Implementation Plan

National Partnership Agreement

Hospital and Health Workforce Reform

Schedule C: Sub acute care

Schedule C: Sub acute care

Context

The funding available under this NPA provides the opportunity to enhance the provision of subacute care across the four areas of rehabilitation, palliative care, geriatric evaluation management and psychogeriatric care as defined in the national health data dictionary 14th edition (AIHW 2008).

Queensland's Implementation Plan for the subacute care reform component focuses on enhancing the rehabilitation service capacity in targeted locations across the State.

Implementation of this plan will increase the number of rehabilitation beds by 89 and the sub-acute workforce over the four year period, enhancing rehabilitation capacity in the south east corner, central Queensland and north Queensland. This will in turn enhance the provision and mix of inpatient, outpatient and community-based sub-acute services. This will enable Queenslanders to access sub-acute services in the right place and at the right time, to meet their needs.

Although Queensland is focusing on enhancing rehabilitation capacity, a number of initiatives are also being progressed in tandem in sub acute care to build a comprehensive service system. These initiatives will contribute to growth in overall activity over the four year period.

The funding available under this NPA will deliver the following enhancements to sub acute care services in Queensland:

SUB ACUTE CARE TYPE	ENHANCEMENT
Rehabilitation $96.2M	• 15 rehabilitation places at Rockhampton Hospital plus outreach services around the district e.g to Yeppoon and Mt Morgan. • 44 more rehabilitation beds in Sandgate, Brisbane • 30 rehabilitation beds or step down beds at Parklands Townsville.
Palliative Care funded within existing Queensland Health resources	• Queensland Health will undertake a review of the current palliative care service system during 2009-10 and develop a strategic direction for palliative care services in Queensland.
Geriatric evaluation and management $1M	• Queensland Health will expand the provision of the Online Geriatric Assessment Service to the 20 major Queensland public hospitals.
Psychogeratric services Additional FTE are funded through an existing Queensland Government commitment.	• 44.30 additional FTE over a three year period from 2007-08 to 2009-10 have been allocated to the Older Person's Mental Health program.

Final bed numbers will subject to available budget.	• Additional beds have also been planned within the State run residential aged care facilities and the older persons extended treatment inpatient services.

Opportunities and Constraints

1. Rehabilitation Services

Rehabilitation Services in Queensland comprise both general and specialist rehabilitation, delivered in both hospital and community settings. For example:

- In Queensland most metropolitan and regional hospitals have designated rehabilitation units. Some have services that in-reach to acute wards, others have services that outreach to the community. Models of care vary depending on location, complementary services, funding and staffing.
- The Spinal Injuries Unit at the Princess Alexandra Hospital in Brisbane is a 40 bed inpatient unit that provides both acute care and rehabilitation for people with a spinal cord injury.
- The Brain Injury Rehabilitation Unit at the Princess Alexandra Hospital in Brisbane is the only one in Queensland and services both Queensland and Northern NSW. It is a 26 bed unit and provides intensive rehabilitation for people with an acquired brain injury.
- There are seven Community Based Rehabilitation Teams (CBRT) in Queensland. These teams were initially established to focus on stroke rehabilitation but now provide more general rehabilitation services. The goal is to enable earlier discharge from hospital, reduce demand on hospital based rehabilitation programs and improve access to services for patients closer to home.

Opportunities

- **Increased capacity**

The funding available to Queensland through this NPA provides the opportunity to enhance the number of rehabilitation beds and complement the already planned increase in bed numbers over the four year period. This focus is consistent with one of the key objectives identified in the *Statewide Rehabilitation Medicine Services Plan 2008-12.*

This plan was developed with input from a broad range of stakeholders including, medical specialists, planners, health care providers and regional executives. It provides both the strategic and operational direction to service delivery and resource investment in rehabilitation services statewide.

Queensland has fewer rehabilitation beds than other jurisdictions, based on a benchmark of 30 beds/100,000 population[1]. As the Queensland population ages and grows in number, demand for rehabilitation services will increase.

