Policy and funding guidelines 2019–20

Policy guide

Appendices – Funding rules

VICTORIA State Government | Health and Human Services

The *Policy and funding guidelines 2019–20* (guidelines) represent the system-wide terms and conditions (for funding, administrative and clinical policy) of funding for government-funded healthcare organisations.

The guidelines reflect the government and department's role as a system manager and underpin the agreements at an organisational level. The guidelines are relevant for all funded organisations including health services and hospitals, community service organisations and other funded organisations such as Ambulance Victoria and the Victorian Institute of Forensic Mental Health that are funded pursuant to the Statement of Priorities.

Service agreements are the contractual arrangements between the organisation delivering services and the department providing funding to the organisation. For community service sector funding information and activity tables that underpin service agreements, visit the Policy and funding guidelines webpage <https://www2.health.vic.gov.au/about/policy-and-funding-guidelines>.

In addition to these guidelines, funded organisations are expected to comply with all relevant policy documents and guidelines. A list of key policies and guidelines can be found at the Policy and funding guidelines webpage <https://www2.health.vic.gov.au/about/policy-and-funding-guidelines>.

Hospital circulars provide updates on the changes that affect health services during the year. These are available at the Hospital circulars webpage <https://www2.health.vic.gov.au/about/news-and-events/hospitalcirculars>.

Funded organisations should always refer to the guidelines' website for the most recent version of the guidelines, as items may be updated throughout the year.

Where these guidelines refer to a statute, regulation or contract, the reference and information provided is descriptive only.

In the case of any inconsistencies or ambiguities between these guidelines and any legislation, regulations and contractual obligations with the State of Victoria acting through the department or the Secretary to the department, the legislative, regulatory and contractual obligations will take precedence. Each funded organisation should refer to the relevant statute, regulation or contract to ascertain all the details of its legal obligations. If any funded organisation has questions in relation to its legal obligations, it should seek independent legal advice.

To receive this publication in an accessible format, please phone 03 9096 8572 using the National Relay Service 13 36 77 if required, or email policy and funding guidelines <pfg@dhhs.vic.gov.au>.

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Where the term 'Aboriginal' is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

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Contents

Ministers' foreword

The *Victorian Budget 2019–20* invests a further $5.5 billion over the next four years to ensure every Victorian can get the best care, in the very best facilities, when they need it.

For our hospitals, the budget provides an unprecedented additional $2.5 billion over four years for hospital service delivery. This includes additional funding for emergency department presentations, critical care admissions, elective surgery, maternity admissions, outpatient services, sub-acute care services, chemotherapy treatments and radiotherapy treatments.

This year's budget also provides $13.6 million for the Royal Commission into Victoria's Mental Health System – a once-in-a-generation opportunity to redesign our system, and ensure people get the services they need, when they need them.

In 2019–20 it is expected that 203,020 patients will be admitted from the elective surgery waiting list and 756,000 patients will be admitted into our hospitals from emergency presentations. In all, a total of 2,021,000 admitted patients are expected to move through our health system in 2019–20.

We're rolling out new programs to dramatically expand healthcare provision across the State including our flagship demand driven school dental program, which will progressively scale up to provide free treatment to all public school students by 2022. The budget also delivers $214 million in support for new parents including building seven new early parenting centres and expanding our 24 hour maternal and child health line with specialists in sleep and settling issues. We've funded Bass Coast Health to deliver free 24 hour care to Phillip Island residents and visitors on an ongoing basis. The budget also funds an additional 500,000 specialist appointments in rural and regional Victoria.

Strengthening nurse to patient ratios

To ensure our dedicated health professionals have the support they need, there is additional $64.4 million investment to further improve patient ratios across our hospitals and recruit more nurses and midwives, new investment to equip frontline health workers with the skills they need to recognise and respond to occupational violence, and 100 scholarships will be available to hospital staff seeking to grow their careers in the health sector.

Responding to people's end of life care choices

The Government continues to support Victorians requiring end of life care, including home-based palliative care. A 24 hour support line will be established giving people access to expert advice and guidance on issues and concerns regarding all aspects of end of life and palliative care.

Backing our paramedics to keep saving lives

In a medical emergency, every second of every minute counts and can be the difference between life and death. The budget invests nearly $300 million in our ambulance service to meet growing demand, support improved response times and deliver on the Government's election commitment in full.

This includes $109 million to deploy a 23-vehicle surge fleet across Victoria to improve emergency ambulance availability and reduce paramedic fatigue. Ocean Grove and Gisborne branches will be upgraded, and new stations will be built in Clyde North and East Bentleigh. An additional 90 paramedics will be employed to facilitate the upgrade of 15 single officer branches to dual-officer crewing, base MICA officers in Ararat and Bellarine, and new resources at Churchill, Geelong, Gisborne, Bendigo region and South-Barwon region to meet higher demand for ambulance services across Victoria.

The budget goes beyond the Government's election commitment. $190.8 million will also be invested to enable Ambulance Victoria to meet the ever-increasing demand for ambulance services, maintain significant improvements in response performance, and support Ambulance Victoria's 24/7 Secondary Triage Service.

Since 2014, the Labor Government has invested $1 billion in Victoria's ambulance service, ensuring Victorians get the best emergency care, when they need it, faster than ever before.

Royal Commission into Victoria's Mental Health System

The Government has established the Royal Commission into Victoria's Mental Health System – the first of its kind in the country. The Royal Commission will give us the answers we need to transform our mental health system and change lives. While the Royal Commission is underway, the *Victorian Budget 2019–20* will invest in prevention and recovery care facilities, additional community services to meet demand, an extra 28 acute mental health inpatient beds, 30 residential rehabilitation beds to support Victorians recovering from addiction, investment in treatment and support services for Aboriginal Victorians, and further investment in the Mental Health Complaints Commissioner and Mental Health Tribunal to safeguard patients' rights.

Health infrastructure

The budget kickstarts the Labor Government's unprecedented $3.8 billion plan to build modern hospitals and health infrastructure for a growing Victoria.

The centrepiece of the budget is the landmark $1.5 billion 504-bed New Footscray Hospital. The new hospital will cut waitlist times, allowing almost 15,000 additional patients to be treated and almost 20,000 additional people to be seen by the emergency department each year. The world-class New Footscray Hospital will ensure that people in Melbourne's west have greater access to quality care closer to home.

Key highlights of the budget also include:

- $100 million boost to the Regional Health Infrastructure Fund, helping build the world-class hospitals and health facilities that rural and regional communities count on
- $60 million for the medical equipment and engineering infrastructure replacement programs in the coming year to help our hospitals and health services maintain assets and grow services
- $31 million for an expansion of the Royal Children's Hospital, including a new 30-bed flexi ward and expansion of the emergency department to treat some of our sickest young patients.

Bendigo patients recovering from injury or illness will benefit from a $60 million investment in a cutting-edge Bendigo Hospital Day Rehabilitation Centre, consolidating the various rehabilitation services spread across the Bendigo Hospital site into one new location.

The budget also includes funding to enable important planning work to progress for a number of the Government's election commitments including the Frankston Hospital Redevelopment, Latrobe Regional Hospital Stage 3 expansion, ten new community hospitals and dedicated children's emergency department space at Geelong, Maroondah, Frankston, Casey and the Northern hospitals.

Funding has also been set aside for the $100 million Marybourgh Hospital Redevelopment and $100 million Geelong Women's and Children's Hospital.

This budget builds on our $3.2 billion investment in hospital infrastructure during our first term and keeps our promises – building the hospitals our state needs and backing the first-class care Victorians deserve.

Jenny Mikakos MP
Minister for Health
Minister for Ambulance Services

Martin Foley MP
Minister for Mental Health
Minister for Equality
Minister for Creative Industries

Guidelines overview

The guidelines represent the system-wide terms and conditions (for funding, administrative and clinical policy) of funding for government-funded healthcare organisations.

The guidelines reflect the government and department's role as a system manager and underpin the contracts at an organisational level (Statements of priorities (SOPs) and service agreements). They set out the requirements that funded organisations must comply with as part of their contractual and statutory obligations, outline activity that is required to receive funding, and detail expectations of administrative and clinical conduct.

The guidelines are relevant for all funded organisations, which includes health services, community service organisations and other funded organisations such as Ambulance Victoria.

Policy guide

The policy guide articulates the funding policy priorities, and performance and financial frameworks, including their conditions, within which Victorian government-funded organisations operate.

Chapter 1: Funding arrangements for Victoria's health system

Details funding arrangements for funded organisations and all other outputs provided by the department.

Chapter 2: Conditions of funding

Outlines relevant standards and policies that funded organisations must adhere to in order to receive funding from the Victorian Government, ensuring the delivery of safe, high-quality services and responsible financial management.

Appendices – Funding rules

The funding rules specify the financial parameters, specifically the detailed pricing and prescribed budgetary targets, that funded organisations are expected to work to, and within, in order to achieve the outcomes expected by the Victorian Government.

Appendix 1: Pricing arrangements for Victoria's health system

Details pricing arrangements for funded organisations and all other outputs provided by the department.

Appendix 2: Funding and activity levels

Provides funding and activity tables detailing the modelled budgets for 2019–20, as well as the 2019–20 targets for a range of programs across the health system.

Policy guide

Overview of chapters

The policy guide articulates the funding policy priorities, and performance and financial frameworks, including their conditions, within which State government-funded organisations operate.

Chapter 1: Funding arrangements for Victoria's health system

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Chapter 1: Funding arrangements for Victoria's health system

Introduction

Chapter 1 details the funding arrangements for funding the broad range of services delivered in the Victorian health system. It details the mechanisms used to fund organisations and the rules about how these prices apply. The funding models vary across the activities depending on the nature of the service to be delivered. This chapter also explains the Commonwealth–State Government funding arrangements that affect funded organisations.

A note on terminology

The term 'funded organisations' relates to all entities that receive departmental funding to deliver services. Aspects of these guidelines referring to funded organisations are applicable to all department-funded entities.

For the purposes of these guidelines, the term 'health services' relates to public health services, denominational hospitals, public hospitals and multipurpose services, as defined by the *Health Services Act 1988*, regarding services provided within a hospital or a hospital-equivalent setting. Aspects of these guidelines that refer specifically to 'health services' are only applicable to these entities.

The term 'community service organisations' refers to registered community health centres, local government authorities and non-government organisations that are not health services.

These guidelines are also relevant for Ambulance Victoria, Health Purchasing Victoria, Mildura Base Hospital and the Victorian Institute of Forensic Mental Health. The guidelines specify where aspects of the guidelines are relevant for these organisations.

1.1 Budget highlights

The *Victorian Budget 2019–20* continues to build on our State's economic success, with Victoria outperforming the nation across a broad range of economic indicators. Victoria's economic growth ensures more Victorians have the security and dignity of work, and in 2019–20, investment in infrastructure will reach a record $14.2 billion, delivering new schools, better hospitals, and more reliable road and rail for Victorians.

Continued strong investment in our health system will help meet the needs of our growing state, ensuring more patients will receive care, treatment and surgeries sooner.

Highlighted additional budget investments for 2019–20 include:

- $780 million of additional funding for hospital demand
- $17.3 million to ensure the end of life care choices of Victorians continue to be met
- $58.9 million for Ambulance services and paramedic support
- $50.4 million for mental health services.

Table 1.1 details departmental health operations funding by the output categories provided in the *Victorian Budget 2019–20*.

A summary of health service modelled budgets for 2019–20 is provided in the Appendices.

Table 1.1: *Victorian Budget 2019–20* by output group

Output group	2018–19 Budget ($m)	2019–20 Budget ($m)	% increase 2018–19 to 2019–20[1]
Acute health services	14,106.7	14,667.2	4.0%
Ageing, aged and home care	804.8	809.9	0.6%
Ambulance services	1,084.3	1,120.0	3.3%
Drugs services	259.9	273.1	5.1%
Mental health	1,605.7	1,742.6	8.5%
Primary, community and dental health	655.1	645.0	–1.6%
Public health	369.0	389.5	5.6%
Small rural services	592.0	630.6	6.5%
Total	**19,477.5**	**20,277.9**	**4.1%**

Source: 2019–20 Victorian Budget Paper No. 3

1.2 Output initiatives 2019–20

The *Victorian Budget 2019–20* has allocated $1.1 billion in 2019–20 and $5.5 billion over five years for new output initiatives that will grow and strengthen the health, ambulance, mental health and aged care sectors.

1.2.1 Acute health and ambulance services

The *Victorian Budget 2019–20* is investing $888.1 million in 2019–20 ($2.8 billion over four years) in health and ambulance services programs across metropolitan Melbourne and in rural communities.

[1] Variation between 2018–19 Budget and 2019–20 Budget.

- $2.3 billion over four years will respond to growing patient demand across Victoria including additional funding for emergency department presentations, critical care admissions, elective surgery, maternity admissions, outpatient services, subacute care services, chemotherapy treatments and radiotherapy treatments.
- $190.8 million investment in ambulance services over four years will respond to the growing demand for emergency services, including an additional 90 paramedics. Funding will also support Ambulance Victoria's secondary triage service, maintain non-emergency transport capacity and further improve Code 1 response times.
- $72 million over four years will continue support for Victorians requiring end-of-life care, including home-based palliative care in rural and regional Victoria and regional palliative care consultancy as well as a 24-hour support line.
- $70.5 million will upgrade the emergency services radio, transitioning Ambulance Victoria from the outdated analogue system to digital communication, enabling our paramedics to better respond to emergencies across Victoria.
- $64.4 million over four years will be provided to increase nurse and midwife to patient ratios in rehabilitation, mental health, special care nurseries and medical surgery wards. The changes will also upgrade Warrnambool Hospital to a level 2 hospital to reflect increasing demand.
- $53.9 million over four years will support paramedics to recruit an additional 90 paramedics to facilitate the upgrade of 15 single officer branches and for new resources at five ambulance stations to meet higher demand for ambulance services across Victoria.
- $50 million over four years will help establish the Nursing and Midwifery Workforce Development Fund to retain, recruit and train more nurses and midwives in Victoria including increasing the graduate program for nurses, midwives and enrolled nurses.
- $15.4 million over four years will enable the Health Complaints Commissioner to continue resolving complaints about health service providers and the handling of health information, conducting investigations and reviewing health complaints data to help providers improve the quality of their services.
- $3.5 million over four years will be provided to enhance the skills of frontline health service workers to recognise and respond to occupational violence as well scholarships to health service workers with a capped fund to supplement employee wages to ensure health service workers can train while maintaining their income.
- $2.4 million over two years will deliver the first stage and planning of a new Melton Hospital to determine the capacity and range of services and how it will link into services at other hospitals in the region over the long term.
- $2 million in 2019–20 will be provided to develop a business case to establish public IVF services that are bulk-billed and subsidised for low-income Victorians in metropolitan Melbourne and at least one regional location.

1.2.2 Primary, community, public and dental health

The *Victorian Budget 2019–20* is investing $97.9 million in 2019–20 ($551.4 million over four years) in primary, community, public and dental health including the following:

- $321.9 million over four years will ensure the School Dental Program provides free dental care each year to Victorian government school students. Once fully implemented, oral health teams will visit all government primary and secondary schools once per year to conduct a dental check-up of all students and provide oral health education. Children who are identified as requiring follow-up treatment will be offered this treatment free of charge in a dental van that will separately visit the school or via a free follow-up treatment at a public dental service.
- $116.5 million over two years will maintain Victoria's position as a leader in health and medical research through:
  - establishing the Australian Drug Discovery Centre at the Walter and Eliza Hall Institute for Medical Research

  - the Australian Clinical Trials Network 'Trial Hub'
  - establishing a Gamma Knife Service at the Peter MacCallum Cancer Centre
  - further planning for the Aikenhead Centre for Medical Discovery at St Vincent's Hospital.
- $90.7 million over four years will provide more help for new Victorian mums and dads with infants experiencing sleep and settling problems from dedicated sleep and settling specialists on the Maternal Child Health Line.
- $15.1 million over four years will provide grants to schools and community groups to increase shading and provide hats, sunscreen and other sun protection measures as well as promotion for early detection and intervention.
- $4.1 million over four years will enable the Victorian Assisted Reproductive Treatment Authority to continue administering the registration system of assisted reproductive treatment providers, provide public education about treatments and continue managing donor registers, including counselling support services.
- $2.8 million over four years will be provided to continue PRONTO, Victoria's existing community-based, rapid, peer-led HIV testing service in Fitzroy. The service uses an innovative non-clinical and patient-centred approach to HIV testing.
- $0.3 million in 2019–20 will help increase services to vulnerable people and communities at the Merri Health facility.

1.2.3 Mental health and drug services

The *Victorian Budget 2019–20* is investing $52.5 million in 2019–20 ($106.3 million over four years) in mental health and drug services including the following:

- $173 million over four years will focus on early intervention and better supporting our mental health care workers.
- $67.6 million over two years will address critical mental health service demand by including an additional 28 inpatient beds, more intensive services and additional community service hours for new clients as well as an increase in capacity of the nurse transition program, and more support provided to psychiatrists, in response to workforce pressures.
- $16.2 million in 2019–20 will allow the Victorian Fixated Threat Assessment Centre to continue to deliver coordinated responses with collocated police and mental health clinicians to respond to serious threats of violence posed by people with complex needs. Specialised mental health services will continue to provide support to this cohort.
- $6.0 million over four years will provide better mental health care for our emergency workers. This includes establishing an Early Intervention and Prevention Fund for Victoria Police employees to access better mental health and wellbeing support services and for the department to establish a specialist network of clinicians to provide support services for emergency service workers. A Centre of Excellence for emergency worker mental health will also be established as well as a provisional acceptance payment scheme pilot to support emergency workers suffering from mental health injuries sustained at work.
- $4.2 million over two years will be provided to roll out the new nasal spray containing naloxone with essential training and education provided across Victoria. Additional needle and syringe products will also be made available to help address drug harms. Extended hours of operation will improve access to the Medically Supervised Injecting Room.
- $3.6 million over two years will provide additional support for the Office of the Chief Psychiatrist and establish a campaign to reduce the stigma around mental health while the Royal Commission into Mental Health undertakes its wide-ranging inquiry.
- $3.2 million over four years will ensure the Mental Health Tribunal continues to protect the rights of mental health patients receiving compulsory treatment.
- $3.0 million in 2019–20 will provide services to asylum seekers living in the Victorian community. Funding will go towards mental health and trauma counselling, material aid (food, clothing), health

assistance and subsidised medications, housing assistance and case coordination while applications for asylum are being processed.

- $2.5 million over two years will enable the Mental Health Complaints Commissioner to continue safeguarding rights, resolving complaints about Victorian public mental health and recommending improvements for service and system improvements.

1.2.4 Ageing, aged and home care

The *Victorian Budget 2019–20* is investing $44.6 million in 2019–20 ($81.8 million over four years) in ageing, aged and home care including the following:

- $49.5 million over four years will mean Victorian carers benefit from increased support through additional respite hours including expanded eligibility for carers of people with a mental illness and younger carers as well as public transport travel initiatives and grants to both grassroots and statewide carer support groups that focuses on regional areas and under-recognised carer groups.
- $26.9 million in 2019–20 will support public sector residential aged care services to provide high-quality care to vulnerable aged persons, including those with mental health issues.
- $5.4 million in 2019–20 will support multicultural aged care in Victoria through upgrades to facilities at seven multicultural aged care providers. Funding will also be provided to purchase land for three multicultural aged care facilities. This will help improve and expand aged care services for culturally diverse Victorians.

1.3 Asset initiatives

The *Victorian Budget 2019–20* includes a $1.8 billion acute health capital, infrastructure and equipment program incorporating the construction, upgrade and expansion of metropolitan and regional hospitals as well as $54.9 million for essential ambulance services equipment and infrastructure. There is also $20 million in capital funding allocated for mental health facilities, $103.4 million in capital funding for a new 120-bed public sector residential aged care facility in Wantirna, grants for upgrades to multicultural residential aged care facilities, and the purchase of land for three new multicultural residential aged care facilities. Capital expenditure of $123 million will provide seven new centres and safety equipment for new families (see Table 1.2 to Table 1.6).

Table 1.2: Funding for asset initiatives – acute health

Initiative	Description	TEI ($ million)
Building a better hospital for Melbourne's inner west	A new 504-bed Footscray Hospital will be built in Footscray to cater for the growing demand for health services in Melbourne's inner west, specifically allowing up to 15,000 additional patients to be treated. It will boost capacity and services in outpatients, palliative care and mental health services.	$1,430
Regional Health Infrastructure Fund	Further funding provided to the Regional Health Infrastructure Fund to improve infrastructure across a range of rural and regional health services to respond to local priorities and maintain and enhance their service delivery capacity. This initiative includes funding for Ararat Hospital (East Grampians), the renewal of rural residential aged care facilities and to begin planning for stage 2 of the Goulburn Valley Health redevelopment.	$100
Engineering infrastructure and medical equipment replacement programs	Critical engineering infrastructure that has reached the end of its useful life will be replaced in selected metropolitan, rural and regional hospitals to enable the continuity of health service delivery and compliance with regulatory requirements to reduce risks to patients and improve service availability.	$60
Building a new rehabilitation centre for Bendigo	A new rehabilitation centre will be built at Bendigo Hospital, which will include the relocation and consolidation of outpatient rehabilitation services and staff administration services into newly upgraded buildings.	$59.5

Initiative	Description	TEI ($ million)
Royal Children's Hospital expansion	30 new inpatient beds and an expansion of the emergency department to cater for growing demand.	$31.4
Clinical technology refresh	To provide the technical infrastructure to improve operational stability and enhance cybersecurity required to support and deliver patient-related services such as diagnostic imaging, patient management systems and electronic medical records will be upgraded.	$13
Building a bigger and better Latrobe Regional Hospital	Planning to redevelop and expand the Latrobe Regional Hospital to increase the service capacity of operating theatres and the maternity and intensive care units.	$7
Building a world-class hospital for Frankston families	Funding to begin planning for the redevelopment of Frankston Hospital, providing new hospital beds, operating theatres, expanded child and maternal health services and areas dedicated to mental health services.	$6
Planning for new children's emergency departments	Planning will begin for dedicated children's emergency departments at Northern Hospital, Frankston Hospital, Casey Hospital, Maroondah Hospital and Geelong University Hospital.	$5.9
Angliss Hospital expansion	Planning will begin for the next stage of the Angliss Hospital expansion at Ferntree Gully, which will provide additional hospital beds, upgrade infrastructure and support the re-accommodation of clinical functions.	$4.6
Phillip Island Urgent Care Centre	To provide funding to expand the Phillip Island Health Hub for operation 24-hours a day, seven days per week for uninterrupted access to urgent health care.	$3.4
World-class care for Wangaratta	To begin infrastructure and service planning work for the redevelopment of Wangaratta Hospital.	$2.4
Ten new community hospitals to give patients the best care	Funding will be provided to plan the construction and expansion of 10 community hospitals to increase capacity and ensure patient access to high-quality healthcare services in key growth areas. This investment will increase capacity and ensure patient access to high-quality healthcare services in key growth areas.	$2

Table 1.3: Funding for asset initiatives –ambulance services

Initiative	Description	TEI ($ million)
New ambulances and new stations	Funding for 23 ambulances, giving Victorians confidence that in an emergency they will continue to get the fast, life-saving care they need. Two new stations in Clyde North and East Bentleigh, and upgrades to Ocean Grove and Gisborne stations, and 15 single-officer stations to make them dual-officer crews.	$54.9

Table 1.4: Funding for asset initiatives – ageing, aged and home care

Initiative	Description	TEI ($ million)
Wantirna Public Sector Residential Aged Care redevelopment	A new 120-bed aged care facility will be constructed at Wantirna Health, including 60 high-care beds and 60 mental health aged-care beds. It will also provide accommodation for the aged care residents during the Angliss Hospital stage 2 expansion.	$81.6
Multicultural Victoria – residential aged care	To support multicultural aged care in Victoria through upgrades to facilities at seven multicultural aged care providers. Funding will also be provided to purchase land for three multicultural aged care facilities. This will help improve and expand aged care services for culturally diverse Victorians.	$21.8

Table 1.5: Funding for asset initiatives – mental health

Initiative	Description	TEI ($ million)
Relocation of Barwon Health clinical facilities	The relocation of Barwon Health clinical facilities to an alternate site in the central Geelong area will enable a transformation of drug and alcohol and mental health service delivery, through development of integrated continuing care service responses for people with coexisting mental health and alcohol / other drug problems.	$20

Table 1.6: Funding for asset initiatives – primary, community and dental health

Initiative	Description	TEI ($ million)
More help for new Victorian families	Funding for seven new early parenting centres to be established. Funding will be provided for free car seat fitting and safety checks plus approximately 35,000 new parents will receive a baby bundle and up to 7,000 vulnerable new families will receive extra home-based sleep support from a maternal child health nurse.	$123

1.4 Pricing and funding

1.4.1 Pricing and funding framework

Refer to the pricing framework for 2018–19 <https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/pricing-funding-framework>.

1.4.2 Commonwealth funding

1.4.2.1 National Health Reform Agreement

Health services are required to ensure their operations comply with the obligations of the Victorian Government under various Commonwealth–state government agreements. These agreements include the National Health Reform Agreement (and the addendum to this agreement), which has provided joint funding for public hospital services since 1 July 2012.

The National Health Reform Agreement outlines the responsibilities for delivering key health services including: public hospital services; general practitioner and primary healthcare; and aged care and disability services. Health services are expected to comply with the business rules contained in the national agreement.

In April 2017 Victoria signed the National Health Reform Addendum Agreement, which substantially rolls over National Health Reform Agreement arrangements from 2017–18 to 2019–20 and commits to:

- delivering reforms designed to improve health outcomes for patients and decrease avoidable demand for public hospital services
- introducing models to integrate quality and safety into hospital funding and pricing and reduce avoidable readmission rates in conjunction with the Australian Commission on Safety and Quality in Health Care and the Independent Hospital Pricing Authority.

Under the current arrangements, Commonwealth funding growth for public hospitals, which was previously unlimited and based on the services provided, will be capped at 6.5 per cent each year and the Commonwealth contribution to efficient growth funding will remain at 45 per cent of the efficient growth, rather than moving to the 50 per cent contribution rate from 2017–18 as originally agreed in the National Health Reform Agreement.

In February 2018 the Council of Australian Governments (COAG) considered a draft Heads of Agreement for a longer term 2020–25 National Health Agreement Addendum. Victoria did not sign the offer because it was insufficient to meet the state's growing demand for public hospital services and did not restore the conditions under the original National Health Reform Agreement.

Cooperative development of the 2020–25 National Health Agreement Addendum for COAG's consideration before end of 2019 is underway with commencement of the new Agreement from 1 July 2020. Victoria will continue to negotiate for a sustainable funding outcome. Public hospital funding is a shared responsibility between the Commonwealth, state and territory governments.

1.4.2.2 Commonwealth investment in public dental services

Through the Mid-Year Economic and Fiscal Outlook 2018–19, the Commonwealth announced a one-year extension of the existing *National partnership agreement on public dental services for adults.* Funding under this 12-month extension reflects the 30 per cent reduction in Commonwealth investment for this National Partnership Agreement compared with previous National Partnership Agreements.

Public dental providers also have access to the Commonwealth's Child Dental Benefits Schedule, a means-tested scheme (Family Tax Benefit A) for children aged 2–17 years, capped at $1,000 per child over two years. A three-year extension to public sector access to the Child Dental Benefits Schedule until 31 December 2022 was announced in the 2019–20 Commonwealth Budget.

1.4.3 Funding reforms 2019–20

The department continues to refine and develop its hospital funding models to ensure the investment made is delivering the best value to all Victorians. Funding models must remain contemporary if Victoria is to continue to deliver better value through high-quality care, delivered in the most effective settings using the most efficient model of care.

In 2019–20 the department has further refined existing funding models and will also continue to develop more innovative approaches such as capitation and bundled payments.

In line with the Victorian *Pricing and funding framework*, Victoria will maintain a state-based funding system that adopts and adapts elements of the national approach where it is suitable in the Victorian context.

In addition to the funding reforms outlined below, in 2019–20 regular updates, including rebasing, have been made to account for the most recent cost and activity data. Changes include updates to the Weighted Inlier Equivalent Separation model (WIES27), the Non-Admitted Emergency Services Grant and Subacute Weighted Inlier Equivalent Separation (SWIES) model. See Chapter 1 for more details.

The 2019–20 funding reforms will improve system outcome by:

- encouraging accountability for both health service providers and government
- remaining simple and transparent
- supporting efficient and sustainable health service operations.

These reforms will not affect patient access or care and will ensure patients receive appropriate care in a timely way, and in the most appropriate setting, by the right providers.

1.4.3.1 HealthLinks: Chronic Care

HealthLinks: Chronic Care is a funding reform that aims to improve care for patients who have a combination of specific characteristics that identify them as experiencing chronic and complex health conditions and are at risk of multiple unplanned admissions.

The basis of the model is a capitated grant, converted from existing funding, and based on the modelled utilisation of the enrolled patient cohort. The capitation grant can be used flexibly to design care around patient needs. This can include services that reach beyond traditional hospital-based settings, delivered by a range of providers. Any acute activity that is delivered to the enrolled patients is also funded from the capitation grant. Over time, it is anticipated that patients with chronic and complex needs will be provided with targeted active management, therefore reducing unplanned hospitalisations and improving patient outcomes.

Implementation is staggered based on health service readiness. Four health services actively participated in HealthLinks: Chronic Care in 2018–19.

The *HealthLinks: Chronic Care business rules* provide more detailed information about the funding model, the enrolled patient cohort and the implementation model. The rules and information about some of the interventions being implemented at participating health services are available at the HealthLinks – Chronic Care webpage <https://www2.health.vic.gov.au/primary-and-community-health/integrated-care/healthlinks>.

1.4.3.2 Department of Veterans' Affairs

In March 2017 the Secretary to the Department of Veterans' Affairs, delegates from the Military Rehabilitation and Compensation Commission and Repatriation Commission, and the Victorian Minister for Health, signed the Hospital Services Arrangement between the Commonwealth of Australia and the Repatriation Commission and the Military Rehabilitation and compensation Commission and the State of Victoria. The arrangement implements a uniform national purchasing arrangement for public hospital services provided to eligible veterans.

The arrangement saw the Department of Veterans' Affairs pay Victoria according to the Independent Hospital Pricing Authority's funding models, with modifications to reflect the contribution that the Department of Veterans' Affairs makes separately to medical practitioners. As a result of these new funding arrangements, the Department of Veterans' Affairs will pay the department the National Efficient Price.

Funding for admitted acute and subacute services will continue to be paid to actuals, while the funding for emergency departments, acute non-admitted services and the Health Independence Program will continue to be provided on a block basis, with the available revenue from Department of Veterans' Affairs allocated based on a health service's share of the total weighted activity.

Further information on eligibility and funding arrangements is available in Chapter 1, section 1.24.3.1 'Department of Veterans' Affairs patients'.

1.4.3.3 Mental health

The department will fund acute admitted mental health care on an input basis in 2019–20. Health services will be funded based on their capacity to provide inpatient mental health care, with the number of bed days available. Acute adult, child, aged and specialist bed types will receive the same price regardless of the location of the health service.

To further support the transition to a single price model, a transition grant will continue to be provided to health services to maintain funding equivalence with 2019–20 allocations.

Further review of the funding model for acute mental health admitted care across all patient types will be considered in the future. As the Victorian Cost Data Collection will be used to further understand the costs of mental health care, health services should continue to contribute to mental health costing processes within the collection.

Admitted extended care and non-admitted acute mental healthcare (such as ambulatory, subacute and residential aged mental health services) will continue in 2019–20 via a mixture of input (per day or service hour) and block grants.

Mental health services will receive additional funding packages in 2019–20 to provide more community care for their most severe group of adult community-based mental health consumers.

The purpose of the Intensive Community Mental Health Packages is to provide more hours of treatment, focused on delivering evidence-based multidisciplinary therapeutic interventions for a cohort of adults with serious mental illness and high needs being treated in the community. The funding targets adult consumers whose diagnosis and wellbeing assessments indicate they are at risk of recurring acute episodes and associated hospital admissions without more intensive therapeutic intervention.

Further information on the 2019–20 prices is available in the Appendices, Appendix 1, section 1.1 'Price tables'.

1.4.3.4 Specialist clinics

In 2017–18, the department introduced the Weighted Ambulatory Service Event (WASE) funding model for acute non-admitted specialist clinic activity that is not funded by another Victorian funding model (such as home renal, radiotherapy, home enteral nutrition). The WASE model is intended to encourage health services to improve their data reporting, drive technical efficiency, and deliver greater transparency and accountability for the funding received by services.

Activity is counted as service events and classified according to the national Tier 2 classification with cost weights calculated based on Victorian cost data. The funding unit is a WASE.

In 2019–20 the model will continue to include public and MBS-billed acute non-admitted specialist clinic activity and has different prices for both these types of activity. The model has been revised using cost data of 2017–18.

Health services have been allocated WASE activity targets that match their historical non-admitted specialist clinics funding. Targets are calculated based on a health service's public and MBS-billed activity split.

Further information on the 2019–20 prices is available in the Appendices, Appendix 1, section 1.1 'Price tables' and information on the technical aspects of the funding model are available in the Appendices, Appendix 1, Addendum 1.6: 'Weighted ambulatory service events – technical specifications'.

1.4.3.5 Pricing for quality

In 2014–15 Victoria implemented a pricing for quality scheme, providing an opportunity to link funding allocations to discrete performance measures that demonstrate a health service's success in reducing preventable harm and improving the quality of care.

In line with COAG commitments, commencing in July 2017, Victoria will progressively introduce funding policies to reflect non-payment for avoidable harm.

Victoria's 2019–20 approach to pricing for sentinel events involves a staged implementation of the national pricing model for sentinel events. If a sentinel event occurs, and the event is deemed to be avoidable, health services will not receive payment for the episode of care.

A national pricing and funding model for Hospital Acquired Conditions (HAC), developed by the Independent Hospital Pricing Authority, will continue in 2019–20. The national HAC model applies a risk-adjusted discount factor for each episode in which a HAC is present. The national model adopted by Victoria will apply the same discount factors to WIES to determine a WIES adjusted HAC value. In 2019–20, Victoria will adopt a shadow funding approach to the introduction of the HAC adjustment and not apply any discount to health service funding.

1.4.3.6 Subcutaneous immunoglobulin therapy

The National Blood Authority has made available immunoglobulin products since 1 September 2013, which can be delivered at home to treat:

- primary immunodeficiency with antibody deficiency
- specific antibody deficiency
- acquired hypogammaglobulinaemia secondary to haematological malignancy
- secondary hypogammaglobulinaemia (including iatrogenic immunodeficiency).

There are about 2,200 patients who are currently treated with intravenous immunoglobulin. Approximately 30 per cent of these patients could be treated with subcutaneous immunoglobulin therapy.

The department will provide hospitals with quarterly funding for each patient being treated with subcutaneous immunoglobulin at home in 2019–20. More information can be found on the Subcutaneous Immunoglobulin (SCIg) access program webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/blood-matters/scig-implementation-program>.

1.4.3.7 Dental pricing

The Victorian Auditor-General's report *Access to public dental services in Victoria* made a range of recommendations in relation to pricing, funding, performance management and other parameters for state government-funded services. The department is working with Dental Health Services Victoria to review current Dental Weighted Activity Unit (DWAU) pricing arrangements, with a view to developing options to standardise pricing across the state.

The development of standardised pricing will be addressed through a staged approach. The first stage was completed in 2017–18 when a new minimum floor price per DWAU was introduced for all public dental providers.

The department will continue to work with Dental Health Services Victoria in 2019–20 to pursue a common single price and other associated pricing arrangements for implementation in accordance with the Auditor-General's recommendations.

1.4.3.8 High cost, low volume cross-border patients

The department allocates funding according to the expected activity levels. The department usually estimates its expected revenue for a relevant financial year (Commonwealth, state, net cross boarder funding) and also sets aside funding for known commitments to be incurred during the financial year.

In general, funded organisations are cash-flowed during the financial year according to their funding allocations. Funded organisations are expected to manage their resident and non-resident demand based on the funding provided.

Where required, adjustments to this funding for over- and under-activity are made in the following financial year according to the policies set out in the prior year adjustment section of the guidelines. The prior year adjustment policy does not make adjustments for changes for annual variations in this cohort.

In accordance with Clause A91 of the National Health Reform Agreement, cross-border agreements are developed between jurisdictions that experience significant cross-border flows. The department has established agreements with all other states and territories (jurisdictions), based on a standard agreement. These agreements form the basis of the flow of funds between Victoria and other jurisdictions for residents treated from those respective states and territories. Annual reconciliations of cross-border flows occur to determine the liability of each jurisdiction. This revenue/liability is then factored into the available revenue available for redistribution as part of the modelled budget each year.

Under these agreements, all financial transactions are to be transacted by the relevant health departments and not through inter-agency transfers (for example, hospital to hospital or state health department to hospital).

Under the cross-border agreement, there is an exemption for high cost procedure. A high cost procedure is defined as a procedure that is not reasonably funded by the existing classification system and cost weights and are agreed to at a jurisdictional level prospectively on a case-by-case basis. For the avoidance of doubt, this definition excludes experimental procedures.

Admitted acute high cost procedures (for example, those funded by WIES) are defined by procedures that:

- are provided at limited sites nationally
- have low volume (< 200 separations nationally)
- cost significantly more (> $20,000) than the funding provided based on the relevant year's National Efficient Price Determination <https://www.ihpa.gov.au/what-we-do/national-efficient-price-determination>.

Prior to the procedure, hospitals may seek this exemption (in limited circumstances) from the department for those services classified as high cost procedures and that will be provided to patients who reside in another state or territory. Subject to meeting the definition of a high cost procedure and complying with the agreed criteria and process, hospitals may be paid a supplementary payment by the department through the prior year adjustment process to meet the difference between the department's funding allocation and the actual cost of the procedure paid by the resident's jurisdiction.

Hospitals should advise the department in advance (wherever possible) and care to non-resident patients should not be subject to or impacted by financial arrangements and should be based on standard clinical protocols.

Hospitals may not seek an exemption for Nationally Funded Centre (NFC) procedures as the funding for these procedures are already shared by jurisdictions and set annually by the Australian Health Ministers' Advisory Council.

1.5 Notification obligations

1.5.1 Issues of public concern

The *Health Services Act 1988* (HSA), *Ambulance Services Act 1986* (ASA) and *Mental Health Act 2014* (MHA) specify the functions of health service boards and chief executive officers. Included in these functions is the requirement for boards to ensure that the relevant portfolio Minister (Health, Mental Health or Ambulance Services) and the Secretary are advised about significant board decisions and are promptly informed about any issues of public concern or risks that affect or may affect the public health service (HSA ss. 65S(2)(i), 33(2)(i) and 115E(2)(l); ASA s. 18(1)(i); MHA s. 345). Chief executive officers must also inform the board, Secretary and relevant Minister, without delay, of any significant issues of public concern or significant risks affecting the health service (HSA ss. 40I(1)(h), 65XB(1)(h) and 115JC(1)(h); ASA s. 21(3)(h); MHA s. 340(3)(ch)).

1.5.2 Changes to range or scope of activities

Before health services undertake a significant change in the range or scope of services, the planning implications of such a move must be discussed with the department. All health services should contact their departmental performance lead. The department must provide explicit approval before a health service may significantly alter its services.

1.5.3 Exceptional events

There may be circumstances (including industrial action and natural disasters) beyond the reasonable control of health service management that may prevent the health service reaching its targeted throughput. At its discretion, and on a case-by-case basis, the department will consider submissions to adjust funding to health services, irrespective of throughput, for so long as such events continue.

Health services are expected to actively mitigate their financial exposure and any decline in throughput during and following such events.

1.6 Data and reporting changes

1.6.1 Revisions to the *Victorian Admitted Episode Dataset: Criteria for Reporting*

The Victorian Admitted Episodes Dataset: Criteria for Reporting document provides guidelines to enable health services to distinguish between admitted and non-admitted patient episodes for the purpose of data reporting. The document can be downloaded from the HDSS website <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems>.

Refer to the VAED policy, related factsheets and the procedure code lists <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vaed>.

1.6.2 Data collection changes

The following sections describe the key data collection changes. Refer to information about data collection changes <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/annual-changes>.

1.6.2.1 Victorian Admitted Episodes Dataset

The department will undertake a proof of concept project during 2019–20 to investigate the feasibility of collecting clinical data from health service clinical systems instead of from the Victorian Admitted Episodes Dataset (VAED). This project will focus on key data elements already in the VAED and may provide an alternative for health services that record VAED-related data outside of their patient administration systems.

There are no major changes to VAED for 2019–20.

1.6.2.2 Elective Surgery Information System

The following changes to the Elective Surgery Information System (ESIS) will apply from 1 July 2019:

- add an identifier for the surgeon referring the patient onto an elective surgery waiting list
- implement a new codeset to describe the elective procedure for which the patient has principally been placed on the waiting list.

1.6.2.3 Agency Information Management System

The following changes to the Agency Information Management System (AIMS) will apply from 1 July 2019:

- a new Clinical Indicators for Breathlessness collection for admitted and community palliative care
- a new data collection for Transition Care Program Key Performance Indicators
- expansion of the Public Sector Residential Aged Care Services data collection to include quality indicators.

1.6.2.4 Victorian Emergency Minimum Dataset

The following changes to the Victorian Emergency Minimum Dataset (VEMD) will apply from 1 July 2019:

- telehealth presentations will be included within the scope of VEMD
- mental health, alcohol and drug treatment hubs will be incorporated into the VEMD for non-admitted patients.

1.6.2.5 Victorian Ambulance Dataset

There are no major changes to the Victorian Ambulance Dataset (VADS) for 2019–20.

1.6.2.6 Victorian Integrated Non-Admitted Health dataset

The department will focus on improving the coverage of the Victorian Integrated Non-Admitted Health dataset (VINAH) in 2019–20, as well as investigating complementary systems to collect non-admitted patient activity. Additional programs and health services that are not currently in scope for VINAH reporting will be investigated and a plan for implementation will be developed.

The following key changes to the VINAH will apply from 1 July 2019:

- record the start and end time of all non-admitted patient contacts (optional)
- include activity for a new stream of non-admitted patients attending the Palliative Care Day Hospice program
- report the health condition for all specialist clinic episodes (optional).

1.6.2.7 Victorian Perinatal Data Collection

Health services where births occur (or where a midwife or medical practitioner attends a birth not in a health service) are required to report the information set out in the birth report specified by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) for inclusion in the Victorian Perinatal Data Collection (VPDC). Refer to Chapter 2, section 2.13.2.13 'Consultative councils reporting requirements'. Under the Public Health and Wellbeing Regulations 2009, VPDC data is to be submitted within 30 days of the birth, unless otherwise specified by the CCOPMM.

The VPDC is a population-based surveillance system to collect and analyse comprehensive information on and in relation to the health of mothers and babies to contribute to improvements in their health outcomes. It contains information on obstetric conditions, procedures and complications, neonatal morbidity and congenital anomalies relating to every birth in Victoria from 20 weeks' gestation. The definition of a birth for this purpose means a birth or stillbirth that is required to be registered under the *Births, Deaths and Marriages Registration Act 1996*.

The VDPC manual, including data definitions, business rules and submission guidelines, is available at Notifying to the Victorian Perinatal Data Collection – Better Safer Care website <https://bettersafercare.vic.gov.au/about-us/about-scv/councils/ccopmm/notifying-the-vpdc>.

In 2019–20 there will be a continuing data compliance focus to ensure the data is received in a timely manner and that data quality issues are identified as early as possible.

1.6.2.8 Public sector residential aged care services

Performance and quality improvement changes:

- Services should note that from 1 July 2019 a set of performance measures for PSRACS will be piloted, with a sector-wide rollout expected in 2020–21.
- From 1 July 2019 health services will be accredited against a new set of aged care standards and it is expected that services develop a transition plan to support this change.

The following key changes to the Agency Information Management System (AIMS) will apply from 1 July 2019:

- Public sector residential aged care data collections Forms S5_129 and S5_115: following on from changes implemented on 1 July 2018, further changes have been made to improve the quality of data and to augment the data collection to better inform policy and planning. Changes include additional demographic data fields (noting that this is no longer collected monthly) to include for example, the numbers of residents under 65 years of age and numbers of residents; services will also be able to record additional residential aged care activity that is over and above that funded by DHHS as well as record other care provided in the PSRACS. These changes come into effect 1 July 2019 and it is

envisaged that minimal staff training will be required and that software modifications will not be required with the proposed amendments.

1.6.2.9 Aged Care Assessment Services

On 7 March 2016 Victorian Aged Care Assessment Services transitioned to operating in the national My Aged Care gateway. The former ACE database has been decommissioned. Since August 2016, all Aged Care Assessment Services data is being recorded in the My Aged Care system. The Commonwealth provides monthly performance reports to the department.

1.6.2.10 Home and Community Care Program for Younger People: NDIS reporting

Organisations funded by the Home and Community Care Program for Younger People (HACC-PYP) should use the provider report available online to monitor the impact of the NDIS rollout in the three years to December 2019.

The department produces the provider report twice a month. Its spreadsheets contain information that is essential to HACC-PYP-funded providers during the phase-in period, charting the progress of clients through NDIS intake and assessment.

This is in addition to continuing to participate in the quarterly HACC minimum dataset.

1.7 Acute inpatient services (WIES)

Budgets for acute admitted services will continue to be determined using the weighted inlier equivalent separation (WIES) funding model, which accounts for approximately 60 per cent of health services' funding. Additional funding is provided through block funding and specified grants.

In Victoria, casemix is a method of funding that is used to support funding policy objectives such as equity, transparency, accountability, allocative efficiency and technical efficiency by funding hospitals according to industry standards for like services.

Allocations of the statewide health budget to Victorian public hospitals are based on a combination of casemix and other funding. This approach recognises that not all hospital services are directly related to providing inpatient care, and not all hospital services are equivalent.

Casemix refers to classifications that bundle patient care episodes into clinically coherent and resource homogeneous groups. Casemix commonly means the mix of types of patients treated by a hospital.

Read more about the casemix funding model <https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/activity-based-funding>.

In 2019–20 the unit of measure for acute admitted casemix-adjusted throughput will be known as WIES26.

1.7.1 Acute admitted services

In Victoria health services are funded to provide 24-hour acute admitted care. Some health services provide specialist admitted care services (for example, intensive care) or designated statewide services (for example, trauma or transplantation).

Health services are responsible for:

- ensuring the health service has the capability and capacity to deliver services described in its SOP with the ability to transfer patients to another health service if a patient requires services outside the scope of the health service's service delivery
- the medical, nursing and personal care, hotel services (for example, nutrition, bed, clean facilities), the required clinical support services (for example, allied health, pharmacists and medicines, blood management and blood products, pathology) and other support services (for example, infection prevention, language services, clinical trial support)
- the provision of prosthetics, devices, medicines and wound care consumables prescribed during the admission and, if required, on discharge from the health service
- the availability of suitably credentialed and privileged staff and the management of contracted or brokered staff or services
- ensuring equitable access to services, treating each patient based on their clinical need
- offering services in the person's home via telehealth, with the required cultural and linguistic support
- ensuring discharge planning and service coordination with other health service programs (for example, rehabilitation, the Health Independence Program) and community-based services in the form of a timely clinical handover that includes a complete and current medication list
- offering services such as patient pathways and electronic or telephone advice lines to support referring clinicians that may reduce demand for admitted services
- clinical governance
- ensuring that no charges are raised for any service during the admission and that charges raised on discharge are only those included in the *National Health Reform Agreement*
- meeting all requirements for claiming monies through private health insurance, Medicare, Department of Veterans' Affairs, Transport Accident Commission (TAC), WorkSafe and patients that are ineligible for Medicare

- ensuring there are fit-for-purpose facilities to:
  - support the treatment of inpatients by multidisciplinary teams
  - reduce the risk of errors, accidents and hospital-acquired conditions
  - ensure the safety of patients, staff, visitors, volunteers and students
  - ensure the privacy and dignity of patients, their carers and family
  - enable isolation or transfer of patients with infectious conditions or who are immunocompromised
  - support the care of terminally ill and dying patients
  - support home-delivered admitted care.

1.7.2 Admission policy

Please note the following:

- Admission policy applies to acute (admitted and non-admitted), subacute and specialist clinics patients' admissions.
- Only acute non-admitted services that are not funded by another Victorian funding model are eligible to be funded under the acute non-admitted specialist clinics weighted ambulatory service event (WASE) funding model.

A distinction is drawn between admitted and non-admitted patients throughout the classification, coding and funding systems. This distinction divides those patients with longer lengths of stay and more serious illnesses from those presenting with less serious conditions or shorter treatment times. Generally, admitted patients are treated in wards and non-admitted patients in specialist clinics. The criteria for admission are provided in the *Victorian Admitted Episode Dataset: criteria for reporting* policy <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems>.

The *Victorian Admitted Episode Dataset: criteria for reporting* policy provides guidelines to enable hospitals to distinguish between admitted and non-admitted patient episodes for the purpose of reporting. Care provided in an emergency department is not considered part of admitted care. In order to be reported to the Victorian Admitted Episodes Dataset (VAED) patients must meet one of the admission criteria outlined in the policy.

Patients not meeting one of these criteria are non-admitted patients. No data for these encounters is to be reported to the VAED. The policy applies to public and private hospitals as well as all health services registered under the Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002.

Admissions are actual formal admissions, or statistical (when the care type may change). Admission practices must ensure that an eligible person's priority for receiving health services is not determined by:

- whether the person has health insurance
- the person's financial status or place of residence
- whether the person intends to elect or elects to be treated as a public or private patient
- a person's status as a Medicare-ineligible asylum seeker (refer to Hospital Circulars 27/2005 and 29/2008).

As part of their admission practices, health services will:

- ensure that an eligible person, at the time of admission or as soon as practicable thereafter, elects or confirms in writing whether they wish to be treated as a public patient or a private patient and that this election process conforms to the *National Standards for Public Hospitals Admitted Patient Election Processes*
- ensure that any ineligible person is appropriately identified as such in the VAED
- report admitted Medicare-ineligible asylum seekers to the VAED with the account class code MF – Ineligible Asylum Seeker (see Hospital Circular 27/2005)
- make every effort to verify the place of residence of interstate patients

- ensure that all patients admitted to hospital are asked whether they are of Aboriginal or Torres Strait Islander background. (Identifying Indigenous status is a mandatory data item to be reported by hospitals to the VAED. Aboriginal and Torres Strait Islander patients identified on the VAED will be funded at a 30 per cent loading to the nominated WIES payment for 2019–20.)

1.7.3 Classification, counting and costing

Victoria's casemix funding model allocates funding on the basis of the numbers and types of patients treated, and the average cost of treating patients. In practice, casemix funding requires three basic measures:

- classifying patients treated (diagnosis-related groups)
- counting patients treated (administrative health data collections)
- costing patients treated (hospital cost data collections).

1.7.3.1 Classifying patients

Diagnosis-related groups

Diagnosis-related groups (DRGs) are a method of classifying treated patients with similar clinical conditions and similar levels of resource use. In particular, the objectives of the DRG classification are:

- Each DRG is clinically meaningful – the diagnostic clusters must be accepted by clinicians and must be similar for episodes within the DRG
- Each DRG is resource homogeneous – the type of resources used, and their amount, should be similar for episodes within the DRG
- Within each DRG, the specific diagnostic episodes should 'map' to that DRG alone and not to multiple possible DRGs.

Victoria currently uses the Australian Refined Diagnosis Related Groups (AR-DRG) classification, which incorporates:

- *International Statistical Classification of Diseases and Related Health Problems*, 10th revision, Australian Modification (ICD-10-AM)
- Australian Classification of Health Interventions (ACHI)
- Australian Coding Standards (ACS).

The AR-DRG classification is continuously updated nationally, with AR-DRG Version 9.0 (AR-DRG9.0) being the latest available version at the time of the WIES26 formulation. Victoria will use AR-DRG9.0 for funding purposes in 2019–20.

Victoria also makes minor modifications to AR-DRGs, known as Victorian-modified DRGs (VIC-DRG), to suit local funding requirements. The majority of these modifications have been incorporated in subsequent versions of AR-DRGs.

1.7.3.2 Counting patients

Each time a patient is admitted and discharged from hospital during the year, it is counted as an episode of care. Episodes can also be called admissions or separations. Full diagnostic and treatment information is determined once the patient leaves (separates from) the hospital. A single patient may have a number of separations during the year.

Separations can also occur when admitted patients are transferred to another hospital, change the type of care required (see below) or die in hospital.

On each episode of care, a patient may have a number of diagnoses and procedures recorded. The principal diagnosis is the reason for the patient being admitted following investigation and is the primary driver for the allocation to a DRG. The principal diagnosis is not the preliminary diagnosis. It is only assigned after the patient's condition has been investigated.

In Victoria it is a condition of funding that health services collect and report electronic records for every patient treated. The department maintains health data collections that span a range of healthcare settings including admitted patients, emergency department presentations, non-admitted encounters and elective surgery.

Inpatient activity is reported to the VAED and includes all admitted episodes of patient care from all public hospitals.

Read more about the VAED <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems>.

1.7.3.3 Costing patients

It is expected that health services maintain and report acute (admitted and non-admitted), subacute, mental health, emergency and specialist clinic patient-level costing data which is used in the development of funding models.

Victorian public hospitals are required to report patient-level cost information about the services used to deliver care across all hospital patient settings. The department currently maintains annual cost data collections for all patients treated covering admitted, non-admitted and emergency services from all metropolitan, major rural and some small rural public hospitals. The data collections include:

- admitted including acute, subacute (geriatric evaluation and management (GEM)), palliative care (including phase of care), rehabilitation and mental health
- non-admitted contacts including subacute and mental health
- home-based service delivery
- emergency activity including all emergency department presentations and urgent care centre activities
- mental health community activity including subacute residential services (prevention and recovery care, community care units, aged persons residential) and consultation liaison services
- radiotherapy
- community health services
- specialty programs such as the Victorian Perinatal Autopsy Service and other diagnostic and therapeutic services.

Health services' cost method is to allocate actual expenditure to patients' actual interactions and events (including allocation of hospital overhead expenses) known as patient-level costing. This approach is more direct and sophisticated because it uses service volumes (for example, actual tests and minutes in theatre) and minimises assumptions, thereby achieving more accurate cost allocations at the individual patient level.

By contrast, cost modelling is a top-down allocation method where expenses are allocated based on averages and apportionments attributing the same costs to all patient episodes. This method of patient costing is not recommended because it achieves a less accurate cost allocation. However, hospitals cost-model to some extent when there is an absence of patient service volumes, but hospitals can differ widely in the extent to which they model.

In Victoria, actual expenditure (direct and indirect/overhead) is allocated, capital and depreciation costs are excluded (not allocated) and all allocated costs must reconcile with the general ledger. Costs are reported by service areas (cost centres as found in the chart of accounts) and by account types such as salary and wages (by professions), medical supplies or drugs etc. For ease of analysis these are mapped into generic cost buckets such as nursing, medical, theatre and pathology etc.

Health services must adhere to the specifications, business rules and costing guidance outlined in the documentation found within the data collections list of reports for the Victorian Cost Data Collection <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vcdc>. The VCDC document is guided by the *Australian Hospital Patient Costing Standards* (version 4.0 or the most recent version available).

To ensure the integrity and assurance of quality data and as part of good hospital management practice health services are expected to:

- maintain activity and costing systems
- review allocation methodologies
- reconcile financial and non-financial information to source systems
- identify and review fluctuations in cost results.

1.7.4 Basic WIES cost weights

1.7.4.1 Weighted inlier equivalent separation

Casemix funding is based on a patient episode (separation) that is cost-weighted according to its DRG group and length of stay (LOS). A cost-weighted separation is called a weighted inlier equivalent separation (WIES) and is calculated using different cost weights (weighted) for different types of stay (inlier equivalent separation) within each DRG. In general, the longer a patient stays in hospital, the costlier the episode will be, and the more WIES that will be allocated (for instance, patients who stay five hours will generally use fewer resources and cost less than a patient who stays five days, even though both patients might be in the same DRG).

Health services receive an annual budget consisting of WIES target levels of activity plus a range of specified grants. Health service management is then responsible for allocating the annual budget across different areas of the hospital and for managing variable activity to within the allocated WIES target budget.

1.7.4.2 Inliers and outliers

If all separations within a DRG were weighted by a single average cost weight, hospitals with short-stay patients would benefit and those with long-stay patients would be disadvantaged.

Statistical approaches are often used to identify patients with atypical hospital stays. However, the purpose of setting limits is not to identify 'atypical patients' but to limit the financial impact of the most and least expensive cases. In many heterogeneous DRGs, a significant proportion of low-cost or high-cost patients is expected.

To minimise the relative financial risk for hospitals, the concept of 'inliers' (or usual patients) and 'outliers' was introduced. Under the Victorian acute-inpatient cost-weight model, an average patient stay for most DRGs is in the range given by the average length of stay (ALOS) multiplied and divided by three (L3H3 boundary policy). This range is called the 'inlier' and the boundary points of the range are called 'high' or 'low'. Cases outside the inlier range are called low outliers (for a short LOS) or high outliers (for a long LOS). If the patient's LOS falls within the inlier range, the episode will attract the standard inlier WIES payment for that DRG. For a minority of DRGs that are clinically heterogeneous and contain high-cost cases, the inlier range is given by the ALOS multiplied and divided by 2/3 (L2/3H3/2 boundary policy).

For some DRGs, separate cost weights are developed for same-day and multi-day patients to ensure that multi-day cost weights are not diluted by high-volume, low-cost, same-day patients. Similarly, for other DRGs, separate cost weights are developed for cases with a LOS of one day to ensure that multi-day cost weights are not diluted by high-volume, low-cost, same-day and overnight patients.

If the patient stays longer than the inlier, the hospital will receive an additional payment for every day over the inlier range.

In most DRGs, the costs per day decrease with a longer LOS; in others the costs can remain the same.

To account for this, the daily payment level beyond the inlier range can be altered to suit the DRG patient profile. Payment rates are set at 80 per cent of the average daily inlier cost for medical patients and 70 per cent of the average inlier daily cost (excluding theatre and prosthesis costs) for surgical patients.

The total value of the WIES is based on the sum of cost weights for the inlier and outlier components of the stay (if appropriate).

This mechanism provides the incentive for efficiency (in that hospitals will aim to provide services within the inlier range) and equity (in that patients below the range receive less funding and those higher than the range receive additional funding).

For 2019–20 (WIES26), boundary points have been informed by trends in ALOS within the VAED over the period from 1 July 2012 to 31 March 2018.

1.7.4.3 WIES co-payments

In some instances, patients have higher costs, but these higher costs are not found for all patients within the DRG or group of DRGs.

One example is the higher costs of patients in intensive care units (ICU). While all ICUs generate higher costs, ICUs differ across hospitals, and within an ICU some patients receive far more intensive care. As a way of recognising the higher costs of the ICU, a co-payment is provided for mechanical ventilation and for non-invasive ventilation over a specified time period. In addition, each year as new technologies are used, some patients will have significantly higher costs associated with prostheses. In recognition of these costs, a co-payment may be provided if appropriate.

Similarly, particular types of patients will have more complex needs regardless of the DRG. A co-payment is provided in recognition of the higher costs for these patients.

Details and technical specifications of all current WIES co-payments are in the Appendices, Appendix 1, Addendum 1.1: 'Calculating WIES26 for individual patients'. These co-payments include the following procedures and patients:

- invasive mechanical ventilation
- non-invasive ventilation
- thalassaemia patients
- stents used in the endovascular repair of abdominal aortic aneurysm (AAA stent)
- atrial septal defect (ASD) closure devices used in cardiac surgery
- cochlear prosthetic device
- Aboriginal and Torres Strait Islander patients.

To improve outcomes for Aboriginal and Torres Strait patients, hospitals that receive WIES co-payments are required to complete the *Aboriginal health and wellbeing – improving care for Aboriginal patients* continuous quality improvement tool.

1.7.5 Development of WIES26 cost weights

1.7.5.1 WIES26 cost weights

Cost weights represent a relative measure of resource use for each episode of care in a DRG. They are essentially calculated as the ratio of the average cost of all episodes in a DRG to the average cost of all episodes across all DRGs. Victorian cost weights are developed each year using the costs of treating patients as reported to the Victorian Cost Data Collection by public hospitals.

As mentioned, in 2019–20 the unit of measure for acute-admitted, casemix-adjusted throughput is known as WIES26. WIES26 cost weights have been developed using 2017–18 acute-admitted cost data as reported by Victorian public hospitals to the annual Victorian Cost Data Collection. WIES26 cost weights are scaled to equal the number of WIES25 reported by public hospitals for the latest 12 months of measured activity available at the time of WIES25 formulation (1 March 2018 to 28 February 2019).

The following changes from the WIES25 (2018–19) funding model have been introduced for WIES26:

- Inclusion of a Victorian modification of AR-DRG v 9.0 where 31 specific Eleventh Edition ICD-10-AM diagnosis codes, when not coded as the principal diagnosis, will be omitted for the purpose of grouping to VIC-DRG 9.0 (see the Appendices, Appendix 1, Addendum 1, section A1.1.2 'Victorian AR-DRG modifications'). This modification anticipates the 2020–21 implementation of AR-DRG v 10.0 where these same 31 diagnosis codes will also be excluded from the AR-DRG v 10.0 episode clinical complexity model.
- Pharmacy costs that are funded by the Commonwealth under the Highly Specialised Drugs program (i.e. Section 100 and Pharmaceutical Benefits Scheme) are excluded from the cost weight set for VIC-DRG90 R63Z Chemotherapy. This change results in a closer alignment of funding with cost by more accurately accounting for the Commonwealth's funding contribution for DRG R63Z Chemotherapy.
- Inclusion of three new public hospital intensive care units (ICU) for eligibility to receive ICU-related WIES co-payments triggered by hours of mechanical ventilation or non-invasive ventilation, namely: Angliss Hospital, Casey Hospital and Werribee Mercy Hospital (see the Appendices, Appendix 1, Addendum 1, section A1.1.3 'Co-payments, Table 1.33).

The DRG cost weights to be applied in 2019–20 are listed in the Appendices, Appendix 1, section 1.3.1 'WIES26 Victorian cost weights'. The table in this section shows the boundary points, co-payments and the ALOS for inliers used to determine high outlier per diem cost weights.

A series of modifications are made to allow for the adjustment of technical difficulties in the costing process and to ensure WIES equivalence over time. These include:

- Adjustments for under-reporting of prosthesis costs.
- Adjustments for the proportions of private patients.
- Adjustments for the number of outliers where the boundary range is reduced to ALOS × 2/3 and ALOS × 3/2.
- Exclusion of individual patient episodes with unreasonably low costs and referral back to the hospital for verification of records with atypically high costs or other apparent inconsistencies.
- Averaging over multiple years where there are large unexplained cost movements (where there are relatively few cases this is done routinely; where more than 150 cases occur in a given DRG, the department, industry and clinical groups review the situation).

Detailed instructions about calculating the WIES for individual patients is at the Appendices, Appendix 1, Addendum 1.1: 'Calculating WIES26 for individual patients'.

The definitions of WIES26 variables are in the Appendices, Appendix 1, Addendum 1.2: 'Definition of WIES26 variables'.

1.7.5.2 WIES26 eligibility

The majority of patients in hospital will be allocated a WIES26 price weight. However, as in previous years, WIES cannot be calculated for incomplete or uncoded episodes. Further, WIES is not necessarily an appropriate measure of resource use for many non-acute patients.

WIES cost weights are sometimes allocated to some patient episodes that are ineligible for casemix funding. WIES from these episodes will need to be excluded when comparing health service activity against targets during 2019–20.

Eligible patients might be entitled to base WIES payments and WIES co-payments. Base WIES payments are made according to the formula, which models the average costs for patients in each VIC-DRG9.0. WIES co-payments are made to cover the higher costs of care provided to some special types of patients.

Base WIES payments for long-stay patients can be affected by co-payments, so it is advisable to determine if a patient is eligible for WIES co-payments first.

All episodes in VAED with the care type '4 – Other care (Acute), including qualified newborns' are WIES fundable, except for:

- private hospital separations
- incomplete or uncoded episodes, or episodes coded to a problem VIC-DRG9.0 (zero weight) including Ungroupable (960Z), Unacceptable Principal Diagnosis (961Z) and Neonatal Diagnosis Not Consistent W Age/Weight (963Z)
- episodes with an account class on separation of Newborn – Unqualified, not birth episode (NT), Victorian WorkCover Authority (WC), Ineligible non-Australian residents – not exempted from fees (XX), Armed Services (AS), Common Law Recoveries (CL), Other compensable (OO) and Seamen (SS)
- episodes where the contract role is B (service provider hospital)
- episodes from hospitals not eligible for WIES funding
- episodes with DRG L42Z unless the episode is reported by St Vincent's Health, Ballarat Health Services, Bendigo Health, Barwon Health, Goulburn Valley Health, The Royal Children's Hospital, Mildura Base Hospital, Western Health or Mercy Health (Werribee campus only)
- episodes that have been coded as follows – this activity has been funded through specified grants:
  - include an electroconvulsive therapy code [9334100–9334199]
  - care type 4 (Acute)
  - separated from The Royal Melbourne Hospital (campus code 1334)
  - funding arrangement 2 (Hub and Spoke)
  - contract/spoke identifier in (0010, 0011 and 0012).

1.7.6 Pricing

The standard WIES26 price is established in terms of the general budget and considers other forms of funding. It is not the same as the average cost per WIES.

WIES26 prices can be found in the Appendices, section 1.1 'Price tables'.

The funding provided to any patient or all patients can be calculated by multiplying WIES26 by the price.

1.7.6.1 Peer group prices

The 2018–19 peer groups have been maintained for 2019–20. The two peer groups are:

- **metropolitan and regional** – this group is unchanged
- **subregional and local** – this group is unchanged.

The WIES peer groups for 2019–20 are outlined in the Appendices, section 1.2 'Peer groups for WIES purposes'. Note that these peer groups only relate to the price for acute hospital activity and are for recall and throughput policy purposes.

1.7.6.2 Normative pricing

In 2019–20 as a continuation of efficient pricing, the WIES26 cost weights for the following VIC-DRG9.0s are based on the median (rather than average) prosthesis costs:

- I03A Hip Replacement for Trauma, Major Complexity
- I03B Hip Replacement for Trauma, Minor Complexity
- I04A Knee Replacement, Major Complexity
- I04B Knee Replacement, Minor Complexity
- I33A Hip Replacement for Non-Trauma, Major Complexity
- I33B Hip Replacement for Non-Trauma, Minor Complexity.

1.7.7 Pricing for quality

In line with recommendations arising from the Independent Hospital Pricing Authority (IHPA) *Consultation paper on the pricing framework for Australian public hospital services 2017–18* (2016), the Australian Government determined that, from 1 July 2017, any admitted or non-admitted episode of hospital care associated with a sentinel event would not be funded in its entirety (also known as 'pricing for quality'). In response, Victoria introduced a new pricing mechanism for sentinel events in 2017–18, where episodes of care with an avoidable sentinel event, as defined by the nationally agreed sentinel event categories, are not funded. This model excludes 'category 11 (previously category 9) – Other catastrophic' because this sentinel event category is only used in Victoria and not subject to the national pricing for quality.

Health services are required to report all sentinel events (see list below) to the Sentinel Event Program, which is coordinated by Safer Care Victoria. All sentinel events in categories 1–10 are analysed to determine avoidability. If an event is found to be avoidable, a health service will not receive payment for the entire episode of care.

The IHPA has developed a national pricing and funding model for hospital-acquired conditions (HAC). This model applies a risk-adjusted discount factor to each HAC episode. In 2019–20 Victoria will continue to apply the IHPA model and the national discount factors to the WIES model. Victoria will apply a shadow funding approach in 2019–20 and will not adjust health services funding for HAC episodes.

1.7.7.1 Sentinel events list

- Surgery or other invasive procedure performed on the wrong *site* resulting in serious harm or death
- Surgery or other invasive procedure performed on the wrong *patient* resulting in serious harm or death
- Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death
- Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death
- Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death
- Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward
- Medication error resulting in serious harm or death
- Use of physical or mechanical restraint resulting in serious harm or death (new)
- Discharge or release of an infant or child to an unauthorised person
- Use of an incorrectly positioned oro- or nasogastric tube resulting in serious harm or death (new)
- Other catastrophic: Incident severity rating one (ISR1)

1.7.7.2 Hospital-acquired conditions

A HAC refers to a complication that is acquired in hospital for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.

The list of HACs was determined by a joint working group of the Australian Commission on Safety and Quality in Health Care and the IHPA.

The HACs are:

- pressure injury
- falls resulting in fracture or other intracranial injury
- healthcare-associated infection
- surgical complications requiring unplanned return to theatre
- unplanned intensive care unit admission
- respiratory complications
- venous thromboembolism

- renal failure
- gastrointestinal bleeding
- medication complications
- delirium
- persistent incontinence
- malnutrition
- cardiac complications
- third- and fourth-degree perineal laceration during delivery
- neonatal birth trauma.

More information on the HAC list, including diagnosis codes used to identify each HAC, is available at Hospital-acquired complications – Australian Commission on Safety and Quality in Health Care <https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications>.

The funding adjustment for HACs has been risk-adjusted to take account of the increased predisposition of some patients to experiencing a HAC during their hospital stay and adjusts the reduction in funding accordingly.

More information on the risk adjustment model for HACs, including the risk factors for each HAC group, is contained in the National Pricing Model Technical Specifications 2019–20 – Independent Hospital Pricing Authority website <https://www.ihpa.gov.au/publications/national-pricing-model-technical-specifications-2019-20>.

1.7.8 Transport supplement to health services

Ensuring patients have access to the right service can result in some patients being transported to another health service for their care. Decisions to transport patients are based on clinical factors, and it is important that funding approaches support the appropriate decisions being made.

In 2019–20 the eligible threshold for health services that had transport costs (as a proportion of total funding) will be 1.45 per cent.

Health services are also encouraged to consider strategies that will assist in reducing inappropriate costs associated with patient transport.

1.7.9 Interpreter supplement to health services

Departmental policy requires health services to provide professional interpreting and translating services for people who speak limited or no English when making significant health decisions.

The current funding approach of including all interpreter services funding in WIES is not aligned with the distribution of total costs associated with providing interpreter services.

The department will continue to provide a funding supplement for those services with significantly higher than average costs for the provision of interpreter services in 2019–20.

In 2019–20, health services with reported interpreter costs that exceed 0.2 per cent of their total funding will receive additional funding from the department (excluding Dental Health Services Victoria). Health services deemed to be eligible will receive funding equal to 75 per cent of the reported costs above the 0.2 per cent of total funding threshold.

1.7.10 Hospital in the Home

Admitted care provided to patients at home is seen as equivalent to in-hospital care. Patients treated through Hospital in the Home (HITH) are funded through WIES. HITH patients are identified through changes in accommodation type and the WIES high outlier payment for HITH patients is reduced (by 20 per cent) to better approximate costs.

HITH patients must fulfil the criteria for admission as per the department's *Victorian Admitted Episode Dataset: criteria for reporting* policy. HITH activity is reported to the VAED. Client consent to HITH treatment must be obtained, and documentation must be in the medical record to support the HITH episode being a direct substitution for in-hospital WIES-funded acute care.

HITH separations and bed days are included in the program report for integrated service monitoring (PRISM) reports sent to chief executive officers to enable benchmarking against other health services, particularly in relation to the percentage of multi-day separations managed by HITH. Health services are encouraged to investigate opportunities to use HITH as a substitute for in-hospital acute admitted care.

1.8 Acute specialist services

1.8.1 Emergency department funding

Patients attending the 40 designated and funded emergency departments are either admitted to hospital or discharged after they receive care in the emergency department. The funding approach for emergency department activity mirrors this patient flow through two streams of funding.

In 2019–20 the department will continue funding reforms from previous years and maintain the split-funding approach for the different patient pathways (admitted or non-admitted). Improving the specificity of the two funding streams will provide a clearer signal to health services about the efficient level of resources required for admitted and non-admitted emergency care.

In addition to improving the alignment between cost and funding for non-admitted emergency care, the department has used different measures to allocate the availability and activity component of the funding. The funding model design will retain the two components.

Urgent care centres

Many small rural health services operate urgent care centres, which are equipped to provide first-line emergency care to patients.[2]

Local health services with urgent care centres receive the Group C Accident and Emergency Grant. Small rural health services with urgent care centres fund these services within their small rural health service flexible funding.

At a minimum, urgent care centres have the capacity to perform emergency resuscitation and stabilisation for adults and children and prepare and manage patients for transfer to a higher level of care as clinically appropriate. Depending on the model, patients treated by general practitioners may be billed by the general practitioner.

1.8.1.1 Non-Admitted Emergency Services Grant activity component

The availability component of the Non-Admitted Emergency Services Grant (NAESG) allocated to health services represents 80 per cent of the health service's reported costs for salaries and wages for clinical and administrative staff in the emergency department and the costs for hospital goods and services.

The availability component aims to provide health services with a reimbursement based on the level of staffing required to maintain open cubicles to provide emergency care.

1.8.1.2 Total funding provided through the Non-Admitted Emergency Services Grant

The activity component of the NAESG is allocated to health services based on the proportion of their total (unweighted) reported non-admitted emergency department presentations.

The spilt between the availability and activity pools (80:20) within the 2019–20 NAESG is consistent with the split used in the 2018–19 model.

1.8.1.3 Transition funding adjustment to the altered 2015–16 Non-Admitted Emergency Services Grant

To provide budget stability for health services, a specified grant (positive or negative) has been retained but adjusted to partly reflect the changes observed in the NAESG between years. This approach will be continued in 2019–20

[2] Urgent care centres also provide minor injury/illness services after hours when general practitioner services are not available.

1.8.2 Hepatitis C

The Integrated Hepatitis C Service (IHCS) is a key driver for initiating hepatitis C treatment in Victoria.

The IHCS operating at health services have been funded recurrently through the specialist clinics funding model in 2016–17. Two community health centres currently receiving IHCS funding will continue to be funded under the Hepatitis C Service (Non-Hospital) Grant.

IHCS activity will be reported in the Victorian Integrated Non-Admitted Health (VINAH) dataset. For community health centres with IHCS, activity is reported through the Service Agreement Management System (SAMS) to the Community Health Minimum Dataset.

1.8.3 Renal services

1.8.3.1 Facility dialysis

The funding model for routine haemodialysis in designated public health services providing same-day haemodialysis is through the admitted WIES payment paid to all dialysis providers, and a non-admitted WASE component.

Currently all health services providing satellite dialysis are required to pay their hubs a set rate for each per L61Z dialysis separation based on expected activity levels.

Renal activity and WIES are incorporated within the total agency public and private WIES activity targets. As such, they are subject to the standard health service recall policy.

The WIES recall policy does not apply to small rural health services, which continue to be funded to actual renal activity in 2019–20. Their health service targets have been adjusted based on the average actual activity over the past three years. Recall adjustments for small rural health services will be made at the end of the financial year.

1.8.3.2 Home dialysis funding

Home dialysis is funded as an annual grant of $57,499 per patient in 2019–20 and includes payments to be administered by the hub services for home peritoneal dialysis and home haemodialysis.

Home-based dialysis will continue to be funded to actual activity.

1.8.4 Radiotherapy

Public radiotherapy services are provided at 12 hospitals in Victoria across metropolitan and regional campuses.

1.8.4.1 Non-admitted radiotherapy funding model

Radiotherapy is predominantly (~90 per cent) provided on an outpatient basis and funded under a specific complexity-based funding model. Under this model, the various components of a course of radiotherapy are weighted and aggregated for each course of care. Remaining activity (~10 per cent) is admitted and WIES-funded.

The health services that are funded under the non-admitted radiotherapy funding model are Alfred Health, Austin Health, Barwon Health and the Peter MacCallum Cancer Centre. These four 'hub' services also receive funding for the spoke services they operate across metropolitan Melbourne and regional Victoria.

Find radiotherapy locations <https://www2.health.vic.gov.au/about/health-strategies/cancer-care/radiotherapy/radiotherapy-locations>.

In 2019–20 funding for non-admitted radiotherapy services will continue to comprise:

- a variable payment per weighted activity unit (WAU) to set targets for public, the Department of Veterans' Affairs and private patient categories (costs for associated services are included in this payment and must be provided to all patients as required)
- a Department of Veterans' Affairs premium (where applicable) above the variable payment.

The WAU price can be found in the Appendices, section 1.1 'Price tables'.

In addition to the state contribution for radiotherapy, health services will retain all third-party revenue. Changes to third-party revenue will be considered annually in determining WAU pricing.

The Victorian Radiotherapy Minimum Dataset is the key source of radiotherapy data for funding and service planning. Consultations will continue to be collected via the Agency Information Management System (AIMS) S8 and S10 in 2019–20. In addition, it is expected that health services maintain and report radiotherapy patient level costing data via the Victorian Cost Data Collection.

1.8.4.2 Contracted services

The department funds contract arrangements with private sector radiotherapy operators to provide services at South West Healthcare Warrnambool and at Albury Wodonga Health. Under these arrangements all patients are treated at no cost to them, with the private operators actively participating in public multidisciplinary cancer meetings and providing specialist outreach services across their regions.

1.8.4.3 Shared care

The department provides funding to eligible metropolitan public health services that have entered into shared care contracts with local private radiotherapy operators. Under these arrangements, cancer patients receiving care as public patients and can access local radiotherapy in coordination with their public hospital care at no cost to them. Health services that currently receive funding for radiotherapy shared care are Western Health (Footscray Hospital), Northern Health, Peninsula Health (Frankston Hospital) and Monash Health (Casey Hospital).

Targets for shared care (the number of patients for whom funding is provided) are set with health services prior to each financial year.

Current year WAU targets and health service information are available on the Radiotherapy webpage <https://www2.health.vic.gov.au/about/health-strategies/cancer-care/radio-therapy>.

1.8.4.4 Quality

Statewide Knowledge Based Learning Project

The department has funded and coordinates the Statewide Knowledge Based Learning Project. The project enables participating public radiotherapy providers to more effectively and efficiently benchmark and optimise treatment plans for their cancer patients, leading to fewer side effects for patients from their course of radiotherapy.

The project will continue to develop models across new tumour streams in 2019–20.

Assessment against the Tripartite Radiation Oncology National Practice Standards

Victorian public radiotherapy providers assess their services against the Tripartite Radiation Oncology National Practice Standards using the relevant Self Audit Tool. The tool is used as part of their internal quality management protocols. The results of these assessments are integrated into the annual performance discussions with the department.

Radiotherapy providers forums

The department convenes a public radiotherapy providers forum biannually to discuss system improvement and coordination, performance, outcomes and service planning with the sector. A focus in 2019–20 will be on service planning, mortality and morbidity analysis, pathways of care and variations in practice and utilisation.

1.8.5 Perinatal autopsy service

The Victorian Perinatal Autopsy Service (VPAS) is fully funded for Victorian families that require this specialist perinatal pathology service. Services are coordinated at an agreed rate by the lead agency and provided at any of the three level 6 maternity services (and respective pathology service providers). The Royal Women's Hospital is responsible for administering and coordinating the service.

The value of a perinatal or infant autopsy and pathological examination of the placenta should be explained and offered to parents where there is uncertainty about the cause of death.

All public health services are expected to use the VPAS. Private health services are also encouraged to use the service. The information obtained through the VPAS assists the Consultative Council on Obstetric and Paediatric Mortality and Morbidity to provide expert advice on maternal and perinatal outcomes.

For comprehensive information on access to the service (including pathology request), parental consent forms, 24-hour advice and clinical practice guidelines please refer to the VPAS website <www.thewomens.org.au/health-professionals/vpas>.

1.8.6 Organ and tissue donation

The Australian Organ and Tissue Donation Authority, in partnership with the department, funds the operational costs of DonateLife Victoria (organ donation organisation) and the employment by health services of clinical staff dedicated to organ and tissue donation. Medical and nursing organ and tissue donation specialists are based in a number of metropolitan and regional health services. The Australian Organ and Tissue Donation Authority also provides additional support funding for health services to cover the extra costs associated with organ donation.

Read more about organ and tissue donation <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/organ-tissue-donation>.

1.8.7 Blood products supply funding

Funding for the Victorian blood and blood products supply will continue as per the *National Blood Agreement* (2003) using the Commonwealth–state government funding model of 63–37 per cent, respectively. In compliance with the supply and funding arrangements in the agreement, sufficient volumes of blood and blood products will be available to public and private Victorian health services in 2019–20. This supply plan has been negotiated between the government, the National Blood Authority and the Blood Service. Victoria's contribution in 2019–20 will be over $110 million.

Access to blood and blood products will be guided by the *Blood and blood products charter*, which continues to be implemented with health providers nationally in 2019–20. The National Stewardship Expectations for the Supply of Blood and Blood Products is available from the National Blood Authority website <https://www.blood.gov.au>.

Intravenous immunoglobulin is made available through the supply plan to health services for uses that have been agreed according to the *Criteria for the clinical use of immunoglobulin in Australia*. Intravenous immunoglobulin is also available for direct purchase by health services for uses that have not been included in the criteria due to a lack of sufficient evidence of efficacy as demonstrated by the literature or specialist clinical consensus.

Further information about intravenous immunoglobulin is available at Version 3 Criteria – National Blood Authority website <https://www.blood.gov.au/igcriteria-version3>.

Subcutaneous immunoglobulin is available to health services through the supply plan for agreed uses. The department is funding hospitals for patients being treated at home with self-administered subcutaneous immunoglobulin. More information about access is available from the department's website <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/blood-matters/scig-implementation-program>.

Normal immunoglobulin is subject to national governance arrangements. More information about normal immunoglobulin is available at Access to Normal Human Immunoglobulin (NHIg) – National Blood Authority website <https://www.blood.gov.au/NHIg>.

There is an ongoing commitment to safe transfusion practice in health services through the Blood Matters Program.

Read more about blood and blood products <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/national-blood-authority>.

1.8.8 Genetics outpatient program

Public genetic outpatient services in Victoria provide a range of clinical consultations and laboratory testing. Services are provided in outpatient settings, with hospital ward consultations provided as needed. This program does not fund genetic or genomic tests for admitted patients. As genetics and genomics become more integrated with routine health care in both the acute and outpatient settings, funding and policy models will be reviewed for both inpatient (WIES) and outpatient settings (Tier 2 class 20.08).

This program funds access to public genetic services, with referral from a general practitioner or medical specialist, but self-referral may occur.

Public clinical genetic services are located at three metropolitan hubs:

- the Parkville hub – the Victorian Clinical Genetics Services, The Royal Children's Hospital, The Royal Melbourne Hospital, The Royal Women's Hospital and the Peter MacCallum Cancer Centre
- the Monash hub – the Monash Medical Centre
- the Austin hub – the Austin Hospital and the Mercy Hospital for Women.

These hubs also provide periodic clinical outreach clinics to other metropolitan, regional and rural centres.

Accredited laboratories provide genetic and genomic testing. Publicly funded testing can only be requested by publicly funded clinical genetic services. If a genetic or genomic test is not available in Victoria, it can be requested from an interstate or overseas-accredited laboratory.

In 2017–18 the Victorian Government allocated an additional $8.3 million over four years for genomic sequencing for children and adults with rare diseases and undiagnosed conditions. This budget commitment facilitates access to clinical diagnosis, therefore avoiding the costly and lengthy diagnostic odyssey that these patients currently undergo. This funding supports access to genomic sequencing currently not funded under Medicare. The clinical care is provided through the metropolitan hubs, including regional and rural Victoria through outreach clinics. Laboratory testing will be provided by accredited laboratories.

As new genetic and genomic tests are added to Medicare, it is expected that publicly funded clinical genetic services, where appropriate, will redirect savings to address growing demand.

Participating services must use AIMS to upload and report genetic outpatients clinic activity and report the costs using the Victorian Cost Data Collection.

Read more about genetic services in Victoria <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/genetic-services>.

1.8.9 Pharmaceuticals

Health services are required to provide pharmaceuticals at no charge to their admitted public and private patients. Health services participating in the programs outlined below can access reimbursements for pharmaceuticals and charge patient co-payments, where applicable.

1.8.9.1 Pharmaceutical reform

Pharmaceutical reforms are designed to make it safer, easier and more convenient for patients to receive adequate medication, and to bring public health services onto a more equal footing with private hospitals.

Health services participating in the *Pharmaceutical reform agreement* have access to the Commonwealth-funded Pharmaceutical Benefits Scheme and the Repatriation Schedule of Pharmaceutical Benefits for non-admitted and admitted patients on discharge, as well as a Commonwealth-subsidised list of pharmaceuticals for same-day admitted patients requiring chemotherapy. These health services are required to incorporate the Australian Pharmaceutical Advisory Council's guidelines into their practice to achieve the continuum of quality use of medicines between the health service and the community.

Read more about the pharmaceutical reforms <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/pharmaceuticals/public-hospital-pbs>.

1.8.9.2 Highly Specialised Drugs Program

The Highly Specialised Drugs Program provides Commonwealth funding for certain specialised medications that are prescribed for chronic conditions and are supplied through health service pharmacies. The highly specialised drugs on the Community Access Program that are prescribed in public hospitals can also be supplied to patients through community pharmacies.

For health services to be eligible for funding, the patient must:

- attend a hospital
- be same-day admitted or non-admitted
- be under appropriate specialised medical care
- meet the specific clinical indications for each medication
- be an Australian resident (or other eligible person).

The prescribing doctor must be affiliated with the specialised hospital unit. Health services are reimbursed for the medicine supplied, less a patient co-payment, via claims submitted to Medicare Australia.

Read more about the Highly Specialised Drugs Program <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/pharmaceuticals/highly-specialised-drug-program>.

1.8.9.3 Direct-acting antiviral hepatitis C treatments

The Commonwealth listed a number of direct-acting antivirals for treating hepatitis C on both the Pharmaceutical Benefits Scheme and the Highly Specialised Drugs Program on 1 March 2016. Health services have access to both programs. Unlike Highly Specialised Drugs Program prescriptions, prescriptions approved under the Pharmaceutical Benefits Scheme have the advantage of being able to be dispensed in both hospital and community pharmacies.

Read more about direct-acting antiviral hepatitis C treatments <https://www.pbs.gov.au/info/publication/factsheets/hep-c/hepc-factsheet-hospital-prescribers-dispensers>.

1.8.10 Total parenteral nutrition

Additional funding will be provided to support total parenteral nutrition services given to non-admitted patients who self-administer total parenteral nutrition at home. The additional funding will assist Victoria's five health services that are funded to provide total parenteral nutrition to transition to a model that better aligns funding with activity.

Service targets were introduced in 2016–17 based on the latest 12 months of activity. These service targets have been updated based on the latest 12 months of activity. A recall/throughput adjustment will be applied at the full rate at the end of 2019–20 for health services whose activity is below or over target.

1.8.11 Home enteral nutrition

Service targets were introduced in 2016–17 based on the latest 12 months of activity. These service targets have been updated based on the latest 12 months of activity. A recall/throughput adjustment will be applied at the full rate at the end of 2019–20 for health services whose activity is below or over target.

1.9 Subacute inpatient services (subacute WIES)

1.9.1 Classification, counting and costing

Subacute admitted rehabilitation and GEM activity moved to an episodic funding model in 2016–17. Subacute admitted palliative care moved to an episodic funding model in 2017–18.

The funding model classifies activity according to the Australian National Subacute and Non-Acute Patient Version 4 (AN-SNAP V4) classification and uses boundary points and cost weights based on Victorian activity.

All metropolitan, regional and sub-regional health services are delineated to provide rehabilitation and GEM services through the *Subacute capability framework*. Local health services delineated as level 2 (and Swan Hill) will provide and report maintenance care.

Read the Subacute capability framework <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/subacute-planning>. Targets for these health services can be found in the Appendices, Appendix 2, 'Table 2.15: Admitted subacute and non-acute targets (subacute WIES4) 2019–20'.

The department is no longer reimbursing hospitals for public nursing home type episodes. Health services are expected to manage nursing home type patients using other funded activity streams such as the Transition Care Program. Current arrangements for the Department of Veterans' Affairs, compensable and private patients remain in place regarding the nursing home type process and funding.

1.9.1.1 Care type

Care type refers to the nature of the clinical service provided to an admitted patient during an episode of admitted patient care, or the type of service provided by the hospital.

The care type selected must reflect the primary clinical purpose or treatment goal of the care provided. Where there is more than one focus of care, the care type selected must reflect the major reason for care.

Subacute care types are assigned by the clinician who is taking over responsibility for managing the patient's care at the time of transfer, with clear evidence of this acceptance of the referral.

For subacute activity to be recognised, there must be evidence of the care type change (including the date of handover, if applicable) and the multidisciplinary management plan clearly documented in the patient's medical record within seven days of admission. The plan should outline the negotiated goals of care evidenced by a collaborative approach with the patient and/or their family.

An admission or stay can consist of one or more episodes and therefore one or more care types. A care type change occurs when there is a change in the primary clinical purpose or treatment goal of the care provided to the patient. When the intensity of treatment or resource utilisation changes but the primary clinical purpose or treatment goal does not change, a care type change is not warranted.

Details of the national care type definitions are outlined below. The National Minimum Dataset definitions can be found at the metadata online registry (METeOR) <https://meteor.aihw.gov.au>.

Rehabilitation

Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating in rehabilitation.

Rehabilitation care is always:

- managed by a clinician with special expertise in rehabilitation
- evidenced by an individualised multidisciplinary management plan that is documented in the patient's medical record, including negotiated goals within specified timeframes and documented assessment of functional ability.

Geriatric evaluation and management

GEM is care in which the primary clinical purpose or treatment goal is improving the functioning of a patient with multidimensional needs associated with medical conditions related to ageing such as falls, incontinence, reduced mobility, delirium and depression. The patient may have complex psychosocial problems and is usually (but not always) an older patient.

GEM is always:

- managed by a clinician with special expertise in GEM
- evidenced by an individualised multidisciplinary management plan that is documented in the patient's medical record, which includes negotiated goals within indicative timeframes and documented assessment of functional ability.

Palliative care

Palliative care is care that improves the quality of life for patients and their families facing the problems associated with life-threatening or life-limiting illness through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems/symptoms – physical, psychosocial and spiritual (World Health Organization).

Palliative care:

- is always managed or informed by a clinician with specialist qualifications in palliative care
- is always evidenced by an individualised multidisciplinary assessment and management plan that is documented in the patient's medical record; it covers the physical, psychological, emotional, social and spiritual needs of the patient and their negotiated goals
- offers a support system to help patients live as actively as possible until death
- is applicable early in the course of a patient's illness, in conjunction with other therapies that are intended to prolong life such as chemotherapy or radiation therapy
- should be responsive to the needs, preferences and values of the person, their family and carers.

The *National Palliative Care Standards* (5th edition) 2018 define the patient, their carer and family as the one unit of care. The needs of carers and families should be addressed in each palliative care patient's management plan. The plan must outline the negotiated goals of care evidenced by a collaborative approach with the patient and/or their family or carer.

Maintenance care

Maintenance care is care in which the primary clinical purpose or treatment goal is supporting a patient with impairment, activity limitation or participation restriction due to a health condition. Following assessment or treatment, the patient does not require further complex assessment or stabilisation.

It is not intended that maintenance care substitutes for other forms of non-acute care and should emphasise a restorative approach to care after treatment.

1.9.1.2 Care type changing

The primary clinical purpose or treatment goal of care may change during an admission or hospital stay. When this occurs, the care type also changes.

Only one care type can be assigned at a time. In cases where a patient is receiving multiple types of care, the care type that best describes the primary clinical purpose or treatment goal should be assigned. It is essential that any change in care type is supported by documentation reflecting the change in

purpose and goal of care. Care type changes must be reported in accordance with the VAED business rules.

The care type is assigned by the clinician responsible for managing the care based on clinical judgements as to the primary clinical purpose of the care provided and, for subacute care types, the specialised expertise of the clinician who will be responsible for managing the care.

At the time of a subacute care type assignment, a multidisciplinary management plan may not be in place, but the intention to prepare one should be known by the clinician assigning the care type.

The clinician determining the appropriate care type to be assigned must ensure that clear documentation of the care type is recorded in the patient's medical record. This clinician must also ensure that the ward clerk (or staff member responsible for updating the patient administration system) is informed of the care type decision.

Responsibility for the decision to change care type ultimately rests with the senior medical officer but may be delegated to other senior members of the clinical team.

The care type should not be retrospectively changed unless it is:

- to correct a data recording error
- clearly documented in the patient's medical record and approved by the hospital's director of clinical services or delegated officer.

1.9.1.3 Counting patients

In Victoria it is a condition of funding that health services collect and report electronically for every patient treated. The department maintains health data collections that span a range of healthcare settings. Inpatient activity is reported to the VAED and includes all admitted episodes of patient care from all health services.

Funding for subacute admitted services is based on episodes for eligible care types (see Appendices, Appendix 1, Addendum 1.4: 'Calculating subacute WIES for individual patients'). The following episodes are not eligible for subacute WIES funding:

- private hospital separations
- incomplete or uncoded episodes
- episodes with an account class on separation of W (Victorian WorkCover Authority), T (Transport Accident Commission), X (Ineligible non-Australian residents – not exempted from fees), A (Armed Services), C (Common Law Recoveries), O (Other compensable) or S (Seamen)
- episodes where the contract role is B (service provider hospital).

1.9.1.4 Costing patients

It is expected that health services maintain and report subacute patient level costing data, to the Victorian Cost Data Collection which is used in the development of funding models.

Counting and reporting geriatric evaluation and management activity

GEM care can be delivered in the patient's home or in another care setting. This cost-effective approach can improve independence and reduce adverse events associated with hospital admission for some older people. Health services retain accountability for the care of the patient.

GEM activity funded through subacute WIES and provided in a setting outside the hospital will be counted towards a health service's GEM target. GEM provided in a person's home must meet the national METeOR definitions and required data elements as for GEM inpatient activity. GEM in the home undertaken as admitted activity is reported as care type 9 with accommodation as care type 4 (in the home). Admitted GEM activity provided in any other offsite setting is to be reported as accommodation type R.

Home-based GEM-type services can also be delivered through the HIP non-admitted platform, with activity reported in the VINAH. Health services should review the most appropriate platform to deliver GEM services at home based on patient cohort needs and the local hospital and community resources available.

1.9.2 Pricing

The standard subacute WIES price is established in terms of the general budget and considers other forms of funding. It is not the same as the average cost per subacute WIES.

The funding provided to any patient or all patients can be calculated by multiplying subacute WIES by the price.

See the Appendices, Appendix 1, section 1.1 'Price tables'.

1.10 Acute specialist clinics (weighted ambulatory service events)

1.10.1 Classification, counting and costing

Tier 2 categorises a hospital's non-admitted services into classes, which are generally based on the nature of the service provided and the type of clinician providing the service. The structure of the classification is first differentiated by the nature of the non-admitted service provided. The major categories are:

- procedures
- medical consultation services
- diagnostic services
- allied health and/or clinical nurse specialist intervention services.

The next level of classification is the type of clinician providing the service. This could be based on the specialty or profession of the clinician. For example, a clinic run by a cardiothoracic surgeon who sees patients for consultations before and after cardiac surgery is classified to the cardiothoracic class. A clinic run by an obstetrician who sees women for consultations before they give birth is classified to the obstetrics class. A clinic run by a physiotherapist who sees patients for consultations and treatments is classified to the physiotherapy class.

There are also a number of classes for specialist clinics that treat patients with specific conditions. For example, there are classes for specialist burns clinics, transplant clinics and cystic fibrosis clinics.

Classification rules exist to guide the decision making regarding which Tier 2 class a clinic should be classified to. The IHPA has developed two reference documents to assist with consistently allocating non-admitted services to a Tier 2 class:

- Tier 2 Non-Admitted Services Compendium
- Tier 2 Non-Admitted Services National Index.

Read more about the Tier 2 classification system <https://www.ihpa.gov.au/what-we-do/tier-2-non-admitted-care-services-classification>.

Further information can be found in the Appendices, Appendix 1, Addendum 1.6: 'Weighted ambulatory service events – technical specifications'.

1.10.1.1 Counting patients

The WASE model is based on the 'service event' unit of count.

A non-admitted patient service event is defined as an interaction between one or more healthcare provider(s) with one non-admitted patient. This event must contain therapeutic or clinical content and result in a dated entry in the patient's medical record. The interaction may be for assessment, examination, consultation, treatment or education.

A non-admitted service event must be counted once only, regardless of the number of healthcare providers present:

- Non-admitted services involving multiple healthcare providers must be counted as one non-admitted patient service event.
- If the clinic providing the service is a clinic where care is provided by multiple healthcare providers, then it is irrelevant whether the patient was seen jointly or separately by multiple providers on a given calendar day. This must still be counted as one non-admitted patient service event.

Care provided to two or more patients by the same service provider(s) at the same time can also be referred to as a group session when the patients within the group receive the same service. One service

event is recorded for each patient who attends a group session regardless of the number of healthcare providers present, where the definition of a non-admitted patient service event is met.

Patient education services can be counted as non-admitted patient service events where they meet the definition of a non-admitted patient service event. Staff education and training must not be counted as a non-admitted patient service event.

Services from diagnostic clinics (30 series) are not counted as non-admitted patient service events.

Read the department's Agency Information Management System (AIMS) manual <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/aims-manual-2016-17>.

1.10.1.2 Costing patients

The WASE model also uses the cost data to determine the funding therefore all health services are expected to report patient level cost data to the Victorian Cost Data Collection.

1.10.2 Pricing

The acute non-admitted specialist clinics WASE price is established in terms of the general budget and considers other forms of funding. It is not the same as the average cost per acute non-admitted specialist clinics WASE.

The funding provided to any patient or all patients can be calculated by multiplying acute non-admitted specialist clinics WASE by the relevant price.

See the Appendices, Appendix 1, section 1.1 'Price tables'.

1.10.3 Exclusions

The majority of non-admitted acute patient service events reported to the AIMS S10 data collection will be allocated a Weighted Ambulatory Service Event cost weight. However, a cost weight will not be allocated for Tier 2 clinics that are funded by another Victorian funding model. For more information on Tier 2 clinics excluded from the WASE funding model, refer to Appendices, Appendix 1, Addendum 1.6: 'Weighted ambulatory service events – technical specifications'.

1.11 Subacute non-admitted services

1.11.1 Health Independence Program and community palliative care

In 2019–20 non-admitted subacute programs and services under HIP and community palliative care will remain block-funded. These programs will receive an associated activity target (health services will receive an aggregate HIP activity target).

Services that do not meet the overall HIP target are subject to recall. Community palliative care targets for 2019–20 are not subject to recall. Funding recall will be applied to subacute non-admitted services. When determining whether recall applies, the department will consider activity against the total HIP target:

- 0–5 per cent below target: no recall
- > 5 per cent below target: the department may recall at the full HIP rate for the amount that is beyond the five per cent underperformance.

Non-admitted targets by health service and program type can be found in the Appendices, Appendix 2, section 2.2.7 'Health Independence Program contact targets 2019–20'.

HIP funding considers all elements of care delivery. The unit price for direct non-admitted considers the time spent completing both indirect and administrative tasks.

Activity with patients in admitted (including admitted services that are provided in the home or other settings) and emergency department settings is expected but not recorded as a direct contact towards target. The foundation principle is that the direct contact count assumes that indirect, inpatient and emergency department activity may be required to deliver HIP direct care to clients.

Funding for throughput above target

There is no funding for any over-activity for non-acute care (Transition Care Program or nursing home activity) or non-admitted HIP.

Department of Veterans' Affairs patients

Victoria will fund eligible veterans in alignment with the revised Commonwealth revenue in 2019–20.

Funding for admitted acute and subacute services will continue to be paid to actual throughput based on the Victorian WIES and subacute WIES funding models.

Funding for emergency departments (non-admitted presentations), acute non-admitted and HIP will be paid as a block grant and based on the health service's activity share of total weighted activity.

Community palliative care

Designated community palliative care services are integral to achieving the goals of *Victoria's end of life and palliative care framework* (July 2016). Designated community palliative care services must provide care in line with the Palliative care webpage <https://www2.health.vic.gov.au/palliative-care>.

A designated community palliative care service is assigned to each Victorian local government area. Each service has a prescribed catchment area. It is expected designated services will accept referrals and provide care to clients in residential aged care facilities and disability group homes as these facilities are the client's home.

All community palliative care services have access to flexible funds to care for clients at home. These funds are incorporated in each service's annual non-admitted (community) palliative care funding allocation.

1.11.1.1 Counting unit

In 2019–20 the counting unit for HIP and community palliative care activity will continue to be a 'contact', which is reported in the VINAH dataset. The definition of a HIP and community palliative care contact is defined in the VINAH business rules.

Health Independence Program

The HIP counting unit will be 'direct non-admitted contacts'. Contacts where all of the following VINAH characteristics are met will count as contacts:

- contact account class Public Eligible (MP) or Reciprocal Health Care Agreement (MA)
- contact client present status where either the patient, their carer, or both, are present (10, 11, 12, 13 or 20)
- contact delivery mode that is direct (1, 2, 3, 4 or 5)
- contact delivery setting that is not the emergency department (13)
- contact inpatient flag of outpatient/non-admitted present.

The overall funding provided for HIP activity considers all elements of care delivery. For example, the unit price for direct non-admitted contacts counted towards HIP activity targets, considers the time spent completing indirect and administrative tasks. Activity with patients in admitted (including admitted services that are provided in the home or other settings) and emergency department settings is expected, but not recorded as a direct contact towards target. The foundation principle is that the direct contact count assumes that indirect, inpatient and emergency department activity may be required to deliver HIP direct care to clients.

Work will continue to review the HIP price and service stream weights to better reflect stream costs over 2019–20. Further work to improve the HIP classification data, including potential VINAH refinements for 2019–20, will also continue.

Community palliative care

The counting unit for community palliative care will be the 'contact'. All contacts (both direct and indirect) where the contact account class is either MP, MA or Department of Veterans' Affairs (VX) will contribute to the contact count. The inclusion of indirect contacts recognises the consultancy role of community palliative care providers.

1.11.1.2 Reporting of activity

The VINAH dataset is the data collection on which recall will be based.

In 2019–20 the activity level of each community palliative care provider will not be subject to funding recall or additional payments.

1.11.1.3 Reporting of costs

It is expected that health services maintain and report subacute patient level costing data to the Victorian Cost Data Collection which is used in the development of funding models.

1.11.1.4 HIP WASE3 Shadow funding model

HIP provides non-admitted care to subacute patients. Broadly, the setting and incentives of the program are similar to specialist clinics activity. The key difference between the two programs is that HIP patients can receive home-based, centre-based and community-based care because they require regular services across a range of disciplines over an extended period.

HIP currently includes the following program streams:

- post-acute care (PAC) services
- subacute ambulatory care services (SACS), including centre-based, home-based and specialist clinics

- Hospital Admission Risk Program (HARP) services
- residential in-reach (RIR) services.

In 2019–20 non-admitted subacute programs and services under the HIP are block-funded. These programs will receive an associated activity target (health services receive an aggregate HIP activity target, with the counting unit being 'direct non-admitted contacts'). Services that do not meet the overall HIP target are subject to recall.

The department will continue to shadow HIP through the WASE3 funding model by using HIP-specific cost weight segments and provide shadow reports to health services during 2019–20.

This will enable the sector to become familiar with the new funding model, including a different counting unit for these services (service events versus contacts) and a different pricing model, and allows the department to assess whether the proposed funding model aligns with program objectives or if any unforeseen consequences are created.

HIP activity is currently reported at patient level through the VINAH dataset and at an aggregate service event level through the AIMS S11 form.

Reported VINAH activity will be the basis for the service event count under the shadow WASE3 model. This is consistent with the current measurement of HIP activity, being VINAH contacts.

For further details on the HIP shadow funding model, refer to the Weighted Ambulatory Service Event Technical Specifications.

1.11.2 Victorian Artificial Limb Program

Funding for the Victorian Artificial Limb Program will continue to be provided as a block grant to health services as a non-admitted subacute service. Victorian Artificial Limb Program services are required to report service events as a non-admitted subacute service through the AIMS S11 form. Services expected to provide artificial limbs under the Victorian Artificial Limb Program in 2019–20 are: The Royal Children's Hospital, Peninsula Health, Melbourne Health, Alfred Health, Barwon Health, Ballarat Health Services, Austin Health, St Vincent's Health, Latrobe Regional Hospital, Bendigo Health and South West Healthcare.

To monitor the maintenance of effort, the pre-existing annual activity statement regarding limbs and repairs, including expenditure, will also be required for 2019–20.

People accessing the Victorian Artificial Limb Program service and equipment may be eligible for the National Disability Insurance Scheme (NDIS). Health services are expected to identify NDIS participants, or those eligible to become participants, accessing their Victorian Artificial Limb Program services and ensure NDIS-eligible activity and equipment is billed to the NDIS.

Recall will not apply to Victorian Artificial Limb Program activity in 2019–20.

A review of the program outcomes and funding methodology will commence in 2019–20.

1.11.2.1 Costing patients

It is expected that health services maintain and report Victorian Artificial Limb Program patient-level costing data to the Victorian Cost Data Collection.

1.11.3 Victorian Respiratory Support Service

Funding for the Victorian Respiratory Support Service will continue to be provided as a block grant to Austin Health as a non-admitted subacute service. The Victorian Respiratory Support Service is required to report service events as a non-admitted subacute service through the AIMS S11 form and report contacts through VINAH.

Recall will not apply to Victorian Respiratory Support Service activity in 2019–20.

1.11.3.1 Costing patients

It is expected that health services maintain and report Victorian Respiratory Support Service patient-level costing data to the Victorian Cost Data Collection.

1.11.4 Palliative care consultancy services

Palliative care consultancy services are funded in all metropolitan health services and in the five rural regions.

Consultancy services work across all healthcare settings. They provide specialist advice and support to clinical services within hospitals and in the community, including to community palliative care services and residential facilities. They address complex issues that otherwise would necessitate admission to hospital. They also provide education and training about palliative care to other clinicians and provide palliative care input for cancer streams and at chronic disease management meetings.

1.11.4.1 Hospital-based palliative care consultancy

Funding for hospital-based palliative care consultancy is part of the price paid for acute inpatient activity. In 2019–20, 11 metropolitan health services will receive a specified grant to support their palliative care consultancy teams to respond to immediate service demand and to develop systems that support an outreach model. This model may include expediting early discharge and supporting clients in the short term with some acute supports until such time as community services can take over the ongoing care component.

It is anticipated this funding will be allocated as a specified grant over the next four years with plans to incorporate the funds into the base funding allocation in year five.

1.11.4.2 Regional palliative care consultancy

Regional consultancies provide regular primary and secondary consultation to generalist health (including general practitioners, acute and subacute services) and community services (including aged care and disability services) on a region-wide basis. All generalist health and community services are expected to be able to care for people who are at the end of life, and the consultancy teams provide the specialist expertise and skill to support these services to provide good end-of-life care.

Funding for regional palliative care consultancy teams is provided as a block grant in 2019–20. In the majority or regions, this funding includes aged and disability link nurses. This funding is recurrent.

1.11.4.3 Statewide palliative care consultancy

Funding for statewide palliative care consultancy teams is also provided as a block grant in 2019–20. Statewide consultancy services include the Victorian Paediatric Palliative Care Program, Very Special Kids, Motor Neurone Disease Association (Vic) and the Australian Centre for Grief and Bereavement.

1.11.4.4 Costing patients

It is expected that health services maintain and report Palliative care consultancy services patient-level costing data to the Victorian Cost Data Collection.

1.11.5 Day hospice

Acute health services funded to provide day hospice receive a non-admitted funding allocation for this activity. Recall does not apply to day hospice services in 2019–20.

1.12 National programs

1.12.1 Nationally Funded Centres Program

The objective of the Nationally Funded Centres Program is to ensure there is optimal access for all Australians to high-cost but low-demand technologies and procedures. While the program operates nationally, funding for this program is provided by state and territory governments. Health services that provide Nationally Funded Centre services will be funded based on estimated annual activity and the cost per procedure as determined by the Nationally Funded Centres Program and the Australian Health Ministers' Advisory Council. This figure will then be adjusted after the financial year to reflect actual activity. The health services that host Nationally Funded Centre services in Victoria are Alfred Health, The Royal Children's Hospital, Monash Health and St Vincent's Hospital Melbourne.

1.12.2 Transition Care Program

The Transition Care Program is jointly funded by the Commonwealth, state and territory governments through joint per diem contributions. The flexible care places used in the program are legislated by the *Aged Care Act 1997* and the Aged Care Principles made under the Act. The *Transition Care Program Guidelines 2015* govern the program.

Commonwealth Government subsidies are provided directly to health services by the Department of Human Services (Medicare) and are paid on a monthly advance and acquittal basis for occupied places. Health services are required to submit a monthly claim form directly to Medicare for payment.

Commonwealth Government subsidies are paid for up to 12 weeks (with an option for a single extension of up to six-weeks where appropriate and with prior approval from the Aged Care Assessment Service (ACAS)) for each client, up to the maximum number of approved Transition Care Program places at each health service.

The department no longer provides financial support to health services that support clients beyond their maximum permitted stay on the program (that is, 18 weeks where a six-week extension has been approved by ACAS). It is expected that any potential discharge challenges are made known prior to this time and are worked through to achieve a safe discharge for the client.

Daily care fees for Transition Care Program recipients are determined by the Commonwealth under the Aged Care Act. Maximum care fee charges must not exceed 85 per cent of the basic single age pension for care delivered in a bed-based setting and 17.5 per cent of the basic single age pension for care delivered in a home-based setting. Such fees are adjusted twice yearly (March and September) in line with the consumer price index, which also affects the age pension payment.

The state-funded component of the Transition Care Program is subject to recall for under performance as outlined in the recall policy detailed in these guidelines.

The Commonwealth Government continues to implement its aged care reforms. All Transition Care Program referrals are received via the My Aged Care provider portal. It is imperative that program staff ensure that clients have current approvals to avoid loss of the Commonwealth subsidy component for episodes of care. Approvals can be verified with ACAS or online with Medicare.

1.13 Ambulance Victoria

The Victorian Government funds clinically necessary transport for concession patients, primarily pensioners and Health Care Card holders. The government provides this funding to Ambulance Victoria, which is responsible for delivering these transports. Ambulance Victoria's Membership Subscription Scheme insures patients against Ambulance Victoria ambulance transport costs. The membership subscription scheme fees will be indexed and are due to rise by 2.5 per cent in 2019–20. A single 12-month membership is now $48.35, and a family 12-month membership is $96.70.

Ambulance Victoria also receives fees from third parties that are responsible for transporting patients using Ambulance Victoria services including:

- the Department of Veterans' Affairs for eligible veterans
- the TAC for eligible Victorians involved in a transport accident
- the Victorian WorkCover Authority for eligible Victorians involved in a workplace accident
- public healthcare services
- private healthcare facilities
- general patients who are not eligible under any of the other criteria and do not have a membership subscription.

1.13.1 Fee structure

Ambulance Victoria's fees for each of its service lines are based on the average cost of delivering each of these services. The average cost of service recognises all direct and indirect costs of actual service delivery including paramedics, transport platform, contribution to depreciation (vehicle replacement costs) and associated corporate costs.

Fees for ambulance services are included in the Appendices, Appendix 1, section 1.1 'Price tables' and can be found on the Ambulance fees webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/ambulance-and-nept/ambulance-fees>.

A number of additional services provided through Ambulance Victoria will be funded directly or are included as loading in the above costs. For example, adult retrieval services.

In addition to the funding provided directly to Ambulance Victoria, the government also provides funding to Victoria's health services for the inter-hospital transfer of patients (for example, the transfer of patients between health services or between the different campuses of a health service). Health services have discretion as to which patient transport provider they choose to engage to transfer non-concessional patients – either Ambulance Victoria or from a range of private non-emergency patient transport providers that are licensed by the department. Timely payment for ambulance transports provided through Ambulance Victoria is expected under normal commercial terms.

1.14 Mental health acute admitted

Best practice mental health clinical care provides for accessible treatment delivered in the least restrictive way possible. However, within a community treatment-based model, admitted care forms an important part of the overall continuum of care and needs to be funded so it is available when it is in the best interests of the person with a mental illness.

In 2019–20, funding for admitted mental health activity will be distributed to health services based on the bed capacity that is available at each health service, with the number of bed days available. Adult, child, aged and specialist bed types will receive the same price regardless of the location of the health service.

Health services will receive funding in proportion to the acute bed capacity that is available at the health service, with an additional supplementary transition grant.

1.14.1 Acute – child and adolescent, adult, aged and specialist bed availability component

In 2019–20, acute (child and adolescent, adult, aged and specialist care) provided by health services that deliver admitted inpatient mental health care will be reimbursed based on a single unit price, irrespective of the bed setting or patient characteristics.

The health service target will be based on the total number of acute bed days. Statewide targets associated with acute admitted care are set out in *Victorian State Budget Paper No 3*.

As part of consolidation work on achieving a single price, a supplementary transition grant to ensure existing funding is maintained will continue to be provided.

The unit price is not intended to reimburse health services for the total cost of providing admitted care because there are a number of supplementary funding grants. The transition grant and other mental health specified grants contribute to meeting the costs of mental health admitted care.

1.14.2 Transition funding

As funding for admitted mental health care progresses towards a single price, and to ensure budget stability for health services, a transition grant (block funding) has been applied in 2019–20. This transition grant is under review.

1.14.3 Costing patients

It is expected that health services maintain and report mental health acute admitted patient-level costing data to the Victorian Cost Data Collection.

1.15 Mental health non-admitted

In Victoria, 18 health services, including Mildura Base Hospital and Forensicare, are funded on a service hours basis to provide mental health clinical non-admitted services. Victoria's non-admitted mental health care encompasses clinical (ambulatory) community care and non-admitted bed-based treatment services (prevention and recovery care services, community care units and aged care residential beds). Statewide targets associated with mental health non-admitted care are set out in the *Victorian State Budget Paper No 3*.

Clinical community care

Clinical community (ambulatory) care consists of a range of community-based clinical services, including bed substitution programs provided to people with a mental illness.

Intensive community mental health packages

Mental health services will receive additional funding packages in 2019–20 to provide more community care for their most severe group of adult community-based mental health consumers.

The purpose of the intensive community mental health packages is to provide more hours of treatment, focused on the delivery of evidence-based multidisciplinary therapeutic interventions for a cohort of adults with serious mental illness and high needs being treated in the community. The funding targets adult consumers whose diagnosis and wellbeing assessments indicate they are at risk of recurring acute episodes and associated hospital admissions without more intensive therapeutic intervention.

