National Partnership Agreement on Hospital and Health Workforce Reform

Victorian Government and Commonwealth Government

Sub-acute Care Reform Component Implementation Plan

Contents

1.0 Introduction

As people get older, changes in their physical condition and social circumstance mean that they use health services and community care services more frequently. In the coming years population growth, together with population ageing, will mean that a greater number of people will need health services that are responsive to the needs of older people and those with complex needs.

There is a strong correlation between age and the demand for medical and hospital services. As Victoria's population of people aged over 65 years and particularly people aged over 85 years increases, the number of age-related illnesses and disabilities, for example, stroke, cancer, dementia, fractured neck of femur, arthritis and diabetes, are projected to rise.

People are staying in hospital for shorter periods due to advances in medical treatment and increased opportunities for community-based care. Improving the alignment and integration of community-based programs to support the discharge from inpatient services and preventing or substituting for hospitalisation is a key focus of the Victorian Government. Victoria's vision is for a modern, integrated system aimed to meet the future needs and expectations of communities and individual users of health services. Sub-acute services play a vital role in achieving this vision.

This implementation plan for the National Partnership Agreement on Hospital and Health Workforce Reform (NPA) outlines:

- the current sub-acute service system, the policy context and service mix in Victoria
- strategies to be implemented over the duration of the NPA
- workforce initiatives
- accountability and reporting
- opportunities that are available to sub-acute services in Victoria
- constraints that may affect the delivery of the strategies outlined in this plan
- baseline data and projected service growth and impact on service mix
- contribution to national benchmarks and information dissemination.

It should be noted that Victoria has a significantly higher base for sub-acute services than other jurisdictions. Consequently to raise services by twenty per cent by June 2013 is a significant task. The extent of this risk is not yet fully understood and work during the 2009-2010 year will include further scoping of the impact of the constraints on delivery of the sub-acute implementation plan and the efficiencies possible within the current sub-acute care system.

Victoria's 2007-08 baseline investment in sub-acute care of approximately $480 million delivered approximately 494,000 admitted patient days and 770,000 non-admitted occasions of service.

This implementation plan is a reflection of the current view of sub-acute services in Victoria. We reserve the right to change the strategies outlined in this plan as required while ensuring required expansion of services is met through out the duration of the NPA.

1.1 Victorian sub-acute services

Sub-acute services are a vital stage along the care journey for many patients. They provide a number of programs that support the independence of older people and those with chronic and complex health care needs in hospital and in the community.

Demand for sub-acute services in Victoria is growing with an increase in population, an ageing population and an associated increase in chronic conditions. There is also growth in demand due to increased flow through acute services and changing models of care to enable delivery of services closer to the patient's home.

There are a range of sub-acute services in Victoria such as:

- Rehabilitation: inpatient, community rehabilitation (including centre based and home based rehabilitation), and paediatric rehabilitation services
- Geriatric Evaluation and Management (GEM): inpatient and ambulatory specialist services
- Restorative care: slow stream rehabilitation
- Palliative care: inpatient and community palliative care
- Psychogeriatric care: community mental health services

Rehabilitation, GEM

Rehabilitation, including restorative care and GEM services, is delivered in both an inpatient (admitted) and ambulatory (non-admitted) setting.

- Rehabilitation has a focus on working with people who have a physical disability, are frail, chronically ill or recovering from traumatic injury or illness, to regain and/or maintain optimal function, and to allow people to maximise their independence and return to, or remain in, their usual place of residence.
- GEM involves the sub-acute care of chronic or complex conditions associated with ageing, cognitive dysfunction, chronic illness or disability. These conditions require patients to be admitted for review, treatment and management by a geriatrician and multi-disciplinary team for a defined episode of care. The patient group is usually older people with complex, chronic or multiple health care conditions requiring treatment and stabilisation of those conditions and/or medical review for future treatment options or service planning.
- Sub-acute Ambulatory Care Services (SACS) includes community rehabilitation (centre-based and home-based) and specialist GEM clinics. Community rehabilitation services aim to reduce inpatient length of stay, prevent admissions and readmissions to inpatient services by providing people with home-based or centre-based therapeutic interventions that prevent the deterioration of an existing condition and/or improve functionality. GEM clinics provide specialist assessment, diagnosis, intervention, management, education, advice and support to clients with specific medical conditions.
- Restorative care is slow stream rehabilitation for older people who have completed their acute or sub-acute episode of care and who require low intensity therapy to return to their previous place of residence or to be supported into long-term care. Restorative care encompasses a range of services delivered in residential care settings or the older person's home. It is not the Commonwealth funded Transition Care Program.