[1] Australasian Faculty of Rehabilitation Medicine (AFRM) standards 2005.

The Queensland government has already provided additional funding to progressively expand non-admitted sub-acute services throughout the state. This funding has been used to expand the allied health workforce attached to sub-acute outpatient clinics, day hospitals, community-based rehabilitation teams and specialist outreach services in Townsville, Cairns, Mackay, Sunshine Coast, Toowoomba and Brisbane.

The Queensland government has already provided significant funding for the purchase of additional rehabilitation beds. These beds are being implemented progressively throughout the state in line with comprehensive local planning to ensure the most appropriate targeting of these resources.

The 89 additional beds and community based rehabilitation services will be provided in both central and north Queensland regions, therefore building on the recently enhanced access to rehabilitation for people living outside the main population centres.

- **Collaborative work across Government.**

Queensland Health is continuing to work with other Government Departments to support the transition of patients with a disability from hospital to live within the community. This will free up beds within both dedicated rehabilitation facilities and acute hospital wards and also improve the quality of life for people with severe disabilities who require support to live independently.

- **Optimal care for acute stroke**

A framework for the delivery and monitoring of optimal acute stroke care is being developed by Queensland Health. This framework will draw on data gathered as part of the National Stroke Audit, international comparisons, input from stroke clinicians and the work of clinical networks around Australia. The framework will include a focus on coordinated care, early active rehabilitation and the involvement of a multi-disciplinary team.

A Service Model is being developed for community rehabilitation services of which post acute stroke patients make up a large proportion of the treatment group. The service model has a patient centred approach using the International Classification of Functioning, Disability and Health (ICF)[2] and provides the following:

- Emphasis on effective and ongoing communication between the Community Rehabilitation Teams and the client's General Practitioner.
- Encouragement of the client and carer to be involved in the rehabilitative process
- Emphasis on the need to provide staff with the support they require to work effectively and safely.

2. Palliative Care

Queensland Health Service Districts received approximately $8.3M in Commonwealth funding in the 2008-09 year to purchase palliative care services in a community setting from domiciliary nursing services like Blue Care, Spiritus or through Community Health.

Health Service Districts also provide inpatient palliative care services from their base funding in all public hospitals and for public patients in private hospitals. In the 2007-08 year 5,237

[2] The ICF recognises that disability is a universal human experience and shifts the focus from cause to impact it places all health conditions on an equal footing allowing them to be compared using a common metric – the ruler of health and disability. Furthermore ICF takes into account the social aspects of disability and does not see disability only as a 'medical' or 'biological' dysfunction.

episodes of palliative care equating to 54,494 bed days were provided to public patients in public hospitals and to public patients in private hospitals.

Queensland Health also funds ten organisations to provide a range of direct and indirect palliative care services including hospice care, respite care for children with a life-limiting condition, hospice services in the home, specialist palliative care counselling advice, bereavement and counselling support and information, education/training and research.

The ten organisations (government and non-government) receive a combined total of approximately $4M per annum from Queensland Health to assist in the cost of delivering these services. In addition to this funding Karuna Hospice Services receives approximately $200,000 per annum to provide the Palliative Care Information Service (PCIS). This is a database with information about palliative care services and other community based services. This is a free service providing information to members of the public and health professionals.

Queensland Health also funds Mt Olivet Hospital $10.8M per annum to provide a range of inpatient services including palliative care and a palliative care consulting service to Wynnum Hospital.

Demand for palliative care services continues to grow as the Queensland population grows and ages. In February 2009, the Queensland Government delivered a funding support package of $886,000 to seven non-Government providers of palliative care services across the state.

Opportunities

Queensland Health will undertake a review of the current palliative care service system during 2009-10 to map the existing service system and Government investment, identify gaps and longer term funding opportunities within the context of increasing demand and viability of the current funding arrangements.