This targeting reflects development work on an activity-based funding model appropriate to mental health that can allocate resources for adult community mental health services on the basis of the severity and complexity of consumers' needs, and the associated volume and intensity of service responses. The funding model will be linked to developments in performance monitoring and clinical guidelines outlining expected levels and types of service responses for consumers of varying levels of need for treatment and care.

1.15.1 Mental health outputs

Targets for the number of service hours to be provided are set per health service. They are calculated on the hours of service provided per clinician and adjusted for historical and projected service levels. The funding rate per service hour has been used in setting ambulatory targets. This rate is provided in the Appendices, Appendix 1, 'Table 1.6: Mental health – funded units applicable to clinical bed-based services 2019–20 – admitted care'. A description of all mental health outputs is at the Appendices, Appendix 1, section 1.4 'Output and activity tables'.

Targets for 2019–20 are provided in the Appendices, Appendix 2, section2.2.13 'Mental health ambulatory targets 2019–20'.

1.15.2 Mental health community support services

The mental health community support services (MHCSS) program is an integral part of the Victorian Government's specialist mental health service system.

State-funded MHCSS are delivered across 15 service catchments. In metropolitan Melbourne there are nine catchments. The non-metropolitan area is divided into seven catchments. Delivered largely by non-government organisations, MHCSS provide psychosocial rehabilitation support to people aged 16–64 years old living with an enduring psychiatric disability that is attributable to a psychiatric condition.

The MHCSS program includes activity types such as individualised client support packages, youth and adult residential rehabilitation, supported accommodation, mutual support and self-help, carer support, planned respite, Aboriginal mental health support and catchment-based intake assessment.

Individualised client support packages are funded on the basis of a standard, single-price unit known as a 'client support unit'. Service providers have been funded for a specified total volume of client support units on a catchment basis. A client support unit is based on the average efficient total hourly cost.

The funding model also includes youth and adult residential rehabilitation based on a bed-day rate, planned respite on an hourly rate, and catchment-based intake assessment and planning functions and some mutual support and self-help services, which are block-funded.

Funding provided to service providers will be indexed consistent with the government's annual determination for community service organisations.

Funding commitment to in-scope MHCSS programs will fully transition to the National Disability Insurance Scheme (NDIS) by mid-2019 as clients of these services become NDIS participants. In-scope programs include individualised client support packages, adult residential rehabilitation and select supported accommodation services.

Early Intervention Psychosocial Support Response

The *Early Intervention Psychosocial Support Response* is a psychosocial support model targeted to adult clients of the clinical mental health service system living with a severe mental illness and associated psychiatric disability who are:

(a) not eligible for the NDIS because they do not have significant, permanent functional impairment/s associated with their mental health condition, or

(b) are eligible for the NDIS and are waiting for an access decision and their NDIS plan to begin.

The service model will provide short to medium term, specialist psychosocial support to help eligible clients to:

- build their capacity to better manage their mental illness
- develop practical life skills for independent living and social connectedness
- achieve healthy, functional lives, and
- if eligible, transition to the NDIS.

1.15.3 Performance targets

Funding for MHCSS activities is output-based. Statewide targets are set out in the *Victorian State Budget Paper No 3*. Targets for MHCSS activities are listed in the *Funding and Service Agreement* and these represent the minimum deliverables expected for the funding provided. See Chapter 2, section 2.3.8 'Mental health services' for more information.

Targets for individualised client support packages, adult residential rehabilitation and supported accommodation services will be reduced as these activity types progressively transition to the NDIS by mid-2019.

1.15.4 Costing patients

It is expected that health services maintain and report mental health non-admitted patient-level costing data to the Victorian Cost Data Collection.

1.15.5 National Disability Insurance Scheme

The NDIS is a new way of providing individualised support for people up to 65 years of age who have disability, including those with a psychiatric disability.

The Victorian Government has been working closely with the National Disability Insurance Agency to support the phased implementation of the NDIS, which has been rolling out across Victoria since 1 July 2016.

Victoria and the Commonwealth have agreed that people will not be disadvantaged by the rollout of the NDIS. Victoria will continue to fund supports for existing state clients until they become NDIS

participants. Victoria will also continue to provide MHCSS to older Victorians and others who are not eligible for the NDIS.

From 1 July 2019, Victoria will contribute $2.5 billion per annum to the NDIS, including funding for MHCSS. Victoria's contribution to the NDIS includes funding withdrawn from service providers as clients transition to the scheme.

Funding committed to the following MHCSS activity types is in scope for transition to the NDIS: individualised client support packages, adult residential rehabilitation services, and selected supported accommodation services.

Victoria has been responsible for operating quality and safeguards for in-scope existing and new NDIS providers during the transition period. These arrangements will be replaced by the new *National quality and safeguards framework* for the NDIS from 1 July 2019. For more information, visit NDIS Victoria – Quality and safeguards for Victorian approved providers <https://w.www.vic.gov.au/ndis/service-providers/quality-and-safeguards-for-victorian-approved-providers.html>.

1.16 Alcohol and drug services

The Victorian alcohol and drug services sector currently operates under a mixed funding model:

- Residential services and the majority of adult community-based services are funded via drug treatment activity units.
- Aboriginal and youth-specific services and some out-of-scope community-based services are funded on the basis of episodes of care.
- Other drug treatment activities such as research, drug prevention and control, local initiatives and pharmacotherapy programs continue to be block or grant-funded.

Funding provided to service providers is indexed in line with the government's annual determination for community service organisations.

1.17 Ageing, aged and home care services

Ageing, aged and home care unit prices are provided at the Appendices, Appendix 1, section 1.1 'Price tables'.

1.17.1 Aged care assessment services

Aged care assessment services (ACAS) conduct comprehensive assessments of the care needs of frail older people. They have delegated authority to determine eligibility for Commonwealth home care, residential respite care, permanent residential care and flexible care. My Aged Care is the central point for referrals for community-based assessments. Referrals for inpatient assessments continue to be made directly to the relevant ACAS. The department continues to support ACAS and health services to deliver high-quality and timely comprehensive assessments for people needing access to health and aged care services.

1.17.2 Regional assessment services

Regional assessment services (RAS) conduct home support assessments for older people who require entry-level home support and assistance to keep living independently at home and in their community. My Aged Care is the central point for referrals for a home support assessment.

1.17.3 Home and Community Care Program for Younger People

Targeted to people aged under 65 (and Aboriginal people aged under 50) who need assistance with daily activities due to physical and/or psychosocial functional impairment related to disability (for which they are not eligible for the NDIS), chronic illness and short-term health needs and their carers. The Home and Community Care Program for Younger People (HACC-PYP) is funded by the Victorian Government to provide a range of services in the home or in the community. The goal of the program is to allow participants to continue living in their homes and their communities.

About 380 organisations, including local councils and health services, will continue to receive funding to support younger people by providing a range of services including domestic assistance, personal care, nursing, allied health and social support. Funding for most recurrent services is based on a published set of unit prices per hour to determine the output targets for each service provider. Outputs are reported and monitored via the HACC minimum dataset.

Read the fees policy for HACC-PYP services <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/hacc-schedule-of-fees>.

Recurrent funds may be recalled from service providers. See Chapter 1, section 1.23.1 'Victorian funding recall policy'.

1.17.3.1 Home and Community Care and the NDIS

The Victorian and Commonwealth governments have committed to implement the NDIS from July 2016.

A proportion of HACC-PYP clients aged under 65 will transfer to the NDIS as it rolls out in Victoria. About 16,000 HACC-PYP clients will get into the NDIS.

1.17.4 The Victorian Aids and Equipment Program

The Victorian Aids and Equipment Program (VA&EP) is a statewide program that provides a range of subsidised aids and equipment such as hoists, home and vehicle modifications and other items such as continence products and domiciliary oxygen. The program also funds the repairs of equipment owned by the department.

Other assistive technology programs and schemes funded under the VA&EP include:

- an equipment loan service for people who have been diagnosed with motor neurone disease
- specialist low cost aids and equipment for people who have vision impairment
- lymphoedema compression garments
- individualised solutions
- electronic communication devices
- smoke alarms for those with a profound/severe deafness.

The VA&EP assists eligible clients to enhance their independence and participate in the community. It supports families and carers to maintain care arrangements.

The client group for this activity is people of all ages where their need for the aids and equipment items available under the VA&EP relates to a health condition and those aged over 65 years with age- or disability-related needs for aids and equipment. Applicants must be permanent residents of Victoria or hold a permanent protection visa.

1.17.5 Aged support services

Aged support services provide a range of different types of support, mostly for people who are living in their own homes. Clients of the services are mostly aged 65 years or older. However, people aged under 65 years also access all the services listed. All aged support services are funded by the Victorian Government only.

1.17.5.1 Supported residential services and accommodation support

A range of community service organisations receive funding for a variety of initiatives that aim to improve the viability of pension-level supported residential services and the quality of life of the residents using the services (through the Supporting Accommodation for Vulnerable Victorians Initiative).

1.17.5.2 Personal Alert Victoria

Personal Alert Victoria is a daily monitoring and emergency response service for frail older people and people with a disability who have high ongoing health and support needs and mostly live alone. Personal Alert Victoria aims to keep clients living independently for as long as possible. Personal Alert Victoria assists more than 29,000 Victorians.

Personal Alert Victoria relies on nominated contacts (such as family, friends and neighbours) to provide assistance in responding to calls, ensuring public emergency services are used effectively.

The Personal Alert Victoria Response Service is used when people do not have any relatives or other contact people. About 15 per cent of Personal Alert Victoria clients use the Personal Alert Victoria response service.

1.17.5.3 Support for Carers Program

The Support for Carers Program provides $18.5 million distributed to 49 agencies for services for people in care relationships where other services are not available or where clients are not eligible for other services. Services may include respite, information, advice, counselling and subsidised goods and equipment. Eligibility criteria was expanded in January 2019 to include carers of all ages.

The Support for Carers Program delivers an average 160,000 hours of respite and support per year to approximately 8,200 Victorian carers, many of whom receive several episodes of support a year.

1.17.5.4 Victorian Eyecare Service

The Victorian Eyecare Service (VES) provides subsidised eyecare and visual aids to people experiencing disadvantage via metropolitan, outreach and rural services. The VES is delivered by the Australian College of Optometry in Melbourne metropolitan regions and private practice optometrists in rural regions. Every year, the VES delivers 75,800 occasions of service. Clients eligible for VES pay from $39 to $95 for visual aids, depending on clinical need and choice of glasses. To deliver the VES (and

complementary programs), the Australian College of Optometry delivers approximately 50,000 visual aids per year. Clients who identify as Aboriginal or Torres Strait Islander will be eligible for the Victorian Aboriginal Spectacles Scheme (VASS), which is an additional subsidy to the VES. It aims to improve access to visual aids and eyecare to Aboriginal Victorians by further reducing the client contribution to $10. The VASS is delivered through the VES statewide and is supported by the Commonwealth Government's Visiting Optometrist Scheme.

Since commencing in 2010, the Aboriginal Health and Wellbeing branch has managed and provided funding annually to the VASS. More than 11,000 pairs of visual aids have been supplied to Aboriginal Victorians since its introduction, and it has made significant improvements to the eye health of Aboriginal people, particularly in rural Victoria.

1.17.5.5 Dementia services

Within the Support for Carers Program, support for carers of people with dementia (including young people with dementia) is available through 10 agencies. Dementia Australia (Victoria) is funded for support, counselling, education and training, Dementia Awareness Week activities and dementia service hubs in regional centres.

1.17.6 Public sector residential aged care

The department provides funding to public sector residential aged care services (PSRACS) to assist with operational expenses. PSRACS are funded to provide a specified number of available bed days and to meet set targets for resident occupancy.

In 2019–20 the department will continue to provide top-up funding to designated PSRACS to support the viability of small rural services, services supporting residents with specialised care needs and additional costs of the public sector workforce. This includes continuation of the unit priced funding approach for high-care and low-care beds in designated services, as introduced in 2011–12.

Health services or other PSRACS providers are required to ensure they provide the number of available bed days for which they are funded for residential aged care. There is also an expectation that the available beds will be efficiently managed to optimise the availability and benefit for Victorians requiring residential aged care. Where providers fail to maintain the agreed number of available beds or bed days or elect to reduce the number of available (operational) places, funding to the service may be adjusted to reflect this change.

This funding policy and process applies to departmental funding to PSRACS in the following situations:

- A PSRACS provider deciding to make a reduction (time-limited or ongoing) in the number of available residential aged care places it operates, due to local changes in demand over a period of time
- A PSRACS provider seeking to convert residential aged care places to other care types or programs (such as transition care)
- Requests by PSRACS providers to reinstate non-operational (off-line) places or increase operational places
- A review indicates failure to optimise service provision for those requiring residential care.

Health services must notify the department if they wish to change their service model mix. This includes changes to the number of total allocated places, operational residential care places or flexible care places. Rural and regional services should notify their local Rural Health representative in the first instance (the representative will liaise with the program), and metropolitan Melbourne services should notify the Residential Aged Care unit, detailing any plans, prior to implementing any change. The department will contact organisations that consistently fail to meet occupancy targets to discuss appropriate action. For example, to increase occupancy or review operations to better manage costs.

Where funding may be affected by service changes, the service may be requested to submit a 'transition plan' outlining their intentions, a description of the changes and proposed timelines, and to seek the department's agreement to the effective date for any associated funding adjustments.

Services may elect to increase their operational or flexible care places in the absence of further funding from the department, but should demonstrate to their board that the additional costs can be covered from other income.

If services obtain additional residential aged care places though the Commonwealth's Aged Care Approvals Round without the approval of the department, state funding will not be provided to the service.

The department will work closely with services where opportunities to optimise available bed management are identified.

1.17.7 Seniors programs and participation

Seniors community programs projects will be funded through grant applications. Agencies providing elder abuse prevention, response and information will be funded through funding and service agreements.

1.18 Rural health

Rural and regional health services play a key role in delivering safe, high-quality care close to where people live. The system has a hierarchy of health services with small rural, local, subregional and regional hospitals providing services appropriate to their capacity, capability and the needs of their community.

Providing health care in rural areas presents particular issues including:

- Victorians living in rural and regional areas are generally older and have poorer health outcomes on measurements including life expectancy and cancer survival rates.
- Remote and sparsely populated communities must travel relatively long distances to access care.
- Workforce shortages are often most acute in regional area.

Rural and regional health services and hospitals work hard to improve the health and wellbeing of their communities, delivering services ranging from health promotion and primary health through to acute inpatient services, aged care, mental health, drug services and end-of-life care.

Targeting Zero made a number of recommendations that are particularly relevant to rural health services.

The Rural and Regional Health branch within Health and Wellbeing has responsibility for the performance management and policy leadership for the rural health service system.

1.18.1 Small rural health services

Public hospitals in communities across Victoria play a vital role as part of an integrated healthcare system, which allows care to be safely provided closer to where people live.

Forty-two small rural health services (SRHS), including seven multipurpose services, deliver public admitted acute services in Victoria. This enables health services to use funds flexibly to deliver a range of admitted and non-admitted services that meet the needs of their community including primary health care, health promotion and prevention activity.

Flexible funding to SRHS includes an allocation to health promotion and prevention activity (under the activity name 'Small rural – primary health flexible services').

The department will continue to explore and develop options for any revisions to the SRHS funding model. It is important that the SRHS funding model maintains organisations' flexibility to determine service mix and models of care to meet local needs while also increasing accountability, transparency and equity. Any proposed adjustments will be subject to endorsement processes and staged implementation.

Updates on the development of the funding model will be provided to the sector throughout 2019–20.

The description of SRHS outputs and activities are provided in the Appendices, Appendix 1, section 1.4 'Output and activity tables' (see also the Appendices, Appendix 1, 'Table 1.30: Small rural health services – outputs and activities 2019–20'). Funding arrangements for public sector residential aged care services are outlined in Chapter 1, section 1.17.6 'Public sector residential aged care'.

1.18.2 Rural and regional health partnerships

The *Statewide design, service and infrastructure plan for Victoria's health system 2017–2037* emphasises the importance of regional and local partnerships to Victoria's future health system. It outlines an ambitious vision for a more connected and networked service system supported by close and effective partnerships with Victoria's regional and rural health services. These partnerships would:

- improve the safety and quality of care to patients
- increase the capacity and accessibility of care and regional self-sufficiency
- strengthen the sustainability of rural services and their workforce.

The plan articulates 13 Local Area Health Partnerships that make up six larger Regional Partnership Areas.

The *Rural and regional health partnership guidelines 2018–19* were released in September 2018 and outline the increased scope for health partnerships across five functional areas:

- planning and networks
- workforce planning, recruitment and development
- quality and safety
- access and care
- key enablers.

Regional and Local Health Partnerships will create a platform for long-term and systemic collaboration on service planning, delivery and coordination by health services. The department is actively working with both Regional and Local Area Health Partnerships to embed and expand their functions in line with the guideline expectations.

1.18.3 Victorian Patient Transport Assistance Scheme

The Victorian Patient Transport Assistance Scheme (VPTAS) subsidises the travel and accommodation costs incurred by rural Victorians and an approved escort(s), who have no option but to travel more than 100 kilometres one way or an average of 500 kilometres a week for one or more weeks to receive approved medical specialist services or specialist dental treatment.

The 2019–20 VPTAS guidelines <https://www2.health.vic.gov.au/hospitals-and-health-services/rural-health/vptas-how-to-apply> include a new online claim form to support electronic banking for travel and accommodation subsidy payments. This will mean Victorians eligible to receive this financial assistance will receive the subsidy in a timelier manner compared to being paid by cheque.

In the *Victorian Budget 2019–20*, the Victorian Government allocated $2.6 million to VPTAS to ensure sustainability and meet the growth in new claims. Demand for VPTAS assistance, growth in claims, has been increasing by an average of 8.1 per cent per annum over the past five years.

The current eligibility criteria and subsidy rates include:

- private vehicle costs reimbursement rate of 21 cents per kilometre
- the rate of a patient and an approved escort(s) staying in accommodation is a maximum of $49.50 per night including GST
- entitlement to two escorts if the travelling patient is a newborn infant (up to six months of age)
- entitlement for up to two escorts (parents, guardians or family members) when the patient requires treatment or admission to a hospital over two or more consecutive days for patients over six months of age and under the age of 18 years
- being available to living organ donors from other Australian states or territories who travel to Victoria to participate in a transplant procedure where the recipient is a Victorian resident. This includes travel for donor screening, specialist assessment and transplant procedures.

The four-year review cycle of VPTAS commenced in January 2019.

1.18.4 Bush nursing centres

The *Statewide design, service and infrastructure plan for Victoria's health system 2017–2037* sets out the framework for planning across settings and locations. In planning for service delivery, bush nursing centres should align with Victoria's strategic and service planning frameworks where applicable. Bush nursing centres are to maintain their current service profile and provision to rural isolated communities.

During 2019–20 the department will continue to work with bush nursing centres to implement longer term arrangements that best align with bush nursing centre service delivery and government policy and administration, with oversight mechanisms that enable safety and quality.

This includes bush nursing centres moving to undertake accreditation against the *National Safety and Quality Health Service Standards* (second edition) from 1 January 2019. It also includes memoranda of understanding between bush nursing centres and health services to enable the bush nursing centres to participate in clinical governance activities.

Similarly, the department will continue to support bush nursing centres in transitioning to reporting on the Community Health Minimum Dataset.

1.18.5 Director of Medical Services

The Victorian public healthcare system is predicated upon a medical leader being appointed in the role of Director of Medical Services or Chief Medical Officer for each health service. This role includes:

- leading the development, monitoring and reporting of effective clinical governance systems
- giving strategic guidance on service planning issues
- contributing to the accreditation efforts of a health service.

The department recognises the critical function of this role. It will continue to work with health services and with Safer Care Victoria in 2019–20 to address several issues identified in consultation with the sector including:

- developing the Rural and Regional Director of Medical Services role outline
- establishing a Rural and Regional Directors of Medical Services Forum
- the priority areas of the Medical Workforce Planning Advisory Group
- encouraging Rural and Regional Health Partnerships to collaboratively address clinical governance across rural services.

Outcomes of this body of work will be communicated to health services as work progresses.

1.19 Primary, community, public and dental health

1.19.1 Primary health services

1.19.1.1 Community health program

Community health program funding is activity-based, and the activity measure is service hours.

Community health program funding provides for general counselling, allied health and community nursing. These services aim to intervene early to maximise health and wellbeing outcomes and to prevent or slow the progression of ill health.

The community health program prioritises access for populations, families and children and those at risk of stigma and discrimination that are socially or economically disadvantaged, experience poorer health outcomes and have complex care needs, or have limited access to appropriate healthcare services.

The program's priority population groups are:

- Aboriginal and Torres Strait Islander people
- people with an intellectual disability
- refugees and people seeking asylum
- homeless people and people at risk of homelessness
- people with a serious mental illness
- children in out-of-home care.

Funding is to be used flexibly to meet the needs of local populations. To ensure services are targeted appropriately, the following factors should be considered when planning:

- population health needs across different age groups and across the care continuum
- gaps in services for specific population groups that experience inequity in access or health outcomes
- the development of service models that are appropriate and accessible to local populations
- complementary services offered by other service providers and mechanisms for service coordination.

Funded organisations that identify a need for a specific population response should prioritise their community health program funding appropriately and refer to the relevant initiative guidelines.

Community health services are also funded to also deliver a range of other health care services and programs, including sexual and reproductive health and place-based primary prevention (under the activity name 'Community health – health promotion'). Primary prevention aims to prevent illness occurring by eliminating or reducing underlying causes.

Additional support for specific population groups is also provided through the following programs:

- The Refugee Health Program – this program aims to increase refugee and asylum seeker access to primary health services and assist newly arrived communities to improve their health and wellbeing.
- The Healthy Mothers, Healthy Babies Program – this program provides pregnancy, resilience and antenatal material support. It aims to improve the health outcomes for pregnant vulnerable women and their babies. The *Victorian Budget 2018–19* invested $1.2 million (over two years) to continue the program through community health services in rural and regional locations.
- Early Intervention in Chronic Disease – this initiative aims to assist people with chronic disease to improve their capacity to manage their condition, prevent complications and improve their health and wellbeing.
- The Community Health Nurse Program in Sexual Assault Multidisciplinary Centres– this program provides health needs identification, holistic person direct care planning and support and referral to

appropriate services to children and adults who have experienced sexual assault and their non-offending family members. More recently, nurses now also support clients of family violence referrals. The nurses also raise awareness and educate health care providers, community organisations and MDC partner and client groups on client's health issues

Agencies receiving specific initiative funding are required to demonstrate that funds are targeted to meet the aims of the initiative. This is achieved through reporting requirements (refer to Chapter 2, section 2.13.7: 'Primary, community and dental health data reporting requirements').

The community health schedule of fees and income ranges used when assessing clients are available from the Community health fees policy webpage <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/community-health-fees-policy>.

1.19.1.2 Supercare Pharmacies

The Victorian Government committed $28.7 million over four years from the 2015–16 State Budget to introduce 20 Supercare Pharmacies by 2018. An additional $25.7 million was provided in 2016–17 to further support the rollout of the Supercare Pharmacies initiative.

Supercare Pharmacies are open 24 hours a day, seven days a week, with a nurse onsite from 6.00 pm to 10.00 pm for assessment and treatment of minor injuries and illnesses and risk assessment of lifestyle conditions. Supercare Pharmacies provide round-the-clock access to pharmacists for advice, supply of medicines and dispensing prescriptions.

Five Supercare Pharmacies began operating in June 2016, with a further seven commencing in June 2017. The final eight Supercare Pharmacies opened in June 2018. This brings the number of Supercare Pharmacies across Victoria to 20, in line with the government's commitment. Six Supercare Pharmacies are located in regional areas of the state.

Pharmacies and nursing services in the initiative are engaged through fixed-price contracts with the department. Out-of-hours service delivery must be in line with key performance indicators set out in these contracts. These performance indicators include access and safety and quality measures, and are reviewed and monitored by the department on an ongoing basis.

Activities to further embed the initiative in the primary health sector include significant communication work and marketing activities to increase awareness of the initiative. In late 2019, the department will arrange for experts to evaluate the initiative.

1.19.1.3 Health Condition Support Grants Program

Peer support helps decrease the overall burden of disease by encouraging better health outcomes for members. This includes improved health literacy and self-management.

Every two years the Health Condition Support Grants Program assists small health-condition-specific peer support groups with administrative costs of up to $5,000 per year. The grants program provides one-off grants for a two-year period to peer support groups for people with chronic health conditions and diseases to:

- increase the capacity of people with a chronic health condition to live independently in their community
- encourage a network of peer support and information exchange for people with chronic health conditions and their families and carers
- increase opportunities for peer support groups to access education about their condition and share their experiences and strategies for managing the condition.

The grants are open to health condition peer support groups that:

- meet of their own accord to provide mutual support to self-manage their health needs
- provide education programs and information to members.

In 2019–20 there will be a new round of Health Condition Support Grants. For further details, please refer to the Health Conditions Support Grants webpage <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/health-conditions-support-grants>.

1.19.1.4 Primary Care Partnerships

Twenty-eight Primary Care Partnerships operate across Victoria. The partnerships are established networks of local health and human service organisations primarily funded by the department. The partnerships work together to improve the health and wellbeing of their local communities.

The focus for Primary Care Partnerships is to align priorities to the department's strategic focus on place-based efforts, prevention and population health, family violence, the integration of health and social care and strategic partnership development or chronic disease management, where this work is already occurring or has been identified as a local need.

Read more about Primary Care Partnerships <https://www2.health.vic.gov.au/primary-and-community-health/primary-care>.

1.19.2 Dental health services

The Dental Health Program funding model is activity-based, using the Australian Dental Association service item codes, rather than courses of care. Performance is measured in terms of Dental Weighted Activity Units (DWAU), calculated using weighted Australian Dental Association item codes.

Funding is aligned to DWAUs to ensure that state activity targets are met.

1.19.2.1 Participation in Commonwealth initiatives

The Child Dental Benefits Schedule is a means-tested benefit scheme (Family Tax Benefit A) for children aged 2–17 years covering preventative and basic dental treatment. Eligible children have access to a benefit cap of $1,000 over a two-calendar-year period. A three-year extension to public sector access to the Child Dental Benefits Schedule until 31 December 2022 was announced in the 2019–20 Commonwealth Budget.

1.19.2.2 Dental Health Program fees policy

Fees for public dental services apply to:

- people aged 18 years or older who are health care or pensioner concession card holders or dependants of concession card holders
- children aged from birth to 12 years who are not health care or pensioner concession card holders and are not dependants of concession card holders.

Read more about the policy, including a fees schedule and exemptions, on the Dental health webpage <https://www2.health.vic.gov.au/primary-and-community-health/dental-health>.

1.20 Public health

1.20.1 Health promotion and primary prevention

The department invests in a range of activities that aim to reduce the likelihood of developing a chronic disease or disorder. The focus is on environmental, social and behavioural approaches at the population level that contribute to reducing or eliminating the causes of poor health and wellbeing.

Primary prevention aims to prevent problems occurring in the first place by eliminating or reducing underlying causes. This is achieved by controlling the exposure to risk and promoting factors that protect health, wellbeing, safety and social outcomes. Examples include immunisation, tobacco control legislation and universal maternal and child health services.

Secondary prevention aims to stop, interrupt, reduce or delay the progression of a problem through early detection and intervention. Examples include screening, school-based mental health programs and the stabilisation of housing.

The *Victorian public health and wellbeing plan 2015–2019* is a Victorian Government plan that guides the collective efforts of the department, other state government departments, health services, local government, non-government organisations, the private sector and communities. The plan establishes an ambitious vision for the state: a Victoria free of the avoidable burden of disease and injury so that all Victorians can enjoy the highest attainable standards of health, wellbeing and participation at every age. The overall aim is to improve the health and wellbeing of all Victorians and to reduce inequalities in health and wellbeing.

The plan affirms the need for a life course approach to maximising the health and wellbeing of all Victorians to achieve this vision. Six health and wellbeing priorities for Victoria are identified:

- healthier eating and active living
- tobacco-free living
- reducing harmful alcohol and drug use
- improving mental health
- preventing violence and injury
- improving sexual and reproductive health.

The plan also identifies three platforms through which change can be achieved: healthy and sustainable environments, place-based approaches and people-centred approaches. Place-based approaches focus on intervening at the local level to deliver an integrated approach to chronic disease prevention.

The plan specifically advocates a collective effort by multiple stakeholders to address these complex issues.

The next plan is due on 1 September 2019.

The *Victorian public health and wellbeing outcomes framework* provides a new approach to monitoring and reporting on our collective efforts to improve Victorians' health and wellbeing over the long term. It provides a comprehensive set of outcomes, indicators, targets and measures for our major population health and wellbeing priorities and their determinants. Where data is available, the framework also enables an assessment of health and wellbeing inequalities.

Measures of shorter term change – or progress measures – have been identified for selected priorities of the *Victorian public health and wellbeing plan 2015–2019*. Progress measures can be used at the state and local levels for priority setting and monitoring the impact of collective effort.

Community health services and some small rural health services are funded to deliver place-based primary prevention (under the activity names 'Community health – health promotion' and 'Small rural – primary health flexible services'). It is expected that their local prevention effort is coordinated with councils, the department and other local partners to establish a common approach to preparing local

health and wellbeing plans, and that there is alignment to the *Victorian public health and wellbeing plan* and other key strategic directions of the government. Further information can be found in *Advice for public health and wellbeing planning in Victoria: planning cycle 2017–2021* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/public-health-wellbeing-planning-advice-2017-2021>.

1.20.1.1 Chronic disease prevention

The Victorian Government funds a range of strategies to reduce the risk factors for chronic disease.

The Achievement Program is a comprehensive health and wellbeing quality framework for schools, early childhood services and workplaces (including health services) to support the creation of healthier environments. The framework provides best practice benchmarks to guide settings in determining the policy, cultural and environmental changes needed to improve the health of their workers, students, children and the wider community. The standards cover health priority areas such as healthy eating, physical activity and mental health and wellbeing. Once the settings and benchmarks for the health priority areas have been met, the organisations can apply for Victorian Government recognition. Further information is available on the Achievement Program website <https://www.achievementprogram.health.vic.gov.au>.

Reducing risk factors for chronic disease through a place-based approach to prevention also includes increasing access to healthy food and drinks in places where people spend their time. The Healthy Choices policy guidelines are a framework for improving the provision and promotion of healthier foods and drinks that are available in the community through retail outlets, vending machines and workplace catering. The policy guidelines support the implementation of Healthy Choices in hospitals, health services, sport and recreation centres, workplaces and parks. There are similar guidelines for schools and early years services. Many health services are integrating the Healthy Choices policy guidelines into their retail food service and vending contracts.

Read the Healthy Choices policy guidelines. <https://www2.health.vic.gov.au/public-health/preventive-health/nutrition/healthy-choices-for-retail-outlets-vending-machines-catering>.

The Healthy Choices policy guidelines have been integrated into the funding requirements for local government sport and recreation grants. This includes the 2017–18 Better Indoor Stadiums Fund and the 2018–19 Community Sports Infrastructure Fund in the criteria of the Better Pools category.

Funded by the Victorian Government and delivered by Nutrition Australia Vic Division, the Healthy Eating Advisory Service (HEAS) provides free support for implementing the Healthy Choices policy guidelines. It supports organisations to develop the skills and knowledge needed to remove sugary drinks and increase healthy food choices in their retail food outlets, vending and catering. HEAS is available to health services, as well as early childhood services, schools, workplaces, sport and recreation facilities, parks and universities. It provides: email and phone implementation advice from qualified dietitians; comprehensive online resources, recipes, tips, factsheets and case studies; FoodChecker – an online food and drink assessment tool; online and face-to-face training, including a mentorship program. Further information is available on the Healthy Eating Advisory Service website <https://heas.health.vic.gov.au>.

1.20.1.2 Life! Helping you prevent diabetes, heart disease and stroke program

Funding is provided to deliver the Life! program and associated activities aimed at people with a high risk of diabetes and cardiovascular disease. The program includes group courses and telephone coaching aimed at addressing the risk factors for diabetes and cardiovascular disease. Associated activities include evaluation and continuous quality improvement of the program as part of the prevention system in Victoria.

Results for participants in the Life! program are collected quarterly. Data collection and reporting requirements and the funding recall policy are provided in the relevant sections of these guidelines (Table 1.7).

1.20.1.3 Funding for colonoscopy arising from a positive National Bowel Cancer Screening Program test

The National Bowel Cancer Screening Program (NBCSP) is a Commonwealth Government population health initiative to improve the early detection and prevention of bowel cancer. People eligible to participate in the program receive an invitation through the mail to complete a faecal occult blood test at home, which is sent by mail to a laboratory for analysis. Participants with a positive screening test are required to see their general practitioner and are usually referred for a colonoscopy.

The NBCSP is in a period of expansion. From January 2019 all eligible people aged 50–74 will be invited to screen every two years.

During the NBCSP expansion period, all Victorian public hospitals providing colonoscopy are allocated a separate NBCSP WIES target. This funding is provided in addition to the funding provided for other activity and is paid according to actual activity. The WIES target will be modelled to align with growth resulting from the NBCSP. A prior year adjustment process will reconcile NBCSP activity with targets. Variation in activity against the NBSCP WIES target will be recalled or paid at the full WIES rate. It is not part of public and private WIES for determining recall and throughput.

To be admitted for a colonoscopy under the NBCSP, with or without gastroscopy, a patient must have been referred for the procedure due to a positive faecal occult blood test as a result of participating in the NBCSP. Other patients admitted for a procedure to investigate a positive faecal occult blood test, for surveillance or for follow-up colonoscopies, are not eligible for admission under the NBCSP funding arrangement. Patients admitted for an NBCSP colonoscopy may elect to be public or private according to the usual election procedure. WIES for the episode will be calculated accordingly.

NBCSP participants must be coded under funding arrangement code 8 and will be funded under the WIES funding model. It is expected that most episodes will be grouped to AR-DRGs G48C colonoscopy, same-day or G46C complex endoscopy, same-day. A small number of episodes may group to other diagnosis-related groups where the patient has required an overnight stay or other circumstances have arisen.

NBCSP activity will be paid against the health service's NBCSP WIES target based on actual throughput. Reconciliation for under or over activity will be adjusted at the end of 2018–19.

The department may ask hospitals to confirm episodes with unusual diagnosis-related groups to ensure correct coding or that the patient was a participant in the NBCSP.

Read more about the National Bowel Cancer Screening Program <https://www2.health.vic.gov.au/public-health/population-screening/cancer-screening/bowel-cancer-screening>.

1.20.1.4 Sexual health and viral hepatitis

The department's Sexual Health and Viral Hepatitis unit commissions prevention services and programs to reduce the burden of disease to improve the wellbeing of communities at risk or affected by high prevalence rates of HIV, viral hepatitis and sexually transmissible infections.

A wide range of agencies are funded to provide peer-based care and support, clinical care, health promotion, research, surveillance and workforce training.

The *BBV/STI program guidelines for funded agencies* outline reporting requirements against funded activity. All agencies funded for BBV/STI activities are required to acquit funding using the guidelines. Standard contract management processes apply, including performance output monitoring, regular reporting and face-to-face meetings.

Read the *Victorian HIV strategy 2017–2020*, and hepatitis C and B strategies 2016–2020 at the department's Sexual health webpage <https://www2.health.vic.gov.au/public-health/preventive-health/sexual-health>.

1.20.1.5 Tobacco control

To reduce the burden of smoking on the community, the Victorian Government funds non-government organisations, such as Quit Victoria, the Victorian Aboriginal Community Controlled Health Organisation and Alfred Health, to provide:

- clinical smoking cessation support services, including the Quitline and dedicated Aboriginal Quitline, which provide expert advice and personalised counselling to smokers wanting to quit
- programs targeted at sub-populations with the highest rates of smoking, low socioeconomic groups, Aboriginal Victorians, people experiencing mental illness and those affected by alcohol and drugs
- continuous, sustained Victorian anti-smoking social marketing campaigns (integrated across television, radio, print and social media) to reduce smoking uptake and increase cessation
- research to inform tobacco control policy and regulatory reform such as annual surveys of smoking prevalence and behaviours
- training for health professionals (including Aboriginal health workers) in providing brief smoking cessation interventions
- support for health services to implement best practice smoking cessation support in routine care.

The department funds the Municipal Association of Victoria to manage the distribution of funds to councils to educate businesses and the community regarding their responsibilities under the *Tobacco Act 1987*, and to take enforcement action where necessary.

1.20.1.6 Victorian Tuberculosis Program

The department funds Melbourne Health to provide the Victorian Tuberculosis Program. The program is a statewide service based at the Peter Doherty Institute for Infection and Immunity. Program staff provide case management to people with active tuberculosis for the duration of their treatment and conduct appropriate contact-tracing and screening to minimise the public health risk of the spread of infection. The department has developed performance measures for Melbourne Health, which are outlined in the *Victorian Tuberculosis Program service objectives and scope* document.

1.20.2 Health protection

The Victorian Chief Health Officer leads the Health Protection branch, is the lead public health adviser to the Minister for Health and the Victorian Government and is the state's spokesperson on public health issues. The Chief Health Officer also leads the department's response to climate change, including chairing the Climate Change Reference Group and having overarching responsibility for delivering the department's climate change adaptation plan and emissions reduction plan under the *Climate Change Act (2017).* The Chief Health Officer has statutory powers under the *Public Health and Wellbeing Act 2008* to protect the health and wellbeing of Victorians and is involved in overseeing strategy and policy in health protection, coordinating investigations and management of public health risks, and undertaking all manner of risk communication with stakeholders including the Victorian public.

The Chief Health Officer regularly informs Victorians about issues that have the potential to affect their health. Information is provided via health alerts and a range of other documents accessible on the Victorian Chief Health Officer's website <https://www2.health.vic.gov.au/about/key-staff/chief-health-officer>.

The department's responsibility for health protection is to reduce the incidence of preventable disease by protecting the community against hazards resulting from or associated with communicable disease, food, water or the environment.

Key areas of health protection activity include communicable disease prevention and control. This work aims to reduce the risk of current and emerging infectious diseases in Victoria through implementing patient and population-focused control strategies (including immunisation) based on surveillance and risk assessment.

The department's environmental health unit works to prevent ill health arising from environmental factors. It responds to major threats to public health and regulates hazards such as radiation, pesticides, cooling towers and plumbing systems to promote the health and wellbeing of the Victorian community.

Food safety and regulatory activities are aimed at protecting the community from food-related illnesses and hazards. Activities support public health improvement through strategic regulatory policy and programs to achieve a healthier community.

1.20.2.1 The Peter Doherty Institute

The Victorian Government has contributed to building the Peter Doherty Institute for Infection and Immunity in the Parkville precinct. The Peter Doherty Institute for Infection and Immunity is a purpose-built facility that integrates microbiology research with leading public health laboratories to strengthen capabilities in infectious diseases and immunology.

The Peter Doherty Institute for Infection and Immunity is a partnership between the University of Melbourne and Melbourne Health, established to create a world-class institute that combines research into infectious disease and immunity with teaching excellence, reference laboratory diagnostic services, epidemiology and clinical services.

The Peter Doherty Institute for Infection and Immunity brings together six organisations into a new state-of-the-art facility, which aims to:

- develop strong working partnerships between two iconic Victorian organisations – the University of Melbourne and Melbourne Health
- drive Victoria's domestic and global leadership position in infectious diseases prevention and immunity research
- promote best practice in infectious diseases diagnosis, treatment, education and research
- facilitate innovation, harmonisation and integration in infectious diseases care, research, education and training to achieve a world-leading infectious diseases institute and workforce
- become a world leader in life sciences research through developing a leading computational biology facility
- facilitate the integration of several leading health units from the university and Melbourne Health to form a critical mass and a scope of activity unrivalled in infections and immunity research within Australia
- identify and advance research, clinical education and promotional opportunities that are unable to be realised by the parties individually.

1.21 Teaching and training

1.21.1 Training and development grants

Training and development funding is provided to public health services to recognise the additional costs inherent in the teaching and training activities of public health services. The grants aim to support the development of a high-quality future health workforce for Victoria through subsidising:

- professional-entry student placements
- transition-to-practice positions for medical, nursing and allied health
- postgraduate medical, nursing and midwifery study
- other targeted workforce training and development initiatives.

In 2019–20 the department will be increasing our investment in the nursing and midwifery workforce through a range of programs, including expanding existing graduate and postgraduate programs.

In 2019–20 the department will be investigating options to confirm training and development program funding and expected activity levels earlier in the fiscal year to provide health services with greater certainty of annual budgets, with the aim of making minimal adjustments during the year if reported activity is within the expected range.

1.21.1.1 Professional-entry student placements

Subsidies to health services are allocated to support the delivery of professional-entry student placements. Subsidies are based exclusively on health services' proportion of total (weighted) clinical placement activity for students enrolled in a professional-entry course of study in medicine, nursing (registered and enrolled), midwifery or allied health (including allied health assistance and health information management).

A limited number of professional clinical placements, professional development year or industry-based learning positions are not eligible for the professional-entry student placement subsidy because they are funded through the transition-to-practice and postgraduate study streams of the grant. These include internships in hospital pharmacy, medical imaging (radiography), nuclear medicine, radiation therapy, medical biophysics, medical laboratory science and employment model midwifery.

Beginning in 2020, the department will be providing additional funding on a time-limited basis to increase clinical placements to support the Victorian Government's commitment to expanding enrolled nurse training through the offer of free training with Victorian Technical and Further Education (TAFE) providers. Health services will be advised of the conditions of this funding through an application process to provide an increase in placements in 2020.

1.21.1.2 Transition to practice – (graduate) positions

The aim of this stream of funding is to ensure new graduates make a positive transition into the public sector health workforce and are encouraged to stay working within the sector.

The transition-to-practice funding stream includes five program areas:

- allied health graduates
- allied health interns
- nurse and midwifery graduates
- medical graduates (year one and two – PGY1 and PGY2)

Subsidies to health services contribute to the cost of supervision and on-the-job training in the first year for approved nursing, midwifery and allied health graduate positions, and the first two years for approved medical graduate positions.

A limited number of funded transition-to-practice positions are allocated to university students undertaking professional clinical placements in medical imaging and radiation therapy and to students completing industry-based learning placements in medical biophysics and medical laboratory science.

Public mental health services across Victoria are excluded from receiving transition to practice subsidies for nursing and allied health graduates as they are provided with subsidies through the Mental Health Training and Development grant.

For all program areas subsidies are approved and allocated based on each health service's activity as a proportion of total reported graduate activity.

1.21.1.3 Postgraduate positions – medical, nursing and midwifery

Subsidies to health services contribute to postgraduate study or employment arrangements, including the cost of supervision, for approved positions.

All health services are required to reconcile actual activity each year to receive postgraduate funding. Subsidies are approved and allocated based on each health service's activity and priority workforce considerations.

Medical specialist training

The following programs are available for postgraduate medical specialist training.

Victorian Medical Specialist Training Program

The Victorian Medical Specialist Training Program provides funding in targeted specialties to assist health services to increase the number of accredited medical specialist training positions. The program is being reviewed in 2019–20 to ensure it is the best model to support the expansion of accredited medical specialists training.

Funding allocation for the program is determined through an Expression of Interest process that occurs once every two years.

Victorian Paediatric Training Program

The Victorian Paediatric Training Program provides subsidies to support a statewide basic paediatric training program. Subsidies ensure that the distribution and rotation of accredited paediatric trainees are aligned with the workforce requirements of outer metropolitan, regional and rural Victoria and that they promote access to local paediatric services across the state. The program is being reviewed in 2019–20 to ensure it is the best model to support the required development of paediatric specialists.

Eligibility for the program is determined in collaboration with health services.

Basic Physician Training Consortia

The Basic Physician Training Consortia program provides annual funding to five consortia comprising all Victorian hospitals with accredited physician training positions to support distribution and management of basic physician trainees, address workforce shortages and improve the quality of education and training in rural Victoria. The program is being reviewed in 2019–20 to ensure it is the best model to support the required development of physicians.

Positions are made available through this program via the 'match' undertaken annually by the Postgraduate Medical Council of Victoria.

Nursing and Midwifery

The postgraduate nursing and midwifery program provides subsidies for postgraduate studies that lead to an award classification of graduate certificate, graduate diploma or master's-level studies.

In 2019–20 the department will be reviewing the eligibility requirements to prioritise postgraduate qualifications that assist health services to implement the amended *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015*.

1.21.1.4 Other targeted workforce training and development programs

Allied Health Leadership Program

The *Allied health leadership strategy* is underpinned by the *Allied health leadership development framework*, which identifies four levels of leadership development across the career continuum: Transition to Practice, Emerging Leaders, Growing Leaders and Established Leaders. This framework will underpin the development and delivery of targeted interventions by the sector, in partnership with the department.

Allied Health Research Translation and Clinical Educator Roles

To support allied health workforce development 10 senior allied health research and translation roles and 10 clinical education positions have been implemented across Victorian health services. The plan also supports Victoria's investment in building the leadership capability and capacity of the allied health workforce.

Continuing Nursing and Midwifery Education Program

The Continuing Nursing and Midwifery Education program provides funding to health services to support planned and targeted nursing and midwifery education that maintains and improves the skills and knowledge of nurses and midwives employed in their organisation.

Funding is allocated on the bases of total nursing/midwifery full-time equivalent staff.

Nursing and Midwifery Postgraduate Scholarships

Postgraduate scholarships are allocated to registered nurses and midwives working in Victorian public health services, to undertake postgraduate study in areas of clinical practice where there is an identified workforce need.

Scholarship funding is allocated annually to eligible public health services (or for rural health services, to fund holders within the five rural health regions) and calculated based on nursing/midwifery full-time equivalent staff.

Maternity Connect Program

The Maternity Connect Program provides funding that supports the ongoing education of rural midwives and neonatal nurses through facilitating clinical placements in larger, higher acuity services. The funding covers travel and accommodation of participants, backfill of staff for the rural service and a subsidy for the placement service to ensure clinical support. Participants are prioritised according to rural workforce need and the availability of placements.

Eligibility for funding through the program is determined in collaboration with health services.

Nuclear Medicine Intern Cluster Program

St Vincent's Hospital Melbourne will be provided with funding to provide centralised clinical education support for workplaces involved in the Nuclear Medicine Intern Cluster Program. This funding will facilitate the continued employment of up to one full-time equivalent statewide nuclear medicine clinical educator.

Prevocational Medical Education and Training

Prevocational medical education and training funding is provided to health services to support junior medical staff training, primarily through employing medical education officers. Funding is limited to the size of the funding pool, with the allocated model including a base payment per health service, plus a per capita allocation per intern position as reported for 2018. In addition, rural and regional health services receive a rural loading on the per capita allocation. Payment rates for 2019–20 are outlined in the Appendices, Appendix 1, 'Table 1.18: Training and development funding rates in 2019–20'.

Rural Clinical Academic Program

The Rural Clinical Academic Program supports rural and regional health services that, in conjunction with Rural Clinical Schools, provide academic teaching and regional coordination for medical students hosted at the health service for an extended period. The funding recognises the increased costs of providing academic teaching, support, coordination and infrastructure for medical students while based at a rural and regional health service for a period greater than six weeks. The program is intended to ensure that the types of learning experiences that medical students receive in rural and regional health services are of a high quality and demonstrate the varied and rewarding work occurring in these services. This funding is provided in addition to other training and development funding for professional-entry clinical placements that help students acquire clinical skills through applying theoretical knowledge to practice.

In 2019–20 the department will review the rural clinical academic funding with the aim of ensuring greater alignment with rural training pathways.

Rural Community Intern Training program

The Rural Community Intern Training (RCIT) program provides medical interns with exposure to a wide range of clinical experiences that emulate the practice of a rural general practitioner, both within the hospital system and in community general practice settings. Interns are based in small rural and sub-regional hospitals, with core and non-core rotations to larger regional hospitals, general practices and community settings. The RCIT program will be merged into an overarching Victorian Rural Generalist training pathway and will be renamed the Rural Generalist Intern Year (RG- Year 1) in 2020.

Rural Generalist Training Program

The Victorian General Practitioner – Rural Generalist (GP-RG) program supports medical practitioners to gain advanced skills as part of supported pathways of general practice training. This helps ensure Victorian rural generalists are well equipped to work across general practice and achieve advanced skills competency. Following two years of prevocational training, trainees who intend to pursue general practice training will have successfully enrolled within the Australian General Practice Training Program. The program provides trainees with an opportunity to obtain advanced skills in areas such as obstetrics, anaesthetics, emergency medicine, geriatric medicine, paediatrics, indigenous health and mental health. In addition to trainees, the program is also available to fully qualified general practitioners who wish to undertake advanced skills training through a lateral entry pathway. The GP-RG program will be merged into an overarching Victorian Rural Generalist Training Program and will be renamed as the Rural Generalist Advanced (RG-Advanced) training year in 2020.

Rural Health Workforce Support

The department works collaboratively with Rural Workforce Agency Victoria to support education and training to meet a range of identified rural workforce development requirements. Funding in 2019–20 will be allocated to support recruitment, training and professional development for the rural medical workforce.

1.21.1.5 Funding conditions and allocation

Health services that receive training and development grant funding should ensure they meet eligibility and reporting requirements as outlined in Chapter 2, section 2.13.9 'Training and development funding reporting and eligibility requirements'.

Nursing and midwifery program areas must comply with the *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015*. Where the department is made aware of noncompliance with the Act, training and development grant funding may be withheld or recovered.

All programs supported through training and development funding must conform to the most recent versions of guidelines (where available), including the guidelines and standards set by the Australian Health Practitioner Regulation Agency and the national health practitioner boards.

Allocation of the training and development funding is limited by the total grant pool. Funding allocations for professional-entry student placements, transition-to-practice and postgraduate programs are based on weighted prior year activity and depend on appropriate reporting of all activity by health services.

If programs or training positions include a period of rotating placements, lead organisations are required to ensure the other host organisation(s) receive a pro rata portion of the grant equal to the length of the rotation.

Training and development allocations in 2019–20 are listed at the Appendices, Appendix 1, section 1.1 'Price tables'.

For further details regarding these funding streams refer to the Health Workforce website <https://www2.health.vic.gov.au/health-workforce> or download the *Training and development program guidelines 2019–20* from the Training and Development Funding webpage <https://www2.health.vic.gov.au/health-workforce/education-and-training/training-development-grant>.

1.22 Capital Funding Programs

The department administers several capital grant programs to assist health services with the costs of hospital infrastructure. The Infrastructure Renewal Contribution Grant, Regional Health Infrastructure Fund, Medical Equipment Replacement Program and Engineering Infrastructure Replacement Program support health services to manage risk and maintain patient safety, occupational health and safety, and service availability and continuity by maintaining and replacing assets in a planned manner, prior to failure.

The department has adopted a coordinated approach to the allocation and management of funds from these four separate sources. Where projects are unable to be completed and acquitted within a two-year period, allocations may be recalled and re-appropriated to other priority projects.

Read more about the programs at the Medical equipment and engineering infrastructure webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/planning-infrastructure/medical-equipment>.

1.22.1 Infrastructure Renewal Contribution Grant

In 2019–20, $40 million will be distributed to all hospitals including rural and small rural health services to assist health services with the costs of replacing hospital infrastructure. Grants will be appropriated to health services from October, on receipt of Asset Management Plans by the health service to the Victorian Health and Human Services Building Authority.

Read more about asset management plans at the Asset property management and operations webpage <http://www.capital.health.vic.gov.au/Asset_property_management_and_operations>.

1.22.2 Medical Equipment and Engineering Replacement Funding

In 2019–20, $35 million will be provided for the Medical Equipment Replacement program and $25 million for the Engineering Infrastructure Replacement program. $17.5 million from the Medical Equipment Fund and $12.5 million from the Engineering Replacement Fund will be distributed to metropolitan and regional hospitals based on activity as a specific purpose grant. The balance of funding from each program will be centrally managed and allocated through a submission-based process by the department for highest priority at-risk, high-value replacements.

1.22.2.1 Specific-purpose capital grants

Replacement priorities for medical equipment and engineering infrastructure specific-purpose capital grants are to be determined by health services in accordance with highest critical risk assessment of in-scope assets. Grant expenditure will be acquitted in accordance with the requirements for capital appropriations and reported through the Agency Information Management System – 7B reporting.

1.22.2.2 High Value Statewide Replacement Funds

The High Value Statewide Replacement Funds for medical equipment and engineering infrastructure are bid-based and centrally managed. The funds replace critical high-value in-scope assets that carry a high risk to the statewide provision of acute services in public hospitals. The assessments, prioritisation and allocations consider a whole-of-system perspective and proposals are prioritised to highest critical risk scores against set criteria.

Health service investments should align with health service asset management plans, must maximise value-for-money procurement and be consistent with government policies, practices and asset management frameworks.

1.22.3 Regional Health Infrastructure Fund

In 2019–20, $50 million will be provided for regional and rural health services on a bid-based process and will be managed by the department centrally where projects exceed $1 million. Investment will be targeted to construction, remodelling and refurbishment projects; equipment (including furniture, fittings); medical equipment; engineering infrastructure and plant; information and communications technology; and new technologies including systems to reduce usage and increase efficiencies of power and/or water. Applications will be assessed on readiness of the project, demand for services, compliance risk, clinical risk and if infrastructure and assets are fit for purpose.

1.22.4 National activity-based funding arrangements

The National Health Reform Agreement established a new framework for funding public hospital services under a national approach to activity-based funding.

The goal of the national approach is to provide a national platform for accurately and visibly allocating funding to Australian hospitals based on activity performed. This funding approach is across several service streams including:

- acute admitted
- emergency departments
- subacute
- non-admitted care
- in-scope mental health
- block-funded services.

The national model recognises that activity-based funding may not always be practicable and that some services will need to be funded on a block-grant basis. Under current arrangements, small rural health services and teaching, non-admitted mental health training and research outputs will continue to be funded nationally through block grants.

Under the national activity-based funding model, activity funded by the Commonwealth Government is referenced to the national efficient price (NEP) determination published by the IHPA, which is revised annually.

Activity is measured and funded in terms of national weighted activity units (NWAU). The NWAUs provide a way of comparing and valuing each public hospital service, whether they are admissions, emergency department presentations or non-admitted service events, weighted for clinical complexity.

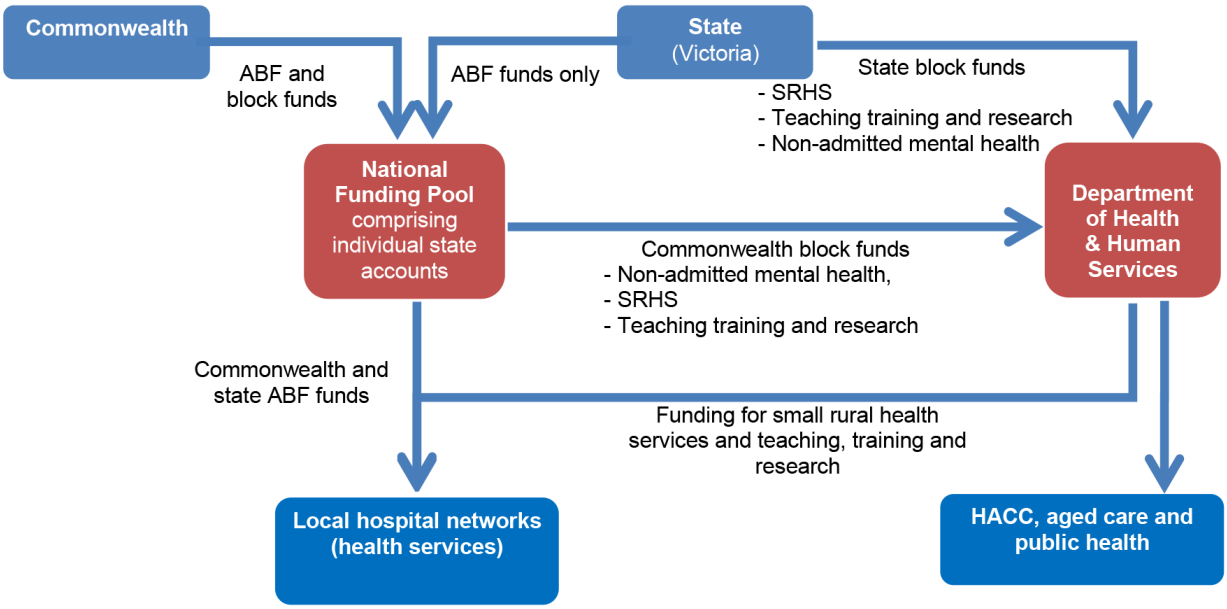
The national weighted activity unit targets will be included in health services' Statement of Priorities Part D, in addition to the WIES targets (Part C).

In 2019–20 the NEP has been set at $5,134 per NWAU(19). Details are published in the IHPA's NEP determination and pricing framework each year. Documents relating to the NEP and NWAUs are available at the Independent Hospital Pricing Authority website <https://www.ihpa.gov.au>.

While health service budgets will be calculated according to Victorian funding models, Commonwealth activity-based funding will flow to health services through the national funding pool managed by the administrator. The administrator (established as an independent statutory office holder) oversees both the Commonwealth and state and territory funding of the public hospital system and will publicly report on what funds were provided to each health service, and on what basis.

As system managers, the Victorian Government instructs when payments are to be made out of the pool in accordance with the activity levels agreed between the state and each health service in their SOP. The Victorian Government will continue to manage block-funded payments, including small rural health services, teaching, training and research and non-admitted mental health services. Block-funded payments will be paid to health services by the department through the state-managed fund (see Figure 1).

Figure 1: Payment flows under national activity-based funding



1.22.5 The pricing framework for Australian public hospitals: activity-based

In 2019–20 the in-scope public hospital services that will be funded through the *National Health Reform Agreement* are:

- all acute admitted patient services, including HITH
- all emergency department services
- all admitted subacute services
- all admitted mental health services
- non-admitted acute and non-admitted subacute patient services.

In 2019–20:

- The national activity unit will be known as NWAU(19).
- The national efficient price is set by the IHPA at $5,134 per NWAU. Costing information used to determine the NEP was drawn from the 2016–17 National Hospital Cost Data Collection (Round 21).

The national model uses a number of classification systems to express the relative cost weights in terms of NWAUs for each 'group' of activity-based funding services. The national classification systems used to group patients for each activity-based funding service are:

- admitted patient services: AR-DRG Version 9.0
- emergency department services: Urgency Related Groups Version 1.4 (for recognised emergency departments at levels 3B–6) and Urgency Disposition Groups Version 1.3 (for recognised emergency departments at levels 1–3A)
- non-admitted patient services: Tier 2 Outpatient Clinics Definitions Version 4.1
- admitted mental health patient services: modified version of AR-DRG Version 9.0
- admitted subacute patient services: Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) Version 4.0.

Health services' total funding will continue to be determined based on activity volumes and prices according to the Victorian funding models such as WIES and subacute WIES in 2019–20. The Commonwealth and state contributions to health services, through the national funding pool, will be based on the projected equivalent NWAUs generated by the activity levels as set by the Victorian funding models and will be cash flowed according to a health service NWAU-specific rate.

The technical specifications of the national activity-based funding model are referred to in the IHPA's National Pricing Model Technical Specifications 2019–20 <https://www.ihpa.gov.au/publications/national-pricing-model-technical-specifications-2019-20>.

1.22.6 The pricing framework for Australian public hospitals: block-funded based

The national model includes recognition that activity-based funding may not always be practicable and that some services will need to be funded on a block-grant basis.

The government provides advice to the IHPA on which services meet the criteria to be block-funded. Services currently funded through the small rural health services model will continue to be block-funded. Those currently receiving output funding through the casemix model will be subject to activity-based funding and will therefore be paid via the National Health Funding Pool. The government also provides advice to the IHPA on the funding for teaching, training and research and non-admitted mental health in November each year, which the IHPA then includes as the block amount in its national efficient cost determination.

The IHPA has applied these criteria in developing the national costing model and the national efficient cost determination for 2019–20 that applies to block-funded services.

In 2019–20 the national efficient cost is $5.319 million. This represents the average cost of a block-funded hospital. The national efficient cost was determined using the average in-scope expenditure data for 2016–17 reported to the National Public Hospital Establishment Database of $4.783 million indexed at 3.6 per cent per annum (based on national cost data) to account for price and activity growth over the three years.

Read more about the pricing framework for Australian public hospitals and the categorisation of small rural health services <https://www.ihpa.gov.au/publications/national-efficient-cost-determination-2019-20>.

1.23 Prior year adjustment: activity-based funding reconciliation

The department allocates funding according to the expected activity levels for healthcare services. In general, funded organisations are cash flowed during the financial year according to their funding allocations. Where required, adjustments to this funding for over- and under-activity are made in the following financial year according to the policies set out in this section.

1.23.1 Victorian funding recall policy

Funding recalls will be triggered by a drop-in service activity that is below targeted levels. Recall rates are set out in Table 1.7.

Recalling funds depends on accurate and timely data submission. Funded organisations should ensure they adhere to the data requirements as specified in these guidelines. Significant under- or over-activity should be discussed with the department.

In 2019–20, public/private WIES and subacute WIES will be recalled based on the rates detailed in Table 1.7. The marginal WIES policy aims to maintain minimal levels of funding for under-activity in recognition of fixed costs and variable demand but incentivise efficient service delivery above target where it is cost-effective for health services to do so and up to a capped amount.

Department of Veterans' Affairs and TAC activity will continue to be funded to actual activity that is approved by the Department of Veterans' Affairs. Health services are expected to update the VAED for any rejected or denied episodes of care prior to reconciliation. Any denied or rejected records that are not amended will not be paid as either public or Department of Veterans' Affairs when the 2019–20 Prior Year Adjustment is calculated.

In 2019–20, National Bowel Cancer Screening Program WIES be recalled based on rates detailed in Table 1.7 and continue to be funded to actual activity.

Home renal dialysis will continue to be funded to actual activity during the year.

Recall rates are based on a proportion of the price, rather than a specified dollar value. This enables rates to be applied consistently across services and reflects price adjustments.

Small rural health services are exempt from the recall policy for acute, subacute and primary health. Recall applies to renal, Home and Community Care Program for Younger People, Aged Care Assessment Services and residential aged care services in the same way as other services.

For subacute services, the department considers activity across several subacute admitted funding streams within a health service when deciding to apply funding recall or to provide additional funding. This process is referred to as the 'subacute wrap'. The following services are included in the subacute wrap:

- rehabilitation (including spinal rehabilitation and paediatric rehabilitation)
- geriatric evaluation and management
- admitted palliative care
- maintenance care.

Public and private activity is included for these care types. The subacute wrap encourages flexibility for health services to meet client needs.

Recall will apply to the total HIP activity target. Recall will also apply to the Transition Care Program. Transition Care Program recall will be calculated separately and will not be included in the subacute wrap. Funding recall applies for the state component of the Transition Care Program, with recall for the Transition Care Program wrapped between bed-based and home-based.

A recall policy also applies to Home and Community Care Program for Younger People, and Aged Care and Assessment Services as outlined in Table 1.7. Funded organisations should note that significant underperformance in any activity should be discussed with the department in a timely manner.

Nationally Funded Centres activity will continue to be funded to actual activity. The WIES associated with the Nationally Funded Centres including procedures undertaken up to three months post discharge will not be recognised as public-private WIES for the purposes of calculated funding recall for acute admitted services.

In 2019–20, recall will not apply to acute admitted specialist clinics activity eligible to be funded under the Weighted Ambulatory Service Event (WASE) funding model.

An overview of the calculation process for recall can be found at the Appendices, Appendix 1, Addendum 1.7: 'Calculating funding recall'.

Table 1.7: Victorian funding recall rates 2019–20

Service	Funding recall policy
Acute admitted services Subacute admitted services (wrap includes GEM, rehabilitation and palliative care) Non-acute admitted services (maintenance care)	• 0–3 per cent below target: 50 per cent of the weighted relevant rate or wrap value. • > 3 per cent below target: 100 per cent of the relevant rate.
Nationally Funded Centres (NFC)	Full recall of under-activity at the NFC determined cost per procedure.
National Bowel Cancer Screening Program	Full recall of under-activity.
Department of Veterans' Affairs • Acute admitted services • Subacute admitted services (wrap includes GEM, rehabilitation and palliative care)	Full recall of under-activity.
Transport Accident Commission and WorkSafe • Acute admitted services	Full recall of under-activity.
Small rural health services	Recall applies to renal, HACC-PYP, ACAS and residential aged care services. No recall applies for acute, subacute and primary health.
Acquired brain injury unit	Full recall of under-activity at the full rate.
Mental health admitted services	The department may recall funds associated with funded beds, which remain unopened or have been temporarily closed. Recall will depend on statewide priorities and the need for funding redistribution to achieve these priorities as defined by the department.
Non-admitted emergency services	Non-admitted emergency services are currently not subject to recall.
Subacute non-admitted services	Funding recall will be applied to subacute non-admitted services. When determining whether recall applies, the department will consider activity against the total HIP target: • 0–5 per cent below target: no recall. • > 5 per cent below target: the department may recall at the full HIP rate for the amount that is beyond the five per cent underperformance.

Service	Funding recall policy
Mental health non-admitted services	• 0–5 per cent below target: no recall. • > 5 per cent below target: the department may recall at the relevant rate. The amount subject to recall is that beyond the five per cent underperformance.
Transition Care Program (bed-based and home-based wrapped)	• 0–5 per cent below target: no recall. • > 5 per cent below target: the department may recall at the home bed day rate. The amount subject to recall is that beyond the five per cent underperformance.
Dialysis services	Admitted dialysis activity is incorporated within the total health service acute admitted activity. Payment from the dialysis provider to the specialist service (hub) should be adjusted to actual by the end of the year, before the recall is applied. Home dialysis activity (determined on a monthly basis) under target will be subject to full recall.
Non-admitted radiotherapy	Funding will be recalled at the full rate for performance below target.
Non-admitted specialist clinics	Funding recall will not be applied for non-admitted specialist clinics.
Integrated cancer services	The department may recall unexpended integrated cancer services funds. Recall will depend on statewide cancer reform priorities and the need for funding redistribution to achieve these priorities as defined by the department.
Primary health funding approach	• 0–5 per cent below target: no recall. • > 5 per cent below target: the department may recall at the full rate. The amount subject to recall is that beyond the five per cent underperformance. Read more about the primary health funding approach recall policy on the Community health webpage <https://www2.health.vic.gov.au/primary-and-community-health/community-health>.
BreastScreen Victoria services	• 0–3 per cent below target: no recall. • 3–5 per cent below target: recall at 50 per cent of relevant rate. • > 5 per cent below target: recall at full rate. Recall policy is subject to the terms and conditions of BreastScreen Victoria's Funding and Service Agreement with the department.
Aged Care Assessment Service (ACAS)	The department recognises that ACAS may find it difficult to meet the exact annual targets for the number of assessments. In the case of sustained underperformance compared with annual targets of more than five per cent for two years or longer, a funding reduction may be applied that corresponds to the level of underperformance.
Home and Community Care Program for Younger People (HACC-PYP)	Recurrent and/or one off funds HACC-PYP s may be recalled from service providers, including small rural services that achieve less than 95 per cent of funded targets or fail to achieve agreed deliverables for block-funded activities in a timely way.
Diabetes prevention	Program funding recalled per participant target not met.
Residential aged care	Recurrent funds may be recalled from service providers, including small rural residential aged care services where they reduce the number of operational places. As funding is calculated on the basis of operational places any reduction will result in a corresponding adjustment to funding.
Total parenteral nutrition	Total parenteral nutrition activity (determined on a monthly basis) under target will be subject to full recall.
Home enteral nutrition (HEN)	Recall may apply for health services where reported HEN service events are below the target. Funding may be recalled based on the service events below target.

Exceptional events

There may be circumstances (including industrial action and natural disasters) beyond the reasonable control of health service management that prevent targeted throughput being met. At its discretion, and

on a case-by-case basis, the department will consider submissions to adjust funding to health services, irrespective of throughput, for as long as such events continue.

Health services are expected to actively mitigate their financial exposure and throughput decline during and following such events.

The department will take into consideration the net change to health service finances and resources caused by exceptional events. However, health services will not receive additional funding for 'catch-up' throughput, nor will health services receive funding for additional throughput in service areas not directly affected by these events. The department assesses the net impact of such events by assessing the data it collects on health service performance and other indicators.

1.23.2 Funding for throughput above target

Funding for health service throughput above target will be based on a proportion of the funding rate (see Table 1.8).

The Department of Veterans' Affairs and the TAC will continue to be funded to actual activity and will therefore attract additional funding for throughout above target.

National Bowel Cancer Screening Program WIES will be funded to actual activity and will therefore attract additional funding for throughout above target.

Throughput funding for above target will not apply for acute non-admitted specialist clinics WASE activity in 2019–20.

For subacute admitted services, when determining how to apply funding for throughput, the department will consider throughput across the following subacute inpatient funding streams within a health service:

- rehabilitation (including spinal and paediatric rehabilitation)
- geriatric evaluation and management
- palliative care
- maintenance care.

Significant under- or over-activity in any stream should be discussed with the department. Transition Care Program, nursing home type activity and non-admitted services are not included in the subacute wrap.

There is no funding for any over-activity for non-acute care (Home and Community Care Program for Younger People, Transition Care Program or nursing home activity) or non-admitted HIP.

Table 1.8: Funding for throughput above target 2019–20

Service	Funding recall policy
Acute admitted services Subacute services (GEM, rehabilitation and palliative care combined) Non-acute admitted services (maintenance care)	Fifty per cent of relevant public rate or wrap value for activity up to four per cent above target. Any activity above four per cent will not attract additional funds.
Nationally funded centres (NFC)	Full payment of over-activity at the NFC determined cost per procedure.
Department of Veterans' Affairs Transport Accident Commission WorkSafe	Funding will be reconciled to actual activity.
National Bowel Cancer Screen Program WIES	Funding will be reconciled to actual activity.
Dialysis services	Admitted dialysis activity is incorporated within the total health service acute admitted activity. Payment from the dialysis provider to specialist service (hub) should be adjusted to actual by the end of the year. Home dialysis activity (determined on a monthly basis) over target will be paid to actual activity.
WASE funded non-admitted acute specialist clinics activity	Any activity above target will not attract additional funds.
Total parenteral nutrition	Total parenteral nutrition over target will be paid to actual activity.
Home enteral nutrition	Home enteral nutrition over target will be paid to actual activity.

1.23.3 Prior-year adjustment of Commonwealth contribution

The National Health Funding Body is required to complete a six-monthly reconciliation against national weighted activity unit (NWAU) targets for each local hospital network in Victoria.

The department will keep health services informed of any implications arising from the administrator's determination. However, it is expected that the administrator will recall the full amount of the Commonwealth contribution for any health services not achieving the target (irrespective of percentage) and will pay to actual activity for any activity in excess.

To counteract this, the department will make adjustments to recall cash flows so that health services are accountable to the Victorian funding model and recall policy, rather than the national funding model and recall policy, to ensure health service funding certainty and stability.

1.23.4 Hospital activity, WIES and subacute WIES reports

The hospital activity, WIES and subacute WIES reports are provided to nominated public health services contacts by the department shortly after the VAED consolidation on the 10th day of each month. The reports contain a financial year-to-date summary by month of admitted patient separations, patient days, WIES and subacute WIES.

Further information, including the report specifications, are available on the Victorian Admitted Episodes Dataset webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vaed>.

1.24 Health service compensable and ineligible patients

1.24.1 Funding for interstate patients

The National Health Reform Agreement (NHRA) allows jurisdictions to enter into agreements to make adjustments for costs incurred where admitted patient services are provided to eligible residents of other states or territories.

In Victoria, health services provide admitted acute, subacute, mental health emergency and non-admitted services to eligible residents of other jurisdictions as public patients (if the patient chooses) and at no charge as required under the Medicare principles and the NHRA. Residents from other jurisdictions who elect to be treated as a private patient will be admitted and treated subject to the normal private patient admission requirements. A private admitted patient will be responsible for paying doctors' medical fees and any charges levied by the hospital for their stay. Private health insurance may cover all or part of these costs depending on the type of insurance policy the patient holds.

The services provided by Victorian health services to residents of other Australian jurisdictions (who are not normally a Victorian resident) are part of a health service's normal throughput targets and are not counted as additional throughput or funded separately.

1.24.2 Medicare-ineligible patients and international patients seeking health services

Health services should charge Medicare-ineligible patients for the full cost of their treatment. While individual health services may determine the level of fees chargeable, they should at a minimum be set to achieve full cost recovery. All health services should ensure that appropriate verification, billing and debt collection processes are in place to minimise bad debts.

Exemptions from charging fees are as follows:

- Health services are required to provide Medicare-ineligible asylum seekers with full medical care under the same arrangements that apply to all Victorian residents. Patients in this category are not to be billed, with the exception of some non-admitted services. Funding for these patients is provided by the department as part of normal public patient throughout. Refer to Hospital Circulars 27/2005 and 29/2008 for more information.
- Tuberculosis (TB) patients are eligible to receive publicly funded services for TB-related treatment. Refer to Hospital Circular 06/2014 for more information.
- Visitors from a country that has a Reciprocal Health Care Agreement (RHCA) with Australia are eligible for medically necessary treatment. Refer to Hospital Circular 23/2009 for more information.

The following principles provide a guide to making decisions regarding the treatment of Medicare-ineligible patients. Additional principles have been developed to guide health services that wish to treat people visiting Victoria where health treatment is their primary focus.

1.24.2.1 Medicare-ineligible patients – principles

These principles apply to all Medicare-ineligible patients treated in Victorian public hospitals. Health services should use the following principles to guide decisions about treating Medicare-ineligible patients:

- Health services have a duty of care to treat emergency patients. All patients are able to access care in an emergency department regardless of their eligibility status. Medicare-ineligible patients are expected to pay for these services.
- Fees charged to Medicare-ineligible patients are at the discretion of individual health services. Fees should be set at a minimum to achieve full cost recovery.

- Health services are encouraged to obtain an assurance of payment from all Medicare-ineligible patients before treatment.
- Medicare-ineligible patients should be provided with an indicative cost of treatment, including advice that they may incur out-of-pocket expenses for their treatment if costs are not fully met by their private health insurance fund.
- Health services are encouraged to have collaborative arrangements in place to enable an appropriate referral to either another public or private health service if treatment is not available at the patient's first choice of health service.
- Health services may provide advice to Medicare-ineligible patients about alternative options for treatment if a patient has been triaged within an emergency department as requiring non-urgent emergency care.
- Medicare-ineligible patients may access planned services within a public health service subject to:
  - the health service's capacity to provide treatment within the context of overall demand for services
  - an assessment of the patient's clinical need for treatment during their stay in Australia
  - the patient's ability to provide an assurance of payment for services provided.
- When it is clear that the patient is unable to pay for the treatment provided, some form of regular financial contribution should be encouraged. When the patient demonstrates an inability to give the required assurances for treatment already provided, a schedule of periodic payments should be negotiated.

1.24.2.2 Patients who have travelled to Victoria for the primary purpose of accessing healthcare services (medical tourism)

Health services that wish to bring international patients to Victoria for the specific purpose of medical treatment must seek their board's endorsement of this activity and develop appropriate policies and guidelines to ensure any international patient activity protects the primacy of Victorian patients.

Board endorsement is not required for treatment provided to an international patient on a pro bono basis or for charitable purposes, or treatment provided to interstate or international patients under a government agreement. Where a health service delivers care in collaboration with a private provider, board endorsement is only required where the public health services is the primary care provider.

In endorsing policies and guidelines, the board must assure themselves that the following principles will be met:

- Preferential treatment should not be given to full-fee-paying international patients over Victorian patients. Delivery of services and treatment within a public health service should only be provided to international patients where capacity to provide treatment exists without disadvantaging Victorian patients.
- Health services need to assess the risks of the patient undergoing treatment in Victoria to ensure the risk of complications is low and that they are able to respond to any potential complications that may arise, including access to emergency treatment and care.
- Prior to accepting a patient for treatment, health services should ensure any required after-care management and follow-up is available within the patient's home country. This should include appropriate processes to transfer care back to a health service or clinician in the patient's home country.
- Health services need to ensure the patient is able to pay the full cost of treatment or service and that the details are recorded in a contract that outlines the services provided, costs and related timelines before treatment begins.
- Patients should be provided with an indicative cost of treatment, including advice on additional treatment that may be required in the future.
- Contracts and fees for treatment should take into account any unexpected complications that may arise and how any additional costs will be managed.

- Fees charged to international patients are at the discretion of individual health services. Fees may be set to achieve a profit.

These principles apply to all types of treatment or care provided to international patients. Health services must not provide treatment to international patients outside the scope of what is currently provided at the relevant public hospital site.

Health services should note the unclear international legal frameworks and regulatory environment for international patients seeking legal redress following unsatisfactory outcomes from medical treatment in Victoria. Prior to accepting international patients, health services should assess these legal risks and the potential impact on medical indemnity insurance. Complaints from international patients should be handled as part of a health service's normal complaints process.

Health services should advise the department if they are delivering services to full-fee-paying international patients. These services will be monitored as part of a health service's normal operational oversight under the *Victorian health services performance framework*.

Health services can email the department's International Health team <internationalhealth@dhhs.vic.gov.au> if they require further advice or assistance in relation to treating international patients.

1.24.3 Compensable patients

1.24.3.1 Department of Veterans' Affairs patients

Eligibility

Eligible veterans and war widows or widowers have access to a wide range of benefits and services through the Department of Veterans' Affairs including: hospital; medical and allied health services; respite and convalescent care; rehabilitation aids and appliances; and assistance with transport and accommodation.

Organisations must ensure that patients formally elect to be treated as a veteran at each admission and that they collect and provide to the department the eligible veteran's name, their Department of Veterans' Affairs unique identifier, their date of birth and their sex. Final payment will only be authorised after the veteran's eligibility has been confirmed by the Department of Veterans' Affairs.

Eligible veterans will not be covered under the Department of Veterans' Affairs arrangement if they:

- do not elect to be treated as a Department of Veterans' Affairs' patient
- elect to be treated as a public patient
- are another category of compensable patient, such as a TAC or Victorian WorkCover Authority patient
- elect to use their private health insurance.

Health services will need to retrospectively reclassify patients as public patients in the event that the Department of Veterans' Affairs eligibility criteria are not met and resubmit the rejected records to the department. The department will not accept any risk for assumed revenue lost because Department of Veterans' Affairs eligibility requirements have not been met.

Experience has shown that those health services that actively develop service quality and marketing plans and employ veteran or patient liaison officers are more likely to retain Department of Veterans' Affairs patients.

Admission requirements

Within two days of admission to hospital, health services should complete a Department of Veterans' Affairs Hospital Admission Voucher (or form that captures equivalent information) for each admitted eligible veteran. Health services should ensure that the admission of eligible veterans is in accordance with Victoria's admission policy and other relevant policies and procedures.

Eligible veterans will continue to be provided public health services on a private patient basis, which entitles them to a minimum of:

- choice of doctor (subject to the doctor having rights of private practice)
- shared accommodation
- if medically necessary, private accommodation
- private accommodation, if available, where the patient or their private health insurer agrees to pay the difference between the shared and private accommodation.

Eligible veterans are eligible to access convalescent care or respite care in public health services following an acute or subacute stay without the need for financial authorisation from Department of Veterans' Affairs.

Pharmaceuticals

Health services should ensure medication reviews (including self-management) are completed before discharge by the clinical pharmacist or doctor for patients:

- who require administration of four or more different medications or more than 12 doses of medication daily
- where a change in medication has occurred during the admission
- where anti-coagulant therapy has commenced during the admission.

Medication reviews are to be documented on an appropriate approved form, be available to the patient and care providers on discharge and involve education as a component.

The Veteran Affairs Pharmaceutical Advisory Centre can be contacted on 1800 552 580.

Long stay

If the hospitalisation of an eligible veteran is likely to exceed a continuous period of 35 days in any care type other than nursing home type and palliative care, the Department of Veterans' Affairs requires that health services ensure the veteran's status is reviewed and that either:

- a certificate similar to that previously required under s. 3B of the *Health Insurance Act 1973* is completed by a medical practitioner and held on the patients file for audit purposes
- reclassifies the patient as either maintenance or, in the case of small rural health services, the eligible veteran is reclassified to a nursing home type patient and the changed status and payment adjusted accordingly. Where the patient is reclassified, the hospitals should use their best endeavours to ensure the patient is assessed and a discharge plan is developed.

Under the new arrangement, the Acute Care Certificate or equivalent is no longer required to be sent to the Department of Veterans' Affairs.

Nursing home type patients

If eligible veterans are assessed as needing nursing home type or respite care and are at a multipurpose service (facilities that receive Commonwealth funding to operate residential care beds), then the health service must attempt to reclassify the patient from a hospital patient to a residential aged care recipient. If there are no residential aged care beds available, the patient should be reclassified as a nursing home type patient and Department of Veterans' Affairs charged at the nursing home type patient rate. Department of Veterans' Affairs will not pay for residential aged care under the arrangement.

Health services should collect any co-payment for nursing home type patient from the patient with the exception of Victoria Cross or Prisoners of War recipients. For this group, health services should make a claim directly based on prior approval to the Department of Veterans' Affairs for reimbursement using MBS item number NH05.

Discharge planning

Health services will use their best endeavours to demonstrate effective discharge planning for Department of Veterans' Affairs patients including the regular contribution of a multidisciplinary team, supporting documentation, discharge follow-up and communication with care providers and family and carers (with permission from the patient).

Written documentation in the form of a discharge plan should be provided to the patient or carer on the day of discharge. Should e-Discharge summaries be available these are to be used. The Department of Veterans' Affairs may request to see documentation of hospital discharge policies and procedures, as well as copies of the patient and hospital discharge plans. If the patient is enrolled in a Coordinated Veterans' Care program, then the local medical officer or nurse coordinator must also receive a copy of the patient discharge plan (and is involved as appropriate).

Health services should coordinate for a health professional to assess eligible veterans before discharge for community nursing, personal care, aids and appliances, home modifications or convalescent care. Any aids, equipment or modifications will be arranged through Department of Veterans' Affairs services in a timely manner and be available to the patient prior to discharge. Public hospitals must provide a summary of discharge to the original referring doctor and local medical officer at, or within, 48 hours of discharge.

Referrals for community nursing services for Department of Veterans' Affairs patients may be made to a Victorian or Commonwealth Government-funded program or to a Department of Veterans' Affairs contracted provider.

To arrange home and personal care services for eligible veterans, health services must contact the National Veterans' Home Care assessment agency (1300 550 450). Discharge aids and equipment for veteran patients must be provided to facilitate safe discharge for a period of 30 days after discharge. For further information visit the Rehabilitation Appliances Program (RAP) webpage <https://www.dva.gov.au/health-and-wellbeing/home-and-care/rehabilitation-appliances-program-rap> or call 1300 550 457 (metro) or 1800 550 457 (rural).

Funding arrangements

In April 2017 the Commonwealth Government signed an agreement with Victoria that implements a uniform national purchasing arrangement for public hospital services provided to eligible veterans. The Commonwealth–state funding arrangements will be based on the national funding model developed by the IHPA, with modifications to reflect the contribution that the Department of Veterans' Affairs provides to medical practitioners.

Victoria will fund eligible veterans in alignment with revised Commonwealth revenue in 2019–20. Funding for admitted acute and subacute services will continue to be paid to actual throughput based on the Victorian WIES and subacute WIES funding models. Funding for emergency departments (non-admitted presentations), acute non-admitted and HIP will be paid as a block grant and based on the health service's activity share of total weighted activity.

Funding arrangements for Department of Veterans' Affairs patients are detailed in Table 1.9. Throughput-based services will continue to attract a premium from the department for eligible veterans in recognition of the cost of treating these patients. Payment will be made on a reconcilable basis.

Payment for interfacility transport (excluding Secondary Aeromedical retrieval) is included in the payment arrangements for services.

Table 1.9: Funding arrangements for Department of Veterans' Affairs patients

Service	Funding arrangements
Admitted patient services	Funding for the following services is based on throughput and attracts a premium: • acute: health services receive the Department of Veterans' Affairs WIES throughput payments from the department • subacute: categories for funding are palliative care, rehabilitation, GEM and maintenance care, and mirror funding and reporting arrangements for public patients • maintenance • admitted dialysis • admitted mental health services. Hospitals should bill the Department of Veterans' Affairs separately for medical and diagnostic costs for admitted patients.
Emergency department attendances	Emergency department services will receive a block grant that is based on the health service's proportionate share of the total non-admitted emergency weighted activity. There will be no separate billing of medical and diagnostic costs. Veteran patients who are subsequently admitted will be funded under the WIES model.
Acute non-admitted	Acute non-admitted services will receive a block grant that is based on the health service's proportionate share of the total acute non-admitted weighted activity. Veteran patients may access all services, and funding and reporting arrangements mirror those for public patients. Where eligible veterans have been privately referred as a Privately Referred Non-Inpatient (PRNI) to a named specialist and consents to be treated as a private outpatient, the Department of Veterans' Affairs will pay separately for specialist consultations and procedures, and associated pathology and radiology services.
Subacute non-admitted	Subacute non-admitted services will receive a block grant that is based on the health service's proportionate share of the total subacute non-admitted weighted activity. Veteran patients may access all services, and funding and reporting arrangements mirror those for public patients. Where eligible veterans have been privately referred as a PRNI to a named specialist and consents to be treated as a private outpatient, the Department of Veterans' Affairs will pay separately for specialist consultations and procedures, and associated pathology and radiology services.
Non-admitted radiotherapy	Weighted activity units are funded on a throughput basis. Where eligible veterans have been privately referred as a PRNI to a named specialist and consents to be treated as a private outpatient, the Department of Veterans' Affairs will pay separately for specialist consultations and procedures, and associated pathology and radiology services.
Specialist mental health acute care	Funding for mental health services to eligible Veterans are funded within the total funding provided to services. Veteran patients may access all services, and funding and reporting arrangements mirror those for public patients.
Non-specialist mental health acute care	Funding for mental health services to eligible Veterans are funded within the total funding provided to services. Veteran patients may access all services, and funding and reporting arrangements mirror those for public patients.
Transition Care Program	The Transition Care Program is available to all members of the Australian community, including veterans. However, the Department of Veterans' Affairs will only fund the patient contribution for veterans who are former prisoners of war. Further details are available on the Department of Veterans' Affairs website <https://www.dva.gov.au>.
Community Health Program	Community health services should bill the Department of Veterans' Affairs directly for allied health and nursing services provided under the Community Health Program.

Payments

If a claim is not accepted by the Department of Veterans' Affairs either:

- health services must transmit additional or corrected information to allow the claim to be accepted
- claims should be retrospectively reclassified to reflect the patient's changed care type or preferences.

Health services are required to make changes before consolidating the VAED, otherwise funding will not be paid at either the Department of Veterans' Affairs or public rate.

The Department of Veterans' Affairs agreement prohibits organisations from raising any charges directly on an eligible veteran except where provided for under Commonwealth legislation. This prohibition does not, however, prevent organisations from charging a cost for providing personal services such as television access or telephone services at the facility.

The Department of Veterans' Affairs agreement recognises that treatment for Department of Veterans' Affairs patients may occasionally be subcontracted to a private hospital or facility. Where that private hospital or facility is contracted to the Department of Veterans' Affairs, and claims for the service, the Department of Veterans' Affairs will pay the facility directly through their payment arrangements with Medicare Australia. Under these circumstances, the public hospital cannot also claim payment separately for the treatment provided.

Subcontracting for Transition Care is exempt from this requirement, as public hospitals do not directly bill the Department of Veteran's Affairs for this service (see Table 1.9).

1.24.3.2 Transport Accident Commission patients

Eligibility

Patients are required to complete and sign a TAC claim form before the TAC will accept responsibility for payment. Health services should make themselves aware of the form's specific requirements. If health services' data does not exactly match the details a patient has entered on a claim form, there will be significant delays in payment from the TAC while the errors are addressed by health services, the TAC and the department.

Funding arrangements

Funding arrangements for TAC patients are detailed in Table 1.10. View TAC rates in the *Fees manual* <https://www.health.vic.gov.au/feesman>.

Table 1.10: Funding arrangements for TAC patients

Service	Funding arrangements
Emergency department attendances	Health services charge the TAC directly at a flat rate per attendance for patients treated in the emergency department only. Health services should bill the TAC directly for medical and diagnostic costs.
Admitted patient services	Acute: Health services receive WIES throughput payments from the department at the TAC-specific rate. Rehabilitation: Health services charge the TAC directly at the TAC-specific bed day rate. Other admitted services: Health services charge the TAC directly at the public rate. Health services should bill the TAC directly for medical and diagnostic costs.
Non-admitted services	Health services should bill the TAC directly at the rates set out in the *Fees manual* <https://www.health.vic.gov.au/feesman>.

Payments

The department will continue to provide health services payments based on WIES throughput.

Funding for TAC patients is provided to the department by the TAC. This is cash flowed to health services throughout the year and adjusted to actual at year end based on data reconciled with the TAC. Separate uncapped TAC WIES targets are incorporated into health service budgets for 2019–20 based on the latest available 12-month throughput reported in the VAED.

The department will only pay a rate applicable for all accepted TAC patients matched with TAC records (as reported in the VAED) including numbers in excess of the target. If health services do not achieve the TAC target, any funding that has been cash flowed will be recalled at the full TAC rate. It is imperative that health services ensure their own records are complete, comprehensive and timely.

For the department to receive payment from the TAC, the TAC must accept the claim and issue a claim number. The patient information reported by health services to the department via VAED must match those held by the TAC for each admitted patient separation.

Health services should ensure their TAC records are updated in the VAED, with TAC remittance advice fed back by the department. This will ensure updated records are accepted by the TAC and that delays in reconciling activity and payment for records are minimised.

The department will cash flow TAC funding to accepted TAC cases. If a TAC claim is later rejected, the department will automatically fund the claim using public WIES in the prior year adjustment process unless the health service has exceeded its WIES target.

To minimise errors and delays, health services are required to ensure that the information is entered accurately and to proactively identify and resolve errors before sending the data to the TAC or to the department. Errors that are not accurately corrected by health services, such as an incorrect date of birth, continually cycle through both the department and the TAC databases and remain unmatched and consequently unfunded. This requires additional review, reconciliation and problem solving by the health services, the department and the TAC.

If a claim is not accepted by the TAC, either:

- health services must transmit additional or corrected information to allow the claim to be accepted
- claims should be retrospectively reclassified to reflect the patient's changed care type or preferences.

In 2019–20 the department will no longer make changes to the VAED for denied or rejected claims after consolidation through the prior year's adjustment. Health services are required to make changes before consolidating the VAED, otherwise funding will not be paid at either the TAC or public rate.

Additional information

More detailed information on the TAC's policy, services and funding is available at Public hospitals– TAC website <https://www.tac.vic.gov.au/providers/for-health-professionals/hospital-resources/public>.

Agreed amendments to the current services and prices will be documented on the department's fees and charges website and in the department's circulars.

1.24.3.3 Victorian WorkCover Authority patients

Victorian WorkCover Authority patients treated in Victorian health services are directly funded by Victorian WorkCover Authority insurers. This process will continue in 2019–20 at the rates agreed between the authority and the department on behalf of health services.

Patients treated in an emergency department only will continue to be directly billed to the Victorian WorkCover Authority at a flat rate per attendance. This rate will apply to all emergency department attendances (in lieu of the previously charged facility fee). Health services should also bill the Victorian WorkCover Authority directly for medical and diagnostic costs.

Read more about the current services and prices in the *Fees manual* <https://www.health.vic.gov.au/feesman>.

1.24.3.4 Prisoners

Prisoners receiving admitted, emergency department and specialist clinic services in Victorian public hospitals are treated and funded as public patients. The following arrangements apply:

- Acute admitted activity is funded at the public WIES price.
- Admitted subacute services are funded at the public subacute WIES price.
- Emergency department services are funded through the Non-Admitted Emergency Services Grant, as the prisoner population is included in the calculation of this grant.
- Specialist clinic services are funded through the Acute Specialist Clinics Grant.

- Health services should not bill the Department of Justice and Regulation via primary care providers for these services provided to prisoners.

Health services should ensure they:

- report all prisoners to the VAED with the account class 'JP – Prisoner' or 'JN – Prisoner Non-Acute' as relevant and a Medicare Suffix of P-N
- record the 'type of usual accommodation' data element in the VEMD as 'prison/remand centre/youth training centre' and a Medicare Suffix of P-N
- report all prisoners to VINAH with the contact account class 'JP – Prisoner' and Contact Client Medicare Number of P-N.

Health services are not permitted to raise additional fees or charges for pharmaceuticals or other items described in Chapter 2, section 2.12.4 'Health service fees and charges'.

1.24.3.5 Direct billing compensable patients

For compensable patients who are directly billed, the following arrangements are in place:

- armed services – paid by the Department of Defence and billed through Medibank (refer to Hospital Circular 02/2013)
- seamen – paid by private health insurers that cover care for international seafarers
- common law recoveries – paid by a third party where health costs are provided for under a common law damages claim
- other compensables – paid by a third party where health costs are provided for under a public liability claim.

For these patients, health services should directly bill the relevant organisation responsible for payment. Billing rates are as determined by health services and should be set to provide for full cost recovery. Recommended fees are outlined in the department's *Fees manual* <https://www.health.vic.gov.au/feesman>.

Chapter 2: Conditions of funding

Introduction

Chapter 2 details the conditions and expectations of funding that apply to funded agencies, including the relevant standards and policies.

A note on terminology

The term ‘funded organisations’ relates to all entities that receive departmental funding to deliver services. Aspects of these guidelines referring to funded organisations are applicable to all department-funded entities.

For the purposes of these guidelines, the term ‘health services’ relates to public health services, denominational hospitals, public hospitals and multipurpose services, as defined by the *Health Services Act 1988*, regarding services provided within a hospital or a hospital-equivalent setting. Aspects of these guidelines that refer specifically to ‘health services’ are only applicable to these entities.

The term ‘community service organisations’ refers to registered community health centres, local government authorities and non-government organisations that are not health services.

These guidelines are also relevant for Ambulance Victoria, Health Purchasing Victoria, Mildura Base Hospital and the Victorian Institute of Forensic Mental Health. The guidelines specify where aspects of the guidelines are relevant for these organisations.

2.1 Standards

2.1.1 Public sector values and principles

Responsiveness

- Providing frank, impartial and timely advice to the government
- Providing high-quality services that acknowledge, and are tailored to meet the needs of Victoria's diverse community
- Identifying and promoting best practice

Integrity

- Being honest, open and transparent in their dealings
- Using powers responsibly
- Reporting improper conduct
- Avoiding real or apparent conflicts of interest
- Striving to earn and sustain public trust at the highest level

Impartiality

- Making decisions and providing advice on merit without bias, caprice, favouritism or self-interest
- Acting fairly by objectively considering all relevant facts and applying fair criteria
- Implementing government policies and programs equitably

Accountability

- Working to clear objectives in a transparent manner
- Accepting responsibility for their decisions and actions
- Seeking to achieve best use of resources
- Submitting themselves to appropriate scrutiny

Respect

- Treating others fairly and objectively
- Ensuring freedom from discrimination, harassment and bullying
- Using their views to improve outcomes on an ongoing basis

Leadership

- Actively implementing, promoting and supporting these values

Human rights

- Making decisions and providing advice consistent with the human rights set out in the *Charter of Human Rights and Responsibilities Act 2006*
- Actively implementing, promoting and supporting human rights

Section 8 of the *Public Administration Act 2004* outlines the principles of the public sector and articulates what employers must do to comply. Employers must establish employment processes to ensure:

- employment decisions are based on merit
- employees are treated fairly and reasonably
- equal employment opportunity is provided
- human rights, as set out in the Charter of Human Rights and Responsibilities Act, are upheld
- public sector employees have a reasonable avenue of redress against unfair or unreasonable treatment
- a career in the public service is fostered (in the case of public service bodies).

The Public Sector Standards Commissioner issues codes of conduct to reinforce the public sector values, and standards on how to apply the employment principles. The codes and standards are binding but not detailed. They enable employers to introduce policies and practices that suit their organisation while also complying with the codes and standards. Employees should consider the codes, standards and any organisational policies when deciding what action to take.

Further information about public sector values is available at Public sector values – Victorian Public Sector Commission website <http://vpsc.vic.gov.au/ethics-behaviours-culture/public-sector-values>.

2.1.2 Safety

2.1.2.1 Pre-employment screening

There are pre-employment screening requirements for all health practitioners registered with the Australian Health Practitioners Regulation Authority. Pre-employment screening of medical practitioners with independent responsibility for patient care is subject to the requirements of the *Credentialing and defining scope of clinical practice for senior medical practitioners policy*. See the *Credentialing and defining scope of clinical practice for senior medical practitioners policy* <https://bettersafercare.vic.gov.au/reports-and-publications/credentialing-and-scope-of-clinical-practice-for-senior-medical-practitioners-policy>.

Prior to undertaking any relevant pre-employment and pre-placement police record checks, the department and all funded organisations must undertake identity checks on all applicants to minimise the risk of employing unsuitable or unqualified people. Safety screening may also include a Working with Children Check, which is a mandatory screening process for people who work with children.
Referee checks should be undertaken by direct contact with nominated referees. The bona fides of the referees should be considered.

Health services must have a vaccination policy for all workers. Each worker and their role should be individually assessed for specific vaccine requirements before, or at the start of employment. This is determined by the likelihood of contact with patients and/or blood or body substances, taking possible contraindications into account. Health Care Workers (HCW) are required to provide a vaccination record and or documented evidence of natural immunity to vaccine preventable diseases recommended for HCWs to their health service employer. The employer is required to keep the information on file in the event the HCW is in contact with a vaccine preventable disease. Refer to information about Vaccination for healthcare workers <https://www2.health.vic.gov.au/public-health/immunisation/adults/vaccination-workplace/vaccination-healthcare-workers>.

2.1.2.2 Staff safety in Victorian health services

All funded organisations are responsible for the safety of their staff, patients and visitors. Funded organisations must have the systems and processes in place to enable them to identify, assess and control occupational health and safety risks in accordance with their obligations under the *Occupational Health and Safety Act 2004*.

The department is committed to working collaboratively with health services to enhance the health, safety and wellbeing of health service staff. Fundamental to this work will be an emphasis on building a positive and respectful workplace culture, with actions focused in the immediate term on addressing systemic issues in relation to bullying and harassment, and occupational violence and aggression.

2.1.2.3 Child safety

Commission for Children and Young People

The Commission for Children and Young People commenced operation in March 2013, replacing the former Office of the Child Safety Commissioner, and is an independent statutory authority. The *Commission for Children and Young People Act 2012* provides for the role of the commission.

The commission provides guidance across systems to ensure child-friendly and child-safe practices. The objective of the commission is to promote continuous improvement and innovation in policies and practices relating to the safety and wellbeing of children and young people and the provision of out-of-home care services for children.

The commission's functions include: conducting inquiries into the deaths of children known to child protection, monitoring out-of-home care services and Working with Children Checks, administration of the Victorian Reportable Conduct Scheme, oversee and enforce compliance of organisations with the Child Safe Standards and conducting inquiries into individual cases involving:

- child protection clients
- youth justice clients
- young people under the age of 21, who have or are leaving the care of the Secretary to the Department of Health and Human Services to live independently
- children who die from abuse or neglect
- children who, or whose primary family carer is, receiving or has received services from registered community services, such as out-of-home care or community-based child and family services.

The commission may also initiate or undertake inquiries, on referral by the Minister for Families and Children, into services provided to children and their primary carers such as health, human and educational services where systemic or recurring issues have been identified that impact on a child's safety or wellbeing.

Children, Youth and Families Act 2005

The *Children, Youth and Families Act 2005* creates a shared responsibility for family services, the Child Protection program, out-of-home care services and the Children's Court to act in the best interests of the child. This must always be the paramount consideration. To determine whether an action or decision is in a child's best interests, the following must be considered:

- protect the child from harm
- protect the child's rights
- promote the child's development.

There are other numerous other principles that, where they are relevant to the decision or action, must also be considered. The 'best interests' principles focus on children's safety, development and wellbeing in the context of their age and stage of life, their culture and gender. They draw attention to critical dimensions of a child's experience, which may be affected by their family dynamics and circumstances, and the need for timely decision-making, given the possible harmful effects of delay, and continuity and permanency in the child's care. Intervention into the parent-child relationship is limited to that necessary to secure the safety and wellbeing of the child, and removal from parental care only where there is unacceptable risk of harm.

Departmental and community services are also required to consider various decision-making principles when making decisions or taking action in relation to a child. The decision-making principles promote fair and transparent processes and enabling active participation of relevant parties. Additional decision-making principles are included for Aboriginal children, recognising Aboriginal self-determination and self-management.

To adhere to these principles, all services are required to adopt an approach to practice that is child-centred and family-focused.

The Children, Youth and Families Act provides for intervention by the Child Protection program to protect children from abuse and neglect where their parents have not or are unlikely to protect them from harm, and balances these powers with comprehensive safeguards, including judicial oversight, and accountability procedures to protect the rights of children and parents.

This Act enables the Family Division of the Children's Court to make various orders for the care or protection of children. These orders are administered by the Child Protection program.

The legislation also provides for the department and community services to support to families and, where necessary, care for children. It allows for the principal officer of an Aboriginal agency to be authorised to undertake specified functions and powers in relation to a protection order for an Aboriginal child. The department is working with Aboriginal agencies to progressively implement these provisions, with the first authorisations having been made in 2018.

Child Wellbeing and Safety Act 2005 and the *Commission for Children and Young People Act 2012*

The Victorian Government's *Children Legislation Amendment (Information Sharing) Act 2018* amends the *Child Wellbeing and Safety Act 2005*, to create the Child Information Sharing scheme to enable prescribed workers to share information to promote children's wellbeing and safety. The Act also authorises the creation of Child Link, an IT platform that will extract and collate a thin layer of factual information about children's enrolment in universal services, as well as the presence of child protection orders and out-of-home care status. Child Link will be accessible to a subset of prescribed professionals working directly with children, and will assist in forming a full picture of a child's service history and identifying potential risks early on.

The scheme promotes earlier intervention to prevent harm to children, as well as enabling better collaboration between government agencies and funded services. The scheme responds to several child death inquiries and is consistent with the recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse. The scheme commenced operation in September 2018 in alignment with related family violence reforms, and was accompanied by comprehensive guidelines and an implementation strategy. The scheme is being introduced in a phased approach with a further phase of professionals being prescribed in the scheme in 2020.

Working with Children Act 2005

The *Working with Children Act 2005* ensures that only people with a valid Working with Children Check (Check) are engaged in child-related work (where a child is under the age of 18 years).

It is the department's expectation that, the places and occupations that require a Check are those that involve regular and direct contact with children. Though the facility may not be a paediatric specific ward, if the ward has regular or planned admissions of patients below the age of 18 years, this is considered non-incidental contact and all staff including the admissions, theatre, recovery, ward staff cleaning staff and food services would require a Check. See further information about the Working with Children Check <https://www.workingwithchildren.vic.gov.au>

Child Safe Standards – Child Safeguarding Regulation

Child Safe Standards aim to improve the way organisations that provide services for children prevent and respond to child abuse that may occur within their organisation.

The standards are compulsory for organisations providing services to children, and aim to drive cultural change in organisations, so that protecting children from abuse is embedded in the everyday thinking and practice of leaders, staff and volunteers. This will assist organisations to:

- prevent child abuse
- encourage reporting of any abuse that does occur
- improve responses to any allegations of child abuse.

The Child Safe Standards are a central feature of the Victorian Government's response to the Family and Community Development Committee of the Victorian Parliament's *Betrayal of Trust: Inquiry into the Handling of Child Abuse by Religious and Other Non-Government Organisations* (Betrayal of Trust Inquiry).

The Commission for Children and Young People has primary oversight and regulatory responsibility for the Child Safe Standards. The department is defined as a relevant authority under the *Child Wellbeing and Safety Act 2005* and has responsibility for promoting and overseeing compliance with the Child Safe Standards for organisations that it funds and/or regulates which provide services or facilities to children.

The Commission and department play important complementary roles in promoting and overseeing compliance with the Child Safe Standards.

The *Child Safe Standards Compliance Monitoring Framework* (the framework) <http://providers.dhhs.vic.gov.au/child-safe-standards-compliance-monitoring-framework-2018-2019-word> sets out the department's approach to monitoring compliance of in-scope organisations with the Child Safe Standards. The framework is supported by a maturity assessment model which provides guidance to in-scope organisations about their obligations in implementing the standards and focuses on continuous improvement following an identified non-compliance. The *Child Safe Standards Compliance Monitoring Framework* and *Child Safe Standards Compliance Assessment Model* are available on the Resources for Child Safe Standards webpage <http://providers.dhhs.vic.gov.au/resources-child-safe-standards>.

Reportable Conduct Scheme – Child Safeguarding Regulation

The scheme requires organisations with a degree of responsibility for children to report allegations of abuse to the Commission for Children and Young People.

Safe environments for Aboriginal and Torres Strait Islander people

Funded organisations have a responsibility to provide a culturally safe environment for their Aboriginal and Torres Strait Islander patients and clients. Services should develop local policies and procedures in consultation with local Aboriginal staff and community members.

This includes:

- being respectful of cultural protocols
- offering patients or clients the opportunity to access male or female staff as required
- preventing stigmatism and racial discrimination.

It includes a responsibility for developing an understanding about what cultural safety means for managers, staff, patients and clients. All staff should undertake cultural safety training specific to their region.

The department has developed the following documents to provide guidance to health services:

- The *Aboriginal health, wellbeing and safety strategic plan* (currently under development) addresses the responsibility of health and human services to deliver services to Aboriginal Victorians that are culturally safe, culturally responsive and free of racism.
- The department is currently developing an *Aboriginal cultural safety framework*, which will outline an approach to actively strengthen the inclusion of Aboriginal culture in the workplace and support successful Aboriginal participation in the design, implementation and assessment of policies and programs.

Refer also to:

- the Aboriginal culturally informed addendum to the *Department of Human Services Standards evidence guide* (September 2015) <https://providers.dhhs.vic.gov.au/human-services-standards-evidence-guide-word>.
- Enable 3: Cultural responsiveness chapter (Page 60) in *Koolin Balit: Victorian Government strategic directions for Aboriginal health 2012–2022* <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/koolin-balit>.
- *Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health: A National Approach to Building a Culturally Respectful Health System* <http://www.health.gov.au/internet/main/publishing.nsf/Content/indigenous-crf>.

2.1.2.4 Safe environments for people who are trans and gender diverse or have intersex variations

Funded organisations have a responsibility to provide a safe and inclusive environment for people who are trans and gender diverse or have intersex variations. In response to increasing service access and demand by trans and gender diverse people and people with intersex variations, the department expects all funded services to develop local policies, procedures and appropriate training for staff to competently and respectfully engage in gender and body-diverse sensitive practice. This includes using pronouns and names preferred by the individual, providing non-gendered facilities where possible, minimising potentially embarrassing encounters with other patients, and avoiding assumptions about gender and sex-specific health issues, such as the need for cervical or breast/chest screening for women and some trans and gender diverse people. For trans and gender diverse people, it also means providing respectful, supportive advice on access to health services associated with gender affirmation.

To support these policy priorities, an LGBTI Taskforce and Commissioner for Gender and Sexuality have been established. The Taskforce's Health and Human Services Working Group is working to support safe environments for people who are trans and gender diverse or have intersex variations and has identified the following priorities:

- Inclusive practices within hospitals and health services.
- Implementation of the new trans and gender diverse health initiative, which will expand the health system's capacity to support and better meet the needs of trans and gender diverse Victorians, which can be accessed at the Populations webpage <https://www2.health.vic.gov.au/about/populations>.
- Development of a suite of health policies and resources to support and enhance the wellbeing of people with intersex variations, which can be accessed at the Health of people with intersex variations webpage <https://www2.health.vic.gov.au/about/populations/lgbti-health/health-of-people-with-intersex-variations>.
- Following an inquiry undertaken by the Health Complaints Commissioner (HCC) into "gay conversion therapy" in 2018, the Victorian Government announced that new legislation will be developed and introduced to ban this practice in Victoria. In addition, the Victorian Government has committed to developing mental health supports needed for survivors (including lesbian, gay, bisexual and trans and gender diverse Victorians). See the Executive Summary of the Health Complaints Commissioner Inquiry into gay conversion therapy <https://hcc.vic.gov.au/file/permalink/7019>.

The department has developed the following documents to provide guidance to services:

- *Rainbow eQuality: a guide to LGBTI inclusive practice for health and human services* <https://www2.health.vic.gov.au/rainbowequality>
- *Service guideline for gender sensitivity and safety* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/service-guideline-for-gender-sensitivity-and-safety>
- Development of Trans and Gender Diverse Services in Victoria <https://www2.health.vic.gov.au/about/populations/lgbti-health/trans-gender-diverse>.

Funded organisations are encouraged to consider working towards the Rainbow Tick accreditation. The Rainbow Tick guides organisations through a cycle of self-assessment and review by external assessors to determine the extent to which the organisation (or a service within the organisation) meets the needs of LGBTI consumers.

Further information is available at About us – Gay and Lesbian Health Victoria website <http://www.glhv.org.au/about-us>.

2.1.2.5 Patient and client safety

All funded organisations are responsible for the safety of their patients or clients. Funded organisations should have systems and processes in place to enable them to identify, manage and respond to adverse events, reducing the risk of such events recurring in future.

Health services and community service organisations that provide services on behalf of the department and report patient or client safety incidents through the Victorian Health Incident Management System (VHIMS) are subject to the Victorian health incident management policy (currently under review) <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/clinical-risk-management>.

Community service organisations that provide services on behalf of the department and do not report incidents through VHIMS are subject to the (former) Department of Health's *Incident reporting instruction 2013*. The *Incident reporting instruction 2013* and accompanying incident report form are available at the Funded Agency Channel. More information can be found at the Funded Agency Channel's Health incidents webpage <https://fac.dhhs.vic.gov.au/incident-reporting/health>.

The *Incident reporting instruction 2013* provides guidance for reporting incidents or alleged incidents that involved or impacted patients or clients during service delivery. It does not replace an organisation's own incident management systems and processes. Organisations' incident management policies and processes may be reviewed as part of the departments' routine contract and performance management arrangements.

For community health services a dedicated community health services incident reporting webpage hosts health and human services incident reporting instructions and forms. Visit Incident reporting arrangements for community health services <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/incident-reporting> for more information.

Supported Residential Services

- Supported Residential Services (SRS) are privately operated services, not funded by the department.
- Supported Residential Services are registered with the department, which has responsibility for administration of the legislation governing SRS under the *Supported Residential Services (Private Proprietors) Act 2010* and a regulatory responsibility under the Supported Residential Services (Private Proprietors) Regulations 2012.
- Effective from 10 April 2014, the incident reporting process for SRS is as follows:
  - Prescribed reportable incidents in SRS are detailed in the Supported Residential Services (Private Proprietors) Act and Regulations. Authorised Officers are responsible for recording prescribed reportable incidents through a separate and independent database, the Compliance Reporting and Monitoring System (CRAMS).
  - SRS Authorised Officers are no longer required to report SRS incidents via the Category One reporting process.

2.1.2.6 Meeting the needs of all Victorians

The government is committed to pursuing a safe and secure Victoria, good health and wellbeing, full participation in society, cultural connection and genuine equality for every Victorian. The department promotes an intersectional approach in designing services and developing policies, which recognises that communities are not homogenous and that services must ultimately be designed to the unique needs of individuals.

The pursuit of these outcomes is reflected in the following policy documents: *Safe and Strong: A Victorian Gender Equality Strategy*, *Victorian. And proud of it: Victoria's Multicultural Policy Statement*, *Absolutely everyone: state disability plan 2017–2020*. The *Premier's Circular* on Good Board Governance (from *Victoria's Multicultural Policy Statement*) also outlines the government's drive to obtain more equitable gender and cultural representation on boards.

The department is focused on improving the lives of all Victorians, especially those vulnerable and at risk. In addition to the whole-of-government policies, this focus is reflected in the department's plans and resources including:

- *Designing for Diversity: Policy and service design resources*: <https://www2.health.vic.gov.au/about/populations/designing-for-diversity>.

- *Delivering for diversity: cultural diversity plan 2016–2019*
- *Language services policy: Department of Health and Human Services*, and its supporting guidelines: *How to work with interpreting and translating services*
- *Rainbow eQuality: a guide to LGBTI inclusive practice for health and human services*
- *Development of Trans and Gender Diverse Services in Victoria* available at the department's Trans and gender diverse health and wellbeing webpage <https://www2.health.vic.gov.au/about/populations/lgbti-health/trans-gender-diverse>
- *Victoria's 10-year mental health plan*, including the *Aboriginal social and emotional wellbeing framework*
- *Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027.*

Some of these policies require reporting for some types of services. For example, in relation to the arrangement for the provision of language services, and for public sector bodies: the development of a Disability Action Plan.

Services should consider the effectiveness of the ways in which they respond to the diversity in the Victorian community.

2.1.2.7 Language services

Language service provision is an important aspect of the department's efforts to deliver accessible, person-centred services that respond to the needs of culturally and linguistically diverse (CALD) and deaf communities. Language services are a key component in achieving our strategic directions of person-centred services and care, and advancing quality, safety and innovation.

Failure to provide an appropriately certified interpreter or have important health and human services information translated accurately into community languages can have significant negative impacts, including reduced or adverse health and well-being outcomes. Staff may breach their duty of care to a client if they unreasonably fail to provide or inform a client of their right to an interpreter. Government and its agencies can fulfil their duty of care by taking reasonable steps to actively identify whether language assistance is required and acting accordingly.

The department's *Language services policy* reflects the priority that the department places on ensuring the provision of quality interpreting and translating to support Victorians. It identifies critical points for language service provision, and details implementation support measures to ensure people with low English proficiency, or who use a form of sign such as Auslan, have access to those services.

The policy also stipulates appropriately certified interpreters and translators should be used to ensure the provision of high quality language services. The use of automated interpreting and translating technologies in place of certified interpreters and translators should be carefully considered, noting the duty to ensure translations are accurate, culturally appropriate, not likely to cause harm, and communicate concepts effectively. To that end, the policy also states that requesting family or friends, who are children under 18 years of age, to act in place of an accredited interpreter is not appropriate.

The department expects all those involved in the planning, funding and delivery of funded health and human services to familiarise themselves with this policy and ensure quality language services are an integral part of their service responses. All funded services are required to ensure interpreters engaged through an external language services provider are remunerated in accordance with Victorian government minimum remuneration rates and conditions.

