proceed with setting the VACS teaching grant on the basis of total outpatient activity, subject to:* ➢ *Modelling/analysis to identify the potential size of any distributional impacts; and* ➢ *Release of the DHS review into the Training and Development Grant to understand whether there may be benefits in aligning the determination of the T&D and VACS teaching grants.*	Agreed. The 08/09 year will enable the collection of MBS data to support the re-distribution of teaching grants on a total activity basis in subsequent years.
30	*That the following technical parameters may be useful in guiding the calculation of the VACS teaching grant:* ➢ *The total quantum of funding now included in the teaching grant is transferred into the new teaching grant and expressed as a fixed % (or price in Year 1) for each*	Agreed. DHS will strive to ensure that the quantum of funds relating to teaching grows in proportion to the variable price subject to budget limitations.

	unit of outpatient activity (public and private); ➢ *In subsequent years, the quantum of funding invested in the teaching grant at a statewide level grows so that the grant remains at a constant % share of the variable grant price (i.e. the real value of the grant is not eroded by being allowed to remain at historical levels); and* ➢ *The distribution of the teaching grant across health services is made on the basis of total outpatient activity, lagged by one year. This is intended to provide certainty of funding and avoid the need for adjustments that would be required if the grant were calculated on the basis of actual encounters. The 'total' outpatient activity may be set at equivalent to the VACS targets (hence excluding public activity in excess of target) and MBS encounters (with the need for robust business rules on the counting and auditing of these data). VACS targets would include medical/surgical, allied health, EAL, MDC and CPC activity.*	
31	*That DHS cease the VACS ambulance specified grant in its current form and roll the funding into VACS variable grants in order to ensure that the funding is retained by health services, on a more equitable basis.*	Agreed in principle. Ambulance funds would be retained within the system however the initial impact of their withdrawal and reallocation may significantly impact some health services. DHS will determine into which component(s) these funds would be reallocated.
32	*That DHS discuss with relevant health services the proposed translation of specified grants assessed as falling within Group 2 to alternative funding arrangements.*	Agreed.
33	*That DHS request the VACS Clinical Panel to assess whether individual Group 2 grants can be translated into existing VACS categories or require the creation of additional, new VACS categories. In addition, or alternatively, DHS may want to consider translating some of these Group 2 grants to other program funding streams outside VACS.*	Agreed - awaiting further information. Shadow funding arrangements may be prudent
34	*That DHS adopt a life-cycle approach to the ongoing management and regular review of remaining VACS specified grants that might comprise the following elements:* ➢ *Involvement of the Clinical Panel in reviewing the clinical effectiveness of the services covered under these grants; and* ➢ *Implementation of reporting by health services to ensure ongoing monitoring.*	Agreed. Routine reporting of associated activity will be instigated. Regular review of the effectiveness of programs and sufficiency of funding needs to be balanced against the associated administrative cost and effort involved.
35	*That DHS include a Reform and Innovation Grant in the new funding model, with further consideration of:* ➢ *Timing: option of delayed implementation of this element of the funding model to allow health services to manage introduction of other new models of care;* ➢ *Quantum and source: preference for new or growth funding to be directed towards reform and innovation, rather than funding through internal reinvestment; and* ➢ *Allocation, reporting and accountability: preference for a non-grant based mechanism, but need for some clearly agreed and shared priorities to guide investment by health services.*	Agreed in principle. DHS notes the preference for recurrent funding, but initially anticipates funding on a project basis to trial emerging models of care and promoting targeted reform.
36	*That DHS consider changing the role of the VACS Clinical Panel over time to include:* ➢ *An expanded responsibility for the review and development of VACS categories to ensure that the classification system keeps pace with changing clinical practice;* ➢ *A function of describing the services included within each of the VACS categories and;*	Agreed in principle. Whether this is a redefinition of the role of the VACS Clinical Panel or implemented through various sub-committees is yet to be determined. Category assignment role may be reduced once patient level clinical information becomes available. In the interim, maintenance of accurate clinic schedules will be essential.

	➢ *A reduced role for mapping/assignment of individual clinics to VACS categories.*	
37	*That greater transparency in setting and reviewing the level of VACS targets would enhance the confidence of health services in VACS.*	The setting of activity levels (targets) is undertaken through direct negotiation between the health services and Access and Metropolitan Performance branch/RRHACS.
38	*That DHS consider regular release of detailed costing data to senior management of health services that identifies costs for each health service for each VACS category (broken down into staffing, imaging, pharmaceuticals, pathology, and other costs) in order to:* ➢ *Promote improvement in the underlying costing data through analysis and investigation of apparent differences in outpatient costs between health services;* ➢ *Encourage benchmarking by health services on opportunities to improve the efficiency of outpatient service delivery; and* ➢ *Provide health services with data that allows them to identify further potential splits in the VACS categories to ensure there is greater homogeneity of costs and better matching of costs with VACS payments.*	Further dissemination of comparative costing data for benchmarking purposes is generally supported subject to administrative cost and burden. While DHS is prepared to assist hospitals in identifying potential new VACS categories, it is largely the responsibility of health services to justify these cases on **clinical** grounds.
39	*That DHS ensures adequate priority is given to improving outpatient costing data through VACCDI and other forums, noting the need for senior management participation to ensure that these data are improved..*	Agreed.