The review will be informed by key national and international directions in palliative care and will draw on recent work by the Council of Palliative Care Australia in developing the national policy document: *A Guide to Palliative Care Service Development.*

One of the key deliverables will be development of a strategic direction for Palliative Care in Queensland that describes a range and mix of service types delivered in a number of different settings.

3. Geriatric evaluation and management

Geriatric evaluation and management is care in which the clinical intent or treatment goal is to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient. This may also include younger adults with clinical conditions generally associated with old age. This care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. Geriatric evaluation and management includes care provided:

- in a geriatric evaluation and management unit; or
- in a designated geriatric evaluation and management program; or
- under the principal clinical management of a geriatric evaluation and management physician or,
- in the opinion of the treating doctor, when the principal clinical intent of care is geriatric evaluation and management.

The Geriatric Liaison Service (GLS) which has been established at The Prince Charles and Royal Brisbane and Women's Hospitals is interdisciplinary and provides comprehensive medical, nursing, functional and psychosocial assessment, with a particular focus on discharge planning for the older adult.

The GLS includes a geriatric registrar supported by a geriatrician, clinical nurse consultant, ward social workers, allied health and continuity of care coordinators and offers the following:

- Screening of all referrals received for inpatient care in geriatric and rehabilitation (internal and external)
- Risk assessment of patients age >65
- Inpatient geriatric assessment of the acute care patient
- Inpatient Consultation by geriatrician
- Liaison with acute services for early identification of need for subacute care or rehabilitation
- Prioritise and acceptance of referrals to waitlist for admission to extended care or rehabilitation units

Since being introduced the length of stay for patients who have been managed using the service has decreased significantly.

Opportunities

- **The Online Geriatric Assessment Services.**

Geriatricians are vitally important to the care of older people but are in short supply and are inaccessible to older patients in many provincial and rural hospitals in Queensland. The distribution of geriatricians shows a concentration in the South-East corner of the State with no geriatricians located between the Sunshine Coast and Cairns.

In addition to the geriatric assessment services provided by the geriatricians[3] (staff and visiting specialists) working for Queensland Health, an e-health supported geriatrician-led comprehensive geriatric assessment (CGA) service has been established at Princess Alexandra Hospital, Toowoomba Base Hospital and Redland Hospital. This model has been operating for 12 months and outcomes to date include improved access to geriatric assessment and reduced waiting times for assessments by the Aged Care Assessment Teams.

$1M funding provided under this NPA will be used to expand the provision of this service throughout Queensland through the provision of comprehensive electronic geriatric assessments over the internet to the 20 major Queensland public hospitals.

Expanding access to geriatric services through online services will improve equity of access to Geriatric Evaluation Management Services (GEM) through more efficient utilisation of geriatricians' time. The model utilises existing clinical staff (nurses) to conduct standardised assessments using a well established suite of assessment tools (interRAI) and for these assessments to be forwarded online to a geriatrician for review. Information from assessments is synthesised into a profile that includes problem lists, risk profiles and recommended areas for intervention and review.

The use of common assessment tools will ensure that there is a common understanding of a patient's profiles regardless of the location of the assessment and who conducted the assessment. This will enable an alternate geriatrician to provide services should the usual

[3] There are 21.91 FTE geriatricians

geriatrician be unavailable to provide services, thus creating more flexibility within the geriatrician workforce.

The processes uses existing Queensland Health IT infrastructure and will comply with Queensland Health's IT security arrangements.

Older people will benefit from this program as it enables:

- Improved access to geriatricians
- Comprehensive case preparation
- Reliable, consistent and standardised measurement of clinical indicators
- Reduced data duplication
- Streamlined discharge planning
- Electronic communication both within and outside the hospital including direct referrals to the Aged Care Assessment Program to facilitate access to Australian Government funded aged care programs.