Find further information on the new remuneration rates for interpreters – Victorian Multicultural Commission website <https://www.multicultural.vic.gov.au/images/2018/Victorian-Government-Minimum-Rates-for-Interpreters---1-July-2018.pdf>.

2.2 Capability frameworks

2.2.1 Maternity and newborn capability levels

The *Capability frameworks for Victorian maternity and newborn services* describe the requirements for providing safe and high-quality maternity and newborn care across six levels. Health services are required to operate in within their agreed and published maternity and newborn capability level.

The service capability levels for all public health services providing planned maternity and newborn care are reviewed and determined by the department, in conjunction with individual services. Capability levels are published at the Maternity and newborn care in Victoria webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/maternity-newborn-care>.

The recently released *Capability frameworks for Victorian maternity and newborn services* (2019) replaces the existing *Capability framework for Victorian maternity and newborn services* (2010) and *Defining levels of care for Victorian newborn services* (2015).

Continuity of maternity services

Planned or unplanned changes to a services maternity and newborn capability (such as planned infrastructure works, unplanned changes to essential workforce) must be escalated to the department and a management plan developed, agreed and communicated to staff, patients, key partners and the community.

The periods of time a service cannot meet their capability requirements should be rare, and each health service must have plans to ensure service continuity.

Rural services that are unable to provide care at their determined level for short periods (such as a weekend) are required to:

- Ensure the details of the change in service capability and the plan to manage the temporary change in service delivery (such as transfer of labour care agreements), is formally agreed and documented with local health services and other providers that will be impacted (including Ambulance Victoria and PIPER).
- Develop and communicate a clear, personalised care plan for women who are booked in and likely to deliver over the period, including key contacts at both the referring and the receiving hospital(s).
- Ensure information about how the local community can access care during this period is communicated effectively.
- Advise the department in advance of this change by contacting the Manager, Performance, Governance and Quality, Rural and Regional Health (in the regional office). Regional office staff will then advise the department's central office staff of the change and steps taken to action the above requirements.

The frequency and duration of service provision outside the determined capability level will be monitored by the department and (along with other factors) will inform decision making about ongoing capability levels for the service.

2.2.2 New capability frameworks

In addition to the existing capability frameworks for maternity and newborn service, subacute services and palliative care, and in line with the recommendations of Targeting Zero[3] and the Statewide Design, Service and Infrastructure Plan[4], the department will release four new capability frameworks in 2019–20. The new frameworks are for the following clinical service streams:

- cardiac care
- surgery and procedural care
- urgent, emergency and trauma care
- renal care.

For each clinical service stream, there are six levels of complexity from Level 1 (the lowest complexity of care) to Level 6 (the highest complexity of care). As a rule, each service level builds on the preceding service level.

In 2018–19, the department worked with health services and other key stakeholders to develop the service descriptors and service requirements for each level of complexity for each of these clinical streams. In 2019–20, the department will begin a process to assess health services current capability levels and service gaps. This step will be the baseline to assist health services to develop action plans to meet the service requirements in each clinical stream capability framework.

[3] A key recommendation of *Targeting Zero* was that "within three years, the department has expanded its capability frameworks to cover all major areas of hospital clinical practice, be monitoring adherence to them (across public and private hospitals) and sharing information on adherence with hospitals and boards" – recommendation 2.12.2. Targeting Zero is available from the Review of hospital safety and quality assurance in Victoria webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-safety-and-quality-review>.

[4] Department of Health and Human Services (DHHS) (2017) *Statewide design, service and infrastructure plan for Victoria's health system 2017–2037* <https://www2.health.vic.gov.au/hospitals-and-health-services/health-system-designplanning/statewide-plan> commits to the development of capability frameworks to ensure that:

- patients are treated at facilities that can appropriately manage their level of clinical risk, and
- within each capability level, health services are providing the same quality of care, regardless of location.

2.3 Expectations, policies and performance

As a condition of funding, funded agencies are required to comply with the following published expectations, guidelines, policies and performance reporting requirements.

2.3.1 Acute and specialist

2.3.1.1 Surgical and procedural services

All Victorian health services are to meet the requirements of Victoria's *Access policy for planned surgery and procedures.* This new policy will be released in 2019 and provides guidance to the clinical, administrative support staff, managers and executives of all public health services that provide surgery and other planned procedures.

The *Access policy for planned surgery and procedures 2019* will be available at https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/acute-care/surgical-services.

See details of the Elective Surgery Information System (ESIS) reporting requirements <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/esis>.

2.3.1.2 Non-admitted specialist services

An updated Access policy for Non-admitted specialist services in Victorian public hospitals will be released in 2019. This new policy builds on and replaces the previous version of the specialist clinic access policy. It provides guidance to the clinical, administrative support staff, managers and executives of all public health services that provide non-admitted specialist services.

The updated Access policy for non-admitted services will be available at the Access to specialist clinics in Victoria webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/specialist-clinics/access-policy>.

2.3.1.3 Victorian endoscopy categorisation guidelines

Victorian health services who provide endoscopy services are expected to ensure that clinicians use the Victorian endoscopy categorisation guidelines.

The *Guidelines for the categorisation for clinical urgency of patients being waitlisted for a colonoscopy* and gastroscopy can be accessed online at the Specialist clinics – resources webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/specialist-clinics/specialist-clinics-program/specialist-clinics-resources>.

2.3.1.4 Bariatric surgery

Bariatric surgery is limited to three designated centres: The Alfred, The Austin and Western District Health Service. In 2019–20, there will be a review of the current service model, including referral and eligibility criteria and services requirements.

2.3.1.5 Cardiac care

Refer to the *Design, service and infrastructure plan for Victoria's cardiac system* (2016) (the cardiac plan) <https://www2.health.vic.gov.au/hospitals-and-health-services/health-system-design-planning/cardiac-design-service-and-infrastructure-plan>.

To implement the priority actions from the cardiac plan, all public health services providing cardiac care are part of one of three designated service networks. The funding provided to the designated service network fund holder is to support the activities of all the health services in the network, in a coordinated and collaborative way.

2.3.1.6 Admitted palliative care

Palliative care is provided in designated inpatient palliative care beds (or units) and by specialist consultancy services. Specified palliative care beds can be located in acute hospitals or as part of subacute units or stand-alone facilities.

All designated palliative care inpatient units must provide care in line with the *Guidelines for Victorian designated palliative care providers, 2019–20*. These can be accessed at: <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care>.

All health services providing designated inpatient palliative care are required to report data elements linked to the AN-SNAP phase of care, including specific elements for the final phase. This is a mandatory VAED reporting requirement. Relevant reports submitted to the department without a phase of care identified will be rejected. They are also required to report patient level costs for palliative care at the phase through the Victorian Cost Data Collection to enable a more accurate link of cost data to the phase of care.

Designated services are required to submit quarterly Clinical Indictors for Pain (CLiP) audit data via the HealthCollect data portal, and participate in the palliative care experience module of the Victorian Health Experience Survey.

Day hospice

Some acute health services are funded to provide day hospice.

Day hospice provides people living with a life-limiting illness and their families and carers with a supportive environment to help improve their quality of life. This may include therapeutic activities, social interaction or assistance with treatments. This service applies to people of all ages living with a life-limiting illness and does not include overnight stays.

Health services funded for day hospice must submit activity data using the AIMS form and cost data to the Victorian Cost Data Collection.

2.3.1.7 Maternity and newborn services

All health services providing maternity services are required to have an arrangement to regularly review all maternal and perinatal deaths and morbidity. The hospital's processes should align to the *Perinatal Society of Australia and New Zealand: Clinical practice guideline for perinatal mortality* <http://www.psanz.com.au/guidelines>.

All level 2–4 rural health services that provide birthing are expected to participate in the Maternity and Newborn Education (MANE) program provided by The Royal Women's Hospital and PIPER. This multidisciplinary training program commenced in 2017 and ensures all small rural services have regular access to high-quality training and a specific program for level 1 maternity services with a focus on the skills and knowledge needed to manage unplanned maternity care.

For further information see:

- Maternity and newborn services <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services>.
- Eligible midwives and collaboration arrangements <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Eligible-midwives-and-collaborative-arrangements-An-implementation-framework-for-Victorian-public-health-services>.
- Implementing a public home birth program <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/implementing-public-home-birth-program>.

Maternal and perinatal mortality and morbidity committees

All rural public hospitals providing birthing services have been participating in one of six regional maternal and perinatal mortality and morbidity review committees since 2015. The regional committees provide an additional layer of case review for cases of serious harm or death, and specifically support smaller rural services to ensure all maternal and perinatal deaths have a comprehensive and multidisciplinary case review. The committees have also been reviewing selected morbidity cases and time-critical transfers since 2017.

Incentivising Better Patient Safety

The Victorian Managed Insurance Authority (VMIA) launched the Incentivising Better Patient Safety (IBPS) program in July 2018. The program supports Victorian maternity services who provide planned maternity care to continue their commitment towards improvements in quality and safety through the increased throughput of birth suite staff in certain evidence based, maternity skills education and training programs. The program identifies three high-risk, maternity focus areas. A refund on the maternity component of the health services medical indemnity premium will be provided when education and training is delivered, according to the programs' eligibility criteria.

From 2018, health services providing planned birthing services (levels 2–6 maternity capability) are expected to be working towards achieving the eligibility criteria established by the Incentivising Better Patient Safety program.

Adult, paediatric and neonatal intensive care registry data reporting

Health services that operate an adult or paediatric critical care unit must submit data to the Adult Patient Database and the Australian and New Zealand Paediatric Intensive Care Registry, administered by the Australian and New Zealand Intensive Care Society (ANZICS) Centre for Outcome and Resource Evaluation (CORE).

Health services operating a level 5 or level 6 newborn service must submit data on babies who meet the collection's eligibility criteria to the Australian and New Zealand Neonatal Network (ANZNN).

Retrieval and Critical Health Information System (REACH) system capacity

To facilitate statewide access to critical care beds, all health services providing adult, newborn and paediatric critical care services are required to update bed occupancy data on the Retrieval and Critical Health Information System (REACH) website four times a day as per the REACH manual.

For comprehensive information on access to the service (including geographical allocation to VPAS providers, pathology request, parental consent forms, 24-hour advice and clinical practice guidelines), please refer to the VPAS website <http://www.thewomens.org.au/health-professionals/vpas>.

Koori Maternity Services

Victoria's Koori Maternity Services provide culturally safe and responsive care. All Aboriginal women and women having an Aboriginal baby are eligible to access pregnancy care through a Koori Maternity Service.

Strong and effective partnerships between Koori Maternity Services and public health services underpin good perinatal outcomes for Aboriginal women, babies and their families. Koori Maternity Services and public hospitals operate with formal partnerships and agreed referral pathways for the provision of high quality and safe antenatal, intrapartum and postnatal care for Aboriginal women and boorai.

The *Koori Maternity Services guidelines: Delivering culturally responsive and high-quality care* (March 2017) establish the program objectives and requirements for service delivery. All maternity services are encouraged to also consider how the guidelines principles can be incorporated into their maternity service models.

There are 14 Koori Maternity Services located across Victoria, with 11 services located in Aboriginal community-controlled organisations and three in public health services. The key partnerships between Koori Maternity Services and public health services are outlined in Table 2.1.

Table 2.1: Public health services partnering with Koori Maternity Services

Region	Koori Maternity Service	Key birthing partners
North and West Metropolitan	Victorian Aboriginal Health Service	The Royal Women's Hospital
	Western Health (Sunshine Hospital)	Sunshine Hospital (Western Health
	Northern Health (The Northern Hospital)	The Northern Hospital (Northern Health)
Southern Metropolitan	Dandenong and District Aboriginal Cooperative	Monash Health
	Peninsula Health (Frankston Hospital)	Frankston Hospital (Peninsula Health)
Barwon South West	Wathaurong Aboriginal Health Service	University Hospital Geelong
	Gunditjmara Aboriginal Cooperative	Warrnambool (South West Healthcare)
Hume	Rumbalara Aboriginal Cooperative	Goulburn Valley Health
	Mungabareena Aboriginal Cooperative	Albury Wodonga Health
Gippsland	Gippsland and East Gippsland Aboriginal Co-operative	Bairnsdale Regional Health Service
	Central Gippsland Aboriginal Health Service	Central Gippsland Health Service (Sale)
Loddon Mallee	Mallee District Aboriginal Service	Mildura Base Hospital
	Swan Hill Aboriginal Health Service	Swan Hill District Health
	Njernda Aboriginal Corporation	Echuca Regional Health

Public health services funded to provide a Koori Maternity Service (Western Health, Northern Health and Peninsula Health) are required to submit data to the Koori Maternity Services minimum dataset via the online form at the Aboriginal maternity services webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/aboriginal-maternity-services>.

See the *Koori Maternity Services guidelines* <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/aboriginal-maternity-services>.

2.3.1.8 Victorian Paediatric Rehabilitation Service

The Victorian Paediatric Rehabilitation Service (VPRS) specifically caters for children and adolescents who, as a result of injury, medical and surgical intervention, or functional impairment, will benefit from a program of developmentally appropriate, time-limited, goal-focused multidisciplinary rehabilitation.

The Victorian Paediatric Rehabilitation Service is composed of:

- a statewide director and program manager
- two inpatient services at The Royal Children's Hospital and Monash Children's Hospital (Monash Health) and medical directors
- eight ambulatory services, as part of the Health Independence Program at Ballarat Health Services, Barwon Health, Bendigo Health Care Group, Eastern Health, Goulburn Valley Health, Latrobe Regional Hospital, Monash Health and The Royal Children's Hospital.

The Victorian Paediatric Rehabilitation Service statewide appointments provide support, leadership and clinical services where appropriate across the Victorian Paediatric Rehabilitation Service sites. Participating health services facilitate visiting rights for Victorian Paediatric Rehabilitation Service staff conducting clinical work. Visiting clinical staff will observe local policies and procedures, enabling the safe and effective provision of specialist paediatric rehabilitation care.

An advisory group is comprised of members of all Victorian Paediatric Rehabilitation Services and departmental representatives.

Activity is reported through the Victorian Admitted Episodes Dataset (VAED) and VINAH datasets respectively. Cost data is reported at patient level through the Victorian Cost Data Collection.

2.3.1.9 Hospital in the Home

Treatment provided to patients at home as Hospital in the Home (HITH) is equivalent to in-hospital acute care.

Health services are encouraged to continually investigate opportunities to utilise HITH as a substitute for in-hospital acute admitted care as acute care practice and treatments evolve.

HITH patients must fulfil the criteria for admission as per the department's Victorian *Admitted Episode Dataset: Criteria for Reporting* policy.

Client consent must be obtained before providing admitted services in the home. Documentation to support that the home-delivered services are a direct substitution for in-hospital WIES funded acute admitted care must be in the health record.

HITH separations and bed days are reported in the program report for integrated service monitoring (PRISM) reports sent to chief executive officers. This enables benchmarking against other health services, particularly the percentage of multi-day separations provided through HITH.
Cost data is reported at patient level through the Victorian Cost Data Collection.

See the *Hospital in the Home Guidelines* <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/acute-care/hospital-in-the-home>. These guidelines will be refreshed in 2019–20.

2.3.1.10 Specialist clinics

Specialist clinic access policy

Health services currently in scope to report specialist clinics data through the VINAH minimum dataset are expected to comply with the *Non-admitted specialist services in Victorian public hospitals: Access Policy 2019*. This new policy comes into effect from 1 July 2019 and provides guidance to the clinical, administrative support staff, managers and executives of all public health services that provide non-admitted specialist services in Victorian public hospitals. This document builds on and replaces previous versions of the specialist clinics access policy. Key changes introduced with the new policy include that the policy now applies to both Acute Specialist Clinics and the Health Independence Programs.

See the *Non-admitted specialist services in Victorian public hospitals: Access Policy 2019* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Specialist-clinics-in-Victorian-public-hospitals-Access-policy>.

Other health services providing specialist clinic services practice, must ensure that their procedures and policies align with the objectives and principles of the policy.

In line with health services responsibility for payment of ambulance transport to specialist clinics, health services are responsible for booking and authorising any Ambulance Victoria ambulance transport needed to transport patients to specialist clinics or health independence programs where clinically necessary.

Hospitals must provide patient level specialist clinics data to the Victorian Integrated Non-Admitted Health (VINAH) dataset. Those health services currently reporting specialist clinics activity only through the Agency Information Management System (AIMS) will progress their capability to report patient level specialist clinics data through the VINAH dataset.

Hospitals are expected to report patient level cost data for all specialist clinic activity through the Victorian Cost Data Collection. All health services are expected to continue to improve their AIMS and cost data.

2.3.1.11 Telehealth

Health services should continue to drive choice and better patient experience through increased use of telehealth (video consulting), to deliver acute and specialist services in 2019–20 particularly to target patient cohorts that are underserviced by the conventional face to face service model irrespective of the clinic/specialty. This includes people from rural areas, Aboriginal Victorians, the elderly and people with mobility issues or disabilities.

The commitment to deliver an additional 500,000 specialist appointments to rural and regional patients over four years will also begin in 2019–20. Health services will be expected to increase telehealth activity to support this commitment in line with a new telehealth activity target.

Telehealth activity in specialist clinics and emergency departments is funded through existing funding models for acute care.

Services provided via telehealth video consultations in specialist clinics must align to the advice in the *VINAH and Telehealth consultations* factsheet. The factsheet can be accessed at the department's Telehealth program website <https://www2.health.vic.gov.au/hospitals-and-health-services/rural-health/telehealth>. The telehealth activity must be reported through the VINAH as described in the VINAH manual for 2019–20.

Services provided via telehealth video consultations in emergency departments to patients located in other Victorian public emergency departments or Urgent Care Centres or Victorian sub-regional government or non-government residential aged care services must align with the *Funding Telehealth Video Consultations in the Emergency Department* guidelines. The Guidelines can be accessed at the Telehealth program website <https://www2.health.vic.gov.au/hospitals-and-health-services/rural-health/telehealth>. The emergency department telehealth services can now be reported through the VEMD as described in the VEMD manual for 2019–20.

Further information on telehealth is available at the Telehealth program website <https://www2.health.vic.gov.au/hospitals-and-health-services/rural-health/telehealth>

2.3.1.12 Integrated Hepatitis C Services

The department funds 10 public health services and two community health services to provide nurse-led Integrated Hepatitis C Services.

In 2019–20, health services are to continue to re-align their service to focus on the effective use of primary care and targeted use of hospital specialist services. This includes:

- implementing localised hepatitis C pathways developed by Public Health Networks with local Public Health Networks
- building capacity in primary care and community settings to deliver hepatitis C testing, treatment and care for non-complex clients
- strengthening referral pathways between specialist clinics and primary care for management of complex clients
- working with pharmacy providers to have drug supply in the community.

Direct acting antiviral hepatitis C treatments

The Commonwealth lists a number of medicines for the treatment of hepatitis C on the Pharmaceutical Benefits Scheme and the Highly Specialised Drugs Program. Medicines for the treatment of hepatitis C are listed for prescribing by authorised nurse practitioners under the General Schedule only. Medicines for the treatment of hepatitis C are not listed for prescribing by authorised nurse practitioners under the S100 Highly Specialised Drugs Program. See Further information about hepatitis C treatments <https://www.pbs.gov.au/info/publication/factsheets/hep-c/hepc-factsheet-hospital-prescribers-dispensers>.

In 2019–20, the department will be undertaking a review of the revenue generated by health services in the supply of Hepatitis C medications to patients.

Integrated Hepatitis C Services (IHCS) activity is reported as part of the Victorian Integrated Non-Admitted Health (VINAH) dataset. For community health centres with IHCS, activity is reported through the Service Agreement Management System (SAMS) to the Community Health Minimum Dataset.

Health services who are funded to provide Integrated Hepatitis C Services are required to provide aggregate data on the numbers of patients attending clinics, waiting times and the numbers of patients being transitioned to community providers to the department on request.

For further information please visit:

- Community Health Minimum Dataset <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/community-health-data-reporting>.
- Victorian Health Services Performance website <http://performance.health.vic.gov.au/Home/Category.aspx?CategoryKey=138#Anchor>.
- Hepatitis C – Better Health Channel <https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/hepatitis-c>.

2.3.1.13 NDIS – health interface

Health services are expected to deliver high-quality care that is accessible, welcoming, safe and effective to all Victorians, including people with a disability, wherever they are treated. People with a disability should receive treatment and care, and the application of patient rights and responsibilities, that are afforded to any person in the community receiving healthcare with the same or similar clinical needs.

Consistent with person-centred care, aids (such as Auslan) should be used where necessary to overcome communication difficulties and promote active participation of people with a disability in decisions about their treatment and care.

Absolutely everyone: state disability plan 2017–2020 recognises the opportunities for Victoria as we transition to the National Disability Insurance Scheme (NDIS). The plan sets out 10 key priorities for the state public and private sectors to ensure that people with disability can participate in everyday life.

Health services are encouraged to develop disability action plans to improve the quality of care for people with a disability.

See further information on *Absolutely everyone* <http://statedisabilityplan.vic.gov.au>.

See Guidance on developing disability action plans <https://providers.dhhs.vic.gov.au/disability-action-plans>.

Working with the National Disability Insurance Scheme

Health services are responsible for effective interaction with the NDIS to enable timely access to supports and services for people with disability that have new or changed needs following a hospital admission. Health services are expected to understand and operate effectively in the new market based environment that is presented by the NDIS for the delivery of disability services:

- People accessing health-funded services and equipment may be eligible for the NDIS Health services are expected to identify NDIS participants, or those eligible to become participants. When providing care to NDIS participants, health services should ensure that NDIS eligible activity and equipment is billed to the NDIS.
- NDIS participants may access health services to seek care that is funded in their NDIS support plan. It may be that health services are their provider of choice for specialist services or the provider of last resort in areas where markets are developing.

Health services should register as NDIS service providers. This will enable health services to access additional revenue by billing the NDIS for funded activities in relation to eligible clients. In regional areas this will ensure access to certain NDIS-eligible allied health and nursing interventions for NDIS participants where these services may otherwise not be available locally.

Health service responsibility for aids, equipment and domiciliary oxygen

This information is provided to clarify responsibilities of public health services in the provision of aids, equipment and domiciliary oxygen for patients being discharged.

Health services have a responsibility to provide aids and equipment for up to 30 days at no cost to the patient (excluding a refundable deposit if applicable). This includes domiciliary oxygen and continence aids required by patients for recuperation, and safe and effective discharge in order to prevent unnecessary continued hospitalisation or readmission. This responsibility applies with the exception of pre-existing Victorian Aids and Equipment Program and NDIS clients in receipt of domiciliary oxygen or continence aids.

Health services may charge the patient fees for these aids and equipment after the expiry of the 30-day post discharge period. Alternatively, patients may choose to make their own arrangements.

Health services will need to work closely with the NDIS to ensure the smooth discharge for admitted patients who are eligible for NDIS. For admitted patients being discharged who are not eligible for the NDIS, health services should provide any aids or equipment necessary to enable discharge for as long as these are required.

For more information about fees and charges for the provision of aids, equipment and domiciliary oxygen see the department's *Fees manual* <http://www.health.vic.gov.au/feesman>.

2.3.2 Subacute and non-acute

2.3.2.1 Rehabilitation geriatric evaluation and management and maintenance care

Rehabilitation

Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating in rehabilitation.

Rehabilitation care is always:

- managed by a clinician with special expertise in rehabilitation
- evidenced by an individualised multidisciplinary management plan that is documented in the patient's medical record, including negotiated goals within specified timeframes and documented assessment of functional ability.

Geriatric evaluation and management

Geriatric evaluation and management (GEM) is care in which the primary clinical purpose or treatment goal is improving the functioning of a patient with multidimensional needs associated with medical conditions related to ageing such as falls, incontinence, reduced mobility, delirium and depression. The patient may have complex psychosocial problems and is usually (but not always) an older patient.

Geriatric evaluation and management is always:

- managed by a clinician with special expertise in geriatric evaluation and management
- evidenced by an individualised multidisciplinary management plan that is documented in the patient's medical record, which includes negotiated goals within indicative timeframes and documented assessment of functional ability.

Maintenance care

Maintenance care is care in which the primary clinical purpose or treatment goal is supporting a patient with impairment, activity limitation or participation restriction due to a health condition. Following assessment or treatment, the patient does not require further complex assessment or stabilisation.

It is not intended that maintenance care substitutes for other forms of non-acute care and should emphasise a restorative approach to care post treatment.

Health services are delineated to provide rehabilitation and GEM services through *Planning the future of Victoria's subacute service system: a capability and access planning framework*. Services are expected to align their services with the department's published capability level at all times.

Health services providing rehabilitation, GEM and Health Independence Program (HIP) services should ensure they align their services based on their service capability level. Local health services delineated as level 2 will provide and report maintenance care.

Admitted GEM and rehabilitation – reporting requirements

All health services providing inpatient rehabilitation and geriatric evaluation and management services are required to report a Functional Independence Measure (FIM™) score on admission and separation for patients with rehabilitation (excluding paediatric rehabilitation) and GEM. This is a mandatory VAED reporting requirement. Relevant records submitted to the department without a FIM™ score will be rejected.

A Program Identifier for Specialist Acquired Brain Injury (ABI) Rehabilitation Service (code 09) is to be reported for patients in the two designated specialist ABI rehabilitation services located at Caulfield Hospital, Alfred Health and the Royal Talbot Rehabilitation Centre, Austin Health.

A Program Identifier for Specialist Spinal Rehabilitation Service (code 10) is to be reported for patients in the two designated specialist ABI rehabilitation services located at Caulfield Hospital, Alfred Health and the Royal Talbot Rehabilitation Centre, Austin Health.

See *Planning the future of Victoria's subacute service system: a capability and access planning framework* <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/subacute-planning>.

For program details and service model information refer to the department's Patient care webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care>.

2.3.2.2 Transition Care Program

The Transition Care Program is jointly funded by the Commonwealth, state and territory governments through joint per diem contributions. The flexible care places used in the program are legislated by the *Aged Care Act 1997* and the Aged Care Principles made under the Act. The *Transition Care Program Guidelines* (2015) govern the program.

Refer to further information on the Transition Care Program <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/transition-care-program>.

2.3.2.3 Health Independence Program

Health Independence Program (HIP) services aim to provide hospital substitution and diversion services by supporting people in the community, in ambulatory settings and in their homes, this may include disability residential facilities. Health Independence Program services focus on improving and optimising people's function and participation in activities of daily living to allow them to maximise their independence and return to, or remain in, their usual place of residence.

Non-admitted specialist services in Victorian public hospitals: Access Policy 2019

Health services that currently reporting HIP data through the VINAH minimum dataset are expected to comply with the *Non-admitted specialist services in Victorian public hospitals: Access Policy 2019*. This new policy comes into effect from 1 July 2019 and provides guidance to the clinical, administrative support staff, managers and executives of all public health services that provide non-admitted specialist services in Victorian public hospitals. Health services will have 12 months in which to make the necessary changes to comply with the policy.

Refer to the Non-admitted specialist services in Victorian public hospitals: Access Policy 2019 <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Specialist-clinics-in-Victorian-public-hospitals-Access-policy>.

Conditions of funding

It is expected that health services will continue to provide the HIP service components for which they are funded, based on their subacute service capability framework level <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care>.

HIP service delivery components

The components of the HIP that a client receives will be based on the client's assessed needs and will assist the client to meet their identified goals. This may consist of one or more of the following:

- non-admitted rehabilitation (such as rehabilitation at home or in a community rehabilitation centre)
- care coordination – short-term or complex
- client self-management, education and support
- access to specialist services, including specialist assessment (such as linking to residential in-reach services, a specialist medical clinic or specialist subacute clinic such as chronic pain management, falls and balance or continence clinics)
- short-term supports (such as post-acute care)
- complex psychosocial issues management.

In 2019–20 health services will continue to progress the HIP consolidation, with the aim of providing a responsive, integrated and flexible approach to service provision.

Reporting requirements

Health services must report their non-admitted subacute costing data to the Victorian Cost Data Collections as detailed in Chapter 1, section 1.11 'Subacute non-admitted services'.

The definition of a HIP contact is provided in the VINAH business rules. The HIP counting unit will be 'direct non-admitted contacts' which are defined as contacts where all of the following VINAH characteristics are met:

- contact account class Public Eligible (MP) or Reciprocal Health Care Agreement (MA)
- contact client present status where either the patient, their carer, or both, are present (10, 11, 12, 13 or 20)
- contact delivery mode that is direct (1, 2, 3, 4 or 5)
- contact delivery setting that is not the emergency department (13)
- contact inpatient flag of outpatient/non-admitted present.

Organisations that receive funding under any of the following programs must transmit data to the VINAH MDS:

- specialist clinics (outpatient)
- HIP:
  - subacute ambulatory care services (including paediatric rehabilitation)
  - Hospital Admission Risk Program (HARP)
  - post-acute care (PAC)
  - residential in-reach service
- community-based palliative care
- Family Choice Program
- Victorian HIV Service
- Victorian Respiratory Support Service
- Medi-hotel (optional)
- Transition Care Program (TCP)
- hospital-based palliative care consultancy teams.

The AIMS S11 form will continue to be required to report service events for Commonwealth reporting processes.

Non-admitted subacute care programs and services that reliably submit VINAH data for all subacute program streams will be able to cease providing AIMS data once agreement has been reached with the department.

Hospitals are expected to report patient level cost data for all subacute and non-acute activity through the Victorian Cost Data Collection.

For further information:

- *Planning the future of Victoria's subacute service system: a capability and access planning framework (2013)* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Planning-the-future-of-Victorias-subacute-service-system-A-capability-and-access-planning-framework---February-2013>.
- The *Health Independence Program guidelines* will continue to guide health service and departmental directions for these services in 2019–20 and are available at <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/health-independence-program/hip-guidelines>.

2.3.2.4 Community palliative care

Designated community palliative care services provide end of life and palliative care to clients and carers that is responsive, multidisciplinary and evidence-based. Care is tailored to the preferences, values and goals of the individual and to their stage of illness, and can be early or late in the illness trajectory. Care includes complex pain and symptom management and assistance with physical, spiritual, social and cultural concerns related to life-limiting illness and bereavement. Practical help includes respite and financial assistance for equipment that supports the safety of clients, carers and staff in the home.

These services must provide care in line with the *Guidelines for Victorian designated palliative care providers, 2019–20*. These can be accessed at the End of life care webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care>.

After hours

Outside business hours (usually between 7.00 am and 5:00 pm Monday to Friday, excluding public holidays), all designated community palliative care services must provide or arrange the following minimum level of service to their clients:

- Specialist palliative care telephone advice to clients, carers and families primarily (but not only) about symptom management if required. This may include secondary consultation with a specialist palliative care provider where relevant.
- A health professional visit if required based on the client's, carer's or family's needs (if it is safe for staff to undertake the visit).
- Any other after-hours care negotiated between clients, their carer and the community palliative care service will be on an individual basis.

Reporting requirements

All designated community palliative care services must report activity using the program and stream element, as described in the VINAH data collection system:

- Contacts will be reported through VINAH as per the standard VINAH reporting requirements.
- The AIMS form will continue to be required to report service events for commonwealth reporting processes.
- Funded services are required to submit quarterly Clinical Indictors for Pain (CLiP) and Breathlessness (CLiB) audit data via the HealthCollect data portal. Noting the CLiB data collection is scheduled to commence in 2019–20.
- Funded services are required to participate in the palliative care experience module of the Victorian Health Experience Survey.
- Patient level cost data for community palliative care activity are to be reported through the Victorian Cost Data Collection.

2.3.2.5 Palliative care consultancy teams

Hospital-based consultancy teams

Reporting requirements

Hospital-based consultancy programs are eligible to report patient-level data using the VINAH dataset in 2019–20. Individual health services should make an assessment about the resource impacts of reporting their information using the VINAH dataset against the benefits.

If a service does not report hospital-based consultancy activity data in VINAH, they must report their activity in AIMS.

Regional palliative care consultancy teams

Funding allocations for regional palliative care consultancy form part of the health service modelled budgets in their Acute & Subacute allocation (refer to the Appendices, Appendix 2, section 2.1.1 'Health service modelled budgets 2018–19 and 2019–20' for health services and the Appendices, Appendix 2, section 2.1.5 'Registered community health centres budgets 2018–19 and 2019–20' for NGO providers).

Recall does not apply to specified grants for regional palliative care consultancy services in 2019–20.

Reporting requirements

Regional consultancy programs are required to use the AIMS form to ensure aggregate activity counts comply with the definition of a service event in 2019–20.

Regional consultancy teams must report:

- number of contacts
- number of referrals
- active episodes
- number of episodes opened
- number of episodes closed
- number of patients.

Services are required to report AIMS data by the 14th of each month.

Statewide consultancy services

A range of statewide services are funded to provide specialist advice in relation to particular diagnoses or population groups. These are:

- Victorian Paediatric Palliative Care Consultancy Program
- Very Special Kids
- Statewide Specialist Bereavement Service
- Motor Neurone Disease Association (MNDA) Victoria.

Funding allocations for palliative care statewide consultancy services are included in the organisations Acute & Subacute allocation (refer to the Appendices, Appendix 2, section 2.1.1 'Health service modelled budgets 2018–19 and 2019–20' for health services and the Appendices, Appendix 2, section 2.1.5 'Registered community health centres budgets 2018–19 and 2019–20' for NGO providers).

Recall does not apply to statewide palliative care consultancy services in 2019–20.

Reporting requirements

Statewide consultancy programs are required to report data via AIMS in 2019–20 Services must report:

- number of contacts
- number of referrals
- active episodes
- number of episodes opened

- number of episodes closed
- number of patients.

Hospitals are expected to report patient level cost data for all Statewide consultancy program activity through the Victorian Cost Data Collection.

For further details relating to all palliative care consultancy services including Victorian Paediatric Palliative Care Consultancy Program business rules go to the Palliative care webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/palliative-care>.

2.3.2.6 Palliative care consortia

Palliative care consortia support the department to implement *Victoria's end of life and palliative care framework* across the state. Consortia play an important role in regional education and training activities, and linking palliative care into the regional health and community care system.

Each consortium receives funding to support the manager role and contribute to consortium activities. One member organisation of each consortium acts as the fund holder.

- All funding grants for consortia are allocated to the nominated fund holder organisations.
- Each Consortium Executive Committee is responsible for the allocation of funds to consortium activities in their region.

Each consortium is required to submit an annual report to the department prior to the 30 September 2019. The report should outline their key achievements and activities for 2018–19 and include a financial statement that accounts for expenditure throughout the financial year.

For more information about palliative care consortia visit the Palliative care webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/palliative-care>.

2.3.2.7 Victorian Artificial Limb Program

Funding for the Victorian Artificial Limb Program will continue to be provided as a block grant to health services as a non-admitted subacute service.

Victorian Artificial Limb Program services are required to report service events as a non-admitted subacute service through the AIMS S11 form and report the cost data to the Victorian Cost Data Collection.

Services expected to provide artificial limbs under the Victorian Artificial Limb Program in 2019–20 are: The Royal Children's Hospital, Peninsula Health, Melbourne Health, Alfred Health, Barwon Health, Ballarat Health Services, Austin Health, St Vincent's Health, Latrobe Regional Hospital, Bendigo Health and South West Healthcare.

To monitor maintenance of effort, the annual activity and expenditure report regarding limbs and repairs will again be required for 2019–20.

A funding review of the Victorian Artificial Limb Program will be undertaken in 2019–20.

People accessing the Victorian Artificial Limb Program service and equipment may be eligible for the National Disability Insurance Scheme. Health services are expected to identify National Disability Insurance Scheme participants, or those eligible to become participants, accessing their Victorian Artificial Limb Program services and ensure National Disability Insurance Scheme eligible activity and equipment is billed to the National Disability Insurance Scheme.

Recall will not apply to Victorian Artificial Limb Program activity in 2019–20.

2.3.2.8 Victorian Respiratory Support Service

Funding for the Victorian Respiratory Support Service will continue to be provided as a block grant to Austin Health as a non-admitted subacute service.

The Victorian Respiratory Support Service is required to report service events as a non-admitted subacute service through the AIMS S11 form and report contacts through VINAH. They are also required to report patient level cost data through the Victorian Cost Data Collection.

2.3.2.9 Total parenteral nutrition

In 2019–20 funding will again be provided to five health services to support total parenteral nutrition (TPN) services for non-admitted patients who self-administer total parenteral nutrition at home. The services are Austin Health, Melbourne Health, Monash Health, St Vincent's Health and The Royal Children's Hospital.

All non-admitted patient sessions performed in a single month will be bundled and counted as one, non-admitted service event. A recall/throughput adjustment will be applied for health services whose activity is below or over target.

Health services funded to provide total parenteral nutrition will be required to report activity and cost data to the department in 2019–20.

Activity is to be reported via the AIMS S12 by the 14th day following the end of month and to be reported to VINAH. Cost data reported via the Victorian Cost Data Collection should consider the cost of consumables, equipment, maintenance and overheads. It should not include the cost of consultations with a health professional. Health services should count and report consultations with health professional separately.

For more information see references in the Home Enteral Nutrition section below.

2.3.2.10 Home enteral nutrition

Funding is provided to support home enteral nutrition (HEN) services given to non-admitted patients who self-administer enteral nutrition at home. All non-admitted patient sessions performed in a single month will be bundled and counted as one, non-admitted service event. A recall/throughput adjustment will be applied for health services whose activity is below or over target. For a list of event targets by health service, see the Appendices, Appendix 2, 'Table 2.19: Home enteral nutrition service event targets 2019–20'.

Health services funded to provide home enteral nutrition are required to report activity and cost data to the department in 2019–20.

Activity is to be reported via the AIMS S12 by the 14th day following the end of month and to be reported to VINAH. Cost data reported via the Victorian Cost Data Collection should consider the cost of consumables, equipment, maintenance and overheads. It should not include the cost of consultations with a health professional. Health services should count and report consultations with health professional separately.

For more information about subacute non-admitted services:

- See *Planning the future of Victoria's subacute service system: a capability and access planning framework* (2013) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Planning-the-future-of-Victorias-subacute-service-system-A-capability-and-access-planning-framework---February-2013>.
- Further information on VINAH is contained in the VINAH manual <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vinah>.

Information on what type of equipment can be provided; client eligibility criteria and the application process can be found in the *Victorian Aids and Equipment Program Guidelines (2010)* <https://providers.dhhs.vic.gov.au/aids-and-equipment>.

2.3.3 System improvements

2.3.3.1 Strengthening hospital responses to family violence

Health services are expected to progressively rollout and embed a whole-of-hospital model for responding to family violence. They should implement a train-the-trainer approach to staff education; actively participate in the community of practice; coordinate reporting and be prepared to meet the requirements for future information sharing legislation and the revised Common Risk Assessment Framework.

Lead health services are expected to actively mentor and support their nominated health services to rollout and embed their whole-of-hospital model.

The project is managed by The Royal Women's Hospital and Bendigo Health, and reporting requirements are outlined by the project managers. The project toolkit is available at SHRFV Documents – The Royal Women's Hospital website <http://haveyoursay.thewomens.org.au/shrfv-project/documents>.

For more information, see:

- Family violence reform website <https://www.vic.gov.au/familyviolence.html>
- Have Your Say @ The Women's <https://haveyoursay.thewomens.org.au>.

2.3.3.2 Prevent and respond to risks of occupational violence and aggression and bullying and harassment

All funded organisations are responsible for the safety of their staff, patients and visitors. Funded organisations must have the systems and processes in place to enable them to identify, assess and control occupational health and safety risks in accordance with their obligations under the *Occupational Health and Safety Act 2004*.

The department will continue to work with health services in 2019–20 to implement initiatives to better prevent and respond to risks of occupational violence and aggression and bullying and harassment. These initiatives can be found at the Worker Wellbeing webpage. Health services are expected to regularly refer to the information provided on the webpage and implement the guidance and resources including minimum standards.

The implementation of the minimum standards, guidance and supporting tools at each health service will be monitored by the department during 2019–20. The department requires that all Victorian public health services undertake the Victorian Public Sector Commission's People Matter Survey in 2019, including the Diversity and Inclusion and Sexual Harassment modules.

Health services are required to publicly report all incidents of occupational violence in their annual report. The department will be working with health services and boards in 2019–20 to improve the reporting and support risk management.

For more information about occupational violence and bullying and harassment resources visit the Worker health and wellbeing in Victorian health services webpage <https://www2.health.vic.gov.au/health-workforce/worker-health-wellbeing>.

2.3.3.3 Implementation of the Medical Treatment Planning and Decisions Act 2016

The *Medical Treatment Planning and Decisions Act 2016* came into effect on 12 March 2018. The Act places a greater emphasis on person-directed care and clarifies the health practitioner's obligations when treating people who do not have decision-making capacity.

The Act ensures that people are provided with medical treatment that is consistent with their preferences and values.

The Act establishes a single framework for health practitioners that will support good clinical practice. This will require an emphasis on good communication between health practitioners, patients, families and carers.

The Act clarifies the legal effect of an advance care directive and provides a single process for identifying who should make decisions on behalf of a person, and a process for making these decisions. This will clarify decision making and reduce conflict by creating clear roles and responsibilities.

If a registered health practitioner fails to act in accordance with the Act, this will constitute unprofessional conduct.

Health services should continue to be working towards:

- including advance care planning and identification of medical treatment decision-makers in communication with other providers
- including advance care planning as a parameter in assessment of outcomes such as mortality and morbidity review reports, patient experience and other routine data collection
- enabling and promoting the use of My Health Record, an initiative of the Commonwealth Government, to support communication of advance care plans.

As advance care planning delivery becomes embedded into the usual care health services provide, health services should be seeing an increase in the number of both admitted and non-admitted patients with an advance care directive/plan alert and an identified medical treatment decision-maker. This will be measured through mandatory VAED, VEMD and VINAH data items.

A suite of resources has been created in collaboration with the Victorian Office of the Public Advocate and the Victorian Medical Treatment Planning and Decisions Act Implementation Working Group.

These resources are available at the Advance care planning webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning>.

2.3.4 Improving Care for Aboriginal and Torres Strait Islander Patients

The Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) program was established in 2004 and built on the previous Aboriginal Hospital Liaison Officer (AHLO) program. The program requires health services to report progress against four key result areas through the Continuous Quality Improvement (CQI) tool, to demonstrate the provision of quality care for Aboriginal patients. The four Key Result Areas (KRA) are:

1. Engagement and partnerships
2. Organisational development
3. Workforce development
4. Systems of care

The department supports the sharing of best practice through the ICAP program. It encourages relationship building, peer support and professional development across health services.

Version 2 of the *National Safety and Quality Health Service Standards* (NSQHS) was released in 2017, for commencement from 1 January 2019. Version 2 requires health services across Australia to adhere to six actions across three standards, with the objective to improve access and outcomes for Aboriginal peoples.

The purpose of the standards is to ensure that health services:

- increase the recruitment and retention of Aboriginal people
- develop career pathways for Aboriginal people working in clinical and non-clinical roles
- develop and strengthen partnerships between both Aboriginal communities and Aboriginal community-controlled organisations
- improve the cultural safety for Aboriginal workers and service users.

The department undertook a review of the 30 per cent Aboriginal WIES loading in 2017, *Improving the effectiveness of the Aboriginal WIES loading (the loading review).* As part of the recommendations from the loading review and the need to align with Version 2 of the standards, the department has committed to a review of the ICAP program. The purpose of this review is to:

- improve health outcomes for Aboriginal patients
- improve the accountability of health services who are in receipt of funding for Aboriginal patients
- support and prepare Victorian health services for accreditation.

Further information on the loading review is provided below.

Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027, section 3, highlights the importance and necessity of the ICAP program to improve health outcomes for Victorian Aboriginal peoples.

Further information regarding the revised ICAP program will be provided in late 2019.

Aboriginal and Torres Strait Islander loading

Cultural safety is a key driver of Aboriginal health outcomes in Victoria. In 2016, an independent evaluation identified numerous deficits in cultural safety practices in Victorian hospitals, particularly in areas such as; a strong Aboriginal health workforce, cultural safety training, a welcoming environment, and relationships with Aboriginal community-controlled health organisations (ACCHOs).

In 2017, the department undertook a review of the loading applied to acute and subacute funding for Aboriginal patients, which is a key policy lever for improving outcomes for Aboriginal people in hospital care. To address the findings of the review, a range of recommended reforms were proposed to Aboriginal patient funding, monitoring and cultural safety guidance, which will be fully implemented in 2020–2021. The four broad recommendations relate to funding design, funding accountability, supporting reforms and Aboriginal self-determination.

There will be no reduction in overall funding provided across health services in Victoria. Under the changes, new reporting requirements will be introduced to ensure all health services are accountable for using Aboriginal funding for Aboriginal patients. WIES funded health services will be required to develop a cultural safety investment strategy at the start of each financial year, and acquit against this strategy at the end of each financial year. Further information on these new changes will be provided to health services in the first half of the financial year. The revised ICAP program will provide health services with adequate support to meet these new requirements, as well as prepare them for Version 2 of the NSQHS.

In line with *Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027*, self-determination is central to the proposed reforms. Health services are strongly encouraged to partner with Aboriginal-led organisations in developing their cultural safety investment strategies. They are also strongly encouraged to employ Aboriginal people and engage Aboriginal-led organisations in the delivery of cultural safety and clinical services.

Requirements for 2019–20

The department will shadow alternate funding arrangements during 2019–20 and work with and support health services to understand the proposed changes to the funding model for Aboriginal patients.

Under the shadow arrangements, health services will have additional requirements in the 2019–20 financial year. WIES and SWIES funded services will be required to complete an acquittal form at the end of the financial year, outlining cultural safety expenses incurred over the year.

Expected changes in 2020–2021

In 2020–2021 the 30 per cent Aboriginal loading will be split into three distinct streams.

1. A reduced loading closer to the National pricing adjustment of 5 percent (on top of normal activity-based funding) will be retained to cover excess clinical costs for Aboriginal patients.
2. A significant proportion of the remaining loading will be redirected into annual block grants to contribute to key workforce (e.g. AHLO) costs, and other recurrent costs associated with cultural safety and supplementary programs for Aboriginal patients. The size of the block grant will vary and will be calculated using a number of criteria which may include, but not limited to, the size of the health service and the Aboriginal population within the health services catchment.
3. Funding grants will be available through a competitive application process to cover the costs of one-off purchases for innovative projects (including research and evaluation) designed to improve cultural safety.

Ahead of the 2020–2021 financial year, the department will clarify expectations of cultural safety and how this funding is to be used. Guidance on best practice in improving cultural safety will also be provided through the revised ICAP program.

2.3.5 Integrated cancer services

All health services that treat cancer patients are expected to be active members of the Integrated Cancer Service (ICS) for their area and support the implementation of the network's vision to improve patient experiences and outcomes by coordinating cancer care and driving best practice. The Integrated Cancer Services will support the achievement of the following goals stated in the Victorian cancer plan:

- Victorians know their risk and have their cancer detected earlier
- Victorians with cancer have timely access to optimal treatment
- Victorians with cancer and their families live well.

A continuing focus for the ICS in 2019–20 is to work in collaboration with the relevant cancer centres to streamline service improvement priorities within and across the ICS areas. This is in addition to participating in statewide initiatives to support improvement in cancer outcomes.

Host organisations are required to hold funds on behalf of the ICS and act as employers for ICS program staff. Host organisations need to ensure that appropriate human resource management, fiscal management processes and accounting procedures are in place. A senior executive should be nominated as the key management contact regarding these matters.

The ICS governance committees, with clinician input, are responsible for:

- decision making about using funds in accordance with both local and statewide priorities for cancer reform
- accountability for the ICS funding
- ensuring value for money
- ensuring sound project management and evaluation processes are employed.

Host organisations and the ICS governance committees must agree to any charges levied by the host for infrastructure support. These charges must be reflective of actual costs incurred and should be reported in the ICS budget. A detailed reporting schedule for Integrated Cancer Services will be provided in September 2019. The report will identify requirements, dates and timelines.

The accountability requirements of the ICS governance committees are to:

- provide an annual review and report of progress against the current strategic plan
- provide half-yearly financial statements (for periods ending 31 December and 30 June)
- participate in the department's cancer reform meetings and workshops
- provide an annual report (for 2019–20) for public dissemination
- participate in processes to evaluate the impact of cancer reform activities, including reporting outcomes against targets and milestones.

The department reserves the right to conduct an ICS program office performance and financial audit.

See further information about Victoria's Integrated Cancer Services <https://www2.health.vic.gov.au/about/health-strategies/cancer-care>.

2.3.6 Perinatal services performance indicators

Safer Care Victoria publishes an annual report of Victorian perinatal services performance indicators. The report contains individual hospital (or campus) level data allowing comparison with the statewide public hospital average and the statewide private hospital average.

Health services should use this report to:

- track their own performance and trends, using raw local data more frequently if required
- compare results with services of a similar profile (size and capability)
- undertake ongoing local audits, including adverse event reviews through their perinatal mortality and morbidity committees
- perform local analysis of specific groups or cohorts of cases such as age profiles
- identify priority areas for focus and plan for performance improvement within a continuous quality framework
- evaluate improvement programs and provide feedback to relevant stakeholders
- disseminate results internally to build engagement with the maternity team
- provide education and support to staff and local communities
- collaborate with neighbouring health services and community-based healthcare providers to improve local practice, referral systems and performance.

Each indicator has a list of recommended actions that should be undertaken by health services and, in particular, health services with unexpected outcomes to ensure ongoing performance improvement. These include:

- an assessment of their local capability and the processes to support regular clinical audits and the provision of performance data feedback to clinicians
- a multidisciplinary review of local clinical practice guidelines and protocols to ensure they are based on current evidence and research
- a review of organisational barriers that constrain continual practice improvement
- benchmarking with peer group services
- engaging with other health services to achieve better outcomes that support local and regional improvement (this may include referral of results to their regional perinatal morbidity and mortality committee for expert multidisciplinary consideration).

Identifying improvement goals including timelines, and working with Safer Care Victoria and the department to monitor performance and improvement initiatives over time. Safer Care Victoria will work with health services to identify areas warranting attention in 2019–20. See further information about the perinatal services indicators report <https://bettersafercare.vic.gov.au/reports-and-publications/victorian-perinatal-services-performance-indicators-reports>.

2.3.7 Blood Matters Program

The Blood Matters Program assists health services to monitor patient blood management and transfusion practices in line with guidelines and standards to provide recommendations and support for best practice.

Health service performance reporting is required through participation in audits and surveys on practice and governance. Health services will be advised of the audits to be conducted in 2019–20.

Participation in the Blood Matters Program's Serious Transfusion Incident Reporting Program is strongly encouraged and supports national healthcare standards. It is expected that serious adverse events related to blood or blood components are reported. These are clinical reactions and procedural events including:

- near-miss incidents
- events related to Rh D immunoglobulin
- cell salvage.

Health services are expected to align blood management and transfusion practices with national guidelines, standards and strategies such as:

- *National Stewardship Expectations for the Supply of Blood and Blood Products* and the *National Patient Blood Management Guidelines Modules 1–6*, both available at the National Blood Authority website <https://www.blood.gov.au>
- *National Safety and Quality Health Service (NSQHS) Standards*, second edition available at Assessment to the NSQHS Standards – Australian Commission on Safety and Quality in Health Care website <https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards>
- *National wastage and haemovigilance strategies*, available at the National Blood Authority website <https://www.blood.gov.au>.

The department established the transfusion nurse/trainer/safety officer, patient blood management role across Victoria, and continues to financially support these positions. Health services are expected to have roles in place to ensure compliance with national guidelines and the NSQHS standards, and are funded to achieve this through acute admitted funding.

Health services are expected to support compliance with the national guidelines and the *NSQHS standards through activities that* include:

- Employment of an appropriately trained nurse or scientist, such as one who holds a Specialist Certificate in Blood Management Foundations/Graduate Certificate of Transfusion Practice.
- Ensuring the role operates within an effective health service blood management and quality governance structure.
- Incorporating patient blood management practices – that is, a patient-centred approach to safe and appropriate transfusion practice in line with national clinical guidelines, standards and strategies (NSQHS Blood Management Standard (7)).
- Participation in Blood Matters Program audits, educational forums and other activities.
- Annual progress reports to the Blood Matters Program.

See further details on the Blood Matters Program <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/blood-matters>.

2.3.8 Mental health services

Clinical mental health services in Victoria are delivered to three specific age groups:

- children and adolescents (0–18 years)
- adults (16–64 years)
- aged persons (65 years or older).

Youth-specific mental health services have also been developed for adolescents and young people (16–25 years) and are delivered largely through adult mental health services.

2.3.8.1 Clinical mental health services for children and adolescents (0–18 years)

Child and adolescent mental health services (CAMHS) provide specialist mental health treatment and care to children and adolescents. These services assess and treat children and adolescents experiencing moderate to severe mental health problems and disorders, and assist those with less severe problems with advice and information about where and how to access help. Vulnerable children and young people, particularly those involved with statutory services such as child protection, are prioritised.

There are 13 health services that provide CAMHS services across the system. The CAMHS acute inpatient service units are located in general hospitals, and mostly admit young people aged 13–18 years of age:

- The Royal Children's Hospital admits young people aged 13–17 years of age from their local catchment.
- Orygen Youth Health admits young people aged 18–25 years of age from their local catchment.

Austin Health's child mental health inpatient unit is a specialist statewide service for children aged less than 13 years. Monash Children's Hospital recently opened a new specialist statewide inpatient service for children up to 12 years of age.

Each Area Mental Health Service has referral relationships with CAMHS inpatient services across the state.

2.3.8.2 Young people's mental health services (16–25 years)

- Youth program – early psychosis services are for young people who are experiencing a first episode of psychosis. These services are provided statewide as a subspecialty program in some specialist adult mental health services (Melbourne Health).
- Orygen Youth Health (Melbourne Health) provides a specialised youth mental health clinical service for young people 15–25 years old, with a focus on early intervention and youth-specific approaches.
- Youth Prevention and Recovery Centres (PARC) are for young people experiencing significant mental health problems who are either leaving an acute hospital inpatient admission or who would benefit from 24-hour support to avoid a hospital admission. Youth PARCs are located in Dandenong, Bendigo and Frankston and are intended to support regional accesses.

2.3.8.3 Adult mental health services (16–64 years)

17 health services constitute the Victorian adult clinical mental health system. Adult specialist mental health services are provided for people experiencing severe mental illness (for example, schizophrenia). People may also present in situational crisis that may lead to self-harm or inappropriate behaviour towards others.

Clinical adult area mental health services generally include:

Inpatient treatment services

- *Acute inpatient services* – provide a range of therapeutic interventions and programs to patients and their families during an acute episode to learn more about the impact of the illness, explore ways to better manage the illness, improve coping strategies and move towards recovery. (All of the age-based mental health services provide acute inpatient services for people who cannot be assessed and treated safely and effectively in the community).
- *Consultation and liaison psychiatry* – delivers mental health services to people who have a primary medical condition admitted to general hospital settings that may be associated with a mental illness. The Victorian Government funds 14 health services to provide consultation and liaison psychiatry.

- *Psychiatric assessment and planning units* (PAPUs) – deliver fast access to short-term specialist psychiatric assessment and treatment for people experiencing an acute episode of mental illness.

Residential treatment services

- *Secure extended care units* (SECUs) – provide medium to long-term inpatient treatment and rehabilitation for people who have unremitting and severe symptoms of mental illness or disorder. These units are located in hospital settings. As SECU are not in all catchments cross area access arrangement are established.
- *Community care units* (CCUs) – provide medium to long-term clinical care and rehabilitation services in a home-like environment. They support the recovery and rehabilitation of people seriously affected by mental illness to develop or relearn skills in self-care, communication and social skills in a community-based residential facility with the aim to returning to the community.
- *Prevention and Recovery Centres (PARC)* – adult prevention and recovery care (PARC) services are community-based, short-term supported residential services for people experiencing a mental health problem, but who do not need (or no longer require) a hospital admission.

Outpatient treatment services (community based clinical treatment)

- *Acute community intervention service* – provides urgent advice, referral and treatment to people with a mental illness who are acutely ill or in crisis. The service is provided through telephone triage, mental healthcare in emergency departments and community mental health.
- *Continuing care* – provide non-urgent assessments, treatment, case management, support and continuing care services in the community. This is the largest component of adult community-based services.

2.3.8.4 Aged persons mental health services (65 years and over)

Fourteen health services constitute the Victorian aged clinical mental health system. These are specialist mental health services for people with longstanding mental illness or for those who have developed a functional illness such as depression, a mood disorder, anxiety or schizophrenia later in life. Services include inpatient units located in general hospitals or with other aged care facilities, and specialist residential care.

Statewide, area based and specialist mental health services

There are a range of specialist mental health services that are specifically targeted to Victorians with severe and complex illnesses that are offered in a smaller number of health services and support the needs of a broader area catchment or the state. These include:

- *Eating disorder services* are delivered by the Royal Children's Hospital, Melbourne Health, Austin Health and Monash Health. Services include intensive community-based treatment models for children, young people and adults with eating disorders, and their families, in addition to specialist beds.
- *A personality disorder service* (Spectrum based at Eastern Health) works with local area-based clinical services to provide treatment for those aged 16–64 years old with a personality disorder, focusing on people who are at risk from serious self-harm or suicide and who have complex needs. Spectrum receives referrals from area-based clinical services and primary health providers such as GPs or private psychiatrists.
- *Parent and Infant mental health services* (previously Mother and Baby Units) provide support for parents experiencing severe mental illness in the antenatal or postnatal period. Six health services have specialist parent and infant units that provide a residential setting for psychiatric treatment, assessment and support for parents experiencing severe mental illness and their infants aged up to 12 months. The units are located in the Austin, Bendigo, Ballarat, La Trobe, Mercy, Monash.
- *Brain disorder service,* located at Austin Health, is for people with acquired brain injury or neurogenerative conditions with associated psychiatric conditions. Services include inpatient, residential and community programs, outreach services and secondary consultation.

- A statewide specialist *neuropsychiatry service* specialises in mental illnesses associated with disorders of the nervous system. The service is located at the Royal Melbourne Hospital (Melbourne Health).
- The *Victorian Dual Disability Service* is located at St Vincent's Hospital Melbourne and works with specialist mental health services across Victoria to assess, treat and support people with a dual disability. A person with a dual disability has an intellectual disability or autism spectrum disorder, as well as a mental illness.
- *Dual diagnosis* services aim to improve treatment outcomes for individuals who have co-existing mental health and substance use issues. Services include education and training for Area Mental Health Services, drug and alcohol and MHCSS staff, support to organisations to develop dual diagnosis capabilities, and clinical consultations in collaboration with primary case managers. The service is auspice by Melbourne Health, St Vincent's, Eastern Health and Monash Health.
- *Aboriginal mental health services* aim to improve access and the cultural appropriateness of services provided to Aboriginal people. Koori mental health liaison officers are based in rural/ regional mental health services and provide culturally appropriate support and services. St Vincent's Hospital Melbourne has five specialist Aboriginal beds in the mental health acute inpatient unit that are managed with the Victorian Aboriginal Health Service Family Counselling Service.
- *Victorian Transcultural Mental Health* supports area-based clinical services and MHCSS to work with consumers, carers and communities from diverse cultural backgrounds. It is a nonclinical unit administered by St Vincent's Hospital Melbourne and provides education and training, clinician support through an external enquiries service, consultation and service development and research.
- *Torture and trauma counselling* is provided by the Victorian Foundation for Survivors of Torture ('Foundation House'). Victorian adults and children who have experienced torture, persecution or war-related trauma prior to arrival in Australia. Foundation House receives direct referrals to its services and also works to improve the skills and competency of healthcare services providing other treatment and support to refugees.

Other programs

There are a range of other programs provided by health services. Recent programs include:

- *Hospital Outreach Post-Suicidal Engagement (HOPE) program* – mental health professionals provide one-on-one support to people who have attempted suicide and make sure they get the support they need to recover. Current sites: Albury Wodonga Health; St Vincent's Hospital; Maroondah Health; Barwon Health; Peninsula Health; Alfred Health; Latrobe Regional Hospital; Sunshine Hospital; Casey Hospital; Ballarat Health Service including Horsham, Werribee Mercy Health; and Bendigo Health Service including Mildura.
- *Mental health and AOD hubs* – people presenting at Emergency Departments with acute mental health and AOD issues can be fast tracked to specialist, dedicated care, providing them with the right support sooner and easing pressure on emergency departments. The mental health and AOD hubs will be located at Monash Medical Centre, St Vincent's, the Royal Melbourne, Geelong, Sunshine and Frankston Hospitals. Operations will commence in April 2019.
- *Aboriginal mental health traineeship program* – provides full-time ongoing employment to Aboriginal Victorians who successfully undergo supervised workplace training and clinical placements over three years while concurrently completing the three-year full-time Bachelor of Health Science (Mental Health) degree at Charles Sturt University. The program is offered through: Eastern Health (two positions), Bendigo Health (two positions), Alfred Health, Peninsula Health, Monash Health, Latrobe Regional Health, Mildura Base Hospital and Forensicare.
- *Improving Outcomes Aboriginal Victorians with moderate to severe mental illness* – four consortia demonstration projects are being funded to deliver integrated, culturally safe mental health services that are designed to meet the mental health, and social and emotional wellbeing needs of their local Aboriginal communities. The four demonstration sites are: Ballarat and District Aboriginal Co-operative (in partnership with Ballarat Health), Mallee District Aboriginal Services (in partnership with Mildura Base Hospital and Mallee Family Care, Victorian Aboriginal Health Service (in partnership

with St Vincent's Health, Austin Health, North Western Mental Health) and Wathaurong Aboriginal Co-operative (in partnership with Barwon Health).

Forensic mental health

The Victorian Institute of Forensic Mental Health (better known as Forensicare) delivers inpatient and community forensic mental health services across Victoria. Services include clinical assessment, treatment and management of people with a severe mental illness and offending behaviours, provision of psychiatric reports for court, and multidisciplinary treatment for people at high risk in the community.

Forensicare is a statutory authority and provider of specialist forensic mental health services under the *Mental Health Act 2014*. Forensicare provides adult mental health services in Victoria for people involved in the criminal justice system, or who are at high risk of offending.

Services include:

- Thomas Embling Hospital, a 134-bed secure hospital for people from the criminal justice system who need specialist psychiatric assessment and treatment, and patients from the public mental health system who require specialised management
- Community Forensic Mental Health Service, providing assessment and multidisciplinary treatment to high-risk consumers referred from area mental health services, correctional providers, courts, the Adult Parole Board, Thomas Embling Hospital, prison services, government agencies and private practitioners.

Joint Regional Planning for Integrated Regional Mental Health and Suicide Prevention

Commonwealth, state and territory governments have agreed that Public Health Services and Primary Health Networks will develop and publicly release joint mental health and suicide prevention plans by 2020.

Joint regional mental health and suicide prevention planning is vital to embed integrated mental health and suicide prevention pathways for people with or at risk of mental illness or suicide through a whole of system approach.

2.3.8.5 Key policies and guidelines for mental health services

The *Chief Psychiatrist's guidelines* provide specialist advice on clinical practice, especially in those areas regulated by the *Mental Health Act 2014.*

See the *Chief Psychiatrist's guidelines* <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines>.

Program management circulars articulate or clarify departmental policy on key aspects of service provision and are available at the Chief Psychiatrist website <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist>.

All funded clinical mental health services are required to be accredited against the *National Safety and Quality in Health Service (NSQHS) Standards (Second edition)* in 2019–20. As a condition of funding, organisations are required to adhere to the service standards and guidelines applicable to the funded activity, including program management circulars, Chief Psychiatrist's and the *Chief Psychiatrist's guidelines*.

Information on mental health programs and program guidelines can be found at the Mental health webpage <https://www2.health.vic.gov.au/mental-health>.

See the Guidelines for Joint Regional Planning for Integrated Mental Health and Suicide Prevention <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-health-intergrated-reg-planning>.

Organisations can obtain copies of the relevant standards and guidelines from their department program and service advisor or, in some instances, through the department's Funded Agency Channel.

Standards and guidelines are available at the Funded Agency Channel website <http://www.dhs.vic.gov.au/funded-agency-channel>.

Further information on mental health services is available at the Mental health webpage <https://www2.health.vic.gov.au/mental-health>.

The Your Experience of Service (YES) survey is designed to collect information on consumer experience in adult mental health services and selected Mental Health Community Support Services. This survey will be implemented annually.

2.3.8.6 Mental health community support services performance framework

The *Mental health community support services performance management framework* specifies the performance requirements of the department for funded mental health community support services (MHCSS) agencies and outlines how the department will measure, monitor and assess performance at the agency, service and program levels. In this regard, the framework provides a key mechanism for monitoring whether a funded agency is delivering services consistent with the requirements of their Funding and Service Agreement.

The framework also outlines the processes, roles and responsibilities of all relevant stakeholders who are involved in the performance management of the MHCSS program.

2.3.9 Alcohol and drug services

2.3.9.1 Key standards and guidelines

Service standards and guidelines that apply to funded alcohol and drug services are listed in Chapter 2, Addendum 2.2: 'Service standards and guidelines'. Where organisations receive funding for an activity or service, it is a condition of funding that they adhere to the service standards and guidelines listed under the relevant activity.

Organisations can obtain copies of the relevant standards and guidelines from their departmental program and service advisor or, in some instances, through the department's Funded Agency Channel.

Standards and guidelines are available at the Funded Agency Channel website <http://www.dhs.vic.gov.au/funded-agency-channel>.

Information can also be obtained from the Alcohol and other drugs webpage <https://www2.health.vic.gov.au/alcohol-and-drugs>.

Organisations are required to deliver services in line with the Victorian alcohol and other drug program guidelines, the Victorian alcohol and other drug client charter and the Victorian alcohol and drug treatment principles.

Copies of the guidelines, charter and principles are available at the Alcohol and other drugs webpage <https://www2.health.vic.gov.au/alcohol-and-drugs>.

2.3.10 Ageing, aged and home care services

Service standards and guidelines that apply to funded aged care services are listed in Chapter 2, Addendum 2.2: 'Service standards and guidelines'. If organisations receive funding for an activity or service, it is a condition of funding that they adhere to the service standards and guidelines listed under the relevant activity. The performance targets and monitoring requirements for the relevant ageing, aged and home care services are outlined at Chapter 2, Addendum 2.1: 'Performance targets and monitoring'.

2.3.10.1 Public sector residential aged care – infection control

The department provides funding to public sector residential aged care services (PSRACS) to assist with operational expenses. PSRACS are funded to provide a specified number of available bed days and to meet set targets for resident occupancy.

Health services are required to report on the aged care infection control module to the Victorian Healthcare Associated Infection Surveillance System (VICNISS) Coordinating Centre to monitor of infection control practices and antimicrobial use in PSRACS.

2.3.10.2 Ageing, aged residents' rights and interests

Health services operating public sector residential aged care services (PSRACS) are required to meet Commonwealth Government legislative requirements relating to protecting residents' rights and interests. This includes meeting obligations for resident accommodation agreements, aged care accreditation standards, police checks for key personnel, staff and volunteers, compulsory reporting for reportable assaults and unexplained absences, and responsive management of complaints including those lodged through the Aged Care Complaints Commissioner.

Supported residential services proprietors have obligations to residents under the *Supported Residential Services (Private Proprietors) Act 2010* and Regulations. The department will continue supporting services to address the Accommodation and Personal Support Standards, including through the Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI), as well as working with community service organisations through a partnerships management model to implement the Pension Level Projects initiative in other pension-level supported residential services.

2.3.11 Primary, community and dental health

2.3.11.1 Community health

The service standards and guidelines that apply to the community health program are listed in Chapter 2, Addendum 2.2: 'Service standards and guidelines'. If organisations receive funding for an activity or service, it is a condition of funding that they adhere to the service standards and guidelines listed under the relevant activity. The performance targets and monitoring requirements for community health are outlined in Chapter 2, Addendum 2.1: 'Performance targets and monitoring'.

2.3.11.2 Identification and management of vulnerable children

Healthcare that counts: a framework for improving care for vulnerable children in Victorian health services was produced in 2017 and articulates the role of all Victorian health services in the early identification and effective response to vulnerable children. The framework is a quality improvement and best-practice guide that should be implemented in all health services and community service organisations delivering health programs in Victoria.

Healthcare that counts replaces and broadens the scope of an earlier framework for acute health providers. The framework includes five action areas to guide system improvement, as well as indicators of best practice. This will enable health services to annually benchmark and self-assess their implementation progress using the accompanying *Self-Assessment Tool.*

Healthcare that counts aligns with the Child Safe Standards and assists all health services to meet these and other legislative requirements relevant to the safety and wellbeing of children.

Healthcare that counts is also supported by free online training at the Children at Risk Learning Portal <https://vulnerablechildren.kineoportal.com.au> and the Vulnerable Children website <https://www2.health.vic.gov.au/about/populations/vulnerable-children>, where copies of the framework and other resources are available.

Victorian Forensic Paediatric Medical Service

The Royal Children's Hospital is the statewide governing body for Victorian Forensic Paediatric Medical Services (VFPMS). Services are provided by The Royal Children's Hospital, Monash Medical Centre and all regional health services. A key function of the VFPMS is to provide a forensic assessment of injury and neglect to children from birth to 18 years where there is suspected child abuse and neglect. The Royal Children's Hospital is responsible for providing leadership and clinical guidance for the statewide service and all regional health services are expected to provide appropriate 24-hour clinical forensic services for these children.

2.4 Accreditation

Funded organisations have a range of obligations related to clinical service provision. These requirements have been put in place to ensure the quality of services and the safety of patients.

2.4.1 Australian Health Service Safety and Quality Accreditation Scheme

Accreditation of health services falls under the Australian Health Service Safety and Quality Accreditation Scheme. Under this scheme, health services are accredited against the *National Safety and Quality Health Service Standards (second edition)*. Information regarding the standards can be found at NSQHS Standards – Australian Commission on Safety and Quality in Health Care website <https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/nsqhs-standards-second-edition>.

All Victorian public health services, including metropolitan (this includes specialist and denominational health services), regional, subregional, local and small rural and multi-purpose services, clinical mental health services provided by public health services (including Forensicare), public dental housed within health or community health services, and Bush Nursing Centres, must undergo regular assessments to maintain their accreditation through the Australian Health Service Safety and Quality Accreditation Scheme

The department, as the regulator, is responsible for monitoring and responding to the accreditation status of health service organisations. This response includes addressing and resolving issues, concerns, recommendations and instances of non-compliance.

Accreditation status is monitored by the department in accordance with the *Accreditation policy for Victorian publicly funded health services organisations* <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-accreditation>. This policy details the department's regulatory approach to accreditation outcomes and provides health services with a clear understanding of the requirements of the new scheme and reporting obligations.

Performance against accreditation will be reviewed as part of the department's performance monitoring processes. The regulatory response will be based on the outcome of the accreditation assessment and allow for escalation of monitoring and intervention, including possible action under the *Health Services Act 1988*, *Mental Health Act 2014*, or terms of the Funded Organisation Performance Monitoring Framework.

2.4.2 Pathology services

Victoria entered into a memorandum of understanding (MOU) with the National Association of Testing Authorities (NATA) in September 2004, in recognition of their role as the national authority in Australia for accrediting laboratories and as an accreditor of inspection bodies.

One of the undertakings made in the MOU is that Victoria will encourage all service providers to adhere to the principles of good laboratory practice, which are contained in NATA's relevant accreditation criteria.

An additional MOU that specifically relates to pathology laboratories was entered into by NATA and Victoria's chief health officer on behalf of the department. It embodies the spirit of cooperation between the department and NATA in relation to protecting public health.

On the basis of these undertakings, the conditions of funding are:

- Any laboratory operated by a health service whose principal function is to conduct pathology services must obtain and maintain accreditation from NATA or the Royal College of Pathologists of Australasia for the pathology services it provides.

- Any pathology service required for a public, private or compensable admitted patient of a health service must only be requested from a laboratory that holds accreditation from NATA or the Royal College of Pathologists of Australasia for the type of service required.
- Any pathology service required for a patient attending an outpatient clinic of a health service must only be requested from a laboratory that holds accreditation from NATA or the Royal College of Pathologists of Australasia for the type of service required.

The conduct of any pathology service provided for a health service that is not under the direct management of a pathology laboratory accredited by NATA or the Royal College of Pathologists of Australasia (for example, services provided by research laboratories, specialist clinical laboratories or at the point of care) must be overseen by a pathology laboratory that is accredited by NATA or the Royal College of Pathologists of Australasia for the relevant scope of services.

2.4.3 Ambulance

With the exception of Victoria, ambulance services in Australia are not currently part of an accreditation or external assessment process. Ambulance Victoria has organisation-wide accreditation to the business standards ISO9001. Ambulance Victoria self-assess against appropriate and relevant *National Safety and Quality Health Service Standards* and continue to investigate broader implementation or incorporation of those standards.

2.4.4 Mental health clinical and community support services

All funded clinical mental health services are required to be accredited against the *National Safety and Quality in Health Service (NSQHS) Standards (Second edition).*

Organisations that receive funding for a Mental Health Community Support Services program are encouraged to implement the *National Standards for Mental Health Services 2010*. During transition to the National Disability Insurance Scheme (NDIS), Victoria will monitor providers of defined MHCSS programs who deliver funded NDIS supports to ensure they meet the quality and safeguards in accordance with the Bilateral Agreement for Transition to the NDIS.

New providers who register to deliver psychosocial supports in scope of Victoria's Quality and Safeguarding arrangements for the NDIS are also required to be accredited against the *National Standards for Mental Health Services 2010.*

Health services providing alcohol and other drug treatment services are required to be accredited against the NSQHS standards (see Chapter 2, section 2.4.1 'Australian Health Service Safety and Quality Accreditation Scheme').

Organisations that receive funding for alcohol and other drug services are required to establish and implement plans to deliver services consistent with the Victorian alcohol and other drug charter. The ongoing implementation of plans to deliver services consistent with the Victorian charter is also expected of organisations that will receive funding for alcohol and other drug services in 2018–19.

These services are also required to continue to be accredited within existing generic accreditation frameworks by an entity certified by either the International Society for Quality in Health Care or the Joint Accreditation System of Australia and New Zealand.

2.4.5 Aged care

2.4.5.1 Public sector residential aged care service accreditation and quality approach

The Commonwealth Government has the primary responsibility for funding and regulating residential aged care services under the *Aged Care Act 1997*. In accordance with this legislation, all Victorian public sector residential aged care services (PSRACS) are expected to comply with minimum aged care accreditation standards at all times to receive recurrent Commonwealth subsidies. Accreditation of

residential aged care services against the aged care accreditation standards is undertaken by the Australian Aged Care Quality Agency.

The department actively supports PSRACS to provide high-quality care to residents. The department's *Beyond compliance* strategy provides the strategic framework for focusing on safety and quality in PSRACS. It aspires to broaden approaches to quality, beyond minimum Commonwealth accreditation requirements and support care excellence.

Beyond compliance programs and initiatives are designed to encourage and support PSRACS to excel in the delivery of person-centred, safe, effective, appropriate, integrated and coordinated services so that a good quality of life is experienced by every resident, every day.

The focus of initiatives to be progressed in 2019–20 include:

- supporting PSRACS transition to the new aged care standards and other Commonwealth regulatory changes
- progressing priorities for strengthening PSRACS governance and leadership
- building nurse workforce capacity
- better use of evidence in practice to reduce care variation
- rollout of additional measures within the quality indicator program
- piloting performance measures for safety and quality in PSRACS.

2.4.5.2 Home and Community Care Program for Younger People

Organisations funded under the Home and Community Care Program for Younger People (HACC-PYP) who also have funds under the Commonwealth Home Support Programme (CHSP) must meet certain quality review requirements. These organisations are required to provide the department with a copy of the Home Care Standards: Final Quality Review Report and/or Plan for Continuous Improvement (PCI) and/or Timetable for Improvement (TFI), following their review by the Australian Aged Care Quality Agency (AACQA).

The Home Care Standards are common to both the CHSP and the Victorian HACC-PYP. Therefore, the AACQA quality review results against the Home Care Standards will meet quality reporting requirements for HACC-PYP funded organisations.

The department will provide further information about quality review arrangements for providers funded under HACC-PYP.

2.5 Clinical governance

2.5.1 Health service clinical governance

All health services and funded organisations are required to ensure that their clinical governance policies and frameworks comply with the current *Delivering high-quality healthcare: Victorian clinical governance framework*. The framework can be found at < https://bettersafercare.vic.gov.au/our-work/governance/clinical-governance>.

2.5.1.1 Incident management and the sentinel event program

In 2019, Safer Care Victoria will publish a new clinical incident management policy and associated resources, specifying the requirements for all funded health services. During 2019–20, health services will be expected to:

- notify Safer Care Victoria's Sentinel Event program and complete an open disclosure process within the specified timeframes
- ensure sentinel event review processes are timely, appropriately resourced and high quality (utilising human factors and systems thinking)
- ensure the review team is led by suitably qualified staff, including a consumer representative and an independent external expert
- apply learnings from the review to improve systems of care and patient safety, and
- work with Safer Care Victoria to continually improve the quality of sentinel event review processes in Victoria – see Sentinel events program – Safer Care Victoria <https://bettersafercare.vic.gov.au/our-work/incident-response/sentinel-events>.

Sentinel event notifications and review outcomes must be submitted by emailing Sentinel events as Safer Care Victoria <sentinel.events@safercare.vic.gov.au>.

Guidance on review processes and additional resources can be accessed from Sentinel events program – Safer Care Victoria <https://bettersafercare.vic.gov.au/our-work/incident-response/sentinel-events>.

2.5.1.2 Health services quality and safety reporting

The Victorian Agency for Health Information (VAHI) currently reports a range of quality and safety measures as part of its suite of four reports on the performance of health services, Monitor, Program Report for Integrated Service Monitoring (PRISM), Inspire, and Board Safety and Quality Report (BSQR). VAHI has also produced a Quality and safety in Victorian private hospitals report on safety and quality of private hospitals and intends to produce further private hospital reporting in the future.

In the Performance Monitoring Framework, the department identifies performance measures relating to high quality and safe care, strong governance, leadership and culture, timely access to care and effective financial management. VAHI reports these measures in Monitor and the measures reflect the targets set for performance in each health services' SOP. The audience for Monitor is public health services executives and the department.

PRISM reports on health services' performance on a wide range of access, quality and safety, operational and financial performance measures not reported in Monitor. These include the Core Hospital Indicators (CHBOIs) developed by the Australian Commission for Safety and Quality in Health Care (ASCQHC), including unplanned readmissions for acute myocardial infarction (AMI), knee replacement, hip replacement, paediatric tonsillectomy and adenoidectomy and heart failure; overall in-hospital mortality and in-hospital mortality for AMI, fractured neck of femur, stroke and pneumonia. The audience for PRISM is also public health services executives and the department.

The Inspire report is produced quarterly and specifically targeted towards clinicians such as chief medical and nursing officers. It contains results for a range of quality and safety measures, including safety

culture, patient experience, infection prevention and control and potentially preventable infections, maternity and newborn care, continuing care, mental health, unplanned readmissions, hospital-acquired complications and sentinel events. VAHI also produces a biannual Mental Health Inspire to report on the safety and quality of mental health services. BSQR is also released quarterly and reports on a similar set of measures but is designed for board members to support their governance role.

VAHI has undertaken consultations to seek feedback from health services and other stakeholders on what additional measures should be developed and reported and is currently undertaking a process to prioritise areas of additional reporting for development in 2019–20. VAHI has undertaken work to adapt the national ACSQHC measures for the Victorian context, such as the death in low mortality diagnosis related groups measure and hospital acquired complications measures, including cardiac complications. It is also developing a number of new measures for reporting, including a 30-day in- and out-of-hospital mortality measure for AMI and all-cause, all-hospital unplanned readmissions measures.

2.5.1.3 Clinical quality registries

Clinical registries collect information to drive improvements in the quality and safety of healthcare. Victorian hospitals and clinicians currently contribute data to approximately 50 health-related national and state-based clinical registries. The Victorian Government provided direct or indirect funding for 20 clinical registries in 2017–18, ten of which met the criteria as clinical quality registries.

The Victorian Government is committed to ensuring that data from clinical quality registries (CQRs) could be much better used by the government and the health sector to drive quality improvements.

In 2018–19 the Victorian Agency for Health Information (VAHI) worked with registry custodians and key stakeholders to implement standardised contractual arrangements for CQRs with a contract expiry date in financial years 2018–19 and 2019–20. The new three-year contracts for CQRs address key recommendations in Targeting Zero as they relate to the distribution of quarterly reports, the provision of data to the department and escalation of outliers. In consultation with Safer Care Victoria and the department, VAHI has prepared a clinical registry strategy. The strategy will guide future investment for identified priority areas, as well as additional operational requirements for registries funded by the Victorian Government. Any policy implications will be clearly communicated to health services regarding any changed data collection requirements for identified priority clinical registries funded by the Victorian Government. It is noted that for the State Trauma Registry, the Cardiac Surgery Registry and the Australian and New Zealand Intensive Care Society Adult Patient Database that it is mandatory for public health services covering procedures captured by these registries to provide data to these collections.

2.5.1.4 VICNISS surveys and health service reporting requirements

The effective prevention and control of infection are an integral part of the quality, safety and clinical risk management operations of any health service.

Monitoring the occurrence and rate of infections at your health service and comparing these with peer services will provide you information on how well you are doing. The following measures to assist in this process can be found on the VICNISS website <http://www.vicniss.org.au>.

Healthcare associated infections

VICNISS collects and analyses data from individual hospitals on risk-adjusted, procedure-specific infection rates, *Staphylococcus aureus* bacteraemia (SAB) associated infections and Central Line Associated Blood Stream Infections (CLABSI) in intensive care units.

Hand hygiene

Improved hand hygiene practices are linked to a reduction in healthcare-associated infection rates. All health services are required to participate in the National Hand Hygiene Australia Initiative. This initiative was established to implement a national hand hygiene culture-change program to standardise hand hygiene practice and placement of alcohol-based hand rub in every Australian hospital. For submission criteria see the Hand Hygiene Australia website <https://www.hha.org.au>.

Public reporting of individual hospital or health service hand hygiene compliance is via the My Hospitals website <https://www.myhospitals.gov.au> and the Victorian Health Services Performance website <https://performance.health.vic.gov.au/Home/Category.aspx?CategoryKey=5#Anchor>.

Healthcare worker influenza immunisation

Health services must take all reasonable steps to ensure staff members are protected against vaccine-preventable diseases. High coverage rates for immunisation in healthcare workers are essential to reduce the risk of transmission in healthcare settings.

Health services are required to report healthcare workers' influenza vaccination rates to the department annually. Information on the healthcare worker influenza immunisation program can be found at the Vaccination for healthcare workers webpage <https://www2.health.vic.gov.au/public-health/immunisation/adults/vaccination-workplace/vaccination-healthcare-workers>. It is expected that by 2022, 90 per cent of the healthcare workforce will receive an influenza vaccination annually.

Health service and hospital reporting requirements

Depending on the size and type of services provided, all public health services are required to provide data to the VICNISS for one or more of the above measures. This data is then submitted to the department for monitoring against the *Victorian health service performance monitoring framework* and associated *National Health Reform Agreement* performance measures.

The measure results are shared with health services through the Monitor, PRISM and Inspire reports.

2.5.1.5 Streamlining clinical trial research

The government continues to encourage clinical trial activity within health services. In particular, the department's framework for streamlining the ethical and scientific review of multisite clinical trials is managed centrally by the Coordinating Office for Clinical Trial Research. Since January 2015, the scope of this framework also includes multisite health and medical research projects.

The streamlining framework includes all human research that is conducted as a single site or multisite project. All health services participating in the Victorian framework to streamline ethical and scientific review should assist the consolidation of research activity information concerning Victoria's public hospital sector. This is done by using the electronic information platform nominated by the department to enter data for all ethics applications (both single and multisite) and research governance/site specific assessments for single and multisite studies involving human subjects. Additional data collection may be required at health services as determined by the department and communicated through the Coordinating Office for Clinical Trial Research.

Health services that participate in the review and those accepting single scientific and ethical review of research on human subjects involving multisite research at more than one public health service site are required to:

- sign the standard MOU between the department and the health service for the purpose of facilitating a single ethical review in Victoria – this has extended to the initiative involving national mutual acceptance of multisite ethical review for clinical trials and health and medical research in other jurisdictions that have joined national mutual acceptance
- have their ethics committees provide intra and inter-jurisdictional ethical review, certified with the National Health and Medical Research Council and accredited by the department in Victoria and comply with any additional accreditation requirements.

It is expected that health services participating in the streamlining of ethical and scientific review of multisite research will comply with all matters agreed in the MOU, including acceptance of a single ethics review decision by an accredited and certified human research ethics committee, reporting requirements, research governance obligations associated with the conduct of a research project. They must also ensure that electronic data is captured for national reporting of clinical trial activity under the directive of the Council of Australian Governments Health Council (COAG HC).

Health services hosting an accredited and certified human research ethics committee that reviews multisite clinical trials and health and medical research are required to demonstrate sufficient ethical reviews to maintain expertise.

Further information is available at the Clinical trial research webpage <https://www2.health.vic.gov.au/about/clinical-trials-and-research/clinical-trial-research>.

2.5.2 Community health clinical governance

Funded organisations receiving community health program funding are expected to have strong clinical governance systems and practices in place, to ensure the quality and safety of services. Organisations are required to review their clinical governance structures and have adequate internal documentation to ensure consistency and compliance with the *Victorian clinical governance policy framework*.

Accreditation is a key measure of the performance of organisational clinical governance and the management systems which underpin good governance.

Organisations that receive funding through primary health output group activities must be accredited by a body or entity that is accredited by the International Society for Quality in Health Care or the Joint Accreditation System of Australia and New Zealand. For governance and management standards, community health services are able to choose an accreditation body, which offers standards that are consistent with the governance and management requirements of the Human Services Accreditation. See the Human Services Standards webpage <https://dhhs.vic.gov.au/publications/human-services-standards> for details. Relevant quality standards could include the *National Standards for Disability Services*, EQuIP, ISO 9001:2015, the *National Safety and Quality Health Service Standards* and the QIC Standards.

Where the selected governance and management standards do not cover all gazetted requirements for registered community health services, these requirements will be included under the Funded Organisation Performance Management Framework.

Community health services are also guided by The Community Services Quality Framework and with Safer Care Victoria's Clinical Governance Framework.

All public dental services are required to be assessed against the *National Safety and Quality Health Service Standards*.

Performance monitoring of accreditation against the national standards by the department and Dental Health Services Victoria in 2019–20 will be undertaken as per the *Accreditation: performance monitoring and regulatory approach business rules* (2013).

2.6 Consumer rights and community participation

2.6.1 Australian Charter of Healthcare Rights in Victoria

The *Australian Charter of Healthcare Rights in Victoria* (the Charter) is based on the *Australian Charter of Healthcare Rights* (2008) and is aligned with the *Victorian Charter of Human Rights and Responsibilities Act 2006*. It describes and promotes the rights of patients, consumers and family members using the Victorian healthcare system. The charter specifies seven healthcare rights: access, safety, respect, communication, participation, privacy and comment. These rights are applicable across all funded organisations in Victoria. This includes public and private hospitals, general practice clinics, medical specialists, aged care services, disability services, mental health services, registered community health centres and allied health providers.

The aim of the Charter is to ensure that healthcare is provided in a manner that embodies the seven healthcare rights and is safe and of high quality. Access to the Charter is a requirement of the *National Safety Quality Health Service Standards* under the Australian Health Service Safety and Quality Accreditation Scheme.

The Australian Commission for Safety and Quality in Healthcare has undertaken a review of the *Australian Charter of Healthcare Rights* during 2018–19, in partnership with all States and Territories. Revisions to the national Charter are expected to be completed in 2019, including resources and strategies to improve Charter awareness and activation across the healthcare sector. The outcome of this work will inform future enhancements to the Victorian Charter, as well as system-level strategies to better embed the Charter into the foundations of Victorian healthcare. Safer Care Victoria will be contributing to this process and health services will be expected to be ready to implement the revised Charter and activation strategies during 2019–20.

The Charter is available in a variety of formats in Victoria, including audio file, Auslan video, Braille and 25 community languages, at the department's Australian Charter of Healthcare Rights webpage <www2.health.vic.gov.au/about/participation-and-communication/australian-charter-healthcare-rights>.

2.6.2 Consumer, carer and community participation

Safer Care Victoria has developed the Partnering in healthcare framework (2019) to support health services with practical strategies for consumer participation and partnerships between consumers and health professionals to deliver higher quality care that is safe, equitable and clinically effective. The Partnering in healthcare framework replaces Doing it with us not for us: Strategic Direction 2010–2013 (2011) and the Cultural Responsiveness Framework: guidelines for Victorian health services (2009). It states the expectations Victorians have about how we can improve partnering with consumers to achieve better outcomes. The framework the sector with a single integrated consumer participation in healthcare policy that aligns diversity, equity and consumer participation in response to the diversity of Victoria's population.

The framework comprises five domains that are interdependent and together can have a cumulative effect to produce better outcomes. The five domains are: Personalised and holistic; Working together; Shared Decision Making, Equity and inclusion; and Effective communication. The framework supports implementation of a new approach to strengthen person and family-centred healthcare, equity, health literacy, partnerships and participation across the Victorian healthcare system. It focuses on direct care, at the service and system levels to improve Victorians' participation and experience in their own healthcare. It is an iterative guide designed to bring consistency to how Victorians can participate in their own healthcare and clearly describes consumer priorities for health services, SCV and aligns with the department's priority areas.

The framework will be progressively implemented in public hospitals from February 2019.

All funded organisations are required to actively support and promote consumer, carer and community participation at all levels of healthcare, including support for community advisory committees. In achieving the baseline requirements of the policy, health services will be required to meet the second edition of the National Safety Quality Health Service Standards <https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/nsqhs-standards-second-edition>.

Under the *Carers Recognition Act 2012* people in care relationships, and the contribution of carers, need to be recognised by:

- Councils, within the meaning of the *Local Government Act 1989.*
- Organisations funded by government that are responsible for developing or providing policies, programs or services that affect people in care relationships.

The Act lists the principles that must be respected by councils and relevant funded organisations. These principles promote understanding of the significance of care relationships, and the people in them. The Act is supported by the *Victorian charter supporting people in care relationships*. Councils and relevant funded organisations are required to report on how they have met their obligations under the Act in their annual report. This may be as simple as including a paragraph detailing the actions taken during the year to comply with the Act.

Information, including legal responsibilities and obligations of local government and organisations, is available at the Supporting people in care relationships webpage <https://www2.health.vic.gov.au/ageing-and-aged-care/supporting-independent-living/supporting-people-in-care-relationships>.

2.6.3 Victoria's health experience

2.6.3.1 Victorian Healthcare Experience Survey

The Victorian Healthcare Experience Survey (VHES) seeks feedback from recent users of Victoria's public health services. It is a voluntary survey, focusing on both adult and paediatric inpatient and emergency department care as well as maternity care. These data are collected continually throughout the year. An independent organisation Ipsos is under contract to administer the survey on behalf of the Victorian Agency for Health Information.

The VHES program measures patient experiences. This enables identification of the areas where these experiences can be improved leading to actions that enhance person-and family-centred care. The program also provides health services, Safer Care Victoria, VAHI and the department with actionable results.

All questionnaires were developed in consultation with key stakeholders including clinicians and consumers. They were cognitively tested with consumers (and, where appropriate, carers) and piloted through a representative sample. The results include verbatim comments thematically streamed from survey respondents.

Annual program specific surveys have been established for community health services, specialist clinics, ambulance services, paediatric inpatient, paediatric emergency and palliative care services. In 2019 a state-wide Cancer Patients' Experiences of Care survey will be released.

The Victorian Agency for Health Information will continue in 2019–20 with its VHES program of reform, to ensure patient quality and safety is central to its design, and consistent with a patient-centred approach to service delivery. Key areas of focus will include the current length of the survey questionnaire, opportunities for inclusion of questions relating to patient reported outcomes and alternative approaches to measuring patient experiences in rural areas. In 2019, at the end of the current contract with Ipsos, an approach to market will be made for a survey administrator.

Health services will be kept updated on the progress of the review, and any changes to the VHES program.

2.6.3.2 Community Health Services Victorian Healthcare Experience Survey

All community health services are expected to participate in the Community Health Services Victorian Healthcare Experience Survey. As part of their participation in the annual survey, each service will be required to identify three areas of improvement using the Community Health Services Victorian Healthcare Experience Survey data. Community health services will report their performance under the three areas in their annual Quality Accounts.

2.6.4 Patient-reported outcome measures

Patient-reported outcome measures (PROMS) are data obtained from structured surveys of patients, conveying information about patients' assessments of their health-related quality of life. PROMS can be used to measure the health gain associated with a treatment of a disease or management of a chronic condition. They are particularly useful for providing information about a patient's health outcomes that are best known to the patient and best measured from the patient's perspective. They differ from data obtained from patient experience surveys, which focus on patients' experiences of care.

In 2019–20 the Victorian Agency for Health Information will run three PROMs initiatives:

1. Utility of PROs in Cancer Care
2. Closing the data feedback loop utilising Clinical Quality Registry patient reported outcomes data
3. Australian Orthopaedic Association Joint Replacement Registry PROMs Pilot

The outcome of these initiatives with inform the future approach to a rollout of PROMs.

2.6.5 Health service community advisory committees

Public health services listed under Schedule 5 of the *Health Services Act 1988* are required to have a community advisory committee. Health services should continue to work with their committee to ensure that consumer, carer and community participation are integrated into service development, quality improvement planning and other relevant activities across all levels of their organisation.

Public health services have been required to develop and report to the department on their community participation plan covering a one- to five-year period as part of each scheduled public health service's strategic plan.

Health services are no longer required to submit their community participation plan or progress report on implementation to the department. However, health services should continue to undertake relevant planning outlining the role of the community advisory committee, the health service's board and executive management to ensure that consumers, carers and community members are actively involved and supported to participate in service development, planning and quality improvement.

Primary care and population health advisory committees

Health services are required to have a primary care and population health advisory committee under the *Health Services Act 1988*. Health services should continue to work through these committees to consider the broader needs of the community.

2.6.6 Reporting on quality of care

All public health services, multipurpose services and registered community health services are required to produce an annual quality account. Safer Care Victoria will provide guidelines on the content and submission requirements for the quality account for 2019–20.

Further information, including contact details and recommended reporting guidelines, is provided at <https://bettersafercare.vic.gov.au/our-work/governance/quality-accounts>.

2.6.7 Partnerships

All funded organisations are encouraged to participate in locally relevant partnerships, local collaboratives and alliances with other health and human services organisations where appropriate.

The focus for State-funded Primary Care Partnerships is in prevention, access, equity and integration. The work of Primary Care Partnerships should align with the department's focus on place-based efforts, prevention and population health, family violence, the integration of health and social care and strategic partnership development or chronic disease management, where this work is already occurring or has been identified as a local need.

Commonwealth funded Primary Health Networks are charged with improving access to primary care services and ensuring better coordination of care with local health care providers. They do not deliver services but commission and integrate local services to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes.

The department has entered into a Memorandum of Understanding (MOU) with the six Victorian PHNs and the Victorian PHN Alliance to strengthen collaborative working arrangements. The MoU will support and enable the successful implementation of national and state health policies, including Mental Health, Alcohol and Other Drugs and will provide governance to support key joint initiatives.

The *Coordinated Care Bilateral Agreement* between the Victorian and the Commonwealth Government aims to improve the delivery of care for patients with chronic and complex conditions to improve health outcomes and reduce avoidable demand for health services through system integration and reform activities. PHNs have been implementing stepped models of care in Mental Health and look to build the capacity and capability of the mental health workforce and development of more effective mental health services.

2.6.8 Primary Health Network funding and emergency management

The department provides annual indexed funding of $15,484 to each of the six Primary Health Networks to support Victoria's response to an emergency event. This funding requires networks to be responsive in the event of an emergency and support the department by; participating in local, regional and health service emergency planning in line with the *State Health Emergency Response Plan* (SHERP) and to facilitate the department's access to general practitioners to work in a range of local, time-limited primary care settings, such as field primary care clinics.

The department requires Primary Health Networks to establish and enable communications with general practitioners; other primary care services; local emergency planning and response organisations, and neighbouring Primary Health Networks as requested in an emergency. The department also requires Primary Health Networks to provide intelligence to the department on local factors affecting the delivery of general practice and other primary healthcare, in and around areas affected by the emergency. The networks also aid the provision of recovery services after an emergency and document their activity during an emergency event.

2.6.9 Informed consent for receipt of services

Funded organisations are required to ensure all clients receiving services have had an opportunity to discuss options regarding their care and to provide full consent to the care they receive. Health services must ensure that their informed consent policy and processes comply with legislation and best practice. Evidence of informed consent should be documented in the client record. Whereby the client is regularly accessing services or treatment over an extended period of time it is best practice to review their consent periodically and ensure their decision-making capacity and their choices (which can change) are understood and documented and any necessary action taken to address the changes. Where necessary health services need to have processes that can identify a substitute decision maker if the patient does not have the capacity to make decisions for themselves. See NSQHS Standards – Healthcare rights and

informed consent <https://nationalstandards.safetyandquality.gov.au/2.-partnering-consumers/partnering-patients-their-own-care/healthcare-rights-and-informed-consent>.

2.6.10 Complaint management

All funded organisations are required to have effective and responsive complaint management systems in place, which are timely, appropriate and lead to improvements in quality and safety. All hospitals are required to have an identified person who is responsible for addressing patient concerns and who is visible and accessible to patients. The contact details for the identified person should be readily accessible (including on the hospital's website) and consumers must be able to meet with them in person within a week of initial contact.

Under the *Health Complaints Act 2016*, the Health Complaints Commissioner (HCC) is actively engaged in the health sector through training in complaints handling and the relevant laws governing health service and health records complaints. The HCC's revised Complaint Handling Standards (2019) expand on the interim standards originally specified within the Act. These revised standards stipulate the legislative requirements for health services in effectively managing complaints. The revised standards are available at the Health Complaints Commissioner website <https://hcc.vic.gov.au>.

Under the Act, the HCC has the authority to ensure that health service providers implement quality improvement recommendations made by the Commissioner during the complaint resolution process.

Training sessions regarding the Act, the role of the HCC and the expectations of health services are provided on the Health Complaints Commissioner website <https://hcc.vic.gov.au>.

2.6.11 Health service cultural and linguistic diversity requirements

The *Cultural responsiveness framework: guidelines for Victorian health services*, was evaluated in 2014 as part of the *Doing it with us not for us* summative evaluation.

Safer Care Victoria has developed the *Partnering in healthcare framework* to help improve participation of consumers and carers in healthcare, as well as healthcare experience and outcomes. The framework will be progressively implemented in public hospitals in 2019–20.

The framework will implement a new approach to strengthen person and family-centred healthcare, equity, health literacy, partnerships and participation across the Victorian healthcare system. It will focus on direct care, service and system levels to improve Victorians' participation and experience in their own healthcare.

All funded organisations are required to actively support and promote cultural responsiveness at all levels of healthcare. Health services should continue to report on the provision of accredited interpreters to patients who require one in the annual quality account. In achieving the standard and indicators of the policy, health services will be ensuring that they meet the *National Safety and Quality Health Service Standards*.

The department's *Language services policy* and accompanying guidelines, *How to work with interpreters and translators: a guide to effectively using language services*, support the department and its funded services in responding to the needs of linguistically diverse people, including migrants, refugees and people seeking asylum and those who use sign language. All health services are required to ensure completion of two data elements in the Victorian Emergency Minimum Dataset (VEMD) and VINAH collections relating to preferred language spoken and interpreter required as proxy measures of local demand for language services.

Refer to information about the *Language services policy* <https://dhhs.vic.gov.au/publications/language-services-policy-and-guidelines>.

2.7 Financial requirements

2.7.1 Health service procurement and purchasing requirements

Under the *Health Services Act 1988,* Health Purchasing Victoria has responsibility to:

- develop, implement and review policies and practices to promote best value and probity in relation to the supply of goods and services to health services, along with the management and disposal of goods
- ensure probity is maintained in purchasing, tendering and contracting activities in health services
- provide advice, staff training and consultancy services in relation to the supply of goods and services to the health sector
- monitor compliance by health services with purchasing policies and Health Purchasing Victoria directions and to report irregularities to the Minister for Health.

The Health Purchasing Policies establish a procurement policy framework for health services incorporating the strategic approach and guidance of the Victorian Government Purchasing Board (VGPB) policies. These policies are mandated for all Schedule 1 and 5 health services and may be viewed on the Health Purchasing Victoria website at <https://www.hpv.org.au/resources/health-purchasing-policies/>.

To meet its responsibilities in monitoring health service compliance with Health Purchasing Policies and reporting irregularities to the Minister for Health, Health Purchasing Victoria has developed a compliance framework that includes support and prevention activities such as education, training, advice and guidance, as well as monitoring. All mandated health services must:

- Complete an annual compliance self-assessment requiring:
  - Compliance with Health Purchasing Policies and the Health Purchasing Victoria Collective Agreements.
  - The self-assessment to be approved and submitted to Health Purchasing Victoria by the health service chief executive officer (CEO) or delegated officer for inclusion in the Health Purchasing Victoria annual report.
- Complete compliance audits to the Health Purchasing Policies:
  - As per the *Health Services Act 1988*, Health Purchasing Victoria requires the CEO of a mandated health service to audit compliance with Health Purchasing Policies.
  - Health services are required to audit their compliance to the policies once every three years as per Health Purchasing Victoria's rolling audit program. Health services are required to provide the final audit report to Health Purchasing Victoria by 30 June in the year the audit is scheduled.
  - Findings identified as part of the compliance audits will be reported to the Health Purchasing Victoria Board and monitored until the health service has addressed and closed the issues. Health Purchasing Victoria has a responsibility to report high-risk areas of non-compliance to the Minister for Health.
- Provide information and data on procurement activities:

Health Purchasing Victoria can require the CEO of a mandated health service to provide information and openness and probity in purchasing, tendering and contract activities.

Health services should ensure the following overlapping probity directives are met:

- Mandated health services must be compliant with the Health Purchasing Policies to support best-value procurement.
- Health services are required to ensure their probity controls take into consideration recommendations contained in the Victorian Ombudsman's report *Probity controls in public hospitals for the procurement of non-clinical goods and services* <https://www.ombudsman.vic.gov.au/Publications/Parliamentary-Reports/Probity-controls-in-public-

hospitals-for-the-procu> and the Victorian Auditor-General's report *Procurement practices in the health sector* <https://www.audit.vic.gov.au/report/procurement-practices-health-sector>.

All health services are encouraged to complete the probity training provided by Health Purchasing Victoria for health service management and staff with procurement responsibilities. Health services are also encouraged to consult with Health Purchasing Victoria on any high-value or high-risk procurement activities.

2.7.2 Compliance with financial requirements

Section 30(2) of the *Health Services Act 1988* requires registered funded agencies to obtain approval from both the Minister for Health and the Treasurer before seeking financial accommodation. An approved borrower may obtain financial accommodation, whether within or outside Victoria, secured or arranged in a manner and for a period approved by the treasurer. These borrowings are guaranteed by the state.

Section 44 of the *Ambulance Services Act 1986* requires an ambulance service to obtain approval from the Treasurer before seeking financial accommodation. An approved borrower may obtain financial accommodation, within Australia, secured or arranged in a manner and for a period approved by the treasurer.

All registered funded agencies and ambulance services must obtain the appropriate approvals prior to seeking to borrow funds from third parties and prior to entering into third-party finance arrangements for any overdrafts, borrowings or finance leases. These funds may be for purposes such as capital works and equipment expenditure.

The Standard Motor Vehicle Policy issued under the authority of the Minister for Finance now mandates the acquisition of new vehicles through VicFleet, which is funded through the government's finance lease facility. Under these requirements, all registered funded agencies and ambulance services are approved borrowers for the purpose of motor vehicle finance leases obtained through VicFleet asset acquisition and disposal.

Registered funded agencies and ambulance services must not enter into any expenditure related to equipment purchases, capital works or purchase or disposal of real property where the estimated total costs, real property value or total end costs of the works exceeds ten per cent of the annual revenue of the agency or health service or $2 million (whichever is the lesser amount) unless:

- the agency or health service has provided a detailed business plan relating to the proposed expenditure to the Secretary of the department
- the expenditure has been approved by the Secretary to the department.

The Secretary's approval in relation to any expenditure referred to the above clauses does not imply or in any way obligate the Secretary or the department to provide any financial support for the works.

2.7.2.1 Operating leases

From 1 July 2019 compliance with AASB16 *Leases* will require most operating leases (the exceptions being low value leases and leases of less than 12 months duration) to be reported on the balance sheet and it will be mandatory for all balance sheet leases to be reported in the lease software provided by the department.

All leases are also required to be assessed to determine whether they include a Financial Accommodation as defined by the *Borrowing and Investment Powers Act 1987* (which is referenced in the *Health Services Act 1988*) and health services are required to follow the existing processes for approving a lease that includes a Financial Accommodation (borrowing). As a guideline, leases that would have been accounted for as an operating lease under the previous lease standard are deemed not to include a financial accommodation.

Lease commitments should continue to be undertaken in accordance with the *Victorian Government Risk Management Framework* (2015). The framework adopts the Australian and New Zealand Standard

AS/NZS ISO 31000:2009 *Risk Management – Principles and Guidelines*, which provides a generic, internationally accepted basis for best practice risk management.

All agencies must fully comply with the requirements of Ministerial Standing Direction 3.7.1 *Risk management framework and processes*, and are responsible for appropriately identifying, assessing and managing all risks to which they are exposed. Agencies should establish and maintain effective risk governance that includes an appropriate internal management structure and oversight arrangements for managing risk. The responsible bodies are directly accountable for their organisation's risk management obligations.

Even though the accounting distinction between operating and finance leases does not exist, there is still a legal distinction between operating and finance leases based on the transfer of rights between the lessor and lessee. This means that the definition of Financial Accommodation under the Borrowing and Investment Powers Act 1987 (which is referenced in the Health Services Act 1988) does not include operating leases. As such, there is no change to the processes for approving operating leases and borrowings for health agencies.

See information about the Victorian Government Risk Management Framework <https://www.dtf.vic.gov.au/planning-budgeting-and-financial-reporting-frameworks/victorian-risk-management-framework-and-insurance-management-policy>.

2.7.2.2 Investments

Ministerial Standing Direction 3.7.2 *Treasury management, including Central Banking System* requires all public sector entities, including public hospitals, to ensure that all money, subject to the exceptions identified in the Standing Direction, be deposited within the Central Banking System unless an exemption has been provided by the Treasurer.

Exemptions include money held on trust by the Agency for, and repayable to, a known beneficiary pursuant to a statutory function or where the Treasurer has provided an exemption under Direction 1.5(b). This means that:

- Investments that health services currently hold with the Victorian Funds Management Corporation and other compliant managed funds are not required to be transferred to the Central Banking System, where these investments were in accord with the previous version (February 2016) of the Standing Directions
- Funds raised by hospital auxiliaries or community fundraising are not required to be transferred to the Central Banking System. In recommending the establishment of the Central Banking System (and as subsequently approved by the Treasurer) the Department of Treasury and Finance specifically addressed the issue of money receipted by agencies from a specific donation (i.e. a bequest, parents and friends or hospital auxiliaries).

2.7.3 Goods and services tax

Funded organisations must register for an Australian Business Number and register for goods and services tax (GST) if required. Each funded organisation is responsible for its own tax compliance and liabilities.

Funding between one government-related entity and another government-related entity that is sourced from appropriations and for non-commercial activity is outside the scope of GST pursuant to s. 9–17(3) of the *Goods and Services Tax Act 1999*. Funding from the department to non-government organisations are taxable supplies.

Public hospitals and Ambulance Victoria are government-related entities under s.8 and s. 41 of the *Australian Business Number Act 1999*.

2.7.4 Strategic procurement

Health Purchasing Victoria and health services are collaborating on a strategy to expand the definition of 'best value' procurement to better meet health service needs and improve patient outcomes.

Health services support a more versatile operating model for Health Purchasing Victoria that encourages a more strategic approach to procurement, involving long-term category management strategies to drive improved financial and patient outcomes.

Health Purchasing Victoria is committed to deploying a common catalogue across the state to support high-quality patient care. The common catalogue improves efficiencies for health services and suppliers by integrating supply chain data into the patient care cycle.

In addition, Health Purchasing Victoria continues to support the implementation of Bravo as a contract management and sourcing system as well as the implementation of electronic data interchange (EDI) capabilities.

2.8 Asset and environmental management

Asset management is the coordinated activities, carried out over the asset's whole lifecycle, to realise the full value from assets in delivering their service delivery objectives. Realisation of value will normally involve a balance of costs, risks, opportunities and performance benefits.

Health services are required to manage, maintain and replace assets in accordance with the Standing Directions of the Minister for Finance under the *Financial Management Act 1994* and the Victorian Government's *Asset Management Accountability Framework* (AMAF).

The Standing Directions of the Minister for Finance made under the *Financial Management Act 1994* requires the Chief Executive Officer of funded organisations (health services) to attest compliance with the requirements of AMAF in their annual reports, and that their organisation is compliant with the requirements of AMAF. In meeting its compliance with the AMAF, the department requires health services to submit annual asset management plans and maintenance assets registers.

This requirement is for all the physical asset classes held and extends across all stages of the lifecycle, including planning, acquisition, operation and maintenance and disposal.

The Chief Executive Officer of funded organisations (health services) is required to assign responsibility, accountability and reporting requirements, and to establish and maintain management processes to plan, report, monitor and assess controlled assets.

Consistent with Victorian Government policy expressed in AMAF, the department expects asset management governance, planning and practice in funded organisations to be consistent with the scale of their organisation.

The health service board should be regularly informed about the status of asset performance and any material risk posed in addition to any planned timing of specific investment or disinvestment.

Health services should refer to the *Asset Management Policy (2018)* <https://vhhsba.vic.gov.au/sites/default/files/VHHSBA-Asset-Management-Policy-2019.pdf> and the *Strategic Asset Management Plan (2019)* and associated guidelines for further information when developing their asset management plans.

Further information on the Victorian government's asset management framework is available at the Asset management webpage <https://www.dtf.vic.gov.au/infrastructure-investment/asset-management-accountability-framework>.

2.8.1 Asset management strategy and planning

Health services need to systematically identify their service delivery and asset needs over time, to establish a plan on how to manage their entire asset base and how to manage individual assets throughout their lifecycle.

A key requirement of the Victorian Government's *Asset Management Accountability Framework* is an asset management strategy. The asset management strategy should consider various options to achieve the desired service delivery results, and include an evaluation of the costs, benefits and risks associated with each option.

Effective asset management planning relies on strong governance, aligned corporate leadership and the input of key affected and specialist groups across the health service. It also requires ongoing strategic oversight to facilitate prudent risk assessment, asset allocation, overall asset management planning quality and implementation.

Each health service is required to submit an asset management plan for 2019–20 detailing how they are managing their asset base.

2.8.1.1 Asset Management Plans

As part of the assurance framework for appropriate management of assets, health services are required to annually submit asset management plans to the Victorian Health and Human Services Building Authority no later than 30 September covering (as a minimum) summary asset data, asset performance, current condition, asset risk, demand analysis, maintenance program, renewal forecast (operation and capital), disposal plan and resourcing plan.

Asset management plans are to be submitted with the department annually at the end of September in order to receive appropriation of their Infrastructure Renewal Contribution grant.

Further information, and templates are available at the Asset management webpage <http://www.capital.health.vic.gov.au/Asset_property_management_and_operations/Asset_management>.

2.8.1.2 Reporting

As a condition of funding, all 2018–19 specific-purpose capital grant expenditure is required to be reported as part of Agency Information Management System (AIMS) by the end of September 2019. The report needs to correlate with the lodged health service asset management plans to demonstrate effective asset management planning and prioritised replacement of in-scope assets. This annual reporting helps demonstrate financial and asset accountability (including potential audits) and that critical risk mitigation is achieved.

2.8.1.3 Planning and implementation

Health services should use their asset management plans to prioritise asset replacement according to critical risk and to guide investment of specific-purpose capital grants at the health service level. The devolved funding model facilitates responsive and flexible time-critical replacements, enabling a health service to intervene to avert unacceptable clinical service interruptions or failures.

Health services may also submit for funds to replace high-value engineering infrastructure or medical equipment. Consistent with prioritisation and rationing requirements, health services are required to fund the installation and infrastructure associated with the replacement of the high-cost medical equipment, or the scoping of the works/tender documentation for high-cost engineering infrastructure. Health services may choose to use their specific-purpose capital grant for this purpose if it is considered by the health service to be the highest risk of all the outstanding in-scope assets.

2.8.1.4 Accountability

Specific-purpose capital grants must be managed and invested in accordance with health service or hospital board fiduciary responsibilities and as set out in the program guidelines.

Health services reporting on asset replacement under the initiative are required to demonstrate financial and asset accountability, including investment against asset management plans. Grant reporting will be used for both accountability and policy and practice development purposes.

The level of grant is conditional upon meeting funding requirements – risk-based prioritisation of investment aligned with health service asset management plans.

Where health services have not fully acquitted received capital funding, the Victorian Health and Human Services Authority may recall distributed funds for reallocation to other high-risk projects across the sector.

2.8.1.5 Procurement of medical assets

Health services must comply with government policies and guidelines in their procurement activities.

The department requires health services to engage early and work collaboratively with Health Purchasing Victoria to maximise value-for-money procurement of medical equipment and deliver the

most efficient purchasing arrangements, including standardisation and bulk purchasing and achievement of economies of scale.

For further information, refer to procurement and purchasing requirements and the Health Purchasing Victoria website <http://www.hpv.org.au>.

2.8.1.6 Disposal of assets

Planning for disposal should start well before the economic life of the asset has ended or the need for service has finished. It should incorporate consideration of unplanned disposals or destruction of assets.

Health services must comply with relevant approval processes and, where possible select a disposal method including retirement, replacement, renewal or redeployment that maximises the financial benefits associated with the disposal.

The asset status should be updated in the asset management plan and asset register.

2.8.2 Property portfolio management

Property portfolio management supports the delivery of services from real property assets. In this context, real property means both the land and the buildings attached to that land.

Health services are required to actively manage their property portfolios to ensure real property assets under their control or ownership are fully utilised and realise full service delivery potential.

Health services must:

- maintain an accurate dataset of all real property assets and annually review landholdings in accordance with the Victorian Government landholding policy
- ensure formal tenure agreements are executed on all land which is department owned or controlled (such as Crown land Committee of Management)
- ensure all real property transactions undertaken comply with the requirements of all relevant legislation, ministerial directions and Victorian Government policy (such as the *Land Transactions Policy and Guidelines*).

