NSW Health Subacute Care Reform Implementation Plan

A component of the National Partnership Agreement on Hospitals and Health Workforce Reform

1. Executive summary

Under the subacute care component of the National Partnership Agreement on Hospitals and Health Workforce Reform, NSW is to receive $165.652m. This funding will be allocated to the 8 Area Health Services (AHSs) in NSW to enhance services across all four subacute care types – rehabilitation, palliative care, geriatric evaluation and management (GEM), and psychogeriatric care - targeting older people, children, Aboriginal people and other residents in geographic areas in urban and rural NSW that are currently under-serviced.

The structure and profile of subacute services varies across NSW. Logically, services are better developed in areas with larger populations, and especially in the Sydney greater metropolitan region. Funding will be distributed among AHSs based on a needs-weighted funding formula that takes into account both historical activity levels and the health needs of each Area's population. This funding model has been selected as it provides a strong equity component. Funding will also be provided to the Children's Hospital at Westmead as it provides subacute care to a discrete population group.

Specifically, NSW Health will use the funding made available under the National Partnership Agreement to establish and/or strengthen:

1. Evidence-informed models of subacute care including supported patient self management and rehabilitation in acute care settings;
2. Effective service delivery models such as day hospitals, hub and spoke models where specialist teams in hubs provide support to generalist teams in community, and specialist networks;
3. The subacute care workforce by:
    - increasing the numbers of specialist and generalist clinical staff to increase the volume and quality of subacute services in hospital and community settings
    - investigating new roles and extended scope of practice for specific disciplines including Nurse Practitioners and non-medical clinical specialists/"leads" in nursing and allied health to enhance the quality of care provided in the community and improve health outcomes for patients and clients
    - designating Data and Performance Management positions to monitor performance in subacute care against agreed targets so as to improve health outcomes for the residents of NSW.
4. Clinical and decision-support technology through developing telehealth models in subacute care.

Enhancing subacute care services will also provide an opportunity to strengthen links with General Practitioners (GPs) and for community health services to provide integrated primary health care. Improving access to subacute care in both hospital and community settings is also expected to assist in acute demand management.

NSW also proposes to implement information systems for the improved collection of activity and performance data.

The funding will also provide an opportunity to train and educate the generalist workforce in subacute care. In rural and remote NSW, services are necessarily small in size as the population numbers are also comparatively small. There is therefore a need for the generalist workforce to be skilled across the range of subacute care types. The education and training of this workforce is critical to improving access to quality subacute care in rural and remote NSW.

The NSW Health Implementation Plan for Subacute Care Reform presents a high level synthesis of plans currently being developed by each AHS. Initial planning has already taken place at both statewide and AHS levels. Further work is required to finalise the particular strategies to be pursued by each AHS and at a statewide level, and the contribution each will make to achieving the growth target of 20% additional activity over the four years. The national work to be undertaken on improved measurement and data for subacute care, including an auditable method for measuring growth in service provision for subacute care, will assist in finalising AHS-level planning. NSW Health expects to provide AHS-by-AHS activity targets for both hospital and community subacute services – using the data and conversion factors agreed nationally – by December 2009.

A number of risks and constraints have been identified in developing this state Implementation Plan, including data quality, coding practices, workforce supply and lead time for capital works. Consideration must also be given to the fact that the NP funding is limited to a four-year period. The NSW Department of Health will work with AHSs to mitigate these risks and will implement statewide strategies where necessary. NSW will also work with other states and territories and the Commonwealth to resolve issues of national significance.

2. Background

A number of significant demographic factors affect access to and delivery of subacute services in NSW. The NSW population of 6.9 million is heavily concentrated along the eastern seaboard, with 85% of residents living within 50km of the coast. The much smaller numbers who live inland tend to be clustered in the larger regional centres (eg. Tamworth, Bathurst, Orange, Dubbo, Goulburn, Albury, Wagga Wagga), with a scattering of people living in or near smaller satellite towns and more remote communities.

The majority of Aboriginal people in NSW live in metropolitan and inner regional areas, with only 29% of the Aboriginal living in outer regional, rural and remote areas. However, the proportion of Aboriginal people living in an Area increases with remoteness of location in NSW.