4. Psychogeriatric care

Psychogeriatric care is care in which the clinical intent or treatment goal is improvement in health, modification of symptoms and enhancement in function, behaviour and/or quality of life for a patient with an age-related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance. The care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. It includes care provided:

- in a psychogeriatic care unit;
- in a designated psychogeriatic care program; or
- under the principal clinical management of a psychogeriatic physician or,
- in the opinion of the treating doctor, when the principal clinical intent of care is psychogeriatic care.

The State's largest psychogeriatric unit (16 beds) is co-located with the Geriatric and Rehabilitation unit at the Princess Alexandra Hospital. Ten beds adapted for older people are sited in the Royal Brisbane and Women's Hospital Mental Health Unit. Small community teams serve Rockhampton, Sunshine Coast, Gympie and Royal Brisbane and Women's Hospital Districts. The Toowoomba Older Persons' Mental Health Service provides outreach services to some areas such as South Burnett. A limited service (mostly nursing only) is provided to Mackay, Moranbah, Charters Towers and Cairns districts.

At Princess Alexandra Hospital, sub-specialist services are provided to medical and surgical inpatients but in most places all hospital based mental health consultations are provided by general mental health services or specialised consultation-liaison psychiatry services.

Extended Treatment Older Persons Inpatient Units are specifically designed for people generally aged 65 years and over who have severe and persistent mental illness which is complicated by disorders associated with ageing. Services provided include assessment, ongoing treatment, rehabilitation and residential support for consumers who require non acute mental health care and aged care services.

Some extended treatment older person's mental health beds are located within general aged care facilities specifically for this purpose. This integrated treatment approach requires clear clinical governance structures between mental health and aged care sectors which facilitates effective service provision including defined role statements, standards of care and adequate and equitable reporting, resource allocation, staff education and support.

Opportunity

Additional staff have been allocated to the Older Person's Mental Health program with 44.30 additional FTE over a three year period from 2007-08 to 2009-10.

Additional beds have also been planned within the State run residential aged care facilities and the older persons extended treatment inpatient services. However, final numbers will subject to available budget.

Constraints

In Queensland 12% of the population is over 65 years of age and represents 30% of the total number of hospital admissions. By 2020, 16% of the population will be over 65 years. Demand for sub acute care increase with age and meeting this demand will be an ongoing challenge for the public health system. Longer term funding will be a key challenge in the current fiscal environment across all service types.

Recruiting suitably qualified medical, nursing and allied health staff is an ongoing challenge in the rehabilitation speciality. The current ratios of medical and nursing staff to patients is below the AFRM benchmark. This a result of a lack of specialist skills available in Queensland along with funding shortages. There are 21 fellows of the AFRM in Queensland. This provides a ratio of 0.005 physicians per 1,000 population, compared with 0.02 per 1,000 in NSW and 0.01 in Victoria[4]. The speciality areas of psychogeriatric care and aged care assessment face similar challenges.

Older persons have unique needs due to their often complex care needs which are indicated by co-morbidities and degenerative, disabling and age-associated chronic conditions. Rehabilitation for the older person often leads to extended Lengths of Stay compared to younger persons receiving rehabilitative care.

Baseline data

Baseline data is available for the four care types (attached)

Queensland is also contributing data to the national AROC[5] collections. AROC is a joint initiative of the Australian rehabilitation sector (providers, payers, regulators and consumers). AROC was established by the Australasian Faculty of Rehabilitation Medicine (AFRM) of the Royal Australasian College of Physicians (RACP). The AFRM is the auspice body and data custodian.

AROC was established in July 2002, with the prime objective to collect standardised data for rehabilitation episodes of care. Collection of these data has enabled the provision of a national benchmarking system, which in turn has led to an improved understanding of factors that influence rehabilitation outcomes and costs, and therefore performance of the sector [6].

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[4] Queensland Statewide Rehabilitation Medicine Services Plan 2008-12

[5] Australasian Rehabilitation Outcomes Centre (AROC)

[6] Extract from the Australian Health Review website and the University of Wollongong website.