It is desirable that real property assets under health service management are zoned appropriately for current or proposed use and health services consolidate multiple freehold parcels held under separate titles to simplify future property management activities.

As funded organisations seek to best match services to patient needs, service agreements with third parties will require legal tenure agreements relating to the occupation of premises that adequately address legislative and service requirements and related risks. Where tenure agreements are proposed for premises located on Crown land, funded organisations must ensure they have the right to enter into such agreements and must comply with legislative requirements and government policy regarding their implementation.

Further information on government land policies and processes, including Crown land management, is available at the Property management – Related legislation, policies and guidelines webpage <http://www.capital.health.vic.gov.au/Property_Management/Related_legislation_policies_and_guidelines>.

2.8.3 Asset maintenance

In accordance with the Victorian Government's *Asset Management Accountability Framework*, Clause 3.4.3 requires the establishment of systems and processes for undertaking maintenance activities.

Maintenance is defined as 'a combination of all technical, administrative and managerial actions during the life cycle of an item intended to retain it in, or restore it to, a state in which it can perform the required function'.

Asset maintenance enables targeted action to be undertaken in a timely and cost-effective manner. This helps the asset portfolio to remain safe and reliable for the lowest possible long-term cost.

Health Services are responsible for providing appropriate maintenance activity within the right frequency for assets under their direct or indirect control to ensure asset risks are being mitigated or eliminated during the lifecycle in order to:

- keep them in an appropriate condition for the health services they support;
- prevent service delivery interruptions or service quality risks;
- minimise risks to patient safety and occupational health and safety; and
- Ensure long-term service performance.

The *Maintenance standards for critical areas in Victorian health facilities* <https://www2.health.vic.gov.au/about/publications/researchandreports/maintenance-standards-for-critical-areas-in-victorian-health-facilities> provides a set of general and additional maintenance standards that should be applied to all critical areas in hospitals and health services.

2.8.4 Critical Asset Service Failure

In accordance with the Victorian Government's *Asset Management Accountability Framework*, Clause 3.1.5 requires appropriate risk management strategies and processes to support the establishment of asset management, including processes to identify and maintain assets that are at risk of critical service failure.

Within business continuity plans, health services are required to define critical assets, recovery procedures for systems as well as processes for the management of emergency events and issues within its operational context, capability and associated risk.

In the event of a critical asset service failure, health services are required to provide a summary incident report detailing the critical asset service failure and the corrective action to the Victorian Health and Human Services Building Authority within four weeks of the incident.

2.8.5 Health Service environmental management and planning and reporting

In order to assist health services to manage their environmental impact and increase their operational efficiency, health services are required to develop and implement a whole-of-organisation environmental management plan and report publicly on environmental performance.

The environmental management plan is to focus on the organisation's material environmental impacts, which could include energy, carbon, water, waste and procurement. Health services are encouraged to expand the plan to include all sites under their control.

Health services are to report publicly on environmental performance in accordance with the department's *Environmental reporting guidelines*. As a minimum health services are to publicly report environmental data relating to carbon, energy, water, waste and transport (fleet and air travel). The environmental data management system produces a standard report, which meets these reporting guidelines.

A template environmental management plan and the environmental reporting guidelines are available at the Environmental management planning and reporting webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/planning-infrastructure/sustainability/planning-reporting>.

Health services are to report any energy, water, waste and paper data, which is not centrally uploaded, in to the environmental data management system. The reporting of medical gases and refrigerant data is encouraged but is not mandated for the 2019–20 reporting year. The environmental data management system can be accessed at the Edensuite website <https://dse.edensuite.com.au>.

2.9 Information and communication technology standards

The Digital Health Branch, through the department's health systems manager role, aims to ensure health services operate their ICT safely, securely, cost-effectively and in alignment with Victorian and national digital health strategies.

Health services have accountability and responsibility through their boards for deploying ICT and digital health technology to support service delivery within their health service, based on their local needs.

The *Digitising health* strategy was endorsed by the Minister for Health in November 2016. The department, in partnership with health services, has primary accountability for delivering the outcomes and realising the benefits from *Digitising health*.

Health services are required to work with the Digital Health Branch within the department to develop and agree digital health initiatives that:

- align to the *Digitising health* strategy
- adhere to architecture and interoperability standards that enable the sharing of clinical information across the health sector.

2.9.1 Governance

The Victorian Health Chief Information Officer Forum (VHCIOF) meets monthly. It is the sector's primary information sharing and decision-making forum, seeking to achieve a consistent and interoperable public health system for Victoria. VHCIOF is chaired by a health service CIO, with secretariat provided by the Digital Health Branch. All health service and Rural Health ICT Alliance CIOs (or their equivalent) are expected to attend on a regular basis, and contribute to the working groups that support VHCIOF. These are:

- cyber security
- ICT operational assurance
- Microsoft licensing
- Clinical Grade Network
- image-sharing.

2.9.2 Statewide programs

Through VHCIOF and its working groups, health services are expected to align with and participate in sector wide initiatives. These include Unique Patient Identification (UPI), the Victorian health sector cyber security program, and ICT operational assurance.

2.9.2.1 Strategic investments

Prior to approaching the market for strategic ICT investments, health services are required to seek approval from the Secretary, Department of Health and Human Services (via the Digital Health Branch) This includes business projects with a strategic ICT component. Strategic projects should align with *Digitising health* strategy and where there is ambiguity, health services should consult with the Digital Health Branch.

Health services are required to report their ICT strategies, plans and projects to the Digital Health Branch. The Branch has a planning and assurance role for the sector, to ensure:

- minimum levels of ICT capability are in place to support safe clinical care
- appropriate project governance and planning is in place to support the delivery of successful ICT-enabled health service projects.

All health service projects with an ICT component greater than $1 million must be reported to the Department of Premier and Cabinet for inclusion in the ICT project dashboard, for reporting to the government on public sector ICT activities. Additionally, all projects on this dashboard with ICT budget $10m and above are to be subjected to independent project quality assurance.

2.9.3 ICT incidents

Digital Health in its role as System Manager needs to be informed of unscheduled critical or major ICT incidents when they occur in health services. In many cases, the Digital Health Branch and the department's Health Technology Solutions can contribute to resolution of incidents.

Critical incidents are those that impact the delivery of quality and safe care to patients. These are to be reported to the department within one hour of the incident occurring.

Critical incidents also include data breaches and cyber incidents. For more information on cybersecurity, please refer to the *Victorian Public Health Sector – Cybersecurity Incident Management Plan.*

Major incidents are those that place the delivery of patient safety and care at risk. Incidents that may have a significant clinical impact on business processes are also included in this classification. Major incidents are to be reported within two hours of occurrence.

2.9.4 Health ICT standards

Adoption of health ICT health standards enhances patient safety and supports continuity of care across settings, as specified in the *Statewide Health Strategic ICT Framework* (2015) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Statewide-Health-ICT-Strategic-Framework>.

The health ICT standards cited below are specified on the Catalogues and guides webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/planning-infrastructure/health-design-authority/catalogues-guides>.

Funded health services must comply or align with these standards when planning or implementing digital health and ICT projects:

- National terminology for enterprise-wide electronic medical record (EMR) implementations: Australian standard terminology (SNOMED-CT-AU) and the Australian Medicines Terminology (AMT).
- The prevailing Australian version of the Health Level 7 (HL7), as referenced on the Digital Health Digital Design website for use in Victoria. Currently the recommended Victorian standard is HL7 v2.4.
- Interaction with the My Health Record system and the requirements of the *My Health Record Act 2012* (Cwlth) will enhance the safety and continuity of patient care. This includes the ability to apply national individual healthcare identifiers (IHIs) for patients, healthcare provider identifiers for individual clinicians (HPI-Is) and healthcare provider identifiers for organisations (HPI-Os), as well as other requirements under the *Healthcare Identifiers Act 2010* (Cwlth). These identifiers should be incorporated into all new or updated applications as defined in the minimum interoperability requirements).
- Interactions with My Health Record are also cited in Action 1.17 and Action 1.18 of the National Safety and Quality Standards <https://www.nationalstandards.safetyandquality.gov.au/1.-clinical-governance/patient-safety-and-quality-systems/healthcare-records>.
- Similarly, standard national clinical documents including *eReferral*, *Discharge Summary*, *Shared Health Summary* and *Event Summary* are specified at Clinical documents – Australian Digital Health Agency website <https://developer.digitalhealth.gov.au/specifications/clinical-documents>.
- The *National Product Catalogue* and associated standards and specifications are specified by GS1 at the National Product Catalogue website <https://www.gs1au.org/our-services/national-product-catalogue>.
- Adoption of the *National Health Services Directory* as the primary source for services directory and location information.

- Alignment with the *National ehealth security and access framework* (NESAF) <https://www.digitalhealth.gov.au/implementation-resources/ehealth-foundations/national-ehealth-security-and-access-framework> maintained by the Australian Digital Health Agency through its national Cybersecurity Centre. The NESAF can be found at.
- Compliance with the *Health Records Act 2001* Health Privacy Principles for security of health information and for storing personal and sensitive information outside of Victoria.
- Compliance and alignment with international standards for Cybersecurity: ISO27001/2, and ISO27018 and the National Institute of Standards and Technology (NIST) *Cybersecurity Framework*.
- Alignment with Standards Australia's *Digital Hospital Handbook* <https://www.standards.org.au/news/new-australian-publication-to-accelerate-digital-hospitals>.
- Alignment with the *Electronic Medications Management Systems – A guide to safe implementation* maintained by the Australian Commission on Safety and Quality in Health Care (ACSQHC).
- Alignment with National Guidelines for On-Screen Display of Medicines Information and National Guidelines for On-Screen Display of Discharge Summaries maintained by the Australian Commission on Safety and Quality in Health Care.
- ACSQHC reference documents can be found at Safety in e-Health – Australian Commission on Safety and Quality in Health Care website <https://www.safetyandquality.gov.au/our-work/safety-in-e-health>.

The Australian Digital Health Agency (the Agency) website is a useful source of reference material for digital health planning. Technical specifications can be found at the Agency's Resources for Implementers and Developers webpage <https://digitalhealth.gov.au/implementation-resources>.

The information contained on the site is subject to changes in both standards and their policy settings. Health services are required to always review the information on the Digital Health Branch website. This references information from the Agency, but includes specific Victorian extensions and other local information that take account of the Victorian legislative and policy framework.

2.10 Risk management

2.10.1 Risk management and assurance

Risk management and assurance activities are essential components of good corporate governance for all funded organisations. These activities will facilitate better service outcomes and quality care, and minimise claims and losses.

2.10.1.1 Risk management

The *Health Services Act 1988*, *Public Administration Act 2004* and the *Financial Management Act 1994* require funded organisations to have effective and accountable risk management systems and strategies in place.

Management and the board are responsible for their organisation's governance, risk management and control processes. Internal auditors assist both management and the audit committee by examining, evaluating, reporting and recommending improvements on the adequacy, efficiencies and effectiveness of these processes.

To ensure risks are being managed in a consistent way, some funded organisations are required under the department's service agreement, Direction 3.7.1 of the *Standing Directions of the Minister for Finance* and the *Victorian Government Risk Management Framework* to attest annually that the responsible body is satisfied that:

- the organisation has a risk management framework in place consistent with *AS ISO 31000:2018 Risk Management – Guidelines*
- the risk management framework is reviewed annually to ensure it remains current and is enhanced, as required; and supports the development of a positive risk culture within the organisation
- the risk management processes are effective in managing risks to a satisfactory level
- it is clear who is responsible for managing each risk
- inter-agency risks are addressed, and the organisation contributes to the management of shared risks across government, as appropriate
- the organisation contributes to the identification and management of state significant risks, as appropriate
- risk management is incorporated in the organisation's corporate and business planning processes
- adequate resources are assigned to risk management
- the organisation risk profile has been reviewed within the past 12 months.

An organisation's risk management framework can consist of the following components:

- a risk management policy and plan that integrates with corporate planning
- risk registers and profiles
- an incident management system (refer to Chapter 2, section 2.1.2.5 'Patient and client safety')
- risk management tools, templates and training
- business continuity and emergency management plans
- compliance and quality systems
- a fraud and corruption control plan.

These components assist funded organisations in developing an effective risk-aware culture that includes clinical and all other operational activities.

Health services should articulate how they are managing asset related risk in their asset management strategy as developed as part of their compliance with the *Asset Management Accountability Framework*

For more information on risk management, refer to AS ISO 31000:2018 Risk Management – Guidelines <https://infostore.saiglobal.com/en-au/Standards/AS-ISO-31000-2018-1134720_SAIG_AS_AS_2680492> and *HB 158:2010 Delivering assurance based on ISO 31000:2009: Risk management – principles and guidelines* <https://infostore.saiglobal.com/en-au/Standards/HB-158-2010-129591_SAIG_AS_AS_274229>.

2.10.1.2 Assurance activities

Assurance activities are designed to provide independent conclusions and a degree of confidence regarding the outcome of the evaluation or measurement of the subject matter against predetermined criteria. The subject matter can take many forms such as:

- corporate governance practices
- effectiveness and efficiency of operations
- systems, processes, people and performance
- data reliability, completeness, integrity and availability
- accreditation and certifications
- patient or client outcomes and satisfaction
- compliance with laws, regulations and contracts.

Attestations, internal and external audits, accreditations and surveys are some categories of assurance activities that funded organisations may use to provide independent and reasonable assurance to their board, audit committee and management that they are on track to achieve their objectives.

An organisation's assurance framework can consist of the following components:

- an assurance strategy and internal audit charter linked to organisational objectives
- an assurance map detailing the sources of all assurance activities
- a risk-based assurance and audit plan outlining planned activities
- registers and reports to track implementation progress of recommendations
- key performance indicators of assurance activities.

2.10.1.3 Integrity governance

All health services must have the appropriate assessment and mitigation strategies in place to ensure better integrity practice across their organisation. The *Integrity Governance Framework and Assessment Tool* has been developed as a better practice assessment and reporting tool to guide and support better integrity practice. The tool focuses on four domains of integrity risks within a health service; employment principles and personnel, procurement, contract and project management, finance and governance. Refer to the Integrity Governance Framework and Assessment Tool <https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/integrity-governance-framework>.

Health services will also be required to attest that appropriate internal controls exist to review and address integrity, fraud and corruption risks in their Annual Reports.

2.10.2 Emergency management

2.10.2.1 Health and human services sector emergency preparedness policy

The department's *Health and human services sector emergency preparedness policy 2018–19* supports the health and human services sector to maximise the health, wellbeing and safety of Victorians who access their services before, during and after emergencies.

The policy requires the health and human services sector to prepare for and respond to emergencies. It achieves a consistent sector-wide approach to preparing for emergencies, whilst considering the need for local flexibility and individual client needs.

Compliance requirements of funded agencies are outlined in the policy.

The policy and other emergency management information relevant to funded organisations is available at the Emergency preparedness webpage <https://providers.dhhs.vic.gov.au/emergency-preparedness>.

2.10.2.2 Vulnerable people in emergencies policy

The *Vulnerable people in emergencies policy* assists funded organisations to improve the safety and wellbeing of people who are vulnerable in emergencies through personal emergency planning.

The policy applies to in-home and community-based services that are delivered within the 64 municipal council areas wholly or partly covered by Country Fire Authority (CFA) districts.

The *Vulnerable people in emergencies policy* and relevant guidelines are available at the Emergency preparedness webpage <https://providers.dhhs.vic.gov.au/emergency-preparedness>.

2.10.2.3 State health emergency response arrangements

The *State health emergency response plan, edition 4* (SHERP4) is a subplan of the *Victorian State emergency response plan.* It outlines the arrangements for coordinating the health response to emergency incidents that go beyond day-to-day business arrangements. Under these arrangements, the department's key health responsibilities include Control Agency for public health emergencies and managing the health response during any emergency.

Such emergencies are complex incidents and local resources may not be able to respond effectively to emergencies such as mass casualty and complex trauma incidents, mass gatherings and other incidents that can affect the health of Victorians.

SHERP4 is supported by a suite of operational response plans and protocols that provide additional detail to support the health sector before during and after emergencies.

SHERP4 and the operational response plans, protocols and guidelines make up the State Health Emergency Response Arrangements and are available at the State Health Emergency Response Arrangements webpage <https://www2.health.vic.gov.au/emergencies/shera>. Plans relevant to health services include:

- *Code Brown guidelines* – each health service and facility is required to have a site-specific Code Brown plan to manage a significant surge in demand in emergency presentations resulting from an external emergency.
- *Emergency Incident Casualty Data Collection Protocol* – each health service is required to provide casualty information related to an emergency incident when the protocol is activated by the department.

Copies of SHERP4, the *Code Brown guidelines* and the *Emergency Incident Casualty Data Collection Protocol* are available at the State Health Emergency Response Arrangements webpage <https://www2.health.vic.gov.au/emergencies/shera>.

Emergency incident notifications to the department

- The CEO or delegated officer of a health service is required to notify the department:
  - when they become aware of a notifiable public health incident (refer to the list of notifiable conditions and the timeframes in which to notify at the Notify a condition webpage <https://www2.health.vic.gov.au/public-health/infectious-diseases/notify-condition-now>
  - immediately, upon declaration of a Code Brown emergency
  - immediately, following declaration of any other emergency, where that emergency is likely to have an impact on any other or all health services in Victoria
  - as soon as practicable following activation of any other emergency arrangements or awareness of an emergency incident where the emergency is likely to have an impact on service continuity (for example, an energy disruption that results in declaration of a code yellow emergency).

- Notifications are to be made in accordance with the State Health Emergency Response Arrangements.
- Stand down notification must also be provided once the event has concluded.

Hospital single contact points for emergency management

Each health service must maintain a 'hospital single contact point' for emergency management purposes, comprised of the following:

- a 24/7 mobile phone number (to receive SMS early advisory notifications)
- a 24/7 generic email address (to receive first wave email notifications and other emergency management correspondence)
- a 24/7 contingency landline number (preferably a direct line as opposed to a switchboard, for use if mobile communications are down)
- an internal process that embeds the hospital single contact point arrangements within their organisation as appropriate.

Health services are strongly encouraged to introduce or maintain a hospital single contact point arrangement that is not tied to an individual within the organisation, to ensure the 24/7 operability of the contact point.

Further detail, including maintenance of the arrangements can be found in the *Hospital single contact point factsheet.*

Real-time Health Emergency Monitoring System

For emergency management and broader health system management purposes, the department has a need to access unvalidated data at any time to more immediately understand the issues affecting the sector. This is especially the case if issues are across geographic areas or the whole health system.

Public health services must have systems in place to enable the electronic transmission and integration of a health service's data into departmental data collection systems, such as, but not limited to, the Real-time Health Emergency Monitoring System (RHEMS).

Ongoing connection to data collection systems should also be factored into any ICT upgrades to ensure continuity of current applications. Any unvalidated data received is not used to formally measure performance against key performance indicators, which can only be based on validated data.

2.10.3 Fire risk management

Funded organisations are responsible for ensuring they comply with the department's Capital Development Guidelines on Fire Risk Management relevant to the premises they operate. The guidelines are available at < http://providers.dhhs.vic.gov.au/fire-risk-management-procedures-and-guidelines >.

Any building surveyor, fire safety engineer or auditor appointed for any works must be accredited by the department. A list of accredited practitioners is at the Fire risk management accreditation webpage <https://providers.dhhs.vic.gov.au/fire-risk-management-accreditation>.

Funded organisations are responsible for ensuring they comply with all laws, regulations and mandatory standards relating to fire and life safety in buildings (also includes protection from external threats such as bushfire), and general safety requirements that apply to any premises from which the funded organisation operates – irrespective of whether the relevant regulatory requirements place the obligation on the owner or occupier of those premises.

Key fire risk management requirements include the following:

- Funded organisations must ensure that appropriate operational readiness measures are developed, implemented and reviewed. In doing so, funded organisations should prepare for, respond to and recover from emergencies in accordance with the 'all hazards' approach. This includes bushfire, flood, relocation and evacuation and prolonged service interruption.
- Funded organisations must also ensure that essential services are maintained.

- Funded organisations must comply with the department's capital development guidelines on fire risk management.
- At the time of client placement in any premises, funded organisations must ensure that the premises comply with all laws relating to fire protection, health and general safety that apply to any premises from which the organisation operates.
- Funded organisations must also ensure that the premises are suitable for efficient client evacuation, taking into account the fire systems installed, and the relocation and evacuation capacities of the client. If any relevant change occurs that may affect a client's ongoing ability to evacuate safely, the suitability of the placement must be reassessed, and appropriate action taken.

Health services and funded organisations that are required to comply with the department's guidelines on fire safety management shall complete and return Certificate No. 6 of fire safety compliance for 2018–19 to the department via the certificates email <FRMUCertificatesFidhhs.vic.gov.au>, or through their respective regional fire risk management unit coordinator by 30 September 2019.

More information on fire risk management, and a copy of the certificate template is available at the Fire risk management procedures and guidelines webpage <http://providers.dhhs.vic.gov.au/fire-risk-management-procedures-and-guidelines>.

2.11 Legal obligations

2.11.1 Privacy

Funding is provided on the condition that the funded organisation:

- complies with the provisions of the *Privacy and Data Protection Act 2014*, the *Health Records Act 2001* and other information-sharing and privacy obligations imposed by law, codes of practice or guidelines made under those laws in performing funded services
- ensures its employees, officers, agents and subcontractors comply with the Acts and the terms of a funding agreement.

2.11.2 Protected disclosure

Where applicable, the funded organisation agrees to comply with and be bound by the provisions of the *Protected Disclosure Act 2012*.

2.11.3 Intellectual property

The rights and obligations of funded organisations and the State of Victoria regarding ownership and management of intellectual property are set out below.

Funding is provided with the following conditions:

- All intellectual property developed by a funded organisation with funding provided by the department (Project IP) vests in the funded organisation unless the department advises the funded organisation in writing prior to the delivery of all or part of the funded services that the State of Victoria will own the Project IP.
- The funded organisation grants to the State of Victoria a non-exclusive, world-wide, everlasting, irrevocable, royalty free licence to exercise all rights in relation to the Project IP (including background and third party intellectual property incorporated into Project IP) as if the State of Victoria was the owner, including the right to sub-license. For the avoidance of doubt, the rights conferred on the State of Victoria under the licence include, without limitation, the right to use, reproduce, adapt, broadcast, publish, communicate to the public, and otherwise disseminate the Project IP for the benefit of the Victorian public.
- The funded organisation will ensure it obtains all necessary consents (including moral rights consents) to enable the State of Victoria to exercise all the rights conferred on the State of Victoria referred to above.
- Immediately following a written request, the funded organisation will provide all Project IP to the department.
- The funded organisation will properly manage the Project IP in a manner which allows the State of Victoria to enjoy the full benefit of providing the funding to the funded organisation.
- The funded organisation must not accept co-funding, or involve any person in the delivery of the services, on terms that would jeopardise or limit any licence to be granted to the State of Victoria without obtaining the department's prior agreement and consent in writing.

Where a funded organisation has a service agreement with the department, the department's service agreement more fully records the parties' rights with respect to Project IP and takes precedence over these guidelines.

2.12 Payments and cash flow

2.12.1 Payments to funded organisations

In 2019–20 the department will make monthly payments over 13 periods (two payment periods in July) to all health services through the Modelling and Payments System (MAPS). Details of grants and payments can be accessed via the Tableau website <https://tableau.reporting.dhhs.vic.gov.au>. The department will monitor hospital cash flows as reported monthly in the financial data (F1) cash flow statement.

The department will make monthly payments to community service organisations through the Service Agreement Management System (SAMS2). Cash flow percentages of individual payment schedules of service agreements and details of the funded activities can be found on the Funded Agency Channel website <https://fac.dhhs.vic.gov.au>. The department will monitor community service organisation performance and financial sustainability.

Payments may be adjusted for recall, loans, enterprise bargaining agreements, indexation, awards and prepayments (refer to Chapter 1, section 1.23 'Prior year adjustment: activity-based funding reconciliation').

2.12.2 Enterprise bargaining

2.12.2.1 Expiring agreements and enterprise bargaining

Five Enterprise Agreements will expire in the 2019–20 financial year (covering Ambulance Victoria administrative staff, Nurses and Midwives, Mental Health, Institute of Forensic Medicine and Allied Health staff). Another Enterprise Agreement is currently in negotiation (Ambulance Victoria). It is possible that some of these agreements will be settled in the 2019–20 financial year.

2.12.2.2 Wages policy

The Victorian Government's updated Wages Policy and Enterprise Bargaining Framework (Framework) commenced on 17 April 2019. The Wages Policy has three pillars:

- Wages – increases in wages and conditions capped at a rate of growth of 2.0 percent per annum.
- Best Practice Employment Commitment – public sector agencies are to outline measures to operationalise elements of the Government's Public Sector Priorities that reflect good practice and can be implemented operationally or without significant cost.
- Additional Strategic Changes – changes to allowances and other conditions will only be allowed if Government agrees that the changes will address key operational or strategic priorities

Health services are generally expected to comply with other aspects of government policy, including wages and industrial relations policy as made from time to time.

More information on the Framework is available at the Wages Policy and the Enterprise Bargaining Framework website <https://www.vic.gov.au/wages-policy-and-enterprise-bargaining-framework>.

2.12.2.3 Budgeting for new agreements

Enterprise bargaining settlements are rarely timed to coincide with the beginning of a financial year. Therefore, there may be part-year cost effects in any given financial year relating to both expiring and new enterprise bargaining outcomes. In contrast, budget indexation applies on a full financial year basis.

Health services must identify and account for indexation as it relates to supporting increased wage and salary costs. The baseline wage increases contained in the applicable wages policy must be funded by health services prior to any additional supplementation being sought from Treasury. When new Enterprise Agreements take effect, or are likely to take effect in a financial year, health services must keep funding equal to these amounts available for such increases. This remains true even when

enterprise bargaining processes become protracted or complex and remain unresolved at the end of the financial year in which settlement was expected to occur and have cost effect.

Health services must also ensure Enterprise Agreement costs are properly attributed to other relevant revenue sources where existing employment costs are met from those other sources.

2.12.2.4 Interim payments for long-stay, high-cost patients

The department will consider interim payments (both cash flow and recorded WIES revenue) for long-stay patients who have accumulated significant amounts of WIES, or Subacute WIES, and who remain admitted at 30 June 2019.

Health services may apply to the department for special consideration for individual admitted patient episodes. Applications for special consideration must indicate the number of WIES or Subacute WIES. For WIES-funded episodes, the interim diagnostic-related group (DRG) must also be indicated. For Subacute WIES-funded episodes, the AN-SNAP V4.0 must also be indicated. Under no circumstances should agreement to fund an interim payment result in a statistical separation.

If the department agrees to provide an interim payment, the health service will be asked to designate the episode as a contracted patient using a specific contract/spoke identification code. When the patient is finally separated, the payment will be adjusted accordingly. For example, the interim amount will be deducted from the final payment. The final DRG may differ from the interim DRG, due to the addition of further complications, comorbidities and procedures, in which case the payments will be adjusted to reflect actual activity.

Interim payments for long-stay, high-cost patients will be considered on a case-by-case basis. While interim payments are not governed by strict length of stay (LOS) or WIES criteria, a patient might be recognised as a long-stay, high-cost patient if the patient is:

- still admitted at 30 June 2019 and their LOS already exceeds a year
- still admitted at 30 June 2019, their LOS already exceeds six months and the patient might reasonably be expected to still be in the hospital at 31 December 2019
- still admitted at 30 June 2019, their LOS already exceeds six months and the patient is receiving significant mechanical ventilation.

2.12.3 Use of contract WIES

On occasion, where a health service has reduced capacity (for example, due to workforce shortages or capital works) it may contract with another service to undertake activity for a time-limited period. Contract arrangements of this type must be approved in advance by the health service Performance Lead/Regional Manager.

Applications can be received by emailing the HDSS helpdesk <HDSS.helpdesk@dhhs.vic.gov.au>.

Approval will only be granted where the health service can demonstrate that the capacity reduction is temporary and that the contract is an appropriate use of allocated WIES, taking into account local demand for services. Technical information for recording and reporting contract WIES is available in the VAED manual.

2.12.4 Health service fees and charges

Any fees and charges raised by health services must be in accordance with the department's manual, *Fees and charges for acute health services in Victoria: a handbook for public hospitals.*

The fees are available in the department's *Fees manual* <https://www.health.vic.gov.au/feesman>.

Health services are permitted to raise fees for the following non-admitted patient services:

- dental services
- spectacles and hearing aids

- surgical supplies
- prostheses, however, the following categories of prostheses must be provided free of charge:
  - artificial limbs
  - prostheses that are surgically implanted, either permanently or temporarily, or are directly related to a clinically necessary surgical procedure
- external breast prostheses funded by the National External Breast Prostheses Reimbursement Program
- other services, as agreed between the Commonwealth and Victoria.

Upon an admitted patient separation, a health service may raise fees for:

- pharmaceuticals at a level consistent with the Pharmaceutical Benefits Scheme statutory co-payments
- aids
- appliances
- home modification.

2.12.5 Private patient accommodation charges

Section 72.1(2) of the *Private Health Insurance Act 2007* states that an insurance policy covering hospital treatment must provide at least the 'minimum benefit' for that treatment. The Commonwealth Minister for Health stipulates the minimum benefits payable by private health insurers for shared ward accommodation in public hospitals through the private health insurance (benefit requirements) rules. The Commonwealth does not set a minimum benefit for single room accommodation.

Health services are able to make their own determination on accommodation fees to be charged to private patients who receive treatment at their campuses. In coming to this decision, health services should consider:

- the benefit that private health insurance funds will assign to the public hospital in their health insurance products
- any co-payment a patient may be willing to pay as a private patient
- the amount of any co-payment or excess the hospital can viably forego.

To assist health services with this decision, the department provides a guide to average costs and nominal cost recovery rates for private patient accommodation in the department's *Fees manual* <https://www.health.vic.gov.au/feesman>.

At a minimum, these rates would be reasonable to apply to private patient charges.

Health services should note the *Private health insurance (health insurance business) rules 2007* Part 3 s. 8(b), which state that treatment provided to a person at an emergency department is excluded treatment for the purposes of private health insurance. Health services should ensure that private health funds are not billed for accommodation or services provided to admitted private patients at an emergency department.

2.12.6 Redirection of funds

If the total revenue for a funded program exceeds the expenses incurred in delivering the full quantity of services specified in the SOP or service agreement, the surplus may be used by the funded organisation for any purpose connected with its agreed function. This clause does not apply if there is a contrary arrangement regarding unexpended funding provided for a specially identified purpose.

2.12.7 Doctors in training secondment arrangements

Many training programs for junior doctors involve a rotation to a site other than their parent hospital. The parent hospital is responsible for managing and paying the annual leave of doctors in training while on rotation, and where annual (or other) leave is planned within the rotation period, both hospitals should

approve this leave. Only the parent hospital is to pay out annual leave, as this is included in the overheads paid to the parent hospital (refer to Hospital Circular 6/2013 or a successor circular where relevant).

The parent hospital will make every endeavour to organise suitable relief when a doctor in training takes other leave (either planned or unexpected) for a period longer than one week. The parent hospital should also make every endeavour to ensure the relieving doctor has commensurate experience and skills to ensure the expected level of service in the external hospital can continue to be provided.

2.12.8 Long service leave

The department assumes the liability arising from the net increase in the long service leave provision for public hospitals and some statutory authorities ('Eligible agencies'), except for changes to the long service leave provision due to the impact of bond rate and probability factors (revaluations), which is in accordance with the Department of Treasury and Finance's Budget Operating Framework. Eligible agencies must, however, reflect the movements in the long service leave provision associated with the revaluations in their long service leave provision.

The department funds the annual increase in the long service leave provision[5] of its eligible agencies as follows:

- An amount equal to 2.8% of defined salaries and wages is included in price and paid as grants to the department's eligible agencies (with a few exceptions).
- A grant payable to the department's eligible agencies is recognised for the balance not paid as the grant described above. (A debtor in respect of this non-cash grant will be recognised by each eligible agency).

Eligible agencies will continue to manage their long service leave and cash requirements. Long service leave funding paid by the department in excess of actual long service leave payouts during the current and prior financial years should be maintained and managed by eligible agencies and be used as the first call for any future settlements over and above the (current) 2.8% of long service leave included in price.

2.12.9 Medical indemnity insurance

The department has developed the medical indemnity risk-rated premium (RRP) model in consultation and on the advice of the Victorian Managed Insurance Authority and its actuaries. The medical indemnity risk-rated premium model allocates a share of the statewide medical indemnity insurance premium to individual hospitals and health services.

[5] The increase excludes the impact of bond rate and probability factors (revaluations).

2.13 Data collection requirements

Data reporting and analysis are core elements of the department's health monitoring and funding system. In general, health services and other funded organisations are required to comply with standard definitions for reporting financial and statistical data, as set out in the relevant 2019–20 versions of data collection manuals and any other amending documents prepared by the department.

2.13.1 Data integrity

Accurate data are critical for funding purposes, performance monitoring, reporting, policy development and planning and for maintaining public confidence in the health system.

Health service boards of management are accountable for the accuracy of reported data. Boards are expected to make data integrity the responsibility of their audit committee and ensure that data accuracy is subject to appropriate controls, including regular internal audits.

Health services are required to:

- maintain board and board audit committee scrutiny of data integrity practices
- complete implementation of security improvements for elective surgery and emergency department information technology systems, including implementation of unique user identity and password controls, and routinely reviewing ICT system transaction logs
- implement recommendations from audits conducted at their health services
- provide a data quality attestation in the health service's annual report.

Data integrity guidelines for health services are also provided to assist health services in ensuring the integrity of data they report about their activity and performance.

The Health Data Integrity Program plan 2018–19 to 2019–20 supports the transition of the health data integrity program from an emphasis on random reviews (or audits) designed to achieve statewide estimates of overall accuracy, to a more targeted approach based on data analytics and risk assessment. It sets out the initiatives designed to ensure that health data collections accurately reflect the care that was provided to patients and increase confidence in the accuracy of health services' data by:

- reviewing data recording and reporting practices and health service compliance with department policies and business rules
- monitoring, reporting on and strengthening internal controls used in health services
- monitoring, detecting, reporting on and mitigating the risks and consequences of inaccurate health data
- providing stakeholders with an accurate picture of the strengths, weaknesses and threats related to health data integrity and recommend opportunities to improve it.

The program covers the same core health data collections that were previously the subject of regular review, including:

- Victorian Admitted Episodes Dataset (VAED)
- Elective Surgery Information System (ESIS)
- Victorian Emergency Minimum Dataset (VEMD)
- Victorian Cost Data Collection (VCDC)
- Victorian Integrated Non-Admitted Health (VINAH) – Specialist clinics
- Admitted Subacute Care data reported to VAED.

The health data integrity program may be expanded to additional health service data collections based on stakeholder priorities and analytics.

Health services are expected to actively participate in the program of system-wide inspections, checks and reviews of their health service data and related processes, including responding to data analytics queries

2.13.1.1 System updates

These data collections are reviewed annually to ensure they are relevant for performance monitoring against current operational priorities, as well as to provide up-to-date indicators of ongoing clinical activity trends. The department remains committed to balancing the resources required to collect and report data against the need for quality data for monitoring, planning and fulfilment of the department's own reporting obligations. These aims are achieved through various consultative committees and reference groups for specific data collections and feedback received through specific departmental program areas.

Proposed changes to data collections are released for comment, and specifications for change are published by 31 December prior to the financial year to which they apply.

The *Health Data Standards and Systems (HDSS) bulletin* provides advice on data quality issues to health services that contribute to the VAED, VEMD, ESIS, VINAH and AIMS. The bulletin is the primary method by which amendments to standards and reporting timelines are published during the year.

Health services should ensure that appropriate staff subscribe to the *HDSS bulletin* to remain up-to-date with any changes. The *HDSS bulletin* is issued electronically via both web and email and is free. Subscriptions may be arranged by emailing the Health data standards and systems helpdesk <HDSS.Helpdesk@dhhs.vic.gov.au>.

2.13.1.2 Penalties for noncompliance

If health services are noncompliant with the timelines specified in these guidelines, penalties may apply. Refer to the relevant dataset for more information.

2.13.2 Key systems

The department operates several data collections on different aspects of health service activity. Key systems include:

- F1/Common Chart of Accounts
- Portfolio Financial Reporting
- the VAED for admitted patient activity
- the VEMD for designated emergency department activity
- the ESIS for monitoring elective surgery waiting lists
- the VINAH minimum dataset for non-admitted patient activity
- AIMS, used primarily to collect summary-level financial and statistical information
- the VCDC for patient-level costs
- the Victorian Perinatal Data Collection (VPDC) for births
- total parenteral nutrition activity
- CMI/ODS for mental health client data.

2.13.2.1 Financial data

F1 financial returns for all health services and other portfolio entities (excluding cemeteries and VicHealth), at the entity level, are required 12 calendar days after the end of the month to which the financial data relates (for example, the F1 for July is required by 12 August). Data relating to approved budgets and revised estimates are required less frequently and as advised by the department.

A timetable for the portfolio financial reporting requirements for whole-of-government will be released separately. F1 submitted data will be used each month as a basis for further data requirements in the portfolio financial reporting system (also called "PFR") which is used for whole-of-government reporting.

This collective data is then reported to the Department of Treasury and Finance and must be complete and accurate. If the data submitted to the department is inaccurate or incomplete, hospitals will be required to amend and re-submit this data through the F1. This re-submission must occur in a timely manner.

Public hospitals are also required to report both an approved budget and a revised estimate (end-of-year forecast) to the department through the F1.

- The submitted approved budget should match the agreed Statement of Priorities and only be amended when agreed with the department.
- The revised estimate is to be in the form of a full end-of-year trial balance and reflect the most up to date forecast result and financial position. At certain dates, as advised separately by the department, the revised estimate submissions must be accompanied by a Chief Financial Officer sign-off (a template will be provided by the department). The revised estimates due dates for sign-off will be in line with the budget update and end-of-year forecast timelines required for reporting to the Department of Treasury and Finance which are generally as follows:
  - initial estimate – 12 August
  - mid-year estimate – 12 December
  - year-end forecast – 12 April, 12 May and 5 June.

Public hospitals will provide this information in accordance with the department's timelines, except where an extension is sought and approved. Late data submissions of trial balances for both the F1 and Portfolio Financial Report, will be monitored and reported through performance monitoring staff in the department.

2.13.2.2 Victorian Admitted Episodes Dataset

The Victorian Admitted Episodes Dataset (VAED) contains the core set of clinical, demographic, administrative and financial data for admitted patient episodes occurring in Victorian health services. Maintaining the accuracy of the VAED is critical to ensuring accurate and equitable funding outcomes, supporting health services' planning, policy formulation, program evaluation and epidemiological research. Analyses and consolidated activity data are provided from the VAED to meet the department's reporting obligations to the commonwealth and to various research institutes.

Further information on the VAED is contained in the *VAED manual* <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems>.

Submission of admitted patient data

All organisations that receive funding for admitted patient services must submit data to the VAED minimum dataset.

Health services (including small rural health services) will code patient episodes reported to the VAED in accordance with the current Australian Coding Standards, along with Victorian additions, and any amending documents issued by the department.

Public health services must submit admitted patient data to the VAED according to the timelines in Table 2.2. Health services may submit data more frequently than the minimum standards specified in the table.

Table 2.2: Victorian Admitted Episodes Dataset timelines

VAED	Timeline
Admission and separation details for the month (E5, J5 and V5 records)	Must be submitted by 5.00 pm on the 10th day of the following month
Diagnosis and procedure, subacute and palliative details (X5, Y5, S5 and P5 records)	Must be submitted by 5.00 pm on the 10th day of the second month following separation
Data for the 2019–20 financial year	Must be submitted by 5.00 pm on 10 August 2020
Final corrections to data for 2019–20	Must be submitted by 5.00 pm on 24 August 2020

It is the health service's responsibility to ensure that data files are submitted on or prior to the 10th of each month regardless of the actual day of the week.

Penalties for noncompliance

Where health services are noncompliant with the timelines specified above, the department may apply the following penalties:

- up to $20,000 per month if more than one per cent of admission and separation details (E5, J5) for a given month are submitted after the timeline specified
- up to $20,000 per month if more than one per cent of episodes for a given month are submitted without diagnosis, procedure, subacute or palliative care details (X5, Y5, S5, P5) by the deadline specified
- up to $2,000 per episode if there is a significant number of episodes that are 'dummy coded' or do not meet the VAED business rules.

The above requirements apply to all account classes, including Department of Veterans' Affairs.

Exemptions for late submission penalties

If difficulties are anticipated in meeting the relevant data transmission timeframes, the health service must contact the department indicating the nature of the difficulties, remedial action being taken and the expected submission schedule.

A pro forma to assist this process is provided on the HDSS website <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems>.

If difficulties prevent the reporting of patient-level data to the VAED, the health service must complete the AIMS S1A form by the 10th of the month. The AIMS S1A form is submitted via HealthCollect. For assistance with the S1A, email the HDSS helpdesk <hdss.helpdesk@dhhs.vic.gov.au>. Failure to complete the S1A form by the due date will result in late submission penalties.

Software upgrades and migrations

Health services undertaking software migrations must undertake VAED data submission testing prior to resuming live VAED data submission. Health services will be exempt from late data submission penalties for an agreed period of no more than two months, provided the S1A form is completed on time.

Health services undertaking software upgrades may choose to undertake the VAED data submission testing process prior to resuming live VAED data submission. Health services will be exempt from late data submission penalties for one month, provided the S1A form is completed on time.

2.13.2.3 Victorian Emergency Minimum Dataset

Emergency departments must submit data to the Victorian Emergency Minimum Dataset (VEMD) according to the timelines in Table 2.3. Health services may submit more frequently than the minimum standards specified in the table.

Table 2.3: Victorian Emergency Minimum Dataset timelines

VEMD	Timeline
All presentations for the first 14 days of the month	At least one submission must be received by 5.00 pm on the third working day after the 14th of the reporting month.
All presentations for the full month	Data for the remainder of the month must be supplied by 5.00 pm on the third working day of the following month.
All presentations for the full month without errors	Must be complete and correct – that is, zero rejections and notifiable edits by 5.00 pm on the 10th day of the following month, or the prior business day.

Any corrections to 2019–20 data must be submitted before final consolidation of the VEMD on 27 July 2020.

Penalties for noncompliance

If health services are noncompliant with these timelines, the department may apply the following penalties:

- up to $5,000 per month, if a file containing presentations for the first 14 days of the month is not submitted by the timelines specified in Table 2.3
- up to $10,000 per month, if a file containing presentations for the full month is not submitted by the timelines specified in Table 2.3
- up to $10,000 per month, if a file with all presentations for the full month contains errors by the timelines specified in Table 2.3.

Data flagged as unfit for reporting and analysis will be regarded as noncompliant and penalties as above will apply.

Exemptions from penalties

If difficulties are anticipated in meeting the relevant data submission timeframes, the health service must contact the department indicating the nature of the difficulties, remedial action being taken and the expected submission schedule.

A pro forma to assist this process is provided on the Health data standards and systems website <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems>.

Requests for an exemption from late penalties will only be considered if received prior to the relevant deadlines, and the manual aggregate data spreadsheet has been completed by the due date. Extensions or exemptions are not issued in advance. Late submissions penalties are assessed after the end-of-year consolidation deadline, taking into account the health service's compliance performance for the financial year.

For any full month period that the health service is unable to supply unit record data, the health service is required to submit aggregate data using the manual aggregate data spreadsheet. The spreadsheet is available from the Victorian Emergency Minimum Dataset (VEMD) webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vemd>.

Failure to complete the manual aggregate data spreadsheet by the due date will result in late submission penalties.

Data resubmissions for previous months

Health services wishing to resubmit data for a previous period must complete a VEMD data resubmission request as soon as the health service is aware of the circumstances requiring resubmission. The request form must be submitted prior to the resubmissions. Resubmissions received without the request form will not be processed.

The pro forma is available on the Victorian Emergency Minimum Dataset (VEMD) webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vemd>.

Software upgrades and migrations

Health services undertaking software migrations will be exempt from late data submission penalties for an agreed period of up to two months, provided the manual aggregate data spreadsheet is completed on time. Health services undertaking software upgrades will be exempt from late data submission penalties for one month, provided the manual aggregate data spreadsheet is completed on time.

2.13.2.4 Elective Surgery Information System

Health services reporting to the Elective Surgery Information System (ESIS) must adhere to the minimum submission timelines in Table 2.4.

Table 2.4: Elective Surgery Information System timelines

ESIS	Timeline
First 15 days of the month	At least one submission must be received by the third working day after the 15th of the reporting month.
The remaining days of the month (16th and subsequent)	Data for the remainder of the month must be supplied by the third working day of the following month.
All activity for the full month without errors	Data must be complete: that is, zero rejections, notifiable or correction edits by the 14th day of the following month, or the prior business day.

Any corrections to 2019–20 data must be submitted before final consolidation of the ESIS database on 24 August 2020.

Penalties for noncompliance

If health services do not comply with these timelines, the department may apply a penalty of:

- up to $5,000 per month if a file containing episodes for the first 15 days is not submitted by the timelines specified in Table 2.4
- up to $10,000 if a file containing episodes for the full month is not submitted by the timelines specified in Table 2.4
- up to $10,000 if a file with all episodes for the full month contains errors by the timelines specified in Table 2.4.

Data that is flagged as unfit for reporting and analysis will be regarded as noncompliant and penalties as above will apply.

Exemptions from penalties

If difficulties are anticipated in meeting the relevant data transmission timeframes, the health service must contact the department indicating the nature of the difficulties, remedial action being taken and the expected transmission schedule.

A pro forma to assist this process is provided on the Elective Surgery Information System webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/esis>.

Requests for an exemption from late penalties will only be considered if received prior to the relevant deadlines, and the manual aggregate data spreadsheet is completed by the due date. Extensions or exemptions are not issued in advance. Late submission penalties are assessed after the end-of-year consolidation deadline, taking into account the health service's compliance performance for the financial year. For any full-month period that the health service is unable to supply unit record data, the health service is required to submit aggregate data using the manual aggregate data spreadsheet.

The spreadsheet is available from the Elective Surgery Information System webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/esis>.

Requests for an exemption from late penalties will only be considered if it is received prior to the relevant deadlines and the manual aggregate data spreadsheet is completed.

Failure to complete the manual aggregate data spreadsheet by the due date will result in late submission penalties.

Software upgrades and migrations

Health services undertaking software migrations will be exempt from late data submission penalties for an agreed period of up to two months, provided the manual aggregate data spreadsheet is completed on time.

Health services undertaking software upgrades will be exempt from late data submission penalties for one month, provided the manual aggregate data spreadsheet is completed on time.

2.13.2.5 Victorian Integrated Non-Admitted Health Minimum Dataset

The Victorian Integrated Non-Admitted Health Minimum Dataset (VINAH MDS) is a patient-level reporting system built around a generic framework suitable for reporting a wide range of non-admitted patient-level data.

Organisations that receive funding under any of the following programs must transmit data to the VINAH MDS:

- specialist clinics (outpatient)
- Health Independence Program
  - subacute ambulatory care services (including paediatric rehabilitation)
  - hospital admission risk program (HARP)
  - post-acute care (PAC)
  - residential in-reach service
- community-based palliative care
- palliative care day hospice
- family choice program
- home enteral nutrition
- total parenteral nutrition
- Victorian HIV service
- Victorian Respiratory Support service
- Medi-hotel (optional)
- Transition care program (TCP)
- hospital-based palliative care consultancy teams.

Further information on VINAH is contained in the VINAH manual <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vinah>.

Submission guidelines

Health services reporting VINAH will be required to adhere to the minimum submission timelines in Table 2.5. Health services may submit more frequently than the minimum standards specified below.

Table 2.5: Victorian Integrated Non-Admitted Health timelines

VINAH	Timeline
Submission date for client, referral, episode and contact details for the month	Must be submitted before 5.00 pm on the 10th day of the following month.
Clean date for client, referral, episode and contact details for the month	Must be submitted before the VINAH file consolidation at 5.00 pm on the 14th day of the following month, or the preceding working day if the 14th falls on a weekend or public holiday data must be complete: that is, zero rejections.

Submitting funded organisations are encouraged to transmit VINAH MDS data frequently and may transmit as often as desired. Funded organisations must meet the following minimum requirements:

- VINAH data compliance is reckoned on a monthly basis. Data for each calendar month (reference month), as specified in the 'reported when' component of each data element in the VINAH manual, must be transmitted as specified below.
- Funded organisations must make at least one submission to the HealthCollect portal for the reference month by no later than 5.00 pm on the 10th day of the month following the reference month.
- All errors are to be corrected in time for the VINAH MDS file consolidation at 5.00 pm on the 14th day of the month following the reference month. Complete data for the month is expected to be transmitted by the 14th.

Data for the financial year must be completed in time for the VINAH MDS file consolidation on 24 August. Any final corrections must be received at the HealthCollect portal before the VINAH MDS database is finalised on 24 August 2020.

It is the funded organisation's responsibility to ensure the department receives the data in time to meet the processing schedule detailed above, regardless of the actual day of the week.

Penalties for noncompliance

If funded organisations do not comply with these timelines, the department may apply a penalty of:

- up to $10,000 if an initial transmission of a reference month's activity for a program is not submitted within the timelines specified in Table 2.5
- up to $10,000 if a reference month's complete activity for a program is not submitted in accordance with the timelines specified in Table 2.5.

Funded organisations that have VINAH MDS reporting obligations for multiple programs (for example, subacute ambulatory care services, HARP, PAC) should note that the above penalties apply per program.

Data that is flagged as unfit for reporting and analysis will be regarded as noncompliant and penalties as above will apply.

Exemptions from penalties

Organisations seeking exemption from penalties for late data must complete a 'Late Data Request Form' (available on the HealthCollect portal) advising of the issues experienced, the organisation's plan for overcoming the issues and the expected submission date. Exemptions will be granted at the discretion of the department.

Organisations must report aggregate data for acute non-admitted activity via the AIMS S10 form, subacute non-admitted activity via the AIMS S11 form and episodic non-admitted activity via the AIMS S12 form.

Software upgrades and migrations

Health services undertaking software migrations will be exempt from late data submission penalties for three months.

Health services undertaking software upgrades will be exempt from late data submission penalties for one month.

Health services must ensure their 2019–20 VINAH transmitted completely by 24 August 2020, and should ensure software updates and migrations do not prevent complete VINAH transmissions by this date, as no extensions will be possible.

2.13.2.6 Agency Information Management System

Health services will provide Agency Information Management System (AIMS) data to the department electronically via the HealthCollect web portal and in accordance with the timelines specified in the *Agency Information Management System (AIMS) public hospital user manual*.

Visit the HealthCollect web portal <https://www.healthcollect.vic.gov.au>.

Penalties for noncompliance

If health services are noncompliant with these timelines, the department may apply a penalty of up to $5,000 for each return not submitted by the due date specified in the AIMS manual.

Organisations seeking exemption from penalties for late data must notify the Health data standards and systems helpdesk <hdss.helpdesk@dhhs.vic.gov.au>, advising of the issues experienced, the organisation's plan for overcoming the issues and the expected submission date.

See further details about AIMS <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/aims>.

2.13.2.7 Victorian Cost Data Collection

Victorian public hospitals are required to report costs for all hospital activity, regardless of funding source, and are expected to maintain patient level costing systems that monitor service provision to patients and determine accurate patient-level costs.

Victorian health services are required to adhere, where possible, to the *Australian Hospital Patient Costing Standards* – version 4.0 (or the most recent version in the instance that a successor becomes available) in conjunction with VCDC documentation, specifications and business rules and any other guidance provided by the department in the coming year.

Format and scope

The cost data submission to the department must comply with the Victorian Cost Data Collection (VCDC) file specifications and reporting requirements. See VCDC specifications and requirements <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vcdc>.

The cost data submitted should be fit-for-purpose and cover all areas of hospital activity undertaken by the health service. Including (but not limited to) four broad categories:

- Admitted – A patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care are provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients) and include acute, subacute and mental health.
- Emergency – A dedicated area in a hospital that is organised and administered to provide emergency care (including reception, triage, initial assessment and management) to people who perceive the need for, or are in need of, acute or urgent care.
- Non-Admitted – A patient who does not undergo a hospital's formal admission process. There are three categories of non-admitted patient: emergency department, outpatient, subacute and other non-

admitted patient (treated by hospital employees off the hospital site – includes community/outreach services).

- Specialist Clinical Mental Health – A dedicated area in a hospital that delivers a range of hospital and community based clinical mental health services. This includes both admitted and non-admitted (community) patients.

Health services are to examine and review their current cost data for completeness across all services and an assurance of the quality of the cost data that provides a level of understanding of the usefulness of the patient level data for analysis, reporting and use in funding models.

The *National Health Reform Agreement* specifies that these areas will be activity-base funded from 1 July 2013 and cost data is required from all these services to support development of national weights.

Submission and timeframes

The VCDC submission involves a five-phase process to ensure the data submitted meets the requirements specified in the documentation. The five phases include:

- Phase 1 – receipt of submission
- Phase 2 – file validations
- Phase 3 – linking/matching VCDC to activity
- Phase 4 – data quality assurance checks
- Phase 5 – receipt of reconciliation report.

Health services reporting VCDC data will be required to adhere to the minimum submission timelines in Table 2.6. Health services may submit more frequently than the minimum standards specified below.

Table 2.6: Victorian Cost Data Collection actions and reporting timelines

Actions	Date
Submission portal open to accept submission	23 September 2019
First submission of files to VCDC – Phase 1	23 September to 31 October 2019
Final submission of files to VCDC following completion of Phase 2 and Phase 3	22 November 2019
DHHS to provide Quality assurance (QA) reports to health services – Phase 4	25 November 2019
Health services to provide comments on QA checks and conclude submission to the VCDC	13 December 2019
Health services to submit signed Reconciliation reports[6]	20 December 2019
Re-submissions completed following re-costing due to major impacts on cost data following phase 4 checks[7]	17 January 2020
DHHS to consolidate Victorian cost database	8 February 2020
DHHS to provide benchmark tool and underlying data to health services (following receipt of consent forms)	8 March 2020

[6] Reconciliation templates including a signed attestation are to be submitted no later than five business days after the final submission of cost data.

[7] Any major corrections to 2018–19 submissions that will impact on the cost data must be submitted before final consolidation of the cost database on 8 February 2020.

Penalties for noncompliance

Where health services are noncompliant with the format or timelines specified above, the department may apply the following penalties:

- up to $20,000 per month if cost data is not submitted by the timeline specified
- up to $2,000 per episode if there are a significant number of episodes that are do not meet the VCDC business rules.

Exemptions from penalties

If difficulties are anticipated in meeting the relevant data transmission timeframes, the health service must contact the department indicating the nature of the difficulties, remedial action being taken and the expected transmission schedule.

Software upgrades and migrations

Health services undertaking software migrations must undertake VCDC data submission testing prior to resuming live VCDC data transmissions. Health services must ensure their 2018–19 VCDC is transmitted by the due date and should ensure software updates and migrations do not prevent complete VCDC transmissions by this date.

2.13.2.8 Victorian Health Incident Management System

The Victorian Agency for Health Information is leading the Victorian Health Incident Management System (VHIMS) reform program; to ensure information collected is better able to inform quality, safety and experience improvements for Victorians.

These reforms are detailed at Victorian Health Incident Management System – Better Safer Care website <https://bettersafercare.vic.gov.au/our-work/incident-response/VHIMS>.

In the meantime, interim reporting arrangements have been designed and established to support the collection of a minimum dataset from the current VHIMS for statewide reporting.

Health services and other relevant funded organisations (including registered community health services) must submit quarterly VHIMS extract data to the department's Secure Data Exchange (SDE) according to the timelines in Table 2.7.

Table 2.7: Victorian Health Incident Management System quarterly reporting timelines

2019–20 VHIMS reporting	Quarterly extract due
Quarter 1	1st working day in November 2019
Quarter 2	1st working day in February 2020
Quarter 3	1st working day in May 2020
Quarter 4	1st working day in August 2020

2.13.2.9 Better Patient Dataset

The Better Patient Dataset (BPD) contains a core set of demographic information about every patient who has been treated in Victorian health services. Regular updates of the Better Patient Dataset are essential for optimum health services' planning, policy formulation, program evaluation and epidemiological research.

Health services will provide the Better Patient Dataset to the department electronically via the Secure Data Exchange in accordance with specifications advised directly by the department, by the 10th day of each month, for Patient Master Index data as at the end of the preceding month.

Penalties for noncompliance

If health services are noncompliant with these timelines, the department may apply a penalty of up to $3,800 for each return not submitted by the due date specified above.

Organisations seeking exemption from penalties for late data must write to the Manager, Centre for Victorian Data Linkage advising of the issues experienced, the organisation's plan for overcoming the issues and the expected submission date.

2.13.2.10 Victorian Healthcare Associated Infection Surveillance System

Safer Care Victoria receives infection surveillance reports from health services via the Victorian Healthcare Associated Infection Surveillance System (VICNISS) coordinating centre. All public health services are required to participate in the VICNISS HAI surveillance program.

Mandatory reporting requirements exist for a number of indicators that are included in the Statement of Priorities Part B. These include:

- surgical site infections following hip and knee arthroplasty, coronary artery bypass graft surgery, colorectal surgery and caesarean section
- intensive care unit central line-associated blood stream infections
- hand hygiene compliance rates
- hospital identified *Clostridium difficile* infections
- *Staphylococcus aureus* bacteraemia.

Further infection surveillance activities can be undertaken by health services on a voluntary and needs basis. Health services with a statistically significant higher rate than the aggregate are notified and requested to provide information on actions that are being taken to reduce this rate.

A limited number of healthcare-associated infections (HAI) performance indicators are reported publicly on the Victorian Health Services Performance website <https://performance.health.vic.gov.au/Home.aspx>.

Rates for *Staphylococcus aureus* bacteraemia and compliance with Hand Hygiene Australia guidelines are publicly reported on the MyHospitals website <https://www.myhospitals.gov.au>.

2.13.2.11 Victorian State Trauma Registry

All public health services, including the three designated major trauma services, are required to participate in the Victorian State Trauma Registry. The key requirement is the delivery of trauma data, in the form requested by the Registry, to the Registry on time. The department contracts the Victorian State Trauma Registry to collect data on major trauma patients from health services.

The performance and effectiveness of the Victorian State Trauma System is monitored via the registry. The failure to deliver data on time affects the governance of the Victorian State Trauma System and the ability of the registry to deliver reports to health services. State aggregate data is reported every year in the Victorian State Trauma Registry summary report. Annual reports are available at the Victorian State Trauma System webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/acute-care/state-trauma-system>.

2.13.2.12 Victorian Audit of Surgical Mortality

The Victorian Audit of Surgical Mortality (VASM) is a peer-review audit of deaths associated with surgical care that is undertaken through the Royal Australasian College of Surgeons (RACS) Victorian Office. Surgeon participation in the VASM is a requirement of the RACS continuing professional development program.

2.13.2.13 Consultative councils reporting requirements

Consultative councils are ministerial advisory committees that review and report on specialised areas within healthcare to reduce mortality and morbidity. The councils' functions and reporting requirements are legislated under the *Public Health and Wellbeing Act 2008*.

2.13.2.14 Koori Maternity Services reporting by public health services

Health services that are funded to provide a Koori Maternity Service program are required to submit data to the Koori Maternity Services minimum dataset via the online form at the Aboriginal maternity services webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/aboriginal-maternity-services>.

Table 2.8: Public health services funded to provide Koori Maternity Service

Public health services Koori Maternity Service
Western Health (Sunshine Hospital)
Northern Health (The Northern Hospital)
Peninsula Health (Frankston Hospital)

2.13.2.15 Cardiac surgery registry

Since 2001 the department has contracted the Australian and New Zealand Society of Cardiac and Thoracic Surgeons to collect data to monitor clinical performance in cardiac surgery. The Cardiac Surgery Database Project is coordinated by the Monash University School of Public Health and Preventative Medicine. The department expects all health services that perform cardiac surgery to participate.

The Cardiac Surgery Database Project includes maintenance of a comprehensive clinical registry, statistical analysis and report generation. These components enable a structured peer-review process that can identify variation in performance at the practitioner and health service level.

The department publishes a public version of the Cardiac Surgery Database Project annual reports on its website and more detailed reports are provided to participating health services. From 1 July 2018, the Victorian Agency for Health Information will manage the contractual arrangements for the registry.

2.13.2.16 Victorian Cardiac Outcomes Registry

The department has supported the development and implementation of a cardiac outcomes registry that aims to help improve the safety and quality of healthcare provided to cardiovascular patients in Victoria. All public health services that perform percutaneous coronary interventions must provide this data to the Victorian Cardiac Outcomes Registry. Additional modules planned relate to implantable cardiac devices (such as pacemakers and defibrillators) and a dataset for patients presenting to hospital with heart failure.

This registry is coordinated by the Monash University School of Public Health and Preventive Medicine and has the support of the Cardiac Society of Australia and New Zealand. The Victorian Cardiac Clinical Network supports and promotes the implementation of the registry. Since 1 July 2018, the Victorian Agency for Health Information has managed the contractual arrangements for this registry.

2.13.2.17 Australian Stroke Clinical Registry

The Australian Stroke Clinical Registry is a collaborative national effort to monitor, promote and improve the quality of acute stroke care. It is a prospective, multicentre, observational outcomes database designed to collect data on the demographics, presentation, diagnosis, treatment and outcomes of hospitalised patients with stroke. The Victorian Stroke Clinical Network promotes the implementation of the registry at all metropolitan and regional stroke units, and is supporting the development of automated data extraction platforms to reduce the burden of data entry for clinicians. On 1 July 2018, the Victorian Agency for Health Information assumed responsibility for management and contractual arrangements for the Australian Stroke Clinical Registry.

2.13.2.18 Radiotherapy services reporting

Radiotherapy providers are required to report:

- monthly to the Victorian Radiotherapy Minimum Dataset (VRMDS)
- monthly to AIMS form S8 consultations only
- monthly to the AIMS form S10.

The department continues to contribute data from the VRMDS to the Australian Institute of Health and Welfare (AIHW), along with other jurisdictions. The data is included in the AIHW report *Radiotherapy in Australia*, released annually. The report presents waiting times at public radiotherapy providers by state or territory. Waiting times for private providers are amalgamated into a national figure.

2.13.2.19 Renal dialysis reporting

All health services that provide facility dialysis must report public and private admitted activity at a unit record level to the VAED. This includes activity in all facilities.

The department maintains a dialysis register comprising patient-level data provided by specialist services and coordinated by Melbourne Health. The register excludes private patients dialysing in private hospitals.

2.13.2.20 Victorian Healthcare Experience Survey

The Victorian Healthcare Experience Survey (VHES) seeks feedback from recent users of Victoria's public health services. It is a voluntary survey, focusing on both adult inpatient and emergency department care as well as maternity care. Data for these categories is collected continually throughout the year. An independent organisation Ipsos is under contract to administer the survey on behalf of the Victorian Agency for Health Information.

The VHES program measures patient experiences. This enables identification of the areas where these experiences can be improved leading to actions that enhance person- and family-centred care. The program also provides health services, Safer Care Victoria, VAHI and the department with actionable results.

All questionnaires were developed in consultation with key stakeholders including clinicians and consumers. They were cognitively tested with consumers (and, where appropriate, carers) and piloted through a representative sample. The results include verbatim comments thematically streamed from survey respondents.

Annual program specific surveys have been established for community health services, specialist clinics, ambulance services, paediatric inpatient, paediatric emergency and palliative care services. In 2019 a state-wide Cancer Patients' Experiences of Care survey will be released.

The Victorian Agency for Health Information will continue in 2019–20 with its VHES program of reform to ensure patient quality and safety is central to its design, and consistent with a patient-centred approach to service delivery. Key areas of focus will include the current length of the survey questionnaire, opportunities for inclusion of questions relating to patient reported outcomes and alternative approaches to measuring patient experiences in rural areas. In 2019, at the end of the current contract with Ipsos, an approach to market will be undertaken for a survey administrator.

Health services will be kept updated on the progress of reforms being undertaken, and any changes to the VHES program.

Upload procedures

For continuous surveys, health services are required to upload contact details of eligible consumers to the contractor by the 15th of the month following discharge. This upload includes the service received, which determines the type of questionnaire sent.

For the annual specialist clinics survey, nominated health services are required to upload contact details of eligible consumers for the three months nominated for survey collection.

For the annual ambulance services survey, nominated health services are required to upload contact details of eligible patients for the two months nominated for survey collection.

For the annual community health service survey, health services are required to support the census survey process.

For the annual cancer patients survey, nominated health services are required to upload contact details of eligible patients for the three months nominated for survey collection.

Data transfers occur in a secure online environment through the Project Control Portal <https://www.vhes.com.au/depthealth>. The Project Control Portal provides access to the Data Upload manual and the template required for submission.

Quarterly reports are available online at the Victorian Healthcare Experience Survey website <https://results.vhes.com.au>. At present these results are only available to registered health services and departmental staff.

2.13.3 Subacute data reporting requirements

For all subacute program data reporting requirements (other than 'Nursing home care type', described below) please see Chapter 2, section 2.3.2. 'Subacute and non-acute'.

2.13.3.1 Nursing home type care

The department no longer provides direct funding for public patients reported as nursing home type (NHT) in Victorian hospitals with subacute or non-acute care services. Therefore, it is not expected that health services will report NHT activity. Current arrangements for Department of Veterans' Affairs, compensable and private patients remain in place regarding the NHT process and funding. A patient co-contribution payment cannot be levied on patients in admitted acute and subacute care types (excluding the Transition Care Program).

2.13.4 Ambulance Victoria data reporting requirements

Stage 1 of the Victorian Ambulance Data Set (VADS) became operational in 2015–16. The department will continue to work with Ambulance Victoria to validate and extend the VADS collection. Ambulance Victoria will be required to continue existing reporting requirements until both the department and Ambulance Victoria confirm the accuracy of VADS data for the purposes of public reporting and performance monitoring.

Ambulance Victoria will supply data to the department according to the timelines specified in Table 2.9.

Table 2.9: Victorian Ambulance Data Set timelines

VADS	Timeline
Request for service and response data	Year-to-date submission to be received by the 10th day of the month following the Case Date.
Transport and patient data	Year-to-date submission to be received by the 10th day of the second month following the Case Date.
Data for the 2018–19 financial year	Year-to-date submission must be received before final consolidation of VADS on 10 August 2020.

Table 2.10: Existing ambulance data collections

Collection	Description and submission timeline
Aggregate Ambulance Minimum Dataset	The indicators identified in Table 2.19 will be supplied to the department in spreadsheet format by the 10th day of the month following the monthly reporting period.
Ambulance membership movements	Changes in Ambulance Victoria membership in spreadsheet format to be emailed to a nominated departmental contact on the seventh day of each month following the end of the monthly reporting period.

2.13.5 Mental health services data reporting requirements

Information about clinical mental health services relevant to funding, activity and performance monitoring is collected by the department through a range of channels including:

- the Client Management Interface and Operational Data Store (CMI/ODS), which captures service activity data and aspects of mental healthcare required under the *Mental Health Act 2014*
- the mental health triage minimum dataset
- reportable deaths and other notifications to the Chief Psychiatrist
- annual Mental Health Establishments collection
- quarterly Data Collection (Mental Health Community Support Services reporting)
- quarterly Mental Health Community Support Service aggregate spreadsheet report
- the VAED (see Chapter 2, section 2.13.2.2 'Victorian Admitted Episodes Dataset')
- the VEMD (see Chapter 2, section 2.13.2.3 'Victorian Emergency Minimum Dataset').

The collections form an essential underpinning of public accountability for service provision, quality and safety, with the outputs from these collections contributing to a range of national datasets, as well as performance measurement and monitoring for commonwealth, state and departmental purposes.

Mental health data and performance reporting can be found at the Victorian Health Services Performance website <http://performance.health.vic.gov.au> and the Mental health performance reports website <https://www2.health.vic.gov.au/mental-health/research-and-reporting/mental-health-performance-reports>.

2.13.5.1 Client Management Interface and Operational Data Store

The statewide Operational Data Store (ODS) is simultaneously updated from local Client Management Interface (CMI) systems as data are captured, providing a live 24-hour, seven-day-a-week statewide view of the transactional history of mental health services.

Health services are expected to use the CMI/ODS to record clinical mental health activity to ensure statewide visibility of client care across all designated mental health services. Data entry timeframes differ according to the type of data being recorded. See Table 2.11 for details.

Table 2.11: Client Management Interface and Operational Data Store reporting timelines

Data entry	Rationale	Due date
Compulsory order/legal status	Timely information regarding compulsory/forensic/security client status	Twice daily, seven days per week
Admissions, transfers and separations	Statutory reporting Maintenance of statewide bed register	Twice daily, seven days per week
Contacts	Statutory reporting	10th of the month following the contact

Data entry	Rationale	Due date
Outcome measures	Statutory reporting	10th of the month following the measure collection
Electroconvulsive therapy procedures	Statutory reporting	As soon as practicably possible
Seclusion and restraint	Statutory reporting	10th of the month following the period of seclusion/restraint
Diagnosis	Statutory reporting	10th of the month following the diagnosis event

Departmental circulars and bulletins detail the business rules for key data requirements and guidelines for data recording practices.

Business rules for data recording can be found under CMI/ODS at the Reporting requirements and business rules for clinical mental health services webpage <https://www2.health.vic.gov.au/mental-health/research-and-reporting/reporting-requirements-for-clinical%20mental-health-services>.

Regular meetings are held with hospital mental health system administrators to discuss system and data issues. Regular system upgrades are performed to improve the functionality and utility of the system and data.

Data integrity

Services are required to review and reconcile data quality issues identified by the department and provide return advice on a quarterly basis. Validation reports are updated monthly.

Quarterly returns are to be submitted by the following due dates:

- July – September 2019: 30 November 2019
- October – December 2019: 28 February 2019
- January – March 2020: 31 May 2020
- April – June 2020: 31 August 2020.

Outstanding validation issues for the 2019–20 financial year must be reconciled by 30 November 2020.

Selected health services may be subject to audits of their mental health service hours reported via the Client Management Interface and Operational Data Store (CMI/ODS).

Electroconvulsive therapy

The Chief Psychiatrist requires that all occasions of electroconvulsive therapy (ECT) be reported to the Office of the Chief Psychiatrist. All ECT course details and procedures are to be recorded on the CMI/ODS as soon as practicably possible after each procedure.

2.13.5.2 Mental Health Establishments National Minimum Dataset

The Mental Health Establishments National Minimum Dataset collection captures all mental health workforce data and expenditure and is compiled to meet the *Mental health services annual report* and national mental health reporting requirements.

The data collection for the previous financial year (Stage 1) begins in September each year, with health services, residential service providers and departmental divisions required to submit a return.

As has been the practice in previous years, the Mental Health Establishment collection for 2019–20 will be pre-populated with health service activity data from the CMI/ODS. This information is subject to health service confirmation or amendment as required.

Health service finance data from the F1 return is available on request to assist with completion of organisation-level finance information. Further advice will be provided prior to the HealthCollect portal opening for the stage 1 2019–20 data submission.

Visit the HealthCollect web portal <https://www.healthcollect.vic.gov.au>.

Reporting timelines for the Mental Health Establishments National Minimum Dataset are outlined in Table 2.12.

Table 2.12: Mental Health Establishments National Minimum Dataset reporting timelines

Collection period	Reporting requirements	Due date
2017–18	Stage 2: Resolution of final validation issues identified by the AIHW for 2017–18. Validations to be finalised by health services by 30 August 2019 when the HealthCollect portal will close.	30 August 2019
2018–19	Stage 1: Data submission opens through the HealthCollect portal and remains open for one month. Data entry by health services to be finalised by 12 October 2019 when the portal will close.	12 October 2019
2018–19	Stage 1: Resolution of services' initial validation issues arising from the HealthCollect portal.	26 April 2020
2018–19	Stage 2: Resolution of final issues identified by the AIHW for 2018–19. Validations from health services must be finalised by 30 August 2020 when the HealthCollect portal will close.	16 August 2020

2.13.5.3 Mental health triage minimum dataset

Triage minimum dataset submissions are to be provided in the prescribed format on a monthly basis by the 15th of each month. The data file must be sent to the mental health triage secure email <triagemds@dhhs.vic.gov.au>.

Documentation detailing the format and reporting timelines can be found at the Reporting requirements and business rules for clinical mental health services webpage <https://www2.health.vic.gov.au/mental-health/research-and-reporting/reporting-requirements-for-clinical%20mental-health-services>>.

2.13.5.4 Mental health community support services

Agencies funded to deliver mental health community support service activity are expected to provide data via the Quarterly Data Collection (QDC) and the supplementary MHCSS excel spreadsheet. Compliance with these reporting requirements is a key accountability requirement to be used as part of the ongoing review and monitoring processes.

Quarterly Data Collection data must be submitted by 7th of the month following the end of the quarter. The QDC has a dedicated helpdesk support team to assist users with the quarterly data collection. Contact the team via the QDC helpdesk email <qdchelp@dhhs.vic.gov.au>.

The aggregate supplementary excel spreadsheet data file must be submitted by the 15th of the month following the end of the quarter. The file must be submitted by emailing Mental Health and Drugs Data team <mhcssdata@dhhs.vic.gov.au>.

Due to the transition to the National Disability Insurance Scheme, Individualised Client Support Packages, previously in scope, will cease reporting to the MHCSS in 2019–20.

2.13.5.5 Reportable deaths

The Chief Psychiatrist requires that the deaths of consumers of designated mental health services and mental health community support services be reported in the following circumstances.

Deaths on mental health inpatient units

All deaths of mental health inpatients, including expected deaths, must be notified to the Chief Psychiatrist within 24 hours. Notifications can be made by telephone (03) 9096 8124, or email the Office of the Chief Psychiatrist<ocp@dhhs.vic.gov.au>.

For the purposes of this policy, an inpatient is defined by the Chief Psychiatrist as any person, regardless of legal status, who:

- has been admitted to a mental health inpatient unit
- is on approved leave from an inpatient unit
- has absconded from an inpatient unit
- has been transferred to a non-psychiatric ward during a mental health admission
- has been discharged from a mental health inpatient unit within the previous 24 hours.

Deaths in the community

The Chief Psychiatrist must be notified in writing of:

- All unexpected, unnatural or violent deaths (including suspected suicides) of community-resident persons who were registered as mental health consumers within the previous three months or who had sought service from a mental health provider within that period and not been provided with service.
- All deaths of community-resident patients under the *Mental Health Act 2014* (including forensic orders). People are considered to be mental health consumers until their case is closed and they have been notified of this closure (or the service has made all reasonable efforts to do so).
- Designated mental health services and mental health community support service notify the Chief Psychiatrist of a death consumers using the MHA 125 'Notice of Death' form.
- VHIMS reporting community service organisations providing MHCSS programs are required to report the incident in accordance with the *Victorian health incident management policy.* Non-VHIMS reporting community service organisations providing MHCSS are required to report the incident in accordance with the *Incident reporting instruction 2013.*

More information on what is meant by a 'reportable death' and the procedures for reporting them can be found in the Chief Psychiatrist's guideline on reportable deaths <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/reportable-deaths>.

Suicides on other hospital wards

Suicides on inpatient units (including medical, surgical and other are categorised nationally as sentinel events (that is, unexpected health care incidents that result in death or serious disability). The sentinel event program is managed by Safer Care Victoria which must be notified by area mental health services. The non-psychiatric wards are one of eight nationally defined sentinel event categories that must be notified to the department's Sentinel Event Program. See more information on the Sentinel Event Program <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/clinical-risk-management/sentinel-event-program>.

2.13.5.6 Restrictive Interventions reporting (seclusion and bodily restraint)

The *Mental Health Act 2014* closely regulates the use of 'restrictive interventions'. Part 6 of the Act outlines when restrictive interventions can be used, who can authorize them and the monitoring of restrictive interventions when used. Section 3 of the Act defines 'restrictive interventions' as 'bodily restraint or seclusion'.

All restrictive interventions are required to be reported to the Chief Psychiatrist.

In accordance with the *Mental Health Act 2014* and the Chief Psychiatrist Guidelines *Restrictive interventions in designated mental health* services, an authorised psychiatrist must give a written report to the Chief Psychiatrist on the use of any restrictive intervention (s. 108(1)). This report must contain the details required by the Chief Psychiatrist and be given to the Chief Psychiatrist within the time stipulated (s. 108).

In practice, this information is entered monthly onto the Client Management Interface (CMI) database in each service and must include information relating to restrictive interventions which have occurred in

emergency departments and other areas where the intervention has occurred with people receiving compulsory treatment under the *Mental Health Act 2014*.

The service must also provide appropriate information to persons subject to restrictive interventions about their rights, including post intervention support.

Episodes of extended seclusion

In addition to the routine monthly reporting procedures, designated mental health services are required to notify the Chief Psychiatrist of any episode of seclusion which is continuous and exceeds 48 hours. This report must be made before the episode exceeds 48 hours in length.

Where an extended period of seclusion in excess of 48 hours is anticipated, the authorised psychiatrist or delegate must provide the Chief Psychiatrist with a written clinical summary and management plan at the time of notification.

Mental health services will be required to present evidence of an active case conferencing process to assist in bringing the seclusion episode to conclusion for any episode of seclusion exceeding 30 consecutive days and at any time on request thereafter.

Extended admission to high dependency area

Designated mental health services are required to notify the Chief Psychiatrist of any extended admission to a high dependency area which is continuous and exceeds 48 hours. This report must be made at the time the episode has not exceeded 48 hours in length.

Where an extended period of seclusion in excess of 48 hours is anticipated, the authorised psychiatrist or delegate must provide the Chief Psychiatrist with a written clinical summary and management plan at the time of notification.

Mental health services will be required to present evidence of an active case conferencing process to assist in bringing the admission to conclusion for any admission to a high dependency area exceeding 30 consecutive days and at any time on request thereafter.

2.13.5.7 Sexual safety reporting

The Office of the Chief Psychiatrist established a new reporting process regarding sexual safety incidents in all inpatient units across specialist mental health services effective from March 2018. Designated mental health services are required to report known occurrences or allegations of sexual activity, including sexual activity between patients or staff, sexual harassment or assault on an acute psychiatric inpatient unit within 24 hours of being identified in accordance with the requirements of the Chief Psychiatrist.

2.13.5.8 Electroconvulsive therapy

Treatment reports

Designated mental health services are required to report the use of ECT to the Chief Psychiatrist. The information to be submitted includes:

- the date, name, UR number, sex and age of each person
- the names of the doctors giving the anaesthetic and ECT
- treatment laterality and stimulus level
- the nature of the consent given for treatment.

The authorised psychiatrist is responsible for ensuring that reports are submitted but may designate a staff member, preferably the ECT coordinator, to undertake this function. Reports are now submitted online. Data must be returned within a month of treatment. Individual services should determine if other information is required for local purposes, such as quality improvement programs.

Adverse events

The Chief Psychiatrist must be notified immediately either by telephone or electronically of adverse events directly related to ECT that:

- result in death (including near misses), serious injury, serious illness, or
- require transfer to an emergency department or similar setting.

Other incidents and near misses should be reported to the service's own ECT committee and safety-monitoring bodies.

People under the age of 18 years

The Act regulates the use of ECT for '**all young persons**' under the age of 18 years in Victoria, whether voluntary or involuntary, including those in both public mental health services and private hospitals and clinics, even when the young person has given informed consent to treatment.

A psychiatrist must apply to the Mental Health Tribunal to perform a course of ECT, even if the young person provides informed consent. The Chief Psychiatrist does not make decisions concerning treatment but must be informed **in advance** of plans to administer ECT to a young person receiving mental health services from a designated mental health service.

The Chief Psychiatrist must also be informed of the clinical outcomes for the young person after ECT has been administered to assist in the preparation of annual and five-yearly reports to the Minister for Health.

The Chief Psychiatrist is required to monitor outcomes in this age group. To facilitate this, service providers are required to complete a number of outcomes measures at specified intervals before and after ECT is administered.

2.13.5.9 Neurosurgery for mental illness

Treatment of psychiatric illness by means of neurosurgery (specifically, deep brain stimulation) must be approved by the Mental Health Tribunal. Following treatment, the authorised psychiatrist treating the person must provide a written report to the Chief Psychiatrist including a description of the treatment's outcome within 3 months after the surgery is performed and again within 9 to 12 months after the surgery is performed.

Alcohol and other drug services data reporting requirements

Information about alcohol and other drug services which are relevant to funding, activity and performance monitoring is collected through a range of channels including the:

- Victorian Alcohol and Drug Collection
- Needle and Syringe Program Information System.

2.13.5.10 Victorian Alcohol and Drug Collection

The Victorian Alcohol and Drug Collection (VADC) supports public accountability for service provision. Outputs contribute to the national AODTS dataset, as well as performance measurement and monitoring for Commonwealth, state and departmental purposes. All alcohol and drug treatment service providers are required to submit activity data via the VADC.

Alcohol and other drug treatment service providers are required to ensure client management systems can meet VADC reporting requirements. Details on data specifications, bulletins and the submission process can be found at the VADC data specification and supporting documentation webpage <https://www2.health.vic.gov.au/alcohol-and-drugs/funding-and-reporting-aod-services/data-collection/vadc-specifications>.

VADC data must be submitted monthly with data due by the 15th day of the subsequent month.

2.13.5.11 Needle and Syringe Program Information System

The Victorian and Commonwealth Governments fund services to reduce the harms associated with alcohol and other drug use. The harm reduction services data collection records the level of activity in these services in terms of contacts, service provision (for example, needles provided and returned, education and referrals), responses to harm reduction questions, as well as information about the free provision of a range of injecting and safe-sex equipment, and the disposal of returned waste.

Harm reduction services data is provided by:

- needle and syringe programs
- mobile overdose response services
- mobile drug safety workers.

All Primary Needle and Syringe Program providers and recipients of Ice Action Plan funding are required to report monthly by the end of each month via the Needle and Syringe Information System Agency Reporting (NSPIS-AR) application. Organisations using the NSPIS-AR application can generate the extract and email it to the Needle and Syringe Program <nsp-is@dhhs.vic.gov.au>.

Paper-based surveys should be sent to the department by emailing NSP Data Collection <nsp-is@dhhs.vic.gov.au>, by fax to (03) 9096 8726, or posted to:

NSP Data Collection
Mental Health & Drugs Data unit
Level 3
Department of Health and Human Services
GPO Box 4541
Melbourne VIC 3001

2.13.5.12 Drugs and poisons information system

The department operates an electronic information system known as the drugs and poisons information system to support its administration of the *Drugs, Poisons and Controlled Substances Act 1981*.

The drugs and poisons information system is a stand-alone system. It provides the department with the ability to record treatment permits issued to doctors prescribing Schedule 8 drugs to patients. This includes methadone and buprenorphine prescriptions for opioid replacement therapy (pharmacotherapy).

The system is additionally used to record information collected during prescription-monitoring activities and during investigative processes. Interventions are initiated if unlawful or possibly unsafe prescribing is identified. Non-compliant health practitioners may be subject to further action, ranging from educational counselling to prosecution or other disciplinary action. More serious offending (for example, trafficking) will commonly be the subject of joint investigations involving departmental officers and police.

The drugs and poisons information system also records licences and permits issued to organisations or individuals who have a legitimate need to use, possess, manufacture or supply medicines and poisons as part of their practice or business (such as for research, industrial or health services). The information system also records the payment of fees relating to such licences and permits associated with the possession of drugs and poisons.

2.13.5.13 SafeScript, Victoria's Real-Time Prescription Monitoring System

SafeScript is computer software that allows prescription records for certain high-risk medicines to be transmitted in real-time to a centralised database which can then be accessed by doctors, nurse practitioners and pharmacists during a consultation with a patient.

SafeScript provides these practitioners with a clinical tool to make safer decisions about whether to prescribe or dispense a high-risk medicine, as well as facilitating early identification, treatment and support for patients who are developing signs of substance use disorder.

The data for SafeScript is collected automatically from Prescription Exchange Services (PES) which currently support the electronic transfer of prescriptions from medical clinics to pharmacies.

When a prescription is issued at a medical clinic or dispensed at a pharmacy, the PES sends a record of the prescription in real-time to SafeScript. No additional data entry is necessary to record a prescription in SafeScript.

Authorised departmental officers may also access SafeScript as part of their regulatory role in ensuring the safe supply of medicines in the community.

From April 2020, it will be mandatory for doctors, nurse practitioners and pharmacists to check SafeScript before prescribing or dispensing a medicine monitored in SafeScript.

2.13.5.14 Opioid Replacement Therapy Dispenser Census

The department conducts the opioid replacement therapy dispenser census annually. It surveys all community, correctional, health service and specialist pharmacotherapy service dispensaries dosing opioid replacement therapy clients in Victoria. All dispensers are faxed the survey form, to be returned by fax, recording the number of clients being dosed with respective opioid replacement therapy medications. It also records the numbers of opioid replacement therapy clients on a minimal supervision regimen, and persons who are eligible for departmental dispensing support, or with interstate prescriptions. Finally, it collects data of clients who identify as Aboriginal, Torres Strait Islander, Aboriginal and Torres Strait Islander or neither as of June 30.

The data provides a count of clients being dosed at a given time. This allows patterns of opioid replacement therapy access to be monitored across the state, which in turn informs departmental sector support activities.

2.13.6 Aged care data reporting requirements

Data collection requirements and timelines for ageing, aged and home care services are provided in Table 2.13. This includes information for the Home and Community Care Program for Younger People (HACC-PYP), public sector residential aged care and aged care assessment services (ACAS) through a range of channels including:

- the HACC minimum dataset
- My Aged Care Reporting
- RAS assessment activity database for reporting hours
- HACC-PYP fees data collection
- HACC-PYP annual service activity reports
- residential aged care services data collection.

Since the Home and Community Care Program was split between the Commonwealth and the state on 1 July 2016, reporting requirements for clients aged 65 and over (and Indigenous clients aged 50 and over) are now determined by the Commonwealth Department of Health, which administers the Commonwealth Home Support Programme.

For clients aged less than 65 (and Indigenous clients aged less than 50) who remain in HACC-PYP managed by Victoria, reporting requirements remain unchanged – that is, via the HACC Minimum Data Set. Organisations should continue to send the data to the department.

The *Carers Recognition Act 2012* sets out obligations for councils and organisations covered by that Act, including the obligation to raise awareness and understanding of the care relationship principles as set out in the Act. Relevant organisations are required to report on their compliance against these obligations in their annual report. Specific requirements can be found in ss. 5, 11 and 12 of the Act.

Table 2.13: Ageing, aged and home care data collection and reporting requirements

Activity no.	Activity name	Measure description
13005	ACAS assessment[8]	Six-monthly report on ACAP operations
13005	ACAS assessment	Six-monthly report on ACAP staffing
13230	RAS assessment	RAS assessment activity database for reporting hours
13015	HACC linkages packages	HACC minimum dataset
13015	HACC linkages packages	HACC-PYP fees data collection
13023	HACC service development grant	Electronic project report
13056	Home and Community Care planned activity group – core	HACC minimum dataset
13056	Home and Community Care planned activity group – core	HACC-PYP fees data collection
13057	Home and Community Care planned activity group – high	HACC minimum dataset
13057	Home and Community Care planned activity group – high	HACC-PYP fees data collection
13038	Home and Community Care service system resourcing	Service activity report
13043	Home and Community Care flexible service response	Service activity report
13043	Home and Community Care flexible service response	HACC minimum dataset where relevant
13063	Home and Community Care volunteer coordination	Service activity report
13063	Home and Community Care volunteer coordination	HACC minimum dataset where relevant
13096	Home and Community Care allied health	HACC minimum dataset
13096	Home and Community Care allied health	HACC-PYP fees data collection
13096	Home and Community Care allied health	Service activity report where relevant
13097	Home and Community Care delivered meals	HACC minimum dataset
13099	Home and Community Care property maintenance	HACC minimum dataset
13099	Home and Community Care property maintenance	HACC-PYP fees data collection
13131	RDNS Home and Community Care allied health	HACC minimum dataset
13131	RDNS Home and Community Care allied health	HACC-PYP fees data collection
13131	RDNS Home and Community Care allied health	Service activity report
13223	Home and Community Care nursing	HACC minimum dataset
13223	Home and Community Care nursing	HACC-PYP fees data collection
13223	Home and Community Care nursing	Service activity report

[8] Where 'HACC' is referred to, the activity name relates to the Home and Community Care Program for Younger People (HACC-PYP)

Activity no.	Activity name	Measure description
13226	Home and Community Care personal care	HACC minimum dataset
13226	Home and Community Care personal care	HACC-PYP fees data collection
13227	ACCO services – aged and home care	HACC minimum dataset
13227	ACCO services – aged and home care	HACC-PYP fees data collection
13227	ACCO services – aged and home care	Service activity report
13229	Home and Community Care access and support	HACC minimum dataset
13229	Home and Community Care access and support	HACC-PYP fees data collection
13229	Home and Community Care access and support	Service activity report – A&S activity 6 monthly report
35030	Small Rural – HACC Health Care and Support	HACC minimum dataset
35030	Small Rural – HACC Health Care and Support	HACC PYP fees data collection
35030	Small Rural – HACC Health Care and Support	Service activity report
13026	HACC domestic assistance	HACC minimum dataset
13026	HACC domestic assistance	HACC-PYP fees data collection
13027	HACC respite	HACC minimum dataset
13027	HACC respite	HACC-PYP fees data collection
13031	Public sector residential aged care supplements (including Small Rural – residential aged care supplements previously reported under 35011).	Residential aged care services data collection and residential aged persons mental health data collection Forms: AIMS S5_129 for Residential aged care services data collection; AIMS Public sector residential aged care services quality indicators; and AIMS S5-115 for Aged persons' mental health; PSRACS financial data submitted to the department for the F1 data collection must be submitted using the Campus codes allocated to each Health Service (for assistance, email Planning and Operations <Planning&Operations@health.vic.gov.au>) Public sector residential aged care services VICNISS infection control module; participation in the annual Aged Care National Antimicrobial Prescribing Survey (acNAPS); monitoring and reporting on Significant organisms such as MRSA, VRE and CDI; resident vaccination rates for influenza, herpes zoster and pneumococcal; staff vaccination rates for influenza. (for assistance contact VICNISS Coordinating Centre by phone 9342 9333 or VICNISS email <vicniss@mh.org.au>)

2.13.7 Primary, community and dental health data reporting requirements

A summary of reporting requirements is shown in Table 2.14.

2.13.7.1 Community health services

All funded organisations receiving community health program funding are required to submit data that outlines service delivery performance against targets. Agencies are responsible for the timely submission of data as per the documented reporting requirements.

The *Community Health Program Data Submission Guidelines* are available from the Community health data reporting webpage <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/community-health-data-reporting>.

All health services receiving community health program funding are required to ensure that:

- information systems comply with the department's reporting requirements
- service information remains up-to-date on the National Human Services Directory.

Additional evidence may be required from time-to-time to demonstrate that funding has been used appropriately.

Community health services can also contribute to the Primary Care Partnerships reporting, as outlined in Chapter 2, section 2.6.7 'Partnerships'.

2.13.7.2 Primary Care Partnerships

Primary Care Partnerships are required to report annually to demonstrate progress in achieving strategic outcomes. Primary Care Partnerships are responsible for the timely submission of reports as per the documented reporting requirements.

A key objective of Primary Care Partnership activity is to strengthen integration across health and human services sectors. Reporting should demonstrate meaningful engagement and partnership with organisations from both these sectors and provide an overview of their key activities in prevention. Primary Care Partnership reporting should reflect partnerships with Primary Health Networks and other locally relevant collaboratives and networks to progress this work.

E-referral reporting is used to report annually to the Department of Treasury and Finance on the number of referrals made using electronic referral systems. Reporting provides an indication of the level of participation of health and human services in securely sharing standardised consumer information electronically. Work is ongoing to replace this outdated measure. Updates to Primary Care Partnerships reporting requirements will be provided as changes occur. Primary Care Partnerships are required to submit their annual financial statement in accordance with the department's monitoring framework.

Primary Health Networks reporting requirements for state funded programs and priorities are adhered to as outlined in their service agreements with the department.

2.13.7.3 Dental health services

The department requires a monthly extract of dental health program dataset items. This extract includes all episodes created during the reporting period and any episodes modified during the reporting period. Agencies with multiple databases should provide one extract per database.

Funded organisations are required to submit data to the department by the third business day of each month. The department is responsible for validating monthly extracts and providing error reports to agencies. Funded organisations must correct errors in their data before the next extract of all health program dataset items is submitted.

Table 2.14: Primary and dental health data collection and reporting requirements

Activity no.	Activity name	Data collection description
27017	Oral health – health promotion	Report against agreed deliverables linked to the *Victorian action plan to prevent oral disease 2019–23*
27019	Royal Dental Hospital Melbourne dental care	Dental health program dataset
27023	Community dental care	Dental health program dataset
28000	Health Self Help (Band 1)	Annual activity report
28015	Family and Reproductive Rights Education Program (FARREP)	Community health minimum dataset
28016	FARREP – health promotion	Report against health promotion plan
28018	Family planning – health promotion	Report against health promotion plan
28021	Innovative Health Services for Homeless Youth (IHSHY) – health promotion	Report against health promotion plan
28048	Language services	Community health minimum dataset
28050	Women's health – health promotion	Report against health promotion plan
28062	Telephone counselling	Regional report
28063	Family planning – education and training	Quarterly report
28064	Family planning – clinical services and training	Community health minimum dataset
28066	IHSHY	Community health minimum dataset
28068	Family planning	Community health minimum dataset
28071	Aboriginal services and support	
28072	Integrated chronic disease management	Community health minimum dataset
28076	Refugee and asylum seeker health services	Community health minimum dataset
28080	Healthy Mothers Healthy Babies	Community health minimum dataset
28081	National Diabetes Services Scheme	Monthly report
28085	Community health – health promotion	Report against health promotion plan
28086	Community health	Community health minimum dataset
28087	Primary Care Partnerships	Report against PCP planning and reporting guidelines
28088	ACCO services – primary health	Round table reporting
28090	MDC – Community Health Nurse	Community health minimum dataset
28091	Community Asthma Program	Community health minimum dataset
35048	Small rural – Primary Health Flexible Services	Community health minimum dataset or other relevant data collection if funding used for another allowable purpose

Table 2.15: Ageing, aged and home care performance targets and monitoring

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
13230	Regional Assessment Service assessment	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13230	Regional Assessment Service assessment	Number of completed assessments	Reports	Quarterly	Mandatory	Key output measure
13230	Regional Assessment Service assessment	My Aged Care Key Performance Indicators	Percentage	Quarterly	Mandatory	Other standard measure
13004	Aged Care Assessment Service project	Report against agreed objectives	Reports	Yearly	Mandatory	Key output measure
13005	Aged Care Assessment Service assessment	Percentage of priority 1, 2 and 3 clients assessed on time	Percentage	Quarterly	Mandatory	Other standard measure
13005	Aged Care Assessment Service assessment	Average (Median) number of days from referral to first clinical intervention	Number	Quarterly	Mandatory	Key output measure
13005	Aged Care Assessment Service assessment	Number of assessments	Assessments	Quarterly	Mandatory	Key output measure
13019	Personal Alert Victoria	Number of units allocated	Number of units	Yearly	Mandatory	Key output measure
13015	Home and Community Care linkages packages	Number of packages	Packages	Quarterly	Mandatory	Key output measure
13023	Home and Community Care service development grant	One electronic project report submitted	Reports	Yearly	Mandatory	Key output measure
13024	Home and Community Care assessment	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13026	Home and Community Care domestic assistance	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13027	Home and Community Care respite	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13031	Public sector residential aged care supplement	Number of occupied bed days	Occupied bed days	Monthly	Mandatory	Key output measure
13035	Support for carers	Number of carers	Carers	Yearly	Mandatory	Key output measure
13035	Support for carers	Number of hours of service	Hours	Quarterly	Mandatory	Other standard measure
13038	Home and Community Care service system resourcing	Service activity report	Reports	Yearly	Mandatory	Key output measure

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
13043	Home and Community Care flexible service response	Service activity report	Reports	Yearly	Mandatory	Key output measure
13053	Victorian Eyecare Service	Number of occasions of service (metropolitan)	Occasions of service	Quarterly	Mandatory	Key output measure
13053	Victorian Eyecare Service	Number of occasions of service (outreach)	Occasions of service	Quarterly	Mandatory	Other standard measure
13053	Victorian Eyecare Service	Number of occasions of service (rural)	Occasions of service	Quarterly	Mandatory	Other standard measure
13056	Home and Community Care planned activity group – core	Number of hours of service (provided to clients)	Hours	Quarterly	Mandatory	Key output measure
13057	Home and Community Care planned activity group – high	Number of hours of service (provided to clients)	Hours	Quarterly	Mandatory	Key output measure
13059	Residential aged care complex care supplement	Number of occupied bed days	Occupied bed days	Monthly	Mandatory	Key output measure
13063	Home and Community Care volunteer coordination	Number of hours of coordinator time	Hours	Yearly	Mandatory	Key output measure
13063	Home and Community Care volunteer coordination	Number of hours of service (provided to clients)	Hours	Quarterly	Non mandatory	Other standard measure
13067	Aged community grants	Number of projects	Projects	Yearly	Mandatory	Key output measure
13082	Low-cost accommodation support	Number of clients assisted	Clients	Quarterly	Mandatory	Key output measure
13083	Aged training and development	Number of filled positions (academic)	Positions	Quarterly	Mandatory	Key output measure
13083	Aged training and development	Number of filled positions (training)	Positions	Quarterly	Non-mandatory	Other standard measure
13096	Home and Community Care allied health	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13097	Home and Community Care delivered meals	Number of meals (funding is a subsidy only)	Meals	Quarterly	Mandatory	Key output measure
13099	Home and Community Care property maintenance	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13100	Aged research and evaluation	Report against agreed objectives	Reports	Yearly	Mandatory	Key output measure
13103	Language services	Number of occasions of service	Occasions of service	Monthly	Mandatory	Key output measure

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
13107	Rural small high-care supplement	Number of occupied bed days	Occupied bed days	Monthly	Mandatory	Key output measure
13131	RDNS Home and Community Care allied health	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13155	Dementia services	Number of contacts	Contacts	Yearly	Mandatory	Other standard measure
13155	Dementia services	Number of hours of service	Hours	Yearly	Mandatory	Key output measure
13156	Seniors health promotion	Report against agreed objectives	Reports	Yearly	Mandatory	Key output measure
13210	Aged Care Assessment Service training and development	Funds expended on training needs of staff	Dollars	Yearly	Mandatory	Key output measure
13223	Home and Community Care nursing	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13226	Home and Community Care personal care	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13227	ACCO services – aged and home care	Development of service profile	Completed service profile	Yearly	Mandatory	Key output measure
13229	Home and Community Care access and support	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13301	Aged quality improvement	Current authorisations for information exchange between the department and: • Department of Health and Human Services • Australian Aged Care Quality Agency	Signed documents	Yearly	Mandatory	Other standard measure
13302	SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI)	Number of facility cost relief expenditure plans developed and implemented	Plans	Yearly	Mandatory	Key output measure
13302	SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI)	Number of facility cost relief cluster plans developed and implemented	Plans	Yearly	Mandatory	Other standard measure
13302	SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI)	Number of proprietors of assisted supported residential services that meet accountability and	Proprietors	Yearly	Mandatory	Other standard measure

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
		reporting requirements for facility cost relief				
13303	SAVVI Supporting Connections	Number of clients	Clients	Yearly	Mandatory	Key output measure
13352	Victorian Seniors Festival	Number of events and participants	Events Participants	Yearly	Non-mandatory	Other standard measure
13354	Elder abuse prevention and response	Number of telephone calls	Calls	Six-monthly	Non-mandatory	Other standard measure
13354	Elder abuse prevention and response	Number of professional educations sessions attendees	Events participants	Six-monthly	Non-mandatory	Other standard measure
13354	Elder abuse prevention and response	Number of community education sessions	Events	Six-monthly	Non-mandatory	Other standard measure
13355	Seniors community programs	Number of projects	Reports	Quarterly	Non-mandatory	Other standard measure
13356	Information and lifelong learning	Number of information requests/contacts	Contacts	Quarterly	Non-mandatory	Other standard measure
13356	Information and lifelong learning	New programs New U3As	Programs U3As	Six-monthly	Non-mandatory	Other standard measure

Table 2.16: Primary and dental health performance targets and monitoring

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
27019	RDHM Dental Care	Number of clients	Clients	Yearly	Mandatory	Key output measure
27023	Community Dental Care	Number of clients	Clients	Yearly	Mandatory	Key output measure
28015	FARREP	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28016	FARREP – Health Promotion	Report against health promotion plan	Reports	Yearly	Non-mandatory	Other standard measure
28018	Family Planning – Health Promotion	Report against health promotion plan	Reports	Yearly	Non-mandatory	Other standard measure
28021	IHSHY – Health Promotion	Report against health promotion plan	Reports	Yearly	Non-mandatory	Other standard measure
28048	Language Services	Number of occasions of service	Occasions of service	Monthly	Mandatory	Key output measure
28050	Women's Health – Health Promotion	Report against health promotion plan	Reports	Yearly	Non-mandatory	Other standard measure

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
28062	Telephone Counselling	Number of calls answered	Calls	Quarterly	Mandatory	Key output measure
28062	Telephone Counselling	Percentage of calls answered	Calls	Quarterly	Mandatory	Other standard measure
28063	Family Planning – Education and Training	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28064	Family Planning – Clinical Services and Training	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28066	IHSHY	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28068	Family Planning	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28071	Aboriginal Services and Support	Number of hours of service	Hours	Quarterly	Mandatory	Other standard measure
28071	Aboriginal Services and Support	Report against agreed objectives	Reports	Yearly	Mandatory	Key output measure
28072	Integrated Chronic Disease Management	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28076	Refugee and Asylum Seeker Health Services	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28080	Healthy Mothers Healthy Babies	Numbers of hours of service	Hours	Quarterly	Mandatory	Key output measure
28081	National Diabetes Services Scheme	Number of packs of needles and syringes	Needles and syringes	Monthly	Mandatory	Key output measure
28085	Community Health – Health Promotion	Report against health promotion plan	Reports	Yearly	Mandatory	Other standard measure
28086	Community Health	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28087	Primary Care Partnerships	Report against PCP planning and reporting guidelines	Reports	Yearly	Mandatory	Key output measure
28088	ACCO Services – Primary Health	Development of service profile	Completed service	Yearly	Mandatory	Key output measure
28090	MDC – Community Health Nurse	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28091	Community Asthma Program	Number of hours of service	Hours	Quarterly	Mandatory	Key Output measure

2.13.8 Workforce data reporting requirements

Reporting is required against the workforce programs and datasets to inform statewide policy, planning and funding, to ensure more effective investment in the development of Victoria's future workforce.

2.13.8.1 Health Services Payroll and Workforce Minimum Employee Dataset

Health services are required to transmit information detailed in the Health Services Payroll and Workforce MDS Data Dictionary to the department. Data must be transmitted to the department by the 10th day of the following month, or the prior working day if the 10th day of the following month falls on a weekend or public holiday. Payroll data is required monthly, while workforce information is required biannually, covering the periods ending 31 December and 30 June each year. Where health services undertake their own payroll processing, they are required to transmit the information directly to the department. In cases where health services engage a payroll bureau to process their payroll, health services may authorise the bureau to transmit the data to the department on their behalf. Notwithstanding such an arrangement, health services remain responsible for the accuracy of the data transmitted.

Where a health service decides to change payroll providers, it will be necessary to complete an accreditation process, prior to the change, to ensure that continuity of data transmission to the department will not be compromised.

2.13.9 Training and development funding reporting and eligibility requirements

2.13.9.1 Eligibility requirements

All public health services, Mildura Base Hospital and the Victorian Institute of Forensic Mental Health are eligible to receive training and development funding.

To receive funding organisations are required to:

- ensure that all funded programs conform to the most recent versions of guidelines (where available), including the guidelines and standards set by the Australian Health Practitioner Regulation Agency and the national health practitioner boards
- comply with specific eligibility and reporting requirements for each stream (described below)
- report against the mandatory externally reportable *Best practice clinical learning environment* (BPCLE) Framework indicators through the BPCLE tool.

Further information regarding the BPCLE Framework and detailed guidelines for the training and development funding are available via the following links:

- BPCLE Framework <https://www2.health.vic.gov.au/health-workforce/education-and-training/building-a-quality-health-workforce/bpcle-framework>.
- Training and Development Funding <https://www2.health.vic.gov.au/health-workforce/education-and-training/training-development-grant>.

2.13.9.2 Professional-entry student placements

Professional-entry student placement funding is provided for eligible clinical placement days reported for eligible disciplines and courses at Victorian public health services. For details of eligible activity, disciplines and courses, refer to the Training and Development Funding Guidelines <https://www2.health.vic.gov.au/health-workforce/education-and-training/training-development-grant>.

To access the professional-entry student placement subsidy, health services are required to:

- plan and report clinical placement activity through Placeright biannually (or the interim reporting tool for agreed medical placement activity not yet using Placeright)

- adhere to the *Standardised schedule of fees for clinical placement of students in Victorian public health services* ('the schedule'), including recording of fees in Placeright (or the interim reporting tool for agreed medical placement activity not yet using Placeright)

Health services are also encouraged to:

- establish a Student Placement Agreement (SPA) with all education provider partners, including uploading to Placeright where the system is used to manage eligible funded activity
- adhere to the Standard Student Induction Protocol (SSIP) to ensure conformity of practices across the sector.

Note that work is underway to review the SPA template and SSIP provided by the department to assist the sector. Any feedback on these resources should be emailed to Workforce Funding, Performance and Review <vicworkforce@dhhs.vic.gov.au>.

Further information on these resources is available via the following links:

- Fee schedule for clinical placement in public health services <https://www2.health.vic.gov.au/health-workforce/education-and-training/student-placement-partnerships/fee-schedule-for-clinical-placement-in-public-health-services>
- Placeright <https://www2.health.vic.gov.au/health-workforce/education-and-training/student-placement-partnerships/placeright>
- Student Placement Agreement <https://www2.health.vic.gov.au/health-workforce/education-and-training/student-placement-partnerships/student-placement-agreement>
- Standard Student Induction Protocol (SSIP) <https://www2.health.vic.gov.au/health-workforce/education-and-training/student-placement-partnerships/standardised-student-induction-protocol>.

2.13.9.3 Transition to practice (graduate) positions

To access transition to practice funding for allied health, medical (year one and two) and nursing midwifery graduates, the following criteria must be met:

- Transition to practice (graduate) positions for medical, nursing and midwifery and medical radiations are filled through the statewide matching process, or by another process as determined by the department.
- Health services are required to report on the headcount and full-time equivalent of new graduates for the previous calendar year and a projection for the forthcoming year.
- Health services must allocate adequate training and supervision to each position and meet the accreditation requirements where relevant and must provide advice to the department if a graduate does not commence in, or complete, an allocated position.
- No fees may be charged to graduates applying for, undertaking, or exiting from transition to practice programs.

For further information relating to eligibility criteria refer to the Health Workforce webpage <https://www2.health.vic.gov.au/health-workforce>.

2.13.9.4 Postgraduate positions – medical, nursing and midwifery

All health services are required to reconcile actual activity at the completion of the calendar year.

All health services receiving funding for the Victorian Medical Specialist and Victorian Paediatric Training Programs and the Basic Physician Training Consortia Program are required to provide confirmation at each stage of training, including at recruitment, resignation, completion or any other change in the training pathway by completing program reports.

Funded postgraduate nursing and midwifery programs must lead to an award classification at Graduate Certificate, Graduate Diploma or Master level. Where students are enrolled in a Master-level program with exit points at Graduate Certificate or Graduate Diploma level, only the Graduate Certificate or

Graduate Diploma components are eligible. Master-level studies that lead to endorsement as a nurse practitioner may be eligible; however, individuals receiving Nurse Practitioner Candidate Support Packages are excluded.

Eligible postgraduate education programs must include a requirement for supervised clinical support.

Postgraduate (entry-to-practice) clinical placement model midwifery studies are not eligible for this stream of the training and development grant but are eligible for a professional-entry student placement subsidy.

For further information relating to eligibility criteria refer to the Health Workforce webpage <https://www2.health.vic.gov.au/health-workforce>.

2.13.9.5 Other targeted workforce training and development programs

Nursing and midwifery postgraduate scholarships

The department requires annual reporting of the value and number scholarships allocated and the field of study undertaken. Health services in receipt of this stream of funding will be provided with a reporting template and guidelines on the allocation and reporting requirements.

Continuing nursing and midwifery education

The department requires the reconciliation of continuing nursing and midwifery activity that occurred in 2019–20 to be submitted by 26 July 2020. A link to an online reporting form will be provided to recipients of the funding.

Prevocational medical education and training

The department requires annual reconciliation of the expenditure of funds allocated for prevocational medical education and training. Health services in receipt of this stream of funding will be provided with a reporting template.

Rural clinical academic program

Rural clinical academic program accountability requires that health services and their partner universities jointly sign-off an acquittal of 2018–19 funding and provide a funding submission for 2019–20. A template for health services to complete will be provided to participating health services.

Table 2.17: Training and development funding – reporting requirements

Program	Reporting required by health services	Due date
All programs	Automated reporting of seven externally reportable *Best practice clinical learning environment* (BPCLE) framework indicators through BPCLE tool <https://www.bpcletool.net.au/accounts/login>	14 February 2020
Professional-entry student placements	Automated reporting of clinical placement activity from Placeright biannually. An interim reporting tool can be provided to health services not yet using Placeright for medical student placements. Email Workforce Funding, Performance and Review <vicworkforce@dhhs.vic.gov.au> to request exemption from using Placeright and access to the interim reporting tool.	14 February 2020 (for July–December 2019 activity). 26 July 2020 (for activity January–June 2020) and
Transition to practice (graduate) – allied health, medical (PGY1 and PGY2), nursing and midwifery	Report on the headcount and full-time equivalent hours of 2019 graduate activity.	14 February 2020
Postgraduate – medical specialist training	Victorian Medical Specialist Training Program acquittal of posts and positions in 2019.	14 February 2020
	Victorian Paediatric Training Program acquittal of posts and positions in 2019.	14 February 2020

Program	Reporting required by health services	Due date
	Basic Physician Training Consortia Program acquittal of posts and positions in 2019.	14 February 2020
Postgraduate – nursing and midwifery	Report on the headcount and full-time equivalent hours of 2019 postgraduate activity.	14 February 2020
Targeted workforce training and development programs	Recipients of targeted workforce training and development programs must meet the reporting requirements as specified for each program through the acceptance process.	Annually as specified by each program

Note: The department is developing a web-based portal through the Health Collect platform for reporting of training and development activity. Health services will be informed when it is available.

2.13.10 Commonwealth–state reporting requirements

Funded organisations may receive payments arising from Commonwealth–state agreements. Funding received under such arrangements is subject to each program's specific conditions of funding. Organisations funded under Commonwealth–state programs are required to submit regular statistical and financial reports for the monitoring of activity, payment of grants and acquittal to the Commonwealth. The information required, format and timelines for individual programs are detailed in the relevant Intergovernmental Agreements with the Commonwealth and the guidelines applicable to the appropriate Commonwealth–state programs.

Addendum 2.1: Performance targets and monitoring

Organisations funded by a Service Agreement can search for activity descriptions. Activity descriptions include: policy and guidelines, data requirements and key performance measures. Visit Health and Human Service activity search at <https://providers.dhhs.vic.gov.au/human-services-activity-search>.