Palliative care

Of all the deaths in Victoria annually, nearly 50 per cent have a diagnosis that would benefit from palliative care. This includes all cancers, Motor Neurone Diseases, end stage renal failure, stroke, chronic obstructive pulmonary disease, and end stage chronic cardiac failure. An international study shows that 56 per cent of people with a terminal illness would prefer to die at home.

Palliative care bed based services support those people with the most complex care and treatment needs. Clients receiving community palliative care services in their own homes are less likely to be admitted to an acute hospital bed than people who are not receiving community palliative care services. Community Palliative care is both cost effective and delivers improved care pathways with more appropriate access to services.

Psychogeriatric care

Psychogeriatric care within sub-acute care has been narrowed to people with age–related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by a psychiatric or behavioural disturbance.

Victorian psychogeriatric services are organised and delivered on an area basis known as Aged Persons Mental Health Services (APMHS). These are multidisciplinary teams who provide community-based psychological, behavioural, social and functional assessments and a corresponding range of therapeutic interventions, rehabilitation and case management for older people with severe and enduring mental illness.

1.2 Victoria's investment in sub-acute care

The Victorian Government investment in sub-acute care in 2007-2008 financial year was $480 million. The detail of this is documented in Table 1.

Table 1: Victorian Sub-acute Care Investment 2007-2008

Care Type	**Service**	**Investment ($M)**
Rehabilitation and GEM	Inpatient rehabilitation	144
	Inpatient GEM	126
	Sub-acute ambulatory care services	101
Palliative care	Inpatient palliative care	44
	Community palliative care	29
	Statewide palliative care	3
Psychogeriatric services	Aged Persons Mental Health (sub-acute support)	32
Total		**479**

Activity against this funding is located in Table 2, National Partnership Agreement on Hospital and Health Workforce Reform: Schedule C – Sub-acute care, in section 4.0 of this document.

2.0 Sub-acute service strategies

The following section outlines key strategies that will be implemented in Victoria from July 2008 until June 2013. These strategies will inform Victoria's approach to improving sub-acute services for this implementation plan.

2.1 Victorian Sub-acute Services Planning Framework

The Sub-acute Services Planning Framework (the Framework) was developed in response to the need for an evidence-based approach to service planning. The Framework aims to ensure that the level and mix of existing and future rehabilitation and GEM services is targeted appropriately.

The Sub-acute Services Planning Framework identified the relative deficit of inpatient and ambulatory rehabilitation and GEM services for four of the five rural regions. This will be addressed within the limitations of existing capital infrastructure and available workforce. To progress this work there will be a regional working group established in each region that will review and develop an action plan. This plan will include:

- an outline in gaps in service profiles
- available capacity and what may need to be built
- workforce issues
- gaps in service mix and funding
- alternative models of care and bed substitution impacting on inpatient capacity.

Throughout the duration of the NPA, the Framework will inform the strategies to be systematically implemented. However, it is foreseen that the full implementation of the Framework will not be complete until 2019.

Further information on the Sub-acute Services Planning Framework can be found at http://www.health.vic.gov.au/sub-acute.

2.2 Promoting health independence

The incremental growth in services over time has resulted in a number of different sub-acute care programs, each with their own selection criteria. This has inadvertently created barriers to access and service gaps, resulting in individuals not being able to receive timely care.

The Health Independence Programs (HIP) guidelines have been developed to provide health and community services with direction for more closely aligning these programs. Common policy and procedures between such programs will ensure a less complicated journey for people who require multiple health services.

A person can require one or a combination of services delivered by health independence programs to meet their care needs. During an episode of care this may involve moving between programs. The challenge is to ensure that the person receives the right care, in the right place, at the right time, unhampered by program boundaries (see Figure 1). Each program will continue to have its particular role but will be underpinned by common processes that facilitate improved health outcomes and community integration.

Figure 1: Health independence programs model of care

Further information on the HIP Guidelines can be found at:
http://www.health.vic.gov.au/sub-acute

2.3 Centres Promoting Health Independence

A key strategy to improve integration and coordination to meet the demand for sub-acute services is the development of Centres Promoting Health Independence (CPHI).

The major sub-acute settings in each major metropolitan health service, and each rural region, have been designated as the CPHI for their catchment areas. These centres provide the full suite of continuing care services including inpatient services, both rehabilitation and GEM and a comprehensive range of community rehabilitation and specialist ambulatory GEM services that are delivered in either community based or home based locations.