The above demographic profile is arguably the most significant factor contributing to differences in the level and configuration of subacute care services provided by each of the 8 AHSs that collectively cover NSW.

This Implementation Plan encompasses subacute service enhancements in all 8 AHSs as well as the Children's Hospital at Westmead which is a major paediatric referral hospital in NSW.

The four subacute service types of rehabilitation, palliative care, GEM and psychogeriatric care are delivered in AHSs across three settings: hospitals, community-based centres, and people's homes.

Preliminary analysis of activity data for subacute care indicates the following for NSW Health:

1 AHS population size correlates with the total volume of subacute care, however the data also reflects differences in classification and coding practices between AHSs which prevent any valid conclusions being drawn at this time about differences in access

ratios by AHS.

2 The vast majority (over two-thirds) of subacute care provided to inpatients is for rehabilitation, with the second highest admitted activity level being for palliative care.
3 Community-based rehabilitation activity may be classified as rehabilitation or GEM. Typically these care types are intermingled as they are provided by Aged Care and Rehabilitation services.
4 GEM and psychogeriatric services represent a much smaller proportion of total subacute activity and are provided largely in the community. Hospital activity in these care types is generally classified as acute for the duration of a patient's admission. This may point to the need for a review of classification/coding practices for these services.

Subacute care is usually evidenced by multidisciplinary management and regular assessments against a management plan for a patient/client that is working towards negotiated goals within indicative time frames. Subacute activity in NSW will be increased by enhancing the medical, nursing and allied health workforce across the state. These enhancements will be further complemented by improvements in service models, systems and processes to strengthen the quality and efficiency of the subacute care workforce.

NSW Health is committed to achieving a 20% growth in subacute activity over the four years 2009/10 - 2012/13. In light of apparent historical variations in classification and coding of subacute care across NSW, and the work still to be undertaken at a national level on data items and conversion ratios, AHS targets for both hospital and community subacute services will be set by December 2009, and may require further refinement with anticipated further improvements in data integrity. Accordingly, this Implementation Plan provides a high level summary of proposed activity, with further AHS-level detail to be provided by December 2009.

3. Elements of the State Implementation Plan

The strategies to be implemented by NSW Health seek to improve the health outcomes, functional capacity and quality of life of patients by increasing the volume and quality of subacute care services in both hospital and community settings. In developing and refining strategies for service enhancements, AHSs are drawing on their AHS Clinical Service Plans (which in turn are informed by the Clinical Service Plans of the clinical streams responsible for delivering subacute care in regional areas).

3.1 Rehabilitation

Rehabilitation services are provided to people with a loss of function or ability due to injury or disease who can reach the highest possible level of independence (physically, psychologically, socially and economically) through a combined and co-ordinated use of medical, nursing and allied health professional skills. Rehabilitation is a vital service, typically but not always following an acute episode, which is aimed at restoring function, with clearly defined treatment goals. The best results are achieved when a patient is highly motivated, well-supported and has the physical and cognitive capacity to take or share responsibility for their program. Rehabilitation is not only important as a means of improving individuals' (and families') quality of life, but can also assist in reducing avoidable demand for acute services.

The need for the establishment and/or enhancement of rehabilitation services has been identified by most AHSs in NSW. There is a demand for hospital, centre based and home based rehabilitation services across NSW, both for high complexity rehabilitation such as in Paediatrics and lower complexity rehabilitation such as that provided in Geriatrics. Older people represent a large proportion of the patient referrals to rehabilitation services, but the

rehabilitation needs of young people and working-aged adults are also being considered by AHSs.

A number of AHSs have identified the need for hospital rehabilitation services to commence in the acute care setting. It has been shown that patients in acute care benefit from early intervention to improve functional capacity and quality of life, and that this can also shorten the subsequent rehabilitation average length of stay. AHSs are also developing plans to increase the volume and quality of hospital rehabilitation services by recruiting medical specialists. A number of these staff will be able to be accommodated in new, state-of-the-art facilities. The proposed increases in hospital staff will also enable consultative services to be provided to community based clients.