Table 2.18: Ageing, aged and home care performance targets and monitoring

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
13230	Commonwealth Regional Assessment Service assessment	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13230	Commonwealth Regional Assessment Service assessment	Number of completed assessments	Reports	Quarterly	Mandatory	Key output measure
13004	Aged Care Assessment Service project	Report against agreed objectives	Reports	Yearly	Mandatory	Key output measure
13005	Aged Care Assessment Service assessment	Percentage of priority 1, 2 and 3 clients assessed on time	Percentage	Quarterly	Mandatory	Other standard measure
13005	Aged Care Assessment Service assessment	Percentage of referrals actioned within 3 calendar days	Percentage	Quarterly	Mandatory	Key output measure
13005	Aged Care Assessment Service assessment	Number of assessments	Assessments	Quarterly	Mandatory	Key output measure
13019	Personal Alert Victoria	Security activity report	Reports	Yearly	Mandatory	Key output measure
13015	Home and Community Care linkages packages	Number of packages	Packages	Quarterly	Mandatory	Key output measure
13023	Home and Community Care service development grant	One electronic project report submitted	Reports	Yearly	Mandatory	Key output measure
13024	Home and Community Care assessment	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13026	Home and Community Care domestic assistance	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13027	Home and Community Care respite	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
13031	Public sector residential aged care supplement	Number of occupied bed days	Occupied bed days	Monthly	Mandatory	Key output measure
13035	Support for carers	Number of carers	Carers	Yearly	Mandatory	Key output measure
13035	Support for carers	Number of hours of service	Hours	Quarterly	Mandatory	Other standard measure
13038	Home and Community Care service system resourcing	Service activity report	Reports	Yearly	Mandatory	Key output measure
13043	Home and Community Care flexible service response	Service activity report	Reports	Yearly	Mandatory	Key output measure
13053	Victorian Eyecare Service	Number of occasions of service (metropolitan)	Occasions of service	Quarterly	Mandatory	Key output measure
13053	Victorian Eyecare Service	Number of occasions of service (outreach)	Occasions of service	Yearly	Mandatory	Other standard measure
13053	Victorian Eyecare Service	Number of occasions of service (rural)	Occasions of service	Yearly	Mandatory	Other standard measure
13056	Home and Community Care planned activity group – core	Number of hours of service (provided to clients)	Hours	Quarterly	Mandatory	Key output measure
13057	Home and Community Care planned activity group – high	Number of hours of service (provided to clients)	Hours	Quarterly	Mandatory	Key output measure
13059	Residential aged care complex care supplement	Number of occupied bed days	Occupied bed days	Monthly	Mandatory	Key output measure
13063	Home and Community Care volunteer coordination	Number of hours of coordinator time	Hours	Yearly	Mandatory	Key output measure
13063	Home and Community Care volunteer coordination	Number of hours of service (provided to clients)	Hours	Quarterly	Non-mandatory	Other standard measure
13067	Aged community grants	Number of projects	Projects	Yearly	Mandatory	Key output measure
13082	Low-cost accommodation support	Number of clients assisted	Clients	Quarterly	Mandatory	Key output measure
13083	Aged training and development	Number of filled positions (academic)	Positions	Quarterly	Mandatory	Key output measure
13083	Aged training and development	Number of filled positions (training)	Positions	Quarterly	Non-mandatory	Other standard measure

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
13096	Home and Community Care allied health	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13097	Home and Community Care delivered meals	Number of meals (funding is a subsidy only)	Meals	Quarterly	Mandatory	Key output measure
13099	Home and Community Care property maintenance	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13100	Aged research and evaluation	Report against agreed objectives	Reports	Yearly	Mandatory	Key output measure
13103	Language services	Number of occasions of service	Occasions of service	Monthly	Mandatory	Key output measure
13107	Rural small high-care supplement	Number of occupied bed days	Occupied bed days	Monthly	Mandatory	Key output measure
13109	Aged Care Assessment Service evaluation	Evaluation unit meets requirements of commonwealth conditions of grant	Rating	Yearly	Mandatory	Key output measure
13131	RDNS Home and Community Care allied health	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13155	Dementia services	Number of contacts	Contacts	Yearly	Mandatory	Other standard measure
13155	Dementia services	Number of hours of service	Hours	Yearly	Mandatory	Key output measure
13155	Dementia services	Number of sessions	Sessions	Yearly	Mandatory	Other standard measure
13156	Seniors health promotion	Report against agreed objectives	Reports	Yearly	Mandatory	Key output measure
13210	Aged Care Assessment Service training and development	Funds expended on training needs of staff	Dollars	Yearly	Mandatory	Key output measure
13223	Home and Community Care nursing	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13226	Home and Community Care personal care	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
13227	ACCO services – aged and home care	Development of service profile	Completed service profile	Yearly	Mandatory	Key output measure
13229	Home and Community Care access and support	Hours of client care coordination	Hours	Quarterly	Mandatory	Key output measure
13301	Aged quality improvement	Current authorisations for information exchange between the department and the:	Signed documents	Yearly	Mandatory	Other standard measure

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
		• Commonwealth Department of Health and Human Services • Australian Aged Care Quality Agency.				
13302	SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI)	Number of facility cost relief expenditure plans developed and implemented	Plans	Yearly	Mandatory	Key output measure
13302	SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI)	Number of facility cost relief cluster plans developed and implemented	Plans	Yearly	Mandatory	Other standard measure
13302	SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI)	Number of proprietors of assisted supported residential services that meet accountability and reporting requirements for facility cost relief	Proprietors	Yearly	Mandatory	Other standard measure
13303	SAVVI Supporting Connections	Number of clients	Clients	Yearly	Mandatory	Key output measure
13352	Victorian Seniors Festival	Number of events and participants	Events Participants	Yearly	Non-mandatory	Other standard measure
13354	Elder abuse prevention and response	Number of telephone calls	Calls	Six-monthly	Non-mandatory	Other standard measure
13354	Elder abuse prevention and response	Number of professional education sessions attendees	Events participants	Six-monthly	Non-mandatory	Other standard measure
13354	Elder abuse prevention and response	Number of community education sessions	Events	Six-monthly	Non-mandatory	Other standard measure
13355	Seniors community programs	Number of projects	Reports	Quarterly	Non-mandatory	Other standard measure
13356	Information and lifelong learning	Number of information requests/contacts	Contacts	Quarterly	Non-mandatory	Other standard measure
13356	Information and lifelong learning	New programs New U3As	Programs U3As	Six-monthly	Non-mandatory	Other standard measure

Table 2.19: Ambulance Victoria performance targets and monitoring

Service plan	Activity	Measure description	Unit of measure	Reporting frequency	Status
Quantity – transports	Emergency road: all Emergency road: metro Emergency road: rural and regional Non-emergency stretcher: all Non-emergency stretcher: metro Non-emergency stretcher: rural and regional Non-emergency clinic car Fixed-wing emergency Fixed wing non-emergency Rotary wing	Number of transports provided	Number	Monthly	Mandatory
Quantity – incidents	Emergency road: all Emergency road: metro Emergency road: rural and regional Treatment without transport Non-emergency stretcher: all Non-emergency stretcher: metro Non-emergency stretcher: rural and regional Non-emergency clinic car Fixed-wing emergency	Number of 000 calls or planned events to which one or more ambulance resources are dispatched	Number	Monthly	Mandatory
Patient experience	Patient satisfaction	Proportion of respondents to VHES survey question reporting a 'good' or 'very good' response to overall ambulance experience	Percentage	Annual	Mandatory
Governance leadership and culture	Safety culture	Composite of safety culture score based on eight safety culture items in the People Matter Survey	Percentage	Annual	Mandatory
Safety and quality	HCWI – influenza	Healthcare worker immunisation – influenza	Percentage	Annual	Mandatory
	Pain reduction	Adult patients who achieve a meaningful reduction in pain	Percentage	Quarterly	Mandatory
	Stroke patients transported	Adult patients suspected of having a stroke who were transported within 60 minutes to a health service with the capability to deliver intravenous thrombolysis	Percentage	Quarterly	Mandatory
	Trauma patients transported	Trauma patients transported to the highest level trauma service within 45 minutes, or transported by air directly to a Major Trauma Service	Percentage	Quarterly	Mandatory
	Cardiac arrest survived event rate	Adult VF/VT patients with vital signs at hospital	Percentage	Quarterly	Mandatory

Service plan	Activity	Measure description	Unit of measure	Reporting frequency	Status
		Adult VF/VT patients surviving to hospital discharge	Percentage	Quarterly	Mandatory
Access	Response time statewide	Emergency Code 1 incidents responded to within 15 minutes	Percentage	Monthly	Mandatory
		Emergency Priority 0 incidents responded within 13 minutes	Percentage	Monthly	Mandatory
	Response time urban	Emergency Code 1 incidents responded to within 15 minutes in centres with population > 7,500	Percentage	Monthly	Mandatory
	Average response time	Average time to respond to Emergency Code 1 incidents	Minutes	Monthly	Mandatory
	Clearing time at hospital	Average ambulance hospital clearing time	Minutes	Monthly	Mandatory
	Call referral	Events where 000 caller receives advice or service from another health service provider as an alternative to emergency ambulance response	Percentage	Monthly	Mandatory
	40-minute transfer	Proportion of patients transferred from paramedic care to hospital emergency care within 40 minutes of ambulance arrival	Percentage	Weekly	Mandatory

Note: Additional measures will be developed and included in the data submissions.

Table 2.20: Mental health service performance indicators

Measure or indicator	Unit	Adult report	CAMHS report	Older person report	Government target
28-day readmission rate	per cent	Yes	No	Yes	<14 All age ranges
Pre-admission contact	per cent	Yes	Yes[9]	Yes	60 All age ranges
Post discharge follow up	per cent	Yes	Yes[9]	Yes	80 All age ranges
Total seclusion rate	Episodes per 1,000 bed days	Yes	Yes	Yes	<15 All age ranges
HoNOS[10] compliance – all inpatient, all ages	per cent	Yes	Yes	Yes	>85
HoNOS[10] compliance – ambulatory, all ages	per cent	Yes	Yes	Yes	>85
Emergency department presentations departing to a mental health bed within eight hours	per cent	Yes	No	No	80
Basis/SDQ[11] compliance	per cent	Yes	Yes	Yes	>85

[9] Slight variation in definition as results attributed to client's home AMHS not the separating AMHS as for adult and older person.

[10] HoNOS refers to the Health of the Nation Outcome Scale and is a key mental health consumer outcome measure that has been implemented nationally.

[11] Basis and Strengths and Difficulties Questionnaire (SDQ) are used by the consumer's and/or carer's (SDQ only) to present their views on behaviour to inform discussions with the AMHS. There are collected as part of the outcome measures suite at predefined points of time.

Table 2.21: Primary and dental health performance targets and monitoring

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
27019	RDHM Dental Care	Number of clients	Clients	Yearly	Mandatory	Key output measure
27023	Community Dental Care	Number of clients	Clients	Yearly	Mandatory	Key output measure
28015	FARREP	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28016	FARREP – Health Promotion	Report against health promotion plan	Reports	Yearly	Non-mandatory	Other standard measure
28018	Family Planning – Health Promotion	Report against health promotion plan	Reports	Yearly	Non-mandatory	Other standard measure
28021	IHSHY – Health Promotion	Report against health promotion plan	Reports	Yearly	Non-mandatory	Other standard measure
28048	Language Services	Number of occasions of service	Occasions of service	Monthly	Mandatory	Key output measure
28050	Women's Health – Health Promotion	Report against health promotion plan	Reports	Yearly	Non-mandatory	Other standard measure
28062	Telephone Counselling	Number of calls answered	Calls	Quarterly	Mandatory	Key output measure
28062	Telephone Counselling	Percentage of calls answered	Calls	Quarterly	Mandatory	Other standard measure
28063	Family Planning – Education and Training	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28064	Family Planning – Clinical Services and Training	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28066	IHSHY	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28067	Women's Health	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28068	Family Planning	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28071	Aboriginal Services and Support	Number of hours of service	Hours	Quarterly	Mandatory	Other standard measure
28071	Aboriginal Services and Support	Report against agreed objectives	Reports	Yearly	Mandatory	Key output measure
28072	Integrated Chronic Disease Management	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28076	Refugee and Asylum Seeker Health Services	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28080	Healthy Mothers Healthy Babies	Numbers of hours of service	Hours	Quarterly	Mandatory	Key output measure

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
28081	National Diabetes Services Scheme	Number of packs of needles and syringes	Needles and syringes	Monthly	Mandatory	Key output measure
28085	Community Health – Health Promotion	Report against health promotion plan	Reports	Yearly	Mandatory	Other standard measure
28086	Community Health	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure
28087	Primary Care Partnerships	Report against PCP planning and reporting guidelines	Reports	Yearly	Mandatory	Key output measure
28088	ACCO Services – Primary Health	Development of service profile	Completed service	Yearly	Mandatory	Key output measure
28090	MDC – Community Health Nurse	Number of hours of service	Hours	Quarterly	Mandatory	Key output measure

Table 2.22: Public health performance targets and monitoring

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
16119	School and adult immunisation services	Number of people immunised	People	Yearly	Mandatory	Key output type
16163	Food safety education	Report against agreed objectives	Reports	Yearly	Mandatory	Key output type
16203	Regulation of ART and associated legislation	Report against agreed objectives	Reports	Yearly	Mandatory	Key output type
16206	Laboratory testing	Provision of a public health reference/testing service	Services	Yearly	Mandatory	Key output type
16206	Laboratory testing	Percentage of notifications within specified timelines	Notifications	Yearly	Mandatory	Other standard measure
16206	Laboratory testing	Provision of required testing in accordance with accredited standards	Testing	Yearly	Mandatory	Other standard measure
16234	Public Health Legislative Review	Report against agreed objectives	Reports	Yearly	Mandatory	Key output type
16308	Injury prevention	Report against agreed objectives	Reports	Yearly	Mandatory	Key output type
16348	Children's obesity	Report against agreed objectives	Reports	Half-yearly	Mandatory	Key output type
16349	Obesity – community projects	Report against agreed objectives	Reports	Yearly	Mandatory	Key output type
16373	BBV and STI – clinical services	Report against agreed objectives	Report	Annual	Mandatory	Key output type
16381	Risk management and emergency response	Report against agreed objectives	Reports	Yearly	Mandatory	Key output type
16449	Smoking information – advice and interventions	Research reports	Reports	Yearly	Mandatory	Key output type

Activity no.	Activity name	Measure description	Unit of measure	Frequency	Status	Output type
16450	Diabetes prevention	Report against agreed objectives	Reports	Quarterly	Mandatory	Key output type
16452	Aboriginal health advancement	Report against agreed objectives	Reports	Half-yearly	Mandatory	Key output type
16453	Aboriginal health worker support	Report against agreed objectives	Reports	Half-yearly	Mandatory	Key output type
16454	Health promotion initiatives	Report against agreed objectives	Reports	Quarterly	Mandatory	Key output type
16460	Targeted recruitment for screening programs	Report against agreed deliverables	Reports	Yearly	Mandatory	Key output type
16505	BBV and STI – training and development	Report against agreed deliverables	Reports	Yearly	Mandatory	Key output type
16507	BBV and STI – laboratory services	Report against agreed deliverables	Reports	Reports	Mandatory	Key output type
16508	BBV and STI – health promotion and prevention	Report against health promotion plan	Reports	Yearly	Mandatory	Key output type
16509	BBV and STI – community-based care and support	Report against agreed deliverables	Reports	Yearly	Mandatory	Key output type
16513	Screening and preventative messages	Report against agreed deliverables	Reports	Yearly	Mandatory	Key output type
16514	Screening service development	Report against agreed deliverables	Reports	Yearly	Mandatory	Key output type
16515	Education and training in screening programs	Report against agreed deliverables	Reports	Yearly	Mandatory	Key output type
16516	Screening counselling and support	Number of occasions of service	Occasions of service	Yearly	Mandatory	Key output type
16517	Cancer and screening registers	Statistical report within an agreed timeline and publicly available	Reports	Yearly	Mandatory	Key output type
16518	Cancer and screening intelligence	Report against agreed objectives	Reports	Yearly	Mandatory	Key output type
16519	Screening tests and assessments	Percentage of target population screened over an agreed period	Percentage	Yearly	Mandatory	Other standard measure
16519	Screening tests and assessments	Number of clients screened	Clients	Yearly	Mandatory	Key output type

Addendum 2.2: Service standards and guidelines

Table 2.23: Small rural health services – service standards and guidelines

Activity no.	Activity name	Service standards and guidelines description
35010	Small rural – aged support services	*Aged Care Act 1997* as amended Commonwealth Department of Health resources: MyAged Care website <https://www.myagedcare.gov.au> Factsheets <https://agedcare.health.gov.au/publications-articles/factsheets> Guides and policy <https://agedcare.health.gov.au/publications-articles/guides-advice-policy> *mall rural health services guide 2003–04* and updates
13031	Small rural – Aged Care (Residential only)	*Aged Care Act 1997* as amended Commonwealth Department of Health resources: MyAged Care website <https://www.myagedcare.gov.au> Factsheets <https://agedcare.health.gov.au/publications-articles/factsheets> Guides and policy <https://agedcare.health.gov.au/publications-articles/guides-advice-policy> *Small rural health services guide 2003–04 and updates*
35024	Small rural – flexible health service delivery	*Small rural health services guide 2003–04* and updates
35025	Small rural – TAC[12] – acute health	*Small rural health services guide 2003–04* and updates
35026	Small rural – Department of Veteran's Affairs – acute health	*Small rural health services guide 2003–04* and updates
35028	Small rural – acute health service system development and resourcing	*Small rural health services guide 2003–04* and updates
35030	Small rural – HACC healthcare and support	*Victorian HACC program manual* *Small rural health services guide 2003–04* and updates
35036	Small rural – Department of Veteran's Affairs HACC	*Victorian HACC program manual* *Small rural health services guide 2003–04* and updates
35042	Small rural – drugs services	Adult AOD Screening and Assessment Tool *Incident reporting instruction* (May 2013) Victorian Alcohol and Other Drug Treatment Principles

[12] TAC = Transport Accident Commission

Activity no.	Activity name	Service standards and guidelines description
		Victorian AOD Client Charter *Severe Substance Dependence Treatment Act 2010* *Shaping the future: the Victorian alcohol and other drug quality framework*, April 2008
35048	Small rural – primary health flexible services	*Small rural health services guide 2003–04* and updates Advice for public health and wellbeing planning in Victoria: planning cycle 2017–2021 <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/public-health-wellbeing-planning-advice-2017-2021>
35052	Small rural – specified services	*Small rural health services guide 2003–04* and updates

Table 2.24: Drug services – service standards and guidelines

Standards and guidelines description	Activity name
Alcohol and other drug program guidelines	34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34074, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34057, 34060, 34061, 34062, 34066, 34069, 34070, 34078, 34079, 34082, 34084, 34200, 34202, 34203, 34205, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310
Alcohol and other drug withdrawal practice guidelines (2018)	34050, 34056, 34064, 34203, 24204, 34214, 34303, 34310
Alcohol in the workplace: guidelines for developing a workplace alcohol policy	34009
Assessment and intervention tool for youth alcohol and drug treatment services (prepared by Turning Point Alcohol and Drug Centre Inc. for the Department of Human Services) 2004	34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34075, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208, 34309, 34310
Adult AOD intake and assessment tools	34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34057, 34060, 34061, 34062, 34066, 34069, 34070, 34078, 34079, 34082, 34084, 34200, 34202, 34203, 34205, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310
Child Wellbeing and Safety Act 2005	34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310
Children, Youth and Families Act 2005 *Commission for Children and Young People Act 2012* *Working with Children Act 2005* Protocol between drug treatment services and child protection for working with parents with alcohol and drug issues	34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310
Clinical treatment guidelines for alcohol and drug clinicians: co-occurring acquired brain injury/cognitive impairment and alcohol and drug use disorders	34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079,

Standards and guidelines description	Activity name
National comorbidity guidelines	34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310
Clinical treatment guidelines for methamphetamine dependence and treatment	34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310
Code of practice for running safer music festivals and events	34004
Cultural diversity guide	34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310
COATS, Community Correctional Services and Drug Treatment Services protocol (2016)	34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34309, 34310
Drugs, Poisons and Controlled Substances Act 1981	34061, 34308, 34070
Health Complaints Act 2016	34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34074, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34057,34060, 34061, 34062, 34066, 34069, 34070, 34078, 34079, 34082, 34084, 34200, 34202, 34203, 34205, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34302, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310
Incident reporting instruction (May 2013)	34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310
Client incident management guide	34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310
Interagency protocol between Victoria Police and nominated agencies	34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204,

Standards and guidelines description	Activity name
	34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34309, 34310
Management response to inhalant use: guidelines for the community care and drug and alcohol sector (2003)	34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34309, 34310
Victorian AOD client charter	34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310
Victorian policy for maintenance pharmacotherapy for opioid dependence (2016) *National guidelines for medication-assisted treatment of opioid dependence* (2014)	34047, 34057
The Victorian hepatitis C strategy 2016–2020 *The Victorian hepatitis B strategy 2016–2020* *The Victorian HIV strategy 2017–2020* *Eighth national HIV strategy 2018–2022* *Fourth national sexually transmissible infections strategy, 2018–2022* *Fifth national Aboriginal and Torres Strait Islander blood-borne viruses and sexually transmissible infections strategy 2018–2022* *Third national hepatitis B strategy 2018–2022* *Fifth national hepatitis C strategy 2018–2022*	34070, 34308
National needle and syringe programs strategic framework 2010–2014	34070, 34308
Medically supervised injecting room performance monitoring framework	34308
National Ice Action Strategy 2015	34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34074, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34057, 34060, 34061, 34062, 34066, 34069, 34070, 34078, 34079, 34082, 34084, 34200, 34202, 34203, 34205, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310
National Drug Strategy 2017	34041, 34045, 34046, 34048, 34049, 34051, 34053, 34056, 34060, 34064, 34074, 34078, 34080, 34084, 34202, 34204, 34205, 34206, 34208, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34057, 34060, 34061, 34062, 34066, 34069, 34070, 34078, 34079, 34082, 34084, 34200, 34202, 34203, 34205, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310

Standards and guidelines description	Activity name
Service specification for the delivery of selected non-residential alcohol and drug treatment services in Victoria 2015	34300, 34301, 34302, 34303, 34304
Rainbow eQuality Guide	34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310
Severe Substance Dependence Treatment Act 2010	34003, 34004, 34006, 34009, 34021, 34040, 34041, 34042, 34044, 34045, 34046, 34047, 34048, 34049, 34050, 34053, 34056, 34057, 34060, 34061, 34062, 34064, 34066, 34069, 34070, 34071, 34078, 34079, 34080, 34082, 34084, 34200, 34202, 34203, 34204, 34205, 34206, 34207, 34209, 34211, 34212, 34213, 34214, 34300, 34301, 34303, 34304, 34305, 34306, 34307, 34308, 34309, 34310
SHPA standards of practice for Australian poisons information centres	34003
Victorian needle and syringe programs operating policy and guidelines, Department of Health (revised November 2008)	34070, 34308

Table 2.25: Ageing, aged and home care service standards and guidelines

Activity no.	Activity name	Service standards and guidelines description
13004	Aged Care Assessment – Projects	*Aged Care Act 1997*, as amended
13004	Aged Care Assessment – Projects	*My Aged Care National Education and Training Strategy (2018–2020)*
13004	Aged Care Assessment – Projects	*Aged Care Act 1997*, as amended
13005	Aged Care Assessment	*My Aged Care Assessment Manual – for Regional Assessment Services and Aged Care Assessment Teams (2018) and addendums*
13005	Aged Care Assessment	*Aged Care Act 1997*, as amended
13005	Aged Care Assessment	*My Aged Care National Education and Training Strategy (2018–2020)*
13005	Aged Care Assessment	*Aged Care Assessment Program Style Guide*, April 2016 (Commonwealth Department of Health)
13005	Aged Care Assessment	Protocol Between Aged Care Assessment Services and the Office of the Public Advocate, 2011
13005	Aged Care Assessment	Protocol between Victorian Aged Care Assessment services and Aged Persons Mental Health, 2008 (Department of Human Services)
13005	Aged Care Assessment	*Strengthening access to Aged Care Assessment Services for Aboriginal consumers*
13015	HACC Linkages Packages	*Victorian HACC program manual*
13019	Personal Alert Victoria	*Personal Alert Victoria program and service guidelines* *Personal Alert Victoria response service guidelines*
13023	HACC Service Development	*Victorian HACC program manual*

Activity no.	Activity name	Service standards and guidelines description
13024	HACC Assessment	*Victorian HACC program manual*
13026	HACC Domestic Assistance	*Victorian HACC program manual*
13027	HACC Respite	*Victorian HACC program manual*
13031	Public Sector Residential Aged Care Supplement	*Aged Care Act 1997*, as amended *Commonwealth Department of Health resources:* MyAged Care website <https://www.myagedcare.gov.au> Factsheets <https://agedcare.health.gov.au/publications-articles/factsheets> Guides and policy <https://agedcare.health.gov.au/publications-articles/guides-advice-policy>
13035	Support for Carers	*Carers Recognition Act 2012* *A Victorian charter supporting people in care relationships and information kit* *Program guidelines – Support for Carers Program* *Victorian HACC program manual*
13038	HACC Service System Resourcing	*Victorian HACC program manual* *SRS Service Coordination and Support Program service activity report, guidelines and pro forma*
13043	HACC Flexible Service Response	*Community Connection Program quality standards framework and data collection guidelines*, 2001 *Victorian HACC program manual* *SRS Service Coordination and Support Program service activity report, guidelines and pro forma*
13053	Victorian Eye Service	*Victorian Eye Service program guidelines*, 2015 (interim)
13056	HACC Planned Activity Group – Core	*Victorian HACC program manual*
13057	HACC Planned Activity Group – High	*Victorian HACC program manual*
13063	HACC Volunteer Coordination	*Victorian HACC program manual*
3082	Low Cost Accommodation Support	*Community Connection Program quality standards framework and data collection guidelines*, 2001 *Flexible Care Fund guidelines for the Older Persons High Rise Support Program*, August 2002 *Older Persons High Rise Support Program submission guidelines*, 2001 *Housing Support for the Aged Program submission guidelines*, 2000 *SRS Oral Health initiative service model specifications*, 2011
13096	HACC Allied Health	*Victorian HACC program manual*
13097	HACC Delivered Meals	*Victorian HACC program manual*
13099	HACC Property Maintenance	*Victorian HACC program manual*
13109	Aged Care Assessment Service Evaluation Unit	*My Aged Care Assessment Manual – for Regional Assessment Services and Aged Care Assessment Teams (2018) and addendums*
13109	Aged Care Assessment Service Evaluation Unit	*Aged Care Act 1997*, as amended
13109	Aged Care Assessment Service Evaluation Unit	*My Aged Care National Education and Training Strategy (2018–2020)*

Activity no.	Activity name	Service standards and guidelines description
13109	Aged Care Assessment Service Evaluation Unit	*Aged Care Assessment Program Style Guide*, April 2016 (Commonwealth Department of Health)
13109	Aged Care Assessment Service Evaluation Unit	Protocol between Aged Care Assessment Services and the Office of the Public Advocate, 2011
13109	Aged Care Assessment Service Evaluation Unit	Protocol between Victorian Aged Care Assessment Services and Aged Persons Mental Health, 2008 (Department of Human Services)
13109	Aged Care Assessment Service Evaluation Unit	*Transition Care training handbook for Aged Care Assessment Teams*, 2006 (Commonwealth Department of Health and Ageing)
13109	Aged Care Assessment Service Evaluation Unit	*Strengthening access to Aged Care Assessment Services for Aboriginal consumers*
13130	HACC Volunteer Coordination – Other	*Victorian HACC program manual*
13131	RDNS HACC Allied Health	*Victorian HACC program manual*
13155	Dementia Services	*Carers Recognition Act 2012* *Program guidelines: Support for carers of people with dementia including younger people with dementia guidelines* (updated 2013) Support and Links Service program statement
13156	Seniors Health Promotion	*Victorian HACC program manual* *Older Persons High Rise Support Program guidelines*
13210	ACAS Training and Development	*Aged Care Assessment Programme national training strategy*, January 2012
13223	HACC Nursing	*Victorian HACC program manual*
13224	Department of Veterans' Affairs HACC	*Victorian HACC program manual*
13226	HACC Personal Care	*Aged Care Act 1997* (as amended)
13227	Aboriginal Community-Controlled Organisations Services – Aged and Home Care	*Victorian HACC program manual*
13229	HACC Access and Support	*Victorian HACC program manual*
13301	Aged Quality Improvement	*Aged Care Act 1997,* as amended Commonwealth Department of Health resources: MyAged Care website <https://www.myagedcare.gov.au> Factsheets <https://agedcare.health.gov.au/publications-articles/factsheets> Guides and policy <https://agedcare.health.gov.au/publications-articles/guides-advice-policy>
13302	Supporting Accommodation for Vulnerable Victorians Initiative	*SRS supporting accommodation for vulnerable Victorians guidelines*, 2012
13303	SAVVI Supporting Connections	*SRS supporting accommodation for vulnerable Victorians guidelines*, 2012 *SAVVI Supporting Connections flexible funds guidelines*, 2010 *SAVVI Supporting Connections services specifications*, 2008
13352	Victorian Seniors Festival	*Victorian Seniors Festival Community Grants Program guidelines*
13354	Elder Abuse Prevention and Response	*Contract guidelines and schedules*
13355	Seniors Community Programs	*Funded program guidelines*

Activity no.	Activity name	Service standards and guidelines description
13356	Information and Lifelong Learning	*Funded program guidelines*
13303	SAVVI Supporting Connections	*SRS supporting accommodation for vulnerable Victorians guidelines*, 2012 *SAVVI Supporting Connections flexible funds guidelines*, 2010 *SAVVI Supporting Connections services specifications*, 2008

Table 2.26: Public health service standards and guidelines

Service standards and guidelines description	Activity no.
Advice for public health and wellbeing planning in Victoria: planning cycle 2017–2021 <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/public-health-wellbeing-planning-advice-2017-2021>	28085
Community Health Integrated Health Promotion Program: Planning Guidelines 2013–17	16454
Community Health and Women's Health Integrated Health Promotion: Reporting Guidelines 2013–17	16454
Guide to Municipal Public Health and Wellbeing Planning, 2013 (including the Environments for Health Framework)	16454
BBV/STI Program Guidelines for Funded Agencies (current edition)	16373 16377 16505 16506 16507 16508 16509

Table 2.27: Primary, community and dental health service standards and guidelines

Activity name	Activity no.	Service standards and guidelines description
Dental health	27010 27011 27017 27019 27020 27023 27024 27025 27026 27028 27029	Dental health <https://www2.health.vic.gov.au/primary-and-community-health/dental-health>
Community health	28033 28043 28069 28074 28080 28084 28085 28086	Community health integrated program guidelines: direction for the community health program <https://www2.health.vic.gov.au/primary-and-community-health> Advice for public health and wellbeing planning in Victoria: planning cycle 2017–2021 <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/public-health-wellbeing-planning-advice-2017-2021> *Victorian Aboriginal affairs framework* (VAAF) standards <https://www.vic.gov.au/aboriginalvictoria/policy/victorian-aboriginal-affairs-framework.html>

Activity name	Activity no.	Service standards and guidelines description
Maternal health	28080 28085 28086	Community health integrated program guidelines: direction for the community health program <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Community-Health-Integrated-Program> Healthy Mothers, Healthy Babies Program <https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/children-youth-and-families/healthy-mothers-healthy-babies>
Child health	28082 28085 28086	*Child health services: Guidelines for the community health program* Child health teams <https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/children-youth-and-families>
Young people	28021 28066 28085 28086	Community health integrated program guidelines: direction for the community health program <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program> Child, youth and family health <https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/children-youth-and-families> Innovative Health Services for Homeless Youth (IHSHY) <https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/children-youth-and-families>
Women's health	28015 28016 28018 28050 28063 28064 28068 28067 28085 28086	Women's health <https://www2.health.vic.gov.au/about/populations/womens-health> Health promotion <https://www2.health.vic.gov.au/public-health/population-health-systems/health-promotion>
Aboriginal health	28071 28085 28086	Community health integrated program guidelines: direction for the community health program <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Community-Health-Integrated-Program---CHIP---guidelines> Various other publications <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health>
People with chronic disease	28072 28074 28081 28085 28086	*Community health integrated program guidelines: direction for the community health program* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Community-Health-Integrated-Program---CHIP---guidelines> Early intervention in chronic disease <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/integrated-chronic-disease-management/icdm-in-victoria> Integrated chronic disease management <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/integrated-chronic-disease-management/icdm-in-victoria>
Culturally and linguistically diverse groups	28048 28076 28085 28086	Refugee health <https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/refugee-health-program> Includes: *Guide to asylum seeker access to health and community services in Victoria.* These standards should be referenced until superseded; *Guide for the Refugee Health Nurse Program;* *Refugee and asylum seeker health services- Guidelines for the community health program*

Activity name	Activity no.	Service standards and guidelines description
		Refugee and asylum seeker health and wellbeing <https://www2.health.vic.gov.au/about/populations/refugee-asylum-seeker-health>, includes the *Refugee and Asylum Seekers Health Action Plan 2014–18* *Cultural Responsiveness Framework: guidelines for Victorian health services* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Cultural-responsiveness-framework---Guidelines-for-Victorian-health-services> outlines the government's approach to cultural responsiveness in health services focusing on four key areas: organisational effectiveness, risk management, consumer participation and effective workforce *Language services policy* <https://www.dhhs.vic.gov.au/publications/language-services-policy-and-guidelines> Health Translations Directory <https://www.healthtranslations.vic.gov.au>
Partnerships and system support	28054 28087	Primary Care Partnerships (PCPs) <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships> Primary Care Partnerships 2013–2017 planning and reporting requirements <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships/pcp-reporting> Service coordination <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships> General practice and private providers <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/general-practice-private-providers> Working with general practice: position statement and resource guide <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/working-with-gps-resource-guide-2008> Integrated health promotion <https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships>

Note: Organisations that receive funds associated with activity 28085 and 28086 should note that these funds can be applied flexibly across the broad range of programs and initiatives to meet the needs of the local community.

Appendices – Funding rules

Overview of appendices

The appendices – funding rules specify the financial parameters, specifically the detailed pricing and prescribed budgetary targets, that funded organisations are expected to work to, and within, to achieve the outcomes expected by the Victorian Government.

Appendix 1: Pricing arrangements for Victoria's health system

Details pricing arrangements for funded organisations and all other outputs provided by the department.

Appendix 2: Funding and activity levels

Provides tables detailing the modelled budgets for 2019–20, as well as the activity tables that detail the 2019–20 targets for a range of programs across the health system.

Appendix 1: Pricing arrangements for Victoria's health system

Introduction to Appendix 1

Appendix 1 details the pricing arrangements for funding the broad range of services delivered in the Victorian health system. It details the prices organisations face and the rules about how these prices apply. The funding models vary across the activities depending on the nature of the service to be delivered.

A note on terminology

The term 'funded organisations' relates to all entities that receive departmental funding to deliver services. Aspects of these guidelines referring to funded organisations are applicable to all department-funded entities.

For the purposes of these guidelines, the term 'health services' relates to public health services, denominational hospitals, public hospitals and multipurpose services, as defined by the *Health Services Act 1988*, regarding services provided within a hospital or a hospital-equivalent setting. Aspects of these guidelines that refer specifically to 'health services' are only applicable to these entities.

The term 'community service organisations' refers to registered community health centres, local government authorities and non-government organisations that are not health services.

These guidelines are also relevant for Ambulance Victoria, Health Purchasing Victoria, Mildura Base Hospital and the Victorian Institute of Forensic Mental Health. The guidelines specify where aspects of the guidelines are relevant for these organisations.

1.1 Price tables

1.1.1 Acute and subacute

Table 1.1 to Table 1.5 provide prices for acute and subacute services.

Table 1.1: Acute admitted services 2019–20

Payment	All health services ($)	Metropolitan and regional ($)	Subregional and local ($)	Small rural ($)
Public WIES26	–	5,029	5,295	4,950
Private WIES26	–	3,650	3,839	–
Transport Accident Commission WIES26[1]	5,843	–	–	–
Department of Veterans' Affairs WIES26	5,162	–	–	–
Public Specialist Clinics WASE3[2]	283.88	–	–	–
Private Specialist Clinics WASE3[2]	227.10	–	–	–

Table 1.2: Subacute services 2019–20

Payment	All health services ($)	Metropolitan and regional ($)	Subregional and local ($)
Public Subacute WIES4	10,737	–	–
Private Subacute WIES4	9,985	–	–
Department of Veterans' Affairs Subacute WIES4	12,991	–	–
TCP bed places[3] (per diem rate)	157.16	–	–
TCP home places[3] (per diem rate)	57.63	–	–

Table 1.3: Non-admitted radiotherapy 2019–20

Payment	All health services ($)	Metropolitan and regional ($)	Subregional and local ($)
WAU	239.94	–	–
Department of Veterans' Affairs WAU	296.51	–	–
Shared care	1,707	–	–

[1] Prices are subject to confirmation of the final indexation rate provided by the Transport Accident Commission.

[2] Note that changes to Weighted Ambulatory Service Event prices will be implemented during 2019–20 to reflect continued development of the specialist clinics funding model, which continues to be shadowed in 2019–20. No impact to funding will arise from these changes.

[3] State component only.

Table 1.4: Total parental nutrition and home enteral nutrition 2019–20

Payment	All health services ($)	Metropolitan and regional ($)	Subregional and local ($)
Total parental nutrition (TPN)	7,930	–	–
Home enteral nutrition (HEN)	215.83	–	–

Table 1.5: Nationally funded centres program 2019–20

Payment[4]	Hosting health service ($)
Islet cell transplantation	200,697
Paediatric heart transplantation – no ventricular assist device	412,579
Paediatric heart transplantation – with ventricular assist device	956,477
Paediatric liver transplantation	336,929
Paediatric lung/heart-lung transplantation	294,172
Pancreas transplantation	185,216

1.1.2 Mental health services

Table 1.6: Mental health – funded units applicable to clinical bed-based services 2019–20 – admitted care

Service element	Funded unit	All health services ($)
Acute care – child/adolescent, adult, aged[5]	Available bed day	835.87
Acute care specialist[5]	Available bed day	835.87
Extended care – adult	Available bed day	580.45
Transition support unit	Available bed day	580.45

Table 1.7: Mental health – funded units applicable to clinical bed-based services 2019–20 – non-admitted care

Service element	Funded unit	All health services ($)
Community care unit	Available bed day	400.23
Adult PARC	Available bed day	516.17
Youth PARC	Available bed day	615.73
Aged persons nursing home supplement	Available bed day	102.68
Aged persons hostel supplement	Available bed day	91.16

Table 1.8: Mental health – funded units applicable to clinical bed-based services 2019–20 – clinical community care

Service element	Funded unit	All health services ($)
Ambulatory	Community service hour	408.62

[4] Prices are subject to approval by the Nationally Funded Centres Reference Group and the Australian Health Ministers' Advisory Council.

[5] Supplement grant provided to support the acute care unit price.

Table 1.9: Mental health community support services unit prices 2019–20 – community support services

Service element	Funded unit	All health services ($)
Individualised client support packages	Client support unit	99.87
Youth residential rehabilitation – 24-hour	Bed day	240.21
Youth residential rehabilitation – non-24-hour	Bed day	206.24
Continuity of support	Client support unit	99.87

Table 1.10: Mental health community support services unit prices 2019–20 – mutual support and self-help

Service element	Funded unit	All health services ($)
Standalone (high availability)	Weighted block grant	253,096
Standalone (high availability)	Weighted block grant	Variable
Individual support referral and advocacy	Contact hour	43.80
MSSH group support	Contact hour (group)	115.90
Group education and training	Contact hour (group)	394.95
Volunteer coordination	Hour	50.75

Table 1.11: Mental health community support services unit prices 2019–20 – planned respite

Service element	Funded unit	All health services ($)
In home	Client contact hour	39.57
Community	Client contact hour	39.57
Residential	Client contact hour	39.57

Table 1.12: Mental health community support services unit prices 2019–20 – supported accommodation

Service element	Funded unit	All health services ($)
24-hour on-site small facilities (0–11 beds)	Available bed day	165.82
24-hour on-site small facilities (> 11 beds)	Available bed day	58.04
Non-24-hour on-site small facilities (0–11 beds)	Available bed day	108.20
Non-24-hour on-site other facilities (> 11 beds)	Available bed day	108.20

Table 1.13 shows unit prices for drug services in 2019–20.

Table 1.13: Drug services – unit prices 2019–20

Service element	Funded unit	Metro unit price ($)	Rural unit price ($)
Drug treatment services – intake	Drug treatment activity unit	820.99	
Drug treatment services – assessment	Drug treatment activity unit	820.99	
Drug treatment services – care and recovery coordination	Drug treatment activity unit	820.99	
Drug treatment services – counselling	Drug treatment activity unit	820.99	
Drug treatment services – non-residential withdrawal	Drug treatment activity unit	820.99	

Service element	Funded unit	Metro unit price ($)	Rural unit price ($)
Drug treatment services – therapeutic day rehabilitation	Drug treatment activity unit	820.99	
Adult residential drug withdrawal	Drug treatment activity unit	820.99	
Adult residential rehabilitation	Drug treatment activity unit	820.99	
Youth residential drug withdrawal	Drug treatment activity unit	820.99	
Youth residential rehabilitation	Drug treatment activity unit	820.99	
Aboriginal residential rehabilitation	Drug treatment activity unit	820.99	
Youth alcohol and drug supported accommodation	Episodes of care	6,312	8,414
Aboriginal alcohol and drug worker	Episodes of care	2,124	
Youth outreach	Episodes of care	1,879	
Specialist pharmacotherapy program	Episodes of care	3,439	
Mobile overdose response	Episodes of care	7,416	
Rural withdrawal	Episodes of care	1,904	
Women's alcohol and drug supported accommodation	Episodes of care	6,312	
ACCO services – community model 1	Episodes of care	773.85	
ACCO services – community models 2 and 3	Episodes of care	2,391	
ACCO services – community alcohol and drug worker	Episodes of care	2,124	

1.1.3 Ambulance

Table 1.14 shows unit prices for ambulance services.

Table 1.14: Ambulance 2019–20

Program area	Service	Unit price ($)
Emergency road	Metro	1,265
Emergency road	Rural	1,866
Non-emergency road	Metro – stretcher	341
Non-emergency road	Metro – clinic car	112
Non-emergency road	Rural	577
Treatment without transport		546
Air	Fixed wing – variable component[6]	2,242
Air	Fixed wing – fixed component	3,033
Air	Rotary – variable component[6]	11,280
Air	Rotary – fixed component	26,852
Membership Subscription Scheme	Single	48.35
	Family	96.70

[6] General patients will continue to pay the variable component for rotary transport only.

1.1.4 Ageing, aged and home care

Table 1.15 shows estimated unit prices for ageing, aged and home care services.

Table 1.15: Ageing, aged and home care 2019–20[7]

Program area	Service	Funded unit	Estimated unit price ($)
Residential aged care[8] – public sector residential aged care supplements	Rural Small High Care Supplement 1–10 places	Bed day	10.80
	Rural Small High Care Supplement 11–20 places	Bed day	8.10
	Rural Small High Care Supplement 21–30 places	Bed day	6.76
	Low Care Supplement[9]	Bed day	6.190
	High Care Supplement	Bed day	66.80
	Public Sector Residential Aged Care Supplement[10]	Bed day	13.39
	Complex Care Supplement	Bed day	40.52
Aged support services[11]	Supporting accommodation for vulnerable Victorians – Cluster plans	Plans	7,187
	Supporting accommodation for vulnerable Victorians – Expenditure plans	Plans	13,580
HACC primary health, community care and support	HACC Access and Support	Hour	70.83
	HACC Allied Health	Hour	105.18
	HACC Assessment	Hour	96.40
	HACC Counselling	Hour	105.18
	HACC Delivered Meals	Meal	3.50
	HACC Dietetics	Hour	105.18
	HACC Domestic Assistance	Hour	48.59
	HACC Nursing	Hour	96.40
	HACC Nursing – RDNS Top up	Hour	15.54
	HACC Occupational Therapy	Hour	105.18
	HACC Personal Care	Hour	48.59
	HACC Personal Care – RDNS Top up	Hour	27.15
	HACC Physiotherapy	Hour	105.18
	HACC Planned Activity Group – Core	Per person	14.46
	HACC Planned Activity Group – High	Per person	20.21

[7] Where 'HACC' is referred to, the service relates to the Home and Community Care Program for Younger People (HACC-PYP).

[8] Annual funding is generally calculated as follows:

Number of operational places × 365.25 days per year × 99 per cent occupancy factor × relevant unit price. Places that are not operational (for a time-limited period or ongoing), or used for any other purpose, will not attract state government PSRACS supplements.

[9] This supplement was previously referred to as HSUA 1 EBA – hostel.

[10] This supplement offsets the Adjusted Subsidy Reduction applied by the Commonwealth. As the price is determined by the Commonwealth Department of Health for the 2019–20 financial year and the rate is likely to be confirmed in July 2019 this figure is indicative as it may vary. An indexation rate of 1.5 per cent has been estimated.

[11] Other aged support services are not funded by unit prices (PAV, VES, SHP, SCP).

Program area	Service	Funded unit	Estimated unit price ($)
	HACC Podiatry	Hour	105.18
	HACC Property Maintenance	Hour	50.38
	HACC Respite	Hour	48.59
	HACC Speech Therapy	Hour	105.18
	HACC Volunteer Coordination	Hour	41.08
	RDNS HACC Allied Health	Hour	77.17
	Commonwealth regional assessment services	Hour	92.01
HACC primary health, community care and support – ACCO Services[12]	HACC Access and Support	Hour	72.69
	HACC Allied Health	Hour	107.96
	HACC Occupational Therapy	Hour	107.96
	HACC Podiatry	Hour	107.96
	HACC Dietetics	Hour	107.96
	HACC Speech Therapy	Hour	107.96
	HACC Physiotherapy	Hour	107.96
	HACC Assessment	Hour	98.95
	HACC Delivered Meals	Meal	3.59
	HACC Domestic Assistance	Hour	49.85
	HACC Nursing	Hour	98.95
	HACC Personal Care	Hour	49.85
	HACC Planned Activity Group – Core	Hour	14.85
	HACC Planned Activity Group – High	Hour	20.74
	HACC Property Maintenance	Hour	51.70
	HACC Respite	Hour	49.85
	HACC Volunteer Coordination	Hour	42.16
	Commonwealth regional assessment services	Hour	92.47

Note:

All residential aged care unit prices assume a 1.5 per cent indexation rate.

[12] Where 'HACC' is referred to, the service relates to the Home and Community Care Program for Younger People (HACC-PYP).

1.1.5 Small rural health services – ageing, aged and home care

Table 1.16 shows estimated unit prices for small rural health services – ageing, aged and home care.

Table 1.16: Small rural health services – ageing, aged and home care 2019–20

Program area	Service	Funded unit	Estimated unit price ($)
Small rural health services – HACC Health Care and Support	HACC Access and Support	Hour	70.83
	HACC Allied Health	Hour	105.18
	HACC Allied Health – Occupational Therapy	Hour	105.18
	HACC Allied Health – Podiatry	Hour	105.18
	HACC Allied Health – Dietetics	Hour	105.18
	HACC Allied Health – Speech Therapy	Hour	105.18
	HACC Allied Health – Physiotherapy	Hour	105.18
	HACC Assessment	Hour	96.40
	HACC Counselling	Hour	105.18
	HACC Delivered Meals	Meal	3.50
	HACC Domestic Assistance	Hour	48.59
	HACC Nursing	Hour	96.40
	HACC Personal Care	Hour	48.59
	HACC Planned Activity Group – Core	Per person	14.46
	HACC Planned Activity Group – High	Per person	20.21
	HACC Property Maintenance	Hour	50.38
	HACC Respite	Hour	48.59
	HACC Volunteer Coordination	Hour	41.08
Small rural health services – Primary Health	Counselling/Casework	Hour	109.36
	Allied Health	Hour	109.36
	Nursing	Hour	96.64
Residential aged care[13] – public sector residential aged care supplements	Rural Small High Care Supplement 1–10 places	Bed day	10.80
	Rural Small High Care Supplement 11–20 places	Bed day	8.10
	Rural Small High Care Supplement 21–30 places	Bed day	6.76
	Low Care Supplement[14]	Bed day	6.19
	High Care Supplement	Bed day	66.80
	Public Sector Residential Aged Care Supplement[15]	Bed day	13.39
	Complex Care Supplement	Bed day	40.52

Note: All residential aged care unit prices assume a 1.5 per cent indexation rate.

[13] Annual funding is generally calculated as follows:

Number of operational places × 365.25 days per year × 99 per cent occupancy factor × relevant unit price. Places that are not operational (for a time-limited period or ongoing), or used for any other purpose, will not attract state government PSRACS supplements.

[14] This supplement was previously referred to as HSUA 1 EBA – hostel.

[15] This supplement offsets the Adjusted Subsidy Reduction applied by the Commonwealth. As the price is determined by the Commonwealth Department of Health for the 2019–20 financial year and the rate is likely to be confirmed in July 2019 this figure is indicative as it may vary. An indexation rate of 1.5 per cent has been estimated.

1.1.6 Primary, community and dental health output group

Table 1.17 shows estimated unit prices for primary community health care output.

Table 1.17: Primary community health care output 2019–20

Service	Service sub-section	Funded unit	Estimated unit price ($)
Family and Reproductive Rights Education Program	Direct care	Hours	109.36
Innovative Health Services for Homeless Youth	Counselling/casework	Hours	109.36
	Nursing	Hours	96.64
Family planning	Counselling/casework	Hours	109.36
	Nursing	Hours	96.64
Aboriginal services and support	Case coordination	Hours	109.36
Integrated chronic disease management	Allied health	Hours	109.36
	Nursing	Hours	96.64
Refugee and asylum seeker health	Allied health	Hours	109.36
	Nursing	Hours	96.64
Healthy Mothers, Healthy Babies	Allied health	Hours	109.36
	Nursing	Hours	96.64
Community health	Allied health	Hours	109.36
	Nursing	Hours	96.64
ACCO services	Counselling/casework	Hours	111.70
MDC community health nurses	Nursing	Hours	96.64
Community Asthma Program	Allied health	Hours	109.36

1.1.7 Training and development

Table 1.18 shows unit prices for training and development activities to all services.

Table 1.18: Training and development funding rates in 2019–20

Stream	Program	Rate per EFT ($)
Professional-entry student placements	Medical, nursing, allied health, (including allied health assistance and health information management)	Not calculated based on an EFT rate
Transition to practice	Allied health graduate – metro	9,469
	Allied health graduate – rural	11,134
	Pharmacy interns	31,681
	Medical radiation interns	30,239
	Medical biophysics placements	18,721
	Medical laboratory science placements	18721
	Medical graduate year 1 (PGY1)	37,803
	Medical graduate year 2 (PGY2)	41,351

Stream	Program	Rate per EFT ($)
	Nursing and midwifery	18,842
Postgraduate – medical specialist training	Victorian Medical Specialist Training Program	71,050
	Victorian Paediatric Training Program	96,425
	Basic physician training consortia	Not calculated based on an EFT rate
Postgraduate – nursing and midwifery	Nursing and midwifery postgraduates	18,842

1.2 Peer groups for WIES purposes

Table 1.19 shows peer groups for WIES purposes.

Table 1.19: Peer groups for WIES purposes

Health service	Peer group
Alfred Health	Metropolitan and regional
Austin Health	Metropolitan and regional
Barwon Health	Metropolitan and regional
Melbourne Health	Metropolitan and regional
Mercy Public Hospitals Inc.	Metropolitan and regional
Monash Health	Metropolitan and regional
Peter MacCallum Cancer Centre	Metropolitan and regional
St Vincent's Hospital (Melbourne) Limited	Metropolitan and regional
The Royal Children's Hospital	Metropolitan and regional
The Royal Victorian Eye and Ear Hospital	Metropolitan and regional
The Royal Women's Hospital	Metropolitan and regional
Ballarat Health Services	Metropolitan and regional
Bendigo Health Care Group	Metropolitan and regional
Eastern Health	Metropolitan and regional
Latrobe Regional Hospital	Metropolitan and regional
Northern Health	Metropolitan and regional
Peninsula Health	Metropolitan and regional
Western Health	Metropolitan and regional
Albury Wodonga Health	Metropolitan and regional
Goulburn Valley Health	Metropolitan and regional
Bairnsdale Regional Health Service	Subregional and local
Bass Coast Regional Health	Subregional and local
Benalla Health	Subregional and local
Castlemaine Health	Subregional and local
Central Gippsland Health Service	Subregional and local
Colac Area Health	Subregional and local
Djerriwarrh Health Services	Subregional and local
East Grampians Health Service	Subregional and local
Echuca Regional Health	Subregional and local
Gippsland Southern Health Service	Subregional and local
Kyabram and District Health Services	Subregional and local
Maryborough District Health Service	Subregional and local
Mildura Base Hospital	Subregional and local
Northeast Health Wangaratta	Subregional and local

Health service	Peer group
Portland District Health	Subregional and local
Stawell Regional Health	Subregional and local
South West Healthcare	Subregional and local
Swan Hill District Health	Subregional and local
West Gippsland Health Care Group	Subregional and local
Western District Health Service	Subregional and local
Wimmera Health Care Group	Subregional and local

1.3 Cost weight tables

1.3.1 WIES26 Victorian cost weights

Table 1.20 shows WIES26 cost weights for 2019–20.

Table 1.20: WIES26 cost weights 2019–20

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-navment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
A13A	Ventilation ≥ 336 Hours, Major Complexity	4	D		36	81	53.2				3.0384	3.5830	1.0589	41.7049	0.3621	0.2897
A13B	Ventilation ≥ 336 Hours, Minor Complexity	4	D		21	47	30.8				1.3838	1.9662	1.1093	25.2618	0.3621	0.2897
A14A	Ventilation ≥ 96 Hours and < 336 Hours, Major Complexity	4	D		24	56	37.4				3.5083	3.9690	0.8830	25.1621	0.3621	0.2897
A14B	Ventilation ≥ 96 Hours and < 336 Hours, Intermediate Complexity	4	D		13	31	20.7				1.6101	2.1272	0.9547	14.5385	0.3621	0.2897
A14C	Ventilation ≥ 96 Hours and < 336 Hours, Minor Complexity	4	D		8	20	12.9				0.9856	1.5790	1.0384	9.8860	0.3621	0.2897
A15A	Tracheostomy, Major Complexity	D	D		22	51	30.3				4.6062	4.9016	0.5640	17.3093	0.3006	0.2405
A15B	Tracheostomy, Intermediate Complexity	D	D		12	27	18.4				4.2656	4.5849	0.5854	11.6097	0.2916	0.2333
A15C	Tracheostomy, Minor Complexity	D	D		8	20	12.8				3.0889	3.4345	0.6049	8.2735	0.3021	0.2416
A40Z	ECMO	4	D		16	37	23.5				4.6807	5.5840	1.6938	32.6842	0.3621	0.2897
B01Z	Ventricular Shunt Revision	D	D		1	15	3.8				1.7392	2.5262	0.0000	2.5262	0.2863	0.2291
B02A	Cranial Procedures, Major Complexity	D	D		6	55	19.3				2.8254	3.5151	1.1494	10.4115	0.3007	0.2406
B02B	Cranial Procedures, Intermediate Complexity	D	D		2	23	8.0				2.7540	3.5795	0.8255	5.2305	0.2888	0.2310
B02C	Cranial Procedures, Minor Complexity	D	D		1	15	5.1				2.3722	3.4216	0.0000	3.4216	0.2878	0.2302
B02Y	Endovascular Clot Retrieval	D	D		2	18	5.8				4.8590	5.7854	0.9264	7.6382	0.3621	0.2897
B03A	Spinal Procedures, Major Complexity	D	D		4	40	14.0				2.8906	3.4902	0.8994	7.0878	0.2397	0.1918

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
B03B	Spinal Procedures, Intermediate Complexity	D	D		2	21	6.7				2.4300	3.0290	0.5990	4.2271	0.2515	0.2012
B03C	Spinal Procedures, Minor Complexity	D	D		0	8	2.5				2.1324	2.1324	0.0000	2.1324	0.2726	0.2181
B04A	Extracranial Vascular Procedures, Major Complexity	D	D		4	37	14.2				1.7088	2.3488	0.9600	6.1889	0.2526	0.2021
B04B	Extracranial Vascular Procedures, Intermediate Complexity	D	D		2	20	7.6				1.6043	2.3120	0.7078	3.7275	0.2595	0.2076
B04C	Extracranial Vascular Procedures, Minor Complexity	D	D		1	11	3.5				1.6081	2.3128	0.0000	2.3128	0.2835	0.2268
B05Z	Carpal Tunnel Release	D	D		0	3	1.0				0.3810	0.3810	0.0000	0.3810	0.1024	0.0820
B06A	Procedures for Cerebral Palsy, Muscular Dystrophy and Neuropathy, Major Complexity	D	D		3	31	11.8				1.3773	2.0560	0.9049	4.7705	0.2415	0.1932
B06B	Procedures for Cerebral Palsy, Muscular Dystrophy and Neuropathy, Intermediate Complexity	D	D		1	15	3.9				1.5038	2.2322	0.0000	2.2322	0.2647	0.2118
B06C	Procedures for Cerebral Palsy, Muscular Dystrophy and Neuropathy, Minor Complexity	D	D		0	6	1.6			Same day	0.5540	1.4034	0.0000	1.4034	0.2869	0.2295
B07A	Cranial or Peripheral Nerve and Other Nervous System Procedures, Major Complexity	D	D		2	24	8.4				1.4363	2.1269	0.6906	3.5081	0.2297	0.1838
B07B	Cranial or Peripheral Nerve and Other Nervous System Procedures, Minor Complexity	D	D		0	5	1.7			Same day	0.5705	1.1344	0.0000	1.1344	0.2655	0.2124
B40Z	Plasmapheresis W Neurological Disease, Same-day	D	D		0	3	1.0				0.1447	0.1447	0.0000	0.1447	0.1155	0.0924
B41A	Telemetric EEG Monitoring, Major Complexity	D	D		1	18	5.9				1.0534	2.1009	0.0000	2.1009	0.2847	0.2277
B41B	Telemetric EEG Monitoring, Minor Complexity	D	D		1	12	4.2				0.7211	1.4357	0.0000	1.4357	0.2710	0.2168

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
B42A	Nervous System Disorders W Ventilator Support, Major Complexity	D	D		4	43	13.7				0.7274	1.4274	1.0500	5.6273	0.3260	0.2608
B42B	Nervous System Disorders W Ventilator Support, Intermediate Complexity	D	D		2	21	7.7				0.9718	1.9260	0.9541	3.8342	0.3621	0.2897
B42C	Nervous System Disorders W Ventilator Support, Minor Complexity	D	D		1	9	2.9				1.1706	2.2982	0.0000	2.2982	0.3621	0.2897
B62Z	Apheresis	D	D		0	3	1.0				0.4111	0.4111	0.0000	0.4111	0.3249	0.2599
B63A	Dementia and Other Chronic Disturbances of Cerebral Function, Major Complexity	D	D		2	25	8.5				0.4866	0.9733	0.4866	1.9465	0.1837	0.1469
B63B	Dementia and Other Chronic Disturbances of Cerebral Function, Minor Complexity	D	D		1	17	5.3	S	0.2834	Same day	0.0865	1.2107	0.0000	1.2107	0.1819	0.1455
B64A	Delirium, Major Complexity	D	D		2	19	6.4				0.4126	0.8252	0.4126	1.6503	0.2068	0.1655
B64B	Delirium, Minor Complexity	D	D		1	9	2.6	S	0.3148		0.4046	0.8092	0.0000	0.8092	0.2512	0.2009
B65Z	Cerebral Palsy	D	D		0	3	1.0				0.3219	0.3219	0.0000	0.3219	0.2546	0.2037
B66A	Nervous System Neoplasms, Major Complexity	D	D		2	23	7.7				0.5760	1.1520	0.5760	2.3040	0.2384	0.1907
B66B	Nervous System Neoplasms, Minor Complexity	D	D		1	11	3.7	S	0.4201	Same day	0.3977	1.1966	0.0000	1.1966	0.2604	0.2083
B67A	Degenerative Nervous System Disorders, Major Complexity	D	D		3	28	10.1				0.4590	0.9180	0.6120	2.7540	0.2173	0.1738
B67B	Degenerative Nervous System Disorders, Intermediate Complexity	D	D		1	13	4.0			Same day	0.1718	1.2096	0.0000	1.2096	0.2400	0.1920
B67C	Degenerative Nervous System Disorders, Minor Complexity	D	D		0	3	1.0				0.1441	0.1441	0.0000	0.1441	0.1107	0.0886
B68A	Multiple Sclerosis and Cerebellar Ataxia, Major Complexity	D	D		1	15	4.8			Same day	0.1891	1.7181	0.0000	1.7181	0.2853	0.2282
B68B	Multiple Sclerosis and Cerebellar Ataxia, Minor Complexity	D	D		0	3	1.0				0.1371	0.1371	0.0000	0.1371	0.1073	0.0858
B69A	TIA and Precerebral Occlusion, Major Complexity	D	D		1	12	4.0				0.6342	1.2685	0.0000	1.2685	0.2569	0.2055

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
B69B	TIA and Precerebral Occlusion, Minor Complexity	D	D		0	6	1.9	S	0.3718	Same day	0.4475	0.7181	0.0000	0.7181	0.3078	0.2463
B70A	Stroke and Other Cerebrovascular Disorders, Major Complexity	D	D		4	38	12.7				0.4420	0.8840	0.6630	3.5359	0.2222	0.1778
B70B	Stroke and Other Cerebrovascular Disorders, Intermediate Complexity	D	D		2	18	6.6				0.4893	0.9786	0.4893	1.9573	0.2388	0.1911
B70C	Stroke and Other Cerebrovascular Disorders, Minor Complexity	D	D		1	10	3.2	S	0.3949	Same day	0.4139	1.0907	0.0000	1.0907	0.2689	0.2152
B70D	Stroke and Other Cerebrovascular Disorders, Transferred < 5 Days	D	D		0	8	2.6	S	0.5063		1.0467	1.0467	0.0000	1.0467	0.3231	0.2585
B71A	Cranial and Peripheral Nerve Disorders, Major Complexity	D	D		1	14	4.4	S	0.2984	Same day	0.1467	1.2322	0.0000	1.2322	0.2239	0.1791
B71B	Cranial and Peripheral Nerve Disorders, Minor Complexity	D	D		1	11	3.2	S	0.2565	Same day	0.0936	0.9752	0.0000	0.9752	0.2404	0.1923
B72A	Nervous System Infection Except Viral Meningitis, Major Complexity	D	D		3	34	11.4				0.5628	1.1255	0.7504	3.3766	0.2373	0.1898
B72B	Nervous System Infection Except Viral Meningitis, Minor Complexity	D	D		2	20	5.8			One day	0.2077	0.2077	0.7204	1.6485	0.2258	0.1806
B73A	Viral Meningitis, Major Complexity	D	D		1	16	5.1				0.6941	1.3882	0.0000	1.3882	0.2192	0.1754
B73B	Viral Meningitis, Minor Complexity	D	D		0	7	2.5	S	0.3246		0.9034	0.9034	0.0000	0.9034	0.2886	0.2308
B74A	Nontraumatic Stupor and Coma, Major Complexity	D	D		1	14	3.6				0.6153	1.2307	0.0000	1.2307	0.2756	0.2204
B74B	Nontraumatic Stupor and Coma, Minor Complexity	D	D		0	5	1.5	S	0.2724		0.5048	0.5048	0.0000	0.5048	0.2609	0.2087
B75Z	Febrile Convulsions	D	D		0	4	1.2	S	0.1399		0.4422	0.4422	0.0000	0.4422	0.2892	0.2314
B76A	Seizures, Major Complexity	D	D		1	13	3.8			Same day	0.3358	1.4712	0.0000	1.4712	0.3118	0.2494
B76B	Seizures, Minor Complexity	D	D		0	6	1.8	S	0.2402	Same day	0.3142	0.6830	0.0000	0.6830	0.3030	0.2424

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
B77A	Headaches, Major Complexity	D	D		1	10	3.0	S	0.3284	Same day	0.3190	0.9442	0.0000	0.9442	0.2483	0.1986
B77B	Headaches, Minor Complexity	D	D		0	6	1.9	S	0.2287	Same day	0.2772	0.6485	0.0000	0.6485	0.2694	0.2155
B78A	Intracranial Injuries, Major Complexity	D	D		2	24	8.5				0.6626	1.3253	0.6626	2.6506	0.2492	0.1993
B78B	Intracranial Injuries, Minor Complexity	D	D		1	10	3.2	S	0.3838		0.5379	1.0758	0.0000	1.0758	0.2652	0.2121
B78C	Intracranial Injuries, Transferred < 5 Days	D	D		0	7	2.3	S	0.4621		0.9228	0.9228	0.0000	0.9228	0.3227	0.2582
B79A	Skull Fractures, Major Complexity	D	D		1	13	4.5				0.7489	1.4978	0.0000	1.4978	0.2663	0.2130
B79B	Skull Fractures, Minor Complexity	D	D		0	6	1.9	S	0.3548		0.8012	0.8012	0.0000	0.8012	0.3374	0.2699
B80A	Other Head Injuries, Major Complexity	D	D		1	12	3.7	S	0.3912		0.5517	1.1033	0.0000	1.1033	0.2407	0.1925
B80B	Other Head Injuries, Minor Complexity	D	D		0	4	1.4	S	0.2288	Same day	0.3061	0.5713	0.0000	0.5713	0.3385	0.2708
B81A	Other Disorders of the Nervous System, Major Complexity	D	D		2	20	6.9				0.4574	0.9147	0.4574	1.8295	0.2119	0.1695
B81B	Other Disorders of the Nervous System, Minor Complexity	D	D		1	9	3.0	S	0.2976	Same day	0.3569	0.9305	0.0000	0.9305	0.2508	0.2006
B82A	Chronic and Unspec Para/Quadriplegia, Major Complexity	D	D		9	22	13.4				0.2074	0.4147	0.3686	3.7324	0.2796	0.2237
B82B	Chronic and Unspec Para/Quadriplegia, Intermediate Complexity	D	D		4	10	6.1				0.2239	0.4477	0.3358	1.7910	0.2947	0.2358
B82C	Chronic and Unspec Para/Quadriplegia, Minor Complexity	D	D		2	5	2.9				0.2419	0.4839	0.2419	0.9678	0.3337	0.2670
B83A	Acute Paraplegia and Quadriplegia and Spinal Cord Conditions, Major Complexity	D	D		12	28	19.8				0.2093	0.4187	0.3838	5.0243	0.2540	0.2032
B83B	Acute Paraplegia and Quadriplegia and Spinal Cord Conditions, Intermediate Complexity	D	D		4	10	6.8				0.2825	0.5650	0.4237	2.2599	0.3322	0.2657
B83C	Acute Paraplegia and Quadriplegia and Spinal Cord Conditions, Minor Complexity	D	D		2	5	3.0				0.3106	0.6213	0.3106	1.2425	0.3621	0.2897

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
C01A	Procedures for Penetrating Eye Injury, Major Complexity	D	D		0	8	2.6				1.7505	1.7505	0.0000	1.7505	0.3218	0.2574
C01B	Procedures for Penetrating Eye Injury, Minor Complexity	D	D		0	4	1.5				0.9978	0.9978	0.0000	0.9978	0.3090	0.2472
C02A	Enucleations and Orbital Procedures, Major Complexity	D	D		1	11	2.6				1.1143	1.6920	0.0000	1.6920	0.3075	0.2460
C02B	Enucleations and Orbital Procedures, Minor Complexity	D	D		0	4	1.3				0.9494	0.9494	0.0000	0.9494	0.3098	0.2478
C03A	Retinal Procedures, Major Complexity	D	D		0	3	1.1				0.7182	0.7182	0.0000	0.7182	0.2670	0.2136
C03B	Retinal Procedures, Minor Complexity	D	D		0	3	1.0				0.2126	0.2126	0.0000	0.2126	0.1085	0.0868
C04A	Major Corneal, Scleral and Conjunctival Procedures, Major Complexity	D	D		0	6	1.4				1.6339	1.6339	0.0000	1.6339	0.3621	0.2897
C04B	Major Corneal, Scleral and Conjunctival Procedures, Minor Complexity	D	D		0	3	1.1				1.4602	1.4602	0.0000	1.4602	0.3577	0.2862
C05Z	Dacryocystorhinostomy	D	D		0	3	1.0				0.8009	0.8009	0.0000	0.8009	0.2966	0.2373
C10Z	Strabismus Procedures	D	D		0	3	1.0				0.7484	0.7484	0.0000	0.7484	0.2605	0.2084
C11Z	Eyelid Procedures	D	D		0	4	1.4			Same day	0.5561	0.9085	0.0000	0.9085	0.2856	0.2285
C12A	Other Corneal, Scleral and Conjunctival Procedures, Major Complexity	D	D		1	9	2.7				0.8959	1.2325	0.0000	1.2325	0.1767	0.1414
C12B	Other Corneal, Scleral and Conjunctival Procedures, Minor Complexity	D	D		0	3	1.0				0.5089	0.5089	0.0000	0.5089	0.1593	0.1274
C13Z	Lacrimal Procedures	D	D		0	3	1.1				0.3993	0.3993	0.0000	0.3993	0.1372	0.1097
C14A	Other Eye Procedures, Major Complexity	D	D		0	6	1.8				0.5802	0.5802	0.0000	0.5802	0.1657	0.1326
C14B	Other Eye Procedures, Minor Complexity	D	D		0	3	1.0				0.3985	0.3985	0.0000	0.3985	0.1363	0.1091
C15Z	Glaucoma and Complex Cataract Procedures	D	D		0	3	1.0				0.6040	0.6040	0.0000	0.6040	0.1922	0.1538
C16Z	Lens Procedures	D	D		0	3	1.0			Same day	0.4731	0.7501	0.0000	0.7501	0.2936	0.2349

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C60A	Acute and Major Eye Infections, Major Complexity	D	D		1	15	4.9				0.5109	1.0218	0.0000	1.0218	0.1665	0.1332
C60B	Acute and Major Eye Infections, Minor Complexity	D	D		1	11	3.4	S	0.2475	Same day	0.1002	0.8215	0.0000	0.8215	0.1935	0.1548
C61A	Neurological and Vascular Disorders of the Eye, Major Complexity	D	D		1	11	2.5	S	0.3342		0.3911	0.7822	0.0000	0.7822	0.2512	0.2010
C61B	Neurological and Vascular Disorders of the Eye, Minor Complexity	D	D		0	7	2.4	S	0.3049	Same day	0.1168	0.8317	0.0000	0.8317	0.2769	0.2215
C62A	Hyphaema and Medically Managed Trauma to the Eye, Major Complexity	D	D		1	10	3.4	S	0.2891		0.4453	0.8907	0.0000	0.8907	0.2121	0.1697
C62B	Hyphaema and Medically Managed Trauma to the Eye, Minor Complexity	D	D		0	5	1.6	S	0.2674		0.5753	0.5753	0.0000	0.5753	0.2931	0.2345
C63A	Other Disorders of the Eye, Major Complexity	D	D		1	13	4.1	S	0.275	Same day	0.3832	1.1222	0.0000	1.1222	0.2175	0.1740
C63B	Other Disorders of the Eye, Minor Complexity	D	D		0	6	1.9	S	0.231	Same day	0.1926	0.6155	0.0000	0.6155	0.2559	0.2047
D01Z	Cochlear Implant	D	D	Bilat	0	3	1.0				6.7569	6.7569	0.0000	6.7569	0.2769	0.2215
D02A	Head and Neck Procedures, Major Complexity	D	D		2	24	8.2				2.6056	3.2255	0.6199	4.4654	0.2116	0.1693
D02B	Head and Neck Procedures, Minor Complexity	D	D		0	5	1.7				1.4235	1.4235	0.0000	1.4235	0.3179	0.2543
D03A	Surgical Repair for Cleft Lip and Palate Disorders, Major Complexity	D	D		0	7	2.0				2.3391	2.3391	0.0000	2.3391	0.3621	0.2897
D03B	Surgical Repair for Cleft Lip and Palate Disorders, Minor Complexity	D	D		0	4	1.3				1.5966	1.5966	0.0000	1.5966	0.3450	0.2760
D04A	Maxillo Surgery, Major Complexity	D	D		0	5	1.8				1.9211	1.9211	0.0000	1.9211	0.3354	0.2683
D04B	Maxillo Surgery, Minor Complexity	D	D		0	4	1.4				1.1242	1.1242	0.0000	1.1242	0.2513	0.2010
D05Z	Parotid Gland Procedures	D	D		0	8	2.4				2.1098	2.1098	0.0000	2.1098	0.3082	0.2465
D06Z	Sinus and Complex Middle Ear Procedures	D	D		0	3	1.0				1.0665	1.0665	0.0000	1.0665	0.3590	0.2872

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
D10Z	Nasal Procedures	D	D		0	3	1.0				0.8091	0.8091	0.0000	0.8091	0.2708	0.2166
D11Z	Tonsillectomy and Adenoidectomy	D	D		0	3	1.0				0.5658	0.5658	0.0000	0.5658	0.2142	0.1713
D12A	Other Ear, Nose, Mouth and Throat Procedures, Major Complexity	D	D		1	12	3.7			Same day	0.5779	2.1758	0.0000	2.1758	0.2856	0.2285
D12B	Other Ear, Nose, Mouth and Throat Procedures, Minor Complexity	D	D		0	4	1.4			Same day	0.4955	1.0145	0.0000	1.0145	0.2868	0.2294
D13Z	Myringotomy W Tube Insertion	D	D		0	3	1.0				0.3204	0.3204	0.0000	0.3204	0.0985	0.0788
D14A	Mouth and Salivary Gland Procedures, Major Complexity	D	D		0	5	1.6				0.9389	0.9389	0.0000	0.9389	0.2513	0.2010
D14B	Mouth and Salivary Gland Procedures, Minor Complexity	D	D		0	3	1.0				0.4490	0.4490	0.0000	0.4490	0.1402	0.1122
D15Z	Mastoid Procedures	D	D		0	3	1.1				1.7728	1.7728	0.0000	1.7728	0.3621	0.2897
D40Z	Dental Extractions and Restorations	D	D		0	3	1.0				0.6119	0.6119	0.0000	0.6119	0.2432	0.1945
D60A	Ear, Nose, Mouth and Throat Malignancy, Major Complexity	D	D		2	20	7.5				0.5695	1.1390	0.5695	2.2779	0.2443	0.1955
D60B	Ear, Nose, Mouth and Throat Malignancy, Minor Complexity	D	D		0	7	1.8			Same day	0.4763	0.7845	0.0000	0.7845	0.3396	0.2716
D61A	Dysequilibrium, Major Complexity	D	D		1	11	3.5	S	0.3523		0.4933	0.9867	0.0000	0.9867	0.2250	0.1800
D61B	Dysequilibrium, Minor Complexity	D	D		0	6	2.1	S	0.2512	Same day	0.2930	0.6387	0.0000	0.6387	0.2462	0.1969
D62A	Epistaxis, Major Complexity	D	D		1	11	3.0				0.4636	0.9272	0.0000	0.9272	0.2440	0.1952
D62B	Epistaxis, Minor Complexity	D	D		0	6	2.0	S	0.2303	Same day	0.2513	0.5637	0.0000	0.5637	0.2290	0.1832
D63A	Otitis Media and Upper Respiratory Infections, Major Complexity	D	D		0	8	2.8	S	0.2789	Same day	0.3315	0.8886	0.0000	0.8886	0.2510	0.2008
D63B	Otitis Media and Upper Respiratory Infections, Minor Complexity	D	D		0	4	1.5	S	0.2091	Same day	0.2417	0.4773	0.0000	0.4773	0.2568	0.2054
D64A	Laryngotracheitis and Epiglottitis, Major Complexity	D	D		0	6	2.0	S	0.164		0.9686	0.9686	0.0000	0.9686	0.3621	0.2897

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
D64B	Laryngotracheitis and Epiglottitis, Minor Complexity	D	D		0	4	1.3	S	0.1384	Same day	0.2209	0.5475	0.0000	0.5475	0.3386	0.2709
D65A	Nasal Trauma and Deformity, Major Complexity	D	D		1	10	3.0	S	0.4404		0.5090	1.0180	0.0000	1.0180	0.2723	0.2178
D65B	Nasal Trauma and Deformity, Minor Complexity	D	D		0	4	1.4	S	0.2949	Same day	0.2894	0.6676	0.0000	0.6676	0.3621	0.2897
D66A	Other Ear, Nose, Mouth and Throat Disorders, Major Complexity	D	D		1	10	2.7	S	0.2958	Same day	0.3917	0.8702	0.0000	0.8702	0.2546	0.2037
D66B	Other Ear, Nose, Mouth and Throat Disorders, Minor Complexity	D	D		0	4	1.2	S	0.2181	Same day	0.3375	0.3185	0.0000	0.3185	0.2170	0.1736
D67A	Oral and Dental Disorders, Major Complexity	D	D		1	11	3.5	S	0.2813	Same day	0.3408	1.0398	0.0000	1.0398	0.2386	0.1909
D67B	Oral and Dental Disorders, Minor Complexity	D	D		0	5	1.7	S	0.2668	Same day	0.2348	0.6326	0.0000	0.6326	0.3045	0.2436
E01A	Major Chest Procedures, Major Complexity	D	D		5	50	16.9				1.9707	2.6192	1.0377	7.8075	0.2684	0.2147
E01B	Major Chest Procedures, Intermediate Complexity	D	D		3	27	9.5				1.7287	2.2898	0.7482	4.5343	0.2488	0.1991
E01C	Major Chest Procedures, Minor Complexity	D	D		1	17	6.1				2.0828	3.1619	0.0000	3.1619	0.2484	0.1987
E02A	Other Respiratory System GIs, Major Complexity	D	D		3	33	11.0				1.0874	1.6836	0.7949	4.0681	0.2272	0.1818
E02B	Other Respiratory System GIs, Intermediate Complexity	D	D		1	9	2.6			Same day	0.5255	1.6468	0.0000	1.6468	0.2867	0.2293
E02C	Other Respiratory System GIs, Minor Complexity	D	D		0	3	1.1			Same day	0.3444	0.7148	0.0000	0.7148	0.2764	0.2212
E03Z	Lung or Heart-Lung Transplant	4	D		10	99	27.9				4.0533	5.0579	1.8084	23.1418	0.3621	0.2897
E40A	Respiratory System Disorders W Ventilator Support, Major Complexity	D	D		4	39	13.1				0.7421	1.4540	1.0679	5.7254	0.3478	0.2783
E40B	Respiratory System Disorders W Ventilator Support, Minor Complexity	D	D		2	19	7.0				0.9862	1.8959	0.9097	3.7153	0.3621	0.2897

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
E41A	Respiratory System Disorders W Non-Invasive Ventilation, Major Complexity	D	1		3	33	11.3				0.7763	1.5276	1.0017	4.5325	0.3192	0.2554
E41B	Respiratory System Disorders W Non-Invasive Ventilation, Minor Complexity	D	1		1	18	6.0				1.1186	2.2331	0.0000	2.2331	0.2977	0.2381
E42A	Bronchoscopy, Major Complexity	D	D		3	35	12.1				0.7822	1.3737	0.7887	3.7396	0.2341	0.1873
E42B	Bronchoscopy, Intermediate Complexity	D	D		1	16	5.2			Same day	0.4638	2.0419	0.0000	2.0419	0.2639	0.2111
E42C	Bronchoscopy, Minor Complexity	D	D		0	9	2.3			Same day	0.4202	1.2320	0.0000	1.2320	0.2986	0.2389
E60A	Cystic Fibrosis, Major Complexity	D	D		3	36	13.2				0.6729	1.3458	0.8972	4.0375	0.2442	0.1954
E60B	Cystic Fibrosis, Minor Complexity	D	D		2	19	8.9				0.7209	1.4418	0.7209	2.8835	0.2588	0.2071
E61A	Pulmonary Embolism, Major Complexity	D	D		1	17	5.3				0.8223	1.6446	0.0000	1.6446	0.2492	0.1994
E61B	Pulmonary Embolism, Minor Complexity	D	D		0	8	2.5	S	0.4322		0.8224	0.8224	0.0000	0.8224	0.2662	0.2130
E62A	Respiratory Infections and Inflammations, Major Complexity	D	D		1	14	4.6				0.6553	1.3107	0.0000	1.3107	0.2297	0.1837
E62B	Respiratory Infections and Inflammations, Minor Complexity	D	D		1	10	3.5	S	0.2979	One day	0.4453	0.4453	0.0000	0.9121	0.2105	0.1684
E63A	Sleep Apnoea, Major Complexity	D	D		1	15	4.1			One day	0.2507	0.2507	0.0000	1.4304	0.2760	0.2208
E63B	Sleep Apnoea, Minor Complexity	D	D		0	7	4.1			One day	0.2348	0.2348	0.0000	0.4997	0.0985	0.0788
E64A	Pulmonary Oedema and Respiratory Failure, Major Complexity	D	D		1	16	5.0				0.9154	1.8309	0.0000	1.8309	0.2924	0.2339
E64B	Pulmonary Oedema and Respiratory Failure, Minor Complexity	D	D		0	4	1.3				0.5357	0.5357	0.0000	0.5357	0.3228	0.2582
E65A	Chronic Obstructive Airways Disease, Major Complexity	D	D		1	14	4.5				0.6479	1.2958	0.0000	1.2958	0.2280	0.1824
E65B	Chronic Obstructive Airways Disease, Minor Complexity	D	D		1	10	3.5	S	0.2798	One day	0.4057	0.4057	0.0000	0.9109	0.2089	0.1671

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E66A	Major Chest Trauma, Major Complexity	D	D		2	24	8.7				0.6319	1.2638	0.6319	2.5276	0.2331	0.1865
E66B	Major Chest Trauma, Intermediate Complexity	D	D		1	10	3.8				0.6605	1.3210	0.0000	1.3210	0.2816	0.2253
E66C	Major Chest Trauma, Minor Complexity	D	D		0	7	2.2	S	0.4311		0.8423	0.8423	0.0000	0.8423	0.3090	0.2472
E67A	Respiratory Signs and Symptoms, Major Complexity	D	D		1	10	3.1	S	0.3047	Same day	0.4368	0.9286	0.0000	0.9286	0.2432	0.1946
E67B	Respiratory Signs and Symptoms, Minor Complexity	D	D		0	4	1.3	S	0.2243	Same day	0.3020	0.4330	0.0000	0.4330	0.2755	0.2204
E68A	Pneumothorax, Major Complexity	D	D		1	16	4.8				0.8284	1.6568	0.0000	1.6568	0.2773	0.2218
E68B	Pneumothorax, Minor Complexity	D	D		0	8	2.9	S	0.3604		0.9099	0.9099	0.0000	0.9099	0.2521	0.2017
E69A	Bronchitis and Asthma, Major Complexity	D	D		1	9	2.8				0.4931	0.9863	0.0000	0.9863	0.2797	0.2238
E69B	Bronchitis and Asthma, Minor Complexity	D	D		0	5	1.6	S	0.1922	Same day	0.2484	0.5445	0.0000	0.5445	0.2762	0.2210
E70A	Whooping Cough and Acute Bronchiolitis, Major Complexity	D	D		0	7	2.3				0.8699	0.8699	0.0000	0.8699	0.3003	0.2403
E70B	Whooping Cough and Acute Bronchiolitis, Minor Complexity	D	D		0	7	2.5	S	0.1756	One day	0.3562	0.3562	0.0000	0.8265	0.2611	0.2089
E71A	Respiratory Neoplasms, Major Complexity	D	D		2	22	7.6				0.5178	1.0356	0.5178	2.0713	0.2184	0.1747
E71B	Respiratory Neoplasms, Minor Complexity	D	D		1	11	3.2			Same day	0.2732	0.9612	0.0000	0.9612	0.2416	0.1933
E72Z	Respiratory Problems Arising from Neonatal Period	D	D		0	4	1.1				0.2322	0.2322	0.0000	0.2322	0.1639	0.1311
E73A	Pleural Effusion, Major Complexity	D	D		2	24	8.0				0.5603	1.1207	0.5603	2.2413	0.2241	0.1793
E73B	Pleural Effusion, Intermediate Complexity	D	D		1	14	5.1			One day	0.4103	0.4103	0.0000	1.4486	0.2267	0.1814
E73C	Pleural Effusion, Minor Complexity	D	D		0	8	2.5	S	0.2848	Same day	0.1786	0.8465	0.0000	0.8465	0.2675	0.2140
E74A	Interstitial Lung Disease, Major Complexity	D	D		1	16	5.1				0.7393	1.4787	0.0000	1.4787	0.2335	0.1868

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E74B	Interstitial Lung Disease, Minor Complexity	D	D		1	10	3.0			Same day	0.2174	0.9700	0.0000	0.9700	0.2561	0.2049
E75A	Other Respiratory System Disorders, Major Complexity	D	D		1	12	3.6	S	0.3236	Same day	0.2304	1.0339	0.0000	1.0339	0.2296	0.1837
E75B	Other Respiratory System Disorders, Minor Complexity	D	D		0	6	2.0	S	0.2528	Same day	0.2720	0.6621	0.0000	0.6621	0.2607	0.2085
E76Z	Respiratory Tuberculosis	D	D		2	18	7.6				0.5511	1.1022	0.5511	2.2045	0.2324	0.1859
E77A	Bronchiectasis, Major Complexity	D	D		2	23	8.6				0.5274	1.0549	0.5274	2.1097	0.1968	0.1575
E77B	Bronchiectasis, Minor Complexity	D	D		1	17	5.6	S	0.2503	Same day	0.1210	1.1839	0.0000	1.1839	0.1703	0.1362
F01A	Implantation and Replacement of AICD, Total System, Major Complexity	D	D		3	30	10.7				4.4156	5.2523	1.1156	8.5991	0.3270	0.2616
F01B	Implantation and Replacement of AICD, Total System, Minor Complexity	D	D		0	5	1.3				4.0241	4.0241	0.0000	4.0241	0.3621	0.2897
F02Z	Other AICD Procedures	D	D		0	8	1.9				2.0648	2.0648	0.0000	2.0648	0.3621	0.2897
F03A	Cardiac Valve Procedures W CPB Pump W Invasive Cardiac Investigation, Major Complexity	D	D		7	71	26.1				4.9357	5.6943	1.3005	14.7975	0.2852	0.2282
F03B	Cardiac Valve Procedures W CPB Pump W Invasive Cardiac Investigation, Minor Complexity	D	D		2	21	6.6				6.4712	7.2618	0.7906	8.8431	0.3346	0.2677
F04A	Cardiac Valve Procedures W CPB Pump W/O Invasive Cardiac Invest, Major Complexity	D	D		6	56	20.6				4.8208	5.6595	1.3978	14.0462	0.3428	0.2742
F04B	Cardiac Valve Procedures W CPB Pump W/O Invasive Cardiac Invest, Intermediate Complexity	D	D		2	26	9.0				4.5924	5.9540	1.3616	8.6773	0.3621	0.2897
F04C	Cardiac Valve Procedures W CPB Pump W/O Invasive Cardiac Invest, Minor Complexity	D	D		1	17	6.1				4.9856	6.9933	0.0000	6.9933	0.3621	0.2897
F05A	Coronary Bypass W Invasive Cardiac Investigation, Major Complexity	D	D		5	50	17.8				2.9529	3.7733	1.3126	10.3365	0.3231	0.2585

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F05B	Coronary Bypass W Invasive Cardiac Investigation, Minor Complexity	D	D		4	38	13.0				2.6330	3.3718	1.1081	7.8044	0.3186	0.2549
F06A	Coronary Bypass W/O Invasive Cardiac Investigation, Major Complexity	D	D		5	46	15.7				3.0931	3.8847	1.2666	10.2178	0.3523	0.2818
F06B	Coronary Bypass W/O Invasive Cardiac Investigation, Intermediate Complexity	D	D		3	30	10.3				2.9543	3.8427	1.1845	7.3962	0.3612	0.2889
F06C	Coronary Bypass W/O Invasive Cardiac Investigation, Minor Complexity	D	D		2	24	7.8				3.0483	4.0703	1.0220	6.1142	0.3621	0.2897
F07A	Other Cardiothoracic/Vascular Procedures W CPB Pump, Major Complexity	D	D		4	40	12.9				5.0043	6.1204	1.6741	12.8170	0.3621	0.2897
F07B	Other Cardiothoracic/Vascular Procedures W CPB Pump, Minor Complexity	D	D		2	20	6.7				3.5729	4.6762	1.1033	6.8829	0.3621	0.2897
F08A	Major Reconstructive Vascular Procedures W/O CPB Pump, Major Complexity	D	D	AAA	6	60	21.0				3.1960	3.8608	1.1081	10.5093	0.2654	0.2123
F08B	Major Reconstructive Vascular Procedures W/O CPB Pump, Intermediate Complexity	D	D	AAA	2	25	8.6				3.0302	3.8655	0.8353	5.5360	0.2716	0.2173
F08C	Major Reconstructive Vascular Procedures W/O CPB Pump, Minor Complexity	D	D	AAA	1	13	4.2				2.2686	3.0355	0.0000	3.0355	0.2576	0.2061
F09A	Other Cardiothoracic Procedures W/O CPB Pump, Major Complexity	D	D		4	37	10.0				1.7787	2.4033	0.9369	6.1509	0.3481	0.2785
F09B	Other Cardiothoracic Procedures W/O CPB Pump, Intermediate Complexity	D	D		1	16	5.5				1.9437	3.0451	0.0000	3.0451	0.2814	0.2251
F09C	Other Cardiothoracic Procedures W/O CPB Pump, Minor Complexity	D	D		0	5	1.6				2.0233	2.0233	0.0000	2.0233	0.3621	0.2897
F10A	Interventional Coronary Procedures, Admitted for AMI, Major Complexity	D	D		2	19	6.4				1.3051	2.0734	0.7683	3.6100	0.3339	0.2671
F10B	Interventional Coronary Procedures, Admitted for AMI, Minor Complexity	D	D		1	9	3.2				1.3346	2.1541	0.0000	2.1541	0.3621	0.2897
F11A	Amputation, Except Upper Limb and Toe, for Circulatory Disorders, Major Complexity	D	D		10	95	33.4				2.0359	2.4896	0.8167	10.6562	0.1905	0.1524

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F11B	Amputation, Except Upper Limb and Toe, for Circulatory Disorders, Minor Complexity	D	D		5	48	17.3				1.4363	1.8818	0.7128	5.4456	0.1799	0.1439
F12A	Implantation and Replacement of Pacemaker, Total System, Major Complexity	D	D		2	18	6.7				1.8263	2.5730	0.7467	4.0663	0.3099	0.2479
F12B	Implantation and Replacement of Pacemaker, Total System, Minor Complexity	D	D		0	6	2.0				1.9436	1.9436	0.0000	1.9436	0.3621	0.2897
F13A	Amputation, Upper Limb and Toe, for Circulatory Disorders, Major Complexity	D	D		5	52	17.4				1.1956	1.6446	0.7185	5.2372	0.1805	0.1444
F13B	Amputation, Upper Limb and Toe, for Circulatory Disorders, Minor Complexity	D	D		2	23	7.9				1.0849	1.5992	0.5143	2.6278	0.1830	0.1464
F14A	Vascular Procedures, Except Major Reconstruction, W/O CPB Pump, Major Complexity	D	D		3	36	11.8				1.5846	2.2760	0.9220	5.0420	0.2460	0.1968
F14B	Vascular Procedures, Except Major Reconstruction, W/O CPB Pump, Intermediate Complexity	D	D		1	10	3.0				1.3505	2.0392	0.0000	2.0392	0.3259	0.2607
F14C	Vascular Procedures, Except Major Reconstruction, W/O CPB Pump, Minor Complexity	D	D		0	4	1.3				1.1362	1.1362	0.0000	1.1362	0.3621	0.2897
F17A	Insertion and Replacement of Pacemaker Generator, Major Complexity	D	D		1	10	2.8				1.4866	2.1601	0.0000	2.1601	0.3323	0.2658
F17B	Insertion and Replacement of Pacemaker Generator, Minor Complexity	D	D		0	3	1.0				1.1046	1.1046	0.0000	1.1046	0.3338	0.2670
F18Z	Other Pacemaker Procedures	D	D		1	12	2.5				1.2927	2.0097	0.0000	2.0097	0.3621	0.2897
F19A	Trans-Vascular Percutaneous Cardiac Intervention, Major Complexity	D	D	ASD	1	13	3.5				1.7756	2.5590	0.0000	2.5590	0.3116	0.2493
F19B	Trans-Vascular Percutaneous Cardiac Intervention, Minor Complexity	D	D	ASD	0	4	1.1				1.8849	1.8849	0.0000	1.8849	0.3621	0.2897
F20Z	Vein Ligation and Stripping	D	D		0	3	1.0				0.7581	0.7581	0.0000	0.7581	0.2419	0.1935

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F21A	Other Circulatory System GIs, Major Complexity	D	D		6	55	21.1				0.8865	1.3755	0.8151	6.2663	0.1950	0.1560
F21B	Other Circulatory System GIs, Intermediate Complexity	D	D		2	27	9.3				0.8907	1.5024	0.6117	2.7258	0.1837	0.1470
F21C	Other Circulatory System GIs, Minor Complexity	D	D		0	7	2.1				1.2073	1.2073	0.0000	1.2073	0.2670	0.2136
F22Z	Insertion of Artificial Heart Device	4	D		51	116	72.8				29.9019	30.5368	1.2450	94.0305	0.3621	0.2897
F23Z	Heart Transplant	4	D		11	100	32.0				5.0344	5.9894	1.7363	25.0888	0.3621	0.2897
F24A	Interventional Coronary Procs, Not Adm for AMI, Major Complexity	D	D		2	18	6.2				1.2792	2.0230	0.7438	3.5105	0.3369	0.2695
F24B	Interventional Coronary Procs, Not Adm for AMI, Minor Complexity	D	D		0	4	1.3			Same day	1.3686	1.7304	0.0000	1.7304	0.3621	0.2897
F40A	Circulatory Disorders W Ventilator Support, Major Complexity	D	D		4	42	14.8				0.7763	1.5129	1.1049	5.9323	0.3180	0.2544
F40B	Circulatory Disorders W Ventilator Support, Minor Complexity	D	D		1	13	3.6				1.3018	2.5748	0.0000	2.5748	0.3621	0.2897
F41A	Circulatory Disorders, Adm for AMI W Invasive Cardiac Inves Proc, Major Complexity	D	D		1	18	5.9				1.2044	2.3287	0.0000	2.3287	0.3071	0.2457
F41B	Circulatory Disorders, Adm for AMI W Invasive Cardiac Inves Proc, Minor Complexity	D	D		0	8	2.7				1.3058	1.3058	0.0000	1.3058	0.3621	0.2897
F42A	Circulatory Disorders, Not Adm for AMI W Invasive Cardiac Inves Proc, Major Complexity	D	D		1	15	4.9			Same day	0.5335	1.9670	0.0000	1.9670	0.3051	0.2440
F42B	Circulatory Dsrds, Not Adm for AMI W Invasive Cardiac Inves Proc, Minor Complexity	D	D		0	6	2.1			Same day	0.4781	1.0516	0.0000	1.0516	0.3621	0.2897
F43A	Circulatory Disorders W Non-Invasive Ventilation, Major Complexity	D	1		4	41	13.8				0.6610	1.2933	0.9485	5.0872	0.2941	0.2352
F43B	Circulatory Disorders W Non-Invasive Ventilation, Minor Complexity	D	1		2	23	8.1				0.7269	1.4421	0.7152	2.8724	0.2841	0.2273

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
F60A	Circulatory Disorders, Adm for AMI W/O Invas Card Inves Proc	D	D		1	12	3.7				0.5720	1.1441	0.0000	1.1441	0.2480	0.1984
F60B	Circulatory Disorders, Adm for AMI W/O Invas Card Inves Proc, Transf < 5 Days	D	D		0	5	1.9	S	0.5078	Same day	0.7164	0.8629	0.0000	0.8629	0.3621	0.2897
F61A	Infective Endocarditis, Major Complexity	D	D		7	69	28.9				0.4380	0.8761	0.7509	6.1327	0.1696	0.1357
F61B	Infective Endocarditis, Intermediate Complexity	D	D		5	47	18.7				0.3971	0.7942	0.6354	3.9710	0.1698	0.1358
F61C	Infective Endocarditis, Minor Complexity	D	D		3	27	9.1				0.2552	0.5105	0.3403	1.5314	0.1347	0.1077
F62A	Heart Failure and Shock, Major Complexity	D	D		2	21	7.2				0.4506	0.9011	0.4506	1.8022	0.2001	0.1601
F62B	Heart Failure and Shock, Minor Complexity	D	D		1	12	4.1	S	0.2708	One day	0.4092	0.4092	0.0000	1.0194	0.1983	0.1586
F62C	Heart Failure and Shock, Transferred < 5 Days	D	D		0	9	2.9	S	0.2952	One day	0.4332	0.4332	0.0000	0.9303	0.2581	0.2065
F63A	Venous Thrombosis, Major Complexity	D	D		1	15	4.8	S	0.3783		0.5943	1.1887	0.0000	1.1887	0.1997	0.1598
F63B	Venous Thrombosis, Minor Complexity	D	D		1	10	2.8	S	0.2301		0.3163	0.6325	0.0000	0.6325	0.1818	0.1455
F64A	Skin Ulcers in Circulatory Disorders, Major Complexity	D	D		2	26	9.9				0.6038	1.2077	0.6038	2.4154	0.1959	0.1567
F64B	Skin Ulcers in Circulatory Disorders, Intermediate Complexity	D	D		1	16	5.3				0.5830	1.1659	0.0000	1.1659	0.1769	0.1415
F64C	Skin Ulcers in Circulatory Disorders, Minor Complexity	D	D		0	7	1.7	S	0.2335		0.3973	0.3973	0.0000	0.3973	0.1907	0.1526
F65A	Peripheral Vascular Disorders, Major Complexity	D	D		1	17	5.4			Same day	0.3791	1.5907	0.0000	1.5907	0.2349	0.1879
F65B	Peripheral Vascular Disorders, Minor Complexity	D	D		0	8	2.3	S	0.3199	Same day	0.2890	0.8008	0.0000	0.8008	0.2810	0.2248
F66A	Coronary Atherosclerosis, Major Complexity	D	D		1	14	4.0				0.5706	1.1412	0.0000	1.1412	0.2302	0.1841
F66B	Coronary Atherosclerosis, Minor Complexity	D	D		0	6	1.9	S	0.2629	Same day	0.2797	0.6185	0.0000	0.6185	0.2668	0.2135

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
F67A	Hypertension, Major Complexity	D	D		1	13	3.5	S	0.288		0.6365	1.2730	0.0000	1.2730	0.2880	0.2304
F67B	Hypertension, Minor Complexity	D	D		0	6	1.8	S	0.2126	Same day	0.1931	0.4897	0.0000	0.4897	0.2152	0.1721
F68Z	Congenital Heart Disease	D	D		1	11	2.3			Same day	0.3594	1.1343	0.0000	1.1343	0.3621	0.2897
F69A	Valvular Disorders, Major Complexity	D	D		1	14	3.8				0.5637	1.1275	0.0000	1.1275	0.2393	0.1915
F69B	Valvular Disorders, Minor Complexity	D	D		1	10	3.1	S	0.2167	One day	0.3385	0.3385	0.0000	0.8817	0.2313	0.1850
F72A	Unstable Angina, Major Complexity	D	D		1	11	3.1	S	0.403		0.4711	0.9423	0.0000	0.9423	0.2424	0.1939
F72B	Unstable Angina, Minor Complexity	D	D		0	6	1.9	S	0.3062	Same day	0.3484	0.6462	0.0000	0.6462	0.2676	0.2141
F73A	Syncope and Collapse, Major Complexity	D	D		1	14	4.4			Same day	0.2997	1.2843	0.0000	1.2843	0.2326	0.1860
F73B	Syncope and Collapse, Minor Complexity	D	D		0	6	2.1	S	0.2502	Same day	0.4001	0.6862	0.0000	0.6862	0.2659	0.2127
F74A	Chest Pain, Major Complexity	D	D		0	7	2.2	S	0.3158		0.7228	0.7228	0.0000	0.7228	0.2585	0.2068
F74B	Chest Pain, Minor Complexity	D	D		0	4	1.3	S	0.2367		0.3956	0.3956	0.0000	0.3956	0.2489	0.1992
F75A	Other Circulatory Disorders, Major Complexity	D	D		3	28	9.4				0.4986	0.9971	0.6647	2.9913	0.2538	0.2030
F75B	Other Circulatory Disorders, Intermediate Complexity	D	D		1	15	4.8			One day	0.4856	0.4856	0.0000	1.5779	0.2607	0.2085
F75C	Other Circulatory Disorders, Minor Complexity	D	D		0	7	2.3	S	0.2685	Same day	0.3529	0.7664	0.0000	0.7664	0.2722	0.2178
F76A	Arrhythmia, Cardiac Arrest and Conduction Disorders, Major Complexity	D	D		1	12	3.9			Same day	0.3586	1.2337	0.0000	1.2337	0.2558	0.2046
F76B	Arrhythmia, Cardiac Arrest and Conduction Disorders, Minor Complexity	D	D		0	6	1.9	S	0.2505	Same day	0.2818	0.6768	0.0000	0.6768	0.2793	0.2234
G01A	Rectal Resection, Major Complexity	D	D		7	68	24.2				2.5150	3.0519	0.9204	9.4946	0.2178	0.1742
G01B	Rectal Resection, Intermediate Complexity	D	D		4	37	13.0				2.1947	2.7108	0.7741	5.8074	0.2230	0.1784

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G01C	Rectal Resection, Minor Complexity	D	D		2	21	7.3				2.0568	2.6397	0.5829	3.8056	0.2233	0.1786
G02A	Major Small and Large Bowel Procedures, Major Complexity	D	D		7	64	22.8				1.9872	2.5432	0.9532	9.2155	0.2386	0.1909
G02B	Major Small and Large Bowel Procedures, Intermediate Complexity	D	D		3	28	9.4				1.5789	2.0820	0.6707	4.0940	0.2245	0.1796
G02C	Major Small and Large Bowel Procedures, Minor Complexity	D	D		1	15	4.9				1.6670	2.4551	0.0000	2.4551	0.2267	0.1814
G03A	Stomach, Oesophageal and Duodenal Procedures, Major Complexity	D	D		5	53	18.1				3.0875	3.7812	1.1099	9.3305	0.2679	0.2143
G03B	Stomach, Oesophageal and Duodenal Procedures, Intermediate Complexity	D	D		2	22	6.8				1.9313	2.5745	0.6432	3.8608	0.2632	0.2105
G03C	Stomach, Oesophageal and Duodenal Procedures, Minor Complexity	D	D		0	8	2.6				1.6883	1.6883	0.0000	1.6883	0.2593	0.2074
G04A	Peritoneal Adhesiolysis, Major Complexity	D	D		3	35	12.2				1.6404	2.2944	0.8721	4.9106	0.2260	0.1808
G04B	Peritoneal Adhesiolysis, Intermediate Complexity	D	D		1	15	5.2				1.6065	2.4439	0.0000	2.4439	0.2268	0.1815
G04C	Peritoneal Adhesiolysis, Minor Complexity	D	D		0	7	2.3				1.4335	1.4335	0.0000	1.4335	0.2625	0.2100
G05A	Minor Small and Large Bowel Procedures, Major Complexity	D	D		3	31	10.3				1.2071	1.7093	0.6696	3.7181	0.2046	0.1637
G05B	Minor Small and Large Bowel Procedures, Minor Complexity	D	D		1	11	3.7				1.0756	1.6004	0.0000	1.6004	0.1970	0.1576
G06Z	Pyloromyotomy	D	D		1	11	3.4				1.1597	1.8876	0.0000	1.8876	0.2965	0.2372
G07A	Appendicectomy, Major Complexity	D	D		1	12	4.0				1.2105	1.8898	0.0000	1.8898	0.2394	0.1915
G07B	Appendicectomy, Minor Complexity	D	D		0	6	2.0				1.2178	1.2178	0.0000	1.2178	0.2786	0.2229
G10A	Hernia Procedures, Major Complexity	D	D		1	9	2.6				1.0716	1.5319	0.0000	1.5319	0.2493	0.1995
G10B	Hernia Procedures, Minor Complexity	D	D		0	3	1.1				0.8796	0.8796	0.0000	0.8796	0.2614	0.2091
G11A	Anal and Stomal Procedures, Major Complexity	D	D		1	12	3.4			Same day	0.5547	1.4193	0.0000	1.4193	0.2061	0.1649

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G11B	Anal and Stomal Procedures, Minor Complexity	D	D		0	5	1.5			Same day	0.4192	0.7609	0.0000	0.7609	0.2171	0.1737
G12A	Other Digestive System GIs, Major Complexity	D	D		5	50	17.0				1.1050	1.6378	0.8525	5.9001	0.2200	0.1760
G12B	Other Digestive System GIs, Intermediate Complexity	D	D		2	21	7.4				0.9767	1.5649	0.5881	2.7411	0.2226	0.1781
G12C	Other Digestive System GIs, Minor Complexity	D	D		0	6	1.6				0.9859	0.9859	0.0000	0.9859	0.2421	0.1937
G46A	Complex Endoscopy, Major Complexity	D	D		2	18	6.1			Same day	0.4518	1.2345	0.4790	2.1924	0.2493	0.1994
G46B	Complex Endoscopy, Minor Complexity	D	D		0	5	1.6			Same day	0.4071	0.8141	0.0000	0.8141	0.2894	0.2315
G47A	Gastroscopy, Major Complexity	D	D		2	19	6.1			Same day	0.4892	1.0955	0.4566	2.0086	0.2405	0.1924
G47B	Gastroscopy, Intermediate Complexity	D	D		0	9	2.8			Same day	0.3470	1.0923	0.0000	1.0923	0.2612	0.2089
G47C	Gastroscopy, Minor Complexity	D	D		0	5	1.7			Same day	0.2748	0.7562	0.0000	0.7562	0.2712	0.2170
G48A	Colonoscopy, Major Complexity	D	D		1	16	5.3			Same day	0.3686	1.6209	0.0000	1.6209	0.2155	0.1724
G48B	Colonoscopy, Minor Complexity	D	D		0	5	1.6			Same day	0.3409	0.7185	0.0000	0.7185	0.2684	0.2147
G60A	Digestive Malignancy, Major Complexity	D	D		1	18	5.5			Same day	0.2832	1.4839	0.0000	1.4839	0.2147	0.1718
G60B	Digestive Malignancy, Minor Complexity	D	D		0	6	2.1			Same day	0.2132	0.5320	0.0000	0.5320	0.2048	0.1639
G61A	Gastrointestinal Haemorrhage, Major Complexity	D	D		1	11	3.4				0.5093	1.0185	0.0000	1.0185	0.2409	0.1927
G61B	Gastrointestinal Haemorrhage, Minor Complexity	D	D		0	9	2.9	S	0.2382	One day	0.3391	0.3391	0.0000	0.7472	0.2076	0.1661

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G64A	Inflammatory Bowel Disease, Major Complexity	D	D		1	13	4.2			Same day	0.1815	1.2737	0.0000	1.2737	0.2442	0.1954
G64B	Inflammatory Bowel Disease, Minor Complexity	D	D		0	7	2.4			Same day	0.1237	0.7920	0.0000	0.7920	0.2640	0.2112
G65A	Gastrointestinal Obstruction, Major Complexity	D	D		1	18	5.8			One day	0.5310	0.5310	0.0000	1.5824	0.2192	0.1754
G65B	Gastrointestinal Obstruction, Minor Complexity	D	D		1	9	3.2	S	0.3807	One day	0.4319	0.4319	0.0000	0.8507	0.2114	0.1692
G66A	Abdominal Pain and Mesenteric Adenitis, Major Complexity	D	D		0	8	2.4	S	0.2933	Same day	0.3130	0.7368	0.0000	0.7368	0.2456	0.1965
G66B	Abdominal Pain and Mesenteric Adenitis, Minor Complexity	D	D		0	5	1.6	S	0.2327	Same day	0.2705	0.5228	0.0000	0.5228	0.2633	0.2106
G67A	Oesophagitis and Gastroenteritis, Major Complexity	D	D		1	12	3.7	S	0.3106	Same day	0.2394	1.0549	0.0000	1.0549	0.2263	0.1810
G67B	Oesophagitis and Gastroenteritis, Minor Complexity	D	D		0	6	1.9	S	0.1985	Same day	0.2466	0.5901	0.0000	0.5901	0.2444	0.1955
G70A	Other Digestive System Disorders, Major Complexity	D	D		1	16	4.9			Same day	0.2696	1.3946	0.0000	1.3946	0.2267	0.1814
G70B	Other Digestive System Disorders, Intermediate Complexity	D	D		0	8	2.7	S	0.3356	Same day	0.2293	0.7712	0.0000	0.7712	0.2256	0.1805
G70C	Other Digestive System Disorders, Minor Complexity	D	D		0	6	1.8	S	0.2248	Same day	0.2575	0.5684	0.0000	0.5684	0.2525	0.2020
H01A	Pancreas, Liver and Shunt Procedures, Major Complexity	D	D		7	68	22.0				2.9768	3.5267	0.9427	10.1256	0.2447	0.1957
H01B	Pancreas, Liver and Shunt Procedures, Intermediate Complexity	D	D		2	22	7.9				2.4604	3.2246	0.7642	4.7530	0.2724	0.2179
H01C	Pancreas, Liver and Shunt Procedures, Minor Complexity	D	D		1	12	4.2			One day	0.9450	0.9450	0.0000	2.7470	0.2775	0.2220
H02A	Major Biliary Tract Procedures, Major Complexity	D	D		5	53	18.3				1.8216	2.3839	0.8997	6.8824	0.2156	0.1725

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H02B	Major Biliary Tract Procedures, Intermediate Complexity	D	D		2	23	8.6				1.3636	2.0162	0.6526	3.3215	0.2123	0.1698
H02C	Major Biliary Tract Procedures, Minor Complexity	D	D		1	9	2.3				0.8109	1.2003	0.0000	1.2003	0.2369	0.1895
H05A	Hepatobiliary Diagnostic Procedures, Major Complexity	D	D		3	36	13.8				1.6658	2.3786	0.9504	5.2296	0.2165	0.1732
H05B	Hepatobiliary Diagnostic Procedures, Intermediate Complexity	D	D		1	11	3.5				1.0223	1.5371	0.0000	1.5371	0.2056	0.1645
H05C	Hepatobiliary Diagnostic Procedures, Minor Complexity	D	D		0	4	1.1				0.5036	0.5036	0.0000	0.5036	0.1797	0.1437
H06A	Other Hepatobiliary and Pancreas GIs, Major Complexity	D	D		6	61	19.6				0.9641	1.4395	0.7924	6.1942	0.2038	0.1630
H06B	Other Hepatobiliary and Pancreas GIs, Intermediate Complexity	D	D		2	25	8.9				0.9705	1.5906	0.6201	2.8309	0.1962	0.1570
H06C	Other Hepatobiliary and Pancreas GIs, Minor Complexity	D	D		0	4	1.2				1.1329	1.1329	0.0000	1.1329	0.3621	0.2897
H07A	Open Cholecystectomy, Major Complexity	D	D		4	37	16.1				1.6938	2.2672	0.8601	5.7077	0.1993	0.1594
H07B	Open Cholecystectomy, Intermediate Complexity	D	D		2	21	8.5				1.6046	2.1810	0.5765	3.3340	0.1892	0.1514
H07C	Open Cholecystectomy, Minor Complexity	D	D		1	15	5.4				1.7555	2.6522	0.0000	2.6522	0.2320	0.1856
H08A	Laparoscopic Cholecystectomy, Major Complexity	D	D		1	15	4.9				1.5402	2.3679	0.0000	2.3679	0.2355	0.1884
H08B	Laparoscopic Cholecystectomy, Minor Complexity	D	D		0	6	1.8				1.3531	1.3531	0.0000	1.3531	0.2890	0.2312
H09Z	Liver Transplant	D	D		9	85	27.8				5.9945	7.1919	2.1286	26.3497	0.3621	0.2897
H60A	Cirrhosis and Alcoholic Hepatitis, Major Complexity	D	D		3	35	11.3				0.5678	1.1355	0.7570	3.4065	0.2415	0.1932
H60B	Cirrhosis and Alcoholic Hepatitis, Intermediate Complexity	D	D		1	16	5.3			One day	0.4183	0.4183	0.0000	1.5261	0.2292	0.1834

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H60C	Cirrhosis and Alcoholic Hepatitis, Minor Complexity	D	D		1	9	2.3			Same day	0.2354	0.7521	0.0000	0.7521	0.2561	0.2049
H61A	Malignancy of Hepatobiliary System and Pancreas, Major Complexity	D	D		2	25	8.4			One day	0.5606	0.5606	0.9436	2.4477	0.2320	0.1856
H61B	Malignancy of Hepatobiliary System and Pancreas, Minor Complexity	D	D		0	8	2.6			Same day	0.3700	0.7872	0.0000	0.7872	0.2466	0.1973
H62A	Disorders of Pancreas, Except Malignancy, Major Complexity	D	D		2	19	6.4				0.4929	0.9859	0.4929	1.9717	0.2466	0.1972
H62B	Disorders of Pancreas, Except Malignancy, Minor Complexity	D	D		0	8	2.7	S	0.3741	Same day	0.3374	0.7475	0.0000	0.7475	0.2224	0.1780
H63A	Other Disorders of Liver, Major Complexity	D	D		2	21	6.6			One day	0.4910	0.4910	0.8039	2.0987	0.2536	0.2029
H63B	Other Disorders of Liver, Intermediate Complexity	D	D		1	10	3.0			Same day	0.2780	0.9946	0.0000	0.9946	0.2667	0.2133
H63C	Other Disorders of Liver, Minor Complexity	D	D		0	6	1.7			Same day	0.2667	0.6344	0.0000	0.6344	0.3010	0.2408
H64A	Disorders of the Biliary Tract, Major Complexity	D	D		2	19	7.0				0.5579	1.1158	0.5579	2.2316	0.2546	0.2036
H64B	Disorders of the Biliary Tract, Intermediate Complexity	D	D		1	10	3.4			Same day	0.4021	1.0928	0.0000	1.0928	0.2547	0.2037
H64C	Disorders of the Biliary Tract, Minor Complexity	D	D		0	7	2.3	S	0.2596	Same day	0.3985	0.7197	0.0000	0.7197	0.2523	0.2018
H65A	Bleeding Oesophageal Varices, Major Complexity	D	D		3	27	9.5				0.6767	1.3534	0.9023	4.0603	0.3402	0.2721
H65B	Bleeding Oesophageal Varices, Intermediate Complexity	D	D		1	13	4.5				1.0674	2.1348	0.0000	2.1348	0.3621	0.2897
H65C	Bleeding Oesophageal Varices, Minor Complexity	D	D		0	5	2.0				0.8003	0.8003	0.0000	0.8003	0.3277	0.2621
I01A	Bilateral and Multiple Major Joint Procedures of Lower Limb, Major Complexity	D	D		6	56	15.5				3.3013	3.6523	0.5849	7.1619	0.1908	0.1526

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
I01B	Bilateral and Multiple Major Joint Procedures of Lower Limb, Minor Complexity	D	D		1	15	5.6				3.8566	4.8433	0.0000	4.8433	0.2463	0.1970
I02A	Microvascular Tissue Transfers or Skin Grafts, Excluding Hand, Major Complexity	D	D		9	83	29.7				5.2672	5.7752	0.9031	13.9034	0.2153	0.1723
I02B	Microvascular Tissue Transfers or Skin Grafts, Excluding Hand, Intermediate Comp	D	D		4	43	15.2				2.9714	3.5565	0.8777	7.0671	0.2151	0.1721
I02C	Microvascular Tissue Transfers or Skin Grafts, Excluding Hand, Minor Complexity	D	D		3	27	9.2			One day	0.7716	0.7716	1.0856	4.0284	0.2028	0.1623
I03A	Hip Replacement for Trauma, Major Complexity	D	D		3	32	10.4				1.9317	2.4518	0.6934	4.5321	0.2102	0.1682
I03B	Hip Replacement for Trauma, Minor Complexity	D	D		2	19	6.5				1.7937	2.2869	0.4932	3.2733	0.2139	0.1712
I04A	Knee Replacement, Major Complexity	D	D		2	21	7.3				2.3868	2.9263	0.5394	4.0052	0.2080	0.1664
I04B	Knee Replacement, Minor Complexity	D	D		1	12	4.3				2.4584	3.1571	0.0000	3.1571	0.2290	0.1832
I05A	Other Joint Replacement, Major Complexity	D	D		2	21	6.4				3.0542	3.6066	0.5523	4.7113	0.2409	0.1927
I05B	Other Joint Replacement, Minor Complexity	D	D		0	7	2.5				3.3211	3.3211	0.0000	3.3211	0.3258	0.2606
I06Z	Spinal Fusion for Deformity	D	D		2	21	5.4				7.2181	8.1729	0.9548	10.0825	0.3621	0.2897
I07Z	Amputation	D	D		6	59	20.3				1.8127	2.2524	0.7329	6.6496	0.1818	0.1454
I08A	Other Hip and Femur Procedures, Major Complexity	D	D		4	39	12.6				1.8984	2.3977	0.7489	5.3931	0.2219	0.1776
I08B	Other Hip and Femur Procedures, Intermediate Complexity	D	D		2	21	7.5				1.6176	2.2137	0.5961	3.4059	0.2213	0.1771
I08C	Other Hip and Femur Procedures, Minor Complexity	D	D		1	14	4.8				1.5563	2.3262	0.0000	2.3262	0.2232	0.1786
I09A	Spinal Fusion, Major Complexity	D	D		6	55	18.3				4.1941	4.6999	0.8428	9.7570	0.2324	0.1859
I09B	Spinal Fusion, Intermediate Complexity	D	D		2	20	7.6				3.4835	4.1489	0.6654	5.4796	0.2451	0.1961
I09C	Spinal Fusion, Minor Complexity	D	D		1	11	3.8				2.7433	3.5038	0.0000	3.5038	0.2781	0.2225