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Annual Reporting Arrangements/ongoing implementation

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

1. provide annual progress reports and data against the implementation plan.
2. participate in national arrangements to develop agreed data definitions
3. nominate and support representatives to participate in the working party to assist with the development of a nationally agreed data definitions.
4. note the Commonwealth will facilitate the national coordination of data collection and support states' efforts in using these data to improve performance.

Relevant Definitions

ADMITTED PATIENT: a patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients). *METeOR id 268957*

REHABILITATION CARE: (admitted care) rehabilitation care is care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap. It is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames which are evaluated by a periodic assessment using a recognised functional assessment measure. *Code: 2.0*

It includes care provided:

- in a designated rehabilitation unit (code 2.1), or
- in a designated rehabilitation program, or in a psychiatric rehabilitation program as designated by the state health authority for public patients in a recognised hospital, for private patients in a public or private hospital as approved by a registered health benefits organisation (code 2.2), or
- under the principal clinical management of a rehabilitation physician or, in the opinion of the treating doctor, when the principal clinical intent of care is rehabilitation (code 2.3).

CODE 2.1 Rehabilitation care delivered in a designated unit (optional)

A designated rehabilitation care unit is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for rehabilitation care and/or primarily delivers rehabilitation care.

CODE 2.2 Rehabilitation care according to a designated program (optional)

In a designated rehabilitation care program, care is delivered by a specialised team of staff who provide rehabilitation care to patients in beds that may or may not be dedicated to rehabilitation care. The program may, or may not be funded through identified rehabilitation care funding. Code 2.1 should be used instead of code 2.2 if care is being delivered in a designated rehabilitation care program and a designated rehabilitation care unit.

CODE 2.3 Rehabilitation care is the principal clinical intent (optional)

Rehabilitation as principal clinical intent (code 2.3) occurs when the patient is primarily managed by a medical practitioner who is a specialist in rehabilitation care or when, in the opinion of the treating medical practitioner, the care provided is rehabilitation care even if the doctor is not a rehabilitation care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which case code 2.1 or 2.2 should be used, respectively.

CODE 4.0 Geriatric evaluation and management

Geriatric evaluation and management is care in which the clinical intent or treatment goal is to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient. This may also include younger adults with clinical conditions generally associated with old age. This care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is

working towards negotiated goals within indicative time frames. Geriatric evaluation and management includes care provided:

- in a geriatric evaluation and management unit; or
- in a designated geriatric evaluation and management program; or
- under the principal clinical management of a geriatric evaluation and management physician or,
- in the opinion of the treating doctor, when the principal clinical intent of care is geriatric evaluation and management.

CODE 5.0 Psychogeriatic care

Psychogeriatic care is care in which the clinical intent or treatment goal is improvement in health, modification of symptoms and enhancement in function, behaviour and/or quality of life for a patient with an age-related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance. The care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. It includes care provided:

- in a psychogeriatic care unit;
- in a designated psychogeriatic care program; or
- under the principal clinical management of a psychogeriatic physician or,
- in the opinion of the treating doctor, when the principal clinical intent of care is psychogeriatic care.

Code 3.0 Palliative care

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

- in a palliative care unit (code 3.1); or
- in a designated palliative care program (code 3.2); or
- under the principal clinical management of a palliative care physician or, in the opinion of the treating doctor, when the principal clinical intent of care is palliation (code 3.3).