Increased community geriatric rehabilitation services are being considered by some Areas to address the needs of older people, people with chronic disease or dementia. Allied health enhancements proposed include neuro-psychology, podiatry, speech pathology, community pharmacy and dietetics. Recruitment will be subject to workforce availability. One AHS proposes to increase centre based rehabilitation for older people with complex needs by providing services through some of its existing Community Health Centres. The expansion of home based services, particularly allied health services, is also proposed for those people who are less mobile and may not receive services otherwise.

In general, the intended creation of new medical specialist, nursing and allied health positions in subacute care will improve the capacity of AHSs to provide clinical student placements and clinical supervision. In rural NSW where workforce supply problems are more serious, consideration is being to appointing non medical “clinical leads” in rehabilitation in a number of hospitals. Clinical leads are senior nursing or allied health staff within a clinical stream providing clinical leadership and supervision. The hospitals appointing these staff would act as service hubs with services delivered primarily in the community. This strategy is proposed to improve clinical supervision and clinical systems and processes which in turn are aimed at improving the quality and efficiency of service delivery.

New and/or enhanced paediatric rehabilitation services are proposed in the major healthcare facilities providing services to children in NSW. Enhancements in paediatric services include those for spinal injury and general neuro-rehabilitation. Positions being considered include Medical Rehabilitation, Case Manager, Clinical Psychologist and Neuropsychologist.

3.2 Palliative care

The emergence of palliative care as a discrete specialty over the last 20 years has been accompanied by an increase in clinical knowledge, skills and expertise in managing complex life-limiting conditions, and particularly in caring for those with advanced chronic disease or other terminal illness. The importance placed on supporting individuals and their families through psycho-social and pastoral care is one of the characteristics that can distinguish end of life care from other types of subacute care. A further distinguishing feature of palliative care is the need for professional advice and support to be accessible around-the-clock for patients being cared for at home.

Proposals being developed by AHSs to enhance existing palliative care services include expanding designated palliative care units in selected hospitals, creating new services for paediatric inpatients, and increasing the clinical workforce (including possibly Nurse Practitioners). The expanded workforce is expected to enable the establishment or improved availability of consultative services for community-based clients.

Enhancing medical, nursing and allied health staffing in palliative care will improve AHSs' capacity to provide clinical supervision and student placements. A number of AHSs are considering the establishment of advanced medical and nursing training places.

As is the case for rehabilitation services, some AHSs are considering enhancing the capacity of nursing and allied health staff to provide quality palliative care by appointing non medical clinical leaders in a number of hospitals. Under this arrangement, the hospitals would act as service hubs with services delivered primarily in the community. Establishing networked Cancer Care and Palliative Care Clinical Services using a hub and spoke service model is also proposed in rural NSW.

Another strategy proposed to increase the efficiency of the workforce and the quality of care provided is to employ nurses to support the existing Palliative Care Clinical Nurse Consultants in rural clusters. The new nurse positions would provide clinical services to clients and carers, advice to other health care professionals, and would develop and evaluate care management plans for clients with complex care needs.

There is also a recognised need for a much larger number and range of clinical staff to build their competence in addressing the needs of people with end stage chronic disease. To this end, a number of AHSs are expressing an interest in educating their clinical workforces on the "Palliative Approach" to care.

Improving access to culturally competent palliative care services for Aboriginal people is being explored by one AHS, through the recruitment of an Aboriginal Health worker in palliative care services.

The expansion of Day hospital/Day Therapy Centre services is under consideration by a metropolitan AHS to enhance access to multidisciplinary assessments, procedures and treatments to enable palliative care clients to remain at home. Day hospitals are a service model used primarily in urban areas in NSW.

The development of community (centre and home based) palliative care services with the recruitment of additional medical, nursing and allied health staff, and procurement of necessary equipment, is being considered by many AHSs.

There are currently relatively few palliative care services targeting children and their families in NSW. New paediatric palliative care services are proposed in urban parts of the State. A new Parent and Sibling Bereavement Service is also being considered for children requiring end of life care and their families.

The need for specialist palliative care support services for residents of Aged Care facilities has been identified as a service gap. Further investigation of options to meet this need is required.