As a key health resource, CPHI will be a recognised centre of excellence and a 'one stop shop' for older people's health care. Features of the CPHI as a community resource will ensure that it is:

- high profile and easily accessed
- a resource for the acute sector, the community and the consumer, providing expertise in the treatment and care for older people
- an education and training resource – promoting evidence-based practice and intra-sector professional support networks
- a central point in the regional network.

2.4 Reforming care pathways

A significant aspect of delivering the right care in the right place is ensuring care is provided in the least intrusive and most cost effective setting. Initial investigations of care pathways suggest that people are not always receiving care from the most appropriate setting within the care continuum.

Reforming care pathways is a key strategy which will see sub-acute services work closely with emergency departments (ED), acute hospital units and community agencies to prevent admissions and improve access and pathways into sub-acute services. Pathways currently being examined include:

- elective surgery patients
- people waiting for residential care

- geriatric medicine patients.

2.5 Palliative care

The *Strengthening Palliative Care Policy* provides an overarching framework and strong support for an integrated service system that links inpatient and community palliative care services to meet patient choice and ensure best use of bed based resources within Victoria.

This policy also supports regional care coordination and integration of inpatient, community and statewide palliative care services, through population-based approaches to planning and service delivery (the Regional Palliative Care Consortia).

A statewide Palliative Care Clinical Network Advisory Committee will be established in 2009 to provide advice on the implementation of a clinical services improvement program through the Regional Palliative Care Consortia, to explore opportunities for reducing unwanted variation in practice and for benchmarking optimal care.

Use of data is critical to the development of clinical service improvements and the development of effective outcome measures within community palliative care. The Victorian Integrated Non Admitted Health Minimum Dataset (VINAH MDS) community palliative care data base has been modified to collect key outcome measures (refer to section 2.7). Other clinical indicators will be identified and collected through the Consortia for reporting to the department by 2011.

As part of the Strengthening Palliative Care Policy implementation, eight Regional Palliative Care Consortia have been established. There are three metropolitan and five regional Consortia. The Consortia have four major roles within their geographic areas of responsibility:

- regional planning
- coordinating care
- determining priorities for future service development and funding
- designating palliative care service roles to ensure consistent access to specialist palliative care services.

2.6 Psychogeriatic care

The recently released whole of government *Because mental health matters: The Victorian Mental Health Reform Strategy 2009-2019* includes a forward looking reform agenda for older people. This will have a significant impact on acute and sub-acute mental health services and the broader health and aged care service systems.

The Strategy articulates a number of directions that aim to improve mental health outcomes for all Victorians, with a focus on prevention and early intervention. The sub-acute service components are outlined below.

- Developing new and expanding alternatives to inpatient care for older people with severe mental illness, including greater access to sub-acute prevention and recovery care services and intensive in-home treatment and support for older people.
- Strengthening the capacity of specialist aged persons mental health services to provide secondary consultation, training and short term shared care to primary health and mainstream residential aged care services. This

will improve the early identification, assessment and treatment of older people with emerging or existing mental illness and co-morbid physical health problems.
- Developing new collaborative ways of working to better support older people with chronic disease, surgical conditions and co-morbid mental health problems in both hospital and community settings.
- Implementing health promotion and prevention strategies to promote healthy ageing and reduce the risk factors associated with mental illness in an ageing population.

The effective management of older people with a co-morbid mental health and chronic medical conditions was identified as an area of priority in the development of the Victorian Government's Mental Health Reform Strategy. There is a need to ensure that all components of sub-acute care in Victoria can work together to achieve the best outcome for this target group. To this end there is a need for GEM services, APMH and aged residential care providers to work in a more coordinated and integrated way. This will ensure that patients in GEM units receive improved access to Psycogeriatricians and APMH team support whilst those older people receiving care for primary psychiatric diagnosis receive increased support from geriatricians and GEM teams.

2.7 Standardised accountability and reporting

Admitted rehabilitation, GEM, Palliative Care and Psychogeriatric services are all collected using the Victorian Admitted Episode Dataset (VAED). As part of this data collection, scores for the Modified Barthel Index are currently being submitted by health services as the functional independence measure. Work is currently underway to scope and replace the Modified Barthel Index with the Functional Independent Measure (FIM).

Standardised accountability and reporting for non-admitted services is possible through VINAH MDS. Primarily VINAH MDS will provide consistent activity and performance data across Victoria and it will enable the department to meet state and national accountability requirements. The data will inform future policy and service development and provide support for current and future investment in the sub-acute service system. It will provide information about program effectiveness, target population benchmarking, and can be used for service planning and research in the future.