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
I10A	Other Back and Neck Procedures, Major Complexity	D	D		2	21	6.8				1.7108	2.2419	0.5311	3.3041	0.2198	0.1758
I10B	Other Back and Neck Procedures, Minor Complexity	D	D		0	8	2.5				1.9540	1.9540	0.0000	1.9540	0.2531	0.2025
I11Z	Limb Lengthening Procedures	D	D		0	8	3.3				4.3177	4.3177	0.0000	4.3177	0.3205	0.2564
I12A	Misc Musculoskeletal Procs for Infect/Inflam of Bone/Joint, Major Complexity	D	D		7	65	23.7				1.1158	1.4969	0.6534	6.0705	0.1575	0.1260
I12B	Misc Musculoskeletal Procs for Infect/Inflam of Bone/Joint, Intermediate Complexity	D	D		3	29	9.5				0.8519	1.2332	0.5084	2.7586	0.1680	0.1344
I12C	Misc Musculoskeletal Procs for Infect/Inflam of Bone/Joint, Minor Complexity	D	D		2	19	5.4			One day	0.6754	0.6754	0.5787	1.8329	0.1787	0.1429
I13A	Humerus, Tibia, Fibula and Ankle Procedures, Major Complexity	D	D		2	26	9.2				2.0619	2.7521	0.6902	4.1325	0.2091	0.1673
I13B	Humerus, Tibia, Fibula and Ankle Procedures, Intermediate Complexity	D	D		1	12	3.8				1.5673	2.2316	0.0000	2.2316	0.2477	0.1981
I13C	Humerus, Tibia, Fibula and Ankle Procedures, Minor Complexity	D	D		0	6	1.9				1.4702	1.4702	0.0000	1.4702	0.2917	0.2334
I15Z	Cranio-Facial Surgery	D	D		1	13	4.0				3.6062	4.7003	0.0000	4.7003	0.3621	0.2897
I16Z	Other Shoulder Procedures	D	D		0	3	1.1				1.3577	1.3577	0.0000	1.3577	0.3621	0.2897
I17A	Maxillo-Facial Surgery, Major Complexity	D	D		1	10	3.0				1.9276	2.6256	0.0000	2.6256	0.3243	0.2594
I17B	Maxillo-Facial Surgery, Minor Complexity	D	D		0	4	1.3				1.3062	1.3062	0.0000	1.3062	0.3349	0.2679
I18A	Other Knee Procedures, Major Complexity	D	D		1	9	2.7			Same day	0.6087	1.4714	0.0000	1.4714	0.2450	0.1960
I18B	Other Knee Procedures, Minor Complexity	D	D		0	4	1.2			Same day	0.5718	1.0089	0.0000	1.0089	0.3052	0.2442
I19A	Other Elbow and Forearm Procedures, Major Complexity	D	D		1	17	5.0				1.8429	2.7028	0.0000	2.7028	0.2400	0.1920
I19B	Other Elbow and Forearm Procedures, Minor Complexity	D	D		0	5	1.5				1.3686	1.3686	0.0000	1.3686	0.2941	0.2353

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
I20A	Other Foot Procedures, Major Complexity	D	D		1	12	3.5				1.5252	2.1099	0.0000	2.1099	0.2370	0.1896
I20B	Other Foot Procedures, Minor Complexity	D	D		0	4	1.3				1.1283	1.1283	0.0000	1.1283	0.2960	0.2368
I21A	Local Excision and Removal of Internal Fixation Devices of Hip and Femur, Major Complexity	D	D		0	6	1.4				1.0982	1.0982	0.0000	1.0982	0.2757	0.2206
I21B	Local Excision and Removal of Internal Fixation Devices of Hip and Femur, Minor Complexity	D	D		0	3	1.1				0.7722	0.7722	0.0000	0.7722	0.2274	0.1820
I23A	Local Excision and Removal of Internal Fixation Device, Except Hip and Femur, Major Complexity	D	D		0	6	1.6			Same day	0.5606	1.4252	0.0000	1.4252	0.3135	0.2508
I23B	Local Excision and Removal of Internal Fixation Device, Except Hip and Femur, Minor Complexity	D	D		0	3	1.1			Same day	0.4600	0.9113	0.0000	0.9113	0.2893	0.2314
I24A	Arthroscopy, Major Complexity	D	D		0	5	1.7				1.0961	1.0961	0.0000	1.0961	0.2540	0.2032
I24B	Arthroscopy, Minor Complexity	D	D		0	3	1.0				0.6374	0.6374	0.0000	0.6374	0.1984	0.1587
I25A	Bone and Joint Diagnostic Procedures Including Biopsy, Major Complexity	D	D		2	27	10.0				0.9869	1.7232	0.7363	3.1958	0.2058	0.1646
I25B	Bone and Joint Diagnostic Procedures Including Biopsy, Minor Complexity	D	D		0	5	1.3				0.6051	0.6051	0.0000	0.6051	0.2378	0.1903
I27A	Soft Tissue Procedures, Major Complexity	D	D		2	23	7.6				1.2834	1.8776	0.5942	3.0659	0.2192	0.1754
I27B	Soft Tissue Procedures, Minor Complexity	D	D		0	6	1.7			Same day	0.5326	1.1197	0.0000	1.1197	0.2654	0.2123
I28A	Other Musculoskeletal Procedures, Major Complexity	D	D		3	33	11.0				1.1949	1.7509	0.7414	3.9750	0.2118	0.1694
I28B	Other Musculoskeletal Procedures, Intermediate Complexity	D	D		0	7	2.0				1.4563	1.4563	0.0000	1.4563	0.2732	0.2185
I28C	Other Musculoskeletal Procedures, Minor Complexity	D	D		0	4	1.3				0.7372	0.7372	0.0000	0.7372	0.2124	0.1699
I29Z	Knee Reconstructions, and Revisions of Reconstructions	D	D		0	3	1.1				1.4731	1.4731	0.0000	1.4731	0.3621	0.2897

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
I30Z	Hand Procedures	D	D		0	5	1.5			Same day	0.5287	0.9933	0.0000	0.9933	0.2564	0.2051
I31A	Revision of Hip Replacement, Major Complexity	D	D		6	59	20.7				3.2014	3.6451	0.7395	8.0821	0.1803	0.1442
I31B	Revision of Hip Replacement, Intermediate Complexity	D	D		2	25	8.3				2.9883	3.6647	0.6765	5.0177	0.2293	0.1835
I31C	Revision of Hip Replacement, Minor Complexity	D	D		1	17	4.7				2.7749	3.5802	0.0000	3.5802	0.2376	0.1901
I32A	Revision of Knee Replacement, Major Complexity	D	D		5	53	17.8				3.0266	3.4835	0.7311	7.1389	0.1794	0.1435
I32B	Revision of Knee Replacement, Minor Complexity	D	D		2	22	6.2				3.1917	3.6579	0.4662	4.5903	0.2117	0.1694
I33A	Hip Replacement for Non-Trauma, Major Complexity	D	D		2	21	6.9				2.5630	3.1380	0.5750	4.2879	0.2322	0.1857
I33B	Hip Replacement for Non-Trauma, Minor Complexity	D	D		1	11	4.0				2.5124	3.2041	0.0000	3.2041	0.2409	0.1927
I60Z	Femoral Shaft Fractures	D	D		1	9	3.0				0.6369	1.2737	0.0000	1.2737	0.3397	0.2717
I61A	Distal Femoral Fractures, Major Complexity	D	D		3	33	10.3				0.3629	0.7257	0.4838	2.1772	0.1693	0.1355
I61B	Distal Femoral Fractures, Minor Complexity	D	D		0	8	2.1				0.5926	0.5926	0.0000	0.5926	0.2241	0.1793
I63A	Sprains, Strains and Dislocations of Hip, Pelvis and Thigh, Major Complexity	D	D		1	13	4.5	S	0.3977		0.6052	1.2105	0.0000	1.2105	0.2139	0.1711
I63B	Sprains, Strains and Dislocations of Hip, Pelvis and Thigh, Minor Complexity	D	D		0	6	1.7	S	0.3062		0.5789	0.5789	0.0000	0.5789	0.2688	0.2150
I64A	Osteomyelitis, Major Complexity	D	D		4	44	16.7				0.4194	0.8387	0.6290	3.3549	0.1607	0.1286
I64B	Osteomyelitis, Minor Complexity	D	D		3	29	9.0	S	0.2927	Same day	0.1717	0.5615	0.3743	1.6845	0.1502	0.1202
I65A	Musculoskeletal Malignant Neoplasms, Major Complexity	D	D		2	22	7.3				0.6352	1.2703	0.6352	2.5406	0.2788	0.2230
I65B	Musculoskeletal Malignant Neoplasms, Minor Complexity	D	D		1	12	3.6			Same day	0.4059	1.2818	0.0000	1.2818	0.2881	0.2305

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
I66A	Inflammatory Musculoskeletal Disorders, Major Complexity	D	D		2	20	7.1			Same day	0.1817	1.0856	0.5428	2.1712	0.2442	0.1953
I66B	Inflammatory Musculoskeletal Disorders, Minor Complexity	D	D		0	9	2.9			Same day	0.1562	0.9517	0.0000	0.9517	0.2623	0.2099
I67A	Septic Arthritis, Major Complexity	D	D		4	40	15.3				0.3458	0.6917	0.5188	2.7668	0.1447	0.1158
I67B	Septic Arthritis, Minor Complexity	D	D		2	23	7.0	S	0.2946		0.3241	0.6481	0.3241	1.2962	0.1481	0.1185
I68A	Non-surgical Spinal Disorders, Major Complexity	D	D		1	17	5.5	S	0.4308	Same day	0.2954	1.4474	0.0000	1.4474	0.2119	0.1695
I68B	Non-surgical Spinal Disorders, Minor Complexity	D	D		0	8	2.7	S	0.2829	Same day	0.2550	0.7938	0.0000	0.7938	0.2350	0.1880
I69A	Bone Diseases and Arthropathies, Major Complexity	D	D		1	15	4.6			Same day	0.2057	1.2476	0.0000	1.2476	0.2190	0.1752
I69B	Bone Diseases and Arthropathies, Minor Complexity	D	D		0	9	2.9	S	0.2531	Same day	0.0963	0.7318	0.0000	0.7318	0.2026	0.1621
I71A	Other Musculotendinous Disorders, Major Complexity	D	D		1	15	4.9	S	0.2903	Same day	0.2136	1.2634	0.0000	1.2634	0.2075	0.1660
I71B	Other Musculotendinous Disorders, Minor Complexity	D	D		0	7	2.3	S	0.2387	Same day	0.2169	0.6624	0.0000	0.6624	0.2267	0.1814
I72A	Specific Musculotendinous Disorders, Major Complexity	D	D		2	18	6.2	S	0.3084		0.3647	0.7293	0.3647	1.4587	0.1876	0.1501
I72B	Specific Musculotendinous Disorders, Minor Complexity	D	D		0	9	2.8	S	0.2486	Same day	0.2124	0.6982	0.0000	0.6982	0.2012	0.1609
I73A	Aftercare of Musculoskeletal Implants or Prostheses, Major Complexity	D	D		4	38	14.6				0.3205	0.6410	0.4808	2.5640	0.1401	0.1121
I73B	Aftercare of Musculoskeletal Implants or Prostheses, Intermediate Complexity	D	D		1	17	3.2	S	0.2823	Same day	0.3359	0.7728	0.0000	0.7728	0.1905	0.1524
I73C	Aftercare of Musculoskeletal Implants or Prostheses, Minor Complexity	D	D		0	4	1.2			Same day	0.3737	0.5858	0.0000	0.5858	0.3621	0.2897
I74A	Injuries to Forearm, Wrist, Hand and Foot, Major Complexity	D	D		1	13	4.1	S	0.3582	Same day	0.3330	1.1736	0.0000	1.1736	0.2294	0.1835

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
I74B	Injuries to Forearm, Wrist, Hand and Foot, Minor Complexity	D	D		0	4	1.3	S	0.2665	Same day	0.3302	0.5800	0.0000	0.5800	0.3577	0.2862
I75A	Injuries to Shoulder, Arm, Elbow, Knee, Leg and Ankle, Major Complexity	D	D		2	21	7.3			Same day	0.2366	0.9255	0.4627	1.8510	0.2040	0.1632
I75B	Injuries to Shoulder, Arm, Elbow, Knee, Leg and Ankle, Intermediate Complexity	D	D		0	8	2.5	S	0.3144	Same day	0.3295	0.7764	0.0000	0.7764	0.2485	0.1988
I75C	Injuries to Shoulder, Arm, Elbow, Knee, Leg and Ankle, Minor Complexity	D	D		0	6	1.9	S	0.2378	Same day	0.2755	0.6430	0.0000	0.6430	0.2736	0.2189
I76A	Other Musculoskeletal Disorders, Major Complexity	D	D		1	17	5.3			Same day	0.3802	1.4868	0.0000	1.4868	0.2242	0.1793
I76B	Other Musculoskeletal Disorders, Minor Complexity	D	D		0	6	2.0	S	0.3014	Same day	0.3237	0.6996	0.0000	0.6996	0.2861	0.2289
I77A	Fractures of Pelvis, Major Complexity	D	D		2	19	6.5				0.4196	0.8392	0.4196	1.6784	0.2058	0.1646
I77B	Fractures of Pelvis, Minor Complexity	D	D		1	11	3.3	S	0.366		0.4528	0.9056	0.0000	0.9056	0.2164	0.1731
I78A	Fractures of Neck of Femur, Major Complexity	D	D		2	22	7.4				0.4447	0.8894	0.4447	1.7787	0.1924	0.1540
I78B	Fractures of Neck of Femur, Minor Complexity	D	D		1	12	3.6	S	0.3793		0.4340	0.8681	0.0000	0.8681	0.1945	0.1556
I79A	Pathological Fractures, Major Complexity	D	D		2	26	10.6				0.6545	1.3090	0.6545	2.6181	0.1984	0.1587
I79B	Pathological Fractures, Intermediate Complexity	D	D		2	18	6.5				0.4144	0.8287	0.4144	1.6574	0.2032	0.1626
I79C	Pathological Fractures, Minor Complexity	D	D		1	11	3.4	S	0.3656		0.4610	0.9219	0.0000	0.9219	0.2145	0.1716
I80Z	Femoral Fractures, Transferred to Acute Facility < 2 Days	D	D		0	3	1.0	S	0.3659		0.4593	0.4593	0.0000	0.4593	0.3621	0.2897
J01A	Microvas Tiss Transf for Skin, Subcut Tiss and Breast Disorders, Major Complexity	D	D		7	65	17.8				3.5521	3.8771	0.5570	7.7763	0.1793	0.1434
J01B	Microvas Tiss Transf for Skin, Subcut Tiss and Breast Disorders, Minor Complexity	D	D		2	23	8.2				3.7761	4.5818	0.8058	6.1934	0.2763	0.2210
J06A	Major Procedures for Breast Disorders, Major Complexity	D	D		2	25	7.8				1.4436	1.9501	0.5065	2.9630	0.1813	0.1450

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J06B	Major Procedures for Breast Disorders, Minor Complexity	D	D		1	13	4.0				1.3651	1.9583	0.0000	1.9583	0.2089	0.1671
J07Z	Minor Procedures for Breast Disorders	D	D		0	3	1.0				0.8543	0.8543	0.0000	0.8543	0.2995	0.2396
J08A	Other Skin Grafts and Debridement Procedures, Major Complexity	D	D		5	50	17.5			Same day	0.7221	1.6059	0.6522	4.8668	0.1632	0.1305
J08B	Other Skin Grafts and Debridement Procedures, Intermediate Complexity	D	D		1	12	3.3			Same day	0.5223	1.2126	0.0000	1.2126	0.1797	0.1437
J08C	Other Skin Grafts and Debridement Procedures, Minor Complexity	D	D		0	7	2.0			Same day	0.5090	1.0265	0.0000	1.0265	0.2136	0.1709
J09Z	Perianal and Pilonidal Procedures	D	D		0	7	1.3				0.6825	0.6825	0.0000	0.6825	0.1949	0.1559
J10A	Plastic GIs for Skin, Subcutaneous Tissue and Breast Disorders, Major Complexity	D	D		1	13	3.5			Same day	0.5551	1.5200	0.0000	1.5200	0.1855	0.1484
J10B	Plastic GIs for Skin, Subcutaneous Tissue and Breast Disorders, Minor Complexity	D	D		0	4	1.3			Same day	0.4832	1.0353	0.0000	1.0353	0.2751	0.2201
J11A	Other Skin, Subcutaneous Tissue and Breast Procedures, Major Complexity	D	D		1	12	2.9			Same day	0.5150	1.1475	0.0000	1.1475	0.1883	0.1507
J11B	Other Skin, Subcutaneous Tissue and Breast Procedures, Minor Complexity	D	D		0	5	1.3			Same day	0.3992	0.8452	0.0000	0.8452	0.2420	0.1936
J12A	Lower Limb Procedures W Ulcer or Cellulitis, Major Complexity	D	D		4	43	15.1				0.8518	1.3025	0.6761	4.0068	0.1674	0.1339
J12B	Lower Limb Procedures W Ulcer or Cellulitis, Minor Complexity	D	D		2	19	6.6				0.5608	0.9242	0.3634	1.6509	0.1538	0.1231
J13A	Lower Limb Procedures W/O Ulcer or Cellulitis, Major Complexity	D	D		2	19	7.2				0.9031	1.3085	0.4054	2.1192	0.1572	0.1258
J13B	Lower Limb Procedures W/O Ulcer or Cellulitis, Minor Complexity	D	D		1	15	5.1			One day	0.6008	0.6008	0.0000	1.5071	0.1507	0.1206
J14Z	Major Breast Reconstructions	D	D		2	26	9.4				2.8935	3.5993	0.7059	5.0111	0.2101	0.1681
J60A	Skin Ulcers, Major Complexity	D	D		3	30	9.3				0.3484	0.6968	0.4645	2.0904	0.1807	0.1446
J60B	Skin Ulcers, Intermediate Complexity	D	D		1	14	4.2	S	0.3		0.4358	0.8717	0.0000	0.8717	0.1672	0.1337

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
J60C	Skin Ulcers, Minor Complexity	D	D		1	14	3.9	S	0.2044	Same day	0.1047	0.7565	0.0000	0.7565	0.1548	0.1238
J62A	Malignant Breast Disorders, Major Complexity	D	D		2	18	6.9				0.4832	0.9665	0.4832	1.9330	0.2242	0.1794
J62B	Malignant Breast Disorders, Minor Complexity	D	D		0	8	2.4				0.5187	0.5187	0.0000	0.5187	0.1704	0.1364
J63A	Non-Malignant Breast Disorders, Major Complexity	D	D		0	8	2.3	S	0.2508		0.6208	0.6208	0.0000	0.6208	0.2174	0.1739
J63B	Non-Malignant Breast Disorders, Minor Complexity	D	D		0	6	1.7	S	0.1764		0.5016	0.5016	0.0000	0.5016	0.2351	0.1881
J64A	Cellulitis, Major Complexity	D	D		1	15	4.5				0.5707	1.1414	0.0000	1.1414	0.2028	0.1622
J64B	Cellulitis, Minor Complexity	D	D		1	11	3.7	S	0.27	One day	0.4122	0.4122	0.0000	0.7589	0.1624	0.1299
J65A	Trauma to Skin, Subcutaneous Tissue and Breast, Major Complexity	D	D		1	13	4.1	S	0.3836	Same day	0.3831	1.1828	0.0000	1.1828	0.2296	0.1837
J65B	Trauma to Skin, Subcutaneous Tissue and Breast, Minor Complexity	D	D		0	5	1.5	S	0.2827	Same day	0.3767	0.6393	0.0000	0.6393	0.3301	0.2641
J67A	Minor Skin Disorders, Major Complexity	D	D		1	12	3.5	S	0.254	Same day	0.2793	0.9469	0.0000	0.9469	0.2188	0.1751
J67B	Minor Skin Disorders, Minor Complexity	D	D		0	7	1.9	S	0.1844	Same day	0.3042	0.6117	0.0000	0.6117	0.2573	0.2058
J68A	Major Skin Disorders, Major Complexity	D	D		1	15	4.6	S	0.2679	Same day	0.2762	1.2788	0.0000	1.2788	0.2204	0.1763
J68B	Major Skin Disorders, Minor Complexity	D	D		0	9	2.8	S	0.184	Same day	0.1362	0.7983	0.0000	0.7983	0.2243	0.1794
J69A	Skin Malignancy, Major Complexity	D	D		1	18	5.3				0.7844	1.5689	0.0000	1.5689	0.2356	0.1885
J69B	Skin Malignancy, Minor Complexity	D	D		1	10	3.2			Same day	0.2779	0.8861	0.0000	0.8861	0.2207	0.1765
K01A	GIs for Diabetic Complications, Major Complexity	D	D		10	92	31.2				1.3430	1.7338	0.7034	8.7682	0.1753	0.1403

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K01B	GIs for Diabetic Complications, Intermediate Complexity	D	D		5	46	15.9				0.7816	1.1367	0.5682	3.9776	0.1566	0.1252
K01C	GIs for Diabetic Complications, Minor Complexity	D	D		3	28	8.5			Same day	0.0494	0.9693	0.4548	2.3336	0.1679	0.1343
K02Z	Pituitary Procedures	D	D		2	20	6.6				1.7578	2.3087	0.5509	3.4104	0.2335	0.1868
K03Z	Adrenal Procedures	D	D		1	10	2.7				1.5410	2.1138	0.0000	2.1138	0.3003	0.2402
K05A	Parathyroid Procedures, Major Complexity	D	D		1	13	4.1				1.6583	2.4834	0.0000	2.4834	0.2822	0.2258
K05B	Parathyroid Procedures, Minor Complexity	D	D		0	4	1.3				1.2513	1.2513	0.0000	1.2513	0.3441	0.2753
K06A	Thyroid Procedures, Major Complexity	D	D		1	9	2.8				1.7686	2.4569	0.0000	2.4569	0.3483	0.2786
K06B	Thyroid Procedures, Minor Complexity	D	D		0	4	1.4				1.4817	1.4817	0.0000	1.4817	0.3621	0.2897
K08Z	Thyroglossal Procedures	D	D		0	4	1.3				1.1852	1.1852	0.0000	1.1852	0.3421	0.2736
K09A	Other Endocrine, Nutritional and Metabolic GIs, Major Complexity	D	D		5	50	16.7				1.0049	1.4884	0.7736	5.3566	0.2029	0.1623
K09B	Other Endocrine, Nutritional and Metabolic GIs, Minor Complexity	D	D		1	13	3.4				1.0112	1.6539	0.0000	1.6539	0.2623	0.2098
K10Z	Revisional and Open Bariatric Procedures	D	D		1	16	4.4				2.1651	3.0141	0.0000	3.0141	0.2731	0.2185
K11Z	Major Laparoscopic Bariatric Procedures	D	D		0	8	2.8				2.4454	2.4454	0.0000	2.4454	0.2813	0.2251
K12Z	Other Bariatric Procedures	D	D		0	3	1.1				1.6805	1.6805	0.0000	1.6805	0.2935	0.2348
K13Z	Plastic GIs for Endocrine, Nutritional and Metabolic Disorders	D	D		1	13	4.4				1.3944	2.0169	0.0000	2.0169	0.1979	0.1583
K40A	Endoscopic and Investigative Procedures for Metabolic Disorders, Major Complexity	D	D		2	24	8.1			Same day	0.4399	1.6112	0.6960	3.0033	0.2765	0.2212
K40B	Endoscopic and Investigative Procedures for Metabolic Disorders, Minor Complexity	D	D		0	3	1.0				0.3972	0.3972	0.0000	0.3972	0.1724	0.1379
K60A	Diabetes, Major Complexity	D	D		1	16	4.7			Same day	0.3690	1.7388	0.0000	1.7388	0.2966	0.2373
K60B	Diabetes, Minor Complexity	D	D		1	9	2.7	S	0.2686	Same day	0.1979	0.9440	0.0000	0.9440	0.2765	0.2212

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K61A	Severe Nutritional Disturbance, Major Complexity	D	D		3	27	9.7				0.4333	0.8665	0.5777	2.5995	0.2154	0.1723
K61B	Severe Nutritional Disturbance, Minor Complexity	D	D		1	11	3.6				0.5014	1.0028	0.0000	1.0028	0.2260	0.1808
K62A	Miscellaneous Metabolic Disorders, Major Complexity	D	D		1	16	5.0				0.7885	1.5770	0.0000	1.5770	0.2543	0.2034
K62B	Miscellaneous Metabolic Disorders, Intermediate Complexity	D	D		0	8	2.6	S	0.2849	Same day	0.1950	0.8125	0.0000	0.8125	0.2523	0.2019
K62C	Miscellaneous Metabolic Disorders, Minor Complexity	D	D		0	7	2.1	S	0.2129	Same day	0.0687	0.6281	0.0000	0.6281	0.2397	0.1917
K63A	Inborn Errors of Metabolism, Major Complexity	D	D		1	11	2.7				0.5310	1.0619	0.0000	1.0619	0.3148	0.2518
K63B	Inborn Errors of Metabolism, Minor Complexity	D	D		0	3	1.0				0.2674	0.2674	0.0000	0.2674	0.2087	0.1670
K64A	Endocrine Disorders, Major Complexity	D	D		1	17	5.1			Same day	0.3467	1.7971	0.0000	1.7971	0.2827	0.2261
K64B	Endocrine Disorders, Minor Complexity	D	D		0	7	2.4	S	0.2461	Same day	0.1262	0.7699	0.0000	0.7699	0.2599	0.2080
L02A	Operative Insertion of Peritoneal Catheter for Dialysis, Major Complexity	D	D		3	29	10.2				0.9936	1.5393	0.7275	3.7218	0.2248	0.1799
L02B	Operative Insertion of Peritoneal Catheter for Dialysis, Minor Complexity	D	D		0	4	1.3				0.9174	0.9174	0.0000	0.9174	0.2888	0.2310
L03A	Kidney, Ureter and Major Bladder Procedures for Neoplasm, Major Complexity	D	D		4	40	13.4				2.5186	3.1626	0.9660	7.0267	0.2699	0.2159
L03B	Kidney, Ureter and Major Bladder Procedures for Neoplasm, Intermediate Comp	D	D		1	14	5.2				2.4392	3.5084	0.0000	3.5084	0.2855	0.2284
L03C	Kidney, Ureter and Major Bladder Procedures for Neoplasm, Minor Complexity	D	D		0	8	2.7				2.1552	2.1552	0.0000	2.1552	0.2896	0.2316

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L04A	Kidney, Ureter and Major Bladder Procedures for Non-Neoplasm, Major Complexity	D	D		3	34	11.9				1.4609	2.1522	0.9217	4.9171	0.2437	0.1950
L04B	Kidney, Ureter and Major Bladder Procedures for Non-Neoplasm, Intermediate Complexity	D	D		1	11	3.2			Same day	0.7758	1.7911	0.0000	1.7911	0.2510	0.2008
L04C	Kidney, Ureter and Major Bladder Procedures for Non-Neoplasm, Minor Complexity	D	D		0	5	1.5			Same day	0.6321	1.1862	0.0000	1.1862	0.3078	0.2462
L05A	Transurethral Prostatectomy for Urinary Disorder, Major Complexity	D	D		2	24	5.6				0.8773	1.2653	0.3880	2.0412	0.1946	0.1557
L05B	Transurethral Prostatectomy for Urinary Disorder, Minor Complexity	D	D		0	6	2.0				1.1165	1.1165	0.0000	1.1165	0.2377	0.1901
L06A	Minor Bladder Procedures, Major Complexity	D	D		4	39	12.8				1.3202	1.7771	0.6853	4.5181	0.1994	0.1595
L06B	Minor Bladder Procedures, Intermediate Complexity	D	D		1	11	3.2				0.9515	1.4436	0.0000	1.4436	0.2126	0.1700
L06C	Minor Bladder Procedures, Minor Complexity	D	D		0	5	1.5				0.8309	0.8309	0.0000	0.8309	0.2273	0.1818
L07A	Other Transurethral Procedures, Major Complexity	D	D		1	11	3.0				0.9942	1.5066	0.0000	1.5066	0.2386	0.1909
L07B	Other Transurethral Procedures, Minor Complexity	D	D		0	4	1.2				0.6902	0.6902	0.0000	0.6902	0.2222	0.1778
L08A	Urethral Procedures, Major Complexity	D	D		0	8	1.9				1.5085	1.5085	0.0000	1.5085	0.2929	0.2344
L08B	Urethral Procedures, Minor Complexity	D	D		0	4	1.3				0.8188	0.8188	0.0000	0.8188	0.2345	0.1876
L09A	Other Procedures for Kidney and Urinary Tract Disorders, Major Complexity	D	D		4	41	14.3				1.1194	1.6886	0.8538	5.1037	0.2222	0.1777
L09B	Other Procedures for Kidney and Urinary Tract Disorders, Intermediate Complexity	D	D		1	11	3.2				1.1114	1.6843	0.0000	1.6843	0.2504	0.2003
L09C	Other Procedures for Kidney and Urinary Tract Disorders, Minor Complexity	D	D		0	3	1.1				0.8735	0.8735	0.0000	0.8735	0.2469	0.1976

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L10A	Kidney Transplant, Age ≤ 16 Years or Major Complexity	D	D		4	42	12.9				2.9329	4.0422	1.6640	10.6981	0.3621	0.2897
L10B	Kidney Transplant, Age ≥ 17 Years and Minor Complexity	D	D		2	26	8.8				2.7778	4.2488	1.4710	7.1908	0.3621	0.2897
L40Z	Ureteroscopy	D	D		0	3	1.1				0.6322	0.6322	0.0000	0.6322	0.2214	0.1771
L41Z	Cystourethroscopy for Urinary Disorder, Same-day	D	D		0	3	1.0				0.2120	0.2120	0.0000	0.2120	0.0931	0.0745
L42Z	ESW Lithotripsy	D	D		0	4	1.5			Same day	0.0000	0.6056	0.0000	0.6056	0.3272	0.2618
L60A	Kidney Failure, Major Complexity	D	D		3	29	10.1				0.5583	1.1166	0.7444	3.3498	0.2658	0.2126
L60B	Kidney Failure, Intermediate Complexity	D	D		1	14	4.7			One day	0.3843	0.3843	0.0000	1.4083	0.2380	0.1904
L60C	Kidney Failure, Minor Complexity	D	D		0	7	2.3	S	0.2964	Same day	0.4641	0.6894	0.0000	0.6894	0.2368	0.1895
L61Z	Haemodialysis	D	D		0	3	1.0				0.1055	0.1055	0.0000	0.1055	0.1055	0.0844
L62A	Kidney and Urinary Tract Neoplasms, Major Complexity	D	D		2	25	7.9				0.5682	1.1363	0.5682	2.2727	0.2309	0.1847
L62B	Kidney and Urinary Tract Neoplasms, Intermediate Complexity	D	D		1	10	3.3				0.5016	1.0031	0.0000	1.0031	0.2399	0.1920
L62C	Kidney and Urinary Tract Neoplasms, Minor Complexity	D	D		0	7	1.8			Same day	0.2807	0.7175	0.0000	0.7175	0.3170	0.2536
L63A	Kidney and Urinary Tract Infections, Major Complexity	D	D		1	14	4.3	S	0.3616		0.5674	1.1349	0.0000	1.1349	0.2100	0.1680
L63B	Kidney and Urinary Tract Infections, Minor Complexity	D	D		0	8	2.4	S	0.2551	Same day	0.2125	0.6971	0.0000	0.6971	0.2277	0.1822
L64A	Urinary Stones and Obstruction, Major Complexity	D	D		0	7	2.2	S	0.3497		0.8585	0.8585	0.0000	0.8585	0.3101	0.2480
L64B	Urinary Stones and Obstruction, Minor Complexity	D	D		0	4	1.5	S	0.272	Same day	0.2593	0.6056	0.0000	0.6056	0.3272	0.2618

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L65A	Kidney and Urinary Tract Signs and Symptoms, Major Complexity	D	D		1	15	4.5				0.6057	1.2114	0.0000	1.2114	0.2166	0.1733
L65B	Kidney and Urinary Tract Signs and Symptoms, Minor Complexity	D	D		0	7	2.2	S	0.2317	Same day	0.2185	0.6269	0.0000	0.6269	0.2247	0.1798
L66Z	Urethral Stricture	D	D		0	4	1.2				0.5352	0.5352	0.0000	0.5352	0.3571	0.2857
L67A	Other Kidney and Urinary Tract Disorders, Major Complexity	D	D		1	15	4.3			Same day	0.2869	1.2749	0.0000	1.2749	0.2361	0.1889
L67B	Other Kidney and Urinary Tract Disorders, Intermediate Complexity	D	D		0	7	2.0	S	0.2088	Same day	0.1956	0.6677	0.0000	0.6677	0.2627	0.2102
L67C	Other Kidney and Urinary Tract Disorders, Minor Complexity	D	D		0	3	1.0				0.1338	0.1338	0.0000	0.1338	0.1057	0.0846
L68Z	Peritoneal Dialysis	I	I		0	3	1.0				0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
M01A	Major Male Pelvic Procedures, Major Complexity	D	D		1	15	4.9				2.6507	3.7613	0.0000	3.7613	0.3171	0.2537
M01B	Major Male Pelvic Procedures, Minor Complexity	D	D		0	7	2.4				2.9260	2.9260	0.0000	2.9260	0.3621	0.2897
M02A	Transurethral Prostatectomy for Reproductive System Disorder, Major Complexity	D	D		1	16	4.5				1.1627	1.8579	0.0000	1.8579	0.2159	0.1727
M02B	Transurethral Prostatectomy for Reproductive System Disorder, Minor Complexity	D	D		0	6	2.1				1.1035	1.1035	0.0000	1.1035	0.2301	0.1841
M03A	Penis Procedures, Major Complexity	D	D		0	8	1.6				1.2204	1.2204	0.0000	1.2204	0.2815	0.2252
M03B	Penis Procedures, Minor Complexity	D	D		0	3	1.0				0.6705	0.6705	0.0000	0.6705	0.1951	0.1561
M04Z	Testes Procedures	D	D		0	3	1.0				0.6431	0.6431	0.0000	0.6431	0.2018	0.1614
M05Z	Circumcision	D	D		0	3	1.0				0.5085	0.5085	0.0000	0.5085	0.1428	0.1142
M06A	Other Male Reproductive System GIs, Major Complexity	D	D		2	18	5.5			Same day	1.1394	2.7800	0.6257	4.0314	0.3621	0.2897
M06B	Other Male Reproductive System GIs, Minor Complexity	D	D		0	4	1.3			Same day	1.1394	4.0314	0.0000	4.0314	0.3621	0.2897

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M40Z	Cystourethroscopy for Male Reproductive System Disorder, Same-day	D	D		0	3	1.0				0.2419	0.2419	0.0000	0.2419	0.0931	0.0745
M60A	Male Reproductive System Malignancy, Major Complexity	D	D		1	13	4.3				0.6500	1.3001	0.0000	1.3001	0.2428	0.1943
M60B	Male Reproductive System Malignancy, Minor Complexity	D	D		0	3	1.0				0.4128	0.4128	0.0000	0.4128	0.3229	0.2583
M61A	Benign Prostatic Hypertrophy, Major Complexity	D	D		1	14	3.4				0.5108	1.0217	0.0000	1.0217	0.2422	0.1937
M61B	Benign Prostatic Hypertrophy, Minor Complexity	D	D		0	3	1.1	S	0.2268		0.3892	0.3892	0.0000	0.3892	0.2831	0.2265
M62A	Male Reproductive System Inflammation, Major Complexity	D	D		1	16	4.1				0.5720	1.1440	0.0000	1.1440	0.2236	0.1789
M62B	Male Reproductive System Inflammation, Minor Complexity	D	D		0	7	2.2	S	0.2392	Same day	0.2835	0.6274	0.0000	0.6274	0.2285	0.1828
M63Z	Male Sterilisation Procedures	D	D		0	3	1.0				0.3697	0.3697	0.0000	0.3697	0.2957	0.2366
M64A	Other Male Reproductive System Disorders, Major Complexity	D	D		0	6	1.5				0.5820	0.5820	0.0000	0.5820	0.3115	0.2492
M64B	Other Male Reproductive System Disorders, Minor Complexity	D	D		0	3	1.0	S	0.2086		0.3936	0.3936	0.0000	0.3936	0.3027	0.2421
N01Z	Pelvic Evisceration and Radical Vulvectomy	D	D		1	18	5.0				1.8107	2.7980	0.0000	2.7980	0.2745	0.2196
N04A	Hysterectomy for Non-Malignancy, Major Complexity	D	D		1	11	3.7				1.6756	2.4855	0.0000	2.4855	0.3025	0.2420
N04B	Hysterectomy for Non-Malignancy, Minor Complexity	D	D		0	7	2.6				1.8886	1.8886	0.0000	1.8886	0.3183	0.2547
N05A	Oophorectomy and Complex Fallopian Tube Procedures for Non-Malignancy, Major Complexity	D	D		0	9	2.5				1.9304	1.9304	0.0000	1.9304	0.3397	0.2718
N05B	Oophorectomy and Complex Fallopian Tube Procedures for Non-Malignancy, Minor Complexity	D	D		0	4	1.4				1.2587	1.2587	0.0000	1.2587	0.3583	0.2866

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
N06A	Female Reproductive System Reconstructive Procedures, Major Complexity	D	D		1	9	3.2				1.3967	2.0585	0.0000	2.0585	0.2914	0.2331
N06B	Female Reproductive System Reconstructive Procedures, Minor Complexity	D	D		0	5	1.9				1.3050	1.3050	0.0000	1.3050	0.2884	0.2307
N07A	Other Uterus and Adnexa Procedures for Non-Malignancy, Major Complexity	D	D		0	5	1.6			Same day	0.7875	1.4404	0.0000	1.4404	0.3621	0.2897
N07B	Other Uterus and Adnexa Procedures for Non-Malignancy, Minor Complexity	D	D		0	3	1.0				0.4864	0.4864	0.0000	0.4864	0.1497	0.1198
N08Z	Endoscopic and Laparoscopic Procedures, Female Reproductive System	D	D		0	5	1.6			Same day	0.6691	1.1699	0.0000	1.1699	0.3027	0.2422
N09A	Other Vagina, Cervix and Vulva Procedures, Major Complexity	D	D		0	5	1.4				0.8489	0.8489	0.0000	0.8489	0.2505	0.2004
N09B	Other Vagina, Cervix and Vulva Procedures, Minor Complexity	D	D		0	3	1.0				0.4629	0.4629	0.0000	0.4629	0.1523	0.1218
N10Z	Diagnostic Curettage and Diagnostic Hysteroscopy	D	D		0	3	1.0				0.4035	0.4035	0.0000	0.4035	0.1210	0.0968
N11A	Other Female Reproductive System GIs, Major Complexity	D	D		1	13	3.1				1.2002	1.8430	0.0000	1.8430	0.2863	0.2291
N11B	Other Female Reproductive System GIs, Minor Complexity	D	D		0	3	1.0				0.4840	0.4840	0.0000	0.4840	0.3247	0.2597
N12A	Uterus and Adnexa Procedures for Malignancy, Major Complexity	D	D		2	22	7.5				1.7308	2.4477	0.7169	3.8814	0.2678	0.2143
N12B	Uterus and Adnexa Procedures for Malignancy, Intermediate Complexity	D	D		1	11	3.9				1.6789	2.5048	0.0000	2.5048	0.2995	0.2396
N12C	Uterus and Adnexa Procedures for Malignancy, Minor Complexity	D	D		0	7	2.5				1.9139	1.9139	0.0000	1.9139	0.3333	0.2666
N60A	Female Reproductive System Malignancy, Major Complexity	D	D		2	22	7.7				0.5203	1.0407	0.5203	2.0813	0.2158	0.1726
N60B	Female Reproductive System Malignancy, Minor Complexity	D	D		0	7	2.1				0.7189	0.7189	0.0000	0.7189	0.2779	0.2223

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
N61A	Female Reproductive System Infections, Major Complexity	D	D		1	10	3.2				0.5108	1.0215	0.0000	1.0215	0.2559	0.2047
N61B	Female Reproductive System Infections, Minor Complexity	D	D		0	8	2.8	S	0.2406	One day	0.3506	0.3506	0.0000	0.7720	0.2199	0.1760
N62A	Menstrual and Other Female Reproductive System Disorders, Major Complexity	D	D		1	9	2.6	S	0.2965	Same day	0.3554	0.7991	0.0000	0.7991	0.2492	0.1994
N62B	Menstrual and Other Female Reproductive System Disorders, Minor Complexity	D	D		0	4	1.5	S	0.2178	Same day	0.2546	0.4811	0.0000	0.4811	0.2648	0.2119
O01A	Caesarean Delivery, Major Complexity	D	D		1	18	5.6				1.5951	2.7626	0.0000	2.7626	0.2920	0.2336
O01B	Caesarean Delivery, Intermediate Complexity	D	D		1	12	4.0				1.2425	2.1143	0.0000	2.1143	0.3071	0.2457
O01C	Caesarean Delivery, Minor Complexity	D	D		1	9	3.1				1.0717	1.7848	0.0000	1.7848	0.3174	0.2539
O02A	Vaginal Delivery W GIs, Major Complexity	D	D		1	11	3.8				1.2304	2.1109	0.0000	2.1109	0.3207	0.2565
O02B	Vaginal Delivery W GIs, Minor Complexity	D	D		0	8	2.9				1.5889	1.5889	0.0000	1.5889	0.3621	0.2897
O03Z	Ectopic Pregnancy	D	D		0	5	1.6			Same day	0.2866	1.1116	0.0000	1.1116	0.3248	0.2598
O04A	Postpartum and Post Abortion W GIs, Major Complexity	D	D		1	14	3.4				1.0703	1.7888	0.0000	1.7888	0.2928	0.2342
O04B	Postpartum and Post Abortion W GIs, Minor Complexity	D	D		0	5	1.8			Same day	0.4536	0.9895	0.0000	0.9895	0.3015	0.2412
O05Z	Abortion W GIs	D	D		0	3	1.0				0.4808	0.4808	0.0000	0.4808	0.1372	0.1098
O60A	Vaginal Delivery, Major Complexity	D	D		1	10	3.5			One day	0.7572	0.7572	0.0000	1.5051	0.3411	0.2729
O60B	Vaginal Delivery, Intermediate Complexity	D	D		0	8	2.7			One day	0.6052	0.6052	0.0000	1.1343	0.3308	0.2647
O60C	Vaginal Delivery, Minor Complexity	D	D		0	7	2.4			One day	0.5043	0.5043	0.0000	0.9217	0.3096	0.2477
O61A	Postpartum and Post Abortion W/O GIs, Major Complexity	D	D		1	12	3.8			One day	0.4673	0.4673	0.0000	1.2169	0.2595	0.2076

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
O61B	Postpartum and Post Abortion W/O GIs, Minor Complexity	D	D		0	6	2.1	S	0.2138	Same day	0.2309	0.5431	0.0000	0.5431	0.2078	0.1662
O63A	Abortion W/O GIs, Major Complexity	D	D		0	4	1.5				0.7407	0.7407	0.0000	0.7407	0.3621	0.2897
O63B	Abortion W/O GIs, Minor Complexity	D	D		0	4	1.2	S	0.1954	Same day	0.2186	0.4609	0.0000	0.4609	0.2974	0.2379
O66A	Antenatal and Other Obstetric Admissions, Major Complexity	D	D		0	8	2.3			Same day	0.2266	0.7615	0.0000	0.7615	0.2658	0.2127
O66B	Antenatal and Other Obstetric Admissions, Intermediate Complexity	D	D		0	5	1.5	S	0.1873	Same day	0.1440	0.4533	0.0000	0.4533	0.2403	0.1922
O66C	Antenatal and Other Obstetric Admissions, Minor Complexity	D	D		0	4	1.2	S	0.1575	Same day	0.1753	0.3438	0.0000	0.3438	0.2210	0.1768
P01Z	Neonate W Sig GI/Vent ≥ 96 Hours, Died or Transfer to Acute Facility < 5 Days	I	I		1	10	2.8				2.2002	3.5859	0.0000	3.5859	0.3621	0.2897
P02Z	Cardiothoracic and Vascular Procedures for Neonates	I	I		17	38	26.1				8.3382	9.2971	1.8049	39.9809	0.3621	0.2897
P03A	Neonate, AdmWt 1000–1499g W Significant GI/Vent ≥ 96 Hours, Major Complexity	I	I		42	95	63.7				0.5732	1.0416	0.9145	39.4504	0.3621	0.2897
P03B	Neonate, AdmWt 1000–1499g W Significant GI/Vent ≥ 96 Hours, Minor Complexity	I	I		22	51	37.2				0.4877	0.9599	0.9014	20.7906	0.3621	0.2897
P04A	Neonate, AdmWt 1500–1999g W Significant GI/Vent ≥ 96 Hours, Major Complexity	I	I		46	106	59.0				1.0642	1.5664	0.9825	46.7607	0.3621	0.2897
P04B	Neonate, AdmWt 1500–1999g W Significant GI/Vent ≥ 96 Hours, Minor Complexity	I	I		16	38	24.6				0.5171	0.9653	0.8402	14.4089	0.3621	0.2897
P05A	Neonate, AdmWt 2000–2499g W Significant GI/Vent ≥ 96 Hours, Major Complexity	I	I		42	96	62.6				3.3058	3.8948	1.1499	52.1910	0.3621	0.2897

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
P05B	Neonate, AdmWt 2000–2499g W Significant GI/Vent ≥ 96 Hours, Minor Complexity	I	I		12	28	17.2				0.7233	1.1461	0.7751	10.4479	0.3621	0.2897
P06A	Neonate, AdmWt ≥ 2500g W Significant GI/Vent ≥ 96 Hours, Major Complexity	I	I		24	56	35.1				2.7123	3.3884	1.2958	34.4886	0.3621	0.2897
P06B	Neonate, AdmWt ≥ 2500g W Significant GI/Vent ≥ 96 Hours, Minor Complexity	I	I		3	34	11.4				1.6456	2.8921	1.6620	7.8782	0.3621	0.2897
P07Z	Neonate, AdmWt < 750g W Significant GIs	I	I		86	195	127.7				0.8961	1.3223	0.8425	73.7749	0.3621	0.2897
P08Z	Neonate, AdmWt 750–999g W Significant GIs	I	I		60	137	111.8				2.3683	3.0297	1.3008	81.0766	0.3621	0.2897
P60A	Neonate W/O Sig GI/Vent ≥ 96 Hours, Died/Transfer Acute Facility < 5 Days, Major Complexity	I	I		0	7	2.4				0.9597	0.9597	0.0000	0.9597	0.3621	0.2897
P60B	Neonate W/O Sig GI/Vent ≥ 96 Hours, Died/Transfer Acute Facility < 5 Days, Minor Complexity	I	I		0	6	2.0			Same day	0.2662	0.7584	0.0000	0.7584	0.3621	0.2897
P61Z	Neonate, AdmWt <750g W/O Significant GI procedure	I	I		57	130	98.4				0.5779	1.1558	1.1355	65.8791	0.3621	0.2897
P62A	Neonate, AdmWt 750–999g W/O Significant GIs, Major Complexity	I	I		45	101	70.3				0.4400	0.8801	0.8605	39.6036	0.3621	0.2897
P62B	Neonate, AdmWt 750–999g W/O Significant GIs, Minor Complexity	I	I		26	59	37.3				0.3415	0.6830	0.6568	17.7592	0.3621	0.2897
P63A	Neonate, AdmWt 1000–1249g W/O Significant GI/Vent ≥ 96 Hours, Major Complexity	I	I		19	44	29.6				0.3777	0.7554	0.7156	14.3521	0.3621	0.2897
P63B	Neonate, AdmWt 1000–1249g W/O Significant GI/Vent ≥ 96 Hours, Minor Complexity	I	I		7	16	11.5				0.3628	0.7255	0.6219	5.0786	0.3621	0.2897
P64A	Neonate, AdmWt 1250–1499g W/O Significant GI/Vent ≥ 96 Hours, Major Complexity	I	I		18	42	29.6				0.3617	0.7234	0.6832	13.0208	0.3621	0.2897

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
P64B	Neonate, AdmWt 1250–1499g W/O Significant GI/Vent ≥ 96 Hours, Minor Complexity	I	I		14	32	21.9				0.3204	0.6408	0.5950	8.9712	0.3621	0.2897
P65A	Neonate, AdmWt 1500–1999g W/O Significant GI/Vent ≥ 96 Hours, Extreme Complexity	I	I		17	39	27.2				0.2196	0.4391	0.4133	7.4647	0.2743	0.2194
P65B	Neonate, AdmWt 1500–1999g W/O Significant GI/Vent ≥ 96 Hours, Major Complexity	I	I		12	29	20.6				0.2259	0.4519	0.4142	5.4227	0.2630	0.2104
P65C	Neonate, AdmWt 1500–1999g W/O Significant GI/Vent ≥ 96 Hours, Intermediate Complexity	I	I		11	26	18.0				0.2070	0.4140	0.3763	4.5535	0.2527	0.2021
P65D	Neonate, AdmWt 1500–1999g W/O Significant GI/Vent ≥ 96 Hours, Minor Complexity	I	I		9	20	14.4				0.2151	0.4302	0.3824	3.8720	0.2681	0.2145
P66A	Neonate, AdmWt 2000–2499g W/O Significant GI/Vent ≥ 96 Hours, Extreme Complexity	I	I		11	25	16.8				0.2230	0.4459	0.4054	4.9052	0.2339	0.1871
P66B	Neonate, AdmWt 2000–2499g W/O Significant GI/Vent ≥ 96 Hours, Major Complexity	I	I		8	19	12.7				0.2126	0.4253	0.3721	3.4023	0.2952	0.2361
P66C	Neonate, AdmWt 2000–2499g W/O Significant GI/Vent ≥ 96 Hours, Intermediate Complexity	I	I		5	13	8.4				0.2146	0.4293	0.3434	2.1464	0.2545	0.2036
P66D	Neonate, AdmWt 2000–2499g W/O Significant GI/Vent ≥ 96 Hours, Minor Complexity	I	I		1	16	4.9				0.5298	1.0595	0.0000	1.0595	0.2153	0.1723
P67A	Neonate, AdmWt ≥ 2500g W/O Sig GI/Vent ≥ 96 Hours, < 37 Comp Weeks Gest, Extreme Complexity	I	I		4	41	14.2				0.5290	1.0581	0.7935	4.2322	0.2984	0.2387
P67B	Neonate, AdmWt ≥ 2500g W/O Sig GI/Vent ≥ 96 Hours, < 37 Comp Weeks Gest, Major Complexity	I	I		3	28	9.7				0.4442	0.8884	0.5923	2.6651	0.3290	0.2632

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
P67C	Neonate, AdmWt ≥ 2500g W/O Sig GI/Vent ≥ 96 Hours, < 37 Comp Weeks Gest, Intermediate Complexity	I	I		2	25	8.2				0.5032	1.0064	0.5032	2.0129	0.1970	0.1576
P67D	Neonate, AdmWt ≥ 2500g W/O Sig GI/Vent ≥ 96 Hours, < 37 Comp Weeks Gest, Minor Complexity	I	I		1	18	5.8				0.6614	1.3228	0.0000	1.3228	0.1818	0.1454
P68A	Neonate, AdmWt ≥ 2500g W/O Sig GI/Vent ≥ 96 Hours, ≥ 37 Comp Weeks Gest, Extreme Complexity	I	I		2	24	7.7				0.6129	1.2258	0.6129	2.4516	0.3191	0.2553
P68B	Neonate, AdmWt ≥ 2500g W/O Sig GI/Vent ≥ 96 Hours, ≥ 37 Comp Weeks Gest, Major Complexity	I	I		1	13	4.4				0.6056	1.2113	0.0000	1.2113	0.3288	0.2631
P68C	Neonate, AdmWt ≥ 2500g W/O Sig GI/Vent ≥ 96 Hours, ≥ 37 Comp Weeks Gest, Intermediate Complexity	I	I		1	11	3.8			One day	0.3550	0.3550	0.0000	1.0153	0.2117	0.1694
P68D	Neonate, AdmWt ≥ 2500g W/O Sig GI/Vent ≥ 96 Hours, ≥ 37 Comp Weeks Gest, Minor Complexity	I	I		1	10	3.3	S	0.1592	One day	0.3004	0.3004	0.0000	0.7674	0.1863	0.1490
Q01Z	Splenectomy	D	D		1	17	5.1				2.1404	3.2715	0.0000	3.2715	0.3076	0.2461
Q02A	Blood and Immune System Disorders W Other GIs, Major Complexity	D	D		3	28	9.3				1.0098	1.5815	0.7623	3.8684	0.2595	0.2076
Q02B	Blood and Immune System Disorders W Other GIs, Minor Complexity	D	D		0	7	2.2			Same day	0.4940	1.2445	0.0000	1.2445	0.2712	0.2170
Q60A	Reticuloendothelial and Immunity Disorders, Major Complexity	D	D		1	15	4.4			Same day	0.2551	1.4340	0.0000	1.4340	0.2588	0.2071
Q60B	Reticuloendothelial and Immunity Disorders, Minor Complexity	D	D		0	7	2.3			Same day	0.1051	0.7387	0.0000	0.7387	0.2621	0.2096
Q61A	Red Blood Cell Disorders, Major Complexity	D	D	Thal.	1	12	3.5			Same day	0.2940	1.1477	0.0000	1.1477	0.2604	0.2083
Q61B	Red Blood Cell Disorders, Intermediate Complexity	D	D	Thal.	0	5	1.7	S	0.2688	Same day	0.1324	0.5875	0.0000	0.5875	0.2826	0.2261

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
Q61C	Red Blood Cell Disorders, Minor Complexity	D	D	Thal.	0	3	1.0				0.0523	0.0523	0.0000	0.0523	0.0931	0.0745
Q62A	Coagulation Disorders, Major Complexity	D	D		1	16	4.8			Same day	0.2187	1.4278	0.0000	1.4278	0.2388	0.1910
Q62B	Coagulation Disorders, Minor Complexity	D	D		0	8	2.3	S	0.2113	Same day	0.1474	0.8069	0.0000	0.8069	0.2812	0.2249
R01A	Lymphoma and Leukaemia W Major GIs, Major Complexity	D	D		6	55	20.1				1.7477	2.3144	0.9446	7.9819	0.2369	0.1896
R01B	Lymphoma and Leukaemia W Major GIs, Minor Complexity	D	D		1	12	3.1				0.9703	1.5371	0.0000	1.5371	0.2589	0.2071
R02A	Other Neoplastic Disorders W Major GIs, Major Complexity	D	D		4	42	12.0				2.4671	2.9842	0.7756	6.0868	0.2420	0.1936
R02B	Other Neoplastic Disorders W Major GIs, Intermediate Complexity	D	D		2	23	7.4				1.8625	2.4135	0.5509	3.5154	0.2082	0.1666
R02C	Other Neoplastic Disorders W Major GIs, Minor Complexity	D	D		1	12	3.8				1.3117	1.8992	0.0000	1.8992	0.2191	0.1753
R03A	Lymphoma and Leukaemia W Other GIs, Major Complexity	D	D		10	95	40.1				1.3927	2.0313	1.1494	13.5258	0.2228	0.1783
R03B	Lymphoma and Leukaemia W Other GIs, Intermediate Complexity	D	D		4	37	15.4			One day	0.9255	0.9255	1.0850	5.2923	0.2256	0.1805
R03C	Lymphoma and Leukaemia W Other GIs, Minor Complexity	D	D		1	15	4.9			Same day	0.4881	2.1252	0.0000	2.1252	0.2486	0.1989
R04A	Other Neoplastic Disorders W Other GIs, Major Complexity	D	D		4	39	14.1			Same day	1.5333	2.0081	0.7102	4.8490	0.1883	0.1507
R04B	Other Neoplastic Disorders W Other GIs, Minor Complexity	D	D		1	12	2.9			Same day	0.9165	2.2103	0.0000	2.2103	0.3249	0.2599
R05A	Allogeneic Bone Marrow Transplant, Age ≤ 16 Years or Major Complexity	4	D		34	78	49.5				1.1767	1.6644	0.9466	33.8492	0.3621	0.2897
R05B	Allogeneic Bone Marrow Transplant, Age ≥ 17 Years and Minor Complexity	D	D		17	40	29.1				0.5767	1.0425	0.8768	15.9479	0.3621	0.2897

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
R06A	Autologous Bone Marrow Transplant, Major Complexity	D	D		14	34	21.5				0.3505	0.6546	0.5647	8.5608	0.2769	0.2215
R06B	Autologous Bone Marrow Transplant, Minor Complexity	D	D		10	24	17.2				0.5416	0.8774	0.6045	6.9222	0.2733	0.2186
R60A	Acute Leukaemia, Major Complexity	D	D		12	28	20.6			One day	0.5324	0.5324	0.6437	8.2574	0.3207	0.2566
R60B	Acute Leukaemia, Intermediate Complexity	D	D		2	19	6.1			Same day	0.2527	0.9825	0.4912	1.9649	0.2594	0.2076
R60C	Acute Leukaemia, Minor Complexity	D	D		1	15	5.4			Same day	0.1703	1.1065	0.0000	1.1065	0.1643	0.1314
R61A	Lymphoma and Non-Acute Leukaemia, Major Complexity	D	D		3	27	8.9			Same day	0.2858	0.9702	0.6468	2.9105	0.2622	0.2098
R61B	Lymphoma and Non-Acute Leukaemia, Intermediate Complexity	D	D		1	10	3.6			Same day	0.2314	1.3474	0.0000	1.3474	0.3014	0.2411
R61C	Lymphoma and Non-Acute Leukaemia, Minor Complexity	D	D		1	9	3.1			Same day	0.1507	0.9813	0.0000	0.9813	0.2541	0.2033
R62A	Other Neoplastic Disorders, Major Complexity	D	D		2	22	7.9				0.6430	1.2860	0.6430	2.5720	0.2605	0.2084
R62B	Other Neoplastic Disorders, Intermediate Complexity	D	D		1	11	3.6			Same day	0.4415	1.1887	0.0000	1.1887	0.2640	0.2112
R62C	Other Neoplastic Disorders, Minor Complexity	D	D		0	9	2.2			Same day	0.3642	0.6196	0.0000	0.6196	0.2233	0.1786
R63Z	Chemotherapy	D	D		0	3	1.0			Same day	0.1884	0.0000	0.0000	0.0000	0.0000	0.0000
R64Z	Radiotherapy	D	D		2	25	7.7			Same day	1.0913	1.5260	0.7630	3.0519	0.3151	0.2521
T01A	Infectious and Parasitic Diseases W GIs, Major Complexity	D	D		8	73	26.4				1.3959	1.8855	0.8570	8.7412	0.2077	0.1661
T01B	Infectious and Parasitic Diseases W GIs, Intermediate Complexity	D	D		4	37	12.8				0.9159	1.3455	0.6444	3.9233	0.1880	0.1504

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
T01C	Infectious and Parasitic Diseases W GIs, Minor Complexity	D	D		2	20	6.9				0.8172	1.2976	0.4804	2.2583	0.1950	0.1560
T40Z	Infectious and Parasitic Diseases W Ventilator Support	D	D		3	33	11.5				0.9262	1.8061	1.1732	5.3258	0.3621	0.2897
T60A	Septicaemia, Major Complexity	D	D		3	36	11.7				0.6271	1.2542	0.8361	3.7625	0.2583	0.2066
T60B	Septicaemia, Intermediate Complexity	D	D		2	19	6.3				0.4861	0.9721	0.4861	1.9443	0.2483	0.1986
T60C	Septicaemia, Minor Complexity	D	D		1	13	4.2			One day	0.4506	0.4506	0.0000	1.2528	0.2388	0.1910
T61A	Postoperative Infections, Major Complexity	D	D		2	20	6.4				0.3766	0.7532	0.3766	1.5063	0.1874	0.1499
T61B	Postoperative Infections, Minor Complexity	D	D		1	15	4.1	S	0.2508	One day	0.3310	0.3310	0.0000	0.8513	0.1675	0.1340
T62A	Fever of Unknown Origin, Major Complexity	D	D		1	15	4.6				0.7401	1.4802	0.0000	1.4802	0.2597	0.2077
T62B	Fever of Unknown Origin, Minor Complexity	D	D		1	9	3.1	S	0.1988	One day	0.4143	0.4143	0.0000	0.9283	0.2373	0.1899
T63A	Viral Illnesses, Major Complexity	D	D		1	13	3.7			Same day	0.1673	1.2214	0.0000	1.2214	0.2614	0.2091
T63B	Viral Illnesses, Minor Complexity	D	D		0	5	1.7	S	0.197	Same day	0.2203	0.5736	0.0000	0.5736	0.2744	0.2195
T64A	Other Infectious and Parasitic Diseases, Major Complexity	D	D		6	56	20.6				0.5056	1.0111	0.8426	6.0666	0.2361	0.1889
T64B	Other Infectious and Parasitic Diseases, Intermediate Complexity	D	D		2	25	7.7				0.5439	1.0879	0.5439	2.1757	0.2265	0.1812
T64C	Other Infectious and Parasitic Diseases, Minor Complexity	D	D		1	15	4.3	S	0.2831	Same day	0.2290	1.0521	0.0000	1.0521	0.1961	0.1569
U40A	Mental Health Treatment W ECT, Same-day, Major Complexity	D	D		0	3	1.0				0.1704	0.1704	0.0000	0.1704	0.1044	0.0835
U40B	Mental Health Treatment W ECT, Same-day, Minor Complexity	D	D		0	3	1.0				0.1405	0.1405	0.0000	0.1405	0.0931	0.0745
U60Z	Mental Health Treatment W/O ECT, Same-day	D	D		0	3	1.0	S	0.2235		0.2840	0.2840	0.0000	0.2840	0.2272	0.1818

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
U61A	Schizophrenia Disorders, Major Complexity	D	D		2	22	7.0				0.4699	0.9397	0.4699	1.8795	0.2160	0.1728
U61B	Schizophrenia Disorders, Minor Complexity	D	D		1	12	3.7	S	0.5115		0.3365	0.6731	0.0000	0.6731	0.1461	0.1169
U62A	Paranoia and Acute Psychotic Disorders, Major Complexity	D	D		3	28	8.4				0.4089	0.8178	0.5452	2.4535	0.2333	0.1867
U62B	Paranoia and Acute Psychotic Disorders, Minor Complexity	D	D		1	12	3.8	S	0.4792		0.4396	0.8791	0.0000	0.8791	0.1843	0.1474
U63A	Major Affective Disorders, Major Complexity	D	D		2	26	8.5				0.5594	1.1187	0.5594	2.2374	0.2116	0.1693
U63B	Major Affective Disorders, Minor Complexity	D	D		1	11	3.6	S	0.5161		0.3466	0.6931	0.0000	0.6931	0.1521	0.1217
U64A	Other Affective and Somatoform Disorders, Major Complexity	D	D		1	17	4.9				0.7381	1.4761	0.0000	1.4761	0.2395	0.1916
U64B	Other Affective and Somatoform Disorders, Minor Complexity	D	D		1	10	3.2	S	0.3851		0.3357	0.6714	0.0000	0.6714	0.1693	0.1354
U65A	Anxiety Disorders, Major Complexity	D	D		1	14	4.0				0.6214	1.2428	0.0000	1.2428	0.2488	0.1990
U65B	Anxiety Disorders, Minor Complexity	D	D		1	11	3.7	S	0.3188	One day	0.4234	0.4234	0.0000	1.0342	0.2232	0.1786
U66A	Eating and Obsessive-Compulsive Disorders, Major Complexity	D	D		5	45	15.8				0.4998	0.9996	0.7996	4.9978	0.2524	0.2019
U66B	Eating and Obsessive-Compulsive Disorders, Minor Complexity	D	D		3	29	11.0				0.6472	1.2945	0.8630	3.8834	0.2814	0.2251
U67A	Personality Disorders and Acute Reactions, Major Complexity	D	D		2	22	6.0				0.4333	0.8666	0.4333	1.7332	0.2318	0.1855
U67B	Personality Disorders and Acute Reactions, Minor Complexity	D	D		0	9	3.0	S	0.4074		0.6602	0.6602	0.0000	0.6602	0.1765	0.1412
U68A	Childhood Mental Disorders, Major Complexity	D	D		2	21	6.2				0.4508	0.9015	0.4508	1.8031	0.2327	0.1861
U68B	Childhood Mental Disorders, Minor Complexity	D	D		1	13	2.6				0.4928	0.9856	0.0000	0.9856	0.3061	0.2449
V60A	Alcohol Intoxication and Withdrawal, Major Complexity	D	D		1	12	3.9	S	0.3982		0.5726	1.1452	0.0000	1.1452	0.2362	0.1890

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
V60B	Alcohol Intoxication and Withdrawal, Minor Complexity	D	D		0	6	2.0	S	0.269		0.6083	0.6083	0.0000	0.6083	0.2415	0.1932
V61A	Drug Intoxication and Withdrawal, Major Complexity	D	D		1	11	3.5	S	0.3113		0.5715	1.1429	0.0000	1.1429	0.2598	0.2079
V61B	Drug Intoxication and Withdrawal, Minor Complexity	D	D		0	7	2.2	S	0.3112		0.6385	0.6385	0.0000	0.6385	0.2307	0.1845
V62A	Alcohol Use and Dependence, Major Complexity	D	D		1	17	6.0				0.7306	1.4612	0.0000	1.4612	0.1962	0.1570
V62B	Alcohol Use and Dependence, Minor Complexity	D	D		1	13	4.6	S	0.3408		0.5907	1.1814	0.0000	1.1814	0.2051	0.1641
V63Z	Opioid Use and Dependence	D	D		1	14	4.2	S	0.2792		0.4884	0.9768	0.0000	0.9768	0.1875	0.1500
V64A	Other Drug Use and Dependence, Major Complexity	D	D		1	16	4.8				0.5605	1.1210	0.0000	1.1210	0.1868	0.1495
V64B	Other Drug Use and Dependence, Minor Complexity	D	D		1	13	4.0	S	0.2958		0.4113	0.8226	0.0000	0.8226	0.1633	0.1306
W01A	Vent, Trac and Cran Procs for Multiple Significant Trauma, Major Complexity	4	D		20	47	30.3				4.7971	5.2962	0.9481	24.2584	0.3621	0.2897
W01B	Vent, Trac and Cran Procs for Multiple Significant Trauma, Intermediate Complexity	4	D		12	28	19.2				4.0075	4.5759	1.0421	17.0811	0.3621	0.2897
W01C	Vent, Trac and Cran Procs for Multiple Significant Trauma, Minor Complexity	D	D		6	14	10.0				2.8831	3.5516	1.1141	10.2364	0.3621	0.2897
W02A	Hip, Femur and Lower Limb Procedures for Multiple Sig Trauma, Major Complexity	D	D		4	43	13.8				4.2577	4.9247	1.0005	8.9265	0.2710	0.2168
W02B	Hip, Femur and Lower Limb Procedures for Multiple Sig Trauma, Minor Complexity	D	D		2	25	8.1				1.8635	2.5072	0.6437	3.7946	0.2238	0.1791
W03Z	Abdominal Procedures for Multiple Significant Trauma	D	D		3	30	9.5				1.9966	2.6823	0.9142	5.4250	0.3028	0.2422
W04A	Multiple Significant Trauma W Other GIs, Major Complexity	D	D		4	38	13.3				3.0943	3.8103	1.0740	8.1062	0.3004	0.2403

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
W04B	Multiple Significant Trauma W Other GIs, Minor Complexity	D	D		2	20	7.8				2.2130	2.8737	0.6606	4.1949	0.2378	0.1903
W60Z	Multiple Significant Trauma, Transferred to Acute Facility < 5 Days	D	D		0	6	2.2				1.8151	1.8151	0.0000	1.8151	0.3621	0.2897
W61A	Multiple Significant Trauma W/O GIs, Major Complexity	D	D		2	26	8.8				0.7926	1.5851	0.7926	3.1703	0.2880	0.2304
W61B	Multiple Significant Trauma W/O GIs, Minor Complexity	D	D		1	12	3.9				0.7880	1.5761	0.0000	1.5761	0.3197	0.2558
X02A	Microvascular Tissue Transfer and Skin Grafts for Injuries to Hand, Major Complexity	D	D		1	16	6.0				1.9804	2.7368	0.0000	2.7368	0.1774	0.1419
X02B	Microvascular Tissue Transfer and Skin Grafts for Injuries to Hand, Minor Complexity	D	D		0	4	1.3				0.8000	0.8000	0.0000	0.8000	0.2164	0.1731
X04A	Other Procedures for Injuries to Lower Limb, Major Complexity	D	D		2	25	6.7				1.1768	1.7037	0.5269	2.7575	0.2200	0.1760
X04B	Other Procedures for Injuries to Lower Limb, Minor Complexity	D	D		0	4	1.4				0.7620	0.7620	0.0000	0.7620	0.2252	0.1801
X05A	Other Procedures for Injuries to Hand, Major Complexity	D	D		0	7	1.9				1.0711	1.0711	0.0000	1.0711	0.2196	0.1757
X05B	Other Procedures for Injuries to Hand, Minor Complexity	D	D		0	3	1.1				0.5201	0.5201	0.0000	0.5201	0.1580	0.1264
X06A	Other Procedures for Other Injuries, Major Complexity	D	D		4	39	13.1				1.1578	1.5911	0.6499	4.1905	0.1847	0.1478
X06B	Other Procedures for Other Injuries, Intermediate Complexity	D	D		1	17	4.7			One day	0.7142	0.7142	0.0000	1.7329	0.1915	0.1532
X06C	Other Procedures for Other Injuries, Minor Complexity	D	D		0	4	1.3				0.6263	0.6263	0.0000	0.6263	0.1920	0.1536
X07A	Skin Grafts for Injuries Excluding Hand, Major Complexity	D	D		5	48	16.3				1.6921	2.0697	0.6041	5.0901	0.1623	0.1298
X07B	Skin Grafts for Injuries Excluding Hand, Intermediate Complexity	D	D		2	23	8.4				1.2009	1.6890	0.4881	2.6652	0.1632	0.1306

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
X07C	Skin Grafts for Injuries Excluding Hand, Minor Complexity	D	D		1	12	3.8				0.9123	1.3859	0.0000	1.3859	0.1766	0.1413
X40A	Injuries, Poisoning and Toxic Effects of Drugs W Ventilator Support, Major Complexity	D	D		2	24	7.6				1.0546	2.0683	1.0137	4.0958	0.3621	0.2897
X40B	Injuries, Poisoning and Toxic Effects of Drugs W Ventilator Support, Minor Complexity	D	D		1	13	3.9				1.1890	2.3707	0.0000	2.3707	0.3621	0.2897
X60A	Injuries, Major Complexity	D	D		1	13	3.9	S	0.3216	Same day	0.3481	1.0270	0.0000	1.0270	0.2105	0.1684
X60B	Injuries, Minor Complexity	D	D		0	5	1.6	S	0.2841	Same day	0.3309	0.6029	0.0000	0.6029	0.2981	0.2385
X61A	Allergic Reactions, Major Complexity	D	D		0	6	1.8	S	0.2288		0.8679	0.8679	0.0000	0.8679	0.3621	0.2897
X61B	Allergic Reactions, Minor Complexity	D	D		0	4	1.2	S	0.1718	Same day	0.2450	0.4823	0.0000	0.4823	0.3289	0.2631
X62A	Poisoning/Toxic Effects of Drugs and Other Substances, Major Complexity	D	D		1	13	4.1	S	0.4041	One day	0.7191	0.7191	0.0000	1.6866	0.3287	0.2629
X62B	Poisoning/Toxic Effects of Drugs and Other Substances, Minor Complexity	D	D		0	5	1.6	S	0.2597	Same day	0.3219	0.7215	0.0000	0.7215	0.3621	0.2897
X63A	Sequelae of Treatment, Major Complexity	D	D		1	16	4.3			Same day	0.2547	1.2688	0.0000	1.2688	0.2348	0.1879
X63B	Sequelae of Treatment, Minor Complexity	D	D		0	7	1.9	S	0.2302	Same day	0.2274	0.5384	0.0000	0.5384	0.2326	0.1861
X64A	Other Injuries, Poisonings and Toxic Effects, Major Complexity	D	D		1	14	4.1				0.6466	1.2932	0.0000	1.2932	0.2497	0.1997
X64B	Other Injuries, Poisonings and Toxic Effects, Intermediate Complexity	D	D		0	5	1.5	S	0.3544		0.5107	0.5107	0.0000	0.5107	0.2816	0.2253
X64C	Other Injuries, Poisonings and Toxic Effects, Minor Complexity	D	D		0	4	1.3	S	0.256	Same day	0.2536	0.4414	0.0000	0.4414	0.2782	0.2226
Y01Z	Vent ≥ 96 Hours or Trach for Burns or GIs for Severe Full Thickness Burns	4	D		33	76	42.0				10.7506	11.4033	1.2658	53.1733	0.3621	0.2897

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
Y02A	Skin Grafts for Other Burns, Major Complexity	D	D		7	66	23.9				1.9586	2.3672	0.7004	7.2700	0.1677	0.1342
Y02B	Skin Grafts for Other Burns, Intermediate Complexity	D	D		2	26	11.2				1.5834	2.3679	0.7845	3.9368	0.1955	0.1564
Y02C	Skin Grafts for Other Burns, Minor Complexity	D	D		1	12	2.4				0.8803	1.2300	0.0000	1.2300	0.2015	0.1612
Y03A	Other GIs for Other Burns, Major Complexity	D	D		3	30	9.4			One day	0.7660	0.7660	0.7024	2.8732	0.2473	0.1979
Y03B	Other GIs for Other Burns, Minor Complexity	D	D		1	17	4.9			One day	0.4936	0.4936	0.0000	1.5510	0.2072	0.1657
Y60Z	Burns, Transferred to Acute Facility < 5 Days	D	D		0	5	1.7	S	0.3413		0.7698	0.7698	0.0000	0.7698	0.3621	0.2897
Y61Z	Severe Burns	D	D		1	11	2.0				0.2866	0.5733	0.0000	0.5733	0.2909	0.2327
Y62A	Other Burns, Major Complexity	D	D		1	15	4.9			Same day	0.1965	1.3976	0.0000	1.3976	0.2859	0.2287
Y62B	Other Burns, Minor Complexity	D	D		1	11	2.6	S	0.2155	Same day	0.2444	0.6806	0.0000	0.6806	0.2623	0.2098
Z01A	Other Contacts W Health Services W GIs, Major Complexity	D	D		2	21	7.9			Same day	0.7147	1.8019	0.5203	2.8424	0.2650	0.2120
Z01B	Other Contacts W Health Services W GIs, Minor Complexity	D	D		0	4	1.2			Same day	0.4911	1.1107	0.0000	1.1107	0.3621	0.2897
Z40Z	Other Contacts W Health Services W Endoscopy	D	D		0	3	1.0				0.2592	0.2592	0.0000	0.2592	0.1051	0.0840
Z60A	Rehabilitation, Major Complexity	I	I		0	0	0.0				0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
Z60B	Rehabilitation, Minor Complexity	I	I		0	0	0.0				0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
Z61A	Signs and Symptoms, Major Complexity	D	D		2	19	6.0	S	0.3189	One day	0.4127	0.4127	0.5276	1.4679	0.1942	0.1554
Z61B	Signs and Symptoms, Minor Complexity	D	D		0	7	2.1	S	0.2436	Same day	0.1648	0.6480	0.0000	0.6480	0.2504	0.2004

Vic DRG 9.0	Description	Mech. vent co-payment	No invasive vent co-payment	Other co-payment	Boundary – low	Boundary – high	Avg inlier stay	Short stay DRG	Short stay weight	Same/ one-day DRG	Same-day weight	One-day weight	Multi-day low outlier per diem	Inlier weight	High outlier per diem	HITH outlier per diem
Z63A	Other Follow Up After Surgery or Medical Care, Major Complexity	D	D		2	18	5.9				0.3108	0.6215	0.3108	1.2430	0.2117	0.1693
Z63B	Other Follow Up After Surgery or Medical Care, Minor Complexity	D	D		1	16	4.7			One day	0.2032	0.2032	0.0000	0.8029	0.1716	0.1373
Z64A	Other Factors Influencing Health Status, Major Complexity	D	D		2	19	5.7	S	0.3863	Same day	0.2617	0.6784	0.3392	1.3567	0.1888	0.1511
Z64B	Other Factors Influencing Health Status, Minor Complexity	D	D		0	7	1.5	S	0.2647	Same day	0.2155	0.4418	0.0000	0.4418	0.2282	0.1826
Z65Z	Congenital Anomalies and Problems Arising from Neonatal Period	D	D		0	6	1.4				0.5433	0.5433	0.0000	0.5433	0.3143	0.2515
Z66Z	Sleep Disorders	D	D		0	3	1.0				0.2393	0.2393	0.0000	0.2393	0.1848	0.1479
801A	GIs Unrelated to Principal Diagnosis, Major Complexity	D	D		6	61	19.5				1.3553	1.8824	0.8785	7.1532	0.2276	0.1821
801B	GIs Unrelated to Principal Diagnosis, Intermediate Complexity	D	D		2	24	8.6				1.3547	2.0879	0.7332	3.5543	0.2384	0.1907
801C	GIs Unrelated to Principal Diagnosis, Minor Complexity	D	D		0	6	1.6				0.9783	0.9783	0.0000	0.9783	0.2393	0.1914
960Z	Ungroupable	I	I		0	0	0.0				0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
961Z	Unacceptable Principal Diagnosis	I	I		0	0	0.0				0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
963Z	Neonatal Diagnosis Not Consistent W Age/Weight	I	I		0	0	0.0				0.0000	0.0000	0.0000	0.0000	0.0000	0.0000

1.3.2 Subacute WIES4 cost weights

Table 1.21 shows subacute WIES4 cost weights for 2019–20.

Notes:

i. Maintenance care and Department of Veterans' Affairs nursing home type patients will continue to be paid on a per diem basis in 2019–20.

ii. In 2019–20 a loading to SWIES will apply to level 5 statewide specialist spinal rehabilitation services.

Table 1.21: Subacute WIES4 cost weights 2019–20

Code	Class	Description	Per diem funded	Boundary-low	Boundary-high	Avg inlier stay	Per diem weight	Low outlier weight	Inlier weight	High outlier weight
4A21	AN-SNAP (Rehab)	Orthopaedic conditions, all other (including replacements), weighted FIM™ motor 68–91	0	4	12	8.15	–	0.1202	0.4809	0.0648
4A22	AN-SNAP (Rehab)	Orthopaedic conditions, all other (including replacements), weighted FIM™ motor 50–67	0	6	15	10.88	–	0.1076	0.6460	0.0629
4A23	AN-SNAP (Rehab)	Orthopaedic conditions, all other (including replacements), weighted FIM™ motor 19–49	0	12	20	16.33	–	0.0850	1.0207	0.0627
4A31	AN-SNAP (Rehab)	Cardiac, Pain syndromes, Pulmonary, weighted FIM™ motor 72–91	0	6	15	10.67	–	0.1076	0.6461	0.0660
4A32	AN-SNAP (Rehab)	Cardiac, Pain syndromes, Pulmonary, weighted FIM ™ motor 55–71	0	8	16	12.47	–	0.0883	0.7068	0.0589
4A33	AN-SNAP (Rehab)	Cardiac, Pain syndromes, Pulmonary, weighted FIM™ motor 34–54	0	11	20	15.95	–	0.0853	0.9383	0.0596
4A34	AN-SNAP (Rehab)	Cardiac, Pain syndromes, Pulmonary, weighted FIM™ motor 19–33	0	17	25	21.19	–	0.0755	1.2842	0.0600
4A91	AN-SNAP (Rehab)	All other impairments, weighted FIM™ motor 55–91	0	11	19	15.08	–	0.0778	0.8562	0.0624
4A92	AN-SNAP (Rehab)	All other impairments, weighted FIM™ motor 33–54	0	14	23	18.96	–	0.0863	1.2088	0.0635
4A93	AN-SNAP (Rehab)	All other impairments, weighted FIM™ motor 19–32	0	21	29	25.28	–	0.0686	1.4414	0.0700
4AA1	AN-SNAP (Rehab)	Stroke, weighted FIM™ motor 51–91, FIM™ cognition 29–35	0	8	16	12.23	–	0.0943	0.7545	0.0691

Code	Class	Description	Per diem funded	Boundary-low	Boundary-high	Avg inlier stay	Per diem weight	Low outlier weight	Inlier weight	High outlier weight
4AA2	AN-SNAP (Rehab)	Stroke, weighted FIM™ motor 51–91, FIM™ cognition 19–28	0	11	19	15.09	–	0.0995	1.0948	0.0693
4AA3	AN-SNAP (Rehab)	Stroke, weighted FIM™ motor 51–91, FIM™ cognition 5–18	0	17	25	21.09	–	0.1020	1.7346	0.0745
4AA4	AN-SNAP (Rehab)	Stroke, weighted FIM™ motor 36–50, Age ≥ 68	0	19	27	23.31	–	0.0861	1.6361	0.0661
4AA5	AN-SNAP (Rehab)	Stroke, weighted FIM™ motor 36–50, Age ≤ 67	0	22	31	26.83	–	0.0874	1.9231	0.0708
4AA6	AN-SNAP (Rehab)	Stroke, weighted FIM™ motor 19–35, Age ≥ 68	0	28	36	32.26	–	0.0782	2.1916	0.0641
4AA7	AN-SNAP (Rehab)	Stroke, weighted FIM™ motor 19–35, Age ≤ 67	0	36	45	40.72	–	0.0847	3.0508	0.0713
4AB1	AN-SNAP (Rehab)	Brain dysfunction, weighted FIM™ motor 71–91, FIM™ cognition 26–35	0	7	15	11.29	–	0.1193	0.8357	0.0802
4AB2	AN-SNAP (Rehab)	Brain dysfunction, weighted FIM™ motor 71–91, FIM™ cognition 5–25	0	18	26	22.39	–	0.1180	2.1246	0.0779
4AB3	AN-SNAP (Rehab)	Brain dysfunction, weighted FIM™ motor 41–70, FIM™ cognition 26–35	0	13	22	17.64	–	0.0886	1.1525	0.0704
4AB4	AN-SNAP (Rehab)	Brain dysfunction, weighted FIM™ motor 41–70, FIM™ cognition 17–25	0	16	24	20.01	–	0.1042	1.6672	0.0776
4AB5	AN-SNAP (Rehab)	Brain dysfunction, weighted FIM™ motor 41–70, FIM™ cognition 5–16	0	32	40	36.01	–	0.0746	2.3885	0.0742
4AB6	AN-SNAP (Rehab)	Brain dysfunction, weighted FIM™ motor 29–40	0	25	33	29.38	–	0.1071	2.6787	0.0748
4AB7	AN-SNAP (Rehab)	Brain dysfunction, weighted FIM™ motor 19–28	0	35	44	39.54	–	0.0850	2.9777	0.0716
4AC1	AN-SNAP (Rehab)	Neurological conditions, weighted FIM™ motor 62–91	0	8	16	12.39	–	0.1030	0.8243	0.0651
4AC2	AN-SNAP (Rehab)	Neurological conditions, weighted FIM™ motor 43–61	0	14	22	18.32	–	0.0803	1.1254	0.0637
4AC3	AN-SNAP (Rehab)	Neurological conditions, weighted FIM™ motor 19–42	0	22	31	26.78	–	0.0762	1.6781	0.0645
4AD1	AN-SNAP (Rehab)	Spinal cord dysfunction, Age ≥ 50, weighted FIM™ motor 42–91	0	17	25	21.40	–	0.0654	1.1122	0.0740
4AD2	AN-SNAP (Rehab)	Spinal cord dysfunction, Age ≥ 50, weighted FIM™ motor 19–41	0	30	39	34.64	–	0.0979	2.9393	0.0753

Code	Class	Description	Per diem funded	Boundary-low	Boundary-high	Avg inlier stay	Per diem weight	Low outlier weight	Inlier weight	High outlier weight
4AD3	AN-SNAP (Rehab)	Spinal cord dysfunction, Age ≤ 49, weighted FIM™ motor 34–91	0	19	27	23.48	–	0.0981	1.8655	0.0831
4AD4	AN-SNAP (Rehab)	Spinal cord dysfunction, Age ≤ 49, weighted FIM™ motor 19–33	0	77	85	81.08	–	0.1013	7.8043	0.0886
4AE1	AN-SNAP (Rehab)	Amputation of limb, Age ≥ 54, weighted FIM™ motor 68–91	0	7	16	11.75	–	0.1208	0.8461	0.0816
4AE2	AN-SNAP (Rehab)	Amputation of limb, Age ≥ 54, weighted FIM™ motor 31–67	0	19	28	23.78	–	0.0735	1.3973	0.0724
4AE3	AN-SNAP (Rehab)	Amputation of limb, Age ≥ 54, weighted FIM™ motor 19–30	0	19	27	23.19	–	0.0690	1.3115	0.0602
4AE4	AN-SNAP (Rehab)	Amputation of limb, Age ≤ 53, weighted FIM™ motor 19–91	0	16	24	20.44	–	0.0829	1.3276	0.0653
4AH1	AN-SNAP (Rehab)	Orthopaedic conditions, fractures, weighted FIM™ motor 49–91, FIM™ cognition 33–35	0	8	17	12.89	–	0.0919	0.7354	0.0614
4AH2	AN-SNAP (Rehab)	Orthopaedic conditions, fractures, weighted FIM™ motor 49–91, FIM™ cognition 5–32	0	11	20	15.94	–	0.0818	0.9002	0.0568
4AH3	AN-SNAP (Rehab)	Orthopaedic conditions, fractures, weighted FIM™ motor 38–48	0	15	23	19.24	–	0.0727	1.0907	0.0569
4AH4	AN-SNAP (Rehab)	Orthopaedic conditions, fractures, weighted FIM™ motor 19–37	0	19	28	23.57	–	0.0701	1.3334	0.0569
4AP1	AN-SNAP (Rehab)	Major Multiple Trauma, weighted FIM™ motor 19–91	0	20	28	24.34	–	0.0938	1.8760	0.0833
4AR1	AN-SNAP (Rehab)	Reconditioning, weighted FIM™ motor 67–91	0	6	14	10.50	–	0.1055	0.6330	0.0647
4AR2	AN-SNAP (Rehab)	Reconditioning, weighted FIM™ motor 50–66, FIM™ cognition 26–35	0	8	17	12.60	–	0.0941	0.7532	0.0620
4AR3	AN-SNAP (Rehab)	Reconditioning, weighted FIM™ motor 50–66, FIM™ cognition 5–25	0	10	19	14.58	–	0.0831	0.8319	0.0594
4AR4	AN-SNAP (Rehab)	Reconditioning, weighted FIM™ motor 34–49, FIM™ cognition 31–35	0	15	24	19.50	–	0.0667	1.0013	0.0652

Code	Class	Description	Per diem funded	Boundary-low	Boundary-high	Avg inlier stay	Per diem weight	Low outlier weight	Inlier weight	High outlier weight
4AR5	AN-SNAP (Rehab)	Reconditioning, weighted FIM™ motor 34–49, FIM™ cognition 5–30	0	14	22	18.47	–	0.0695	0.9732	0.0619
4AR6	AN-SNAP (Rehab)	Reconditioning, weighted FIM™ motor 19–33	0	19	28	23.88	–	0.0718	1.3653	0.0628
4AZ1	AN-SNAP (Rehab)	Weighted FIM™ motor score 13–18, Brain, Spine, MMT, Age ≥ 49	0	41	50	45.66	–	0.1130	4.6347	0.0824
4AZ2	AN-SNAP (Rehab)	Weighted FIM™ motor score 13–18, Brain, Spine, MMT, Age ≤ 48	0	41	50	45.87	–	0.1231	5.0479	0.0893
4AZ3	AN-SNAP (Rehab)	Weighted FIM™ motor score 13–18, All other impairments, Age ≥ 65	0	24	33	28.68	–	0.0810	1.9441	0.0643
4AZ4	AN-SNAP (Rehab)	Weighted FIM™ motor score 13–18, All other impairments, Age ≤ 64	0	31	40	35.70	–	0.0844	2.6164	0.0734
4F01	AN-SNAP (Rehab)	Rehabilitation, Age ≤ 3	0	9	17	13.46	–	0.3502	3.1524	0.1370
4F02	AN-SNAP (Rehab)	Rehabilitation, Age ≥ 4, Spinal cord dysfunction	0	16	25	20.59	–	0.1433	2.2930	0.1322
4F03	AN-SNAP (Rehab)	Rehabilitation, Age ≥ 4, Brain dysfunction	0	14	22	18.43	–	0.2076	2.9069	0.1347
4F04	AN-SNAP (Rehab)	Rehabilitation, Age ≥ 4, Neurological conditions	0	7	15	11.10	–	0.1901	1.3313	0.1285
4F05	AN-SNAP (Rehab)	Rehabilitation, Age ≥ 4, All other impairments	0	6	14	10.39	–	0.3011	1.8066	0.1397
4J01	AN-SNAP (Rehab)	Adult same-day rehabilitation	0	1	1	1.00	–	0.0396	0.0396	0.0396
4O01	AN-SNAP (Rehab)	Paediatric same-day rehabilitation	0	1	1	–	–	0.0396	0.0396	0.0396
4BD1	AN-SNAP (Pall Care)	Deteriorating phase, RUG-ADL 4–14	0	3	11	7.17	–	0.1499	0.4497	0.0775
4BD2	AN-SNAP (Pall Care)	Deteriorating phase, RUG-ADL 15–18, Age ≥ 75	0	1	8	4.42	–	0.2100	0.2100	0.0783
4BD3	AN-SNAP (Pall Care)	Deteriorating phase, RUG-ADL 15–18, Age 55–74	0	1	9	5.43	–	0.2489	0.2489	0.0838
4BD4	AN-SNAP (Pall Care)	Deteriorating phase, RUG-ADL 15–18, Age ≤ 54	0	2	11	6.69	–	0.3050	0.6101	0.0887
4BS1	AN-SNAP (Pall Care)	Stable phase, RUG-ADL 4–5	0	4	12	8.39	–	0.1304	0.5219	0.0825
4BS2	AN-SNAP (Pall Care)	Stable phase, RUG-ADL 6–16	0	4	12	8.02	–	0.1288	0.5154	0.0738
4BS3	AN-SNAP (Pall Care)	Stable phase, RUG-ADL 17–18	0	4	13	8.92	–	0.1517	0.6071	0.0760

Code	Class	Description	Per diem funded	Boundary-low	Boundary-high	Avg inlier stay	Per diem weight	Low outlier weight	Inlier weight	High outlier weight
4BT1	AN-SNAP (Pall Care)	Terminal phase	0	1	7	2.78	–	0.2269	0.2269	0.0980
4BU1	AN-SNAP (Pall Care)	Unstable phase, First phase in episode, RUG-ADL 4–13	0	1	9	4.77	–	0.1874	0.1874	0.0667
4BU2	AN-SNAP (Pall Care)	Unstable phase, First phase in episode, RUG-ADL 14–18	0	1	7	2.79	–	0.1256	0.1256	0.0626
4BU3	AN-SNAP (Pall Care)	Unstable phase, Not first phase in episode, RUG-ADL 4–5	0	1	7	2.87	–	0.1806	0.1806	0.0805
4BU4	AN-SNAP (Pall Care)	Unstable phase, Not first phase in episode, RUG-ADL 6–18	0	1	7	3.28	–	0.1646	0.1646	0.0776
4G01	AN-SNAP (Pall Care)	Palliative care, Not terminal phase, Age < 1 year	0	2	10	–	–	0.1288	0.5154	0.0738
4G02	AN-SNAP (Pall Care)	Palliative care, Stable phase, Age ≥ 1 year	0	2	10	–	–	0.1288	0.5154	0.0738
4G03	AN-SNAP (Pall Care)	Palliative care, Unstable or deteriorating phase, Age = 1 year	0	2	10	1.00	–	0.1806	0.1806	0.0805
4G04	AN-SNAP (Pall Care)	Palliative care, Terminal phase	0	2	10	–	–	0.2269	0.2269	0.0980
4K01	AN-SNAP (Pall Care)	Adult same-day palliative care	0	1	1	1.00	–	0.0423	0.0423	0.0423
4P01	AN-SNAP (Pall Care)	Paediatric same-day palliative care	0	1	1	–	–	0.0423	0.0423	0.0423
4CH1	AN-SNAP (GEM)	FIM™ motor 57–91 with delirium or dementia	0	16	25	20.91	–	0.0758	1.2143	0.0585
4CH2	AN-SNAP (GEM)	FIM™ motor 57–91 without delirium or dementia	0	10	19	14.53	–	0.0824	0.8241	0.0597
4CL1	AN-SNAP (GEM)	FIM™ motor 13–17 with delirium or dementia	0	23	32	27.68	–	0.0730	1.6801	0.0624
4CL2	AN-SNAP (GEM)	FIM™ motor 13–17 without delirium or dementia	0	19	28	23.74	–	0.0778	1.4786	0.0630
4CM1	AN-SNAP (GEM)	FIM™ motor 18–56 with delirium or dementia	0	20	28	24.33	–	0.0738	1.4779	0.0598
4CM2	AN-SNAP (GEM)	FIM™ motor 18–56 without delirium or dementia	0	15	24	19.90	–	0.0802	1.2033	0.0606
4L01	AN-SNAP (GEM)	Same-day GEM	0	1	1	1.00	–	0.0266	0.0266	0.0266
4DL1	AN-SNAP (Psychogeriatric)	Long-term care	0	0	0	0	0	0.0000	0.0000	0.0000

Code	Class	Description	Per diem funded	Boundary-low	Boundary-high	Avg inlier stay	Per diem weight	Low outlier weight	Inlier weight	High outlier weight
4DS1	AN-SNAP (Psychogeriatric)	HoNOS 65+ Overactive behaviour 3–4, LOS ≤ 91	0	0	0	0	0	0.0000	0.0000	0.0000
4DS2	AN-SNAP (Psychogeriatric)	HoNOS 65+ Overactive behaviour 1–2, HoNOS 65+ ADL 4, LOS ≤ 91	0	0	0	0	0	0.0000	0.0000	0.0000
4DS3	AN-SNAP (Psychogeriatric)	HoNOS 65+ Overactive behaviour 1–2, HoNOS 65+ ADL 0–3, LOS ≤ 91	0	0	0	0	0	0.0000	0.0000	0.0000
4DS4	AN-SNAP (Psychogeriatric)	HoNOS 65+ Overactive behaviour 0, HoNOS 65+ total 18–48, LOS ≤ 91	0	0	0	0	0	0.0000	0.0000	0.0000
4DS5	AN-SNAP (Psychogeriatric)	HoNOS 65+ Overactive behaviour 0, HoNOS 65+ total 0–17, LOS ≤ 91	0	0	0	0	0	0.0000	0.0000	0.0000
4M01	AN-SNAP (Psychogeriatric)	Same-day psychogeriatric care	0	0	0	0	0	0.0000	0.0000	0.0000
4EL1	AN-SNAP (Non-Acute)	Long-term care	1	0	0	0	0.0512	0.0000	0.0000	0.0000
4ES1	AN-SNAP (Non-Acute)	Age ≥ 60, RUG-ADL 4–11, LOS ≤ 91	1	0	0	0	0.0512	0.0000	0.0000	0.0000
4ES2	AN-SNAP (Non-Acute)	Age ≥ 60, RUG-ADL 12–15, LOS ≤ 91	1	0	0	0	0.0512	0.0000	0.0000	0.0000
4ES3	AN-SNAP (Non-Acute)	Age ≥ 60, RUG-ADL 16–18, LOS ≤ 91	1	0	0	0	0.0512	0.0000	0.0000	0.0000
4ES4	AN-SNAP (Non-Acute)	Age 18–59, LOS ≤ 91	1	0	0	0	0.0512	0.0000	0.0000	0.0000
4ES5	AN-SNAP (Non-Acute)	Age ≤ 17, LOS ≤ 91	1	0	0	0	0.0512	0.0000	0.0000	0.0000
499A	AN-SNAP (Rehab)	Adult overnight rehabilitation – ungroupable	0	0.00	0	0	0.0000	0.0000	0.0000	0.0000
499B	AN-SNAP (Pall Care)	Adult overnight palliative care – ungroupable	0	0.00	0	0	0.0000	0.0000	0.0000	0.0000
499C	AN-SNAP (GEM)	Overnight GEM – ungroupable	0	0.00	0	0	0.0000	0.0000	0.0000	0.0000
499D	AN-SNAP (Psychogeriatric)	Overnight psychogeriatric care – ungroupable	0	0.00	0	0	0.0000	0.0000	0.0000	0.0000

Code	Class	Description	Per diem funded	Boundary-low	Boundary-high	Avg inlier stay	Per diem weight	Low outlier weight	Inlier weight	High outlier weight
499E	AN-SNAP (Non-Acute)	Overnight non-acute care – ungroupable	0	0.00	0	0	0.0000	0.0000	0.0000	0.0000
499F	AN-SNAP (Rehab)	Paediatric overnight rehabilitation – ungroupable	0	0.00	0	0	0.0000	0.0000	0.0000	0.0000
499G	AN-SNAP (Pall Care)	Paediatric overnight palliative care – ungroupable	0	0.00	0	0	0.0000	0.0000	0.0000	0.0000

1.3.3 WASE cost weights

The Tier 2 non-admitted services classes as shown in Table 1.22 provide the relevant WASE3 cost weights for 2019–20. The table also shows the Tier 2 classes out of scope for WASE3 that are funded from other sources.

Note:

i. In relation to these services: all non-admitted patient sessions performed per month are to be bundled and counted as one non-admitted patient service event per patient per calendar month, regardless of the number of sessions.

Table 1.22: WASE3 cost weights 2019–20

Tier 2 code	Tier 2 class	VIC-Tier 2 group	Price weight
10.01	Hyperbaric Medicine	36	1.15
10.02	Interventional Imaging	36	1.15
10.03	Minor Surgical	37	0.60
10.04	Dental	36	1.15
10.05	Angioplasty/angiography	37	0.60
10.06	Endoscopy – Gastrointestinal	38	0.66
10.07	Endoscopy – Urological/Gynaecological	37	0.60
10.08	Endoscopy – Orthopaedic	37	0.60
10.09	Endoscopy – Respiratory/ENT	38	0.66
10.10	Renal Dialysis - Hospital Delivered	Out of scope	0.00
10.11	Chemotherapy Treatment	39	1.62
10.12	Radiation Oncology (Treatment)	Out of scope	0.00
10.13	Minor Medical	36	1.15
10.14	Endoscopy – Orthopaedic	37	0.60
10.15(i)	Renal Dialysis - Haemodialysis - Home Delivered	Out of scope	0.00
10.16(i)	Renal Dialysis - Peritoneal Dialysis - Home Delivered	Out of scope	0.00
10.17(i)	Total Parenteral Nutrition - Home Delivered	Out of scope	0.00
10.18(i)	Enteral Nutrition - Home Delivered	Out of scope	0.00
10.19(i)	Home Ventilation	Out of scope	0.00
10.20	Radiotherapy (simulation and planning)	Out of scope	0.00
20.01	Transplants	22	1.48
20.02	Anaesthetics	20	1.26
20.03	Pain Management	7	1.52
20.04	Developmental Disabilities	13	1.98
20.05	General Medicine	9	0.95
20.06	General Practice and Primary Care	Out of scope	0.00
20.07	General Surgery	21	0.70
20.08	Genetics	Out of scope	0.00
20.09	Geriatric Medicine	10	0.70
20.10	Haematology	11	0.88

Tier 2 code	Tier 2 class	VIC-Tier 2 group	Price weight
20.11	Paediatric Medicine	12	0.91
20.12	Paediatric Surgery	20	1.26
20.13	Palliative Care	9	0.95
20.14	Epilepsy	10	0.70
20.15	Neurology	9	0.95
20.16	Neurosurgery	20	1.26
20.17	Ophthalmology	23	0.64
20.18	Ear, Nose and Throat	21	0.70
20.19	Respiratory	5	0.95
20.20	Respiratory – Cystic Fibrosis	5	0.95
20.21	Anti-coagulant Screening and Management	10	0.70
20.22	Cardiology	14	0.83
20.23	Cardiothoracic	20	1.26
20.24	Vascular Surgery	21	0.70
20.25	Gastroenterology	5	0.95
20.26	Hepatobiliary	24	0.88
20.27	Craniofacial	21	0.70
20.28	Metabolic Bone	9	0.95
20.29	Orthopaedics	21	0.70
20.30	Rheumatology	15	0.97
20.31	Spinal	16	0.48
20.32	Breast	20	1.26
20.33	Dermatology	17	0.77
20.34	Endocrinology	10	0.70
20.35	Nephrology	18	0.97
20.36	Urology	25	0.85
20.37	Assisted Reproductive Technology	19	1.40
20.38	Gynaecology	21	0.70
20.39	Gynaecology Oncology	20	1.26
20.40	Obstetrics	1	0.63
20.41	Immunology	5	0.95
20.42	Medical Oncology (Consultation)	8	1.14
20.43	Radiation Oncology (Consultation)	Out of scope	0.00
20.44	Infectious Diseases	7	1.52
20.45	Psychiatry	7	1.52
20.46	Plastic and Reconstructive Surgery	26	0.54
20.47	Rehabilitation	6	0.51
20.48	Multidisciplinary Burns Clinic	10	0.70
20.49	Geriatric evaluation and management (GEM)	Out of scope	0.00

Tier 2 code	Tier 2 class	VIC-Tier 2 group	Price weight
20.50	Psychogeriatric	Out of scope	0.00
20.51	Sleep Disorders	6	0.51
20.52	Addiction Medicine	8	1.14
20.53	Obstetrics – Management of Complex Pregnancy	2	0.57
20.54	Maternal Fetal Medicine	3	0.70
20.55	Telehealth – Patient Location	10	0.70
20.56	Multidisciplinary case conference (MDCC) - patient not present	Out of scope	0.00
30.01	General Imaging	Out of scope	0.00
30.02	Medical Resonance Imaging (MRI)	Out of scope	0.00
30.03	Computerised Tomography (CT)	Out of scope	0.00
30.04	Nuclear Medicine	Out of scope	0.00
30.05	Pathology (Microbiology, Haematology, Biochemistry)	Out of scope	0.00
30.06	Positron Emission Tomography (PET)	Out of scope	0.00
30.07	Mammography Screening	Out of scope	0.00
30.08	Clinical Measurement	Out of scope	0.00
40.02	Aged Care Assessment	Out of scope	0.00
40.03	Aids and Appliances	35	0.37
40.04	Clinical Pharmacology	33	0.90
40.05	Hydrotherapy	35	0.37
40.06	Occupational Therapy	34	0.50
40.07	Pre-Admission and Pre-Anaesthesia	30	0.45
40.08	Primary Health Care	Out of scope	0.00
40.09	Physiotherapy	34	0.50
40.10	Sexual Health	28	0.82
40.11	Social Work	33	0.90
40.12	Rehabilitation	34	0.50
40.13	Wound Management	29	0.60
40.14	Neuropsychology	27	1.52
40.15	Optometry	34	0.50
40.16	Orthoptics	35	0.37
40.17	Audiology	33	0.90
40.18	Speech Pathology	34	0.50
40.21	Cardiac Rehabilitation	35	0.37
40.22	Stomal Therapy	28	0.82
40.23	Nutrition/Dietetics	34	0.50
40.24	Orthotics	33	0.90
40.25	Podiatry	34	0.50
40.27	Family Planning	Out of scope	0.00

Tier 2 code	Tier 2 class	VIC-Tier 2 group	Price weight
40.28	Midwifery	4	0.60
40.29	Psychology	33	0.90
40.30	Alcohol and Other Drugs	27	1.52
40.31	Burns	29	0.60
40.32	Continence	28	0.82
40.33	General Counselling	Out of scope	0.00
40.34	Specialist Mental Health	Out of scope	0.00
40.35	Palliative Care	Out of scope	0.00
40.36	Geriatric evaluation and management (GEM)	Out of scope	0.00
40.37	Psychogeriatric	Out of scope	0.00
40.38	Infectious Diseases	27	1.52
40.39	Neurology	28	0.82
40.40	Respiratory	27	1.52
40.41	Gastroenterology	29	0.60
40.42	Circulatory	30	0.45
40.43	Hepatobiliary	27	1.52
40.44	Orthopaedics	29	0.60
40.45	Dermatology	29	0.60
40.46	Endocrinology	31	0.49
40.47	Nephrology	30	0.45
40.48	Haematology and Immunology	27	1.52
40.49	Gynaecology	28	0.82
40.50	Urology	28	0.82
40.51	Breast	32	0.71
40.52	Oncology	28	0.82
40.53	General Medicine	30	0.45
40.54	General Surgery	30	0.45
40.55	Paediatrics	27	1.52
40.56	Falls prevention	Out of scope	0.00
40.57	Cognition and memory	Out of scope	0.00
40.58	Hospital avoidance programs	Out of scope	0.00
40.59	Post-acute care	Out of scope	0.00
40.60	Pulmonary Rehabilitation	35	0.37
40.61	Telehealth – Patient Location	35	0.37
40.62	Multidisciplinary case conference (MDCC) - patient not present	Out of scope	0.00

1.3.4 WASE review proportions

The following table applies to health services not reporting to VINAH. The statewide proportion of review service events will be applied instead of a health-specific factor. The statewide proportions are shown in Table 1.23.

Table 1.23: WASE Review proportion for non-VINAH reporting health services for 2019–20

Vic-Tier 2 group	Statewide review ratio
Vic-Tier 2 Group 1	0 per cent
Vic-Tier 2 Group 2	0 per cent
Vic-Tier 2 Group 3	0 per cent
Vic-Tier 2 Group 4	0 per cent
Vic-Tier 2 Group 5	74 per cent
Vic-Tier 2 Group 6	69 per cent
Vic-Tier 2 Group 7	64 per cent
Vic-Tier 2 Group 8	93 per cent
Vic-Tier 2 Group 9	74 per cent
Vic-Tier 2 Group 10	77 per cent
Vic-Tier 2 Group 11	86 per cent
Vic-Tier 2 Group 12	69 per cent
Vic-Tier 2 Group 13	78 per cent
Vic-Tier 2 Group 14	76 per cent
Vic-Tier 2 Group 15	84 per cent
Vic-Tier 2 Group 16	92 per cent
Vic-Tier 2 Group 17	79 per cent
Vic-Tier 2 Group 18	89 per cent
Vic-Tier 2 Group 19	68 per cent
Vic-Tier 2 Group 20	58 per cent
Vic-Tier 2 Group 21	73 per cent
Vic-Tier 2 Group 22	97 per cent
Vic-Tier 2 Group 23	85 per cent
Vic-Tier 2 Group 24	74 per cent
Vic-Tier 2 Group 25	73 per cent
Vic-Tier 2 Group 26	73 per cent
Vic-Tier 2 Group 27	58 per cent
Vic-Tier 2 Group 28	62 per cent
Vic-Tier 2 Group 29	39 per cent
Vic-Tier 2 Group 30	95 per cent
Vic-Tier 2 Group 31	87 per cent
Vic-Tier 2 Group 32	91 per cent
Vic-Tier 2 Group 33	85 per cent
Vic-Tier 2 Group 34	34 per cent

Vic-Tier 2 group	Statewide review ratio
Vic-Tier 2 Group 35	75 per cent
Vic-Tier 2 Group 36	80 per cent
Vic-Tier 2 Group 37	66 per cent
Vic-Tier 2 Group 38	44 per cent
Vic-Tier 2 Group 39	100 per cent

1.3.5 WASE multiple healthcare provider proportions

The following table applies to health services not reporting to VINAH. The statewide proportion of multiple healthcare provider service events will be applied instead of a health-specific factor. The statewide proportions are shown in Table 1.24.

Table 1.24: WASE multiple healthcare provider (MHCP) proportions for non-VINAH reporting services 2019–20

Vic-Tier 2 group	Statewide MHCP ratio
Vic-Tier 2 Group 1	0 per cent
Vic-Tier 2 Group 2	0 per cent
Vic-Tier 2 Group 3	0 per cent
Vic-Tier 2 Group 4	0 per cent
Vic-Tier 2 Group 5	0 per cent
Vic-Tier 2 Group 6	0 per cent
Vic-Tier 2 Group 7	0 per cent
Vic-Tier 2 Group 8	0 per cent
Vic-Tier 2 Group 9	1 per cent
Vic-Tier 2 Group 10	1 per cent
Vic-Tier 2 Group 11	0 per cent
Vic-Tier 2 Group 12	1 per cent
Vic-Tier 2 Group 13	0 per cent
Vic-Tier 2 Group 14	0 per cent
Vic-Tier 2 Group 15	0 per cent
Vic-Tier 2 Group 16	0 per cent
Vic-Tier 2 Group 17	0 per cent
Vic-Tier 2 Group 18	0 per cent
Vic-Tier 2 Group 19	0 per cent
Vic-Tier 2 Group 20	2 per cent
Vic-Tier 2 Group 21	0 per cent
Vic-Tier 2 Group 22	0 per cent
Vic-Tier 2 Group 23	0 per cent
Vic-Tier 2 Group 24	0 per cent
Vic-Tier 2 Group 25	0 per cent
Vic-Tier 2 Group 26	0 per cent
Vic-Tier 2 Group 27	0 per cent

Vic-Tier 2 group	Statewide MHCP ratio
Vic-Tier 2 Group 28	0 per cent
Vic-Tier 2 Group 29	0 per cent
Vic-Tier 2 Group 30	0 per cent
Vic-Tier 2 Group 31	0 per cent
Vic-Tier 2 Group 32	0 per cent
Vic-Tier 2 Group 33	0 per cent
Vic-Tier 2 Group 34	3 per cent
Vic-Tier 2 Group 35	0 per cent
Vic-Tier 2 Group 36	0 per cent
Vic-Tier 2 Group 37	0 per cent
Vic-Tier 2 Group 38	0 per cent
Vic-Tier 2 Group 39	0 per cent

1.3.6 Hospital-acquired complications

Table 1.25 shows funding adjustments for hospital-acquired complications.

Table 1.25: Funding adjustments for hospital-acquired complications

No.	Complication	Low (%)	Moderate (%)	High (%)
1.	Pressure injury	12.1	2.8	1.7
2.	Falls resulting in fracture or other intracranial injury	2.5	1.4	0.3
3.	Healthcare-associated infection	8.3	2.4	1.6
4.	Surgical complications requiring unplanned return to theatre	13.0	10.4	8.8
5.	Unplanned intensive care unit admission	Nil	Nil	Nil
6.	Respiratory complications	15.6	10.4	8.1
7.	Venous thromboembolism	11.0	7.9	6.7
8.	Renal failure	20.5	9.6	6.1
9.	Gastrointestinal bleeding	9.1	7.3	6.4
10.	Medication complications	8.7	4.8	2.8
11.	Delirium	9.1	6.8	5.4
12.	Persistent incontinence	3.4	2.6	2.0
13.	Malnutrition	6.5	5.5	4.6
14.	Cardiac complications	10.8	7.4	5.8
15.	Third- and fourth-degree perineal laceration during delivery	Nil	Nil	Nil
16.	Neonatal birth trauma	Nil	Nil	Nil

Notes:

No funding adjustment for 'Unplanned intensive care unit admission' (5) will be applied in 2019–20 because it cannot be identified in current datasets.

No funding adjustment for 'Third- and fourth-degree perineal laceration during delivery' (15) and 'Neonatal birth trauma' (16) will be applied in 2019–20 due to small patient cohorts or other issues that have prevented development of a robust risk-adjustment approach at this time.

The adjustments for hospital-acquired complications are available as an Excel spreadsheet on the Independent Hospital Pricing Authority's website <https://www.ihpa.gov.au/>.

1.4 Output and activity tables

A range of inpatient, residential and community-based clinical services are provided to people with a mental illness and their families so that those who experience mental health problems can access timely, high-quality care and support to recover and live successfully in the community (see Table 1.26).

Table 1.26: Mental health – outputs and activities: clinical care 2019–20

Activity no.	Activity name	Activity description
15005	Crisis Assessment and Treatment	A 24-hour, seven-day-a-week mobile crisis service that provides effective assessment and treatment throughout the community to individuals in crisis due to a mental illness. This includes assessing the most effective and least restrictive client service options and screening inpatient bed admissions.
15006	Community Care Units	Community care units are purpose-built units of up to 20 beds located in community settings with 24-hour staffing. They are designed for adults who require longer term support, on-site clinical services and individualised rehabilitation.
15007	Adult Continuing Care	A range of community-based services that provide assessment, treatment and additional continuing care and case management for adults with a mental illness.
15008	Adult Integrated Community Service	An integrated range of services that meet the client's treatment needs, ensuring efficient and effective community-based mental health services are provided.
15012	Acute Care – Adult	Acute inpatient units provide for the short-term assessment, treatment and management of mentally ill adults aged 15–65 years. The focus is on intervention designed to reduce symptoms and promote recovery from mental illness.
15014	Secure Extended Care – Adult	Long-term inpatient treatment and support for adults aged 15–65 years who have unremitting and severe symptoms, together with an associated significant disturbance in behaviour that inhibits the person's capacity to live in the community.
15019	Aged Persons Mental Health Community Teams	Mobile services that provide assessment, treatment, rehabilitation and case management for people with a mental illness primarily over 65 years of age.
15022	Acute Care – Aged	Inpatient units providing short-term assessment and treatment for older people aged 65 or older with acute symptoms of mental illness who cannot safely be cared for in the community.
15026	Child and Adolescent Assessment Treatment	A range of services including crisis assessment, case management, individual or group therapy, family therapy, parent support and medication-based treatments for children and adolescents experiencing significant psychological distress or mental illness. Services support a timely response to referrals, including crises, delivered on an outreach basis, where appropriate.
15028	Intensive Youth Support	Mobile intensive mental health case management and support to adolescents who display substantial and prolonged psychological disturbance and have complex needs that may include challenging, at-risk and suicidal behaviours, and who have been difficult to engage using less-intensive treatment approaches.
15030	Acute Care – Specialist Statewide	A range of specialist clinical inpatient mental health assessment, treatment or consultancy services that support specific and general target groups on a statewide, inter-regional or specific catchment area basis. The focus of these inpatient services is on clinical service provision to people with a mental illness.