3.3 Geriatric Evaluation and Management (GEM)

Australia's population is ageing and has an increased life expectancy. This demographic trend is particularly important for the health system given the higher per capita use of health services by older people. For example, people aged 70 and over represent 9.7% of the population but account for 41.6% of total public hospital utilisation in NSW. Older people requiring health services often have complex needs relating to a cluster of medical conditions, disabilities and psychosocial issues. Such older people in particular benefit from multi-disciplinary care management and regular assessments against management plans that are working towards negotiated goals within indicative timeframes.

A number of AHSs have identified the need to enhance GEM services in hospitals. Enhancements being considered include the recruitment of additional medical specialists, nurses and allied health professionals to deliver multidisciplinary team care, the development of new units and the expansion of existing services. New teams should also have the capacity to provide services in the community.

Several AHSs in rural NSW are planning to expand inpatient capacity for GEM, or GEM combined with Psychogeriatric or Rehabilitation services. In at least one instance this is likely to require capital works to be funded from the NP allocation.

In rural NSW, AHSs are proposing to establish hub and spoke service networks in rehabilitation and aged care services. In these networks, generalist service providers across the AHS would be supported by specialist multidisciplinary teams. New non-medical clinical specialist positions might also be created in each network to improve the quality and efficiency of GEM services. The capacity of the workforce will be further increased by recruiting at least one additional Aged Rehabilitation Physician and more nursing and allied health staff. Utilising GPs with an interest in aged care is also under consideration due to workforce shortages and difficulties in attracting specialist staff to rural NSW.

Centre based services are proposed to be developed as day hospital services in metropolitan Sydney. This model has been established and evaluated in other parts of Sydney. Day hospital services provide a mix of medical, nursing and allied health interventions to assist people to improve functional outcomes, reduce the need for hospitalisation and achieve earlier discharge from hospital. The service is usually associated with the provision of a range of therapies over the course of 4 hours, which provides opportunities for socialisation and a shared meal. Transport to and from the Day hospital facility is also provided.

A number of AHSs have identified the need for home based Geriatric Evaluation and Management services, particularly allied health services, for those people who are less mobile and may not receive services otherwise. Some services are proposing to target specific disciplines such as Occupational Therapy to enhance their multidisciplinary team and address clients' needs.

3.4 Psychogeriatric care

Psychogeriatric care is care in which the clinical intent or treatment goal is improvement in health, modification of symptoms and enhancement of function, behaviour and/ or quality of life for a patient with age-related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance.

Psychogeriatric care in NSW is provided by aged care and rehabilitation services and mental health services. NSW Health data for both hospital and community psychogeriatric care indicates both significant variation in classification and coding practices across the state, and a strong probability of under-enumeration. Data for this care type will be reviewed and, if necessary, revised by December 2009 to ensure that growth is achieved on actual baseline activity.

Proposals by AHSs to enhance psychogeriatric care services address access to both hospital and community-based services. For example, consideration is being given to developing combined GEM/psychogeriatric units for selected hospitals in northern NSW.

Workforce supply issues are also being taken into account. In rural and remote NSW, options are being explored to recruit geriatricians or physicians with an interest in geriatric medicine to improve access to services, across settings, for people with dementia. The enhancement of community psychogeriatric services to provide support to residents and staff in residential aged care facilities is also being considered.

4. Risks, constraints and mitigation strategies

A number of risks and constraints have been identified in relation to NSW Health's achievement of the agreed performance measures set out in the National Partnership Agreement. These are listed in Table 1 below, along with proposed mitigation strategies that will be further developed as AHS-level plans are finalised.

5. Baseline activity

Baseline activity (2007/08) for the four subacute care types by setting - hospital, centre and home-based - is provided in Attachment A. NSW will report growth in admitted services using separations, and growth in non-admitted services using occasions of service. NSW is unable to report episodes of non-admitted care.