The VINAH MDS is a common data collection infrastructure utilising common standards and the knowledge gained from existing major data collections. VINAH MDS is a person-centred group of data items and definitions that have been aligned with other departmental collections such as the VAED, standard definitions used in the National Health Data Dictionary and Common Client Data Set. It is a robust, integrated framework for reporting unit-level data about complex, multidisciplinary, non-admitted care. This database is used to collect data on SACS (non admitted rehabilitation) and GEM, as well as community palliative care. Of note psychogeriatric data is collected by another system which reflects the alignment of these services with Mental Health.

Implementing the VINAH MDS is a major change process involving managers, clinicians, information technology and health information management staff from health services, departmental staff from both the program areas and the health data sections, and a number of commercial software vendors. In addition to the database itself, reporting is enabled via a centralised electronic reporting structure utilising Health Level 7 (HL7) messaging.

Standardised accountability and reporting measures support the development of frameworks for integrated service planning based on an individual's needs and outcomes, with a better understanding about the clients journey from hospital to home. VINAH MDS will assist with the development of a solid service structure based on a common service model that is informed by effective data collection. This is essential to support the current and future investment in health independence programs, as well as support future reform and the development of better care pathways to improve care for older people and people with complex needs in the community. Further information can be obtained at: http://www.health.vic.gov.au/hdss/vinah/index.htm.

2.8 Workforce enablers

The sub-acute health care workforce is challenged by the increasing complexity of patients as the population ages and medical technology advances. A more multi-skilled workforce with knowledge of the specific care needs of older people and people with complex health needs is required to meet this demand. In response to this Victoria is participating in national arrangements to strengthen the sub-acute care workforce, developing multidisciplinary and interdisciplinary skills and support structures to ensure access to services across hospital and community settings.

The implementation of the Framework, the HIP Guidelines and the *Strengthening Palliative Care Policy,* will inform the strategies to address workforce-related risks to achieve service models and growth targets articulated in this plan. Sub-acute care within Victoria will work with regions and health services to develop and implement local plans to achieve the required workforce mix, and to deliver multidisciplinary and interdisciplinary responses in an increasingly ambulatory and regional service development focus.

Current recruitment strategies within Victoria, in response to sub-acute workforce issues, include:

- specialist training programs such as the Victorian Geriatric Medicine Training Program and the Palliative Medicine Training Program
- academic appointments and centres to support relevant clinical and academic research into sub-acute services
- Nurse Practitioner Program within palliative care.

In addition, workforce retention strategies include the development and implementation of support structures and processes such as:

- communities of practice: promoting partnerships and networks between health services to achieve improved outcomes for target populations in healthcare settings
- scholarships: offered within rehabilitation, GEM and palliative care, in recognition that there have been limited opportunities for health professionals working in sub-acute services to access funding to support professional development activities
- development and implementation of resources and education packages to promote evidence-based practice and provide support for practice change
- Rural Palliative Medicine Purchasing Fund
- administration of Commonwealth Program of Experience in the Palliative Approach (PEPA)
- Training & Development Grants in palliative care

- supporting innovative models to develop allied health assistant and division 2 registered nurses to minimise functional decline for older people in hospital.

Although the Sub-acute Implementation Plan will not address the requirements of the Workforce Enablers section of the NPA, there is a commitment in Victoria to ensuring that the workforce strategies identified in this document reflect and are closely aligned with those being implemented in response to the Workforce NPA.

2.9 Access for Aboriginal and Torres Strait Islander people

Victorian sub-acute care services are committed to ensuring programs are culturally sensitive and can respond to the needs of Aboriginal and Torres Strait Islander people. Health services have been encouraged to work closely with their respective Aboriginal Liaison Officers to improve awareness and practices in providing support, with a particular focus in restorative care. Implementation of the Sub-acute Services Planning Framework will also consider the needs of Victoria's Aboriginal and Torres Strait Islander, particularly in regional areas.

3.0 Opportunities and constraints

Sub-acute care services in Victoria have a number of opportunities that will be pursued throughout the life of the NPA and constraints that will need to be managed.

3.1 Opportunities to improve care

Improve equity of access to service provision

This will be underpinned by the Framework, the implementation of the HIP guidelines for people receiving rehabilitation and GEM services and the Palliative Care Consultancy development. By reorienting health services to deliver on improved access practices and processes, the quality of care will be improved as programmatic boundaries become less siloed and the service system more readily navigated.