STRATEGY	RATIONALE	CARE TYPE	OUTCOME/OUTPUTS	BUDGET (OVER 4 YEARS)	UNIT OF MEASURE FOR SERVICES
Additional rehabilitation bed capacity within targeted Health Service Districts	Queensland has fewer rehabilitation beds than other jurisdictions, based on a benchmark of 30 beds/100,000 population[7]. The expansion of rehabilitation capacity will result in patients receiving the care they need in the most appropriate setting. There is an average of 450 beds occupied by frail and aged patients on any given night in Queensland public hospitals. Many of these patients would receive more appropriate care in special rehabilitation or transition care facilities. The additional beds will contribute to freeing up beds in public hospitals, enhancing patient flow and relieving pressure on emergency departments	Rehabilitation	15 rehabilitation places at Rockhampton Hospital plus outreach services around the district e.g. to Yeppoon and Mt Morgan. 44 more rehabilitation beds and associated rehabilitation workforce. (Sandgate, Brisbane) 30 rehabilitation beds or step down beds at Parklands (Townsville).	$96.2M (Total)	Rehabilitation patient days, separations, occasions of service[8] Number of rehab beds
Enhanced Palliative Care	The need for a new strategic direction for palliative care services in Queensland has been identified.		Internal funding allocated to the review of Palliative Care services that will provide a new strategic direction for these services in Queensland		

[7] Australasian Faculty of Rehabilitation Medicine (AFRM) standards 2005.

[8] As identified in baseline data attachment 1

Attachment 1

Baseline Data 2007-08

	Type of care				
	Rehabilitation	Psychogeriatric	Geriatric Evaluation and Management	Palliative	Totals
			Admitted		
Patient days (volumes)					
Hospital based	213,631	11,101	8,113	39,312	272,157
Hospital in the Home	-	-	-	-	-
Combined Hospital based & HITH	-	-	-	-	-
Other (please specify)	-	-	-	-	-
Total admitted patient days	213,631	11,101	8,113	39,312	272,157
Separations (patients)					
Hospital based	16,656	498	537	4,266	21,957
Hospital in the Home	-	-	-	-	-
Combined Hospital based & HITH	-	-	-	-	-
Other (please specify)	-	-	-	-	-
Total admitted separations	16,656	498	537	4,266	21,957
			Non-admitted		
Occasions of service (volumes)					
Centre based	10,490	na	21,535	4,396	36,421
Home based	-	-	-	-	-
Combined Centre & Home based	-	-	-	-	-
Other (please specify)	-	-	-	-	-
Total occasions of service	10,490	na	21,535	4,396	36,421

Source: Admitted data: Queensland Hospitals Admitted Patient Data Collection. Non-admitted data: Queensland Health Monthly Activity Collection.

Attachment 2

National Partnership Agreement on Hospital and Health Workforce Reform
Subacute care reform component - Plan to enhance Sub-acute Services
State: Queensland

Sub-Acute Growth Targets by Year

Year	**Patient Type** **Unit of measure for services**	**Admitted** Admitted patient days*	**Non-Admitted** Occasions of service	**Combined** **	**Explanation**
2009-10	Services in 2009-10	277600	37149	296174.5	
	Targeted growth for year	7000	2000	8000	Increased growth in state-wide sub-acute Initiatives
	Targeted growth (%)	2.5%	5.4%	2.7%	
2010-11	Services in 2010-11	284600	39149	304174.5	
	Targeted growth for year	7500	2500	8750	Increased growth in state-wide sub-acute Initiatives
	Targeted growth (%)	2.6%	6.4%	2.9%	
2011-12	Services in 2011-12	292100	41649	312924.5	Increase rehabilitation bed capacity by 89 in designated areas in addition to increased growth in state-wide sub-acute initiatives
	Targeted growth for year	24200	3000	25700	
	Targeted growth (%)	8.3%	7.2%	8.2%	
2012-13	Services in 2012-13	316300	44649	338624.5	Increase rehabilitation bed capacity by 89 in designated areas in addition to increased growth in state-wide sub-acute initiatives
	Targeted growth for year	24200	3500	25950	
	Targeted growth (%)	7.7%	7.8%	7.7%	
2013-14		340500	48149	364574.5	
Accumulative growth over 4 years		22.7%	29.6%	23.1%	

*Does not include transitional care places
**Assume one patient day is equivalent to 2.0 occasions of service
The National Health Data Dictionary V14 Definitions have been used where possible.
NHDD v14 definitions are at http://www.aihw.gov.au/publications/hwi/nhddv14/nhddv14.pdf