Activity no.	Activity name	Activity description
15031	Acute Care – Child and Adolescent	Inpatient units provide short-term psychiatric assessment and treatment for children and adolescents with severe psychological disturbance who cannot be effectively assessed or treated in a less-restrictive community-based setting.
15032	Forensic Community Service	Provides community-based assessment and multidisciplinary treatment services to high-risk clients referred from a range of criminal justice agencies, mental health services and private practitioners. Also provides secondary consultations and specialist training to area mental health services.
15041	Acute Care – Forensic	Inpatient services for the assessment, diagnosis and treatment of the crisis and acute phases of mentally disturbed offenders referred by the courts, prison system, police and general mental health services.
15049	Aged Persons Mental Health Nursing Home Supplement	Community residential services for aged clients who cannot be managed in the general residential system due to their level of persistent cognitive, emotional or behavioural disturbances. Services include: long-term accommodation; ongoing assessment, treatment and care of residents; rehabilitation; and respite care.
15054	Training – Statewide	All activities associated with training and staff development.
15057	Prevention and Recovery Care	Prevention and recovery care subacute clinical bed-based treatment services option for people with a significant mental health problem requiring pre-crisis or post-acute treatment and support. Prevention and recovery care assists in averting acute inpatient admission and facilitates earlier discharge from inpatient units. It is not a substitute for inpatient admission.
15060	Homeless Outreach Psychiatric Services	Outreach services that provide assessment, treatment, rehabilitation and case management for homeless people with a mental illness. Also includes secondary consultation and support to the homelessness service sector.
15070	Academic Positions – Health Services	All activities associated with specified academic positions attached to tertiary institutions, regardless of the location of the position.
15071	Training – Graduate Year Training	Funding provided to health services to support nurses and allied health staff participating in specialist mental health graduate-year programs for training, supervision, backfill and subsidy to enable reduced clinical loads during orientation phase.
15200	Community Specialist Statewide Services	A range of specialist clinical community mental health assessment, treatment or consultancy services that support specific and general target groups on a statewide, inter-regional or specific catchment area basis. The focus of these community services is on a clinical service provision to people with a mental illness.
15203	Statewide Support – Clinical Services	A range of services including resourcing to the clinical mental health service system on a statewide, inter-regional or specific-purpose basis.
15250	Aged Persons Mental Health Hostel Supplement	Hostel-based community residential services for aged clients who cannot be managed in the general residential system due to their level of persistent cognitive, emotional or behavioural disturbances. Services include long-term accommodation, ongoing assessment, treatment and care of residents, low-level nursing home or hostel care, rehabilitation and respite care.
15251	Consultation and Liaison	Consultation liaison psychiatry is the diagnosis, treatment and prevention of psychiatric morbidity among physically ill patients who are patients of an acute general hospital. This activity includes providing psychiatric assessment, consultation, liaison and education services to non-psychiatric health professionals and their patients.

Activity no.	Activity name	Activity description
15262	Prevention and Promotion	The development and delivery of mental health promotion and the prevention of mental health problems and disorders.
15264	Consumer Participation	Participation of consumers, which may include employing consumer consultants to provide input into service planning, development and evaluation, establish consumer networks and become involved in consumer participation plans for area mental health services.
15265	Ethnic Consultants	Strategies that increase the accessibility of mental health services for people from culturally diverse backgrounds. This includes developing and implementing strategic plans for providing culturally sensitive services and for establishing and maintaining partnerships with ethnic community groups and bilingual health workers.
15267	Research and Evaluation	All activities associated with academic appointments, research and evaluation.
15272	Quality Incentive Strategy	Financial incentives for service quality in adult, aged persons and child and adolescent mental health services. The QIS includes measures of consumer and carer satisfaction, service responsiveness and timeliness of data reporting.
15274	Carer Support Program	Individualised support for carers of people with a mental illness to respond to, or prevent, a crisis. Includes carer consultation and a carer support program.
15275	Carer Support Program – Brokerage	The Mental Health Carer Support Fund Brokerage comprises discretionary funds accessed by carers of people with a mental illness receiving treatment from area mental health services and a selection of statewide specialist services. The funds meet some of the direct and indirect costs related to the caring role to promote and sustain a caring relationship.
15300	Conduct Disorder Program	Services that provide prevention programs for children and young people at risk and clinical services for those with established conduct disorder.
15320	Early Psychosis Program	Specialist treatment and improved continuity of care services for young people with an emerging disorder, particularly co-existing substance abuse problems.
15321	Koori Liaison Officers	All activities associated with the mental health Koori liaison positions.
15350	Community Specialist Statewide Services – Mother Baby	A range of specialist clinical community mental health assessment, treatment or consultancy services that support mother–baby groups (now known as Parent and Infant services) on a statewide, inter-regional or specific catchment area basis. The focus of these community services is on a clinical service provision to people with a mental illness.
15351	Community Specialist Statewide Services – Eating Disorders	A range of specialist clinical community mental health assessment, treatment or consultancy services that support eating disorder groups on a statewide, inter-regional or specific catchment area basis. The focus of these community services is on a clinical service provision to people with a mental illness.
15352	Aged Persons Intensive Community Treatment	Short-term assessment and treatment for people over 65 years of age with acute symptoms of a mental illness, delivered in community settings.
15353	Acute Care – Mother Baby (now known as Parent and Infant services)	A range of specialist clinical inpatient mental health assessment, treatment or consultancy services that support mother and baby groups on a statewide, inter-regional or specific catchment area basis. The focus of these inpatient services is on clinical service provision to people with a mental illness.

Activity no.	Activity name	Activity description
15354	Acute Care – Eating Disorders	A range of specialist clinical inpatient mental health assessment, treatment or consultancy services that support eating disorder groups on a statewide, inter-regional or specific catchment area basis. The focus of these inpatient services is on clinical service provision to people with a mental illness.
15355	Emergency Department Crisis Assessment	Extended-hours coverage in emergency departments for mobile crisis services that provide effective assessment and treatment throughout the community to people in crisis due to a mental illness.
15357	Community Specialist-Statewide Services – Non-Government	A range of specialist clinical community mental health assessment, treatment or consultancy services delivered by non-government organisations that support groups on a statewide, inter-regional or specific catchment area basis. The focus of these community services is clinical service provision to people with a mental illness.
15359	System Capacity Development – Non-Government	Block grants provided for a specified purpose or as a contribution towards a program that assists with developing system capacity. They exclude funding for clinical positions.
15361	Academic Positions – Other	All activities associated with specified academic positions attached to tertiary institutions, regardless of the location of the position.
15362	Workforce Support	Specialist clinical inpatient mental health assessment, short-term admission and treatment services that support neuropsychiatric disorders on a statewide, inter-regional or specific catchment area basis.
15366	Youth Suicide Prevention	Programs that aim to reduce suicide among young people. Programs that provide preventative support, activities and early intervention services to young people (aged 10–25 years), their family and friends and the broader community. Includes the Hospital Outreach Post-suicidal Engagement (HOPE) program.
15060	Mental Health and AOD Hubs	People presenting at emergency departments with acute mental health and alcohol and other drug (AOD) issues can be fast-tracked to specialist, dedicated care, providing them with the right support sooner and easing pressure on emergency departments.
38001	Family Violence Reform (Not Mental Health output)	Specialist family violence program to drive family violence service development, capacity building and sector collaboration. The program increases the capacity of mental health services and AOD agencies to recognise and respond appropriately to family violence at both the agency and individual practitioner levels.
15026	Child Clinical Specialist	Improve the leadership and responsiveness in engaging, assessing and treating children (aged 0–12 years) with behaviour disorders linked to mental illness, such as conduct disorder and precursors, depression and anxiety, and their families/caregivers.
15057	PARC Supplement	Improves the capacity of prevention and recovery care (PARC) units to accept patients being discharged from acute inpatient units by providing extra clinical input.
15054	Aboriginal Mental Health Traineeship Program	All activities associated with supporting full-time employment to 10 Aboriginal mental health traineeship positions who will undergo supervised workplace training and clinical placements over three years while concurrently completing the three-year full-time Bachelor of Health Science (Mental Health) degree at Charles Sturt University.
15300	Personality Disorder Specialist Program	Assessment, treatment and support for people with severe personality disorders who are at high risk of suicide, high-lethality self-harm or violent or aggressive behaviours.

Activity no.	Activity name	Activity description
15365	Perinatal Emotional Health Program	Improve early detection of antenatal and postnatal depression and provide better support and treatment for expectant and new mothers experiencing depression.
15371	Forensic Mental Health in Community Health	Delivery of community-based mental health services and supports to forensic clients with a moderate mental health condition referred by Corrections Victoria.

Table 1.27 shows outputs and activities for mental health community support services. MHCSS are a range of rehabilitation and support services provided to youth and adults with a psychiatric disability, and their families and carers, so that those experiencing mental health problems can access timely, high-quality care and support to recover and reintegrate into the community.

Table 1.27: Mental health community support services 2019–20 – outputs and activities

Activity no.	Activity name	Activity description
15067	Planned Respite – In Home	In-home planned respite services assist in sustaining existing relationships between people with a mental illness and their carers by providing short-term respite at home.
15068	Planned Respite – Community	Community planned respite services assist in sustaining existing relationships between people with a mental illness and their carers by providing short-term respite in the community.
15069	Planned Respite – Residential	Residential planned respite services assist in sustaining existing relationships between people with a mental illness and their carers by providing short-term respite in a residential situation.
15074	Training – MHCSS	This includes all MHCSS activities associated with training and staff development of funded agency staff. It also includes training for participants of funded agencies and their carers. It does not include training provided as part of a mutual support and self-help (MSSH) service or as part of a community development function of any MHCSS-funded agency.
15075	MHCSS Carer Support	This includes those services and programs that have as their primary client the carer of a person with a mental illness, and that do not fit into the components of 'planned respite' or MSSH.
15076	MHCSS Centrally Funded Support	Funding provided by central office for MHCSS services on a specific-purpose grant.
15091	MSSH Statewide Specialist Availability Grant	Availability grants are only provided to statewide specialist MSSH organisations. This is a block grant that encompasses two of the five core MSSH activities: individual support, referral and advocacy; and information development and dissemination.
15092	MSSH Individual Support Referral and Advocacy	Direct contacts between the service provider and the client for information and advice, including referral and one-on-one support. Clients include those with a mental illness, their carers or friends and family members and health professionals.
15093	MSSH Information Development and Dissemination	Costs associated with developing primary reference material. This does not include disseminating existing materials developed by other organisations to clients in the course of normal business. It can include website development costs, writing and so on.
15094	MSSH Groups Support	Facilitated support groups conducted for clients with a mental illness, their carers or friends or family members.
15095	MSSH Groups Education and Training	This refers to groups conducted to provide training or information and education for members of the public or health professionals.
15096	MSSH Volunteer Coordination	Volunteer coordination refers to those activities associated with recruitment, training and education, support and management of volunteers.
15097	Supported Accommodation – 24-Hour Support Model	Staff provide on-site support 24 hours a day, seven days a week. This type of model is generally delivered in a larger facility. Under this model residents normally have their own bedroom but may share bathroom facilities and communal areas such as a lounge and kitchen.

Activity no.	Activity name	Activity description
15098	Supported Accommodation – Non-24-Hour Support	Support is provided either in a cluster environment on the same site or in units and houses located within close geographic proximity. Support is provided during standard work hours (9.00 am to 5.00 pm Monday to Friday) and after hours and weekend support or on call. Note: this activity is progressively transitioning to the National Disability Insurance Scheme.
15099	ACCO Services – Mental Health	Funding for those mental health services provided by Aboriginal community-controlled organisations.
15266	Statewide Support – MHCSS	The statewide funding stream supports the activities of peak organisations that provide advocacy and sector leadership and specialist organisations that provide a range of targeted mental health advocacy and social inclusion services.
15500	Individualised Client Support Packages	The range of non-bed-based supports a client receives based on their recovery plan. Note: this activity is progressively transitioning to the National Disability Insurance Scheme.
15501	Community Intake Assessment Function	Determines and prioritises client eligibility for MHCSS. Note: this activity will be affected by the transition of MHCSS services to the National Disability Insurance Scheme.
15503	Youth Residential Rehabilitation – 24 Hour	Youth residential rehabilitation provides transitional accommodation with rehabilitation support. Support is provided at the facility 24 hours a day, seven days a week.
15504	Youth Residential Rehabilitation – Non-24-Hour	Youth residential rehabilitation provides transitional accommodation with rehabilitation support. Support is provided at the facility on a non-24-hour basis.
15507	Continuity of Support	Continuity of support arrangements for current clients of MHCSS that are transitioning to the National Disability Insurance Scheme (NDIS) who are not eligible to become a NDIS participant because they do not meet the age and residency access requirements outlined in the *National Disability Insurance Act 2013*.

Table 1.28 shows outputs and activities for drug prevention and control. These encourage all Victorians to minimise the harmful effects of illicit and licit drugs, including alcohol, by providing a comprehensive range of strategies that focus on enhanced community and professional education, targeted prevention and early intervention, and the use of effective regulation.

Table 1.28: Drug services – outputs and activities: drug prevention and control 2019–20

Activity no.	Activity name	Activity description
34001	Family Counselling	A variety of supports for family members of people who use AOD, including information, advice, referral, brief interventions and single-session therapies, counselling, peer support and education programs. It aims to deliver additional capacity for family support in each catchment area that is responsive to local need and complements existing family support services so service providers, referrers and affected community members know what is available and how to access it.
34003	Poisons Information	Provides information and advice to the public on drugs and poisons, especially following exposure.
34004	Client Information and Support	Provides information, training, support, advice and referrals to equip people to manage and respond to harmful drug use.
34006	Targeted Interventions	Provides programs and services that prevent or reduce harms associated with alcohol and other drug use.
34020	Community Education	Provides different groups in the community with information about the impacts of substance use and, in the case of parents, resources to inform their children about substance use issues.

Activity no.	Activity name	Activity description
34021	Local Initiatives	Delivers programs, services and projects to support local stakeholders, business, residents and communities to reduce harms related to alcohol and other drug use or dependence.
34070	Needle and Syringe Program	Makes available sterile injecting equipment for injection drug users, promote safe disposal, promote safer injecting practices and provide information, education and referral.

Table 1.29 shows outputs and activities for drug treatment and rehabilitation. Drug services assist the community and individuals to control and reduce the harmful effects of illicit and licit drugs, including alcohol, by providing community-based services, non-residential and residential treatment services, education and training, and support services.

Table 1.29: Drug services – outputs and activities: drug treatment and rehabilitation 2019–20

Activity no.	Activity name	Activity description
34022	Capacity Building	To improve the ability of organisations to identify and respond to AOD support needs of specific cohorts of clients and their families.
34024	Education and Training	To provide information, training, consultancy, curriculum and training needs analysis for workers, including peer workers, in dealing with clients with alcohol and drug problems, and education to alcohol and drug treatment clients.
34025	Research, Service Development, Evaluation	To develop and enhance high-quality public health research into AOD issues, including targeted and general population surveys, risk and protective factors and effects of AOD use and evaluation of services. This activity supports the delivery of a range of initiatives to equip the specialist AOD sector to prevent the harmful uptake of AOD use, intervene earlier, deliver effective treatments and other holistic health interventions, and better understand the impact of AOD use across the community. This enables the application of research findings, which inform policy, planning and practice.
34040	Education (FOCiS)	To provide a drug education program for people requiring it as a condition of their sentence for possessing a small amount of illicit drugs. The aim is to increase the likelihood of the individual maintaining behaviour that reduces drug-related harm.
34041	Youth Day Program	To support young people who are currently involved in treatment with youth AOD treatment services and to complement these services to provide a pathway for the client following treatment.
34042	Community Offenders Advice and Treatment	To provide post-sentence assessments and treatment plans for offenders who have received a community-based disposition from the courts. To provide pre-sentence assessments (in exceptional circumstances) as ordered by the court and treatment plans for offenders whose offending is related to drug use. To provide pre-release assessment and treatment plans on release for prisoners on parole with an AOD treatment condition and offenders who have received a custody and community treatment order. To purchase appropriate treatment from AOD agencies for offenders who have received a community-based disposition with an AOD treatment condition.

Activity no.	Activity name	Activity description
34044	Ante and Post Natal Support	To provide inpatient, outpatient, distance case management and secondary consultation activities to minimise the harms of AOD use to mothers and their children.
34046	Youth Alcohol and Drug Supported Accommodation	To provide short-term accommodation support to those who require assistance in controlling their AOD use.
34047	Specialist Pharmacotherapy Program	To provide specialist assessment and treatment for people receiving methadone who have complex medical, psychiatric or psychosocial problems and to provide training and consultancy services for relevant health practitioners.
34048	Outdoor Therapy	To coordinate case-managed, therapeutic wilderness adventures for young people aged 12–21 years who have AOD issues and to facilitate wilderness adventure skills in the AOD sector.
34049	Koori Community Alcohol and Drug Worker	Aboriginal AOD diversion workers operate in mainstream AOD services located near Koori courts. Their role is to provide a link between the Koori court, the Aboriginal community and the AOD treatment service system, and to provide a service tailored to the needs of offenders appearing before the Koori court.
34050	Adult Residential Drug Withdrawal	To provide a high level of support to ensure a client satisfactorily and safely completes drug withdrawal treatment.
34053	Adult Residential Rehabilitation	To provide a residential treatment program for clients with serious and entrenched drug misuse to achieve significant reduction in drug-related harm.
34054	Peer Support	Peer support facilitates workers with lived experience of AOD use to provide information and support to other people with AOD use to improve their health, wellbeing and safety, and facilitate access to treatment and support services.
34056	Youth Residential Drug Withdrawal	To provide a short-term drug withdrawal, time out and intensive support residential service for young people aged 12–21 years in a physically and emotionally safe, drug-free environment within a multidisciplinary, psychosocial health framework.
34057	Pharmacotherapy Regional Outreach	To support and enhance the role of trained general practitioners and dispensers of drug substitute pharmacotherapies in encouraging, recruiting and retaining opiate-dependent people in drug substitution programs.
34061	Mobile Drug Safety	To provide education on drug safety to drug users and refer users for treatment and rehabilitation.
34062	Mobile Overdose Response	To provide counselling, information and support to non-fatal overdose clients and facilitate access to treatment and support services.
34064	Youth Home-based Withdrawal	To provide a safe and effective drug withdrawal in a home-based setting with medical, pharmacotherapy and supportive care.
34071	Youth Outreach	To make available sterile injecting equipment for injection drug users, promote safe disposal, promote safer injecting practices and to provide information, education and referral.
34074	Counselling Consultancy and Continuing Care	AOD youth consultants provide secondary consultation, support and advice to child protection clients and staff in out-of-home care residential facilities, adolescent community placement and secure welfare services.
34076	Statewide Support – Drug Treatment and Rehabilitation	A range of services, including resourcing to the drug treatment and rehabilitation service system on a statewide, inter-regional or specific-purpose basis.
34078	ACCO Services – Drug Services	Funding for those drugs services provided by Aboriginal community-controlled organisations.

Activity no.	Activity name	Activity description
34079	Koori Youth A and D Healing Service	To provide Aboriginal youth with a supportive environment to address their AOD issues through active participation in therapeutic and structured programs designed to assist them to develop living skills, and to strengthen their cultural identity and spiritual wellbeing.
34080	Youth Residential Rehabilitation	To provide a residential treatment program for young clients with serious and entrenched drug misuse by assisting changes in behaviour through a variety of counselling and therapeutic activities.
34081	Workforce Education and Training	To provide workforce development education, information, training and consultancy for workers dealing with clients with AOD problems, and to provide education to AOD treatment clients.
34084	Therapeutic Counselling	To deliver therapeutic interventions that assist young people and their parents/carer(s)/family to address difficulties associated with AOD use among young people. This supports young people to make positive choices about their AOD use and encourages stronger family relationships, promoting family function.
34200	Forensic Education and Training (Cannabis)	To provide education to clients issued with a cannabis caution, agency training, curriculum development and training needs analysis for workers.
34208	Forensic Consultancy and Continuing Care	To provide specific service system responses and initiatives to enhance the AOD sector's ability to provide enhanced responses to those presenting with highly complex needs including those referred Victoria's Fixated Threat Assessment Centre.
34210	Youth Justice	To deliver AOD programs to youth justice clients.
34211	Diversion Programs	Brokerage funds to purchase AOD therapeutic treatment for pre-arrest/pre-sentence diversion clients.
34212	COATS Post Sentence	Community Offenders Advice and Treatment Service brokerage funds to purchase AOD therapeutic treatment for post-sentence/post-prison clients.
34213	Justice Programs	To deliver criminogenic AOD programs to clients attending treatment via the justice system. Programs currently funded under this activity include targeted criminogenic interventions delivered in group settings.
34214	Severe Substance Dependence Treatment Withdrawal Services	Specified services provided under the *Severe Substance Dependence Treatment Act 2010* including coordination of client care, individual care planning and ensuring clients are linked into services in their local area that provide appropriate care and support.
34300	Care and Recovery Coordination	Facilitates seamless and integrated treatment pathways for complex clients and their families and improves access to other services and support systems in the community through a range of mechanisms including peer support options.
34301	Counselling	Counselling includes providing face-to-face, online or telephone treatment and support for individuals and families, including group counselling and day programs. Duration can range from a single session to extended periods of engagement.
34303	Non-Residential Withdrawal	Non-residential withdrawal services support people to safely achieve neuroadaptation reversal in conjunction with a medical practitioner. Includes clinical withdrawal assessment, withdrawal treatment and referral and information provision via home-based, outpatient, outreach or hospital-supported modalities.
34304	Catchment-Based Planning	Enables catchment-based AOD treatment providers to develop a common plan identifying service gaps and strategies to

Activity no.	Activity name	Activity description
		address these, improve cross-sector coordination and enable effective participation in service coordination and planning platforms.
34305	Therapeutic Day Rehabilitation	Non-residential rehabilitation programs for people recovering from AOD substance misuse. These programs are intensive, structured interventions to address the psychosocial causes for drug dependence through evidence-based treatment, with the aim of sustainable recovery. The program typically includes a mix of motivational enhancement, cognitive behavioural therapies and individual and group counselling, self-help and peer support, and supported reintegration into the community and the re-engagement with recreation and activities.
34306	Intake	The intake function delivers standardised good-practice triage to identify a person's need for, and prioritise their referral to, specialist AOD treatment and other services. This activity includes brief interventions and bridging support, where appropriate, up until the point of a client's assessment.
34307	Assessment	The assessment function delivers standardised, good-practice comprehensive assessment and treatment planning to identify and prioritise a person's treatment and referral needs. This activity includes brief interventions and bridging support, where appropriate.

Table 1.30 shows outputs and activities for small rural health services.

Table 1.30: Small rural health services – outputs and activities 2019–20

Output name	Activity no.	Activity name	Activity description
Acute health	35024	Small rural – flexible health service delivery	A range of health services provided to small rural communities.
	35025	Small rural – TAC – acute health	Transport Accident Commission-funded inpatient services.
	35026	Small rural – DVA – acute health	Department of Veterans' Affairs-funded inpatient services.
	35028	Small rural – acute health service system development and resourcing	Provides funds for workforce, community, service development and IT projects that support SRHSs.
	35051	Acute health – bush nursing hospitals	Provides funds to bush nursing hospitals to support a variety of purposes including inpatient services, 24-hour emergency stabilisation services, agency support and stabilisation grants.
	35052	Small rural – specified services	Provides funding for services and projects as specified in applicable grant descriptions and conditions of funding. Includes specific-purpose activities of both a one-off and recurrent nature.
	35023	Acute health – bush nursing centres	Provides funds to bush nursing centres to support clinical care, practical assistance, support, referral and advocacy with the goal of improving quality of life, social function and health.
Aged care	35010	Small rural – aged support services	A range of health promotion and community service activities that support older Victorians and their carers in small rural communities such as seniors health promotion, aged carer support and respite, dementia services and aged care community grants.
	35030	Small rural – HACC healthcare and support	A range of services to support frail older people and younger people with disabilities and their carers to remain at home.
	35011	Small rural – residential aged care	Care and support for people in small rural communities who are approved for care and accommodation in residential aged care facilities. This includes the state contribution towards matching the reduction in the recurrent funding paid by the Commonwealth to public sector residential aged care providers for the adjusted subsidy reduction for pre-1997 places.
	35042	Small rural – drugs services	Delivery of a range of health and aged care services as per an agreed service profile and business rules.
	35048	Small rural – primary health flexible services	Suitably qualified people assessing and providing direct care to individuals for therapeutic intervention, clinical care, practical assistance, support, referral and advocacy with the goal of improving quality of life, social function and health. Promoting health, independence and wellbeing to prevent illness, injury and disease through screening, risk assessment, immunisation, social marketing of health information, community action for social and environmental change, organisational development, workforce development and resources.

Table 1.31 shows outputs and activities for aged and home care.

Table 1.31: Aged and home care – outputs and activities 2019–20

Output name	Activity no.	Activity name	Activity description
Residential aged care	13031	Public sector residential aged care supplement	Funds designated places for: • adjusted subsidy reduction supplement – this is the state contribution towards equalising the recurrent funding paid by the Commonwealth as adjusted subsidy reduction places to public sector residential aged care operators • contribution to public sector wage adjustments.
	13059	Residential aged care complex supplement	Funds designated places to support services targeting people with particular complex conditions to provide a higher level of specialised care management.
	13107	Rural small high care supplement	Funds designated small-sized high-care public sector residential aged care services (up to 30 places) that are located in rural Victoria. There are three levels of supplement paid for services of various sizes: • services with one to 10 high-care places • services with 11–20 high-care places • services with 21–30 high-care places.
	13211	Aged annual provisions – minor works	This activity provides minor capital funds for funded organisations and includes vehicles, minor building modifications, repairs and furniture and equipment expenses.
	13301	Aged quality improvement	To support safety and through a range of activities including performance monitoring, workforce development, infrastructure development and social inclusion.
Home and Community Care Program for Younger People, primary health, community care and support	13015	Home and Community Care Linkages Packages	Individualised packages of care incorporating assessment, case management and funds to purchase services to HACC-PYP clients.
	13023	Home and Community Care Service Development Grant	One-off projects (up to six months' duration) to improve quality, effectiveness and efficiency of HACC-PYP services and service system. Service provision is not funded under this activity.
	13024	Home and Community Care Assessment	This activity is described in the *Framework for assessment in the HACC program* and requires the delivery of living-at-home assessments. Living-at-home assessments include home-based holistic assessment of need and service-specific assessments to younger people.
	13026	Home and Community Care Domestic Assistance	Assistance with housekeeping tasks such as cleaning, making beds, laundry, shopping, escorting and meal preparation, plus some cyclical tasks such as spring cleaning. Assistance is provided in a manner that promotes skills development, capacity building and independence to HACC-PYP clients.
	13027	Home and Community Care Respite	Support for the care relationship by providing carers of younger people with a disability with a break from their caring responsibilities. Respite can be provided in the care recipient's home or in the community.
	13038	Home and Community Care Service System Resourcing	Resources to assist the sector to better meet the needs of younger people in the HACC-PYP target group and assist clients to gain better access to services, including the SACS Award.

Output name	Activity no.	Activity name	Activity description
	13043	Home and Community Care Flexible Service Response	Funding to support innovative, developmental approaches to HACC-PYP service delivery that cannot be funded under the unit pricing structure.
	13056	Home and Community Care Planned Activity Group – Core	Planned program of activity to maintain a younger person's ability to live at home and in the community by maintaining daily living and social skills. The group may meet at a local venue or go on outings and is for younger clients in the HACC-PYP target group with core needs.
	13057	Home and Community Care Planned Activity Group – High	Planned program of activity to maintain a person's ability to live at home and in the community by maintaining daily living and social skills. The group may meet at a local venue or go on outings.
	13063	Home and Community Care Volunteer Coordination	Funding to coordinators to recruit, train and supervise volunteers and manage the volunteer services to HACC-PYP clients.
	13096	Home and Community Care Allied Health	Allied health services, including clinical assessment, treatment, therapy or professional advice, which may be provided in the home or at a centre.
	13097	Home and Community Care Delivered Meals	Subsidy for meals delivered to people in the HACC-PYP target group at home and or in a local venue.
	13099	Home and Community Care Property Maintenance	Assistance with home maintenance or modification, including maintenance and repair of the client's home, garden or yard to keep it in a safe and habitable condition, and home modification or minor renovations to the client's home to help them cope with a disabling condition.
	13130	Home and Community Care Volunteer Coordination – Other	Block funding to cover volunteer reimbursements and some program costs.
	13131	Royal District Nursing Service Home and Community Care Allied Health	Allied health services by the RDNS, including clinical assessment, treatment, therapy or professional advice that may be provided in the home or at a centre.
	13217	Home and Community Care Minor Capital	Minor capital funds to HACC-PYP funded organisations to maintain, refurbish or upgrade infrastructure to support HACC-PYP services.
	13223	Home and Community Care Nursing	Professional nursing care including direct clinical care, clinical assessment and the provision of education and information to younger people.
	13226	Home and Community Care Personal Care	Assistance with daily self-care tasks and other tasks provided in a way that promotes skills development, capacity building and independence.
	13227	Aboriginal Community-Controlled Organisations Services – Aged and Home Care	Funding for HACC-PYP services provided by Aboriginal community-controlled organisations.

Output name	Activity no.	Activity name	Activity description
	13229	Home and Community Care Access and Support	One-on-one support to HACC-PYP-eligible people with complex needs to access a wide range of services.
	13231	Sector Support and Development	Resources to assist the sector to better meet the needs of people and assist clients to gain better access to services.
Commonwealth Aged Care Assessment – Regional Assessment Service	13230	Regional Assessment Service	Assess care needs of frail older people and determine eligibility for the Commonwealth Home Support Programme.
Commonwealth Aged Care Assessment – Aged Care Assessment Service	13005	Aged Care Assessment Services Assessment	Assess care needs of frail older people and determine eligibility for services under the *Aged Care Act 1997*.
Aged Care Assessment Service	13004	Aged Care Assessment Service Project	Projects to improve the quality and efficiency of aged care assessment services.
Aged Care Assessment Service	13109	Aged Care Assessment Services Evaluation	Audit data integrity and conformance with My Aged Care systems and processes.
Aged support services	13155	Dementia Services	Funding to Dementia Australia (Victoria) for support, counselling, education and training, Dementia Awareness Week activities and dementia service hubs in regional centres.
	13019	Personal Alert Victoria	Daily monitoring and emergency response service for frail older people and people with a disability who have high ongoing health and support needs and mostly live alone.
	13053	Victorian Eyecare Service	Provides subsidised eyecare and visual aids to people experiencing disadvantage via metropolitan, outreach and rural services.
	13156	Seniors Health Promotion	Provides staff positions and support and capacity building to improve the health and wellbeing of older people, especially those who are disadvantaged or isolated.
	13035	Support for Carers	Services for carers including respite, information, advice, counselling and subsidised goods and equipment.
	13082	Low-cost Accommodation Support	Outreach programs for older and vulnerable Victorians with unmet complex needs who are homeless or living in insecure or low-cost accommodation. Programs link clients to relevant health, community care and welfare services to improve their health, social connectedness and stabilise their tenancies.
	13302	Supporting Accommodation for Vulnerable Victorians Initiative	This program ensures the availability of pension-level supported residential service beds for older and vulnerable Victorians who require supported accommodation.
	13303	Supporting Connections	This program provides service coordination, support and brokerage to residents of pension-level supported residential services.

Table 1.32 shows outputs and activities for public health.

Table 1.32: Public health – outputs and activities 2019–20

Output name	Activity no.	Activity name	Activity description
Health advancement	16035	Communication, information and advice	To communicate information, via one or more media, to members of the public or other specific external people and groups.
	16308	Injury prevention	To undertake the design, management and evaluation of projects aimed at fostering best practice in injury prevention program planning and delivery.
	16347	Obesity information provision	To provide obesity information and resources to the community and other stakeholders.
	16348	Children's obesity	To implement initiatives to increase healthy eating and physical activity among children.
	16349	Obesity – community projects	To implement obesity prevention place-based initiatives in a community and develop activities to increase healthy eating and physical activity.
	16449	Smoking information – advice and interventions	To provide smoking cessation advice/support and to educate the community and stakeholders about tobacco and smoking-related legislative requirements and to enforce the *Tobacco Act 1987*.
	16450	Diabetes prevention	To undertake primary and secondary prevention initiatives aimed at reducing the number of people in the Victorian community developing type 2 diabetes and cardiovascular disease.
	16452	Aboriginal health advancement	To undertake policy and program development and promote access to programs and services.
	16453	Aboriginal health worker support	To facilitate training and professional development opportunities for Aboriginal health workers employed by mainstream organisations.
	16454	Health promotion initiatives	To develop and support programs that prevent illness and promote wellbeing through using a mix of health promotion interventions and capacity-building strategies delivering place-based approaches in Victorian communities.
	16460	Targeted recruitment for screening programs	To undertake a range of activities aimed at improving participation of under-screened and never-screened people in screening programs.
	16461	ACCO services – public health	Funding for those public health services provided by Aboriginal community-controlled organisations.
	16462	Prevention system initiatives	To undertake initiatives aimed at improving prevention system and population health outcomes aligning with local planning mechanism.
	16518	Cancer and screening intelligence	To undertake research and analysis activities to inform policy, program development and future directions.
Health protection	16037	Immunisation education	To provide educational and promotional resources and programs for immunisation providers as well as parents, adolescents and older people.
	16038	Tuberculosis screening – management	To provide services and activities related to tuberculosis management.
	16042	Infectious disease investigation and response	To investigate sporadic cases or outbreaks of infectious disease and the institution of suitable control measures.

Output name	Activity no.	Activity name	Activity description
	16047	Food system quality improvement	To oversee the State Safe Food System through inter-sectoral linkages with an aim of continuous improvement in system operation through consultation and cooperation.
	16049	Cemetery sector governance	To undertake a range of projects relating to the governance of the cemetery sector.
	16084	Immunisation services	To provide subsidy payments to local governments for childhood immunisation (under six years old) plus associated activities.
	16102	Infectious disease surveillance	To collect, collate and report on data relating to notifiable infectious diseases, as required by legislation.
	16103	Food safety surveillance	To provide microbiological testing and analysis of food samples and surfaces in food premises.
	16119	School and adult immunisation services	To provide subsidy payments to local governments for immunisation service delivery in secondary schools and for adults.
	16163	Food safety education	To provide education to local government, public and food businesses on food safety.
	16206	Laboratory testing	To provide a range of laboratory tests for infectious diseases (including arbovirus where applicable), including reference functions, advice on microbiological issues and undertaking education and training in relation to laboratory services.
	16234	Public health legislative review	To review public health legislation.
	16360	Infectious disease education and advice	To provide education and awareness programs in the investigation and control of infectious diseases.
	16373	BBV and STI – clinical services	To provide diagnoses and the clinical management of clients in relation to blood-borne viruses (BBVs), sexually transmissible infections (STIs) and sexual health.
	16377	BBV and STI – surveillance	To collect, collate and report on data relating to notifiable BBVs/STIs.
	16381	Risk management and emergency response	To investigate, evaluate and respond to environmental health risks, emergencies or incidents, and to perform activities that help us to better respond to emergencies.
	16505	BBV and STI – training and development	To provide education and training to the BBV/STI sector, including volunteers and organisation staff, and coordination of information updates.
	16506	BBV and STI – research	To support commission or undertake research projects related to BBV/STIs in Victoria.
	16507	BBV and STI – laboratory services	To provide laboratory-testing services related to BBV/STIs in Victoria.
	16508	BBV and STI – health promotion	To provide for the delivery of BBV/STI health promotion/prevention services to the community or targeted population groups.
	16509	BBV and STI – community-based care and support	To provide the delivery of community-based care and support to clients, carers and significant others.
	16513	Screening and preventative messages	To undertake a range of activities within the community aimed at enabling people to make positive decisions about their health and wellbeing.

Output name	Activity no.	Activity name	Activity description
	16514	Screening service development	To undertake specific activities to improve service delivery, capacity and program effectiveness.
	16515	Education and training in screening programs	To undertake a range of education and training activities with program stakeholders to support and enhance the delivery of organised screening programs.
	16516	Screening counselling and support	To provide counselling, support and clinical care to individuals and families who have, or are at risk of, a disease or condition that has been identified through a screening program.
	16517	Cancer and screening registers	To maintain a register (as prescribed by legislation where applicable) to record data about cancers and screening results for Victorians.
	16519	Screening tests and assessments	To provide screening tests and assessments to the target population of an organised screening program.
	16521	Real-time prescription monitoring	To enable prescribers and pharmacists to access dispensing history of medications at the time of consultation.
Public health development	16020	Multisite research ethics review	To establish a centralised ethical review system to streamline regulatory processes.
	16034	Languages services	To provide funds for language services (interpreting and translating) to assist clients with no or low English language proficiency to access and receive quality services from funded organisations.
	16061	Strategy development and review	To develop, coordinate, evaluate and review statewide strategies addressing priority risk and protective factors.
	16069	Public and professional education and support	To undertake planning, development and project management of information provision, social marketing and community and professional education activities addressing priority risk and protective factors.
	16116	Partnership development	To encourage and participate in developing partnerships on public health priorities at the local, state and federal government levels.
	16203	Regulation of ART and associated legislation	To provide funding and support of legislation for assisted reproductive technology (ART).

Addendum 1.1: Calculating WIES26 for individual patients

To calculate the WIES funding allocated to a patient you need to:

- Determine if the episode is eligible for WIES funding (see Box 1.1).
- Calculate VIC-DRG9.0 by applying Victorian modifications to AR-DRG9.0 (see Box 1.2, Box 1.3 and Box 1.4).
- Calculate any WIES co-payments (see Box 1.5, Box 1.6, Box 1.7, Box 1.8, Box 1.9 and Box 1.10).
- Calculate the base WIES allocation using the VIC-DRG9.0, the patient's accommodation type and the patient's length of stay (LOS) adjusted for mechanical ventilation, non-invasive ventilation and high outlier days – this can be done using the appropriate weights from the WIES weights table (see Box 1.11, Box 1.12 and Box 1.13).
- Apply the Aboriginal and Torres Strait Islander loading if applicable (see Box 1.14).
- Add the base WIES payment, any co-payments and Aboriginal and Torres Strait Islander loading (see Box 1.15).

The steps are described in detail below. The technical specifications are provided in the corresponding boxes.

A1.1.1 WIES26 eligibility

The majority of patients in hospital will be allocated a WIES26 cost weight. However, as in previous years, WIES cannot be calculated for incomplete or uncoded episodes. Further, WIES is not necessarily an appropriate measure of resource use for many non-acute patients.

WIES cost weights are sometimes allocated to some Victorian Admitted Episodes Dataset (VAED) patient episodes that are ineligible for casemix funding. WIES from these episodes will need to be excluded when comparing health service activity against targets during 2019–20.

Eligible patients are entitled to base WIES payments and may also be entitled to WIES co-payments. Base WIES payments are made according to the formula and are derived from the average costs for patients in each VIC-DRG9.0. WIES co-payments are made to cover the higher costs of care provided to some special types of patients.

Base WIES payments for long-stay patients can be affected by co-payments, so it is advisable to determine if a patient is eligible for WIES co-payments first.

Box 1.1: Episodes eligible for WIES26 funding

All episodes in the VAED with a care type of:

- 4 – Other care (Acute), including qualified newborns.

Except for:

- private hospital separations
- incomplete or uncoded episodes, or episodes coded to a problem VIC-DRG 9.0 (zero weight) including VIC-DRG 9.0 960Z (Ungroupable), 961Z (Unacceptable Principal Diagnosis) and 963Z (Neonatal Diagnosis Not Consistent W Age/Weight)
- episodes with an account class on separation of NT (Newborn – Unqualified, not birth episode), WC (Victorian WorkCover Authority), XX (Ineligible non-Australian residents – not exempted from fees), AS (Armed Services), CL (Common Law Recoveries), OO (Other compensable), SS (Seamen)
- episodes where the contract role is B (service provider hospital)
- episodes from hospitals not eligible for WIES funding
- episodes that have been coded as follows as this activity has been funded through specified grants:
  - include an electroconvulsive therapy code [1422400–1422406]
  - care type 4 (Acute)
  - separated from The Royal Melbourne Hospital (campus code 1334)
  - funding arrangement 2 (Hub and Spoke)
  - contract/spoke identifier in (0010, 0011, 0012)
- episodes with DRG L42Z unless the episode is reported by St Vincent's Health, Ballarat Health Services, Bendigo Health, Barwon Health, Goulburn Valley Health, The Royal Children's Hospital, Mildura Base Hospital, Western Health or Mercy Health (Werribee campus only).

While contracted patients are allocated a WIES score they are not eligible for WIES funding.

A1.1.2 Victorian AR-DRG modifications

In 2019–20 hospitals will assign diagnosis and procedure codes using the 11th edition of the ICD-10-AM/ACHI classifications. For funding purposes, these codes will be mapped back to 10th edition codes and then grouped to AR-DRG version 9.0 (AR-DRG9.0).

As in previous years, some Victorian-specific adjustments will be made to the original AR-DRG9.0 grouping to produce the Victorian modified VIC-DRG9.0. The calculation of WIES26 is based on VIC-DRG9.0 groupings. The VIC-DRG9.0 for Radiotherapy (R64Z) and Endovascular Clot Retrieval (B02Y) remain for WIES26 (Box 1.2 and Box 1.3). In addition, the following new VIC-DRG9.0 modification will be created under WIES26:

- The 31, 11th edition ICD-10-AM diagnosis codes listed in Box 1.4 will not be recognised as a complication and/or morbidity code for the purpose of grouping to VIC-DRG9.0.

Box 1.2: Radiotherapy

The Australian Coding Standard (ACS) 0229 Radiotherapy instructs coders to assign a code for the malignancy as the principal diagnosis in multi-day episodes for radiotherapy. This results in episodes grouping to a wide range of AR-DRG 9.0s. To maintain funding equity, a VIC-DRG 9.0 of R64Z Radiotherapy will be assigned for:

i. non-same-day non-surgical episodes that include a radiation oncology procedure from ACHI blocks [1786] to [1792], [1794] or [1795] for treatment of a neoplastic condition (at least one code from the ICD-10-AM range C00–D48), except for episodes with the following adjacent AR-DRG9.0s: A40, B82, B83, W60, and W61

ii. same-day episodes initially grouped to the adjacent AR-DRG9.0 R62 Other Neoplastic Disorders that have an ICD-10-AM 11th edition principal diagnosis code of Z51.0 (Radiotherapy session).

Box 1.3: Endovascular clot retrieval

Endovascular clot retrieval is a highly specialised procedure and requires a well-organised system to identify suitable candidates for therapy and to rapidly transport them to a capable centre. To support the provision of the service and ensure funding equity, a VIC-DRG9.0 of B02Y Endovascular Clot Retrieval will be assigned for episodes that:

i. originally group to the adjacent AR-DRG9.0 of B02 Cranial Procedures

AND

ii. include an 11th edition ICD-10-AM principal or secondary diagnosis code of I63.x, I64, I65.x or I66.x AND an ACHI 11th edition procedure code of 35414-00 Embolectomy or thrombectomy of intracranial artery.

Box 1.4: Adjustment to the AR-DRG9.0 episode clinical complexity model

Under the AR-DRG9.0 episode clinical complexity model, the 31 11th edition ICD-10-AM diagnosis codes listed below can affect the calculation of episode clinical complexity (DRG outcome) in particular adjacent DRGs. To maintain funding equity and stability, and to ensure greater alignment with the anticipated 2020–21 introduction of AR-DRG v10.0 where the same 31 diagnosis codes will also be excluded from the AR-DRG v10.0 episode clinical complexity model, these 31 ICD-10-AM diagnosis codes in the 11th edition, when not coded as the principal diagnosis code, will be ignored for the purpose of grouping to VIC-DRG9.0.

- E559 Vitamin D deficiency, unspecified
- E833 Disorders of phosphorus metabolism and phosphatases
- F172 Mental and behavioural disorders due to use of tobacco, dependence syndrome
- G470 Disorders of initiating and maintaining sleep [insomnias]
- G478 Other sleep disorders
- G479 Sleep disorder, unspecified
- H250 Senile incipient cataract
- K219 Gastro-oesophageal reflux disease without oesophagitis
- K30 Functional dyspepsia
- K5730 Diverticulosis of large intestine without perforation, abscess or mention of haemorrhage
- K590 Constipation
- K640 First degree haemorrhoids
- K649 Haemorrhoids, unspecified
- L22 Diaper [napkin] dermatitis
- L299 Pruritus, unspecified
- L304 Erythema intertrigo

- L539 Erythematous condition, unspecified
- L989 Disorder of skin and subcutaneous tissue, unspecified
- M2551 Pain in a joint, shoulder region
- M2555 Pain in a joint, pelvic region and thigh
- M2556 Pain in a joint, lower leg
- M542 Cervicalgia
- M5499 Unspecified dorsalgia, site unspecified
- M7962 Pain in limb, upper arm
- M7966 Pain in limb, lower leg
- M7986 Other specified soft tissue disorders, lower leg
- M8199 Unspecified osteoporosis, site unspecified
- O9901 Anaemia complicating pregnancy
- O992 Endocrine, nutritional and metabolic diseases complicating pregnancy, childbirth and the puerperium
- O994 Diseases of the circulatory system complicating pregnancy, childbirth and the puerperium
- O998 Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium

A1.1.3 Co-payments

The six types of WIES25 co-payments used in 2018–19 will continue under WIES26 in 2019–20.

A1.1.3.1 Mechanical ventilation

Technical specifications for mechanical ventilation co-payments are provided in Box 1.5. To be eligible for a mechanical ventilation co-payment the patient must be admitted to specific health services (see Table 1.33), have had more than six hours of continuous mechanical ventilation and be allocated to a VIC-DRG9.0 that is eligible for a mechanical ventilation co-payment. Each VIC-DRG9.0 will fall into one of the following mechanical ventilation classes:

- eligible for daily co-payments of 0.7659 WIES (mv_elig = 'D' in the WIES26 weights table)
- eligible for daily co-payments at 0.7659 WIES for ventilated days in excess of four days (96 hours) mechanical ventilation (mv_elig = '4' in the WIES26 weights table)
- ineligible for co-payments (mv_elig = 'I' in the WIES26 weights table).

All patients who are eligible for a mechanical ventilation co-payment receive an additional one-off payment of 0.6980 WIES. This additional WIES payment is to provide health services with the capacity to run at lower levels of intensive care unit (ICU) occupancy so that ICU beds will be available for periods of peak demand. However, the additional co-payment is subject to health services staffing appropriate to the number of ICU beds.

Mechanical ventilation severity co-payment eligibility

Below is a list of hospitals that are eligible for attracting mechanical ventilation co-payments for ventilated patients in non-neonate eligible DRGs ('D', '4').

Only episodes with the campus codes listed in Table 1.33 may be eligible.

Table 1.33: Health service campus codes

Code	Name
1010	The Alfred
1021	Bendigo Health
1031,1032	Austin and Repatriation Medical Centre
1050	Box Hill Hospital
1071	Western District Health Service [Hamilton]
1121	Goulburn Valley [Shepparton]
1150	Wangaratta
1170	Monash Medical Centre [Clayton]
1180	Western Hospital
1191	The Royal Children's Hospital
1210	Maroondah Hospital
1230	The Royal Women's Hospital [Parkville]
1280	Northern Hospital
1320	Werribee Mercy Hospital
1334	The Royal Melbourne Hospital
1390	Sunshine Hospital
1450	St Vincent's Hospital
1550	Peter MacCallum Cancer Centre
1590	Angliss Hospital
2010	Ballarat Health Services
2050	Barwon Health [Geelong]
2060	Central Gippsland Health Service
2111	Dandenong Hospital
2160	South West Healthcare [Warrnambool]
2170	Wimmera Health Care Group [Horsham]
2220	Frankston Hospital
2320	New Mildura
2440	Latrobe Regional Hospital
3660	Casey Hospital
6200	Valley Private Hospital [Mulgrave]
6400	Knox Private Hospital [Wantirna]
6470	Freemasons Hospital [East Melbourne]
6490	Epworth Hospital [Richmond]
6511	Cabrini Malvern
6520	St John of God Health Care Ballarat
6550	St John of God Health Care Geelong
6620	St Vincent's Private Hospital [Fitzroy]
6770	Melbourne Private Hospital [Parkville]
6910	Warringal Private Hospital [Heidelberg]
7350	South Eastern Private Hospital [Noble Park]
8550	John Fawkner – Moreland Private Hospital
8890	Jessie McPherson Private Hospital [Clayton]

Box 1.5: Calculating mechanical ventilation co-payments

```
Select mv_elig
case 'D' then
    if (hours on mechanical ventilation > 6) and (ICU hospital) then
        adjmvday = round ((hours mechanical ventilation +12)/24)
    else
        adjmvday = 0
    mv_copay = adjmvday × 0.7659+ 0.6980
    go to Box 1.6
case '4' then
    if (hours on mechanical ventilation > 96) and (ICU hospital) then
        adjmvday = round ((hours mechanical ventilation +12)/24) – 4
    else
        adjmvday = 0
    mv_copay = adjmvday × 0.7659+ 0.6980
    go to Box 1.6
otherwise do
    adjmvday = 0
    mv_copay = 0
    go to Box 1.6
```

Base WIES payments for high outliers are reduced when a patient receives daily mechanical ventilation co-payments. To make this reduction, it is necessary to record the number of days the patient is receiving mechanical ventilation co-payments ('adjmvday' in the technical specifications).

A1.1.3.2 Non-invasive ventilation

Technical specifications for non-invasive ventilation co-payments are provided in Box 1.6. To be eligible for a non-invasive ventilation co-payment the patient must: have received a zero mechanical ventilation co-payment (Box 1.5), be admitted to specific health services (see Table 1.33), have had more than six hours of continuous non-invasive ventilation provided in an ICU and be allocated to a VIC-DRG9.0 that is eligible for a non-invasive ventilation co-payment. Each VIC-DRG9.0 will fall into one of the following non-invasive ventilation classes:

- eligible for daily co-payments of 0.7659 WIES (niv_elig = 'D' in the WIES26 weights table)
- eligible for daily co-payments at 0.7659 WIES for ventilated days in excess of one day (24 hours) non-invasive ventilation (niv_elig = '1' in the WIES26 weights table)
- ineligible for co-payments (niv_elig = 'I' in the WIES26 weights table).

Non-invasive ventilation severity co-payment eligibility

Table 1.33 (above) lists the hospitals that are eligible for attracting non-invasive ventilation co-payments for ventilated patients in non-neonate eligible DRGs ('D', '1'). Only episodes with the campus codes listed in Table 1.33 may be eligible.

Box 1.6: Calculating non-invasive ventilation co-payments

```
If mv_copay = 0 then
 Select niv_elig
 case 'D' then
      if (hours on non-invasive ventilation > 6) and (ICU hospital) then
           adjnivday = round ((hours non-invasive ventilation +12)/24)
      else
           adjnivday = 0
      niv_copay = adjnivday × 0.7659
      go to Box 1.7
 case '1' then
      if (hours on non-invasive ventilation > 24) and (ICU hospital) then
           adjnivday = round ((hours non-invasive ventilation +12)/24) – 1
      else
           adjnivday = 0
      niv_copay = adjnivday × 0.7659
      go to Box 1.7
 otherwise do
      adjnivday = 0
      niv_copay = 0
      go to Box 1.7
else
      adjnivday = 0
      niv_copay = 0
 go to Box 1.7
```

Base WIES payments for high outliers are reduced when a patient receives daily non-invasive ventilation co-payments. To make this reduction, it is necessary to record the number of days the patient is receiving non-invasive ventilation co-payments ('adjnivday' in the technical specifications).

A1.1.3.3 Thalassaemia

Thalassaemia co-payments are made to patients with any ICD-10-AM diagnosis code of D56.x or D57.2 who are allocated to an eligible VIC-DRG9.0 (indicated with a 'Thal' in the 'Other Co-payment' column in the WIES26 weights table). The WIES26 thalassaemia co-payment is set at 0.1089 WIES per episode. Technical specifications are provided in Box 1.7.

Box 1.7: Calculating thalassaemia co-payments

```
If (copay = 'Thal') and record has an ICD-10-AM 11th edition diagnosis of D56.x or D57.2 then
      th_copay = 0.1089
else
      th_copay = 0
go to Box 1.8
```

A1.1.3.4 Abdominal aortic aneurysm stent

Abdominal aortic aneurysm (AAA) stent co-payments are made to patients undergoing an endoluminal repair of an aortic aneurysm as indicated by any ACHI 11th edition procedure code of 33116-00 and who are allocated to an eligible VIC-DRG9.0 (indicated with a 'AAA' in the 'Other Co-payments' column in the WIES26 weights table). The WIES26 AAA stent co-payment is set at 3.1421 WIES per episode. Technical specifications are provided in Box 1.8.

Box 1.8: Calculating abdominal aortic aneurysm stent co-payments

```
If (copay = 'AAA') and record has an ACHI 11th edition procedure of 33116-00 then
    AAA_copay = 3.1421
else
    AAA_copay = 0
go to Box 1.9
```

A1.1.3.5 Atrial septal defect closure device

Atrial septal defect (ASD) co-payments are made to patients receiving an atrial septal defect closure device as indicated by the presence of any ACHI 11th edition procedure code of 38742-00 and who are allocated to an eligible VIC-DRG9.0 (indicated with a 'ASD' in the 'Other Co-payments' column in the WIES26 weights table). The WIES26 ASD co-payment is set at 2.4713 WIES per episode. Technical specifications are provided in Box 1.9.

Box 1.9: Calculating atrial septal defect co-payments

```
If (copay = 'ASD') and record has an ACHI 11th edition procedure code of 38742-00 then
    ASD_copay = 2.4713
else
    ASD_copay = 0
go to Box 1.10
```

A1.1.3.6 Cochlear prosthetic device

Cochlear co-payments are made to patients receiving a bilateral cochlear implantation in the one (same) episode (indicated by the occurrence of ACHI 11th edition procedure code 41617-05 within the one episode) and who are allocated to an eligible VIC-DRG9.0 (indicated with a 'Bilat' in the 'Other Co-payments' column in the WIES26 weights table). The WIES26 cochlear co-payment is set at 5.0544 WIES per episode. Technical specifications are provided in Box 1.10.

Box 1.10: Calculating cochlear co-payments

```
If (copay = 'Bilat') and record has
    (Number of times the ACHI 11th edition procedure code 41617-05 is reported)
    less
    (Number of times the ACHI 11th edition procedure code 41617-06 is reported)
    = 1
then bilat_copay = 5.0544
else
    Bilat_copay = 0
go to Box 1.11
```

A1.1.4 Base WIES26

To calculate a patient's base WIES26 you need to determine:

- the patient's VIC-DRG9.0
- the patient's LOS
- the patient's LOS category (LOS_cat: 'S' or same-day, 'O' or one-day, 'M' or multi-day)
- the patient's accommodation type occupied during the first and second status segments of their admission (ACCTYPE1 and ACCTYPE2) and on separation (SEPACCOM) (refer to Box 1.13)
- the number of mechanical ventilation co-payment days ('adjmvday', refer to Box 1.5)
- the number of non-invasive ventilation co-payment days ('adjnivday', refer to Box 1.6)
- the patient's inlier equivalence ('I' or inlier, 'L' or low outlier, 'H' or high outlier).

The patient's LOS and LOS category are derived from the admission date, separation date and leave days. For payment purposes a maximum LOS of five years (1,825 days) is used. This ensures that WIES are not allocated to extreme stays that are likely to represent non-acute care. Technical specifications are provided in Box 1.11.

Box 1.11: Determining LOS category and maximum LOS

```
If admission date = separation date then same day = 'Y'
else same day = 'N'
If (same day = 'Y') then
        LOS_cat = 'S'
        go to Box 1.12
else if (same day = 'N') and (LOS =1) then
        LOS_cat = 'O'
        go to Box 1.12
else
        LOS = min (LOS,1825)
        LOS_cat = 'M'
    go to Box 1.12
```

The patient's inlier funding equivalence is determined by comparing the patient's LOS with the inlier boundaries for the VIC-DRG9.0 to which the patient is allocated. The low and high inlier boundaries are given in the WIES26 weights table. For the purpose of reporting, a patient is classified as an inlier based only on LOS. However, the high outlier per diems are adjusted for any mechanical ventilation and any

non-invasive ventilation co-payments. Consequently, some high outliers are paid at the inlier rate (where: [LOS – HB] < (adjmvday + adjnivday)).

A patient is funded as an inlier when their LOS is greater than or equal to the low inlier boundary and less than or equal to the sum of the high inlier boundary plus any mechanical ventilation co-payment days and any non-invasive ventilation co-payment days.

Patients with a LOS less than the low inlier boundary are funded as low outliers. Patients with a LOS greater than the sum of the high inlier boundary, mechanical ventilation and non-invasive ventilation co-payment days are funded as high outliers. Technical specifications are provided in Box 1.12.

Box 1.12: Calculating inlier funding equivalence

```
If LOS < lb, then
    Inlier = 'L'
    go to Box 1.13
else if LOS > (hb + adjmvday + adjnivday) then
    Inlier = 'H'
    go to Box 1.13
else
    Inlier = 'I'
    go to Box 1.13
```

Separate columns occur in the WIES26 weights table for:

- short-stay observation unit weights
- same-day weights
- one-day weights
- multi-day low outlier per diem weight
- multi-day inlier weights
- high outlier per diem weights
- high HITH per diem weights.

The base WIES cost weight for short-stay observation unit episodes (same-day, one-day and multi-day; inlier, low and high outlier) that group to short-stay designated DRGs (short_stay= 'S') can be read directly from the WIES26 weights table using the appropriate columns (short_stay and ss) and row (VIC-DRG9.0).

The base WIES cost weight for same-day episodes (inlier and low outlier), one-day episodes (inlier and low outliers), and multi-day inliers can be read directly from the WIES26 weights table using the appropriate column and row (VIC-DRG9.0). The base WIES cost weight for multi-day low outliers can be calculated by multiplying the low outlier per diem weight given in the WIES26 weights table by the patient's LOS less one day and adding the one-day weight.

The base WIES cost weight for high outliers is obtained by:

- calculating the number of high outlier days (high_days) by subtracting the high boundary and any mechanical ventilation co-payment days (adjmvday – see Box 1.5) and any non-invasive ventilation co-payment days (adjnivday – see Box 1.6) from the LOS
- calculating the number of high outlier days (high_days) that are paid at the discounted HITH rate (hith_days) (this is the minimum of either the number of HITH LOS or high outlier days)
- adding the multi-day inlier weight (md_in), the number of high outlier HITH days (hith_days) by the high HITH per diem weight (hith_pd) and the number of remaining high outlier days (high_days – hith_days) by the high outlier per diem weight (ho_pd).

Technical details are provided in Box 1.13.

Box 1.13: Calculating base WIES26

```
If short_stay = 'S' and ACCTYPE1 = 'S' and ACCTYPE2 = blank and SEPACCOM = 'S' then
    Base_WIES = ss
    go to Box 1.14
Else select inlier
    case 'L' do
        select LOS_cat
            case 'S' do
                base_WIES = sd
                go to Box 1.14
            case 'O' do
                base_WIES = od
                go to Box 1.14
            case 'M' do
                base_WIES = od + (LOS – 1) × lo_pd
                go to Box 1.14
    case 'I' do
        select LOS_cat
            case 'S' do
                base_WIES = sd
                go to Box 1.14
            case 'O' do
                base_WIES = od
                go to Box 1.14
            case 'M' do
                base_WIES = md_in
                go to Box 1.14
    case 'H' do
        if hithLOS = missing then hithLOS = 0
        high_days = max(0, LOS – hb – adjmvday – adjnivday)
        hith_days = min(high_days, hithLOS)
        base_WIES = md_in + (high_days – hith_days) × ho_pd + (hith_days × hith_pd)
    go to Box 1.14
```

A1.1.5 Aboriginal and Torres Strait Islander loading

A 30 per cent WIES loading is paid to health services for treating Aboriginal and Torres Strait Islander patients in recognition of their higher costs of care. Technical details are provided in Box 1.14.

Box 1.14: Applying the Aboriginal and Torres Strait Islander loading

```
If Indigenous status in (1,2,3) then do
    Aboriginal and Torres Strait Islander_WIES =
    0.3*(base_WIES + mv_copay+ niv_copay + th_copay + AAA_copay + ASD_copay + Bilat_copay)
else
    ATSI_WIES = 0
    go to Box 1.15
```

A1.1.6 Calculating WIES cost weight

The WIES cost weight is calculated by adding base WIES, co-payment WIES and Aboriginal and Torres Strait Islander WIES. Details are provided in Box 1.15

Box 1.15: Calculating WIES cost weight

```
WIES = base_WIES + mv_copay+ niv_copay + th_copay + AAA_copay + ASD_copay + Bilat_copay + ATSI
_WIES
```

Addendum 1.2: Definition of WIES26 variables

Definitions and descriptions of each variable within the WIES26 formulae are provided in Table 1.34.

Table 1.34: WIES26 variables

Variable	Label	Description
Victorian DRG 9.0	VICDRG9.0	AR-DRG9.0 with Victorian modifications.
Mechanical ventilation co-payment	mv_elig	This describes the way invasive mechanical ventilation severity co-payments are made for VIC-DRG9.0. Options are: • D: funded if more than six hours of ventilation is provided. Patients attract a one-off payment of 0.6980 WIES plus a daily rate of 0.7659 WIES for patients in hospitals with appropriate ICU facilities. • 4: funded for each day of mechanical ventilation after four days. Patients attract a one-off payment of 0.6980 WIES plus a daily rate of 0.7659 WIES for patients in hospitals with appropriate ICU facilities. • I: ineligible for mechanical ventilation co-payments.
Non-invasive ventilation co-payment	Niv_elig	This describes the way non-invasive ventilation severity co-payments are made for VIC-DRG9.0. Options are: • D: funded if more than six hours of non-invasive ventilation is provided. Patients attract a daily rate of 0.7659 WIES for patients in hospitals with appropriate ICU facilities. • 1: funded for each day of non-invasive ventilation after one day. Patients attract a daily rate of 0.7659 WIES for patients in hospitals with appropriate ICU facilities. • I: ineligible for non-invasive ventilation co-payments. (Note: Patients are first tested for eligibility to attract a mechanical ventilation co-payment; and patients can only attract a non-invasive ventilation co-payment if they receive a 0 (zero) mechanical ventilation co-payment).
Other co-payment	copay	Some groups of patients attract additional funds in recognition of their higher costs. Options are: • Thal: a co-payment of 0.1089 WIES is made to patients with a reported ICD-10-AM thalassaemia diagnosis code of D56.x or D57.2. (Note: These do not have to be principal diagnoses.) • AAA: a co-payment of 3.1421 WIES for patients with the procedure code for the insertion of a stent for endovascular repair of aneurysm of the aorta (AAA stent). • ASD: a co-payment of 2.4713 for patients with a procedure code for using an ASD closure device. • Bilat: a co-payment of 5.0544 is made to patients with procedure codes for the bilateral implantation of cochlear prosthetic devices within the same (one) episode.
Inlier boundary – low	lb	The low LOS boundary for inliers. Patients with a LOS of less than the low boundary are classed as low outliers. For most VIC-DRG9.0s the low boundary has been set at a third of the estimated ALOS for the VIC-DRG9.0. Boundaries are truncated to the nearest whole number.
Inlier boundary – high	hb	The high LOS boundary for inliers. Patients with a LOS greater than the high boundary are classed as high outliers. For most VIC-DRG9.0s the high boundary has been set at three times the estimated ALOS for the VIC-DRG9.0. Boundaries are rounded to the nearest whole number.
Average inlier stay	I_alos	The ALOS (days) for inliers only (based on costed episodes and used to set the high-outlier per diem).

Variable	Label	Description
Short-stay unit DRG	short_stay	DRG designation for allocating the short-stay weight to patients admitted to and subsequently discharged from a short-stay observation unit. Options are: • S: Short-stay patients in this DRG are eligible for the short-stay weight that is based on the cost of short-stay patients only. • Blank: Short-stay patients in this DRG are not eligible for the short-stay weight (set to blank). Instead short-stay patients attract same-day, one-day or multi-day weights that include the costs of all patients (short-stay and non-short-stay patients).
Short-stay weight	ss	The short-stay weight is used to allocate WIES to patients admitted to and subsequently discharged from a short-stay observation unit, irrespective of LOS type (same-day, one-day or multi-day stay) and inlier status (inlier, low or high outlier). Short-stay observation unit patients are identified by: *ACCTYPE1='S' and ACCTYPE2=blank and SEPACCOM='S'* ***Designated short-stay VIC-DRG9.0s (marked as 'S')*** Short-stay weight is used to allocate WIES to short-stay patients and is based on the cost of short-stay patients. ***Non-designated short-stay unit VIC-DRG9.0s (blank value)*** Short-stay weight is blank (not used to allocate WIES to short-stay patients).
Same-day/one-day DRG		VIC-DRG9.0s marked as 'Same-day' have same-day weights based on the costs of same-day patients. VIC-DRG9.0s marked as 'One-day' have one-day and same-day weights based on the costs of patients with an LOS of one day. VIC-DRG9.0s with a blank value have same-day and one-day weights derived from the multi-day inlier weight. (Note: For short-stay designated VIC-DRG9.0s, short-stay patients are excluded from same-day, one-day and multi-day weights.)
Same-day weight	sd	The same-day weight is used to allocate WIES to patients admitted and separated on the same day. Depending on the VIC-DRG9.0, same-day patients may be either low outliers or inliers: ***Designated same-day VIC-DRG9.0s*** The same-day weight is based on the costs of same-day patients. ***Designated one-day VIC-DRG9.0s*** The same-day weight is based on the costs of patients with a LOS of one day. ***Non-designated VIC-DRG9.0s with a low boundary of zero days*** The same-day weight is set at the multi-day inlier weight. ***Non-designated VIC-DRG9.0s with a low boundary of one day*** The same-day weight is based on the average cost of multi-day inliers. For medical DRGs the weight is set at half of the multi-day inlier average cost. For non-medical DRGs the same-day weight is set at 100 per cent of theatre and prosthesis costs plus 50 per cent of the average for other costs. ***Non-designated VIC-DRG9.0s with a low boundary of two days or more (low outliers)*** The same-day weight is based on the average cost of multi-day inliers. For medical DRGs the same-day weight is set at half of the multi-day inlier average cost divided by the low boundary. For non-medical DRGs the same-day weight is set at 100 per cent of theatre and prosthesis costs plus 50 per cent of the average for other costs divided by the low boundary. (Note: For short-stay designated VIC-DRG9.0s, short-stay patients are excluded from same-day, one-day and multi-day weights.)
One-day weight	od	The one-day weight is used to allocate WIES to patients with an LOS of one-day that are admitted and separated on different days.

Variable	Label	Description
		Depending on the VIC-DRG9.0, one-day patients may be either low outliers or inliers: ***Designated same-day VIC-DRG9.0s*** The one-day weight is based on the costs of all inliers excluding same-day patients. If the patient is an inlier they attract the full multi-day inlier weight. For low outliers in medical DRGs the one-day weight is based on the average cost of multi-day inliers divided by the low boundary. For low outliers in non-medical DRGs the one-day weight is based on 100 per cent of the average theatre and prosthesis costs plus the average of other costs divided by the low boundary. ***Designated one-day VIC-DRG9.0s*** The one-day weight is based on the costs of patients with a LOS of one day. ***Non-designated VIC-DRG9.0s with a low boundary of zero or one day*** The one-day weight is set at the multi-day inlier weight. ***Non-designated VIC-DRG9.0s with a low boundary of two days or more (low outliers)*** For medical DRGs the one-day weight is based on the average cost of multi-day inliers divided by the low boundary. For non-medical DRGs the one-day weight is based on 100 per cent of the average theatre and prosthesis cost plus the average of other costs divided by the low boundary. (Note: For short-stay designated VIC-DRG9.0s, short-stay patients are excluded from same-day, one-day and multi-day weights.)
Multi-day low outlier per diem	lo_pd	The low outlier multi-day per diem weight is used to allocate WIES to low outliers who have a LOS of at least two days. Not all VIC-DRG9.0s have low outliers. No weight is reported in these cases. For most VIC-DRG9.0s the low outlier weight is derived from the average cost of multi-day inliers (excluding costs associated with setting the one-day weight) divided by the low boundary. (Note: A minimum criterion applies.) The base WIES for low outliers is calculated by multiplying the low outlier per diem by the patient's LOS less one day and adding the one-day weight: Low outlier WIES = od + (LOS –1) × lo_pd
Inlier weight	md_in	The inlier multi-day weight is used to allocate WIES to inliers that have an LOS of at least two days. For designated VIC-DRG9.0s, short-stay and same-day/one-day patients are excluded when deriving the inlier multi-day weight.
High outlier per diem	ho_pd	The high outlier multi-day per diem weight is used to allocate additional WIES for all days of stay in excess of the high boundary after adjusting for any mechanical ventilation co-payment days, non-invasive ventilation co-payment days and Hospital in the Home days. The high outlier multi-day per diem rate is based on the average cost of inliers (excluding all prosthesis and theatre costs for non-medical DRGs only) according to the following formula: ho_pd = high factor × (av. inlier cost less theatre and prosthesis costs for non-medical DRGs only) ÷ i_alos Where the high factor is set at 0.7 for surgical VIC-DRG9.0s and 0.8 for medical VIC-DRG9.0s to recognise that days at the end of a patient's stay are less resource intensive than days at the beginning of a patient's stay. Inlier ALOS (i_alos) is based on costed episodes. A number of variations exist on the general formula:

Variable	Label	Description
		1) The high factor is set at one or greater for some high-cost VICDRG9.0s. 2) Maximum and minimum criteria apply.
Hospital in the Home outlier per diem	hith_pd	The HITH high outlier multi-day per diem weight is used to allocate additional WIES for all days of stay in excess of the high boundary that can be attributed to HITH. These days can occur at any stage of the patient's treatment, including before the high boundary. For example, suppose a patient stayed seven days in hospital, followed by five days of HITH, but a complication occurred requiring another four days in hospital care and was subsequently allocated to a DRG with a high boundary of 10 days. The patient has a LOS of 16 days resulting in six high days, five of which will be paid at the HITH high outlier multi-day per diem rate and one of which will be paid at the high outlier per diem rate. The HITH high outlier multi-day per diem rate is based on 80 per cent of the high outlier per diem and subject to maximum and minimum criteria.

Addendum 1.3: Australian National Subacute and Non-acute Patient Classification technical specifications

A1.3.1 AN-SNAP version 4 classes

The admitted branch of AN-SNAP version 4 comprises 89 overnight admitted and five same-day classes for rehabilitation, geriatric evaluation and management, non-acute and palliative care. However, same-day classes will only be funded as admitted activity if the patient's separation mode falls into one of the following categories:

- death (code D)
- left against medical advice (code Z)
- separation and transfer to acute hospital/extended care (code T).

There is also an error class for each care type where episode type codes or age details are missing from the record. For the rehabilitation and palliative care types, a second error class is present to account for the adult and paediatric split.

Further information can be found on the AN-SNAP version 4 website <http://ahsri.uow.edu.au/aroc/an-snapv4/index.html>.

The weighting of each element of the FIM™ score for each impairment category is shown in Table 1.35.

Table 1.35: Impairment specific weightings for the FIM™ motor score

Impairment group	FIM™ eat1	FIM™ grm2	FIM™ bath3	FIM™ upp4	FIM™ low5	FIM™ toil6	FIM™ blad7	FIM™ bow8	FIM™ xfer9	FIM™ xftlt10	FIM™ tub11	FIM™ walk12	FIM™ stair13
Stroke	1.007	0.983	1.199	1.028	1.054	1.058	0.799	0.835	1.121	1.108	1.145	1.018	0.645
Brain Dysfunction	1.512	1.348	1.282	1.060	0.941	1.021	0.867	1.039	0.925	0.964	0.972	0.783	0.286
Neuro Conditions	1.143	1.239	1.225	0.817	0.935	1.082	0.671	0.787	1.132	1.175	1.278	0.897	0.619
Spinal Cord Dys	0.924	0.803	1.238	0.843	0.926	1.246	0.822	0.810	1.137	1.455	1.465	0.233	1.098
Amp of Limb	1.218	0.831	1.278	0.624	0.700	1.027	0.241	0.400	1.290	0.961	0.974	0.747	2.709
Arthritis	0.761	0.839	1.184	0.910	1.161	0.955	0.748	0.828	1.577	1.189	1.492	0.763	0.593
Pain Syndromes	0.984	1.016	1.325	0.687	0.937	1.108	0.828	0.751	1.416	1.341	1.461	0.781	0.365
Ortho Cond – Fract	0.934	0.903	1.201	0.707	0.935	1.053	0.771	1.100	1.405	1.303	1.332	0.828	0.528
Ortho Cond – Repl	1.184	0.872	1.194	0.809	1.013	1.081	0.744	0.998	1.400	1.235	1.317	0.668	0.485
Ortho Cond – Other	1.184	0.872	1.194	0.809	1.013	1.081	0.744	0.998	1.400	1.235	1.317	0.668	0.485
Cardiac	0.984	1.016	1.325	0.687	0.937	1.108	0.828	0.751	1.416	1.341	1.461	0.781	0.365
Pulmonary	0.984	1.016	1.325	0.687	0.937	1.108	0.828	0.751	1.416	1.341	1.461	0.781	0.365
Burns	0.761	0.839	1.184	0.910	1.161	0.955	0.748	0.828	1.577	1.189	1.492	0.763	0.593
Congen Deform	0.761	0.839	1.184	0.910	1.161	0.955	0.748	0.828	1.577	1.189	1.492	0.763	0.593
Oth Disabling Imps	0.761	0.839	1.184	0.910	1.161	0.955	0.748	0.828	1.577	1.189	1.492	0.763	0.593
MMT	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Devel Disabs	0.761	0.839	1.184	0.910	1.161	0.955	0.748	0.828	1.577	1.189	1.492	0.763	0.593
Reconditioning	1.077	0.938	1.181	0.717	0.887	1.084	0.795	0.924	1.282	1.307	1.330	0.930	0.548

Note: 1.FIM™ Eating, 2.FIM™ Grooming, 3.FIM™ Bathing, 4.FIM™ Upper body dressing, 5.FIM™ Lower body dressing, 6.FIM™ Toileting, 7.FIM™ Bladder management, 8.FIM™ Bowel management, 9. FIM™ Bed to chair transfer, 10.FIM™ Toilet transfer, 11.FIM™Shower transfer, 12.FIM™ Locomotion, 13.FIM™ Stairs.

A1.3.2 Grouping to AN-SNAP version 4

A1.3.2.1 Variables used in AN-SNAP version 4 classes

In the admitted branch, the variables used for grouping (not funding) are:

- care type – characteristics of the person and the goal of treatment
- function (motor and cognition) on admission – all care types
- phase (stage of illness) – palliative care
- impairment – rehabilitation
- delirium or dementia – geriatric evaluation and management (GEM)
- age – palliative care, rehabilitation, non-acute and to identify paediatric episode/phases
- length of stay (LOS) – psychogeriatric and non-acute
- same-day flag – to distinguish between same-day and overnight episodes/phases.

There are also two situations where required variables will not be available until the end of an episode:

- In the admitted GEM branch of the classification, diagnoses of delirium and dementia have been introduced as grouping variables. These diagnoses are coded after the episode has ended using the 10th edition of the *International statistical classification of diseases and related health problems*, 10th revision, Australian Modification (ICD-10-AM).
- The episode length of stay is required to assign an AN-SNAP class for non-acute and psychogeriatric episodes.

A1.3.2.2 Grouping process classes

The process of grouping records to AN-SNAP version 4 can be summarised as follows:

- Identify the record as admitted or non-admitted.
- Identify the care type based on the characteristics of the patient and the primary clinical purpose or treatment goal, rather than the specialisation of the treating physician or the type of facility in which the treatment is provided.
- For rehabilitation and palliative care, identify the record as adult or paediatric.
- Identify admitted records as overnight or same-day.
- Calculate total assessment scores where required, including the weighted FIM™ motor score for adult admitted rehabilitation.
- Group to AN-SNAP version 4 class.

A1.3.2.3 Grouping to admitted rehabilitation care classes

The variables used to define the rehabilitation classes include impairment, age, FIM™ cognition score and a weighted FIM™ motor score.

In AN-SNAP version 4 there are 59 classes for admitted rehabilitation care, specifically:

- 50 admitted adult overnight classes (Table 1.36)
- five admitted paediatric overnight classes (Table 1.37)
- two admitted same-day classes – one for adult and one for paediatric care
- two error classes – one for adult and one for paediatric care.

Table 1.36: Adult admitted rehabilitation care classes

Code	Description
4AZ1	Weighted FIM™ motor score 13–18, Brain, Spine, MMT, Age ≥ 49
4AZ2	Weighted FIM™ motor score 13–18, Brain, Spine, MMT, Age ≤ 48
4AZ3	Weighted FIM™ motor score 13–18, All other impairments, Age ≥ 65
4AZ4	Weighted FIM™ motor score 13–18, All other impairments, Age ≤ 64
4AA1	Stroke, weighted FIM™ motor score 51–91, FIM™ cognition 29–35
4AA2	Stroke, weighted FIM™ motor score 51–91, FIM™ cognition 19–28
4AA3	Stroke, weighted FIM™ motor score 51–91, FIM™ cognition 5–18
4AA4	Stroke, weighted FIM™ motor score 36–50, Age ≥ 68
4AA5	Stroke, weighted FIM™ motor score 36–50, Age ≤ 67
4AA6	Stroke, weighted FIM™ motor score 19–35, Age ≥ 68
4AA7	Stroke, weighted FIM™ motor score 19–35, Age ≤ 67
4AB1	Brain dysfunction, weighted FIM™ motor score 71–91, FIM™ cognition 26–35
4AB2	Brain dysfunction, weighted FIM™ motor score 71–91, FIM™ cognition 5–25
4AB3	Brain dysfunction, weighted FIM™ motor 41–70, FIM™ cognition 26–35
4AB4	Brain dysfunction, weighted FIM™ motor score 41–70, FIM™ cognition 17–25
4AB5	Brain dysfunction, weighted FIM™ motor score 41–70, FIM™ cognition 5–16
4AB6	Brain dysfunction, weighted FIM™ motor score 29–40
4AB7	Brain dysfunction, weighted FIM™ motor score 19–28
4AC1	Neurological conditions, weighted FIM™ motor score 62–91
4AC2	Neurological conditions, weighted FIM™ motor score 43–61
4AC3	Neurological conditions, weighted FIM™ motor score 19–42
4AD1	Spinal cord dysfunction, Age ≥ 50, weighted FIM™ motor score 42–91
4AD2	Spinal cord dysfunction, Age ≥ 50, weighted FIM™ motor score 19–41
4AD3	Spinal cord dysfunction, Age ≤ 49, weighted FIM™ motor score 34–91
4AD4	Spinal cord dysfunction, Age ≤ 49, weighted FIM™ motor score 19–33
4AE1	Amputation of limb, Age ≥ 54, weighted FIM™ motor score 68–91
4AE2	Amputation of limb, Age ≥ 54, weighted FIM™ motor score 31–67
4AE3	Amputation of limb, Age ≥ 54, weighted FIM™ motor score 19–30
4AE4	Amputation of limb, Age ≤ 53, weighted FIM™ motor score 19–91
4AH1	Orthopaedic conditions, fractures, weighted FIM™ motor score 49–91, FIM™ cognition 33–35
4AH2	Orthopaedic conditions, fractures, weighted FIM™ motor score 49–91, FIM™ cognition 5–32
4AH3	Orthopaedic conditions, fractures, weighted FIM™ motor score 38–48
4AH4	Orthopaedic conditions, fractures, weighted FIM™ motor score 19–37
4A21	Orthopaedic conditions, all other (including replacements), weighted FIM™ motor score 68–91
4A22	Orthopaedic conditions, all other (including replacements), weighted FIM™ motor score 50–67

Code	Description
4A23	Orthopaedic conditions, all other (including replacements), weighted FIM™ motor score 19–49
4A31	Cardiac, Pain syndromes, Pulmonary, weighted FIM™ motor score 72–91
4A32	Cardiac, Pain syndromes, Pulmonary, weighted FIM™ motor score 55–71
4A33	Cardiac, Pain syndromes, Pulmonary, weighted FIM™ motor score 34–54
4A34	Cardiac, Pain syndromes, Pulmonary, weighted FIM™ motor score 19–33
4AP1	Major Multiple Trauma, weighted FIM™ motor score 19–91
4AR1	Reconditioning, weighted FIM™ motor score 67–91
4AR2	Reconditioning, weighted FIM™ motor score 50–66, FIM™ cognition 26–35
4AR3	Reconditioning, weighted FIM™ motor score 50–66, FIM™ cognition 5–25
4AR4	Reconditioning, weighted FIM™ motor score 34–49, FIM™ cognition 31–35
4AR5	Reconditioning, weighted FIM™ motor score 34–49, FIM™ cognition 5–30
4AR6	Reconditioning, weighted FIM™ motor score 19–33
4A91	All other impairments, weighted FIM™ motor score 55–91
4A92	All other impairments, weighted FIM™ motor score 33–54
4A93	All other impairments, weighted FIM™ motor score 19–32
4J01	Adult same-day rehabilitation
499A	Adult overnight rehabilitation – ungroupable

Table 1.37: Paediatric admitted rehabilitation care classes

Code	Description
4F01	Rehabilitation, Age ≤ 3
4F02	Rehabilitation, Age ≥ 4, Spinal cord dysfunction
4F03	Rehabilitation, Age ≥ 4, Brain dysfunction
4F04	Rehabilitation, Age ≥ 4, Neurological conditions
4F05	Rehabilitation, Age ≥ 4, All other impairments
4O01	Paediatric same-day rehabilitation
499F	Paediatric overnight rehabilitation – ungroupable

The calculation of the AN-SNAP version 4 admitted rehabilitation class is as follows:

- Determine if record is an adult (adult ≥ 18 years) or paediatric (age ≤17 years).

For adults:

- Same-day records are split from the overnight records into a single class.
- For the overnight admitted episodes:
  - Determine the impairment group that is derived from the AROC Impairment Code.
  - Calculate a weighted FIM™ motor score by multiplying each FIM™ item score by the corresponding weight for the impairment group of the record.
  - Sum the weighted scores to create a weighted FIM™ motor score for each episode.
  - Sum the five FIM™ cognition scores.
  - Add the weighted FIM™ motor score with the sum of the FIM™ cognition score.
  - Overnight admitted episodes are spilt using the weighted FIM™ motor score into a lower function (FIM™ 13–18) and a higher function group (FIM™ ≥19).

  - Episodes are further split by impairment group.
  - All impairment groups except for MMT are then split using a combination of the weighted FIM™ motor score, the FIM™ cognition score and age to create the AN-SNAP version 4 classes.

For paediatric:

- Same-day records are split from the overnight records into a single class.
- For the overnight admitted episodes:
  - Episodes where the patient's age on admission is three or less are split into a single class.
  - Episodes where the patient's age is four years or more are then split into four groups of impairment categories.

A1.3.2.4 Grouping to admitted palliative care classes

Palliative care activity is different from the other subacute activity because there can be multiple phases within one episode. The different types of phases are used to derive an AN-SNAP version 4 class. This means that for an episode of care (between admission and separation) there may be multiple AN-SNAP version 4 classes, each with a different subacute WIES. Also, some classes may be repeated in the episode because palliative care phases are not sequential, and a patient may move back and forth between phases.

In addition to a palliative care phase, the total score on the Resource Utilisation Groups – Activities of Daily Living (RUG-ADL) tool, age and a derived variable, 'first phase in episode', which distinguishes a phase at the beginning of an episode from the subsequent phases of a palliative care episode are variables that are used to derive a palliative care class.

In AN-SNAP version 4 there are 20 classes for admitted palliative care:

- 12 admitted adult overnight classes (Table 1.38)
- four admitted paediatric overnight classes (Table 1.39)
- two admitted same-day classes – one for adult and one for paediatric care
- two error classes – one for adult and one for paediatric care.

Table 1.38: Admitted palliative care classes

Code	Description
4BS1	Stable phase, RUG-ADL 4–5
4BS2	Stable phase, RUG-ADL 6–16
4BS3	Stable phase, RUG-ADL 17–18
4BU1	Unstable phase, First phase in episode, RUG-ADL 4–13
4BU2	Unstable phase, First phase in episode, RUG-ADL 14–18
4BU3	Unstable phase, Not first phase in episode, RUG-ADL 4–5
4BU4	Unstable phase, Not first phase in episode, RUG-ADL 6–18
4BD1	Deteriorating phase, RUG-ADL 4–14
4BD2	Deteriorating phase, RUG-ADL 15–18, Age ≥ 75
4BD3	Deteriorating phase, RUG-ADL 15–18, Age 55–74
4BD4	Deteriorating phase, RUG-ADL 15–18, Age ≤ 54
4BT1	Terminal phase
4K01	Adult same-day palliative care
499B	Adult overnight palliative care – ungroupable

Table 1.39: Admitted paediatric palliative care classes

Code	Description
4G01	Palliative care, Not terminal phase, Age < 1 year
4G02	Palliative care, Stable phase, Age ≥ 1 year
4G03	Palliative care, Unstable or deteriorating phase, Age ≥ 1 year
4G04	Palliative care, Terminal phase
4P01	Paediatric same-day palliative care
499G	Paediatric overnight palliative care – ungroupable

The calculation of the AN-SNAP version 4 admitted palliative care class is as follows:

- Determine if record is an adult or paediatric.

For adults:

- Same-day records are split from the overnight records into a single class.
- For the overnight admitted episodes:
  - RUG-ADL item scores are added to create a RUG-ADL total score.
  - Split into four groups based on the palliative care phase.
  - For the stable phase, split using the RUG-ADL total score.
  - For the unstable phase, split based on whether the phase is the first phase of an episode, and then by the RUG-ADL total score.
  - For the deteriorating phase, split by the RUG-ADL total score and age (if RUG-ADL total score 15–18).

For paediatric classes:

- Same-day records are split from the overnight records into a single class.
- For the overnight admitted episodes:
  - RUG-ADL item scores are added to create a RUG-ADL total score.
  - Split into two groups based on the terminal phase or not terminal phase.
  - The 'Not terminal phase' group is split based on age. If age ≥ 1, then split based on the stable or unstable/deteriorating phase.

A1.3.2.5 Grouping to admitted geriatric evaluation and management classes

The variables used to define the admitted GEM classes are the FIM™ motor score (the sum of the first 13 items of the FIM™ tool) and 10th edition ICD-10-AM diagnosis (dementia and delirium).

In AN-SNAP version 4 there are eight classes for admitted GEM (Table 1.40):

- six admitted overnight classes
- one admitted same-day class
- one error class.

Table 1.40: Geriatric evaluation and management classes

Code	Description
4CH1	FIM™ motor 57–91 with delirium or dementia
4CH2	FIM™ motor 57–91 without delirium or dementia
4CM1	FIM™ motor 18–56 with delirium or dementia
4CM2	FIM™ motor 18–56 without delirium or dementia
4CL1	FIM™ motor 13–17 with delirium or dementia
4CL2	FIM™ motor 13–17 without delirium or dementia
4L01	Same-day GEM
499C	Overnight GEM – ungroupable

The calculation of the AN-SNAP version 4 admitted GEM class is as follows:

- Same-day records are split from the overnight records into a single class.
- For the overnight admitted episodes:
  - FIM™ item scores are added to create a FIM™ total score.
  - Split records by FIM™ total score.
  - Split records based whether or not any of the diagnoses recorded for the patient is delirium or dementia.

A1.3.2.6 Grouping to admitted non-acute care classes

The variables used to define the admitted non-acute classes are LOS, total RUG-ADL score and age. In AN-SNAP version 4 there are seven admitted non-acute care (formerly called 'maintenance') classes (Table 1.41).

Table 1.41: Non-acute classes

Code	Description
4ES1	Age ≥ 60, RUG-ADL 4–11, LOS ≤ 91
4ES2	Age ≥ 60, RUG-ADL 12–15, LOS ≤ 91
4ES3	Age ≥ 60, RUG-ADL 16–18, LOS ≤ 91
4ES4	Age 18–59, LOS ≤ 91
4ES5	Age ≤ 17, LOS ≤ 91
4EL1	Long-term care
499E	Overnight non-acute care – ungroupable

The calculation of the AN-SNAP version 4 admitted non-acute class is as follows:

- For the overnight admitted episodes:
  - Episodes are split into two groups based on LOS (≤ 91 or ≥ 92).
  - For episodes where LOS is ≤ 91, spilt by age.
  - RUG-ADL item scores are added to create a RUG-ADL total score.
  - Split 'Age ≥ 60' group by RUG-ADL total score.

A1.3.2.7 Grouping to error classes

If, at any step in the care type grouping process described above, a variable is missing or invalid, the episode/phase will be assigned to the error class for the relevant care type/treatment setting combination. It should be noted that some clinical tools include an option for 'not assessed'. If this score is used, the total cannot be calculated, and the record would be assigned to an error class.

Addendum 1.4: Calculating subacute WIES for individual patients

To calculate the subacute WIES funding allocated to a patient:

- Determine if the episode is eligible for subacute WIES funding (see Box 1.16).
- Calculate the base subacute WIES allocation using AN-SNAP version 4 and the patient's LOS adjusted for the high outlier days (see Box 1.16 to Box 1.22) – this can be done using the appropriate weights from the subacute WIES weights table (see Table 1.21).
- Apply the Aboriginal and Torres Strait Islander loading if applicable (see Box 1.24).
- Add the base subacute WIES payment and Aboriginal and Torres Strait Islander loading (see Box 1.24).

The steps are described in detail below with technical specifications provided in boxes.

A1.4.1 Subacute WIES eligibility

The majority of admitted subacute patients in hospital will be allocated a subacute WIES cost weight; however, subacute WIES cannot be calculated for incomplete or uncoded episodes.

Subacute WIES cost weights are sometimes allocated to patient episodes that are ineligible for casemix funding. Subacute WIES from these episodes will need to be excluded when comparing health service activity against targets during 2019–20.

Eligible patients are entitled to base subacute WIES payments and may also be entitled to subacute WIES loadings. Base subacute WIES payments are made according to the formula derived from the average costs for patients in each AN-SNAP version 4 class. Subacute WIES loadings are made to cover the higher costs of care provided to certain types of patients.

Base subacute WIES payments for long-stay patients can be affected by co-payments, so it is advisable to determine if a patient is eligible for subacute WIES co-payments first.

Box 1.16: Episodes eligible for subacute WIES funding

All episodes in the VAED with a care type of:

- 6 – Designated Rehabilitation Program/Unit
- P – Designated Paediatric Rehabilitation Program/Unit
- 8 – Palliative Care Program
- 9 – Geriatric Evaluation and Management Program
- MC – Maintenance Care.

Except for:

- private hospital separations
- incomplete or uncoded episodes, or episodes coded to an ungroupable AN-SNAP V4.0 (zero weight) including AN-SNAP V4.0 499A (Adult Overnight Rehabilitation – Ungroupable), 499B (Adult Overnight Palliative Care – Ungroupable), 499C (Overnight GEM – Ungroupable), 499E (Overnight Non-acute Care – Ungroupable), 499F (Paediatric Overnight Rehabilitation – Ungroupable), 499G (Paediatric Overnight Palliative Care – Ungroupable)
- episodes with an account class on separation of W* (Victorian WorkCover Authority), T* (Transport Accident Commission), X* (Ineligible non-Australian residents – not exempted from fees), A* (Armed Services), C* (Common Law Recoveries), O* (Other compensable) or S* (Seamen)
- episodes where the contract role is B (service provider hospital)
- episodes from hospitals not eligible for subacute WIES funding
- same-day episodes with a separation mode G (Posthumous Organ Procurement), S (Statistical Separation), B (Separation and transfer to Transition Care bed-based program), A (Separation and transfer to mental health residential facility), N (Separation and transfer to aged care residential facility) and H (Separation to private residence/accommodation).

While contracted patients are allocated a subacute WIES score, they are not eligible for subacute WIES funding.

A1.4.2 Base subacute WIES

A1.4.2.1 Rehabilitation care and geriatric evaluation and management

To calculate a patient's base subacute WIES for rehabilitation (care type 6 and P) and geriatric evaluation and management care (care type 9), you need to determine the patient episode:

- AN-SNAP class
- length of stay (LOS)
- inlier equivalence ('I' or inlier, 'L' or low outlier, 'H' or high outlier).

The patient's LOS and LOS category are derived from the admission date, separation date and leave days. Technical specifications are provided in Box 1.17.

The patient's inlier funding equivalence is determined by comparing the patient's LOS with the inlier boundaries for the AN-SNAP version 4 class to which the patient is classified. The low and high inlier boundaries are given in the subacute WIES4 cost weights table.

A patient is funded as an inlier when their LOS is greater than or equal to the low inlier boundary and less than or equal to the high inlier boundary.

Patients with a LOS less than the low inlier boundary are funded as low outliers. Patients with a LOS greater than the high inlier boundary are funded as high outliers. Technical specifications are provided in Box 1.17.

Box 1.17: Calculating inlier funding equivalence

```
If LOS < lb then
    Inlier = 'L'
    go to Box 1.18
else if LOS > (hb) then
    Inlier = 'H'
    go to Box 1.18
else
    Inlier = 'I'
    go to Box 1.18
```

Separate columns occur in the subacute WIES cost weights table for:

- low outlier per diem weight
- inlier weights
- high outlier per diem weight.

The base subacute WIES cost weight for inliers can be read directly from the subacute WIES4 cost weights table using the appropriate column and row (AN-SNAP version 4).

The base subacute WIES4 cost weight for low outliers can be calculated by multiplying the low outlier per diem weight given in the subacute WIES4 cost weights table by the patient episode's LOS.

The base subacute WIES4 cost weight for high outliers is obtained by:

- calculating the number of high outlier days (high_days) by subtracting the high boundary from the LOS
- adding the inlier weight (in), and the number of high outlier days (high_days) by the high outlier per diem weight (ho_pd).

Technical details are provided in Box 1.18.

In 2019–20 a separate loading to SWIES for level 5 statewide specialist spinal rehabilitation services has been calculated by the department. This will be provided separately to these health services.

Box 1.18: Calculating base rehabilitation care and geriatric evaluation and management subacute WIES

```
Select inlier
    case 'L' do
        base_Subacute WIES = LOS × lo_pd
        go to Box 1.24
    case 'I' do
        base_Subacute WIES = in
        go to Box 1.24
    case 'H' do
        high_days = max(0, LOS – hb)
        base_Subacute WIES = in + (high_days × ho_pd)
        go to Box 1.24
```

A1.4.2.2 Non-acute care

To calculate a patient's base subacute WIES for non-acute care (care type MC), you need to determine the patient episode:

- LOS.

The patient's LOS is derived from the admission date, separation date and leave days. Technical specifications are provided in Box 1.19.

Box 1.19: Calculating the non-acute care base subacute WIES

base_Subacute WIES = LOS x pd
go to Box 1.24

A1.4.2.3 Department of Veterans' Affairs nursing home type

To calculate a patient's base subacute WIES for Department of Veterans' Affairs nursing home type care (care type NHT), you need to determine the patient episode:

- LOS.

The patient's LOS is derived from the admission date, separation date and leave days. Technical specifications are provided in Box 1.20.

Box 1.20: Calculating the Department of Veterans' Affairs nursing home type care base subacute WIES

base_Subacute WIES = LOS x pd
go to Box 1.24

A1.4.2.4 Palliative care

To calculate a patient's base subacute WIES4 for palliative care (care type 8) you need to determine the:

- subacute WIES for each phase of care using the LOS of each phase
- AN-SNAP class
- leave days for the whole episode
- inlier equivalence ('I' or inlier, 'L' or low outlier, 'H' or high outlier).

The patient's LOS and LOS category are derived from the admission date, separation date and leave days for each phase. Technical specifications are provided in Box 1.21 and Box 1.22.

The patient's inlier funding equivalence is determined by comparing the patient's LOS with the inlier boundaries for the AN-SNAP version 4 class to which the patient is classified. The low and high inlier boundaries are given in the subacute WIES4 cost weights table.

A patient is funded as an inlier when their LOS is greater than or equal to the low inlier boundary and less than or equal to the high inlier boundary.

Patients with a LOS less than the low inlier boundary are funded as low outliers. Patients with a LOS greater than the high inlier boundary are funded as high outliers. Technical specifications are provided in Box 1.21.

Box 1.21: Calculating base palliative care subacute WIES for each phase of care

```
If LOS < lb then
    Inlier = 'L'
    go to Box 1.22
else if LOS > (hb) then
    Inlier = 'H'
    go to Box 1.22
else
    Inlier = 'I'
    go to Box 1.22
```

Separate columns occur in the subacute WIES cost weights table for:

- low outlier per diem weight
- inlier weights
- high outlier per diem weight.

The base subacute WIES cost weight for inliers can be read directly from the subacute WIES4 cost weights table using the appropriate column and row (AN-SNAP V4). The base subacute WIES4 cost weight for low outliers can be calculated by multiplying the low outlier per diem weight given in the subacute WIES4 cost weights table by the patient episode's LOS.

The base subacute WIES4 cost weight for high outliers is obtained by:

- calculating the number of high outlier days (high_days) by subtracting the high boundary from the LOS
- adding the inlier weight (in), and the number of high outlier days (high_days) by the high outlier per diem weight (ho_pd).

Technical details are provided in Box 1.22.

Box 1.22: Calculating base palliative care subacute WIES for each phase of care

```
Select inlier
    case 'L' do
        base_Subacute WIES = LOS × lo_pd
        go to Box 1.23
    case 'I' do
        base_Subacute WIES = in
        go to Box 1.23
    case 'H' do
        high_days = max (0, LOS – hb)
        base_Subacute WIES = in + (high_days × ho_pd)
        go to Box 1.23
```

Box 1.23: Calculating base subacute WIES for each palliative care episode

If age ≤ 17 then:

base_Subacute WIES = sum (phase of care base_Subacute_WIES) – (leave days of episode X Paediatric Same-Day Palliative Care inlier weight (AN-SNAP Code 4P01))

go to Box 1.24

If age ≥ 18 then

base_Subacute WIES = sum (phase of care base_Subacute_WIES) – (leave days of episode X Adult Same-Day Palliative Care inlier weight (AN-SNAP Code 4K01))

go to Box 1.24

A1.4.3 Aboriginal and Torres Strait Islander loading

A 30 per cent subacute WIES loading is paid to health services for treating Aboriginal and Torres Strait Islander patients in recognition of their higher costs of care. Technical details are provided in Box 1.24.

Box 1.24: Applying the Aboriginal and Torres Strait Islander loading

If Indigenous status in (1,2,3) then do

    Aboriginal and Torres Strait Islander_Subacute WIES =

    0.3*(base_Subacute WIES)

else

    Aboriginal and Torres Strait Islander_Subacute WIES = 0

    go to Box 1.25

A1.4.4 Calculating subacute WIES cost weight

The subacute WIES cost weight is calculated by adding base subacute WIES and Aboriginal and Torres Strait Islander subacute WIES. Details are provided in Box 1.25.

Box 1.25: Calculating subacute WIES cost weight

Subacute WIES = base_Subacute WIES + Aboriginal and Torres Strait Islander_Subacute WIES

Addendum 1.5: Definition of subacute WIES variables

Definitions and descriptions of each variable within the subacute WIES formulae are provided in Table 1.42.

Table 1.42: Subacute WIES variables

Variable	Label	Description
AN-SNAP	AN-SNAP V4	Australian National Subacute and Non-Acute Patient Classification System Version 4.
Inlier boundary – low	lb	The low LOS boundary for inliers. Patients with a LOS of less than the low boundary are classed as low outliers. For most AN-SNAP V4s the low boundary has been set at –4 days of the ALOS for the AN-SNAP Version 4 Boundaries are truncated to the nearest whole number. This variable applies to rehabilitation, geriatric evaluation and management, and palliative care.
Inlier boundary – high	hb	The high LOS boundary for inliers. Patients with a LOS greater than the high boundary are classed as high outliers. For most AN-SNAP V4.0s the high boundary has been set at +4 days of the estimated ALOS for the AN-SNAP Version 4. Boundaries are rounded to the nearest whole number. This variable applies to rehabilitation, geriatric evaluation and management, and palliative care.
Average inlier stay	I_alos	The ALOS (days) for inliers only (based on costed episodes and used to set the high-outlier per diem). This variable applies to rehabilitation, geriatric evaluation and management, and palliative care.
Low outlier	lo_pd	The low outlier multi-day per diem weight is used to allocate subacute WIES to low outliers who have a LOS less than the low inlier boundary. For most AN-SNAP Version 4s the low outlier weight is derived from the average cost of multi-day inliers (excluding costs associated with setting the one-day weight) divided by the low boundary. (Note: A minimum criterion applies.) The base subacute WIES for low outliers is calculated by multiplying the low outlier per diem by the patient's LOS: Low outlier subacute WIES =LOS × lo_pd This variable applies to rehabilitation, geriatric evaluation and management, and palliative care.
Inlier weight	in	The inlier multi-day weight is used to allocate subacute WIES to inliers. This variable applies to rehabilitation, geriatric evaluation and management, and palliative care.
High outlier per diem	ho_pd	The high outlier multi-day per diem weight is used to allocate additional subacute WIES for all days of stay in excess of the high boundary. The high outlier multi-day per diem rate recognises that days at the end of a patient's stay are less resource intensive than days at the beginning of a patient's stay. This variable applies to rehabilitation, geriatric evaluation and management, and palliative care.
Bed day weight	pd	This bed day weight applies to non-acute care.

Addendum 1.6: Weighted ambulatory service events – technical specifications

A1.6.1 Introduction

The weighted ambulatory service event (WASE) funding model was introduced in 2017–18 to replace block grant funding for acute specialist clinics in Victoria. It is an activity-based funding model that:

- aligns Victorian specialist clinics funding with national funding models
- drives technical and allocative efficiency
- provides funding accountability and transparency
- encourages improved specialist clinics data reporting.

The WASE model is underpinned by concepts such as service events, the Tier 2 classification system, public and MBS-billed activity, new and review activity and single and multiple healthcare provider activity. The WASE model uses data from various systems to calculate WASE funding:

- The Non-Admitted Clinic Management System (NACMS) is used to classify activity.
- The Victorian Integrated Non-Admitted Health Minimum Dataset (VINAH) is used to calculate review and multiple healthcare provider service event proportions.
- The Agency Information Management System (AIMS) S10 form is used to obtain total service event counts.
- The Victorian Cost Data Collection (VCDC) data is used to calculate cost weights.

Victoria's casemix funding model allocates funding based on the numbers and types of patients treated and the average cost of treating patients. In practice, casemix funding requires classifying patients with similar clinical conditions and similar levels of resources used into diagnostic related groups or Tier 2 classes, counting the number of patients treated and costing them.

A1.6.2 Classification – Tier 2

The WASE model uses the Tier 2 non-admitted Services Classification to classify activity. The Tier 2 Non-admitted Services Classification is the national non-admitted classification system. It was developed by the Independent Hospital Pricing Authority (IHPA) and is used by the Commonwealth Government to calculate national funding contributions to Victorian non-admitted activity.

Tier 2 categorises a hospital's non-admitted services into classes that are generally based on the nature of the service provided and the type of clinician providing the service. The structure of the classification is first differentiated by the nature of the non-admitted service provided. The major categories are:

- procedures (10.01 to 10.20)
- medical consultation services (20.01 to 20.55)
- diagnostic services (30.01 to 30.08)
- allied health and/or clinical nurse specialist intervention services (40.02 to 40.61).

The next level of the classification is the type of clinician providing the service. This could be based on the specialty or profession of the clinician. For example, a clinic run by a cardiothoracic surgeon who sees patients before and after cardiac surgery is classified to the cardiothoracic (20.23) Tier 2 class. A clinic run by an obstetrician who sees women for consultations before they give birth is classified to the obstetrics (20.40) Tier 2 class. A clinic run by a physiotherapist who sees patients for consultations and treatments is classified to the physiotherapy (40.09) Tier 2 class.

There are also several classes for specialist clinics, which treat patients with specific conditions. For example, there is a class for specialist burns clinics (40.31), transplant clinics (20.01) and cystic fibrosis clinics (20.20).

Classification rules exist to guide the decision making regarding which Tier 2 class a clinic should be classified to. The IHPA has developed two reference documents to help with consistently allocating non-admitted services to a Tier 2 class. These documents are:

- *Tier 2 Non-Admitted Services Compendium*
- *Tier 2 Non-Admitted Services National Index*.

Further information about the Tier 2 classification system, including these documents, can be found at Tier 2 Non-Admitted Care Services Classification – IHPA website <https://www.ihpa.gov.au/what-we-do/tier-2-non-admitted-care-services-classification>.

Victoria groups each Tier 2 class funded by the WASE funding model into one of 39 Vic-Tier 2 (proportion) groups, based on costs reported by health services to the Victorian Cost Data Collection.

A1.6.3 Tier 2 classes in Victorian systems

All health services classified as an Activity Based Funded health service or Small Rural Health Service under the National Health Reform Agreement must register non-admitted clinics with the department. Clinics are registered in the Non Admitted Clinic Management System (NACMS). This can be done via the HealthCollect portal.

When hospitals register new MBS-billed clinics with the department, the remuneration model must be specified. This change was implemented in 2018 to the department's NACMS. Hospitals are required to review their registered clinics regularly and ensure the MBS remuneration model has been correctly identified for each registered clinic.

Further information about NACMS can be found in the NACMS manual, accessible at the Non Admitted Clinic Management System (NACMS) Manual 2018–19 webpage <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/nacms-manual-2018-19>.

All health services must identify and classify their non-admitted clinics providing acute clinical services to the most appropriate Tier 2 class. This process occurs when registering the clinic in NACMS, available on the HealthCollect portal, prior to submitting activity on the S10 form. S10 users can view registered non-admitted clinic details on HealthCollect or run reports to view registered clinics.

Service events are reported in the AIMS S10 against clinics that have been registered in NACMS.

Every VINAH acute non-admitted contact reported (that is, Program/Stream between 101 and 406) must include a Clinic Identifier. The Clinic Identifier must exactly match the code, which has been registered in NACMS. This is how the Tier 2 class is determined in VINAH. If the Clinic Identifier is not an exact match, the Tier 2 class cannot be determined.

A1.6.4 Counting

The WASE model is based on the national 'non-admitted patient service event' unit of count.

A non-admitted patient service event is defined as an interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record. The interaction may be for assessment, examination, consultation, treatment and/or education.

The WASE model funds health services according to the aggregate number of service events reported to the AIMS S10: Acute Non-Admitted Clinic Activity form. Both group and individual service events reported to AIMS are included. Health services can access reports through the HealthCollect portal to see their AIMS reported service events. VINAH will only be used to calculate review proportions and multiple healthcare provider service event proportions.

Counting rules:

- Services provided to patients in the admitted or emergency department settings will not be counted as non-admitted patient service events.

- Only one non-admitted patient service event may be counted for a patient in a clinic on a given calendar day. It is irrelevant whether the patient was seen jointly or separately by multiple providers on a given calendar day, even in a clinic with multiple healthcare providers, only one service event will be counted.
- Non-admitted clinics where services are provided by multiple healthcare providers must not be registered as separate clinics to count increased non-admitted patient service events.
- If the service, or any part of the service, is funded through the MBS, the service event is counted as a 'private' service event.
- Diagnostic services (such as pathology and diagnostic imaging) are not counted as non-admitted service events and are considered an input or intermediate product to the specialist clinic appointment. These services must be linked to the related appointment in costing data submitted to the department.
- Non-admitted service events delivered via telehealth where two public hospital service non-admitted clinics are involved are counted twice. One service event is counted at the clinic where the patient attends and one service event is counted at the clinic providing the consultation.
- For multiple non-admitted patient service events to be counted on a given day, the patient will have attended separate clinics where they received a service that meets the definition of a non-admitted patent service event.
- Care provided to two or more patients by the same service provider(s) at the same time can also be referred to as a group session when the patients within the group receive the same service. One service event is recorded for each patient who attends a group session regardless of the number of healthcare providers present where the definition of a non-admitted patient service event is met.
- Patient education services can be reported where they meet the definition of a non-admitted patient service event. Staff education and training must not be reported as a non-admitted patient service event.

A1.6.4.1 Service events in the Agency Information Management System (AIMS)

AIMS service events from the AIMS S10 form are used to calculate the total count of service events for the WASE funding model.

AIMS reported acute non-admitted activity must be within the scope of a non-admitted public hospital service as determined annually by the IHPA. For 2019–20, the detailed definition of what falls within the scope of a non-admitted public hospital service is contained in the *Pricing framework for Australian public hospital services* <https://www.ihpa.gov.au/publications/pricing-framework-australian-public-hospital-services-2019-20>.

For more information about the AIMS data collection, see the *Agency Information Management System (AIMS) manual* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/aims-manual-2018-19>.

Health services can access reports through the HealthCollect portal to see their AIMS-reported service events.

A1.6.4.2 Service events in the Victorian Integrated Non-Admitted Health (VINAH) minimum dataset

In the WASE model, VINAH is used to calculate review and multiple healthcare provider (MHCP) service event proportions for each Vic-Tier 2 group for each health service. Twenty-eight health services currently report specialist clinic data to VINAH. VINAH is also used to calculate the statewide proportions to apply to those services that do not report VINAH data.

The VINAH model consists of an episode of care around which referral and contact information is collected. A healthcare organisation receives a patient referral to their service. If the organisation accepts the referral, the patient is registered in the patient administration system and an episode of care begins.

During the episode, the organisation has various contacts with the patient during which services are delivered. At the end of, or during, the episode the patient may be referred to another service.

Contacts are reported to VINAH, and these have different counting rules from service events. The department derives service events based on the parameters outlined in the following paragraphs.

A contact is between a patient (or other relevant person) and a professional associated with a VINAH reporting program that results in a dated entry being made in the patient's health record.

A contact must meet all the following criteria:

- be clinically significant in nature
- be provided (or brokered) by an agency funded by a program area that requires reporting via the VINAH minimum dataset
- be for a patient who has provided consent (either implied or explicit)
- result in a dated entry in the clinical record of the patient (or a reference to a clinical record held by the brokered service).

VINAH consists of various linked data structures that reflect aspects of service delivery within a healthcare setting. This information is structured consistently and is periodically submitted to the department. The submission process builds in validation and reporting to make data quality an integral part of the data life cycle.

It is worth noting that not all health services that receive acute specialist clinics funding report to VINAH and other health services report significantly less activity to VINAH compared to their AIMS submission. Therefore, VINAH service event counts are not used to calculate a health service's total service event count. The department is working with health services to improve patient level activity data.

For all activity in-scope for WASE funding, the derivation of service events is the same. See Box 1.26 for inclusion criteria.

Box 1.26: VINAH contact inclusion criteria for the derivation of service events

For contacts to be included in service events, they must comply with all of the following criteria:

- The contact must be direct.
  Contact Session Type NOT EQUAL TO '3 – Indirect contact'
- The patient must be present at the contact.
  Contact Client Present Status IS EQUAL TO '10', '11', '12' or '13'.
- The contact must be delivered in person, via telephone, via teleconferencing, or via written means.
  Contact Delivery Mode IS NOT EQUAL TO '9 – Not applicable'
- The contact cannot occur in the emergency department.
  Contact Delivery Setting must NOT EQUAL 13 Hospital Setting – Emergency Department

Where a patient has multiple contacts in the same clinic on the same date, these contacts may be rolled up to be one service event. Box 1.27 illustrates the detailed criteria for deriving service events from contacts.

Box 1.27: Derivation of service events from VINAH contacts

Where contacts have the same value for all the following data elements, the contacts will be counted as one service event:

- Patient Identifier
- Organisation Identifier
- Referral Identifier
- Episode Campus Code
- Episode Identifier
- Episode Program/Stream
- Contact Account Class
- Contact Clinic Identifier
- Contact Date
- Contact Delivery Mode.

Box 1.28: Mapping VINAH code values to national values

In Victoria, multiple permissible values for a VINAH data element may be required to be mapped to a single national value (specified in the Activity Based Funding: Non-admitted patient care Data Set Specification). When deriving service events, if contacts occurring on the same date are reported with different values for certain data elements (such as Contact Delivery Mode), those contacts will usually not be incorporated into one service event. For example, two contacts occur on the same date, one is reported as a 'face-to-face' contact the other is delivered via telephone. This would be considered two service events. However, some code values are sufficiently similar to 'roll up' and be considered as one code. For example, two contacts occur on the same date, one is reported with Contact Account Class 'PO-Private patient: Other payer', the other is reported with 'XX-Other non-compensable'. These would be considered one service event because the two codes indicate the patient is private.

Table 1.43 to Table 1.45 show mapping of VINAH code values to national values for Contact Account Class, Contact Indigenous Status and Contact Session Type.

Table 1.43: VINAH code values Contact Account Class

National permissible value	VINAH code	VINAH permissible value
01 Health service budget – not covered elsewhere	MP	Public eligible
	JP	Prisoner
02 Health service budget – reciprocal health care agreement	MA	Reciprocal health care arrangement
03 Health service budget – no charge raised	ME	Ineligible – hospital exempt
	MF	Ineligible – asylum seeker
04 Department of Veterans' Affairs	VX	Department of Veterans' Affairs
05 Department of Defence	AS	Armed Services
07 Medicare Benefits Scheme	QM	Private clinic: MBS funded
09 Private health insurance	PI	Private patient insured
10 Workers compensation	WC	WorkSafe Victoria
11 Motor vehicle third party	TA	Transport Accident Commission
	SS	Seamen

National permissible value	VINAH code	VINAH permissible value
12 Other compensation (public liability, common law, medical negligence)	OO	Other compensable
	CL	Common Law Recoveries
13 Self-funded	PS	Private patient: Self-funded
88 Other funding source	PO	Private patient: Other payer
	XX	Other non-compensable

Table 1.44: VINAH code values Contact Indigenous Status

National permissible value	VINAH code	VINAH permissible value
Not stated/inadequately described	8	Question unable to be answered
	9	Client refused to answer

Table 1.45: VINAH code values Contact Session Type

National permissible value	VINAH code	VINAH permissible value
Individual sessions	1	Individual
	4	Group – Individual program

For more information on the definition of service events, please see the factsheet: 'Definition of Service Events, derivation of Tier 2 categories and calculation of NWAU' <https://www2.health.vic.gov.au/about/publications/factsheets/definition-service-events-derivation-tier-2-categories-calculation-nwau-2015-16>.