The development of the CPHI will ensure patients, especially in regional or rural settings, have improved access to clinical expertise and staff with improved professional support.

Integrate and coordinate services across settings

The Framework and the HIP guidelines implementation will improve integration and coordination of services for people receiving rehabilitation and GEM services.

The development of the CPHI and the implementation of the Framework will improve service coordination between metropolitan and regional settings, with clarity of roles and program designation assisting services to work in partnership to achieve the best outcome for people with complex care needs.

The integration and coordination work to be undertaken between psychogeriatric services and GEM will enhance patient care by ensuring access to appropriate specialists, be it for mental health or an age related medical condition.

Respond efficiently and effectively to demand

Improved data management will assist with increasing efficiencies. VINAH MDS creates economies of scale, adds value to the data (especially around continuum of care) and allows for consistent reporting across numerous non-admitted services. That, in turn, reduces the burden of collecting and reporting for health services while improving the quality and integrity of data reports. Further efficiencies are also created at the department end in receiving and analysing the data.

In addition to the improved data management, improved care pathways will assist in creating efficiencies in care management using processes that are able to deliver more effective care, providing the right care in the right place at the right time.

With both service capability and service access components being comprehensively covered in the Framework it is foreseen that rehabilitation and GEM services can be more fully understood and service development map more closely to need.

Develop practice based on the best available evidence

It is important that health services understand the specific care issues for older people and people with complex care needs, and how to manage these issues according to practice based on best evidence. The design and implementation of the organisational change within health services will be supported by statewide resource development and implementation based on best available evidence.

Improved care pathways to support better patient outcomes

The Reforming Care Pathways strategies provide opportunities for sub-acute services to understand current care pathways for clients and to promote and support health services to develop, implement and evaluate pathways to achieve better patient outcomes.

Implement quality standards and clinical guidelines

The Framework and the implementation of the HIP guidelines will ensure that sub-acute services are included in health service quality improvement programs and that services are of a standard to comply with the Australian Council on Healthcare Standards (ACHS) or an equivalent accreditation agency.

Manage data and funding to support person-centred care

The VINAH MDS is based on a person-centred philosophy, with data items developed to support increased understanding and utilisation of processes that promote the person's care being designed around their needs, rather than what is convenient for the health service. This will support the development of models of service that promote better care for older people and those with complex care needs.

Attract and retain a skilled workforce

Sub-acute care is a preferred area of work for some allied health professionals in Victoria. It is important that we build on this strength through workforce strategies such as skill development, workforce support, such as issues based communities of practice, and support of clinical research.

3.2 Constraints to be addressed

There are a number of constraints that could impact on Victoria's work in sub-acute care. The full impact and solutions to these constraints will be explored in the implementation of the Framework, HIP guidelines and the *Strengthening Palliative Care Policy.*

Data management

It is important that issues relating to data transmission are resolved in a timely manner. Although data is being collected by all relevant health services, difficulties with the HL7 message system remain, due to issues with individual database vendors. These issues are being addressed by health services in partnership with the department. Until this issue is resolved performance against targets for some ambulatory care items will need to be extrapolated. This will not impact on Victoria's ability to undertake service improvements against the NPA targets but will affect initial accuracy in ambulatory rehabilitation. This will be updated and adjusted once all data is collected.

Capital development

The implementation of the Framework is limited by the physical capabilities of some health services for service expansion. Health services need to be able to demonstrate that there is the physical infrastructure to support the quality of services required. These physical constraints will impact on the implementation of the Framework where improving the service mix is dependent upon capital development. It will also influence the overall mix of regional versus metropolitan sub-acute services in rehabilitation and GEM services. Some health services, particularly in regional areas, will not be able to move to the appropriate level of service until capital works are undertaken. These works may not be undertaken during the life of the NPA.

Workforce

Although significant efforts will be made throughout the duration of this agreement to develop and support the sub-acute workforce it will be noted that employment of suitably qualified and competent medical, nursing and allied health staff in the locations most needed to ensure equity of access is difficult and could have an impact on delivering and improved sub-acute service mix particularly in regional settings. This constraint will be addressed in negotiation with regions and health services by exploring solutions that are supported by the NPA Workforce Plan and are in line with regional and local community needs.

The impact of recruitment in regional areas will be minimised where possible by the promotion of partnerships and the exploration of electronic solutions, such as videoconferencing.

Change management

The implementation of this plan requires significant change in health services with both the reorientation of current services as well as the ability to establish and integrate new services. Such changes will ensure sub-acute services play an increasing role in the management of acute hospital pressures assisting with hospital throughput and achieving improved patient outcomes.