Table 1: Identified risk and proposed mitigation strategies

Identified Risk	Mitigation Strategies
AHSs could have different capacities to implement their local service enhancements, potentially leading to different rates of progress across the state that place at risk the achievement of overall performance targets.	A NSW Health governance structure will be established to oversee, monitor and support implementation of the AHS-level and statewide implementation plans. The NSW Department of Health will also work in a timely manner with the Commonwealth and other jurisdictions to address issues (particularly in relation to data) that may have national significance.
The availability of workforce will greatly influence NSW's capacity to deliver agreed increases in activity across settings and care types.	Strategies to address workforce issues being investigated at AHS level (and particularly for rural AHSs) include use of private and fly-in services, GPs with an interest in subacute care and nurse practitioners. The use of allied health assistants is also being considered in some Areas. It is also expected that progressive national implementation of the Health Workforce Reform NP will assist.
The data collected relating to clinical activity in subacute care in NSW is of varying reliability. The rollout of information systems for the collection of activity and performance data across the State may also impact on NSW's capacity to record the required increase in activity.	Additional designated data collection and quality staff are proposed to strengthen data management and analysis practices.
Variations in practice exist across NSW (and very possibly across all jurisdictions) in relation to recording changes in the type of care that a patient receives during their stay in hospital (eg. their progression from acute to subacute care). This variation raises questions about the accuracy and completeness of data on inpatient subacute care activity.	NSW will work with the Commonwealth, other States and Territories to develop guidelines for care type changes during hospital admission.
Currently there is a 6 month lag in the availability of accurate activity data.	The NSW Department of Health will work with AHSs to improve data quality and completeness to reduce lag.

Identified Risk	Mitigation Strategies
The lead time for capital works and equipment such as modified buses to accommodate wheelchairs (day hospital) and other specialised equipment may impact on NSW's capacity to deliver the required increase in activity.	AHSs will commence the detailed planning required as soon as their implementation proposals are approved.
Lack of formal in-service training opportunities for the generalist health workforce in subacute care.	The NSW Department of Health will work with AHSs to investigate and pursue training options.
The quality of Information regarding clinical training places for the workforce categories in subacute care in NSW needs to be improved.	The Department of Health will work with AHSs to ensure that appropriate data capture and reporting systems are in place.
Opportunities and systems for knowledge management and information sharing at both a statewide and national levels.	NSW supports the establishment of a national web-based knowledge management centre.
Increasing subacute care activity is likely to have flow-on effects in terms of increasing demand for other services for which no additional funds are available.	The NSW Department of Health will work with AHSs to address these issues in the wider budget context, as far as possible. Inter-agency discussions may also be required in terms of managing flow-on demands on non-health community care services.
Minimal capacity to sustain increased activity beyond 2013 in the absence of ongoing NP funding.	AHSs will take this into account in their final Implementation Plans.

6. NSW commitment

As agreed in the National Partnership Agreement on Hospital and Health Workforce Reform, NSW will:

1. Review this plan at least biannually to take account of emerging issues (unless otherwise agreed nationally).
2. Participate in national arrangements established to address:
    1 Enhanced provision and mix of subacute care services, with a particular focus on the types of subacute care most needing expansion and on regional areas with the greatest need for enhanced services.
    2 Quality and data improvements through agreed models of care, including improved data collection and reporting arrangements.
    3 Strengthened capacity of the multi-disciplinary subacute care workforce; including improved geographical distribution, an increase in the supply of the workforce and development new workforce models.
3. Provide agreed data to the Commonwealth—including performance information as set out in the National Partnership agreement—and participate in work with national data collection agencies to collect and evaluate data on subacute care.
4. Publicly report (in a nationally agreed format) on its performance against the annual growth targets for subacute care published in this plan. The first report will measure the first 6 months of progress (June-December 2009) while subsequent reports will measure progress over a full financial year.

NSW will work with the other States and Territories and the Commonwealth to achieve national agreement on improved measurement and data for subacute care including an auditable method for measuring growth in service provision for subacute care.

NSW will nominate and support representatives on a Subacute Care Measurement Working Party to steer the following stages.

1. Define the measures and data required to report the Subacute NPA performance indicators.
2. Develop and agree data item definitions.
3. Undertake a cost study to establish suitable conversion ratios to enable annual growth in services to be measured for:
    - both hospital and community-based services,
    - each of the four care types; and
    - subacute care as a whole.