A1.6.5 Exclusions

Most non-admitted acute patient service events reported to the AIMS S10 data collection will be allocated a WASE cost weight. However, a cost weight will not be allocated for Tier 2 clinics that are funded by another Victorian funding model. These Tier 2 classes out of scope for WASE funding are outlined in Table 1.46.

Table 1.46: Tier 2 groups excluded from WASE3

Tier 2 clinic	Description	Note/relevant funding model
10.10	Renal dialysis – hospital delivered	Weighted inlier equivalent separation
10.12	Radiation oncology (treatment)	Radiotherapy weighted activity unit
10.15	Renal dialysis – haemodialysis – home delivered	Home renal dialysis
10.16	Renal dialysis – peritoneal dialysis – home delivered	Home renal dialysis
10.17	Total parenteral nutrition – home delivered	Total parenteral nutrition (TPN)
10.18	Enteral nutrition – home delivered	Home enteral nutrition (HEN)
10.19	Home ventilation	Victorian Respiratory Support Service, Family Choice Program
10.20	Radiotherapy (simulation and planning)	Radiotherapy weighted activity unit
20.06	General practice and primary care	Commonwealth program
20.08	Genetics	Genetic clinical activity / genetic counselling and information / genetic testing / screening
20.43	Radiation oncology (consultation)	Radiotherapy weighted activity unit
20.49	Geriatric evaluation and management (GEM)	Subacute weighted inlier equivalent separation – GEM
20.50	Psychogeriatric	Non-admitted mental health
20.56	Multidisciplinary case conference (MDCC) – patient not present	Out of scope
30.01	General imaging	Out of scope
30.02	Medical resonance imaging (MRI)	Out of scope
30.03	Computerised tomography (CT)	Out of scope
30.04	Nuclear medicine	Out of scope
30.05	Pathology (microbiology, haematology, biochemistry)	Out of scope
30.06	Positron emission tomography (PET)	Out of scope
30.07	Mammography screening	Out of scope
30.08	Clinical measurement	Out of scope

Tier 2 clinic	Description	Note/relevant funding model
40.02	Aged care assessment	Commonwealth program
40.08	Primary health care	Commonwealth program
40.27	Family planning	Family planning
40.33	General counselling	Commonwealth program
40.34	Specialist mental health	Non-admitted mental health
40.35	Palliative care	Palliative care non-admitted / palliative care non-admitted non-government organisation
40.36	Geriatric evaluation and management (GEM)	Subacute weighted inlier equivalent separation – GEM
40.37	Psychogeriatric	Non-admitted mental health
40.56	Falls prevention	Health Independence Program
40.57	Cognition and memory	Health Independence Program
40.58	Hospital avoidance programs	Health Independence Program
40.59	Post-acute care	Health Independence Program
40.62	Multidisciplinary case conference (MDCC) – patient not present	Out of scope

A1.6.6 Public and MBS-billed non-admitted patients

In 2019–20, public and MBS-billed activity is included in the WASE funding model.

Public activity is reported as 'Public Service Events' in AIMS and activity with a Contact Account Class of 'MP – Public: Eligible' in VINAH.

MBS-billed activity is activity reported as 'MBS Service Events' in AIMS and activity with a Contact Account Class of 'QM – Private clinic: MBS funded' in VINAH.

While MBS-billed specialist clinic activity is reported nationally, it is out of scope for Commonwealth funding purposes under the National Health Reform Agreement.

Clinics operated by medical practitioners or other healthcare providers on a completely private basis, where the medical record is not held by the health service, should not be registered because these clinics will be ineligible for WASE funding.

A1.6.7 Cost weights

Each Tier 2 class included in the WASE funding model is allocated a cost weight. The cost weights have been calculated using the 2017–18 Victorian Cost Data Collection.

Prior to cost weight development, quality assurance checks of the cost data are undertaken to provide a level of understanding of the usefulness of the patient-level data for analysis, reporting and use in funding models. Records not meeting the criteria are flagged for health services to review and provide feedback on the validity of these records to determine the usability for the next phase(s) of the review. These checks are reviewed annually.

All public cost data reported for non-admitted was considered in scope for developing cost weights except costs:

- that did not pass validation and quality assurance processes
- of activity that are funded under other funding streams (for example, HEN)
- that cannot be mapped to a NACMS-registered specialist clinic
- applied to clinics with less than five costed contacts
- that are associated with s100 and PBS medicines.

To weight the reference average cost (denominator) according to the total population reported in the AIMS collection, service event counts reported in the VCDC for each health service are reconciled back to the AIMS S10 form (Specialist Clinics). Total costs of each health service's Tier 2 class are then adjusted for any reconciliation variance by multiplying the variance by the average total cost for each Tier 2 class. This provides an estimate of the total cost based on activity reported in AIMS.

The stability of each cost weight is measured against the previous year's average total cost for each Tier 2 class. Stability is defined as a less than a 5 per cent movement in average clinic costs between years. In comparison, IHPA's stability policy allows for a less than 20 per cent movement in average clinic cost between years.

For 2019–20, Tier 2 classes are grouped into Vic-Tier 2 groups for the purposes of developing the final cost weight and this may change year on year. This is to provide funding stability while the cost data collection matures.

A base cost weight is derived by dividing the average cost for each Vic-Tier 2 group by the average cost across all service events. Base cost weights are used to estimate the system cost and then a new cost weight is determined based on the estimated system average costs. In 2019–20 there are 39 different cost weights. In future years, as Victoria's non-admitted cost data matures, the department will consider increasing the number of different cost weights to improve the funding allocation of the model.

A1.6.8 WASE Variables

Table 1.47 outlines the Vic-Tier 2 groups and mapped Tier 2 class. The method of calculation for both review proportions and multiple healthcare provider proportions is detailed in the following sections.

Table 1.47: Definition of WASE variables

Variable	Description
Vic-Tier 2 Group 1	Refers to Tier 2 class 20.40
Vic-Tier 2 Group 2	Refers to Tier 2 class 20.53
Vic-Tier 2 Group 3	Refers to Tier 2 class 20.54
Vic-Tier 2 Group 4	Refers to Tier 2 class 40.28
Vic-Tier 2 Group 5	Refers to Tier 2 classes 20.19, 20.20, 20.52, 20.41
Vic-Tier 2 Group 6	Refers to Tier 2 classes 20.47, 20.51
Vic-Tier 2 Group 7	Refers to Tier 2 classes 20.03, 20.44, 20.45
Vic-Tier 2 Group 8	Refers to Tier 2 classes 20.42, 20.52
Vic-Tier 2 Group 9	Refers to Tier 2 classes 20.05, 20.13, 20.15, 20.28
Vic-Tier 2 Group 10	Refers to Tier 2 classes 20.09, 20.14, 20.21, 20.34, 20.48, 20.55
Vic-Tier 2 Group 11	Refers to Tier 2 class 20.10
Vic-Tier 2 Group 12	Refers to Tier 2 class 20.11
Vic-Tier 2 Group 13	Refers to Tier 2 class 20.04
Vic-Tier 2 Group 14	Refers to Tier 2 class 20.22
Vic-Tier 2 Group 15	Refers to Tier 2 class 20.03
Vic-Tier 2 Group 16	Refers to Tier 2 class 20.31
Vic-Tier 2 Group 17	Refers to Tier 2 class 20.33
Vic-Tier 2 Group 18	Refers to Tier 2 class 20.35
Vic-Tier 2 Group 19	Refers to Tier 2 class 20.37
Vic-Tier 2 Group 20	Refers to Tier 2 classes 20.02, 20.12, 20.16, 20.23, 20.32, 20.39

Variable	Description
Vic-Tier 2 Group 21	Refers to Tier 2 classes 20.07, 20.18, 20.24, 20.27, 20.29, 20.38
Vic-Tier 2 Group 22	Refers to Tier 2 class 20.01
Vic-Tier 2 Group 23	Refers to Tier 2 class 20.17
Vic-Tier 2 Group 24	Refers to Tier 2 class 20.26
Vic-Tier 2 Group 25	Refers to Tier 2 class 20.36
Vic-Tier 2 Group 26	Refers to Tier 2 class 20.46
Vic-Tier 2 Group 27	Refers to Tier 2 classes 40.14, 40.30, 40.38, 40.40, 40.43, 40.48, 40.55
Vic-Tier 2 Group 28	Refers to Tier 2 classes 40.10, 40.22, 40.32, 40.39, 40.49, 40.50, 40.52
Vic-Tier 2 Group 29	Refers to Tier 2 classes 40.13, 40.31, 40.41, 40.44, 40.45
Vic-Tier 2 Group 30	Refers to Tier 2 classes 40.07, 40.42, 40.47, 40.53, 40.54
Vic-Tier 2 Group 31	Refers to Tier 2 class 40.46
Vic-Tier 2 Group 32	Refers to Tier 2 class 40.51
Vic-Tier 2 Group 33	Refers to Tier 2 classes 40.04, 40.11, 40.17, 40.24, 40.29
Vic-Tier 2 Group 34	Refers to Tier 2 classes 40.06, 40.09, 40.12, 40.15, 40.18, 40.23, 40.25
Vic-Tier 2 Group 35	Refers to Tier 2 classes 40.03, 40.05, 40.16, 40.21, 40.60, 40.61
Vic-Tier 2 Group 36	Refers to Tier 2 classes 10.01, 10.02, 10.04, 10.13
Vic-Tier 2 Group 37	Refers to Tier 2 classes 10.03, 10.05, 10.07, 10.08, 10.14
Vic-Tier 2 Group 38	Refers to Tier 2 classes 10.06, 10.09
Vic-Tier 2 Group 39	Refers to Tier 2 class 10.11
71 – Follow up/ Monitoring/ Evaluation/Review	The data for this field is sourced from the VINAH minimum dataset. This code is reported if the appointment has the primary purpose of reviewing the patient following a previous outpatient appointment or treatment as an inpatient or day surgery patient. It includes: • post-operative review • routine review of chronic condition • monitoring results of interventions • evaluation of action plans • re-assessing client needs are being met.
72 – New patient consultation	The data for this field is sourced from the VINAH minimum dataset. This code is reported if the appointment is the clinician seeing a new patient for initial assessment or treatment.
Contact Professional Group	The data for this field is sourced from the VINAH minimum dataset. This code is reported for each professional group or profession(s) providing services for a contact.

A1.6.9 WASE adjustments

There are two adjustments in the WASE model:

- A 20 per cent discount for review activity. The discount is applied by calculating the proportion of VINAH service events that are review service events. This section outlines important information for defining and deriving 'new' and 'review' service events and calculating review proportions. How the discount is applied is demonstrated in section A1.6.9.8 'Calculating WASE for individual Tier 2 classes'.
- A 55 per cent loading for public multiple healthcare provider service events. The loading is applied by calculating the proportion of VINAH service events that have three or more healthcare providers present.

A1.6.9.1 Review ratio

The WASE funding model has a 20 per cent discount for review service events. The 20 per cent discount was chosen based on 2015 Specialist Clinics Advisory Committee feedback. The committee noted 20 per cent was a manageable discount that still sent an appropriate pricing signal. The price signal will encourage health services to treat more new patients, to reduce waiting lists and wait times, and to improve their reporting of the data field. Current cost and VINAH activity data are not sufficiently mature to calculate a more definitive discount rate.

The review proportion will be calculated using VINAH data. In 2019–20, health services will report New Public Service Events and Review Public Service Events in the AIMS S10 form to identify variance with the VINAH dataset.

To calculate the review discount, a proportion of review service events, using VINAH data, is calculated and applied to the number of service events reported in AIMS. The adjusted field, as outlined above, is used to count the number of new and review service events.

To calculate the review proportion, health services should first calculate, for the given time, their proportion of total service events (public and MBS-billed) categorised as 'review' (see 'New and review service events') for each Vic-Tier 2 group.

For VINAH reporting health services that have not reported to VINAH any new or review service events for a specific Vic-Tier2 group, a 100 per cent review discount will be applied to total service events instead of a health-specific factor.

For non-VINAH reporting health services, the statewide review proportions (Table 1.23 in Appendix 1, section 1.3.4) will be applied to total service events instead of a health-specific factor. Please refer to Table 1.48 in Appendix 1, section A1.6.15 for a list of health services that are required to report to the department via the VINAH minimum dataset.

A1.6.9.2 'New' and 'review'

The department defines a 'new' service event as a patient attending a clinic within a specific program/stream for the first time. A 'new' contact is the first contact of the referral to that program/stream (for example, 101 – General medicine). If a patient receives two referrals to a program/stream (say, Nutrition in allied health, and Physiotherapy in allied health) then that would be two 'new' appointments.

A patient can be referred to multiple clinics. If the clinics are in the same program/stream, the first service event within the program/stream would be classified as 'new' and any subsequent service events within the program/stream would be 'review'. If the clinics are in different programs/streams, then the first appointment within each separate program/stream would be considered new and any subsequent within each program/stream would be classified as 'review'. If a patient is referred to a clinic at another health service within the same program/stream, their appointment at the next health service would be considered 'new'.

A 'new' service event must meet this definition and be the first service event of the episode for that specialist clinics program/stream. Inversely, the first service event in an episode in a specialist clinic program/stream is only a 'new' service event if it meets the above definition.

A 'review' service event is where the primary purpose is to review the patient following a previous contact or treatment (where the patient attended), or an admission to the same health service for that program/stream. As described above, this only applies within a referral at a health service.

A1.6.9.3 Reporting 'new' and 'review'

A new or review contact is reported to the department through VINAH under 'Contact purpose'. Each contact from a specialist clinic should have a contact purpose of either:

- 71 – Follow up/Monitoring/Evaluation/Review
- 72 – New patient consultation.

Box 1.29 has some examples of new and review service events. These examples demonstrate possible patient pathways. While these pathways outline possibilities of whether a service event is counted as 'new', the service event must still meet the definition outlined above.

This field is at a contact level. For the WASE model, this needs to be attached to service events. How new and review is translated from contacts to service events is detailed in the following section.

Box 1.29: Examples of 'new' and 'review'

Example 1: Patient attends multiple clinics for the one condition

Health service 1: Referral → Orthopaedic surgery contact program/stream 311 → Orthopaedic applications (New) → Physiotherapy allied health contact program/stream 313 (New) → Plastic contact program/stream 206 (New) → Orthopaedic surgery contact program/stream 311 → Orthopaedic applications (Review)

Example 2: Patient attends a clinic for a second or subsequent time

Referral → Metabolic bone medical contact program/stream 310 (New) → Metabolic bone medical contact program/stream 310 (Review)

Example 3: Patient has a pre-op and post-op specialist clinic service event at the same clinic under the same referral

General surgery contact program/stream 201→ Referral → Pre-admission and pre-anaesthesia contact program/stream 209 (New) → Hospital admission for elective surgery → Post-op general surgery contact program/stream 201 (Review) → Allied health contact program/stream 313 (New)

Example 4: Patient has a post-op specialist clinic service event with no pre-op specialist clinic service event

Hospital admission for emergency surgery → General surgery contact program/stream 201 (New)

Example 5: Patient attends a clinic and sees multiple specialists

Referral → Brain injury rehabilitation service event and sees a rehabilitation physician, a clinical nurse specialist and a social worker program/stream 109 (New)

Example 6: Post inpatient/day surgery admission

Inpatient or day surgery admission → Clinic contact (Review)

A1.6.9.4 Adjusted contact purpose

The adjusted contact purpose is the field by which the department identifies new service events that have been adjusted to review service events where the reporting is inconsistent with the rules outlined above. In 2019–20, the adjusted contact purpose will be used to calculate the proportion of review service events. This is the same field that is used in the Specialist Clinics Activity and Wait Time Report and is derived from the data submitted in VINAH.

All acute specialist clinics occasions of service activity submitted in VINAH should have a contact purpose value of '71 – Follow up/ Monitoring/ Evaluation/ Review' or '72 – New patient consultation'. There can only be one new service event per program/stream in the one episode.

Where a health service has reported multiple new service events for the one program/stream in the one episode, subsequent service events are adjusted to be review service events. Only one new service event per patient per program/stream in the one episode can be reported.

For health services not reporting VINAH data, the statewide proportion of review service events will be used to calculate the review discount.

The count of 'new' contacts, and subsequently 'new' service events, are those that have an 'Adjusted contact purpose' of 'new' (see Box 1.30).

In the event of multiple 'new' contacts within a derived contact program/stream only the first contact in the episode where the patient attends, is counted as a new contact (see Box 1.30). Subsequent 'new' contacts in the same program/stream are adjusted to 'review'.

The count of 'review' contacts includes contacts that meet the requirements to be in scope and have a contact purpose code = '71 – Follow up/ Monitoring/ Evaluation/ Review' or have been reclassified from '72 – New patient consultation' as a result of the 'New' contact adjustments (see Box 1.30).

Box 1.30: 'New' contact adjustments

Rule 1: If the program/stream has more than one contact in the same episode with a contact purpose = '72 – New patient consultation', only the contact occurring first in the program/stream is counted as a 'new' contact and subsequent contacts are counted as 'reviews'.

Rule 2: If there is a contact in the program/stream with a contact purpose = '72 – New patient consultation' but there is a preceding contact with contact purpose code = '71' then all the contacts within the program/stream are counted as 'review'.

A1.6.9.5 'New' and 'review' service events

When contacts are rolled into service events, if one of the contacts has an adjusted contact purpose of 'new', the service event will be categorised as 'new'. If none of the contacts rolled into a service event have an adjusted contact purpose of 'new', the service event will be categorised as 'review'. Where there is a one-to-one relationship between a contact and a service event, the service event will be categorised according to the adjusted contact purpose.

A1.6.9.6 Multiple healthcare provider proportion

Multiple healthcare provider (MHCP) service events are predominantly delivered by MHCP provider specialist clinics. These occur where three or more healthcare providers deliver care either individually or jointly within a non-admitted patient service event. The healthcare providers may be of the same profession (medical, nursing or allied health). However, they must each have a different scope of practice so that the care provided by each provider is unique and meets the definition of a non-admitted patient service event.

Under the counting rules, both nationally and for WASE, only one non-admitted patient service event may be counted for a patient at a specific clinic on a given day, irrespective of whether the patient was seen jointly or separately by multiple providers. Where a patient attends multiple clinics on the same day, each visit is counted as a separate service event, provided each service received meets the definition of a service event.

For patient-level information reported through VINAH, an MHCP service event is derived using the Contact Professional Group field. This data element allows repeat entries, so records with three or more distinct healthcare provider recorded are flagged as being an MHCP service event.

A loading of 55 per cent based on the percentage of public MHCP service events to total public service events as reported through VINAH will be applied to the AIMS service event count. For VINAH-reporting health services that have not reported to VINAH, any MHCP service events for a specific proportion group, a loading factor will not be applied to the total public service events. The MCHP loading does not apply to MBS-billed ('private') service events.

For non-VINAH-reporting agencies, a loading of 55 per cent will be based on a statewide percentage. The MHCP loading factor that applies to non-VINAH-reporting health services is listed in Table 1.24 in Appendix 1, section 1.3.5. Please refer to Table 1.48 in Appendix 1, section A1.6.15 for a list of health services that are required to report to the department via the VINAH minimum dataset.

A1.6.9.7 WASE price

For the 2019–20 WASE public price and WASE private price, please refer to the price tables in Appendix 1, section 1.1.

The discounted private price reflects the fact that MBS funding for MBS-funded specialist clinics do not cover the full cost. MBS billing is expected to the cover the cost of medical salaries and diagnostic costs. The WASE private price covers all other specialist clinics costs. This is intended to provide a neutral revenue choice between establishing a clinic as public or MBS-funded.

A1.6.9.8 Calculating WASE for individual Tier 2 classes

To calculate the WASE3 funding allocated to a patient:

- Determine if the service event is eligible for WASE funding (see Box 1.31).
- Calculate the base WASE (see Box 1.32).
- Calculate the review ratio for each Vic-Tier 2 (proportion) group (see Box 1.33).
- Calculate the MHCP loading for public service events (see Box 1.34).

The steps are described in detail below with technical specifications provided in boxes.

A1.6.9.9 WASE eligibility

Metropolitan and regional health services and subregional and local health services that are eligible for WIES25 funding are eligible for funding under the acute non-admitted WASE funding model (WASE3). The funding model was introduced in 2017–18 to replace block grant funding for specialist clinics in Victoria.

Only public or MBS-billed (defined as the MBS activity submission in AIMS S10 – acute non-admitted services collection) service events are eligible for funding. Patients reported as Department of Veterans' Affairs (DVA) or 'Other' will not be eligible. Patients recorded as 'Other' include workers compensation, Transport Accident Commission, criminal injury and common law cases, members of the defence forces / seafarers, patients not eligible under Medicare and not exempt from fees or other patients who elect to self-fund. Some Tier 2 classes service events are also excluded from WASE funding because they are funded by another Victorian funding model but are still required to be reported nationally. Please refer to Table 1.46 in Appendix 1, section A1.6.5.

Box 1.31: Episodes eligible for WASE3

All service events reported to the AIMS S10: Acute Non-Admitted Clinic Activity collection except for:

- DVA service events
- other funded service events
- private hospitals
- small rural health services
- Tier 2 classes: 10.10, 10.12, 10.15, 10.16, 10.17, 10.18, 10.19, 10.20, 20.06, 20.08, 20.43, 20.49, 20.50, 20.56, 30.01, 30.02, 30.03, 30.04, 30.05, 30.06, 30.07, 30.08, 40.02, 40.08, 40.27, 40.33, 40.34, 40.35, 40.36, 40.37, 40.56, 40.57, 40.58, 40.59, 40.62.

A1.6.9.10 Base weighted ambulatory service event

To calculate a Tier 2 class' base WASE, you need to determine the:

- Tier 2 class cost weight
- number of service events that have occurred for each Tier 2 class separately for both public and MBS-billed service events.

The Tier 2 cost weight can be read directly from the WASE3 Tier 2 cost weights at Table 1.22 in Appendix 1, section 1.3.3.

Box 1.32: Calculating base WASE

Vic_Tier2_group_base_WASE = number of service events x Vic_Tier2 class weight

A1.6.10 Calculating the review ratio for each Vic-Tier 2 group

The review discount is health service specific, with a different discount for each of the Vic-Tier 2 groups of Tier 2 classes. There is no discount applied to Vic-Tier 2 Groups 1, 2, 3 and 4. For definitions of the WASE3 variables, refer to Table 1.47 in Appendix 1, section A1.6.8.

A 20 per cent discount is applied to all service events according to a health service's proportion of review service events based on the relevant Vic-Tier 2 group.

To calculate the review discount, you need to determine the:

- Tier 2 class
- number of 71 – Follow up/ Monitoring/ Evaluation/ Review contacts from VINAH by Tier 2 class
- number of 72 – New patient consultation

Box 1.33: Calculating the review ratio

where i represents the Vic-Tier2 Group
where R represents the number of 71 – Follow up/Monitoring/Evaluation/Review
where N represents the number of 72 – New patient consultation
if i = 1 to 4 then
do
i_review_adjustment = 1
end
else
if i = 5 to 39 then
do
i_review_adjustment = (Sum VINAH i_contacts (R)) ÷
(Sum VINAH i_contacts(R) + Sum VINAH i_contacts (N))
end

For health services not reporting VINAH, the statewide proportion of review service events will be applied.

A1.6.11 Calculating the multiple healthcare provider service event ratio for each Vic-Tier 2 group

The MHCP service event ratio is health service specific, with a different loading for each of the Vic-Tier 2 groups of classes.

To calculate the multiple healthcare provider loading, you need to determine the:

- Tier 2 class
- number of unique Contact Professional Group codes from VINAH by Tier 2 class.

Box 1.34: Calculating the MHCP ratio for public service events

Where i represents the Vic-Tier 2 Group

if i = 1 to 39 then

do

i_MHCP_adjustment =

(i_group contacts (where Contact Professional Group =>3)) ÷

((i_group contacts(where Contact Professional Group=>3)) + (i_group contacts (where Contact Professional Group<3)))

end

For non-VINAH-reporting health services, the statewide proportion of multiple healthcare service events will be applied.

A1.6.12 Calculating the WASE

To calculate a Tier 2 class' WASE, you need to determine the:

- base WASE separately for both public service events and MBS-billed service events
- relevant review proportion
- relevant MHCP proportion for public service events.

Box 1.35: Calculating WASE

where i represents the Vic-Tier2 Group
where review_adjustment represents the review adjustment of the Vic-Tier2 Group (see Box 1.33)
where MHCP_adjustment represents the MHCP adjustment of the Vic-Tier 2 Group (see Box 1.34)
if i = 1 to 4 then
do
public_WASE = i_base_WASE + i_base_WASE x (1 – i_review_adjustment) x i_MHCP_adjustment x 55%
end
else
if i = 5 to 39 then
do
public_WASE = i_base_WASE x (i _review_adjustment x 80%) + i _base_WASE x (1 – i_ review_adjustment)
+ [i_base_WASE x i_ review_adjustment x 80% + i_base_WASE x (1 – i_ review_adjustment)]
x i_MHCP_adjustment x 55%
end
else
public_WASE = i_base_WASE
end

where i represents the Vic-Tier2 Group
where review_adjustment represents the review adjustment of the Vic-Tier2 Group (see Box 1.33)
if i = 1 to 4 then
do
mbs_WASE = i_base_WASE + i_base_WASE x (1 – i_review_adjustment)
end
else
if i = 5 to 39 then
do
mbs_WASE = i_base_WASE x (i _review_adjustment x 80%) + i _base_WASE x (1 – i_ review_adjustment)
end
else
mbs_WASE = i_base_WASE
end

WASE=public_WASE + mbs_WASE

A1.6.13 Calculating WASE revenue

To calculate WASE revenue, a health service should multiply the public WASE by the public price, and the MBS-billed WASE by the private price. This calculation is shown in Box 1.36. The public and private prices are shown in Appendix 1, section 1.1.

Box 1.36: Calculating WASE revenue

WASE_rev = public_WASE x Public_price + mbs_WASE x Private_price

A1.6.14 Calculating WASE target

Health services have been allocated a WASE target.

Targets have been calculated according to health services' 2018–19 funding and quarter 3 year-to-date public and MBS-billed weighted activity split. The funding lines included are the 'Acute Specialist Clinics – Non DVA' and 'VACS – Teaching' grant lines.

The target calculation is shown in Box 1.37. To calculate the target, divide total specialist clinics budget by the public price multiplied by the proportion of public WASE, and the private price multiplied by the proportion of MBS-billed WASE.

Box 1.37: Calculating WASE targets

Target = (Total specialist clinics budget) ÷
((public price x proportion of public WASE) + (private price x proportion of MBS-billed WASE))

Proportion of public activity = (Total public WASE) ÷
(Total public and MBS-billed WASE)

Proportion of MBS-billed activity = (Total MBS-billed WASE) ÷
(Total public and MBS-billed WASE)

Targets will be recalculated at the end of 2019–20 based on actual public and MBS-billed WASE split.

A1.6.15 Health Independence Program

The Health Independence Program (HIP) will continue to be shadowed through the WASE funding model in 2019–20; no targets will be set. Revised HIP specific cost weight segments will be used, and the assessment activity loading will be increased from 30% to 40%, based on revised data. Health services will continue to be provided with quarterly shadow reports during 2019–20.

Table 1.48: VINAH reporting health services

Health service	Programs reported
Albury Wodonga Health	OP, PAC, SACS, PC, HARP, TCP
Alfred Health	HARP, TCP, OP, SACS
Austin Health	PAC, SACS, OP, RIR, TCP, HARP, VRSS
Bairnsdale Regional Health Service	PAC, PC, OP, RIR, HARP, SACS
Ballarat Health Services	PAC, SACS, HBPCCT, HARP, OP, RIR, TCP
Ballarat Hospice Care Inc.	PC
Banksia Palliative Care Service Inc.	PC
Barwon Health	HARP, TCP, OP, PAC, RIR, PC, SACS
Bass Coast Regional Health	PAC, HARP, SACS, PC, RIR
Bellarine Community Health Inc	PC
Benalla Health	HARP, SACS, PAC, PC
Bendigo Health Care Group	OP, PAC, HARP, SACS, HBPCCT, RIR, PC, TCP
Calvary Health Care Bethlehem	SACS, PC
Castlemaine Health	HARP, SACS, PAC, PC
Central Gippsland Health Service	HARP, PC, SACS, OP, PAC, RIR
Colac Area Health	HARP, SACS, PAC, PC

Health service	Programs reported
Djerriwarrh Health Service	OP, SACS, PC
East Grampians Health Service	PC, HARP
Eastern Health	TCP, HARP, RIR, PAC, SACS, HBPCCT, OP
Eastern Palliative Care Association	PC
Echuca Regional Health	HARP, SACS, PC, PAC, RIR
Gippsland Lakes Community Health Inc.	PC
Goulburn Valley Health	PAC, RIR, HARP, SACS, OP, TCP
Goulburn Valley Hospice Care Service Inc.	PC
Hepburn Health Service	TCP
Inner South Community Health Service	PAC
Kyneton District Health Service	PC
Latrobe Community Health Service Inc.	PC
Latrobe Regional Hospital	RIR, TCP, HARP, SACS, OP, PAC
Lyndoch Living Inc	SACS
Maryborough District Health Service	HARP
Melbourne City Mission	PC
Melbourne Health	OP, PAC, SACS, RIR, HARP, TCP
Mercy Hospice Inc.	PC
Mercy Public Hospitals Inc.	HBPCCT, RIR, TCP, HARP, OP, SACS
Mildura Base Hospital	SACS, PAC, RIR, HARP, OP, TCP
Monash Health	HARP, RIR, PAC, TCP, SACS, OP
North Richmond Community Health Service	PAC
Northeast Health Wangaratta	HARP, RIR, PC, TCP, PAC, SACS, OP
Northern Health	HBPCCT, OP, PAC, SACS, HARP, RIR, TCP
NCN Health	PC, SACS
Palliative Care South East	PC
Peninsula Health	OP, HARP, SACS, PAC, RIR
Peninsula Home Hospice	PC
Peter MacCallum Cancer Centre	HBPCCT, OP
Portland District Health	PAC, SACS, PC, HARP, TCP
The Royal Children's Hospital	FCP, HARP, PAC, SACS, HBPCCT, OP
The Royal Victorian Eye and Ear Hospital	OP
The Royal Women's Hospital	OP
Seymour Health	HARP, PC, SACS, PAC
South West Healthcare	HARP, TCP, OP, PAC, RIR, PC, SACS
St Vincent's Health	HBPCCT, RIR, TCP, HARP, SACS, OP
Stawell Regional Health	SACS, PAC, HARP, TCP
Sunraysia Community Health Service	PC, HBPCCT
Swan Hill District Health	HARP, SACS, PAC, PC

Health service	Programs reported
West Gippsland Healthcare Group	PC, PAC, OP, RIR, HARP, SACS
Western District Health Service	HARP, TCP, PAC, PC, SACS
Western Health	HBPCCT, RIR, TCP, HARP, SACS, OP, PAC
Wimmera Health Care Group	OP, HARP, SACS, PAC, PC, RIR, TCP
Yarram and District Health Service	PC, SACS

Addendum 1.7: Calculating funding recall

A1.7.1 Calculating WIES26 funding recall

Funding adjustments are calculated as follows.

Step 1: Calculate the proportion of public and private activity.

Using actual activity figures, calculate the percentage of public and private activity for the service.

Step 2: Calculate revised activity targets.

Using the percentages obtained in step 1; recalculate the public and private targets for the service. The total activity target will remain the same, but the public and private target split may change.

Step 3: Calculate the public/private cash flow adjustment.

To calculate the dollar amount of the public/private cash flow adjustment:

- Subtract the initial activity target from the revised activity target.
- Multiply the difference between initial and revised activity targets by the relevant price to calculate the cash flow adjustment.

Step 4: Calculate the revised total funding for the health service.

- Multiply the revised activity targets from step 2 by the relevant public and private prices.
- Add the figures for targets together to get the revised target value.
- Multiply the actual activity figures by the relevant public and private prices.
- Add the figures for actuals together to get the actual value.

Step 5: Calculate the total performance percentage.

- Express the actual value as a percentage of the revised target value (calculated in step 4). This will show the extent to which the health service has performed above or below target.

Step 6: Calculate the relevant recall rate.

To calculate the dollar amount of the relevant recall rate:

- Determine the relevant rate applicable for the target value.
- Multiply the percentage of public activity by the relevant public rate.
- Multiply the percentage of private activity by the relevant private rate.
- Add the figures together to obtain the relevant recall rate.

Step 7: Calculate the throughput adjustment.

To calculate the dollar amount of the throughput recall/payment adjustment:

- Multiply the percentage falling within each bracket (in Chapter 1, section1.23.1 'Victorian funding recall policy') by the amount of revised target value (calculated in step 4).
- Multiply that amount by the relevant recall (calculated in step 6).
- Add the amounts for all brackets together to obtain the throughput adjustment.

Step 8: Calculate the total financial adjustment.

Add the public/private cash flow adjustment (step 3) to the throughput adjustment (step 7) to calculate the total financial adjustment for the health service.

A1.7.2 Calculating Transport Accident Commission/Department of Veterans' Affairs WIES26 funding recall

Funding adjustments are calculated as follows.

Step 1: Calculate the over or under activity.

Calculate the over or under activity by subtracting the total full-year target from total full-year activity.

A negative variance indicates that actual activity is less than the funded target (under performance), and a positive variance indicated activity is greater than funded performance (over activity).

Step 2: Calculate the amount of funding to be recalled or paid.

Calculate the amount of funding to be recalled (health service liability to department) or paid (department liability to health service) by multiplying the variance calculated in step 1 by the Transport Accident Commission/DVA WIES unit rate.

A1.7.3 Calculating National Bowel Cancer Screening Program colonoscopy WIES26 recall

Funding adjustments are calculated as follows.

Step 1: Calculate the proportion of public and private activity.

Using actual activity figures, calculate the percentage of public and private activity for the service.

Step 2: Calculate the revised activity targets.

Using the percentages obtained in step 1, recalculate the public and private targets for the service. The total activity target will remain the same, but the public and private target split may change.

Step 3: Calculate the public/private cash flow adjustment.

To calculate the dollar amount of the public/private cash flow adjustment:

- Subtract the initial activity target from the revised activity target.
- Multiply the difference between initial and revised activity targets by the relevant price to calculate the cash flow adjustment.

Step 4: Calculate the revised total funding for the health service.

- Multiply the revised activity targets from step 2 by the relevant public and private prices.
- Add the figures for targets together to get the revised target value.
- Multiply the actual activity figures by the relevant public and private prices.
- Add the figures for actuals together to get the actual value.

Step 5: Calculate the total performance percentage.

- Express the actual value as a percentage of the revised target value (calculated in step 4). This will show the extent to which the health service has performed above or below target.

Step 6: Calculate the relevant recall rate.

To calculate the dollar amount of the relevant recall rate:

- Determine the relevant rate applicable for the target value.
- Multiply the percentage of public activity by the relevant public rate.
- Multiply the percentage of private activity by the relevant private rate.
- Add the figures together to obtain the relevant recall rate.

Step 7: Calculate the throughput adjustment.

To calculate the dollar amount of the throughput recall/payment adjustment:

- Multiply the percentage falling within each bracket by the amount of revised target value (calculated in step 5).
- Multiply that amount by the relevant recall rate (calculated in step 7).
- Add the amounts for all brackets together to obtain the throughput adjustment.

A1.7.4 Calculating subacute WIES4 funding recall

Funding adjustments are calculated as follows.

Step 1: Consolidate (wrap) subacute WIES into public and private activity.

- Sum all target public activity for GEM, palliative care, rehabilitation and maintenance care types – this becomes the public wrap.
- Sum all target private activity for GEM, palliative care, rehabilitation and maintenance care types – this becomes the private wrap.
- Repeat the above steps for results, as submitted to the VAED, to derive the public and private wrap for actual results.

Step 2: Calculate the proportion of public and private activity.

Using actual public and private wrap activity figures, calculate the percentage of public and private activity for the service against public and private wrap targets.

Step 3: Calculate revised activity targets.

Using the percentages obtained in step 2, recalculate the public and private targets for the service at the wrap level. The total activity target will remain the same, but the public and private target split may change.

Step 4: Calculate the public/private cash flow adjustment.

To calculate the dollar amount of the public/private cash flow adjustment:

- Subtract the initial activity target from the revised activity target.
- Multiply the difference between initial and revised activity targets by the relevant price to calculate the cash flow adjustment.

Step 5: Calculate the revised total funding for the health service.

- Multiply the revised activity targets from step 3 by the relevant public and private prices.
- Add the figures for targets together to get the revised target value.
- Multiply the actual activity figures by the relevant public and private prices.
- Add the figures for actuals together to get the actual value.

Step 6: Calculate the total performance percentage.

- Express the actual value as a percentage of the revised target value (calculated in step 5). This will show the extent to which the health service has performed above or below target.

Step 7: Calculate the relevant recall rate.

To calculate the dollar amount of the relevant recall rate:

- Determine the relevant rate applicable for the target value.
- Multiply the percentage of public activity by the relevant public rate.

- Multiply the percentage of private activity by the relevant private rate.
- Add the figures together to obtain the relevant recall rate.

Step 8: Calculate the throughput adjustment.

To calculate the dollar amount of the throughput recall/payment adjustment:

- Multiply the percentage falling within each bracket by the amount of revised target value (calculated in step 5).
- Multiply that amount by the relevant recall rate (calculated in step 7).
- Add the amounts for all brackets together to obtain the throughput adjustment.

Step 9: Calculate the total financial adjustment.

Add the public/private cash flow adjustment (step 4) to the throughput adjustment (step 8) to calculate the total financial adjustment for the health service.

A1.7.5 Calculating DVA subacute WIES4 funding recall

Funding adjustments are calculated as follows.

Step 1: Calculate the over or under activity.

Calculate the over or under activity by subtracting the total full-year target from the total full-year activity.

A negative variance indicates that the actual activity is less than the funded target (under performance), and a positive variance indicates that the activity is greater than the funded performance (over activity).

Step 2: Calculate the amount of funding to be recalled or paid.

Calculate the amount of funding to be recalled (health service liability to the department) or paid (department liability to the health service) by multiplying the variance calculated in step 1 by the subacute DVA unit rate.

A1.7.6 Calculating home dialysis funding recall

Funding adjustments are calculated as follows.

Step 1: Calculate the average activity.

Calculate the average activity for the financial year by summing results for each month of the year together and dividing by 12 (12 months).

Step 2: Calculate the over or under activity.

Calculate the over or under activity by subtracting the health service target from the average activity (calculated in step 1).

A negative variance indicates that the average activity is less than the funded target (under performance), and a positive variance indicates that activity is greater than the funded performance (over activity).

Step 3: Calculate the amount of funding to be recalled or paid.

Calculate the amount of funding to be recalled (health service liability to the department) or paid (department liability to the health service) by multiplying the variance calculated in step 2 by the unit rate.

A1.7.7 Calculating total parental nutrition recall

Funding adjustments are calculated as follows.

Step 1: Calculate the average activity.

Calculate the average activity for the financial year by summing results for each month of the year together and dividing by 12 (12 months).

Step 2: Calculate the over or under activity.

Calculate the over or under activity by subtracting the health service target from the average activity (calculated in step 1).

A negative variance indicates that the average activity is less than the funded target (under performance), and a positive variance indicates that activity is greater than the funded performance (over activity).

Step 3: Calculate the amount of funding to be recalled or paid.

Calculate the amount of funding to be recalled (health service liability to the department) or paid (department liability to the health service) by multiplying the variance calculated in step 2 by the unit rate.

A1.7.8 Calculating home enteral nutrition recall

Funding adjustments are calculated as follows.

Step 1: Calculate the average activity.

Calculate the total activity for the financial year by summing results for each month of the year together and dividing by 12 (12 months).

Step 2: Calculate the over or under activity.

Calculate the over or under activity by subtracting the health service target from the average activity (calculated in step 1).

A negative variance indicates that the average activity is less than the funded target (under performance), and a positive variance indicates that activity is greater than the funded performance (over activity).

Step 3: Calculate the amount of funding to be recalled or paid.

Calculate the amount of funding to be recalled (health service liability to the department) or paid (department liability to the health service) by multiplying the variance calculated in step 2 by the unit rate.

Appendix 2: Funding and activity levels

Introduction to Appendix 2

Provides tables detailing the modelled budgets for 2019–20, as well as the activity tables that detail the 2019–20 targets for a range of programs across the health system.

A note on terminology

The term ‘funded organisations’ relates to all entities that receive departmental funding to deliver services. Aspects of these guidelines referring to funded organisations are applicable to all department-funded entities.

For the purposes of these guidelines, the term ‘health services’ relates to public health services, denominational hospitals, public hospitals and multipurpose services, as defined by the *Health Services Act 1988*, regarding services provided within a hospital or a hospital-equivalent setting. Aspects of these guidelines that refer specifically to ‘health services’ are only applicable to these entities.

The term ‘community service organisations’ refers to registered community health centres, local government authorities and non-government organisations that are not health services.

These guidelines are also relevant for Ambulance Victoria, Health Purchasing Victoria, Mildura Base Hospital and the Victorian Institute of Forensic Mental Health. The guidelines specify where aspects of the guidelines are relevant for these organisations.

2.1 Budget tables

2.1.1 Health service modelled budgets 2018–19 and 2019–20

Notes:

i. Please see Table 2.3 for details on funding flowing through the National Health Funding Pool.

ii. Please see Table 2.4 for details on mental health expenditure.

iii. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018.

iv. Subtotals and totals may not add up due to rounding.

Table 2.1: Expenditure budgets 2018–19 and 2019–20

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	Public health $'000s	2019–20 Total $'000s
Metropolitan and regional														
Albury Wodonga Health	210,718	765	740	37,583	4,266		**254,072**	221,402	770	755	43,509	4,276		**270,711**
Alfred Health	800,740	6,203	607	62,306	2,035	9,033	**880,924**	822,707	6,328	623	77,019	2,070	8,479	**917,225**
Austin Health	633,245	1,130	1,728	59,657	5	51	**695,815**	651,701	1,129	1,775	72,647		17	**727,270**
Ballarat Health Services	244,645	11,158	138	38,450	1,104	13	**295,509**	255,677	11,342	141	46,192	1,123		**314,475**
Barwon Health	489,307	13,328	2,420	42,701	4,931	133	**552,819**	503,361	13,503	2,486	54,252	5,004	108	**578,714**
Bendigo Health Care Group	246,746	13,037	2,058	55,097	1,122		**318,060**	260,245	13,594	2,104	65,036	1,137		**342,116**
Calvary Health Care Bethlehem Limited	21,279	86					**21,365**	22,168	88					**22,256**
Eastern Health	715,005	8,062	12,278	108,286	3,975	533	**848,140**	741,873	8,073	15,247	130,251	4,032		**899,476**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	Public health $'000s	2019–20 Total $'000s
Goulburn Valley Health	165,741	3,991	1,891	25,153	1,682		**198,457**	174,603	4,035	2,715	30,773	1,665		**213,791**
Latrobe Regional Hospital	171,922		138	46,449	1,433	277	**220,220**	179,861		141	54,676	1,471	273	**236,423**
Melbourne Health	639,801	6,124	371	212,636		15,629	**874,561**	661,076	6,232	303	246,998		15,584	**930,192**
Mercy Public Hospitals Inc.	307,748		138	57,952	84		**365,922**	326,319		141	65,170	85		**391,715**
Monash Health	1,249,449	11,878	1,828	167,924	13,347	1,055	**1,445,481**	1,302,236	12,086	4,317	200,704	13,262	700	**1,533,304**
Northern Health	483,630	4,150	138		10	13	**487,940**	516,876	4,200	140				**521,217**
Peninsula Health	433,913	6,327	2,504	49,663	7,160	139	**499,706**	452,908	6,362	2,597	59,814	6,931	115	**528,727**
Peter MacCallum Cancer Centre	196,855			71		17	**196,942**	210,166			72			**210,238**
St Vincent's Hospital Melbourne Limited	452,059	3,679	1,159	59,770	304	181	**517,153**	467,920	3,658	3,092	69,091	299	187	**544,247**
The Royal Children's Hospital	445,120	19		7,962	331	961	**454,392**	458,145	20		22,138	479	596	**481,377**
The Royal Victorian Eye and Ear Hospital	93,198					16	**93,214**	96,608						**96,608**
The Royal Women's Hospital	202,128		968	664	273	108	**204,141**	214,171		996	674	277	58	**216,177**
Western Health	653,129	3,580	9,989	173	5	1,015	**667,891**	686,918	3,605	13,561	175		903	**705,162**
Total	**8,856,376**	**93,517**	**39,094**	**1,032,497**	**42,068**	**29,174**	**10,092,725**	**9,226,941**	**95,025**	**51,135**	**1,239,193**	**42,111**	**27,020**	**10,681,421**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	Public health $'000s	2019–20 Total $'000s
Subregional and local														
Bairnsdale Regional Health Service	65,303	1,321	136		213		**66,973**	68,476	1,341	334		216		**70,368**
Bass Coast Health	49,953	1,647	81		1,657		**53,338**	54,855	1,672	83		1,874		**58,484**
Benalla Health	18,703	1,182			1,469		**21,354**	20,915	1,190			1,147		**23,252**
Castlemaine Health	24,312	2,908					**27,220**	26,292	3,031					**29,322**
Central Gippsland Health Service	61,004	3,910	136		904		**65,954**	63,957	3,965	465		1,627		**70,014**
Colac Area Health	25,338	1,982	8		623		**27,951**	27,720	2,012	8		633		**30,374**
Djerriwarrh Health Services	42,801	2,343			2,547		**47,690**	45,659	2,377			2,584		**50,620**
East Grampians Health Service	19,627	1,660			839		**22,126**	20,864	1,687			853		**23,404**
Echuca Regional Health	54,872	1,932			955		**57,758**	62,502	1,961			967		**65,430**
Gippsland Southern Health Service	19,792	2,367			458		**22,616**	21,807	2,402	195		395		**24,800**
Kyabram and District Health Services	15,151	1,381			1,130		**17,662**	15,677	1,432			1,145		**18,255**
Maryborough District Health Service	20,446	2,591			737		**23,774**	21,997	2,584			746		**25,327**
Northeast Health Wangaratta	105,295	1,980	136		754	13	**108,178**	112,235	2,009	139		746		**115,130**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	Public health $'000s	2019–20 Total $'000s
Portland District Health	25,312	1,182	8		1,828		**28,331**	26,734	1,195	8		1,858		**29,795**
Ramsay Health Care Limited	100,017		138	16,344	5		**116,505**	103,808		394	19,864			**124,066**
South West Healthcare	121,000	1,534	399	21,865	1,817	18	**146,633**	133,567	1,555	409	25,880	1,847		**163,259**
Stawell Regional Health	14,711	1,095		240	1,196		**17,241**	15,493	1,109		244	1,216		**18,061**
Swan Hill District Health	36,089	2,017			1,815		**39,921**	41,258	2,047			1,520		**44,826**
West Gippsland Health Care Group	75,626	2,868			978		**79,471**	80,956	2,919			994		**84,869**
Western District Health Service	43,549	3,487		111	876		**48,023**	48,444	3,546		113	656		**52,758**
Wimmera Health Care Group	59,894	3,038	136		1,254		**64,322**	62,881	3,074	139		1,275		**67,368**
Total	**998,795**	**42,423**	**1,180**	**38,560**	**22,054**	**31**	**1,103,043**	**1,076,097**	**43,109**	**2,175**	**46,100**	**22,301**		**1,189,782**
Grand total	**9,855,171**	**135,940**	**40,274**	**1,071,056**	**64,122**	**29,205**	**11,195,767**	**10,303,038**	**138,133**	**53,310**	**1,285,293**	**64,412**	**27,020**	**11,871,203**

2.1.2 Small rural health services expenditure budgets 2018–19 and 2019–20

Notes:

i. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018–19.

ii. The expenditure budget for the Coleraine campus is reported as part of the Western District Health Service.

iii. Subtotals and totals may not add up due to rounding.

Table 2.2: Small rural health services expenditure budgets 2018–19 and 2019–20

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Total $'000s
Alexandra District Health	6,661	146		442	**7,249**	6,886	149		449	**7,485**
Alpine Health	11,797	1,778		305	**13,880**	12,352	2,010		310	**14,672**
Beaufort and Skipton Health Service	4,751	994		149	**5,894**	5,550	1,010		151	**6,711**
Beechworth Health Service	5,021	1,059		344	**6,424**	5,038	1,155		350	**6,543**
Boort District Health	2,608	374			**2,982**	2,918	380			**3,298**
Casterton Memorial Hospital	3,989	991		38	**5,018**	4,260	1,006		38	**5,305**
Cohuna District Hospital	6,422	560			**6,982**	6,883	568			**7,452**
Corryong Health	4,128	779		120	**5,027**	4,425	836		122	**5,383**
East Wimmera Health Service	12,930	2,611		609	**16,150**	13,970	2,734		619	**17,323**
Edenhope and District Memorial Hospital	3,779	614		67	**4,460**	4,070	637		68	**4,774**
Great Ocean Road Health	5,589	1,016		208	**6,813**	6,220	1,017		211	**7,448**
Heathcote Health	2,973	517		127	**3,617**	3,212	525		129	**3,866**
Hepburn Health Service	9,707	2,248		1,052	**13,007**	10,394	2,282		1,071	**13,747**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Total $'000s
Hesse Rural Health Service	2,254	768		580	**3,602**	2,504	779		589	**3,873**
Heywood Rural Health	2,753	490			**3,243**	3,056	497			**3,553**
Inglewood and Districts Health Service	2,287	560		544	**3,391**	2,570	561		553	**3,684**
Kerang and District Health	6,700	1,106		5	**7,811**	7,178	1,109			**8,288**
Kilmore and District Hospital	14,468	1,047			**15,515**	16,237	1,048			**17,285**
Kooweerup Regional Health Services	5,291	915			**6,206**	5,572	918			**6,490**
Kyneton District Health Service	10,726	177			**10,903**	11,277	94			**11,371**
Maldon Hospital	1,775	558			**2,333**	1,863	558			**2,422**
Mallee Track Health and Community Service	4,257	1,668			**5,925**	4,717	1,670			**6,387**
Mansfield District Hospital	7,579	1,076		392	**9,047**	8,262	1,077		398	**9,737**
Moyne Health Services	4,086	1,208		7	**5,301**	4,675	1,290		7	**5,973**
NCN Health	19,310	2,752		379	**22,441**	20,639	2,770		385	**23,794**
Omeo District Health	1,940	398			**2,338**	2,125	399			**2,523**
Orbost Regional Health	6,220	629		499	**7,348**	6,675	631		551	**7,857**
Robinvale District Health Services	6,074	945		232	**7,251**	6,219	947		236	**7,402**
Rochester and Elmore District Health Service	5,989	1,007			**6,996**	6,296	1,055			**7,351**
Rural Northwest Health	9,422	1,585		581	**11,588**	9,905	1,643		591	**12,138**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Total $'000s
Seymour District Memorial Hospital	12,968	1,052		88	**14,108**	13,620	1,054		89	**14,763**
South Gippsland Hospital	5,944	46		142	**6,132**	6,644	47		82	**6,772**
Tallangatta Health Service	3,773	575		228	**4,576**	4,566	600		227	**5,393**
Terang and Mortlake Health Service	5,569	534		1,236	**7,339**	5,882	656		1,255	**7,793**
Timboon and District Healthcare Service	3,879	292		288	**4,459**	4,094	342		293	**4,729**
West Wimmera Health Service	15,284	3,063	259	2,414	**21,020**	16,125	3,222	263	2,725	**22,335**
Yarram and District Health Service	5,653	837		406	**6,896**	6,199	841		484	**7,524**
Yarrawonga District Health Service	9,706	1,351		644	**11,701**	10,326	1,351		655	**12,333**
Yea and District Memorial Hospital	2,694	379		363	**3,436**	3,066	379		370	**3,815**
Total	**256,958**	**38,705**	**259**	**12,489**	**308,411**	**276,471**	**39,845**	**263**	**13,011**	**329,592**

2.1.3 Activity-based funding: Health service expenditure budgets 2018–19 and 2019–20 by service category

Notes:

i. This table shows (state and Commonwealth) funding flowed through the National Health Funding Pool to activity-based funding funded hospitals by the National Health Reform Agreement (NHRA) service (refer to Chapter 1, section 1.4.1 'Pricing and funding framework') and out-of-scope funding.

ii. This table does not include public hospital services provided by small rural health services or non-health service organisations.

iii. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018–19.

iv. Subtotals and totals may not add up due to rounding.

Table 2.3: Activity-based funding: Health service expenditure budgets 2018–19 and 2019–20 by service category

Health service	Total 2018–19 $'000s	Acute admitted $'000s	Acute non-admitted patients $'000s	Emergency $'000s	Subacute $'000s	Subacute non-admitted $'000s	Non-admitted home ventilation $'000s	Teaching, training and research $'000s	Mental health admitted $'000s	Non-admitted mental health $'000s	Non-admitted CAMHS $'000s	Other non-admitted services $'000s	Other public hospital programs $'000s	Out-of-scope funding $'000s	Total 2019–20 $'000s
Metropolitan and regional															
Albury Wodonga Health	**254,072**	92,736	5,828	13,770	4,201	6,020	–	3,457	7,743	19,800	3,198	–	–	113,958	**270,711**
Alfred Health	**880,924**	562,176	52,253	36,350	60,280	25,018	–	19,650	24,751	39,617	8,400	–	–	88,730	**917,225**
Austin Health	**695,815**	453,572	46,095	32,586	44,369	18,210	8,546	19,616	29,708	23,233	9,492	–	–	41,843	**727,270**
Ballarat Health Services	**295,509**	156,376	15,484	24,720	18,394	9,889	–	8,933	15,698	23,446	4,747	–	–	36,788	**314,475**
Barwon Health	**552,819**	333,054	30,003	28,016	25,266	19,684	–	12,921	12,742	35,412	5,238	5	37,150	39,223	**578,714**
Bendigo Health Care Group	**318,060**	179,708	18,225	21,471	22,788	16,394	–	10,266	23,235	34,718	5,805	–	–	9,506	**342,116**
Calvary Health Care Bethlehem Limited	**21,365**	1,967	146	–	7,639	10,964	–	809	–	–	–	–	–	731	**22,256**
Eastern Health	**848,140**	526,229	42,087	59,970	54,827	29,946	–	19,114	39,741	81,607	11,794	–	–	34,161	**899,476**
Goulburn Valley Health	**198,457**	112,506	12,344	19,232	12,739	6,884	–	6,154	7,149	21,009	2,868	–	–	12,906	**213,791**
Latrobe Regional Hospital	**220,220**	132,058	7,974	12,637	11,891	7,901	–	5,589	16,561	31,318	4,399	–	–	6,095	**236,423**

Health service	Total 2018–19 $'000s	Acute admitted $'000s	Acute non-admitted patients $'000s	Emergency $'000s	Subacute $'000s	Subacute non-admitted $'000s	Non-admitted home ventilation $'000s	Teaching, training and research $'000s	Mental health admitted $'000s	Non-admitted mental health $'000s	Non-admitted CAMHS $'000s	Other non-admitted services $'000s	Other public hospital programs $'000s	Out-of-scope funding $'000s	Total 2019–20 $'000s
Melbourne Health	**874,561**	457,512	53,924	26,705	36,175	25,404	–	25,593	84,446	140,355	9,616	–	–	70,462	**930,192**
Mercy Hospitals Victoria Limited	**365,922**	256,592	33,627	17,306	7,057	3,346	–	5,429	28,676	33,257	704	–	–	5,721	**391,715**
Monash Health	**1,445,481**	900,782	89,492	67,271	61,975	39,231	–	32,797	79,233	102,336	14,083	–	103,126	42,978	**1,533,304**
Northern Health	**487,940**	367,855	32,889	36,682	36,628	24,269	–	11,381	12	140	–	–	–	11,361	**521,217**
Peninsula Health	**499,706**	320,370	15,542	36,772	42,305	19,982	–	10,001	16,384	39,775	2,008	–	–	25,588	**528,727**
Peter MacCallum Cancer Institute	**196,942**	121,113	25,318	–	–	–	–	3,441	–	–	–	–	–	60,366	**210,238**
St Vincent's Hospital Melbourne Limited	**517,153**	309,046	37,637	24,539	33,159	17,624	–	20,172	22,044	43,113	1,690	–	–	35,223	**544,247**
The Royal Children's Hospital	**454,392**	340,546	41,316	34,288	5,671	15,917	2,327	9,682	5,266	4,212	13,195	–	–	8,957	**481,377**
The Royal Victorian Eye and Ear Hospital	**93,214**	62,422	24,797	6,482	–	–	–	1,838	–	–	–	–	–	1,069	**96,608**
The Royal Women's Hospital	**204,141**	169,029	39,376	2,459	–	–	–	4,638	381	294	–	–	–	–5,574	**216,177**
Western Health	**667,891**	422,482	50,509	56,754	38,362	24,675	–	14,186	2	10,856	–	–	71,387	15,949	**705,162**
Metropolitan and regional total	**10,092,725**	**6,283,710**	**674,864**	**558,009**	**523,724**	**321,357**	**10,873**	**245,666**	**413,773**	**684,500**	**97,238**	**5**	**211,662**	**656,040**	**10,681,421**
Subregional and local															
Bairnsdale Regional Health Service	**66,973**	43,552	3,889	8,390	3,919	4,422		2,315	–	334	–	0		3,546	**70,367**
Bass Coast Health	**53,338**	30,633	2,470	8,398	4,629	3,761		1,420	–	–	–	–		7,172	**58,483**

Health service	Total 2018–19 $'000s	Acute admitted $'000s	Acute non-admitted patients $'000s	Emergency $'000s	Subacute $'000s	Subacute non-admitted $'000s	Non-admitted home ventilation $'000s	Teaching, training and research $'000s	Mental health admitted $'000s	Non-admitted mental health $'000s	Non-admitted CAMHS $'000s	Other non-admitted services $'000s	Other public hospital programs $'000s	Out-of-scope funding $'000s	Total 2019–20 $'000s
Benalla Health	**21,354**	17,011	651	–	471	1,769		294	–	–	–	–		3,056	**23,252**
Castlemaine Health	**27,220**	17,516	468	–	4,141	2,912		367	–	–	–	–		3,917	**29,321**
Central Gippsland Health Service	**65,954**	42,879	6,116	7,266	2,793	2,684		2,076	–	465	–	–		5,735	**70,014**
Colac Area Health	**27,951**	23,102	1,851	–	625	1,366		349	–	–	–	–		3,080	**30,373**
Djerriwarrh Health Services	**47,690**	34,583	8,033	–	693	1,487		562	–	–	–	–		5,262	**50,620**
East Grampians Health Service	**22,126**	17,411	487	–	616	803		1,235	–	–	–	–		2,852	**23,404**
Echuca Regional Health	**57,758**	38,507	4,906	9,054	3,807	2,607		2,495	–	–	–	–		4,054	**65,430**
Gippsland Southern Health Service	**22,616**	17,539	2,097	–	966	415		352	–	195	–	–		3,236	**24,800**
Kyabram and District Health Services	**17,662**	14,246	346	–	779	–		98	–	–	–	–		2,786	**18,255**
Maryborough District Health Service	**23,774**	18,863	1,284	–	165	685		546	–	–	–	–		3,785	**25,328**
Northeast Health Wangaratta	**108,178**	79,378	5,544	10,369	5,711	5,771		3,115	13	139	–	–		5,090	**115,130**
Portland District Health	**28,331**	21,574	1,856	–	935	1,196		350	–	–	–	2		3,881	**29,794**
Ramsay Health Care Limited	**116,505**	75,730	4,425	10,411	3,729	2,782		3,781	4,647	11,686	1,799	–		5,075	**124,065**
South West Healthcare	**146,633**	91,725	9,299	11,147	9,373	4,915		4,808	7,376	14,916	2,070	4		7,625	**163,258**
Stawell Regional Health	**17,241**	12,632	791	–	144	1,416		218	–	225	–	–		2,635	**18,061**

Health service	Total 2018–19 $'000s	Acute admitted $'000s	Acute non-admitted patients $'000s	Emergency $'000s	Subacute $'000s	Subacute non-admitted $'000s	Non-admitted home ventilation $'000s	Teaching, training and research $'000s	Mental health admitted $'000s	Non-admitted mental health $'000s	Non-admitted CAMHS $'000s	Other non-admitted services $'000s	Other public hospital programs $'000s	Out-of-scope funding $'000s	Total 2019–20 $'000s
Swan Hill District Health	**39,921**	23,651	2,190	7,142	3,595	2,855		816	–	–	–	–		4,576	**44,825**
West Gippsland Health Care Group	**79,471**	58,155	4,427	9,037	1,771	3,325		2,712	–	–	–	–		5,441	**84,868**
Western District Health Service	**48,023**	34,060	3,177	4,669	1,914	2,230		823	–	113	–	2		5,769	**52,757**
Wimmera Health Care Group	**64,322**	42,077	5,028	5,929	3,317	2,986		1,650	–	139	–	7		6,235	**67,368**
Subregional and local total	**1,103,043**	**754,824**	**69,337**	**91,813**	**54,093**	**50,388**		**30,384**	**12,036**	**28,212**	**3,870**	**16**		**94,808**	**1,189,781**
Grand total	**11,195,767**	**7,038,534**	**744,201**	**649,822**	**577,817**	**371,745**	**10,873**	**276,050**	**425,809**	**712,712**	**101,108**	**21**	**211,662**	**750,848**	**11,871,202**

2.1.4 Mental health expenditure budgets 2018–19 and 2019–20 by service type

Notes:

i. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018–19.

ii. Subtotals and totals may not add up due to rounding.

Table 2.4: Mental health expenditure budgets 2018–19 and 2019–20 by service type

Health service	2018–19 Total $'000s	2019–20 Acute $'000s	2019–20 Non-acute $'000s	2019–20 Ambulatory $'000s	2019–20 Psychosocial rehabilitation and support $'000s	2019–20 Residential $'000s	2019–20 Service system capacity $'000s	2019–20 Subacute $'000s	2019–20 Total $'000s
Metropolitan and regional									
Albury Wodonga Health	**37,583**	17,989	–	16,603	1,105	1,443	486	5,883	**43,509**
Alfred Health	**62,306**	23,697	–	43,030	1,817	–	2,645	5,829	**77,018**
Austin Health	**59,657**	30,114	5,297	25,976	1,166	–	2,434	7,661	**72,648**
Ballarat Health Services	**38,450**	12,813	2,543	26,441	1,369	750	814	1,463	**46,193**
Barwon Health	**42,701**	11,579	636	33,928	1,314	1,688	1,280	3,828	**54,253**
Bendigo Health Care Group	**55,097**	18,542	4,238	31,815	1,421	1,301	1,828	5,890	**65,035**
Eastern Health	**108,286**	38,813	–	71,850	3,257	2,567	3,126	10,639	**130,252**
Goulburn Valley Health	**25,153**	6,845	–	18,159	1,045	750	626	3,347	**30,772**
Latrobe Regional Hospital	**46,449**	14,813	1,272	31,745	1,045	375	1,494	3,933	**54,677**
Melbourne Health	**212,636**	76,475	5,509	130,223	4,571	2,191	6,829	21,200	**246,998**
Mercy Public Hospitals Inc.	**57,952**	27,837	–	28,710	1,568	–	1,226	5,829	**65,170**
Monash Health	**167,924**	66,608	10,587	93,221	3,135	3,564	3,950	19,639	**200,704**
Peninsula Health	**49,663**	15,778	–	31,624	1,646	1,286	1,400	8,080	**59,814**
Peter MacCallum Cancer Centre	**71**	–	–	–	–	–	72	–	**72**

Health service	2018–19 Total $'000s	2019–20 Acute $'000s	2019–20 Non-acute $'000s	2019–20 Ambulatory $'000s	2019–20 Psychosocial rehabilitation and support $'000s	2019–20 Residential $'000s	2019–20 Service system capacity $'000s	2019–20 Subacute $'000s	2019–20 Total $'000s
St Vincent's Hospital Melbourne Limited	**59,770**	21,022	–	34,148	1,689	2,720	3,684	5,829	**69,092**
The Royal Children's Hospital	**7,962**	5,201	–	15,833	135	–	968	–	**22,137**
Victorian Institute of Forensic Mental Health	**64,525**	54,135	–	12,511	–	–	1,793	–	**68,575**
The Royal Women's Hospital	**664**	–	–	587	–	–	87	–	**674**
Western Health	**173**	–	–	–	–	–	175	–	**175**
Metropolitan and regional total	**1,097,022**	**442,261**	**30,081**	**646,403**	**26,282**	**18,634**	**34,918**	**109,050**	**1,307,768**
Subregional and local									
Ramsay Health Care Limited	**16,334**	4,274	–	11,523	1,045	–	1,136	1,885	**19,864**
South West Healthcare	**21,865**	6,384	636	14,863	1,105	–	715	2,178	**25,880**
Stawell Regional Health	**240**	–	–	–	–	244	–	–	**244**
Western District Health Service	**111**	–	–	–	–	113	–	–	**113**
Subregional and local total	**38,560**	**10,658**	**636**	**26,386**	**2,150**	**356**	**1,851**	**4,063**	**46,100**
Small rural health service									
West Wimmera Health Service	**259**	–	–	–	–	263	–	–	**263**
Small rural health service total	**259**					**263**			**263**
Other									
La Trobe University	**1,943**	–	–	1,270	–	–	810	–	**2,080**
Lyndoch Living Inc.	**369**	–	–	–	–	375	–	–	**375**

Health service	2018–19 Total $'000s	2019–20 Acute $'000s	2019–20 Non-acute $'000s	2019–20 Ambulatory $'000s	2019–20 Psychosocial rehabilitation and support $'000s	2019–20 Residential $'000s	2019–20 Service system capacity $'000s	2019–20 Subacute $'000s	2019–20 Total $'000s
Tweddle Child and Family Health Service	**136**	–	–	–	–	–	138	–	**138**
The Queen Elizabeth Centre	**132**	–	–	–	–	–	134	–	**134**
The University of Melbourne	**369**	–	–	–	–	–	349	–	**349**
Other total	**2,949**			**1,270**		**375**	**1,431**		**3,076**
Grand total	**1,138,790**	**452,919**	**30,718**	**674,059**	**28,433**	**19,628**	**38,200**	**113,114**	**1,357,207**

2.1.5 Registered community health centres budgets 2018–19 and 2019–20

Note:

i. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018–19.

Table 2.5: Registered community expenditure budgets 2018–19 and 2019–20

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Access Health and Community		388			3,251		**3,640**		919			3,332		**4,251**
Ballarat Community Health	69	174	2,325	700	2,885	244	**6,397**	70	437	3,031	711	3,002	250	**7,499**
Banyule Community Health		317			3,328		**3,645**		597			3,420		**4,017**
Bellarine Community Health Ltd	448	399			2,307		**3,154**	456	463			2,415		**3,334**
Bendigo Community Health Services Limited	139	134	4,349		3,682	301	**8,606**	142	186	4,467	136	3,910	308	**9,149**
Bentleigh Bayside Community Health		411			2,279		**2,690**		419			2,335		**2,754**
Castlemaine District Community Health Limited		142			863		**1,006**		147			892		**1,038**
Central Bayside Community Health Services Limited		693	13		3,464		**4,170**		705			3,560		**4,266**
Cohealth Limited		6,689	3,678	11,742	10,003	113	**32,226**		6,944	2,901	10,629	11,167	115	**31,756**
Darebin Community Health Service		505	507		5,521		**6,533**		666	521		5,620		**6,807**
Dpv Health		1,949		2	9,063		**11,014**		2,293		2	10,066		**12,361**
Eastern Access Community Health Inc.		1,781	8,829	7,827	6,729		**25,166**		2,628	8,388	6,959	8,432	112	**26,519**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Gateway Health Limited		1,592	2,474		2,592	306	**6,964**		2,063	2,541	136	2,760	320	**7,820**
Gippsland Lakes Community Health	385	801	158	34	2,977		**4,354**	392	1,212	82	35	3,784	112	**5,617**
Grampians Community Health		481	249	79	1,323		**2,131**		531	256	81	1,358		**2,225**
Ipc Health		4,036	18		9,308		**13,362**		4,105			9,414		**13,519**
Latrobe Community Health Service Limited	1,233	6,313	5,119	765	5,699	98	**19,228**	1,255	7,773	5,756	779	6,335	100	**21,998**
Link Health and Community Limited		96			2,682		**2,778**		454			2,761		**3,215**
Merri Community Health Services Limited		5,624		70	4,303		**9,998**		5,875		72	4,466		**10,413**
Nexus Primary Health		1,526	194		1,857		**3,576**		2,242	199		1,907		**4,348**
Nillumbik Community Health Service Ltd		349	519		4,622		**5,490**	20	906	534		4,721		**6,181**
North Richmond Community Health Limited	1,633	56	4,078		2,393	1,115	**9,273**	1,657	86	4,148		2,465	1,146	**9,501**
Primary Care Connect			1,242		1,115		**2,357**			1,188		1,128		**2,316**
Ranges Community Health		48			2,476		**2,524**		245			2,557		**2,802**
Star Health Group	1,887	3,620	3,377	3,640	4,405	701	**17,630**	1,911	3,709	3,239	3,636	4,567	721	**17,781**
Sunbury Community Health Centre Limited		713			2,121		**2,834**		755			2,178		**2,933**
Sunraysia Community Health Services Limited	1,323	1,514	579		3,404	114	**6,935**	1,125	1,539	956		3,600	118	**7,338**
Total	**7,115**	**40,353**	**37,709**	**24,859**	**104,653**	**2,992**	**217,682**	**7,027**	**47,898**	**38,205**	**23,175**	**112,153**	**3,302**	**231,760**

2.1.6 Local government authorities 2018–19 and 2019–20

Notes:

i. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018–19.

ii. This table shows the health funding to local government authorities that receive > $1 million from specific health outputs.

iii. The Primary and dental health column includes the impact of machinery of government changes for Maternal and child health services.

iv. Subtotals and totals may not add up due to rounding.

Table 2.6: Local government authorities 2018–19 and 2019–20

Health service	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Banyule City Council	498				**498**	1,121		1,078		**2,198**
Baw Baw Shire Council	252				**252**	814		742		**1,556**
Bayside City Council	233				**233**	1,357		599		**1,956**
Brimbank City Council	483				**483**	1,644		2,600		**4,243**
Campaspe Shire Council	267		282		**549**	474		750		**1,224**
Cardinia Shire Council	52				**52**	56		1,425		**1,480**
Casey City Council	3,730		85		**3,815**	4,873		4,734		**9,607**
City of Ballarat	233				**233**	1,058		1,170		**2,228**
City of Boroondara	184				**184**	838		886		**1,724**
City of Darebin	662		43		**705**	1,422		1,301		**2,723**
City of Greater Geelong	900			59	**959**	2,277		2,394	60	**4,731**
City of Kingston	1,520				**1,520**	3,521		1,247		**4,768**
City of Manningham	299				**299**	907		770		**1,676**
City of Port Phillip	1,217				**1,217**	1,683		839		**2,522**
City of Stonnington	138				**138**	1,006		640		**1,645**

Health service	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Frankston City Council	289				**289**	1,561		1,532		**3,092**
Glen Eira City Council	229				**229**	1,793		1,090		**2,883**
Golden Plains Shire Council	189		460		**649**	348		743		**1,092**
Greater Bendigo City Council	288				**288**	771		1,304		**2,075**
Greater Shepparton City Council	446				**446**	572		936		**1,508**
Hobsons Bay City Council	363				**363**	1,496		925		**2,421**
Hume City Council	2,041				**2,041**	2,924		3,707		**6,630**
Knox City Council	153				**153**	787		1,277		**2,064**
Latrobe City Council	515		31		**546**	1,661		1,153		**2,814**
Maribyrnong City Council	300				**300**	1,101		892		**1,994**
Maroondah City Council	291				**291**	539		1,061		**1,600**
Melbourne City Council	221				**221**	1,115		803		**1,918**
Melton City Council	1,161				**1,161**	1,775		2,219		**3,994**
Mildura Rural City Council	181		347		**529**	892		1,252		**2,145**
Monash City Council						1,288		1,236		**2,524**
Moonee Valley City Council	1,167				**1,167**	1,677		932		**2,608**
Moreland City Council	230				**230**	1,426		1,731		**3,157**
Mornington Peninsula Shire Council	404				**404**	2,246		1,505		**3,751**
Municipal Association of Victoria	173			1,819	**1,992**	323		175	1,843	**2,341**
Nillumbik Shire Council	377				**377**	566		496		**1,061**
The City of Greater Dandenong	454	54			**508**	2,270		2,046		**4,316**
Warrnambool City Council	343				**343**	729		372		**1,102**
Whitehorse City Council	227				**227**	1,253		1,133		**2,386**
Whittlesea City Council	1,061				**1,061**	1,970		3,113		**5,082**

Health service	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Wyndham City Council	455				**455**	2,004		4,061		**6,064**
Yarra City Council	578				**578**	761		707		**1,468**
Yarra Ranges Shire Council	448				**448**	1,758		1,685		**3,443**
All other local government organisations (< $1 million)	3,427		351		**3,779**	8,983		9,834		**18,817**
Total	**26,678**	**54**	**1,599**	**1,878**	**30,210**	**67,635**		**69,095**	**1,903**	**138,633**

2.1.7 Non-government providers 2018–19 and 2019–20

Notes:

i. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018–19.

ii. This table shows the health funding to non-government organisations that receive > $1 million from specific health outputs.

iii. Subtotals and totals may not add up due to rounding.

Table 2.7: Non-government providers 2018–19 and 2019–20

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Alzheimer's Australia Vic Inc.		2,494					**2,494**							
Anglicare Victoria			997	1,926	36		**2,959**			1,105	1,621			**2,726**
Australian Centre for Grief and Bereavement Inc.	1,843						**1,843**	1,880						**1,880**
Australian College of Optometry		6,660					**6,660**		6,794					**6,794**
Australian Community Support Organisation Inc.			16,392	3,253			**19,645**			13,624	3,228			**16,852**
Australian Drug Foundation Inc.			1,424				**1,424**			1,463				**1,463**
Australian Red Cross Blood Service	12,333						**12,333**	13,505						**13,505**
Ballan and District Soldiers Memorial Bush Nursing Hospital and Hostel Inc.	108	90					**198**	130	135					**265**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Ballarat Hospice Care Inc.	2,082						**2,082**	2,083						**2,083**
Banksia Palliative Care Service Inc.	3,914						**3,914**	3,197						**3,197**
Beyond Blue Limited				2,200			**2,200**				2,200			**2,200**
Break Thru People Solutions				1,463			**1,463**				955			**955**
Breastscreen Victoria Inc.						39,617	**39,617**						48,458	**48,458**
Brotherhood of St Laurence		2,321					**2,321**		2,362					**2,362**
Cancer Council Victoria	2,492					4,750	**7,243**	523					2,387	**2,910**
Caraniche Pty Ltd			1,961				**1,961**			2,011				**2,011**
Care Connect Limited		744		477			**1,221**		1,265		475			**1,741**
Carers Victoria Inc.		3,625		251	596		**4,472**		3,726		258	605		**4,589**
Centacare, Catholic Diocese of Ballarat Inc.		1,842		148			**1,990**		1,886		152			**2,038**
Cobaw Community Health Services Limited	35	106		42	1,309		**1,492**	71	227		216	1,348		**1,862**
Council on the Ageing (Victoria) Inc.		1,001					**1,001**		1,308					**1,308**
Darlingford Upper Goulburn Nursing Home Inc.		1,223					**1,223**		1,254					**1,254**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Diabetes Australia – Victoria					1,137		**1,137**					1,154		**1,154**
Eastern Palliative Care Association Inc.	12,111						**12,111**	10,776						**10,776**
Ermha Limited		2,718		1,875			**4,593**		2,783		1,189			**3,972**
Family Planning Victoria Inc					4,125	195	**4,320**					4,195	200	**4,395**
Gegac	196	166	1,230	35	144		**1,771**	201	171	1,506	36	147		**2,061**
Gippsland Health Network Limited					15	1,614	**1,629**					16	971	**986**
Goulburn Valley Family Care Inc		989		89	365		**1,443**		1,092		92	371		**1,554**
Gunditjmara Aboriginal Co-Operative Limited	241	50	280	364	144		**1,079**	247	114	288	370	147		**1,166**
Harm Reduction Victoria Inc.			392			664	**1,056**			487			683	**1,169**
Hepatitis Victoria Inc.						1,369	**1,369**						1,408	**1,408**
Indigo North Health Inc.		1,121			544		**1,665**		1,186			553		**1,739**
Integrated Clinical Oncology Network Pty Ltd	1,712						**1,712**							
La Trobe University	3,612	880		1,949	705	536	**7,683**	3,815	896		2,289	716	524	**8,242**
Loddon Mallee Housing Services Limited		1,556					**1,556**		1,595					**1,595**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Mcauley Community Services for Women		349		892			**1,241**		356		918			**1,274**
Mdas Limited	443	52	1,041	733	321		**2,591**	454	53	1,322	330	328		**2,488**
Mecwa		4,785					**4,785**		8,587					**8,587**
Melbourne City Mission	6,448	185					**6,633**	5,591	190					**5,780**
Melbourne Primary Care Network Limited	1,269				15	655	**1,940**					16	610	**626**
Mentis Assist Limited		115		1,190			**1,305**		117		724			**841**
Mercy Palliative Care Ltd	8,162						**8,162**	7,070						**7,070**
Merri Outreach Support Service Inc.		1,434					**1,434**		1,473					**1,473**
Mind Australia				9,150			**9,150**				8,010			**8,010**
Moira Inc.		1,111					**1,111**		1,135					**1,135**
Monash University	5,005		962			161	**6,127**	1,078		557			767	**2,402**
Murdoch Childrens Research Institute	908					602	**1,510**	150					7,548	**7,698**
National Ageing Research Institute Ltd	368	800					**1,169**	374	814				188	**1,376**
Neami Limited				14,823			**14,823**				13,657			**13,657**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Ngwala Willumbong Limited		103	1,356		85		**1,545**		106	1,382		87		**1,575**
Njernda Aboriginal Corporation	248	161	603	64			**1,077**	254	166	620	66			**1,105**
Northern District Community Health Service		119			1,329		**1,448**		121			1,399		**1,519**
Odyssey House, Victoria			16,185				**16,185**			15,201				**15,201**
Peninsula Home Hospice	4,284						**4,284**	3,713						**3,713**
People Living with HIV/AIDS Victoria Inc.						1,657	**1,657**						1,704	**1,704**
Red Cliffs and Community Aged Care Services Inc.		1,069					**1,069**		1,125					**1,125**
Royal District Nursing Service Limited		25,664			108	699	**26,470**		26,086			109	719	**26,914**
Rumbalara Aboriginal Co-Operative Limited	197	189	522	65	204		**1,177**	202	274	796	67	209		**1,547**
Rural Workforce Agency, Victoria Limited	5,770						**5,770**	5,419						**5,419**
Sacred Heart Mission Inc.		433		1,322			**1,754**		444		1,360			**1,804**
Spiritual Health Victoria Incorporated	1,190			124			**1,314**	1,208						**1,208**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Tandem Inc.				2,130			**2,130**				2,165			**2,165**
Task Force Community Agency Inc.			3,146				**3,146**			3,245				**3,245**
The Goulburn Valley Hospice Care Service Inc.	1,491						**1,491**	1,482						**1,482**
The Salvation Army (Victoria) Property Trust		2,816	10,607		81		**13,504**		2,889	10,362		83		**13,334**
The University of Melbourne	4,037			2,375	255	8,001	**14,668**	3,140			2,378	259	8,132	**13,909**
The Victorian Foundation for Survivors of Torture Inc.				1,831	2,105		**3,937**				1,886	2,140		**4,026**
Very Special Kids	2,090						**2,090**	2,131						**2,131**
Victoria Legal Aid				2,796			**2,796**				2,838			**2,838**
Victorian Aboriginal Community Controlled Health Organisation Inc.	599	145	303	355	676	1,182	**3,259**	614	149	392	365	611	1,129	**3,260**
Victorian Aboriginal Health Service Co-Operative Limited	246	179	661	2,245	144	180	**3,655**	253	184	674	1,947	384	185	**3,626**
Victorian Aids Council Inc.			441			6,041	**6,481**			452	84		6,212	**6,749**
Victorian Clinical Genetics Services Limited	4,671					1,956	**6,627**	5,017					1,995	**7,012**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Victorian Cytology Service Limited						15,668	**15,668**	56					15,654	**15,710**
Victorian Health Promotion Foundation						40,223	**40,223**						41,027	**41,027**
Villa Maria Catholic Homes Limited		3,627		98			**3,725**		3,762		100			**3,863**
Vincentcare Victoria		1,000					**1,000**		1,024					**1,024**
Wellways Australia Limited		75		10,406			**10,482**		77		9,365			**9,442**
Wesley Mission Victoria		2,627	16,801	7,770	852		**28,050**		3,287	18,193	7,014	866		**29,361**
Western Region Alcohol and Drug Centre Inc.			1,953				**1,953**			2,296				**2,296**
Western Victoria Primary Health Network Limited			550		15	546	**1,111**			565		16	514	**1,094**
Windana Drug and Alcohol Recovery Inc.			12,781				**12,781**			12,304				**12,304**
Within Australia Incorporated				1,590			**1,590**				1,408			**1,408**
Women's Health Victoria Inc.	687				1,765		**2,452**	697				1,393		**2,090**
Women's Health West Inc.		114			1,133		**1,247**		117			1,159		**1,276**
Yooralla	1,118						**1,118**		327					**327**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Youth Projects Limited			1,871				**1,871**			1,418				**1,418**
Ysas Pty Ltd			15,185		21		**15,205**			17,125	136			**17,261**
All other organisations (< $1 million)	11,963	22,726	5,413	10,633	11,541	3,398	**65,674**	11,357	29,258	5,128	10,791	11,678	12,736	**80,947**
Total	**101,874**	**97,468**	**113,056**	**84,662**	**29,772**	**129,715**	**556,548**	**86,686**	**108,914**	**112,515**	**78,691**	**29,989**	**153,750**	**570,545**

2.1.8 Other funded organisations 2018–19 and 2019–20

Note:

i. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018–19.

Table 2.8: Other funded organisations expenditure budgets 2018–19 and 2019–20

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Ambulance services $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Ambulance services $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Ambulance Victoria	29,843		744,711	338				**774,892**	18,276		768,209					**786,485**
Childrens Health Partnership Pty Ltd	161,070							**161,070**	138,432							**138,432**
Dental Health Services Victoria	–1					159,311	256	**159,565**	–3					161,494	261	**161,752**
Exemplar Health Partnership	74,147							**74,147**	54,814							**54,814**
Health Purchasing Victoria	14,905							**14,905**	15,148							**15,148**
Karingal St Laurence Limited		2,150			221			**2,371**		2,203			227			**2,430**
Lyndoch Living Inc.	1,981	3,876			369			**6,226**	2,099	4,671			375			**7,146**
National Blood Authority	106,456							**106,456**	108,053							**108,053**
Plenary Health Casey Pty Ltd	13,769							**13,769**	16,296							**16,296**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Ambulance services $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Ambulance services $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Plenary Health (CCC) Pty Ltd	170,792							**170,792**	66,042							**66,042**
Postgraduate Medical Council of Victoria	1,943							**1,943**	1,596							**1,596**
Rw Health Partnerships Pty Ltd	45,241					10		**45,251**	45,205							**45,205**
South East Palliative Care Ltd	5,609							**5,609**	4,691							**4,691**
The Florey Institute of Neuroscience and Mental Health	342				1,669		360	**2,371**	281				1,582		4,467	**6,330**
The NSW Ministry of Health	9,600							**9,600**								
Victorian Comprehensive Cancer Centre Ltd	8,517							**8,517**	4,519							**4,519**
Victorian Institute of Forensic Mental Health	516				62,471			**62,987**	292				70,794			**71,086**
All other organisations (< $1 million)	5,296	446		65	486	873	708	**7,874**	6,399	266		66	475	881	15,206	**23,295**
Total	**650,025**	**6,472**	**744,711**	**403**	**65,216**	**160,194**	**1,323**	**1,628,345**	**482,140**	**7,140**	**768,209**	**66**	**73,453**	**162,376**	**19,934**	**1,513,318**

2.1.9 Health operations 2018–19 and 2019–20

Notes:

i. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018–19.

ii. Acute and subacute category includes ambulance services.

iii. Subtotals and totals may not add up due to rounding.

Table 2.9: Health operations expenditure budgets 2018–19 and 2019–20

Provider type	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Ambulance services $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Ambulance services $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Health service	9,855,171	135,940	–	40,274	1,071,056	64,122	29,205	**11,195,767**	10,303,038	138,133	–	53,310	1,285,293	64,412	27,020	**11,871,203**
Small rural health service	256,958	38,705	–	–	259	12,489	–	**308,411**	276,471	39,845	–	–	263	13,011	–	**329,590**
Community health centre	7,115	40,353	–	37,709	24,859	104,653	2,992	**217,682**	7,027	47,898	–	38,205	23,175	112,153	3,302	**231,760**
Health consortium	–	7	–	157	184	2,499	–	**2,847**	–	8	–	161	188	2,508	–	**2,864**
Local government	–	26,678	–	54	–	1,599	1,878	**30,210**	–	67,635	–	–	–	69,095	1,903	**138,633**
Non-government provider	101,874	97,468	–	113,056	84,662	29,772	129,715	**556,548**	86,686	108,914	–	112,515	78,691	29,989	153,750	**570,545**
Other	650,025	6,472	744,711	403	65,216	160,194	1,323	**1,628,345**	482,140	7,140	768,209	66	73,453	162,376	19,934	**1,513,318**
Total	**10,871,143**	**345,623**	**744,711**	**191,653**	**1,246,236**	**375,328**	**165,113**	**13,939,810**	**11,155,362**	**409,574**	**768,209**	**204,257**	**1,461,062**	**453,543**	**205,907**	**14,657,913**

2.2 Activity target tables

2.2.1 Victorian acute admitted activity targets (WIES26) 2019–20

Notes:

i. NBCSP WIES refers to the National Bowel Cancer Screen Program colonoscopy WIES, which is an expansion of the program to all Victorian public hospitals providing colonoscopy in 2019–20.

ii. Note that changes to weighted ambulatory service event (WASE) prices will be implemented during 2019–20 to reflect continued development of the specialist clinics funding model, which continues to be shadowed in 2019–20. No impact to funding will arise from these changes.

Table 2.10: Victorian acute admitted activity targets (WIES26) 2019–20

Health service	Public/private WIES (including elective surgery)	National Bowel Screening WIES	WIES DVA	WIES TAC	Total WIES
Albury Wodonga Health	27,688	14	117	15	27,834
Alfred Health	103,894	34	473	6,164	110,564
Austin Health	84,218	182	677	583	85,660
Bairnsdale Regional Health Service	7,839	67	146	25	8,077
Ballarat Health Services	32,835	75	124	224	33,257
Barwon Health	61,566	47	343	584	62,541
Bass Coast Health	5,264	14	50	5	5,333
Benalla Health	2,734	8	86	–	2,828
Bendigo Health Care Group	33,877	53	340	231	34,501
Castlemaine Health	2,887	12	25	1	2,925
Central Gippsland Health Service	7,403	44	73	34	7,554
Colac Area Health	3,621	12	40	9	3,682
Djerriwarrh Health Services	5,134	13	16		5,163
East Grampians Health Serv	2,884	13	27	1	2,925
Eastern Health	102,066	205	566	485	103,321
Echuca Regional Health	7,043	46	81	43	7,213
Gippsland Southern Health Service	2,483	28	27	8	2,546
Goulburn Valley Health	21,538	66	151	139	21,894
Kyabram District Health Services	2,486	8	31	0	2,525
Latrobe Regional Hospital	25,317	52	217	128	25,715
Maryborough District Health Service	2,809	10	49	1	2,868
Melbourne Health	90,027	47	411	5,596	96,081
Mercy Hospitals Victoria Limited	49,334	58	360	9	49,760
Monash Health	166,114	116		592	166,822
Northeast Health Wangaratta	14,793	44	201	97	15,135
Northern Health	71,356	190	257	308	72,111
Peninsula Health	63,121	29	456	306	63,912
Peter MacCallum Cancer Institute	23,074		129		23,203
Portland District Health	3,232	15	39	11	3,297
Ramsay Health Care Limited	13,203	44	153	47	13,447

Health service	Public/private WIES (including elective surgery)	National Bowel Screening WIES	WIES DVA	WIES TAC	Total WIES
Royal Victorian Eye & Ear Hospital	12,130		46	6	12,181
South West Healthcare	16,607	57	145	71	16,880
St Vincents Hospital Melbourne Limited	57,222	63	203	184	57,671
Stawell Regional Health	2,110	4	25	6	2,146
Swan Hill District Health	4,245	20	71	31	4,367
The Royal Childrens Hospital	59,758			514	60,272
The Royal Womens Hospital	32,783			5	32,788
West Gippsland Healthcare Group	10,117	0	68	50	10,235
Western District Health Service	5,331	83	79		5,493
Western Health	79,746	144	389	266	80,545
Wimmera Health Care Group	7,645	44	129	41	7,858
Total	**1,327,533**	**1,961**	**6,820**	**16,820**	**1,353,130**

2.2.2 Victorian small rural health service acute admitted activity targets 2019–20

Notes:

i. Recall is not applied on notional public/private WIES targets for small rural health services.

ii. NBCSP WIES refers to National Bowel Cancer Screen Program colonoscopy WIES, which is an expansion of the program to all Victorian public hospitals providing colonoscopy in 2019–20.

iii. NBCSP WIES is paid to actual activity. Targets shown in the table are estimated activity volumes only.

Table 2.11: Victorian small rural health service notional acute admitted activity targets 2019–20

Health service	National Bowel Screening WIES	WIES DVA	WIES TAC	WIES renal	Total
Small rural health service					
Alexandra District Health	5.66	27.77	2		35.43
Alpine Health	0.36	42.15	2	68.9	113.41
Beaufort and Skipton Health Service		13.84	0		13.84
Beechworth Health Service		9.99	–3		6.99
Boort District Health		1.67			1.67
Casterton Memorial Hospital	3.54	10.77	–4	16.55	26.86
Cohuna District Hospital	3.22	9.82	1	45.06	59.1
Corryong Health	0	14.8		30.75	45.55
East Wimmera Health Service		23.94		49.32	73.26
Edenhope and District Memorial Hospital		3.24	1	9.31	13.55
Great Ocean Road Health		0.63		19.74	20.37
Heathcote Health		1.86	0		1.86
Hepburn Health Service	10.26	27.61	2	57.06	96.93
Hesse Rural Health Service		1.27	2		3.27
Heywood Rural Health		3.95	0		3.95
Inglewood and Districts Health Service		3.66	0		3.66
Kerang and District Health	6.17	15.34			21.51
Kilmore and District Hospital	0.36	15.06			15.42
Kooweerup Regional Health Services		7.99	–1		6.99
Kyneton District Health Service	14.75	14.16	0	75.37	104.28
Maldon Hospital		1.7			1.7
Mansfield District Hospital	0.71	10.22	3	48.33	62.26
Moyne Health Services		36.9			36.9
NCN Health	4.18	42.36	1		47.54
Orbost Regional Health		6.92	2	45.17	54.09
Robinvale District Health Services		5.77	0	47.74	53.51
Rochester and Elmore District Health Service	3.53	5.1	–2		6.63
Rural Northwest Health		56.88	0		56.88
Seymour District Memorial Hospital	13.37	40.28		115.02	168.67
South Gippsland Hospital	10.02	16.45	0		26.47
Tallangatta Health Service		15.51	0		15.51

Health service	National Bowel Screening WIES	WIES DVA	WIES TAC	WIES renal	Total
Terang and Mortlake Health Service	4.44	16.66		6.72	27.82
Timboon and District Healthcare Service	0.71	6.51	0		7.22
West Wimmera Health Service	0	49.89	9	0.37	59.26
Yarram and District Health Service		13.81	1	24.59	39.4
Yarrawonga District Health Service	10.55	39.77	0	167.32	217.64
Yea and District Memorial Hospital		7.17	3		10.17
Total	**91.83**	**621.42**	**19**	**827.32**	**1559.57**

2.2.3 Victorian acute non-admitted activity targets 2019–20

Note:

i. Total WASE includes public and private activity.

ii. Note that changes to WASE targets will be implemented during 2019–20 to reflect continued development of the specialist clinics funding model, which continues to be shadowed in 2019–20. No impact to funding will arise from these changes.

Table 2.12: Victorian acute non-admitted activity targets 2019–20

Health service	Total Weighted Ambulatory Service Events
Albury Wodonga Health	20,423
Alfred Health	186,801
Austin Health	166,910
Ballarat Health Services	61,402
Barwon Health	106,161
Bendigo Health Care Group	61,756
Eastern Health	152,197
Goulburn Valley Health	47,296
Latrobe Regional Hospital	27,246
Melbourne Health	164,429
Mercy Hospitals Victoria Limited	126,172
Monash Health	289,269
Northern Health	127,230
Peninsula Health	63,240
Peter MacCallum Cancer Institute	88,325
Royal Victorian Eye and Ear Hospital	93,814
St Vincent's Hospital Melbourne Limited	119,314
The Royal Children's Hospital	154,726
The Royal Women's Hospital	138,286
Western Health	182,416
Bairnsdale Regional Health Service	14,904
Bass Coast Health	8,250
Benalla Health	2,256
Castlemaine Health	1,650
Central Gippsland Health Service	22,903
Colac Area Health	6,526
Djerriwarrh Health Services	27,612
East Grampians Health Service	1,674
Echuca Regional Health	16,858
Gippsland Southern Health Service	7,370
Kyabram District Health Services	1,219
Maryborough District Health Service	4,512
Northeast Health Wangaratta	19,149
Portland District Health	7,309

Health service	Total Weighted Ambulatory Service Events
Ramsay Health Care Limited	14,950
South West Healthcare	32,594
Stawell Regional Health	2,745
Swan Hill District Health	7,223
West Gippsland Healthcare Group	17,204
Western District Health Service	10,765
Wimmera Health Care Group	17,224
Total	**2,622,311**

2.2.4 Non-admitted radiotherapy activity (WAU) targets 2019–20

Table 2.13: Non-admitted radiotherapy activity targets 2019–20

Health service	Radiotherapy base variable WAU	Radiotherapy DVA base variable WAU	Total
Alfred Health	80,160	648	80,808
Austin Health	71,390	731	72,121
Barwon Health	40,463	551	41,014
Peter MacCallum Cancer Institute	292,068	2,092	294,160
Total	**484,080**	**4,022**	**488,103**

Table 2.14: Shared-care radiotherapy activity targets 2019–20

Health service	Radiotherapy non-admitted shared care
Monash Health	153
Northern Health	209
Peninsula Health	165
Western Health	17
Total	**545**

2.2.5 Admitted subacute and non-acute targets (subacute WIES4) 2019–20

Table 2.15: Admitted subacute and non-acute targets (subacute WIES4) 2019–20

Health service	Palliative care public/private	Rehabilitation public/private	GEM public/private	Maintenance public	Total public/private	Total Department of Veterans' Affairs	Total Admitted subacute
Albury Wodonga Health	15	460	199		673	13	685
Alfred Health	–	2,018	2,231		4,249	55	4,304
Austin Health	489	1,852	1,712		4,053	125	4,178
Ballarat Health Services	284	708	670		1,661	34	1,695
Barwon Health	384	1,058	837		2,279	71	2,350
Bendigo Health Care Group	178	1,141	743		2,061	58	2,119
Calvary Health Care Bethlehem Limited	301	420	–		721	–	721
Eastern Health	940	1,804	2,475		5,219	128	5,347
Goulburn Valley Health	161	533	457		1,151	22	1,173
Latrobe Regional Hospital	89	598	346		1,033	47	1,080
Melbourne Health	258	977	2,104		3,339	42	3,381
Mercy Hospitals Victoria Limited	288	76	292		656	19	675
Monash Health	472	2,871	2,479		5,822	25	5,846
Northern Health	535	639	2,272		3,446	41	3,487
Peninsula Health	401	1,562	2,058		4,021	146	4,167
Peter MacCallum Cancer Institute	–	–	–		–	–	–
St Vincent's Hospital Melbourne Limited	627	1,331	1,190		3,148	48	3,197
The Royal Children's Hospital	–	365	–		365	–	365
Western Health	365	897	2,341		3,603	79	3,682
Bairnsdale Regional Health Service	39	202	129	–	370	17	387
Bass Coast Health	35	247	151	–	432	16	449

Health service	Palliative care public/private	Rehabilitation public/private	GEM public/private	Maintenance public	Total public/private	Total Department of Veterans' Affairs	Total Admitted subacute
Benalla Health	–	–	–	44	44	5	49
Castlemaine Health	–	266	129	–	395	23	418
Central Gippsland Health Service	71	62	128	–	261	8	269
Colac Area Health	21	–	–	37	58	–	58
Djerriwarrh Health Services	44	–	–	–	44	–0	44
East Grampians Health Serv	9	–	–	46	55	–	55
Echuca Regional Health	40	183	136	–	358	3	362
Gippsland Southern Health Service	33	–	–	57	90	7	97
Kyabram District Health Services	–	–	–	73	73	–	73
Maryborough District Health Service	–	–	–	15	15	0	16
Northeast Health Wangaratta	43	252	248	–	542	28	570
Portland District Health	42	–	–	45	87	0	88
Ramsay Health Care Limited	40	284	23	–	347	20	368
South West Healthcare	170	347	316	–	832	9	842
Stawell Regional Health	–	–	–	13	13	–	13
Swan Hill District Health	–	26	250	60	336	4	340
West Gippsland Healthcare Group	36	–	106	–	142	1	142
Western District Health Service	36	113	31	–	180	25	205
Wimmera Health Care Group	19	143	153	–	315	24	339
Total	**6,464**	**21,433**	**24,205**	**390**	**52,493**	**1,142**	**53,635**

2.2.6 Transition Care Program targets 2019–20

Table 2.16: Transition Care Program targets 2019–20

Health service	Bed days	Home days	Total
Metropolitan and regional			
Alfred Health	27,010	5,110	32,120
Austin Health	7,652	10,617	18,270
Ballarat Health Services	13,847	9,153	23,000
Barwon Health	12,390	6,590	18,980
Bendigo Health Care Group	18,220	12,814	31,034
Eastern Health	26,237	8,054	34,291
Goulburn Valley Health	13,118	13,546	26,665
Latrobe Regional Hospital	8,381	6,956	15,337
Melbourne Health	10,568	12,448	23,015
Mercy Hospitals Victoria Limited	2,186	1,464	3,651
Monash Health	17,491	10,983	28,475
Northern Health	8,746	15,743	24,488
Peninsula Health	16,762	5,492	22,254
St Vincent's Hospital Melbourne Limited	10,932	11,349	22,281
Western Health	12,390	10,983	23,373
Subregional and local			
Portland District Health	1,458	732	2,190
Ramsay Health Care Limited	2,551	3,295	5,846
South West Healthcare	3,645	3,663	7,309
Western District Health Service	1,093	1,464	2,558
Total	**214,678**	**150,458**	**365,136**

2.2.7 Health Independence Program contact targets 2019–20

Note: Seymour, Yarram and NCN Health are small rural health services.

Table 2.17: Health Independence Program contact targets 2019–20

Health service	Public contacts target
Metropolitan and regional	
Albury Wodonga Health	26,926
Alfred Health	94,170
Austin Health	75,016
Ballarat Health Services	41,898
Barwon Health	75,393
Bendigo Health Care Group	60,592
Calvary Health Care Bethlehem	14,826
Eastern Health	134,496
Goulburn Valley Health	30,814
Inner South Community Health Service	13,830
Latrobe Regional Hospital	32,567
Melbourne Health	100,866
Mercy Public Hospitals Inc.	13,792
Monash Health	170,618
North Richmond Community Health Service	11,994
Northern Health	105,316
Peninsula Health	87,636
The Royal Children's Hospital	23,628
St Vincent's Hospital	66,263
Western Health	99,451
Subregional and local	
Bairnsdale Regional Health Service	25,792
Bass Coast Regional Health	19,531
Benalla and District Memorial Hospital	7,474
Castlemaine Health	17,052
Central Gippsland Health Service	11,841
NCN Health	4,148
Colac Area Health	6,649
Djerriwarrh Health Services	9,062
East Grampians Health Service	1,134
Echuca Regional Health	12,578
Lyndoch Living Inc.	7,720
Maryborough District Health Service	1,503
Mildura Base Hospital	14,410
Northeast Health Wangaratta	31,574
Portland District Health	5,911
Seymour Health	12,806

Health service	Public contacts target
South West Healthcare – Warrnambool	24,942
Stawell Regional Health	9,030
Swan Hill District Hospital	13,921
West Gippsland Healthcare Group	17,341
Western District Health Service	12,118
Wimmera Health Care Group	13,761
Yarram and District Health Service	3,248
Total	**1,544,284**

2.2.8 Total parenteral nutrition service event targets 2019–20

Table 2.18: Total parenteral nutrition service event targets 2019–20

Health service	Service event target
Austin Health	123
Melbourne Health	147
Monash Health	200
St Vincent's Hospital Melbourne Limited	76
The Royal Children's Hospital	95
Total	**641**

2.2.9 Home enteral nutrition service event targets 2019–20

Table 2.19: Home enteral nutrition service event targets 2019–20

Health service	Service event target
Metropolitan and regional	
Albury Wodonga Health	336
Alfred Health	947
Austin Health	1,405
Ballarat Health Services	553
Barwon Health	1,232
Bendigo Health Care Group	360
Calvary Health Care Bethlehem Limited	677
Eastern Health	473
Goulburn Valley Health	415
Latrobe Regional Hospital	208
Melbourne Health	928
Monash Health	4,479
Northern Health	420
Peninsula Health	551
Peter MacCallum Cancer Institute	1,282
St Vincent's Hospital Melbourne Limited	1,667
The Royal Children's Hospital	7,047
Western Health	877
Subregional and local	
Bairnsdale Regional Health Service	88
Bass Coast Health	36
Benalla Health	47
Central Gippsland Health Service	95
Colac Area Health	62
East Grampians Health Service	55
Gippsland Southern Health Service	21
Maryborough District Health Service	12
Northeast Health Wangaratta	80
Portland District Health	7
Ramsay Health Care Limited	281
South West Healthcare	213
Stawell Regional Health	57
Swan Hill District Health	89
West Gippsland Healthcare Group	122
Western District Health Service	–
Wimmera Health Care Group	82
Total	**25,204**

2.2.10 Home renal dialysis targets 2019–20

Table 2.20 Home renal dialysis targets 2019–20

Health service	Annual target
Alfred Health	98
Austin Health	72
Barwon Health	51
Bendigo Health Care Group	29
Eastern Health	64
Melbourne Health	104
Monash Health	168
Northern Health	33
St Vincent's Hospital Melbourne Limited	83
The Royal Children's Hospital	7
Western Health	84
Total	**793**

2.2.11 Nationally Funded Centres program 2019–20

Notes:

i. Targets are subject to approval by the Nationally Funded Centres Reference Group and the Australian Health Ministers' Advisory Council.

ii. Prices are subject to approval by the Nationally Funded Centres Reference Group and the Australian Health Ministers' Advisory Council.

iii. Paediatric liver transplantation – 55 per cent for The Royal Children's Hospital and 45 per cent for Austin Health.

iv. Paediatric lung/heart-lung transplantation – 97 per cent for Alfred Health and 3 per cent for The Royal Children's Hospital.

Table 2.21: Nationally Funded Centres program targets 2019–20

Nationally Funded Centres program	Funded organisation	Annual target
NFC – Islet Cell Transplantation	St Vincent's Hospital Melbourne Limited	6.00
NFC – Paediatric Heart no VAD	The Royal Children's Hospital	3.00
NFC – Paediatric Heart VAD	The Royal Children's Hospital	6.00
NFC – Paediatric Lung Transplantation	Alfred Health	4.85
	The Royal Children's Hospital	0.15
NFC – Pancreas Transplants	Monash Health	20.00
NFC – Transplants – Paediatric Liver	Austin Health	4.95
NFC – Transplants – Paediatric Liver	The Royal Children's Hospital	6.05
Total		**51.00**

2.2.12 Mental health acute, non-acute, subacute and residential available beds 2019–20

Note for the following three tables:

i. Mental health funded bed days – total reflects part-year effect for beds scheduled to open in 2019–20.

ii. Increased capacity will occur across five mental health services. Further capital developments during 2019–20 will create additional capacity throughout the year.

iii. Increased capacity through the purchase of public beds from private hospitals is *not* included in the table.

Table 2.22: Mental health acute available beds 2019–20

Health service	Mental health funded bed – acute specialist	Mental health funded bed – acute adult	Mental health funded bed – acute aged	Mental health funded bed – acute child and adolescent	Total Mental health funded acute bed	Total Mental health funded acute bed days
Metropolitan and regional						
Albury Wodonga Health		15	5		20	7,305
Alfred Health	4	54	15		73	26,663
Austin Health	11	53		23	87	31,777
Ballarat Health Services	5	23	10	2	40	14,610
Barwon Health		28	6		34	12,419
Bendigo Health Care Group	5	35	20		60	21,915
Eastern Health		88	30	12	130	45,564
Goulburn Valley Health		15	5		20	7,305
Latrobe Regional	5	29	10	2	46	16,802
Melbourne Health	16	152	54		222	81,085
Mercy Health	8	70			78	28,490
Monash Health	8	111	40	23	182	66,476
Peninsula Health		35	15		50	18,263
St Vincent's Hospital		44	20		64	23,376
The Royal Children's Hospital				17	17	6,209.25
Victorian Institute of Forensic Mental Health	54				54	
Subregional and rural						
Mildura Base Hospital		10	2	2	14	5,114
South West Healthcare		15	5		20	7,305
Total	**116**	**777**	**237**	**81**	**1,211**	**420,678**

Table 2.23: Mental health non-acute, subacute and residential available beds 2019–20

Health service	Mental health funded bed – non-acute	Mental health funded bed – subacute CCU	Mental health funded bed – subacute PARC	Mental health funded bed – residential	Total Mental health funded subacute and residential bed	Total Mental health funded subacute and residential bed days
Metropolitan and regional						
Albury Wodonga Health		26	10	15	51	18,628
Alfred Health		20	10		30	10,958
Austin Health	38	22	10	20	90	32,873
Ballarat Health Services	12	10		32	54	19,724
Barwon Health	3	12	12	45	72	25,933
Bendigo Health Care Group	20	12	20	30	82	29,951
Eastern Health		40	20	64	124	45,291
Goulburn Valley Health		10	10	20	40	14,610
Latrobe Regional	6	14	10	10	40	14,610
Melbourne Health	26	80	40	62	208	75,972
Mercy Health		20	10		30	10,958
Monash Health	60	40	50	94	244	89,121
Peninsula Health		20	20	30	70	25,568
St Vincent's Hospital		20	10	60	90	32,873
The Royal Children's Hospital		–	–	–	–	–
Victorian Institute of Forensic Mental Health	82				82	
Subregional and local						
Mildura Base Hospital			10		10	3,653
South West Health	3	2	10	13	28	10,227
Total	**250**	**348**	**252**	**495**	**1,345**	**460,950**

Table 2.24: Mental health total acute, non-acute, subacute and residential available beds and available bed days 2019–20

Health service	Mental health funded acute bed	Mental health funded acute bed days	Mental health funded non-acute, subacute and residential bed	Mental health funded non-acute, subacute and residential bed days	Mental health beds	Mental health beds
Metropolitan and regional						
Albury Wodonga Health	20	7,305	51	18,628	71	25,933
Alfred Health	73	26,663	30	10,958	103	37,621
Austin Health	87	31,777	90	32,873	177	64,650
Ballarat Health Services	40	14,610	54	19,724	94	34,334
Barwon Health	34	12,419	72	25,933	106	38,352
Bendigo Health Care Group	60	21,915	82	29,951	142	51,866
Eastern Health	130	45,564	124	45,291	254	90,855
Goulburn Valley Health	20	7,305	40	14,610	60	21,915
Latrobe Regional Hospital	46	16,802	40	14,610	86	31,412
Melbourne Health	222	81,085	208	75,972	430	157,057
Mercy Health	78	28,490	30	10,958	108	39,448
Monash Health	182	66,476	244	89,121	426	155,597
Peninsula Health	50	18,263	70	25,568	120	43,831
St Vincent's Hospital	64	23,376	90	32,873	154	56,249
The Royal Children's Hospital	17	6,209	–	–	17	6,209
Victorian Institute of Forensic Mental Health	54		82		136	
Subregional and local						
Mildura Base Hospital	14	5,114	10	3,653	24	8,767
South West Health	20	7,305	28	10,227	48	17,532
Total	**1,211**	**420,678**	**1,345**	**460,950**	**2,556**	**881,628**

2.2.13 Mental health ambulatory targets 2019–20

Table 2.25: Mental health acute, non-acute, subacute and residential service hour targets 2019–20

Health service	Ambulatory contacts
Metropolitan and regional	
Albury Wodonga Health	37,754
Alfred Health	92,271
Austin Health	62,332
Ballarat Health Services	61,208
Barwon Health	72,115
Bendigo Health Care Group	73,500
Eastern Health	166,096
Goulburn Valley Health	42,009
Latrobe Regional Hospital	73,138
Melbourne Health	271,244
Mercy Health	65,644
Monash Health	195,861
Peninsula Health	61,104
St Vincent's Hospital	70,952
The Royal Children's Hospital	37,584
The Royal Women's Hospital	505
Victorian Institute of Forensic Mental Health	0
Subregional and local	
Mildura Base Hospital	27,037
South West Healthcare	35,629
Total	**1,445,983**

2.2.14 Alcohol and other drugs output targets 2019–20

Table 2.26: Alcohol and other drugs output targets 2019–20

Health service	DTAU– residential drug withdrawal	DTAU – residential rehabilitation	DTAU - Assessment	DTAU – care and recovery coordination	DTAU- counselling	DTAU - Intake	Episodes of care – mobile overdose response	DTAU – non-residential withdrawal	Episodes of care - Pharmacotherapy	DTAU – therapeutic day rehabilitation	Episodes of care – youth A&D supported accommo-dation	Episodes of care – youth outreach	DTAU – youth residential drug withdrawal	Total
Metropolitan and regional														
Alfred Health									140					**140**
Austin Health									140					**140**
Barwon Health			280	263	669	424		304			5	55		**2,000**
Bendigo Health Care Group		2,391												**2,391**
Eastern Health	3,441	1,598	701	562	1,786	545	19	669	170					**9,491**
Goulburn Valley Health	933		237	196	622			226						**2,213**
Monash Health	3,113										32	28		**3,173**
Peninsula Health			222	140	562	294		253			8	109		**1,589**
St Vincent's Hospital Melbourne Ltd	2,769													**2,769**
Western Health	2,765	6,041	497	392	1,583			578	140	660		220	1,597	**14,472**
Subregional and local														
Bairnsdale Regional Health Services	238													**238**
Central Gippsland Health Service	396													**396**
Colac Area Health											1			**1**
Gippsland Southern Health Service	238													**238**
Portland District Health											1			**1**

Health service	DTAU– residential drug withdrawal	DTAU – residential rehabilitation	DTAU - Assessment	DTAU – care and recovery coordination	DTAU- counselling	DTAU - Intake	Episodes of care – mobile overdose response	DTAU – non-residential withdrawal	Episodes of care - Pharmacotherapy	DTAU – therapeutic day rehabilitation	Episodes of care – youth A&D supported accommo-dation	Episodes of care – youth outreach	DTAU – youth residential drug withdrawal	Total
Ramsay Health Care Limited	308													**308**
South West Healthcare									12					**12**
Total	**14,200**	**10,029**	**1,936**	**1,554**	**5,222**	**1,263**	**19**	**2,029**	**602**	**660**	**47**	**412**	**1,597**	**39,571**

List of figures, tables and boxes

Policy guide

Appendices – Funding rules

Acronyms and abbreviations

ABO	blood group system
ACCO	Aboriginal community-controlled organisations
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standard
AIDS	acquired immune deficiency syndrome
AIMS	Agency Information Management System
ALOS	average length of stay
AN-SNAP	Australian National Subacute and Non-Acute Patient
AOD	alcohol and other drugs
AR-DRG	Australian Refined Diagnosis Related Groups
ASD	atrial septal defect
CCU	Critical Care Unit
CORE	Centre for Outcome and Resource Evaluation
CSO	Community service organisation
DRG	diagnosis-related group
EBA	enterprise bargaining agreements
ECT	electroconvulsive treatment
ED	emergency department
F1	Financial Data
FCP	Family Choice Program
FIM™	Functional Independence Measure
GEM	geriatric evaluation and management
HACC	Home and Community Care
HARP	Hospital admission risk program
HBPCCT	Hospital based palliative care consultancy team
HEN	Home Enteral Nutrition
HITH	Hospital in the Home
HIV	human immunodeficiency virus
ICT	information communication technology
ICU	intensive care unit
IHPA	Independent Hospital Pricing Authority
LOS	length of stay
MDS	Hospital Minimum Payroll and Workforce Employee Dataset
MHCSS	mental health community support services
MICA	Mobile Intensive Care Ambulance
NBCSP	National Bowel Cancer Screening Program
NGO	non-government organisation
NHT	nursing home type
NFC	Nationally Funded Centres
NHRA	National Health Reform Agreement
OP	Specialist (Outpatient) Clinics

PAC	post-acute care
PARC	prevention and recovery care
PC	palliative care
PSRACS	public sector residential aged care service
RIR	residential in-reach
SACS	Subacute ambulatory care services
SMF	State managed fund
SOP	Statement of Priorities
STI	sexually transmissible infections
TAC	Transport Accident Commission
TCP	Transition Care Program
TPN	total parenteral nutrition
VACS	Victorian Ambulatory Classification and Funding System
VAED	Victorian Admitted Episodes Dataset
VCDC	Victorian Cost Data Collection
VIC-DRG	Victorian-modified Diagnosis Related Group
ViCTOR	Victorian Children's Tool for Observation and Response
VINAH	Victorian Integrated Non-Admitted Health
VRSS	Victorian Respiratory Support Service
WASE	Weighted Ambulatory Service Event
WAU	weighted activity unit
WIES	weighted inlier equivalent separation