The impact of this constraint is partly dependent on the amount of change happening within each health service, how well this work aligns with the organisation's strategic plans and accountabilities, and the size of the organisation. The impact of this constraint will be minimised by the implementation processes employed in the implementation of the Framework, the HIP guidelines, reforming care pathways, the *Strengthening Palliative Care Policy* and the *Because mental health matters: The Victorian Mental Health Reform Strategy 2009-2019.* This will be done in partnership with regions and health services.

Infrastructure, equipment and supporting services

The implementation of the Framework requires an articulated minimal level of supporting services (such as pharmacy or pathology) and access to a comprehensive range of therapy areas, equipment, aids and appliances commensurate to the patient needs within the level of service being delivered. These infrastructure, equipment and supporting services may be difficult to resource within health services, dependent upon the capital development and workforce issues named above as well as access to funding for equipment. This constraint has the ability to impact substantially on the implementation of the plan, particularly in relation to access and quality of services in regional settings, but needs to be more fully understood at regional and health service level.

4.0 Service activity

Service growth targets have been established that improve mix of services within sub-acute care.

4.1 Improved service mix for sub-acute care

Rehabilitation and GEM service mix will be informed by the Framework. Consequently, in addition to the increased focus on community rehabilitation there will be an increase in the proportion of people receiving care at home. It is anticipated that this will increase over the duration of the NPA, particularly in regional settings.

For palliative care there will be an increase in the number of patients in palliative care who are supported to die in their place of choice, with the aim to increase the proportion of patients who realise their preference by 10 per cent each year.

As can be extrapolated from Table 3, the first two years of the plan will concentrate on enhancing bed based services in both metropolitan and regional settings. This will have rehabilitation and palliative care focus. In the subsequent years, service enhancements will have an increasingly ambulatory focus across all aspects of sub-acute care.

4.2 Outcomes (measures against targets)

To measure the 20 per cent growth in services across sub-acute care in Victoria from 2008-09 until 2012-13, targets have been set against an established baseline (see Table 2). These have been determined using definitions outlined in the *Draft Data Guide to establish benchmarks for Sub-acute Care Services*. For comments relating to the baseline measurements see Appendix A.

Appendix B provides a listing of Sub-acute priorities for service growth against targets for 2008-09 to 2012-13. This ranks regions in terms of priority and provides the reasons post 2008-09.

Table 2: National Partnership Agreement on Hospital and Health Workforce Reform : Schedule C - Sub-acute care - Template for sub-acute care baseline activity, using 2007-08 data

	Type of care				
	Rehabilitation	Psychogeriatric	Geriatric Evaluation and Management	Palliative	Totals
	Admitted				
Patient days (volumes)					
Hospital based	208277		214838	70519	493634
Hospital in the Home					
Combined Hospital based & HITH					
Other (please specifiy)					
Total admitted patient days	208277		214838	70519	493634
Separations (patients)					
Hospital based	9806		7864	4797	22467
Hospital-in-the-home					
Combined Hospital based & HITH					
Other (please specify)					
Total admitted separations	9806		7864	4797	22467
	Non-admitted				
Occasions of service (volumes)					
Centre based	306945	44539	46906		398390
Home based	78803	46620	17888	215805	359116
Combined Centre & Home based					
Other (please specify)		5934		6000	11934
Total occasions of service	385748	97093	64794	221805	769440
Episodes (patients)					
Centre based	29941		7160	2616	39717
Home based	3956		2822	8007	14785
Combined Centre & Home based	7423	11972	4231		
Other (please specify)					
Total episodes	41320	11972	14213	10623	78128
Total group sessions	21708	5064	490		27262

Unit measures have been developed with an admitted (beddays) to non-admitted (occasions of service) ratio of 1:2. With this in mind Table 3 demonstrates how Victoria will achieve the required increase in services over the duration of the NPA.