    The conversion study is to develop resource weightings to be used to:
    - recalculate 2007/08 baselines, for reporting from 1 July 2010; and
    - measure growth against those baselines.
4. Identify suitable benchmarks for all subacute care types.
5. Develop business cases for the addition of new data items to existing National Minimum Data Sets (NMDSs) for ongoing reporting.

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Subacute care baseline activity: 2007-08

	Type of care				
	Rehabilitation	**Psychogeriatric**	**Geriatric Evaluation and Management**	**Palliative**	**Totals**
			Admitted		
Separations (patients)					
Hospital based	25,750	1,010	1,806	8,341	36,907
Hospital-in-the-home	0	0	0	0	0
Total admitted separations	25,750	1,010	1,806	8,341	36,907
			Non-admitted		
Occasions of service (volumes)					
Centre based	452,832	43,147	429,271	214,924	1,140,174
Home based	64,686	9,764	177,861	147,142	399,453
Combined Centre & Home based	517,518	52,911	607,132	362,066	1,539,627
Other (please specify)	10,712	3,358	38,106	1,902	54,078
Total occasions of service	528,230	56,269	645,238	363,968	1,593,705
Total group sessions	25,075	2,319	23,645	1,954	52,993

Notes and definitions

- All HITH in NSW at present is regarded as acute care provided in the community.
- NSW Health classifies non-admitted occasions of service by 'clinic type'. For the purpose of reporting baseline data, NSW Health has mapped clinic types to the four subacute care types.
- NSW is unable to report episodes of non-admitted care.
- Subacute care activity in the community is supplemented by nursing and allied health services funded by Home and Community Care and/ or National Respite for Carers Day Therapy Program.
- Urgent further work is being undertaken to ensure that only relevant activity is included in the baseline data. It is expected that the refined data will be included in the December 2009 version presenting AHS-level plans.

Data item	Meteor ID or other definition
Admitted	
Admitted patient	268957
Separations	327268
Care type	270174
Patient day	270045
Hospital-in-the-home	327308
Non-admitted	
Non-admitted patient	268973
Episode	N/A to NSW
Group Session	A group service is provided where a group of non-admitted patients who are not members of the same family receive any health care service(s) directly from an employee/s of a service unit of a health care facility and a record is made of the occasion showing the nature of the service(s) and the number of participants.
Care type	270174 (this is the admitted definition and does not apply to NSW)
Occasion of Service	313837

National Partnership Agreement on Hospital and Health Workforce Reform
Subacute care reform component — Plan to enhance Subacute Services

Year	Patient type Unit of measure for services	Admitted Separations[1]	Non-admitted NAPOOS[2]	Combined (*) Patient day Equivalents[3]	State-wide strategies: care types to be grown and the modes of care to be emphasised (e.g. out-patient rehabilitation, admitted GEM, etc.). Consideration of regional aspects and regional service provision should be discussed where appropriate.
2009-10	Services in 2007-08	36,907	1,646,698	853,622	
2009-10	Targeted growth for 2 years			5% + 5% compounded	In the first 2 years (2009/10 and 2010/11), NSW will deliver 5% plus 5% compounded growth on 2007/08 baseline data (ie. 42,681 plus 44,815 patient day equivalents, equalling an additional 87,496 patient day equivalents). It is expected that a number of the strategies to be implemented will have a lead time of 6-12 months. Proposals to enhance subacute services across care types and settings are outlined in the body of the document. AHS targets will be set by December 2009 when definitions for non-admitted occasions of service and conversion ratios are confirmed.
2010-11	Targeted growth (%) for 2 years				
2011-12	Services in 2010-11			988,174	
2011-12	Targeted growth for year			47,056	
2011-12	Targeted growth (%)			5%	
2012-13	Services in 2011-12			1,037,583	
2012-13	Targeted growth for year			49,409	
2012-13	Targeted growth (%)			5%	In summary, over the 4 years, NSW will deliver an additional 448,690 patient day equivalents across the different care types and settings

1 To convert separations to patient days, multiply separations by 17.18 days (ALOS)
2 In NSW, using local definitions for non-admitted occasions of services, 1 patient day is equivalent to 7.5 NAPOOS.
3 "Patient day equivalents" is the term used to describe the sum of admitted patient days and NAPOOS converted to patient day equivalents.