Table 3: Victorian targets 2008-2013

Year	Parameter	Admitted	Non Admitted	Combined
		bed days	OOS	Ratio 1:2
2007-08	actual	493634	769440	878354
2008-09	services in 08-09	534565	808440	938785
	targeted growth for year	40931	39000	60431
	targeted growth(%)	8.3%	5.1%	6.9%
2009-10	services in 09-10	565981	825940	978950.5
	targeted growth for year	31416	17500	40165.5
	targeted growth(%)	5.9%	2.2%	4.3%
	growth on 07/08			11.5%
2010-11	services in 10-11	572537	865940	1005507
	targeted growth for year	6556	40000	26556
	targeted growth(%)	1.2%	5%	3%
	growth on 07/08			14.5%
2011-12	services in 11-12	577742	904440	1029962
	targeted growth for year	5205	38500	24455
	targeted growth(%)	0.9%	4.4%	2.4%
	growth on 07/08			17.3%
2012-13	services in 12-13	582600	942940	1054070
	targeted growth for year	4858	38500	24108
	targeted growth(%)	0.8%	4.3%	2.3%
	growth on 07/08	18.0%	22.5%	20.0%

4.3 National benchmarks

There is a commitment that Victoria will contribute to work with the Commonwealth and other jurisdictions on the development of any national benchmarks that are required within the NPA, sub-acute care. Consequently Victoria will actively participate in collaborative jurisdictional work on the development of uniform data collection and definitions.

As agreed in the National Partnership Agreement on Hospital and Health Workforce Reform, Victoria 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:
    - enhanced provision and mix of sub-acute care services, with a particular focus on the types of sub-acute care most needing expansion and on regional areas with the greatest need for enhanced services;
    - quality and data improvements through agreed models of care, including improved data collection and reporting arrangements; and
    - strengthened capacity of the multi-disciplinary sub-acute 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 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 sub-acute care;
4. publicly report (in a nationally agreed format) on its performance against the annual growth targets for sub-acute 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.

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

Victoria will nominate and support representatives on a Sub-acute Care Measurement Working Party to steer the following stages.

1. Define the measures and data required to report the Sub-acute NPA performance indicators;
2. Develop and agree data item definitions;
3. Undertake a cost study, funded by the Commonwealth, 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
    - sub-acute care as a whole.

    The conversion study is to develop resource weightings to be used to:

    - establish new baselines for reporting from 1 July 2010; and
    - measure growth against those baselines.
4. Identify suitable benchmarks for all sub-acute care types.

5. Develop business cases for the addition of new data items to existing National Minimum Data Sets (NMDSs) for ongoing reporting.

Victoria has submitted the initial baseline data in line with the templates and guidelines provided by the Commonwealth. As agreed this has been collected from 2007-08 data. Victoria will submit progress data on the nationally standardised measurement as required by the NPA.

5.0 Victorian contact details

The senior managers and contact officers responsible for implementation of the sub-acute care reform component of the NPA are:

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It is understood that following the signed acceptance of this plan by the state and commonwealth ministers that the sub-acute care implementation plan will be made public. The report will then be publicly reported annually. This will be done by making the implementation plan and approved progress reports available on the Department of Human Services website.

Appendix A: Comments National Partnership Agreement on Hospital and Health Workforce Reform : Schedule C - Sub-acute care

REVISED Template for su-acute care baseline activity, using 2007-08 data Optional Comments

	Type of Care			
	Rehabilitation	Psychogeriatric	Geriatric Evaluation and Management	Palliative
	Admitted			
Patient days (volumes)				
Explanation of Pt Days Count	Includes: Rehabilitation Level 1 (Non DVA); Rehabilitation Level 2 (Non DVA); Slow Stream Rehabilitation (Non DVA); Paediatric Rehabilitation; and Non Designated Rehabilitation Care type K (Non DVA) actuals for 2007/08.		Includes: GEM (Non DVA) actuals for 2007-08	
Separations (patients)				
Explanation of Separations Count	Includes: Rehabilitation Level 1 (Non DVA); Rehabilitation Level 2 (Non DVA); Slow Stream Rehabilitation (Non DVA); Paediatric Rehabilitation; and Non Designated Rehabilitation Care type K (Non DVA) actuals for 2007/08.		Includes: GEM (Non DVA) actuals for 2007/08	Separations other = hospital based palliative care consultancy teams - total number of new referrals pa
	Non-admitted			
Occasions of service (volumes)				
Explanation of OOS Count	Includes: Rehabilitation Sub-acute Ambulatory Care Services (non DVA), groups counted separately. Note final 07-08 numbers will be calculated using VINAH once all VINAH data in to ensure consistent measure over NPA. Direct contacts only	Distinction between Client Recipient and Non-Client Recipient (Indirect) service contacts Registered contacts only Non DVA 'Other' relate to service contacts within an admitted setting.	Includes: Specialist Clinics (GEM) Sub-acute Ambulatory Care Services(non DVA), groups counted below. Note difference for home based and centre based for specialist clinics not collected by AIMS and therefore use of VINAH which is 35% complete for 2007-08 is used to	Includes all direct care Occasion of service (face to face and telephone contacts). Excludes all indirect care OOS. Other includes consultation occasions of service

			extrapolate home versus centre occasions of service, total number though is from AIMS. Note final 07-08 numbers will be calculated using VINAH once all data in to ensure consistent measure over NPA. Direct contacts only	
Episodes (patients)				
Explanation of Episodes Count	Includes: Rehabilitation Sub-acute Ambulatory Care Services (non DVA), Note AIMS does not collect episode level data so ratio of episodes to occasions of service in VINAH used to calculate total episodes based on total OOS in AIMS as VINAH has only 35% data transmitted at this stage. Note final 07-08 numbers will be calculated using VINAH once all VINAH data in to ensure consistent measure over NPA.		Includes: Specialist Clinic Sub-acute Ambulatory Care Services (non DVA), Note AIMS does not collect episode level data so ratio of episodes to occasions of service in VINAH used to calculate total episodes based on total OOS in AIMS as VINAH has only 35% data transmitted at this stage. Note final 07-08 numbers will be calculated using VINAH once all VINAH data in to ensure consistent measure over NPA.	Centre based care counts total number of palliative care clients attended pa across the four day hospices
Explanation of Group Sessions Count	Includes rehabilitation groups (Non DVA) -using VINAH definition where session type=group. Groups calculated using VINAH data which is 35% complete and averaged for total AIMS occasions of service. Note final 07-08 numbers will be calculated using VINAH once all data in to ensure consistent measure over NPA		Includes GEM specialist clinic groups (Non DVA) -using VINAH definition where session type=group. Groups calculated using VINAH data which is 35% complete and averaged for total AIMS occasions of service. Note final 07-08 numbers will be	

		calculated using VINAH once all data in to ensure consistent measure over NPA	

Notes and definitions

Explanation of Count lines have been added to allow jurisdictions to provide optional comment on what has been included

Note: The data should include only the care types specified. Do not include Transition Care or Maintenance care.

Please do not record services as both group and individual services.

Appendix B: Sub-acute Priorities for service growth 2008-09 to 2012-13

1. Rehabilitation and GEM

The development of Rehabilitation, GEM and Palliative Care has encompassed the following service growth that will impact on the performance against the targets in the NPA Sub-acute Implementation Plan in 2008-09:

Victorian Sub-acute Service Growth in 2008-2009

Location by Health Service	Service Type
Metropolitan:	
Alfred Health	Restorative Care GEM
Austin Health	Restorative Care GEM
Calvary Hospital	GEM
Eastern Health	Restorative Care
Melbourne Health	Restorative Care
Northern Health	Restorative Care
Peninsula Health	Restorative Care
Southern Health	Restorative Care GEM
St Vincents Health	Restorative Care GEM
Western Health	GEM
Regional:	
Ballarat Health Service	Restorative Care GEM
Barwon Health	Restorative Care Bed based Palliative Care
Bendigo Health	Restorative Care GEM
Goulburn Valley Health	Restorative Care
Latrobe Regional Hospital	Rehabilitation GEM

For the remaining years of the NPA Sub-acute Implementation Plan, 2009-13, service development will be prioritized across regions as follows:

Rehabilitation and GEM:

- **Priority 1: Barwon South West region**. Currently this region is characterized by having the lowest relative level of inpatient (GEM and rehabilitation) services. Of note, South West Healthcare (Warrnambool) has been approved for a capital development that will have an impact on capacity for rehabilitation in 2010-2011.
- **Priority 2: Grampians region**. There is an identified need for inpatient rehabilitation, GEM and sub-acute ambulatory care services.
- **Priority 3: Hume region**. There is a need to develop inpatient rehabilitation and GEM in the region.
- **Priority 4: Gippsland region**. This requires a particular focus on rehabilitation and sub-acute ambulatory care services.
- **Priority 5: Loddon Mallee region**. Access to sub-acute services for the northern part of the region is a significant issue.

Palliative Care

- **Priority 1:** North West Metropolitan region
- **Priority 2:** South East Metropolitan region
- **Priority 3:** Eastern Metropolitan region
- **Priority 4:** Barwon South West region

Some of these needs will be addressed concurrently. The specific services implemented will be informed by:

- Investigating and implementing possible improved efficiencies, (as outlined in the IP)
- Investigating specific service development possibilities within existing capital and infrastructure within regions and health services. In the IP we proposed doing this via the regionally based working groups. This will result in action plans for each region against the recommendations of the Sub-acute Services Planning Framework
- Applying for funding via the annual ERC process.
- Informing capital planning as required.